Integrated Community Based Care (ICBC) Transformation Update

Audience: B&NES HoSC

Date: July 2025

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WE CHANGE LIVES BY TRANSFORMING HEALTH AND CARE.

Revisiting the vision for community health services

Our vision for BSW ICBC

Personalised
care

Maximise
use of skills and services within communities

Innovate
and improve at pace

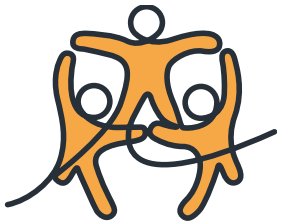
Harmonisation
of services

Maximise
the value of informal provision

A culture of collaboration
centred around communities

Our vision for BSW ICBC

Easy to access



Community-first

Fair access to services

High quality

Outcome focussed

What will it feel like?

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

Service user

"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."

Service user

"I feel competent, confident and adequately supported to be able to meet the needs of service users."

Colleague

"My assessment is thorough and addresses my holistic needs, it is not driven by my diagnosis, but by what matters to me"

Service user

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

Service user

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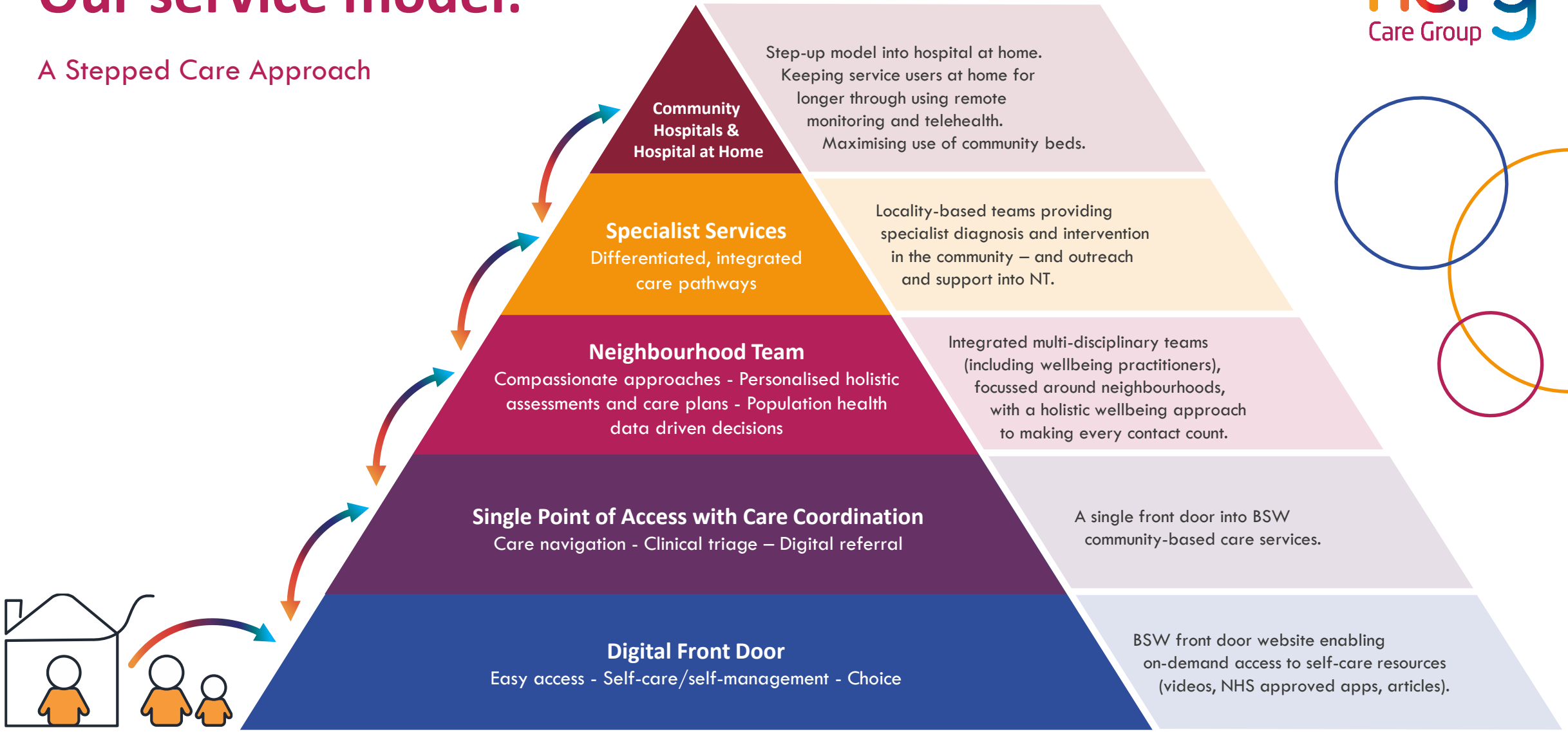
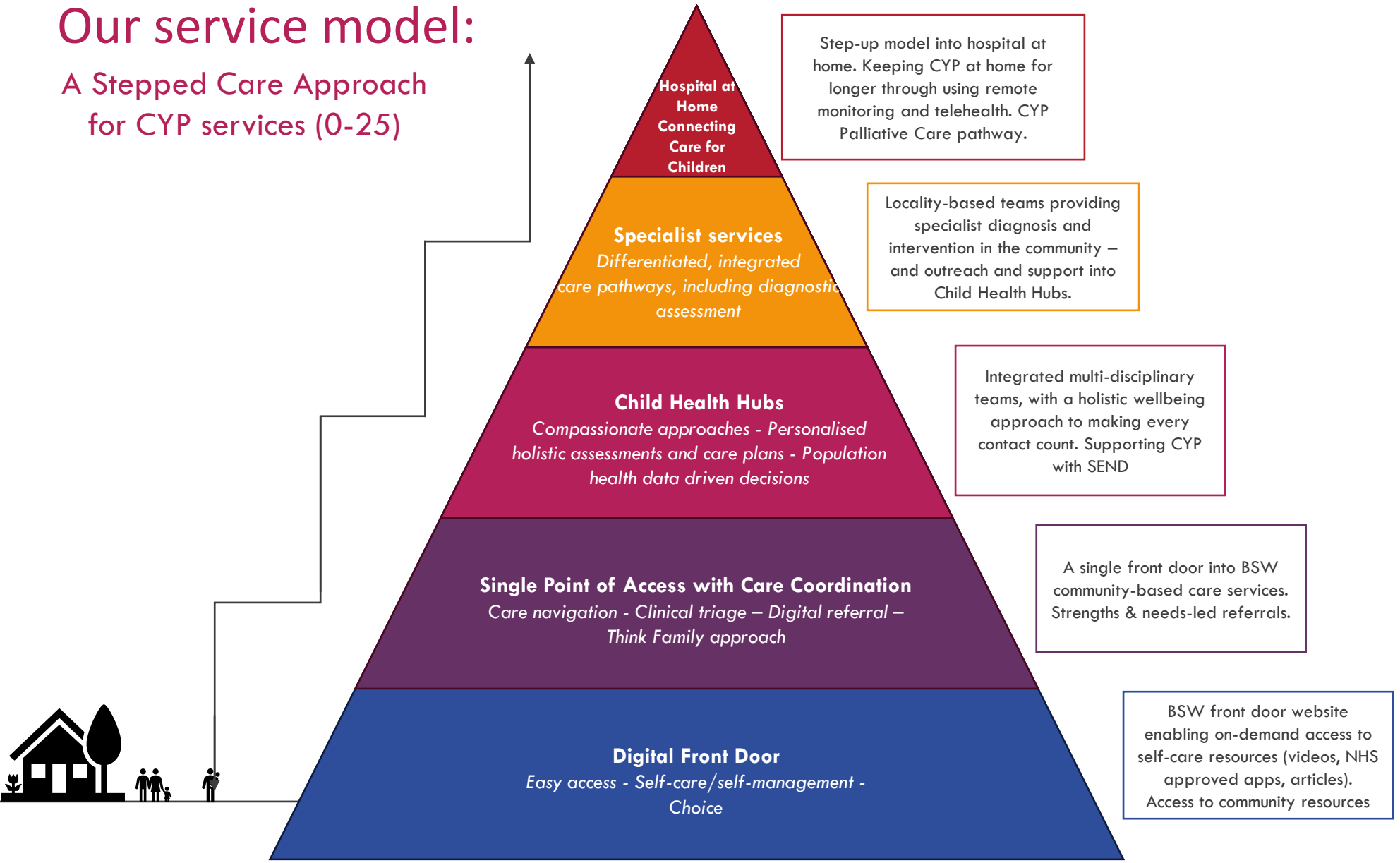
Our service model:

