Bristol, North Somerset & South Gloucestershire

Sustainability and Transformation Plan

October 2016 Submission

KEY INFORMATION SUMMARY

FOOTPRINT AREA: Bristol, North Somerset & South Gloucestershire (BNSSG)

FOOTPRINT LEAD: Robert Woolley,

Chief Executive University Hospitals Bristol FT

PARTNER ORGANISATIONS:

CCGS/COMMISSIONERS: Bristol, South Gloucestershire and North Somerset CCGs, NHS England

LOCAL AUTHORITIES: South Gloucestershire, Bristol and North Somerset Local Authorities which includes the West of England Public Health Partnership

PROVIDERS: Weston Area Health NHS Trust, North Bristol NHS Trust, University Hospitals Bristol NHS Foundation Trust, Avon and Wiltshire Mental Health Partnership NHS Trust, Sirona Care and Health, Bristol Community Health, North Somerset Community Partnership, South Western Ambulance Service NHS Foundation Trust

Version: 1.1

Date: 21 October 2016

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1. Introduction

1.1 Key messages

Our Sustainability and Transformation Plan (STP) has evolved from the Checkpoint submission made in June. In developing our October submission, we have drawn upon the feedback received from NHS England and have described the progress we have made in defining and developing our interventions.

The focus of our STP remains on achieving the triple aims of improved population health, quality of care and cost-control, by successful integration and removal of the boundaries between mental and physical health (Parity of Esteem), primary and specialist services, health and social care.

1.2 NHS England Feedback

Set out below is the feedback we received following our June submission. We have highlighted how this submission addresses the feedback received and referenced the relevant sections for easy identification.

NHS England feedback	**BNSSG Response within this submission**	**Section**
Great depth and specificity, with clear and realistic actions, timelines, benefits, resources and owners.	Articulation of the key priority projects that we are taking forwards in years 2 & 3 of the STP and inclusion of summary business cases for each of these. Finance & workforce schedules	Sections 4.1, 4.2 & 4.3 Appendix B
Year on year financial trajectories.	Finance schedule	Chapter 7.2 & Separate Financial Templates
Articulate more clearly the i**mpact on quality of care.**	We are developing our approach to the management of quality with the support and participation of the Academic Health Science Network.	Section 5.2
Include **stronger plans for primary care and wider community services** that reflect the General Practice Forward View, drawing on the advice of the RCGP ambassadors and engaging with Local Medical Committees.	We have established an Integrated Primary Care portfolio within our Integrated Primary and Community Care Workstream, which details how we are tackling the General Practice Forward View.	Chapter 4.2
Set out more fully your **plans for engagement.**	Engagement approach and materials included in the submission.	Chapter 6.1 & Appendix E
Trajectories for performance on A&E, RTT and GP Access	This information is work in progress and trajectories are being developed as part of the Operational Planning process.	N/A

NHS England feedback	BNSSG Response within this submission	Section
Capital funding	Finance section on expectations around capital funding.	Chapter 7.2
Information technology investment	LDR submission due 31/10/16 Short update on LDR development, governance and resourcing included in this STP submission.	Chapter 6.4 & Appendix H
Mental Health Plans and Investment	Explanation of our approach to redesigning and increasing investment in Mental Health Services.	Chapter 5.5 & Appendix D
Governance arrangements to ensure strong collective leadership for the STP	Outline of our emerging Governance Framework for delivering the STP.	Chapter 3.1 and Appendix A
Recommend that all **organisations contribute an equitable level of resources** to the programme to support leadership and ensure sufficient capacity to accelerate implementation.	Outline of our approach to resources.	Chapter 3.1 and Appendix A
Pathways for acute and specialised services	Updates on the key programmes within the Acute Care Collaboration are set out in this document. This includes the work being undertaken with regards to specialised services.	Chapter 4.3 & Appendix B and C
Workforce implications of the plan and how they will be managed.	Approach to full integration of the workforce programme within the core STP is set out in our response.	Chapter 5.2 & Appendix G

1.3 Context and approach

The development of our STP is being undertaken in a difficult organisational context, with a number of our partners currently subject to external intervention as a consequence of the financial challenges they face. Aligning these interventions with the development of the STP is critical if we are to optimise their impact and create a successful and sustainable system for the future.

In our original submission we defined and acknowledged the scale of the challenge in delivering a sustainable health and care system and set out the case for change. Since then, we have been working together to establish the new relationships, behaviours, systems and processes that will be required to address the "wicked issues" we face. The STP approach has created a new culture and environment within which our organisations need to operate and we recognise that we are at the start of our collaborative journey. As we progress the STP, we will develop our approach further and learn new ways of working together for system benefit.

This submission reflects the progress we are making and recognises the challenges that lie ahead. Our intention is therefore to:

- Reaffirm the model of care we are developing;
- Demonstrate how the programmes and projects we are undertaking will contribute to the delivery of the model of care;
- Provide greater detail on the projects we are undertaking, the outcomes they are seeking to achieve and their relationship to the overall model of care;
- Begin to illustrate the impact these projects will have on the experience and outcomes for our population, the quality and accessibility of our services, the roles and opportunities for our staff and the financial sustainability of our care system;
- Describe the way we will enable change through the transformation of our service delivery, workforce, our deployment of technology and the optimal use of our estate; and
- Articulate how we will use the operational planning and contracting processes to embed the STP approach and incentivise the delivery of the model of care.

Since our June submission, we have continued to develop our new model of care through three major transformational workstreams: Prevention, Early Intervention and Self-Care; Integrated Primary and Community Care; and Acute Care Collaboration. Our focus in the last three months has been on defining and initiating our short and medium term priority projects within each of these programmes and assessing the impact these will have on the overall sustainability challenge. We have also sought to ensure that mental health is effectively integrated within all three workstreams.

In developing our STP, we are building on the advances we have made in our local infrastructure. These include our use of digital technology to support care, the redesigned estate at the Bristol Royal Infirmary campus, South Bristol and Southmead hospitals and the combination of general, specialist and tertiary services that we offer and help to make BNSSG an attractive place to work.

The analysis required to estimate the impact of the new model of care is ongoing and we are using the Operational Planning timetable and requirements as the framework through which the intended impacts will be built into service contracts. At this stage of the process our planned interventions will only generate part of the financial savings we need. This reflects two things:

- The limited evidence base that exists for achieving the scale of change needed; and
- The multifactorial influences that determine the demand for care services.

At the heart of our STP will be a drive to improve our collective understanding and analysis of the influences on demand for our services and how the respective interventions that we make (e.g. shared decision making or self-care) can positively influence these at a scale previously not achieved. We also acknowledge the evidence around the influence that 'supply' can have on the demand for a service and will seek to take bold collaborative decisions to manage supply in areas where there is unwarranted variation in demand.

We know from the scale of our quality, accessibility and sustainability challenge that there is more we need to do to identify and define the significant transformational changes that are required. In support of this, we are evolving our governance structures to facilitate effective decision making. We are also utilising the opportunities presented by the two year Operational Planning process to ensure organisations are incentivised to operate in a manner which aligns with the goal of our STP.

Our discussions around the organisational forms that will be required in the future are still in progress, as our focus at this moment is on delivering the short to medium term changes we have defined. We will, however, increasingly focus our attention on the implications of the changes in our model of care for existing organisations and the opportunities presented by organisational reform.

In this regard, our STP is deliberately both ambitious and pragmatic, ensuring that we build momentum through our new ways of working, strengthening our relationships and improving our effectiveness as we create the model of care for the future.

1.4 Case for change update

In our original submission we set out the case for change which largely remains as previously described. Where our thinking has developed further we have included short updates.

Health and Wellbeing Gap

Our model for prevention, early intervention and self-care requires a focus on targeted areas, populations and interventions that will deliver tangible benefits. The model involves strong collaboration across service providers, the wider workforce and stakeholders including local government, public / community representatives, and the voluntary sector.

Care and Quality Gap

Our care system continues to experience the significant performance challenges that were set out in our original submission. We recognise that addressing these performance challenges is central to the development of our STP and are using the Operational Planning process to help define and embed the performance improvement measures that we will collectively pursue.

Affordability Gap

Since our submission in June we have reviewed and refined the financial and activity modelling that underpins the 'Do nothing' option in the STP. The most significant factor in this change was to update the modelling from its original baseline of 2015/16 forecast activity, to the 2016/17 operating plans that BNSSG organisations are now working to. The 'Do Nothing' positions and financial savings for the period to March 2020/21 were signed off and

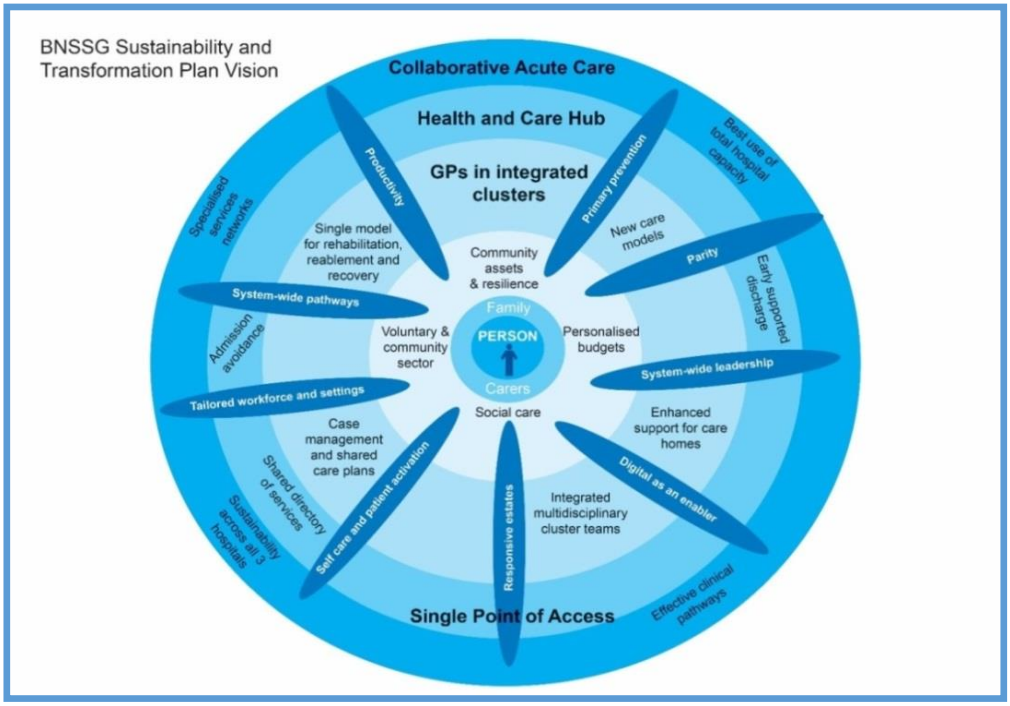
submitted by Directors of Finance on the 14th October 2016. The 'Do Nothing' deficit across the BNSSG STP as at 31st March 2021 totals £305.5m as reflected below.

Surplus / (Deficit)	**"Do Nothing" 2020/21 Positon**
Providers	**£'m**
University Hospitals Bristol NHS FT (UHB)	(47.6)
North Bristol NHS Trust (NBT)	(80.6)
Weston Area Healthcare NHS Trust (WAHT)	(20.6)
Avon & Wiltshire Mental Health Partnership (AWP)	(17.3)
South Western Ambulance Service (SWAST)	(3.2)
Community Interest Companies (CiCs)	(15.0)
Sub-total Providers	**(184.3)**
Commissioners	
Bristol CCG	(60.9)
North Somerset CCG	(30.3)
South Gloucestershire CCG	(30.0)
Sub-total Commissioners	**(121.2)**
System Wide	
Total Organisational Financial Plans	**(305.5)**

2. Vision

"Health is made at home; hospitals are for repairs" – African Proverb

In our June submission we defined the model of care that we are aspiring to create using the image on the right.



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

In our model, prevention, early intervention and self-care will be targeted on areas, populations and interventions that will deliver tangible benefits. The model involves strong collaboration across commissioners, service providers, the wider workforce and stakeholders including local government, public /community representatives, and the voluntary sector.

The design of our model, the principles on which it is based and the key programmes through which it will be delivered remain the same as in our previous submission, but since June we have been working to better define, design and assess the impact of the changes that will make the model reality.

3. Our programme approach

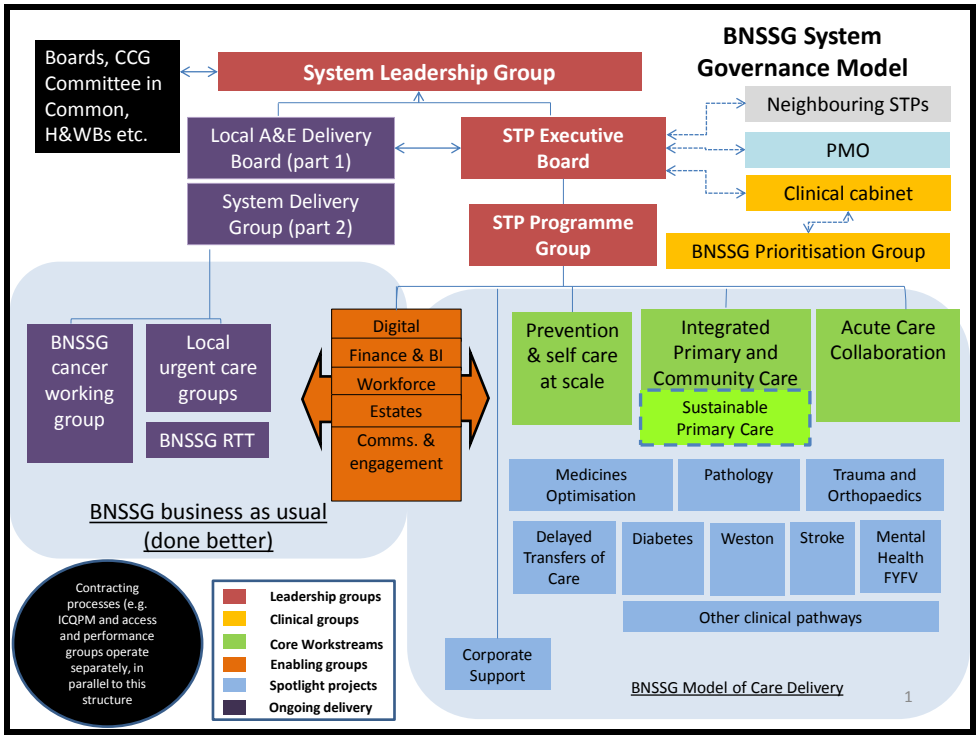
3.1 Governance & Leadership

With the recent appointment of an STP Programme Director, further development of the governance structure has been initiated. The STP Governance will soon be further strengthened, we hope, by the appointment of an independent Chair.

