NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Transforming community-based care in Bath and North East Somerset, Swindon and Wiltshire

October 2024

Agenda

1: Introduction

2: Our case for change

3: Our vision, ambition and improvement priorities

4: What would things look like in the future - example patient stories

5: Next steps

1: Introduction

About us

- BSW Integrated Care Board (ICB) brings together NHS organisations, local authorities and other partners
- Working to improve population health and establish shared strategic priorities.
- Oversee spending and ensure effective and high quality health services
- Hospitals, primary care, local councils, hospices, VCSE organisations and Healthwatch partners work together in three localities: Bath and North East Somerset, Swindon and Wiltshire.
- Part of the BSW Together Integrated Care System (ICS)

We serve a combined population of **940,000** and cover **1,511 square miles**, including the densely populated and growing town of Swindon to the north, the historic city of Bath, Salisbury plains to the south and the rolling Mendip Hills to the west.

Our purpose, vision and aims

Our purpose: Planning and arranging provision of integrated health and care services to meet needs of the population and better address inequalities in health and care. This involves managing the NHS budget for the area and co-ordinating delivery of our strategy, to allow us to be held to account by our local population.

Our vision is to listen and work effectively together to improve health and wellbeing and reduce inequalities.

We will deliver this vision by prioritising **three clear aims:**

Focus on prevention and early intervention

Fairer health and wellbeing outcomes

Excellent health and care services

About community-based care

- Community-based care helps people to live independently.
- Broad term that covers lots of different types of care, support and services.
- Includes supporting people to manage their own health and wellbeing.
- Many different types of organisation provide community-based care: NHS, local authorities and the VCSE.

Community-based care in BSW

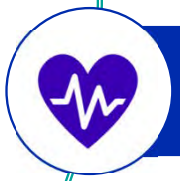
- HCRG Care Group has been appointed to lead an innovative new community-based care partnership with the NHS, local authorities and charities
- Will transform care and support for people at every stage of their lives
- More health and social care in or near home, in a more joined-up and streamlined way
- This presentation gives more detail about what this will mean in practice and plans to improve community-based care across BSW

2: Our case for change

Our changing population will impact on our services and the need for community-based care

The BSW population is projected to grow by 6 per cent over the next 15 years - an extra 60,000 people by 2038

The number of people aged under 60 will remain stable. All growth will be in people over 60 - a 35 per cent increase



Older people tend to live with more health conditions and have more care needs – expecting an additional 32,000 people with two or more long-term conditions by 2038

Proportion of people over 65 compared to those of working age will increase - fewer younger people to support people as they age. Also have an ageing NHS workforce

Continued

Cost of acute care is currently £340 million per year - in 15 years this will rise to £410 million – £5 million each year – before inflation or the costs of new treatments and innovations

In five years we will need additional 115 hospital beds and 40 ambulance journeys per day – will also see 50+ additional visits to A&E a day

Children and young people's services are under extreme pressure post-Covid with long waiting times. Need to improve health of children and young people now to impact on future need

Additional demand on mental health services since the pandemic with increased waiting times

Requests for social care support have risen but number able to access support has fallen. Changes in our population will mean an increase in the need for social care.

- We are shifting our focus towards community-based care with a specific priority to ensure that people will receive more personalised care
- New focus on prevention and early intervention to help people manage their health proactively and stay healthier for longer

3: Our vision, ambition and transformation priorities

Community-based care transformation is linked to wider BSW vision and priorities

The BSW Vision

We listen and work together to improve health and wellbeing and reduce inequalities.

Our strategic objectives

1) Focus on prevention and early intervention
2) Fairer health and wellbeing outcomes
3) Excellent health and care

Overarching outcome measures

If we are successful, we will see the following long-term improvements:

1) An overall increase in life expectancy across our population
2) A reduction in the gap between life expectancy and healthy life expectancy across our population
3) Reduced variation in healthy life

Transforming community-based care is a key element of our Integrated Care Plan and Primary and Community Care Delivery Plan.

