Agenda item 13

Bristol CCG
South Gloucestershire CCG
North Somerset CCG

Joint Vision for Health and Social Care in Bristol, North Somerset and South Gloucestershire (BNSSG)

1. Following discussion by the BNSSG System Leadership Group (SLG) on 2 December, the draft vision for health and social care in BNSSG has been amended to reflect further comments from local authority colleagues working in public health and social care teams.

2. The revised version of the BNSSG vision for health and social care is attached. As you know, the NHS national bodies have recently requested the development of a place-based Sustainability and Transformation Plan (STP). In the light of this, we propose that any further work on the vision, together with the development of plans for its delivery, should be taken forward under the auspices of programme to develop the STP.

3. As you may recall, the joint vision was originally commissioned by the BNSSG CCG Partnership Board, with the aims of promoting consistency in the CCGs' commissioning plans and providing greater clarity to provider organisations about the direction of travel. The CCGs decided that this should focus primarily on the individual's experience of services, avoiding references to changes in the provider landscape or in the range of services delivered by individual providers, although significant transformation would be implicit in the draft vision. The CCGs will use the draft vision in their 2016/17 operational plans, providing a clear link between these plans and the future STP. We would encourage provider organisations also to do so.

Jennifer Norman, NHS North Somerset CCG
Justine Rawlings, NHS Bristol CCG
Louise Rickitt, NHS South Gloucestershire CCG
25 January, 2016

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Working together










A joint vision for health and social care in Bristol, North Somerset and South Gloucestershire

Foreword

This document describes a commitment we have jointly made as leaders of health and social care services in Bristol, North Somerset and South Gloucestershire to a collective effort to transform services and improve outcomes for the population we serve.

Locally and nationally, the health and social care system is facing major challenges to meet the demands on services within available resources. We know that it is only by working together that we can address these challenges.

The health care organisations and local authorities in Bristol, North Somerset and South Gloucestershire have reviewed the themes in all our plans and agreed an initial vision, which is set out in the following pages.

This will form the basis for future collective working. We will of course continue to have our own organisational plans. These plans are supportive of this high level vision which will provide us with a shared common purpose, promoting greater integration of care in the future.

We know that there is already some good joint working happening and we look forward to building on this and developing further the work that will support this commitment.

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North Somerset CCG

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North Somerset Community Partnership

Julia Clarke, Chief Executive
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Dr Jon Hayes, Chair
South Gloucestershire CCG

Mike Jackson, Chief Executive and Director of Corporate Services
North Somerset Council

Dr Martin Jones, Chair
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Introduction

Across England, local health and social care systems are working on plans for transforming their services in response to the challenges posed by people living longer with poor health, workforce shortages and growing financial shortfalls in the absence of change.

Shared aspirations are vital for successful change across systems.

A great deal of work needs to be done to turn this into reality. However, we believe that this shared vision can provide us with a common basis for working through the difficulties associated with changing services and the challenges facing individual organisations.

Work is already underway at system level so that local health and social care services can successfully meet future needs. This includes the award-winning Connecting Care programme for enabling individuals' information to be shared electronically, easily and quickly.

As we develop our plans we will need to involve a wide range of service users and stakeholder organisations to ensure services are shaped by their feedback and are accessible to all, including people with learning disabilities.

This document sets out our vision in a series of themes, focused on improving people's experience of health and social care, and developing a sustainable health and social care system that makes better use of existing capacity and resources.

Improving Experience

1. Prevention
2. Self-care
3. Co-ordinated care
4. Complex physical and mental health needs

Improving Services

5. Urgent and emergency care
6. Rehabilitation and recovery
7. Mental health
8. Cancer care
9. Children and young people
10. Adult social care

A sustainable health and social care system

11. Sustainable primary and community care
12. Efficient and effective hospitals
13. Good quality care homes
14. A well managed system

1. Improving Experience

1: Prevention

Goal: Helping local people to maintain good health and wellbeing, reducing their risk of ill health in the future and to reduce inequalities in health outcomes

What we want to achieve

Working in partnership with Public Health England and the voluntary sector.

