

# BNSSG Operational Plan 2017 - 2019

# Contents

- Planning for BNSSG Sustainability and Transformation
  - Our population
  - Plan on a page
  - Our strategic approach
- Financial Planning
- Quality and Safeguarding
- Performance Management
- Approach to Work Programmes
- CCG Priorities: 2017 – 19
- Enabling Programmes
- Operational Plan Risks and Mitigations
- Glossary of acronyms

# Planning for BNSSG Sustainability and Transformation

# Introduction

Bristol, North Somerset and South Gloucestershire is a vibrant, dynamic area with a growing and diverse population of nearly one million people. Known for its high quality of life and standard of living, Bristol, North Somerset and South Gloucestershire's population continues to grow year on year. This is as a result of a relatively high birth rate, more people moving into the area each year, and growing life expectancy.

Bristol, North Somerset and South Gloucestershire Clinical Commissioning Groups have committed to work together to commission high quality health services and ensure value for money. In acknowledgement of this, a single accountable Chief Executive Officer has been appointed for the BNSSG CCGs. Our vision remains to improve the health of the whole population, reduce health inequalities and ensure NHS services are fit for the long term.

We want to continue to modernise care and treatment to make it truly designed around patients, efficient and in line with modern life. If a treatment or test can take place in a GP surgery or health centre near a patient's home rather than in hospital, then that is better for the patient and the health system. If patients can request follow-up appointments after treatment only if they feel they need them, rather than by automatic invitation, it saves them and the system valuable time and money.

As well as modernising systems and treatments to improve care, we also need to make the best possible use of resources and return the local health system to financial balance. This will allow us to protect the widest possible range of healthcare services for the broadest possible population.

This Operational Plan highlights the key programmes of work across the BNSSG system, together with the outcomes we expect to achieve. These, along with our CCG strategic objectives and priorities are summarised in the 'Plan on a Page'. We look forward to feedback and comments from patients and the public.

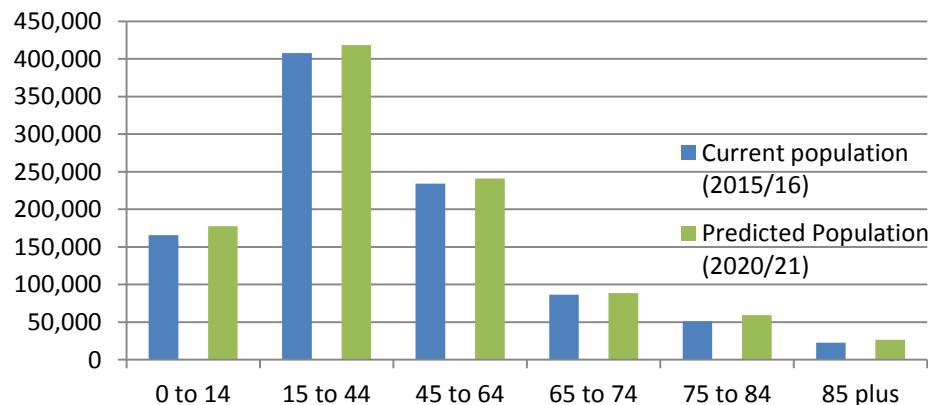
# Our Population

## A growing and ageing population

The total population across BNSSG is 968,314, with 17.5% (164,613) of the population in BNSSG living in the most deprived areas of England. As commissioners we need to plan for population growth as a result of planned housing developments that will attract young families as well as greater numbers of older people who may have complex health needs.

The graphic below shows the expected population changes over the next five years by age bands across BNSSG. The overall population increase is predicted to be in the region of 50,000 additional residents in BNSSG.

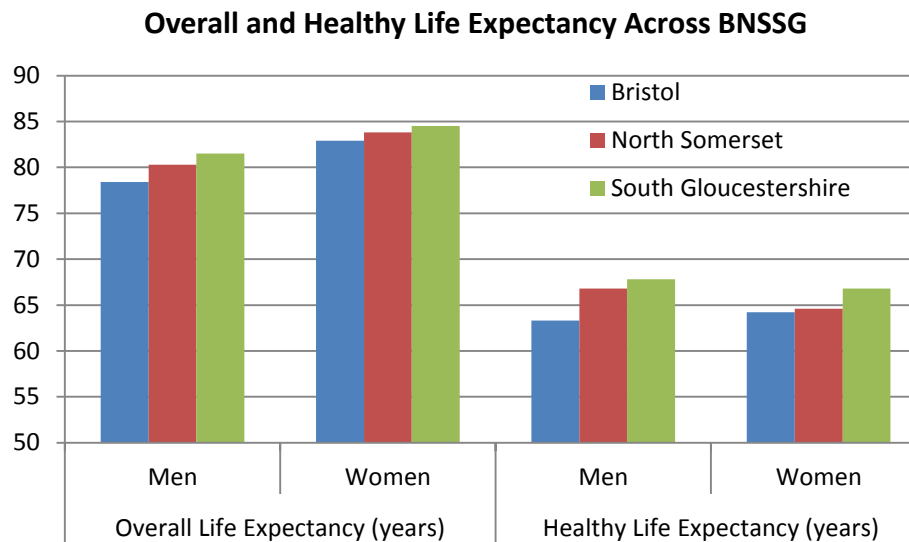
**Predicted Population Change in  
BNSSG 2015/16 to 2020/21**



# Life Expectancy

## Understanding differences in life expectancy

Life expectancy is the average number of years a person is expected to live based on a range of factors. Healthy life expectancy is an estimate of the years of life that will be spent in good health. The below graphic presents the differences in life expectancy across BNSSG.



As well as differences in life expectancy between men and women, we know there are significant differences in life expectancy depending on where people live and their personal circumstances. As commissioners we need to focus on closing this gap in life expectancy.

# Health Equality

Health inequalities are differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact because they result in people who are worst off experiencing poorer health and shorter lives. The Joseph Rowntree Foundation estimates that poverty costs the NHS £29bn per year (equivalent to 25% of the entire NHS budget in England).

It has been demonstrated that people in lower socio-economic groups are more likely to have a greater prevalence of severe and enduring mental and physical health problems. Children living in poverty suffer more than anybody else. More than one in five children starting primary school in England are overweight or obese. Obesity leads to serious increased risk of lifelong health problems including type 2 diabetes, heart disease and cancer. Based on data for 2012-2014, in males the leading causes of the inequality gap are cancers, circulatory diseases, respiratory diseases and digestive disorders, and for females respiratory diseases, circulatory and cancers.

As commissioners our approach to addressing health inequalities is to ensure health services are equitable and address the specific needs of our most deprived communities.

# Health Needs

## Increasing health needs

The health needs of a population reflect the numbers of people suffering from different types of illness. Looking only at the numbers of patients currently being treated for a disease does not show the true prevalence and impact on the population's health. At any given time, there are many people who have a disease but are not aware of it because they have not yet been diagnosed. A robust and well-researched disease prevalence model can help commissioners to assess the true needs of their community, calculate the level of services needed and invest the appropriate level of resources for prevention, early detection, treatment and care.

Disease prevalence methodology was used to forecast the expected increase in disease prevalence for various causes of death for Bristol, North Somerset and South Gloucestershire including: cardiovascular disease, chronic obstructive pulmonary disease, Dementia, Diabetes, and Obesity.



# BNSSG Plan on a Page

**OUR AMBITIONS FOR  
BNSSG RESIDENTS**

**COMMISSIONING PRIORITIES**

**Transforming care pathways to provide better outcomes and value for money**

- Design and implementation of transformed care pathways for Diabetes, Musculoskeletal, Frailty, Stroke and Respiratory \*
- Reducing unwarranted clinical variation and driving value in care pathways
- Cost effective discharge-to-assess and rehabilitation pathways\*

**A resilient and financially sustainable health and care system**

- North Somerset Sustainability Programme\*
- Improving the resilience of primary care services via cluster development and roll out of multi-disciplinary team working\*
- Consistent model of care for care homes residents\*
- Development of detailed proposals for a BNSSG single point of access, as part of a wider approach to urgent care system management\*
- Medicines optimisation\*
- More efficient use of hospital capacity, addressing variation in service delivery, improving patient flow and eliminating out of area mental health placements\*
- Cluster-based model of care for children's community services in Bristol and South Gloucestershire

**Better health through prevention and self care**

- Promoting better self care via social prescribing and patient activation\*
- Focusing on early intervention and self care in care pathway transformation programmes\*

**Better access to good quality services**

- Progress towards the sustainable achievement of NHS Constitution standards , prioritising those for urgent & emergency, cancer and mental health\*
- Pathways for local mental health care, including for those in a mental health crisis

**Our vision is to:**

- improve the health of the whole population
- reduce health inequalities and
- ensure NHS services are fit for the long term.

**ENABLING DELIVERY OF THE CCGs' PRIORITY INITIATIVES**

Successful implementation of the CCGs' commissioning priorities will be dependent on:

**Partnership working with local authorities, Health and Wellbeing Boards, voluntary and community organisations, and NHS England**

**Involving the public, patients and their families in service redesign initiatives**

**Creating a single commissioner voice for BNSSG, supported by a transition programme**

**Roll out of the Digital Roadmap for BNSSG**

**Fit for purpose primary and community care facilities**

***\*BNSSG Sustainability and Transformation Partnership initiatives that the CCGs will prioritise for delivery in 2017-19***

# Our Strategic Approach (1)

## **Working in the BNSSG Sustainability and Transformation Partnership to Deliver the Five Year Forward View**

Every health and care system in England is required to create their own local blueprint for implementing the Five Year Forward View (5YFV). Published in October 2014, the 5YFV is NHS England's national vision for future health services that sets out how the NHS should change so that it can successfully meet the challenges of a growing and ageing population within available resources. The aim is to enable a place-based approach to planning for local health and care systems, encompassing all services commissioned by CCGs and NHS England, and also self-care, prevention and social care, reflecting Joint Health and Wellbeing Strategies. This reflects the need for system-wide involvement and commitment for the successful delivery of major service redesign and transformation.

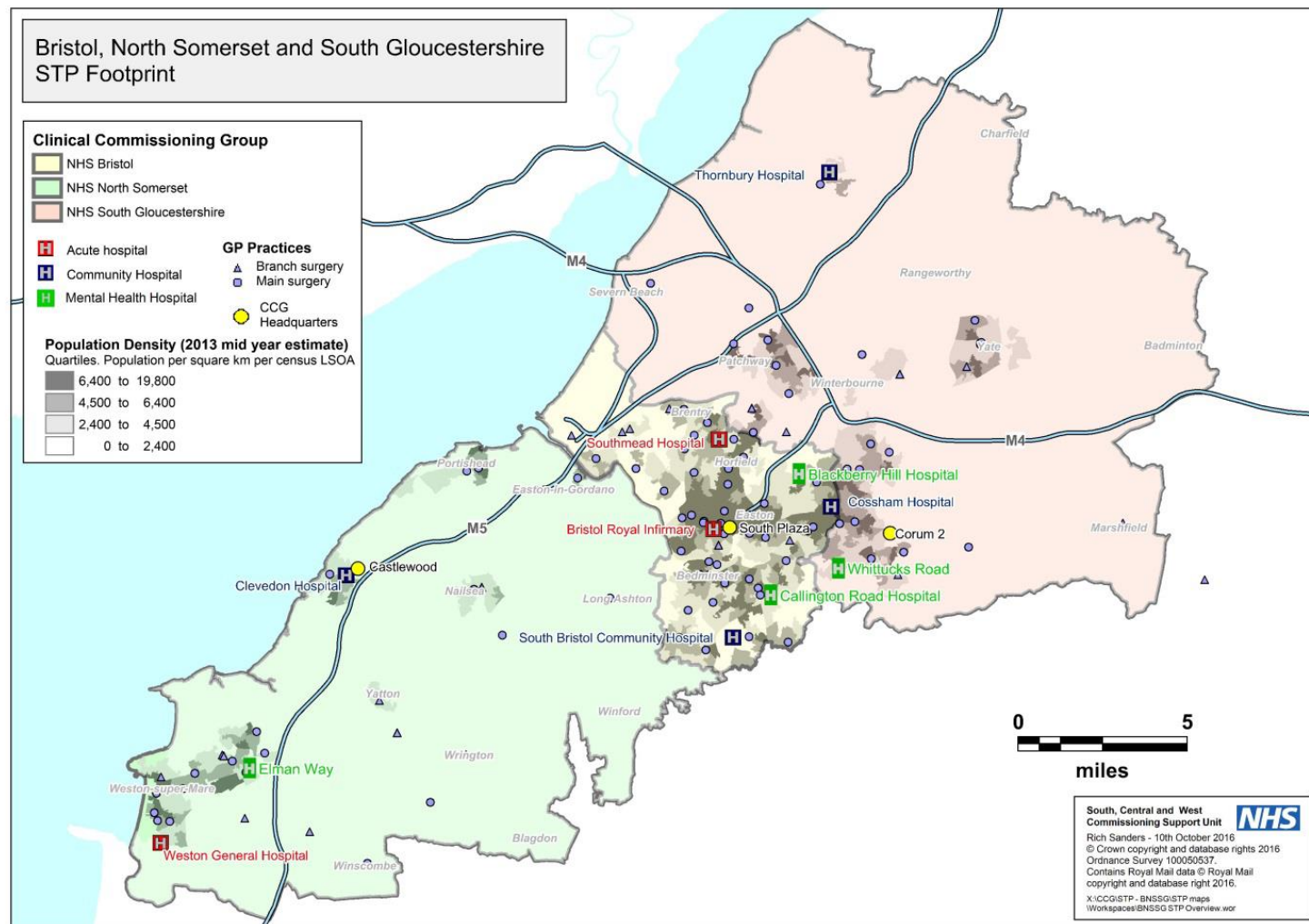
The BNSSG CCGs have worked with NHS provider organisations in the area, including representatives of GP practices, and the three local authorities to develop a Sustainability and Transformation Partnership (STP). Initial, outline plans developed by the BNSSG STP were published on the websites of the STP organisations – including the BNSSG CCGs – in November 2016. The BNSSG health system has agreed to develop a single sustainability and transformation approach for the services provided to a population of over 900,000 people. It reflects a commitment jointly made by the leaders of health and social care services in BNSSG to a collective effort to transform services and improve outcomes for this population.

## Our Strategic Approach (2)

The NHS as a whole faces a very challenging period financially with a need to identify significant efficiency savings, while continuing to meet growing health needs and continue to secure quality improvements. The 2017-18 budget for NHS services in Bristol, North Somerset and South Gloucestershire is £1.15 billion, but health spending in our area is exceeded this budget and there is a growing deficit. If spending continues at its current rate, the deficit will continue to grow, putting the future of health services at risk. Substantial change may be needed if increasing health needs are to be successfully met in future. There is therefore a focus in 2017-19 on system financial recovery, which has been a key driver underpinning our approach to the development of the work programmes and priorities described in this document.

The BNSSG STP plans build on existing plans and learning nationally and locally. This includes the work of BNSSG CCGs to roll out the models of care proposed in the 5YFV:

- Work is already well underway to deliver the new care models for Modern Maternity Services, and Urgent and Emergency Care Networks;
- The learning from the successful enhanced health in care homes model in South Gloucestershire of care is being used to inform a BNSSG model of enhanced care for care home residents;
- The BNSSG STP vision and BNSSG GP Primary Care Strategy reflect the Multispecialty Community Providers model of care; and
- The Viable Smaller Hospitals model of care is informing the North Somerset Sustainability Programme.



The BNSSG Sustainability and Transformation Partnership has 16 member organisations

**Commissioners:** the BNSSG CCGs and NHS England (Specialist and Primary Care)

**Providers:** University Hospitals Bristol NHS FT, North Bristol NHS Trust, Weston Area Healthcare NHS Trust, Avon & Wiltshire Mental Health Partnership, South Western Ambulance Service, Bristol Community Health, Sirona Care and Health, North Somerset Community Partnership  
Primary Care Provider - One Care (BNSSG) Ltd

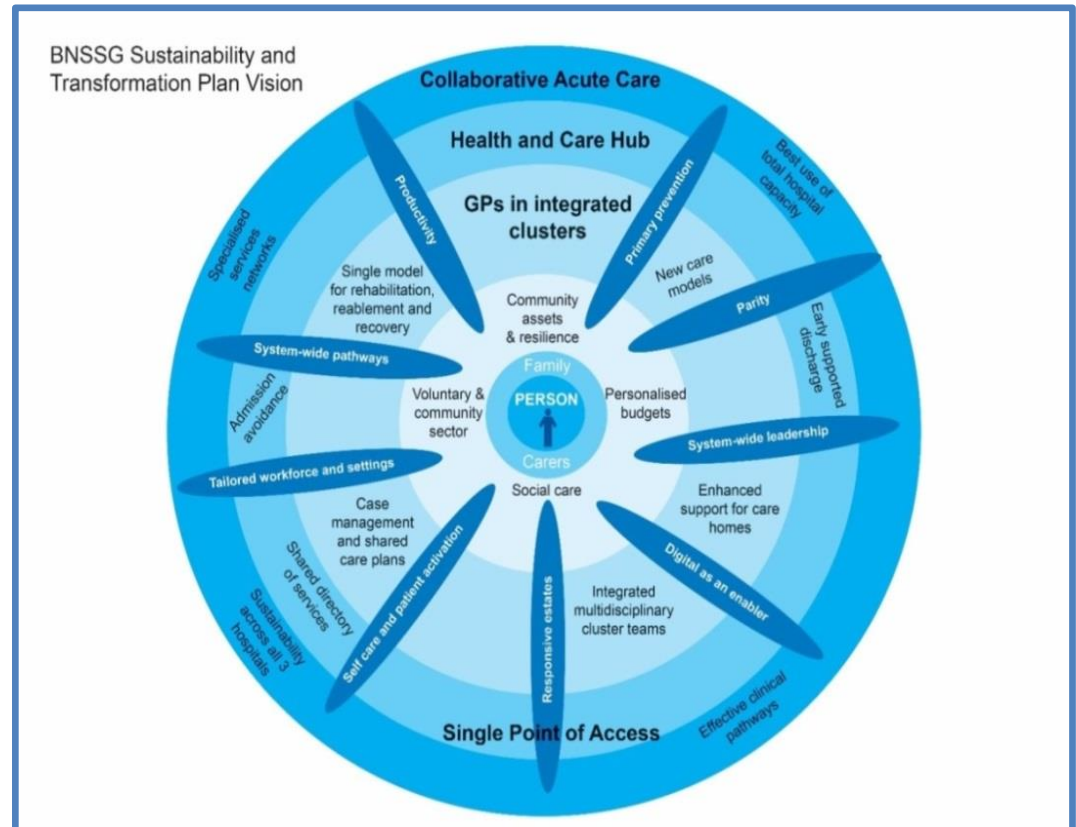
**Local Authorities:** Bristol City, North Somerset and South Gloucestershire

# The BNSSG Sustainability and Transformation Partnership Model of Care

The BNSSG Sustainability and Transformation Partnership (STP) has developed a model of care which lies at the heart of the system wide plans under development for transforming services.

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

The STP has developed its model of care through three major transformational work streams: Prevention, Early Intervention and Self-Care; Integrated Primary and Community Care; and Acute Care Collaboration. Mental health is explicitly integrated within the three work streams.