Works alongside the other strategic programmes including primary care, elective recovery, urgent and emergency care, mental health and learning disabilities, autism and neurodivergence.

Our aim is to support people to stay well and offer joined-up care

Working in partnership with HCRG Care Group we are focused on delivering better outcomes against the three strategic objectives agreed by the NHS, local government and the voluntary and community sector:

- **Focus on prevention and early intervention** - more services and support to identify illnesses and health conditions early
- **Fairer health and wellbeing outcomes** – addressing health inequalities and ensuring services meet the needs of local people, wherever they live
- **Excellent health and care services –** developing thriving community-based services, reducing pressure on GPs and hospitals, helping reduce waiting times and making sure people get the right care, in the right place, at the right time

We have identified transformation priorities and outcome measures

- Transformation priorities support new ways of working
- Linked to outcome measures used to assess progress in delivering improvements
- HCRG Care Group will lead on delivering transformation priorities - work will take place in phases.
- Opportunities for local people and communities to continue to help shape health and wellbeing services including those with lived experience.

Our transformation priorities in more detail

Neighbourhood teams

- Work in local areas to understand health and care needs of communities
- Prevent ill health
- Plan and coordinate personalised care
- Meet mental and physical health and wellbeing needs of most vulnerable in our communities
- Reduce health inequalities, improve access to care and improve outcomes.

VCSE organisations will be key partners in neighbourhood teams.

All-age single point of access

- Single 'front door' to direct public and health and care professionals to the most appropriate service for their needs
- Those with an urgent or emergency clinical need will receive the right help from the most appropriate clinician in the most appropriate place, at the right time.

Family child health hubs

- Improve access to specialist child health and care professionals
- join up care by bringing professionals together
- improve quality of care
- reduce pressure on services and increase productivity.

Continued

Care pathways and admission avoidance

- Do more to help people to stay as well as possible and avoid hospital admission
- Proactively identify those attending or being admitted to hospital that could be managed elsewhere
- Redesign planned care pathways so - where safe - people receive support closer to home.

Specialist advice and support in communities and primary care

- Specialist health and care professionals providing expert advice in community and primary care - more care closer to home
- Establish a children's single point of access offering one stop shop for all requests for support.

Specialist advice and support for people with LDAN

- Deliver improvements in identifying, understanding, meeting, maintaining and escalating needs
- Focus on early intervention and getting support as soon as possible
- Single point of access for LDAN.

Continued

A sustainable and innovative workforce

- Implement initiatives to improve recruitment and retention, encourage innovative ways of working, offer career development and positive working environment
- Organisations providing care will work in partnership with teams focused on prevention and proactive care.

Harnessing digital innovation

Make the most of modern technology, including:

- Secure digital patient records, accessible by different organisations
- Greater use of digital or remote health diagnostic and monitoring tools
- Making full use of the NHS App
- Considering how to best use artificial intelligence (AI) in patient care.

Shifting funding and capacity into community-based care

Working productively and effectively (e.g., by making best use of our estate) to create capacity to reinvest in our transformation priorities and shifting investment into community-based care, including VCSE organisations and preventative approaches.

Timeline for transforming community-based care in BSW

Year 1 (by March 2026)

- Implement integrated neighbourhood teams
- Phase 1 of single point of access
- Phase 1 of Family Child Health Hubs
- Design and implement BSW neurodevelopmental pathway
- Improve digital access to services, join up IT systems and make more use of remote monitoring
- Begin review of estates
- Develop workforce to be flexible, sustainable, with well-supported, highly-trained staff

Year 2 (by March 2027)

- Build on integrated neighbourhood teams
- Phase 2 of single point of access
- Phase 2 of Family Child Health Hubs
- Implement 'virtual ward' for children and young people
- Implement specialist LDAN team
- Expand use of digital technology
- More consistent services and care pathways in place across BSW

Years 3-5 (by March 2031)

- Neighbourhood teams fully implemented, with 7-day working
- Complete roll out of Family Child Health Hubs
- Phase 3 of single point of access
- Finalise review of estates to deliver fit for purpose community-based spaces
- Sustainable workforce thanks to joined up working across the system

Transforming community-based care will lead to a number of positive changes

- Improve the health and wellbeing of local people
- Increase overall life expectancy
- Reduce the impact of long-term conditions
- Improve access to care and improve experience of care
- Improve the sustainability of our workforce so we can recruit and retain the right staff
- Make the best use of the things that help us deliver care, such as digital technology

4: Example patient stories

- Example patient stories help bring to life how community-based care might work in the future
- These stories are not based on real patients but are common scenarios.

