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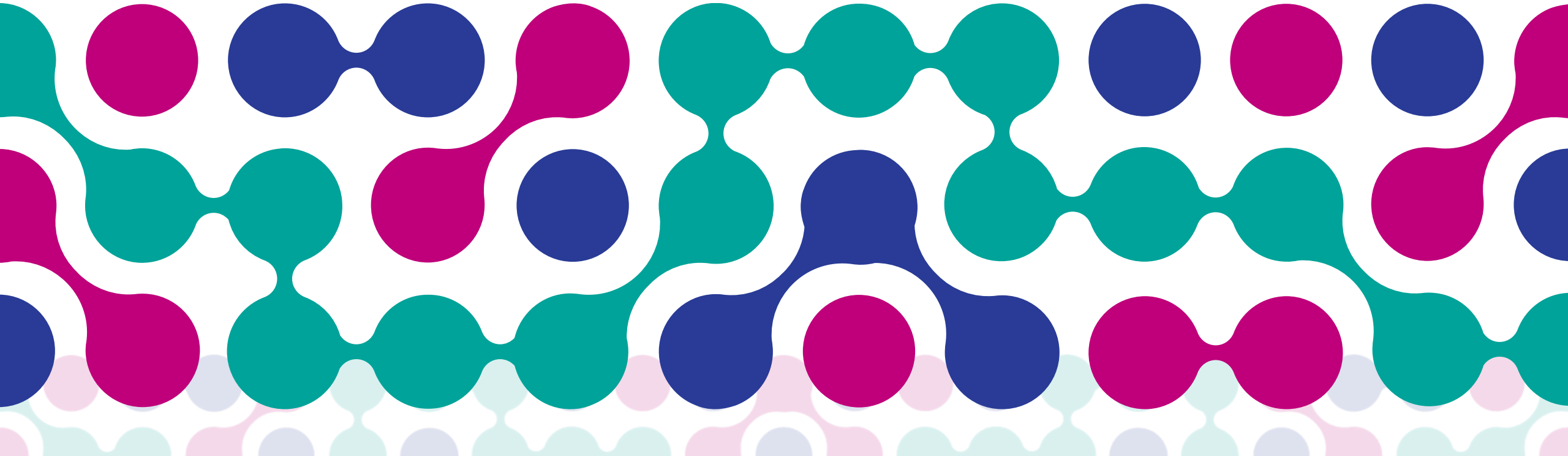
BSW Integrated Care Partnership (ICP) Meeting

26 November 2024



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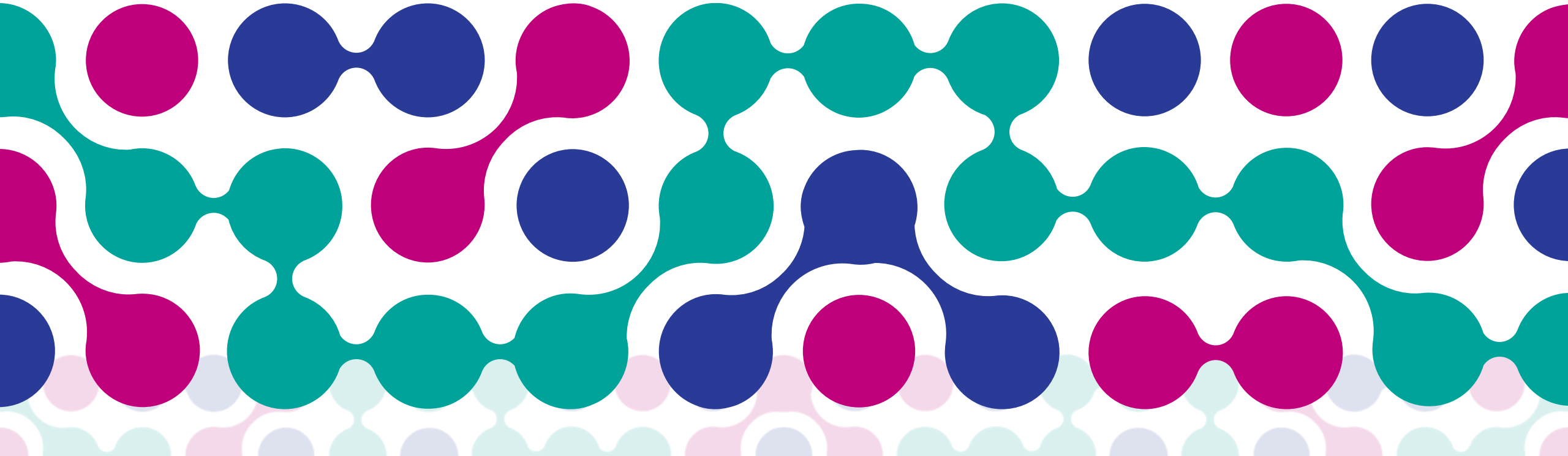
BSW Together Strategy

Rachael Backler – Chief Delivery Officer, ICB



Introduction

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- The ICP strategy consists of three key objectives, as per below

- Today's focus – Excellent health and care services
- We want to ensure that when people do require services, they receive excellent care.
- BSW Integrated Care Partnership is proud of the high-quality health and care services we have across our system.
- We have a record of excellence; aiming to deliver timely, safe and effective interventions for our residents. We have also had positive rates of patient and service user satisfaction

BSW Care Model

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This objective builds on the BSW Care Model. The components of this model feature across different strategic objectives and are key to delivering the vision and goals of our Integrated Care Strategy

Areas of focus

1. Personalised care
2. Joined-up local teams
3. Responsive local specialist services
4. High quality specialist centres
5. Mental health and parity of esteem

