Bath and North East Somerset,
Swindon and Wiltshire Partnership

Working together for your health and care

NHS

Shaping a Healthier Future Engagement Report

February 2022

Contents

1. Introduction

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

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

2. Aims of engagement

1.	To raise awareness and inform local population about the BSW Partnership, why we need a health and care model and what it means for local people and communities.

2.	To have a two-way dialogue with stakeholders about the key principles that underpin the health and care model to understand the barriers to access and the impact of these, particularly on those most affected by health inequalities.

3.	To provide details to the public of how they can keep involved in the work going forward.

3. Approach

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

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

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

3.1 Engagement with those experiencing health inequalities

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

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

3.2 Children and Young People

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

4. Results

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

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

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

4.1 Social Media campaign results

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

4.2 Survey responses

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

Survey Responses

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

Not at all important	Not very important	Neither important nor unimportant	Quite important	Very important

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

3% | 7% | 32% | 58%

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

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

3% | 28% | 68%

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

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

4% | 27% | 68%

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

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

6% | 30% | 62%

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

Survey Responses

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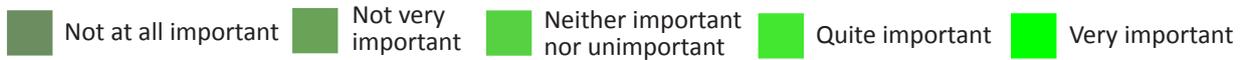
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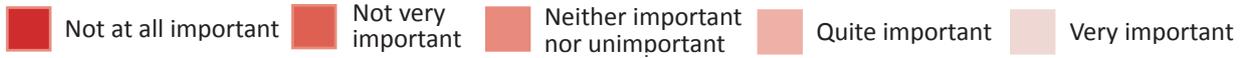
6% | 30% | 62%

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

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

Legend: Not at all important | Not very important | Neither important nor unimportant | Quite important | Very important

We will build communities up by working with their strengths
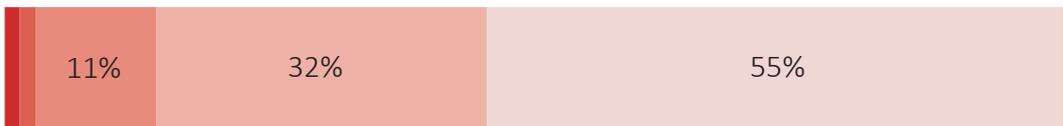3% | 16% | 40% | 40%

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

Health and care professionals will be able to refer people to a range of local, non-clinical services that will enable people to take more control of their own health
8% | 39% | 51%
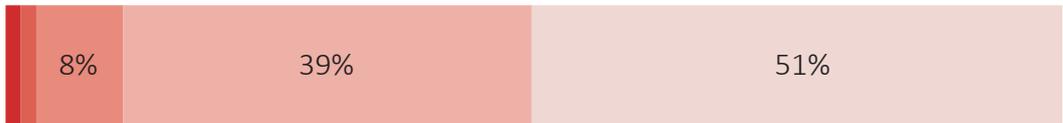
In this reponse, 'Not at all important' scored 1%, 'Not very important' scored 1%. The combined total for 'Quite important' and 'Very important' is **90%**

Local health and social care teams will have access to good data about the communities they work in so they can provide proactive support to communities and individuals so they can maintain good health and wellbeing.
11% | 32% | 55%

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

We will work to prevent illness and reduce health inequalities in all our communities
4% | 24% | 72%

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

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

Legend: Not at all important · Not very important · Neither important nor unimportant · Quite important · Very important

When people need health or care support local teams with NHS, local authority and third sector members will work together to provide that support.
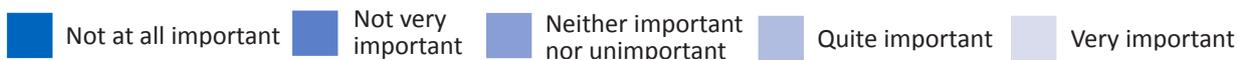
5%	31%	62%