Clara, 85 - retired bookkeeper

Clara lives alone. She is relatively independent, however she has had a number of falls at home in the last five years and has had a number of urine infections. She wishes to remain independent, but her family would like her to have more support.

Admitted to hospital following a fall, but **discharge to assess** meant she was able to get home quickly.

GP and **care coordinator** use **risk stratification tool to** identify Clara as high risk and recommend **remote monitoring**.

Care coordinator and **social care team** work with Clara and her family to assess her home and to develop a comprehensive care package involving both health and social care.

With some small modifications and the installation of **monitoring devices**, everyone is satisfied Clara can continue to live at home safely.

Digital monitoring devices and software assure Clara and her family that she is safe and well.

In the event of an emergency or fall, staff at the **Community Hub** can act immediately and gain full access to her **shared care record** at any time of day.

If Clara does fall, a **Rapid Response Team** is alerted via the monitoring devices in her home. They are able to access Clara's **shared care records** and provide updates to the other teams supporting Clara.

Clara can be referred to a **community-based clinic** with an enhanced **Community Frailty Multi-Disciplinary Team** who understand her history, have access to community diagnostics and can provide specialist support to the community team.

If required, Clara can be admitted to a **virtual ward** for monitoring and treatment.

As part of her **wellbeing plan,** a **voluntary sector group help** Clara attend her **local community centre** so she can meet her friends.

She is also able to attend the **community frailty clinic** at the **Community Hub** and has been offered **virtual appointments** so she can see health professionals from home and does not have to rely on others to get to hospital or clinics.

Jasek, 48 - builder

Jasek has suffered with increasing aches and pains for the past few years after a knee injury 10 years ago, which has been complicated by early arthritis, but is unsure if he wants to undergo an operation and take time off work. He also is concerned about the impact his health condition and lack of mobility is having on his wife.

Jasek is referred to the **Community Musculoskeletal (MSK) Service** by his **GP**. Jasek has been identified as a high risk of deterioration through the hospital **risk stratification tool** because of his arthritis and previous attendance at hospital.

The **MSK Service** work with Jasek to develop a **care plan** which he is able to access from his phone. Using the **virtual chat service**, he is able to have a lot of his questions answered.

As part of his **care plan**, Jasek has access to his local gym where he attends classes and even **virtual sessions** around his working pattern.

Jasek has ongoing support from a **Community Physiotherapy Team** and is able to attend the **Community Diagnostic Hub** for regular check-ups and **CT/MRI scans** if required.

Some time later, Jasek's knee feels much worse and he is referred for assessment for surgery. He books an appointment at his **Community Diagnostic Hub** for a **CT scan**. The **CT radiographer** refers him to an **orthopaedic surgeon**.

Jasek discusses his options with the surgeon via a **virtual consultation** and through a **shared decision making** process Jasek decides to proceed with surgery.

Jasek is able to book his surgery on his phone at the **Local Treatment Centre** for a date after he gets back from holiday.

Jasek attends the **Local Treatment Centre** for his knee surgery and he is discharged with a **rehab plan** to adhere to at home.

Jasek uses the **virtual chat service** to answer a number of post op questions and is able to **initiate a follow-up appointment** if required at the local community hospital at a time and day that suits him.

Marvin, 60 – warehouse manager

Marvin is a night shift worker in a warehouse, who values the time outside of work with his family. He has type 2 diabetes which he finds hard to manage, and has recently been diagnosed with chronic obstructive pulmonary disease (COPD). He has a poor diet and is distrusting of health professionals, so avoids visiting his GP.

