NHS
Bath and North East Somerset
Clinical Commissioning Group

Sustainability and Transformation Plan

Update to Health & Wellbeing Board 8th June 2016

Healthier. Stronger. Together.

Sustainability & Transformation Plans

- A shared vision for securing a sustainable local health and social care system
- Triple aim to:

- improve the health & wellbeing of our local population
- improve quality of local health & care services
- deliver financial stability & balance throughout the local health care system

Sustainability and Transformation Plans

- **A five year Sustainability and Transformation Plan (STP), place-based and driving the *Five Year Forward View***
- **Plans are expected to include:**

	Theme
1	Prevention and self care
2	Out of hospital/community sector including delivery of primary care at scale
3	Seven day services & urgent care
4	Planned care
5	New care models
6	Quality Improvement
7	National Priorities: Cancer, Mental Health Services etc
8	Financial balance
9	The digital road map/interoperability
10	Stakeholder engagement

STP: Leadership, governance and engagement

Public & Patient Engagement

NHS Boards & Governing Bodies

H&WB Boards

Local Authority Cabinets

Health & Social Care STP Board

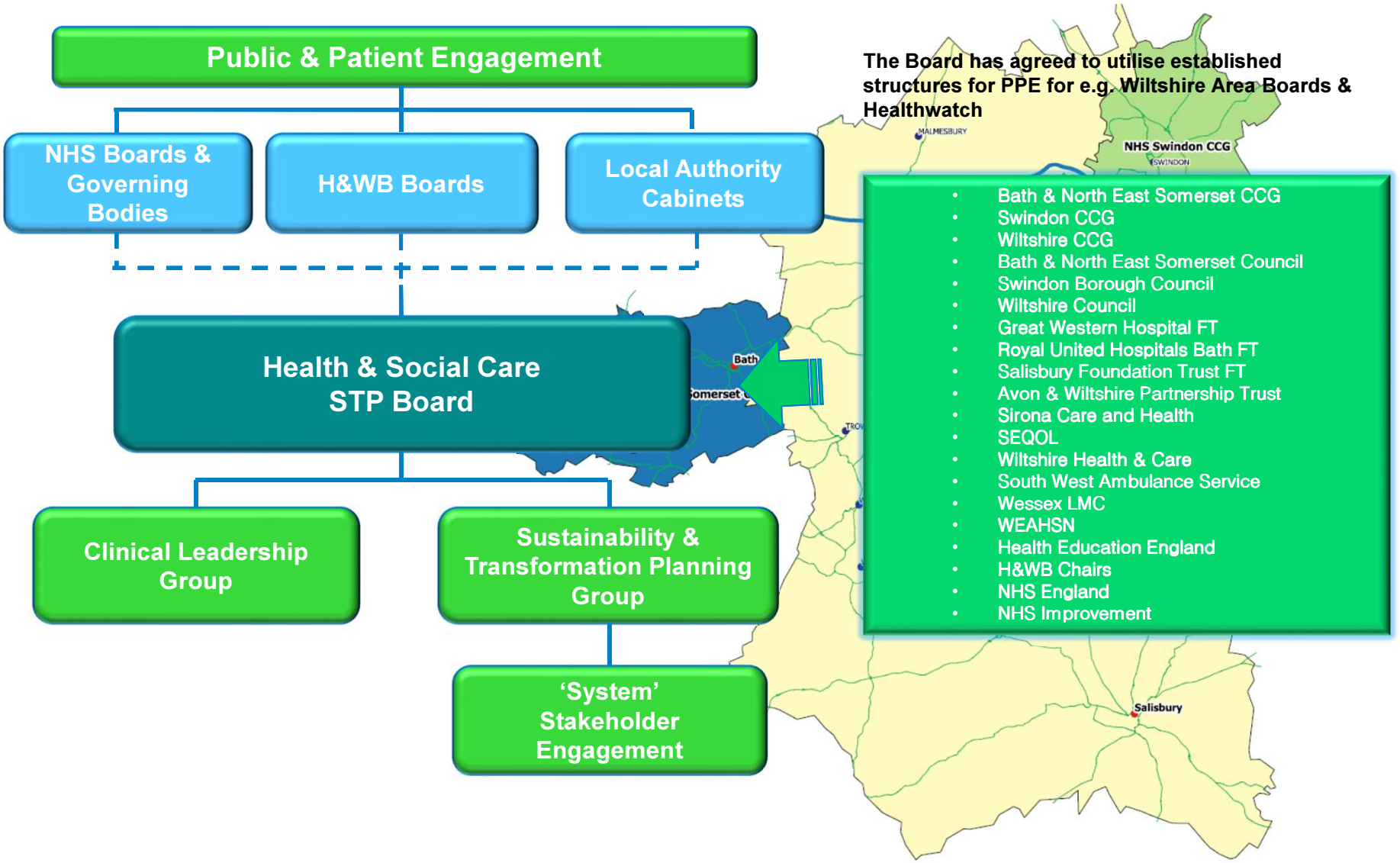
Clinical Leadership Group

Sustainability & Transformation Planning Group

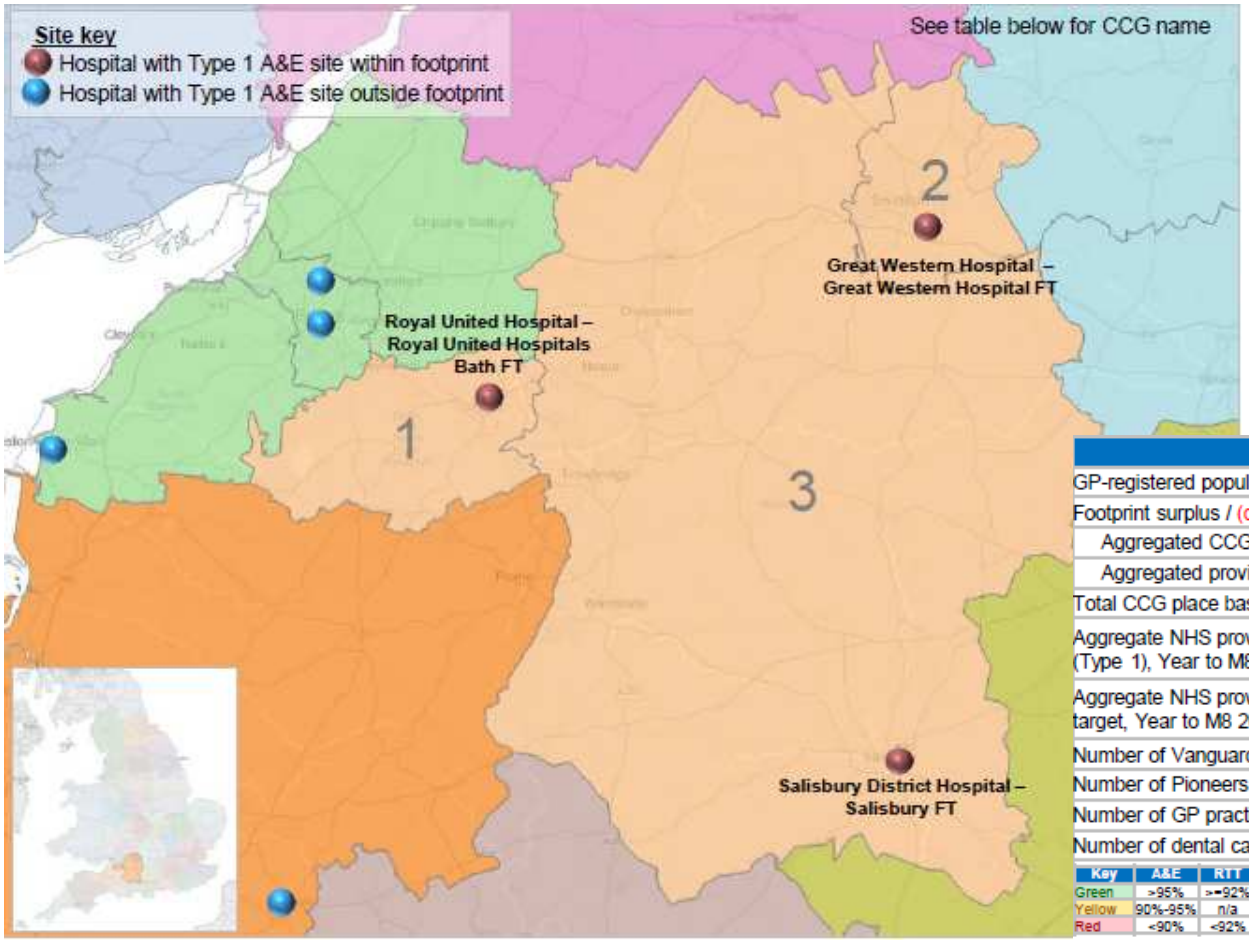
'System' Stakeholder Engagement

The Board has agreed to utilise established structures for PPE for e.g. Wiltshire Area Boards & Healthwatch

- Bath & North East Somerset CCG
- Swindon CCG
- Wiltshire CCG
- Bath & North East Somerset Council
- Swindon Borough Council
- Wiltshire Council
- Great Western Hospital FT
- Royal United Hospitals Bath FT
- Salisbury Foundation Trust FT
- Avon & Wiltshire Partnership Trust
- Sirona Care and Health
- SEQOL
- Wiltshire Health & Care
- South West Ambulance Service
- Wessex LMC
- WEAHSN
- Health Education England
- H&WB Chairs
- NHS England
- NHS Improvement



