Wiltshire Council

AGENDA

Meeting: **Health and Wellbeing Board**

Place: **Kennet Room - County Hall, Bythesea Road, Trowbridge, BA14 8JN**

Date: **Thursday 28 November 2024**

Time: **10.00 am**

Please direct any enquiries on this Agenda to Max Hirst - Democratic Services Officer of Democratic and Members' Services, County Hall, Bythesea Road, Trowbridge, email Max.Hirst@wiltshire.gov.uk

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Please see the agenda list on following pages for details of deadlines for submission of questions and statements for this meeting.

For extended details on meeting procedure, submission and scope of questions and other matters, please consult Part 4 of the council's constitution.

The full constitution can be found at this link.

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AGENDA

1 **Chairman's Welcome and Introductions**

The Chairman will welcome everyone to the meeting.

2 **Apologies for Absence**

To receive any apologies for absence.

3 **Minutes** *(Pages 7 - 14)*

To confirm the minutes of the meeting held on 11 July 2024.

4 **Approval of Notes and Recommendations from 26 September 2024**

For the Board to consider the notes and recommendations from 26 September 2024.

Due to the scheduled meeting not being quorate, no official resolutions could be made, therefore recommendations were read out for the awareness of attendees, although no official debate or action was held or taken. The link to the agenda, agenda supplement, reports and notes for 26 September 2024 is below:

Agenda and draft minutes - Democratic Services - Wiltshire Council

The recommendations to be considered are as follows:

Better Care Plan - standing update

i) Notes the quarterly report submitted to the national team on 29 August 2024 (Appendix A).

ii) Notes a verbal update on the investment agreed at cabinet in community health services and the related ICB procurement (see links under background papers)

iii) Notes a verbal update on the refresh of a s75 agreement between BSW ICB and Wiltshire Council

iv) Notes the latest performance in delivery against indicators in the Joint Local Health and Wellbeing Strategy (appendix B)

BSW Implementation Plan

i) To note the update

SEND AP and Inclusion Strategy

i) To note the update

Gypsy-Roma-Traveller-Boater Strategy

i) Note the findings of the review of the Gypsy, Roma, Traveller &Boater Strategy (2020-2025);

ii) Note progress against the current strategy, and areas for development;

iii) Encourage partners to work with Wiltshire Council: to raise awareness of the community's needs, and to further develop the aims and objectives for a new Strategy; and

iv) Request an update report from officers on the development of the Strategy.

Wiltshire Community Safety Partnership Update

i) To note the update

5 **Declarations of Interest**

To declare any personal or prejudicial interests or dispensations granted by the Standards Committee.

6 **Public Participation***(Pages 15 - 16)*

The Council welcomes contributions from members of the public.

Statements
If you would like to make a statement at this meeting on any item on this agenda, please register to do so at least 10 minutes prior to the meeting. Up to 3 speakers are permitted to speak for up to 3 minutes each on any agenda item. Please contact the officer named on the front of the agenda for any further clarification.

Questions
To receive any questions from members of the public or members of the Council received in accordance with the constitution.

Those wishing to ask questions are required to give notice of any such questions in writing to the officer named on the front of this agenda no later than 5pm on **Thursday 21 November** in order to be guaranteed of a written response**.** In order to receive a verbal response questions must be submitted no later than 5pm on **Monday 25 November 2024.** Please contact the officer named on the front of this agenda for further advice. Questions may be asked without notice if the Chairman decides that the matter is urgent.

Details of any questions received will be circulated to Committee members prior to the meeting and made available at the meeting and on the Council's website.

7 **Chair's Announcements** *(Pages 17 - 18)*

A brief item to allow attention to be drawn to the following developments:

- Public Health Annual Report
- SEND & CQC Inspections Update
- Joint Chief Executive announced for new hospital collaboration

8 **Community Services and Hospitals** *(Pages 19 - 62)*

To receive an update on the work of the BSW Integrated Care Board on community-based care.

9 **HomeFirst** *(Pages 63 - 64)*

To receive an update on the in-sourcing of HomeFirst from Wiltshire Health and Care

10 **Better Care Plan - standing update** *(Pages 65 - 76)*

To receive an update on developments relating to the implementation of the Better Care Plan.

11 **Neighbourhood Collaboratives** *(Pages 77 - 130)*

To receive an update on Neighbourhood Collaboratives, specifically the Well Farmers for Wiltshire Pilot.

12 **Safeguarding Vulnerable People Partnership** *(Pages 131 - 162)*

To receive the Safeguarding Vulnerable People Partnership (SVPP) Annual Report for 2023-2024.

13 **Healthwatch Wiltshire Annual Report** *(Pages 163 - 164)*

To receive and note Healthwatch Wiltshire's Annual Report for 2023-2024.

14 **Date of Next Meeting**

The date of the next meeting will be 30 January 2025.

15 **Urgent Items**

To discuss any items the chair agrees to as a matter of urgency.

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Wiltshire Council

Health and Wellbeing Board - NOTES

NOTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 26 SEPTEMBER 2024 AT KENNET ROOM - COUNTY HALL, BYTHESEA ROAD, TROWBRIDGE, BA14 8JN.

Present:
Cllr Laura Mayes, Cllr Gordon King, Cllr Iain Blair-Pilling, Kate Blackburn, Lucy Townsend

Also Present:
Cllr Christopher Williams, Caroline Holmes, Helen Mullinger, Alison Ryan, Ian Saunders, David Bowater

38 **Chairman's Welcome, Introduction and Announcements**

Cllr Laura Mayes, Deputy Leader of the Council and Vice-Chair of the Health and Wellbeing Board, welcomed those present and explained that in the Chair's absence she would be chairing the meeting.

Cllr Mayes also explained that the meeting was unfortunately not quorate, and therefore no formal decisions could be made at this meeting. It was suggested that the proposals for each item be informally noted, so that they could potentially be formally ratified at the next meeting.

39 **Apologies for Absence**

Apologies were received from:

Cllr Richard Clewer (Chairman)
Kevin Peltonen-Messenger
Rob Llewellyn - Office for Police and Crime Commissioner
Dr Nick Ware

40 **Minutes**

The minutes of the previous meeting on 11 July 2024 were presented for comments.

41 **Declarations of Interest**

There were no declarations of interest.

42 **Public Participation**

A question had been received in time for a written response and is attached to the Agenda Supplement.

A follow up question was asked and is attached to the notes.

It was agreed that due to the level of detail contained within the question and the complexity of the situation, that the question would be taken away by senior officers and an answer would be provided after the meeting.

43 **Better Care Plan - standing update**

Helen Mullinger briefly introduced the update and asked for any questions.

The following recommendations were noted:

i) Notes the quarterly report submitted to the national team on 29 August 2024 (Appendix A).

ii) Notes a verbal update on the investment agreed at cabinet in community health services and the related ICB procurement (see links under background papers)

iii) Notes a verbal update on the refresh of a s75 agreement between BSW ICB and Wiltshire Council

iv) Notes the latest performance in delivery against indicators in the Joint Local Health and Wellbeing Strategy (appendix B)

44 **BSW Implementation Plan**

The Board received receive a report and presentation from Caroline Holmes highlighting revisions in the BSW's Implementation Plan.

The presentation included Wiltshire ICB's successes and priorities moving forward and is attached to the minutes.

CORE20PLUS5 was clarified as allowing local areas to highlight their own priorities on top of the "Core 20" provided centrally.

It was clarified that objectives had not been listed endlessly to allow focus and clarity, and that outcomes were being closely monitored.

The following recommendations were noted:

i) To note the update

45 **SEND AP and Inclusion Strategy**

The Board received from Kai Muxlow the new SEND Alternative Provision (AP) and Inclusion Strategy.

The Board was reminded of the strategies vision that 'People in Wiltshire are empowered to live full, healthy and enriched lives.' Children and young people need a good start in life in order to build resilience and enhance their education.

The strategy was also to offer support to all children, young people and their families, focusing on reducing inequality by helping those who need it the most.

Following the successful implementation of the 2020-2024 SEND and Inclusion Strategy, close collaboration with parents and carers, children and young people was undertaken to understand what was required from the next iteration.

As a result of this work, the new strategy "Meeting Needs Together - Ambitious for All" had been written. The Strategy has six key priorities:

Priority 1: Children and young people and their families will be at the centre of planning, their views and aspirations heard and acted upon, as true partners.

Priority 2: Getting the right support at the right time, identifying and acting on our children's needs at the earliest opportunity and through promotion of inclusive approaches and practice across the local area.

Priority 3: Provide opportunities for timely planning, reflective of the views of the child or young person and parent carers' current needs, that have clear outcomes.

Priority 4: Ensure good quality communication and information, for families to have a positive experience when navigating services, with information that is easy to access and use.

Priority 5: Professionals and officers across the SEND system will have the skills, knowledge and training to enable effective collaboration across services, joint assessments and sharing of good practice.

Priority 6: Children and young people will be prepared for adulthood and experience timely transitions, leading to increased skills, greater independence, and a greater range of opportunities in life.

The Board wanted to see clear examples of how families would notice the differences made by the strategy in order to build their confidence in the system.

It was clarified that the strategy was dynamic in its constant communication with families rather than relying solely on data analysis.

The Board raised concern as to how easy access to the system through this strategy could be and wanted to clarify its importance.

The following recommendations were noted:

i) To note the update

46 **Gypsy-Roma-Traveller-Boater Strategy**

The Board received a report highlighting the findings of the review of the Gypsy, Roma, Traveller & Boater Strategy (2020-2025).

The review was described as a great opportunity to learn from the strategy ending in 2025 before the new strategy is created. It was described as Public Health led and conducted to update understanding of nomadic communities and assess progress against the existing strategy's ambitions.

Significant challenges gathering data from those within GRTB communities were highlighted. Therefore, improving systems to record appropriate information with would be an aim of the emerging new Strategy alongside a commitment to share information.

Challenges with those from GRTB communities registering at a GP were also raised, with people still being refused access based on not having a fixed address.

The Board welcomed the report and described it as a great piece of work. The Board commended Officers for their work and vocalised its understanding of the challenges and barriers present in working with GRTB communities.

The Board expressed concern that GRTB communities could feel patronised or that assistance is being forced upon them. Officers did clarify that as long as understanding of their way of life and trust was gained, that such a barrier could be removed, and closer collaboration be achieved to help those who want it.

It was clarified that the work with traveller communities was in its very early stages, with the other groups further ahead in terms of groups and programmes that had been set up. The opportunity to deliver the same for travellers was welcomed.

It was clarified that the strategies were long term and could only work at "the speed of trust". Avoiding fatigue within the communities was also seen as significant.

It was clarified that barriers such as needing an address to register with your GP was set by national policy.

It was clarified that nomadic communities were often registered with GPs in different counties to where they currently reside, such as boaters "skedaddling" between BaNES and Wiltshire, and individual practitioners had different approaches to handling this.

The following recommendations were noted:

i. Note the findings of the review of the Gypsy, Roma, Traveller &Boater Strategy (2020-2025);

ii. Note progress against the current strategy, and areas for development;

iii. Encourage partners to work with Wiltshire Council: to raise awareness of the community's needs, and to further develop the aims and objectives for a new Strategy; and

iv. Request an update report from officers on the development of the Strategy.

47 **Healthwatch Wiltshire Annual Report**

The Board deferred Healthwatch Wiltshire's Annual Report for 2023/2024 until the next meeting.

48 **Wiltshire Community Safety Partnership Update**

The Board received a presentation from Ian Saunders, Assistant Chief Constable, on the Wiltshire Community Safety Partnership.

The CSP included five responsible authorities:

- Police
- Local Authority
- Fire and Rescue Service
- Health partners (Integrated Care Board)
- Probation Services

The CSP has statutory responsibility to review or scrutinise decisions made, or other action taken, in connection with the discharge of crime and disorder functions and to make reports or recommendations to the local authority or its executive with respect to the discharge of those functions.

The CSP gave updates on each of its "headlines":

Domestic Abuse Local Partnership Board

- The prevalence of DA in Wiltshire remains high, with increasing demand on services.

- The Domestic Abuse Local Partnership Board has embedded a **Line-of-Sight approach** to monitor how well the system was functioning, improve scrutiny and oversight of response, as a partnership, to DA. the Board worked to hold Wiltshire Police as the lead agency to account to ensure that the backlog was cleared

Exploitation

- Wiltshire and Swindon are part of a National Referral Mechanism pilot scheme regarding devolved decision-making. Since this local panel has been in place, there has been a 50% increase in referrals to the NRM relating to children (16 in 2022-23 and 24 in 2023-24)

- The system response to **Adult Exploitation** response requires improvement. Currently, work is happening regarding increasing awareness of Adult Exploitation, amongst the workforce and the community, and also mapping what support services there are for adults who are victims of exploitation.

- The Strategic Group are working on the development of an **All-Age Exploitation Strategy** and delivery plan.

Safer Communities

- Working hard on the development of a partnership dashboard to direct the work of the group, in an evidence-based way.

- A small Working Group has been formed, led by the OPCC, to develop an **ASB strategy** for Wiltshire

CSP Transformation

New guidance from the Home Office was described as follows:

1. Create a power for PCCs to make recommendations on the activity of CSPs to support the delivery of the objectives set out in the **Police and Crime Plan**.
2. Create a **duty** on CSPs to take those recommendations into account. A CSP will not be mandated to implement the recommendations but should demonstrate consideration.
3. Create a requirement for CSPs to include in their Strategic Assessments how it has had **due regard** to the police and crime objectives set out in the Police and Crime Plan.
4. Create a requirement for the CSP to **send a copy** of its Strategic Assessment to the PCC or equivalent.
5. Create a requirement for the CSP to **publish the executive summary** of their strategic assessment.
6. Clarify how PCCs can **best fulfil** their duty to have regard to the priorities of the responsible authorities making up the CSPs in the police force area.

The CSP's proposed strategic objectives were listed including where different areas of crime would sit within them.

- Protect Vulnerable People
    - Domestic Abuse

- Exploitation

- Reduce Harm
  - Substance Use
  - Serious Violence Duty
  - Serious and Organised Crime

- Create Safer Communities
  - Anti-Social Behaviour
  - Acquisitive Crime
  - Business Crime
  - Rural Crime
  - VAWG
  - Road Safety

It was also raised that a new CSP Analyst role had been created by the OPCC to lead the Strategic Assessment and developments going forward. This role had gone out for advertisement.

The Board thanked Ian for the presentation and welcomed progress demonstrated by the Community Safety Partnership.

The Board commented that wider and more significant visibility of Community Safety was important. The Board were pleased with the focus on engagement and working with other partners.

It was clarified that at least one public meeting of the CSP must be held and dates would be provided. Cllr Dominic Muns was said to have been appointed to attend meetings.

It was clarified that knife crime sits within “Safer Communities”.

The following recommendations were noted:

i) To note the update

49 **Date of Next Meeting**

The date of the next meeting will be the 28 November 2024.

50 **Urgent Items**

Alison Ryan wished to highlight that Organ Donor week was taking place and urged attendees to consider registering.

(Duration of meeting: 10:00am – 11:45am)

The Officer who has produced these notes is Max Hirst - Democratic Services, direct line , e-mail Max.Hirst@wiltshire.gov.uk

Press enquiries to Communications, direct line 01225 713114 or email communications@wiltshire.gov.uk

This question follows a previous one discussed at the meeting on 26 September 2024.

Question

In the planning consultation webinar held on 14th August Nick Thomas and Richard Clewer discussed an appetite for cross border collaboration. Having personally attended the planning consultation in March this year for the Test Valley development of Ludgershall I discussed their plans for healthcare provision, and they stated they had already been having discussions with Primary Care- when questioned further, those conversations were practices in Andover, Hampshire Practices and with Hampshire ICB. Those practices are some 6 miles plus away, NOT Ludgershall which is within a mile of the proposed construction area. We highlighted this to our own ICB Estates Team who subsequently wrote to Test Valley, as did the practice.

There needs to be a joined-up approach with the councils working together, carrying out due diligence, consulting with the *correct* primary care services who will be serving those new residents. Planning is key and *must* include *both* county councils, due to Ludgershall's location on the county border. How can we ensure that a collaborative approach will be taken to develop the area with a coherent and planned approach, rather than allowing it to just "evolve" using Richard Clewer's analogy to "cookie cutter developments". How can we ensure that whilst "easy options" such as using the greenfield areas for development by developers, (which our local area is surrounded by), rather than brownfield sites, that healthcare provision is not also taken down the "easy option" of maybe building a care home rather than investing in Primary Care services.

To ensure that those providing and using the local Primary Care services are included and involved in shaping those services and cease the eroding of Primary Care for the local community and to represent good value for money for the public purse.

Response

Thank you for sharing your thoughts following the response to Question 1, provided as part of your note following the meeting.

With regard to Question 2, we agree that the impact of development does not stop at local authority boundaries and there is a need to ensure that any potential impacts arising from developments in neighbouring areas on infrastructure, including health, is appropriately considered. Any additional development planned for by Test Valley Borough Council at Ludgershall and neighbouring sites would need to take into consideration the impact on access to healthcare services feedback from the Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (BSW ICB)

so that further dialogue can take place as necessary. BSW ICB has confirmed that they are engaged with Test Valley Borough Council's Local Plan process and continues to engage with NHS Hampshire & Isle of Wight ICB. Your concerns are noted and we will continue with our ongoing engagement with Test Valley Borough Council on their emerging Local Plan and responding to planning consultations, raise the issue of health infrastructure need as part of our cross boundary working with them.

A full update on primary care estates will be provided at the Wiltshire Health and Wellbeing Board meeting in January.

Chair's Announcements

Wiltshire's Director of Public Health Annual Report 2023/24

The Director of Public Health, Kate Blackburn, is required to produce an annual report each year to highlight the health of the population, raise awareness of local health issues and make recommendations for change.

This year's report is framed around the four Public Health Across Boundaries (PHABs) themes of mental health and wellbeing, workplace wellbeing, children and young people's health and smokefree Wiltshire.

A key development in 2023 to 2024 has been targeting the approach to three priority population groups, which are highlighted throughout the report, where the team is working to help reduce inequalities. These groups are:

- Gypsy, Roma, Traveller, and Boater (GRTB) Communities
- Routine and manual workers (where English isn't their first language)
- The 20% most deprived communities (particularly rural areas).

Some of the key activities that Wiltshire Council's Public Health team has focused on in the past year includes the health coaches, a boaters' survey and webinars to promote wellbeing in the workplace.

Link to the full report: Wiltshire Director of Public Health Annual Report 2023 - 2024

SEND & CQC Inspections Update

The Local Area Partnership was visited by Ofsted and Care Quality Commission (CQC) inspectors in October for the anticipated Area SEND Inspection. Their feedback letter is expected to be published early in December. Darryl Freeman, Corporate Director for Children and Education, wanted to thank families and carers, children and young people, and colleagues across the partnership who contributed to the inspection activity.

CQC spent three days on site at the end of September as part of their adult assurance process and also met with a number of partners, statutory, providers and from the voluntary and community centre. They also spoke to a number of people who use services including unpaid carers to hear their views and we are very grateful for their input. We expect their final report to be published in the next few months although we do not have a firm date at this point.

Joint Chief Executive Announced for New Hospital Collaboration

Read more about this development here:

https://bswtogether.org.uk/blog/triangle/joint-chief-executive-announced-for-new-hospital-collaboration/

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Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Transforming community-based care in Bath and North East Somerset, Swindon and Wiltshire

October 2024

Agenda

1: Introduction

2: Our case for change

3: Our vision, ambition and improvement priorities

4: What would things look like in the future - example patient stories

5: Next steps

1: Introduction

About us

- BSW Integrated Care Board (ICB) brings together NHS organisations, local authorities and other partners
- Working to improve population health and establish shared strategic priorities.
- Oversee spending and ensure effective and high quality health services
- Hospitals, primary care, local councils, hospices, VCSE organisations and Healthwatch partners work together in three localities: Bath and North East Somerset, Swindon and Wiltshire.
- Part of the BSW Together Integrated Care System (ICS)

We serve a combined population of **940,000** and cover **1,511 square miles**, including the densely populated and growing town of Swindon to the north, the historic city of Bath, Salisbury plains to the south and the rolling Mendip Hills to the west.

Our purpose, vision and aims

Our purpose: Planning and arranging provision of integrated health and care services to meet needs of the population and better address inequalities in health and care. This involves managing the NHS budget for the area and co-ordinating delivery of our strategy, to allow us to be held to account by our local population.

Our vision is to listen and work effectively together to improve health and wellbeing and reduce inequalities.

We will deliver this vision by prioritising **three clear aims:**

- Focus on prevention and early intervention
- Fairer health and wellbeing outcomes
- Excellent health and care services

About community-based care

- Community-based care helps people to live independently.
- Broad term that covers lots of different types of care, support and services.
- Includes supporting people to manage their own health and wellbeing.
- Many different types of organisation provide community-based care: NHS, local authorities and the VCSE.

Community-based care in BSW

- HCRG Care Group has been appointed to lead an innovative new community-based care partnership with the NHS, local authorities and charities
- Will transform care and support for people at every stage of their lives
- More health and social care in or near home, in a more joined-up and streamlined way
- This presentation gives more detail about what this will mean in practice and plans to improve community-based care across BSW

2: Our case for change

Our changing population will impact on our services and the need for community-based care

- The BSW population is projected to grow by 6 per cent over the next 15 years - an extra 60,000 people by 2038
- The number of people aged under 60 will remain stable. All growth will be in people over 60 - a 35 per cent increase
- Older people tend to live with more health conditions and have more care needs – expecting an additional 32,000 people with two or more long-term conditions by 2038
- Proportion of people over 65 compared to those of working age will increase - fewer younger people to support people as they age. Also have an ageing NHS workforce

Continued

Cost of acute care is currently £340 million per year - in 15 years this will rise to £410 million – £5 million each year – before inflation or the costs of new treatments and innovations

In five years we will need additional 115 hospital beds and 40 ambulance journeys per day – will also see 50+ additional visits to A&E a day

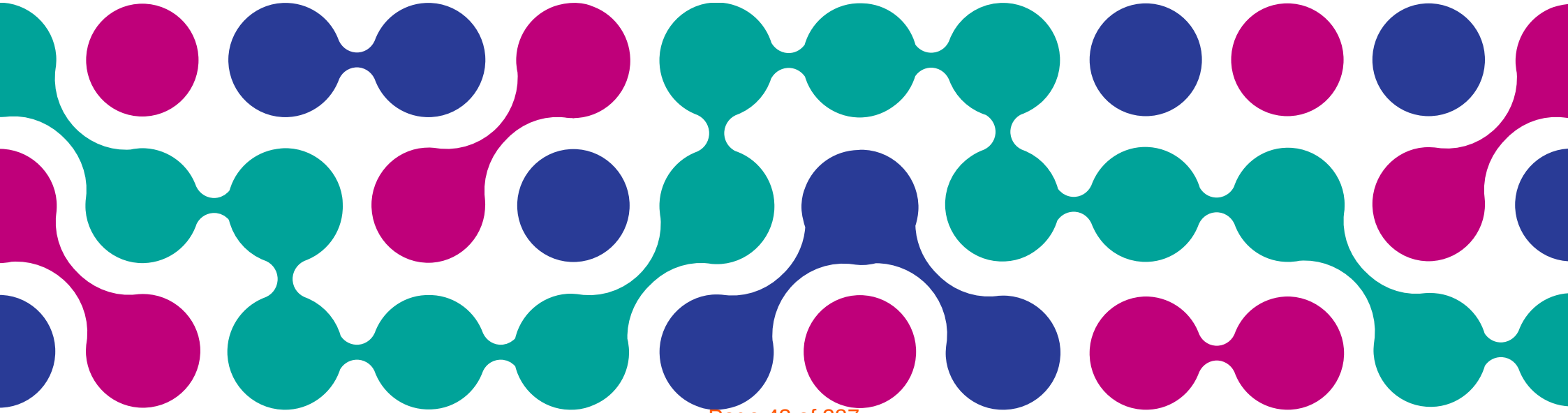
Children and young people's services are under extreme pressure post-Covid with long waiting times. Need to improve health of children and young people now to impact on future need

Additional demand on mental health services since the pandemic with increased waiting times

Requests for social care support have risen but number able to access support has fallen. Changes in our population will mean an increase in the need for social care.

- We are shifting our focus towards community-based care with a specific priority to ensure that people will receive more personalised care
- New focus on prevention and early intervention to help people manage their health proactively and stay healthier for longer

3: Our vision, ambition and transformation priorities



Community-based care transformation is linked to wider BSW vision and priorities

The BSW Vision

We listen and work together to improve health and wellbeing and reduce inequalities.

Our strategic objectives

1) Focus on prevention and early intervention
2) Fairer health and wellbeing outcomes
3) Excellent health and care

Overarching outcome measures

If we are successful, we will see the following long-term improvements:

1) An overall increase in life expectancy across our population
2) A reduction in the gap between life expectancy and healthy life expectancy across our population
3) Reduced variation in healthy life

Transforming community-based care is a key element of our Integrated Care Plan and Primary and Community Care Delivery Plan.

Works alongside the other strategic programmes including primary care, elective recovery, urgent and emergency care, mental health and learning disabilities, autism and neurodivergence.

Our aim is to support people to stay well and offer joined-up care

Working in partnership with HCRG Care Group we are focused on delivering better outcomes against the three strategic objectives agreed by the NHS, local government and the voluntary and community sector:

- **Focus on prevention and early intervention** - more services and support to identify illnesses and health conditions early
- **Fairer health and wellbeing outcomes** – addressing health inequalities and ensuring services meet the needs of local people, wherever they live
- **Excellent health and care services –** developing thriving community-based services, reducing pressure on GPs and hospitals, helping reduce waiting times and making sure people get the right care, in the right place, at the right time

We have identified transformation priorities and outcome measures

- Transformation priorities support new ways of working
- Linked to outcome measures used to assess progress in delivering improvements
- HCRG Care Group will lead on delivering transformation priorities - work will take place in phases.
- Opportunities for local people and communities to continue to help shape health and wellbeing services including those with lived experience.

Our transformation priorities in more detail

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.

Continued

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.

Continued

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.

Timeline for transforming community-based care in BSW

Year 1 (by March 2026)

- Implement integrated neighbourhood teams
- Phase 1 of single point of access
- Phase 1 of Family Child Health Hubs
- Design and implement BSW neurodevelopmental pathway
- Improve digital access to services, join up IT systems and make more use of remote monitoring
- Begin review of estates
- Develop workforce to be flexible, sustainable, with well-supported, highly-trained staff

Year 2 (by March 2027)

- Build on integrated neighbourhood teams
- Phase 2 of single point of access
- Phase 2 of Family Child Health Hubs
- Implement 'virtual ward' for children and young people
- Implement specialist LDAN team
- Expand use of digital technology
- More consistent services and care pathways in place across BSW

Years 3-5 (by March 2031)

- Neighbourhood teams fully implemented, with 7-day working
- Complete roll out of Family Child Health Hubs
- Phase 3 of single point of access
- Finalise review of estates to deliver fit for purpose community-based spaces
- Sustainable workforce thanks to joined up working across the system

Transforming community-based care will lead to a number of positive changes


Improve the health and wellbeing of local people


Increase overall life expectancy


Reduce the impact of long-term conditions


Improve access to care and improve experience of care


Improve the sustainability of our workforce so we can recruit and retain the right staff


Make the best use of the things that help us deliver care, such as digital technology

4: Example patient stories

- Example patient stories help bring to life how community-based care might work in the future
- These stories are not based on real patients but are common scenarios.