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

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

7%	36%	56%

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

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

4%	26%	70%

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

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

More specialist services will be available closer to where people live

| 7% | 35% | 56% |

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

We will make more use of community locations like public buildings and high streets to provide access to information, appointments, group sessions, tests and treatments.
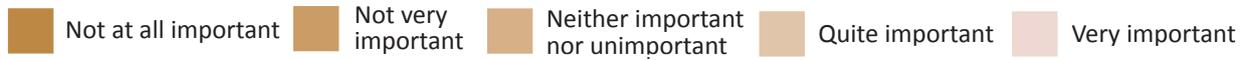
| 9% | 42% | 46% |

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

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

| 4% | 7% | 15% | 42% | 32% |

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

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

Legend: Not at all important | Not very important | Neither important nor unimportant | Quite important | Very important

As more services are available online and in community locations, our NHS, local authority and third sector specialist centres will be able to focus more on providing specialist care.
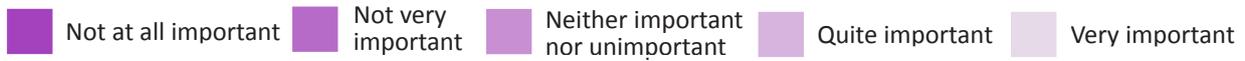
| 12% | 48% | 35% |

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

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

| 7% | 36% | 55% |

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

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

| 8% | 36% | 54% |

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

4.3 Combined survey, workshop and interview results

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

4.3.1 Understanding of the model

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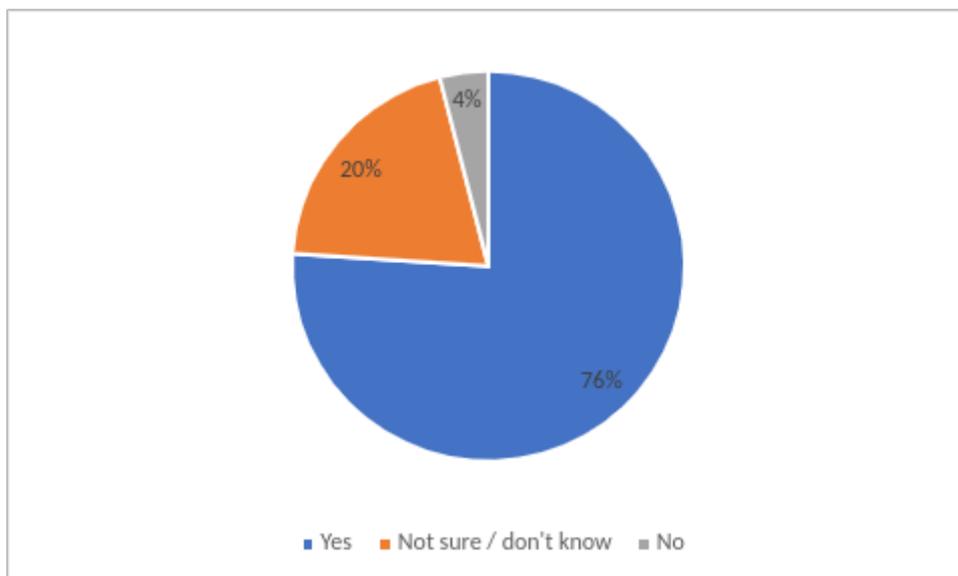
Comments

