Integrated health and care strategy

Draft for discussion

Health and care organisations across Bath and North East Somerset, Swindon and Wiltshire working together to build services for the future

Contents

Foreword

In January 2019 the NHS published its Long Term Plan and laid out its vision for improving the quality of patient care and health outcomes as well as building a health and care service fit for the future by:

- Enabling everyone to get the best start in life
- Delivering world class care for major health problems
- Supporting people to age well.

These aims and aspirations also sit at the heart of this integrated health and care strategy.

Like other parts of the country, people in our area are living longer, but often with a number of long-term conditions which add complexity to their health and care needs. Many adults and children are dealing with mental health issues, sometimes alongside a long-term physical health condition. We know there are people in hospital (in acute and mental health beds) and in nursing and residential homes across Bath and North East Somerset, Swindon and Wiltshire (BSW) who would be better cared for in the community or at home. Many organisations providing health and care within BSW are struggling with a combination of rising demand and increasing financial challenges.

These pressures are very real. Our nurses, doctors, social workers, therapists and clinical support staff work incredibly hard to provide the very best care they can. Their hard work and dedication in caring for our family members, relatives and friends, day in and day out, all year round is inspirational. But if we are to maintain safety and quality of care in the future, we have to change. And we need to address the issues we currently face in a way that will improve outcomes for individuals, the communities we serve and our staff.

We believe the only way to do this is to build closer ties between all partner organisations across BSW. We also need to support more people to manage their condition themselves and to improve our approach to our community-based care.

While individual clinical strategies from constituent BSW partners have existed in the past, this document is the first to bring together our joint approach to health and care provision across B&NES, Swindon and Wiltshire. It has been developed through a process of collaboration by health and care leaders from across the BSW area and, as such, it marks a real step forwards.

This document is very much the start of our journey. Feedback, engagement and discussion with the public and our health and care colleagues will be of central importance to the development of the strategy. It will also inform the BSW Partnership's five year plan, as will other strategies covering wider development with BSW's workforce, estates and approach to digital technology. This strategy can only progress and be implemented with your input, so please share your views by sending an email to bswstp.communication@nhs.net.

Dr Ian Orpen

Dr Christine Blanshard

Co-chairs, BaNES, Swindon and Wiltshire Clinical Board

Introduction

This strategy builds on discussions between health and care leaders and clinicians across the BSW area in late 2018. It is the basis for further discussion and engagement and will be a key element of our five year plan which we intend to produce during autumn 2019.

We all know these are challenging times, particularly with difficult economic conditions and the changing needs of the people across our region. We know people in BSW live longer and healthier lives than those in other areas across England. We also know that BSW is an area in which we aspire to improve the wellbeing of everyone.

This is why this strategy seeks to enable children and young people to start well, then to live well and older people to age well. We want to develop a bold set of ambitions for the next five years for our combined populations.

While it doesn't describe the detail of the developments at this stage, this strategy does outline the direction we feel it is important to take.

Our health and care priorities will be addressed through three life stage programmes:

- Early life including maternity, children and young people: Making sure everyone gets the best start in life
- Staying healthy: Delivering world-class care for major health problems
- Later life: Supporting people to age well until the end of life.

This means we will spend more time and effort helping people to stay well, to help them act early to prevent ill health and get support and, where care and treatment is required, that we work with people to ensure care is joined up and based on what matters most to the individual.

Our proposed priorities are:

Priority 1: Improving the Health and Wellbeing of our Population

- Increasing our focus on prevention and reducing inequalities
- Taking a life course approach which aims to increase the effectiveness of interventions throughout a person's life
- Health in all Policies (HiAP) – to always take into account the health implications of policy decisions on matters such as housing, transport and education, seek synergies, and avoid harmful health impacts in order to improve population health and health equity
- Ensuring shared decision-making with individuals regarding their care is the norm
- Supporting people to take more responsibility for their own health and wellbeing
- Using initiatives such as Making Every Contact Count & 3 Conversations, strength-based approaches to care and support that take the day-to-day interactions that health and care professionals have with other people to support patients in making positive changes to their physical and mental health.

Priority 2: Developing Sustainable Communities

- Ensuring Primary Care Networks, community services, secondary care, the voluntary sector and community mental health services work together with an initial focus on managing frail individuals to maintain independence, reducing length of stay and preventing admission to hospital wherever appropriate.

Priority 3: Sustainable secondary care services

- Supporting the Acute Hospitals Alliance of the Great Western Hospital (GWH), Salisbury Hospital and the Royal United Hospitals Bath NHS Foundation Trust (RUH) to continue working together to address capacity issues, specialties under pressure, back office services and co-design care pathways
- Supporting acute patient flow by reducing length of stay where safe and appropriate.

