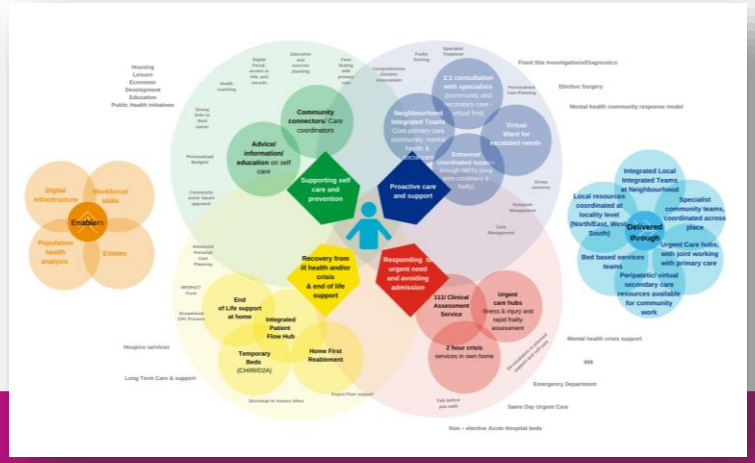
Bath and North East Somerset,
Swindon and Wiltshire Partnership

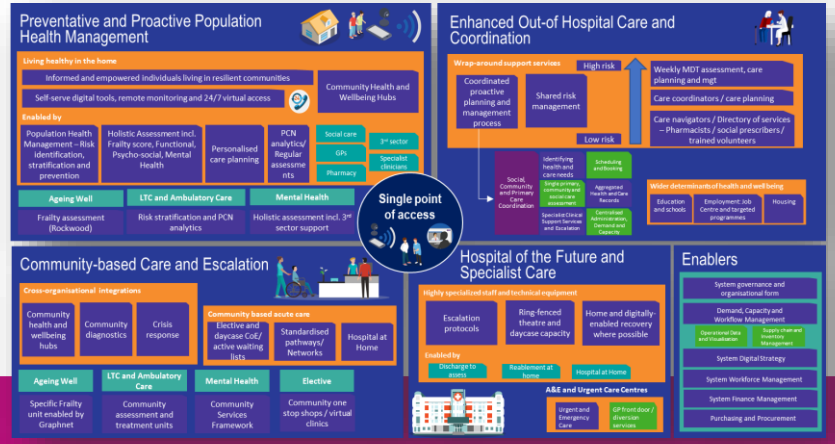
Working together for your health and care

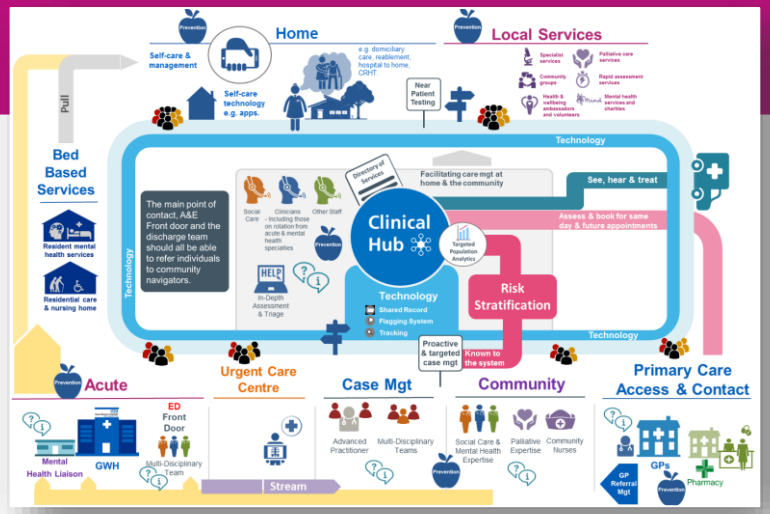
Shaping a Healthier Future
BSW Health and Care Model

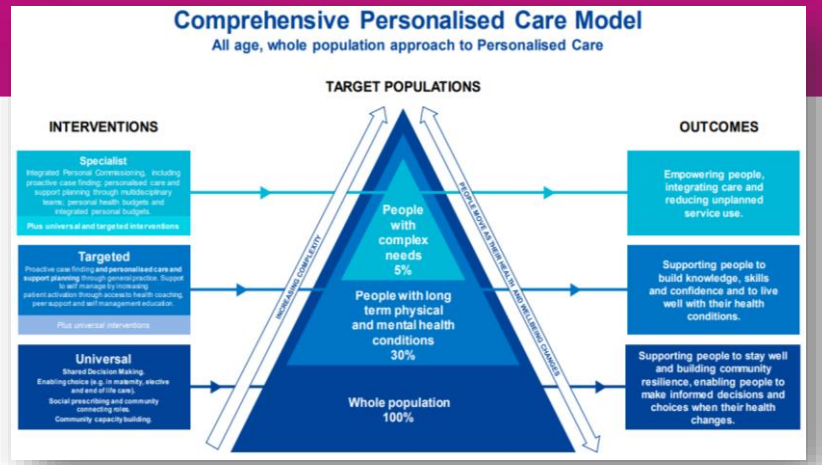
22 October 2022

The development journey









BSW Health and Care Model

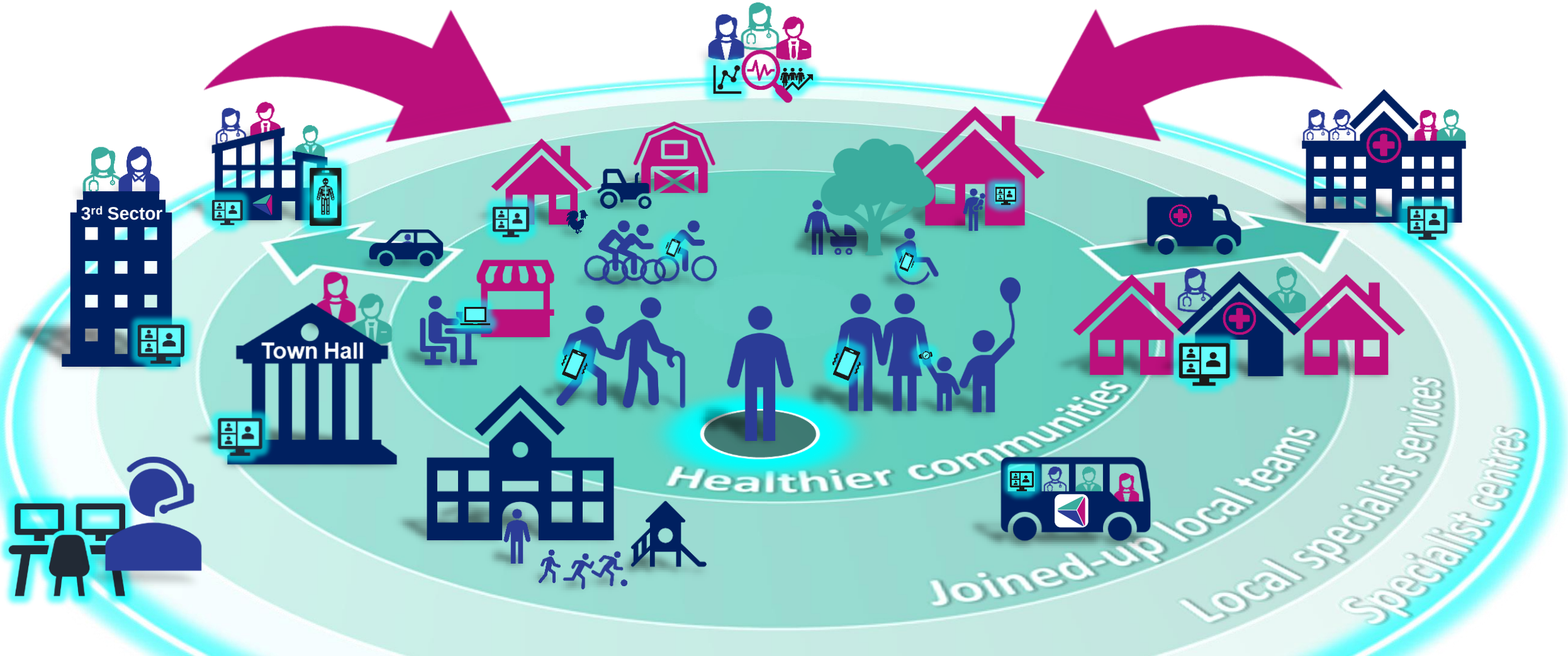
Version 1.0

Bath and North East Somerset,
Swindon and Wiltshire Partnership

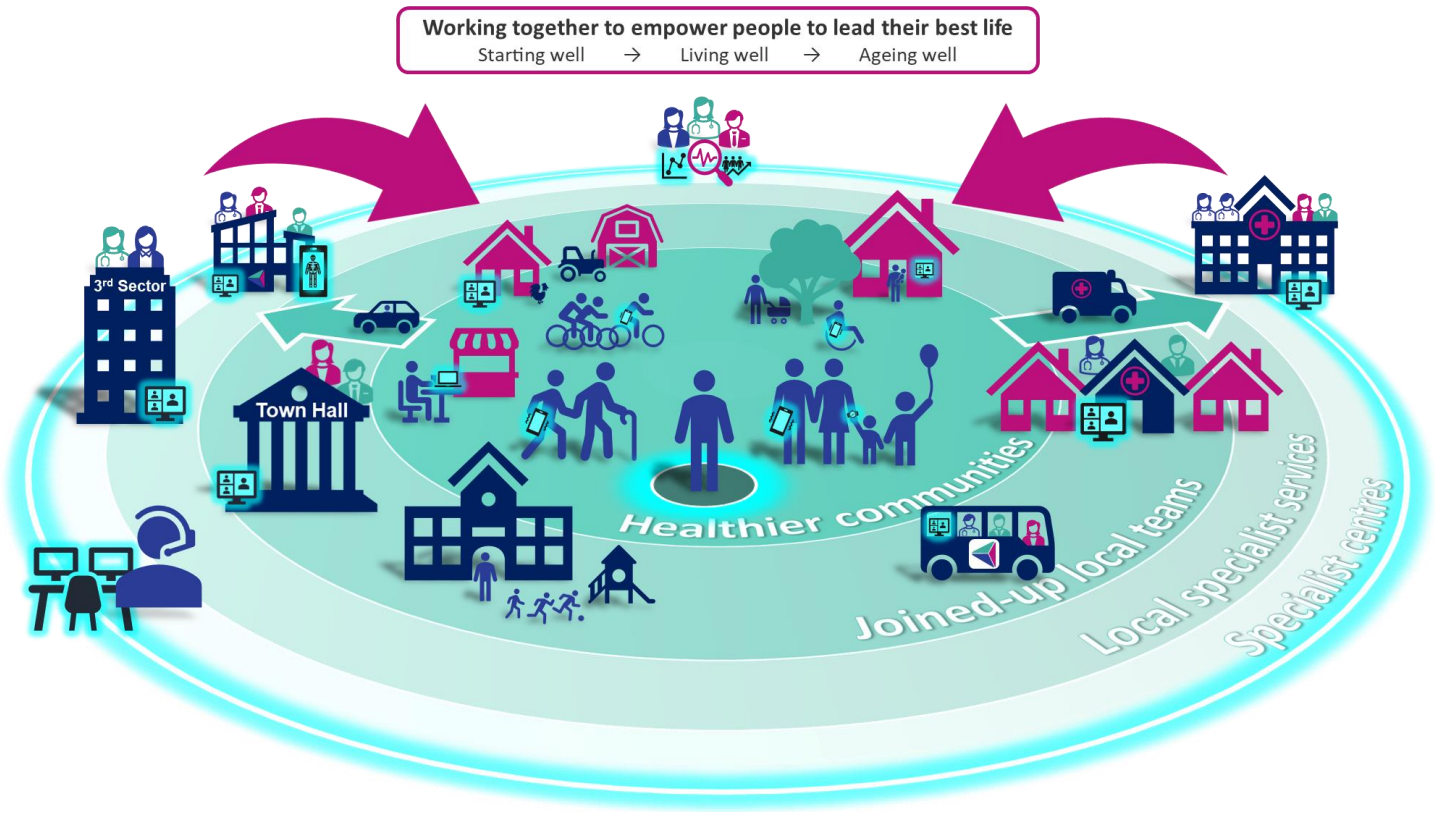
Working together for your health and care

Working together to empower people to lead their best life

Starting well → Living well → Ageing well



Five parts of the model

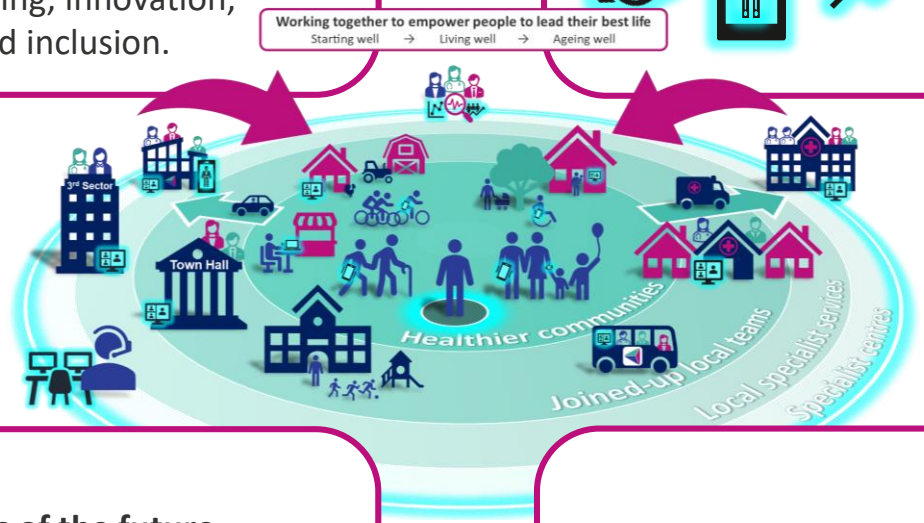


1. Personalised care
2. Healthier communities
3. Joined-up local teams
4. Local specialist services
5. Specialist centres

How we are going to make this happen

Developing our workforce
Over 34,000 people work in health and care in BSW. We are establishing the BSW Academy to unite and develop our workforce by investing in leadership, learning, innovation, improvement and inclusion.

Using digital by default
We will make full use of digital technology and data to improve health and care for people in BSW. We will make sure that all our teams and services are inclusive for people with limited access to technology.



Building facilities of the future
We will invest millions of pounds to improve our specialist centres, to build new community facilities and to buy more equipment.

Financial sustainability
We will make the best use of our combined available resources to deliver high quality care.

Next steps

Engagement

Engagement

- Launch on 2nd November 2021
- Aim:
  - To raise awareness of the BSW model and what it means for local communities
  - Two way dialogue with stakeholders about key principles of model in order to understand the barriers to access and the impact of these - especially for those affected by health inequalities
  - To provide details to the public of how they can keep involved going forward
- Approach:
  - Blended approach - mostly digital though with some off-line engagement opportunities.
  - Pragmatic – given resource and time constraints - and so targeted at communities experiencing health inequalities.
  - Collaborative with partners to maximise messaging
  - Using storytelling to explain engagement so far and highlight what new ways of working will mean for people in practice.
  - Engaging on the system-wide model but with options for localised additional engagement.

Engagement

- Who we will engage with:
  - HealthWatch, Patient Participation Groups and Champions
  - General public – particularly identified communities experiencing health inequalities e.g. homelessness, mental health, rural isolated, BAME etc
  - BSW partner organisations and their staff, neighbouring CCG's
  - Clinicians and locality leads, social care organisations, out of hours and 111 providers
  - 3rd sector organisations
  - Educational institutions, Housing Associations, major local employers
  - Media, politicians, neighbourhood and residents groups

- How we will engage:
  - Surveys with localised questions – on websites and via press release
  - Posters and leaflets
  - Workshops with community, 3rd sector and patient groups
  - Interviews with key stakeholders

Appendix

More detail about the model

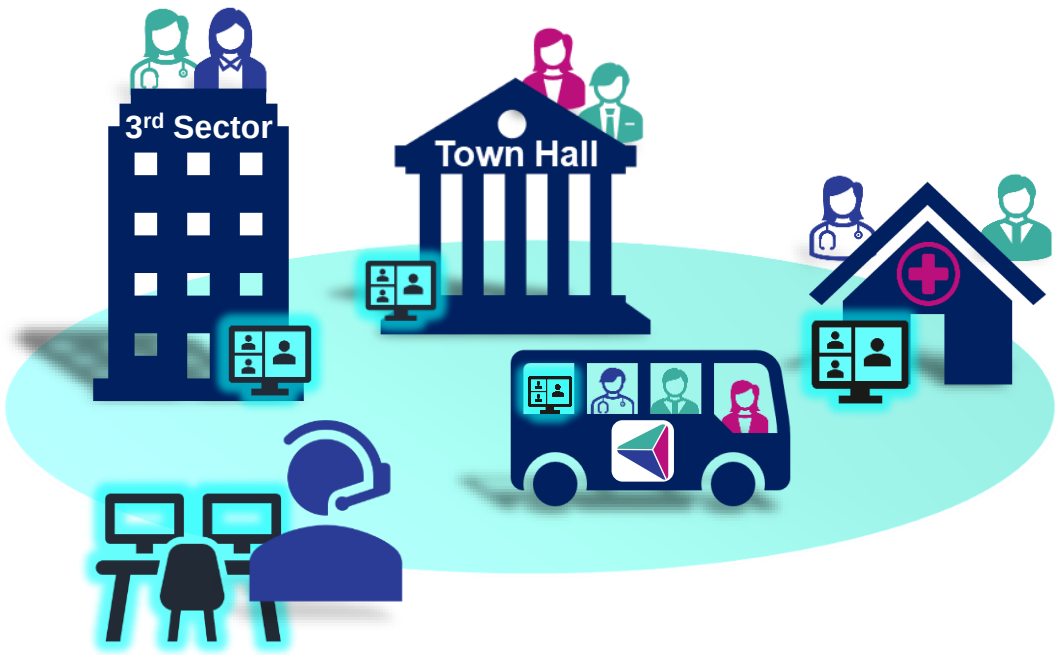
1. Personalised care

- Personalised care will be at the heart of everything we do in the future
- Shared decision making will enable people to make informed decisions and choices when their physical or mental health changes
- We will use proactive case finding and personalised care and support planning to support people with long-term physical and mental health conditions to build knowledge, skills and confidence to live well with their health conditions
- People with complex needs will be supported by multi-disciplinary teams and we will use tools like personal health budgets so that people can take charge of their own care

2. Healthier communities

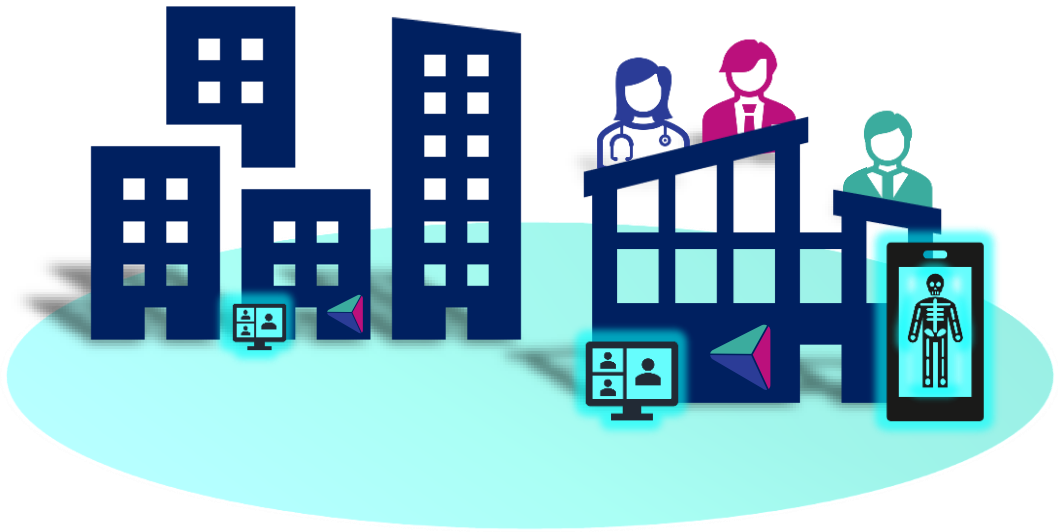
- We will use a strengths-based approach to build capacity in communities
- We will connect with local resources to develop social prescribing and build connection within communities
- Population health management will give local teams the data to provide proactive support to communities and individuals so that they can maintain good health and wellbeing
- We will work to prevent illness and reduce health inequalities in all our communities

3. Joined-up local teams



- When people need health or care support, local teams with NHS, local authority and third sector members will work together to provide that support
- Teams will be set up locally to meet local needs
- Coordinators will make sure that the support that people need is joined-up and works for them. We want to stop people “falling in the cracks” between different teams or services

4. Local specialist services



- More specialist services will be available closer to where people live
- We will make more use of community locations like public buildings and high streets to provide access to information, appointments, group sessions, tests and treatments
- Digital technology will enable more services to be delivered remotely so there will be less need to travel to attend appointments in person

5. Specialist centres

- As more services will be available remotely and in community locations, our NHS, local authority and third sector specialist centres will be able to focus more on providing specialist care
- We will invest in our specialist centres to make sure that they are ready to meet the needs that our population will have in the future
- Specialists in our centres will be able to do more to support local teams and people in their own homes

How care could be different - Ageing well

Clara

85, Retired Bookkeeper

Clara has remained relatively independent despite the death of her husband 3 years ago, however she has had a number of falls in the last 5 years, and also been treated for multiple UTIs. She has fallen repeatedly at home, but wishes to remain independent. Her family would like to see her better supported.

Clara has just received acute care following a fall in her home. The **discharge to assess** initiative has allowed Clara to return home rapidly. The **GP** and **Care Coordinator**, using their **risk stratification tool**, identify Clara as high risk and recommend **remote monitoring**.

The **Care Coordinator** and **Social Care Team** work with Clara and her family to evaluate her home environment and develop a comprehensive care package through a **trusted assessment** between 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 utilising 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 with the appropriate course of action 24 hours a day, with **full shared access to her care record**.

Clara is able to attend her **local community centre** to meet her friends with support from the a **local third sector group** as part of her **wellbeing plan**.

She is also able to attend the **community frailty clinic** at the **Community Hub** and has been offered **virtual appointments** so she does not have to rely on others.

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

Clara can be referred to a **community-based clinic** with 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.

How care could be different – Long term conditions

Marvin

52, Warehouse Night Manager

Marvin is a night shift worker in a warehouse, who values the time outside of work he can spend with his family. He has poorly managed Type 2 diabetes and has been recently been diagnosed with COPD. He has a poor diet and is distrusting of health professionals so avoids visiting his GP.

The **Population Health Management** tool flags Marvin for a review using **risk stratification**. The **Care Coordination Team** contact Marvin and encourage him to attend 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 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.

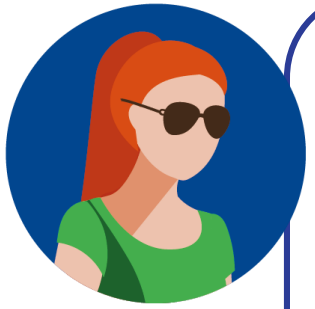
Marvin is able to access **diabetics group support sessions** and **1:1 virtual support** from his **GP** to help make changes in his life sustainable.

Marvin uses **remote monitoring** and the data he records is reviewed by a Diabetes Nurse in primary care. Marvin and the Diabetes Team can both initiate virtual appointments if they 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** in an ambulatory care setting. 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. He is able to access a local gym out of hours and is able to lead an active lifestyle.

How care could be different – Mental health



Sophie

25, Postgraduate Student

Sophie is an independent Masters student who lives on her own away from home. She is finding the pressures of writing her thesis stressful and her tutors have noticed she has not shown up to some seminars. Sophie has been struggling with anxiety. She has started drinking in the morning to take the edge off, and has also started abusing prescription drugs and cannabis. Sophie's family have noticed that she has become more withdrawn but she doesn't want to open up to them.

Sophie's tutors have received **training in awareness of mental health disorders** and notice alcohol on her breath. They also notice she is not as engaged in class and appears distracted when she does attend. They refer her to the campus **support team**.

Sophie attends an event at her campus organised by a **third sector mental health organisation**, in which people talk openly about their challenges with mental health. She downloads the **recommended app** and recognises that she needs support. The app contains a **24/7 virtual chat and helpline** which Sophie uses to talk about her concerns.

Using the app, Sophie arranges **face-to-face counselling sessions** at her campus. She discusses her progress with the counsellor, who is able to **message Sophie via the app** in between their sessions. Sophie commences evidence-based treatment for her addiction which continues for 3-6 months and she has an **allocated coordinator** to check in on her.

Sophie decides to tell her family more about how she is doing. Her family join an **online support forum** where they can chat to other families and attend webinars about how to best support their daughter

Sophie is able to **update her health records to share her progress from her phone.** Her **Coordinator** works to a **shared risk protocol** and knows the triggers and when to escalate to a **GP** or **Crisis Team**.

Sophie is encouraged to broaden her social network by joining an **art class** on campus, where she can nurture her talent for art alongside building her confidence. She joins a **peer support group** which gives her resilience and makes her feel like she's not alone.

Following the **early intervention**, Sophie's alcohol addiction is prevented from escalating and she is better equipped to manage her mental health challenges. She completes her thesis and graduates later that year.

How care could be different – Elective care

Jasek

48, Builder

Jasek has suffered with increasing aches and pains for the past few years after a knee injury 10 years ago and this has been complicated by early arthritis (which he believed runs in his family) but he 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 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 attendances.

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 he can even attend **virtual sessions** around his work times.

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.