Healthier **Together**

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

Developing our Five Year System Plan

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Healthier Together

Contents

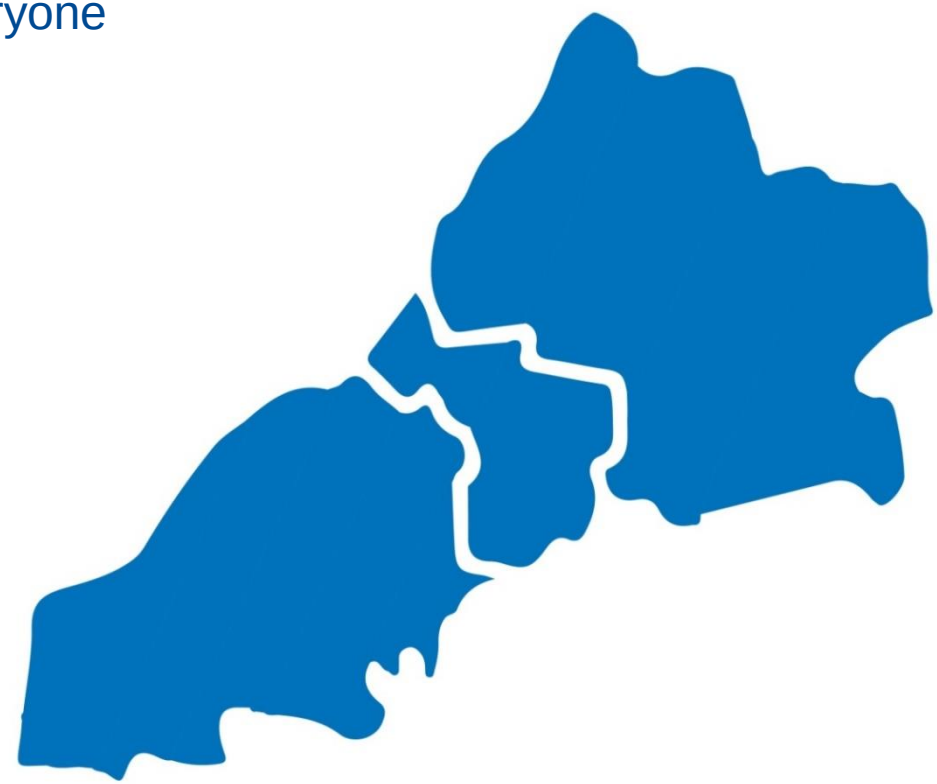
1. Approach to developing our 5-year plan

Our five year plan will focus on improving health and wellbeing for our populations

Vision - healthy, fulfilled lives for everyone

Goals

- Reduce inequalities in healthy life expectancy
- Release and reallocate resources from low value to high value activity
- Optimise people's independence
- Ensure our system deliver compassionate and high quality care
- Build a healthy and fulfilled workforce



Our starting point is to understand our populations better….

We have agreed design principles to guide our approach

Focusing on population, people and place – focusing on population health and wellbeing, identifying the outcomes that matter to people and understanding place from a resident's perspective

Targeting interventions to address inequality – tailoring approaches to address variation and under/over representation, and to take account of geography and cultural diversity

Addressing wider determinants of health and inequalities – working in partnership to give children the best possible start in life; improve education and employment outcomes; and contribute to inclusive growth

Reducing our impact on the environment – assessing the environmental impact of developments; reducing our carbon footprint and promoting better air quality

Investing in localities and neighbourhoods and in community capacity building to support health and wellbeing – devolving accountability and decision making as close to the community as possible

Applying data, intelligence and resources in a value based approach to understand population health, focus on outcomes that matter to people and ensure best possible use of all our resources

Identifying what matters to people – measuring outcomes, promoting independence and personalising care

Focusing on hearts and minds to drive change – facilitating cultural shift, embracing innovation and adopting best practice

Evidencing committed ownership of all partners – agreeing credible plans and timelines for delivery and embedding them in our organisational plans

We are developing a framework for our 5-year plan that reflects local and national priorities and strategies…

Ambitions

Improve Population Health and reduce gap in healthy life expectancy

Systematic delivery of value-based care

Shift to personalised, integrated, proactive and preventive care

Rebalance resources

Our Population

Local needs

Inequalities

Outcomes focus

Targeted interventions

Architecture

Strengthen primary care

Build integrated care partnerships at a locality level – including building healthier communities

Network acute care, deliver consistent standards and integrate access to specialist care closer to home

Develop further our specialist services to lead regionally, nationally and internationally

Promote research and innovation

Priority Care Programmes

- Prevention
- Children and Families
- Mental Health
- LD and Autism
- Frailty
- End of Life
- Maternity
- Diabetes
- Respiratory
- Cancer
- CVD
- Stroke
- Planned care
- Outpatients
- Urgent care/SDUC
- Medicines Optimisation

Key Enablers

- Digital
- Workforce
- Estates

Delivery Plans

Locality Plans

Performance management

Finance narrative

Roadmap for delivery

Activity Plan

Financial Plan

Workforce Plan

Performance trajectories

Strategic narrative ← → **Delivery plans and numerical returns**

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2. Our Population & Outcomes

Our approach to population health & population health management

Taking a population health approach means that we are collectively responsible for improving the physical and mental health outcomes and wellbeing of the people of Bristol, North Somerset and South Gloucestershire, while reducing health inequalities.

In doing so this approach guides us to prevent ill health, deliver quality health and care services and impact on the wider determinants of health. We believe this will only be achieved though working as a health and care community, which includes our patients and public.

A key enabler of our value based population health approach is the Population Health Management (PHM) programme, which aims to improve population health by data-driven planning, delivery and evaluation of care. Operationally this has involved the construction of a linked dataset across primary, secondary, community and mental health care, which is then used to facilitate analysis of a single longitudinal person record to enable more sophisticated intervention planning.

Through our involvement on Wave Two of the National Population Health Management development programme, we expect to expand our capability to broaden the breadth and depth of the linked dataset and over time bring together our data and intelligence assets to enable our system to deliver better value for our population.

