Wiltshire Council

AGENDA

Meeting: **Health and Wellbeing Board**

Place: **Wiltshire Music Centre, Ashley Road, Bradford On Avon, BA15 1DZ.**

Date: **Thursday 28 September 2023**

Time: **Not before 10.00 am**

A Celebrating Age Event will be held prior to the meeting from 8.30am

---

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

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

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

---

Voting Membership:

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

Non-Voting Membership:

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

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

Recording and Broadcasting Information

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

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

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

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

Parking

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

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

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

Public Participation

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

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

The full constitution can be found at this link.

Our privacy policy is found here.

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

AGENDA

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

The Chairman will welcome everyone to the meeting.

2 **Apologies for Absence**

To receive any Apologies for Absence.

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

To confirm the minutes of the meeting held on 20 July 2023.

4 **Declarations of Interest**

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

5 **Public Participation**

The Council welcomes contributions from members of the public.

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

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

Those wishing to ask questions are required to give notice of any such questions in writing to the officer named on the front of this agenda no later than 5pm on **Thursday 21 September 2023** in order to be guaranteed of a written response**.** In order to receive a verbal response, questions must be submitted no later than 5pm on **Monday 25 September 2023.** 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 **Carers Strategy** *(Pages 15 - 38)*

To receive a report from Mel Nicolaou on the Carers Strategy.

7 **Dementia Strategy** *(Pages 39 - 68)*

To receive a report from Rob Holman on the Dementia Strategy.

8 **Mental Health Crisis Care Concordat Update** *(Pages 69 - 86)*

To receive an update on the Mental Health Crisis Care Concordat (Right Care Right Person) from the Office of the Police and Crime Commissioner/ Wiltshire Police.

9 **Primary and Community Care Delivery Plan and Future Commissioning of Community Care Services** *(Pages 87 - 128)*

To receive a report from Caroline Holmes on the Primary and Community Care Delivery Plan.

10 **Annual Health Protection Report** *(Pages 129 - 184)*

To receive the Annual Health Protection Report from Dr Michael Allum.

11 **Date of Next Meeting**

The next meeting of the Health and Wellbeing Board will be on 30 November 2023.

12 **Urgent Items**

Any other items of business which the Chairman agrees to consider as a matter of urgency.

Health and Wellbeing Board

MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 20 JULY 2023 AT KENNET ROOM - COUNTY HALL, BYTHESEA ROAD, TROWBRIDGE, BA14 8JN.

Present:

Cllr Richard Clewer (Chairman), Alan Mitchell, Gina Sergeant,

Also Present:

Max Hirst, David Bowater, Cllr Gordon King, Kate Blackburn, Sarah Cardy, Cllr Ian Blair-Pilling, Cllr Tony Jackson, Rob Llewelyn

39 Chairman's Welcome, Introduction and Announcements

Cllr Richard Clewer, Chairman of the Board and Leader of the Council, welcomed all attendees to the meeting.

Before the meeting began, each Member of the Board, other Councillors and officers who would be contributing to the meeting were given the opportunity to introduce themselves.

Cllr Clewer, through a chairman's announcement, informed members of a Briefing Note in relation to the Procurement of Community Health Services.

Fiona Slevin-Brown wanted to assure the board that efforts to procure services are making progress.

40 Apologies for Absence

Apologies were received from:

- Terence Herbert (CEO)
- Jo Madeley
- Dr Nick Ware
- Cllr Laura Mayes
- Jane Davies
- Philip Wilkinson (Police and Crime Commissioner)
- Claire Thompson
- Judith Sellers

41 Minutes

The minutes of the previous meeting of the Board held on 25 May 2023 were presented for consideration. After which, it was:

Decision - The Wiltshire Health and Wellbeing Board approved and signed the minutes of the previous meeting of the Health and Wellbeing Board held on 30 March 2023 as a true and correct record.

42 Declarations of Interest

There were no declarations of interest.

43 Public Participation

No questions were received.

44 BSW Integrated Care Strategy Implementation Plan Update

The Board received a verbal update from David Jobbins regarding the implementation plan of the BSW Integrated Care Strategy. Following engagement, the 2023/24 Plan has been finalised and is brought to the HWB to note. The main changes are noted in the report and slides which can be found in the agenda pack.

The report was very long, in excess of 200 pages, which has seen significant editing down and its design altered to make it more user friendly. A refresh process was described as a means to reduce the page number further. The process of putting the plan together showed more work is needed and many actions are process based not delivery based.

One significant difference is that the part of the plan relating to youth has been pulled together into one themed section rather than being spread out across multiple areas of the report which made it harder to understand.

It was noted that there was a requirement for each regional HWB to state their opinion on the plan. However, due to the need to publish the plan at the end of June before the meeting, opinions were expressed through Chair's action, and it is part of the recommendations to note those.

During the debate the following points and clarifications were made:

The Board complimented numerous positive changes to the plan, and it was described as far more focused, easier to read and understand and as expressing good aspirations.

However, concern was raised that the resources to deliver these aspirations have not been detailed. What impacts on the 5-year plan from a workforce shortage, and organisational stability from numerous institutional changes were also identified as an area to investigate.

It was raised that GP's would need to understand how the plan would affect their role, as would managing the expectations of local residents and illustrating what differences this plan would make to their daily lives.

It was clarified that means to monitor against commitments made in the plan would come into place within the next few months. It was understood that there are risks and challenges to the plan, but recognizing how we are delivering against our aims will mean success even if changes have to be made.

The process of writing the plan is almost more beneficial than what is in the plan as it has brought the whole ICB working together. Some of the diagrams and schematics are extremely useful to understanding what the ICB is and what the plan is.

Resolved

i) note the finalised the 2023/24 BSW Implementation Plan; and
ii) note the opinion the HWB has provided that the plan takes proper account of the Wiltshire JLHWS.

45 **ICB Capital Plan**

The Board received a verbal update from Bina Kakad on the ICB Capital Plan. The full report can be found in the agenda pack.

Within the plan the priorities for 2023/24 had been highlighted This had been broken down into what's contained within these priorities including local and national schemes. The aim is to produce a capital strategy framework and to integrate the community and primary care network into our objectives.

During debate, the following points and clarifications were made:

That it would be useful to understand how the capital application links to the five-year plan and there is work still taking place to align this under a single overall strategy and how it underlines what the Capital Plan is aiming to achieve.

Each of our objectives and strategies will have risk analysis and contingencies in place.

The development of the broader structure of the plan is still in progress but using estates available to deliver objectives is at the forefront.

Resolved

i) Notes the Joint Capital Resource Use Plan at Appendix 1;
ii) considers how the capital plan interrelates with other relevant plans for system infrastructure and estates; and how it will

support delivery of the Integrated Care Partnership strategy and the priorities of the Health and Wellbeing Board

46 **Update On The Transfer of Pharmacy, Optometry and Dental Services to BSW**

The Board received a verbal update from Jo Cullen on the transfer of pharmacy, optometry and dental services to the BSW. The full report can be found in the agenda pack.

The paper set out the context as to why these areas have been delegated to the BSW. Although only a few months into the process, local committees and lead personnel for each of these areas had already been established. A discussion with the Health Select Committee had taken place regarding dental services. The main priority across all areas was stressed as access, especially given the news coverage on difficulties accessing services. The workforce was also noted as a serious priority given shortages.

During debate, the following points and clarifications were made:

It was clarified that the priority was not just access but also affordability, with many dentist surgeries moving away from providing NHS Care and with the cost-of-living crisis the knock-on effects are clear. A focus on good education on oral hygiene is something that can be focussed on. The importance of sugar tax as a preventative measure was indicated.

The lack of pharmaceutical provisions that are currently available in Wiltshire was accepted as a serious concern. Mapping of dentists for the area was shown at the recent Health Select Committee meeting and the creation of one for what pharmacies are currently available across the county was suggested as a means of assistance for residents.

Resolved

i) To note the report

47 **CYP Strategy**

The Board received a verbal update from Sadie Hall regarding the CYP Strategy. The full report and PowerPoint can be found in the agenda pack.

As discussed in the previous agenda item covering the BSW Integrated Care Strategy, all work with children and vulnerable adults (0-25 years old) was undertaken together under the CYP Strategy.

Reference to “CORE20PLUS5” was made:

CORE20 – Targeting the most deprived 20% of the national population as identified by the Index of Multiple Deprivation.

PLUS – Informed by Integrated Care Systems, population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the CORE20 alone and would benefit from a tailored healthcare approach.

5 – The five key clinical areas of health inequalities. Asthma, Diabetes, Epilepsy, Oral Health, and Mental Health.

During debate, the following points and clarifications were made:

Some of the CYP Strategy sits within SEND and the MIND Board plays a big part in recognising links within Schools. Asthma support is delivered through the Healthy Schools programme to help schools be asthma friendly.

Whilst funding allows testing processes and investment, the CYP Strategy's work is not wholly dependant on it. This was seen as a major positive by the Board.

Integration within Wiltshire's sectors including secondary schools and housing isn't at a detailed level yet, but progress is being made.

Resolved

i) Note the role and function of the BSW CYP Programme Board as set out in Appendix 1.

48 **Better Care Plan - standing update**

The Board received a verbal update from Helen Mullinger on developments relating to the implementation of the Better Care Plan. The full report and PowerPoint can be found in the agenda pack.

The Better Care Fund (BCF) programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.

It was shared that a total pooled fund of £69,511,569 in 2023-24 was spent across 66 schemes.

The BCF is underpinned by 2 core objectives to:

- Enable people to stay well, safe, and independent at home for longer.
- Provide people with the right care, at the right place, at the right time.

The BCF's Themes were also shared:

Reducing Inequalities – linking to Core20PLUS5.

Hospital Discharge – Focussing on improving flow across services and reducing unnecessary hospital admissions and delayed discharges.

Avoidable Admissions - Work aims to deliver improvement in 2hr Rapid Response times and expand same-day emergency care to support a reduction in avoidable admissions.

Support for Mental Health, LD and Autism – support through BCF funded schemes such as the Intensive Enablement Service. Additional funding for Shared Lives through the Winter Discharge funding.

Use of the Voluntary Sector – both to provide services (Home from Hospital) but also so support existing services (e.g meal deliveries to support reablement service – funded through the Winter Discharge.

During debate, the following points and clarifications were made:

The Board praised the successes that the BCF was reporting, however highlighted the need to give the Board information that can be shared with residents in a way they can appreciate.

The need to coordinate more with partners was stressed, as was the risk workforce issues could have on the plans.

Resolved

i) Note the final BCF planning submissions.

49 **Healthwatch Wiltshire Annual Report**

The Board received an annual report from Stacey Sims on behalf of Healthwatch Wiltshire. The full report and PowerPoint can be found in the agenda pack.

Healthwatch Wiltshire was specified as a local health and social care champion, that listened to local resident's experiences and had the power to hold NHS Leaders to account over local feedback and ensure standards of care were improved. Healthwatch helped inform other areas of society including in schools, dental hygiene etc and could monitor efforts at prevention, including through their own workshops.

The report highlighted the statistics for the year in Wiltshire:

637 people shared their experiences of health and care.

4,125 people approached Healthwatch for information and advice.

7 reports were published that made **31** recommendations.

21 volunteers gave up over **680** hours of their time.

The priorities for 2023-2024 were included:

- Mental health and Autism
- The wellbeing of children and young people
- Hospital discharge and virtual wards
- Access to GP services

Resolved

i) Notes the key messages from the report.

ii) Notes the contribution made by Healthwatch volunteers.

iii) Confirms its commitment to listening to the voice of local people to influence commissioning and service provision.

50 **Date of Next Meeting**

The date of the next meeting is 28 September 2023.

51 **Urgent Items**

There were no urgent items.

(Duration of meeting: 10:00 – 11:42)

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

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

This page is intentionally left blank

Wiltshire Council

Health and Wellbeing Board

28 September 2023

Subject: Draft All age carers strategy and delivery plan 2023- 2026

Executive Summary

Whilst we have made progress through the previous Wiltshire Carers Strategy, we still have further to go. Each year in a national survey, carers are asked five questions about their experiences.

Although carers in Wiltshire report better-than-average satisfaction with the support they get, and often feel part of the decision-making process, they currently report poorer quality of life and social contact than the national and regional averages.

We also have hidden need – for example people with a learning disability living at home with older parents are unknowns to us until there is carer breakdown or parents pass away. This draft strategy and delivery plan has been co-produced with carers of all ages across Wiltshire, as well as consultation with people who are cared for, and service delivery partners.

Our approach needs to meet the needs of carers and the cared for in the context of changes post COVID, the cost of living, advances in technology and changes in the care market.

We have looked at examples of good practice in the South West and nationally to better understand what is possible and how to deliver it in the most effective way.

This strategy will inform the commissioning of services going forward, and the way in which we measure the impact of our commissioned services.

Proposal(s)

It is recommended that the Board:

i) Notes and comments on the draft strategy

.

Reason for Proposal
To consult with HWB on the draft strategy

Melanie Nicolaou
Head of Adults and resources commissioning
Wiltshire Council

Carer Friendly Wiltshire

Draft
All Age Carers Strategy
2023 - 2028

Contents

Foreword

We are delighted to introduce our Joint Wiltshire All-age Carers Strategy.

We recognise caring is an important part of life and it is unpaid carers - daughters, sons, partners, or friends, who often hold families together and fill the gaps in support that statutory services are not always able to provide.

This strategy has been developed following the Covid-19 pandemic, which brought the important role and experience of carers of all ages to the forefront. We understand that some carers would have struggled to manage additional hours of care during this time, and many would have felt the impact of increased anxiety, isolation, loss, and loneliness.

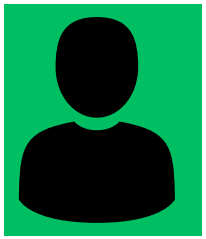
We hope that this Carers Strategy will help us to build on the achievements of the last joint strategy and will present some real opportunities for us to reaffirm our recognition and appreciation of the vitally important role that unpaid Wiltshire carers make to the cared for person and our communities .

We are committed to making Wiltshire Carer Friendly and we will do our best to ensure that support for carers in Wiltshire continues to develop and improve.

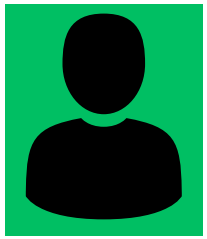
This strategy sets out some important priorities:

- Early identification and recognition of carers.
- Improved information and advice.
- The need for systems and services that work for carers.
- Improved health and wellbeing of carers
- Young carers having the same recognition and priority as adult carers, as well as access to information and support services

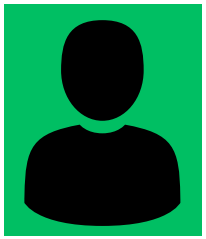
We want to thank our voluntary sector partners for helping to facilitate our engagement with carers of all ages over the past year.



Cllr. Jane Davies
Cabinet Member for Adult Social Care, SEND and Inclusion
Wiltshire Council

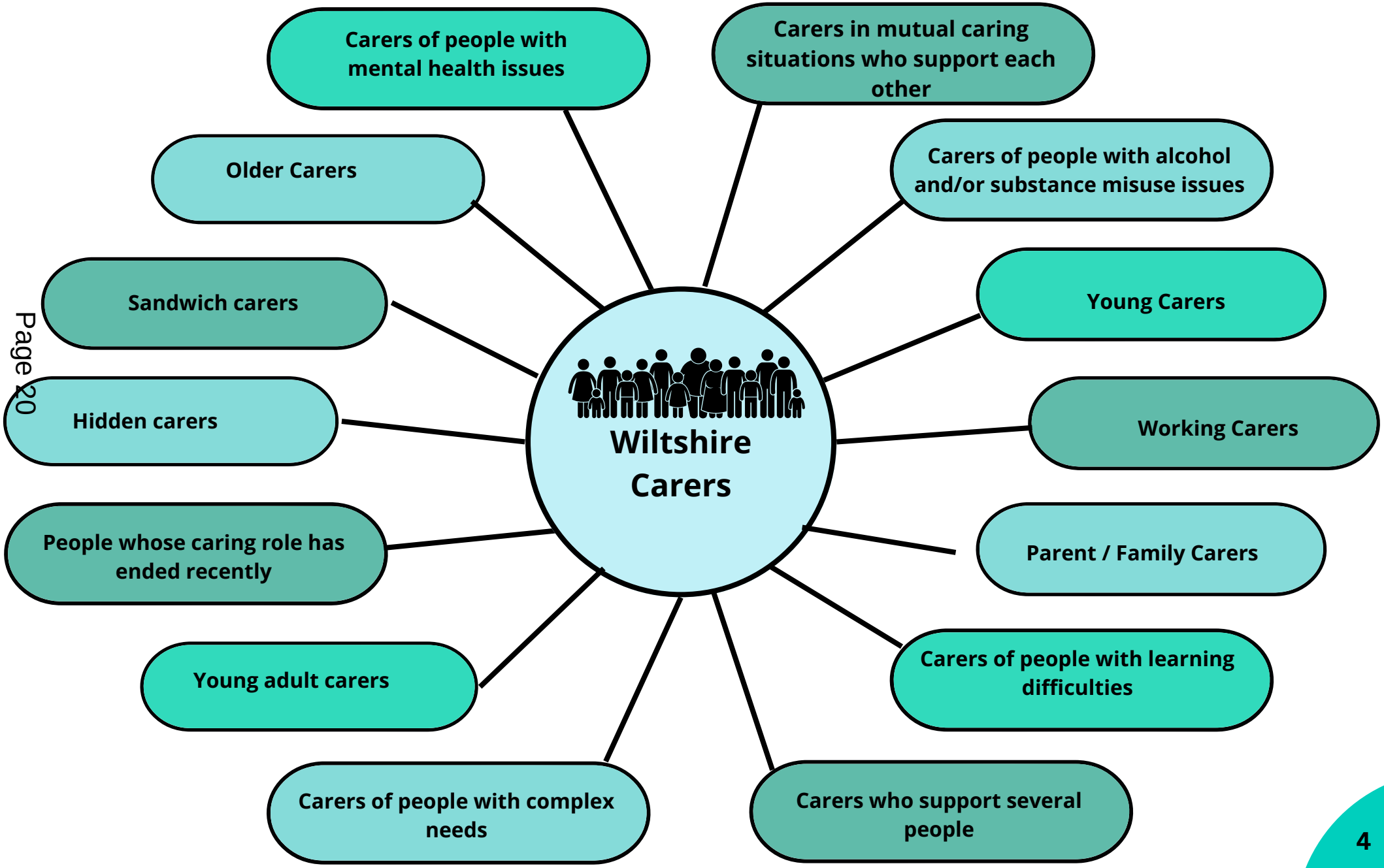


Cllr. Laura Meyes
Cabinet Member for Children's Services, Education, and Skills
Wiltshire Council



Richard Clewer
Chair
Bath and North East Somerset, Swindon and Wiltshire Integrated Care Partnership

This Strategy is for all unpaid carers who live in, or are caring for someone that lives in Wiltshire (excluding Swindon), including but are not limited to:



Introduction

A person is a carer if they provide unpaid care to a family member, friend, or neighbour because of long-term physical or mental ill health or disability or care needs relating to old age.

Carers provide a range of support including personal care, emotional support, help with practical tasks such as shopping, and reminding or giving medication. Most unpaid care is provided by children and spouses. Research suggests that 1 in 5 children under he age of 18 provide some level of care.

As a society, we rely on unpaid carers, and improving support for carers must be at the heart of how we meet the needs of both our ageing population and the demands on our health and social care systems. This is an issue that can affect any of us - the need to provide care for a friend, neighbour or loved one in our lifetime, often with very little time to plan. However, the impacts of being a carer are wide ranging: it affects carers' social and family lives; their mental and physical health; their mental and physical health; their education, work and income.

Wiltshire Council's vision is to create strong communities where here people can fulfil their potential, be actively involved and included in their communities, make informed decisions, have control over their lives, and be valued and included within society. In Wiltshire, we start from the strengths, talents and assets that each person has – this means looking beyond their diagnosis or needs, however important these may be. This strategy describes how we will work together to make Wiltshire a supportive, carer-friendly place where the contribution of unpaid carers of all ages is valued and recognised, and where carers are able to live good lives alongside their caring responsibilities. the delivery plan that goes with it will set out how we will make that happen.

Quotes are from Wiltshire Carers in 2022-2023

"I need to know where to get help in a crisis"

"I don't want to be treated differently to my peers"

"A break that is right for me is important - time to recharge my battery"

"I want to have choice and be able to find information that will support me in my caring role"

"My financial situation needs to be recognised - there is a financial impact to caring so I may need help"

"Quality services are important for both me and the person I care for"

"I don't want to be seen as just an overprotective parent. I want to be listened to"

"I need to be prepared to adapt to changes"

"I want to be able to access support in my local community"

"Early recognition will help me to work longer"

"I matter too. I want to enjoy my own life and achieve my own goals"

"I want to access the right help as my life changes"

"I want to carry out my role safely"

"Peer support is really helpful"

"I want to have some support when my caring role ends"

"Caring can be rewarding but it can take its toll on your own health"

Our Vision and Aims

Our aim is to ensure that carers can maintain good physical and mental health and wellbeing, achieve a healthy balance between their caring responsibilities and a life outside of caring, whilst enabling the person they care for to enjoy a good quality of life.

The strategy has been shaped by the diverse range of carer voices in Wiltshire. They have told us that caring is often uniquely rewarding but sometimes incredibly frustrating. So many people do not realise they are carers; they do what they do because they love those they care for. They need our recognition, creativity, and tangible action so they feel confident, supported, and able to cope with the often-tough demands they face daily.

Our Vision

We want Wiltshire to be a carer friendly County, where communities recognise and support un[aid carers of all ages, so people do not feel alone in their caring role.
It is important that carers are able to continue to support the person they look after and care about, to a degree of their choosing; and that in doing this, carers are still able to look after their own health and wellbeing.

Local & National Context

A) The Impact of Caring

The impact of caring is significant and varied. The financial value of unpaid care work in England Wales is roughly equivalent to the annual NHS England budget. The quality of care provided by a family member will often be high-quality and personalised, to an extent which a paid worker arguably could not reach. However, caring can also negatively affect relationships, as well as the health, quality of life, education, skills, work status and income of the carer. Often the impact will be more negative for carers that provide personal care (such as helping to dress), care for 50 or more hours of care per week, and for those that live with the person for which they care.

The contribution that unpaid family members, partners, friends, neighbours and others make in caring for people with age-related frailty, disabilities, health conditions, substance misuse and other needs is enormous. New findings from Carers UK and the University of Sheffield show that unpaid carers in England and Wales contribute £445m to the economy in England and Wales every day – that's £162bn per year, roughly equivalent to NHS England's entire annual budget.

These impacts are felt disproportionately by some groups more than others, and this strategy will target the right support where it is needed most.

According to the 2021 Census, there are an estimated **5 million** unpaid carers in England and Wales. **(Carers UK, 2021)**

Nationally 59% of unpaid carers are women. Woman are more likely to become carers and provide more hours of unpaid care then men. **(Carers UK, 2021)**

1 in **7** 1 in 7 carers in the UK are juggling work and care. **(Census 2021)**.

1 in **5** As many as 1 in 5 children and young people are young carers. **(Action for Children, 2023)**

B) Local Profile

The 2021 Census showed that there are approximately 44,000 unpaid carers in Wiltshire. The proportion of the total population who provide care has dropped since the last Census**[1]**; however, the number of people providing significant levels of care increased. Carers who provide more than 20 hours per week, and particularly more than 50 hours per week, are more likely to experience poor mental and physical health outcomes, lose out in the workplace, and feel unable to cope.

	2011 Census	2021 Census
% of population providing unpaid care for family, friends, neighbours etc	**10.1%**	**8.7%**
Number of carers providing more than 20 hours unpaid care per week	**14,500**	**19,300**
Number of carers providing more than 50 hours unpaid care per week	**9,500**	**11,800**

[1] This may be because the wording of this question in the Census changed between 2011 and 2021.

On Census Day 2021, there were approximately 5m carers in England and Wales – equivalent to 9.1% of the usual resident population aged 5 years and over. Nationally, a higher proportion of females than males are unpaid carers; a higher percentage of people living in the most deprived areas provide care, compared to people living in the least deprived areas. Almost half (41%) of unpaid carers are between 46-65.

1 in 7 carers in the UK are juggling work and care, and as many as 1 in 5 children are carers. The latest census data shows 166,000 young carers in England and Wales; however, there are estimated to be an additional 600,000 hidden young carers who may not be receiving any support.

We know that the number of young carers nationally is under-recorded, and this is likely to be reflected in Wiltshire. A survey of young people in 2020/21 provided stark evidence of the impact of caring on young people's lives:

- Young carers are significantly more likely to drink alcohol daily or weekly than their peers. 4% of young carers at primary school drink alcohol often / most days.
- Young carers are the group of vulnerable young people most likely to take prescription drugs recreationally.

Local & National Context

- Young carers at primary school are less likely to feel safe at home than their peers, and young carers are least likely to feel safe from crime.

- 36% of secondary school age young carers have either been a victim of domestic abuse or violence themselves or witnessed a family member being a victim.

- 33% of primary age young carers and 42% of secondary age young carers have spent money on gambling.

Less than two thirds of primary school age young carers and less than one third of secondary school age young carers feel confident about their future. Half of young carers have felt so worried, they cannot sleep at night.

- More than a third of young carers in Year 12 and above have self-harmed – the highest proportion in this age group.

- Amongst primary school pupils, young carers are the least likely to eat breakfast and have 5 or more portions of fruit and vegetables per day.

Whilst we have made progress through the previous Wiltshire Carers Strategy, we still have further to go. Each year, carers nationally are asked five questions about their experiences of being a carer. Although carers in Wiltshire report better-than-average satisfaction with the support they get, and often feel part of the decision-making process, they currently report poorer quality of life and social contact than the national and regional averages.

	Wiltshire	England	South West
% of carers who said they were extremely/very satisfied with Social Service support for carer or cared-for person	39.3	36.3	37.8
Proportion of carers who report that they have been included or consulted in discussion about the person they care for	65.7%	64.7%	66.5%
Proportion of carers who find it easy to find information about support.	58.9%	57.7%	61.5%
Carer-reported quality of life score	6.6	7.3	7.1
% of carers who reported they have as much social contact as they want	16	28	23.9

National Policy and Legislation

This strategy aligns with and supports implementation of national and local priorities

National Policy / Legislation / Guidance

- The Care Act 2014
- NHS Commitment to Carers (2014)
- The NHS Long Term Plan (2019)
- The White Paper - People at the Heart of Care: Adult Social Care Reform (2021)
- The Children and Families Act (2014)
- National Carers Action Plan (2018 - 2020)
- The White Paper - Health and Social Care Integration (2022)
- NICE Guidelines
- The Triangle of Care: A guide to best practice in Mental Health Care in England

Local Policy / Guidance

- Wiltshire Council Business Plan 2022 - 2032
- Wiltshire's Joint Health and Wellbeing Strategy
- Wiltshire Joint Strategic Needs Assessment
- Wiltshire Independent Living Strategy 2022
- Wiltshire Autism Strategy 2022
- Wiltshire Dementia Strategy 2023

Co-production

Wiltshire Council and the ICB have worked with carers, practitioners, BSW Integrated Care Board, our local voluntary sector and other stakeholders to create a shared vision of what support for carers in Wiltshire should look like.

In Spring 2022, Carers Support Wiltshire hosted a series of conversations with carers to explore experiences of providing unpaid care. This included a conference attended by around 30 carers, an online survey and 1:1 and group discussions with carers who attend CSW carer support groups. Separate sessions and workshops were also held with young carers.

The themes that emerged included:

- The importance of peer-to-peer support for carers to get the information and support they need.
- The need for professionals to be sensitive to and aware of the challenges carers face.
- The need for clearer communication between professionals and carers.
- Carers are often not aware of the full range of support that is available.
- Respite is still a critical part of helping carers manage their wellbeing, allowing them to take breaks from their caring role and access training.
- Training and support needs to be delivered flexibly so carers can access it at a time and a place that's convenient to their caring role.

Carers Support Wiltshire have written a report summarising these conversations, in which they review the experience of being a carer:

"Many carers go on a journey that is uniquely rewarding but sometimes incredibly frustrating. Their experiences may reflect that of others, but the diversity of carers and their loved ones means that one size does not fit all when it comes to finding solutions. So many people do not realise they are carers; they do what they do because they love those they care for. They need our recognition, creativity, and tangible action so they feel confident, supported, and able to cope with the often-tough demands they face daily."

Feedback sessions and workshops were held with young carers in schools and young adult carer groups to explore:

- What makes you feel good about yourself?

Co-production

- What has helped you in your caring role?

- What would help you to manage your role and achieve your goals in life?

Young carers reported that they need their caring role to be recognised and appreciated, and that they require support (1:1 and peer support) around developing skills, counselling and other mental health support for their emotional health and wellbeing, and access to breaks.

Co production will continue and will include partnership with a range of voluntary sector organisations using different models of engagement to make sure there is good insight into hard er to reach communities.

Engagement with carers that have or are experiencing looking after someone with dementia was also conducted over the Summer of 2023 to inform our dementia strategy at Wiltshire Council. This consisted of group sessions held in Trowbridge, Salisbury and Corsham.

The main outcomes of this were:

- Understanding a carer and their role when the cared for moves out of the family home
- The impact of COVID on families and people with a diagnosis of dementia
- A guide for families when receiving a diganosis
- Peer support

This will support and inform dementia commissioners on what works well for the carer and family members as well as the person being diagnosised ensuring a whole family approach and more joined up working in commissioning.

Lastly, Wiltshire Council have commissioned over the late summer/autum of 2023 an external provider to hear and relay Wiltshire carers voices since the change in contract in 2018.

This provider will encourage carers of all ages and backgrounds to use creativity to talk about their experiences and lives as a carer, through the uses of:

- Poetry
- Song writing and music
- Movement, perfomrance through play
- 360 filmmaking and animation

These will be used by Wiltshire Council commissioners to create a new contract for carers from 2024

Achievements from last strategy

Outcome 1

- Carers cafes in every area (support group for other carers to get together)
- Bereavement groups
- Health checks at GPs surgeries (this is a expectation in the GP accreditation)
- Schools accreditation launching

Outcome 2

- Training provided to carers from WC (manual handling, safeguarding yourself and understanding autism)
- Carers support is still running
- Hospital liaison service commissioned

Outcome 3

- Cost of living crisis support by public health
- Free cooking classes, slow cookers and vouchers given to select young carers
- WC employment of young carers
- Citizens advice specialist services for carers

Outcome 4

- Monthly meeting with carers commissioners and centres across UK
- Monthly meetings with carers commissioners and centres across ICB
- Events for carers week
- GP and schools accreditation

Outcome 5

- Regular engagement events
- Carers sit on the Wiltshire carers forum as board members
- Hospital liaison service

Priority Outcomes

Our priorities are informed by the outcomes that carers have said are important to them. We have worked with carers, care professionals and partner organisations to design our approach to supporting and working with carers under the vision of a carer-friendly Wiltshire.

Priority 8

Awareness raising in communities, within schools, and workplaces and services is a consistent action . Carers to be expert partners in the growth and monitoring of services

Priority 7

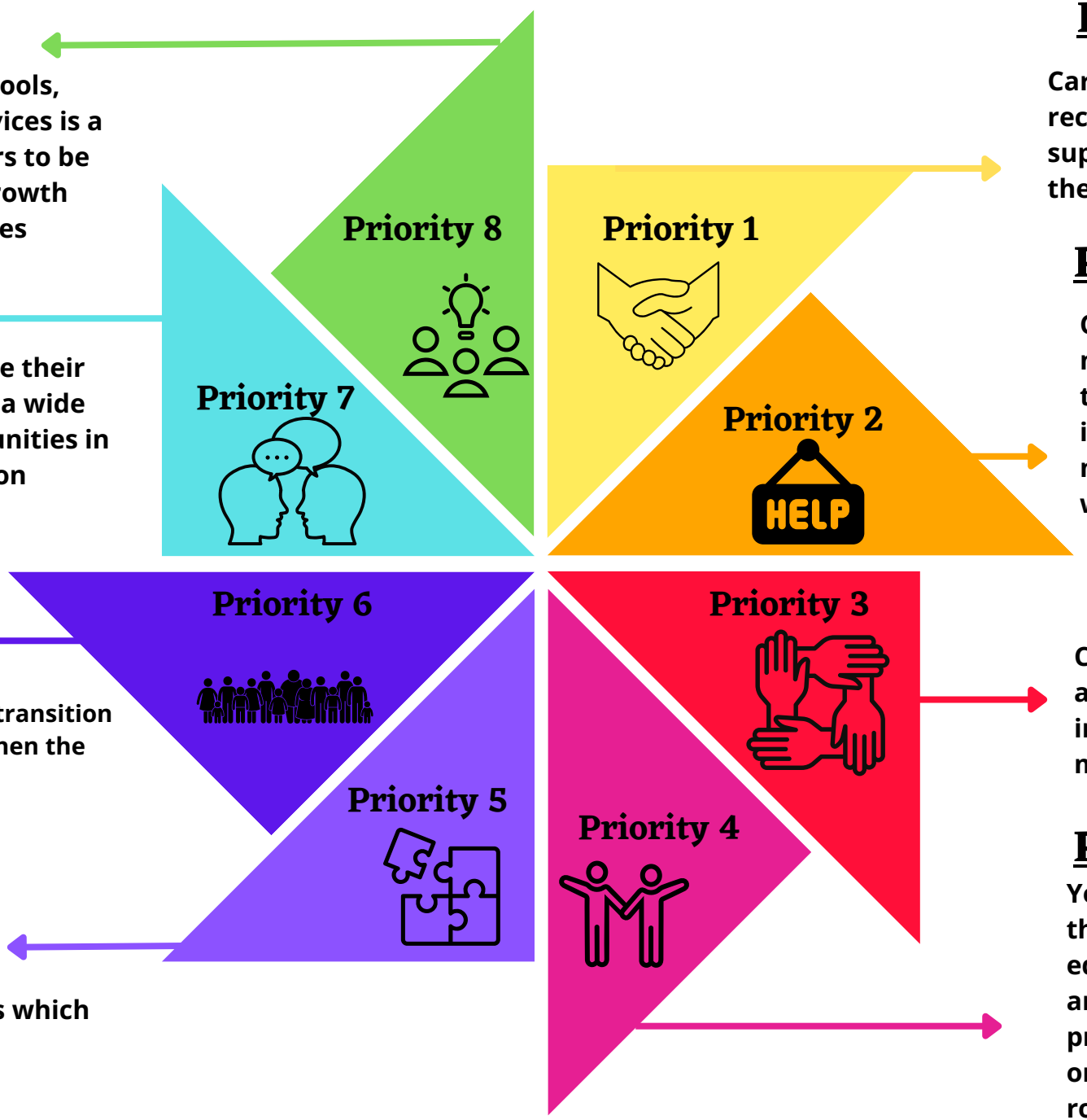
Carers are able to share their experiences, and have a wide range of social opportunities in order to reduce isolation

Priority 6

Carers are supported to transition from their caring role when the time comes

Priority 5

Carers have access to information and services which support their health and wellbeing



Priority 1

Carers are identified, recognised and offered support if they need it, at the earliest opportunity.

Priority 2

Carers with different needs are able to access the right support and information when they need it, in the way that works best for them.

Priority 3

Carers have equitable access to support and information on financial matters and their rights

Priority 4

Young carers are able to thrive and develop educationally, personally and socially, and are protected from excessive or inappropriate caring roles.

Principles underpinning the delivery plan

Community recognition and understanding of the issues faced by unpaid Carers of all ages

The needs of cared for and carer should not be seen in isolation of each other

Readily available information and support to access services for children ,young people and adults

Working together to commission a range of easily accessible services to support unpaid carers

Personalised care

Organisations working together

Reducing social isolation of carers

Delivery plan

Community engagement	Easy access to information and assessment	A range of personalised support	Support during crisis	Support when the caring stops
Review and extend the carers champion role	Online assessment tools as well as paper based information and support	Online resources for workplaces on supporting carers at work and into employment	7 day a week 8am-8pm urgent community response services	Counselling support and mentorship
Community meeting events	Range of assessors including social prescribers, hospital carer liaison, care provider facilitators and school-based champions	Developing flexible at home and residential options for respite care for self directed support	Carers advanced care planning support	Bereavement support
Young carer community projects	WC dedicated web page and links to delivery partners. Financial assessment tools to maximise benefits, financial advice	manual handling training , end of life care, as well as CV support and careers advice	Carers hospital based liaison	Housing and employment advice
Awareness raising projects in workplaces and communities	Broad communications campaigning and events throughout the year to raise awareness on key issues	Expert carers mentor role developed. Health checks for all carers Wiltshire Carers passport with wellbeing benefits	Safeugarding for young carers	Support for 18 months after caring role has ended

MEASURES

OUTCOMES REQUIRED	MEASURES
I want to access support , contribute to and be valued by my community (inc. work, education, family & social life)	• % of identified carers receiving carer assessment & review • Satisfaction survey of carer services & experience of being a carer (via survey) • Spend on carer services • Impact of caring on working hours • School attendance/attainment for young carers • Active identification of people with LD living at home with older parents, •
I don't want to be financially disadvantaged because of my caring role	• •Referrals to / uptake of financial advice • •Impact of caring on working hours
I want good mental and physical health and wellbeing	• Referrals to / uptake of MH services (inc. counselling, psychotherapy) • Caregiver Strain Index • Number of cares registered as a carer with GP
I want to be identified as a carer, recognised as an expert partner and be informed, involved, included and listened to	• Access to training • Survey of carers feeling involved in decision-making around the cared-for
I want to spend quality time on myself, away from my caring role	• Number of people receiving respite • Number of hours respite provided
I want to be able to adjust to transitions in life, including a life outside of caring when the time comes	• Access to bereavement counselling support • Access to employment and financial advice
I want support to prevent crisis	• number of referrals to rapid response • number of emergency admissions to hospital for cared for persons

Glossary

"BSW"	Bath & North East Somerset, Swindon and Wiltshire
"Hidden Carers"	Hidden carers are those who may not recognise themselves as a carer and consequently are less likely to access support.Some studies suggest that identification as a carer and seeking support can vary across the spectrum of caring, with some carers being more at risk of being hidden. For example, those who do not care for people with very complex and/or intensive needs are more likely to be hidden. Parent carers of children and young people with SEND, may not always recognise themselves as a carer. There can also be a resistance to adopting the label of 'carer' because of close family relationships.
"Sandwich Carers"	There is an increasing number of 'sandwich carers' (Carers UK estimate 2.4 million in the UK) – those looking after more than one person at the same time. For example, caring for young children and caring for older parents.This terminology can also be used much more broadly to describe a variety of multiple caring responsibilities for people in different generations.
"Working Carers"	An increasing number of people are having to work longer, often beyond retirement age. According to the 2021 Census, the largest proportion of carers are in employment either full or part-time. This means that carers are often juggling working with caring responsibilities and some with multiple caring responsibilities.
"Young Carers"	A young carer is someone aged 18 or under whose life is affected by caring for at least one family member, over and above just 'helping out'. Young carers might look after, parents, grandparents, siblings or close relatives.

