Wiltshire Council

AGENDA

Meeting: **Health Select Committee**

Place: **Council Chamber - Council Offices, Monkton Park, Chippenham, SN15 1ER**

Date: **Wednesday 16 March 2022**

Time: **10.30 am**

Please direct any enquiries on this Agenda to Matt Hitch matthew.hitch@wiltshire.gov.uk, of Democratic Services, County Hall, Bythesea Road, Trowbridge, direct line or email matthew.hitch@wiltshire.gov.uk
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Membership:

Cllr Johnny Kidney (Chairman)
Cllr Gordon King (Vice-Chairman)
Cllr Clare Cape
Cllr Mary Champion
Cllr Caroline Corbin
Cllr Dr Monica Devendran
Cllr Gavin Grant
Cllr Howard Greenman
Cllr Antonio Piazza
Cllr Pip Ridout
Cllr Mike Sankey
Cllr David Vigar
Cllr Ernie Clark

Substitutes:

Cllr Liz Alstrom
Cllr Trevor Carbin
Cllr Jon Hubbard
Cllr Mel Jacob
Cllr Dr Nick Murry
Cllr Tony Pickernell
Cllr Ricky Rogers
Cllr Tom Rounds
Cllr Ian Thorn
Cllr Graham Wright

Stakeholders:

Irene Kohler — Healthwatch Wiltshire
Diane Gooch — Wiltshire Service Users Network (WSUN)
Lindsey Burke — South West Advocacy Network (SWAN)
Sue Denmark — Wiltshire Centre for Independent Living (CIL)

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

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

The full constitution can be found at this link.

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

AGENDA

PART I

Items to be considered whilst the meeting is open to the public

1 **Apologies**

To receive any apologies or substitutions for the meeting.

2 **Minutes of the Previous Meeting** *(Pages 7 - 16)*

To approve and sign the minutes of the meeting held on 11 January 2022.

3 **Declarations of Interest**

To receive any declarations of disclosable interests or dispensations granted by the Standards Committee.

4 **Chairman's Announcements**

To note any announcements through the Chairman.

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 Wednesday 9 March 2022 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 Friday 11 March 2022. 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 **Shaping a Healthier Future - Health and Care Model** *(Pages 17 - 62)*

The committee at its 11 January meeting received a presentation outlining the results of the public engagement exercise around the new health and care model being developed across the Bath and North East Somerset, Swindon and Wiltshire (BSW) region. The engagement ran from 2 November to 14 December 2021 and the formal report is now attached for information.

The project team will update the committee on the next steps for the programme as plans are developed ahead of the formal launch of the Integrated Care System in July 2022.

7 **Primary Care Update**

The committee to receive an update from Clinical Commissioning Group (CCG) officers on current priorities and performance as the organisation transitions to the formal launch of the Integrated Care System in July 2022.

8 **NHS Health Checks Programme in Wiltshire** *(Pages 63 - 72)*

A report is attached from the Director of Public Health updating the committee on the NHS Health Checks programme in Wiltshire, including how the programme is restarting following the impacts of the Covid-19 pandemic.

The committee is invited to input into the development of the community outreach element of NHS Health Checks and how this intends to address health inequalities across Wiltshire.

9 **Day Opportunities Transformation** *(Pages 73 - 90)*

A report is attached from the Director of Procurement and Commissioning outlining the council's intentions in relation to the transformation of day opportunities. The report will be considered formally by Cabinet at its 29 March meeting and the committee is invited to input in advance of this Executive decision.

10 **Rapid Scrutiny Exercise: Day Care Provision: Open Framework Tender; Lunch and Friendship Clubs** *(Pages 91 - 98)*

Full Council on 15 February 2022 invited Overview and Scrutiny (OS) to consider the transformation proposals for grant funded lunch and friendship clubs.

In response a rapid scrutiny (RS) exercise took place on 2 March 2022, the report of which is attached for consideration by the committee.

11 **Rapid Scrutiny Exercise: Housing Related Support** *(Pages 99 - 104)*

On 13 October 2021 a RS was undertaken where members concluded that they were satisfied with the council's preferred position to end the Housing Related Support (HRS) service on 31st March 2022. As part of the exercise members

agreed to meet in early 2022 to ensure that alternative support would be in place for residents up to and beyond 1 April 2022.

The second RS exercise took place on 11 February 2022, the report of which is attached for consideration by the committee.

12 **Forward Work Programme** *(Pages 105 - 106)*

The committee is invited to consider the forward work programme.

13 **Urgent Items**

To consider any other items of business that the Chairman agrees to consider as a matter of urgency.

14 **Date of Next Meeting**

To confirm the date of the next ordinary meeting as Tuesday 7 June, at 10:30am.

PART II

Items during whose consideration it is recommended that the public should be excluded because of the likelihood that exempt information would be disclosed

None.

Health Select Committee

MINUTES OF THE HEALTH SELECT COMMITTEE MEETING HELD ON 11 JANUARY 2022 AT COUNCIL CHAMBER - COUNTY HALL, BYTHESEA ROAD, TROWBRIDGE, BA14 8JN.

Present:

Cllr Johnny Kidney (Chairman), Cllr Gordon King (Vice-Chairman), Cllr Clare Cape, Cllr Dr Monica Devendran, Cllr Gavin Grant, Cllr Howard Greenman, Cllr Antonio Piazza, Cllr Pip Ridout, Cllr Mike Sankey, Cllr David Vigar, Diane Gooch and Irene Kohler

Also Present:

Cllr Ian Blair-Pilling, Cllr Richard Clewer and Cllr Jane Davies

1 **Apologies**

Apologies for absence were received from:

Cllr Mary Champion
Cllr Jack Oatley
Cllr Caroline Corbin
Lindsey Burke, SWAN Advocacy
Sue Denmark, Wiltshire Centre for Independent Living
Cllr Nick Holder
Elizabeth Disney, BaNES, Swindon and Wiltshire (BSW) Clinical Commissioning Group (CCG)
Tracy Cox, BSW CCG
Claire Thompson, Great Western Hospitals NHS Foundation Trust

2 **Minutes of the Previous Meeting**

Resolved

To confirm the minutes of the meeting held on 2 November 2021 as a true and correct record.

3 **Declarations of Interest**

There were no declarations of interests.

4 **Chairman's Announcements**

The Chairman announced that the meeting was being recorded and webcast online.

He reminded the committee that the new statutory date for the implementation of the Integrated Care System (ICS) had moved to 1 July 2022, allowing an additional three months to scrutinise the transition from the existing Clinical Commissioning Group (CCG) model.

The Chairman then invited committee members to an informal committee meeting on 21 January to consider the health and care aspects of the council's draft business plan.

Details of relevant recent meetings attended by the Chairman and Vice-Chairman since the previous meeting were also relayed to the committee, including with AWP and Wiltshire Health and Care. The Chairman reported that the Vice-Chairman and he had received a briefing on the new block contract for care homes and were happy with the approach being taken. They would attend a further meeting to consider the outcome of the procurement process.

5 **Public Participation**

Questions Q22-01 and Q22-02 were received from the following member of the public:

Mr Chris Caswill

The Chairman referred the committee to questions and written responses included in Agenda Supplement 1.

A supplementary question was received from Mr Caswill in relation to Q22-01. The member of the public asked whether the CCG would be invited to the March committee meeting to explain their analysis of the issues at Patford House GP Practice, to note the steps being taken to address the findings of the Care Quality Commission (CQC) inspection as well as to report the lessons learnt.

The Chairman thanked Mr Caswill for highlighting the issue. He noted that it was for the committee to maintain oversight to ensure that the CCG's plan was being put in place. To that end, the Vice-Chairman and he had arranged a meeting with the CCG's Director of Primary Care to discuss the CQC's report and the steps being taken by the CCG to address the issues raised. If, as an outcome of that meeting, it was deemed appropriate to bring the item to a future committee then that course of action would be taken.

A supplementary question was also received in relation to Q22-02. Mr Caswill clarified that his initial question related specifically to the future BSW Health and Care Model and specifically whether the committee endorsed, without comment, a policy proposal of digital by default consultation appointments. If this was not the case, he asked whether the committee would take the opportunity to question this during the 11 January meeting.

In response to Mr Caswill's question the Chairman reassured the public that the model would be discussed during item 10, so there would be the opportunity for members to debate the issue.

6 **Impact of Winter Pressures on Acute Hospital Services in Wiltshire**

The Chairman reported that in November the Vice-Chairman and he had attended a positive meeting with Stacey Hunter, Chief Executive Officer for the Salisbury NHS Foundation Trust, and that she had kindly agreed to provide an update on the pressures being felt by the acute hospitals supporting Wiltshire.

The chief executive gave an overview of the pressures facing the NHS and compared them to the winter pressures normally faced outside of a pandemic. Focusing specifically on the last few weeks, she reported that Royal United Hospital (RUH) in Bath and Great Western Hospital (GWH) in Swindon had both recently declared major incidents and that the RUH still had a critical incident declared.

She explained that the need to separate Covid-19 infected and non-infected patients made the delivery of services more complex and meant that hospital infrastructure couldn't be used at 100 percent capacity. However, she was keen to stress that there were a number of incremental factors causing the pressures, such as staff shortages, increased demand and issues around hospital discharge.

The chief executive stressed the importance of working together and was keen to thank local partners for their support, explaining that positive things could be built upon the back of those relationships. She highlighted that it was important for the trust to understand how it could best use its expertise to contribute to the local community.

During the discussion points included:

• Members thanked the chief executive for the update and were pleased to hear about the collaborative working between primary care and community services.
• In response to a question about why the RUH had so many staff absences, 781 as of 5 January, when compared to Salisbury Foundation Trust, the chief executive stated that one possible reason was that many RUH staff lived in Bristol, an area with higher Covid-19 rates.
• Questions were also asked about the contribution of mental health issues to staff absence and it was noted that mental health issues were in the top three issues for absence, but this had been the case pre-pandemic.
• In response to a question about the relatively high level of Covid-19 admissions to GWH, it was noted that Swindon had a higher community infection rate than other areas such as Salisbury.
• The chief executive spoke about the importance of ensuring equal access to healthcare services in achieving consistent patient outcomes across communities.

• Cllr Richard Clewer, Leader of Wiltshire Council and Co-Chairman of the Health and Wellbeing Board explained that the council was looking into the factors contributing to inequality in order to holistically address systemic issues. He noted that the Health and Wellbeing Board would be focusing on health inequalities as part of this work.
• The chief executive stated that restrictions had reduced the numbers of hospital admissions. Of patients found to have Covid-19, approximately two thirds were admitted because of the condition and around a third were incidental findings, where Covid-19 was found after testing.
• When asked about potential changes to self-isolation rules, the chief executive noted that there could be benefits in staff being able to return to work earlier than under the current rules.

Resolved

1) To thank the Chief Executive, Salisbury NHS Foundation Trust, for the update.
2) To acknowledge the committee's appreciation of the work of health and care staff in their response to the pandemic.
3) To note the commitment within the system to address health inequalities.

7 **Overview of Adult Social Care Winter Pressures**

Emma Legg, Director for Adult Care, Living and Ageing Well, introduced the report noting that it had been written before Christmas, so the figures had changed. The director reported that there had been unprecedented demand for supported discharge over the past two years. To illustrate this point, she highlighted that in 2019/20 they had purchased 60 care home beds for people needing 24 hours support, once they had been in hospital, but that the current figure stood at 143. There had also been a marked increase in the number of referrals to the reablement service.

The director drew attention to the council's new in-house domiciliary care service Wiltshire Support at Home, stating that it was now delivering more hours of care than anticipated and was allowing them to better support patients as they were being discharged.

Concerns were raised about the recent increase in the number of care homes being closed due to Covid-19, 53 at the time of the meeting. However, the director noted that the majority of Covid-19 outbreaks were now community infections found in staff, rather than in the residents themselves. Staffing was an area of particular concern with over 700 provider staff having left their jobs in the last six months.

During the discussion points included:

• In response to a question about the number of patients being readmitted, 27 percent within four weeks of discharge, the director reported that the figures

related to the reablement service, where patients tended to have a high degree of need. It was reported that the situation was being monitored and the council was working closely with acute providers.

• When asked about the long-term viability of domiciliary care providers working with the council, the director noted that providers had their own sustainability plans, but they were encouraged to notify the council of issues as early as possible. It was reported that the council's commissioning and brokerage teams worked closely with providers and through Wiltshire Care Partnership. Mitigation measures were in place and nationally there had been changes to funding packages for discharged patients.

• Given the staffing pressures in the industry, care was taken not to recruit from other providers wherever possible. The director spoke about the importance of promoting care as a career and of using the apprenticeship levy. The reasons for West Wiltshire losing a larger proportion of its workforce than other areas of the county were unclear, but she noted that there were more retail opportunities located in that area.

• It was reported that the Wiltshire Support at Home Service was still new but focused on expanding capacity. Modelling was ongoing to access the impact of the service.

• Members asked about the use of the Shared Lives Programme in supporting hospital discharge. The director noted that this was being used by some local authorities (LAs) and explained that Wiltshire was keen to liaise with other LAs to learn about their experiences. Work was also being done to review the use of technology, although there was not a one size fits all approach.

• In response to a question about the use of prophylactic natural supplements in supporting immunity, Dr Peter Collins, Chief Medical Officer at Salisbury Foundation Trust, noted that a number of Covid-19 medicines were in development and it was hoped that this would reduce pressure on hospitals over time. Prophylactic treatments would likely be used in subsequent iterations of Covid-19 as the population learned to live with the disease, but the current focus was primarily on measures such as mask wearing and social distancing.

• Chief Executive Officer for the Salisbury NHS Foundation Trust, Stacey Hunter, explained that the care system should be a health model, rather than an ill health model, so lots of work was being done to focus on reducing admissions by aging and living well.

• In response to a question about how help from the voluntary sector was being organised, the chief executive stated that they had rethought their workforce strategy to see to make the most of the resources offered by the voluntary sector.

• Cllr Jane Davies, Cabinet Member for Adult Social Care, SEND, Transition and Inclusion, spoke about the importance of co-working. She explained that the council's new Prevention and Wellbeing Team would work alongside Community Engagement Managers (CEMs) to assist the community sector.

• Lucy Townsend, Corporate Director of People, reported that a Home from Hospital Service contract was due for tender and they were encouraging bids from the voluntary sector. A further contract for day care opportunities would also be open to voluntary sector bids.

Resolved

1) To note the contents of the report.
2) To recognise the work of the council in its support of the provider market.
3) To acknowledge and express the committee's appreciation to care staff and the voluntary sector in their response to the pandemic.
4) To invite a further update within six months, updating on the challenges facing adult social care and its ongoing response.

8 **BSW Diagnostics Programme Update**

Dr Peter Collins, Chief Medical Officer at Salisbury Foundation Trust, referred the committee to the report starting on page 33 of the agenda pack updating the committee about the national diagnostics programme and how it would impact local residents. The doctor noted that the need to provide urgent care during the pandemic had impacted routine testing. He reassured the committee that diagnostics would be a key part of the integrated care system and then invited them to provide comment on the report.

During the conversation key point included:

• Members thanked the doctor for the report. The chief medical officer noted that it was not yet a fully formed plan as he wanted to give the committee and the public a chance to input into the proposals.
• In response to a question about how transport had been considered in the development of the programme, the chief medical officer reassured the committee that this had been an important consideration due to the rural nature of the area. The aim was to deliver care as close to the population as possible. He explained that it was difficult to move around CT scanners, but the aim was to separate elective and emergency work.
• The doctor stressed that staffing was an important consideration when deciding where to locate sites, as experts were required to interpret the results and it was vital to employ the staff as efficiently as possible.
• When asked about whether the aim was to create a one-stop-shop, he stated that it could be a way forward, but some compromises might be required. The chief medical officer explained that a one-size fits all approach would not be suitable for all patients and services had to be delivered based on the resources available.
• Members asked questions about the financing of the programme and it was stressed that it was anticipated that there would be a number of funding bids to the national programme.
• Mark Harris, Director of Commissioning at BSW CCG, confirmed that the revenue cost, money over and above the standard funding provided, of the MRI scanner on the Sulis Estate in Bath was approximately £800,000 per year. The revenue cost of providing additional transport, to reduce the time needed to wait for phlebotomy results, was around £400,000 annually. Additional FeNO testing had revenue costs of roughly £200,000 per year. He also confirmed that funding was in place for five years, with around £20 million revenue funding per year. Further demand modelling, and a productivity review of existing services, would influence the business case as the programme developed.

• In response to a question about the distribution of the hubs, the chief medical officer noted that it was anticipated that there would be one diagnostic centre in each of the three places of the ICS (BaNES, Swindon and Wiltshire) but the final distribution would depend on local need.

Resolved

1) To thank officers for the update.
2) To welcome the aspirations documented in the report.
3) To invite a further update to the committee as plans become more refined.

9 **Better Care Plan**

Melanie Nicolau, Head of Resources and Commissioning at Wiltshire Council, invited the committee to consider the Better Care Fund plan after its consideration by the Health and Wellbeing Board on 2 December 2021. She reported that the Better Care Fund was a pooled budget shared between Wiltshire Council and BSW CCG. She then explained that the plan offered opportunities to support the integration of health and care, had to be evidenced based and meet a series of central government conditions.

During the discussion the following points were made:

• Members thanked the officer for the report.
• In response to a question about the number of patients being discharged from hospital whilst receiving end of life care, the officer stated that an audit had been carried out and stressed importance of providing wrap around support in different settings, such as in the home or in hospice care, rather than relying on a bed-based strategy.
• Emma Legg, Director for Adult Care, Living and Ageing Well, stressed that lots of work was being conducted within the Integrated Care Alliance to ensure that a collaborative management structure was in place between Wiltshire Council and other local partners.
• When asked about the progress made towards achieving the aspirations identified in the report, the Head of Resources and Commissioning explained that a large amount of work had already taken place and gave the establishment of the Rapid Response Service within seven months as an example of how health and social care teams had effectively worked together. She stated that further work could be done with the voluntary sector enhance the prevention agenda as we transition out of the pandemic.
• It was noted that the Better Care Fund could work with other funding areas to provide additional support to areas such as mental health provision.
• Members asked questions about what was included in the plan to address workforce issues and in particular to attract older workers and those currently in education. Lucy Townsend, Director of People, stressed that the plan focussed on Wiltshire, but work was being done jointly with partners across the whole of the BSW area to address workforce issues.
• Emma Legg, Director for Adult Care, Living and Ageing Well, explained that work was being done to promote a career in care to people across the whole

age range to ensure that talented individuals were not being excluded from applying.

Cllr Greenman left the meeting at 16:50pm.

Resolved

1) To thank officers for the update on the Better Care Plan 2021-22.
2) To note the importance of a system approach in ensuring its successful delivery.
3) To invite a future update on the workforce strategy currently being developed.

10 **Shaping a Healthier Future - Health and Care Model**

Geoff Underwood and Simon Cook, programme directors at Shaping a Healthier Future updated the committee on the results of their six-week public engagement that had taken place between 2 November and 14 December 2021. The directors reported that they held 51 engagement events over the six-week period, cumulatively attended by over 1,400 people, when allowing for double counting of those attending more than one event. They had also reached out to harder to reach groups, such as those representing asylum seekers, and received a total of 915 responses to their online survey.

The proposals had generally received a positive response, although respondents were keen to have more detail, particularly about specific localities or conditions. Results showed that the public were also appreciative that the consultation had taken place and welcomed further opportunities to input into the plan as it developed. The directors stated that further detail would be forthcoming as the health and care model progressed and discussions would be ongoing with the integrated alliances across BSW. By the time that the ICS becomes statutory in July 2022 they anticipated that there would be a high level of alignment in order to deliver the care model. The final report about the findings of the consultation would be published on 17 January.

The directors stressed that the business case for capital expenditure at Bath RUH was contingent on the model taking place. The business case could not be put forward until the committee, and equivalent bodies in BaNES, were satisfied that formal public consultation on the new model of care was not required. The directors explained were keen to attend the March committee meeting to understand what further engagement that the committee felt was necessary and stressed that public engagement would be ongoing as the model developed.

During the discussion the following points were raised:

• Members thanked the directors for the update and commended the breadth of the consultation, commenting that many of the points raised echoed the feedback given to councillors. They were also pleased to see the recognition of the demographic changes facing Wiltshire reflected in the plans.

• Cllr Jane Davies, Cabinet Member for Adult Social Care, SEND, Transition and Inclusion, stated that Wiltshire Council was excited about working collaboratively and that it was important to ensure that the voices of partners, such as Wiltshire Council, were adequately reflected in the plans.
• The cabinet member expressed disappointment about the level of engagement with the council's public health team that had taken place and asked for a commitment to meet with the Corporate Director for People to discuss alignment with adult social care. In response the directors explained that they had held meetings with some of the local authorities within BSW, including the public health team in BaNES and would be happy to meet with officers. The also pledged to produce a narrative document to provide greater detail about the development of the plans.
• The directors noted that respondents had expressed reservations about the language relating to digital by default appointments, so this would be reviewed to reassure the public that it was not the intention to hold all appointments remotely. The directors were keen to stress that digital appointments would not be appropriate in many cases.
• Given that the consultation was primarily carried out online, concerns were raised that the views of those without internet access would not have been reflected in the results. The directors noted that an in-person meeting had been held with a group representing mothers and paper copies of the survey had been made available in GP surgeries. However, they did accept that the opinions of those without internet access could have been underrepresented and pledged to consider how they could be better reflected in future.
• In response to a question about the role of the voluntary sector in the consultation the directors reported that they had involved the Wiltshire Voluntary Sector Leadership Alliance. They also took onboard a comment by a stakeholder of the committee that it would be useful to work with CEMs given their contacts with voluntary organisations in Wiltshire.
• Members stated that they would welcome a report about the development of the Health and Care Model in relation to the wider developments within BSW to gain a clearer understanding of the roles and responsibilities of different actors within the ICS. The directors stated that they would pass that feedback onto colleagues to see who would be best placed to provide further information to the committee.
• When asked about the emphasis that would be placed on signposting patients to the relevant services, the directors explained that those details would be developed locally, as a uniform approach would not necessarily be the most effective.
• The directors committed to circulating the final report of the findings of the survey well in advance of the March committee meeting.

Irene Kohler and Diane Gooch left the meeting at 17:28pm.

Resolved

1. To thank officers for the update.
2. To welcome a further update on the developments on the engagement plan.

3. To request further detail on the proposed model being developed by the project team.
4. To invite a future update defining roles and responsibilities within the Integrated Care System.
5. To request that officers meet with the Corporate Director for People in advance of 16 March to discuss alignment with adult social care.

11 **Forward Work Programme**

The Chairman announced that, in addition to the items on the Forward Work Plan, he had also asked the Chief Executive of Wiltshire Health and Care to brief the committee in March on some of the transformational work they are currently undertaking.

During the discussion members asked whether the Chief Executive of BSW could also be invited to the meeting. The Vice-Chairman also reassured the committee that they would be meeting the Director of Primary Care at the CCG and would discuss the steps being taken to address the issues at Patford House GP practice.

Resolved

1. To note the Forward Work Programme.
2. Invite the new Chief Executive Officer of BSW to a future meeting of the Health Select Committee.

12 **Urgent Items**

There were no urgent items.

13 **Date of Next Meeting**

The date of the next ordinary meeting was confirmed as Wednesday 16 March 2022, at 10.30am.

(Duration of meeting: 2.30 - 5.45 pm)

The Officer who has produced these minutes is Matt Hitch matthew.hitch@wiltshire.gov.uk of Democratic Services, direct line , e-mail matthew.hitch@wiltshire.gov.uk

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

Bath and North East Somerset,
Swindon and Wiltshire Partnership

Working together for your health and care

Shaping a Healthier Future Engagement Report

February 2022

Contents

1. Introduction

In early 2020 the Bath and North East Somerset, Swindon and Wiltshire (BSW) Partnership published priorities for the delivery of health and care services across the region. These priorities were the results of discussions with health and care staff and local residents and were developed into a model that outlined the collective vision for the way forward. Shortly after publication, resources had to be focused on dealing with the pandemic. In October 2021 BSW Partnership was able to return to those plans in the light of learnings from the pandemic and wanted to test with the local population whether the health and care model was still the right one or whether any changes need to be made.

An independent public engagement consultant, Martha Cox of Engagement Solutions, was contracted to plan, manage and deliver a six-week public engagement project around the health and care model, focusing specifically on those facing health inequalities. She worked closely with the Bath and North East Somerset, Swindon and Wiltshire (BSW) Clinical Commissioning Group's (CCG) and Royal United Hospitals Bath NHS Foundation Trust (RUH) communications and engagement teams and South, Central and West Commissioning Support Unit.

2. Aims of engagement

1. To raise awareness and inform local population about the BSW Partnership, why we need a health and care model and what it means for local people and communities.
2. To have a two-way dialogue with stakeholders about the key principles that underpin the health and care model to understand the barriers to access and the impact of these, particularly on those most affected by health inequalities.
3. To provide details to the public of how they can keep involved in the work going forward.

3. Approach

Public engagement on Shaping a Healthier Future ran from 2 November to 14 December 2021. A public survey and a series of webinars, workshops, interviews and presentations with health and care staff, people who use local health and care services and the voluntary, community and social enterprise (VCSE) sector took place during this time-period. In addition, two virtual webinars were held that were open to local people and communities to attend.

The survey, workshops and webinars were publicised through social media, local networks, community newsletters, local media and presentations to key staff groups and other local organisations. The Partnership's collective networks and contacts were used to amplify the engagement campaign.

Case studies were used to highlight examples of the new ways of working and a video was produced that was available on the BSW Partnership website which explained the health and care model in detail.

3.1 Engagement with those experiencing health inequalities

Leaflets and printed copies of the survey were widely distributed to GP practices (via the Primary Care Networks), community centres and housing associations to ensure that those who were digitally excluded also had an opportunity to participate and give their views. The surveys had a physical return address for people to respond.

Over 39 VCSE organisations who work with those experiencing health inequalities (excluding VCSE networks) were contacted directly with the request to engage with their clients. 69 per cent of organisations responded and workshops and/or interviews were then organised with people with lived experience of health inequalities, or frontline staff working with those experiencing health inequalities.

3.2 Children and Young People

The BSW Partnership has contracted Participation People to run a year-long participation project with children, young people and families with lived experience of services across the region. They will establish a Youth Voice Task and Finish Group, Young Champions and four Listening Labs to explore what works, where the gaps are and review proposed service and pathway changes that are developed in response to application of the health and care model.

4. Results

During the engagement period **1,441** people were engaged with at **65** events. In addition, **918** people completed the survey. **40** people were spoken to directly about their experiences of health inequalities. These included refugees and asylum seekers, people with learning disabilities and autism, members of the LGBTQ+ community, people with chronic long-term conditions, an unpaid carer and people recovering from alcohol and substance misuse.

26 per cent of these events were in person and 74 per cent online.

Type of Engagement Activity	Number held
Presentations	25
Meetings	6
Workshops / webinars	13
Interviews	21

4.1 Social Media campaign results

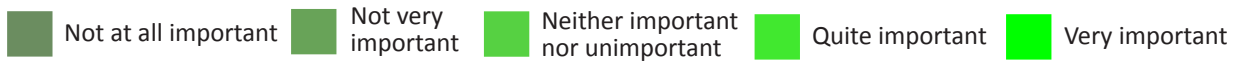
The survey and public workshops were publicised on all the BSW CCG social media networks – Facebook, Instagram, Twitter and LinkedIn. There were 14,000 impressions received and the average engagement rate was 1.9% (the industry standard is 1 – 1.5%). Content performed best on LinkedIn with a 6.1% engagement rate. The link to the survey and/or workshops received the most clicks from accounts on Twitter, compared to the other profiles. Partnership organisations also promoted the engagement exercise via their social media channels.

4.2 Survey responses

Survey respondents were asked to rate the importance of our health and care model principles:

Survey Responses

Personalised Care – overall importance rating of **93%**



Care arranged specifically for you will be at the heart of everything we do in the future

In this reponse, 'Not at all important' scored 0%. The combined total for 'Quite important' and 'Very important' is **90%**

Decision making jointly between you and your care professionals will enable people to make informed decisions and choices when their physical or mental health changes.

In this reponse, 'Not at all important' scored 0%, 'Not very important' scored 1%. The combined total for 'Quite important' and 'Very important' is **96%**

We will use personalised care and support planning to support people with long-term physical and mental health conditions to build the knowledge, skills and confidence to live well with their health conditions.

In this reponse, 'Not at all important' scored 0%, 'Not very important' scored 1%. The combined total for 'Quite important' and 'Very important' is **95%**

People with complex needs will be supported by staff from different professions working together and we will use tools like personal health budgets so that people can take charge of their own care.

In this reponse, 'Not at all important' scored 1%, 'Not very important' scored 1%. The combined total for 'Quite important' and 'Very important' is **92%**

Survey Responses

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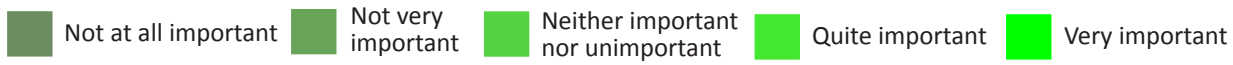

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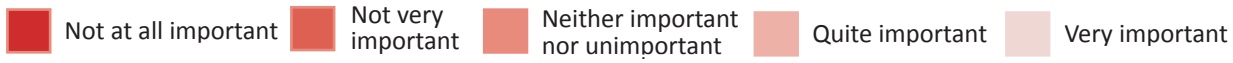
In this reponse, 'Not at all important' scored 1%, 'Not very important' scored 1%. The combined total for 'Quite important' and 'Very important' is **92%**

Healthier Communities – overall importance rating of **88%**



We will build communities up by working with their strengths

In this reponse, 'Not at all important' scored 1%. The combined total for 'Quite important' and 'Very important' is **80%**

Health and care professionals will be able to refer people to a range of local, non-clinical services that will enable people to take more control of their own health

In this reponse, 'Not at all important' scored 1%, 'Not very important' scored 1%. The combined total for 'Quite important' and 'Very important' is **90%**

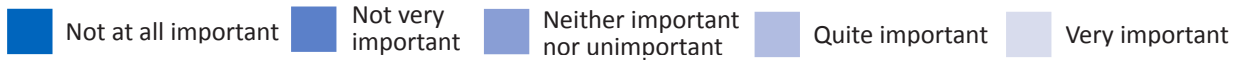
Local health and social care teams will have access to good data about the communities they work in so they can provide proactive support to communities and individuals so they can maintain good health and wellbeing.

In this reponse, 'Not at all important' scored 1%, 'Not very important' scored 1%. The combined total for 'Quite important' and 'Very important' is **87%**

We will work to prevent illness and reduce health inequalities in all our communities

In this reponse, 'Not at all important' scored 0%, 'Not very important' scored 0%. The combined total for 'Quite important' and 'Very important' is **96%**

Joined Up Local Teams – overall importance rating of **94%**



When people need health or care support local teams with NHS, local authority and third sector members will work together to provide that support.

In this reponse, 'Not at all important' scored 1%, 'Not very important' scored 1%. The combined total for 'Quite important' and 'Very important' is **93%**

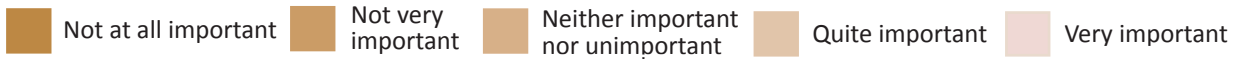
Teams of health and social care staff will be set up locally to meet local needs

In this reponse, 'Not at all important' scored 0%, 'Not very important' scored 1%. The combined total for 'Quite important' and 'Very important' is **92%**

Co-ordinators will make sure that the support people need is joined up and works for them.

In this reponse, 'Not at all important' scored 0%, 'Not very important' scored 0%. The combined total for 'Quite important' and 'Very important' is **96%**

Local Specialist Services – overall importance rating of **84%**



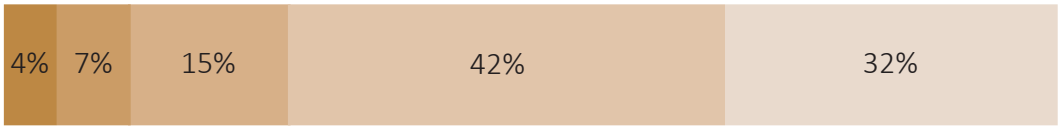
More specialist services will be available closer to where people live

In this reponse, 'Not at all important' scored 1%, 'Not very important' scored 1%. The combined total for 'Quite important' and 'Very important' is **91%**

We will make more use of community locations like public buildings and high streets to provide access to information, appointments, group sessions, tests and treatments.

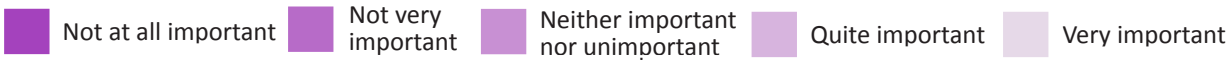
In this reponse, 'Not at all important' scored 1%, 'Not very important' scored 2%. The combined total for 'Quite important' and 'Very important' is **88%**

Digital technology will enable more services to be delivered remotely so there will be less need to travel to attend appointments in person.



The combined total for 'Quite important' and 'Very important' is **74%**

Specialist Centres – overall importance rating of **88%**



As more services are available online and in community locations, our NHS, local authority and third sector specialist centres will be able to focus more on providing specialist care.

In this reponse, 'Not at all important' scored 2%, 'Not very important' scored 3%. The combined total for 'Quite important' and 'Very important' is **83%**

We will invest in our specialist centres to make sure that they are ready to meet the needs that our population will have in the future.

In this reponse, 'Not at all important' scored 1%, 'Not very important' scored 1%. The combined total for 'Quite important' and 'Very important' is **91%**

The health and care professionals in our centres will be able to do more to support local teams and people in their own homes.

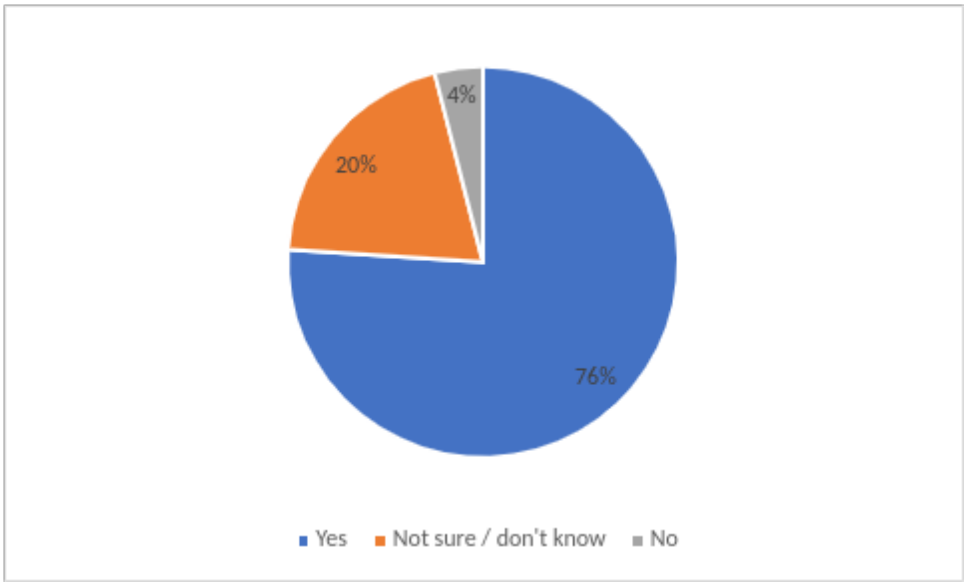
In this reponse, 'Not at all important' scored 1%, 'Not very important' scored 1%. The combined total for 'Quite important' and 'Very important' is **90%**

4.3 Combined survey, workshop and interview results

Survey respondents and workshop and interview participants were asked further questions about the model:

4.3.1 Understanding of the model

In response to the question 'taking into account everything you have seen and read so far about the proposed new model for health and care in the region do you feel you have a reasonable understanding of it?' there were the following results:



Comments

- Many felt positive about the model and felt that it was clear, ambitious and had excellent principles. A number of respondents expressed frustration with the shortcomings of the current system like the difficulty of getting access to a GP and long waiting times and hoped that this model would address some of those issues – a belief that the unwritten assumption of the model was to relieve pressure on the system.

> *"In principle it is easy to understand and entirely logical and should already form the basis of a collaborative, multi-faceted social care system."*
> ***Survey Response***

- The aspiration for better integration and collaboration between the VCSE sector and the statutory and other sectors was welcomed, though some respondents said there was a need for greater understanding about the joint working. The model was felt to be about values and attitudes, improving communication and not making assumptions. The hope was expressed that the language of collaboration is part of learning in the new BSW Academy.

- An unpaid carer welcomed the data sharing and hoped that would stop the need for patients to explain their story many times with many different professionals.
- Some respondents felt the model is very much about values and attitudes and improving communication and not making assumptions. The emphasis on preventative care was welcomed.
- Many were keen that it wasn't a one size fits all approach.
- How the model and changes were communicated across providers, systems and with the public was seen as being really key to getting people engaged.

"This may enable groups to access care more often and avoid bigger problems in the future."
Survey Response

- To counteract the positive comments above there was a degree of cynicism about the model, as well, with many not being convinced that it will happen, especially given current issues and without huge investment.
- A number of people were withholding judgement until a greater level of detail about how the model will work in different geographical locations, for different conditions and for different communities is shared. The model was felt to lack wider context, scheme of reference, background, explanation for how it will be realised, what has gone wrong before and why this will be different, weaknesses in the system and how to address them, alternatives to the model proposed and barriers.
- Some felt that the model ignored the current issues facing the system and was vague about definitions like 'community' and the difference between specialist services and specialist centres. The model was also felt to be vague about the assumptions and data underpinning it.
- Some didn't understand how the new system would be organised or how health professionals would engage with the local authorities and other organisations.

"I think that the information provided has been detailed enough to gain enough information but also simple enough for everyone to understand."
Survey Response

4.3.2 How respondents would rate the model

In response to the question 'taking everything into account that you have seen and read so far about the proposed new model, how do you rate it?' there was an overall rating score of 6.9 on a scale of 1 – 10.

Comments

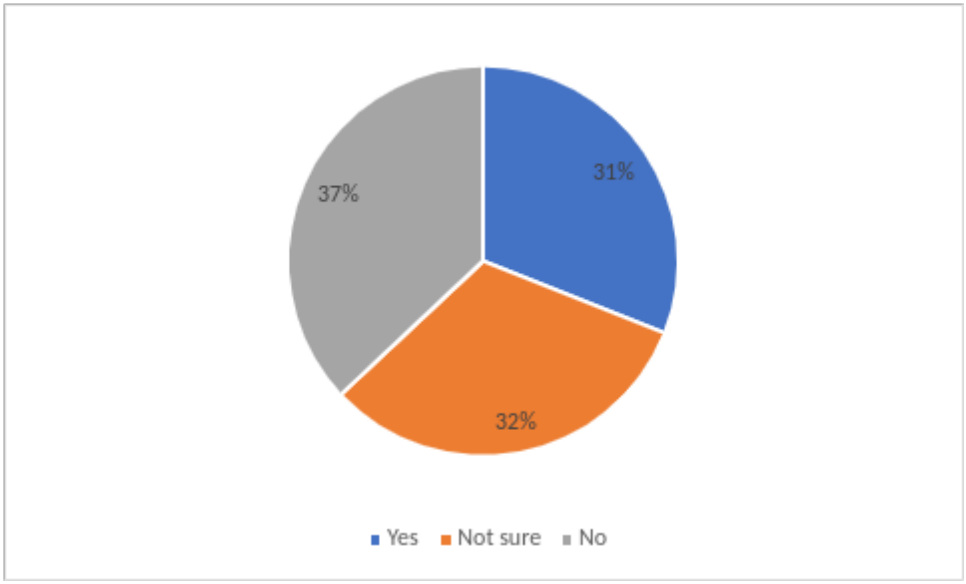
- There was concern expressed about the things the model isn't in control of – for example a decision by a developer will influence the level of physical activity in a particular locality. Some felt that the model is based on a lot of assumptions that people are going to sign up and be committed to the whole approach when actually there is very little control over some people and organisations and the decisions they make. The point was also made that key partners may be working to very different agendas to the one the model is working to.
- Many felt that as a vision it works and felt optimistic and enthusiastic about it but that it is very aspirational, yet to be tested and there are so many changes and service redesigns that will have to happen to make it work.

"Yes it's highly aspirational but I can see it all working if we work together."
Survey Response

- A number of respondents felt the model was too health focused and it felt like some of the decision making around governance is about the NHS allowing social care and the VCSE sector to, as one respondent put it; 'have some crumbs from the table' - that these sectors were almost an adjunct.
- Staff from Julian House (refugees, homeless, travellers, boaters, ex-prisoners) felt that their clients wouldn't fit into the model, particularly from a mental health point of view, as they don't generally engage with mainstream services and are reluctant to trust professionals. Language is another barrier if English is poor. They felt that most mainstream services struggle to deal with the complexity and trauma a refugee brings. Many of these most vulnerable communities are therefore hugely isolated from wider support and services.

4.3.3 What is missing from the model?

In response to the question 'is there anything missing from the model that is important to you or your clients?' there were the following results:



Comments

A number of areas were raised by respondents as requiring more focus:

- A plan to tackle the backlog, waiting lists, the bottlenecks of people still in hospital waiting to be discharged, the staffing crisis in care homes.
- Social prescribers. The role of volunteers. Dentists. Pharmacists. Private care. Links to private specialists like psychologists. Specialised community post-natal services and post-natal care. Out of hours services. Radiological Diagnostics. Elective surgery. Maternity services.
- Continuity of care – especially for those with long-term conditions and unpaid carers.

"The importance of continuity of care and how digital solutions can recognise and support the role of unpaid carers eg can enable them to join phone / video calls."
Carers Wiltshire on Twitter

- Aftercare. Provision for those with special needs – physical or emotional ongoing support and follow up. Support for single people convalescing after hospital. More community hospital beds. Packages of care don't cover night needs – essential to help people stay at home. Supporting carers with own complex needs. Dying well. Transition from childrens to adults' services. Provision for the LGBTQ+ community.

"With more support I could be more involved."
Survey Response

- Issues around physical access like parking, cost of travel, rural isolation

- There were repeated requests for a greater emphasis on mental health and the physical implications, for example, an enhanced link between maternal and paternal mental health services and post-natal care.
- Some thought there was potential within the model for disparity of opportunity. A lot of the time there is knowledge assumed about the system that more vulnerable clients such as asylum seekers, just don't have.
- Patient / public education so people can make informed decisions about treatment and illness prevention
- Key wider determinants of health – employment, housing, childcare, low income, fuel and food poverty. Reducing health inequalities.
- How to join two models that are vastly different from a funding point of view – with health being accessible to all and free at the point of delivery vs social care that is all means tested and reliant on people meeting eligibility criteria.
- Barriers, asset mapping, horizon scanning, impact of Covid, shared NHS and local authority budgets. How decisions will be made, what criteria will be applied, current demand, envisaged demand, population size, spread and age, investment plans already made, how to achieve consistency across different demographic areas. Local accountability. Monitoring.
- Housing and population growth.
- Link with other transformation and integration programmes currently underway, for example in Swindon.
- The need to recognise the really good, localised work already going on in communities, particularly by the voluntary sector, to address health inequalities. VCSE need true equity and investment. A request for more clarity about expectations of the VCSE sector.
- The need to recognise the good practice that already exists within health and not dishearten staff.
- A plea was made for better communication about waiting times and a tiered system so people don't go straight to A&E.

4.3.4 Views on changing how people access services in line with the new model

In response to the question 'how willing are you or your clients to change how you or they access services in response to our new model?' there was an overall rating score of **6.8** on a scale of 1 – 10.

Comments

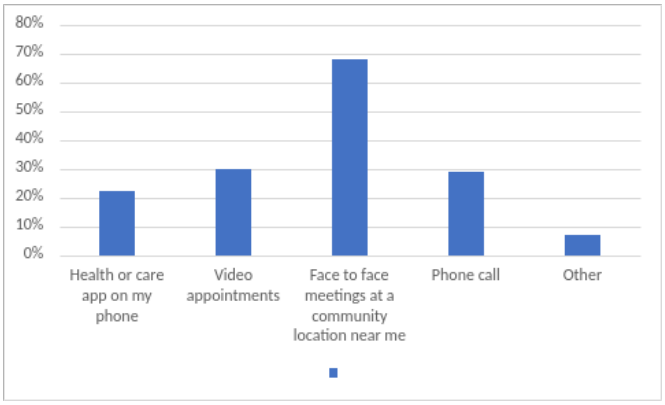
- Many felt that putting more services closer to where people live, rather than expecting them to travel to big centres, would be of benefit and that this has the potential to work really well in rural areas. This was felt to be particularly true if services are going to be more effective, efficient and streamlined – although a transition period would be needed. The Polish Consul, for example, felt that the Polish community will love the local options.
- Others thought that adapting to new ways of accessing services would depend on personal ability to use IT, financial situation, data allowance on phone, access to wi-fi and other pressures.

- Some organisations, for example, Swindon Women's Aid, believed that most of their clients would adapt to new ways of working.

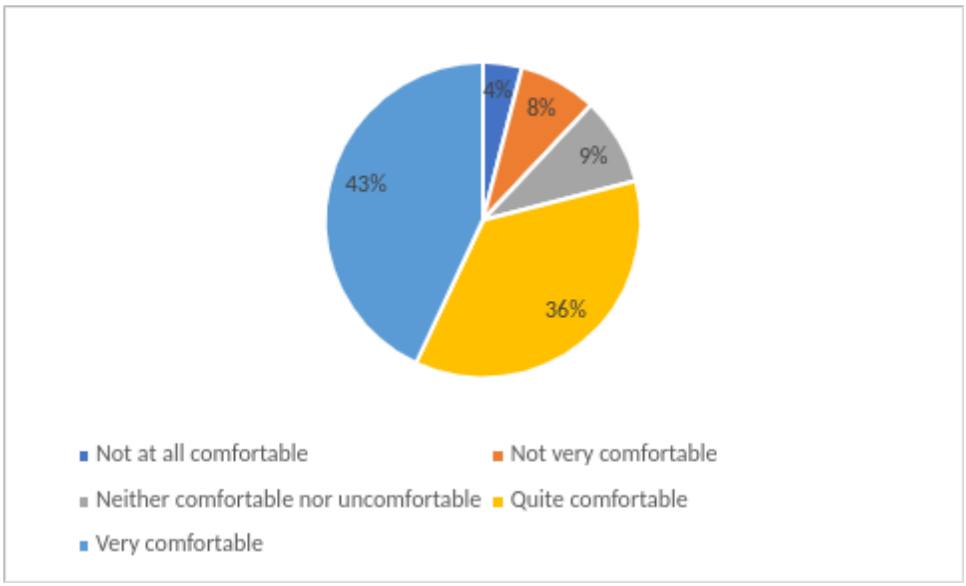
4.3.5 Importance of personalised care

In response to the question 'How best do you or your clients like to communicate with professionals to make sure their care is personalised to them and how comfortable are you or your clients with a digital approach?' there were the following results:

Preferred method of communication:



Level of comfort/discomfort with a digital approach:



Comments

- Much concern was expressed by respondents that digital won't work for everyone, for example, those with dementia, brain injuries, speech and comprehension difficulties. Those with poor literacy or language difficulties also struggle with being online and risk indirect discrimination if there are insufficient alternative language and easy read options. Those with sight impairments wouldn't know if they had been emailed. Many disliked the word

'default' and felt more explanation was needed about how that would work in practice. The model will need diversity that includes digital but as part of a range of communication options – a hybrid model. Any online system also needs to be simple, user friendly and tested by patients and the public.

"People may use digital once and fail and if they don't get a good experience that's it and they'll never use it again – we hear that a lot."
Citizens Advice Wiltshire

- Some worried that over-reliance on digital solutions has the potential to worsen health inequalities and that robust alternative access is needed for the most vulnerable groups to ensure that people don't fall through the cracks. For example, clients of the Harbour Project (asylum seekers and refugees) need the privacy to have conversations about healthcare. Most people have got some sort of device but many couldn't use it to make appointments. If the digitally excluded could, for example, just walk up the road to a local church or community centre where there was someone to help them make a video call or other online activities, then that would be massively helpful.
- Some asked whether equipment would be supplied for those without access and how will this be installed, replaced, accessed or paid for?
- It was suggested that there could be a system of identifying early on what people's communication preference is – as everyone is going to be slightly different.
- There was a fear that over-reliance on online services can breed an isolation culture – particularly for those already experiencing mental health issues. There's some nervousness from clients about having sensitive personal discussions online.

"You sometimes just want to be in a room with someone you know."
Workshop attendee

- Many, but far from all, felt that face to face in person needs to remain the best option, for example, there was a request to keep face to face in people's homes as vulnerable people are being missed and issues with safeguarding are easily missed online. A patient representative said that bad news should always be delivered face to face.

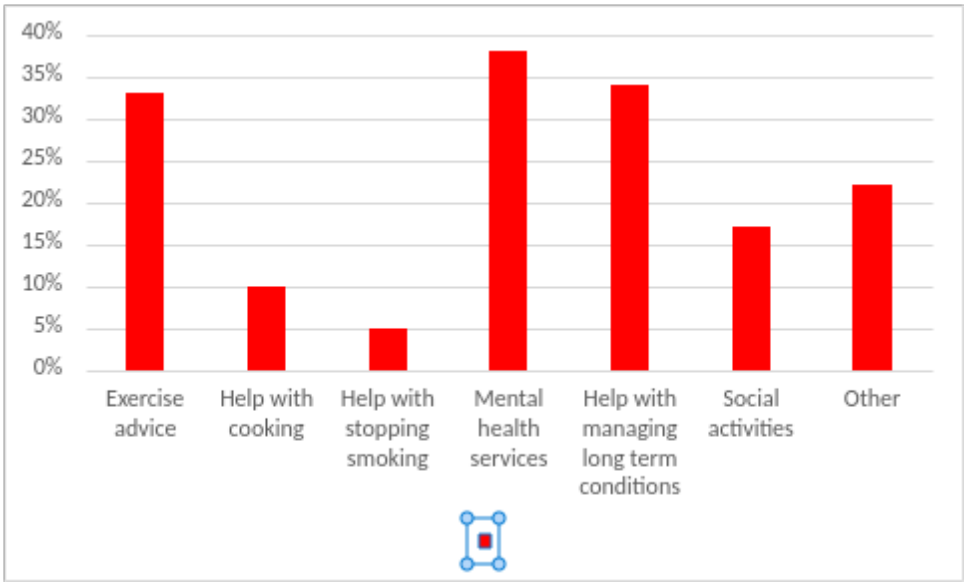
"I don't mind whether it's online or in person, I just need to be able to see someone's face."
Workshop attendee

- For a number of people, phone calls don't work either, for example those with hearing difficulties and learning disabilities.
- Unreliable connectivity was mentioned a number of times – particularly for those living in rural areas – both for the clients and staff.
- Charities relying on volunteers thought they would need a real upskilling for people to enable them to offer the same level of support using tech.
- For some, however, online appointments are beneficial and there are advantages to not having to leave home as it can save time and money. Carers appreciated the possibility of not having to stressfully transport the person they care for long distances for appointments. Use of technology is really key for army personnel and their families. There can be a lot of isolation in that community so online can really help.
- It was also felt that technology will really help with the move towards more of a multiagency, interdisciplinary approach.

"Moving everything to digital worries me because I feel that my generation are being pushed into a digital world that we are not comfortable with. It makes me feel inadequate to be honest and I don't want to feel like that."
Survey Response

4.3.6 Empowering people to live their best lives

In response to the question 'What support might you or your clients need or want to help you or them stay as well as possible for as long as possible?' there were the following results:



Comments

- Mental health was felt to be one of the biggest issues that needs to be addressed by the model, for example, regular mental health check-ups to help with managing a condition.

"Mental health services are the most important aspect of the model to me. It is currently quite difficult to find help for mental health issues and when help is found there is usually a waiting list or a delay in receiving treatment."
Survey Response

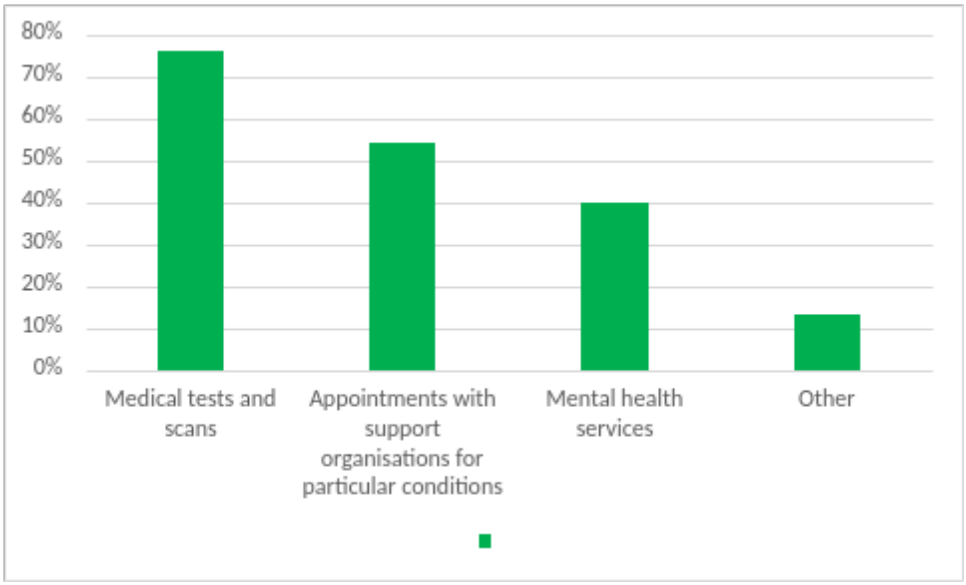
- Many felt that prevention, encouragement and support will reduce greater needs and therefore less cost in the future by keeping people healthy and out of hospital but that this is a wider societal issue not just solvable by health and care. Respondents said the model was not holistic enough and made no mention of social prescribing nor how the wider determinants of health be addressed. A number mentioned that the model focussed too much on how services will be delivered and not on how people will be encouraged and enabled to lead good and meaningful lives through preventative care and evidence-based changes.
- Many said they didn't need any additional support at the moment – but would do as they age.
- A number of respondents wanted better data and an authoritative source of information about risks and outcomes to help them make judgements about lifestyles and treatment options. They wanted tailored advice not formulaic options. Those with long term conditions, for example, arthritis, requested regular and updated information and support when needed and thought that would be reassuring.
- A number wanted greater emphasis on personal responsibility in ageing well.
- A number of practical difficulties were raised, such as, support often being geared to those who don't work; lack of easy, affordable transport making accessing support impossible; suspicion from some communities about types of support offered; army families missing out on some local preventative initiatives; respite for carers often not being in place to enable them to take part and much of the support on offer isn't accessible by design – thus excluding many.

"These are things I feel I already need but cannot access due to not being severe enough in my conditions but struggle daily in everyday activities in housework, cooking, making friends, managing anxiety, pain and fatigue."
Survey Response

The people we spoke to, offered a long list of suggestions of the kinds of services and support they would want to help them stay as well as possible for as long as possible. See appendix 3.

4.3.6 Services closer to home

When asked the question 'What kind of services would you or your clients like to access nearer where they live, which may be currently provided in hospital or big towns?' respondents fed back as follows:



Comments

- This aspect of the model was very well received, particularly if it reduced travel and waiting times and people felt that this would work particularly well for families and older people. For the Polish community, for example, local, easily accessible, highly visible services staffed by local, trusted people would be very popular.

"Local services geared to local people is so important."
Survey Response

- Some participants mentioned that in secondary care there is nowhere that people who need extra care or time for rehab to go and that the model needs to reinforce the community ability to deal with those patients and prevent them coming to hospital in the first place. The vast majority of these patients are those with chronic conditions and they could avoid repetitive admissions if dealt with properly in the community. There was a plea for more community matrons and geriatricians in community settings and that the cottage hospitals need to be re-opened.
- Concern was expressed by those living at the edges of the BSW area and how cross-border services would work.

- Not everyone was happy with increased localisation – some felt health and care is being decentralised. Certain patients will still need to be seen at main hospitals – attending local services won't improve their situation. Community services don't have the capacity to cope with current work demands, let alone more and there was a plea to keep services in hospitals. Others felt that localisation would mean expensive medical staff sitting in traffic jams trying to get from A to B.
- Some wanted a more detailed explanation of what 'local' actually means in the context of the model.
- Another made the point that the model doesn't address the possible conflict where decisions will have to be made eg playing to specialist / community strengths may mean no local availability for some areas.
- A number mentioned the need to deliver services that are clinically appropriate in that area. Co-production is key and that would be different from locality to locality.
- Transport was a big issue for many – particularly in rural areas. If you can't get there it doesn't really matter if it's five miles away or forty miles, the barrier is the same.
- A number were keen on roaming services – where a team comes to an area rather than patients coming out to them – maybe in a mobile van.
- An ideal place for a lot of these services was felt to be primary care. Some health centres are already community hubs so the suggestion was to build on that. Primary care was seen as being key to getting local services on board.
- Many were keen to re-use existing buildings already in the community, rather than developing new ones.
- Participants in the engagement project offered many suggestions the services they and/or their clients would like to see nearer to where they live. See appendix 4.

4.3.7 Impact of changes

When asked the question 'What difference do you think these changes will make to your clients and their families or you and your family?' there was an overall combined rating score of 5.5 on a scale of 1 – 10.

Comments

- Some felt that the changes would lead to greater peace of mind and more confidence to visit services if they were local and people know the staff involved. The massive difference will be to save money and have a better healthcare system with evaluation and feedback.
- Others were happy that the model will help with getting more connectedness between primary care, secondary care and VCSE sector providers so that it wraps around the patient. Health professionals can then have the whole picture about a patient but that any changes need to be collaborative.

"I think if the model can incorporate all the things we've flagged about vulnerable clients needing more resource and face to face contact with professionals then it would be transformative."
Julian House

- Staff working with vulnerable clients felt the difference would be if there was a professional to talk through with them and help the clients understand it would really help with self-esteem, anxiety, all those kinds of things. On the other hand, it could undermine clients trust in professionals. It could add to their sense of despair that no-one's ever going to take their story seriously or act on what they're being told. When vulnerable clients have an encounter with a health professional, it can either be hugely uplifting and empowering or devastating.
- Some felt that the model being catered to the individual is massive and individual choice should be supported but others asked for more detail about what the personalised care agenda was going to look like.

"Anything that allows people to have a bit more control in their lives is great."
Swindon Harbour Project

- Some thought the model could make a big difference depending on the detail, for example it would be great to have more options for clients, whilst others thought that a lot of what is described is happening already.
- The army personnel thought that a lot of what was proposed wouldn't affect the wider army but would affect army families. There is a need to recognise that what might work for people living in one location is very different for those moving around from place to place – like travellers or army families.
- Some respondents were sceptical that the model would make any difference at all or that it was too early to tell. One person thought this was not a helpful question as it won't be possible to achieve the model in the next five years, instead we're looking to this model for our children and our children's needs.

"The potential to make my life better is there, but I have no confidence that the resources will be made available."
Survey Response

4.3.8 Additional feedback

When asked 'Is there anything else you would like to tell us about our plans?' there were the following comments:

"The reality on the ground is nothing like we've been promised. We're being fobbed off with meetings like this. It feels like we're endlessly reinventing the wheel."
Your Health Your Voice member, BANES

"I'm very excited. I think that your revision of the way the whole current support works would be wonderful."
Carer, BANES

- One comment was that what's proposed indicates a reduction in services not an improvement and another that the plan is based around cost not health but is all about saving money and stopping people seeing NHS staff in person.
- The point was made that residents need to be shown what the disadvantages of the model are in order to make an informed choice.
- Others felt the plans were conservative and didn't go far enough but were hampered by legislation and funding remits.
- Some said there was a need to give people the confidence that something is being done and not promise things that can't or won't be delivered. Concern was expressed that there has been previous attempts with the IT systems and there's been a failure of linkages between mental health and acute services. The question was asked how confident are we that this will work this time?
- A number requested a focus on delivery and outcomes, ongoing assessments of any improvements the need to keep asking for feedback. One asked how the plans will be evaluated honestly?
- The point was made that a model will only be successful if it is future-proof. It has to have a capability to adapt to new technology quickly (ensuring the technology is easy to use by the end users), funded to reflect the local population, including marginalised groups. The makeup of the population has to be evaluated every 3 years.
- Definitions were asked for Care Co-ordinator, Risk Stratification Tool and clarification of the roles of the Community Hubs, Community Hospitals, Diagnostic Hubs.
- A request was made to think about the patient journey. The message needs to be clear so that the local population buys into the plans.
- The dentists are not taking anyone new and that is a big issue for many.
- A couple of participants asked how the postcode lottery will be addressed in this model?
- Patient and Public Involvement groups requested to be involved in designing and delivering the plan with actual authority for their agreed responsibilities.

5. Main themes

5.1 Data sharing

- Many people who participated in the engagement activity were enthusiastic about data sharing and all hospitals, clinics and care providers having access to the same information. For example, the army felt this would be brilliant for armed services personnel and their families moving around and would be really helpful to smooth the transition between different healthcare providers in different locations and also with the transition into civilian life.

"I think this idea of data sharing is a really, really crucial element of it. Trying to streamline people's experience but also taking the stress off the hospital system."
Attendee at public webinar

- A number felt that all medical information should also be available to the patient with a central portal accessed by people the patient gives consent to.
- A significant number of respondents were not happy that their personal information could potentially be available to any third parties and big systems selling data to big pharma or insurance companies. There were also safeguarding concerns.
- For people in recovery from alcohol or substance misuse, however, it's very important that they are seen as a whole by all professionals who are caring for them.

"I've been through the drug and alcohol system, So for people like me there were all sorts of things that were on my GP records that nobody else knew about. When I was really struggling with my addiction my GP was totally aware of it but nobody else could use that information so nobody else could intervene. In 2014 if my GP had spoken to DHI and they had been in touch with somebody else and you know the whole NHS and Council then I may have not spent the last six years on the whole treatment cycle. Being joined up is just so much more logical."
Edwina – DHI client

- Some people were sceptical that the notion of patients only having to tell their story once will work as professionals don't have time to read complicated medical notes before seeing someone and felt the model doesn't present a realistic and reliable way for people to share their story once. There was also concern about the practicality of joining up databases and how a central system would work. Some pointed out that this will require major investment.

5.2 Health inequalities / inclusion

- There was concern expressed for those lacking the skills to access facilities.
- Focus on the community forgets those who don't feel part of it or who feel excluded. There was a plea to think carefully about 'community' for those not automatically integrated into it.
- The question was raised about how the model will ensure no-one is left behind and health inequalities are measured and monitored in real time?
- A question was asked about ensuring that the voice of the people receiving services is genuinely heard and at the heart of decision-making for example by investing in advocacy and family support.
- Staff working with the most vulnerable clients felt they would definitely need more resource than someone else might, for example, some will require interpreting and interpreters aren't always available. People's ability to explain pain and articulate their situation is challenging if their English is poor. For example, refugees and asylum seekers don't always understand the health system or how to access public services and that the GP is the gateway to services. They require a lot of support to navigate services and understand appointments and often have complex mental health issues and trauma.
- The point was made that the system needs to be more adaptable to different circumstances and needs to be more specific to target social groups and less generic. For example, customers at the Rainbow Café told me that nurses used to come along to talk to them about safe sex but that with a change of community healthcare provider that hasn't happened for some time and as a group they were missing out.
- Continuity of care is key for some facing health inequalities and the need to develop trusted relationships with health and care professionals. Continuity of care is also crucial for armed services personnel moving in and out of different locations.
- Many staff spoke of the need for access to health and care to be as easy and accessible as possible as many groups for example homeless people, can give up quickly if navigating the system is too difficult.

5.3 Finance

- Many asked where the finances and investment were going to come from to fund the proposed changes as the model depends on resources to deliver the plans fully, for example, to train and pay the salaries of the additional staff, better facilities, equipment and buildings. The question was asked about how the NHS is going to take on all the skills that social services provide with no extra funding?

> *"Until the entire commissioning and funding structure changes to support better working together between*

organisations and digital infrastructure aligns I think it will be hard to progress such ambitious plans."
Survey Response

- A number of people that were spoken to were sceptical about the model and thought the plans disguised reduced funding for normal care provision and benefits overall. Some pointed out that there are financial implications of joint working across sectors and that this model shouldn't be used to offload costs from the NHS to other sectors. One person felt that until the funding structure changes to support better working together then this model will be hard to progress.

"Can we trust that more people will be able to reach more services in the community with less budget?"
Workshop Attendee

- Some people mentioned the need for reasonable pay for health and care staff otherwise people will continue to leave the sector.
- There were questions about financial sustainability and the need for cost benefit analysis. What will be funded locally and what is reliant on central funds?
- Other questions asked were about how care in the home will be funded? There will be a reduced cost with the health prevention measures so a hope was expressed that fewer older people would have to pay for their care.

5.4 Integration

- Questions were asked about how putting the local authority, social services and the NHS together could be made to work in terms of governance and in practice. And also how the people delivering services would be engaged with about what they need to be effective.
- A number of commentators from the VCSE sector thought that culturally there's still a long way to go for the VCSE sector to feel fully integrated. There's a danger of repeating old patterns and some are not convinced there is enough ownership or behaviour change, although there is a lot of interest in having a different system. One person mentioned that currently it feels quite competitive between organisations and providers.

"There's a theme of 'we're not funded to do that' ie it's another organisation's remit, so you just don't get helped when you need it."
Survey Response

- A number of participants thought that there needs to be a clearer understanding of how partnerships across the model will be funded so that everyone involved in the care of a person receives the resources and support they need to deliver so that this is sustainable, flexible and every smaller organisation is given equal or proportionate financial help to keep a high and consistent level of care for their community. For example, IPSUM felt that smaller organisations, whilst eager and willing to be involved, might find the extra costs required to be a barrier. There needs to be agreements in place so all work together as equal partners and don't get side-tracked by each partner's red tape, bureaucracy, money and unwillingness to accept responsibility or accountability.
- There was a request for recognition that in reality voluntary sector organisations are all independent and driven by their own governance and own aims and ambitions. Independent charities are driven by their trustees. There is a reality that you can commit to be part of the system but each individual charity is an independent organisation delivering its own aims and ambitions and you can't necessarily dictate what they do in that way.
- There was a degree of cynicism about whether integration will happen effectively as some people felt that there is currently little joined-up thinking and ineffective communication and some weren't convinced there was anything in the model that would ensure implementation. Others weren't keen on what they saw as over-reliance on the charity sector.
- As mentioned before, many felt the model was very health focussed, with no little mention of leisure and fitness facilities or mental health activities like walking groups or allotment groups.
- Some asked for greater patient and service user involvement to be embedded in the model.
- A CCG staff member thought it would be helpful if there was more of a joined-up approach from national to regional to locality. It feels like a lot of the time there is a disconnect and there's an overreliance on reporting.

5.5 Access to GPs and other services

- Current difficulties people are having trying to get through to their GP surgeries to make appointments came up again and again during the engagement exercise. This was true across the whole range of communities that were spoken to, although very vulnerable groups of people faced additional barriers, for example, if they don't understand the way the NHS works, their English is poor or they get confused by automated systems. Having to ring for GP appointments at 8am is another barrier for the most vulnerable as support organisations are not around to help at that time in the morning.

"Inability to access GP's does not promote the community model. It effectively encourages Emergency

Department attendance."
Survey Response

- For many the need to provide more GPs and open up access to GPs was the key.

"I have no faith in the model as we cannot even make first contact to get help. Unless this changes nothing will improve."
Workshop Attendee

- Some asked about whether GP independence would be changed under the model and how their relationship with their GP would alter under the proposals.

5.6 Personalisation

- Many felt that it is important for care to be tailored to an individual's needs and the patient has to be at the forefront of all decisions. The whole NHS must become more patient-centred rather than consultant or GP-led.

"Treat me as a person rather than a condition. Give me the tools to manage my health and support when needed and I will save you a fortune in the long term."
Survey Response

- Others thought that the skill set wasn't there to achieve this. It is often not really the patient's choice but is skewed to the consultants. Will the patients really be listened to? The NHS doesn't have the time to listen and formulate plans with the patient. Ready-made pathways are more efficient even if they are not the most appropriate or what the patient wants. Another thought there was no groundswell of demand for personalised care.

"Talk of putting the patient first is a slogan – I don't see it in practice. It will be a lot less personal under the model."
Survey Response

- Citizens Advice Wiltshire thought that the definition of personalised care is more than putting the person at the centre – practically it's about ensuring that that person doesn't have to go to eight different places to see eight different people.

- Some felt that the health element of personalised care should be quite a small percentage and has to be delivered in an evidence-based way. The question was also asked how will this be enforced with delivery partners?
- It was pointed out that there are no mention of carers or families in the model but that their support is crucial to the personalisation agenda.
- The question was asked, how will it work if you have a Direct Payment or Personal Health Budget?

5.7 Workforce

- A number asked how does this model will work for staff? How much change is expected of their roles and locations? There is a fear that patients will be allocated more junior professionals without sufficient skills to manage the workload.
- The issue of recruitment of staff prior to launch was raised repeatedly. Where are we going to get those skills from? There's currently a lack of carers, therapists, doctors, nurses etc. Recruitment and high enough pay is crucial. More social workers and care workers in care homes are needed. The point was made that the model focuses on buildings but that nationally 1,000's more radiologists are needed. We need to invest in the future workforce and develop talent pipelines.
- Training of staff was also mentioned a number of times. A great need to train carers at a lower level. Medical staff lacking awareness of autism and any learning disability. A question was also asked about the governance standards within the new BSW Academy. And where do medical trainees fit into the model?
- Finally there was a plea to consult thoroughly with all staff – GP surgeries, doctors, nurses, administrative staff and many others – as they are the ones who face demands. Also that staff and patients will need plenty of time and support to adjust to the new ways of working proposed with this model.

5.8 Specialist Centres

- It was suggested that specialist centres would be too remote for poor people to access them.
- How will access to care advice in urgent situations be improved?
- Some asked for a definition of a specialist service and what specialists will be accessed at them? There needs to be clarity that specialised services and specialised centres are two different things.

5.9 Mental Health

Many felt that mental health services and support should be far easier to access and in a timely manner, as when someone recognises they have a problem and asks for help, they are usually really in need of it and sometimes even in crisis.

> *"Collaborative working and person-centred care is imperative to quality of care and positive outcomes in being able to thrive and not just survive."*
> ***Survey Response***

- There were requests on change the stigma around mental health, to encourage support networks, aid early intervention and improve access to specialist support. There are also myths around long term mental health that need to be busted to raise awareness and create understanding and acceptance.
- The issue of helping those with mental health issues gain and retain employment, apprenticeships and volunteering was also mentioned.

6. Recommendations for changes to the model

- The term 'digital by default' needs more explanation and more detail is needed about how the move to digital will work and how non-digital choice will be maintained.
- The model is currently very health focussed and needs greater emphasis on the role of the VCSE sector.
- Evidence is needed of the role of the wider determinants of health; for example housing, education, employment, childcare and how they will be addressed within the model and how people will be encouraged to lead healthy, meaningful lives rather than the current focus on service delivery.
- The model needs to acknowledge the current shortages in workforce and difficulties in recruiting.
- The model has a gap in provision for those with physical and mental special needs and support for those with long term conditions.
- The model needs to illustrate how health inequalities will be addressed, how vulnerable clients who won't fit into the model because they don't engage with mainstream services like homeless, asylum seekers, will be supported and how the system needs to be, and can be, more adaptable to different circumstances.
- Mention needs to be made in the model of accountability for the success of the model to the local population.
- There needs to be greater integration across the VCSE sector, pharmacy and dentistry within the model.
- There is currently no information on accessing GPs or providing more GPs within the model. This needs to be addressed as many are currently

experiencing difficulties accessing services through their GP practices due to problems getting initial appointments. The model also needs to explain how people's current relationship with their GP will be altered by these proposals.

- The model should mention the role of families and unpaid carers in supporting people and how they are supported in turn.
- The model needs to explain how home care, nursing homes for older people and the disabled and private care fits in.
- Explanation is needed of how the proposed changes represent an improvement on what is already happening. Before and after illustrations needed, along with an explanation of why this is happening now and why not before now, what this will achieve when others haven't and what will be lost from current structures. Concrete examples are needed, for example, for a person newly diagnosed with diabetes 2 in Bath – how will this be done differently under the model?
- Need specific targets on how this will be achieved.
- The role of volunteers, universities, schools and public health should be explained.
- The model should be set in the wider context as it doesn't exist in isolation. How does it fit with the Integrated Care Alliances (collaboration of partners in each of our localities)? Where do HCRG fit in? How does it fit with the Community Services Mental Health Framework model?
- Dying well needs to be mentioned.
- Transitioning well from childrens into adult services needs to be mentioned.
- There needs to be recognition of the good, localised work, often led by the VCSE sector, that's already going on in communities to address inequalities.
- Expand the definition of Community Hubs to show what they mean.
- Provision of transport is a big issue in rural areas in order to enable people to access services and this needs to be included in the model.
- There needs to be a much greater emphasis on mental health.

7. What went well with the Shaping a Healthier Future public engagement project?

1. The aim was achieved of gathering a snapshot across the BSW region from a variety of people who use services, staff, the public and seldom-heard groups about what they thought of the health and care model.
2. A wide range of individuals and staff from organisations across the BSW areas and from a wide variety of communities of interest were spoken to during the six-week engagement period.
3. A number of people experiencing health inequalities were spoken to in spite of obstacles such as Covid-19, timescales and limited capacity for co-operation from some VCSE sector organisations.
4. There was good co-operation and working together of the Shaping a Healthier Future engagement planning team from the Engagement and Communications team at the CCG, RUH and Commissioning Support Unit.
5. Some VCSE sector organisations were very keen and enthusiastic about getting involved and giving their views and enabling staff and people who use their services to attend workshops and interviews. This will form a good springboard for the development of a cooperative working relationships going forward and should enable future engagement and co-production activities to be easier to arrange.
6. A number of organisations and communities were really pleased and grateful that they were being asked their views and that someone was taking the time to ask their opinions, for example refugees and the Polish Consul.

8. What could be improved about the engagement project?

1. It was agreed that 6-weeks was a proportionate amount of time for the engagement period, given that the focus was on checking if the principles that drove our model were still the correct ones. However, the challenge of running engagement in a pandemic meant that more planning time would have been useful as many organisations felt they had insufficient time to gather staff or people who use services for a workshop.
2. Some VCSE organisation leaders wanted to find out for themselves what we were talking about before they would consider involving people who use their services. This restricted the amount of time that was then available for direct engagement with their networks or supporters. There was an underestimation of the administrative time required to coordinate interviews and workshops with the VCSE sector organisations. Lack of pre-existing relationships with

some VCSE sector organisations or a detailed database of contacts made things slower.

5. Longer lead up time before the commencement of the engagement period would have been better to prepare materials.

6. Our strategy was to reach out to the co-ordinators and leaders of groups and give them the resources to talk through the model with people on our behalf, adapting the communications as appropriate for their groups' requirements. But best practice is to produce easy read versions of the engagement materials.

7. A minority of respondents felt the survey rating questions were biased in favour of the proposed model. Time allocated for a pilot survey would have highlighted this and been beneficial to reduce any biases. It could have been explained more fully as part of supporting communications that the purpose of the public engagement activity was to check the health and care principles were still the right ones and was not intended to be a full consultation. Some survey respondents felt that decisions had already been made and that we were undertaking a ratification exercise.

8. There was a lower turnout than expected at both public webinars. This could reflect the timing for example close to Christmas or issues with the promotion of the workshops or the high-level concepts being described not feeling immediately engaging to the public.

9. It was difficult to engage with healthcare staff across BSW and to get them to complete the survey or attend the public webinars. This could be to do with current capacity issues in the system, winter pressures and staff shortages or that high level concepts and ideas weren't immediately engaging to staff. The next version of the health and care model will be described in more detail.

9. Engagement project recommendations

1. Revise health and care model in line with recommendations in section 6.
2. Disseminate new model and engagement report to public and those who participated in workshops, presentations and interviews and those who completed the survey and left their contact details. Include how we are using their insights and aspirations for services to inform the health and care model and how we deliver services in the future.
3. Undertake a gap analysis of which groups were not adequately represented during this stage of engagement to ensure they are engaged with going forward.
4. Develop engagement strategies and a co-production approach (including co-production workshops) tailored for all relevant audiences including the public, staff, vulnerable groups and VCSE sector to support future service and pathway changes and transformational projects that arise from adaptation the model. Building on the relationships already established and developing from initial engagement period. Workshops to be sector and location specific.
5. Ensure regular updates (6 and 12 months) on how the health and care model is being applied and how people can get involved. Ensure a constant cycle of communication and involvement opportunities to develop and maintain trust, involvement and community 'buy-in'.
6. Develop greater, wider and much closer links with the VCSE sector for example through attendance at 3SG, Wessex Community Action meetings but also maintaining and building on the relationships developed thus far. Building on existing good will make it easier to progress future engagement activities effectively.
7. Ensure adequate planning time for future engagement and that the length of engagement is proportionate. A longer lead-up time would give an opportunity to pilot the survey with a small sample to test for any biases before a full survey goes live and also to enable pre-conversations to occur with participating organisations.
8. Ensure easy read / translatable / audio versions of engagement materials are ready to ensure full participation of all vulnerable groups.
9. Create a database of the individuals and organisations who were involved (those interviewed, attended workshops and left their contact details on the survey). Also those organisations who weren't able to be involved but who expressed interest in being informed / involved in the future. It will then be possible to refer back to these organisations/ individuals for future involvement around model. A system needs to be in place to ensure this database is kept up to date.
10. Operational leads and commissioners start to use the health and care model to design new services and pathways across all areas of health and care.

There is an expectation that there is proportionate public engagement and co-production alongside all these separate projects.

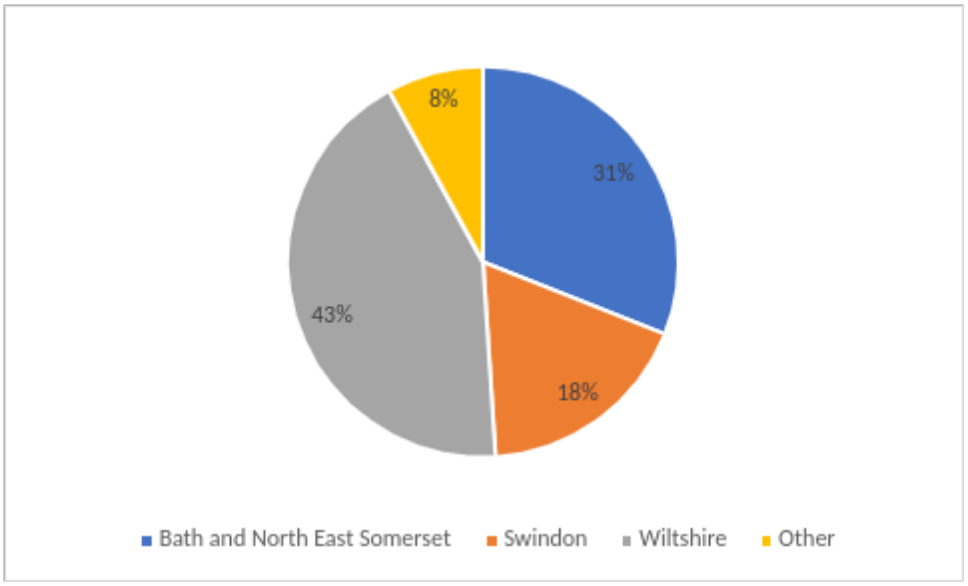
10. Conclusion

“It is detailed and comprehensive in its aims to improve care delivery and access while making sure new developments are sustainable in the future.”
Survey Response

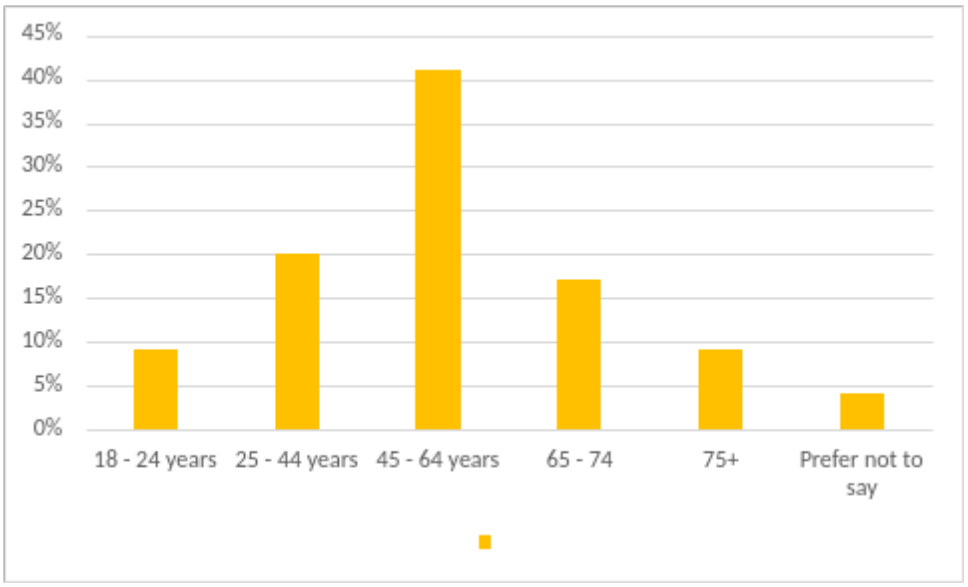
There was an adequate sample of people who were engaged with in a wide enough variety of ways to be able to say that, broadly speaking, people in BSW are in favour of the model. The significant sample size of people that were spoken to about their lived experience of health inequalities means that a number of the issues facing the most vulnerable in our society were highlighted and now can be addressed under the model. There were a number of concerns raised that need to be emphasised or clarified and most people requested further detail about how the model would work for their location or particular experience. There was general enthusiasm and willingness amongst local organisations to work collaboratively to effect this change and so the next phase will be to start genuine and meaningful co-production building on some of the relationships generated during this engagement exercise.

11. Appendix One

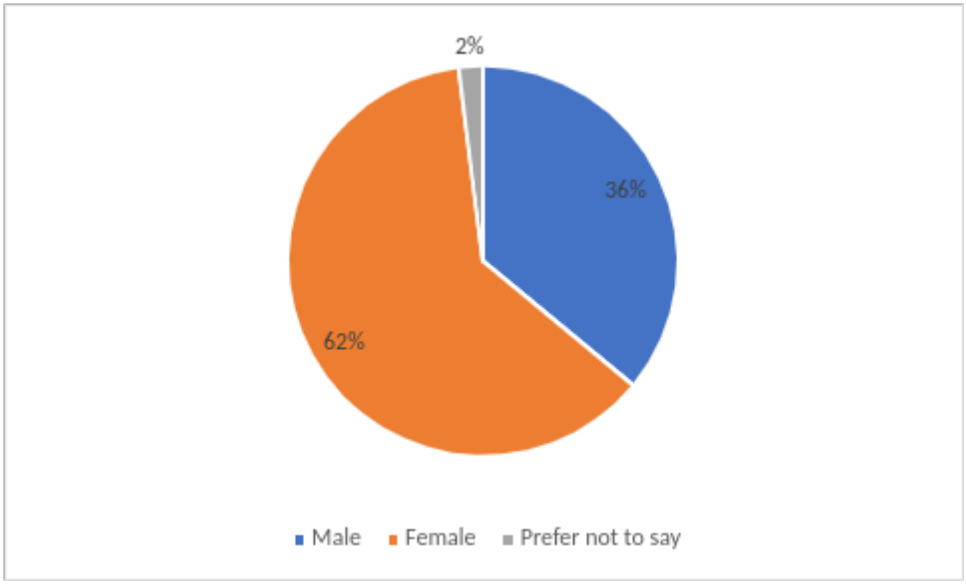
Breakdown of survey respondents by area



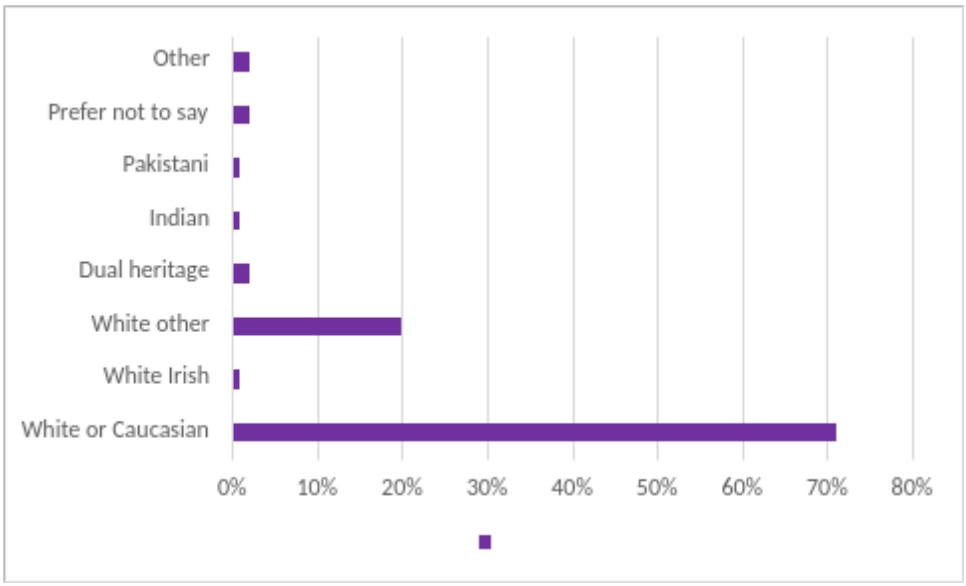
Breakdown of survey respondents by age



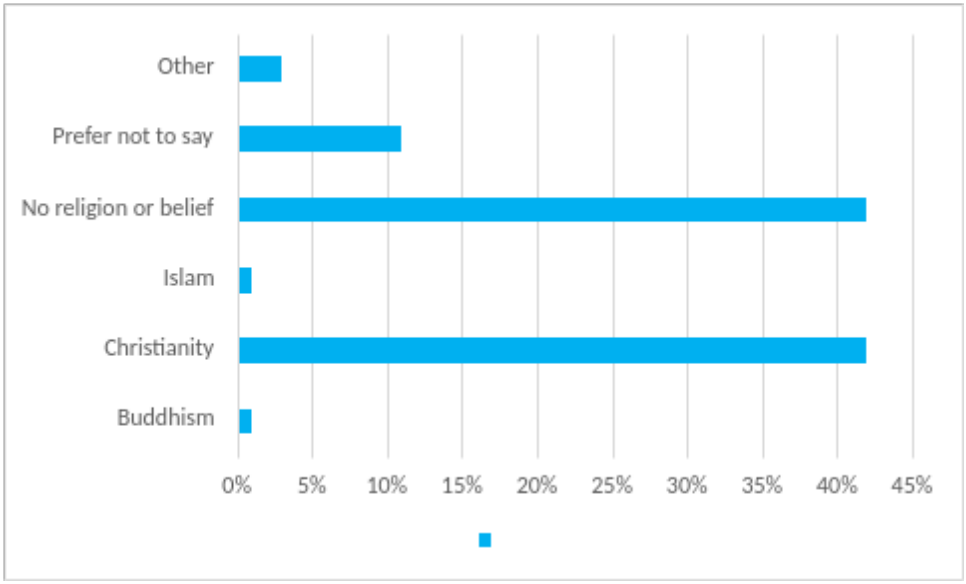
Breakdown of survey respondents by gender



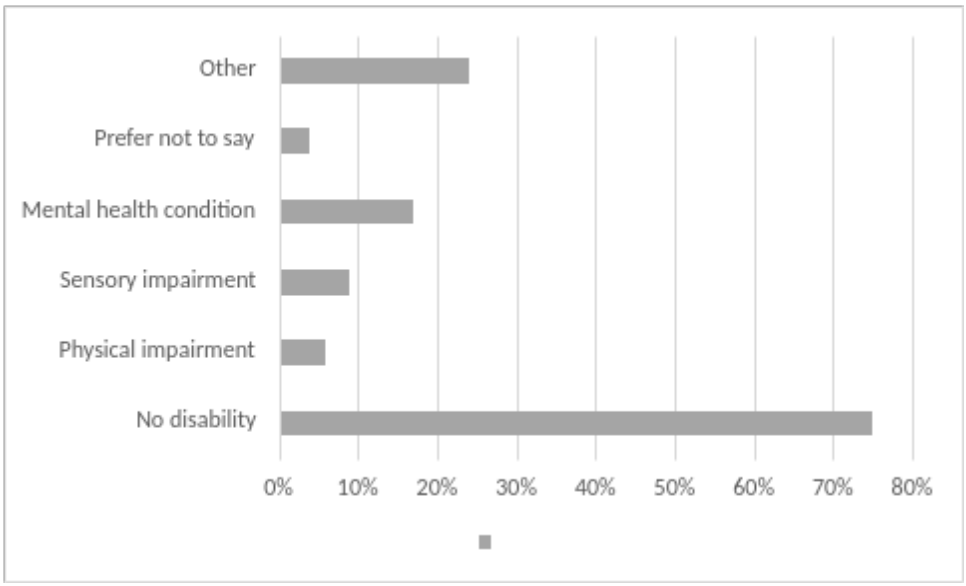
Breakdown of survey respondents by ethnicity



Breakdown of survey respondents by religion or belief



Breakdown of survey respondents by disability



12. Appendix Two

List of all organisations and individuals involved in the engagement project (initials of individuals only to protect their identity)

1. RW – Patient Representative Swindon
2. Swindon Professional Leadership Network
3. RP – Patient Representative B&NES
4. Gay West, Rainbow Café, Bath
5. HealthWatch Swindon
6. HeathWatch Bath
7. HealthWatch Wiltshire
8. JK - Swindon Women's Aid
9. MO - Patient Representative B&NES
10. SS - Polish High Consul for Wiltshire
11. MP – carer, BANES
12. Wiltshire Voluntary Sector Leadership Alliance
13. SW - Citizens Advice Wiltshire
14. Lt. Col DJ - Armed Forces, Wiltshire
15. Warminster Knowledge Café, Wiltshire Centre for Independent Living
16. CG - staff and clients of Swindon Harbour Project
17. KR- Army Families Federation, Wiltshire
18. MG - Sight Support
19. Your Health Your Voice members, B&NES
20. Wiltshire Faith Leaders
21. MIND, B&NES
22. Swindon Therapy Centre – staff and clients
23. Developing Health and Independence (DHI) – staff and clients
24. Headway
25. Swindon Food Collective
26. Julian House, B&NES
27. JM - IPSUM, Swindon
28. BSW CCG clinical leads and colleagues
29. BSW Public Engagement Leads
30. Health and Wellbeing Boards
31. Overview and Scrutiny Committees
32. RUH Bath staff, members and governors
33. B&NES Care Forum
34. 3SG, B&NES
35. Virgin Care Voluntary Sector sub-contracts
36. Swindon PPE Forum
37. Area Forums, B&NES
38. Swindon carer organisations
39. B&NES Interagency Group
40. Swindon VCSE Leaders Alliance

13. Appendix Three

Suggestions for support services to enable people to stay as well as possible for as long as possible.

- Regular proactive medical checks for the over 50's - bloods, cholesterol, dementia.
- Diabetes support
- Weight loss, nutritional advice, meal planning
- Dementia support
- Retinal screening
- Menopause support
- Volunteer groups
- Help with loneliness eg social gatherings for those alone, lunch clubs. Counselling and psychotherapy – free and face to face
- Exercise support, discounted access to gyms, sports / gyms accessible for physically disabled – not just during daytime, dancing
- Self-help via community groups, community connectors to signpost, green and social prescriptions
- Named GP
- Osteopathy on the NHS
- Better support and aftercare to help manage long term conditions
- Easy access to health professionals to talk about little niggles. Better information about health problems. Longer appointment times to talk about health problems all together
- People with neurological conditions often have co-morbidities and are severely economically, socially and physically disadvantaged – need financial advice, meditation, mindfulness, pain management, peer support
- Need better wheelchair access in public places
- Youth work
- Access to MSK services locally
- Help with stopping drinking
- Community Champions eg Polish to help people overcome language barriers.
- Foodbank vouchers and referrals from support workers and agencies, discharge teams, social workers etc.
- Inpatient stopping smoking support

14. Appendix Four

Suggestions for services people would like to access nearer to where they live.

- Radiotherapy in Wiltshire
- blood tests
- social care support
- Occupational Health
- minor procedures
- community step down beds,
- walk in Minor Injuries Unit support
- Out of Hours GP support
- specialist consultant appointments - maybe at GP surgery
- Physiotherapy
- therapy for those with Alzheimer's
- retinal screening
- home visits from District Nurses
- weight loss with exercise
- support groups
- menopause clinic
- eating disorder services,
- early diagnostic tests
- x-ray
- ultrasound
- ECG
- Podiatry
- Dentistry
- MRI
- Annual health checks and physical health checks – somewhere where the stigma isn’t there
- Respite and day care

Produced in partnership with
Martha Cox Engagement Solutions

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Shaping a Healthier Future – Together

In early 2020 we published the priorities for the delivery of health and care services but shortly afterwards had to focus our resources on responding to the Covid-19 pandemic.

Our health and care model has been revised to reflect the feedback from the public surveys held throughout November and December 2021. The updated health and care model captures a range of findings and sets out what the health and care to be like for people in the next ten years. This will provide a framework to ensure we take a coordinated approach to how we design and plan services across our partner organisations.

We ran a public survey and a series of webinars, workshops, interviews and presentations with health and care staff, users of services and the voluntary, community and social enterprise (VCSE) sector during this time. In addition, two virtual webinars were held that were open for anyone from the public to attend.

We publicised through social media, local networks, community newsletters and presentations to key staff groups and other local organisations. Communities who experience health inequalities were engaged with in a very targeted way. Case studies were used to highlight examples of the new ways of working within the health and care model.

We wanted to thank everyone who gave their time and got involved in contributing to feedback on the health and care model across Bath and North East Somerset, Swindon, and Wiltshire. This feedback directly influenced proposed recommendations in the new revision of the health and care model including:

- Digital inclusion and exclusion
- Mental health provision
- Workforce, recruitment, and access to services
- Finance models
- Vulnerable clients and their access to mainstream services
- Role of the voluntary, community and social enterprise sector
- Role of unpaid carers, volunteers, universities, schools, and public health

The completed findings and recommendations are now available to view:

- Full Shaping a Healthier Future report
- Summary Shaping a Healthier Future report
- Shaping a Healthier Future Infographic

These will be presented at the upcoming BSW Partnership Board meeting on 25 February 2022. Members of the public are welcome to attend as observers to find out more about the Partnership, our progress as an Integrated Care System and our plans for the future. The meeting will be from 9am to 12pm and will be held virtually via Zoom. You can request to attend and observe the meeting and submit a question to the BSW Partnership board by emailing bswccg.partnership@nhs.net

Alongside the refresh of our system-wide health and care model, the Royal United Hospitals Bath NHS Foundation Trust (RUH) is developing investment proposals for

new infrastructure to enable it to deliver the new health and care model. Some funding has already been confirmed with the Dyson Cancer Centre which is now under construction. However, further investment will be needed to support the delivery of the future BSW model of care. This will include significant improvements in the estate at the Combe Park site which will focus on greater integration, a higher quality patient environment, a person-centred approach and more care being delivered closer to home. Additional investment will also be needed in digital to support integration with other partners in the system, better patient care and better use of clinicians' time. The outcomes from our Shaping a Healthier Future engagement will underpin the RUH's Strategic Outline Case for this additional investment. Therefore, our engagement activity will cover Mendip and South Gloucestershire that are within the RUH catchment area.

Link: Shaping a Healthier Future - BSW Partnership

Wiltshire Council

Health Select Committee

16 March 2022

NHS Health Checks Programme in Wiltshire

Purpose of Report

1. Provide an update on the NHS Health Checks programme in Wiltshire including how the programme is restarting since the impacts of Covid-19 pandemic on service delivery.

Background

NHS Health Checks in England

2. Cardiovascular disease is one of the largest causes of mortality in Wiltshire and the largest single cause of long-term ill health and disability. Cardiovascular disease risk increases with age, progresses faster in men than women, and in those with a family history of cardiovascular disease, and in some ethnic groups. These are all factors which cannot be changed, but modifiable factors such as being overweight or obese, smoking and having a sedentary lifestyles all form part of the behaviour change advice provided during an NHS Health Check.

3. The NHS Health Check programme started in 2013, with the aim of reducing the development of cardiovascular disease and its related illnesses. It is a rolling programme, inviting people to attend a check every 5 years, and targets two fifths of the eligible population each year. Between 2015-2020, 41% of England's population had accessed an NHS Health Check.

4. During an NHS Health Check, the health professional completing the check will support the patient to reduce their risk of cardiovascular disease by supporting them to adopt healthier behaviour which may provide advice, and is delivered by General Practices in Wiltshire.

5. The programme aims to improve the health and wellbeing of eligible adults through the promotion of early awareness, assessment and management of the risk factors of cardiovascular disease. By raising awareness and instigating a discussion, the intention is that the individual better understands their risk status, and is able to make informed healthy lifestyle changes and potentially decrease their risk of developing cardiovascular disease. Where appropriate, the healthcare professional may also make a referral to existing specialist services, such as smoking cessation support,

or prescribe medication. The programme also aims to help reduce inequalities in the distribution and burden of behaviour risks, related conditions and multiple morbidities.

6. The NHS Health Check programme is commissioned by Wiltshire Council as a mandated service required by the Health and Social Care Act (2012).

7. In December 2021, an evidence review of NHS Health Checks was published by the Office of Health Improvement and Disparities. The review acknowledged that the programme had largely achieved it's aims nationally of reaching 2 in 5 eligible people including those at a higher risk of cardiovascular disease and delivering better outcomes for these patients. There were national recommendations; having multiple opportunities to improve NHS Health Check across the entire pathway, behaviour change is needed sooner as many people's risks set in early, a wider view of health could address the current burden of disease and greater use of technology may help target, reach and personalise the NHS Health Check for individuals. National colleagues are reviewing the recommendations to consider how these can be implemented in local programmes.

NHS Health Checks in Wiltshire

8. Wiltshire's population is healthier than the England average with lower prevalence of cardiovascular disease. Nonetheless, between 2017-2019 around 400 people in Wiltshire aged under 75 died from a coronary heart disease event, and cardiovascular disease remains the second most common cause of all age mortality in Wiltshire.

9. In April 2013, the Health and Social Care Act (2012) moved responsibility for NHS Health Check from the NHS to local authorities.

10. The Public Health Services contract with Primary Care contains the Service Level Agreement for the delivery of NHS Health Checks in Wiltshire. Each check attracts a payment of £26 per 20-minute consultation which includes payment for point of care tests for cholesterol ratios.

11. The Office for Health Improvement and Disparities provide modelling for the potential benefit of NHS Health Checks. In Wiltshire it is estimated that based on the current 45% uptake rate in Wiltshire the following benefits could be realised in each year:

    - 846 additional people will complete weight loss programme
    - 118 additional people will be diagnosed with diabetes
    - 219 additional people will increase physical activity
    - 15 additional people will quit smoking

    Further estimations are provided within Appendix A

12. It is estimated that the cost savings to health and social care as a result of the interventions associated with an NHS Health Check cumulate year on

year as the numbers of strokes, heart attacks and diabetes cases prevented also increase. Cost savings also arise when individuals who receiving their NHS Health Check modify their lifestyle behaviour or are treated for a newly diagnosed condition. Modelling indicates potential cost savings to the Wiltshire system of over £1.5M in 10 years and over £2.4M by 2031. This is based on modelling in 2010/11 and for continuing the NHS Health Check programme over a 20 year period. These estimates are based of the 20% of the eligible population who are invited each year, 75% will attend a NHS Health Check.

Main Considerations for the Council

Covid-19 pandemic

13. During the pandemic there was significant disruption to Primary Care services, leading to NHS Health Checks being paused nationally in March 2020 as part of the national prioritisation of Primary Care Services. In July 2020, Wiltshire Council agreed a continuation of financial payment to Primary Care with a focus on targeting health inequalities in any NHS Health Check delivery that a GP Practice undertook. Examples of this health inequalities work across Wiltshire GP Practices included;

    - Prioritising patients with learning difficulties
    - Offering asylum seekers and NHS Health Check on registration
    - Evening clinics to support access
    - Wider promotion of the NHS Health Check through social media and websites

14. It was the decision of local authorities from December 2020, as commissioners, of when to restart the NHS Health Check programme depending on local prioritisation and impact of COVID-19 response and vaccination work. Since the restart of NHS Health Checks in Wiltshire, there has been variation amongst GP Practices in offering and delivering the programme, primarily due to capacity; influenced by the continued Covid-19 vaccination work. It is expected during 2022 that GP Practices will return to usual operating and thus return to offer and uptake levels seen prior to the pandemic. However, there is a significant backlog of NHS Health Checks, as well as many other Primary Care appointments which will have a significant impact on the health system.

15. The Covid-19 pandemic has heightened the impact and risks of cardiovascular disease on our populations. Some groups have had worse outcomes from Covid-19 which relate to socio-economic, behavioural and clinical risk factors. Opportunities to address these modifiable risk factors through the NHS Health Checks will support action on addressing health inequalities across Wiltshire which may have been exacerbated as a result of the Covid-19 pandemic.

Cardiovascular disease prevention as a priority

16. Cardiovascular disease links with many elements of Wiltshire Council's Business Plan 2022 to 2032, through supporting people of Wiltshire to increase activity levels, improving health outcomes for all population groups across Wiltshire and reducing smoking prevalence.

17. Cardiovascular disease prevention remains a high priority for our Public Health Team and with partners in the Clinical Commissioning Group. Public Health continue to collaborate with partners to address health inequalities and support early detection and prevention of cardiovascular disease amongst the Wiltshire population.

18. Engagement in health improvement interventions which reduce the risk of cardiovascular disease such as smoking cessation, weight management services, physical activity and substance misuse continue to be promoted. Close working with primary care enables efficient referral and feedback pathways from Primary Care to these services.

19. In Wiltshire, 95.5% of the cumulative population (eligible population to date) have been offered an NHS Health Check between 2015/16–2019/20, higher than the England average of 87.7%, The uptake of the NHS Health Check in Wiltshire over the same 5 years is 45.9% which is much higher than the England average of 41.3%. This is a fantastic achievement for Wiltshire and demonstrates how well the NHS Health Check programme has been embedded within the County.

Integrated Care System and NHS England and NHS Improvement

20. The NHS Long Term Plan has committed actions towards the prevention of ill health through improving upstream prevention of avoidable illnesses and their exacerbations, including smoking cessation, diabetes prevention and obesity reduction, all of which are encompassed within the NHS Health Check.

21. Integrated Care Systems (ICSs) play a key role in working with local authorities at 'place' level to work together to improve population health. Further work through this partnership will be focusing on addressing health inequalities within the NHS Health Check programme, and widening the opportunities for diverse population groups to engage in the programme.

22. NHS England and NHS Improvement have published their national approach to support the reduction of health inequalities at a national and system level. Core20PLUS5 defines a target population cohort as well as identified 5 clinical area requiring accelerated improvement. ICS's are determining their population groups who experience poorer than average health access, experience and/or outcomes e.g. ethnic minority groups, Gypsy, Roma and Traveller communities, people with multi-morbidities.

Proposals

23. Groups in Wiltshire who have lower uptake of NHS Health Checks include;
- People living in the most deprived quintiles
- Adults aged 45-54 years old
- Males
- Ethnic groups

24. Public Health England published data on the NHS Health Check programme in 2020/21, which can be viewed in Appendix B which details these findings of groups where uptake is lower.

25. There is considerable learning from the COVID vaccination programme which provides potential opportunity to capitalise on this engagement across communities, specifically in reducing the health inequalities. The planned delivery of a community outreach NHS Health Check offer will apply learning from COVID response to wider elements of public health work.

26. In 2022, the Public Health team will undertake a Health Equity Assessment of the NHS Health Check programme in Wiltshire and following recommendations from national colleagues from the evidence review, further recommendations and improvements to the programme locally will be considered. This will support with the development of community outreach offer for NHS Health Checks.

Safeguarding Considerations

27. Patients with learning difficulties who are included on Practice Learning Difficulties registers will already receive regular health checks and so are excluded from this NHS Health Check programme.

28. GP Practices are required to follow their own safeguarding pathways for any concerns for vulnerable adults identified within the NHS Health Check programme.

Public Health Implications

29. This is a Public Health report which throughout has considered the health implications of the report.

Environmental and Climate Change Considerations

30. Nationally, following the NHS Health Checks evidence review, considerations for digital elements of the NHS Health Checks are being undertaken, which would reduce the carbon footprint of patients travelling to their GP Practice for their appointment.

31. As the NHS Health Checks programme restarts and considers how it can tackle health inequalities within the programme; engaging with inclusion groups where there is low uptake, the programme could be offered in

workplaces where there is a significant proportion of the eligible population which would also reduce the carbon footprint.

Equalities Impact of the Proposal

32. The NHS Health Check is a universal programme and should be offered to all eligible people aged 40-74 years old. However, in achieving this there is an opportunity to reducing health inequalities by prioritising checks to those groups with the greatest health need.

33. In 2021, data was collected from Primary Care following a health inequalities survey which illustrated how health inequalities was being tackled through the NHS Health Check programme during the Covid-19 pandemic. Examples of healthy inequality work undertaken was by offering asylum seekers an NHS Health Check on registration, and evening clinics to help with access.

34. The Public Health team will undertake a Health Equity Assessment of the NHS Health Check programme in 2022 incorporate findings into any community outreach work.

Risk Assessment

35. The budget allocated to NHS Health Checks is paid to GP Practices based on activity and based on the average uptake rate of 45% which has been consistent in recent years there has always an underspend in the budget.

36. There will be a cost implication for the community outreach work of the NHS Health Check programme, which will be funded through Public Health Grant allocation. The budget covers GP activity payments for NHS Health Checks, annual Best Practice training for Health Care Professionals, as well as quality assurance checks on point of care testing machines used within the Health Checks. Public Health will undertake a cost analysis of the NHS Health Check outreach programme and review the most appropriate way of commissioning and contract managing this service to enable a higher uptake rate and improvement in addressing health inequalities, whilst maintaining the current provision through the Primary Care delivery model.

Risks that may arise if the proposed decision and related work is not taken

37. The NHS Health Check programme will continue to be delivered and accessed through Primary Care, but the opportunity to reduce the health inequalities associated with cardiovascular disease will be limited.

Risks that may arise if the proposed decision is taken and actions that will be taken to manage these risks

38. Any community outreach provider commissioned by Wiltshire Council will need to work closely with Primary Care to offer a joined up approach to

patients, of which Public Health will manage and will work closely with colleagues in the Integrated Care System to ensure this works effectively.

39. Best practice from other local authority areas which undertake this approach will be considered when designing this work.

Financial Implications

40. The NHS Health Check programme is a statutory programme for Public Health teams in local authorities and funded by the Public Health ring fenced grant.

41. The majority of the £368k NHS Health Check budget is allocated against activity based spend. The proposal in this paper will not require additional funding through the public health grant allocation and will be delivered through the existing budget allocated to NHS Health Checks.

Legal Implications

42. The NHS Health Check programme is commissioned by Wiltshire Council as a mandated service required by the Health and Social Care Act (2012).

Conclusions

43. Cardiovascular disease prevention remains a high priority for Public Health and the wider health and social care system. The NHS Health Check programme in Wiltshire is fully embedded and uptake of the programme is good and above the national average. Further work is needed to target and engage with inclusion groups across Wiltshire and Public Health will explore innovative ways to develop this further and to work in partnership across the health system to ensure this works effectively.

Proposal for Health Select Committee to consider

44. Public Health are inviting comments from the Health Select Committee on the development of community outreach element of NHS Health Checks and to note the intention to address inequalities through this approach.

45. Agree mechanism for reporting back to the Health Select Committee including timescales and/or key milestones to be reported on.

(Professor Kate Blackburn)
(Public Health)

Report Authorship:
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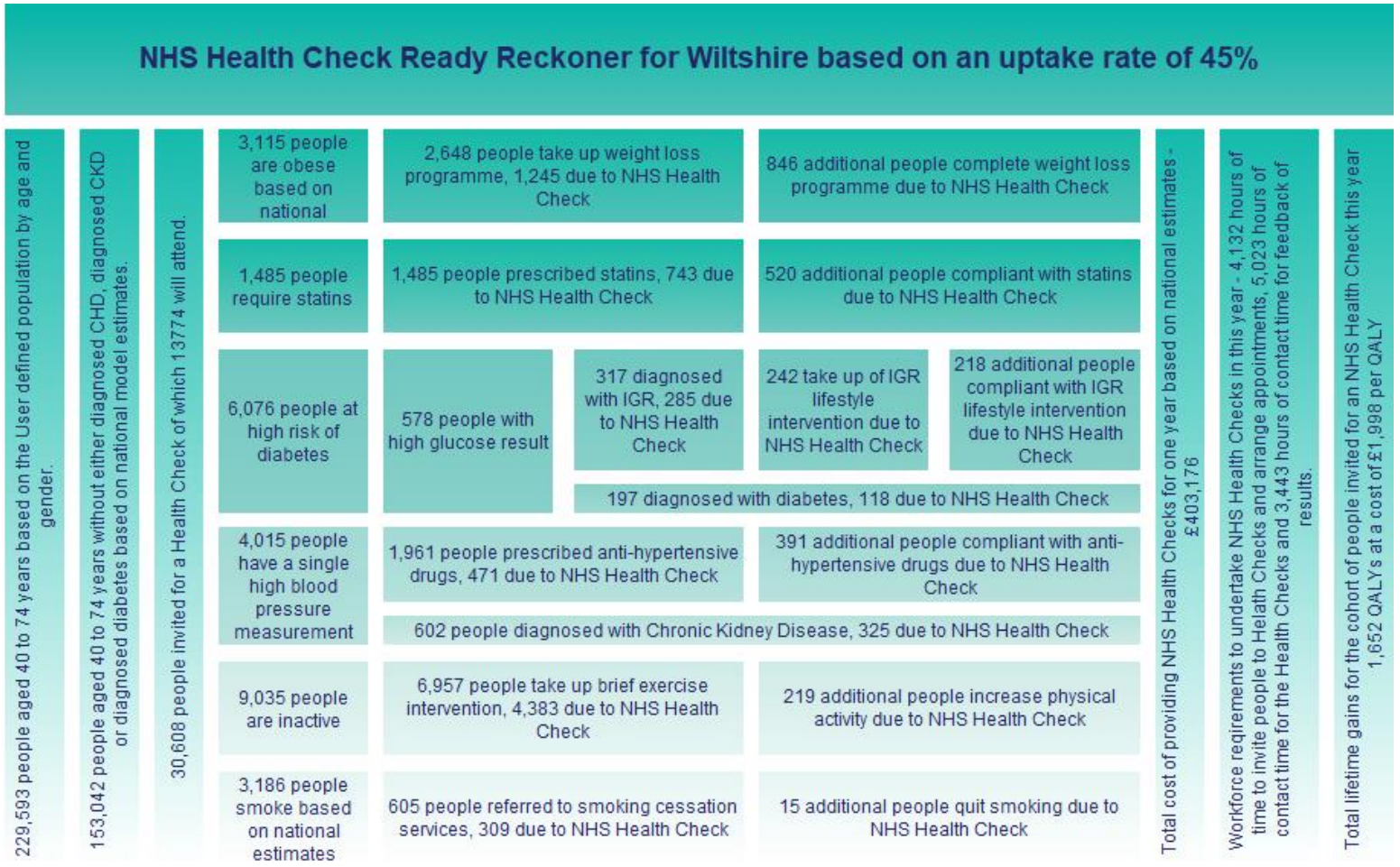
(Gemma Brinn, Public Health Consultant, Gemma.Brinn@wiltshire.gov.uk)

(16 March 2022)

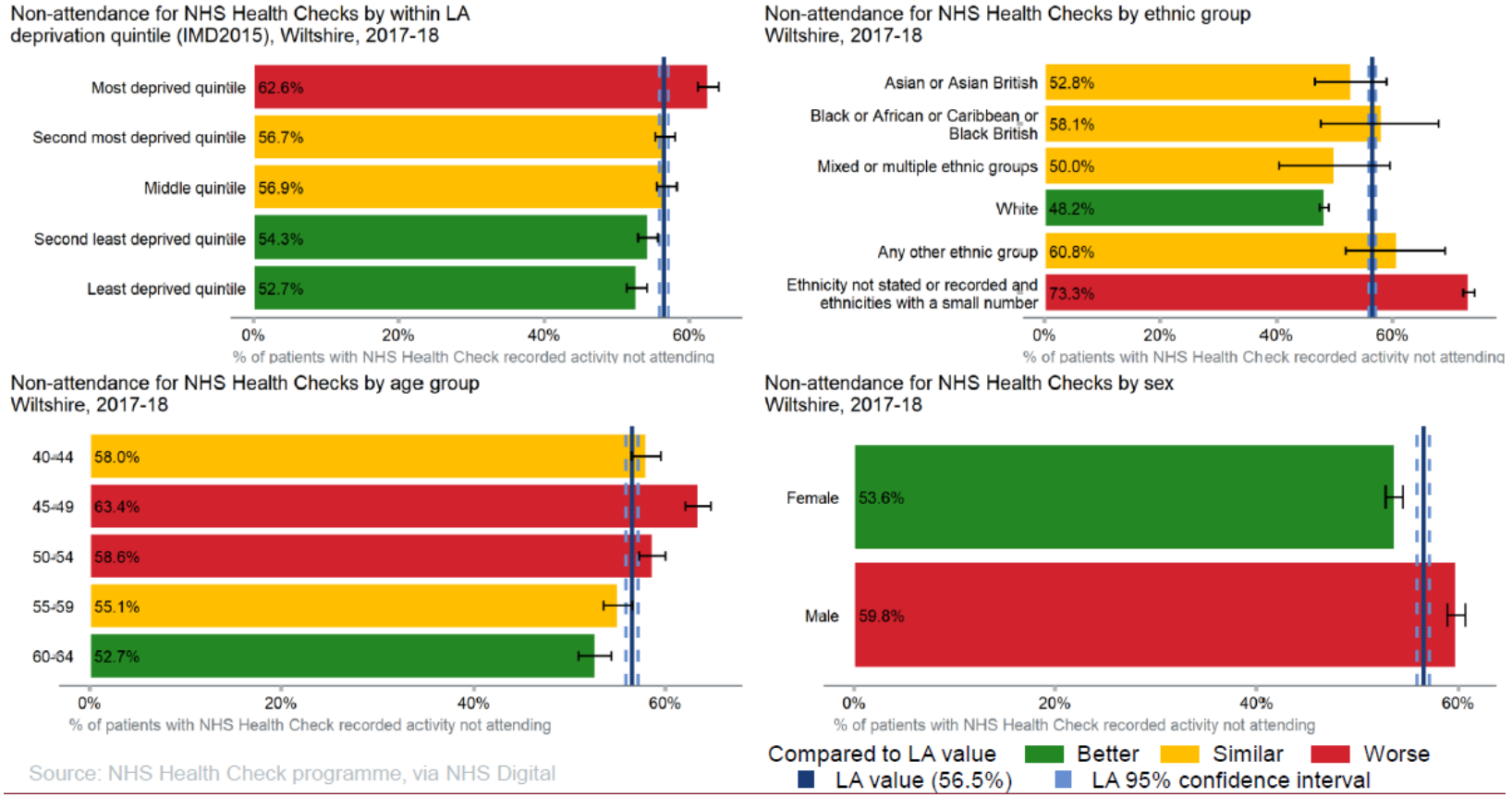
Appendices

Appendix A, NHS Health Check predicted benefits based on uptake of 45% for Wiltshire population



Appendix B, Graphs from Public Health England's CVD Prevention Packs on non-attendence by inequality breakdowns

NHS Health Checks non-attendance by inequality breakdowns: Wiltshire



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Wiltshire Council

Cabinet

29 March 2022

Subject:	**Day opportunities transformation**
Cabinet Member:	**Councillor Jane Davies – Cabinet Member for Adult Social Care, SEND and Transition and Inclusion** **Councillor Laura Mayes – Deputy Leader and Cabinet Member for Children's Services, Education and Skills**
Key Decision:	**Key**

Executive Summary

This report describes a proposed commissioning and procurement approach which will transform how disabled young people, adults and older people access daytime and evenings activities which meet their needs and aspirations in life.

The Council will spend approximately £2.1m in 2021/22 on commissioned and grant-funded day opportunities[1]. These services are delivered to approximately 800 adults with learning disabilities, autism spectrum conditions, sensory needs, cognitive impairment, dementia and other age-related frailties[2].

Day opportunities should meet people's needs as assessed under the Care Act. These needs will lie on a spectrum, from support that promotes independence and community engagement, through to more intensive personal care. Day opportunities must have a clear purpose and meet people's goals and aspirations.

Wiltshire Council has engaged with a range of people who access day opportunities, or potentially would do if those opportunities were in line with what people want to do with their lives. People have clearly described what a good life looks like, and what support they need to live their good life: people want to be accepted and valued, attend a variety of activities, be actively involved in their community, enjoy mainstream services, have fun, learn and try new things, have positive relationships, etc. People want to meet people with similar interests, build ongoing friendships and relationships, be understood and supported to live independently. This means moving towards innovative and creative support which helps people lead meaningful lives.

The current model of commissioning day opportunities does not fully meet these objectives, and historically there has been no overarching commissioning strategy around how the Council works with providers and

[1] This does not include day opportunities funded through block contracts, nor those provided in-house.
[2] These figures for costs and number of customers are full-year effects based on a snapshot from 30/09/21.

purchases services to meet the goals and aspirations of its local population. This plan therefore sets out what we commission now, how we will modernise our offer, and a proposed procurement route to achieve this.

Proposal(s)

Cabinet is recommended to agree:

- To the procurement of day opportunities that are goal-oriented and outcome-focused
- To the development of a service specification that is informed by the views of disabled and older people and the people who support them
- To the procurement of an open framework arrangement under the light touch regime
- That the decision to award contracts against the framework is delegated to the Director of Procurement and Commissioning in consultation with the Corporate Director of People and the Corporate Director of Resources & Deputy Chief Executive

Reason for Proposal(s)

Currently, day opportunities offer limited choice and control for customers. The offer is usually building-based and provides a traditional menu of activities. Whilst services are often valued, we have heard from customers and carers that whilst they access what is on offer, if a more diverse choice of opportunities was available, they would have higher aspirations for themselves.

Wiltshire Council has engaged with disabled and older people about what a good life looks like, and what support they would need to live that good life. The current model of spot-purchasing day opportunities does not enable the Council to shape the market, nor to have sufficient assurance of the quality and capacity of commissioned providers to deliver good outcomes to residents.

Procuring an open framework under the light touch regime will ensure that all providers are vetted to ensure they adhere to legal and quality standards and financial parameters. Successful providers will join the open framework, which will be clearly publicised to customers, carers and practitioners. People assessed under the Care Act as requiring a day opportunity will then be placed with the most appropriate service, using a combination of customer choice, geography, availability, etc – with the most cost effective option that meets need and choice being chosen. Each service user is placed with an individual service contract (rather than an overarching or block contract) which matches the needs of the individual.

Terence Herbert
Chief Executive

Wiltshire Council

Cabinet

29 March 2022

Subject: **Day opportunities transformation**

Cabinet Member: **Councillor Jane Davies - Cabinet Member for Adult Social Care, SEND and Transition and Inclusion**

Key Decision: **Key**

Purpose of Report

1. This report sets out what we commission now, how we will modernise our offer, and a proposed procurement route to achieve this. Cabinet is asked to approve the outcome-driven approach to commissioning day opportunities, and specifically to approve the proposed procurement approach to achieve this.

Relevance to the Council's Business Plan

2. Wiltshire's joint commissioning priorities for 2022/23 are to ensure services are in the right place at the right time; delivered by the right people; and that customers get the right services at the right price. Wiltshire's Market Position Statement (MPS) for Whole Life Commissioning emphasises that people should receive the support they need at the earliest opportunity to live independently and safely within their community.

3. This proposal will ensure that day opportunities:
    a. Focus on the strengths, assets and potential of people
    b. Have a positive and meaningful impact on people's lives
    c. Increase choice and control
    d. Develop people's life skills

Background

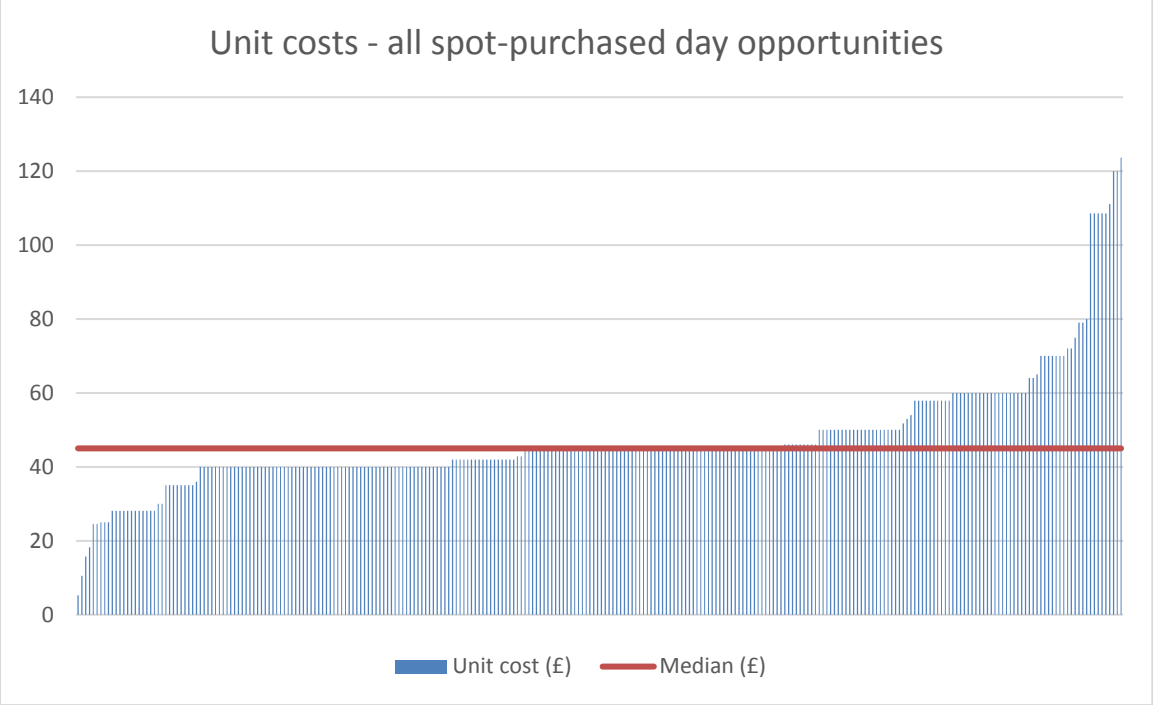
Current supply arrangements

4. Wiltshire Council currently commissions 40 organisations via spot-contracts, 32 via annual grant funding and an additional two via block contracts (Alzheimer's Support and Order of St John). There are five organisations from which we spot-purchase 20 or more day opportunities packages.

5. 277 customers use services provided by the spot purchased organisations – the majority of these (204 people) are adults with learning disabilities.

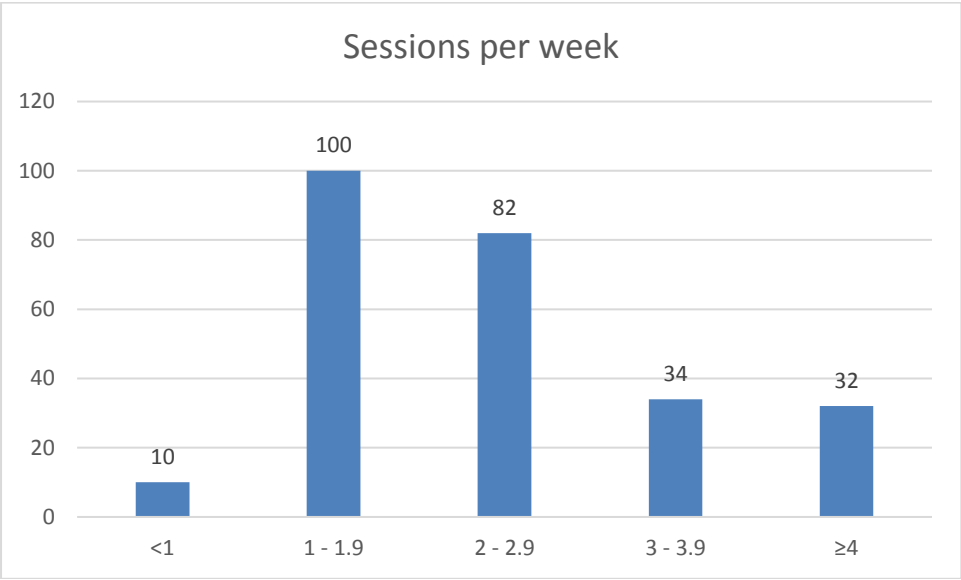
6. These spot-purchased services vary considerably in unit cost, with day rates ranging from £5.25 up to £123.66. The graph below shows the distribution of sessional costs, with 80% of packages costing between £40 and £60 per day.

The median (red line in graph below) and mode day rates are £45; the mean is £48.58.



7. The mean weekly cost per customer of day opportunities is £109.18 overall – this is broadly similar across different customer groups (£104.63 for Mental Health, £112.40 for LDAS, £96.41 for Living Well). The median day rate is £80 per week.

8. More than one third of customers who access spot-purchased day opportunities access them only one day per week. 12% of day opportunities customers access four or more days per week. On average (both median and mean), customers access 2 days per week.



9. The table below shows the breakdown of the gross weekly and gross annual spend on day opportunities currently commissioned:

Commissioned Service / provider	Contract type	Forecast spend in 2021/22
Day opportunities for adults/older people – various providers	Spots	£1,906,744
Friendship groups	Annual grant	£90,961
Luncheon clubs	Annual grant	£117,906
Total		**£2,115,611**

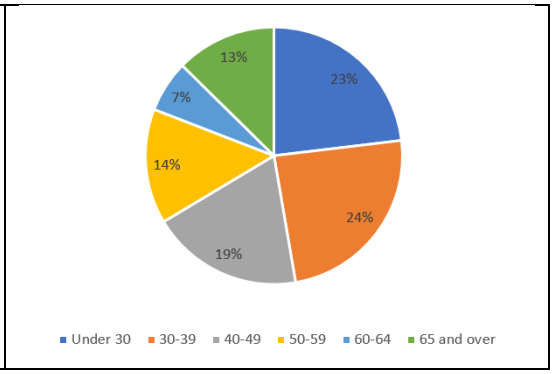
10. The total spend on commissioned and grant-funded day opportunities has reduced slightly since November 2020, mainly due to reductions in activity following COVID-19.

11. In addition to the above, and out of the scope of this proposal, there are two block contract arrangements in place for day opportunities for older people - one with the Order of St. John and the other with Alzheimer's Support.

12. The age range and primary need of people using day opportunities who have a support package are broken down in the pie charts below:

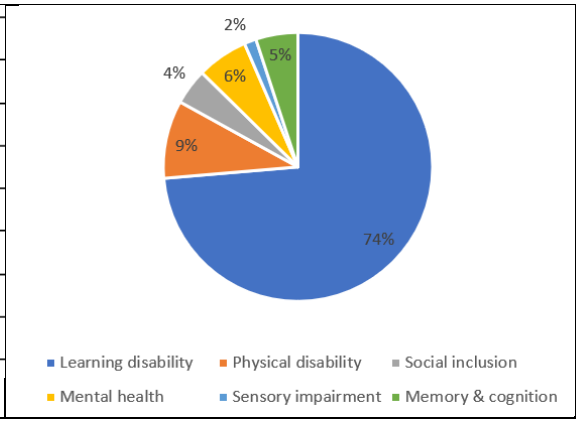
Breakdown by age

Age Range	Number of people who attend
Under 30	64
30 to 39	67
40 to 49	53
50 to 59	40
60 to 64	18
Over 65	35
Total	**277**



Breakdown by primary need

Age Range	Number of people
Learning Disability support	204
Physical disability	26
Social inclusion	12
Mental Health support	17
Sensory Impairment	4
Support with Memory and Cognition	14
Total	**277**



Market Position

13. In 2020, Commissioners set up a Day Opportunities Provider Forum. This was mainly to support providers during the COVID-19 pandemic – e.g. through sharing of information from Public Health about PPE, re-opening etc. It also provided an opportunity for day opportunities providers to meet and have strategic discussions both with commissioners and operational teams, and with other services such as the Wiltshire Employment Support Team (WEST). This forum will be re-launched in March 2022 to inform existing providers about the forthcoming tender, share the Council's vision, and introduce forthcoming market engagement sessions.

14. Council officers will first meet specifically with luncheon club and friendship group providers to explain the tender process. This meeting has been set for 9 March 2022.

15. Following this meeting, the council will start engaging with the market in early-April. Officers will run workshops with providers to set out the vision and outcomes for day opportunities, to explain the bidding and onboarding processes, and to offer support for providers who require it. This is in recognition that tender processes can feel daunting to small organisations – although as this procurement will be under the "light touch" regime, it will be relatively straightforward. Officers will share details of the South West procurement portal (https://www.supplyingthesouthwest.org.uk/) so that organisations can register. The luncheon clubs and friendship groups will also be able to attend these events.

Main Considerations for the Council

16. Currently, the Council spot-purchases most day opportunities for adults of working age and older adults. Spot agreements do not include service specifications and/or outcomes, and there is a lack of transparency around what value the customer and/or the Council get from this investment. Furthermore, there are several providers from whom the Council spot-purchases 20 or more packages.

17. In addition to these spot arrangements, a number of "friendship groups" and "luncheon clubs" have continued in 2021/22 to receive grants from the Council. A savings proposal has been submitted to reduce these payments by 50% in 2022/23, and by the remaining 50% in 2023/24. These providers will have the opportunity to apply to join the Open Framework and win new business; all will be invited to a meeting with Council officers in March 2022.

18. Existing day opportunities offer limited choice and control for customers. The offer is usually buildings-based and provides a traditional menu of activities.

19. Current services are often designed for a specific user group – e.g. volunteering in a garden centre for adults with learning disabilities, or a day centre for older people. This means people don't have the opportunity to access the sort of mainstream and universal options their peers who do not have a disability, condition or frailty can access. Community assets are not consistently promoted, and there is a lack of support for customers to design and develop their own groups, clubs and activities.

20. The Adult Social Care Outcomes Framework 2020/21 shows that 5.1% of adults with a learning disability in England were in paid employment (ASCOF measure 1E). This compared to 5.3% in the South West region and 5.0% in Wiltshire. Whilst Wiltshire performs similarly to the national and regional average, there is still room for improvement and day opportunities could become more of a stepping-stone into paid employment.

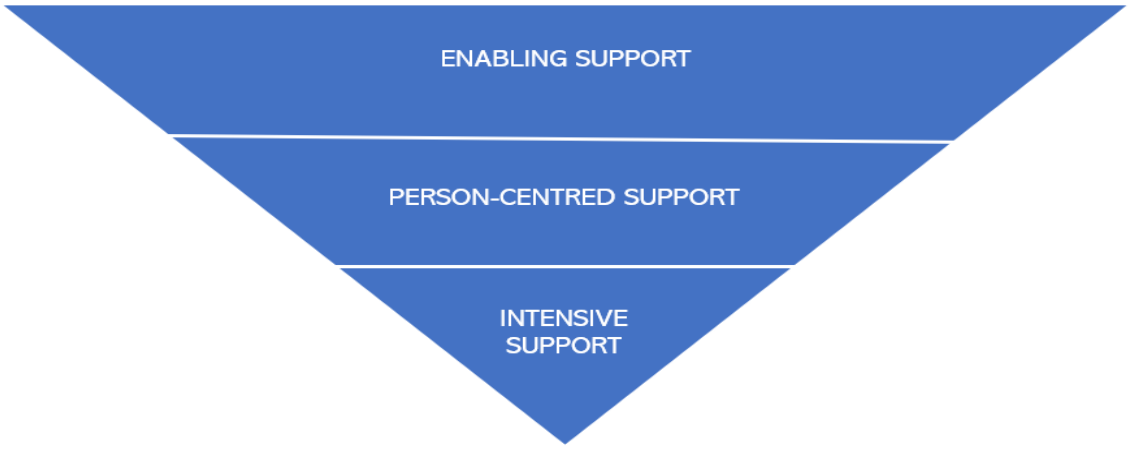
21. We want services to fit around people's wishes and goals, not the other way round. We will do this by:

    - **Developing a tiered model of day opportunities**, where most customers get time-limited, personalised enablement support to promote their independence, help link them to their communities, and regain skills. This may be relatively low-level or high-level support, depending on needs, but will be time-limited. Long-term day care will still be available for people who require it – e.g. people with dementia, learning disabled people who are entering old age, etc.
    - **Communicating a clear message to the market** about the way we work in Wiltshire, and the expectations we have of providers – i.e. that person-centred planning supports people to reach their aspirations and goals.
    - **Reviewing existing packages** and ensuring that people receive the right service in the right place at the right level.
    - **Promoting personal budgets and direct payments**, as a more personalised means by which people can access the right option for them.
    - **Minimising passenger transport usage** by a) promoting independent travel training and b) ensuring that people access opportunities close to home. This will have benefits for the customer and for the environment.
    - **Developing a service specification and outcomes framework** which promote the principles outlined above (and especially, for adults of working age, employability), and which providers will be expected to report on. As stated above, customers will be invited to feed into and review the service specification, to ensure we have got it right.
    - **Introducing a cap on day / half-day rates** so that all providers work within a financial model that represents good value for money.
    - **Procuring an open framework of day opportunities**. This will establish a menu/database of providers which have been vetted for financial sustainability, are compliant in key areas, and which demonstrate a commitment to Wiltshire's values and priorities.
    - Throughout and beyond the procurement process, **engaging with the market** to bring innovative providers on board and support smaller organisations, community assets and/or micro-enterprises with the procurement process.
    - **Creating a database of framework opportunities**, so that customers, families, social workers, commissioners and providers have clear information about what opportunities are available, how much they cost, where they are located.

22. **Proposed new model of day opportunities**

23. The potential for day opportunities to promote independence, connect people with others and help them learn or re-learn new skills will be emphasised in

this re-commissioning. It is therefore proposed that Wiltshire commissions day opportunities which are graduated to meet different levels of need. This acknowledges that one size does not fit all and that, whilst some people will need day opportunities on an ongoing basis, most people can benefit from time-limited, goal-oriented support. It also acknowledges that people will need different levels of support at various times to "get them back on their feet" and maximise their independence.



24. **Enabling support:** When people first access a day opportunity, in the majority of cases an initial package of up to 12 weeks would be commissioned, with clear goals and outcomes around identifying and meeting personal aspirations, supporting the person to gain or regain skills (e.g. independent living skills, or skills that will enable them to get paid work), connecting the person with local groups, services and interests. This level of support would be suitable for people with less complex needs (to be defined).

25. **Personalised support:** People with more complex needs and/or frailties should still be offered goal-oriented support to help them become more independent, feel more confident and maximise their abilities. However, they may require a longer period (albeit still time-limited – e.g. six months) of reablement-focused support, where the day opportunity "does with" rather than "does for".

26. **Intensive support:** A smaller number of customers with more complex needs will need longer-term, more specialist day opportunities which, in some cases, may provide personal and health care as well as activities to promote independence. This will often be primarily to give the person's carer a regular break, as assessed through the carer assessment. However, the principle of supporting people to pursue their own interests and talents will often be as core to this level of support as the others.

27. Critical to the success of this model is that customers are regularly and robustly reviewed to ensure a) that each customer is accessing the most appropriate day opportunity, b) that each customer is accessing the right level of day opportunity – i.e. that they are not being under- or over-prescribed, c) that customers are not having to travel unnecessarily far to access their day opportunity, and d) to identify if the customer could access a more personalised opportunity with a direct payment or personal budget.

28. The adult social care client groups covered by this paper are:

- Adults with a learning disability
- Autistic adults
- Adults with a physical disability and/or a sensory impairment
- Adults with a mental health need
- Adults with needs relating to memory loss, cognition and/or frailty
- Older adults with social isolation

29. Whilst some of these customers access day opportunities directly provided by the Council, these services are outside of the scope of this paper. However, the enablement-focused vision and outcomes of in-house and commissioned day opportunities are well-aligned.

30. The key objectives that the proposed open framework will deliver are:

- Greater choice of day opportunities available.
- All open framework providers will work to a clear service specification and will be monitored consistently on outcomes.
- The Council will be assured of the legitimacy, sustainability and capability of all providers on the open framework.
- Customers will be able to make an informed choice about the opportunities they wish to take up.
- There will be increased focus on enablement, with day opportunities being focused on a clear purpose and specific, person-centred goals.
- There will be a transparent pricing structure which will demonstrates value for money.

Overview and Scrutiny Engagement

31. This report will be shared with Health Select Committee, who will discuss the proposal on 16 March 2022.

Safeguarding Implications

32. The aim of this transformation is to enable disabled and older people to enjoy meaningful activities, take positive risks and stay safe. This approach aligns with Wiltshire's Safeguarding Plan, which emphasises safeguarding children and vulnerable adults from abuse and neglect, as well as increasing community resilience.

33. It also aligns with the safeguarding principles enshrined in the Care Act of:

- **Empowerment** – people will be encouraged to make their own decisions about what they want to do during the daytime or evening.
- **Prevention** – building individual and community resilience.
- **Proportionality** – day opportunities offer a non-intrusive, person-centred way of meeting a person's needs and wishes.
- **Protection** – supporting people who are in the greatest need.

- **Partnership** – through supporting community-based activities, communities themselves becomes key partners in preventing, detecting and reporting neglect and abuse.
- **Accountability** – the tender will ensure accountability and transparency in how organisations are commissioned.

34. Abuse and/or neglect can happen in any setting, including a day opportunity. As part of the tender, the Council will rigorously check that providers have in place safeguarding children and safeguarding vulnerable adults' policies and ensure that any member of staff has been checked under the Disclosure and Barring Scheme as being fit to work with vulnerable people.

Public Health Implications

35. There is a considerable body of evidence relating to the impacts of loneliness and isolation on health outcomes for the whole population Research has shown that chronic social isolation increases the risk of mental health issues like depression, anxiety and substance misuse, as well as chronic conditions like high blood pressure, heart disease and diabetes. This is exacerbated in those already disadvantaged by age, disability and inequality of access.. Social activity and engagement are just as important as physical activity in promoting longer life and reducing the need for people spending time in care settings, or being reliant on social care services, and – most importantly – leading a good life. An important outcome that contributes to people's overall sense of wellbeing is ensuring that they are not socially isolated.

36. Currently, day opportunities offer limited choice and control for customers. The offer is usually building-based and provides a traditional menu of activities. Services are often valued, but we have heard from customers and carers that whilst they access what is on offer, if a more diverse choice of opportunities was available, they would have higher aspirations for themselves and/or their loved ones.

37. Wiltshire Council has commissioned Wiltshire Centre for Independent Living to engage with disabled and older people about what a good life looks like to them, and what support they would need to live that good life. The findings of this engagement are set out in Wiltshire CIL's report entitled *It's my life* and published in January 2022. Below are direct quotations from people who were surveyed:

My good life:

- "Being accepted and valued and using my individual strengths;"
- "I don't want people to write me off for being different;"
- "I have hopes and aspirations like everyone else;"
- "To have positive relationships and spend time with family, friends and neighbours and to have a partner;"
- "I want to be independent and have access to a car;"
- "I want affordable options for college courses which are open to adults to help with employment and computer skills;"
- "I'd like someone to help me re-train for work and get online;"
- "I want to go to music festival and the theatre with friends".

My good support:

- “Support should be inclusive and person centred;”
- “Would be good to match people with support based in interests;”
- “Travel training for new places to build confidence (both on foot and on public transport) together with help when planning a journey;”
- “I like support staff to be experienced, consistent faces, friendly, welcoming, flexible, patient, listening to me, understanding autism, have good communication skills;”
- “I can't get my words out always so people need to be patient and not jump in;”
- “To understand me properly - understand my background and where I am coming from;”
- “I like music and technology and support when cooking with recipes if they are more complicated;”
- “I like going to the park and to do disco;”
- “I sometimes need emotional support (as there have been difficult times);”
- “I would like learning to be kinder and more enthusiastic”.

38. People of working age also often expressed a strong desire to find work. This may mean volunteering as a stepping-stone towards employment, but people also emphasised the importance of a job that pays a proper salary: “paid work gives money and you get annual leave and sick leave, [it] gives you security, helps build up a pension, [makes you] feel secure in what you do, gain confidence in yourself.” Job coaching and other support to apply for, get and keep a job would be valued by many disabled people.

39. More broadly, people want support that gives them control over how they live their lives: “Living my life is having independence, developing life skills with choice and control over my life and choice over who I want to be. Not having to ask permission.” Wiltshire Council wants to commission providers who will support disabled and older people to do the things that many people take for granted: managing money, going on holiday, having a circle of friends, getting married, practicing their faith, going clubbing or going to gigs, filling out forms and doing admin, being loved.

40. There is clear evidence that loneliness and social isolation are key determinants of physical and mental ill-health. The proposals in this report have potential to positively impact health outcomes and healthy life expectancy across a broad range of elements that contribute to the wider determinants of health for this population.

Procurement Implications

41. Procurement options identified are as follows:

42. **Option 1:** Continue with current purchasing arrangements, which has the advantage of retaining the status quo for providers. The drawback of this option would be:

- It is difficult to monitor quality of spot purchasing day opportunities without a specific service specification
- It is difficult to negotiate fair rates for services
- It is inefficient use of social worker/brokerage officer time, searching for appropriate provider services and negotiating prices
- Potential providers may see spot purchasing as offering no level of security to operating their business
- Does not consistently offer an asset-based approach with choice and personalisation

43. **Option 2:** Bundle existing services into a single contract with a number of lots – e.g. one for older people/frailty, one for learning disabilities, one for mental health etc. This may have the advantage of simplifying commissioning arrangements and, through the due diligence of a procurement exercise, would give assurance about the compliance and capacity of providers. However:

    - It would establish a fixed model of provision for the duration of the contract, not allowing for new and innovative providers to enter the market
    - It would disadvantage small organisations and micro-providers, which are often customer/carer-led, well established within their communities, and provide more bespoke services
    - It may mean the Council pays for care that is not in fact used (as happens currently with the OSJ block contracts)

44. **Option 3:** Procure an open framework under the light touch regime. Providers would be admitted onto the framework after having been evaluated as adhering to legal and quality standards and financial parameters. Providers then sign an overarching framework Terms & Conditions which govern the way they will operate if they have anyone placed with them. Providers are onboarded onto the open framework; however, this would not be a guarantee of work. Individuals would then be placed with the most appropriate service, using a combination of customer choice, geography, availability, etc – with the most cost effective option that meets need and choice being selected. Each service user is placed with an individual service contract (rather than an overarching or block contract) which matches the needs of the individual.

45. The indicative timetable for this option is set out below:

Event	Proposed Date
Engagement sessions with potential applicants	Early-April 2022
Open Framework opened for applications	Mid-April 2022
Initial Submission Period	Mid-April to Mid-May 2022
Open Framework temporarily closed whilst Initial Evaluation of Applications	Mid-May 2022

takes place	
Open Framework re-opens	Mid-June 2022
First direct awards are made	Late-June / early-July 2022

46. The advantages of this approach would be:

- This would be a flexible procurement route which allows new providers to apply and join during the period of the framework
- The system could offer greater choice associated with attracting a wider range of providers to working locally
- As the framework would be procured under the light touch regime, there is greater flexibility and choice for the individual customer
- Formalising the commissioning arrangements around day opportunities will enhance our ability to manage price and monitor quality. It can also offer a level of security to providers as they will develop a closer working relationship with the Council
- The model could offer helpful synergy with the existing Good Lives Alliance DPS model
- The model would be outcome driven and could allow the opportunity to look at incentives
- The model would offer opportunities to small and medium sized enterprises
- The model could encourage the development of a micro-provider market

47. Potential Disadvantages:

- Providers may choose not to join the DPS. However, this could be mitigated if we allowed providers to keep existing business (so as not to disrupt existing arrangements for customers who wished to stay with their current provider) but not allow new business from going to non-framework providers (unless customers wished to purchase with a direct payment).
- The outcome of the Covid pandemic may see providers moving away from providing day opportunities. This will be mitigated by extensive market stimulation, including by targeting providers which do not currently provide day opportunities in Wiltshire, and encouraging the growth of micro-enterprises.

48. On 9 December 2021, Commercial Board gave its recommendation to Option 3. The mitigations for reducing the risks of introducing this model ensuring its success are as follows:

- Ensure effective communication with providers so that they can see the benefits of joining a DPS model e.g., regular forum meeting
- Co-design the service specification which will be used with providers and direct recipients of current services to secure ownership
- Allowing creativity and innovation in meeting people's individual outcomes. This will require a review of current support plans

49. If agreed, it will take approximately 3-4 months to engage with the market and undertake the procurement. Hampshire Procurement have been engaged and, if this option is approved, are ready to proceed. Hampshire Council have conducted a similar procurement exercise in recent years and have found it very successful in changing the culture of day opportunities and meeting the objectives detailed above. The Council has undertaken significant co-production and engagement with customers in recent months, and the views of young people, adults and older people have fed into the draft service specification.

50. The Council will continue to engage with Wiltshire residents and customers by working with Wiltshire Centre for Independent Living, Wiltshire Parent Carer Council and other groups to ensure that the feedback and recommendations made in Wiltshire CIL's *It's my life* report are implemented.

51. It is proposed that the Open Framework runs for an initial period not exceeding four years, with the option to extend by a further period not exceeding four years. The Open Framework would therefore have a maximum duration of eight years; however, the Council could re-commission any time before this period is up.

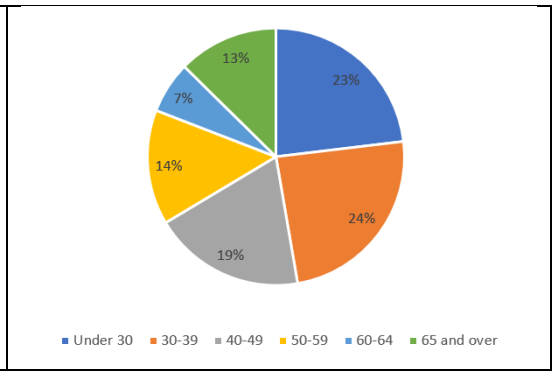
Equalities Impact of the Proposal

52. An Equality Impact Assessment was undertaken to review the potential impact on: (1) the suppliers of day opportunity service provision who currently support people referred by the Authority; and (2) to evaluate the potential impact on those people currently receiving a service.

53. As day opportunities are currently either spot-purchased or grant-funded, the Council holds very limited equalities data about customers. The tables and pie-charts below show all customers broken down by age and primary disability:

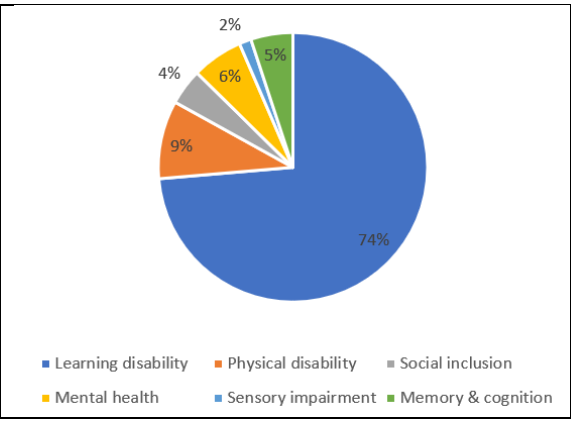
Breakdown by age

Age Range	Number of people who attend
Under 30	64
30 to 39	67
40 to 49	53
50 to 59	40
60 to 64	18
Over 65	35
Total	**277**



Breakdown by primary need

Age Range	Number of people
Learning Disability support	204
Physical disability	26
Social inclusion	12
Mental Health support	17
Sensory Impairment	4
Support with Memory and Cognition	14
Total	**277**



54. Two thirds of customers are under 50 years of age, and yet currently services are mainly buildings-based and disability-specific. Disabled people (and especially younger people) have told us they want support which enables them to be part of their communities, not separated from them. They want to access services which are meaningful, enjoyable and useful to them. It is only by procuring an Open Framework and developing our market to deliver personalised support that we will meet people's needs and aspirations.

55. Whilst we have robust data on age and primary disability (see tables & pie-charts above), we lack demographic data about sexual orientation, marital/civil partnership status, race, religion or belief etc. We therefore cannot say with confidence that existing day opportunities are tailored to meet people's protected characteristics.

56. It is likely that customers of day opportunities come from all equalities target groups. By procuring an Open Framework and engaging the market proactively, we can encourage new groups, providers and micro-enterprises to join the Wiltshire market. For example, if a group of LGBT people with learning disabilities wished to go clubbing once a month, or form a peer support or social group, we could relay this to the market and encourage a provider to plug that gap.

Environmental and Climate Change Considerations

57. This proposal aligns with the Council's draft Climate Strategy, and particularly its commitment to carbon neutrality by 2030. By ensuring a choice of service provision across Wiltshire, the proposal will support people to stay local to their place of residence and help to ensure that Wiltshire residents attend opportunities in their local community area. There will be a reduction in travel distances which will enable local transport links and other means of transport to be utilised locally.

58. The emphasis of the new service offer will be to increase use of community assets and outdoor activities. It is anticipated this will reduce carbon emissions from static sources.

59. Procuring an open framework of day opportunities will mean that providers can be vetted for compliance and their commitment to Wiltshire's values and priorities. This means that if the council develops specific environmental

priorities or principles that are relevant to the service, they can be included easily in the procurement process, where appropriate to do so. Potential providers can be made aware of the council's commitments and policy on environmental issues and can build this into their offer over time. This will be part of how the social value of the contract is demonstrated.

60. There will be an expectation that suppliers reflect the Authority's commitment to carbon neutrality in how they operate and report on their carbon footprint. The tender will also include a question asking how suppliers will contribute towards the Council's Climate Strategy.

Risks that may arise if the proposed decision and related work is not taken

61. If the proposed decision and work is not taken, the Council would continue spot-purchasing day opportunities from the same limited range of suppliers. It would not get the legal, governance and financial assurances from suppliers that a tender would provide, and there would be no framework around which commissioners could stimulate the market. There would be a high risk that disabled people would continue not to be able to access the activities and opportunities they say they need to thrive in life.

Risks that may arise if the proposed decision is taken and actions that will be taken to manage these risks

62. Given the transformative nature of this proposal, there is a risk that the continued need for day care which is primarily aimed at giving respite to the carer and which is likely to be needed long-term will be overlooked. This will be mitigated by emphasising the need for a breadth of provision – from time-limited and outcome-focused, to longer-term and driven by carer needs.

63. This proposal also mitigates any risk which arises from savings proposals to cease grant payments to friendship groups and luncheon clubs by offering those providers affected the opportunity to apply to join the Open Framework and thereby win new business.

64. There is a risk that existing providers may choose not to apply to join the Open Framework (e.g. because they do not wish to participate in a tender). This is considered a low risk, given previous experience of procuring Open Frameworks. Existing suppliers that choose not to apply will be able to retain existing spot-purchased business (though not to gain new business), which means that customers with eligible needs, as identified through a Care Act assessment, will not see their packages disrupted. The risk of a wider failure of market stimulation will be mitigated by the market engagement described above.

Financial Implications

65. In the Invitation to Tender (ITT) documentation, the Council is obliged to publish its total aggregate budget for the duration of the contract. The Council is not committed to spending the totality of this budget; however, this figure cannot be exceeded within the terms of the contract.

66. The Council has an aggregate budget of £17,100,000, exclusive of VAT, for call-offs from this Open Framework. (This does not include transport costs.) This is calculated on the basis of the approved budget for 2022/23 and projected price inflation and demographic pressures over subsequent years.

67. As the framework proposed within this paper is a call-off contract, there are no savings or pressures directly arising from the proposals. As the contracts are call-off ones there will be an incentive for providers to be competitive in both their service offer and price if they wish to win business.

Legal Implications

68. Any procurement exercise should be conducted in accordance with the requirements set out in Part 10 of the Council's Constitution, the SPH Manual and the Public Contract Regulations (2015). Legal Services will need to be engaged throughout this process, with the relevant legal and procurement advice sought.

69. Wiltshire Council's Legal Services must draft a robust Framework Agreement, Terms of Inclusion, Individual Service Contract and legal documentation for this matter. Legal Services will need to be consulted to review the final documentation before execution.

70. Cabinet should delegate authority to enter into the Framework Agreement, Terms of Inclusion, Individual Service Contract and any other legal documentation to an appropriate individual.

Workforce Implications

71. There are no TUPE or staffing implications for existing Wiltshire Council staff should these proposals be agreed, as the proposal only impacts external partners and providers.

Recommendations

Cabinet is recommended to agree:

- To the procurement of day opportunities that have a purpose, are goal-oriented and outcome-focused
- To the development of a service specification that is informed by the views of disabled and older people and the people who support them
- To the procurement of an open framework arrangement under the light touch regime
- That the decision to award contracts against the framework is delegated to the Director of Procurement and Commissioning in consultation with the Corporate Director of People and the Corporate Director of Resources & Deputy Chief Executive

Helen Jones (Director - Joint Commissioning)

Report Author: Robert Holman, Commissioning transformation lead

Date of report: 08/03/2022

(Make sure above includes name, title and contact details of report author)

Appendices

N/A

Background Papers

The following documents have been relied on in the preparation of this report:

Wiltshire Centre for Independent Living, *It's my life,* January 2022.

Wiltshire Council

Health Select Committee

16 March 2022

Rapid Scrutiny Exercise:
Day care provision: Open framework tender; lunch and friendship clubs

Purpose

1. To present the rapid scrutiny (RS) findings of the transformation proposals for council grant funded luncheon and friendship clubs.

Background

2. Full Council on 15 February 2022 invited Overview and Scrutiny (OS) to consider the transformation proposals for grant funded lunch and friendship clubs.

3. As part of legacy arrangements, several friendship and luncheon clubs have received grants from the council, totalling around £0.2m per annum. The approved 2022-23 budget included a proposal to reduce these payments by 50% for 2022-23, and by the remaining 50% in 2023/24.

4. From April 2022, the clubs will have the opportunity to bid to join a list of council vetted providers of day care as members of a list known as an open framework. This is part of a wider transformation of day opportunities, to offer increased choice and control for those receiving day care. Organisations on the list would be available to provide council-funded day opportunity placements to people assessed under the Care Act, as well.

5. The 2022-23 budget for day opportunities provided through the open framework is approximately £1.5 million. The friendship and luncheon clubs to secure revenue from this budget will need to meet the council's vetting requirements and look to attract people assessed as requiring a day opportunity.

6. The council's commissioning and procurement leads are scheduled to host an engagement event with the grant funded clubs and groups on 9 March 2022. In response, it was agreed by the Chairs of the Management Committee and Health Select Committee to hold a RS exercise in advance of this date.

7. The RS took place exercise on 2 March 2022. Members were given a presentation of the proposals for clubs and groups, questions followed.

Terms of Reference (ToRs)

8.

A) **Rationale for change** – to briefly revisit the reasons for transformation of the historic grant funding arrangements for luncheon and friendship clubs.

B) **Communication**
- to explore how the council intends to engage and communicate with the clubs to ensure understanding of the transformation proposals and future opportunities
- to ensure that communication around the tender encourages geographical consistency in the future provision across the county.

C) **Future funding criteria** – to establish what funding opportunities will be available for users with/without a formal social care assessment as part of the transformation plans.

D) **Overview of an open framework**
- to consider what is meant by a light-touch open framework and to seek reassurance that the process will be fully inclusive to the voluntary and community sectors
- to consider whether the framework includes a revolving door for any new bidders or resubmissions following unsuccessful bids

E) **Sharing best practice** – to consider any potential role the council has in facilitating the voluntary sector in this area by encouraging the sharing of best practice e.g., volunteer recruitment**.**

Membership

9. Cllr Johnny Kidney (Lead member)
Cllr David Bowler
Cllr Gordon King
Cllr Jerry Kunkler
Cllr Pip Ridout
Cllr Graham Wright
Cllr David Vigar

Witnesses

10. Cllr Richard Clewer (Leader)
Cllr Jane Davies - (Cabinet Member: Adult Social Care)
Cllr Mike Sankey – (observing)
Lucy Townsend (Corporate Director- People)
Helen Jones (Director Procurement & Commissioning)
Robert Holman – Commissioning Manager – Transformation
Victoria Bayley – Head of Commissioning
Karen Wade – Senior Commissioner
Nick Buchanan – Procurement lead

Summary of findings

11. The grants to the friendship groups and luncheon clubs were legacy arrangements initiated by Wiltshire's former district councils. It was understood that no new groups had joined the list since pre- May 2009.

12. The council funded 32 luncheon and friendship clubs. This had reduced from 38 because of the impacts of the pandemic. Funding arrangements with clubs varied considerably, with grants to individual groups ranging from £37,686.06 to £893.48. Five community areas did not benefit from any funding (BoA, Calne, Corsham, Tidworth, Warminster). In several areas there are luncheon clubs for elderly people and other organisations with potential to offer day care that do not receive a council grant but perform a similar function to the grant-supported clubs.

13. Data was unavailable on the number of people accessing the luncheon and friendship clubs with/without a current care assessment. Using local examples scrutiny councillors highlighted that many of the members do not currently have assessments. Concern was raised that attendance at the clubs may have masked a potential care need. In response, the organisations were being made aware of the council's Contact and Referral service, the gateway to securing a formal care assessment.

14. Members challenged whether the £1.5m budget would be sufficient, particularly if the numbers of people with a care assessment increased. Confirmation was given that adult social care (ASC) was a demand driven service and that the budget would be managed carefully, and new service users would be given open access to opportunities.

15. An engagement event had been organised with the clubs/groups on 9 March to communicate the future proposals around day opportunities. At the time of the meeting, over twenty groups had accepted the invite, with officers continuing to encourage even wider participation. Members felt it imperative that communication at this event was in 'plain-English' to avoid losing potential community providers, intimidated by technical and formal language.

16. Members were told that the process to join the list of future providers (the framework) had been made as user friendly as possible. The clubs would be required to complete a questionnaire, with many simple yes/no answers. IT Support would also be available to help use the council's preferred procurement platform, Pro-contract. The framework would remain open indefinitely for new applications or resubmissions, hence the terminology 'an open framework'. The emphasis of the transformation was to encourage a well distributed countywide offer.

17. In parallel, members were introduced to the process that customers with a care assessment would follow:

    - Step 1 – individual is given an assessment where their needs and preferences are recorded.
    - Step 2 - suitable services are identified, with one selected from a combination based upon customer preference and price.
    - Step 3 - a formal agreement (known as a Confirmation of Service Agreement – COSA) between the council and the selected provider is agreed. This contract captures the specifics of required support and provides assurance to the provider on what funds they will receive.

18. It was emphasised to the members that joining the list of providers would not guarantee business. To secure placements the offer would need to be attractive to encourage people to want to attend. The new model also offered the opportunity to continue to cater for those without an assessment who pay their own fees for lunches and activities, including those who are carers themselves.

19. Confirmation was given to members that people with a care assessment who were happy with their current placements would be able to remain with their current group where that offer remained appropriate and was on the framework.

20. By moving to a new contract management arrangement, the intention was to ensure an acceptable quality of service, introduce a mechanism to address any issues and increase certainty for both providers and users.

21. Subject to Cabinet approval the timeline for the framework procurement was as below; previous experience from similar exercises suggested that approximately two thirds of the 32 existing grant recipients would be expected to join the framework. The 50% grant awarded for 2022-23 was intended to provide a buffer to protect these groups as they made the transition to the new arrangements, with its subsequent revenue generation potential from early July 2022.

Event	Proposed date
Cabinet	29 March 2022
Open framework open for applications	Mid-April 2022
Initial submission period	Mid-April to mid-May 2022
Open framework temporarily closed for initial evaluation of applications	Mid-May 2022
Open framework re-opens	Mid-June 2022
First direct awards are made	Late-June or early-July 2022

22. Members were initially concerned that the proposals would require all voluntary groups, including those currently not grant-funded, to join the framework to continue: for example, a luncheon club that had been operating without a council grant, supporting individuals without a care assessment. Confirmation was given that the council very much encouraged the continuation of voluntary activity. However, if a group did wish to provide an offer for care assessed residents, then they would need to be part of the framework.

23. Members were introduced to some potential funding streams that were available to voluntary groups that may not wish to be part of the framework, including the Morrison's Foundation and Asda Foundation. The community engagement managers (CEMs) were a tool available to the community groups to identify potential alternative funding sources. It was noted by some members that securing community grant funding was an extremely competitive process.

24. Health and Wellbeing Funding was also available from the area boards, although some concern was raised that this was not based upon population and was fixed at £7,700 per community.

25. Members were also concerned that the costs associated with providing a club would be prohibitive when a provider determined their rates. For example, a group using a village hall with high rental costs. It would be for the provider to determine their rates, which would have to reflect costs such as staff and buildings. Reassurance was given that people would not be asked to travel longer distances to access activities because rates were lower.

26. Members learnt that the focus going forward was not necessarily about buildings but would be increasingly community orientated. The example of gig buddies was given, where people with a learning disability are matched to a volunteer to access activities such as music concerts.

Conclusion

27. The RS exercise has established the historic funding arrangements for luncheon and friendship clubs, that are ending over two years, and the opportunities going forward. To secure ongoing funds from the council, the clubs will need to become day care providers for those assessed under the Care Act as well as community groups catering for those not so assessed. To do this, they will need to evolve to embrace the transformation taking place within day opportunities, underpinned by the new open framework. The organisations will need to be attractive to customers, competitively priced, and aspire to attract self-funders. It is anticipated that approximately two thirds will choose to bid to join the framework.

    The 50% grant buffer was seen as essential to support organisations through the transition to the first direct awards in July 2022.

    It was felt the use of plain English was key to maximise the numbers who saw this change as an opportunity rather than a restriction on operations.

    By introducing a more rigorous contract management arrangement with a finite budget, concerns were raised that the available funds could be insufficient. Commitment was given that newly assessed customers would be given open access to opportunities, but members felt that ongoing scrutiny of this area was a necessity, and this has been addressed within the recommendations.

    For the grant recipients who choose to not join the framework but wish to continue providing a community offer, the role of the council's CEMs in offering support to identify and access alternative funding streams was seen as paramount. Future communication with the clubs and groups should look to raise awareness of this support avenue.

Recommendations

28. **The Health Select Committee (HSC) is asked to approve:**

a) That the luncheon and friendship clubs be given practical council support, including use of Pro-Contract, if they decide to bid to be placed on the new open framework;
b) That all future communications with the luncheon and friendship clubs is underpinned by the use of plain English, including the 9 March engagement event;
c) That the COSA agreements between the council and successful bidders provide certainty of funding for those individuals over a reasonable period;
d) That the council through its commissioning and community engagement team communicate to all 32 clubs the information shared with members on alternative funding sources;

e) That the council use all possible means of communicating the tender opportunity to clubs and organisations not currently receiving day care funding or grant funding – including community lunch clubs and innovative providers such as music clubs, book clubs and ‘gig buddies’;
f) That the Health Select Committee invite an update on the effectiveness of the new framework at its September and November 2022 meetings, including a focus on spend to date, outcomes achieved and geographic coverage.

Cllr Johnny Kidney, lead member for the rapid scrutiny exercise

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Appendices None
Background documents None

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Wiltshire Council

Health Select Committee

16 March 2022

Rapid Scrutiny Exercise:
Housing Related Support (HRS)

Purpose

1. To present the findings and recommendations of the second housing related support (HRS) rapid scrutiny (RS) exercise.

Background

2. The Health Select Committee (HSC) at its 6 July meeting 2021 initiated a rapid scrutiny exercise to review the council's preferred position in respect of the HRS service.

3. This followed the Cabinet decision of 29 June 2021, where it was agreed to note the preferred position of the council to end the HRS service and support residents through a transition phase (Option B).

4. Cabinet gave delegated authority to the Director of Joint Commissioning, in consultation with the Cabinet Member/Corporate Director to take the final decision following a further consultation.

5. The RS group met with the Executive on 13 October 2021 to review the final proposals in advance of the delegated decision. The scrutiny panel concluded that it was satisfied with the council's preferred position however, a second RS was proposed for early 2022 to ensure that alterative ongoing support would be in place for residents up to and beyond 1 April 2022.

6. The scrutiny group also requested that the second meeting included detail on the following:

   a) The number of residents who have had a care act assessment
   b) The number of residents who have care act assessments outstanding
   c) The number of residents who have been linked directly with Voluntary Community Sector (VCS) groups

7. The second RS took place on 11 February 2022; landlords, Community Engagement Managers (or a representative) and VCS partners were also invited to attend the exercise.

Membership

8. Cllr Ruth Hopkinson (Lead Member)
   Cllr Johnny Kidney
   Cllr Mike Sankey (apologies for 2nd RS)
   Cllr David Vigar
   Diane Gooch

Witnesses

9. Cllr Jane Davies - (Cabinet Member: Adult Social Care)
   Helen Jones - (Director Procurement & Commissioning)
   Deborah Elliot - (Commissioning Manager)
   Jessica Mitchell - (Senior Commissioner)
   Jacqui Abbot - (Community Engagement Manager)
   Maria Gibbs (Aster), Tony Helm (Aster)
   Gemma Castley Adams (Greensquare Accord)
   Hannah Perkins (Selwood)
   Sarah Cardy (Age UK), Pippa Webster (Age UK)
   Jane Mason (Mere VCS)

Summary of findings

10. The meeting commenced with officers emphasising that delivery of the Cabinet resolution is very much a partnership approach. The breath of stakeholder representation in attendance was used to illustrate this collaboration.

11. The primary concern to emerge from the first RS exercise was the potential implications for residents when the HRS service ended. In response, the group was presented with the table below, detailing the number of residents that had been referred to Adult Social Care (ASC) and those currently in receipt of care whose packages had been reviewed. The table also included the number of residents referred to the voluntary community sector (VCS).

	Activity	**Total Number of Residents**
	Number of residents with active care packages (as of January 2022)	243- 63 opted in
	Number of HRS customers i.e. opted in with active care packages who have had these reviewed within the previous ten months (since March 2021)	30
	Number of HRS customers who require their care package to be reviewed before 31 March 2022. Adult Social Care has provided assurance us that all reviews will be completed by 31 March 2022	33
	Referrals made by HRS to Adults Social Care (ASC) (period August 2021 to January 2022)	12
	Referrals made by HRS to VCS (period August 2021 to January 2022	65

12. There were currently sixty-three residents who had opted into the HRS service with active care packages (i.e., known to ASC). Of these, thirty packages had already been fully reviewed, with a further thirty-three to be finalised. The group explored in detail whether it would be possible to complete all reviews by the deadline of 31 March. Members were given the commitment that the thirty-three outstanding assessments would be completed on time. It was also reaffirmed to the group that the ASC officers responsible for the reviews had confirmed this timeline. Several members were concerned at the short timescale available to complete the outstanding assessments and felt that this presented significant risk to vulnerable residents who required continuity in support.

13. Members explored the impact for residents whose care review determined they needed a revision to their current package. In that instance it was learnt that the request would be referred to the council's Brokerage Team, who would secure the necessary support, as appropriate. Once more some members felt that this was a potential further area of risk, particularly if there were delays in assessment leading to additional delays in securing appropriate support packages.

14. During the first RS exercise there was concern that HRS had masked potential social care needs, where residents would have been in receipt of a social care package if not for HRS. In the June Cabinet report this was estimated at approximately one hundred and forty residents. This was based upon one hundred residents (unknown to ASC) who had contacted the council's Wellbeing Hub during the pandemic, plus estimates from housing provider partners.

15. To date twelve additional residents had been referred to ASC for an assessment by the HRS service. Data protection regulations prevented the details of those individuals who had contacted the Wellbeing Hub being shared to further facilitate a referral. However, contact information for ASC's access point for referrals - 'the Advice and Contact Team' had been shared with landlords and residents to help with signposting and to access support. Additionally, two letters had been sent to all residents making them aware of the referral process and the availability of wider support. The difference between estimated and realised numbers concerned several members, particularly when one of the housing providers stated that they too were worried about the future support available to help residents complete an assessment. In response, it was highlighted that the Council's Prevention and Wellbeing Team was now embedded within the organisation and was receiving positive feedback about the quality of their work. This team would be a tool available to support residents as they made the transition to the new arrangements.

16. The housing providers attending the meeting confirmed their commitment towards meeting duties relating to housing support. It was highlighted that this would exclude any care provision, which was not within their remit. Some members felt that this challenged the message that the HRS service had

duplicated the responsibilities of the providers, and because of this vulnerable residents were potentially being exposed to risk from 1st April.

17. Although not available at all schemes, the feedback from landlords was that residents benefitted mostly from activity provision that the HRS provided. In response to this the community engagement managers (CEMs) had been working with ASC to produce a directory of information on community groups in local areas to support with wellbeing. The intention was to make this list available to the public through Your Care Your Support. Feedback at the meeting from the VCS reinforced the importance of a single portal providing this information.

18. VCS representatives from Age UK told members that they aspired to take activities into schemes, but resources made this challenging on a wider scale. The VCS representatives also highlighted that they also faced resource challenges with retention of volunteers difficult. The opportunities presented within the council's proposed open framework for adult day services was highlighted to the meeting and members agreed that this would be a potential area for future overview and scrutiny (OS).

Conclusion

19. The RS exercise established that progress had been made towards providing a care referral for residents with an active care package and a commitment that all assessments would be completed by 31st March. There was concern within the group that this would not be completed by the deadline and confirmation has been requested within the recommendations.

20. The efforts to ensure residents were referred to ASC was welcomed, however the estimated numbers within the Cabinet report had not yet translated into formal referrals and this had been raised as a significant risk by several members. The commitment by the Executive to provide wellbeing support beyond 1st April, through such mechanisms as the CEMs and Prevention and Wellbeing teams, was seen as key in addressing any potential concerns for this area.

21. The housing providers clarified for members their statutory duties, which focused on housing support functions as opposed to social care. Again, several members felt this did not complement the justification to end the service because of duplication with the statutory duties of providers.

22. The scrutiny group welcomed the commitment to create a central portal for community activities and commended the commitment of the VCS and CEMs in identifying and providing community-based activities to ensure a successful transition post April 2022.

23. The members felt that open framework arrangements being developed as part of the transformation of ASC was a key development that required further scrutiny, particularly in respect of the opportunities that this presented the voluntary sector.

Recommendations

The Health Select Committee (HSC) is asked to approve:

i) That a written update is given to the Chair and Vice-Chair of the HSC on 31st March 2022 confirming the status of the HRS related care assessments.

ii) That the Prevention and Wellbeing team prioritise its focus on sheltered housing schemes particularly during the transition period up to and beyond 1st April; and any associated delivery plan is shared with the members of the rapid scrutiny group.

iii) That the HSC incorporates into its work programme how the Council's ASC transformation intends to collaborate with the voluntary sector in relation to the proposed open framework for day care opportunities.

Cllr Ruth Hopkinson, lead member for the rapid scrutiny exercise – Housing Related Support

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Appendices None
Background documents None

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Wiltshire Council

Health Select Committee
Forward Work Programme

Last updated 1 APRIL 2022

Health Select Committee – Current / Active Task Groups			
Task Group	**Details of Task Group**	**Start Date**	**Final Report Expected**
N/A			

Health Select Committee – Forward Work Programme			Last updated 1 APRIL 2022		
Meeting Date	**Item**	**Details / Purpose of Report**	**Corporate Director and / or Director**	**Responsible Cabinet Member**	**Report Author / Lead Officer**
7 Jun 2022	Adult Social Care System Review	Health Select Committee to consider the outcomes of a system review of Adult Social Care.	Lucy Townsend (Corporate Director - People)	Cllr Jane Davies	Lucy Townsend
7 Jun 2022	AWP Transformation Programme	Overview of AWP's Transformation Programme and associated opportunities for Wiltshire.	Lucy Townsend (Corporate Director - People)	Cllr Jane Davies	Dominic Hardisty
7 Jun 2022	Long Covid Support Service	Wiltshire Health and Care to outline the long covid support available to Wiltshire residents, outlining associated challenges and opportunities.	Lucy Townsend (Corporate Director - People)	Cllr Jane Davies	Douglas Blair
7 Jun 2022	Integrated Care Alliance	Update report on the development of an Integrated Care Alliance within Wiltshire as part of the Integrated Care System proposals.	Lucy Townsend (Corporate Director - People)	Cllr Richard Clewer	David Bowater Elizabeth Disney
7 Jun 2022	South West Ambulance Service update	Performance update and overview of transformation proposals.			Nicola Ash