We are already working with our frailty programme to improve the modelling of integrated locality hubs, urgent and emergency care where we have identified that 1% of users of those services use 50% of resource and are comprised of a frail and multimorbid cohort, and developing a targeted approach to improving the early diagnosis of cancers.

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We know that we need to address the wider determinants of health to improve health and have a sustainable system. We can address these as a partnership.

46% **of Bristol secondary school leavers are not achieving five GCSEs grade A*-C including mathematics and English**

North Somerset 42%; South Gloucestershire 43%

27% **of children across BNSSG are not considered to have achieved a good level of development at the end of reception.**

5.1% **of mortality in Bristol and South Gloucestershire is attributable to air pollution**

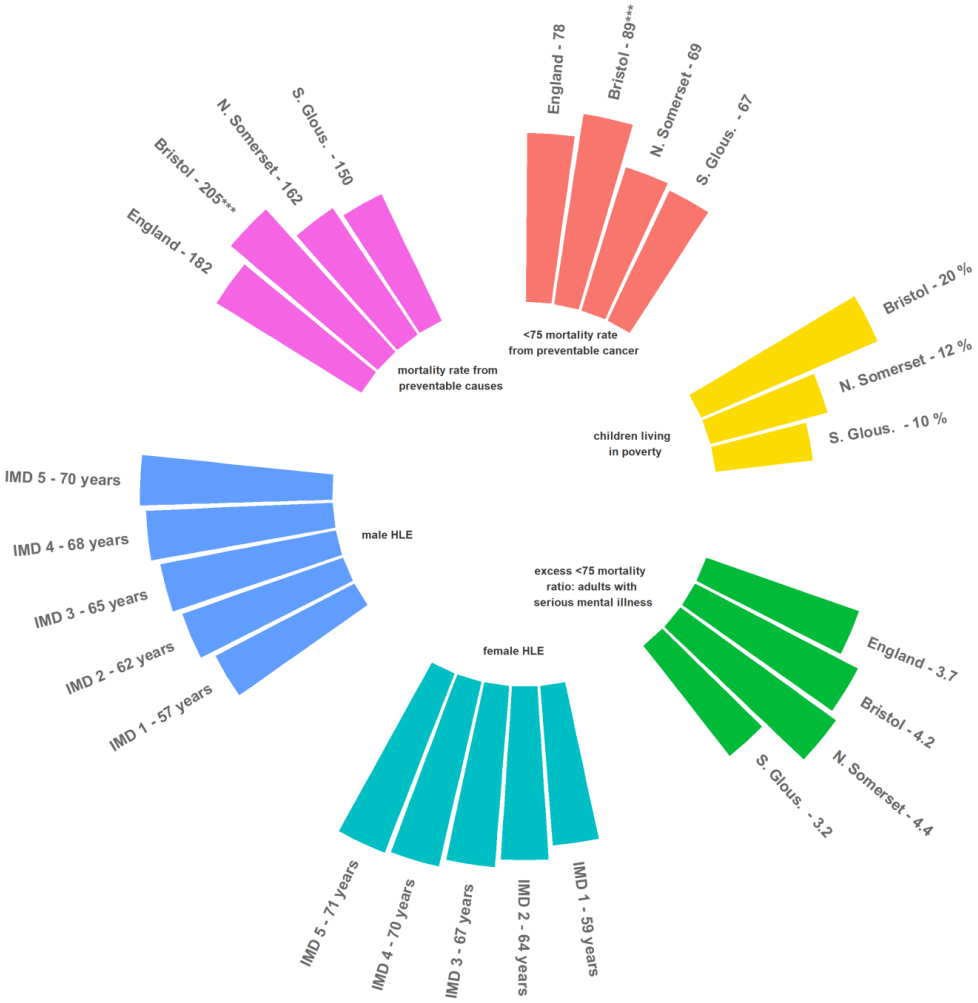
North Somerset 4.3%

21% **of people aged 16-64 in North Somerset are unemployed**

Bristol 22%; South Gloucestershire 21%

We also know that health inequalities play a large part in the demand for health and care services

The inequalities in health outcomes that we observe in the system are the result of the current state of the wider determinants of health, how people manage their own health and the function of the health system.



Guidance Notes

HLE: Healthy Life Expectancy.

IMD 1: most deprived population quintile by index of multiple deprivation.

Excess <75 mortality ratio is the number of times greater than the background population.

Mortality rates are directly standardised per 100,000 population.

Outliers with statistically significant differences from the England average are denoted ***.