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

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

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

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

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

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

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

4.3.2 How respondents would rate the model

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

Comments

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

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

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

4.3.3   What is missing from the model?

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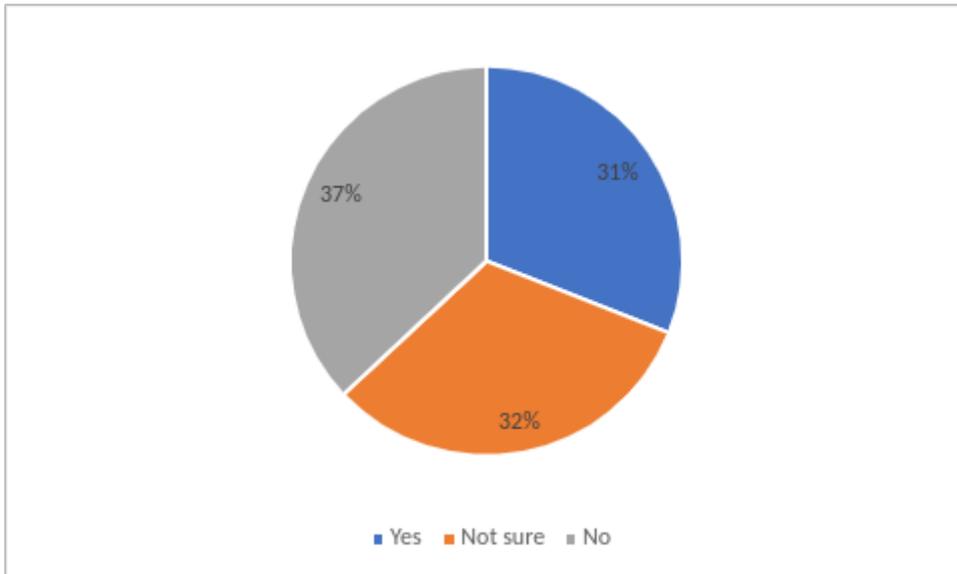
Comments

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

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

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

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

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

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

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

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

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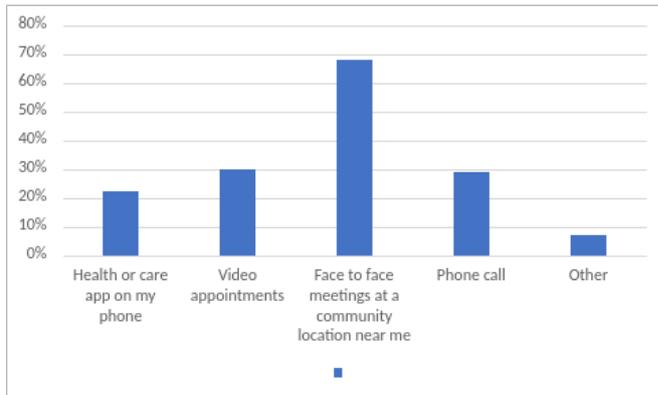
Comments

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

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

4.3.5 Importance of personalised care

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

Preferred method of communication:

Level of comfort/discomfort with a digital approach:
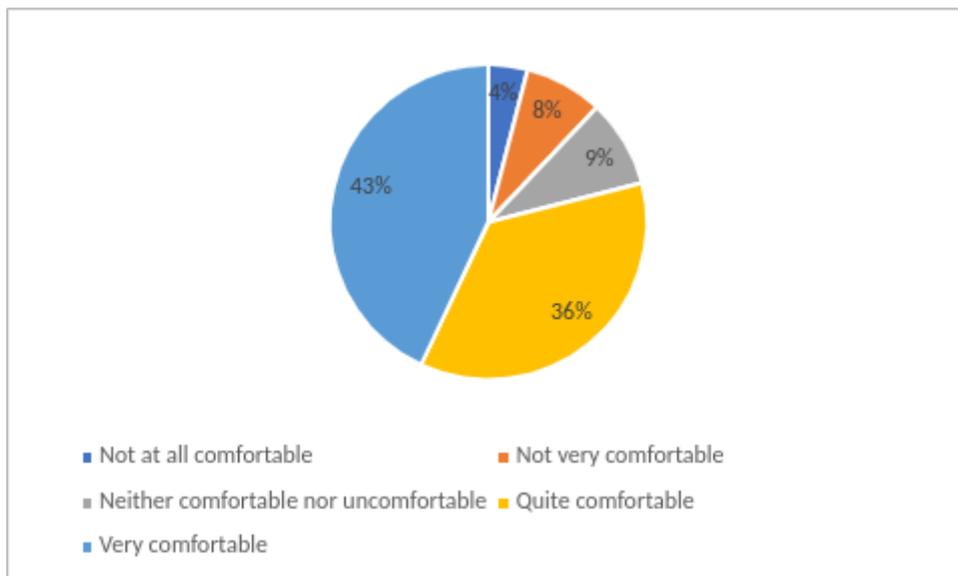
Comments

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

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

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

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

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

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

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

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

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

4.3.6 Empowering people to live their best lives

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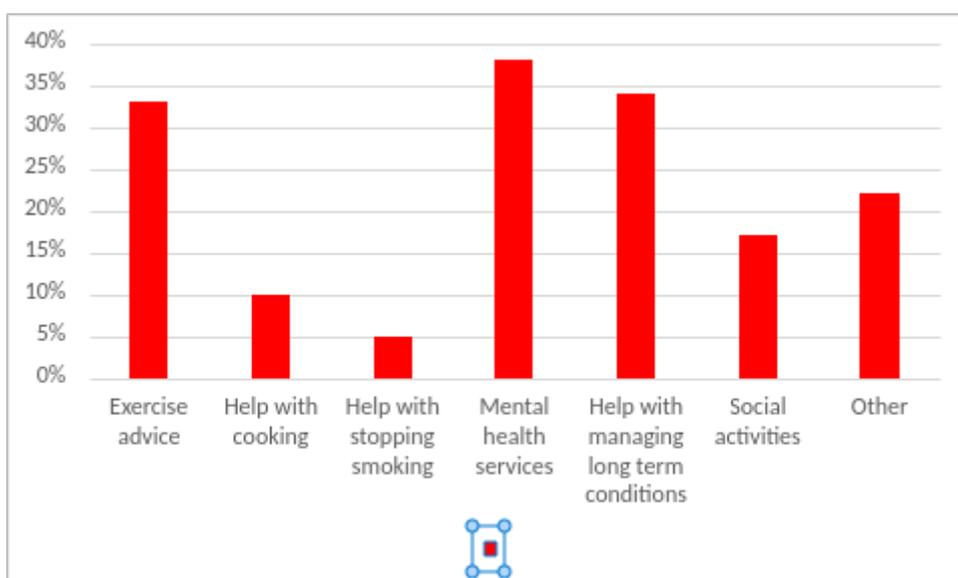
Comments

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

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

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

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

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

4.3.6 Services closer to home

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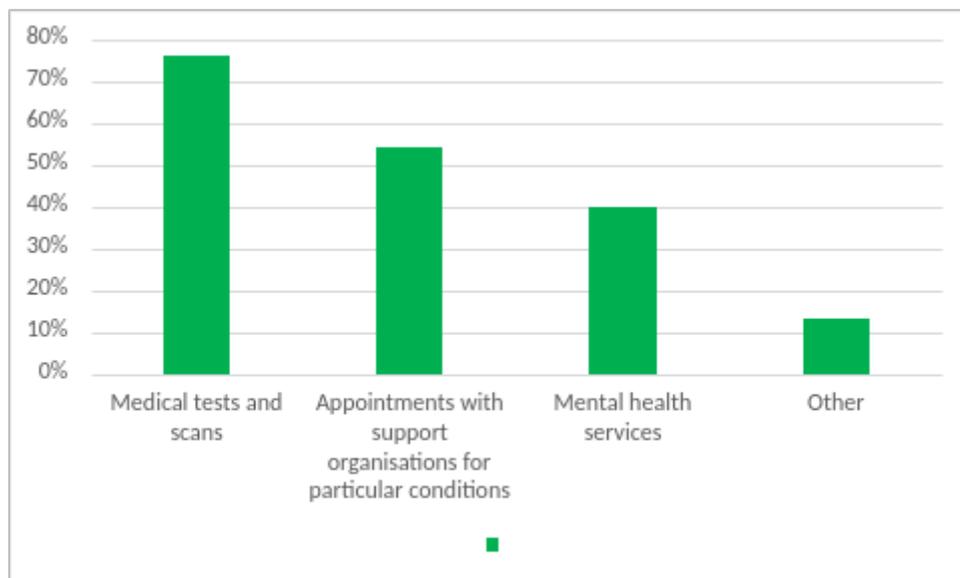
Comments