Glossary

“Parent/Family carers”	Parent and family carers can provide support for their children, including grown up children if they cannot manage without their help. They can be ill, disabled or have mental health and substance missue problems.
“Strategy”	Outlines the key priorities we’ll focus on for Carers services over the next 5 years and the vision of Wiltshire Council. It describes how we'll work together to improve the health and needs of carers and provide support when needed. The plan has been developed by listening to carers living in Wiltshire in our communities, our partners and stakeholders.
"Unpaid Carers"	Carers who are not employed by a business and not receiving a typical wage to care for the person they are caring for, this does not include incomes such as: benefits or employment for another job.
"Outcomes"	Focusing on achievements for the carers due to the changes in processes and services.
"Priorities"	Important factors based on importance to Wiltshire Council and Wiltshire Carers.

This page is intentionally left blank

Wiltshire Council

Health and Wellbeing Board

28 September 2023

Subject: Wiltshire Dementia Strategy 2023-28

Executive Summary

This joint, all-age dementia strategy is guided by a vision where we work together to make Wiltshire an inclusive, vibrant, supportive place for people with dementia, and their family members and carers, to live. Our work will be underpinned by prevention and early intervention, tackling inequalities, understanding our communities, and promoting independence.

Proposal(s)

The Wiltshire Dementia Strategy 2023-28 is attached, including appendices which summarise our priorities, detail about our demographics and prevalence, and the wealth of co-production and engagement that fed into the strategy. Further details will be provided via a PowerPoint presentation at the Board.

It is recommended that the Board:

i) Approves and signs off the Wiltshire dementia strategy 2023-28
ii) Notes the governance arrangements for its implementation.

Reason for Proposal

Dementia is one of the biggest challenges of our time. Almost one million people live with dementia in the UK and 1 in 11 people over the age of 65 have dementia. In Wiltshire, we have one of the fastest growing numbers of older people. Between the 2011 and 2021 Censuses, Wiltshire was one of only three local authorities in the South West whose 65+ population grew by more than 30%. This is highly relevant to this strategy because age is the biggest risk factor for developing dementia, although dementia is not a natural part of ageing.

This strategy describes how we will work together to make Wiltshire an inclusive, vibrant, supportive place for people with dementia and their family members and carers to live. It describes the national and local context, and sets out five priority areas which have come out of significant co-production and engagement.

Robert Holman **Commissioning transformation lead** **Wiltshire Council**	**TBC** **Wiltshire locality** **NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB)**

Wiltshire Council

Health and Wellbeing Board

28 September 2023

Subject: Wiltshire Dementia Strategy 2023-28

Purpose of Report

1. To provide a summary of the joint, all-age Wiltshire Dementia Strategy.

Relevance to the Health and Wellbeing Strategy

2. This strategy describes how we will work together to make Wiltshire an inclusive, vibrant, supportive place for people with dementia and their family members and carers to live. It is underpinned by prevention and early intervention, tackling inequalities, understanding our communities, and promoting independence.

3. The strategy uses population data to assess current and forecast future prevalence and demand on services.

Background

4. Dementia is an umbrella term to describe a set of symptoms caused by a number of conditions. 95% of people with dementia have one or more of four main diseases[1]:

   - The most common cause of dementia is Alzheimer's disease, which accounts for around two thirds of people living with dementia.
   - Up to 20% of people with dementia have vascular dementia.
   - Around 15% have dementia with Lewy Bodies.
   - Fewer than 5% have fronto-temporal dementia.

5. There are approximately 8,300 people living with dementia in Wiltshire, although not all these people will have a diagnosis. Based on the prevalence of dementia by age and the recent 2021 Census date, we can accurately predict that around 5,200 women (62.7%) and 3,100 men (37.3%) in Wiltshire have dementia.

6. Wiltshire's population is getting older. This is highly relevant to this strategy, as age is the biggest risk factor for developing dementia. We know that Wiltshire's older population will continue to grow in the next 20

[1] A description of the most common types of dementia can be found at https://www.dementiauk.org/about-dementia/types-of-dementia/

years, and this means the number of people living with dementia (and especially living with *advanced* dementia) will grow significantly.

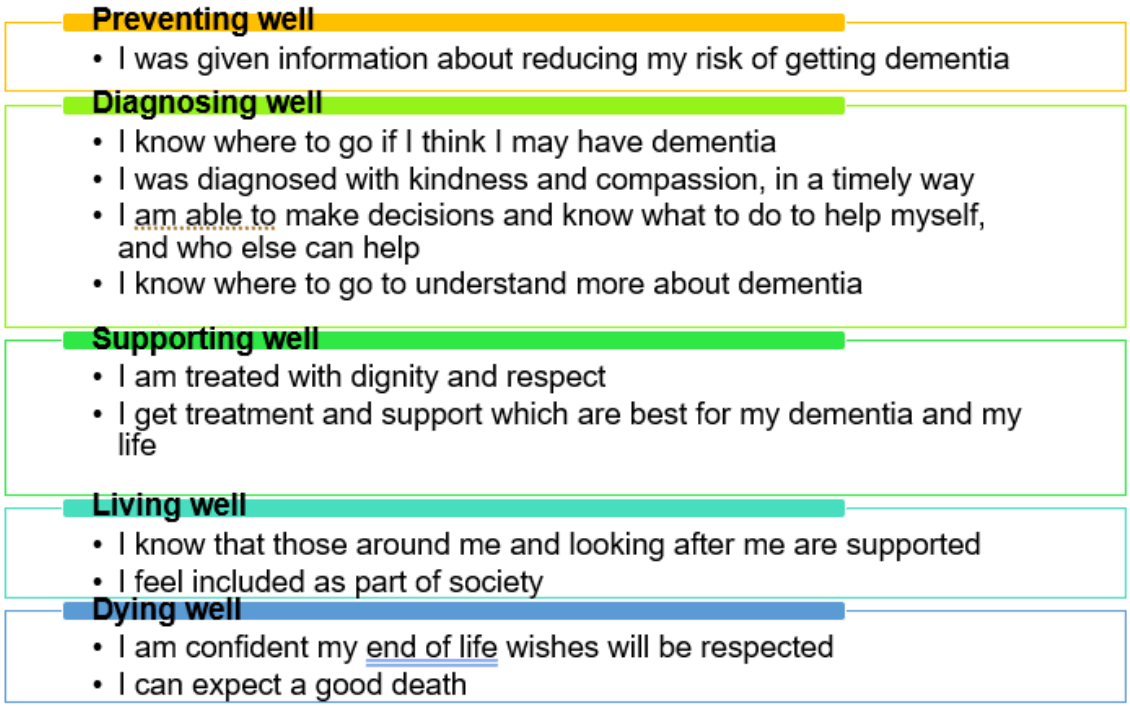
7. This strategy reflects national policy and guidance, but without the huge contributions of local people, it would not be possible to produce a plan which works for people in Wiltshire. The strategy puts the voice of people with dementia and their families, carers and friends at the forefront of our plans.

Main Considerations

8. This strategy sets out a vision of a dementia-friendly Wiltshire, where we work together to make Wiltshire an inclusive, vibrant, supportive place for people with dementia, and their family members and carers, to live. Our work will be underpinned by prevention and early intervention, tackling inequalities, understanding our communities, and promoting independence.

9. Through consultation and co-production, five priorities have been identified, along with "I statement" outcomes that we aim to achieve:

Priorities



Co-production and engagement

10. The Wiltshire Dementia Strategy is driven by the voices of people with dementia and carers, as well as the views of the wider public and professionals. Over 400 people, including more than 150 people with dementia and/or unpaid carers, took part in the development of the strategy and told us what was important to them. Appendix 4 of the strategy provides a detailed summary of what people told us.

Next Steps

11. A detailed implementation plan will be developed following the sign-off of the principles set out in this strategy.

Robert Holman
Commissioning transformation lead
Wiltshire Council

Report Authors:
[Name, title, organisation]

This page is intentionally left blank

CARING FOR SOMEONE LIVING WITH DEMENTIA

Carer Support Wiltshire

Wiltshire Council, BSW ICB and Carer Support Wiltshire Dementia Strategy Engagement Summer 2023

About us

Carer Support Wiltshire is a registered charity that supports all unpaid carers, including young carers and young adult carers, across Wiltshire and Dorset. We help them to access services, information, education and training, respite, and breaks from their caring role.

We ensure unpaid carers have a voice that is heard and work with health and social care professionals and employers to raise carer awareness and develop best practice.

A carer is anyone who cares, unpaid, for a family member or friend who could not always manage without their support. They might look after someone with a physical disability, learning disability, autistic spectrum disorder, long-term health condition, mental health issue, or a problem with substance misuse.

Find out more at www.carersupportwiltshire.co.uk and www.carersupportdorset.co.uk

Foreword

In Dorset and Wiltshire one of our goals is to ensure that the views and experiences of unpaid carers are heard in the development of strategy and service developments that impact them. Over 200 carers have recently contributed to a series of engagement activities specifically looking at the support for some who is looking after someone living with dementia in Wiltshire. They told us what they felt was most important to them in terms of the support they needed from diagnosis to end of life. Our report highlights the things that matter most to carers in terms of the support they receive to live their lives well. A big thank-you to all the carers who took part in these activities.

Liz Brown – Chair of Trustees Carer Support Wiltshire and carer

Summary

A core part of our mission is to ensure that carers' voices are heard when developing our services and so that we can feedback carers' needs to our key local partners. As part of the development of Wiltshire Council's and BSW ICB's new dementia strategy, we were asked to help facilitate three focus groups with carers and issue an online survey to ensure that the draft strategy accurately reflects their support needs.

We carried out the following engagement activity:

- An online survey completed by 186 carers
- Three focus groups held in Corsham, Trowbridge and Salisbury

The aim was to investigate, across four themes, what support carers looking after someone living with dementia value when carrying out their caring role. The four themes were:

- Diagnosis and support
- Wellbeing
- Dementia-friendly communities
- Dying well

The findings were quite clear:

- As with other carers we've spoken to, it is the inconsistency in support that frustrates many. What one person is told, another may not be.
- Many professionals don't seem to know enough about dementia and its many symptoms, and often ignore or dismiss the huge amount of knowledge that the carers themselves have. This causes a lot of anxiety for carers as they worry that their loved one isn't being looked after properly.
- Again, as we've heard at our other carer engagement events, more liaison/signposting between services is needed so that people don't fall through the gaps.
- There were several services that were very highly praised by those that had been offered them including Alzheimer's Support's dementia advisors and introductory training course.

This piece of work will be shared with Wiltshire Council and BSW ICB who will use it to inform their new dementia strategy document. We will also use the feedback provided to inform our future planning for services for unpaid carers and on continuing to develop our plans for a carer friendly Wiltshire.

Introduction

Many dementia carers go on a journey that is uniquely rewarding but sometimes incredibly frustrating. Their experiences may reflect that of others, but the diversity of carers and the progression of this terrible disease means that one size does not fit all when it comes to finding solutions. So many people do not realise they are carers; they do what they do because they love those they care for. They need our recognition, creativity, and tangible action so they feel confident, supported, and able to cope with the often-tough demands they face daily.

The 2021 census revealed there were approximately 43,860 unpaid carers in Wiltshire. Most of us are likely to experience caring at some point in our lives; indeed 3 in 5 of us will be carers in our lifetimes and many of us will also need care.

With 1 in 2 of us likely to be affected by dementia in our lifetime (either by caring for someone or developing it ourselves, or both)*, it's been important carers voices are heard as Wiltshire Council and BSW ICB develops their new dementia strategy.

There were close to 1 million people living with dementia in the UK in 2021. This number is expected to rise to 1.6 million by 2050.

Source: Luengo-Fernandez, R. & Landeiro, F. (in preparation). The Economic Burden of Dementia in the UK.

The stark reality for many dementia carers is that the system seems disproportionally unfair. Dementia is one of the few medical conditions that doesn't receive ongoing support from the NHS so carers are left to navigate the complicated and underfunded social care system.

We also know that carers are facing unprecedented pressures on their finances during the cost of living crisis. Dementia care costs are often significantly higher than those of standard social care which places additional pressures on those families. Many may take on additional caring needs as they simply don't have the long-term funds to pay for specialist dementia care. This can result in their own health declining and lead to them needing care of their own.

And when families do access care, many find that staff lack the knowledge and understanding of dementia and the impact it has on both the person living with the disease and the person caring for them. This results in poor quality care and increased anxiety on the part of the carer.

This was the purpose of the recent engagement work we did in Wiltshire. It was an opportunity to look at what has been working well and look ahead to identify local long-term solutions. We welcome the opportunity to work with our partners in Wiltshire to make the county truly dementia carer friendly.

*Office of Health Economics for Alzheimer's Research UK

Method

To help Wiltshire Council and BSW ICB ensure that their new dementia strategy accurately reflects the support needs of unpaid carers we used a variety of engagement methods, including an online survey and three focus groups held across the county.

We invited unpaid carers from across Wiltshire from our carer register. We received 186 responses to our online survey and 23 people attended the focus groups.

The online survey focused on four key areas:

- Diagnosis and support
- Wellbeing
- Dementia-friendly communities
- Dying well

Each attendee at the focus groups had the opportunity to feed in their views on their experiences of caring for someone living with dementia in Wiltshire.

Findings

These findings are a summary of the online survey responses and comments and suggestions from the three focus groups that were carried out during May to July 2023.

Diagnosis

Of those people who responded to our dementia survey, 97% have received an official dementia diagnosis. For nearly a third of respondents, the diagnosis took more than twelve months.

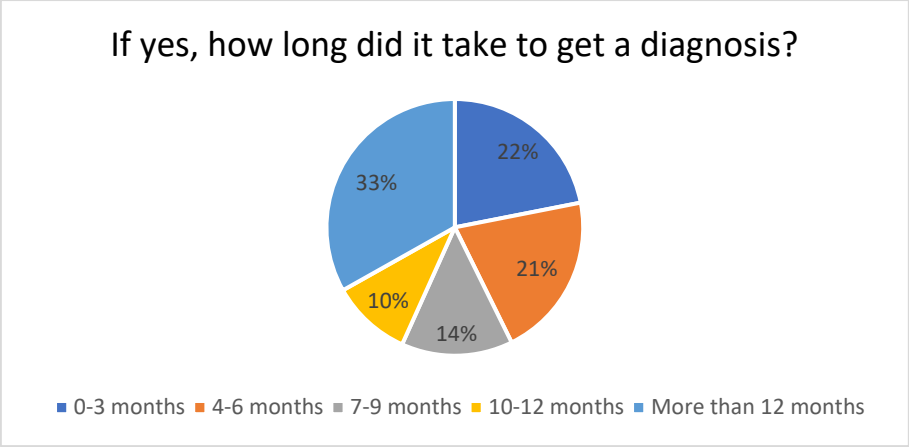
Feedback from the focus groups would suggest that, due to the progression of the disease, this can have a significant effect on the support needs of the person with the disease and therefore the impact on the carer. Several carers said that they'd noticed things weren't quite right several years before diagnosis. This is backed up by research from the Alzheimer's Society in 2016 that showed that 1 in 4 people wait for 2 years before getting help for dementia symptoms.

I WISH I'D KNOWN

How long it takes to get any kind of diagnosis or assistance and that I'd had a realistic understanding of the pathway and what diagnosis meant for my mum.

CARER FRIENDLY TAKEAWAY

Better awareness of the symptoms of mild cognitive impairment, and how it can be a sign of dementia, would help those living with the disease maintain their independence for longer.



Some of those we spoke to at the focus groups questioned what getting an official diagnosis gave them other than a label. They weren't initially convinced that it achieved anything. However, there were those that said that without it they wouldn't have got the support they now have.

I WISH I'D KNOWN

An official dementia diagnosis is critical to accessing support for both the carer and cared for.

However, an official diagnosis isn't always that simple to get. Some at the focus groups found that the results of the various tests can be talked about in quite vague terms. Some had to ask if the official diagnosis was dementia.

The memory clinic is a critical part of the diagnosis pathway. For many carers who attended the memory clinic, there seemed to be inconsistencies as to how much information was given at diagnosis, with some carers being left to find things out for themselves. Once in the care of their GP it can also be pot luck as to how much information and support is offered.

Many said that a diagram of how the system works would have been useful as it was noted that you can't care 24/7 and be able to navigate the system. Someone at the focus group described the system as a labyrinth.

CARER FRIENDLY TAKEAWAY

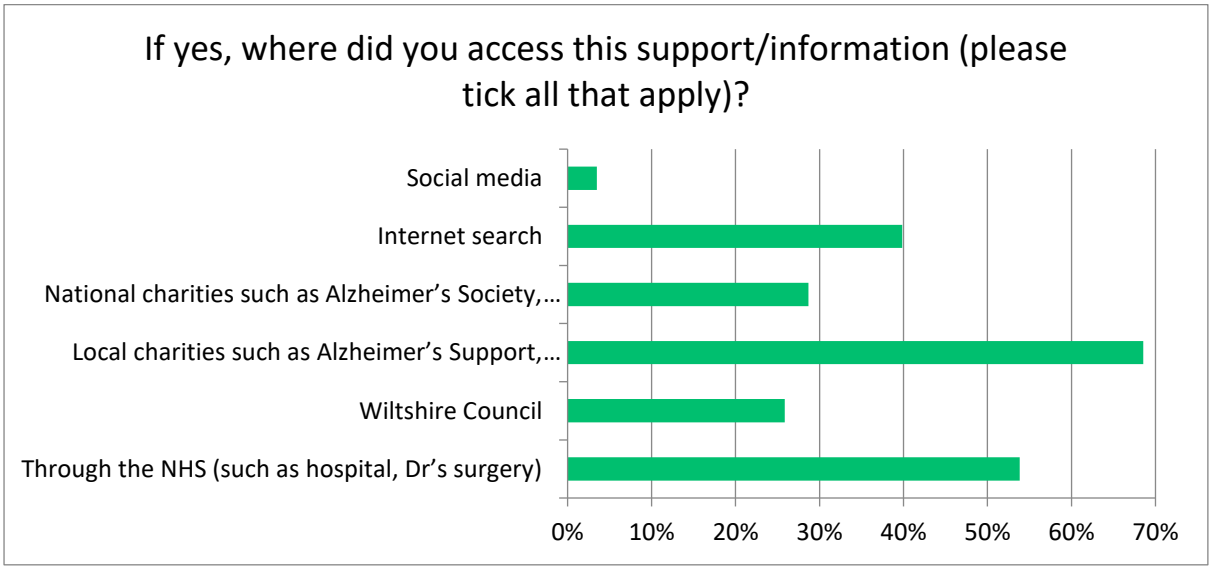
The consistency of information given at diagnosis is critical for carers so as they aren't left to fend for themselves at a time when they have a lot to deal with.

Support

Once someone received their diagnosis, it was about 50:50 as to whether they were given the support and information they needed about the condition.

"I didn't know what I didn't know" Husband caring for his wife

70% of people felt they knew where to get support from. The majority of respondents sourced their information from local charities such as Alzheimer's Support and the NHS.



In terms of other support or information that would have been helpful at diagnosis the most common comments in the survey and at the focus groups were:

- A booklet with information about the support available both to carer and cared for as the disease progresses
- Information on the diagnosis timeline so as to help manage expectations ie when to expect an appointment with the memory clinic, time to diagnosis after the appointment, progression of the disease

- Access to face-to-face support wherever you are in the county
- Better promotion of Alzheimer's Support's introductory dementia course
- More proactive follow-up from post diagnostic services
- More liaison between services as system doesn't feel very joined up
- A single point of contact. So much to think about when you've had the diagnosis and can be difficult to remember who to contact for what.
- A buddy system would allow someone to talk to someone with lived experience
- Help with form filling as they can be long and complicated
- Everyone's journey is different, so support needs to be personalised

There were several mentions in the survey responses of cross border issues, where the carer lives in one county but the GP is in another. These carers seem to often fall through the cracks.

CARER FRIENDLY TAKEAWAY

A single source of information about the support available would be extremely useful. Ideally this would be a booklet.

I WISH I'D KNOWN

How to deal with the changes in the person with dementia.

Within the focus groups, there seemed to be mixed awareness of Admiral Nurses, specialist dementia nurses provided by Dementia UK. It was felt that there clearly weren't enough of them but that as they were expensive to train and support, perhaps there should be more of a focus on specialist dementia carers within the community.

This also linked into concerns from several carers that all too often they come across health and social care professionals that didn't seem to understand dementia and often lacked empathy. This can lead to huge anxiety amongst carers that their cared for isn't being looked after properly. It was doubly frustrating for them when their own expert knowledge was ignored or dismissed. This seemed to often result in carers not being able to take the breaks they need, impacting on their own health and wellbeing.

CARER FRIENDLY TAKEAWAY

Should there be an Admiral equivalent for paid carers? At the very least a minimum standard of dementia knowledge?

At the focus groups there were several sources of information and support that had been found to be really useful:

- Alzheimer's Support – dementia advisors, introductory training course
- Music therapy
- Peer support groups have been helpful for info exchange (Alzheimer's Support groups and Carer Support Wiltshire ones)
- Contented Dementia book a really useful read
- Age UK Wiltshire
- Tell us once – service when someone passes

I WISH I'D KNOWN

That I could get a 25% discount on my council tax with a diagnosis of dementia. And that I could use a prescription as proof of address.

I WISH I'D KNOWN

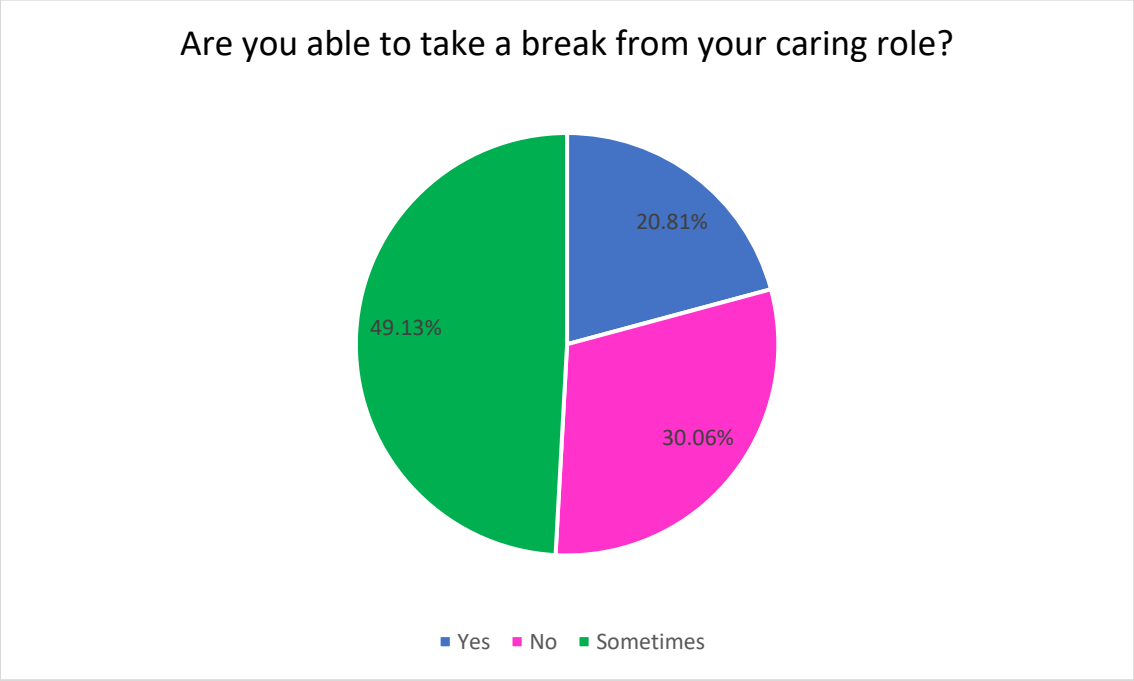
Don't leave asking for support until you've reached crisis point. Dementia can progress very quickly and services can take time to set up.

"You have to have patience and humour to get through the day"

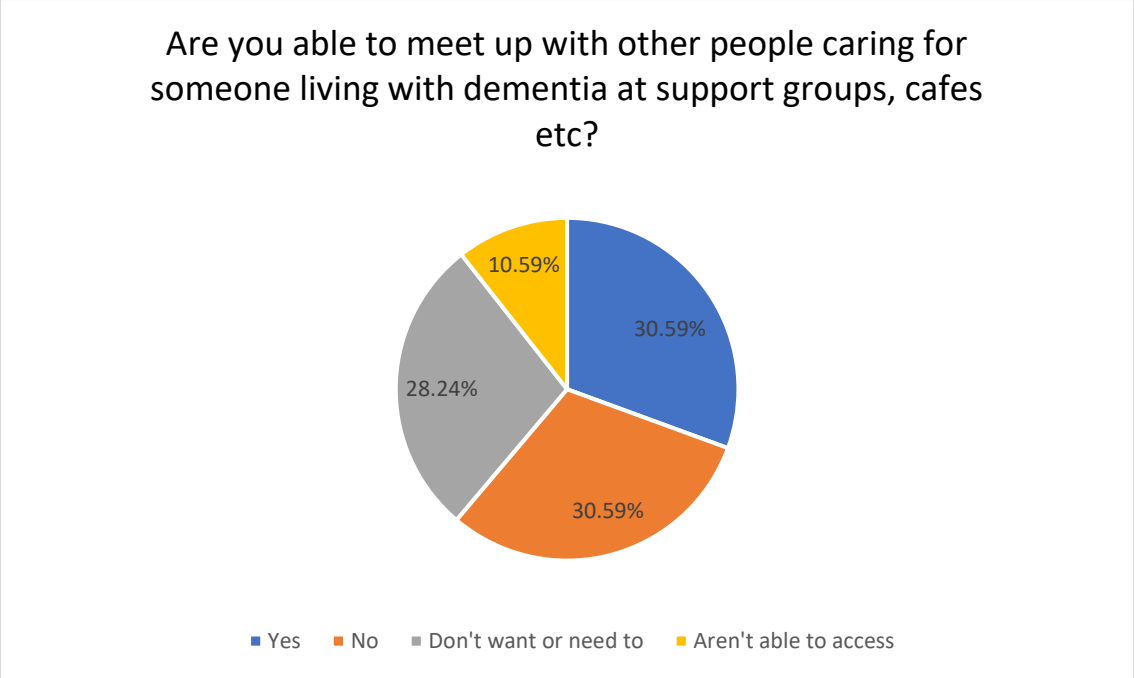
Male carer looking after his wife

Managing your wellbeing

Nearly a third (30%) of carers said they are unable to take a break from their caring role. Just under half are only sometimes able to take a break.



When asked if they are able to meet up with other people caring for someone living with dementia at support groups etc, only 30% said yes. 31% said they aren't able to and 11% said specifically that they aren't able to access these sorts of groups.



In terms of the wellbeing support that people have found the most useful, the most popular were:

- Carers groups run by organisations such as Carers Support Wiltshire and Alzheimer's Support
- Alzheimer's Support home support

Carers were asked what the barriers are to accessing support for them:

- Not knowing what's available so more communication
- A sitting service to allow carer to attend groups/funding to pay for that
- Groups not being at convenient times/sitting service not offered at times that match available groups – online and evening would help
- Transport
- Not being allowed to bring cared for with them

As being able to take a break from their caring role means having replacement care, we asked how many were currently accessing a sitting service. 62% said no.

There were mixed views from carers that are accessing a sitting service.

- A lack of dementia training amongst care staff was a common issue
- The cost
- Not enough hours offered to do anything really meaningful
- Others felt it was a lifeline, enabling them to do the shopping, manage their own appointments and meet friends

About half of carers (48%) said in our survey that they'd had a carers assessment. 14% said they'd not had a 12mth review, but an additional 29% said they didn't know.

57% of people who responded to our survey said they have had the opportunity to talk about the support they need and for this to change as and when their needs change.

Those that came to the focus groups, said that usually didn't have time to attend events for carers. The specific barriers they mentioned were a lack of options and that people needed

different things as they progressed along the dementia journey rather than a one size fits all approach. Transport was also cited as a barrier. Online options were welcomed but again it shouldn't be the only option.

Planning for the future

73% of respondents to the survey said that they had made and registered a lasting power of attorney. Of those that said they hadn't, over 50% said they've interested in doing so. For those that have an LPA, the majority (74%) said they'd done so to help with both financial and care and support decisions.

Dementia support in the community

The average response to the question of how friendly they find their local community on a scale of 1-10 was only six.

Those things that have helped to make the community more dementia friendly are:

- Carer Support Wiltshire and Alzheimer's Support services
- Neighbours, friends & family
- Shops, local services and GP being more understanding
- Local churches

Carers were also asked what difficulties or barriers they face within their community:

- Isolation – friends dropping off once diagnosis is made as there seems to be a stigma around dementia
- A lack of understanding about dementia in all settings – shops, care homes, carers, GP surgeries
- Some mentioned transport, in particular accessible wheelchair transport, and the state of the pavements.

At the Trowbridge focus group, Bradford on Avon was mentioned as a good example of a dementia friendly town. It was felt that there was good collaboration between the voluntary sector, the town council and private sector.

There was some support for continuing to be part of the wider community for people recently diagnosed rather than creating 'special' groups. It was felt important for maintaining a sense of independence for the cared for.

However, with lots of discussion at the groups about a lack of awareness about dementia there would perhaps be more dementia awareness training needed amongst key community services. This would avoid any misunderstandings or conflict.

CARER FRIENDLY TAKEAWAY

Additional dementia awareness training needed amongst professionals and the local community in order to improve the quality of care.

This seemed to be a particular issue amongst paid carers, care homes and day centres. We were given many examples of paid carers not treating carer as an expert in the care of their loved one. They have often been doing it for years so know what works and what doesn't. Paid carers, either domiciliary or care home, often don't seem to have had dementia training. Don't seem to understand how to manage the care of someone with dementia. Family members have often been told they are interfering when making suggestions as to how to look after their cared for. Changes in carers also don't help with someone with dementia.

CARER FRIENDLY TAKEAWAY

Professionals need to respect the knowledge that many carers have of their cared for's condition and see them as partners in their care.

There were several complaints about parking at Wiltshire Council car parks. Some carers are now struggling to be able to pay for parking as they don't use the MiPermit app and the machines are often broken and won't take cash. Many of the carers at the groups wanted the free blue badge parking back. It was also mentioned that payment machines are often not where disabled parking spaces are which, particularly when you are with someone with dementia, can be an issue. It is very easy for someone with more advanced dementia to disappear if you aren't focused on them.

CARER FRIENDLY TAKEAWAY

There seems to be a strong case that there must be adequate provision maintained for those who cannot or do not wish to use online public services, often the most vulnerable, becoming more isolated.

Conclusion

In conclusion, the five key areas that were raised consistently during this engagement work were:

- Inconsistencies - as with other carers we've spoken to, it is the inconsistency in support that frustrates many. What one person is told or offered; another may not be.
- More dementia training for professionals - many professionals don't seem to know enough about dementia and the affect it has on both on the person living with it and the carer
- Partners in care – professionals often ignore or dismiss the huge amount of knowledge that the carers themselves have about the condition.
- Better co-ordination between services - as we've heard at our other carer engagement events, more liaison/signposting between services is needed so that people don't fall through the gaps.

- Better promotion - There were several services that were very highly praised by those that had been offered them including Alzheimer's Support's dementia advisors and introductory training course but they weren't always that well promoted.

Recommendations and next steps

We have identified the following recommendations to lead on as an organisation. We cannot do this alone and our priority will be to ensure that the voices of carers are at the forefront of all the work we do. We will seek to work with a range of organisations to embed these recommendations in Wiltshire.

- We will ensure that all dementia carers that come to us are made aware of the key support that is available to them in the community.
- We will also look to strengthen our links with organisations such as Alzheimer's Support and the Alzheimer's Society and look for opportunities to jointly provide additional services for dementia carers.
- We will ensure that all of our support staff and volunteers have completed the Alzheimer's Society's dementia awareness training.

Acknowledgement

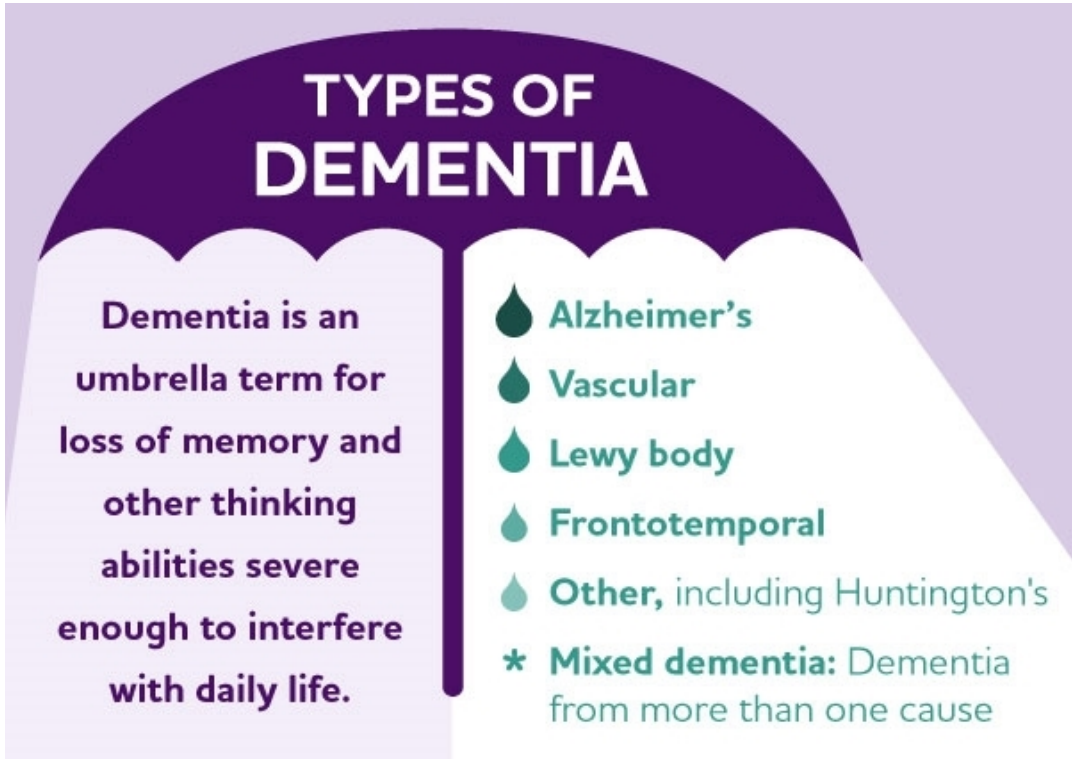
Thank you to all that attended and contributed to the online survey and focus groups about the Wiltshire Council and BSW ICB dementia strategy. We look forward to working with our partners in Wiltshire on making the county more carer friendly.

Wiltshire Dementia Strategy

Health & Wellbeing Board

28 September 2023

What is dementia?



Dementia is different from delirium, although some of the symptoms are similar.

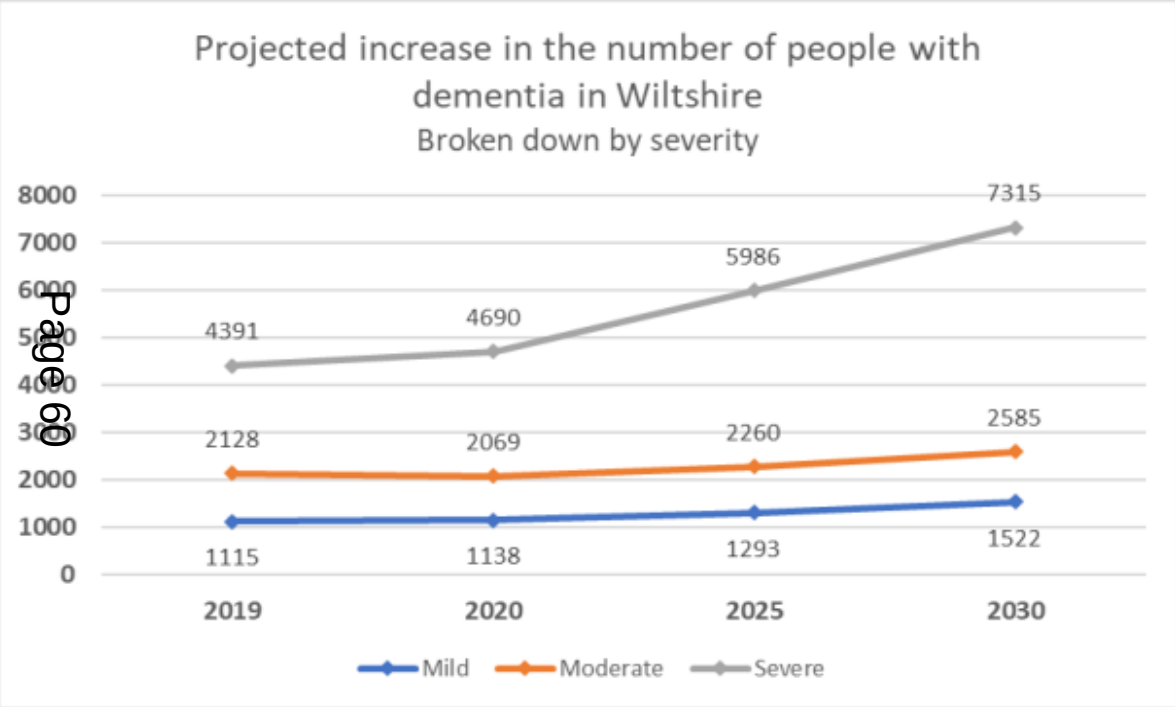
Delirium develops suddenly and may be caused by infection, urine retention, constipation, pain, change of routine or environment, etc.