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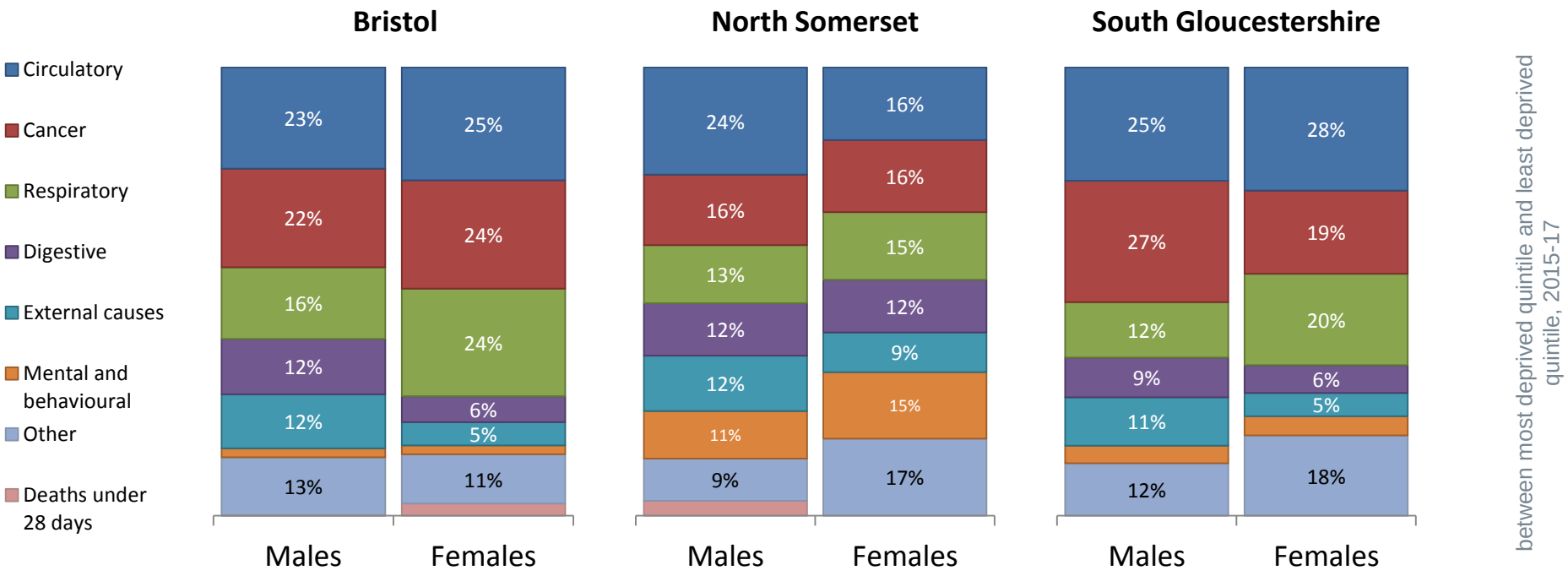
Our approaches to reducing inequalities are determined through local insight about population health

This insight is generated through local engagement with communities and stakeholders, as well as data from population health management to enable us as a system to develop a common understanding of the complex causes and costs of health inequalities and what we can do to address them. We will use national tools and guidance such as such as the PHE Place-based approaches for reducing health inequalities to support us in this work.



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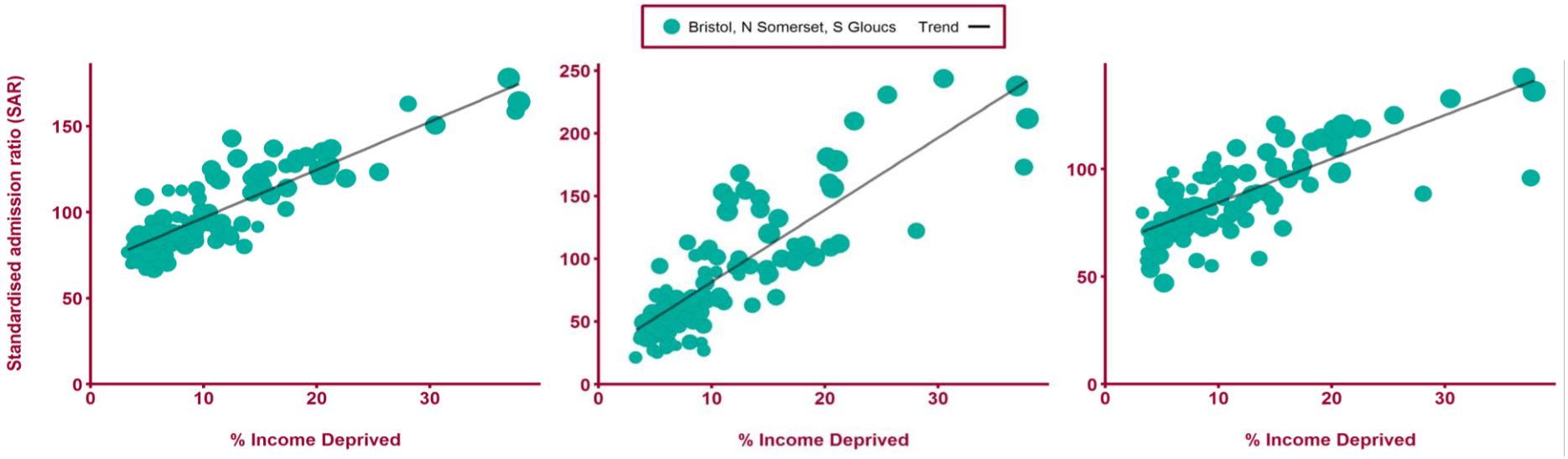
Health inequalities are not only bad for the people who experience them, but there is a strong correlation between deprivation and demand on the health system, and in particular the acute system

Across a range of indicator conditions, health inequalities have a significant impact on acute hospital activity.

Alcohol related harm | **COPD** | **Coronary Heart Disease**



We know that people living with mental health problems, learning disabilities and/or autism have poorer access and outcomes

Bristol autistic spectrum service for adults
292 people waiting, average wait 8 months

Autistic Spectrum Diagnosis Pathway for children and young people
463 people waiting (January 2019)

Child and adolescent mental health services
660 children waiting for access (December 2018)

Improving access to psychological therapies (IAPT)
Estimated by September 2019 there will be 3400-3840 people waiting for their second treatment

Completeness of the GP learning disability register (BNSSG prevalence 1.7%, England prevalence 1.5%)
0.46% of population on a register (6th/11 CCG peers; 104/195 in England)

Proportion of people with a learning disability on the GP register receiving an annual health check
51.9% (5th/11 CCG peers; 72/195 in England)

Self-harm
2,200 emergency admissions annually, predominantly females and Bristol more than other areas

In line with the global Value Based Healthcare movement we are taking a value based approach to population health

For us this means following three core principles:

- Firstly it means that the outcomes we are trying to improve are outcomes that matter to people and our population. We need to understand and respond to these outcomes from the level of the clinic to the board room.
- Secondly it means delivering quality, cost-effective services based on the best available evidence to the people who will benefit; avoiding both under and overuse of healthcare.
- Thirdly it means taking both a ‘bottom up’ and ‘top down’ approach to analysing and planning the allocation of resources across our system in order to achieve the greatest overall benefit.

