Wiltshire Council

AGENDA SUPPLEMENT (1)

Meeting: **Health Select Committee**

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

Date: **Tuesday 1 November 2022**

Time: **10.30 am**

The Agenda for the above meeting was published on *24 October 2022*. Additional documents are now available and are attached to this Agenda Supplement.

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Press enquiries to Communications on direct lines (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

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7 **Winter Pressures Preparedness** *(Pages 3 - 12)*

8 **Wiltshire Neighbourhood Collaboratives** *(Pages 13 - 34)*

9 **Mental Health Community Service Framework** *(Pages 35 - 48)*

10 **Learning Disabilities Mortality Review** *(Pages 49 - 60)*

11 **Report of the Rapid Scrutiny Exercise: New Health Overview and Scrutiny Principles Document** *(Pages 61 - 72)*

DATE OF PUBLICATION: 28 October 2022

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

Wiltshire ICA Partnership

Winter Plan up-date to Health Select Committee

October 2022

Content

Across Wiltshire we have developed an urgent care improvement plan, pulling together all our actions that will support urgent care and flow. We continue to develop and review this plan.

This presentation will cover

- An overview of the current system urgent care and flow challenges
- Provide a summary of the Wiltshire approach, our key Wiltshire Winter Plans for 2022/23 and share our risk assessment
- BSW ICB has also taken a whole system approach to winter planning and there are 3 system wide plans in place for 2022/23
- NHSE Letter published on 19 October 2022 ‘Going Further on our winter resilience plans’ – summary of the additional requests we are now working on

Wiltshire – Locality System Urgent Care and Flow Overview

Sector / Area	Challenges and Overview
Acute Trusts	Link to all 3 discharge teams via weekly operational calls – Tuesday and Thurs and daily flow calls.
Emergency Departments	Very challenged EDs, regularly treating numbers of people the department was not designed to manage. HALO at front doors
Community Services including hospital beds	Delays in discharging from CH beds, but maintaining good flow through the beds. Limited impact from Covid infections.
Home First, Reablement and Care at Home	Since April 2019, Home First and Reablement have expanded to provide c200 POCs per week, from a previous average of 90-95. This is despite increasing size of the packages and complexity. 18% readmission rate across the acutes and community hospitals within 28 days of discharge.
Residential and Nursing Care Homes	Care Home closures due to COVID significantly impact flow on flow. New care home pilot ongoing – establishing new model of delivery to provide flexible use of beds, whilst reducing numbers and cohorting staff, to reduce LOS.
Domiciliary Care	Rurality remains a significant challenge in sourcing home care – costs for rural delivery are very high and often unable to source. Scare domiciliary care workforce means increasing 'handbacks' of care – high risk for individuals and increases Brokerage team demand.
Ambulance Delays and Delayed Handovers	Ambulance delays significant at RUH Bath, and also higher then previously seen at GWH and SFT. Significant impact on ambulance services response times.
Care Coordination	Single Point of Access – with Medvivo. Opportunity to look again at provision. Medvivo already provide for Wiltshire a significant element of the Care Coordination and need to develop this within the BSW wide plans.

Wiltshire Approach to 2022/23 Winter plan

Bath and North East Somerset, Swindon and Wiltshire Partnership
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BSW Key Line of Enquiry	Response
Who has been involved in your 22/23 plans?	Plans developed via the Wiltshire Operational Group which includes partners from Council, Wiltshire Locality (ICB), WH&C, UEC team, SFT & RUH,VCSE Partners including Carer Support Wiltshire.
What Lessons learnt from last year and have been built into this year's plans?	• Focus on fewer projects to deliver impact • Clarity on anticipated outcomes and measurables • Build on existing processes rather than establishing new routes – consistency is key • Agree a single version of the truth – we now have one Wiltshire plan • Release as much clinical / professional time as possible to support service delivery. • Focus on admission avoidance where possible • Scope for additional staffing is limited with long recruitment and lead-in times
What is your locality's plan for oversight of delivery, performance and escalation?	• Twice weekly Operational Delivery Group meetings – attended by broad discharge services partnership. • Weekly Partner Calls (leadership) – focusses on coordinating resources to resolve identified challenges. • Bi-weekly Alliance Delivery Groups • Option for daily escalation calls and ICA escalation process agreed

Wiltshire 8 Key Winter Plans

Bath and North East Somerset, Swindon and Wiltshire Partnership
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Plan	Impact	Funding source
Surge beds commissioned in care homes (BSW Funded)	**30 additional care home beds** remain open for 2022/23	BSW ICB non-recurrent
Additional domiciliary care hours – this is in addition to the recruitment of staff into Wiltshire Support at Home	**750 hrs** - 80% availability. 480 600 hrs - support about 26-32 people.	BCF non-recurrent funding
Retained the additional care homes beds and funding for spot beds	40 to 70 additional beds, dependent on number of spot beds in use	BCF non-recurrent funding
Additional staffing in council brokerage team and Wiltshire Health and Care Flow Hub.	Support efficient processes in Wiltshire.	BSW ICB non-recurrent
Reablement additional staff – range of council posts to support flow	Improved flow through home pathways and reduced LOS through D2A homes.	BSW ICB non-recurrent
Wiltshire's Carers Liaison Service – agreed in Q4 2021/22 delayed starting due to recruitment. Started on 1st October 2022.	Impact on speed of discharge, staff allocated to each acute Trust for Wiltshire residents.	BSW ICB non-recurrent
New model for Pathway 2 Beds – testing started 1st September in South Wiltshire	Reduce LOS and support flow with more clients able to return home after a period of rehabilitation in a care home.	BCF recurrent funding
VIRTUAL WARDS – implementation of an agreed BSW model across Wiltshire. To commence from November.	10 bed equivalents in December to increase as staff are recruited.	National transformation funding – within BCF

These plans are in addition to other services implementation started for last year: Wiltshire Support at Home, 2 hr Rapid Response health and care and Overnight Nursing service. All of these continue to develop

Wiltshire Risks and mitigations

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Constraint / Risk	RAG	Mitigations
Scarce domiciliary care resource– in some areas of Wiltshire (South and rural) this picture is more challenging; reduction in care provision capacity impacts on experience and quality of care when people are delayed in their discharge. It also impacts hospital flow.	Amber	Work through how families can contribute to providing care (link with DC comms) Ensure staff on wards understand the use of single handed equipment <need for DH care (Link to D/C comms) South Newton beds and Surge Bed capacity
Cost of locums increasing so backfill costs becoming unaffordable – the risk is that we will not be able to utilise as much agency support, further limiting capacity and potentially safety.	Red	Building Bank capacity locally.
COVID and Flu and seasonal infection – impact on staff and provider capacity – this particularly impacts Pathway 2 capacity which we know severely impacts flow when care home closures increase.	Red	Vaccinations on site for staff Promotion of uptake in vaccinations. POST team supports care homes to open as soon as possible.
Cost of living – impacting recruitment into the care market and family support etc.. Impact on dependency and possible increase in attendances. *30% increase in homelessness applications (large number >65yrs). Impact of people being in temporary accommodation means if they are admitted to hospital people will not be well enough to go back to their accommodation.*	Amber	Food banks in consideration for discharge. Cost of living payments Council co-ordination of a response to be supported by partners e.g. Hot hubs
Funding – ability to provide recurrent resources into services – some services (reablement and flow hub) are funded by non-recurrent funding.	Amber	Financial planning at scale/ secure sustainable resourcing of schemes. Plans in development to review impact and risks around these services.
St**aff sickness and wellbeing**, impact on mental health	Amber	Support networks & Wellbeing Hubs, enabling staff to access these.
Increase of POCs handed back by Dom Care providers due to affordability and staffing gaps – additional pressure on care market and staff, reduces flow.	Red	Surge beds still in place (30) and South Newton beds opening Nov 22.
Recruitment of staff for South Newton is likely to impact on the ability of Salisbury-centred services to recruit staff (all searching in the same pool)	Red	Aligned and collaborative recruitment plans to jointly recruit – (does not include SN provider).

BSW System key winter plans

Bath and North East Somerset, Swindon and Wiltshire Partnership
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There has been agreement by the ICB Board to support 3 key winter plans for 2022/23.

1. **Winter Community Hospital Ward**, St Martins in Banes – an additional community ward will open as BSW capacity. Managed by HCRG in Banes. Opening

2. **South Newton Hospital** – Funded to open 57 winter beds, 35 beds in November 2022. Wiltshire Council on the steering group.

3. **Care Co-ordination approach** and setting up a **winter control room** to co-ordinate system information across partners. These are in development currently.

The implementation of virtual wards is also being co-ordinated across BSW, with implementation at place.

BSW Partner Actions in BSW winter plan

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For example

Mental Health providers (from the BSW Winter plan)

- **Community Wellbeing Houses**
- Existing community Wellbeing Houses in Wiltshire will be fully operational during the winter period. These will operate at 90% occupancy in line with NHSE standards. We have also invested in an additional 2 beds within one of our Wiltshire Wellbeing Houses to mitigate risks associated with our B&NES Wellbeing House not being fully operational until Q1 2023/24.

- **Places of Calm in person evening support**
- Places of Calm have increased capacity available to support service users in person in the evening period. As a result, we will increase the number of appointments available from 107 to 203 (increase of 96) per week for people requiring this service.

- **Outreach provision**
- Third sector providers are delivering an intensive outreach offer which we will continue throughout the winter period. This team provide support to enable early appropriate discharge, offering help to manage tenancy and mental health needs in the community.

Other plan areas – Primary Care, Infection Control, Workforce

National Winter Letter - 19 October

Bath and North East Somerset, Swindon and Wiltshire Partnership
Working together for your health and care

Going further on our winter resilience plans – Amanda Pritchard

This includes;

- **£500m fund to recruit and retain more care workers and speed up discharge.** Details pending on this, anticipated to come via the better care fund.

- **A focus on falls and developing a clear community response** – This is a pathway supported in Wiltshire via the 2hr Urgent response service and by Medvivo currently.

- **Address unwarranted variation in ambulance conveyance rates in care homes** working collaboratively with care homes to identify and access alternative interventions and sources of support.

- **Consider targeted, proactive support for people who have high probability of emergency admission**, sometimes called High Frequency Users. Wiltshire already has a service in place delivered by Wiltshire CIL

Work has started to review the letter and ensure in place in Wiltshire and BSW, using our existing planning approach.

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Wiltshire Alliance

Neighbourhood Collaboratives

Programme Update – v2. 06.10.22

Why are we working towards Neighbourhood Collaboratives?

- Improved population health and wellbeing outcomes
- Addressing local concerns and priorities
- Opportunity to be led by the people who live and work in our neighbourhoods
- Longer term vision and change – sustainable and meaningful
- Alignment with the Fuller Stocktake report
- PCN Network DES 2022 ; Tackling Neighbourhood Health Inequalities
- Making better use of resources – integrated working and effectiveness
- Supporting our workforce – effectiveness and wellbeing
- Alignment with our Health and Wellbeing strategy and the BSW Care Model

What are Neighbourhood Collaboratives?

