Wiltshire Council
Where everybody matters

AGENDA

Meeting:	**HEALTH AND WELLBEING BOARD**
Place:	**The Kennet Room - County Hall, Trowbridge BA14 8JN**
Date:	**Thursday 25 January 2018**
Time:	**9.00 am**

Please direct any enquiries on this Agenda to Will Oulton, of Democratic and Members' Services, County Hall, Bythesea Road, Trowbridge, direct line 01225 713935 or email william.oulton@wiltshire.gov.uk

Press enquiries to Communications on direct line (01225) 713114/713115.
This agenda and all the documents referred to within it are available on the Council's website at www.wiltshire.gov.uk

Voting Membership:

Cllr Baroness Scott of Bybrook OBE	Leader of Council
Dr Richard Sandford-Hill	Chair of Wiltshire Clinical Commissioning Group
Dr Toby Davies	CCG - Chair of SARUM Group
Dr Andrew Girdher	CCG -Co-Chair of NEW Group
Dr Lindsay Kinlin	Acting Chair of NEW Group
Christine Graves	Chairman – Healthwatch
Nikki Luffingham	NHS England
Angus Macpherson	Police and Crime Commissioner
Cllr Laura Mayes	Cabinet Member for Children, Education and Skills
Cllr Ian Thorn	Liberal Democrat Group Leader
Cllr Jerry Wickham	Cabinet Member for Adult Social Care, Public Health and Public Protection

Non-Voting Membership:

Bill Bruce-Jones	Avon & Wiltshire Mental Health Partnership
Cllr Ben Anderson	Portfolio Holder for Public Health and Public Protection
Dr Gareth Bryant	Wessex Local Medical Committee
Tony Fox	Non-Executive Director - South West Ambulance Service Trust
Terence Herbert	Corporate Director - Children and Education
Linda Prosser	Wiltshire Clinical Commissioning Group
Mike Veale	Wiltshire Police Chief Constable
Cara Charles-Barks	Chief Executive or Chairman Salisbury Hospital
James Scott	Chief Executive or Chairman Bath RUH
Nerissa Vaughan	Chief Executive or Chairman Great Western Hospital
Graham Wilkin	Interim Director – Adult Care
Tracy Daszkiewicz	Director of Public Health

AGENDA

1 **Chairman's Welcome and Introduction**

2 **Apologies for Absence**

3 **Minutes***(Pages 5 - 10)*

To confirm the minutes of the meeting held on 9 November 2017.

4 **Declarations of Interest**

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

5 **Chairman's Announcements***(Pages 11 - 70)*

- CQC inspection in March
- Progress on integration

6 **Public Participation**

The Council welcomes contributions from members of the public.

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

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

Those wishing to ask questions are required to give notice of any such questions in writing to the officer named on the front of this agenda no later than 5pm on **Monday 22 January 2018** in order to be guaranteed of a written response**.** In order to receive a verbal response questions must be submitted no later than 5pm on **Wednesday 24 January 2018**. Please contact the officer named on the front of this agenda for further advice. Questions may be asked without notice if the Chairman decides that the matter is urgent.

Details of any questions received will be circulated to Committee members prior to the meeting and made available at the meeting and on the Council's website.

7 **Sustainability and Transformation Partnership Update**

A presentation inform the current priorities for collaborative working, and to introduce the board to the new senior responsible officer for the STP.

Responsible Officers: Chris Bown

8 **Winter Pressures - Update**

A presentation on the implementation of winter planning measures, the additional funding announced in the budget and to consider the current situation across the system.

Responsible Officers: Linda Prosser, Graham Wilkin
Report author: Jo Cullen

9 **Delayed Discharges***(Pages 71 - 96)*

To receive an update on the latest figures for delayed discharges.

Responsible Officers: Linda Prosser, Graham Wilkin
Report author: Sue Shelbourn-Barrow

10 **Better Care Plan***(Pages 97 - 186)*

To receive an update on the delivery of the Better Care Plan for Wiltshire and emerging plans for 2018/19.

Responsible Officers: Linda Prosser, Graham Wilkin
Report author: Sue Shelbourn-Barrow

11 **Pharmaceutical Needs Assessment***(Pages 187 - 322)*

To agree the final Pharmaceutical Needs Assessment, following recent consultation.

Responsible Officers: Tracy Daszkiewicz
Report author: Steve Maddern

12 **CCG Local Transformation Plan (CAMHS) Refresh***(Pages 323 - 334)*

To approve the refresh of the CCG's local transformation plan for child adolescent mental health services in 2018/19.

Responsible Officer: Ted Wilson
Report author: James Fortune

13 **Wiltshire CCG Care Operating Model**

A presentation outlining the proposed care operating model for Wiltshire.

Responsible Officers: Linda Prosser
Report author: Mark Harris

14 **Domestic Abuse***(Pages 335 - 420)*

To receive an update on domestic abuse strategy, needs assessment and contract award.

Responsible Officer: Graham Wilkin
Report author: Tracy Daszkiewicz

15 **Adult Social Care Transformation Programme***(Pages 421 - 426)*

An update on the delivery of the programme.

Responsible Officers: Graham Wilkin
Report author: Catherine Dixon

16 **Health and Wellbeing Board progress report 2017***(Pages 427 - 442)*

To receive an update on progress in delivering the joint health and wellbeing strategy.

Responsible Officer: Linda Prosser, Graham Wilkin
Report author: David Bowater

17 **Date of Next Meeting**

The next meeting will be 29 March 2018

18 **Urgent Items**

Wiltshire Council
Where everybody matters

HEALTH AND WELLBEING BOARD

DRAFT MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 9 NOVEMBER 2017 AT THE KENNET ROOM - COUNTY HALL, TROWBRIDGE BA14 8JN.

Present:

Cllr Baroness Scott of Bybrook OBE (Chair), Dr Richard Sandford-Hill (Vice-Chairman), Dr Toby Davies, Dr Andrew Girdher, Dr Lindsay Kinlin, Christine Graves, Cllr Laura Mayes, Cllr Ian Thorn, Cllr Jerry Wickham, Dr Gareth Bryant, James Scott, Terence Herbert and Linda Prosser

143 **Chairman's Welcome and Introduction**

The Chair, Baroness Jane Scott, welcomed all to the meeting.

144 **Apologies for Absence**

Apologies were received from Councillor Ben Anderson, Nerissa Vaughan, Cara Charles-Barks, Dr Bill Bruce-Jones, and Chief Inspector Mike Veale.

145 **Minutes**

The meeting considered the minutes of the previous meeting.

Resolved

To approve for signing the minutes of the meeting held on 19 September 2017.

146 **Declarations of Interest**

There were no declarations of interest.

147 **Chairman's Announcements**

There were no announcements.

148 **Public Participation**

There were no public questions.

149 **Winter Pressures**

The meeting received an update on preparations for winter pressures.

Matters highlighted in the course of the presentation and discussion included: that an STP area-wide plan had been developed; that series of engagement events had been delivered to spread best practice; how national communication material had been tailored for local circumstances to make them more relevant; the links to the national plans; the targets and changes in relation to integrated urgent care; how lessons on demand management over bank holiday periods had been used in planning for similar periods in the Christmas and New Year period; that SWAST had been a national pilot for the new Response Programme; how risk is assessed and plans developed; the links to public health activities such as flu vaccination; how elective care planning is maintained through-out the period; the structure of local delivery boards; how scenarios are tested with a range of health and social care partners; how data on capacity across the system is shared; the acknowledgement that there were some workforce issues that needed addressing; that officers were confident that the system was prepared as best it could.

In answer to a question from Cllr Brian Matthew regarding mixed sex wards, James Scott from the Bath RUH said he would seek to respond outside the meeting to the issues raised.

Resolved

That the update be noted.

150 **Better Care Plan**

The meeting received an update on the trajectory and plans for reducing delayed discharges ahead of winter and an update on the wider delivery of the Better Care Plan for Wiltshire.

Matters highlighted in the course of the presentation and discussion included: that the plan submitted in October and had been approved; the plan was being delivered, but that more action was required to improve performance regarding delayed transfers of care; the work with partners to accelerate delivery in this area; the progress that had been made against other key areas; the better use of technologies; how best practice has been shared from successful projects; the analysis of the causes of DTOCs and the opportunities to address this; how additional beds would be used to support transition back to community care; how spot purchasing is using to meet extra-demand; how process improvements have resolved community equipment; the additional demand placed on the plan due to winter; and that an additional bed spaces purchased should not be to the detriment of the vision to treat more people in their own home.

Resolved

1. **To note the update;**

2. **That the Health and Wellbeing Board, as system leaders, take collective responsibility for delayed transfers of care and regularly review progress in reducing numbers at future meetings**

151 **Procurement of Integrated Urgent Care**

The meeting received an update on the procurement of integrated urgent care

Matters highlighted in the course of the presentation and discussion included: the model being delivered in Wiltshire and the different services provided depending on the needs of the patient; the added complexity due to the diverse geography of the area, and the challenges of moving to location based commissioning; how intelligent mapping tools are used to analyse data to locate services appropriately; the focus on delivering care at the appropriate level; how commissioning strategies are aligned to deliver better outcomes; how best practice has been shared across different areas; how patient self-care is a continuing focus; how demographic data is used to plan services; the transition arrangements in relation to the mobilisation of service included in the package of procurement, especially given to the risk of winter pressures; how links are made through to emergency care through the urgent care hub; and the efforts to expand access to pharmacy based services.

Resolved

To note the update.

152 **Health and Wellbeing JSNA**

The meeting considered the report which sought the agreement for the JSNA overarching documentation.

Matters highlighted in the course of the presentation and discussion included: that since last iteration, the data had been presented in a more user-friendly way; how the structure of the document has changed into five areas and how more detailed data packs were available for each area; how data is benchmarked and analysed by different demographic groups; how presenting key information as infographics is used to disseminate the information consistently and effectively; how the information is made available to download for use; the implications of deprivation and gender on life expectancy; the implications of population change to 2030 and the increase particularly in the

older population; the concerns on what action needed to take in response to the information on premature mortality slide.

The Chair, Baroness Scott, thanked the officer for the presentation and recorded her thanks for team's efforts.

Resolved

1. **To approve the publication of the Health and Wellbeing JSNA.**
2. **To note that the 2018 JSNA product will focus on the CCG JSNA's and that work to develop this will commence early in 2018 with key partners.**
3. **To request that officers attend to present a briefing prior to a future meeting.**

153 **Mental Health Crisis Care**

The meeting received an update on the work undertaken by the Alexander Group reviewing s136 pathways across the Avon and Wiltshire Mental Health Partnership footprint and the work going forward.

Matters highlighted in the course of the presentation and discussion included: the continuing work on the project; the locations of the place of safety; the consultation undertaken and the preference to centralise facilities into one suite in Devizes; the ongoing concerns from Swindon regarding the centralisation in Devizes and the ongoing engagement to address these concerns; that there was due to be further round table discussions, with NHS England planning to undertake further consultation.

Councillor Jerry Wickham expressed concern that Swindon Borough Council were not, apparently, adequately helping to facilitate the transition to one site which may place further resource burdens on Wiltshire Council.

The Chair, Baroness Jane Scott, stated that whilst she understood the concerns raised from Swindon, she believed the new model would result in a better service overall, and hoped that the Leader of the Borough Council may be encouraged to visit the new facility.

Resolved

To note the progress update

154 **Strategic Outline Programme**

An update was received on the development of a whole county Strategic Outline Programme for investment in out of hospital care.

Matters highlighted in the course of the presentation and discussion included: that some drivers for the project included having access to capital funding to build some new facilities in North West Wiltshire and the opportunity to review the remaining areas in the rest of Wiltshire; that the timetable was 6 months to identify the requirements and then the asset strategy; and how the housing needs are being taken into account.

The Chair, Baroness Scott, thanked the officers for the update.

Resolved

To note the approach taken by Wiltshire CCG

155 **Multi-Agency Safeguarding Hub For Adults**

The meeting received an update on the development of a Multi-Agency Safeguarding Hub (MASH) for adults.

Matters highlighted in the course of the presentation and discussion included: that the MASH was part of an overarching transformation project; the development of closer working relationships with partner organisations, and the focus of improving communication through co-location; that increases in reporting was largely due to heightened awareness of reporting mechanisms; that 17% of referrals resulted a formal enquiry; how triage arrangements can be reviewed to sign-post people to the relevant support; how the MASH was building on the existing links with police, and the developing links with health partners; how the partnership was taking a comprehensive approach to safeguarding, and ensuring consistency across different teams; the structure of the MASH and links to those providing initial contact; the changes to processes for dealing with reports, and how best practice lessons will be learnt; the importance of the early sharing of information; how the better management of cases through the MASH will take some pressure of other teams thereby improving retention of staff; and the opportunities for efficiencies and saving; the potential for widening the role of the MASH to include input from other emergency services; and how the experience of the public contacting the service is measured to assess the appropriate level of triage undertaken.

The Chair, Baroness Scott, thanked the officers for the update and stated that she would welcome a further briefing on the matter.

Resolved

To note the progress on the development of the Adults Multi-Agency Safeguarding Hub

156 **Public Health Annual Report**

The meeting received the Public Health Annual Report and feedback on the recent roadshows.

Matters highlighted in the course of the presentation and discussion included: the statutory duty to present the report to the meeting; the desire to get more interaction from partners in the future; the innovative use of graphics and the interest in the areas of achievement and challenges; and the progress in taking a preventative approach to issues such as suicide.

Resolved

To note the publication of the Director of Public Health's Annual Report 2016-17

157 **Date of Next Meeting**

It was noted that the next meeting would be on 25 January 2018.

158 **Urgent Items**

There were no urgent items.

(Duration of meeting: 10.00 am - 12.11 pm)

The Officer who has produced these minutes is Will Oulton, of Democratic & Members' Services, direct line 01225 713935, e-mail william.oulton@wiltshire.gov.uk

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

Chairman's announcement
Care Quality Commission Review

In 2017, Government set out targets and plans to reduce hospital admissions, length of stay in hospital and delayed transfers of care across England. As part of these plans the CQC were commissioned by the Secretaries of State for Health and for Communities and Local Government to undertake a local system reviews across some twenty areas in England.

These Local system reviews will now include our local Health and Social Care System, supporting our older adult community in Wiltshire.

The CQC local system review will cover:

- how people move between health and social care, and what are the outcomes for people?

- What is the maturity of our local area to manage the interface between health and social care?

- How can this improve and what is the improvement?

The Review will also consider:

Is there a golden thread connecting the local vision to delivery including:

  - Are we meeting the needs of our local population?
  - are we putting people first?
  - Do we have a shared vision and strong leadership?
  - Do all staff share the vision

The review will take place over a fourteen-week period, with the main review week scheduled for mid-March (12th -16th inclusive).

On completion of the system review CQC's findings will be made available to the Health and Wellbeing board during May, with copies to all relevant partners across health and social care. We will then be expected to work together as system leaders to agree a joint action plan to progress any recommendations that arise from the CQC findings.

This review should be viewed as an opportunity to provide us with useful reflection; highlighting what is working well and where there are opportunities for improving how the system works for people using services. A slide briefing on the process being followed by CQC is appended.

It is important to note that this is a review not an Inspection.

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Local system reviews briefing day

Friday 12 January 2018

Welcome

Alison Holbourn, Deputy Chief Inspector

Housekeeping

Agenda for today

Time	Agenda Item	Lead
11:00	Introduction	Sir David Behan, Chief Executive, CQC
11:25	Overview of the programme	Alison Holbourn, Deputy Chief Inspector, CQC
11:45	Review methodology	Charles Rendell, Strategy Manager, CQC
12:00	End-to-end process	Charles Rendell, Strategy Manager, CQC Rich Brady, Project / Policy Manager, CQC
12.30	Break	
12.45	End-to-end process cont.	
13:00	Questions	Panel
13:30	Lunch, meet the team and networking	
14:30	Improvement offer	Tony Hunter, Chief Executive, Social Care Institute for Excellence
15:00	Questions	Panel
15:20	Close	Alison Holbourn

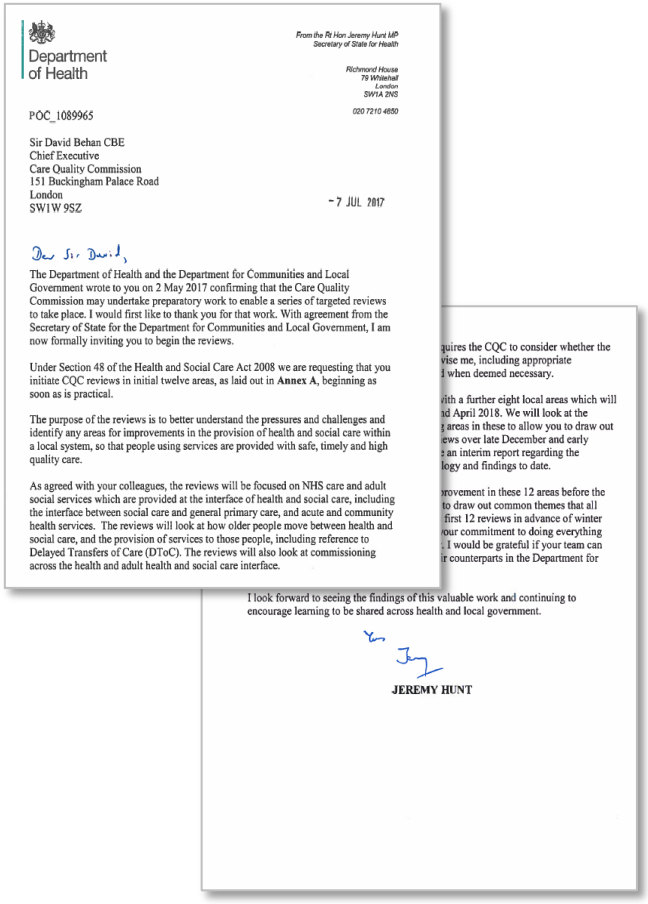
Introduction

Sir David Behan, Chief Executive

Background

- Following budget announcement of additional funding for adult social care, Secretaries of State asked CQC to undertake a programme of targeted reviews in local authority areas

- Reviews sit outside CQC's usual legal powers (under Section 48 of the Health and Social Care Act)



Department of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS

020 7210 4850

POC_1089965

Sir David Behan CBE
Chief Executive
Care Quality Commission
151 Buckingham Palace Road
London
SW1W 9SZ

7 JUL 2017

Dear Sir David,

The Department of Health and the Department for Communities and Local Government wrote to you on 2 May 2017 confirming that the Care Quality Commission may undertake preparatory work to enable a series of targeted reviews to take place. I would first like to thank you for that work. With agreement from the Secretary of State for the Department for Communities and Local Government, I am now formally inviting you to begin the reviews.

Under Section 48 of the Health and Social Care Act 2008 we are requesting that you initiate CQC reviews in initial twelve areas, as laid out in **Annex A**, beginning as soon as is practical.

The purpose of the reviews is to better understand the pressures and challenges and identify any areas for improvements in the provision of health and social care within a local system, so that people using services are provided with safe, timely and high quality care.

As agreed with your colleagues, the reviews will be focused on NHS care and adult social services which are provided at the interface of health and social care, including the interface between social care and general primary care, and acute and community health services. The reviews will look at how older people move between health and social care, and the provision of services to those people, including reference to Delayed Transfers of Care (DToC). The reviews will also look at commissioning across the health and adult health and social care interface.

quires the CQC to consider whether the
vise me, including appropriate
l when deemed necessary.

ith a further eight local areas which will
d April 2018. We will look at the
areas in these to allow you to draw out
ews over late December and early
an interim report regarding the
logy and findings to date.

rovement in these 12 areas before the
to draw out common themes that all
first 12 reviews in advance of winter
our commitment to doing everything
. I would be grateful if your team can
r counterparts in the Department for

I look forward to seeing the findings of this valuable work and continuing to encourage learning to be shared across health and local government.

Yours,

JEREMY HUNT

The questions

- How do people move through the system and what are the outcomes for people?
- What is the maturity of the local area to manage the interface between health and social care?
- How can this improve and what is the improvement offer?

Local collaboration and joined-up care

Golden thread connecting vision to delivery

- Meeting the needs of local populations is only achievable through local collaboration
- Putting people first
- Shared vision and strong leadership
- All staff to share that vision and deliver to action

How this fits with our usual work

Local system reviews build on our existing programme of 'place reviews':

- 2015/16 - North Lincolnshire, Tameside, Salford
- 2016/17 – Cornwall, London Borough of Sutton

Reflect key findings of recent reports including:

- State of Care 2015/16
- Integrated care for older people
- State of Care 2016/17

Any questions?

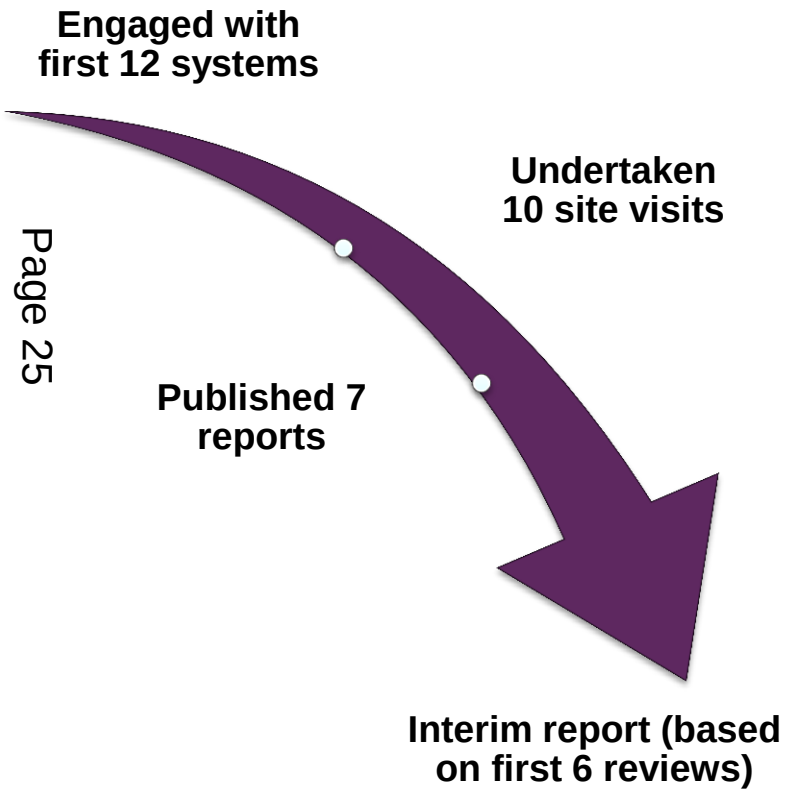
Local system review programme

Alison Holbourn, Deputy Chief Inspector

Remaining review programme

Area	Site visit	Lead reviewer
Bradford	12 to 16 February	Deanna Westwood
Cumbria	12 to 16 February	Wendy Dixon
Liverpool	19 to 23 February	Rebecca Gale
Sheffield	5 to 9 March	Karmon Hawley
Wiltshire	12 to 16 March	Deanna Westwood
Hampshire	12 to 16 March	Wendy Dixon
Northamptonshire	9 to 13 April	Julia Daunt
Stockport	16 to 20 April	Rebecca Gale

Progress to date



Area	Site visit
Halton	21 to 25 August
Bracknell Forest	4 to 8 September
Stoke-on-Trent	4 to 8 September
Hartlepool	9 to 13 October
Manchester	16 to 20 October
Trafford	16 to 20 October
York	30 October to 3 November
East Sussex	13 to 17 November
Oxfordshire	27 November to 1 December
Plymouth	4 to 8 December
Birmingham	22 to 26 January 2018
Coventry	22 to 26 January 2018

Key findings so far

How systems work together

Managing capacity, market supply and workforce

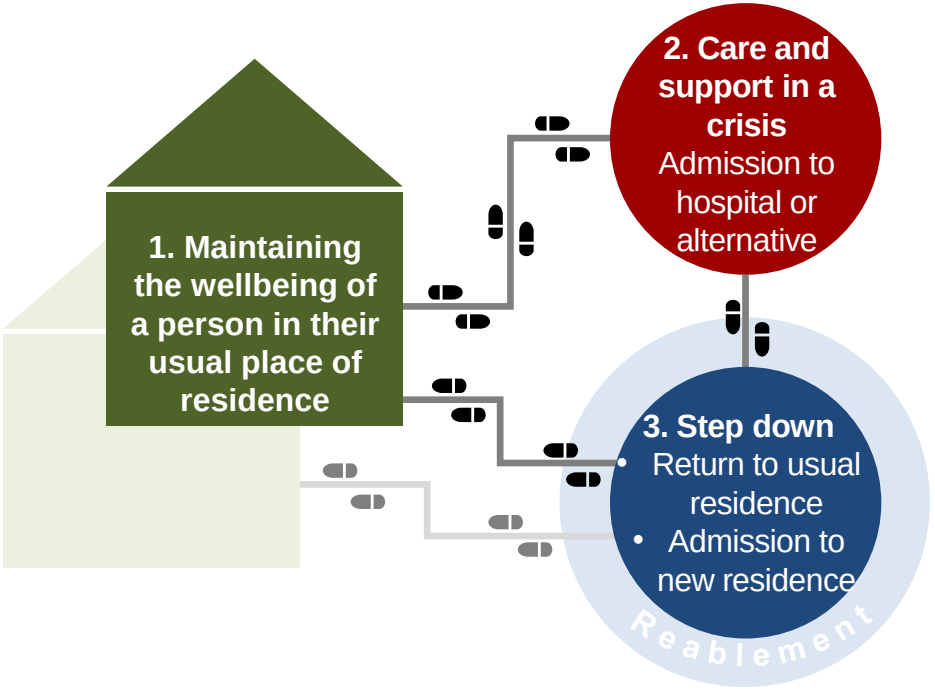
Moving beyond delayed transfers of care

Review methodology

Charles Rendell, Strategy Manager

Approach to reviews

- Focused on the interfaces between **social care, general primary care, acute health services and community health services and on older people aged over 65**
- Consider **system performance** along a number of **'pressure points'** on a typical pathway of care



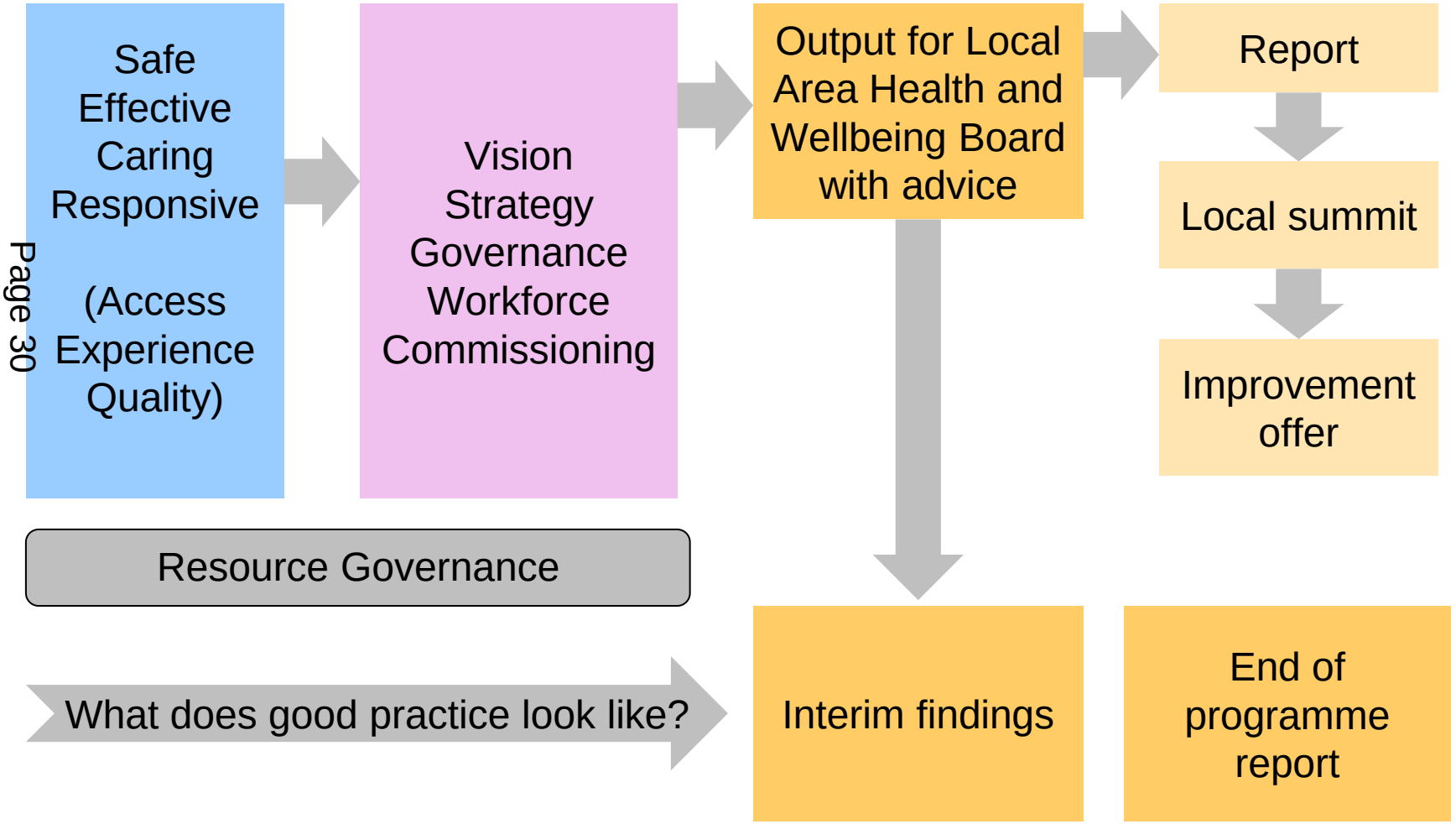
- Each area will have a **local report** and the findings of the reviews will also be used to inform a **national report** to give overall advice to the Secretaries of State
- Reports will not include ratings and the reviews will not affect existing ratings

Methodology

We developed the methodology using:

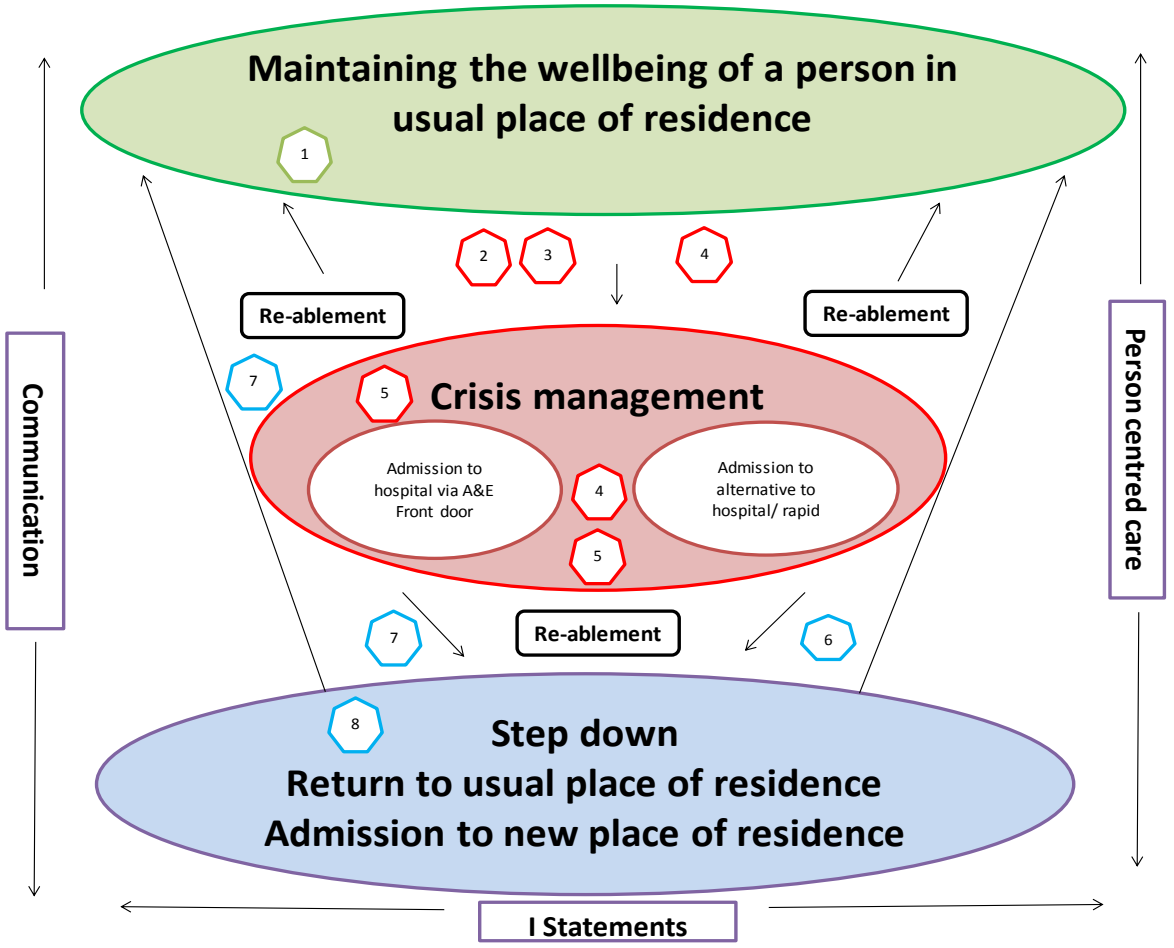
- CQC tools:
  - Provider inspection findings and reports
  - Quality in a Place Framework (year 1)
  - Quality in a Place Framework (year 2 – Cornwall/Sutton)
  - Integrated Care for Older People
  - Tools from thematic reviews
- Wide range of external documents and tools developed
- Co-production with people who use services, their cares and families, professionals and staff working across the system and national organisations
- Walk through with Hertfordshire County Council which added a further focus on well-led and workforce

Summary of review approach



Areas of focus and pressure points

1. Maintenance of peoples health and well being in their usual place of residence
2. Multiple confusing points to navigate in the system
3. Varied access to GP/ Urgent Care centres/ Community care/ social care
4. Varied access to alternative to hospital admission
5. Ambulance interface
6. Discharge planning delays and varied access to ongoing health and social care
7. Varied access to re-ablement
8. Transfer from re-ablement



‘I’ statements

- Work with Experts by Experience and Think Local Act Personal to develop 37 ‘I’ Statements that can be used
- ‘I’ statements are split across the spheres
- ‘I’ statements are being woven into the review process:

Focus groups with people who use services, their families and carers

Interviews and focus groups with staff

Pathway scenarios

I statements – person-centred, coordinated care

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”

Review process end-to-end

Charles Rendell, Strategy Manager
Rich Brady, Project/Policy Manager

Local system review timeline

Pre-preparation Week 1-3 → **Preparation Weeks 4-5** → **Review Week 6** → **Report Writing Week 7-9** → **Quality Week 10-14**

Weeks 1-2

- **Letter**
- **Contact request.**
- **System Overview Information Return (SOIR) sent out.**
- Discharge information flow
- Case tracking
- Call for evidence from inspectors.
- Call for evidence from local stakeholders
- Agree review schedules

Week 2

- Relational audit.

Week 3

Review leads:

- Meet senior staff/ run through local context
- Attend local events with people living in the area
- Meeting with other local partners
- Cross-directorate inspectors focus group

Weeks 4-5

- SOIR returned
- Analysis of documents.
- Analysis of qualitative and quantitative data.
- Data profile
- Liaison with statutory bodies and others (e.g. NHS England, NHS Improvement, Health Education England, Sustainability and Transformation Partnerships, regional leads).
- Agree escalation process if required.

People's experience, quality and access

(Days should include out-of-hours)

Day 1: Focus groups

- Commissioning staff.
- Provider staff (across broad groups).
- Social workers and occupational therapists.
- People using services, carers and families.
- VCSE sector.

Day 2-3: Interface pathway interviews

- Focus on individuals' journey through the interface through services (with scenarios) and case tracking/dip sampling

Day 4: Well-led interviews

- Senior leaders
- Sense check with nominated people from key partners

Day 5: Final interviews, mop up and feedback.

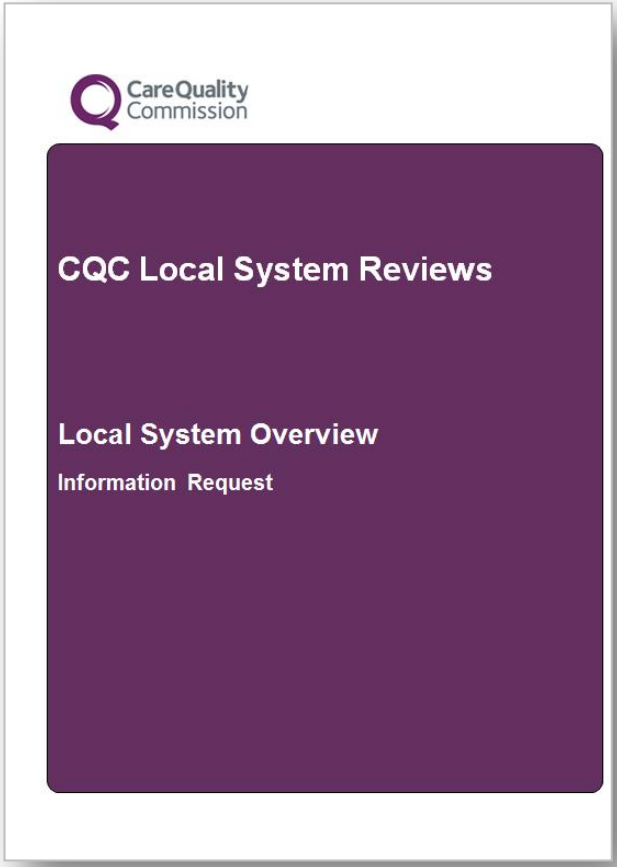
Single shared view of quality

Team – 4-5 CQC/ 3-4 SpA

- Drafting
- Quality assurance
- Editorial
- Focused report / letter with advice for the area Health and Wellbeing Board (cc other partners
- Factual accuracy
- Local summit (with improvement partners)
- Publication

System Overview Information Request

- A request for information sent at the start of the process (week 1)
- A chance to tell us about your system
- Helps us prepare for the review and develop findings
- System contact identified
  - Regular engagement with CQC review lead
  - Confirm schedules



System Overview Information Request

Questions grouped under four sections:

1. Background to your local system
2. People who use services, their families and carers
3. Market shaping
4. Integrated service delivery
5. Monitoring performance and progress

System Overview Information Request

Please answer the questions:

- From whole systems perspective
- Concisely
- Candidly
- Specifically
- With reference to supporting materials

System Overview Information Request

Process:

- Sent to local system contact in week one
- One person to coordinate but whole system contribution
- Direct questions to your lead reviewer or our mailbox: healthandsocialcarereviews@cqc.org.uk
- Please return within four weeks

Local system review timeline

Pre-preparation Week 1-3 → **Preparation Weeks 4-5** → **Review Week 6** → **Report Writing Week 7-9** → **Quality Week 10-14**

Weeks 1
- Letter
- Contact request.
- System Overview Information Return (SOIR) sent out.
- **Discharge information flow**
- Case tracking
- Call for evidence from inspectors.
- Call for evidence from local stakeholders

Week 2
- Relational audit.

Week 3
Review leads:
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- Attend local events with people living in the area;
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Weeks 4-5

- SOIR returned
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- Agree escalation process if required.

People's experience, quality and access

Week 6

Day 1: Focus groups
- Commissioning staff.
- Provider staff (across broad groups).
- Ambulance
- Social workers and occupational therapists.
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- VCSE sector.

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Day 4: Well-led interviews
- Senior leaders
- Sense check with nominated people from key partners

Day 5: Final interviews, mop up and feedback.

***Days include out-of-hours**

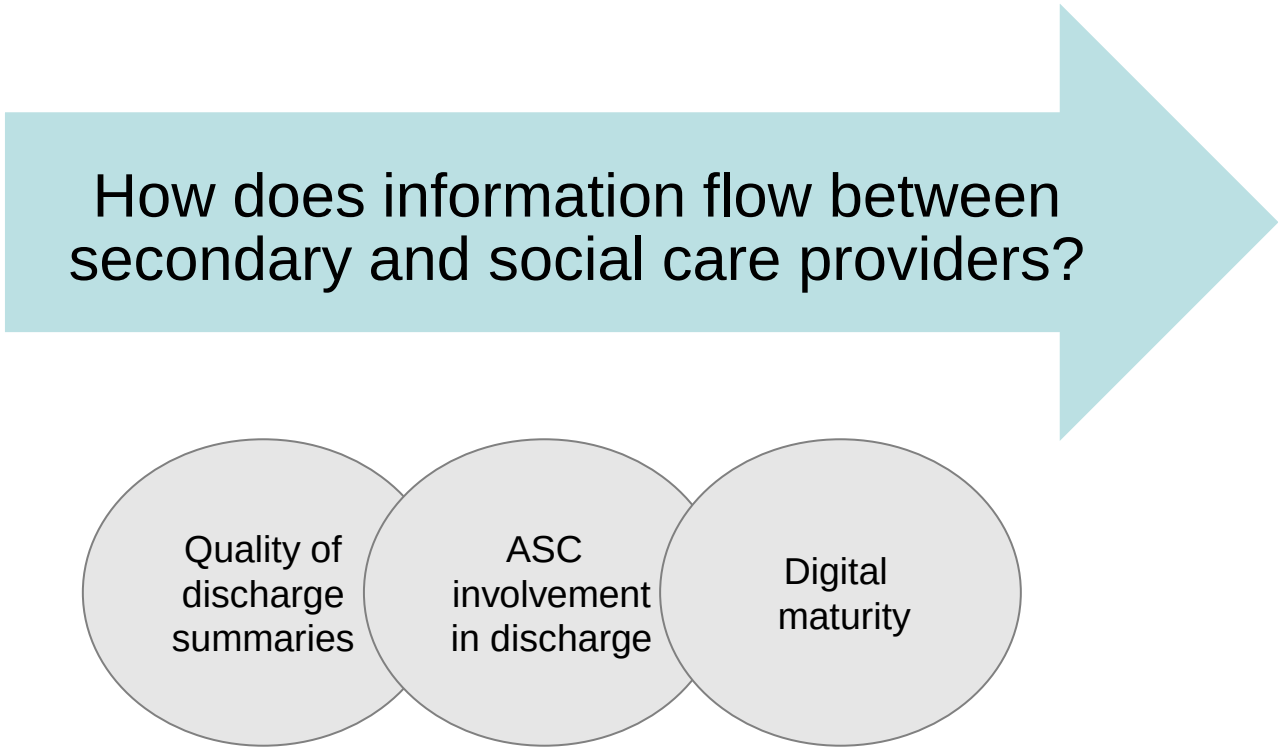
Single shared view of quality

Team – 4-5 CQC/ 3-4 SpA

- Drafting
- Quality assurance
- Editorial
- Focused report / letter with advice for the area Health and Wellbeing Board (cc other partners
- Factual accuracy
- Local summit (with improvement partners)
- Publication

Discharge information flow

Based on evidence from the Professional Record Standards Body for Health and Social Care, we have developed a tool which looks at information flow as care is transferred between health and social care.



Local system review timeline

Pre-preparation Week 1-3 → **Preparation Weeks 4-5** → **Review Week 6** → **Report Writing Week 7-9** → **Quality Week 10-14**

Weeks 1-2
- Letter
- Contact request.
- System Overview Information Return (SOIR) sent out.
- Discharge information flow
- **Case tracking**
- Call for evidence from inspectors.
- Call for evidence from local stakeholders

Week 2
- Relational audit.

Week 3
Review leads:
- Meet senior staff/ run through local context
- Attend local events with people living in the area;
- Meeting with other local partners
- Cross-directorate inspectors focus group

Weeks 4-5

- SOIR returned
- Analysis of documents.
- Analysis of qualitative and quantitative data.
- Data profile
- Liaison with statutory bodies and others (e.g. NHS England, NHS Improvement, Health Education England, Sustainability and Transformation Partnerships, regional leads).
- Agree escalation process if required.

People's experience, quality and access

Week 6

Day 1: Focus groups
- Commissioning staff.
- Provider staff (across broad groups).
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Case tracking

Local authority

- Identify six people over 65 with a post code in the system
- Two people who have received social services in last three months and avoided hospital admission
- Two people who attended A&E but were not admitted
- Two people who have had an hospital episode and completed a community of rehab intervention

Commissioning support unit
Retrieve SUS record for the six people so NHS information can be obtained

Contact care providers/ GPs

Collated activity for review

Local system review timeline

Pre-preparation Week 1-3 → **Preparation Weeks 4-5** → **Review Week 6** → **Report Writing Week 7-9** → **Quality Week 10-14**

Week 1
- Letter
- Contact request.
- System Overview Information Return (SOIR) sent out.
- Discharge information flow
- Case tracking
- **Call for evidence from inspectors**
- **Call for evidence from local stakeholders**

Week 2
- Relational audit

Week 3
Review leads:
- Meet senior staff/ run through local context
- Attend local events with people living in the area
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Weeks 4-5

- SOIR returned
- Analysis of documents.
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Single shared view of quality

Team – 4-5 CQC/ 3-4 SpA

- Drafting
- Quality assurance
- Editorial
- Focused report / letter with advice for the area Health and Wellbeing Board (cc other partners
- Factual accuracy
- Local summit (with improvement partners)
- Publication

Call for evidence

- Local stakeholder groups
- CQC inspectors
- Case studies
- Good practice!
- Contacts identified through local system contact and CQC engagement databases

Local system review timeline

Pre-preparation Week 1-3 → **Preparation Weeks 4-5** → **Review Week 6** → **Report Writing Week 7-9** → **Quality Week 10-14**

Week 1
- Letter
- Contact request.
- System Overview Information Return (SOIR) sent out.
- Discharge information flow
- Case tracking
- Call for evidence from inspectors
- Call for evidence from local stakeholders

Week 2
- **Relational audit**

Week 3
Review leads:
- Meet senior staff/ run through local context
- Attend local events with people living in the area;
- Meeting with other local partners
- Cross-directorate inspectors focus group

Weeks 4-5

- SOIR returned
- Analysis of documents.
- Analysis of qualitative and quantitative data.
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Single shared view of quality

Team – 4-5 CQC/ 3-4 SpA

- Drafting
- Quality assurance
- Editorial
- Focused report / letter with advice for the area Health and Wellbeing Board (cc other partners
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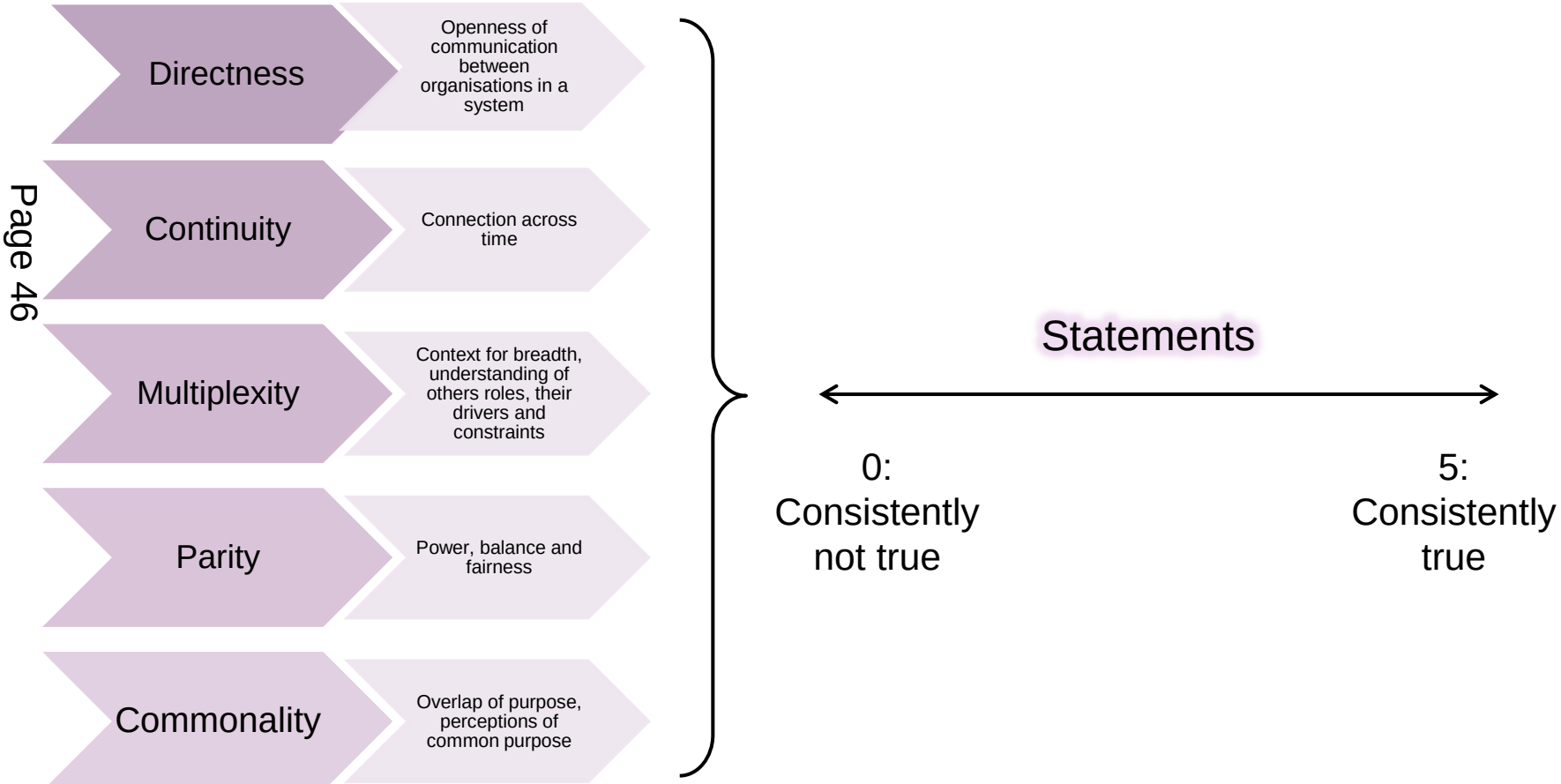
Relational audit

We have worked with the Relationship Foundation to develop a relational audit.



Relational audit

- Sent in week 2 to system leader contacts provided in the system overview information request
- Please cascade through your organisations
- Understanding of relationships within and across organisations

Relational value – a definition

Relational value is the lifeblood of a system, organisation, partnership or team of people. It is the medium through which our interactions pass that either enhances or distorts our ability to achieve our common goals.

The attributes of relational value

- **System integrity -** how things interconnect and function
- **Respect** - how we treat each other
- **Fairness** - how equity is achieved
- **Empathy or compassion -** how we understand each other
- **Trust** - how much we put ourselves in other people's hands

Local system review timeline

Pre-preparation Week 1-3 → **Preparation Weeks 4-5** → **Review Week 6** → **Report Writing Week 7-9** → **Quality Week 10-14**

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- Letter
- Contact request.
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- Case tracking
- Call for evidence from inspectors
- Call for evidence from local stakeholders

Week 2
- Relational audit

Week 3
Review leads:
- **Meet senior staff/ run through local context**
- **Attend local events with people living in the area**
- **Meeting with other local partners Cross-directorate inspectors focus group**

Weeks 4-5

- SOIR returned
- Analysis of documents.
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- Data profile
- Liaison with statutory bodies and others (e.g. NHS England, NHS Improvement, Health Education England, Sustainability and Transformation Partnerships, regional leads).

People's experience, quality and access

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Day 5: Final interviews, mop up and feedback.

***Days include out-of-hours**

Single shared view of quality

Team – 4-5 CQC/ 3-4 SpA

- Drafting
- Quality assurance
- Editorial
- Focused report / letter with advice for the area Health and Wellbeing Board (cc other partners
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- Local summit (with improvement partners)
- Publication

Week three – early engagement

Initial meeting between CQC review leads and system leaders

- Agree approach to on site activity in week six
- Agree escalation process, if required
- Information sheet for people in local area

Engagement events

- People who use services, their families and carers
- Local stakeholder groups including, overview and scrutiny committee, Healthwatch and representatives from VCSE sector
- Site visits to talk with people who use services

CQC inspector focus group

Local system review timeline

Pre-preparation Week 1-3 → **Preparation Weeks 4-5** → **Review Week 6** → **Report Writing Week 7-9** → **Quality Week 10-14**

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- Contact request.
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Week 2
- Relational audit

Week 3
Review leads:
- Meet senior staff/ run through local context
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Weeks 4-5

- **SOIR returned**
- **Analysis of documents.**
- **Analysis of qualitative and quantitative data.**
- Data profile
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***Days include out-of-hours**

Single shared view of quality

Team – 4-5 CQC/ 3-4 SpA

- Drafting
- Quality assurance
- Editorial
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- Publication

Analysis

- System Overview Information Request returned
- Analysis of additional documents provided by system
- Analysis of qualitative and quantitative data
    - Discharge information flow
    - Relational audit
    - Call for evidence

Local system review timeline

Pre-preparation Week 1-3 → **Preparation Weeks 4-5** → **Review Week 6** → **Report Writing Week 7-9** → **Quality Week 10-14**

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- Call for evidence from inspectors
- Call for evidence from local stakeholders

Week 2
- Relational audit

Week 3
Review leads:
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Weeks 4-5

- SOIR returned
- Analysis of documents.
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People's experience, quality and access

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***Days include out-of-hours**

Single shared view of quality

Team – 4-5 CQC/ 3-4 SpA

- Drafting
- Quality assurance
- Editorial
- Focused report / letter with advice for the area Health and Wellbeing Board (cc other partners
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Data profile

What is it?

To support the review, CQC has developed a local authority-level data profile containing cross-sector analysis.

- Features analysis of a range of quantitative metrics including CQC's own data as well as nationally available data collections and analysis the Department of Health carried out to select areas for review.

Purpose

- Aid review team's understanding of the local area
- Prompt review activity and;
- Provide supporting evidence for the local area report.

Data profile

- Local areas will receive a copy of the profile in week four and also when they receive their local area report to support factual accuracy checking.
- Feedback on the data profiles to support ongoing development is much appreciated!
- We have produced data profiles for every local system
- Disseminated to chairs of health and wellbeing boards

Local system review timeline

Pre-preparation Week 1-3 → **Preparation Weeks 4-5** → **Review Week 6** → **Report Writing Week 7-9** → **Quality Week 10-14**

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- Call for evidence from local stakeholders

Week 2
- Relational audit

Week 3
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Weeks 4-5

- SOIR returned
- Analysis of documents.
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- Data profile
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People's experience, quality and access

Week 6

Day 1: Focus groups
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- **Sense check with nominated people from key partners**

Day 5: Final interviews, mop up and feedback.

***Days include out-of-hours**

Single shared view of quality

Team – 4-5 CQC/ 3-4 SpA

- Drafting
- Quality assurance
- Editorial
- Focused report / letter with advice for the area Health and Wellbeing Board (cc other partners
- Factual accuracy
- Local summit (with improvement partners)
- Publication

Week six – site visit

People's experience, quality and access

Day 1: Focus groups

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Day 2-3: Interface pathway interviews

- Focus on people's journeys through the interface of health and social care services (with scenarios) and case tracking/dip sampling

Day 4: Well-led interviews

- Senior leaders
- Sense check with nominated people from key partners

Day 5: Final interviews, mop up and feedback

***Days include out-of-hours**

Team – 4-5 CQC/ 3-4 SpA

Single shared view of quality

Break

Review process end-to-end (continued)

Charles Rendell, Strategy Manager
Rich Brady, Project/Policy Manager

Local system review timeline

Pre-preparation Week 1-3 → **Preparation Weeks 4-5** → **Review Week 6** → **Report Writing Week 7-9** → **Quality Week 10-14**

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- Contact request.
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- Case tracking
- Call for evidence from inspectors
- Call for evidence from local stakeholders

Week 2
- Relational audit

Week 3
Review leads:
- Meet senior staff/ run through local context
- Attend local events with people living in the area
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Weeks 4-5

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People's experience, quality and access

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Day 4: Well-led interviews
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Day 5: Final interviews, mop up and feedback.