A Stepped Care Approach



Our service model:

A Stepped Care Approach for CYP services (0-25)



Step-up model into hospital at home. Keeping CYP at home for longer through using remote monitoring and telehealth. CYP Palliative Care pathway.

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

Integrated multi-disciplinary teams, with a holistic wellbeing approach to making every contact count. Supporting CYP with SEND

A single front door into BSW community-based care services. Strengths & needs-led referrals.

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

hcrg Care Group

"I feel that my care is needs-led, personalised to me and my family, our 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 strengths and needs, it is not driven by my diagnosis, but by what matters to me"

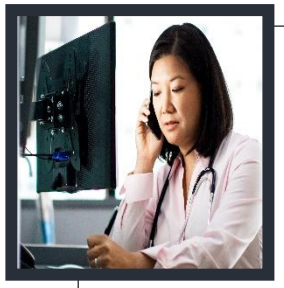
"I can self-refer, reducing the need to contact my GP and arrange for a referral to be made"

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

The ICB's nine transformation priorities

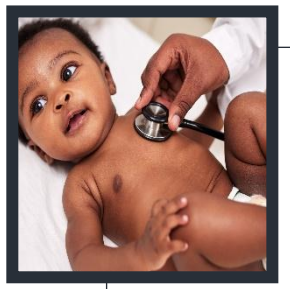
Neighbourhood teams

- Work in local areas to understand health and care needs of communities
- Prevent ill health
- Plan and coordinate personalised care
- Meet mental and physical health and wellbeing needs of most vulnerable in our communities
- Reduce health inequalities, improve access to care and improve outcomes.
- VCSE organisations will be key partners in neighbourhood teams.



All-age single point of access

- Single 'front door' to direct public and health and care professionals to the most appropriate service for their needs
- Those with an urgent or emergency clinical need will receive the right help from the most appropriate clinician in the most appropriate place, at the right time.



Family child health hubs

- Improve access to specialist child health and care professionals
- join up care by bringing professionals together
- improve quality of care
- reduce pressure on services and increase productivity.

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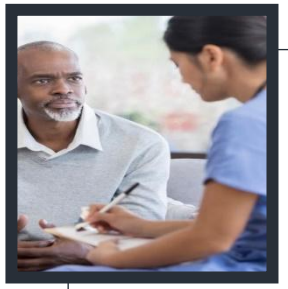
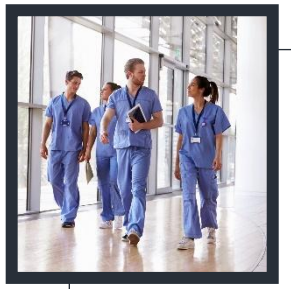


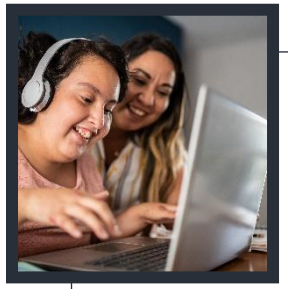
Care pathways and admission avoidance

- Do more to help people to stay as well as possible and avoid hospital admission
- Proactively identify those attending or being admitted to hospital that could be managed elsewhere
- Redesign planned care pathways so - where safe - people receive support closer to home.



Specialist advice and support in communities and primary care

- Specialist health and care professionals providing expert advice in community and primary care - more care closer to home
- Establish a children's single point of access offering one stop shop for all requests for support.



Specialist advice and support for people with LDAN

- Deliver improvements in identifying, understanding, meeting, maintaining and escalating needs
- Focus on early intervention and getting support as soon as possible
- Single point of access for LDAN.

