Bath & North East Somerset Council

Improving People's Lives

Health and Wellbeing Board – Informal Meeting

Date: Tuesday, 22nd June, 2021
Time: 10.30 am
Venue: Zoom Online - Private

Members: Dr Bryn Bird (Clinical Commissioning Group), Councillor Dine Romero (Bath and North East Somerset Council), Cara Charles Barks (Royal United Hospital), Councillor Alison Born (Bath and North East Somerset Council), Corinne Edwards (Clinical Commissioning Group), Alison Elliott (Bath and North East Somerset Council), Sara Gallagher (Bath Spa University), Andrew Girdher (Clinical Commissioning Group), Will Godfrey (Bath and North East Somerset Council), Paul Harris (Curo), Nicola Hazle (Avon and Wiltshire Partnership Trust), Mary Kearney-Knowles (Bath and North East Somerset Council), Steve Kendall (Avon and Somerset Police), Stuart Matthews (Avon Fire and Rescue Service), Kate Morton (Bath Mind), Anthony Payne (University of Bath), Rachel Pearce (NHS England), Laurel Penrose (Bath College), Rebecca Reynolds (Bath and North East Somerset Council), Vanessa Scott (Healthwatch), Val Scrase (Virgin Care), Dr Andrew Smith (BEMS+ (Primary Care)) and Richard Smale (Clinical Commissioning Group)

Observers: Councillor Robin Moss (Bath and North East Somerset Council)

Other appropriate officers
Press and Public

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Health and Wellbeing Board - Tuesday, 22nd June, 2021

at 10.30 am - Zoom Online - Private

A G E N D A

1. WELCOME AND INTRODUCTIONS

2. APOLOGIES FOR ABSENCE

3. DECLARATIONS OF INTEREST

   At this point in the meeting declarations of interest are received from Members in any of the agenda items under consideration at the meeting.

   (a) The agenda item number in which they have an interest to declare.

   (b) The nature of their interest.

   (c) Whether their interest is a **disclosable pecuniary interest** or an **other interest**, (as defined in Part 2, A and B of the Code of Conduct and Rules for Registration of Interests)

   Any Member who needs to clarify any matters relating to the declaration of interests is recommended to seek advice from the Council's Monitoring Officer or a member of his staff before the meeting to expedite dealing with the item during the meeting.

4. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

5. MENTAL HEALTH TRANSFORMATION PLAN (Pages 3 - 18)

   To receive a presentation regarding the Mental Health Transformation Plan.

   10.35am – Lucy Baker – 30 minutes

6. HEALTH NAVIGATORS - CURO (Pages 19 - 28)

   To receive a presentation from Paul Harris regarding the Curo Navigator model.

   11.05am - Paul Harris – 30 minutes

7. SHAPING A HEALTHIER FUTURE (Pages 29 - 44)

   To receive a presentation regarding the Shaping a Healthier Future Programme.

   11.35am – Simon Cook and Geoff Underwood – 30 minutes

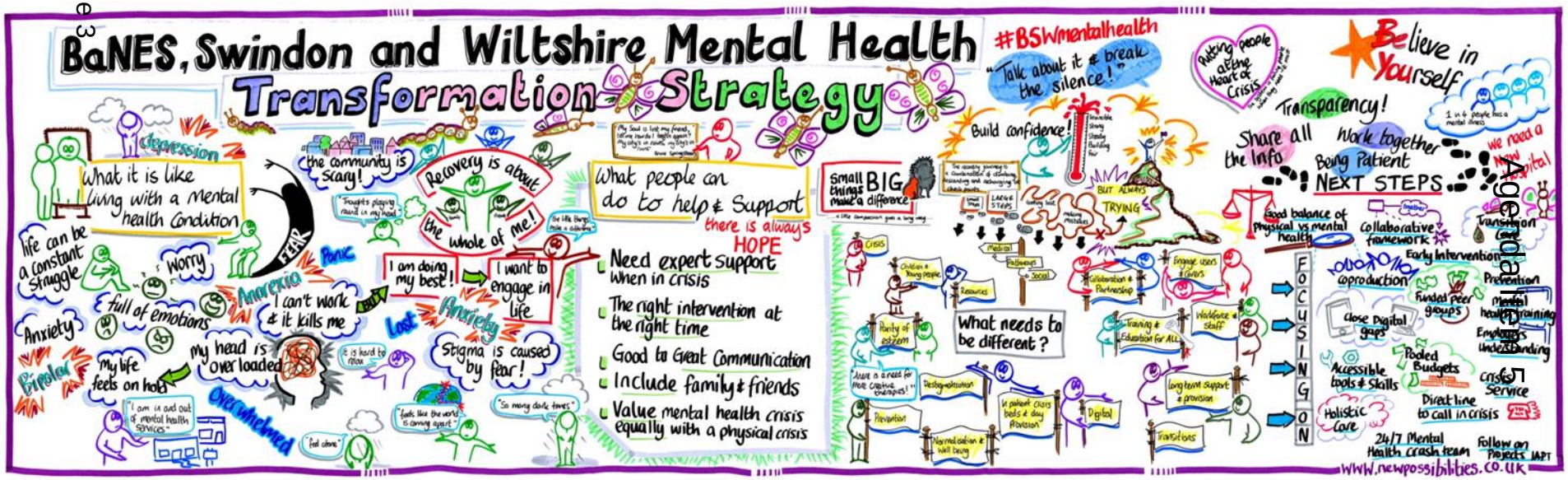
8. DATE OF NEXT FORMAL MEETING

   To note that the next formal meeting will take place on 28 September 2021 at 10.30am.

All Age Mental Health and Emotional Wellbeing Update

B&NES Health and Wellbeing Board

June 22nd 2021



Where are we now ?

- Need to improve early access and referral process – make getting support easier for people
- MH referrals are increasing as lockdown has eased
- Increase in emotional wellbeing presentations. Increased anxiety in communities –including parental and family anxiety. Impact of wider determinants of MH such as housing, employment, family breakdown, bereavement
- Increase in acuity across all age and all services – hot spots include LD/ASD, CYP particularly eating disorder, psychosis presentations
- National shortage of PICU beds – BSW reduction due to urgent safety work. Additional beds commissioned by AWP to mitigate risk
- National shortage of CYP tier four beds – NHSE and national work to explore alternatives
- Workforce risks
- Requirement to transform at pace - new drivers for change including community MH framework, crisis alternatives and THINK FIRST 111
- **Understanding what people, families and staff have thought of the changes**

What have people told us ?

