Wiltshire Council

AGENDA

Meeting: **Health and Wellbeing Board**

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

Date: **Thursday 21 March 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, direct line or email Max.Hirst@wiltshire.gov.uk

Press enquiries to Communications on direct line (01225) 713114/713115.

This agenda and all the documents referred to within it are available on the Council's website at www.wiltshire.gov.uk

---

Voting Membership:

Cllr Richard Clewer (Chairman)	Leader of the Council and Cabinet Member for Climate Change, MCI, Economic Development, Heritage, Arts, Tourism and Health & Wellbeing
Gina Sergeant	Healthcare Clinical Professional Director (NHS BSW ICB)
TBC	GP clinical lead (Wiltshire Integrated Care Alliance)
Cllr Laura Mayes	Deputy Leader and Cabinet Member for Children's Services, Education and Skills
Philip Wilkinson	Police and Crime Commissioner
Alan Mitchell Dr Nick Ware Or Dr Catrinel Wright	Wiltshire Locality Healthcare Professional, NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB)

Non-Voting Membership:

Kate Blackburn	Director - Public Health (DPS)
Dr Edd Rendell	Wessex Local Medical Committee – Medical Director
Dr Andy Purbrick	Wessex Local Medical Committee – Medical Director

Terence Herbert	Chief Executive Wiltshire Council
Stacey Hunter	Chief Executive NHS Salisbury Foundation Trust
Stephen Ladyman	Wiltshire Health and Care - Chair
Shirley-Ann Carvill	Wiltshire Health and Care – Interim Chief Executive
Kevin Mcnamara	Chief Executive or Chairman Great Western Hospital
Clare Thompson	Director of Improvement & Partnerships - GWH
Clare O'Farrell	Interim Director of Commissioning
Catherine Roper	Wiltshire Police Chief Constable
Alison Ryan	RUH Bath NHS Foundation Trust - Chair
Val Scrase	Regional Director B&NES, Devon and Wiltshire Community Services
Lucy Townsend	Corporate Director of People (DCS)
Emma Legg	Director of Adult Social Services
Marc House	Dorset and Wiltshire Fire & Rescue Service - Area Manager Swindon and Wiltshire
Sarah Cardy	VCSE Leadership Alliance Representative
Cllr Gordon King	Opposition Group Representative
Cllr Ian Blair-Pilling	Cabinet Member for Public Health and Public Protection, Leisure, Libraries, Facilities Management and Operational Assets
Cllr Jane Davies	Cabinet Member for Adult Social Care, SEND, Transition and Inclusion
Fiona Slevin-Brown	Place Director – Wiltshire, NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB)
Marc House	Dorset and Wiltshire Fire and Rescue
TBC	Avon and Wiltshire Mental Health Partnership
James Fortune	Oxford Health (CAMHS)
Maggie Arnold	South West Ambulance Service - Non-Executive Director
Stephen Otter	South West Ambulance Service
Laura Nicholas	NHSE, SW Director of Strategic Transformation / Locality Director
Emma Higgins	Associate Director – Wiltshire ICA Programme and Delivery Lead

Recording and Broadcasting Information

Wiltshire Council may record this meeting for live and/or subsequent broadcast. At the start of the meeting, the Chairman will confirm if all or part of the meeting is being recorded. The images and sound recordings may also be used for training purposes within the Council.

By submitting a statement or question for a meeting you are consenting that you may be recorded presenting this and that in any case your name will be made available on the public record. The meeting may also be recorded by the press or members of the public.

Any person or organisation choosing to film, record or broadcast any meeting of the Council, its Cabinet or committees is responsible for any claims or other liability resulting from them so doing and by choosing to film, record or broadcast proceedings they accept that they are required to indemnify the Council, its members and officers in relation to any such claims or liabilities.

Details of the Council's Guidance on the Recording and Webcasting of Meetings is available on request. Our privacy policy can be found here.

Parking

To find car parks by area follow this link. The three Wiltshire Council Hubs where most meetings will be held are as follows:

County Hall, Trowbridge
Bourne Hill, Salisbury
Monkton Park, Chippenham

County Hall and Monkton Park have some limited visitor parking. Please note for meetings at County Hall you will need to log your car's registration details upon your arrival in reception using the tablet provided. If you may be attending a meeting for more than 2 hours, please provide your registration details to the Democratic Services Officer, who will arrange for your stay to be extended.

Public Participation

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.

Our privacy policy is found here.

For assistance on these and other matters please contact the officer named above for details

AGENDA

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

The chairman will welcome attendees to the meeting.

2 **Apologies for Absence**

To receive any apologies for absence

3 **Minutes***(Pages 7 - 12)*

To confirm the minutes of the meeting held on 30 November 2023.

4 **Declarations of Interest**

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

5 **Public Participation**

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 14 March 2024** 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 18 March 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.

6 **NHS BSW Operational Plan Update**

To receive a report updating on the NHS BSW Operational Plan.

7 **Better Care Plan - standing update***(Pages 13 - 32)*

To receive an update on developments relating to the implementation of the

Better Care Plan.

8 **Right Care Right Person Police Baseline Update***(Pages 33 - 50)*

To receive an update on Right Care Right Person.

9 **Community Area JSNA Update***(Pages 51 - 64)*

To receive a presentation updating on the Community Area JSNA.

10 **Workplace Health Update***(Pages 65 - 72)*

To receive an update on Workplace Health.

11 **Urgent Items**

Any items of urgency where the chair allows its discussion.

12 **Date of Next Meeting**

The date of the next meeting is the 23 May 2024.

Wiltshire Council

Health and Wellbeing Board

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 30 NOVEMBER 2023 AT KENNET ROOM - COUNTY HALL, BYTHESEA ROAD, TROWBRIDGE, BA14 8JN.

Present:
Cllr Richard Clewer, Dr Alan Mitchell, Gina Sargeant

Also Present:
Cllr Gordon King, Kate Blackburn, Col Ricky Bhabutta, Marc House, Clare O'Farrell, Helen Henderson, Victoria Bayley, Claire Thompson, David Bowater, Max Hirst

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

The Chairman welcomed everyone to the meeting.

65 **Apologies for Absence**

Apologies for absence were received from:

Cllr Laura Mayes
Dr Nick Ware

66 **Minutes**

The minutes of the previous meeting on 28 September 2023 were presented for consideration. After which, it was:

Resolved

The Wiltshire Health and Wellbeing Board approved and signed the minutes of the previous meeting held on 28 September 2023 as a true and accurate record.

67 **Declarations of Interest**

There were no declarations of interest.

68 **Public Participation**

There was no public participation.

69 **Community Pharmacy**

The Board received an update and presentation on pharmacies in Wiltshire from Victoria Stanley.

During the presentation, the following topics were discussed:

- Challenges for Wiltshire
- The Development of Community Pharmacy
- Workforce

Debate

It was reiterated that development was extremely important to the ICB.

The need to see the situation from a patient perspective was stressed, especially given that Boots are currently the only pharmacy that deliver for free for those stuck at home. It was made clear that ensuring the public can access their medication was vital and plans without proper resourcing fall apart.

Resolved

i) To note the report

70 **Technology Enabled Care Update**

The Board received an update on the Technology Enabled Care service, achievements, and progress to date.

TEC, created in 2022, covers health related technology including wearable sensors, devices in the home and health care apps. There was a strong appetite to innovate and embed a wider range of solutions into care.

The TEC Strategy 2023-2028 was put forward as a clear vision for the future, with priorities and a detailed action plan.

Pilots, including a “robocat” which was demonstrated at the meeting, were highlighted as means to test new technology.

Debate

Communication as to when initiatives begin in areas in Wiltshire was highlighted as important for the public.

It was clarified that the process for recommissioning of alarm monitoring and equipment supply contracts would be completed before the current contract finished in Spring 2024.

Resolved

i) To note the report

71 **Better Care Plan Update**

The Better Care Plan Quarterly Report was required to be brought to the Board and was considered as read by members of the board ahead of the meeting.

Resolved

i) Notes the quarterly report submitted to the national team on 31st October 2023 (Appendix A).

ii) Approves the revised quarterly report for submission to the national team (Appendix C)

72 **Winter Preparedness**

The Board received an update on preparations for winter health pressures.

A presentation included:

- Issues likely to occur over the winter months.
- The approach planned to tackle such pressures.
- The current statistics.

A discharge communications project, called Caring Steps Together, was also presented as a means of improving awareness of life after time in hospital and the support available.

Debate

It was clarified that the need for more mental health staff and higher training relates around a lack of 24hr support, especially given higher levels of delirious patients and other mental health patients.

It was clarified that work was ongoing on how community beds and care home beds can be most appropriately used.

Resolved

i) To note the presentations and reports

73 **Community Care Contract Update**

The Board received an update on the Integrated Care Board (ICB) Community Care Contract.

The ICB would be tendering on behalf of the NHS and the 3 Local Authorities a BSW-Wide Community Services Health contract, to start from 1 April 2025 with a proposed length of 7 plus 2 years.

The ICB Board supported the commencement of the procurement at its meeting on the 21st of September. The future procurement of services was now underway.

Cabinet agreed on the 14th of November 2023 to consider continue funding, at the same level, from the BCF for new contract from April 1st, 2025, until 31st March 2032, with a possible further 2-year extension.

Debate

The importance of understanding stakeholder concerns was stressed and the fact this had been done upfront was commended.

It was clarified that there has been interest from service providers and risks associated with such a huge contract had been considered and mitigated. The service provider would be given instructions as to what to do and they would then be responsible for informing exactly how they would achieve the necessary objectives and standards.

It was understood that the Armed Forces struggle with access to care for their dependants, especially given their significance in Wiltshire. This issue was known to the ICB and being discussed.

Resolved

i) To note the past and ongoing work between the ICB and Wiltshire Council regarding the tender of a BSW-wide Community Health Services contract.

ii) To note the approval at the ICB Board to the agreed procurement approach to, and commencement of the procurement process.

iii) To note the Cabinet decision to the 'in principle' agreement to commit Better Care Funding to the ICB Community Health Contract from 2025 to 2032 (with potential for a further 2 years to 2034). Formal commitment is dependent on a revised and agreed S.75 Agreement (Health and Social Care Act 2012) that covers the period of the contract, along with a signed Collaborative Commissioning agreement. Formal agreement will be sought in early 2024 before the contract is awarded.

74 **Carers Strategy Update**

The Board received an update on the Carers strategy.

It was noted that the Carers Strategy was returning for a second time and although this was the final draft it wasn't necessarily the final iteration.

Debate

The importance of understanding what carers need in terms of support and equipment was stressed given the ever-growing role carers will play in the next 20-30 years and beyond.

Resolved

i) That the Board approves the final draft strategy

75 **Integrated Care Strategy Performance Monitoring Arrangements**

The Board received a report outlining the Integrated Care Strategy Implementation Plan for Wiltshire Performance Monitoring Arrangements.

Having put the Integrated Care Strategy together, this item covers the back end of the overall strategy as to how the strategy performance is monitored.

Debate

The Board had looked and contributed to the metrics of the Strategy, and it was important that flexibility remained, and data was continuously provided through progress reports.

Resolved

i) Notes the proposed template for Wiltshire ICA and associated subgroups to monitor performance and the latest performance information where available (Appendix 1)

ii) Notes that further work will be undertaken through Wiltshire ICA andthe chair of each sub-group to further refine the proposed template, associated measures and targets and latest performance status in time for the next meeting of the Health and Wellbeing Board

iii) Asks Wiltshire ICA to provide progress reports from each sub-group, highlighting things going well, areas further work is required and areas that need particular attention from the Health and Wellbeing Board

76 **Smoke Free Generation**

The Board received a short presentation highlighting actions being taken to address youth smoking and vaping.

Resolved

To note the report

77 **Urgent Items**

There were no urgent items.

78 **Date of Next Meeting**

The next meeting of the Health and Wellbeing Board will be held on 1 February 2024.

(Duration of meeting: 10:00am – 11:55am)

The Officer who has produced these minutes is Max Hirst - Democratic Services Officer of 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

Wiltshire Council

Health and Wellbeing Board

21st March 2024

Subject: BCF Reporting Q3

Executive Summary

I. The BCF Q3 quarterly reporting document was submitted to the national team on 9th February 2024.
2. Authority for sign-off prior to submission was agreed by the HWB Chair on 9th February 2024.
3. This is a formal presentation of the documents to the Board.
4. The Q3 reporting focussed on performance against metrics and spend and activity.
5. Additional requirements were a formal response to the Q2 feedback and the submission of a BCF funded scheme case study.

Proposal(s)

It is recommended that the Board:

i) Notes the quarterly report submitted to the national team on 9th February 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

Wiltshire Council

Health and Wellbeing Board

21st March 2023

Subject: Better Care Fund Quarterly Reporting

Purpose of Report

1. To formally present the BCF nationally required Q3 quarterly 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 our performance against the submitted plans, agreed at Health and Wellbeing Board.