Clara, 85 - retired bookkeeper

Clara lives alone. She is relatively independent, however she has had a number of falls at home in the last five years and has had a number of urine infections. She wishes to remain independent, but her family would like her to have more support.

Admitted to hospital following a fall, but **discharge to assess** meant she was able to get home quickly.

GP and **care coordinator** use **risk stratification tool to** identify Clara as high risk and recommend **remote monitoring**.

Care coordinator and **social care team** work with Clara and her family to assess her home and to develop a comprehensive care package involving both health and social care.

With some small modifications and the installation of **monitoring devices**, everyone is satisfied Clara can continue to live at home safely.

Digital monitoring devices and software assure Clara and her family that she is safe and well.

In the event of an emergency or fall, staff at the **Community Hub** can act immediately and gain full access to her **shared care record** at any time of day.

If Clara does fall, a **Rapid Response Team** is alerted via the monitoring devices in her home. They are able to access Clara's **shared care records** and provide updates to the other teams supporting Clara.

Clara can be referred to a **community-based clinic** with an enhanced **Community Frailty Multi-Disciplinary Team** who understand her history, have access to community diagnostics and can provide specialist support to the community team.

If required, Clara can be admitted to a **virtual ward** for monitoring and treatment.

As part of her **wellbeing plan,** a **voluntary sector group help** Clara attend her **local community centre** so she can meet her friends.

She is also able to attend the **community frailty clinic** at the **Community Hub** and has been offered **virtual appointments** so she can see health professionals from home and does not have to rely on others to get to hospital or clinics.

Jasek, 48 - builder

Jasek has suffered with increasing aches and pains for the past few years after a knee injury 10 years ago, which has been complicated by early arthritis, but is unsure if he wants to undergo an operation and take time off work. He also is concerned about the impact his health condition and lack of mobility is having on his wife.

Jasek is referred to the **Community Musculoskeletal (MSK) Service** by his **GP**. Jasek has been identified as a high risk of deterioration through the hospital **risk stratification tool** because of his arthritis and previous attendance at hospital.

The **MSK Service** work with Jasek to develop a **care plan** which he is able to access from his phone. Using the **virtual chat service**, he is able to have a lot of his questions answered.

As part of his **care plan**, Jasek has access to his local gym where he attends classes and even **virtual sessions** around his working pattern.

Jasek has ongoing support from a **Community Physiotherapy Team** and is able to attend the **Community Diagnostic Hub** for regular check-ups and **CT/MRI scans** if required.

Some time later, Jasek's knee feels much worse and he is referred for assessment for surgery. He books an appointment at his **Community Diagnostic Hub** for a **CT scan**. The **CT radiographer** refers him to an **orthopaedic surgeon**.

Jasek discusses his options with the surgeon via a **virtual consultation** and through a **shared decision making** process Jasek decides to proceed with surgery.

Jasek is able to book his surgery on his phone at the **Local Treatment Centre** for a date after he gets back from holiday.

Jasek attends the **Local Treatment Centre** for his knee surgery and he is discharged with a **rehab plan** to adhere to at home.

Jasek uses the **virtual chat service** to answer a number of post op questions and is able to **initiate a follow-up appointment** if required at the local community hospital at a time and day that suits him.

Marvin, 60 – warehouse manager

Marvin is a night shift worker in a warehouse, who values the time outside of work with his family. He has type 2 diabetes which he finds hard to manage, and has recently been diagnosed with chronic obstructive pulmonary disease (COPD). He has a poor diet and is distrusting of health professionals, so avoids visiting his GP.

Marvin speaks to his employer about his **care plan** and how they can work together to ensure his health is prioritised and maintained. Marvin is able to access the **Community Hub** out of hours to suit his shifts. Marvin is able to access **diabetics group support sessions** and **1:1 virtual support** from his GP to help make changes in his life sustainable.

The population health management tool flags Marvin for a review by identifying he is at risk of worsening health. The **Care Coordination Team** contact Marvin and encourage him to see his GP. The **GP** and **Care Coordination Team** work with Marvin to co-develop a **care plan** that suits his work and family life so that he can self-monitor his diabetes and control its impact.

Marvin uses **remote monitoring** and the data he records is reviewed by a **diabetes nurse** in primary care. Both Marvin and the **Diabetes Team** can initiate virtual appointments if either have concerns. The local team can access specialist input if required.

In the event of an acute COPD episode, Marvin can be seen by a **respiratory nurse specialist** in his **local community assessment and treatment unit** without having to go to hospital. If required, he can be admitted to a **virtual ward**.

Marvin is able to better control his diabetes through **self monitoring** and diet. This has enabled him to stay well and out of the hospital. In BSW he lives in a **health promoting environment** where he is able to access a **local gym** out of hours and lead an active lifestyle.

5: Next steps

What happens next?

- HCRG Care Group will take responsibility for community services from 1 April 2025
- Contract will run for at least seven years
- No immediate changes to services
- Mobilisation of new partnership will be carefully planned to ensure that there is no break in services.
- Transformation will take place in phases.
- Opportunities for local people and communities to continue to help shape health and wellbeing services.

Start, Live and Age Well

in Bath and North East Somerset, Swindon and Wiltshire

Adult and Children's Community Services BSW

BSW ICB Board

21st November 2024

Part of hcrg Care Group

Good CareQuality Commission

NET ZERO

NHS England

Hard to replace provider

Start, Live and Age Well

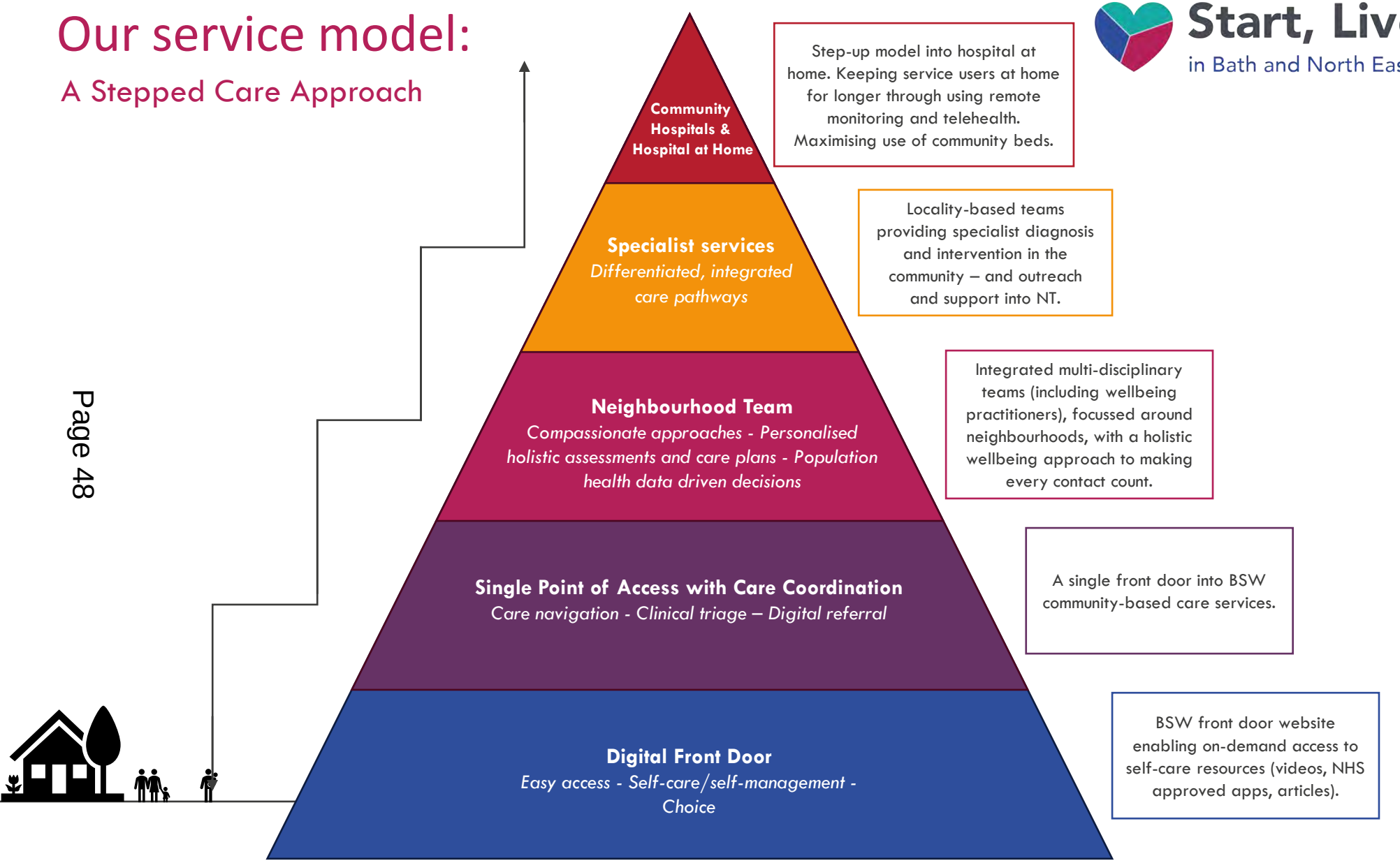
in Bath and North East Somerset, Swindon and Wiltshire

Our BSW Integrated Community Based Care Model

Our service model:

A Stepped Care Approach

Start, Live and Age Well
in Bath and North East Somerset, Swindon and Wiltshire



Step-up model into hospital at home. Keeping service users at home for longer through using remote monitoring and telehealth. Maximising use of community beds.

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

Integrated multi-disciplinary teams (including wellbeing practitioners), focussed around neighbourhoods, with a holistic wellbeing approach to making every contact count.

A single front door into BSW community-based care services.

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

"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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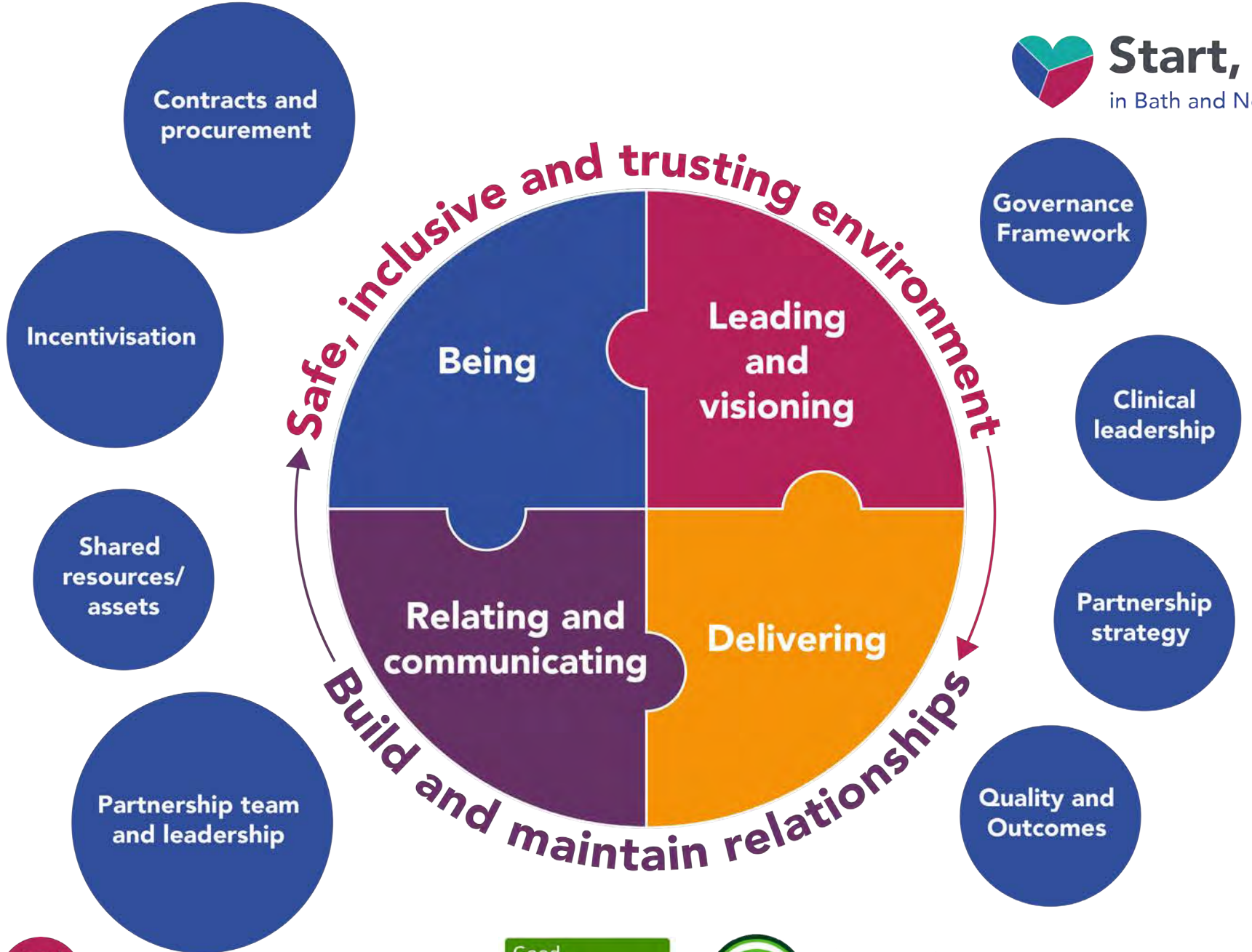

Hard to replace provider

Key enabler spotlight:
Digital Front Door

Start, Live and Age Well
in Bath and North East Somerset, Swindon and Wiltshire

Overview:

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

Key features:

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:

- 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

Start, Live and Age Well
in Bath and North East Somerset, Swindon and Wiltshire

Overview:

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:

1. **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:

- 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.

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Key enabler spotlight:
Integrated Neighbourhood Teams

Start, Live and Age Well
in Bath and North East Somerset, Swindon and Wiltshire

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 wiser 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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Start, Live and Age Well

in Bath and North East Somerset, Swindon and Wiltshire

Ensuring a healthy, happy workforce

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Colleague Wellbeing

Start, Live and Age Well
in Bath and North East Somerset, Swindon and Wiltshire

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Good CareQuality Commission

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Hard to replace provider

Start, Live and Age Well

in Bath and North East Somerset, Swindon and Wiltshire

Mobilisation and Transformation

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."

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."

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

Start, Live and Age Well
in Bath and North East Somerset, Swindon and Wiltshire

Leading the system through the change journey

Transition to healthcare first model

Harmonisation

Upfront investment to implement key enablers

Start, Live and Age Well service brand activation campaign

Part of hcrg Care Group

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Transformation – by end Year 1

Start, Live and Age Well
in Bath and North East Somerset, Swindon and Wiltshire

Single Point of Access (SPA) with Care Coordination

Integrated Neighbourhood Teams

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."

Transformation – by the end of Year 2

Start, Live and Age Well
in Bath and North East Somerset, Swindon and Wiltshire

Implementation of the BSW Estates strategy

Digital innovation

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."

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Wiltshire Council

Health and Wellbeing Board

28th November 2024

Subject: Update on the in-sourcing of HomeFirst from Wiltshire Health and Care

Executive Summary

Wiltshire Council's Reablement team currently deliver the Wiltshire HomeFirst service in partnership with Wiltshire Health and Care. Following the recommissioning of the Community Health Contract and HCRG Care Group being awarded this contract, Cabinet approved the proposal to remove the Wiltshire HomeFirst service from the Community Health Contract and to deliver this service under one single provider – Wiltshire Council's Reablement Service.

The existing arrangement between Wiltshire Council's Reablement team and Wiltshire Health and Care to deliver this service jointly will cease effective from 31 March 2025 and the proposal is that employees involved in the HomeFirst Service and activities at Wiltshire Health and Care will be transferred to the Council on 01 April 2025 when the existing contract ceases.

Update

- A Service Specification has been drafted for the "Wiltshire HomeFirst and Reablement Service;" it will be presented at the next meeting of Wiltshire Local Commissioning Group on 02 December 2024 for approval.
- TUPE arrangements – The Record of Decision has been completed and passed to HR. The Unions have been advised of the potential TUPE of staff. Regular fortnightly meetings are being held with Wiltshire Health and Care's HR Team; the first meeting took place on 14 November 2024.
- A piece of work has started under the Project Management umbrella. Risks are being identified and worked through. A timetabled project plan is being drafted.
- The Mobilisation Group (internal Council Stakeholders) has held its first of fortnightly meetings.

Marion Goldsmith & Karl Deeprose
Senior Commissioners, Better Care Fund Team
Wiltshire Council

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Wiltshire Council

Health and Wellbeing Board

28 November 2024

Subject: Better Care Fund Quarterly Reporting

Executive Summary

The BCF Q1 quarterly reporting document was submitted to the national team on 31 October 2024. Sign-off prior to submission was agreed by the HWB Chair on 31 October 2024. This is a formal presentation of the documents to the Board.
The quarter two requirement had a wider reporting remit than quarter one, which focussed only on schemes funded by the Additional Discharge fund (reported to the Health and Wellbeing Board on 26 September 2024). The quarter two template required detail on spend and outputs for all schemes plus a performance metric update general narrative.

Proposal(s)

It is recommended that the Board:

i) Notes the quarter two report submitted to the national team on 31 October 2024 (Appendix A).

Reason for Proposal

It is a condition of funding that the BCF reporting submissions are agreed and signed off by Wiltshire HWB.

Helen Mullinger
Better Care Fund Commissioning Manager
Wiltshire Council

Alison Elliott
Director of Commissioning
Wiltshire Council

Caroline Holmes
Place Director
NHS Bath and NE Somerset, Swindon, Wiltshire Integrated Care Board

Wiltshire Council

Health and Wellbeing Board

28 November 2024

Subject: Better Care Fund Quarterly Reporting

Purpose of Report

1. To formally present the Better Care Fund (BCF) nationally required quarter two reporting submission.

Relevance to the Health and Wellbeing Strategy

2. The Better Care Fund supports the integration of health and social care services across Wiltshire, 'ensuring health and social care is personalised, joined up and delivered at the right time and place'.

3. Regular reports are required by the national team to monitor Wiltshire's performance against the approved plans.

Background

4. It is a condition of funding that BCF plans and monitoring reports are agreed and signed off by Wiltshire HWB.

5. The Health and Wellbeing Board signed off the BCF Planning Refresh for 2024-25 on 11th July 2024.

6. The quarter one reporting focussed on expenditure and outputs of schemes associated with the Discharge Fund only. The quarter two template required detail on spend and outputs for all schemes plus a performance metric update general narrative.

Main Considerations

7. The demand and capacity data shows good correlation with that in the planning documents.

8. The Wiltshire plan reflects a balance of schemes that increase capacity in discharge schemes alongside additional support for community services that support the prevention of admissions.

9. Wiltshire is on target to meet planned outputs. Spend is also on track for the quarter two reporting period. (See Appendix A).

Next Steps

8. That the submission is formally approved by the Board.

Helen Mullinger
Commissioning Manager, Better Care Fund
Wiltshire Council

Report Authors:
Helen Mullinger, Commissioning Manager, Better Care Fund.

Appendix A: BCF quarterly report: Submitted 31 October 2024

Appendix B:

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Source of Funding	Planned Expenditure	Actual Expenditure to date	Planned outputs	Outputs delivered to date (estimate if unsure) (Number or NA)
10	Integrated Equipment - CCG (excluding continence)- Discharge funded	Home first /discharge to assess	High Impact Change Model for Managing Transfer of Care	Housing and related services	ICB Discharge Funding	£800,343	£200,086	6,187	640
44	TF Dom Care - in house - a - Discharge Fund - ICB	Dom Care - Rapid response	Home-based intermediate care services	Reablement at home (accepting step up and step	ICB Discharge Funding	£829,378	£207,345	380	62
46	Dom Care - Rapid response a Discharge Fund ICB	Dom Care - Rapid response (WS@H)	Home Care or Domiciliary Care	Domiciliary care to support hospital	ICB Discharge Funding	£1,100,279	£275,070	199	32
48	Wiltshire Council Discharge Fund	Discharge Fund	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning	Local Authority Discharge Funding	£2,393,210	£598,303	-	60
70	Brokerage Support	Programme Office, internal staff	Workforce recruitment and retention	Improve retention of existing	ICB Discharge Funding	£190,000	£47,500	-	3
71	WC In Reach (Discharge Hubs)	Staffing support to coordinate hospital discharges	Integrated Care Planning and Navigation	Care navigation and planning	ICB Discharge Funding	£339,000	£84,750	-	6.2
72	Urgent Community Response (Flow staffing supports rapid response)	Rapid response service	Urgent Community Response	0	ICB Discharge Funding	£320,000	£80,000	-	7
73	WC Reablement Staffing	HomeFirst/Reablement	Home-based intermediate care services	Rehabilitation at home (to prevent	ICB Discharge Funding	£228,000	£57,000	825	37

Better Care Fund 2024-25 Q2 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Wiltshire

5.1 Assumptions

	Checklist Complete:
1. How have your estimates for capacity and demand changed since the plan submitted in June? Please include any learnings from the last 6 months.	
The system Demand and Capacity Plans are monitored in each locality and at system level against performance. From a Wiltshire perspective the number of discharges has remained in line with expected trajectories despite some fluctuations and a continued increase in pathway 1 and 2 demand. Projections however did not consider level of need - an increasing trend for high intensity support is testing our service provision and with other factors is limiting anticipated reduction in NCTR rates despite significant financial investment. Performance has been maintained in this context. Overall, the UEC demand has increased above plan in all BSW areas. Review work in the summer identified several focus areas for demand management, which will be monitored across urgent care and flow delivery group as well as other system wide delivery groups. Using the latest activity information, the BSW's Business Intelligence team have been updating the demand and capacity model with forward, winter projections. This is still being refined and developed further as initial focus has been on front door demand which has been shared with system partners. Further work is needed and priorities are back door and out of hospital capacity. However, non-criteria to reside remains above plan although has significantly improved compared to historical baseline. Also noted that the average non criteria to reside length of stay is reducing. Data shows that the percentage of non-elective admissions that were falls related is an improving picture. However, work is underway with our partners to review non-injury falls referred to the ambulance service as activity indicates a significant increase in HCP referrals and work to improve consistency in Directory of Service profiles for UCR response due to an indicating activity is under plan due to a drop in referrals.	Yes
2. How have system wide discussions around winter readiness influenced any changes in capacity and demand as part of proactive management of winter surge capacity?	
The BSW system continues to work with all partners to review plans for this Winter. We have agreed priority workstreams which include maximisation of commissioned capacity such as Hospital @ Home models. Our dedicated Paediatric Acute Respiratory Illness hubs will be going live in Nov 2024 taking the learning from pilots last Winter and as a key part of our surge planning. HAving agreed that modelling for 24/25 is sufficient for the current period and will undergo a simple update to align with current demand patterns, BSW system colleagues are working on the development of a full pathway demand and capacity model which will inform service decisions planning for 25/26 onwards. Wiltshire has brought forward plans to reduce Pathway2 beds in line with the trend towards Home First which will enable further investment in Pathway1. Additional actions are currently being planned to maximise Home First capacity during the winter period.	Yes
3. Do you have any capacity concerns or specific support needs to raise for the winter ahead?	
Availability of specialist dementia care home capacity remains a concern and this is being addressed. Home First services are leading up to the transition from a dual-provider model to a sole-delivery model with the Local Authority from April 2025. This poses potential staffing and resource risks which are actively being managed. The start of the new community healthcare contract across BSW will start in April 2025 and we are conscious of our need to support the workforce during the period of transition over the winter months.	Yes
4. Where actual demand exceeds capacity for a service type, what is your approach to ensuring that people are supported to avoid admission to hospital or to enable discharge?	
We do not have any noted areas where demand exceeds capacity. We have an embedded 'blueprint' of daily tactical calls cross health, social care and third sector partners to track through at patient level actions across admission avoidance and enabling discharge.	Yes

Guidance on completing this sheet is set out below, but should be read in conjunction with the separate guidance and q&a document

5.1 Guidance

The assumptions box has been updated and is now a set of specific narrative questions. Please answer all questions in relation to both hospital discharge and community sections of the capacity and demand template.

You should reflect changes to understanding of demand and available capacity for admissions avoidance and hospital discharge since the completion of the original BCF plans, including

- actual demand in the first 6 months of the year
- modelling and agreed changes to services as part of Winter planning
- Data from the Community Bed Audit
- Impact to date of new or revised intermediate care services or work to change the profile of discharge pathways.

Hospital Discharge

This section collects actual activity of services to support people being discharged from acute hospital. You should input the actual activity to support discharge across these different service types and this applies to all commissioned services not just those from the BCF.

- Reablement & Rehabilitation at home (pathway 1)

- Short term domiciliary care (pathway 1)

- Reablement & Rehabilitation in a bedded setting (pathway 2)

- Other short term bedded care (pathway 2)

- Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)

Community

This section collects actual activity for community services. You should input the actual activity across health and social care for different service types. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support and this applies to all commissioned services not just those from the BCF.. The template is split into these types of service:

Social support (including VCS)

Urgent Community Response

Reablement & Rehabilitation at home

Reablement & Rehabilitation in a bedded setting

Other short-term social care

Better Care Fund 2024-25 Q2 Reporting Template

5. Capacity & Demand

Selected Health and Wellbeing Board: Wiltshire

Actual activity - Hospital Discharge		Prepopulated demand from 2024-25 plan						Actual activity (not including spot purchased capacity)						Actual activity through only spot purchasing (doesn't apply to time to service)						Checklist Complete:
Service Area	Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	
Reablement & Rehabilitation at home (pathway 1)	Monthly activity. Number of new clients	218	216	248	214	205	274	216	214	175	202	197	160	0	0	0	0	0	0	Yes
Reablement & Rehabilitation at home (pathway 1)	Actual average time from referral to commencement of service (days). All packages (planned and spot purchased)	10.9	9.7	8.5	10.8	9	8.9	4.6	4.9	5.1	4.6	5.8	4.7							Yes
Short term domiciliary care (pathway 1)	Monthly activity. Number of new clients	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Short term domiciliary care (pathway 1)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0							Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly activity. Number of new clients	104	104	104	94	94	94	104	104	104	104	104	104	0	0	0	0	0	0	Yes
Reablement & Rehabilitation in a bedded setting (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	10.5	14	13.6	16.8	11.6	11.4	2.2	3.3	3.5	3.2	3.3	3							Yes
Other short term bedded care (pathway 2)	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Yes
Other short term bedded care (pathway 2)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	0	0	0	0	0	0	0	0	0	0	0	0							Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly activity. Number of new clients	48	48	48	48	48	48	33	30	36	29	44	38	0	0	0	0	0	0	Yes
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Actual average time from referral to commencement of service (days) All packages (planned and spot purchased)	21	42	30.2	32.9	33.9	30.9	28.5	26.1	20.8	17.4	22.3	23.2							Yes

Actual activity - Community		Prepopulated demand from 2024-25 plan						Actual activity:					
Service Area	Metric	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Social support (including VCS)	Monthly activity. Number of new clients.	56	56	56	56	56	56	73	54	48	63	61	46
Urgent Community Response	Monthly activity. Number of new clients.	596	596	596	596	596	596	635	575	510	550	435	497
Reablement & Rehabilitation at home	Monthly activity. Number of new clients.	45	43	46	50	52	63	40	39	50	52	46	57
Reablement & Rehabilitation in a bedded setting	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	Monthly activity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

Yes
Yes
Yes
Yes

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The ten changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.