***Days include out-of-hours**

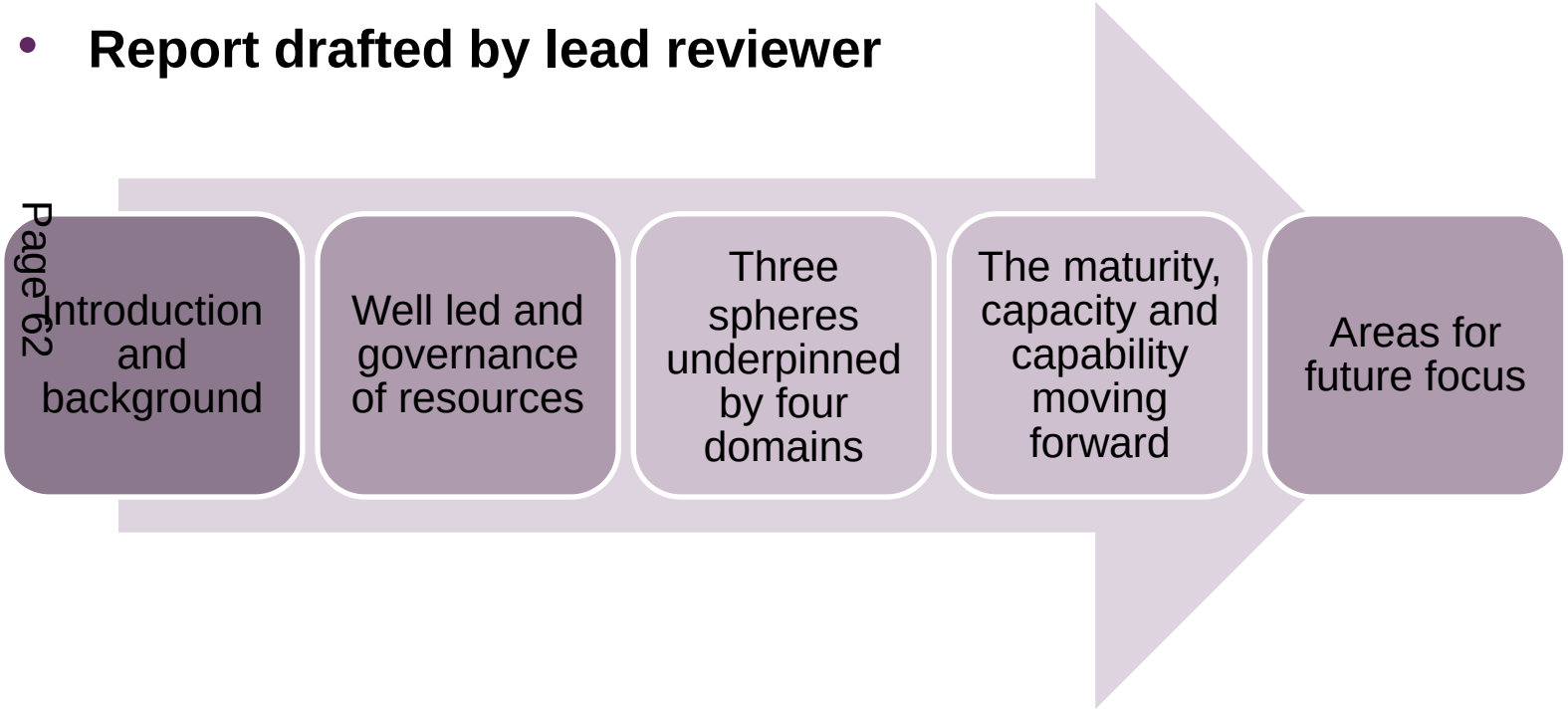
Single shared view of quality

Team – 4-5 CQC/ 3-4 SpA

- **Drafting**
- **Quality assurance**
- **Editorial**
- **Focused report / letter with advice for the area Health and Wellbeing Board (cc other partners**
- **Factual accuracy**
- **Local summit (with improvement partners)**
- **Publication**

Report drafting and quality assurance

- **Evidence coded and analysed**
- **Report drafted by lead reviewer**



Findings, Evidence, Impact

- **Internal quality assurance and editorial review**

  Cross-sector quality assurance panel

Factual accuracy check and publication

Factual accuracy check

- Final draft report and data profile shared with system partners for **factual accuracy** check
- Collated response within five working days
- Final report shared ahead of local summit (week 14)

Tony Hunter speaking after lunch

Publication

- Publication on CQC website following local summit
- Media release and report shared with local stakeholders in advance

Questions

Lunch

Improvement offer

Tony Hunter, Chief Executive,
Social Care Institute for Excellence

Questions

Close

Alison Holbourn, Deputy Chief Inspector

Chairman's announcement
Progress on integration

In 2017, Wiltshire Council and Wiltshire CCG agreed to the creation of a joint post covering both the roles of the Wiltshire CCG Accountable Officer post and the Council Director of Adult Services. Both roles are vacant, providing an opportunity for Wiltshire to take the next step towards an integrated health and social care system with a single individual overseeing both functions.

Keeping people well and living independent, productive and healthy lives at home is at the heart of the Wiltshire ambition. Integration of health and social care services supports a sustainable system and promotes the good health and wellbeing of our local population, set against high service standards for the achievement of good outcomes. We propose our approach be based on sound evidence with a focus on population needs: better prevention, self- care, improved detection, early intervention, proactive and joined up responses to people who require care and support across organisational and geographical boundaries.

The move towards a joint post was allied to a recognition that the integration of health and social care is the only option if we are to manage the demand for these services in the coming years. However, the creation of the joint post will not affect statutory responsibilities - the Clinical Commissioning Group will remain the statutory body responsible for commissioning health care in Wiltshire and likewise Cabinet for adult social care.

Both Cabinet and the CCG Governing Body reviewed a series of options, and concluded that seamless working between front line health and social care services will benefit Wiltshire people and patients in the best way. This means closer working between Wiltshire Council and Wiltshire CCG. The challenges faced by the health and care system are huge; and one way to address the issues we face is to integrate the leadership of health and social care services across our organisations and explore further options together.

Since agreement on the concept of the joint post, further work has taken place - agreeing the Job Description, the process for recruitment and the employment model. Work continues to establish the supporting legal agreements which are required to be in place in time for the appointment, including a Section 75 agreement and a Joint Employment Protocol. It is also necessary for the CCG to submit a Business Case for Integration to NHS England to sign off on any appointment agreed between Wiltshire Council and the CCG.

Alongside the implementation of the joint post, there is recognition that work on other aspects of integration cannot stand still. The Health and Wellbeing Board agreed a statement of intent on integration, agreeing with the concept of an accountable care system and noting that work now needs to take place on:

- Aligning budgets and commissioning intentions to develop whole place commissioning

  A single source of commissioning intentions will provide more efficient, effective and coherent services to our population enabled by a single source of strategic commissioning intentions. This will allow better cohesion and collaboration across the sector, enabling strong market management, better use of resources against local priorities and drive unerring focus on the right outcomes for our people, which can become obscured when services are divided on budgetary lines.

  To enable this, the potential for closer working between strategic commissioning teams in both organisations is being scoped – as well as considering how the intelligence and

expertise of the public health team can best be drawn upon – with options such as co-location of teams being explored.

- Developing the contractual vehicle for an accountable care alliance

  This framework is likely to be based on the existing and evolving suite of contracts produced by NHS England for new care models. They will be long term contracts which incorporate new payment models, such as whole population budgets, improvement schemes and gain/loss share agreements.

  The framework will take several years to implement (bearing in mind existing contracting timetables) and decisions will need to be made on where 'tactical' commissioning functions are best situated as well as how adult social care assessment staff are best integrated with the new arrangements.

Programme support is being put in place to deliver these commitments. In the meantime a considerable body of work continues to be delivered through existing but related programmes:

- Better Care Programme

  Commissioning intentions for a range of intermediate care schemes have been agreed with the aim of reducing hospital admissions, length of stay in hospital and delayed transfers of care.

- Adult Social Care Transformation Programme

  Delivering a one stop approach for the public to access guidance on social care; the establishment of a reablement service; remodelling of our safeguarding provision and; a review and redesign of our commissioning and procurement processes.

- Bath & NE Somerset, Swindon and Wiltshire Sustainability and Transformation Partnership

  The STP is currently outlining areas where collaboration across the footprint makes sense (such as on workforce issues, specialist commissioning and ensuring value for money). This will provide the context for the development of healthcare commissioning arrangements in Wiltshire. Developments in Greater Manchester provide one model which can be drawn upon for future arrangements and the split between local strategic and tactical functions and those undertaken by the STP.

With this work underway to transform the way in which business is done, and recognising the complex and legal and logistical framework needed for successful integration, Wiltshire Council and CCG have agreed a revised timeline for the appointment to commence during 2018. This allows time for advertising the post in the new year, recruitment and for notice to be served by the successful candidate. The Steering Group overseeing the integration will meet again in February 2018 to receive the proposed governance arrangements for integration and the business case for submission to NHS England.

Wiltshire Council

Health and Wellbeing Board

25 January 2018

Subject: Better Care Fund DTOC Performance and Recovery

Executive Summary

I. The Wiltshire system has seen an improvement in our performance against DTOC lost beds days when compared to April 2017. However, although the Wiltshire system has reported a reduction in lost bed days the aggregate position for November 2017 reported remains above the trajectory.

II. The DTOC task and finish group has enabled a system wide discussion related to actions underpinned in the recovery plan and supported by the High Impact Actions seen nationally as good practice.

III. The Wiltshire system has much to celebrate however to enable delivery of our Better Care Fund Discharge plan and programme we now need to take forward the transformational and integration programme in 2018/19. This requires the latter part of 17/18 to establish the programme deliverables and governance framework.

Proposal(s)

It is recommended that the Board:

i) To note performance, variation for DTOC trajectory and actions interwoven in the delivery of the 8 High Impact Actions

ii) To note the delivery and actions to support winter pressures capacity

iii) To note the establishment of the Better Care Fund DTOC sub group

Reason for Proposal

To share the DTOC performance vs. Wiltshire trajectory
To provide an update on the recovery actions and the establishment of the DTOC sub group incorporated in the Better Care Fund Governance Framework

Sue Shelbourn-barrow
Director of Transformation and Integration
Wiltshire Council and Clinical Commissioning Group

Wiltshire Council

Health and Wellbeing Board

25 January 2018

Subject: Better Care Fund DTOC Performance and Recovery

Purpose of Report

1. To provide a status report on the DTOC performance against the system trajectory for November 2017. To outline the DTOC recovery plan actions supported by the 8 High Impact Actions and new DTOC sub group proposed to commence in February 2018

Background

2. In July 2017, NHS England and Local Government Association required submission of a DTOC trajectory to recovery performance by December 2017 to report 1.325 lost bed days. The DTOC lost bed days trajectory included an aggregate and by provider expectation.

Main Considerations

3. Overall the Wiltshire system has reported an improved position for lost bed days when compared to April 2017 however to enable performance to improve and sustain the focus must now more to transformation and integration. The full performance on the dashboard is set out at **Appendix 1.**

4. The focus in quarter 4 is to establish a DTOC sub group as the DTCO winter pressures Task and Finish group is disbanded. The governance framework supporting the Better Care Fund sets out the operating parameters of each board and sub-group to include the membership. The newly established DTOC sub group will provide the platform to take forward the High Impact Actions and to enable system partners to explore learning from implementing the programme requirements.

Next Steps

5. The Health and Wellbeing Board to note the improved performance. To note the Better Care Fund programme commitment to take forward the High Impact Actions working across the system to establish the operating model as part of a transformation programme.

Sue Shelbourn-barrow
Director of Transformation and Integration
Wiltshire Council and Clinical Commissioning group

Report Authors: Sue Shelbourn-barrow
Appendix 1: DTOC dashboard

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Wiltshire Council
Where everybody matters

BETTER CARE PLAN

NHS
Wiltshire
Clinical Commissioning Group

BCF November DTOC Summary

11th January 2018

Wiltshire Council
Where everybody matters

BETTER CARE PLAN

NHS
Wiltshire
Clinical Commissioning Group

November DTOC Delayed Days - Summary

- Wiltshire delayed days decreased 10.4% (214 days) in November but remain higher than trajectory (1,275).
- NHS delays (1,120):
  - Reduced in November by 15.5% over trajectory by 361 days.
  - GWH RUH & WH&C have the largest number of delays
- ASC delays (611):
  - Reduced in November by 4.5% over trajectory by 204 days.
  - SFT & WH&C have the largest number of delays
  - Acute delays account for around 38.9% of ASC delays

Wiltshire Council
Where everybody matters

NHS
Wiltshire
Clinical Commissioning Group

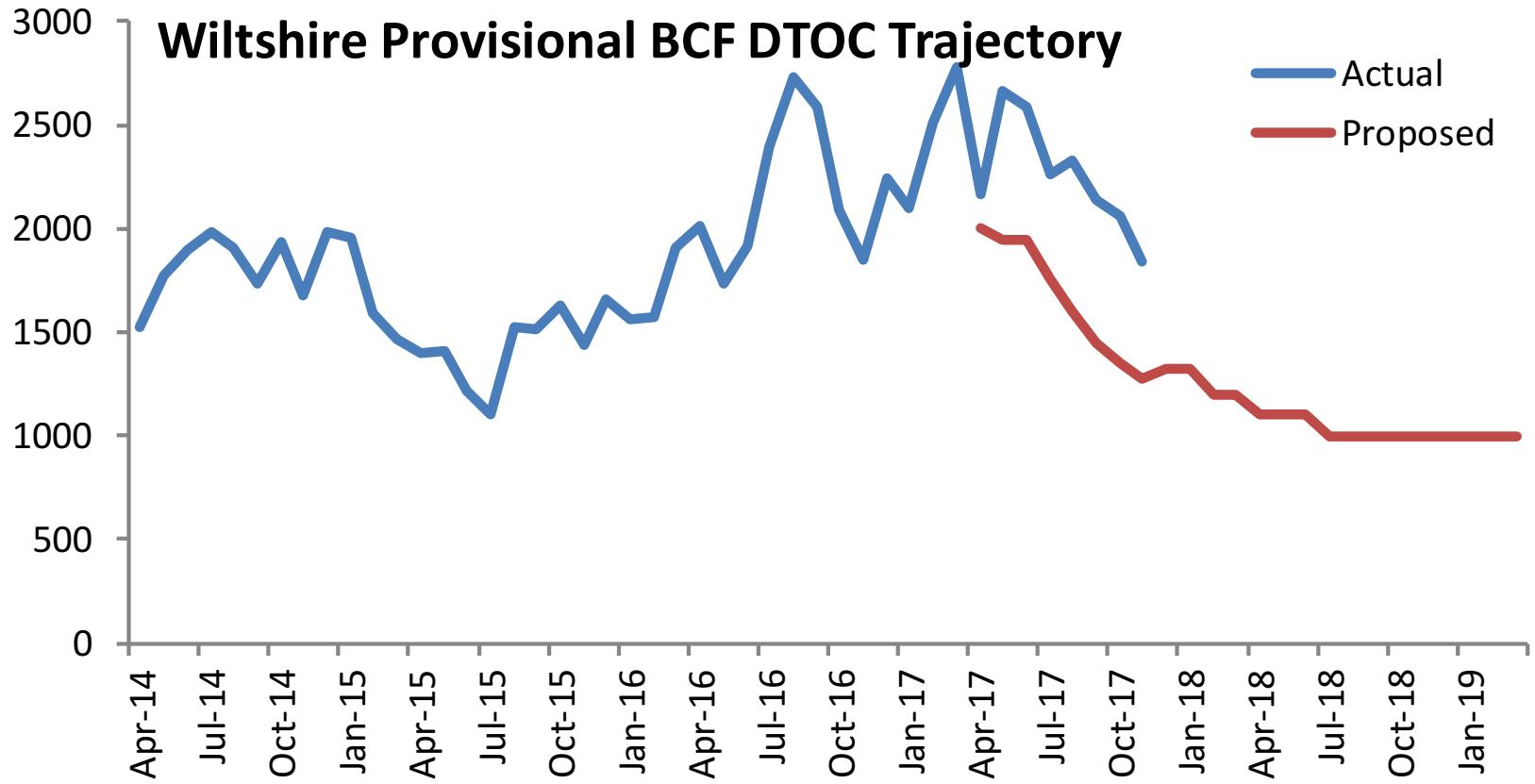
November DTOC Delayed Days

	NHS	ASC	Both	Total	Trajectory
Wiltshire	1,120	611	113	1,844	1,275
GWH	232	27	0	259	150
RUH	150	15	0	260	175
SFT	150	196	5	351	250
AWP	70	102	108	280	200
WH&C	408	200	0	608	450
Others	15	71	0	86	50

Wiltshire Council
Where everybody matters

NHS
Wiltshire
Clinical Commissioning Group

Trend for All Delayed Days



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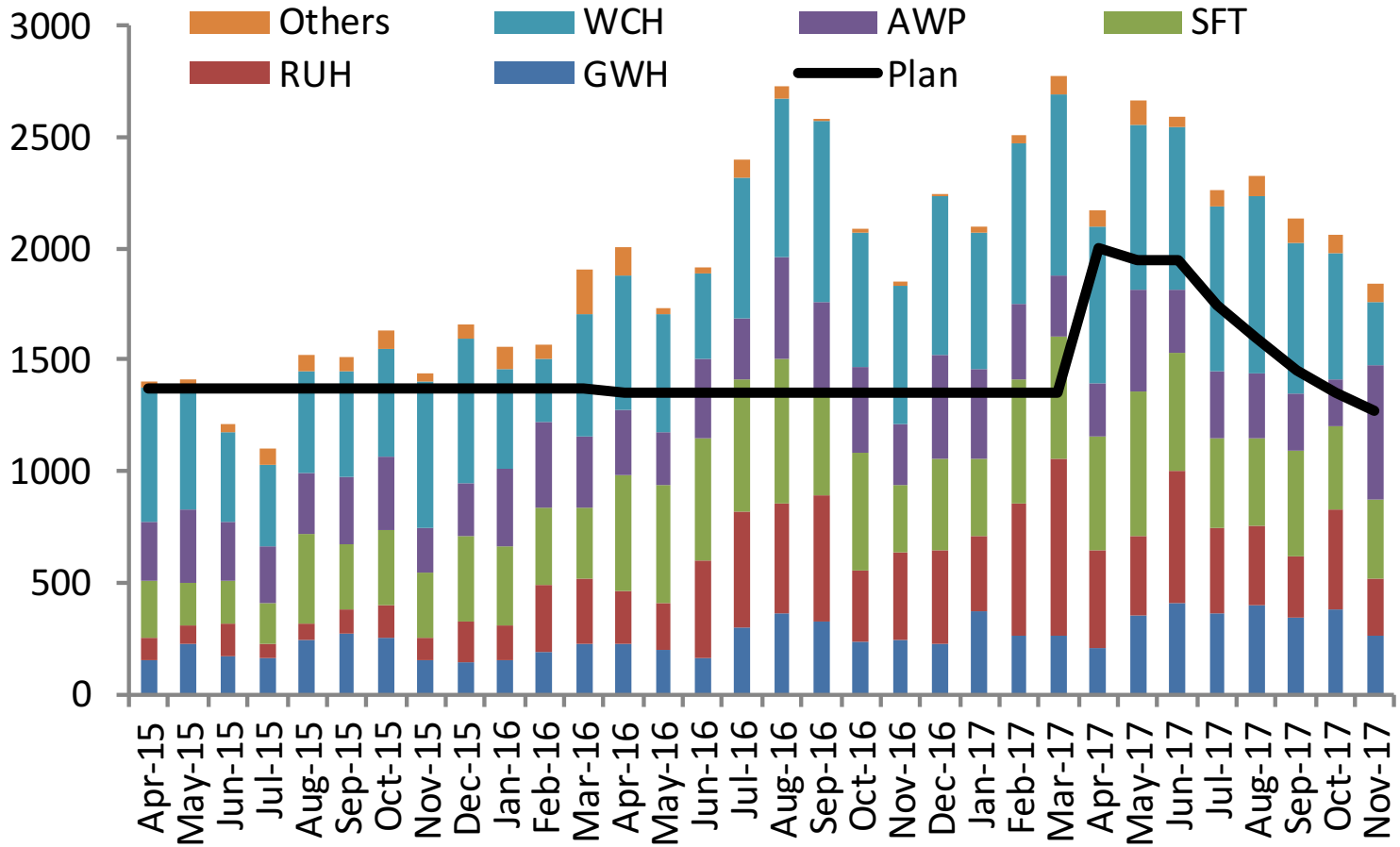
Trend for All Delayed Days by Provider



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Reason for All Delayed Days

Reason	2015-16	2016-17	2017-18 (to M8)	Nov 2017
Assessment	36.6	53.2	74.6	32
Public Funding	10.2	8.0	28.0	6
Non Acute transfer	299.0	447.3	301.1	139
Residential home	191.2	301.3	324.5	252
Nursing home	343.2	378.5	504.3	449
Dom Care	435.2	795.3	714.6	622
Equipment/ adaptations	39.8	76.7	97.5	106
Patient/ family choice	88.0	128.2	205.4	230
Disputes	9.7	14.0	1.4	7
Housing	42.8	43.3	45.3	1

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November NHS DTOC Delayed Days

	NHS	Trajectory	Gap	% of GAP
Wiltshire	1,120	759	361	47.6
GWH	232	126	106	84.1
RUH	245	139	106	76.3
SFT	150	143	7	4.9
AWP	70	56	14	25.0
WH&C	408	271	137	50.6
Others	15	23	-8	-34.8

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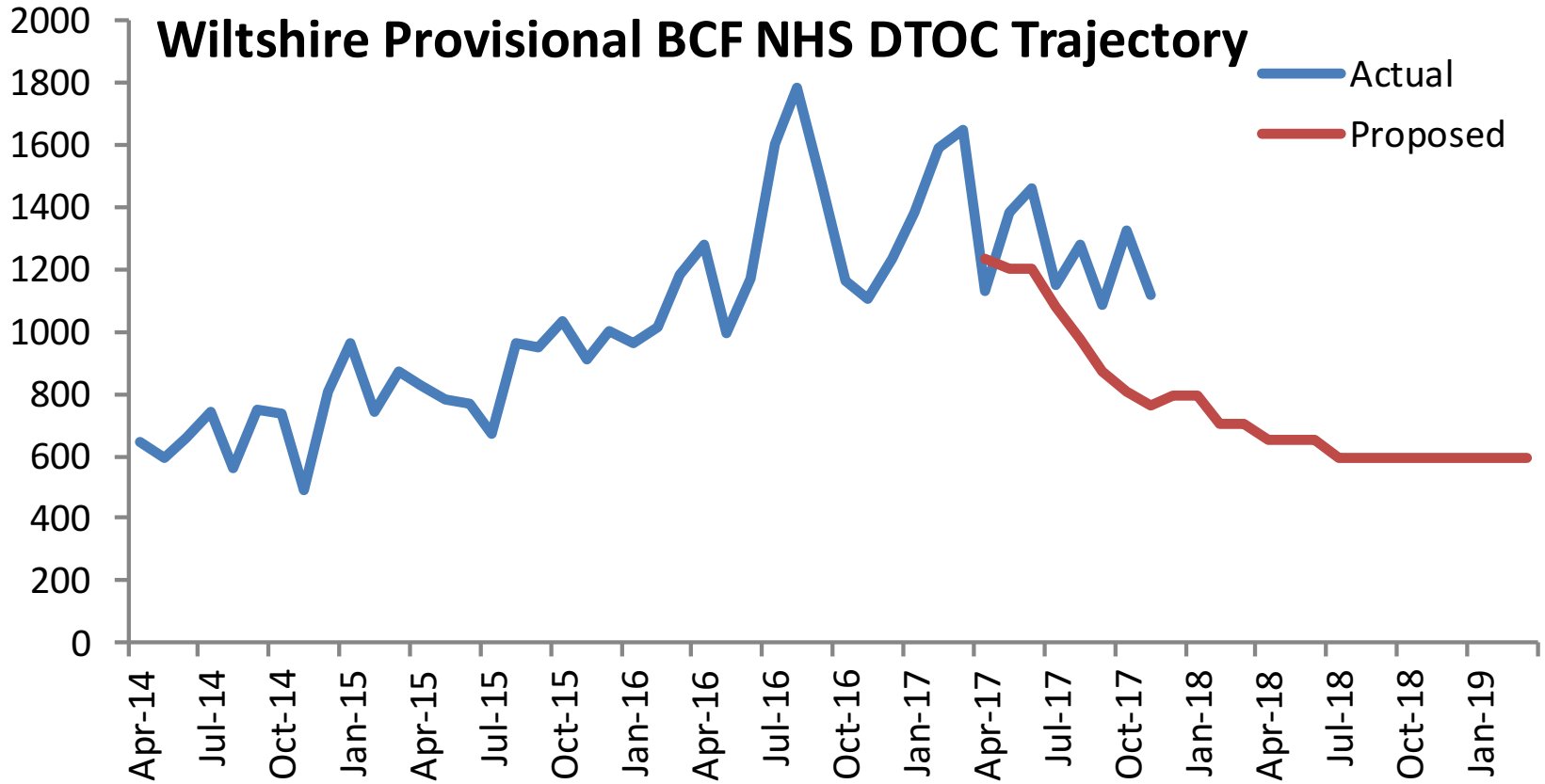
Trend for NHS Delayed Days



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November ASC DTOC Delayed Days

	ASC	Trajectory	Gap	% of GAP
Wiltshire	611	407	204	50.1
GWH	27	23	4	17.4
RUH	15	35	-20	-57.1
SFT	196	103	93	90.3
AWP	102	56	46	82.1
WH&C	200	171	29	17.0
Others	71	18	53	294.4

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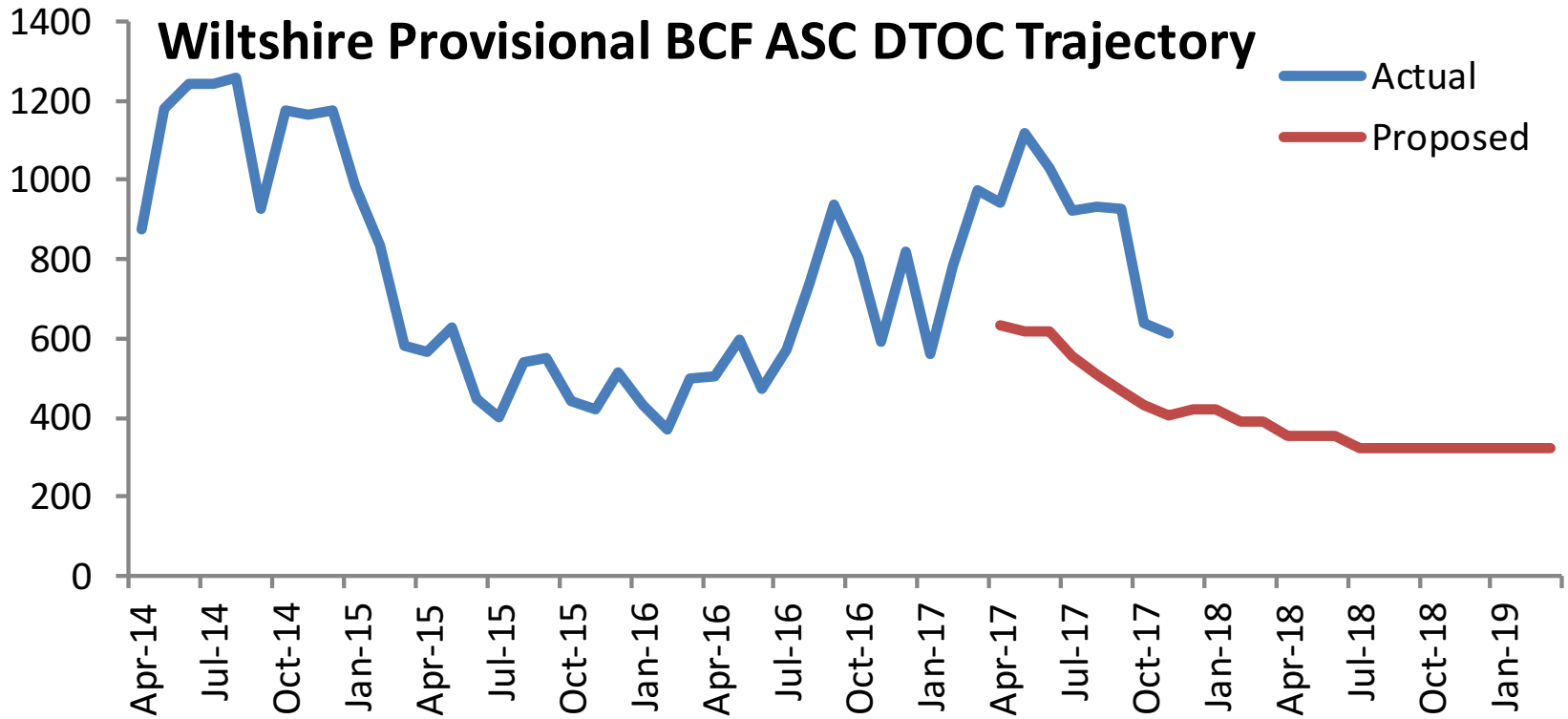
Trend for ASC Delayed Days



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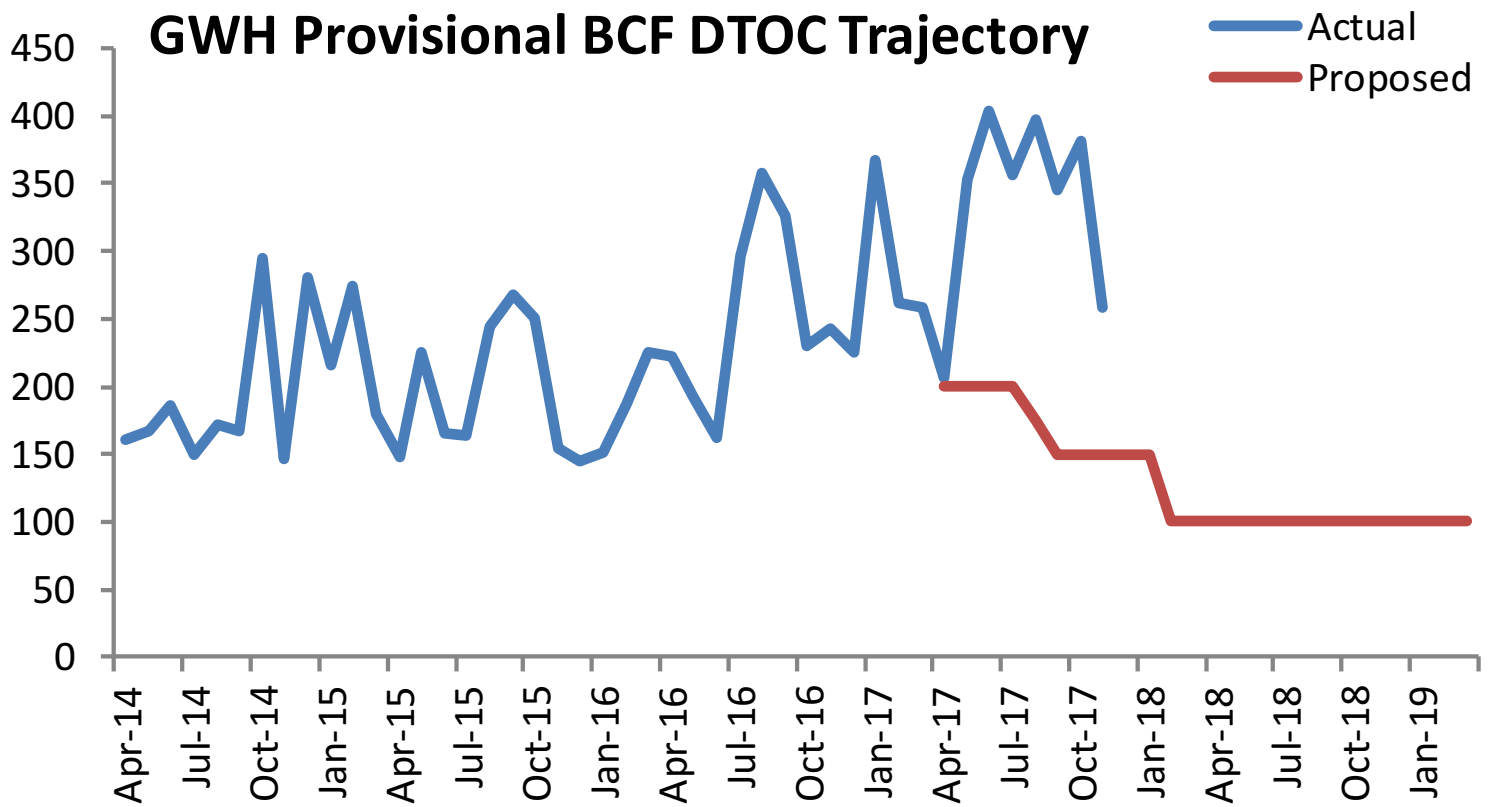
Trend for GWH Delayed Days



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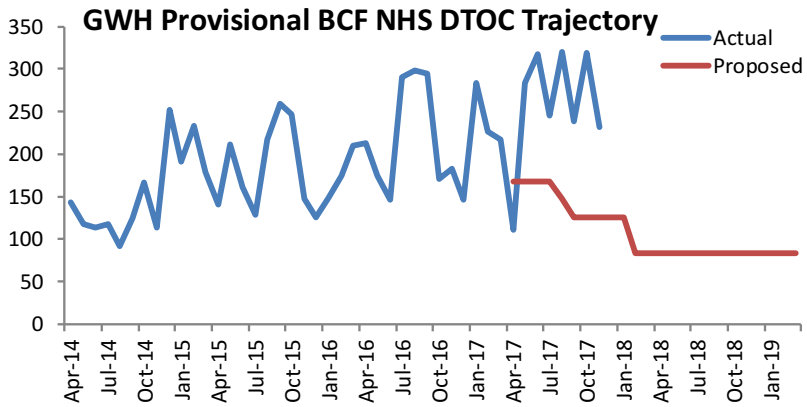
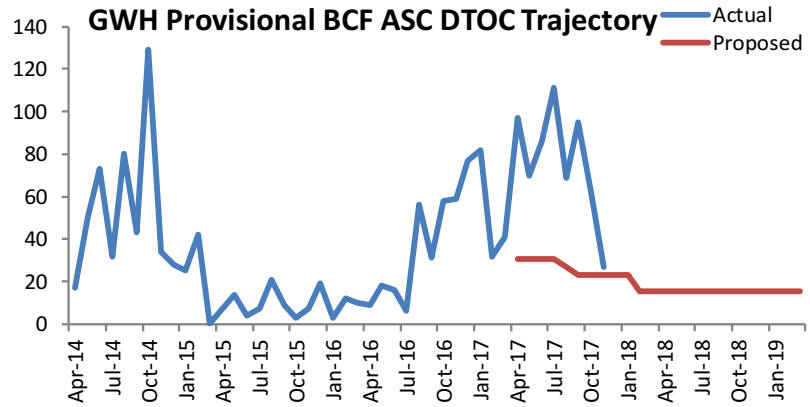
Trend for GWH Delayed Days





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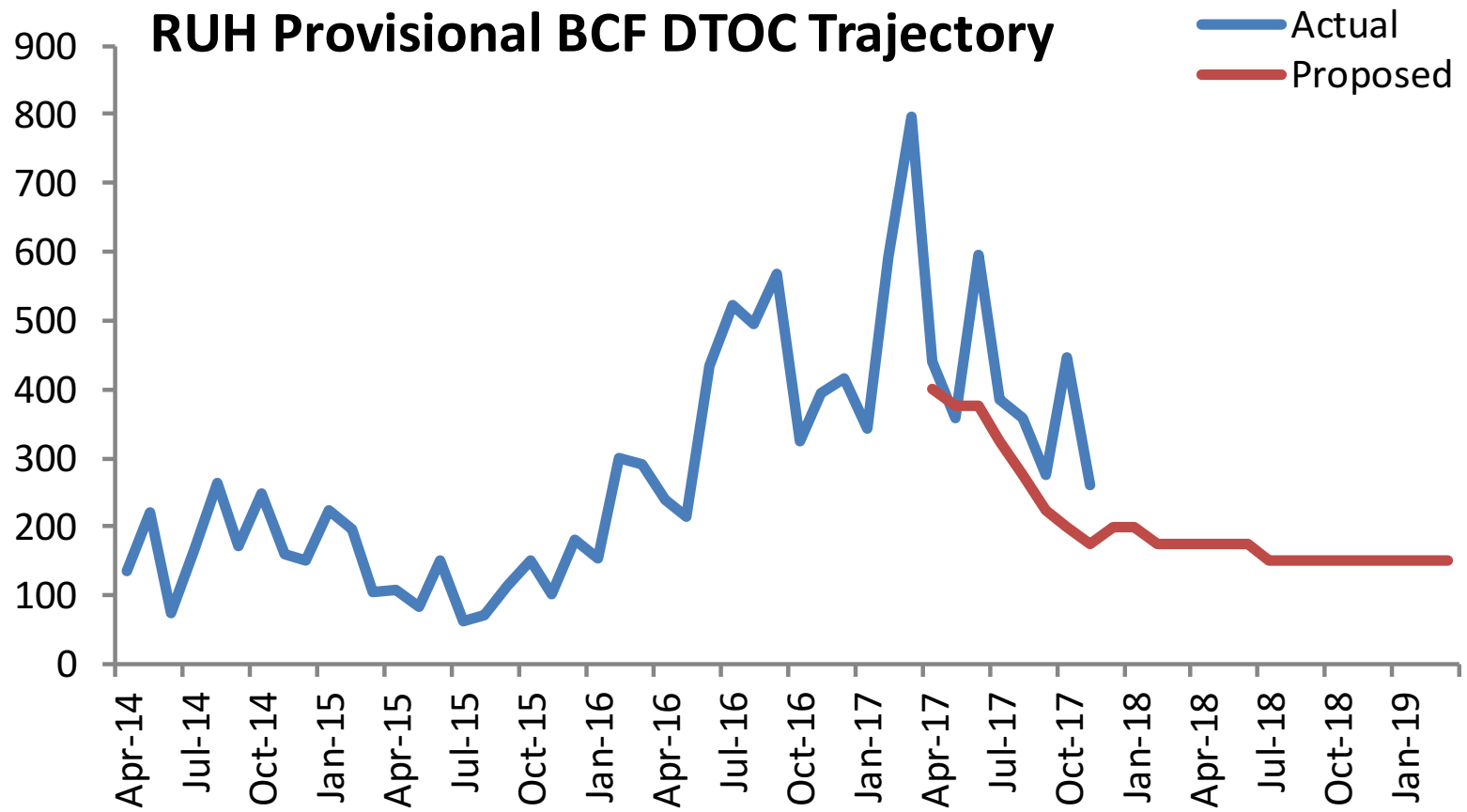
Trend for RUH Delayed Days



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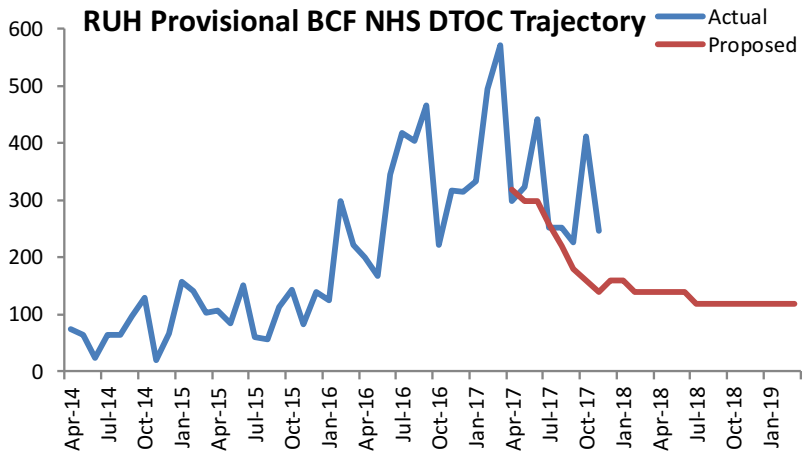
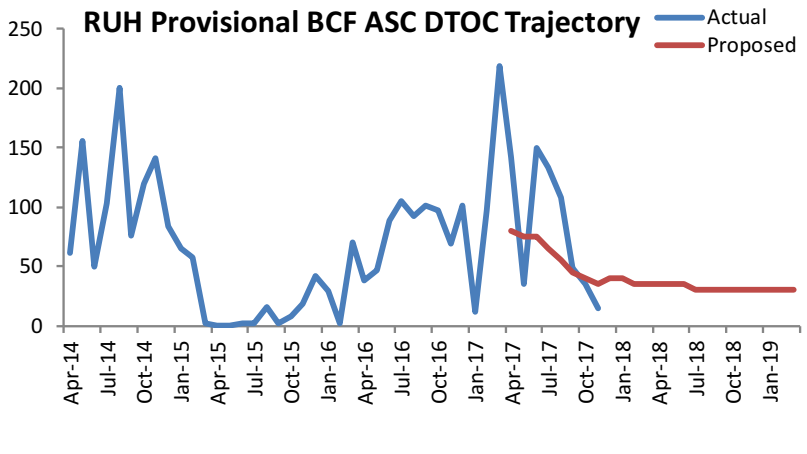
Trend for RUH Delayed Days





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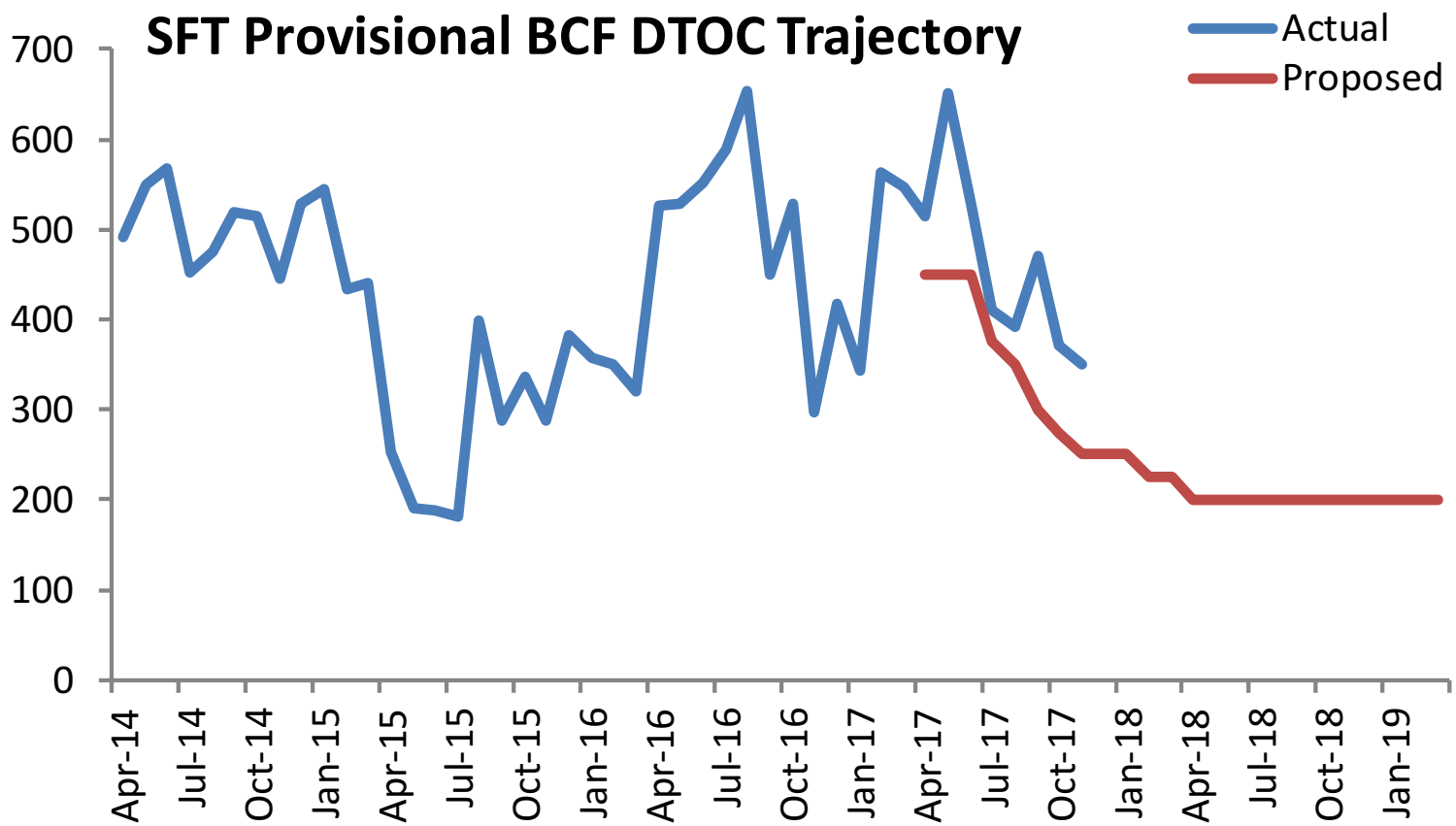
Trend for SFT Delayed Days



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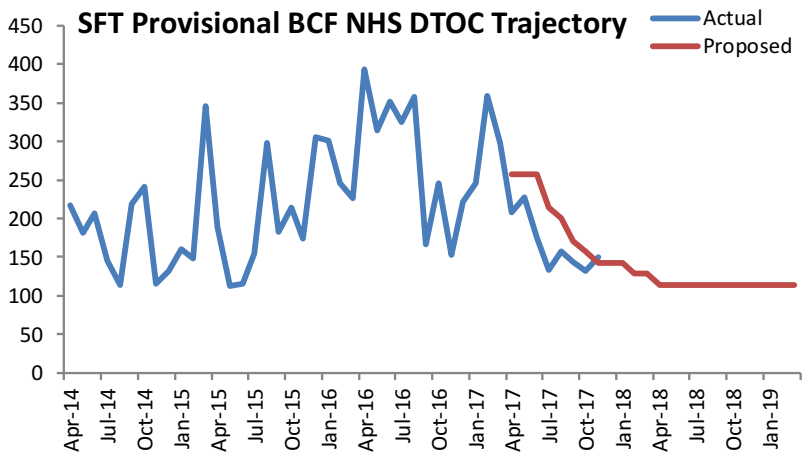
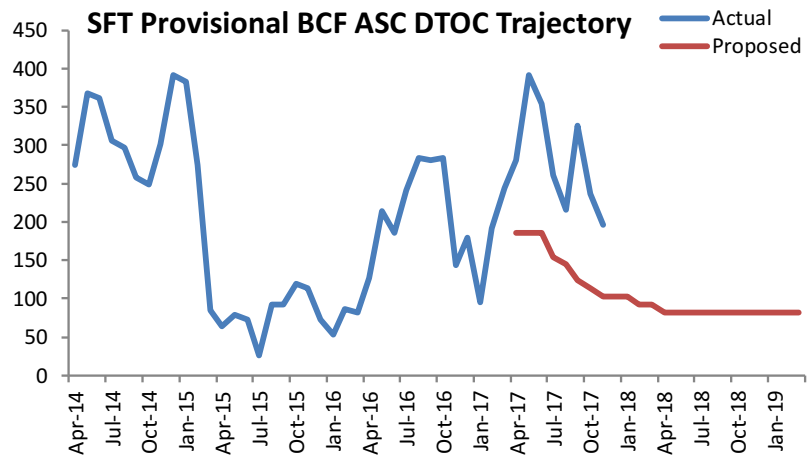
Trend for SFT Delayed Days





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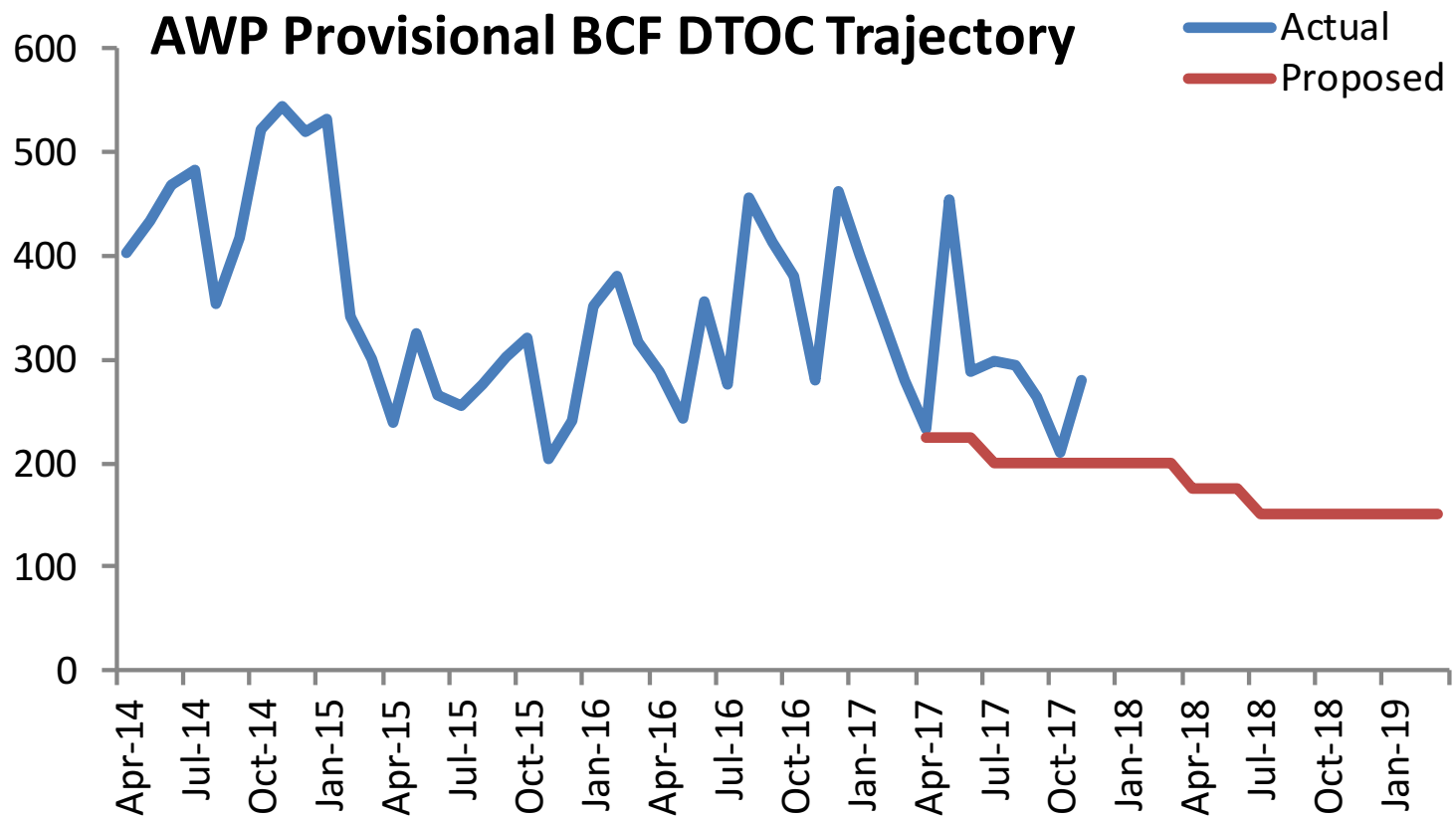
Trend for AWP Delayed Days



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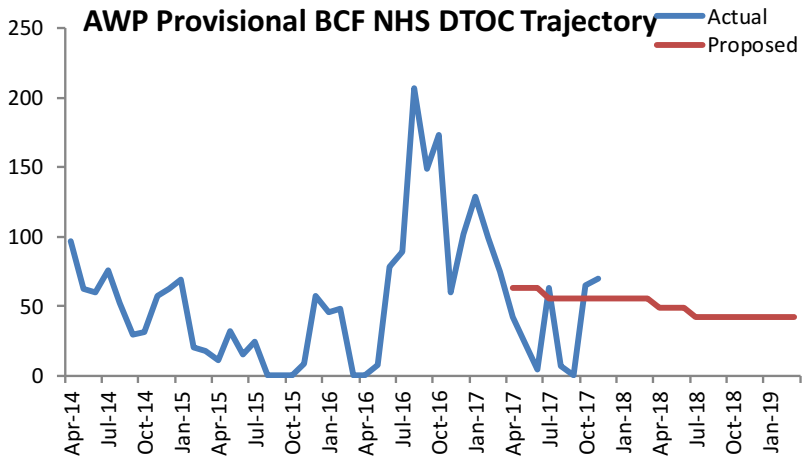
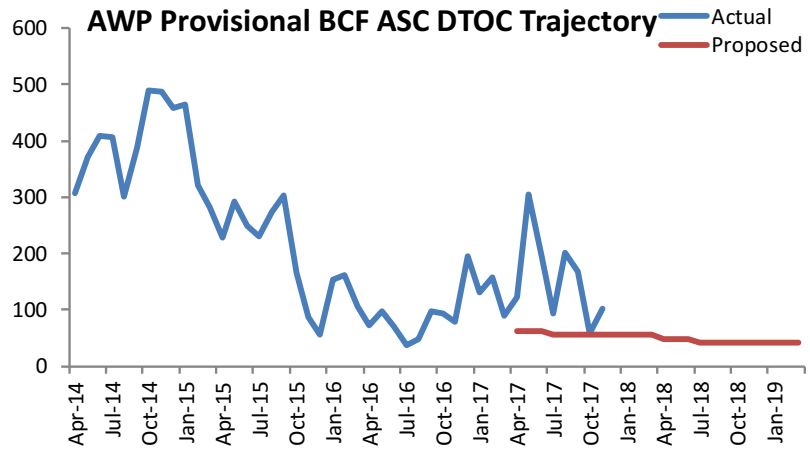
Trend for AWP Delayed Days





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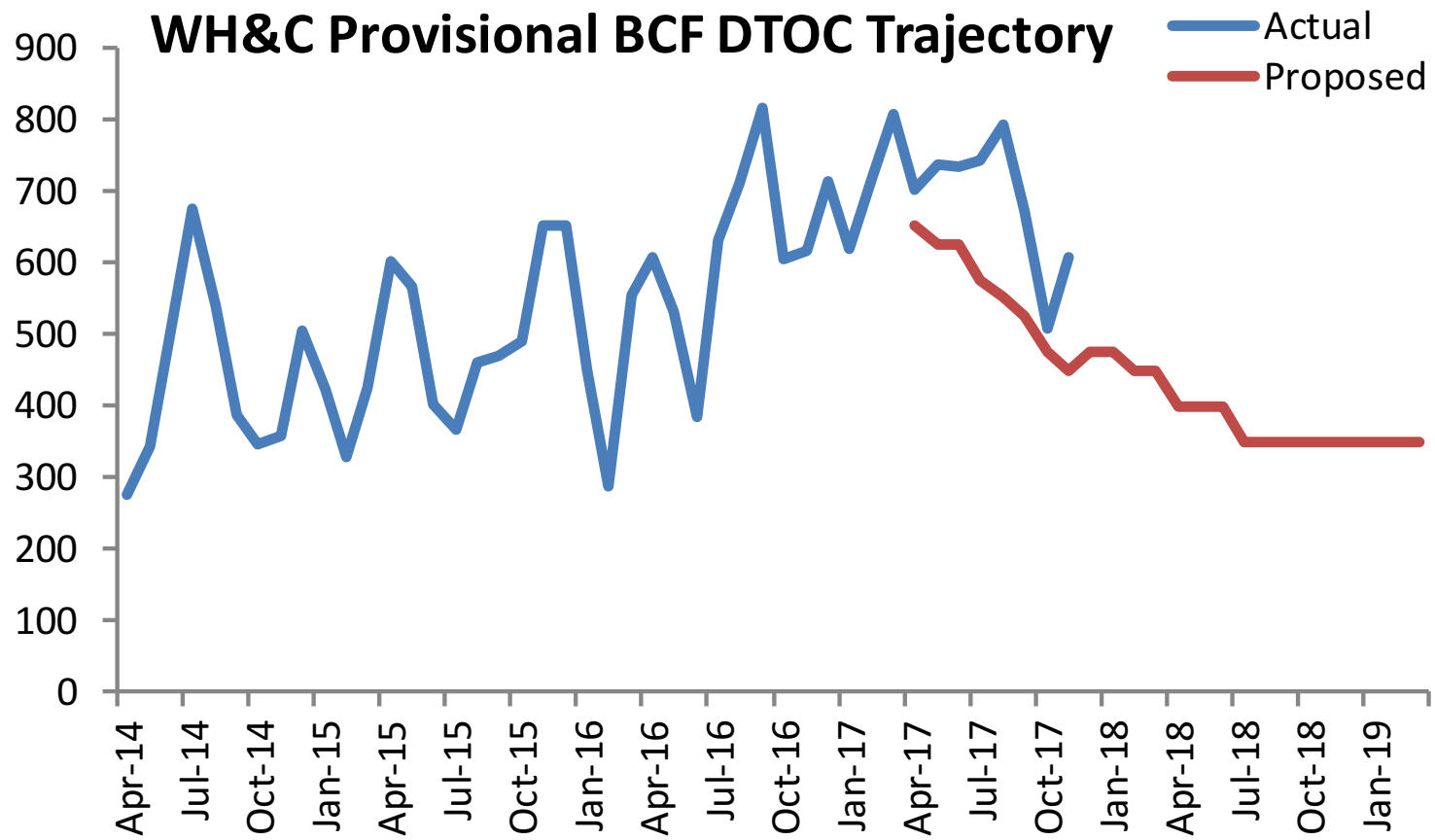
Trend for WH&C Delayed Days



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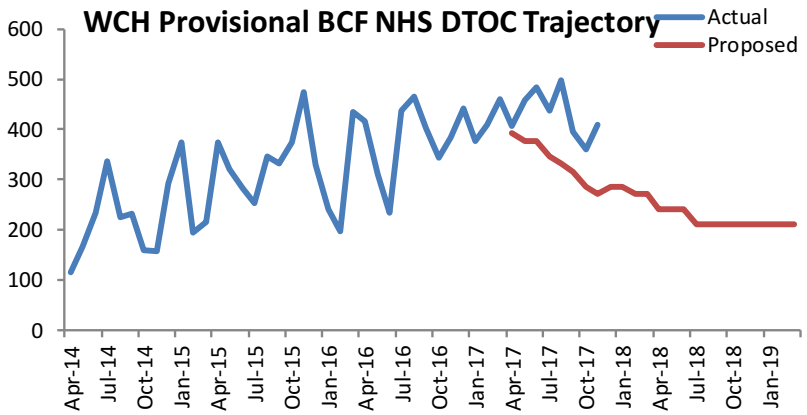
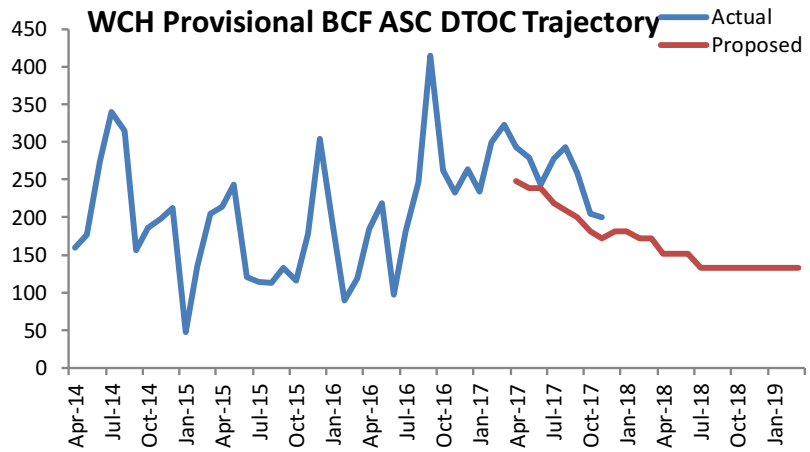
Trend for WH&C Delayed Days





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Benchmarking Performance

Table shows percentage increase or reduction in delayed days from October to November.