Background

4. The Health and Wellbeing Board signed off the BCF plans for 2023-25 on 20th July 2023.

5. It is a condition of funding that BCF plans and monitoring reports are agreed and signed off by Wiltshire HWB. Previous quarterly reports are as follows:
    - Q2 was submitted to the national team on 31st October 2023 and included a refresh of demand and capacity figures.
    - The was no requirement to submit a Q1 report.

6. The Q3 reporting also required the submission of a case study highlighting the impact of BCF spend. We prepared a case study that highlighted the work and outcomes of the changes to the PW2 bedded rehabilitation provision. This case study is attached at Appendix B.

7. We were also required to make a formal response to feedback received on our original demand and capacity modelling. This response is attached at Appendix C.

Main Considerations

8. We are on track to meet four of the five performance metrics. We have exceeded our target for residential admissions. Changes to Pathway two and increased capacity in pathway one will increase the number of people

returning to independence and will likely reduce the need for residential admissions. We also acknowledge that our target was very conservative and work is underway to understand the reasons behind the admissions which will inform a more realistic baseline for 2024-25 reporting.

Next Steps

11. That the submission is formally noted by the Board.

12. The next submission required for national reporting is a refresh of the 2023-25 planning. Details are yet to be published but it is likely that a submission will be due in May/June 2024.

Helen Mullinger
Commissioning Manager, Better Care Fund
Wiltshire Council

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

Appendix A: BCF quarterly report: Submitted 9th February 2024 (separate document)

Appendix B: BCF required Case Study: PW2 Development

Title: Pathway 2 Case Study

HWB area / location: Wiltshire

Organisation: Wiltshire Council

Date**: 06/02/24**

Scheme type(s): Intermediate care services

Brief description of the case study, including how it is linked to either full or partial Better Care Fund (BCF) funding:

This case study relates to the re-commissioning of Wiltshire Pathway 2 (PW2) bed cohort. This service is fully funded by the Better Care Fund and has had a positive impact upon the discharge outcomes for the residents of Wiltshire.

Author(s): Helen Mullinger, Karl Deeprose
Job title(s) Commissioning Manager, Senior Commissioning Officer
Email address(es): helen.mullinger@wiltshire.gov.uk karl.deeprose@wiltshire.gov.uk

Would the author / organisation be willing to present the information captured in this case study at any BCF event / webinar / virtual visit? Yes

All information captured in this document will be shared on the Better Care Exchange once it has been agreed for publication.

By agreeing to publication you consent to:

- The document being published by BCF and shared publicly through our communications channels
- BCF using the information you have provided both in full or partially
- The publication being shared with BCF partners (NHS, the Department of Health and Social Care, the Department for Levelling Up Housing and Communities) for their own use.

Overview

This case study will set out the rationale, process and final model change for PW2 bed provision in Wiltshire. PW2 beds are a short-term, time-restricted, goal-based service with health and social care assessments and interventions to support people to maximise their potential to live as independently as possible.

PW2 beds are required for people who no longer meet the NHS criteria to reside in hospital, but who are not able to return home without further assessment and rehabilitation in a bedded facility. These beds are not for people who require long term care from hospital, are end-of-life or are likely to be readmitted to hospital. The aim is to enable people to return home.

The existing PW2 model was assessed against customer-based outcomes as well as how well it was supporting system flow. This case study will demonstrate the impact that the change in PW2 model has had on Wiltshire discharges from hospital:

- 65% of customers have returned home, since the change of model.
- there has been an 8% reduction in readmissions to hospital.
- 14% reduction in permanent transfers into care homes.

Aims and objectives

The aim of the service is to reduce length of stay in hospital for people who are NCTR who require further assessment or rehabilitation, increase the opportunities for people to return to living safely and independently at home and to reduce admissions to long term care.

Method and approach

The methodology behind the re-model of Pathway 2 was an evidenced review of the existing model, partnership working and co production.

The review evidenced the following factors:

- Inequitable access to therapy - As the national requirement for discharge moved at pace during the pandemic, D2A and IR beds were sought at various locations across the county. The resulting provision was a piecemeal collection of beds in homes across the county which was not an efficient use of therapy or social care resources, given the travel time between homes and inevitably resulted in an inequitable service for patients.

- Excessive lengths of stay – from June 2022 to September 2022 the average length of stay in a D2A or IR bed was 56 days. Some stays were over 100 days. These lengths of stay indicated that an individual would have been better suited to another placement, for example a long-term bedded care or end-of-life placement. It also reduced discharge capacity across the system.

- The beds were not meeting patient needs - The change in access criteria because of the Hospital Discharge and Community Support Policy and Operating Model[1] created a cohort of patients with higher complexity and clinical need than the existing beds could meet. The analysis of outcomes (see Table 1 and Appendix A) showed excessive lengths of stay, hospital readmissions and end-of-life cases that indicated a level of complexity not usually compatible with intensive, short-term therapy.

- Home closures due to infection outbreaks – whole home closures are a significant risk to patient discharge and flow as it removes beds from the system and requires spot purchases elsewhere. It was evidenced that not all venues were able to provide optimum mitigation against this risk in terms of infection, prevention and control. Whole home closures had a significant impact on the ability to discharge patients from hospital.

- Effective use of support services - The model had become unstainable, with therapists and social care staff having to travel large distances between individual care home beds to deliver therapy and social care support.

A new model of delivering the PW2 beds was proposed which aimed to increase the capacity per bed, make more efficient use of therapy, social care and provider resources and result in increasing independence and a return home for more patients. The need for change from the perspective of the service users can be seen in Table 1:

Table 1: PW2 Discharge Outcomes ('old' model)

PW2 discharge outcomes	**Average % (Oct 20-Mar 22)**	**Notes**
Hospital readmission	17%	This is likely due to a worsening of an existing condition – whatever the reason, PW2 bed are not appropriate for this level of need.
Nursing home	18%	These customers would have been better suited to PW3 rather than a therapy-based bed
Residential home	14%	
Home independently	10%	This is the aim for most people being admitted to a PW2 therapy-based model
Home with Package of Care	16%	

Home First	12%	For those discharged with Home First it is assumed this could have been an option in the first instance. The bed review showed a high proportion of PW2 customers who, on clinical reassessment, were deemed to have been appropriate for Home First rather than a bedded facility.
End-of-life	13%	On many levels, this is not satisfactory, and alternative bedded provision should be found.

Alongside the analysis of the PW2 destination outcomes a stratification of the patients using the pathway was conducted. This was achieved collaboratively between the Better Care Fund, Adult Social Care, the Integrated Care Board and Health colleagues as well as Care Providers. The stratification highlighted that if the correct patients are admitted into a therapy-based bed model then Wiltshire would require between 53 and 61 beds.

Table 2: Stratification Criteria

PW	**Definition**	**Current outcomes (Oct 21-Mar 22) as % of demand**	**Beds required**	**Beds required plus 15% capacity to aid system flow**
2a	Medically stable cognitively and physically able to participate in rehabilitation activities. Current dependency, rehabilitation or cognition mean not yet able to be managed in community	21%	22 PW2 Hub Model	25
2b	As per 2a plus: Higher rehab complexity (but not reaching requirement for NHSE&I Level 1 and 2 rehabilitation)	20%	21 PW2 Hub Model	24
2c	Clinical risk is too high to go home at this stage. relatively low rehab e.g., end of life care	16%	18 Nursing beds	21
2d	As per 2a plus; Both clinical risk and rehab requirements are high (but not reaching requirement for NHSE&I Level 1 and 2 rehabilitation) delirium and complex MH with clinical complexity	10%	10 PW2 Hub Model (Complex)	12
2e	Residing in P2 due to lack of P1 capacity	6%	6 HomeFirst Service	
2f	Residing in P2 due to other reasons (e.g., P3, Specialist capacity, other	11%	12 PW3	14
-	Hospital readmissions from PW2	20%	21 Community Hospital or clinical optimisation	24
Totals of PW2a, 2b and 2d suitable for PW2 'Hub' model			53	61

Better Care Fund Commissioners worked in collaboration with providers, social care, therapy teams, the patient flow hub and brokerage colleagues to create a pilot which ran from 1st September 2022 – 28th November 2022. The pilot had the following aims:

- To understand what needed to be in place to successfully deliver the 28-day LOS ambition.
- To test how to identify those patients that will benefit most from a therapy-based model.
- To 'test' ways of collaborative working.
- To understand how to affect a cultural shift in the provision of therapy to improve independence and increase the number of people returning to their own homes.
- Over the course of the pilot there were positive outcomes around the number of discharges that took place and the length of stay. There were 44 discharges, an average of 14 a month, compared to an average of 7 per month prior to the start of the pilot. These discharges included patients who were admitted into the home prior to the pilot commencing on 1st September 2022.
- Prior to the pilot, admissions to the beds averaged 4 per month. During the pilot this averaged 10 per month.
- The average length of stay for patients admitted during the pilot was 28 days. Some patients did exceed the 28-day target. Of 15 patients to exceed the 28-day length of stay, only 2 was due to the patient requiring further rehabilitation. The other patients were held up by issues such as awaiting a package of care, home adaptations, or onward placements.
- The model proved to have improved outcomes for patients on discharge (table 3).

Table 3: Pilot Outcomes

Outcome	'Old' D2A/IR beds	New Model
Returned home (independently or with a package of care)	31%	56%
Returned to an acute setting	17%	20%
Discharged to either a nursing or residential home	35%	21%
Passed away	14%	7%

Healthwatch Wiltshire were included as partners at the start of the pilot and were able to evidence feedback from service users and staff. Service users were very complimentary of the service they received, that they were aware of their rehabilitation goals, and most were very motivated and intent on recovering as soon as possible to get home. All appreciated the amount of rehabilitation they were receiving.

Staff were clear that being able to work closely across teams (social care, therapy, and care home) had a positive impact on care. More staff have input to the goal setting, providing a more holistic picture of the patient. This was cited as an improvement on the usual way or working. Being on site gave professionals the ability to see patients both frequently and easily so questions and issues could be addressed face to face rather than through time-consuming emails. Several care home staff commented on how the different way of working resulted in a quicker turnover of patients. While this could be a challenge in terms of familiarising themselves with patients and

the additional paperwork, they cited they appreciated working with patients who were able to make a recovery and be discharged home. This was very satisfying for staff.

As a result of the positive outcomes the decision was made to implement the pilot processes into new block bed contracts for 60 beds, across two sites.

Successes, measurable impact and quantifiable benefits

The positive outcomes from service users have continued through into the main contract, which started on the 1st of April 2023.

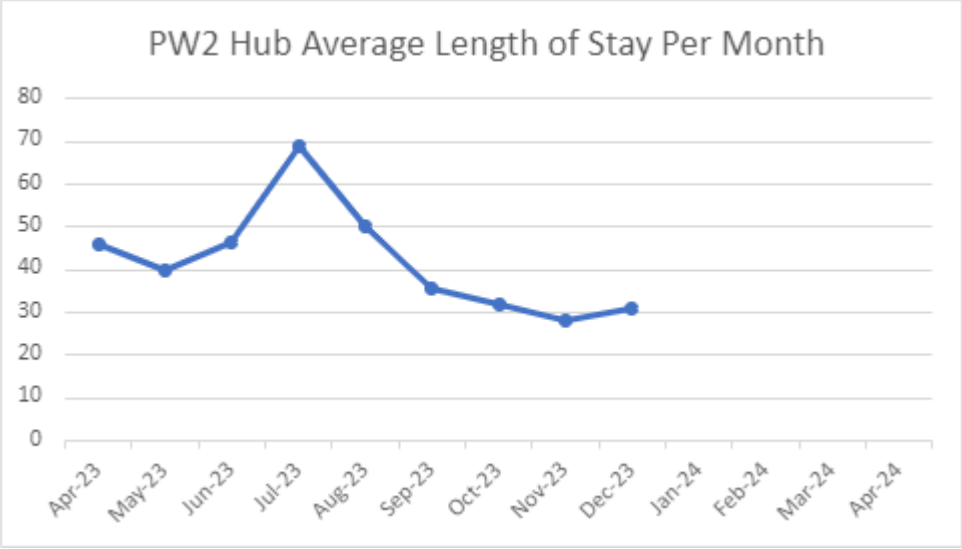
Table 4: Admissions/Discharges

Outcome	'Old' D2A/IR beds	Contract – Apr 23 onwards	Percentage Increase since 'old' PW2 model
Average monthly admissions into contracted PW2 Beds	4	22	450%
Average monthly discharges into contracted PW2 Beds	7	23	228%

- Table 4 demonstrates the positive impact that the change of model has had upon both admissions and discharges. This can be seen through in increased number of admissions into the home and discharges after receiving therapy.

- The length of stay (diagram 1) has also been positively impacted by the change in model. From September 2023 onwards the average stay has been 28 days.

Diagram 1: Average LOS per Month



- The outcomes of the individuals using the new therapy model have also improved (table 5). A higher proportion of individuals using the service are returning home. There is still a percentage of service users who are being discharged into either nursing or residential setting and this is being investigated further to ensure the correct individuals are being admitted into the therapy beds.