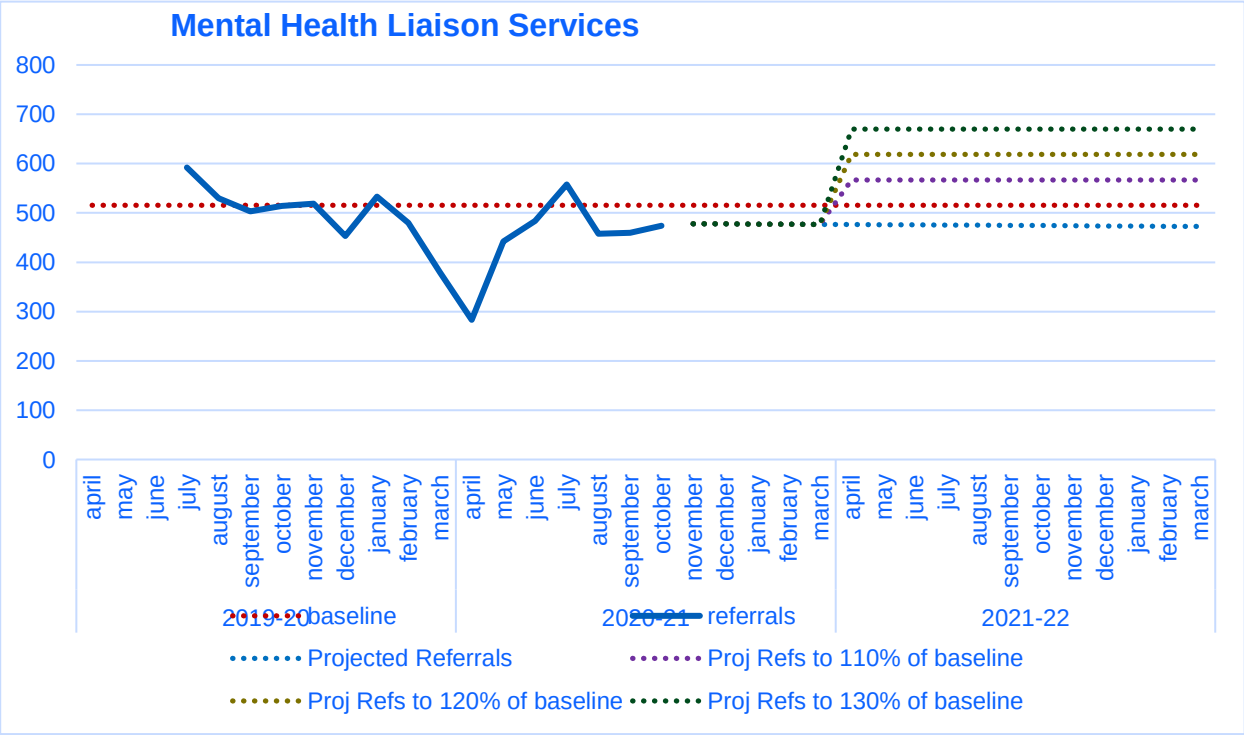
Listening event held to understand views of people, families, carers, supporters and our staff

Key Messages

- Current offer is inconsistent and one size does not fit all – some really great experiences and some not so good
- People miss face to face and human contact – if some cant get this they will present to hospital or police as they know they will be seen
- People feel its left to them to reach out for help
- People feel organisations are not talking to each other and feel that they can slip through the gaps
- People don't all know about what support is out there particularly around early intervention and prevention
- Staff feel they are being referred people that they cant treat 'I can't fix their finances, find them a job or bring their family back together'
- Better offer requested for people who feel digitally excluded needed
- Staff on journey – new ways of working, increased flexibility but having to adjust to working in different ways. Not all assessments can be carried out virtually

What are we doing together ?
Understanding Demand and Capacity

- Need to understand what future MH demand looks like for BSW system and at locality level to help us plan and prioritise – particular focus on how Covid has impacted on the wider determinants of MH and people's emotional wellbeing
- Using CREST to develop a detained view of demand scenarios – second drafts currently being developed



Working in partnership in B&NES

- **Wellbeing House** – re focused to provide step up and step down. Curo in partnership with Bath Mind. Q 4 20/21 - 60 referrals and 24 people housed. 100% occupancy over the enhanced 7 day service. 77 people supported n total to date

- **Breathing Space** (Place of Calm) Bath Mind. Initially opened at telephone line 7 eves a week. Q4 20/21 85 referrals, 65 of which were through agencies/services and 20 of which were self-referrals. 891 phone call sessions. Total 112 face to face contacts since 13/04. 2,874 telephone contacts in 12 months

- **New Intensive Outreach support** – Provided by Bath Mind. 10 people supported since April

- **Third Sector Mental Health Discharge allocation in B&NES -** used to support:
  - Bath Mind & Off The Record providing a Fast Track / Early Access service focusing on customers in Curo's homelessness services and others in supported accommodation. Bath Mind supported 9 people, an average of 18 hours of support per week (92% of which was face to face).

  - St Mungo's - floating support dedicated to discharge / prevention linked to the AWP Recovery team to support those on the waiting list and to support some less acute clients on Recovery caseloads - actively worked with 9 clients with a current total of 31 direct support hours per week at peak.

Working in partnership continued

- **Crisis Alternatives funding – Bath MIND outreach IN B&NES**
  - non-clinical person centred intensive outreach for 60 individuals across B&NES, Swindon and Wiltshire in Year 1 (2021/22) and Year 2 (2022/23) increasing to 160 in Year 3 (2023/24).
  - It is a step-up and step-down service within people's own homes and / or within supported living and provides wrap-around support for 6 weeks.
- **Community Wellbeing Hub** Virgin Care in partnership with 3SG, the CCG and the Council. The Hub has provided a single point of access for community response and provides the most appropriate, joined-up intervention for anyone seeking support or guidance esp re COVID-19. Response teams include; food support, welfare support, mental wellbeing (led by Bath Mind), housing support and physical wellbeing advice. Since 20th March to 5th January 2021 the service has supported over 10, 300 calls into Triage and 69% of calls are resolved at this stage.

- **B&NES Council** - invitation to providers to participate in whole-system design for the provision of specialist mental health outreach / community support, supported living and residential care which will align with the implementation of the community services framework.

Extended Use of our Community Wellbeing Houses

- Extended scope in partnershi between AWP and third secto
- Step up and step down to su admission avoidance and exp discharge – 188 people

"This place has been a saver to me. It also allo me to develop social sk my autism. I also feel m has been rested." "It ke alive and gave my wife break and some peace mind". "…before I came Wellbeing House I woul become unwell and go hospital. I now know the an alternative". "If I had come here I don't know would have done."

