Wiltshire Council

AGENDA SUPPLEMENT (1)

Meeting: **Health Select Committee**

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

Date: **Tuesday 5 September 2023**

Time: **10:30 am**

The Agenda for the above meeting was published on 25 August 2023. Additional documents are now available and are attached to this Agenda Supplement.

Please direct any enquiries on this Agenda to Cameron Osborn of Democratic Services, County Hall, Bythesea Road, Trowbridge, direct line 01225 718224 or email cameron.osborn@wiltshire.gov.uk

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

---

6 **Integrated Care Centres** *(Pages 3 - 16)*

7 **Reablement and Wiltshire Support at Home** *(Pages 17 - 32)*

8 **Technology Enabled Care (TEC) Strategy** *(Pages 33 - 42)*

9 **Inquiry Session: System-wide review of the demands on Urgent Care** *(Pages 43 - 50)*

10 **Emotional Wellbeing and Mental Health Strategy** *(Pages 51 - 58)*

DATE OF PUBLICATION: 31 August 2023

This page is intentionally left blank

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

Update on Integrated Care Centres Health Select Committee

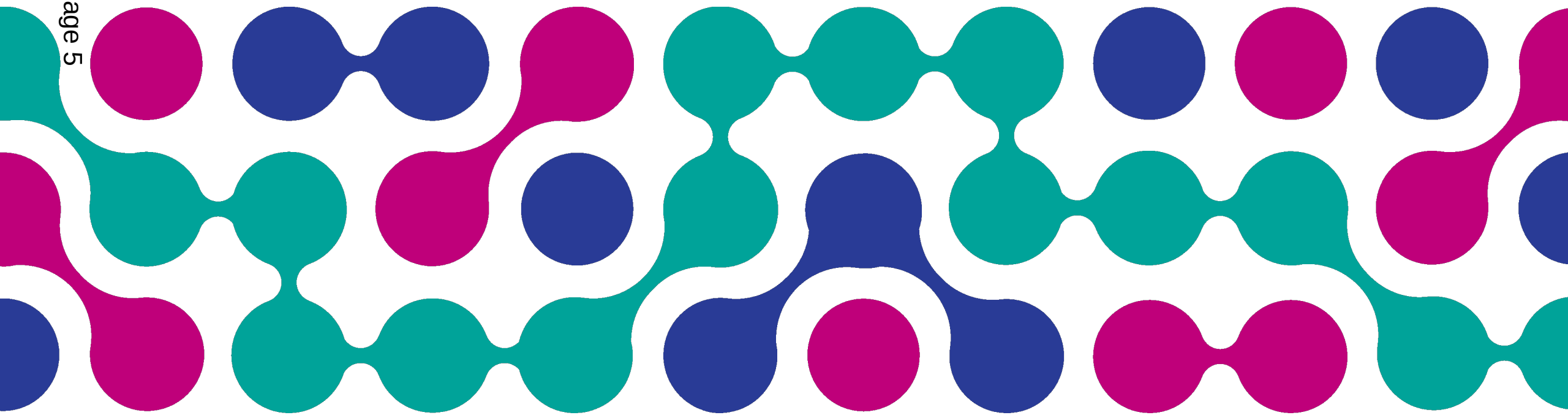
5th September

Purpose:

- To understand how integrated care centres link to Neighbourhood Collaboratives and support the Wiltshire Alliance priorities.
- To receive an update on the development and impact of the integrated care centres with a focus on Devizes Health Centre

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

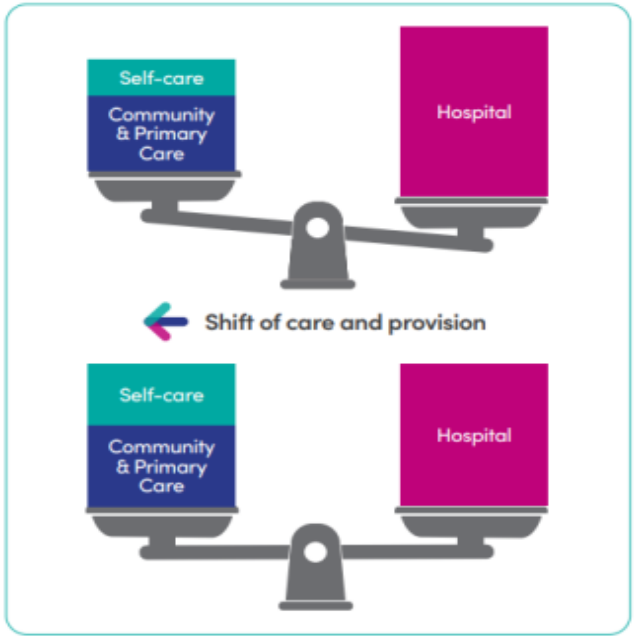
Context of strategic direction – national and local



Strategic Context

National

- Primary and Community Care Transformation (including Fuller)
- Delegation of pharmacy, optometry and dentistry commissioning responsibilities from NHSE to ICBs
- Major Conditions Strategy (expected July 23)
- Health and Care Act 2022 including delivery of core aims of ICSs
- NHSE Recovery priorities and the Long Term Plan
- Health and social care integration White paper
- People at the Heart of Care – Adult social care reform white paper
- NHS workforce Plan
- Better Care Fund guidance 2023-25



What does it mean for primary care? What challenges and strategic changes are we aiming to address/link in the strategy?

- Making it easier to access primary care services (linking to the General Practice Access Recovery Plan)
- Delivery of the vision outlined in the Fuller Stocktake, and the opportunities for new models of care and integrated neighbourhood teams
- The left shift and managing demand: transferring low acuity care away from general practice such as Community Pharmacy Consultation Service, and direct access routes to other services such as MSK Physiotherapy, Podiatry, Ophthalmology.
- Developing effective primary, community and secondary care clinical interfaces – improving patient experience and outcomes, and addressing variation and duplication
- Tackling Health Inequalities – Core 20+5, primary prevention, and improved outcomes for people with Long term conditions
- Workforce – recruitment and retention and additional ARRS roles
- Digital Transformation – Modern General Practice programme (such as cloud based telephony and digital platforms)
- Estates and Premises – linking to the longer term estates strategy for primary care as part of wider ICB estates programme

GP Access Recovery Plan

Why we need the plan:

- General practice is under immense pressure, with demand outstripping capacity in many areas. This negatively impacts patient access and experience, which in turn can shift pressure to other parts of the system as patients seek alternative routes to access care.
- The ageing population is a key driver of the increase in pressure as the majority of over 70s live with one or more long term conditions.
- The pandemic also contributed to the changing nature of demand with the COVID–19 backlogs contributing to a 20-40% increase in patient contacts with practices.
- Though the general practice workforce has grown by 27%, the net number of GPs has lagged behind and the impact of measures to increase the number of GPs have not yet been felt in practices.
- Existing GPs are under greater pressure, managing larger practices, supervising ARRS and trainee GPs, estimated to take up to 20% of GP time, in addition to core clinical responsibilities.
- As demand rises, patient satisfaction is falling across 99% of PCNs, with the greatest decreases being linked to difficulty booking an appointment.

1. Empowering patients

General practice is delivering more than 1 million appointments every day

Enabling patients to take a more active role in the management of their health and care by utilising technology that i) provides patients with access to information to inform their health decisions; (ii) removes inefficiencies and (iii) increases flexibility for the workforce.

FOCUS AREA

Supporting patients to manage their own health and care, by rolling out tools and technology that give accurate and trusted information, and expanding services offered by community pharmacies.

Recommendations

Improving information and NHS App functionality

- Enable patients in over 90% of practices to access core functions on the NHS App
- All practices to enable prospective medical record access for patients access by November 2023, enabling them to view information on immunisations, test results and consultations

Increasing self-directed care

- Increase the number of self-referral options for patients - up to 50% more patients self-referring by March 2024
- Increase use of digital tools and remote monitoring eg. blood pressure control through home monitoring devices
- ICBs to support development of link worker role, connecting people to activities and community-based services

Expanding community pharmacy

- Pharmacy First to launch before the end of 2023, enabling pharmacists to: i) supply prescription-only medicines and (ii) treat common health conditions
- Expand community pharmacy capacity to provide blood pressure checks and manage ongoing oral contraception
- Improve IT infrastructure and interoperability between community pharmacy and general practice
- Changes to various legislation to give community pharmacy contractors more choice about how they deploy staff and release pharmacists' time for more patient-facing services

2. Implementing Modern General Practice Access

Patient experience scores 6% points higher than national average using this model

Patients shouldn't be told to call back another time to secure an appointment on the day. Better digital online contact tools and telephony, and changes to workflow have successfully increased accessibility for patients - the Modern General Practice Access Model.