8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care or Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed based intermediate Care Services	Number of placements
Home-based intermediate care services	Packages
Residential Placements	Number of beds
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2024-25 Q2 Reporting Template

To Add New Schemes

6. Expenditure

Selected Health and Wellbeing Board: Wiltshire

<< Link to summary sheet

Running Balances	2024-25 Income	Expenditure to date	Percentage spent	Balance
DFG	£4,050,899	£2,025,450	50.00%	£2,025,449
Minimum NHS Contribution	£40,335,427	£20,127,722	49.90%	£20,207,705
iBCF	£10,242,097	£5,124,049	50.03%	£5,118,048
Additional LA Contribution	£5,080,155	£2,540,096	50.00%	£2,540,059
Additional NHS Contribution	£2,102,263	£1,051,132	50.00%	£1,051,131
Local Authority Discharge Funding	£2,393,210	£1,196,605	50.00%	£1,196,605
ICB Discharge Funding	£3,807,000	£1,903,500	50.00%	£1,903,500
Total	**£68,011,051**	**£33,968,554**	**49.95%**	**£34,042,497**

Comments if income changed

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2024-25 Minimum Required Spend	Expenditure to date	Balance
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£11,462,185	£7,455,426	£4,006,759
Adult Social Care services spend from the minimum ICB allocations	£22,465,242	£11,431,086	£11,034,156

Checklist	Column complete:	Yes	Yes

Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Planned Outputs for 2024-25**	Outputs delivered to date (Number or NA if no plan)	Units	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Previously entered Expenditure for 2024-25 (£)	Expenditure to date (£)	Comments
1	IC Therapy (Wiltshire Health and Care ASC)	Intermediate Care Therapies	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		391	195	Number of placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£991,137	£495,569	Schemes 1, 5 and 41 suport this output.
2	Access to Care inc SPA	Systems to manage patient flow	Integrated Care Planning and Navigation	Care navigation and planning		20178	13647		Community Health		NHS			Private Sector	Minimum NHS Contribution	£1,086,519	£543,260	
3	Patient Flow (WHC ACS)	Systems to manage patient flow	High Impact Change Model for Managing Transfer of Care	Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£184,485	£92,243	
4	Acute Trust Liaison b	Discharge Teams	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	N/A		Acute		NHS			NHS Community Provider	Minimum NHS Contribution	£248,572	£124,286	
5	Intermediate Care Beds GP Cover	Home first /discharge to assess	Other	Bed-based intermediate care with rehabilitation (to support discharge)	GP support to cover temp residents	391	195		Primary Care		NHS			NHS	Additional NHS Contribution	£162,263	£81,132	Schemes 1, 5 and 41 support this output.
6	Step Up Beds (WHC ACS) Community	Community Hospital beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		616	308	Number of placements	Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£1,037,532	£518,766	
7	Community Services - Community	Community Services	Community Based Schemes	Integrated neighbourhood services		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£4,513,239	£2,256,620	
8	Rehabilitation Support Workers (WHC ACS)	Home first /discharge to assess	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£1,475,637	£737,819	
9	Integrated Equipment - CCG (excluding	Home first /discharge to assess	High Impact Change Model for Managing Transfer of Care	Housing and related services		0	4160		Community Health		NHS			Private Sector	Minimum NHS Contribution	£2,824,304	£1,412,152	Schemes 9, 10, 17, 18 same service. Outputs distributed as percentage of spend. Unclear why there was no data at
10	Integrated Equipment - CCG (excluding	Home first /discharge to assess	High Impact Change Model for Managing Transfer of Care	Housing and related services		6187	1174		Community Health		NHS			Private Sector	ICB Discharge Funding	£800,343	£400,172	Schemes 9, 10, 17, 18 same service. Outputs distributed as percentage of spend.
11	EOL - 72 hour pathway Discharge Service	Seven-Day services	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	N/A		Community Health		NHS			Charity / Voluntary Sector	Minimum NHS Contribution	£225,191	£112,596	
13	Community geriatrics (WHC ACS)	Enhancing health in care homes	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£135,056	£67,528	
15	Discharge service staffing WHC	Discharge service staffing	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs		0	N/A		Community Health		NHS			NHS Community Provider	Minimum NHS Contribution	£429,374	£214,687	

17	Integrated Equipment - Local Authority (Adults)	Home first/ discharge to assess	High Impact Change Model for Managing Transfer of Care	Housing and related services		12588	2405		Social Care		LA			Private Sector	Additional LA Contribution	£1,635,089	£817,545	Schemes 9, 10, 17, 18 same service. Outputs distributed as percentage of spend.
18	Integrated Equipment - Local Authority	Home first/ discharge to assess	High Impact Change Model for Managing Transfer of Care	Housing and related services		2346	447		Social Care		LA			Private Sector	Additional LA Contribution	£310,112	£155,056	Schemes 9, 10, 17, 18 same service. Outputs distributed as percentage of spend.
19	Homefirst Plus- Local Authority Contribution	Home first/ discharge to assess	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		825	28	Packages	Social Care		LA			Local Authority	Additional LA Contribution	£414,994	£207,497	Linked to schemes 43, 31, 69,73,75,76. Output figure of 825 is for the total spend across those schemes. Output given in this
20	Carers - LA contribution to pool (Adults)	Carers	Carers Services	Carer advice and support related to Care Act duties		470	1,193	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£706,425	£353,213	the difference in figures is due to the change in provider in April. The figures from our BCF planning where most like
21	Carers - LA contribution to pool (Childrens)	Carers	Carers Services	Carer advice and support related to Care Act duties		428	1,182	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Additional LA Contribution	£76,787	£38,394	the difference in figures is due to the change in provider in April. The figures from our BCF planning where most like
22	Protecting Adult Social Care - maintaining	Protecting Adult Social Care	Community Based Schemes	Integrated neighbourhood services		0	N/A		Social Care		LA			Local Authority	Additional LA Contribution	£1,936,748	£968,392	
23	Disabled Facilities Capital Grant	Disabled Facilities Grant	DFG Related Schemes	Adaptations, including statutory DFG grants		146	83	Number of adaptations funded/people supported	Social Care		LA			Private Sector	DFG	£4,050,899	£2,025,450	Housing - Figure is total number of DFG's completed plus (due to data lag related to new recording system) 53 completed but
24	Protecting Adult Social Care - maintaining	Protecting Adult Social Care	Care Act Implementation Related Duties	Other	Maintaining social care capacity	0	N/A		Social Care		LA			Local Authority	Minimum NHS Contribution	£8,680,786	£4,340,393	
25	Care Act - maintaining services C	Protecting Adult Social Care	Care Act Implementation Related Duties	Other	Maintaining social care capacity	0	N/A		Social Care		LA			Local Authority	Minimum NHS Contribution	£3,288,177	£1,644,089	
26	Medvivo - Telecare Response and Support	Preventative Services	Assistive Technologies and Equipment	Assistive technologies including telecare		2562	2902	Number of beneficiaries	Social Care		LA			Private Sector	Minimum NHS Contribution	£1,285,359	£642,680	£650,000 Appello -no of Telecare clients and £650,000 Telecare Response service - response numbers - 558 2344 - number of individuals supported through Apello. This is the total number
27	Website Data Admin & Content Officers	Focus on choice	Integrated Care Planning and Navigation	Support for implementation of anticipatory care		0	N/A		Social Care		LA			Local Authority	Minimum NHS Contribution	£67,869	£33,935	
28	Complex Care packages	Protecting Adult Social Care	Home Care or Domiciliary Care	Domiciliary care packages		275	34	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	Minimum NHS Contribution	£526,108	£263,054	Same Output as scheme 57 Total output across the funding is 97 - output allocated per scheme as
29	ASC transformation	Discharge teams	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	N/A		Social Care		LA			Local Authority	Minimum NHS Contribution	£408,153	£204,077	
30	Hospital Social Care Disharge Services	Home first/ discharge to assess	Integrated Care Planning and Navigation	Assessment teams/joint assessment		0	N/A		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,920,856	£960,428	
31	Homefirst Plus - ICB Contribution	Home first /discharge to assess	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs		769	47		Social Care		LA			NHS Community Provider	Minimum NHS Contribution	£694,296	£347,148	Output should read 825. Linked to schemes 43, 31, 69,73,75,76. Output figure of 825 is for the total spend across
32	Carers - ICB contribution to pool (CCG)	Preventative Services	Carers Services	Respite services		956	1,310	Beneficiaries	Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£858,015	£429,008	the difference in figures is due to the change in provider in April. The figures from our BCF planning
34	Trusted Assessors	Home first/ discharge to assess	High Impact Change Model for Managing Transfer of Care	Trusted Assessment		3	3		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£196,944	£98,472	Covers 3 FTE Trusted Assessors
35	BCF Support Team	Programme Office, internal staff	Workforce recruitment and retention			4	4	WTE's gained	Other	Staff costs to support BCF programme	LA			Local Authority	Minimum NHS Contribution	£157,522	£78,761	Existing 4 FTE staff members
36	Resource Specialist	Integrated Brokeridge	Other			1	1		Other	Staff costs to support integrated	LA			Local Authority	Minimum NHS Contribution	£340,482	£170,241	
37	Urgent Care at Home Domiciliary Care	Rapid Response Service	Urgent Community Response			615	226		Community Health		LA			Private Sector	Minimum NHS Contribution	£1,006,189	£503,095	No of people supported under UC@H service. There was a drop in referrals in August due to a temporary pause on
38	Home from Hospital - ageing well	Home first /discharge to assess	Enablers for Integration	Voluntary Sector Business Development		664	336		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£442,755	£221,378	HfH dashboard. Link to community D&C (community VCSE)
41	Step Up/Down Beds - IR Beds	Home first/ discharge to assess	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		391	195	Number of placements	Social Care		LA			Private Sector	Minimum NHS Contribution	£3,723,748	£1,861,892	Same as scheme 1, and 5
43	Council reablement	Home first/ reablement	Home-based intermediate care services	Reablement at home (to support discharge)		266	30	Packages	Community Health		LA			Local Authority	Minimum NHS Contribution	£433,163	£216,582	Linked to schemes 43, 31, 69,73,75,76. Output figure of 825 is for the total spend across those schemes. Output given in this
44	TF Dom Care - in house - a - Discharge Fund -	Dom Care - Rapid response	Home-based intermediate care services	Reablement at home (accepting step up and step down users)		380	13599	Packages	Social Care		LA			Local Authority	ICB Discharge Funding	£829,378	£414,689	Revised annual output for service (schemes 44,45,46 is 72,336 hours of care) Outputs should be in hours of care.
45	TF Dom Care - in house - a	Dom Care - Rapid response	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		2128	4449	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Local Authority	Minimum NHS Contribution	£270,901	£135,451	Revised annual output for service (schemes 44,45,46 is 72,336 hours of care) Outputs should be in hours of care.
46	Dom Care - Rapid response a Discharge Fund	Dom Care - Rapid response (WS@H)	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge (Discharge to Assess		199	18084	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Local Authority	ICB Discharge Funding	£1,100,279	£550,140	Revised annual output for service (schemes 44,45,46 is 72,336 hours of care) Outputs should be in hours of care.

48	Wiltshire Council Discharge Fund	Discharge Fund	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		0	N/A		Social Care		LA			Local Authority	Local Authority Discharge	£2,393,210	£1,196,605	
52	Home First Plus - WHC	Home first/ discharge to assess	Home-based intermediate care services	Reablement at home (to support discharge)		825	471	Packages	Community Health		LA			NHS Community Provider	iBCF	£817,355	£408,678	
53	Providing stability and extra capacity in the local care	iBCF Protecting Adult Social Care	Workforce recruitment and retention			0	N/A	WTE's gained	Social Care		LA			Private Sector	iBCF	£2,803,170	£1,404,585	
54	Investigating Officers	iBCF Protecting Adult Social Care	Integrated Care Planning and Navigation	Support for implementation of anticipatory care		0	N/A		Social Care		LA			Local Authority	iBCF	£139,800	£69,900	
55	Providing stability and extra capacity in the local care	iBCF Preventative	Other			0	N/A		Social Care		LA			Private Sector	iBCF	£927,200	£463,600	
56	Prevention & wellbeing Team	iBCF Preventative	Prevention / Early Intervention	Social Prescribing		0	N/A		Social Care		LA			Local Authority	iBCF	£652,900	£326,450	
57	New: Providing stability and extra capacity in the local care system - Complex Cases	iBCF Protecting Adult Social Care	Home Care or Domiciliary Care	Domiciliary care packages		275	63	Hours of care (Unless short-term in which case it is packages)	Social Care		LA			Private Sector	iBCF	£1,014,700	£507,350	Same Output as scheme 28 Total output across the funding is 97 - output allocated per scheme as percentage of spend
58	Providing stability and extra capacity l the local care	iBCF Protecting Adult Social Care	Residential Placements	Nursing home		247	113	Number of beds	Social Care		LA			Private Sector	iBCF	£972,900	£486,450	
59	Providing stability and extra capacity in the local care	iBCF Protecting Adult Social Care	Residential Placements	Nursing home		190	97	Number of beds	Social Care		LA			Private Sector	iBCF	£1,342,300	£671,150	
63	Transformational Staff Charges - iBCF	Other	Enablers for Integration	Workforce development		0	N/A		Social Care		LA			Local Authority	iBCF	£151,800	£75,900	
65	Contribution to System Management Role	iBCF Preventative	Other			0	N/A		Other	Contribution to System Management	LA			Local Authority	iBCF	£100,000	£50,000	
66	Additional Adult Care LA Provision	Protecting Adult Social Care	Enablers for Integration	Integrated models of provision		0	N/A		Social Care		LA			Private Sector	iBCF	£1,319,972	£659,986	
67	2024/25 expected uplifts	2024/25 expected uplifts	Other			0	N/A		Social Care		Joint	50.0%	50.0%	Local Authority	Minimum NHS Contribution	£207,016	£103,508	
68	Intermediate Care Beds GP Cover	GP cover for PW2 beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)	GP support to cover temp residents	40	40	Number of placements	Primary Care	0	NHS	0.0%		NHS	Minimum NHS Contribution	£95,627	£47,814	Number of beds supported is constant
14	Home first WHC	Home first/Reablement	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs	0	0	N/A		Community Health	0	NHS	0.0%		NHS Community Provider	Minimum NHS Contribution	£846,380	£423,190	
16	Overnight Nursing WHC	Overnight Nursing WHC	Personalised Care at Home	Physical health/wellbeing		0	N/A		Community Health	0	NHS	0.0%		NHS Community Provider	Minimum NHS Contribution	£732,862	£366,431	
69	Homefirst Plus-Local Authority Contribution	Home first/Reablement	Home-based intermediate care services	Reablement at home (accepting step up and step down users)	0	825	19	Packages	Social Care	0	LA	0.0%		Local Authority	Minimum NHS Contribution	£279,824	£139,902	Linked to schemes 43, 31, 69,73,75,76. Output figure of 825 is for the total spend across those schemes. Output given in this
70	Brokerage Support	Programme Office, internal staff	Workforce recruitment and retention	Improve retention of existing workforce	0	0	N/A	WTE's gained	Other	Staff costs to support BCF programme	LA	0.0%		Local Authority	ICB Discharge Funding	£190,000	£95,000	
71	WC In Reach (Discharge Hubs)	Staffing support to coordinate hospital discharges	Integrated Care Planning and Navigation	Care navigation and planning	0	0	N/A		Primary Care	0	LA	0.0%		Local Authority	ICB Discharge Funding	£339,000	£169,500	
72	Urgent Community Response (Flow	Rapid response service	Urgent Community Response	0	0	0	N/A		Community Health	0	LA	0.0%		Local Authority	ICB Discharge Funding	£320,000	£160,000	
73	WC Reablement Staffing	HomeFirst/Reablement	Home-based intermediate care services	Rehabilitation at home (to prevent admission to hospital or residential care)	0	825	16	Packages	Community Health	0	LA	0.0%		Local Authority	ICB Discharge Funding	£228,000	£114,000	Linked to schemes 43, 31, 69,73,75,76. Output figure of 825 is for the total spend across those schemes. Output given in this
74	Urgent Community Response (Carer	Rapid response service	Urgent Community Response	0	0	0	N/A		Community Health	0	LA	0.0%		Local Authority	Minimum NHS Contribution	£400,000	£200,000	
75	Wiltshire P1 (Home First Winter)	Homefirst/Reablement additional capacity	Home-based intermediate care services	Reablement at home (to support discharge)	0	825	113	Packages	Primary Care	0	LA	0.0%		Local Authority	Additional NHS Contribution	£1,640,000	£820,000	Linked to schemes 43, 31, 69,73,75,76. Output figure of 825 is for the total spend across those schemes. Output given in this
76	P1 Complex (Winter)	Homefirst/Reablement additional capacity	Home-based intermediate care services	Reablement at home (to support discharge)	0	825	21	Packages	Primary Care	0	LA	0.0%		Local Authority	Additional NHS Contribution	£300,000	£150,000	Linked to schemes 43, 31, 69,73,75,76. Output figure of 825 is for the total spend across those schemes. Output given in this
77	WH&C In Reach	Avoidable admission support	Integrated Care Planning and Navigation	Care navigation and planning	0	0	N/A		Community Health	0	NHS	0.0%		NHS Community Provider	Minimum NHS Contribution	£310,000	£115,000	
40	Bed Review Co-ordinator	Home first/ discharge to assess	Enablers for Integration	Workforce development	0	0	N/A		Social Care	0	LA	0.0%		Local Authority	Minimum NHS Contribution	£11,349	£5,675	

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Wiltshire Council

Health and Wellbeing Board

November 2024

Subject: Neighbourhood Collaboratives; Well Farmers for Wiltshire Pilot; Evaluation

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Executive Summary

This paper is applicable to each of the 4 JLHW strategy theme areas, however there is specific reference in the strategy to:-

- Support local community action – through initiatives such as neighbourhood collaboratives allied to the development of Primary Care Networks, community based programmes and social prescribing, the community mental health model, area board activity.

This report provides a brief overview of progress in the Neighbourhood Collaboratives, and then offers a full evaluation and review of the Well Farmers for Wiltshire Pilot, which was a scheme tested through the Salisbury Neighbourhood Collaborative.

Neighbourhood Collaboratives Progress

The Health and Wellbeing Board previously received an update on the Neighbourhood Collaboratives at the May 2024 meeting. That report provided background back ground information and context which the reader may find useful to refer to.

Area	Progress
Calne	Readiness Review has been shared, waiting for confirmation that Health and Wellbeing Forum wish to progress.
Chippenham, Corsham and Box	Identified first target aim of preventing hypertension (high blood pressure) in identified group of at risk individuals. Data sharing processes have delayed the engagement process however this is now scheduled for January 2025. This is supported by the Health Inequalities Funding.
Devizes	Established (moving to session 3 of the launch programme). First project area will be resilience in children and young people's emotional health and wellbeing.

	Supported by the Health Inequalities funding.
Kennet	No current engagement
Melksham and Bradford on Avon	First cohort completed (prevention of significant falls). Additional group of people identified and next step is engagement (planned Jan 25).
North Wiltshire	Readiness Review has been shared – planning early 2025 launch.
Salisbury (all PCNs)	Salisbury Livestock Market pilot completed as first initiative. Supported by the Health Inequalities Funding and Vaccine Accelerator programme.
Trowbridge	Re-establishing group December '24
Warminster	Readiness Review completed – in discussions about next steps.
Westbury	Readiness Review completed, next steps meeting planned November '24 to plan launch sessions.

The Neighbourhood Collaboratives team has led the development of a BSW 'blueprint' model for Integrated Neighbourhood Teams – Neighbourhood Collaboratives is one example model of this. The learning from the Collaboratives has fed into the development of the blueprint.

The incoming Intermediate Community Based Care provider has a remit to work within and lead Integrated Neighbourhood Teams working with ICS colleagues. The planning phase for the transition is ongoing.

Salisbury Livestock Market Pilot

The attached report (**Neighbourhood Collaboratives; Well Farmers for Wiltshire Pilot; Evaluation Report**) includes an executive summary for that review.

The report offers an evaluation of the pilot and describes the impact in identification and support to people who are unwell, and also in terms of prevention work and education people about how to stay well. It does not describe however, the planned next steps within the market to extend the prevention work.

This includes using a co-production model to develop a 'pack' of information and products that will help farmers and the rural community to understand the actions they can take to stay well and avoid developing life limiting or life changing conditions.

The packs will be funded by contributions from partner organisations, and the Health Inequalities funding. It will be based on the insights gained through the Livestock pilot and evaluation and will be co-designed with the community themselves.

The packs will include some 'myth busting', education and practical support.

An example of this (which is still to be developed with the farmers themselves) would be a water bottle aimed at increasing hydration:-

Water bottle prevention pack example

- Insight: When we were with you in the market, we came to understand many of you were suffering with bladder infections and high blood pressure and you told us you don't take time to drink water or stop and go to the toilet. We also found a lot of you had high blood pressure which was causing you to feel unwell.
- Did you know that if you don't drink much, not only can this cause uncomfortable infections which can be a serious risk to your health, but because your blood vessels tighten to save water, this increases your blood pressure. If that's untreated it significantly elevates your risk of heart attacks, strokes and other symptoms.
- People in your community have designed a water bottle and marked on it how much you should drink each day to stay feeling well and hydrated. You should drink even more in the warm weather!
- *Water bottle will be provided of the right style according to community feedback.*

Other things the community have also suggested other ideas for information and tools that would help them become more aware of how they can look after themselves and each other.

The intension is to complete the planning for this work ready for the co-production to start in January 2025. The funding for the packs is from the Health Inequalities award to Neighbourhood Collaboratives.

Proposal(s)

It is recommended that the Board:

i) Notes the content of the report.

Reason for Proposal

Awareness and assurance regarding the progress and impact of Neighbourhood Collaboratives and sharing learning arising from the Livestock Market pilot in Salisbury.

Emma Higgins
Head of Combined Place

Wiltshire Integrated Care Alliance

NHS
Bath and North East Somerset, Swindon and Wiltshire
Integrated Care Board

Well Farmers for Wiltshire Pilot.
A Salisbury Neighbourhood Collaborative.
Evaluation Report.

16th July 2024 – 24th September 2024.

Foreword

"....the pure nature of a farmer is that he's not going to complain about his health, that will be last thing he does and probably leaves it too long before he does see a doctor, so then if there is a real problem, the problem is compounded, they're very proud people Farmers. They would look after their stock a lot better than they look after themselves."
Farmer, 2024.

"For farming people - farmers, farm workers, contractors, and their households – their health and wellbeing are inextricably linked to the business of farming. They face challenging, isolated conditions characterised by long working hours.

Farming people work in a sector with a rate of accidents 20 times higher than the all-industry rat2. In addition, farmers and farm workers can often face physical health challenges: musculoskeletal injury, for example, is over three times the rate for all industries. More than one farmer a week takes their own life. Less visible are high rates of mental ill-health and poor quality of life."

Rural Agricultural Benevolent Institution (RABI) (2021)

The Well Farmers for Wiltshire pilot would not have been possible without the brilliant engagement and enthusiasm of system partners and individuals. Together we have made a real difference to the community of people who spend time in the Livestock market and who told us just how impactful and important the pilot has been for them.

Those of us involved the pilot however would all agree that most of the credit for determination to get this 'off the ground' goes to Richard Kirlew of the Rural Chaplaincy Team. What a brilliant example of services being led by community voices.

Contents

1. Executive Summary

1.1. Part of the Wiltshire Integrated Care Alliance priorities and programme of work, the Well Farmers for Wiltshire Pilot, conducted at the Salisbury Livestock Market, aimed to address the distinct health and wellbeing challenges faced by the farming community in Wiltshire and the wider area. Bringing together 14 system partners to work collaboratively, this Neighbourhood Collaboratives initiative delivered healthcare, prevention and support services over a 12 week period directly to the market, a familiar and convenient setting for local farmers.

'I saw the pharmacist last week; he took my blood pressure, and we talked about my medication running out. I had a call from him this week, it is all sorted now….'

1.2. The pilot engaged traditionally hard-to-reach rural populations [part of the Wiltshire CORE20Plus5 group as manual workers], who often face barriers such as geographical isolation, time constraints, farming and livestock care needs and cultural reluctance to engage with traditional healthcare settings. It took a co-produced approach, dynamically responding to community feedback.

"I didn't carry out my blood pressure readings because of lambing season... But when my husband had his blood pressure checked at the market, I decided to do it too" – [urgent care referral for treatment for immediate risk]

1.3. Key outcomes of the pilot include the identification of six early cancer cases, numerous urgent and non-urgent referrals, and significant engagement in preventive health practices, including blood pressure monitoring, mental health discussions, and wellness education. The pilot successfully highlighted the importance of delivering services in familiar environments, demonstrated the value of preventive care, showed the strategic importance of multidisciplinary, integrated working between services including community and VCSE organisations and provided critical insights into the health barriers faced by the rural farming community.

"I was feeling funny, and they found my blood pressure was low... I was referred for urgent help."

1.4. Importantly, the pilot demonstrated the cost effectiveness of this model. The pilot was made possible through £10,000 funding from the Vaccine Accelerator programme. A total of £5,000 was spent during the 3 month pilot period (the un-paid contribution of many organisations should be noted). In relation to the six early cancer diagnoses alone, not only are the longer term outcomes for these individuals likely to be significantly more positive, the savings to the NHS system as a whole are very conservatively estimated to be in the region of £60,000 [Cancer

Research UK]. See Appendix F for more details of financial assumptions and costings.

"honestly I could cry thinking about it – I had no idea how ill I was and how lucky I've been that you and the guys spotted it. Now I stand a better chance of getting better"

1.5. Objectives and Key Achievements

1.5.1. **Deliver On-Site Health, Support and Prevention Services**: Working alongside the Rural Chaplaincy team as advocates, the pilot provided on-site physical and mental health checks, ranging from blood pressure checks, physio checks and vaccines advice (and will offer vaccines themselves in November) through to community pharmacist consultations, visits by the SFT cancer team and support from the RABI and Citizens Advice. Farmers engaged positively with the accessible services, many of whom were first-time participants in health checks and discussions about their health and wellbeing.

1.5.2. **Reduce Barriers to Healthcare Access**: By situating services at the market, the pilot effectively addressed logistical challenges such as time constraints and transport issues. Farmers appreciated the opportunity to receive healthcare without disrupting their work schedules. Face-to-face consultations and conversations allowed for overcoming technological barriers, and casual settings helped to mitigate cultural stigma. The ability to have in depth conversations about vaccine concerns and barriers to access means there is now significant demand for the clinics that will be offered in November within the market environment.

1.5.3. **Promote Preventive Care**: The pilot's focus on early detection and wellness education successfully encouraged proactive health management, with several farmers receiving timely referrals for serious conditions. Wellness education on topics like blood pressure management and lifestyle changes specifically related to the challenges people told us about, fostered self-care practices. This element in particular is the focus of ongoing work within the Collaborative in Salisbury and aims to have a long-lasting impact.