What they are / will be

- Offer of a supported mechanism to drive change
- Informal but structured – this might be different for each Collaborative
- Inclusive groups bringing together a wide variety of partners
- Evolving over time - sustainability
- Supported by data and information and driven via a PHM approach
- Encouraging of community involvement
- Community asset based
- Opportunities to connect work across the system

What they are not / won't be

- Performance managed / PM tools
- Contracted
- Mandated – both in terms of establishing or structurally
- Unstructured – need to be clear about governance and decision-making
- Regulated
- Independent organisations / structures /employers
- Spaces to undermine other groups / existing projects or work
- Vehicles to drive all the system work

Principles Behind The Development of our Model

- Partnership working – solving problems together
- Data-based. Population-health approach to target solutions against need
- Communicating clearly and articulating what we are working on so people can engage and use their strengths
- Bringing to the fore some of the problems we have and building consensus and a movement for change.
- Prioritising neighbourhood working – and seeing Primary Care as integral to our approach.
- Co-production
- Work we can only do if we do it together

Neighbourhood Collaborative Model

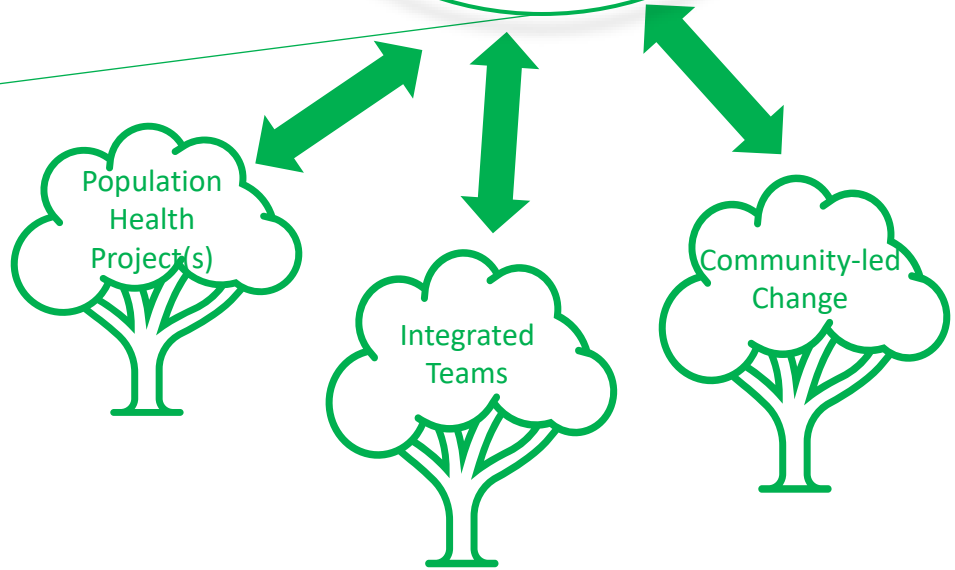
BSW Programmes and Regional Forums
Links with Health and Care Senate, Wiltshire Programme Board etc…
Learning and Sharing beyond Wiltshire borders

Wiltshire Neighbourhood Collaborative
Learning and Sharing across Wiltshire and between Collaboratives, Focussing on Population Health and Wellbeing Gaps across Wiltshire.
Links with Health and Wellbeing Board

Learning and Sharing Between Collaboratives

Neighbourhood Collaborative

Most work will be community driven – some change Wiltshire -wide



Objectives 22/23

1. To establish three Neighbourhood Collaborative sites - April 2023 (possibly broadening across Wiltshire and working with BSW colleagues to review synergies across the system).

   - Governance and membership in place, having undertaken data and listening exercises and commenced at least 1 population health and wellbeing-led project.

2. To develop and offer a Readiness Review to facilitate the development of the Neighbourhood Collaboratives by those living and working within each PCN footprint – Oct/ Nov ‘22

3. To provide additional support and advice via a series of launch/ induction events offered to those steering the project within the Neighbourhoods – Oct/ Nov ‘22

4. To develop and offer a toolkit of supporting resources and information for use by each collaborative.

5. To establish the Wiltshire Collaborative as a connecting, learning and sharing forum.

6. To ensure that a reporting/governance model is in situ to support the improvement process – Oct/Nov ‘22

To roll out the improvement work to facilitate 13 neighbourhood collaboratives to establish themselves across the footprints of the 13 PCNs - 2024

Progress Against Objectives

Ref	Objective	Progress	Next Steps
1	To establish three Neighbourhood Collaborative sites - April 2023 - *Governance and membership in place, having undertaken data and listening exercises and commenced at least 1 population health and wellbeing-led project.*	Salisbury (both PCNs), and Devizes PCNs have agreed to participate in the programme and have been updated on progress. Trowbridge has participated in the pilot and is well place to continue. Other PCN areas are very interested and have approached us. Interest across BSW also.	- Developing wider partnership in each neighbourhood, bringing more partners into the programme. - Agree induction programme dates and who will participate – part of this will be about sustainable commitment. - Continue to engage with neighbourhoods across Wiltshire. - Agree initial group formats and membership. - Consider how to expand the programme beyond 3 initial sites so everyone can start together.
2	To develop and offer a Readiness Review to facilitate the development of the Neighbourhood Collaboratives by those living and working within each PCN footprint – Oct/ Nov '22	Readiness Review document currently in draft format and ready for pilot stage for feedback. This is not a yes / no but develops an action plan for each neighbourhood of gaps to work on and builds on strengths already in place.	Share Readiness Review and pilot with a PCN for feedback and co-development. Use Readiness Review as part of launch programme and include in toolkit.
3	To provide additional support and advice via a series of launch/ induction events offered to those steering the project within the Neighbourhoods – Oct/ Nov '22	Programme development nearing completion - currently in first draft stage. 6 sessions – can be offered weekly or on a longer term. Scalable to work with many collaboratives at the same time.	Finalise induction programme and review via Steering Group Ensure input from Alliance partners and neighbourhoods themselves. Agree dates and book sessions – explore whether there is interest from other areas in BSW.
4	To develop and offer a toolkit of supporting resources and information for use by each collaborative. This includes access to data and tools to interpret, support with community listening and improvement methodologies.	Toolkit is being drafted – this will map to the areas of the Induction Programme and the ICA NC Model Listening model developed via Connecting with Our Communities programme. ICB-developed data tools now available – linked to the launch programme and toolkit. Improvement resources section in draft.	Complete development list Need to review via Steering Group and finalise content Agree who will participate (data and comms in place) Pilot resources and gather feedback to inform what needs to be included. Formalise links with CWOC and Council Listening Programme
5	To establish the Wiltshire Collaborative as a connecting, learning and sharing forum.	Likely to be held early 2023. Based on previous Professional Leadership forum. Ideally in person but may have virtual engagement facility. This space is to connect, share, learn and progress our collaboratives.	Work with incoming HCPD to develop this further – plans include inviting other systems and areas to share their progress and learning as well as locally. * Develop clear comms and engagement plan.l
6	To ensure that a reporting/governance model is in situ to support the improvement process – Oct/Nov '22	Both at programme and neighbourhood level. Aligned to the Alliance model – may look difference for each neighbourhood.	This is part of the structure development and the induction process.

Programme Enablers

- Identify and brief programme SRO – Clare O'Farrell confirmed as SRO, briefing 6/10/22
- Establish Steering Group – including widening the partners currently 'at the table' – to act as connecting links to partners, and drive progress, approving milestones etc…
- Establish programme management system – including risks and milestones, EQIAx
- Identify supporting resources across the system and programme points of contact
- Establish information sharing and learning platform – Glasscubes?
- Develop and implement communications and engagement plan.
- Develop and agree tests of change – specific to each neighbourhood.

Steering Group?

Representative organisation/service	Potential named reps
Programme Director Equality, Innovation	Massimo Morelli
Area Boards – Wiltshire Council	Representation confirmed – named reps to be agreed
Wiltshire Council Social Care	Council colleagues to be requested to offer representation.
Public Health	To be confirmed – links to Public Health Team and Community Conversations
Wiltshire Council – Library Services	To be confirmed
Healthwatch	Catherine Symington
Primary Care	Nick, Catrinell, Sam Domini
VCSE	Request to be made via Alliance Leadership Group
Acute Trust -?Strategy Teams	Request for representation from Acute Alliance?
AWP	Request representation
Safeguarding	Wilts locality team rep ? Colette O'Neill
WHC	WHC colleagues to be requested to offer representation.
CYP	Representation to be sought via Children's Board
Police	Police colleagues to be requested to offer representation
Fire	Fire colleagues to be requested to offer representation
Education	Education colleagues to be requested to offer representation
Housing	Housing colleagues to be requested to offer representation
Environment	Environment colleagues to be requested to offer representation
Community Groups	Lived experiences to represent to experiences and views from our community
Area Boards	Rich Rogers – to be confirmed

Steering Group invitations to be issued by November 2022

The Steering Group will be supported by an operational group / Task and Finish Group structure, to be confirmed.

What we did in our ICA development session

We heard from Optum who have been supporting the Integrated Care System with developing capacity and capability for Population Health Management. The presentation and slides with embedded video is available to access here: https://wiltshireccg.glasscubes.com/share/s/vlb6h9b1pbuikq0cnaeet1d36f

The early learning from the Trowbridge Neighbourhood Focus Site project about their population health management pilot work. This prompted a rich discussion about our ways of working together. The presentation is here: https://wiltshireccg.glasscubes.com/share/s/tdrs6c0nc9hmvkbnvf7r0ro103

We were shown how the BSW system is developing tools and capability to embed population health management and these as support for localities and neighbourhoods. We had a live system demonstration and a discussion on the development path. The slides are available here: https://wiltshireccg.glasscubes.com/share/s/k8uqsk86f10nk2vpjvj1hs8l6o

The remainder of the session was full of rich conversation about our Neighbourhood Model 'recipe' – we talked about the key things that will be core to our Neighbourhood Model and the what else we need to agree to put in place to ensure we launch successful neighbourhood work programmes and collaboratives.

Our Neighbourhood Model

We have committed to expanding our Neighbourhood Model across Wiltshire. Although there are some ‘building blocks’ of the model, we know that each neighbourhood is different and so the model and work itself will also be different across each area.

We have a working title of “Neighbourhood Collaborative” – but our Neighbourhoods might have a better idea of what they should be called.

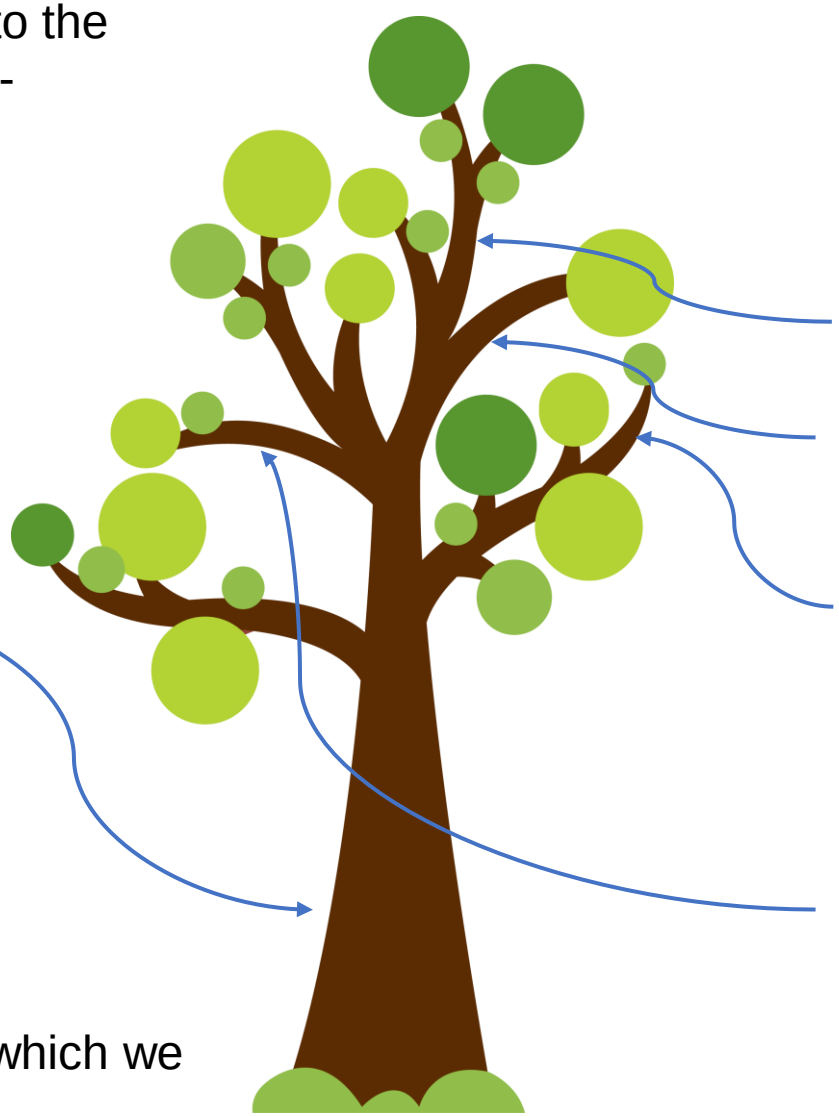
The next slides walk through our conversations and agreements about our neighbourhood way of working.

Our Growing Neighbourhood Model

There are some things that are core to the support of our neighbourhood model:-

- Data and information – BSW population health tool and local intelligence and systems
- Working in a population health focussed way
- Integrated working between teams and organisations
- Neighbourhood (PCN) level
- Community involvement
- Longer term view – months *and* years
- Inclusive partnership
- Structured, with a process and allocated time and resource
- Connected to other 'trees and gardens' to learn and share.

These are the strong foundations on which we will grow our model and expand it.



There are other things (branches) that we need to put in place for our model to grow green shoots and flourish:-

- Staff and Resources, integration and behaviour
- Community voice, comms and engagement
- Partnership working and movement for change, including wider Alliance working (housing, education, environment, leisure etc…)
- Structure, systems, process, governance

These are the things we spent some time talking about in our development session.