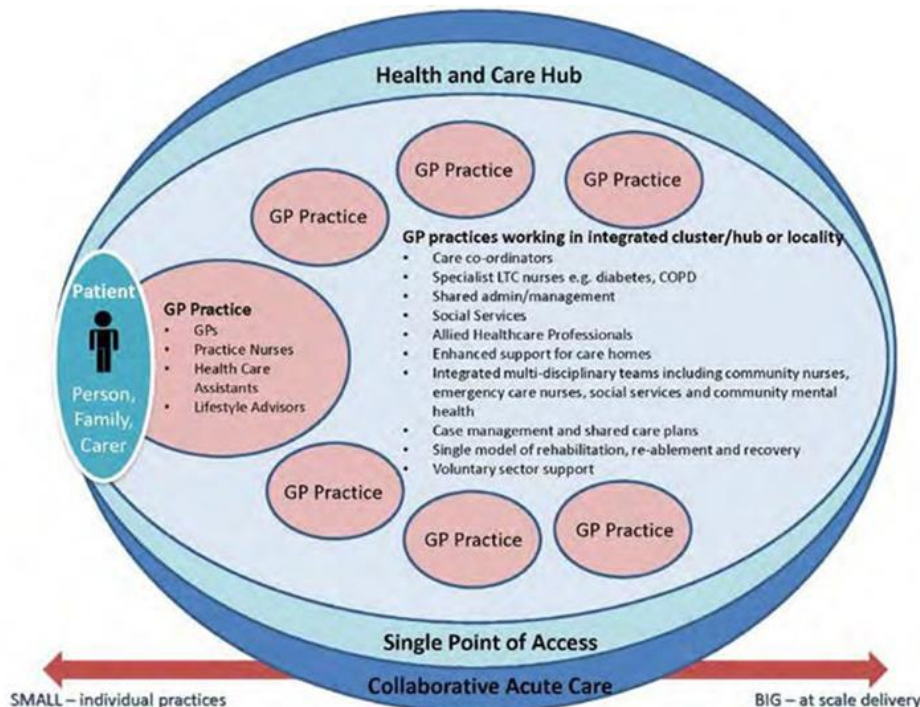
The work of these work streams and enabling programmes has been set out in the submission made to NHS England in October 2016, which is available on the websites of STP member organisations.



# Our New Model of Primary Care (1)

Active collaboration between healthcare providers and the people they care for will sit at the heart of primary care. This patient-focussed, multi-specialty approach will require collaboration between professionals and stronger integrated approach both within and across organisational boundaries to ensure that both personalised and continuity of care is provided and the need to go to hospital is reduced.

Our model will build on the traditional strengths of our 'expert GPs' who will continue to deliver equitable, personalised and continuity of care, proactively targeting services at, and working with, the population with complex on-going needs such as the frail elderly and those with chronic conditions.



By working at scale, primary care providers will ensure consistent, resilient, high quality and safe care with all patients having access to a range of core services but allowing the flexibility to develop services that meet the specific needs of their population. Instead of a 'one size fits all' model, we will work to determine the best solution based on local need and circumstances. The term 'at scale' describes a locality or cluster of practices working together across a larger area to produce efficiencies and therefore increase sustainability.

## Our New Model of Primary Care (2)

Increasingly the general practice teams will be supported by specialist nurses, mental health workers, pharmacists, physicians' associates, healthcare assistants and other healthcare professionals. Building on the tradition of hosting services such as the diabetic retinal screening and mental health services, the teams will be capable of offering more services locally.

An integrated approach will provide the capacity for greater continuity of care through better case management and greater use of shared care plans and a single model of rehabilitation, reablement and recovery. This will benefit those with complex care needs including those who are particularly vulnerable, frail or elderly, the housebound, those in care homes and patients who are in need of end-of-life care.

General practice teams will work collaboratively with, and be closely aligned to, community services and social care. There will be a general shift of appropriate work and resources from acute hospitals where it can be demonstrated that funding would be freed up and it would deliver safe and quality care more efficiently.



# Transforming Out of Hospital Care: Health and Social Care Integration

The BNSSG CCGs have made significant progress towards the integration of our health and social care systems both individually and as part of the Sustainability and Transformation Partnership (STP).

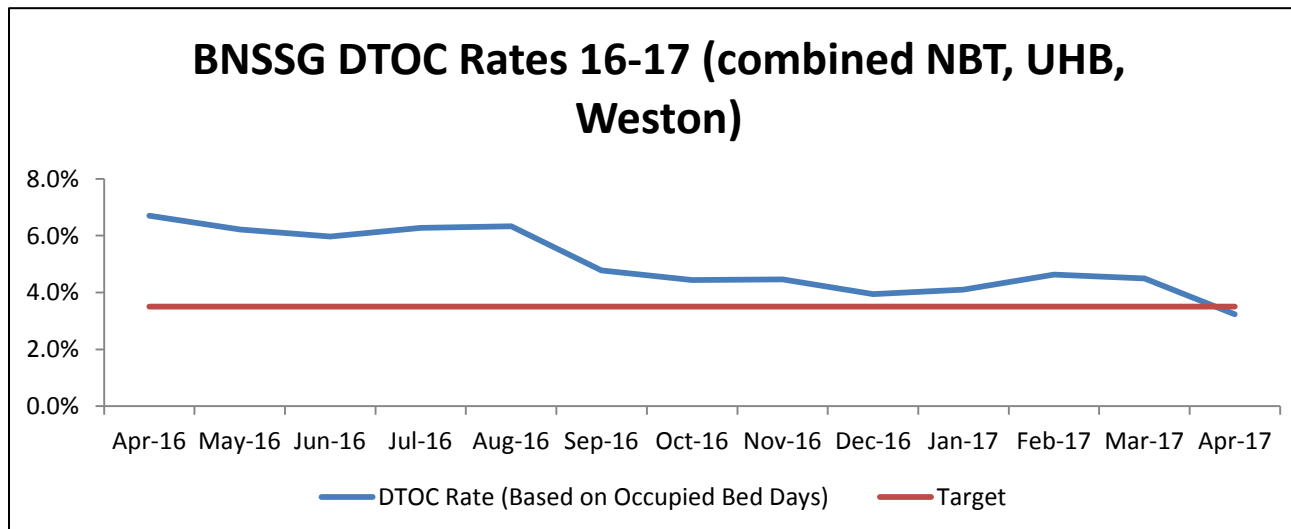
At present, the CCGs each operate a joint commissioning model with their respective local authorities with arrangements that support the alignment of commissioning intentions and pooled budgets. As part of the wider BNSSG CCGs' transition programme to create a single commissioning voice and to support the further development and delivery of the STP's Integrated Primary and Community Health Care plans, in 2017-19 the BNSSG CCGs are working towards greater alignment in their joint commissioning arrangements, including for Better Care Fund plans. The approach will be based on achievements to date and the areas for improvement that have been identified. The three local authorities are also working to deepen their co-operation and recently commissioned a review of the opportunities for increased collaboration across the local authority adult social care departments.

# Integrating Health and Social Care

The STP's Integrated Primary and Community Health Care plans underpin our vision for the integration of the BNSSG health and social care system with the aim to improve peoples' care through:

- Early intervention and management to keep people as well as possible
- Enabling independence ,enabling patients to enjoy the best possible quality
- Plans for 17-18 include :
- Integrated models of care at primary and community level with care planning and coordination provided via multi-disciplinary teams
- Integrated health and care hub providing a single standard service offer across BNSSG

Progress to date has resulted in significantly reduced Delayed Transfers of Care (DTOCs ) across BNSSG :



# Financial Planning

# BNSSG Financial Picture

The CCGs face significant financial challenge during the planning period 2017-2019. The combined financial position for 2016/2017 was a deficit of £55.3m which resulted in an underlying deficit of £58m being carried forward into 2017/18.

The CCGs have been working with providers on a system-wide financial recovery plan, which has identified CCG savings of £83.2m in 2017/18 with a full year effect of £106.7m in 2018/19, leaving a residual gap of £16.8m in 2018/19 to achieve the control totals in both financial years. There is a process in place of continuous identification and delivery to support this achievement and to identify a further £17m of savings to deliver a 1% surplus in 2018/19 and restore financial resilience to the commissioning health system in future years.

It is important to note that many of these savings are high risk and that the residual risk in 2017/18 is estimated to be in the order of £22.5m (1.9%). The CCGs are committed to reducing this residual risk by application of the above process and robust cost containment strategies.

The following diagram shows the Income and Expenditure for 2017/2018 and 2018/2019:

Income and Expenditure	2017/18	2018/19
	£m	£m
Baseline expenditure	1189.5	1161.2
In Year Growth in Expenditure:		
Growth in activity/demand	39.2	44.9
Reinstate Reserves	6.0	0.3
Tariff Inflation	1.1	1.2
HRG4+ Impact	5.4	
Specialist Commissioning Transfer	(1.1)	
RTT	4.9	
	<b>1245.0</b>	<b>1207.6</b>
Baseline Allocation	1131.2	1154.0
Growth in Allocation	24.3	24.9
HRG4+ Allocation	(0.3)	
Specialist Commissioning Transfer	(1.3)	
	<b>1154.0</b>	<b>1178.9</b>
Financial Gap Before Savings	91.0	28.7
Identified Savings	83.2	46.4
<b>(Deficit)/Surplus</b>	<b>(7.8)</b>	<b>17.7</b>
<b>Control Total</b>	<b>(8.0)</b>	<b>(1.8)</b>

Note: This represents the in year position and excludes any debt repayment in either year.

# Financial Allocation

- Five year allocations were published in December 2015, with confirmed allocations from 2016/2017 to 2018/2019 and indicative allocations from 2019/2020.
- 2017/2018 and 2018/2019 allocations have been reconfirmed, with additional allocations received to fund a change in tariff to HRG4+ and to fund the transfer of some specialist activity back to the CCG from NHS England.
- It is important to note that the CCGs have an outstanding historic debt repayment of £55.2m in 2017/2018 which will increase to £68.4m in 2018/2019 based on current plans and is deducted from the allocation in each year.
- The CCGs have received programme growth of 2.1% in 2017/2018 and 2.2 in 2018/2019. Running cost allocations have increased by 0.2% which represents a real terms reduction after inflation as the allowance per head of population is reduced on a sliding scale each year.

Resources	2017/18	2018/19
	£m	£m
Recurrent Baseline Allocation	1,110.6	1,134.9
Growth	24.3	24.9
<b>Total Recurrent Allocation</b>	<b>1,134.9</b>	<b>1,159.8</b>

Non Recurrent Allocations		
HRG4+ Tariff Impact	(0.3)	(0.3)
Transfers to specialist Commissioning	(1.3)	(1.3)
<b>Total Non- Recurrent Allocation</b>	<b>(1.6)</b>	<b>(1.6)</b>

<b>Running Cost Allocation</b>	<b>20.6</b>	<b>20.7</b>
--------------------------------	-------------	-------------

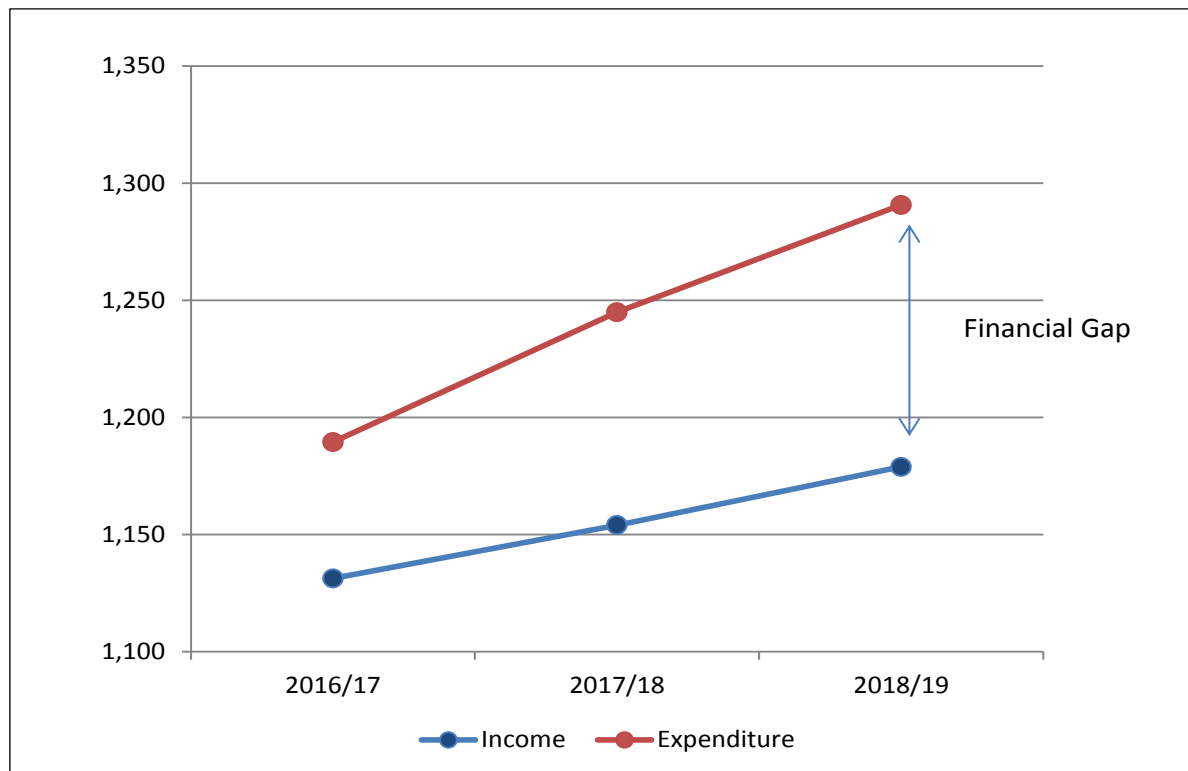
<b>Total Allocation</b>	<b>1,154.0</b>	<b>1,178.9</b>
-------------------------	----------------	----------------

<b>Historic Debt Repayment</b>	<b>(55.2)</b>	<b>(68.4)</b>
--------------------------------	---------------	---------------

# Ensuring Affordability (1)

CCGs have been notified that they need to reduce the deficit from £58m in 2016/17 to £8m in 2017/18 and £1.8m in 2017/18 and 2018/19 to meet the aggregate CCG control total in each year.

The chart below shows the projected growth in the gap between income and expenditure over the next 2 years if no savings are delivered.



## Ensuring Affordability (2)

To achieve the control total in each year requires savings of £83.2m in 2017/2018 and £26.9 in 2018/2019, a total of £110.1m. Schemes have been identified which once implemented for a full 12 months will achieve savings of £106.7m leaving a residual gap of £3.4m to deliver the required control total in each year. Work is ongoing with providers to identify this balance and optimally further savings of £19.5m in order to restore a commissioner surplus in 2018/19.

It is imperative that we implement our share of the system financial recovery plan, working with providers, to deliver the above.

There is a shared recognition with providers of the magnitude of both commissioner savings and provider cost improvement plans and work is continuing to assure total alignment.



# Planning Assumptions

The key financial assumptions on which plans for 2017/18 and 2018/19 are based include the following growth assumptions:

- Acute growth of 2.3%
- Prescribing growth of 5.4% and 4.5% respectively
- Mental health growth of 1.9% in each year
- Community growth of 3.7% and 3.4% respectively
- Continuing healthcare growth of 5.3% and 5.0% respectively

The total cost impact of natural growth is estimated at £36.4m in 2017/18 and £35.0m in 2018/19

Plans are based on national tariff assumptions of 2.1% inflation offset by 2.0% provider efficiency giving a net tariff uplift of 0.1% and a financial cost pressure of £1.1m in 2017/18 and £1.2m in 2018/19

The implementation of the HRG4+ based tariff creates an estimated cost pressure of £5.6m in 2017/18 built into plans

Reserves which were fully utilised in 2016/17 have been reinstated in 2017/18 totalling £17.1m including

- 0.5% CCG contingency reserve
- 0.5% reserve for CCG non- recurrent use only
- 0.5% system reserve to be released only subject to agreement with NHSE

# Overall System Financial Position

## Financial Position

- Commissioner requirement of £82m savings to deliver £8m deficit control total
- Initial Turnaround process identified £65m *commissioner* savings
- The new System Financial Recovery Plan (SFRP) process has identified additional savings opportunities of £17m
- A number of these schemes do not release full costs from a provider perspective and therefore further cost reductions of £3.8m are required to achieve system control totals
- The system has identified back office, estates and a system approach to bank & agency to deliver £3.8m system savings
- Provider CIPs total £75m to achieve control totals

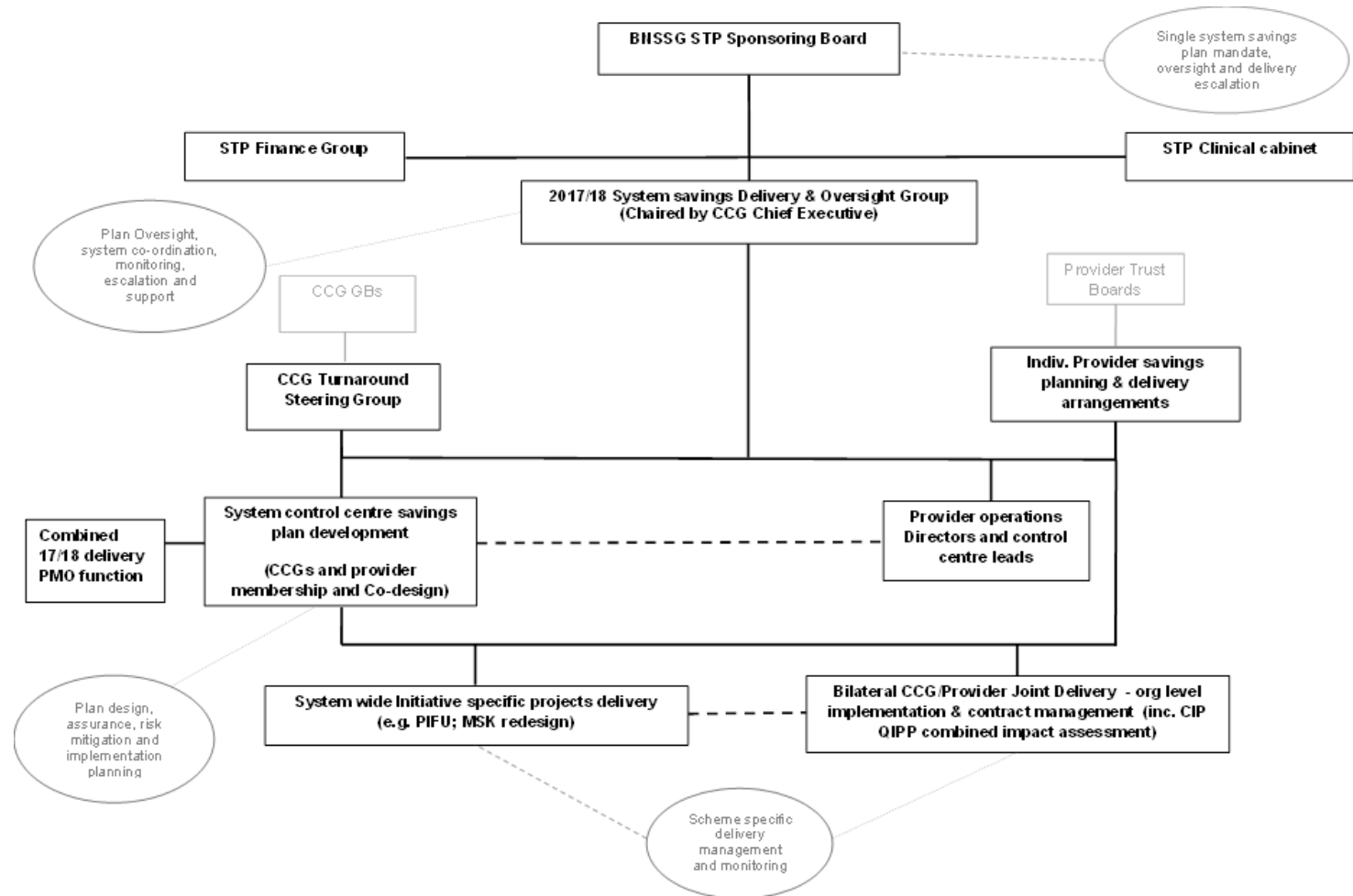
## System Financial Recovery Plan

- £26.0m deliverable by CCGs
- £11.7m in contracts with a focus on PIFU & MSK
- £13.4m in provider subsidies outside PbR contract
- £14.8m in year through system transformation and pathway redesign
- £17.3m SFRP savings
- £3.8m Back office, estates and system approach to bank & agency to eliminate the provider impact of the SFRP savings