Vision and objectives

Our vision

Health and local authority partners across BSW will work together to create a sustainable health and care system. We aim to do this by becoming an Integrated Care System and build on the progress made in bringing together local organisations to deliver the 'triple integration' of primary and specialist community care, physical and mental health services, and health with social care.

We want to support and sustain healthy, independent living, with two key aims:

Healthy lives

Wherever possible, encouraging communities, families and individuals to take on more responsibility for their own health.

Empowered lives

Personalising and delivering care in the most appropriate setting to allow people to be in control of their own health, choose what treatments they want at the end of their lives and ensure decisions about their health are shared with relevant health professionals.

Our objectives for the BSW Integrated Care System are to:

- Improve the health of our population through prevention of illness, early intervention and promoting independence
- Improve the quality of services through reducing unwarranted variation, delivering national and international best practice, while also adopting innovative approaches to health and care delivery through integrated services
- Deliver value for the individual and the taxpayer by being efficient and working across organisational boundaries to achieve economies of scale and optimisation of services where it makes sense to do so.

These translate into the triple aim of improving:

- Population health and wellbeing
- Experience of care and patient outcomes
- Cost effectiveness *

By demonstrably linking the benefits of health, education, housing and employment to economic and social wellbeing for our communities, we will deliver better and more equal outcomes for more people, in a more integrated way, maximising the gain that can be achieved with the collective resources available.

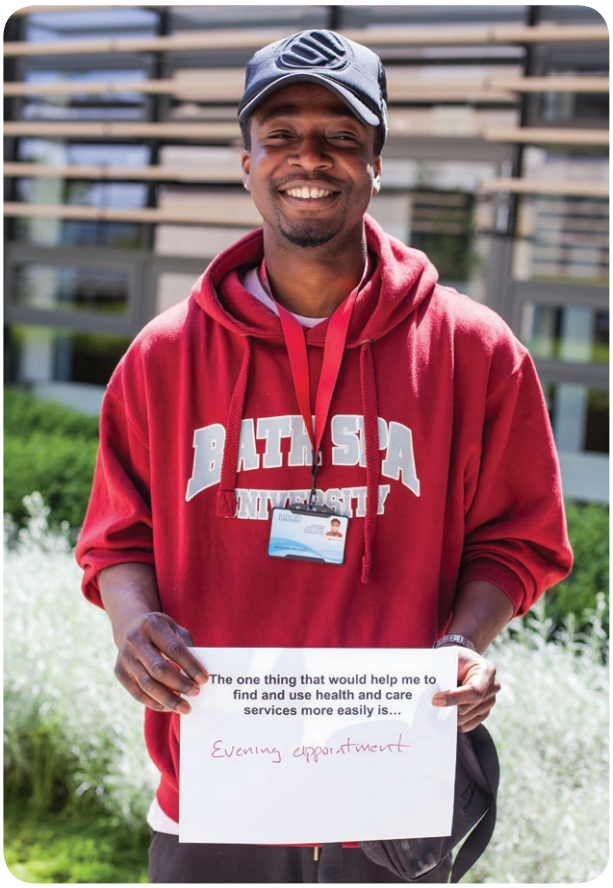
**Details of our financial plan have not been included in this Integrated health and care strategy. More information on this will be included in our forthcoming five year plan. We expect our financial plan to be led by our clinical priorities.*

Our area – challenges and opportunities

Who we are

BSW has a combined population of approximately 941,000 people.

There are three local authorities, 94 GP practices, three Clinical Commissioning Groups (CCGs), three hospital trusts, a mental health provider, and an ambulance trust, as well as community services providers and many voluntary and charitable organisations. All are working together as the BSW Partnership. The hospital trusts are located on the fringes of the BSW boundary and some patients are referred outside BSW for specialist services such as cardiac surgery that we do not provide. We have a combined health and care workforce of approximately 40,000 people.



Why is change needed?

There is a compelling need for change, which is driven by the developing needs of our local population. In BSW, we are expected to experience significant population growth in the older age groups. There are currently over 80,000 people aged over 75 across the area. By 2025 this number is expected to grow by over 40 per cent to over 100,000 and the BSW population is likely to exceed one million, with one in five people - or more than 200,000 - aged over 65 years.

We are also expected to experience a significant population growth through the ongoing programme to re-locate army personnel in Wiltshire over the coming years.

Both services and our workforce need to develop to meet the rapidly changing needs of our people and communities. While there are many examples of excellent and high quality services, there is too much variation in standards of care and the system has become very complex. We need to transform services to help us respond to rising demand.

Why we need to change – improving health and wellbeing

Access to good quality education, housing and employment alongside social inclusion and a healthy environment all have a significant impact on people's health and wellbeing. Many illnesses, such as heart disease and diabetes can be prevented or improved by addressing lifestyle factors such as smoking, alcohol consumption, lack of physical activity and obesity. Social factors such as poverty, loneliness and substance misuse also have an impact on mental health.