- Raise awareness around healthy lifestyles and early warning signs, reinforcing messages about how individuals can reduce their risk of ill health
- Consistent messages and information provided across the health system
- Promote Making Every Contact Count, with training for front line staff in brief interventions around specific lifestyle issues such as alcohol and smoking
- Better signposting services, so that NHS staff know what support is available for people who need help with social issues that are affecting their health
- Encourage access and uptake of preventative services, identifying people at increased risk of disease, with focused action to reach vulnerable groups
- Encourage uptake of screening services to increase the early diagnosis of health conditions
- Promote healthy lifestyles amongst staff through Workplace Health initiatives

What will be different?

- Local people enjoying longer lives with better health-related quality of life
- Less reliance on health and social care services
- Fewer inequalities in health outcomes across the region

2: Self-care

Goal: People with known health conditions supported to achieve and maintain good health and wellbeing, monitoring and managing their own health with appropriate education and support

What we want to achieve

A step change in self-care for individuals diagnosed with a long term health condition

- Information tools for people with diagnosed conditions (and their carers) so that they know what to do when their condition worsens
- Training and ongoing support for people with long term conditions in self-care and the setting of their own health goals
- Training for primary care and community teams in effective goal setting and encouraging self-care
- Hospital outpatient services re-designed to promote self-care
- Identifying and addressing any mental health concerns that may affect people's ability to look after themselves
- Signposting people to lifestyle support and advice, and other sources of locally available support including social prescribing

What will be different?

- Fewer appointments needed with GPs
- A better understanding of what individuals can do themselves, with signposting to the local support available to help them achieve this
- Fewer trips to hospital, including to emergency departments and hospital admissions
- Better health-related quality of life for people with long term conditions

3: Co-ordinated care

Goal: For local people with known physical and mental health conditions to get the care and support they need to lead as healthy and active a life as possible, seamlessly coordinated across providers

What we want to achieve

Helping individuals with known physical and mental health conditions that can be maintained safely in the community to stay well.

- Targeted self-care support (eg patient or citizen portal)
- A single electronic health record that reflects their wishes and health needs, used across the health care system
- Health and social care plan developed and shared with community and voluntary organisations, and domiciliary support providers as appropriate
- Care plans to be supported by technology where appropriate, and by personal health and integrated personalised care budgets
- Well defined care pathways for health conditions
- Accessible advice and support from specialists outside the hospital environment
- Dementia friendly approaches to services

What will be different?

- Individuals' experience of community-based care will be much better, joined up and well-coordinated
- Fewer emergency admissions as a result of early action to address health and other care needs
- Individuals will be involved in their care planning and an increased number will achieve the goals jointly agreed in their care plans

4: Complex physical and mental health needs

Goal: Local people with complex physical and mental health needs, including long term conditions, chaotic lifestyles and the very frail, to be proactively supported wherever possible in the community

What we want to achieve

Better support for people with complex needs, including the very frail

- Identified individuals with care plans in place, and with their health and social care proactively coordinated and managed in the community
- Clear access points to pathways for people experiencing a worsening of their physical and mental health conditions, including to specialist support in the community
- The provision of real time information on people's needs available to primary, community, ambulance and acute healthcare providers, enabling an integrated service experience
- Rapid assessment at hospital front doors to prevent admissions where possible
- Enhanced care for care home residents, including supporting staff skills development

Better care at the end of life

- Better planning for end of life care, involving people and their carers
- Coordinated end of life care that allows people to die where they choose with rapid response services to help avoid unnecessary and unwanted hospital admissions

What will be different?