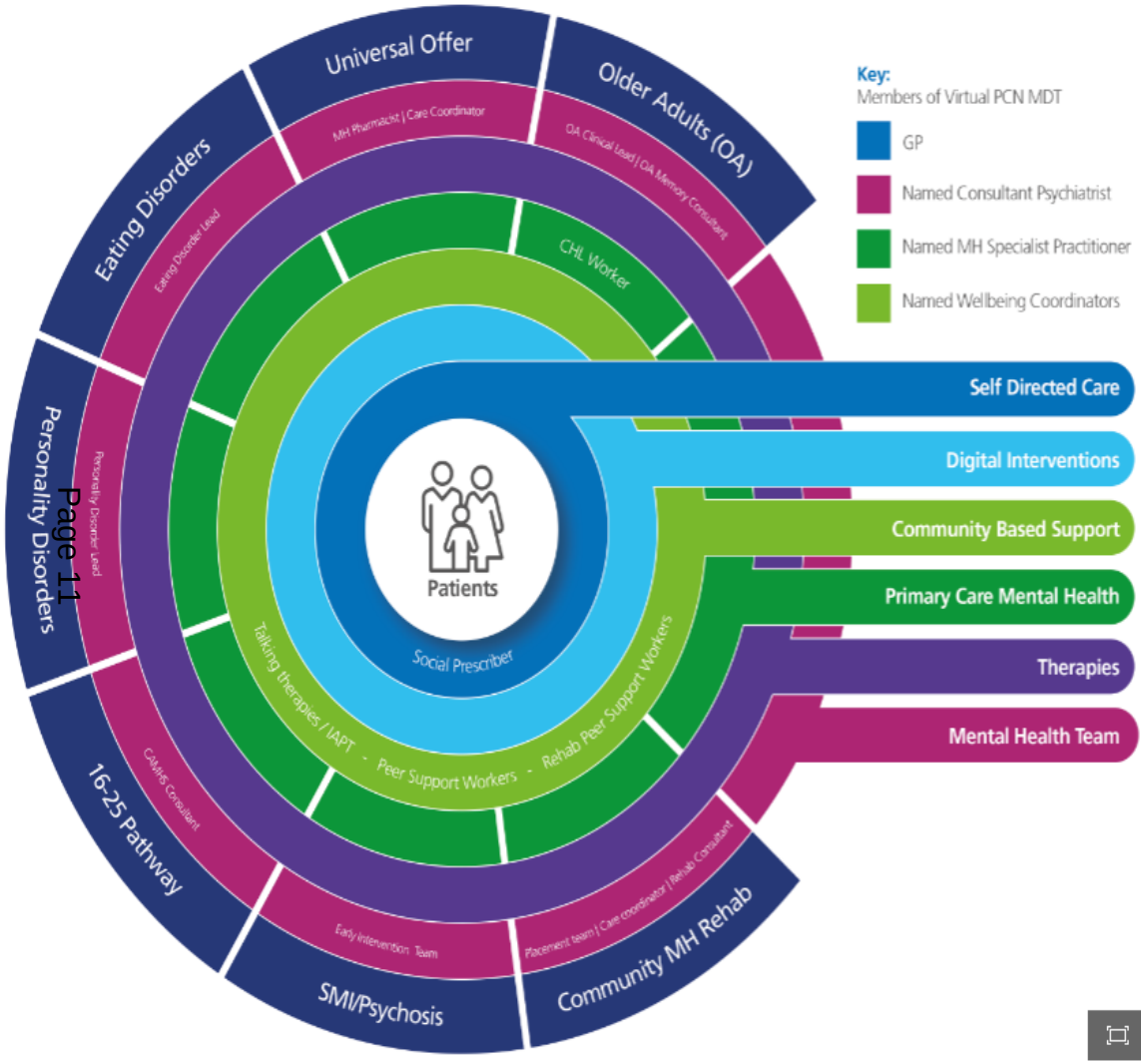
Foundations:

What are we doing together ?
Co-designing the future

- System response bringing partners and localities together to co-design our response to the national community MH services framework to meet needs of local people and supporting them in their local communities
- £10m new money for BSW over next three years. Vehicle for total redesign and transformation of community MH. Key elements include:

Early and timely access to the right support	No wrong front door	Open access - self-directed, GP, family/carer, or professional 'request' [vs referral]	Move from [often repeated] assessment to intervention and support
A seamless model of care through integrated working across primary, secondary health and social care, and the third sector; through "one team" partnership working along whole community pathway	Support and treat all levels of MH need and wider determinants	Enable development of individual and community resilience	Adopt a strengths-based approach in working with people
Outcomes focused and bespoke pathways of support based on self-directed need and preferences	Deliver revolutionary and people-centric change through self-directed support and intervention	Consistency of support	Cessation of cliff edges – needs led, warm hand overs and proactive follow up

What are we doing together ?



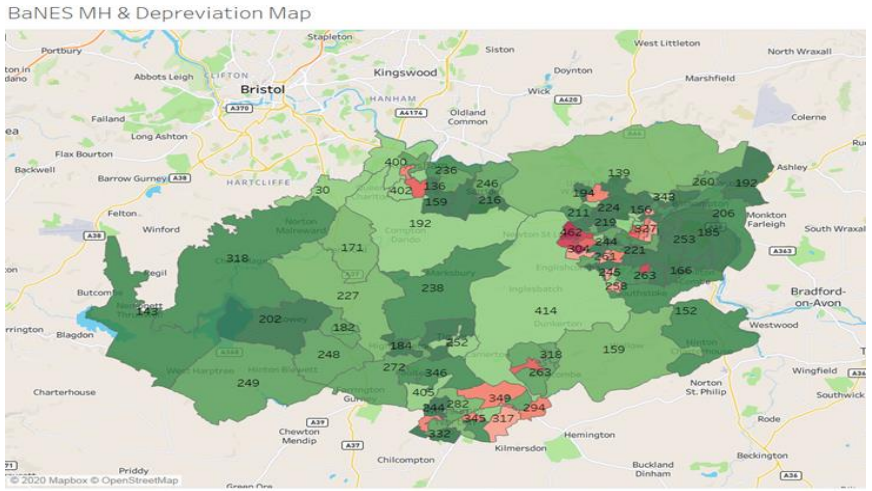
Next steps

- Submission approved May 2021
- Third sector recruitment
- CAP trainees
- Enhanced advice and guidance – early implementation
- Seven pilot PCNS across BSW moving to implementation planning
- **Co-designing how we get from what we have now to the espoused vision**

Community Framework next steps

The seven PCNs which will work more closely with us in year one of the transformation are:

- **Heart of Bath**
- **Bath Independents**
- Calne
- Westbury/Warminster
- Salisbury Plain
- Wyvern
- Brunel 4



Selection was made based upon the criteria/process laid out by NHSE, which was worked through with the following key areas:

- PCN demographic profile and population health information – BaNES example above
- Mixture of rural and urban geography, with representation across BSW
- Mixture of PCNs with established MH resourcing [such as PCN recruited RMNs], and those with none

Engagement events with all practices and PCNs to co-design improvements between now and new model – focus on emotional wellbeing and crisis. New offer for enhanced advice and guidance for primary care being co-designed at pace

Implementing the CSF in B&NES

- This is a transformation priority for B&NES.
- Re-launched the Mental Health Collaborative as the delivery group responsible for embedding collaborative working in B&NES. This will progress the Community Services Framework implementation. Those with an interest in the improved wellbeing for people in B&NES are welcome to join. Will consider the role of social care, housing and wider partners to tackle determinants of poor mental health.
- A series of task and finish groups will sit underneath the Collaborative to support local implementation.
- The Collaborative will regularly report into the B&NES Integrated Care Alliance and the Council Transformation Board.
- Our main locality responsibilities are:
  - Coordination of third sector elements
  - Asset mapping
  - Co-production and engagement
  - Any localisation needed (e.g. student population)
  - Locality communications

Working in Partnership

CAMHS Transformation:

- **Implementation of iThrive**
- **Expanding CYP eating disorders services**
- **CYP Crisis Resolution and Home Treatment Service**
- **Mental Health Support Teams in schools – further successful expansion bid**
- **Mental Health Helpline**
- **CAMHS in-reaching into children's services within Local Authorities to support vulnerable young people**
- **Flexible transitions and additional workforce to support 16 – 25 pathway**
- **Increased DBT offer**
- **Piloting additional digital workforce**
- **Positive Behaviour Support service model**
- **Workforce and new roles (development posts, apprenticeships, Consultant Mental Health Practitioners etc.)**

Making a Difference Together

He starts RO DBT informed sessions and is able to continue getting this with CAMHS until he is 19.5.