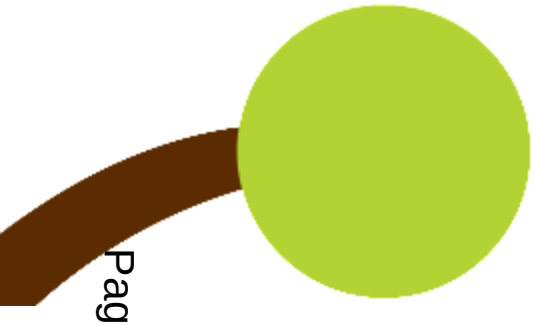
Partnership working and movement for change, including wider Alliance working (housing, education, environment, leisure etc…)

1. Identify what / who already exists in terms of data, needs, plans, organisations and stakeholders – create a ‘readiness framework / checklist’,
2. Use data and co-develop with the community – be honest, build trust and seek sustainability “we will…”, “you will…”, “together we will….”
3. Adopt the principle that ‘partners’ are there to meet need, not represent organisations
4. Identify a leadership framework including behaviours, values and accountability for the plan – to be successful everyone needs to ‘show up’.
5. Sustainability – neighbourhoods need to be clear about the story they tell, build resilience to continue even when operational challenges are significant, and resources must be shared,

Staff and Resources, integration and behaviour

1. Community-led vision and response to what the community needs (equality gaps)
2. Identify and establish expectations of anchor organisations that can help with training and supervision
3. Your neighbourhood organisations and teams have recurrent funding to support sustainable teams through reallocation of resources
4. Leaders will enable and support teams to challenge the status quo and innovate.
5. Value what matters to staff and colleagues as individuals as well as communities and people living in the neighbourhood.

Community voice, comms and engagement



1. Listen to communities and correct insights with the data and analysis
2. Understand the strengths and assets of the voluntary community sector partners and communities and champion them
3. Enable and invest in local change that makes a difference
4. Support teams, organisations and services in ‘trying’. It is OK to fail.
5. Make engagement and talking with colleagues and people working in the neighbourhood the first thing we do, not the last.

Structure, systems, process and governance

1. Nailing the Structure – learn from other ‘saplings’ and spend time on getting this right for your neighbourhood.
2. Local decision making is key – close the gap between those affected and those making decisions.
3. Governance supports us to allocate our resources around our priorities and desired outcomes.
4. Use intelligent information – embed the voices of people living and working in the neighbourhood, as well as checking that against data and information.

Themes

As well as the specific points for the development of our Neighbourhood Collaborative Model, some themes emerged which not only relate to the model, but the way in which we work together

- Community Focus Culture
- Co-design / co-development
- Funding and Flexibility
- Leadership in the context of Culture and Supporting a Community Focus
- Using data and information - Quantitative & Qualitative Data, improving our data and the way we share it, Narrative/ Evidence Based
- Personalisation

These are shown in more depth on the slides that follow

Community Focussed Culture

- Understand what strengths and resources communities have already and help them develop it further, building on what's there.
- Talking and listening to community voices is critical to understand what's important to them and what they can offer.
- Respond to what the community asks and do this by understanding community needs though local groups but ..
- Avoid the 'easy' option of limiting community connection only to VCSE partners, - many people are not connected to a voluntary sector organisation.
- Build trust with the community by "walking the walk" and bringing back evidence of the change and improvement we've made.
- Networking using alternatives to formal routes – be open to using graphics, tweets and community Facebook pages to keep communications open, responsive and accessible.
- Community desires and aspirations should influence / govern the allocation of resources.
- Recognising the range of neighbourhoods – recognise that there are all sorts of diverse areas which are valued, but work to create equity across the system.
- Remember services must be available to the whole population, we should not bespoke something so far that it is accessible only to fractions of our population.
- Recognise that disadvantage and deprivation is often located in the shadow of affluence and privilege – all neighbourhoods have health gaps to close.

Co-Design

- Create a “readiness checklist” that identifies key partners and gaps in our discussions and neighbourhood work.
- Focus on partnership working “you will, we will and together we will”.
- We should agree a blueprint designed by working in partnership, which prevents paternalism
- “Small projects working together to create ripple effect”.
- Avoid working in siloes – instead challenge ourselves to always ask who we can work with.
- As elected representatives our politicians can and should be key in representing our communities and should be part of our work – engagement with them sits alongside engagement with communities and individuals.
- Recognise different groups have different needs and different things are important to them.
- Create governance structures that don’t hinder creativity and allow for “everyone’s voice”.
- Work with ‘anchor organisations’ to bring expertise into our programmes. These skills can be disseminated out to other areas, e.g training in a particular subject could sit under one organisation but is accessible to all.

Funding and Flexibility

- Acute hospitals were acknowledged to hold the most resources. This needs to be considered as communities increase capacity and capability. While some neighbourhoods are competing for finite resource, bigger systems / structures will be asked to recognise and offer the support they can give.
- Strong sense that sustainable funding is a minimum requirement so that there is no continuous need to apply for money to do the work. Currently funds have to be reallocated to ‘urgent priorities’, putting development as risk.

Leadership

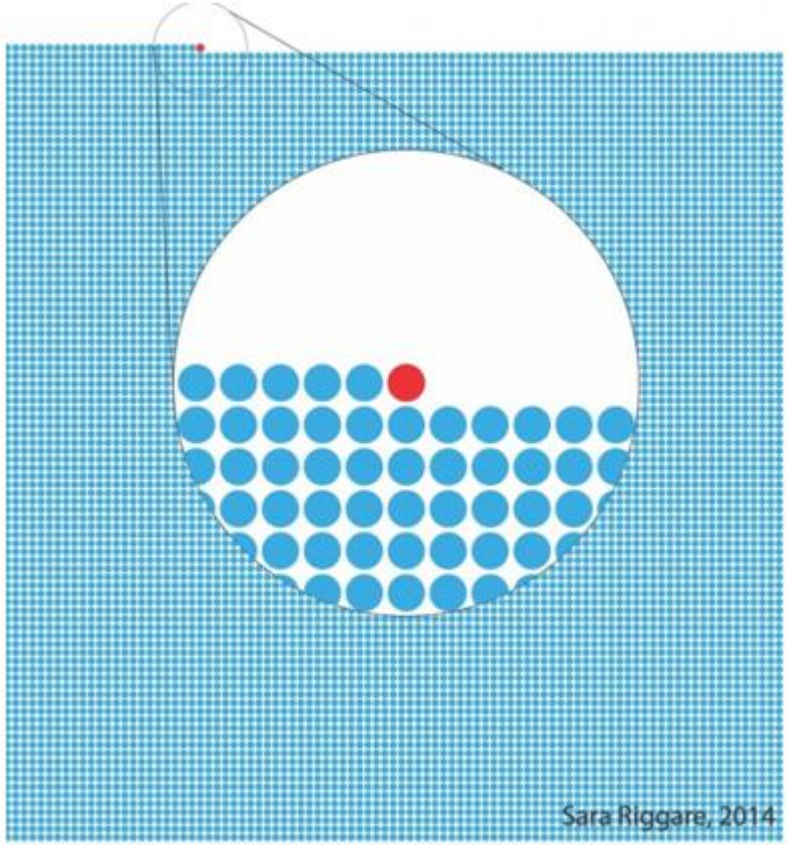
- Strong request for the creation of a leadership framework. The framework should identify behaviours and values and serve to enable a plan to be formulated and provide accountability. “Plan can be used to influence the agenda further up”.
- Leaders should offer support and can challenge strategic goals if they’re inadvertently going to create wider gaps.
- Changing the culture of working so that staff are work effectively across boundaries as a new normal. Teams should work in collaboration so that every contact counts. This will drive change as teams interconnect with others and the wider system.

Using data and information

- We must enable appropriate information sharing across our Alliance – narrative/ comms should be open and honest about our challenges and the asks within our locality. BUT
- Our comms and engagement must also “celebrate success” and recognise when we’ve done well, so sharing the experience and the learning.
- “Story Telling” is an essential tool to help everyone understand the vision and what we’re working towards.
- Using data and information intelligently – triangulating it with experience and feedback, allows us to develop a clearer and more reliable picture on which to plan and take action.

Personalisation

- Some groups discussed the importance of looking at the nature of the Neighbourhood e.g. needs of different age groups, cultural needs, religious beliefs etc –how can our work be representative of our population at neighbourhood level?
- The discussion around using evidence led to a reflection of work undertaken in Manchester to create vaccination centres and the discussions with residents to capture the needs of the people the centres would support. This work was also done in Wiltshire, B&NES and Swindon.
- Value what matters to people as individuals, some groups discussed that the ‘collection of blue dots’ matter (which represents all the interactions in a person’s day – most are ‘blue dots). Think of all the resources and data we have so that we can address issues about looking through a single red lens (red dots are the number of health or social care related interactions which are far outweighed by blue) amongst all those blue dots.



Collaboratives Pathway

Initial Stage

- Co-Develop collaborative model
- Identify possible next collaborative areas

3 Months

Preparation

- Develop and share toolkit, including readiness checklist
- Launch Collaboratives – co-design event

6 Months

Launch

- Establish collaborative neighbourhoods (further 2 in 22/23)
- Test, Learn and Share – restables Professional Leadership Network

12 Months

Expand

Expand the collaboratives across Wiltshire to include all areas.

24 Months

Wiltshire Council

Health Select Committee

Monday 1st November

Subject: **Community Mental Health Services Update**

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

Key Decision: No decisions required – supplied for information

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Executive Summary

This report is provided to the Committee for information. It summarises:

- The Community Mental Health Framework from NHS England and associated priorities
- Work underway within B&NES, Swindon and Wiltshire and anticipated impact on service users, carers and our communities
- Measuring our impact – moving from outputs to outcomes
- Leadership and governance of implementation
- Looking forward – the future for Community Mental Health Services

This report is a briefing report, however should Council colleagues wish to investigate any aspect of the report, further meetings can be scheduled accordingly.

Proposal(s)

This is a briefing paper, no formal recommendations are made to the Board however should council partners wish to receive further reports or updates, then this can be arranged.

Reason for Proposal(s)

Briefly explain the justification for the proposal.

Claire Edgar
Director of Adult Social Care

Wiltshire Council

Health Select Committee

Monday 1st November

Subject: **Community Mental Health Framework update**

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

Key Decision: **None required - supplied for information**

Purpose of Report

1. The purpose of this report is to provide an briefing to the Health and Wellbeing Board regarding the implementation of the Community Mental Health Framework (CMHF) across B&NES, Swindon and Wiltshire (BSW).

   It summarises the key features of the plan, how this is being implemented across BSW and specifically Wiltshire, and the anticipated impact for service users, carers and our wider stakeholders.

   The CMHF is a long term programme of work and its development will continue in the coming years. This report also summarises the key features of the next stages of this transformation programme and its link to the wider Mental Health Strategy for BSW.