In further developing the STP governance we are using the following elements as our design principles to establish our Governance:

- **Shared common purpose:** A core shared purpose that is understood, owned and rigorously followed by all organisations. This needs to be owned by all the organisations involved and incorporate all of their objectives.
- **Mechanisms for managing financial risk and benefit:** Local agreements that govern financial flow to ensure that all organisations are incentivised to achieve the shared goal of service model redesign
- **Shared understanding of where we are competing and collaborating:** Failure to have a shared understanding of this can cause whole system working to collapse. This is particularly true for systems that are attempting to reconfigure acute services with multiple current suppliers, or where there are opportunities to compete for community services between acute, community and primary care providers.
- **Process for escalation, resolution / arbitration**: Systems need to agree upfront, prior to any disagreements, how disputes will be resolved. Failure to agree this causes systems working to fail at the points of greatest tension.
- **Clinical defensibility**: It is essential for sustainable change that any plans are based on the best available clinical evidence and knowledge.
- **Quality of interpersonal relationships**: Strong interpersonal relationships between organisational leaders are essential and can secure success even when fault lines appear in the five areas above. Whilst it must be acknowledged where there have been rapid and frequent changes to leadership, it is still possible to galvanise relationships in new groups of leaders.

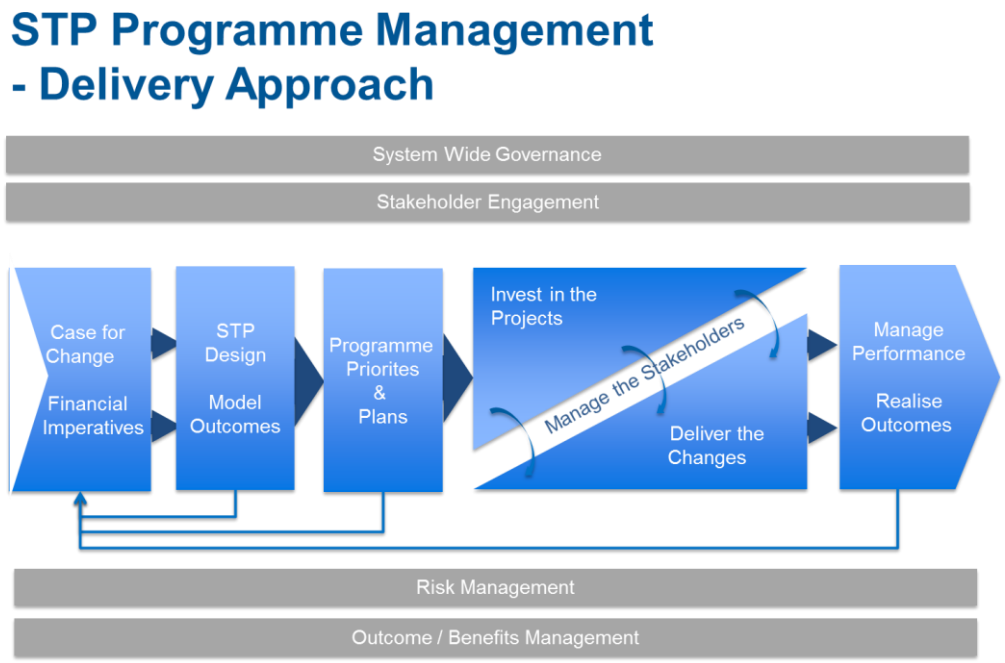
BNSSG STP Programme Governance Structure



Programme Management Environment – Key Elements

In developing the STP programme we have used the following to guide the creation of the right programme environment for success:

- Create and articulate a shared understanding/common narrative;
- Allocate the time for people to focus on the transformation (small, purpose built and dedicated teams);
- Reset the balance between organisational sovereignty and doing the right thing;
- Unblock the money, by not letting the contractual framework be a barrier to change;
- Listen and respond proportionately/appropriately to the feedback from stakeholders involved and / or impacted by change.

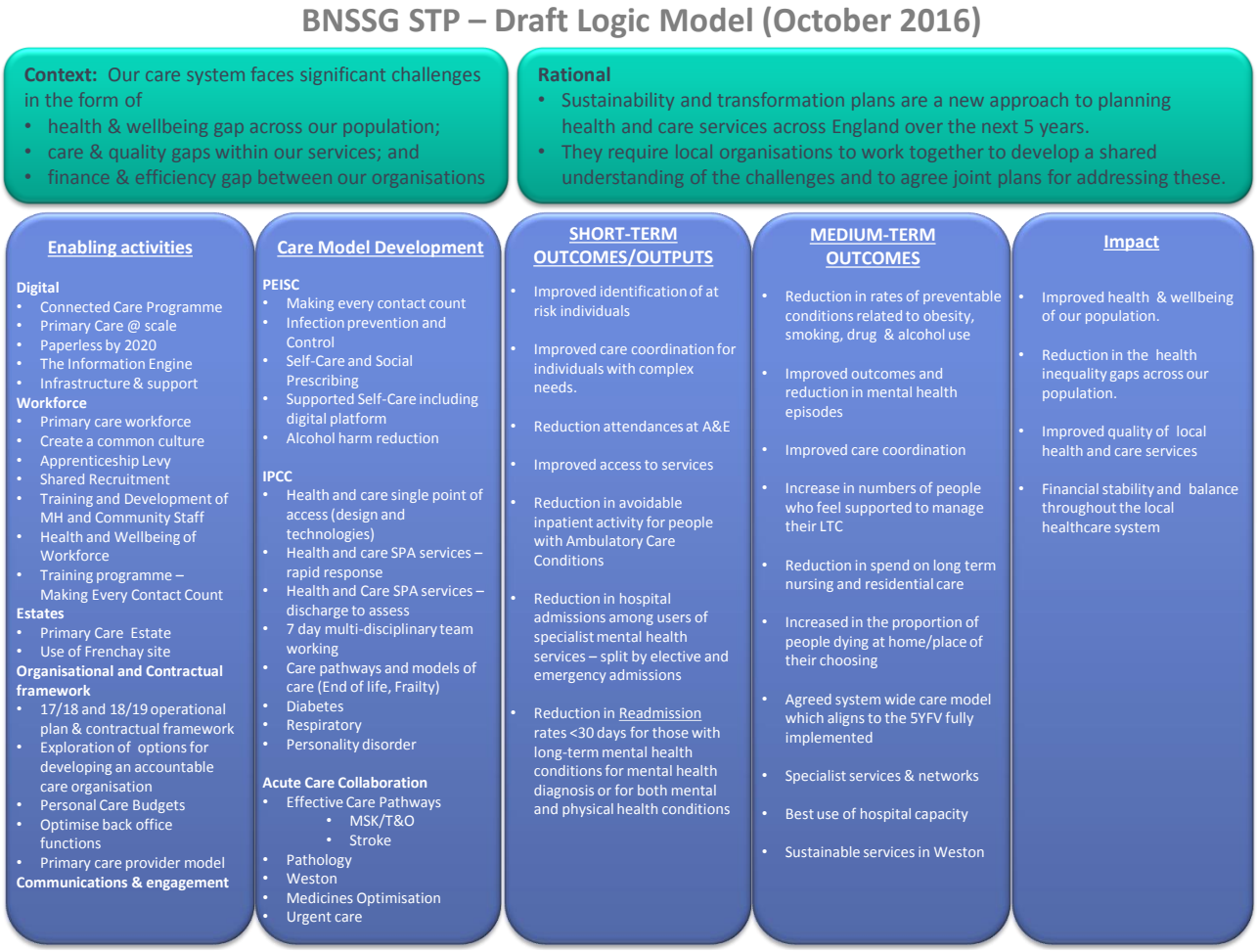


Our programme management approach will enable us to have full line of sight of our Development, Enabling and Delivery projects for Case for Change to Realisation.

See appendix A for Governance and Resourcing.

4. BNSSG overview

Our June submission included a Plan on a Page as a mechanism for providing an overview of how our STP would operate. We are currently transitioning the Plan on a Page into a Logic Model to more explicitly demonstrate how the projects that we are prioritising in the early years of our STP will lay the foundations for achieving the outcomes described.



Our STP initiatives are coordinated through three core transformation portfolios:

- Prevention, Early Intervention and Self-Care
- Integrated Primary and Community Care
- Acute Care Collaboration

We are also undertaking a range of enabling programmes (Digital, Estates and Workforce) which will underpin delivery.

Set out in the following chapter is a summary of each Portfolio, Programme and Project that we are taking forward. The projects selected at the start of our STP have been chosen because of their potential to either unlock further improvement opportunities or deliver early wins. Underpinning our redesign approach will be a focus on tackling unwarranted variation within our care system. This will be reinforced by putting *'individual goal setting'* and *'shared decision making'* between individuals and the care providers who support them at the centre of every care conversation (Making Every Contact Count).

4.1 Prevention, Early Intervention and Self-Care

Our model for prevention, early intervention and self-care requires a focus on targeted areas, populations and interventions that will deliver tangible benefits. The model involves strong collaboration across service providers, the wider workforce and stakeholders including local government, public / community representatives, and the voluntary sector.

The model is based on four principles:

1. Resource: Ensure that strategic initiatives are costed and adequately resourced.
2. Enable: The population and patients need to be enabled to adopt healthy behaviours.
3. Align: Alignment of strategies and pathways ensuring consideration of the wider determinants of health.
4. Innovate: Finding new and better ways of achieving outcomes through making the best use of available resources (including workforce) and ensure co-production (community involvement in the development of initiatives).

Transformation

We have identified the key decisions necessary to deliver a radical shift towards prevention. These are:

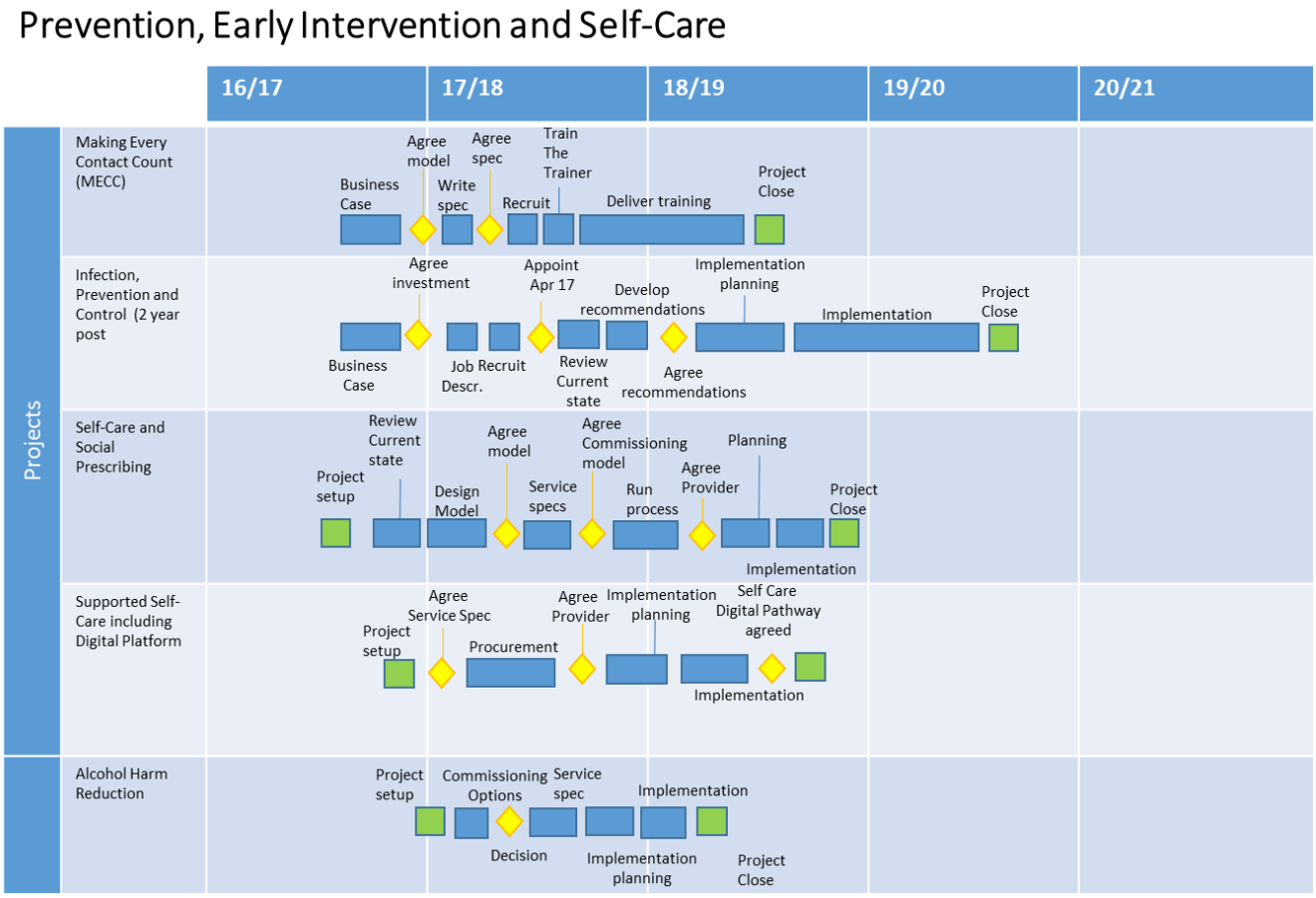
- Self-care and patient activation will be implemented at scale with consistent delivery across our system.
- A population health approach will be embedded across pathways (activate the population, carers and health professionals; reduce admissions; increase proactive prevention across the pathway).
- We will enable care settings to be innovative and effective e.g. using digital technology to support self-care.
- Inequalities – we will take a system wide approach with a focus on inequalities within our footprint rather than regional comparisons and take into account key groups (e.g. people with learning difficulties).
- In order to achieve the short and medium/long term priorities investment is required for prevention, early intervention and self-care at scale. Modelling suggests that 2% of BNSSG NHS funding is required for this purpose over the next 5 years. Through the Operational Planning process we will assess the realism of BNSSG transitioning to achieving this level of investment in prevention and wellbeing.