1.5.4. **Understand Health Challenges in the Rural Community**: The pilot shed light on the unique health challenges of the farming population, including mental health stigma, financial pressures, and untreated chronic conditions. Fear of losing driving or firearms licenses remained a significant barrier to mental health support.

1.5.5. Insights and feedback from the community were pivotal in developing and adapting the approach throughout the course of the pilot, so the team learned what and how people needed services to work for them – a genuine

model for co-producing services together.

1.5.6. **Test Different Engagement Methods**: The pilot demonstrated that informal, face-to-face engagement in familiar environments is the most effective way to connect with farmers (and potentially other communities). Simplifying communication materials and maintaining a consistent presence built trust over time and deepened the conversations and insights. It became obvious that 'knowing and understanding' the community and individuals there was critical to success. It was important that the team demonstrated responsiveness to feedback.

1.6. Impact and Recommendations

1.6.1. The Well Farmers for Wiltshire Pilot delivered clear evidence that targeted, community-based healthcare interventions can significantly improve engagement and health outcomes in rural populations. The approach and lessons learned are very transferrable to other communities. Key recommendations include:

1.6.2. Maintaining a Consistent Presence at the Livestock Market: Continued healthcare services at the market will sustain the engagement momentum, focusing on preventive care and routine health checks, particularly targeting high-risk groups such as older isolated farmers and working with younger people on longer term prevention strategies. Currently there is no identified funding stream for this. **The recommendation is for an options appraisal to determine possible routes to deliver this.**

1.6.3. Enhancing Clinical Infrastructure: In order to achieve the maximum impact improvements to facilities, including private consultation areas, appropriate clinical equipment, and infection prevention resources, should be considered and would expand the range of services offered to include clinical interventions which would reduce the workload on primary care and further benefit the system through delivering an early intervention / prevention approach. **The recommendation is for an assessment of options and benefits assessment to be agreed.**

1.6.4. **Broader Integration of VCSE Partners**: Strengthening collaboration with Voluntary, Community, and Social Enterprise (VCSE) organisations will provide a holistic approach to health, addressing financial, mental, and social needs. There is ongoing work in BSW to consider how working with VCSE colleagues can be strengthened. This pilot has evidenced the value of an integrated approach.

1.6.5. **Tailored Mental Health Support**: Specifically with this environment, developing a confidential, community-specific approach to mental health,

with sensitivity to cultural concerns and financial implications, will help overcome stigma and encourage engagement. It's important that the system responds to the feedback and concerns raised and works to 'myth bust' perceptions about what might happen to someone who seeks help.

1.6.6. **Exploring Transferability**: The success of the pilot suggests that similar models could be effectively implemented in other rural and even urban communities, with adjustments to meet the unique needs of each population. There is a case for sharing the learning from this pilot across the system.

"what do you know about feet? – 'cause I can't feel mine" - [diagnosed with diabetes and peripheral neuropathy]

1.7. Conclusion

1.7.1. The report concludes that the Well Farmers for Wiltshire Pilot offers a transferable, scalable, efficient and cost effective model for rural health interventions, with clear benefits for the NHS in terms of early detection, reduced emergency admissions, and long-term healthcare savings. If possible, further work to determine the scope of necessary funding for this model is recommended to consolidate the progress made and explore opportunities for expansion.

"Thanks for asking and listening, it's been so hard and it's been good to talk" – [Dad of a young family with multiple health struggles].

2. Background

2.1 Neighbourhood Collaboratives

2.1.1. Aligned with the vision set out in the Fuller Stocktake Report (NHS England, 2022) and integrated and explicitly outlined in the Wiltshire's Joint Local Health and Wellbeing Strategy 2023 to 2032 (Wiltshire Council, 2023), and BSW Implementation Plan - Bath and North East Somerset, Swindon and Wiltshire ICB (BSW, 2024), Neighbourhood Collaboratives are a key approach within the Integrated Care System (ICS) that aim to address health inequalities by fostering partnerships across health, social care, voluntary organisations, and community groups.

2.1.2. Each collaborative is typically based on a Primary Care Network (PCN) footprint and brings together local partners to co-design and deliver services tailored to the specific needs of their population.

2.1.3. The collaboratives focus on:

- **Partnership working**: Engaging local organisations, services, and the community to pool resources and expertise.

- **Community-led health initiatives**: Ensuring that health interventions are co-produced with the local population, particularly those in Core20Plus5 groups, which represent the most vulnerable.
- **Integrated care:** Promoting coordination between healthcare providers and other community resources to deliver preventive care and address long-term conditions early.
- **Data-driven decision-making**: Using local population data to guide health interventions and address specific challenges in each area

2.1.4. The aim is to create a tailored, community-focused approach that improves health outcomes through prevention, early intervention, and collaboration across sectors.

2.1.5. Please refer to Appendix A – What are Neighbourhood Collaboratives (NCs).

"It's powerful to have shared understanding across organisations of the needs of our population and aligning together to work on priorities. We have more impact together." Collaborative Partner (2024).

2.1 Neighbourhood Collaborative Engagement Lead

2.2.1 The Wiltshire Neighbourhood Collaborative Steering Group was successful in bidding for funding which focuses on the reduction of health inequalities related to the Core20+5 priority areas within the Wiltshire population. The funding awarded to Neighbourhood Collaboratives is to support the development of the Collaborative model, with particular focus on engagement in a Collaborative setting.

2.2.2 This Health Inequalities Funding (HIF) has supported the creation of a new fixed term role - the Neighbourhood Collaboratives Engagement Lead. This position has been designed to play a pivotal role in addressing health inequalities by fostering stronger connections between service providers and the communities they serve.

2.2.3 The primary focus of the Neighbourhood Collaboratives Engagement Lead role is to collaborate with partners involved in Neighbourhood Collaboratives (NCs) to innovate and enhance approaches to community engagement. A key component of the role is ensuring that the voices and perspectives of individuals with lived experience are integrated into the planning, decision-making, and actions of the NCs. By bringing this vital perspective into the forefront, the NCEL ensures that interventions are not only designed for communities but also with them, making these initiatives more relevant, targeted, and impactful.

2.2.4 The role will be pivotal in supporting the development of an engagement model and supporting information to enable all Collaboratives to ensure they are using best practice methods of engagement and are being led by the views of their communities.

2.1 The Salisbury Neighbourhood Collaborative

2.3.1 Following initial discussions with Salisbury-based partners to establish a Salisbury Collaboratives, the Salisbury Primary Care Networks (PCNs) proposed a Salisbury-wide initiative to develop a shared NC that addressed both urban and rural challenges, recognising the unique needs of each community.

2.3.2 Initial key areas of interest identified by partners included supporting those living with dementia and (following an approach by a VCSE organisation – the Rural Chaplains) addressing the specific needs of farming and rural communities, where access to services and resources is often limited.

2.3.3 The Neighbourhood Collaborative approach entails a full review of evidence-based data and information as well as establishing the views of the communities. For people living in rural / farming areas, the data availability is very poor – people living in deprivation live alongside people who are considered very affluent. The available data is distorted because of this and there is no primary care code for 'farmer'. Triangulating information was therefore challenging and relied on sharing information between partners and using VCSE insights which provide to be invaluable. This work established that the needs of this community are often 'hidden' to healthcare providers and not taken into account in planning and delivering services.

2.3.4 After careful consideration, it was agreed that the initial focus of the Collaborative would centre on piloting an offer of support to farming and rural populations, given the increasing concerns raised about their health and wellbeing.

2.3.5 Research and feedback from the community and local service providers told us farming and rural communities often face distinct challenges, such as geographic isolation, reduced access to healthcare, mental health stigma, and economic pressures that contribute to health inequalities. These challenges have been further compounded by changes in agricultural policies, financial uncertainty, and the demands of an aging rural workforce.

2.4. Agriculture in Wiltshire

2.4.1 The Southwest region is home to a quarter of the nation's agricultural holdings, contributing twice as much to the economy and generating twice as many jobs as the average English region. Within the Southwest, Wiltshire is the most farmed county, with more than three quarters of its land being

farmed commercially (273,555 hectares of Wiltshire's total 348,500hectares) (Wiltshire Council, 2021). More than 7,000 people in Wiltshire are farmers, this population increases greatly when you consider the industries and communities associated with farming.

2.4.2 The farming community in Wiltshire are part of the Core20Plus5 Health Inequality groups (manual workers).

2.5 The Health and Wellbeing of Farmers

2.5.1 The Big Farming Survey (RABI, 2021) considered for the first time the relationship between the physical and mental health of farming people, and the health of the farm business. Key findings drawn from the survey included:

2.5.2 Low levels of mental health and wellbeing – 36% of the farming community are probably or possibly depressed

2.5.3 Concerning mental health and wellbeing picture amongst women in agriculture – over one-half of women (58%) experience mild, moderate, or severe anxiety

2.5.4 Multiple causes of stress amongst the farming community – an average of six factors cause stress. The most reported sources of stress are regulation, compliance, and inspection, Covid-19, bad/unpredictable weather, loss of subsides/future trade deals

2.5.5 High levels of physical health issues impacting across the farming community – over half (52%) experience pain and discomfort, one in four have mobility problems and 21% have problems in undertaking usual tasks due to health issue

3 The Well Farmers for Wiltshire Pilot

3.1 The Case for Rural and Farming Focus

3.1.1 The Rural Chaplains, a voluntary, community, and social enterprise (VCSE) group based at the Salisbury Livestock Market, approached a Salisbury GP practice, who contacted the Wiltshire ICB team in relation to exploring a possible initial Collaborative project. The chart below shows that most of the 'significant' contact with the Chaplaincy team concerns health and wellbeing. This was the 'tip of the iceberg'.

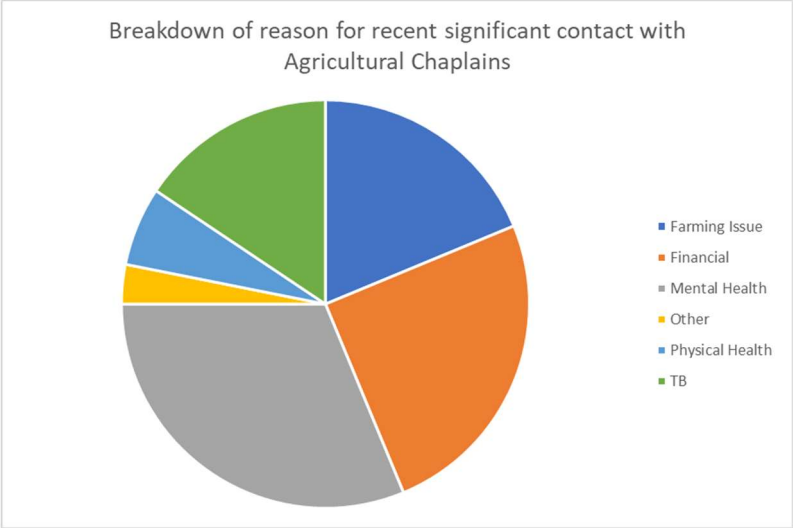

Figure 1. Breakdown of reasons for significant contacts with Rural Chaplains between 03/01/23 – 12/12/23 at the Livestock Market.

…. I have known Michael (pseudonym), age 78, a retired farming contractor, for several years. He now comes to market for social reasons, much enjoying contact with people he seems to have known for decades. During recent years he has suffered mightily with progressive hearing loss and eyesight failure. Questioning about him following up with relevant medical services always resulted in a, frankly unconvincing, response along the lines of "I have appointments booked but they keep being cancelled."

Over time, hearing aids were provided but met with constant operating difficulties. Two consecutive cataract operations resulted in one "going wrong" - causing severe discomfort - and there being some months passing before corrective action was taken.

About 18 months ago, a number of us began to be concerned about Michael's complexion - a very pale whitish yellow tinged with green might best describe it. Again, reports of imminent checks never seemed to result in actual appointments.

Today I heard that Michael was admitted two weeks ago to Salisbury District Hospital with heart problems (friends reported today that he had major bypass surgery some ten years ago). After some form of treatment, he was discharged to home last Friday. His home help visited on Sunday afternoon to find him collapsed and unconscious. He was readmitted that afternoon but has not regained consciousness.
Rural Chaplain. (August 2024).

3.1.2 Recognising the importance of addressing health and wellbeing issues, the chaplains, and key stakeholders (including the Livestock Market Directors), supported by the ICB Wiltshire Improvement Team, initiated a collaborative effort group to develop and pilot an offer of support to the rural farming community.

3.1.3 In partnership with various VCSE organisations, the PCNs, local community groups, and Wiltshire Council, a pilot program was developed to provide on-site health and wellbeing services at the Salisbury Livestock Market.

3.1.4 The following graphic shows the partners involved.

Figure 2 Partners involved in the Livestock Market Pilot

3.2 The Well Farmers for Wiltshire Pilot Outline

3.2.1 The project ran from July 16 to September 24, 2024, and was held weekly at Salisbury Livestock Market during its busiest hours. Farmers were engaged through a range of health and wellbeing services provided on-site, addressing issues from hypertension and diabetes to mental health.

3.2.2 The services included offered were by thirteen different service providers, and included:-

- Fully funded bank farming support
- Fully funded counselling
- Mental health advice – in market
- Physiotherapy advice and guidance
- Vaccines – advice (and vaccine clinics in November 2024)

- Nursing
- Community pharmacy
- Dental health
- Cancer – early signs and advice on screening
- Financial and other advice and support
- Health screening and checks (including high blood pressure etc..)
- Optometry
- Skin care advice and support
- Managing infections and signs of Sepsis

3.3 Aim

3.3.1 To reduce health inequalities in the rural farming community (via the Livestock Market) by offering access to crucial health and wellbeing services, ranging from physical health screenings to mental health support, financial advice, and social care resources.

3.4 Objectives

3.4.1 Within the scope of environment and resources available:-

- **Deliver and test on-site health and support services**: Provide physical and mental health screenings and services in an environment familiar to farmers.
- **Reduce barriers to healthcare access**: Address logistical and cultural challenges, such as lack of time, technological barriers, and reluctance due to stigma.
- **Promote preventive care**: Identify health issues early and provide actionable advice to prevent more serious health crises
- **Understand the health challenges** and barriers faced by farmers and rural workers, including mental health stigma, financial concerns, and physical health issues such as hypertension.
- **Test different engagement methods** to identify the most effective ways of connecting with this audience

3.5 Service Delivery

3.5.1 There were three primary areas of the market where services could be provided: the main entrance, the café, and a small storage room ich was converted into a usable space. A risk assessment indicated that, for lone working purposes, two people would need to always be present if the small room were used for consultations as there was no panic alarm or signal for mobile phone use.

3.5.2 The Livestock café setting provided an ideal opportunity to engage with many community members in a relaxed and familiar environment,

maximising the reach and impact of the health and wellbeing services offered during the pilot.

3.6 Criteria for Inclusion

3.6.1 The pilot was designed to be inclusive, ensuring that no member of the farming community who attended the Livestock Market was excluded. The community also included hauliers, staff working at the Livestock Market, and any external visitors, such as the rural policing team, and animal welfare team.

3.6.2 This pilot was extended to all individuals, regardless of their place of residence, meaning even those living outside of Wiltshire were welcomed. Additionally, there were no age restrictions, allowing people of all generations, whether young farmers, families, or older, retired farmers, to benefit from the health and wellbeing services offered. This openness allowed for a broad and comprehensive understanding of the community's diverse needs and often mean whole families were talking about health and wellbeing together, particularly during school holiday periods.

3.7 Funding

3.7.1 A budget of £10,000 was allocated to the pilot through the Integrated Care Board (ICB) BSW Vaccines Accelerator Programme. This funding was instrumental in supporting the successful delivery of the initiative by covering several key expenses. The allocation provided:

3.7.2 Backfill for services attending the market: ensuring that healthcare and wellbeing professionals could participate in the pilot without disrupting their regular responsibilities.

3.7.3 Travel costs: Covering transportation for staff, service providers.

3.7.4 Funding materials for outreach and engagement, including promotional materials, signage, and other communications tools aimed at informing the community about the available services and encouraging participation.

3.8 Communication with external partners

3.8.1 The Salisbury Walk-in Centre, PCNs, Ambulance Service and Salisbury Hospital Emergency Department were made aware of the pilot in case onward referrals were required.

3.9 Communication with visiting services

3.9.1 Information about Neighbourhood Collaboratives was sent to all visiting services (see Appendix A).

3.9.2 A Briefing Pack was sent to all visiting services prior to their attendance at the

market, providing key information pertaining to Infection Prevention and Control, Health and Safety and Safeguarding. A risk assessment accompanied the Briefing Pack.

3.9.3 Visiting services met with the Chaplaincy Team and ICB Improvement Team representative before every session at 9am for a pre brief prior to the market, and again at 12:30 for a debrief – risk and issue identification, reflection and shared learning.

3.10 Communication with the farming community

3.10.1 A4 information cards were placed on café tables to provide information about the pilot program (see Appendix B).

3.10.2 A5 information leaflets were developed for café tables to share details about visiting services available every Tuesday (see Appendix C).

3.10.3 A3 information posters were created for display around the café and near the entrance doors, highlighting information about visiting services offered each Tuesday. In this way, the community stayed up to date and aware of who was visiting and what services were on offer.

4 Learning from the Pilot

4.1 Key Insights

4.1.1 Key areas have been identified where valuable learning can be drawn from the experience of the visiting services and the farming community. These insights are crucial for informing considerations in supporting the farming and rural communities on a sustainable basis.

4.1.2 Additionally, key insights from the tested engagement approaches will inform the future success and development of the Collaborative engagement model and supporting tools.

4.1.3 A summary of the learning is below.

4.1.4 Service Commissioning: Practical and Structural Challenges

- **Space and Environment**: The livestock market lacked suitable infrastructure for healthcare delivery, including insufficient intervention space, inadequate handwashing facilities, and limited privacy for consultations. Privacy issues, in particular, prevented some people from seeking care. Nevertheless, this pilot proved that significant impact can be made in a limited environment.
- **Service Constraints**: Many services were not fully funded for this work, and while good will from service providers helped, some services remained out of reach.

- **Access to Records**: The inability to access GP records without significant workarounds was a challenge. However, the national pharmacy system allowed pharmacists to send critical updates to primary care, which ensured timely follow-ups

4.1.5 Lessons for Engagement and Community Insights

- **Trust Building**: It takes time to build trust within this community. Farmers were initially hesitant to engage, but consistent visits from familiar personnel improved participation over time
- **Face-to-Face Interaction**: Personal engagement was more effective than formal outreach methods like surveys. Casual, conversational approaches resonated better with the farmers, particularly in the social setting of the café
- **Literacy Barriers**: Low literacy levels were a barrier to engagement, particularly with printed materials. Iconography and simplified posters helped improve information accessibility
- **Cultural sensitivity** is essential: Mental health stigma is deep-rooted in the farming community, particularly among men. Initiatives need to be carefully tailored to ensure that discussions are framed in ways that resonate with farmers' experiences, rather than using medicalized language

4.1.6 Health and Wellbeing Needs in the Community

- **Physical Health**: Many farmers struggled with untreated conditions like high blood pressure, back and joint issues from heavy labour, and poor eyesight due to limited access of eye tests. Infections from minor injuries were common but often neglected
- **Mental Health Stigma**: Concerns about losing firearms or driving licenses discouraged individuals from seeking mental health support. Fear of government intervention and misunderstanding of medical consequences were significant barriers
- **Preventive Care Gaps**: Farmers were missing routine health checks, cancer screenings, and vaccinations due to lack of understanding or access. Women, in particular, were not recognising their roles as informal carers and were not accessing the support they were entitled to

4.1.7 Community-Specific Solutions

- **Warm Transfers**: Direct, personal referrals from one service provider to another (rather than remote or formal referrals) were found to be more effective. Building trusted relationships through repeated interactions was essential
- **Empowering Through Education**: Providing farmers with accessible health information (e.g., the importance of hydration, sun protection, or minor injury care) was crucial. With proper education, they were more willing to take steps to

improve their health

4.1.8 Opportunities for Future Services

- **Market as a Community Hub**: The market served as a social hub for many in the community, offering warmth, companionship, and food. It is an ideal location to continue offering health services, especially for older and retired farmers who may face isolation. Other community hubs may serve well for similar models in different communities.
- **Defibrillator Installation**: The need for a defibrillator was raised, with the community expressing willingness to purchase one through grants – this has now happened.

"a conversation today was one they may not have had at all..."
Chaplain. (July 2024).

"The attendees have become used to seeing visitors, and happy if they can get help with a niggle while they're there."
Chaplain. (July 2024).

"I don't go to the doctors; there is nowhere to park my tractor..."

The ease of having the blood pressure taken at that time and not having to make a separate appointment and take time out of his day spoke volumes. He fainted previously and did nothing as it was "inconvenient"

'I went to the GP yesterday; he knew I had low blood pressure, and I'd had it done here...'

'I saw the pharmacist last week; he took my blood pressure, and we talked about my medication running out. I had a call from him this week, it is all sorted now....'

5 Pilot Challenges

5.1 Key areas of challenge in working in this way and in this environment were identified:-

5.1.1 1. Community Trust and Engagement

- **Mistrust of Government and NHS**: Many farmers expressed negative opinions about the government and NHS, specifically regarding access to and fairness of healthcare services. Building trust required careful, patient engagement, with a

strong emphasis on effective communication skills. It was essential to clearly explain how services could support their health without interrupting their livelihoods.

- **Vaccine Hesitancy**: A prevalent issue within the farming community was reluctance to receive vaccines. However, through thoughtful conversations, many farmers became more receptive to discussing the importance of vaccines for diseases like flu, shingles, and TB. Increasing vaccine accessibility at the market was proposed as a potential solution for future engagement.
- **Mental Health Stigma**: Discussing mental health remained challenging. The informal setting of the café helped build relationships, but the casual environment often made it difficult to address deeper issues like mental well-being. Some farmers were hesitant to seek support due to fear of losing firearms or driving licenses, which are crucial for their livelihoods. There is a pervasive attitude of "just getting on with it" regarding mental health, making these conversations sensitive and complex.

5.1.2 Service Delivery Constraints

- **Clinical Service Limitations**: Several clinical services, such as diabetic eye screening and dental care, were unable to be delivered due to a lack of clinical facilities at the market. The small consultation room did not meet Infection Prevention and Control (IPC) standards (e.g., no clinical hand wash sink or waste disposal), and essential clinical equipment like couches and lighting were missing. This limited the types of healthcare interventions that could be provided on-site.
- **Information Governance Issues**: Visiting services were unable to access patient records, which hindered the continuity of care. Without a system to share clinical information with primary care, outcomes from examinations could not be recorded effectively.
- **Equipment Shortages**: Despite the importance of blood pressure monitoring, farmers were not provided with loaned blood pressure monitors. This posed practical challenges, as some farmers lacked the resources or time to purchase their own. Without these monitors, the effectiveness of preventive care was reduced.

5.1.3 Seasonal and Logistical Challenges

- **Harvest Season Impact**: A decline in attendance during August, attributed to the harvest season, demonstrated the importance of understanding the farming calendar when planning services. While fewer farmers visited the market, those who did remained engaged, showcasing the need for flexibility in service delivery. Over the same period, there was an increase in families with children who came to the market, offering different opportunities for prevention and

health focussed discussions. The supervised tooth brushing team were particularly busy!

Sophie' – 4 years old. Told the dental team "Mum and Dad don't brush their teeth". Supervised Tooth Brushing Team taught her (and her parents) how to brush properly and gave advice on diet and tooth ache symptoms

- **Transport and Accessibility Issues**: Farmers faced logistical barriers such as long distances, lack of parking for tractors, and limited transport options. These factors further reduced their ability to access healthcare, particularly if they had to travel for routine appointments.

5.1.4 4. Cultural and Political Sensitivities

- **Political Awareness**: Discussions about national farming support services required careful navigation, as differing opinions on government policies and funding could polarize conversations. It was important to maintain a neutral, inclusive stance when addressing these sensitive topics.
- **Sensitive Conversations in Social Spaces**: While the market was an ideal location for casual health conversations, certain topics like mental health required a more private, safe environment. Farmers often avoided seeking help for deeper issues in the public café setting.

5.1.5 Broader Health and Equipment Needs

- **Unmet Health Needs**: The community faced several unaddressed health issues, such as dental problems, poor eyesight, and missed cancer screenings. Women were especially affected, often not realizing their roles as informal carers, leading to missed opportunities for preventive health checks.
- **Lack of Equipment for Self-Monitoring**: Farmers who were advised to monitor their blood pressure had no access to loaned monitors, which affected their ability to follow through on recommendations. This lack of equipment posed a barrier to engaging in long-term self-care.

6 Engagement Evaluation

6.1. Engagement achieved six key purposes during the pilot:

- **Informed the project design**: continual engagement with the farming community provided valuable insights that shape the pilot's objectives, strategies, and overall design. Their feedback helped ensure that the project addressed real needs.
- **Ensured buy-in and support**: Continuous engagement fostered a sense of ownership among the farming community e.g. *'you said, we did.'*

- **Improved adaptability of service provision**: continuous engagement allowed for real-time feedback, which helps identify challenges or unexpected issues early. This responsiveness ensured that adjustments could be made during the pilot to improve outcomes. E.g. the team changed working practices to have a blood pressure station at the back of the café, rather than clinicians approaching the tables whilst farmers were eating breakfast – whilst this was still valued, there was a shift towards clinical activity away from the tables.
- **Built trust and credibility**: Transparent communication and collaboration with the farming community which built trust in the process and credibility for the results.
- **Enhanced learning and innovation**: By engaging diverse perspectives from both the farming community and the visiting service, the pilot benefited from innovative ideas and solutions that might not have been considered.
- **Validated findings**: Engagement ensured that the pilot's results were grounded in reality, making the findings more relevant and actionable.

Please refer to the Engagement Report (Appendix C) for more information.

7 Case Studies

7.1. During the pilot, quantitative data was difficult to acquire (e.g., the number of farmers attending the market and café varied each hour and by each day – service demand was gauged by how may cows were for sale!).

7.2. Engagement through conversation (case studies) was a significant method of data collection, qualitative findings have been utilised for evaluation purposes. These conversations provided depth and contextual insights, which were essential for understanding the true impact of the pilot, identifying areas for improvement and future service need.

7.3. Please refer to Appendix I for examples of the case studies.

8 Impact of the Pilot

8.1 Summary of Outcomes

8.1.1. Given the nature of the way the teams were working; informally and without access to clinical systems, formally capturing the detail of each interaction was challenging. A mechanism of debriefing after each session, highlighting the relevant cases and case studies were important parts of the evaluation process.