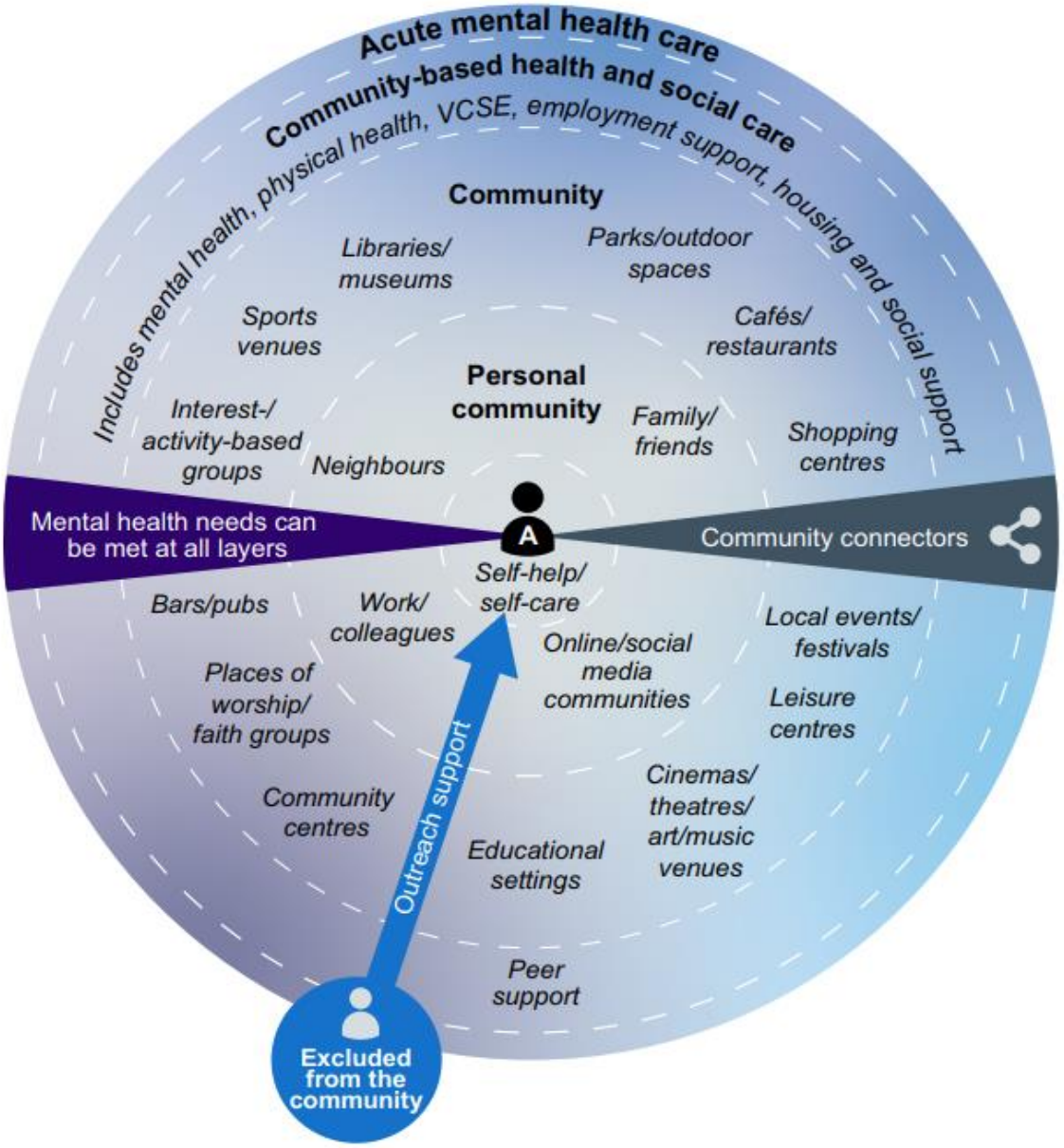
   Council colleagues are asked to note this briefing at this stage. Further more detailed updates regarding specific pieces of work can be provided at the direction of the Committee, and opportunities to do this are welcomed by all members of the CMHF Programme Team.

Relevance to the Council's Business Plan

2. The information contained within this report is relevant to:
   a. The Council's Joint Strategic Needs Assessment – we would expect that the delivery of the CMHF will have a positive impact on inequalities outlined in the JSNA
   b. The Health and Wellbeing Strategy for Wiltshire
   c. Wider Council strategies such as its Economic Strategy and implementation of Community Infrastructure Levy funding

1. The Community Mental Health Framework – National context

The Community Mental Health Framework (CMHF) was published by NHS England in 2019. It set out a new and ambitious model of mental health provision that would provide integrated community health care for people with all levels of mental illness. The diagram below sets out this vision:



The principles and aims underpinning the CMHF are set out in the statements below:

Key aims

People with mental health problems will be enabled as active participants in making positive changes rather than passive recipients of disjointed, inconsistent and episodic care. Delivering good mental health support, care and treatment in the community is underpinned by the following six aims:

1. Promote mental and physical health, and prevent ill health.
2. Treat mental health problems effectively through evidence-based psychological and/ or pharmacological approaches that maximise benefits and minimise the likelihood of inflicting harm, and use a collaborative approach that:
   - builds on strengths and supports choice; and
   - is underpinned by a single care plan accessible to all involved in the person's care.
3. Improve quality of life, including supporting individuals to contribute to and participate in their communities as fully as possible, connect with meaningful activities, and create or fulfil hopes and aspirations in line with their individual wishes.
4. Maximise continuity of care and ensure no "cliff-edge" of lost care and support by moving away from a system based on referrals, arbitrary thresholds, unsupported transitions and discharge to little or no support. Instead, move towards a flexible system that proactively responds to ongoing care needs.
5. Work collaboratively across statutory and non-statutory commissioners and providers within a local health and care system to address health inequalities and social determinants of mental ill health.
6. Build a model of care based on inclusivity, particularly for people with coexisting needs, with the highest levels of complexity and who experience marginalisation.

Alongside the redesign of core community services, NHS England also required systems to focus on improving specific pathways for people with the following conditions:

- Personality Disorders & Complex Emotional Needs
- Older Adults
- Young people aged 16-25
- Community based rehabilitation
- Eating Disorders

Building on the CMHF, the subsequently published Long Term Plan for the NHS reinforced these ambitions with new access standards and metrics.

The roadmap summary below provides a diagrammatic overview of the key features of each aspect of the CMHF and the key elements that systems would be expected to deliver by the end of 2023/24:

Dedicated focus[6]

Model development	Care provision	Workforce	Data & outcomes	CEN / 'personality disorder'	Community rehab	Eating disorders
Joint governance with ICB oversight[1]	"Must have" services[3] commissioned at PCN level tailored for SMI[7]	Recruitment in line with indicative 23/24 MH workforce profile	Record access data from new model (inc. primary, secondary and VCS orgs)	Dedicated function linked to core model: increased access to dedicated function and consultation, support, supervision and training to core model		
Model design coproduced with service users, carers & communities	"Additional" services[4] commissioned at PCN level tailored for SMI[7]	Expand MHP ARRS roles in primary care	Interoperable standards for personalised and co-produced care planning	Embed experts by experience in service development and delivery		
Integration with primary care with access to the model at PCN level[2]	Improved access to evidence-based psychological therapies	Staff accessing national training to deliver psychological therapies	Routine collection of PROMs using nationally recommended tools	Development of trauma-specific support, drawing on VCSE provision	Ensure a strong MDT approach[5]	No barriers to access e.g. BMI or weight thresholds
Commissioning and partnership working with range of VCSE services	No wrong door approach means no rejected referrals recorded	Multi-disciplinary place-based model[6] in place	Waiting time measured for CMH services (core & dedicated focus areas)	Co-produced model of care in place to support a diverse group of users	Clear milestones are in place to reduce reliance on inpatient provision	Early intervention model (e.g. FREED) embedded
Integration with Local Authority services	Tailored offer for young adults and older adults	Staff retention and well-being initiatives	Interoperability for activity from primary, secondary and VCSE services		Co-produced care and support planning is undertaken	Clear arrangements in place with primary care for medical monitoring
100% PCN coverage for transformed model	Principles for advancing equalities embedded in care provision	Dedicated resource to support full range of lived experience input	Impact on advancing equalities monitored in routine data collection		Supported housing strategy delivered in partnership with LAs	Support across spectrum of severity and type of ED diagnoses
Shift away from CPA towards personalised care	Support for co-occurring physical needs & substance use	Staff-caseload ratios to deliver high quality care				Joint working with CYP ED services including transitions
Alignment of model with IAPT, CYP & perinatal	Trauma-informed & personalised care approaches	Place-based co-location approaches				Accept self-referrals, VCS referrals and Primary Care referrals.

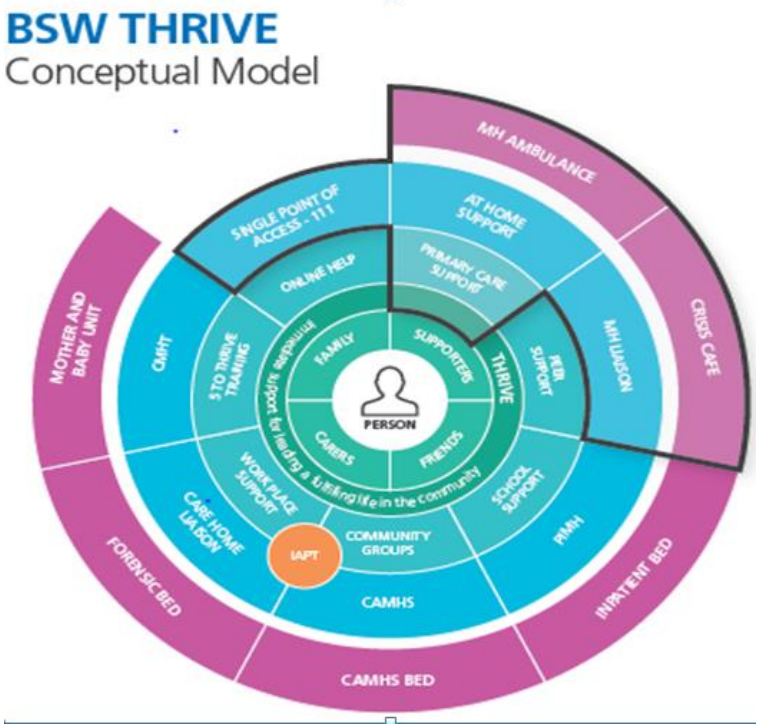
1. Governance to include commissioners, primary care (inc. PCN leadership), mental and physical health services, local authorities, VCSE, service users and carers
2. "PCN level" defined as a footprint of typically 30,000 and 50,000 people (this can also be thought of as "sub-place", "localities", or "clusters of wards"). More targeted, intensive and longer-term input for people with more complex needs can be provided at the wider community or "place" level of around 250,000–500,000 people (this can also be thought of as a "PCN-cluster")
3. Must-have: physical health checks, EIP, employment support, psychological therapies. social prescribing, personalised care planning, care coordination, peer support, outreach for inequalities
4. Additional: advocacy services, carer support, community assets, culturally competent services, financial advice, housing, social care, support groups, volunteering & education
5. Should include clinical psychologists; MH nurses; MH pharmacists; occupational therapists; primary care staff; psychiatrists; psychological therapists; social workers; community connectors; paid peer support workers
6. Systems should have commenced work on 2 of 3 dedicated focus areas in 2021/22, meeting relevant expectations. Where appropriate, aspects of core transformation model should be applied to dedicated focus areas
7. In this context 'SMI' covers a range of needs and diagnoses, including but not limited to: psychosis, bipolar disorder, 'personality disorder' diagnosis, eating disorders, severe depression and mental health rehabilitation needs – some of which may be co-existing with other conditions such as frailty, cognitive impairment, neurodevelopmental conditions or substance use

In place by end of year
In progress by end of year
Planning underway by end of year

2. Local context

In 2020/21, systems were required to produce a draft outline of their plans for implementation of the CMHF. Within BSW, we collaboratively developed our new offer, co-creating a new model of provision that would deliver earlier help and support to service users and carers as well as targeted improvements for people with more specialist needs (as outlined in the care pathways above).

Our conceptual model underpins our Thrive Strategy which not only focuses on community mental health services, but also considers wider service provision across all aspects of mental health. This is summarised in the diagram below:



As with the CMHF, we want to develop and enhance our mental health system through providing more support in the community – largely delivered by third sector organisations – with wider secondary provision then aligning with this. In making these changes, we want to keep more people living well in their communities, reducing demand for secondary mental health provision and supporting improved mental health and wellbeing for our populations.

Delivery of this model is contingent on a number of factors, specifically:

- Building and developing community wellbeing and resilience, supporting people to access community based services when they need it
- Enabling individuals to connect with one another and services, empowering them to take control of their mental health and wellbeing
- Addressing physical and mental health needs, positively reducing the impact of severe mental illness on a person's physical health
- Co-producing our new model with service users, carers and families – making sure that their lived experience underpins the changes we deliver
- Providing better and earlier support for people in crisis, enabling them to access local services to avoid admission to hospital based settings
- Through our new model, walk alongside people so that we help them to reach the support they need
- Ensure that we are making and taking opportunities to develop a new mental health workforce that is built from our collective skills and expertise
- Train wider health and care staff and people in our communities to recognise and support people with mental health needs
- Make best use of digital solutions so that people can access help and support via a range of applications and media

These are our long term strategic aims and represent the foundations of our five year strategy for Mental Health. Our CMHF implementation reflects these aims.

3. Delivery 2021/22

In order to deliver our new model of provision, we were provided with additional system investment of £5.64m (comprising uplifts to our existing baseline plus a further £1.59m transformation funding to support implementation of the CMHF).

As we moved out of the Covid pandemic, we focused on sustaining some of the changes we had made throughout Covid and implementation of our CMHF ambitions within the additional resource allocated. Key achievements are summarised below.

