



# Start, Live and Age Well

in Bath and North East Somerset, Swindon and Wiltshire

## Adult and Children's Community Services BSW



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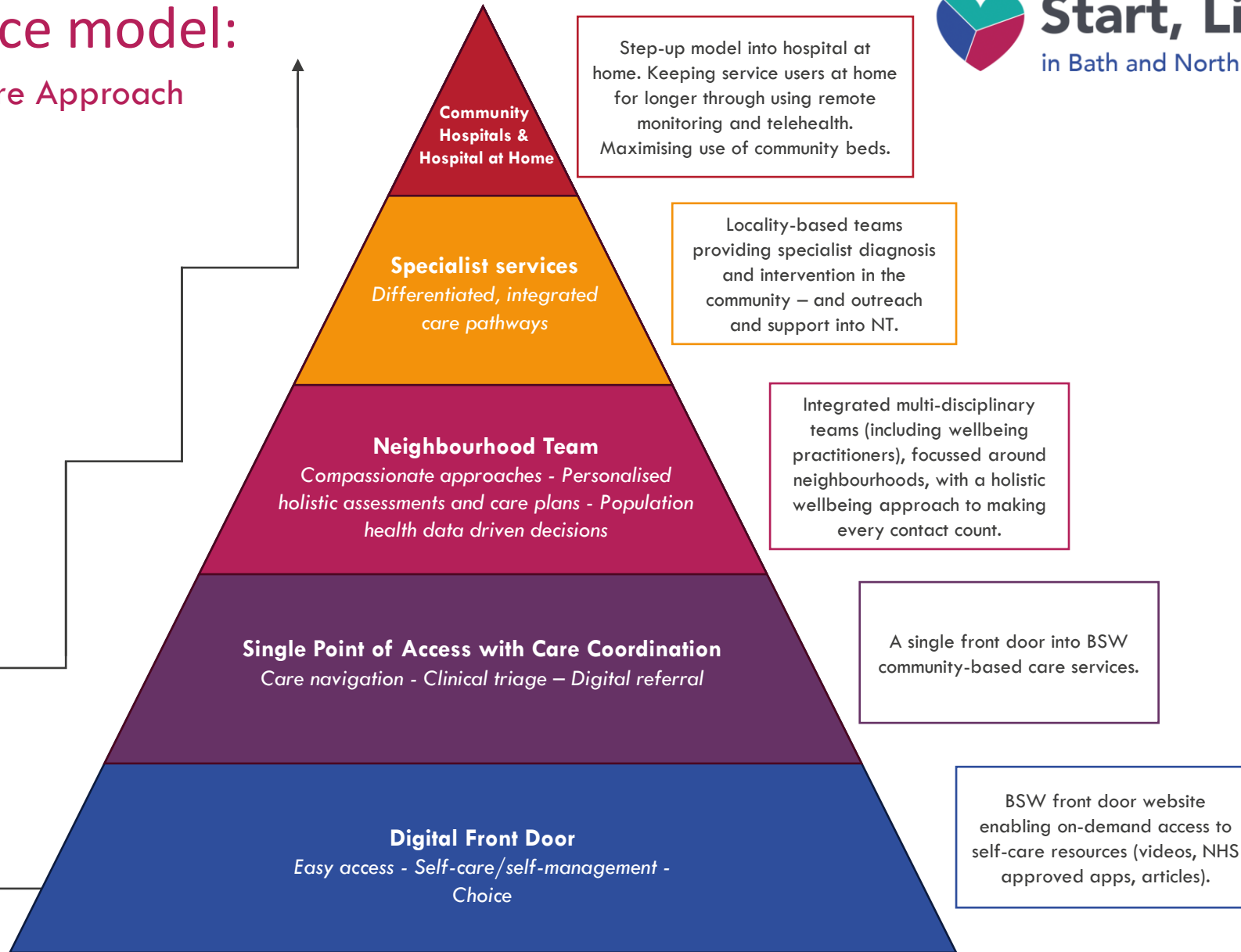
## Our BSW Integrated Community Based Care Model



# Our service model: A Stepped Care Approach



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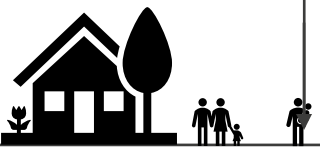
*“I feel that my care is personalised to me, my goals are heard and reviewed.”*