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

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

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

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

4.3.7 Impact of changes

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

Comments

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

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

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

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

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

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

4.3.8 Additional feedback

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

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

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

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

5. Main themes

5.1   Data sharing

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

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

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

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

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

5.2   Health inequalities / inclusion

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

5.3   Finance

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

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

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

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

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

5.4 Integration

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

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

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

5.5 Access to GPs and other services

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

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

Department attendance."
Survey Response

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

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

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

5.6   Personalisation

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

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

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

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

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

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

5.7 Workforce

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

5.8 Specialist Centres

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

5.9   Mental Health

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

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

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

6. Recommendations for changes to the model

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

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

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

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

1.   The aim was achieved of gathering a snapshot across the BSW region from a variety of people who use services, staff, the public and seldom-heard groups about what they thought of the health and care model.

2.   A wide range of individuals and staff from organisations across the BSW areas and from a wide variety of communities of interest were spoken to during the six-week engagement period.

3.   A number of people experiencing health inequalities were spoken to in spite of obstacles such as Covid-19, timescales and limited capacity for co-operation from some VCSE sector organisations.

4.   There was good co-operation and working together of the Shaping a Healthier Future engagement planning team from the Engagement and Communications team at the CCG, RUH and Commissioning Support Unit.

5.   Some VCSE sector organisations were very keen and enthusiastic about getting involved and giving their views and enabling staff and people who use their services to attend workshops and interviews. This will form a good springboard for the development of a cooperative working relationships going forward and should enable future engagement and co-production activities to be easier to arrange.

6.   A number of organisations and communities were really pleased and grateful that they were being asked their views and that someone was taking the time to ask their opinions, for example refugees and the Polish Consul.

8. What could be improved about the engagement project?

1.   It was agreed that 6-weeks was a proportionate amount of time for the engagement period, given that the focus was on checking if the principles that drove our model were still the correct ones. However, the challenge of running engagement in a pandemic meant that more planning time would have been useful as many organisations felt they had insufficient time to gather staff or people who use services for a workshop.

2.   Some VCSE organisation leaders wanted to find out for themselves what we were talking about before they would consider involving people who use their services. This restricted the amount of time that was then available for direct engagement with their networks or supporters. There was an underestimation of the administrative time required to coordinate interviews and workshops with the VCSE sector organisations. Lack of pre-existing relationships with

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

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

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

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

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

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

9. Engagement project recommendations

1. Revise health and care model in line with recommendations in section 6.

2. Disseminate new model and engagement report to public and those who participated in workshops, presentations and interviews and those who completed the survey and left their contact details. Include how we are using their insights and aspirations for services to inform the health and care model and how we deliver services in the future.

3. Undertake a gap analysis of which groups were not adequately represented during this stage of engagement to ensure they are engaged with going forward.

4. Develop engagement strategies and a co-production approach (including co-production workshops) tailored for all relevant audiences including the public, staff, vulnerable groups and VCSE sector to support future service and pathway changes and transformational projects that arise from adaptation the model. Building on the relationships already established and developing from initial engagement period. Workshops to be sector and location specific.

5. Ensure regular updates (6 and 12 months) on how the health and care model is being applied and how people can get involved. Ensure a constant cycle of communication and involvement opportunities to develop and maintain trust, involvement and community 'buy-in'.

6. Develop greater, wider and much closer links with the VCSE sector for example through attendance at 3SG, Wessex Community Action meetings but also maintaining and building on the relationships developed thus far. Building on existing good will make it easier to progress future engagement activities effectively.

7. Ensure adequate planning time for future engagement and that the length of engagement is proportionate. A longer lead-up time would give an opportunity to pilot the survey with a small sample to test for any biases before a full survey goes live and also to enable pre-conversations to occur with participating organisations.

8. Ensure easy read / translatable / audio versions of engagement materials are ready to ensure full participation of all vulnerable groups.