FOCUS AREAS

Enabling patients to know on the day how their request will be handled, based on clinical need and preference for appointment type, reducing long waits on the telephone and providing patients with more timely information

Recommendations

Better digital telephony

- All practices to transition to digital telephony by December 2025 to make full use of i) multiple call management; (ii) call-back functionality; (iii) call-routing and (iv) integration with clinical systems
- NHSE to support transition to digital telephony to those practices that commit by 1st July 2023
- 1000 practices to be utilising this technology by the end of 2023

Simpler online requests

- NHSE to provide general practices with high quality online-consultation, messaging and booking tools by July 2023
- ICBs, Primary Care Networks and GPs to agree most appropriate tools to support transition to new model

Faster navigation, assessment and response

- NHSE to invest in new National Care Navigation Training programme for up to 6500 staff starting in May 2023
- NHSE to fund higher-quality tools that enable the shift to online requests and enable all practice team to contribute to rapid assessment and response
- NHSE to support practices committing to transformation with extra capacity over the next two years - £13,500 per practice

3. Building capacity

Up to £35 million funding for general practice fellowships in 2023/24

There is a shortage of GPs to meet the needs of a growing and ageing population, with increasingly complex needs. A focused effort is required to bring new doctors into general practice and retain current GPs

FOCUS AREA

Ensuring general practice is utilising all resources to manage increasing demand, managing more patient requests and optimising the use of the full practice team

Recommendations

Larger multidisciplinary teams

- 26,000 more professionals in general practice and 50 million more appointments by 31 March 2024
- Funding for up to £385m for Additional Roles Reimbursement Scheme (ARRS) in 2023/24
- All primary care staff to be able to access suite of health and wellbeing offers and the Practitioner Health Service

Increase in new doctors

- Up to £35 million of SDF funding available for GP fellowships in 2023/24
- Further expansion of GP specialty training – and make it easier for newly trained GPs who require a visa to remain in UK
- NHSE to work with partners to identify opportunities for other doctors, eg SAS doctors, to work in general practice multidisciplinary team

Retention and return of experienced GPs

- DHSC agreement to make retire and return easier and protect NHS staff from higher tax charges driven by inflation
- Encourage experienced GPs to stay through the pension reforms announced in the Budget
- NHSE to launch campaign to encourage GPs to return to general practice and invest in GP retention schemes

Primary care estates

- ICBs to work with local partners to better anticipate where housing developments are putting pressure on existing services
- Changes to local authority planning guidance this year to ensure due consideration of primary care capacity

4. Cutting bureaucracy

30% of GP time is spent on indirect patient care

In some practices patient contacts have increased from 20% to 40% since before the pandemic; and there is a risk that GPs are overloaded and spend less time with patients. Reducing paperwork will improve efficiency

FOCUS AREAS

Reducing the time spent by practice teams on low-value administrative work, and improving join up between primary and secondary care services, to give teams more time to focus on patients' clinical needs

Recommendations

Improving the primary – secondary care interface

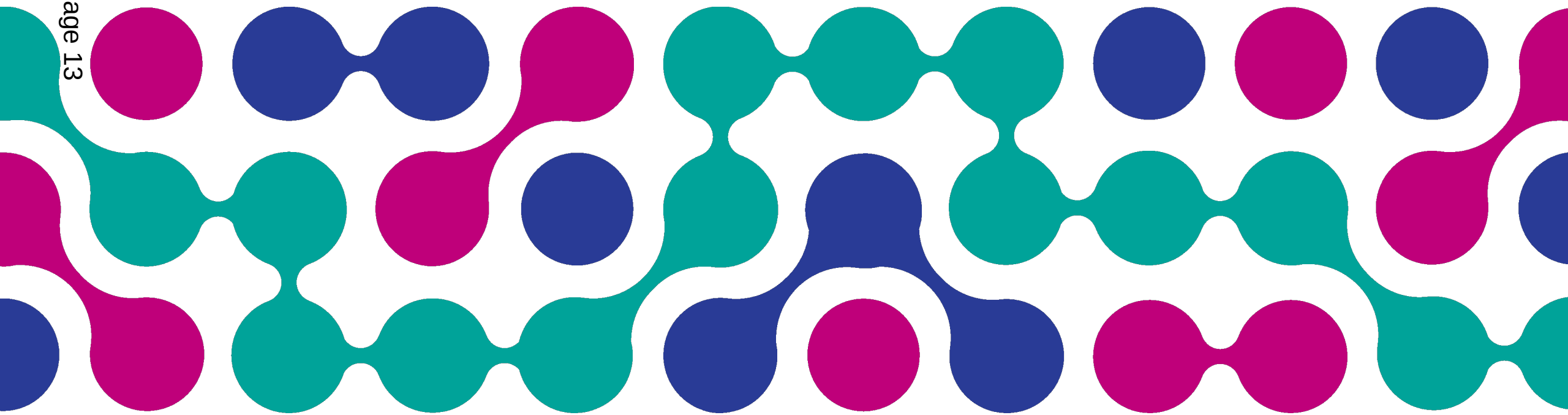
- Secondary care to prioritise onward referrals to ensure referrals are not sent back to general practice and resulting in further delays
- NHS trusts to provide accurate and up to date fit notes and discharge letters, highlighting clear actions for general practice
- NHS trusts to establish their own call/recall systems for patient follow ups
- ICBs to ensure providers establish single routes for general practice and secondary teams to communicate rapidly
- ICBs to report progress on improving the interface with primary care

Building on the Bureaucracy Busting Concordat

- Reduce requests to GPs to verify medical evidence, including by increasing self-certification, by continuing with the Bureaucracy Busting Concordat
- Examples include, working with the aviation industry to encourage clear, proportionate and pragmatic processes, so passengers with medical conditions who need to fly with medication/medical equipment can do so easily

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

Wiltshire ICA Priorities



Wiltshire Alliance Priorities – key highlights

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

- Development of Neighbourhood Collaboratives across Wiltshire
  - aligned to PCN footprints with population-health and wellbeing, prevention focus.
- Alliance Delivery Sub Groups established
  - Living Well – long term conditions population health focus
  - Mental Health, LD and Autism; driving local improvement
  - Ageing Well and Urgent Care; including improving discharge services performance and other key work programmes.
  - Families and Childrens Transformation; implementing family help hubs and wider programme
- Community Services post 2025
- Carers – improving recognition and support
- Joining up service commissioning
- Targeting outreach activity
- All priorities are detailed in the Joint Local Health and Wellbeing Strategy Actions and BSW Implementation Plan.

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

Update from Devizes PCN

This page is intentionally left blank

Wiltshire Council

Health Select

August 2023

Wiltshire Council Reablement Service

1.0 Purpose of Report

1.1 This report has been prepared as an update on Wiltshire Council Reablement Service's activity and service delivery.

2.0 Relevance to the Council's Business Plan

2.1 The Reablement Service (part of the "Living Well" directorate within Adult Social Care), ensures that the council is empowering the people of Wiltshire to live full, healthy, and enriched lives by working with people who, for reasons of illness, disability or aging, lost aspects of their functional independence (their ability to do things for themselves).

3.0 Reablement Service Background and Development

3.1 Wiltshire Reablement Service was established in May 2018 to provide a person-centred service aiming to achieve the best possible outcomes for each individual. Referrals are received from people and their carers, via GPs, from hospitals (including community), and via family members.

3.2 Wiltshire Reablement Service is made up of two elements: CQC (Care Quality Commission) Registered Provider working alongside the Operational Occupational Therapy Service as an integrated team.

3.3 The service expanded in 2020 to take patients from acute hospital via Home First. This was to bridge the gap between hospital and home, meaning people no longer needed to wait unnecessarily for assessments in hospital. In turn this improved the position in relation to delayed discharges and improved patient flow in the acute hospitals.

3.4 In 2021 the service expanded again to accommodate Discharge to Assess (D2A) working to support customers being discharged home from hospital who require a period of assessment within a non-hospital environment; beds are purchased within specified residential care homes with whom contracts are in place to support designated numbers of beds to facilitate these discharges. These beds are referenced as Discharge to Assess beds**.**

3.5 The Reablement Locality Hub Team was developed in 2021. This team works 7 days per week triaging and planning discharges from the acute hospitals.

4.0 Main Considerations

4.1 The Reablement Service has worked with over 5,000 customers since its inception in 2018, to support them to learn/re-learn the skills necessary to live as independently as possible and to prevent, reduce, and delay the need for ongoing services.

5.0 Reablement Strategy and Vision

5.1 The Reablement strategy includes:

- deliver a service that is person centred and achieves the best possible outcomes for each individual whilst achieving savings for Adult Social Care
- Teach customers new skills or help them to regain skills they may have lost, which may include dressing and undressing, getting into and out of bed, preparing meals, moving around the home.
- look at support after Reablement, for example from local community groups and volunteer organisations.
- ensure customers are safely supported home from hospital in a timely and efficient way.
- ensure customers receive the appropriate case management and support from the service that can best meet their needs.
- information is collated to report on performance and to enable the future development of the service.
- ensure good relationships are established with partners – including acute hospital discharge services and community health colleagues.
- co-ordination of services working with managers/practitioners in the Reablement Service Locality Hub, facilitating safe hospital discharge

6.0 Safeguarding Implications

6.1 Reablement is a CQC registered service and therefore works to the regulations in The Health and Social Care Act 2008. As a regulated service there are five standards that are inspected: Safe, Effective, Caring, Responsive and Well-led. CQC has rated Reablement as Good in all five areas. Safeguarding is evaluated as part of the Safe Key Lines of Enquiry.