*“I feel confident that I receive the right care, in the right place, at the right time, through truly integrated community health care services”*

*“My assessment is thorough and addresses my needs, it is not driven by my diagnosis, but by what matters to me”*

*“I can self-refer, reducing the need to contact my GP and arrange for a referral to be made”*

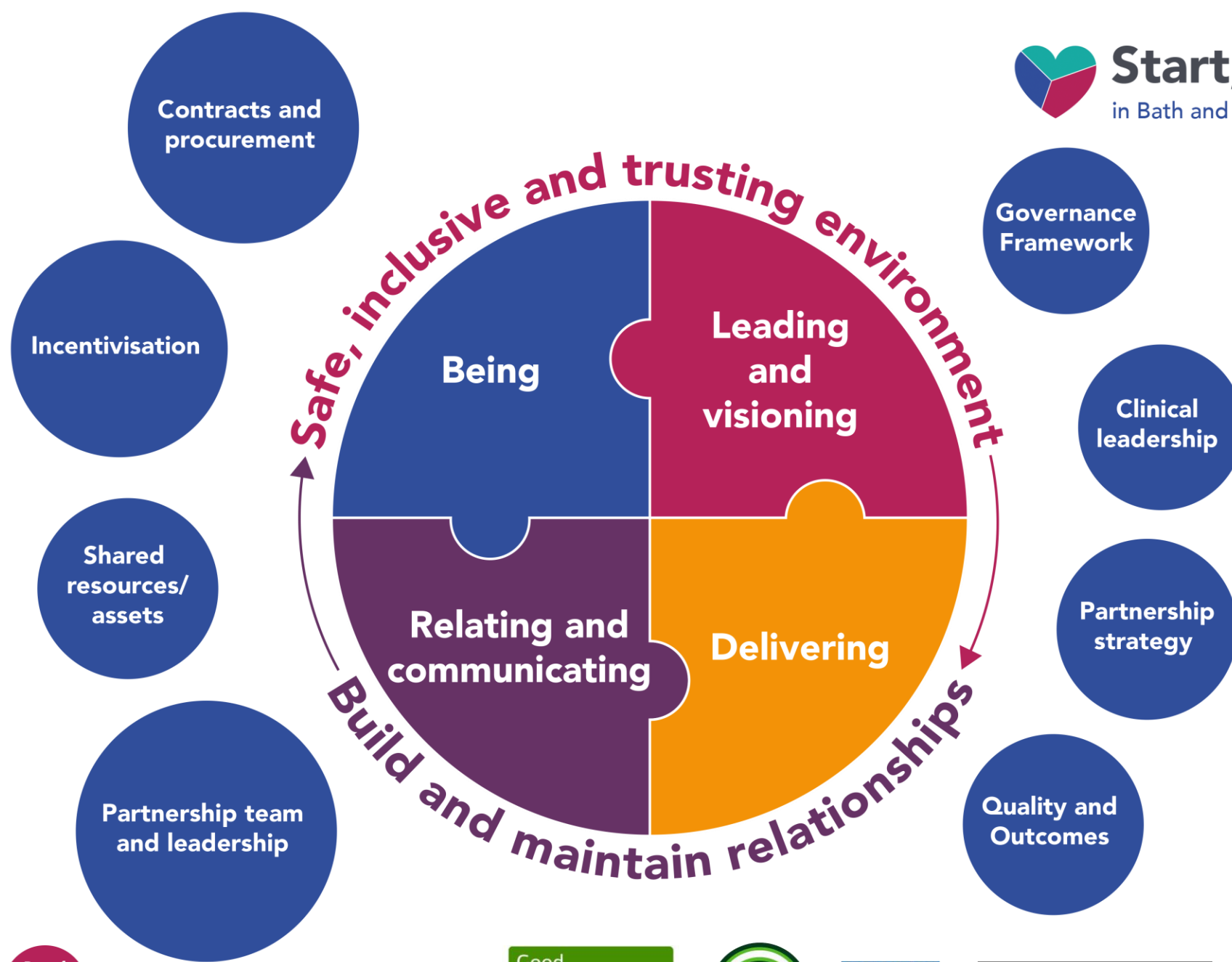
*“I can access community health and wellbeing support digitally 24/7, at a time convenient to me.”*