# SFRP Risk Mitigation

- CEOs' joint sponsorship of System Financial Recovery Plan
- Agreed principles
  - Single system plan approach on open book basis
  - Avoid cost shifting
  - Secure STF and avoid RAB impact
- Single joint process
  - Control centres now focussed on joint system delivery
  - Regular weekly DoF and DoOps meetings to manage system delivery
  - Clear alignment of STP & Turnaround
  - New System project mandate process
- Specific risk assessment of entire system plan underway by System CFOs

The Governance arrangements for the management of the System Financial Recovery Plan are:



# Quality and Safeguarding

## Our approach to Quality and Safeguarding

- We are committed to ensuring local, sustainable and high quality services for our population.
- We have a shared vision for quality and safeguarding. We have sought to define this for our patients and partners so we can work together in ensuring *the right care* is delivered *in the right place at the right time*.
- Our definition describes three areas:
  - **Safety**, where high quality care is delivered in a safe environment and where those at risk are protected
  - **Clinical effectiveness**, where high quality care reflects the best available evidence on what works.
  - **Patient experience**, where high quality care gives someone an experience of treatment and recovery that is as positive as possible, including acknowledging their wants or needs, and treating them with compassion, dignity and respect.
- We will undertake robust quality assurance for our local providers, where appropriate involving our social care and multi-agency partners, to ensure that services offer '*high quality for all*', i.e. services that our safe, clinical effective, responsive to patient's needs and offer a positive patient experience and are well-led.
- We will do this by:
  - Ensuring all patients have access to high quality care delivered in a timely and effective way embracing the approach '*the right care in the right place at the right time*'
  - Ensuring active patient and public participation to inform CCG decision making
  - Ensuring learning from national guidance and reports, including statutory safeguarding reviews, is identified and implemented where appropriate being built into CCG assurance processes
  - Ensuring quality is at the heart of any transformation or improvements to health services
  - Ensuring that quality is everyone's responsibility and ensuring that effective mechanisms are in place to proactively monitor, triangulate and ensure continuous improvement

# Quality Priorities

Priorities	We will achieve this by doing...	And by when...
Improving quality of services within all local providers	Monitoring of harm free care data and promote improvements in the overall quality, safety and experience of care	March 2018
	Assisting providers to develop a culture where learning from patient safety incidents and from patient experience is embedded in everyday practice	March 2018
	Development of a framework for monitoring quality in nursing homes in partnership with social care and regulatory organisations	
Active involvement in service redesign to ensure quality is addressed at all stages to reduce/mitigate negative impact on patients and service users	BNSSG Quality team to be active members in all project planning discussions and design key stages	July 2017
	Ensuring Quality and Equality Impact Assessments are embedded into project planning cycles	

# Quality Priorities

Priorities	We will achieve this by doing...	And by when...
Develop systems and processes for quality monitoring in primary care services	Developing a Primary Care quality dashboard to provide assurance on quality performance	March 2018
	Mirroring existing systems and processes ensure evidence of learning from incidents (and Significant Event Audits), serious incidents and complaints within Primary Care is shared and embedded	
	Working with AHSN colleagues to promote a safety culture in the primary care setting through the use of tools and training in quality improvement methodology	
Develop a multiagency approach across BNSSG to support the achievement of CCG infection control targets	Developing a BNSSG care pathway, agreed with all partner agencies for achieving zero MRSA cases	August 2017
	Working collaboratively to achieve the reduction in E coli cases and C Diff across the healthcare communities	March 2018



# Safeguarding Priorities

Priorities	We will achieve this by doing...	And by when...
Greater aligned systems and processes for quality assuring safeguarding adults and safeguarding children and embedding these within the wider quality agenda	Safeguarding quality metrics included in BNSSG quality schedule with monthly reporting included in provider quality dashboards which report to monthly provider quality subgroups	July 2017
Work in partnership with the three Local Authorities and Police to respond to the recommendations of the Wood Review in respect of Safeguarding Children Boards and Safeguarding Adults Boards in respect of domestic homicide reviews	Strategic safeguarding lead to attend Avon wide multiagency meeting to shape the new safeguarding arrangements and represent health	July 2017
	Strategic safeguarding lead to interface with National Home Office team to ensure CCG meets statutory requirements for DHR	July 2017

# Improving Performance

# Improvement and Assessment Framework



Bristol, North Somerset and South Gloucestershire  
Clinical Commissioning Groups

Clinical Commissioning Groups are assured by NHS England against their delivery of the Improvement and Assessment Framework.

The attached tables summarise our current performance against the national Improvement and Assessment Framework

Our programmes are aligned to these areas and are working towards improving performance.

IAF Key Metrics	Bristol	North Somerset	South Gloucestershire
Cancer	Needs improvement	Needs improvement	Needs improvement
Diabetes	Greatest need for improvement	Needs improvement	Greatest need for improvement
Maternity	Needs improvement	Needs improvement	Greatest need for improvement
Mental Health	Needs improvement	Needs improvement	Needs improvement
Learning Disability	Needs improvement	Needs improvement	Needs improvement
Dementia Care	Top Performing	Performing Well	Performing Well
Good GP Satisfaction	86.6%	86.7%	85.8%
GP workforce	1.02/1,000 pts	1.00/1,000 pts	1.08/1,000 pts
Electronic Referrals	65.2%	86.0%	62.6%
A&E	83.3% (UHB)	77.7% (Weston)	88.3% (NBT)

Domain	Bristol	North Somerset	South Gloucestershire
Better Health	Requires improvement	Requires improvement	Requires improvement
Better Care	Requires improvement	Requires improvement	Requires improvement
Sustainability	Requires improvement	Inadequate	Inadequate
Leadership	Requires improvement	Inadequate	Inadequate
Overall	Requires improvement	Inadequate	Inadequate

# Delivering Constitutional Standards

The BNSSG CCGs' performance in ensuring constitutional standards are met for local residents is closely tied to that of our main acute providers: NBT, UHB and Weston. We have robust contract mechanisms in place for managing provider performance in achieving these standards consistently, together with a supporting infrastructure of system-wide partnerships for managing the flow of patients in and out of hospitals. The attached table summarises our current performance against the national Improvement and Assessment Framework. A description of how we are approaching performance improvement against our most challenging standards is outlined in the following slides

Our programmes are aligned to these areas and are working towards improving performance

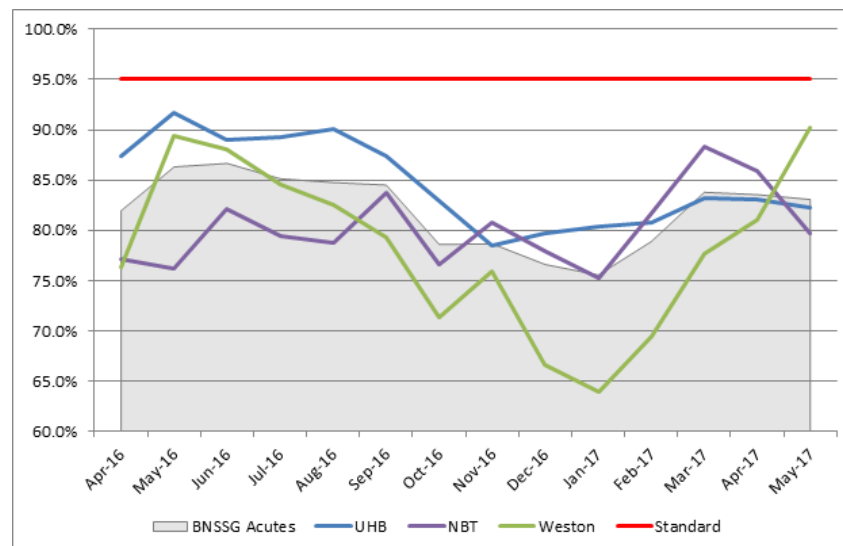
Key indicator	March 2017 Performance	2017/18 & 2018/19 Plan
Referral to treatment time – incomplete pathways	90.6% - below the 92% standard	90.6%
Referral to treatment time – diagnostic pathways	1% - Meeting standard	Meet the 1% breach standard
Cancer 62 day to treatment	83.8% - below the 85% standard	Meeting the 85% standard
Other cancer standards	Achieved 5/7 standards across the full year	Plan to achieve all standards
A&E treatment in 4 hours	Significantly below the 95% standard at all providers (see previous page)	Improve to meet local assurance expectations
Psychological therapy access	Below standard	Bristol – to meet standard across the 2 years North Somerset – meet and maintain from October 17 South Gloucestershire – improve through each year to reach the standard at the end of the year
Dementia	Achieving in Bristol & North Somerset, below standard in South Gloucestershire	Maintain achievement in Bristol & North Somerset, South Gloucestershire meet standard in Sept 2017

# A&E Treatment in 4 Hours

## BNSSG 16/17 Performance

	UHB	NBT	Weston	BNSSG Acutes
Apr-16	87.3%	77.1%	76.3%	82.0%
May-16	91.7%	76.2%	89.3%	86.3%
Jun-16	89.0%	82.2%	88.1%	86.7%
Jul-16	89.3%	79.4%	84.6%	85.1%
Aug-16	90.0%	78.8%	82.6%	84.8%
Sep-16	87.3%	83.7%	79.3%	84.5%
Oct-16	82.9%	76.6%	71.3%	78.6%
Nov-16	78.5%	80.7%	75.9%	78.7%
Dec-16	79.6%	78.0%	66.6%	76.6%
Jan-17	80.4%	75.3%	63.9%	75.6%
Feb-17	80.7%	81.7%	69.5%	78.9%
Mar-17	83.3%	88.3%	77.7%	83.8%
Apr-17	83.0%	85.9%	81.1%	83.6%
May-17*	82.3%	79.8%	90.2%	83.1%

\*until 21<sup>st</sup> May



## Our Approach for 2017/18:

- Create an Urgent & Emergency Care Delivery Plan for STP including a 4 hour performance recovery plan that is linked to the system diagnosis and breach analysis (by end Q1)
- Take forward the following key initiatives:
  - 111/ OOH – Fast track progress towards a clinical hub (revised model Q3/4)
  - Admission Avoidance – Progress with ED streaming and frailty at the front door (Q3 onwards)
  - Hospital flow – Full implementation of the SAFER initiatives and strengthening Ambulatory Emergency Care provision (ongoing)
  - Enabling discharge – Implementation of 'trusted assessor' across BNSSG, strengthening D2A pathways, therapy integration and consistent review of stranded patients

# Referral to treatment time – Incomplete Pathways



Bristol, North Somerset and South Gloucestershire  
Clinical Commissioning Groups

## 16/17 Performance

Stable BNSSG RTT position throughout 2016/17. Year end position of 90.92%.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
<b>BNSSG</b>	90.5%	90.5%	90.5%	90.6%	90.4%	90.4%	90.4%	90.6%	90.3%	90.7%	90.6%	90.9%

## BNSSG RTT Performance 16/17 – Sub-Speciality

Treatment Function Name	Sum of %<18wks
Neurosurgery	75.05%
Trauma & Orthopaedics	82.92%
General Surgery	83.55%
Neurology	90.16%
Other	90.18%
Gynaecology	90.85%
Gastroenterology	91.54%
Cardiology	92.45%
Thoracic Medicine	93.05%
Plastic Surgery	94.27%
Urology	95.82%
Ophthalmology	96.14%
Cardiothoracic Surgery	96.75%
ENT	97.24%
Dermatology	97.26%
Rheumatology	97.51%
General Medicine	98.51%
Geriatric Medicine	98.65%
Oral Surgery	100.00%
<b>Grand Total</b>	<b>90.64%</b>

## Our Approach for 2017/18:

- In line with 'Next Steps on the 5YFV' and as part of system financial recovery plan, we plan to maintain performance at 2016/17 level
- RTT Programme Board in place with delivery plan
- Implement BNSSG Referral Management Service
- All BNSSG T&O referrals now managed via Referral Management service to support patient choice, in line with system capacity
- Implementation of revised clinical policies in orthopaedic surgery
- Redesign clinical pathways in MSK, Ophthalmology and DVT services to reduce demand on hospital services
- Delivery of Elective Care Transformation Programme's High Impact Interventions

# Cancer 62 Day Treatment

## 16/17 Performance

- 2 week wait: BNSSG CCGs as a whole achieved standard, although Q4 decline in performance at WAHT
- Consistent achievement of 31 day standard since September 2016
- 62 day wait standard not consistently achieved despite system-wide CQUIN.. Significant progress is being made and monitored through improvement plans in each Trust
- National Transformation bids for Early Diagnosis being resubmitted which will further aid work towards achieving the target

## 62 Day Cancer standard

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	2016/17
NBT	83.65%	83.46%	85.21%	84.35%	86.52%	81.05%	78.26%	88.66%	90.08%	88.79%	87.50%	89.24%	85.66%
UHB	76.36%	70.65%	70.81%	72.94%	84.45%	80.48%	79.53%	85.20%	81.52%	84.66%	79.03%	81.22%	79.26%
WAHT	88.68%	81.25%	70.00%	75.47%	75.41%	72.58%	76.56%	75.71%	86.67%	73.33%	71.43%	83.05%	77.59%
BNSSG Trusts	81.70%	78.65%	78.25%	79.69%	84.45%	79.93%	78.48%	85.79%	86.56%	85.79%	82.84%	85.60%	82.44%

## Our Approach for 2017/18:

- Continue to refine & hold providers to account for shared timed pathways including robust monitoring of Trust improvement plans
- Performance management of trusts in delivery of actions through contractual processes eg RAPs
- CCG facilitated cancer managers breach resolution meetings in place monthly
- Work with Cancer Alliance to adopt wider system best practice

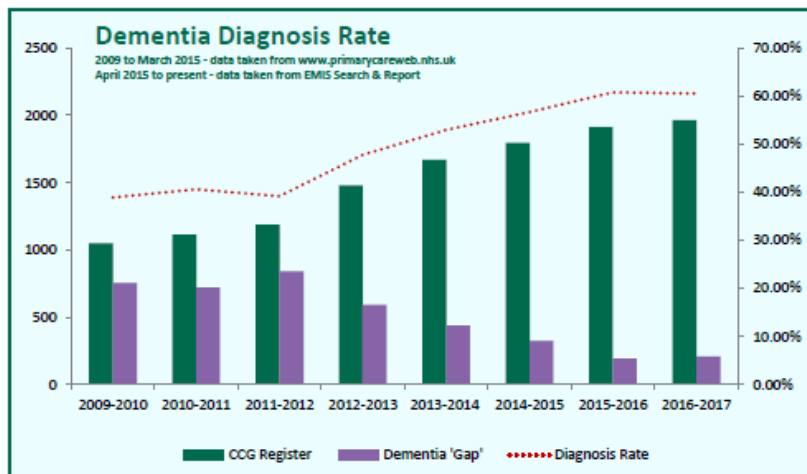
# Dementia

Bristol, North Somerset and South Gloucestershire  
Clinical Commissioning Groups

## 16/17 Performance

- Bristol CCG rating 'top performing', and South Gloucestershire and North Somerset CCGs 'performing well' on the IAF scorecard
- Good performance across BNSSG (81%, 77.4% and 78.1% respectively) in maintaining care plans
- Bristol CCG achieved the diagnosis target, with a diagnosis rate of 73.2% (up from 65.2% in April 2016). Now best performing CCG in South West Region.
- No change in South Gloucestershire diagnosis rate which remains below target. Approach to diagnosis recognised as best practice and CCG clinical lead appointed to the national NHSE CCG Improvement and Assessment Framework expert panel for Dementia
- North Somerset diagnosis rate steadily improved in 2016/17, and in March 2017 reached 64.2%. AWP Memory Assessment Service now seeing 91% of patients within 4 weeks

### South Gloucestershire position:



### Our Approach for 2017/18:

- Continue to engage with GP practices, including to improve data collection
- Work with national team on measurement methodology
- Ongoing programme to raise awareness in wider community, and encourage people to come forward for diagnosis

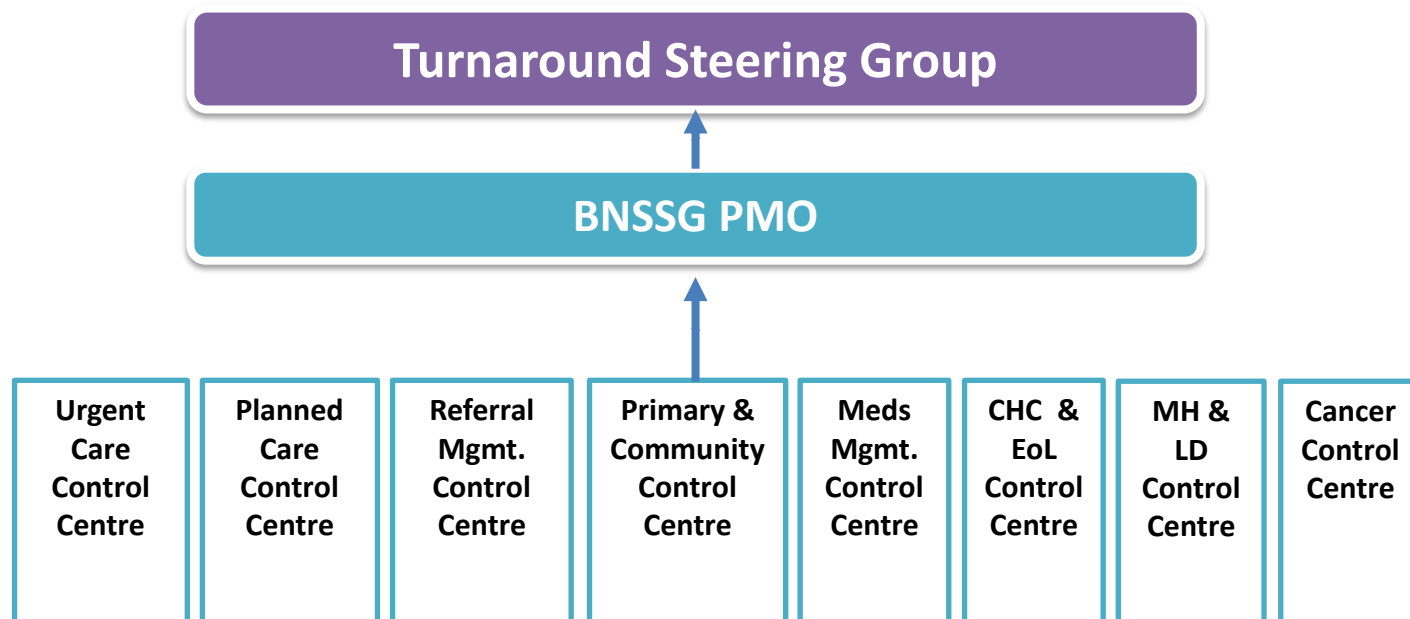


# Delivering our 2017-19 Priorities

# BNSSG Delivery Mechanism

BNSSG CCGs have set up a process to ensure oversight of the delivery of the Operational Plan. The Executive Team require clear insight into progress against the System Financial Recovery Plan to deliver £83.2m of savings. These processes are set up to monitor the design, implementation, and delivery of system plans to achieve our deficit control total.