6.2 All staff attend mandatory safeguarding training annually.

6.3 The service closely monitors both safeguarding and incidents through the provider Performance and Outcomes Group. There is robust governance in place.

6.4 As a part of Wiltshire Council, Reablement is committed to the principles of 'Making Safeguarding Personal' and aims to ensure that safeguarding is person-led and focused on the outcomes that customers want to achieve.

7.0 Public Health Implications

7.1 Wiltshire is classified as a predominantly rural local authority by DEFRA's rural-urban classifications with an overall population of 510,400 (*Census 2021, Office for National Statistics*). Approximately 14,000 people live in the most

deprived areas of Wiltshire and are more likely to experience poorer health outcomes including life expectancy as a result (Wiltshire Intelligence, 2019).

7.2 Our 65+ population currently represents over a fifth of Wiltshire's population, but by 2040 this age group will make up nearly a third of the total population.

7.3 By 2040 in Wiltshire:

- 65+ population expected to have increased by 43%
- Under 65+ population expected to have decreased by 3%
- 85% population expected to have increased by 87%
- Aged 85 years and above increase from 15,200 to 28,438

8.0 Procurement Implications

8.1 Reablement is an internally commissioned service.

9.0 Equalities Impact of the Proposal

9.1 An Equalities Impact statement was undertaken when Reablement launched in 2018. There has been no requirement to repeat this core services remain unchanged.

10.0 Environmental and Climate Change Considerations

10.1 The service is community based and therefore there are environmental and climate implications for its delivery. The rotas are reviewed to ensure that travel is as efficient as possible; however, the majority of visits are face to face in customers' homes so gains in this area are limited.

10.2 The service is constantly looking at efficiencies and has recently reprocured the scheduling system moving to electronic records which will reduce both paper held records and the requirement to deliver updated support plans to customer homes.

10.3 Alternative models for assessment are being considered such as virtual online assessments for equipment which would again reduce travel time and fuel costs.

10.4 Carbon Literacy awareness has been cascaded through team meetings to all staff and mangers and Senior Admin Officers have attended the training to act as environmental champions in the service.

11.0 Workforce Implications

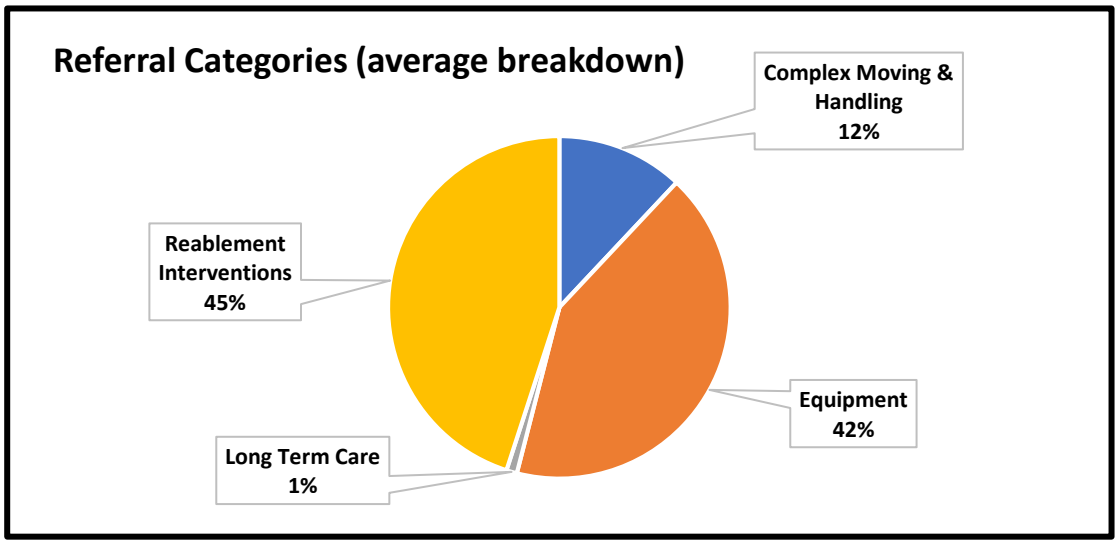
11.1 Recruitment and retention remain a priority for both qualified occupational therapists and support staff. A market supplement and recruitment/retention grants are currently in place and are essential to sustain delivery of the core functions of the service.

11.2 It is recognised that recruitment will remain an on-going challenge in the labour market where so many vacancies exist. The turnover of staff places pressure on the service with the additional need to recruit, train and retain experienced and well-trained staff.

11.3 Retention remains a key factor to ensure that the service remains stable and continues to deliver the quality of service required. All of the team members are trained to a high standard and are considered across the sector as a highly skilled workforce losing staff has a negative effect on the service we deliver, as it takes time to replicate the training and skills. The marketplace remains extremely competitive, with increased incentives being offered by other provider services.

12.0 Performance

12.1 Referrals – on average the reablement service manages 260 referrals per month.



12.2 The Reablement data set has evolved since the inception of Reablement and we are now required to provide a number of performance reports which include:

12.3 SHREWD - Strategic Health Resilience Early Warning Dashboard. This shows the operational situation of local urgent care systems as a simple view in real time. Reablement report activity weekly to this BSW platform.

12.4 Performance Outcomes Groups (POG) – Provider POG and Operational POG held 6-weekly. Reporting into the Performance and Outcomes Board.

12.5 Customer outcomes are measured when the customers' Reablement journey ends. From the table below you can clearly see the rise in customers who are independent (requiring no further support).

Outcomes at the end of Reablement	2021/2022	2022/2023	2023/2024 Qtr. 1
Hospital discharge/referral cancelled	6%	9%	4%
Care increased	1%	1%	0%
Care reduced	6%	7%	8%
Care unchanged	3%	3%	4%
Independent	65%	69%	70%
Deceased	3%	3%	2%
Hospital admission	11%	7%	11%
Residential/Nursing placement	4%	1%	1%

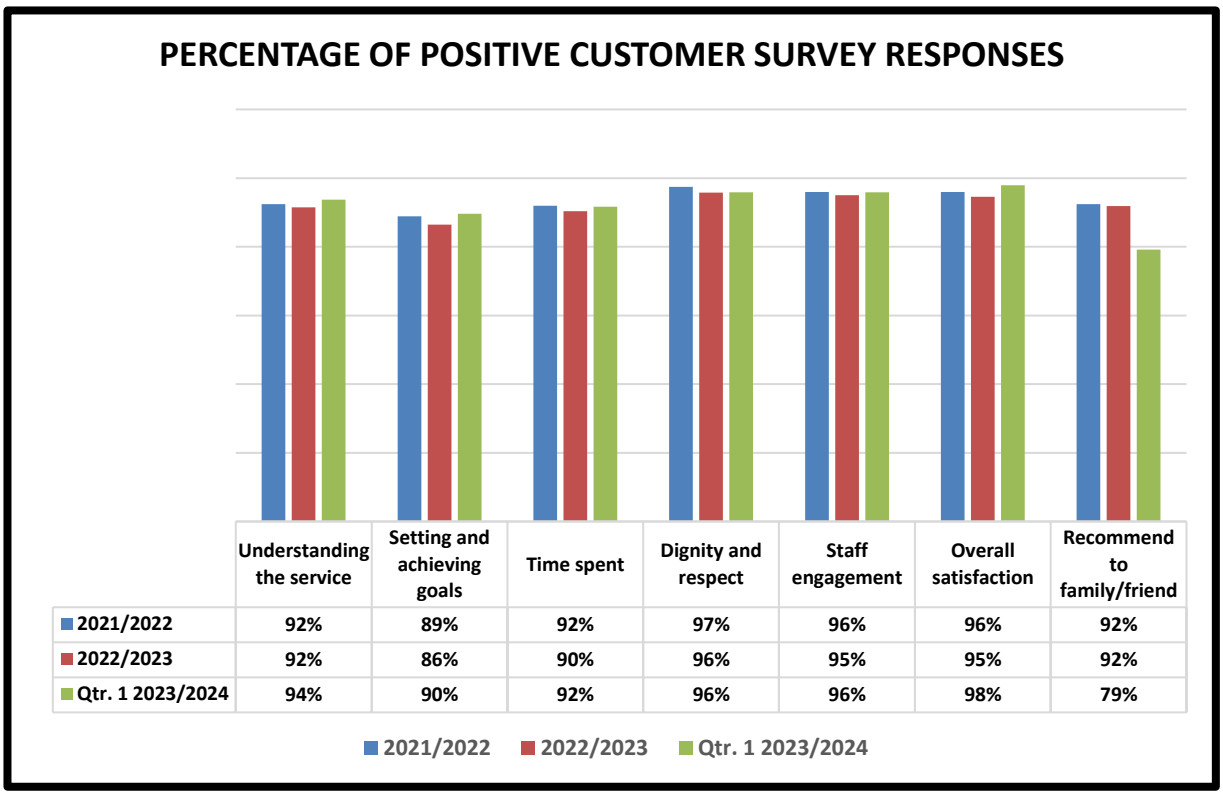
12.6 The number of people achieving independence after Reablement is a good indication of the impact the service is having. This is particularly noteworthy as Wiltshire Reablement unlike many similar services is non- selective. This means that everyone referred can benefit from the Reablement approach. Other services use a form of eligibility criteria and only offer reablement to customers who meet this specification.