Table 5: New Model Outcomes

Outcome	Existing	Model Pilot	Therapy Model

	D2A/IR beds		Apr 23 - onwards
Returned home (independently or with a package of care)	31%	56%	60.5%
Returned to an acute setting	17%	20%	12.5%
Discharged to either a nursing or residential home	35%	21%	23%
Passed away	14%	7%	3%

- The average vacancy rate for the beds, which sits at 1.35 bed per month, shows that the beds being used for the therapy model are consistently occupied.

To conclude, the evidence shown above demonstrates that the change of PW2 discharge model to one based around therapy has had a positive impact on outcomes for the individuals using the service whilst also greatly increasing the number of individuals that can access the PW2 therapy model. The new therapy model has meant an improvement in patient outcomes at a lower cost than previously.

Challenges

The main challenge is managing the assessment process for access to the service to ensure that the correct cohort of individuals, who meet the therapy guidelines, are admitted into the bed base.

Links can also be draw between correct admissions and the increased length of stay in the PW2 beds. It can be suggested that if individuals being admitted are unable to engage with therapy teams it will have a direct impact of the length of stay as they are unable to be discharged within the 28 days target. However, it must be acknowledged that we are aware that not all those admitted into the beds will be discharged within 28 days. If an individual requires an extended period of therapy to ensure they have a positive discharge outcome and a return home this is the main aim of the beds.

Key learning points

The main learning points to take away from this case study are based around ensuring that all parties involved in the model and the subsequent pilot are aware of and adhere to the admission criteria. We found that there was confusion around who was eligible for admission and who was not. Upon reflection, if a change of model were undertaken more engagement events would be arranged to ensure that all parties involved fully understand the eligibility criteria.

Next steps

The next steps of the PW2 Therapy beds will be to investigate the increased length of stay and conduct a deep dive to look at the individuals using the service to ensure they are meeting the specified criteria for the therapy beds.

Appendix C: Formal response to Q2 Feedback (separate document

Department of Health & Social Care

Department for Levelling Up, Housing & Communities

Local Government Association

NHS England

Wiltshire HWB
Q2 Report Feedback
Responses

Integration and Better Care Fund

Feedback-Wiltshire 1/2

Area	Metric
Metrics	**Avoidable Admissions–slightly over Q1 but on track.** Emma Matthews, Virtual Wards Lead, NHSE: note focus on step down in the model. How does this link with Wiltshire health and care frailty model and how could pathways be maximised to support frailty and respiratory virtual wards in the alternatives to admission space are you linking with Gemma Pugh in WHC? The NHS@Home service has patients referred approximately 50/50 step up/down. Patients are mostly frailty and respiratory related conditions. UCR and NHS@H are an integrated service and therefore patients who are unwell and need hospital level care are referred to one another to avoid admission to hospital wherever possible. Julia Cutforth, Urgent Community Response Lead, NHSE: note UCR referral expected capacity decreased from 900 to 596/month – CSDS notes last 5/12 of data – average referral rate of 818 and continue not to meet their target to reach >70% within 2 hours – average target for last 5/12 is 55.6%. How will Wiltshire meet the 70% target when not achieved previously on a demand between 400-600? Is their demand data accurate as reality would appear much higher and not being met already? Eg: Nov 23 = 596 but CSDS for Sept 23 = 795 – Wiltshire not consistently able to meet this demand The UCR service has been performing at 71-74% since September 2023 with average referral numbers of 807/month. A data quality issue was identified and work completed to review records and rectify the performance reporting.

Feedback-Wiltshire 1/2

Area	Metric
Metrics	***Falls-good performance against target on Q1 and on track.*** *Emma Matthews, Virtual Wards Lead, NHSE: we can see you are linking with falls programme across ICB and Wiltshire. How does this care homes work link with urgent community response and virtual wards if people are acutely unwell. How is this linking to alternatives to admission pathways and are there areas you could support?* *Julia Cutforth, Urgent Community Response Lead, NHSE: falls programme underway – purchase of equipment and training in care homes: is there a sustainable programme of training? What has been impact? Have you evaluated their care homes with maximum conveyance rates?* The WH&C Urgent Care Response service has undertaken a programme of work that has delivered targeted staff training alongside revised Falls policies and operating procedures. The training on handling falls included Band 3 staff which, when supported with clear escalation routes has increased the capacity of the service to respond to falls. The result has been an improvement in the performance in terms of falls response times and capacity to manage non-injurious falls within a community setting. Averaging 30 UCR falls responses per month prior to training (Jan-Nov 2023) being fully embedded and averaging 45 in the last two months – this also reflects a busier period over winter as well so is not likely solely attributed to training. Prior to training averaging 77% of UCR Falls responses meeting 2-hour response target, in last 2 months have met target for 89% of responses. ICB funded additional Raizer chairs and alongside existing Mangar Camels and the additional training has led to an increased capacity to manage non injurious falls in the community and has reduced admissions to hospital. 377 UCR falls responses in 2023, 46 admitted to hospital, 313 kept in the community, 14 referrals where response was closed prior to outcome (e.g. patient declined care, another service arrived before us, service not appropriate) . This is an alternative to admission, which the outcome figures demonstrate. Any ‘long-lie’ patients are automatically referred to the NHS@Home/Virtual Ward service for review and whether further support or monitoring is required. The person will also stay on the UCR caseload and will receive therapy support if needed. This process continues to be reviewed and working with system partners to capture most effective way of keeping people in the community with additional monitoring. The team are also beginning to focus on falls prevention work within the county. At present people are referred via GP’s and offered therapy support on an ad hoc basis but the team are working on falls prevention with a targeted cohort of high-risk residents as part of the Melksham and Bradford-on-Avon neighbourhood Collaborative work. It is recognised that the rural nature of the county where we have a high percentage of elderly and frail residents (I’ll get exact figures from the JSNA) is likely the reason why we have a high fall rate in comparison to the rest of the Southwest. The focus on falls prevention is in recognition of this. Regarding the Care Home training outcomes an evaluation is pending and will be shared in the year-end reporting.

Feedback-Wiltshire 1/2

Area	Metric
Metrics	**Discharge to Usual Place of Residence–on track but concern about increased acuity challenging rehabilitation and reablement services.**Emma Matthews, Virtual Wards Lead, NHSE: you note home 1st now BAU. What about people who do not meet criteria to reside but could be supported to be discharged sooner via a virtual ward have you consider pathways to reduce LoS in those cohorts (Resp and frailty pathways) The NHS@Home service has patients referred approximately 50/50 step up/down. Patients are mostly frailty and respiratory related conditions. UCR and NHS@H are an integrated service and therefore patients who are unwell and need hospital level care are referred to one another to avoid admission to hospital wherever possible. **Reablement –no formal data but informal data showing performance 10% above target (which is comparatively low)** Latest performance for Q3 shows us performing 2% below the regional average at 79% (regional average 22-23 was 81%). We have increased capacity within PW1 (see Q2 refreshed submission) and we will be monitoring performance across the supporting services. **Residential Admissions-no data – Wiltshire have set a comparatively low annual target.** As at Q3 we had exceeded the target (total of 499 admissions against a target of 370). We will revise the target for the 24-25 planning round.

Feedback-Wiltshire 2/2

Area	Metric
Capacity and Demand Plan	**Overall** • Noted revised plan signed off by HWB 30/11/2023. Q2 return re-submitted. ICB recently indicated in a return to NHSE that there were concerns around gaps in provision in Pathway 1 hospital discharge. Work underway to address and additional system funding in place enabling brokerage of additional domicillary care to support peaks in demand. • Demand assessments will be checked as part of demand and capacity planning for 2024/25. • All 5 questions answered in template. • Note challenges in social care and mental health services to meet complex needs **Hospital Discharge** • *Emma Matthews, Virtual Wards Lead, NHSE: how are your pathway 0 services supporting virtual wards in respiratory and frailty? Are you maximising opportunities for people to be discharged sooner with wrap around low level services to meet personalised need?* We fund a 'Home from Hospital' service from BCF funds. This supports around 150 people per month and referrals come from a range of services. The virtual wards are still not at full capacity – this is something that has increased over the past year as recruitment is successful. We would expect to see referrals from virtual wards to increase accordingly. Many people who are cared for through virtual wards also require some level of personal or domiciliary care. As a result, they are often known to our brokerage and/or ASC teams and can be referred to HfH service for support in signposting to other support resources, such as meal delivery services, befriending schemes etc. **Community** • Additional P0 support for the community reported in refresh. • Julia Cutforth, Urgent Community Response Lead, NHSE: note UCR referral expected capacity decreased from 900 to 596/month – CSDS notes last 5/12 of data – average referral rate of 818 and continue not to meet their target to reach >70% within 2 hours – average target for last 5/12 is 55.6%. How will Wiltshire meet the 70% target when not achieved previously on a demand between 400-600? Is their demand data accurate as reality would appear much higher and not being met already? Eg: Nov 23 = 596 but CSDS for Sept 23 = 795 – Wiltshire not consistently able to meet this demandSee slide 2 for response
Other-Advisories from BCF Planning	I would be grateful if you could respond to the outstanding advisories from 23-25 BCF planning, outlined in the table below. If you would like to access any support for Intermediate Care Capacity and Demand planning, we would be happy to pick this up in the new year. **PR** / **KLOE (shorthand)** / **Issue to resolve** **4&6** / **C&D** / **Disconnect between narrative and template needs to be reviewed and resolved. NB REVISED TEMPLATE** **4&6** / **C&D** / **DHSC comments to follow up. Is BCF Support offer**

This page is intentionally left blank

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Wiltshire

National data may be unavailable at the time of reporting. As such, please use data that may only

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and

Achievements Please describe any achievements, impact observed or lessons learnt wh

Metric	Definition	For informa Q1
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	134.6
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	91.7%
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	

/ be available system-wide and other local intelligence.

please highlight any support that may facilitate or ease the achievements of metric plans

ıen considering improvements being pursued for the respective metrics

ation - Your planned performance as reported in 2023-24 planning			For information - actual performance for Q1	For information - actual performance for Q2
Q2	Q3	Q4		
131.6	157.4	140.3	137.7	139.7
92.2%	92.1%	92.1%	90.5%	91.8%
		2,227.0	406.4	455.3
		317	2022-23 ASCOF outcome: 531.7	
		75.2%	2022-23 ASCOF outcome: 77.9%	

Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs in Q3
Not on track to meet target	None
On track to meet target	None
On track to meet target	None
Not on track to meet target	Target set was very low comparatively. Our monitoring shows we have already exceeded the target. We are investigating the reasons for the increase in PW3 which will inform a more accurate baseline for 2024-25.
On track to meet target	None

Q3 Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
Analysis shows that the most common conditions for hospitalisation are COPD, Atrial Fibrillation and Heart failure. We have started some work to understand prevention methods across social care, public health and	Yes
Increased capacity in the HomeFirst services enables us to support an increasing number of patients on this pathway.	Yes
Targeted training in the UCR service has improved both the response times to Falls and has enabled more falls to be managed wihtin the community. Conveyances to hospital following falls is 46 in 2023 to date.	Yes
The introduction of the PW2 Hub model beds that provide co-ordinated rehabilitation is ensuring more people are able to return to independent living in their own homes. An increase in capacity in our HomeFirst	Yes
Reablement and HomeFirst services continue to deliver coordinated support to ensure people discharged from hospital get the support they need to live independently at home.	Yes

Wiltshire Council

Health and Wellbeing Board

21 March 2024

Subject: Right Care Right Person

Executive Summary

At the September meeting of the Board an update was provided on the Right Care Right Person approach being implemented by the Police across the country, including in Wiltshire, and the implications for local public services and residents.

Right Care Right Person is about reducing inappropriate police involvement in mental health crises and its six Core Principles are:

- Members of the public have the right to receive the "Right Care from the Right Agency".
- The police should concentrate on Core Policing Duties.
- Understanding the Police's Legal Duty to attend.
- Listening to Feedback from staff.
- Partnership working.
- Ensuring staff feel properly trained and supported to make the right decisions.

In the discussion that followed, the Board stressed that it wanted to see evidence of improvement in care through a reduced police response replaced with mental health referrals and considered the potential for other partners such as the fire service to be more involved with appropriate training and funding. An offer of further updates on the subject was also made.

Proposal(s)

It is recommended that the Board notes the update provided at Appendix 1.

Reason for Proposal

A phased approach to implementation is underway and continued engagement with partners is critical to the success of delivery.

David Minty QPM
T/Ch/Supt Crime and Communications Centre
Wiltshire Police

This page is intentionally left blank

Right Care Right Person

Briefing paper 26th February 2024

Introduction.

The aim of this paper is to bring together the current RCRP position within Wiltshire, it aims to bring some clarity to the governance structure, the use of data and in particular what the baseline data will contain. It will also highlight the current timeline of events for the successful implementation of RCRP in Wiltshire.

Background

Earlier this year the national partnership agreement was signed by the Home Office, Health, and Police and is aimed at supporting the implementation of RCRP nationwide.

Police Force areas are at different stages within the RCRP Process and are taking slightly different approaches.

The college of Policing and the National Police Chiefs Council are overseeing the delivery of RCRP. A national working group has been created, and several supporting documents have been produced, these include: the legal overview and basis for RCRP; advice on what data to create a baseline and evaluate the scheme, policy considerations; and guidance for the senior responsible officer.

Practical operational support is also being given through the production of training materials and toolkits to support the role out of RCRP.

Wiltshire Approach

Initially, at the national level, 4 phases of implementation were identified: 1) responding to 'Concern for Welfare' calls; 2) Dealing with those that walk out of healthcare facilities and are absent without leave from mental health establishments; 3) The transportation of patients; 4) Section 136 of the Mental Health Act and voluntary Mental health patients. This has subsequently been reduced to 3 phases, with the original phases 3 and 4 being amalgamated as Medical incidents.

In Wiltshire, following discussion at both the strategic group and the task and finish group, it has been decided to combine phases 1 and 2, and therefore there will be just 2 implementation phases in Wiltshire.

It is the current intention that Phases 1 and 2, 'Concern for Welfare' calls, and those leaving healthcare facilities will go live on the 8th April. There is no specific date given for the final stage but an indicative timescale of July 2024 is felt to be achievable.

Meeting and Oversight structure

It is important that a structured partnership approach is in place to deliver RCRP in Wiltshire and that the governance structures are appropriate to support it's delivery. There are three levels of governance overseeing the implementation of RCRP:

The task and finish group is responsible for bringing together practitioners from all appropriate statutory and non-statutory partners, to deliver the operational effects of RCRP. This group now meet weekly, their main focus is that each agency has the right policies and procedures in place to support the delivery of RCRP and in particular that the Memorandum of Understanding that it is hoped that each agency will sign is appropriate, practical and supports the delivery of RCRP.

The Strategic group chaired by T/C/Supt Minty, is a further partnership group with representation across the statutory and non-statutory partners including commissioned support networks. This group oversees the work undertaken at the operational level by the task and finish group and ensures that the operational work is in line with the strategic vision for RCRP. It highlights potential strategic issues with a view to removing any barriers to the successful, partnership, delivery of RCRP.

Finally, the Executive group, chaired by DCC Dibdin, is again a partnership group with overall responsibility for the delivery of RCRP.

Memorandum Of Understanding

Wiltshire has a very strong partnership approach that means that we are in a very good position to deliver RCRP. In line with this all partners will be asked to inform and sign a memorandum of understanding. This will not be a legally binding document with significant consequence but will allow different organisations to understand what is expected of them and what they can expect from other agencies. The MOU will be critical as part of the escalation process.

The draft MOU is attached, and it is currently with the Task and Finish Group to ensure it will work at the operational level. Importantly they will also look to include complex examples of potential scenarios to ensure that practitioners are given the best support possible.

The signing of an MOU is not mandatory, it is believed that some areas of the country have not written an MOU. Although it is recognised as best practice and what the Wiltshire partnership both want and need to do, signing of the MOU cannot hold up the overall implementation of RCRP.

There will be separate MOUs for each implementation phase within Wiltshire. A copy of the MoU is appended.

RCRP Process within the Police Control room in relation to a 'Concern for Welfare Call'

To instigate the process a 'Concern for Welfare' call will be received within the Police Control room. This will either be from a partner agency or a member of the public.

The Call Taker will create a log to record the details of the concern for safety.

All Call takers will be trained in the use of a specific RCRP decision making toolkit to support them in their decision making. This is a nationally developed decision-making tool that has been made available to the call takers in Wiltshire and ensures that any obligations under Article 2 and 3 of ECHR are met.

Based on the outcome of the decision-making process the call taker will decide whether to deploy a police resource or not.

If the decision is not to deploy a resource, this will be recorded on the log and the caller will be advised to call back if further information comes to light that changes the level of threat and risk, and if appropriate they will be suitably sign posted to partner agency or commissioned service.

If the police call taker is still not clear as to whether they should deploy a police unit or not, they will firstly make any further enquiries that are immediately available to them before escalating the decision making through their line management and ultimately to the Force Incident Manager.

In all cases of RCRP calls for service, a log will be raised with an RCRP incident type and as per usual protocol THRIVE applied. THRIVE is a nationally established way of assessing Threat Harm and Risk.

Call takers will endorse the log to confirm the toolkit was used in making the decision.

Children

One significant area where an Executive decision is required is on whether the principles of RCRP relate to children. It is understood that the Department for Education has recently called for a pause in the implementation of RCRP. The national RCRP tactical board reviewed the request and have indicated that this is a decision for local areas. This approach is supported by the College of Policing.

If RCRP is to include children, there are already increased safeguarding measures built into the decision-making process. All RCRP calls for service will have Article 2 and 3 (ECHR) thresholds applied, when these are not met the next question asked will be “Does the incident involve children?” if this is a yes, a further threshold is applied as to whether the child is at risk of “significant harm”. Section 31(9) of the Children Act 1989 defines significant harm as “The ill-treatment or the impairment of health or development including, for example, impairment suffered from seeing or hearing the ill treatment of another”. It is only following this assessment that a decision under RCRP will be made.

It is recognised that even with increased thresholds for decision making the decision on whether to include children within RCRP is for the Executive Board to make.

Escalation Process

In the event of a disagreement between agencies in relation to any RCRP decision making there will be two methods of escalation.

The first will be an immediate escalation to the Force Incident Manager within Policing and the Duty Officer of the relevant partner agency.

The second method will be through the task and finish group. This group will meet daily following the implementation of RCRP and will remain in place for as long as is necessary.

The group will discuss any disagreements or any concerns that have been raised with a view to understanding any themes and addressing the root causes of any disagreements.

Any significant themes or issues can be raised to the Strategic board and subsequently the Executive as required.

Case Monitoring

To ensure that RCRP is achieving its stated outcomes and that any threat, harm, or risk to the community is not increased, there must be a mechanism for monitoring all those cases that are subject to the RCRP process.

To achieve this, the Wiltshire Police, STORM command and control system has been amended to create tags specifically for RCRP. This will allow detailed analysis of the work to take place. Ensuring that decisions can be reviewed over time.

The use of the STORM system gives an accurate, time and date stamped, record of every decision.

Floor Walking provision

To support the decision-making process and to ensure that the case monitoring processes are working appropriately, subject matter experts will be on duty within the control room for the key hours, every day, from the go live date until such point that they are no longer necessary. Their specific role will be to support call takers, identify any process gaps, and to feed directly into the task and finish group.

Data

To fully evaluate the implementation of RCRP, the accurate collation of data will be key. Wiltshire Police have significantly adapted the STORM system to ensure that appropriate tags are in place so that a retrospective data analysis can take place.
The aim is to identify sets of data that can be used as a benchmarking. This will include:

- RCRP Concern for Welfare
- RCRP Concern for Welfare (Child)
- RCRP Concern for Welfare (Partner Agency)
- RCRP AWOL

- RCRP Walk out of Healthcare
- RCRP S135
- RCRP S136
- RCRP Medical incident

This data is currently not available due to the RCRP tagging. Operators will need to specifically identify RCRP cases through the decision making tool outlined above. This will not happen until full training has been rolled out and the Force are confident that all staff are competent in its use.

Current data on 'Concern for Welfare Calls' is attached to this document in Appendix B. This data covers all the Concern for Welfare data above, but cannot be easily broken down into the relevant, specific, RCRP sections.

Policy Revision

RCRP is a new process for Wiltshire Police and will need to be supported by the amendment of policies that directly impact on how we respond to calls for service. This policy amendment is happening with two new policies being reviewed. These are a 'Concern for Welfare' policy and a 'Walking out of Healthcare' policy. With both being directly relevant to the first implementation phase in Wiltshire.

Equality Impact Assessment

A full Equality Impact Assessment has been undertaken and can be shared appropriately on request.

Timeline of Activity Undertaken

This timeline shows the work undertaken so far, and the workstreams still to be completed:

Sept 2023

- Legal advice reviewed

Oct 2023

- New mental health qualifiers established
- Initial face to face RCRP input with CCC staff
- Initial tactical board – Supt Minty

Nov 2023

- April 8th agreed as live date with partners

Dec 2023

- Draft policies and Equality Impact Assessment
- EIA with Equality and Diversity department
- Task and finish group established – Insp Tippetts

Jan 2024

- Policies sent for internal consultation
- Decision making toolkit in development
- Comms strategy established – Clare Woods

Feb 2024

- Inputs to County/Swindon/PPD DLTs
- Decision making toolkit complete and fit for purpose
- College learn package to made available for all front line staff
- Commence Face to face training for CCC staff – Insp Tippetts
- 1st draft MOU circulated to T and F group
- T and F group meeting increased to weekly

March 2024

- Policies to be signed off
- MOU to be agreed
- Press release confirming start date

April 2024

- Go live 8th April
- Floor walkers in CCC review at 2 weeks
- T and F group to meet daily review at 2 weeks

May 2024

- Draft policy for medical incidents
- Draft MOU for medical incidents
- Develop Webley handover

July 2024

- Comms for front line staff/CCC
- Go live RCRP medical incidents

Conclusion

The aim of this briefing paper was to give an overview of the current position for the delivery of RCRP. There are several ongoing work streams that should demonstrate how RCRP will work, the governance of the project, the process and data capture, along with how any issues will be dealt with. Further updates will be provided as the project continues to develop.

Monthly 'Concern for Safety Logs'

	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Total Logs	693	770	701	707	763	762	688	767	705	653	646	668
Logs Attended	500	533	468	476	564	500	489	570	499	427	432	456

January 2024 broken down.

Total Logs =	668		
Attended =	456	Per day =	15
Immediate response=	97		
Priority Response=	269		
Scheduled Response=	64		
No Deployment (Actual Attendance)	25		
Priority ASB	1		
(Total not including immediate)			
Total =	359	Per Day =	11.5

Immediate Response : An incident that is taking place and in which there is , or is likely to be a risk of:
* Danger to Life
* Use, or immediate threat of violence
* Serious Injury
*Serious Damage.

Police will still attend these

Priority Response : An incident that does not merit an immediate response, but where a resource deployment should be made on a priority basis, either because of:
* the potential impact on the individual or the community.
* the likelihood of reoccurrence or escalation.
* the serial nature of the offence.
* the vulnerability of the victim.

Police still likely to attend a significant number of these logs

Scheduled Response : Where a caller is assessed as a vulnerable victim, because of ASB or a concern for safety, and an immediate or priority attendance is not essential, but a response is required due to the vulnerability of the caller (in line with the Three Strands of Vulnerability).

Police unlikely to attend

January Location Data

The below numbers related to the logs attended that were not an immediate response

Location	Jan- Total	No. Per Day
Swindon	131	4
Trowbridge Hub	92	3
Salisbury Hub	74	2
Chippenham Hub	36	1
Devizes Hub	26	1

Appendix

Memorandum of Understanding

Right Care Right Person

Contents

1. Introduction

This Memorandum of Understanding (MOU) has been developed to implement the Right Care Right Person (RCRP) initiative within the Wiltshire Police force area which includes both unitary authorities, Wiltshire County Council and Swindon Borough Council.
As an MOU it is not a legally binding document, but it formalises expectations around calls for service relating to RCRP, how Wiltshire Police will respond and in the event of any disagreement a clear escalation process.

2. Background

RCRP was initiated by Humberside Police in 2019 and was designed to ensure that when there are concerns for a person's welfare linked to mental health, medical or social care issues, the right person with the right skills, training and experience will respond. The aim is that when someone needs assistance from a professional practitioner, they get the right help from the right person.
Following a reduction in demand which allowed Humberside to focus more on core Policing responsibilities this was recognised by the College of Policing (CoP) as best practice. A national partnership agreement was made in 2023 by Government ministers, partnership leads and the CoP. As a result, RCRP is being implemented across all 43 force areas with national guidance available from the CoP.
RCRP sets out a set of principles which is underpinned by legal advice
The phases of RCRP are;

1. Concern for Welfare
2. AWOL from mental health facilities and persons leaving health establishments unexpectedly
3. Medical incidents

3. Scope

Not all aspects of this MOU will apply to all partner agencies however the ethos of RCRP is constant across all phases. The intention is for a more consistent decision-making process that will support locally agreed partnership arrangements between health, social care and Wiltshire Police.

4. Principles

Where a call for service has been received by Wiltshire Police and there is no policing purpose, legal power, or duty to attend. Police control room staff will undertake an assessment as to who is the appropriate agency and provide the appropriate advice to the caller. This may include signposting to another agency e.g advising to call for an ambulance or it maybe the caller taker offer to do so on behalf of the caller dependant on the circumstances. The aim will be to get it right first time

The threshold for Police intervention will be;

- There is an **immediate risk** to life or serious harm to an identified person.
- Immediate harm – it is obvious to the police that there is a risk to life presently, at this moment or in the immediate future, or has already occurred.
- Serious harm – there is a risk of significant harm to the person concerned, this can be physical harm, serious neglect issues, significant mental health symptoms; all of which would amount to the suffering of potential significant injuries or psychological harm

It should be noted that distinctions will be made between calls received from partners agencies with statutory obligations and those from members of the public as they may not be in a position to carry out a welfare check themselves for example.

