Wiltshire NHS
Primary Care Trust

Wiltshire Primary Care Trust
Urgent Care Strategy
2007 - 2010

Contents

1 Introduction

1.1 The aim of the document is to describe the vision and direction for development of urgent care services for Wiltshire. It will inform commissioning intentions and is based on a partnership approach to addressing urgent care needs and promoting well-being.

1.2 This strategy outlines the commissioning intentions of Wiltshire PCT. The strategy has taken into account the content and direction already set in urgent care strategies which relate to the Bath and North East Somerset (BaNES), Swindon and Wiltshire (BSW) health economy.[1] Other partner organisations both statutory and voluntary will have the opportunity to contribute to this vision' through the development of robust partnerships delivering urgent care services.

1.3 This document provides a framework on which to develop partnership and good practice in the commissioning and delivery of services and will be reviewed at regular intervals as the commissioning partnerships develop. It is intended as a journey towards providing more relevant and responsive services for those people with urgent care needs

1.4 The strategy outlines an overarching vision, the current position, the case for change and proposed model of urgent care with background and supporting information

1.5 For the purpose of this strategy, the definition of urgent care is aligned with the definition in the department of health discussion document, *the direction of travel for urgent care*[3] . Urgent care is;

'*the range of responses that health and care services provide to people who require - or who perceive the need for – urgent advice, care, treatment or diagnosis.. People using services and carers should expect 24/7 consistent and rigorous assessment of the urgency of their care need and an appropriate and prompt response to that need*'

1.5.1 In Wiltshire both nationally and locally set response times will be met in the delivery of emergency and urgent care

1.5.2 Urgent care services include delivery by Wiltshire Community Health Services (PCT) neighbourhood teams, mental health services, GP's, hospital emergency departments (previously known as Accident and Emergency Departments-A&E's), pharmacies, the ambulance service, NHS Direct, Primary Care out of hours, dental care and social care.

[1] Swindon and North Wiltshire Urgent Care Strategy, March 2006; B&NES Urgent Care Strategy, August 2006
[3] The Direction of Travel for Urgent Care, a discussion document. Department of Health, October 2006
[5] Improving Ambulance Response Times; Department of Health, April 2007

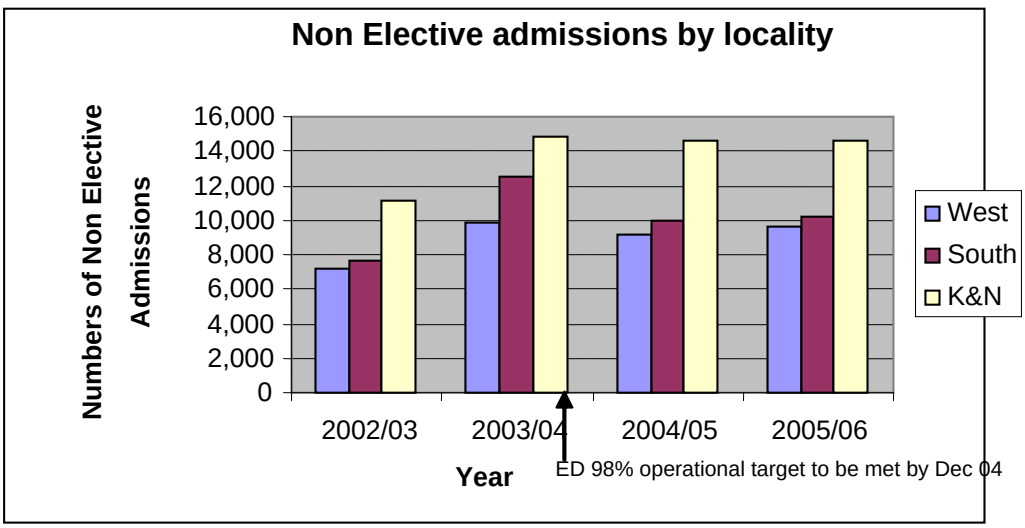
2 Urgent Care – Current Position

2.1 When a person feels ill or is in pain it is distressing for them, and those close to them and they will access health services at the point that is easiest for them or the one they feel is most appropriate to meet their need.

2.2 Urgent care services are reported and perceived as uncoordinated and confusing for the public and professionals. There are poor information flows across providers leading to duplication in service delivery and patients receiving multiple assessments. There are more than 30 telephone numbers for health and social care professionals to access community services.

2.3 Total admissions to the Royal United Hospital, Bath, Great Western Hospital, Swindon and Salisbury Foundation Trust by Wiltshire residents have risen around 14% between 2002/02 – 2005/06. Within this increase, non elective admissions have risen by an average of 25% over the same period, with a marked increase in 2003/04. Also in this period, emergency departments were expected to meet the four hour operational target where 98% of patients are seen, transferred or admitted patients within four hours by December 2004.

Diagram 1 Non elective admission rates



2.4 The attendances to the emergency departments at the Royal United Hospital (RUH) and Great Western Hospital (GWH) by Wiltshire residents are under the expected/assumed 5% annual growth in activity. However, both hospitals, in managing patient flows, have consistently failed to meet the nationally set four-hour operational target where 98% of patients should be discharged, admitted or transferred within four hours of arrival. Attendances to the emergency department at Salisbury Foundation Trust (SFT) are above 5% growth and the hospital consistently meets the four hour target.

2.5 '999' calls to the ambulance service have doubled over the last 10 years. Great Western Ambulance Service currently fails to meet the performance targets[5] outlined below:

- To reach 75% of immediately life threatening emergencies (Category A) within 8 minutes
- To reach 50% of non-life threatening emergencies (Category B) within eight minutes
- To reach 95% of all emergencies within 14 minutes
- The Doctors' Urgent standard requires that 95% of patients requiringurgent hospital admission reach hospital within 15 minutes of the time requested by their doctor

3 The Case for Change

3.1 This strategy is not 'change for change sake' it is responding to the need for improvement in the way people access urgent care and the services available to them. The redesign of urgent care will build on what currently works well, and change areas that need improving. This section describes the national and local drivers for change then goes on to identify existing good practice as a foundatonn for future service delivery.

3.2 **National Drivers**

- To consistently meet the emergency department four hour operational standard across the three main acute hospital providers
- The requiremnt to meet the 18 week target, where no-one waits more than 18 weeks from GP Referral to start of treatment by December, 2008
- For the Ambulance Service to meet and sustain national performance targets
- To meet the reduction in emergency beds days utilised by 5% by March 2008

3.3 **Local Drivers**

- To ensure local NHS and social care services stay responsive and relevant to local need
- The need to deliver a service that is both sustainable and affordable
- To reverse the trend in non elective activity and the associated increase in costs for the PCT and Wiltshire County Council Social Services

  The target to reduce to zero, by 31st March 2008, the number of people in an acute hospital bed, community hospital bed or mental health bed whose transfer of care is delayed
- The need to prepare local systems that are able to respond to potential new targets for shorter patient waiting times

[7] Christian Grönroos – Service Management and marketing. A customer relationship management approach. July 2000 (The concept of perception matching and/or exceeding expectation)

3.4 What currently works well

3.4.1 There are a number of urgent care services currently in place that work well. Building on these services will provide a model of urgent care that best meets the needs of the population of Wiltshire and provides the relevant economies of scale to make the services affordable.

3.4.2 Some GP practices provide a nurse or doctor triage service for patients telephoning for an urgent appointment. This system improves access for patients and frees up appointment time for those who really need to be seen by a health care professional that day. This should be the norm.

3.4.3 Emergency Care Practitioners (ECP's), employed by the ambulance service, can assess, treat and support patients with a need for urgent care in their own home. Experience suggests this service works best where ECPs are based with community teams because it improves communication and information sharing between the members of the team and ensures that the person with the right skills within the team is deployed to meet the urgent care need of the patient.

3.4.4 The ambulance service triages and categorises '999' calls into three categories A,B,C. Category A are potentially life or limb threatening emergencies and require an immediate response. Category C calls require an urgent response and are deployed to either an urgent care nurse or an ECP. Currently the PCT and Ambulance Trust do not have enough ECPs in post or nurses skilled in urgent care assessment to generate a reduction in to the number of people transported by ambulance to an emergency department. Local performance data demonstrates the potential effectiveness this could have for local services.

3.4.5 Community teams (PCT neighbourhood teams and ambulance service) and specialist nurses in some areas are providing a higher level of support to some residential and nursing homes through both informal training and practical support. The community services in the south of the county are piloting a scheme where a care home can telephone a central referral point if it is concerned about a resident's health. The call is triaged and either offers advice or deploys a health care professional to the home to assess, treat and follow up. This has only been operating for four weeks but has already reduced the number of hospital admissions of residents of those homes within the pilot.

3.4.6 Frail elderly and people with a long term condition are supported through case management by Community Matrons and Nurses specialising in long term conditions such as diabetes, heart failure, chronic obstructive pulmonary disease, multiple sclerosis and Parkinson's. This style of case management means acute phases of a patient's illness become more predictable so action can be

taken to prevent an urgent admission to hospital. Patients using these services say they value knowing they have one healthcare professional co-ordinating their care.

3.4.7 30% of admissions to community hospitals are already 'step up' (that is people who require 24-hour nursing care but don't require 24-hour medical assessment in an acute hospital) and preventing unnecessary admissions to acute hospitals.

3.4.8 A central referral point has operated in the south of the County managing referrals into community services during the day (including weekends) and a single point of entry has operated in the north managing discharge from acute hospitals and admissions/transfers into community hospitals. Both improve information and communication flows in their area and ensure the right service is provided to meet the patients need. This approach should be extended across the county and improved.

3.4.9 Swindon PCT operate a primary care centre, the Clover Centre, next door to the emergency department at the Great Western Hospital. Operational 24-hours a day, it sees and treats people with minor illness and minor injury who would otherwise have attended the emergency department.

3.4.10 The PCT has, in the South of the County, piloted an 'urgent care GP'. Experienced GPs with leadership and change management skills have worked with Salisbury emergency department and MAU and the community urgent care team. They have provided a higher level of medical care than a GP provides within their contract and can demonstrate the potential long term reduction in unnecessary admissions through the change in relationships and developed understanding of skills and roles across secondary, primary and community services.

3.4.11 Intravenous antibiotic (IV) therapy is provided within people's homes by community nurses in the south of the county for people with chest infections or cellulites who are able to cope with their illness at home. This service requires a higher level of GP service than provided for within the general medical services contract so the urgent care GP liaises with the patients own GP and takes on the care of that patient through the acute phase of their illness

3.4.12 The PCT have piloted a service to three residential and nursing homes, offering training, support and direct access to the urgent care team (including GP and ECP) via the central referral point which has reduced admissions to hospital of residents of those homes.

4. The Vision and Key Principles

4.1 The vision set out in the strategy is to develop a proactive, robust system for patients that redirects current levels of urgent care into planned or managed care. This requires a sea change in the traditional culture and relationships within and across the NHS, County Council and independent sector , including not for profit/voluntary organisations to ensure a consistent and co-ordinated response to urgent care need, regardless of service provider.

4.1.1 Patients should expect to receive the same quality of care regardless where they live, who their doctor is or where they are treated. Patients should also expect to be as involved as they want to be in their own care.

4.1.2 Implementing this vision requires a model of urgent care that adopts a relationship marketing approach[7] to service delivery that ensures needs are met by canvassing and incorporating the views of stakeholders, supported by intelligent use of information systems and robust commissioning frameworks.

4.1.3 Service providers will be required to add value by developing strategic and operational partnerships ensuring the patient's experience of urgent care is consistent, regardless of provider.

4.2 Key Principles

Urgent care services will be designed and commissioned to support the delivery of this vision through five key principles:

- Access/availability
- Needs led
- Continuous improvement
- Excellence
- Cost effectiveness

4.2.1 Access/availability

- Urgent care services will be easy to access and available both in hospital and outside of hospital twenty four hours a day, seven days a week for all age groups.

- Service providers will work in partnership to ensure service capacity and therefore delivery can be responsive across the health and social care system to meet both anticipated and unanticipated demand.

- Service delivery will be timely with the right care provided, in the right place by a person with the right skills, first time.

- Access to a non appointment service for both minor and major urgent care needs (considered to be of high importance to the public).

- Advice should be available in a range of formats which must include telephone, face-to-face, digital and online as well as multi-lingual hard copies which are accessible to people with sensory impairment and learning disabilities.

- All health and social care providers must meet DDA (Disability Discrimination Act, 2004) access standards without exception and be situated locally where possible.

- To ensure an empathetic response from first point of contact reception staff must have good communication and interpersonal skills.

- Co-located health and social care services that can complete most care within a single episode.

- Carer support should be considered as an integral part of all assessments

4.2.2 Needs led

- The local community know that services are reliable, safe and meet their need.

- Service delivery will be process driven, based on the patient journey through the health care system.

- A single assessment process will be adopted across all providers to minimise the incidence of patients repeating general demographic information with the understanding that information about the patient belongs to the patient and is transferred across service providers with the patient

- Primary/community clinicians will have access to simple diagnostics, fast reporting and rapid specialist advice.

- Minimal/no delay within and between services.

4.2.3 Continuous improvement

- The achievement and maintenance of service provider's performance targets will be robustly monitored through the commissioners' performance management processes.

- The PCT is an open and learning organisation. Formal and informal complaints, accolades and ideas will inform service development and delivery

- Urgent care service delivery will be primary care led and have a consistent NHS brand image regardless of provider.

- Clear communication to both the user, and where appropriate, their carer about condition/needs, treatment/care and follow up, with appropriate supportive information including contingency plans

4.2.4 Excellence

- Excellence is dependant on service providers working in partnership to modernise the medical, nursing, therapy and social care workforce to ensure the wide range of knowledge, skills and competencies are available to deliver treatment and care to people at home, or as close to home as possible.
- Relevant information about a patient's medical history and social support systems will be available across a 24 hour period.
- Integrated care pathways will be simple to follow and understand.
- Service delivery will be evidence based and use, as a starting point, the wide resource of best practice examples across the health economy.
- Rapidly shared clinical information and documentation between the urgent care services, key workers and care or case managers.

4.2.5 Cost effectiveness

- Commissioners will know that service providers are providing services that are able to respond to changes in demand in the most effective way to meet need.
- The potential financial benefits of urgent care service redesign are essentially based on the principle of reducing non elective demand in the acute sector, manifested usually (but not exclusively) through the use of emergency departments and medical/acute assessment units These benefits can be realised by;
  - Redirecting need to existing primary care, neighbourhood teams and advice services at minimal or no additional cost, *or*
  - Redirecting need away from the NHS altogether and directing it to pharmacy services or self care or other support services as appropriate

Therefore any cost benefits would eventually come from economies of scale acute admission avoidance and associated improvement in productivity.

- The PCT will continue to support the development of preventative services that identify and support vulnerable users (eg falls service, expert patient programme) that can be accessed by users and carers.

5 The Future Service Model

5.1 The future service model will build on what works well and provide efficient, effective, affordable services across Wiltshire so the patient experience is consistent regardless of where people live or access the service. Access points into urgent care services will be effectively co-ordinated, information flows improved, duplication reduced with national and local targets consistently met.

5.2 The PCT's commissioning arrangements will provide clear service specifications, effective care pathways described for specific conditions and a managed system of care across a number of providers. This approach will enable current activity flows to shift to where their need can be met most effectively.

- Approximately 40% of people attending Emergency Department with a minor injury or illness now have a problem that could be resolved by primary care or neighbourhood teams. A reduction from 62,842 (2006/07 FOT) to 25, 137 by 2008/09 with a financial shift from secondary care to primary £1.8m.

- Approximately 5% of urgent (non-elective) admissions could be cared for by primary care and neighbourhood teams now, rising to 30% within three years. A reduction from 38,556 (2006/07 FOT) to 26,909 by 2009/10[8]. A financial shift from secondary care to primary and social care of around £6.3m.

- Approximately 40% of GP practice appointments could be diverted to self care, pharmacy and NHS Direct.

- Great Western Ambulance receive around 500,000 '999' calls from Wiltshire every year and at least 70% of these calls are not life threatening. The Ambulance Trust aim to reduce the number of people transported to emergency departments by 30% in five years by diverting calls to a range of neighbourhood teams and will be working towards this target through the lifetime of this strategy. A reduction from 500,000 (2006/07 FOT) to 350,000.

- The requirement across the Wiltshire health economy to reduce the current level of Wiltshire health and social care delayed transfers of care to an absolute minimum by March 2008.

Table 1. Expected change in access to urgent care & estimated financial impact

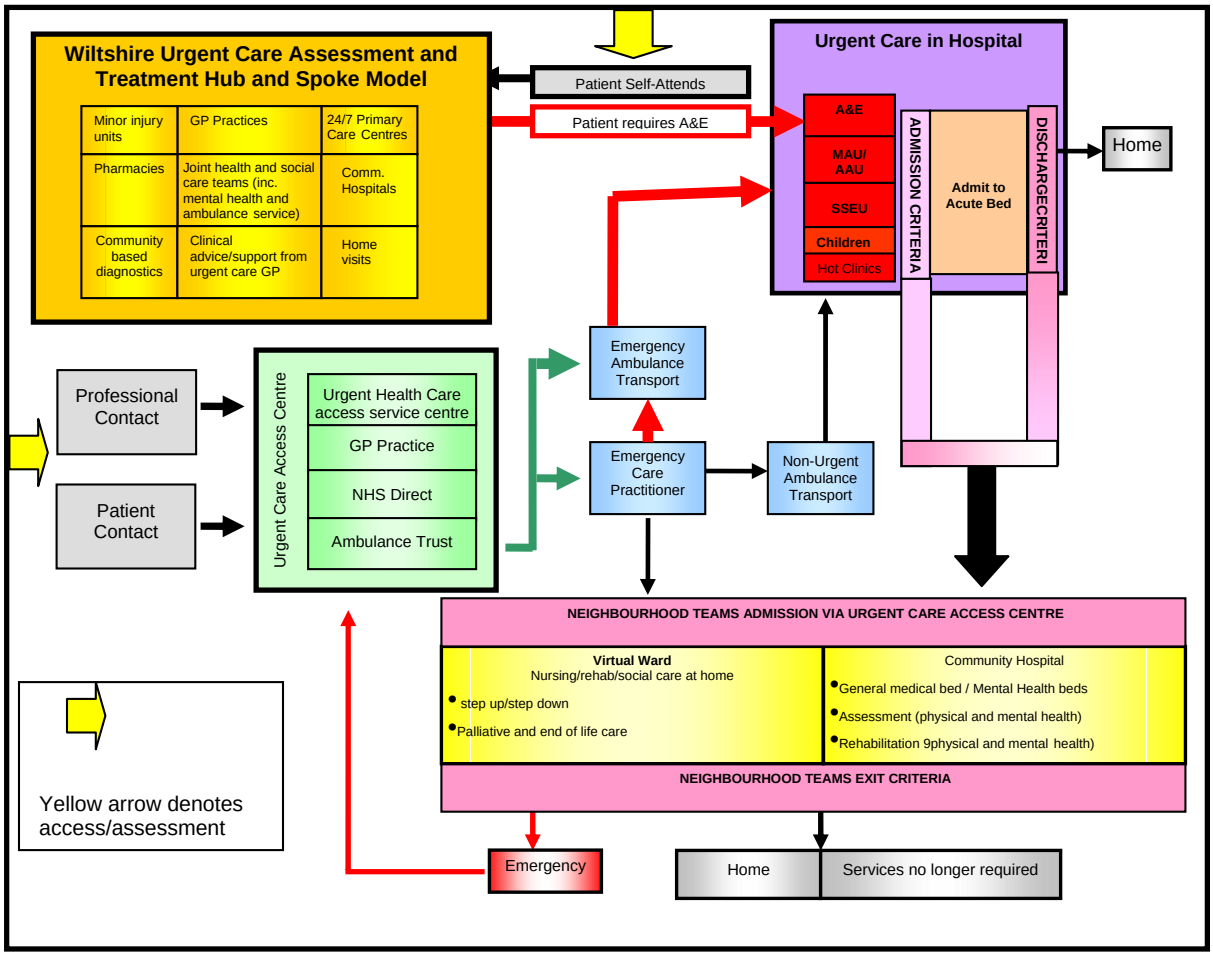
[8] 40% minors and 30& non elective targets evidenced by the Urgent Care GP Project, Salisbury, 2006/07

Table 1 Expected redistribution of current activity to more appropriate service

Current access	Future access
Emergency department minor stream	20% to a Minor Injury Unit or Primary Care Centre 10% to GP Practice 10% to Pharmacy/self care
Non-elective admission	20% Neighbourhood Teams 10% Community Hospitals
Primary Care appointments	Support to Self Care 10% Pharmacy 20% NHS Direct range of services 10% No support required
Ambulance conveyance to emergency departments	20% to Neighbourhood Teams 5% to Community Hospitals 5% to Pharmacy/Self Care
Financial shift from secondary to primary and social care	£8.1m

5.3 The following diagram illustrates the preferred model of urgent care, (based on a "hub & spoke" principle) to support the patient journey.

The diagram sets out the key components of the model and indicates the options for meeting patient needs. A more detailed description of the patient journey is set out in section 5.4. below



5.4 The Patient's Journey

5.4.1 Access points for service delivery will be consolidated to ensure a consistent response, triage/assessment process and appropriate outcomes for the public.

5.4.2 The patient will be triaged by a community/primary care clinician (including those attending emergency departments). The same triage standards and system will be used across the health economy

5.4.3 The patient will either be given advice or a primary care appointment will be made on their behalf (hear and treat); or seen face to face and either given advice or treated or a primary care appointment will be made on their behalf (see and treat).

5.4.4 If the patient requires a service, the urgent care access centre will manage the referral process

5.4.5 If the patient accessed the system at a point least appropriate to meet the need, the see and treat process will be followed and advice/leaflet given for future reference.

5.4.6 If the patient does require emergency assessment (where immediate action is required to preserve either life or limb) they will be directed immediately to the 999 ambulance service, an emergency department or assessment unit.

Once the assessment is completed the patient will either be discharged with no further intervention required, or discharged to neighbourhood team/community hospital or admitted to an acute bed

5.4.7 If the patient requires urgent assessment as an inpatient they will be admitted to a community hospital. Once the assessment is completed (4 – 24 hours) the patient will either be discharged with no further intervention required, discharged to a neighbourhood team or will remain in the community hospital.

5.4.8 If the outcome of the urgent care assessment is that the patient requires the services of an acute hospital, they will be transferred.

5.4.9 The urgent care access centre will manage the referral and transfer process for a patient whilst maintaining communication and information flows between the patient (and family/carers where appropriate), the patients GP and the person making the referral. The urgent care access centre will be supported by e-capacity management system[9]

5.4.10 Patients requiring a high level of nursing and rehabilitation but who do not need to be an inpatient will be referred to the neighbourhood teams and join the 'virtual ward[10]'. Patients registered onto the virtual wards will be cared for in their own homes and/or other community based settings, It is anticipated that each virtual ward will have a team of nurses, a pharmacist, social worker, physiotherapist, occupational therapist and an administrator. The 'virtual ward' telephone number will be the urgent care access centre.

5.4.11 Health and social care professionals who require a community based service, a community hospital bed or an acute hospital bed for a patient/service user will use the urgent care access centre as the referral management centre.

5.4.12 Patients admitted to a community hospital bed will be expected to stay for an average of 20 days by March 2008. As community based rehabilitation services are developed over time, the average length of stay should be reduced to an average of 7 days be March 2010.

5.4.13 A revised protocol to assess for residential care must be established which accepts that all other forms of non residential care must be considered before transfer to a residential home earlier than necessary. Wiltshire Community Health Services and Wiltshire County Council (DCS) will need to review current assessment processes to ensure people are screened and assessed prior to any crisis point and/or admission to hospital.

5.5 Pooled Budgets

5.5.1 Successful service delivery is dependant on partnership working across all service providers and on developing working protocols which allow funding to follow the patient through the use of health act flexibilities and working protocols that split tariff across a managed pathway ensuring patients admitted to hospital are discharged at the optimum time of recovery

[9] Surrey Ambulance NHS Trust, 2005. http://www.surrey-ambulance.nhs.uk/operations/ecms/view
[10] Croyden PCT, 2006

6. Service Development – The Plan

6.1 This section describes the different components of the service model required to support the strategy and plan for change to shift services and resources from hospital into the community. It describes the key developments required to support the highest users of current urgent care services. Using current examples of best practice to evidence the plans. It is expected that these proposed changes will be developed as commissioning specifications and associated business cases for consideration.

6.2 The plan addresses

- Self care
- Primary Care Services
- Urgent care access centre
- Access to emergency departments
- Minor injury units
- Long Term conditions
- Falls Services
- Residential and Nursing Homes
- Mental Health

7.0 Self Care

7.1 Most health care starts with people looking after themselves at home[11] whether they have a minor illness or injury, a long term condition, or the early stages of an acute illness.

7.2 There is growing evidence to show that supporting self care leads to:

- Improved health and quality of life
- Rise in patient satisfaction
- Significant impact on the use of services, with fewer primary care consultation, reduction in visits to out patients and ED, and decrease in hospital resources.

7.3 Research[12] has shown that the impact of self care on urgent care services is:

- Requests for appointments at GP Practices will reduce by 40%.
- A reduction in the lengths of stay in hospital.
- Better medicines' management.
- A reduction by 50% in days taken off work due to illness.

[11] Department of Health. *Self Care – a real choice. Self care support - a practical option* January 2005
[12] http://www.dh.gov.uk/selfcare

7.4 The public have asked for more support to enable self care. The role of the NHS is to provide a range of options that help to reduce anxiety and increase people's confidence in their ability to self care.

Table 2 The role of "self care" in meeting urgent care needs

Plan for change	*Benefits to patients*
NHS Direct health information advice packs ***NHS Direct web site*** ***NHS Direct and Wiltshire County Council Digi T.V.***	• Patients understand their condition • Better symptom management • Peer support
Health promotion services	• Leaflets and posters will be widely available
Pharmacies treatment & advice	• Triage, treatment and advice (ADAPT scheme) • Available 24 hours a day in areas with most demand

8. Primary Care

8.1 Primary care should be the first point of access for people who need to see a health care professional for an urgent care need 24 hours a day.

8.2 Learning from GP practices currently providing a triage service, the PCT will work with practices to establish and ensure a consistent approach across the county ensuring those people with an urgent care need requiring a primary care appointment are seen at the Practice/Surgery.

8.3 National evidence suggests that a consistent triage process and signposting patients to self care or community pharmacies can reduce the number of people requesting GP appointments (by up to 40%).

8.4 The developing Neighbourhood Teams will be caring for people at home that are currently admitted to hospital during a more acute stage of their illness. This requires access to a greater level of medical care than currently available in a community setting. Wiltshire Community Health Services – have trialled, in some areas, an enhanced primary care service. This is where an 'urgent care' GP works as part of the community team (including urgent care nurses and therapists, social care teams and the emergency care practitioners). The GP role in the team provides medical support to intermediate care and home based intravenous therapy. This project has demonstrated how partnership working and early assessment can prevent people being admitted to hospital by enhancing and extending the type of care and support that can be offered to patients at home. A discussion to extend this model should be taken following evaluation of this trial.

8.5 Primary care provided within GP Practice opening times and Primary care provided at evenings, overnight weekends and bank holidays are not efficiently coordinated. Consequently, there is a knowledge/information gap between services which means patients can have different outcomes to their urgent care need dependant on the time of day they access the services. There is also a perception that the increase in attendances to emergency departments is due to the changes in the way out of hours primary care services have been delivered since October 2004, although apart from Saturdays, there is no evidence to support this perception

Table 3 The role of Primary care in meeting urgent care needs

Plan for change	***Benefits to patients***
All GP Practices will provide a triage process	• Patients will always be signposted to the right service, person, place (or self care support) that meets their need
All Practices will divert telephones to the urgent care access centre when they close in the evenings (The urgent care access centre replaces the current OOH's call handling function)	• Patients can use their GP Practice number 24 hours a day. They will not need to listen to an answerphone message and redial. • Patients will receive the same triage response 24 hours per day
Urgent Care GP's	• There will be urgent care GP's working with urgent care to be formed from neighbourhood teams 24/7

9.0 Urgent care access centre

9.1 The development of neighbourhood teams will add to the number of alternative services available. The wider range of options for health and social care professionals to contact may hamper the speed and effectiveness of the referral processes. The urgent care access centre will provide an effective contact point (by one telephone number, one email address and one fax number) to access a range of services for both planned and urgent care.

9.3 Access to urgent care will be managed and can be reduced by providing an intelligent "linked" overview of the pressures within the health economy. This will be through using a web based capacity management system, so that patients can be "scheduled" for urgent care appointments and, where appropriate, referred to a neighbourhood service.

9.4 The web based capacity management system e-CMS© was developed by Surrey Ambulance Service and is now owned by the NHS Institute for innovation and Improvement. It's a sophisticated, user friendly software system that tracks capacity across the whole health economy at locally agreed timescales. Because it is web based clinicians will be able to see what the current the demand on hospitals and neighbourhood teams is, track their own patients admitted to hospital through the system to discharge, see what capacity is within community based services, and see where ambulance transport is available. The capacity management system is extremely cost effective (revenue costs are less than £0.02 per head of population) and has a proven track record in supporting efficiencies within the system across the UK.

9.5 Urgent ambulance transport booking and scheduling for patients who really need an acute hospital bed will be directly linked to the acute hospitals ability to accept patients. This will enable the reduction of peaks in arrivals at the emergency departments (and also inhibit the queues of ambulances at the Royal United Hospital, Bath) and an increase in options to take or signpost patients to other provider options.

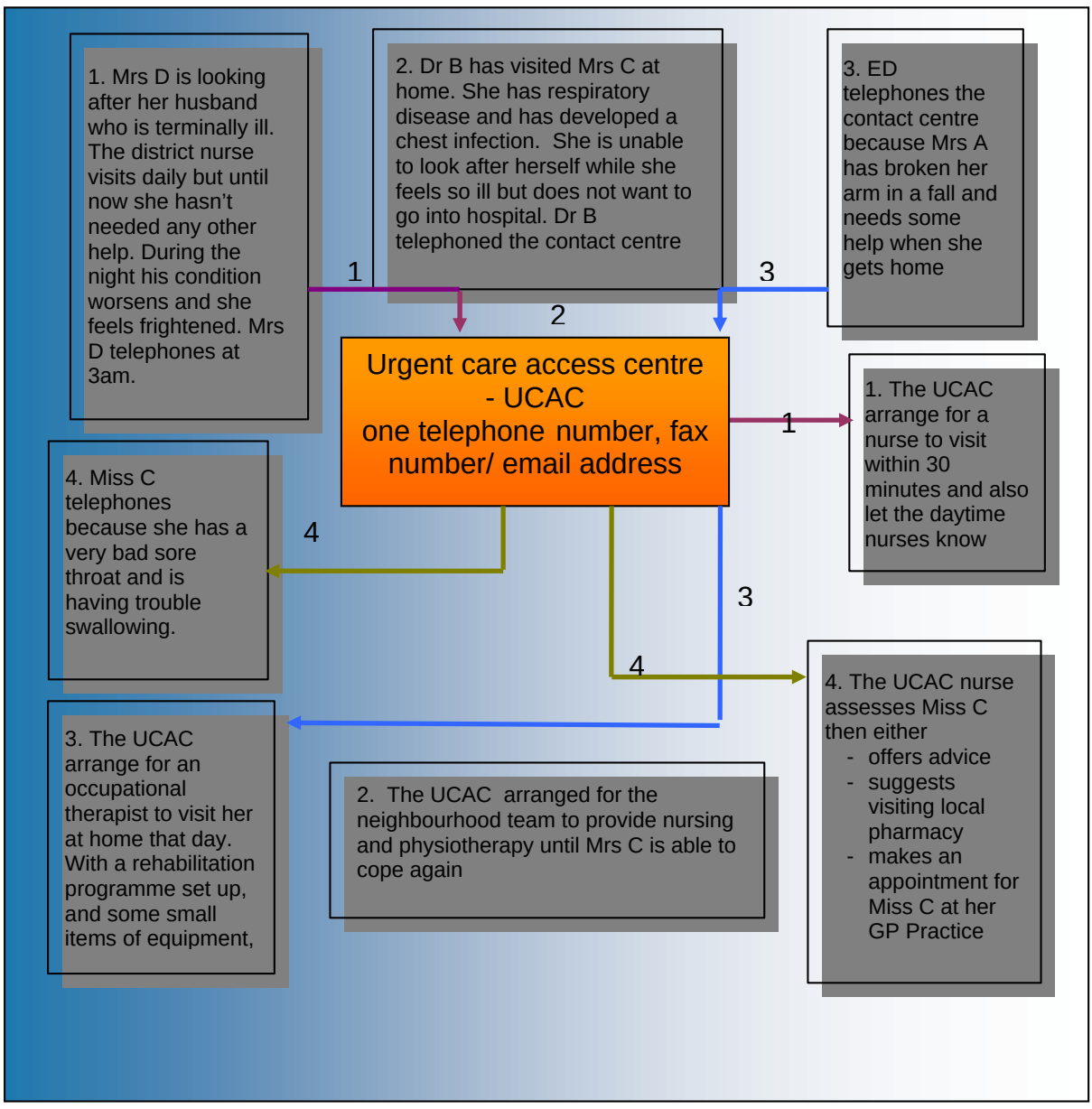
9.6 The urgent care access centre does not replace NHS Direct. The difference is it's local knowledge of service delivery, it's understanding of capacity within the local health economy and it's direct referral access. It therefore enhances the options for NHS Direct by providing a route through which it can access neighbourhood teams.

9.7 The urgent care access centre will replace the current four telephone numbers to access primary care out of hours services, and provide a route to access neighbourhood teams 24 hours a day. This is the first step to bridging the gap between 'in hours' primary care and 'out of hours' primary care.

9.8 It is anticipated that the public will mainly use the single point of access when their GP practice is closed and for advice and support when needed. Because the urgent care access centre manages and co-ordinates referrals across the health economy, it knows who the patients are, who has been discharged from hospital, who is receiving palliative care services etc. so will be able to provide relevant support, reassurance, advise or arrange for a health care professional to visit.

Plan for change	*Benefits to health professionals*
• Develop an urgent care access centre with local focus	• Easy access to a range of services • Fast and efficient patient management • Time savings, especially for GP's • Co-ordination of patients pathways – whole system working • An understanding of capacity across the system – able to offer real and safe alternatives to hospital admission • Improved communication and information flows • Data capture will inform future developments • NHS Direct will be able to refer to local services via the urgent care access centre

Diagram 3 How the urgent care access centre (UCAC) will work



10. Access to Emergency Departments

10.1 To ensure only those patients requiring the specialist services of an emergency department are seen in the department, a primary care or community clinician (nurse, ECP, GP) will provide triage/assessment on entry to the emergency department and treat, advise or direct patients to a primary care facility on the hospital site for fuller assessment/treatment.

10.2 These triage arrangements build on and further develop the primary care services provided on the Great Western Hospital site (Clover Centre), through working in partnership with BaNES and Swindon PCTs, and relevant providers to extend this model. The triage services will be expected to see all attendances, regardless of where they live. The service will operate 24 hours 7 days a week and offer:

- Direct access to diagnostic investigations and tests as appropriate in accordance with agreed protocols
- Multi-professional service delivery making full use of other services such as pharmacy, community services and practitioners etc
- Independent Nurse/Pharmacist Prescribing
- Commitment to completing an episode of care where appropriate.

10.3 Patients who arrive at an emergency department when the most appropriate service to meet their need is their GP practice, minor injury centre, local pharmacy or self care, will be seen, treated and advised then signposted to the appropriate services for future reference.

10.5 Community physiotherapists, social care staff and mental health trained staff will in-reach into the emergency department majors stream and medical assessment units/acute assessment units to help prevent unnecessary admissions.

Table 5 The role of Primary Care/Community Services at the entry points of emergency departments

Plan – Primary care services within emergency departments	***Benefits***
• PrimaryCare or Community Clinician will provide triage/assessment to patients on entry to the emergency department	• Shared reception area • Maintaining use of some types of acute staff; typically Emergency Nurse Practitioners (ENPs) working on the "minors" stream. • New roles for community nurses/ECP's, such as triage role to stream patients to the most appropriate service at the reception. • Moving the 'minors' stream of work (minor illness, minor injury) into primary care. • Acute hospital teams understand the skills and roles within primary care and community services and vice – versa which facilitates changes in behaviour/develops partnership working • Educating the public to use alternative services that more adequately meet their need •

11.0 Minor Injury Units /Primary Care Centres at Swindon and Salisbury

11.1 The commissioning specification for minor injury units and primary care centres are outlined in Reforming Community Services. Minor injury service is also available at the Clover Centre (GWH). Proposed developments in Salisbury for Primary Care Centres also include some level of minor injury service. Specifications for their development are being reviewed. This section demonstrates the benefits of these services to urgent care, it does not duplicate information already published

11.2 The PCT will work in partnership with the ambulance trust to provide an interim service to the population in the east of the county. The interim service will be closely monitored and a mainstream solution sought though the lifetime of this plan once demand is fully understood

11.3 In addition to the MIUs in Chippenham and Trowbridge, Wiltshire residents close to the Swindon border can access the Primary Care Centre on the Great Western Hospital site, the Clover Centre, and those close to the BaNES border can access the walk in centre in Bath

11.4 The proposed Primary Centres Salisbury will not be operational through the lifetime of this plan. A reduction in minor illness/injury attendances will be achieved through primary care working in partnership with Salisbury Foundation Trust's increase use of primary care appointments and self care. A reduction in non elective admissions will be achieved through the current delivery of community services, enhanced by urgent care GPs and ECPs

11.5 The ambulance services will use the minor injury units as an alternative destination point to an emergency department.

11.6 The following sections will outline the areas that will have the greatest impact on urgent care services, and the strategic approach of the local health economy to each area.

12.0 Long Term Conditions

12.1 Long term conditions can be defined as those conditions that can be managed through medication and/or other interventions, but cannot currently be cured. For example; diabetes, asthma, arthritis, heart disease, epilepsy, renal disease and some mental health illnesses, multiple sclerosis and skin diseases such as psoriasis. These conditions vary in their degree and severity, but the impact on a person's life and on those close to them can be considerable.

12.2 Currently people with long term conditions are high users of urgent care services. For instance; appointments with their GP or Practice Nurse, calling an ambulance, urgent admission to hospital

Table 6 How the NHS will support people with long term conditions

Plan for the change	***Benefits to patients***
Providing expert patient programmes and education programmes for people newly diagnosed with a long term condition	• Patients understand their condition and how best they can manage it to maintain the lifestyle they choose • Provide peer support • The patients expectation of service quality meets their perception • Patients have more informed involvement in care planning/treatment as health needs change • Improved quality of life and sense of well being
Primary Care Centre gymnasiums and cafés	
Implementation of telecare (including telehealth)to support independence	• Increase safety by treating more people at home • Reduces anxiety as patients and carers know help is at hand
Developing information sharing protocols across providers, understanding the information	• Reduced duplication in information giving • Patients own and have shared

Plan for the change	*Benefits to patients*
about the patients belongs to the patients	responsibility for their records
Implementing a virtual ward system , co-ordinated by Community Matrons, so people can receive high levels of nursing, therapy and social care through the acute phases of their illness. ***Integrated health and social care services***	• Identification and protection of vulnerable people • Providing safe services in safe places • Increase safety by treating more people at home • Open and transparent environment where patients can raise concerns • Predictable, equitable outcomes • Clear, transparent responsibilities • Consistent quality of care across all providers • Care pathways include domiciliary visits from hospital consultants • Proactive case management maximises predictability of demand for individuals who are currently frequently admitted
Early identification and monitoring of people who may require extra care, residential or nursing home care	• Timely assessment of need for long term care reduces the stress and anxiety of moving home for the individual patient and those close to them. • Stops assessment taking place in an hospital setting whilst the person is recovering from an illness or accident
Working with partner agencies to ensure more support is provided to Carers	• Practical training in basic care such as how to prevent pressure sores • Emotional support • Short term respite

13. Falls

13.1 Falls are a major cause of disability and the leading cause of mortality due to injury in older people aged over 75. National evidence suggests that around one third of people over the age of 65 years will experience a fall in any given 12 month period. In Wiltshire this equates to around 584 people.

13.2 The Older People's NSF, standard six,[13] claims that by introducing an integrated falls services, falls and their consequences can be reduced, thereby improving outcomes for older people (promoting their independence) and reducing pressures on the NHS and Social Care Services.

[13] Department of Health, National Service Framework for Older People, March 2001

13.3 Although there has been activity across Wiltshire in relation to prevention of falls (early discussion on the development of falls assessment tool; falls care pathways; establishment of falls clinics), in the main falls services are secondary care led. The PCT does not have an integrated falls service as outlined within the NSF, nor a consistent service across Wiltshire.

13.4 The development of a falls strategy is one of the targets in the Local Area Agreement (2007 -2010) and reducing falls is one of the Local Public Service Agreement targets (2008). Therefore it is outside the remit of this strategy.

13.5 The national target is to reduce falls and hip fractures by 15% by 2010 through a range of interventions delivered across Wiltshire, led by community therapists. The benefits to patients will be to improve their health and wellbeing.

Table 7 How people who fall will be supported

Plan for change	***Benefits to patients***
A wide range of approaches delivered by a wide range of providers including screening and assessment, medication reviews, modification to the home environment and treatment of postural hypotension, identifying those at risk of osteoporosis (already in place) ***Balance Training within primary Care centres or leisure Centres– such as Tai chi*** ***Falls service within emergency departments and MIU's ensuring reassessment, follow up and changes to risk factors where required*** ***Provision of hip protectors to people assessed as at risk of falling***	***A reduction in the number of people whose fall causes injury*** ***An improvement in health and well being***

14. Residential and Nursing Homes

14.1 There were approximately 800 non elective admissions during 2006/07 by residents of residential or nursing homes. Only one percent had been seen by a primary care clinician prior to admission.

14.2 It is acknowledged that traditionally Community Nurses have not supported residents of nursing homes because the homes have 24 hour nursing cover. However, it is recognised that both residential and nursing homes need the support of multi-professional community services to support older people with complex needs

Table 8

Plan for change	***Benefits to patients***
Provide formal and informal education and training to care home staff particularly; ***End of life care, infection control, nutrition, hydration, basic care skills***	Well trained and supported staff Decreased staff turnover Reduced admissions to hospital (esp, for end of life care and conditions linked to dehydration)
Every resident will have a nutritional assessment	Ensures health and well being
Every resident will be screened to assess the need for a comprehensive falls assessment	Ensures all residents requiring comprehensive assessment receives such Resulting action reduces falls and fractures
The urgent care access centre will be the first access point for care homes to access urgent care services. The urgent care access centre will triage then either; ▪ ***Provide support and advice*** ▪ ***Make an appointment/book a home visit with the patients own GP Practice*** ▪ ***Arrange for an ECP, Urgent Care GP or neighbourhood team to assess.***	Easy to access system for a full range of services. Visiting clinicians can treat, support and follow up within the care home setting Only those residents requiring the specialist skills of an acute hospital will be admitted

15 Mental Health[14]

15.1 To facilitate the improvement to community based services the PCT will develop a model for community services which is based on assessed levels of local need, offers effective services and is developed based on local and national evidence. This should include a commitment to:

- Developing a model for local community mental health services including:
  - A range of primary care mental health services that people with mild to moderate mental health problems can access through their G.P.
  - Specialist community mental health teams in each of the four district areas
- Reconsidering the role of the Community Mental Health Team within community services and linking these teams effectively to primary care, hospital provision and other services.
- Reviewing the pathway of care to ensure effective liaison between all mental health services in both the primary and acute sector; and including partnership working between specialist teams as set out in the Mental Health NSF[15] and national models of care for drugs and alcohol services.
- Developing improved access to psychological therapies and counseling.
- Improve initiatives to support the needs of carers, including access to respite services.
- Review the mental health out of hours system, to ensure that the pathway care is known and understood by service users, carers and GPs for all mental health referrals.

16. Expected Outcomes

6.1 The redesign of urgent care services will realign service delivery to the most appropriate setting for the public, ensuring the right care is delivered, by the right person, first time. The outcome of this realignment will: Reduce attendances by Wiltshire residents self presenting to the emergency departments of the three District General Hospitals; Royal United Hospital, Bath; Great Western Hospital, Swindon and Salisbury Foundation NHS Trust; by 40% in two years

- Reduce non elective admissions from Wiltshire residents by 30% in three years Reduce ambulance conveyances to emergency departments by a minimum of 30% in five years (GWAS strategy timescales)

[14] A strategic framework for mental health Services in Wiltshire 2007 - 2012
[15] National Service Framework for Mental Health, 1999

16.2 Critical Success Factors

Making the Shift: key Success Factors[16] summarises the initiatives that support a shift from hospital care to care at home or close to home as;

- Strong leadership within commissioning and provider organisations that empowers individual staff to take responsibility
- Focussing on changing behaviours and culture within internal and external stakeholders
- The commitment of all stakeholders, from front line staff to executive teams, to implementing the strategy
- Ensuring frontline staff have the skills and resources required to deliver the services
- Centralised operational control (through a single point of contact) with the skills and resources to co-ordinate and manage patient pathways that can:
  - Send the clinician with the right skills to the patient
  - Ensure information is shared across the system to meet both patient and clinician/professional need
- Effective information management systems

17 Risks

This section outlines the potential risks to implementing the strategy

17.1 Public expectation

This strategy is in line with and supports national policy which has already been informed by public opinion. The strategy supports significant changes to local services which have already been subject to public consultation. Other improvements to services will require engagement with local service providers to develop action plans for change. Public engagement and opinion has consistently reported the need for greater and clearer levels of communication about what services are available where and for what conditions. Some aspects of this strategy have already been not been consulted on.

17.2 Affordability

The strategy has to be implemented within the PCTs overall allocation of resources. A significant level of investment has already been identified to support both the programme of Reforming Community Services and the introduction of Emergency Care Practitioners.

Other developments and improvements will require the use of Health Care Act flexibilities and re-negotiating working protocols with acute trusts ensuring funding follows the patient.

[16] Debbie Singh; Making the Shift: Key Success Factors. A rapid review of best practice in shifting hospital care into the community. University of Birmingham Health Services Management Centre/NHS Institute for Innovation and Improvement, July 2006

The Business cases for key development areas identified within the strategy will need to demonstrate both affordability through improved productivity. Service providers may be reluctant to alter their services and associated cost structures

Successful implementation of this strategy has implications for the model of service and associated cost structures of the current three main emergency departments used most often by Wiltshire residents

17.3 Data and Information

Accurate and substantial data is necessary to monitor the implementation and impact of the strategy. Relevant reporting will be mandatory for service providers, with data sets and reviews of the results through the appropriate Urgent Care Network. There is a risk around the quality of data that is received and the subsequent decisions made.

17.4 Clinical Engagement and Ownership

Lack of engagement and ownership will threaten new service plans as clinicians will be required to lead substantial components of the strategy. Significant change in the way people work brings risk to implementation because of the change in behaviours and culture required to initiate change.

Successful delivery of the strategy is dependent on partnership working and a workforce with the right skills and competence to meet need. Workforce development and training plans need to be shared across providers to reduce duplication of key skills and to ensure the skill mix is evenly distributed across the County

18. Conclusion

18.1 This strategy outlines the overarching vision and the PCT's commissioning intentions for urgent care services in Wiltshire move the next three years

18.2 We will achieve this by:

- Moving more care currently provided within district general hospitals into appropriate community settings. This is more than simply increasing capacity within primary and community services. It requires a partnership and integrated approach across providers and commissioning organisations, investment in community and primary care services, in training and support for health and social care teams, investment in information systems and investment to support informal carers who, supported by NHS funded services and Social Care will be caring for much sicker people at home, when being at home is the best option for that person.

- Developing managed care strategies that integrate primary and secondary care pathways ensuring needs are met by the right health and social care professional at the right time and in the right place

- Acknowledging, sharing and collaborating to manage risks and meet the challenges involved for all stakeholders.

- Taking a whole system approach, with 'money following the patient', e.g. through the development of integrated care pathways, through local enhanced primary care services and pharmacy services and through the contracts with district general hospitals.

18.3 It is acknowledged that the strategy sets a number of challenges.. However, the PCT believes the principles and key developments will best meet the urgent care needs for Wiltshire residents.

Appendix 1

1. National Policy

1.1 The publication of the NHS Plan in 2000[17] was the first step in national policy aimed at improving emergency care services. The NHS Plan set out the target that has been the focal point and main driver for the improvements we have seen in emergency services over the last four years meaning:

98% of all patients attending the ED will be admitted, discharged or transferred within four hours of arrival at a type 1, 2,or 3 emergency unit.

1.2 The NHS Plan was followed by *Reforming Emergency Care*, a ten year strategy based on the following six principles:

- Services should be designed from the patient's point of view
- Patients should receive a consistent response, wherever, whenever and however they contact the service
- Patient's needs should be met by the professional best able to deliver the service
- Information obtained at each stage of the patient's journey should be shared with other professionals who become involved in their care
- Assessment or treatment should not be delayed through the absence of diagnostic or specialist advice, and
- Emergency care should be delivered to clear and measurable standards.

1.3 In 2001, the DoH also published the Carson Report which recommended a new model for the provision of out of hours services based on prompt response times, simplified access and integrated delivery of services.

1.4 National figures now report that 98% of patients spend less than four hours in the Emergency Department (ED) despite unprecedented increases in numbers of ED attendances. Whilst the four hour target/standard was the catalyst for much of the change, it is now recognised that to further develop the provision of emergency care, organisations must look beyond secondary care. *Transforming Emergency Care in England*, October 2004, describes a comprehensive, patient-centred emergency care system that transcends the conventional boundaries of primary, secondary and social care.

1.5 The health and social care white paper *Our Health, Our Care, Our Say* published 31st January 2006 clarifies the national vision for out of hospital care.

[17] Department of Health *NHS Plan* (2000)

1.6 The drivers for achieving such a patient-centred system are described as:

- Empowered and effective Urgent Care Networks which break down existing barriers and develop services around patient need
- Simple local access to services supported by Connecting for Health
- The roll out of Urgent Care Centres/Primary Care Centres replacing or supplementing Minor Injury Units and Walk in Centres to increase choice for patients and quicker access to assessment and diagnosis
- The new GMS contract and Pharmacy Contract which can offer new solutions for the delivery of both in hours and out of hours care which matches patients with the clinician most suited to their needs.
- Payment by Results and Practiced Based Commissioning providing incentives for service providers to offer improved access to appropriate care.
- The development of new roles in the delivery of emergency and urgent care such as Emergency Care Practitioners.
- Emergency prevention – including national targets to improve health outcomes for older people with long term conditions by offering personalised care plans and to reduce emergency bed days through improved care in primary and community settings.
- The development of crisis intervention teams for secondary mental health service users, incorporating out of hours crisis support

1.7 A Direction of Travel for Urgent Care[18] outlines what people want from urgent care services;

- services that support them to prevent ill health, that are quick and simple to access and that put them in control.
- when they need care, it will be available close to or in their own homes.
- they have been given the advice and care that will keep them safe.
- they like the changes already happening such as; more emphasis should be placed on prevention and support to self-care, the extended role of community pharmacies, NHS Direct telephone services, more Direct Payments and Individual Budgets.

1.8 The document goes on to outline what is frustrating with the current systems;

- delays in getting the services they need when they need them,
- duplication between services and being passed from one service to another
- having to repeat basic information about themselves
- some groups remain disadvantaged in their access to care

[18] Department of Health. *A Direction of Travel for Urgent Care*, *a discussion document* October 2006

Appendix 2

Current Urgent Care Services

- Out of hours GP services for Wiltshire residents are provided by Wiltshire PCT for the majority of the population registered with a GP in South Wiltshire. This out of hours service provides call handling and nurse triage for Bath and North East Somerset PCT (BANES) and the Ministry of Defence. All GPs have opted out of providing 'out of hours' cover. Additionally in the south

    - 5 Practices use Emergency Care Service – Dorset and Somerset (previously known as Dorset Emergency Care Services – DECS)
    - 2 Practices use North Hampshire Out of Hours Service

- Out of hours GP services for patients registered with a Kennet, North and West Wiltshire GP are provided by Wiltshire Medical Services. WMS also provide out of hours services to the RAF and prisons
- All patients registered with dentists in Wiltshire are able to access emergency treatment by contacting their dentists in hours. The PCT operates an out of hours dental service in collaboration with Swindon PCT and Wiltshire Medical Services
- There is one pharmacy in Chippenham open for 100 hours a week in Wiltshire
- Social care is provided by Wiltshire PCT and Wiltshire County Council
- Salisbury NHS Foundation Trust, Royal United Hospital,Bath and Great Western Hospital, Swindon are the local providers of acute hospital services with a Type 1 Emergency Department is located at each
- Current Minor injury/walk in to add
- In addition to Wiltshire residents, people use the acute trusts from the following PCT areas which contributes significantly to the emergency and elective admission workload

    - New Forest PCT (Hampshire)
    - North Dorset PCT
    - South and East Dorset PCT
    - Bath and North East Somerset PCT
    - Mendip
    - Oxfordshire
    - Berkshire

    - Salisbury NHS Foundation Trust is the centre for specialist services in burns and plastics for the Wessex region, and for spinal injuries for much of southern England, equating to a population of 11 million.
    - Nationally, ED attendances have shown around 17.6% growth in 2003/04 compared to 2002/03, and a further 8% growth in 2004/05. Local reporting demonstrates 10% of A&E attendances to Salisbury Foundation Trust are MOD personnel.
    - Overall outcomes across the health economy for the main National Service Frameworks areas of cancer, mental health, coronary heart disease, diabetes, respiratory disease and stroke are good.

Appendix 3

Profile of local population[13,14,15]

The geographical area served by Wiltshire PCT has a usual resident population of around 444,600. The population served by Wiltshire PCT covers a total of 3,255 square kilometers (around 1,400 miles).

There are 63 GP Practices with a registered population of 425,768 plus a transient 7,206 Ministry of Defence personnel and their dependents.

Deprivation[19,16]

Overall, the population served by Wiltshire PCT is much better than the national average in terms of its low crime and disorder levels, the good health of its residents, income levels, employment, education levels and living environment. It is worse than average for the domain of barriers to housing and services due to poor geographical access to GP's and shops for its rural population.

- None of Wiltshire's Super Output Areas (SOAs) ranked among the most deprived 10% in England, although some SOAs are comparatively health deprived by local standards.
- Three SOA's in Wiltshire are among the most deprived 20% nationally, two in West Wiltshire (both in Trowbridge) and one in Salisbury (within St Martin and Milford).

Socio Economic[13,17,18]

- The population of Wiltshire has an average age of 39.27 years with 6.14% under the age of five years and 20% at or above retirement age (65 years for men, 60 years for women). This compares to the national average of 38.6 years with 6% under the age of five and 19% at or above retirement age. The population of Wiltshire aged 60 – 65+years is predicted to grow at a rate of 25.2% between 2001 - 2011 Only 13.85% of retirement age households are lone households, compared to a national average of 14.3%. 4.76% of dependent children are recorded as living with lone parents, compared to a national average of 6.42%[20]
- There are around 278 looked after children in Wiltshire. Of these 197 are fostered, 13 are placed for adoption, 20 live in children's homes, 29 are placed with their own parents, 9 are placed in residential schools and 10 are supported in other ways. 39 children went on the South Wiltshire Child Protection Register, and 23 were removed, during the period April 2004 – March 2005. 64 children went on the West Wiltshire Child Protection

[13] GOSW Regional Intelligence Team – Wiltshire Brief (www.gosw.gov.uk/wiltsstatbrief)
[14] Kennet and North Wilts PCT and West Wilts PCT Report and Accounts 2005/2006 and South Wiltshire PCT Annual Report and Accounts 2005/2006
[15] The Information Centre for Health and Social Care (www.ic.nhs.uk/pubs/ gpregpopulations2005)
[16] Intelligence Network (www.intelligencenetwork.org.uk/social inclusionandpoverty)
[17] Wiltshire & Swindon Intelligence Network (www.intelligencenetwork@wiltshire.gov.uk)
[18] Wiltshire Strategic Analysis 2002 (www.wiltshire-cpre.org.uk/tpp/WiltshireStrategicAnalysis)

Register, and 53 children went on the Kennet and North Wiltshire Child Protection Register, in 2005.

Health Problems[13,19,20]

- In 1997-1999 the average male life expectancy in Wiltshire was 76.9 years (75.2 for England) and for women 81.14 years (80.1 for England).
- Infant mortality is lower than the national average at 3.3 deaths per 1,000 live births (national average with approximately 5.2 deaths per 1,000 live births) before the age of 12 months in 2002-2004.
- There were 102.9 deaths per 100,000 population from smoking in 2002 -2004. But the death rate from smoking was significantly better than the national rate.
- Similarly the premature death rate from heart disease and stroke (76.1 per 100,000 under 75 years) was significantly better than the national rate.
- The death rate from cancer (107.9 per 100,000 under 75 years) was significantly better than the national average.
- In 2002-2004 average suicide rate for Wiltshire was 10.6% per 100,000 population. Kennet was 12.8% and Salisbury 11.7%, which is higher than national data, but this was not statistically significant as the 95% confidence levels were large (-30% to +44%).
- The number of people living in South Wiltshire and accessing health services for HIV rose from 11 to 20 between 2002 and 2004.
- There were 685 newly reported cases of sexually transmitted infection in 2004. This is only the number of people who actively sought health services and the actual number of new cases is likely to be higher.
- Conception rates per 1,000 women aged 15 –17 in Wiltshire for 2002 - 2004 were 28.7, which lower than both the South West (34.6) and England (42.0) rates. The Wiltshire figure has reduced from 30.5 in 2000 – 2002.
- About 13,483 people (3.0% of the registered practice population) have been diagnosed with diabetes, mostly type 2 which is largely preventable with a healthy lifestyle. It is thought a similar number probably are affected but not diagnosed.
- The estimated number of problem drug/alcohol users living in Wiltshire (2004/2005) is 1692 (less than 1% of the population).

Ethnicity[13]

At 1.6% of the population, Wiltshire has a lower proportion of people who consider themselves ethnic minorities than the region as a whole, and considerably less than the national share (SW: 2.3%, Eng: 9.1%).

[13] GOSW Regional Intelligence Team – Wiltshire Brief (www.gosw.gov.uk/wiltsstatbrief)
[19] APHO and DoH – Health Profile for Wiltshire 2006 (www.communityhealthprofiles.info/profiles)
[20] Office for National Statistics (www.statistics.gov.uk/statbase)
[13] GOSW Regional Intelligence Team – Wiltshire Brief (www.gosw.gov.uk/wiltsstatbrief)