To improve everyone's health and wellbeing and for services to be sustainable, we need to enable people to live their lives well, promote independence and prevent disease, not just treat it. We can do this to a certain extent through initiatives such as cancer screening programmes. We also need to strengthen collaboration between public health, other council departments such as housing, leisure, education and planning and our partner organisations to encourage everyone to take more responsibility for managing their own care.

Why we need to change – putting the individual at the centre of the services we provide

Navigating the health and care system can be complicated and confusing. People tell us they want to receive care locally or in their own home wherever possible, and experience joined-up care, regardless of who is caring for them. They want health and care services that are well-coordinated and available for early intervention so they can get help at an early stage to maintain independence and avoid a crisis at a later time.

Our area – challenges and opportunities

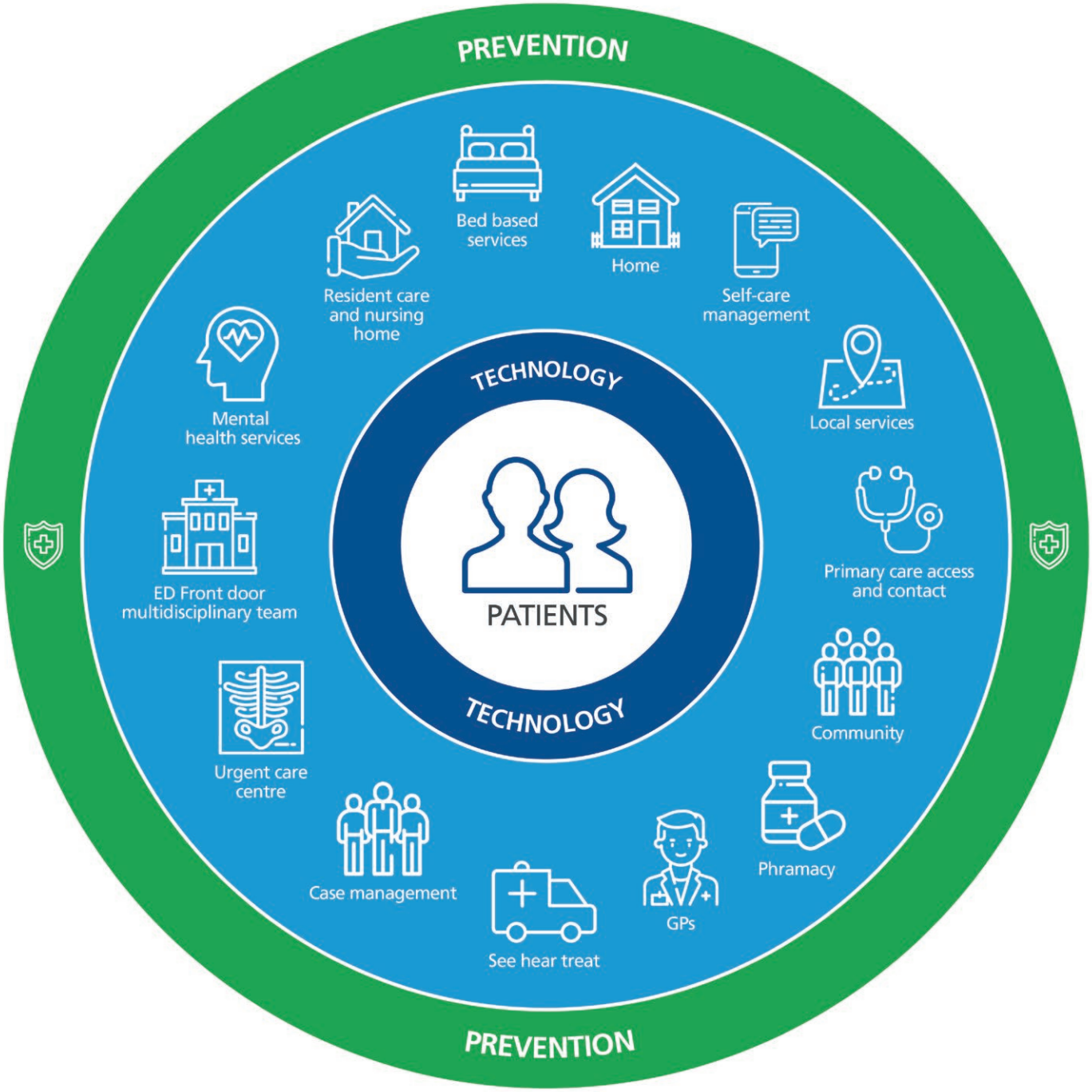
People are living longer and need a wider range of health and care services over a longer period of time. The diagram above – created by the King's Fund in 2014 – illustrates how our health and care system could be better engineered to look after an ageing population. But care can be disjointed across different organisations and our workforce is not equipped to handle the increased demand. It is essential that this disconnect between our health and care service providers, as well as with our wider mental health services, is addressed so we can offer a truly seamless approach.

The system wide impact of these drivers for change is seen across all our services which are under extreme and increasing pressure in urgent, primary, community, mental health and social care. The overall picture is simple: unless we fundamentally change the way we operate, all of our services will become unsustainable.

Our proposed care model for BSW

With the shift to system-wide working, there will be changes to how health and care services are delivered. We have the opportunity to develop a new collaborative model of care for BSW that provides people with best practice care and services.

The integrated model of health and care described below is the first step in that process. We also need to sharpen our focus on continuous quality improvement and continue to develop a transformational learning culture to facilitate more collaborative approaches to solving shared problems. The model of care described here will operate at a place-based level. These systems will be built around Primary Care Networks (PCNs) supporting populations of between 30,000 and 50,000 while providing proactive, integrated care and strengthened, enhanced primary care.



Our proposed care model for BSW

The model on the previous page is the basis for our integrated health and care strategy. The patient is at the centre of our model, surrounded by our different services.

- Our model starts with the individual and looks to place prevention at the heart of everything we do. We will do this through encouraging healthy living, reducing levels of smoking and alcohol consumption and encouraging weight loss
- Self-care and self-management also form a central part of the story and are underpinned by self-care technology and domiciliary care
- Local services play an important role, including specialist services, community groups, health and wellbeing ambassadors, palliative care, rapid assessment services and mental health services being available to people near to where they live
- Primary care also plays a role through the foundation of strong, inter-connected Primary Care Networks offering a wider range of roles including clinical pharmacists, social prescribers, paramedics and physiotherapists
- Wider support will also be provided by social care and mental health teams focused on adults, children and young people, palliative care and community nurses
- Our advanced practitioners and multi-disciplinary teams provide support through case management, while our ambulance service is central
- Our urgent treatment centres (UTCs), walk-in centres and minor injury units will see those who need urgent medical attention
- In our emergency departments, mental health liaison services for adults, children and young people will play an important role
- Finally bed-based, mental health and nursing homes will provide services to those in need.

In real terms, we anticipate services will be arranged and provided along the following lines:

On a Primary Care Network level

- Health and care professionals will work together and involve voluntary sector partners and community groups to support social, physical and mental health based around GP practices in an area covering populations of between 30,000 and 50,000
- Local people will be supported and given the help and support they need by health and care professionals so they can keep themselves fit and healthy

On a local level (place based)

- Care will be delivered, managed and planned locally
- Local people will be seen as partners and encouraged to support one another
- Community providers, community groups and local teams including GPs and primary care teams will work with local people, pooling resources to achieve greater improvement in outcomes and efficiencies

On a system level

- BSW will plan care across the region, sharing good practice, staff skills and buildings
- We will ensure we have the best approach to our workforce for the future through developing and supporting our staff and making BSW a desirable place to work
- We will create a BSW Academy for quality improvement methodology and training to enable partner organisations to learn together, collaborate and solve problems
- Our hospitals will work together to offer the best possible treatment
- We will make the best use of all available staff and their combined expertise
- We will work across the region to improve performance in areas such as mental health, cancer, stroke and urgent care.

To enable the delivery of this integrated approach, we have developed three interventions to deliver the key aspects of the new care model and create the infrastructure needed to move care out of hospital and other bed-based locations into peoples' homes. Primary Care Networks will be central to the delivery of this approach.

Comprehensive assessment

Risk stratification identifies people who are frail or becoming frail, and therefore at risk of being admitted to hospital. Comprehensive assessment enables a care plan, owned by the individual that outlines possible avenues for escalating care when it is required, to be put in place.

Main point of contact (single point of access)

One phone number will make getting additional support when it is needed as easy as possible. It will be connected to a comprehensive rapid response service.

Comprehensive rapid response (assessment and care at home) service

Assessment within an agreed timeframe to help people to remain at home with support, rather than referral to a hospital for assessment and the possibility of admission. Where hospital assessment and admission is unavoidable, additional support will be provided that makes it safe for the person to return home as soon as possible. This will include health and care professionals delivering rehabilitation alongside traditional care to enable people to stay at home.

Priorities

We will spend more time and effort helping people to stay well, act early to prevent ill health and get support.

Where care and treatment is required, we will work to ensure it is joined up and based on what matters most to the individual.

Our priorities will be approached through life stages programmes:

Early life including maternity, children and young people: Making sure everyone gets the best start in life.

Staying healthy: Delivering world-class care for major health problems and improving participation in screening programmes, particularly in lower-income populations.

Later life: Supporting people to age well until the end of life.

Priority1: Improving the health and wellbeing of our population

Prevention – Improving health and wellbeing

Prevention is a key theme of this strategy and BSW is well placed to play a much greater role in helping local people to be healthy and live well.

Including prevention and wellbeing as a clinical priority has direct benefits. Reducing demand through early intervention by our Primary Care Networks, particularly on people needing emergency treatment, allows staff within our hospitals to focus on providing healthcare to people whose needs are urgent, complex and best met in a hospital setting.

Wider action on prevention will help people across BSW stay healthy, happy and take better care of themselves. This approach is a complement to - not a substitute for - the important role of individuals, communities and local authorities in shaping the health of people across our region.

In BSW, we will have a specific focus on a preventative approach which covers a wide range of areas including smoking, mental health, sexual health, alcohol, obesity, diabetes and cardiovascular disease. The voluntary sector and community groups will play a crucial role in reinforcing and helping to spread our important prevention messages to local communities.

Involving people in their own care and sharing decision making

Evidence tells us that supporting people to be actively involved in their own care and treatment can improve health outcomes and overall experience of care.

Through an approach based on shared decision making, we will ensure that patients are supported to make decisions that are right for them. This will involve a collaborative process in which a clinician supports a patient to reach a decision about their treatment. These conversations will bring together the clinician's expertise, such as treatment options, evidence, risks and benefits and the patient's preferences, personal circumstances, goals, values and beliefs.

The health and care system across BSW will make a commitment to become much better at involving individuals and their carers in their own care in the following ways:

- Ensuring patients have access to the information they need in order to make decisions about their care and the opportunity to discuss and share their decisions with everyone involved in their care
- Supporting people to improve their health while also giving them the best opportunity to lead the life that they want
- Developing patient engagement and self-management by improving access to health records, offering access to health information in an interactive way and signposting into peer and support groups.

Person-centred care supports people to develop the knowledge, skills and confidence they need to effectively manage and make informed decisions about their own health and care. It is coordinated and tailored to the needs of the individual, as well as health and care professionals who work collaboratively with the people who use the services.

We will work towards involving patients in their own care by:

Supporting self management and self care

We will encourage people as much as possible to protect their own health, through choosing appropriate treatments and managing long-term conditions independently or in partnership with the healthcare system. For example through supported self management for cancer patients.

Enabling people to make informed health decisions

Poor health literacy – a lack of knowledge, skill, understanding and confidence to make decisions about health – limits opportunities for vulnerable and disadvantaged groups to be actively involved in decisions about their health and care. Giving people more control of their own health through greater understanding will be a core element of our approach to delivering truly integrated health and care.

Personalised care and support planning

By encouraging our patients to access facilitated conversations to ensure they are getting the care that's right for them, we will ensure they get the treatment and outcomes they need, leading to improved chances of success.

CASE STUDY

Diabetes prevention: helping people to manage their own health

People at risk of developing Type 2 diabetes are being encouraged to take control of their health thanks to a support programme running across B&NES, Swindon and Wiltshire.

The National Diabetes Prevention Programme is a free, nine-month course designed to help people become more active and enjoy a healthier way of living targeted at those at risk of developing the condition.

The programme offers a chance to join a local group, each of which can support up to 25 people. Currently the course can be accessed by those aged 18 and over who have not already been diagnosed with diabetes, are not pregnant and are physically able to take part.

Around 59,000 adults in BSW are at risk of developing the condition – and all of them are eligible to attend the programme. Around 7,000 people from the area are already taking part in the course.

Patient view:

"The course provided information about what was right and what was wrong, and how to make the correct choices, but it was done in such a way that it made you really want to do it. I've lost more than a stone and people keep telling me how great I'm looking. I keep telling others about it."– Janet Tooze, Swindon

Tackling health inequalities

People from our more vulnerable communities experience health inequalities which impact on their life expectancy and healthy life expectancy. We know that levels of smoking, obesity, alcohol abuse and mental health issues are significantly higher in our areas of deprivation and among our more vulnerable communities.

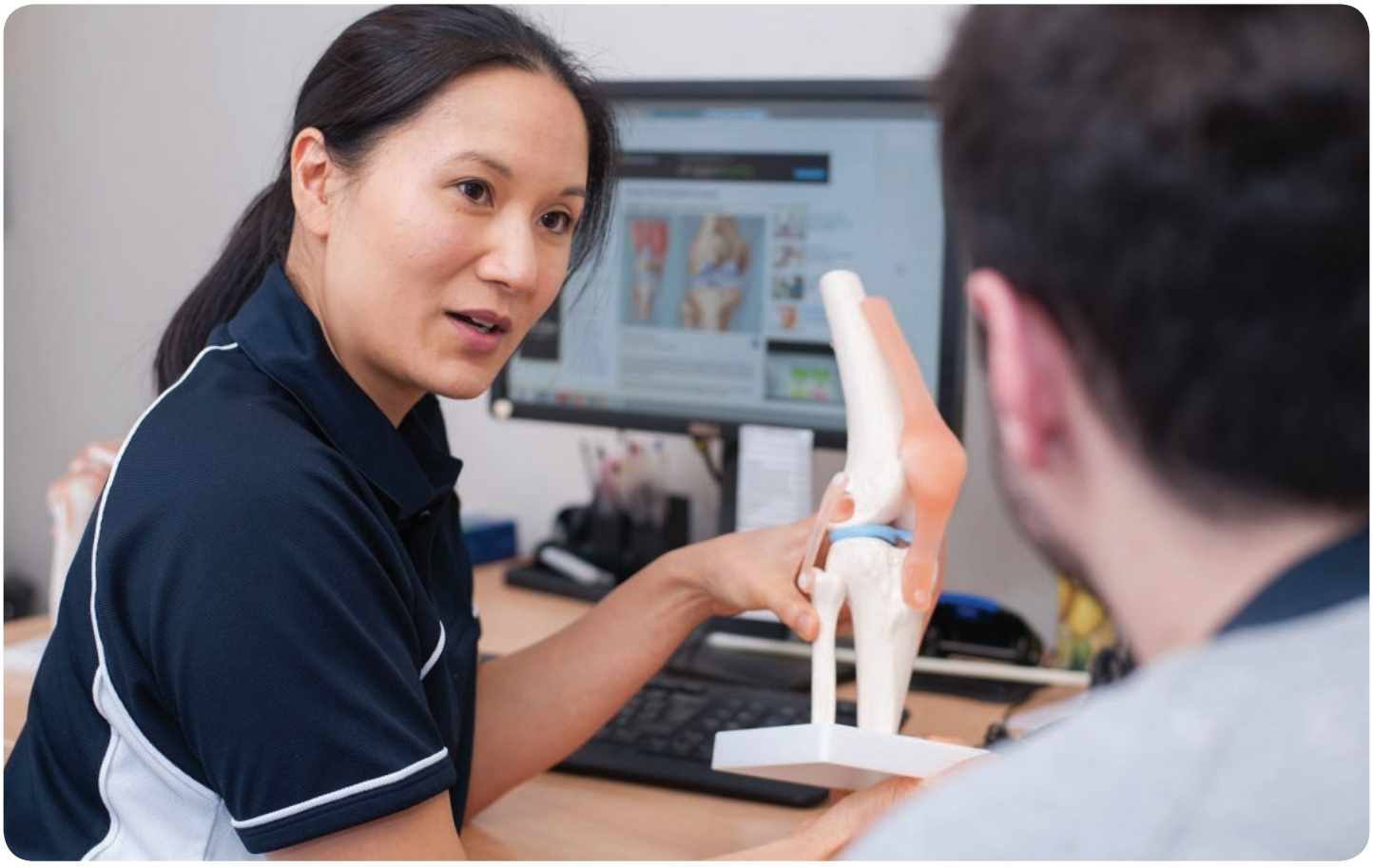
This can be tackled across BSW, in part, through the adoption of a Health in All Policies approach. Formalising and implementing this across BSW will systematically and explicitly take into account the health implications of the decisions

made across the system; target the key social determinants of health; look for synergies between health and other core objectives and the work we do with partners and try to avoid causing harm with the aim of improving the health of the population and reducing inequity.

Through "social prescribing" we will connect people – through link workers – to community groups and other services that can play a role in improving their health and wellbeing, for example running or walking groups to help with weight loss.

BSW will look to tackle health inequalities by:

- Working to reduce the gap in life expectancy and healthy life expectancy
- Looking to increase the uptake of health checks with a particular focus on our more vulnerable and at risk communities including adults, children and young people living with severe mental health problems
- Investing to ensure that children with learning disabilities have their need met by eyesight, hearing and dental services as part of their general screening services
- Establishing a rough sleeping pathway to address housing and finance
- Embedding Making Every Contact Count and Connect 5 behaviour change programmes into key organisations across BSW
- Extending and promoting our Healthy Schools programme
- Focusing on delivering targeted and bespoke support to our diverse population including black, Asian and minority ethnic people, carers, homeless people, people with mental health conditions, routine and manual workers, military personnel and their dependants
- Addressing the poor outcomes experienced by mental health service users



CASE STUDY

Falls Rapid Response Trial: reducing further falls and avoiding hospital admission

An initiative underway in B&NES bringing together health and care services is aiming to reduce falls, improve response time and cut down unnecessary hospital admissions.

The Falls Rapid Response Team, which includes a specialist paramedic and an occupational therapist, will respond to up to four B&NES patients per day if they have contacted the emergency services for assistance after a fall. The team will help the person get comfortable, carry out a home-based falls risk assessment and recommend any necessary interventions that could help prevent future falls.

The new service also aims to support independence and reduce the risk of further falls that could result in more serious injury or admission to hospital. Any immediate concerns will be addressed using a range of community and hospital services to offer the most appropriate support.

The pilot is the result of collaboration between BaNES CCG, South Western Ambulance Service NHS Foundation Trust (SWASFT), Virgin Care – who deliver health and care services in B&NES – and Bath's Royal United Hospital.

Priority2: Developing sustainable communities

Integration and primary care

Primary care is the cornerstone of our clinical approach and we will seek to meet the aspiration of the NHS Long Term Plan to finally dissolve the historic divide between primary and community health services. We have 94 GP practices serving a combined population of 941,000 people. Our clinical approach in BSW will be based around the development of Primary Care Networks.

Primary Care Networks build on the core of current primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care. They represent a sea-change from reactively providing appointments to proactively caring for people and communities. Where emerging primary care networks are in place in parts of the country, there have been clear benefits for patients and clinicians.

Every practice in BSW will be part of a Primary Care Network. These networks will be based on GP registered lists, typically serving communities of between 30,000 to 50,000 people. They should be small enough to provide the personal care valued by both patients and GPs, but large enough to have impact and economies of scale through better collaboration between practices and others in the local health and social care system.

Our practices will be strong and resilient practices working in Primary Care Networks and will strive for closer integration with other community services, the voluntary sector and secondary care. Thanks to the promise of fresh funding as part of the NHS Long term Plan, our primary care services will develop as part of expanded community multidisciplinary teams aligned with new Primary Care Networks.

Our expanded neighbourhood teams will comprise a range of staff such as GPs, pharmacists, district nurses, community geriatricians, dementia workers and allied health professionals (AHPs) such as physiotherapist, podiatrists and chiropodists, joined by social care and the voluntary sector.

We will build on the success of programmes already under way in BSW to improve access to primary care through longer opening hours including evening and weekends. To deliver this, we will develop a BSW wide approach, tailored to differing place needs, of Primary Care transformation. We will set common characteristics for PCNs and provide tools and support for them to develop. We see them at the heart of a revised health and care delivery model for BSW.

Integrated Care Alliances

To help people remain healthy and live in their own home while avoiding unnecessary admissions to hospitals and care homes, services need to be available to support those which require specialist support in their community.

Over the past decade, a consistent health and social care policy has been to encourage a greater range of care to be delivered outside the walls of the traditional district general hospital and care homes. This was consolidated in the Health and Social Care Act 2012 and there has been a policy shift towards integration ever since.

BSW will strive to support people more within their own communities, chiefly by putting the individual at the centre of services. By doing this we will drive improvements in the quality of clinical and local authority-provided care so, as much as possible, we can help people to avoid going into hospital. Although our key concern is always the patient, this strategy will have a knock on effect in terms of reducing the mounting pressure on our acute hospitals.

Our Integrated Care Alliance will also help to facilitate more personalised support in the community, help people to live more independently, help all of our services work more closely together and develop and utilise a wide range of new clinical and technological tools which are outlined in BSW's Digital Strategy.

This part of the strategy highlights areas across the system that can be delivered using care services and interventions that do not require attendance or admission to hospital. Using services already available in the community, such as primary care services, community pharmacists, social services and third sector services means that individuals can be supported to stay well and at home.

The strategy highlights activity and service areas that are currently commissioned to support these pathways, but also identifies areas for future development and possible integration opportunities to enhance pathways.

Priority 3: Sustainable secondary care services

Integration and secondary care

The core functionality of secondary care, to treat those with urgent problems and needing planned and specialist care, will remain the same in BSW's integrated health and care strategy but the 'front' and 'back' door of hospital based services will focus on making sure patients are triaged and discharged in a way which supports outcomes while also reducing avoidable admissions and stays in hospital. We will look to improve planned care through shorter waiting times, more streamlined pathways and better communication between the hospital, patients and GPs.

Our emergency care system is under pressure and undergoing a period of profound change. The number of Emergency Department (ED) patients successfully treated within four hours is around 100,000 per month higher than five years ago. New ways of delivering urgent care such as UTCs are growing far faster than hospital ED attendances. For those that do need hospital care, emergency admissions requiring an inpatient stay are increasingly being replaced by same day emergency care. That, alongside successful action to reduce delayed hospital discharges, means the number of inpatient emergency bed days is now actually falling.

By expanding and reforming urgent and emergency care services across BSW we can ensure people get the care they need fast, relieve pressure on ED and better manage increased demand for services over the winter period. Once again, our Primary Care Networks will also shoulder some of this responsibility, looking to relieve pressure on ED, where they can, through early intervention.