Initial projects

Our initial priorities are:

- Making every contact count
- Infection prevention and control
- Self-care and social prescribing
- Supported self-care (digital)
- Alcohol harm reduction

These have been chosen because they are evidence based, will improve the health of the target population, have an impact across the system and will reduce hospital admissions. They have been developed based on a life course approach and the need to embed prevention and self-care across the pathway taking into account primary, secondary and tertiary prevention opportunities.



Please see appendix B1 for the Plan on a Page for each project and B2 for additional programme narrative.

4.2 Integrated Primary & Community Care (IPCC)

The overarching objectives of the new IPCC model are to improve peoples' care and experience through:

- Early intervention and management to keep people as well as possible, improving the stability of their health and wellbeing.
- Supporting independence, so that people enjoy the best quality of life possible in their places of residence.
- Personalising care and support planning to ensure patients and their families have increased choice, flexibility and control over their health, care and wellbeing.

Programme outcomes

The expected outcomes of the IPCC Programme and new model are both quantitative and qualitative:

Quantitative

- Delivering a best case 15% avoidance of primary and community health contacts.
- Overall 30% reduction in admissions and attendances by STP year 3 for certain LTCs, from care homes and at end of life.
- Reduced Length of Stay and Pre-Operative Assessment in acute hospitals for people with mental health issues
- Reduction in outpatient appointments by 15%
- Reduction in LOS of 20%
- More effective utilisation of community beds by streamlining access via the Health and Care Single Point of Access.
- Savings in consolidating and reducing premises

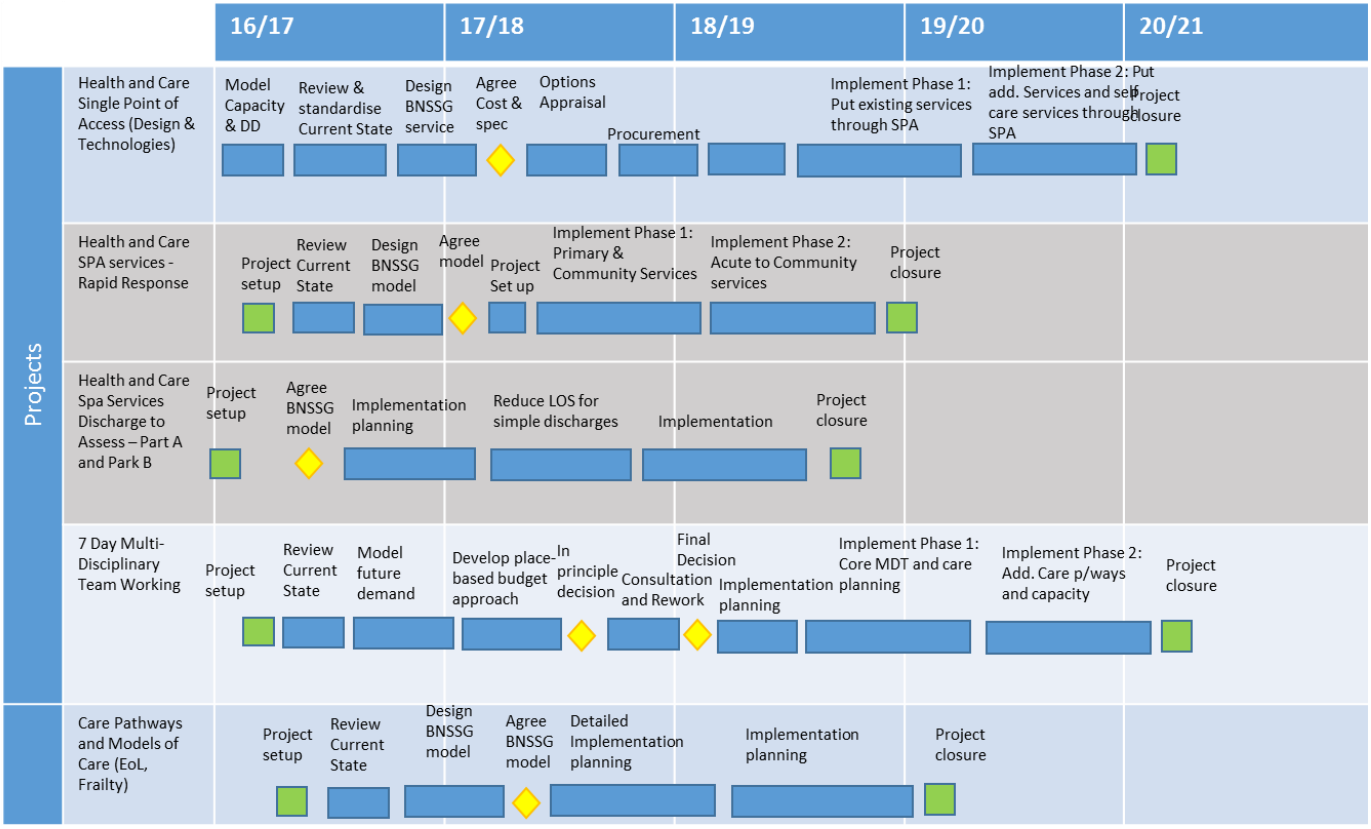
Qualitative

- Addressing health inequalities across BNSSG.
- Increased independence and improved patient and carer satisfaction.
- More people achieving their preferred place of death.
- Improved GP and health and care staff satisfaction.
- Improved health outcomes for people with LTCs.
- Reduced variation in practice across clusters and localities, leading to improved efficiency.

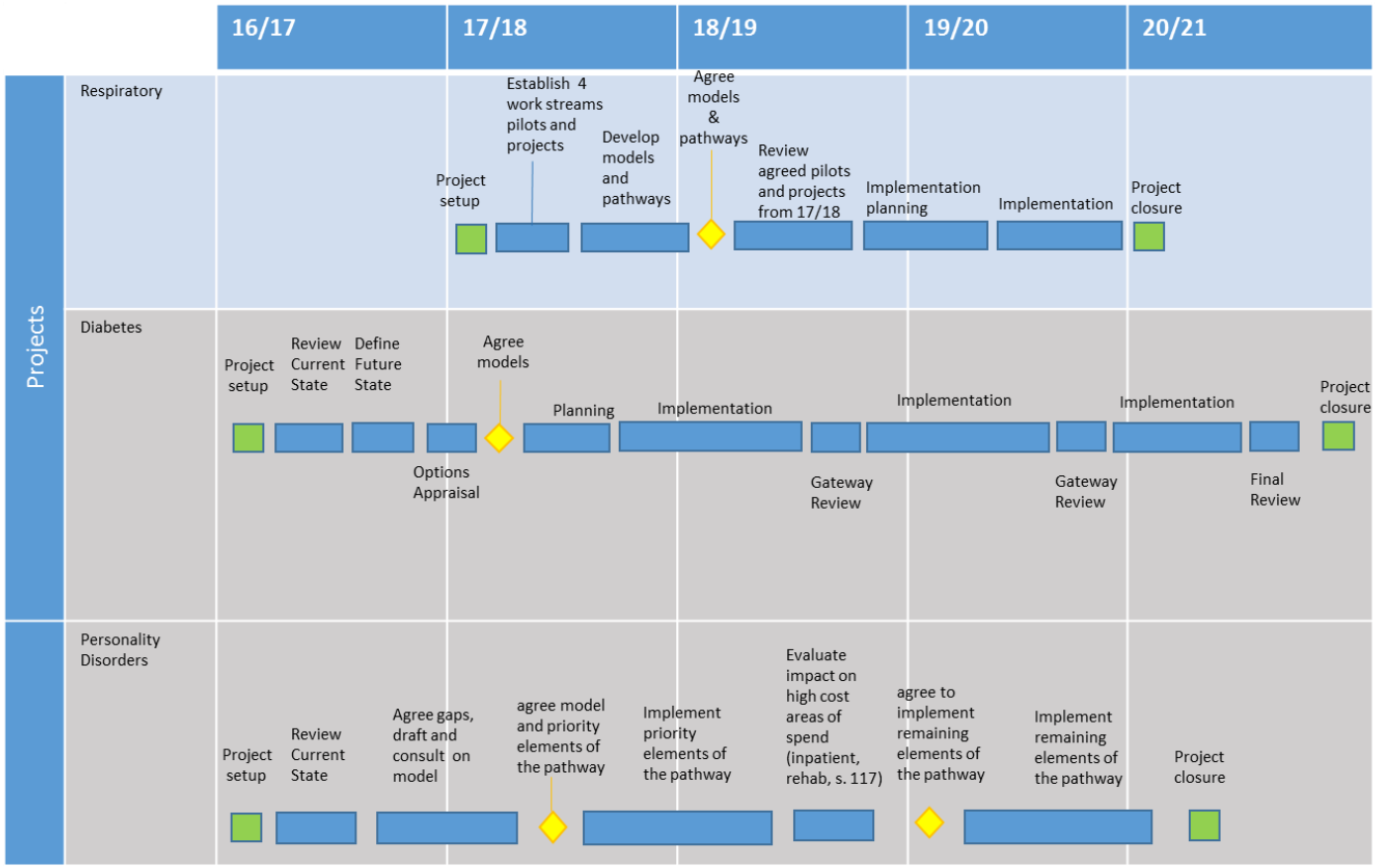
This includes the following projects:

- Sustainable Primary Care (Timeline to be developed shortly by NHS England)
- Health and Care Single Point of Access (Design & Technologies)
- Health and Care SPA services - Rapid Response
- Health and Care Spa Services -Discharge to Assess – Part A and Part B
- 7 Day Multi-Disciplinary Team Working
- Care Pathways and Models of Care (End of Life, Frailty)
- Diabetes
- Respiratory
- Mental Health

Integrated Primary and Community Care

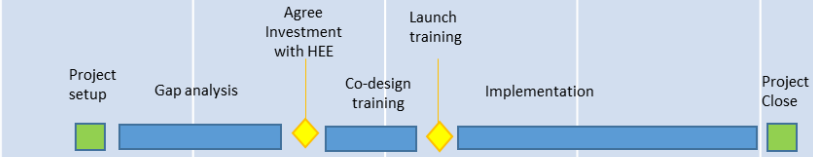
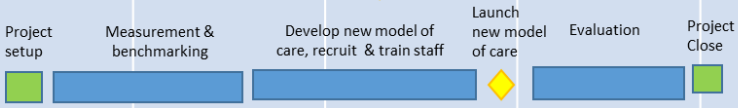
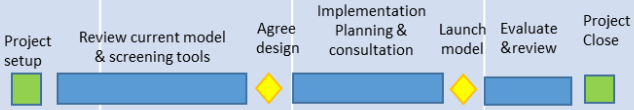
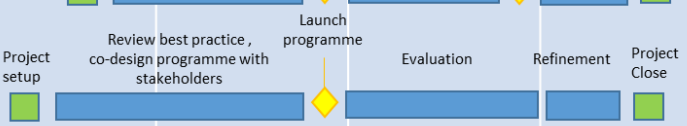
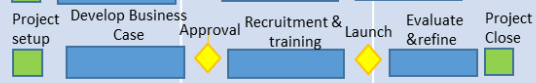


Integrated Primary and Community Care - Clinical Pathways

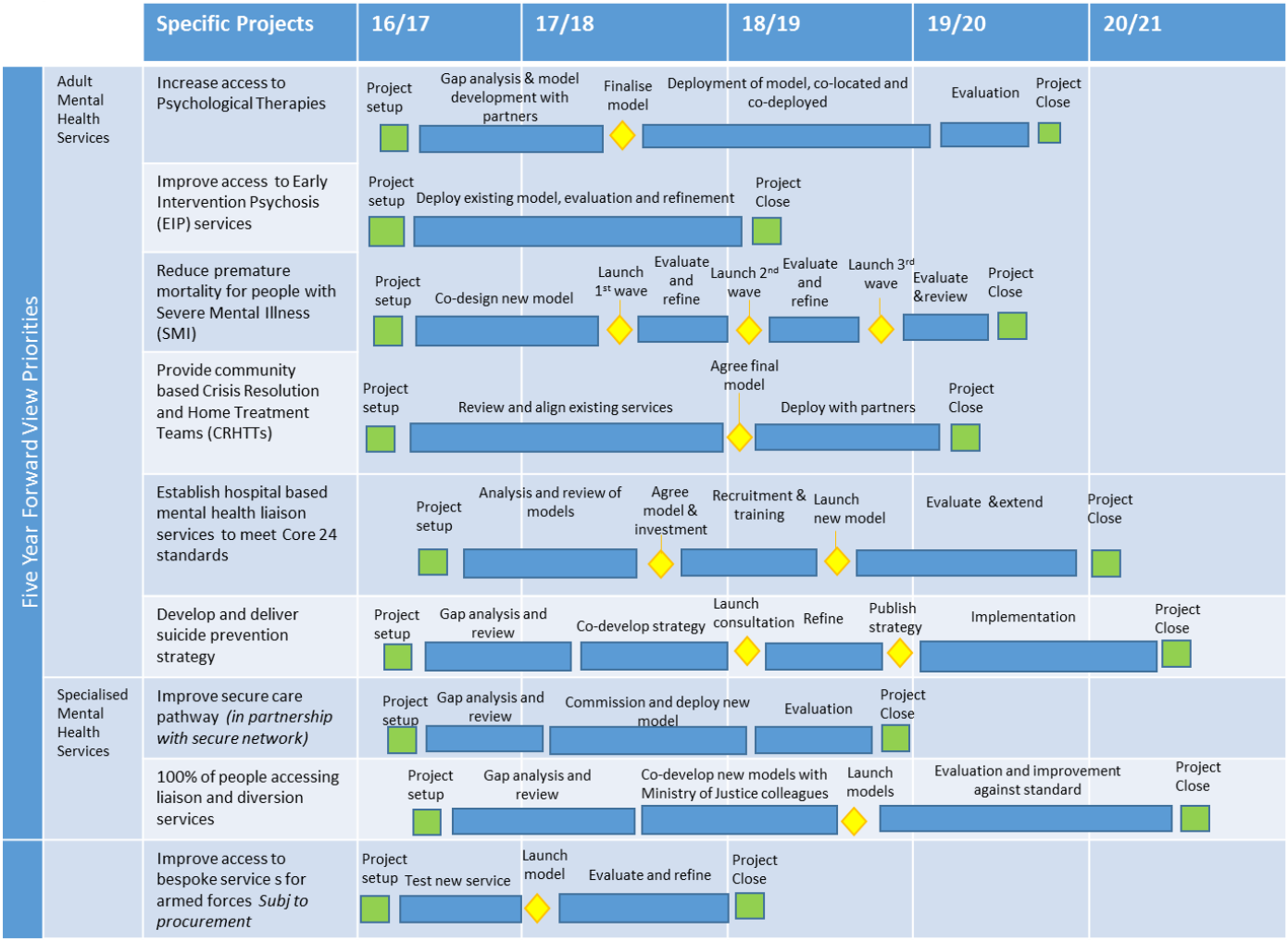


Please see appendix B1 for the Plan on a Page for each project and B2 for additional programme narrative.