9. Create a database of the individuals and organisations who were involved (those interviewed, attended workshops and left their contact details on the survey). Also those organisations who weren't able to be involved but who expressed interest in being informed / involved in the future. It will then be possible to refer back to these organisations/ individuals for future involvement around model. A system needs to be in place to ensure this database is kept up to date.

10. Operational leads and commissioners start to use the health and care model to design new services and pathways across all areas of health and care.

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

10. Conclusion

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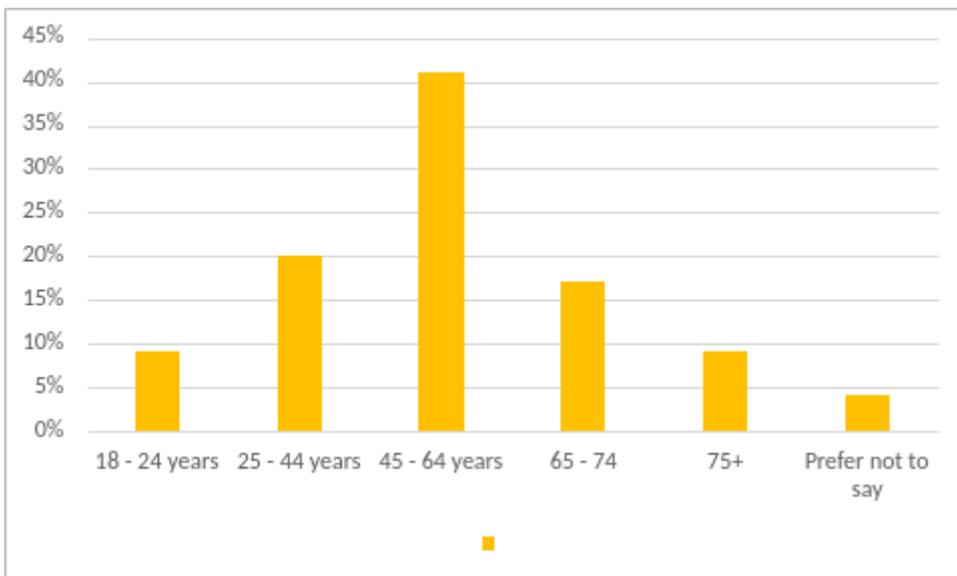***Survey Response***