8.1.2. Section 8.2 goes into more detail on each point, however, during the course of the pilot, the team were able to demonstrate:-

- Approximately **6 early cancer cases** were identified and are now receiving treatment and the care and support they need to recover well. This includes help from services that were present within the market, who are enabling the individuals to focus on getting better without fear of losing their livelihood.
- **2 to 6 urgent cases were identified in every session** – this ranged from very high blood pressures, to infected wounds, falls risks and mental health concerns.
- Additionally **per session, a further 8 to 10 onward non-urgent referrals** for services such as GP, Pharmacy, Optician, Dentist, mental health support and other VCSE services were made.
- Many people were **supported with medications advice** and setting up on postal pharmacy services each day.
- **Advice and guidance** was offered to people on a range of topics. Visiting services were valuable in having conversations that continued in following weeks – for example the cancer team's visit was still being talked about 3 weeks later. Some regular topics included:-
    - Healthy weight and lifestyle
    - Dental hygiene
    - Vaccine hesitancy
    - Staying hydrated
    - Good skin protection and SPF application
    - Caring for injuries and wounds
    - Access to benefits and wider support
    - Carers support and advice

8.1.3. A sample of cases demonstrates the type of intervention and impact:-

- '**Jenny'** – last saw a doctor 25 years ago, traumatic childbirth. In-market check showed Very high blood pressure, palpitations and menopause symptoms. Scared to make a GP apt. Advice given; purchased own cuff, monitor for 1 week within parameters given. Contacted GP via email (to avoid talking) and receiving support (all prep done up front and reduced anxiety).
- '**Tom'** – Has lost 3 stone of weight in 6 weeks, did not recognise this or other symptoms as cause for concern (?cancer). Referred to GP for 2-week referral. Diagnosed with cancer – caught early!
- '**Ben'** – Nurse assessment in market; Can't feel his feet, or some of his fingers. Advice given and urgent appointment for GP to be made. Diabetes and peripheral neuropathy diagnosis. Receiving treatment.

- '**George'** – high blood pressure. Disclosed he's already taking medication but 'eeks it out' because he only gets 28 days supply at a time [not attending meds review] and can't get to the pharmacy. Supported by pharmacist in market for meds review and sign up to postal meds deliveries [was not aware of this option]. Subsequent check showed his BP now back to normal.
- '**Ralph'** – BP taken in market - 'feeling funny'. Covered in bruises from falls at home. Postural BP drop (100/65 sitting, standing 90/47). Unsteady. Despatched to urgent care ASAP.
- '**Jack'** – autistic 12-year-old boy, not been in school for a year. Failed knee Op. Sister diagnosed with cancer. Support given to parents and Jack. Thanks, received from parents for listening and coordinating.
- '**Sophie'** – 4 years old. Told dental team "Mum and Dad don't brush their teeth". Supervised Tooth Brushing Team taught her (and her parents) how to brush properly and gave advice on diet and tooth ache symptoms.

8.2 Evidence-Based Assessment of Outcomes from the Pilot

8.2.1. This section sets out more detail on the health and system impacts for each observed high level impact area set out in section 8.1.

8.2.2. **Six Early Cancer Diagnoses in 12 Weeks**

- Health Outcomes:
  - Early-stage cancer detection is critical in improving survival rates and reducing the intensity of treatments needed. When cancer is detected early, treatment is often less invasive and more successful. According to Cancer Research UK, early diagnosis can lead to 90% five-year survival rates for some cancers, compared to late-stage diagnosis where the survival rate drops significantly.

- System Impact:
  - Cost of Early vs. Late Cancer Treatment: Treating early-stage cancer is significantly less expensive than managing late-stage cancers. For example, early-stage breast cancer treatment can cost the NHS around £5,000 per patient, while advanced-stage treatment can exceed £15,000 per patient. With six early diagnoses, the potential savings in treatment costs as a result of the pilot alone could be substantial, preventing higher costs from later-stage care, hospital admissions, and complex treatments.

8.2.3. **Urgent Cases (2 to 6 per session)**

- Health Outcomes:

- Managing urgent cases early can prevent the escalation of health issues into emergencies, which would otherwise require hospital admissions or complex interventions. Immediate intervention, such as stabilising blood pressure or identifying life-threatening conditions like strokes, can reduce the risk of long-term disability or complications.

- System Impact:
  - Avoidance of Emergency Admissions: Each emergency hospital admission conservatively costs the NHS approximately £1,500 to £2,000 per stay. Preventing just one or two urgent cases from escalating into emergencies per session could result in significant savings over time, reducing the pressure on emergency services and hospitals.

8.2.4. **Referrals to Other Services (8 to 10 per session)**

- Health Outcomes:
  - Timely referrals to GPs, pharmacies, opticians, and dentists can address untreated conditions, leading to early interventions and preventive care. This helps patients manage chronic conditions more effectively, improving their quality of life and avoiding complications.

- System Impact:
  - Reduced Complications from Untreated Conditions: For example, regular GP check-ups and follow-ups for conditions like high blood pressure can prevent the development of more serious cardiovascular diseases. Each patient managed through primary care services saves the NHS money by avoiding expensive specialist care, emergency admissions, or surgeries. Treating high blood pressure early prevents strokes, which can cost the NHS between £12,000 and £30,000 per patient. The Livestock market team have been able to support GPs and other onward services making their work load quick and easier when referred patients make contact.

8.2.5. **Other New Diagnoses (Dementia, Menopause, High Blood Pressure, Mental Health)**

- Health Outcomes:
  - Identifying potential previously undiagnosed conditions like dementia and mental health issues allows for earlier management, improving patients' long-term outcomes. Early diagnosis of high blood pressure, for instance, reduces the risk of strokes, heart disease, and kidney problems.

- System Impact:

- Preventing Cardiovascular Events: Managing high blood pressure early can reduce the likelihood of strokes and heart attacks. The average cost of a stroke to the NHS is approximately £12,000 per patient in the first year alone. Identifying and managing high blood pressure early leads to substantial savings by avoiding these costly events.
- Dementia Management: Early detection allows families and health systems to prepare better care pathways, delaying the need for costly long-term care facilities and hospital admissions.

8.2.6. **Wellness Education and Self-Management**

- Health Outcomes:
  - Wellness education empowers individuals to manage their health more proactively, leading to better health outcomes and reducing the burden on NHS services. Patients educated on self-management techniques for conditions like diabetes, heart disease, minor wounds or mental health are more likely to comply with treatment plans and avoid complications. People who understand the importance of staying well – such as staying hydrated or applying SPF, and much less likely to develop significant health needs later.

- System Impact:
  - Cost of Preventing Hospitalisations: Effective self-management has been shown to reduce the need for hospitalisations and emergency interventions. For example, educating individuals with diabetes on managing their blood sugar levels (which occurred multiple times in the market) can prevent hospitalisations for diabetic complications, which cost the NHS approximately £3,000 per admission.

8.2.7. **Connection to VCSE Services for Wider Support (Financial and Other Support)**

- Health Outcomes:
  - Connecting individuals to Voluntary, Community, and Social Enterprise (VCSE) services can help address broader social determinants of health, such as financial stress, housing instability, and social isolation. These factors can have a profound impact on physical and mental well-being.

- System Impact:
  - Reducing Pressure on NHS Services: By providing access to wider social support systems, individuals are less likely to experience worsening health due to stress or social isolation, reducing the demand for NHS mental health

and social care services. Addressing these issues through VCSE services may result in long-term savings, as patients with better social support require fewer healthcare interventions. In the market environment, Citizens Advice were a key partner and assisted people with anything from benefits advice, accessing wider support, guidance on succession planning and advice following bereavement. They were even able to help some people complete distressing divorce paperwork.

- In summary; The outcomes of the Livestock Market Pilot have clear positive impacts on health and financial savings for the NHS. Early detection of conditions, timely referrals, and ongoing self-management contribute to improved health outcomes and cost savings across various areas of the healthcare system. Continuing this model of healthcare delivery, particularly in rural or hard-to-reach populations, can help reduce the long-term burden on NHS services while promoting better health across communities.

8.3 Achievement of Objectives

8.3.1. The following section sets out an assessment of how the pilot Well Farmers for Wiltshire has achieved its stated objectives (section 2.4)

Objective 1: Deliver and Test On-Site Health and Support Services

8.3.2. Objective: Provide physical and mental health screenings and services in an environment familiar to farmers.

Achievement:

- Physical Health Screenings: The pilot successfully delivered on-site health services, including blood pressure checks, consultations with Community Pharmacists, and urgent referrals to GPs and hospitals. Notably, as a result of the pilot, 6 early cancer diagnoses were made within the 12-week period, highlighting the effectiveness of offering preventive services in a familiar and accessible setting.

"I had a hoarse voice for over a month... I was urgently referred to the hospital by the GP [having been referred from the market]*, and now I'm awaiting a biopsy."* – case study 5

"I went to the GP yesterday; he knew I had low blood pressure, and I'd had it done here..." – Ralph's story

- Mental Health Advice and Support: Mental health support was also provided, though engagement in this area was more challenging due to stigma (see Objective

4). Conversations around mental health stress and stigma occurred, but deeper engagement was often constrained by the public, social setting of the market.

"Having a nurse or medical professional at the market really helps. It's so hard to get a GP appointment and attend in a normal farming day." – farmer

"Being able to offer health checks right where the farmers gather made a real difference. Most of them wouldn't have attended a GP appointment otherwise." – health care professional

The Livestock Market proved to be an effective venue for delivering these services, particularly as farmers felt comfortable in their natural environment. Farmers, often reluctant to visit traditional healthcare settings, responded well to receiving care in the familiar, informal atmosphere of the market.

Objective 2: Reduce Barriers to Healthcare Access

8.3.3. Objective: Address logistical and cultural challenges, such as lack of time, technological barriers, and reluctance due to stigma.

Achievement:

- Logistical Barriers: The convenience of offering health services at the market helped overcome logistical challenges, particularly related to time constraints. Farmers often cited their busy schedules as a reason for avoiding health check-ups, but the pilot brought the services to them, mitigating the need to travel or schedule appointments. This was reflected in 10 to 12 referrals per session, where farmers were connected to GPs, opticians, dentists, and other services
- Technological Barriers: Some farmers struggled with using technology to book appointments or track their health. The pilot circumvented this by offering face-to-face interactions and simplifying processes like blood pressure monitoring. Practical advice and explanations were provided in person, helping those who might otherwise avoid or misunderstand the necessary follow-ups
- Cultural Barriers and Stigma: One significant challenge was overcoming the cultural reluctance of farmers to seek healthcare. While physical health services were widely accepted, mental health support faced more resistance due to fears around losing driving or firearms licenses, particularly for those managing heavy machinery or firearms. However, open discussions about "everyday stress" helped ease some of these concerns

"I didn't carry out my blood pressure readings because of lambing season... But when my husband had his blood pressure checked at the market, I decided to do it too" – case study 2

Objective 3: Promote Preventive Care

8.3.4. Objective: Identify health issues early and provide actionable advice to prevent more serious health crises.

Achievement:

- Early Diagnoses and Referrals: The pilot successfully promoted preventive care by identifying health issues before they became critical. Over the 12 weeks, 2 to 6 urgent cases per session were identified each session, including serious issues like high blood pressure, which could lead to strokes or heart attacks if left untreated and diabetes. Regular blood pressure checks also enabled the detection of undiagnosed conditions such as hypertension, leading to early referrals to GPs and specialists
- Wellness Education and Self-Management: Farmers were also provided with wellness education on topics like blood pressure monitoring, lifestyle changes, and the importance of regular check-ups. This guidance empowered them to take ownership of their health, further supporting the preventive care initiative

Example: A 50-year-old farmer with elevated blood pressure (162/92) had not attended a follow-up appointment since starting medication a year ago. The on-site screening highlighted the need for an immediate medication review.

"I hadn't had my blood pressure checked in five years, but they found it was very high at the market."

Objective 4: Understand the Health Challenges and Barriers Faced by Farmers and Rural Workers

8.3.5. Objective: Gain insight into challenges such as mental health stigma, financial concerns, and physical health issues like hypertension.

Achievement:

- Mental Health Stigma: One of the most significant findings of the pilot was the stigma surrounding mental health in the farming community. Several farmers expressed reluctance to seek help for fear of losing their firearms or driving licenses, which are essential for their livelihood. This was highlighted in multiple case studies, where farmers spoke about their apprehensions regarding mental health disclosures.
- Financial Concerns: Financial pressure was another major barrier to seeking healthcare. Many farmers, particularly those who were self-employed, feared the financial impact of taking time away from their work to attend medical appointments. In one case, a farmer delayed seeking treatment for sepsis due to the cost of hiring a contractor to cover his work.

"I left it until I felt well enough to get out of bed... There is support out there for farmers, but no one that I spoke to knew about it." Case study 8

- Physical Health: Hypertension and unmonitored blood pressure were common issues within the community. The pilot provided valuable insight into how conditions like high blood pressure are often left unmanaged due to lack of time or awareness, further reinforcing the importance of regular health checks.

"I was feeling funny, and they found my blood pressure was low... I was referred for urgent care." - Case study 10

Objective 5: Test Different Engagement Methods

8.3.6. Objective: Identify the most effective ways to connect with the farming community.

Achievement:

- Face-to-Face Engagement: The most effective engagement method was face-to-face interaction. Farmers were more likely to participate in health services when approached in a casual, familiar environment like the market café. Building trust was essential, and the consistent presence of familiar healthcare professionals week after week helped foster this trust.
  Flexible and Personalised Approaches: Health professionals learned to adapt their approaches based on the individual's comfort level. For example, while some farmers preferred private conversations, others were more comfortable with casual discussions in social settings. This flexibility increased participation(HIF livestock report).

"Farmers were more likely to participate in health services when approached in a casual, familiar environment like the market café." - health professional

- Educational Posters and Icons: Early in the pilot, the use of A5 information posters was tested but was found to be less effective due to low literacy levels and overly complicated content. The information was later simplified, using iconography and larger fonts to improve understanding. This improved the accessibility of information.

"We realised that the posters needed simpler information and larger fonts to engage better, especially given the literacy levels."

Learning: Engagement was most successful when it was personal, simple, and consistent. Relying on the presence of familiar, trusted figures and accessible information was key to engaging this community effectively

9 Professional and Partner Feedback on the Livestock Market Pilot

9.1. Throughout the pilot, healthcare professionals and partner organisations provided valuable feedback on the process, outcomes, and effectiveness of delivering health services at the Livestock Market. Their insights highlighted both the strengths and challenges of the initiative, as well as opportunities for improvement in future iterations. The feedback was gathered through weekly debrief sessions and reflective discussions with service providers, including healthcare workers, community organisations, and local market representatives.

9.1.1. Accessibility and Convenience:

Healthcare Professionals: Staff from services such as community nursing, pharmacists, and GPs consistently emphasised the success of offering on-site services in an easily accessible, familiar setting. Many remarked that the convenience of receiving healthcare while already attending the market for other purposes encouraged farmers to participate.

"Being able to offer health checks right where the farmers gather made a real difference. Most of them wouldn't have attended a GP appointment otherwise."

Partner Organisations: Partners like the Rural Chaplaincy and VCSE organisations also noted that the familiar environment reduced barriers to healthcare. Farmers felt more at ease discussing their health concerns in a setting they trusted, compared to formal clinical settings.

9.2. Engagement with Hard-to-Reach Populations:

Healthcare Professionals: Several service providers highlighted that the pilot successfully engaged a typically hard-to-reach population. Farmers, who are known to be reluctant healthcare users due to time constraints and cultural barriers, were more open to engaging with healthcare providers in this informal setting.

"We were able to reach people who have been avoiding the healthcare system for years, and in some cases, we identified serious health concerns that might have otherwise gone undiagnosed."

Partner Organisations: The Rural Chaplaincy emphasized how the informal conversations over a cup of tea made farmers more comfortable discussing their health concerns, which eventually led to formal assessments and referrals.

9.3. Partnership Working:

Healthcare Professionals and Partners: Many professionals commented on the strength of partnership working between healthcare providers, the market management, and community organisations. The pilot allowed for effective **"warm transfers"**, where farmers were seamlessly referred from one service to another without the traditional delays and barriers of formal healthcare systems.

"Having all of the services working together in one space created a supportive network. The farmers were able to get the help they needed without having to navigate the healthcare system on their own."

9.4. Proactive Approach to Preventive Care:

Pharmacists and Nurses: Healthcare staff praised the proactive nature of the service, with early identification of conditions like high blood pressure, diabetes, and even cancer. Several professionals mentioned that without these on-site services, many of these cases would have gone unnoticed until they became emergencies.

"The preventive aspect of the pilot is perhaps its greatest success. By detecting these issues early, we've likely prevented future hospital admissions and serious health complications."

10 Well Farmers for Wiltshire Next Steps

10.1. The work in the Livestock Market has not yet come to an end. Partners were able to work flexibly, meaning that only half the £10,000 budget has been used. The services have been extended for another 3 months (to December 2024) whilst this evaluation is prepared.

10.2. Additionally, the Neighbourhood Collaborative Group in Salisbury continues to work on developing a prevention-focussed intervention which plans to further promote health and wellbeing by developing a set of resources and information for the farming community which promotes self-care actions specifically relevant to the farming and rural communities. This is being led in a co-production way which means the community themselves will develop and share the resources.

10.3. Further, the Collaborative has been successful in being awarded an additional £5,000 specifically to research and carry out engagement work with women in rural and farming communities. Initial plans, developed in response to what

women in the market told us, are to work with women with young families, and those at any point in their menopause journey or those in an informal caring role.

10.4. Lastly, this evaluation report is key to understanding both whether the pilot has identified a need for a continued presence in the market and whether the model is transferrable to other settings.

11 Conclusion and recommendations

This section outlines some key findings and recommendations drawn from the evaluation of this pilot. This report contains more detail and references have been provided to direct the reader to relevant sections for more information. It is divided into Livestock Market-Specific and Wider System Impact sections, with each recommendation grounded in the evidence and insights gathered through the pilot. The findings highlight both location-specific outcomes and broader system-level considerations for expanding or adapting this model.

11.1. Livestock Market-Specific Conclusions and Recommendations

Conclusion 1: The Livestock Market as a Familiar, Accessible Venue for Healthcare

11.1.1. The Livestock Market proved to be an effective setting for delivering health services to the farming community, overcoming logistical barriers like travel time and work constraints. Farmers valued the accessibility and convenience of healthcare at the market, which aligned with their schedules and daily routines.

Recommendation 1: **Establish a Regular Healthcare Presence at the Livestock Market**

Rationale: A consistent healthcare presence, including services such as blood pressure checks, mental health support, vaccinations, and musculoskeletal physiotherapy, would ensure ongoing engagement with this underserved population.

Actions:

- Work within the system to secure funding or delivery routes for regular service provision at the Livestock Market.
- Incorporate health education components focused on lifestyle advice and early intervention, allowing farmers to better understand and manage their health.

Report Reference: Refer to Section 3.4 and 8 for more detail on the Pilot Objectives and for further details on the successful integration of on-site healthcare services.

Conclusion 2: Engagement Learning and Tailored Communication

11.1.2. The pilot revealed that effective engagement requires understanding the cultural context and unique challenges faced by the farming community. Casual interactions and a respectful, non-clinical approach were particularly successful in fostering trust.

Recommendation 2: Implement Tailored, Culturally Sensitive Engagement Strategies

Rationale: A tailored approach to communication, including face-to-face interactions, simplified materials, and familiar, consistent personnel, fosters trust and ensures farmers feel understood and respected.

Actions:

- Develop training for healthcare staff on culturally sensitive approaches to discussing health with farmers, focusing on mental health stigma and addressing fears about livelihood impacts.
- Use engagement techniques such as simplified posters and iconography to increase accessibility, especially given low literacy levels.

Report reference: Section 7 and 8.1.3 ("Findings and Case Studies") includes feedback on successful engagement techniques.

Conclusion 3: Preventive Health Impact and On-Site Referrals

11.1.3. The pilot's preventive care focus led to early detection of serious health issues, with six early cancer diagnoses and multiple urgent referrals for things like high blood pressure and diabetes. Regular health checks like blood pressure monitoring demonstrated the impact of proactive healthcare on long-term health outcomes.

Recommendation 3: Expand Preventive and Routine Services to Include Comprehensive Screenings

Rationale: Expanding on preventive care will help reduce emergency healthcare needs by detecting conditions early and promoting self-care practices.

Actions:

- Offer blood pressure monitors via loan or purchase (funded through community support) to enable ongoing health monitoring.
- Schedule regular sessions for seasonal vaccinations, routine screenings, and self-care education.

Document Reference: See Section 8 ("Impact of the Pilot") for the health outcomes achieved through preventive services.

Conclusion 4: Infrastructure Challenges and Facility Upgrades

11.1.4. The current Livestock Market facilities limit the types of healthcare services that can be provided. Issues such as inadequate privacy, lack of handwashing facilities, and insufficient equipment restricted the scope of care during the pilot.

Recommendation 4: Upgrade Market Facilities to Meet Clinical Standards

Rationale: Improving infrastructure will allow for a broader range of services and ensure compliance with infection control standards.

Actions:

- Renovate consultation spaces to include private areas, handwashing stations, and clinical-grade equipment.
- Explore options for a mobile health unit to supplement existing facilities and expand service capabilities.

Report Reference: Section 4.1.4 and 5.1.2 (Learning and Pilot Outcomes) outlines feedback from professionals regarding facility limitations.

Conclusion 5: Overcoming Mental Health Stigma in the Farming Community

11.1.5. The pilot identified a strong stigma around mental health among farmers, exacerbated by fears that mental health support could affect their livelihoods, such as losing firearms or driving licenses. The reluctance to discuss mental health points to a need for more culturally sensitive approaches.

Recommendation 5: **Develop Confidential, Tailored Mental Health Support Approaches**

Rationale: Confidential mental health support that respects the unique challenges and privacy concerns of farmers will encourage engagement and reduce stigma.

Actions:

- Partner with mental health organizations to develop culturally sensitive mental health outreach specifically tailored to rural populations.
- Offer private mental health consultations on-site and provide trusted points of contact for follow-up care.

Report Reference: Refer to Section 8, (review of objectives ref mental health) for a detailed account of mental health challenges and the reluctance to engage with support services.

11.2. System-Level Conclusions and Recommendations

Conclusion 6: Transferability of the Livestock Market Model

11.2.1. The pilot's success highlights its potential adaptability for other rural and non-farming populations, especially those facing similar healthcare access challenges, such as geographic isolation, logistical barriers, and cultural reluctance to engage with traditional healthcare settings. Engaging people in familiar community spaces could improve healthcare uptake in populations with limited access to traditional services.

Recommendation 6: **Explore the Expansion of Community-Based Healthcare in Other Rural and 'Hard-to-Reach' Populations**

Rationale: Applying the Livestock Market model to other rural and community settings (e.g., community centres, religious groups, and other community social groups including local cafes) could significantly enhance healthcare access for isolated populations and those facing logistical and cultural barriers.

Actions:

- Identify key locations across BSW ICS where similar community-based services can be implemented.
- Develop tailored engagement strategies, considering the cultural and linguistic needs of each community.

Report Reference: The Transferability of the Pilot Model is discussed in Section 11.2, "Transferability of the Livestock Market Pilot Model to Other Communities and Settings."

Conclusion 7: Patient Outcomes and Financial System Benefits through Early Intervention

11.2.2. The pilot demonstrated that early detection and preventive care can deliver better patient outcomes and produce significant cost savings for the NHS by avoiding emergency admissions and managing conditions before they worsen. For example, treating conditions like high blood pressure early can prevent costly interventions for cardiovascular events.

Recommendation 7: Embed Early Intervention Models to Reduce Long-Term System Costs

Rationale: Although well understood already, this pilot has shown regular preventive screenings and education in high-risk communities reduce hospital admissions and emergency care needs, delivering substantial cost savings and improved outcomes.

Actions:

- Potential to conduct further research to quantify the long-term financial impact of preventive healthcare models in rural communities.

- Identify opportunities across the system for early intervention initiatives that can be replicated in other settings, highlighting potential savings from reduced emergency admissions and improved outcomes.

Report Reference: Refer to Section 8 and Appendix I for calculations and evidence of cost-effectiveness.

Conclusion 8: Integrated Partnership and Cross-Sector Collaboration

11.2.3. The pilot demonstrated that partnerships between healthcare providers and Voluntary, Community, and Social Enterprise (VCSE) organisations were crucial in providing comprehensive support that extended beyond healthcare. These collaborations helped address not only physical health but also social and economic factors (wider determinants) affecting health outcomes.

Recommendation 8: **Strengthen Multi-Sector Collaboration and VCSE Partnerships**

Rationale: Collaboration with VCSE and local organizations enhances the scope of support available, addressing financial, social, and mental health needs alongside physical health

Actions:

- Share learning and engage with the ongoing VCSE Alliance discussions with the ICB on collaborative working and the outcomes from the Quality assessment tool.
- Explore funding opportunities to expand VCSE involvement and ensure sustained engagement with vulnerable populations.

Report Reference: Section 9, "Professional and Partner Feedback," illustrates the benefits of collaboration between healthcare providers and VCSE partners.

Conclusion 9: Implementation of Digital Health Solutions for Continuity of Care

11.2.4. The lack of access to patient records during the pilot was a limitation, restricting continuity of care. A digital solution would allow clinicians to securely access and update medical records, improving personalised care in community settings.

Recommendation 9: Embed Mobile Health Technologies for Remote Record Access

Rationale: Digital health solutions enable services to deliver integrated, informed care by accessing patient histories and updating records in real time. Allowing access to these systems in a flexible but compliant way would enable this model to be even more effective and efficient.

Actions:

- Collaborate with system partners to pilot or identify access routes to mobile health technologies for secure, remote access to patient records.
- Provide training for use of digital tools effectively in non-traditional healthcare settings.

Report Reference: Infrastructure challenges impacting continuity of care are detailed in Section 5.1.2 ("Service Delivery Constraints").

12.3 Closing Conclusion

12.3.1 Through the Neighbourhood Collaborative approach, the Well Farmers for Wiltshire pilot was an ambitious attempt by a wide group of partners to test and learn over a 3 month period a variety of services and approaches that could deliver both improved health and wellbeing outcomes and support for the farming community, and focus on early intervention and prevention to reduce demand in the health and care system in the longer term.

12.3.2 The pilot has shown that the rural farming community frequently neglects their health and well-being due to their deep commitment to their farms and livelihoods. There is a noticeable reluctance to engage with general healthcare services, primarily because of time constraints, difficulties in finding adequate cover for their farms or businesses, a limited understanding of the importance of health screenings and well-being support, and barriers in accessing relevant information.

12.3.3 Uptake of services is more likely if they are offered in convenient, familiar settings, such as the Livestock Market, which align better with the farmers' schedules and work demands. This highlights the opportunity for tailored, accessible healthcare solutions that respect the unique challenges faced by the farming community.

12.3.4 The learning from this work is transferrable to many settings and communities and further demonstrates the important of integrated working across services, and being led by the voices and views of our communities.

12.3.5 This is of course not without constraints – most significantly but not exclusively funding limitations. This pilot has added to the wealth of evidence that proves the cost and outcomes benefit of personalised, integrated approaches to prevention and wellbeing. Not withstanding this 'return on investment' to other parts of the NHS and social care system over time, there are multiple routes to further explore and deliver this kind of model within existing financial and service envelopes if as system partners we work together to step through traditional barriers and limitations.

END

Authors:-

Aimee Jones, Improvement Lead
Emma Higgins, Head of Combined Place

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Appendices

Appendix A. What are Neighbourhood Collaboratives.

Appendix B. A4 posters placed on café tables to provide information about the pilot program.

Hi,

Exciting News!

In July we are launching the **Well Farmers for Wiltshire** pilot at your market. Every Tuesday until the end of September, you will find various health and wellbeing services available for you. **Look for us in the café or by the main entrance.**

This is your chance to:

- Speak to someone about keeping your back and joints strong
- Have your blood pressure checked
- Learn about the vaccinations you may need
- Recognise the signs of infection and SEPSIS

We also have services such as Citizens Advice, the RABI, and many more for you.

Don't miss out! Those from other counties are welcome too.

Come say hello or invite us for a chat.

See you soon,

The Well Farmers for Wiltshire Team.

Do you have any questions?

Who is part of the pilot? – We're working together as a Collaborative group of NHS, Council and Charity sector organisations.

How often will people be here? – Every Tuesday! You'll see some of the same faces, but there might be new ones along the way. We know this is your space and we'll try hard not to get in the way. Please say hello.

How long are you here for? – Each week from about 9 am to 12.30 pm but we want to find out if that's the right time, so we might change it if you tell us we need to.

We only have a small amount of money to support this pilot (test), but we'll be here throughout the summer into September. At the end of that time, hopefully you will have told us whether what we've tried was useful and what you want so we can plan out what might work after that.

Why are you here? – We know that people working on and around farms are super resilient, but we also know it's a struggle to juggle everything and look after your health and wellbeing. So, following an invite, we're coming along to see if we can make that easier.

What are you doing? – Over the summer, we are trialing some differing things to find out from you what you want, need and like. We're hoping to make things available to you like:

- help for joint and back pain
- dentistry
- foot care
- Vaccinations for things like flu, shingles and others
- checks for high blood pressure which can lead to heart attacks and strokes
- help and advice on looking after your skin
- how to spot early signs on cancer
- people you can talk to if you or someone you know might be struggling a bit emotionally
- Advice from groups who can give you practical support at the farm, because we know wellbeing is much more than just being healthy

Can I give you feedback? – Absolutely! We welcome your views and thoughts; we NEED you to tell us how to make this work for you. There have been lots of people visiting the market and speaking to some of you so we can plan the pilot, now we need you to tell us how to make it better and more useful as we do it. There will be more people working alongside us talking to you about all this, but please do speak to any of the team, they will take your feedback and make sure we use it.

How will I know what's where? – We're aiming each week to give you a schedule of what's coming and where it will be, it might change if your feedback tells us we need to do something differently.

Appendix C. Example of A5 table posters detailing visiting services.

Our team will be here to talk and advise you about:

Tuesday 23rd July

- Coping with everyday stresses
- Back and joint aches and pains
- Your eyesight
- Vaccinations you and your family may need E.g., flu (adults and children), shingles, covid, tetanus, MMR

Tuesday 30th July

- Services from Citizens Advice
- Coping with everyday stresses
- Your blood pressure and staying well – get your free blood pressure check with a nurse
- Vaccinations you and your family may need E.g., flu, shingles, covid, tetanus, MMR
- Your eyesight

Please be aware, services may be subject to change.

Appendix D. Visits to the Market.

13/08/2024. John Glenn (MP) with Aimee Jones (BSW ICB) and Richard Collinge (BSW ICB).

02/10/2024. Members of the Livestock Chaplaincy Team (green tabards) with Emma Higgins (BSW ICB), Laura Gowan (Wiltshire Health & Care), and Dr Olivia Chappell (High Sherrif for Wiltshire).

Appendix E. Neighbourhood Collaboratives Engagement Lead Engagement Report.

The report below was produced by Community First following their engagement work in the market space. This took place prior to, during and after the pilot.

HIF Livestock Report

Appendix F – Financial Assumptions

General NHS and NICE cost data has been used to establish financial assumptions. These specify approximate figures based on standard NHS economic assessments. The exact costs may vary by condition and complexity, but these estimates offer a strong foundation for illustrating the cost-saving potential of preventive care and early intervention

1. **Cancer Treatment Costs**:
    - **National Institute for Health and Care Excellence (NICE)** and **Cancer Research UK** often provide general costs for cancer treatment. For instance, early-stage breast cancer treatment costs around **£5,000**, while advanced-

stage cancer treatment can exceed **£15,000** per patient.
    - **Source**: Cancer Research UK reports on treatment costs and survival rates associated with early vs. late diagnosis.

2. **Emergency Hospital Admissions**:
    - **NHS Digital** and **NHS Improvement** data estimate that each emergency hospital admission costs the NHS between **£1,500 and £2,000** on average. This figure includes acute admissions for conditions like heart attacks, strokes, and severe infections.
    - **Source**: NHS Digital data on Hospital Episode Statistics (HES) and NHS Improvement analysis on the cost of emergency care.

3. **Stroke Costs**:
    - The **Stroke Association** in the UK provides cost estimates, with an average stroke costing the NHS approximately **£12,000** in the first year alone, covering hospital care, rehabilitation, and other related costs.
    - **Source**: Stroke Association UK reports on the economic impact of stroke and the cost of acute stroke management.

4. **Preventive Self-Management and Hospitalization Prevention**:
    - Studies on self-management for chronic conditions (such as diabetes and hypertension) indicate that effective self-management can prevent hospitalizations, with estimated savings of **£3,000 per admission** for diabetes-related complications, for example.
    - **Source**: NHS England reports on long-term conditions, as well as NICE guidance on cost-effectiveness of self-management for chronic illnesses.

5. **Blood Pressure Management and Cardiovascular Event Prevention**:
    - According to **NICE** and public health research, the cost of managing high blood pressure early can prevent more serious events such as heart attacks or strokes. For example, the cost to the NHS of treating a heart attack ranges from **£2,500 to £6,000**, while more complex cardiovascular interventions can be much higher.
    - **Source**: NICE guidelines on hypertension and cardiovascular disease prevention, as well as NHS Digital reports on the cost-effectiveness of primary care management.

Appendix H – Summary of Challenges

Key areas have been carefully identified where valuable learning can be drawn from the experience of the visiting services and the farming community. These insights are crucial for informing considerations in the development of any future service provision at the Livestock Market.

Several challenges were identified over the course of the pilot. The below highlight those that were key to demonstrating the pilot's success:

Visiting services frequently encountered farmers who voiced negative opinions about the government, the NHS, and concerns around access and fairness in health services. Building trust required time and a careful approach—listening attentively, responding thoughtfully, and clearly communicating how the services could support their health and well-being without disrupting their livelihoods. During feedback sessions, the importance of effective communication skills when engaging with the farming community was emphasised, underscoring the critical role these skills play in fostering trust and effective collaboration.

Vaccine hesitancy was a prevalent issue within the community, stemming from mistrust in healthcare systems and challenges in accessing medical services. Despite these concerns, the farming community showed a willingness to engage in discussions about the significance of vaccines for various diseases, including flu, shingles, tuberculosis (TB), and tetanus. These conversations highlighted the importance of protecting both individual health and the well-being of the wider community. Moreover, the farming community seemed receptive to the idea of improving vaccine accessibility, particularly through the potential availability of vaccinations at the Livestock Market in the future.

The summer holiday period offered an opportunity to engage with families of school age children and talk about vaccines and children's wellbeing. This yielded insights both for children's health and the views of parents, many of whom were struggling with child care, caring for others and trying to manage businesses.

"Mummy and Daddy don't brush their teeth but we will do it all together"
Sophie age 6

Issues related to mental health were often challenging to discuss in the casual, social environment of the café. The atmosphere, though perhaps open for conversation, did not lend itself easily to the deeper and more sensitive topic of mental well-being. Visiting services often softened their language, using more general terms like "everyday stresses"

which, while relatable, in hindsight may have inadvertently downplayed the complexity and significance of mental health and well-being, particularly within the farming community.

After a few questions, I broached the subject of mental health, and would he ever have any reservations in reaching out if he thought he needed support. He shared his concerns and said that he would never reach out for support because he knows that if you have any issues with your mental health and the authorities find out, they will take your [gun] licence away. He grew up with a father who suffered with his mental health and as a boy he remembers periods of time when they were not allowed to have any guns in the house, and he thinks that made his father's health worse because he used shooting as a chance to escape. This highlights a real lack of understanding and clarity around mental health and holding a firearms certificate. From talking to others, the same can be said for reaching out to doctors in case they get put on medication and their driving licence is removed.
They said one of the main issues that would concern them is mental health. They both feel that farmers "gloss over mental health and have an attitude of that's the way life is, so just get on with it."
Husbands and wives / partners working together day in day out can be a joy, but it can be hard to share your thoughts and worries and this is an area that came up a few times throughout engagement.
Neighbourhood Collaboratives Engagement Lead (July 2024).

Critical issues that prevented the delivery of clinical services such as dentistry, podiatry, screening, and physiotherapy on site included:

Screening Requirements: Unable to undertake diabetic eye screening as dilation was required prior to screening, and people would not be able to drive afterwards.

Infection Prevention and Control: The small room did not meet the infection prevention and control requirements. E.g. clinical hand wash sink, and clinical waste disposal. This is crucial in clinical settings to prevent cross-contamination and ensure patient safety.

Equipment: Essential clinical equipment was required in the small room, e.g. a clinical couch, and suitable lighting.

Information Governance: no access to patient records during the pilot, therefore outcomes from clinical examinations and consultation could not be recorded and appropriately shared with primary care for continuity of care and patient safety.

In August, there was a noticeable decline in attendance from the farming community at the café, which was attributed to the harvest season. However, those who did attend remained actively engaged with the visiting services.

Political awareness was essential when discussing the national farming support services available to the community. This was necessary to navigate differing viewpoints on government policies, funding allocations, and agricultural reforms, ensuring that conversations remained neutral and inclusive.

Following the advice to undertake blood pressure monitoring, the visiting services were unable to provide farmers with blood pressure monitors for loan. This limitation may have affected the farmers' ability to engage in monitoring as they may have faced uncertainty about which type of monitor to purchase or how to use it correctly. Additionally, the lack of access to a monitor could have posed practical challenges, such as time constraints in sourcing equipment.

Appendix I – Case Studies

Case Study One

An 80-year gentleman with a 20-year history of high blood pressure was taking medication. This had not been reviewed for 5 years (reasons unknown). His blood pressure at the market was significantly high. He was advised to have an urgent review of blood pressure management with the surgery Practice Nurse or GP.

Case Study Two

A 40-year-old female had a blood pressure check one year ago which was raised. She was asked by the GP to undertake one week's blood pressure readings. This was not carried out due to farming pressures - lambing session. Also, she was unable to understand the blood pressure monitoring chart provided. The lady's husband had his blood pressure checked at the Livestock Market and asked his wife to do the same. Her blood pressure was raised, and she was feeling tired all the time. She was referred to the visiting Community Pharmacist who could make an onward referral to the GP via the Pharmaoutcomes platform. She was also given support on how to record her blood pressure twice a day for one week.

Case Study Three

A 42-year-old female become tearful when having her blood pressure taken. She disclosed she was tired all the time, had increased weight, was experiencing mood swings, and felt stressed and low. I was able to take the time to discuss this with her,

signposting her to support services and advice about perimenopause, empowering her to talk to the GP.

Case Study Four

"What do you know about feet, because I can't feel mine…"
Older gentleman complaining of "lack of feeling in feet", following discussion this gentleman is receiving treatment regarding this condition. I had speculated it may be "something called peripheral neuropathy" when I spoke with him; he was under the impression it was something that may be due to aging.

Case Study Five

An older gentleman said he was concerned he had had a hoarse voice for over a month which despite over-the-counter lozenges and linctus it had not improved. I advised him to seek a GP appointment as it had continued after simple treatment. The gentleman was urgently referred to the hospital by the GP and received investigations; he now awaiting a biopsy.

Case Study Six

An older retired farmer, born in 1932, drives 55 miles in each direction to attend the café every Tuesday for a cup of tea and chat. Despite limited mobility, he can drive, and he enjoys the routine and social contact the café offers. *"I've come this week; I might not be here next!"*

Case Study Seven

A female member of staff at the livestock market was concerned about a bruise she had sustained following a fall, she said she would like it looked at. The bruise was on her left buttock/upper thigh, so we went into her office to examine it. It was a simple but extensive bruise, about the size of a dinner plate. There was no visible break in the skin, and she did not feel unwell at all, neither was her mobility impaired. I reassured her but safety-netted her explaining should she feel unwell, experience pain/swelling/redness she should seek prompt medical advice. She was a little concerned as it felt slightly warm, but I said this was due to increased blood supply to the area which happens following an injury, but should this get noticeably worse seek medical advice. She came to see me the following week in the café and was feeling better and healing well.

Case Study 8

He was extremely ill last year and was admitted to hospital with sepsis – he explained that he did not want to go in but knew he had no choice. He said that he even had to pay for a contractor to come in and do they work he could not. He said

he left it until he felt well enough to get out of bed and then stopped the contractor because he could not afford it. There is support out there for farmers and its free but no one that I spoke to knew about it. Again, there is more clarity needed around support that is available to farmers.

Case Study 9

One of the first conversations I had was with a table of five farmers, four of whom were related. You could instantly feel they had a great relationship and were all open with each other. Only two worked on the same farm but they always came together every Tuesday for a bit of banter and a bacon sandwich (and a bit of buying and selling). We spoke quite openly about health issues and except for one, they were all of the opinion that they do not have time for the doctors and will only go if its life or death, which usually means it is a trip to A&E.

Case Study 10

Gentleman had his blood pressure taken as he was 'feeling funny.' He was covered in bruises from falls at home. His blood pressure showed a postural drop (100/65 sitting, standing 90/47) which could account for his falls; he was signposted to urgent care for a same day review.

Case Study 11

A 34-year-old lady farmer came for her blood pressure check. The check went well, and reading was within normal limits, we then discussed health and managing on the farm, she is a new mum with an 18-month-old, but managing well with family support, on a small-sized sheep farm. During pregnancy, she did suffer from gastric reflux badly, but this had recently subsided, but then mentioned within the past 3 weeks she had been woken from her sleep at night by tight chest pain. We discussed that any pain waking you from sleep needs medical review and she has been advised to contact her GP on that day, which she said she would do. We discussed panic attacks, gastric disorders, and heart concerns. She will be contacting her GP and thanked us for the service we were providing.

Case Study 12

A tractor driver knew that we were at the market and encouraged his partner (who has recently moved from London to live with him) to come and have her blood pressure checked and chat with the nurse. The lady was in her early 40's and had been checking her blood pressure once or twice a year, but with the move had not done this for a while. On checking the first time, it was slightly raised, on rechecking and talking it returned to within normal limits. On asking if she had managed to register with a new GP, she had, which she was glad about as she then disclosed

that she was on antidepressants and she was feeling low, they were not helping as much as normal. She was going to see her GP but did not want the normal response – to 'up her medication.' We discussed options of mental health IAP services or the equivalent mental health self-referral support, or speaking with a GP to discuss options (she was out of county, I was unsure of her local services).

We then we discussed family life. Her mum and dad who remain in London have health concerns - mum is disabled following a dog attack and her dad has recently had a massive stroke; they currently do not have any carers and no benefits. She visits mum and dad every other weekend when she is off from her full-time job as a Carer. I gave her the CAB leaflet with their national helpline number and encouraged her to call it so they could give advice on benefits and care support. She appeared relieved as she said she wants to help everyone but feels not sure where to start, and she knows that there will be a health presence at the Market until end Nov 2024.

Case Study 13

An 89-year-old farmer wanted his blood pressure checked as he was on blood pressure medication. This was slightly raised and felt that he could have better control with a review from his GP. He stated that he has not had a review of his meds for 10 years and no blood tests during this time. I encouraged him to visit his GP and make a routine appointment for a review (he was registered in Hampshire).

Case Study 14

50-year-old male farmer, who and been started on blood pressure medication 1yr ago. He had been taking them but has not had any follow up - initially or throughout the year. His blood pressure was 162/92. I asked him to contact his surgery this week to make an appointment for a review as his medication may need adjustment / changing. He was happy with the service, and he hopes that long may it continue as it is so hard to get a GP appointment and attend in a normal farming day. Having a nurse or medical professional at market really helps.

END

Wiltshire Council

Health and Wellbeing Board

26 September 2024

Subject: Safeguarding Vulnerable People Partnership (SVPP) Annual Report 2023-2024.

Executive Summary

I. This is the annual report of the SVPP for 2023-2024. The SVPP are the multiagency safeguarding arrangements for Wiltshire. These arrangements are a statutory requirement under Children Act 2004 and in Wiltshire bring together the work and governance of the safeguarding adult partnership the children's partnership and the community safety partnership.

Headlines:

- Recruitment of an independent scrutineer who has scrutinised the progress against our strategic priorities, including:
  - Domestic Abuse – lime of sight has improved visibility of the system response to DA and our ability to hold partners to account where improvement is needed and development of a Strategic Improvement Plan for MARAC
  - Continued focus on safeguarding unborn babies and under 1s with a BSW virtual summit, BSW wide policies and commissioning of ICON programme to prevent abusive head trauma (led by the ICB)
  - Focus on transitional safeguarding

In addition:

- Mapping of activity in relation to violence against women and girls (VAWG)
- Responding to new statutory requirements set out in Working Together 2023, including ensuring strategic education representation
- Response to a significant increase in referrals for case reviews, particularly for safeguarding adult reviews, and sharing learning effectively
- Publication of two Domestic Homicide Reviews
- Embedding the programme of safeguarding walkabouts as part of our assurance activity

Key work for 2024-2025

- Review of strategic priorities
- Improve how voice and lived experience informs our work
- Strengthen our work on perpetrators through the Perpetrator and Offending subgroup
- Develop our understanding of and response to adult exploitation

Proposal(s)

It is recommended that the Board:

i. Notes the publication of the SVPP Annual Report

ii. Agrees to support the work of the SVPP

Reason for Proposal

The work of the SVPP is directly related to improving health and wellbeing outcomes for chidlren and vulnerable adults across the county

Lucy Townsend
Chief Executive
Wiltshire Council

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Wiltshire Safeguarding Vulnerable People Partnership

Annual Report 2023-2024

Contents

1. Foreword by the Independent Scrutineer

I am very pleased to offer my contribution in my first year as Independent Scrutineer for the SVPP, having started in October 2023. My role and approach is to remain as objective as possible whilst acting as a critical friend when required; identifying both the strengths of the partnership and the challenges, as the partners navigate the statutory requirements within their safeguarding responsibilities. I have advised and supported where required, through conversations with strategic leads, attending strategic level meetings, chairing the Safeguarding Adults System Assurance group and completing regular update reports for the SVPP Executive. Going forward I intend to offer more assurance through participation in multi-agency audits and the regular reviews of decision making on referrals sent to the Partnership Practice Review Group.

Through reviewing policies, procedures and activities I have identified the strength of a fully engaged leadership across all the partners, which can be demonstrated by the comments made by OFSTED, see page 24. This partnership has been ably supported by an excellent Business Support Team, who have gathered the information and detail which has informed this report. This collaborative approach has largely delivered well on its priorities, in addition to the safeguarding workplans for children and adults, that have helped to focus on those areas that need further development, see pages 16-18.

As you will see there are many positive changes in how the report is presented this year compared to previously, with more focus on the engagement of all safeguarding partners, see page 3. I am particularly pleased to see that there is a realisation and commitment to looking at "what still needs to be done" against all the priorities. It has rightly identified that there are still areas of safeguarding that require further focus, for instance the development of an all-age exploitation strategy, so it can mirror the great work in this area that has already been evidenced in relation to exploitation of children. Over the next year I will support partners in reviewing progress against these areas that require further development and continue to offer scrutiny, as the partnership continues in its journey of continual improvement. Part of that continued improvement going forward is to have future reports reflect a wider spectrum of voice activity and how it impacts on practice and informs the partnership in the coming year. The conversations I have had both in groups and with leaders, appreciate and support, how important it is that service users and those with lived experience have their voice heard.

Audit activity both previously and going forward continues to be an area that the partnership looks to help inform practice and to test how well they are doing. A good example is the audit that took place across BSW focusing on the vulnerabilities of under 1s (page 6). The partnership recognises that these audits require further check and tests going forward so I am pleased to see a further audit planned for 2025.

It is widely acknowledged, both locally and nationally, that there has been a significant rise in the number of referrals for case reviews across all types. The information on the two published DHRs within the report, evidences the positive impact on practice and progress of outcomes and is also reflected in the Adults Safeguarding Workplan in relation to reviews. This report also identifies that the system assurances are in place and can be highlighted through positive action like the safeguarding walkabouts. These are a fantastic tool to improve engagement with safeguarding support services, with the aim to improve better outcomes for both practitioners and service users, which the feedback suggests it does.

Looking forward I would still like to see an improvement in attendance and participation in the Safeguarding Week training sessions in 2024, but with the earlier planning that has taken place this should help support this action.

Finally, the external scrutiny that has taken place during this period, shows a transparent partnership willing to embrace challenges going forward, knowing that these reviews help inform the safeguarding partnership approach across the network, but more importantly recognises the tireless effort of both practitioners and leaders across the whole of Wiltshire who continue to support those most vulnerable within our communities.

David Williams, Independent Scrutineer

2. Partner agency contributions and engagement

Stakeholder Networks and Senior Partners meetings have continued to provide opportunities for partner engagement. In addition to what is set out in the following report and participation in subgroup activity, here are some headlines on the impact of the SVPP and partner engagement:

Royal United Hospital Bath Maternity Services are leading the pilot of the GCP2a (antenatal) tool on behalf of Wiltshire(for more information see page 17).

Great Western Hospital NHS Foundation Trust (GWH) use the SVPP priorities to inform their Integrated Safeguarding Strategy. The Trust is also working on an initial assessment proforma for adult patients to include a routine enquiry question regarding being safe at home, as a response to learning from case reviews and has been part of the National Referral Mechanism pilot (see page 5) to inform their internal spotlight on child exploitation.

Adult Social Care are promoting a culture of professional curiosity for practitioners encouraging them to seek to explore and understand what is happening in someone's life as a response to learning from case reviews. Their strategic actions are also informed by learning from case reviews.

They have also been proactive in raising awareness of the SVPP within Wiltshire Council by inviting SVPP Business Unit to deliver presentations during Wiltshire Council's Social Care Week events, as part of their induction for staff and at Adult Social Care Roadshows.

HCRG Care Group who provide our community health services for children support the Integrated Front Door quality assurances audits. In addition, they have responded to learning from a DHR to raise awareness of male victims of DA and the dynamic as a victim and perpetrators. This has also led to a review of safeguarding training; They are also making improvements to their recording templates to enable their ability to better capture details of father and information on any risks/vulnerabilities.

Police have put in place an Organisational Learning Board to oversee implementation of recommendations from case reviews and impact.

Spurgeons (providers of Children's Centres) have developed action plans in response to learning from case reviews which are monitored and tracked within their organisation. This has changed how they record their work, specifically in relation to writing case records from a child's perspective and instigated improved management oversight and audit practice within the organisation.

3. Responding to our strategic priorities as set out in our Strategic Plan 2023-2026

Domestic Abuse

What has been done

Prevalence of DA in Wiltshire remains high with data indicating it is increasing. There were 4413 DA related contacts into MASH with 1435 of these resulting in a referral to children's social care, an increase on last year; referrals into Fear Free, Wiltshire's commissioned DA Services, also continue to grow with 2869 referrals from adults. This landscape is well understood by the Domestic Abuse Local Partnership Board (DALPB) which has continued to embed a 'Line of Sight' approach to support scrutiny and oversight of the system response to DA in the last 12 months. Quarterly workshop style meetings have further improved engagement and partnership working in this area of business. There has been a focus on:

- Timeliness of Encompass notifications due to backlogs in triaging of police notices into the Children's MASH. Police have been proactive in responding to any backlog with additional capacity identified to provide an immediate response; additional recruitment is now in place and a new app, due to go live in the autumn will improve the submission of notices.
- The effectiveness of MARAC – an independent review by Oxford Brookes University in 2022 and the Wiltshire Police PEEL inspection both generated a number of recommendations relating to the functioning and effectiveness of MARAC. In response the Police are now the lead agency, and a multi-agency MARAC Oversight Group has been established to improve assurance in relation to the MARAC process. This group is leading on implementing the actions identified from the findings of Police Inspections and working with the DALPB to set out a strategic improvement plan in response to the findings from the Oxford Brookes Review.
- 3,500 Domestic Abuse Violence Disclosure Scheme (DVDS) applications were reviewed by Wiltshire Police after concerns were identified about quality of research undertaken. By January 2024, all affected applications had been triaged; where disclosures had already been made, there was no evidence that further disclosures had been missed. Two cases were identified where a failure to disclose resulted in harm, and these have been reported to the Independent Office for Police Conduct.
- DA Matters training has been rolled out across Wiltshire Police to improve knowledge and understanding of DA especially in relation to coercive control, resulting in a more effective and more consistent response: over 1,360 police staff have received the training and there is a commitment to continue to provide this to their officers.
- In Year 3 (2023-24) of the DLUHC Domestic Abuse Safe Accommodation Grant, Wiltshire utilised their allocation to fund a number of posts/provisions, all of which reflected identified local areas of need. These allocations included: support for children and young people who have witnessed domestic abuse and specialist support for victim-survivors with complex needs or those impacted by the Trilogy of Risk; support in safe accommodation for victim-survivors and their children; specialist support for male victim-survivors and for victim-survivors in the military community.

What needs to be done

The demand on MARAC continues so further consideration to how we can enable it to be as effective as possible in the context of our broader system wide response to DA is needed. This includes proposals to commission an audit of repeat referrals to MARAC in 2024-25 to better understand our system response in this area.

Explore our understanding and system response to the prevalence of elder adult abuse - this will be the main focus of a workshop in September 2024.

Strengthen our work on perpetrators through the Perpetrator and Offending Steering Group by:

- Establishing a Line-of-Sight approach to improve oversight and the group's ability to provide assurance in relation to practice and service provision for perpetrators.
- Development of a dashboard to inform an evidence-based approach
- Developing a map of current support for perpetrators of DA in Wiltshire, its effectiveness and any gaps
- Increase uptake of perpetrator behaviour change support

Exploitation

What has been done

In September 2023, a new model of partnership working was implemented with two Working Groups set up on adults and children respectively, reporting into a Strategic Exploitation Subgroup.

Partnership activity relating to the exploitation of children and young people remains strong with effective mechanism in place and there is good understanding of what this looks like in Wiltshire: the Emerald Team (child exploitation team) has mostly worked with children aged 14-15 years, and these were most commonly males; the team are seeing more referrals relating to criminal exploitation rather than sexual exploitation, which is a shift.

- The continued piloting of Risk Outside the Home (ROTH) as a fifth category for child protection has enabled innovative working with children most at risk of exploitation, using a contextual safeguarding model. During 2023/24, 106 children were considered at the ROTH panel and the numbers and application of threshold have remained consistent over the year. In their Inspection report, 2024, Ofsted noted that "*Children at risk of extra-familial harm, including youth violence, are supported by skilled and tenacious social workers who understand their needs and the risks to them very well. The style of children's plans and the focus on seeing risk through a strengths-based lens is having a very positive impact in helping children and parents to focus on the actions that increase safety for children.*"
- The multi-agency Safer Young People Context meetings continue to ensure sufficient management oversight of young people families and contexts associated with extra-familial harm on individual and group interventions, and monitor the effectiveness of interventions, support, outcomes, and impact. This group has directly impacted on outcomes for children with 7 young people supported and funded to pass their Constructions Skills Certification Scheme Card, building their self-esteem and confidence, and increasing their employability and for some leading them to take further qualifications. Feedback from the parents of these young people has also evidenced the impact and their appreciation of the support provided.
- Wiltshire and Swindon are part of the national pilot of the National Referral Mechanism (NRM) devolved decision making, with the pilot site going live in March 2023:
  - Since the panel has been in place, there has been a 50% increase in referrals to the NRM relating to children: 16 in 2022–23 and 24 in 2023-2024
  - A webinar was provided to CPS staff to improve their understanding of the process, and this has resulted in improved channels of communication to ensure the outcome is the right one for the child and that there is a child first approach, and improved decision-making timeframes
  - Children who have a conclusive grounds decision are now referred into Escape Line for an 'expert by experience' mentor to carry our tailored intervention around the child exploitation

Adult Exploitation remains less developed and more focussed activity is needed in this area to increase partner engagement and momentum to drive improvement

What needs to be done

- Develop an all-age Exploitation Strategy in Wiltshire
- Ensure strong links between the Children and Young People's Exploitation Group and the Education Safeguarding Committee
- Increase awareness and understanding of adult exploitation across the workforce and improve the impact of the adult exploitation subgroup
- Understand what training is provided by agencies in relation to adult exploitation
- Development of a scorecard to provide an evidence-based approach

Safeguarding unborn babies and under 1s

What has been done

Safeguarding partners agreed the creation of the BaNES, Swindon and Wiltshire (BSW) Unborn Babies and Under 1s Steering group which has now been in place since January 2022. The group has coordinated activity and system improvements in relation to safeguarding unborn babies and under 1s across BSW. Key impact in the last 12 months:

- A very successful BSW unborn babies and under 1s virtual summit delivered a range of workshops and reached over 300 practitioners across BSW on the day and more widely with knowledge being shared across agencies: feedback described the summit as "*excellent*" and "*clear and informative*"; "*I have already shared with my team the different attachment names and examples of capturing the voice of the unborn child.*"
- Changes to practice in the children's MASH now mean that all pregnant mothers and fathers to be, are flagged by police when they come to their attention, including through intel and risks to unborn babies and under 1s continue to be part of monthly MASH audits
- Differentiating our response to this vulnerable group - inclusion of a specific paragraph on the vulnerabilities of under 1s for the first time in our thresholds document

A multiagency case audit across BSW, focussed on vulnerabilities of under 1s, identified strengths as multi-agency working and information sharing once risk understood; and areas for improvement as working with fathers, information sharing and professional curiosity

Responding to learning from case reviews - ICB have explored ways to improve sharing of information on fathers with GPs – this is in response to learning from case reviews which identified that GPs were not always aware of men becoming fathers as this information is not routinely shared. However, there are significant information governance barriers to this in the system and this is now being raised nationally

- Sharing of learning from the evaluation of the Dad's Matter Too Project in Wiltshire to further improve our understanding of best ways to engage and work fathers
- Supporting all agencies to deliver safe sleep messages - raising awareness across the system through regular communications to all agencies, improved website content and development of a BSW policy and guidance

In addition, safeguarding partners have continued to support this agenda through:

- Agreement for Wiltshire to be a pilot site for GCP2A (antenatal tool) which will enable us to better assess parental strengths and areas for support in the antenatal period to enable parents to provide the best care for their babies
- Further commitment to preventing abusive head trauma through the agreement to commission ICON across BSW – an implementation group is now in place led by the ICB

Safeguarding partners have now agreed that this group will step down from October 2024 and a final report will provide a summary of activity and impact and key areas of work to continue to take forward and drive improvement in.

What needs to be done

We will continue to keep a focus on this agenda when the Steering Group steps down. The final report will set out key areas of work to take forward and where this work and oversight will sit, to include:

- Working with and engaging fathers
- Repeat of the under 1's audit in 2025 to see if we can evidence practice improvement in the themes identified in the audit completed in 2023.
- Key metrics on unborn babies and under 1s to be included on the children's safeguarding dashboard to ensure continued oversight of issues emerging
- Publication of a BSW Pre Birth Protocol, supporting consistent practice across the ICB footprint
- Publication of a BSW SUDI Policy and pathway for the wider workforce to support the provision of key safe sleep messages to parents by all who have contact with them.

Transitional Safeguarding

What we have done

The focus of this work in Wiltshire has continued to be on a small group of complex young people aged 16-24, typically displaying high risk behaviours, led by the Families and Children's Transformation Project (FACT). Significant progress has been made including agreement of the creation of a new provision in 2024-2025, within Wiltshire Council Adult Social Care to work with this cohort. The new arrangements will support early planning, provide relationship-based support, safeguarding oversight and risk management arrangements including through the National Referral Mechanism. There has been explicit identification of vulnerabilities specific to those with SEND who are also vulnerable to exploitation and work to understand what they need to ensure they stay in education or employment. The project is also exploring how partners can best share information related to risk and vulnerability and how we can ensure that transitions at 18 for this cohort are well planned and effective. This is a real step forward for improving outcomes for these individuals and Wiltshire is at the forefront of national developments on this.

What needs to be done

- Continued support for this agenda and ensuring all relevant agencies are involved in the development of the new provision and associated processes so that we improve outcomes for these vulnerable individuals.
- Ensure appropriate housing provision with support is available for this cohort.
- Evidence impact of new provision and practice
- Establish governance and oversight of this agenda under 'business as usual' arrangements when the FACT project closes 31st March 2025.

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Social, emotional and mental health

What we have done

Work in relation to understand and improve services and support in relation to this priority continues to be led by the ICB through the Mental Health Learning Disability and Autism Board. An all-age Mental Health Strategy is in development and will include current performance assessment based on mental health service benchmarking and national best practice; demand and capacity modelling to support future service approach and priorities for mental health services in next 5 years.

More widely Wiltshire Public Health hosted a first Self-harm Summit in November 2023 – A Call for Action, attended by over 80 delegates and evaluated as increasing understanding of self-harm by attendees. A Self-Harm Insight Report has set out next steps to improve partner response. The Suicide Reduction Group have established a real time Suspected Suicide System Process to capture information and help in the identification of emerging themes. The outcome of this work is fed into the Partnership Practice Review group to support identification of system wide themes. The research into links between suicide and perpetrators of domestic abuse has also been shared with partners to raise awareness of this theme.

There has been scrutiny of the quality improvement journey of Avon and Wiltshire Partnership (AWP) NHS Foundation Trust, providers of our adult mental health services, following recent CQC inspections and an organisational abuse enquiry. The scrutiny response has been through the ICB Quality Improvement Group which is monitoring the action plan as part of the enhanced level of surveillance in place and providing regular assurance updates.

What needs to be done

Continued oversight of improvement journey for AWP and system wide demand and capacity.

Improve content on SVPP website in relation to mental health.

We have also focused on other key safeguarding priorities, as set out below:

Violence against women and girls (VAWG)

In response to the National VAWG Strategy, a mapping exercise was carried out for the first time in Wiltshire to understand the breadth of the activity and our response across the partnership to date, focusing on prioritising prevention; supporting victims; pursuing perpetrators; strengthening the system.
The exercise told us that:

- There has been strong engagement from across partners with the Wiltshire Police VAWG conferences that have been held over the past 2 years
- Street Safe allows anonymous reporting where someone feels unsafe to allow proactive intervention
- Proactive policing approach to reduce sexual offences in Wiltshire
- Wiltshire's Safety at Night Charter in place to proactively improve the night-time economy and make Wiltshire/Swindon safer
- Partnership awareness campaigns through 16 days of action
- Wiltshire Police led VAWG-related education sessions in Wiltshire schools.
- Using the voice of Wiltshire captured in surveys to inform response

The impact of this is that we now have a baseline in Wiltshire from which to measure further activity and developments and evidence impact. An action plan to reopen to the gaps identified, including a commitment to carry out an annual audit of VAWG related work across the partnership. We also need to clarify oversight and governance of this agenda within the arrangements.

Child Sexual Abuse

This year the Child Sexual Abuse Task and Finish Group has worked to provide system assurance about the partnership's oversight of CSA following the Local Safeguarding Practice Review LCSPR Long term sexual abuse of children in care.

Outcomes

- We know what services are available to victims and their families in Wiltshire, are assured of their effectiveness and have identified any gaps in terms of capacity.
- We understand the prevalence of CSA related crime in Wiltshire, including prosecution rates, and have in place key indicators that can inform development of a dashboard for safeguarding children.
- We are assured that children with a disability at risk of or subject to sexual abuse in the family environment are being identified and protected

Outputs: Key data indicators for ongoing monitoring; CSA practice framework including service provision for raising awareness and signposting, and local data to provide context will be available on the SVPP website by autumn 2024

Whilst this group will now stand down they have identified a number of recommendations about future pieces of work to continue to ensure system assurance, this will include seeking assurance from partner agencies about how they have disseminated, embedded the CSA framework within their workforce and evidence of impact; this request will include assurance in relation to evidencing that practitioners across the workforce understand the increased risk of CSA for children and young people with a disability and enabling their voice; and a multi-agency audit with a focus on CSA to be completed in 18 months' time to evidence impact of CSA framework/awareness raising.

4. Responding to new requirements in Working Together 2023

Wiltshire have been in a strong position to respond to the new requirements set out in Working Together 2023, supported by the commitment of the safeguarding partners to effective multiagency safeguarding arrangements. Our Lead and Delegated Safeguarding Partners are committed to their joint and equal duties and have met with the DfE Facilitators to discuss these new roles and responsibilities. They have also committed to carry out the national *MASA Health Check* in the next 12 months to enable us to be as effective as possible. In addition:

- The Lead Safeguarding Partners (across Swindon and Wiltshire) have continued to meet in 2023-2024 to ensure they maintain strategic oversight of key business, learning from case reviews and discuss partner contributions and funding; they have committed to continuing to meet 3 times per annum going forward. The SVPP Executive Chair also attends these meetings to ensure they are in a position to provide feedback to the LSPs and escalate any issues or risks as needed.
- Delegated Safeguarding Partners are senior leaders and have been chairing the SVPP Executive since 2021, rotating on an annual basis; the Executive meets a minimum of 6 times per year
- An Independent Scrutineer has been in place since October 2023 and has provided regular feedback to the safeguarding partners ensuring that safeguarding practices are effective and aligned with best practice and supporting the continuous development and enhancement of the partnership's approach to safeguarding.

We are working closely and directly with headteachers to identify strategic education representation, having attend both the secondary and primary headteachers forums to set out the ask and expectation, and hope to have this in place from September 2024. The Education Safeguarding Committee has been in place since 2022 and has provided a key link between education and the safeguarding partners and strengthening the role of this group will further improve the strategic role of education in the arrangements.

Working Together 2023 provided an opportunity to review our current arrangements to assess individual organisational responsibilities (Section 11) and have reinstated a number of elements. Safeguarding partners have agreed that going forward the Section 11 process in will consist of:

- **Section 11 Compliance statement** – all agencies will be asked to complete this on a biannual basis and for 2024-25 they will be asked to provide assurance in relation to the new requirements set out in Working Together 2023
- **Deep dives** – a programme of deep dives will be set out on an annual basis, which some partner agencies will be asked to participate in; the areas of focus will be informed by learning from case reviews, audit activity, data and intelligence and national reports/research messages
- **Safeguarding Walkabouts** - a programme of walkabouts will be set out on an annual basis
- Where agencies participate in Section 11 assessment carried out by other safeguarding partnerships, we will request that these are also shared with us

We will report on the outcome of Section 11 2024-2025 in the next annual report.

We have yet to be able to fully demonstrate how the experiences of children and families shape the delivery of local arrangements. There is a significant amount of voice activity that takes place across partner agencies, and we have previously mapped this putting us in a strong position from which to take this forward. To ensure this is prioritised voice is included in both the children and adults safeguarding strategic plans for 2024-5. We are on track to publish our updated safeguarding arrangements in December 2024.

Supporting the Serious Violence Duty

Partner agencies have engaged well with the duty which is led by the joint Swindon and Wiltshire Serious Violence Steering group. The needs assessment has enabled a comprehensive understanding of what this means for Wiltshire and learning from local case reviews has further informed this. A number of pilot projects have been put in place as follows:

- Focused deterrent approach to group offending in targeted hot spots
- Street Doctors training for young people to help them to know what to do if a young person sees someone stabbed on the street and how they can potentially save a life.
- Funding training to further support a trauma informed approach

We anticipate being able to better evidence the impact of this work in 2024-5.

5. Practice Reviews – activity and impact

The Partnership Practice Review group (PPRG) is our local mechanism for the consideration of all case reviews for the partnership including serious child safeguarding cases. This year has seen another increase in activity and referrals to the PPRG; from 15 in total during 2022-2023 to 24 this year. The increase has been seen in the number of referrals relating to adults for consideration of a SAR. To support sharing of learning from case reviews we delivered a virtual briefing on an analysis of learning from case reviews 2022-2023 to safeguarding leads across partner agencies in October 2023; this will be embedded going forward.

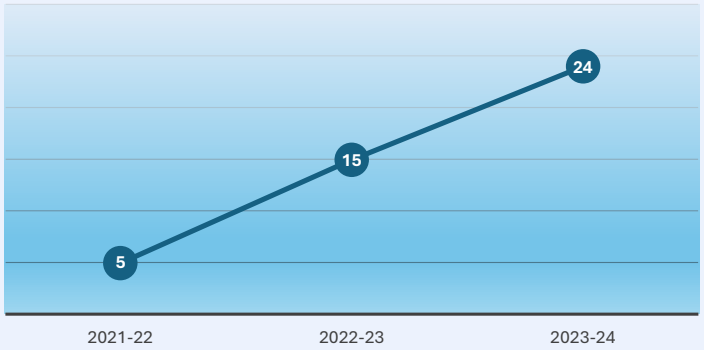
As the data on page 11 shows, the number of case referrals in the last 12 months has risen significantly; this has meant that:

- There is increased demand on the SVPP Business Support Team to commission and coordinate case reviews in addition to business as usual and reduces their capacity to respond to the recommendations from previously published reviews
- Increased demand on partner agencies to provide summary information to inform discussion making, in addition to their participation in active case reviews
- Increased costs to the partnership

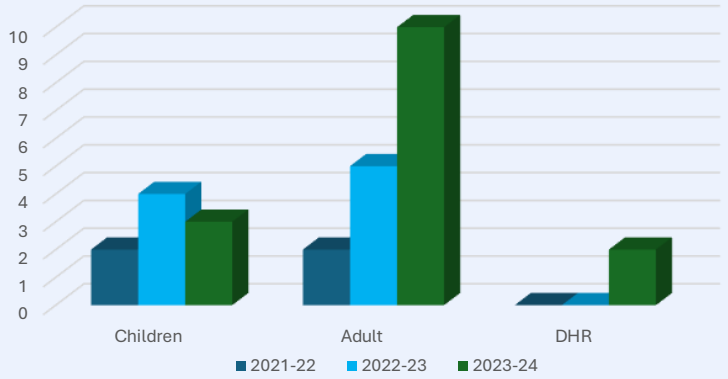
Wiltshire will not be alone in this, and we consider the most appropriate and proportionate methodology for each review and whether it will provide new learning in our decision making. Additional capacity has also recently been added to the SVPP Business Support Team, with a Partnership Support Officer to specifically focus on case reviews and the next 12 months will evidence if this is sufficient to meet demand. In addition, there have been challenges in finding independent reviewers adding to delay in starting 3 of our statutory reviews. To manage demand and ensure the right cases are considered, there is a triage process for all referrals to the PPRG which includes feedback to the referrer if a case is not progressed for consideration of a case review; these cases will now be audited by the Independent Scrutineer to provide assurance about the triage decision making.

Nationally we can compare ourselves with national data on serous incident notifications and this indicates that we are in line with other safeguarding children partnership. Equivalent data is not available for DHRs or SARs however feedback from regional and national networks indicate we are not an outlier.

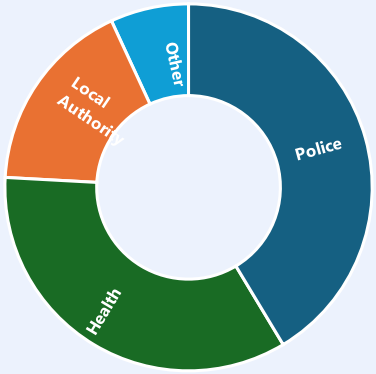
Number of Referrals received



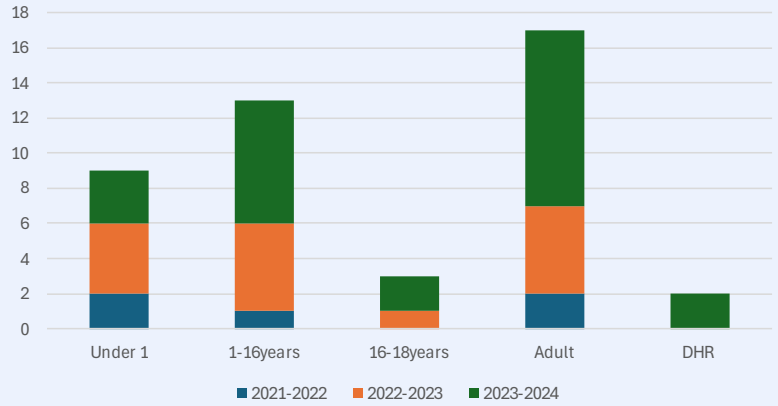
Referral Type



Referral Source



Referrals by age



Cases relating to children

We have notified 2 cases to the national CSPR Panel, within the statutory timeframes.

Rapid Review 1: death of a 5-week-old in the context of concerns about safe sleeping arrangements and parental neglect. Known to social care, baby subject to CIN (assessed prebirth) due to family history and known vulnerabilities. • Themes: safer sleep guidance not followed when out of routine • Recommendation: no CSPR, agreed by panel.
Rapid Review 2: suspected non accidental injuries to a 17-day old baby. Family was open to support from a Family Key Worker. • Themes: cannabis use by mother; understanding and assessing the adults in a child's life; nonattendance and disengagement with services; sharing of police intel in relation to cannabis use. • Recommendation: no CSPR, agreed by panel.

Analysis of the learning from these cases has identified that there is more to do in relation to embedding the GCP2 tool to support the assessment of parental capacity and neglect and continued to reinforce and raise awareness of safe sleep messages. A pathway and policy on Sudden and Unexpected Death in Infancy (SUDI) will be published in 2024-25 in response to this learning.

In addition, we have discussed 5 other children referred for consideration for a case review and carried out local learning reviews in relation to 4 of these children

- Suicide of a young person (local learning review commissioned)
- Two young people arrested /convicted for murder/manslaughter (local learning review commissioned)
- Physical abuse of an 18-month-old in the context of concerns about abuse (local learning review commissioned)

Learning briefings will be shared with partner agencies but will not be published.

Safeguarding Adult Reviews

Safeguarding Adult Reviews (SARs) are undertaken where an adult with care and support needs has died or suffered serious harm, and it is suspected or known that the cause was neglect or abuse, including self-neglect, and there is concern that agencies could have worked together more effectively to protect the adult. In addition to the new cases referred this year there are two other SARs in progress.

Four referrals were received by the PPRG in relation to adults during 2023-2024, two of which met the threshold for a SAR.

Referral 1: Adult with multiple health conditions who died in hospital following a long lie at home. Concerns around self-neglect, declined support, concern around ability of adequate care being provided by family. Concern around capacity to make decision to decline/refuse care. This case is subject to a SAR.
Referral 2: Adult died in hospital showing evidence of neglect/self-neglect, malnourishment and suspected sepsis. Themes: adult with care and support needs when discharged from hospital was unable to receive care package due to rurality. Family was main carer; all other input was refused by the adult. This case did not meet criteria for a SAR – professionals briefing was held in relation to self-neglect and rurality.
Referral 3: Adult with care and support needs died in hospital with evidence of serious neglect/self-neglect.

This case was referred for consideration following the death of an adult in hospital with sepsis and evidence of serious neglect/self-neglect. Adult was assessed as being capacitated in relation to her care and support needs. Care provided by spouse. Known to a number of agencies with a history of refusing help and support. This case did not meet criteria for a SAR however relevant lines of enquiry to be included within a SAR already in progress with similar themes.
Referral 4: Adult resident of a care home with multiple health needs died after refusing food for 2 weeks. Adult with diabetes, possible learning disability died after refusing food for 2 weeks. She was deemed to not have capacity to manage her care and support and health needs and a best interest decision was made. She was unable to return home due to high care needs which she did not accept and was non-compliant with care and refused to eat. This case did not meet the criteria for a SAR. Although the adult had care and support needs there was insufficient evidence of neglect or abuse.

Self-neglect has been highlighted this year as a significant theme, in line with the findings from the national SAR Analysis. As well as being included in the Safeguarding Adult Workplan, it was the focus on the Adults Safeguarding Partner Workshop in June 2024 and there will be a BSW Virtual Conference on self-neglect in November 2024-25. Mental Capacity Assessment is also a consistent theme and activity to drive practice improvements is set out in the Adult Safeguarding Workplan for 2024-25.

Domestic Abuse-Related Death Reviews (Domestic Homicide Reviews)

During 2023-2024, two referrals were made to the PPRG relating to DHRs.

Referral 1: This case was referred for consideration of a DHR as the victim died by suicide following reported domestic abuse from his partner and her family. The referral highlighted the difficulties of multi-agency working when there are counter-allegations between the victim and alleged perpetrator, as well as citing the unique nature of DA support with male victims, especially single fathers of children with additional needs. This case will be subject to a Domestic Abuse-Related Death Review.
Referral 2: This case was referred for consideration to the PPRG as the victim died by suicide following reported physical and financial abuse from her partner, as well as coercion and controlling behaviours. The referral highlighted the impact of this on the victim's mental health, as well as the system response to young adult repeat victims of DA. This case will be subject to a Domestic Abuse-Related Death Review.

The decision to commission DHRs for these referrals aligns with the new Home Office guidance published in February 2023 stating that DHRs would be renamed Domestic Abuse-Related Death Reviews, to include suicide and therefore better reflect the impact that DA can have on a victim. The SVPP will be working to strengthen partnership links between DHRs and work on Wiltshire's Suicide Prevention Strategy in order to ensure that the learning from DHRs informs this wider work.

Published case reviews

DHR Krystyna and Elzbieta

Krystyna and her husband, moved from Poland to the UK and had three daughters together, including Elzbieta. The relationship between Krystyna and her husband became abusive, with him becoming increasingly controlling and violent. They separated and, six weeks later, he fatally stabbed both Krystyna and Elzbieta in their home.

Recommendation	What have we done

Promote awareness of economic abuse as a method of coercive control.	• Training delivered to 21 frontline professionals to cascade learning within organisation. • FearFree have seen an increase in referrals sighting specifically economic abuse as a concern every year since the end of 2021. • SVPP multi-agency DA training now has more specific learning on economic abuse and coercive control and improved economic abuse content and guidance on SVPP website.
Routine enquiry into domestic abuse where housing agencies become aware that an individual has separated or is undergoing relationship breakdown.	• Wiltshire Council now have a dedicated DA Housing Officer who works with cases where DA is identified. • Sovereign Housing Association have a DA Champion in all localities to provide DA-specific knowledge. • Increase in referrals from housing bodies to Fearfree (89 in 2021-2022 to 98 in 2023-2024).
Assurance that routine enquiry into domestic abuse, where health indicators are present, is being undertaken and embedded into local procedures.	• Increase in referrals from health services to FearFree: 117 in 2021-2022 to 132 in 2023 to 2024.
Increase awareness of DA and support services available amongst Polish communities. Assurance that services are meeting the needs of Polish victims.	• Task and Finish Group established to seek assurance about support offer for minoritised groups. • Referrals into FearFree for White European people (they do not specify a country) have decreased since 2021/2022 (192 to 152)
Dedicated domestic abuse training for support assistants in schools should be provided.	• Information about marginalised communities added to Designated Safeguarding Lead training
CSP should promote the DA Toolkit for Employers and promote membership of the Employer's Initiative on Domestic Abuse amongst its partner agencies	• PH have developed a website page dedicated to Workplace Health for business across Wiltshire which included a focus on domestic abuse and a toolkit for employers.

DHR Emily

Emily was a young woman who had struggled with her mental health and substance abuse throughout her life. She was raped as a teenager. She maintained contact with her attacker and lived with him for a short period, moving back in with her parents at the start of the first COVID-19 lockdown. She disclosed that she had been a victim of domestic abuse, and Emily's parents were concerned about her worsening mental health and possible substance use after a period of abstinence. Emily was found deceased in her bed; the coroner recorded a verdict of accidental overdose.

Recommendation	What have we done
Improved understanding of the referral process for Adult Social Care.	• Webinar on making adult safeguarding referrals held Oct 21. • Updated information available on SVPP website regarding making an effective referral – promoted via SVPP Newsletter
The SVPP should promote the use of the DASH risk assessment as the primary tool for assessment of risk in relation to domestic abuse and seek assurance that it is being used appropriately and consistently across the partnership.	• DASH and MARAC multi-agency training to run via SVPP from Spring 2022 with 217 practitioners trained since then, with take up monitored by the DALPB; evidence fo a correlation between an increase in referrals to MARAC from agencies where this training has been delivered. • Non-police referrals into MARAC and our support services are high - a useful indicator also of DASH being used by a wide source of partners.
Promote learning about the multi-faceted aspects of family members and carers supporting adults with complex needs.	• Now included as a standard enquiry on the SVPP's walkabouts to agencies to highlight and assess awareness.

6. System Assurance

The safeguarding partners have collectively ensured they are sighted on and assured about key safeguarding issues both locally and nationally:

- Right Care Right Person – regular reports into the SVPP Executive have helped to ensure that all key partners were part of strategic implementation discussions and oversight of impact as it has gone live and provided ongoing assurance. There is in recognition that although impact has been low to date continued oversight is key to ensure this continues as it becomes business as usual.
- Incident at the Countess of Chester Hospital discussed and assurance provided that there are appropriate mechanisms and oversight are in place that would identify such concerns at the earliest opportunity, including establishing a System Mortality Group to provide a learning from deaths report.
- Review of Domestic Violence Disclosure Scheme (DVDS) by Wiltshire Police following identification of issues with the quality of research undertaken; over 3,500 records were reviewed with police dedicating additional resource and providing regular reports to ensure that any risks as a result were identified and responded to. An independent IOPC investigation is ongoing.
- MARAC – following a review of MARAC in 2022-2023 safeguarding partners agreed that Wiltshire Police would take over as lead agency this transition has now taken place however was delayed due to challenges in relation to contributions from other partners to support coordination and administration of this mechanism and was escalated to the Lead Safeguarding Partners to resolve. The focus is now on further improvements to the functioning of MARAC and an improvement plan is being developed.
- The Partnership Risk Register has provided a record of identified risks to the system and mitigating actions in place; risks recorded this year include DVDS review, rollout of Right Care Right Person and changes to national guidance in relation to the sharing of DVDs disclosures by probation.

- Response to international recruitment within care providers and concerns about modern slavery – concerns were initially raised by Primary Care colleagues which led to a joint response demonstrating that all 3 safeguarding partners understand the risks faced by people who are vulnerable: one provider who was impacted commented, "*this was an amazing piece of cross team collaboration to get the job done and ensure that our customers are safe and remain well supported at home.*" There is ongoing partnership working through the Modern-Day Slavery Forums.

In addition, the safeguarding partners have been transparent in their sharing of internal challenges which may impact the safeguarding system. For example, Wiltshire Police have provided updates on the improvements made and change still needed following the findings from inspections that placed with into ENGAGE. In addition, they shared the challenge of having a new and inexperienced workforce and the additional oversight and scrutiny needed as a result.