12.7 Long term outcomes are measured by reviewing the customer's location, 91-days after discharge from the service, as required by ASCOF (Adult Social Care Outcomes Framework) Measure 2B.
The National Average for England is 81%, the service is tracking just above average for 23/24.
There is a decrease in the number of people at home in the first quarter of 23/24 with a higher number of people being readmitted to hospital which is due to the frailty of the cohort, and more people choosing to move into a care home placement after being discharged home for a trial period.

Long Term Outcomes (Hospital Discharges only)		2022/2023	2023/2024 Qtr. 1
Home		91%	82%
Hospital		4%	8%
residential/nursing placement		2%	7%
deceased		3%	2%

13 Customer Voice and Feedback

13.1 All customers who receive a package of care are asked to complete a satisfaction survey. We are constantly receiving positive feedback and are interested in getting more detailed responses, so a guided conversation' has also been developed which will be carried out by the management team, face to face in customer's home. The 'guided conversation' is a gentle and personal way of gathering rich data from customers about the quality of the service they received.



	Understanding the service	Setting and achieving goals	Time spent	Dignity and respect	Staff engagement	Overall satisfaction	Recommend to family/friend
2021/2022	92%	89%	92%	97%	96%	96%	92%
2022/2023	92%	86%	90%	96%	95%	95%	92%
Qtr. 1 2023/2024	94%	90%	92%	96%	96%	98%	79%

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

14.1 Not relevant, no decision required.

15.0 Financial Implications

The Reablement Service makes significant financial savings for Wiltshire Council by:

15.2 Reablement of the customer, thereby negating the need for ongoing services

15.3 Provision of equipment to enable customers to reconvene tasks they have not been able to undertake therefore preventing or delaying the need for formal care services.

15.4 Reablement is provided pre care act and is therefore accessible to

self-funding customers. Working with this cohort of customers can support them to preserve their resources reducing or delaying their need for future social care support.

16.0 **Legal Implications**

16.1 There are no legal implications as part of this paper.

17.0 **Options Considered**

17.1 There are no options as part of this paper.

18.0 **Proposals**

18.1 There are no proposals as part of this paper.

19.0 **Conclusion**

19.1 Reablement continues to deliver high quality outcomes for the customers who receive their support. The focus for the next 12 months will be to look for efficiencies in the way that the service works with customers both through the model of delivery and by taking advantage of improvements in Technology Enabled Care. There is continued high demand for the service which places pressure on the staff who are working at the front line in the Community. Recruitment and retention remain a priority for both qualified occupational therapists and support staff and ensuring that the market supplement and recruitment/retention grants remain in place is essential to sustain delivery of the core functions of the service.

Lead Director Emma Legg (Director of Adult Social Services)

Report Author: Helen Henderson, Head of Reablement, Therapy, & Community Services

29th August 2023

Appendices None

Background Papers None

This page is intentionally left blank

Wiltshire Council

Health Select

25/08/2023

Wiltshire Support at Home

Purpose of Report

1. Wiltshire Support at Home is a provider service within Reablement, Therapy and Community Services which is part of Wiltshire Council's Adult Social Care directorate, the service works in partnership as an integrated team with the HomeFirst, Reablement and Rapid Response Services. This report provides an update on the key work that is being undertaken.

Relevance to the Council's Business Plan

2. The Wiltshire Support at Home service ensures the council improves the way we work together, we deliver our service in partnership with service users, local communities, and other public sectors where appropriate. Safeguarding customers from harm is one of Wiltshire Council's most important responsibilities, Wiltshire Support at Home, works closely to ensure customers in receipt of services are safe in line with CQC's legislation and registration requirements.

Wiltshire Support at Home background

3. Wiltshire Support at Home was launched in May 2020 at the start of the COVID-19 pandemic, initially sitting under the Reablement CQC registration. At the beginning of the pandemic, Wiltshire Council were inundated with volunteer applications from those furloughed from work and wanting to support their local community. Wiltshire Council were keen to utilise this volunteer workforce, as a result, a pilot project to create an in-house domiciliary care team was implemented.
4. Wiltshire Support at Home began with, a small team of newly recruited staff and seconded staff from services who were not fully working due to the lock down status. In August 2020, the service went Live, accepting domiciliary referrals for the North of Wiltshire only initially as it had been identified by commissioning as an area which had reduced domically care coverage.
5. Wiltshire Support at Home launched in its new format in January 2022. Developing the service from the original concept of the domically care service to our new provision supporting Pathway One and Rapid Response. Wiltshire Support at Home was able to use the lessons learned from the development of the Reablement Service and phase the recruitment of the Senior/Admin and Management roles to support the recruitment of the Support Worker team and the CQC registration requirements. This has enabled the service to effectively manage the demand of hospital discharges in North, West, and South of Wiltshire.

Main Considerations / Service provision

6. In January 2022, a Registered Manager was appointed into the role. The new service provision and CQC applications were completed and later successful. The CQC Fit Persons interview was completed on the 17th of November 2023 and confirmation of the Registration of Wiltshire Support at Home as a CQC provider in March 2023.
7. The Wiltshire Support at Home service has a reablement ethos, referrals are case managed by the referring practitioner (a therapist for hospital discharges and a social worker for Rapid Response) and a Senior Support Worker from the service. At the first visit a joint assessment is undertaken and a bespoke support plan built to meet the person's agreed outcomes. The support is delivered by our team of Support Workers who have been provided with specialised training to promote both a person centred and reablement ethos. We work closely with the customer to discuss what goals they want to achieve and how best they can achieve them.
8. The service relies on effective communication between all parties, our support workers, our case managers, our customers, and individuals that our customers request to be a part of their support such as families, friends, and carers. Regular reviews take place to ensure that the package is responsive to the customer's changing abilities. Case managers, the Team Leader and Senior Support Workers play a vital role in identifying how the customer may benefit from using technology and adaptive equipment, if it is thought it will help, they take a lead role in arranging and introducing it to the customer.
9. Wiltshire Support at Home provides customers with four weeks intervention, during this time, our customers will be provided with regular reviews, information, and advice as well as the provision of equipment and adaptations.
10. The Service is supported by a small office-based team of staff, who provide the administrative assistance required to enable our Support Workers, Senior Support Workers and First Responders be fully utilised in hands on community support.
11. The service will support the following groups of individuals:
    - Vulnerable adults
    - People with dementia
    - Physical disabilities
    - Sensory impairment
    - Illness/End of life/Palliative
    - Adults recovering from illness.

Wiltshire Support at Home strategy

12. The main aims and objectives of the Wiltshire Support at Home service are;
    - Provide a high standard of person-centred care to those in need to enable them to remain in their own home.
    - Treat customers with consideration and respect, ensuring they are safeguarded from the risk of abuse.
    - Ensure confidential information is always protected and only shared with others strictly in accordance with our policies.
    - Support customers in their own homes by assisting and improving the quality of their lives whilst maintaining their independence and personal choices.
    - Offer non-discriminatory support that is sensitive to cultural needs and respectful of environments and traditions.