- Individuals and their carers know what to do if symptoms worsen suddenly and understand who is responsible for coordinating their care
- Fewer hospital admissions and shorter stays when admitted, with better care coordination within hospital for people with multiple health problems
- Improved professional access to real-time patient information, while respecting patient confidentiality, so that more people are treated early and appropriately in line with their wishes
- More people helped to maintain their independence, enjoying a better quality of life in their own homes
- A better experience of health and social care, including for people at the end of life

2. Improving Services

5: Urgent and emergency care services

Goal: An urgent and emergency care system that delivers measurably high quality care, by the person with the right skills, in the right place, first time

What we want to achieve

General practice and community services

- Common standards for access to same day appointments, seven days a week
- Primary and Community care services supported by an enhanced 111 service and a range of specialist community services targeted to meet priority health needs
- Expert and comprehensive assessments available quickly in community settings, avoiding unnecessary trips to a hospital emergency department

Hospital services:

- Early senior review by a specialist on arrival to enable the right care quickly and avoid unnecessary admissions
- Easy access for emergency department staff to patients' care plans and summary medical records to avoid unnecessary assessments and treatment
- Effective and efficient emergency departments that follow best practice and deliver good outcomes for patients

What will be different?

- A better understanding of the local support available so that patients know where to go
- Patients consistently managed at the right time in the right place, and by the right people
- A greater proportion of urgent care services provided in primary care and community settings
- Fewer trips to hospital, including to emergency departments, and reduced hospital admissions

6: Rehabilitation, Reablement and recovery

Goal: Local people to be as well and as independent as possible following illness or injury

What we want to achieve

Community services

- The majority of rehabilitation, reablement and recovery services to be provided outside of acute hospitals in community settings, including at home.
- Support for individuals to remain independent and well at home in order to avoid admission to hospital
- Support for early discharge from acute hospitals, to help people regain their independence
- Comprehensive multidisciplinary assessments, enabling a holistic approach to meeting each individual's needs
- Home-based rehabilitation and reablement, with access to specialist support for people recovering from serious illnesses
- A focus on reablement to enable people to regain the skills and confidence to live independently
- Care navigators to help individuals access all sources of support available locally, including from social care, private providers of care services and the voluntary sector

While in hospital

- A focus on discharge, with proactive planning reviewed daily
- For those people unable to return directly to their usual place of residence, longer term decisions to be taken out of hospital, and support given to self-funding patients so they do not stay in an acute hospital for longer than needed

What will be different?

- Support will be available to keep people out of hospital
- People spend less time in hospital and are able to leave safely with appropriate support as soon as possible
- People are clear about what care and support they will receive when they leave hospital
- Information is shared between organisations so that people have as few assessments as possible
- Where necessary, people get the ongoing support they need to live safely and as independently as they can

7: Mental health

Goal: Local people to achieve and maintain good mental health and wellbeing and to ensure they can access high quality and responsive services at times of need

What we want to achieve

A step change to achieve parity of esteem, valuing mental health equally with physical health

- Joined up physical and mental health services through partnership working between providers
- Mental health services that work seamlessly with GPs, community services and social care to deliver holistic, person-centred care
- Improved support, including at times of crisis for all ages
- Services meet the principles of the national mental health crisis concordat, with seamless triage across police, health and fire services
- Provide seamless care from children and adolescent mental health services into adult services
- Responsive, local and effective talking therapies
- The majority of specialised mental health services to be delivered in community settings
- Lead the way nationally in implementing new innovative borderline personality disorder services
- Transform the provision of inpatient mental health bed facilities available locally, minimising the need for out-of-area placements

What will be different?