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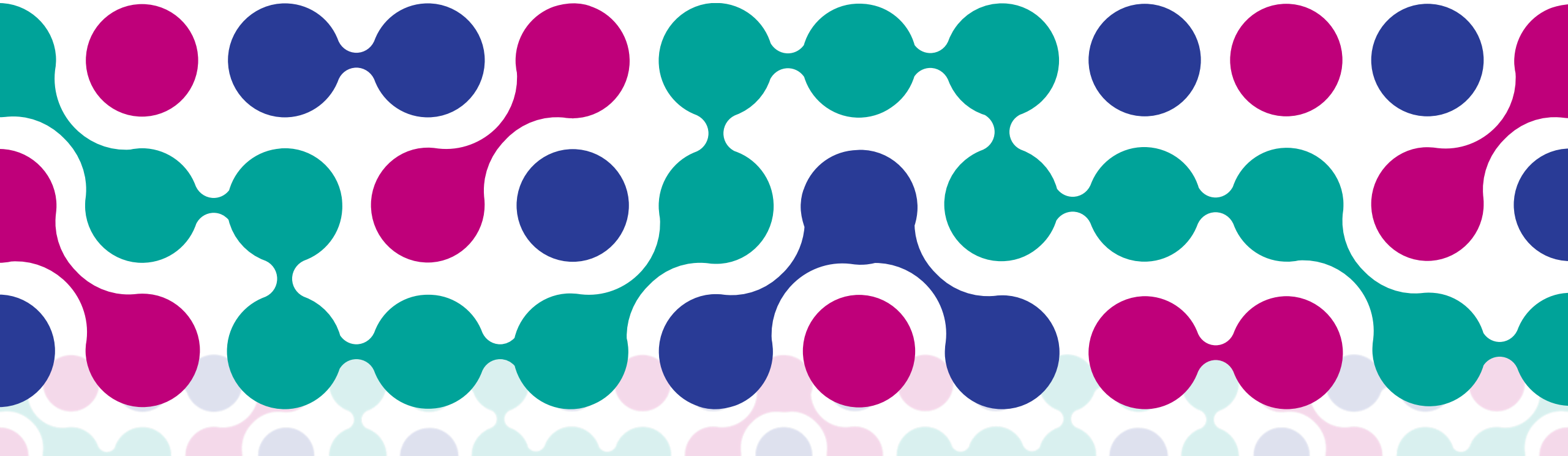
Personalised Care

Gill May – Chief Nurse, BSW ICB
Lucy Heath – Health and Care Professional Director, BSW ICB



Health and Care Professional Event – 8th October 2024
The power of personalised care: leading transformation in BSW ICS

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- Inspiring keynote speech from international expert in Personalised Care – Professor Al Mulley (MD, MPP) The Dartmouth Institute
- Table discussions focussing on the six areas of personalised care:

Patient Choice	Shared Decision Making	Supported Self-Management
Social prescribing and community-based support	Personalised care and support planning	Personal Health Budgets

- Inspired by case studies presented by BSW Health and Care Professional leaders
- Focussed on what is happening already, what could happen in the future and what is stopping us?

There were many examples of personalised care in BSW

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Shared Decision Making in Cardiology, Orthopaedics, and Community Hospital

collaboRATE

integRATE

Personal Health Budgets in All Age Continuing Care (AACC) BSW ICB

Wiltshire HEALTH AND CARE

BSW Long Covid Team

- What matters to you?
- Co-produced personal goals
- **Supported self-management**
- Improved outcomes

Live Well Swindon

- Behaviour change
- Building connections
- Person-centred
- Overcoming obstacles
- Strong relationships

Barriers to action

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Next steps

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- Raising awareness
- Training and Education
- Digital as an enabler
- Embedding in continuous improvement
- Focus on Personalised Health Budgets
- Governance

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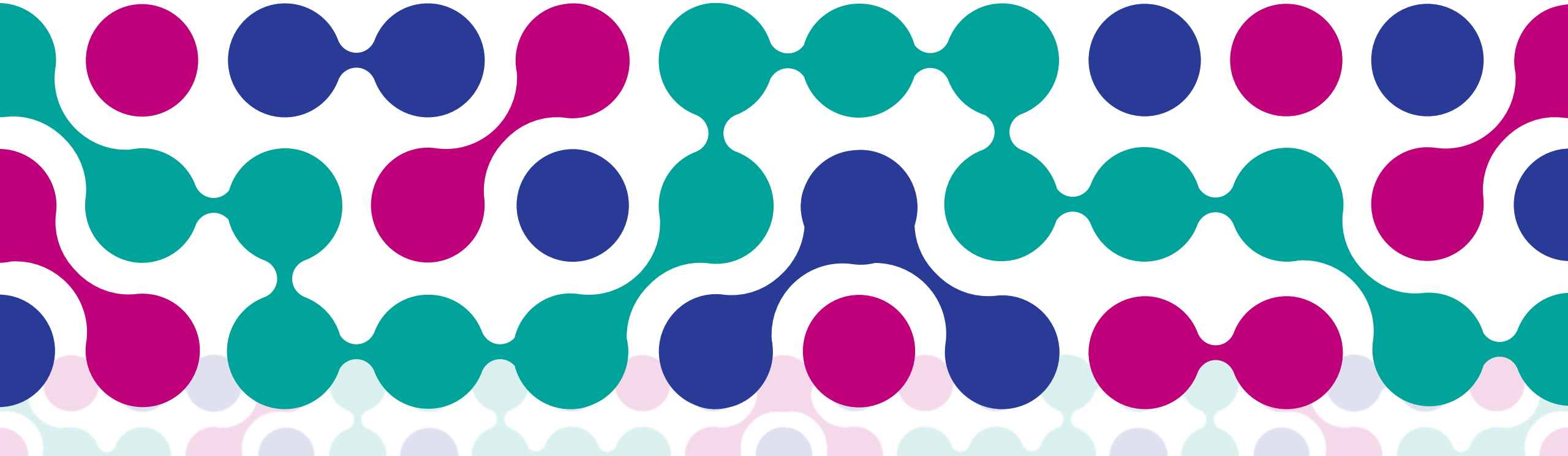
Joined up local teams

Caroline Holmes, Interim Place Director for Wiltshire
Val Scrase – Regional Director, HCRG



What did we say we wanted to achieve in the ICP Implementation Plan?