Core community mental health services and underpinning service model

As outlined, a feature of our new model is the development of our third sector offers, aligned with community mental health service provision, so that we deliver an increasingly seamless service for people across our communities. To that end we have:

- Established our third sector Mental Health Alliance, bringing together the skills and expertise of our core third sector providers in readiness to deliver our new 'Access Mental Health' (Single Point of Access) service. Additional funding approved for this model, recruitment commenced with postholders starting from Jan 2022. For Wiltshire, our third sector partners are Alabare and Rethink Mental Illness, both of whom are founding members of our third sector alliance.
- Invested in our third sector capacity to 'walk alongside' individuals as they progress through their individualised pathway, recruiting new staff to work with people from point of contact and into secondary mental health services where appropriate
- Completed local knowledge and engagement sessions, using the input of service users and people with lived experience to co-produce our integrated offer, building on the existing strengths and resources of both individuals and communities, including in

Wiltshire. Healthwatch Wiltshire also completed an independent review of our current methods for engaging with an co-producing our transformation plans. The outputs of this review contributed to our revised governance approach which has now been implemented across our system.

- Creating new mental health practitioner roles in primary care with a core group of seven Primary Care Networks (PCNs) that compliment and align with our developing access model. Of the PCNs choosing to take up this offer, two are in Wiltshire – Chippenham, Corsham and Box PCN and North Wiltshire Border PCN
- Improving the number of people on our GP Severe Mental Illness registers receiving holistic health checks, achieved through commissioning an external provider working in partnership with the third sector. Performance improved to 41.9% of people receiving an annual health check by the end of 2021/22
- Developing our community wellbeing houses to provide earlier support to people in crisis and to enable supported discharge from inpatient care – we have two wellbeing houses in Wiltshire provided by Rethink Mental Illness.
- Recruited to new roles in our community Eating Disorders services, including both third sector and statutory roles, to provide earlier intervention and support for people with eating disorders
- Increased capacity to support people with personality disorders/complex emotional needs – we successfully recruited two new clinical practitioners into our Wiltshire services to provide specific therapeutic interventions
- Developed our approach to transitions for young people aged 16-25, with recruitment of three new practitioners (one each for B&NES, Swindon and Wiltshire) responsible for supporting young people to transition from children and young people's services to adult services
- Increased psychological interventions for 18-25 year olds to provide earlier support for those with emerging personality disorders/complex emotional needs or who are experiencing emotional dysregulation

Although we made good progress in the first year of our development work, this was in the context of our continued pandemic response and therefore we know that progress was perhaps not as rapid in some areas as we would have wanted it to be.

A key reason for this was our ability to recruit to our planned posts – largely within AWP and Oxford Health. As with other mental health trusts nationally, both providers have been affected by the reducing number of registered mental health staff and consequently their ability to recruit to new roles. We have continued to work with both organisations to identify how we can implement innovative approaches and new roles, and this will be a feature of our future plans.

Delivery 2022/23

At the start of 2022/23, NHS England once again asked systems to set out their plans to develop and expand their community mental health provision in line with the ambitions set out in the CMHF. We have, once again, co-produced our plans with service users and carers and highlights are outlined below:

Improving access to services

Establishing our Access Mental Health service is one of our agreed priorities for this year, and we are working with third sector alliance and AWP services to develop this. This will transform our core adult community services to create a more responsive and dynamic secondary care offer that is able to respond and align with this. Key features of our plans include:

- Extending our Alliance Wellbeing Team to support PCNs and secondary care providers across BSW, providing a 7 day service comprising 22 Wellbeing Practitioners and 22 Wellbeing Peer Practitioners (2WTE / PCN). Recruitment is well underway and we are implementing revised models in all three localities, including Wiltshire

- Our new access staff will collaborate with wider third sector partners and secondary care services, drawing expertise to the service user as and when needed - including EIP, IPS, housing, social care and specialist pathway support. Early help and timely interventions will reduce the number of high intensity users, create more resilient communities and enhance community engagement.
- As part of and alongside a redesign and restructure of our PCLS and core mental health provision, increasing our senior psychology posts across our system (Consultant, Band 8A and Band 7), providing therapeutic interventions and treatment for people with Serious Mental Illness
- Levelling up our Family Therapy support in Wiltshire and providing interventions and supervision of staff already trained in this model within our CMHTs

We piloted the use of this new access model in our B&NES locality during Covid to reduce both waiting times and caseload for PCLS. During this pilot period 60 people who were on the waiting list were reviewed by our third sector team. Of these only 1 remained with PCLS and was subsequently seen in secondary services, the remaining 59 were supported by community-based alternatives and were not seen within secondary care. As a result, we have extended this pilot into Swindon and Wiltshire. We anticipate that this will have a similarly positive impact to that which was seen in B&NES, with early evidence showing that our third sector partners in Wiltshire took over 40 calls in the first week of operation. We expect that this will enable us to mitigate demand and capacity risks during the winter period. We expect that this will enable us to mitigate demand and capacity risks and, based on the evidence so far, we forecast that this could mitigate up to 10-15% of the demand on PCLS services each month.

Alongside operational capacity developments, we are also implementing our new Advice and Guidance system. We will be piloting this over this year with both signposting and advice for clinicians to reduce demand where clinically appropriate and to provide a more immediate response to clinical queries. Analysis suggests that c30% of referrals into PCLS are triaged without the need for assessment and it is this group of patients that will be targeted initially, with direct support to primary care, eliminating the need for a referral and giving timely support to service users and carers.

Eating Disorders service developments

Over the course of the coming year we will continue to recruit to new posts across our eating disorders services. Whilst we have had some challenges in recruitment, we achieved a 69% fill rate on the new workforce we had planned, with the remainder now being recruited. This will enable us to deliver the following improvements this year:

- Aligning our service offer across BSW through the common use of a digital CBT approach and shared group resources.
- Investing in the development of a FREED model to provide rapid access and early intervention for particularly our 16-25 cohort of service users, building on best practice from South London and the Maudsley (SLAM). We anticipate that this development will help mitigate current surges in demand, provide a more responsive service for this cohort of our population and improve access and equity of service for our student/young adult population

- Investing in a new physical health monitoring service for people with Eating Disorders, ensuring that co-morbid physical illness is picked up and addressed through a structured review process.

Through implementation of our new approach to Eating Disorders, we are operating an open service with no barriers to access, we are delivering early intervention and we have implemented a new approach to medical monitoring. Continued implementation of these quality improvements will provide more targeted and early support for our service users.

Personality Disorders/Complex Emotional Needs

Much of the work we have planned for this year focuses on increasing the knowledge, understanding and capacity of staff across all mental health services to support people personality disorders/complex emotional needs. To that end, we have commenced and are making good progress in:

- Rolling out a new Mentalisation Based Therapy (MBT) service in Wiltshire following successful completion of Health Education England training.
- Supported by the roll out of our new advice and guidance system – Cinapsis, we will be able to offer more advice and guidance to staff working in primary care
- Core training remains a focus of our plans, and we anticipate that as our primary care workforce expands (through ARRS workers) and we develop the role of third sector staff in multi-disciplinary teams, we will complete further training and development.

Improving services for children and young people aged 16-25

- Identify and address variation across the three BSW localities to ensure consistent representation from specialist mental health providers and the voluntary sector in Swindon, Wiltshire and BaNES.
- Working across system partners to design and document a new flexible transitions process which allows young people to remain in services beyond the age of 18.5 where this is clinically appropriate and the best way of meeting their needs, or to access adult services early.
- Delivering training across children and adult services about their respective pathways and models.
- Embedding the role of the enhanced third sector offer into the 16 – 25 clinical pathway so these services are working in partnership. This will mean that the support provided by the third sector is incorporated into care planning both alongside treatment and at the point of discharge, and that clinicians have a good and up to date knowledge of the offer.
- Creating a process for shared screening, triage and assessment of new transition cases between specialist mental health providers and the third sector. This will be done through an MDT approach across specialist mental health providers and the third sector. Initially this will focus just on complex cases, but over time it will widen to a broader remit.
- Identifying the training needs of system partners (particularly the third sector) and offering training to support them to better meet the needs of 16 - 25 year olds.
- Working with young people aged 16 – 25 to involve them further in shaping service design.

Older Adults

In our older adults service improvements, we are focusing on improving services for adults with functional mental illness (ie those people who have a diagnosed severe mental illness and who are over the age of 65) and those with dementia. The key activities we will be undertaking in year are:

- Asset mapping and gap analysis of current community support and interventions – working across B&NES, Swindon and Wiltshire
- Multi-professional Approved Clinicians in post – these are new roles which are supported by NHS England and come from all areas of practice, whether therapies, psychology or nursing.
- System agreement on a consistent prescribing formulary for dementia medication – recognising that we have different formularies across B&NES, Swindon and Wiltshire

- Review dementia diagnosis rates in primary care to understand process improvements to be made so that we can ensure that we are recording diagnosis and supporting older adults to access services for their needs
- Stratification of care home capacity to inform MDT model for the future building on pilot in Swindon

This workstream is well-supported by service users and carers, including representatives from Wiltshire.

Community rehabilitation

We agreed as a system that we would not prioritise specific work in this area this year, but that we would undertake a comprehensive review of best practice nationally, build a strong understanding of our local position and then co-develop an action plan to address this. This will be implemented in 2023/24. This work has commenced and is progressing well. In addition to this we are starting a piece of work with Local Authority partners to review our Section 117 aftercare arrangements.

Workforce

The development of the CMHF is contingent on making best use of existing and new roles across our system. Considerable work is underway across services to support this including:

- **Recruitment to Wellbeing Peer Practitioner roles** – these are new roles in our third sector services, they are integral to the delivery of our access model as outlined and are a core component of new workforce to support the CMHF
- **Developing Trainee Nurse Associates/Nurse Associates –** AWP developing these Nurse Associate roles across their services. Work continues to assess the level of Trainee and Registered Nurse Associates within services, including in BSW.
- **Registered Nurse Degree Apprenticeship (RNDA) –** an initial cohort is undertaking the accelerated two-year programme, with work underway to assess the prospects to support further applicants. This includes recruit-to-train initiatives.
- **Mental Health Wellbeing Practitioners (MHWPs)** – after recruiting an initial cohort of MHWBPs work is underway to recruit more MHWBP colleagues across AWP services. These roles are a key element of our changing community services as the community mental health framework is taken forward; MHWBPs provide wellbeing-focused psychologically informed interventions and coordinate care plans for adults with severe mental health problems.
- **Multi-Professional Approved Clinicians** (MPAC) – AWP's initial cohort of MPAC trainees are now well into their training, having started in the training programme in June 2022. An approved clinician is a mental health professional able to take certain decisions under the Mental Health Act; this programme enables clinicians from several different professions to train to become MPACs, supporting services, which may be struggling to recruit sufficient doctors.
- **Physician Associates** – Physician Associates (PAs) are healthcare professionals with a generalist medical education who work alongside doctors, providing medical care as an integral part of the multidisciplinary team. PAs work under the supervision of a doctor but can work autonomously with appropriate support. Work is underway to introduce Physician Associate roles into a number of our services.
- **Clinical Associate Psychologists** (CAP) – AWP colleagues in BSW currently have three trainee CAPs nearing qualification. Further trainees will be added this year to add to the psychological professional workforce and increase capacity for psychological therapies across the system.

We have a newly established Mental Health Workforce Planning Oversight Group in place where we review these initiatives, share learning and experience and consider how we can further transform our workforce to deliver the aims and objectives of the CMHF.

Measuring our impact

In addition to planned service improvements, we are required to develop a new approach to measuring our impact – using a new outcomes framework and methodology. We have been working with colleagues in Bristol, North Somerset and South Gloucestershire (BNSSG) ICS to co-develop our outcomes framework. Given that much of the data covers adult services provided by AWP which spans both BSW and BNSSG, bringing together the two systems will ensure that we are making efficient use of our business intelligence resources and ensure that there is a pan-Trust approach to measuring outcomes.

Access to early support and treatment	People will receive first contact from Access services within 24 hours
	People will have to wait a maximum of 4 weeks from initial contact to evidence informed treatment
	People will access the right support first time: • % of people accessing advice & guidance (reducing referrals into secondary MH care) • Patient survey
	Supporting metrics: • How many people needed access to a service (i.e. total referrals)? • How long did their support last (i.e. length of treatment)? • How many people are still awaiting first contact (i.e. waiting list size for assessment)? • How many people are still awaiting start of their treatment (i.e. waiting list size for treatment)? • How many people are still receiving treatment (i.e. the active caseload)?
People will experience equal access to support	Programme of work to test equity of service for all, aiming to answer key questions: • Do rates of service request mirror those of the population being served? • Is a timely response for assessment and treatment provided equitably for all groups? • Is the range of treatment options offered the same for all groups? • Are the outcomes achieved the same for all groups?
People will receive support aimed at preventing crisis episodes and avoidable harm	People will be supported by their community mental health team, reducing their use of other services • How many A&E attendances were there due to issues related to mental wellbeing? • How many admissions were there to Acute Hospital inpatient services due to issues related to mental wellbeing? • How many people were detained under s135 or s136? • How many people were admitted into a Health-based Place of Safety? • Evidence of appropriate drugs monitoring / medication review (incl. the impact on physical health)

	People will be supported by their community mental health team, minimising their need for crisis / inpatient support
	
	• How many people required support from mental health intensive / crisis teams?
	• How many people were admitted to an acute mental health inpatient bed?
	  ○ Total admitted into an NHS or private bed in the region
	  ○ Total admitted into a non-NHS bed outside the region
	• How many people required s117 aftercare?