Mental Health – Women, Children and Families

		Specific Projects	16/17	17/18	18/19	19/20	20/21
Five Year Forward View Priorities	Children and Young People's Mental Health	Improve access to C&YP services through training and development of staff in early detection & treatment					
		Improve access to community based Eating Disorders Services					
		Reduce inpatient stays for C&YP					
		Establish programmes for parents of children with conduct disorders					
	Perinatal Mental Health *NB NHS England commission*	Expand inpatient perinatal mental health service					
		Expand community perinatal mental health service					

Mental Health – Adult Mental Health & Specialised Services



4.3 Acute Care Collaboration

The overarching objectives are:

- Best use of hospital capacity
- Effective clinical pathways
- Specialist services and networks
- Sustainable services at Weston General Hospital

These themes have been converted into specific and deliverable projects. Each project has been selected as a priority based on the scale of opportunity and potential to impact on reducing our known gaps in Care and Quality, Finance and Efficiency and Health and Wellbeing.

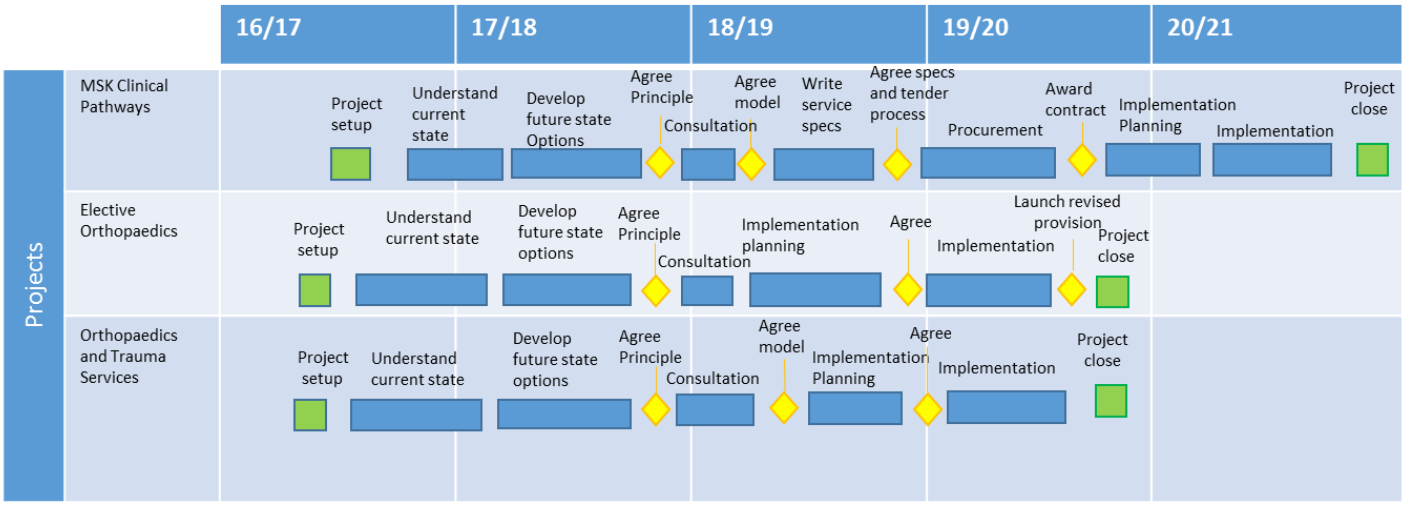
The phase one priority projects identified are;

- Effective Care Pathways
  - Musculoskeletal (MSK) / Trauma & Orthopaedic
  - Stroke
- Pathology
- Weston
- Medicines optimisation
- Corporate services consolidation
- Urgent Care
- Specialised Services

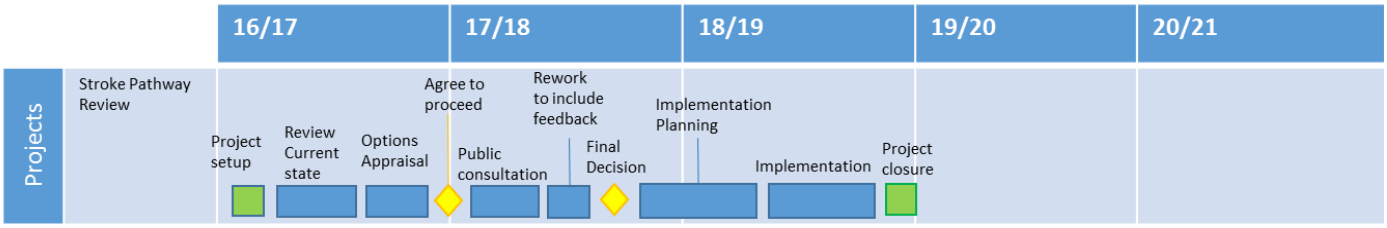
Example – Urgent Care:
The STP approach will ensure the system undertakes a comprehensive review of urgent care services so that it delivers for patients in need of urgent care. This will include:

- Effective and responsive NHS 111 service and primary care out of hours provision - a functionally integrated urgent care service, primarily through the establishment of a "clinical hub", in line with recommendations from NHS England.
- A single point of access for BNSSG that provides professionals with one number to support access to rapid responses and crisis services, supporting the community. This will support coordinated discharge and access to rehabilitation, recovery and reablement services. This will combine health and social care professionals, using up to date IT to enable rapid response.
- Links from that single point of access to a joint "front door" at the acute hospital staffed by primary and acute care clinicians, enabling appropriate streaming of care and comprehensive assessment for frail older people .
- Achievement of the 4-hour emergency access standard through:
  - **Admission avoidance and prevention**: Ensuring community alternatives to hospital admission are easily accessible by patients and Primary Care and other healthcare professionals in their local communities.
  - **Improving flow through hospitals** by ensuring the patient journey through hospital is efficient and the patient is not subjected to any unnecessary delays.
  - **Enabling discharge**: Ensuring that patients are discharged as soon as they are no longer in need of acute hospital care
  - **Frail & elderly care**: Ensuring there is holistic, multi-disciplinary end-to-end care for people living with frailty and complex conditions.