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Joined up local teams will have a critical role to play in providing both same day access for urgent care and continuity of care for individuals with long term conditions or complex care needs. They will focus on three key 'offers' to the local population:

1. Improved access to care and advice
2. Proactive personalised care from a range of team members for individuals with long term or complex health needs
3. Helping everyone to stay well for longer (prevention)

Joined up local teams will be designed to serve populations of around 30,000-50,000 people in natural neighbourhoods across BSW.

They will enable partner organisations to work together to ensure that individuals are accessing care and support from the most appropriate sources, including voluntary and third sector organisations.

Integrated Neighbourhood Teams developed so far…

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Bath & Northeast Somerset

Frailty Multidisciplinary Team (started June 23)

Proactively identify and support older adults with early frailty.

Referrals come from community organisations.

A multidisciplinary team, assesses referrals and provides tailored support.

Aims to prevent health decline and improve the quality of life for vulnerable older individuals.

Swindon

Team Around Me – Multidisciplinary approach to managing high intensity users (started April 24)

Proactive Long Term Condition Management - Multidisciplinary approach to people living with COPD (started October 24)

Connective Care for Children – Multidisciplinary approach to children with high needs (starting January 25)

Wiltshire

Multiple Neighbourhood Collaboratives, at various stages of development. Examples:-

Salisbury Livestock Market pilot – unmet need, prevention and early intervention in rural and farming communities.

Prevention of High Blood pressure in specified at risk population group.

Our Integrated Neighbourhood Teams are not currently at the scale to enable robust evaluation there are indications of the following outcomes:

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Individual improvements

- Early Identification and Intervention
- Enhanced Access to Care
- Increased Health Literacy
- Improved Mental Health
- Enhanced Quality of Life

Individual level outcomes

- Improved physical health and function
- Reduced hospitalisations and falls
- Enhanced mental well-being
- Increased independence
- Improved quality of life for individuals and their families

Systemic Improvement

- Integrated Care
- Efficient Referral Systems
- Data-Driven Decision Making
- Community Empowerment
- Innovation and Pilot Projects

System-Level Outcomes:

- Reduced healthcare costs
- Improved population health
- Increased efficiency and effectiveness of healthcare services
- Strengthened community partnerships
- Enhanced social capital

Key priority in Integrated Community Based Care procurement…

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One of our key transformation priorities for the community contract

Take early neighbourhood/local team models, PHM, care coordination, personalised care planning and preventative approaches and mature them so that they a) meet both the mental and physical health and wellbeing needs of the most vulnerable adults and children with long term conditions in our communities, and b) reduce health inequalities and improve access/outcomes. The third sector will be key delivery partners in this model.

(1 of 9 priorities)

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.

Year 1 – Implement integrated neighbourhood teams

Year 2 – Build on integrated neighbourhood teams

Year 3-5 – Neighbourhood teams fully implemented with 7 days working

Left shift of care

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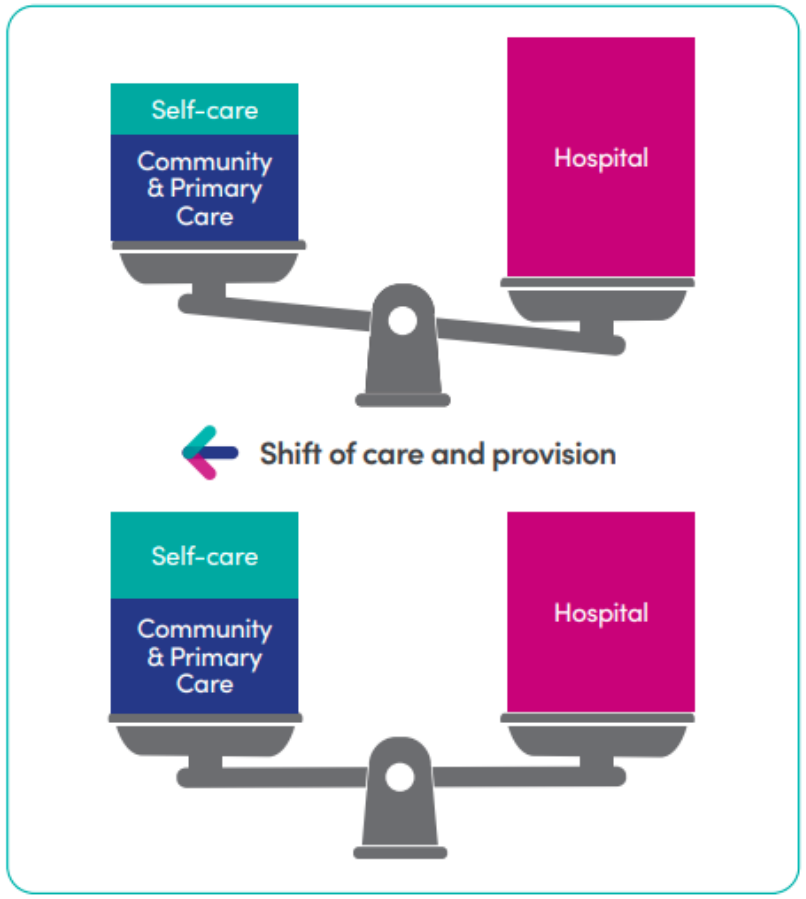

- Development of joined up local teams and mobilisation of the wider integrated community-based care (ICBC) contract are key actions to shift care and provision.
- Joined up local teams will support self-care.
- The integrated community-based care contract will transform our approach to community and primary care.
- A key outcome in the ICBC outcome framework is reduced hospital activity – particularly urgent care.