BSW Footprint - Summary



Bath, Swindon and Wiltshire		Rank* (x/44)
GP-registered population Jan 2016[1] (m)	0.9	33
Footprint surplus / (deficit) 2015/16 (£m) forecast at Q3 2015/16	(£8)	9
Aggregated CCG surplus / (deficit) 2015/16[2] (£m)	£8	28
Aggregated provider surplus / (deficit) 2015/16[3] (£m)	(£16)	9
Total CCG place based budget allocation 2016/17[2] (£m)	£1,356	32
Aggregate NHS provider performance against the 4 hour A&E target (Type 1), Year to M8 2015/16[4]	90.7%	22
Aggregate NHS provider performance against the 18 week RTT target, Year to M8 2015/16[4]	90.6%	36
Number of Vanguards impacting on the footprint	0	-
Number of Pioneers impacting on the footprint	0	-
Number of GP practices in the footprint[5]	110	30
Number of dental care practices in the footprint[5]	134	30

Key	A&E	RTT
Green	>95%	>=92%
Yellow	90%-95%	n/a
Red	<90%	<92%

* Rank within the 44 STP footprints; best to worst, or highest to lowest

CCG No.	CCGs
1	NHS Bath and North East Somerset CCG
2	NHS Swindon CCG
3	NHS Wiltshire CCG

NHS Providers
Great Western Hospitals NHS Foundation Trust
Royal United Hospitals Bath NHS Foundation Trust
Salisbury NHS Foundation Trust
South Western Ambulance Service NHS Foundation Trust

Local Authorities
Bath And North East Somerset Council (Unitary)
Swindon Council (Unitary)
Wiltshire Council

Challenges we face…

- Population age structure slightly older than England as a whole
- Increasing demand for acute services
- Obesity and smoking prevalence in Swindon
- Hypertension prevalence in Wiltshire
- Demographic changes
- c£100m p/a challenge over the next 5 years
- 3 acute providers that have historically faced out of the footprint
- 18 weeks RTT & 4 Hours performance
- Right Care opportunities on MSK

Positives we can build on…

- % children aged 10-11 classified as overweight or obese
- % deaths which take place in hospital
- Women's experience of maternity services
- People with LTC who feel supported to manage their condition
- Quality of life of carers – health status score (EQ5D)
- 1st definitive treatment for cancer within 62 days
- 3 acute providers are already collaborating on provision of community services (in Wiltshire)
- Well developed population-based models of care for the three populations

Place-based models of care

A place-based model will be set out on how care will be organised around different geographies and population groupings. This reflects the need to deliver local, joined up care for different patient groups as well as the need to manage some services across a wider geography due to scarcity of resources, workforce or demand.

Tier 1 circa 20,000 - 60,000 population:

- The majority of health and care provision will be organised around populations of around 50,000.
- This will support a patient-centric model and enable care management and co-ordination for complex patients.

Tier 2 circa 250,000 - 600,000 populations:

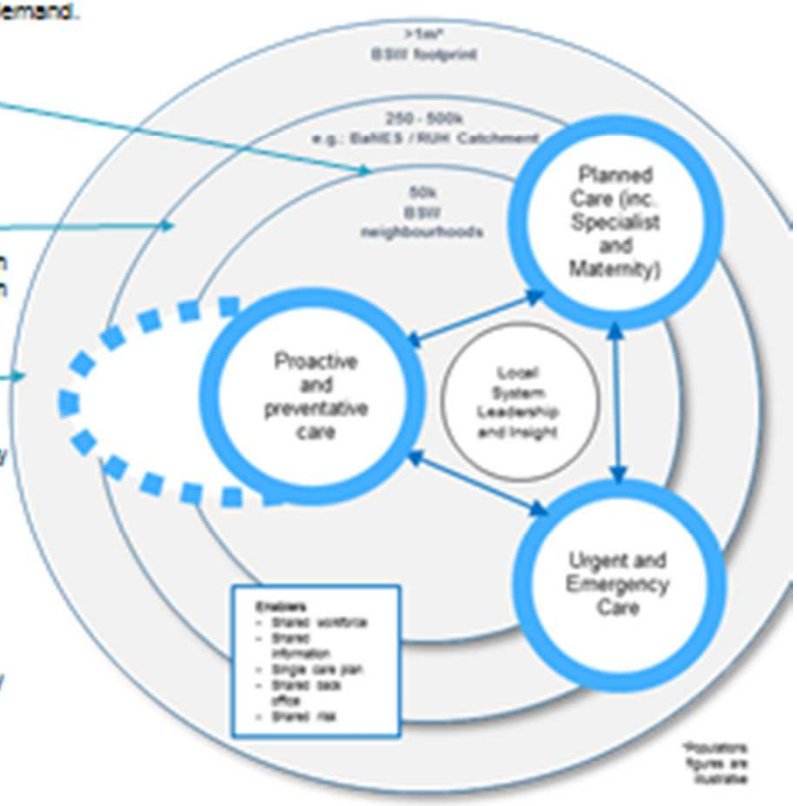
- Planned care and U&EC services will become viable although some service may still operate as a hub and spoke model with neighbouring hospitals.
- Services should be fully integrated with other areas of provision.