	NHS	ASC	Total
England	-6.9%	-12.1%	-8.8%
South West	-15.9%	-14.1%	-13.9%
Statistical Neighbours	-9.2%	-14.2%	-11.4%
Wiltshire	-15.1%	-4.5%	-10.4%

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Benchmarking Performance

This shows the Wiltshire rank nationally, 151 would be the highest and 1 would be the lowest.

	NHS	ASC	Total
July 2017	117	130	132
August 2017	128	128	137
September 2017	116	133	134
October 2017	135	127	134
November 2017	128	125	126

Wiltshire Council

Health and Wellbeing Board

Thursday 25 January 2018

Subject: Better Care Plan and emerging plan 18/19

Executive Summary

The Better Care Fund plan for 2017/18 continues to take forward the transformational change programme for reducing hospital based care and increasing care local to or at home. This is supported by a responsive Home First model that will continue to be strengthen in 2018/19 as our new service model is commissioned.

The Better Care Fund Programme has seen a positive change in DTOC since April 2017 however we remain off trajectory. The priority for Wiltshire is to strengthen the delivery of the high impact actions in the last quarter of 17/18 and into 2018/19, and take forward the core elements of the programme to transform the form and function of the Wiltshire wide system.

Proposal(s)

It is recommended that the Board:

i) Note the new Better Care Fund Dashboard
ii) Note the Better Care Fund Risk Register 2017/18
iii) Consider the emerging plan for 2018/19
iv) Give strategic approval to the proposed draft BCF Section 75 Agreement 2017/2019 between Wiltshire Council and NHS Wiltshire CCG which will continue to provide the legal framework for the Better Care Fund and underpin the Better Care Plan (delegating any future minor amendments to the Chair and Vice Chair)

Reason for Proposal

To provide assurance the Better Care Fund Programme is taking forward the Health and Wellbeing Board priorities aligned to transforming care from an acute to community or home.

To provide a position statement on the emerging priorities for 2018/19

Sue Shelbourn-barrow
Director of Transformation and Integration
Wiltshire Council and Clinical Commissioning Group

Wiltshire Council

Health and Wellbeing Board
25 January 2018

Subject: Better Care Fund Programme Dashboard

Purpose of Report

1. To provide a status report for the Better Care Fund Programme, including the Better Care Fund Risk Register, NHS England approval of the 2017/19 Plan and an update on the S75. The second element of the paper is to provide a position statement for 2018/19 plan.

Background

2. The Better Care Plan is established across Wiltshire, leading schemes, managing the system in terms of flow, responding to increased pressures and developing a consistent approach in relation to measurement, monitoring and delivery. The Better Care Fund Programme provides a platform for transformation and system wide integration in accordance with the priorities outlined in 2017/18.

Main Considerations

3. The Better Care Fund plan for 2017/18 continues to take forward the commitment of reducing hospital based care to care local or at home. This is supported by a responsive Home First model that will continue to be strengthened in 2018/19 as our new service models are commissioned.

4. The dashboard at **Appendix 1a** shows that:
   - Overall non-elective admissions for Wiltshire are around 6.5% higher than last year, while avoidable emergency admissions and admissions from non-LD care homes are both 2% lower than the same period last year with Great Western Hospital and Royal United Hospital reporting the majority of the increases however Salisbury Hospital has remained similar.
   - New permanent admissions to care homes remain at historically low levels due in part to availability of care at homes.
   - The percentage of people at home 91 days post hospital discharge has reduced, however data quality has been a focus in Q3 to improve the counting in Q4 and into 2018-19.
   - The Delayed Transfers of Care shows signs of improvement but remains above the planned trajectory. The published data will be presented on the day of the meeting.
   - Urgent Care at Home continues to see more referrals, however performance dipped in October.
   - The number of new clients supported by Help to Live at Home was lower in December than November

- Intermediate Care admissions and discharges were around the average for the year.
- Winter Pressures: patients are now being placed in the additional beds purchased to support winter pressures and we would expect to see that impact the flow through these beds next month.

Wiltshire Better Care Fund Outcome and Performance (slide 13) shows that:

- Non-elective admissions are up 3.6% on the same period last year and permanent admissions to care homes are 1.2% higher than last year but remain well under the target. This perhaps suggests the change in demographics as seen in the joint Strategic needs assessment and supports the importance of identifying further admission avoidance work streams in 2018/19
- Urgent Care at home activity has increase 47% on the same period last year which aligns to the delayed days that have reported 6.4% lower than the same period last year, but remain well above trajectory for October 2017. This is a positive move as the Better Care Fund workstreams embed however further is required to enable the system to be sustainable in 2018 an into 2019.
- Intermediate Care Bed admissions are 3.7% lower than the same period last year but discharges are 1% higher. Domiciliary Care activity for new clients is 14.3% higher than the same period last year and ongoing support is 1.9% higher suggesting the new models of care to support Home First is starting to change the system model from residential to normal residential of choice.

Better Care Fund 2017/19

5. In December 2017, the Better Care Fund programme stocktake was completed. This is being used to provide a baseline to inform the evaluation of the programme workstreams and agreement on the 2018/19 draft programme and budget. A detailed update on this will be provided at the next meeting in March. A risk register for the programme is attached at **Appendix 1b**.

6. On 20 December 2017, NHS England wrote to the council and CCG to provide notification that the Better Care Fund 2017-19 for Wiltshire has passed the assurance process and funds approved for release. A copy of the letter is at **Appendix 2**.

7. As part of finalising this there is a need to refresh the s75 agreement underpinning the Better Care Fund. The draft agreement is attached at **Appendix 3** and the Board is asked to give strategic approval to this, delegating any future minor amendments to the Chair and Vice Chair. Overall, minor amendments have been made to last year's agreement but with the addition of a new senior board comprising council, CCG and provider representatives to give additional senior level focus and time on how the Better Care Fund is used. The role of the Joint Commissioning Board and Health and Wellbeing Board remains the same.

Sue Shelbourn-Barrow
Director of Transformation and Integration

Report Authors: Sue Shelbourn-Barrow
Director of Transformation and Integration

Appendices:
Appendix 1a: BCP Dashboard
Appendix 1b: Risk register
Appendix 2: BCP Approval Letter
Appendix 3: BCF s75 agreement

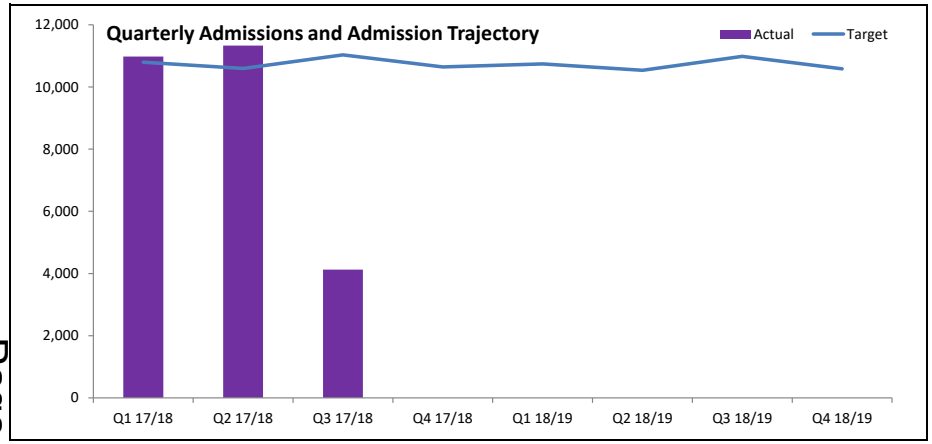
Wiltshire Better Care Fund Dashboard - January 2018

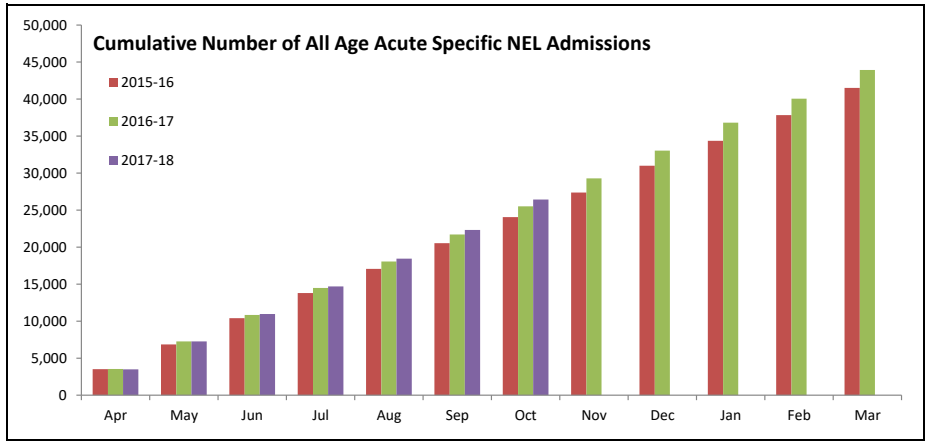
DTOC has continued to report improvement in Q3 as an aggregate with both NHS delays and ASC delays reducing in November. The overall Better Care Fund Programme has seen non-elective admissions increase by 6.5% when compared to last year and Urgent Care at Home has continued to see more referrals. Help to Live at Home has taken forward the person centered model to enable individuals to have care that enables resilience and self care. However looking forward into 2018/19 the new market model for Wiltshire that supports the transformational change of delivering care closer to home or at home will be strengthen by a domiciliary care market development, Home First and the in house reablement service that will provide a platform for performance to be sustained once embeded.

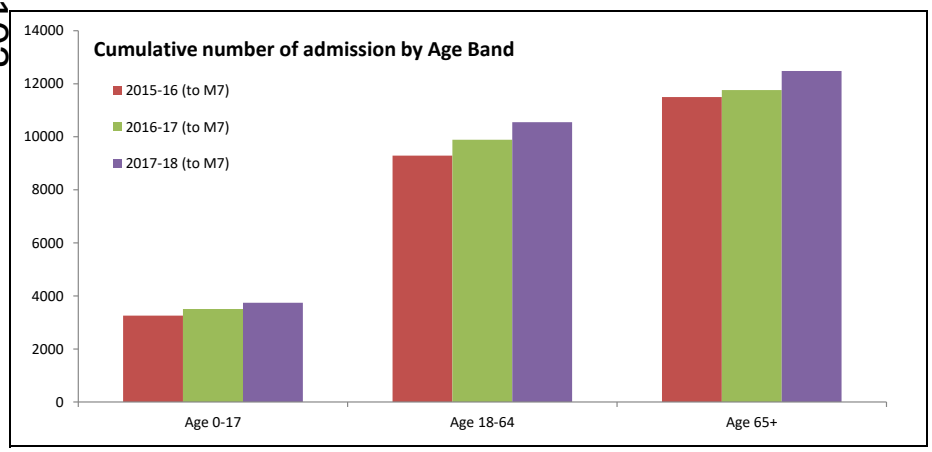
		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Red	Amber	Green
National Indicators																
	Specific Acute Non Elective Admissions	3,373	3,914	3,835	3,813	3,842	3,877	4,126						<3250	3250 or <375	>3750
	Permanent Admissions to Care Homes	300	276	348	474	518	496	423	423	433				>525	<525 or >500	<500
	At Home 91 days post discharge with reablement		70.9											<80%	80% or <86	>86%
	Delayed transfers of Care	2,169	2,667	2,589	2,260	2,329	2,134	2,058	1,844					>1500	1500 or >13	<1325
Wiltshire BCF Schemes																
	Intermediate Care Beds - Step Down	54	47	52	47	42	49	43	47					<45	>45 or <60	>60
	Intermediate Care Beds - Step Up	2	6	5	3	6	1	3	4					<7	>7 or <10	>10
	Community Hospital Beds - Admissions	79	73	93	70	74	78	72	80					<60	>60 or <80	>80
	High Intensity Care - Referrals	17	16	21	24	25	23	23	13					<12	>12 or <18	>18
	Urgent Care at Home	49	60	64	64	68	62	77						<60	>60 or <80	>80
	Rehab Support Workers	13	31	47	58	67	65	75	56					<60	>60 or <80	>80
	Community Geriatrics															
	Fracture Liaison															
	CHS															
Wiltshire iBCF Activity																
	20 Additional SD IC Beds															
	3 Specialist MH IC Beds															
	Additional RSW / UCAH Reablement															
	Housing Adviser															

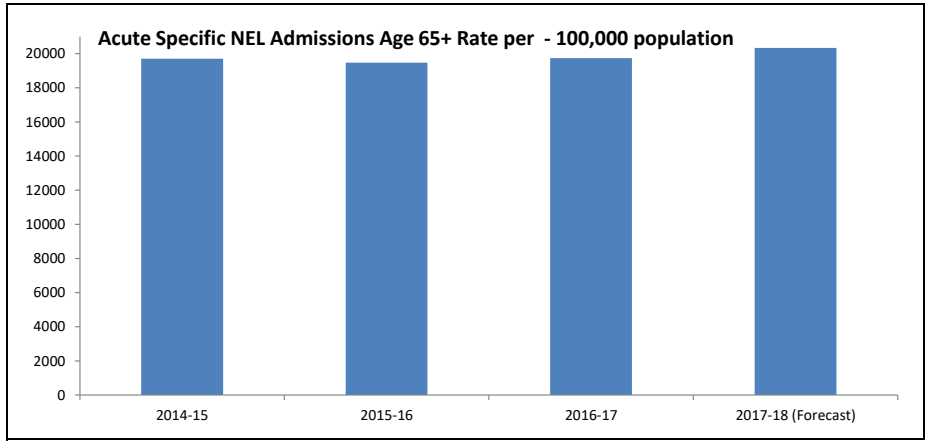
Acute Specific Non Elective Admissions

Activity has been increasing through the year and at M7 admissions are 6.5% (1,624 admissions) higher than the same period last year. This year admission growth is broadly the same in each of the 3 broad age bands. The forecast admission rate in those aged 65 and over looks as if it will increase this year.





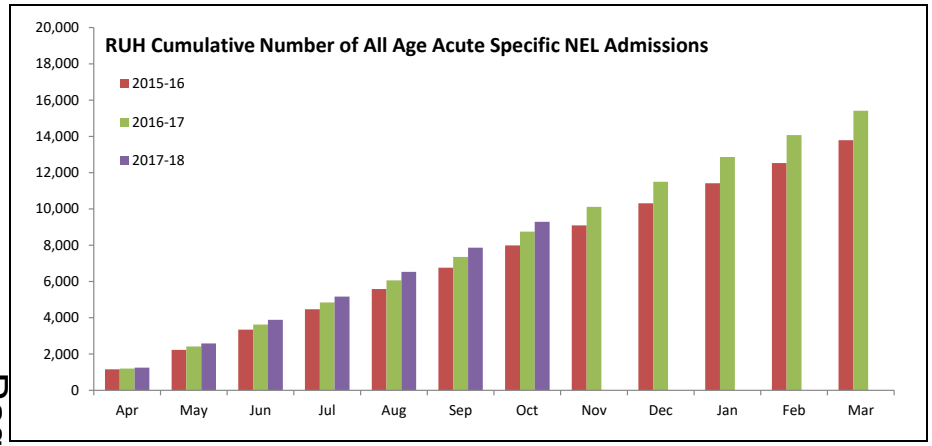


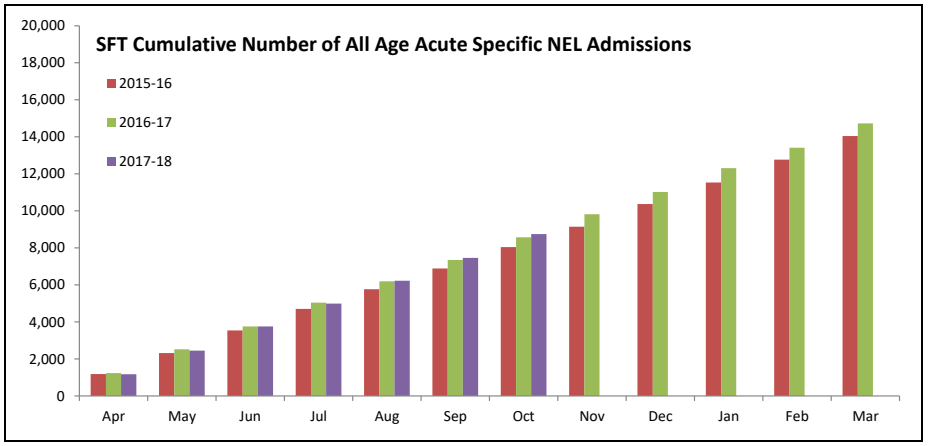


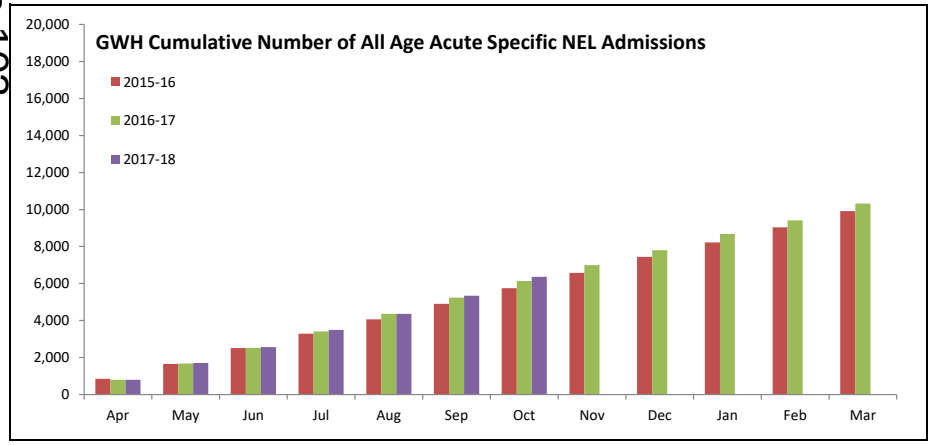
Source: CCG SUS Data

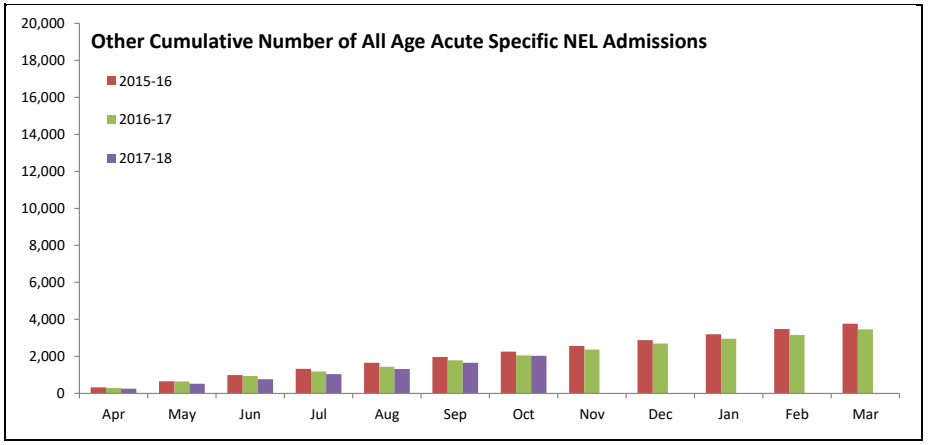
Acute Specific Non Elective Admissions

GWH and RUH have seen increases of 7.4% (436 adms) and 6.8% (584 adms) respectively while SFT is broadly similar to the same period last year. RUH has seen a 8.6% rise in admissions for those aged 65 and over, while at GWH there has been a 31.1% increase in admissions for young people aged under 18. Admissions out of area to other providers are broadly similar to the same period last year.





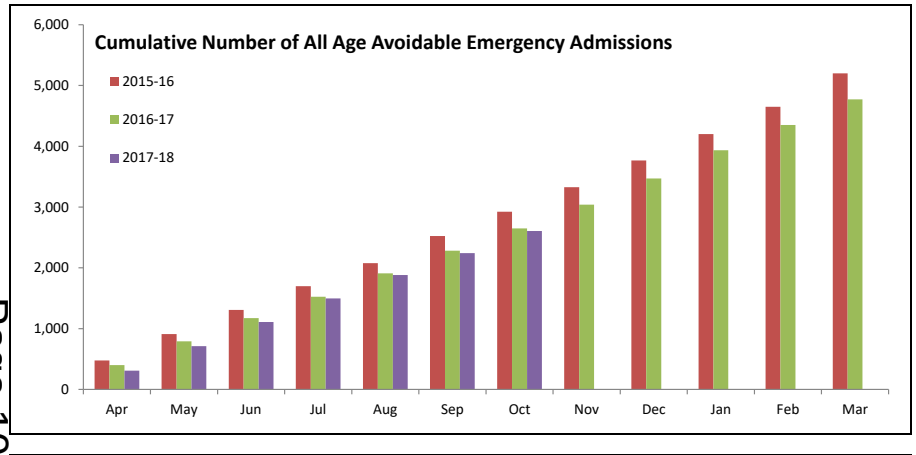


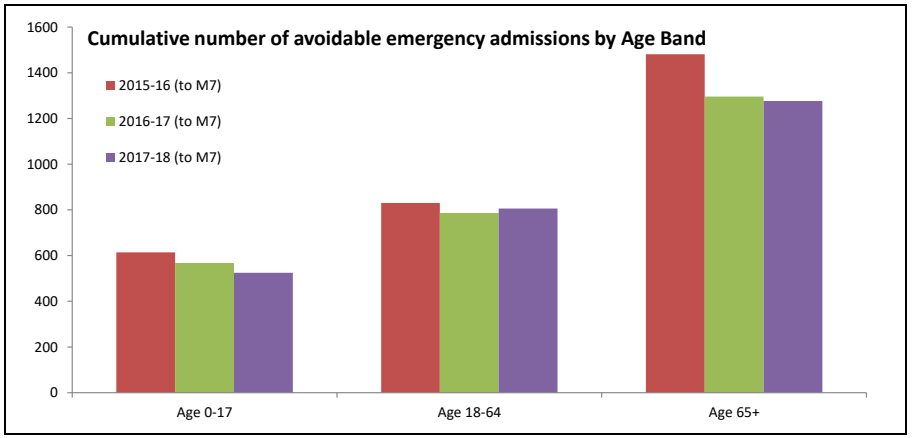


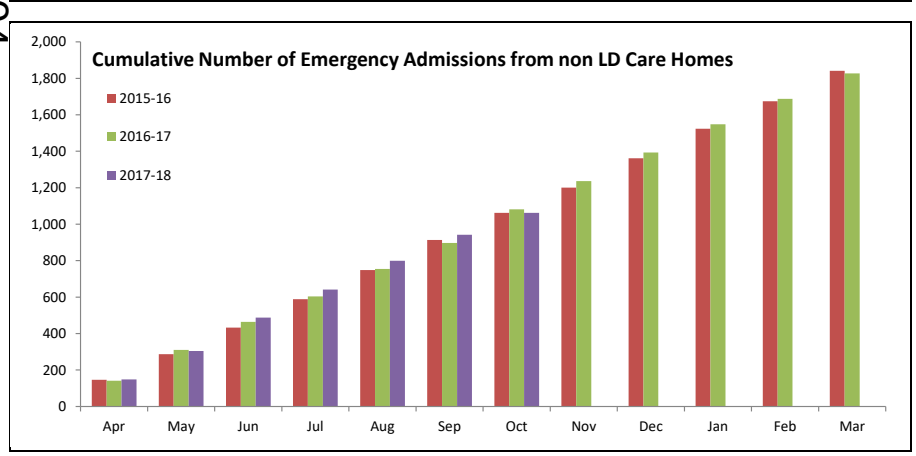
Source: CCG SUS Data

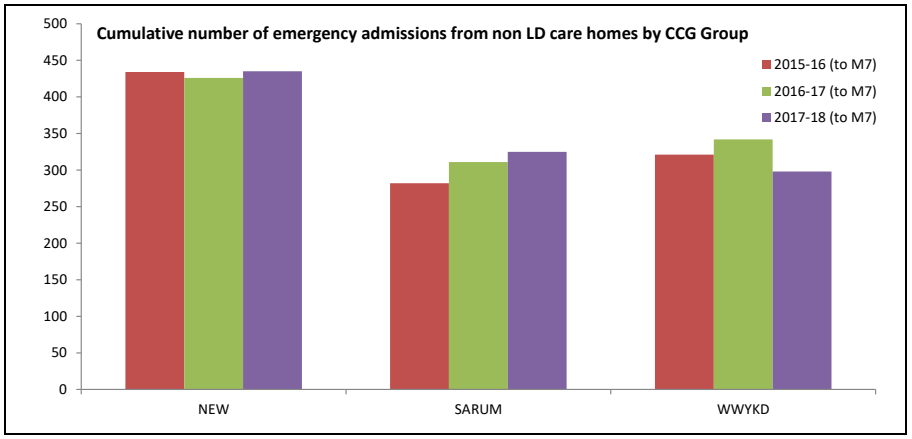
Avoidable Emergency Admissions & Admissions from Care Homes

Avoidable emergency admissions are around 2% lower (43 admissions) lower than for the same period last year, although the cost of these admissions is around 7% higher. These admissions are lower in both young people and older people but slightly higher in those of working age.
Admissions from non LD care homes are also down on the same period last year by around 2% (23 admissions). When split by CCG group area we see an increase in the South, a decrease in the West and broadly similar in the North.





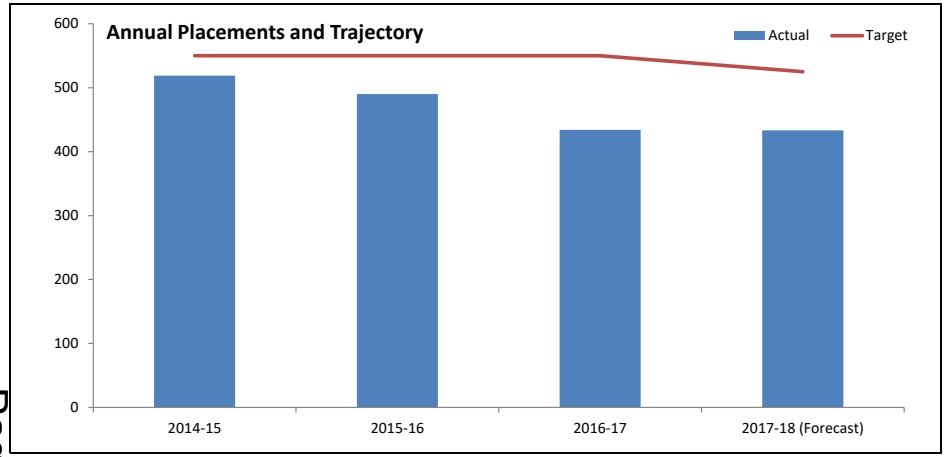


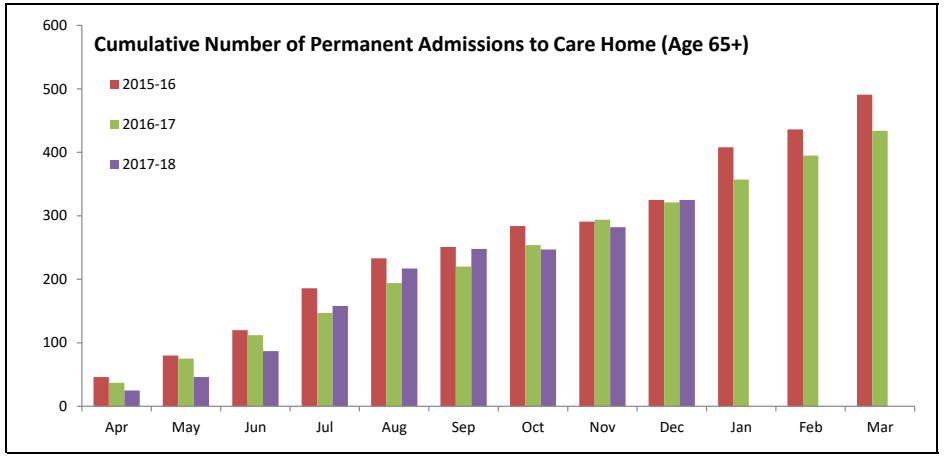


Source: CCG SUS Data

Permanent Admissions to Care Homes

There was a net increase of 43 permanent placements in December, this is around 19% higher than the monthly average for this year and 2016-17 (36). A simplistic forecast for year end remains around 435 which is well under the 525 target.

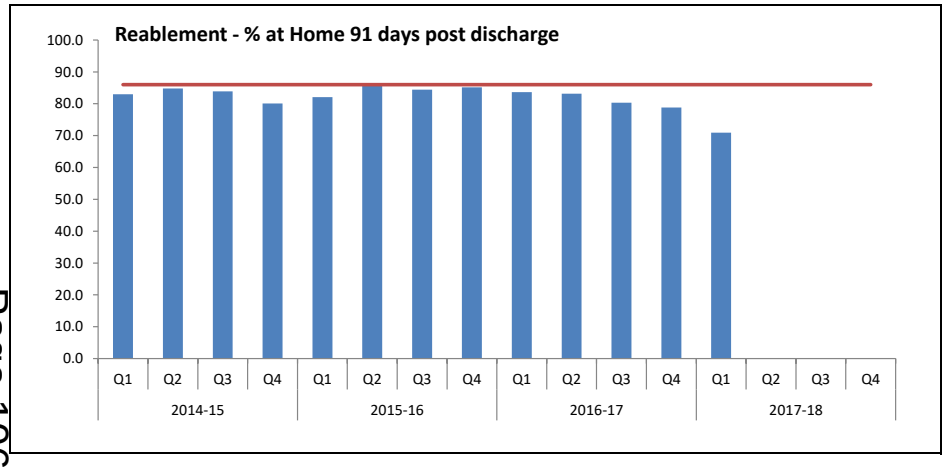


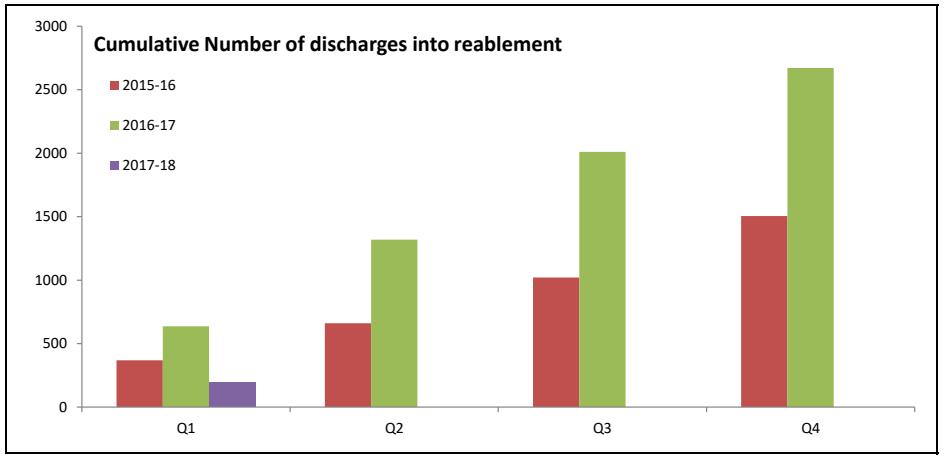


Source: ASC Performance Team

Patients at home 91 days post discharge from hospital

The number of patients entering reablement has reduced due to changes in the discharge pathway following the introduction Home First. Discussions with WH&C confirm this is likely to be more accurate than the 2016-17 position and numbers will return to expected levels in the coming months. Performance has also dropped slightly but should improve in the coming months.

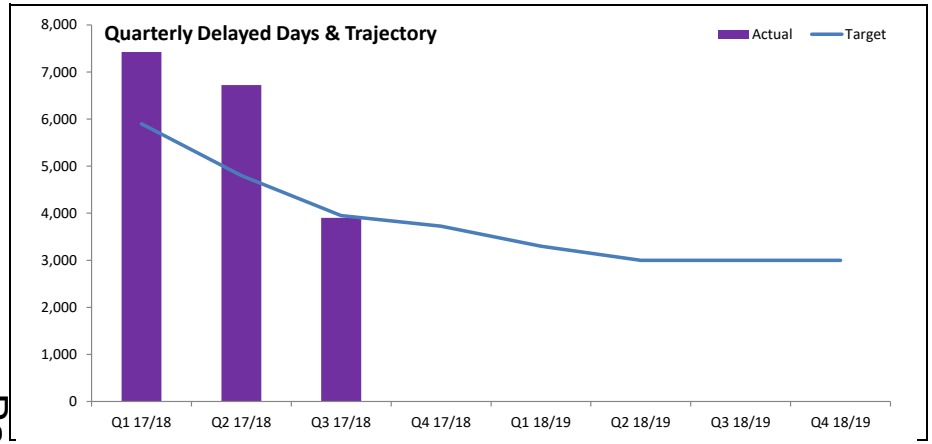


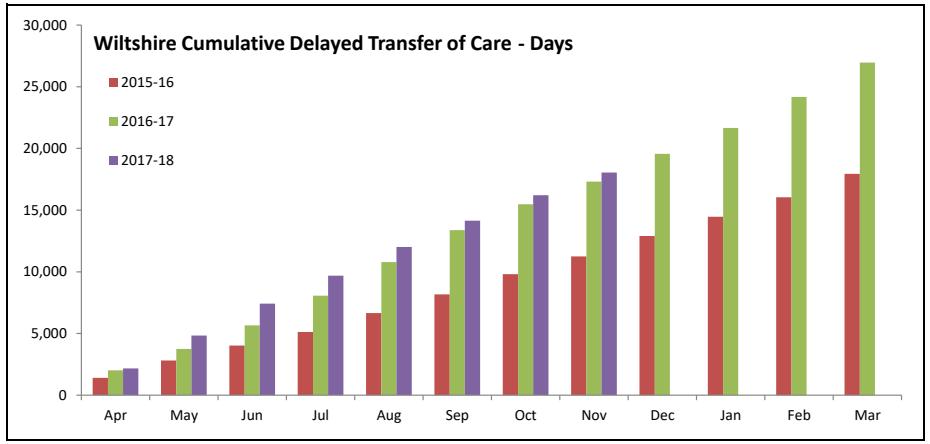


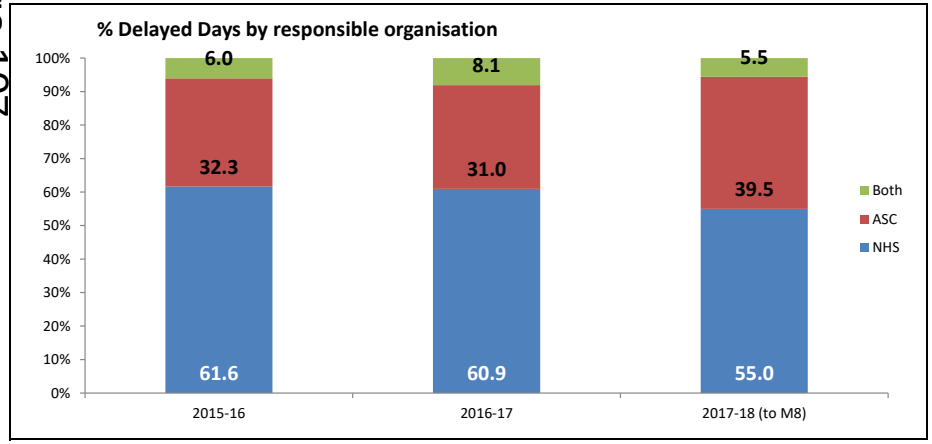
Source: ASC Performance Team & WH&C

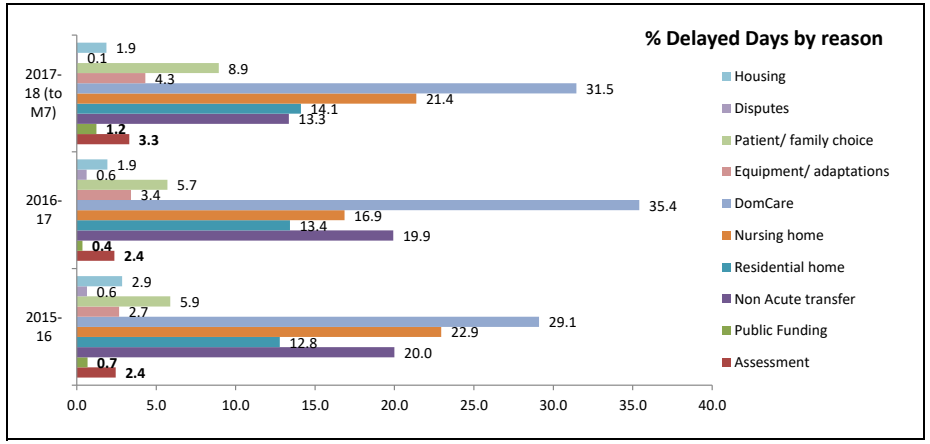
Delayed Transfers of Care - Delayed days

The number of delayed days reduced by 10.4% (214 days) in November to 1,844 but this remains well above the trajectory target of 1,275. Both NHA and ASC attributable delays improved in November. Waiting for Packages of Care and Nursing Home Placements account for over 50% of the delayed days.





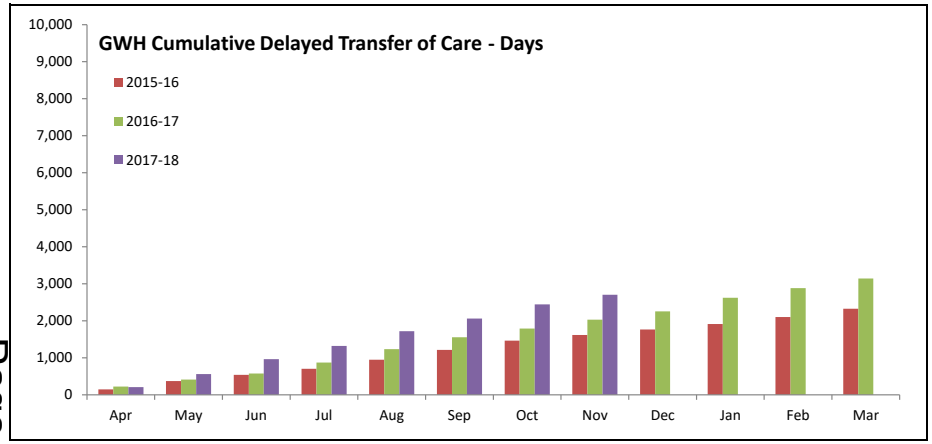


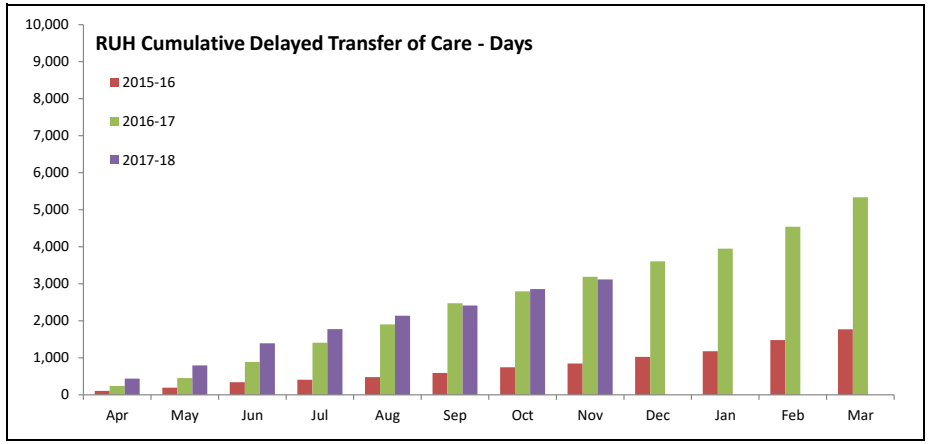


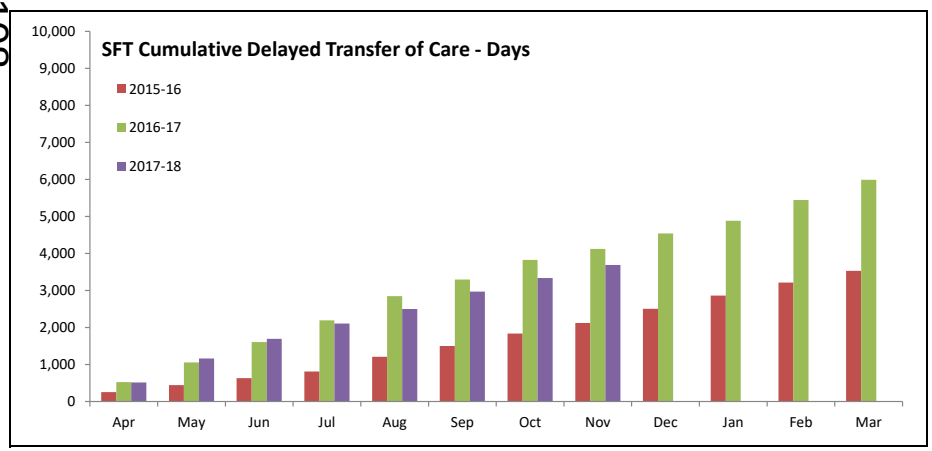
Source: NHS England Monthly Data

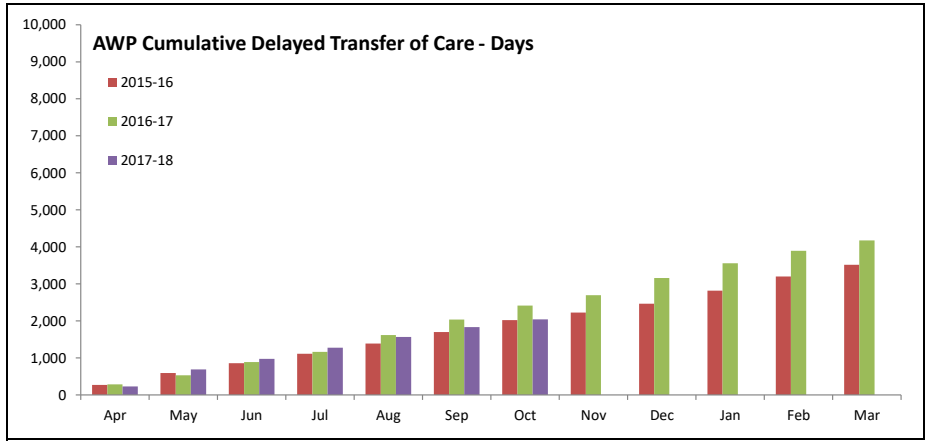
Delayed Transfers of Care - Delayed Days

RUH, SFT and AWP have seen a reduction in delayed days compared to the same period last year, while GWH has seen a rise.





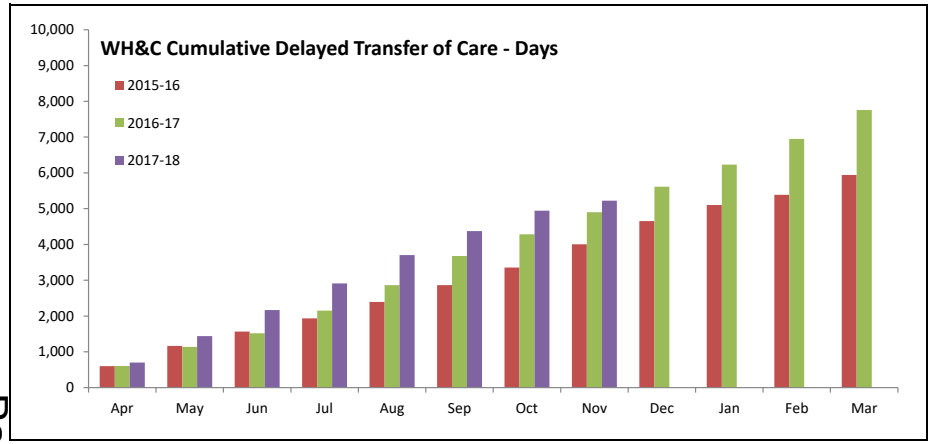


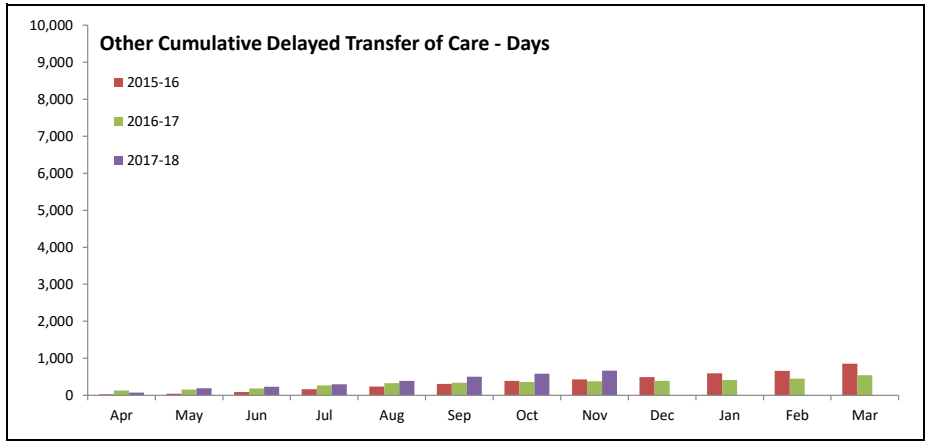


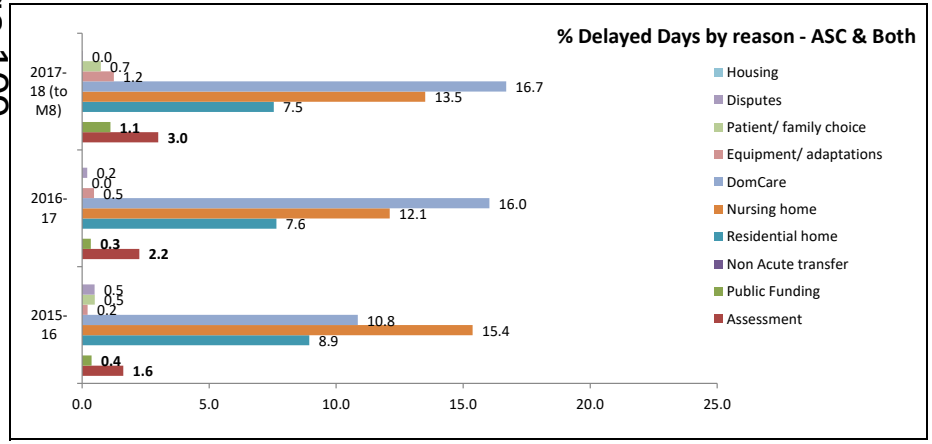
Source: NHS England Monthly Data

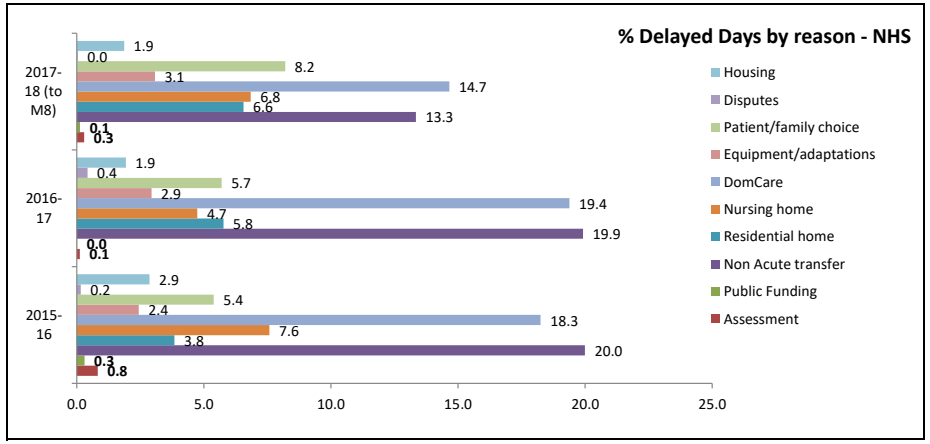
Delayed Transfers of Care - Delayed Days

Delays in Community Hospital and in Out of Area Hospitals have increased compared to the same period last year.





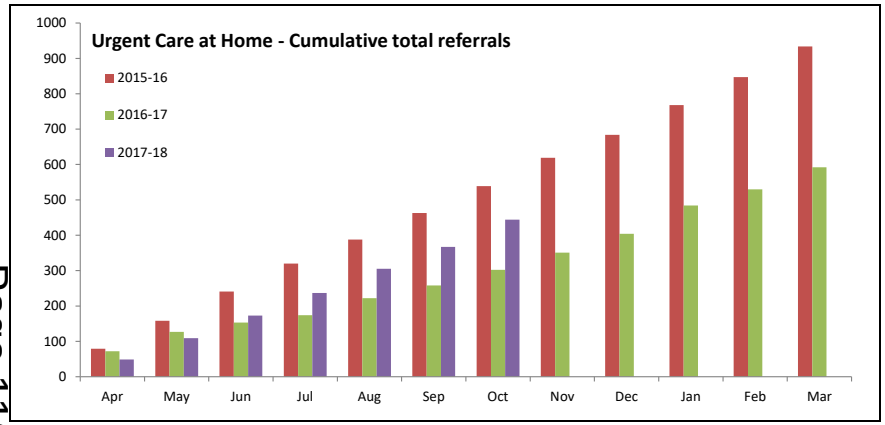


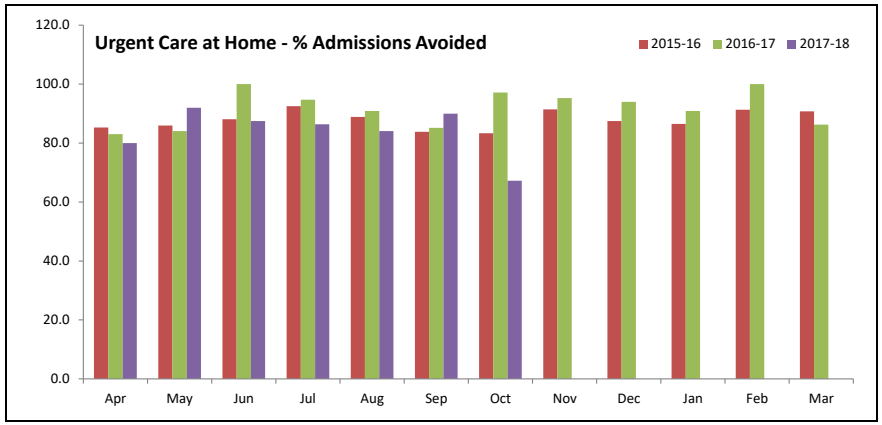


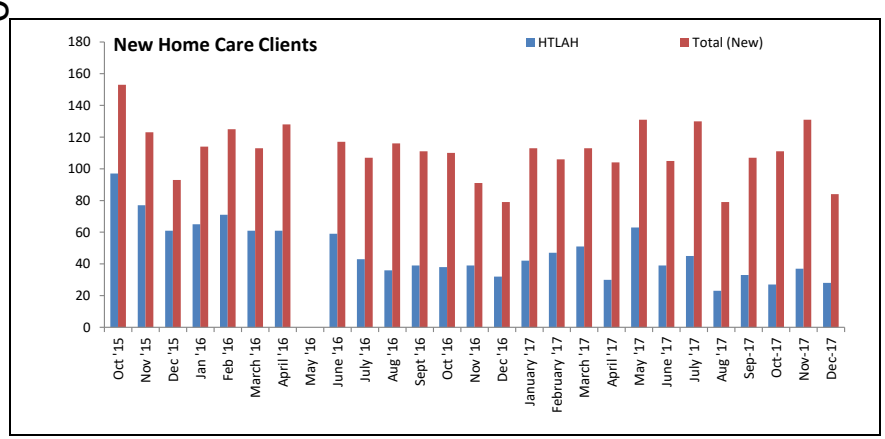
Source: NHS England Monthly Data

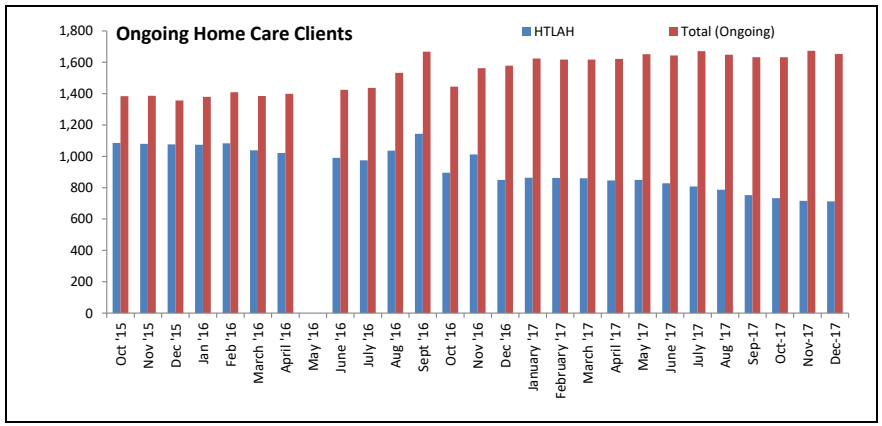
Home Care and Urgent Care at Home Activity

Urgent Care at Home referrals were higher in October at 77, which is close to the 80 target, however the % of admissions avoided reduced to around 67%. The average number of referrals to M7 is now around 63 per month which is higher than the 2016-17 of 50. The average percentage of admissions avoided is around 85%. The average number of referrals to support discharge is now around 17, this is higher than 2016-17 (9) and 2015-16 (12).
New Help to live at Home activity was lower in December for new cases the total was 28 compared to 37 in November for ongoing cases it was 712 clients in December compared to 716 in November. Overall total clients (including SPOT purchase) decreased from 1,673 in November to 1,653 in December.





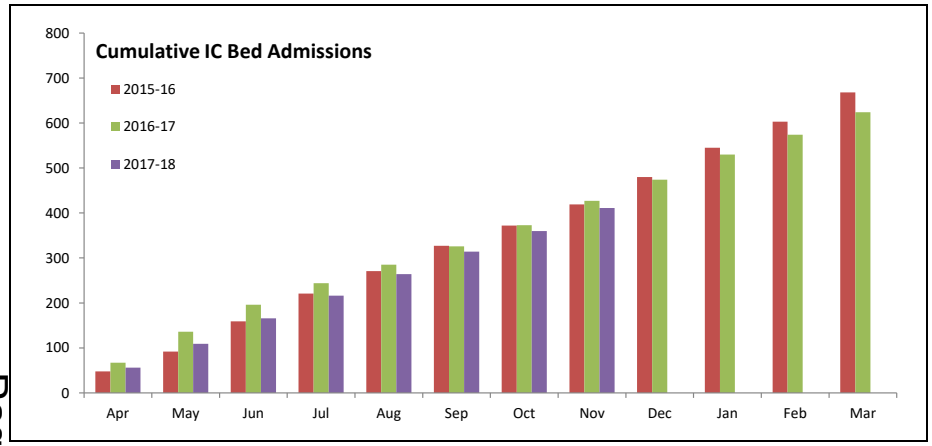


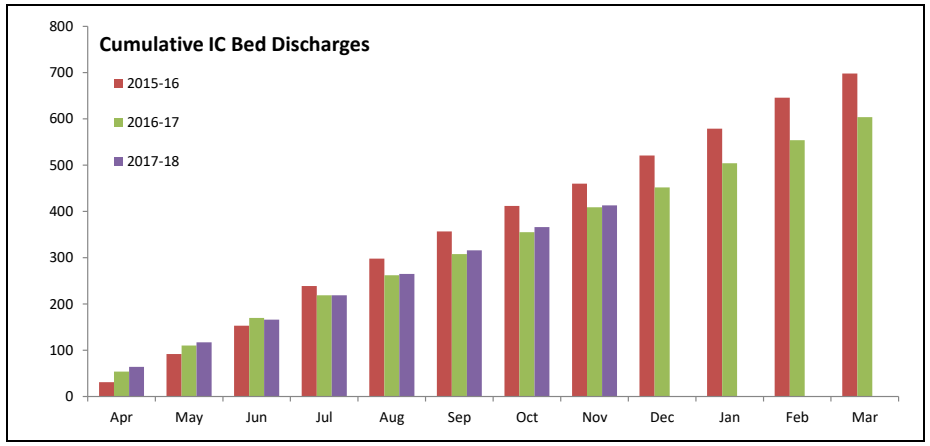


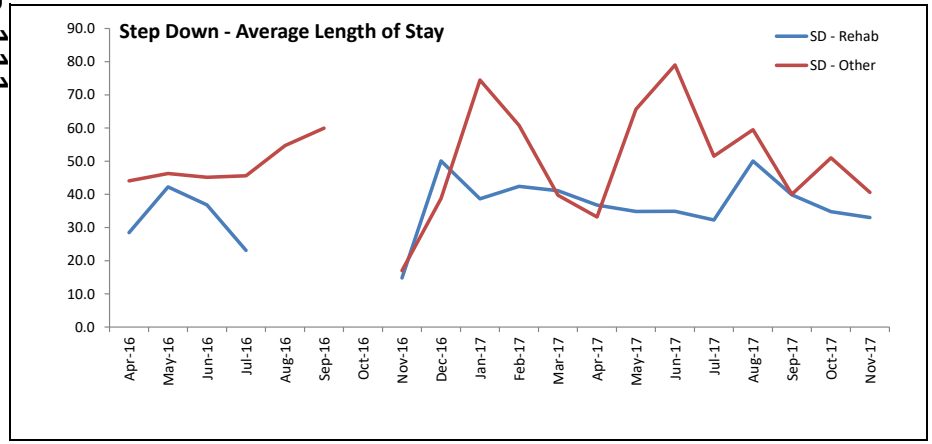
Source: Home Care Data, Wiltshire Council ASC Performance Team. UC@H Data, MEDVIVO

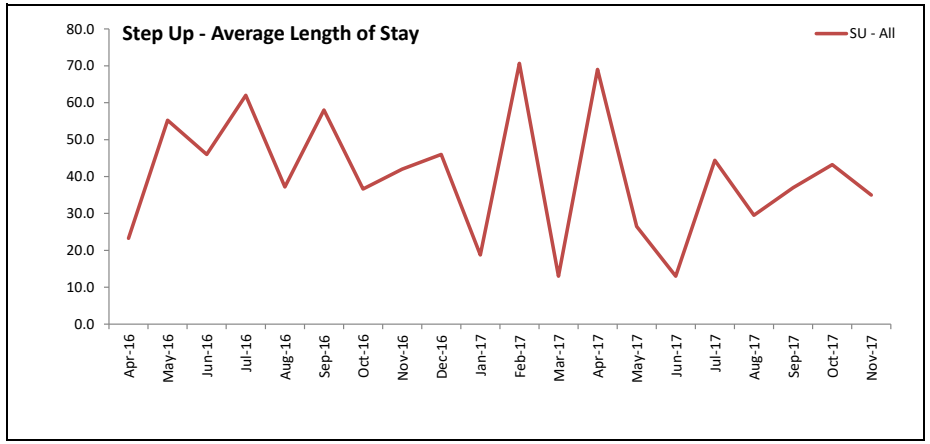
Home Care and Urgent Care at Home Activity

Length of stay for rehab patient has fallen to around 33 days, for non rehab patients the length of stay is higher at around 41 days. Admissions have decreased slightly as one of the homes is on the Council "red list" due to a poor CQC inspection, increased SPOT purchase is being used to try and maintain flow. Step up bed admissions remain very low at around 5 per month.