- Improved outcomes, including a reduction in premature mortality for people with serious mental illness
- Improved pathways between both mental health and physical services
- Improved crisis response at times of need
- Better alternatives to mental health hospital admission

8: Cancer care

Goal: To improve cancer outcomes for local people

What we want to achieve

Services that provide good quality care

- National priorities set out in 'Achieving World-Class Cancer Outcomes – A Strategy for England 2015-2020' achieved, delivering better prevention, swifter diagnosis, and better treatment, care and aftercare for all cancer patients
- NHS Constitution Standards for cancer consistently met
- BNSSG implementation plan developed for NICE guidance
- Enhanced direct access diagnostic pathway developed, in line with NICE Guidance
- GPs supported with the use of innovative tools, advice and guidance in assessing the level of risk
- Use of one-year cancer survival data and other information to reduce variation across BNSSG in terms of outcomes and patients' experience of health care and other sources of support

Better partnership working

- Work with organisations across the local health and social care system to ensure system-wide leadership is in place to improve cancer outcomes for the local population
- Work with GPs, public health, acute hospital trusts, community partnerships, local authorities, private hospital providers, NHS England and third sector organisations

What will be different?

- Patients offered timely, effective and appropriate screening
- Patients will feel better informed, and more involved and empowered in decision around their care
- Better outcomes and a radical improvement in experience and quality of life for the majority of patients, including at the end of life
- Better integration of health and social care such that all aspects of patients' care are addressed, particularly at key transition points

9: Children and young people

Goal: Timely and appropriate access to good quality services that help children and young people stay healthy and achieve their potential

What we want to achieve

Better support for children, young people and their families

- Timely access to earlier interventions for children and young people so those with mental health issues are helped quickly, and do not have to wait for a diagnosis or worsen before they are eligible for support
- Support for emotional wellbeing through comprehensive community mental health services commissioned jointly with local authorities
- Coordinated support for children and young people with special educational needs, disabilities, or those who are looked after by local authorities, including access to timely therapy and other health services
- Community paediatric nursing services to support children and young people with complex health needs at home, avoiding and shortening hospital admissions where possible
- A 'key worker 'model so everyone knows who to contact
- Easy access to clear information and signposting so everyone is better informed and empowered to help themselves
- Smoother transition into adult services
- A range of ways to access services including through mobile technology

What will be different?

- A person-centred (child and family) approach so people feel listened to and can get the care they need
- Training for parents/carers so they feel better equipped to play a greater role in their child's care
- More appropriate ways to feedback on services for children and young people so the service learns and develops from these experiences
- Fewer children in residential placements outside their local area
- Increased emotional resilience in children and families

10: Adult social care

Goal: Access to good quality social care services that are personal, promote choice and maximise opportunities to live independently in comfort and safety

What we want to achieve

- Work with partners to support and promote strong communities, so that people live their lives as successfully, independently and safely as possible
- A framework of shared objectives for stakeholders including voluntary and community sector, primary care, community health, social care
- Virtual or organisational integration of services delivering benefits that justify the process of change, in particular where it improves ease of use and outcomes
- Provision of commissioning and brokerage services that promote access to good quality services, including information and advice for people who fund their own care
- Person-centred assessment and care planning that enables an individual to have choice and control over their self-directed support
- A range of housing support options, including equipment and adaptations, to reflect people's wish to live as independently as possible, including in their own home, where practicable
- Good quality and reliable support to unpaid carers, reflecting their important role
- A rapid and sensitive safeguarding response to people whose safety and well-being may be at risk.

What will be different?

- Joint social care and health support and care planning that is straight-forward and enables an individual to tell their story once
- Access to good quality information and advice that enables people to make well-informed choices
- Support will be easier to access within local communities, improving people's ability to sustain an independent and healthy life
- NHS Personal Health Budgets and Local Authority Direct payments to patients and service users will combine to create greater choice and control for people
- Fewer people experiencing delay in their hospital stay and more hospital admissions are avoided
- A comprehensive range of support for unpaid Carers providing assurance that will enable them to continue in their caring role

3. A sustainable health and social care system

11: Sustainable primary and community care

Goal: Primary and community care providers working together to deliver locally-available, integrated multi-disciplinary care that maintains and promotes independence, health and well being

Sustainable primary care provision working at scale in new ways to provide a wider range of services

What we want to achieve

- Partnership working/federation between practices, with hubs capable of providing consultant-led ambulatory care services
- Enhanced urgent care services providing same day in-hours access for all those who need it
- A wider range of services for those with complex care needs including those who are frail and elderly, the housebound and those in care homes – with sufficient resource to manage end of life care when it becomes appropriate
- Patient education, training and self-management , optimising opportunities for self-management and reducing demand on other parts of the care system.