Marvin speaks to his employer about his **care plan** and how they can work together to ensure his health is prioritised and maintained. Marvin is able to access the **Community Hub** out of hours to suit his shifts. Marvin is able to access **diabetics group support sessions** and **1:1 virtual support** from his GP to help make changes in his life sustainable.

The population health management tool flags Marvin for a review by identifying he is at risk of worsening health. The **Care Coordination Team** contact Marvin and encourage him to see his GP. The **GP** and **Care Coordination Team** work with Marvin to co-develop a **care plan** that suits his work and family life so that he can self-monitor his diabetes and control its impact.

Marvin uses **remote monitoring** and the data he records is reviewed by a **diabetes nurse** in primary care. Both Marvin and the **Diabetes Team** can initiate virtual appointments if either have concerns. The local team can access specialist input if required.

In the event of an acute COPD episode, Marvin can be seen by a **respiratory nurse specialist** in his **local community assessment and treatment unit** without having to go to hospital. If required, he can be admitted to a **virtual ward**.

Marvin is able to better control his diabetes through **self monitoring** and diet. This has enabled him to stay well and out of the hospital. In BSW he lives in a **health promoting environment** where he is able to access a **local gym** out of hours and lead an active lifestyle.

5: Next steps

What happens next?

- HCRG Care Group will take responsibility for community services from 1 April 2025
- Contract will run for at least seven years
- No immediate changes to services
- Mobilisation of new partnership will be carefully planned to ensure that there is no break in services.
- Transformation will take place in phases.
- Opportunities for local people and communities to continue to help shape health and wellbeing services.

Start, Live and Age Well

in Bath and North East Somerset, Swindon and Wiltshire

Adult and Children's Community Services BSW

BSW ICB Board

21st November 2024

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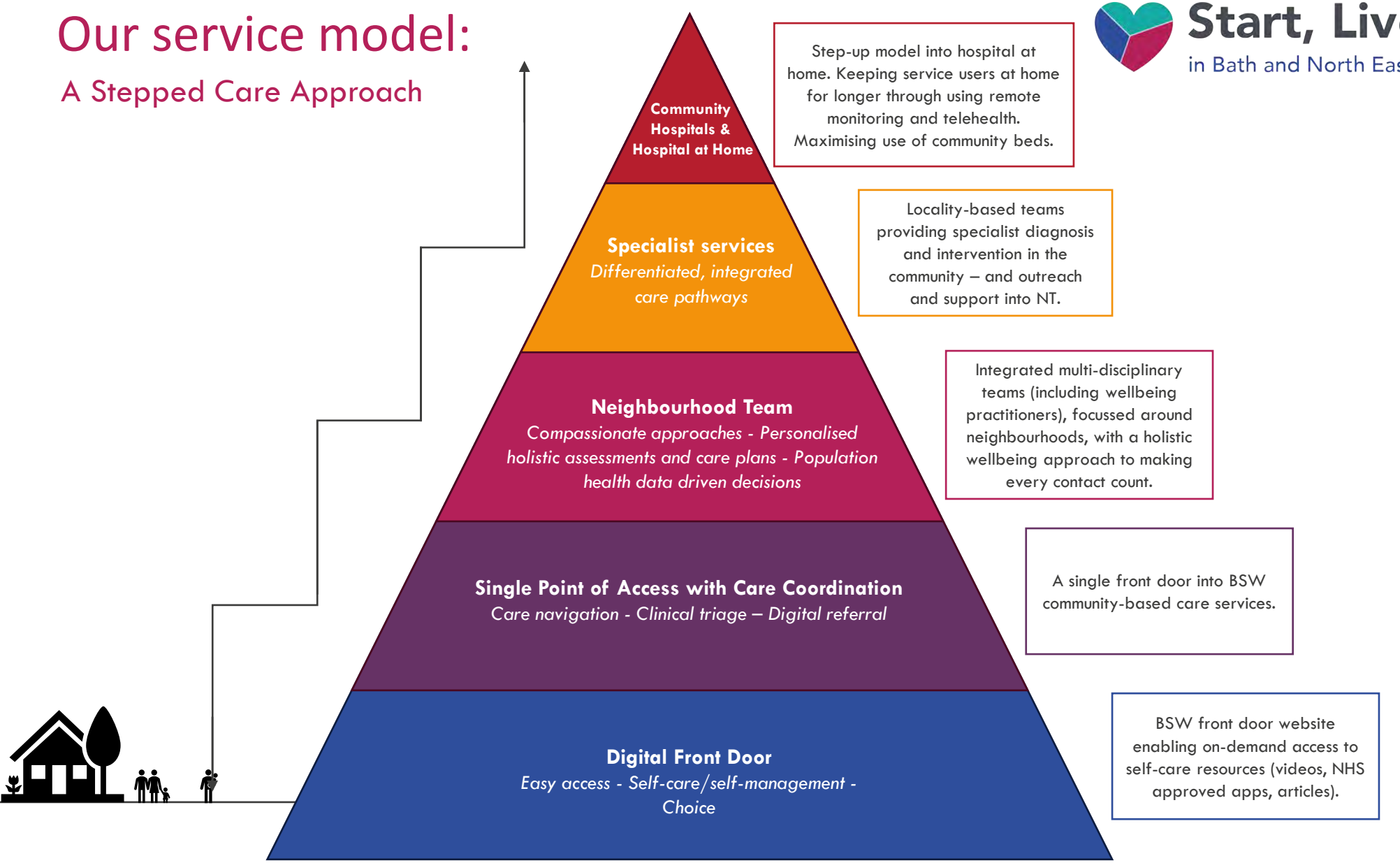
Our BSW Integrated Community Based Care Model