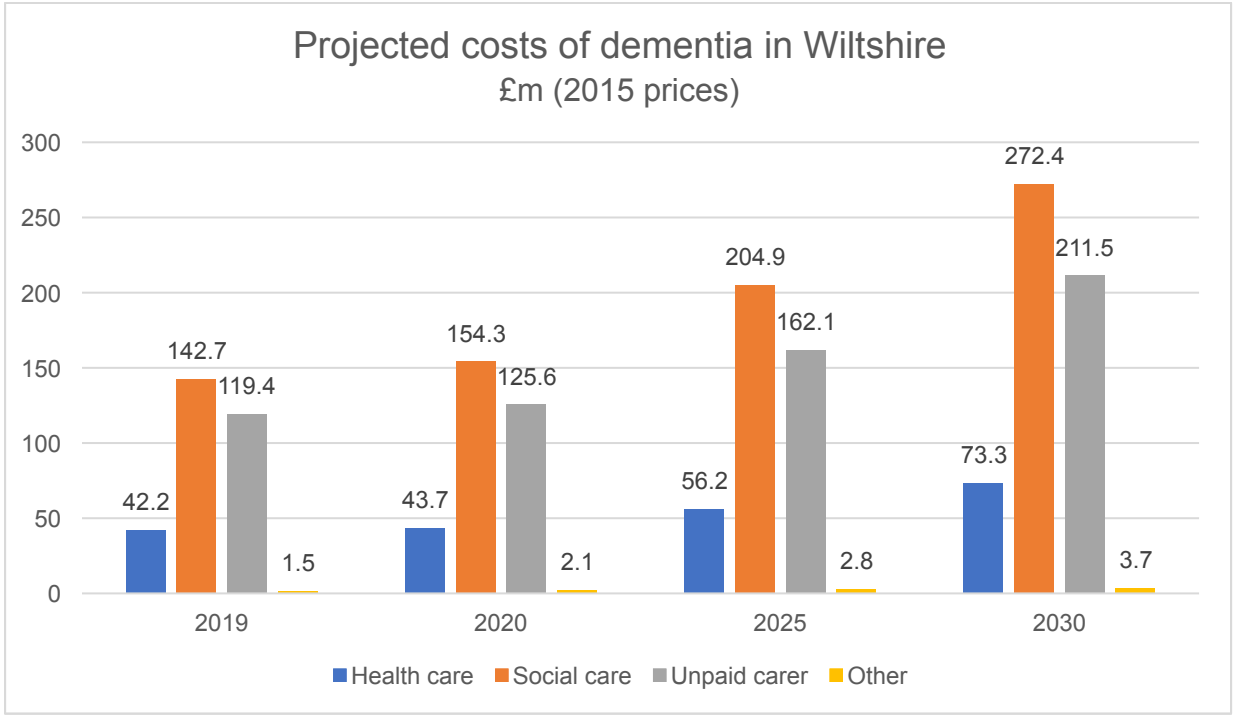
If correctly identified, delirium can be treated.

Dementia - a **national** challenge

- Approximately 950,000 people live with dementia in the UK. 1 in 11 people aged 65+ have dementia. Dementia costs £25 billion per year in the UK.
- In 2022, dementia was the leading cause of death in the UK. Many dementias do not yet have a treatment to prevent, cure or slow progression.
- Supporting a person to live at home for as long possible is less expensive than a care home admission, and better for the person's quality of life.
- However, this is only possible due to the huge caring contribution made by unpaid carers.

Dementia – a **local** challenge





Wiltshire dementia strategy – 2023-2028

- All-age, joint strategy – supporting people with dementia and carers
- Aligned to national guidance (e.g. NICE), policy and strategy (National Dementia Strategy), as well as local strategies
- Informed by extensive co-production and engagement during 2023 – public, professionals, clinicians, Members (e.g. via Health Select) – **over 400 people engaged, including 150+ people with dementia & carers**
- Strengths-based approach, focus on prevention and early intervention, raising awareness, supporting communities, building resilience, enabling people
- One Council approach – dementia is everybody's business, not just social care

Health Select Committee feedback – 8th June 2023

- Emphasis on improving dementia pathway and increasing diagnosis rates
- Need for evidence-based screening for dementia
- Using Area Boards, Parish Councils etc to champion dementia awareness locally
- Opportunities to link this work up with Community Conversations
- Importance of clear information and advice – e.g. Lasting Power of Attorney
- Importance of joined-up approach across Wiltshire Council – e.g. ensuring digital inclusion (as well as providing non-digital / paper-based information) for people with dementia, supporting young carers, raising awareness and educating in schools and colleges

Draft vision

We will work together to make Wiltshire an inclusive, vibrant, supportive place for people with dementia and their family members and carers to live.

Our work will be underpinned by prevention and early intervention, tackling inequalities, understanding our communities, and promoting independence.

Priority outcomes

Preventing well

- I was given information about reducing my risk of getting dementia

Diagnosing well

- I know where to go if I think I may have dementia
- I was diagnosed with kindness and compassion, in a timely way
- I am able to make decisions and know what to do to help myself, and who else can help
- I know where to go to understand more about dementia

Supporting well

- I am treated with dignity and respect
- I get treatment and support which are best for my dementia and my life

Living well

- I know that those around me and looking after me are supported
- I feel included as part of society

Dying well

- I am confident my end of life wishes will be respected
- I can expect a good death

How we will deliver the priorities

We will raise awareness of dementia across Wiltshire

We will develop a corporate approach to making Wiltshire dementia-friendly

We will effectively screen for & identify dementia at an early stage

We will ensure assessment and diagnosis is delivered consistently

We will reduce waiting times and increase the diagnosis rate

We will ensure people diagnosed can access NICE-recommended support

How we will deliver the priorities (cont.)

We will review emergency and out-of-hours support

We will THINK DELIRIUM

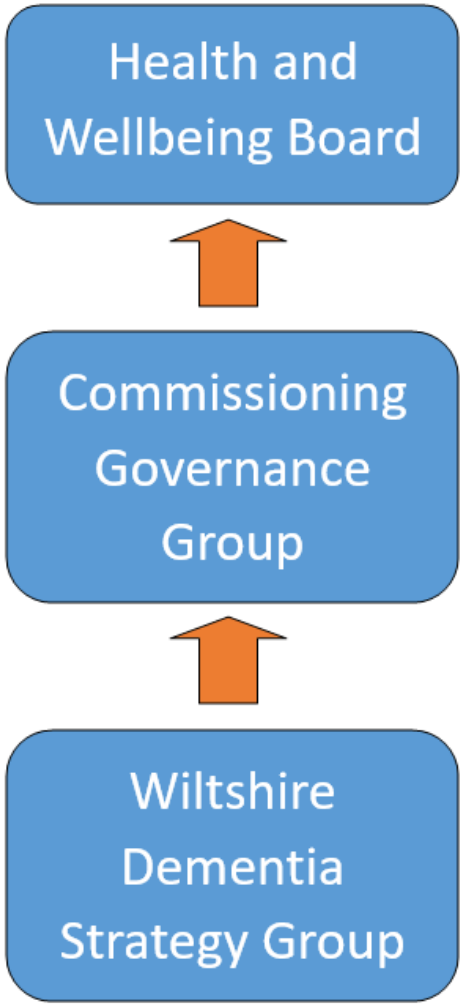
We will ensure information and support is easy to find and access

We will invest in communities and markets

We will develop a training strategy for carers and professionals

We will give people opportunities to plan for the future

Governance


Health and Wellbeing Board
Commissioning Governance Group
Wiltshire Dementia Strategy Group

This page is intentionally left blank

WILTSHIRE POLICE

Right Care Right Person

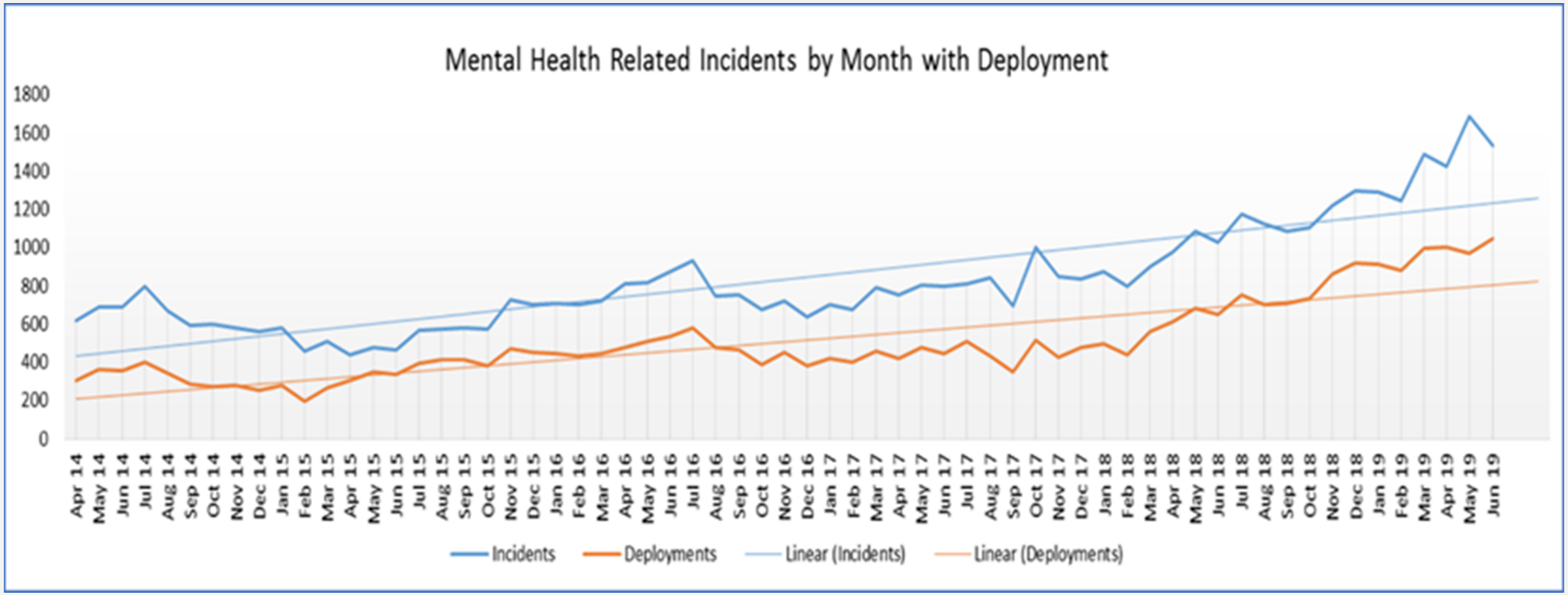
Chief Inspector Matthew Armstrong

Background

- Humberside RCRP journey started in 2019
- Demand for mental health and concern for welfare calls in Humberside had been rising exponentially.
- Concern for Welfare:
  - Over 25k calls p/a; 11% of overall demand; 25% increase over 2 years
- Mental Health:
  - Over 14k calls p/a; 35% rise over 2 years; 6% of overall demand
- Many of these calls came from partner agencies.
  - 18% of all Concern for Welfare calls came from our partners.
  - Top locations in terms of demand - 8 of the top 11 locations were NHS or care settings.

HMICFRS report ‘Picking up the Pieces’ (Nov 2018)

- Mental health demand was rising exponentially with no method to reduce it.
- Welfare checks were taking up a disproportionate amount of police time and were mostly health related.
- Partner services were unable to cope with their demand and the police were filling the gaps.



Police Productivity Review 15/02/23

Mental Health Demand on Policing – Sir Stephen House QPM

Key Findings

Use of the Section 136 has increased by **10%** in the last four years.
Forces report spending **12 hours** with each patient.

Requests for assistance from individuals suffering from mental ill health are **increasing across all services**. End of 2021: 4.3 million referrals to NHS mental health services. (An increase from approximately 3.8 million referrals in the years 2019 and 2020)

3,000-5,000 individuals are held in police cells each year, without any legal framework, suffering from acute mental ill health and awaiting an appropriate bed in a health care setting.

Thousands of individuals are reported every year to the police as missing from mental health settings and hospitals.

800,000 officer hours a year, for calls to mental health incidents that do not involve a crime or safety risk.

THE POLICING PRODUCTIVITY REVIEW

6 Core Principles of RCRP

1. Members of the public have the right to receive the “Right Care from the Right Agency”
2. The police should concentrate on Core Policing Duties
3. Understanding the Police’s Legal Duty to attend
4. Listening to Feedback from staff
5. Partnership working
6. Ensuring staff feel properly trained and supported to make the right decisions

Humberside Phased Approach

Objective 1: Partners within Health and Social care should conduct their own Welfare checks rather that rely on the Police to conduct them.

Objective 2: AWOL mental health patients should not be routinely reported to the police

Objective 3: Police should not be routinely called to locate patients who leave unexpectedly from the Emergency Departments (ED) of Acute Hospitals

Objective 4: Transportation for physical and mental health patients will not be carried out by the police unless in exceptional circumstances

Objective 5: Police handovers at Mental Health Crisis Suites should take place within 1 hour

Humberside evaluation

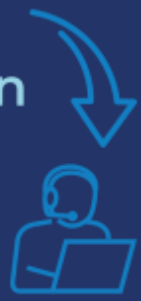
540 less deployments per month

1,441 officer hours saved per month

55,707 officer hours saved so far (between June 2020 - December 2022)

Reduction in the proportion of RCRP incidents deployed to: from **78% at its peak** in January 2019 to **25% at its lowest in May 2021**, which is **a 53% pts reduction**

8% of demand taken out of the system: Reduction of 4% in overall deployments (April - December 2022)



Legal Responsibilities

Legal duties to act arise on the police in the following general circumstances:

- A ***real and immediate*** threat to life: Duty under Article 2 ECHR
- A ***real and immediate*** threat of really serious harm/torture/inhumane or other conduct within Article 3 ECHR.
- ***Common law*** duties of care.
- ***Specific statutory duties***. Arrest, detain, restrain.

Article 2 ECHR

…..any threat would have to comprise all the following before a duty to act would arise:

A threat to life. A threat merely of injury was not enough.

The threat had to be against a specific and identifiable person.

That threat must be imminent, and not conditional on other acts or events.

A positive duty to protect against a risk will arise where:

The Police know or ought to know;

- Of a real and immediate risk to life or serious injury
- To a person or group of persons;
- Even if that person (or group of persons) is not specifically identified. The fact the person/group is/are known to exist me be enough

Osman v UK 29 EHRR 245

Öneryildiz v Turkey (2004) 41 EHRR 325, para 71

Article 3

Article 3 ECHR has the following elements:

- Prohibition of torture, or inhumane or degrading treatment or punishment.
- The duties arising under the ECHR are not limited to risks to life. There are similar duties where there is a real and immediate risk of conduct within the terms of Article 3.
- What is set out above in relation to Article 2 applies equally to Article 3. Article 3 broadens out the circumstances in which a duty may arise, in particular where the risk is less than death.
- Interpret as ***serious harm***

Common Law

The police do not owe a private duty of care in common law towards individual members of the public to protect them from harm.

Where the police omit to act, it is unlikely that they will be held to have breached a duty of care.

In general terms, if the police do nothing they will not be breaching any common law duty of care.

Exceptions to this general position: Assumption of care

The police may assume a responsibility to care for a person. Where there is such an assumption the police will be under a duty to care for the person.

When do the Police create or assume a duty of care and how is that duty then discharged? Taking a phone call? Passing on a message? Attending a call for service? Taking someone somewhere? Calling an ambulance?

When do Police assume a duty of care under Common Law?

The police may assume a responsibility to care for a person. Where there is such an assumption the police will be under a duty to care for the person.

- ***Robinson v CC of WYP***

When do the Police create or assume a duty of care and how is that duty then discharged?

- Taking a phone call?
- Passing on a message?
- Attending a call for service?
- Taking someone somewhere?
- Calling an ambulance?

- **Sherratt v Chief Constable of Greater Manchester Police**
- **Webley v St Georgie's Hospital NHS Trust**

College of Policing: Risk APP

The police service is not responsible for all forms of risk

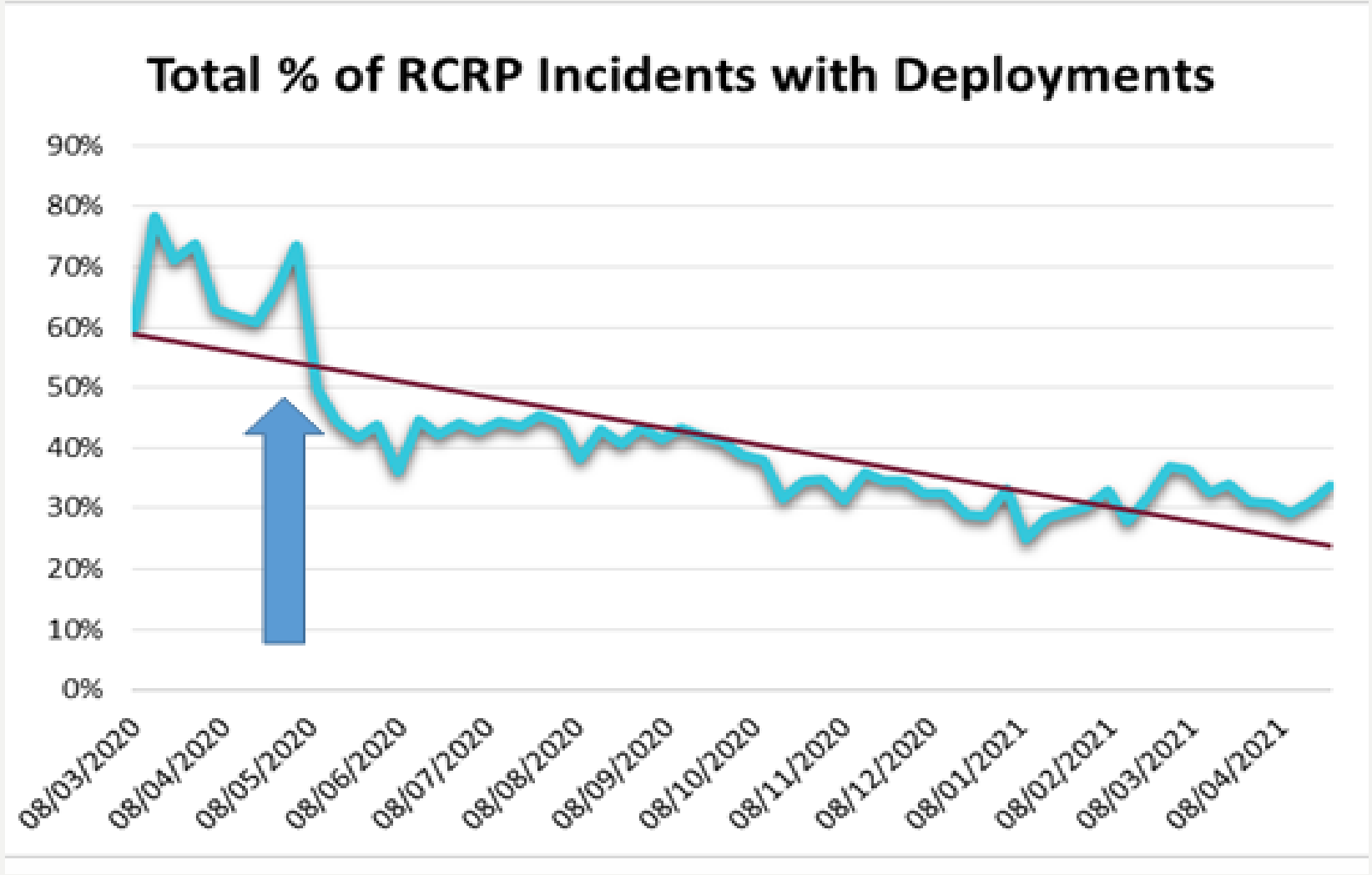
The police should not assume, directly or indirectly, responsibility for all forms of risks. They may have no legal right or power to do so and could compromise their reputation by exceeding their role. Other agencies may have more appropriate skills (eg, in risk assessment), resources (eg, ability to provide long-term interventions) and legal powers.

- Officers should consider whether it is appropriate for them to accept, or to continue to accept, responsibility for a risk when there are more appropriate agencies or methods of tackling the problem. They should not encourage the public to think automatically of the police the first or most appropriate port of call for every problem. The police must work with partner agencies rather than take on their responsibilities.

College of Policing: Mental Health APP

In general, when there is no reason to suspect that a crime has been, or is likely to be committed, responses to the needs of people with mental ill health and vulnerabilities should be provided by appropriately commissioned health and social care services. The police have a duty to prevent and investigate crime, however, they also provide an emergency response to intervene and protect life and property from harm.

Humberside experience



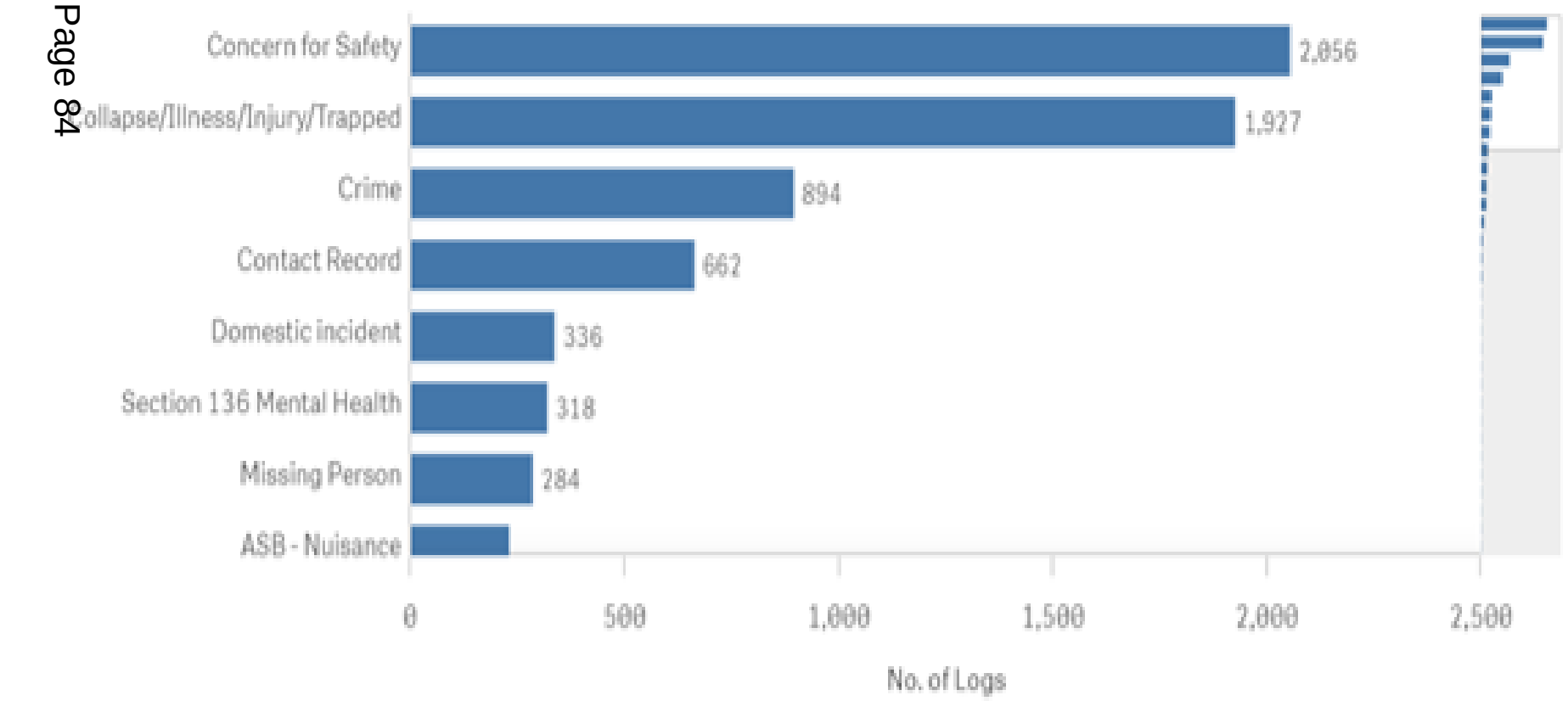
Wiltshire snapshot

MH Logs	MH Logs as a % ...	MH Logs with D...	Units Dispatche...	Officers Dispat...	MH Log Open to...	MH Log Time at ...
7,541	6.1%	2,229	14,126	18,707	Hours : Minutes	Hours : Minutes

MH Log by Caller Tel No | MH Log Detail | MH Logs over Time | MH Logs by Disposal

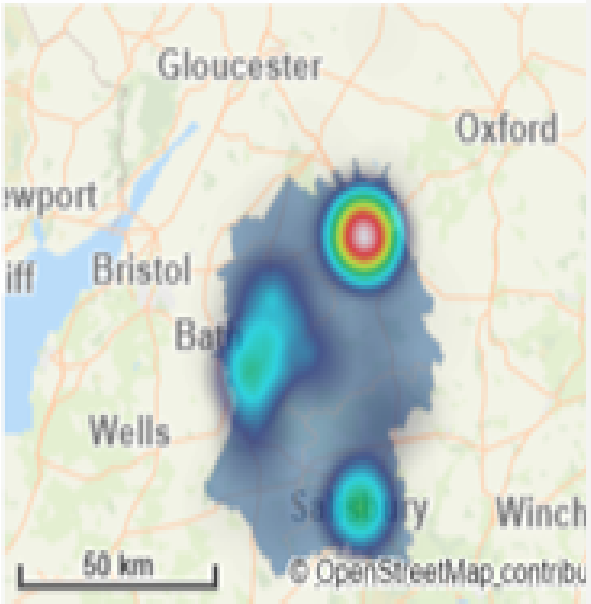
MH Logs: logs with '136 Mental Health' Disposal OR 'Mental' Tag OR 'Mental Health' Qualifier OR 'Mental' within Summary.
Domestic Logs: logs with the 'Domestic' Qualifier

MH Logs by Disposal



MH Logs

Filter to 10,000 MH logs or less to see points on map



Police Productivity Review 15/02/23

Mental Health Demand on Policing – Sir Stephen House QPM

Action since the reports

£7 million capital funding for the procurement of specialised mental health ambulances

£143 million for new, or to improve existing, mental health crisis response infrastructure

The Home Office, DHSC, NHSE and the NPCC are engaging on the National Partnership Agreement with police and health partners

Right Care, Right Person & the National framework for missing adults

THE POLICING PRODUCTIVITY REVIEW

Next steps……

- College of Policing Police National Tactical Delivery Board set up
- College of Policing National guidance provided for:
    - Senior Reporting Officer role
    - Baselining and evaluation criteria
    - Communication plan considerations
- National Legal advice to Police, operational guidance and policy considerations in progress for delivery Q3/4
- National Partnership Agreement has Ministerial sign off
- Wiltshire to hold first tactical partnership meeting 19th September 2023
- Phased approach to implementation starting in the New year with Concern for Safety

Bath and North East Somerset, Swindon and Wiltshire Together

Bath and North East Somerset, Swindon, and Wiltshire Integrated Care System (BSW Together)

Primary and Community Care Delivery Plan

September 2023

V1

Contents

Executive summary

Primary and community care services work to improve our populations' health, support them when they are unwell, and achieve fairer outcomes for children and adults across our system.

BSW Together has the opportunity to transform how we deliver primary and community care services across the integrated care system (ICS). We want those living and working within our communities, and those who use and deliver these services to feel a step change in how we come together and collaborate. This will create a truly integrated network where everyone's contribution is valued and recognised.

We need to address important drivers including an ageing population with increasingly complex needs, including frailty; growing demand and pressure across our services and on our workforce; the need for a person-centred approach to care; and the relationship between greater equality, better care, and a healthier economy.

This delivery plan builds on our existing strategies, including the BSW Together Integrated Care Strategy and Implementation Plan, and national policy and guidance. It consolidates existing documentation (over 20 documents) and reflects the engagement work completed to date with service users, providers (including market engagement events) and wider stakeholders to identify initiatives and solutions to deliver our ambition. This delivery plan also incorporates direct feedback from over 40 stakeholders including primary care GPs, integrated care board (ICB) members, the clinical oversight group, and the integrated community-based care (ICBC) programme.

Our delivery plan sets out six transformation priorities:

1. **Deliver enhanced outcomes and experiences for our adults and children by evolving our local teams.** We will build on our existing primary care networks to create more integrated neighbourhoods serviced by providers who can share information, caseloads, and estates to provide more joined up care and the capacity to do so.

2. **Adopt a scaled population health management approach by building capacity and knowledge.** We will use data and insight to understand our populations better, identify health inequalities, target marginalised groups, and develop initiatives and services that improve access and result in fairer health and outcomes.

3. **Actively co-design and co-deliver preventable models of care by strengthening local partnerships and assets**. We can promote healthier communities and increase healthy life expectancies through better understanding and working with our local communities. We recognise that care and support is best delivered by those who understand the adults and children who live within them.

4. **Increase personalisation of care through engaging and empowering our people.** We need to shift towards greater prevention and early intervention. We can do so by tailoring our support to a persons' specific needs and using technology

advances to provide support in formats that fit with individuals' needs and preferences.

5. **Improve access to a wider range of services closer to home through greater connection and coordination.** We will deliver excellent health and care services closer to people's homes and overcome inequality of access by creating stronger physical and virtual connections between primary and community care and specialist services.

6. **Support access to the right care by providing co-ordinated urgent care within the community.** We want emergency care to be for those who need it most and know we can help people to address their urgent needs within the community. This can prevent avoidable admissions and result in better outcomes and experiences.

Within each priority, we have outlined its **context** and rationale, the **ambition** of what will look and feel different and identified **interventions and actions** that will support its delivery. These are intended to enable places, neighbourhoods, and providers to understand the direction of travel for primary and community care and support them to make decisions on how they are delivered within their local populations.

We also recognise the importance of the five **focus areas** which have been considered for each priority. The focus areas are health inequalities, children and young people, mental health, major conditions, and learning disabilities and autism.

This delivery plan will be supported by the six enablers identified in the BSW Together Integrated Care Strategy, as well as an additional enabler on commissioning and contracting:

- Shifting funding to prevention
- Developing our workforce
- Technology and data
- Estates of the future
- Environmental sustainability
- Our role as an anchor institution
- Commissioning and contracting

This document is intended to be a strategic articulation of the future of our primary and community care services across BSW as we work better, and closer, with our partners and providers including the NHS, local authorities, the private sector, and voluntary, community and social enterprise (VCSE) organisations.

The intention is for this delivery plan to evolve over time as we hear and learn more from those who deliver and those who receive our services. We know we have more work to do to build the detail to deliver on these priorities and recognise this document is the starting point for our journey to transform primary and community services across BSW.

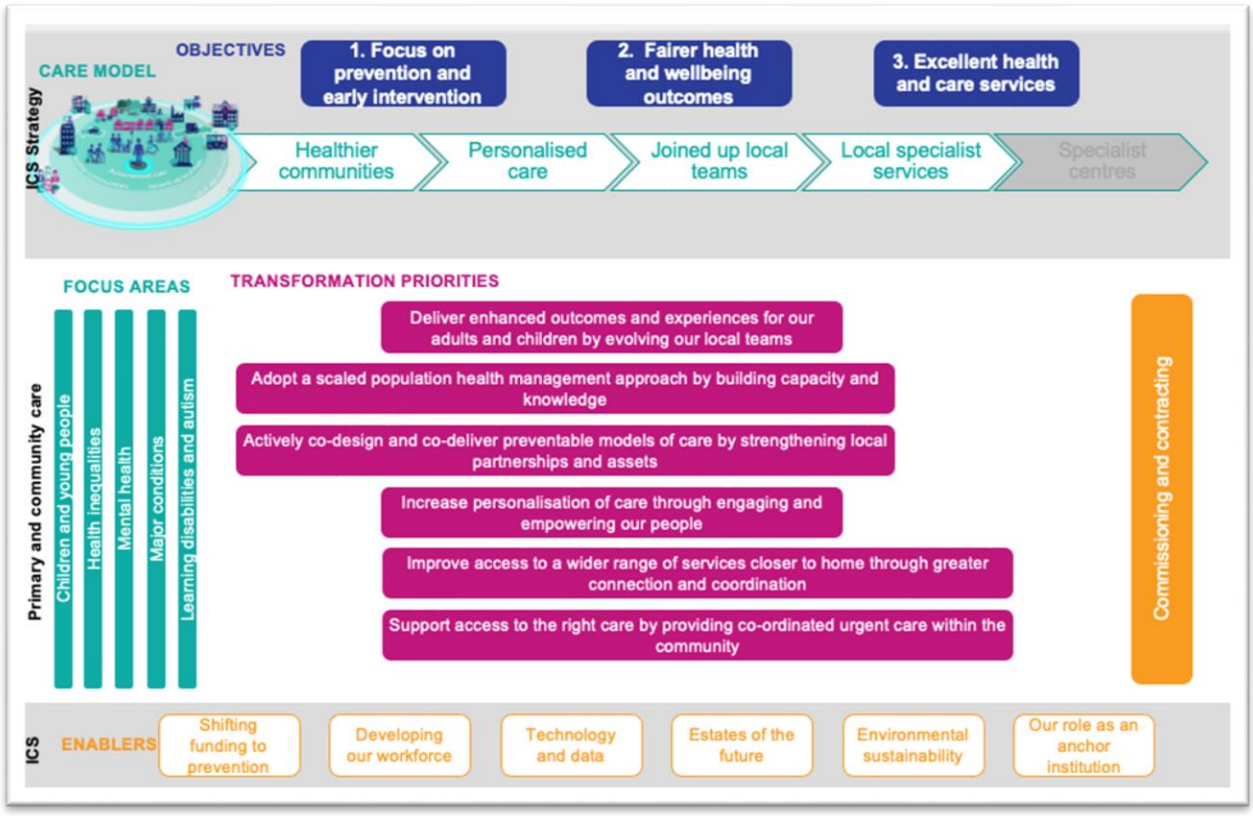


Figure 1: Summary of transformation priorities and alignment to BSW care model

Delivering our transformation priorities will mean:

- Our children, young people and their families and carers are recognised and valued, with a healthy environment to grow and learn in, and access to the support they need
- Individuals can equitably access care closer to home, within their communities and delivered by people who understand their specific needs
- Our older people, particularly those living with frailty, are supported to age well and stay independent at home for longer, where they are cared for at or near their home
- Our workforce is engaged and inspired, supported by technology, data and space that helps them to be happier at work
- Our providers and partners collaborate and innovate to drive fairer outcomes as well as delivering services. These providers are supported to be sustainable, providing the basis for transformation and shifting services into the community.

Introduction

The primary and community care delivery plan is a strategic document that supports the broader BSW Together Integrated Care Strategy and Implementation Plan and informs operational planning and financial recovery, so that we can better serve our BSW population of children and adults.

Scope

This delivery plan has been developed at the system level and encompasses primary and community care services. It focusses on the first four parts of the BSW care model (personalised care, healthier communities, joined up local teams, and local specialist services).

Central to delivering locally is our ability to enable joined-up local teams. However, we also need to consider how we best provide care and support to our communities and our peoples' individual needs, reduce health inequalities, and how we integrate with secondary care. As a result, not all care will be provided through joined-up teams, some will be delivered by other providers, across multiple neighbourhoods or at place to address the challenges we face.

Primary care, specifically general practice (GP), will remain the point of access for many patients and, working within PCNs/neighbourhoods are the foundations for transforming community-based care. We recognise the challenges faced by GPs both in terms of demand (increasing activity), and supply (workforce, estates). As such, focus will be given to creating a resilient structure.

This system level delivery plan outlines transformation priorities for primary and community care services. It is not prescriptive, as the way in which places, neighbourhoods and providers deliver these priorities may differ. We want to empower GPs, VCSEs, or individual providers to make their own decisions for their local populations.

This is intended to be a dynamic document that represents current priorities and activities and should not be seen as an exhaustive list of actions to be taken.

Key definitions[1]

- **Primary care services** ("primary care") should be considered in its broadest sense and encompasses GPs/ Primary Care Networks (PCNs), pharmacy, optometry and dental (POD) services.
- **Community based care services** ("community care") includes universal or core services (place based), extended services, and community-based specialist services (such as virtual wards and community diagnostic services).

We expect that a variety of partners and providers (including VCSEs, NHS, local authorities, and the private sector) will contribute to the delivery of these services, as we

[1] As defined in the Primary and Community Care exec summary presentation

acknowledge that many different organisations operate across our neighbourhoods and places.

Acute level care is out of scope of this delivery plan. We have however considered where primary and community care services intersect with acute services and pathways.

Investment assumptions

Defining the financial envelope required to deliver the priorities outlined within this delivery plan is out of scope. We have indicated a desire to shift activity and outcomes through the BSW Together Integrated Care Strategy. This infers an associated increase in investment in future years. The system is however required to ensure fiscal sustainability and final investment decisions will emerge through the development of the BSW ICB Medium Term Financial Plan. Consideration by the ICB and Local Authority partners of the strategic benefits as part of this work will identify the optimal and sustainable level of investment they wish to commit into primary and community care services.

Key drivers

This delivery plan is an opportunity to address drivers for change across the system; reframing and transforming how we deliver primary and community care. It will also guide the upcoming recommissioning exercise for community service providers. Below is a summary of drivers, with a more complete narrative provided in the appendix.