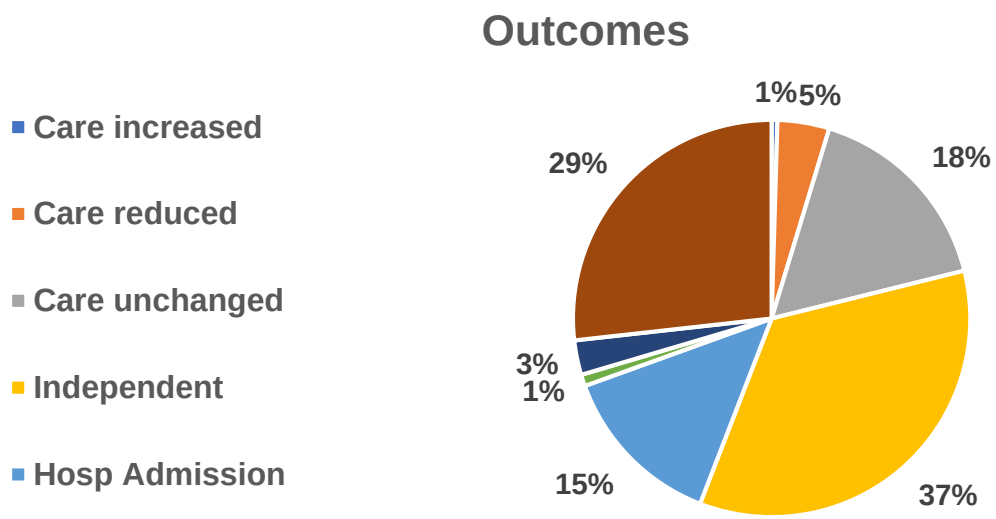
13. The overall responsibilities of the Wiltshire Support at Home team are:
    - To work with customers and carers/families to identify goals and design creative support plans to achieve them
    - To connect customers with local resources and facilities.
    - To operate within legal frameworks and defined budgets for social care.
    - To work closely with colleagues from Health, private providers, the voluntary sector, and others, to support the occupational needs of customers.

Referrals & Care Hours

14. The referral system for Pathway 1 uses Wiltshire Support at Home as a filtering facility and therefore the demand appears high compared to the number converted to successful discharge. This system offers packages through Pathway 1 to the service with a 3-hour KPI target to respond to those awaiting discharge. The pathways are currently being reviewed and are a target for further improvement next year.
15. Care Hours are now meeting the target KPI on delivery against recruited capacity.
16. Since April 2023, on average per month we have received 160 referrals, 30% of which were accepted and 74% of these were converted into discharges.

Outcomes

17. As part of reporting, we analyse and report all customer outcomes when they end their support journey with Wiltshire Support at Home.



Workforce

.

18. There has been a considerable amount of effort and resource devoted to the recruitment of support workers into the new service over the past 18 months. This has delayed the roll out of the full service.
19. 98% recruitment was achieved in July 2023 therefore the full effect has yet to be evaluated.
20. This year, both Registered Manager, and the Team Leader, achieved their Level 5 in Leadership and Management in Adult Care. Wiltshire Support at Home currently have five staff members completing Apprenticeships with an additional two that are within the sign-up stages.
21. It is important to retain the workforce and therefore invest in staff learning and development. The service holds regular team meetings embedding the values of our organisation and celebrate both the organisations and individual achievements. We try to promote a positive working environment and inclusive culture, ensuring our leadership team model desired behaviours. In March 2023 we started a time to shine award which is covered in both our newsletter and on social media to celebrate success.

Customer Satisfaction Surveys

22. All customers who receive a package of care are asked to provide feedback regarding the service, these are collated using Customer Satisfaction Surveys. These surveys are issued to all customers during their time with the service and are collated and reported on in performance and outcome groups. As a new service it is important for us to obtain consistent feedback about the customer experience. In March 2023, the management team started face to face reviews with customers, speaking to customers who were new or in the 3-week period of their short-term care and support. Over the past 18 months the below percentages have been collated from our surveys.
    - 97% of customers were able to achieve their goals following their support with Wiltshire Support at Home
    - 100% of customers confirmed they were treated with dignity and respect.
    - 99% were satisfied with the overall service they received.
    - 98% of customers would recommend the service to someone else.

Achievements & Development

23. On the 3rd of March 2023 Wiltshire Support at Home supported Wiltshire College with our first T Level student. Lemuel is studying Social Care and had the opportunity to meet our wonderful customers alongside our Support Workers, but also assisted with

supporting / shadowing our office staff to better understand the different roles throughout Social Care. The placement allowed Lemuel to learn different types of communication, as well as completing a sign language course alongside our Learning and Development team. Our customers really enjoyed Lemuel visiting them, as well as being a friendly face, he has been handy man by fixing two of our customers TV's. Here is what Lemuel had to say about his placement. "I am a student at Wiltshire University Centre and have a placement with the Wiltshire support at Home. It has been fantastic and amazing being in the team. The people are so lovely, engaging, funny, encouraging, and supportive. I am so glad I was part of the team during my placement."

24. Over the past 12 months we have worked on data reporting and are required to provide a number of reports which include CQC PIR, Pathway 1 HomeFirst Dashboard and Performance Outcome Groups (POG) – Provider Performance Outcome Groups's are held 6 weekly and report into the Performance and Outcomes Board.
25. Digital Social Care Records and Scheduling System procured – Over the past 12 months the service started the procurement process to acquire a new rostering system that would allow both the WSAH service and Reablement service to become paperless. Birdie is in the last week of being implemented before going Live on Monday 4th September.

Safeguarding Implications

26. All staff attend mandatory safeguarding training annually.

27. The service closely monitors both safeguarding and incidents through the provider Performance and Outcomes Group. There is robust governance in place.

28. Wiltshire Support at Home is a CQC registered service and therefore works to the regulations in The Health and Social Care Act 2008. As a regulated service there are five standards that are inspected: Safe, Effective, Caring, Responsive and Well-led. C Safeguarding is evaluated as part of the Safe Key Lines of Enquiry

Public Health Implications

29. Wiltshire Support at Home, work alongside Public Health closely in the development of policy and the update of infection control training.

Procurement Implications

30. There are no current procurement implications as part of the work that is being completed by Wiltshire Support at Home. Wiltshire Support at Home is an internally commissioned provider service.

Equalities Impact of the Proposal

31. An equalities Impact Assessment was undertaken as part of the project development; this remains current and has not required updating.

Environmental and Climate Change Considerations

32. Wiltshire Council is on the path to carbon neutral (net zero). The council's aim is to become Carbon neutral organisation by 2030.

33. Carbon Literacy awareness has been cascaded through team meetings to all staff and mangers and Senior Admin Officers have attended the training to act as environmental champions in the service.

34. The service is community based and therefore there are environmental and climate implications for its delivery. The rotas are reviewed to ensure that travel is as efficient as possible; however, the majority of visits are face to face in customers' homes so gains in this area are limited.

35. The service is constantly looking at efficiencies and has recently procured tablet devices to trial with the staff to enable real time update to the electronic records which will reduce the use of paper held records and the requirement to deliver updated support plans to customer homes.

Financial Implications

36. There are no financial implications as a result of this paper.

Legal Implications

37. There are no legal implications as part of this paper.

Options Considered

38. There are no options as part of this paper.

Background Papers

- None

Proposals
N/A

Lead Director Emma Legg (Director of Adult Social Services)

Report Author: Helen Henderson, Head of Reablement, Therapy and Community Services
Helen.Henderson@wiltshire.gov.uk

Kerry A'Court, Registered Manager Wiltshire Support at Home Kerry.A'Court@wiltshire.gov.uk and Emma Tomes, Senior Admin Officer, Emma.Tomes@wiltshire.gov.uk.

This page is intentionally left blank

Technology Enabled Care

Victoria Bayley
HoS Whole Life Commissioning
5 September 2023

Wiltshire Council

What is Technology Enabled Care?

Technology Enabled Care (TEC), is the use of technology to support and enhance health and social care outcomes and includes devices, systems and software that enable people to live more independently and supports their wellbeing.

These may include

- Pendants and wearable devices linked to a monitoring centre
- Sensors fixed in the home to monitor movement and change
- Medication prompts

There has also been a huge growth in Smart Technology and everyday devices can now be used to enhance the TEC offer

- Mobile phone apps
- Alexa devices to set reminders and enhance quality of life
- Interactive Artificial Intelligence devices

Wiltshire Council's TEC team

- Created in April 2022
- Commissioning Manager, 3 Senior Commissioner/TEC advisors
- Working across operations and commissioning, covering localities and specialisms
- Technology Enabled Care Strategy 2023-2028
- Focus on transformation and innovation

Wiltshire Council's Vision

- We will use technology to enable people to fulfil their potential, be actively involved and included in their communities, make informed decisions, have control over their lives, and be valued and included within society.

- Leaders will empower staff to be innovative and creative and to work with people to find the right technology-enabled care solutions for their lives.

Context and Development of the Strategy

- Local context
  - Ageing population within Wiltshire
  - 21.8% of population is over 65
  - Forecast that by 2040 the 85+ age group will double

- Strong focus on Co-Production

  300 people took part in workshops led by WCIL

- Working with the TSA (the industry and advisory body for TEC)

  Sessions across the council including leaders and front-line staff.

Our Core Objectives

1) To develop a TEC offer that empowers people and supports them meet their aspirations to live independent lives

2) To develop a TEC first Culture

3) To work with our partners across Social Care, Housing and the NHS

4) To deliver change in the way we provide care – by 2028 we expect that 60% of packages funded by the council will be enabled by Technology.

Future Innovation

- There is a strong appetite to innovate and to embed a wider range of solutions into care and support provision, especially for adults with learning disabilities and/or dementia.