The savings are developed and delivered through Control Centres supported by a robust Programme Management Office and software programme.



## Delivery and RightCare

RightCare is a value, quality and evidenced-based approach. RightCare is a national programme designed to improve people's health. It helps the NHS and local health economies deliver better value for patients, the public and tax-payers. RightCare is designed to increase the value from our resources. It facilitates and supports clinical commissioning through an approach based on understanding the variation in costs and outcomes in the health system.

*"NHS RightCare has something to offer the whole health economy. It gives everyone the opportunity to concentrate on their population's health and identify and focus on the key areas that will maximise value for patients, the population and the tax payer."*

In January 2017, a financial recovery process was implemented by the three CCGs in order to develop a single set of proposals for achieving reductions in expenditure to meet the agreed control total. We have significantly overhauled planning processes across BNSSG to align business planning and financial recovery across the 3 CCGs as part of this process. It was decided that the rigorous and evidence-informed RightCare approach would be embedded in our processes. RightCare uses a number of tools such as *Commissioning for Value*, Deep Dive packs and the Atlases of Variation to help commissioners, service providers and health professionals deliver the best healthcare.

## NHS RightCare Approach - Maximising value

### PHASE 1

#### Where to Look

Highlighting the top priorities and best opportunities to increase value by identifying unwarranted variation.

### PHASE 2

#### What to Change

Designing optimal care pathways to improve patient experience and outcomes.

### PHASE 3

#### How to Change

Delivering sustainable change by using systematic improvement processes.

Key ingredients **Indicative & Evidential Data**

Key ingredients **Clinical Leadership & Engagement**

Key ingredients **Effective Improvement Processes**

# Delivery and RightCare

The financial recovery process has been progressed through 8 Control Centres which have been established on a BNSSG system-wide basis. Senior Responsible Owners (SROs) for each Control Centre have been identified to lead the development of ideas and work up of those ideas into detailed proposals for consideration by the Executive Management Team prior to respective Governing bodies.

There are 8 planned cycles between April 2017 and April 2019, with each cycle running from an initial Ideas phase through to Implementation and Delivery. Commissioning for Value and other benchmarking tools are key pieces of information for Control Centres to develop ideas for savings.

Each Control Centre will have relevant Commissioning for Value (CfV) Deep Dive packs which will help to link CfV opportunities with current system spend. Control Centres will be expected to use the generic RightCare methodology and approach for everything they do.

# Delivery and RightCare

We have opted for a model in which plans are rigorously assessed for viability and impact by panels of experts covering finance, operations, quality, public health, research, evidence and evaluation.

Control Centre plans are subject to detailed assessments which scrutinise financial savings, the activity impacts on Providers, an initial screening for impacts on both quality and equality, together with a draft project plan for implementation. SROs are held accountable for delivery against them. We believe that our face to face assessment centres provide a forum for a deeper understanding, better discussions and more open challenge to plans.

A working group consisting of Business Intelligence, Finance and GP Evidence Fellows have developed a standard Deep Dive methodology for Commissioning for Value. These packs are issued to each Control Centre, along with suggestions for further investigation and will be used to inform the next planning cycle.

# Infrastructure for Delivery and Reporting

## **Design and Review**

The PMO has been working with Control Centres on the design and submission of Ideas and Plans in 8 week cycles. To date, there are 76 plans in Verto from Cycle 1 and 21 plans from Cycle 2. In the last 4 weeks, the PMO has been working closely with Control Centres to ensure that plans have detailed timelines for delivery with sequential milestones and well-described tasks so that we can monitor progress in implementation.

## **Implementation**

Fully completed Plans when approved are then moved into the Implementation phase. The detailed milestones of the project allow the PMO to track progress against timeline for delivery on a weekly basis.

## **BNSSG Reporting Processes**

A new reporting process is being established between BI, Finance and the PMO on the recognition that the legacy and discrete BI and Finance processes that existed in the 3 CCGs needed to be aligned to the Design, Review and Implementation activities that drive system savings.

# Infrastructure for Delivery and Reporting

## Reporting

The PMO have worked with BI and Finance colleagues to create a process which aligns reporting functions into a critical path which will deliver a consolidated monthly report to the Executive Team. The new process will deliver the first BNSSG CCG monthly consolidated report for EMT and TSG at the end of July.

A reporting structure for BNSSG Executive Management Team has been developed that will describe:

- Savings achieved to date by Control Centre
- Run rates
- Identified savings against planned savings by Control Centre
- Variance from planned activity and financial impacts
- Slippage against implementation milestones
- Gateway Reviews of plans
- Key risks and issues
- Ideas and Plans pipeline
- Exception reports



# BNSSG Work Programme 2017 – 19

# BNSSG Work Programmes

We have identified priorities for the plan with reference to the requirements of our local BNSSG population, the Five Year Forward View and the NHS England planning guidance. This guidance includes the nine 'must do' priorities, which have been woven through the delivery of our programmes. Ensuring successful delivery of the plan is also in part through its alignment to the STP. In developing the STP with a variety of stakeholders across multiple health functions and bodies, this has led to a credible plan that has factored in the views from a number of specialties and health professions.

In delivering our priorities:

- We will work as part of the BNSSG Sustainability and Transformation Partnership to deliver these priorities
- The focus in 2017/18 will be on those that support the delivery of the system financial recovery plan
- A system-wide control centre delivery mechanism will ensure accountability clarity and maintain momentum

Cancer	Cardiovascular	Children & Maternity	Community Services	Continuing Healthcare
Dementia	Diabetes	End of Life	Frailty	Learning Disabilities
Mental Health	North Somerset Sustainability	Planned Care	MSK	Referral Management
Respiratory	Stroke	Transforming Primary Care	Urgent and Emergency Care	Enabling Programmes

# Cancer

**Aim:** The aim is to ensure more cancers are prevented, diagnosis is made earlier, treatment is carried out within national guidance timeframes, patients live well with and beyond cancer and patient experience is improved.

**Current State :** Inequalities with high rates of premature cancer mortality (compared to England) for lung, breast and colorectal cancer in particular, due in part to inequalities, such as gender and deprivation, leading to poor awareness of how to prevent cancer, lower screening uptake, lower proportions of early diagnosis of cancer and increased health risk behaviours (smoking, being overweight, alcohol, poor diet etc.). Due to the changing demographics there will be an increase in the number of cancers diagnosed in the coming years, diagnostic and pathway capacity planning will need to anticipate this.

## Objectives:

- Implement the cancer taskforce recommendations with a particular focus on prevention, early diagnosis, improving patient experience and living well and beyond cancer
- Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

# Cancer

## Prevention

- Increasing uptake of screening for Bowel, Breast and Cervical cancers through working with PHE to distinguish the roles of primary care, community services, the voluntary sector, the CCG and PHE.
- Reducing levels of obesity in the population, specifically targeting those with a long term condition
- Reducing smoking prevalence in adults and preventing uptake of smoking in young people
- Increasing levels of physical activity in the population, specifically targeting those with a long term condition
- Increasing understanding and knowledge of the signs and symptoms of cancer – supporting PHE campaigns on raising awareness of cancers

## Early diagnosis

- Working with Public Health England and GP practices to improve uptake of cancer screening programmes where uptake is poor.
- Continue to work with Public Health to further understand the cancer outcomes for the BNSSG population at various levels; support activities around helping people to help themselves be well; understand more about how our commissioning activities and the arrangements we have with a range of providers can support early diagnosis
  - Deliver on cancer constitutional targets in particular 62 days, and with a focus on ensuring sufficient diagnostic capacity
  - Implementation of NICE guidance
  - Implement stratified follow-up pathways as per the planning guidance
  - Commission the recovery package

# Cancer Programme Summary

## Aims and expected outcome of programme

Implement the cancer taskforce recommendations with a particular focus on prevention, early diagnosis, improving patient experience and living well and beyond cancer.

Deliver on cancer constitutional targets in particular 62 days, and with a focus on ensuring sufficient diagnostic capacity.

## Risk and mitigations

- Performance against the national 62 day cancer standard remains volatile across BNSSG. The work plan is focussed on addressing the issues and monthly performance monitoring meetings are in place.
- Working across multiple organisations as part of the SWAG Cancer Alliance delays decision making and the required pace for work to be carried out. BNSSG STP Cancer Working Group is managing priorities.

## National Must Do

- ✓ STP
- ☐ Finance
- ☐ Primary Care
- ☐ Urgent & Emergency
- ☐ Planned Care & RTT
- ✓ Cancer
- ☐ Mental Health
- ☐ Learning Disabilities
- ☐ Improving Quality

## Five Year Forward View requirements

- ☐ Urgent & Emergency Care
- ☐ Primary Care
- ✓ Cancer
- ☐ Mental Health
- ☐ Integrating Care Locally
- ☐ Funding and Efficiency

## STP Priorities

- ✓ Preventing illness and injury
- ☐ Providing care closer to home
- ☐ Personalised care

## Financial summary

- It is not currently possible to unpick a financial summary for cancer
- Work is carried out on individual initiatives to understand where possible relevant activity and finance information

# Cancer Programme Priorities

Priorities	We will achieve this by doing...	And by when...
To consistently achieve the 85% NHS Constitutional Standard for 62 day waits.	<ul style="list-style-type: none"> <li>Performance monitoring of the timed pathway work.</li> <li>Collaborative working between Trusts and monthly commissioner facilitated breach analysis meetings.</li> <li>Improvement plans in each Trust</li> <li>Delivery against the 10 high impact cancer actions (July 2015)</li> <li>Cancer 62 day rapid recovery plan (NHSI South Region)</li> </ul>	The ambition is to achieve this by July 2017.
Improving earlier diagnosis of cancer with a focus on ensuring sufficient diagnostic capacity	<ul style="list-style-type: none"> <li>Review diagnostic demand and capacity and model impact</li> <li>Monitor waiting times for diagnostic tests by modality</li> <li>Collect and monitor diagnostic reporting times in radiology, endoscopy and pathology</li> </ul>	This extensive piece of work will be carried out in a phased approach from July 2017.
Ensure all patients living with and beyond cancer (LWWBC) have access to the elements of the recovery package	<ul style="list-style-type: none"> <li>Complete a cost benefit analysis</li> <li>Design new model for delivery and commissioning of LWWBC</li> <li>Implement risk stratified follow-up pathways as per the planning guidance</li> </ul>	<p>May – November 2017 2018/19</p> <p>Phased 17/18 and 18/19</p>

# Cardiovascular

BNSSG CCGs have identified cardiovascular disease (CVD) as an area of care where there is a significant population health need.

We need to do more to improve outcomes; reduce health inequalities and; use opportunities to develop ways of working and commissioning that will improve efficiency, value and quality of care across BNSSG.

The CVD programme work is at the early stages of development and we have identified three GP clinical leads to lead and take forward this work.

# CVD Programme Summary

## Aims and expected outcome of programme

- Identification of clinical priorities
- Self-care and secondary prevention
- Establish Heart Failure pathway across BNSSG
- Exploration of re-commissioning of ECG reporting and ambulatory ECG provision across BNSSG
- Community IV diuretics for heart failure
- Consistent HF pathways across BNSSG
- Cardiac rehabilitation for heart failure patients
- Scope pathway work for acute chest pain clinic across BNSSG

## National Must Do

- ✓ STP
- ☐ Finance
- ☐ Primary Care
- ✓ Urgent & Emergency
- ✓ Planned Care & RTT
- ☐ Cancer
- ☐ Mental Health
- ☐ Learning Disabilities
- ✓ Improving Quality

## Five Year Forward View requirements

- ☐ Urgent & Emergency Care
- ☐ Primary Care
- ☐ Cancer
- ☐ Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

## Risk and mitigation

The main risk at this time is that the programme does not progress at the pace needed. The mitigation is that the programme is now clearly part of BNSSG CCGs operational plan and therefore the raised profile should ensure that sufficient resources and organisational support are dedicated to it.

## STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ☐ Personalised care

## Financial summary

To be determined as part of the development of the programme.



# CVD Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Identify the clinical priorities for this CVD programme, particularly describing the scope of the work as aspects of CVD are being progressed through other separate programmes	A focussed piece of work using available data and information and the views of commissioning and provider clinicians and managers to gain agreement.	End of July 2017
Develop a robust and achievable programme of work in partnership with providers	A formal piece of programme development to provide clarity on what will be achieved, why and by when and what resources (time, etc.) are needed to achieve the desired outcomes.	End of August 2017

# Children and Maternity

The Children, Young People and Maternity programme continues to focus on prevention, early intervention and timely access to services within a framework of partnership working. Re-commissioning activity in community children's health services has enabled commissioners to have a good understanding of the experience of children, young people, parents and carers in accessing universal, targeted and specialist services. It has also enabled us to identify priorities for service development.

The focus of the Five Year Forward View is primarily on Children and Young People's Mental Health, and this has been reflected in our STP plans. In 17/18 we will continue to implement our Emotional Health and Wellbeing Transformation Plan, improving access to CAMHS services, including specialist Eating Disorder services, and increasing capacity within our system for earlier support through counselling and resilience building work in schools and community settings.

With our partners we are also making progress with the national agenda for maternity services with the implementation of our Maternity Strategy and the establishment of a Local Maternity System in order to plan and deliver consistent, high quality and cost effective maternity services to the local population. We will implement the Saving Babies Lives Care Bundle. Building on the success of our new Specialist Perinatal Mental Health Team, we will develop integrated pathways including more open access community support.

# Children and Maternity cont:

Improvements to services for children and young people with Special Educational Needs and Disabilities (SEND) are underway but there is much work still to do to ensure that all young people in BNSSG are supported to fulfil their potential. We will continue to work with our partners in Local Authorities, schools and community health services to make these improvements, including implementing Integrated Personalised Commissioning.

For children and young people with long term conditions or complex health needs, we will work within the emerging community cluster model to provide better community care helping to avoid unnecessary admissions to hospital, including nursing provision for end of life care.

Our aspiration of delivery high quality children's services needs to be supported by modernisation in information management for community children's health services. We will pursue this through the STP Digital Road Map.

# Children and Maternity Programme Summary

## Aims and expected outcome of programme

We will work with partners to secure improvements in the quality of our services - access, responsiveness, effectiveness, patient experience and integration. In 17/18 we will focus on emotional health and wellbeing, perinatal mental health, SEND and developing our Local Maternity System.

We will support quality and safety through a Digital Road Map for community children's health services.

## National Must Do

- ✓ STP
- ☐ Finance
- ☐ Primary Care
- ☐ Urgent & Emergency
- ☐ Planned Care & RTT
- ☐ Cancer
- ✓ Mental Health
- ☐ Learning Disabilities
- ✓ Improving Quality

## Five Year Forward View requirements

- ☐ Urgent & Emergency Care
- ☐ Primary Care
- ☐ Cancer
- ✓ Mental Health
- ✓ Integrating Care Locally
- ☐ Funding and Efficiency

## Risk and mitigation

- Workforce – significant recruitment difficulties in CYP MH services. BNSSG wide working on workforce planning. Providers working to develop new professional roles
- Digital road map requires capital investment.

## STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ✓ Personalised care

## Financial summary

- Emotional Health and Wellbeing Transformation funding supports implementation of BNSSG plans 2015-2021.
- Capital funding required for developments in electronic records.

# Children and Maternity Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Improve emotional health and wellbeing of children and young people	Implement Emotional Wellbeing and Transformation Plan	2021
Improve the quality and safety of maternity services, enhancing choice, patient experience and maternal and infant health	Develop a Local Maternity System and Maternity Commissioning Strategy for BNSSG	LMS implementation by September 2017
Enable children and young people with long term conditions, disabilities or complex health needs to remain at home as much as possible	Develop community children's nursing service	December 2017
	Develop cluster model for community delivery	January 2018
	Develop Children's Continuing Care Policy	November 2017
Modernise information management in community children's services	Digital road map (STP)	March 2018

# Community Services

Across BNSSG we recognise that we want to remove complexity that has resulted from responding to policy directives, develop simple patterns of services that respond rapidly and work across the system to facilitate discharge and prevent admissions and have a consistent approach across BNSSG

We are committed :

- To ensure effective use of system wide resources to support community and primary care services respond to both the growth in care homes, residential and Extra Care Housing and the increasing complexity of need
- To ensure that those who do not need a medical response are provided with age appropriate relevant alternatives
- Implementation of aligned approaches in recognition of frailty as a clinical diagnosis and a pathway of prevention or intervention
- To align our out of hospital services with urgent care work stream
- To Foster MDT working and clear accountability for individuals and integrated working with jointly local authority partners
- Managing Length of Stay and any subsequent Delayed Transfers of Care including using single assessments across BNSSG
- Deliver equity and aligned access across BNSSG

# Community Services Programme Summary

## Aims and expected outcome of programme

Working together across health and social care to develop high quality, affordable, out of hospital care, including providing an alternative to the Emergency Department, supporting hospital discharge, and keeping people well once they return home

## National Must Do

- ✓ STP
- ✓ Finance
- ☐ Primary Care
- ✓ Urgent & Emergency
- ☐ Planned Care & RTT
- ☐ Cancer
- ☐ Mental Health
- ☐ Learning Disabilities
- ✓ Improving Quality

## Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ☐ Primary Care
- ☐ Cancer
- ☐ Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

## Risk and mitigation

- Workforce to deliver--Review of workforce would need to be undertaken looking at different ways of working
- Impact on LAs of savings both within NHS plans and local Authority plans ----Ensure BCF reviews both financial and quality impact assessment on any joint working
- Impact of ongoing estate capacity --Estates review across BNSSG

## STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ✓ Personalised care

# Community Services Programme Summary

## Financial summary

There is a recognition that CCGs need to address the deficit, achieve financial balance in BNSSG and create a credible financial plan for achieving in-year savings . The programme will :

- Work closely with community providers to review equity and resource across BNSSG understanding both the CCGs QIPP programme and requirements on local providers
- Review recent IBCF funding against Better Care Funding guidance to ensure there is agreement to invest in out of hospital services and support reduction in local DTOC.
- Ensure plans are affordable and achieve value for money – asking whether the intervention improves productivity or provides a more cost-effective response than other ways of delivering the care patients need.
- Work with providers to ensure the resilience and sustainability of core services



# Community Services Programme Priorities

Priorities	We will achieve this by doing...	And by when...
1. To develop capability and capacity in the community so that people with complex needs spend less time in hospital following an acute admission	Confirm scale and scope of BNSSG commissioning programme for community rehabilitation	August 2017
	Establish alignment with existing local programmes (e.g. discharge to assess, community wards, 3Rs, stroke, vascular, T&O)	August 2017
	Create a single demand and capacity model for community rehabilitation to inform operational decision making and long term planning, including in relation to community inpatient capacity	September 2017
	Establish financial model and funds flow requirements, to include tariff unbundling where indicated	September 2017
	Agree BNSSG commissioning programme for community including in-year, medium and long term priorities	September 2017

# Community Services Programme Priorities

Priorities	We will achieve this by doing...	And by when...
2 .To develop and enhance integrated Health and Social care services across BNSSG to support patients at home. Including working closely across STP to deliver People Centred Integration	To Foster MDT working and clear accountability for individuals and integrated working .	September 2017
	Working closely with physical health, mental health, social care and voluntary sector	Ongoing
	Increase the Social Care staff presence within wards and within ED and Medical Assessment Units	August 2017
	Design a single and consistent 7 days a week Hospital Discharge process to operate in each of the three main acute hospitals in the BNSSG STP area	September 2017
	Develop and pilot “Trusted Assessor” arrangements	October 2017
	Undertake an analysis of care/nursing home placements made on discharge from hospital by each of the three local authorities and CHC funded placements made by the three CCG’s in the STP area.	October 2017
	Development of community services that offer opportunities for pooled budgets and joint commissioning.	August 2017

# Community Services Programme Priorities

Priorities	We will achieve this by doing...	And by when...
3. Reduction in variation in Community Services practice across BNSSG	To work closely with community providers to review shared assessment process and complex care pathways . Support community teams with specialist medical input and use of shared skill sets across providers.,	October 2017
	Development of generalist skills across community services to manage multiple co morbidities	October 2017
4.Implementation of BNNSG Frailty programme	See details of Frailty work programme	March 2018
	Implementation of aligned approaches in recognition of frailty as a clinical diagnosis and a pathway of prevention or intervention	December-2017

# Continuing Healthcare

Focus of the Continuing Healthcare (CHC) programme is on:

- Compliance with NHS operating model and quality assurance framework for CHC in relation to 3 month and annual review
- Reducing number of individuals waiting for CHC assessment in an acute setting to achieve the NHSE Quality Premium of 15% of assessments in hospital 2017/19
- Ensuring people eligible for CHC Fast track care / placements receive care in a timely manner
- Alignment of CHC related policies for example CHC commissioning policies
- Establishing a robust clinical governance structure to ensure high quality care for individuals eligible for CHC
- Market supply and management of care homes
- System wide approach to PHB's for those eligible for CHC to achieve NHS PHB expansion trajectory

# CHC Programme Summary

## Aims and expected outcome of programme

Align BNSSG approach to Continuing Healthcare and improve processes of assessment , decision making, local resolution, and the commissioning of care provision. Achieve greater control over CHC spend.