Source: ASC Performance Team

BCF Scheme Activity & Outcomes

This is the proof of concept of this new format for the dashboard, work is ongoing to develop this sheet to include the main KPI information for the schemes managed under the Better Care Fund. It is hoped over the coming months we will be able to update this to include more information on the schemes.

Scheme		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Acute Trust Liaison													
	GWH												
	RUH												
	SFT												
Access to Care (including Single Point of Access)													
Carers Emergency Card													
Telecare Call Centre													
Telecare Equipment													
Urgent Care and Response at Home		49	60	64	64	68	62	77					
Hospital at Home													
	SFT												
Integrated Discharge													
	GWH												
	RUH												
	SFT												
Enhanced Discharge Service for EOL Pathway													
IC Beds - SD													
	Admissions	54	47	52	47	42	49	43	47				
	LoS	37.5	40.8	35.0	36.7	46.4	38.8	37.3	34.4				
IC Beds - SU (South)													
	Admissions	2	6	5	3	6	1	3	4				
	LoS	40.3	26.5	13.0	44.4	29.5	37.0	43.2	35.0				
Therapy provision for Intermediate Care Beds													
Step Up Beds (WHC)													
High Intensity Care (WHC)													
	Admissions	17	16	21	24	25	23	23	13				
	LoS	28.6	30.7	22.2	43.7	23.3	34.7	29.6	48.5				
Care Home Liaison													
East Kennet SHARP													
Community Geriatricians													
Home First (Rehab Support Workers Initiative)		13	31	47	58	67	65	75	56				
Carers													
Integrated Community Equipment													
Community Services													
EOL													
The Leg Club Model													
iBCF Schemes													
	SFT Dom Care												
	20 addition SD Beds												
	3 MH CH Beds												
	Housing Adviser												

BCF Outcomes & Performance Baseline

Non elective admissions are up 3.6% on the same period last year.
Permanent admissions to care homes are 1.2% higher than last year but remain well under the target.
Delayed days are 6.4% lower than the same period last year, but remain well above trajectory.
IC Bed admissions are 3.7% lower than the same period last year but discharges are 1% higher.
Domicilliary Care activity for new clients is 14.3% higher than the same period last year and ongoing support is 1.9% higher. Urgent Care at home activity has increase 47% on the same period last year.

Measue or Scheme		Apr-17	Current month	% Change	206-17 YTD	2017-18 YTD	% Change
National Metrics							
	Specific Acute Non Elective Admissions	3,373	4,126	22.3%	25,509	26,434	3.6%
	Permanent Admissions to Care Homes	300	433	44.3%	321	325	1.2%
	At Home 91 days post discharge with reablement						
	Delayed transfers of Care	2,169	2,134	-1.6%	17,318	16,206	-6.4%
Scheme Activity							
	IC Bed Admissions	56	51	-8.9%	427	411	-3.7%
	IC Bed Discharges	64	47	-26.6%	409	413	1.0%
	Help to Live at Home and Dom Care - New	104	84	-19.2%	859	982	14.3%
	Help to Live at Home and Dom Care - Ongoing	1,622	1,653	1.9%			
	Urgent Care at Home Referrals	49	77	57.1%	302	444	47.0%
	WHC - High Intensity Care	17	19	11.8%			
	WHC - Home First	13	56	330.8%			

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Ref.	Risk Description	Cause / Impact	Risk Owner	Controls fully in place to manage the risk	Impact	Likelihood	Risk score	Level of risk	Progress on actions	Date for review
	Examples: *Ability to …* *Management of …* *Failure to …* *Lack of …* *Inappropriate …* *Opportunity to …*	*What is the cause of the risk?* *What will the impact be?*	*Who is responsible for the risk?*	*What controls are fully in place now?*	*See impact scoring matrix*	*See likelihood scoring matrix*			*Comment on what progress has been made and any problems or delays*	*Date for review and update*
BCF-R001	Failure to deliver BCP objectives within budget	Caused by poor design of chosen schemes and resulting in a failure to manage demand.	DASS / CAO	The models (eg reablement and prevention) being adopted have been implemented in other local authorities and have proven to prevent demand and realise cost avoidance/savings. Ensuring they are delivered to appropriate specifications and requirements will enhance the ability to achieve the intended outcomes. Lessons learnt from historically in Wiltshire and from other local authorities should be adopted where possible to mitigate the risk. Robust ongoing governance and evaluation and monitoring.	4	1	4	Low	implementation of the transformaitional change programme is on target	15.11.2017
BCF-R002	Lack of financial resource	Insufficient / loss of future iBCF funding to fully deliver tranformational change	DASS / CAO	Rigourous application of benefits realisation and prioritisation of resources to key areas of activity	4	1	4	Low	this may be revised subject to non delivery of DTOC trajectory	15.11`2017
BCF-R003	Failure to manage budget and subsequently failing to deliver the finanicial benefits	Reablement Programme runs the risk for overspend due to the timing for transformation to embed	DASS / CAO	Finance and governance group oversee expenditure and generate actions/recommendations for financial control. These recommendations and budget monitoring taken to the JCB/HWB with risks related to overspend noted and actions taken. A s75 is in place between partners to manage the impact of unresolvable financial pressures.	4	2	8	Medium	2017/18 overspend reported to the JCB. Release of funding from iBCF to confirmed in October 2017. However going forward S75 will under pin the response	15.11.2017
BCF-R004	Failure to develop an integrated model	Lack of integration in strategies, priorities, systems, processes and procedures will result in a disjointed, ineffective and inefficient service which has the potential to impact on the services received by our customers and increased costs.	DASS / CAO	Develop joint strategies, priorities, systems, processes and procedure, overseen by the H&WB Board, JCB, and partnership group overseeing the development of an Accountable Care Alliance in Wiltshire.	4	1	4	Low	no further comment at this time	15.11.2017
BCF-R005	Lack of resources in the market	Lack of market capacity to meet demand resulting in service users not being able to access services in a timely manner which in turn could result in increased needs and levels of support across the system	DASS / CAO	Early market engagement to identify the market capacity and map the gaps has taken place. Ongoing work with providers is required to support recruitment and retention of staff in the care market within Wiltshire to meet demand. Creation of a Reablement service aligned to the Home First service to better manage demand.	4	2	8	Medium	Market engagement commenced and continues. Budget is being developed as Business Cases are signed off. Workforce development plan and supporting business case under development.	15.11.2017
BCF-R006	Financial risk associated with a market failure, including CQC quality assessments identifying need for improvements	Alternative care arrangements would result in a financial pressure within the BCF	DASS / CAO	Whole system approach to contingency planning, market map and fully understand the economic and financial stablity of providers and risk assess their viability. The adoption of a fair pricing mechanism in the market	4	3	12	High	no further comment at this time	15.11.2017
BCF-R007	Instability across the system due to leadership changes	Causing a delay in delivery of 3 months or longer or the complete failure to delivery the programme	DASS / CAO	The programme receives full support from the organisations leadership teams, the cabinet member for Adult Social Care, the H&WB Board and the JCB. Current vacant posts (DASS and CAO) are held by interim postholders. A new joint leadership structure has been agreed and a plan is in place to recruit a joint DASS/CAO.	4	2	8	Medium	Progressing	15.11.2017
BCF-R008	Lack of culture change across the system	Resulting in a lack of delivery of the new model. Increased costs to provide the new reablement and front door services will not realise cost avoidance or cost savings targets. Potential model failure and resulting service failure.	DASS / CAO	Market engagement and commissioning specification to support the delivery of the new model. Continued work with staff at all levels, including leadership, across partners, providers and the voluntary sector to influence a change in culture long term. Performance management framework for providers and employees to ensure that the culture is adopted and implemented. Robust communications plans for the public.	4	2	8	Medium	No further comment at this time	15.11.2017

Ref.	Risk Description	Cause / Impact	Risk Owner	Controls fully in place to manage the risk	Impact	Likelihood	Risk score	Level of risk	Progress on actions	Date for review
BCF-R009	Lack of skilled workforce	Lack of skilled staff to support the outputs for the programme including partners, providers, and the voluntary sector to meet the demand resulting in reduced or failed outcomes.	DASS / CAO	Revision of a joint workforce development plan to support delivery of the programme and its outcomes	4	2	8	Medium	Progressing	15.11.2017
BCF-R010	Failure to deal with emerging pressures	Resulting in lack of resources to deliver the outputs of the programme and outcomes. Reputational risk within the provider market and reduced customer satisfaction and confidence. Lack of planning and contingency availability.	DASS / CAO	Effective business continuity and contingency planning to deal with emerging pressures. Effective risk management within business areas. Effective resource management plans that provide flexibility to react to emerging pressures.	3	2	6	Medium	Progressing	15.11.2017
BCF-R011	DTOC - Failure to deliver the Wiltshire DTOC Plan	A Wiltshire wide plan (pooled and grant funding) not clearly demonstrated	DASS / CAO	Wiltshire DTOC plan developed and taken through the Wiltshire A&E Board and aligned to the STP. Regular monitoring of actuals againt trajectory and delivery of the workstreams supporting flow. Deliver fully operational Reablement model	4	4	8	Medium	Plan and recovery plan are in place	15.11.2017
BCF-R012	Failure to deliver the DTOC trajectory	Non delivery of November 2017 1,325 lost bed days	DASS / CAO	Monitor delivery of lost bed days against the trajectory and BCF projects ability to delivery KPIs. Evaluation of projects/work streams to inform decision on pace if off trajectory and new actions to accelerate delivery. • Additional domiciliary care capacity - reablement pilot • 9 additional ICT beds • An immediate diagnostic, identifying the need for system improvement. • iESE to undertake further diagnostic across all 3 acutes but with particular focus on SFT • Developing a Home from Hospital service with Age UK	4	4	16	High	Plan in the development stage with task and finish groups. Actions to accelerate delivery are progressing however Sept reported an improvment but at this time the risk of non delivery is high. Joint Commisisoning Board has ratified a DTOC sub group reporting into the Board and Health and Wellbeing Board	15.11.2017

NHS England
Skipton House
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London
SE1 6LH

20 December 2017

To: *(by email)*

Baroness Scott of Bybrook	Leader of Wiltshire Council and Chair, Wiltshire Health and Wellbeing Board
Linda Prosser	Interim Accountable Officer, Wiltsire CCG
Mark Harris	Chief Operating Officer, Wiltshire CCG
Steve Perkins	Chief Financial Officer, Wiltshire CCG

Dear Colleagues

BETTER CARE FUND 2017-19

Thank you for submitting your Better Care Fund (BCF) plan for regional assurance. We know that the BCF has again presented challenges in preparing plans at pace and we are grateful for your commitment in providing your agreed plan. The Better Care Fund is the only mandatory policy to facilitate integration of health and social care and the continuation of the BCF itself. It brings together health and social care funding, with a major injection of social care money announced at Spring Budget 2017. For the first time, this policy framework for the Fund covers two financial years to align with NHS planning timetables and to give areas the opportunity to plan more strategically.

Your plan has been assessed in accordance with the process set out in the *Better Care Fund 2017-19: Guide to Assurance of Plans.*

In determining and exercising further powers in connection with your application, NHS England has had regard to the extent to which there is a need for the provision of health services; health-related services (within the meaning given in section 14Z1 of the NHS Act 2006); and social care services.

I am delighted to let you know that, following the regional assurance process, your plan has been classified as '**Approved**'. In summary, the assurance team recognises your plan has been agreed by all parties (local authority, Clinical Commissioning Group (CCG), and your Health and Wellbeing Board), and the plan submitted meets all requirements and the focus should now be on delivery.

Your BCF funding can therefore now be released subject to the funding being used in accordance with your final approved plan, and the funding being

transferred into pooled funds under a section 75 agreement.

These conditions have been imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These sections allow NHS England to make payment of the BCF funding subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG(s) in your Health and Wellbeing Board area as to the use of the funding.

Amounts payable to the CCG in respect of the BCF are subject to the following conditions under section 223GA of the NHS Act 2006:

1. That the CCG will meet the performance objectives specified in its BCF plan; and
2. That the CCG will meet any additional performance objectives specified by NHS England from time to time.

If the CCG fails to meet those objectives, NHS England may withhold the funds (in so far as they have not already been paid to the CCG) or recover payments already made; and may direct the CCG as to the use of the amounts payable in respect of the BCF.

In addition to the BCF funding, the Spring Budget 2017 increased funding via the Improved Better Care Fund (IBCF) for adult social care in 2017-19. This has been pooled into the local BCF. The new IBCF grant (and as previously the Disabled Facilities Grant) will be paid directly to local authorities via a Section 31 grant from the Department for Communities and Local Government. The Government has attached a set of conditions to the Section 31 grant, to ensure it is included in the BCF at local level and will be spent on adult social care.

You should now progress with your plans for implementation. Ongoing support and oversight with your BCF plan will be led by your local better care manager.

Once again, thank you for your work and best wishes with implementation and delivery.

Yours faithfully,

Simon Weldon
Director of NHS Operations and Delivery and SRO for the Better Care Fund
NHS England

Copy (by email) to:

Carolyn Godfrey	Director of Adult Social Services, Wiltshire County Council
Sue Shelbourn Barrow	Better Care Fund Lead, Wiltshire CCG
Jo Farrar	Director General, Department for Communities & Local Government
Jonathan Marron	Director General, Department of Health
Sarah Pickup	Deputy Chief Executive, Local Government Association
NHS England South	
Jennifer Howells	Regional Director
Rachel Pearce	Director of Commissioning Operations
Jo Cogswell	Regional Lead
Kevin Johnson	Better Care Manager
Better Care Support Team	
Keziah Halliday	Programme Director
Rosie Seymour	Deputy Director

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Dated **2018**

WILTSHIRE COUNCIL

and

NHS WILTSHIRE CLINICAL COMMISSIONING GROUP

SECTION 75 AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES FOR THE BETTER CARE FUND PLAN

Version 4.0 (17.01.18)

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Contents

THIS DEED OF AGREEMENT is made on day of 2018

PARTIES

(1) **WILTSHIRE COUNCIL** of County Hall, Bythesea Road, Trowbridge, Wiltshire BA14 8JN (the **"Council"** and **"Host Party"**); and

(2) **NHS WILTSHIRE CLINICAL COMMISSIONING GROUP** of Southgate House, Pans Lane, Devizes, Wiltshire SN10 5EQ (the **"WCCG**"),

(each a "**Party**" and together the "**Parties**").

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the county of Wiltshire (excluding the administrative area of Swindon Borough Council).

(B) The WCCG has the responsibility for commissioning health services pursuant to the 2006 Act in the county of Wiltshire.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the WCCG and the Council establish a pooled fund for this purpose.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Parties have agreed to collaborate and to establish a framework through which the Parties can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also a means through which the Parties will pool funds and align budgets as agreed between the Parties.

(F) This Recital summarises the key objectives of the Better Care Fund Plan and joint commissioning in Wiltshire, the functioning of which this Agreement seeks to improve. The aims and benefits of the Parties in entering in to this Agreement are to:

(a) improve the quality and efficiency of the Services;

(b) meet the National Conditions and Local Objectives;

(c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services;

(d) to enable more robust and flexible joint commissioning structures between the Council and WCCG that are better placed to respond to the personalisation agenda or other policy shifts;

(e) to improve financial decision making and essential operational efficiencies across the whole system of health and social care;

(f) to develop services closer to home responding to expert opinion, good practice and Service Users and carers needs, and delivering the strategic objectives of each party;

(g) to facilitate easier integration of preventative services with intermediate and high dependency care packages across the health and social care spectrum to provide a more seamless service to Service Users and their carers;

(h) to provide a clearly integrated point of contact for other health and social care professionals, in order that they can influence strategic commissioning decisions;

(i) to promote greater local decision making across localities about adult health and social care services that secures more innovative ways of providing support and services;

(j) to promote ways of combating social exclusion, tackle inequalities and improve the health and social wellbeing of local communities; and

(k) to ensure service users and their carers receive coherent integrated packages of support so avoiding the anxiety of having to navigate a complicated bureaucracy and these services are of a high quality, safe, and supportive.

(G) The intended outcomes of these arrangements are:

(a) Promote rights, independence, choice and control for both people and their carers including reducing the impact of stigma;

(b) Better health and well-being achieved through preventative, practical and self-help services and support to prevent decline;

(c) Improved ability to cope with critical points and transitions through the availability of intermediate care and community support, avoidance of inappropriate admissions to hospital or residential care and timely discharge from hospital;

(d) Extended timely use of community based housing equipment and support, enabling more Service Users to be supported at home or in extra care housing and preventing the need for unnecessary admission to hospital or long term care;

(e) More effective commissioning for home based care through better information and knowledge across the whole system; and

(f) Reduce pressure on our Acute Hospitals by providing care in alternative localities and enhancing the independence of the Service User.

(H) The aims, objectives and intended outcomes set out in Recitals (F) and (G) will be achieved by:

(a) Using the statutory joint commissioning structures permitted by the Regulations and other relevant Law relating to integrated working between health and social care;

(b) Using the Agreement as a basis for service planning, strategic commissioning in the context of personal budgets;

(c) Using evidence on the outcome for Service Users as the basis for improving standards and targeting resources; and

(d) Working in an integrated way within the overall strategic direction of the Councils and WCCG's Joint Health and Wellbeing Strategy and the relevant joint commissioning strategies agreed by the parties.

(I) The Parties have jointly carried out consultations on the proposals for this Agreement with all those persons likely to be affected by the arrangements.

(J) The Parties are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

(K) The Parties acknowledge that whilst this Agreement is based on a template kindly provided by Bevan Brittan LLP and published on the NHS England website, which referred to the law and guidance in

force in August 2014, the Parties have amended this template document in accordance with their requirements.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Party means, in the context of Clause 24, the Party whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event.

Agreement means this agreement including its Schedules and Appendices.

Annual Review shall have the meaning given to the term in Clause 19.2.

Approved Expenditure means any additional expenditure approved by the Parties (either in the execution of this Agreement or in accordance with Clause 9 or Clause 19, as appropriate) in relation to:

(a) a Service above the relevant Contract Price; or

(b) any additional corporate, administrative or other costs to be specified in a Scheme Specification or Schedule 8 which do not fall within a Service.

Authorised Officers means an officer of each Party appointed to be that Party's representative for the purpose of this Agreement as set out in Clause 18.8.

Better Care Fund or BCF means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Parties.

Better Care Fund Plan or BCP means the plan attached at Schedule 6 setting out the Parties' plan for the use of the Better Care Fund.

Better Care Plan Business Manager means the jointly appointed business manager for the Better Care Fund Plan.

Better Care Plan Finance and Governance Group means the group responsible for delivery of the objectives set out in the Better Care Fund Plan as set out in Schedule 2.

Block Contract means a contract between a Party and any third party for the provision of any part of the Services:

(a) in a care home (as defined in the Care Standards Act 2000);

(b) in accommodation not registered under the Care Standards Act 2000;

(c) in the Service User's home; or

(d) which are within a defined envelope e.g. Community Services,

where (in each case) the identity of some or all of the Service Users benefiting from that contract has not yet been determined or may change at the discretion of the Council during the period of such contract.

Care Contract means a contract between a Party and any third party for the delivery of the Services (or any part of them) to any Service User and/or for the funding of a direct payment to a Service User or their representative for the delivery of the Services (or any part of them) to the Service User.

Carers Pooled Budget means funding to support carers pursuant to the Care Act 2014.

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, which relates to the powers, duties and responsibilities of the Parties and which must be complied with, implemented or otherwise observed by the Parties.

Commencement Date means 00:01 hrs on 1 April 2017.

Confidential Information means information, data and/or material of any nature which any Party may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Party or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price means any sum payable to a Provider under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability.

Data Protection Legislation means the 1998 Act and, from 25 May 2018, the EU General Data Protection Regulation (EU Regulation 2016/679), the Data Protection Bill 2017 (when enacted) and any other applicable data protection laws in each case, to the extent in force, and as such are updated, amended or replaced from time to time including where applicable the guidance and codes of practice issued by the Information Commissioner.

Default Liability means any sum which is agreed or determined by Law or in accordance with the terms of a Service Contract to be payable by any Party or Parties to the Provider as a consequence of:

(a) breach by either or both of the Parties of an obligation(s) (in whole or in part) under the relevant Service Contract; or

(b) any act or omission of a third party for which either or both of the Parties are, under the terms of the relevant Service Contract, liable to the Provider.

DFG means the Disabled Facilities Grant being funding for capital grants to help meet the cost of adapting property for the needs of a disabled person. DFG is paid directly to the Council by DCLG under Section 31 of the Local Government Act 2003 and is subject to grant conditions set out in grant determinations made under that Section.

Financial Contributions means the minimum financial contributions to be made by each Party to the Pooled Fund for each Individual Scheme in any Financial Year as set out in Schedule 8 as varied from time to time in accordance with the terms of this Agreement.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

First Party shall have the meaning given to the term in Clause 26.3.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and

(h) any other event,

in each case where such event is beyond the reasonable control of the Party claiming relief.

Functions means the NHS Functions and the Social Care Related Functions.

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Host Party means the Council, being the Party who undertakes day to day management of the Pooled Fund and who takes primary, although not exclusive, responsibility for preparing financial, performance and other reports as required.

IBCF means the Improved Better Care Fund announced in the Spring Budget 2017 being additional funding for social care. IBCF is paid directly to the Council by DCLG under Section 31 of the Local Government Act 2003 and is subject to grant conditions set out in grant determinations made under that Section.

ICES Pooled Budget means the funding to provide integrated community equipment to service users to enable them to remain living at home.

Indemnified Party has the meaning given to the term in Clause 15.2.

Indemnifying Party has the meaning given to the term in Clause 15.2

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of initiatives being developed and funded under the Better Care Fund Plan which is agreed by the Parties to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification and "**Scheme**" shall be interpreted accordingly.

Integrated Commissioning means arrangements by which both Parties commission Services in relation to an individual Scheme on behalf of each other in exercise of both the NHS Functions and Council Functions through integrated structures.

Joint (Aligned) Commissioning means a mechanism by which the Parties jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75.

Joint Business Arrangements means the overarching agreement for joint business arrangements under the NHS Act 2006 dated 21 March 2014 and made between (1) the Council and (2) WCCG.

Joint Commissioning Board means the partnership board responsible for review of performance and oversight of this Agreement as set out in Schedule 2.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Party(ies) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Party(ies) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Party commissions Services in relation to an Individual Scheme on behalf of the other Party in exercise of both the NHS Functions and the Council Functions.

Lead Commissioner means the Party having the function of commissioning a Service or part of a Service on behalf of the Parties.

Local Objectives means the objectives for the Better Care Fund for Wiltshire as set out in the Better Care Fund Plan.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law (including any claims and proceedings (to include any settlements or ex gratia payments made with the consent of the Parties and reasonable legal and expert costs and expenses) made or brought (whether successfully or otherwise) by or on behalf of any Service User (or his dependants) against an Indemnified Party under this Agreement or any of its employees or agents for personal injury (including death)) but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions as set out in the NHS England Planning Guidance as amended or replaced from time to time.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the WCCG as are relevant to the commissioning of the Services and which may be further described in each Scheme Specification.

Non-Recurrent Payments means funding (if any) provided by a Party to the Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 9.4.

Overspend means any expenditure from the Pooled Fund in a Financial Year in relation to an Individual Scheme which exceeds the total Financial Contributions for that Scheme for that Financial Year which shall be managed in accordance with Clause 11 and Schedule 2Part 11.

Party means each of the WCCG and the Council, and references to "**Parties**" shall be construed accordingly.

Permitted Expenditure has the meaning given in Clause 7.3.

Personal Data means Personal Data as defined by the Data Protection Legislation.

Pooled Fund means the fund of monies maintained by the Host Party for the purpose of securing the Services or part of them pursuant to this Agreement, made up of the Financial Contributions from the Parties in accordance with the Regulations.

Pooled Fund Manager means such officer of the Host Party which includes a Section 113 Officer for the Pooled Fund as is nominated by the Host Party from time to time to manage the Pooled Fund in accordance with Clause 7.6.3.

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.

Public Health England means the SOSH trading as Public Health England. Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Relevant Party shall have the meaning given to the term in Clause 21.2.

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Parties to be commissioned under this Agreement.

Sensitive Personal Data means Sensitive Personal Data as defined in the Data Protection Legislation.

Services means such health and social care services as agreed from time to time by the Parties as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

Service Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Parties in accordance with the relevant Individual Scheme and for the avoidance of doubt the term Service Contract shall include a Block Contract or Care Contract.

Service Users means those individuals for whom the Parties have a responsibility to commission the Services.

Specified Legislation shall have the meaning given to the term in Clause 40.2.

Social Care Related Functions means those of the social care related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

SOSH means the Secretary of State for Health.

Third Party Costs means all such third party costs (including legal and other professional fees) in respect of each Individual Scheme as a Party reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Joint Commissioning Board.

Underspend means any expenditure from the Pooled Fund in a Financial Year for any Scheme which is less than the aggregate value of the Financial Contributions for that Scheme for that Financial Year.

WCCG Statutory Duties means the Duties of the WCCG pursuant to Sections 14P to 14Z2 of the 2006 Act.

Working Day means except in the context of 7-day services, any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Parties shall include their respective statutory successors, permitted assignees or transferees, and employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Parties shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date and shall continue until 31 March 2019 unless extended in accordance with Clause 30 or terminated early in accordance with Clause 21 and shall be subject to an annual review by the Joint Commissioning Board.

2.2 Unless otherwise stated in the relevant Scheme Specification as varied from time to time and subject to the provisions of clause 9.2, the duration of the arrangements for each Individual Scheme shall be

concurrent with the term of the Agreement as set out in Clause 2.1 unless terminated early in accordance with Clause 21.

2.3 This Agreement supersedes previous Agreements relating to the Better Care Fund in Wiltshire, which the Parties acknowledge are referred to as the "BCP Section 75 Agreements" without prejudice to the rights and liabilities of the Parties under those previous Agreements.

2.4 The Parties agree that, if during the term of this Agreement, the Parties become a party to arrangements for an accountable care system in Wiltshire, they shall work together in good faith to agree the status of this Agreement as part of those arrangements which may include (without limitation) a variation to this Agreement pursuant to Clause 30 and/or termination pursuant to Clause 21.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the rights and powers, duties, obligations and liabilities of the Parties to each other or to any third parties in the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty of the Council to set, administer and recover charges for the provision of any services (including the Services) in the exercise of any Health Related Function.

3.1.3 the Council's power to determine and apply eligibility criteria for the purposes of assessment under the National Health Service and Community Care Act 1990.

3.2 The Parties agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme Specification.

3.4 The Parties agree that, in accordance with Clause 36, on and from the Commencement Date this Agreement supersedes all previous arrangements entered into between the Parties under section 75 of the 2006 Act in relation to the Better Care Fund in Wiltshire, and in particular it supersedes such arrangements set out in the Joint Business Arrangements between the Parties. All acts done on and from the Commencement Date in relation to the Better Care Fund shall be deemed to have been done pursuant to the provisions of this Agreement.

3.5 For the avoidance of doubt, subject to Clause 3.4, the Joint Business Arrangements between the Parties shall continue in full force and effect.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Parties will work together to establish one or more of the following:

4.1.1 Lead Commissioning Arrangements;

4.1.2 Integrated Commissioning;

4.1.3 Joint (Aligned) Commissioning;

4.1.4 the establishment of the Pooled Fund,

in relation to Individual Schemes (the "**Flexibilities**")

4.2 The Council delegates to the WCCG and the WCCG agrees to exercise, on the Council's behalf, the Social Care Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions in particular in accordance with the requirements of the Scheme Specifications.

4.3 The WCCG delegates to the Council and the Council agrees to exercise on the WCCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Social Care Related Functions in particular in accordance with the requirements of the Scheme Specifications.

4.4 Where the powers of a Party to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Parties shall agree arrangements designed to achieve the greatest degree of delegation to the other Party necessary for the purposes of this Agreement which is consistent with the statutory constraints.

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Parties can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such functions as shall be agreed from time to time by the Parties.

5.3 The Parties shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.4 Where the Parties add a new Individual Scheme to this Agreement, a Scheme Specification for each Individual Scheme shall be in the form set out in Part 1 to Schedule 1 (as amended subject to agreement between the Parties) and shall be completed and agreed between the Parties. The initial Individual Schemes are listed in Part 2 in Schedule 1 and the Parties agree that during the term of this Agreement, they shall work towards the completion of the template Specifications set out in Part 1 (as amended subject to agreement between the Parties) for each Individual Scheme which is set out in Part 2.

5.5 The introduction of any Individual Scheme will be:

5.5.1 subject to business case approval by the Joint Commissioning Board and authorisation in accordance with the constitutional requirements of each Party;

5.5.2 for insertion as part of this Agreement in accordance with Clause 30 (Variation); and

5.5.3 reported to the Health and Wellbeing Board, which has strategic oversight of this Agreement.

5.6 All Individual Schemes will be subject to robust and regular review to assess the efficiency of these arrangements in accordance with Clause 19 and Schedule 2.

6 COMMISSIONING ARRANGEMENTS

Integrated Commissioning

6.1 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme, both Parties shall work in cooperation and shall endeavour to ensure that the NHS Functions and Social Care Related Functions are commissioned with all due skill, care and attention.

6.2 Both Parties shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.

6.3 Both Parties shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Party's Financial Contribution in respect of that particular Individual Scheme in each Financial Year.

6.4 The Parties shall comply with the arrangements in respect of any Joint (Aligned) Commissioning as set out in the relevant Scheme Specification.

6.5 Each Party shall keep the other Party and the Better Care Plan Finance and Governance Group and the Joint Commissioning Board regularly informed of the effectiveness of the arrangements including any Overspend or Underspend in the Pooled Fund in accordance with the provisions of Clause 10 (Risk Share Arrangements, Overspends and Underspends), Schedule 2 (Governance) and Schedule 2Part 11 (Risk Share, Overspends and Underspends).

6.6 The Joint Commissioning Board will report back to the Health and Wellbeing Board as required by its terms of reference and the Better Care Plan Finance and Governance Group will report to the Joint Commissioning Board in accordance with its terms of reference as set out in Schedule 2.

6.7 Each Party is committed to defining a joint delivery plan for each Individual Scheme as set out in the relevant Scheme Specification.

Appointment of a Lead Commissioner

6.8 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall:

6.8.1 exercise the NHS Functions in conjunction with the Social Care Related Functions as identified in the relevant Scheme Specification;

6.8.2 endeavour to ensure that the NHS Functions and the Social Care Related Functions are funded within the parameters of the Financial Contributions of each Party in relation to each particular Individual Scheme in each Financial Year.

6.8.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

6.8.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Party;

6.8.5 comply with the Law as it applies to both Parties in relation to the Services being commissioned and in particular, but without limitation, ensure that all Service Contracts with care providers require that such element of the Services in any care home (as defined in the Care Standards Act 2000) complies with any national minimum standards under that Act;

6.8.6 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

6.8.7 undertake performance management and contract monitoring of all Service Contracts;

6.8.8 make payment of all sums due to a Provider pursuant to the terms of any Service Contract.

6.8.9 keep the other Party and the Joint Commissioning Board regularly informed of the effectiveness of the arrangements and any Overspend or Underspend in the Pooled Fund.

7 ESTABLISHMENT OF THE POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Parties have agreed to establish and maintain the Pooled Fund for revenue expenditure as set out in the Scheme Specifications.

7.2 The Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.3 It is agreed that the monies held in the Pooled Fund may only be expended on the following:

7.3.1 the Contract Price;

7.3.2 Third Party Costs;

7.3.3 Approved Expenditure;

("**Permitted Expenditure**")

7.4 The Parties may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Party subject to approval by the Joint Commissioning Board.

7.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by both Parties.

7.6 Pursuant to this Agreement, the Parties have agreed to appoint the Council as the Host Party for the Pooled Fund. The Host Party shall be responsible for:

7.6.1 holding all monies contributed to the Pooled Fund on behalf of itself and the other Party;

7.6.2 providing the financial administrative systems for the Pooled Fund;

7.6.3 appointing the Pooled Fund Manager. As at the Commencement Date, this has been agreed as being the Director of Finance and Procurement (Michael Hudson);

7.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

8 POOLED FUND MANAGEMENT

8.1 The Pooled Fund Manager shall have the following duties and responsibilities:

8.1.1 the day to day operation and management of the Pooled Fund;

8.1.2 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specifications;

8.1.3 maintaining an overview of all joint financial issues affecting the Parties in relation to the Services and the Pooled Fund;

8.1.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

8.1.5 reporting to the Better Care Plan Finance and Governance Group and the Joint Commissioning Board in accordance with this Agreement including (without limitation) the requirements of the relevant Scheme Specification and Schedule 2 (Governance);

8.1.6 ensuring action is taken to manage any projected Underspends or Overspends relating to the Pooled Fund in accordance with this Agreement;

8.1.7 preparing and submitting to the Better Care Plan Finance and Governance Group and the Joint Commissioning Board Quarterly reports (or more frequent reports if required by the Joint Commissioning Board) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may reasonably be required by the Parties and the Health and Wellbeing Board to monitor the effectiveness of the Pooled Fund and to enable the Parties to complete their own financial accounts and returns. The Parties agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

8.1.8 preparing and submitting reports to the Joint Commissioning Board and Health and Wellbeing Board as required by it and any other Council/WCCG meeting that is deemed appropriate by the Joint Commissioning Board.

8.2 In carrying out their responsibilities as provided under Clause 8.1 the Pooled Fund Manager shall have regard to the recommendations of the Joint Commissioning Board and be accountable to the Parties.

9 FINANCIAL CONTRIBUTIONS

9.1 Subject to clause 9.2, the minimum Financial Contribution of the WCCG and the Council to the Pooled Fund for the specified Financial Year of operation of each Individual Scheme shall be as set out in the relevant Scheme Specification and Schedule 8, as varied in accordance with Clauses 19.5 to 19.8 and Clause 30.2.

9.2 The Parties acknowledge that as soon as reasonably practicable, this Agreement shall be varied to include indicative Financial Contributions for the Financial Year 2018/2019 in Schedule 8 and these will be confirmed in accordance with the procedure for agreeing the Financial Contributions for future years set out in Clauses 9.4 to 19.8 and will be subject to any variation agreed in accordance with Clause 30.2.

9.3 Notwithstanding any other provisions of this Clause 9, no provision of this Agreement shall preclude the Parties by mutual agreement making Non-Recurrent Payments to the Pooled Fund from time to time but no such additional contributions shall be taken into account in the calculation of the Party's respective contributions for the purposes of Schedule 2Part 11. Any such Non-Recurrent Payments agreed by the Parties shall be explicitly recorded in the relevant Better Care Plan Finance and Governance Group minutes and Joint Commissioning Board minutes and recorded in the budget statement as a separate item.

9.4 The Parties may agree any Approved Expenditure (in addition to Approved Expenditure agreed in a Scheme Specification or Schedule 8) through the Joint Commissioning Board including where relevant through a recommendation approved by the Better Care Plan Finance and Governance Group. For the avoidance of doubt, a business case including any corporate spend for such Approved Expenditure shall be approved by the Parties at the Joint Commissioning Board.

10 NON FINANCIAL CONTRIBUTIONS

10.1 Each Scheme Specification shall set out non-financial contributions of each Party including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of Service Contracts and the Pooled Fund).The Scheme Specifications shall set out whether these contributions shall be provided at a charge to the other Party or to the Pooled Fund.

11 RISK SHARE ARRANGEMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

11.1 The Parties have agreed risk share arrangements as set out in Schedule 2Part 11, which provide for financial risks arising within the commissioning of services from the Pooled Fund.

11.2 The Host Party shall manage expenditure from the Pooled Fund within the Financial Contributions and shall ensure that expenditure is limited to Permitted Expenditure.

11.3 The Pooled Fund Manager shall notify the Joint Commissioning Board as soon as reasonably possible of an actual or projected Overspend or Underspend of the Pooled Fund, and the provisions of the relevant Scheme Specification and Schedule 2Part 11 shall apply. Such arrangements shall be subject to the Law and the constitutional documents, Standing Orders and Standing Financial Instructions (or equivalent) of each Party.

11.4 The Host Party shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from the Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Joint Commissioning Board in accordance with Clause 11.3.

11.5 The provisions of Clause 21 shall apply in respect of Overspends and Underspends upon termination of this Agreement or a Scheme Specification.

11.6 In the event that agreement cannot be reached in respect of any matters referred to in this Clause 11 and Schedule 2Part 11 or indeed in any other matters the Parties shall follow the dispute procedure as set out in Clause 23.

12 CAPITAL EXPENDITURE

12.1 Subject to Clause 12.2, the Pooled Fund shall not normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Parties. If a need for capital expenditure is identified this must be agreed by the Parties acting by the Joint Commissioning Board.

12.2 The Parties agree that capital expenditure may be included in the Pooled Fund where this is in accordance with Better Care Fund requirements and set out in the relevant Scheme Specification. For the avoidance of doubt, this will include capital expenditure using the DFG.

13 VAT AND INVOICING

13.1 The Parties shall agree the treatment of the Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise and wherever possible in line with the Council's policy on the management and dispersal of VAT.

13.2 The Scheme Leader (as identified in the relevant Scheme Specification) shall check and approve the validity of spend in line with the relevant Service Contract and the expectations of the Parties set out in the relevant Scheme Specification, and report to the Better Care Plan Finance and Governance Group and the Joint Commissioning Board as required.

14 AUDIT AND RIGHT OF ACCESS

14.1 Both Parties shall promote a culture of probity and sound financial discipline and control. The Host Party (the Council) shall arrange for the audit of the accounts of the Pooled Fund and shall require the appropriate person or body appointed to exercise the functions of the appropriate person or body appointed to exercise the functions of the Audit Commission under section 29(1)(d) of the Audit Commission Act 1998 by virtue of an order made under section 49(5) of the Local Audit and Accountability Act 2014 to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998. Both parties shall comply with each party's relevant financial reporting timescales and ensure a common approach to financial reporting is in place.

14.2 All internal and external auditors and all other persons authorised by the Parties will be given the right of access to any document, information or explanation they require from any employee or member of the Party in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

15 LIABILITIES AND INSURANCE AND INDEMNITY

15.1 The Parties shall agree and maintain appropriate insurance arrangements in respect of all potential liabilities arising from this Agreement. In the case of the WCCG, it may arrange alternative cover in

accordance with current NHS arrangements administered by the NHS Litigation Authority in lieu of commercial insurance. Each Party shall provide to the other upon request such evidence as that Party may reasonably require to confirm that the insurance arrangements are satisfactory and are in force at all times.

15.2 Each Party ("**Indemnifying Party**") shall indemnify the other Party ("**Indemnified Party**") and its employees and agents against all Losses incurred as a result of or in connection with this Agreement or a Service Contract to the extent that such Losses arise as a result of:

15.2.1 the proper exercise by the Indemnified Party of the Indemnifying Party's Functions in accordance with this Agreement; or

15.2.2 any negligent or wrongful act, or omission, breach of statutory duty, breach of this Agreement or breach of the relevant Service Contract of the Indemnified Party, its employees or agents, save to the extent that the Indemnifying Party was following the instructions or requests of the Indemnified Party, the Health and Wellbeing Board, the Better Care Fund Finance and Governance Group or the Joint Commissioning Board.

15.3 If any third party makes a claim or intimates an intention to make a claim against either Party, which may reasonably be considered as likely to give rise to liability under this Clause 15, that Party will:

15.3.1 as soon as reasonably practicable give written notice of that matter to the Indemnifying Party specifying in reasonable detail the nature of the relevant claim;

15.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Indemnifying Party (such consent not to be unreasonably conditioned, withheld or delayed); and

15.3.3 give the Indemnifying Party and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Party and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

15.4 For the purposes of the indemnity in Clause 15.2 the expression "agents" shall be deemed to include without limitation any nurse or health professional/social care worker or manager providing services to the Council or the WCCG under contract for services for the Better Care Fund and any person carrying out work for the Council or the WCCG under such a contract connected with such of the Council's or the WCCG's facilities.

15.5 The Parties acknowledge that the responsibility for specific indemnity cover lies with the Provider relevant to the Services they operate. However, commissioners need to assure themselves that such indemnity cover is in place.

15.6 Each Party shall at all times take all reasonable steps to minimise and mitigate any loss for which it is entitled to bring a claim against the other Party pursuant to this Agreement.

Conduct of Claims

15.7 In respect of the indemnities given in this Clause 15:

15.7.1 the Indemnified Party shall give written notice to the Indemnifying Party as soon as is practicable of the details of any claim or proceedings brought or threatened against it in respect of which a claim will or may be made under the relevant indemnity;

15.7.2 the Indemnifying Party shall at its own expense have the exclusive right to defend conduct and/or settle all claims and proceedings to the extent that such claims or proceedings may be covered by the relevant indemnity provided that where there is an impact upon the Indemnified Party, the Indemnifying Party shall consult with the Indemnified Party about

the conduct and/or settlement of such claims and proceedings and shall at all times keep the Indemnified Party informed of all material matters; and

15.7.3 the Indemnifying and Indemnified Parties shall each give to the other all such cooperation as may reasonably be required in connection with any threatened or actual claim or proceedings which are or may be covered by a relevant indemnity.

16 STANDARDS OF CONDUCT AND SERVICE

16.1 The Parties will at all times comply with Law and ensure good corporate governance in respect of each Party (including the Parties' respective constitutional documents, Standing Orders and Standing Financial Instructions).

16.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the WCCG will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

16.3 The WCCG is subject to the WCCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Fund are therefore subject to ensuring compliance with the WCCG Statutory Duties and clinical governance obligations.

16.4 The Parties are committed to an approach to equality and equal opportunities as represented in their respective policies. The Parties will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

16.5 The Services shall be purchased for or provided to the Service Users in accordance with the objectives set out in the Recitals to this Agreement and each Scheme Specification.

16.6 Subject to the requirements of its constitution the Host Party (the Council) and the Lead Commissioner for each Service shall implement the decisions of the Joint Commissioning Board in respect of the Pooled Fund. For the avoidance of doubt this Agreement does not affect the statutory responsibilities of either Party.

16.7 The Joint Commissioning Board shall monitor the exercise by the Parties under this Agreement of the Functions in accordance with Schedule 2.

16.8 The annual report(s) provided by the Council under Schedule 2 will set out the spending of the Pooled Fund in relation to the NHS Functions and the Council shall provide such information to the WCCG if the WCCG requests this from time to time.

16.9 The annual report(s) provided by the WCCG under Schedule 2 will set out the spending of the Pooled Fund in relation to the Social Care Related Functions and the WCCG shall provide such information to the Council if the Council requests this from time to time.

17 CONFLICTS OF INTEREST

The Parties shall comply with their respective organisation's Conflicts of Interest Policy for identifying and managing conflicts of interest as referred to in Schedule 7 and as such policies are updated from time to time during the term of this Agreement.

18 GOVERNANCE

18.1 Overall strategic oversight of partnership working between the Parties is vested in the Health and Well Being Board, which for these purposes shall make recommendations to the Parties as to any action it considers necessary.

18.2 The Parties have established a multi-agency/stakeholder Better Care Plan Finance and Governance Group and a Joint Commissioning Board made up solely of officers of the WCCG and the Council. The two bodies shall:

18.2.1 implement, deliver and operationally manage the Better Care Fund Plan;

18.2.2 manage the Better Care Fund budget; and

18.2.3 lead, co-ordinate and monitor delivery of the Better Care Fund programme,

as set out in the terms of this Agreement and the terms of reference included at Schedule 2.

18.3 The Better Care Plan Finance and Governance Group and the Joint Commissioning Board are both based within the joint working group structure and referenced within the individual organisation's decision making process. Each member of the two groups shall be a representative with individual delegated responsibility from the Party employing them to make decisions which enable the Better Care Plan Finance and Governance Group and the Joint Commissioning Board to carry out their objectives, roles, duties and functions. The terms of reference of each of the above 2 groups are set out in Schedule 2.

18.4 Each Party undertakes to the other that it has secured and will continue to secure internal reporting arrangements to ensure the standards of accountability and probity required by each Party's own statutory duties and organisation are complied with.

18.5 The Joint Commissioning Board and the WCCG Governing Body Board and the Council's Cabinet shall be responsible for the overall approval of the use of funds for individual Services, ensuring compliance with the Better Care Fund Plan.

18.6 Each Scheme Specification shall confirm the governance arrangements in respect of the Individual Scheme and how that Individual Scheme is reported to the, Better Care Plan Finance and Governance Group, Joint Commissioning Board and Health and Wellbeing Board.

18.7 The Joint Commissioning Board shall co-operate with the Pooled Fund Manager in relation to reporting requirements set out in relevant guidance in relation to the Better Care Fund as issued from time to time by NHS England, the Department of Communities and Local Government, the Department of Health and/or the Local Government Association.

Authorised Officers

18.8 At the Commencement Date, the Authorised Officers shall be:

18.8.1 for the Council: (Interim) Director of Adult Social Care and Public Health; and

18.8.2 for WCCG: the (Interim) Accountable Officer, and Chief Finance Officer. For the avoidance of doubt, any notice, information or communication given or made by or to either the (Interim) Accountable Officer or the Chief Finance Officer shall be deemed to have been given or made by or to WCCG.

19 REVIEW

19.1 Save where the Joint Commissioning Board agree alternative arrangements (including alternative frequencies) and without prejudice to Clause 19.6, the Parties shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, the Pooled Fund and the provision of the Services within 3 Months of the end of each Financial Year.

19.2 Subject to any variations to this process required by the Joint Commissioning Board, Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2.

19.3 The Parties shall within 2 Months of each Annual Review prepare a joint annual report documenting the matters referred to in this Clause 19. A copy of this report shall be provided to the Joint Commissioning Board.

19.4 The Parties acknowledge that the Joint Commissioning Board and the Better Care Plan Finance and Governance Group shall undertake regular reviews of the operation of this Agreement in accordance with the terms of reference set out in Schedule 2.

Financial Contributions

19.5 The Parties shall use reasonable endeavours to agree no later than 31st March in any Financial Year their respective Financial Contributions to the Pooled Fund for the following Financial Year and the relevant Scheme Specifications and Schedule 8 will be updated to reflect such agreement. Where agreement cannot be reached the Parties may need to use and/or apply the processes as outlined in Clauses 11 and 23.

19.6 The Parties shall review the operation of the Agreement at each meeting of the Joint Commissioning Board including confirmation of their respective Financial Contributions to the Pooled Fund for that Financial Year. The Parties may at this time (acting by written agreement of the Joint Commissioning Board) agree to vary such contributions and the relevant Scheme Specifications and Schedule 8 shall be amended in accordance with clause 30.

19.7 The Parties shall also use reasonable endeavours in each Financial Year to agree by 1st February a draft budget for the following Financial Year which would usually be based on the budget for the previous Financial Year. Such budget will be finalised once the Parties have agreed their Financial Contributions for the relevant Financial Year in accordance with Clauses 19.5 and 19.6 above.

19.8 Reviews under this clause shall be conducted in good faith and in accordance with the governance arrangements set out in Schedule 2, shall be based upon information to be provided as set out in Schedule 2 and shall take account of:

19.8.1 reasonable increases for inflation;

19.8.2 any agreed addition or decrease of funds for development of the Pooled Fund against any agreed targets; and

19.8.3 any commitments under or in connection with any Service Contract,

and the Parties acknowledge that any decision to reduce a Party's Financial Contribution which may impact on either Party's ability to fund a Service shall comply with the requirements of clause 30 including consideration of any associated reduction in the Services, taking account of notice periods within the relevant Service Contracts.

20 COMPLAINTS

Each Party's own complaints procedures shall apply to this Agreement. The Parties agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services.

21 TERMINATION & DEFAULT

21.1 Subject to the requirements of the Law (and in particular the statutory requirements of the Better Care Fund):

21.1.1 this Agreement may be terminated by either Party giving not less than 3 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes; and

21.1.2 unless otherwise agreed in the relevant Scheme Specification, each Individual Scheme may be terminated by either Party giving not less than 12 Months' notice in writing or such shorter notice period agreed between the Parties, provided that the Parties ensure that the statutory Better Care Fund requirements continue to be met and for the avoidance of doubt the operation of the Agreement shall continue in respect of the remaining Individual Services.

21.2 If a Party ("**Relevant Party**") fails to meet any of its obligations under this Agreement, the other Party may by notice require the Relevant Party to take such reasonable action within a reasonable timescale as the other Party may specify to rectify such failure. Should the Relevant Party fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

21.3 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Parties' rights in respect of any antecedent breach and any terms of this Agreement that expressly or by implication survive termination of this Agreement.

22 EFFECTS OF TERMINATION OR EXPIRY

22.1 In the event that this Agreement is terminated in whole or in part (howsoever terminated) the Parties agree to co-operate to ensure an orderly wind down of their joint activities as set out in this Agreement so as to minimise disruption to all Service Users, carers and staff.

22.2 The Council and the WCCG shall co-operate to ensure that:

22.2.1 where possible, existing Service Contracts are assigned to the Party with statutory responsibility for the relevant Service Users. Where this is not possible, subject to Clause 22.2.3, the Council and the WCCG shall continue to be liable to purchase the Services in accordance with this Agreement for all current Service Users at the date of service of the notice of termination and to fulfil all existing obligations to third parties under any Service Contract until the relevant contracts are terminated; and

22.2.2 the Parties shall continue to operate the Pooled Fund in accordance with this Agreement so far as is necessary to ensure fulfilment of the obligations in sub-Clause 22.2.1; and

22.2.3 the Parties shall remain liable to contribute that proportion of the cost of the Services which either is their proportionate contribution to the relevant Scheme in the current Financial Year or, if such contribution has not at the date of notice of termination yet been confirmed under Clause 19.5, the Party's contribution in the immediately preceding Financial Year represented as a proportion of the aggregate contributions of each Party to the relevant Service in that preceding Financial Year, such liabilities to continue for so long as the Service Users shall require the Services or the obligations to third parties under any Service Contract remain to be fulfilled.

22.3 Upon termination of the Agreement or a Scheme Specification the Parties shall use reasonable endeavours to agree an apportionment of any Underspend in relation to the Individual Scheme so terminated in a reasonable and equitable manner taking into account the circumstances of and reasons for the Underspend and such payments as shall be required to reflect this shall be made from the Pooled Fund to the Parties. Where such agreement cannot be reached within 30 days of termination the Underspend shall be returned to the Parties in proportion to their respective Financial Contributions for that Scheme.

22.4 Upon termination of the Agreement or a Scheme Specification the Parties shall use reasonable endeavours to agree an apportionment of any Overspend in relation to the Scheme so terminated in a reasonable and equitable manner taking into account the circumstances of and reasons for the Overspend and such payments as shall be required to reflect this shall be made by the Parties to the Pooled Fund. Where such agreement cannot be reached within 30 days of termination the Parties shall meet the Overspend proportionately to their respective Financial Contributions for that Scheme.

22.5 When determining whether there has been an Underspend or Overspend as at the date of termination of this Agreement, all known liabilities in relation to the Pooled Fund should be assessed and quantified and taken into account. In the case of termination of a Scheme Specification, all known liabilities in relation to that Scheme should be assessed and quantified and taken into account.

22.6 The Parties shall continue to be responsible for any liabilities that arise following any payments made pursuant to Clause 22.3 and/or Clause 22.4. Any liabilities that are subsequently quantified shall be apportioned between the Parties on the same basis as an Overspend in accordance with Clause 22.4 and the Parties shall make such payments to each other or to the Pooled Fund as shall be required to reflect this.

22.7 Unless agreed otherwise assets purchased from the Pooled Fund will be disposed of by the Host Party for the purposes of meeting any of the costs of winding up the Services or where this is not practicable such assets will be shared proportionately between the Council and the WCCG according to their respective Financial Contributions to the relevant Scheme.

23 DISPUTE RESOLUTION

23.1 In the event of a dispute between the Parties arising out of this Agreement, either Party may serve written notice of the dispute on the other Party, setting out full details of the dispute.

23.2 The Parties shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.1 at a meeting convened for the purpose of resolving the dispute.

23.3 If the dispute remains after the meeting detailed in Clause 23.2 has taken place, the Authorised Officer of each Party (or in each case their nominees) shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Parties will attempt to settle such dispute by mediation as follows:

23.4.1 in the case of any financial dispute including in relation to Overspends and Underspends as referred to in Clause 11 and Schedule 2Part 11, by referral to NHS England South West and Local Government Association South West Region peers for determination; and

23.4.2 in the case of any other dispute, in accordance with the CEDR Model Mediation Procedure set out at Schedule 7 or any other model mediation procedure as agreed by the Parties.

23.5 To initiate mediation under 23.4.1 or 23.4.2, either Party may give notice in writing (a "Mediation Notice") to the other requesting mediation of the dispute and shall send a copy thereof to NHS England South West and Local Government Association South West peers, CEDR or the equivalent mediation organisation as agreed by the Parties (as the case may be) asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served (or in the case of mediation of financial issues, such other timescale as NHS England and the Local Government Association shall determine). Neither Party will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Parties). The Parties will co-operate with any person appointed as mediator, providing them with such information and other assistance as they shall require and will pay their costs as they shall determine or in the absence of such determination such costs will be shared equally.

23.6 Nothing in the procedure set out in this Clause 23 shall in any way affect either Party's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

24 FORCE MAJEURE

24.1 Neither Party shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Part or incur any liability to the other Party for any losses or damages incurred by that Party to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Party shall notify the other Party as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Party and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Parties shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Party shall have the right to seek to terminate the Agreement under Clause 21.1. For the avoidance of doubt, no compensation shall be payable by either Party as a direct consequence of this Agreement being terminated in these circumstances.

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Party receives from another Party (the "**Discloser**") and subject always to the remainder of this Clause 25, each Party (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

25.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which'

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Party:

25.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement;

25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25; and

25.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

26.1 The Parties agree that they will each cooperate with each other to enable any the other Party receiving a request for information under the 2000 Act or the 2004 Regulations to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding,

retrieving and supplying information held, directing requests to the other Party as appropriate and responding to any requests by the Party receiving a request for comments or other assistance.

26.2 Any and all agreements between the Parties as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Regulations. No Party shall be in breach of Clause 24 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

26.3 Each Party ("**First Party**") acknowledges that the other Party will, in responding to a request received under the 2000 Act or the 2004 Regulations, be entitled to provide information relating to this Agreement or which otherwise relates to the First Party.

27 OMBUDSMEN

The Parties will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

28 INFORMATION SHARING AND DATA PROTECTION

28.1 The Parties shall at all times after the commencement of this Agreement:

28.1.1 use their best endeavours to comply with their obligations under the Data Protection Legislation;

28.1.2 cooperate with each other to enable the other Party to meet its obligations under the Data Protection Legislation.

28.2 No later than 20 Working Days from the date of this Agreement, the Parties shall procure and agree a policy and procedures for information sharing in order to ensure that:

28.2.1 the Parties comply with any notification requirements under the Data Protection Legislation;

28.2.2 the Parties process information obtained in relation to any Service User in accordance with their obligations under the Data Protection Legislation; and

28.2.3 Providers commissioned pursuant to Individual Schemes have in place appropriate technical and contractual measures to ensure their compliance with the Data Protection Legislation.

28.3 Following the agreement of a policy and procedures in accordance with Clause 28.2, both Parties shall thereafter comply at all times with such policy and procedures for the duration of this Agreement and indefinitely after its expiry or termination.

28.4 The Parties acknowledge that supporting data sharing protocols and agreements are being developed which will underpin the Better Care Fund Plan and which they will adhere to when sharing information under this Agreement. Wherever the Parties intend to share data, they will consider the type of information to be shared and the purpose for sharing it, and they will enter into the appropriate information sharing agreements as developed between the Parties.

28.5 Each Party shall take such steps as may be practicable to afford the other Party access to information which is reasonably required by the first Party in connection with any of its statutory functions and for any purpose connected with its rights and obligations under this Agreement.

28.6 Each Party must exercise its reasonable endeavours to ensure the accuracy of any data entered into the computer system used in carrying out the Party's obligations under the Agreement.

28.7 So far as is permitted in Law (and each Party shall use all reasonable endeavours to ensure such permission exists) all data held on any computer system operated under this Agreement must

immediately on termination of the Agreement be made available on request to the Party with statutory responsibility for the relevant Service Users.

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be sent by first class post or electronic mail. The address for service of each Party shall be as set out in Clause 29.3. A notice shall be deemed to have been served if:

29.1.1 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

29.1.2 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Party sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

29.2 In proving such service, it shall be sufficient to prove that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Party in writing:

29.3.1 if to the Council, addressed to the (Interim) Director of Adult Social Care and Public Health (Graham Wilkin at the Commencement Date) at Wiltshire Council, County Hall, Bythesea Road, Trowbridge, Wiltshire BA14 8JN;

Tel: 01225 713117

Email: graham.wilkin@wiltshire.gov.uk

29.3.2 if to the WCCG, addressed to the (Interim) Accountable Officer (Linda Prosser at the Commencement Date) and the Chief Finance Officer (Steve Perkins at the Commencement Date) both at NHS Wiltshire Clinical Commissioning Group, Southgate House, Pans Lane, Devizes, Wiltshire SN10 5EQ;

Tel: 01380 733830

Email: linda.prosser@nhs.net and steve.perkins@nhs.net

30 VARIATION

30.1 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Parties subject to approval by the Joint Commissioning Board as set out in this Clause.