The Families and Children's System Assurance group (FCSA) and Safeguarding Adults System Assurance group (SASA) are in place to provide assurance to the SVPP Executive that the system to safeguard children and adults respectively are working effectively and improving outcomes. They have met jointly in 2023-24 to ensure more effective and timely oversight of areas that sits across the system, for example multi-agency safeguarding training, the risk register and walkabouts. This will continue going forward.

Safeguarding Walkabouts

A new programme of multi-agency safeguarding walkabouts is now embedded with 3 having taken place this year, providing assurance in relation to safeguarding practice within agencies. The programme now includes joint children and adults' walkabouts which have provided to be very successful in providing all age system assurance and also increasing understanding across children and adults' services. The framework for the walkabout now includes questions in relation to voice activity and cultural competence in response to learning from case reviews and is further tailored to include specific lines of enquiry for exploration relevant to the organisation. Walkabouts are intended to be a two-way conversation and feedback from both the participants and the hosts has been very positive and value in supporting improvements to the safeguarding system.

Walkabout outcomes:

- Marlborough College – evidence of significant improvements to safeguarding and culture within the college following testimonials reports through Everyone's Invited; participants were able to speak to a wide range of staff and students alone and triangulate their responses to gain that assurance.
- Connect Specialist Substance Use Services in Wiltshire (commissioned by Wiltshire Council Public Health) – this was joint children and adult's walkabout and provided assurance in recently commissioned new service evidencing that safeguarding is central to the organisation at both an operational and strategic level. It identified further work to do to support practitioners in Connect with understanding adult safeguarding thresholds.
- Fear Free Specialist Domestic Abuse Services (commissioned by Wiltshire Council Public Health) – highlighted their commitment to safeguarding and the challenges of the demand on DA services and the pressure staff can feel as a result.

Actions are monitored with oversight through the Joint FCSA and SASA subgroup. A programme of future visits is in place which includes Army Welfare, Housing Providers and walkabouts are part of our Section 11 arrangements as set out on page 9.

Children's Safeguarding

The FCSA can evidence an improvement in the quality of exception reporting into the group by both Police and ICB, further improving the line of sight into frontline practice. The development of a multiagency dashboard will further improve this in 2024-2025.

In addition to the areas of focus set out in the Workplan FCSA have ensured that they are assured about any impact on or risks to children as result of the backlog of Police PPNs within the Integrated Front Door and its impact on Encompass notifications to schools. Placement sufficiency has been a significant challenge in Wiltshire, as it is nationally, and the provision of 3 new Children's Homes in Wiltshire evidences the importance given to the need for sustainable provision for this vulnerable cohort of children and young people. SEND has had increased focus, with neurodiversity emerging as a theme within our case reviews, within our electively home education cohort and significant and unsustainable demand in the system in relation to diagnosis and support. The SEND Transformation Plan is due for publication in 2024-25 and there is also an anticipated SEND Inspection, both of which will evidence whether Wiltshire's response to this is effective and sufficient. We will be able to report on the impact of this in 2024-25.

Outcomes from the Children's Safeguarding Workplan 2023-2024	
Outcome	Progress and impact
1. *Improve our response to neglect by publishing a Wiltshire Neglect Framework, further embedding the GCP2 and introduce the GCP2a.*	Wiltshire's Neglect framework provides practice guidance, and a webinar is available which includes learning from case reviews on neglect – numbers accessing the webinar and traffic to the neglect page on the website are being tracked to evidence impact: 32 webinar views and 1305 hits to date. Wiltshire is now a pilot site for GCP2a, the bid was supported by the safeguarding partners and learning from this will further enhance our safeguarding response to vulnerable unborn babies and under 1s. GCP2 training is now part of the FACT Family Help Workforce Strategy which it is hoped will give it more impetus and increase take up, impacting on the use of the tool. This remains an area for ongoing focus and discussions about oversight of this are taking place currently.
2. *Focus on improving practice in relation to ensuring we are considering the day in the life of the child in all our work, we are curious in our practice, and we escalate concerns*	7-minute briefings from case reviews are focussed on practice and are well received by practitioners. Professional curiosity remains a persistent practice issue is carried forward into the work plan for 2024-2025 as well as a review of our current case resolution policy.
3. *Embed line of sight to frontline performance, including the children's MASH*	• Line of sight is now well embedded with clear timeframes for reporting into the Family and Children's system assurance group, improving system assurance and ensuring a focus on the whole system including children looked after. • The MASH Oversight Board is now a Strategic group with an operational group sitting underneath it and provide further assurance in relation to the foundation of MASH but also the wider Integrated Front Door functions.

	• There has been a strong focus in improving the number of early support assessments being completed and registered: evidence of this impact can be seen in the data with an increase from 60% of ESA's being registered in April 2023 to 95% in March 2024, with a clear increasing trend seen across the 12 months.
4. *Ensure links with commissioning are strong in particular for specialist services, to ensure safeguarding is front and centre to the commissioning process*	We have completed walkabouts on two commissioned services this year with commissioners sighted on the whole process including the report. In addition, commissioners provide exception reports into the FCSA. The additional review carried out by Wiltshire Council in response to children with complex needs placed in residential settings has further evidence strengthened commissioning arrangements.
5. *Review and consideration of recommendations from Child Protection in England and Independent Review of social care & any subsequent implementation requirements.*	Our response has been incorporated into the implementation plan for Working together 2023, including our new section 11 arrangements as set out on page 8.
6. *Support the development of the FACT Family Help Model*	The Families and Children's Transformation project (FACT) has led on piloting family hubs with regular reporting into the FCSA. Discussion is now taking place about how this work can become business as usual and any additional oversight /steering of this required within the partnership arrangements.
Improve our contact with schools as safeguarding partners (see also no.6)	As set out on page 8 we are progressing ensuring we have strategic education representation within our arrangements and strengthening the links to the Education safeguarding committee and wider school network. The Safeguarding Partners have been a key speaker at the Schools Safeguarding Conference for the past 2 years. Assurance in relation to safeguarding in schools is provided through the Section 175 audits. Early years settings also complete a safeguarding audit which is best practice. The result of the audits for academic year 2022-2023 show: • 54% of schools rated themselves highly effective, with 425 rated as effective, in line with results from the previous year's audit: to check and test the self-assessment 25 schools that have not been visited in the last 2-3 years are selected from the audit outcome for a detailed follow up every year. The impact of this process has supported building positive relationships with schools and ensuring rag-ratings are accurate. • There was an 89% return rate for early years settings with 58% rating themselves as highly effective, an increase on last year. It has been more challenging to established quality assurance of their self-assessments due to capacity within the local authority, but the plan is that these will begin in 2024-25. Any settings rag rated red are automatically visited by the early years safeguarding leads. • Oversight of children electively home educated and missing education has been robust with further analysis identifying that 30% of the EHE cohort have ASD, further informing plans to ensure sufficient support is in place for both schools and parents, alongside sufficient and appropriate school places for these children.

8. *Develop our understanding and oversight of child sexual abuse: understand the current context at a local and national level; ensure we are sufficiently supporting practice in this area*	See update on page 8.

Wiltshire Overview Report of Children in Residential Settings, Wiltshire Council

Further assurance was provided to the safeguarding partners following an additional multi-agency review of 12 children (11-17 years old) took place between May and June 2023, which supplemented the work carried out in response to the national Child Safeguarding Practice Review Panels review, Safeguarding children with disabilities in residential settings, and their request to Directors of Children's Services to initiate urgent assurance action.

The findings included:

- All children were seen in both their school and home settings; good evidence of child voice, also views of parents and care providers.
- No immediate or significant concerns raised as part of these reviews and areas for improvement were already known and being monitored.
- The Children's Commissioning Team have secured funding for 2 new posts with these roles being focused solely on quality assurance including Supported Accommodation placements ready known and monitored.

This review evidenced good practice in responding to national learning and going above and beyond to ensure very vulnerable children are safe. This review recommended continued review of Wiltshire's vulnerable children living at distance and ensuring that everyone understands their roles in assuring themselves of the quality of care and as a result all children living away from home are now part of the audit report managing system.

Adult Safeguarding

Scrutiny of the safeguarding system for adults continues to be a key area for development and preparations for the new adult social care inspections will support further improvements. In 2023 the group developed a Safeguarding Adults Workplan which set out its annual priorities with key areas of work. To support this the group also put in place a Line-of-Sight document to provide greater assurance in relation to front line activity. This will further embed, and we expect to see its impact in 2024-2025. Frequent updates and assurance have been provided by the ICB in relation to oversight of our Wiltshire patients placed out of county in Mental Health Hospitals; the Edenfield Hospital Review prompted the NHSE Mental Health Director to contact all ICBs to request additional assurance following the Panorama expose into Greater Manchester Mental Health NHS Foundation Trust. These updates have included reports on the improvements to preventing abuse and neglect within the processes for agreeing funding for those patients whose needs for specialist hospital care could only be met outside of the county following the North Somerset SAR, Learning from the circumstances of the deaths of Abi and Kate.

Further improvements in engagement with wider services for adults has been achieved through establishing Adult Safeguarding Partnership Workshop, the first of which took place in September 2023. The purpose of the Workshop was to explore how the SVPP can increase its engagement with wider partners and was attended by 17 representatives from a variety of statutory and voluntary agencies. Outcomes included a request for more awareness around modern slavery, hoarding, self-neglect, in addition to more opportunities for joined up working. Further events are already planned for 2024-5 including one with a focus on self-neglect and hoarding.

Outcomes from the Adult's Safeguarding Workplan 2023-2024	
Outcome	Progress
Develop safeguarding data and intelligence that will provide an understanding of themes, trends and analysis.	• Line of sight document is now in place to provide better assurance in relation to front line activity. • Safeguarding Walkabouts for adult services established to support system assurance. • Exception reporting is now a standing agenda item evidenced through minutes. These reports will include outcomes of partner audits going forward.
Development of quality assurance plan based on themes and trends identified by safeguarding data and learning from local and national case reviews	• Line of sight will be our key QA mechanism going forward, alongside safeguarding walkabouts. • Workplan 2024-25 to include actions on self-neglect and MCA as these continue to be key themes from case reviews
Seek assurance through multi agency audit activity that Making Safeguarding Personal (MSP) is embedded into practice through safeguarding concerns and enquiries.	• The data received and reviewed at SASA meetings from the Performance and Outcomes Group and the Adult MASH Quality Assurance Meetings provide evidence of the voice of the individual. • Outcome of multi-agency Adult MASH audits is included within exception reporting to SASA. • MSP included in Line of Sight so will be specifically reported on going forward
Support dissemination of learning from Safeguarding Adult Reviews and other statutory reviews to ensure that learning is embedded across the partnership	• No SARS were published in 2023-2024. • Learning from a number of local learning reviews has been shared on the following themes: rurality and access to services; self-neglect; responding to complex needs and substance use with 73% of delegates who attended the virtual briefing to share rated it as "excellent". • Knowledge within agencies of learning from SARS/Local Learning Reviews is explored through safeguarding walkabouts
Improve engagement with and learning from organisations and ensure meaningful feedback is sought and used to adapt priorities and ways of working.	• Adult Services Partnership Meeting held September 23. The next meeting is planned for June 2024. • User voice is part of 2024-2025 workplan, alongside plans to create an adult practitioner forum. • Adult Safeguarding Partners Meetings which will meet twice per year.
Develop a 'line of sight' process that includes reporting outcomes of partner inspections and/or safeguarding investigations	Line of sight is in place and now needs to be developed to include wider multi-agency reporting, including data, to give a greater assurance of safeguarding: included in workplan 2024-2025.
Further develop the multi-agency adult safeguarding training offer to include best practice guidance in mental capacity assessment, what constitutes a safeguarding concern and making safeguarding personal	• MCA Training will be in 2024-2025. • There remains work to do to increase the multiagency safeguarding training offer for the adult workforce and is included in the workplan for 2024-25.

	• Stakeholder Networks and Senior Partner Meetings have had a greater focus on adult safeguarding, including learning from a case review in relation to rurality and self-neglect.
Improve understanding of vulnerabilities and risks experienced by young people that are transitioning into adult services	See update on page 7. The oversight of this strategic priority will sit with FCSA/SASA going forward.
Review multi agency safeguarding adult policies and practice guidance in line with learning from case reviews and quality assurance activity. This will include Persons in a Position of Trust and guidance in relation to 'think family' practice	• Plan in place for timely review of all policies to include national guidance and policy updates. • The High-Risk Professional Guidance has been refreshed and a short webinar produced to explain the process. • The Persons in Position of Trust Policy (PiPOT) is being progressed regionally to establish a SW policy.

An emerging theme is the line of sight into care providers and their understanding of the role of the SVPP. There is already work in place to attend the Providers Forum to improve this understanding and support engagement with and understanding of the case review process. SASA will ensure that exception reporting on the outcome of CQC inspections are also part of the line of sight going forward.

Impact of Safeguarding Enquiry Audit presented to GP Safeguarding Leads

Further evidence of collaboration and sharing of system assurance was provided by a presentation of findings from an Adult MASH Audit to a GP Safeguarding Leads Meeting in January 2024. The audit was conducted following a request from Primary Care for a list of adults open to section 42(2) enquiries from Adult Social Care. This led to the Named GP for Safeguarding Adults and Children working with Adult Social Care to collect data around primary care involvement in adult safeguarding enquiries, supported by the Designated Professional for Safeguarding Adults and Specialist Nurses in the ICB.

The methodology used was a random selection of 10 cases, all closed to safeguarding within the previous quarter. The audit considered:

1. What was the nature of the abuse?
2. Was primary care involved in the S42 enquiry?
3. What was the outcome of the S42 enquiry?
4. Could outcome have been different if primary care was involved?

The immediate impact of this was an increase in notifications of safeguarding to GPs in relation to resident-on-resident incidents and falls, enabling them to bring forward any health reviews of the individuals involved in the safeguarding. Longer term impact is that GPs are now notified of Section 42 enquiries where they could bring additional benefits to the enquiry.

A further audit in May 2024 has led to an additional question for care homes to confirm that they have shared the safeguarding concern with the GP, and this will enable outcomes to be measured in future audits which are planned later in 2024 and will be presented to the Safeguarding Adults' System Assurance group.

7. Impact of multi-agency training

The SVPP multi-agency safeguarding training offer continues to provide high quality learning opportunities, with 85% plus of delegates on our instructor led courses rating the course as good or excellent, with most courses achieving 90%. This feedback has been consistent over the past few years. This year we have made more use of webinars and virtual briefings, with over 300 views of new webinars recorded. This included the partnership hosting a webinar on the launch of the new Wiltshire Family Hubs for professionals, which was very well attended with over 100. We will continue to develop this offer as a user-friendly way to access training and workforce development.

An emerging challenge is the decrease of attendance on the day on courses, dropped to 70% attendance on average on the day, with many running under capacity or even having to be cancelled due to low turnout. This does not represent good value for money or resource and will be focus of the Practice Development Group in 2024-2025 who will continue to look at barriers to attendance on the day and how these can be overcome; this drop in attendance on the day was also mirrored in Safeguarding Week. Plans for further development of the programme include hosting events from the Disclosure & Barring Service and Safer Internet Live, launch of a new Early Support Assessment course and a Mental Capacity Act course. During 2023-24 we have seen an increase in the awareness of and increase in take up by colleagues from adult services and as our offer to support this workforce grows, we expect to see this increase further in 2024-2025.

"I will now have a better understanding of levels of risk, types of abuse and the importance of information sharing and a multi-agency approach to child protection."

"I can see how as a school we now fit into the bigger picture of keeping children safe in the community and beyond. It's been very helpful to see the challenges facing our pupils once they leave the school environment."

95% of Attendees* rated course delivery and clarity as 'Excellent' or 'Good'

*** Attendees who completed course evaluations**

Improved knowledge, confidence and access to helpful resources

Enhance my knowledge to give the best support to my families

Please describe how the training will have an impact on the quality of your work.

Really well run course

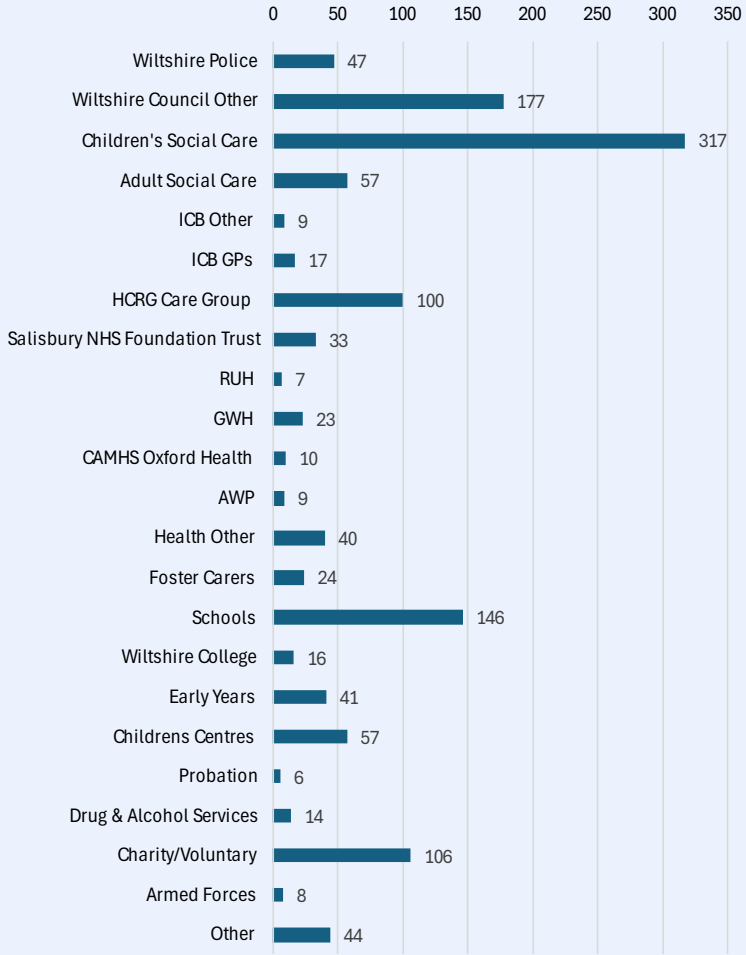
It was a really good interactive day and great to work alongside people from other professions.

Comments from course attendees

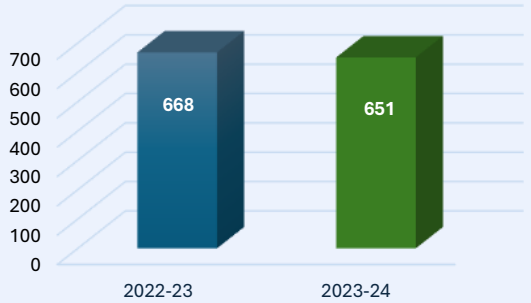
A great course, I learnt a lot

Would recommend others to attend

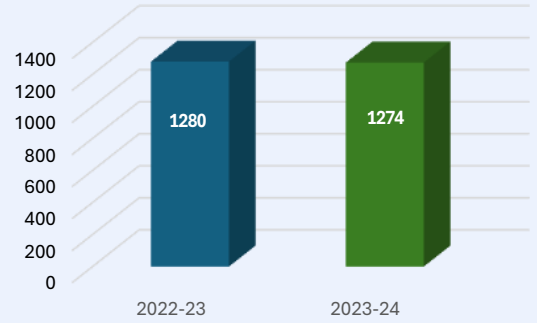
Course Attendance by Agency (Includes One-Off Events)



Core Course Attendance



E-Learning Modules Accessed



"It gives me a new tool to use to assess levels of neglect which is objective rather than neglect being considered in a subjective way by using personal views and expectations of what is 'good enough'"

"'I feel more confident to complete a DASH, I feel more confident to add additional notes and to ask for a MARAC if I feel that the DASH isn't reflecting the danger of a situation."

Safeguarding Week 2023

12 sessions ran across the week
391 delegates booked on with 291 actually attending: attendance overall was 56% of those who booked on

Understanding Transitional Safeguarding
Understanding and preventing radicalisation
Safeguarding risks to people seeking asylum
Tackling Poverty – how it can affect parenting
Relational Leadership within the Children's Sector
Learning from case reviews: An overview of local learning from case reviews in Wiltshire 2022-23
Child Sexual Abuse and the Independent Inquiry and impact on all professionals working with children
Tackling Modern Slavery webinar
Introducing the Safeguarding Vulnerable People Partnership (SVPP)
Child exploitation: contextual safeguarding and the national referral mechanism.
Introduction to the GCP2 Neglect Tool
Applying Trauma Informed Practice to Child Protection Planning
Ways of Writing Workshop

Attendance and engagement was disappointing and we will be promoting and planning the programme earlier for 2024 to improve engagement and participation including in agencies stepping forward to deliver sessions during the week. There is also increase oversight of the programme and engagement by safeguarding partners through the joint FCSA and SASA meetings.

8. External Scrutiny

External scrutiny by inspection bodies further informs safeguarding partners of how well the safeguarding system in Wiltshire is working.

Ofsted Inspection of Wiltshire Council local authority children's services September 2023 – rated as Outstanding.
This outcome built on the findings from the two previous Oxford Brookes Evaluations of Support and Safeguarding completed in 2019 and 2022.
Highlights of the inspection report include:

- Children in need of protection receive swift and effective response from the Integrated Front Door (IFD) team of workers from children services and from partner agencies.
- IFD provides seamless service to children and families during the evening and at weekends. For almost all children, appropriate and timely action is taken by workers to help protect and support them at times of increased concerns and crisis.
- When strategy meetings lead to child protection (CP) enquiries, they are timely and comprehensive.
- CP conferences are timely and well attended, and lead to strength-based that focus on increasing protective factors and reducing harm.

The report also highlighted that:
"Strategic partnerships in Wiltshire are strong. The local authority is central to a number of high-performing strategic and operational partnership boards and forums, including the Safeguarding Vulnerable People Partnership, that regularly measure and evaluate the impact of partnership working for children. There is effective support and challenge between leaders and managers when partnership working, and services are not making the positive difference they need to for children. The family judiciary, the Children and Family Court Advisory and Support Service (Cafcass) and key partners, including police and schools, report positively about the quality of practice, strong partnership working and the impact of services for children."

Adult Social Care Peer Review, September 2023 - areas identified as working well included effective prevention work, good plans and developments for improvement, enthusiastic knowledgeable teams and supportive leadership culture. Whilst recommendations included a strong focus is needed on assurance work, including case files audits to support quality and consistency in practice and to evidence impact of change the peer review provided positive assurance in relation to safeguarding systems and learning ahead of anticipated CQC inspection in autumn 2024.

Independent Safeguarding Review of the Southwest Ambulance Service (SWAST) – Wiltshire partners participated in the regional review, feeding in the challenges that have existed with engaging with SWAST particularly in relation to capacity to participate in case reviews and quality of referrals into the Integrated Front Door and Adult MASH. The outcome of the review has driven organisational wide improvements including additional local safeguarding resource. SVPP have already seen improved engaged with participation in the SVPP Stakeholder Network and Senior Partners meeting for the first time.

Independent Safeguarding Audits of Salisbury and Bristol Diocese have taken place this year. Both dioceses have a number of parishes and schools within Wiltshire. Although the final reports and recommendations have yet to be received, they have both approached the audits with an open and transparent approach.

Wiltshire Health and Care (providers of community health services) – rated requires improvement, however inspection recognised that there are robust arrangements in place in relation to safeguarding. Concerns identified related to inpatient provision.

CQC Inspection of RUH, Bath – a number of safeguarding alerts triggered a CQC unannounced inspection in Aug 2023. Significant allegations resulted in a review which identified learning in relation to:

- Safeguarding processes and staff awareness
- Timeliness of response to incidents/allegations
- Work force and staff welfare including freedom to speak up
- Night cover leadership and culture; micro-cultures within permanent teams

There is now a clear quality assurance framework in place to drive improvements forward.

Wiltshire Police – have continued to drive an improvement programme following the findings of the HMIC Inspection of Child Protection and Peel Inspection in 2022. Further inspections this year have noted improvements including:

- improving the effectiveness of its strategic plans;
- improving how effectively vulnerable people are protected; and
- improving how it identifies vulnerable people at the first point of contact.

There is still work to do in relation to management of serious and violent offenders and missing children. Findings from this additional scrutiny has meant that at the time of publication of this report Wiltshire Police had received notice that they are no longer in the national Engage enhanced monitoring process.

9. SVPP Budget – partner contributions

Partner contributions have reduced this year with one health provider now no longer contributing. Contributions from Probation Service have however been re-established. There has been a challenge to the ICB in relation to the level of their contribution in Wiltshire compared to other partnership areas they cover, which remains under review. Although there remains an underspend in reserve the current level of contributions do not cover the current outgoings. There are also ongoing discussions between the Lead Safeguarding Partners about the equity of contributions, with the local authority continuing to contribute substantially more than the other safeguarding partners.

PARTNER FUNDING 2023-2024	
Salisbury District Hospital NHS Foundation Trust	£13,800
Wiltshire Constabulary	£47,700
ICB BSW	£60,800
Wiltshire Council	£161,500
Probation	£2,000
Total	£295,000

10. Next steps and priorities for 2024-2025

The current strategic priorities will be reviewed in 2025, in readiness for new priorities from 2026. This review will be informed by the health check on the effectiveness of multi-agency safeguarding arrangements that we will undertake with partners in 2024-2025, as well as data and intelligence and learning from case reviews.

The focus of the work of the Independent Scrutineer will include scrutiny of our multi-agency audits planned for 2024-2026; multi-agency auditing has been limited over the last few years.

Current work on a Community Safety Partnership transformation will also impact on and inform current arrangements and will be reflected in the updated safeguarding arrangements due for publication in December 2024.

We will want to ensure ongoing oversight of key emerging themes such as neurodiversity and also ensure that there is a good understanding and scrutiny of the impact of the operational changes being made nationally to the Probation Service and capacity issues within the criminal justice system.

We need to improve how voice and lived experience informs our work in relation to both children and adults safeguarding.

We will respond to the outcome of the CQC inspection of adult social care inspection that will take place in 2024 and 2025 and ensure safeguarding activity relating to adults is at the core of the work of the SVPP.

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Wiltshire Council

Health and Wellbeing Board

28 November 2024

Subject: Healthwatch Annual Report

Executive Summary

Healthwatch Wiltshire is the local independent consumer champion for health and social care. We listen to people's experiences of using health and care services and share these with decision makers and commissioners to influence change. The annual report gives an overview of our recent work including: Improving mental health services for autistic people; improving hospital complaint processes; and working with Eastern European and Boating communities. Headline figures include:

- 4,397 people accessed information advice and guidance
- 3 reports
- 14 recommendations
- 15 volunteers

Proposal(s)

It is recommended that the Board:

i) Note the key messages from the annual report

ii) Confirm its commitment to understanding the voice of local people and ensuring this voice is a key component of future commissioning.

Reason for Proposal

Healthwatch Wiltshire has a statutory duty to promote the voice of local people with regard to health and social care services and has the opportunity to influence commissioners on the Health and Wellbeing Board. This opportunity is provided through Healthwatch Wiltshire's membership of the Board. As such it is important that the Board receive Healthwatch Wiltshire's Annual Report in order to make any comment, recognise the work undertaken to date, and confirm its commitment to listen to the voice of patients, unpaid carers and the wider community through Healthwatch Wiltshire.

Kevin Peltonen-Messenger
CEO
TCF