Healthier **Together**

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

Healthier Together Priority Programme Plans

Summary Slides

Final Slides for Sponsoring Board 24 September 2018
(Item 3 on the agenda)

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Mental Health Strategy

The first BNSSG-wide mental health and wellbeing strategic framework

- All age focus
- Consistent, equitable and sustainable services
- Making sure mental health is everybody's business
- Are responsive to all our population's mental health needs
- Key focus on: prevention, early intervention and resilience

Developed with partners and our population

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Our Life-course Approach

Conception | Birth | Infancy | Childhood | Adolescence | Adulthood | Older Age

Education – Employment- Housing- Poverty – Housing - Transport

Mental Health & Well Being

Population wide

- Determinants
- Prevention
- Gaps

Long Term Conditions

- Unrecognised
- Undiagnosed
- Untreated
- Often in non MH settings

Serious & Enduring Mental Illness

- Often Physical Health Issues
- May affect specific subgroups eg homeless/students

A person's mental health wellbeing will fluctuate over time

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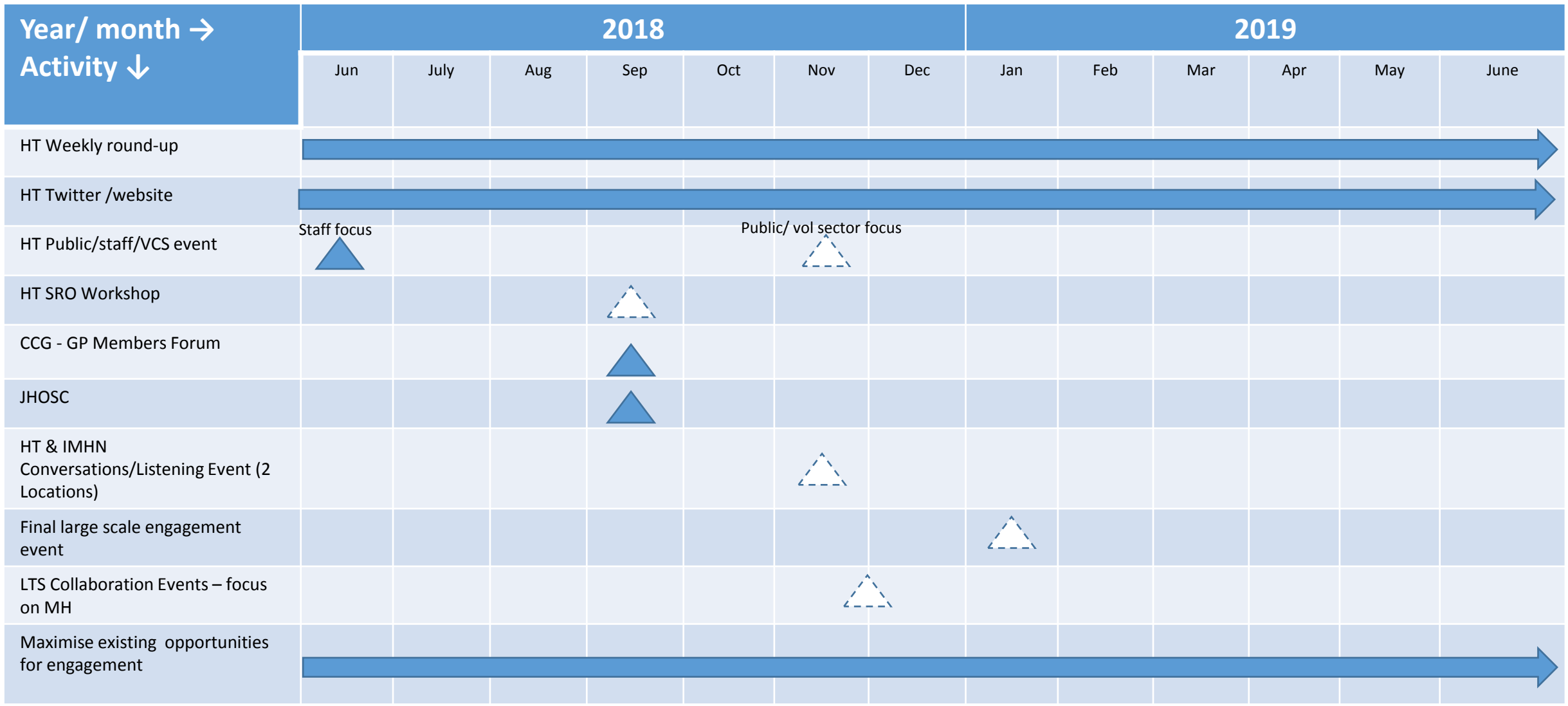
Mental Health Strategy – Action Plan

Deliverables:	Engagement Themes:
• Strategy framework & case for change development (October 2019) • Engagement events with all stakeholders (in progress) • Draft Healthier Together BNSSG Mental Health Strategy (January 2019) • Final/ large scale engagement event (January 2019) • Healthier Together BNSSG Mental Health Strategy (April 2019)	• Adapting services to reflect local communities through the Locality Transformation Scheme • Complexity – Improved recognition, understanding and responses to people with complex needs e.g. Personality Disorder, ADHD, Medically Unexplained Symptoms, multifaceted presentation • Reducing the gap between secondary & primary care by improving the service offering • Crisis – improved responsiveness to crisis and more appropriate responses • Focus on Children & Young People – services designed to meet, support transition and an emphasis on prevention