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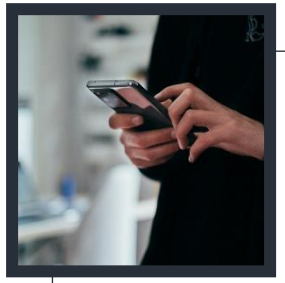
A sustainable and innovative workforce

- Implement initiatives to improve recruitment and retention, encourage innovative ways of working, offer career development and positive working environment
- Organisations providing care will work in partnership with teams focused on prevention and proactive care.



Harnessing digital innovation

Make the most of modern technology, including:

- Secure digital patient records, accessible by different organisations
- Greater use of digital or remote health diagnostic and monitoring tools
- Making full use of the NHS App
- Considering how to best use artificial intelligence (AI) in patient care.

Shifting funding and capacity into community-based care

Working productively and effectively (e.g., by making best use of our estate) to create capacity to reinvest in our transformation priorities and shifting investment into community-based care, including VCSE organisations and preventative approaches.

Our transformation programme
Project structure

Project	Description
Single Point of Access (SPA) with Care Coordination and Digital Front Door	Establish one all-age front door into community services in BSW, improving access to self-help resources, ensuring service users are on a care pathway appropriate to their need, focussing on admission avoidance.
Digital Transformation	Investing in digital enablers to improve service user experience and drive operational efficiencies.
Integrated Neighbourhood teams	Providing personalised, holistic care that meets the needs of the local community, delivered close to people's home.
Partnership Development and Community Engagement	Develop a partnership working and engagement strategy with key system stakeholders including service users. Encourage left shift through investing in 3rd sector (VCFSE) partners.
Community Estates Strategy	Rationalising existing estate by working with system partners to share resources and create estates and facilities that meet the needs of the local population.
Clinical Pathway and Service Transformation	Ensuring integrated care pathways that focus on prevention with seamless transition points and shared caseloads. Harmonising policies and ways of working across BSW.
Service Identity and Brand Development	Co-designing a service identity and brand for the new BSW community services.
Workforce Transformation	Creating a sustainable workforce that is competent and confident in providing more holistic care. Using population health data and demand data to inform workforce needs, including transition to 7 day working.
Outcomes Framework and Benefits Realisation	Developing the outcomes framework and ensuring we realise the expected benefits for each project.

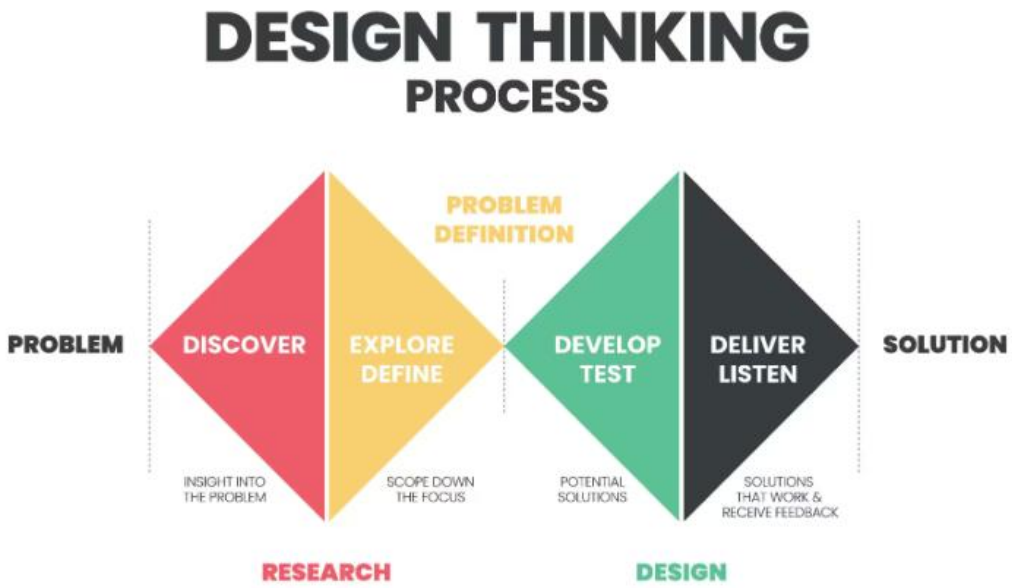
Our transformation programme
Aligned to the nine priorities