17.5 year ol to the GP w mum du emotio dysregulati disordered Signposted 25 hub

At the hub he is introduced to a peer support mentor. They spend some time in a relaxed and non-clinical environment reading magazines and finding out about support options.

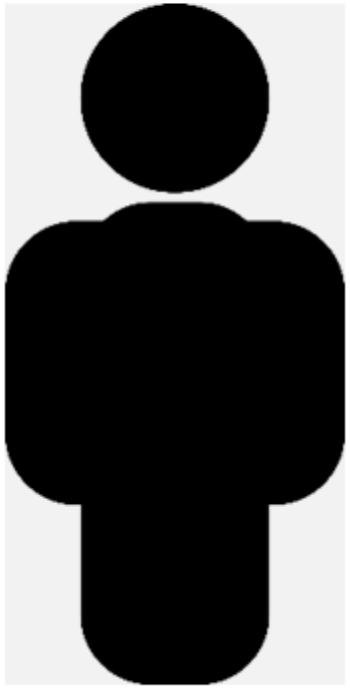
He is discharged aged 20, but knows how to get support from Adult Services if he needs support.

He is identified being in the ear stages of an eati disorder by a FREED worker. starts receivin evidence-base treatment with CYP ED team.

He is supported to apply for a part-time job and goes back to college, where he knows he can access mental health support

People at the heart of transformation

Current Pathway for 'personality disorder' patient



Distressed young woman presents at emergency department after self-harm incident. See by liaison psychiatry, referred to access service for assessment for secondary care services

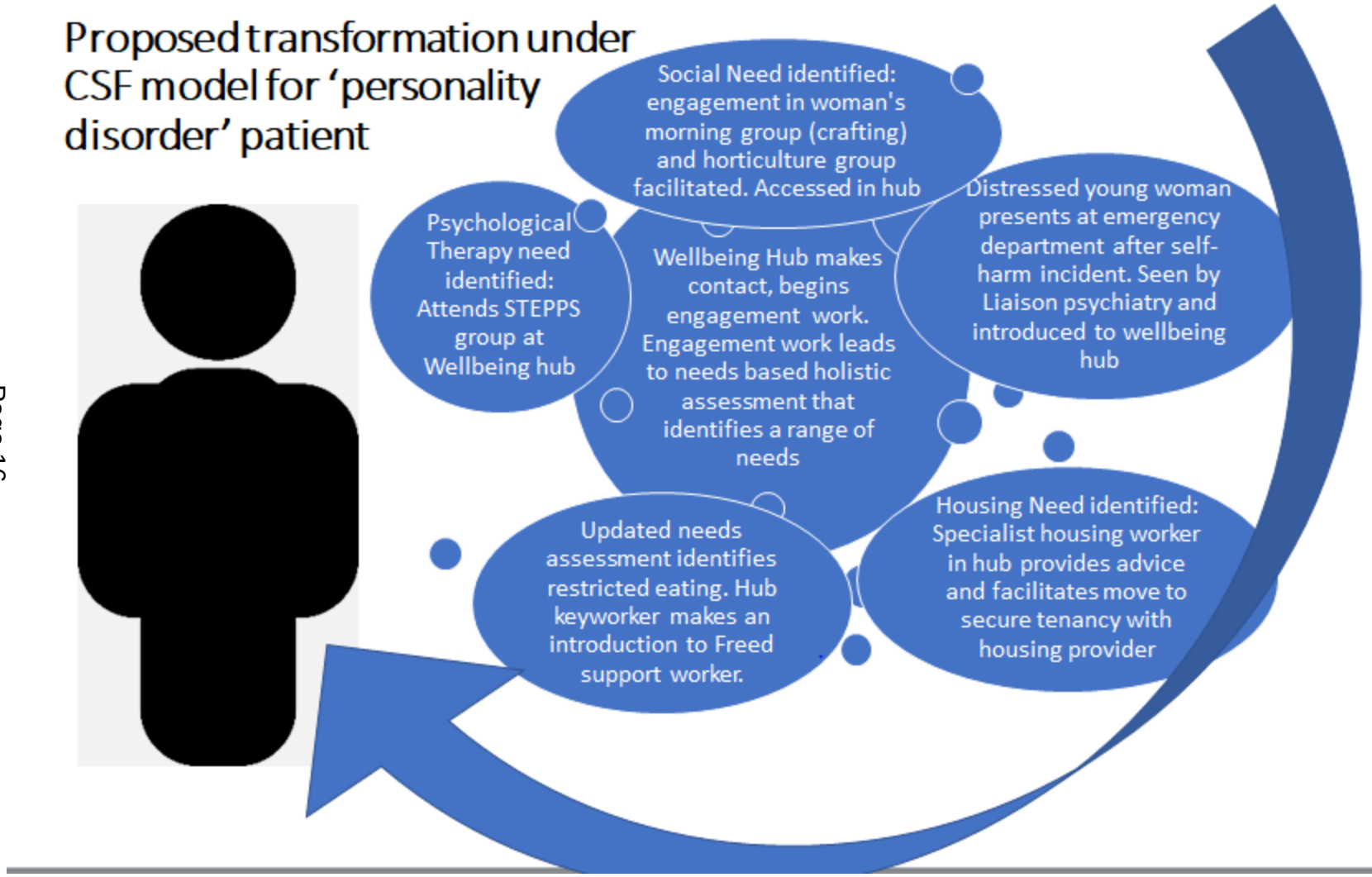
Access services conduct assessment, deemed possible EUPD traits but does not meet threshold for secondary care. No treatment available in IAPT, discharged to GP.

Distress increases, GP makes urgent referral to access service several months later. Assessed again, not deemed to meet threshold and discharged to GP

Ambulance called by flatmate after overdose, seen in emergency department, liaison psychiatry refers to Crisis team

On case load of crisis team for 4 weeks, risk management and brief intervention, crisis team refer to CMHT, referral not accepted, discharged to GP

People at the heart of transformation



Current system Lived Experience Perspective of SMI

Approaches & language

'You don't meet the threshold'

'That is not something we can help with'

'Sorry you are not eligible'

'You must call …. to get help'

'Your score is too low for our service'

'Sorry out of hours'

'Not engaging'

How it could feel to the person

This is all too much.. I don't want to lose it again

I try to get help but keep getting knocked back.

Every thing I have tried has failed, I feel even worse. What's the point?