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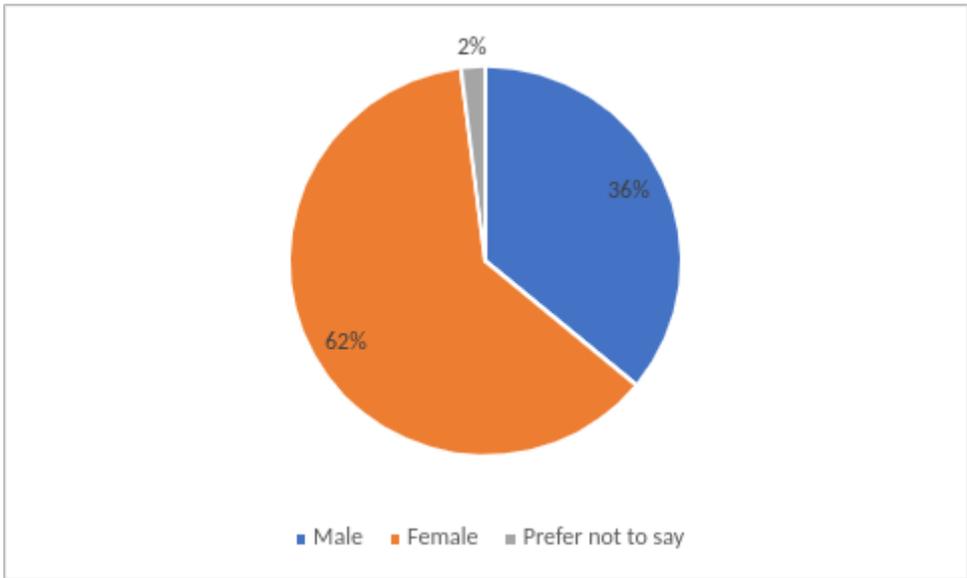
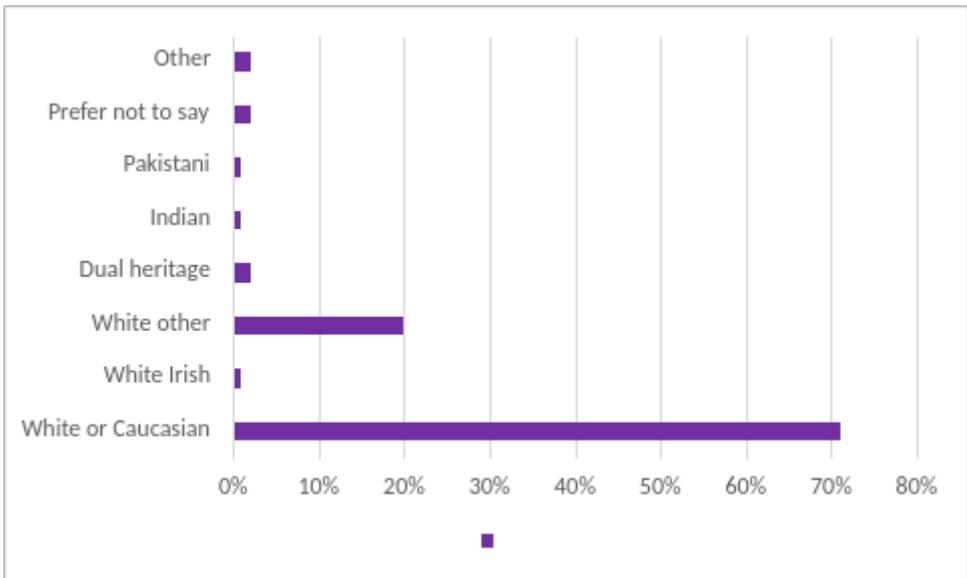# 11. Appendix One

Breakdown of survey respondents by area
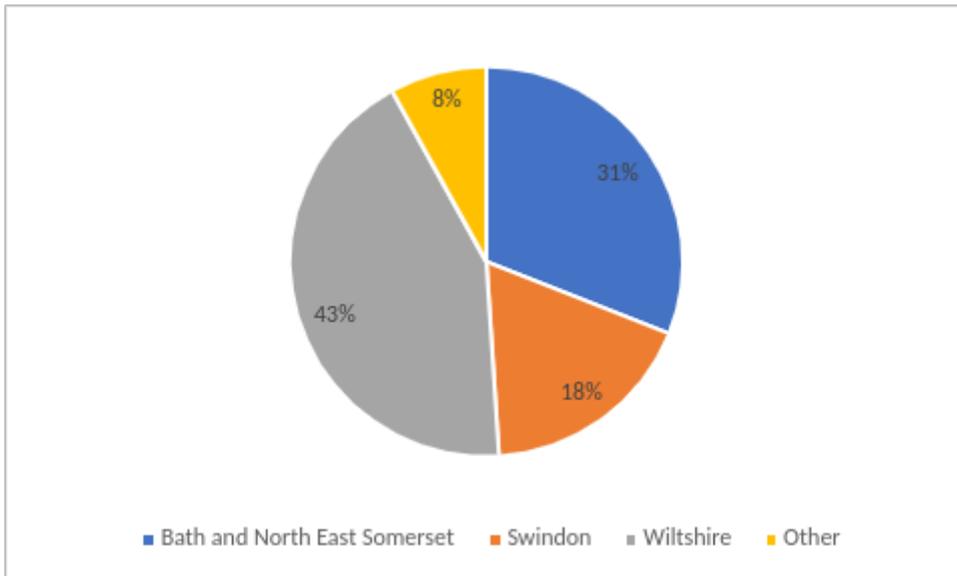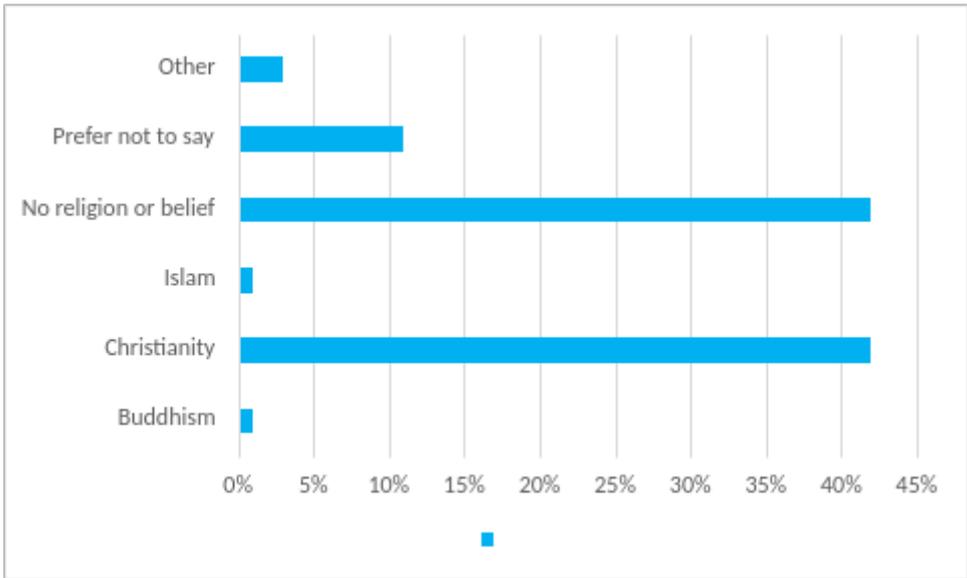