Integrated Neighbourhood Teams – Logic Model

Context and Rationale

There are different type of Integrated Neighbourhood Teams (INTs). Some INTs focus on complex patients who would benefit from coordination of services through and MDT approach. These are the INTs that the ICBC shall lead on. There are other INTs that focus on early intervention and prevention. The ICBC shall contribute to these, but they may be led by other partners.

INTs shall join up services, provide care closer to home and improve access to care. By working seamlessly, sharing information, data, equipment, caseloads and training integration of care will be improved. This shall lead to improved physical and mental wellbeing of those with greatest needs and reduce inequalities.

The ICBC shall work collaboratively with partners including acute, mental health, primary care and VSCE to lead and coordinate INTs.

Project Aim

Take early neighbourhood/ local teams' models, population health management, care coordination, personalised care planning and preventative approaches and mature them using co-production approaches.

Inputs

Population

- Defined cohort of patients (Adults & CYP) with specified needs (EOL, frailty (moderate or severe), at risk of falls, complex needs, not optimally managed, SMI)

Workforce

Partners

Provider to add details on inputs

Activities

- MDTs with holistic representation to address the full scope of health needs and relevant wider determinants of health.
- Personalised, holistic care that supports social, psychological and physical needs.
- Holistic, integrated, strengths based, THINK Family approach.
- Care Plans include MH and wellbeing offer.

- Proactive offers of care to defined cohort of patients
- Shared decision making and patient choice
- Supported self-management including peer support, health coaching and education.
- Social prescribing and community-based support.
- Personalised care and support planning.
- Personal Health Budgets

- Speciality frailty advice out of hours.
- Increased access to support when decompensating.
- Improved access to specialist advice

Provider to add details on change activities planned.

Outputs

- No. people supported by an INT (at least 2% of BSW population per year ~20,000)
- No. people with a Personalised Care and Support Plan (95% of those in contact with INT ~19,000)
- No. PHBs (nationally mandated expectations for relevant cohorts)
- No. people with ColaboRATE and IntegRATE completed (95% people with Care Plan ~18,000)
- Audit of care plans – assess quality and what is included.
- No. referrals for target population (a reduction should be seen through better coordination and care planning)

Expected outcomes and impacts

Outcomes (Compared to do nothing model)

- **Reduced ED attendance in target cohorts (1.8% per year)**
- **Reduced emergency bed days in target cohorts (1.2% per year)**
- **Reduced ambulance discharges in target cohorts (1.8% per year)**
- Improved Quality of Life (EQ5D?)
- 80% scoring 9+/ 8+ on CollaboRATE and IntegRATE.
- % Personalised Care and Support Plans on ICR with 3+ providers involved.

Impact

Improved health and wellbeing – reduced mortality, improved quality of life, better outcomes for vulnerable populations.
Contribute to maintaining demand at 24/25 levels for Acute ED attendance, emergency bed days, ambulance discharges.
Improved patient satisfaction.

Start, Live and Age Well

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Our BSW Integrated Community Based Care Model

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Good
Care Quality Commission

NET ZERO

NHS England

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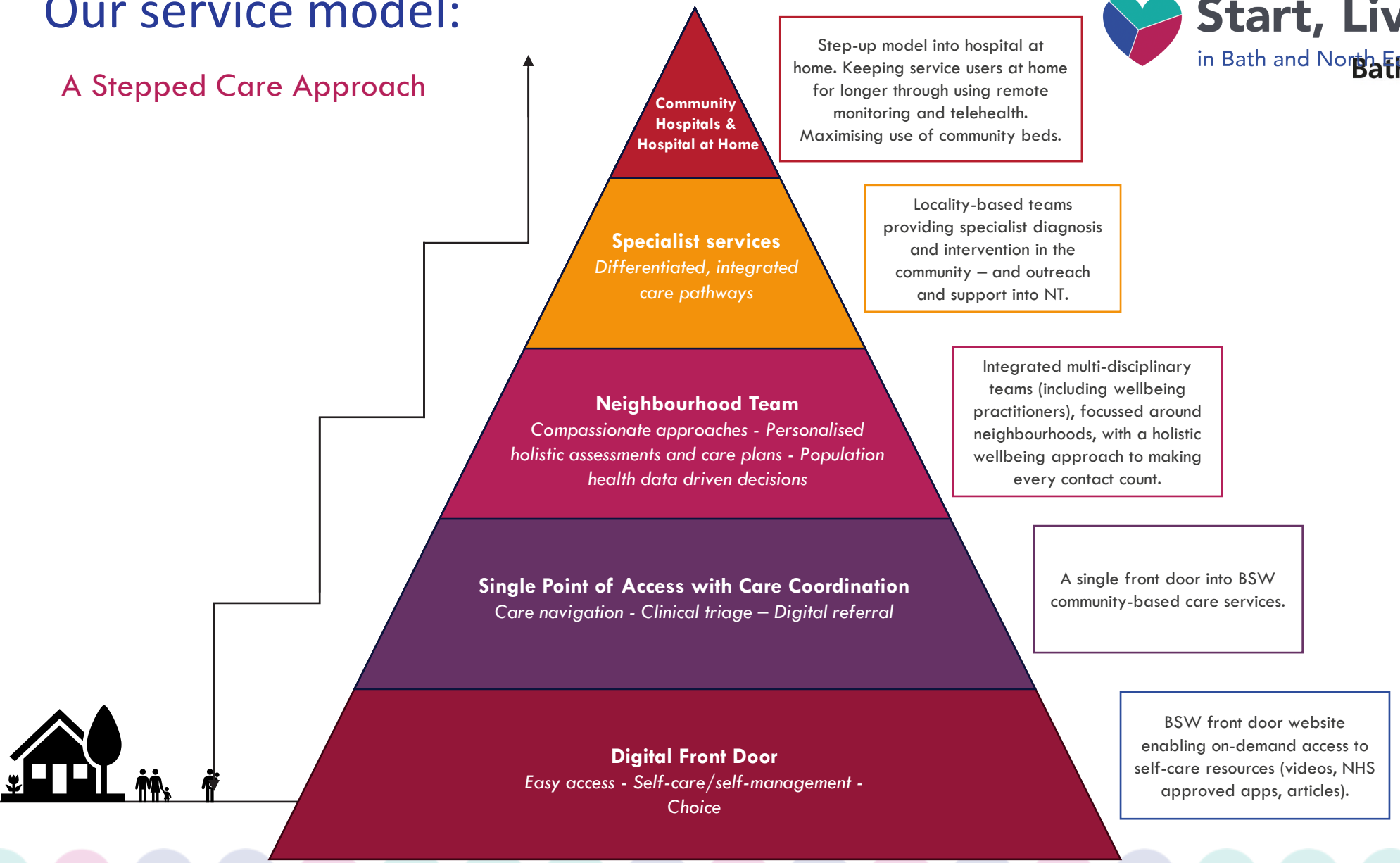
Our service model:

A Stepped Care Approach



Step-up model into hospital at home. Keeping service users at home for longer through using remote monitoring and telehealth. Maximising use of community beds.

Locality-based teams providing specialist diagnosis and intervention in the community – and outreach and support into NT.

Integrated multi-disciplinary teams (including wellbeing practitioners), focussed around neighbourhoods, with a holistic wellbeing approach to making every contact count.

A single front door into BSW community-based care services.

BSW front door website enabling on-demand access to self-care resources (videos, NHS approved apps, articles).

Start, Live and Age Well

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"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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Transformation – first 6 months

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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

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Single Point of Access (SPA) with Care Coordination

Integrated Neighbourhood Teams

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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Key enabler spotlight:
Integrated Neighbourhood Teams

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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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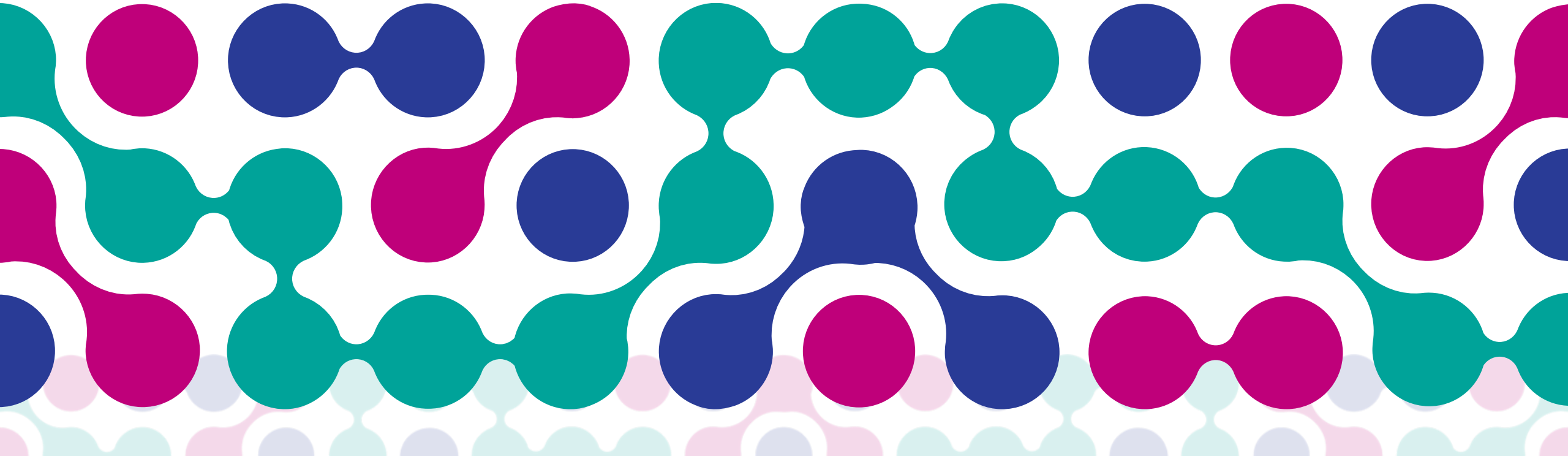
Responsive local specialist teams

Heather Cooper – Director for urgent care and flow, ICB
Clare Evans – Programme Manager, ICB



Responsive, local, specialist services

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1. Care Co-ordination
   - Centralised co-ordination centre staffed by GPs, ACPs and Specialist Paramedics supporting ambulance navigation to out of hospital pathways e.g. Urgent Care Response, Hospital@Home, Social Care.
   - Preliminary assumptions indicated Care Co-ordination would reduce emergency admissions by 11 per month (2 acute beds). To date in 2024 we are exceeding this.
   - Early assumptions suggested Care Co-ordination would reduce Emergency Department attendances by 25 per month and avoid 33 ambulance conveyances. To date in 2024 we are exceeding these metrics.

Care Coordination Principles

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The most appropriate place for the care to happen:
- Home – 2hr UCR, NHS @ Home, Community – Primary Care, Clinical Assessment Service (F2F or remote)
- Community Diagnostic Centre, Hospital, ED, SDEC, UTC.

Create a learning integrated system that:
- Optimise clinician and patient contact time
- Personalised approach that increases patients' satisfaction and reduces inequalities
- Improve access, reduce patient contact points and improve flow
- Understand whole system and clinical need to develop a truly integrated workforce model

Facilitate the earliest clinical conversation independently of where the patient presents in the system:
- Safely connects the patient to the right care this needs
- Provides consistent management irrespective of access route
- Reduces number of stops, handover and waits to deliver better outcomes
- Provide timely access to Same Day Urgent Clinical Assessment

The most appropriate health and care professional for the patient's needs:
- Workforce should be an adaptable multidisciplinary team
- That work across traditional boundaries adopting true integrated care working
- With resilience and well being
- Agnostic of organisation

Match actual demand to the system response to the health and care needs of the population:
- Services should be provided 24 hours a day 7 days a week, including out of hours
- Consistent access and pathways to manage capacity and demand both in and out of hours

Responsive, local, specialist services

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2. Hospital@Home

- Delivering hospital level care to a cohort of patients who are able to receive care during the acute phase of treatment utilising remote monitoring to maximise safety and support patients/families to remain at home.
- The national aim is to maintain occupancy consistently above 80% ensuring patients are able to receive care at home.
- Pathways of care include, but are not exclusive to frailty, acute respiratory infection, heart failure and children and young people.

Care Co-ordination - What has this achieved?

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Between April – October 2024 the service has received 11,046 referrals

Avoided 2520 attendances in 7 months, Approximately 13 per day.
Conveyance rate is 15%

6091 referrals were from the Paramedic on Scene: Approximately. 29 per day.

Emergency Admissions: Avoided 1320 admissions since April 2024. Approx 7 per day.

Via link with SWASFT Call System
4526 referrals were received.
Approximately 21 per day.

Over 46% of patients are over 70 years of age. Avoiding Emergency Departments and utilising out of hospital pathways reduces risk of hard for majority of people.
In this patient cohort there is a potential saving circa £250k, in attendances & over £4m in admissions costs.*

* Based on £214 per attendance and £3563 per admission in those >60years,

Hospital@Home - What has this achieved?

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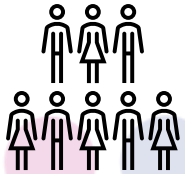
Non elective attendances: Between April – October 2024 the service has avoided **3006** unplanned attendances (average 429 per month exceeding assumptions).

Non elective admissions: Between April – October 2024 the service has avoided **3006** unplanned admissions manging people in their own home during acute phase of care and treatment

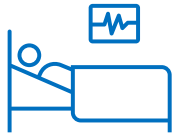
By caring for people in their own home the H@H service has led to a saving of £87,000 in 24/25.



Occupancy in 2024/5 has been ≥70% with the target of >80% achieved in June & October.

We have used remote monitoring technology with 487 patients and recently moved to a model whereby it is “Opt Out” so all patients on H@H will be asked to perform remote monitoring

2024/25: We have cared for 3006 patients in H@H this year in 7 months.
2023/24: We cared for 3775 in 12 months.



In 2023/24 H@H provided 31,641 bed days for patients who otherwise would have been admitted to hospital.
In 2024/25 to date we have provided 26,786 bed days.

Next Steps:

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Care Co-ordination:

1. Continue to support SWASFT colleagues in EOC and beyond to review calls and consider Care Co as first point of call unless time critical

2. Progress at pace work with Care Homes to offer Care Co as first point of contact rather than SWASFT for appropriate patients.

Hospital@Home

1. Increase and sustain remote monitoring to support increased utilisation of H@H to full capacity

2. Evaluate and share learning

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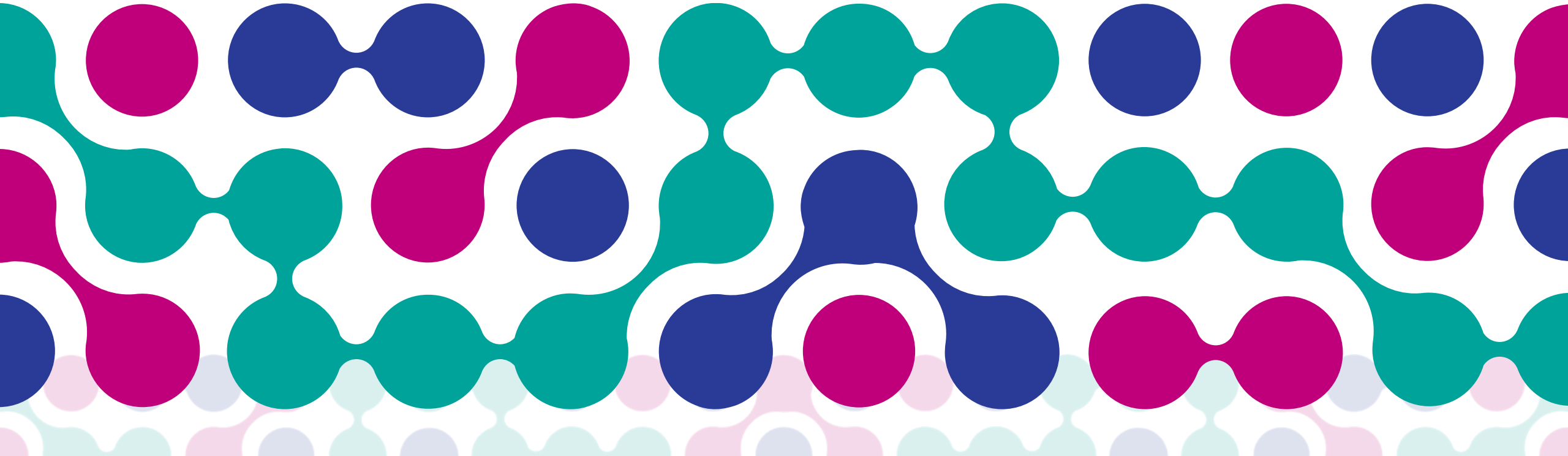
High quality specialist centres