- Shift to a proactive TEC offer

Wearable smart technology	**Falls detection / prevention**	**Dehydration detection / prevention**	**Medication prompting & adherence confirmation**
Discharge to Assess bed monitoring	**Activity monitoring – Connected Care systems**	**Epilepsy episode detection / prevention**	**Applications to support and guide people with MH/LD/A**

Priority Outcomes

- Improve the quality of care
- Promote independence
- Reduce admissions to hospital and care homes
- Provide care that meets individual needs
- Achieve greater efficiency

- We will be able to demonstrate improved outcomes across all age groups, customer groups and care settings
- Empower people and our communities
- Achieve savings through cost avoidance and some costs savings by reducing direct carer support

How we will deliver the priorities

- **Raise awareness and information sharing**
  - Ongoing training including workshops and virtual e-learning
  - Promote TEC champions
- **Develop clear pathways for TEC**
  - TEC will be part of all Care Act Assessments (as a mandatory field)
  - Accessible information for self-funders
- **We will grow our TEC offer**
  - Develop Local places for people to view and test equipment
  - Develop our discharge from hospital offer.

Test and Learn Approach

  - Use data to enrich our knowledge and insights
  - Develop a structured approach to funding to enable creative solutions to be tested
  - Analyse the return on Investment for TEC
  - Utilising pilot opportunities
- **We will provide support to Stakeholders**
  - Shared language across our networks
  - Engage with Integrated Care Board, voluntary and community sector
  - Support Care providers to understand what benefits TEC can bring to services

Questions

Summary of points raised at the Inquiry

Item	Theme	No.	Issue
Contributing Factors			
	Ageing Population	1	Wiltshire has an ageing population with increasingly complex needs. Older people have less resilience to chronic illness and consequently place greater demand on health and adult care services.
	Economic & Social	2	There are fewer carers and generally less support in families as people are working longer hours or returning to work because of the cost-of-living crisis.
		3	There is an increase in working age adult demand for Adult Social Care (ASC).
		4	Demand in children's services has increased, leading to follow-on demand in adult services as they get older.
		5	The ambulance service reported receiving more calls from areas of deprivation.
		6	Since Covid, there has been an increase in levels of anxiety and depression as people struggle to engage and connect with communities.
	Covid	7	Covid has impacted all areas of health and social care. There is a Bath and North East Somerset, Swindon and Wiltshire (BSW) Post Covid Urgent and Emergency Recovery Plan which was outlined in the briefing pack provided before the inquiry session (Appendix 2).
	Staffing	8	There is a recruitment crisis in general practice causing practices to operate with a skeleton staff or close to it. Physician assistants will help but will take three years to train.
		9	Staff worked during Covid and have since faced a hugely challenging backlog, causing greater staff stress and sickness.
		10	Domiciliary care homes are struggling to recruit staff partly due to wage competition with supermarkets.
		11	In hospitals many staff post-covid are trying to catch up while managing significant staff sickness levels. Salisbury NHS Foundation Hospital Trust welcome the new national workforce plan. They are starting to notice a reduction in sickness and are looking at new roles, but this all takes time.
	Primary Care	12	The GP's role is to act as gatekeeper to the NHS and 90% of contacts with health are with primary care. (A drop to 80% of contacts would be felt across the system). At some practices GP triage has turned into a two or three step process, involving call-backs to see if patients need an appointment. It is important that triage and call-backs happen quickly to avoid unnecessary demands on acute care however the system's ability to function effectively has been impacted by GP sickness.
		13	A Healthwatch survey found that some GP surgeries don't have the infrastructure to do multiple calls and call-backs etc. If people know they are in a queue they can manage it, but they need to know that. Different Primary Care Networks (PCN) are adopting different systems – with some advising patients to go to A&E.
		14	Pharmacies and dental services are also primary care contractors and need to play a bigger role in the system. However, some pharmacies are closing and towns are expanding without additional services. There is concern about how these issues will be tackled.
		15	Access to NHS Dentistry is increasingly reducing for adults and the bulk of calls to Healthwatch are about dentistry.
	Community Services	16	Wiltshire Health and Care (Community health services) have noticed that the level of care needs has increased, with the number of visits required per patient going up from 2 to 3-4 visits a day.
		17	It can cost £2K a week for people to be cared for at home.
	Care Homes Domiciliary Care	18	The capacity in care homes is not sufficient and it is likely to get worse.
		19	The type of care available does not meet the complex needs of people on discharge, e.g. people with very challenging behaviours.
		20	Housing is a huge element of the solution. There is a need for single-sex provision and accommodation for younger people too.
The impact of a reduced access to services		21	It became clear through the discussion that all health and social care services are closely interlinked, so any change or block in the system is felt by everyone across the whole system.
	Exacerbation of physical and mental health conditions	22	The post-covid demand on services has led to very long waits for specialist interventions e.g., a 12-month wait for a cardiologist compared with a 2-month wait pre-covid. This is likely to lead to patient deterioration during wait times and routine problems becoming more significant.
		23	There are rising levels of anxiety and depression with young people and at the same time a lack of access to Children and Adolescent Mental Health Service (CAHMS), with waiting lists sometimes over a year. Consequently, young people present at A&E with mental health symptoms.
		24	There is no support for people who fall between the thresholds of mild and severe mental health conditions, which may lead to more people presenting late with complex mental health problems.

Patients going directly to A&E	25	People don't always know where to go for the care.
	26	Patient surveys and feedback suggest frustration at the lack of access to GPs.
	27	Patients report a lack of confidence with online booking systems, unable to complete or system errors advising them to attend A&E.
	28	Younger people are more likely to use A&E for non-emergencies.
Difficulties sourcing appropriate care.	29	It is difficult to source rehab and housing for people with complex mental health problems and community support will no longer be able to provide the level of support needed.
	30	There are challenges with discharging patients with complex needs and sourcing the appropriate care package to meet those needs.
	31	Loss of community hospitals means more people discharged to residential homes without nursing provision.
	32	Delay in clinicians and Adult Social Care (ASC) being able to agree a discharge plan causing Delayed Transfer of Care (DTOC). Delayed hospital discharges and adult social care (parliament.uk).
	33	For Adult Social Care (ASC) the introduction of No Criteria to Reside (NCTR) has resulted in a diversion of resources to manage the increase in patients being discharged home who are not ready to be independent at home and still have high needs.
	34	Social care not being able to provide does have an impact on acute care needs.
	35	Readmissions to hospital are often due to the right care not being available at home or in the community.
The Voluntary Secto	36	The voluntary sector has a role in supporting people, however there is a limit to the services that can be provided purely by volunteers.
	37	The ambulance service noted that reductions to community support services has had an impact on other services e.g. reduction in alcohol support, causing an overall impact on ambulance services.
	38	The Council has had to divert some resources away from prevention in order to handle the impact of more people leaving hospital with significant support needs.
Strategies to mitigate demand on urgent care	39	It is a challenge for people to both 'row the boat' and fix it at the same time, that is to innovate and make improvements at the same time as delivering day-to-day services.
GP Surgeries	40	The Devizes pathway-2 model aims to replicate the care patients with high needs would receive in a hospital. It is working well, and the cost is significantly less than a hospital bed.
	41	Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care Board (ICB) is developing plans from all PCNs to improve access to GP care.
	42	Surgeries need to provide for transactional urgent care (same day appointments) as well as a more traditional life-long care service. Practices are all independent businesses so it is difficult to encourage GPs to all take the same approach.
	43	Some GP practices have now adopted a two-lane system with a) the choice of an urgent appointment with someone, or b) an appointment with a specific person with a longer wait.
	44	There is now a common health record, which is beginning to work well, but bringing the current 12 systems together (Single View) takes a lot of work and clinical input. Currently when a patient arrives at an Minor Injuries Unit (MIU) it is not possible to see if they have called 111 or been to the GP.
Ambulance Service	45	South West Ambulance Service Trust (SWAST) tries to treat on scene or redirect from Emergency Department. The demand is increasing but the ability to treat outside hospital Emergency Department (ED) is also increasing.
Adult Social Care	46	The Council introduced a new homecare framework in April 2023. The specification is clear to new providers that they pay the national living wage to their staff. There are a couple of pilots in Wiltshire testing new ways of doing business with providers.
	47	Under the new commissioning framework, an increase in price per hour has brought more providers into the market. New providers also bring risks around quality assurance. The benefit of a framework is increasing capacity and local provision, but it does need to be carefully managed to ensure quality. Complex care costs are a high risk for providers too. There is an opportunity to have a coherent approach with the upcoming re-commissioning of the community services contract.
	48	Wiltshire Support at Home, the Council's in-house domiciliary care agency has grown well in the last year. Although it can't entirely replace a viable care market, it is having a positive impact.
	49	The Council has an early intervention strategy and now needs to incorporate other partners. There has been a shift in discussion at the Integrated Care Forum towards prevention.