## Risk and mitigation

- Local Authority engagement in agreeing process changes to increase out of hospital CHC assessment, mitigated by early engagement in change process
- Care providers agreeing to aligned approach to care procurement, mitigated by early engagement in change conversation
- Changes to the National Framework for CHC, unable to mitigate but BNSSG CCG'S are development partners in NHSE Strategic Improvement programme

## National Must Do

- ☐ STP
- ☐ Finance
- ☐ Primary Care
- ☐ Urgent & Emergency
- ☐ Planned Care & RTT
- ☐ Cancer
- ☐ Mental Health
- ☐ Learning Disabilities
- ✓ Improving Quality

## Five Year Forward View requirements

- ☐ Urgent & Emergency Care
- ☐ Primary Care
- ☐ Cancer
- ☐ Mental Health
- ☐ Integrating Care Locally
- ✓ Funding and Efficiency

## STP Priorities

- ☐ Preventing illness and injury
- ✓ Providing care closer to home
- ✓ Personalised care

## Financial summary

- BNSSG budget 2017/8 £70.420m (CHC £51.404m, FNC £18.016m)
- Savings £4.642 FYE , £3.326 PYE

# CHC Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Align operational approach to CHC referral , assessment and eligibility determination	<ul style="list-style-type: none"> <li>• Agreeing standard operating procedures with all partners</li> <li>• BNSSG CCGs to cease funding 28 days after CHC ineligibility is determined (not funding during appeal)</li> </ul>	<p>October 2017</p> <p>July 2017</p>
Agree BNSSG approach to commissioning care for individuals eligible for continuing healthcare funding	<ul style="list-style-type: none"> <li>• Implementation of BNSSG CHC Commissioning strategy</li> <li>• Delivering a robust approach to care procurement that improves control over CHC package spend</li> </ul>	<p>July 2017</p> <p>October 2017</p>
Personal Health budget expansion for individuals eligible for Continuing Healthcare and CHC Fast Track	<ul style="list-style-type: none"> <li>• To embed a consistent approach to associate risks and expenditure</li> <li>• Reviewing all current PHBs</li> <li>• Implementing Fast Track PHBs to improve hospital discharge and reduce excess bed day spend.</li> </ul>	<p>October 2017</p>

# Dementia

BNSSG will build on the progress made delivering an increased dementia diagnosis rate for our population. BNSSG will seek to improve access and provision of post diagnostic support for people with dementia, thereby reducing variance across the system.

Our priorities are:

- LTC, Prevention and Self-Care – develop a whole system pathway for dementia, building on best practice within BNSSG
- Improvements in post diagnostic support i.e Dementia navigator/ adviser / support worker role – bid to Heath Foundation for scaling up funding to deliver a BNSSG Dementia service or joint funding to develop a Dementia service (SG)
- Continued commitment to GP education and support
- Further support to care homes to improve care for people with dementia – development of a BNSSG care home PID
- Work with the acute hospitals to improve the patient pathway and timely discharge
- To reduce emergency hospital admissions and short stay admissions
- Joint working with the 3rd sector to deliver aims of the STP
- Developing a shared approach to carer involvement across BNSSG – move towards a trusted assessor model
- To use Rightcare data to guide current and future priorities
- To explore alternatives to acute inpatient provision for people with dementia

# Dementia Programme Summary

## Aims and expected outcome of programme

Long Term Conditions, Prevention and Self-Care – build on best practice to develop a whole system pathway for dementia. This will include revisions to the use of inpatient care and different models of long term nursing care for people with complex dementia presentations.

## National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- ✓ Urgent Emergency
- ☐ Planned Care & RTT
- ☐ Cancer
- ✓ Mental Health
- ☐ Learning Disabilities
- ✓ Improving Quality

## Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ✓ Primary Care
- ☐ Cancer
- ✓ Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

## Risk and mitigation

- Pressure on primary and social care resources may reduce opportunities for pre-emptive and preventative interventions

## STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ☐ Personalised care

## Financial summary

- The economic case for further investment in dementia services is currently being developed.



# Dementia Programme Priorities

Priorities	We will achieve this by doing...	And by when...
LTC, Prevention and Self-Care – develop a whole system pathway for dementia, building on best practice	e.g. Improvements in post diagnostic support i.e Dementia navigator/ adviser / support worker role – bid to Heath Foundation for scaling up funding to deliver a BNSSG Dementia service or joint funding to develop a Dementia service (SG)	By April 2018
Continued commitment to GP education and support	Support GP's to continue primary care diagnostic pathway	Ongoing work
Further support to care homes to improve care for people with dementia – development of a BNSSG care home PID	Implementing better support to care homes including shared care arrangements with secondary care providing specialist input	Started September 2016
Work with the acute hospitals to improve care the patient pathway to reduce emergency hospital admissions and short stay admissions		Work began in 2015, second phase begins April 2018

# Diabetes Transformation Programme

## Five Year Forward View:

- We will 'get serious about prevention' of type 2 diabetes by implementing the National Diabetes Prevention Programme
- Commission a new care model for diabetes that is person focussed, not organisation focussed, tailoring care for people with diabetes.
- We will improve the quality of care by commissioning on outcomes, an integrated diabetes service

## Sustainability and Transformation Plans:

- Deliver the vision of the Integrated Primary and Community Care workstream of the Sustainability and Transformation Plan

## Benefits:

- More people with diabetes able to manage their own care effectively
- A reduction in the health inequality of outcome for people with diabetes
- More effective use of resources across the health care and supporting system to improve outcomes for people with diabetes
- More specifically, a reduction in preventable complications and the associated cost both to the person with diabetes and to the health and social care system
- Commissioning on outcomes, not activity

# Diabetes Programme Summary

## Aims and expected outcome of programme

Commission diabetes care on an outcomes basis across BNSSG. This will cover the all types of diabetes for all people who live in BNSSG. Creating one integrated diabetes team which provides tailored care that wraps round the patient.

## Risk and mitigation

- Risk: The ability of providers to collaborate and transform diabetes services within the year.
- Mitigation: Concerted engagement of all tiers of clinical and managerial staff within providers.

## Financial summary

- New contracting models will be used to ensure an integrated outcome focussed service is commissioned.

## National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- ☐ Urgent & Emergency
- ✓ Planned Care & RTT
- ☐ Cancer
- ☐ Mental Health
- ☐ Learning Disabilities
- ✓ Improving Quality

## Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ✓ Primary Care
- ☐ Cancer
- ☐ Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

## STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ✓ Personalised care

# Diabetes Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Treatment Targets: using NHS England funding we will work with primary, community and secondary care providers to improve care of diabetes patients.	<ul style="list-style-type: none"> <li>• Fund practice staff to attend a diabetes course</li> <li>• Implement virtual clinics and advice and guidance to review and manage patients</li> <li>• Fund an additional Diabetes Specialist Nurse in BNSSG</li> </ul>	From June 2017
National Diabetes Prevention Programme: We will roll out this programme of courses across BNSSG, including an NHS Digital pilot of an online course.	<ul style="list-style-type: none"> <li>• Plan a phased roll out across our geography</li> <li>• Work with Living Well, Taking Control our service provider</li> <li>• Pilot Diabetes UK Know Your Risk tool</li> </ul>	From June 2017
STP Diabetes Transformation Programme: We will write an outcome based service specification for commissioning locally.	<ul style="list-style-type: none"> <li>• Defining our vision; procurement approach; outcomes and service specification</li> <li>• Work collaboratively with STP providers to commission transformed services</li> </ul>	<p>By the end of August 2017</p> <p>April 2018</p>

# End of Life

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

# End of Life Programme Summary

## Aims and expected outcome of programme

Ensure high quality end of life care services are available, through integrated services which embed best practice according to individual need, so that people at the end of their lives have a 'good death'

## Risk and mitigation

System engagement and interconnect ability of IT systems are key enablers. Strategies are in place to achieve this.

## Financial summary

Savings identified £2.5m but in engaging in significant system-wide change it is acknowledged that this is intended to develop further

## National Must Do

- ✓ STP
- ☐ Finance
- ✓ Primary Care
- ✓ Urgent & Emergency
- ☐ Planned Care & RTT
- ✓ Cancer
- ☐ Mental Health
- ☐ Learning Disabilities
- ✓ Improving Quality

## Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ✓ Primary Care
- ✓ Cancer
- ☐ Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

## STP Priorities

- ☐ Preventing illness and injury
- ☐ Providing care closer to home
- ☐ Personalised care

# End of Life Programme Priorities

Priorities	We will achieve this by doing...	And by when...
<ul style="list-style-type: none"> <li>To agree and implement an integrated approach to End of Life care.</li> </ul>	Establish an End of Life Programme within the BNSSG STP.	In place
<ul style="list-style-type: none"> <li>To achieve a % reduction on the 2015/16 rate of the number of non-final emergency admissions for people identified as at End of Life across BNSSG.</li> </ul>	Deliver projects aimed at: Increasing information sharing through use of EPaCCS information system: <ul style="list-style-type: none"> <li>- to GPs</li> <li>- to other providers</li> </ul>	December 2017 May 2018
<ul style="list-style-type: none"> <li>To achieve a % reduction on the 2015/16 rate of patients dying in hospital for BNSSG.</li> </ul>	Seamless pathway for patients / family and carers. Supporting patient to have choice of place of death and advanced care planning	April 2018
<ul style="list-style-type: none"> <li>To increase the number of people that have had the opportunity to discuss and agree their preferences for their end of life care.</li> </ul>	Define the project to support care at home (includes care homes)	July 2017
<ul style="list-style-type: none"> <li>To explore the best use of palliative care services in the community</li> </ul>	Link pathway to include hospice and secondary care	July 2017

# Frailty

## Vision and principles

BNSSG CCGs will further develop community frailty services to ensure patients receive timely, appropriate care closer to home. BNSSG acute services will prioritise the frailty programme and develop system working to deliver seamless care to this cohort of patients. The interface between community and acute frailty will be further developed to support wider partnership working.

## We aim to do this though applying core principles of :

- Reducing variance in practice across the system i.e. MDT and cluster based working across BNSSG
- Replicating best practice within BNSSG and developing a single model of care for community frailty i.e. developing a skilled workforce within care homes and frailty competency training
- Focus on developing frailty teams in the community, shifting activity from secondary care to the community
- Focus on progressing enhanced healthcare in care homes - development of a BNSSG Care Home programme
- Acute Frailty and Community Frailty established as separate workstreams.
- Continue to engage and further develop partnership/interface working with the Acute Trusts (NBT/UHB/Weston) and Community providers (Sirona/Bristol Community Health and North Somerset Community Partnership)
- Confirm governance arrangements and links with STP



# Frailty Programme Summary

## Aims and expected outcome of programme

- Improved patient outcomes following delivery of care for frail patients closer to home.
- To transfer more funding for care of the elderly into the community and closer to the patients home.
- Clear patient pathways for frail patients
- Reduced hospital admissions
- Reduced hospital admissions from care homes

## Risk and mitigation

- Challenges to system/provider engagement across BNSSG – delivery demands the improved system thinking
- Management resource to support delivery of entire frailty programme

## Financial summary

Savings - reduction in admissions to hospital for frail elderly patients. To explore service redesign opportunities to deliver BNSSG frailty community services.

## National Must Do

- ✓ STP
- ☐ Finance
- ✓ Primary Care
- ✓ Urgent & Emergency
- ☐ Planned Care & RTT
- ☐ Cancer
- ☐ Mental Health
- ☐ Learning Disabilities
- ✓ Improving Quality

## Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ✓ Primary Care
- ☐ Cancer
- ☐ Mental Health
- ✓ Integrating Care Locally
- ☐ Funding and Efficiency

## STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ☐ Personalised care

# Frailty Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Delivery of a BNSSG Care Home Programme	Finalising BNSSG Care Home PID and delivery of each identified workstream e.g. enhancing health in care homes	Management resource identified. Delivery will start in September 2017, timescales to be finalised by care home delivery board.
MDT cluster based working	Supporting STP IPCC priority of delivering MDT Cluster based working across BNSSG	Timescales are aligned to STP IPCC workstream
Develop an out of hospital service for frail elderly patients	Ensuring consistency across BNSSG to deliver out of hospital community based provision	Timescales September 2017 to March 2018

# Learning Disabilities

- Our key focus remains the delivery of the Transforming Care Plan (TCP) for all ages. This will ensure that we have less people with learning disabilities (PWLD) and/or autistic spectrum conditions (ASC) in long term hospital placements. Our TCP plan will reduce the current number of PWLD and/or ASC in hospital to a number within the national activity guidelines. We will also put in place the right care and support to reduce the number of people who may be admitted to hospital placements in the future. This will be supported via the delivery of Care and Treatment Review (CTR) programme to adults and children and young people in collaboration with NHSE
- Our other key priority remains improving the physical and mental health of all PWLD. This includes ensuring that our local health services are accessible to PWLD and that reasonable adjustments to access are made where necessary. Specific actions relate to improving the rate of annual health checks to 75% and supporting health professionals to implement the recommendations of the confidential inquiry into premature mortality for people with a learning disability (CIPOLD)
- We will work with partners to develop Improved pathways for early identification of people with a learning disability and or autism at risk of involvement with criminal justice services
- In partnership with children and young peoples services, we are improving transitions services for PWLD including increased provision of personal health budgets and a broader range of care and support options for people with complex needs

# Learning Disabilities Programme Summary

## Aims and expected outcome of programme

Delivery of a Transforming Care Plan for all ages reducing the number of people receiving long term care in hospital settings. Ensuring that there are effective community services to support people with learning disabilities with mental illness and/or challenging behaviour

To reduce the number of PWLD who die earlier than they should through preventable and treatable illnesses

## Risk and mitigation

- The proposed transfers of patients from specialised commissioning to the CCG's may create cost pressures
- Care Costs for PWLD continue to increase

## Financial summary

- Further financial assessment is required to understand the impact of proposed NHSE changes to the TCP programme, particularly the transfer of responsibilities to CCG's

## National Must Do

- ✓STP
- ✓Finance
- ✓Primary Care
- ☐ Urgent & Emergency
- ☐ Planned Care & RTT
- ✓Cancer
- ✓Mental Health
- ✓Learning Disabilities
- ☐ Improving Quality

## Five Year Forward View requirements

- ☐ Urgent & Emergency Care
- ✓Primary Care
- ✓Cancer
- ✓Mental Health
- ✓Integrating Care Locally
- ✓Funding and Efficiency

## STP Priorities

- ✓Preventing illness and injury
- ✓Providing care closer to home
- ✓Personalised care

# Learning Disabilities Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Transforming Care Partnership work	Discharging current patients from hospital back to community settings. Avoiding new patients taking their place by providing evidence based community interventions and alternatives to hospital care	The CCGs are working to a 3 year plan and trajectory with milestones between 2016 and 2019
Improving the health of PWLD	Ensuring that PWLD have equitable access to healthcare and that avoidable deaths are reduced including increasing the rate of annual health checks provided by primary care	An improvement trajectory is currently being developed with NHSE with milestones n 17-18 and 18-19
Effective partnership working across the criminal justice pathway	Building effective relationships with the Police , probation and courts to identify high risk individuals at risk of criminality and subsequent hospitalisation	The CCGs are working to a 3 year plan and trajectory with milestones between now and 2020

# Mental Health

- We are currently undertaking a process to establish how local services can work more effectively across BNSSG. This involves reviewing models of care, service configuration, estate our contractual relationship with key providers. This is to ensure services remain of high quality are resilient and are affordable
- A key element of this is crisis and acute care including S136 and the Emergency Department offer re liaison psychiatry. Would also require the reprofiling of services to deliver more planned care and home treatment
- Suggested increase in psychological talking therapies
- Developing a sustainable and equitable approach to the application of S117 aftercare
- NHSE working with NICE to help facilitate faster access to new digital therapies
- Better mental health care for new & expectant mothers including expanded specialist perinatal MH teams
- Expansion of physical health checks for people with severe mental illness to reduce health inequalities

# Mental Health Programme Summary

## Aims and expected outcome of programme

Deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages

To develop a sustainable and affordable model of mental health care across the BNSSG footprint

## National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- ✓ Urgent & Emergency
- ☐ Planned Care & RTT
- ☐ Cancer
- ✓ Mental Health
- ☐ Learning Disabilities
- ✓ Improving Quality

## Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ✓ Primary Care
- ☐ Cancer
- ✓ Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

## Risk and mitigation

- Referral and activity patterns within mental health have seen significant variation in recent years
- Ongoing need to address quality concerns across a range of mental health services

## STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ✓ Personalised care

## Financial summary

- There remains a high level of cost volatility within MH services including structural cost pressures within the provider and cost improvement requirements within the system wide financial plan

# Mental Health Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Develop and implement a sustainable footprint wide delivery model for mental health	System wide financial plan is driving required change and outline configurations and options are now being discussed and tested	Completion by April 2018
Crisis and acute care including S136 and interface with urgent care. Corresponding shift to if possible doing less crisis work and more planned home treatment	Revision and reconfiguration of current services following review process	Completion by April 2018
Expansion of physical health checks for people with severe mental illness to reduce health inequalities	Working with primary care with pilot work in Bristol then rolled out across BNSSG. CQUIN includes smoking cessation linked to public health work	Starting in September 2017, work will be ongoing for initial 2 year period
Sustainable approach to Section 117 aftercare	Plan in place and outline methodology identified. Currently negotiating with Local Authorities as to how it should be implemented	Started April 2017 completion by April 2018



# North Somerset Sustainability Programme

- Looking at the sustainability of Weston General hospital in a system-wide context
- Clarifying what the wider out-of-hospital model should look like for North Somerset bringing together:
  - Weston Primary Care Transformation Programme, supporting Primary Care resilience & population growth
  - STP MDT Programme (integrated cluster-based working), and how this could potentially be piloted in Weston
  - STP Pathway Programmes (Stroke, Diabetes, Respiratory)
  - Local initiatives (e.g. Weston care homes)
- Identifying other opportunities to address population need and/or support the sustainability of North Somerset
- Ensuring all of this can be delivered within the financial envelope

# North Somerset Sustainability Programme

## Aims and expected outcome of programme

Develop a sustainable configuration of services at Weston General Hospital.

## National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- ✓ Urgent & Emergency
- ✓ Planned Care & RTT
- ☐ Cancer
- ☐ Mental Health
- ☐ Learning Disabilities
- ✓ Improving Quality

## Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ✓ Primary Care
- ☐ Cancer
- ☐ Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

## Risk and mitigation

- Reputational issues affect recruitment and retain the appropriate clinical staff for the required model
- UHB Partnership agreement

## STP Priorities

- ☐ Preventing illness and injury
- ✓ Providing care closer to home
- ☐ Personalised care

## Financial summary

Weston Area Health Trust have a challenging financial position, even when off-set by current commissioner subsidies that pay above national and local tariffs.

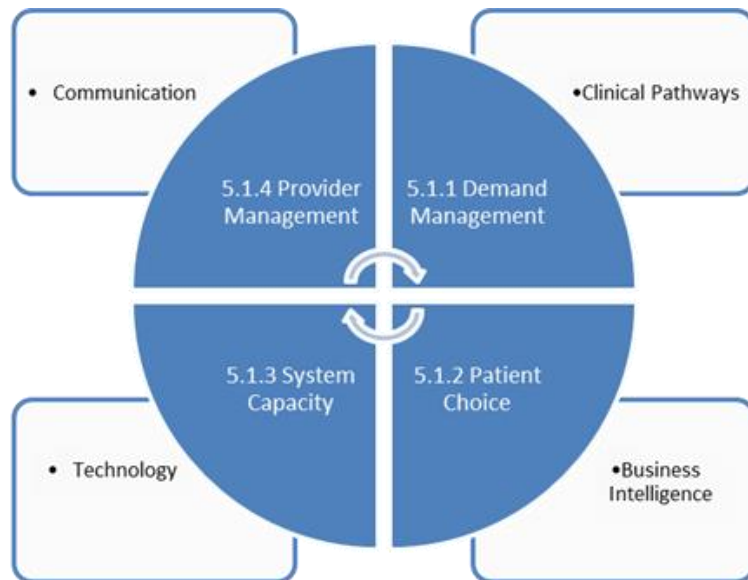
# North Somerset Sustainability Priorities

Priorities	We will achieve this by doing...	And by when...
Commissioning context	Engaging with key partners to ensure a clear and comprehensive vision of the service model and pathways supporting Weston General Hospital	July 2017
Business Case for a sustainable model of care at Weston General Hospital	Working closely with UHB and WAHT as they respond to the Commissioning Context document and develop a detailed business case for service reform	Autumn 2017
Public engagement and consultation	Use the agreed business case to build on earlier engagement work (learning from Health Watch North Somerset's review) to consult with the public on the options for a sustainable future for WGH	Winter 17/18

# Planned Care

## Vision and Principles

BNSSG CCGs aim to provide planned care services designed around patients with greater integration and equality of access, supporting the principle of right care, right place, first time.



We aim to do this though applying core principles of:

- Embedding prevention and self-care along the planned care pathway, reducing or delaying the need for treatment where appropriate
- Providing care closer to home and in the community with key decision making being driven from Primary care to help patients manage their health choices.
- Enabling residents to be able to access the right health care at the right time
- Providing patients with an informed choice of provider
- Continuously seek to improve patient experience and clinical outcomes.
- Minimising waste and maximising value by moving care into different settings and reducing procedures with low clinical value
- Working with the wider health and social care community to enhance the patient journey

# Planned Care

## Objectives

- Supporting planned care strategy to ensure all patients in BNSSG are seen and treated in the community where appropriate, with specialist support where appropriate at the right time in the most appropriate setting
- To develop widespread use of Patient Initiated Follow up for appropriate patients, reducing unnecessary appointments for patients and making best use of hospital capacity
- Through our system wide RTT Delivery Board, manage our elective care contracts, tariffs and activity to deliver the best value to the BNSSG health system
- Continue with the development of clinically developed access policies to ensure funds are used in areas of greatest clinical need and reducing activity for procedures of the least clinical benefit
- Develop and deliver a commissioning strategy for Eye Care across BNSSG
- Commission a standardised, consistent, community based, best value pathways for MSK, DVT and Chronic Liver Disease for all BNSSG patients
- Maintain our current performance against the Referral to Treatment, incomplete Pathways standard through demand management and pathway redesign

## Benefits and impact

- Care and treatment provided in community settings where appropriate
- Reduction in patients required to attend a face to face appointment when alternatives are available
- Ensuring best value from our current contracts
- Ensuring available funding is used to provide the maximum benefit for patients
- Supporting financial recovery

# Planned Care Programme Summary

## Aims and expected outcome of programme

Support the planned care strategy to ensure all patients in BNSSG are seen and treated in the community where appropriate, with specialist support where appropriate at the right time in the most appropriate setting

## National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- ☐ Urgent & Emergency
- ✓ Planned Care & RTT
- ✓ Cancer
- ☐ Mental Health
- ☐ Learning Disabilities
- ✓ Improving Quality

## Five Year Forward View requirements

- ☐ Urgent & Emergency Care
- ✓ Primary Care
- ✓ Cancer
- ☐ Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

## Risk and mitigation

- Engagement of all providers – ongoing communications in place
- Timescales challenging – ensuring resources are allocated to support delivery

## STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ✓ Personalised care

## Financial summary

- Savings identified = £15.7m

# Planned Care Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Clinical Pathways – Developing consistent best value and community based pathways	Focus on MSK , Ophthalmology, DVT and Chronic Liver Disease	Phased delivery, starting July 2017, with key dates in November 17 and April 18
Outpatient Services – developing alternatives to face to face follow - up at scale across BNSSG providers	Supporting widespread use of Patient Initiated Follow ups, and supporting providers to introduce other alternatives, such as telephone appointments	Phased roll out throughout 17/18. Expectations for projects and delivery to start July 2017.
Clinical policies – ongoing development, review and implementation of BNSSG wide clinical policies to ensure patients access clinically appropriate treatment	Implementation and roll out of further clinical polices for orthopaedic procedures , fertility and CPAP devices. Designation of key procedures to 'IFR' request only. Rolling programme of development of new policies	Started from April 2017, and ongoing throughout 17/18

# Planned Care - Musculoskeletal Clinical Pathways

The Musculoskeletal (MSK) Clinical Pathways programme will create a model of MSK care that will integrate and streamline the delivery of services, providing an aligned service for anyone who has an MSK condition in BNSSG. It will enable a greater proportion of patients to self-manage and have their care managed in a community setting. The review will include all MSK services including Core Physio, Enhanced Physio, Podiatry, Orthotics, Orthopaedics, Pain and Rheumatology Services

Ranges of benchmarking indicators have identified that Trauma and Orthopaedic services and the broader MSK pathway are outliers against a number of key performance and outcome metrics. There is also a complex network of service provision across BNSSG with multiple acute and community providers for T&O/MSK services. These drivers have indicated that there are significant opportunities within the T&O/MSK pathway and its associated delivery model to make significant improvements and a streamlining of services for patients within the region, as well as opportunities to address the notable issues of sustainability within the current services

The project will establish whether a different provider model is required (which may include consideration of a lead provider model) and the optimal service delivery model

The project will also review the current provision of services for patients who have suffered a fractured neck of femur to ensure the same level of service is provided across BNSSG



# Musculoskeletal Services – Summary

## Aims and expected outcome of programme

Develop vision and clinical model for future provision of MSK services across BNSSG . Enabling a great proportion of patients to self-manage and create a sustainable model of MSK services for our population

## Risk and mitigation

- Demand for MSK services continues to outstrip demand
- Model of care remains financially unsustainable
- Whole MSK pathway to be recommissioned to contain demand and cost

## Financial summary

- Right Care opportunity of £7m across BNSSG CCGs

## National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- ✓ Urgent & Emergency
- ✓ Planned Care & RTT
- ☐ Cancer
- ☐ Mental Health
- ☐ Learning Disabilities
- ✓ Improving Quality

## Five Year Forward View requirements

- Urgent & Emergency Care
- ✓ Primary Care
  - ☐ Cancer
  - ☐ Mental Health
  - ✓ Integrating Care Locally
  - ✓ Funding and Efficiency

## STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ☐ Personalised care

# Musculoskeletal Services – Priorities

Priorities	We will achieve this by doing...	And by when...
Delivering a financial sustainable model of MSK Services across BNSSG	Development of clinical model and service specification to facilitate commissioning of sustainable service	Clinical Model to be developed by Sept 17 and Service Specification by Dec 17
Addressing significant variation in management of patients in MSK interface services	MSK interface services policies and pathways to be aligned across BNSSG to ensure equity of provision	Single referral form and equity of diagnostic access to be delivered by July 17
Optimal model of Fractured Neck of Femur services across BNSSG .	Current services benchmarked and services developed to reduce length of stay and improve access to theatre.	Community rehabilitation services to be available for patients from December 17.

# Referral Management

## Objectives:

- Establishing a BNSSG referral support system, providing administrative support, clinical triage and commissioner based referral data collection
- Support referrers to ensure patients are referred at the right time to the right place first time
- Providing education, pathway information and support to GP referrers through IT referral support tools, development of local pathways, referral peer review and education
- Addressing significant variation in referral practice and variation in internal hospital referral practice
- Roll out of advice and guidance supported by the BNSSG referral service in line with 17/18 CQUIN

## Benefits and impact

- Commissioner control and knowledge over all activity referred into secondary care
- Ensuring patients are referred into secondary care at the right time, and access the correct services first time
- Supporting primary care management as appropriate
- Reduction in significant variation, and reduction in procedures referred and undertaken which do not meet funding criteria, supporting financial recovery

# Referral Management Programme Summary

## Aims and expected outcome of programme

Establish a BNSSG referral support system, providing administrative support, clinical triage and commissioner based referral data collection

## National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- ☐ Urgent & Emergency
- ✓ Planned Care & RTT
- ☐ Cancer
- ☐ Mental Health
- ☐ Learning Disabilities
- ✓ Improving Quality

## Five Year Forward View requirements

- ☐ Urgent & Emergency Care
- ✓ Primary Care
- ☐ Cancer
- ☐ Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

## Risk and mitigation

- Support from primary care – communications in place
- Impact less than planned – has been trialled and impact demonstrated in CCG localities

## STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ☐ Personalised care

## Financial summary

£1.1m saving identified through 17/18

# Referral Management Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Establishing a single system for referral triage, data collection and primary care support	Integration of current referral support systems into a single BNSSG service available for all practices	July 17, with trajectory for all practices using the service by December 17
Addressing significant practice variations at speciality level	Develop statistical reporting tools for practices, and clinically triaging all referrals where variation is high	July 17
Roll out of Advice and Guidance to key specialities	Introduced to Providers through national CQUIN, and following national timescales in 17/18	A&G to be offered by selected specialties by March 18 in line with national CQUIN

# Respiratory

The BNSSG Respiratory Programme will support the updated Five Year Forward View in the following ways:-

- 'Improving A&E performance': plans to improve the care of people with respiratory conditions in primary care and the emphasis on self care should reduce the number of people attending A&E with an exacerbation
- 'Strengthening access to high quality GP services and primary care' and 'integrating care locally': the integrated respiratory service being developed will improve the quality of the respiratory care provided in primary care and provide teams without walls, making the most effective and efficient use of respiratory specialists across the whole patient pathway

The BNSSG Respiratory Programme will support the national must-dos in the following way:-

- 'Moderate demand growth and increase provider efficiencies': we are working to introduce virtual pulmonary rehabilitation and to provide one pulmonary rehabilitation offer across BNSSG to help people self manage their condition and reduce their need for services and provide efficiencies and economies of scale between the providers of PR
- 'New models of acute service collaboration and more integrated primary and community services': we are working with all six acute and community providers and the STP cluster/MTD working programme to design and implement an integrated respiratory service across primary, community, secondary care and the voluntary sector
- 'Streamline elective care pathways including through outpatient re-design and avoiding unnecessary follow-ups': to release capacity in secondary care to enable their respiratory specialists to have capacity to support primary care we are working with secondary care to ensure the new to follow up ratio for outpatient appointments is in the top 45<sup>th</sup> percentile by reducing unnecessary follow ups and implementing patient initiated follow ups

The impact of this work to improve the care received in primary care and to improve self care will be to reduce the number of A&E attendances, reduce the number of hospital admissions, reduce lengths of stay, increase the number of people who receive their care at home or close to home, increase the number of people who stop smoking or reduce the harm from smoking and improve the care people with respiratory conditions receive at the end of their life

# Respiratory Programme Summary

## Aims and expected outcome of programme

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

## National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- ✓ Urgent & Emergency
- ✓ Planned Care & RTT
- ☐ Cancer
- ☐ Mental Health
- ☐ Learning Disabilities
- ✓ Improving Quality

## Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ✓ Primary Care
- ☐ Cancer
- ☐ Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

## STP Priorities

- ✓ Preventing illness & injury
- ✓ Providing care closer to home
- ✓ Personalised care

## Risk and mitigation

There is a risk that there is not enough capacity in primary and community care to take on the additional care of patients with a respiratory condition that we may want in a new model of care.

## Financial summary

The in –year savings highlighted in the Right Care data pack have been over estimated and are unlikely to be made The Respiratory Programme is expected to release savings in 2018/19. The exact amount of savings are currently uncertain. A Business Case is being written which will include the detailed savings expected. the ambition for the project in the first year has been influenced by the turnaround projects and consequent lack of funding

# Respiratory Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Improving the care of people with respiratory conditions in primary care	Testing respiratory specialist led virtual clinics and diagnostic hubs in conjunction with the STP work on primary care cluster and MTD working	We will work to the STP Cluster/MTD working timescale. We would like to have tested the new model in one cluster of practices per CCG by the end of the 17/18 financial year
Ensuring equity of respiratory services across BNSSG	<p>We plan to ensure there is:-</p> <ul style="list-style-type: none"> <li>• hot clinics provided at all three acute trusts</li> <li>• Early supported discharge provided across BNSSG</li> </ul>	We will produce a Business Case to try and establish both of these services for the North Somerset population from the start of 2018
Improving the depth and breath of pulmonary rehabilitation across BNSSG	<p>We will do this by:</p> <ul style="list-style-type: none"> <li>• Offering virtual PR via MyCOPD</li> <li>• Providing one PR programme across BNSSG</li> <li>• Offering shorter education sessions for people newly diagnosed with COPD</li> </ul>	We plan to start offering MyCOPD by the end of 2017. We are aiming to provide one PR programme and supplement the PR programme with shorter education sessions, offered face to face and virtually by April 2018



# Stroke

- **Programme** – There are 30+ deaths that can be saved each year (RightCare 2016). Services as they are currently structured do not meet the national Cardiovascular Network guidance, or the requirements of the NHS England (NHSE) business case and the NHSE requirement for STP. Areas where stroke services have been transformed have seen significant reductions in mortality and morbidity from stroke. Aligned with NHSE's 2016-17 Business Case, networks for life changing and life threatening conditions, including stroke
- **Prevention** – Preventable risk factors for stroke, including high blood pressure, atrial fibrillation, and Transient Ischaemic Attack can be better identified and managed to reduce the strokes in all three CCGs. This will also reduce the incidence of strokes, heart attacks, heart failure and vascular dementia (NHSE's 5YFV and NHSE's 2017/18 Business Case)
- **Acute Care** – Not achieving all the necessary stroke standards (Sentinel Stroke National Audit Programme) and none of the three trusts meet the criteria for acute stroke care and the seven day standard in England (NHSE, 2016). Stroke services are among the five services that NHSE requires to be centralised to reduce mortality (NHSE's Transforming Urgent and Emergency Care Services). Improving A&E performance, patients directed from A&E to HASU
- **Rehabilitation and Living with Stroke** – Life expectancy is increasing and the number of patients living and surviving with stroke is increasing. Current model - most specialist stroke rehabilitation is provided within the acute trusts, adding to current issues of capacity. New model proposes patients transferring out to community as soon as medically fit for discharge, providing care closer to home wherever possible

# Stroke Programme Summary

Aims and expected outcome of programme	National Must Do	Five Year Forward View requirements
<ul style="list-style-type: none"><li>• Prevent ill health and reduce demand</li><li>• Implement new models of care</li><li>• Support and improve general practice</li><li>• Achieve and maintain performance against core standards</li><li>• Achieve national clinical priorities by 2020</li><li>• Improve quality and safety</li><li>• Use technology and accelerate change</li><li>• Develop the necessary workforce</li><li>• Achieve and Maintain financial balance</li></ul>	<ul style="list-style-type: none"><li>✓ STP</li><li>✓ Finance</li><li>✓ Primary Care</li><li><input type="checkbox"/> Urgent &amp; Emergency</li><li><input type="checkbox"/> Planned Care &amp; RTT</li><li><input type="checkbox"/> Cancer</li><li><input type="checkbox"/> Mental Health</li><li><input type="checkbox"/> Learning Disabilities</li><li>✓ Improving Quality</li></ul>	<ul style="list-style-type: none"><li>✓ Urgent &amp; Emergency Care</li><li>✓ Primary Care</li><li><input type="checkbox"/> Cancer</li><li><input type="checkbox"/> Mental Health</li><li>✓ Integrating Care Locally</li><li>✓ Funding and Efficiency</li></ul>
Risk and mitigation	STP Priorities	
<ul style="list-style-type: none"><li>• Lack of Public Engagement in centralisation – mitigated by involvement of patient in co-design prior to public consultation</li><li>• Capacity (NBT)– movement of services to UHB</li></ul>	<ul style="list-style-type: none"><li>✓ Preventing illness and injury</li><li>✓ Providing care closer to home</li><li>✓ Personalised care</li></ul>	
Financial summary		
<ul style="list-style-type: none"><li>• A full financial and workforce analysis is near completion</li></ul>		

# Stroke Programme Priorities

Priorities	We will achieve this by doing...	And by when...
<p><u>Prevention</u> – Identification of preventable risk factors for stroke, including high blood pressure, atrial fibrillation, and Transient Ischaemic Attack to be better identified and managed. This will reduce the incidence of strokes, heart attacks, heart failure and vascular dementia</p>	<p>Providing training to primary and community care and additional capacity (funded by AHSN) to see additional patients for AF and hypertension. Provide education for GPs and practice staff to identify TIAs and refer urgently to TIA clinics (via CEPN) TIA clinics will be available 7 days a week</p>	<p>Pilot in September 2017, full roll out envisaged for January 2018</p>
<p><u>Acute Care</u> – To achieve the necessary stroke standards (Sentinel Stroke National Audit Programme), to improve quality and necessary stroke specialist workforce. Stroke services are among the five services that NHSE requires to be centralised to reduce mortality and increase efficiency</p>	<p>Centralisation of acute care services on one site. Assessment by stroke specialist staff at A&amp;E/HASU and swift transfer to ASU for continued stroke care and assessment for transfer to community</p>	<p>At the same time as provision is in place in community. Date to be determined by STP approval and NHSE Assurance</p>
<p><u>Rehabilitation</u> – To provide a single specialist stroke service covering Acute Stroke Unit (ASU) and community, enabling seamless transfer from acute services to care closer to home</p>	<p>A multidisciplinary health and social care team to provide a seamless stroke rehabilitation service across ASU and community dependent on patient needs not service criteria. All patients not needing acute hospital care to receive rehab out of hospital with home as the default</p>	<p>Pilot to start following approval to progress from STP and NHSE</p>

# Transforming Out of Hospital Care: Primary Care

The CCGs are co-commissioners of primary care with NHSE (South Gloucestershire CCG has yet to apply for formal co-commissioning responsibilities). The BNSSG CCGs, together with NHS England, have developed a BNSSG GP Primary Care Strategy which is the local blueprint for implementing the **General Practice Forward View (GPFV)**. This focuses on primary care sustainability and transformation, with the aim of ensuring a resilient and thriving primary care service at the heart of an integrated health and social care system. This will mean a sustainable, effective and accessible primary care, with primary care being a more attractive career choice.

The BNSSG GP Primary Care Strategy considers what is important to and for the population of BNSSG using intelligence from primary care patient surveys, local stakeholder events and public health statistics. It considers the challenges facing the primary care system in BNSSG and provides a vision for the future from both a patient and system perspective.

Sustainable primary care is fundamental for delivering the BNSSG STP vision. A new model of care has been developed that draws on national best practice, including the learning from the vanguard models for multi-specialty community providers. Across BNSSG, pilot schemes funded by Prime Minister's Challenge Fund (now renamed the General Practice Access Fund) have been in place to test working at scale and delivery of areas included within the ten high impact actions, this includes back office functions, finance functions, service delivery and IT capabilities.

# Transforming Out of Hospital Care: Primary Care

Within the STP footprint and as part of the CCGs' shared operational plan under development, two areas have been agreed as priorities for work to improve sustainability: Weston and South Bristol. Change managers have been employed by NHSE to work with practices within these areas to develop and support implementation of a programme of work which will deliver a sustainable solution.

The majority of practices across BNSSG are now aligned to cluster delivery models which facilitate multi-disciplinary team working and the development of further initiatives. There is also the need to support those patients in care homes and BNSSG will build on the work that is already happening.

## OUR VISION

*A resilient and thriving primary care service which is the heart of an integrated health and social care system centred around the patient and carer*

*A responsive system that delivers needs-based high quality, equitable and safe care*

# Primary Care Programme Summary

## Aims and expected outcome of programme

To deliver against the BNSSG primary care strategy and FYFV aligned to STP requirements

## National Must Do

- ✓ STP
- ☐ Finance
- ✓ Primary Care
- ✓ Urgent & Emergency
- ☐ Planned Care & RTT
- ☐ Cancer
- ☐ Mental Health
- ☐ Learning Disabilities
- ✓ Improving Quality

## Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ✓ Primary Care
- ☐ Cancer
- ☐ Mental Health
- ✓ Integrating Care Locally
- ☐ Funding and Efficiency

## Risk and mitigation

Sustainability: recruitment difficulties and an ageing workforce are major concerns for primary and community care providers. BNSSG wide workforce planning is required to address the high level of risk and a CCG primary care workforce lead has recently been appointed provide a focus for this.

## STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ✓ Personalised care

## Financial summary

Plans for investment of the anticipated FYFV funding are being developed following allocation of the initial sum.

# Primary Care Programme Priorities

Priorities	We will achieve this by doing...	And by when...
Prepare plans for NHS approval to allow full delegated responsibility for primary care and support delivery of the priorities below	Establish a transition working group to provide robust project support and governance to the process	Before March 2018 (as quickly as national requirements allow)
Building Primary Care Resilience & Transforming Care	Build on work already underway to utilise resilience funding to deliver practice sustainability and enable delivery of out of the hospital care programme	Invest the £3 per head to support primary care to fully operationalise cluster /locality based models and MDT working by March 2019
	Agree clear commissioning intentions which effectively deliver against FVfV allocations	September 2017
Promote and develop inter-professional team working in order to achieve multidisciplinary service delivery	Develop a comprehensive primary and community workforce plan, including introducing new career pathways	November 2017
	Provide training which is consistent across BNSSG, supporting delivery of clinically effective intervention and reducing unwarranted variation	March 2018
To ensure delivery of GP improved access in a way which supports a whole system approach to urgent and out of hours care	Review existing model and ensure targets are met at both BNSSG and CCG level.	Ongoing

# Urgent and Emergency Care

The delivery of high quality and accessible urgent care services is an important priority for Bristol, North Somerset and South Gloucestershire (BNSSG). With the development of the Sustainability and Transformation Planning process, BNSSG perceive this to be an opportunity to become more aligned as a system. The BNSSG Urgent Care Strategy needs to ensure coherence across the prevention and self-care, Integrated Primary Care and the Acute Care Collaboration groups of the STP. This will provide the opportunity for the Urgent Care leads to develop shared pathways, unified care and further system alignment to avoid variation in standards. Our aim as commissioners of care is to ensure that urgent care services in the future are delivered in a seamless integrated way to best meet the needs of our local population.

Underpinning the strategy will be a system wide programme for implementation by way of the Urgent Care STP Delivery Plan. The delivery plan will translate the strategy into a reality for the local population, and will deliver the required changes to the urgent care system for it to be sustainable, responsive and with high clinical quality outcomes.

Urgent Care 5 Year Forward View (5YFV) 7 priorities:

- NHS 111 Online
- NHS 111 Calls
- GP Access
- Urgent Treatment Centres
- Ambulances
- Hospitals
- Hospital to Home



# Urgent and Emergency Care Programme Summary

## Aims and expected outcome of programme

To clearly articulate and deliver our vision for Urgent and Emergency Care, including the creation of a BNSSG Strategy, an STP Delivery Plan and a Performance Recovery plan to bring performance back in line based on intelligence around causes for breaches and system delays.

## National Must Do

- ✓ STP
- ✓ Finance
- ☐ Primary Care
- ✓ Urgent & Emergency
- ☐ Planned Care & RTT
- ☐ Cancer
- ☐ Mental Health
- ☐ Learning Disabilities
- ☐ Improving Quality

## Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ☐ Primary Care
- ☐ Cancer
- ☐ Mental Health
- ☐ Integrating Care Locally
- ☐ Funding and Efficiency

## Risk and mitigation

- Clinicians resist cultural and model changes – Clinical Lead to take responsibility for driving work stream level engagement with clinicians across the system.
- Inadequate infrastructure to deliver the specialist care required. Develop ideal workforce model and utilise available capital money and STF to develop existing estates, ensuring the BNSSG Urgent Model of care is sustainable and of high quality

## STP Priorities

- ☐ Preventing illness and injury
- ☐ Providing care closer to home
- ☐ Personalised care

## Financial summary

- Apply the principle of one health economy budget and ensure a high quality urgent care service is delivered within financial envelope.

# Urgent and Emergency Care Programme Priorities

Priorities	We will achieve this by doing...	And by when...
To place Primary Care at the forefront of urgent care provision.	Primary care will be supported to develop, change and bring to the system approaches for multidisciplinary team working, care planning, clinical risk management and same day urgent primary care.	March 2018
Patients waiting no longer than 4 hours in ED, this will be demonstrated through the achievement of the 95% standard	Implement the requirements of the NHSE Urgent Care 5 year Forward View. Including ED Streaming to Primary Care, Improved flow through hospitals and the wider system.	March 2018
Deliver a standardised UEC service provision across BNSSG.	Align Urgent Care provision in line with Urgent Treatment Centre service specification to reduce variation and increase uniformity.	March 2019
7 day services - Clinical outcomes are the same regardless of the day of the week.	Develop 7 day service models of care to ensure patients receive the same urgent care response over 7 days and are not unnecessarily delayed in hospital at weekends.	March 2018
Ensure that we deliver against the 7 pillars of the urgent care five year forward view.	Delivery Plan in draft with detailed action against how each priority will be delivered. Governance structure in place including STP A&E Delivery Board and associated work streams with Executive and clinical leads.	March 2018

# Enabling Programmes

# Procurement approach

The CCGs ensure full compliance with all procurement regulations (including Public Contract Regulations 2015 and Procurement, Patient Choice & Competition Regulations 2013).

The procurement approach to the commissioning of healthcare services at the CCGs is decided upon on a case by case basis, and is based on an objective, evidence-based assessment of what will deliver improved, more outcomes focussed pathways and clinical care and agreed service specifications.

In making an overarching decision on whether to contest a specific healthcare service, the CCGs consider as a minimum the following key points:

- Transparency, Equity and Proportionality as per our EU Treaty duties
- Choice, Competition or Integration as per the PPCC Regs 2013
- Value, Market, Continuity, Stability and Urgency as per the PCR2015
- Equality and Engagement as per the Public Sector Equality Duty and the Health & Social Care Act 2012

The CCGs have a strong, strategic relationship with their procurement team, and advice and support is sought on a case by case basis in moulding the above key consideration in to a formal decision-making case for each commissioning exercise.

# Procurement timetable

Area of care	Service specification approved	New contracts (variations) drafted	New contracts (variations) agreed
Diabetes	By end Sept 2017	By end Dec 2017	By end Feb 2018
Respiratory	By end Sept 2017	By end Dec 2017	By end Feb 2018
Deep Vein Thrombosis	By end July 2017	By end Nov 2017	By end Dec 2017
Skin	By end Oct 2017	By end Jan 2017	By end March 2018
Eye Care	During 2018/19	During 2018/19	During 2018/19

Timescales subject to change

# Communications and Engagement

## Commitment

We are committed to delivering clear, open communications and engagement with:

- Patients, carers, service users and members of the public
- NHS providers and workforce
- Community and voluntary sector providers and partners
- Local authority and political partners
- Local and regional media

## Principles

Communications and engagement activity will be carried out with the following principles:

- Open
- Responsive
- Relevant
- Timely
- Two-way and ensuring there are mechanisms to feedback to the BNSSG CCGs
- Proportionate and appropriate to the project

## Outcomes

Principle outcomes include ensuring that the needs of our population are met by listening and involving people in our decision making. We will meet our statutory and legal duties on engagement and public consultation - as set out in the Health & Social Care Act 2012 and Local Authority Regulations 2013 and our duties under the 2010 Equality Act - to engage protected characteristic groups and also to meet accessible information regulations.

# Communications and Engagement (2)

Our aim is to ensure public confidence and trust so that we:

- Reflect the needs and aspirations of local people in our prioritisation and decision making
- Design pathways of care and health services that work for the people who use and operate them through co-design
- Enable and empower people to take control of their own health; and support the friends, families and communities who care for them
- Value our stakeholders and keep people informed and involved in everything we do

We will achieve this by:

- Creating a citizen led approach through a systematic, structured user centered design model
- Co-design services with our stakeholders and service users
- Embedding shared decision making and informed self-care in clinical pathway design
- Providing regular and ongoing communication tools for use by all partners
- Ongoing stakeholder, citizen and service user engagement
- Core decision-making meetings in public

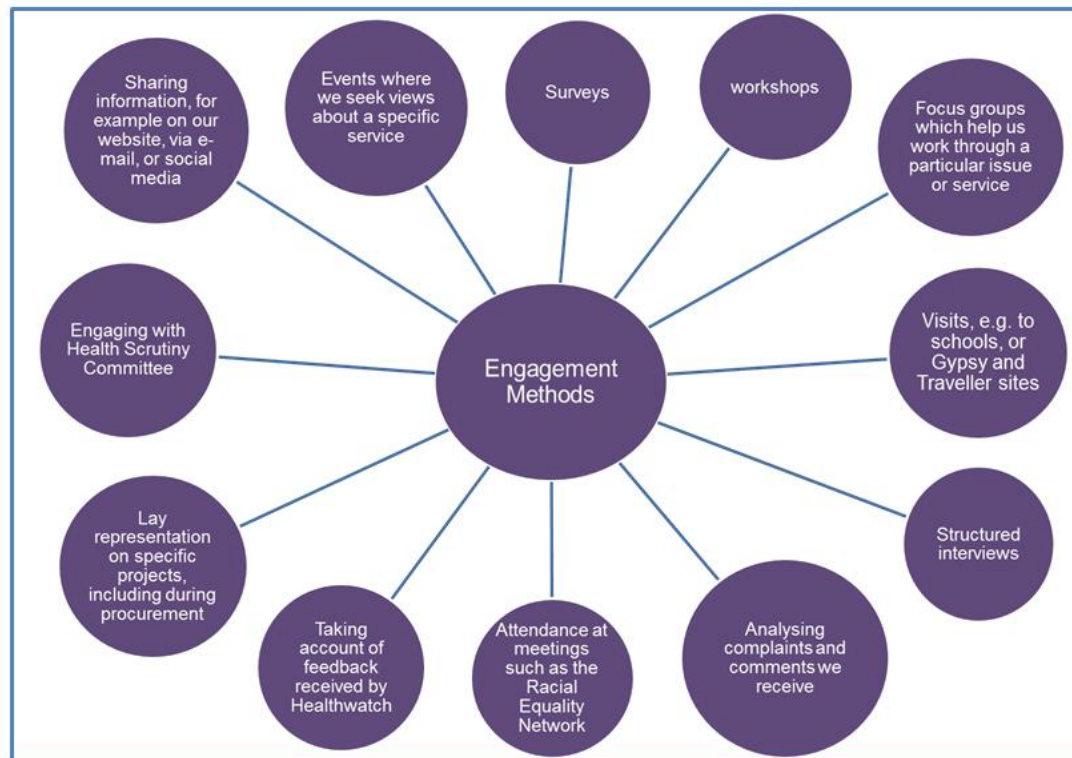
# Our Commitment to Engagement

- We are committed to engagement being at the heart of our work.
- We will continue to listen and act upon patient, carer, service user and public feedback at all stages of the commissioning cycle because of the evident added value of commissioning services that are informed by the experiences and aspirations of local people.
- Our commitment to engagement is supported at a national level in legislation, and in the NHS constitution.
- Public sector equality duties also outline how we must have due regard to the need to eliminate discrimination and harassment, advance equality of opportunity and foster good relations between those who share a protected characteristic and those who do not share it.
- This means it is important that when we undertake engagement we take account of the differing needs of our diverse population.
- Our commissioning intentions for 2017 to 2019 were shaped using evidence from feedback the BNSSG CCGs regularly receive from patients and public
- We published our draft commissioning intentions, inviting comment from patients and public, as well as key stakeholders including: Health and Wellbeing Boards; local Healthwatch organisations and local umbrella organisations for the BNSSG voluntary and community sector



# How we Engage

We will continue to offer proportionate and appropriate engagement opportunities using a range of methods as illustrated below, enabling patients and the public to continue to engage with us in a meaningful way



# Timeline for Engagement

- Our operational plan comprises of programmes of projects aimed at improving service delivery for patients, carers and service users; creating efficiencies where necessary; and re-designing healthcare along pathways of care that minimise variation across our BNSSG area.
- Projects are carefully assessed to determine which ones will both benefit from and require engagement and involvement with the public. This assessment includes ensuring that the timeframe for engagement allows people sufficient opportunity to become meaningfully involved if they wish to.
- Some projects, that have will no impact on the range of services that people receive, or the manner in which they are delivered, do not require public engagement and involvement.
- The projects that do require public engagement and involvement range from very small scale ones, impacting on tens of people, to very large scale ones affecting larger parts of our BNSSG population. Timeframes will vary according to the scale of the project between a minimum of four weeks for those small scale projects to 12 or more weeks for larger scale projects needing formal consultation.
- **Timeframes for each project will be published within the project documentation and on the 'Get Involved' section of our websites.**
- Some projects will commence engagement and involvement following publication of this operational plan.
- We will aim to group projects together that are linked in some way so that we do not create consultation fatigue within our population.

# BNSSG Organisational Development (1)

## Our Aim

Much work has been done to prepare for organisational change in response to an external Capacity and Capability Review commissioned by NHS England in 2016. This included the appointment of a single accountable Chief Executive Officer for the BNSSG CCGs. The aim of the organisational change programme is to embed a clear sense of purpose and identity that enables the three CCGs in BNSSG to operate together as a single entity, with all its energy focused on delivery on behalf of the population we serve.

## Outcomes

- Articulation of shared ambition and vision, underpinned by a single set of organisational values, including a statement of what we want to be known and recognised for as commissioners
- Tangible sense of positive shared commitment to the above within the whole clinical and corporate leadership community, including Members and Governing Bodies, underpinned by a robust governance and decision-making framework
- Clarity of role and purpose throughout the workforce, supported by an emerging proactive, appreciative and developmental culture that enables people to believe in themselves, serve the population, and act as positive advocates for BNSSG
- A systematic approach to identifying and articulating our success on a regular basis, and identifying and learning from the things that don't work
- Clear evidence that the commissioners are taking their rightful place as system leaders across BNSSG, orchestrating change on behalf of the people we serve
- Confidence of the Regulators that BNSSG CCGs are in a strong position for delivery, discharged from regulations pertaining to capacity and capability

# BNSSG Organisational Development (2)

## Our Organisational Development Programme in 2017/18 will:

1. Build a compelling and unified ambition, underpinned by a shared vision and set of values to guide our work, creating a strong sense of the role and purpose of BNSSG commissioners as system leaders and advocates of the local population.
2. Establish the operating model that will enable delivery of our ambition, vision and values, including the appropriate infrastructure for:
  - Governance and decision making
  - Clinical leadership
  - Corporate leadership and management
  - Establishing 'the way we do things around here' – culture by design
3. Supporting people through change throughout the organisation through:
  - Board development
  - Clinical leadership development
  - Corporate leadership development
  - Staff and team development

## Risks and mitigations

### Risks

- Loss of skilled staff due to uncertainty and anxiety about organisational change.
- Inability to balance the competing needs of delivering on the operational plan with the need for organisational change and development
- Inability to deliver the scale of cultural and behavioural change required
- Inability to assure regulators sufficiently to discharge legal directions

### Mitigations

- Appoint single Executive team as quickly as possible to stabilise the workforce
- Appoint a Transition Director to lead the change programme
- Commission experienced consultancy support for delivery of the OD programme

# Digital

Our **2016 Local Digital Roadmap** is not simply a point in time assessment of ‘what to do next’ but a continuation of a long and proud journey. We initiated our award winning **Connecting Care** programme and began the journey of breaking our organisational ‘silos’ to benefit our population long before the *Five Year Forward View* described the high priority of ‘interoperability’.

Our health and care community faces many challenges that we need to address if we are to sustain and improve our system for the future. We understand that technology has a key part to play in helping our region meet its financial challenges – as well as improving efficiency, enabling better care and quality, and closing the wellbeing gap.

In particular the CCGs are committed to:

- Clinical systems – ensuring real-time capture and access to clinical records, regardless of location
- BI and Performance – to provide data, information, knowledge and wisdom in support of the planning, commissioning in and management of care
- Informatics Infrastructure – which is reliable and securely accessible from any location
- Strategic Interoperability – to provide appropriate sharing of clinical information between multiple organisations involved in the health and social care of our patients
- Capability and capacity – so that there is internal and external expertise to support the ongoing running of systems and solutions, as well as research and development in opportunities for new solutions
- Agile working – to drive the most efficient and productive working arrangements across the whole workforce as part of improved health and wellbeing at work

# Digital Programme Summary

## Aims and expected outcome of programme

The ability to operate efficiently, share information and support people is a key priority. Five building blocks for change are:

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

## National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- ✓ Urgent & Emergency
- ☐ Planned Care & RTT
- ☐ Cancer
- ☐ Mental Health
- ☐ Learning Disabilities
- ✓ Improving Quality

## Five Year Forward View requirements

- ☐ Urgent & Emergency Care
- ✓ Primary Care
- ☐ Cancer
- ☐ Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

## Risk and mitigation

- Funding - Whilst it is always possible to be more innovative and more prudent with existing funds, it is also true that adequate funding is needed going forward. Investment funds will require additional savings from system transformation
- Capacity – having enough of the right people with the right skills and the ‘space’ to deliver. We need robust workforce planning and organisational commitment to staff involvement

## STP Priorities

- ☐ Preventing illness and injury
- ☐ Providing care closer to home
- ✓ Personalised care

## Financial summary

- Excellent IT enables delivery of excellent services. Total system spend on IT services is estimated to be in excess of £20m per annum. Further opportunities for system wide procurement planned. Any additional investment will need to deliver improved productivity and financial savings.