New model – Lived Experience of SMI

Approaches & language

'My focus is your wellbeing, I will help you get the right help starting now.

'Let's work together to develop a plan that works for you'

'Here are some options you can consider'

'I can make appointments for you'

'Please call if you have any questions'

'If this doesn't feel the right support for you, let me know'

'There is evening support available'

How it could feel to the person

- I have met with my GP, within days I have a Wellbeing Practitioner, feel heard and valued.
- It is going to be a long journey but I don't feel alone.
- I feel more in control, informed, involved and understand the different elements of my care.
- I am listened to.

Bath & North East Somerset Council	
MEETING/ DECISION MAKER:	**Health and Wellbeing Board**
MEETING DATE:	**22 June 2021**
TITLE:	Navigators – Curo
WARD:	All
List of attachments to this report: Navigators – a case study (ppt)	

1 THE ISSUE

1.1 Residents / customers sometimes need more support than is available through publicly-funded channels, and struggle to navigate their way through our processes and services. This results in a small number of people taking up a hugely disproportionate amount of time, with little success.

2 RECOMMENDATION

The Board is asked to;

2.1 Share thoughts and feedback on the Curo Navigator model

2.2 Consider opportunities to align with or support the model more widely across BANES.

3 THE REPORT

3.1 For some time we have struggled to find the right level of support for some of our more complex customers, with social workers, mental health nurses and the local Crisis team often unable to help when situations worsen and customers struggle to engage with us constructively.

3.2 This has included regular crises involving young people at our homeless schemes, but also customers of all ages who have mental health or physical difficulties.

3.3 The ‘floating support’ model can work well for some customers but in addition to the resourcing challenges, many residents need help when they need it, not only at specific times when this support is usually planned.

3.4 Many of our customer-facing teams were finding themselves spending a huge amount of time managing problems with a small number of residents, and unable to provide the level of service we normally expect to other customers. In turn this has been having an effect on our colleagues' wellbeing and mental health.

3.5 Colleagues also found themselves in a position where a lack of support meant a difficult choice – to overstep the limits of our statutory and contractual obligations to a customer, or watch their health and situation deteriorate.

3.6 Equally, these customers were not getting their situations resolved easily, and were becoming more and more frustrated.

3.7 Our solution was to pilot a new service, called the Navigators. We recruited and trained two Curo colleagues into these new roles, and then asked our teams for candidates to be managed through this new service, starting with about 25.

3.8 The Navigators engaged with each candidate customer, explained what we would like to do and how it would benefit them – all agreed to take part in the pilot, which began in December 2020.

3.9 We also asked the customers to score themselves against a variety of criteria to use as a baseline to measure any improvement.

3.10 The Navigators are not statutory-level mental health practitioners or social workers, but they are able to take the time these customers need to really understand their problems and come up with solutions, while taking the pressure off our other teams. They have also been able to develop closer relationships with agencies and other third parties to whom some of the customers are referred or receive advice and support.

3.11 The results of the six-month pilot were better than we could have hoped. The improvement in customer wellbeing and all other metrics was massive, as was the amount of time saved for our operational teams (who have also reported a commensurate improvement in wellbeing). The relevant data is set out below:

- The average for 'Overall Satisfaction with Service from Curo' has risen from 4.25 pre pilot to 9.25 post pilot (mark out of ten).
- £64,351 of social value delivered across four completed cases so far.
- 110 hours of colleague time released into the business with 30 hours of colleague time saved per week when factoring in the Navigators contact time.
- Colleague wellbeing has increased from a 4 to a 9 (mark out of ten).
- £48-£108k of costs avoided linked to predicted disrepair cases.
- £26,819 of notional colleague costs saved, equating to £58,136 of savings per annum.

3.12 These customers also tend to take up a lot of energy and time from other organisations – such as the Council – but we have not attempted to measure this additional impact at this time.

As a result of this success, Curo has committed to funding these two roles permanently. It is possible the service will expand over time.

3.13 We felt this story was relevant to the Health & Wellbeing Board, and that some members of the group nay be interested in using this kind of model, or

potentially helping us expand it by aligning more closely with existing funding streams and resources across BANES.

4 STATUTORY CONSIDERATIONS

None

5 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

5.1 We have funded these two new roles (and backfill the colleagues).

6 RISK MANAGEMENT

6.1 A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

6.2 Curo undertook a risk assessment while setting up the pilot, and we put measures in place to ensure we could maintain the wellbeing of our colleagues carrying out such intensive support.

7 EQUALITIES

7.1 Curo has carried out an Equalities Impact Assessment, with no specific concerns or issues arising.

8 CLIMATE CHANGE

N/A

9 OTHER OPTIONS CONSIDERED

9.1 The only alternative was to continue with the situation as it was, or ask our teams not to step in when customers needed specialist support that wasn't forthcoming.

10 CONSULTATION

N/A

Contact person	Paul Harris 07802 666077
Background papers	None
Please contact the report author if you need to access this report in an alternative format	

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Navigators

A case study

www.curo-group.co.uk

Background

- Single male living in one bedroom apartment
- Issues with quality of property
- Numerous outstanding requests
- History of Mental Health illness and self harm
- No engagement with support services
- Little engagement with GP.

Pre Navigator Involvement

- Daily erratic contact to many different departments
- Numerous colleagues trying to engage with customer
- Communication with customer became a full time role
- ‘holding’ the customer without making progress
- Safeguarding concerns regarding customer
- Welfare concerns regarding colleagues
- Little or no relationship with Curo

During Navigator Involvement

- full engagement and download of issues affecting customer
- Working towards individual milestones to earn trust and rebuild relationship – focus on
- Repairs
- Behaviours
- Fire improvements
- Engagement with MH, GP and other support services.
- Daily contact reducing in length

Post Navigator Involvement

- Re engaged with MH services and GP
- Structured contact with Curo 20 mins every two weeks
- Improved wellbeing for customer and colleagues
- Improved welfare of customer
- Signed up for third party support
- Relationship with Curo at a positive place built on trust
- All property issues resolved

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Royal United Hospitals Bath
NHS Foundation Trust