DRAFT Communications & Engagement Plan



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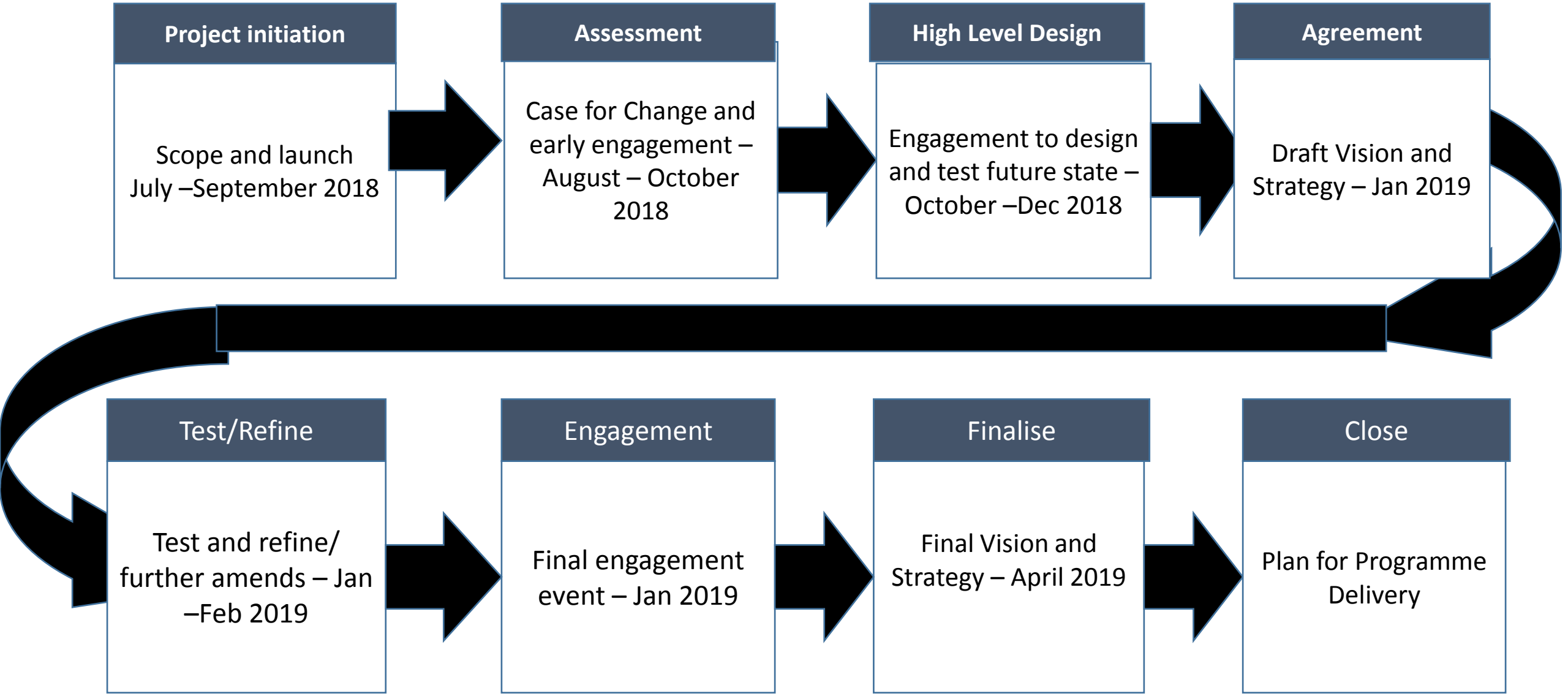
Timeline/ Milestones



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General Practice Resilience and Transformation Programme

Five objectives of the programme

1. Create and deliver a programme to support general practice resilience and enable general practice to be the foundation of integrated community care
2. Monitor the delivery of projects, making sure they are aligned to the vision and identifying gaps
3. Define what we mean by ‘general practice resilience’, then develop and use a methodology to measure the impact of the programme
4. Work in partnership with practices and the public to design new ways of working and develop a vision for general practice in 5 years’ time
5. Facilitate a more consistent and planned approach to future general practice transformation

General Practice Resilience and Transformation

Vision:	Every person feels responsible for their own health and wellbeing. They have timely access to the right GP service, which is provided by staff who understand their needs and have time to care.

Outputs and Outcomes:
In the following timelines, the people of BNSSG will experience…

1 year	**People**	• A better knowledge and understanding of the value of skill mix in meeting their needs • Personal medical records being appropriately available across the healthcare system, so I only tell the story once • Overall reduced waiting times for appointments at practices • Access to high-quality integrated primary care services, 24 hours a day
	Practices	• Will have more appropriate workload and thus have more time to care • Have access to the information they need to provide the best care for their patients • Staff are supported to be healthy at work • Are supported to work in a way that is underpinned by digital and technology
3 years	**People**	• Timely access to the right service • A better understanding about how to care for themselves • A connection with community based care and support options that improve wellbeing and independence • Less need to “see the GP” • Will visit their pharmacy and use self-care more
	Practices	• Will feel they are in a strong position to participate in and support a joined up system in BNSSG • Will collaborate, innovate and routinely share best practice
Beyond	**People**	• General practice isn’t just my local surgery building • My elderly father’s experience will be very different to my teenage son’s but I still feel that I have a relationship with a service that is personal and local to me
	Practices	• The service we provide can flex much more responsively to fit with the needs of the individual

Scope

The scope of the programme includes all general practices in BNSSG and those working within them. It also includes any commissioning activities related to general practice, any One Care activities related to general practice resilience and working at scale, community pharmacy, general practice estates, the national review of the GP partnership model, general practice’s role within ICS development and clinical/non-clinical indemnity. Optometry and dentistry are outside the scope of the programme. Resilient general practice will act as the stable foundation for the formation of Integrated Localities.

Objectives

- Create and deliver a programme to support general practice resilience and enable general practice to be the foundation of integrated community care
- Monitor the delivery of projects, making sure they are aligned to the vision and identifying gaps
- Define what we mean by ‘general practice resilience’, then develop and use a methodology to measure the impact of the programme
- Work in partnership with practices and the public to design new ways of working and develop a vision for general practice in 5 year’s time
- Facilitate a more consistent and planned approach to future general practice transformation

Leadership and Delivery Resource

Sponsor	Ruth Taylor
SRO	Jenny Bowker
Clinical Leadership	Dr Martin Jones (Clinical Sponsor), Dr Jake Lee and Dr Geeta Iyer (Clinical Leads)
Programme Delivery	Ruth Hughes, Bev Haworth

By….	Create and deliver a programme to support general practice resilience and enable general practice to be the foundation of integrated community care	Monitor the delivery of projects, making sure they are aligned to the vision and identifying gaps (* requires resource)	Define what we mean by 'resilience', then develop and use a methodology to measure the impact of the programme	Work in partnership with practices and the public to design new ways of working	Facilitate a more consistent and planned approach to future general practice transformation
Sept 2018 (1 month)	• Confirm governance arrangements for programme • Finalise Terms of Reference for programme working group • Complete mapping of programme and projects across all stakeholders • Align any potential overlap with other HT work streams	Lead • Map all existing practice, CCG, One Care, LMC, CEPN (etc) projects to identify overlaps, gaps, successes and opportunities to pause or stop Monitor • Introduce guidance for practices to enable texting of test results • Provide practices with 'flu search templates in EMIS • Frailty team in WAHT have access to GP record on EMIS – pilot		• Practice staff engaged in the governance structure through working group membership • Articulate vision in compelling, people centric terms • Present at Time for Care showcase event on 20th September	• Promote the Time for Care QI programmes practices can access at event on 20 September
December 2018 (3 months)	• Agree output and outcome measures • Develop a more detailed programme and financial plan with milestones • Align programme to BNSSG Primary Care strategy delivery plan	Lead • Get an overview of delivery across all projects and make sure they are aligned • Provide support to individual practices to implement GPTeamNet • Provide intensive, in-practice support to practice teams to use GPTeamNet in a way that is optimal for their practice (*) • Links in GPTeamNet to other resources, including Remedy and via EMIS templates • Test-bed for NHS app • Agree our vision and ambitions for general practice in 5 years' time • Appraise the options for a Digital First infrastructure across BNSSG Monitor • Programme of support to enable practices to optimise their workflow processes and clinical systems • All practices received Practice Intelligence Reports to help plan demand vs capacity and set thresholds • Deliver further healthcare navigation training • Library of Patient Information Videos available in all practices • Understand requirements for locality analytics • Roll out practice appraisal tool, Pform+	• Establish what we mean by 'practice resilience' and 'system resilience'	• Develop plan to engage with practices throughout the programme life cycle • Consult with Citizen's Panel about new ways of accessing general practice and new roles within general practice • Present at One Care shareholders' meeting in November • Present at One Care Patient Reference Group • Working groups start to meet	• Bid for funding to deliver Productive General Practice for additional practices • Support change management in General Practice for e-consultation pilot and planned roll out
April 2019 (6 months)		Lead • Identify gaps in current programme of work, consider how to fill those • Implement learnings from BNSSG GP recruitment microsite pilot • Calderdale training redesigned and rolled out across BNSSG (*) • Support consistency in practices through development and sharing of searches, templates etc • Provide further benefit to practices through central development of additional EMIS tools (*) • 70% coverage achieved with single telephony solution • Single, collaborative information portal embedded within general practice ways of working Monitor • Completed Intensive Support Scheme in Weston, Worle and Villages • General Practice Analytics Review continues • Design of population stratification model	• Create a resilience framework that practices are able to measure themselves against • Identify the baseline	• Deep dive into specific issues with patients recruited via Citizen's Panel • Practice working groups meet	• Access Time for Care funded support for QI training
August 2019 (1 year)	• Dissemination of an information campaign, linked to navigation, that focuses on ensuring people are aware of what different healthcare professionals within the practice are able to do	Lead • Continue to review and have oversight of project delivery • Share learning of ISS across BNSSG and adopt great ideas – provide intensive support to practices who are struggling to implement best practice (*) • Development of shared back office solutions commonly used across clusters, localities and BNSSG (*) • Development of bank of shared clinical and non-clinical staff (*) • Use of GPTeamNet for a cluster/locality register of services (*) • All partners adopt GPTeamNet as an effective way to communicate with practices (*) • Advise on how to improve patient journey and reduce practice workload (analytically led and digitally enabled) (*) • Optimisation of shared telephony platform opportunities across BNSSG practices – use of data, flexible working Monitor • CEPN training – practice manager, leadership, upskilling HCAs, pathway support etc • International GP recruitment project • GP nursing ten point plan delivery • Introduce new roles into general practice – expansion of physician associate placements, nurse apprenticeship pathways, paramedics, pharmacists (*) • Communicate and roll out population stratification model (*) • Roll out of practice model to manage predictable demand (*)	• Individual practices have plans in place • Regular assessment against the framework begins	• Keep all practices engaged via usual channels	• Procurement exercise for e-consultation provision within practices, building upon pilot learning • Bid for another wave of PGP