Project	Which transformation priorities are addressed?
Single Point of Access (SPA) with Care Coordination and Digital Front Door	All-age single point of access | Care pathways and admission avoidance | Specialist advice and support for people with LDAN | A sustainable and innovative workforce | Harnessing digital innovation | Shifting funding and capacity into community-based care
Digital Transformation	All age single point of access | Care pathways and admission avoidance | Sustainable and innovative workforce | Harnessing digital innovation | Shifting funding and capacity into community-based care
Integrated Neighbourhood teams	Neighbourhood teams | Care pathways and admission avoidance | Specialist advice and support into communities and primary care | Specialist advice and support for people with LDAN | Sustainable and innovative workforce | Shifting funding and capacity into community-based care
Partnership Development and Community Engagement	Care pathways and admission avoidance | Sustainable and innovative workforce | Shifting funding and capacity into community-based care
Community Estates Strategy	Covers all priorities
Clinical Pathway and Service Transformation	Covers all priorities
Service Identity and Brand Development	Covers all priorities
Workforce Transformation	Covers all priorities
Outcomes Framework and Benefits Realisation	Covers all priorities

Transformation programme structure and methodology

Transformation methodology
The ‘4 D’ process

- Our transformation programme will use a person-centred design methodology to ensure we keep the service user at the heart of everything we deliver.
- Every project in the programme will follow a four-step methodology:
  - **Discover:** Understanding the as-is and researching art of the possible.
  - **Define:** Key user needs, pain points, and challenges based on research. What problem are we trying to solve?
  - **Design / Develop:** Innovative and iterative design, involving stakeholders to co-design and test potential solutions.
  - **Deliver:** Implementing the solution, getting stakeholder feedback and evaluating impact.



The ‘double diamond’ design thinking process

High Level Programme plan (Y1 – Y2)

Project / Workstream	FY 25-26		FY 26-27	
	Q1 – Q2	Q3 –Q4	Q1 – Q2	Q3 – Q4
BSW Service Identity and Brand Development	Discover and Define (Q1) Design & Deliver (Q2)			
Single Point of Access with Care Coordination and Digital Front Door	Discover & Define	Design & Deliver (phase 1) Ops and workforce models, digital front door website, Riviam referral management system	Design (phase 2) Patient and referrer portal, additional digitisation of assessments/forms	Deliver (phase 2)
Partnership development & community engagement	Discover and Define (Q1) Design (Q2) Service user & VCSFE engagement strategy	Deliver Service user & VCSFE engagement	Discover and Define (Q1) Design (Q2) Future delivery model	Deliver VCFSE procurement process
Community estates strategy	Discover & Define Estates strategy	Design	Deliver Initial rationalisation opportunities	Deliver Initial rationalisation opportunities
Digital Transformation	Discover & Define	Design & Deliver (phase 1) RPA, SystmOne, ICR, e-room booking, inventory and assets, Tableau	Design (phase 2) Assistive tech and other pilots	Deliver (phase 2)
Clinical pathway and service transformation / harmonisation	Discover & Define Priority 1 pathways	Design & Deliver Priority 1 pathways Discover & Define Priority 2 pathways	Design & Deliver Priority 2 pathways Discover & Define Priority 3 pathways	Design & Deliver Priority 3 pathways
Integrated Neighbourhood Teams	Discover & Define	Design & Deliver		
Workforce Transformation (cross-cutting)	Discover & Define Workforce transformation requirements mapped	Design & Deliver Workforce models developed, signed off and consultations completed		
Outcomes framework and benefits realisation (cross cutting)	Discover & Define OF mapped against expected programme benefits, baselining completed	Design & Deliver Benefits realisation matrix and measures	Deliver	Deliver

Clinical pathway transformation priority

Adult pathways

Adult services	Priority
Frailty	1
EOL & Palliative Care	1
Respiratory	1
Rehabilitation	1
Heart Health	1
Dementia	1
Falls & Balance	1
Dietetics / Healthy Eating	1
MSK	1 or 2
Neurology	1 or 2
Urgent Care: MIU	2
Urgent Care: HCP & Ambulance navigation (Medvivo Care Co)	2
Foot Health	3
Diabetes	3
Speech & Communication	3
Hearing	3
Continence	3
Wheelchair service	3
Tissue Viability, Lymphoedema & Wound Care	3
Community elective alternatives	3