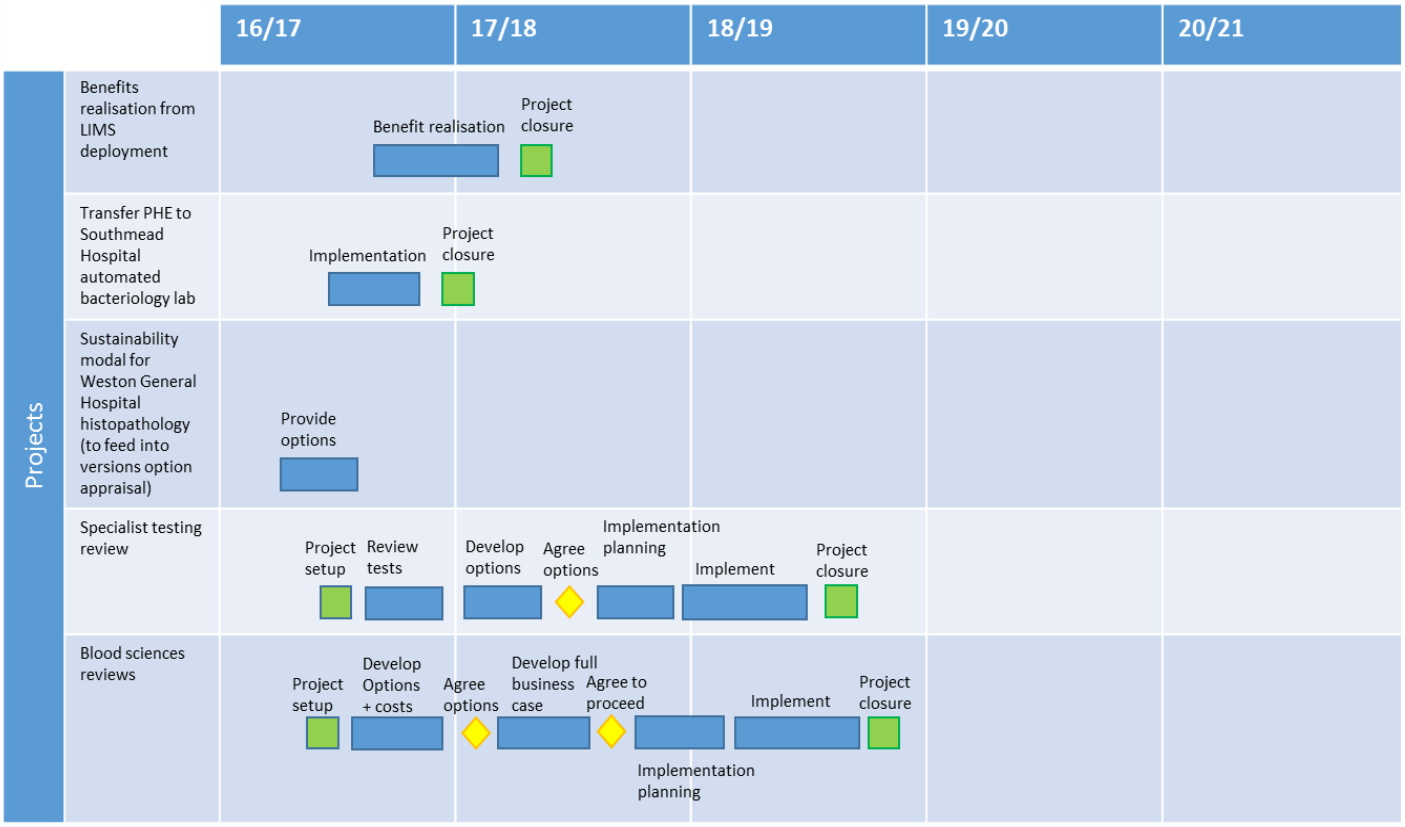
MSK Programme



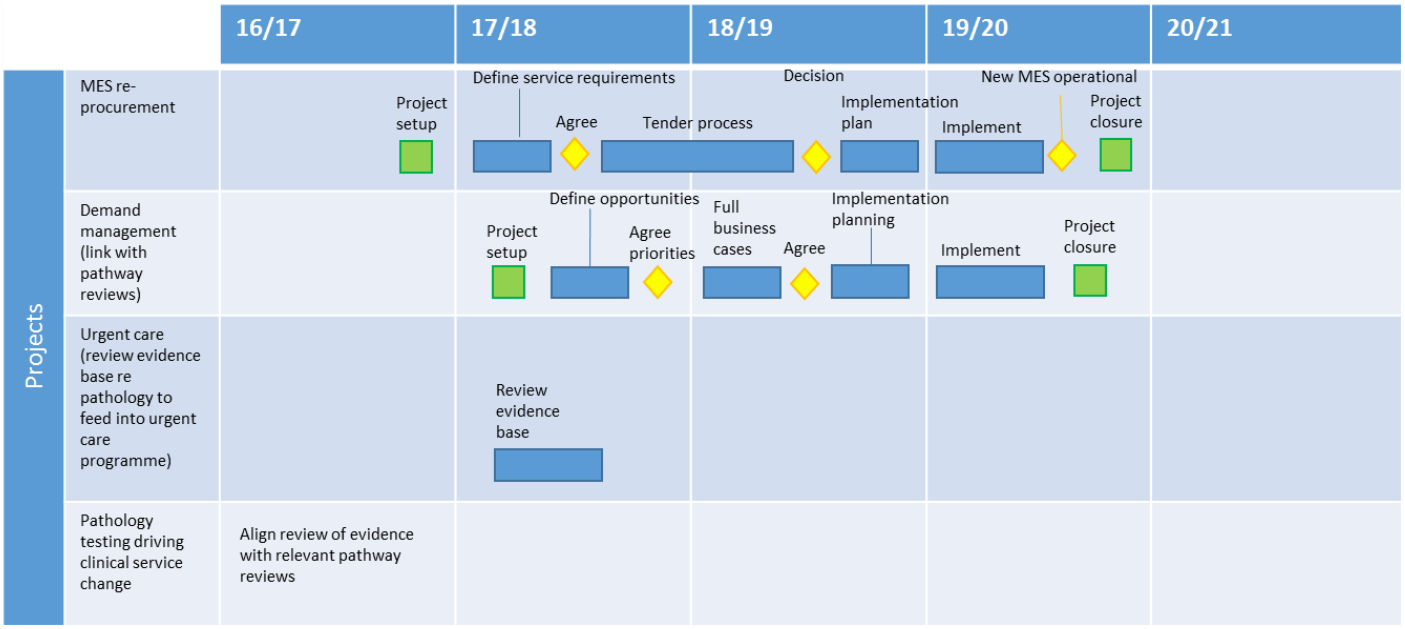
Stroke Pathway Review



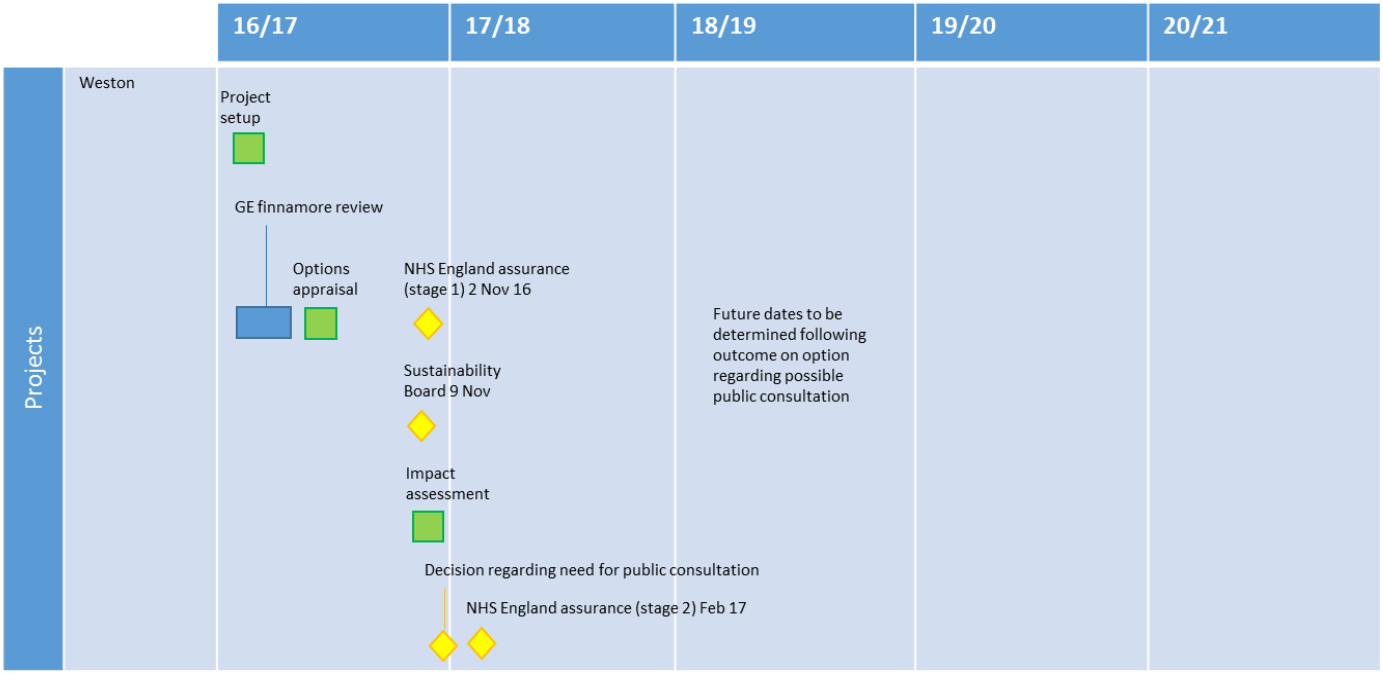
Pathology Programme



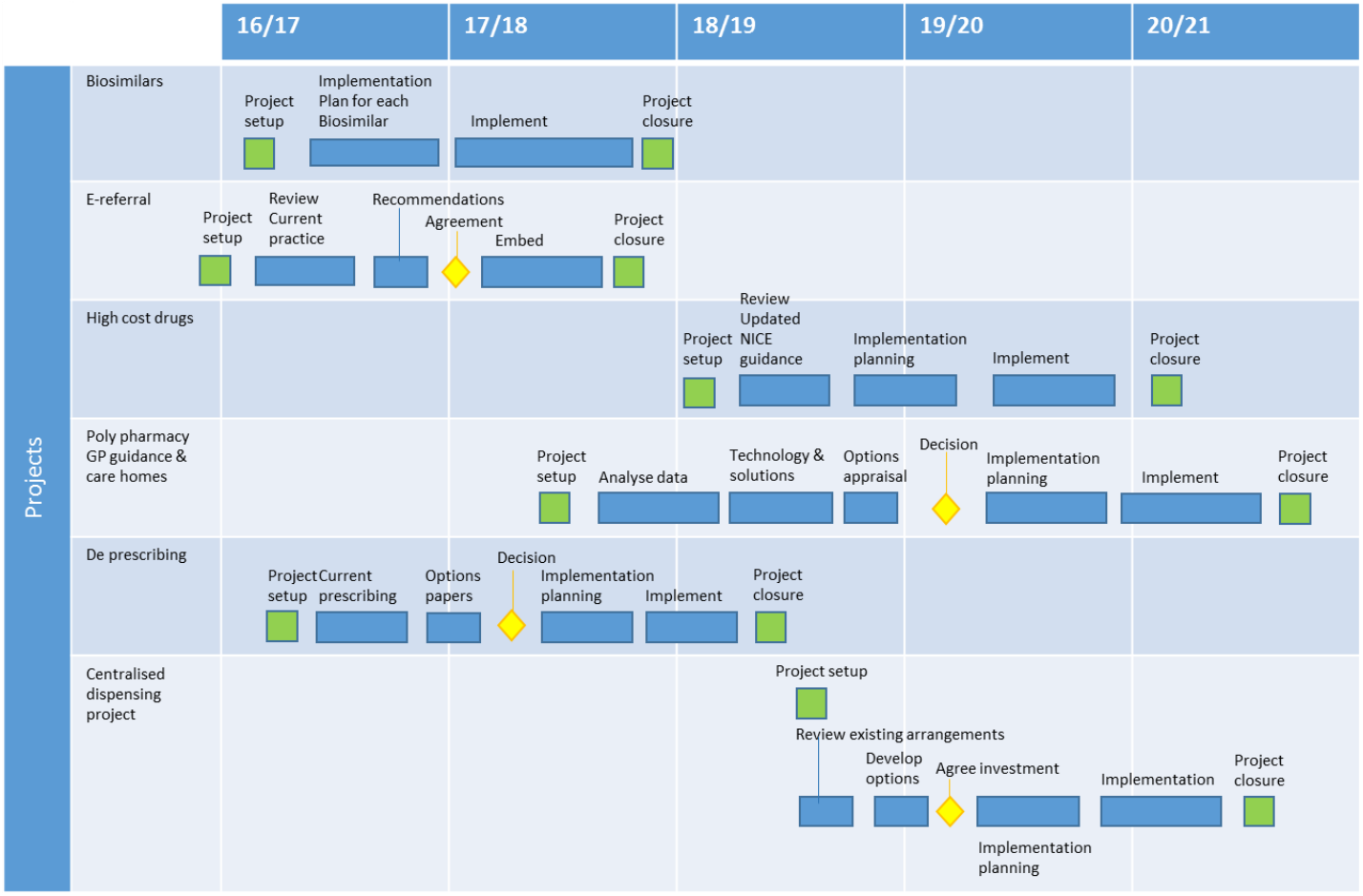
Pathology Programme continued



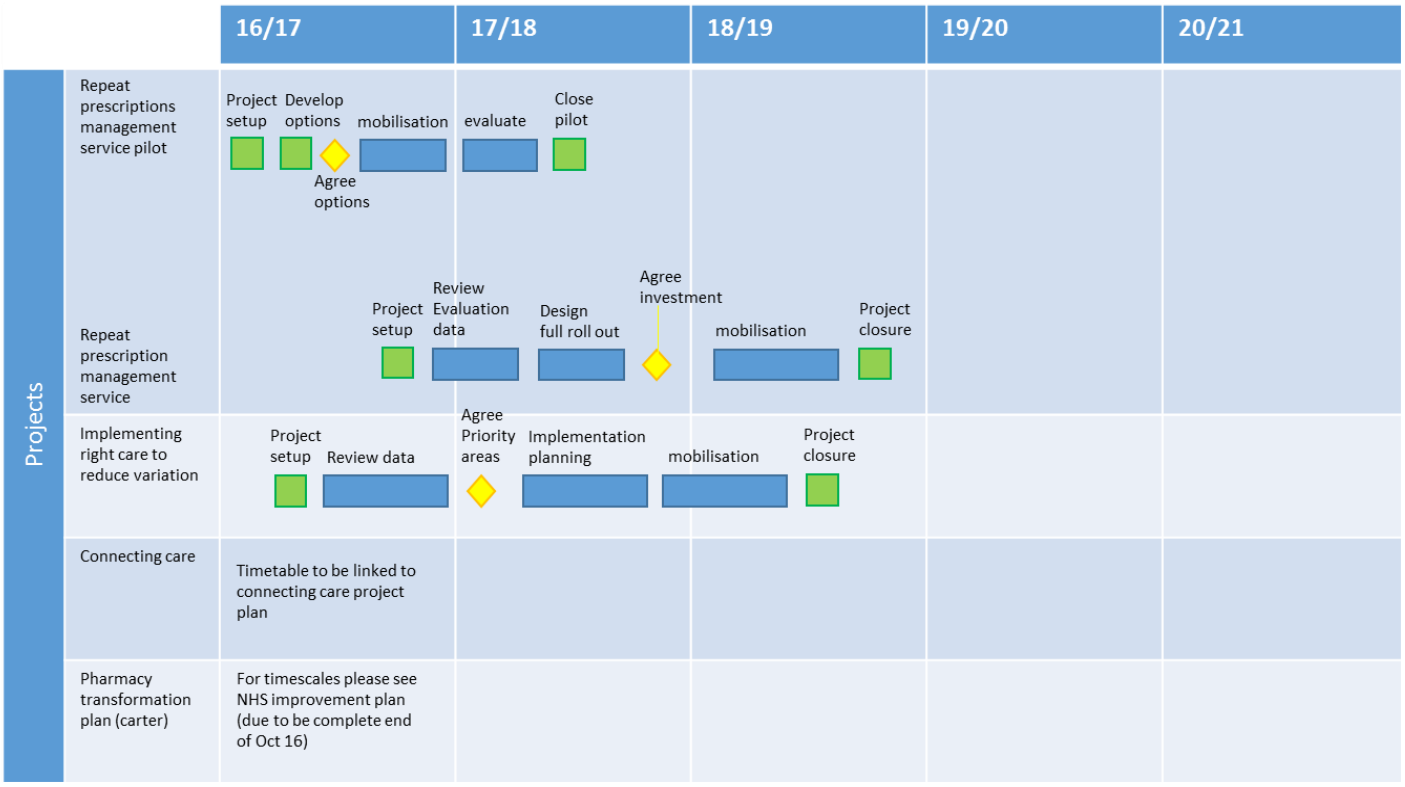
Weston Sustainability



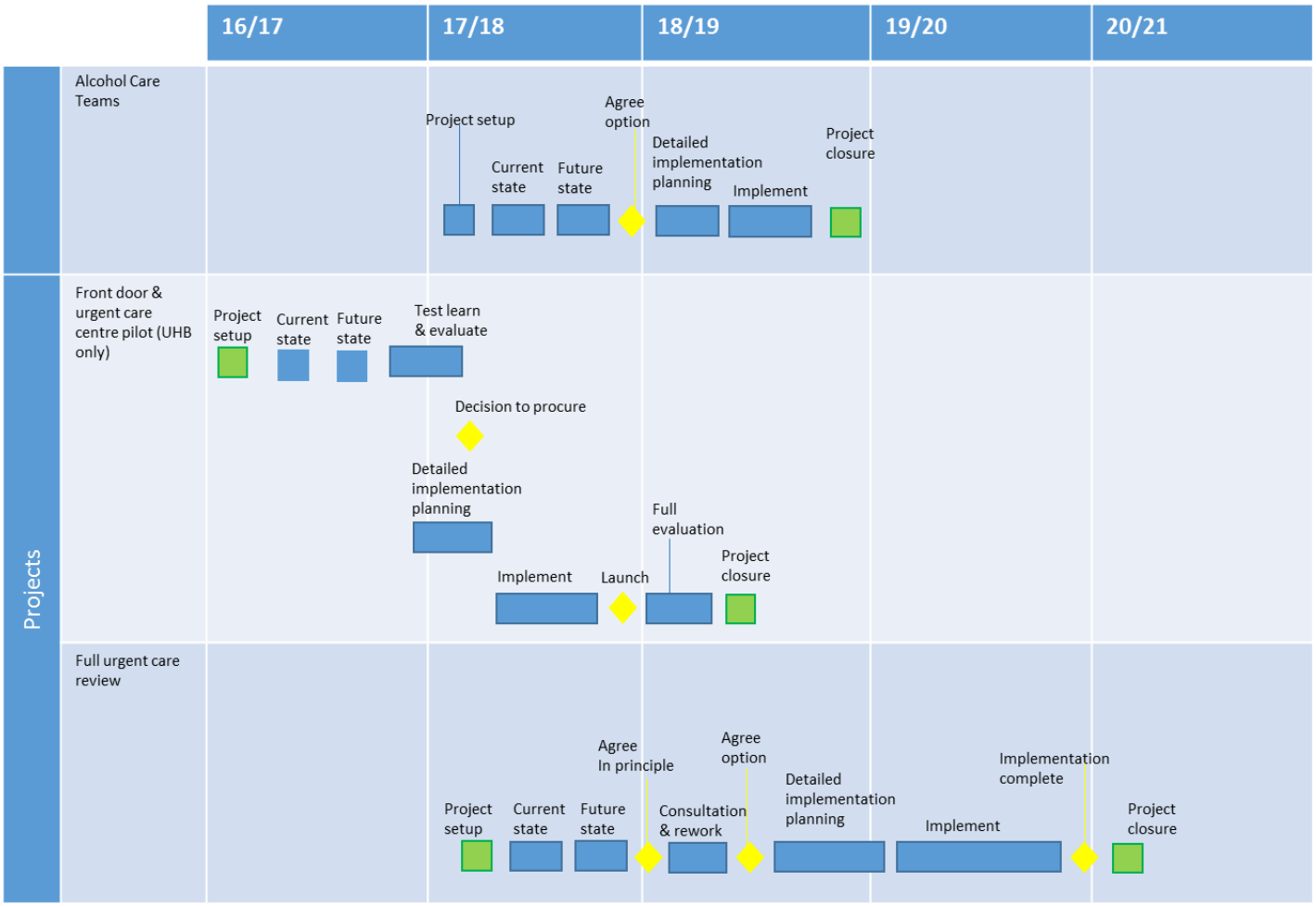
Medicines Optimisation Programme



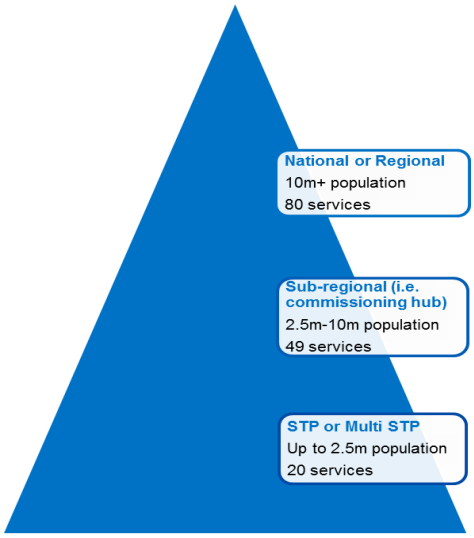
Medicines Optimisation Programme continued