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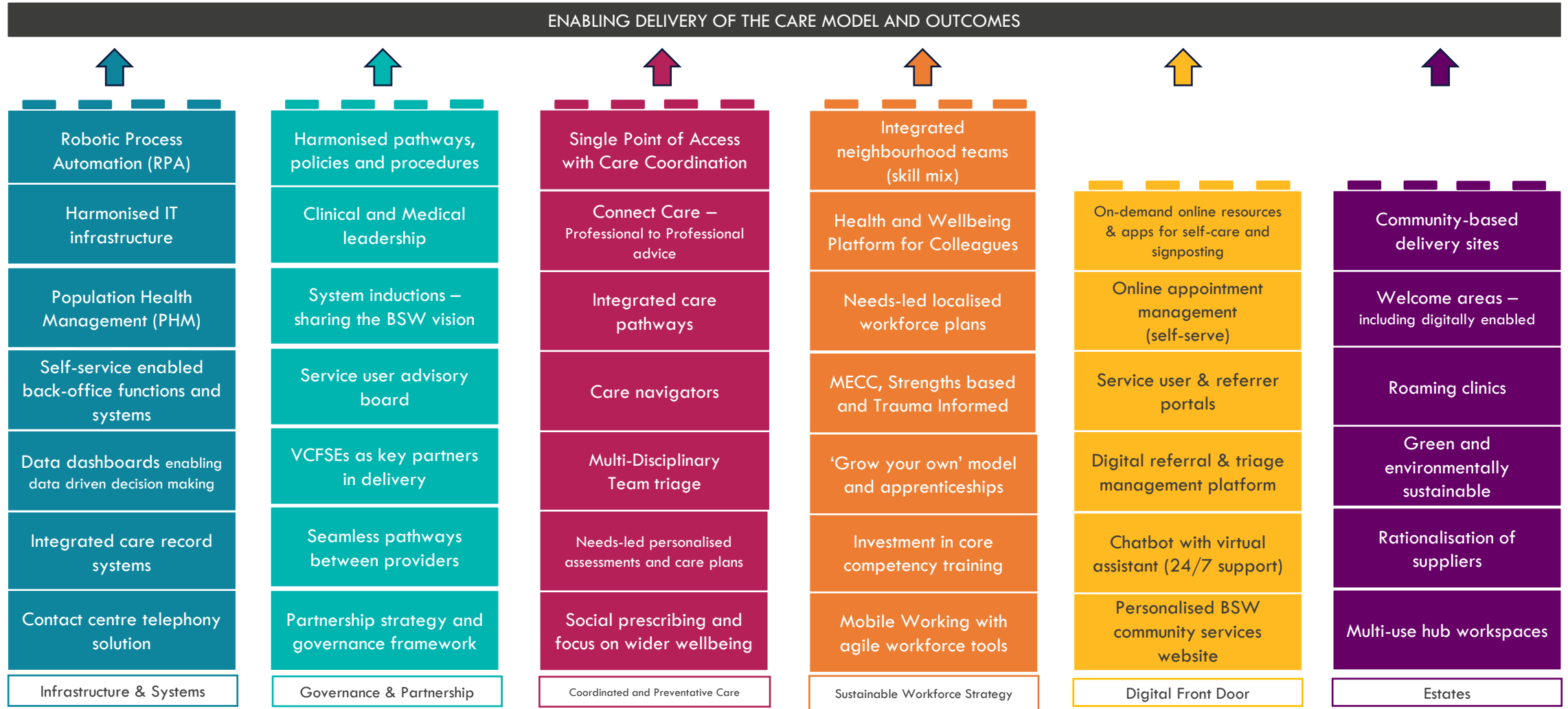


# Key enablers



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# Key enabler spotlight:

## Digital Front Door

### Overview:

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Our Digital Front Door offers easy access to on-demand trusted health and wellbeing resources, self-referral and healthcare journey tracking.

### Key features:

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**Resource Hub:** Apps, videos and links to trusted health and wellbeing resources.



**Digital Referral Form:** Accessible, step-by-step referral form with in-built logic and signposting.



**Service User and Referrer Portal:** Secure portal to track referral progress, upload documents



**Website Chat Bot:** Guiding website users around content, helping with self-management such as appointment management

### Benefits:

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Building resilience through a focus on prevention, self-management and promoting sustained healthy behaviour changes.