Our service model:

A Stepped Care Approach

Start, Live and Age Well

in Bath and North East Somerset, Swindon and Wiltshire



"I feel that my care is personalised to me, my goals are heard and reviewed."

"I feel confident that I receive the right care, in the right place , at the right time, through truly integrated community health care services"

"My assessment is thorough and addresses my needs, it is not driven by my diagnosis, but by what matters to me"

"I can self-refer, reducing the need to contact my GP and arrange for a referral to be made"

"I can access community health and wellbeing support digitally 24/7, at a time convenient to me."

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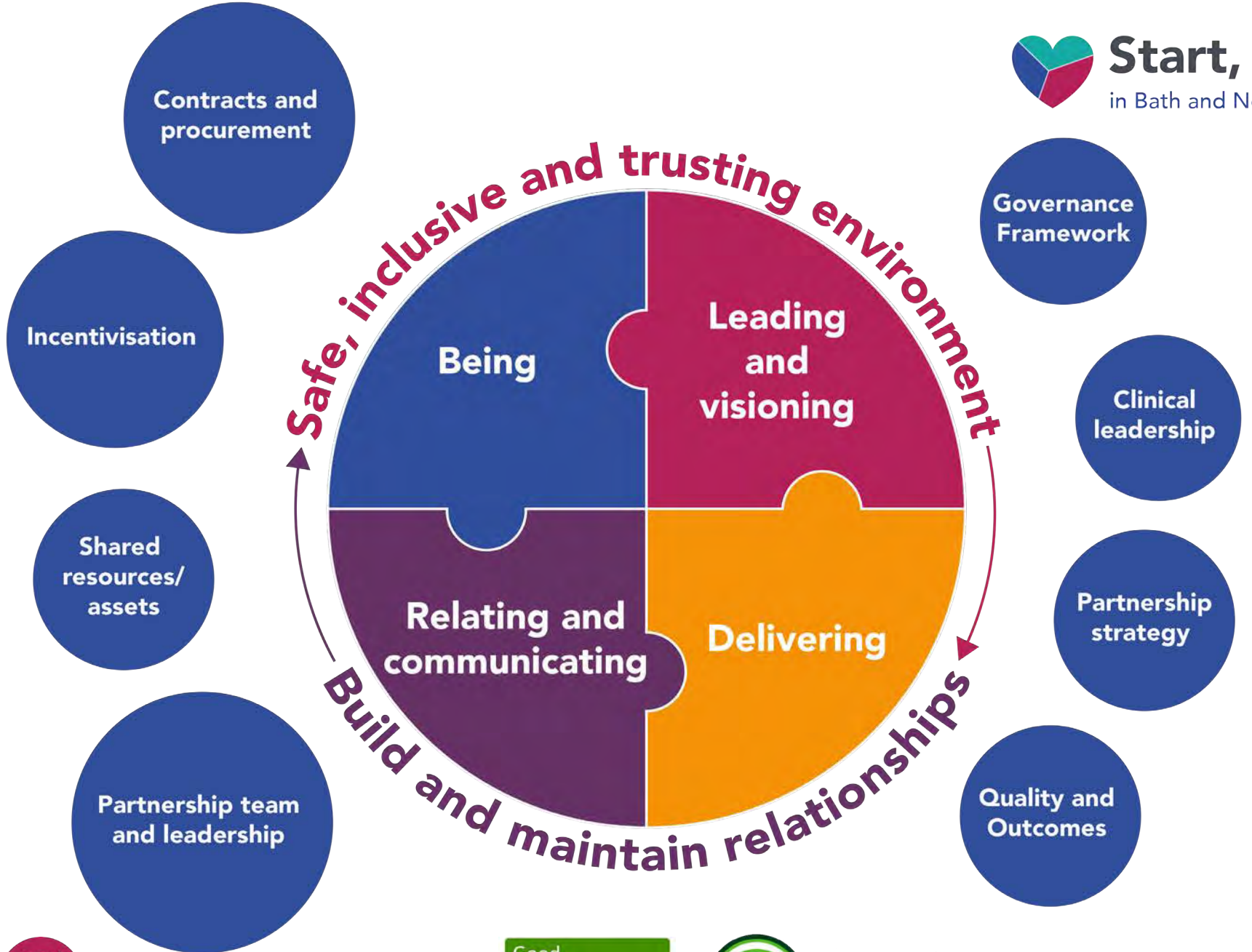

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Key enabler spotlight:
Digital Front Door

Start, Live and Age Well
in Bath and North East Somerset, Swindon and Wiltshire

Overview:

Our Digital Front Door offers easy access to on-demand trusted health and wellbeing resources, self-referral and healthcare journey tracking.

Key features:

Resource Hub: Apps, videos and links to trusted health and wellbeing resources.

Digital Referral Form: Accessible, step-by-step referral form with in-built logic and signposting.

Service User and Referrer Portal: Secure portal to track referral progress, upload documents

Website Chat Bot: Guiding website users around content, helping with self-management such as appointment management

Benefits:

- Building resilience through a focus on prevention, self-management and promoting sustained healthy behaviour changes.
- Improving accessibility and choice through 24/7 access to evidence-based health and wellbeing resources.
- Improving communication between professionals and service users
- More appropriate needs-led referrals, enabling service users to get the right care at the right time

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Key enabler spotlight:
Single Point of Access with Care Coordination

Start, Live and Age Well
in Bath and North East Somerset, Swindon and Wiltshire

Overview:

Our all age BSW-wide Single Point of Access with Care Coordination will be the front door for all community services, including urgent care, helping navigate service users to access the right care to meet their needs.

Key features:

1. **Single Front Door:** One single point of contact, streamlining access to services

Care Coordination: Multi-disciplinary team clinical triage and single holistic assessment to ensure the most appropriate pathway

Fast-track urgent care pathways: Ensuring those with an urgent clinical need are seen by the right person at the right time.

Locality-focused Care Navigators: Helping local people understand the wide range of community assets available to them.

Benefits:

- Improving ease of access to community health services.
- Improved service user and professional understanding of wider resources available within the community.
- Reduction in acute admissions, through better coordination, ensuring care is delivered in the right place at the right time by the right person.
- Improving population health outcomes through proactive prevention and health coaching at the front door.