What will be different?

- Pooled expertise, offering a greater range of generalist and more specialist services delivered by a larger multidisciplinary team
- Improved patient access including the use of technology, advanced telecommunications and greater availability of consultations outside traditional opening hours, and consultations outside of the surgery
- Local systems of extended primary care that work to prevent unnecessary hospital admissions and support safe hospital discharge seven days a week
- Improved and more innovative partnerships sharing learning and ideas, a more systematic approach to governance and risk assessment and opportunities for innovative diagnostic, treatment and care pathways
- Better value through economies of scale in administrative and business functions
- Better development prospects for clinicians and managers, as well as better peer support and mentoring opportunities.

Transforming how primary and community care providers work together to achieve

- Easy access to primary and community services at times and in locations that suit individuals
- Shared clinical information systems across primary and community care, and extending into secondary and social care, with the ability to be updated in real time, and which also offers a patient facing interface, supporting patient education, self-management and optimising access to urgent care
- A wider scope of services provided closer to home, particularly for individuals with long-term conditions, including outreach services by acute sector consultants
- A new workforce model, with more care delivered through a wider range of professionals including advanced nurse practitioners, allied health professionals and pharmacists

12: Efficient and effective hospitals

Goal: Local people who require hospital treatment to receive safe, high quality, sustainable care centred around their needs and delivered in an appropriate setting by respectful, compassionate, expert health professionals

What we want to achieve

Hospital services to be designed around the Future Hospital Commission principles

1. Fundamental standards of care must always be met
2. Patient experience is valued as much as clinical effectiveness
3. Responsibility for each patient's care is clear and communicated
4. Patients have effective and timely access to care, including appointments, tests, treatment and moves out of hospital
5. Patients do not move wards unless this is necessary for their clinical care
6. Robust arrangements for transferring of care are in place
7. Good communication with and about patients is the norm
8. Care is designed to facilitate self-care and health promotion
9. Services are tailored to meet the needs of individual patients, including vulnerable patients
10. All patients have a care plan that reflects their individual clinical and support needs
11. Staff are supported to deliver safe, compassionate care, and committed to improving quality

What will be different?

- Sustainable, quality-assured care 24 hours a day, seven days a week
- An appropriate balance of specialist care and care coordinated expertly and holistically around patients' needs
- Better access in the community to consultant-led services and via GPs to specialist advice

13: Good quality care homes

What we want to achieve

- Joint commissioning by the NHS and Local Authorities to enhance the capability and capacity of the care home sector, the number of residential and nursing care homes rated as good by the Care Quality Commission
- In-reach services and training for staff, improving the quality of care for residents, including those with challenging behaviours
- A focus on supporting individuals to regain independence, empowering them to return to their own homes or to be cared for in a lower intensity setting such as extra-care housing

What will be different?

- Fewer out-of-area placements for people with complex needs
- Fewer admissions from care homes to hospitals, especially for falls and people approacing end of life
- Fewer permanent admissions to care homes

14: A well managed system

Goal: Sustainable organisations working efficiently and effectively together with a financially-sustainable health and social care system

What we want to achieve

- Operational standards for health and social care providers underpinned by shared information tools, supporting the achievement of NHS Constitution standards
- Consistent and rapid coordination of care between health and social care providers so that individuals have an integrated experience of services designed for their needs
- Increased joint commissioning across health and social care to promote efficiency, quality and joined up care provision
- Demand and capacity modelling that encompasses all parts of the health and social care system, enabling effective planning

NHS

In partnership with Avon and Wiltshire Mental Health Partnership NHS Trust, Bristol, North Somerset and South Gloucestershire Clinical Commissioning Groups, NHS England, North Bristol NHS Trust, University Hospitals Bristol NHS Foundation Trust, Weston Area Healthcare NHS Trust.