Improving accessibility and choice through 24/7 access to evidence-based health and wellbeing resources.



Improving communication between professionals and service users



More appropriate needs-led referrals, enabling service users to get the right care at the right time

# Key enabler spotlight:

## Single Point of Access with Care Coordination

### Overview:

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Our all age BSW-wide Single Point of Access with Care Coordination will be the front door for all community services, including urgent care, helping navigate service users to access the right care to meet their needs.

### Key features:

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**Single Front Door:** One single point of contact, streamlining access to services



**Care Coordination:** Multi-disciplinary team clinical triage and single holistic assessment to ensure the most appropriate pathway



**Fast-track urgent care pathways:** Ensuring those with an urgent clinical need are seen by the right person at the right time.



**Locality-focused Care Navigators:** Helping local people understand the wide range of community assets available to them.

### Benefits:

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Improving ease of access to community health services.



Improved service user and professional understanding of wider resources available within the community.



Reduction in acute admissions, through better coordination, ensuring care is delivered in the right place at the right time by the right person.



Improving population health outcomes through proactive prevention and health coaching at the front door.

# Key enabler spotlight:

## Integrated Neighbourhood Teams

### Overview:

*Providing personalised, harmonised and holistic care that meets the needs of the local community, delivered close to people's home. Ensuring seamless integrated care pathways and shared caseloads.*

### Key features:



**Skill-mix:** Bringing together nurses, therapists, wellbeing practitioners and support staff to offer holistic care.



**Compassionate approaches:** Core competency training in Making Every Contact Count (MECC), Strengths based, Trauma informed approaches, wellbeing and prevention focused



**Population Health Management:** Team trained in making data driven decision making, informing targeted approach to reach those most in need.



**Single holistic assessments and personalised care plans:** Focusing on the wider determinants of health and wellbeing, ensuring service users are involved in planning their own care

### Benefits:



Providing care closer to home, improving access and removing barriers, especially for those experiencing inequalities.



Improved health outcomes through taking a holistic approach, tackling the root cause issues with prevention and early intervention.



Reducing frustration and duplication for service users and clinicians providing information multiple times.



Improved understanding of population health and risks to poorer health outcomes.





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## Mobilisation and Transformation



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# Mobilisation – three key priorities

1.

**Building a strong BSW ICBC system  
leadership and governance framework**



**“I know my role and responsibilities as a partner in the BSW ICBC system, and I feel involved in decision making about community services.”**



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# Mobilisation – three key priorities

1.

Building a strong BSW ICBC system  
leadership and governance framework

2.

Ensuring a seamless,  
safe transition



“I had all the tools I need on  
day one to continue seeing  
service users.”

“I was impressed by how seamless the change was. My  
clinic appointment went ahead as usual, and the service  
had all my details. I felt safe knowing that everything  
was handled properly.”



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# Mobilisation – three key priorities

1. **Building a strong BSW ICBC system  
leadership and governance framework**

2. **Ensuring a seamless,  
safe transition**

3. **Establishing  
a route to  
transformation**

“I understand the case for change  
and both myself and my team feel  
excited and optimistic about the  
future vision of our BSW community  
health service”





## Transformation – first 6 months

Transition to healthcare first model

Harmonisation

Upfront investment to implement key enablers

Start, Live and Age Well service brand activation campaign

Leading the system through the change journey





# Transformation – by end Year 1

**Integrated  
Neighbourhood  
Teams**

**Single Point of Access (SPA) with  
Care Coordination**

**Digital  
Front Door**

**Data driven  
decision  
making**



**“I only need to  
tell my story  
once.”**

**“I feel seen as a  
whole person,  
and both my  
strengths and  
needs  
are understood.”**

**“It’s convenient for me  
to manage my own  
health when I feel I  
can, but I also know  
where to go if I need  
extra help.”**





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## Transformation – by the end of Year 2

Digital innovation

Implementation of  
the BSW Estates  
strategy

VCFSEs as integral partner  
in delivery of community-  
based care (£7m invested)



Single holistic  
assessments and all  
age personalised care  
plans embedded

“I feel heard and understood and  
have been involved in planning  
my care.”

“There’s a great  
selection of health and  
care support in my  
community and close to  
my home.”