	People will be supported to prevent / avoid harm • E.g. total incidents of self-harm (list to be expand by quality colleagues)
	Supporting metrics: • Bed availability compared to national benchmark • Admission rate compared to national benchmark

Patient and carer experience of service	People have a positive experience of service and support; people do not experience stigma • Friends & Family Test (FFT) • Total responses to FFT • Service user survey
	Carers feel supported and central to the support offered to service users • Carer survey

The service will help service users on their recovery journey	People's care will be effectively coordinated • % of people with SMI / Complex needs with a link worker
	People will have improved physical health • Mortality gap for people with SMI reduced • Annual physical health check for people with SMI (LTP target)
	Clinician Reported Outcome Measures (CROMs) • Mental Health Cluster Tool (requirement for statutory MH providers)
	Patient Reported Outcome Measures (PROMs), used to understand outcomes for patients (some of which are noted below) – incl. holistic tools • Tools to be agreed in year 1
	People will be able to live more independent lives • Reduction in the number of people with SMI frequently attending their GP
	People able to access education & training • The number of people in employment

	• Data from the Improving Placement Support (IPS) service
	People have access to safe, warm home and a health standard of living • The number of people living in settled accommodation

The workforce feels supported and effective at delivering the service	Staff retention will be above the national average • Turnover rate • Vacancy rate
	Survey results indicate that staff feel that they can make a difference AND that they are enabled by IT to do their jobs • Annual NHS staff survey results • Local staff survey
	Supporting metrics: • Sickness rate (target to be in line with national average for MH services) • Supervision rate (target = 85%) • Appraisal rate (target = 90%) • Statutory/mandatory training rate (target = 90%) • Usage of bank / agency staff (baseline in year 1)
Good quality data will be collected to support monitoring & oversight	The system will ensure timely and accurate Mental Health Services Data Set (MHSDS) submissions • % of providers routinely submitting an MHSDS return (target = 100%) • Data Quality Maturity Index (DQMI) score for each provider (target = 95%) • % patient interventions submitted to MHSDS with a valid SNOMED (clinical coding tool) code assigned (target = 70%) • % patients with protected characteristics recorded (target = 95%

Whilst much of this data is already collected, consolidating this into a single, overarching suite of indicators and report will enable us to link together key metrics such as staff and patient experience. We are also aiming to gather this data by place area, so that we understand the impact of our new model on people from B&NES, Swindon and Wiltshire specifically.

This is a large scale piece of work and will take time to develop over the coming year. As we produce this new data set, we anticipate that we will expand and develop the indicators used, including how we start to use information from other partners (eg Police and Local Authorities) to supplement this core data set and evidence outcomes achieved through increasingly integrated service provision. Likewise, how we share the information we gather with system partners is also important so that we are using data and insights from our population to inform wider work.

As we develop this outcomes framework, we will develop and deepen our understanding of specific inequalities affecting our population. We also intend to align this with the Population Health Management Programme so that we can evidence both impact and outcomes for people from specific groups across our BSW population.

Implementation of a new care planning process

As part of CMHF implementation, NHS England requires all systems to move away from the current Care Planning Approach (CPA). CPA is currently used as an assessment tool around

which treatment is planned by providers. The intention is to move towards a more goal based approach to care planning and work is underway within AWP and across the system to understand what tools we will deploy to enable this.

Leadership and Governance

Given the size and scale of the work underway it is important that we have a structured approach to leadership and governance.

To that end we have a well-established Community Services Framework Oversight Group, at which all places are represented. Beneath this group sit a range of sub-groups aligned with the specific pathways outlined. These are led by provider representatives, with lived experience leads represented in every sub-group.

The CSF Oversight Group reports to the Thrive Working Group and through that to the Thrive Programme Board. This enables us to connect practical delivery and oversight to wider strategic discussions, ensuring that we are taking a whole system view of the future direction of travel informed by evidence gathered through existing transformation.

Future direction

The CMHF was intended as a 5 year transformation programme and as such additional transformation funding will cease at the end of 2023/24. We are in the process of developing our plans for 2023/24, building on what we have set out to do this year and delivering the ambitions set out in the CMHF roadmap.

We know, however, that the transformation work that is happening in community services is the start. The development of the NHS 10 year plan in the coming year, alongside the development of our BSW system Mental Health Strategy, will require us to deliver further transformation in mental health and wellbeing services. This will be informed by our increasing understanding of population health needs and outcomes.

We have started to work on our revised Mental Health Strategy already. Colleagues from Wiltshire Council are and will continue to be part of this development work, and we would welcome the opportunity to share the outputs of this with you in early 2023.

Conclusions

The Committee is asked to **note** this report.

As outlined, this is a briefing document and we would welcome the opportunity to present more specific plans and outcomes in greater detail over the coming months.

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24th October 2022

BSW LeDeR Information Briefing

Wiltshire Health Select Committee

01/10/22

Easy read symbols:

'easy-on-the-I' © Leeds and York Partnership NHS Foundation

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

Agenda Item 10

What is the LeDeR programme?

The **'Learning from Lives and Deaths - people with a learning disability and autistic people' (LeDeR)** inequalities national programme works to:

1) **improve care** for people with a learning disability and autistic people (who often have poorer physical and mental health than other people)

2) **reduce health inequalities** for people with a learning disability and autistic people

1) **prevent people with a learning disability and autistic people dying prematurely** (due to barriers to accessing health and care to keep them healthy)

National policy:
https://www.england.nhs.uk/wp-content/uploads/2021/03/B0428-LeDeR-policy-2021.pdf

Deaths in scope in the LeDeR Programme

- People aged 4 years+ with a learning disability
- People with a medically documented autism diagnosis aged over 18 years

AUTISM SPEAKS™
It's time to listen.

LeDeR Process and Outcomes

- Complete non mandated reviews (not investigations) for the deaths of people with a learning disability and/or autistic people to learn and share lessons
- Learning from LeDeR reviews about good quality care, areas requiring improvement and causes of death
- Driving local service improvements based on themes emerging from LeDeR reviews; to improve the health of people and reduce health inequalities.
- Influencing national service improvements via actions that respond to themes commonly arising from analysis of LeDeR reviews in the national annual LeDeR reports

How to notify a death to LeDeR

Anyone can make a notification as follows:

Online:

https://leder.nhs.uk/report

Telephone

01278 727411

Monday to Friday, 8.30am to 4.30pm (except public holidays)

National LeDeR 2021 Report: National Collective Learning

KEY TAKEAWAY OF COVID-19

During 2021 the rate of excess deaths was more than two times higher for people with a learning disability compared to the general population.

COVID-19 was the leading cause of death for people with a learning disability in 2021.

28% of those who were unvaccinated died from COVID-19 compared to 3.4% of those who were vaccinated.

9x

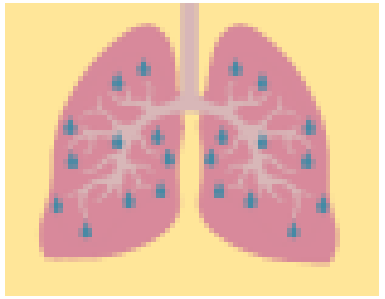
Those who were unvaccinated were 9 times more likely to die of COVID-19 than another cause compared to those who were vaccinated.

As in the general population, there were no excess deaths for children with a learning disability in 2021. Deaths of children

BSW LeDeR 2021 Report Learning: Learning Disabilities

BSW Top Four Causes of Death in 2021

1. Aspiration pneumonia
2. Dementia (noting early onset prevalence)
3. Heart failure
4. Respiratory failure

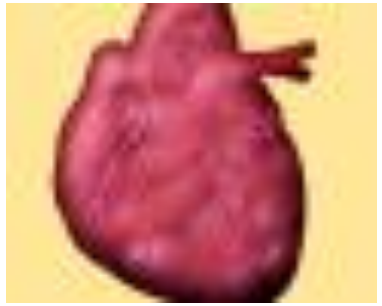


BSW System Thematic Learning from Deaths:

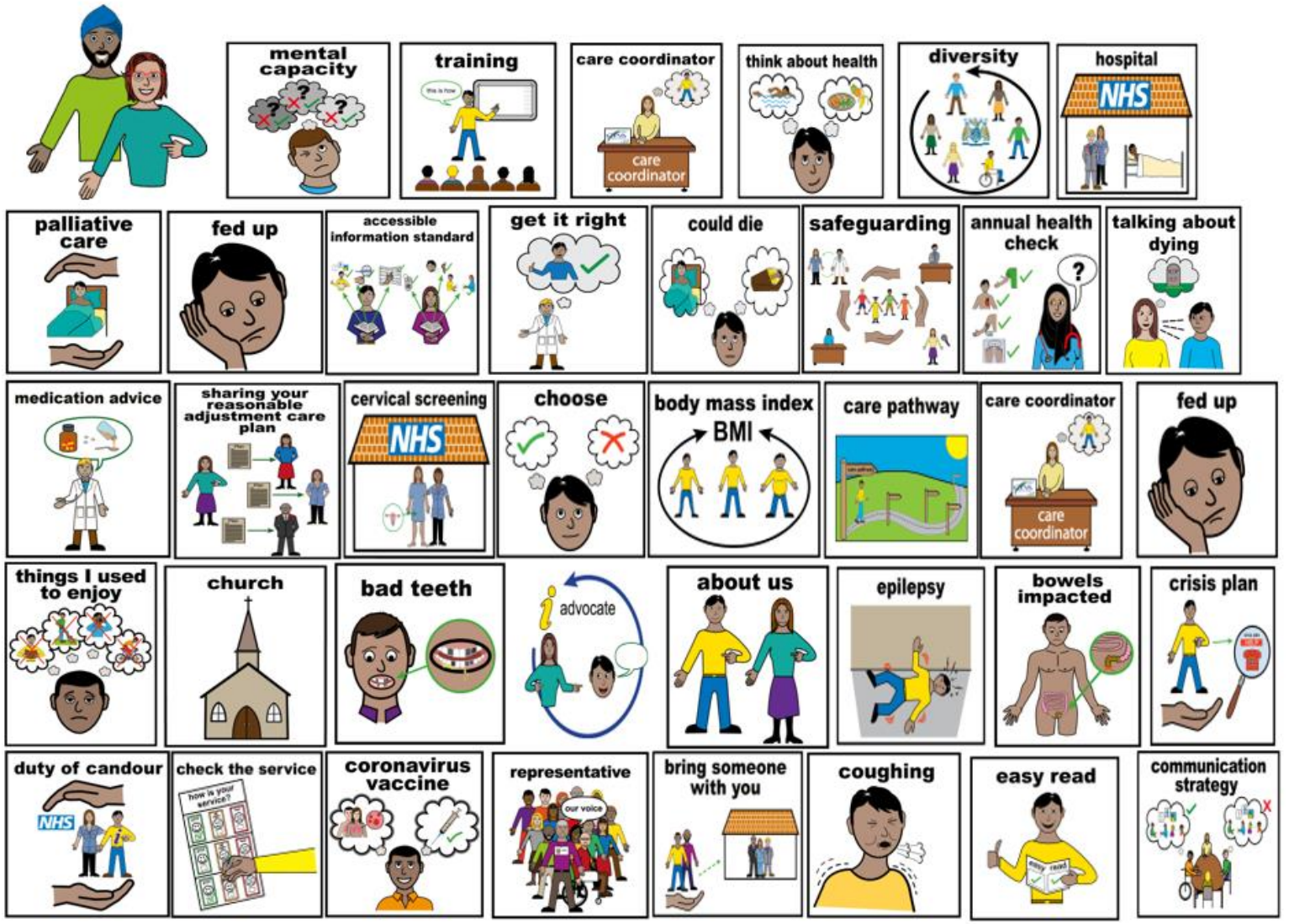
- **Individual risk factors**; i.e. recurrent chest infections, choking risks, obesity
- **Personalised care assurance and choice;** end of life identification and good planning
- **Care coordination**; Use of Hospital/Health passports
- **Lifestyle**; opportunities to improve daily living and choices, meaningful happy lives and health and wellbeing.
- **Annual Health Check/Vaccination/Health Action Plan/Cancer screening;** Prevention management
- **Low minority ethnic LeDeR notifications;** opportunities to increase uptake of vaccinations and other health prevention and promotion initiatives