Healthier Together has developed a Value Programme, working with the Aneurin Bevan University Health Board and Professor Sir Muir Gray’s Oxford Centre for Triple Value Healthcare. Although in the early stages we have trained a clinically led, cross-system multidisciplinary group of 25 leaders, worked with programmes to develop whole system outcome sets in co-production with people with lived experience, and we are engaged in a procurement process to secure a digital platform to enable our system partners to systematically measure patient reported outcomes measures.

Our 5 year plan will be define value in terms of our ambitions for improving outcomes that matter to people in BNSSG and how we will measure progress…

We have started a discussion, working with our Directors of Public Health, on what overarching outcomes our system will direct its efforts at achieving. These outcomes will be ones that can only be achieved using the efforts of all partners, the community's assets and individual people.

We'll be working with public health, wider local authority and other partners over the next few weeks to finalise a set of outcomes

Our overarching aim is to:

Improve the overall health of everyone in BNSSG and improve the health of the poorest fastest

Outcomes we will monitor include:

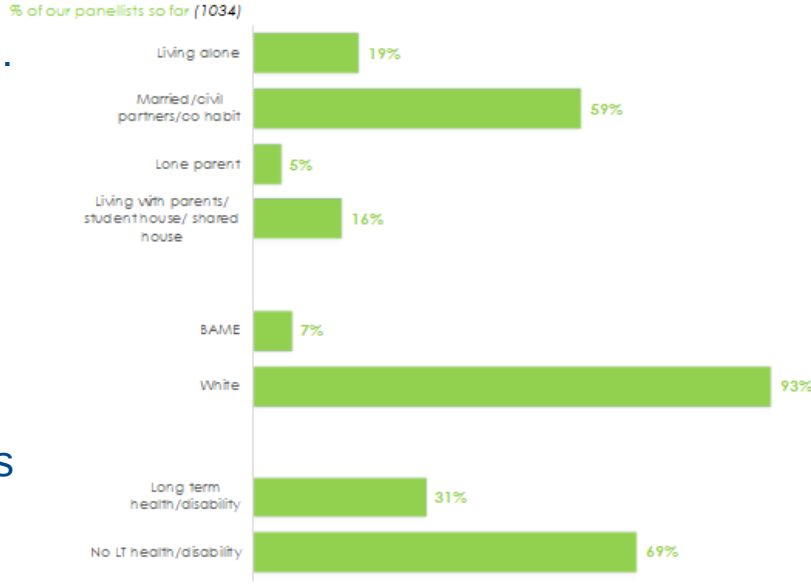
- Healthy life expectancy
- Premature mortality
- Mental health and wellbeing
- Educational attainment
- Inequalities in outcomes

We are also having meaningful conversations with our population to understand their needs and wants further

In 2018, we established the Healthier Together Citizen's Panel. Our vision is to have a detailed understanding of the needs and wants of the population of BNSSG, and use this insight to connect to the behavioural insights gained through Population Health Management to ensure we have a thorough understanding of the key drivers which lead to the behaviour we observe.

This will allow us to make more sophisticated and effective decisions on how we allocate resource and plan services.

The Citizen's Panel has completed 3 waves of research. We have recruited a total of 1,034 panellists, carefully calibrating our recruitment to ensure that we have a panel which is robust and representative of the population we serve.



We will continue to explore key areas of focus from our 5 year system plan using the full panel, and are also conducting deliberative research with smaller subgroups within our population to ensure that our plans are developed through meaningful conversations with our

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These insights are already shaping our decisions

73% of BNSSG residents report that they are **feeling healthy**

65% of BNSSG residents currently **feel in control** of their lives

Only **62%** of BNSSG residents currently **feel happy**

If BNSSG residents were in control of the health and care budget, 28% of it would be split equally between adult and children's mental health

They would split a further 30% of the budget equally between hospital care and General Practice

The remaining 42% of the budget would be shared relatively equally between services for older people, learning disabilities, end of life care, children's social care and adult social care

11% of BNSSG residents report that they have had an outpatient or clinic appointment that they considered to be a waste of their time

13% of BNSSG residents report that they have had surgery or treatment that they later regretted (or know someone who has)

Between one half and two thirds of BNSSG residents would travel (up to 3 hours on average) to receive specialist care with better results, rather than stay close to home


BNSSG
as
100 People
Diet
8 use pre-prepared food
21 prepare simple meals or use pre-prepared ingredients
69 prepare meals from scratch
Age
17 aged 0-4
65 aged 15-64
17 aged 65+
Adult weight
61 overweight or obese
Child weight
32 overweight or obese
Adult Smoking
16 current smokers
Area
48 in Bristol
23 in North Somerset
29 in South Gloucestershire
Geography
86 in urban areas
14 in rural areas
Ethnicity
90 are White
4 are Asian
3 are Black African/Caribbean
2 are of multiple ethnicity
1 is of another ethnicity
Main language
95 English
2 European
1 Polish
2 Asian
1 Arabic or African
Deprivation
16 most deprived
26 least deprived
Alcohol
23 report binge drinking
Childhood immunisation
14 not completed MMR by 5 years old

And we are engaging people through our Stakeholder event (17 Oct), Citizens Panel and deliberative sessions…

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We have been engaging Health & Wellbeing Boards in developing design principles to guide our approach…

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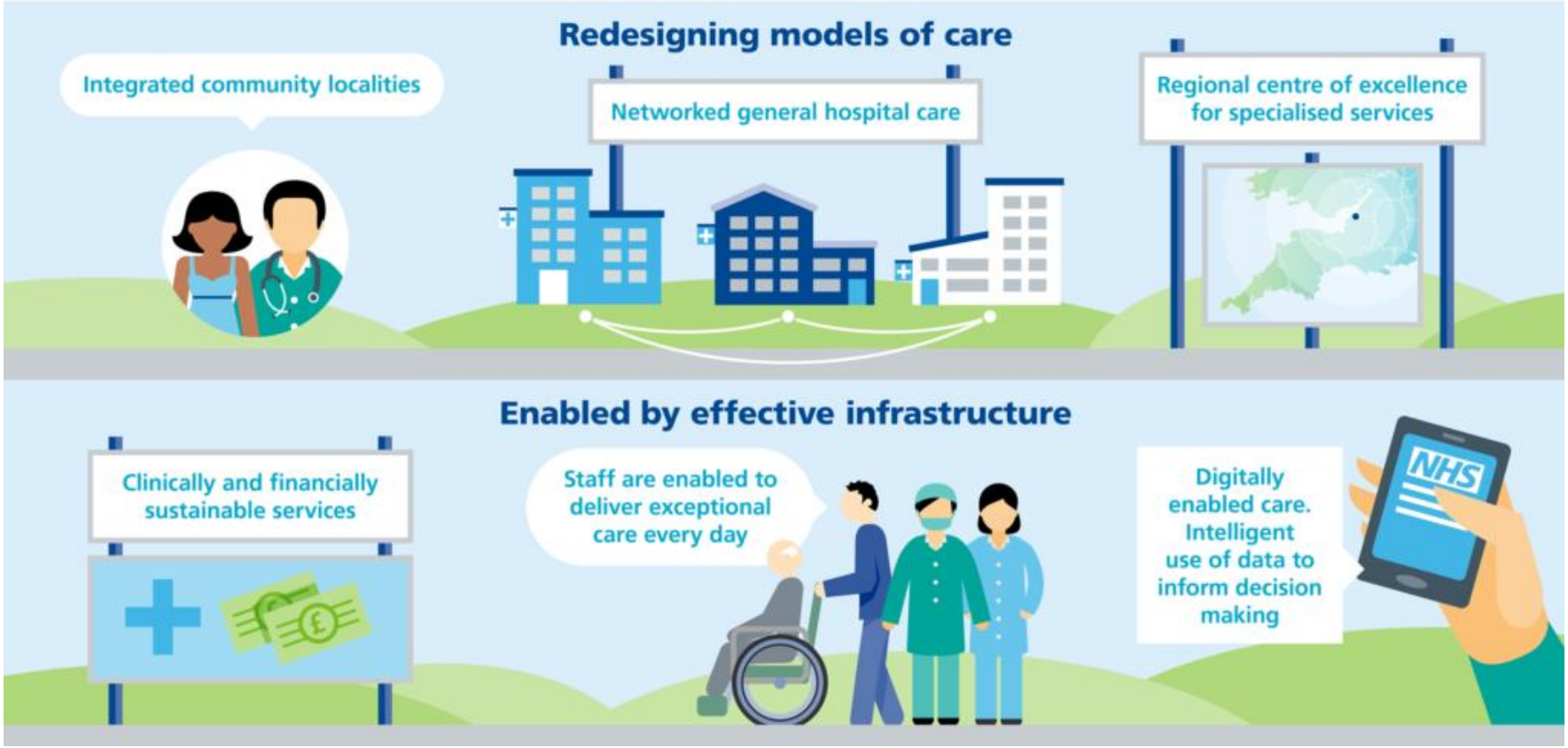
3. Key themes within our 5-year plan

We will build on our vision for redesigning care and support to improve outcomes that matter to citizens, service users and staff



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The foundation of our strategy is to build integrated care partnerships at locality level...

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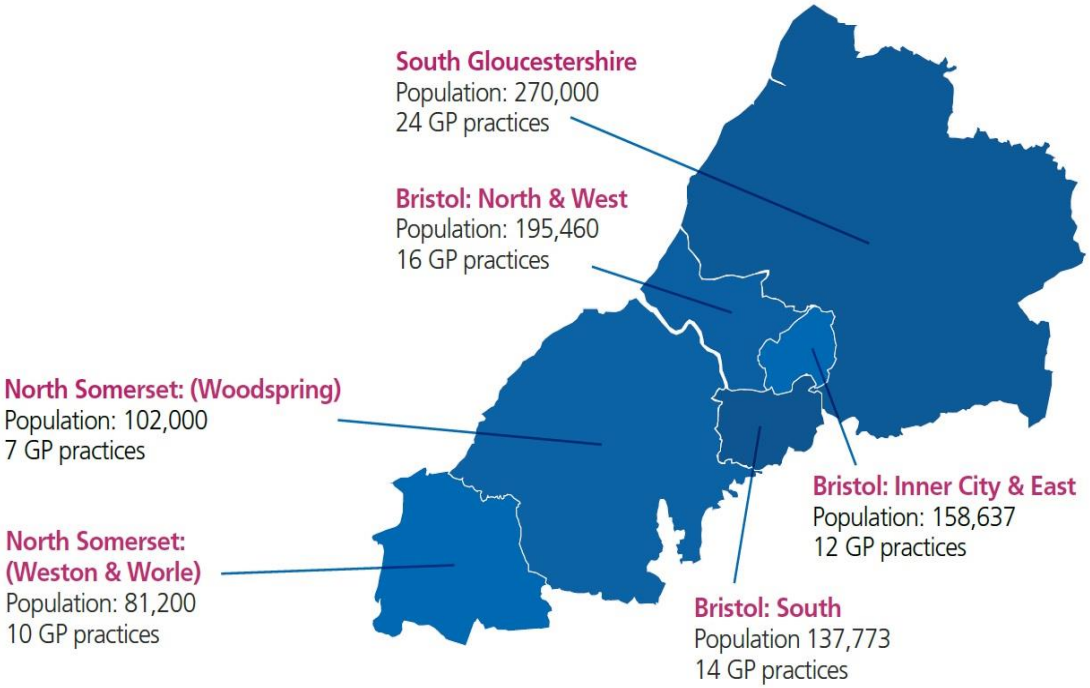
We have six localities across BNSSG, each with a population of between 100-250k