Priorities	We will achieve this by doing...	And by when...
Primary Care at scale	<p>Better access to better information about primary care and community services.</p> <ul style="list-style-type: none"> <li>• More 'digital consultations'</li> <li>• Improved quality of care through read/write access to patient record via EMIS.</li> <li>• Efficiencies in primary care through an improved telephony solution</li> <li>• Increasing reporting and management information in primary care. Eg Radiography Imaging</li> <li>• Establishing new ways to support improved self-care</li> </ul>	2017-2019
Paperless 2020	<p>Faster, more reliable transmission of information throughout our system.</p> <ul style="list-style-type: none"> <li>• mobile working and extended use of Wifi</li> <li>• e-prescribing/ telemedicine / wearable devices;</li> <li>• clinical decision support / pathway visibility</li> <li>• Reduced risk to people through errors caused by e.g. missing paper notes, transcription errors.</li> <li>• Financial benefits through the reduction in the costs associated with the management of paper records.</li> </ul>	2017-2019
Connecting Care	<p>To expand on the progress already made in BNSSG with the Connecting Care interoperability platform. This is the natural foundation on which to build access for people to their own health information.</p> <ul style="list-style-type: none"> <li>• document sharing across BNSSG including discharge summaries; end of life care coordination;</li> <li>• development of personal health record capability including self-care via digital solutions;</li> <li>• radiology images and reporting;</li> <li>• piloting of NHS England approved apps and technology on a national tariff basis</li> </ul>	2017-2019
Information Engine	<p>Successful bid to begin building on existing data flows from acute and community, including Primary Care data sets to inform the design of new models of care and population analytics to inform commissioning of different care pathways</p>	2017-2019
Infrastructure & Support	<p>Includes implementation of a single domain for Primary Care to improve operational networking and workforce mobility; hardware and software refresh programmes to support transition to cloud based computing; user testing for NHS Mail 2 deployment in 2017; and operational workflow enhancements including telephony modernisation</p>	2017-2019

# Estates

The strategic goals of the CCG estates programme for BNSSG are:

- **Transformation of services** by providing fit for purpose accommodation aligned with new models of care, with a specific focus on integrated primary care and community health and care services operating at scale
- **Recovering and sustaining system wide financial balance** by optimising use of existing 'fit for purpose' estate, eliminating void, and disposal of surplus estate which is no longer fit for purpose



# Estates

## Aims and expected outcome of programme

The development of a system wide strategic estates programme for BNSSG will be a key enabler for delivery of the Operational Plan and also contribute towards the development to a strategic approach to asset management across the local public sector (One Public Estate). The strategic estates programme will also closely aligned with the local Digital Roadmap.

## Risk and mitigation

**Risk:** Scale and complexity of the task delays realisation of benefits

**Mitigation:** Consider phased approach with emphasis on benefits that can be delivered in the operational plan timescale

**Risk:** Estate plan duplicates or contradicts STP estates plan

**Mitigation:** Ensure Estates Programme aligns to or merge with STP plan

**Risk:** Current national estate delivery models for NHSPS and CHP

**Mitigation:** Working with NHSPS and CHP to develop new pilots to enable different models for estate funding and contract management arrangements that support delivery of our plans

## National Must Do

- ✓ STP
- ✓ Finance
- ✓ Primary Care
- ✓ Urgent & Emergency
- ☐ Planned Care & RTT
- ☐ Cancer
- ☐ Mental Health
- ☐ Learning Disabilities
- ☐ Improving Quality

## Five Year Forward View requirements

- ✓ Urgent & Emergency Care
- ✓ Primary Care
- ☐ Cancer
- ☐ Mental Health
- ✓ Integrating Care Locally
- ✓ Funding and Efficiency

## STP Priorities

- ☐ Preventing illness and injury
- ✓ Providing care closer to home
- ☐ Personalised care

## Financial summary

To be undertaken as part of the stocktake process during Quarter 2

# Estates Programme Priorities

Priorities	We will achieve this by ...	And by when...
Stock take of primary care and community estate to establish baseline	A rapid stock take of current estate including location, cost, utilisation and quality	July 2017
Analysis of current and future service requirements and map how these align to existing estate to reduce voids or future estates requirements	Work with local STP partner organisations and with national NHS PS and CHP to agree future estate requirements to support the Operational Plan. To include consideration and alignment with existing local schemes and opportunities.	October 2017
Agree a strategic estates programme	Agree a strategic estates programme including in-year, medium and long term priorities for delivering the aims and expected outcomes of the programme	January 2018

# Medicines Optimisation (1)

Sustainable and Transformational improvement in medicines optimisation will deliver cost savings, improve efficiencies, maximise benefits from medicines including cost avoidance, and improve patient outcomes reducing variation across the system.

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

- Cost savings; e.g. Biosimilar implementation results in reduced medicines expenditure; better management of medicines results in reduced wastage
- Cost avoidance; e.g. Improved medicines optimisation results in reduced admission and readmission rates and reduced length of stay
- Patient harm reduction; e.g. medicines safety improvements have a direct impact on avoidance of harm and therefore also result in cost avoidance
- Service efficiencies; e.g. service centralisation in order to focus attention on medicines optimisation
- Ensure appropriate and best use of resources, through strong formulary and guideline adherence,.
- Delivery of STP Medicine Optimisation programme and operational projects to deliver financial requirement

This links to national NHS Strategies and action plans; Carter Review of hospital services, Right Care, NICE Medicines Optimisation Guideline.

# Medicines Optimisation (2)

## Prescribing

Prescribing growth is assumed to be about 5% nationally and therefore is an initial starting point to set local budgets before then locally adding a savings target, which reduces the actual percentage uplift on budgets and therefore significant savings need to be realised to achieve allocated budget and a reduced growth target.

Growth on prescribing can fluctuate year on year and can be dependent on a number of factors including capacity and ability to deliver local savings plans, fluctuations in Category M Drug Tariff prices, volatility and unpredictability of No Cheaper Stock Obtainable (NCSO), patent expiries, and introduction of new drugs including NICE Technology Appraisals.

In 2016/17 prescribing growth compared to the previous year was negative for the first time for many years and was -1.01, -1.76 and -1.65 for Bristol, North Somerset and South Glos respectively.

The savings required for 2017/18 require another year of negative growth. Comprehensive savings plans are in place to achieve this and require some big changes, including reviewing what is available on prescription, waste and more capacity invested in processes to ensure cost effective prescribing is maximised.

# Medicines Optimisation Programme Summary

## Aims and expected outcome of programme

Continue to engage commissioner and provider colleagues across BNSSG through the BNSSG Joint Formulary Group, the BNSSG Drugs & Therapeutics Committee and BNSSG NICE College, to identify and commission for unmet need, highlight unwarranted variation, and implement evidence based medicine and innovation into practice, and challenge medicines use that is not safe or cost effective.

## Risk and mitigation

- Capacity of medicines management teams to deliver programme at pace required mitigated by prioritisation to ensure effective delivery and identification of additional project support required
- GP engagement and impact on primary care workload mitigated by ensuring strong clinical leadership and relationships with practices
- Lack of public understanding where services might be delivered differently mitigated by effective public engagement from the outset

## National Must Do

- ✓ STP
- ☐ Finance
- ✓ Primary Care
- ☐ Urgent & Emergency
- ☐ Planned Care & RTT
- ☐ Cancer
- ☐ Mental Health
- ☐ Learning Disabilities
- ✓ Improving Quality

## Five Year Forward View requirements

- ☐ Urgent & Emergency Care
- ✓ Primary Care
- ☐ Cancer
- ☐ Mental Health
- ☐ Integrating Care Locally
- ✓ Funding and Efficiency

## STP Priorities

- ✓ Preventing illness and injury
- ✓ Providing care closer to home
- ☐ Personalised care

## Financial summary

Effective delivery of the programme to ensure that the medicines management allocation is met across BNSSG

# Medicines Optimisation Programme Priorities

Priorities	We will achieve this by doing...	And by when...
<p>Commissioners in BNSSG will work together to improve patient outcomes through better use of medicines, ensuring that innovation and evidence-based care is embedded into routine practice through medicines optimisation.</p> <p>We will identify and commission for unmet need, highlight unwarranted variation, and implement evidence based medicine and innovation into practice, and challenge medicines use that is neither safe or cost effective.</p>	<p>To apply Right Care medicines data on variation to BNSSG to focus on areas for improvement and implement changes , aligning with other work programmes across the care pathway e.g. Stroke prevention, Breast cancer.</p> <p>BNSSG Joint Formulary Group, the BNSSG Drugs &amp; Therapeutics Committee and BNSSG NICE College. Collaboratively implement the first BNSSG Paediatric Joint Formulary. Engage with Regional Medicines Optimisation Committee</p> <p>Continue to develop evidence based, cost effective BNSSG prescribing guidance and clear pathways of care, to reduce admissions and demand on health care.</p> <p>Continue to commission the same prescribing support tool for use in GP practices across BNSSG, share resource to monitor and manage the system.</p> <p>Through good relationships and working directly with all prescribers ensure cost effective prescribing.</p> <p>Ensure that those services that we commission to reduce unnecessary referral, admission, or prescribing activity continue to improve quality, productivity and outcomes and align across BNSSG.</p> <p>Ensure that those services that we commission from community pharmacists to provide better access to healthcare closer to home continue to improve quality, productivity and outcomes and where possible align across BNSSG</p> <p>Work at local level in collaboration with NHS England, contractors and providers to identify, learn from and reduce medication errors</p>	<p>2017-18</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p> <p>Ongoing</p>

# Medicines Optimisation (2) Bristol, North Somerset and South Gloucestershire Clinical Commissioning Groups

Priorities	We will achieve this by doing...	And by when...
Continue to develop methods to achieve better value for money for the local NHS on high cost 'pass through' drugs excluded from the PbR tariff, ensuring outcomes are achieved in line with NICE Technologies.	Biosimilars. Work with medical teams ( eg GI, Rheumatology, Dermatology) and patients to implement the more cost-effective biosimilar pharmaceutical products & manage the transfer to these drugs where clinically appropriate.	2017-18
	Establish an embedded pharmacist in acute services to ensure robust management of high cost drugs and appropriate medicines optimisation in care pathway design. Introduce the use of BlueTeq across all trusts to aid assurance that drugs are used in line with NICE TA or local pathways.	2017-18
	High Cost Drugs. Review the use of the most expensive drugs and ensure they are being used appropriately and consider if improvements could be made.	2017-18
Continue to address patient care issues that relate to medicines use, where these occur at the interface between primary, secondary, community and local authority.	E-Referrals. Use available technology to transfer discharge information to community pharmacists to provide follow up care for patients taking complex medicines.	2017-18
	Improve the patient experience (timely supply of medicines) when attending for out-patient appointments or day case admissions.	2017-18
Medicines are optimised in primary care, minimising medicines waste	Compliance Aids. Work more closely with colleagues in all care settings to rationalise the use of multi-compartment compliance aids.	2017-18
	Commissioning Options. Conduct options appraisals on the prescribing in the areas of Stoma and Continence with view to upscale; creating efficiencies and introduce a consistent service to patients.	2017-18
	Community Providers. Seek to devolve budgets directly to areas responsible for prescribing certain medicines and appliances prescribed	2017-18
	Repeat Prescriptions management service pilot. To manage repeat prescription services in order to avoid provision of unnecessary medicines and reduce wastage.	2017-18

# Medicines Optimisation (3)

Priorities	We will achieve this by doing...	And by when...
<p>Patient centred care and medicines optimisation for people with Long Term Conditions, leading to improved patient outcomes.</p> <p>Avoidance of adverse drug reactions, especially among vulnerable groups such as the frail, or elderly</p>	<p>Polypharmacy (GP guidance &amp; care homes). Review medicines being taken by the frail elderly, particularly within the care home context, in order to ensure that all medicines are necessary and appropriate.</p> <p>Enhance and continue to commission pharmaceutical support for patients in care homes and patients in their own homes.</p> <p>De-Prescribing. Identify and agree medicines that are considered to have no proven benefit and implement de-prescribing protocols.</p> <p>Enhanced multidisciplinary working e.g. Integrated respiratory service, Diabetes specialist nurse service.</p>	<p>2017-18</p> <p>2017-18</p> <p>2017-18</p> <p>2017-18</p>
<p>Ensuring appropriate use of antibiotics in both primary and secondary care, given the concerns around antimicrobial resistance and risks of healthcare associated infections.</p>	<p>Antimicrobial stewardship activities in line with national policy to reduce overall antibiotic prescribing and the percentage that are broad spectrum, utilising TARGET resources and local guidelines. Work with clinicians in primary and secondary care to achieve the 2017-19 Quality Premium and CQUINs.</p>	<p>Ongoing</p>
<p>Ensure that valuable NHS resources are not consumed by the prescribing of items that do not represent good value for money, or are not a priority for investment</p>	<p>Support patients to self care where appropriate and implement national guidance on reducing the use of drugs of limited clinical value</p>	<p>2017-18</p>



# Operational Plan Risks and Mitigations

Key risks to the delivery of the BNSSG Operational Plan have been identified through the work programmes. Risks are assessed against probability (likelihood) and impact (consequence) and mitigating actions put into place to manage any unacceptable risks. Summary over-arching risks and mitigations that have been identified include :

Risk Area	Risk	Mitigating Actions
Strategic	That commissioning plans required to deliver the operational plan impact adversely on longer term strategic priorities and objectives	<ul style="list-style-type: none"> <li>• Work closely with partners to understand the impact of short-term plans on longer term priorities.</li> <li>• Ensure alignment with system financial recovery plans and strategic commissioning priorities</li> </ul>
Operational	Growth and activity exceed levels within commissioned plans	<ul style="list-style-type: none"> <li>• Robust monitoring of activity levels delivered and waiting time performance against contracted levels.</li> <li>• Ensure patients are signposted to the most appropriate point of care</li> </ul>
Operational	Insufficient provider capacity to deliver commissioned activity.	<ul style="list-style-type: none"> <li>• Plans and contracts to reflect IHAMs activity assumptions and risk assessment of this</li> <li>• Whole system demand and capacity planning to be undertaken</li> <li>• Robust monitoring of provider capacity across BNSSG</li> <li>• Manage demand for elective activity through further development of access protocols and commissioning policy</li> </ul>
Operational	Contractual arrangements with providers don't allow shift of resources between providers to support transformational plans.	<ul style="list-style-type: none"> <li>• Develop risk sharing arrangements between providers that encourage them to shift resources that support transformational change</li> <li>• Explore alternative contractual arrangements that incentivise risk sharing</li> </ul>

# Risks and Mitigations

Risk Area	Risk	Mitigating Actions
Operational	Non-Delivery of constitutional standards with particular risk around 4hr A&E , RTT and 62 Day Cancer Pathway.	<ul style="list-style-type: none"> <li>• System wide recovery plans developed for all core standards</li> <li>• Recovery plans performance managed through BNSSG Delivery Boards</li> <li>• Aligned Performance , Activity and Financial reporting embedded across BNSSG</li> <li>• Utilisation of external expert support where required e.g. ECIP and IMAS</li> </ul>
Workforce	Risk to sustainability of Primary Care due to workforce pressures leading to increasing patient demand elsewhere in the system	<ul style="list-style-type: none"> <li>• As co-commissioners of Primary Care close working with NHSE has resulted in scoping and identification of vulnerable practices</li> <li>• Development work will focus on sustainability</li> </ul>
Financial	Non- Delivery of BNSSG Financial Control Total	<ul style="list-style-type: none"> <li>• System Financial Recovery Plan developed and approved between commissioners and providers</li> <li>• System Financial Recovery governance structure implemented to oversee delivery of plan</li> </ul>

# Risks and Mitigations

Risk Area	Risk	Mitigating Actions
Workforce	Clinical workforce constraints across Primary and Secondary Care result in inability to deliver transformed services	<ul style="list-style-type: none"> <li>The Director of Nursing and Quality chairs a quarterly group with HEE, the universities who provide training to staff groups in North Somerset, to discuss the on-going CPD needs of the workforce and the new models of education required for pre-registration students. Additionally this is discussed at the CCG's QIG.</li> <li>BNSSG Clinical Workforce Strategy to be developed</li> </ul>
Operational	Risk to collaborative relationships across BNSSG due to rapid and substantial changes to the way services are delivered.	<ul style="list-style-type: none"> <li>Clear narrative about why change is needed</li> <li>Close working with partners across BNSSG</li> <li>Early Local authority engagement</li> <li>Increased engagement with all members of the People and Communities Board</li> <li>Involve providers in development of plans</li> <li>Robust Communications and Engagement Strategy and detailed plans for resourcing and delivering these.</li> </ul>
Quality	Risk that proposed commissioning plans negatively impact quality of services provided	<ul style="list-style-type: none"> <li>All plans reviewed through Quality Impact Assessment and Equality Impact Assessment</li> <li>On-going quality and equality monitoring through delivery governance</li> </ul>

## Bristol, North Somerset and South Gloucestershire

Clinical Commissioning Groups

Acronym	Description	Acronym
A&E	Accident and Emergency	MDT
A&G	Advice and Guidance	MH
AWP	Avon and Wiltshire Mental Health Partnership	MSK
BCF	Better Care Fund	NBT
BCH	Bristol Community Health	NHS
BNSSG	Bristol, North Somerset and South Gloucestershire	NHSE/I
CAMHS	Child and Adolescent Mental Health Service	NSCP
CCG	Clinical Commissioning Group	NICE
CFO	Chief Financial Officer	OT
CfV	Commissioning for Value	PbR
CHC	Continuing Healthcare	PCF
CIP	Cost Improvement Plan	PCN
CNS	Clinical Nurse Specialist	PHE
CQUIN	Commissioning for Quality and Innovation	PIC
CVD	Cardiovascular	PIFU
CYP	Children and Young People	PTS
D2A	Discharge to Assess	PWLD
DQIP	Data Quality Improvement Plan	QIPP
DTOC	Delayed Transfers of Care	QOF
DVT	Deep Vein Thrombosis	QP
ED	Emergency Department	RSS
ERS	Electronic Referral System	RTT
FYFV	Five Year Forward View	SEND
GP	General Practice/Practitioner	SIRONA
GPFV	General Practice Forward View	SFRP
HASU	Hyper-acute Stroke Unit	SPA
HRG	Healthcare Resource Groups	STF
IAPT	Improving Access to Psychological Therapies	STP
IBD	Irritable Bowel Disease	TCP
IHAM	Indicative Hospital Activity Model	T&O
LA	Local Authority	UHB
LMS	Local Maternity System	WAHT
LoS	Length of Stay	WiC
LTC	Long Term Condition	YTD
MCP	Multispecialty Community Provider	

Multi-Disciplinary Team
Mental Health
Musculoskeletal
NHS North Bristol Trust
National Health Service
NHSE England/Improvements
North Somerset Community Partnership
National Institute for Health and Care Excellence
Occupational Therapy
Payment by Results
Primary Care Foundation
Prescribing Clinical Network
Public Health England
Patient Initiated Contact
Patient Initiated Follow Up
Patient Transport Service
People with Learning Disabilities
Quality Innovation Productivity and Prevention
Quality and Outcomes Framework
Quality Premium
Referral Support System
Referral To Treatment
Special Educational Needs and Disabilities
Sirona Care & Health
System Financial Recovery Plan
Single Point of Access
Sustainability Transformation Fund
Sustainability and Transformation Partnership
Transforming Care Plan
Trauma & Orthopaedic
University Hospitals Bristol
Weston Area Health Trust
Walk In Centre
Year to date

Final page