30.2 Where the Parties agree that there will be:

30.2.1 a new Scheme Specification; or

30.2.2 an amendment to a current Scheme Specification,

the Joint Commissioning Board shall agree the new or amended Scheme Specification and this must be signed by the Parties. A request to vary an Individual Scheme (which may include a change in the level of Financial Contribution/s) may be made by any Party but will require agreement from all of the Parties in accordance with the process set out in Clause 30.3. The notice period for any variation

unless otherwise agreed by the Parties shall be 3 Months or in line with the notice period for variations within the associated Service Contract/s, whichever is the shortest.

30.3 The following approach shall, unless otherwise agreed, be followed by the Joint Commissioning Board:

30.3.1 on receipt of a request from one Party to introduce a Scheme Specification for an existing Individual Scheme or vary the Agreement or an Individual Scheme, the Joint Commissioning Board will first undertake an impact assessment and identify those Service Contracts likely to be affected;

30.3.2 the Joint Commissioning Board will agree whether those Service Contracts affected by the proposed variation should continue, be varied or terminated, taking note of the Service Contract terms and conditions and ensuring that the Party holding the Service Contract/s is not put in breach of contract; its statutory obligations or financially disadvantaged;

30.3.3 wherever possible agreement will be reached to reduce the level of funding in the Service Contract/s in line with any reduction in budget; and

30.3.4 should this not be possible and one Party is left financially disadvantaged as a result of holding a Service Contract for which the budget has been reduced, then the financial risk will, unless otherwise agreed [and subject to the exceptions set out in Paragraph 5 of Schedule 3], be shared equally between the Parties.

31 CHANGE IN LAW

31.1 The Parties shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 If at any time during the term of this Agreement a change to the manner in which a Service or the Services are commissioned is required as a result of a Change in Law then the provisions outlined in this Clause 31 shall apply.

31.3 The Parties shall jointly investigate the likely impact of the Change in Law on the Services and any other aspect of the Agreement and shall prepare a report in writing, setting out:

31.3.1 the variation proposed;

31.3.2 the date upon which it should take effect;

31.3.3 a statement of whether the variation will result in an increase or decrease in Financial Contributions by reference to the relevant component elements of the Service or Services which are subject to the Change in Law;

31.3.4 a statement on the individual responsibilities of the WCCG and the Council for any implementation of the variation;

31.3.5 a timetable for implementation of the variation;

31.3.6 a statement of any impact on, and any changes required to the Services; and

31.3.7 the date for expiry of the report.

31.4 The Parties shall confirm in writing their decision to proceed with the proposed variation and shall agree a formal variation in accordance with Clause 30.

31.5 In the event of failure by the Parties to agree the relevant amendments to the Agreement (as appropriate), the Clause 24 (Dispute Resolution) shall apply.

32 WAIVER

Any relaxation or delay of either Party in exercising any right under this Agreement shall not be taken as a waiver of that right and shall not affect the ability of that Party subsequently to exercise that right.

33 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUB CONTRACTING

The Parties shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Parties, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Party's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Parties or render either Party directly liable to any third party for the debts, liabilities or obligations of the other.

35.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Party will have authority to, or hold itself out as having authority to:

35.2.1 act as an agent of the other;

35.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

37 ENTIRE AGREEMENT

37.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Parties with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Party.

37.2 Each of the Parties acknowledges and agrees that in entering into this Agreement it does not rely on and shall have no remedy in respect of any statement, representation, warranty or understanding (whether negligently or innocently made) of any person (whether party to this Agreement or not) other than as expressly set out in this Agreement.

37.3 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Party unless in writing and signed by a duly authorised officer or representative of the Parties.

38 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by both Parties shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

39.2 Subject to Clause 23 (Dispute Resolution), the Parties irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

40 STATUTORY OBLIGATIONS

40.1 The Parties shall in the performance of their obligations under this Agreement comply with all relevant Law and all provisions relating to such matters elsewhere in this Agreement.

40.2 Each Party will note the other Party's current and future obligations under the Data Protection Legislation, the 2000 Act, the Human Rights Act 1998, the Equality Act 2010 and Part 1 of the Local Government Act 1999 (as amended from time to time) and any codes of practice and best practice guidance issued by the European Commission Government and the appropriate enforcement agencies (the **"Specified Legislation**") and shall:

40.2.1 comply with the Specified Legislation in so far as it places obligations upon that Party in the performance of its obligations under this Agreement;

40.2.2 facilitate the other Party's' compliance with its obligations under these provisions and comply with any reasonable requests for that purpose;

40.2.3 act in respect of any person who receives or requests services under this Agreement as if that Party were a public authority for the purpose of the Human Rights Act 1998.

40.3 The Parties shall at all times comply with the requirements of the Health and Safety at Work Act 1974 and of any other Acts pertaining to the health and safety of employees and shall ensure that any contractors carrying out work for any purpose relating to the Agreement likewise comply.

40.4 The Parties shall not in relation to the employment of persons for the purposes of providing the Services or in relation to the provision of the Services to any person unlawfully discriminate against any person contrary to UK legislation relating to discrimination or equality whether in relation to race, gender, religion or belief, disability, age, sexual orientation or otherwise.

41 FAIR DEALINGS

41.1 The Parties recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of either of them and that if in the course of the performance of this Agreement, unfairness to either of them does or may result then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

IN WITNESS WHEREOF this Agreement has been executed by the Parties as a DEED on the date which first appears in this Agreement

THE CORPORATE SEAL of
WILTSHIRE COUNCIL
was hereunto affixed In the presence of:

Signed on behalf of NHS WILTSHIRE CLINICAL COMMISSIONING GROUP

SCHEDULE 1 - SCHEME SPECIFICATION

Part 1: Template Scheme Specification

BETTER CARE FUND SCHEME SPECIFICATION
FINANCIAL YEAR [INSERT]
SCHEME: [INSERT]

Background:

1. This Scheme Specification is supplemental to the Better Care Fund Section 75 Agreement made between (1) Wiltshire Council and (2) NHS Wiltshire Clinical Commissioning Group and dated [INSERT] (the "**BCF S75**"). Defined terms in the BCF S75 apply in this Scheme Specification.

2. The purpose of this Scheme Specification is to set out the specific terms on which the Parties have agreed to collaborate in relation to the Scheme named above.

PART A – GENERAL	
Scheme Specification Terms: Commencement Date: [INSERT] End Date: [INSERT]	
Total Value of this Scheme: [INSERT]	
WCCG Lead Representative: [INSERT] NHS Wiltshire CCG Direct Line: 01380 [INSERT] Mobile: [INSERT] Email: [INSERT]@nhs.net	***Council Lead Representative***: [INSERT] Wiltshire Council Direct Line: 01225 [INSERT] Mobile: [INSERT] Email: [INSERT]@wiltshire.gov.uk

PART B – SCHEME DETAILS
Overview of Services and Contract Arrangements within this Scheme 41.2 At commencement of this Scheme Specification, the Services are as follows: ***Service 1 : [insert description]*** **Functions:** *Insert details of all relevant WCCG Functions and Council Functions as specified in regulations 5 and 6 of the 2000 Regulations. If the Functions vary at Service level then they have to be listed here. If they are the same throughout the Scheme, then delete here and insert at Part A above instead.* **Contracts:** *Insert details of any existing contracts i.e. date of contract, parties, identification number and expiry date. State whether new contracts or variations of existing contracts are required.* **Commissioning arrangements:** *State the commissioning arrangements which will apply in relation to the existing and proposed contracts i.e*

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a) *Lead Commissioning by the Council - the delegation by the WCCG to the Council of the WCCG Functions, so that the Council may exercise the WCCG Functions alongside the Council Functions and act as commissioner of the Service; or*

b) *Lead Commissioning by the WCCG - the delegation by the Council to the WCCG of the Council Functions, so that the WCCG may exercise the Council Functions alongside the WCCG Functions and act as commissioner of the Service; or*

c) *Integrated Commissioning - the establishment of an integrated management and commissioning department in relation to the Service.*

If the commissioning arrangements vary by Service then they have to be listed here. If they are the same throughout the Scheme, then delete here and insert at Part A above instead.

Service Users and Eligibility Criteria:
Insert details of the service users and eligibility criteria e.g. individuals with a diagnosis of dementia. Note that some service users may be the responsibility of the Council but not the WCCG and vice versa, so the beneficiaries need to be clearly set out. If the service users vary by Service then they have to be listed here. If they are the same throughout the Scheme, then delete here and insert at Part A above instead.

VAT:
Set out details of the treatment of VAT in respect of the Service. If VAT arrangements vary by Service then they have to be listed here. If they are the same throughout the Scheme because the commissioning arrangements are the same, then delete here and insert at Part A above instead.

CQC:
Set out any CQC registration requirements in relation to the Service. Again, if these apply at Scheme level, move to Part A instead.

Service 2 : [insert description]

Etc

PART C – SCHEME SPECIFICATION TERMS

Additional Terms & Conditions Specific to this Scheme Specification:

General

1.1 Each Party shall use reasonable endeavours to ensure that any change to the Lead Representatives is promptly communicated to the other Party.

1.2 This Scheme Specification may be executed in any number of counterparts each of which shall be an original and all of such counterparts taken together shall be deemed to constitute one and the same instrument.

1.3 Additional Services may be brought within the scope of this Scheme Specification by varying this Scheme Specification in accordance with the terms of the BCF S75.

1.4 The Parties acknowledge that the Contract Arrangements for Services commissioned within this Scheme must comply with the requirements of clause 17 of the BCF S75.

1.5 The Parties acknowledge that the Contract Arrangements for Services commissioned within this Scheme must comply with all relevant Legislation including the Public Contracts Regulations 2015.

Non-financial contributions to be provided by each Party

DN: Consider whether the following should be at Scheme or Service level

1.6 WCCG non-financial contributions: [INSERT]

1.7 Council non-financial contributions: [INSERT]

Set out all non-financial contributions of each Party which may include:

- *the assets and premises (if any) to be provided by each Party;*
- *the contract management services, administration services and IT support (if any) to be provided by each Party;*
- *the Staff to be made available by the WCCG and/or the Council together with any special arrangements which will apply to the Staff in question and specific consideration of:*
  - *whether or not TUPE will apply at any time and which Staff will be affected; and*
  - *how pensions will be dealt with including the financial implications arising from any pension liabilities and membership of the respective NHS and Local Government Pension Schemes*

1.8 Any charges for non-financial contributions made by either Party in relation to this Scheme shall be negotiated and agreed annually for inclusion as budget headings within this Scheme's budget, or separately budgeted to ensure transparency. Any variations to amounts so budgeted must be approved by the Joint Commissioning Board.

1.9 [INSERT ANY OTHER SCHEME OR SERVICE SPECIFIC REQUIREMENTS E.G. TERMINATION RELATED].

PART D – EXECUTION

SIGNED by _____

Duly authorised for and on behalf of **NHS WILTSHIRE CLINICAL COMMISSIONING GROUP** Date:_____

SIGNED by _____

Duly authorised for and on behalf of **WILTSHIRE COUNCIL** Date: _____

Part 2: Initial Individual Schemes

Commissioning Activity	Council / CCG	Description	Lead
Better Care Fund - Intermediate Care	Council	Step Up/Down Beds	Graham Wilkin
Better Care Fund - Intermediate Care	WCCG	Intermediate Care Therapies	S Watson
Better Care Fund - Intermediate Care	Council	Intermediate Care Social Work	Graham Wilkin
Better Care Fund - Intermediate Care	Council	Intermediate Care Programme Manager	Graham Wilkin
Better Care Fund - Intermediate Care	WCCG	Mental Health Liaison	G Ruddle
Better Care Fund - Intermediate Care	Council	HTLAH Support for Community LA	Graham Wilkin
Better Care Fund - Intermediate Care	Council	HTLAH Support for Community CCG	Graham Wilkin
Better Care Fund - Intermediate Care	WCCG	Step Up Beds (Wiltshire Health & Care)	S Watson
Better Care Fund - Intermediate Care	WCCG	SHARP - Social Care Help & Rehabilitation Project	S Watson
Better Care Fund - Intermediate Care	WCCG	SPA Support for STARR	J Cullen
Better Care Fund - Intermediate Care	WCCG	One Number	J Cullen
Better Care Fund - Intermediate Care	WCCG	Community Geriatrics	S Watson
Better Care Fund - Intermediate Care	Council	End of life care - 72 hour pathway	Graham Wilkin
Better Care Fund - Intermediate Care	Council	Bed Management System	Graham Wilkin
Better Care Fund - Intermediate Care	Council	GP Cover	Graham Wilkin
Better Care Fund - Intermediate Care	WCCG	Community Services	S Watson
Better Care Fund - Intermediate Care	Council	Wiltshire Care Partnership	Graham Wilkin
Better Care Fund - Intermediate Care	WCCG	Rehab Support Workers	S Watson
Better Care Fund - Intermediate Care	Council	Palliative Care Contract	Graham Wilkin
Better Care Fund - Intermediate Care	WCCG	Barchester Healthcare Gold Call	J Williamson
Better Care Fund - Intermediate Care	Council	iBCF - Sustainable Transformation - Project Team	Graham Wilkin
Better Care Fund - Intermediate Care	Council	iBCF - Providing stability and extra capacity in the local care system - residential	Graham Wilkin
Better Care Fund - Intermediate Care	Council	iBCF - Providing stability and extra capacity in the local care system - IC	Graham Wilkin
Better Care Fund - Intermediate Care	Council	iBCF - Providing stability and extra capacity in the local care system - Dom Care	Graham Wilkin

Better Care Fund - Intermediate Care	Council	iBCF - Improving Reablement - Front door	Graham Wilkin
Better Care Fund - Intermediate Care	Council	iBCF - Immediate Intervention - Staffing	Graham Wilkin
Better Care Fund - Intermediate Care	Council	iBCF - Immediate Care / DTOC Beds	Graham Wilkin
Better Care Fund - Access & Rapid Response	Council	Medvivo - Telecare Response and Support	Graham Wilkin
Better Care Fund - Access & Rapid Response	Council	Hospital Social Care Capacity (Additional Hospital Social Care Capacity)	Graham Wilkin
Better Care Fund - Access & Rapid Response	Council	Self-funder Support - CHS	Graham Wilkin
Better Care Fund - Access & Rapid Response	WCCG	Medvivo - Acute Trust Liaison	J Cullen
Better Care Fund - Access & Rapid Response	WCCG	Medvivo - Simple Point of Access	J Cullen
Better Care Fund - Access & Rapid Response	WCCG	Medvivo - Additional RR Hub	J Cullen
Better Care Fund - Access & Rapid Response	WCCG	Medical Room	J Cullen
Better Care Fund - Access & Rapid Response	WCCG	Leg Club Accomodation	J Cullen
Better Care Fund - Access & Rapid Response	Council	Urgent Care at Home Domiciliary Care	Council
Better Care Fund - Care Act	Council	Care Act	Not confirmed at Council
Better Care Fund - Self Care & Support	WCCG	Carers - CCG contribution to Pool	Sue Shelbourn-Barrow
Better Care Fund - Self Care & Support	WCCG	Carers - Voyage Respite	T Burns
Better Care Fund - Self Care & Support	Council	Carers - WCC contribution to Pool	Sue Shelbourn-Barrow
Better Care Fund - Self Care & Support	Council	Carers - WCC contribution to Pool (Childrens)	Graham Wilkin
Better Care Fund - Self Care & Support	Council	Info & Advice Portal content management (Healthwatch)	Graham Wilkin
Better Care Fund - Self Care & Support	WCCG	Public Health Prevention - Fracture Liaison	T Wilson
Better Care Fund - Self Care & Support	Council	Public Health Prevention - Training, etc..	Graham Wilkin
Better Care Fund - Self Care & Support	Council	Sound Doctor	Graham Wilkin
Better Care Fund - Protecting Social Care	Council	Maintaining Services Social Care	Graham Wilkin
Better Care Fund - Protecting Social Care	Council	Complex Care Packages	Graham Wilkin

Better Care Fund - Protecting Social Care	Council	Strengthening QA	Graham Wilkin
Better Care Fund - Service User Engagement	Council	Invest in Engagement (Healthwatch)	Graham Wilkin
Better Care Fund - Other Council	Council	Disabled Facilities Grant	Janet O'Brien
Better Care Fund - Management & Admin	Council	Finance & Performance	Michael Hudson
Better Care Fund - Management & Admin	Council	Administration (JRo)	Sue Shelbourn-Barrow
Better Care Fund - Management & Admin	Council	Veritas Analysis Contract (JHo)	Graham Wilkin
Better Care Fund - Management & Admin	WCCG	Workforce - paid by CCG	Steve Perkins
Better Care Fund - ICES	Council	Integrated Equipment - Wiltshire Council (adults)	Graham Wilkin
Better Care Fund - ICES	Council	Integrated Equipment - Wiltshire Council (children)	Graham Wilkin
Better Care Fund - ICES	WCCG	Integrated Equipment - Wilts CCG (excludes continence)	Graham Wilkin (or Gail Warnes?)
Better Care Fund - Unallocated	both	Unallocated funding / Contingency	Not confirmed

SCHEDULE 2 – GOVERNANCE

The Parties acknowledge that the governance arrangements set out in this Schedule relate only to the Better Care Fund. Further work to integrate the Parties' wider commissioning activities may require variations to these governance arrangements.

Part 1

1 Delegated Authority

1.1 The Joint Commissioning Board is authorised within the limited delegated authority for its members (which is received through their respective organisation's own financial scheme of delegation) to:

1.1.1 authorise commitments which exceed or are reasonably likely to lead to exceeding the contributions of the Party to the aggregate contributions of the Party to the Pooled Fund; and

1.1.2 authorise a Lead Commissioner to enter into any contract for services necessary for the provision of Services under an Individual Scheme

2 Information and Reports

The Pooled Fund Manager shall supply to the Joint Commissioning Board on a Quarterly basis the financial and activity information as required under the Agreement.

3 Post-termination

The Joint Commissioning Board shall continue to operate in accordance with this Schedule following any termination of this Agreement but shall endeavour to ensure that the benefits of any contracts are received by the Parties in the same proportions as their respective contributions at that time.

Part 2

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SCHEDULE 3- RISK SHARE AND OVERSPENDS

Unless the context otherwise requires, the defined terms used in this Schedule shall have the same meanings as set out in Clause 1 of the main body of the Agreement.

1 FINANCIAL CONTRIBUTIONS AND MANAGEMENT OF THE POOLED FUND

1.1 In relation to the first Financial Year following the Commencement Date, the Parties have agreed the Financial Contributions for the Individual Schemes that are included as part of the Agreement as at the Commencement Date and these will be set out in each Scheme Specification as set out in Schedule 1 to the Agreement and Schedule 8. Amendments to these Financial Contributions shall be agreed in accordance with Clause 9, Clause 19 (Review) and Clause 30 (Variation) of the Agreement.

1.2 The Host Party shall manage expenditure from the Pooled Fund in accordance with the terms of the Agreement including (without limitation): Clauses 8 (Pooled Fund Management) and 11 (Risk Sharing Arrangements, Overspends and Underspends); the relevant Scheme Specification and this Schedule 2Part 11.

1.3 The Pooled Fund Manager shall develop and maintain appropriate systems to monitor progress on each Individual Scheme and for alerting the Joint Commissioning Board, through the Better Care Plan Finance and Governance Group of any risks to delivery and the actions being taken to mitigate the likelihood of the risk to delivery occurring or impact on delivery of Better Care Fund outcomes, including the financial impact. The Better Care Plan Finance and Governance Group will consider such reports, escalating to the Joint Commissioning Board matters which cannot be resolved at its level.

1.4 Subject to any contrary provision in the relevant Scheme Specification, the Parties agree that Overspends or Underspends shall be managed in accordance with Clause 11 (Risk Sharing Arrangements, Overspends and Underspends) and this Schedule 2Part 11.

1.5 The Parties agree to co-operate fully in order to establish an agreed position in relation to any Overspends or Underspends. Any decision of the Parties regarding an Overspend or Underspend shall be made in accordance with the terms of this Agreement and shall be subject to the Law and the internal governance requirements of each Party. All decisions made by the Joint Commissioning Board will be exercised in accordance with the delegated authority of the individual members of the Joint Commissioning Board.

2 REPORTING ARRANGEMENTS

2.1 Subject to Paragraph 5 below, whenever an Overspend or Underspend is projected within a Financial Year, the Parties shall use best endeavours to agree how to manage the variance in order to achieve financial balance, taking into account the circumstances and reasons for the variance. The Parties shall keep the position under review, in line with the Better Care Fund Plan budget monitoring arrangements, acting in good faith and in a reasonable manner in agreeing the management of the Overspend or Underspend.

2.2 Subject to Paragraph 5 below, in the event that the Pooled Fund Manager identifies an actual or projected Overspend or Underspend:

2.2.1 the Pooled Fund Manager shall notify the Joint Commissioning Board as soon as reasonably possible at least within 10 Working Days of identification of an actual or projected Overspend or as part of the monthly reporting of the Better Care Fund Plan budget to the Better Care Plan Finance and Governance Group including providing evidence to validate the extent of the Overspend or Underspend; and

2.2.2 the Joint Commissioning Board and the Parties shall act in accordance with the provisions of this Schedule 2Part 11 and the relevant Scheme Specification for that Individual Scheme in taking a decision about how to manage the Overspend or Underspend.

2.3 Following the notification in accordance with paragraph 2.1.1 above, the Parties shall act through the Joint Commissioning Board to prepare a joint action plan for the management of the Overspend or Underspend, which shall be prepared:

2.3.1 as soon as practicable following the first meeting of the Better Care Plan Finance and Governance Group to take place after the Overspend or Underspend is notified and in any event at the next Joint Commissioning Board meeting; and

2.3.2 save as otherwise agreed by the Parties or set out in the relevant Scheme Specification, in accordance with Paragraphs 3 or 4 below as appropriate.

3 MANAGEMENT OF OVERSPENDS

3.1 Pursuant to Paragraph 2.2 above and subject to Paragraph 5 below, actual or projected Overspends, shall be managed as set out below (in order of precedence):

3.1.1 first, the relevant Party that is responsible for commissioning the Individual Scheme will take action, wherever possible, to contain expenditure;

3.1.2 secondly, the Joint Commissioning Board will consider whether it is appropriate for the Party responsible for commissioning the Individual Scheme to vire Underspends from any other Individual Scheme for which it is responsible within the Pooled Fund;

3.1.3 thirdly, the Joint Commissioning Board whether it is appropriate to use any Underspend from within that element of this Agreement that comprises the Improved Better Care Fund grant;

3.1.4 fourthly, the Joint Commissioning Board will consider whether other Underspends within the Pooled Fund including the uncommitted / contingency funds, and any Underspends in Individual Schemes for which the other Party is responsible, can be vired to the Individual Scheme that has an Overspend;

3.1.5 fifthly, subject to any continuing obligations under any Service Contract entered into by either Party, the Parties may agree to vary or terminate a Service where the Scheme Specification provides and in accordance with the terms of Clause 22 (Termination) and 30 (Variations) of the Agreement.

3.2 Unless otherwise agreed by the Joint Commissioning Board (which will consider all remaining options), any Overspend will be recovered from the Parties at the end of the relevant Financial Year in proportion with their respective Financial Contributions to the relevant Individual Services.

4 MANAGEMENT OF UNDERSPENDS

4.1 Pursuant to Paragraph 2.2 above and subject to Paragraph 5 below, actual or potential Underspend shall be managed as set out below (in order of precedence):

4.1.1 first, spent, vired between, and/or utilised to manage an Overspend as referred to Paragraphs 3.1.2 and 3.1.3 above;

4.1.2 secondly, save as otherwise agreed by the Parties, the Underspend shall be divided equally between the Parties.

5 EXCEPTIONS

5.1 The following exceptions apply to the provisions above:

5.1.1 Prior to the Commencement Date, the ICES Pooled Budget was operated as an aligned budget within the Joint Business Arrangements. On and from the Commencement Date, the ICES Pooled Budget will be added to the Pooled Fund in order to achieve efficiencies

through joint management of spend under the BCP. The Joint Commissioning Board agreed at its meeting of 8 February 2017 that this transfer was on a non-risk basis so that the provisions of Schedule 3 relating to Overspends and Underspends do not apply to the ICES Pooled Budget. Each Party shall continue to have responsibility for its own contribution to the ICES Budget so that each Party shall be liable for any Overspend in relation to its contribution, and each Party shall have discretion to determine the use of any Underspend in relation to its contribution;

5.1.2 Any Underspend in relation to the Carers Pooled Budget shall be ringfenced and carried forward to the next Financial Year;

5.1.3 The IBCF shall be treated as a Non-Recurrent Payment for the purposes of Clause 9.3 so that the provisions of this Schedule shall not apply and the Council shall have the sole discretion to determine the use of any Underspend of the IBCF. The Council must comply with the grant conditions set out in the IBCF grant determination made under Section 31 of the Local Government Act 2003. The Parties acknowledge that the IBCF must not be used to replace, and must not be offset against, the WCCG minimum contribution to the BCF; and

5.1.4 Any Underspend of DFG shall be carried forward and any Overspend of DFG shall be the responsibility of the Council. The Council must comply with the grant conditions set out in the DFG grant determination made under Section 31 of the Local Government Act 2003.

SCHEDULE 4 - JOINT WORKING OBLIGATIONS

Part 1 - LEAD COMMISSIONER OBLIGATIONS

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1 The Lead Commissioner shall notify the other Party if it receives or serves:

1.1 a Change in Control Notice;

1.2 a Notice of an Event of Force Majeure;

1.3 a Contract Query;

1.4 Exception Reports - and provide copies of the same.

2 The Lead Commissioner shall provide the other Party with copies of any and all:

2.1 Monthly Activity Reports;

2.2 Scheme Updates;

2.3 Joint Performance Dashboards;

2.4 Remedial Action Plans; and

2.5 Service Quality Performance Report;

3 The Lead Commissioner shall not without the approval of both Parties:

3.1 permanently or temporarily withhold or retain monies pursuant to the Withholding and Retaining of Payment Provisions;

3.2 vary any Provider Plans (excluding Remedial Action Plans);

3.3 agree (or vary) the terms of a Joint Investigation or a Joint Action Plan;

3.4 give any approvals under the Service Contract;

3.5 agree to or propose any variation to the Service Contract (including any Schedule or Appendices);

3.6 suspend all or part of the Services;

3.7 serve any notice to terminate the Service Contract (in whole or in part);

3.8 serve any notice;

3.9 agree (or vary) the terms of a Succession Plan; without the prior approval of the other Party (acting through the Joint Commissioning Board) such approval not to be unreasonably withheld or delayed.

4 The Lead Commissioner shall advise the other Party of any matter which has been referred for dispute and agree what (if any) matters will require the prior approval of one or more of the other Party as part of that process.

Part 2 - OBLIGATIONS OF THE OTHER PARTY

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1 Each Party shall (at its own cost) provide such cooperation, assistance and support to the Lead Commissioner (including the provision of data and other information) as is reasonably necessary to enable the Lead Commissioner to:

1.1 resolve disputes pursuant to a Service Contract;

1.2 comply with its obligations pursuant to a Service Contract and this Agreement;

1.3 ensure continuity and a smooth transfer of any Services that have been suspended, expired or terminated pursuant to the terms of the relevant Service Contract;

2 No Party shall unreasonably withhold or delay consent requested by the Lead Commissioner.

3 Each Party (other than the Lead Commissioner) shall:

3.1 comply with the requirements imposed on the Lead Commissioner pursuant to the relevant Service Contract in relation to any information disclosed to the other Parties;

3.2 notify the Lead Commissioner of any matters that might prevent the Lead Commissioner from giving any of the warranties set out in a Services Contract or which might cause the Lead Commissioner to be in breach of warranty.

SCHEDULE 5- PERFORMANCE ARRANGEMENTS

A performance dashboard has previously been agreed as the Key Performance Indicator for the Better Care Plan, as set out below. The Parties agree to work together in good faith to produce an updated performance dashboard by 31 March 2018.

SCHEDULE 6 - BETTER CARE FUND PLAN

Wiltshire BCF Plan - 11 Oct 2017._.pdf

[DN: this PDF document will be printed out before the final version is signed, however, is being inserted as an embedded document for this version]

SCHEDULE 7 - POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

Council's conflict of interest policy

Set out in Part 15 of the Council's Constitution available here:

http://cms.wiltshire.gov.uk/documents/s120489/Part%2015%20-%20Human%20Resources%20Code%20of%20Conduct.pdf

WCCG's conflict of interest policy

Referred in Part 8 of WCCG's Constitution available here:

http://www.wiltshireccg.nhs.uk/wp-content/uploads/2017/04/NHS-Constitution-2017.06.01.pdf

SCHEDULE 8- BETTER CARE FUND PLAN BUDGET 2017/19

2017-2018 Financial Contributions

These are as referred in Appendix 2 to the JCB Report (for meeting held 25 May 2017).

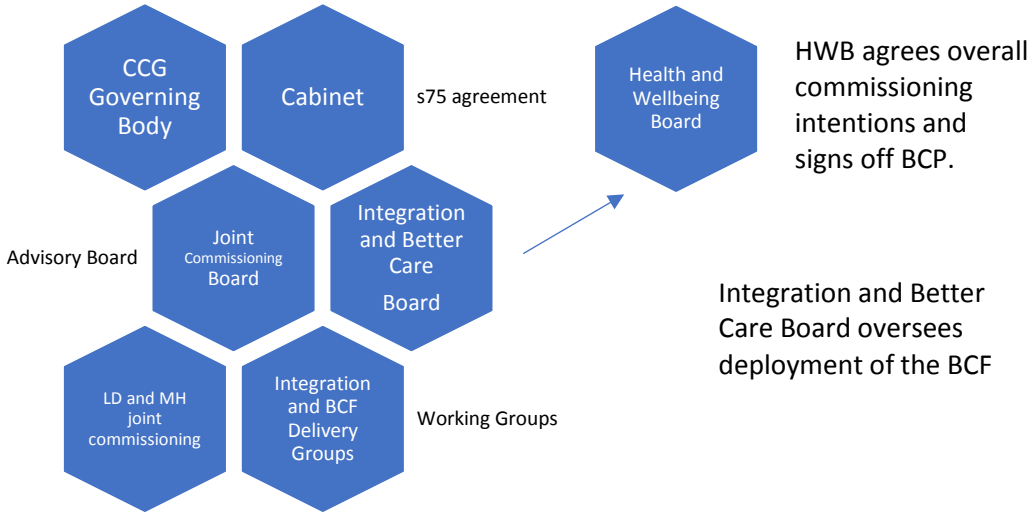
2018-2019 Indicative Financial Contributions

Please note that these are indicative only and will be agreed, reviewed and varied in accordance with the terms of this Agreement.

Taken from Summary of HWB 2017-19 Planning Template:

	2018/19 Indicative Gross Contribution
Indicative Council Financial Contribution excluding IBCF	7,282,953
Indicative IBCF Contribution	7,210,533
Indicative CCG Minimum Financial Contribution	29,011,258
Indicative total CCG Financial Contribution	2,219,742
Total BCF Pooled Budget	**45,724,486**

Wiltshire's Governance for Integration and the Better Care Fund



The governance arrangements for the Better Care Fund in Wiltshire have been designed to drive integrated working. These are summarized as follows:

Wiltshire CCG Governing Body and Wiltshire Council Cabinet:
As the executives of the two organisations pooling budgets, these bodies are responsible for signing off the s75 agreement and agreeing the procurement of significant new initiatives (above the limits set out in the respective organisations' scheme of delegation).

Wiltshire Health and Wellbeing Board:
The Health and Wellbeing Board (HWB) includes lead members and chief officers from the health and social care system. The HWB is also responsible for the signing of the s75 agreement and for gaining system-wide buy-in to the Better Care Plan, which sets out the broad commissioning intentions for the use of the Better Care Fund. The HWB receive standing updates on progress against the high-level BCP outcomes and on the delivery of new schemes.

Joint Commissioning Board
The Joint Commissioning Board (JCB) is an advisory group which brings together senior Council and WCCG officers (with the Council cabinet member for health and adult social care and the chair of the WCCG) to undertake detailed commissioning work and make jointly agreed recommendations for change to the commissioning organisations. This includes overseeing the management of existing joint investments and initiatives alongside a targeted programme of activities that exploits opportunities where greater coordination, alignment and/or integration of resources can lead to improved outcomes and efficiency. A Joint Business Agreement also sets out a range of areas (beyond the BCP) where pooled/ transferred budgets have been agreed. Part 2 of the meeting includes senior staff from providers to deliver a system check and challenge on the delivery of key schemes. In addition to this, sub groups focusing on particular topics with specialist staff (such as mental health or learning disabilities) may be established, reporting into JCB.

In respect of the Better Care Plan, it is referred to as the 'decision making body' in the s75

agreement and as such the JCB receives regular reports from the Better Care Board (although jointly agreed recommendations have to go through the usual decision-making process for the respective organisations). A copy of the full terms of reference is included at Appendix 1. These include provision for establishing executive delivery groups.

Integration and Better Care Board
The Integration and Better Care Board (the Board) delivers the Better Care Plan on behalf of the HWB, reporting on its work to the JCB and making recommendations and providing senior focus for the future direction of the Better Care Fund.

The Board is also tasked with overseeing Wiltshire's collective participation in the Sustainability and Transformation Partnership – in particular, the development of an Accountable Care System, local strategic commissioning arrangements and future contracting mechanisms for a local accountable care alliance.

The membership of the Board includes:

- WCCG Chair
- WCCG Chief Accountable Officer
- Wiltshire Council Cabinet Member
- Wiltshire Council Director of Adult Social Services (and operations representative)
- Better Care and Adult Social Care transformation programme management
- Representatives of the 3 acute hospitals and AWP (Mental Health provider)

The Board reports on its work to the Joint Commissioning Board, as well as the Health and Wellbeing Board.

The Board is underpinned by Delivery Groups comprising

- Operational directors
- Commissioning directors
- A&E Delivery Board representatives
- Finance officers

Working groups focus on specific themes within the BCP and High Impact Change Model (such as tackling delayed transfers of care) as well as the overall finance and risk profile for the BCP.

Full terms of reference are included at Appendix 2.

Function	Group (and membership)	Reporting Schedule
Accountable for overall delivery of the Better Care Plan and agreeing high level commissioning intentions	**Health and Wellbeing Board** Chair: Baroness Scott Vice Chair: Dr Sandford-Hill Council Cabinet Members and WCCG GP locality representatives Healthwatch Wiltshire, NHS England, PCC Directors of Children's Services, Adult Social Care and Public Health. Provider representation from acutes (GWH, SFT, RUH) and SWAST, AWP and LMC.	Meets five times a year
Makes jointly agreed recommendations for change to commissioning bodies	**Joint Commissioning Board** Chair/ Vice Chair: Alternates between CAO and DASS Commissioners Council Cabinet Member and WCCG Chair Lead commissioners and finance officers Part 2 of the meeting includes provider organisations for system check and challenge.	Meets alternate months to HWB
Leads on the establishment of an accountable care alliance. Reports to JCB on the progress with delivering schemes, reviews business cases and makes recommendations to JCB for investment. Evaluates schemes and recommends mainstreaming or closure.	**Integration and Better Care Board** Chair/ Vice Chair: Alternates between CAO and DASS • WCCG Chair • WCCG Chief Accountable Officer • Wiltshire Council Cabinet Member • Wiltshire Council Director of Adult Social Services (and operations representative) • Better Care and Adult Social Care transformation programme management • Representatives of the 3 acute hospitals and AWP (Mental Health provider)	Meets monthly
Undertakes detailed work on finances, risk and outcomes – signing off reporting to NHS England.	**Better Care Finance and Performance Group** • Finance officers • Performance officers • Commissioning and operations officers • Better Care Fund Work stream leads, Wiltshire CCG and Wiltshire Council as appropriate. • Public Health Scientist • Provider representatives	Meets monthly
Includes a delayed discharge working group, producing a recovery Discharge	Delivery Groups	Meets monthly

Plan		

Appendix 1

Joint Commissioning Board (JCB) Terms of Reference

1. Duration

The terms of reference will be reviewed as required, with the minimum of an annual review.

2. Purpose of the JCB

2.1 The JCB will act as an advisory body to the two commissioning organisations (Wiltshire Council and Wiltshire Clinical Commissioning Group), making jointly agreed recommendations for change.

2.2 The JCB will include a Part 2 of the agenda which includes representatives of the Avon and Wiltshire Mental Health Partnership NHS Trust, the acute and adult community service providers enabling a Wiltshire system check of recommendations and progress against plans.

2.3 The JCB will build on a shared vision for the commissioning and development of services, taking into account:

- Local needs and local priorities, as set by the Wiltshire Health and Wellbeing Board (HWB) through the JSA and the Joint Health and Wellbeing Strategy
- An evidence-base of what works to deliver the best outcomes for local people
- A focus on early, creative preventive approaches, based in local communities
- A shared understanding of risk
- A need for improved information, advice and signposting about services available to people, including services available from the voluntary and community sectors
- National direction and national outcomes and frameworks for the NHS and social care.

2.4 The JCB will provide collective governance in relation to the commissioning of health and social care for adults in Wiltshire and to be accountable to the HWB for the delivery of joint commissioning arrangements.

2.5 The JCB will oversee the management of existing joint investments and initiatives.

2.6 The JCB will oversee a targeted programme of activities that exploits opportunities where greater coordination, alignment and/or integration of resources can lead to improved outcomes and efficiency. This could include the recommendation for pooled funds.

2.7 The JCB will ensure that joint commissioning plans are effective and are monitored against the agreed performance measures for each service.

2.8 The JCB will promote and progress the alignment and integration of commissioning plans and deliverables across health and social care, supporting the development of an integrated commissioning function for Wiltshire.

2.9 The JCB will make recommendations to the Wiltshire Council Cabinet and the Wiltshire Clinical Commissioning Group (WCCG) Governing Body on priorities for service redesign, investment and disinvestment: this will include agreeing changes to premises, support

services, and facilities management.

2.10 The JCB will review risks raised by constituent organisations to the delivery of the agreed Health and Wellbeing Strategy and other significant service issues.

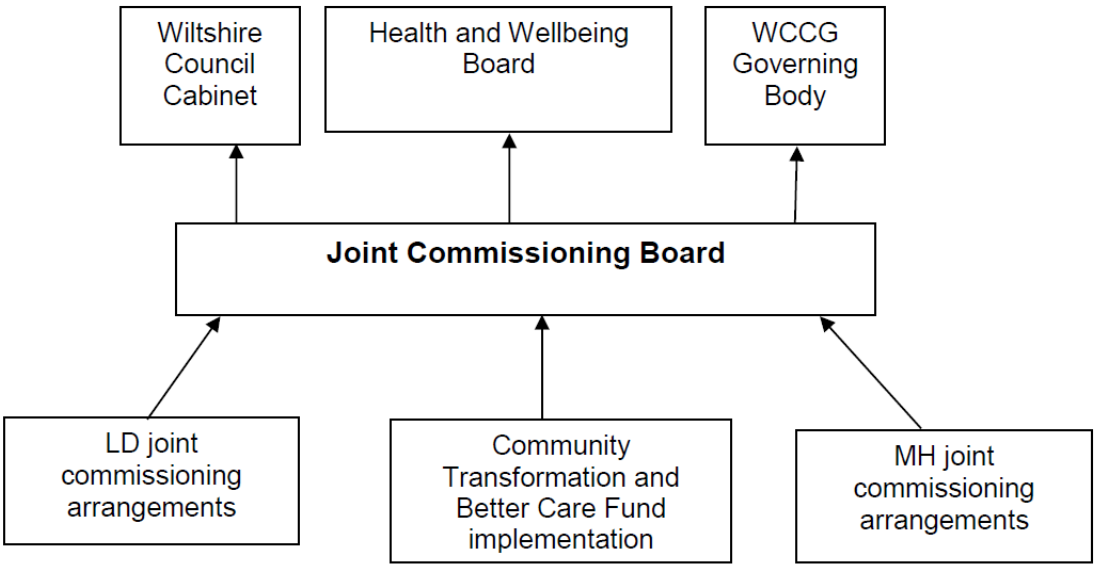
2.11 The JCB will ensure the effective operational performance and implementation of the BCF, and ensure appropriate management of BCF monies.

3 Structure and reporting

3.1 The JCB will work within the schemes of delegation and the accountability arrangements of the Council and the WCCG. Decisions of the JCB will need to be ratified by the Wiltshire Council Cabinet and the WCCG Governing Body. Individual members will be responsible for reporting progress through their organisations' appropriate internal governance arrangements.

3.2 The JCB will report on progress as a minimum of twice each year to the HWB.

3.3 Executive groups will sit beneath the JCB and run the day to day business of each of 3 priority areas for joint commissioning: learning disabilities; mental health; community transformation programme. The diagram below sets out reporting arrangements.



3.4 Frequency of meetings

The JCB will meet 11 times per year (January through November) with meetings being held in private.

3.5 JCB Membership Membership from WCCG

- Clinical Chair of the WCCG (or GP Group Chair as deputy)

- Chief Officer
- Chief Financial Officer
- Chief Operating Officer
- Director of Quality (or nominated deputy)
- Director of Planning, Performance and Corporate Services
- Director of Primary and Urgent Care and Group Director of West
- Acting Director of Acute Commissioning and Group Director of Sarum
- Community and Joint Commissioning Director and Group Director North and East Wiltshire (NEW)

Membership from Wiltshire Council

- Corporate Director
- Associate Director – Adult Care Commissioning, Safeguarding and Housing Associate Director – Finance (or nominated deputy)
- Consultant in Public Health
- Lead Transformation Consultant
- Head of Commissioning, Community Services
- Head of Housing - Strategy & Assets
- Assistant Head of Service, Specialist Commissioning
- Cabinet Member

Other Attendees

- Director of Transformation and Integration (Joint post)
- Transformation Consultant, Adult Social Care
- Representative from Great Western Hospital NHS Foundation Trust
- Representative from Royal United Hospitals Bath NHS Foundation Trust
- Representative from Wiltshire Health and Care
- Representative from Salisbury NHS Foundation Trust
- Representative from the Avon and Wiltshire Mental Health Partnership NHS Trust

Other attendees in an advisory/supporting role as required.

Part 2 attendees

- Chief Operating Officer or nominated deputy – Salisbury Foundation Trust
- Chief Operating Officer or nominated deputy – Royal United Hospital Bath
- Chief Operating Officer or nominated deputy – Great Western Hospital
- Chief Operating Officer or nominated deputy – Wiltshire Health and Care
- Chief Executive or nominated deputy – Avon and Wiltshire Mental Health Partnership NHS Trust

3.6 Quoracy

The meeting will be quorate with the following attendance as a minimum

- Clinical Chair of the WCCG (or GP Group Chair as deputy)
- WCCG Chief Officer, Chief Financial Officer or Chief Operating Officer
- At least one of the CCG Group Directors
- Director of Quality (or nominated deputy)
- WC Corporate Director (or an Associate Director as deputy)
- WC Associate Director - Adult Care Commissioning, Safeguarding and Housing (or nominated deputy)
- WC Associate Director - Finance (or nominated deputy)

- Head of Commissioning, Community Services (or nominated deputy)
- At least one Chief Operating Officer or nominated deputy from the provider organisations

Where a role is unable to attend and quoracy is unaffected; but the agenda dictates; nominated deputies may be invited to contribute to specific agenda items.

3.7 Agenda

The agenda for each meeting will be agreed by the Chair and Vice Chair via email.

3.8 Chair

From July 2017, the WCCG Chief Officer will chair the JCB, with the Wiltshire Council Corporate Director acting in the role of Vice Chair. The role of Chair will rotate annually between the WCCG Chief Officer and the Wiltshire Council Corporate Director.

3.9 Conflicts of Interest

The Chair will ensure that conflicts of interest are formally disclosed and managed in adherence with the Nolan Principles for Standards in Public Life and in favour of the commissioning of high quality, safe and cost effective services.

3.10 Joint Commissioning Board Support

In line with the alternation of the Chair, the secretariat support will also rotate annually between the WCCG and Wiltshire Council. Whoever is Chair, the administration of the meeting falls to the other organisation, with support from July 2017 being with the Council.

Appendix 2

Integration and Better Care Board
Terms of Reference

1. Duration

1.1 The terms of reference will be reviewed as required, with the minimum of an annual review presented for agreement to the chair of the WCCG and the lead Council cabinet member for adult social care, following review at the Joint Commissioning Board.

2. Purpose of the Integration and Better Care Fund Board

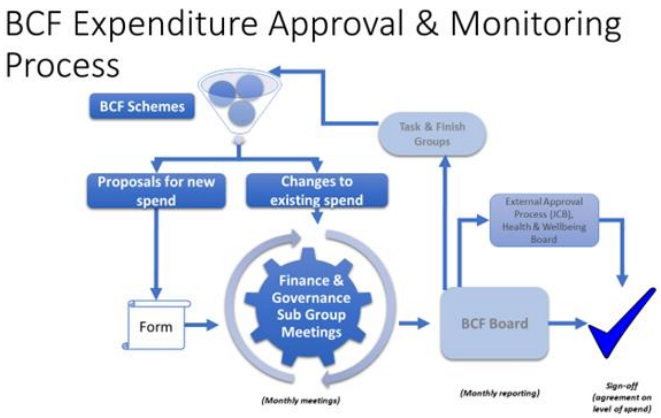
2.1 The Integration and Better Care Fund Board (BCF Board) is tasked with overseeing Wiltshire's participation in the Sustainability and Transformation Partnership – in particular, the development of an Accountable Care System, local strategic commissioning arrangements and future contracting mechanisms for a local accountable care alliance. The Board will also oversee the management of the pooled budget for the Better Care Fund and the IBCF Grant investments and initiatives, making agreed recommendations for change and reporting to the Joint Commissioning Board and Health and Wellbeing Board. This will involve strategic planning and oversight for the Better Care Fund, and collectively reviewing outcomes and delivery for the Better Care schemes.

2.2 The Board will oversee the BCF programme of activities that exploits opportunities where greater coordination, alignment and/or integration of resources can lead to improved outcomes and efficiency.

2.3 The Board will ensure that BCF and IBCF plans are effective and are monitored against the agreed performance measures for each funded project/pilot or workstream. The Board will provide senior strategic level focus on the BCP and provide reports and recommendations to the JCB in their role as formal decision makers in the use of the fund.

2.4 The Board will make recommendations on priorities for the BCF and IBCF for service redesign, investment and disinvestment. Where necessary it can agree use of the fund inbetween JCB meetings, where the Council and WCCG representatives are in agreement (up to the financial limits specified in Wiltshire Council and Wiltshire CCG's own financial scheme of delegation).

3.0 Structure and reporting



3.1 A Better Care Plan Finance and Governance Group will report into the Better Care Fund Board (see separate terms of reference). Other appropriate delivery groups will also be established on topics such as delayed transfers of care (and other high impact changes that can be made) and report into the Joint Commissioning Board and Health and Wellbeing Board

3.6 The BCF Board will work within the schemes of delegation and the accountability arrangements of the Council and the WCCG. Individual members will be responsible for reporting progress through their organisations' appropriate internal governance arrangements.

3.7 The BCF Board will report regularly (at least 6 times per year, if not at each meeting) to the Joint Commissioning Board via the programme management arrangements for the use of the fund.

4. Frequency of meetings

4.1 The BCF Board will meet monthly.

5. Membership

- WCCG Chair
- WCCG Chief Accountable Officer
- Wiltshire Council Cabinet Member
- Wiltshire Council Director of Adult Social Services (and operations representative)
- Better Care and Adult Social Care transformation programme management
- Representatives of the 3 acute hospitals and AWP (Mental Health provider)
- Wiltshire Health and Care

6. Quoracy

6.1 The meeting will be quorate with the following attendance as a minimum:

- Chief Officer from the Wiltshire Clinical Commissioning Group
- Director of Adult Social Care Wiltshire Council
- One acute provider representative

6.2 Where a role is unable to attend and quoracy is unaffected; but the agenda dictates; nominated deputies may be invited to contribute to specific agenda items.

7. Agenda

7.1 The agenda for each meeting will be agreed by the Chair via email.

8. Chair

8.1 This will alternate between the Accountable Officer WCCG and Adult social care Director Wiltshire Council.

9. Conflicts of Interest

9.1 The Chair will ensure that conflicts of interest are formally disclosed and managed in adherence with the Nolan Principles for Standards in Public Life and in favour of the commissioning of high quality, safe and cost effective services.

10. Better Care Fund Board Support

10.1 The Joint Commissioning Board support officer (which rotates between Wiltshire Clinical Commissioning Group and Wiltshire Council).

Appendix 3

Better Care Fund Finance & Performance Delivery Group
Terms of Reference

1.1 The Integration and Better Care Board oversees the delivery of Better Care Plan schemes

2.1 The terms of reference will be reviewed as required, with the minimum of an annual review by the Integration and Better Care Board.

3.1 The Finance & Performance Sub Group has two elements:

4.1 The Group will ensure appropriate management of BCF monies & iBCF.

4.2 The Group will act as an advisory body to the two commissioning organisations (Wiltshire Council and Wiltshire Clinical Commissioning Group), making jointly agreed recommendations in relation to new spend to the BCF Board and JCB.

4.3 The Group will receive and agree reports on the monthly financial position of the BCF and the iBCF.

4.4 Subject to paragraph [INSERT] of Schedule 3, the Group will agree the use of any underspends within each scheme or the overall Programme.

4.5 The Group will agree the use of any slippage within each scheme or the overall programme.

4.6 Subject to paragraph [INSERT] of Schedule 3, the Group will consider what action to take in respect of any actual or potential overspends.

4.7 The Group will sign off financial reporting to NHS England and support the Joint Heath & Care Integration Director in meeting reporting requirements in accordance with relevant National Guidance.

4.8 The Group will receive and review scheme / investment business cases and make recommendations to the Integration and Better Care Board for further investment.

4.9 The Group will make recommendations about cessation of projects in order that resources can be diverted and reprioritised.

5.1 The Group will monitor delivery of existing projects within the Better Care Programme.

5.2 The Group will ensure that specific performance recovery action is put in place where programmes are failing to deliver on their defined objectives.

5.3 The Group will review reporting on emerging programme pressures and wider system pressures across Health & Social Care.

5.4 The Group will sign off new projects with approval of Milestones / Quality Impact including

Equality and Deliverables and make recommendations to the JCB.

5.5 Assist in managing the agenda of the BCF Board by identifying issues that need further joint discussion or decisions.

5.6 Review the established Programme Risk Register and assess contingencies ad mitigating actions.

5.7 Review the BCF Performance Dashboard and agree key actions and areas for escalation to the BCF Board

6.1 The Finance & Governance Sub Group will meet monthly.

6.2 For budget monitoring purposes a standard reporting template will be used and the Council has responsibility for pulling the reporting together with input from WCCG.

6.3 Reporting to NHSE on spend will be co-ordinated by the Council, with input from WCCG.

6.4 Any other financial reporting requirements will be dealt with by either party as appropriate.

6.5 All other reporting will be on the lead party's templates.

7.1 The role of Chair will be the Chief Finance Officer Wiltshire Clinical Commissioning Group or Director of Finance Wiltshire Council vice Chair Director of Transformation and Integration

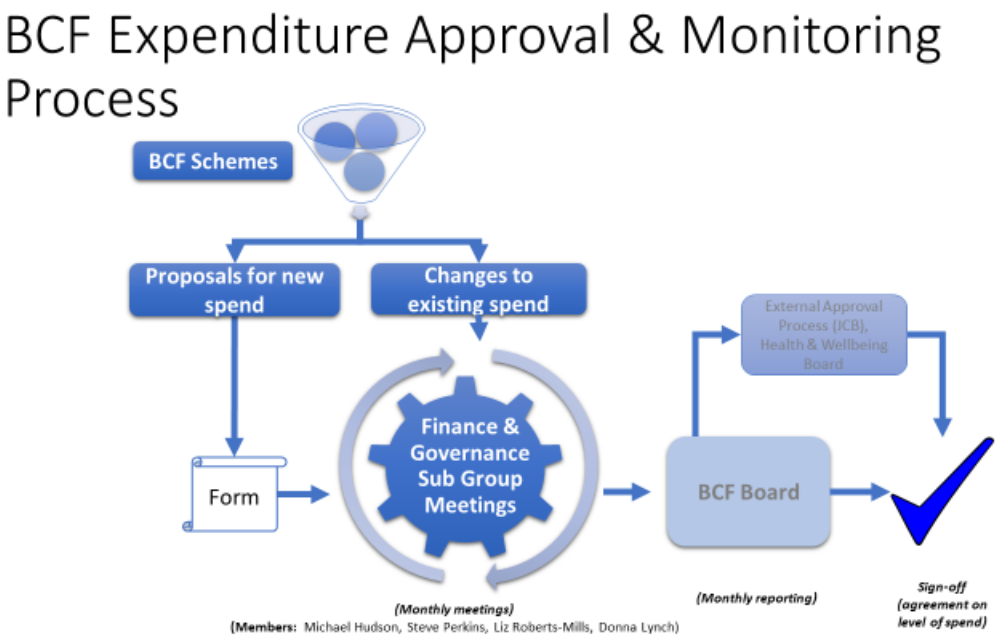
8.1 Membership will consist of:

- Director of Transformation and Integration
- Director of Finance, Wiltshire Council
- Chief Finance Officer, Wiltshire CCG
- Head of Finance, Wiltshire CCG
- Head of Finance, Wiltshire Council
- Director of Planning, Performance and Corporate Services, Wiltshire CCG
- Head of Performance, Health and Workforce, Wiltshire Council
- Director of Adult Social Care, Wiltshire Council
- Director of Commissioning, Wiltshire Council
- Better Care Fund Work stream leads, Wiltshire CCG and Wiltshire Council as appropriate.
- Public Health Scientist
- Acute and AWP representatives
- Wiltshire Health and Care representative
- Named leads for each of the high impact changes

8.2 All attendees must be flexible in making themselves available but there is no quorum. In the event that the above individuals cannot attend they should arrange for an empowered deputy to attend or pre-brief accordingly.

9.1 Below is a flow diagram of both the monthly budget monitoring process together with the new

expenditure approval process.



10.1 These Terms of Reference will be reviewed as required by the Integration and Better Care Board.

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Code	Indicator Name	Defn	RAG	Change	Current Value	Current Period	Last Value	Last Period	Last Updated	Target Value	Target Period	Commentary	Comments	BCF Scheme Impact	Source
National – Better Care Fund – Pay for Performance															
P4P	Non Elective Admissions	Number of Non Elective Admissions		↓	10,098	Jan-16 to Mar-16 (Forecast based on Jan-16 & Feb-16)	9,969	Jan-16 to Mar-16 (Forecast based on Jan-16)	07-Apr-16	N/A		P4P Monitoring covered the 12 months to end of December 2015 January MAR data showed 3,327 & 3,405 in February G&A Non Elective admissions			MAR Data
		Rate per 100,000 population of non elective admissions		↓	2,071	Jan-16 to Mar-16 (Forecast based on Jan-16 & Feb-16)	2,046	Jan-16 to Mar-16 (Forecast based on Jan-16)	07-Apr-16	N/A		The forecast rate per 100,000 population for the quarter and shows a reduction of around 15 admissions per 100,000 population			MAR Data
National – Better Care Fund – Supporting Measures															
BCF1	Permanent admissions to residential or nursing homes	Number of permanent admissions to care homes			491	Mar-16	436	Feb-16	07-Apr-16	575	2015-16	This is provisional year end data. The net number of permanent admissions in March was 55 which is above the monthly average. The overall figure is 84 under the 15-16 target. Data cleaning still requires to be completed and the figure will not be finalised until this has been undertaken.			SALT Tables
		Rate per 100,000 population of permanent admissions to care homes			495	2015-16 (Provisional)	479	Feb-16 (Based on ……..FOT)	07-Apr-16	594	2015-16				
BCF2	Reablement	¼ of people discharged to rehabilitation who are still at home 91 days post discharge		↑	85.0	Jul'15 to Sept'15 Discharges	82.2	Apr'15 to Jun'15 Discharges	17-Feb-16	86%	2015-167	This represents all discharges up to the end of …. In Q2 the streaming data for IC patients ….. performance to ….. Overall we are now at the BCF Target. Our position with respect to the final indicator for 2014-15 was 83.9 which represents an improvement on 13-14 (78.9) although below the target 85.	NT – 87.6 IC – 86.3 ISP - 65.2		NT & Care First
BCF3	Delayed transfer of care (Days)	Average number of delayed days in the month.		↓	4,689	Jan-16 to Mar-16 (Based on Jan-16)	4,735	Oct-15 to Dec-15	10-Mar-16	4,110	Oct-15 to Dec-15	This shows the latest data as published by NHS England, which showed 1,563 delayed days in January which is a slight	In January there was an increase in delayed days at AWP and other Hospitals, while GWH and SFT saw		NHS England

		Rate per 100,000 population of average delayed days per month		↓	1,231	Jan-16 to Mar-16 (Based on Jan-16)	1,243	Oct15 to Dec-15	10- Mar-16	1,079	Oct-15 to Dec-15	decrease on the 1,662 seen in December. This is 193 delayed days over the monthly target of 1,370	delayed consistent with recent months. WCH and RUH saw a slight deceases in delay		NHS England
BCF5	Local Metric Dementia Diagnosis Rate	Percentage of people diagnosed with Dementia as a proportion of the likely number of people with dementia			65.6	Feb'16	64.7	Jan'16	17-Mar-16	66.7%	2015-16	January and February saw a big increase in the number of patients diagnosed with Dementia. Wiltshire is 1.1% below the national target. 21 out of the 56 practices are higher than the target figure and 19 out of the 56 practices have a percentage below 50%. The CCG continues to engage with all practices below the target to support them in achieving the target and a further 70 diagnoses would result in the target being hit.	Date provided by CCG. Recovery plan being developed to be agreed at the next CCG Group meeting.		HSCIC, CCG
BCF6	Patient/Service User Experience Metric												Yet to be defined.		
Wiltshire – Better Care Fund – Supporting Measures															
P4P1	Avoidable emergency admissions	Number of avoidable emergency admissions		↑	7,805	Apr-15 to Feb'15	7,618	Apr'14 to Feb'15	07-Apr-16	N/A	N/A	Data provided by CS CSU. This is no longer a specific BCF target. To M11 admissions are around 2.4% ahead of 2014-15, which is an increase on the position to M10 (2.3%)	Admissions for those aged 65 and over are 1.7% ahead of 2014-15 (4,194 vs 4,264) Admissions for those aged under 18 are around 13.5% ahead of 2014-15 (1,196 vs 1,357) Admissions for those aged 18 to 64 have fallen by around 2% (2,228 vs 2,184)		CS CSU, SUS
		Annual Rate per 100,000 population of avoidable emergency admissions		↑	1,747.7	2015-16 (FOT based on Apr'15 to Feb'16)	1,749.6	2014-15	07-Apr-16	N/A	N/A	This represents the annual rate based on a simple forecast outturn calculation. As the current monthly average of 2015-16 is slightly below the 2014-15 monthly average the rate is slightly lower than 2014-15.			CS CSU, SUS
P4P2	Admissions from Care Homes	Number of admissions from Care Homes		↓	1,332	Apr'15 to Dec'15	1,552	Apr'14 to Dec'14	18-Feb-16	N/A	N/A	The YTD reduction in admissions from care homes is 15% (230) Reductions have been seen across all CCG Groups with the biggest in WWYKD a reduction of 28% (149), the reduction SARUM is 10% (40), and			CS CSU, CCG

												NEW the reduction is 2% (11).			
DT0C1	Delayed transfers of care (People)	Average number of people delayed at midnight on the last Thursday of the		↑	62	Apr-15 to Jan-16	59	Apr-15 to Dec-15	10-Mar-16	N/A	N/A	The number of people delayed increased to 88 in January from around 80 in December. Around two thirds of the delays are Health delays (57), while around three tenths social care (25) Of the 25 Social Care delays only around a third were in Acute hospitals (9) while the remainder are at AWP 98) and WCH (8).			NHS England
		Rate per 100,000 population of average delays per month		↑	16	Apr-15 to Jan-16	15	Apr-15 to Dec-15	10-Mar-16	N/A	N/A				NHS England
IC1	Intermediate Care – Number of Admissions	Number of intermediate care admissions to both Step down and Step Up Beds			58	Feb-16	65	Jan-16	17-Mar-16	N/A	N/A	50 Step Down and 8 Step Up.	Work on improving data …. is ongoing in particular streaming date which began in December. Streaming data did not seem very complete in the February data.		IC Team
IC2	Intermediate Care – Number of Discharges	Number of intermediate care discharges from both Step down and Step Up Beds			67	Feb-16	58	Jan-16	17-Mar-16	N/A	N/A	59 Step Down and 8 Step Up.			IC Team
IC3	Intermediate Care – Average LoS	Average length of stay for all discharges from intermediate care beds.			31.8	Feb-16	47.5	Jan-16	17-Mar-16	N/A	N/A	Step Down was 33.1 while Step Up was 22.4			
ASC1	Help to Live at Home & Domiciliary Care Number of new clients	Number of new HTLAH Clients			113	Mar-16	125	Feb-16	07-Apr-16	N/A	N/A	This provides additional data on Domiciliary Provision in addition to Help to Live at Home. There has been a slight decrease in new clients in March.			Care First
ASC2	Help to Live at Home & Domiciliary Care Number of clients	Number of HTLAH Clients supported in April.			1,385	Mar-16	1,409	Feb-16	07-Apr-16	N/A	N/A	This provides additional data on Domiciliary Provision in addition to Help to Live at Home. There has been a slight decrease in existing clients during March.			Care First
UC at Home 1	Urgent Care at Home – Number of Patients	The number of patients referred to			79	Feb-16	84	Jan-16	29-Mar-16	N/A	N/A	The number of referrals in February was slightly lower than January.			Medvivo

		urgent care at home													
UC at Home 2	Urgent Care at Home – Adms Avoided %	The percentage of patients referred who did not require admission to hospital			79.7	Feb-16	76.2	Jan-16	29-Mar-16	N/A	N/A	The number of admissions avoided was 63 which is above the monthly average for 2015-16			Medvivo

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Wiltshire Council

Health and Wellbeing Board

25 January 2018

Subject: Wiltshire's Pharmaceutical Needs Assessment 2018

Executive Summary

1. Wiltshire's Health and Wellbeing Board (HWB) Pharmaceutical Needs Assessment (PNA) has been written to meet the requirements set out in the Health and Social Care Act 2012. The legislative basis for developing and updating PNAs is set out by the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.

2. The PNA maps current provision, assesses local need and identifies any gaps in provision. The PNA is a key tool for identifying what is needed at a local level to support the commissioning intentions for pharmaceutical services and other services delivered by community pharmacies and other providers.

3. The public consultation on the draft PNA has been completed and the PNA revised accordingly for final sign-off by the HWB.

Proposal(s)

That the Health and Wellbeing Board:

- Notes the public consultation feedback on the draft PNA document.
- Approves the final PNA 2018 document to come into effect as of 01 April 2018.

Reason for Proposal

In line with NHS regulations, the HWBs PNA must go out to public consultation for a minimum of 60 days prior to final sign-off by the Health and Wellbeing Board.

Tracy Daszkiewicz
Director of Public Health

Wiltshire Council

Health and Wellbeing Board

Date of meeting 25 January 2018

Subject: Wiltshire's Pharmaceutical Needs Assessment 2018

Purpose of Report

1. The purpose of this report is to present the final Wiltshire Pharmaceutical Needs Assessment for approval by the HWB (Appendix 1).

Background

2. Wiltshire's Health and Wellbeing Board Pharmaceutical Needs Assessment (PNA) 2018, has been written to meet the requirements set out in the Health and Social Care Act 2012, which transferred responsibility for the developing and updating of PNAs to health and wellbeing boards (HWBs) from Primary Care Trusts (PCTs). The legislative basis for developing and updating PNAs is set out by the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.

3. The PNA maps current provision, assesses local need and identifies any gaps in provision and is a key tool for identifying what is needed at a local level to support the commissioning intentions for pharmaceutical services and other services delivered by community pharmacies and other providers.

4. The development of the PNA in Wiltshire has been led by a PNA Steering Group. A variety of methods were used to develop the document, including drawing on a range of information sources, public and contractor questionnaires and consultation with a range of partners and included data from the Joint Strategic Needs Assessments for Wiltshire.

5. The information gathered from the various sources has been synthesized to provide a comprehensive picture of the population of Wiltshire, their current and future needs and how pharmaceutical services can meet these needs and support future improvements in the health and wellbeing of our population.

6. Wiltshire has a total of 73 community pharmacies and a population of approximately 488, 409. This represents 14.5 pharmacies per 100,000 population. In addition, there are 25 Dispensing General Practices, which serve the more rural parts of the County. There is a range of local provision of Advanced and Enhanced Pharmacy Services in Wiltshire, much more detail of which is provided within the Wiltshire PNA.

7. Pharmacy opening hours in Wiltshire vary, with a range of daytime, evening and weekend opening provided. Seven community pharmacies provide a 100 hour service, eight are open at least one late evening per week and ten open on Sundays. The range of pharmacy provision in Wiltshire extends to meet the needs of various specific diseases, different populations and also lifestyle choices.

Main Considerations

Engagement and Consultation

8. In September 2017, the HWB approved the draft PNA 2018 document for 60-day public consultation which took place between September and December 2017. The draft document was uploaded onto the Wiltshire Council website with an accompanying online survey to determine if the document was fit for purpose.

9. The consultation generated 10 responses using the online survey format. An addition 3 responses were received via email. Six respondents identified themselves as health or social care professionals, three as members of the public and three were responding on behalf of neighbouring health and wellbeing boards. One response was received from the Local Pharmaceutical Committee.

10. 8/13 respondents felt that the that the information contained within the draft PNA accurately reflected the current pharmacy and prescription dispensing services available in Wiltshire; 2/13 felt they did not know (both members of the public) one (a health care professional) said that it did not and two respondents provided additional information to support the redrafting.

11. 6/13 felt that the population needs had been adequately in the PNA document, two did not know (both members of the public) and two said that the PNA did not reflect the needs – they both provided additional information as to why the document did not reflect need and their views were considered as part of the redrafting.

12. 5/13 believed that the future pharmaceutical needs of Wiltshire will be met in the next 3 years; three did not know (members of the public); 3/13 felt that the future needs of Wiltshire would not be met by the PNA and provided additional information which was considered as part of the redraft. 7/13 respondents agreed with the final conclusions of the draft PNA.

13. Certain responses flagged up typing-errors and queries over data. Member of the public responses were very specific to personal needs around the need for providing help to older people, having medicines in-stock, having pharmacies open at lunch time, the need for medicines to be delivered. Typing-errors and data queries have been rectified in the final PNA document. The issues raised by the members of the public were addressed in the original draft document so no additional changes have been made. The members of the public did make comments suggesting the need for pharmacies to better promote the services they do offer (such as delivery, dosette boxes etc).

14. Two responses highlighted that there was lack of effectively consultation with younger people. The focus of the 2018 survey was to highlight the potential pharmaceutical needs of carers (including young carers), as the current (2015) PNA focussed on engaging with young people the steering group wished to change focus for the 2018 PNA.

15. From the responses on behalf of three other HWB, one HWB felt that we had sufficiently highlighted cross-border services and one HWB felt that there was no significant ‘cross-border traffic’ with Wiltshire and thus resulted in no service gaps. The final HWB felt that the Wiltshire PNA did not clearly identify which of their

pharmacies Wiltshire residents were using. As 97% of prescription dispensing occurs within the county, and the remaining 3% between Swindon and Hampshire, it was felt that cross-border pharmacy access was too minimal to identify specific pharmacies accessed.

16. Another response highlighted the additional role that pharmacies have to play in antimicrobial resistance and the use of pharmacists in care homes. Pharmacists have a very clear role to play in antimicrobial resistance but this is cross cutting and does not require specific mention in the PNA. The provision of services to care homes across Wiltshire is currently a non-commissioned service, but this does not mean that pharmacies do not provide care home services. Although a service is not commissioned this leaves future scope to be and several pharmacies in response to the PNA said they would be willing to provide the service if commissioned and in receipt of sufficient training. A member of the public highlighted the need for better integrated working between community pharmacies, NHS commissioners and local health and social care organisations.

17. Comprehensive feedback was provided from the Local Pharmaceutical Committee most of which has been incorporated into the final draft. The public survey also prompted feedback from a primary care practice over concerns that the PNA does not support changes to local healthcare provision as the result of practice mergers. The feedback has been considered and where appropriate has been incorporated into the final PNA document. Although practices merge and practice populations increase, local community area populations may not increase as a result meaning there is not a justified need for additional pharmacy services. That said, should there be changes to the populations size or health and wellbeing needs of the population, then this can be considered when approving pharmacy premises. The PNA recognises no current gaps in provision but additional an updated / supplementary PNA document can be issued as appropriate.

18. Of the 13 responses received, 11 provided additional information in support of their views. These views were taken into consideration as part of the redrafting and as a result around 50 amendments have been made to the original document to reflect these views, as appropriate. A summary of the changes to the document can be found in Appendix 2: Summary of Changes.

Consultation on Neighbouring Authority PNAs

19. HWBs must also consult with other HWBs areas with which they border, for which Wiltshire borders with B&NES, West Berkshire, Hampshire, Gloucestershire, South Gloucestershire, Somerset, Dorset, Swindon and Oxford and similarly each HWB may consult with ours. The responsibility for responding to these consultations was delegated to the PNA lead, public health consultant, Steve Maddern to respond on behalf of the HWB.

20. As of 04 January 2018, 6 neighbouring local authority areas had released their PNA documents for consultation to which we have responded. These authorities are: Gloucestershire, BANES, Swindon, West Berkshire, Hampshire and South Gloucestershire. All PNA recognise Wiltshire and other cross-border neighbours as part of their PNAs with limited issues arising. A summary of the consultation responses is provided in appendix 3.

Implementation and Delivery

21. The PNA 2018 document is required to be in place on or before 01 April 2018. The document will then be used by HWB and stakeholders to understand the pharmaceutical needs of the local population; gain a clear picture of community pharmacy services currently provided; make appropriate recommendations regarding applications for NHS pharmacy contracts; commission appropriate and accessible services from community pharmacy; clearly identify and address any local gaps in pharmaceutical services and consider the potential of community pharmacy in contributing to the redesign of health services

22. In addition to the above, the PNA will be used by NHS England to inform decision making on applications for new pharmacies; applications to change the premises from which a listed pharmacy business is allowed to provide pharmaceutical services and to change the pharmaceutical services that a listed pharmacy business provides.

Overview & Scrutiny Engagement

23. The established PNA Steering Group provided the initial overview and scrutiny of the PNA development process and had oversight of the initial PNA draft prior to the initial and final submissions to the Health and Wellbeing Board.

Governance

24. The completed PNA remains the responsibility of the Health and Wellbeing Board to be published on a 3-year basis under the health and social care act 2012, and in line with the NHS regulations for pharmaceutical services.

Next Steps

25. HWB to approve final document for publication. PNA 2018 document will replace current (2015) document as of 01 April 2018.

Tracy Daszkiewicz
Director of Public Health

Report Author:

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03 January 2017

Background Papers

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

Final Wiltshire Pharmaceutical Needs Assessment 2018

Appendices

Appendix 1: Final Wiltshire Pharmaceutical Needs Assessment 2018
Appendix 2: Summary of Changes
Appendix 3: Cross-border consultation responses

Wiltshire Pharmaceutical Needs Assessment 2018

a single version of the truth

NHS Wiltshire Clinical Commissioning Group

Wiltshire Council Where everybody matters

Wiltshire Assembly Public Services Board

Edition

Edition	Version no.	Changes/Comments
1.0	1.0	Initial draft (10 August 2017)
1.1	1.1	Amended based on feedback from the PNA steering group (September 2017)
2.0	1.0	Amended based on feedback from public and professional consultation (January 2018)

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With input from: Wiltshire PNA Steering Group and data provided by Wiltshire Council Public Health Scientists.

EXECUTIVE SUMMARY

Background

This document describes Wiltshire Health and Wellbeing Board's Pharmaceutical Needs Assessment (PNA), which has been written to meet the requirements set out in the Health and Social Care Act 2012, which transferred responsibility for the developing and updating of PNAs to health and wellbeing boards (HWBs) from Primary Care Trusts (PCTs). The legislative basis for developing and updating PNAs is set out by the *National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.*

The Pharmaceutical Needs Assessment is a key tool for identifying what is needed at a local level to support the commissioning intentions for pharmaceutical services and other services that could be delivered by community pharmacies and other providers. The Pharmaceutical Needs Assessment maps current provision assesses local need and identifies any gaps in provision.

Development of the PNA in Wiltshire

The development of the PNA in Wiltshire has been led by a Wiltshire Pharmaceutical Services Strategy Group. Various methods were used to develop the document, including drawing on a range of other information sources, public and contractor questionnaires and consultation with a range of partners.

The information gathered from the various sources has been synthesized to provide a comprehensive picture of the population of Wiltshire, their current and future needs and how pharmaceutical services can meet these needs and support future improvements in the health and wellbeing of our population.

Health Needs in Wiltshire

Wiltshire is a large, predominantly rural county with a 2016 mid-year population estimate of 488, 409 which is expected to increase to 516, 000 in 2026. Almost half of the population resides in towns and villages with fewer than 5,000 people and a quarter live in villages of fewer than 1,000 people. The population in the South West has higher life expectancy than England as a whole and people in Wiltshire live longer than the general population in the South West.

The two major causes of premature death nationally, and in Wiltshire, are circulatory disease (including coronary heart disease and stroke) and cancers. Overall, mortality from all causes in the under 75 age group has been declining in Wiltshire, the South West and England.

The Wiltshire Joint Strategic Needs Assessment has been used to provide a comprehensive account of the wider diseases and conditions which cause mortality and morbidity in Wiltshire, as described in Chapter 5. This chapter also highlights key strategic priorities for improving health and wellbeing in Wiltshire, including improving life expectancy and reducing health inequalities

As well as considering the wider health needs of the population of Wiltshire, the needs of specific groups are described within the PNA, along with the lifestyle factors which influence health.

Current Provision and Use of Pharmaceutical Services in Wiltshire

Wiltshire has a total of 73 pharmacies of which 2 are registered as distance-selling pharmacies. With 71 community pharmacies and a population of approximately 488, 409. This represents 14.5 pharmacies per 100,000 population. In addition, there are 25 Dispensing General Practices, which serve the more rural parts of the County.

There is a range of local provision of Advanced and Enhanced Pharmacy Services in Wiltshire, much more detail of which is provided within the Wiltshire PNA.

Pharmacy opening hours in Wiltshire vary, with a range of daytime, evening and weekend opening provided. Seven community pharmacies provide a 100 hour service, eight are open at least one late evening per week and ten open on Sundays.

The range of pharmacy provision in Wiltshire extends to meet the needs of various specific diseases, different populations and also lifestyle choices.

Regulations

Regulations 3-9 and Schedule 1 of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 set out the requirements for PNAs.

They require HWBs as a minimum to make statements on the following:

1. Current provision of necessary services (both within the Health and Wellbeing (HWB) locality area and nearby areas outside the locality)
2. Gaps in provision in terms of necessary services
3. Current provision of other relevant services
4. Gaps in provision of services that would secure improvements and better access to pharmaceutical services
5. Other NHS services
6. How the assessment was carried out.

The regulations also require the PNA to include a map identifying the premises at which pharmaceutical services are provided in the HWB area.

Current provision of necessary service and gaps in provision: Wiltshire currently has 73 community pharmacies, 25 Dispensing General Practices, and two distance selling pharmacy. All pharmacies are required to deliver and comply with specifications for all essential services, and as evidenced in this document, the HWB believes that the current number, location and opening times/days of pharmacies is sufficient for a supplying a necessary service with no gaps.

Current provision of other relevant services and gaps in provision: The provision of other relevant services provided through community pharmacy in Wiltshire are evidenced in this document and have secured improvements in better access to service

provision through services such as Medicines Use Review, pharmaceutical services specifically for care homes, Needle and Syringe Exchange, and supervised consumption services. The PNA has not identified any gaps in provision of other relevant services which would secure improvements or better access to pharmaceutical services.

Other NHS services: The provision of other NHS services arranged by the local authority is detailed in this document and the HWB has identified the level of this service to be sufficient with no gaps.

The process of conducting the PNA is detailed in chapter 4. The process and consultation were carried out in accordance with the regulations.

Map of provision: A map which identifies the premises at which pharmaceutical services are provided in the area of the HWB is included in this document in addition to maps which detail the premises at which pharmaceutical services are provided within each community area in Wiltshire.

Conclusion

Taking into account local demography and the provision of pharmaceutical services in Wiltshire, it is evident that there is adequate provision of such facilities. Services are accessible in a range of locations and in a variety of set ups.

Each Community Area has at least one Community Pharmacy within it, and the opening hours of these pharmacies generally reflect the population density. Although there is no requirement in the regulations around future service needs, there are some potential population changes anticipated during the lifetime of the PNA in regard to the relocation of military personnel and family, mergers of GP practices (actual and potential) and anticipated population changes due to housing expansion in Wiltshire and South Swindon.

There is a variation in the range of enhanced services provided across Wiltshire and within the different Community Areas. This provision is reflective of need, with specific enhanced services being delivered in areas where disease and lifestyle factors suggest they are required. There is however scope for further development in relation to the provision of enhanced services, integration of work between community pharmacy, community hospitals and acute hospitals in Wiltshire.

Although current provision is deemed reflective of population need, future provision maybe required in line with the NHS (pharmaceutical services and local pharmacy services) regulations 2013. The reader should bear these regulations in mind when deciding future pharmacy provision as a result of demographic or population size changes or changes in the health and wellbeing needs of the local populations change. The actual/potential merger of primary care services may or may not cause gaps in local pharmaceutical services but requests from pharmacies to change location or hours of business may cause gaps.

1. INTRODUCTION

This document describes the Pharmaceutical Needs Assessment (PNA) for Wiltshire's Health and Wellbeing Board. It has been written to meet the requirements set out in the Health and Social Care Act 2012, which transferred responsibility for the developing and updating of PNAs to health and wellbeing boards (HWBs) from Primary Care Trusts (PCTs). The legislative basis for developing and updating PNAs is set out by the *National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013,* and can be found at:

http://www.dh.gov.uk/health/2013/02/pharmaceutical-services-regulations/

The regulations required HWBs to have prepared and publish their first PNA by 1 April 2015. After this time HWBs are required to publish a revised assessment within three years of publication of their first assessment; and will be required to publish a revised assessment as soon as is reasonably practical after identifying significant changes to the availability of pharmaceutical services since the publication of its PNA. The next publication is due by 01 April 2018.

Pharmaceutical services in relation to PNAs include:

Essential services – which every community pharmacy providing NHS pharmaceutical services must provide and is set out in their terms of service; the dispensing of medicines, promotion of healthy lifestyles and support for self-care.

Advanced services – services community pharmacy contractors and dispensing appliance contractors can provide subject to accreditation as necessary; these are Medicines Use Reviews and the New Medicines Service for community pharmacists and Appliance Use Reviews and the Stoma Customisation Service for community pharmacists; dispensing appliance contractors. The NHS Urgent Medicines Supply Advanced Service (NUMSAS) is commissioned until 30 September 2018. Seasonal flu immunization for at risk groups over the age of 18 is also now an advanced service for community pharmacies nationally.

Enhanced Services – Responsibility for pharmacy local Enhanced services previously commissioned by PCTs has transferred to NHS England (the Area Team). NHS England does not have the power to direct Clinical Commissioning Groups (CCG) to manage these services on its behalf; however, this does not preclude CCGs or local public health teams from commissioning services locally from community pharmacies.

Currently NHS England commissions a rota arrangement as a Directed Enhanced Service to ensure provision of pharmaceutical services on special bank holidays. This is the only known enhanced service in Wiltshire.

Such services commissioned from pharmacies by NHS Wiltshire CCG or Wiltshire Councils Public Health Team are referred to as Locally Commissioned Services. These, and services provided privately are relevant to the PNA, but as not defined as 'pharmaceutical services' within it.

Community pharmacies are offering an ever-expanding range of clinical services, and are involved in roles to support the safe use of medicines, promote the health and wellbeing of individuals and communities and reduce health inequalities.

The PNA provides a coherent account of the commissioning environment for pharmaceutical services in Wiltshire. This presents a local picture covering demographics, the balance of health needs, our strategic goals which emerged from these findings and our current service needs.

A system of commissioning based on the PNA will enable Wiltshire HWB to target specific local needs and focus decisions on local priorities. Over time, this should help reduce variation in service delivery and make local services more reflective of local needs.

There are three key stages to this:

- assess needs
- map existing services
- identify what needs to change.

This document will enable Wiltshire HWB and key stakeholders to:

- Understand the pharmaceutical needs of the local population
- Gain a clear picture of community pharmacy services currently provided
- Make appropriate recommendations regarding applications for NHS pharmacy contracts
- Commission appropriate and accessible services from community pharmacy
- Clearly identify and address any local gaps in pharmaceutical services
- Consider the potential of community pharmacy in contributing to the redesign of health services

This document sets out a revision of the first PNA, which we have prepared to meet the legal and regulatory requirements set out in the *Health and Social Care Act 2012* and The Pharmaceutical Services and Local Pharmaceutical Services Regulations (NHS, 2013).

It should be noted that the information contained within this PNA was correct and accurate at the time of writing (January 2018).

2. POLICY CONTEXT

The 2006 Pharmaceutical Services Act places an obligation on NHS England to put arrangements in place so that drugs, medicines and listed appliances ordered via NHS prescriptions can be supplied to persons.

The Health and Social Care Act 2012 established HWBs and transferred responsibility to develop and update PNAs from PCTs to HWBs. Responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list transferred from PCTs to NHS England from 1 April 2013.

Commissioning activities within the NHS drive the delivery of better health and well-being for all. HWBs are uniquely positioned to develop and produce the PNA acting in their capacity as local leaders to join up commissioning and services across the NHS, social care, public health and voluntary sector to benefit the health and wellbeing of local people.

Under the terms of the NHS Act 2006, as amended by the Health and Social Care Act 2012, pharmaceutical services may only be commissioned by NHS England. This means that pharmaceutical services (Essential, Advanced or Enhanced) can only be commissioned by NHS England.

Responsibility for pharmacy local Enhanced services previously commissioned by PCTs has transferred to NHS England (the Area Team). NHS England does not have the power to direct Clinical Commissioning Groups (CCG) to manage these services on its behalf, however this does not preclude CCGs from commissioning services locally from community pharmacies.

Pharmacies may also be commissioned to provide any other services for which they are qualified, by:

- Local Authorities (e.g. public health services); and
- NHS Clinical Commissioning Groups (CCGs)
- Other providers and organisations (e.g. NHS acute trusts)

A system of commissioning based on the PNA will help the HWB to target specific local needs and focus subsequent commissioning on local priorities.

"*Healthy lives, healthy people*", the public health strategy for England (2010) says: "Community pharmacies are a valuable and trusted public health resource. With millions of contacts with the public each day, there is real potential to use community pharmacy teams more effectively to improve health and wellbeing and to reduce health inequalities." This is particularly relevant to local authorities as they now have responsibility for public health in their communities.

HWBs now have a statutory duty to publish their revised PNA on or before 1 April 2018. Regulations require HWBs to consult on the contents of their PNA at least once during the process of developing the PNA, that there is a minimum period of 60 days for consultation responses; and those being consulted can be directed to a website address containing the draft PNA but can, if they request, be sent an electronic or hard copy version. (*Regulation 8*).

The Pharmacy White Paper, *Pharmacy in England: building on strengths - delivering the future* (DH, 2008) identified that the PNA will be used to form the basis for decisions to:

- grant applications for new pharmacies
- grant applications to change the premises from which a listed pharmacy business is allowed to provide pharmaceutical services
- change the pharmaceutical services that a listed pharmacy business provides

Taking into account the above confirms why it is important that changes in need for pharmaceutical services relating to the movement of pharmacies but also the movement and merger of GP practice premises.

3. DEFINITIONS AND SCOPE

Pharmaceutical services are defined within the regulations and directions governing pharmaceutical services. Pharmaceutical services can include dispensing practices, pharmacies in acute settings and community pharmacies.

Dispensing doctors are GPs who have been approved to dispense medicines to specific patients on their lists. These patients live in an area that has been designated as controlled by NHS England. Dispensing doctors offer a valuable service in providing dispensing services in rural areas where a pharmacy may not sustain sufficient commercial business to be viable. For the purposes of the PNA, Wiltshire HWB is concerned with whether patients have adequate access to dispensing services, which might include dispensing by GPs, but is not concerned with other services dispensing GPs may provide.

The PNA makes no assessment of the need for pharmaceutical services in acute settings. However, Wiltshire HWB is concerned to ensure that patients moving in and out of these care settings have a pharmaceutical service that ensures the continuity of support around medicines, through the development of more integrated working between community pharmacy, community hospitals and acute hospitals. With the growing development of pharmacists based-in and being employed directly by GP practices, the PNA also recognises the need to build on and develop the more integrated working between community pharmacy and primary care practices.

The contractual framework for community pharmacy is divided into three service levels – essential, advanced and enhanced services.

Essential services are provided by all pharmacy contractors. Advanced services can be provided by contractors once accreditation requirements are met. Enhanced services can be commissioned locally in response to the need of the Wiltshire population. Funding levels for the essential and advanced services are nationally determined. There remains significant scope for commissioning community pharmaceutical services locally, via the Enhanced Service route and through direct commissioning by CCG, Local Authorities and others. A review of enhanced and other locally commissioned service is included in the scope of the PNA.

The PNA regulations require that Wiltshire HWB divides the area it commissions services for into localities. These are then used as a basis for structuring the assessment. Twenty Community Areas have been identified within the county of Wiltshire for a number of years. In most parts of the county, the Community Areas include a market town and its surrounding villages. For the purposes of the PNA, consideration has been given to the needs and provision in each of these community areas.

The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013: Regulation 8: states that HWBs must consult the bodies listed below at least once during the process of developing the PNA:

- Any Local Pharmaceutical Committee for its area (including a Local Pharmaceutical Committee for its area and that of one or more other Primary Care Trusts);

- Any Local Medical Committee for its area (including a Local Medical Committee for its area and that of one or more other Primary Care Trusts);
- The persons on its pharmaceutical lists and its dispensing doctors list (if it has one);
- Any LPS chemist with whom PCT has made arrangements for the provision of any local pharmaceutical services;
- Any relevant local involvement network, and any other patient, consumer or community group in its area which in the opinion of commissioner has an interest in the provision of pharmaceutical services in its area;
- Any local authority with which a PCT is or has been a partner PCT;
- Any NHS Trust or NHS Foundation Trust in its area; and
- Any neighbouring Primary Care Trust.

With the change of responsibility for production of PNA's from PCTs to HWBs it is assumed that where a PCT is mentioned in regulation 8 this now refers to HWBs. Wiltshire HWB shares borders with eight Health and Wellbeing Boards: B&NES, West Berkshire, Hampshire, Gloucestershire, South Gloucestershire, Somerset, Dorset, Swindon and Oxfordshire.

The PNA takes account of cross border provision in terms of access to a Community Pharmacy but does not review access in terms of opening hours or enhanced services.

4. DEVELOPMENT OF THE PNA IN WILTSHIRE

A Pharmaceutical Services Strategy Group (PSSG) was created in early 2017 to identify the strategic and developmental agenda for pharmaceutical services including the creation of a PNA. The steering group membership was drawn from the public health department of Wiltshire Council, medicines management from the Clinical Commissioning Group, commissioning from the NHS England Local Area Team, and also includes representatives from the Local Medical Committee, Local Pharmaceutical Committee, Healthwatch, Director of Public Health, Chairman of CCG and the Wiltshire Councillor for HWB as strategic lead.

Wiltshire's PNA has been developed using a mixture of methods, drawing on a range of information sources and reinforced through consultation with the public. These sources are:

- Review of the data from the Wiltshire Joint Strategic Needs Assessment (JSNA) and Community Area JSNAs.
- Responses to two resident surveys one for carers and one for the general population in Wiltshire.
- A baseline survey of community pharmacies in Wiltshire
- Review of data from commissioners of locally commissioned services for community pharmacies in Wiltshire
- Synthesis from national datasets and statistics.

The Joint Strategic Needs Assessment (JSNA) is the means by which the HWB and local authority describe the future health, care and well-being needs of the local population and the strategic direction of service delivery to meet those needs.

The county-wide JSNA report has been updated to include the most up to date information available, in addition a series of community level health profiles were also updated. These, cover a range of health and wellbeing topics, such as life expectancy, obesity, smoking and health inequalities. The information contained in the Wiltshire JSNA and local community area JSNAs have been used extensively in the development of the PNA.

A pharmacy contractor questionnaire was sent to all community pharmacy contractors in Wiltshire in August 2017. The National Pharmaceutical Services Negotiating Committee (PSNC) questionnaire template was used with the aim of validating information already held by the NHS and local commissioners of pharmaceutical provision, and to ascertain contractors' willingness and ability to participate in future services provision, should opportunities arise.

This information was combined to provide a comprehensive picture of the population, their current and future needs and how the pharmacy network could support the health and social care system to improve the health and wellbeing of our population.

With this in mind the PSSG decided that it was important to survey carers opinions as well as the general population of Wiltshire in 2017 to determine current and future need and how this may have changed. There were 218 responses to the carer survey of which 61% identified themselves as carers. In the general population survey 334 were completed both which contribute to the development of a comprehensive picture across

Wiltshire of pharmaceutical provision, and need in order to improve the health and wellbeing of our population.

Wiltshire HWB consulted formally on the draft PNA from September to December 2017. The consultation closed 01 December 2017 and feedback was reviewed and incorporated into the final PNA document which is scheduled for the Wiltshire HWB in January 2018 for approval prior to publication.

5. HEALTH NEEDS IN WILTSHIRE

This section presents an overview of the health needs of the population in Wiltshire, based on data for a variety of sources

5.1 Overview of population health in Wiltshire

Wiltshire is a large, predominantly rural county with a 2016 mid-year population estimate of 488,409 which is expected to increase to 503,900 in 2021. The majority of this growth, 10,100 people (90.2%) is in the 65 and over age group. In 2011, Wiltshire's ethnic minority groups made up 4.4% of the population.

Almost half (47.3%) of the population resides in towns and villages with less than 5,000 people and over a quarter (28.1%) live in villages of fewer than 1,000 people.

People in Wiltshire live longer than the general population in the South West. Life expectancy in Wiltshire for 2013 to 2015 was 80.8 years for males and 84.0 years for females.

Females in Wiltshire can expect to live 66.8 years in favourable health and males can expect to live 64.8 years in favourable health. This is a reduction from 68.0 for females and 66.5 years for males since the last PNA was conducted

In 2016, there were 1,258 deaths under the age of 75. The two major causes of premature death nationally, and in Wiltshire, are circulatory disease (including coronary heart disease and stroke) and cancers.

Deprivation is an important determinant of health and well-being for individuals and communities. Higher levels of deprivation are consistently associated with poorer health outcomes across a range of measures representing a major cause of inequalities in health and wellbeing. Wiltshire overall is a wealthy and prosperous county but does have pockets of deprivation throughout the county. Wiltshire is split into 20 community areas, and in section 10, the deprivation per community area is defined.

Of the 326 district and unitary authorities in England, Wiltshire is ranked as the 234th most deprived in the 2015 Indices of Multiple Deprivation (IMD).

83.8% of the population in Wiltshire reported their general health as either 'Very good' or 'Good' in 2011.

5.2 Specific diseases

In order to commission appropriate and relevant services, it is essential to understand which diseases and conditions are causing mortality and morbidity in Wiltshire.

Cardiovascular disease

Cardiovascular disease (CVD) describes the group of diseases affecting the circulatory system, including Coronary Heart Disease (CHD) and stroke. Premature mortality is defined as deaths occurring before the age of 75, age-standardised premature deaths from CVD in Wiltshire having increased from 52 per 100,000 to 53 per 100,000 population.

Diabetes

Diabetes is a chronic and progressive disease that is associated with an increased risk of certain complications, including CVD and chronic kidney disease.

In 2012/13, there were 20,860 people aged 17 or over living with diabetes (type 1 or 2) in Wiltshire, which has increased to 23,516 in 2015/16. The true prevalence (including those living with undiagnosed diabetes) in Wiltshire is estimated to be 8.4% (approximately 33,510 Wiltshire residents aged over 17), which is higher than the 2015 project of 7.4%

Chronic Obstructive Pulmonary Disease & Asthma

Chronic Obstructive Pulmonary Disease (COPD) is the collective term for a range of conditions that result in long-term damage to the lungs. The most common forms of COPD are bronchitis and emphysema. COPD is largely preventable; particularly as its main cause is smoking. Standardised rates of mortality from COPD in Wiltshire are lower than in England as a whole for both men and women.

Between 2014 and 2016, 13.3% of deaths in Wiltshire were due to respiratory conditions. Hospital admissions for respiratory conditions are increasing nationally, including in Wiltshire, and are projected to increase in the future due to historical smoking rates. Smoking is the main risk factor for respiratory disease.

Asthma is a more common condition than COPD and affects many children as well as adults. There has been a increase in the number of emergency admissions for asthma in Wiltshire over the last 4 years from 374 in 2012/13 to 381 in 2015/16 but this is still lower than the previously reported data in the 2015 PNA.

5.3 Strategic priorities / Principle health outcomes

Wiltshire Public Health has identified six corporate level principal health outcomes that will demonstrate delivery on improvements in the health of our population. These sit alongside two nationally- determined outcome indicators:

- Reducing health inequalities and
- Improving life expectancy.

The six corporate level principle health outcomes for Wiltshire are:

- Alcohol-related admissions to hospital (PHOF 2.18)
- Successful completion of drug treatment and detection of drug use in offenders (PHOF 2.15 and 2.16)
- PHOF Outcome - Increased healthy life expectancy
- Excess weight in 4-5 and 10-11 year olds (PHOF 2.6 ii)
- Take up of NHS Health Checks programme by those eligible – health checks offered (PHOF 2.2 i)
- Mortality rate from causes considered preventable (PHOF 4.03)

- Improving health and wellbeing of 0-5 year olds (PHOF 1.02i)

Delivering improvement in these principal health outcome indicators is the key performance measure of Wiltshire council's delivery of its strategic ambition, that Wiltshire will be a county that actively encourages, provides and enables positive activities for people and fewer people die prematurely or suffer from preventable ill health.

5.4 Specific populations and potential implications on health needs

Older people

In the 2016 the number of older people living in Wiltshire was put at 101, 588. The highest proportion of those people aged 85 and over live in the south of the county (where the lowest proportion of people aged 65-74 years live). The north of the county has the lowest proportion of people aged 75 and over.

Population projections are important for the planning of all community services to ensure that the needs of the local population are met. The projected population figures show a steep increase in older people with the percentage of the population in Wiltshire aged 65 or over reaching 22.7% by 2021. This represents a 32% increase in the number of people over 65 in Wiltshire over this 10-year period. The number of Wiltshire's residents aged over 85 years is projected to increase from around 13,952 in 2016 to approximately 16,600 by 2021.

Population growth, coupled with the growing ageing population, will be key drivers for potentially expanding pharmacy provision. The increase in the population of older people will place a greater demand on community pharmacies to provide prescription collection and delivery services for people who find it difficult to leave their home.

Life Limiting Long Term Illness

The 2011 Census asked people whether they had a limiting long-term illness (LLTI). The number of Wiltshire residents with an LLTI in 2011 according to the census was 31,408, which equates to 6.7% of the population.

The predicted rates of LLTI in elderly people (aged 65 and over) show that Wiltshire, on average, has much lower predicted rates of LLTI than England. The West Wiltshire area has the highest predicted rate of LLTI in Wiltshire and the Kennet area the lowest predicted rate.

Ethnic minorities

At 4.4% of the population, Wiltshire has a low proportion of ethnic minorities. There are well documented links between ethnic origin and health, where people from different ethnic communities have higher levels of illness for some diseases compared to the general population. In addition, differences in cultural background, language skills and residence time in the new country may impact on the access and utilisation of health care services. The county is a largely white and rural area and people in minority groups are often not present in sufficient numbers to form coherent groups. This can result in an unknown demand for services and potentially unmet need.

Disabilities

Defining the specific number of individuals with some form of physical disability is problematic, due to the range and type of conditions that may be considered a 'physical disability'. In Wiltshire, in 2015, it was forecast that there would be 30,129 people aged 18-64 who have a moderate or serious physical disability. The estimated figures by 2016 will be 31,144.

People with learning difficulties

People with learning disabilities are one of the most vulnerable groups in society. They are known to experience inequalities in health and as a result suffer poorer health outcomes compared to the general population. Estimates would currently suggest that there could be approximately 6814 people with a learning disability living in Wiltshire.

Community teams for people with learning disabilities currently provide health or social care support to around 1,191individuals with a learning disability in Wiltshire. The majority of people known to specialist services will have a severe learning disability.

It is predicted that by 2030 the number of adults with learning disabilities, needing support aged over 18, will increase by 632 people. Many people who have a mild learning disability may never have cause to use Community Services, other than the mainstream services within their community.

Military population

Military personnel in Wiltshire presently constitute around 2.9% of the total population and including dependants the total is estimated to be around 30,000. Military personnel and dependants are estimated to constitute over 20% of the total population in Tidworth, Bulford, Durrington, Upavon, Warminster East, Lyneham, Nettleton and Colerne wards.

The increase in personnel towards the south of the county will take place during the lifetime of the PNA, which may have implications for local health services. Any changes will be reflected in additional supplementary guidance/statements.

Changes to the military population in Wiltshire

Army Basing Review

Military personnel in Wiltshire constitute around 3.3% of the total population, and including dependants the total is estimated to be around 30,000 people. Locally, military personnel and their dependents are estimated to constitute over 20% of the total population in some wards (e.g. Tidworth, Bulford, Durrington, Upavon, Warminster East, and Lyneham). Increases in the numbers of military personnel and their dependents in the south of the county will take place during the lifetime of the PNA, which may have implications for local health services.

A major impact on south Wiltshire in particular will be felt from the Army's transformation under the 'Army 2020' concept and the Army Basing programme. The changes to the Army's structure, reorganisations, and relocations will result in an estimated increase of approximately 4,000 uniformed personnel, and an estimated 3,200 dependants, living and working in Wiltshire. All unit moves are planned to be complete by December 2019 following completion of the building of additional single living and service families' accommodation. Following its closure as a RAF station, MOD Lyneham has become a key defence technical training site for electronic and mechanical engineering. Part of the Defence College of Technical Training, MOD Lyneham has around 1,500 military and 700 civilian personnel as students and staff. Additionally, a regular Army unit of approximately 500 personnel will be based at MOD Lyneham from 2019. The Ministry of Defence medical centres provide primary healthcare for service personnel and some families. Tidworth, Larkhill, Bulford, Lyneham and Warminster military sites all have access to a Medical Centre with a dispensary staffed by a Pharmacy Technician on site. Corsham personnel have access to a Medical Centre on site where prescriptions are faxed to a local Lloyds pharmacy for dispensing. In addition, all Military Medical Centres have access to a MOD Regional Pharmacist and pharmacy technician based at the Regional Headquarters of Defence Primary Health Care Central and Wessex Region, based in Tidworth.

Wiltshire's Health and Wellbeing Board will ensure that as part of the planning for army re-basing the provision of pharmaceutical services will be reviewed on an ongoing basis and supplementary statements to this PNA will be issued when necessary.

Prisoners

HMP Erlestoke is an adult male, category 'C' closed training prison and it is the only prison in Wiltshire. It currently has an operational capacity of 524. The 2012 HMP Erlestoke Health Needs Assessment identified specific health needs for the prisoners including sexual health, infectious diseases, mental health and substance misuse. Levels of smoking are extremely high, amounting to almost 70% of prisoners in Erlestoke. Since 2009, 50 offenders have qualified as Health Trainers at HMP Erlestoke and in 2016, 129 offenders were supported by three offender health trainers to improve their lifestyle choices.

Pharmaceutical services to HMP Erlestoke are commissioned and provided separately to community pharmacy services. Prescribers at the prison may provide an NHS prescription to an offender upon release which can be dispensed at any community pharmacy, such NHS prescriptions are exempt from prescription charges.

Gypsies and Travellers

According to the 2011 Census, 757 people in Wiltshire identified themselves as being of Gypsy or Irish Traveller ethnicity; this is 0.2% of the population. In 2017, Wiltshire had 193 children in primary or secondary schools whose ethnic group was Gypsy/Roma according to the January 2017 school census.

As of June 2017, Wiltshire Council owns 5 permanent residential Gypsy and Traveller sites and one transit site. This provides 100 residential pitches (29 serviceable, 5 out of use and 6 undergoing refurbishment) and 12 transit (28-day license) pitches (currently closed) and 1 transit site (currently closed). As of 2013, there are about 175 or so boats without moorings on the Kennet and Avon Canal at any one time between Devizes and Bath. It is believed that around 66% of these are people's homes. A survey is currently being undertaken to update the data on boaters.

Homeless

Homeless people have a significantly lower life expectancy compared with the rest of the population and experience poorer health generally, with particular issues around social isolation, poor access to services, mental health and substance misuse.

During 2016/17, Wiltshire delivered 433 new affordable homes. The number of households living in temporary accommodation at the end of March 2017 was 112 which is a decrease from 127 in March 2016. 269 people were accepted as homeless in 2016/17, which is a decrease from 285 in 2015/16

5.5 Lifestyle factors influencing health

The greatest burden of disease and premature death in the UK today is related to chronic diseases such as cancers and cardiovascular disease. Such diseases are strongly associated with lifestyles or health behaviours.

Drug misuse

Drug misuse results in increased health problems for drug users, impacts significantly on families, and is often a contributory factor to other social problems including anti-social behaviour and acquisitive crime. For the year 2016/17 around 1828 people were receiving treatment in the Wiltshire Substance Misuse Service. Of these 31% were female, British and 993 were aged between 28 and 47.

Alcohol

Alcohol misuse has been directly linked to a range of health issues both acute and chronic. Alcohol related hospital admissions have been rising in Wiltshire (555 per 100,000), although they remain at lower levels than those experienced in either the South West (650 per 100,000) or England (647 per 100,000). Likewise, alcohol specific mortality is increasing in Wiltshire (9.2 per 100,000), although rates are again lower than regional (10.5 per 100,000) and national (11.5 per 100,000).

Alcohol dependence is defined as the percentage of adults (aged 18+) who drink 14 units or more alcohol per week. National prevalence estimates indicate that 28.7% of adults in Wiltshire are dependent on alcohol, this is higher than the south west (26.8%) and England (25.7%) averages.

Sexual health

Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

There were 2,334 acute sexually transmitted infections in Wiltshire in 2016 which is 480 per 100,000 people. This rate was statistically significantly lower than both the England rate (750 per 100,000) and the South West rate (621 per 100,000). 2016 figures for Gonorrhoea show that the number of cases in Wiltshire has decreased to 71, which is still almost two and half times the 2009 figure of 29. Our rates of syphilis infection remain

relatively low in Wiltshire with 9 cases reported in 2016, providing us with a diagnostic rate of 1.9 per 100,000 population compared to a South West rate of 3.0 per 100.000 and an England average of 10.6 per 100,000.

There are a growing number of people living with HIV in Wiltshire. 221 people accessed care and treatment in 2015, which is a rise of 21.4% since 2011. When compared to England this equates to a prevalence rate of 0.72 per 1,000 population in Wiltshire compared to 2.3 per 1,000 in England.

There are issues around access to sexual health services. The range and availability of STI screening is geographically limited although services are available in community venues across the county. Contraception and Sexual Health (CaSH) clinics see a disproportionate number of women seeking Long Acting Reversible Contraception (LARC) methods for reasons other than contraception who should be referred to appropriate gynaecology services and this can have an impact on appointment slots being available for other patients.

Abortion rates in Wiltshire for 2016 stand at 13.6 per 1,000 which is similar to the South West rate of 13.5 per 1,000 but well below the England rate of 16.1 per 1,000 women. The Wiltshire proportion of repeat abortions is 35.8% which is higher than the South West proportion of 34% but lower than the England rate of 38.4%, however these repeat procedures are concentrated within the under 25 age group in which 24.5% of the overall repeat abortions took place.

Smoking

The tobacco control profile suggests that 13.9% of adults in Wiltshire are smokers compared to 13.9% for the South West region and 15.5% for England with prevalence in all three areas having fallen. Data for 2015/16 estimates that 10.3% of pregnant women in Wiltshire are smoking in pregnancy, lower than in the South West (11.2%) and England as a whole (10.6%). Smoking levels are significantly higher among routine and manual workers compared to the rest of the population and according to the Tobacco Control profile stood at 232.8% for Wiltshire in 2014; which is higher than England (28.0%) and the South West (28.3%).

With a community area focus, the highest smoking prevalence is found in Trowbridge at 21.6% of households – Trowbridge is the only Community Area over 20%. Amesbury, Bradford-on-Avon, Malmesbury, Marlborough, Mere, Pewsey, Royal Wotton Bassett, Cricklade, Southern Wiltshire, Tidworth, Tisbury and Wilton Community Areas are all <10% smoking prevalence.

Obesity

Adults with a Body Mass Index (BMI) of 30 or over are classified as obese. According to modelled estimates, adult obesity prevalence is 25.2% in Wiltshire; this is higher than the estimated prevalence in both the South West (24.7%) and England (24.2%). The most recent of these (The Active People Survey, conducted by Sport England) indicated that the prevalence of excess weight in adults over 16 years old in Wiltshire is 65.8%. This equates to almost 2 in 3 adults across the county and is in line with that estimated for the South West (64.7%) as well as England (64.8%).

In Wiltshire, in 2015/16, 52 people were admitted to hospital because of obesity, over half since 2011/12 (123). This equates to 11 people per 100,000 population which is lower than the England rate of 14 per 100,000 population and the South West rate of 19 per 100,000. England data shows that hospital admissions for obesity decreased since 2010/11.

In 2015/16, 35 patients were referred for bariatric surgery in Wiltshire, which is a decrease from 138 in 2012/13, when 138 were referred.

During 2016/17, 5,385 pupils in Reception Year and 4,515 pupils in Year 6 in Wiltshire were weighed and measured as part of the National Childhood Measurement Programme (NCMP). In that period 8.0% of Wiltshire Reception pupils measured were found to be obese; this compares to 9.3% for England. This is the sixth lowest out of 14 Local Authorities in the South West. In Year 6 15.7% of Wiltshire children were found to be obese; in England, the figure was 19.8%. This ranks Wiltshire 9th lowest out of 14 Local Authorities in the South West.

6. CURRENT PROVISION AND USE OF PHARMACEUTICAL SERVICES IN WILTSHIRE

6.1 Overview of access in Wiltshire

Number of pharmacies and type of provision

Wiltshire has a total of 74 community pharmacies and a population of approximately 488, 409. This represents 15.1 pharmacies per 100,000 population. Given the rural nature of Wiltshire a mixture of pharmacies and dispensing GP practices ensure that there is access in all communities to dispensing services. Patients living in rural areas can, and do, access community pharmacy in locations where they access other services, such as shops.

It is recognised that many of the most sparsely populated rural areas do not have local access to community pharmacies. General Practitioners in controlled localities, that is areas determined by the NHS Commissioning Board to be rural in character, may dispense medication on prescription produced at the practice, to those practice registered patients who live within the controlled area. In addition, the NHS Commissioning Board may grant dispensing rights for a practice to dispense to registered patients living outside the controlled area but who have serious difficulty accessing a community pharmacy service.

General practitioners in Controlled Localities, that are areas determined by the NHS to be rural in character, may dispense medication on prescriptions generated at the practice, at the rest of those registered patients who live within the controlled locality but at a distance of more than 1.6km from a community pharmacy. There are 25 Dispensing General Practices serving the rural parts of Wiltshire (see Appendix 2). Therefore, whilst there may not be convenient access to the full range of pharmaceutical services in rural areas, patients living in rural areas are able to access dispensing services as required.

Dispensing Appliance Contractors (DACs) are a specific sub-set of NHS Pharmacy contractors specializing in the supply (on prescription) of appliances, notably stoma and incontinence appliances. Fittleworth Medical (Salisbury) is the only noted DAC in Wiltshire.

Local Pharmaceutical Service (LPS) allows areas to commission community pharmaceutical services tailored to specific local requirements. LPS complements the national contractual framework for community pharmacy but is an important local commissioning tool in its own right. LPS provides flexibility to include within a single local contract a broader or narrower range of services (including services not traditionally associated with pharmacy) than is possible under national pharmacy arrangements. There are no LPS pharmacies in Wiltshire.

Pharmacists can undertake additional training to become an Independent Prescriber. Independent prescribing is prescribing by a practitioner e.g. doctor, dentist, nurse, pharmacist or optometrist responsible and accountable for the assessment of patients with undiagnosed and diagnosed conditions and for decisions about the clinical management, including prescribing. Pharmacist Independent Prescribers can prescribe any medicine for any medical condition within their competence and can issue private prescriptions for any medicine within their competence.

A small number of Community Pharmacists in Wiltshire are Independent Prescribers and may be providing private prescriptions. NHS Wiltshire Clinical Commissioning Group do not currently commission prescribing services from any Independent Prescribing pharmacists.

In Wiltshire, there is now a NHS Wiltshire CCG commissioned service to ensure that palliative care medicines are available on demand as a result of the gap identified in the 2015 PNA.

Advanced and enhanced services

Advanced Services are nationally specified, and there are six Advanced Services within the NHS community pharmacy contractual framework. Community pharmacies can choose to provide any of these services as long as they meet the requirements set out in the Secretary of State Directions. The six Advanced services in the community pharmacy contract are:

- Medicines Use Review (MUR) and Prescription Intervention Service. MURs may be provided by pharmacies if carried out by a pharmacist with MUR accreditation, in a marked room or area of the pharmacy which has seating and where normal speaking volumes cannot be overheard
- New Medicine (NMS) Service. The service provides support for people with long-term conditions newly prescribed a medicine to help improve medicines adherence.
- Appliance Use Review (AUR) Service
- The AUR is carried out by a pharmacist or a specialist nurse in the pharmacy or at the patient's home.
- Stoma Appliance Customisation Service. The service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste.
- Seasonal flu vaccination is communised as an Advanced Service from September to March each year.
- The NHS Urgent Medicines Supply Advanced Service (NUMSAS) is currently commissioned until 30 September 2018.

NHS England commissions one Directed Enhanced Service in Wiltshire. This is an arrangement to ensure access to pharmaceutical services on days when there would otherwise be no service available (e.g. bank holidays). In Wiltshire, a rota has been determined for Special Bank Holidays (Christmas Day, New Year's Day and Easter Sunday). The availability of contracted hours on Sundays and late opening has not required Enhanced Service commissioning to secure Sunday or evening access.

Locally Commissioned Services are commissioned locally in response to the needs of the local population. A range of Locally Commissioned Services may be offered by community pharmacies in Wiltshire:

- Support to Stop smoking

- Needle and Syringe Exchange
- Supervised Administration (Consumption of Prescribed Medicines)
- Chlamydia treatment and supply of test kits
- Emergency Hormone Contraception (EHC) including pregnancy testing services and condom supply
- Hold stock of specific palliative care medicines

Hours

Consideration has been given to accessing pharmaceutical services outside Monday - Friday, 9am - 7pm. Opening after 7pm is considered to be 'late opening'. NHS England holds the following information relating to this provision:

- Seven community pharmacies operate as 100-hour pharmacies.
- 10 are open later into the evening per week and most are open on Saturdays.
- 18 are open on Sundays (an increase from 10 in 2015).

Internet or Wholly Mail-Order Pharmacies

Two pharmacies in Wiltshire operate wholly under a distance selling model. There is anecdotal data suggesting an increase in the use of distance selling pharmacies however the impact this will have on the dispensing of prescription in Wiltshire is currently unknown.

Cross-border access

The Wiltshire Local Pharmaceutical Services Public Survey (2010 and 2014) revealed that the pharmacy being close to the doctor's surgery was ranked the most important factor for location followed by being close to home. Nearly half of respondents travelled less than 1 mile last time they visited the pharmacy. Therefore, whilst important to note access to community pharmacies in surrounding areas will increase access and choice to Wiltshire residents, it is likely that the majority of Wiltshire residents will be accessing pharmacies in the Wiltshire area.

From reviewing sample data from 2016-17 prescribing habits, over 97% of prescriptions issued in Wiltshire are dispensed in Wiltshire, with the remaining largely dispensed in pharmacies across the borders in Swindon and Hampshire.

Acute settings

Wiltshire has one acute trust within its borders, Salisbury Foundation Hospital Trust (SFT). In addition, about two thirds of Wiltshire's population will access acute hospital care outside of the county in Bath or Swindon. Transfer of care is an important issue and with three different systems in the acute settings this is worthy of note. Hospital pharmacies deal with more complex clinical medication management issues when compared with community pharmacies, who often have more complex business and customer relations issues. Hospital pharmacies stock a larger range of medications, including more specialised medications, than would be feasible in the community setting. Hospital pharmacies typically provide medications for hospitalised patients only. SFT and RUH pharmacies sell non-prescription medicines to patients and public but do

not hold a community pharmacy contract. GWH have out-sourced its outpatient dispensing to Boots who have a pharmacy separate to the hospital pharmacy within the hospital. Although it dispenses outpatient medications and sells over the counter medicines to patients and visitors it does not hold a community pharmacy dispensing contract.

Health and social care providers should ensure that patients moving in and out of these care settings have a pharmaceutical service that ensures the continuity of support around medicines, through the development of more integrated working between community pharmacy, community hospitals and acute hospitals.

In a bid for integrated working between community pharmacy and Acute settings, a IT system called PharmOutcomes is being used to facilitate this integrated working across all Acute Trusts and community pharmacies. This includes the Royal United Hospital using the referral service to provide discharge summaries for patients who have medicines packaged into weekly dosage systems. Salisbury Foundation Trust have this functionality and is using it to provide discharge summaries for patients with weekly dosage systems. Great Western Hospital use similar functionality to refer patients starting on anticoagulant medicines for further support.

Choice

Wiltshire is required to consider the benefits of having reasonable choice with regard to obtaining pharmaceutical services. In the more urban community areas there are a variety of providers. Patients choosing to use one type of pharmacy or another are able to do so relatively easily in these areas. In the more rural areas, with the population spread across large areas with some more populated villages and market towns, it is less easy to state that patients have easy access to a variety of providers.

Core Strategy – housing

Within this section on provision it is also important to note that Wiltshire's Core Strategy sets out Wiltshire council's spatial vision, key objectives and overall principles for development in the county.

Housing figures for new development are incorporated within the core strategy for each community area in Wiltshire. These figures are based upon sites with permission, or that have been allocated to date and therefore these figures may be subject to change as time progresses.

The anticipated increase in each community area over the next three-year period until 2020/21 would not have a significant impact on provision of, or access to pharmaceutical services. Wiltshire HWB will ensure that as part of the ongoing planning through the core strategy the provision of pharmaceutical services will be reviewed on an ongoing bases and supplementary statements to this PNA will be issued when necessary.

In addition, the neighbouring authority Swindon Borough's Local Plan will increase housing by approximately 16,000 more dwellings by 2026. A proportion of these houses will be delivered close to the border of North East Wiltshire. The Swindon HWB PNA states that Swindon HWB will monitor the development of major housing sites along its

boundary with other Local Authorities to ensure that relevant Local Authorities can produce supplementary statements to their PNAs if deemed necessary.

6.2 Specific diseases

Cardiovascular disease (CVD)

Wiltshire does not commission any community pharmacies to offer the Vascular Risk Assessment Service (NHS Health Checks).

Diabetes

Two pharmacies are providing non-commissioned diabetes services, 5 pharmacies were willing and able to provide services and a further 35 would be willing and able if provided training.

Chronic Obstructive Pulmonary Disease (COPD)

Wiltshire does not commission any of the community pharmacies to offer specific medicine management for COPD.

Asthma

Three community pharmacies provide asthma related services, however 7 pharmacies felt willing and able to provide services and a further 34 felt they would be able to provide services if offered training.

6.3 Meeting the needs of specific populations

Older people

Seven community pharmacies in Wiltshire provide a pharmaceutical service specifically for Care Homes and a further twelve felt willing and able to provide services. Pharmacists from the medicines management department of the CCG offer visits to each Care Home to provide Individual Medication Reviews and advice on 'The Safe Handling and Administration of Medicines'. Liaison with the Care Home and relevant General Practice(s) takes place prior to visiting each Care Home. This is a service that some pharmacies are not willing or able to provide, but of those that responded 8 said that they would be willing and able to provide the service if commissioned and a further 6 said they would be able to provide the service if offered training.

Twenty-five community pharmacies in Wiltshire provide delivery services and a number provision of monitored dosage systems to support administration of medicines by domiciliary carers (non-commissioned services). A service such as this can support the needs of older and vulnerable people.

Ethnic minorities

All pharmacies in Wiltshire have access to the NHS language line telephone service, however the Local Pharmaceutical Committee would be keen for NHS England to publicise how to access this service to pharmacies. From the pharmacies that responded,

the languages pharmacies identified from their patients included Polish, Spanish and Nepalese. Eleven pharmacies felt they could provide direct language support including Spanish, Polish, Urdu, Chinese, French, German, Kurdish, Punjabi, Hindi, Romanian and Welsh.

Disabilities

All pharmacies are required to be compliant with the Equalities Act.

People with learning difficulties

There are no specifically commissioned pharmaceutical services for people with learning difficulties in Wiltshire.

Military

Tidworth, Larkhill, Bulford, Chippenham and Warminster military sites all have access to a Medical Centre with a dispensary staffed by a Pharmacy Technician on site. The sites at Colerne and Corsham have access to a Medical Centre on site where prescriptions are faxed to a local pharmacy for dispensing.

In addition, all Military Medical Centres have access to a MOD Regional Pharmacist and pharmacy technician based at the Regional Clinical Directorate of the Defence Primary Health Care Headquarters, based in Tidworth. Military families / dependants may access NHS services and community pharmacies in the areas in which they live.

Prisoners

HMP Erlestoke has a contract with a community health provider to supply medication.

Gypsies and Travellers

All registered sites in Wiltshire, apart from Bonnie Park in Bratton, are within two miles of a community pharmacy. The majority of sites are within a 15 minute walking distance of a community pharmacy. The closest community pharmacies to Bonnie Park are in Westbury, just over three miles away.

Homeless

Homeless people can register with a General Practice and then access community pharmacies for dispensing medication. In addition, anybody who is homeless can also access advice and support from a community pharmacy without GP registration or the need to provide an address.

Carers

The term ‘carers’ refers to people who provide unpaid care to a child, relative, friend or neighbour who is in need of support because of age, addiction, mental or physical disability or illness. It does not include people who volunteer or paid workers – they are referred to as ‘care workers’.

The 2011 Census estimates that there are currently approximately 47,608 in Wiltshire. Around 2,723 people are aged 24 or under and 11,876 are aged 65 or over that provide care. 19.9% of carers spend 50 or more hours per week caring. The number of hours of care given is related to age, with older carers providing more hours of care.

6.4 Addressing specific health and lifestyle needs

Health promotion forms part of the essential services offered by all community pharmacies, specifically:

Essential Service 4 – Public Health

This includes the provision of opportunistic healthy lifestyle advice and public health advice to patients receiving prescriptions who appear to have diabetes, or be at risk of coronary heart disease, especially those with high blood pressure, or smoke, or are overweight. It also includes pro-active participation in national / local campaigns to promote public health messages to general pharmacy visitors during specific targeted campaign periods.

Essential Service 5 – Signposting

Signposting is the provision of information to people visiting the pharmacy, who require further support, advice or treatment, which cannot be provided by the pharmacy, or other health and social care providers or support organisations who may be able to assist the person. Where appropriate, this may take the form of a referral.

Essential Service 6 – Support for Self-Care

Support for self-care requires the provision of advice and support by pharmacy staff to enable people to derive maximum benefit from caring for themselves or their families.

A range of locally commissioned services can also be offered to address some of the specific lifestyle factors in relation to health.

Drug misuse

Needle exchange services and supervised methadone consumption are commissioned and delivered as locally commissioned services in Wiltshire. Five community pharmacies in Wiltshire currently offer needle exchange, three felt willing and able to provide and a further 8 felt they could provide with training.

Supervised administration of medicines is commissioned in 21 community pharmacies locally.

Alcohol

No community pharmacies are locally commissioned to deliver alcohol screening and brief interventions, five felt willing and able to provide if commissioned and 13 felt they would be able to provide with training.

Sexual health

Thirty-two community pharmacies are commissioned to deliver the No Worries! service, in Wiltshire. The *No Worries* scheme is a programme designed to reduce teenage conceptions and increase access to contraception, sexual health information and advice, swift and easy access to STI testing and treatment. Emergency Hormonal Contraception is supplied from community pharmacy stock through a patient group direction for patients aged 13-19 at risk of unwanted pregnancy.

Smoking

Forty community pharmacies are commissioned to deliver support to stop smoking as a locally commissioned service. Pharmacies provide one to one support and advice for a maximum 12-week period to people who want to give up smoking. If after this time the client is still smoking, the client is referred to the Stop Smoking Service for specialist advice and support. The pharmacy stop smoking adviser is trained by Wiltshire Stop Smoking Service. The client receives stop smoking support and is able to get Nicotine replacement medications at prescription cost. Champix® is not available directly from a pharmacist as it has to be prescribed by a GP.

Obesity

None of the community pharmacies stated in their contractor survey response that they offer an obesity management service. This service is not currently commissioned in Wiltshire however three pharmacies felt they were willing and able to provide the service, and a further 18 felt they would be able to provide with training.

7. SUMMARY FROM PUBLIC SURVEY

7.1 Wiltshire Local Pharmaceutical Services Carer's Survey 2017

In June 2017, a local pharmaceutical services survey was launched targeted at carers in Wiltshire. The e-survey was promoted via social media, and with the assistance of organisations including Wiltshire Council, NHS Wiltshire CCG, primary care organisations (GP practices and pharmacies), Health Watch Wiltshire and our local community carer champions. The public health team also attended several carer events to promote the survey and supported response rate by allowing the completion of hard-copy survey's when were then manually added to the electronic responses.

The professionals and organisations approached to support engagement with the survey were very engaged and enthusiastic in their support of the survey. A total of 218 respondents completed the survey providing responses to a range of questions, of which 122 (61%) identified themselves as carers.

The responses below only take into account the carer responses:

- 70% of respondents were female.
- 57% of respondents were aged between 55 and 74 years.
- 34% defined their health as 'good' and 49% defined their health as 'fairly good'.
- 42% said that they had a long term limiting illness, health problem or disability that limits their daily activities or work they can do.
- 33% defined themselves as full-time carers

The survey was lengthy and electronic both which may have deterred carers from responding. We did provide hard-copies on request although the request for these was minimal. It should be noted that although this survey was directed at carers nearly 40% of those that responded did not identify themselves as carers. However, carers did engage, and therefore the responses received through this method may not be representative of the wider group of carers resident in Wiltshire and may have an impact on how they responded to the local pharmacy survey. Also, not all respondents answered all questions.

Access to pharmacy services

89% of respondents said they would access their local pharmacy for the dispensing of their medicines, other would access dispending practices (7%) or supermarket pharmacies (3%). Similarly, to obtain advice on medicines they would access their local pharmacy (63%), their dispensing practice (25%) or supermarket pharmacy or look online. Similarly, 63% of respondents would go to their local pharmacy for other services, closely followed by their dispensing practice for other services including vaccinations, continence aides, and prescription requests.

Pharmacy Location

76% of respondents felt that it was important to very important that the pharmacy was close to their GP practice; 80% felt that it was important to very important that the pharmacy is close to their homes and/or close to their local shops (54%). 81% felt that it was important to very important that it was easy to park nearby to the pharmacy and

51% felt that is was not very important to not important at all that the pharmacy was near a bus-stop compared to 26% thought it was important to very important to be near a bus stop. 71% felt that it was not very important (or important at all) for it to be near to their children's school or nursery but this may be reflected in the age of the carers, similarly 69% didn't feel it was important (or important at all) that it was close to a place of work again, reflects the age of the respondents. 49% of carers felt that it was important to very important that was medicines could be delivered straight to their homes, 24% felt this wasn't important (or important at all), and 27% didn't feel it was important or unimportant.

In the last 12 months, 49% of respondents had had a consultant with their pharmacy to ask for help or advice, 18% to have a medicine check and 22% to ask for advice so they didn't need to visit their GP practice.

Access to Pharmacies

42% felt that all pharmacies should be open late at least one evening a week, where 44% felt that only some pharmacies should be as long as they knew where they were; 57% felt that only some pharmacies needed to be open on a Sunday as long as they knew where they were; and the same for bank holiday opening (60%)

Awareness of Services

From the respondents, they had the following awareness of essential service available from their pharmacy:

- 82% aware they could get prescriptions dispensed at a pharmacy of their choice
- 46% were aware they could access medicines online, but only 2% had used them
- The majority of respondents 27%) had the pharmacy manage their repeat prescriptions, 22% ordered online and 18% ordered directly via their GP practice
- 42% had prescriptions managed using electronic transfer from their GP to the pharmacy of their choice.
- 53% felt they didn't need any help on having prescriptions delivered to their homes, 22% already had their prescriptions delivered
- 73% felt they didn't need any help in having their medicines explained to them, 25% already get help.
- 87% didn't feel they needed a reminder on when to take their medicines; 84% felt they didn't need help putting their medicines into an organiser (10% already had this assistance). 84% did not need easier to open containers, 86% felt they did not need larger print labels on their medicines, 2% had accessed this support.

Additional Services

- 25% had had a Medicines Use Review (MUR) at their pharmacy, 31% at their GP practice, 55% had never used the service
- 75% had not used the New Medicines Service (NMS) from their pharmacy, 14% had.
- 99% had not used the help to stop smoking service provided by pharmacies
- 74% had an health check at their GP practice, only 1 respondent had received one at their pharmacy, 29% had not used the service

- 70% had not accessed any weight management programmes from the pharmacy
- Only 2% had received advice about healthy lifestyles form the pharmacy, 60% had not accessed this from the pharmacy
- Only 1 respondent had received a diabetes test at the pharmacy
- 41% had accessed their GP for minor ailments, and 11% their pharmacy
- No respondents had accessed their pharmacy for emergency hormonal contraception
- 95% had not used the pharmacy for chlamydia testing, the %% accessed the GP or somewhere else
- 90% did not access routine contraception medicines or advice from the pharmacy, and 10% from other non-pharmacy locations, and nobody had visited the pharmacy for a pregnancy test
- 6% had attended a flu vaccination at the pharmacy, although 77% did attend their GP
- Only one respondent attended the pharmacy for blood tests to adjust warfarin
- 2 respondents disposed of sharps at the pharmacy, 79% not accessing the pharmacy for this service. No respondents were using the needle exchange programme.
- Only one respondent had attended their pharmacy for advice on inhaler use.
- 40% attended their GP for cholesterol testing; only 1 respondent had attended a pharmacy for a similar service.

When asked where they would prefer for services to be made available, respondents answered:

- Smoking Cessation service: 30% pharmacies, 41% GP practices
- Health Checks: 35% pharmacy, 30% GP practices
- Weight management: 86% of respondents felt this question was not applicable
- Healthy lifestyle advice: 44% GP practice, 25% practice nurse, 7% pharmacy
- Diabetes testing: 31% GP practice, 24% practice nurse, 4% pharmacy
- Minor ailments: 31% GP practice, 21% practice nurse, 7% pharmacy
- Emergency contraception: 27% GP practice, 19% practice nurse, 8% pharmacy
- Chlamydia testing: 29% GP practice; 26% pharmacy
- Routine contraception: 89% felt this question was not applicable
- Free condoms: 93% felt this question was not applicable
- Pregnancy testing: 84% felt this question was not applicable
- Flu vaccination: 92% said not applicable, 6% pharmacy, 2% GP, 2% practice nurse
- Blood testing: 85% said not applicable
- Disposal of sharps: 46% GP practices, 18% practice nurse and 12% pharmacy
- Needle exchange: 85% said not applicable
- Inhaler use: 83% said not applicable, 7% pharmacy
- Cholesterol testing: 92% said not applicable, 3% said pharmacy.

As part of the survey, carers were asked what could be done to improve pharmacy services for them. The majority of the comments very complementary and praising of the services they currently receive however, some critical comments were received in regard to improving professional of pharmacy staff; better pharmacist engagement with patients; pharmacies not closing at lunch times and sound proof/private consultation areas.

7.2 General Wiltshire Local Pharmaceutical Services Public Survey 2017

In July 2017, following the carer's focussed questionnaire, a general population questionnaire was distributed. The methods for distribution were similar for that of the carer's survey. Overall, 334 people responded to the survey.

The survey attracted a higher than representative response from the older age ranges. The 18-24 year old are underrepresented with only 2% of respondents classified in this category. 20% of respondents are retired. This is likely to have an impact on the services which respondents state they would be interested in using at a pharmacy. The survey was electronic but offered hard-copies on request, which may have deterred people from responding. Also, not all those that responded answered all questions.
e following provides an overview of the responses to the online survey:

- 334 responses were received.
- 79% of respondents were female.
- 6% were aged between 35 and 64 years.
- 85% defined their health as 'good' or 'very good'
- 27% said that they had a long term limiting illness, health problem or disability that limits their daily activities or work they can do.
- 10% said that they are either a parent of a child under 16 or look after someone who is sick, disabled or elderly, which is not part of their job and they do not get paid for it.

74% of respondents said they would access their local pharmacy for the dispensing of their medicines; other would access dispending practices (25%) or supermarket pharmacies (24%). Similarly, to obtain advice on medicines they would access their local pharmacy (74%), their dispensing practice (21%) or supermarket pharmacy or look online. Similarly, 68% of respondents would go to their local pharmacy for other services, closely followed by their dispensing practice for other services including vaccinations, continence aides, and prescription requests.

72% of respondents felt that it was important to very important that the pharmacy was close to their GP practice; 77% felt that it was important to very important that the pharmacy is close to their homes and/or close to their local shops (61%). 82% felt that it was important to very important that it was easy to park nearby to the pharmacy and 49% felt that is was not very important to not important at all that the pharmacy was near a bus-stop compared to 15% thought it was important to very important to be near a bus stop. 60% felt that it was not very important (or important at all) for it to be near to their children's school or nursery but this may be reflected in the age of the respondents, similarly 45% didn't feel it was important (or important at all) that it was close to a place of work again, reflects the age of the respondents. 22% felt that it was important to very important that was medicines could be delivered straight to their homes, 41% felt this wasn't important (or important at all), and 36% didn't feel it was important or unimportant.

In the last 12 months, 67% of respondents had had a consultant with their pharmacy to ask for help or advice, 27% to have a medicine check and 33% to ask for advice so they didn't need to visit their GP practice.

24% felt that all pharmacies should be open late at least one evening a week, where 52% felt that only some pharmacies should be as long as they knew where they were; 61% felt that only some pharmacies needed to be open on a Sunday as long as they knew where they were; and the same for bank holiday opening (65%)

Awareness of Services

From the respondents, they had the following awareness of essential service available from their pharmacy:

- 77% aware they could get prescriptions dispensed at a pharmacy of their choice
- 44% were aware they could access medicines online, but only 5% had used them
- 88% felt they didn't need any help on having prescriptions delivered to their homes, 6% already had their prescriptions delivered
- 81% felt they didn't need any help in having their medicines explained to them, 15% already get help.
- 92% didn't feel they needed a reminder on when to take their medicines; 89% felt they didn't need help putting their medicines into an organiser (4% already had this assistance). 88% did not need easier to open containers, 94% felt they did not need larger print labels on their medicines, nobody had accessed this support.

Additional Services:

- 20% had had a Medicines Use Review (MUR) at their pharmacy, 20% at their GP practice, 64% had never used the service
- 86% had not used the New Medicines Service (NMS) from their pharmacy, 11% had.
- 94% had not used the help to stop smoking service provided by pharmacies
- 43% had a health check at their GP practice, only 9 respondents had received one at their pharmacy, 52% had not used the service
- 84% had not accessed any weight management programmes from the pharmacy
- Only 2% had received advice about healthy lifestyles form the pharmacy, 76% had not accessed this from the pharmacy
- 9 respondents had received a diabetes test at the pharmacy
- 27% had accessed their GP for minor ailments, and 24% their pharmacy
- 11 respondents had accessed their pharmacy for emergency hormonal contraception, 94% had not accessed this service
- 95% had not used the pharmacy for chlamydia testing, the 5% accessed the GP or somewhere else
- 83% did not access routine contraception medicines or advice from the pharmacy, 1% had visited the pharmacy for a pregnancy test
- 10% had attended a flu vaccination at the pharmacy, although 33% attend at their GP
- Only 3 respondents attended the pharmacy for blood tests to adjust warfarin
- 9 respondents disposed of sharps at the pharmacy, 90% not accessing the pharmacy for this service. 3 respondents were using the needle exchange programme.
- 5 respondents had attended their pharmacy for advice on inhaler use.

- 21% attended their GP for cholesterol testing, 7 (2%) respondents had attended a pharmacy for a similar service.

When asked where they would prefer for services to be made available, respondents answered:

- Smoking Cessation service: 9% pharmacies, 4% GP practices
- Health Checks: 23% pharmacy, 32% GP practices
- Weight management: 51% of respondents felt this question was not applicable; 22% GP practices, and 18% pharmacy
- Healthy lifestyle advice: 21% GP practice, 18% practice nurse, 19% pharmacy
- Diabetes testing: 9% GP practice, 5% practice nurse, 18% pharmacy
- Minor ailments: 26% GP practice, 19% practice nurse, 46% pharmacy
- Emergency contraception: 27% GP practice, 19% practice nurse, 8% pharmacy
- Chlamydia testing: 7% GP practice; 14% pharmacy
- Routine contraception: 74% felt this question was not applicable
- Free condoms: 81% felt this question was not applicable; 17% pharmacy
- Pregnancy testing: 80% felt this question was not applicable; 15% pharmacy
- Flu vaccination: 28% said not applicable, 32% pharmacy, 36% GP, 21% practice nurse
- Blood testing: 84% said not applicable
- Disposal of sharps: 7% GP practices, 3% practice nurse and 15% pharmacy
- Needle exchange: 88% said not applicable; 10% pharmacy
- Inhaler use: 71% said not applicable, 18% pharmacy
- Cholesterol testing: 51% said not applicable, 24% said pharmacy; 19% GP and 19% practice nurse.

In line with the carer survey, respondents to the general survey were also asked what could be done to improve pharmacy services for them. Again, the majority of the comments very complimentary and praising of the services they currently receive however, some critical comments were received in regard to improving the availability and professionalism of pharmacy staff; better customer service / queue management; faster electronic prescription transfer (EPT) downloads; and increased opening hours (including lunch times).

9. CONCLUSIONS

The Wiltshire HWB PNA has been written to complement and add to the evidence base of NHS Wiltshire's 2015 PNA. It has again taken into account both the current provision of pharmaceutical services in the County and the identified and expressed needs of the local population. In order to assess the provision of pharmaceutical services in a county as large as Wiltshire, the needs assessment has been undertaken on both a county wide and Community Area level to provide detailed information to inform decisions on changes to pharmaceutical services in the future.

There is at least one Community Pharmacy in every Community Area in Wiltshire. It is recognised that in rural areas patients do not always have local access to community pharmacies. However, areas designated for the purposes of dispensing such as dispensing services provided by General Practices. They can also access community pharmacies in larger villages or towns, along with other services.

Opening hours of community pharmacies has increased in provision in Wiltshire since the previous PNA, with a wider range of provision in late evenings, after 7pm on weekdays and at the weekends. The pattern of these opening hours is generally reflective of population density, particularly with regard to Sunday opening times where there is a basic coverage of opening especially in areas of high population density. The majority of respondents to both the 2017 surveys indicated that they did not mind which pharmacies were open outside of office hours as long as they could find out which one was available when they needed it.

The anticipated increase in housing developments in each community area over the next three-year period until 2020/21 will not have a significant impact on provision of, or access to pharmaceutical services, and at present it is not anticipated that additional pharmacy facilities will be required. Wiltshire HWB will ensure that as part of the ongoing planning through the core strategy the provision of pharmaceutical services will be reviewed on an ongoing bases and supplementary statements to this PNA will be issued when necessary.

The availability of Locally Commissioned Services is an important element of Community Pharmacy provision, as these services provide opportunities to manage and prevent ill health at a local level relevant to the local population. There is variation in the range of Locally Commissioned Services in each of the Community Areas in Wiltshire, which is generally reflective of need. The Wiltshire Local Pharmaceutical Services Public Surveys 2010, 2014 and 2017 asked about the local provision of Locally Commissioned Services. This identified that people would like to access more of these services, but not necessarily via their Community Pharmacy. Further exploration with partners across the health service would be required to establish the exact need for these services at a local level and the ability of services to deliver.

It is clear from the response of Community Pharmacy providers within Wiltshire to the Contractor Survey, that there is a willingness, as there was in 2010 and 2014, to provide additional enhanced services. This provision would have to be commissioned upon the basis of health need and Wiltshire HWB will continue to work with local providers to take this forward, based upon the range of sources of information described in this document and changes in service provision or population demographics in the future.

Taking into account the range of information considered within this needs assessment, including current provision of services across the largely rural County and the results of the two public surveys and young people's engagement events, it can be concluded that there is appropriate provision of pharmaceutical services in Wiltshire, and that respondents were, in the main, very happy with the service that they receive from their community pharmacy. Wiltshire HWB recognises that a range of provision is necessary in a county the size and nature of Wiltshire where the population characteristics can vary greatly between community areas.

Therefore, Wiltshire HWB will continue to support the development of pharmaceutical services across the county using the best evidence available and in line with the strategic direction set at a national level. This will be done in conjunction with existing providers, in order to ensure the highest standards of quality and the optimum range of services are delivered. Future commissioning decisions relating to the provision of pharmaceutical services will be informed by the evidence presented within this needs assessment. In addition, consultation with residents of the county as part of the partnership working with Healthwatch Wiltshire and future changing demographics of the population will be undertaken and reviewed on an ongoing basis.

10. ANNEX COMMUNITY AREA DETAIL

The following tables provide detailed information (correct as of July 2017) about each of the twenty Community Areas in Wiltshire on the following:

- Population
- Service provision
- Specific diseases
- Lifestyle factors and enhanced services
- Bordering areas

The information has been taken from a range of sources, including the Joint Strategic Needs Assessment, the Contractor Survey and the Wiltshire Local Pharmaceutical Service Survey (2017), and the carer's survey 2017. These tables should be read in conjunction with information contained throughout the PNA.

The map overleaf provides an illustrated overview of all the Community Areas in Wiltshire. The tables within this annex describe what is available by Community Area only and do not describe what services are provided in neighbouring Community Areas. Instead, reference should be made to the detailed descriptions for neighbouring areas, which can be seen clearly highlighted on the map.

In describing the work undertaken by Community Pharmacies in Wiltshire, it is important to distinguish between that which is commissioned and that which is not commissioned. This is noted through this document, but in order to clarify the following are the lists of commissioned and non-commissioned services provided by pharmacies in Wiltshire:

Locally Commissioned Pharmacy Services in Wiltshire:

- Chlamydia Screening and Treatment Service
- Needle and Syringe Exchange
- Service Supervised Administration
- Service Support to Stop Smoking Service
- Emergency Hormonal Contraception Service (No Worries)
- Access to specific palliative care medicines

Non-commissioned Services Provided by Community Pharmacies in Wiltshire:

- Care Home Service
- Asthma
- Coronary Heart Disease
- Chronic Obstructive Pulmonary Disease
- Diabetes Type I Diabetes Type II Hypertension
- Home Delivery Service (not appliances) Obesity management
- Oral Contraceptive Service
- Diabetes support
- Alcohol brief intervention support

Community Area Maps

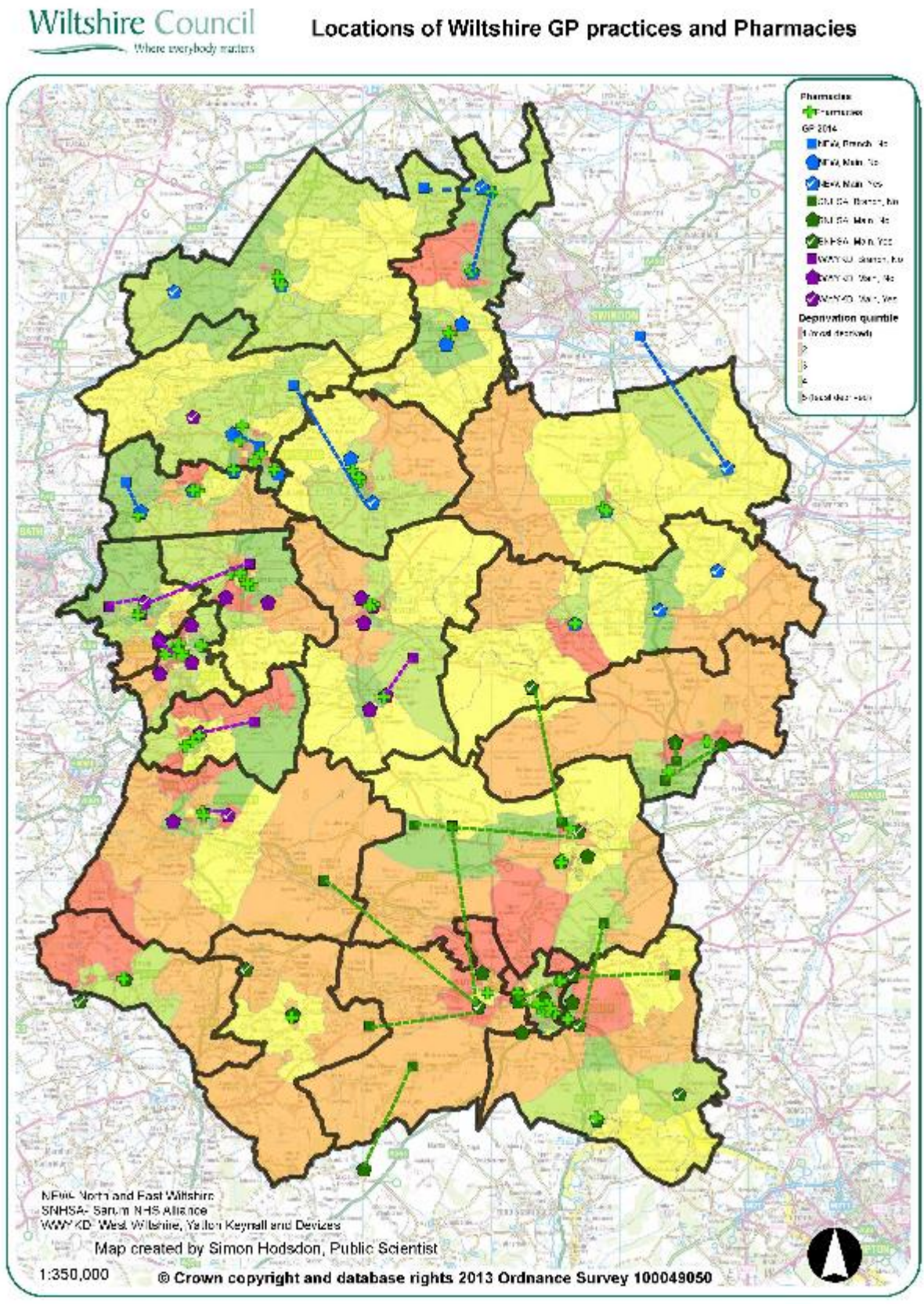
For each community area, a map has been produced which plots the GP surgeries, community pharmacies and dispensing GP's within that area. The GP surgeries both main surgeries and branch surgeries are colour coded dependant on the relevant Clinical Commissioning Group Cluster.

- Blue – North and East Wiltshire
- Green – Sarum
- Purple – West Wiltshire, Yatton Keynell and Devizes

Main GP surgeries are a pentagon in shape and branch surgeries are represented by a square. Dispensing GP practices can be identified with a white tick overlaying the pentagon for the surgery.

Community pharmacies are represented by a green cross and labelled by name. The community area is then shaded to indicate areas of higher or lower deprivation according to adjusted 2011 Indices of Deprivation. In the example below there are four main GP surgeries, one of which is a dispensing GP, one branch surgery, and five pharmacies. The surgeries are commissioned by North and East Wiltshire CCG Cluster.

Map: Overview of Wiltshire Community Areas

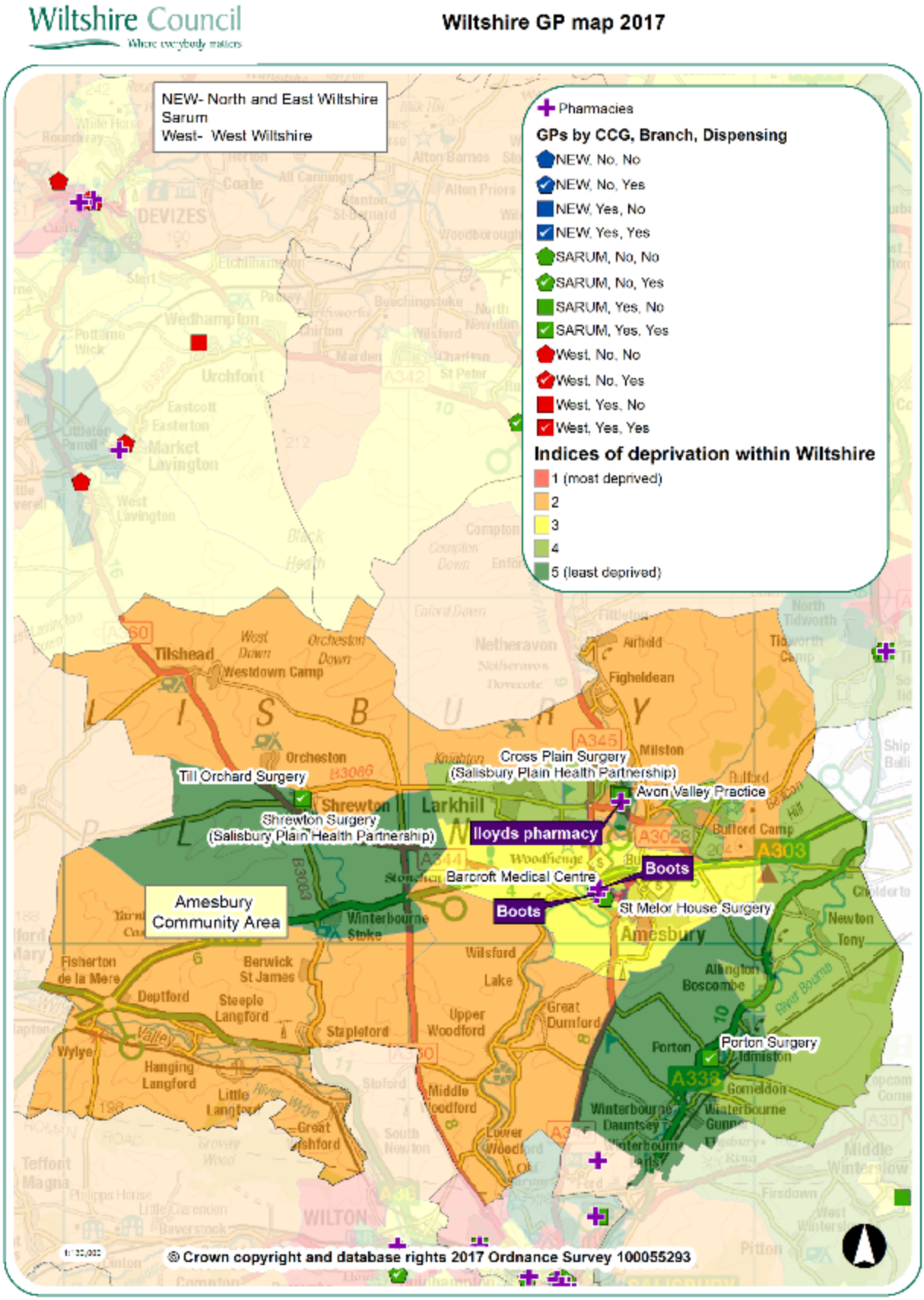


AMESBURY COMMUNITY AREA	
POPULATION	
Demography	• Total population is 34,324 • In relation to the other 19 community areas Amesbury has the second highest percentage of its total population under the age of 15 years. • Amesbury has the 2nd smallest population aged 65 years and over of all Wiltshire's community areas.
Number of LSOA which are within 20% most deprived in Wiltshire	• There are no LSOAs out of a total of 18 in Amesbury within the 20% most deprived in England.
SERVICE PROVISION	
Change in Community Pharmacies since 2015 PNA	• None
Number of Community Pharmacies	Boots Amesbury 40 Salisbury Street, Amesbury SP4 7HD Lloyds Amesbury 67 Bulford Road Durrington SP4 8DL Boots Amesbury Unit 8 Stonehenge Walk The Centre Amesbury SP4 7DB
Number of GP surgeries	• Two main surgeries and five branch surgeries.
Number of Dispensing GPs	• Three dispensing GPs

Access to Community Pharmacies	• One Community Pharmacy provides care home services • No Community Pharmacy offers home delivery service. • All Community Pharmacies in Amesbury area are open on a Saturday. • None open on Sunday. • None open evenings. • It does not show the nearest community pharmacies in Hampshire. Hampshire community pharmacies are further away for Amesbury residents than the alternative pharmacies located within Wiltshire's neighbouring community areas.
SPECIFIC DISEASES	
Cardiovascular disease (CVD)	• Slightly higher than the Wiltshire average, ranking 18th out of the 20 Community Areas for hospital admissions from Cardiovascular Disease. • Wiltshire does not commission any of the community pharmacies in the area to offer specific CVD interventions,
Diabetes	• Comparable with the Wiltshire average for diabetes hospital admissions, with 0.9 admissions per 1000 annually. • None community pharmacy in the area offers diabetes screening (non-commissioned) • Two community pharmacies stated they would offer diabetes screening if commissioned with training. • Two community pharmacies state that they would offer Diabetes Type I and II specific medicines management if commissioned with training.
Chronic Obstructive Pulmonary Disease (COPD)	• Slightly higher admission rates for COPD than the Wiltshire average. (1.5 per 1000 and ranks 8th highest community area for COPD hospital admissions • Wiltshire does not commission any of the community pharmacies in the area to offer specific COPD medicines management.
Asthma	• Ranks 4 out of 20 Community Areas for Asthma hospital related admissions (1.4 per 1000) • Wiltshire does not commission any of the community pharmacies in the area to offer specific Asthma medicines management but two would be willing to provide the service if commissioned with training.

LIFESTYLE FACTORS AND AVAILABLE SERVICES	
Drug misuse & Alcohol	• Two community pharmacies offering both needle exchange and supervised administration service (commissioned). • Out of the 20 Community Areas, Amesbury had the third highest percentage of respondents from the 2010 public survey stating that they would like to use a disposal of injecting equipment service at the pharmacy. • Amesbury is above the Wiltshire average for admissions to hospital related to alcohol for under 18 year olds and adults.
Sexual health	• Two Community Pharmacies in the area deliver the No Worries! service. This means provision of testing for Chlamydia and treatment for those who test positive, emergency hormonal contraception, pregnancy testing and free condoms. • The community based chlamydia screening programme diagnosed 33 young people with the infection in 2016 which was 10.1% of those that tested compared to a Wiltshire average of 8.4%
Smoking	• Estimates show that 20.1% of people in Amesbury smoke which is similar to the Wiltshire average of 20.2%. • One of the Community Pharmacies in this Community Area is commissioned to offer a Support to Stop Smoking Service.
Obesity	• Wiltshire does not commission any of the community pharmacies in this area to provide obesity management but one would be willing to provide if commissioned to do so with training.
BORDERING AREAS	
	• The following Community Areas in Wiltshire border Amesbury - Tidworth, Pewsey, Devizes, Warminster, Wilton, Salisbury, Southern Wiltshire. There will also be pharmaceutical services available across the border in neighbouring Hampshire.

Amesbury Community Area Map

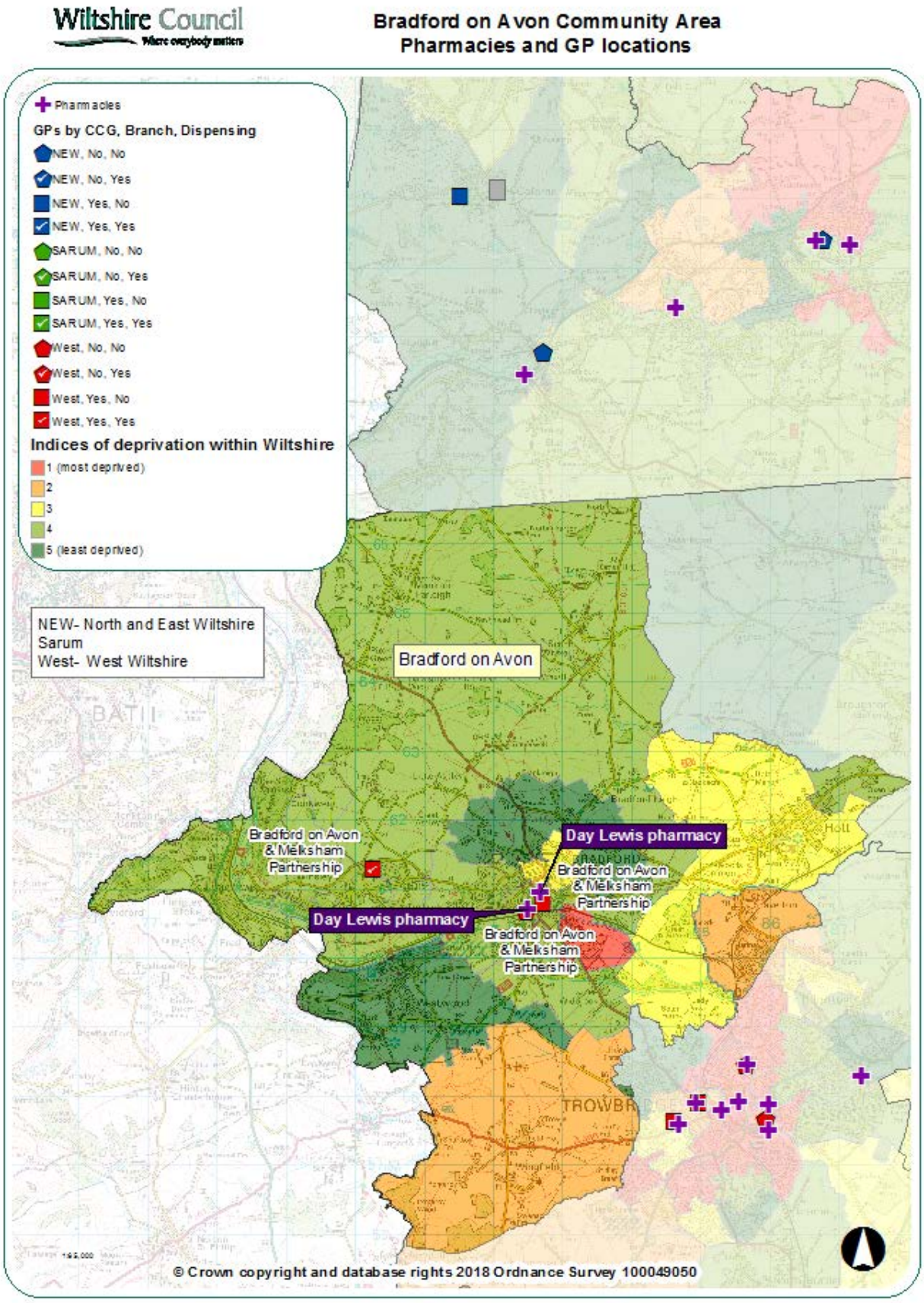


BRADFORD ON AVON COMMUNITY AREA	
Demography	• Total population is 18,275 • Bradford on Avon had the third highest population of people aged 65+
Number of LSOA which are within 20% most deprived in Wiltshire	• There are 11 LSOAs in Bradford on Avon of which none are within the 20% most deprived in Wiltshire quintile.
SERVICE PROVISION	
Change in Community Pharmacies since 2015 PNA	• Both pharmacies in Bradford on Avon are now run by Day Lewis Pharmacy Ltd
Number of Community Pharmacies	Day Lewis Pharmacy Station Approach Bradford on Avon BA15 1DQ Day Lewis Pharmacy 6 Silver Street Bradford on Avon BA15 1JX
Number of GP surgeries	• One main surgery and two branch surgeries
Number of Dispensing GPs	• Two dispensing GPs
Access to Community Pharmacies	• No Community Pharmacy is commissioned to offer a care home service but one provides a delivery service. • Both Community Pharmacies are open on Saturdays. • Neither is open on Sundays. • No evening opening.
SPECIFIC DISEASES	
Cardiovascular disease (CVD)	• Bradford on Avon has a under 75 years CVD mortality rate of 48 per 100, 000 which is not significantly different to the rest of the county. • Wiltshire does not commission either of the community pharmacies in the area to offer specific CVD interventions, but one was willing to deliver with training.

Diabetes	• Diabetes hospital admissions are close to the Wiltshire average at 0.6 per 1000 population. Bradford on Avon ranks 12 highest for diabetes admissions. • Wiltshire does not commission either of the community pharmacies in the area to offer specific Diabetes Type I and II specific medicines management. One stated that they are currently commissioned to provide diabetes services
Chronic Obstructive Pulmonary Disease (COPD)	• COPD hospital admission rate 0.8 per 1000 population and is below to the Wiltshire average. • Wiltshire does not commission either of the community pharmacies in the area to offer specific COPD medicines management.
Asthma	• Asthma hospital admission rate is the third highest across Wiltshire; close the Wiltshire average. • Wiltshire does not commission either of the community pharmacies in the area to offer specific Asthma medicines management but one would be willing to if commissioned to do so with training. One stated they are commissioned to provide an asthma service.
LIFESTYLE FACTORS AND AVAILABLE SERVICES	
Drug misuse & Alcohol	• Bradford on Avon's under 18s alcohol specific admissions rate is 54.9 per 1000, 000 • Both of the community pharmacies offer a supervised administration service. One of the community pharmacies is commissioned to provide a needle exchange service.
Sexual health	• One community pharmacy is commissioned to provide testing for Chlamydia and treatment for those who test positive, emergency hormonal contraception, pregnancy testing and free condoms. • The community based chlamydia screening programme diagnosed 9 young people with the infection in 2016 which was 5.8% of those that tested compared to a Wiltshire average of 8.4%

Smoking	• Estimates show that 9.0% of the population of Bradford -on-Avon smoke, ranking 11th lowest out of the 20 Community Areas for smoking prevalence. • One of the Community Pharmacies in the area is commissioned to offer a Support to Stop Smoking Service.
Obesity	• The number of children in Reception and Year 6 in Bradford on Avon are similar to the Wiltshire average of 21% and 29.8% respectively. • Wiltshire does not commission either of the community pharmacies in the area to offer weight management. Both state they would if commissioned and trained.
BORDERING AREAS	
	• The following Community Areas in Wiltshire border Bradford on Avon - Trowbridge, Melksham and Corsham. There is also availability of Community Pharmacy in Bath, and in Somerset.

Bradford on Avon Community Area Map

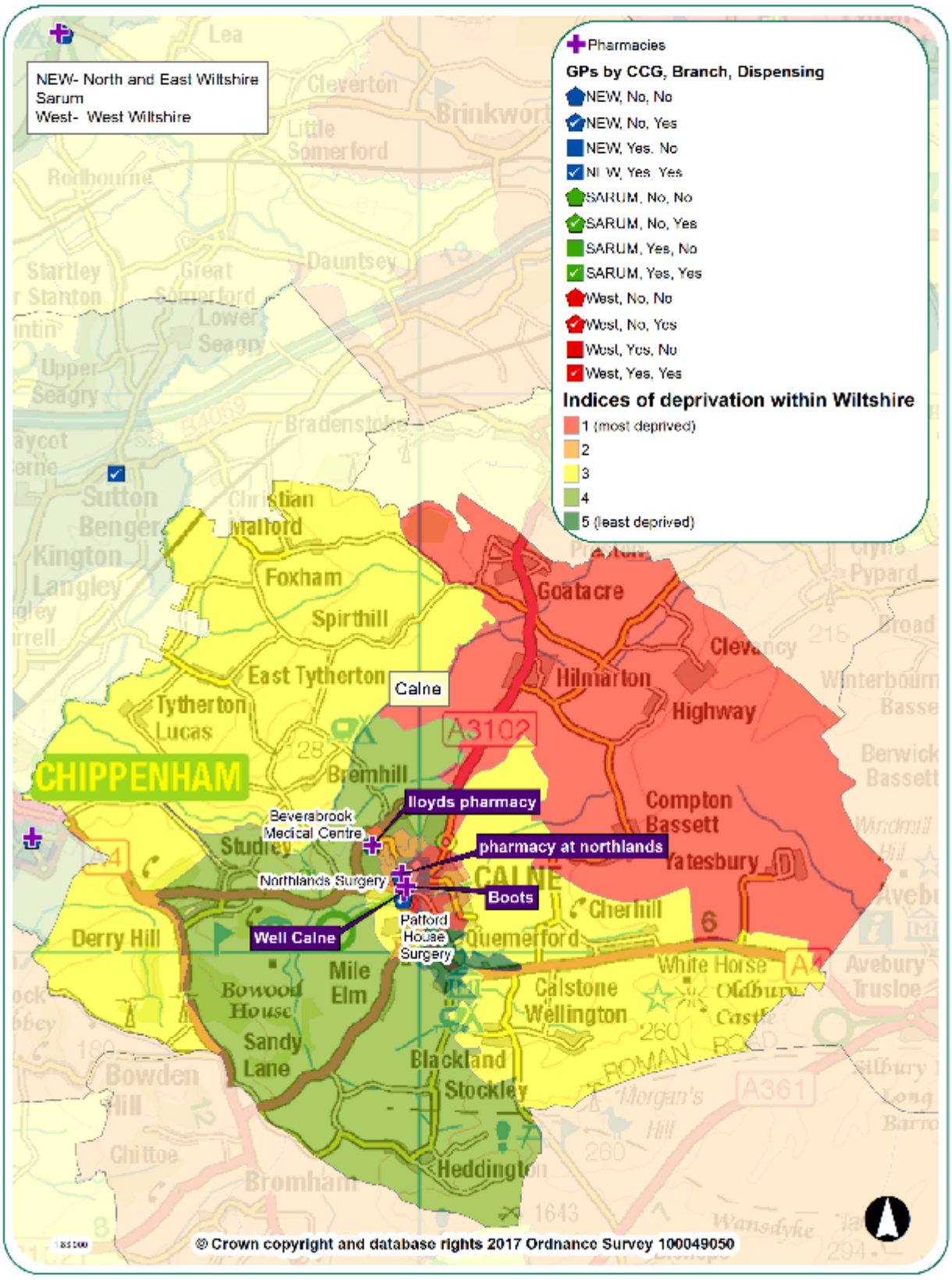


CALNE COMMUNITY AREA	
POPULATION	
Demography	• Total population is 23,817
Number of LSOA which are within 20% most deprived in Wiltshire	• There is one LSOA in Calne out of a total of 14 which is among the 20% in England with the highest percentage of households experiencing three or four types of deprivation.
SERVICE PROVISION	
Change in Community Pharmacies since 2015 PNA	• None
Number of Community Pharmacies *100 hour pharmacy	Well Pharmacy Unit 2 New New High Street Calne SN11 0BH Pharmacy at Northlands (Noorani & Sons Ltd)* 30-32 North Street Calne SN11 0HH Boots Calne 18 Phelps Parade Calne SN11 0HA Lloyds Calne 7 Harrier Close Lansdowne Centre Calne SN11 9UT
Number of GP surgeries	• Three main surgeries
Number of Dispensing GPs	• One dispensing GP
Access to Community Pharmacies	• Two Community Pharmacies provides a home delivery service (non-commissioned). • One Community Pharmacy currently provides a Care Home service (non-commissioned) and the other two states they would if commissioned. • All four Community Pharmacies are open on Saturdays. • One is open on Sundays. • One does evening opening.

SPECIFIC DISEASES	
Cardiovascular disease (CVD)	• CVD admissions equates to 17.1 per 1000 population which is close to the Wiltshire average for admissions from CVD and ranks 16th out of 20. • Wiltshire does not commission any of the community pharmacies in the area to offer specific CVD interventions, three stated they would be willing, if commissioned, to offer specific medicines management for CHD and hypertension and Vascular Risk Assessment Service (NHS Health Check).
Diabetes	• Close to Wiltshire average for Diabetes hospital admissions and ranks 8th of the 20 areas. • Diabetes screening is offered at one Community Pharmacy (non-commissioned) • Wiltshire does not commission any of the community pharmacies in the area to offer specific medicines management for Diabetes I and II. Three community pharmacies state that they would be willing to provide this service of commissioned. Or Diabetes type I and two for diabetes type II.
Chronic Obstructive Pulmonary Disease (COPD)	• Close to the Wiltshire average for COPD hospital admissions and ranks 12th highest out of the 20 Community areas. • Wiltshire does not commission any of the community pharmacies in the area to offer specific COPD medicines management, three would be willing to if commissioned to do so.
Asthma	• Asthma related hospital admissions are above the Wiltshire average, ranking the 2nd highest in Wiltshire. • Wiltshire does not commission any of the community pharmacies in the area to offer specific Asthma medicines management, three pharmacies would be willing to provide.

LIFESTYLE FACTORS AND AVAILABLE SERVICES	
Drug misuse & Alcohol	• Under 18 alcohol specific hospital admission rate 42.3 per 100, 000 • Two Community Pharmacies in the area offer needle/syringe exchange (commissioned) and three offer supervised administration (commissioned). • Calne has a slightly higher than the Wiltshire average rate for hospital admissions related to alcohol
Sexual health	• The community based chlamydia screening programme diagnosed 38 young people with the infection in 2016 which was 15% of those that tested compared to a Wiltshire average of 8.4% • One Community Pharmacies in the area is commissioned to provide the No Worries! Service. This provides testing for Chlamydia and treatment for those who test positive, emergency hormonal contraceptive, pregnancy testing and free condoms.
Smoking	• Estimates show that 17.2% of the population of Wiltshire smoke. Calne ranks 18th highest out of 20 Community Areas for smoking prevalence based upon 2009 lifestyle data. • Two of the community pharmacies in the area are currently commissioned to provide Support to Stop Smoking.
Obesity	• The number of children in Reception and Year 6 in Calne is very similar to the Wiltshire average of 21% and 29.8% respectively. • Wiltshire does not commission any of the community pharmacies in the area to offer specific obesity management currently but two state that they would be willing to if commissioned to do so.
BORDERING AREAS	
	• The following Community Areas in Wiltshire border Calne: Devizes, Corsham, Chippenham, Wootton Bassett & Cricklade, Marlborough.

Calne Community Area Map

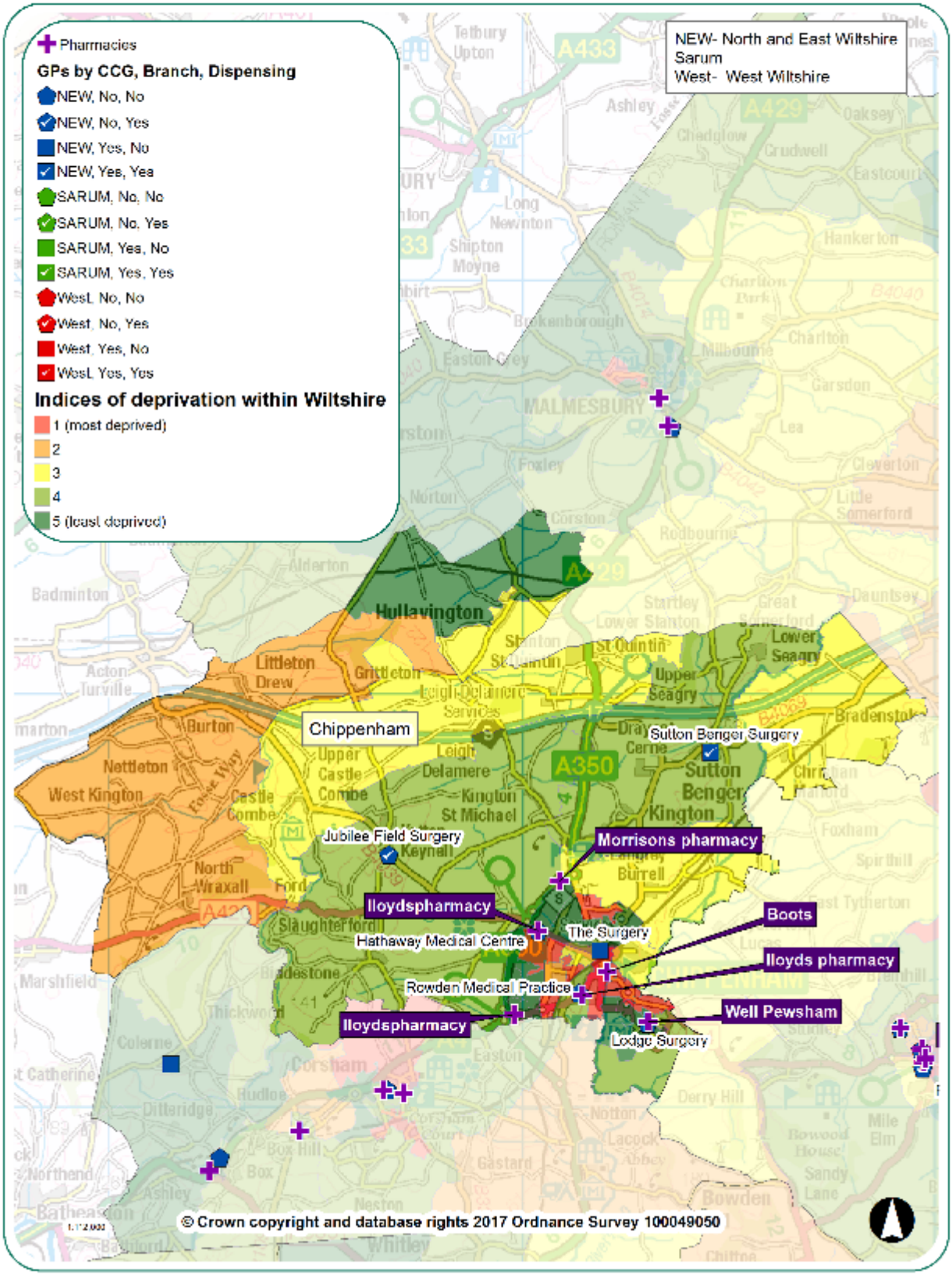


CHIPPENHAM COMMUNITY AREA	
POPULATION	
Demography	• Total population is 45,479
Number of LSOA which are within 20% most deprived in England	• There are 28 LSOAs in this community area, of which 2 are among the 20% in England with the highest percentage of household deprivation.
SERVICE PROVISION	
Change in Community Pharmacies since 2015 PNA	• None
Number of Community Pharmacies *100 hour pharmacy	Boots Chippenham 8-9 High Street Chippenham SN15 3ER Lloyds Chippenham* Hathaway Medical Centre Middlefield Road Chippenham SN14 6GT Morrisons Chippenham Cepen Park North Malmesbury Road Chippenham SN14 6UZ Lloyds in Sainsbury's Bath Road Chippenham SN14 0BJ Lloyds Chippenham St Lukes Drive Rowden Hill Chippenham SN15 2SD Well Pharmacy Lodge Road Chippenham SN15 3SY

Number of GP surgeries	• Four main surgeries and two branch surgeries
Number of Dispensing GPs	• Two dispensing GP
Access to Community Pharmacies	• Three community pharmacies who responded to the survey currently provide a Care Homes service and one stated they would if commissioned with training. • Two pharmacies offer a home delivery service. • All six are open on Saturdays • Four are open on Sundays. • One opens late evenings until 10.30pm every weekday and until 10pm on Sundays.
SPECIFIC DISEASES	
Cardiovascular disease (CVD)	• No significant difference for CVD mortality compared to the rest of Wiltshire. • Wiltshire does not commission any of the community pharmacies in the area to offer specific CHD medicines management or Vascular Risk Assessment Service (NHS Health Check).
Diabetes	• Close to the Wiltshire average for Diabetes hospital admissions and ranks 2nd lowest out of the 20 areas. • One pharmacy provides Diabetes Type I services and four provide diabetes types II medicines management not offered from any pharmacy, two pharmacies are willing and able if commissioned.
Chronic Obstructive Pulmonary Disease (COPD)	• Close to the Wiltshire average for COPD hospital admissions and ranks 14th out of the 20 areas. • Wiltshire does not commission any of the community pharmacies in the area to offer specific COPD medicines management.
Asthma	• Close to the Wiltshire average for Asthma hospital admissions and ranks 8th highest out of the 20 areas. • Wiltshire does not commission any of the community pharmacies in the area to offer specific Asthma medicines management, one does provide (non-commissioned) and two would be willing to provide the service with training.
LIFESTYLE FACTORS AND AVAILABLE SERVICES	
Drug misuse & Alcohol	• Under 18 alcohol specific hospital admissions is 85.2 per 100, 000 • Two Community Pharmacies in the area offer needle/ syringe exchange and supervised administration

Sexual health	• One community pharmacy is commissioned to deliver the No Worries! Service. This provides testing for Chlamydia and treatment for those who test positive, emergency hormonal contraception, pregnancy testing and free condoms. • The community based chlamydia screening programme diagnosed 64 young people with the infection in 2016 which was 8.2% of those that tested compared to a Wiltshire average of 8.4%
Smoking	• Very similar to the Wiltshire average for the estimated percentage of smokers. • Four of the Community Pharmacies are currently commissioned to offer Support to Stop Smoking.
Obesity	• The number of children in Reception in Calne are very similar to the Wiltshire average of 21% however for year 6 the figure is slightly higher in Chippenham at 32.5% compared to the Wiltshire average of 29.8%. • Two Community Pharmacy state they would be willing to offer obesity management service if commissioned with training.
BORDERING AREAS	
	• The following Community Areas in Wiltshire border Chippenham - Malmesbury, Calne and Corsham.