		50	Technology is part of Council's ASC transformation programme. The tech team has been developing a new strategy for this and we will be looking to make gains across the system in the next 12 months.
		51	There was some concern about technology in care not being suitable for some conditions.
	Care Co-ordination	52	The 111 and out of hours service (Medvivo) is implementing a new approach to care co-ordination to reduce duplication and link the services a patient is known to.
	Care Co-ordination (cont.)	53	A single point of access was introduced for health care professionals to access more senior clinical support and advice.
		54	Care co-ordination initially focused on ambulance crews who were able to seek advice on hospital conveyance. It also has representatives from Adult Social Care and community services to help provide alternative care to going to A&E.
		55	The triage system used by 111 is very risk averse and defaults to acute services too. To mitigate this, in Wiltshire a 111 clinician speaks to category 3 callers. They address 3000 callers a month in this way.
		56	Only 16% of patients (across all categories) were conveyed to hospital, which is significantly lower than average.
		57	Support to care homes is also being looked at to reduce 999 calls with a consultant-led multi agency team to support care home staff.
		58	The next step is to address end of life care.
	Resources for delivering urgent care services in the community	59	Wiltshire Health and Care supports 17-18,000 people and aims to avoid them going into crisis and keep people in the community. The service has been recently reviewed and will be starting a new improvement programme.
		60	Money is not the only answer and how services are provided needs to be considered.
		61	NHS at home – there are 32 beds in virtual wards, with a focus on frail people, up to 100 by the end of the year. The initiative has seen over 80% not going on to need admission. The challenge is growing public confidence in the approach. It takes a lot of time to shift the culture away from treating in a hospital to managing in the community.
		62	In terms of providing community services, good data makes a big difference in being able to focus on prevention.
Aspirational Improvements	**Patient-friendly services**	63	Healthwatch surveys highlighted improvements from a patient's perspective to include better communication to help people understand how the system works, consideration around improving acoustics in facilities so people don't have to shout their symptoms, quiet and safe areas for patients, clear signage and colour use, facilities for patients attending hospital with children.
	Transition from hospital to home	64	'Home for lunch' initiatives, getting people home earlier in the day makes it easier to get the required support services in place. 48% from Comm hosp are home before lunch but recognise could do more. Patient transport availability is big challenge to this as well as other things like TTAs (pharmacy/drugs).
		65	Start process earlier so become aware of their needs. Eg need to know if they are a hoarder and will need support to get home. PW2 pilot survey showed how well this worked within the new model setting. Resulted in 28 day LOS and had better understanding of peoples' needs as a whole, not just health.
		66	Involve Adult Social Care from the start. More in-reach in acute wards, even small things like passing on key codes etc. completing info correctly on the ward. Lisa H responded that we have recruited in-reach teams to each acute. They are having clinical conversations to get people in right place and gather right data. Supporting unpaid carers and making referrals to appropriate community organisations.
	Preven repeat readmissions to hospital	67	More could be done to link up to the adaptations service however it is difficult to change current process to access Disabled Facility Grants (DFG).
		68	In terms of quick wins, focusing on smoking cessation does reduce readmissions.
		69	There are lots of small health issues that could be tackled that will make a difference.
		70	More could be done to better monitor those discharged. It would help to know the outcomes for up to a year.
	Integrated approach to care	71	A longer-term vision would be to develop community models for care, like dementia care villages.
		72	Ideally, the Council would want to encourage small, even micro, providers linked to local areas/villages. This would have the added benefit of saving on high-cost care with a county provider.
		73	More could be done to join up care needs in housing strategies and local plans.
		74	The council needs to prevent people from requiring care.

75 There is a need for Adult Social Care to focus on whether we are working effectively with the voluntary sector.

Inquiry Session into Demands on Urgent Care Services and Patient Flow into and out of Hospital

Purpose

1. To present to the Health Select Committee the findings and proposals from the inquiry session into the demands on urgent care services held on 19 July 2023.

Background

2. In July 2022 the Committee resolved to hold an inquiry session looking at the factors contributing to the extreme pressures currently being experienced and reported in urgent care. The committee also agreed the session would consider the systemic challenges impacting on patient flow through acute hospitals used by Wiltshire residents.

Inquiry session attendees

Guests

Paul Birkett-Wendes	South West Ambulance Service Trust (SWAST)
Sarah Branton	Avon & Wiltshire Mental Health Partnership Trust
Sarah Cardy	Age UK
Heather Cooper	Bath & North East Somerset, Swindon & Wiltshire (BSW) Integrated Care Board (ICB)
Jo Cullen	Bath & North East Somerset, Swindon & Wiltshire (BSW) Integrated Care Board (ICB)
Diane Gooch	Wiltshire and Swindon Users Network & Health Select Committee Stakeholder member
Lisa Hodgson	Wiltshire Health & Care
Clare O'Farrell	Bath & North East Somerset, Swindon & Wiltshire (BSW) Integrated Care Board (ICB)
Michelle Reader	Medvivo
Catharine Symington	Healthwatch Wiltshire
Lisa Thomas	Salisbury NHS Foundation Hospital Trust
Ian Williams	Southbrook Surgery, Devizes PCN

Elected Members

Cllr David Bowler	Health Select Committee
Cllr Clare Cape	Health Select Committee
Cllr Mary Champion	Health Select Committee
Cllr Johnny Kidney (Chair)	Health Select Committee
Cllr Gordon King (Vice Chair)	Health Select Committee
Cllr Anthony Pickernell	Health Select Committee

Cllr Tom Rounds	Health Select Committee
Cllr Pip Ridout	Health Select Committee
Cllr Mike Sankey	Health Select Committee
Cllr David Vigar	Health Select Committee
Cllr Jane Davies	Cabinet member for Adult Social Care, SEND & Inclusion
Cllr Elizabeth Threlfall	Portfolio Holder for Adult Social Care Transformation

Officers

Kate Blackburn	Director of Public Health
Helen Henderson	Head of Service, Reablement
Helen Mullinger	Commissioning Manager
Mel Nicolaou	Head of Commissioning – Adult Services
Lucy Townsend	Corporate Director of People

Summary of the Inquiry Session

3. Points raised by participants during the inquiry session are summarised in Appendix 1.

Proposals

4. The Health Select Committee resolve to:

a) Thank all participants in the Inquiry session for their time and contributions.

b) Review progress on the action plan of the Joint Health and Wellbeing Strategy, as key themes of the inquiry, align with the key themes of the strategy i.e., **prevention and early intervention, localisation and connecting with communities and integration and working together.** https://cms.wiltshire.gov.uk/%28S%28hniswsj4w151yf55bd0kmu55%29%29/documents/s211732/Item_7_WJLHWS2023_v1.31.pdf . See also the BSW Integrated Care Strategy, the implementation plan for Wiltshire is on p 35 https://cms.wiltshire.gov.uk/documents/s217184/BSW%20Implementation%20Plan%20v2.pdf

c) Consider the strategies to manage the rise in mental health problems. The development of the BSW Emotional Wellbeing and Mental Health Strategy is an agenda item at Health Select Committee in September 2023.

d) Follow up on the ICB plans for Primary Care Networks to improve access to Primary Care and consider scheduling an item on the subject in the HSC Forward Work Plan in 2024.

e) Explore the voluntary sector's perspective on its role in the health and wellbeing of Wiltshire residents, potentially through rapid scrutiny.

f) Continue to follow the progress and impact of the new care commissioning model and include an update in the HSC Forward Work Plan in 2024.

g) Consider the best approach to gain insight into initiatives to reduce readmissions into urgent care – e.g., 'home for lunch', falls prevention. This could be, for example, through a rapid scrutiny exercise or by featuring preventative initiatives as a recurring agenda item for the committee.

h) Ensure the patient's voice has always been taken into consideration when reviewing new strategies and policies.

Cllr Johnny Kidney, Lead Member for the Inquiry Session into the demands on Urgent Care

Report author: Julie Bielby, Senior Scrutiny Officer, 01225 718702, julie.bielby@wiltshire.gov.uk

Appendices

Appendix 1: Summary of the Discussion

This page is intentionally left blank

Wiltshire Council

Health Select Committee

5th September 2023

Progress Report – Developing our BSW Mental Health Strategy

Executive summary

This report summarises the work underway to develop an all-age Mental Health Strategy for our BSW system. The report provides an overview of the timeline for the development of the strategy, key activities underway and planned in the coming months and identifies how we will be involving and engaging stakeholders from across the system in its development.

The report is a progress update to inform Councillors and colleagues of the work we are and will be undertaking. Decisions are not required by Council members at this stage, however we want to ensure that Council members are aware of the work being undertaken and are clear on the opportunities there will be for them to contribute to the development of the strategy and the associated approval of the draft strategy.

Proposal

That the committee:

a) note the progress report
b) note the timeline and approval process

Reason for proposal

This progress report is intended to ensure that Council colleagues are appraised of the work being undertaken and are aware of the next stages of the process to develop an integrated Mental Health Strategy for our BSW system.