BSW Priority Actions:

- Hospital/Health Passports to be used across the system; understanding/meeting needs
- Reducing Aspiration Pneumonia; awareness and training to identify, report and manage swallow issues
- Increasing covid vaccination uptake



BSW LeDeR Programme Learning over time: Easy Read



BSW LeDeR Guide:

Meeting reasonable adjustment needs in practice

Bath and North East Somerset, Swindon and Wiltshire Partnership

Working together for your health and care

Reasonable Adjustments: Supporting People with a Learning Disability, and/or Autism

BSW LeDeR Learning	Reasonable Adjustment Solution Ideas
Hidden disability 	Flag on records to alert all staff to needs/adjustments required. Offer/promote Sunflower lanyard to enable visual clue to hidden needs Ensure a Health/Hospital Passport is in place, shared, updated, and followed
Noise/Bright Lighting 	Find/dedicate a quiet waiting area to reduce impact of noise Reduce brightness in dedicated waiting area to reduce sensory stimuli
Anxiety/Anger/Procedure planning 	Offer visits to see and understand the appointment area, meet the staff, carer support and social stories Easy Read information, preparation visits, capacity assessment, advocacy support
Promoting Understanding 	Double appointment times to ensure time to explain and gain understanding. Provide a simple written/printed summary of advice and actions to follow. Easy Read materials to support information sharing and understanding Ensure carer/support person attends too
Non-attendance 	Carer/family support for appointments Text reminders Non-responders follow up process
Medication/health compliance concerns 	Annual Health checks with a health action plan Medication reviews Carer/family support during appointments Consider specialist referrals for support i.e. Community LD team

*LeDeR Information Link: https://leder.nhs.uk/

*RESOURCE https://www.wiserun.net/our-work/transforming-services-and-systems/keeping-people-safe-during-and-after-covid-

BSW LeDeR Tips: Improving Care and Support

Ask

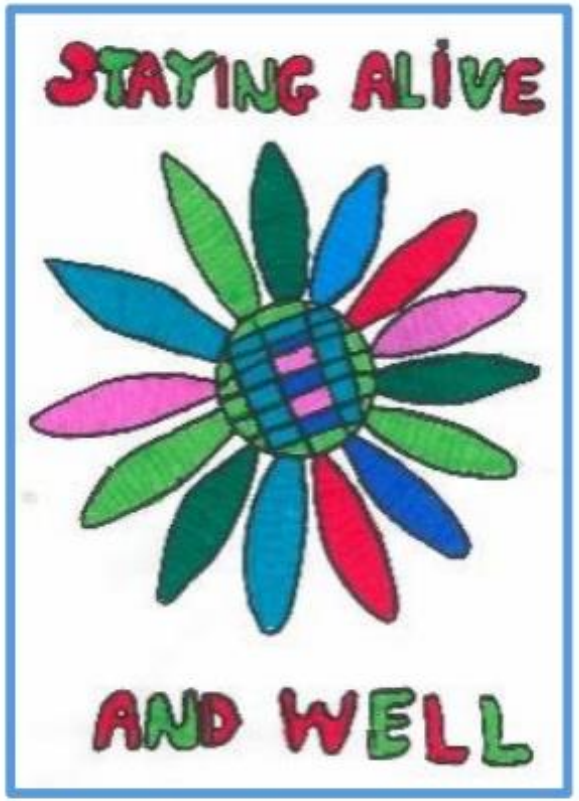
- Do people have reasonable adjustment needs?
- Ensure awareness training is in place for all staff (the BSW LeDeR Awareness Champion role is available for health and social care)
- Ensure that services ask to see and read health/care passports to promote understanding of and the meeting of peoples needs
- Promote the sunflower lanyard and ensure awareness of the lanyard as a visual aid to ask what additional needs people have

Listen

- All services listen to people and their carers or people who know them best
- To what people want-use and comply with the Mental Capacity Act when required to support choices and wishes
- Offer choices and be creative, do not accept ‘how we have always done things’

Do

- Check accuracy of LD diagnosis and needs
- Ensure a record system flag to alert health and care staff to specific needs
- Allow extra time
- Read health/care passports to understand needs and report any health changes/deteriorating conditions
- Ensure that care and support promotes a healthier lifestyle; exercise, health diet and hobbies
- Share easy read/other information to meet needs
- Ensure quiet areas are dedicated for people
- Ensure that commissioned carers request and accompany service users to attend annual health checks, cancer screening and all vaccinations
- Report any concerns through the appropriate incident, complaint or safeguarding route



Designed by logo competition winner
Darren Barnes, Greatstone

- **BSW LeDeR Emails:**
- bswicb.leder@nhs.net

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Wiltshire Council

Health Select Committee

1 November 2022

Report of the Rapid Scrutiny Exercise:
New Health Overview and Scrutiny Principles document

Purpose

1. To present the findings and recommendations of a Rapid Scrutiny Exercise reviewing the implications of a new Health Overview and Scrutiny Principles document published by the Department for Health and Social Care (DHSC).

Background

2. In February 2021, the Government published the White Paper "*Integration and innovation: working together to improve health and social care for all*".

3. This was followed by the introduction of the Health and Care Bill (2021), which was passed into law at the end of April 2022. The Health and Care Act introduced Integrated Care Systems (ICSs), the purpose of which is to:
    - improve outcomes in population health and healthcare;
    - tackle inequalities in outcomes, experience and access;
    - enhance productivity and value for money; and
    - help the NHS support broader social and economic development.

4. In June 2022, Health Select Committee received a report on the development of the new ICS arrangements in the BaNES, Swindon and Wiltshire (BSW) area. The Committee resolved to receive a future report on the development of the ICS. A diagram showing the structure of the BSW ICSs is included at **Appendix 1**.

5. On 29 July 2022, the DHSC published a 'Health overview and scrutiny committee principles guidance document. This sets out the expectations of the Department of Health and Social Care (DHSC), the Local Government Association (LGA) and the Centre for Governance and Scrutiny (CfGS) on how integrated care boards (ICBs), integrated care partnerships (ICPs) and local authority health overview and scrutiny committee (HOSC) arrangements will work together to ensure that new statutory system-level bodies are locally accountable to their communities.

6. The guidance states that:

    "HOSCs, local authorities, ICBs, ICPs and other NHS bodies should use this document to ensure that scrutiny and oversight are a core part of how ICBs and ICPs operate. Leaders from across health and social care should use these principles to understand the importance of oversight and

scrutiny in creating better outcomes for patients and service users and ensure that they are accountable to local communities."

7. In September 2022, Health Select Committee established a rapid scrutiny exercise to review the new principles document and report back to committee on its implications for health scrutiny in Wiltshire.

8. The rapid scrutiny group met on 20 October 2022 and comprised the following members:
   Cllr David Bowler
   Cllr Johnny Kidney
   Cllr Gordon King
   Cllr David Vigar

Main considerations

General findings

9. While the new principles document does not present significant changes to Health Overview and Scrutiny's formal role, the Rapid Scrutiny Group found it useful in reaffirming health scrutiny's importance and what is needed to make it effective. The Group therefore recommends that the Committee uses the document as a catalyst for reviewing its approach as outlined in the Group's recommendations, particularly during this period of transition to an Integrated Care System.

10. The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 continue to apply and HOSCs retain their powers to:
    - review and scrutinise matters relating to the planning, provision and operation of the health service in the area (including finances);
    - require information to be provided by certain NHS bodies about the planning, provision and operation of health services;
    - require employees, including non-executive directors of certain NHS bodies, to attend to answer questions;
    - make reports and recommendations to certain NHS bodies and expect a response within 28 days;
    - set up joint health scrutiny and overview committees (JHOSCs) with other local authorities;
    - respond to consultations by relevant NHS bodies and relevant health service providers on substantial reconfiguration proposals;
    - deal with referrals made by local Healthwatch organisations or local Healthwatch contractors.

11. The only expected change to HOSCs' powers is that the formal statutory route to refer significant service reconfigurations to the Secretary of Stage (when the

HOSC is sufficiently concerned) will be removed when the Health and Care Act 2022 takes effect.

12. Overall, the principles document reaffirms the key role of health and care scrutiny as:
    - providing an opportunity for local people and their elected representatives to contribute to and comment on the local priorities for improving health and care services and outcome;
    - giving a voice to local people and communities on the quality, safety, accessibility and effectiveness of local health and care services;
    - assuring local elected members and the public that health and care services are safe and effective, address local health priorities and reduce health inequalities;
    - helping health and care providers and commissioners gain insight into the health needs and concerns of particular groups; and
    - enabling health and care providers and commissioners to develop new services and care pathways to address local health priorities more effectively.

Principles for effective health and care overview and scrutiny

13. The document sets out five principles for ways of working between HOSCs, ICBs, ICPs and other local system partners to ensure the benefits of scrutiny are realised. These should form the basis of ongoing discussions between these partners about how they will work together. The 5 principles are:
    - outcome focused
    - balanced
    - inclusive
    - collaborative
    - evidence informed

14. The rapid scrutiny group framed its discussions and recommendations against these principles, presented in the following table:

New Guidance for HOSCs from DHSC	**Rapid Scrutiny recommendations for Wiltshire HSC**
1. Outcomes focused	
1.1 HOSCs should overview how well integration is working and make recommendations on how it could be improved.	Receive regular updates on implementation of the new arrangements, including their implications in practice, e.g., what services are being commissioned at a place- and system level and where are service budgets aligned or pooled.

New Guidance for HOSCs from DHSC	Rapid Scrutiny recommendations for Wiltshire HSC
	Engage in the development of the system-level Integrated Care Strategy by the Integrated Care Partnership. Place particular focus on its objectives and how their delivery will be measured.
1.2 HWBs will continue to develop Joint Strategic Needs Assessments (JSNAs) and establish joint local health and wellbeing strategies (JLHWS); HOSCs will continue to scrutinise place-based health services in relation to these.	Receive the JSNA and JLHWS for Wiltshire and understand how it will be used to design services at place-level.
1.3 HOSCs will play a valuable role in scrutinising the wider ICB area and should work with other LAs, forming JHOSCs where appropriate, to scrutinise outcomes against the 5-year forward plan and ICS.	The Chair and Vice-chair to meet with counterparts from BaNES Council and Swindon Borough Council to discuss the programme of integration and opportunities for collaboration, including a JHOSC as appropriate.
2. Balanced	
2.1 Good scrutiny needs balance between future focused and responsive.	Chair and Vice-chair to review the HSC work programme with Cabinet Members and directors on the dates below, ensuring appropriate balance: • 9 November 2022 – Adult Social Care and Transformation • 22 November 2022 – Public Health Chair and Vice-chair to schedule equivalent work planning meetings with the Integrated Care Board.
2.2 ICBs and ICPs should build scrutiny into the cycle of planning, commissioning, delivery and evaluation. 2.3 ICBs should share at an early stage proposals on reconfigurations. 2.4 ICBs should be proactive in involving relevant bodies on contentious matters.	To be discussed in the meetings outlined above (2.1).

New Guidance for HOSCs from DHSC	Rapid Scrutiny recommendations for Wiltshire HSC
2.5 Leaders should establish shared priorities and FWP to improve outcomes. 2.6 ICBs can assist by working with HOSCs to shape their forward plans. 2.7 Providers and commissioners should respond positively to the requests 2.8 ICBs should have protocols in place for sharing information	To be discussed in the meetings outlined above (2.1).
2.9 Scrutiny also needs to be responsive to issues of concern to local communities. 2.10 Local Healthwatch should pass on the views of people about their needs and experience	Following the work planning meetings outlined above, HSC to ensure its work programme has capacity for issues of concern to local communities. Chair and Vice-chair to meet with Wiltshire Healthwatch to share information and reports and inform HSC's topic selection and questioning.
2.11 ICBs should be open and transparent with HOSCs about performance.	In September, HSC agreed to explore how to achieve focused, ongoing scrutiny of key performance indicators within its health and care remit.
3. Balanced	
3.1 HOSCs should strengthen the voice of local people and provide local accountability.	The Chair and Vice-chair to arrange regular meetings with Wiltshire Healthwatch and other service user groups to share information and inform HSC's topic selection and questioning.
3.2 HOSCs should ensure that people's needs and experiences are considered as an integral part of commissioning and delivery	All HSC scrutiny reviews to include consideration of how people's needs and experiences have been considered in developing the proposals or monitoring the quality of service.