Shaping a Healthier Future

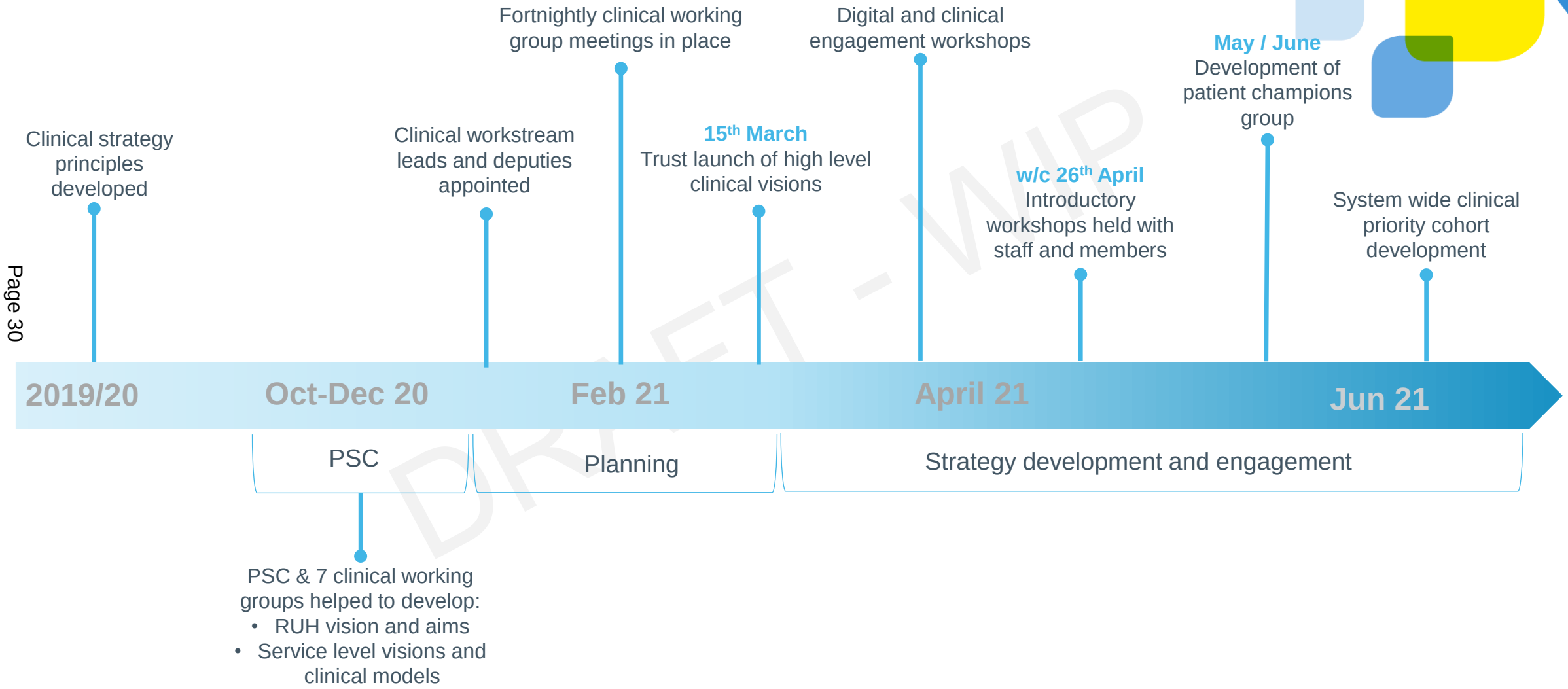
B&NES Health & Wellbeing Board

Health and Care Models Strategy Highlights and Status Update

Everyone Matters
Working Together
Making a Difference

Simon Cook, SaHF Programme Director
Geoff Underwood, Programme Director, SCW CSU

Progress so far



Context and key challenges

The overall population of BaNES is expected to increase to nearly 200,000 by 2024, an increase of 11 per cent from 2014. In line with trends for the wider BSW footprint, population projections suggest there will be large increases in the number of older people in BaNES – by 2029 the number of over 75s in the population is projected to increase by 36 per cent (approximately 6,000 people) compared with 2016.

11-12 year olds in BaNES

26%

% children with unhealthy weight

Increases risk of developing a range of chronic diseases such as heart disease and diabetes

486 ↑

More falls over 65s per 100,000 population than SW average

12% ↑

% Rise in alcohol related hospital admission in BaNES

73,000

People in BaNES with at least one long term health condition

18%

% of local population in BaNES experiencing mental health condition

43%

Expected increase in numbers of men with dementia by 2025

Priority cohorts

- Ageing Well
- Long term conditions and ambulatory care
- Mental Health
- Elective

How can we change this?

- Patient centric Health and care model
- Aligned digital and technology solutions
- System financial framework
- Collaborative governance structure
- Agile workforce

National and local drivers

Clinical Strategy

Strategic context

- The journey so far
- Where are we within the national and local context?
- Drivers for change
- Is there anything we can learn from international models of care?
- Our role within the Integrated Care System

A more complex population The over 75 population in BaNES is anticipated to rise by 36% by 2029; comparable rises will be seen in Wiltshire and Somerset	***Integration*** Working at system, place and neighbourhood levels with our partners to improve population health; tackle inequality; enhance productivity; support broader social and economic development
Societal change In how we live our lives, how we interact with large organisations and how we seek access to healthcare; Covid-19 has accelerated these changes	**Changing workforce** Expectations and needs of our staff are changing, reflecting generational shifts and the impact of Covid-19. What we need from our staff is also changing
Environmental impact Driving new ways to provide services which reduce their impact on our environment	**Digital innovation** Offers new ways to provide services, share information and communicate with patients and families
Advances in clinical care Technological, pharmaceutical and therapeutic developments will change how we will deliver services and the workforce we need	***Resilience*** Ongoing requirement to mitigate the risk of events such as Covid-19 and climate change, on our patients, on our services and on our staff
National workforce shortages With particular pressure points in some specialties and professions	***Focus on keeping people well*** Expectation that all providers of care will play a part in preventing ill health and upstreaming
Value for money In health, social care and public health	***Mental health/vulnerable people*** Parity and integration with physical health, for service planning and delivery

Challenges and opportunities

Clinical Strategy

Where are we now?

- The services we provide
- Our performance
- Challenges and opportunities
- System relationships

We are often unprepared for surges in ED attendances

RUH Staff Member

We need to look after the staff who in turn can look after patients

RUH Public Member

Access to the hospital is very challenging for people with complex needs

RUH Public Member

Some of the challenges and opportunities shared with us by the public and staff

Each time I visit the hospital I have to retell my medical history

RUH Public Member

*We **s**truggle with meeting the demand for our patients who, often would be best served in the community*

RUH Staff Member

Updated design principles

Creating a new future of outstanding healthcare with prevention and intervention when and where it is needed, working together to help our communities enjoy healthier lives

Clinical Strategy

Our clinical vision
Our key aims

The care model for the area includes health, social care and public health and will:

1. *Provide holistic and flexible care seamlessly as one system with embedded innovation and continual improvement*
2. *Care is preventative, proactive and anticipatory, focuses on wellbeing and addresses health inequalities through the lens of wider determinants of health*
3. *Provide person centred care and empowerment to put the person in control of their health and well being, and ensuring that each interaction adds value to the person*
4. *Provide care at home or in the community wherever appropriate, coordinated through strong primary care networks and multidisciplinary teams, and supported by sufficient emergency and specialist capacity in hospitals*
5. *Lead with digital and data to support seamless care for our patients and drive more effective decision making*
6. *Support an agile workforce, champion innovative roles and provide opportunities for training, research and development*
7. *Deliver an efficient way of working to ensure financial sustainability of the system and value for money of services.*

