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

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1: Introduction

About us

Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care Board (ICB) is a statutory body which brings together NHS organisations with local authorities and other partners to work to improve population health and establish shared strategic priorities.

The ICB oversees how money is spent and makes sure that health services work well and are of high quality. It brings together hospitals, primary care, local councils, hospices, voluntary, community and social enterprise (VCSE) organisations and Healthwatch partners in our local places: Bath and North East Somerset, Swindon and Wiltshire.

We are part of the BSW Together Integrated Care System (ICS) which became a statutory body on 1 July 2022, along with 42 other ICSs in England. As an ICB, we have taken on the functions and broader strategic responsibility for overseeing healthcare strategies for the system from Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group, which has now been dissolved.

You can find out more about our constitution here. This is an important document that sets out what the ICB will do and how it will work.

We serve a combined population of **940,000 people** and cover a large and varied geographical area **of 1,511 square miles**, which includes 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 core purpose is planning and arranging for the provision of integrated health and care services that meet the 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 this document

We have recently announced that HCRG Care Group has been appointed to lead an innovative new community-based care partnership with the NHS, local authorities and charities that will transform the care and support that people get to help them with their health and wellbeing at every stage of their lives.

This means that People in Bath and North East Somerset, Swindon and Wiltshire will receive more health and social care in or near their homes, in a more joined-up and streamlined way over the next two years.

This document gives more detail about what this will mean in practice for local people and our plans to improve community-based care across BSW.

About community-based care

Community-based care helps people to live independently. It is a broad term that covers lots of different types of care, support and services.

Community-based care includes supporting people to manage their own health and wellbeing.

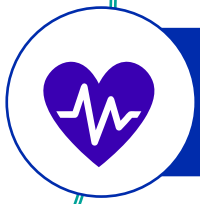
Many different types of organisation can provide community-based care, including the NHS, local authorities and the voluntary and the community and social enterprise sector.

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, which equates to an extra 60,000 people by 2038

The number of people aged under 60 will remain stable. All of the population growth will be in people over 60, meaning a 35 per cent increase in those aged 60 and over



As people get older they tend to live with more health conditions and have more care needs. The rise in people over 60 means there will be an additional 32,000 people with two or more long-term conditions by 2038

These population changes mean the proportion of people over 65 compared to those of working age will increase, meaning there will be fewer younger people to support people as they age. We are also facing an ageing NHS workforce, meaning many of our current staff will retire in the coming years

Continued

The cost of inpatient, outpatient and A&E care in BSW is currently £340 million per year. In 15 years, the changes in our population alone will see this rise to £410 million – or by £5 million each year – and that's before we factor in inflation or the costs of new treatments and innovations

BSW health services, especially those that provide urgent and emergency care, are currently stretched. In five years' time, our ageing population will not only need an additional 115 hospital beds and 40 ambulance journeys per day, but will also make more than 50 additional visits to A&E each day

Many services for children and young people are also under extreme pressure, due to growing post-Covid demand and long waiting times. Improving the health of our children and young people now will make a difference in the future need for health and care services

Nationally and locally, the additional demand on mental health services since the pandemic is putting tremendous pressure on a number of services, and is also increasing waiting times, especially for those needing more routine care

Social care services for adults and children are under pressure locally and nationally. Recent national trends have seen requests for support rise, but the number of people able to access support has fallen. Changes in our population will mean an increase in the need for social care support.

To address this case for change we are going to shift our focus towards community-based care so that people will get more personalised care that is tailored to their needs, and what matters to them.

There will also be a 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 strategy and model of care and supports our Primary and Community Care Delivery Plan. The programme works alongside the other Integrated Care System strategic transformation 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

Our aim is to empower individuals to take control of their health and wellbeing and achieve better joined-up working across the organisations that provide care.

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

- **Focus on prevention and early intervention** - by providing more services and support that catch illnesses and health conditions early to help people stay well and live independently for longer.
- **Fairer health and wellbeing outcomes -** many of our residents have different health needs and life expectancy because of where they live. The new contract will ensure that services will be provided to meet the needs of local people, wherever they live.
- **Excellent health and care services –** by developing thriving community-based services, we will reduce 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

We have developed a number of transformation priorities to support new ways of working.

These priorities are linked to outcome measures that will be used to assess progress in delivering improvements in services and support provided to people across BSW.

HCRG Care Group, the new lead partner for integrated community-based care in BSW will lead on delivering these transformation priorities.

This will take place in phases. There will be opportunity 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

Building neighbourhood teams

Neighbourhood teams work in local areas to understand the health and care needs of specific communities, prevent ill health, and plan and coordinate personalised care for individuals. We want the provider(s) of community-based care to further develop and grow neighbourhood teams so that they:

- meet both the mental and physical health and wellbeing needs of the most vulnerable adults and children with long term conditions in our communities
- reduce health inequalities, improve access to care and improve outcomes.

VCSE organisations will be key partners in neighbourhood teams.

Providing an all-age single point of access for urgent clinical needs

A single point of access is where one information source (for example, a website or phoneline) directs people to the most appropriate service for their needs. The public and health and care professionals can use the single point of access. The BSW single point of access will mean that people with an urgent or emergency clinical need receive the right help from the most appropriate clinician, in the most appropriate place, at the right time.