New Guidance for HOSCs from DHSC	Rapid Scrutiny recommendations for Wiltshire HSC
3.3 HOSCs, subject to time and resources, may engage with members of the public directly	Where appropriate, HSC scrutiny reviews to include engagement with members of the public via appropriate local patient participation groups (PPG's) and the Patient Advice and Liaison service (PALs) to seek their views.
3.4 Systems and NHS bodies should form trusting working relationships with HOSCs	Following work planning discussions with the Integrated Care Board, the Chair and Vice-chair to arrange further discussions with the local NHS trusts.
4. Collaborative	
4.1 HOSC work plans should be informed by communities, providers and planners	To be addressed via the work planning meetings outlined above.
4.2 Need clarity about roles of the HOSC, ICBs, ICPs, NHS, HWBs and Healthwatch	Roles addressed in this report and **Appendix 1**.
4.3 JHOSCs will be important in assessing issues that cover 2+ LA areas 4.4 JHOSCs have a strategic role to play in scrutinising the delivery and outcomes of the integrated care strategy	The meetings with the ICB and other HOSC chairs outlined above to include consideration of what services will be commissioned at system level and whether scrutiny of these is most effectively considered via a JHOSC. All parties will need consider the resource implications of JHOSCs and consider appropriate.
4.5 HOSC work plans should be informed by communities, providers and planners	To be discussed at the meetings with Cabinet members, the ICB, NHS trusts and Wiltshire Healthwatch outlined above.
4.6 ICBs, councils and HOSCs should develop joint protocols in advance of joint scrutiny arrangements 4.7 …and should clarify how councils work together, structure of joint	Collaboration with the HOSCs from BaNES Council and Swindon Borough Council to be discussed in the first instance, taking into account the challenges of each approach including resource implications.

New Guidance for HOSCs from DHSC	Rapid Scrutiny recommendations for Wiltshire HSC
arrangements, and time needed to establish these arrangements 4.8 JHOSCs to recognise potential difficulties of working together, particularly around the political balance between different local areas, as well as resourcing. 4.9 ICBs should support in these situations and recognise the time involved in establishing JHOSCs.	
5. Evidence gathering	
5.1 Qualitative evidence from those with lived experience particularly valuable	To be addressed by introducing regular dialogue and information sharing with Wiltshire Healthwatch, plus engagement with local patient participation groups (PPG's) and the Patient Advice and Liaison service (PALs) where appropriate for deep-dive reviews.
5.2 HOSCs can seek performance info from health services and institutions; challenging and testing this by drawing on different sources	As agreed in September, HSC is exploring how to achieve focused, ongoing scrutiny of key performance indicators within its remit for both council-led and NHS services.

Proposal

15. That Health Select Committee endorses the following recommendations from the Rapid Scrutiny Group:

1. **Health Select Committee to receive regular updates on the transition to integration, including its implications in practice such as the funding, commissioning and delivery of services at both place- and system level.**
2. **Health Select Committee to engage in the development of the system-level Integrated Care Strategy, placing particular focus on its objectives and how their delivery will be measured.**
3. **Health Select Committee to receive the next Joint Strategic Needs Assessment (JSNA) being developed by Wiltshire's Health and Wellbeing Board and understand how it informs the design of services at place-level.**

4. **The Chair and Vice-chair to meet with their counterparts from BaNES Council and Swindon Borough Councils to discuss the programme of integration and opportunities for collaboration.**
5. **The Chair and Vice-chair to review and update the HSC work programme with Cabinet Members and directors at the meetings scheduled in November, ensuring appropriate balance between proactive scrutiny and retaining capacity for scrutiny of issues of concern to local communities, reporting back to Committee.**
6. **The Chair and Vice-chair to meet with representatives from the Integrated Care System to discuss the following and report back to HSC:**
    a) **How they can work together to achieve efficient and effective HSC engagement on system-level proposals and performance.**
    b) **HSC's forward work programme, ensuring key integration milestones and system level service proposals are reflected;**
    c) **How the ICB will be proactive, open and transparent in sharing information, involving HSC early in contentious matters and building scrutiny into the cycle of planning, commissioning, delivery and evaluation;**
    d) **How the ICB can engage in the HSC's performance data monitoring arrangements, currently being developed;**
7. **The Chair and Vice-chair to invite regular liaison with Healthwatch Wiltshire to discuss work priorities, share information and reports and ensure people's needs and experiences are reflected in HSC's work.**
8. **Future HSC task groups and rapid scrutiny exercises to consider direct engagement with residents via local patient participation groups (PP'G) and the Patient Advice and Liaison service (PALs) to ensure their voices are heard.**

Cllr Johnny Kidney, Lead Member for the Rapid Scrutiny Exercise and Chair of Health Select Committee

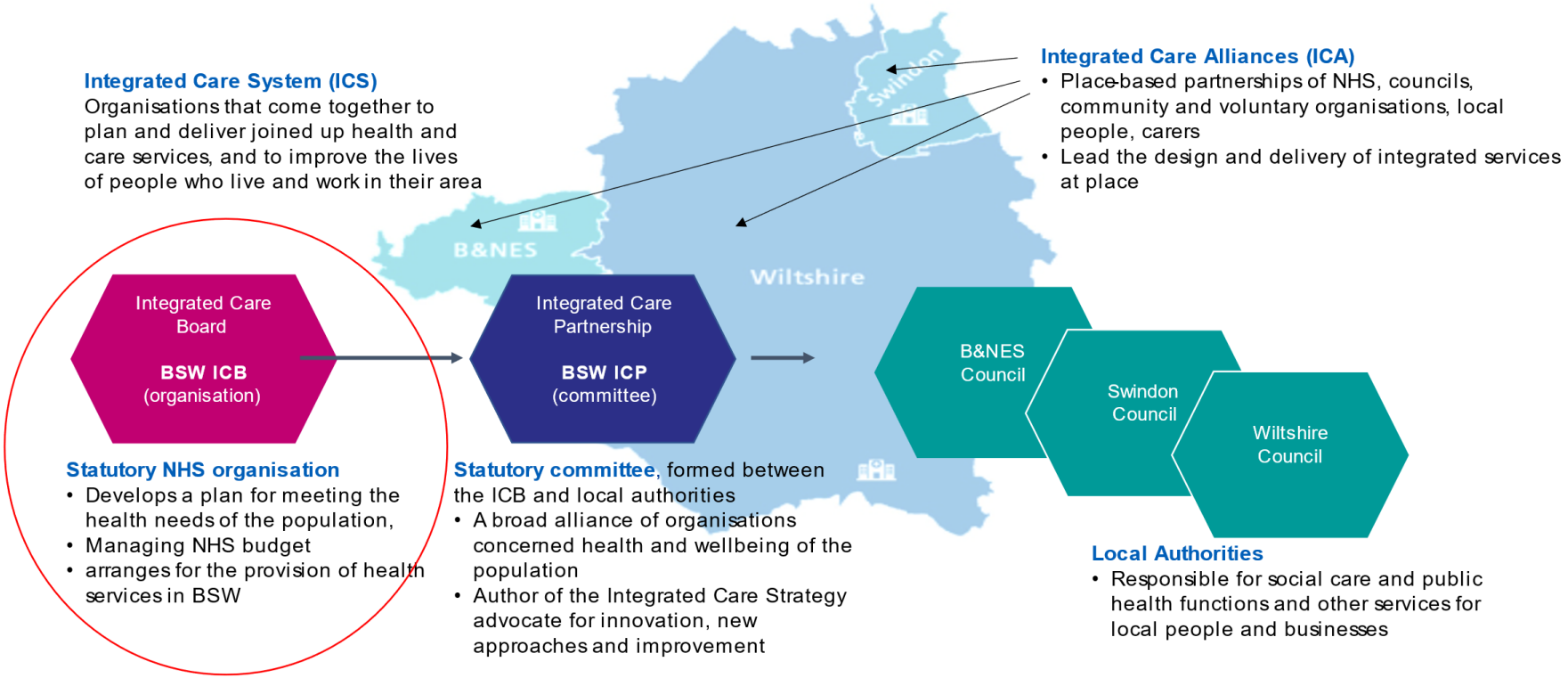
Report author: Henry Powell, Democracy and Complaints Manager,
complaints@wiltshire.gov.uk

Appendices

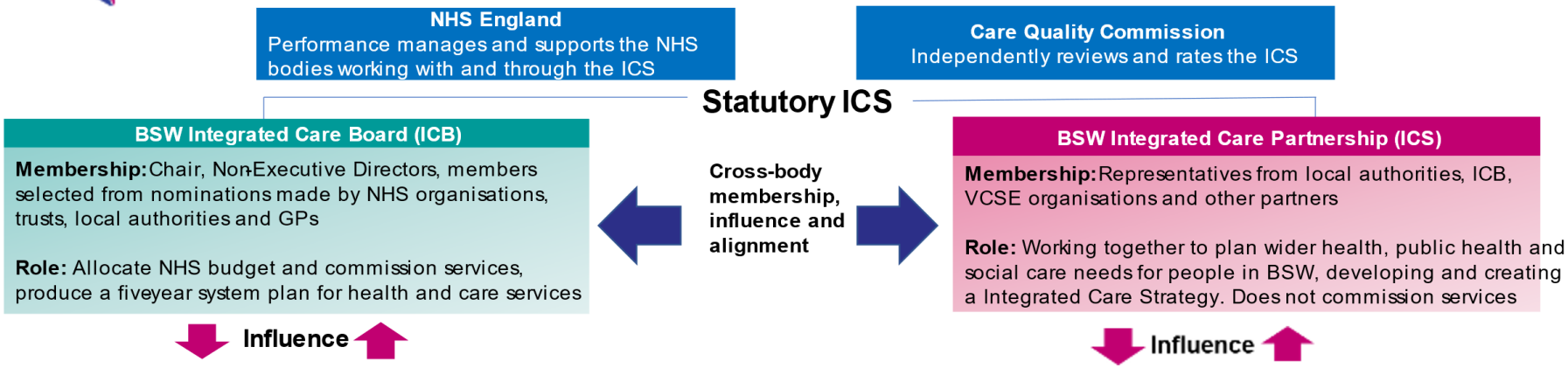
Appendix 1	Integrated Care System structure and roles
Appendix 2	Glossary of acronyms used in this report

Appendix 1 – BSW Integrated Care System structure and roles

The BSW Integrated Care System (ICS)



BSW Integrated Care Board (ICB) with the ICP



Partnership and delivery structures

Geographical footprint	Name	Participating organisations
System Populations of 1-2m	**Provider collaboratives**	NHS trusts (including acute, specialist and mental health), VCSE sector and the independent sector. Can also operate at place level
Place Populations of 250,000-500,000	**Health and wellbeing boards**	ICS, Healthwatch, local authorities and wider membership as appropriate. Can also operate at system level
	Place-based partnership	Can include ICB members, local authorities, VCSE organisations, NHS trusts (including acute, mental health and community services) , Healthwatch and primary care
Neighbourhood Populations of 30-50,000	**Primary care networks**	GPs, community pharmacists, dentistry, opticians

BSW Integrated Care Board (ICB) Composition

Statutory, required by law:
- Chair
- Chief Executive
- One member nominated jointly by NHS trusts and NHS foundation trusts
- One member nominated jointly by primary care providers
- One member nominated jointly by local authorities

Mandatory national expectation:
- Non-executive member Audit
- Non-executive member RemCom
- Chief Finance Officer
- Director of Nursing
- Medical Director

The BSW ICB Board will have 18 members:

- Chair
- Chief Executive
- Chief Finance Officer
- Chief Nurse Officer
- Chief Medical Officer
- Two members nominated jointly by NHS trusts and NHS foundation trusts – one from acute sector, one from mental health sector
- One member nominated jointly by primary care providers
- Three members nominated jointly by local authorities – one from Bath and North East Somerset (BaNES), one from Swindon, one from Wiltshire
- Five non-executive members – Audit, RemCom and People, Finance, Quality, Community Engagement
- One member from the Voluntary Community and Social Enterprise (VCSE) sector
- One member from community provider sector

Appendix 2 – Glossary of acronyms used in this report

BaNES	Bath and North East Somerset
BSW	BaNES, Swindon and Wiltshire
HOSC	Health Overview and Scrutiny Committee
HSC	Health Select Committee (Wiltshire's HOSC)
HWB	Health and Wellbeing Board
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System (a combination of the ICB and ICP)
JHOSC	Joint Health Overview and Scrutiny Committee
JLHWS	Joint Local Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment