

Melksham Area Board

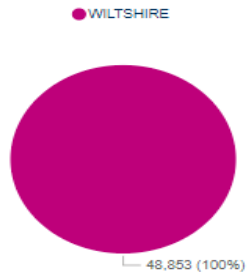


BOA Melksham PCN

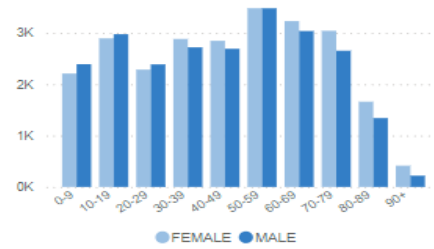
Total number of registered patients
48,853

Difference from previous month
0.08%

Difference same period last year
0.89%



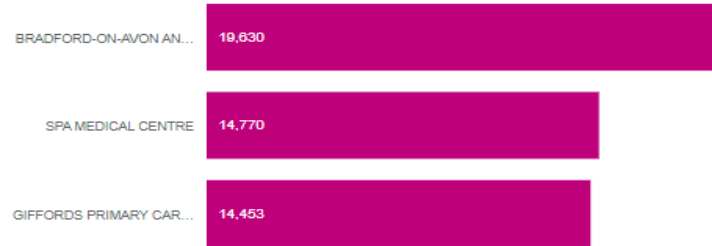
Population by Age Range



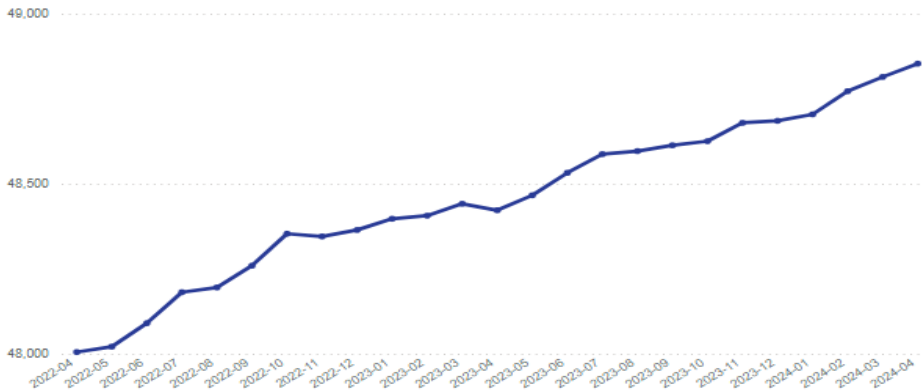
Practice Population by PCN



Practice Population by GP Practice

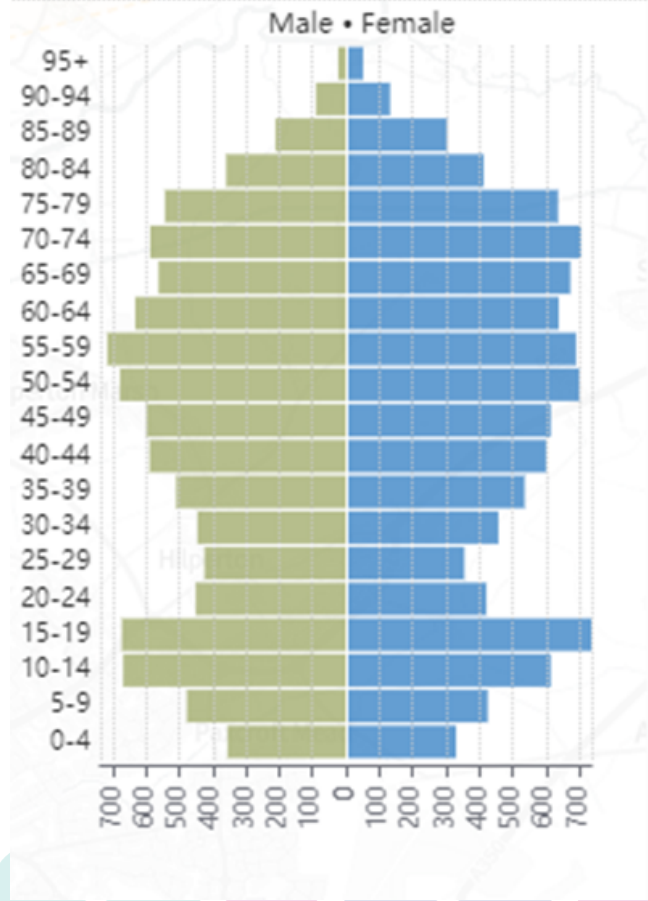


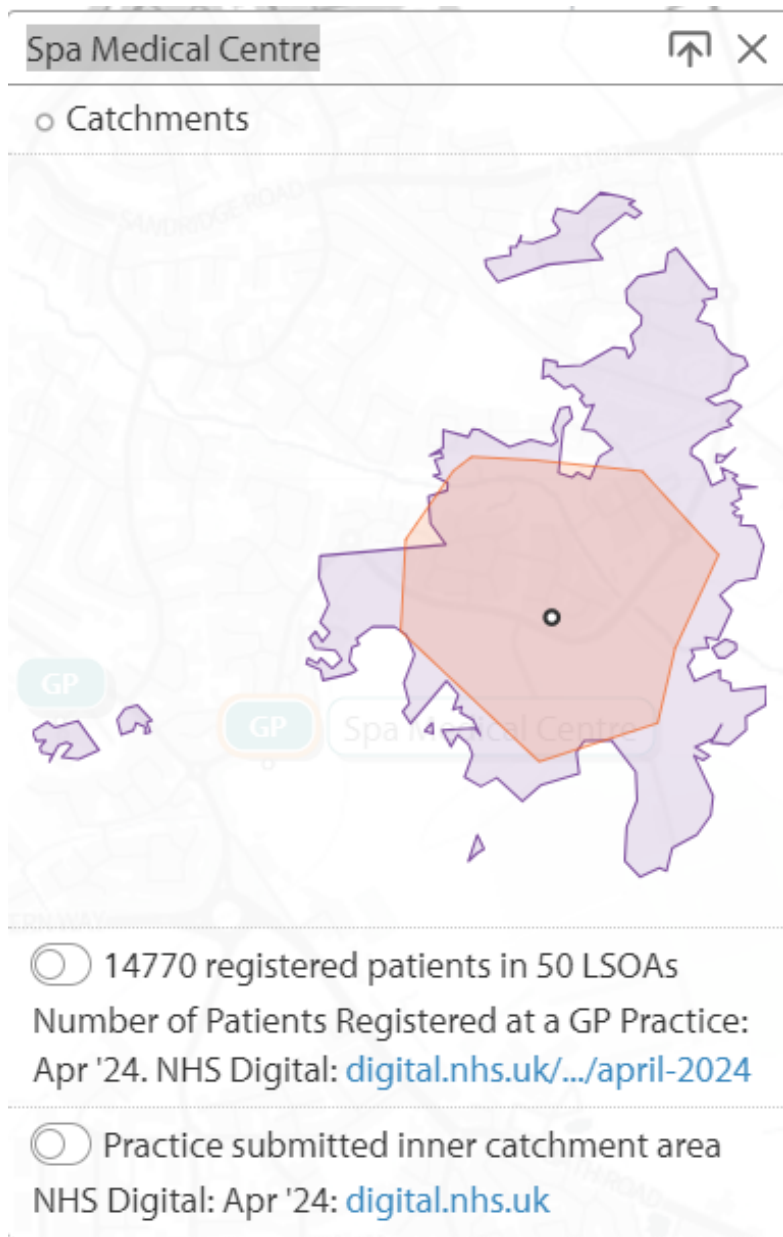
BSW population by period