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Key enabler spotlight:
Integrated Neighbourhood Teams

Start, Live and Age Well
in Bath and North East Somerset, Swindon and Wiltshire

Overview:

Providing personalised, harmonised and holistic care that meets the needs of the local community, delivered close to people's home. Ensuring seamless integrated care pathways and shared caseloads.

Key features:

Skill-mix: Bringing together nurses, therapists, wellbeing practitioners and support staff to offer holistic care.

Compassionate approaches: Core competency training in Making Every Contact Count (MECC), Strengths based, Trauma informed approaches, wellbeing and prevention focused

Population Health Management: Team trained in making data driven decision making, informing targeted approach to reach those most in need.

Single holistic assessments and personalised care plans: Focusing on the wiser determinants of health and wellbeing, ensuring service users are involved in planning their own care

Benefits:

- Providing care closer to home, improving access and removing barriers, especially for those experiencing inequalities.
- Improved health outcomes through taking a holistic approach, tackling the root cause issues with prevention and early intervention.
- Reducing frustration and duplication for service users and clinicians providing information multiple times.
- Improved understanding of population health and risks to poorer health outcomes.

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Ensuring a healthy, happy workforce

Colleague Wellbeing

Start, Live and Age Well
in Bath and North East Somerset, Swindon and Wiltshire

Delivering exceptional services for BSW Communities through:

- Rotational roles across providers
- Career paths, with quickly enabled transfers between providers
- Apprentice Levy gifted to Voluntary, Social Enterprise and Third Sector partners

Enabling colleagues in BSW to bring their best selves to work through partner wide:

- Colleague engagement events, reporting and action planning
- Wellbeing leadership training for managers and colleagues
- PDP and Training Needs Analysis
- Recognition and community events

Providing safe, productive and modern working environments for all

- Safe and supportive working environments – with free tea, coffee and milk
- Flexible working with BSW wide rosters available at least six weeks in advance
- Focus on recruitment, retention and safer staffing across all providers
- Access to our award winning My Reward Hub for sub-contractors
- Co-design of BSW wide HR policies to encourage adoption

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Mobilisation and Transformation

Mobilisation – three key priorities

1.
Building a strong BSW ICBC system leadership and governance framework

"I know my role and responsibilities as a partner in the BSW ICBC system, and I feel involved in decision making about community services."

Mobilisation – three key priorities

1.
Building a strong BSW ICBC system leadership and governance framework

2.
Ensuring a seamless, safe transition

"I had all the tools I need on day one to continue seeing service users."

"I was impressed by how seamless the change was. My clinic appointment went ahead as usual, and the service had all my details. I felt safe knowing that everything was handled properly."

Mobilisation – three key priorities

1.
Building a strong BSW ICBC system leadership and governance framework

2.
Ensuring a seamless, safe transition

3.
Establishing a route to transformation

"I understand the case for change and both myself and my team feel excited and optimistic about the future vision of our BSW community health service"

Transformation – first 6 months

Start, Live and Age Well
in Bath and North East Somerset, Swindon and Wiltshire

Leading the system through the change journey

Transition to healthcare first model

Harmonisation

Upfront investment to implement key enablers

Start, Live and Age Well service brand activation campaign

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Transformation – by end Year 1

Start, Live and Age Well
in Bath and North East Somerset, Swindon and Wiltshire

Integrated Neighbourhood Teams

Single Point of Access (SPA) with Care Coordination

Digital Front Door

Data driven decision making

"I only need to tell my story once."

"I feel seen as a whole person, and both my strengths and needs are understood."

"It's convenient for me to manage my own health when I feel I can, but I also know where to go if I need extra help."

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Transformation – by the end of Year 2

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Implementation of the BSW Estates strategy

Digital innovation

VCFSEs as integral partner in delivery of community-based care (£7m invested)

Single holistic assessments and all age personalised care plans embedded

"I feel heard and understood and have been involved in planning my care."

"There's a great selection of health and care support in my community and close to my home."

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