The NHS Long Term Plan has promised to embed a single multidisciplinary Clinical Assessment Service (CAS) within the integrated NHS 111, ambulance dispatch and GP out of hours services from 2019/20. This will provide specialist advice, treatment and referral from a wide array of health and care professionals, encompassing both physical and mental health supported by collaboration plans with all secondary care organisations, which will help relieve pressure on acute services in BSW.

We will look to our UTCs to provide a consistent offer for out-of-hospital urgent care, with the option of appointments booked through a call to NHS 111. UTCs will work alongside other parts of the urgent care network in BSW, including primary care, community pharmacists, ambulance and other community-based services, to provide a locally accessible and convenient alternative to ED for people who do not need to attend hospital. Improvements for callers to NHS 111 will also allow them to book GP appointments directly, be referred to self-management or to a pharmacy.

Ambulance services are at the heart of the urgent and emergency care system. We plan to put in place timely responses so people can be treated by skilled paramedics at home or in an appropriate setting outside of hospital.

For those who are treated in our hospitals, we will work to ensure they receive the best possible care in the shortest possible timeframe. For people who arrive in ED following a stroke, heart attack, major trauma, severe asthma attack or with sepsis, we will further improve patient pathways to ensure timely assessments and treatments that reduce the risk of death and disability.

Finally, we will ensure our health and care partners will work together to get more people home without unnecessary delay when they are ready to leave hospital.

CASE STUDY

Home First initiative: reducing length of stay

The Home First scheme was launched by the Royal United Hospitals Bath NHS Foundation Trust in 2017. It aims to reduce the length of stay for patients who are clinically well enough to leave hospital, but who might need extra support to return to their usual place of residence. Home First is a partnership of organisations that includes the RUH Bath NHS Foundation Trust, Wiltshire Council, Wiltshire Health & Care, Medvivo, Virgin Care, Age UK Bath, Somerset Partnership NHS Foundation Trust and Somerset County Council.

How it works

Patients are only discharged when the ward team have completed the necessary checks to make sure they are medically-fit. Once at home, the patient is met by a therapist and reablement worker who immediately provide a detailed assessment and organise support for up to six weeks to help the patient regain the skills and confidence to live at home independently – rather than stay in hospital. Health and care partners across the region have agreed a common aim for Home First – to minimise hospital stays and maximise independence.

Since October 2017 Home First has been supporting up to 25 patients every week, including weekends, to return home and regain their independence.

Patient view:

"I had no idea how good the service was going to be. I cannot speak highly enough of the whole team, who were competent, caring, compassionate and professional. They put me and my family all at ease and, at a time when my health was still fragile, made it possible for me to receive convalescent care and support in my own home."

– John Over

Next steps

This year presents a number of significant opportunities for BSW to set its sights on the future and move forward with its triple aim of improving health and wellbeing, the experience of care and cost effectiveness.

During 2019, we will deliver a bold and forward-looking five year plan which will set out the system-wide objectives and vision for the future of integrated health and care across the BSW footprint. Drawn from the NHS Long Term Plan, our own plan will ensure health and care across BSW has a bright future.

Our integrated health and care strategy will form a key part of our five year plan and we will embark on a programme of engagement with clinicians, stakeholders, partners and members of the public to ensure their views, hopes and aspirations are included in our vision for the future.

Further engagement will also take place during the development of this clinical strategy and our five year plan, so individuals and organisations across BSW continue to have the opportunity to influence the final plan up to its publication.

To send us your feedback, please get in touch with by sending an email to bswstp.communication@nhs.net.

Health and care organisations across Bath and North East Somerset, Swindon and Wiltshire are working together to improve health and care for everyone. For more information:

Visit: www.bswstp.nhs.uk

Email: bswstp.communication@nhs.net

Twitter: @BSW_STP

Facebook: @BSWourhealthourfuture

NHS Bath and North East Somerset Clinical Commissioning Group

NHS Swindon Clinical Commissioning Group

NHS Wiltshire Clinical Commissioning Group

Bath & North East Somerset Council

Swindon Borough Council

Wiltshire Council Where everybody matters

NHS Great Western Hospitals NHS Foundation Trust

NHS Royal United Hospitals Bath NHS Foundation Trust

NHS Salisbury NHS Foundation Trust

NHS Avon and Wiltshire Mental Health Partnership NHS Trust

NHS Health Education England

NHS South Western Ambulance Service NHS Foundation Trust

virgincare

Wiltshire Health and Care

WESSEX Local Medical Committees Incorporating Wessex LEaD

healthwatch Bath and North East Somerset

healthwatch Wiltshire

healthwatch Swindon

West of England Academic Health Science Network

Produced By: Bath and North East Somerset, Swindon and Wiltshire Partnership
Published: July 2019