Breakdown of survey respondents by age
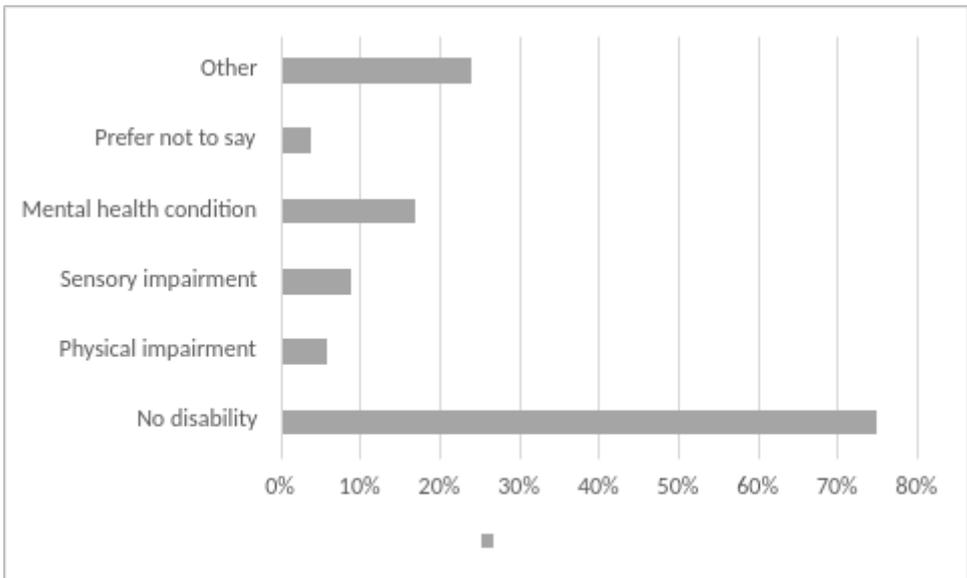

Breakdown of survey respondents by gender

36%
62%
2%

■ Male ■ Female ■ Prefer not to say

Breakdown of survey respondents by ethnicity

Other
Prefer not to say
Pakistani
Indian
Dual heritage
White other
White Irish
White or Caucasian

0% 10% 20% 30% 40% 50% 60% 70% 80%

Breakdown of survey respondents by religion or belief

Breakdown of survey respondents by disability

12. Appendix Two

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

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

13. Appendix Three

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

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

14. Appendix Four

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

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