Key themes

Life course vision	Starting Well	Living Well	Ageing Well
	Children and young people enjoy childhood and are well prepared for adult life	**People feel supported within their B&NES community; where people do need health and care services they are coordinated and timely**	**B&NES ageing population receive person-centred, flexible, integrated care and support in their own "home", that aims to maximise their health and independence**
	"These would resonate more with the public"	"Person-centric rather than patient centric ie wellbeing rather than disease management"	"Proactive planning rather than waiting for a crisis to occur"
	"We need to ensure we are covering off our key challenges with our priority cohorts e.g. childhood obesity"	"Patient accountability and shared decision making"	"We must engage with preventive health measures towards people in the age of 20-30 to help them stay fit and age healthy"

Tiered approach

Tier 1 –Population Health and Care Management

Care Access, Care Navigation and Co-ordination, Clinical Triage and Management, Immediate Care and out of hours services

Tier 2 – Integrated Primary, Long term condition management and Community Services

General Practice at scale and integrated health, social care and voluntary sector teams working through a hub and spoke model across each locality

Tier 3 – Community Outpatient and Diagnostic Services

Outpatients and Diagnostics services delivered from Locality Integrated Wellbeing Centres

Tier 4 – Intermediate and Social Care and Unplanned care Services

Network of care (acute outreach where appropriate) delivered from community hubs and facilities, preventing unnecessary hospital admissions

Tier 5 – Acute Hospital Services

Access to high quality acute hospital services for patients when they need intervention that can only be provided on an acute site

Key Enablers – What needs to be true to deliver change?

Governance and Organisational Form

An agreed system governance framework in place that provides clarity on lines of accountability and gives Boards/Committees the mandate they need to remove blockers and enable collaboration

Financial Framework

An agreed shared system financial model that allows investment in the right places to deliver the objectives of the health and care model regardless of organisational boundaries

Workforce

Multi-disciplinary teams working collaboratively across a fully integrated pathway. Leading practice ICSs have started to work on system level workforce plans to ensure that the system has the right mix of staff, knowledge and skills to deliver integrated care

Digital & Data

Alignment of provider record systems to provide a single, shared view of the truth. Analytics and modelling capability in place to provide insights to inform care delivery and planning

Estates

An estate that supports the right health and care model, with the right estate to provide the right level of acute and community services to meet the needs of the local population

Where do we want to be?

Clinical Strategy

Where do we want to be?

- How our services look and feel for patents, carers and staff
- What services might grow, shrink or move elsewhere
- How the physical space and digital infrastructure support the new model of care
- What system integration looks like at a specialty level?
- Examples of where the new models already exist
- Implications for cancer services, specialised services and private patient services

Digital integration and shared health records with patient held data

MDT working & senior clinician input early in interactions

Improvement through self-management and ‘teachable moments’

Care closer to home

Navigation and support through the patient journey

Staff will be empowered and encouraged to develop to the ‘top of their licence’

Population health management driving decision making

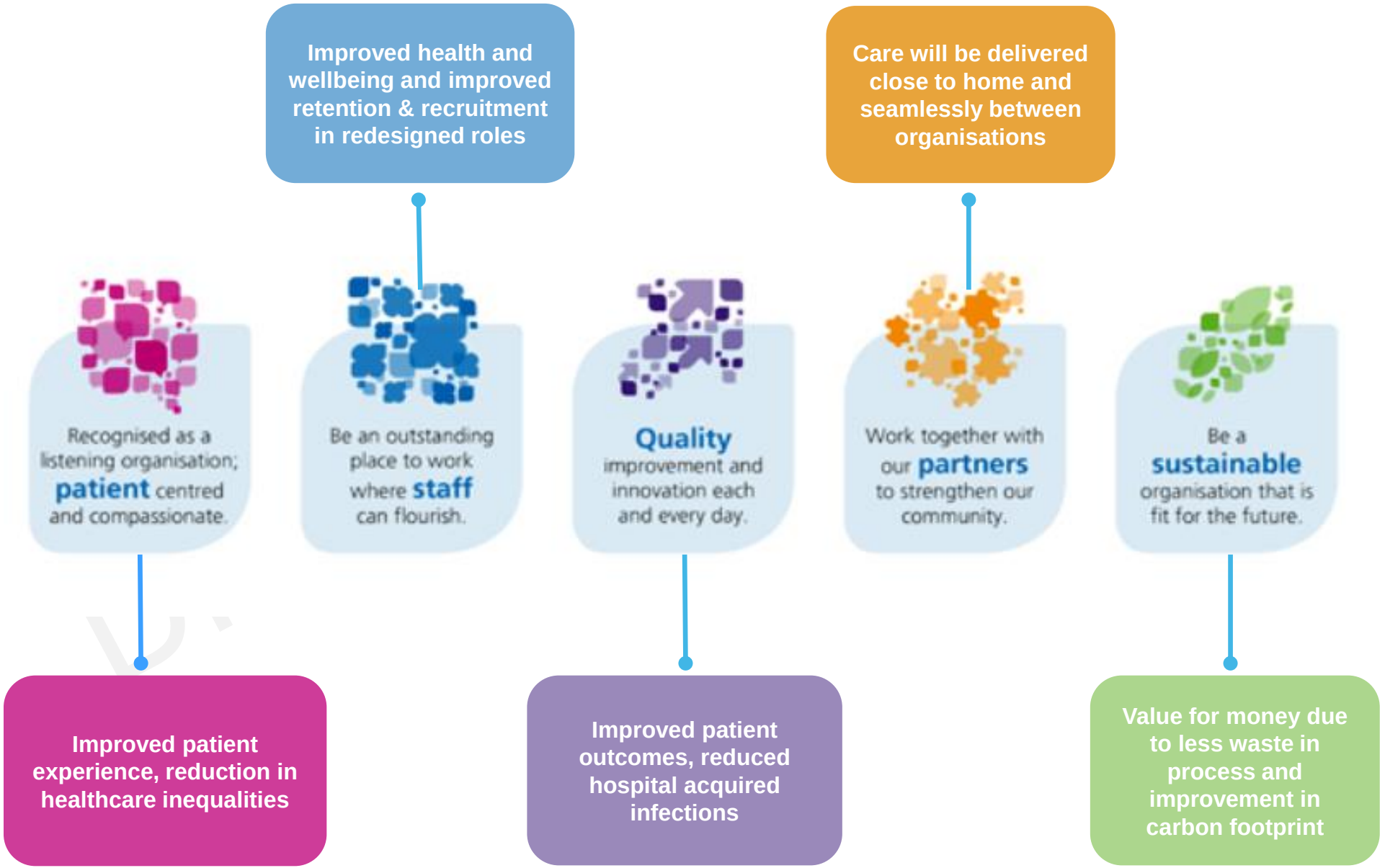
Fully integrated health and social care

What will success look like?

Clinical Strategy

How will we know we have been successful?

- What are the quality outcomes?
- How will we measure the outcomes?