Urgent Care Programme



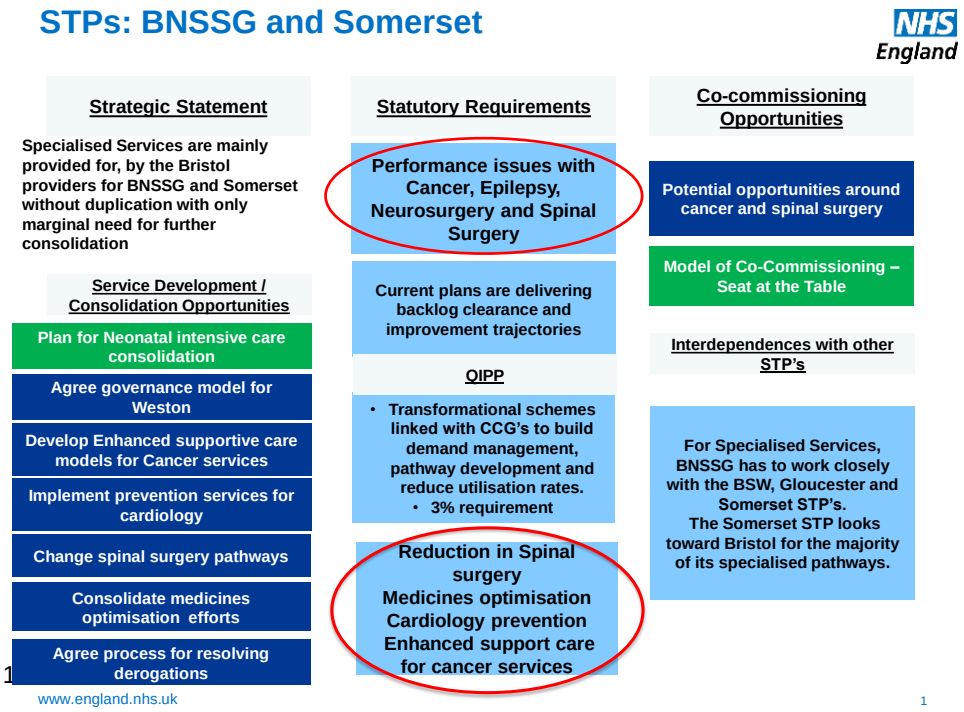
Please see appendix B1 for the Plan on a Page for each project and B2 for additional programme narrative.



4.3.1 Specialised services

More than 30% of the capacity of the acute hospital Trusts in Bristol is occupied with specialist commissioned services which support care for a large regional population. Most specialist services in Bristol are delivered by a single provider working at scale. The specialist capacity needs protection so that it is available for delivering urgent and complex care beyond the STP foot print boundaries. This requires effective networks, endorsed by specialist commissioners, that ensure rapid repatriation of patients to local settings and rehabilitation pathways of sufficient capacity to avoid delays.

The STP will collaborate with Specialised Commissioners to deliver the approach to specialist service provision illustrated below.



Please see appendix C for more information regarding specialised commissioning.

5. System approach to our challenges

5.1 Health & Wellbeing

The table below illustrates the prevalence of lifestyle and mental health issues within our STP area. This highlights the importance of working across our core programmes (PEISC, IPCC, ACC and MH) to ensure a coordinated response.

		Bristol	North Somerset	South Glos
Smoking	Prevalence (av) (QOF)	21.5%	17%	15.9%
	Prevalence (highest)	38.6%	42.3%	24.6%
	Ex-smokers (GP survey data)	25.5%	32.1%	27.9%
Alcohol	Estimated risk drinkers	79,387	39,762	49,068
	Alcohol related admissions	3018	1387	1641
Weight	Obese	21.7%	22.2%	23.3%
	Overweight	56.9%	62.7%	63.2%
Mental Health	Depression (av)	7.6%	9.2%	7.7%
(All QOF)	Depression (highest)	13.7%	5.9%	14.7%
	Long term MH condition (av)	5.9%	5.3%	4.3%
	Long term MH condition (highest)	14.7%	11.9%	9.7%

5.2 Care & Quality

As an STP we will:

- Adopt a system-wide methodology for quality improvement working with the Academic Health Science Network (AHSN);
- Recognise the need for a system wide approach to health and wellbeing for our workforce;
- Address mental and physical health and wellbeing in every pathway; and
- Assign a board champion for mental health on each provider board.

The business case templates we are using for STP initiatives specifically ask project leads to describe how they impact on the three elements of quality:

1. On the clinical effectiveness/clinical outcomes expected,
2. How the case supports a safe system of working and to ensure that the experience of the user/patient is considered alongside their engagement.
3. Having the right intervention first time, at the right time benefits the individual as well as promoting better efficiencies within the system.

5.3 Health & Social Care

At the core of our approach to integration of health and social care is the development of cluster based care, operating with community multi-disciplinary teams and improved care coordination, focused on proactive case management of those at greatest risk within our population.

Our principles for integration are that health and social care organisations will:

- Share common objectives and pursue common outcomes, working together effectively
- Build services around people and communities at both efficient and effective scale that enable their needs, aspirations, capabilities and skills and build up personal autonomy and resilience;
- Prioritise prevention and rehabilitation, reducing inequalities and promoting equality and independence;

- Constantly seek to improve performance and reduce costs;
- Are open, transparent and accountable;
- Adopt a commonality of structure that works for local communities and for all commissioning and provider partners in BNSSG.

North Somerset, South Gloucestershire and Bristol City Councils are seeking to create a Social Care Collaborative based on a commitment to working together:

- **With individuals** as partners in planning their own care and support.
- **With carers and families** as partners in the support they provide to the people they care for. We will ensure the support carers and families can sometimes require for themselves is recognised.
- **With communities** as partners in shaping the care and support available and in providing opportunities for people to get involved in their communities.
- **With organisations** across sectors, including our Community Planning partners and the Third Sector. We will work in partnership to co-commission, forecast, prioritise and take action together.
- **With our staff** as partners in developing and delivering our vision, valuing their knowledge, skills and commitment to health and social care.
- **To improve** demand management across the system and make best use of technology and on line digital services

5.4 Mental Health

BNSSG leaders recognise that the STP presents an opportunity to address the holistic health and care needs of our populations, including mental health and wellbeing. Current mental health service commissioning arrangements result in variable access, varying service specification, waiting times and treatment outcomes across the three CCGs. We have not yet developed fully integrated social, mental and physical health care, focussed in the community and pro-actively delivered at the earliest opportunity. There are fragmented care pathways, with both duplication and gaps in provision.

In BNSSG we are committed to achieving an uplift in mental health investment over the next four years to bring spend in line with the national benchmark.

Our aim is to ensure that all forms of care consider and value mental and physical health equally, so that people receive the treatment to which they have a right and are supported effectively in their recovery.

Our approach for mental health rests on the five core principles we have established for the STP:

1. We will standardise and operate at scale:
   The move to a single commissioning voice enables mental health to standardise service specifications, for example, a single 'offer' from IAPT for long term conditions. We will develop regional specialist provision such as perinatal inpatient care and will work in partnership to create maximum impact for the most vulnerable populations across the region, including Secure Services and other specialised services.

2. We will develop system-wide pathways of care:
   For mental health, this means we will address the current commissioning gaps in service lines across the three CCGs. We will act positively to ensure equity of access to services, prioritising investment in those areas with least access. Starting with prevention, and through closer working with Public Health and primary care, our actions to reduce harm from alcohol and smoking will improve population mental wellbeing yet will include targeted attention for those with severe mental disorder (SMI). Similarly, screening programmes will proactively identify mental ill-health in schools, acute hospitals, care homes and pregnant women, and will positively target those with SMI. In year one, our plan begins to address geographical disparities in specialist provision for

children and young people, perinatal women, early intervention in psychosis, liaison services and crisis services. The five year plan will refocus provision away from hospitals and into the community.

3. We will develop a new relationship with the population:
   Simplifying access to all services through a single point of access ensures the earliest, most appropriate signposting to care. Staff and patients will perceive fewer interfaces in their health and social care pathway and the implicit cultural message is inclusive, reducing stigmatisation.

4. We will develop new relationships between organisations and staff:
   We will increase and simplify access, reduce stigma and improve health outcomes through a deliberate focus on integration of physical and mental health provision. Early success with control room and street triage has created common understanding and has changed behaviour in favour of least restrictive interventions. Inter-organisational, multi-disciplinary teamwork in liaison, services for medically unexplained symptoms, and perinatal and primary care will defend against 'diagnostic overshadowing', will encourage mutual aims in prevention and early intervention, will reduce duplication and will result in 'whole person' care.

   Our workforce enablers include IT and shared HR systems but a more radical change comes from the focus on staff development, retention, health and wellbeing. STP partners are developing the mechanisms: harmonised terms and conditions, training passports and core skill sets enable staff to work and move across organisations. Training for all staff groups in brief intervention and psychologically minded treatment will equip our workforce for the future as will training to work with older people. Apprenticeships, roll out of STP-wide quality improvement training, extended, rotational and innovative roles will attract and retain staff for whom the workplace offer includes stress reduction, psychological support , weight reduction and clinical supervision.

5. We will build on our existing digital work as a driver and enabler of cultural change:
   Access to care records across STP partners will facilitate safe, coordinated care planning and delivery for all patients and will promote integrated care, including shared and co-created risk assessment. For staff, access permits targeted intervention in keeping with our principle of 'least intervention at the earliest opportunity', including opportunity in years two and three for online and virtual therapy and symptom and medication monitoring.

5.4.1 STP Governance and Mental Health

Our governance structures are designed to ensure we deliver:

- parity of esteem, investment and innovation between mental and physical health, to improve the mental health, wellbeing AND physical health of the population;
- increasingly integrated services;
- national mental health indicators;
- the five year forward view for mental health; and

The Clinical Cabinet of key senior clinical experts will apply a 'parity test' to new developments and will assess pathways against the aims of integration and the Five Year Forward View for Mental Health.

All STP partners commit to assign board-level champions for mental or physical health and a board champion for mental health in a provider of physical healthcare.

As the largest NHS provider of mental health services across two STP footprints, Avon and Wiltshire Mental Health Partnership will work with accountable officers through the Mental Health Strategy Group, to advise both on strategy for local and specialist regional and national provision and to align trust clinical strategy appropriately.

As we review our plans, we will be assessing how effectively they support the Five-Year Forward View for Mental Health and how the STP will bring local spend on mental health up to national benchmarks, by demonstrating percentage growth year-on-year.

See appendix D: Mental Health - Parity

5.5 Commissioning Approach

Commissioning & Contracting 2017/18 & 2018/19

In preparing our STP submission, our System Leadership Group have considered how the evolution of commissioning and contracting processes will accelerate delivery of our STP in the short and longer term.

Desired future state

There is agreement that the current model of contracting does not support our agreed long term goals of system outcomes and financial balance. We recognise that we need to achieve improved system (patient) outcomes and reduced health inequality, supported by a financial framework that rewards parties for doing this. Achieving this will take time, trust and collaboration between partners, necessitating its inclusion within the wider STP.

Single version of the truth

There is a need for a single agreed version of the truth in relation to system finances. This includes an open and transparent approach to understanding system income and expenditure, including:

- Risks (to individual organisations & patient care)
- Constraints
- The existence of and approach to managing perverse incentives
- The existence of and approach to managing 'subsidies'
- Sunk costs resulting from changes in the Model of Care

System control total

The development of a system control total is recognised as a potential way to move towards our desired end state, with agreement that a necessary pre-condition would be the single version of the truth described above.

Consistent approach

The adoption of a consistent approach between all 3 commissioners is an essential element of our approach and should be extended to include specialised commissioning. In the short term, we are not intending to adopt multilateral negotiations (all providers in the same room) but will implement a consistent, open book approach between all providers and commissioners.

Key steps for 17/18 & 18/19

Our aim is to divert the energy consumed in taking the traditional annual approach to contracting into creating a 'good enough' understanding of system finances to ensure that the contract settlements move us towards a desired future state. System leaders have committed to:

- consider how multiple contracts create additional system financial risk when there is a finite pot of money and how these risks might be shared;
- continue the development of a single system savings plan; and
- achieve contract signature in a way that moves us towards a system financial framework that safeguards individual organisations and rewards the achievement of patient outcomes.

5.6 System Governance

As system leaders, we recognise that organising ourselves on lines closer to an accountable care system may bring significant benefits in the delivery of the vision we have set out in this STP. Our consideration of these opportunities is at a formative stage, but we are building specific activities into our STP programme to ensure we address them at the appropriate time ('form follows function').

As an early step towards supporting system change the three CCG's have embraced the need for a single commissioning voice and have already taken steps to establish a Joint Commissioning Structure across BNSSG. The two major acute providers in Bristol have also announced their intention to look at options for formalising a closer collaboration between them (that does not involve a merger).

6. Enablers

6.1 Engagement & Communication

As an STP Partnership we are committed to public and patient involvement. We will continue to listen and act upon public, patient and carer feedback at all stages of the STP development cycle because of the evident added value of commissioning and providing services that are informed by the experiences and aspirations of local people.

Within the individual projects, patient and public involvement that is proportionate to the changes that are being considered will be undertaken. In the case of any significant changes to services, appropriate formal public consultation processes will be implemented.