Implementing family child health hubs

Family child health hubs will strengthen neighbourhood teams and primary care services by improving access to specialist child health and care professionals. The hubs will bring health and care professionals together, helping to join up care, improve the quality of care, reduce pressure on services and increase productivity.

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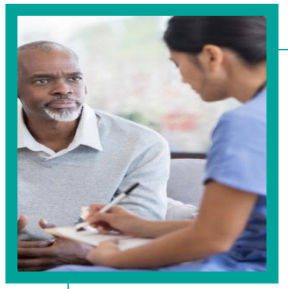

Improving care pathways to help avoid hospital admissions

We know we could do more to prevent some people needing to go to hospital by doing more in the community to help them to stay as well as possible. We want providers of community-based care to proactively identify adults and children who are attending or being admitted to hospital with conditions that could be managed elsewhere. We also want to redesign planned care pathways so that, where it is safe to do so, people receive support closer to home.

Providing specialist advice and support in communities and primary care

Specialist health and care professionals will work with local communities and colleagues in primary care to provide expert advice and support. This will mean more children and adults can be cared for closer to home. We will also establish a children's community services single point of access for babies, children and young people, as well as their parents and carers, that will be a one stop shop for managing all requests for support, including for health and social care professionals to access advice and support.

Providing specialist advice and support for people with LDAN

We will transform community-based care for people with a learning disability, autism or neurodiversity (LDAN) to deliver improvements in identifying, understanding, meeting, maintaining and escalating needs. Our focus will be on early intervention and helping people to get support as soon as possible. We will also develop a single point of access for LDAN.

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Building a sustainable and innovative workforce

We know that having enough of the right staff is key to the successful transformation of community-based care. We need to ensure providers implement initiatives that improve recruitment and retention, encourage and support innovative ways of working, offer career development and a positive working environment. We want organisations providing care to work in partnership with each other and for teams to focus on prevention and proactive care.

Harnessing digital innovation

The providers of community-based care will need to make the most of modern technology, including:

- implementing secure digital patient records that can be accessed by different organisations
- making greater use of digital or remote health diagnostic and monitoring tools, such as wearable devices that measure blood pressure, blood sugar levels and oxygen levels, and share that data with health care teams
- 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

By working productively and effectively (for example by making the best use of our health care buildings) the providers of community-based care will be able to create capacity to reinvest in our transformation priorities, one of which is to shift 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
- Launch phase 1 of single point of access with one number, one email and one digital place to access services
- Launch phase 1 of Family Child Health Hubs providing access to specialist, early intervention in the community
- Design and implement a BSW neurodevelopmental pathway for adults and children
- Improve digital access to services, join up different IT systems and make more use of remote monitoring of health signs
- Implement review of estates to ensure buildings are fit for purpose and cost effective
- Developing our workforce to be flexible and sustainable, with well-supported, highly-trained staff

Year 2 (by March 2027)

- Build on integrated neighbourhood teams to offer more personalised and preventative care
- Launch phase 2 of the single point of access with ability to self-refer to services, book and change appointments and track referrals
- Launch phase 2 of Family Child Health Hubs with more locations across BSW
- Implement a 'virtual ward' for children and young people to help them receive more care at home
- Implement a specialist learning disability, autism and neurodiversity team, linked to neighbourhood teams , with access to specialists
- Expand use of digital technology to improve services and patient care
- More consistent services and care pathways in place across BSW for equitable access and quality of care

Years 3-5 (by March 2031)

- Neighbourhood teams fully implemented, with 7-day working for all appropriate services
- Complete roll out of Family Child Health Hubs, with hubs available in community venues across BSW by 2029
- Implement phase 3 of single point of access with greater access to out-of-hours advice and guidance on-demand
- Finalise review of estates to deliver fit for purpose community-based spaces providing access to care and services closer to home
- 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

We have developed some example patient stories to 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 following the death of her husband three years ago. 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.

Clara was admitted to hospital following a fall in her home, however the **discharge to assess** initiative meant she was able to get home quickly. Her **GP** and **care coordinator** use their **risk stratification tool to** identify Clara as high risk and recommend **remote monitoring**.

The **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.

By using a wide range of **digital monitoring devices and software**, Clara and her family can be assured that she is safe and well at all times. In the event of an emergency or fall, the 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 and the contract will run for at least seven years.

There will be no immediate changes to services and people will continue to receive the care and support they need.

The mobilisation of the new partnership with HCRG will be carefully planned to ensure that there is no break in services.

Transformation will take place in phases. There will be opportunities for local people and communities to continue to help shape health and wellbeing services including those with lived experience. We will let people know more details about these opportunities as soon as they are available.

Contact us

If you have any questions about the integrated community-based care programme you can:

Visit our website at www.bsw.icb.nhs.uk/

Email us at bswicb.post@nhs.net

Call us on 0300 304 7500 Monday - Friday between 9am - 5pm

Write to us at Jenner House, Unit E3, Langley Park, Avon Way, Chippenham SN15 1GG (if you are unable to contact us via email)