CYP pathways

Pathway	Priority
Urgent care: H@H, Family Child Health Hubs, MIU	1
Speech & Communication	1
Neurodisability (e.g. Cerebral Palsy, Developmental Delay, Downs)	1
Sleep	1
Children Looked After	1
Hearing	2
EOL / Child Death / Palliative Care	2
Movement/Coordination/Rehab Integrated Therapies	2
Continence	2
Dietetics / Healthy Eating	3
Wheelchair service transformation	3

LDAN pathways

Pathway	Priority
All age diagnostic & medication/intervention	1
Community LD	1
Community LD forensic	1
Care Coordination	1
Transitions (18-25)	1

Priority 1: Complete pathway redesign by end Year 1 (March 2026)

Priority 2: Complete pathway redesign by mid-Year 2 (September 2026)

Priority 3: Complete pathway redesign by end Year 2 (March 2027)

- ✓ Wellness integration across all pathways
- ✓ Care coordination integration across all pathways

Communications & engagement strategy

Our methodology

Our strategy will be based around incorporating the **NHS Principles for Working with People and Communities** and the **NHS Engagement Cycle** to ensuring we deliver more inclusive, effective, and accountable healthcare services, placing people at the heart of decision-making.

NHS 10 Principles for Working with People and Communities

1. Reach out to people and communities
2. Provide clear and accessible information
3. Work with communities
4. Support people to be involved
5. Value people's lived experience and insight
6. Use co-production, co-design and shared decision-making
7. Be inclusive and tackle health inequalities
8. Work with voluntary, community, faith and social enterprise (VCFSE) organisations
9. Feedback and show the impact of involvement
10. Continue to learn and improve

NHS Engagement Cycle

1. Understand the population data and gather insight
2. Engage communities early to co-produce solutions and design services that reflect real needs.
3. Involve people in decision-making to ensure plans are inclusive, practical, and effective.
4. Co-design services and care pathways in collaboration with service users and stakeholders.
5. Include service users and the public in the commissioning and procurement process where appropriate. (e.g. VCFSE procurement in Y2/3)
6. Continue involving people in assessing service performance and identifying improvements.

Communications & engagement strategy

Group	Planned Activities	HCRG lead/s
Service Users	• Co-define and co-design workshops for each project - reaching out to networks to bolt on to existing forums. E.g. LDAN lived experience, Parent Carer forums, Youth forums. Planning initial workshops from July onwards • ICBC Service User Advisory Board	Phil Walters – Head of Partnerships & Engagement Project Leads / SMEs (for each project)
VCFSEs and community groups	• Engagement with organisations and groups across the system to identify key stakeholder • Co-define and co-design workshops with VCFSE subject matter experts. Planning initial workshops from July onwards	Phil Walters – Head of Partnerships & Engagement Project Leads / SMEs (for each project)
Partner Providers: • Primary Care Networks • Social Care • Local Authority • Acute providers • Public health • Mental health providers	• Establishment of the Partner Provider Group (first meeting 27/06) • Planning drop-ins to existing forums e.g. Primary Care Delivery Group, outreaching to PCNs • Running targeted workshops and engagement sessions for specific project outputs e.g. Neighbourhood Teams population health data review with Primary Care, LA & Acutes; Hospital @ Home pathway consultation with acute consultants. Planning initial engagement from July onwards • Public Health, prevention and inequalities – linking with existing networks / strategies e.g. BSW and locality inequalities group	Operational Leads Medical Director Project Leads / SMEs (for each project)
ICBC Service Colleagues	• Monthly newsletter updating on key milestones and reflections from across the nine projects • Fortnightly engagement update to highlight opportunities to get involved e.g. surveys, upcoming workshops, roadshow days • MS Teams Collaboration space for each project, to • Formal workforce consultations	Penny Emerson – Transformation Director Matt Walker – Transformation Communications Lead Jenny Clayton – People & Change Lead Project Leads / SMEs (for each project)