Paul Doyle – Elective Advisor and SULIS Director, RUH



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- Hospital acquired by RUH in June 21 from Circle Health Group
- Run via Wholly Owned Subsidiary model, acting as independent business – robust oversight by RUH
- Hospital currently provides approximately 50% private patient activity, 50% NHS activity
- A range of specialities provided: General Surgery, Ophthalmology, ENT, Urology, Plastics, Orthopaedics
- Activity is via Private Medical Insurance, Private Self Pay, NHS e-Referrals via patient choice direct from GPs or Inter Provider Transfer (IPT) from other hospitals
- Treat patients from across BSW as well as the wider South West region
- 4 theatres; outpatient rooms; and hub for BSW community diagnostic centre

Sulis Elective Orthopaedic Centre (SEOC) build

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- Ambition set out in ICB Strategy:

  The partners in the AHA are also working together on the development of facilities in the Sulis Hospital in Peasdown St John. This modern facility will play a critical role in reducing the waiting times for surgical procedures for the population of BSW

- SEOC build:
  - BSW System wide approach to delivering additional elective Orthopaedic capacity for BSW patients but also wider South West
  - Business case for £25m investment approved in July 2023
  - Investment is for 2 additional theatres and associated recovery and inpatient bed space
  - Modular build – constructed off-site
  - Upgrade to 2 existing Sulis theatres (conversion to lamina flow)

SEOC delivering for patients

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Strategic case

- Elective Orthopaedic Centre for BSW and the SW region.
- Ringfenced capacity operating at national best practice - 10 hours a day, 6 days a week and 50 weeks a year.
- Each theatre able to deliver around 1,500 cases per year.
- No regrets move – significant excess demand in BSW and the region.

Current plans

- Temporary theatre on site to bridge gap until 2 new theatres open – so already delivering increased activity
- Recruiting new staff to deliver care
- New capacity will be ring fenced for elective Orthopaedic activity all year round
- Plan for facility to become operational Q4 24/25

End result

- Ambition to reduce waits to 52 days rather than 52 weeks
- Centre of excellence / national exemplar in orthopaedics, providing the highest quality care for our patients
- Independent Sector standard facilities
- Facility that attracts and retains the best staff

Timetable

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PROGRAMME			
Key event	**Start Date**	**End Date**	**Comment**
Submit business case to NHS England	16-Jun-23	16-Jun-23	Completed
Business case approved by NHS England	13-Jul-23	13-Jul-23	Completed
Submit planning	09-Oct-23	09-Oct-23	Completed
Planning approval	19-Jan-24	06-Mar-24	Completed
Main construction starts	20-May-24	13-Dec-24	Completed
Modular built off-site	25-Mar-24	02-Aug-24	Completed
Modular installation & fitout	29-Jul-24	03-Dec-24	Commenced / Progressing
Cleaning and commissioning	03-Dec-24	31-Dec-24	Anticipated
SEOC go live	06-Jan-24	06-Jan-24	Anticipated
Laminar flow conversation	08-Jan-25	01-Apr-25	Anticipated
Completion	01-Apr-25	01-Apr-25	Anticipated

Progress with delivery

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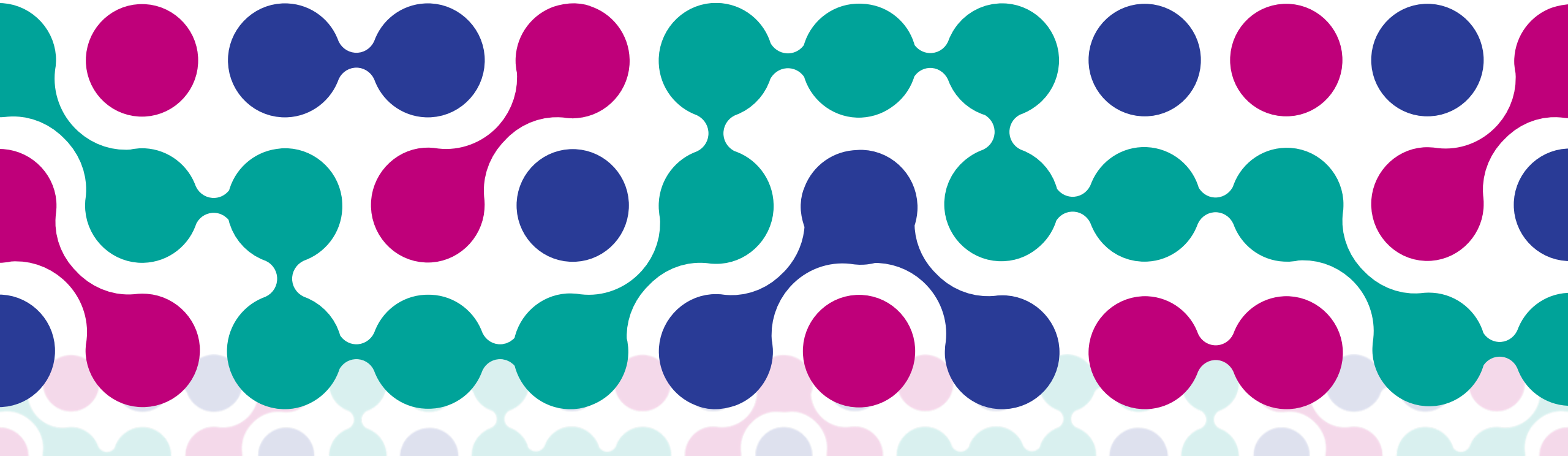
Mental Health and parity of esteem