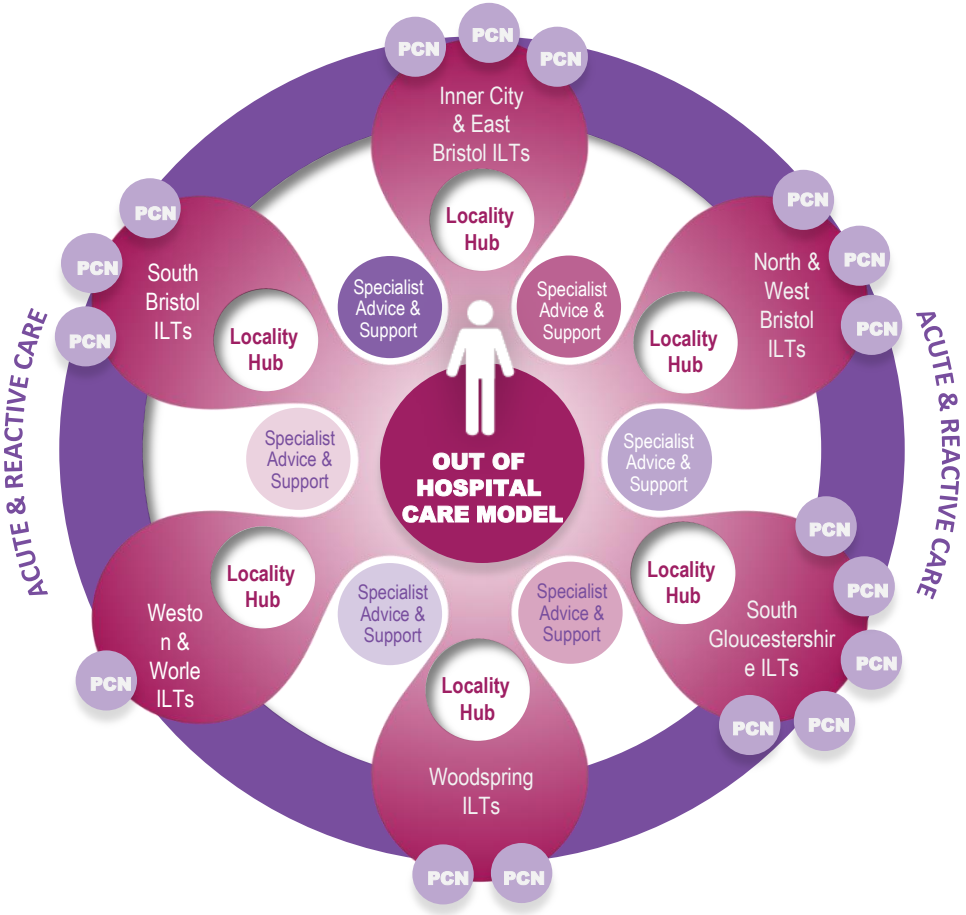
- Natural geographies based around GP practice populations
- GP clinical leadership within a provider alliance, moving towards full Integrated Care Partnerships from 2021
- Large enough to impact on system and delivery of successful integrated model of care in the community
- Able to accommodate smaller units within the locality e.g. 30-50k model to deliver MDT working



Our new single BNSSG wide community services model is designed to accelerate progress towards fully integrated localities as a key enabler of ICPs

These teams will be able to focus more on prevention and proactive, anticipatory care, providing continuity of care for people with varying needs.

They will expand the range of services available from core teams in the community, reducing the need to refer people to new services when they are most vulnerable and the need for specialist referrals, reliance on emergency and crisis services and avoidable admission of people to hospital in-patient wards in acute or mental health hospitals.



Specialist care and support will be integrated within localities and hospital services will be delivered through networks…

We will increasingly use the specialist staff in our hospitals to support the locality teams, in addition to caring directly for their patients, so that generalist teams can deliver technically excellent as well as holistic care to people with more severe health conditions. These changes will reduce the number of people attending urgent care and specialist hospital services who could be better supported in the community, allowing hospital consultants to give direct care to people who most need their support.

One example of closer integration is the proposed model for outpatient services. This model is based on enhanced links between named specialists and locality teams who will work together in a virtual integrated team to support more delivery of care out of hospital, fewer deteriorations of care, ability to manage higher acuity locally and reduce duplication and low value activities for patients and staff.

Our hospitals will work together in a network to improve the quality of all our general hospital services through sharing scarce resources such as particular consultants, working together to benchmark performance and on improvement projects. We will deliver exceptional quality and outcomes through consistent and aligned services. We will reduce cost through better use of estate and reduced service duplication. We will improve clinical sustainability and the experience of our staff by working as one network

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Collaborating for excellence specialist hospital services - making best use of specialist skills and facilities

Our hospitals will continue to develop as regional, national and international centres of excellence delivering highly specialist services for people across the south west of England, building on the progress we have already made in cancer treatment, cardiac surgery and paediatrics amongst others.

Our 5-year plan will set out our ambitions for further development and expansion of some of our most specialist services, working in partnership with our local Universities in promoting research, innovation and education.

We will agree our plans with NHSE Specialised Commissioners so that this work is aligned at a regional and national level. the South West and beyond.

Genomics is an example of the potential opportunities in BNSSG. We have one of only seven genomics laboratory hubs in the country, a genomics medicines service and whole genome sequencing and we want to continue to be at the forefront of supporting more personalised medicine for patients with cancer and rare diseases.

Digital transformation offers an opportunity for us to make these changes within the context of limited workforce supply

We will build on our significant progress to date on delivering digitally enabled health and care in the next five years. Our Connecting Care integrated digital care record has been in use across all partners since 2013 and is paving the way for delivering digital innovation as a partnership by 2024.

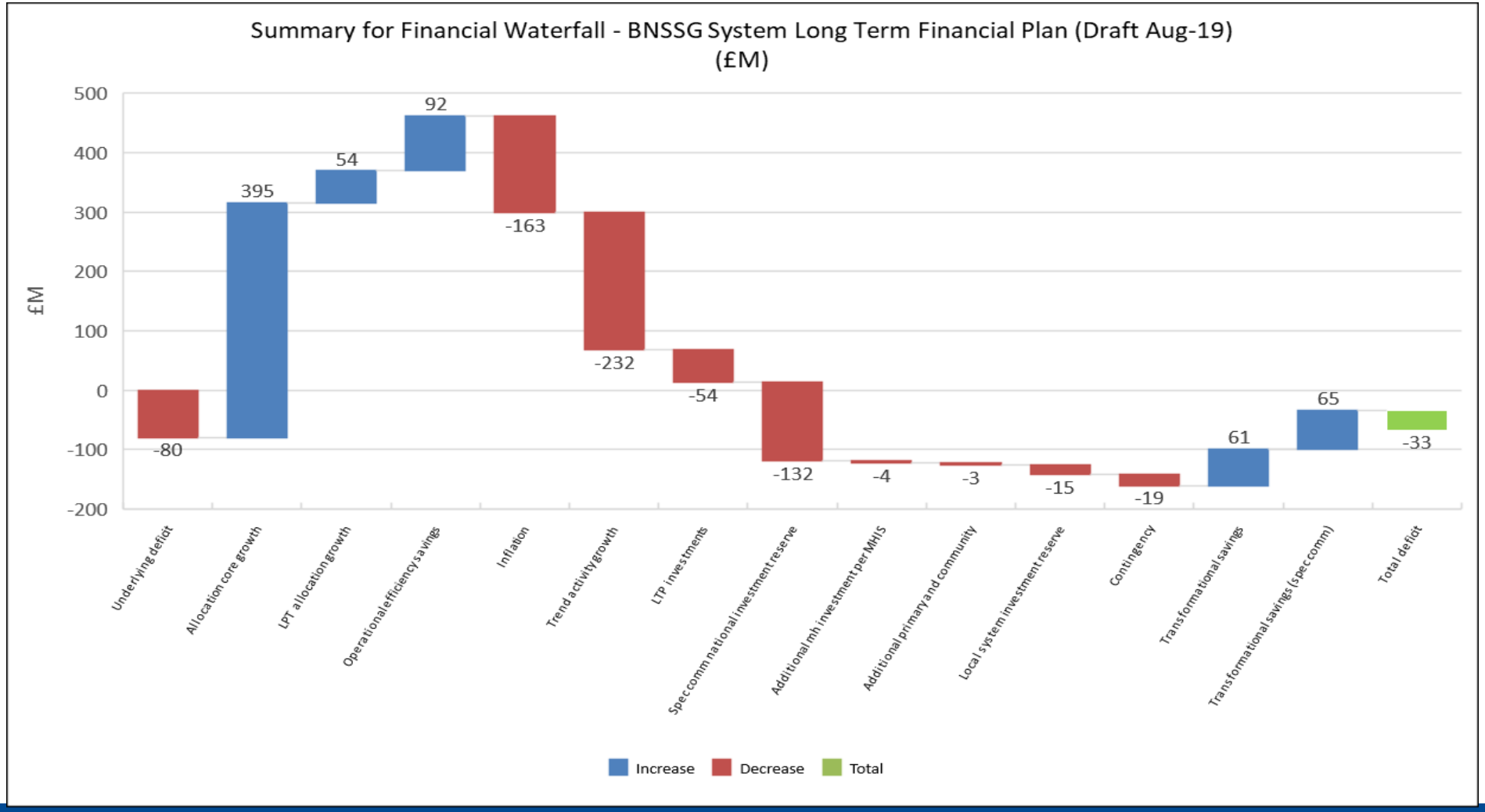
- Digital information captured at the point of care
- Reliable and prompt communication between staff through integrated digital records and messaging systems
- People will be able to access and interact with their records
- Automation of low value transactions such as booking appointments, ordering prescriptions and receiving test results
- Digitally enabled health and social care including assistive technology that builds on our asset-based model
- 24/7 access to advice, guidance and support across different services
- Involvement of the public and staff in developing digital systems and applications

connecting care

4. Rebalancing resources to achieve financial sustainability

We will set out plans for progressing towards financial balance by improving efficiency and reducing unsustainable growth

Summary planning assumptions

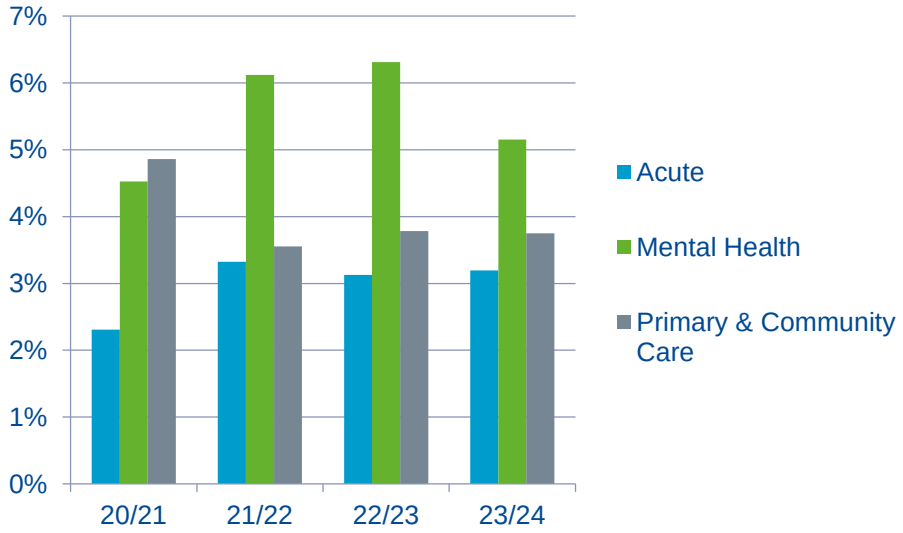


To enable the changes we will set out commitments to invest in primary and community care and mental health

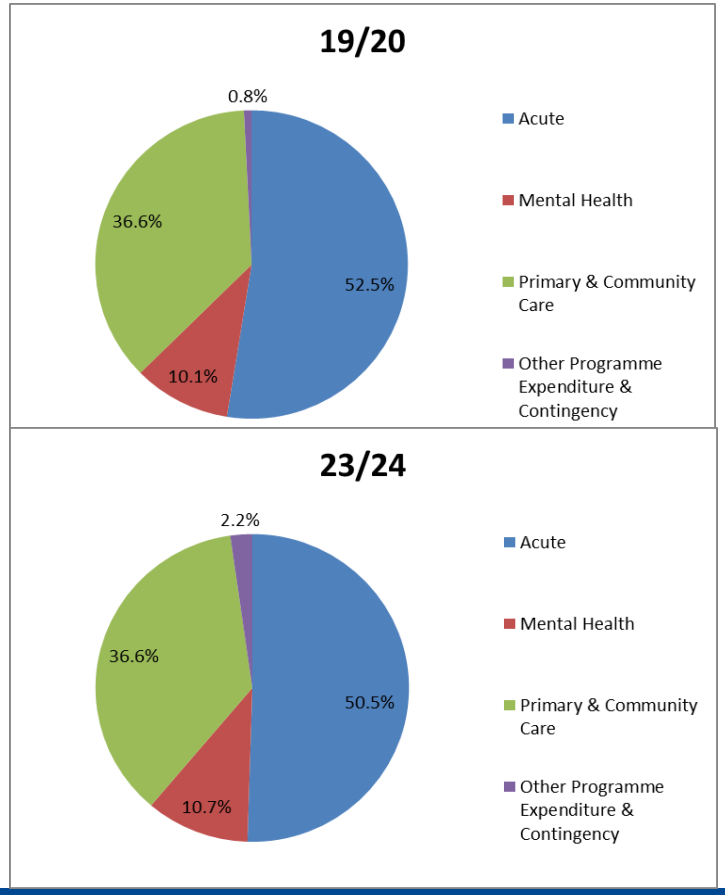
BNSSG will increase investment in Primary & Community Care and Mental Health each year…

…to support improvements in population health and to reduce growing pressures on hospital services

Boosting investment in out of hospital care each year



Reducing growth in acute care



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5. Next Steps

We are engaging with system leaders, staff and citizens in developing our plan …

Key Activities to Date

- Citizens panel deliberative workshop – 3 October
- System leaders workshop – 9 October
- Whole system stakeholder event – 17 October
- System leaders workshop – 24 October

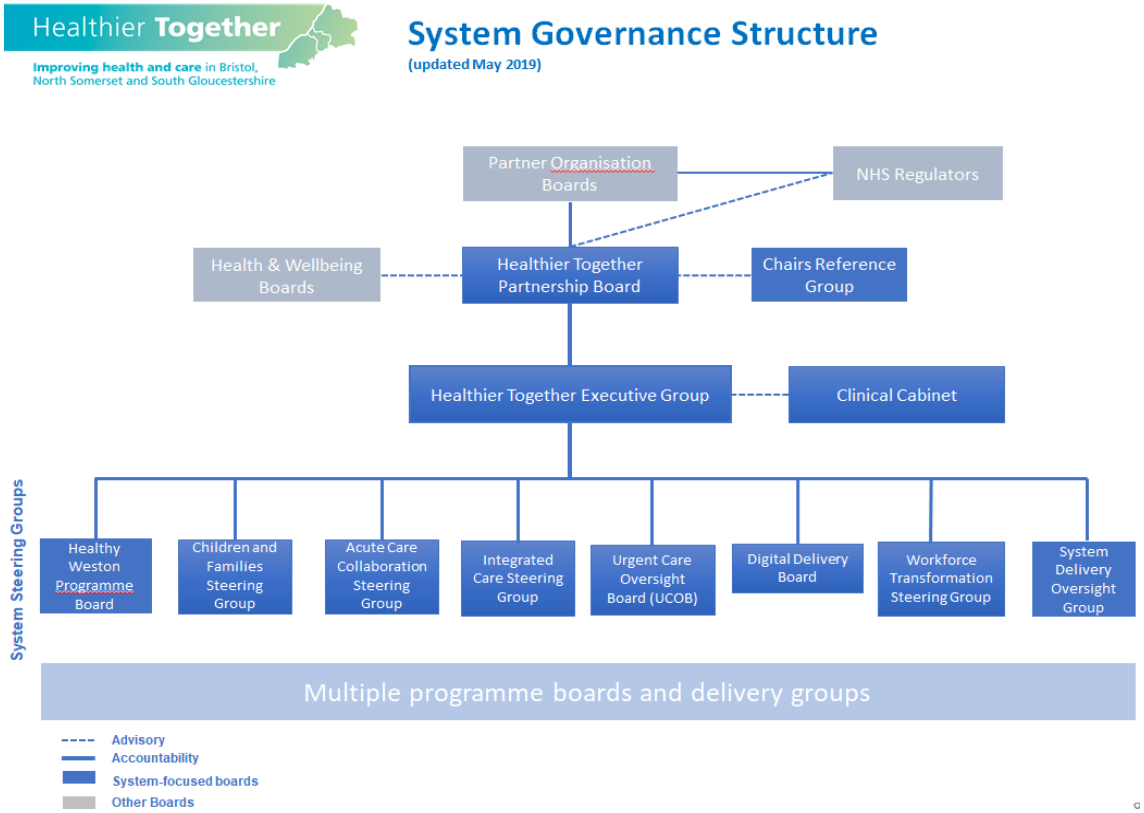
Upcoming Milestones

- Draft plan circulated to BNSSG Partnership Board and submitted to NHSE/I – 1 November
- Partnership Board sign-off – 14 November

Our Partnership Board will oversee delivery of our 5-year plan as BNSSG continue to mature as an Integrated Care System

From April 2020, our system will comprise of ten partner organisations:

- Avon & Wiltshire Partnership NHS Foundation Trust
- BNSSG CCG
- Bristol City Council
- North Bristol NHS Trust
- North Somerset Council
- One Care
- Sirona care & health
- South Gloucestershire Council
- South West Ambulance Services Foundation Trust
- UH Bristol NHS Foundation Trust



All organisations form part of the system's governance structure, with a Partnership Board comprising chairs, chief executives and elected members leading the system.

Healthier **Together**

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

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