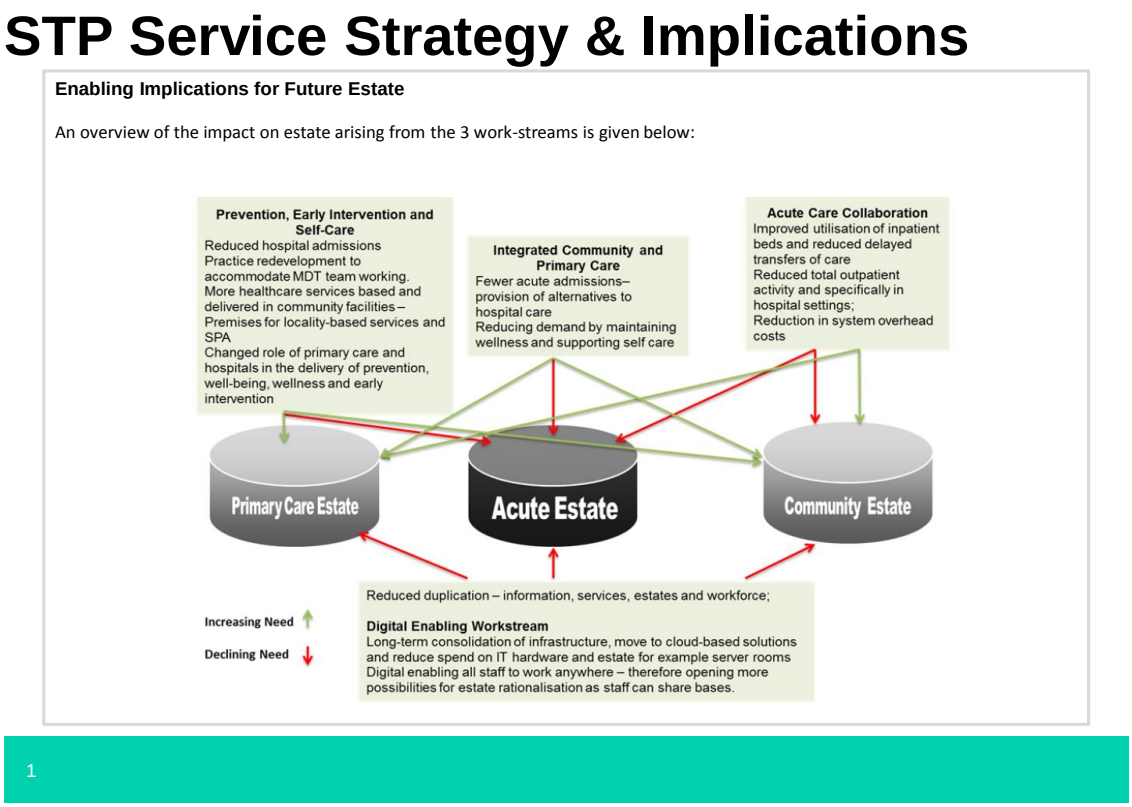
The emerging STP plan has been informed by existing feedback from service users, carers and the public. This includes information from recent public engagement activities, local surveys and local health scrutiny committees, and information collated from 'friends and family' test data, patient complaints and Care Quality Commission reports. This ensures that our thinking is being shaped by the issues that the people who rely on our services have told us is important to them**.**

- Phase one of this plan outlines how we will further our conversations and engage locally to ensure stakeholders understand the case for change. This plan will evolve as more detail emerges from the STP to ensure timely and meaningful engagement with all stakeholders.
- Phase two of the plan will look at key tactics used to engage with others, including MPs, Councillors and influential groups.
- Phase three of this plan will evolve as we move into the engagement phase should there be any proposed changes to the way services are delivered across BNSSG. Specific consultation and engagement plans will be developed in response to these.

Further detail on our Communications and Engagement approach is set out in Appendix E.

6.2 Estates

Our estates strategy is being developed to both enable the delivery of our new Model of Care and optimise the efficiency of our estate. Set out below are the priorities that we will be undertaking.



Enabling implications for future estate

1. Integrated primary and community care:
    - Transformation of community facilities to allow mental and physical health services to be delivered locally from “Clustered” GP Premises.
    - Efficient use of joint estate options with other public sector bodies, by maximising utilisation across the wider public estate.
    - Surplus or expensive estate rented from the private sector is removed from the system, where possible to support a reduction in estate running/operating costs and estate delivers value for money.
    - Investment in the estate with poorer quality buildings that are no longer fit for purpose replaced with new facilities where appropriate funded by a reduction in the overall estate to support the cost of future investments.
2. Prevention, Early Intervention and Self Care
    - Shift of care from an acute setting to primary and community care making best use of available resources.

3. Acute care collaboration

    - Utilisation of fit for purpose existing estate is maximised (Lord Carter targets) with consolidation of activity and sharing of premises.
    - Sharing the acute and mental health hospital facilities and physical assets.

Supplementary information relating to existing estates projects, STP estates initiatives, implementation priorities and financial impacts are contained in Appendix F.

6.3 Workforce

The engagement of our workforce is key to the delivery of all aspects of the STP. The introduction of new models of care, new roles (including the Nursing Associate and Physician's Assistant, using our workforce as advocates of the prevention agenda and changes to how and where staff work require considerable adaptability and careful engagement and change management. Workforce transformation also requires detailed baselining of data across the footprint, which has started, as well as collaborative working across organisations and work streams. We have also developed a modelling capability in BNSSG to respond to change and produce detailed implementation plans.

> Better use of data and technology has the power to improve health, transforming the quality and reducing the cost of health and care services. It can give patients and citizens more control over their health and wellbeing, empower carers, reduce the administrative burden for care professionals, and support the development of new medicines and treatments".
>
> *Personalised Health & Care 2020 – Using Data & technology to Transform Outcomes for Patients and Citizens* – A Framework for Action

Project objectives and desired outcomes

The workforce work stream is an enabling work stream and as such will respond to the outcomes of the three care model work streams (Prevention, Early Intervention and Self Care, Integrated Primary and Community Care and Acute Care Collaboration). This response will include project management of transformational changes to workforce and also scenario modelling to support the cases for change. In addition a number of workforce projects have been defined to contribute to the STP approach to the challenges of wellbeing, quality and affordability of care.

In addition to joint workforce planning, the workforce work stream has identified six projects which support the BNSSG STP. These are:

- Collaborative working on apprenticeships
- Development of shared training of Mental Health and Community Staff
- Improve Staff Health and Well-being
- Shared Recruitment
- Create a common culture
- STP Workforce Transformation

The workforce work stream is working closely with Health Education England (HEE) and AHSN, and increasingly with colleagues in other work streams, including links into the Community Educational Provider Network (CEPN) initiative, to determine the timescales required to achieve workforce change. The requirement for consultation, the length of medical training pipelines and the visibility and clarity of the changes required dictate the timescales for change. The workforce work stream is therefore setting the conditions for success by developing a joint workforce planning capability, progressing the defined projects and building the relationships across the STP community and with other key stakeholders.

The purpose of the CEPNs is to:

- Support workforce planning by responding to local workforce need.
- Co-ordinate educational programmes and ensure educational quality with a faculty of trainers.

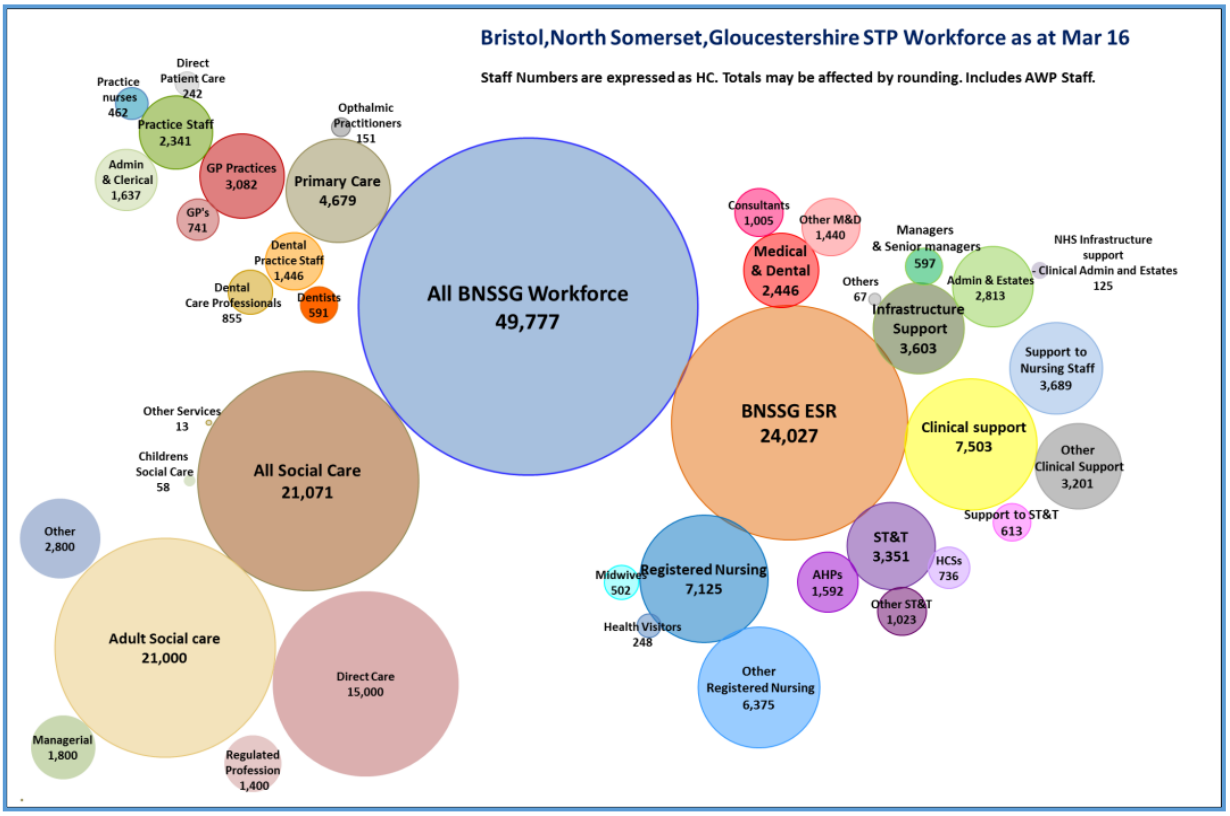
Promote and plan for the development of the existing workforce. We have also undertaken to convene a Social Partnership Forum (SPF) in order to facilitate early engagement with Trades Unions on the STP.

The workforce work stream has identified that Organisational Development facilitation is required to support transformational change and deliver continuous improvement. HEE funding is being used to resource facilitators to support all work streams to deliver change. The facilitators will utilise existing programmes, such as the Calderdale Framework, and 'train the trainer' packages..

The Calderdale Framework is a tool to develop and manage a consistent competence level among practitioners. The original focus of the tool was to provide a level of assurance and risk management for those tasks delegated to the unregistered workforce in clinical settings. The framework seeks to reduce risk ratings, increase patient satisfaction, increase activity, improve attendance and support organisational reviews of skill mix. It has been backed up by research and has been introduced in a number of Trusts in the country as well as in Australia and New Zealand.

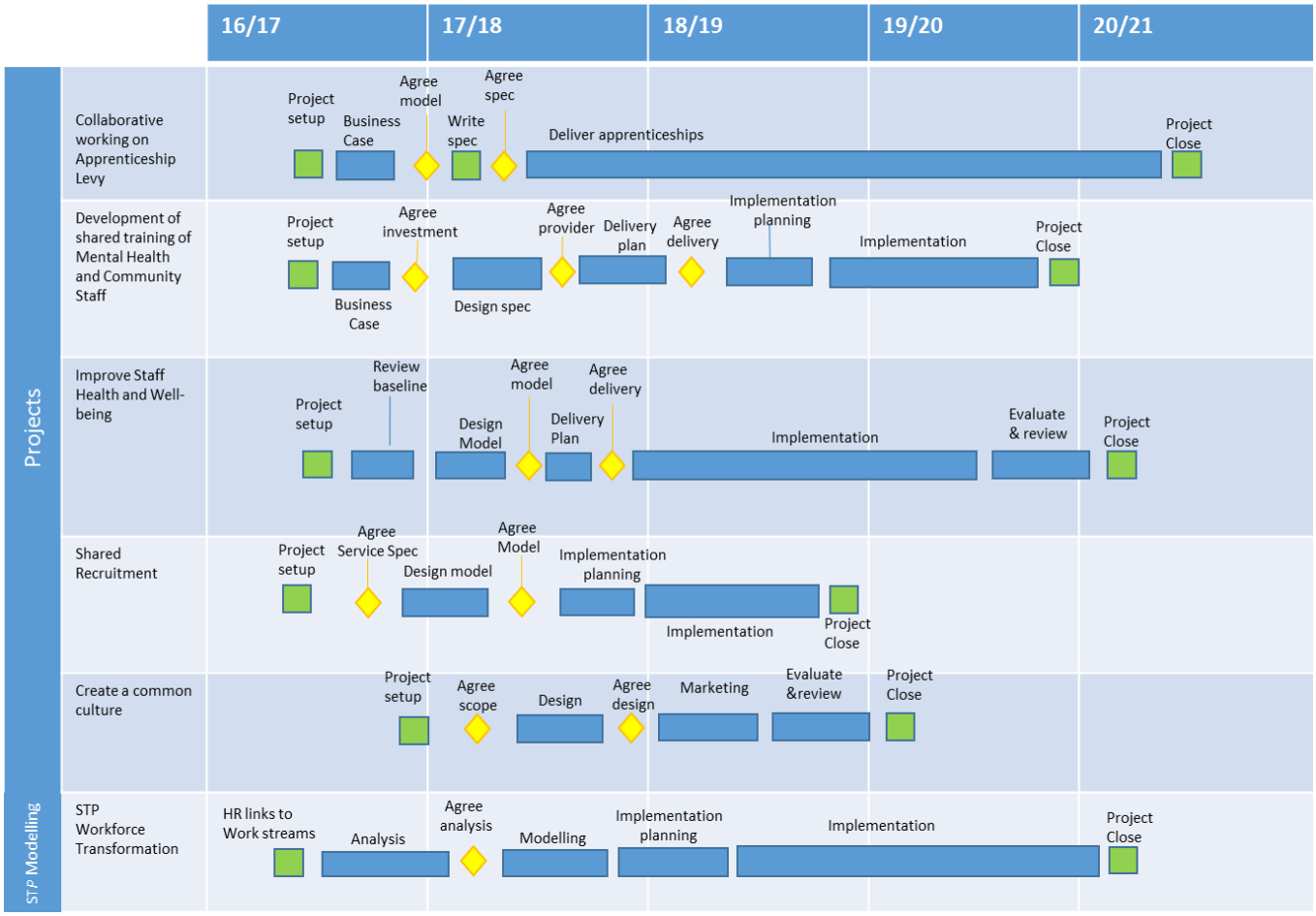
http://www.calderdaleframework.com/

Illustrated below is the workforce across our STP. The independent and voluntary sector makes a significant and valuable contribution as part of this workforce. As the STP develops the workforce work stream will develop further links with these sectors to both better understand the baseline data and ensure coherency in terms of workforce development.



The timeline for delivery can be seen below:

Workforce



For more information about each of the projects and further workforce please see appendix G.

6.4 Digital

Introduction

We understand that technology has a key part to play in helping us **meet our financial challenges** – as well as **improving efficiency**, enabling **better care and quality**, and **closing the wellbeing gap**.

Like the rest of England, we have some significant challenges to overcome if we are to deliver the standard of health and social care that our population requires and deserves, within the very real operational and financial constraints that exist. Our work together on digital transformation has proven that we can collaborate to deliver real, system-wide transformation.