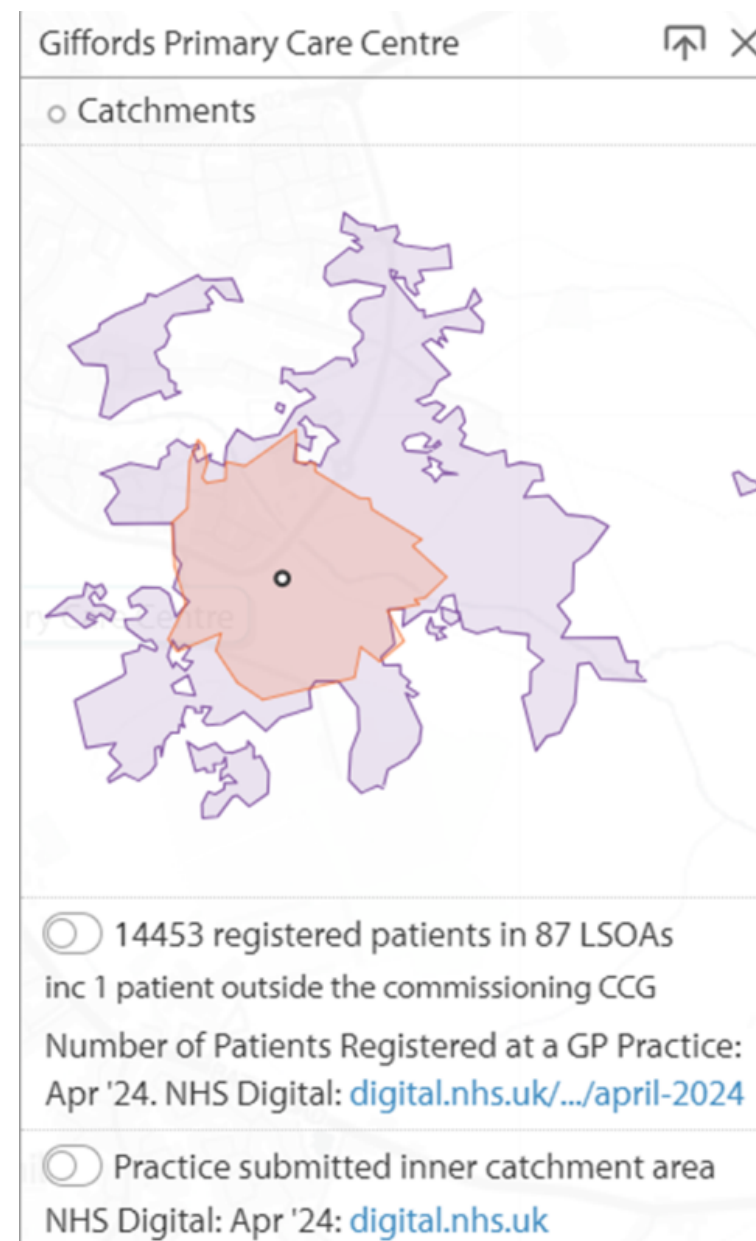
○ Patient age profile

Registered patient total: 19,630
Male: 9,580, Female: 10,050





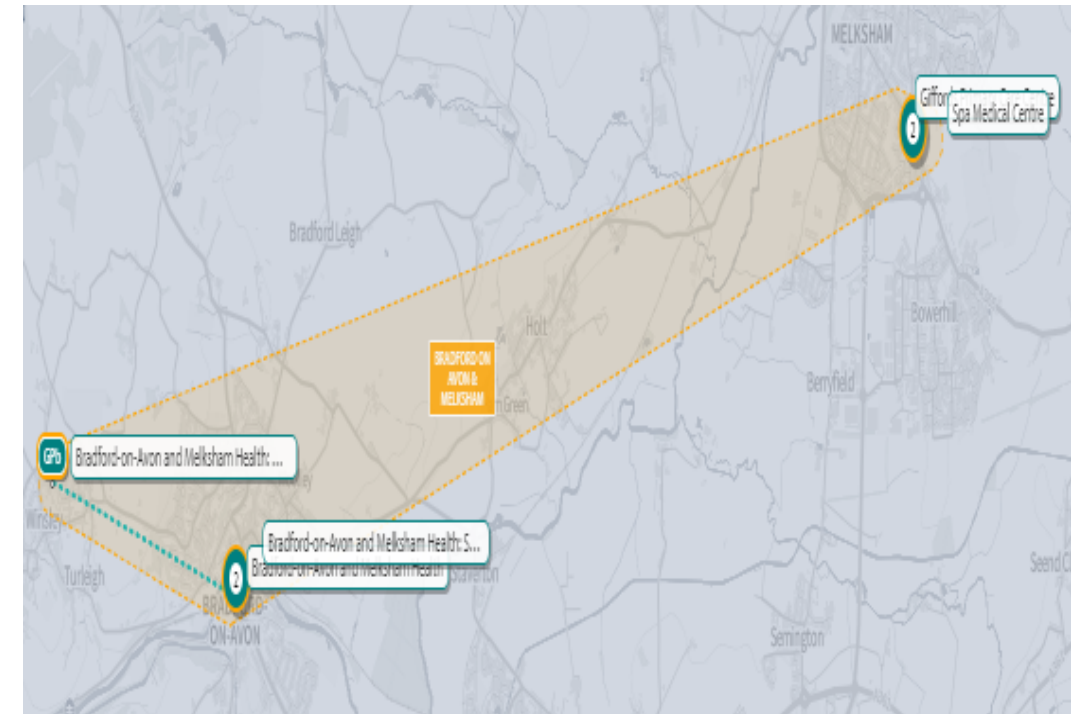
GP Practice's registered patients and practice boundary area across Melksham.