There will also be a distinction made between calls relating to adults and those relating to children in order to take into account the additional safeguarding responsibilities for vulnerable children

All calls for service which are deemed as RCRP will be assessed using a tool kit and receive one of the following decisions in response;

- **Yes** police will attend
- **No** police will not attend at this time should further information be made available this position could change
- **Maybe** police will attend subject to further background checks or consultation with a supervisor.

A yes may mean Police attending in support of another agency in order to execute their given obligations in regard to prevention and detection of crime, keep the king's peace and common law police powers. Other factors may take priority over this e.g. the need for medical intervention, mental health act assessment and therefore not assuming duty of care.

All RCRP calls for service will be logged, and a clear rationale recorded by the call taker which will also be communicated to the caller with the following thresholds being applied.

- Is there a real and immediate risk to life or serious harm to an identified person/persons?
- Is it a medical emergency?
- Is a child at risk of significant harm?

- Is the person suspected to have a mental health problem?
- Has a crime been committed?
- Is this a missing person report?

5. Concern for Welfare

The following are all terms used to describe a request to ensure the safety and wellbeing of an individual.

- Safe and well check
- Welfare check
- Concern for safety

For Wiltshire Police to undertake such a check there must be a real and immediate risk to life or serious harm to an identified person or persons. Should the incident be a medical matter which would include a mental health crisis it may be more appropriate for an ambulance crew to attend as the lead agency. In this case police control room staff will contact SWAST control room and pass all relevant information. Although police have S136 powers it may not always be appropriate for Police to attend particularly if the patient is in a dwelling. Should there be a clear identified threat or risk to the attending ambulance crew or other persons at the address once the incident has been attended and assessed police will also attend until this risk is mitigated. Any requirement to force entry for medical taskings should initially be tasked via Fire and Rescue as per existing protocols.

It is anticipated that before any welfare check is made initial inquiries will have been made by the caller such as;

- Phone call to subject
- Physical visit to address of subject
- Check for signs of life
- Inquiries with neighbours
- Checks with known family members or associates
- Is the concern sufficient for Police S17 PACE powers to be used, entry to save life and limb.

NB this list is not exhaustive.

6. AWOL from Mental Health facilities/Walk out of Health Care Establishments

AWOL from Mental Health Facilities

Patients who are detained under the Mental Health Act who are permitted S2 leave and are late returning are deemed as being AWOL. In the first instance this should not mean that they are reported to the Police as missing or a welfare concern. This is in line with the current Joint Protocol for the Management of Missing Persons and Absent without Leave. Wiltshire Police will only attend if there is a real and immediate risk to life or harm to an identified person or persons.

Prior to any response the following initial inquiries should be conducted;

- Phone call to subject
- Search of immediate area
- Check of home address
- Check of address subject was visiting or known to visit
- Checks with known family members or associates
- Compliance to medication regime

NB this list is not exhaustive

Patients who are detained and have absconded without permitted leave do not fall within the parameters of RCRP or this MOU.

Walk out of Healthcare Establishments

Patients who leave hospital unexpectedly can sometimes present a risk to themselves or others but should not routinely be reported as a missing person. When assessing the potential risks, it can be useful to consider the circumstances under which the patient left the hospital:

- Left without being seen – The patient left before assessment by a decision-making clinician.
- Left before treatment – The patient was assessed by a decision-making clinician but left before treatment was administered.
- Absconded – The patient left hospital without the knowledge of clinical staff, and there is a risk of harm to the patient or others.

When a patient leaves the hospital unexpectedly, the hospital has a duty of care for that patient. The hospital is therefore responsible for conducting reasonable enquiries to establish the whereabouts of the patient to try and persuade them to return to hospital for treatment, if necessary.

Police should only be contacted

- There exists a real and substantial risk to the patient if they are not brought back to the hospital for medical assessment and/or treatment **and**
- The risk is such that action needs to be taken with urgency **and**
- Efforts to contact the patient by telephone have failed **and**
- Reasonable inquiries to ascertain the patient's whereabouts are being carried out, including:
    - Contacting next of kin

- Searching the immediate area
- Checking CCTV to confirm the patient has left the immediate area and, if so, their direction of travel
- Checking the persons home address
- If the person has capacity and does not want to return, there is no power under MCA 2005 to return the patient.

It is not always in the best interests of the patient for uniformed police officers to attend their home to try and persuade them to return to hospital for medical treatment or a mental health assessment. Police have no power to enter or return a patient with capacity to a medical premise. Powers under the Mental Capacity Act are applied when the patient requires lifesaving treatment, and any intervention should be in the least restrictive way this is an any person power. A person's liberty can only be deprived in urgent circumstances to provide life sustaining intervention or to prevent a serious deterioration in their condition.
Ambulance staff and mental health professionals have the appropriate skills, training, and experience to treat and advise the patient. The police only need to be involved at the home address if they are requested to support other health professionals due to presenting risks.

7. Escalation

Public services have competing and different demands upon them, which can lead to operational delays. However, each Agency will make every attempt to manage their own responsibilities appropriately to ensure that personnel and resources can be made available to respond to new calls from the public.

Where any Agency is unable to respond in a timely manner then an agreed escalation process will be followed to ensure effective contact at management level to resolve the matter expeditiously. To reflect the urgent nature of this issue, the escalation process must be executed in accordance with the specific operational demand - this must take precedence over any formal escalation process.

This will be achieved, in the first instance, by contact being made between the relevant parties Duty Officers.

This page is intentionally left blank

Wiltshire Community Area Joint Strategic Needs Assessment (CAJSNA) 2024

www.wiltshireintelligence.org.uk/cajsna/

Public Health Intelligence Team, Wiltshire Council

Main points of this presentation:

- Introduction to the Community Area Joint Strategic Needs Assessment (CAJSNA) 2024
- Producing the CAJSNA
- 10 themes
- 140+ indicators
- Census dashboard
- Infographics
- Next steps

Health and Wellbeing Board, March 2024

What is the Community Area Joint Strategic Needs Assessment?

Brings together information from a range of sources to provide useful insight and actionable intelligence about our 18 Community Areas.

Provides information on local demographics, needs and strengths.

Aims to support local decision-making at Community Area level.

Not been rewritten since COVID-19 pandemic.

Last one published in 2020.

Producing the Community Area Joint Strategic Needs Assessment

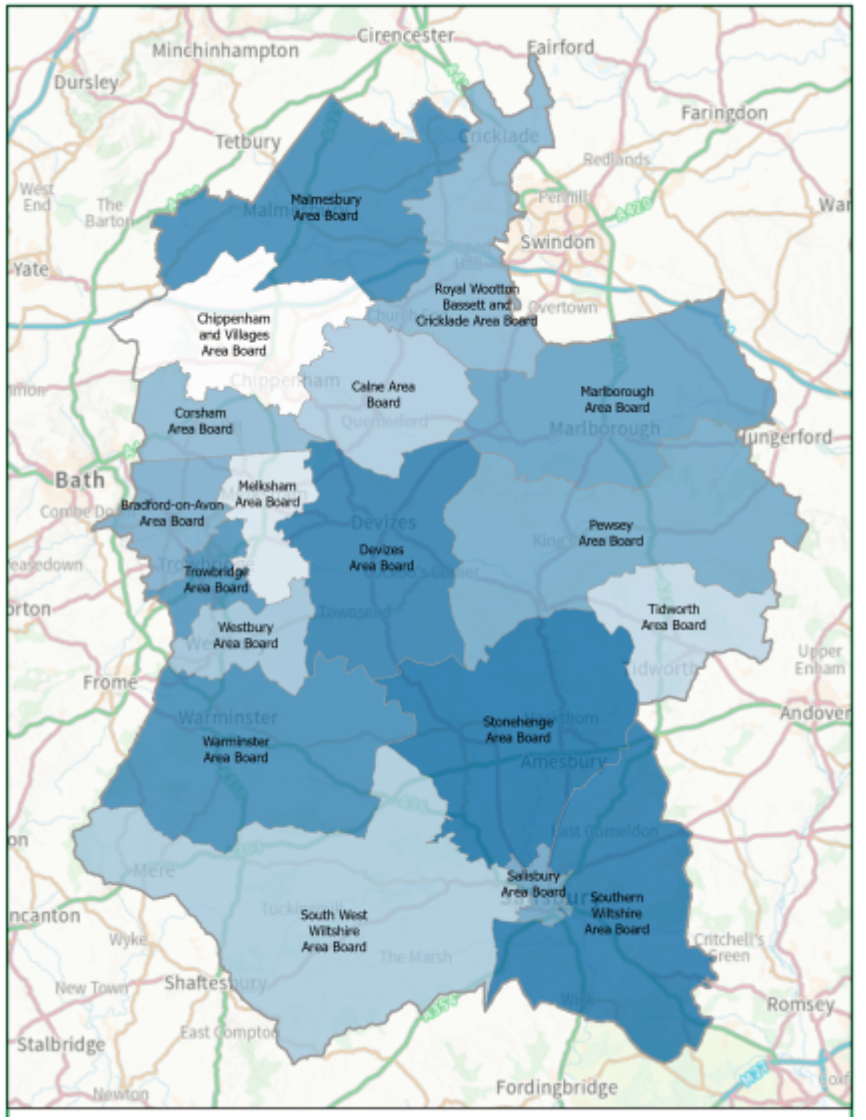
The 2022 Wiltshire Health and Wellbeing JSNA identified 3 key strategic priorities for Wiltshire:

- Ageing Population
- Mental and Emotional Wellbeing
- Cost of Living

These priorities informed the production of the CAJSNA infographic packs.

Directorates and external partners were involved in the selection of indicators, and in the provision of data and insight.

Resident survey to increase community engagement (closes in May).

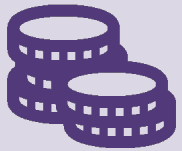


Population

Health

Housing

Economy



Environment

Communities

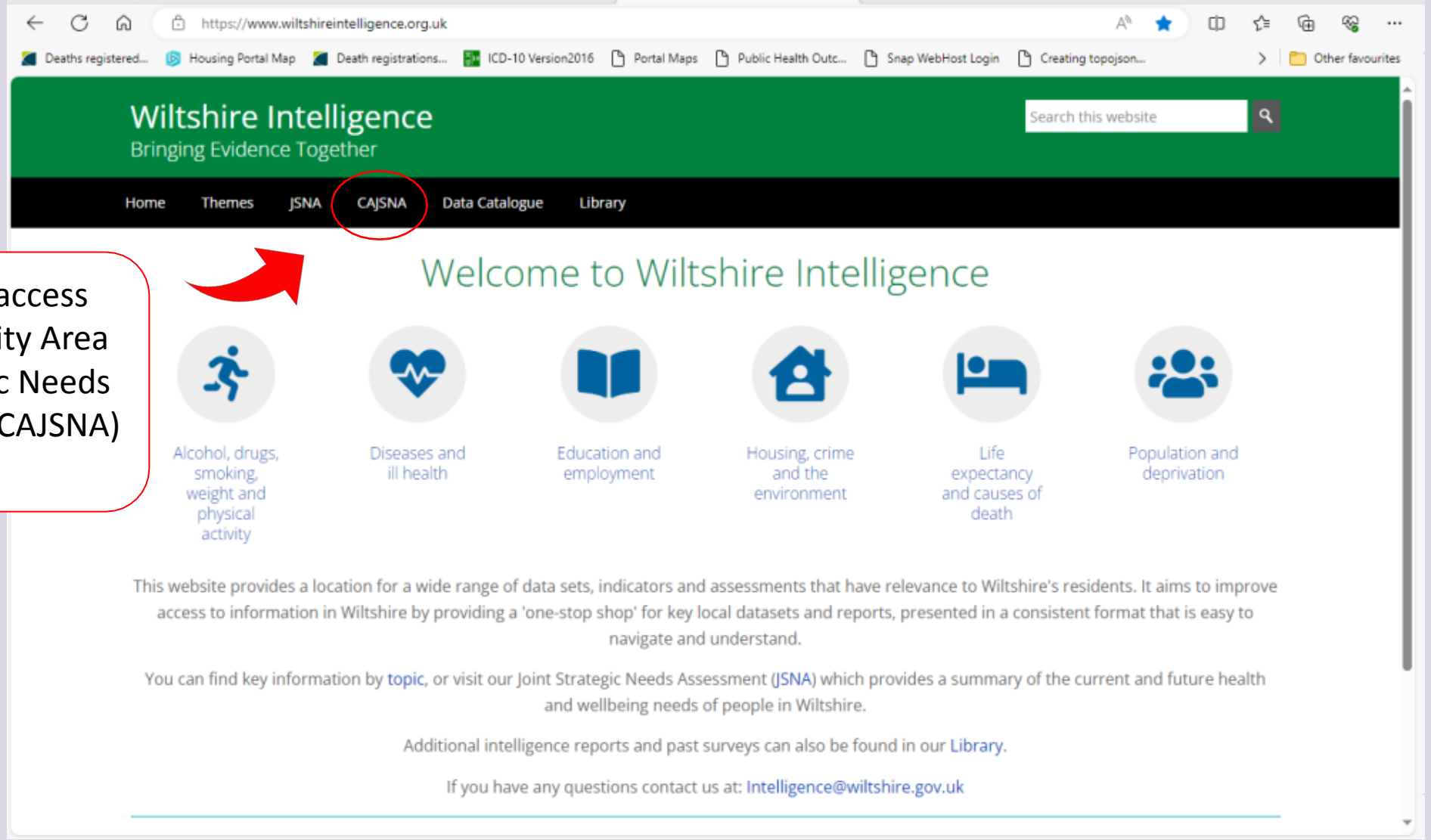
Safety

Cost of Living

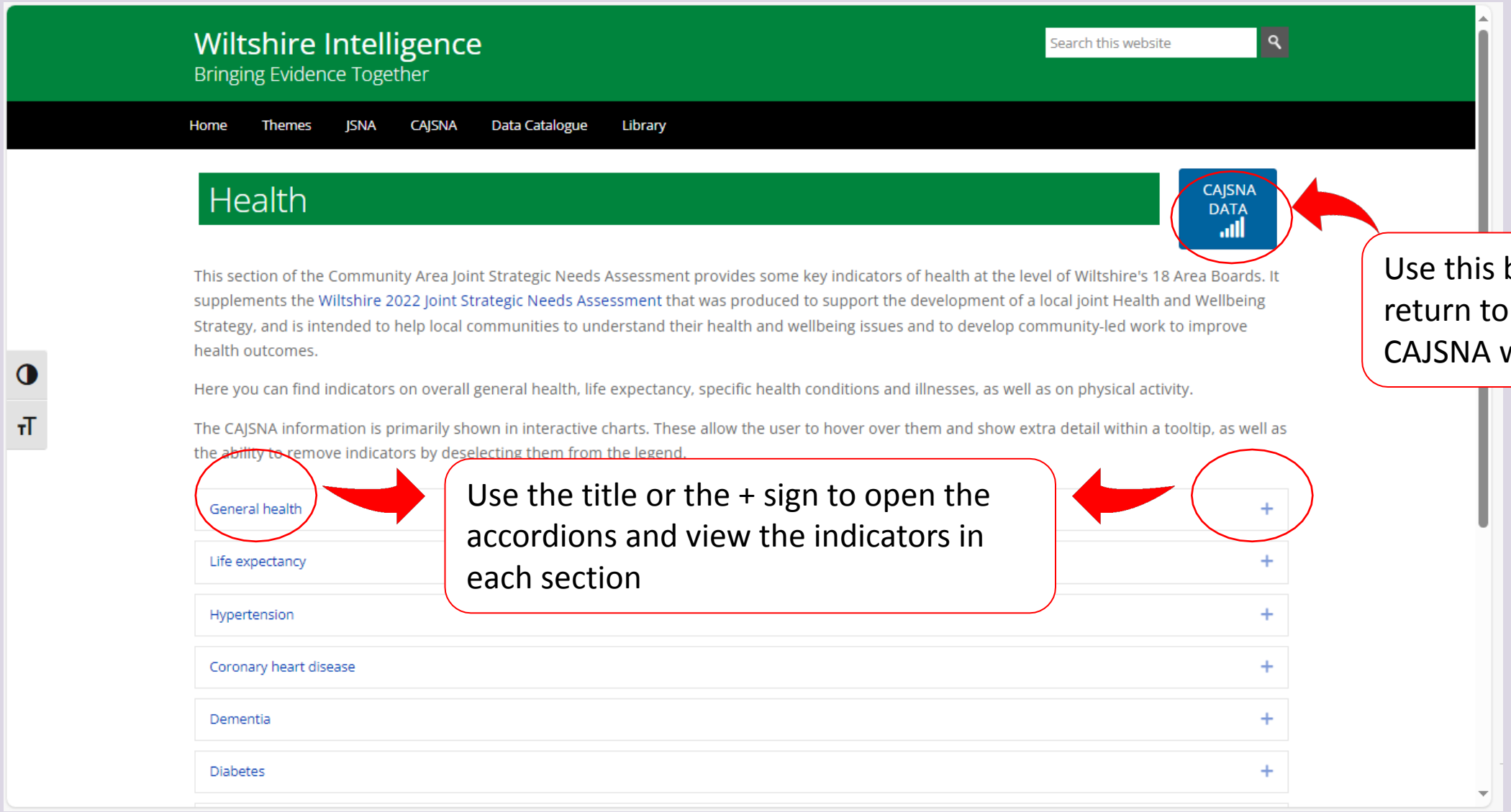
Older People

Children

Click here to access the Community Area Joint Strategic Needs Assessment (CAJSNA) 2024



- Wiltshire Intelligence - Bringing Evidence Together



- CAJSNA 2024 - Health Wiltshire Intelligence

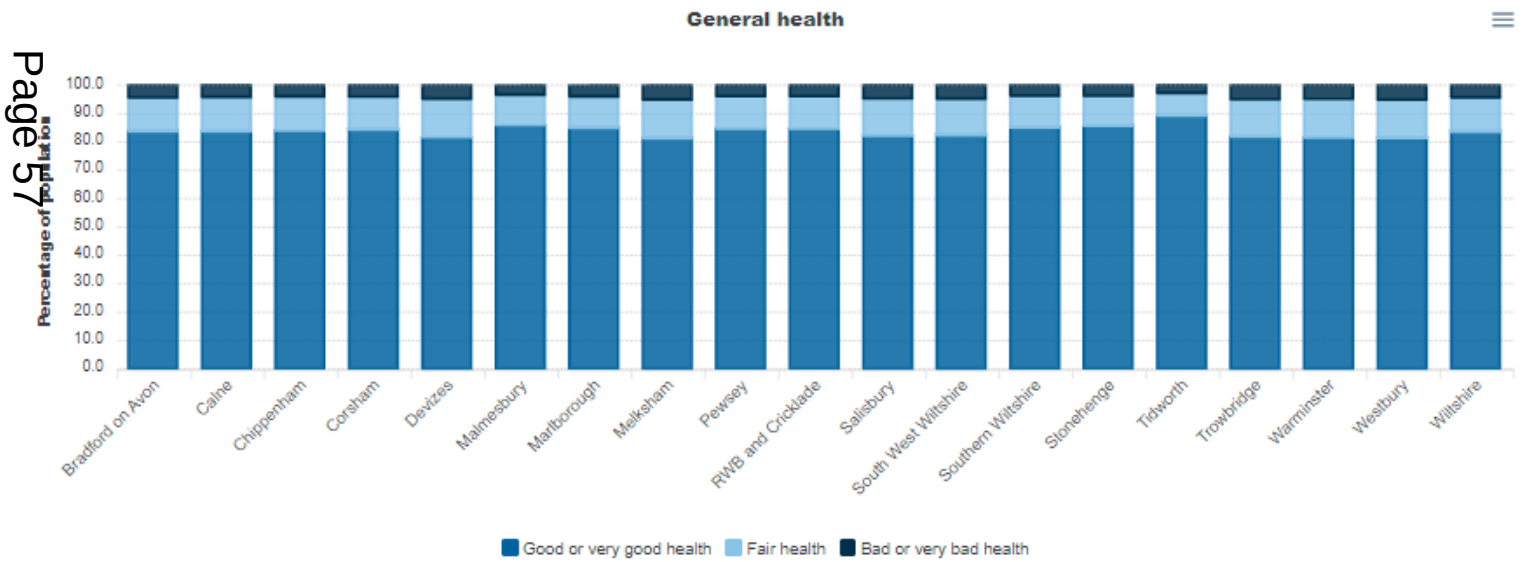
General health

General health

Self-reported health is an important indicator when considering health across Wiltshire. The 2021 Census asked each respondent to evaluate their own health on a five-point scale, either as "Very good", "Good, "Fair", "Bad", or "Very bad".

In Wiltshire, the percentage of those in "Very good" or "Good" health is 83.6%, while 4.2% reported being in "Very bad" or "Bad" health. The chart below provides us with a breakdown by Area Board, allowing us to see where there are higher proportions of self-reported good or bad health.

It should be noted that the 2021 Census was undertaken during the COVID-19 pandemic, which could have influenced how someone perceived their own health at that time.



Definition: Percentage of the population by assessment of general state of health from very good to very bad.

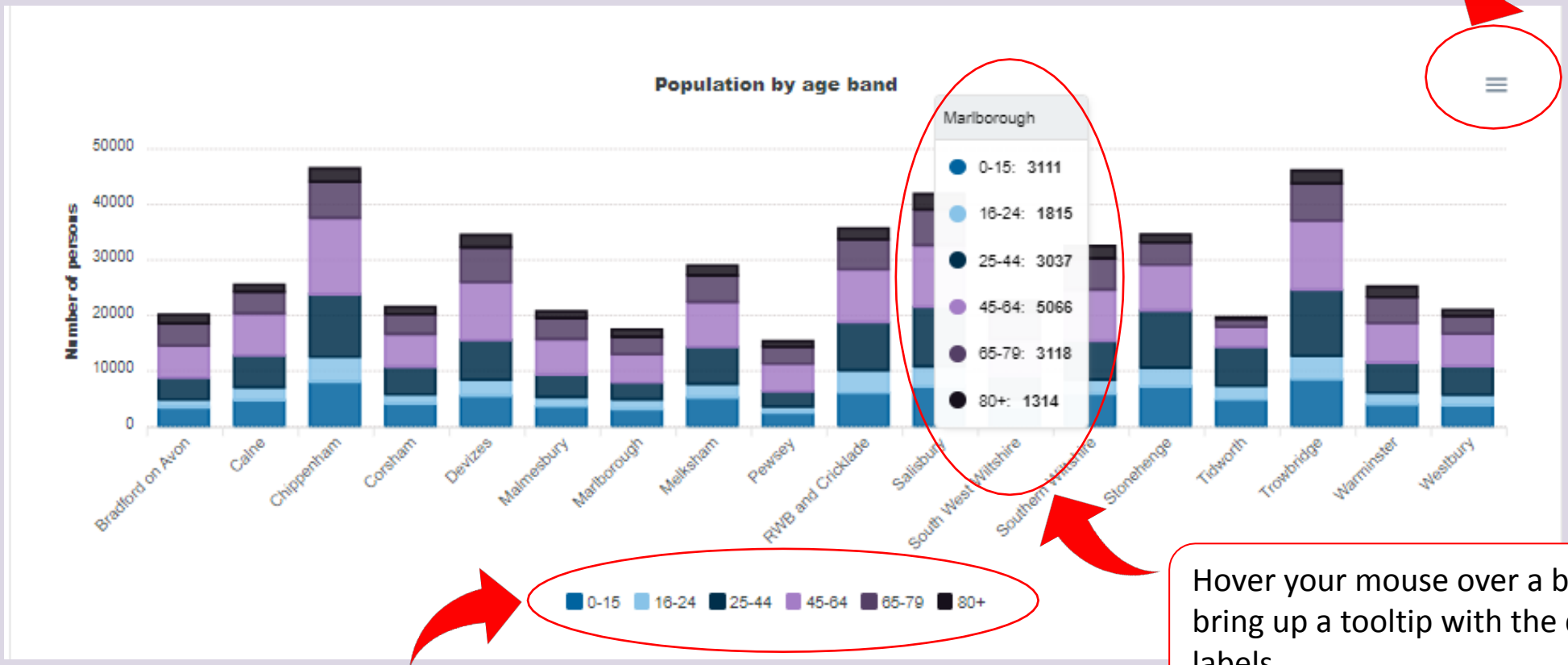
Data source and time period: Office for National Statistics, 2021 Census Table TS037 - General health. March 2021.

- CAJSNA 2024 - Health Wiltshire Intelligence

Descriptive commentary

Data visualisation (usually bar charts)

Definition, data source (inc. link if public), and timeframe



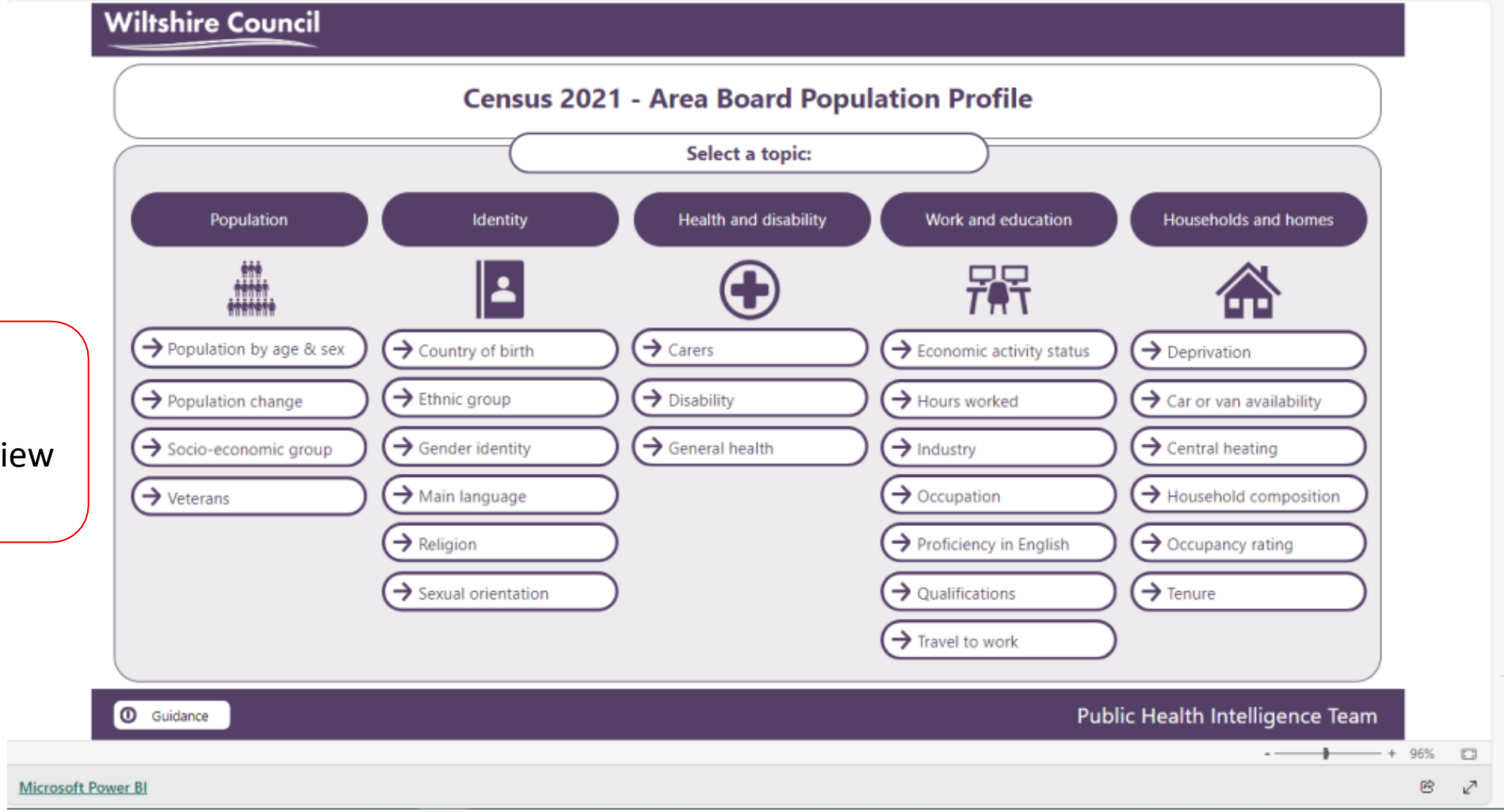
Click here to download the data or a high-res version of the chart

Hover your mouse over a bar to bring up a tooltip with the data labels

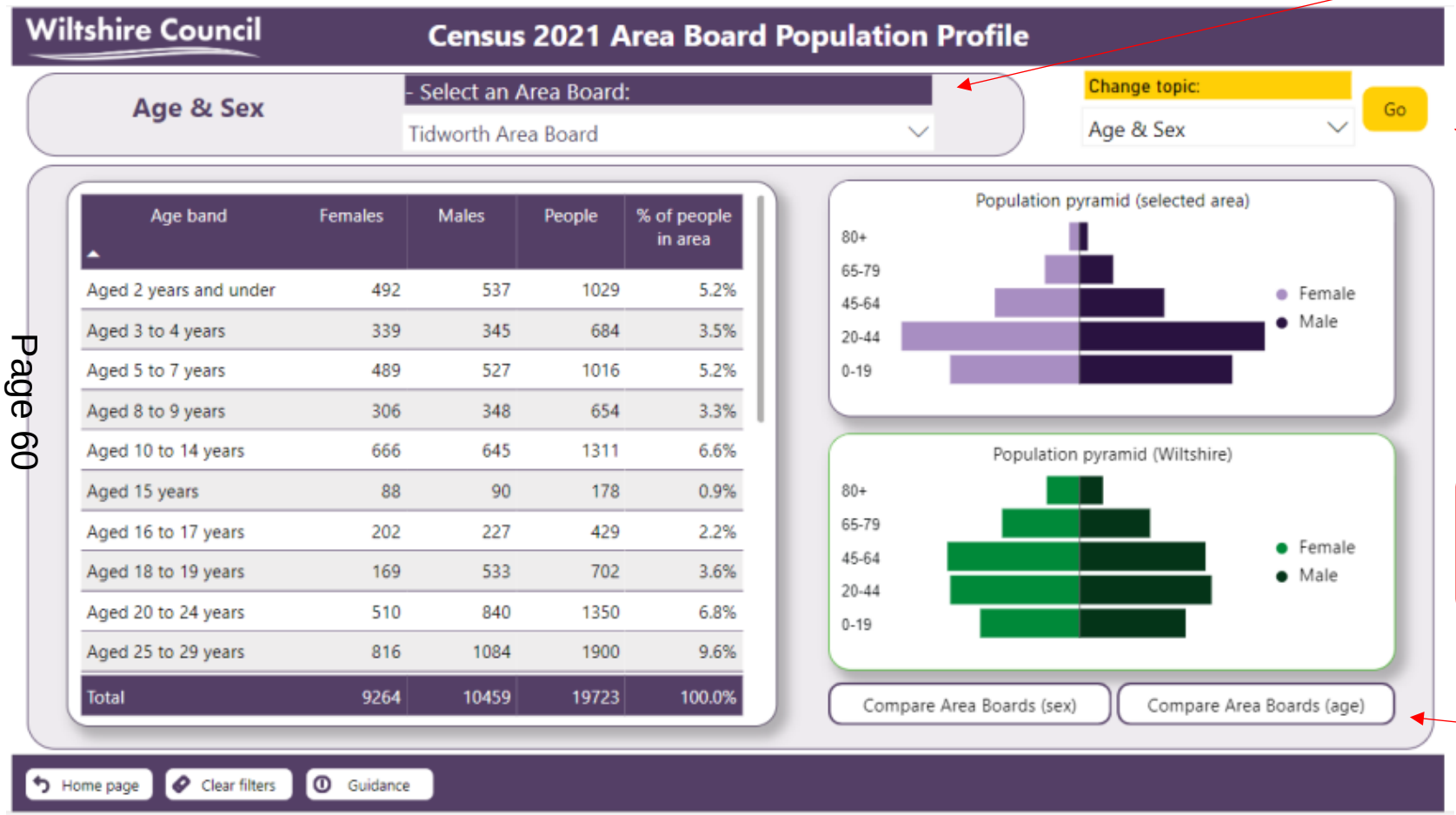
Click on the legend items to show/hide them in the chart

- CAJSNA 2024 - Population Wiltshire Intelligence

Click on the white topic buttons to view the data



[CAJSNA 2024 - Population Wiltshire Intelligence]



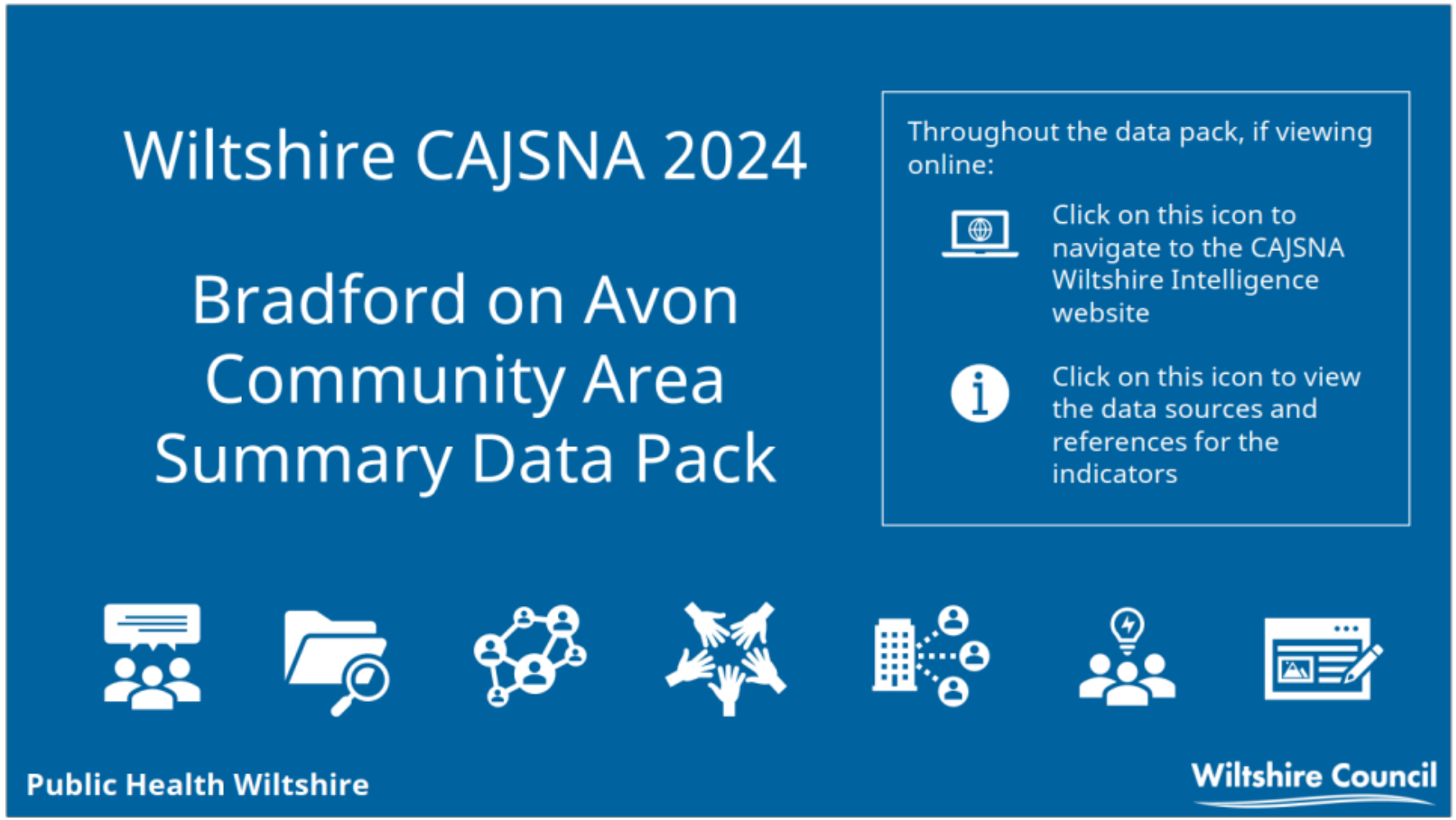
Use the purple ‘Select an Area Board’ menu to choose which area is shown in the purple table and chart

The yellow menu navigates to different topics when you press the ‘Go’ button

The green chart always shows Wiltshire

The ‘Compare Area Boards’ buttons allow you to compare results for all Area Boards

The ‘Guidance’ button has definitions of the indicators and links to further Census resources



CAJSNA 2024 - Bradford on Avon Wiltshire Intelligence

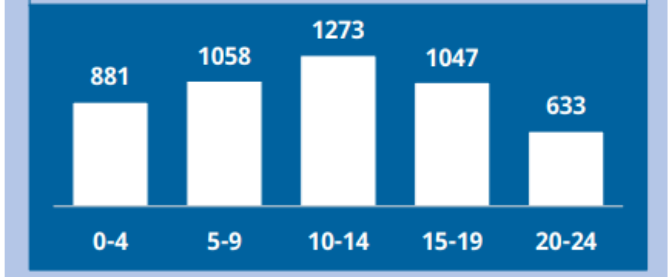
Children and young people in Bradford on Avon community area

Children and young people

Supporting and improving life chances for children and young people is key to the future of Wiltshire. Providing families with access to services that meet their needs at an early stage is crucial to making sure every child and young person has the best possible start in life.

Understanding our younger population

Under 25 year olds in Bradford on Avon in 2021:



In 2021, the rate of those aged under 15 years providing **unpaid care** in Bradford on Avon was 95.7 per 10,000 people. The rate for Wiltshire was 96.3 per 10,000.

9.2% of children aged under 16 in this area live in a **low-income family**, compared with 12.7% in Wiltshire.

Education and employment

Pupils achieving a good level of development at the end of the Early Years Foundation Stage in Bradford on Avon schools:

All pupils	Disadvantaged pupils
76.0%	35.7%

Disadvantaged pupils defined as currently eligible/have been eligible within the last 6 years for free school meals, are looked after or have left care through a formal route.