- **Addressing an ageing population** – ageing well and keeping people healthier for longer within our communities can reduce pressure from increased complexity, multimorbidity, and frailty.

- **Increasing pressure on existing primary, community, and social care services** – many of our services are already stretched and we must transform how we deliver care and support to either reduce pressure or improve our ability to deal with it.

- **Addressing wider health and care pressure** – improving prevention and early intervention will not only help people to live healthier lives, but reduce avoidable demand on our wider health system, meaning resources can be utilised elsewhere.

- **Integrating to deliver a better experience and outcome for our adults and children** – we need to reduce the number of people falling through the gaps as they move between providers and improve our design of services by basing them on what our people need and want.

- **The economic value of health and care** – a healthier population is not only happier, but also more economically active. Investing in care, particularly prevention and early intervention, is key to our ability to maintain a healthy economy.

Delivery plan methodology

This delivery plan was developed through consolidation and alignment of existing documentation as well as engagement with stakeholders across the system.

This delivery plan builds on the Integrated Care Strategy and is aligned to the BSW care model. It should be read in conjunction with wider BSW transformation programmes and strategies outlined in the Implementation Plan. It consolidates and aligns to existing system and national strategies, policy, and guidance. Supporting narrative is provided in the appendix.

Stakeholder engagement took place through a series of market engagement events conducted to gather views from local providers. Feedback was also gathered from primary care GPs, ICB members, the Clinical Oversight group, and the ICBC Programme.

To structure the plan, a framework was developed with five interlinked areas, visualized below. The plan flows from the six **transformation priorities** which are delivered through **interventions and actions** (pink). These are driven by **principles** (blue), supported by **enablers** (yellow), and feature cross cutting **focus areas** (green).

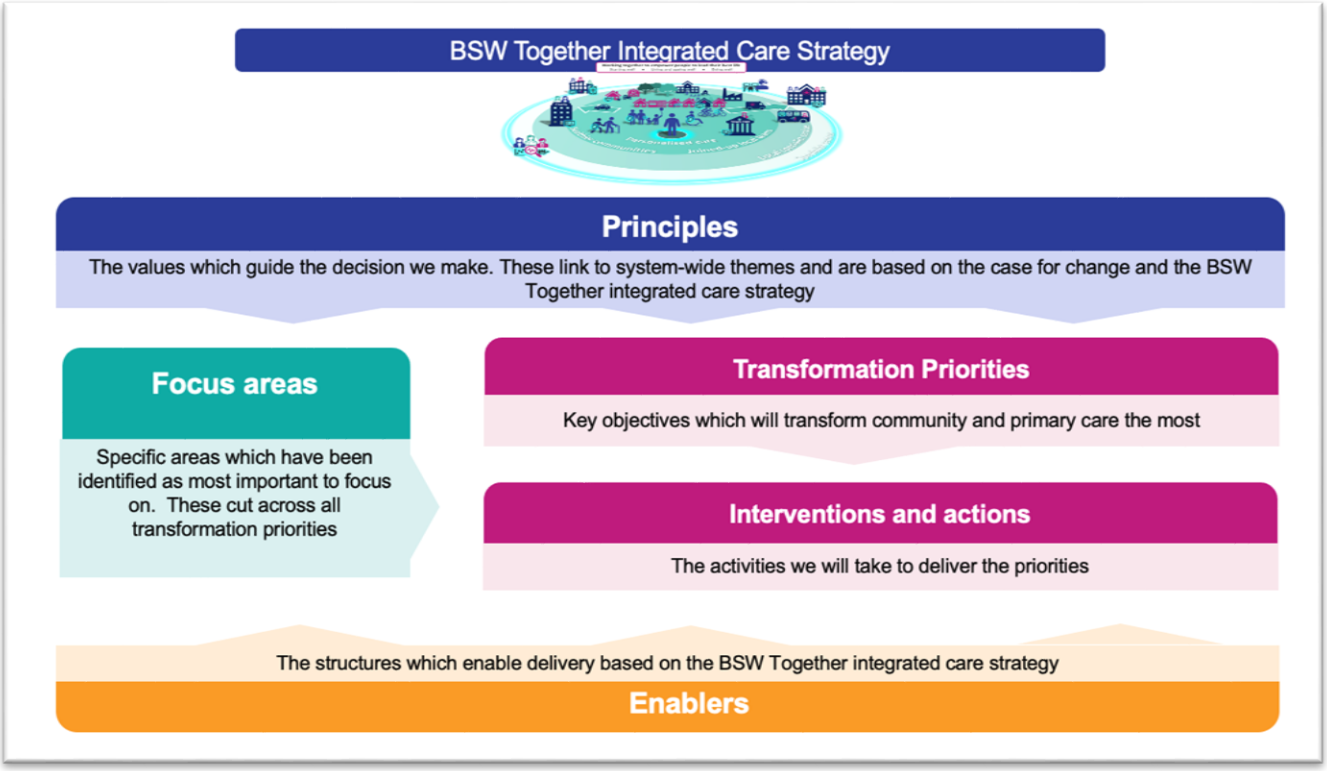


Figure 2: Structure of the delivery plan

Principles

These principles link to system-wide themes and have been developed based on existing principles across system strategy and programmes. They have guided, and underpin, all the focus areas, transformation priorities (including interventions and actions), and enablers.

Localisation - Focusing on the population's needs rather than sectors, organisations, or services. Highlighting the importance of community engagement and activation and emphasising the involvement of the third sector.

Equitable access - Reducing inequalities by utilising data and intelligence to inform planning and decision-making processes. Target interventions and enhancements based on identified areas for improvement.

Collaborating for outcomes - Changing our ways of working (both formal and informal) to create a culture of trust and innovation across providers. Empower local decision-making and delivery and strive for better outcomes.

Closer to home - Wherever possible, our people should be seen, supported, and treated within at-home or near-home settings and in their local communities so that we can keep people well and healthy at home.

Transformation Priorities

Based on the system strategy, national policy and guidance, case for change, and guided by the principles and focus areas, six transformation priorities have been identified for primary and community care:

1. Deliver enhanced outcomes and experiences of our adults and children by evolving our local teams
2. Adopt a scaled population health management approach by building capacity and knowledge
3. Actively co-design and co-deliver preventable models of care by strengthening local partnerships and assets
4. Increase personalisation of care through engaging and empowering our people
5. Improve access to a wider range of services closer to home through greater connection and coordination
6. Support access to the right care by providing co-ordinated urgent care within the community

These priorities support the delivery of, and are aligned to, the BSW care model and focus areas.

Focus areas

At the system, and national level, there are several focus areas that have been identified that should be considered across all transformation priorities:

- Health inequalities
- Children and young people (CYP)
- Mental health
- Major conditions
- Learning disability (LD) and autism spectrum disorder (ASD)

Where relevant, interventions or actions within this plan have been identified for a specific focus area. Those mentioned are not an exhaustive plan for each focus area. Further work is required to align this delivery plan to existing programmes or develop new strategies. Additional detail can be found in the appendix.

Enablers

Reflecting the enablers identified in the BSW Together Integrated Care Strategy, this delivery plan will be supported by the following enablers:

- Shifting funding to prevention
- Developing our workforce
- Technology and data
- Estates of the future
- Environmental sustainability
- Our role as an anchor institution

We have identified an additional enabler for the purposes of this delivery plan:

- Commissioning and contracting

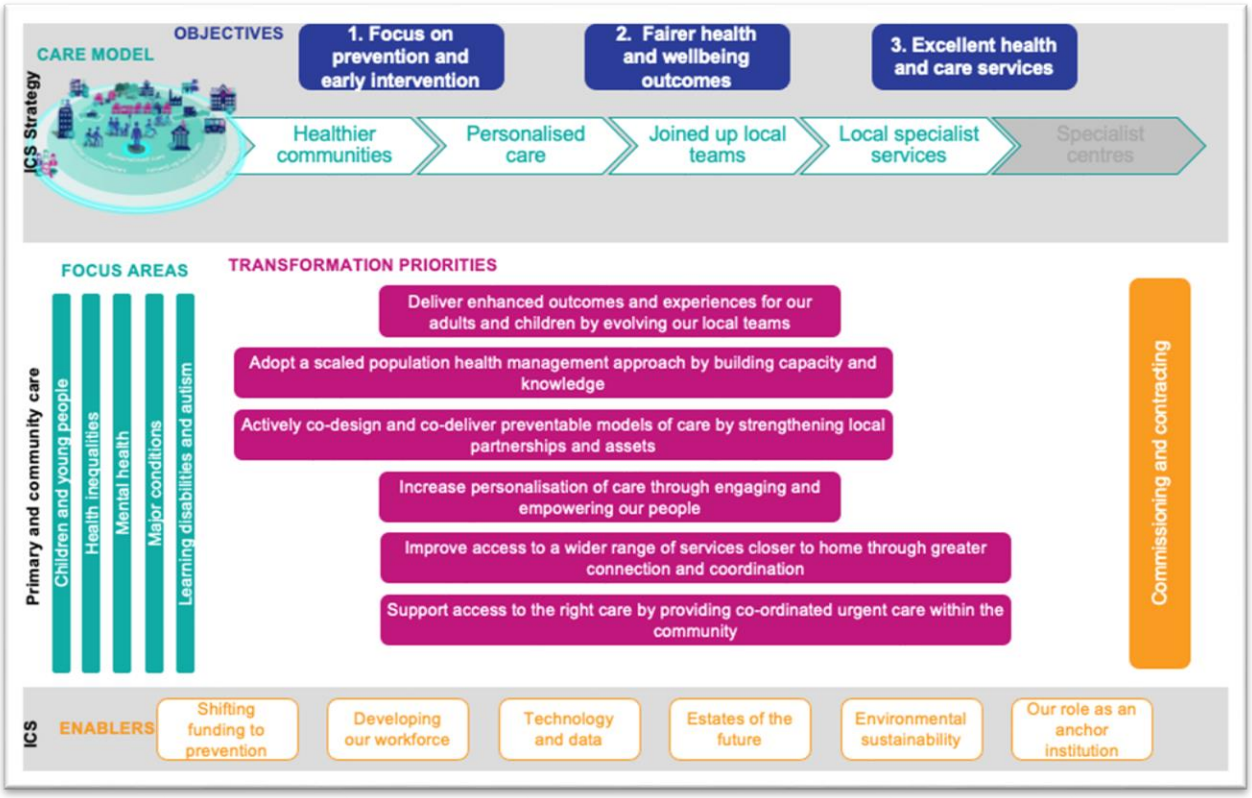


Figure 3: Summary of transformation priorities and alignment to BSW care model

Each transformation priority is described in four sections:

- **Context** – an overview of the priority and rationale
- **Our ambition** – what will be achieved by delivering the transformation priority and address the key drivers identified
- **How we will deliver** – detail on the interventions and activities that support delivery. Interventions and actions are not intended to be exhaustive and further work is required to build the detail required to implement.
- **Impact on focus areas** – commentary outlining how the transformation priority will affect each specific focus area

Priority 1: Deliver enhanced outcomes and experiences for our adults and children by evolving our local teams

Context

Our care model states that joined-up local teams will enable us to deliver in a more coordinated way. We need to shift from operating as individual providers to operating together, using the strengths and expertise of different professionals.

Joined-up local teams[2] (sometimes referred to as integrated neighbourhood teams, INTs) enable providers to work together to personalise the care they deliver to a specific person. INTs were described in the Fuller Stocktake as having the potential to deliver more personalised care through support provided by a multidisciplinary team (MDT) of professionals. Designing our services around our neighbourhoods and connecting health and care professionals through these teams will provide coordinated lifestyle, psychological and medical advice, and support.

These teams bring together individuals from the health and social care sector, such as social care leads, nurse leads, health development coordinators, and GP leads, working alongside local partners such as local housing associations, policy, mental health services and voluntary organisations. Teams do not necessarily need to be physically located together, nor is a dedicated resource needed in every team and neighbourhood from every provider. We need to develop a model that provides greater connection between services so that we can pull in the right expertise when it is needed.

Joined-up local teams and their ways of working will provide benefits to all our adults and children within BSW but be particularly beneficial to those who need the most care or those with the multiple and complex needs including moderate frailty.

As outlined in the Fuller report, support for the new INTs will need to come from ‘larger providers such as GP federations, supra-PCNs, NHS trusts’ as they have the scale required to support this new way of working. This will include integrating enablers such as HR, quality improvement, organisational development, data and analytics, finance, etc.

Our ambition

- Organisations and providers work together to deliver co-ordinated care for those with complex and long-term conditions, delivering continuity of care throughout and leading to a better experience for service users
- Local teams deliver targeted initiatives that support prevention and early intervention and reduce inappropriate referrals and avoidable admissions, reducing pressure on the wider system
- Joined-up local teams and primary care deliver place-based integration of mental and physical health and ensure parity of esteem

[2] As defined in the BSW care model

- We take a trauma informed approach to assessment and care planning so that we can recognise that lived experiences can impact how we support and care for children and adults

How we will deliver

1.1 Create a system-wide blueprint for local teams and set up the structures needed to enable it

1.1.1 Define the 'core' capabilities which should be aligned to neighbourhoods and interactions between neighbourhood-place-system providers
1.1.2 Understand the feasibility (including value for money) of sharing estates and equipment and design a model that enables greater awareness of estate / equipment that is available across the system
1.1.3 Define a BSW approach/policy identifying and removing blockers for sharing risk and caseloads between providers
1.1.4 Define requirements to deliver interoperable systems and required supporting processes and workforce to deliver
1.1.5 Clarify data governance and process requirements to enable and increase the sharing of information and data (such as a shared care record) to deliver greater continuity of care
1.1.6 Review feasibility (including value for money) for establishing a centralised back-office and transformation function for joined-up neighbourhood teams. If feasible define how teams can access it.
1.1.7 Identify what is required (investment, resources, training, etc.) to deliver joined up local teams

1.2 Harness the role of wider primary care in local delivery

1.2.1 Work with providers to understand the variation in provision, and future required alignment and provision of pharmacy, optometry and dental (POD)
1.2.2 Identify opportunities to support GP practices by providing additional capacity through alternative delivery models
1.2.3 Use understanding of community assets (action 3.2.1) to identify opportunities and partnerships that can be used to deliver signposting and preventative measures (such as blood pressure monitors) within non-NHS services

1.3 Build the capacity and capability to deliver local teams within primary care

1.3.1 Support Places to undertake a maturity assessment against the local teams' blueprint (action 1.1) and identify required actions
1.3.2 Develop solutions to address existing challenges impacting general practice sustainability (such as physical estates, workforce recruitment, and finance)
1.3.3 Specific examples include identifying plans to address the need for local teams to have:
- Adequate physical space within general practice required for MDT meetings and delivery of onsite training
- Adequate workforce resource to deliver local teams
- Reasonable adjustments for those with learning disabilities, autism, and other complex needs

- Statutory duties for babies, children and young people, and parental/carer support requirements for CYP specific services

Impact on focus areas

- **Health inequalities** – by knowing communities and the people within them, our local teams can use their interactions to identify and tackle instances of inequality or wider determinants of ill health.
- **Children and young people** – local teams can support those who may be on multiple pathways and have co-dependencies, and during their transition from child to adult services. These local teams must deliver connected care aligned with Connecting Care for Children.[3]
- **Mental health** – local teams will adopt a team-based approach that will include expertise from a range of professions, support greater parity of esteem and recognise the interdependency between mental and physical health.
- **Major conditions** – local teams will be able to support those with long-term and complex conditions to stay at home and access care and support in the community, reducing growth in hospital demand and shift away from a hospital-centric model of care.
- **Learning disability and autism spectrum disorder** – local teams will help us to improve the autism assessment process and post diagnostic services and help to implement the Key Worker Programme.

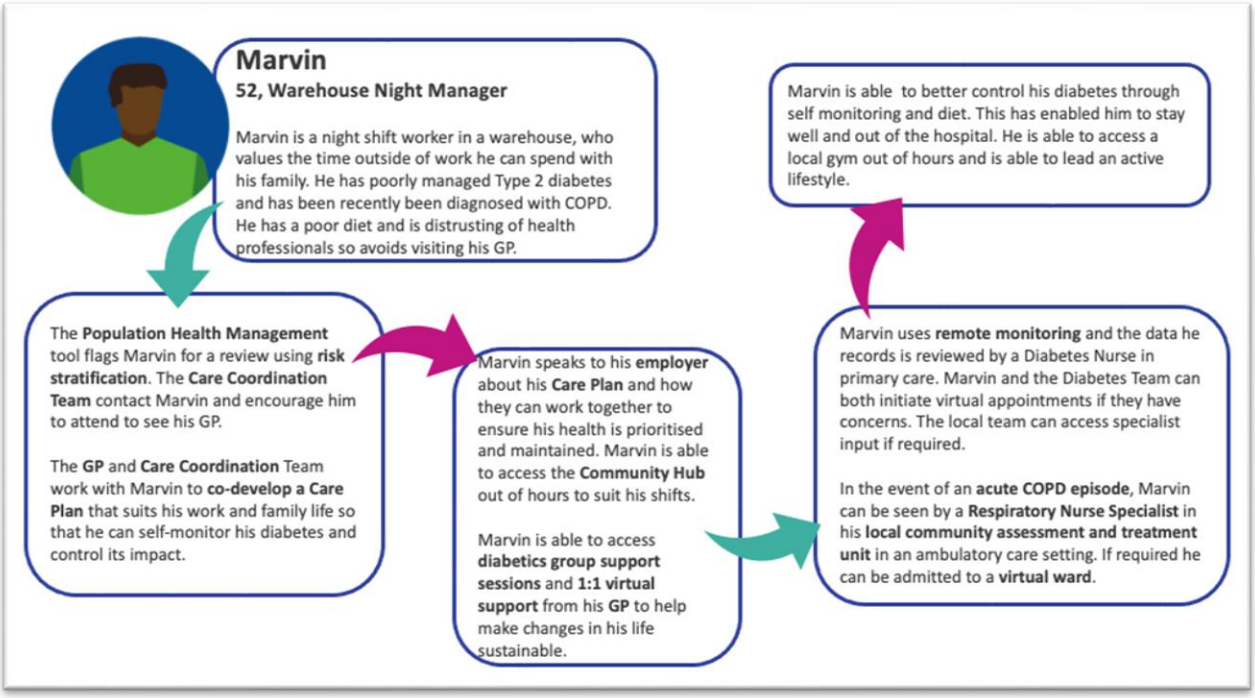


Figure 4: How care could be different – long term conditions[4]

[3] https://www.cc4c.imperial.nhs.uk/
[4] From BSW Together Integrated Care Strategy

Priority 2: Adopt a scaled population health management approach by building capacity and knowledge

Context

Population health management (PHM) is an approach used to understand a populations' current needs and predict what children and adults will need in the future. It uses historical and forecasted data to generate insight that enables providers to tailor better care for individuals, design and deliver in a more joined-up way, ensure that services are sustainable, and make better use of resources.[5]

Approaches typically focus on wider determinants of health to identify at-risk individuals and groups that can benefit from targeted, personalised, or preventative interventions. It can also be used to target and overcome barriers impacting marginalised groups or provide proactive support to older people living with frailty in the community. It is included in the NHS Long Term Plan; Fuller Stocktake; the Major Conditions Strategy; and BSW Together Integrated Care Strategy. We should consider Core20PLUS5 and CYP Core20PLUS5 approaches to reduce inequalities when designing these interventions.

Following participation in the NHSE funded programme, PHM has become an important driver in BSW's ICS journey and will be a key source of intelligence and insight driven solutions. BSW is currently piloting five projects across PCNs. A suite of tools is available to many organisations including data sets of identifiable cohorts, a health inequalities dashboard, and support for population health analysis.[6]

Primary and community care providers and partners must use PHM to support the delivery of longitudinal and preventative care.

Our ambition

- Services provided locally are based on the needs of local populations. While access is equitable there is some variation to reflect local need
- The ICB will develop and commission services according to local need of our children and adults so that we can prioritise resources and effort
- Organisations and providers will be able to work together to deliver across boundaries (organisational and geographical)
- Providers have access to data (both NHS and non-NHS) that enables them to use a PHM approach in their work

[5] https://www.england.nhs.uk/integratedcare/what-is-integrated-care/phm/
[6] BSW Together Integrated Care Strategy and Implementation plan

How we will deliver

2.1 Provide system-wide support to embed a consistent PHM approach

2.1.1 Complete review of current attitudes, cultures, and ways of working to PHM approaches

2.1.2 Define the minimum expectations in relation to PHM approaches (such as risk stratification, segmentation, impact modelling, alignment to Core20PLUS5 approaches) that should be adopted by local teams and set up methods to monitor and support its use

2.1.3 Establish formalised mechanisms to share good practice and learning across the system to spread innovation and success stories

2.1.4 Establish governance and plans related to data sharing and inclusion of non-NHS data such as that provided by adult social care, children's services, domiciliary care and VCSEs

2.1.5 Build dashboards to support providers to understand and identify differences in NHS health check invites and updates, delivery of vaccines, treatment targets, and care process attainment (including health inequality cohorts)

2.2 Use insight to identify care gaps and develop and prioritise targeted initiatives

2.2.1 Based on 2.1.2, use PHM to make evidence-based decisions on prioritisation, specific initiatives currently identified include:

- Increase capacity to provide annual health checks for those with long term conditions, learning disabilities and autism, serious mental health illness and CYP
- Increase focus on behavioural interventions including initiatives like tobacco control/ smoking cessation, weight management, alcohol use, oral health promotion, and high-risk condition monitoring
- Identify groups at risk of missing cancer screening and develop targeted initiatives to increase uptake
- Increase access to tailored Talking Therapies including digitalised programmes for those with long-term physical health conditions and child and adolescent mental health services (CAMHS)

2.3 Support local teams to scale the use of PHM in their work

2.3.1 Establish a programme to boost capability and resource capacity to apply PHM standards across the system, with specific focus on local neighbourhood teams. Specific examples include:

- Undertake a readiness review based on PHM standards of local teams' existing capability and access to data sets
- Review local teams' access to PHM toolkit and provide upskilling on how to use it
- Ensure local teams can operate within governance frameworks

Impact on focus areas

- **Health inequalities** – a PHM approach (such as expanding the use of the BSW Health Inequalities dashboard, and better use of deprivation and ethnicity data) increases our ability to identify where there are areas or cohorts of unwarranted variation such as in access or provision and develop initiatives to address them. Improved identification and targeting is central to reducing inequalities.
- **Children and young people** – we can use insight to better understand our CYP groups[7] and drive a reduction in inequalities. A data-led approach will mean developing targeted initiatives that are specific to their needs and those of their parents and carers.
- **Mental health** – we can use PHM to identify wider determinants of health which are increasing risk of mental illness, and tailor our mental health services for certain cohorts such as asylum seekers / refugees. Bringing data together will allow us to better target patients with both mental and physical health conditions, promoting earlier intervention.
- **Major conditions** - using PHM will enable us to develop more tailored prevention and early intervention initiatives through identifying and closing care gaps. As above, joint datasets will enable us to identify patients with both physical and mental health conditions, as well as those in receiving other services.
- **Learning disability and autism spectrum disorder** – we can use the insight from PHM to identify and deliver our LD, ASD, and neurodevelopment pathways including improving access and uptake of annual health checks.

[7] BSW Together Implementation Plan

Priority 3: Actively co-design and co-deliver preventable models of care by strengthening local partnerships and assets

Context

Care and support are best delivered by those who understand the children and adults who live within their communities. Similarly, organisations outside of the NHS can help people live healthier lives and help us deliver services in a more sustainable, accessible way.

While GP practices remain the foundations, neighbourhoods have multiple assets including physical space and estates, relationships and partnerships, and capabilities. Understanding these mean that we can support people in the most appropriate way and support the resilience of providers within and outside the NHS.

Part of integration is building on and strengthening closer working between health and care providers and wider organisations that operate within our communities. This includes local authorities, VCSEs, the wider public sector, and private organisations. They can be the bridge into local communities and help connect and deliver important services. The information flows both ways; they also provide a wealth of insight and expertise. They will be key to us improving our ability to deliver prevention and early intervention through closer links and better partnerships.

Better and stronger partnerships can help us to direct adults and children to self-care or self-initiated care. Promoting and signposting these services within primary and community care will help us shift towards greater prevention and early intervention.

Our ambition

- Community and local teams work with local organisations to support the design and delivery of health and care services for children and adults, working together to coordinate care and support
- We make best use of our assets including workforce, estates, and technology to reduce pressure across the system

How we will deliver

3.1 Address current barriers to working with local partners and providers

3.1.1 Explore and adapt our approach to commissioning and funding models (with consideration to long term investment in VCSEs and inclusion of training budget for the third sector)

3.1.2 Increase local partner representation within clinical and professional leadership forums and groups (including decision making) across BSW, at Place and Neighbourhood level

3.1.3 Increase training and development pathways available for the community workforce, leveraging opportunities such as the BSW Academy. Specific examples include:

- Community nurses

- Mental first aid
- Physiotherapy rehabilitation for care workers

3.2 Increase our awareness and use of community assets in the delivery of care

3.2.1 Support neighbourhoods to review and record community assets through the creation of frameworks, toolkits, and resources to assist completion

3.2.2 Identify and promote opportunities to promote the multi-use of space within neighbourhoods, utilising NHS estates and other assets

3.2.3 Use alternate workforce roles to complement existing services. Potential options include:

- Uplift in capability and capacity of wellbeing advocates, link workers, care navigators, or village agents
- Increased use of trusted assessor status to reduce delays such as in treatment assessment and discharge

3.2.4 Identify opportunities to increase use of community assets, specific examples include:

- Design a standardised social prescribing offering within local teams
- Continue to build a community mental health model that uses third sector mental health alliance partners to deliver a 'no wrong front door' approach
- Expand and develop our mental health support teams (MHSTs) in schools and work with education providers to support delivery of their local mental health plans
- Increase connections between local authorities, education providers, and health providers within the special education needs and disabilities (SEND) programme
- Deliver healthy weight programmes in partnership with, and based at, schools, gyms, and community centres

3.3 Build meaningful relationships to ensure our communities and local people are involved in the design and delivery of services

3.3.1 Support partners and providers to identify and increase use of innovation and community engagement with the services they provide. Specific examples include:

- Increase resource capacity to undertake community engagement initiatives
- Identify and connect with local groups and agencies (such as education probation, charity organisations, and faith leaders) to understand lived experience and use this to drive design
- Identify and proactively engage with marginalised groups to identify and breakdown barriers to accessing healthcare
- Tailor approach to contacting at-risk people who are less likely to attend services due to barriers they may experience

3.3.2 Create formalised feedback loops (supported by resource and capacity) between providers, VCSEs, and individuals (such as child and adult participation groups and community conversations) to gather and respond to feedback

3.3.3 Demonstrate ongoing commitment to local area partnerships and alignment to initiatives. Specific examples include:

- Healthy high streets[8] and Liveable neighbourhoods[9]
- Local Area Inclusion Partnership (LAIP)
- Family hubs[10]

Impact on focus areas

- **Health inequalities** – research suggests that wider determinants of health are more important to healthcare in determining health outcomes[11]. Closer working of the NHS, local authorities and the VCSE sector can help to improve the lives of people in our communities such as to ensure warm houses and clean air.
- **Children and young people** – stronger relationships with our schools and local authorities will ensure we can give our children and young people a better start in life both in the prevention of preventable conditions and management of long-term conditions.
- **Mental health** – increasing our use of community-based wellbeing services means our third sector mental health alliance partners can 'walk alongside' and direct people to alternative offers in local communities, aligned to the community mental health framework.
- **Major conditions** – initiatives like social prescribing can help those living with long term physical and mental health conditions to build knowledge and skills so that they are confident to live well with their condition.
- **Learning disability and autism spectrum disorder** – if we can strengthen the support in the community, we can build on preventative support that avoids crises and helps to enable people to be active members of their communities, learn new skills and have new experiences.

[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/699295/26.01.18_Healthy_High_Streets_Full_Report_Final_version_3.pdf
[9] https://beta.bathnes.gov.uk/liveable-neighbourhoods
[10] https://www.gov.uk/government/collections/family-hubs-and-start-for-life-programme
[11] https://www.kingsfund.org.uk/projects/time-think-differently/trends-broader-determinants-health

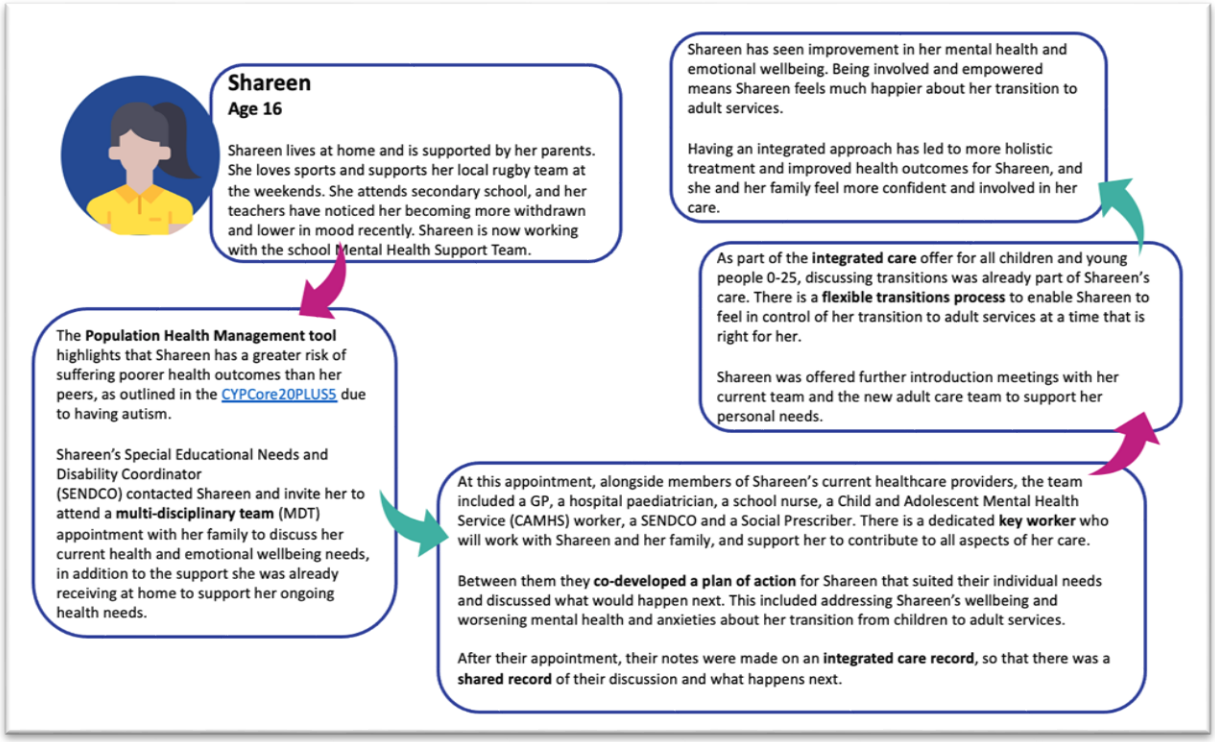


Figure 55: How care could be different – improving outcomes[12]

[12] Provided by the CYP Programme

Priority 4: Increase personalisation of care through engaging and empowering our people

Context

We know that engaged people are more likely to take an active role in their health and wellbeing. We need to support our people to shift mindsets away from doctor-led, on-demand care and encourage self-care and the use of alternate services and professionals. We need to put people at the heart of care: giving them choice and control, and better, fairer access.

Engaging children and adults in the design of services is the first step in supporting their empowerment. By giving a voice to residents and communities, they are actively involved in the design and ongoing improvement of services. This increases our chance of providing services they will be able to, and want to, access.

By providing adults and children with tools, services, and opportunities tailored to their needs, we can give them greater autonomy over their health and wellbeing. Digital and technological based services represent a major opportunity in this area. We expect developments like artificial intelligence (AI) to play an increasing role in future delivery.

Our ambition

- Our people are proactively offered initiatives that are tailored to their needs and circumstances so they can have better experiences and outcomes
- Individuals feel supported by a team that understands their specific needs, provides them choice, and involves them in decision-making
- Children and adults feel they have a voice in the services provided to them and know what services exist and how to access them, so that they access the right care and support

How we will deliver

4.1 Expand the use of personalised budgets across the system

4.1.1 Define a system-level standard set of practices for personalised care and support planning for children and adults

4.1.2 Implement standardised practices for personalised budgets so people have the maximum amount of control on the support they receive

4.2 Increase awareness of services to support better decision making

4.2.1 Undertake ongoing campaigns to increase awareness of alternatives to GPs amongst our communities so that more people access alternate services

4.2.2 Review use of patient-held records and identify initiatives to increase availability and support providers to use technology such as the NHSApp[13] to do so

[13] https://www.nhs.uk/nhs-app/about-the-nhs-app/

4.2.3 Identify and unlock barriers to support providers to access and offer clinical trials and research to their local populations

4.3 Roll out digital and remote initiatives that support at-home and near-home management

4.3.1 Increase the provision and use of NHS@Home[14] offerings including self-monitoring and at-home diagnostics
4.3.2 Build resource capacity and capability, and provide career development pathways across the system to deliver virtual wards (aligned to the BSW NHS@Home virtual wards programme)
4.3.3 Review and select digital tools and systems to enhance care coordination across providers
4.3.4 Support providers to expand the new digital NHS health check to boost capacity

Impact on focus areas

- **Health inequalities** – personalised care will empower our people to take more control of their health. Providing greater choice and awareness will help improve access for all patients, similarly, increasing capacity within primary and community care will enable providers to focus on addressing inequalities and supporting more complex patients.
- **Children and young people** – greater personalised care means that children and young people are actively involved as service users of health services in their own right.
- **Mental health** - we need to bring together treatment for physical and mental health and consider what holistic support an adult or child specifically needs and how best they can access it. Personalised budgets can improve delivery of care and support for those with mental health needs and their unpaid carers.
- **Major conditions** – greater use of technology and personalised care will enable us to consider treatment and support over the long term, particularly when recovery is not possible, managing periods of intensive support followed by periods where less support is needed.
- **Learning disability and autism spectrum disorder** – people with Down's syndrome are at significantly higher risk of experiencing other conditions[15] and we need to make sure we look at people as individuals with needs that may not fit neatly into condition specific pathways.

[14] Refers to NHS@Home definition https://www.england.nhs.uk/nhs-at-home/ which is different to BSW Together NHS@Home (virtual wards programme)
[15] Major conditions strategy

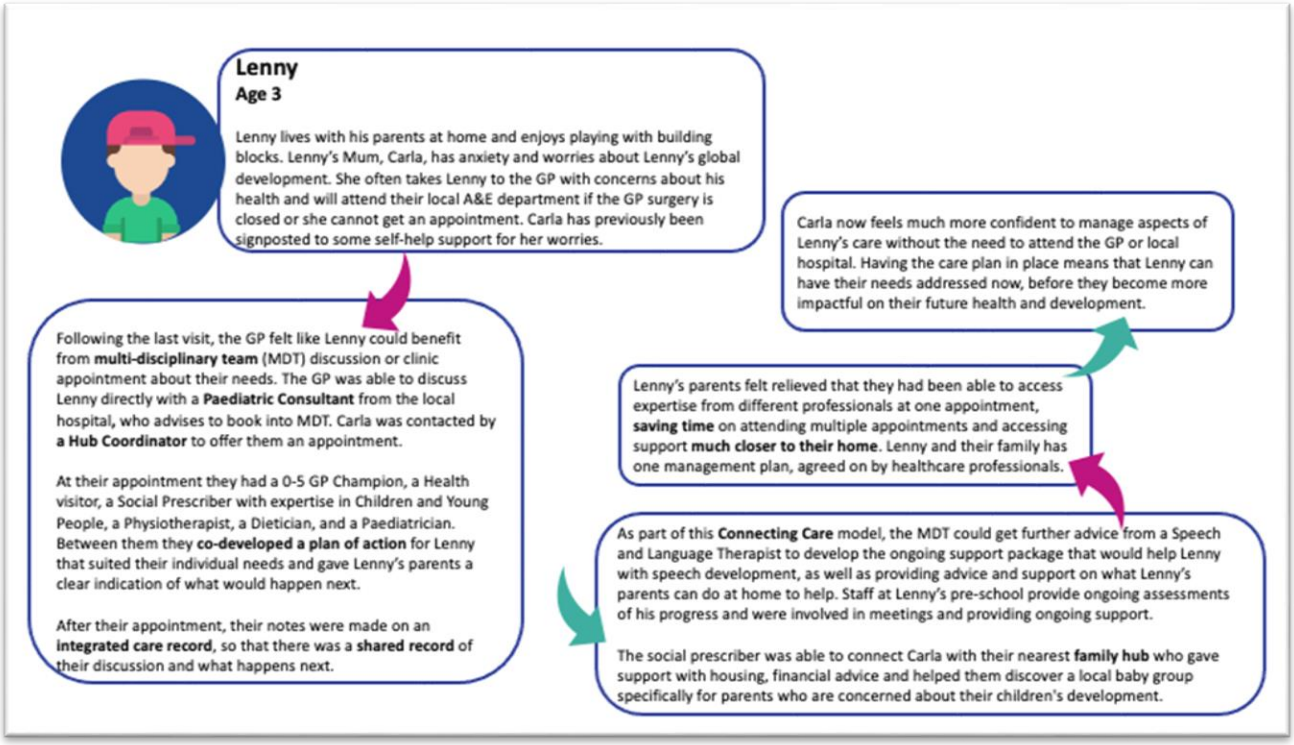


Figure 6: How care could be different – personalised care[16]

[16] Provided by CYP Programme

Priority 5: Improve access to a wider range of services closer to home through greater connection and coordination

Context

Aligned to the BSW Care model, we want to enable our services, particularly specialist services, to be provided and accessed more easily. Equitable access to healthcare and better outcomes can be achieved when we deliver care either at home or closer to where people live. This is particularly the case where there are issues of frailty, deprivation or where there are significant distances required to travel to acute sites from rural locations.