PCN Estate

- There are 3 main GP premises and 2 branch sites across Melksham and Bradford on Avon
- The estate will need to support the expected increase in population from the housing growth by 2032
- The estate will need to evolve and become more flexible to support delivery of a range of services for the population
- The future estate will be informed by the PCN clinical service strategy and supported by activity level data to determine the level of space required
- Gifford Surgery are working with their Landlord to optimise the current premises within the current footprint to support their service delivery
- Various planning application responses have been submitted in response to the healthcare premises needed for the growth

Melksham and Bradford on Avon PCN estate



Primary Care Network Workforce



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

- Melksham and Bradford on Avon Primary Care Network covers the Practice populations of Giffords Surgery, Spa Medical Centre and Bradford on Avon.
- The Primary Care Network currently employs 28 staff recruited through the Additional Roles Reimbursement Scheme.
- Strong emphasis on the Personalised Care roles that support the Living Well and Frailty teams:
 - Social Prescribing Link Workers
 - Health and Wellbeing Coaches
 - Care Co-ordinators.

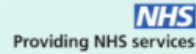


Community Pharmacy in Melksham



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

Most pharmacies can help you with **seven common conditions** without needing a GP appointment



Speak to your pharmacist if you suspect you have:

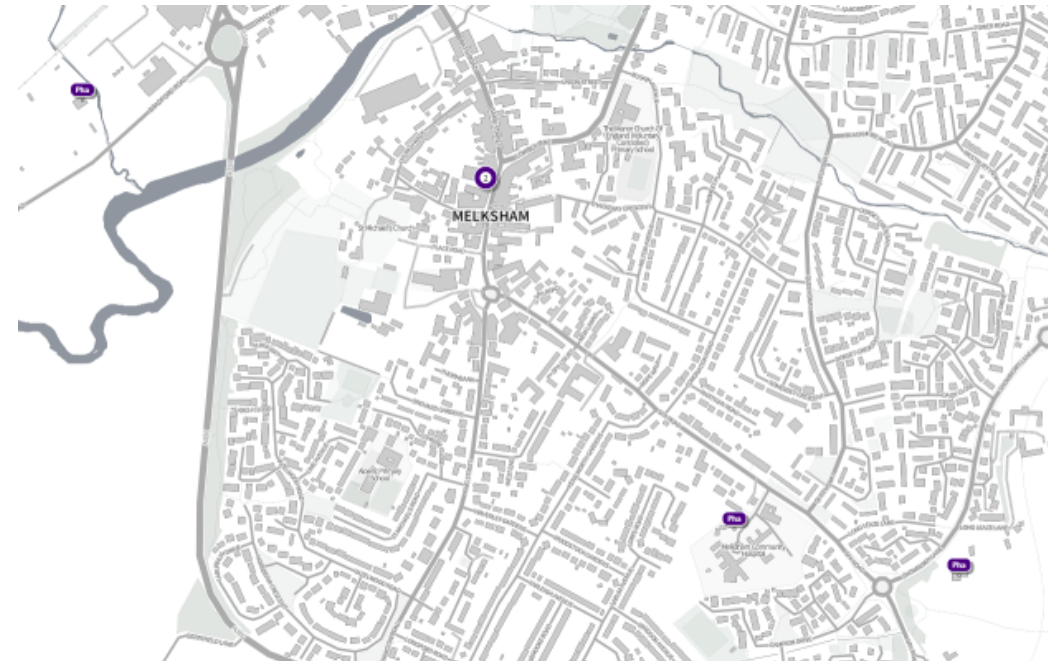
- **Sinusitis**
(adults and children aged 12 years and over)
- **Sore throat**
(adults and children aged 5 years and over)
- **Earache**
(children aged 1 year to 17 years)
- **Infected insect bite**
(adults and children aged 1 year and over)
- **Impetigo**
(adults and children aged 1 year and over)
- **Shingles**
(adults aged 18 years and over)
- **Urinary tract infection**
(women, aged 16 to 64 years)



Visit your
Pharmacy First!

Pharmacy	Address	Opening Hours
Spa Pharmacy	Spa Medical Centre, Snowberry Lane Giffords Primary Care Centre, Spa Road	Mon to Fri: 8.30am to 6.30pm
Melksham Pharmacy	1 Bank Street	Mon to Fri: 8am to 8pm Sat: 9am to 1pm
Gompels Pharmacy	19-23 High Street	Mon to Fri: 9am to 5:30pm Sat: 9am to 4pm
Boots Pharmacy	Bradford Road	Mon to Sat: 9am to 12:30pm 1pm to 4:30pm 5pm to 9pm Sun: 10am to 4pm

Approx. 50,000
prescriptions dispensed
in Jan. 2024



Dental Services in Melksham

Melksham South

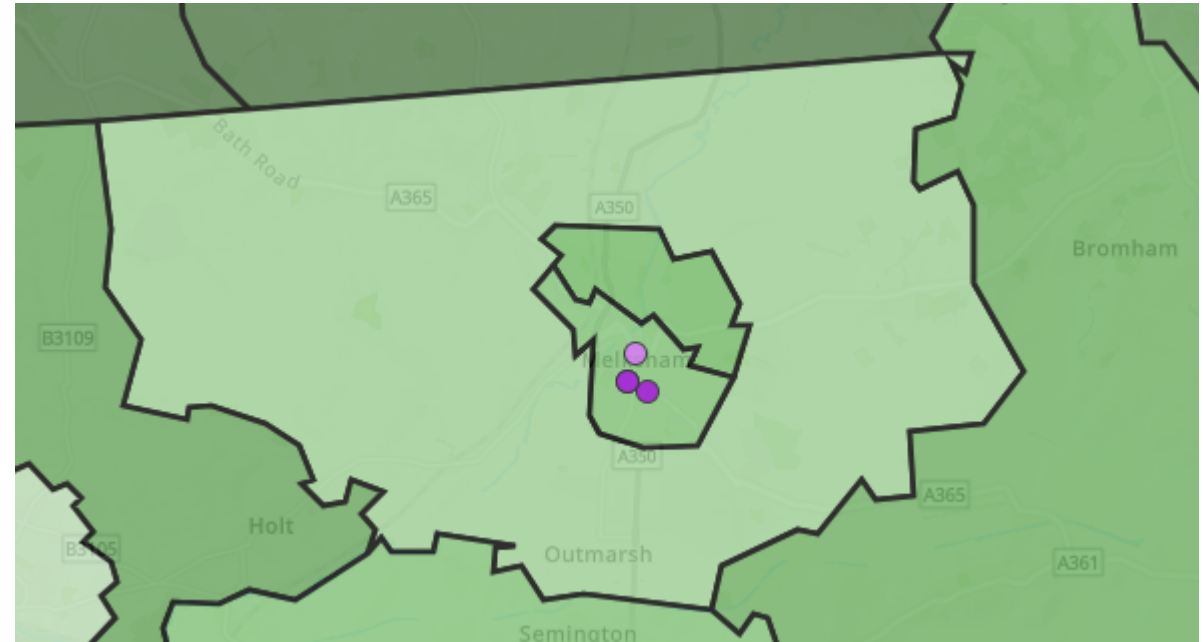
- Approx. 27% ward accessing NHS dentistry (higher than National average)
- 37% children accessing NHS dentistry

Melksham Without North & Shurnhold

- Approx. 28% ward accessing NHS dentistry (higher than National average)
- 42% children accessing NHS dentistry (higher than National average)

Melksham Forest

- Approx. 25% ward accessing NHS dentistry (higher than National average)
- 32% children accessing NHS dentistry



Bowerhill

- Approx. 28% ward accessing NHS dentistry (higher than National average)
- 42% children accessing NHS dentistry (higher than National average)



ICB Updates - Melksham Area Board



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

High Intensity Users of A&E services

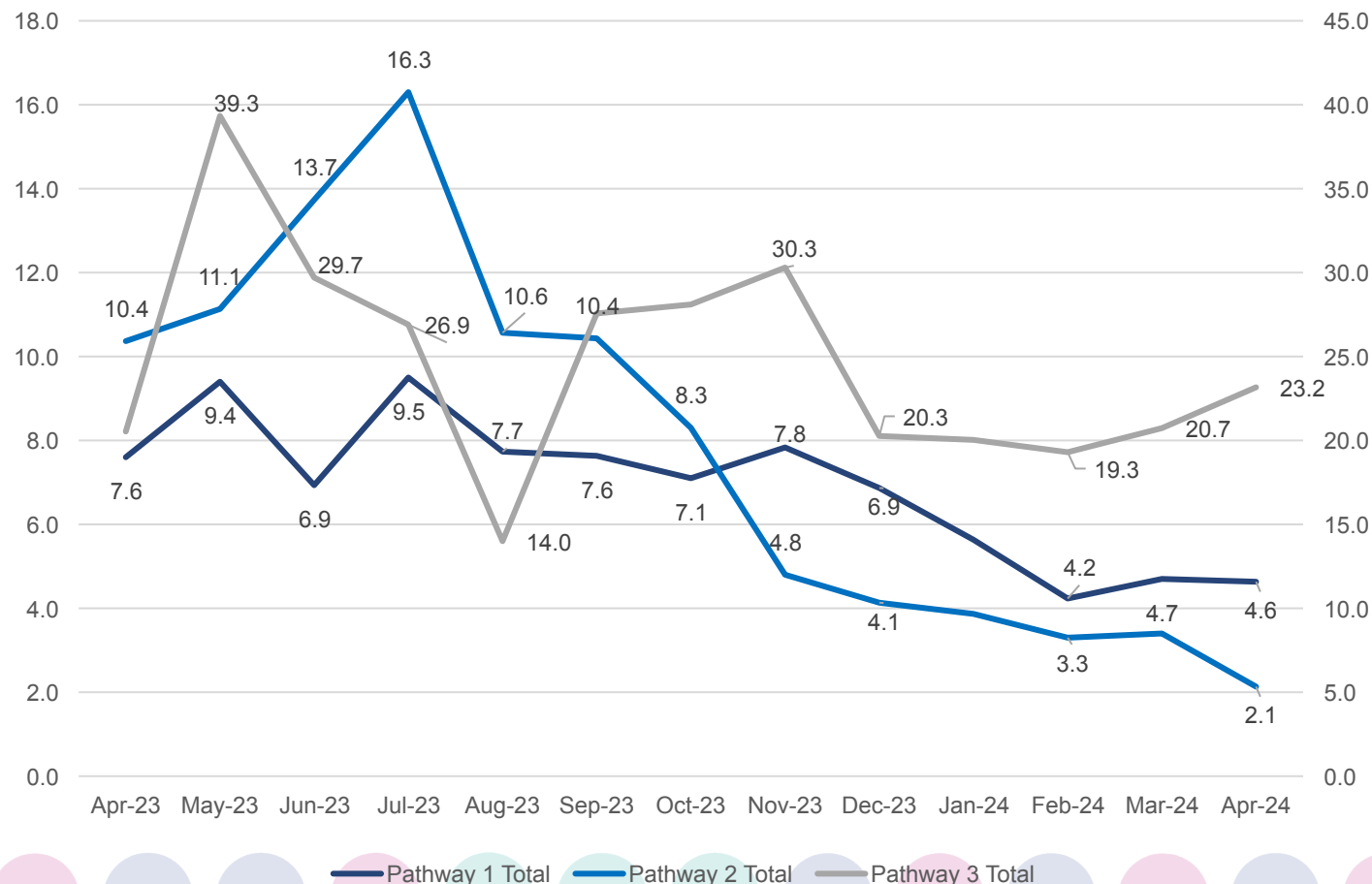
Support that is available to Wiltshire residents that attend A&E departments on multiple occasions

- The High Intensity User Service historically have been commissioned across BSW as pilots since 2018 and funded on a non-recurrent basis.
- Permanent funding has now been secured across BSW and a contract formally awarded to **BSW Connect**, led by Medvivo Group Ltd in association with Wiltshire Centre for Independent Living
- This service supports service users who predominantly attend at emergency departments more than 5 times per year.
- These services offer a robust way of supporting often vulnerable individuals to uncover and address unmet need, improving quality of care, patient experience.
- Several evaluations have been carried out over the past 2 years which demonstrates the positive impact that they have on UEC services, including a 51% reduction in A&E attendances and 62% reduction in emergency admissions.
- **The BSW Connect service will be mobilised and in place on 1st July 2024**



Wiltshire average Time to Discharge reduced

Performance - Time from Referral To Discharge From Acute Trusts
Pathways 1 (Includes 'complex' P1), 2 and 3 (read P3 on secondary axis)



Latest analysis shows improvements April 23 to April 24 of 40% reduction in time to discharge for people going home and going to a community bed for rehabilitation, from acute trust discharges (over 50% for all source referrals) whilst also reducing the backlog and increasing the ability to support increasingly more 'complex' people at home.

Waiting times being discharged to a care home as a permanent place of resident shows a varying picture but with significant improvement in P3 discharge waits at SFT.

Waiting times have been reduced due to:

- Investment into support for patients going home via domiciliary care with local providers.
- Partners across Wiltshire have worked together to improve pathways home
- Caring Steps Together – Information for patients to plan discharge

Learning Disability & Autism update



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

- **Learning Disabilities Physical Health Check (PHC);**

National target for compliance with PHC is **75%** of the register have a complete check. the Wiltshire c compliance level is 75.7%, with 97% of people also receiving a Health Action Plan. LD AHC compliance continues to be a key focus. Compliance with LD AHC for Melksham practices is *79% - higher than the Wiltshire average.

*aggregate data

- **Learning Disabilities Capital Build;**

BSW ICB are the lead commissioner for a new specialist Learning Disability and Autism unit opening in Summer 2025. This unit will support those who need a more specialist environment and cover Wiltshire.

- **LD Screening Practitioner**

BSW ICB have secured recurrent funding from the NHSE Southwest Region to commission a LD screening practitioner. The role will support individuals to access the 5 adult screening programmes in Primary Care, with the intention of aligning this service with the completion of LD Annual Health Checks

- **Learning Disabilities & Autism Keyworkers**

BSW has an established team of keyworkers who are supporting individuals at risk of escalation or entering a period of crisis with the aim of avoiding inpatient admissions to mental health hospitals. Keyworkers support individuals and their families up to the age of 25yrs feedback from, and outcomes for individuals are positive. **As at end of April'24, 33 Wiltshire individuals have either been support, or are being supported by the keyworker service.**

Mental Health update



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

- **Severe Mental Illness Annual Health Checks (SMI AHC)**

National target for compliance with PHC is **76% (5,344)** of the register have a complete check. As at March'24 the Wiltshire compliance level is 61.8%. A BSW SMI AHC Improvement Group has been initiated, supported by both Primary Care and secondary mental health care provision. Compliance with SMI AHC for Melksham practices is *68.9% - higher than the Wiltshire average.

*aggregate data

- **NHS 111-2**

NHS 111-2 has gone live across BSW. The service forms part of the urgent and emergency mental health pathway and will support people to access the mental health support they require.



Melksham & BoA Collaborative

- Developed early 2023 as a 'Pathfinder' Test & Learn site to provide insights for establishing future Collaboratives.
 - Collaborative membership established by Spring 2023.
- Interim Chair provided by the PCN Manager, and agreed across the partnership, until formal roles appointed by Collaborative members.

Early Objectives for the Collaborative

- Complete a Readiness Review as a partnership to show where organisations are in their journey to develop the Collaborative.
- To agree an area of interest with a focus on prevention.
 - To explore data and define a cohort.
 - To engage with those within the chosen cohort.
- To develop a project plan incorporating interventions and outcomes reflecting the voice of the community.
 - To establish a Collaborative Structure.

Membership - Organisations

Wilts Council – Public Health

Wilts Council – Health Inequalities Team

Community First (VCSE)

Wessex Community Action (VCSE)

Age UK (VCSE)

Wilts Council – Area Boards

Wiltshire Health & Care

LA - Wiltshire Library Services

Melksham & BoA PCN

Alzheimer's Support Wiltshire (VCSE)

Wiltshire & Swindon Sport (WASP) (VCSE)

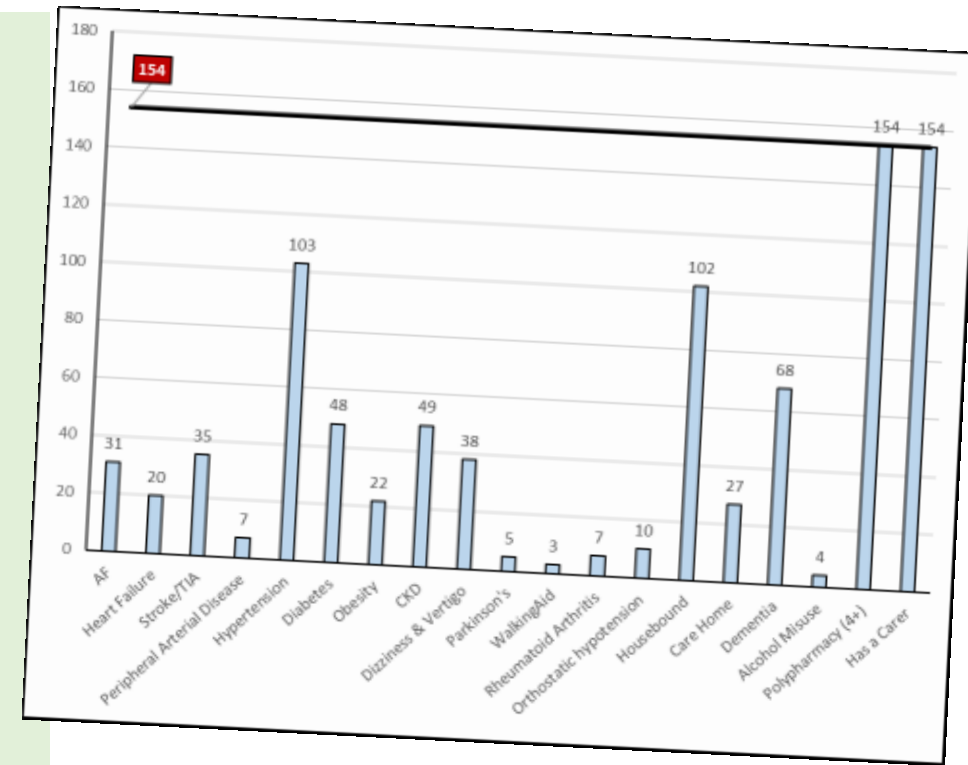
Carer Support Wiltshire (VCSE)

ICB

WCIL (Wiltshire Centre for Independent Living)

Melksham & BoA Collaborative -Achieving Early Objectives

- Readiness Review supported by partnership. Agreed area of interest – prevention of falls for those over 65 years requiring care and with a history of polypharmacy.
- Data interrogated by partners and cohort of 154 initially agreed – this was reduced to 40 after a pre-engagement rerun and criteria for inclusion were considered, (medically well, cognitively able to engage etc.).
- Project plan designed.
- Glass Cubes workspace created to facilitate communication between partners.
- Pilot engagement event designed. Resources list produced to aid conversations.
- Launch Programme Development Day developed to establish the Collaborative.



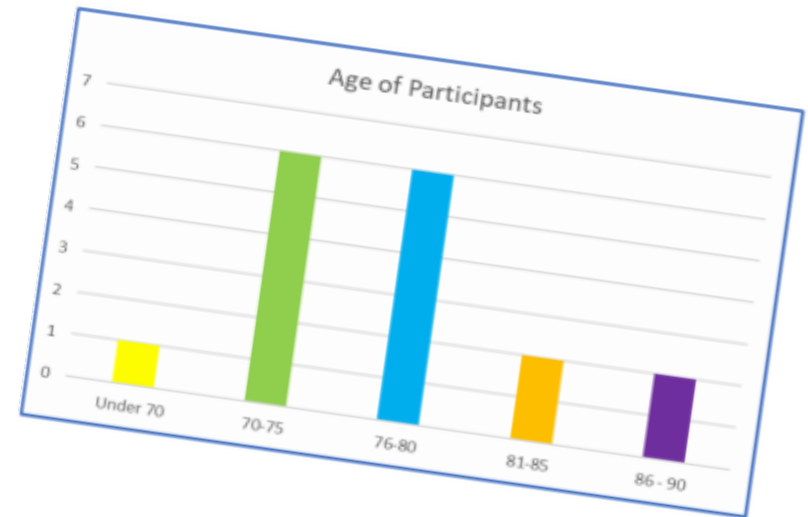
Engagement Event – pilot (Sept – Nov '23)

Supported by WCIL & PCN partners

16 participants – 8 males 8 females
11 cared for by a spouse/family member
1 received care from a care agency

KEY MESSAGES

- People want a personalised approach to the support – creative approaches within their own homes.
- Some had experienced falls but chose not to report to GP because they didn't see it as a significant event.
- People are aware and understand risks in their life. They don't want these risks to stop them living life as they wish to manage risks, whilst getting on with their lives.



REQUIREMENTS

- **Technology Enabled Care (TEC)** e.g., Alexa used rather than pendant alarm
- **Information about other services/ resources** e.g., Radar Keys, access to social events for carers and cared for individuals, equipment availability
- **Exercises classes managed in own home.** Pulmonary Rehab class that was "dull" and "repetitive" so had been developed at home. Slope prevented access to community classes



The Launch Programme Development Day – Nov '23

Partner outcomes

- Achieved a shared understanding of PHM and how it developed into the Neighbourhood Collaborative model.
- Accessed the toolkit and started to explore how the contents could help develop the Collaborative.
- Explored roles and responsibilities, and structural dynamics to help build and embed the culture and behaviours within the Collaborative
- Applied QI methodology to support the growth of the Collaborative and progress the project plan (understanding how to implement improvement and change within the Collaborative)
- Discussed key messages, outcomes and lessons learnt from the engagement.
- Understood the identity of the Collaborative by creating a sustainable vision for Melksham & BoA, (see below).



“Stay connected at every step”



Vision of a “fairytale” created by working differently together

Being part of a Collaborative is “a powerful motivator”.

Next Steps for Melksham & BoA (M & BoA) in 2024

Reflections following the engagement influencing next steps:

- Limited impact of recommendations due to limited number of participants.
- Lack of consent reduced the size of the cohort – comms used to publicise the engagement to be reviewed.
- Lack of uptake of current resources/ activities available in community– explore whether changes to the process could affect this uptake.
- Addressing health issues/concerns that form part of the conversation during engagement – additional support from Social Prescribers/ Health Coach services may help facilitate this process.

The next steps for M & BoA Collaborative are:

- Agree the partners who will oversee a second engagement across M & BoA.
- Agree the ways to implement adjustments to a second engagement event based on lessons learnt.
- Identify a second cohort using data metrics agreed by partners.
- Implement the second engagement and combine the outcomes/recommendations from the two events to develop interventions to support those within the community over 65 years old and at risk of falling.