Tier 3 Over 1m population:

- Services to be delivered at a wider scale would include tertiary services where complexity and volume require such a scale.
- It may also include specialist/acute Mental Health services and Ambulance Services.
- Some preventative/public health services will take place across the wider geography.

System leadership and delivery architecture:

- A single delivery architecture will enable organisations to fully utilise the assets, tailor services for different populations and enable feedback loops between settings of care.
- There are a number of mechanisms to achieve this; for example, Alliances and Accountable Care organisations.



Emerging design principles for BSW collaboration

Common outcomes for all three populations

Adopt a method of achieving consistent outcomes and delivering equality of care across the patch.

- Consistent in clinical priorities decision making
- Consistent use of outcome information to determine what works/what doesn't and therefore change the patients form of treatment
- Consistent use of quality measures across the patch
- Consistent use of performance metrics, driving more efficient care, including determination of when a patient should be discharged

Design once but implement locally

Models of care should be designed centrally to eliminate duplication and drive consistency of patient experience and to allow staff to work flexibility across the BSW footprint

- Creating workstream- specific solutions to be implemented across the patch (i.e., A&E sign posting)
- Create BSW focus groups to test initiatives and methods and then streamline to others (i.e., Diabetes)
- Explore the opportunity to design consistent BSW Clinical pathways
- Common training, sharing of good practice, messaging and education

Emerging design principles for BSW collaboration

A single workforce for the footprint, rather than aligned to individual organisations with:

- A strategic approach to recruitment, retention and productivity
- Consistent training and a customer service mind-set
- A flexibility to respond to patient demand and maintain service sustainability
- More interesting and varied career paths to attract new entrants
- Staff who are a role models for preventative care
- An integrated HR function across the footprint

A common infrastructure including:

- Creating a flexible health estate
- Identifying the various technology platforms that can be procured and shared across the patch (i.e., medical records)
- Utilising and enabling the use technology to provide optimised care (i.e., telemedicine, pharmacy pods)
- Identifying areas of opportunity within the back office, procurement and middle office
- Realising the opportunities within clinical shared services (i.e., pathology & radiology)
- Supply and demand across the footprint

Collaboration within the BSW integrated model of health and care

Preventive/ Proactive Care

Create locality based multidisciplinary teams including GPs to manage long term conditions and complex patients

Specific footprint opportunities:

1. Make Every Contact Count
2. Falls prevention & pressure ulcers
3. Focus on diabetes pathway and scale to others
4. Create hubs of community information inside of hospitals
5. Common training, messaging & education across the patch

Planned Care

Develop prevention portfolio to mitigate demand; single referral management process; standardised specifications for pathways; increased collaboration across acute trusts on workforce to ensure service viability.

Specific footprint opportunities:

1. Specialised commissioning
2. Reducing variation in clinical practice
3. Demand & capacity planning
4. Mental health acute inpatient provision

Urgent & Emergency Care

Create community based rapid response services, single point of access and discharge planning

Specific footprint opportunities:

1. Systemise where there is 'little human impact' (i.e. pharmacy pod)
2. Triage opportunity & create a patient incentive– 'ring before you bring'
3. Standardise referral pathways and entry into the hospital (including Mental Health)

Each of the models of care are to be supported by realising enabler opportunities including:

Creating a single patient record, Business intelligence systems, Alternative finance and contracting mechanisms, Workforce

Current Position

- **Commitment from the system to the overall principle of collaboration - c70 leaders attended Workshop 2 on the 27th May**
- **Dispersed accountability within the programme team has enabled all organisations to lead on work streams**
- **Seeking a balance between ‘pace’ and ‘engagement’ to ensure everyone remains on board**

Next Steps

- **Current dialogue has engaged some clinical leaders but a wider plan on clinical, patient, carer and public engagement is being developed (post-June).**
- **Immediate need to quantify benefits of the new models to enable financial evaluation to take place – remains a challenge.**
- **Programme Plan beyond June will be included within June checkpoint submission – this will also consider longer term governance arrangements.**

Next Steps

- 30th June 2016: Checkpoint submission to NHSE
- July 2016 STP/NHSE Feedback Meetings
- July-Sept 2016 Plan refinement, benefits modelling
- January 2017 Integration of STP plan into 2017/18 Operational Planning process