Engagement – RUH workstreams and BSW health & care model work

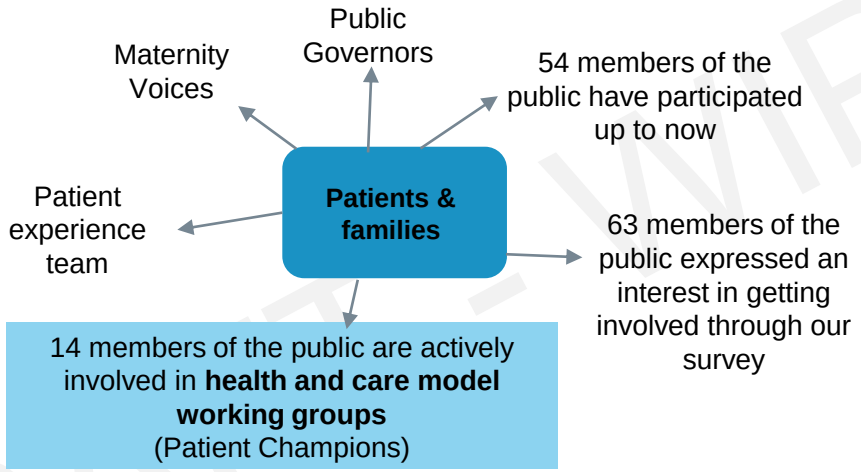
Workstreams:	Unplanned & Emergency Care	Long Term Conditions	Planned Care	Complex Needs (incl Frailty)	Women's & Children	Critical Care	Clinical Support Services (incl Diagnostics)
RUH Leads:	• Mark Edwards • Octavian Maran	• Marc Atkin • Joanne Bond-Kendall	• Steve Dalton • Rebecca Leslie	• Philipa Nash • Andrew Stone	• Jo Ficquet • Nickie Jakeman	• Jonny Price • Rob MacKenzie Ross	• Peter Marden • Dilesh Khandia

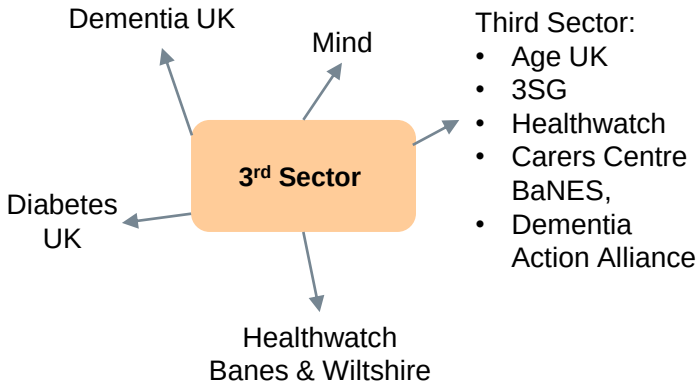
RUH Staff

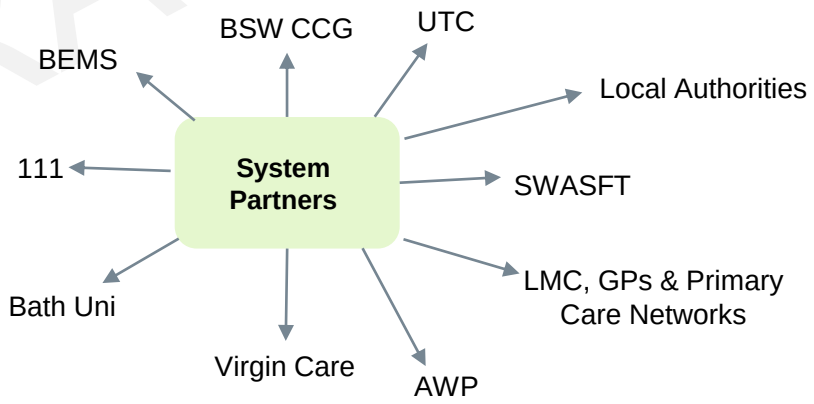
- Medical Nurse Practitioners
- Consultants
- Clinical Cabinet
- ITU teams
- Frailty teams
- ED Consultants
- Acute Medicine
- Medical Equipment Teams
- Palliative Care
- Rheumatology
- Children's therapies
- Cardiology
- Radiology
- Pathology
- Endoscopy
- Gastroenterology
- Anaesthetics
- Gynaecology
- Paediatrics
- Maternity
- Matrons
- Urology
- Therapies
- Discharge Liaison
- Stoma team
- Transfusion team
- Oncology
- Respiratory
- Theatres
- Obstetrics
- Geriatrics
- Nuclear medicine
- Radiotherapy
- Portering
- Cleaning
- Booking teams
- Occupational Health
- Facilities
- IT

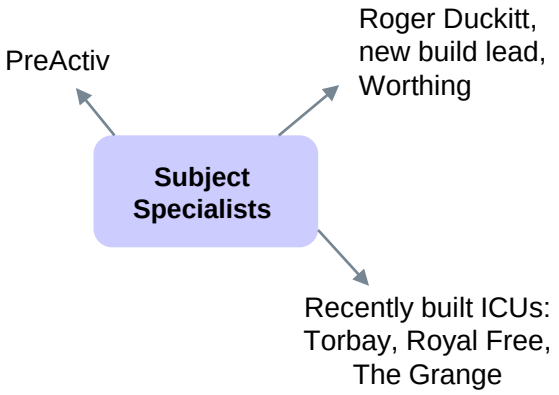
27 staff expressed an interested in actively getting involved through our survey

23 staff are actively involved in clinical working groups









Oversight bodies engaged including Wiltshire OSC & HWB; BaNES OSC & HWB

Staff & Public feedback on vision and aims

How does the vision make you feel?

Hopeful and cynical at the same time

RUH Staff Member

It promises a great deal but to implement it will need creative thinking and user friendly pathways

RUH Public Member

Exhausted. It's a great vision, but are we physically and mentally able to take this on?

RUH Staff Member

Pleased that there is a vision. Concerned that it may be too broad-brush and not deal with some of the simpler issues that would help patient experiences.

RUH Public Member

Excited but cautious

RUH Public Member

Encouraged that a new form of integrated care may emerge at last

RUH Public Member

Proud to be working for the RUH

RUH Staff Member

Hopeful. If I had the extra support I needed at the time, my life as a carer would have been completely different.

RUH Public Member

Inspired to deliver a 1st class healthcare service to everyone when and where they need it

RUH Staff Member

Staff & Public feedback on vision and aims

Greater clarity about the means by which the goals will be achieved

RUH Staff Member

Be brave about stating the responsibility we all have to maintain our own health and not to rely on a health care system to rectify issues borne from our choices.

RUH Public Member

Incorporation of research and development – the pandemic has shown us the crucial role research plays in improving outcomes for patients

RUH Staff Member

What could we add to the vision to make it better?

Listening to service users. Reflecting back to ensure that ambitions have been realised.

RUH Public Member

Greater emphasis on staff wellbeing and support – the RUH is a great place to work, can the vision reflect this more?

RUH Staff Member

Effective and appropriate communication – taking into account that not everyone can hear, see, or use/have access to technology

RUH Public Member

Next steps

- Clinical model workshops for system and Patient Champions
  - Priority cohorts
    - Ageing Well
    - Long term and ambulatory
    - Elective
    - Mental Health
- Development of service user personas
- First draft Health & Care Model and Roadmap
- Wider public engagement

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