Author:

Contact details: Jane Rowland and Georgina Ruddle (jane.rowland4@nhs.net)

Wiltshire Council

Health Select Committee

5th September 2023

Progress Report – Developing our Mental Health Strategy

Purpose of report

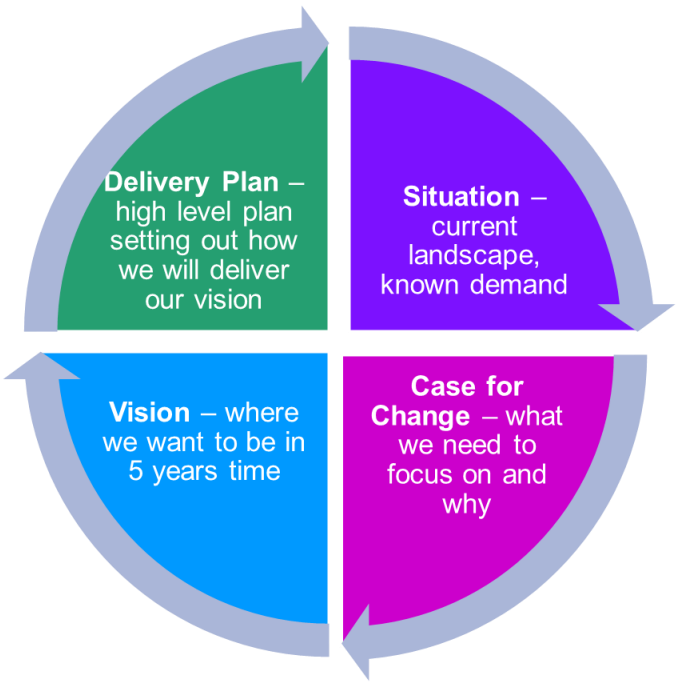
1. The purpose of this report is to provide a summary to Council members of the work currently underway and planned to develop our all-age Mental Health Strategy for BSW.
2. Colleagues are asked to note this report at this stage. It is an interim report intended to ensure that colleagues are appraised of the work that is ongoing, the work we will be doing in the coming months to ensure that our Mental Health Strategy reflects population health needs and priorities from across our communities, and the timeline for final approval of our strategy.

Background

3. In 2019/20, work commenced to develop an all-age Mental Health Strategy for BSW. Although the strategy was drafted, due to the pandemic, it was not formally ratified and remained in draft form.
4. In July 2022, BSW Clinical Commissioning Group evolved to become the Integrated Care Board. It was agreed by system partners that Mental Health should be a key area of focus for transformation and improvement, mindful of the need to improve parity of esteem between physical health and mental health, and to respond to population health needs.
5. For any programme of transformation to be successful, it is vital that there is a clear strategy which reflects the current position, sets out an ambitious but also realistic case for change and provides a direction of travel for future years that will deliver improvements in outcomes for our population. In order to achieve this, we have established a Mental Health Strategy development programme, with the intention to deliver an approved strategy by March 2024.
6. The strategy development programme commenced in May 2023, supported by all system partners including Wiltshire Council.

Strategy development process

7. The strategy development process has four critical elements as shown in the diagram below:



For our strategy to be representative and reflective of our system and its localities, it is important that we work through each element systematically – drawing on qualitative and quantitative evidence to support the development of a clear vision and delivery plan. Throughout, we must make sure that we involve stakeholders – co-producing our priorities with them.

The diagram below reflects the timeline we are working to and the content for each element of the process (to note, colour correspondence):

Main considerations for the committee

Progress against plan – Understanding our current landscape

8. Over the last three months we have started to gather a range of data and information reflecting our current landscape and known demand. This has been informed by all three Local Authority Joint Strategic Needs Assessments, as well as health related performance data and associated benchmarking.

9. We have also engaged with partners and stakeholders to understand their perspectives and ambitions for mental health services, through three Integrated Care Alliance (ICA) workshops (one per locality).

10. In each of these workshops, we used the Local Authority Joint Strategic Needs Assessment and health performance data and benchmarking to inform discussions. From that we asked attendees to reflect on what services are available locally, perceptions of the effectiveness of those local services, and what services require transformation or development in the future.

11. At the Wiltshire ICA workshop, we had excellent attendance from Local Authority colleagues and health partners as well as wider stakeholders from Voluntary, Community and Social Enterprise organisations and NHS provider organisations.

12. There was rich discussion and debate about current service provision and priorities for the future. Themes emerging from this session were:

- Access to diagnosis for people with neurodevelopmental needs (ADHD and Autism) is a challenge for people across our communities.

- We must focus on improving both mental health and emotional wellbeing of children and young people, with a staggered approach to transition into adult services.
- Our future system and services must be trauma-informed, with all professionals aware of how trauma can negatively impact an individuals and communities, and addressing the barriers that people affected by trauma can have when trying to access services.
- We need to consider how we can improve access to wider community services for older adults, reducing the impact of isolation, providing carer support and advice.
- Access to housing and accommodation post admission can be a significant barrier to discharge and we need to consider how we can improve this in order that people do not remain in hospital-based services for longer than clinically indicated.
- The range and breadth of community-based support and offers needs to be clearer for our population so that they make best use of what is available to them locally.
- We need to consider how we can mitigate current workforce challenges, as well as increase the diversity of our workforce to reflect population health needs.

13. The above themes will be used in the development of our case for change as this is developed in October. We have also received further feedback from VCSE colleagues who have identified other priorities that they would wish to see reflected in the strategy and we will continue to engage with them through the next phases of our strategy development to ensure that it reflects their priorities and ambitions as expert partners in service provision across Wiltshire.

Next steps – developing our case for change

14. As outlined, we expect to finalise the 'current situation' element of our strategy by the end of September 2023. The next phase of work will focus on developing our case for change.

15. This is an all-age strategy, spanning the life course of mental health. Consequently, we will need to ensure that our strategy and associated priorities reflect the needs of children and young people – including improving their emotional health and wellbeing and improving early access to mental health support when they need it.

17. In order to support the development of the children and young people's element of our strategy, we will be working with Local Authority colleagues – many of whom were present and contributed to the ICA workshop – to ensure that our strategic priorities for children and young people reflect and align with feedback received from service users, partners and peers (for example through the SEND Peer Review). We will also be working with colleagues in the Children and Young People's Programme to ensure that we are aligning our future plans with wider work, delivering integrated care for children and young people across our communities.

18. We have engaged a team of colleagues from the National Institute for Health and Care Research Applied Research Collaboration (ARC) West, based at the University

of Bristol to support us in developing our strategy further. They will be working with us over the coming months to:

- Undertake further stakeholder engagement including patients, members of the public and partner organisations (including Wiltshire Council)
- Synthesing existing analysis, national best practice and other policy documents
- Drawing the above together and supporting the development of the strategy document and associated delivery plan

19. A key component of this work, as outlined, is engagement with a wide range of stakeholders. Colleagues from the ARC team are currently drawing up their engagement plan. We are working with them to identify key leaders and individuals with whom we would want them to engage, this will include colleagues from Local Authorities, including Wiltshire Council.

20. We will be finalising this engagement plan with the ARC team in the next three weeks and will liaise with Local Authority colleagues accordingly thereafter.

Next steps – approval of the strategy

21. As the strategy progresses to its finalised format, we want to make sure that all partners have the opportunity to comment on the draft document, ensuring that it accurately and adequately represents each place and system. To that end we have agreed with Wiltshire Council scrutiny officers that we will follow the process outlined below:

- Ensure that there is early engagement regarding the development work to date and emerging themes (this paper and associated committee discussion)
- Presentation and discussion of the specific priorities for children and young people's services and their link with the Mental Health Strategy at their 31 October meeting
- A joint Rapid Scrutiny exercise to be carried out by members of Health Select Committee and Children's Select Committee of the draft strategy in December, with the outcome of that exercise to be presented to their Committees on 16 and 17 January 2024 respectively.

22. In line with the above, we are working to the following timeline:

Action	**Date**
Finalise 'Current Situation'	September 2023
Stakeholder engagement	October – November 2023
First draft strategy, priorities and delivery plan	Early December 2023
Rapid Scrutiny exercise of first draft to Health Select Committee and Children's Select Committee	January 2024 (dates as above)
Further engagement activity through key governance groups across BSW	January 2024
Incorporation of comments and feedback into draft strategy	February 2024
Presentation of finalised strategy to:	March 2024

• Health and Wellbeing Boards across BSW • ICB Board	

23. We will continue to work with Scrutiny Officers to ensure that we schedule presentations accordingly and maintain connection with key Wiltshire Council meetings in order that colleagues are appraised of and have further opportunity to contribute to the next stages of the process.

Conclusion

24. Committee members are asked to note the work that is now underway to ensure their continued involvement and engagement in the further development of our mental health strategy.

Report author(s): Jane Rowland
Jane.rowland4@nhs.net

Date of report: 24 August 2023

Background papers

None

Appendices

None

This page is intentionally left blank