Some local specialist services[17] are already organised around neighbourhoods. We want to increase the range that are delivered closer to communities, provide a greater choice of how and where children and adults access services and deepen connections between services. This will require revising existing models of care, where patients are referred to external specialists, and instead focus on embedding specialists within local teams. This may involve providing advice and guidance to our clinicians, to use case finding for the early identification of individuals who require specialist support, and to prevent referrals for acute care that could have been managed, with appropriate resource and governance, more locally.

Traditional models of delivering care through doctors and nurses can be transformed using non-traditional roles and realising the potential of existing community services. Whilst this might not result in the physical relocation of services or people, we want to create better and stronger links between our services and use technology, data, and our facilities to enable this. This will result in improved experience for patients and resilience of providers working within our neighbourhoods, including general practice.

Our ambition

- Local specialist services are designed around treating co-morbidities with equitable delivery and access to children and adults living in the community
- Providers and organisations work together to support the early identification and treatment of conditions and those at risk of potential deterioration

How we will deliver

5.1 Define the local specialist care model to link services together

5.1.1 Aligned to the local team blueprint (1.1.1), develop a local specialist team system level blueprint that supports a 'core' offer through local specialist teams including where they are located, how they interact and how they can support continuity of care. Specific examples include:

- Explore and adopt alternative referral mechanisms such as self-referral, triage of need, or stepped care delivery (reducing the need for a GP to act as a gatekeeper)

[17] As defined in the BSW Care Model

- Explore integration with providers to improve timely conversion of urgent referrals (such as urgent mental health or urgent suspected cancer referral) including booking and validation activities
- Define a risk stratification, complexity-based model that maximises opportunities to provide care outside of an acute setting

5.1.2 Support local teams to define the required representation and alignment of generalist and specialist resources within their area based on the 5.1.1 blueprint

5.2 Provide more wrap around services within the community

5.2.1 Develop processes to increase coordination between local teams and social care in complex discharge and care planning. Specific examples include:

- Dementia, delirium, and diabetes pathways
- Discharge to assess
- Enhanced health in care homes

5.2.2 Drive increased use of pre-habilitation and re-habilitation to enable patients to manage conditions at home while they wait for elective procedures and recover more effectively following a procedure

5.2.3 Increase provision and acute outreach within the community. Specific examples include:

- Provide seven-day extended access to community diagnostic services (both fixed and mobile) to deliver lower complexity services such as cancer screening, phlebotomy, electrocardiograms, spirometry, childhood asthma, and endoscopies
- Provide pulmonary rehab in areas with health inequalities
- Increase use of geriatricians
- Uplift capacity of urgent community response services

5.3 Increase local teams' access and connections to specialist advice and guidance

5.3.1 Support local teams to utilise existing technologies such as Cinapsis to access advice, guidance, and referrals more effectively

5.3.2 Identify opportunities to improve efficiency in shared-care referral and handover processes for individuals moving into and out of secondary care

5.3.3 Create opportunities for providers to identify and engage with local specialists to build strong working relationships that reduce bounce backs and inappropriate referrals

5.3.4 Create opportunities to transfer skills from specialist colleagues to other members of local teams

Impact on focus areas

- **Health inequalities** – extending services to the most vulnerable groups and places with the highest need enables us to have the greatest impact. Driving secondary prevention (stopping, or delaying the progress of conditions) at the local level means we can shape services to meet the needs of different communities and address inequalities. By diversifying how we deliver services, we can reach more people and reduce their risk of developing more serious illness.
- **Children and young people** – we want to reduce out of area placements which can be disruptive and difficult for both CYP and their families and carers. We can

consider the specific needs of children with complex needs through neurodevelopmental pathways and ensure they receive packages of care that are home-based.

- **Mental health** – we can deliver more local mental health offers and improve access to mental health support for people with Severe Mental Illness by using new access models that provide immediate advice, support and signposting to community and secondary services.
- **Major conditions** – pursuing the full potential of pre-habilitation and rehabilitation, such as those waiting for surgery for or in advance of cancer treatment can improve outcomes and result in children and adults who feel more empowered in their care.
- **Learning disability and autism spectrum disorder** – we want to reduce the number of people cared for in an inpatient unit out of area and deliver a centralised, consistent approach to how we manage escalations and complex cases.

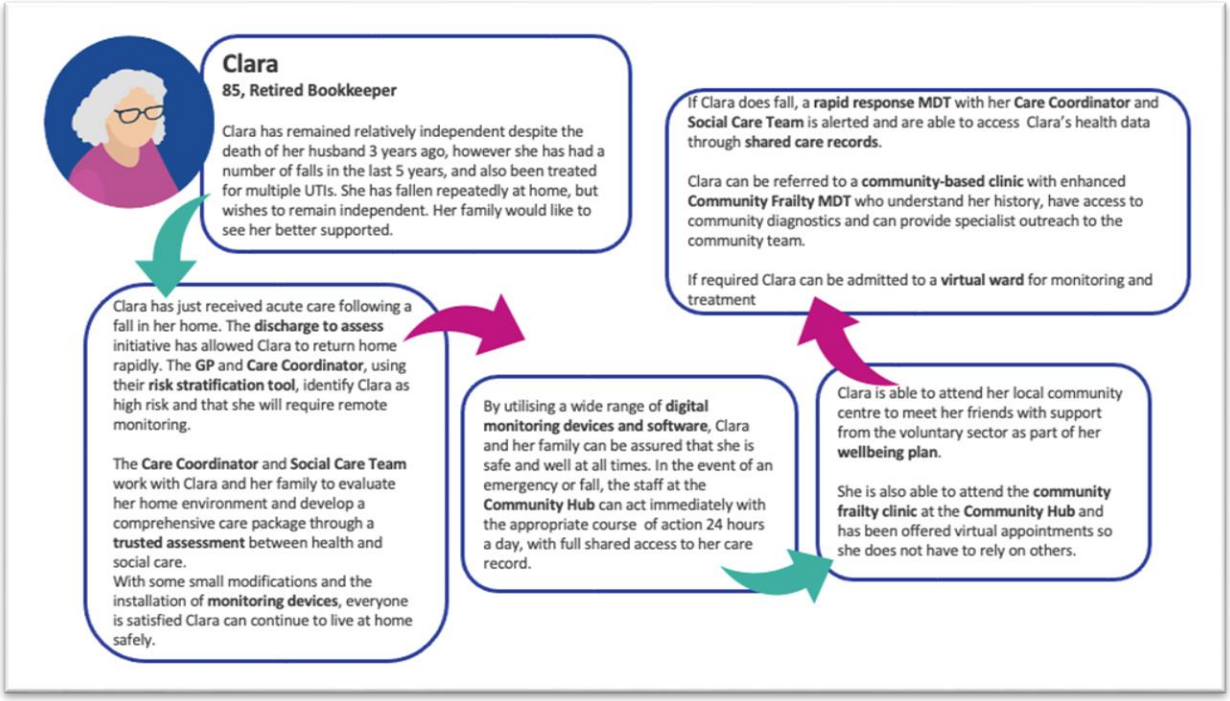


Figure 7: How care could be different – ageing well[18]

[18] BSW Together Integrated Care Strategy

Priority 6: Support access to the right care by providing co-ordinated urgent care within the community

Context

Many children and adults struggle to access same-day urgent care, and this increases the demand on both GP practices and emergency care. In turn, this impacts GPs' ability to provide continuity of care to those who need it most and reduces the capacity of emergency care services to deal with the most life-threatening cases.

Changing how we deliver urgent care – making it more accessible and bringing it closer to babies, children, young people, their parents and carers, and adults – will improve service user experience, staff experience and better management of system wide demand.

Urgent care is currently provided across many different, and often confusing services. They include GP in-hours and extended hours, urgent treatment centres, out-of-hours, urgent community response services, home visiting, community pharmacy, 111 call handling and 111 clinical assessments[19]. We need to move away from these services operating in siloes to a connected system that works together to manage front door demand. We need to make it easier for people to know how they access the right care in the right place, which may be self-care, so they can achieve better outcomes and the system can cope with the demand.

Our ambition

- Increase capacity and capability within the community to enable individuals to resolve urgent but non-emergency needs without recourse to emergency services, reducing avoidable admission and pressure
- Primary and community providers provide consistent access and pathways to manage capacity and demand both in and out of hours, so that we can provide some services 24 hours a day / 7 days a week
- As a system, we offer care that is appropriate to need and makes best use of clinician and patient time
- We use a graduated response in our pathway design to support step-up and step-down services, supporting children and adults to be cared for closer to home

How we will deliver

6.1 Design a system wide single integrated urgent care pathway that can flex to local needs

6.1.1 Investigate opportunities to simplify and standardise services across the system
6.1.2 Explore opportunities to use co-location, local coordination services, or community hubs to deliver single front door access to urgent care

[19] Fuller Stocktake

6.1.3 Identify opportunities to increase access and reduce pressure through winter, while allowing teams to be redeployed as demand changes

6.2 Increase awareness and optimise use of same day urgent care services

6.2.1 Pilot and evaluate a community pharmacy prescribing service for minor ailments, urgent care, and urgent prescriptions

6.2.2 Initiate engagement and communications plan with local communities to improve awareness of urgent care services offered in their area

6.3 Improve the community-based mental health interfaces

6.3.1 Develop appropriate crisis response provision within the community, with first contact provided by third sector partners

6.3.2 Support local teams to deliver mental health crisis response services out of hours and ensure there is provision in rural as well as town areas

6.3.3 Review the provision of mental health practitioners within existing services (such as within general practice)

6.3.4 Deliver the expansion of NHS111 to provide universal access to mental health support

Impact on focus areas

- **Health inequalities** – using co-located hubs and services like community pharmacies, especially those provided locally, can help us to improve access and prevent and reduce health inequalities. Examples include the hypertension care finding service.
- **Children and young people** – delivering urgent care and same day services that are appropriate for children, young people and their parents and carers (such as paediatric short-stay assessment units) can enable them to be cared for closer to home and avoid admission to hospital.
- **Mental health** – we must ensure that we can expand community-based crisis services that are open access, age appropriate and meet local population needs. For example using NHS111 to ensure 24/7 freephone access to mental health helplines
- **Major conditions** – patients with major conditions will have better access to a range of providers to help manage their condition. This will promote and support earlier intervention.
- **Learning disability and autism spectrum disorder** – targeted interventions and support for those at risk of requiring urgent care will improve experience and outcomes.

Enablers

The six enablers outlined in the BSW Together Integrated Care Strategy will underpin interventions and actions that are detailed in this Delivery Plan. Where specifically relevant, the enabling actions are outlined within the transformation priorities, interventions, and actions. Ownership and delivery of these is expected to be driven through existing transformation programmes and strategies.

A summary of the enablers is provided below.

7.1 Financial sustainability and shifting funding to prevention

A key enabler to the primary and community care delivery plan will be the left shift of funds, currently dedicated to treating ill-health, towards initiatives and structures which prevent it in the first place.

The first step will require the system to gain an accurate and consolidated picture of funding and resourcing across self-care, primary care, community care, and hospital care.

Shifting funding to prevention may look like:

- Savings made in core mental health provision are reinvested into targeted wellbeing initiatives, directing funding through our Third Sector Mental Health Alliance
- Focussing on children and young people as they are ‘tomorrow’s adults’
- Investment being reorganised and geared towards personalisation including the wider rollout of personal budgets for service users
- Changing the way we invest so there is more funding for targeted initiatives that address health inequalities
- Supporting our providers (including VCSE and community partners) through more sustainable models

7.2 Developing our workforce

The NHS workforce is under strain throughout the system. To enable this delivery plan, we need to develop both the capacity and the capability of our workforce. Key to unlocking both will be to partner with community partners and VCSEs. This must be aligned with broader programmes such as the BSW workforce programme.

Over 37,600 people work in health and care in BSW, with many more across the VCSE sector as formal and informal carers. Work is underway to develop a BSW People Strategy, with a strong focus on recruitment and retention of the workforce. We must make primary and community care (including non-NHS providers such as adult social care and children’s services) an attractive place to work, address reputational challenges that we know exist and ensure our workforce diversity reflects the communities in which we operate. In particular, we need to build general practice capacity as this workforce is fundamental to our ability to deliver joined-up local teams.

One course of action could be to invest in staff training across providers through links with the BSW Academy so that we can better train, retain and reform. We must also understand how we can offer and support training of the third sector through opportunities like shared budgets, and paid volunteering time. Reviewing our existing ways of working will enable us

to ensure equity of time and funding for workforce development across all our providers and partners.

Additionally, a more flexible approach to resourcing will need to be adopted. Workforce planning will need to include Social Care partners, independent/ private providers, and VCSE provision. We must focus on leadership at all levels and across all providers to contribute to and drive our workforce planning. This will require building on our work on Health and Care Professional leadership to develop our system leaders. We should also consider how we can better share the workforce across providers and make the most of non-traditional roles and workforce models across the system.

A particular area of demand is domiciliary care. BSW workforce projections have identified a growing demand with raising rates of frailty and dementia against a backdrop of high staff turnover and decreasing numbers of people applying for care worker roles. In 2022/23, partnership work led by Local Authorities across BSW resulted in the development of a domiciliary care workforce modelling tool. This now needs to be implemented and integrated into wider community workforce planning.

7.3 Technology and data

The BSW Digital Strategy commits to (1) an electronic patient record (2) shared infrastructure across BSW and (3) a system wide approach to the use of technology. All three commitments will be required to enable a significant part of this primary and community care delivery plan.

We must also understand how our information governance frameworks can enable greater sharing of information and risk across partners, and make sure our workforce has the digital skills to deliver. Specifically, data and technology should support:

- Data unlocking areas within PHM including using predictive capabilities to promote prevention and reduce health inequalities
- Joined-up local teams to work together seamlessly through shared care records and increased sharing of information
- Virtual wards and supporting patients to receive treatment and care at or close to home
- Individuals who are empowered to access information and deliver self-directed care
- Improving service user experience through digital tools including self-monitoring and self-referrals where appropriate
- Increased access through tele-medicine and online appointments
- Successful implementation of Modern General Practice Access[20] in PCNs and practices
- Increasing use of AI to support delivery and clinical decision making

[20] https://www.england.nhs.uk/long-read/delivery-plan-for-recovering-access-to-primary-care-2/

7.4 Estates of the future

The way we use estate needs to evolve and become more flexible to the changing needs of our populations. In addition our estates must be supported by integrated technology that enables us to deliver care at the right place based on those needs.

The ICS Estates Board is already working with NHSE to develop a national estates toolkit and the BSW Infrastructure Strategy[21]. One of its aims is to support clinical pathway redesign and the left-shift of care delivery in line with the BSW care model.

This new direction will support the primary and community care delivery plan. For example, estates should support:

- Modernisation of primary care infrastructure including GP surgeries that creates a positive working environment for staff and service users
- Virtual consultations to reduce the need to come into buildings and bring care closer to home
- Multi-use of existing wider public, community and third sector estates to be able to provide services closer to home
- Increased flexible and mixed use of NHS Estates including allowing community use
- Consolidation of back-office functions enabling the workforce to work across different locations, reducing unwarranted variation in care, and enabling joined-up working
- The removal of organisational barriers and an increase in utilisation across all settings to maximise the use of our investments

7.5 Environmental sustainability

The BSW Green Plan 2022-25 published in July 2022 sets out how we will begin to reduce the environmental and carbon impact of our health and care estate, services, and wider activities over the next three years. It sets out how we will work towards achieving net zero by 2040 for direct emissions and 2045 for the emissions we can influence.

We must consider how we enable people and organisations to make decisions which benefit the environment. Any design or delivery of primary and community services must consider the environmental impact and seek to reduce it wherever possible. Bringing care closer to home can reduce travel time for both service users and practitioners and making better use of our resources and estates can reduce waste and emissions.

7.6 Our role as anchor institutions

We must harness the potential of our anchor institutions (such as the ICS, acutes and local authorities) to play a greater role in promoting the social and economic interests of the local areas they are rooted in.

All primary and community care providers and partners should seek to support and benefit from BSW's role as an anchor institution. This includes creating jobs for local people, investing in local infrastructure, and supporting local businesses. Using local providers for

[21] BSW Together Implementation Plan

our primary and community care services will also support a greater contribution to the social and economic wellbeing of our communities.

7.7 Commissioning and contracting

The way in which our services are commissioned and contracted needs to change for us to deliver more joined up care. We have therefore included an additional enabler for the purposes of this delivery plan.

Our providers will only be able to deliver if they are sustainable, so we need to create a funding model that enables that.

Greater emphasis should be placed on collaboration and working across the system and therefore we must consider how services are funded and incentivised to enable this. At the same time contracts should be reviewed to remove unnecessary barriers as well as support new models of care.

We need to include all those who can support us to deliver better health and care, such as the voluntary sector, and move away from only looking at traditional providers.

Key areas that we need to consider include:

- Exploring alternate models of funding and commissioning such as outcome based and place-based contracts
- Reviewing the primary care and GP commissioning approach
- Develop the capability to measure ‘value for money’ and track progress towards a ‘left shift’
- Reduce contractual barriers between providers that is increasing competition and inhibiting collaboration
- Enabling innovation within our contracts by increasing flexibility of available funding

Appendix

Appendix 1.1: Key drivers

Addressing an ageing population

The BSW population is projected to grow by 6% over the next 15 years with an additional 60,000 residents in 2038 falling in the over-60 category (representing a 35% increase in this age category).[22] An older demography is associated with increasing complexity, multi-morbidity, and frailty of our people. This increases pressure across health and care providers, local authorities, VCSE organisations, and the wider public sector. Primary and community care supports better management of age-related conditions locally, which can prevent deterioration and help people to live independently for longer.

Increasing pressure on existing primary, community, and social care services

Demand on health and care services is increasing year-on-year and is acutely felt on front-line staff and services. Within primary care, there is growing discontent from both children and adult service users and professionals, with patient satisfaction at an all-time low. Challenges with urgent care access is impacting GPs' ability to delivery continuity of care to those who need it most. Additionally, social care services are under pressure both locally and nationally. Growing demand, longer waiting times for both physical and mental health and complex health needs are adding pressure to services for children and young people and leading to preventable deterioration of conditions.

GPs practices are having to work harder and longer to meet contractual targets and they face inflexible funding streams. Estates and technology are extremely variable; old buildings with poor connectivity limit GPs' ability to increase capacity through a digital-first offering. Within community care, BSW needs to improve the sustainability of providers and overcome current commissioning challenges. Without sustainable provision, particularly in GPs, PCNs and VCSEs, BSW will struggle to deliver the core elements of this delivery plan.

Addressing wider health and care pressure

Increasing complexity and frailty for adults is anticipated to cost our acute, inpatient, outpatient, and accident and emergency services an additional £5M per year for the next 15 years (before inflation or new treatments). An already stretched urgent and emergency care is facing an additional 115 acute beds, 40 ambulance journeys, and 51 emergency department attendances a day in five years' time[23]. This significantly impacts the quality of care that individuals receive. For children, there has been an increase in attendances where they could have been seen in community settings and we must address the complex reasons for presenting in urgent care and out of hours settings.

Primary and community care can reduce front door emergency demand and provide alternate urgent care pathways within the community. Similarly, it can support flow through

[22] BSW Case for Change analysis
[23] BSW Case for Change analysis

admission avoidance as well as discharge and at home-support to ensure better continuity of care.

Integrating to deliver a better experience and outcomes for our adults and children

A key tenet of ICSs is to integrate the delivery of health and care services across an area and between providers. Primary and community care is often the first, and last, interaction that individuals have with the health system. Children and adults move from GPs through to secondary and tertiary care, and then are discharged back into the care of primary, community, and social providers. Many people will recognise the pain of constantly repeating symptoms, diagnostic tests, and ineffective and confusing care and support as they are transferred between providers.

Truly integrated care must be based on local population needs and a person-centred approach. This means increasingly integrated ways of working between primary and community care workers and the wider system. This should be supported by technology and data, new commissioning arrangements and flexible estates so that can be coordinated to respond to the individual needs of children and adults.

The economic value of health and care

A healthy population is critical to a healthy economy. In BSW, around 30% of GPs are over 50, and the ratio of people who are over the retirement working age will drop from 1:3.1 to 1:2.3 in 15 years.[24] This ageing population is impacting the number of people in our communities who are economically active and contributing to our economy. Ill health is also a large contributor to economic cost, with lost output due to illness among working age people estimated to be 7% of gross domestic product (GDP).[25] There is some evidence of a relationship between health spending and economic growth, with spend on community and primary care having the largest effect.[26] Healthy babies, children and young people will be the healthy adults of our future and are the future working population. This supports a key enabler of the BSW Together Integrated Care Strategy – shifting funding to prevention (left shift).

[24] BSW Case for change analysis
[25] Major Conditions Strategy
[26] https://www.nhsconfed.org/publications/creating-better-health-value-economic-impact-care-setting

Appendix 1.2: Delivery plan methodology

System and national documents reviewed

- BSW Together Integrated Care Strategy
- BSW Together Implementation Plan
- NHS Long term plan
- Fuller stocktake report
- Major conditions strategy
- Delivery plan for recovering access to primary care
- NHS long term workforce plan
- BSW Case for change
- Avoidable admissions + Frailty
- Benefits Master Version
- SO CSF PWF and Benefits
- ICBC Programme outputs
- ICBC service design
- ICBC service design CYP
- Children's services review
- Care model personas
- NHS long term workforce plan
- Major Conditions Strategy
- Creating better health value: understanding the economic impact of NHS spending by care setting
- Market engagement July
- Market Engagement August
- ICBC SOC extract
- Healthwatch report

Supporting narrative

BSW Together Integrated Care Strategy[27] and Implementation Plan[28]

The BSW Together Integrated Care Strategy 2023-2028 was published in March 2023. It sets out the ambition for the BSW ICS as well as partners in health, social care, and the voluntary sector, to enable local people to live happier and healthier for longer.

The strategy outlines three objectives

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

It is supported by an Implementation Plan published in July 2023. This brings together initiatives underway or planned across the ICS, including Place based plans, related to the strategic objectives and commitments outlined in the strategy. This delivery plan has identified and consolidated key priorities from the Implementation Plan.

NHS long term plan[29]

The 10-year plan published in 2019 sets out the NHS's plan to be fit-for-the-future and for delivering care for patients. Within the plan are commitments to increase investment for primary medical and community health services; increase rapid community response teams; bring people together to coordinate care better; and tackle health inequalities; and a focus on babies, children, young people, and their parents and carers. To enable this, there

[27] https://bswtogether.org.uk/wp-content/uploads/Integrated-Care-Strategy-v4.pdf
[28] https://bsw.icb.nhs.uk/document/bsw-implementation-plan/
[29]https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

must be a focus on attracting and retaining a flexible workforce, and making better use of data, digital and technology.

Fuller stocktake[30]

Published in May 2022, the Fuller report covers the current challenges and outlines a vision for better integration of primary care. Key elements include: the evolution of PCNs into integrated neighbourhood teams; using a population-based approach to build models of personalised care and targeted interventions; bringing together specialist and generalist workforces; and developing a single integrated urgent care pathway. Underpinning these is the ability to drive improvement through system leadership; optimising estates across networks; improving data and digital transformation; and ensuring ongoing primary care sustainability.

The vision outlines key areas for primary and community care: greater choice about how people access care which is available in the community when they need it; providing proactive personalised care through multidisciplinary teams; and helping people stay well for longer.

Major conditions strategy[31]

This strategy, released in August 2023, considers the whole care pathway from prevention to treatment for six major conditions: cancer, cardiovascular diseases including stroke and diabetes, chronic respiratory diseases, dementia, mental ill health, and musculoskeletal disorders. It articulates how these affect people throughout their lives, including children, young people and working age adults as well as older people.

25% of adults in the UK have at least two of these conditions and they drive over 60% of mortality and morbidity. The strategy takes a whole care and whole life approach to tackling these conditions by focussing on proactive prevention and early intervention; better management of multiple conditions; investing in Children's Health; and better connection, integration, and design of services. For those conditions that aren't preventable, we need to deliver specialist support and ongoing management that can be delivered easily in the community.

Delivery plan for recovering access to primary care[32]

Published in May 2023, the delivery plan aims to tackle the 8am rush and ensure individuals get the help they need from primary care. It focuses on four areas to reduce pressure and improve access: building capacity; reducing bureaucracy; empowering patients; and modernising GP access. Delivering this will require improving information,

[30] https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf
[31] https://www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework/major-conditions-strategy-case-for-change-and-our-strategic-framework--2
[32] https://www.england.nhs.uk/wp-content/uploads/2023/05/PRN00283-delivery-plan-for-recovering-access-to-primary-care-may-2023.pdf

functionality, and interoperability of technology; expanding community pharmacy; and increasing capacity through enabling workforce and estates initiatives.

NHS long term workforce plan[33]

Workforce remains a key challenge for the NHS and this plan, published in June 2023, aims to understand future requirements, and set direction for the workforce. It outlines three key areas of focus: train, retain and reform. Train recognises the need to grow the workforce through increased training for doctors and nurses and the expansion of other professions. Retain centres on improving culture, leadership, and wellbeing to improve retention. Reform aims to support the workforce to work and train differently, within multidisciplinary teams, and harnessing digital and technological innovations.

[33] https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/

Appendix 2.1: Focus areas

A summary of the focus area and relevance to primary and community care is provided below.

Health inequalities

Although more affluent than the England average, BSW has a highly inequal distribution of wealth[34]. There is a strong link between a higher prevalence of health conditions, poorer life outcomes and living in less advantaged communities. For example, the most deprived 20% areas of Wiltshire have repeatedly poorer outcomes than the least deprived 20%, with similar patterns seen in other areas.[35] This can be due to factors including ease of access to health and care services and wider determinants of health. Delivering health and care interventions within the community and as close to peoples' homes is key: it improves access; promotes prevention; and often results in better outcomes due to better treatment uptake. We can also build on safeguarding work to have oversight of our most vulnerable communities aligned to our ambition to reduce inequalities.

Primary and community care providers can come together and use data, insight, and their local links to better understand where inequalities exist, and design tailored initiatives that tackle them. A greater focus on improving the life chances of children, especially those under five with a focus on early years will create fairer society and reduce health inequality.[36]

Children and young people (CYP)

Children and young people (0-25 years) represent 30%[37] of our population and are a key opportunity to break progression cycles and enable prevention in action for the improved health and wellbeing of our future population. However, many services are under extreme pressure due to growing demand post-Covid resulting in long waiting times and poorer health and learning outcomes.

As part of the CYP strategy development, BSW must scope, plan, and deliver a comprehensive suite of CYP primary and community services for babies, children and young people that meet local needs. We need to work more closely with local authorities and the education sector to make sure our children get the best possible start in life.

Mental health

Mental health conditions have been rising across BSW for adults and children. We need to focus on improving mental health across the system and ensure the principle of 'parity of esteem' is encompassed across our priorities. People with a mental illness are statistically

---

[34] BSW Together Integrated Care Strategy
[35] BSW Together Implementation Plan
[36] https://www.bmj.com/content/340/bmj.c818#:~:text=News-,Focus%20on%20early%20years%20will%20create%20fairer%20society,health%20inequality%2C%20Marmot%20review%20says&text=More%20public%20money%20should%20be,evidence%20based%20review%20has%20concluded
[37] BSW Integrated Care Strategy

more likely to also have a physical health condition[38] and we need to co-deliver services to provide a more holistic approach to comorbidity.

Many mental health services can, and should, be provided within the community. Aligned to the community mental health framework[39] and BSW mental health strategies[40], we need to expand services by working with local partners and providers who can help people with mental health conditions to easily access services when and where they need it, manage their conditions, or support individualised recovery, and enable them to contribute to and be participants in the community.

Major conditions

Nationally, people with two or more conditions account for around 50% of hospital admissions, outpatient visits and primary care consultations, over half of NHS costs and around three-quarters of the costs of primary care prescriptions. They also have an economic cost to the nation where long-term sickness is the most common reason for being economically inactive.[41] 16% of children up to 15 years old had one or more long standing condition, increasing to one in four for those aged 16 to 24[42]. These children will require support throughout their lives in the management of their long-term conditions.

Locally, major conditions are also a challenge with BSW currently spending over £120m on events and complications due to diabetes and cardiovascular disease.[43] We can address lifestyle drivers and behavioural risk factors, increase prevention, and maximise early intervention through targeted and considered involvement and integration of primary and community providers and partners.

Learning disability (LD) and autism spectrum disorder (ASD)

People with a learning disability have a 49% rate of avoidable death, compared to 22% in the general population.[44] One of BSW's transformation programmes centres around Learning disability and autism and is a key theme within local Implementation Plans for Bath and North East Somerset, Swindon, and Wiltshire. Across the system, we want to reduce the number of people who receive inpatient care; by expanding community provision and delivering initiatives locally that reduce admission. We need to identify and address care gaps such as missing recommended screening or access to early diagnosis and intervention services. We want to improve accessibility and ensure we can deliver care that recognises the specific needs of this cohort and the impact of comorbidity.

[38] https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing
[39] https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf
[40] BSW Together implementation plan
[41] Major Conditions Strategy
[42] https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2018
[43] BSW Together Implementation Plan
[44] https://www.kcl.ac.uk/research/leder

Glossary

Term	Description
AI	Artificial intelligence
ASD	Autism spectrum disorder
BSW Together	Bath and North East Somerset, Swindon, and Wiltshire integrated care system
CAMHS	Child and adolescent mental health service
COPD	Chronic obstructive pulmonary disease
CYP	Children and young people
GP	General practice
HR	Human resources
ICB	Integrated care board
ICBC	Integrated community-based care
ICS	Integrated care system
INT	Integrated neighbourhood team
LD	Learning disability
MDT	Multidisciplinary team
MHST	Mental health support teams
PCN	Primary care network
PHM	Population health management
POD	Pharmacy, optometry, and dentistry
SEND	Special educational needs and disabilities
SENDCO	Special education needs and disability coordinator
UTI	Urinary tract infection
VCSE	Voluntary, community and social enterprise

This page is intentionally left blank

Wiltshire Council

Health and Wellbeing Board

28 September 2023

Subject: Annual Health Protection report 2022

Executive Summary

I. The Director of Public Health (DPH) has a statutory responsibility for strategic leadership and oversight of health protection functions on behalf of the Council. This includes planning and response to threats to public health such as infectious disease, environmental hazards and contamination, and extreme weather. The Health and Wellbeing board, through the DPH, should be assured that arrangements in place locally are sufficient, robust and implemented accordingly to protect public health.

II. The multi-agency Wiltshire Health Protection Assurance Group (HPAG) is the forum in which assurance is sought that adequate arrangements are in place for the prevention, surveillance, planning and response required to protect the public's health.

III. The HPAG produces an annual report for consideration by the Health and Wellbeing Board. This provides an overview of health protection monitoring and surveillance, any significant issues with lessons learned, and recommendations for further development of the local health protection system.

IV. A Health Protection Report 2022 has been prepared for the Board with information on and assurance of the health protection arrangements in Wiltshire. The scope of health protection in this context includes: immunisations, screening programmes, communicable diseases, health emergency planning, environmental hazards and migrant health.

Proposal(s)

It is recommended that the Board:

i) Notes and acknowledges the Wiltshire Health Protection Assurance Group Annual Report 2022;

ii) Supports the recommendations of the Wiltshire Health Protection Assurance Group Annual Report 2022

Reason for Proposal

To provide assurance of the local health protection arrangements for the population for Wiltshire, and to continue to develop the local health protection system through recommendations based on previous experience and evidence.

Dr Michael Allum
Consultant in Public Health
Wiltshire Council

Wiltshire Council

Health and Wellbeing Board

28 November 2019

Subject: Annual Health Protection Report 2022

Purpose of Report

1. To provide an annual update to the Health and Wellbeing Board on the health protection system in Wiltshire in line with the Director of Public Health's statutory responsibility to ensure that adequate arrangements are in place for the surveillance, prevention, planning and response required to protect the public's health.

Relevance to the Health and Wellbeing Strategy

2. The health protection assurance group report outlines strategies, recommendations and workstreams to prevent ill-health through screening and immunisation programmes and communicable disease control, adopting a systems approach. Throughout the report there is a strategic focus on inequalities, ensuring all partners are working towards equitable access to health services for all Wiltshire residents and focusing on those groups that may be disproportionately affected by infectious diseases, cancer and other health threats.

Background

3. Health Protection is concerned with preventing and controlling infectious diseases, environmental threats, and protection from hazards. It uses population-wide surveillance and interventions to prevent disease and provide protection from a range of potential hazards and harms. To achieve this requires effective partnership working arrangements across several organisations.

4. Wiltshire has well-established and effective multi-agency working relationships, and a long history of collaborative working to deliver health protection functions. However, there are new and evolving challenges to population health, emerging epidemics and drug resistance, changing environments and demographics, and the ongoing risk of chemical and biological incidents. This clearly demands an ongoing robust health protection system.

5. The Wiltshire Health Protection Assurance Group is comprised of internal and external stakeholders, with the aim to provide assurance to the Health and Wellbeing Board of Wiltshire Council, that adequate arrangements are in place for the prevention, surveillance, planning and response required to protect the public's health. The scope of the Group is to minimise hazards to human health for Wiltshire, and to ensure that any threats are promptly dealt with.

4. This report builds on the strategy that was developed using the information, recommendations and shared priorities identified in the Wiltshire Health Protection report 2019-21. The report has been agreed upon by the Wiltshire Health Protection Assurance Group and will be used to ensure appropriate and adequate assurance systems are in place, and guide the workplan of the group based on identified gaps and needs, with a particular focus on inequalities.

Main Considerations

5. The report sets out the health protection activities, events and data for the calendar year 2022. Recommendations for continuing work are made with a focus on inequalities to highlight good practice, but also to identify system gaps and needs of the Wiltshire population. This report will further guide the workplan and health protection strategy and gives assurance that the health protection system across Wiltshire is robust and fit for purpose.

6. There is a focus on inequalities in this report and this will continue to be incorporated in all workstreams of health protection and be reported on in future reports.

Next Steps

7. Following sign off, the Wiltshire Health Protection Assurance Group will take forward the recommendations from the report and map these to current workstreams, or initiate new projects. Where gaps in service delivery, data streams or strategy are identified, the Group will determine how best to take this forward and may create task and finish groups as required.

8. This is an annual report and the recommendations and priorities identified in this report will be addressed next year and presented to the Health and Wellbeing Board. The Health Protection Assurance Group reports to the Health and Wellbeing Board and updates can be provided as felt to be appropriate.

Dr Michael Allum
Consultant in Public Health
Wiltshire Council

Report Authors:
Dr Alice Marriott, Public Health Principal, Wiltshire Council
Dr Michael Allum, Consultant in Public Health, Wiltshire Council

This page is intentionally left blank

Wiltshire Health Protection Report 2022

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

UK Health Security Agency

Wiltshire Council

Foreword

The annual Health Protection report seeks to provide assurance to the Health and Wellbeing Board of the systems and measures in place to protect the public's health from threats and hazards. It also captures the key issues identified and activities undertaken by a range of local, regional and national partners involved in supporting the Wiltshire health protection system.

2022 could be considered a transitionary year in health protection. Most COVID-19 measures and large-scale testing programmes were reduced or stopped, and the guidance and management of COVID-19 was incorporated with other acute respiratory infections. Health protection teams and systems that had developed and evolved to respond to the pandemic now needed to tackle many other threats to public health, both new and old. The re-emergence of familiar infectious diseases which had abated during lockdowns and social distancing was expected, but some were also atypical in terms of seasonality and significance, for examples scarlet fever and invasive Group A Streptococcus. New issues such as mpox emerged, and key health protection measures such as screening and immunisation uptake had to recover from the impacts of the pandemic.

This report demonstrates that the Wiltshire health protection system continues to be robust and adaptable in the face of such ongoing challenges. Inter-agency relationships and structures formed during the pandemic response have continued to evolve. The recommendations from this report will help guide the ongoing development of the Wiltshire health protection system, to ensure it is resilient and appropriate for the needs of our population.

Professor Kate Blackburn
Director of Public Health

Contents

Contents

Summary

The Director of Public Health has examined arrangements for health protection in Wiltshire and will provide the Health Protection Assurance Report 2022 to the Health and Wellbeing Board in line with their statutory responsibility to ensure that adequate arrangements are in place for the surveillance, prevention, planning, and response required to protect the public's health.

The key priorities that have been agreed for 2022 – 2024 are:

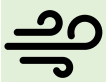
Infection Prevention and Control
Concentrating on educational and care providers and medium-term focus will be on antimicrobial resistance (AMR) and healthcare associated infections (HCAI)

Immunisation
Initial focus will be understanding rates of MMR uptake in pre school children and implementing an action plan to improve this. Medium term focus is school provided immunisations, pertussis vaccinations for pregnant women and shingles for 70s and over.

Screening
Short term focus will be on increasing uptake to breast, cervical and bowel screening programmes, with a particular focus on inequities in access to cervical screening. This will then lead on to work looking at non cancer screening programmes such as abdominal aortic aneurysm, diabetic eye and antenatal screening

Infectious diseases
The short term focus will be on raising awareness of certain infectious diseases in specific groups .e.g., drugs and alcohol services, and rough sleepers. A medium term focus will be to work on a latent TB screening service for eligible Wiltshire residents.

Migrant Health Protection
Short term focus of ensuring refugees and asylum seekers, particularly those in hotel accommodation have received immunisations and screening as required. Medium term focus of assurance that health services are accessible and exploring inequalities.



Air Quality
A continuing focus with public protection on improving local air quality and raising awareness of the health effects of poor air quality.

EPRR
Working with health partners and the Wiltshire and Swindon LHRP to continue to update the BSW communicable disease plan, exercising this and having a plan to ensure local teams are aware of the content.

Inequalities

Health inequalities are understood to be avoidable, unfair and systematic difference in health between different groups of people. There are many groups experiencing health inequalities including those from ethnic minority communities, those experiencing homelessness, people with a learning disability and those living in rural areas

Further information can be found from The King's Fund

Wiltshire specific information can be found in the 2022 Wiltshire Strategic Needs Assessment (JSNA) (population and deprivation).

CORE20PLUS5

Core20PLUS5 is a national NHS England (NHSE) and NHS Improvement (NHSI) approach to support the reduction of health inequalities at both the National and System level. The approach defines a target population cohort - the 'Core20PLUS' - and identifies '5' focus clinical areas requiring accelerated improvement.

The 'Core20' Populations Those living in the most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). Core20PLUS5 focuses on deprivation across the country so as not to exacerbate inequality nationally. Wiltshire has 8 LSOAs in the 20% most deprived according to IMD (2019)

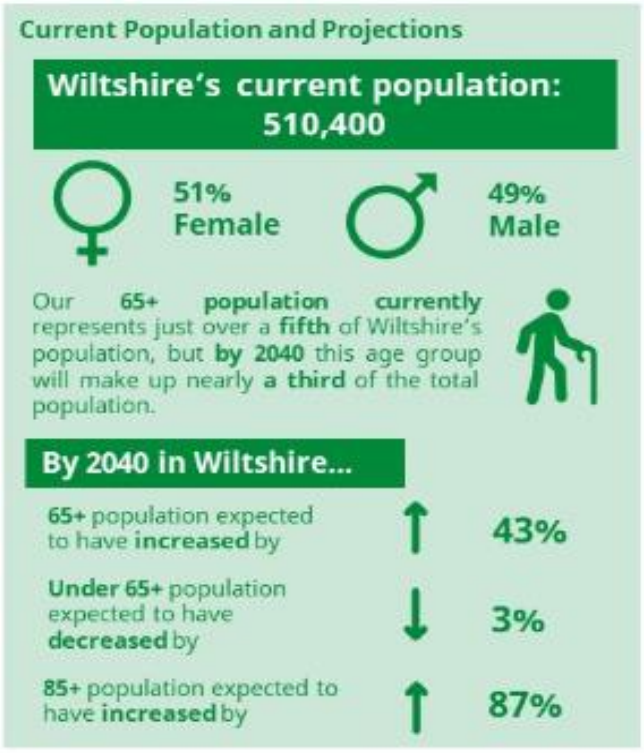
The 'PLUS' populations are population groups experiencing poorer than average health access, experience and/or outcomes that are not captured in the 'Core20' alone. For Wiltshire these have been defined as:

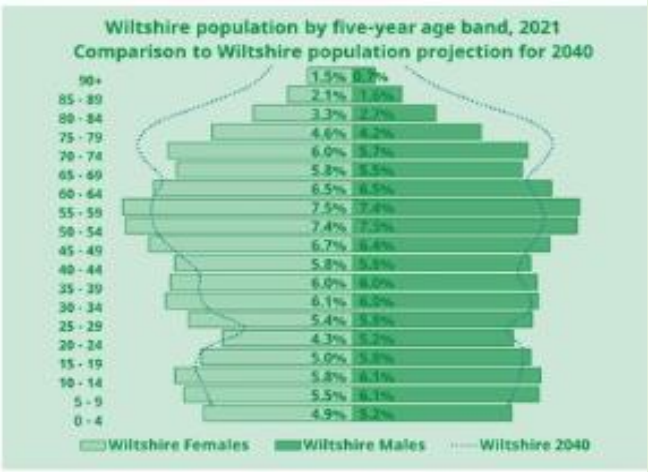
Gypsy, Roma, Traveller and Boater (GRTB) Communities – these are a range of ethnic groups, those with nomadic ways of life but not from a specific ethnicity

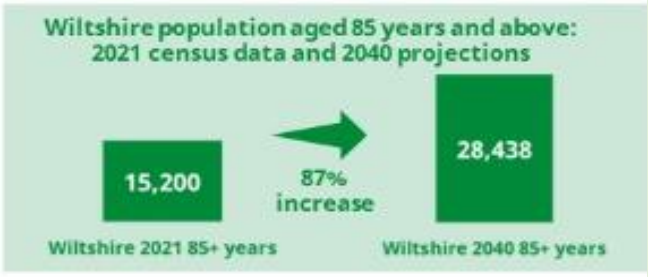
Routine and Manual Workers – describes those between 18-64 years in the routine and manual group from the Annual Population Survey (93,200 people in Wiltshire as reported in the Labour Market Profile for Wiltshire) with a specific focus on those in minority groups**.**

20% most deprived communities and rurality - 20,800 (4%) of Wiltshire live in the nationally most deprived quintile of areas . Rurality drives inequalities through a range of means, including infrastructure sparsity, digital exclusion, access to services, community support/isolation/social exclusion, housing and fuel poverty, and reduced access to employment.

Wiltshire Population and inequalities



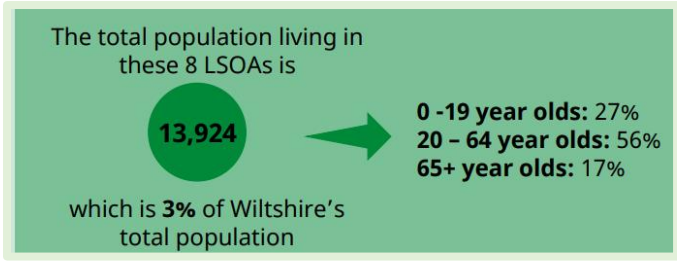


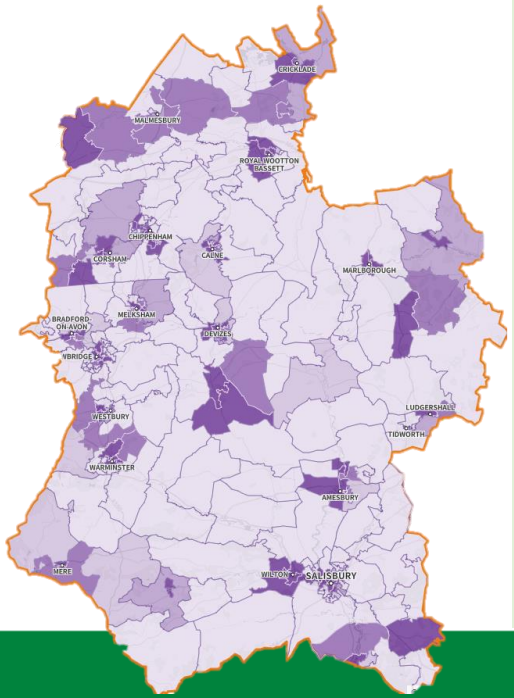


Further information available from: JSNA Wiltshire Intelligence

There are 8 LSOAs in Wiltshire in national quintile 1 (20% most deprived) of the main IMD (home to over 15,000 residents).

Many factors make up the national IMD measure and if broken down by individual 'domain' indices it gives a more localised picture. This shows that the biggest inequalities in Wiltshire appear to be barriers to housing and services and education, skills and training deprivation.





Rurality

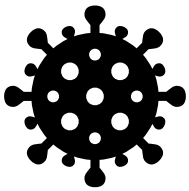
Wiltshire is classified as a predominantly rural local authority by DEFRA's rural-urban classifications (DEFRA). Rurality drives health inequalities through mechanisms such as reduced access to services, digital exclusion, isolation, lack of infrastructure, fuel poverty, and reduced access to employment.

The map to the left shows the percentage of households with access to a GP within 15 mins by public transport or walking. The darker the colour the higher the percentage of households with access within 15 minutes.

The England mean percentage of households is 69.95% Wiltshire's percentage of households is 44.86% reflecting the rural nature of the county and highlighting reduced access to services.

Context

COVID-19 pandemic



The COVID-19 pandemic still continued in 2022 but the World Health Organisation (WHO) declared the end of the pandemic was 'in sight' in September 2022, with the introduction of new bivalent vaccines to help tackle the Omicron variant which had driven most of the previous surges in cases. A timeline of the key events and policy changes through 2022 relating to the COVID-19 pandemic can be found in Appendix 1

Health and Social Care Act 2022

The Act advances on the collaborative working seen throughout the pandemic, to shape a system which is best placed to serve the needs of the population. NHS England established 42 statutory integrated care boards (ICBs) on 1 July 2022 in line with its duty in the Health and Care Act 2022. This was as part of the Act's provisions for creating integrated care systems (ICSs).

Migration and Global Events

In March 2022 the UK Government set up the Homes 4 Ukraine scheme allowing households to provide accommodation for Ukrainian refugees created by the Russian invasion in Ukraine the previous month. In November 2022, there were 879 refugees accommodated in 377 Wiltshire households.

In December 2022 a contingency spot-booking hotel was opened near Royal Wootten Basset, housing asylum seekers from multiple countries of origin.

The humanitarian situations in countries like Syria, Afghanistan, South Sudan and Yeman and other across the world is leading to an increase in the refugee crisis. In 2022 the number of asylum applications to the UK rose to 74,751, the highest level since 2002.

Economy

The UK saw inflation and interest rates rise, putting cost of living at the forefront of many people's minds.
The Consumer Prices Index rose by 10.5% in the 12 months to December 2022. The rising costs of living threatens to exacerbate health inequalities and worsen health and wellbeing.

Immunisations

"The two public health interventions that have had the greatest impact on the world's health are clean water and vaccines."

World Health Organisation (WHO)

There are a number of immunisations that are offered to the residents of Wiltshire as part of the UK national schedule (appendix 2). The overall aim of the routine immunisation schedule is to provide protection against vaccine-preventable infections.

High coverage is required to ensure that the local population is protected and does not become susceptible to outbreaks of these diseases.

Alongside the routine immunisation schedule there are also vaccines available for pregnant women (appendix 3) and those people identified as 'at risk', groups of people who need extra protection.

The Influenza vaccination is available annually to those who are deemed most at risk from infection, the cohorts for 2021/2022 and 2022/2023 are included in appendix 4 and 5 respectively.

COVID-19 vaccinations were offered as part of a national programme during the ongoing pandemic to those eligible. This included a continuation of primary doses, the autumn 2021/2022 booster (eligibility in appendix 6), the 2022 spring booster (eligibility in appendix 7) and the autumn 2022/2023 booster (eligibility in appendix 8).

Vaccine sentiment

Research has shown that despite the success of the COVID-19 vaccination campaigns, vaccine confidence has significantly declined since the onset of the pandemic. It is essential that vaccine uptake remains high to prevent outbreaks of vaccine preventable disease such as measles.

The COVID-19 vaccine also led to widespread negative sentiment, particularly on social media. In the UK, the main driver of negative sentiment was the fear of making the vaccine mandatory. When COVID-19 vaccination was made mandatory for those working in care homes in the UK, research found that only one in six healthcare workers favoured mandatory vaccination.

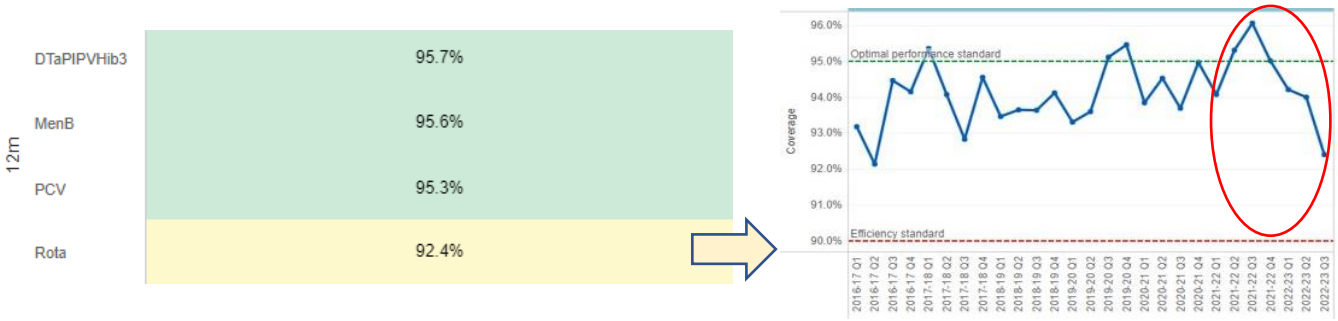
The conclusion recommended that building trust, educating and supporting people who are hesitant about vaccination may be more acceptable, effective and equitable, something that in public health we can support across all vaccinations. The data over the next few years should be interpreted with the context of the pandemic in mind.

Childhood Immunisations

Uptake of routine childhood immunisations among the Wiltshire population is above both the national and regional averages for all vaccinations.

There is an expectation that UK coverage for all routine childhood immunisations evaluated up to five years of age achieve 95% coverage in line with the WHO target stipulated for MMR.

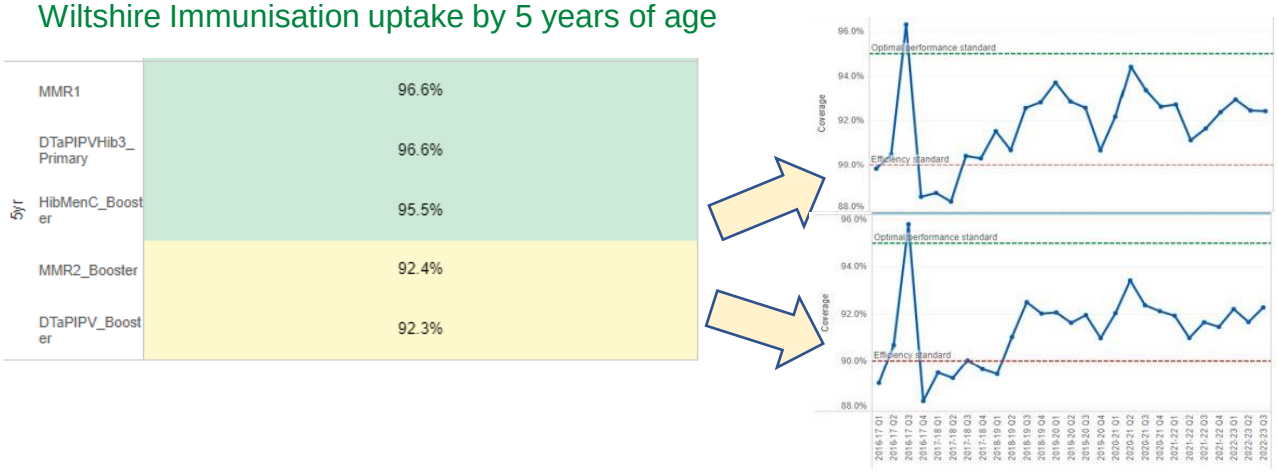
Wiltshire Immunisation uptake by 12 months of age



By 12 months of age, the uptake of infant vaccinations in Wiltshire is above the optimal target (95%) for all vaccinations apart from rotavirus (92.4%). This data represents data as of December 2022.

In contrast to other vaccinations and Bath and North East Somerset and Swindon, the trend has been a sustained decline in rotavirus uptake since the end of 2021 although uptake remains above the efficiency standard (90%).

Wiltshire Immunisation uptake by 5 years of age



Immunisations given at 3 years and 4 months of age (protecting against diphtheria, whooping cough, tetanus, polio and the second MMR dose) are below the optimal standard of 95%, which is the same trend regionally and nationally. This data fluctuates by quarter but has remained at around 92% uptake through 2022.

Data is taken from COVER and represents Q3 22/23 data extracted by the SW Vaccination and Screening Team

Childhood Immunisations

School aged immunisations

The schedule of immunisations given to children found in Appendix 1 - these are generally delivered through the school aged immunisation service once a child reaches school age. During the COVID-19 pandemic all educational settings closed or partially closed from 23rd March 2020 with most children not returning until early September 2020. There was a further period of closure in January 2021. This affected the delivery of school aged immunisations and therefore there are two recovery cohorts for years 20/21 and 21/22. A cohort is considered as recovered once uptake is within 6% (or exceeds) pre COVID levels (18/19 academic year group). HPV vaccination for boys started in September 2019.

BSW	HPV1		HPV2		MenACWY	TD/IPV
	Girls	Boys	Girls	Boys		
20/21 Recovery cohort	82.1%	79.2%	75.1%	70.0%	80.4%	80.5%
21/22 cohort	72.2%	64.8%	72.1%	67.8%	66.3%	65.8%
18/19 uptake	91.3%		83.8%			

The data shown in the table above shows November 2022 uptake data for B&NES, Swindon and Wiltshire (BSW) there is one provider that delivers school aged immunisations across BSW.

There are still gaps in HPV delivery for 2021/22 cohort. This is mainly due to the 6 month gap required between doses. HPV, MenACWY and Td/IPV vaccinations not completed in 2021 are continuing to be picked up in 2022/23.

There has been feedback from providers that some parents are choosing not to consent for vaccination due to vaccine fatigue and that attendance at clinics in schools has reduced due to pupil absence/sickness. Community clinics and school offers for children who miss their vaccinations in 2021/2022 do increase uptake figures however they have recently seen an increased number of cancellations and non attendances.

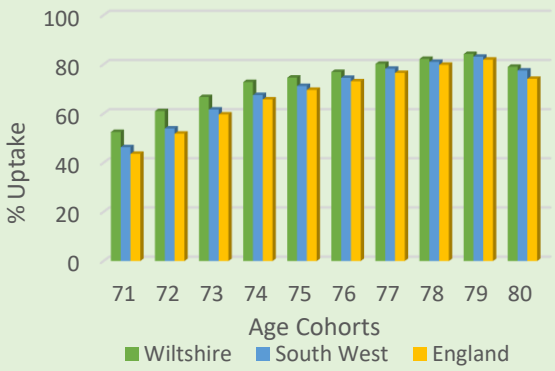
Recommendation:

Continue to engage with the school aged immunisation provider and NHSE to understand areas in Wiltshire where uptake is lower and explore engagement opportunities.

At the end and start of school years continue to distribute information and engage with key school years around catch up vaccinations, including Fresher's events.

Adult Immunisations

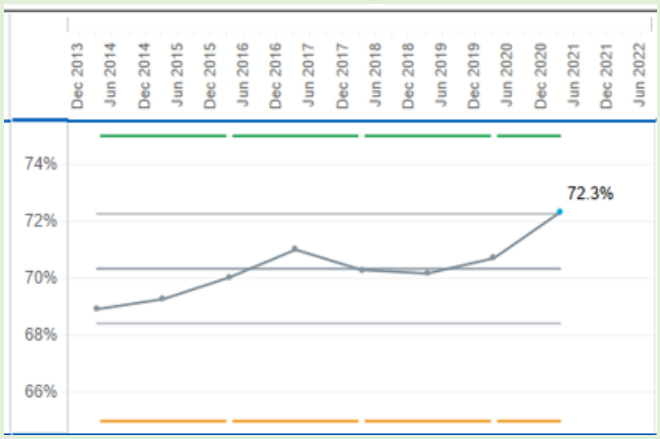
Immunisations given to adults are listed in Appendix 2. Seasonal vaccines such as influenza and COVID-19 are covered in Appendices 4-8.



Shingles Vaccine

This is a vaccine to prevent shingles, a common, painful skin disease that results from the reactivation of the varicella-zoster virus in people who have previously had chickenpox.

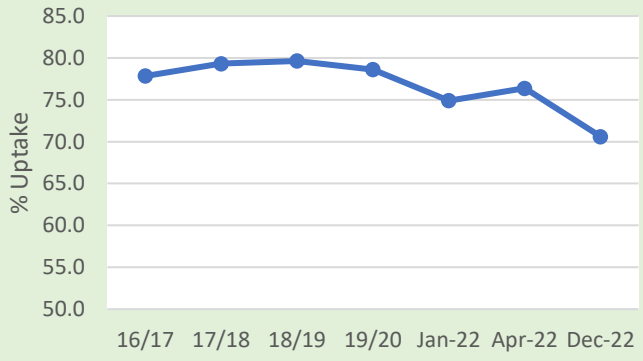
Cumulative uptake in Wiltshire is higher than regional and national rates with 84.2% of residents vaccinated in the year they turn 80.



Pneumococcal Vaccine

The pneumococcal vaccine protects against serious and potentially fatal pneumococcal infection that may lead to pneumonia, sepsis and meningitis. Adults aged over 65 are recommended to have this vaccine, it is a single dose and not given annually.

The graph to the left shows there has been a sustained slight increase in uptake of the Pneumococcal vaccine since December 2018. The latest data available (Q2 21/22) shows an increase in uptake from 19/20 data. This data is at BSW level.



The data presented has been extracted directly from immform in order to present the most recent data at Wiltshire level. This means it has not been processed by UKHSA like other vaccine update data.

Maternal Pertussis

The whooping cough (pertussis) vaccine is given to pregnant women to help protect their babies against whooping cough from birth until they are old enough to be routinely vaccinated.

Data for 2022 shows the average vaccine uptake across England has dropped to 61.5%, the lowest since 2016.

Wiltshire data to the left, is showing a similar downward trend in uptake although remains above the optimal standard (60%) and the England average. None of the acute settings in BSW in 2022 were commissioned to deliver pertussis vaccination in maternity settings which resulted in less choice for Wiltshire residents when compared to the region. Women in Wiltshire get the vaccine through their GP.

Recommendation: Explore method of delivery of pertussis vaccination in Wiltshire (GP vs antenatal) with the aim of understanding any inequalities or areas of low uptake

Seasonal Immunisations

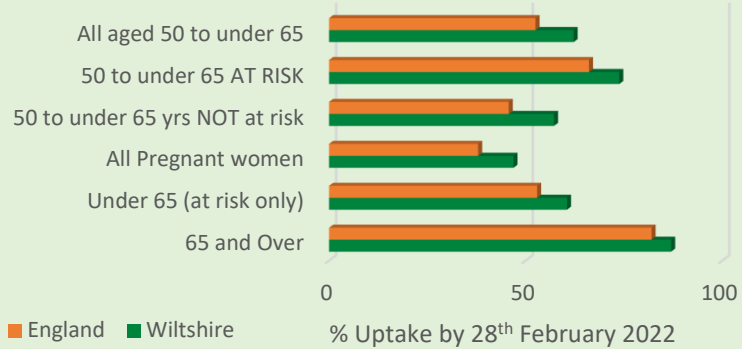
Influenza

The seasonal influenza programme is a long established and successful vaccination programme.

The vaccine is offered to people who are particularly susceptible to the flu. The cohorts for the 21/22 and 22/23 annual flu programme can be seen in appendix 1b.

Data is presented for the completed flu programme for 21/22, the completed 22/23 flu programme data will be presented in the 2023 health protection report.

Adult influenza vaccinations

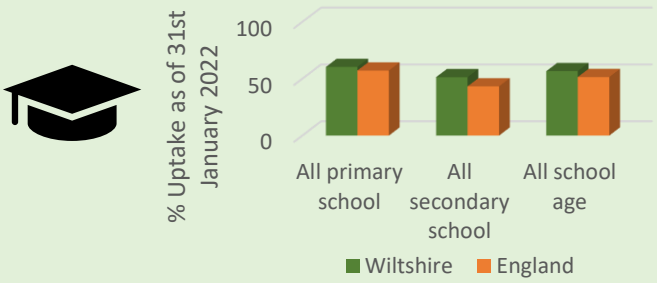


Wiltshire uptake is higher than the England average for all adult cohorts offered influenza vaccination.

The uptake amongst pregnant women has increased from previous years when it was below the England average although uptake in this cohort still needs improvement.

Childhood influenza vaccinations

Vaccinating children reduces transmission of influenza. Uptake of the influenza vaccine delivered by GP surgeries for children aged 2 (60.6%) and 3 (63.4%) were above the England averages (48.7% and 51.4% respectively)



Uptake of the influenza vaccine in schools is above the England average with the highest uptake in primary school aged children. In 2021/2022 the eligibility for flu vaccination was extended to children up to 15 years old, with the JCVI recommending this being cost effective, particularly with COVID-19 still circulating.

Health and social care workers

Healthcare workers that work at NHS trusts in BSW had uptake ranging from 62% to 74%, the uptake for flu vaccines was lower than the uptake for the COVID-19 vaccination. These figures are higher than both the England (60.5%) and South West (61.1%) averages. The flu vaccination rates in health care workers have improved over the last 20 years however, the trend is now a decline in uptake since 2020/2021 season.

Flu uptake in social care workers is difficult to quantify but we have learnt that offering flu vaccinations within workplaces, such as care homes does increase uptake.

Recommendation: Work to encourage pregnant women to take up the offer of a flu vaccination. Understand routes of communication to under 65s ‘at risk’ and promote the benefits of flu vaccination to this cohort.

Investigate data streams for social care flu vaccine uptake.

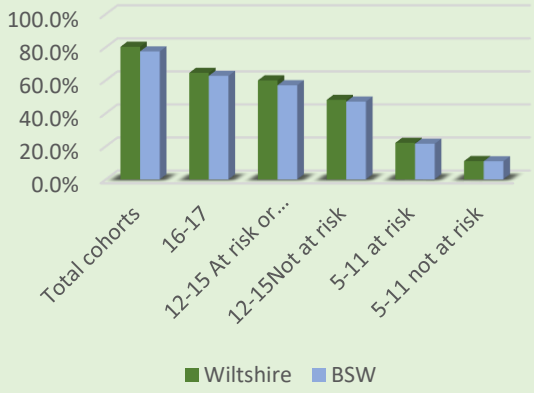
Seasonal Immunisations

COVID-19

During 2022, the 'evergreen' offer of primary doses continued. Alongside this, the 2021 autumn booster programme offering eligible cohorts a booster dose was continuing. In March the Spring booster programme began mainly for those aged 75 and over. In April, the vaccination of 5 to 11 year olds commenced, these vaccinations were not delivered through schools.

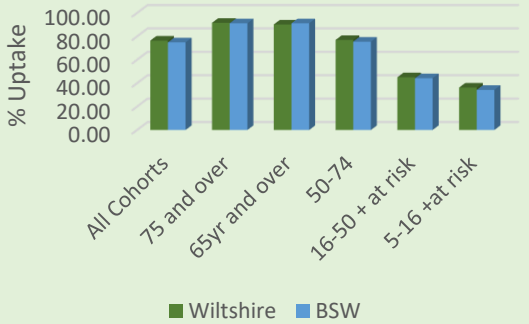
In September, the 2022 autumn booster programme began inviting eligible people with priority groups eligible early in the programme. Vaccinations were given at GP-led local sites, vaccination centres, pharmacy sites and community locations.

Full eligibility for COVID-19 vaccination programmes can be found in Appendices 6-8



Primary doses

Uptake in Wiltshire as at the end of 2022 was slightly higher than the BSW average. Uptake tends to increase with age cohort which reflects national data. High levels of COVID-19 infection in school aged children from September meant that many children were delayed getting their first or second doses due to the recommendation that 5-11 year olds should wait 12 weeks between a positive COVID-19 test and vaccination.



Autumn booster 21/22

Uptake decreases as the age cohort becomes younger. Wiltshire uptake reflects BSW data showing those eligible due to being 'at risk' have the lowest uptake. Wiltshire uptake for all cohorts was 76.4%.

By the end of August 2022, around 70% of people in England had received three or more doses of a Covid vaccine. 2022 autumn booster uptake will be presented in the 2023 report

Health and social care workers

Following the lifting of mandatory COVID-19 vaccinations for social care staff, COVID-19 uptake for older adult care home staff in Wiltshire fell from 95.5% for primary doses to 61.7% having received the booster. Although this was higher than the national average at 53.2%, it was important to understand uptake and the barriers or hesitancies surrounding seasonal vaccinations in this cohort. A survey of care providers in Wiltshire was undertaken in November 2022, with 80 respondents from settings including nursing homes, residential homes and domiciliary care. Key themes for lower uptake amongst staff included:

- **24% concerns around side effects (short and long term)** e.g 'Worried about feeling ill after'
- **15% perceived immunity** e.g 'Feel are immune as had COVID previously'
- **16% anti-vaccination sentiments** e.g 'Doesn't believe in vaccination'
- **14% time and access** e.g 'Time off work', 'Difficulty accessing clinics at appropriate times'

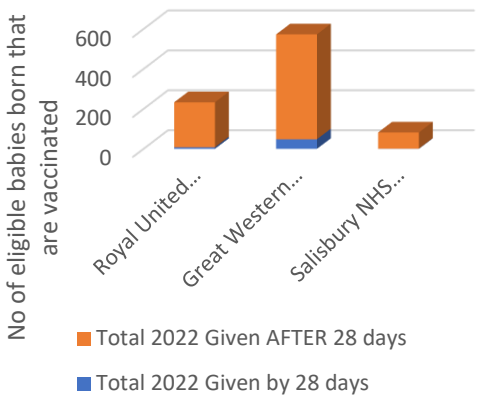
Recommendation: Promote the benefits of COVID-19 vaccination to those defined as 'at risk' and understand any barriers or lack of confidence.
Continue to monitor uptake of covid vaccination, particularly in the 5-11 cohort.

Targeted immunisations

These are immunisations that are not part of the routine universal programme and are only offered to specific eligible cohorts.

Newborn Hepatitis B

All babies should be vaccinated to protect them against hepatitis B infection. The 6-in-1 vaccine offered to all babies when they are 8, 12 and 16 weeks of age includes a vaccine against hepatitis B. Babies at risk of developing hepatitis B infection from infected mothers are given extra doses of the hepatitis B vaccine at birth, 4 weeks and 1 year of age.
Data is available on doses given in quarter 2 of 2022/23 for the South West. Numbers are low but all babies are monitored and chased for any missing doses (especially early doses).



BCG

Infants aged 0-12 months with a parent or grandparent who was born in a country where the annual incidence of TB is 40/100,000 or greater are eligible. Numbers are generally low. The national target is for eligible babies to be offered a BCG vaccination by 28 days. There is an issue nationally as well as the South West with meeting this timeframe, dried blood spot testing results are required before vaccination with BCG to check for immunosuppression.

Providers struggle to get babies booked in to such a tight timeframe as they have limited numbers of clinics running due to low number of eligible patients and if parents can't make a specified date the next available is likely after 28 days of age. This is reflected in the data above which shows babies born in each hospital trust that are eligible for vaccination, recognising that babies resident in Wiltshire will be born at each of these sites.

There is likely to be an increasing number of babies eligible in Wiltshire and BSW due to migrant populations including those seeking asylum housed within the local area.

BCG may also be recommended for older children who have an increased risk of developing TB particularly those with family from a high incidence country and children who have recently arrived from a country with high levels of TB, full eligibility can be found on the NHS website
Work is ongoing with BSW ICB to develop a pathway for those children eligible who are under 16 to be given the BCG vaccination, particularly in migrant populations including asylum seekers and refugees.

Recommendation:
Continue to gain assurance that BCG vaccinations are being given to those babies eligible when born in the UK in a timely manner.
Continue to develop a pathway for children under 16 who are eligible to receive screening for latent TB and a BCG vaccination.

Spotlight on outreach

It is vitally important that all of Wiltshire's eligible population have the opportunity to access seasonal vaccinations to protect their health. One key success from the COVID-19 pandemic has been the outreach vaccination offer to improve vaccination equity. Therefore, a focus during the seasonal vaccination campaign in 2022 was to ensure evidence-based outreach to communities and locations within Wiltshire.

12 outreach clinics were delivered between October and December 22, in which:

- 1,124 COVID-19 booster vaccines administered
- 167 COVID-19 primary vaccines administered
- 182 influenza vaccines administered

Boaters clinics

Boater's nomadic lifestyle and a possible lack of transport can result in increased difficulty accessing health services. Evidence also shows lower immunisation rates in travelling communities. Following the success of previous years, vaccination was offered on a canal boat at stops on the Kennet and Avon canal. A total of 188 vaccinations were administered to the boating community.

Routine and Manual workers clinic

Evidence from previous campaigns has shown barriers to vaccination access for workers due to lack of accessible locations, dates or times as well as lack of drop-in access. An outreach clinic was arranged at a central venue on the West Wiltshire trading estate in Westbury to bring vaccinations to an accessible location for those working in businesses on the estate. The clinic was widely advertised and a total of 55 vaccinations were administered and other health information provided.

Homeless and Rough sleeper clinic

The health outcomes for those experiencing homelessness is known to be significantly worse than the general population, immunisation rates are also lower amongst these groups. Onsite vaccination at services frequented by this community is important to enable easy access. Vaccinations were taken to the Doorway project in Chippenham, a service which provides support to people experiencing homelessness. The team visited during the popular lunchtime slot and a total of 31 vaccinations were administered and other important health information provided.

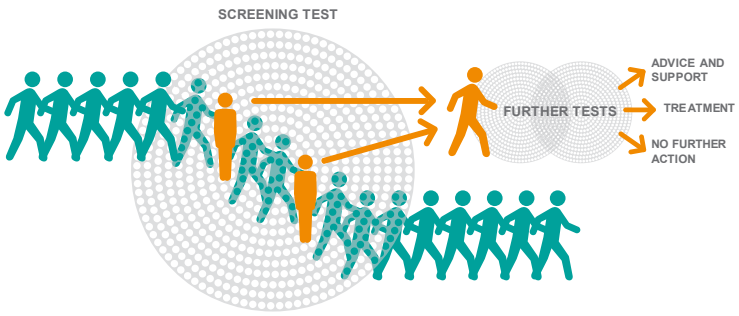
Recommendations:

Continue to develop and build upon the outreach offer, bringing vaccinations to communities and building relationships with a range of community groups and services.

Ensure when arranging clinics these are accessible to working people.

Screening

Screening is the process of identifying apparently healthy people who may have an increased chance of a disease or condition. The screening provider then offers information, further tests and treatment. This is to reduce associated problems or complications.



The sieve represents the screening test and most people pass through it. This means they have a low chance of having the condition screened for.
The people left in the sieve have a higher chance of having the condition. A further investigation is then offered to them.
Identification through this process can show that they have the condition screened for. The person may need further confirmatory diagnostic tests.

Screening can:

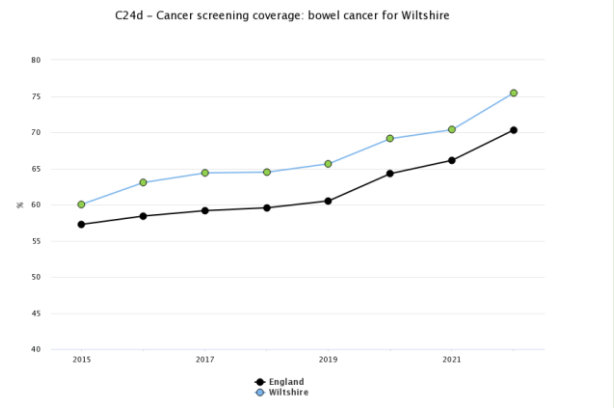
- save lives or improve quality of life through early identification of a condition
- reduce the chance of developing a serious condition or its complications
- give pregnant women informed reproductive choice

Screening does not guarantee protection. Receiving a low chance result does not prevent the person from developing the condition at a later date. Eligibility for screening programmes in England is detailed in Appendix 9

Cancer screening

Bowel

The Bath, Swindon and Wiltshire Bowel Cancer Screening Programme (BCSP) is provided by Salisbury NHS Foundation Trust based at Salisbury District Hospital. The programme is delivered across 3 sites in associations with 2 additional NHS Trusts, Royal United Hospitals, Bath and Great Western Hospitals, Swindon.
Those eligible are automatically sent a bowel cancer screening kit through the post every 2 years. The kit comes with step-by-step instructions for completing the test at home and sending the samples to a laboratory for processing.



In Wiltshire the proportion of eligible people invited for screening who had an adequate screening result was 75.4% as reported in the 2022 update to the Public Health Outcomes Framework and shown to the left. This ranks Wiltshire 10th out of all English local authorities. An extension of the eligibility to include 54 year olds is being mobilised across BSW into 2023. The postal nature of this programme appears to mean that bowel cancer screening did not see a significant drop in coverage during the pandemic.

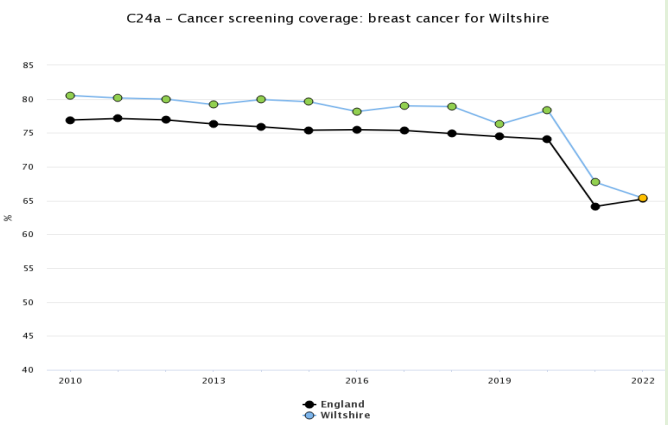
Inequalities Focus Regional work is underway to identify and flag individuals with a diagnosed learning disability with the aim of them receiving an easy read invitation with the aim of improving uptake in this cohort.

Cancer screening

Breast

The UK National Screening Committee (UK NSC) recommends all eligible women aged 50 up to their 71st birthday are invited to breast screening every 3 years. Screening aims to detect breast cancers at the earliest opportunity, maximise the success of treatment and reduce mortality from breast cancer.

The Wiltshire Breast Screening services invite approximately 32,000 women to be screened each year of those approximately 25,000 women per year attend. This is approximately 75% of all those who are invited.

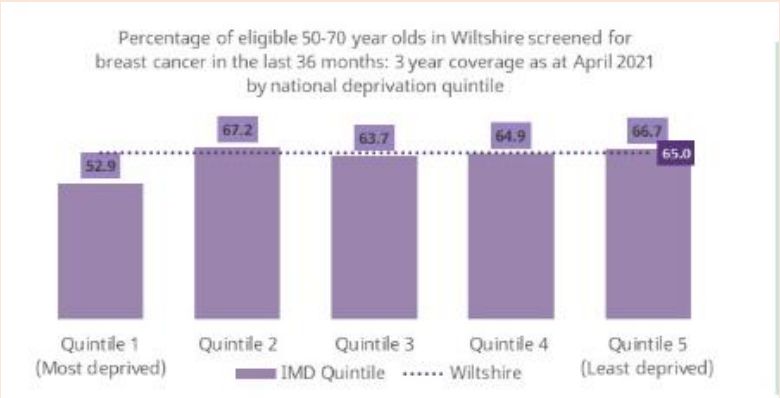


The proportion of women eligible for breast screening who have had a test with a recorded result at least once in the previous 36 months in Wiltshire has started to drop in the most recent years.

This is likely due to the effect of the COVID-19 pandemic which has caused delays to women being invited for routine screening.

Workforce shortages owing to illness, long COVID and an aging workforce has also affected this service in Wiltshire, like many NHS services. By the end of 2022 the Wiltshire programme had fully recovered. Services to 9 GP practices in Salisbury are provided by Southampton and this service has not seen recovery from the pandemic as quickly but is nearing this target.
Future data will be assessed to be assured there is no ongoing delay to women being invited to breast screening programmes and that screening rates recover to pre-pandemic levels.

Inequalities Focus



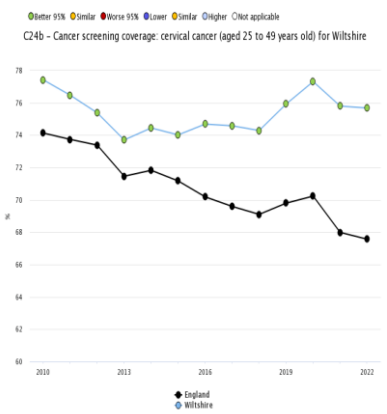
The data using areas in which patients are registered with a GP for the 36 month period to April 2021 shows a significantly lower level of screening among individuals living in areas of Wiltshire ranked in the most deprived 20% of national areas. Inequalities in the screening programme place individuals living in more deprived areas at higher risk of mortality, contributing the gap in life expectancy seen between the most and least deprived populations.

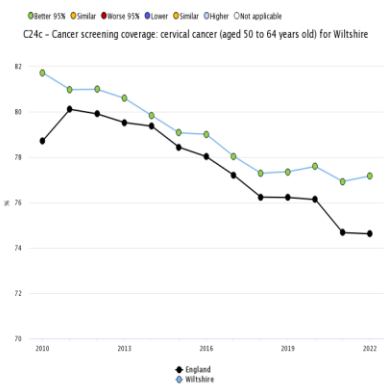
Cancer screening

Cervical

Cervical screening is available to women and people with a cervix aged 25 to 64 in England. The NHS Cervical Screening Programme (CSP) Standard is that 80% of women should have an adequate test within the previous 3.5 years (ages 25-49) or 5.5 years (ages 50-64)

All eligible people who are registered with a GP (as female) automatically receive an invitation by mail. Trans men (assigned female at birth) do not receive invitations if registered as male with their GP but are still entitled to screening if they have a cervix.





Wiltshire cervical screening coverage in 2022 remains above the England (67.6%, 74.6%) and regional averages (72.4%, 76.3%) but are below the national standard (80%). The most recent rates for those aged 25-49 (75.7%) (far left) are slightly lower than those aged 50-64 years (77.2%)

By November 2022 levels of samples received by labs serving Wiltshire had met or exceeded pre-COVID levels.

The RUH has reported increased numbers of referrals through 2022 which has put pressures on the staff. NHSE has agreed funding to support clearing a backlog to improve the proportion of high and low grade referrals seen within the target time.

Focus on inequalities:
Work by NHSE South West is ongoing to increase coverage in people with learning disabilities or autism .This includes the development of a pack to help sample takers support people with learning disabilities through screening.

There is evidence as for breast screening that uptake is consistently lower in the most deprived areas of the country

Recommendations cancer screening programmes:

Understand the inequalities data around cancer screening programmes for Wiltshire and where barriers may exist, particularly for cervical screening which remains below the national standard.

Use data already compiled to focus on uptake in the most deprived areas of the county.

Continue to gain assurance that screening programmes are meeting the needs of the Wiltshire population

Non-cancer screening programmes

Eligibility for these programmes can be found in Appendix 9

Abdominal aortic aneurysm (AAA) screening

In England, screening for AAA is offered to men during the year they turn 65. Men aged 65 or over are most at risk of getting AAAs. Screening can help spot a swelling in the aorta early on when it can usually be treated.

Providers are required to offer all eligible men a single ultrasound screening test during the year they turn 65, the provider covering Wiltshire met this for 99.7% of the eligible population. The cumulative uptake at the end of 2022 was 67.9%.

Focus on inequalities

Work is being planned by the provider for 2023 to include targeting of transient populations including work with employers with large workforces alongside linking with GP surgeries with patients in high deprivation areas to support promotion of the service. This links in with the Wiltshire PLUS groups outlined on page 5.

Antenatal and Newborn screening

Antenatal screening includes, foetal anomaly and infectious diseases in pregnancy screening . Newborn screening includes newborn and infant physical examination, newborn blood spot screening and newborn hearing screening.
Sickle cell screening is offered antenatally depending on prevalence and family background alongside being included in newborn blood spot screening. Screening for thalassaemia is offered to all pregnant women.

Diabetic Eye Screening

Diabetic eye screening is a test to check for eye problems caused by diabetes, these problems can lead to sight loss if not found early.
Coverage for this screening was 79.6% in BSW which is above the acceptable level (75%).

Focus on inequalities

A promotional video outlining what screening involves has been produced and the provider has been doing targeted work with those in higher areas of deprivation. A project to raise awareness in residential and nursing homes has also been planned.

Recommendations

Continue to seek assurance that residents of Wiltshire have access to non-cancer screening services.
Gain understanding from providers and NHSE on specific inequalities work in Wiltshire and where there maybe opportunities to support and promote.

Communicable Diseases

There continues to be a strong working arrangement and relationship in place between the local health protection staff at the UK Health Security Agency (UKHSA), Public Health and Public Protection teams in the council alongside NHS staff.
Through close partnership working, UKHSA South West Health Protection Team (HPT) aims to provide 'assurance that infection prevention and control measures are in place to ensure the protection of those members of the Wiltshire community that may be vulnerable to acquiring an infection both in the general population and whilst in a Health or Social care setting'.
The UKHSA Health Protection Team responds to any Notifications of Infectious Diseases (NOIDs) either from reporting medical practitioners or confirmed samples from the laboratories.

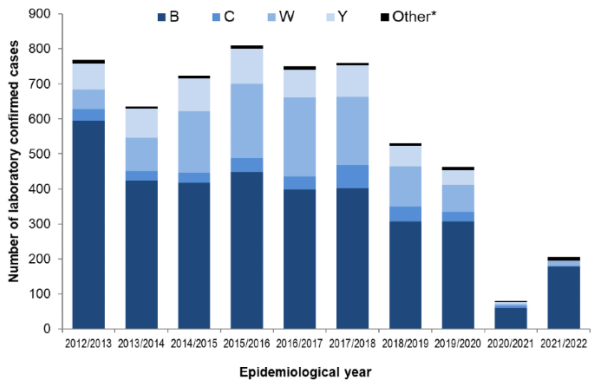
Measles, mumps, rubella and pertussis

Non-pharmaceutical interventions introduced for COVID-19 control, such as, social distancing, reduced the opportunity for transmission of many infectious diseases. In particular the limitations imposed on international travel drastically reduced the number of measles and rubella importations, providing fewer opportunities for new chains of transmission. Health-seeking behaviour during the pandemic also changed, making it more likely that people with mild symptoms did not present to healthcare services and may not have been seen face to face.

Rates of measles, mumps and pertussis remained very low in Wiltshire and the South West throughout 2022, in 2021 there were no confirmed cases of measles in the whole of the South West and 2 in England. Across 2022 there were 47 confirmed cases across England, showing a significant increase however still lower than pre-pandemic numbers.
There have been no new laboratory confirmed cases of rubella reported in the UK since 2019.
There is growing concern about the potential of outbreaks of measles due to falling vaccination rates as covered in the immunisations section of this report.

Meningococcal disease

Meningococcal disease is a life-threatening infection caused by Neisseria meningitidis. Men B is the most common strain in the UK, but other strains include MenA, MenC, MenW and MenY. It can occur at any age but babies and young children are most at risk followed by teenagers and young people.



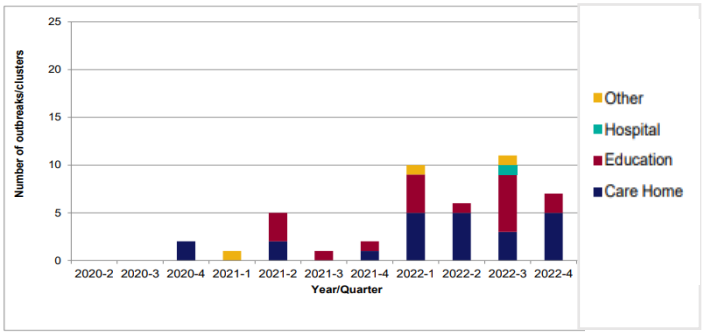
The most recent data available nationally shows an increase in invasive meningococcal disease in 2021-2022 compared to the previous year, although numbers have not returned to pre-pandemic levels.
There are vaccinations available for MenACWY and MenB, given to teenagers and infants respectively. The MenB vaccination was introduced into the routine vaccination schedule in September 2015 so those currently older than 6 are unlikely to be vaccinated against this strain.
In 2022 rates of meningococcal disease remained low in Wiltshire, however there were 3 unlinked cases in quarter 1 of 2022. Apart from that quarter, rates remain comparable to the South West.

Communicable Diseases

Gastrointestinal infections

Gastrointestinal infections are a common global health problem. They most often affect the stomach or intestines and generally result in diarrhoea. Most gastrointestinal infections are not serious and resolve without treatment after a few days. They are most commonly caused by viruses and bacteria.

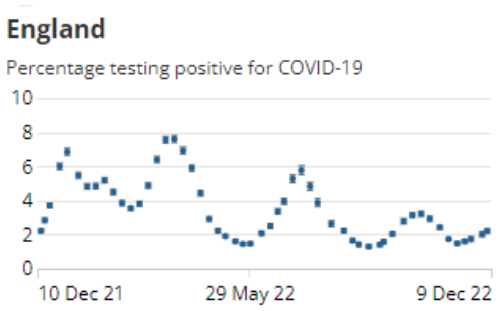
Of the cases in Wiltshire tested for bacterial cause, campylobacter was the most commonly seen infection. Rates peaked in quarter 2 of 2022, similar to other years and were comparable to South West rates. Campylobacter is often associated with eating raw or undercooked poultry or eating something that touched it. This may be associated with more BBQs being held in warmer weather for example. Rates of other causative agents such as cryptosporidium, E.coli, Giardia, Salmonella and Shigella remained at levels close to the SW average (Appendix 10)



Care homes and education settings were the most frequent sites of GI outbreaks in Wiltshire in 2022 (left). These are outbreaks reported to UKHSA. The increase in numbers of outbreaks could reflect the increased mixing and reduction in restrictions compared to 2020-2021.

Respiratory infections

The 2021 to 2022 season saw an increase in the number of incidents of influenza and other respiratory viruses compared to the 2020 to 2021 season, however levels remained low compared to pre-pandemic seasons. Later in 2022, in the 22/23 flu season, activity was concentrated in a relatively short period and early in the flu season, from around late November to early January. Activity was higher than levels observed during the 21/22 season.



2022 saw the end to COVID-19 restrictions and the end of universal testing for COVID-19 as detailed in appendix 1. The Office for National Statistics (ONS) COVID-9 infection survey shows the percentage of private households testing positive for COVID-19 through 2022 in England.
Wiltshire Council public health supported continued messaging around the importance of infection prevention and control methods and the roll out of the COVID-19 vaccination programme, ensuring the most vulnerable had access to vaccines as detailed on page 16.

A single case of Legionnaire's disease was identified in Wiltshire during 2022.

Recommendations

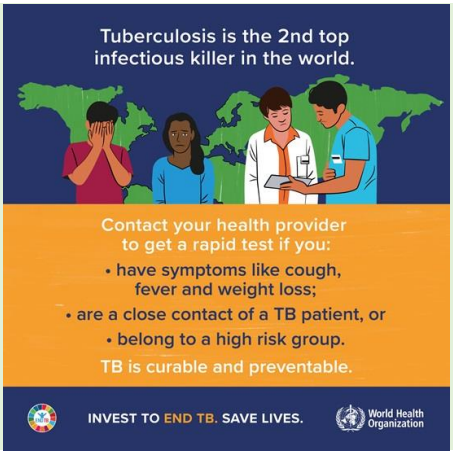
Promote signs and symptoms of meningococcal disease and measles to those most at risk, particularly using fresher's events and the end and start of terms.

Support public protection with messaging about food hygiene as one way to reduce GI infections.

Continue to support care and education settings with infection prevention and control to reduce the burden and transmission of infectious diseases, particularly gastrointestinal and acute respiratory infections

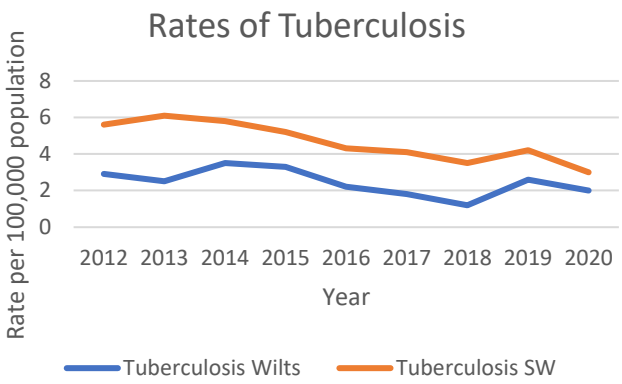
Communicable Diseases

Tuberculosis (TB)



Tuberculosis (TB) is an infectious disease, caused by bacteria of the *Mycobacterium tuberculosis* complex. It is predominantly spread by the respiratory route; people with infection in their lungs breathe out infectious bacteria, which may then be inhaled by others.

Comorbidities with other infections or non-communicable diseases such as diabetes or chronic liver disease may affect TB treatment strategies and outcomes. Untreated HIV infection increases the risk of developing active TB disease and universal HIV testing is conducted within TB programmes.



In 2021: TB incidence in England was 7.8 per 100,000, meeting the World Health Organisation (WHO) threshold for a low incidence country (less than or equal to 10 per 100,000 population) TB incidence decreased overall in England since 2011, but the rate of decline is slowing. 76.4% of people with TB in 2021 were born outside the UK and the TB incidence in this group was 37.6 per 100,000.

Wiltshire rates of TB are below the South West and England but saw a slight rise pre-pandemic, leading to a smaller difference in rates compared to the South West.

With the increase in migrant populations from countries where TB incidence is high (40+ cases per 100,000 population) there may be an increase in incidence of tuberculosis.

Pre-entry screening for active pulmonary TB is a requirement for migrants who apply for a visa to the UK, intend to stay for longer than 6 months and who reside in a high TB incidence country. Migrants who arrive by unofficial routes are not covered by the pre-entry screening programme. Such people may be from high incidence countries and/or experience complex risk factors relating to their trajectory of migration, further increasing their risk of TB. Migration data indicate this group is increasing in number, are experiencing longer stays in the UK and often have shared living arrangements.

The recommendation of the migrant health guide for latent TB is that screening should be offered to 16 to 35 year-olds who have arrived in England in the last 5 years and who were born or lived for more than 6 months in sub-Saharan Africa or countries where the TB incidence is more than 150 per 100,000 population. There is currently no dedicated community latent TB screening service in Wiltshire, which is usual for a low incidence area.

Recommendations

Gain assurance that migrants are being screened for active TB on arrival

Gain assurance there is a process in place for migrants who enter the country via unofficial routes to access active TB screening and that health professionals are recognising and referring suspected cases promptly.

As a system, work to investigate a route of latent TB screening and subsequent follow up for those Wiltshire residents eligible, including migrant populations, this links to priority 2 of the TB action plan for England, 2021 to 2026

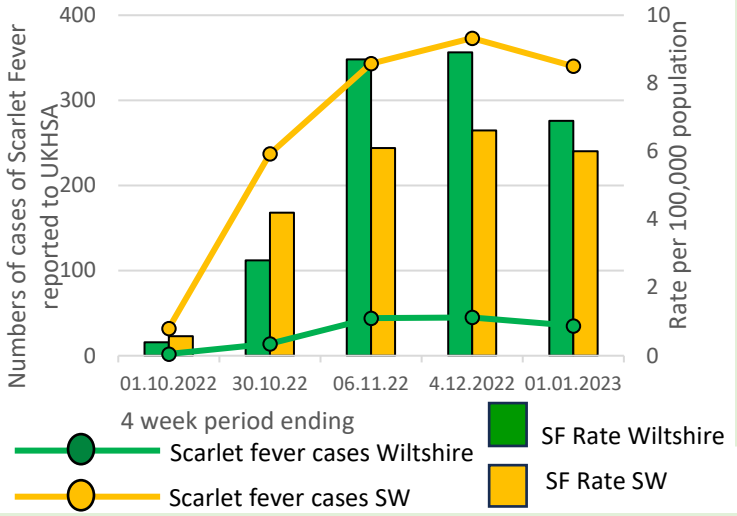
Communicable diseases

Spotlight on: Group A Streptococcus (Strep A)

Group A Streptococcus is a common type of bacteria that usually cause mild infections such as sore throats and scarlet fever. Occasionally these can develop into a more serious infection, named invasive group A streptococcus (iGAS)

In December 2022, there was widespread reporting in the media of iGAS cases that unfortunately led to the deaths of primary school aged children.

UKHSA stated that they were seeing a higher number of cases of group A strep than usual for the time of year (causing high levels of scarlet fever), potentially due to the increased mixing after the previous years of reduced socialisation due to the COVID-19 pandemic.



UKHSA data for Wiltshire and the SW shows that the pattern of notifications was roughly similar. A peak was seen in the week ending 4th December. These numbers only capture the cases recorded by UKHSA that were notified to them but provide an insight into trends.

The rate of cases of scarlet fever per 100,000 allows comparison adjusted for population and shows the South West rate was above Wiltshire's until the week ending 6th November.

After early November the rate of scarlet fever in Wiltshire's population was higher than the of the South West. iGAS cases in the SW and Wiltshire were continuing to increase in the 4 weeks ending 1st January 2023 reflecting a delay from onset of scarlet fever or other group A strep infection to development of iGAS. iGAS is rare, there were a total of 9 cases in Wiltshire between 1st.October 2022 and 1st January 2023. The number of Strep A infectons will be underestimated in this data as only a proportion will be reported to UKHSA whereas all iGAS cases will likely be reported due to the involvement of health professionals.

The Wiltshire Council public health inbox received 39 queries between the 5th and 13th of December 2022, many from schools and early years settings.

The public health messaging that was agreed was to provide advice for confirmed cases of scarlet fever and provide information on when to report cases and who to. Public Health Wiltshire also provided advice on what to do if a child had a sore throat, temperature or was feeling generally unwell. There were significant challenges with this situation. National media reporting of the national increase in iGAS cases generated significant local interest and concern, ahead of national communications and guidance updates.

This work reflected that whilst the local authority public health team's role in risk assessing and managing outbreaks with settings has changed since COVID-19, there is an important role in collaborative working with UKHSA, and the importance of timely, reactive and accurate communications. This work also highlighted the trusted relationships with settings such as schools and early years settings that were built during COVID-19.

Recommendations – Ensure roles and responsibilities of outbreak management and communications are clear amongst partners and the internal team, reflecting changes since the COVID-19 pandemic response

Mpox is a zoonotic infection, caused by the monkeypox virus, that occurs mostly in West and Central Africa. Previous cases in the UK had been either imported from countries where mpox is endemic or contacts with documented epidemiological links to imported cases, with no documented community transmission in previous outbreaks.

Cases of mpox infection were confirmed in England from 6 May 2022. The outbreak has mainly been in gay, bisexual, and men who have sex with men without documented history of travel to endemic countries. The primary reported route of transmission was through close or sexual contact and there were no confirmed instances of airborne transmission. Limited household transmission was described in the UK. The UKHSA advised that people who have had close contact with a person infected with mpox to self isolate for 21 days but this was not mandatory.

By the end of 2022 there had been 3552 diagnosed cases of mpox in England, 2435 of which were in London and 10 of which were in Wiltshire.

In June 2022 the mpox vaccination programme was introduced in response to the outbreak. As mpox is caused by a similar virus to smallpox, the smallpox (MVA) vaccine should give a good level of protection against mpox. Eligibility can be seen in Appendix 11. Vaccination was offered at sexual health clinics.

In September, a limited global supply of vaccines led UKHSA to recommend that first doses should be prioritised with the offer of a second dose for those who continued to be at an increased risk of exposure.

Mpox activity significantly affected sexual health services with added pressures resulting from not just vaccination appointments but a range of other activities listed below.

.

- Time taken to discuss mpox

- Assessing patients with symptoms (both in person and via phone/e-mail)

- Speaking to partner organisations for updates on a changing situation

The vaccination programme continues into 2023. The UKHSA epidemiological overview and accompanying spreadsheet of counts of mpox by region and local authority was published for the last time on 20 December 2022, partially due to low case numbers.

Communicable Diseases

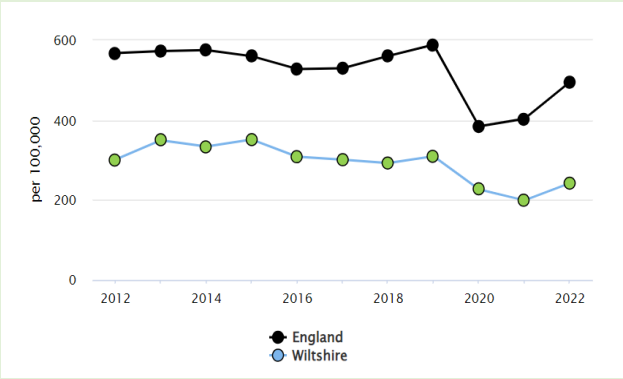
Sexual Health

Sexual Health is an important matter to individuals and communities. Access to high quality sexual health services, quick access to treatment and interventions improves health and wellbeing of both individuals and populations.

Wiltshire Council awarded the contract for open access Sexual Health services to WiSe, Wiltshire Sexual Health Service, Salisbury Foundation Trust in April 2022. Both Genito-Urinary Medicine (GUM) and Contraception and Sexual Health (CASH) services are provided.

WiSe also co-ordinate the National Chlamydia Screening Programme (NSCP) and an online Home testing service to test for a range of sexually transmitted infections including HIV.

Sexually transmitted infections (STIs)

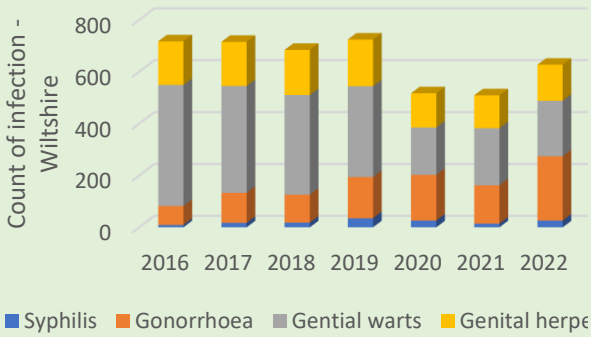


2022 saw diagnoses of new STIs among England residents increase by 23.8% with both gonorrhoea and syphilis returning to the high levels reported in 2019, prior to the COVID-19 pandemic.

Wiltshire rates for 2022 (242 new diagnoses per 100,000) remain below both South West (311) and England (496) rates although they follow the same trends showing a 21.5% increase since 2021. These rates do not include Chlamydia diagnoses in under 25s.

These increases are following a large reduction in new diagnoses in 2020, correlating with the COVID-19 pandemic. 2022 rates are still below pre-pandemic levels (309 per 100,000 in 2019).

It is worth noting that the STI testing rate in Wiltshire is significantly below regional and national averages. Further information can be found in the SPLASH report for Wiltshire 2022



Cases of gonorrhoea in 2022 have seen a 67.5% increase compared to 2021 reflecting regional and national trends. Overall, larger decreases in diagnoses were observed for STIs that are usually diagnosed clinically at a face-to-face consultation, e.g. genital warts or genital herpes, when compared to those that could be diagnosed using remote self-sampling kits e.g. chlamydia and gonorrhoea. Decreases in genital warts diagnoses (particularly under 25s) are also due to the protective effect of HPV vaccination.

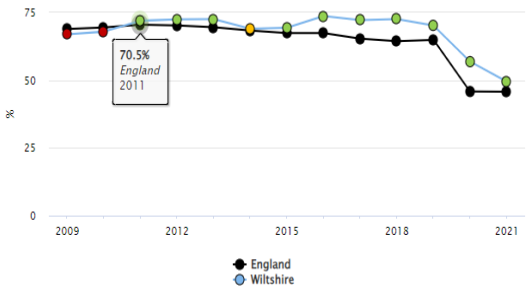
Focus on inequalities

Sexual ill health is not equally distributed within the population. Strong links exist between deprivation and STIs, teenage conceptions and abortions. The highest burden borne by women, men who have sex with men (MSM), teenagers, young adults and black and minority ethnic groups. Some groups at higher risk of poor sexual health face stigma and discrimination, which can influence their ability to access services.

Recommendation: Explore sexual health data for Wiltshire to understand inequalities

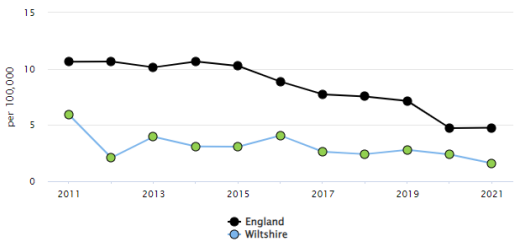
Sexual Health

Blood borne viruses - HIV



HIV Testing

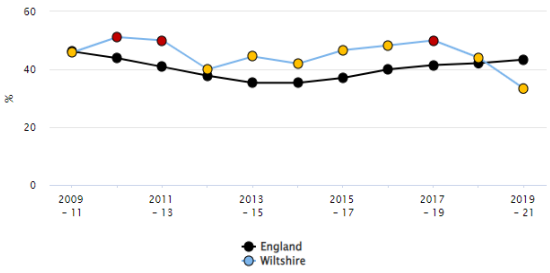
HIV testing is integral to the treatment and management of HIV infection. Knowledge of HIV status increases survival rates, improves quality of life and reduces the risk of onward transmission. Acceptance of HIV testing (left) has dropped in Wiltshire and England which may correlate with the COVID-19 pandemic. A low testing rate could lead to diagnoses being missed or becoming a late diagnosis.



HIV Diagnosis

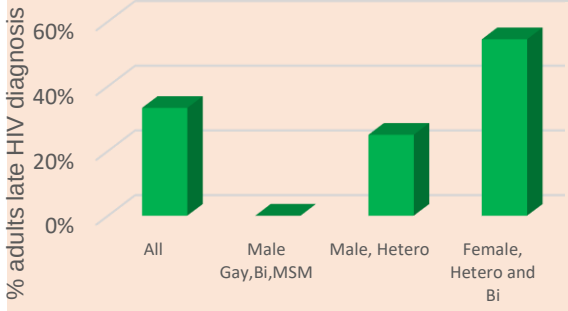
All new HIV diagnoses among people in the UK and Wiltshire, expressed as a rate per 100,000 population (left). New HIV diagnosis is not synonymous with incidence; however, it provides a timely insight into the onward HIV transmission in a country and consequently allows targeting efforts to reduce transmission.

A lower diagnosed HIV prevalence is not necessarily better than a higher HIV prevalence. Rates in Wiltshire are consistently significantly lower than that of England however with a decline in acceptance of testing these rates will need to be interpreted with caution.



Late HIV diagnosis

Late diagnosis (left) is the most important predictor of morbidity and mortality among those with HIV infection. This indicator focuses it upon those first diagnosed in the UK at a late stage of infection. Wiltshire data shows an improvement since 2017 indicating HIV is being detected at an earlier stage, falling below the England and SW averages. Rates are still higher than the 25% goal. With a drop in testing acceptance there is a risk this improvement will not be maintained.



Focus on inequalities

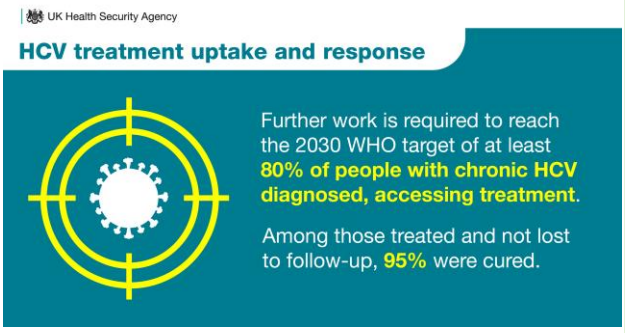
The data to the left shows that more late diagnoses of HIV in Wiltshire are in women. Heterosexual men were more likely to have a late HIV diagnosis than men who are gay, bisexual or have sex with men, this cohort had 0 late diagnoses in 2019-2021 (latest available data)

Recommendations

Monitor acceptance of HIV testing data on reasons for refusal

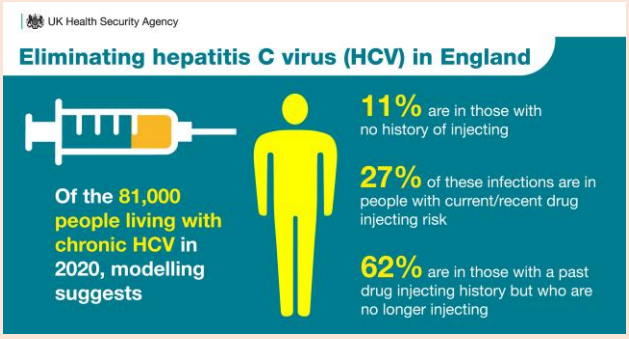
Scope out whether data is available on the demographics of people using HIV services to start to understand inequalities. Consider enhanced engagement with women and heterosexual men about HV testing.

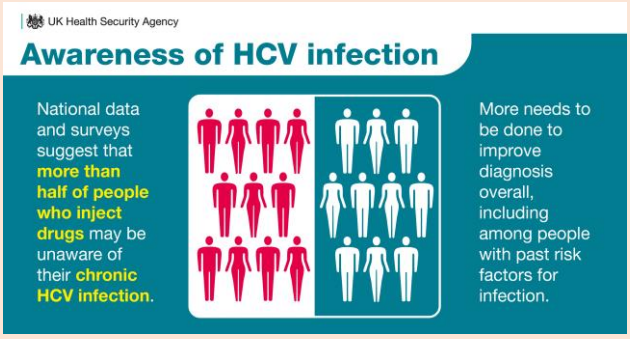
Hepatitis is the term used to describe inflammation of the liver. It's usually the result of a viral infection or liver damage caused by drinking alcohol.
There are several different types of hepatitis. Some types will pass without any serious problems, while others can be long-lasting (chronic) and cause scarring of the liver (cirrhosis), loss of liver function and, in some cases, liver cancer.
There are five main strains of the hepatitis virus, referred to as types A, B, C, D and E. While they all cause liver disease, they differ in important ways including modes of transmission, severity of the illness, geographical distribution and prevention methods. Hepatitis B (HBV) is 50-100 x more infectious than HIV and HCV is 10 times more infectious than HIV.



As of 2021, an estimated 206,000 people are living with a chronic hepatitis B infection in England and 92,900 people are living with hepatitis C infection in the UK. (UKSHA). WHO's global hepatitis strategy, endorsed by all WHO Member States, aims to reduce new hepatitis infections by 90% and deaths by 65% between 2016 and 2030.
NHSE has a national programme for the elimination of HCV and since 2015 the number of cases has been reduced by 43% and deaths by 35%
The latest available data for Wiltshire (2017) shows a detection rate of around 10 per 100,000 population or around 50 cases. The detection rate is around half than seen in England which may reflect differences in the demographics of the population or the approach to testing.

Focus on inequalities





Recommendations

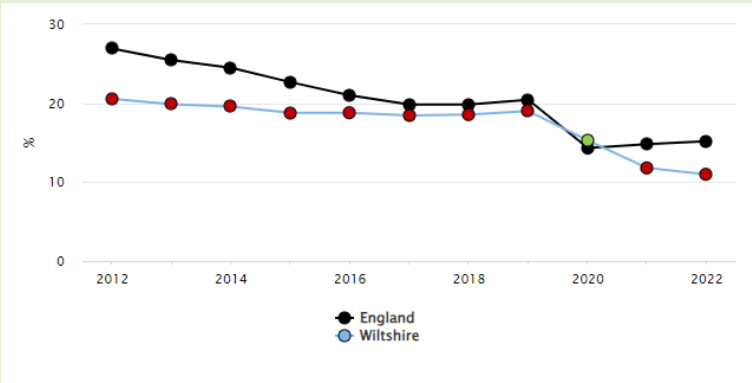
- Continue to gain assurance of Wiltshire resident's access to hepatitis pathways via operational delivery networks (Thames Valley, Wessex and Bristol and Severn)
- Investigate timely Wiltshire or regional specific data for hepatitis testing and treatment
- Continue to work within public health and wider partners, including commissioned drug and alcohol services to improve harm reduction, testing and access to treatment and to reduce inequalities for the most vulnerable populations.

Sexual health

Chlamydia screening

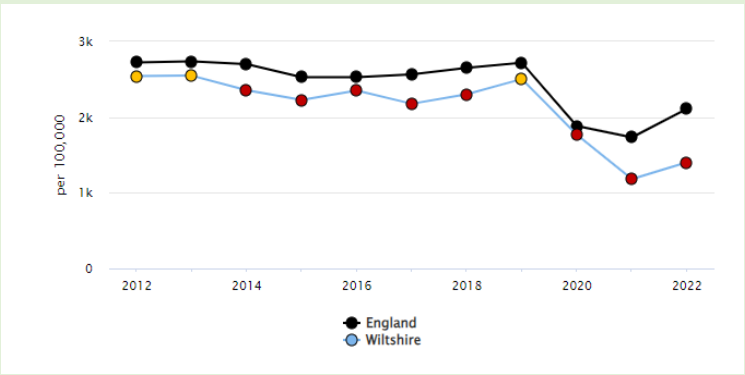
In June 2021, the National Chlamydia Screening Programme (NCSP) changed to focus on reducing the harms from untreated chlamydia infection. These harms occur predominantly in young women and other people with a womb. Therefore, opportunistic screening will focus on these groups, combined with reducing time to test results and treatment, strengthening partner notification and re-testing after treatment.

In practice this means that chlamydia screening in community settings (e.g. GP and Community Pharmacy) will only be proactively offered to young women and other people with a womb or ovaries. Services provided by sexual health services remain unchanged and everyone can still get tested if needed.



Chlamydia screening

The proportion of 15-24 year olds screened for chlamydia in Wiltshire in 2022 was 11%, compared to 14.2% regionally and 15.2% nationally. The trend in Wiltshire is showing a sustained decrease in the proportion of young people tested for chlamydia after the COVID-19 pandemic in contrast to national rates which have not recovered but have stabilised.



Chlamydia detection

The chlamydia detection rate per 100,000 aged 15 to 24 year old (females) in 2022 in Wiltshire was 1,402 per 100,000 population (left) lower than the 3,250 target. This is a measure of chlamydia control activity – an increased rate is indicative of increased control activity. The trend is similar to that of England but the gap has widened since the onset of the COVID-19 pandemic.

Recommendation

Investigate reasons for a continued decline in the proportion of 15-24 year olds screened for chlamydia

Monitor the chlamydia detection rate in Wiltshire and investigate reasons for a slower recovery than that of England.

Investigate reasons for a slower recovery of STI testing in Wiltshire compared to national figures.

Determine if inequalities data is available for chlamydia screening

Healthcare Associated Infections (HCAI)

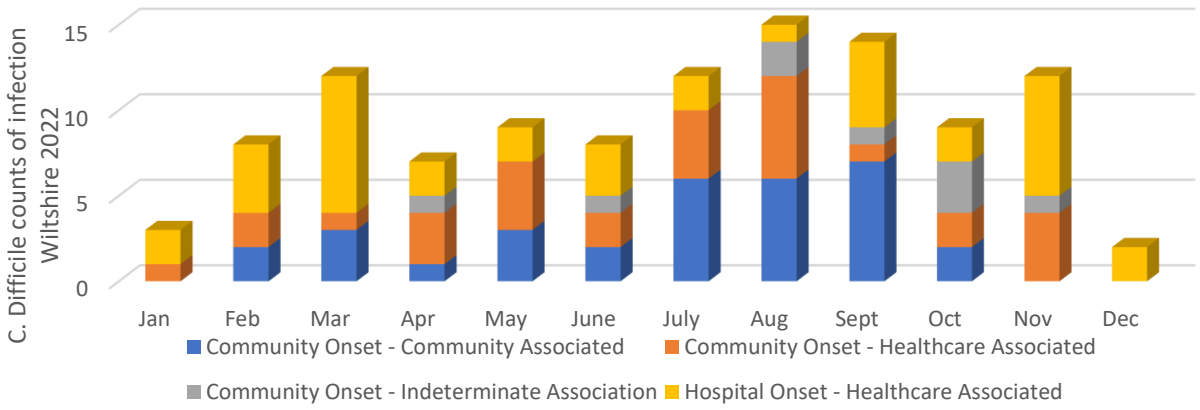
Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment or from being in contact with a healthcare setting. HCAIs pose a serious risk to patients, staff and visitors. They can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention and control is a key priority for the NHS

Community-acquired infections are infections that are contracted outside of a healthcare settings. Indeterminate association is when the patient was discharged from the reporting organisation within 28 days prior to the current specimen date but the case is not hospital onset, healthcare associated

Hospital or health care acquired infections are defined as those that have onset after admission or are associate with acquisition within a hospital environment.

Wiltshire Council work collaboratively in system and regional collaboratives aiming to reduce healthcare associated infections.

Clostroides Difficile (CDI)



CDI cases have decreased across the last part of 2022. A rise in hospital onset, hospital acquired cases in November fell considerably in December.

In Wiltshire there were 95 CDI cases in 2021 meaning 2022 saw 6 more cases. Work is ongoing with system and regional partners to look at reducing inappropriate antibiotic use in the population, it has been noted that whilst BSW are performing well with reducing overall consumption, there is still some progress to be made on the use of broad spectrum antibiotics.

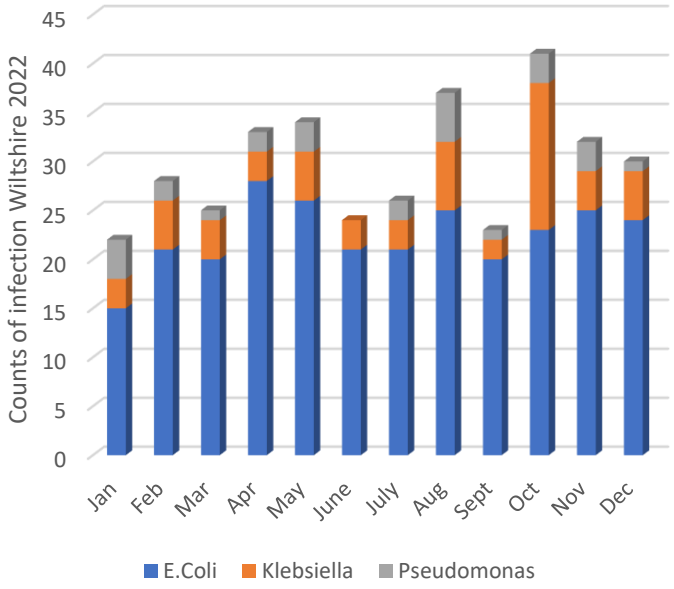
Cases are reviewed along the patient pathway across multiple healthcare providers to understand the journey and contributory factors to the cases. Themes emerging identified a need to focus on the prescribing for skin and soft tissue infections , urinary tract infections (UTI) and community acquired pneumonias.

Healthcare Associated Infections (HCAI)

Gram Negative Blood Stream Infections

Gram negative bacteria such as E. coli, Klebsiella spp. and *Pseudomonas aeruginosa* are the leading causes of healthcare associated bloodstream infections.

In November 2016, the government announced plans to reduce infections across the NHS. This includes plans to reduce the number of healthcare associated Gram-negative bloodstream infections by 50%, by financial year 2020 to 2021. In response to this, UKHSA expanded their collection of Gram-negative blood stream infections from E. coli bacteraemia (mandated to be reported in June 2011) to include *Pseudomonas aeruginosa* and Klebsiella spp.



The BSW system breached NHS thresholds for E. coli in the financial year 2022/2023. An increase in E. coli cases was also seen in the 2022 Wiltshire data (left) when compared to 2021 (calendar years)

Approximately three-quarters of E.coli blood stream infections occur before people are admitted to hospital and therefore reduction requires a whole health economy approach. The enhanced sentinel surveillance programme which showed that the most common source of infection is the urogenital tract at 51.2%. A large study of older adults aged 65+ in England identified that over a 10-year period, 21% had at least 1 clinically diagnosed UTI.

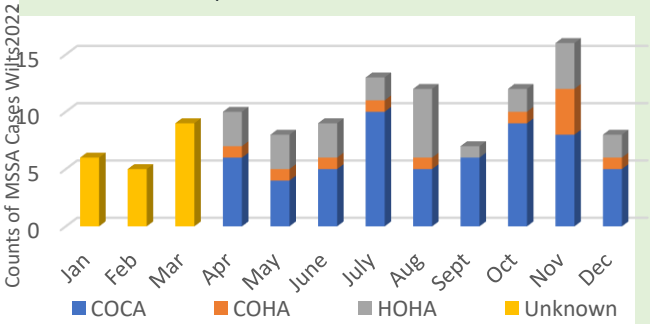
Focus on UTIs

There is a BSW system wide project to reduce urinary tract infections (UTIs) which will have three workstreams running through 2023

1. Correct management and judicial use of antibiotics of lower UTIs
2. Increase hydration within the over 65 population across BSW and increase public awareness for prompt recognition of UTIs
3. Catheter management

MRSA and MSSA

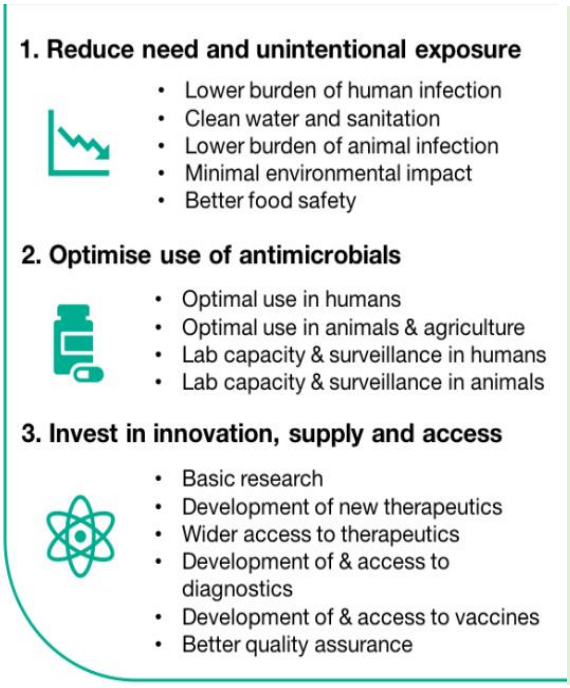
MRSA and MSSA are a type of bacteria that usually lives harmlessly on the skin. If it gets inside the body, it can cause a serious infection that needs immediate treatment with antibiotics. The difference between MRSA and MSSA is their antibiotic resistance, MRSA being more resistant. In 2022 there were 2 MRSA bacteraemia cases in Wiltshire and 5 across BSW, in 2020 and 2021 there were 8 cases in Wiltshire and 16 across BSW.



There is however a rising local, regional and national trend in MSSA cases (Wiltshire data to the left). Case reviews have identified that invasive line management and standard precautions may be a contributory factor associated with these cases. Further work is to be done to review community cases to understand root causes and contributory factors.

Antimicrobial Resistance

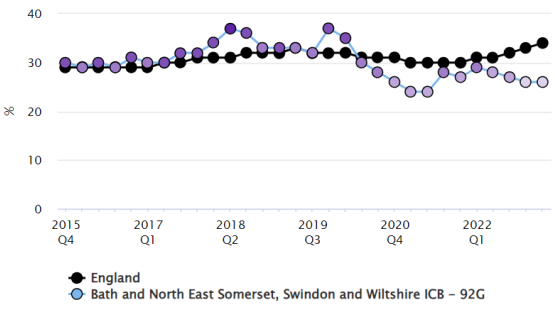
Antimicrobial resistance (AMR) arises when the organisms that cause infection evolve ways to survive treatments. The term antimicrobial includes, antibiotic, antiprotozoal, antiviral and antifungal medicines. No new classes of antibiotic have been discovered since the 1980s. This, together with the increased and inappropriate use of the drugs we already have, means we are heading rapidly towards a world in which our antibiotics no longer work.



The UK's five year national action plan for antimicrobial resistance 2019-2024 supports the 20 year vision for AMR and the content areas within this are shown to the left.

Workstreams in Wiltshire Council public health that support this action plan include infection prevention and control training and awareness including promotion of vaccination and engaging the public on AMR. We support system projects to reduce UTIs and the need for antibiotics and there are several projects aiming to understand and reduce inequalities in access to diagnostics and vaccines.

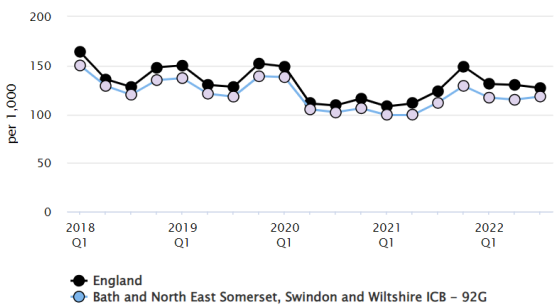
Work in public protection involves ensuring Wiltshire residents have access to clean water and sanitation and businesses adhere to food safety regulations.



The proportion of E. coli blood specimens resistant to any 1 key antimicrobial in England is showing an increase from early 2022 (left)
This trend is not reflected in the BSW ICB data which shows a sustained decline in resistant E.coli blood specimens from 2020 which has largely been maintained.
Wiltshire residents use all three acute trusts in BSW ICB.

Antibiotic prescribing

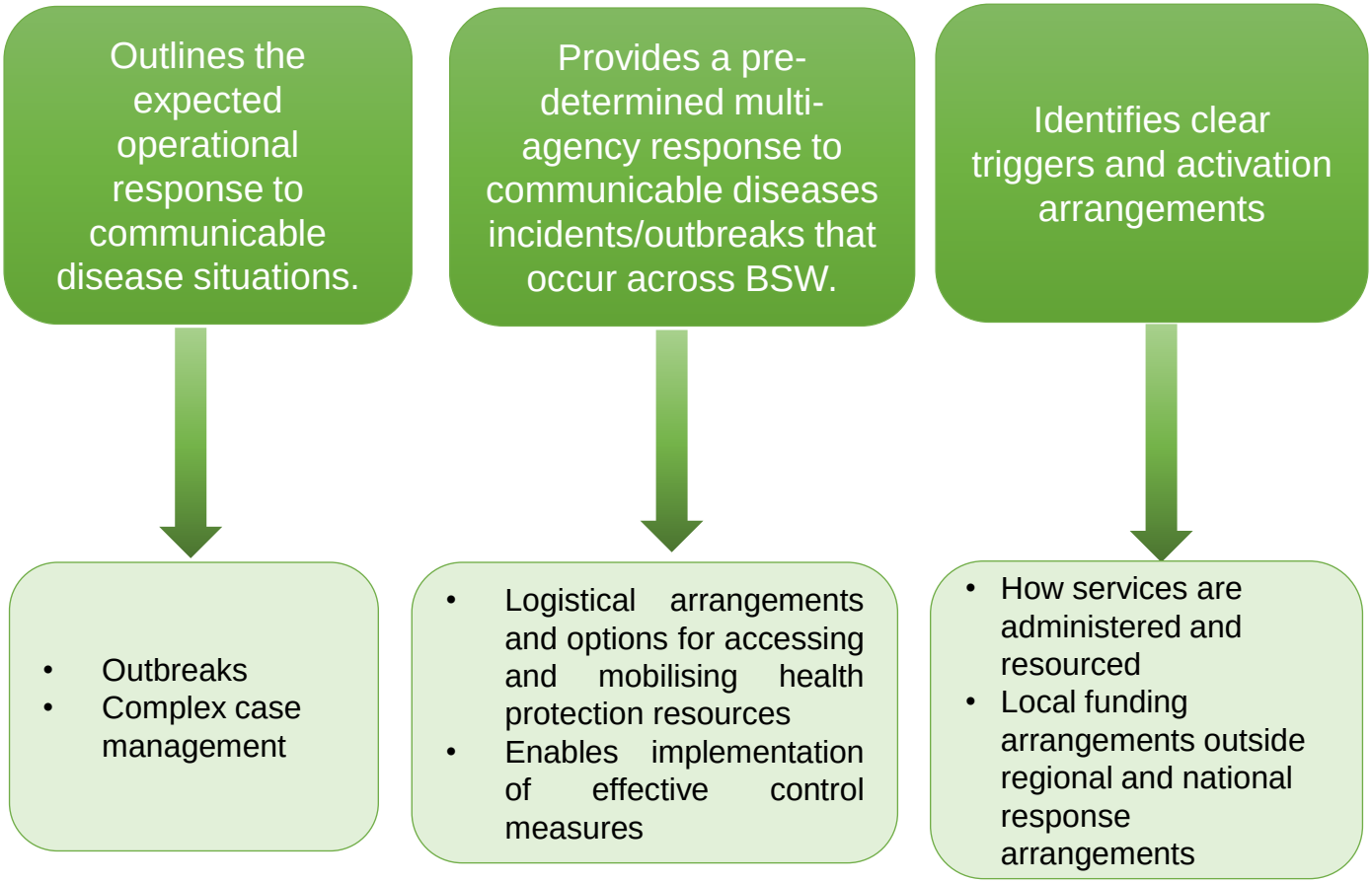
The AMR national action plan has a target to reduce UK antimicrobial use in humans by 15% by 2024, as sub-optimal use of antimicrobials in human medicine is one of the main drivers of AMR.



In England, total antibiotic consumption declined by 15.1% between 2017 and 2021. There were vast reductions in antibiotic consumption in 2020 (left) correlating with the COVID-19 pandemic. Increases in the years post 2020 still remain below pre pandemic levels. Wiltshire prescribing rates are consistently below national rates with general trends following national patterns.

Health Emergency Planning

Through 2022 the BSW Local Health Resilience Partnership (LHRP) Communicable Disease plan was developed and signed off by all three health protection boards. The plan was developed in collaboration with B&NES, Swindon and Wiltshire public health teams, Swindon environmental health, UKHSA, NHSE and BSW ICB.



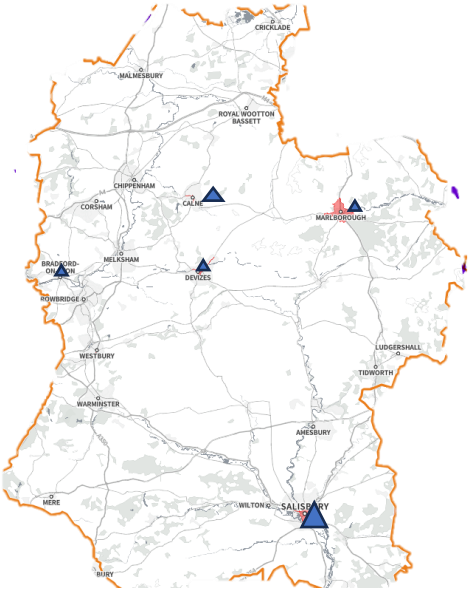
The plan links in with other useful documents such as the national communicable disease plan and the NHS emergency preparedness resilience and response framework

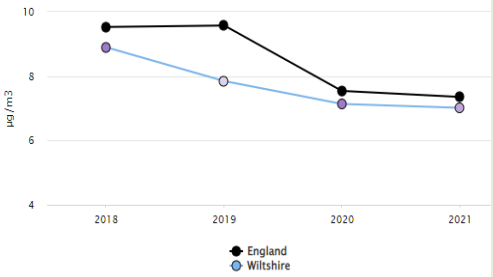
Training and Exercising

UKHSA led a regional preparing for winter workshop to support shared learning, highlighting areas of good practice and lessons learnt. Locally the UKHSA GAAP tool has been filled out and an action plan completed. System partners worked together to identify challenges which will be addressed as part of the action plan

Exercise Arctic Willow was a desktop tabletop exercise held between November and December 2022. The aim was to provide health and social care organisations with an opportunity to explore their response to multiple, concurrent operational and winter pressures as well as review their interdependencies with Local Resilience Forum partners when responding to such pressures. This was exercised at ICB level which allowed participants to exercise the health system structures put in place by the Health and Care Act 2022.

Environmental Hazards





Air Quality

There are an increasing number of studies documenting the impacts of manmade air pollution, including the Chief Medical Officer's annual report 2022: air pollution. The Royal College of Physicians has estimated that air pollution contributed to 40,000 deaths a year and cost the Health Services and Business through treatment, sick days etc is more than £20 billion.

The air quality in Wiltshire is predominantly very good however there are currently eight Air Quality Management Areas (AQMA). These are areas where significant pollution has been identified and plans are put in place to improve the air quality. These are marked on the map to the left.

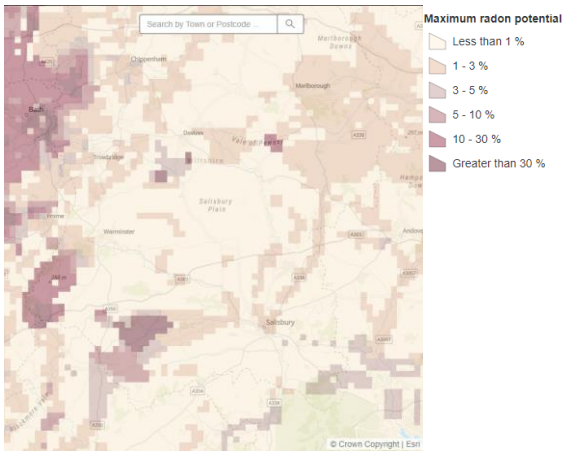
The specific actions being taken in these towns is detailed in Wiltshire's Air Quality Action Plan. This is currently being reviewed and following public consultation, a new version will be published in late 2023/early 2024.

The strategy for Wiltshire Council's approach to improving air quality across the whole area and not just within AQMAs can be found in the Air Quality Strategy for Wiltshire 2019-2024

Wiltshire's total concentrations of particulate matter where particles are less than 2.5 micrometres in diameter (fine particulate matter) has been dropping over the last 4 years and is close to the England average (left). The environmental targets (fine particular matter) regulations 2023 set out targets to be achieved by the end of 2040.

Private water supplies

A private water supply is any supply of water, intended for human consumption, which is not provided by a water company such as Wessex Water, Thames Water or Southern Water. There are around 650 registered private water supplies in Wiltshire. The quality of these water sources is more difficult to control and they are more vulnerable to contamination. The council carries out monitoring and risk assessments of the private water supplies to ensure they are potable and fit for human consumption

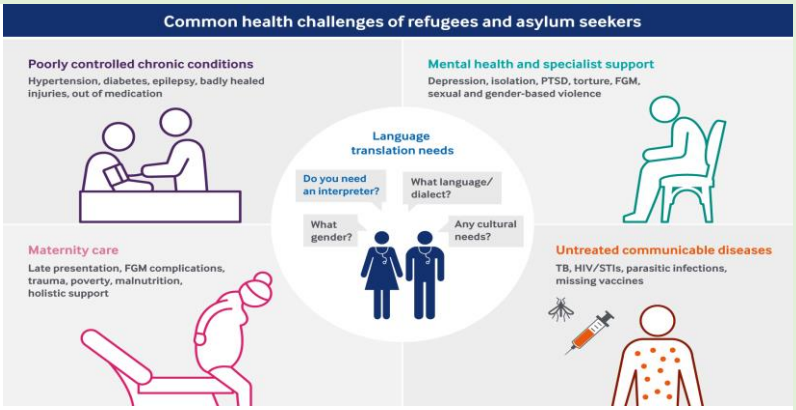


Radon

Radon is a colourless, odourless radioactive gas. It is formed by the radioactive decay of the small amounts of uranium that occur naturally in all rocks and soils. Any exposure to this type of radiation is a risk to health and this occurs where the gas can build up in buildings and voids. There are a few minor hotspots for radon in Wiltshire but generally radon levels are low and the risk to health is small. A monitoring kits can be ordered from the UKHSA at this link https://www.ukradon.org/services/orderdomestic. The radon potential for Wiltshire is shown to the left.

Migrant Health

In all four nations of the UK, refugees and asylum seekers with an active application or appeal are fully entitled to free NHS care. The situation for refused asylum seekers is more complicated and is not the same across all nations.
Refugees, asylum seekers and refused asylum seekers can register for and receive primary and secondary care free of charge in the same way as any other patient in any nation of the UK.



Taken from: Unique health challenges for refugees and asylum seekers - Refugee and asylum seeker patient health toolkit - BMA

Refugees and asylum seekers may arrive in the UK with poorly controlled chronic conditions such as diabetes and hypertension, usually as a result of long periods without access to regular care. Some patients may have old injuries that have not healed properly. These can cause chronic pain or disability. Untreated dental and eye issues may also cause discomfort or impairment.

Refugees and asylum seekers can be at increased risk, particularly if they have experienced violence and trauma, including exploitation, torture or sexual and gender-based violence. Issues can range from low to moderate levels of anxiety and depression through to more severe mental disorders.

Health Protection

Ideally refugees and asylum seekers and other migrants should have their vaccination histories recorded and any missing vaccinations should be offered to children and adults based on the latest UK immunisation schedule.
Screening for infectious diseases that are common in the countries where patients have spent time before coming to the UK is also important. For example screening for tuberculosis (TB), hepatitis B and HIV. The UKHSA Migrant Health Guide includes a section on common communicable diseases and other health issues by country.

Focus on health inequalities - why migrants don't access healthcare

- Fear of being charged for care
- Fear and lack of trust in the health professional NHS and Government
- Fear of information being shared with the Home Office
- Language barriers
- Practical problems reaching healthcare – inaccessibility/cost of public transport
- No access to a telephone / Wifi to make appointments
- Registering with a GP practice with no fixed abode

A large influx of people with complex health needs can put pressure on the local health system.

Through 2022 there was an increase in the numbers of migrants in Wiltshire, the Homes for Ukraine scheme launched on 14th March 2022 and by early February 2023, 1345 Ukrainian guests had arrived in Wiltshire.

The Hong Kong British National (Overseas) (BN(O)) visa route opened in January 2021 and Wiltshire has an estimated over 300 visa holders as of early 2023.

There are Afghan families living in bridging accommodation in an hotel in Wiltshire as part of the Afghan Citizens Resettlement Scheme (ACRS) and Afghan Relocations and Assistance Policy (ARAP). This hotel remains open at the end of 2022 and health protection has liaised with the migration and resettlement team case workers to have targeted conversations, signposting and help to make appointments on a range of topics including:

- Immunisations – including delivery of COVID-19 and influenza vaccinations
- Screening programmes – particularly cervical screening
- IP&C and advice related to COVID-19
- Sexual health

There was a 33% increase in asylum applications to the UK between March 2022 and March 2023, likely to be due to the continued global increase in the number of people displaced due to war and conflict. It became necessary for the Government to source and use additional temporary accommodation such as hotels to ensure the Home Office can continue to meet statutory obligation to provide support to asylum seekers. In December 2022 a contingency spot hotel opened in Royal Wootton Basset opened housing up to 70 single males. These residents are registered with local health services.

Diphtheria

Over the course of 2022 there was an increase in cases of toxigenic *Corynebacterium diphtheriae* reported among asylum seekers arriving in the UK. Whilst many cases originate from diphtheria endemic countries it is likely that the cases acquired their infection either in their country of origin or on their extended journeys to the UK through Europe. In addition to the guidance on management of cases of diphtheria in asylum seeker accommodation settings in England mass antibiotic prophylaxis and vaccination was recommended for those resident in, or previously resident in, initial reception centres where significant barriers to individual targeted case and contact management have been identified (such as challenges with contact tracing, testing and prophylaxis). This was completed as part of the initial health screening for this cohort of people resident in the Wiltshire contingency accommodation.

Recommendation

Continue to provide information, signposting and intervention from health protection in the Afghan bridging hotel and contingency hotel

Gain assurance the health of the population in both hotels is protected

Seek out links into other migrant populations to understand inequalities in accessing health services and information, particularly routine immunisation and screening programmes.

Summary of recommendations

Recommended Actions	Timeline
Immunisations	
Continue to engage with the school aged immunisation provider and NHSE to understand areas in Wiltshire where uptake is lower and explore engagement opportunities.	2023 – 2024
At the end and start of school years continue distribute information and engage with key school years around catch up vaccinations, including Fresher's events.	July – October 2023
Explore Wiltshire data and method of delivery of pertussis vaccination in Wiltshire (GP vs antenatal) with the aim of understanding any inequalities or areas of low uptake.	2023
Work to encourage pregnant women to take up the offer of a flu vaccination. Understand routes of communication to under 65s 'at risk' and promote the benefits of flu vaccination to this cohort.	September – December 2023
Investigate data streams for social care flu vaccine uptake	2023-2024
Promote the benefits of COVID-19 vaccination to those defined as 'at risk' and understand any barriers or lack of confidence.	2023
Continue to monitor uptake of covid vaccination, particularly in the 5-11 cohort.	2023
Continue to gain assurance that BCG vaccinations are being given to those babies eligible when born in the UK in a timely manner	Ongoing
Continue to develop a pathway for children under 16 who are eligible to receive screening for latent TB and a BCG vaccination	January – July 2023
Screening	
Understand the inequalities data around cancer screening programmes for Wiltshire and where barriers may exist, particularly for cervical screening which remains below the national standard. Consider a health equity audit	2023-2024
Use data already compiled to focus on uptake in the most deprived areas of the county	Ongoing
Continue to gain assurance that screening programmes are meeting the needs of the Wiltshire population	Ongoing
Continue to seek assurance that residents of Wiltshire have access to non-cancer screening services.	Ongoing
Gain understanding from providers and NHSE on specific inequalities work in Wiltshire and where there maybe opportunities to support and promote.	2023

Recommended Action	Timescale
Communicable diseases	
Promote signs and symptoms of meningococcal disease and measles to those most at risk, particularly using fresher's events and the end and start of terms.	2023
Support public protection with messaging about food hygiene as one way to reduce GI infections.	2023
Continue to support vulnerable settings, particularly care and education settings with infection prevention and control to reduce the burden and transmission of infectious diseases, particularly gastrointestinal and acute respiratory infections	Ongoing
Gain assurance that migrants are being screened for active TB on arrival	2023
Gain assurance there is a process in place for migrants who enter the country via unofficial routes to access active TB screening and that health professionals are recognising and referring suspected cases promptly.	2023-2024
As a system, work to investigate a route of latent TB screening and subsequent follow up for those Wiltshire residents eligible, including migrant populations, this links to priority 2 of the TB action plan for England, 2021 to 2026	2023-2024
Ensure roles and responsibilities of outbreak management and communications are clear amongst partners and the internal team, reflecting changes since the COVID-19 pandemic response	2023
Explore sexual health data for Wiltshire to understand inequalities, particularly in relation to STIs	2023-2024
Monitor acceptance of HIV testing data on reasons for refusal.	2023-2024
Scope out whether data is available on the demographics of people using HIV services to start to understand inequalities.	2023
Consider enhanced engagement with women and heterosexual men about HV testing.	2023-2024
Continue to gain assurance of Wiltshire resident's access to hepatitis pathways via operational delivery networks (Thames Valley, Wessex and Bristol and Severn)	Ongoing
Investigate timely Wiltshire or regional specific data for hepatitis testing and treatment	2023-2024
Continue to work within public health and wider partners, including commissioned drug and alcohol services to improve harm reduction, testing and access to treatment and to reduce inequalities for the most vulnerable populations	2023 onwards
Investigate reasons for a continued decline in the proportion of 15-24 year olds screened for chlamydia	2023

Monitor the chlamydia detection rate in Wiltshire and investigate reasons for a slower recovery than that of England.	2023-2024
Investigate reasons for a slower recovery of STI testing in Wiltshire compared to national figures,	2023
Determine if inequalities data is available for chlamydia screening	2023
Migrant Health	
Continue to provide information, signposting and intervention from health protection in the Afghan bridging hotel and contingency hotel	Ongoing
Gain assurance the health of the population in both hotels is protected	Ongoing
Seek out links into other migrant populations to understand inequalities in accessing health services and information, particularly routine immunisation and screening programmes.	2023-2024

Appendix 1 - COVID-19 key events in 2022

January	
2nd 	Face masks advised in secondary schools following Christmas holiday
5th 	Plan B measures extended for a further three weeks due to prevalence of Omicron variant. Anyone testing positive for COVID with a lateral flow test but no symptoms, no longer required to do a follow up PCR test but are required to self-isolate for seven days.
7th 	Travel rule changes: those fully vaccinated no longer required to take a COVID test before travelling abroad. Anyone arriving in England who has had both vaccines, not required to self-isolate while waiting for PCR result.
17th 	Period of self-isolation following a positive COVID test cut to five days
27th	Plan B measures lifted and returned to Plan A – bringing an end to mask mandate, COVID passes at venues/events and guidance on working remotely.
31st 	Plans for introduction of legal requirement for frontline NHS staff to be vaccinated by 1 April scrapped. Children aged 5–11 years considered at risk from serious illness with COVID-19, become eligible for their first vaccine.
February	
11th 	Double vaccinated people arriving in England no longer required to take COVID tests.
21st 	Living with COVID-19 document released outlining government's plan. Removal of guidance for staff and students in most education and childcare settings to undertake twice weekly asymptomatic testing.
24th 	As per living with COVID-19 guidance: Removal of legal requirement to self-isolate following a positive test. Fully vaccinated close contacts and those aged under 18 no longer required to test daily for 7 days and no requirement for not fully vaccinated contacts to self-isolate, Routine contact tracing ended and both national and local Test and trace stepped down. End of self-isolation support payments. Removal of additional local authority powers to tackle local COVID-19 outbreaks (No.3 regulations).

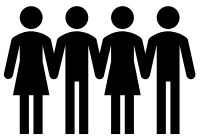
Appendix 1 continued - COVID-19 key events in 2022

March	
15th 	Lifting of mandatory COVID-19 vaccination for care home workers in England.
18th 	The last coronavirus-related legal restrictions in effect in England are revoked
21st 	NHS England launch Spring Booster Programme, for over 75s, residents in care homes, and clinically vulnerable.
24th 	Removal of COVID-19 provisions within the Statutory Sick Pay and Employment and Support Allowance regulations.
April	
1st 	As per living with COVID-19 guidance: Mass free COVID symptomatic and asymptomatic testing ceased, moving to a targeted offer for at-risk groups. Removal of recommendation for venues to use the NHS COVID Pass Removal of the health and safety requirement for every employer to explicitly consider COVID-19 in their risk assessments. Consolidation of COVID-19 guidance for the public and businesses and Adult Social care COVID supplement guidance introduced.
4th  	Demobilisation of testing sites in Wiltshire. COVID-19 vaccines rolled out for those aged 5-11 years.
September	
5th 	Autumn 2022 COVID-19 booster programme begins.
October - December	
	Wiltshire's outreach vaccination clinics commence reaching a range of population groups including boaters, manual workers, homeless/ rough sleepers amongst others. 12 clinics between October and December and 1,246 COVID-19 vaccines administered. Bath Racecourse mass vaccination site closes in December 2022

Appendix 2 – Routine Vaccination Schedules in England

Vaccines for babies under 1 year old	
Age	**Vaccines**
8 weeks	6-in-1 vaccine Rotavirus vaccine MenB vaccine
12 weeks	6-in-1 vaccine (2nd dose) Pneumococcal vaccine Rotavirus vaccine (2nd dose)
16 weeks	6-in-1 vaccine (3rd dose) MenB vaccine (2nd dose)

Vaccines for children aged 1 to 15	
Age	**Vaccines**
1 year	Hib/MenC vaccine (1st dose) MMR vaccine (1st dose) Pneumococcal vaccine (2nd dose) MenB vaccine (3rd dose)
2 to 10 or 11 years	Children's flu vaccine (every year until children finish primary school)
3 years and 4 months	MMR vaccine (2nd dose) 4-in-1 pre-school booster vaccine
12 to 13 years	HPV vaccine
14 years	3-in-1 teenage booster vaccine MenACWY vaccine



Vaccines for adults	
Age	**Vaccines**
50 years (and every year after)	Flu vaccine
65 years	Pneumococcal vaccine
70 to 79 years	Shingles vaccine

Appendix 3 – Vaccines available for pregnant women

Vaccines for pregnant women	
When they are offered	**Vaccines**
During flu season	Flu vaccine
From 16 weeks pregnant	Whooping cough (pertussis) vaccine

Appendix 4 – Autumn/Winter 2021/2022 Influenza vaccine cohorts

	Influenza 21/22
	Cohort
	All children aged 2 to 15 on 31st August 2021
 **50+**	people aged 50 years or over (including those becoming age 50 years by 31 March 2022)
	those aged 6 months to under 50 years in clinical risk groups
	pregnant women
	those in long-stay residential care homes
	carers
	close contacts of immunocompromised individuals
	frontline health and social care staff employed by: • a registered residential care or nursing home • registered domiciliary care provider • a voluntary managed hospice provider • Direct Payment (personal budgets) and/or Personal Health Budgets, such as Personal Assistants.

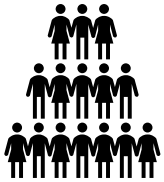
[ARCHIVED CONTENT] National flu immunisation programme 2021 to 2022 letter - GOV.UK (nationalarchives.gov.uk)

Appendix 5 – Autumn/Winter 2022/2023 Influenza vaccine cohorts

	Influenza 22/23
	**Cohort**
	all children aged 2 or 3 years on 31 August 2022
	all primary school aged children (from reception to year 6)
	secondary school-aged children (focusing on years 7, 8 and 9 following the primary school vaccination visits with any remaining vaccine being offered to years 10 and 11, subject to vaccine availability later still in the season)
	those aged 6 months to under 65 years in clinical risk groups
	pregnant women
 65+	those aged 65 years and over
 50+	later in the season; those aged 50 to 64 years old not in clinical risk groups (including those who turn 50 by 31 March 2023). Providers are asked not to start vaccinating this age group until mid-October 2022 to enable prioritisation of those with clinical risks and in the older age groups
	those in long-stay residential care homes
	carers
	close contacts of immunocompromised individuals
	frontline staff employed by the following types of social care providers without employer led occupational health schemes: o a registered residential care or nursing home o registered domiciliary care provider o a voluntary managed hospice provider o Direct Payment (personal budgets) or Personal Health Budgets, such as Personal Assistants

[ARCHIVED CONTENT] National flu immunisation programme 2022 to 2023 letter - GOV.UK (nationalarchives.gov.uk)
[ARCHIVED CONTENT] Statement of amendments to annual flu letter – 21 July 2022 - GOV.UK (nationalarchives.gov.uk)

Appendix 6 - Eligibility for COVID-19 autumn booster 2021/22



After initial roll out to priority cohorts it was announced in November 2021 that the NHS has been asked to offer every eligible adult over the age of 18 a booster vaccination by 31 December.
Those aged 16-18 with an underlying health condition that puts them at higher risk of severe CCOVID-19

Appendix 7 - Eligibility for COVID-19 spring booster 2022

Adults aged 75 years and over - This includes those who turn 75 years old by 30th June 2023 who will be eligible for a vaccination at any point in the campaign.
residents in a care home for older adults
individuals aged 12 years and over who are immunosuppressed, as defined in the Green Book
Those who are admitted to an older adult care home or become immunosuppressed by 30 June should be considered eligible as well.

Appendix 8 - Eligibility for COVID-19 autumn booster 2022/23

residents in a care home for older adults and staff working in care homes for older adults
frontline health and social care workers
all adults aged 50 years and over
persons aged 5 to 49 years in a clinical risk group, as set out in the Green Book
persons aged 5 to 49 years who are household contacts of people with immunosuppression
persons aged 16 to 49 years who are carers, as set out in the Green Book

Appendix 9 – Eligibility for screening programmes

Screening	Cohort	Frequency	Delivery
Cancer Screening			
Bowel	58 years to 74 years Extension to 50, 52 and 54 years old planned in the years ahead	Every 2 years	Home testing
Breast	Registered with a GP as female and aged between 50 and 71.	Every 3 years	Breast screening clinic within a hospital or mobile breast screening unit
Cervical	Women and people with a cervix aged 25 - 64	Aged 25-49*– every 3 years Aged 50-64* – Every 5 years *Frequency can increase dependent on results	GP Surgery or sexual health clinic in some situations
Non-cancer screening			
Abdominal aortic aneurysm	Men during the year they turn 65	One off but can be repeated based on the result	Delivered through locations throughout Wiltshire including GP surgeries and hospitals
Antenatal	Pregnant women	Each pregnancy	Maternity services (pregnant women in Wiltshire could attend clinics by RUH, GWH or SFT)
Newborn	Various points from birth to 6-8 weeks of age	N/A	Maternity services and GP practice
Diabetic Eye	Aged 12 and over with diabetes	Annually	Delivered through locations throughout Wiltshire including GP surgeries and hospitals

Appendix 10 – Gastrointestinal illness in Wiltshire

The table below shows rates of illness (per 100,000 population) for Wiltshire (darker green) and the South West region (lighter green). This data is from routine surveillance reports and subject to change and does not represent official UKHSA statistics. It is a way of looking at trends.

Causative Agent	2020-Q2	2020-Q3	2020-Q4	2021-Q1	2021-Q2	2021-Q3	2021-Q4	2022-Q1	2022-Q2	2022-Q3
Campylobacter	22	30	29.8	23.8	41.7	38.5	28	21.6	35.3	34.3
Campylobacter SW	20.2	27.4	25	20.9	40.2	36.8	28.3	24.2	33.4	31.9
Crypstosporidium	1.4	2.2	3.2	2.8	1	2.2	2.4	1	0.8	2
Crypstosporidium SW	1.2	2.2	2.5	1.7	2	2.5	2.9	1.7	1.6	2.6
E.Coli STEC	0.4	1.4	0	0.2	0	0.8	0	0	0.2	0.8
E.Coli STEC SW	0	0.1	0	0	0.1	0.1	0	0	0.1	0
Giardia	1	1	1.6	1.2	0.4	1.8	1.2	0.8	2.8	1
Giardia SW	1.7	2.2	1.6	1.3	1.6	2.2	2.3	2.2	1.7	2.7
Salmonella Enteriditis	0.6	0.8	0.4	0.2	0	0.8	0.6	0	0.2	1.6
Salmonella Enteriditis SW	0.4	0.6	0.3	0.3	0.1	0.4	0.3	0.3	0.8	1.2
Salmonella Typhimurium	1	1	1	0	0.4	1.8	0	0.2	0.8	1.4
Salmonella Typhimurium SW	0.5	0.8	0.5	0.1	0.8	1.1	0.5	0.5	0.7	1.5
Shigella	0	0	0.2	0	0	0	0.6	0	0	0.2
Shigella SW	0	0	0	0.1	0.1	0	0.4	0.3	0.4	0.4

Appendix 11 - Eligibility for mpox vaccination in England

Eligible Cohort	Doses
Healthcare workers caring for patients with confirmed or suspected mpox	2 doses
Men who are gay, bisexual or have sex with other men and who have multiple partners, participate in group sex or attend sex on premises venues (staff at these venues are also eligible)	2 doses 2nd dose offered from 2 to 3 months after the 1st dose
People who have been in close contact with someone who has mpox	1 dose within 4 days of contact (ideal) OR 1 dose within 14 days

This page is intentionally left blank