Bristol City Council

South Gloucestershire Council

North Somerset Council

Sirona care & health

Bristol Community Health

NSCP

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Agenda Item 13

BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE HEALTH AND CARE SYSTEM

TENDER FOR SUPPORT TO DEVELOP A SUSTAINABILITY AND TRANSFORMATION PLAN

DRAFT SPECIFICATION OF REQUIREMENTS

1. BACKGROUND

The NHS in England is required to produce place-based Sustainability and Transformation Plans, driving the Five Year Forward View over the period October 2016 to March 2021, for submission to national bodies in June 2016.

Bristol, North Somerset and South Gloucestershire (BNSSG) health and care system partners have determined after due consideration that the appropriate local footprint for strategic planning purposes should be BNSSG and have agreed to commission expert, external support to assist the development of an ambitious and realistic five year Sustainability and Transformation Plan (STP) for the area.

The STP initial submission at Appendix 1 sets out the rationale for the chosen planning footprint and lists the system partners (commissioners and providers) involved.

2. SCOPE

BNSSG system partners seek support in the development of a 5 year plan which meets the requirements set out in national guidance[1] for:

- Collaborative system leadership and ownership of the plan
- a vision shared with the local community, including local government
- a coherent forward programme of activities to deliver the vision
- an open and iterative process to engage clinicians, patients, carers, citizens and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards
- governance arrangements which will effectively manage performance against the plan, system learning and adaptation where necessary
- coverage of all areas of CCG and NHS England commissioned activity including specialised services and primary medical care
- plans for better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.

3. SPECIFIC SUPPORT REQUIREMENTS

Strategic advice to BNSSG system leaders about:

[1] Delivering the Forward View: NHS Planning Guidance 2016/17 to 2020/21

- design of a programme to develop an agreed STP for submission at the end of June, that meets the requirements set out in national guidance

- transformational opportunities identified by other health and care systems, nationally and internationally

- approaches to stakeholder engagement in development of the STP and communication about the final, agreed plan

- future leadership and governance of the change programme to take the final STP forward.

Facilitation of discussions between BNSSG system leaders to agree the content of the STP and 'critical friend' challenge to assist the group's deliberations

Facilitation of stakeholder meetings and workshops to develop key components of the STP

Provision of appropriate senior clinical expertise to assist formulation of key proposals for inclusion plan and necessary levels of agreement from system partners and other stakeholders

Project management of the process to develop the STP and co-ordination of system partners' involvement and inputs.

Drafting and proofing of STP content as required

Regular reporting of progress to the BNSSG System Leadership Group and/or any sub-group it may establish to steer the STP development programme

4. EXISTING RESOURCES

A level of planning and other functional resource exists in the health and care system which can contribute to the development of the plan.

Bidders are asked to specify their minimum expectations of system contribution in necessary areas, including:

- Strategy and planning
- Transformation and quality improvement support
- Clinical expertise
- Financial analysis
- Administrative functions

5. ACCOUNTABILITY

The adviser will be accountable to the BNSSG System Leadership Group as whole and to any individual formally designated by the Group to act as system lead for preparation of the STP.

6. COLLABORATION WITH OTHER ADVISORS

The engagement may require collaboration with other similar programmes in parts of the health and care system. Bidders should be aware that this may involve working with other providers of advisory and consultancy services.

7. PARTIES TO THIS COMMISSION

to be confirmed

Appendix 1: BNSSG footprint submission 29 January 2016

RW
29 January 2016
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