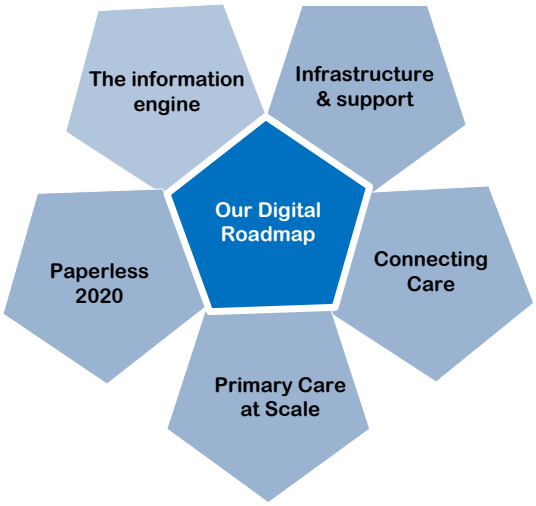
Local Digital Roadmap - building blocks

Our focus in our roadmap is on five key building blocks –

1. Primary Care At Scale – focus on maximising digital across GP practices and Out of Hours services.
2. Paperless 2020 – Embedding digital records in acute, community, mental health and social care.
3. Connecting Care - Information sharing to include putting citizens at the heart of their 'personal health records'.
4. The Information Engine – Fully utilising our electronic data to power our planning and delivery engine.
5. Infrastructure & Support - Ensuring we do all of the above on a solid, efficient infrastructure and delivery mechanism that enables mobile working.

We will deliver these five major themes locally, but in full alignment with our local *Sustainability and Transformation Plan* and the *National Information Board* strategy.

- Primary Care At Scale – focuses on maximising digital across GP practices and Out of Hours services. Supporting primary and community care reconfiguration, new integrated team working and maximising efficiency of practices through shared ways of using technology. This is also about how we can better support people and communities out of hospital



- Paperless 2020 – Embedding and developing fully digital records in acute, community, mental health and social care. Enabling true electronic record keeping, and sharing of those records to support mobile working.

- Connecting Care – Developing and enhancing our existing information sharing from and to all parts of our system – on the back of more fully developed digital records. Improving interoperability. Enabling a 'shift' and putting citizens at the heart of their 'personal health records'. Supporting the wellness of people and communities and out of hospital care

- The Information Engine – Fully utilising our electronic data and intelligence to power our planning and delivery engine. Devising new and innovative ways to use information, integrated population analytics and data driven decision making.

- Infrastructure & Support - Ensuring we do all the above on a solid, efficient infrastructure and delivery mechanism – how we organise our delivery, how we run our digital services and how we work (people, systems & processes).

For more information about Digital please see appendix H

7. Impact of our STP

The introduction of our new model of care will have significant impacts across our care system. Where evidence of improvement is available from elsewhere, we have utilised this to help us estimate the impacts we might achieve.

Set out below is a summary of the impacts modelled so far as part of the STP. These are being further developed as part of the Operational Planning process, which provides the mechanism for embedding intended improvements within contracts.

7.1 Performance impacts

The NHS organisations within our partnership are mandated to achieve all NHS performance standards and it is a key expectation that the STP ensures they are met on a sustainable basis. Presently provider contract management processes monitor in-year performance and improvement trajectories where in place. Where providers are under-performing they are being reviewed and recast. This process will feed into the operational planning process to inform CCG and provider plans for 2017/18 and 2018/19, which will be incorporated into the STP. The need to monitor performance and respond at the STP level is critical with the creation of an STP dashboard for 2017/18 identified as a priority.

7.2 Financial modelling update

The approach and methodology

Finance Directors and Chief Officers have been meeting for three months to support the STP process pro- actively.

The methodology used is as follows:

- Director of Finance review and sign off of 2016/17 position for all bodies in accordance with the recent guidance issued by NHS England;
- Assess the underlying position and document the drivers for any declared underlying deficit;
- Document the medium term financial plans for the period 2017/18 – 2020/21 including underlying positions, inflation, cost pressures, savings, activity growth, sustainability funding, cost of activity and other factors specific to individual organisation. Recurrent and non-recurrent cost analysis was included; and
- The impact of 2017/18 tariff changes and SLA changes have not been included.

The assumptions used include the following:

For Providers

- Inflation at 2.1% from 2017/18 onwards;
- National efficiency requirement of 2.0% pa from 2016/17 to 2020/21;
- General assumption that changes in activity volume require 85% cost of delivery and therefore provide a margin contribution toward Providers financial positions.
- Corporate overhead savings are assumed and included within the identified savings plans; and
- Pathology savings and productivity are assumed and included within the identified savings.
- The Community Interest Companies (CICs) combined deficit (assessed as £15m in June 2016) are included in the overall STP financial position.

For Commissioners

- CCG and NHS England allocation assumptions including growth and distances from target were published in January 2016 for the period 2016/17 to 2020/21, the first three years are fixed, the final two years are indicative.
- The accumulated commissioner RAB outstanding on exit of 2016/17 is not considered in the financial savings plans.
- CCG expenditure plans include national expenditure growth assumptions for demographic growth, tariff price inflation, non-demographic activity and quality cost pressures and nationally mandated priorities.
- CCGs are committed to funding activity volume growth at 100% of National Tariff.
- Corporate overhead savings are assumed and included within the identified savings plans.

What is the financial position?

2.1 'Do Nothing' and 'Do Something' Position

The 'Do Nothing' positions and financial savings for the period to March 2020/21 were signed off and submitted by Directors of Finance on the 14th October 2016. Across the BNSSG STP, the position can be summarised as follows:

1. The 'Do Nothing' deficit as at 31st March 2021 totals £305.5m;
2. Sustainability and Transformation Funding of £61m is received;
3. Savings of £138.9m have been identified to date;
4. Savings of £7.4m are assumed relating to the Weston Sustainability plan;
5. The level of unidentified savings to date is £104.4m; and
6. System wide Transformation savings schemes are work in progress. These solutions require further development including triangulation with provider income and capacity plans. These will be subject to verification and sign off by nominated Director of Finance leads as part of the Operational Planning process.

The overall position is summarised in the table 1 below.

Table 1: Overall BNSSG STP Position

		"Do Something" Solutions				
Surplus / (Deficit)	**"Do Nothing" 2020/21 Positon**	**STF Funding**	**Identified Savings**	**Unidentified Savings**	**Weston Sustainability**	**Total BNSSG STP**
Providers	**£'m**	**£'m**	**£'m**	**£'m**	**£'m**	**£'m**
University Hospitals Bristol NHS FT (UHB)	(47.6)	13.3	36.1	4.4		6.2
North Bristol NHS Trust (NBT)	(80.6)	14.0	65.0	1.6		(0.0)
Weston Area Healthcare NHS Trust (WAHT)	(20.6)	3.1	10.1	0.0	7.4	(0.0)
Avon & Wiltshire Mental Health Partnership (AWP)	(17.3)	0.7	4.6	12.0		(0.0)
South Western Ambulance Service (SWAST)	(3.2)	1.5	1.6	0.1		0.0
Community Interest Companies (CiCs)	(15.0)			15.0		0.0
Sub-total Providers	**(184.3)**	**32.6**	**117.4**	**33.1**	**7.4**	**6.2**
Commissioners						
Bristol CCG	(60.9)		8.0	52.9		0.0
North Somerset CCG	(30.3)		3.7	26.6		0.0
South Gloucestershire CCG	(30.0)		9.8	20.3		0.0
Sub-total Commissioners	**(121.2)**	**0.0**	**21.5**	**99.8**	**0.0**	**0.0**
System Wide		28.4		(28.4)		0.0
Total Organisational Financial Plans	**(305.5)**	**61.0**	**138.9**	**104.4**	**7.4**	**6.2**

'Do something' solutions

The £305.5m 'Do Nothing' deficit can be tackled by the following measures

1. Organisational savings (including corporate overheads, pathology, productivity)
2. Major, system wide transformational changes.
3. Receipt of Sustainability Funding

Organisational Savings

The summary below in table 2 shows, by organisation the identified savings for the period 2020/21. To date BNSSG STP has identified £138.9m savings to the period 2020/21.

It needs to be noted that these savings are subject to organisational risk assessment using the normal processes both in terms of delivery and the impact on clinical services. Consideration still needs to be given to the impact on workforce, activity and any capital investment requirements to deliver. The BNSSG footprint has not progressed this required level of detail yet.

It is recognised that the delivery of these organisational savings are, in part, facilitated by the major system wide transformational changes, which will themselves cause us to alter our model of commissioning care delivery.

Regarding methods of payment to be adopted, these will be developed in line with the new commissioning approach as described in paragraph 4.5

Table 2: Organisational Identified Savings for the Period 2020/21

Organisatonal Savings	UH Bristol	NBT	Weston	AWP	SWAST	NHS Bristol CCG	NHS North Somerset CCG	NHS South Glos CCG	Total
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Continuing Care	-	-	-	-	-	3.0	-	4.4	**7.4**
Corporate / Commercial Opportunities	10.3	11.0	0.6	1.1	1.6	-	-	-	**24.6**
Corporate Overheads	1.7	-	0.6	0.8	-	1.0	0.5	1.0	**5.6**
Facilities and Estates	4.0	0.7	0.7	0.4	-	-	-	-	**5.8**
GP Prescribing	-	-	-	-	-	4.0	3.2	4.4	**11.6**
Medicines Savings	5.9	-	0.4	-	-	-	-	-	**6.3**
Operational Productivity	1.8	35.3	2.5	1.2	-	-	-	-	**40.7**
Other Pay (Not Included in Productivity)	-	8.2	3.2	0.5	-	-	-	-	**11.8**
Pathology	-	-	-	-	-	-	-	-	**-**
Reducing and Conrolling Non Pay	12.5	9.7	1.8	0.7	-	-	-	-	**24.7**
Technology	-	0.1	0.3	-	-	-	-	-	**0.4**
Grand Total	**36.1**	**65.0**	**10.1**	**4.6**	**1.6**	**8.0**	**3.7**	**9.8**	**138.9**

Major System Wide Transformation Changes

The system wide workstreams (PEISC, IPCC and ACC) have been tasked with identification, design and development of cross organisational transformation opportunities. These workstreams are led by a Senior Responsible Officer and supported by their respective Director of Finance. The projects within these workstreams are at various stages of development, but are not yet at the level of maturity required that we can include any numbers to the detail and confidence expected to date. We are working to ensure that where the impacts of system wide changes occur in 2017/18, the required modelling and assumptions are developed sufficiently for inclusion within the Operational Planning submissions in December. These system wide changes will be further developed thereafter as the route to addressing the £104m in savings over the whole period.

There is an indicative capital requirement of circa £60m, which is over and above any business as usual requirement. The requirement for capital funding will be further developed in light of the STP transformational goals, aligned with any NHSE Estates and Technology Fund (ETTF) submission.

Sustainability Funding

Sustainability funding of £61m has been notified by NHS England and included in the STP financial position accordingly.

For further financial information please see the separate financial templates, which have been sent separately to NHSI and NHSE

8. Key risks

Our STP represents an ambitious and challenging transformation programme. In this context the risks associated with the programme are significant and will need careful management by the programme leaders. Set out below in the table below are the key risks identified to date and the initial mitigation plans that we are developing in order to manage these risks.

Description of risk	Proba-bility	Impact	Risk Score (P x I)	Decision made or mitigating action to be taken	Mitigated Risk Score and RAG rating
Benefits The system is unclear about the impact of the proposed changes as the programmes and projects move into start up or design phase, leading to difficulties aligning with required enabling workstreams of finance, estates, workforce and/or digital	5	4	20	Put in place appropriate governance and dedicated resources ensure programmes and projects are progressed quickly with dedicated finance resource are able to assess their impact	8
Leadership Organisational alignment is insufficient to deliver the system transformation at pace	4	5	20	Undertake a review of the governance and decision making alignment to be undertaken, which includes a formalised assurance process	8
Communications and Engagement Failing to bring public, communities, patients and staff with us in developing and delivering system transformation, resulting in resistance to change implementation	4	4	16	Implement communication and engagement plan and continually review and develop in response to stakeholder feedback	10
Capacity Insufficient resources are dedicated to programme and project delivery, resulting in projects not being able to deliver at the pace required	5	3	15	STP Programme Director to scope out resourcing requirements with support from programme and project leads across the organisations and agree a resourcing approach with SLG	10
Capability Staff involved in transformational change have not got the skills or knowledge to deliver or support the required transformation changes at scale	5	3	15	Workforce SRO to develop a system-wide approach to system transformation and start to implement	10

9. Conclusion - Our Way Forward

The STP approach has created a new culture and environment within which our organisations have started to operate. We recognise the three gaps cannot be achieved by working within our organisational boundaries and we need this new collaborative way of working to deliver system wide improvements.

This submission reflects the progress we are making and recognises the challenges that lie ahead. In our submission we have:

- reaffirmed the model of care we are developing;
- demonstrated how the programmes and projects we are undertaking will contribute to the delivery of the model of care;
- provided greater detail on the projects we are undertaking, the outcomes they are seeking to achieve and their relationship to the overall model of care;
- begun to illustrate the impact these projects will have on the experience and outcomes for our population, the quality and accessibility of our services, the roles and opportunities for our staff and the financial sustainability of our care system;
- described the way we will enable change through the transformation of our service delivery, workforce, our deployment of technology and the optimal use of our estate; and
- articulated how we will use the operational planning and contracting processes to embed the STP approach and incentivise the delivery of the model of care.

Our STP builds on a successful track record of delivering major change, including the centralisation in Bristol of ENT surgery, OMF surgery, Breast and Urology Services, specialist paediatrics and cellular pathology, of using digital technology to support shared care across BNSSG through the Connecting Care Programme, as well as the redesigned estate at the Bristol Royal Infirmary campus, South Bristol Community and Southmead hospitals. The learning from these has reaffirmed that clinical leadership is a key success criterion and we will ensure our continuing transformational change is clinically led, focused on people and not organisational boundaries.

Our next steps are to ensure our organisations are fully aligned to support our priority programmes and projects. Our enhanced governance arrangements will ensure we are able to manage and track progress and provide focussed support, as required. We will ensure our early priority projects start to deliver benefit and build confidence in our ability to deliver system wide change.

We do not underestimate the scale of the challenge but across the STP footprint we are strongly committed to delivering the transformation needed for the people of Bristol, North Somerset and South Gloucestershire.