19.2% of pupils aged 4 to 18 years old in this community area in 2023 have **special educational needs.**

Rate of **unemployment** (but actively seeking work) in 16 – 24 year olds

Bradford on Avon	Wiltshire
868.4 per 10,000	743.3 per 10,000

Health

20.1% percent of children aged 10-11 years are **obese or overweight** in Bradford on Avon, compared with 31.5% in Wiltshire.

Hospital admissions as a result of **self-harm** (10-24 years)

Almost 650 young people admitted in Wiltshire, in 2021/22.

Rate per 100,000:	Wiltshire	England
	778.0	427.3

In this community area across 2023 there were **180** accepted referrals into **Children and Adolescent Mental Health Services** (CAMHS).

Safety

Across the last three years, **29.8** per 10,000 under 18-year-olds in this area were in treatment for **substance misuse**, compared with 29.6 per 10,000 in Wiltshire.

Crimes involving persons under 18 years old (2018 – 2022)	Bradford on Avon **15.4**	Wiltshire **15.5** Per 10,000 people

Knife crimes involving under 18 year olds (2018 – 2022)	Bradford on Avon **1.0**	Wiltshire **2.3** Per 10,000 people

Public Health Wiltshire

Wiltshire Council

Next Steps

- Community engagement
- Resident survey
- Wider promotion
- Collecting feedback
- Using feedback for future improvement

Thank You

Wiltshire Council

Health and Wellbeing Board

21 March 2024

Subject: Public health workforce campaign

Executive Summary

In November 2021 the chairs of the Health and Wellbeing Board requested options to inspire the organisations sitting on the Board to implement a workforce wellbeing campaign. The prospect of influencing the health and wellbeing agenda on such a scale presents a unique opportunity. A successful campaign, addressing mental health, was completed in 2022 and subsequently a decision was made to continue the good work.

Organisations were asked at the January 2023 Health and Wellbeing Board to make a commitment to physical health, enabling a healthy workforce through the implementation of smoking cessation interventions. This report provides an update on progress.

Proposal

On 26 January 2023 it was recommended to the Board that the focus of that year's Public Health Workforce Health Campaign was to be smoking cessation. With it the outcome of the campaign was to be brought back to the Board in 12 months' time to see what had been embedded within organisations.

Outcomes

Seven organisations provided a progress update with a combined workforce of c.29,000. Multiple interventions supporting smoking cessation have been implemented with a clear focus on the promotion of national stop smoking campaigns.

Next Steps

The health and wellbeing of any workforce is an organisational priority and even more so given its priority at a national level, the links to the Wiltshire Joint Local Health and Wellbeing Strategy and the continuing increase in health inequalities. A focus on all areas of workplace health is paramount. As such each organisation represented on the Health and Wellbeing Board is asked to maintain its commitment to this important agenda.

Kate Blackburn
Director of Public Health
Wiltshire Council

Wiltshire Council

Health and Wellbeing Board

21 March 2024

Subject: Public health workforce campaign

Purpose of Report

1. To provide an update to the Health and Wellbeing Board on the approaches taken by the organisations represented on the Board to improving their workforce health and wellbeing and to share good practice.

Relevance to the Health and Wellbeing Strategy

2. Employment is a primary determinant of health. Increasing the quality of work helps support prevention and early intervention, improving social mobility and tackling inequalities, which are key guiding themes of the Health and Wellbeing Strategy.

Background

3. Following a successful public health workforce campaign (2022-2023), focussing on mental health, the Board's member organisations agreed to continue the campaign in January 2023. The focus of this year's campaign was on promoting physical health and in particular smoking cessation. The purpose of this paper is to provide an update on progress, share examples of good practice and provide recommendations for continued commitment to the workplace health agenda.

4. Good health and wellbeing are essential to successful, sustainable workplaces. Protecting and improving the health and wellbeing of our employees remains critical to the health and economic wellbeing of our population. Addressing economic inactivity due to ill health is now a Government priority. Since the pandemic, nationally 470,000 more people are out of the workforce on ill-health grounds, while many more continue to work despite long-term health problems[1], highlighting the need for workers health to remain a top priority.

5. In January 2023 member organisations were asked to consider options to continue the campaign and opted to concentrate on smoking cessation. Smoking remains the biggest single cause of preventable death and ill-health in England with costs to the economy and wider society estimated at £17 billion a year[2].

---

[1] The Health Foundation, 2023. What we know about the UK's working-age health challenge - The Health Foundation

[2] HM Government, 2024. Creating a smokefree generation and tackling youth vaping consultation: government response - GOV.UK (www.gov.uk)

6. All members agreed to implement the campaign and the Health and Wellbeing Board agreed that the outcome of the campaign was to be brought back to the Board in 12 months' time to see what had been embedded within organisations.

Progress

7. There are eleven organisations represented on the Health and Wellbeing Board, and a request for an update on progress was made prior to publication of this report. A brief summary of the interventions implemented by the various organisations can be seen in appendix 1. It should be noted that Healthwatch Wiltshire only have four part-time employees and therefore were deemed exempt.

8. Seven organisations provided a progress update with a combined workforce of c29,000 staff.

9. There were a number of smoking cessation interventions implemented across the organisations, as recommended, with the internal promotion of national stop smoking campaigns being one of the most common approaches taken.

10. Other interventions included the signing of the NHS Smokefree Pledge, creation of a smokefree site, signposting to smoking cessation services and targeted training for managers to support staff quitting smoking.

Discussion

11. Smoking is the single most important entirely preventable cause of ill health, disability and death in the UK, responsible for 80,000 deaths a year and 1 in 4 of all UK cancer deaths. Smokers lose an average of 10 years of life expectancy, or around one year for every 4 smoking years[2].

12. In an update to Joint Strategic Needs Assessment figures, the current prevalence of adults smoking in Wiltshire is 10.2%, which is better than the national level (12.7%) . However, there are substantial inequalities in smoking in Wiltshire, with the prevalence in adults in routine and manual occupations reported at just over 23%. According to Business in the Community[3] staff who smoke at work are 33% more likely to be absent from work than non-smokers.

13. The BSW Inequalities Strategy 2021-2024 provides a framework for system activity to reduce health inequalities. The strategy implements the NHS Core20PLUS5 programme and identifies routine and manual workers as a PLUS group in Wiltshire, largely due to higher smoking rates. A PLUS group is a locally determined population that experiences poorer than average health access, experiences and/or outcomes. The 5 clinical areas identified by the programme include CVD, maternity, respiratory

[3] BiTC, 2019. Drugs, Alcohol and Tobacco: A Toolkit For Employers (bitc.org.uk)

illnesses, cancer and mental health with smoking cessation included as a priority that crosscuts all five of these areas for adults.

14. Aligned to the key theme of prevention and early intervention the Wiltshire Joint Local Health and Wellbeing Strategy clearly seeks to achieve change. It will do so by empowering individuals across the life course with advice focusing on smoking cessation and through partnership working, such as the public health workforce campaign, enable a healthy workforce through targeted preventative activity.

15. The focus on smoking cessation proved timely given the once in a generation opportunity to comment on the Government's plan to create a smokefree generation and tackle youth vaping[2]. Ultimately the plan is to create legislation whereby anyone born on or after 1 January 2009 will never legally be sold tobacco products with the aim of phasing out smoking completely. Until such time as that goal is realised work is needed to reduce smoking rates further including in the workplace.

Future Commitment

16. Organisations have shown great application when implementing workplace interventions over the past two years, both in terms of addressing mental and physical health. Subsequently, it is felt that this momentum should be harnessed and continued. To that end organisations represented on the Board should continue interventions that support the collective workforce and align with the themes of the Wiltshire Joint Local Health and Wellbeing Strategy.

17. Along with measures to address people leaving the workforce, employers need to develop new and better ways to support employees to remain well in work. People in employment are in worse health than previously. Compared to 2019, people in employment are 13% more likely to have a health condition and 30% more likely to have multiple health conditions[4].

18. The JSNA indicates that our 65+ population currently represents just over a fifth of the overall population but by 2040 this age group will make up nearly a third. As people live longer they will be expected to work for longer yet are likely to do so with one or multiple health conditions, a key barrier to gaining employment and for staying in work.

19. As well as an ageing population recent evidence highlights a rise in work-limiting conditions that are being driven by sharp increases in reported mental ill health, particularly among younger workers[5]. Across the whole workforce, musculoskeletal and cardiovascular conditions remain the most common form of work-limiting health condition.

[4] IPPR, 2022 – Getting Better? Health and the labour market https://www.ippr.org/research/publications/getting-better-health-and-labour-market

[5] Resolution Foundation, 2024. We've only just begun: Action to improve young people's mental health, education and employment We've only just begun • Resolution Foundation

Anchor Institutions

20. Employment is one of the five ways organisations act as anchor institutions, these being large, public sector organisations that are unlikely to relocate and have a significant stake in a geographical area[6]. Anchor workforce strategies involve thinking not only about how organisations can grow local workforce supply and widen access to employment for local communities, but also how to be a better employer and place to build a career for more people. Such strategies consider widening workforce participation, building the future workforce and being a good employer, which includes supporting I) fair pay and conditions of employment, II) health and wellbeing and III) professional development and career progression[6].

Support

21. Public Health have created an online resource to help support workplaces in Wiltshire. Hosted on The Enterprise Network website there are dedicated webpages on a variety of workplace health topics including but not limited to, mental and physical health, substance use and financial wellbeing. The website can be accessed by visiting www.theenterprisenetwork.co.uk and the workplace health support pages can be viewed by clicking on the Workplace Health tab.

Next Steps

22. Good health and wellbeing remain essential to successful, sustainable workplaces. The health and wellbeing of any workforce is an organisational priority and even more so given its priority at a national level, the links to the Joint Local Health and Wellbeing Strategy and the continuing increase in health inequalities. A focus on all areas of workplace health is paramount. As such each organisation represented on the Health and Wellbeing Board is asked to maintain its commitment to this important agenda.

23. Each organisation should commit to the following:

I. Continue to invest in workplace health
II. Continue to build on the excellent work done thus far on supporting both mental and physical health in the workplace and share best practice
III. Increase employment opportunities by adopting the anchor institute principles

Kate Blackburn
Director of Public Health
Wiltshire Council

[6] The Health Foundation, 2019. Building healthier communities: the role of the NHS as an anchor institution. Building healthier communities: the role of the NHS as an anchor institution - The Health Foundation

Report Authors:
Public Health

Appendix 1

Organisation	Intervention(s)	Outcome(s)
AWP	- No response received	- No response received
BSW ICB	- No response received	- No response received
Dorset & Wiltshire Fire and Rescue Service	- Promotion of No Smoking Day and NFCC campaigns to staff - Providing guidance and training to staff on the NFCCs '7 Steps to Prevent Smoking Related Fires'	
Great Western Hospitals NHS Foundation Trust	- Promotion of Stoptober - Sign up to the NHS Smokefree Pledge - Health check ins for staff including advice/support to help quit smoking	- Signatory of the updated NHS Smokefree Pledge - Weekly check ins, with staff asked about smoking status with cessation support/signposting offered
HCRG Care Group	- Wellbeing offer and 24 access to Employee Assistance	- Positive feedback from colleagues on the advice and support given. Smoking rates are not high in the workforce but wider focus on health, particularly stress and emotional wellbeing, is more of a focus area
Healthwatch Wiltshire	N/A	N/A
RUH	- Smoking cessation clinics for staff	- Between January 2023 and December 2023, 16 staff have accessed the Occupational Health smoking

		cessation service. Of those, 8 have successfully quit smoking
Salisbury FT	- Creation of a smokefree site - Smokefree site task and finish group set up, 18 recommendations identified - Establishment of a SFT smokefree and LTP working group, which meets on a monthly basis.	- Smoking shelters have been rebranded as vaping shelters - Promotion of a smokefree site in all recruitment and external communications. - Occupational health promote smoking cessation and sign post to support services.
Wiltshire Council	- Promotion of Smokefree Service and quit tips to all staff via comms campaign - Promotion of Stoptober, internally and externally including Health Coach presence at main hubs and libraries - Delivery of manager focused training on supporting staff to quit - Review of smokefree HR policy undertaken	- Quit tips and appropriate signposting published via Wellbeing Wednesday internal comms platform over 10 week period Summer/Autumn 2023 - Physical stands in various hubs/libraries across the county during Stoptober, providing advice to employees and residents - 2 x manager focused training sessions delivered on smoking cessation via internal training platform
Wiltshire Health and Care	- No response received	- No response received
Wiltshire Police	- Continued Support and Signposting Through Wellness SharePoint Portal - Links have been created on the Wiltshire Police Well SharePoint - link directly to the NHS support pages for those seeking help and advice to give up smoking.	- Continue to monitor the traffic to the SharePoint site to see how many staff/officers are looking for help. - A targeting campaign could be launched as part of the Wiltshire Police 2024 ‘Summer of Wellness’ campaign running through July and August 2024