Gordon Muvuti – Director of Place, Swindon



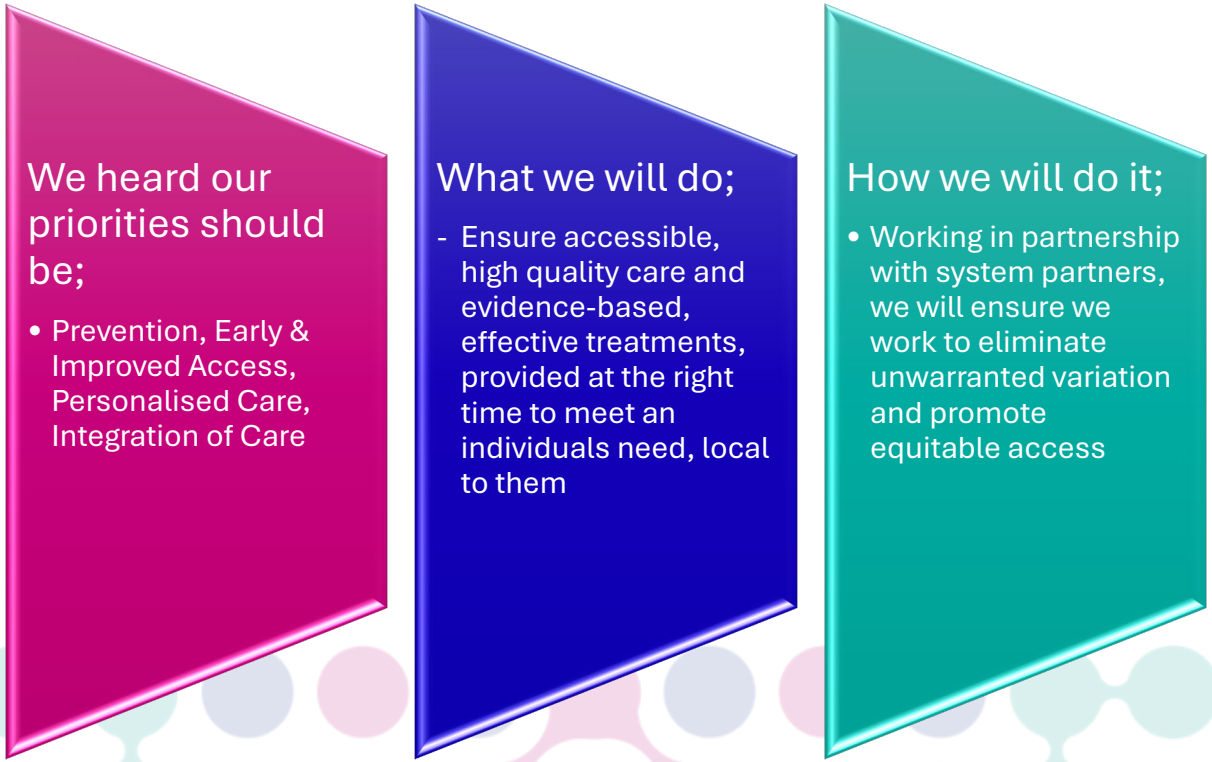
Our Transformation Journey……

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

2025-2030 Mental Health Strategy;

- Our health-based strategy offers a **lifespan view**, from the perinatal period through to older adults – **it is for every person in BSW** regardless of needs and diagnosis/es, demographic, or protected characteristics

- We have utilised significant coproduction & engagement opportunities to listen to our communities and people with lived experience, as well as our system stakeholders



Our transformation journey

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

- What we are already doing well;

➢ ***Core20+5 Serious Mental Illness (SMI); creating improved provision through;***

- ➢ Increasing early access to community-based integrated mental health provision; spanning primary care through into specialist secondary care pathways e.g. Eating disorders, Complex Emotional Needs, and enhancements to psychological therapies, and implementing "Your Team, Your Care, Your Plan".

- ➢ BSW ICB MH strategy assessed by the Mental Health Foundation as an example of excellent commitment to the prevention of mental health.

- ➢ Enabling our crisis pathways to better respond to people's needs; initiation of NHS111-2 service, increase in MH clinical input to SWAST control room [enhancing to 24/7, Q4], mobilisation of Mental Health Ambulance [Q1 2025/26].

- ➢ Enhanced rates of SMI annual physical health checks (PHC), enabled throughout the AWP SMI PHC team – who have moved from under 10% of those on caseload having a review to now over 80%.

Our transformation journey

NHS
Bath and North East Somerset, Swindon and Wiltshire
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Our challenges;

- Enabling effective flow through our adult inpatient mental health wards; system response required (housing and accommodation).
  - *What are we doing?* Working in partnership to agree on 'Wicked' problems, and how to resolve…. Enhanced enabling governance, mobilisation of transfer of care hubs

- Working across organisational boundaries – 'one system' approach.
  - *What are we doing?* Utilising our partnerships – 'stronger together'

- Working at the pace required to make the transformation, quickly.
  - *What are we doing?* Agreement of priorities and timeframes

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The role of the ICP

Richard Collinge – Chief of staff