Where are the overlaps?

- **Prevention** – MECC, implementation of Prevention Principles, smoking cessation, HOPE project (suicide prevention)
- **Workforce** – Intensive Support Service, training, CEPN, Community and Primary Care Workforce Development sub group, LWAB, Education and Training for Transformation, Care navigation training, workflow optimisation
- **Digital** – Digital Delivery Board, GP IT Systems, Assistive Technologies, SW Health and Care record; e-consultation, IUC, NHS England App, child health information system, Docman 10, EPACCS, BNSSG referral management service, UTC direct booking, telephony optimisation, collaboration platform, EMIS optimisation, practice analytics
- **Urgent care** – E-consultations, NHS 111 direct booking
- **Mental health** – alternative roles in general practice, involvement in testing draft Plan on a Page and Helicopter View, Mental Health Programme Board, strategy development and subsequent delivery plan
- **Integrated Localities** – Social Prescribing, care navigation, care co-ordination, frail older people

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BNSSG Healthier Together
General Practice Resilience and Transformation Proposed governance

Sponsor Ruth Taylor
SRO Jenny Bowker
Clinical Sponsor Martin Jones

BNSSG Healthier Together Office
STP Programme Director Laura Nicholas
General Practice Resilience and Transformation Programme Manager TBC

Healthier Together STP Sponsoring Board

BNSSG STP Integrated Care Steering Group
(Chair: Julia Ross)
Membership: Provider CEOs including Local Authorities, GP Locality Leads, Area Directors

BNSSG STP Workforce Transformation Steering Group (LWAB)

Community and Primary Care Workforce Development Group (Chair: Martin Jones)

General Practice Resilience and Transformation Steering Group
(Chair: Ruth Taylor, Clinical Sponsor Martin Jones)

Other workstreams
eg Digital, Prevention, Urgent Care , Mental Health

Working Group 1

Working Group 2

Working Group 3

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Digital Transformation

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Digital Delivery Board:- Mandate Summary

Vision:	We will drive efficiency and create a simplified and more integrated IT estate, enabling digital transformation to be more readily achieved and accessible through a unified digital plan, embedded into our clinical programmes, to enable the right change in our services and ensure we are enabling our population to benefit from the commitments made by wider NHS and Government Policy.

Outputs and Outcomes: In the following timelines, the people of BNSSG will experience…

1 year	▪ Improved referrals to the most appropriate service to support the patient first time, through providing GPs and locality teams with intelligence to plan for their local population requirements, supported with essential digital skills and access to all the data, information and knowledge they need to support triage and on-going management of the patients. ▪ 24/7 On-line e-consultation with direct referral into primary and urgent care. ▪ Improved access to patient records (e.g. Red book & Patient Knows Best), on-line and through Apps.

1 - 3 years	▪ Improved experience and self-management, enabling people to:
	  ▪ make the right health and care choices.
	  ▪ interact with and make choices about health and care services they use.
	  ▪ Improved access to services through knowledge of the services. available to support me and direct booking, e-consultations and access to their own patient records.
	  ▪ through Apps, put the right tool in patients' hands, to enable patients to become experts in their condition and transform the way they use healthcare facilities.
	▪ Empowering our clinicians and staff to work seamlessly through development of shared infrastructure.
	▪ Effective strategic planning, commissioning of services and resource utilisation through the use of population segmentation, patient data and risk stratification to understand the system-level shifts in population health activity and our community's needs.
	▪ Drive efficiency and create a simplified and more integrated IT estate, enabling digital transformation to be more readily achieved and accessible.

Objectives

- Lead the development of a shared infrastructure plan across BNSSG Health and Care Services to consolidate existing infrastructure and create a single flexible solution, across our services, estates, geographical boundaries and organisations.
- Lead the convergence across BNSSG of systems and software, supporting Community, Acute Care and Mental Health.
- Interoperability plans to enhance mobility, remote and flexible working.
- Identification of opportunities for using current and future assets, resources and co-location of support services and facilities.
- Building on existing data flows from Health & Care, enable the development of a system wide information engine.

Leadership and Delivery Resource

Sponsor	**Robert Woolley** CEO University Hospital Bristol
SRO	**Deborah El-Sayed** Director of Transformation BNSSG CCG
Clinical Lead	**Dr Andrew Appleton** BNSSG Clinical Digital Lead
Programme Delivery	**Matthew Nye** BNSSG Head of Digital Transformation

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Digital Delivery Board (DDB) - Action Plan

Deliverables: Action Plan over the next year		
September to November 2018	▪ STP Governance through Digital Delivery Board (DDB) and working groups established.	▪ TOR for DDB working groups agreed and new groups establish from October.
December 2018	▪ Overarching governance and process established to support services ensure, system, infrastructure, software developments, and procurements across BNSSG are aligned to the ambitions of collaboration, integration and the convergence strategy.	
March 2019	▪ Long term roadmap across Health and Care developed to: ▪ mobilise the delivery of convergence and integration across BNSSG to improve connectivity across our services, supporting our patients and clinicians. ▪ consolidate existing infrastructure and create a single flexible solution, across our services, estates, geographical boundaries and organisations.	▪ Completed interoperability lab to support our patients, clinicians and operational staff to aid and enable system wide design of service interface, Apps and software developments to support service transformation.
	▪ Care flow integration roadmap between Acute, Community, Primary Care and Social Care identified.	▪ Detailed plan to embed digital records across acute, community, mental health and social care (Paperless 2020).
	▪ System wide Health and Social Care joint digital roadmap to deliver Paperless 2020.	

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Key National & Local Deliverables

Deliverables: Action Plan over the next year

E-consultation	▪ Launch of e-consultation trial in Nov-18, with full evaluation to support BNSSG system wide procurement and mobilisation by Mar-20 to deliver national target of 95% of GP patients to be offered e-consultation.	July-18 to Mar-20
Maternity	▪ Electronic red book. ▪ Interim solution to improve patient access and efficiency using existing system capability e.g. electronic referral of information back to Primary Care and access Connecting Care to view patient records. ▪ Single Point of Access for shared bookings, capacity management and records, with plan agreed for implementation of paperless 2020. ▪ Single web-site and App across BNSSG.	Phase 1 Sept-18 Plan agreed Jan-19 Plan agreed Jan-19 Plan agreed Jan-19
Medicine Management	▪ Medicines management (ERD/ EPS 25% by March 2019) and ePMA roll-out.	Mar-19
Urgent and Emergency Care	▪ Integrated Urgent Care(IUC) Clinical Assessment Service (CAS), with essential functionality; including ▪ Access to records Inc. Mental Health ▪ Electronic booking capabilities in Primary Care ▪ Electronic Prescribing. ▪ Direct referral to Mental Health teams.	Jul-18 to Mar 19 Dec-18 Dec-18 Dec-18 Dec-18
NHS111 online	▪ NHS111 online initial launch July 2018 with phased approach to enable electronic referral direct into the IUC CAS and wider direct booking for agreed dispositions into primary care.	July-18 to Dec-18

Deliverables: Action Plan over the next year

NHS England App	▪ Pilot new NHSE App replacing NHS Choices in Oct 18 with 2 practices.	Oct-18 to Dec-18
Radiotherapy	▪ Radiotherapy specification review and recommendations.	Mar-19
Connecting Care Access to records	▪ Pathology interface with three Acute Hospitals. ▪ Avon and Somerset Police Safeguarding Engagement. ▪ Theseus Controlled Drug Interface (controlled drugs/meds). ▪ Radiology Images.	Nov-18 Nov-18 Dec-18 Dec-18
Health and Care Partnership with Bristol Open & UWE	▪ Scoping phase in partnership with Bristol City Council, Bristol Open, University of West England, Community, Voluntary, Housing Association to ▪ Explore assistive technology ▪ User cases to use robots to support domiciliary care packages ▪ Use of IoT (Internet of Things - electronics, software, sensors, and connectivity which enables these things to connect and exchange data) to bring together a network of interconnected modern technologies designed to help patients monitor and manage their conditions and clinicians to initially monitor and support remotely.	Jan-19
Collaboration Platform	▪ Develop an online platform for BNSSG, designed to ▪ empower users to more effectively and efficiently collaborate on projects for the delivery of high quality health and social care services ▪ increase engagement and co-production, across service users previously not engaged.	Sprint 1– Aug 18 to Nov 18

Long Term Deliverables

Deliverables: Long Term Action Plan		
Planned (Elective) care	• Detailed plan agreed to create single point of access for booking services online for hospitals and early implementers identified.	Spring 19/20
Urgent and Emergency Care	• Ambulance service has the ability to electronically book and transfer care by March-20 with plan agreed by March-19 with access to care plans to support patient triage and management within a community location. • Direct booking from UTC into primary Care and extended hubs.	Spring 19/20
Primary Care	• Accelerate better use Shared Telephony Solution across Primary Care and consider options to expand across community.	Autumn 19
Acute/Community	• Automatic acute alerts of long stay patients breaching, to support rapid intervention and escalation.	Autumn 19
Cancer	• Waiting times system implementation.	Mar-20
Learning Disability	• Flagging of Learning Disability in shared records to improve patient care.	Mar-20

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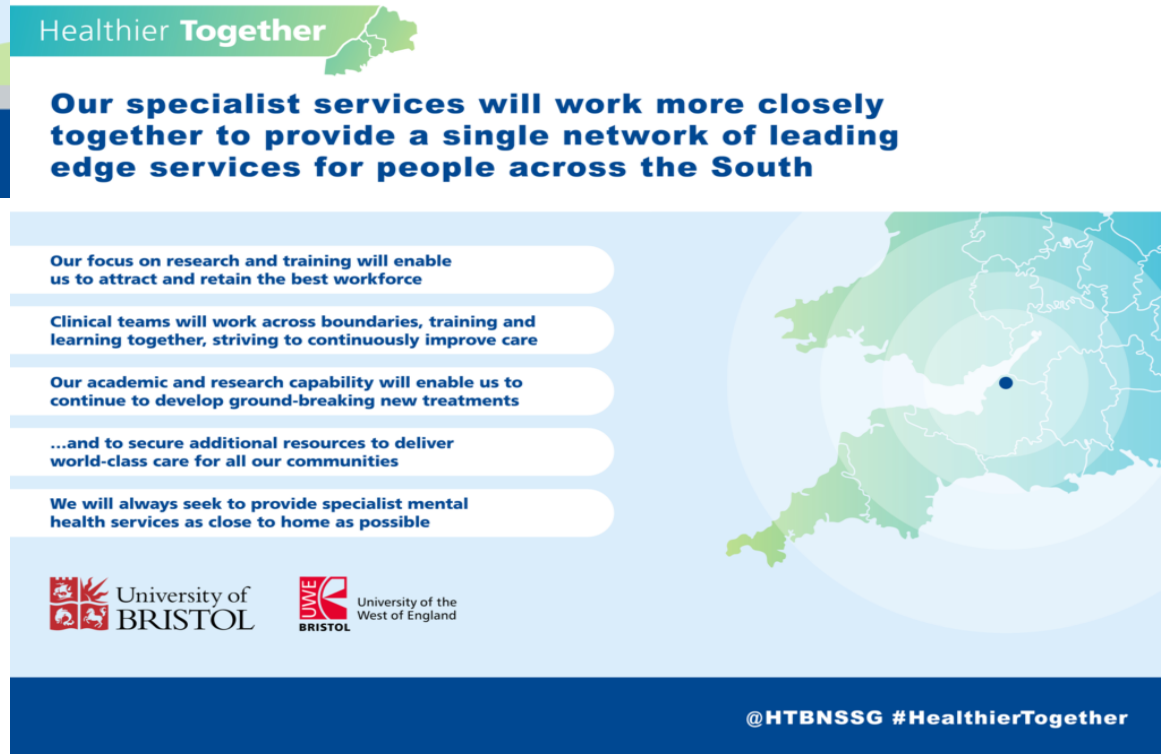
Acute Care Collaboration

The Vision for Acute Care



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Ambition

- Collaborate and co-create **sustainable integrated models of care with our partners** to improve the health of the communities we serve
- Use our **digital, research excellence** and academic expertise to maximise the **implementation of evidenced based clinical pathways**
- **Support staff to be advocates for collaboration** with our partners with an expectation that our teams will actively seek new ways of working together for the benefit of patients.

- Our specialist services will work more closely together to provide a single network of leading edge services for people across the South West, South Wales and beyond
- Clinical teams will work across organisational boundaries, training and learning together, striving to continuously improve care
- Our academic and research capability will enable us to continue to develop ground-breaking new treatments and translate this rapidly into exceptional clinical care

The Acute Care Collaboration Programme will achieve these ambitions through the objectives

Specialist services and networks which consolidate & network Bristol Hospitals' offer for specialist services to meet wider population needs and avoid unnecessary travel for patients to more costly out of region providers

Effective clinical pathways across our providers to improve quality and cost outcomes by increasing standardisation and reducing unwarranted variation with an initial evidence based focus on high volume and high cost services.

Best use of hospital resources To achieve sustainable and safe bed occupancy; To support integrated pathways that deliver care appropriately outside hospital; To ensure acute and emergency hospital care is available for those who need it

Sustainable local acute services through collaboration and clinical networking especially at Weston General Hospital

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Acute Care Collaboration programme - work programme areas

Workstreams	Description
Acute care strategy	Evidenced based strategy which articulates a clear vision, shared ambition and milestones for how acute providers will increasingly work together, providing a collaborative approach to addressing key acute system challenges. This strategy would also outline the plan for how these will be implemented.
Pathology	Assess case for further networking and rationalisation with Gloucestershire and Bath
Stroke pathway	Finalise the Business case for the clinically agreed pathway that identifies the trajectory for a centralised acute stroke care model alongside enhanced prevention, rehab and re-ablement
Medicines optimisation	Moving from traditional primary care savings to a broader programme of service transformation
NICU	Proposals and a business case for the provision of safe and sustainable neonatal services that puts the right baby is in the right place at the right time with the right staffing within Bristol
Re-inventing Outpatients	Transforming the way secondary clinicians work as clinical experts within an integrated care model. Explore models and opportunities to improve pathways, patient experience and outcomes
Cancer	Focus on improving early diagnosis and consistent delivery of 62 day standard.

Interfaces with other programmes:

Maternity; Weston; Integrated Community Localities; Digital; Workforce

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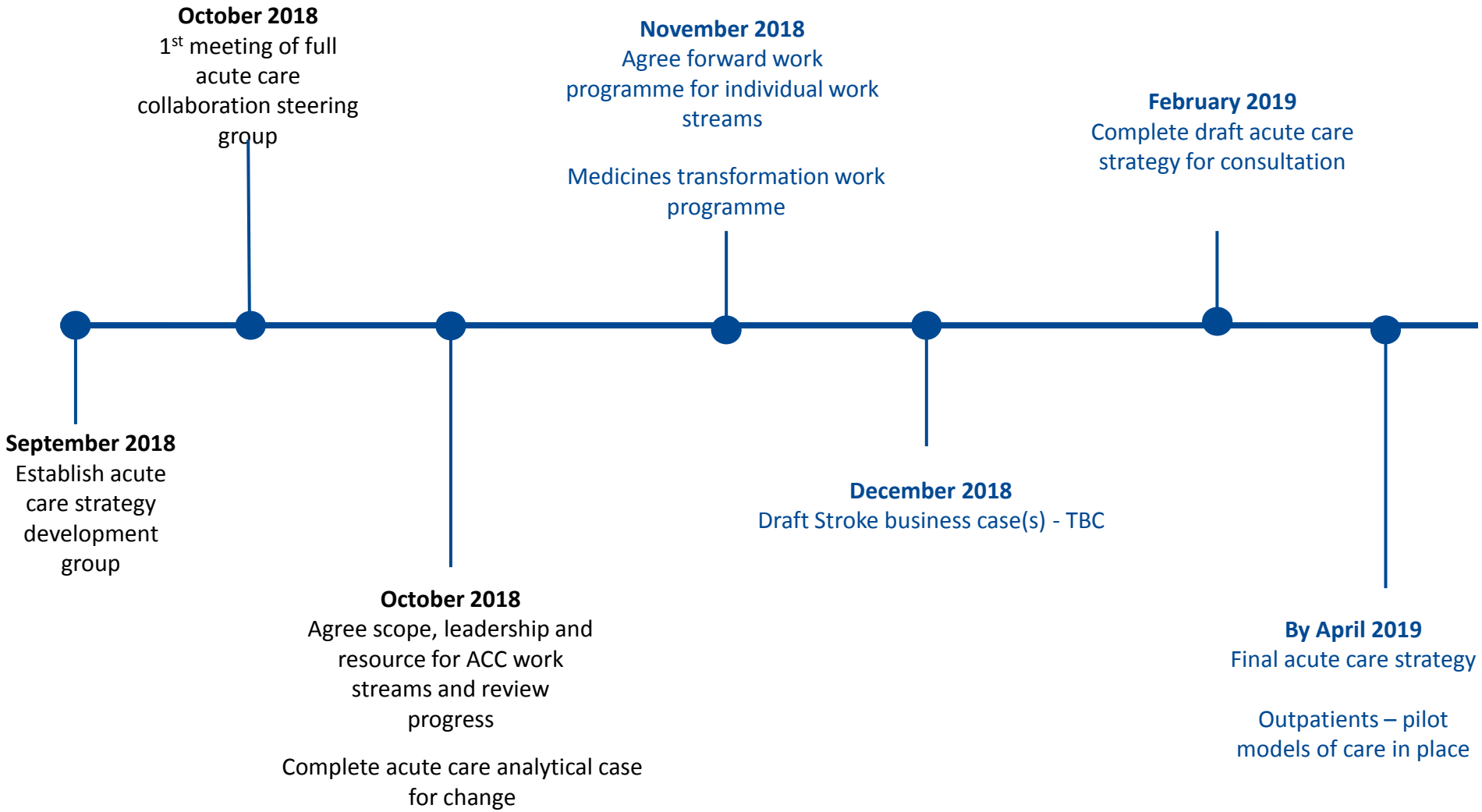
Acute Care Collaboration programme - timeline



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Urgent Care Strategy

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Urgent Care Strategy

Vision:

A simplified, consistent urgent care service, within an integrated care model focused on prevention and self care:

- ***By prioritising self-care, strong integrated services in the community and by targeting prevention services at those who need us most, we have a much lower demand for urgent care or emergency admissions***
- ***The system will be simpler for staff & patients because we waste no time getting patients the right emergency care to meet their needs. Same first assessment wherever you access system, aim to resolve need in one interaction, or direct to most appropriate point of system (local / lowest acuity)***
- ***By having consistency of provision, users will be able to access the right services easily and variation in outcomes will reduce. We are one system joined up to offer the right treatment or solutions, based on an understanding of a patient's circumstances***

Outputs and Outcomes: In the next 1-3 years, the people of BNSSG will experience…

Integration:

- No patient with a known LTC should present to ED (except where planned / directed)
- No patient should attend ED where a need could be more appropriately met in primary / community care
- No patient should be conveyed to ED against the guidance in their RESPECT plan

Targeted Prevention:

- A reduction in admissions from care homes / reduced variation
- A reduction in frequency of attendance / admission for targeted population groups (homeless and vulnerable groups, children in MH crisis)

Simplification:

- There is a single approach to clinical risk and patient assessment that all UC practitioners use and share across the system
- Increase in % of patients whose needs are met or are direct booked into appropriate service from 111 (& don't re-attend elsewhere in system)
- Increase in same day / next day GP appointments booked through 111
- Increase % of see and treat
- There is increased awareness from public about where to access most appropriate care

Consistency:

- Service provision is consistent across acute, community, localities (except where population need dictates)
- There is negligible variation in outcome measures (mortality?) across providers and is top quartile nationally
- There is a single online resource for clinicians to access pathways of care, and these are consistent across providers
- Clinicians can easily access services (advice lines, hot clinics etc.), reducing need for GP → ED attends / increase in appropriate GP direct referrals to specialty services (hot clinic etc.)

Leadership and Delivery Resource

Sponsor	Julia Ross
SRO	Deborah El Sayed, Mark Smith, Kate Hannam
Clinical Lead	Lesley Ward
Programme Delivery	Richard Lyle, James Dunn

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Urgent Care Strategy - Action Plan

Deliverables: Action Plan over the next year

By Sept 2018 (1 month)	• Stock take and prioritisation of current urgent care projects, aligning to four strategic themes ensuring strategic programmes are not lost in operation pressures • Leadership / governance: dedicate the first section of UCOB meeting agenda to advancing strategic programme. Agree sub-set of membership that will drive strategic change
By Dec 2018 (3 months)	• Identify 3 or 4 outcome measures per theme • Strategy document to be accepted by all partner organisations' Boards • Agree scope and interface between this and other programmes (e.g. what locality plans will deliver and when, and how UC programme supports this) • Establish a route of communication / key messaging to front line staff that succinctly describes 4 priority themes and how their work can contribute to this • Establish a small number (3-5) of programmes with system-wide resourcing that will deliver the biggest long-term / strategic impact • Create space for 'bottom up' clinical groups that will make an intervention on specific aspects of change aligned to strategy (e.g. QI-sponsored change programmes delivering a new care pathway, or clinical advisory groups describing the shared approach to clinical risk that would underpin a common first assessment)
April - August 2019 (6 - 12 months)	• Tracking delivery of year 1 & 2 project deliverables (see table) and ensuring these are meeting defined outcomes • Joined up 'bottom up' change programmes under way across provider organisations

Projects/Deliverables

Theme	2018/19	2019/20	2020/21
Integration	• Primary care e-consultations • Primary care improved access • LES recommissioning	• Locality Plans • Integrated commissioning plan • Connecting Care benefits	
Targeted Prevention	• Care Homes project • High Impact Users & Homeless	• Segmentation • Pre-deterioration plans • Children's step up	• All targeted service areas in place • Intermediate capacity
Simplification	• IUC/CAS mobilisation • 111Online • Community COPD • Infusion service • Falls response • Extension of admission avoidance	• Develop Directory of services with targeted alternatives • 111 online	• Common first assessment (streaming linked with 111/DoS)
Consistency	• Integrated care bureau • Psychiatric liaison • REACT • Integrated frailty • Hot clinics/advice & guidance • Predictive system data	• UTC designation • System plan for integrated assessment function • Digital trials, e.g. advice & guidance/tele-med	• Integrated assessment function
Hospital to Home	• CHC assessment out of hospital • Rehab pathways • Trusted Assessor • Optimising social care flow		

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Integrated Community Localities

Integrated Community Localities Plan on a Page

Vision:	• Integrated Community Localities will be the default option for people's care • We will expand the boundaries of "out of hospital care" so the hospital becomes "out of the community" • We will make a significant shift to a proactive model of care • We will deliver a reliable and consistently available 24/7, service that is coordinated and effective • All partners, will be focussed on the needs of the population, sharing collective resources and with a common purpose • We will take an asset approach: valuing the capacity, skills, knowledge, connections and potential in individuals and communities

Scope

- Key components of building blocks for the model design will be: Care navigation, care coordination, proactive care, reactive care, sub-acute services, prevention running through the whole system
- Initially for the following cohorts as a priority: Frail older people, Those with mental health needs, Children
- Other key models/pathways of care such as diabetes/respiratory/EOLC may also be supported through this programme.

Leadership and Delivery Resource	
Sponsor	Julia Clarke/Julia Ross
SRO	Justine Rawlings
Clinical Lead	Mike Jenkins
Programme Delivery	BNSSG area teams are facilitating the locality provider forums Intention to establish collaborative programme and will require associated transformation resource (internal and external as required)
Business Intelligence / Analytics	Required to develop locality commissioning plans

Deliverables: Action plan over the next year

Actions by Sept 2018 (1 month)	• Establish collaborative "faculty" to support and lead service redesign including external inputs • Complete "locality commissioning context" work and outline commissioning plans and test with partners and stakeholders	
Actions by December 2018 (3 months)	• Phase 2 GP locality provider boards starting work with other providers on a few priority areas (October) • 1st accelerated redesign event – frailty (October) • Locality commissioning context and plans agreed • 2nd accelerated event – mental health (December)	
Actions by April 2019 (6 months)	• 3rd accelerated event – children's (February) • Phase 3 Integrated community localities working together in an "alliance" • Implement Phase 3 redesign across priority cohorts (tbc) • Locality enhanced services established	
Actions by August 2019 (1 year)		

Phase 2 plans

Delivering locality model of improved access from 1st October 2018
Work in locality provider forums to deliver small projects as outlined in the grid below, mindful of the phase 2 areas

South Glos	Weston and Worle	Woodspring	Bristol South	Bristol North and West	Bristol ICE
Older persons care	Frailty	Frailty service	Frail older people at risk of admission	Frailty and holistic chronic disease care	Frail elderly housebound patients
Mental health low risk support and care for complex conditions		Teenage mental health	Highly complex mental health patients not engaging with health	More integrated working – mental health MDT	People with mental health problems who fall between services
	Social prescribing			Social prescribing	Support for people with non medical conditions
Acute children's services	Care homes	Community IV service	Pre chemo bloods pilot	Collaborative wound care management	People with drug and alcohol problems
		Cancer as a Long term condition			Children at risk

Areas of focus Phase 3

Cohorts identified through the consistency of priorities chosen as part of phase 2

Key cohorts

Initially for the following cohorts as a priority:

- Frail older people
- Those with mental health needs
- Children

Other key models/pathways of care such as diabetes/respiratory/EOLC may also be supported through this programme

Building blocks for model (s) of care

- Care navigation
- care coordination
- proactive care
- reactive care
- sub-acute services
- Prevention - running through the whole model

Population Health Management

What is needed

- Continued collaboration to deliver phase 2 plans, develop local thinking and building locality relationships
- Input into the phase 3 “faculty” to lead collaborative approach
- Support for the phase 3 system workshops – people; knowledge; data etc
- Joint working on small cycles of change that result

Task	completion date											
	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	
Deliver phase 2 LTS (IA and integrated care priorities)												
Mobilisation completed												
Delivery												
Scope and agree phase 3 including collaborative approach												
Appoint faculty												
Agree collaborative framework												
Set up workshop dates												
Carry out workshops and iterative design work												
Agreed integrated models for key cohorts												
Design application of second tranche of LTS funds												
Propose outline application of funds												
Agree at PCCC												
Formulate locality commissioned services to support phase 3												
Contracting mechanisms in place												
Support provider forums to offer integrated services for key cohorts												
Establish ToR for provider forums with settled membership												
Put in place leadership development support												
Integrated service offer for key cohorts in place												

Top risks or interdependencies identified	*Mitigations*	*Mitigated score (/5)*
Phase 2 IA plans fail to mobilise for 1/10/18 at locality level	Assurance process carried out by area teams and plan requested for BH risk area identified Contractual arrangements with One Care	*2x3= 6*
GP locality leadership are unable to develop practice buy in to working at scale necessary to deliver scale of change required to timescales outlined	Support to locality providers from locality provider leads meetings, LLGs and area teams Consistent and clear communications in key areas e.g. enhanced services	2x4 = 8
Community reprocurement distracts from the ability to develop strong alliances at a locality level	ICSG senior leadership is in place in support of the scheme and development of integrated community localities Engagement of staff “on the ground” to ensure sustainability	2x3 = 6

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Maternity Transformation

Maternity Transformation

Vision:	In BNSSG, we aim to achieve the aspirations of Better Births by: • Delivering consistent maternity care within one single maternity system • Enabling midwives to provide maternity care that is kind, professional and safe • Encouraging partnerships between women and health professionals that co-produce truly personalised care • Supporting women to make informed choices during pregnancy, birth and post-natally • Encouraging women to develop meaningful and trusting relationships with midwives who care for them during pregnancy, birth and post-natally

The families of BNSSG will experience…	
By March 2019	• 20% of women with a personalised care plan • 20% of women booking their maternity care on a full continuity of carer pathway • 20% of women giving birth in a midwifery led settings
By 2021	• A single point of access for information and booking • Integrated BNSSG IT system and digital interface with maternity care • 20% reduction in stillbirth, neonatal and maternal death and brain injury at birth

Key features for success

- Co-production of maternity services by women, clinicians and commissioners
- A culture of shared service planning, innovation, delivery, evaluation and improvement
- An integrated maternity IT system that supports multi-agency working
- Integrated maternity governance that enables joint decision-making
- Financial flows that make collaborative working between providers possible

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Maternity Transformation
Action Plan

Leadership and Delivery Resource	
Sponsor	Andrea Young
SRO	Deborah El-Sayed
Clinical Leadership	Kate Mansfield (GP) Tim Overton (Obstetrician) Emma Gzyb-Yung (Midwife)
Programme Delivery	Alison Ford

Deliverables: Action Plan over the next year		
Actions by Sept 2018 (1 month)	• Finalise, cost and agree pilots for all clinical workstreams • Agree allocation of £200,000 transformation funds • Finalise digital transformation plan and report to STP • Final submission of Transformation Plan to NHS England	• Survey midwifery workforce on views of working in continuity of carer models • Hold recruitment event for continuity of carer pilot workforce and collect expressions of interest
Actions by Dec 2018 (3 months)	• Commence implementation of all workstream pilots • Work with business intelligence to implement Life QI tool to measure improvements, and adapt pilot models in response • Finalise requirements of BNSSG digital system	• Develop BNSSG clinical guidelines for priority areas • Train midwifery workforce for continuity pilots • Hold Maternity Voices Partnership outreach events • Scope opportunities for BNSSG payment mechanism
Actions by April 2019 (6 months)	• Begin national reporting of outcomes for personalised care planning, continuity of carer and reduction in still birth, neonatal and maternal death and intrapartum brain injury	• Improve choice through Single Point of Access for shared bookings, capacity management and records • Agreed plan for implementation of paperless by 2020
Actions by Aug 2019 (1 year)	• Finalise plans to deliver workstream pilots at scale, to achieve long-term trajectories	

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Prevention Programme

Prevention Programme

Vision:	*"…to embed prevention throughout the system and at scale, to achieve better outcomes for the population and to reach a more sustainable health and social care system."*

Outputs and Outcomes: In the following timelines, the people of BNSSG will experience…	
1 year	• Health and social care staff will deliver a consistent approach to Prevention at scale • People are supported and empowered to live healthier lives within their homes, neighbourhoods, and communities
3 years	• The health inequality gap will be reduced • Population rates of smoking, harmful alcohol intake, obesity, and cardiovascular risk factors will be reduced
Beyond	• Reduced premature mortality from heart disease • Fewer deaths attributable to smoking • Fewer deaths from alcohol-related conditions • Reduced premature mortality from cancer

Objectives

1. To embed our five Prevention Principles systematically and at scale across BNSSG so that all commissioners and providers are supported and challenged to address prevention in their own organisation.

2. To deliver, via implementation groups, detailed action plans to address the following priority areas:

- Tobacco – *focus on healthcare settings, pregnancy, people with mental health problems, and adolescents*
- Alcohol – *focus on identification and brief intervention in primary and secondary care*
- Obesity and physical activity – *focus on supporting children and young people to have the best start in life including supporting breastfeeding*
- Vascular disease risk factors – *focus on reducing variation in the detection and management of risk factors for cardio- and cerebrovascular disease, including vascular dementia*
- Public Mental health – *focus on building personal resilience and reducing social isolation*

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Prevention Programme - Action Plan

Key system-wide deliverables set out to achieve by April 2019

- Three year delivery plans for implementation groups:
  - Public Mental Health,
  - CVD Risk Factors
  - Tobacco
  - Alcohol Harm Reduction
  - Obesity & Physical Activity

- Implement SW Clinical Senate policy to ensure that every clinician knows the smoking status of their patient and is equipped to give brief advice and refer to smoking cessation services. Beginning with maternity services.

- Engaging with secondary care providers to ensure achievement of CQUIN on preventing ill health in a way that has population impact.

- Collaborating with HEE to explore opportunities to include Prevention in junior doctor (F1/F2) teaching.

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Workforce Programme

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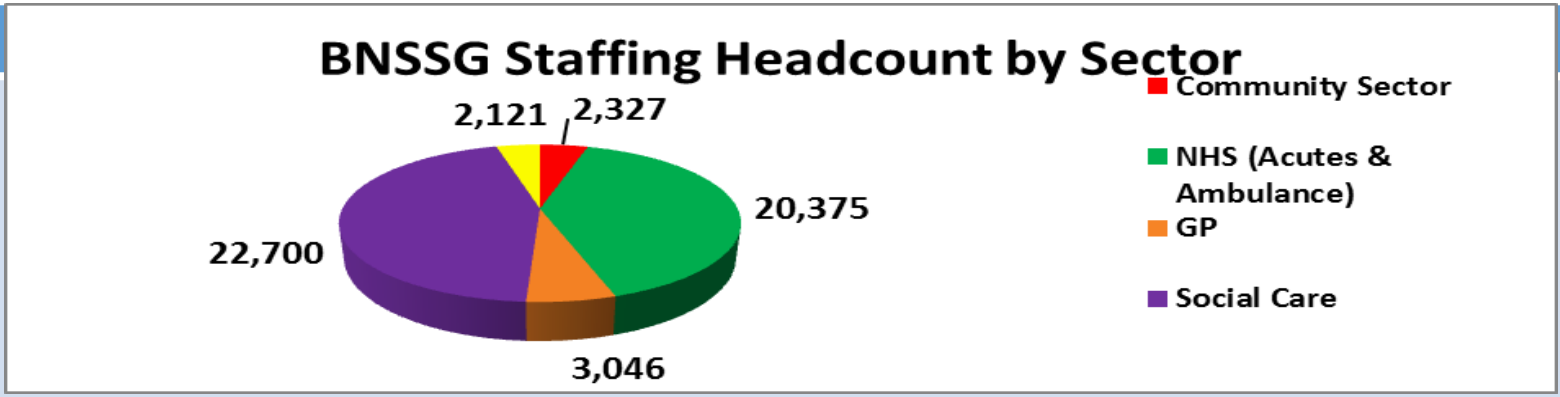
Workforce vision and objectives

Sponsor	Hayley Richards
SRO	Penny Phillpotts
Clinical Lead	Kate Rush
Programme Delivery	Heather Toyne

Vision:	We are thriving not just surviving, attracting, supporting and developing a workforce that is skilled, committed, compassionate and engaged, enabled to deliver exceptional care every day.

Scope:



Objectives

- Develop a sustainable pipeline of **entry level health and social care workers** through the creation of career pathways and frameworks that attract and retain.
- Considerable expansion of the numbers of **registered clinicians** both in post and in the pipeline
- Significant increase in the capacity and capability of **advanced practice skills**
- All organisations are enabled to become **model employers for recruitment**, **retention and health and well being**
- **Workforce planning to** ensure that new models of care have affordable, safe and realistic staffing models, developing workforce solutions as an integral part of delivering locality plans and primary care at scale planning and implementation
- **Equality and diversity** is a theme which runs throughout our goals and vision.

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Our Goals 2018-2020/21

CURRENT WORK PACKAGES

Support primary care locality working
Overseas GP recruitment, develop physicians associates and paramedics

Develop workforce models
to enable multidisciplinary primary care teams to reduce GP workload with CCG/CEPN/One Care, and upskill practice teams in mental health, stroke, etc

Prevention
Significant numbers trained in Make Every Contact Count/Mental Health First Aid to reduce numbers needing secondary care

Streamlining
Stat and man passport for health care/Skills academy /Recruitment passport

ISSUES AND DRIVERS

Primary care workforce gaps
Registered nurse supply shortfall
Social care vacancies and shortages
Medical staff gaps

GOALS

GOAL 1
A sustainable pipeline of highly skilled, motivated and flexible entry-level health and social care workers, recruited and developed at scale and across providers

GOAL 2
Considerable/sizeable expansion of the numbers of B5 registered clinicians both in post and in the pipeline

GOAL 3
Significant increased capability and capacity in Advanced Practice skills

WORK PACKAGES
- Health and social care apprenticeships across organisations to support unregistered workforce development
- Passporting training across health and social care
- Marketing health and social care careers to increase supply

WORK PACKAGES
- Joint BNSSG nurse degree programmes working with universities and HEE.
- Develop joint attraction packages
- Nurse apprenticeship option appraisal and implementation
- Return to Practice

WORK PACKAGES
- Develop spec to commission advanced clinical practice using apprenticeship levy
- Joint delivery, pooling levy, placement capacity and supervision

Integrated care delivered through MDTs at Locality level

ENABLERS
Staff engagement - MOU to underpin joint working - OD to work better together –
Workforce planning - contractual flexibility - collaborative resourcing
All organisations are model employers for retention, recruitment and health & wellbeing

STP PRIORITIES

Redesigned service and workforce models for the following:

Prevention

Maternity

Healthy Weston

Mental Health

Integrated Community Localities

Acute Care Collaboration

Urgent Care

General Practice Resilience and Transformation

Digital

Workforce outputs and outcomes

Outputs and Outcomes: In the following timelines, the workforce of BNSSG will experience…	
1 year	• Agreed system wide **career pathway with a clear training framework**, underpinned by apprenticeships. • **Systematic approach with schools, colleges and community groups** to improve the supply pipeline at all levels • Engagement with clinical work streams to understand workforce changes, building assumptions about activity, care models, technological solutions and workforce changes to develop a **strategic workforce plan**. • Signficant numbers of **staff trained in mental health first aid and MECC**. • **Improved GP retention** through a range of interventions, supported by NHSE funding. • Training and workforce development for **Primary and Community Care staff** through CEPN in a range of areas.
3 years	• Our staff are better trained, and we have reduced costs due to **common competences** across settings and professions in BNSSG, working collaboratively through our **learning academy** to deliver best value. • The improved **supply pipeline** results in better than benchmark levels of turnover and vacancies. • Agreed approaches for **contractual flexibility and pass porting** support a more agile workforce.
Beyond	• Staff are developed and deployed **across organisational boundaries**, and we have implemented workforce solutions as an integral part of delivering **locality plans and primary care at scale planning and implementation**. Reduced variation with **a consistent, MDT workforce model** at locality level, determined by population needs. • Organisations have exemplary approaches **to health and wellbeing, leadership and culture** • Resource planning includes the **community, voluntary sector, third sector and families** in mapping pathways **Transactional support services** are offered collaboratively/jointly where there are clear economies of scale.

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Workforce Programme- Year One Action Plan

BY:	Workforce planning	BNSSG career pathway	Work with schools and colleges	Work stream focussed	Community and primary care
Sept 2018	HEE funding confirmed, work commenced to scope project with system planners	•HEE funding confirmed, group meeting to develop spec for the work	•HEE funding confirmed, spec to link to career framework	•Agreement at LWAB that HR/workforce support through organisational HR resource.	•Develop detailed project plan for NHSE Intensive support site
Dec 2018	•Agreed **spec** with stakeholders •B**aseline** •**Scenarios** and **assumptions** scoped •**Operational planning**	•Review national and local **best practice** •Agreement of advanced practice levels	•Development of spec and project plan •Map **current, provision** and identify **target schools /colleges**	•MECC **super trainers** and **mental health trainers** delivering training	•Design and deliver development including succession planning, mental health, diabetes, falls, frailty, dementia, stroke prevention etc. Implement (CEPN) •NHSE Intensive support site implementation •Workforce planning for localities
April 2019	•Initial **gap analysis** •Workshops with clinical work streams to agree assumptions and **future workforce models**	•Stakeholder **engagement** and **testing** model •**Develop spec** for apprenticeships	•**Commence** initial engagement work with schools	•Focussed recruitment for **urgent care** using career pathway	
Aug 2019	•**Workforce modelling** and testing of plan outputs	•Confirm model and tender collaboratively for apprenticeships	•Use career model in schools •Review next steps – website?	•Use of UWE credits to deliver against priorities	

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This content valid on 18.09.2018 and subject to approval
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