Chippenham Community Area Map

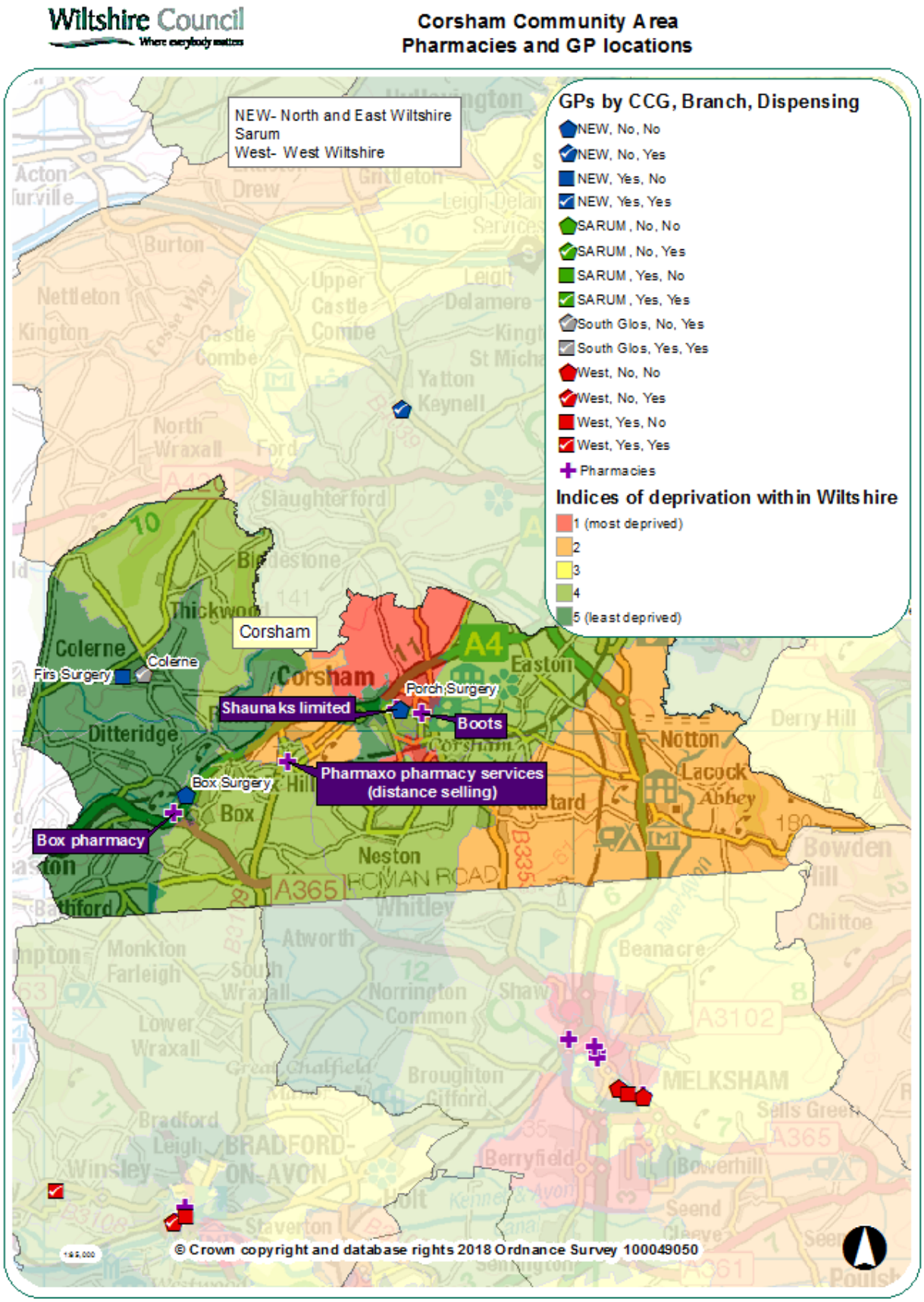


CORSHAM COMMUNITY AREA	
POPULATION	
Demography	• Total population is 20,909 • Fifth highest for under 20s population and forth highest for under 15s. Those aged 65+ account for 20.3% of the population
Number of LSOA which are within 20% most deprived in England	• Corsham community area has 12 LSOA none of which are amongst the most deprived 20% in England.
SERVICE PROVISION	
Change in Community Pharmacies since 2015 PNA	• None
Number of Community Pharmacies	Box Pharmacy 10 High Street Box SN13 8NN Boots Corsham 22 Martingate Corsham SN13 0HL Shaunaks Corsham The Pharmacy – Porch Surgery Beechfield Road Corsham SN13 9DN Distance-selling pharmacy: Pharmaxo pharmacy services (unit A15 Fiveways Estate, Westwell Road, Corsham, SN13 9RG)
Number of GP surgeries	• Two main surgeries plus one branch surgery.
Number of Dispensing GPs	• One – Colerne (commissioned by BANES LA)

Access to Community Pharmacies	• One Community Pharmacy state that they provide a Care Home service. One provides a delivery service • Two open Saturdays. • No Sunday opening. • No late evening opening.
SPECIFIC DISEASES	
Cardiovascular disease (CVD)	• Corsham has no significantly different under 75s CVD mortality rate compared to the rest of Wiltshire. • Wiltshire does not commission any of the community pharmacies in the area to offer specific offer specific CHD or hypertension medicines management or Vascular Risk Assessment Service (NHS Health Check).
Diabetes	• Corsham compares unfavourably (4rd highest) among the Community Areas for diabetes admissions to hospital (high admission rate). • Two Community Pharmacies would be willing to provide Diabetes screening if it was commissioned with training.
Chronic Obstructive Pulmonary Disease (COPD)	• A similar hospital admission rate to the Wiltshire average (10 out of 20) for Chronic Obstructive Pulmonary Disease • Wiltshire does not commission any of the community pharmacies in the area to offer specific COPD medicines management.

Asthma	• Corsham community area Is close to the Wiltshire average for asthma related hospital admissions, and is the 5th highest in the county. • Wiltshire does not commission any of the community pharmacies in the area to offer specific Asthma medicines management, one would be willing and able and another if commissioned with training.
LIFESTYLE FACTORS AND AVAILABLE SERVICES	
Drug misuse & Alcohol	• Under 18s alcohol specific hospital admissions rate 35.3 per 100, 000 • Two Community Pharmacies provide a supervised administration service (commissioned) and one is commissioned to provide syringe/needle exchange. • Alcohol related admissions to hospital are significantly lower than the Wiltshire average in Corsham community area.
Sexual health	• Pickwick Ward has a higher than average teenage conception rate. • The community based chlamydia screening programme diagnosed 20 young people with the infection in 2016 which was 10.2% of those that tested compared to a Wiltshire average of 8.4% • One community pharmacy is commissioned to deliver the No Worries! Service. This provides testing for Chlamydia and treatment for those who test positive, emergency hormonal contraception, pregnancy testing and free condoms.
Smoking	• Estimates show that 10.7% of people in Corsham smoke which is below the County average. • Three of the Community Pharmacies are commissioned to provide Support to Stop Smoking.
Obesity	• None of the Community Pharmacies in the area is commissioned to provide obesity management but two state they would be willing to if commissioned to do so.
BORDERING AREAS	
	• The following Community Areas in Wiltshire border Corsham - Chippenham, Calne, Melksham, Bradford on Avon.

Corsham Community Area Map

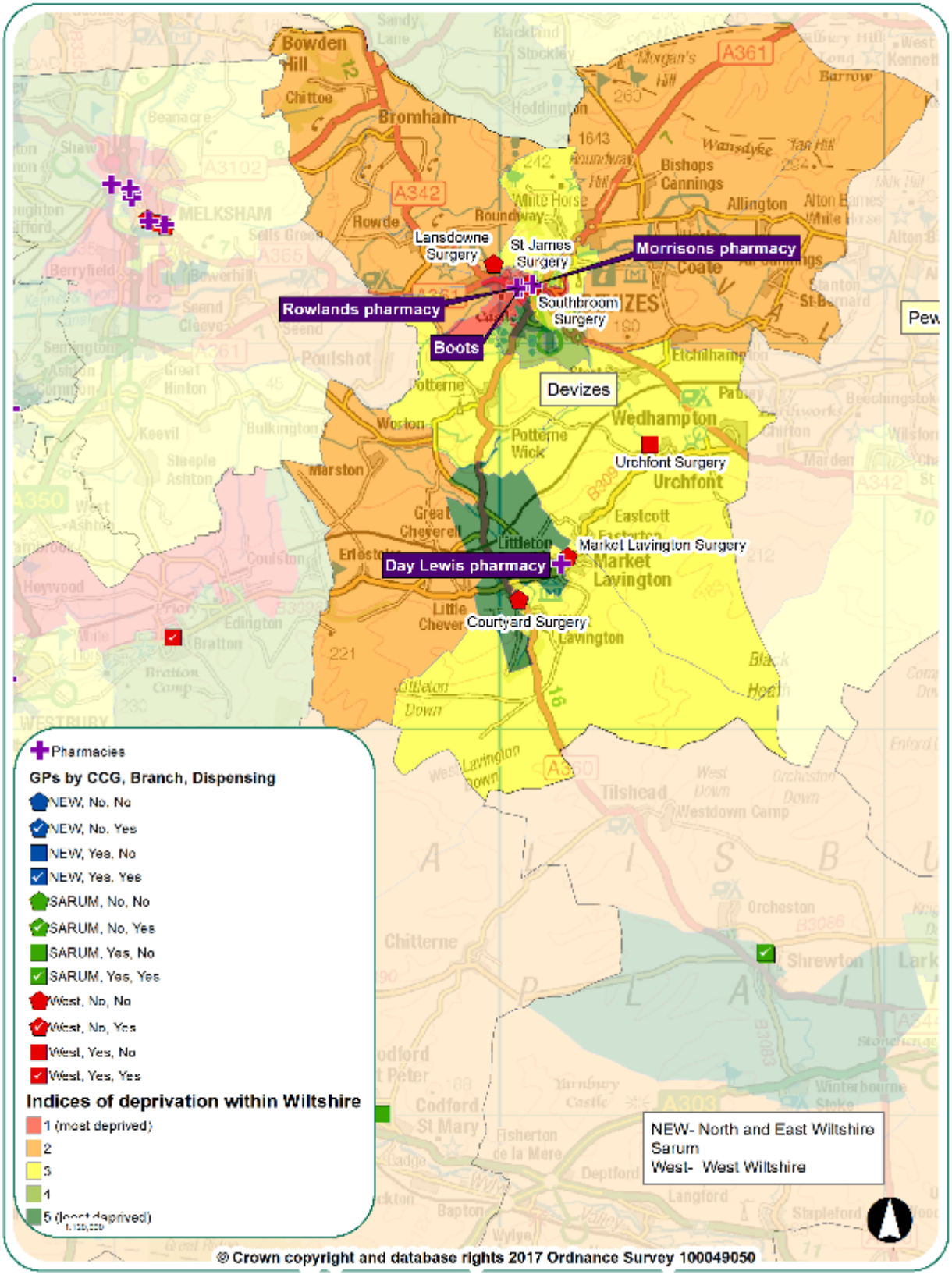


DEVIZES COMMUNITY AREA	
POPULATION	
Demography	• Total population is 32, 849 • 22.4% of those living in Devizes are 65+
Number of LSOA which are within 20% most deprived in England	• There are 19 LSOA in the Devizes Community Area of which none are among the 20% in England with the highest percentage of households experiencing three or four types of deprivation.
SERVICE PROVISION	
Change in Community Pharmacies since 2015 PNA	• None
Number of Community Pharmacies	Day Lewis Market Lavington 37 Rochelle Court Market Place Market Lavington Devizes SN10 4AT Morrisons Devizes 15-16 Estcourt Street Devizes SN10 1LA Boots Devizes 14-15 The Brittox Devizes SN10 1SJ Rowlands Pharmacy 1 The Little Brittox Devizes SN10 1AR
Number of GP surgeries	• Five main surgeries and one branch.
Number of Dispensing GPs	• No dispensing GPs

Access to Community Pharmacies	• No pharmacy would be willing to provide a care home service, and one pharmacy would be willing to provide a delivery service with training. One pharmacy does provide a goodwill delivery service • One opens until 8pm each weekday and until 7pm on a Saturday. • All are open on Saturdays. • Two are open on Sundays.
SPECIFIC DISEASES	
Cardiovascular disease (CVD)	• Similar to the Wiltshire average for mortality from CVD. • Wiltshire does not commission any of the community pharmacies in the area to offer specific CHD or Hypertension medicines management or Vascular Risk Assessment Service (NHS Health Check). Two would be willing to provide with training.
Diabetes	• Similar to the Wiltshire average for Diabetes hospital admissions and ranks 9th out of the 20 areas. • Wiltshire does not commission any of the community pharmacies in the area to offer Diabetes screening or specific Diabetes Type I or II medicines management, three pharmacies stated that they would be willing to if commissioned with training.
Chronic Obstructive Pulmonary Disease (COPD)	• Similar to the Wiltshire average for COPD hospital admissions and ranks 7th highest of the 20 areas. • Wiltshire does not commission any of the community pharmacies in the area to offer specific COPD medicines management.
Asthma	• Above the Wiltshire average for Asthma hospital admissions and ranks highest (1st) out of 20 areas. • Wiltshire does not commission any of the community pharmacies in the area to offer specific Asthma medicines management, two would be willing to provide with training.
LIFESTYLE FACTORS AND AVAILABLE SERVICES	
Drug misuse & Alcohol	• Under 18 alcohol specific hospital admissions rate 39.2 per 100, 000 • Four community pharmacies offer needle/syringe exchange commissioned and supervised administ service (commissioned).

Sexual health	• Devizes and Roundway South and Devizes North both have higher than average teenage conception rates. • One community pharmacy is commissioned to deliver the No Worries! Service. This provides testing for Chlamydia and treatment for those who test positive, emergency hormonal contraception, pregnancy testing and free condoms. • The community based chlamydia screening programme diagnosed 39 young people with the infection in 2016 which was 10% of those that tested compared to a Wiltshire average of 8.4%
Smoking	• 14.2% of Devizes residents estimated to smoke which is slightly higher than the Wiltshire average. • Four Community Pharmacy is commissioned to provide a Support to Stop Smoking Service.
Obesity	• Wiltshire does not commission any of the community pharmacies in the area to offer obesity Management, three stated they would be willing to if commissioned with training.
BORDERING AREAS	
	• The following Community Areas in Wiltshire border Devizes - Calne, Marlborough, Pewsey, Amesbury, Westbury, Melksham, Warminster and Corsham.

Devizes Community Area Map

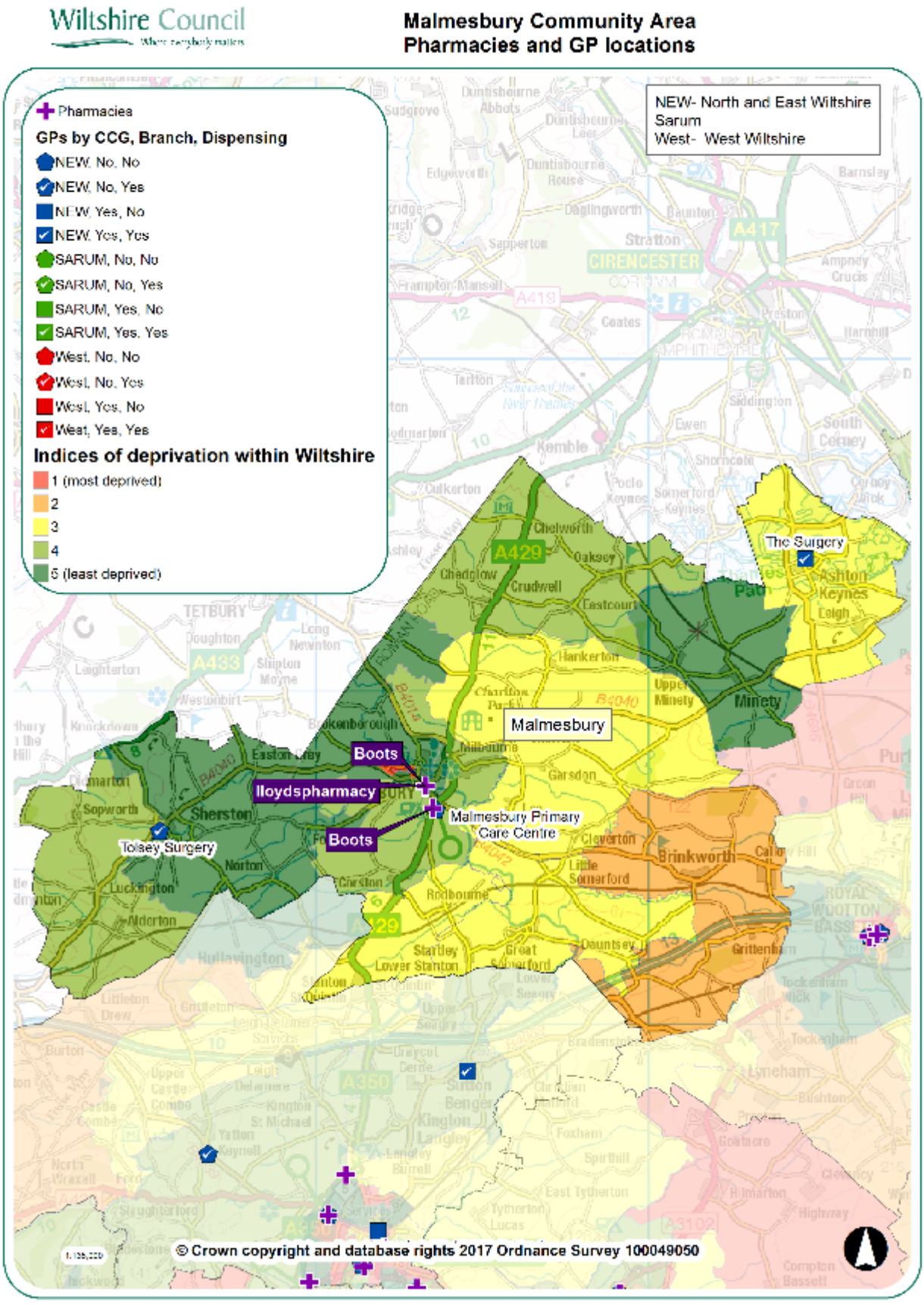


MALMESBURY COMMUNITY AREA	
POPULATION	
Demography	• Total population is 19,871 • Second highest proportion of males in the under 15 age group (52.8% of this age group are male.
Number of LSOA which are within 20% most deprived in England	• There are 13 LSOAs in Devizes of which none is among the 20% in England with the highest percentage of households experiencing three or four types of deprivation.
SERVICE PROVISION	
Change in Community Pharmacies since 2015 PNA	• None
Number of Community Pharmacies *denotes 100 hour pharmacy	Boots the Chemist Malmesbury 39 High Street Malmesbury SN16 9AA Lloyds Malmesbury 28 High Street Malmesbury SN16 9AU Boots Malmesbury* Primary Care Centre Priory Way Burton Hill Malmesbury SN16 0FB
Number of GP surgeries	• Two main surgeries and one branch surgery
Number of Dispensing GPs	• Two dispensing GPs
Access to Community Pharmacies	• One Community Pharmacy in the area offers a home delivery service. • No pharmacy is commissioned to offer a Care Home service. • One Community Pharmacy is open from 6.30am until 10.30pm on weekdays. • All three are open on Saturdays including one open from 6.30am until 8.30pm. • One is open on Sundays.

SPECIFIC DISEASES	
Cardiovascular disease	• Lower than the Wiltshire average for CVD mortality. • Wiltshire does not commission any of the community pharmacies in the area to offer specific CHD medicines management or Vascular Risk Assessment Service (NHS Health Check).
Diabetes	• Below the Wiltshire average for Diabetes hospital admissions and ranks 20th out of the community areas • Wiltshire does not commission any of the community pharmacies in the area to offer specific Diabetes Type I or II medicines management, • One currently offers Diabetes screening (non-commissioned)
Chronic Obstructive Pulmonary Disease (COPD)	• One of the lowest rates in Wiltshire for COPD hospital admissions and ranks 19th out of the 20 community areas. • Wiltshire does not commission any of the community pharmacies in the area to offer specific COPD medicines management.
Asthma	• Similar to the Wiltshire average for Asthma hospital admissions and ranks 16th highest of the 20 areas. • Wiltshire does not commission any of the community pharmacies in the area to offer specific Asthma medicines management. One pharmacy was willing if commissioned with training.
LIFESTYLE FACTORS AND AVAILABLE SERVICES	
Drug misuse	• Malmesbury has no reported under 18 alcohol specific hospital admissions. • One Community Pharmacy offers a needle/syringe exchange service (commissioned) and two offer a supervised administration service (commissioned). • One of the lowest alcohol related hospital admissions out of the 20 community areas with a significantly lower rate than the Wiltshire average.

Sexual health	• One community pharmacy is commissioned to deliver the No Worries! Service. This provides testing for Chlamydia and treatment for those who test positive, emergency hormonal contraception, pregnancy testing and free condoms. • The community based chlamydia screening programme diagnosed 9 young people with the infection in 2016 which was 4.9% of those that tested compared to a Wiltshire average of 8.4%
Smoking	• Very low estimated smoking prevalence. Malmesbury ranks 3rd best out of the 20 Community Areas for smoking prevalence. • One Community Pharmacy is commissioned to provide a Support to Stop Smoking Service.
Obesity	• Wiltshire does not commission any of the community pharmacies in the area to offer obesity management currently, one stated they would not be able or willing to if commissioned.
BORDERING AREAS	
	• The following Community Areas in Wiltshire border Malmesbury - Chippenham, Wootton Bassett & Cricklade.

Malmesbury Community Area Map



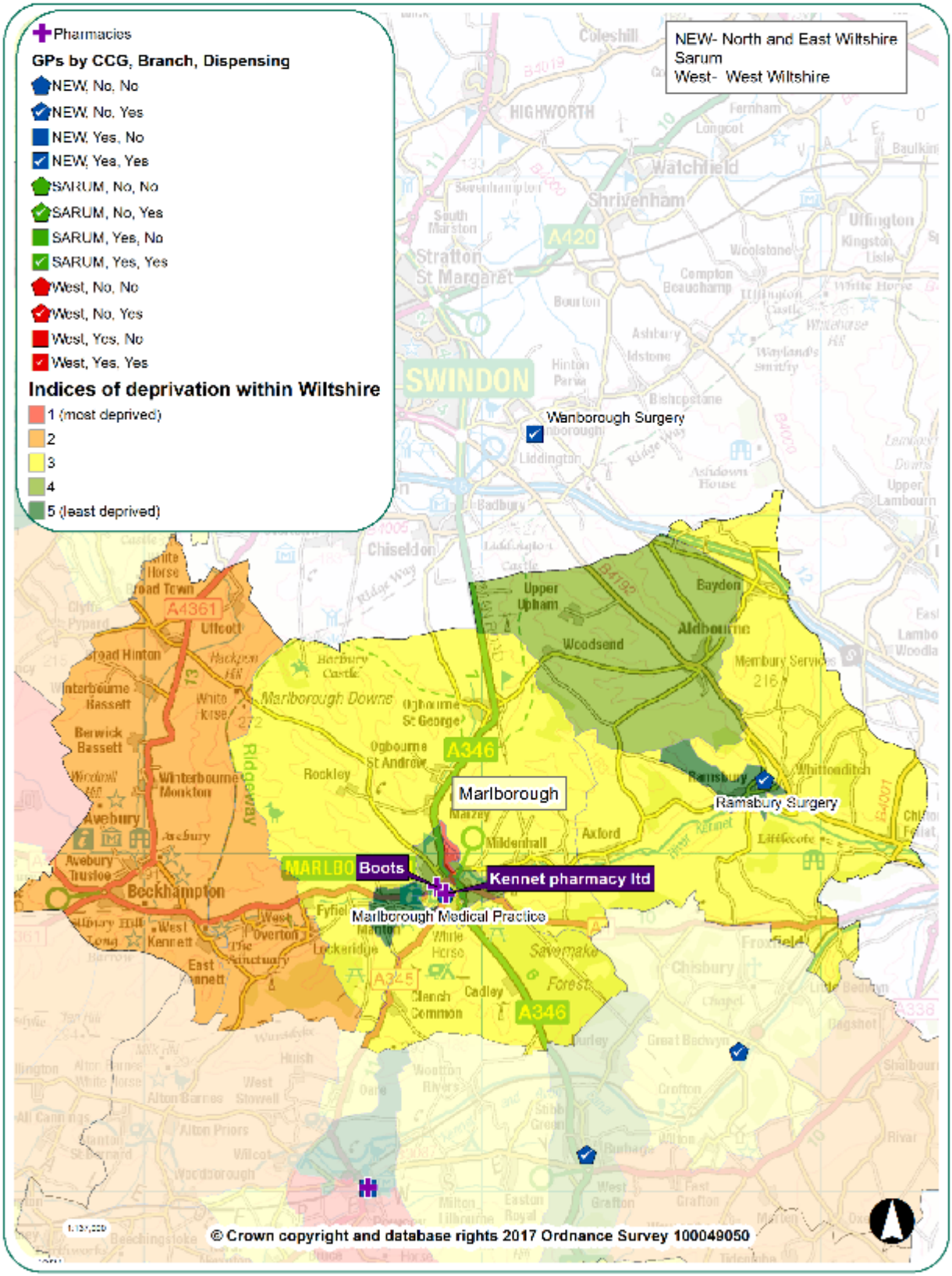
MARLBOROUGH COMMUNITY AREA	
POPULATION	
Demography	• Total population is 18,033 • Lowest proportion of males in the u15 age group (49.7% of this age group are male)
Number of LSOA which are within 20% most deprived in England	• Out of a total of 10 LSOAs there none in the Marlborough Community Area which are among the 20% in England with the highest percentage of households experiencing three of four types of deprivation.
SERVICE PROVISION	
Change in Community Pharmacies since 2015 PNA	• None
Number of Community Pharmacies	Boots Marlborough 103 High Street Marlborough SN8 1LT Kennet Pharmacy 56 George Lane Marlborough SN8 4BY
Number of GP surgeries	• Two main surgeries
Number of Dispensing GPs	• Two dispensing GPs
Access to Community Pharmacies	• One of the pharmacies provides home delivery, one is willing and able to provide a home delivery service (non-commissioned). One pharmacy would provide care home support with training. • One is open on Saturdays. • One is open on Sundays.
SPECIFIC DISEASES	
Cardiovascular disease (CVD)	• Similar to the Wiltshire average for CVD mortality.

Diabetes	• Lower than the Wiltshire average for hospital admissions due to Diabetes, but not significantly so. Ranked 19th lowest out of the 20 community areas. • One of the pharmacies responded and stated that they be able and willing to provide diabetes services and one with training.
Chronic Obstructive Pulmonary Disease (COPD)	• Similar to the Wiltshire average for hospital admission related to COPD, but again not significantly so. Ranked 15th lowest out of the 20 community areas.
Asthma	• Similar to the Wiltshire average for hospital admission related to Asthma, ranked 10th out of the 20 community areas.
LIFESTYLE FACTORS AND AVAILABLE SERVICES	
Drug misuse & Alcohol	• One Community Pharmacy offers a needle/syringe exchange service (commissioned) and one offers a supervised administration service (commissioned). • A lower than the Wiltshire average for alcohol related hospital admissions.
Sexual health	• Marlborough East has a higher than average teenage conception rate. • No Community Pharmacy is commissioned to provide the No Worries! Service, which includes providing testing for Chlamydia and treatment for those who test positive, emergency hormonal contraception, pregnancy testing and free condoms. • The community based chlamydia screening programme diagnosed 14 young people with the infection in 2016 which was 7.2% of those that tested compared to a Wiltshire average of 8.4%
Smoking	• The percentage of people in Marlborough who smoke is lower than the Wiltshire average and ranks Marlborough 7th lowest out of the 20 Community Areas. • One of the Community Pharmacies in the area is commissioned to provide a Support to Stop Smoking Service.

Obesity	• One of the pharmacies stated that they would be willing to provide an obesity management service with training.
BORDERING AREAS	
	• The following Community Areas in Wiltshire border Marlborough – Royal Wootton Bassett & Cricklade, Calne, Devizes and Pewsey.

Wiltshire Council
Where everybody matters

Marlborough Community Area
Pharmacies and GP locations



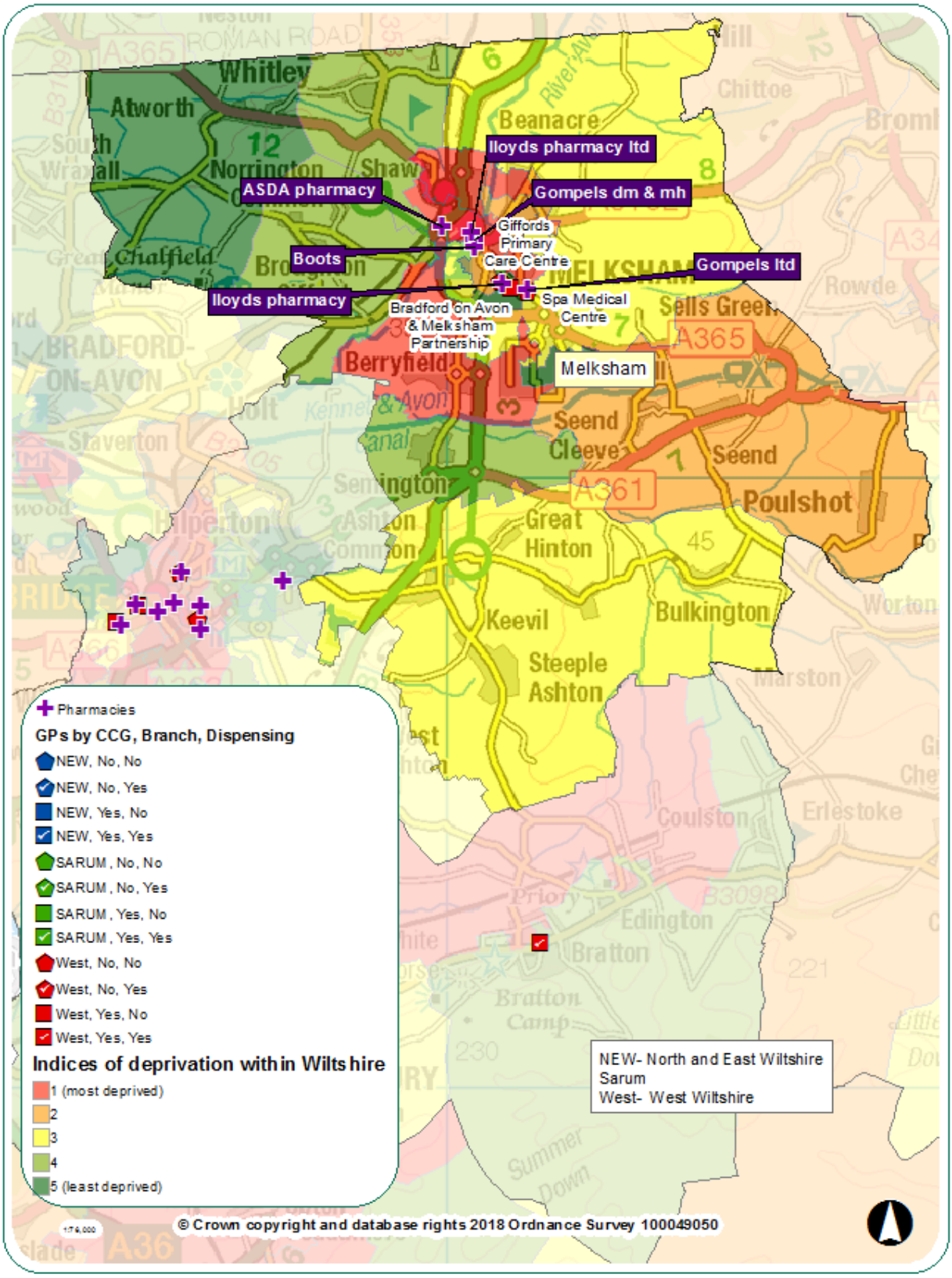
MELKSHAM COMMUNITY AREA	
POPULATION	
Demography	• Total population is 29,829 • Melksham Community Area has the ninth highest percentage of its total population under the age of 20 years and the 11th highest percentage of its total population being of retirement age and over.
Number of LSOA which are within 20% most deprived in England	• There are eight LSOAs of which two are among the top 20% in England for those experiencing deprivation.
SERVICE PROVISION	
Number of GP surgeries	• Two main surgeries and a branch
Number of Dispensing GPs	• No dispensing GPs
Number of Community Pharmacies *denotes 100 hour pharmacy	Gompels Melksham Spa Medical Centre Snowberry Lane Melksham, SN12 6LE Gompels Pharmacy 1Bank Street Melksham, SN12 6LE Boots Melksham 19-23 High Street Melksham, SN12 6JY Lloyds in Sainsbury's* Bath Road Melksham, SN12 6LL Asda Melksham* Bradford Road Melksham, SN12 8LQ Lloyds Melksham Giffords Primary Care Centre Spa Road Melksham, SN12 7EA
Change in Community Pharmacies since 2015 PNA	• None

Access to Community Pharmacies	• No pharmacy delivers a care home service but would if commissioned and trained. • Four offers a home delivery service . • Two are open late evenings. • Four are open on Saturdays. • Two are open on Sundays.
SPECIFIC DISEASES	
Cardiovascular disease	• Similar to the Wiltshire average for CVD mortality. • Wiltshire does not commission any of the community pharmacies in the area to offer specific CHD or hypertension medicines management or Vascular Risk Assessment Service (NHS Health Check).
Diabetes	• Close to the Wiltshire average for Diabetes hospital admissions and ranks 16th out of the 20 community areas. • Wiltshire does not commission any of the community pharmacies in the area to offer specific Diabetes Type I or II medicines management but one said they would be willing to if commissioned. Two pharmacies provide diabetes type 2 services (non-commissioned).
Chronic Obstructive Pulmonary Disease (COPD)	• Higher than the Wiltshire average for COPD hospital admissions. Ranks 2nd highest out of the 20 community areas. • Wiltshire does not commission any of the community pharmacies in the area to offer specific COPD medicines management, four would be willing to if commissioned.
Asthma	• Close to the Wiltshire average for Asthma hospital admissions and ranks 14th highest rate out of the 20 community areas. • Wiltshire does not commission any of the community pharmacies in the area to offer specific Asthma medicines management, one would be willing to if commissioned, and three stated that they if commissioned with training.

LIFESTYLE FACTORS AND AVAILABLE SERVICES	
Drug misuse & Alcohol	• Under 18 alcohol specific hospital admissions 53.2 100, 000 • One community pharmacy in the area is commissi to offer a needle/syringe exchange service and fou a supervised administration service. • Melksham community area has similar rates of alcohol related hospital admissions to the Wiltsh average.
Sexual health	• Three Community Pharmacies are commissioned to provide the No Worries! Service. This provides testing for Chlamydia and treatment for those who test positive, emergency hormonal contraception, pregnancy testing and free condoms. • The community based chlamydia screening programme diagnosed 38 young people with the infection in 2016 which was 9.5% of those that tested compared to a Wiltshire average of 8.4%
Smoking	• The % of the total population who smoke in Melksham is estimated to be slightly higher than the Wiltshire average. • Five of the Community Pharmacies are commissioned to deliver a Support to Stop Smoking Service.
Obesity	• None of the Community Pharmacies in the area are commissioned to deliver obesity management currently but one state that they would be willing to if commissioned.
BORDERING AREAS	
	• The following Community Areas in Wiltshire border Melksham - Bradford on Avon, Trowbridge, Westbury, Devizes and Corsham.

Wiltshire Council
Where everybody matters

Melksham Community Area
Pharmacies and GP locations



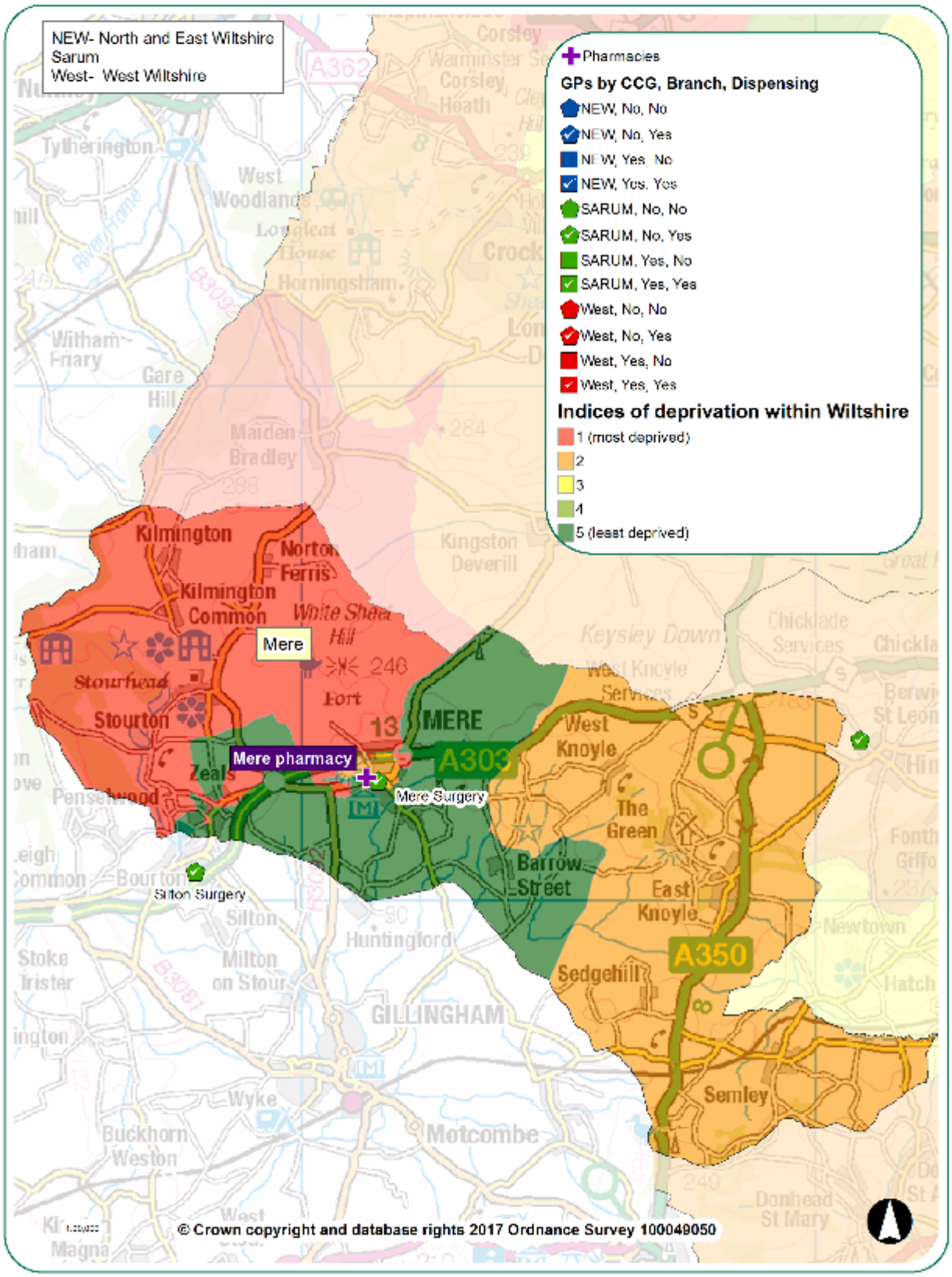
MERE COMMUNITY AREA	
POPULATION	
Demography	• Total population is 5,562 • Highest proportion of males in the u20 age group (53.9% of this age group are male)
Number of LSOA which are within 20% most deprived in Wiltshire	• There are four LSOAs in Mere Community Area of which none are in the most deprived 20% in Wiltshire.
SERVICE PROVISION	
Change in Community Pharmacies since 2015 PNA	• None
Number of Community Pharmacies	Mere Pharmacy – Dudley Taylor The Square Mere Warminster BA12 6DL
Number of GP surgeries	• One main surgeries
Number of Dispensing GPs	• One dispensing GP
Access to Community Pharmacies	• The Community Pharmacy is not commissioned to a home delivery service or Care Home service. • Open on Saturdays but not on Sundays. • No evening opening.
SPECIFIC DISEASES	
Cardiovascular disease (CVD)	• No significant difference between Mere and the Wiltshire average in terms of CVD mortality. • Wiltshire does not commission the community pharmacy in the area to offer specific CHD or hypertension medicines management.

Diabetes	• Highest rate of Diabetes hospital admissions out of the 20 Community areas. • The Community Pharmacy in the area is not commissioned to offer Diabetes screening or specific Diabetes Type I or II medicines management.
Chronic Obstructive Pulmonary Disease (COPD)	• Close to the Wiltshire average for COPD hospital admissions. Ranks 4th out of the 20 Community Areas. • The Community Pharmacy in the area is not commissioned to offer specific COPD medicines management.
Asthma	• Lowest rate of Asthma hospital admissions out of the 20 Community Areas. • The Community Pharmacy in the area is not commissioned to offer specific Asthma medicines Management.
LIFESTYLE FACTORS AND AVAILABLE SERVICES	
Drug misuse & Alcohol	• The Community Pharmacy is commissioned to offer a needle/syringe exchange service and a supervised administration service. • South West Wiltshire (includes Mere, Tisbury and Wilton) is above the Wiltshire average for alcohol related hospital admissions.
Sexual health	• No Community Pharmacy is commissioned to provide the No Worries! Service, which includes providing testing for Chlamydia and treatment for those who test positive, emergency hormonal contraception, pregnancy testing and free condoms. • The community based chlamydia screening programme diagnosed 4 young people with the infection in 2016 which was 7.5% of those that tested compared to a Wiltshire average of 8.4%
Smoking	• Lower than the Wiltshire average smoking prevalence. • The Community Pharmacy is commissioned to provide a Support to Stop Smoking Service.

Obesity	• The Community Pharmacy in the area is not commissioned to offer obesity management currently but states that they would be willing to if commissioned.
BORDERING AREAS	
	• The following Community Areas in Wiltshire border Mere - Warminster and Tisbury. There is also availability of community pharmacy across the border in Somerset.

Wiltshire Council
Where everybody matters

Mere Community Area
Pharmacies and GP locations



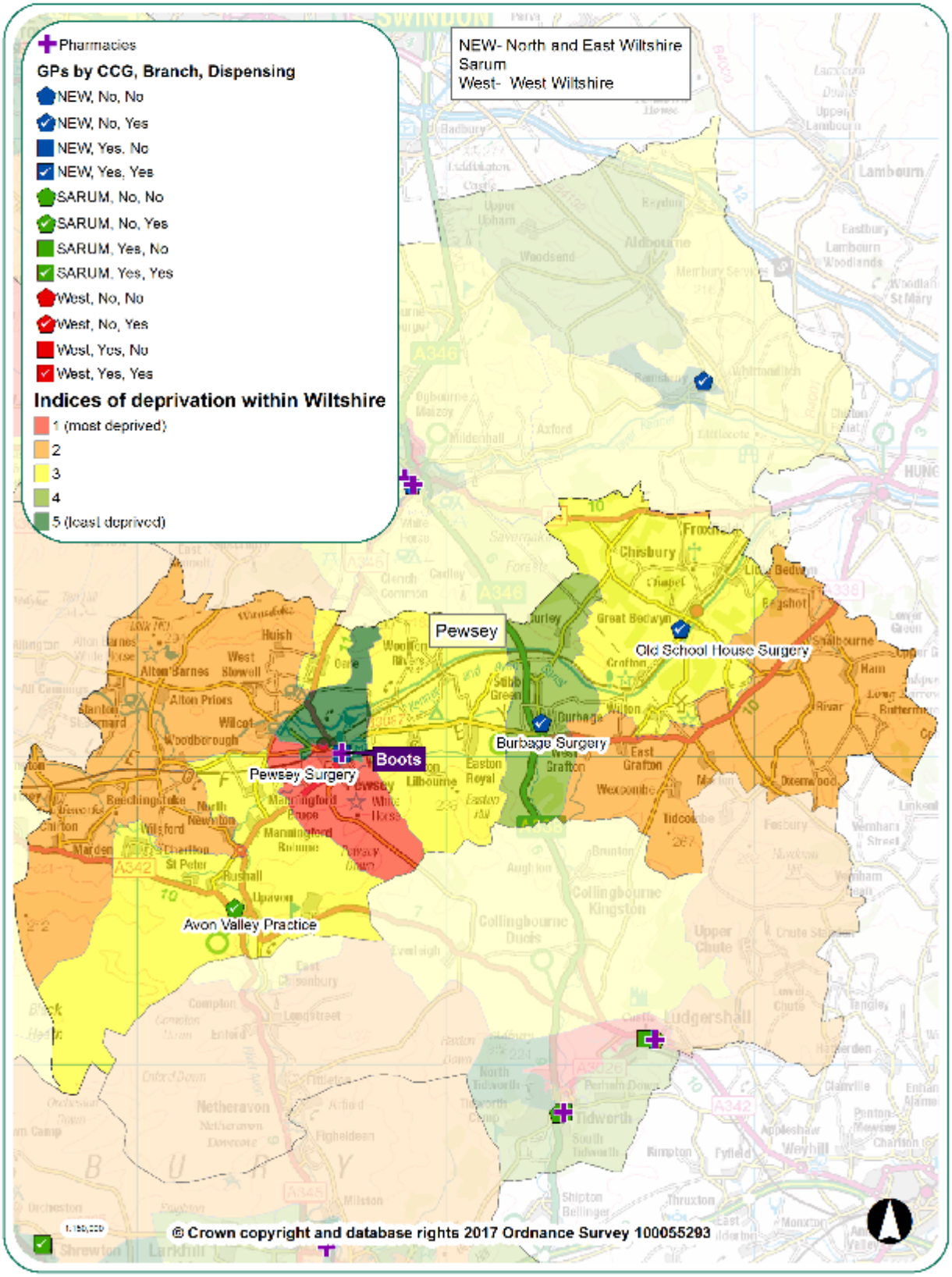
PEWSEY COMMUNITY AREA	
POPULATION	
Demography	• Total population is 14,236 • Pewsey Community Area has the 12th highest percentage of its total population under the age of 15 years. It has the seventh highest percentage of its total population being of retirement age and over.
Deprivation	• Pewsey has 8 LSOAs of which none are within England's 20% most deprived.
SERVICE PROVISION	
Change in Community Pharmacies since 2015 PNA	• None
Number of Community Pharmacies	Boots Pewsey 32 High Street Pewsey SN9 5AQ
Number of GP surgeries	• Four main surgeries.
Number of Dispensing GPs	• Three dispensing GPs
Access to Community Pharmacies	• The Community Pharmacy is not commissioned to provide a Care Home service or home delivery service, and has not shown interest in delivery of these services. • No evening opening. • Open on Saturdays but not Sundays.
SPECIFIC DISEASES	
Cardiovascular disease	• Lower than the Wiltshire average for mortality from CVD. • The Community Pharmacy is not commissioned to offer specific CHD or hypertension medicines management or Vascular Risk Assessment Service (NHS Health Check.

Diabetes	• Close the Wiltshire average for Diabetes hospital admissions rate. Ranks 3rd lowest out of the 20 Community Areas. • The Community Pharmacy in the area is not commissioned to offer Diabetes screening or specific Diabetes Type I or II medicines management but would be willing to if commissioned.
Chronic Obstructive Pulmonary Disease (COPD)	• Lower than the Wiltshire average for COPD hospital admissions rate. Ranks the lowest out of the 20 Community Areas. • The Community Pharmacy is not commissioned to offer specific COPD medicines management.
Asthma	• Lower than the Wiltshire average for Asthma hospital admissions rate. Ranks 2nd lowest out of the 20 Community Areas. • The Community Pharmacy is not commissioned to offer specific Asthma medicines management but would be willing to if commissioned with training.
LIFESTYLE FACTORS AND AVAILABLE SERVICES	
Drug misuse & Alcohol	• Under 18 alcohol specific hospital admission rate is 90.9 per 100, 000 population. • The Community Pharmacy is commissioned to offer a needle/syringe exchange service and sharps disposal and supervised consumption.
Sexual health	• Unable to provide under 18 conception rates for this community area • One community pharmacy is commissioned to deliver the No Worries! Service. This provides testing for Chlamydia and treatment for those who test positive, emergency hormonal contraception, pregnancy testing and free condoms. • The community based chlamydia screening programme diagnosed 10 young people with the infection in 2016 which was 10.5% of those that tested compared to a Wiltshire average of 8.4%
Smoking	• Ranks 4th lowest out of the 20 Community areas for smoking prevalence. • The Community Pharmacy is commissioned to provide a Support to Stop Smoking Service.

Obesity	• The Community Pharmacy is not commissioned to offer an obesity management service but states that they would be willing to if commissioned with training.
BORDERING AREAS	
	• The following Community Areas in Wiltshire border Pewsey – Marlborough, Devizes, Amesbury and Tidworth.

Wiltshire Council
Where everybody matters

Pewsey Community Area
Pharmcies and GP locations



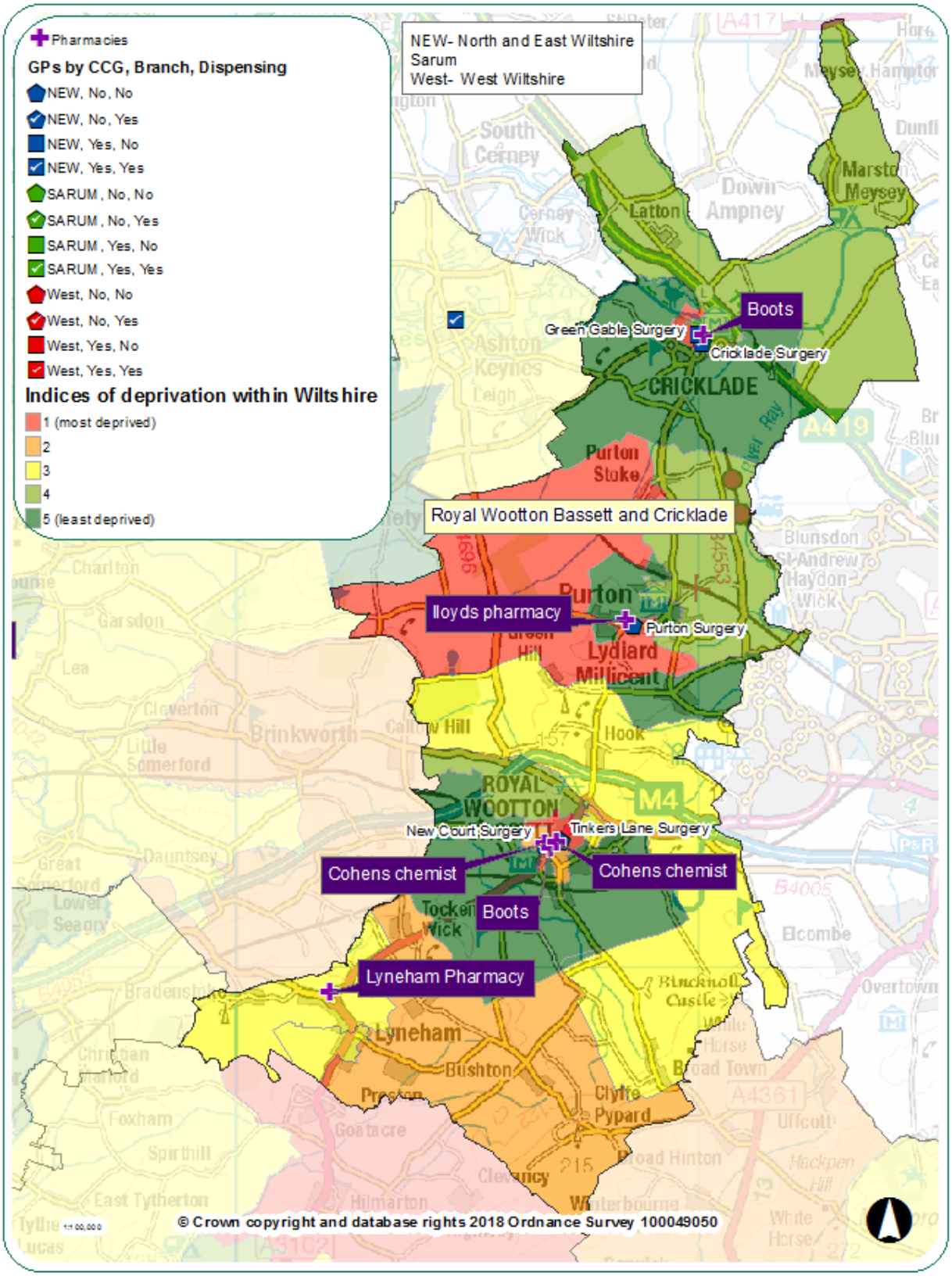
ROYAL WOOTTON BASSETT & CRICKLADE COMMUNITY AREA	
POPULATION	
Demography	• Total population is 30,349 • Highest proportion of males in the under 15 age group (52.9% of this age group are male). 3rd highest proportion of males in the 20-64 age group (50.9%)
Deprivation	• RWB&C has 18 LSOA of which none are in England's 20% most deprived.
SERVICE PROVISION	
Change in Community Pharmacies since 2015 PNA	• Lloyds Pharmacy and CLM Jones and Partner (RWB) are now under ownership of 'Cohen's Chemist – entry amended below. • New pharmacy in Lyneham, details below
Number of Community Pharmacies	• Five Community Pharmacies, of which 4 responded to the contractor survey (non-responder highlighted in red below) Lloyds Purton 7 The Parade Purton Swindon, SN5 4BX Boots Cricklade 100 High Street Cricklade Swindon, SN6 6AA Boots Wootton Bassett 133 High Street Royal Wootton Bassett Swindon, SN4 7AY Cohen's Chemist (formerly Lloyds Pharmacy – Wootton Bassett) Unit 19 - Boroughfields Shopping Centre Royal Wootton Bassett Swindon, SN4 7AX Cohen's Chemist 102 High Street Royal Wootton Bassett Swindon, SN4 7AU Lyneham Pharmacy, Edmonds Garage, The Green, Lyneham, SN15 4PB

Number of GP surgeries	• Three main surgeries and two branch.
Number of Dispensing GPs	• One dispensing GP
Access to Community Pharmacies	• Of those who responded none of the community pharmacies offer a Care Home service (non-commissioned) and one stated that they would be willing to if commissioned. • Four of the respondents' state that they don't offer home delivery service (non-commissioned). • All open on Saturdays except one (Lyneham). • None open on Sundays. • No evening opening.
SPECIFIC DISEASES	
Cardiovascular disease (CVD)	• Higher than the Wiltshire average for CVD mortality rate. • Wiltshire does not commission any of the community pharmacies in the area to offer specific CHD medicines management or Vascular Risk Assessment Service (NHS Health Check).
Diabetes	• Lower than the Wiltshire average for Diabetes hospital admissions rate, ranking 2nd lowest out of the 20 areas. • Three respondents stated that they would be able and willing to provide specific medicines management for Type I and II Diabetes if commissioned with training. One provides a diabetes type 2 service.
Chronic Obstructive Pulmonary Disease (COPD)	• Close to the Wiltshire average for the COPD hospital admissions rate, ranking 5th highest out of the 20 areas. • Wiltshire does not commission any of the community pharmacies in the area to offer specific COPD medicines management.
Asthma	• Close to the Wiltshire average rate for Asthma hospital admissions and ranks 7th lowest of the 20 areas. • Wiltshire does not commission any of the community pharmacies in the area to offer specific Asthma medicines management but three would be willing to if commissioned.
LIFESTYLE FACTORS AND AVAILABLE SERVICES	

Drug misuse & Alcohol	• Under 18s alcohol specific hospital admission rate is 33.6 per 100, 000 pop • Three Community Pharmacies offer needle/syringe exchange (commissioned). Four offer supervised administration (commissioned).
Sexual health	• No Community Pharmacy is commissioned to provide the No Worries! Service, which includes providing testing for Chlamydia and treatment for those who test positive, emergency hormonal contraception, pregnancy testing and free condoms. • The community based chlamydia screening programme diagnosed 15 young people with the infection in 2016 which was 6% of those that tested compared to a Wiltshire average of 8.4% •
Smoking	• Smoking prevalence estimates are lower than the Wiltshire average and Royal Wootton Basset and Cricklade has the 8th lowest rate out of the 20 community areas. • Two Community Pharmacies are commissioned to offer a Support to Stop Smoking Service.
Obesity	• No Community Pharmacy is commissioned to offer obesity management but one stated that they would be willing to if commissioned with training.
BORDERING AREAS	
	• The following Community Areas in Wiltshire border Royal Wootton Bassett and Cricklade - Malmesbury, Chippenham, Calne and Marlborough. There is also availability of pharmacy services in neighbouring Swindon.

Wiltshire Council
Where everybody matters

Royal Wootton Bassett and Cricklade Community Area Pharmacies and GP locations



SALISBURY COMMUNITY AREA	
POPULATION	
Demography	• Total population is 42, 429 • Lowest proportion of males in the 65+ age group (42.9% of this age group are male)
Number of LSOA which are within 20% most deprived in England	• There are 27 LSOAs in the Salisbury Community Area of which three are among the 20% in England with the highest percentage of households experiencing three or four types of deprivation.
SERVICE PROVISION	
Change in Community Pharmacies since 2015 PNA	• None

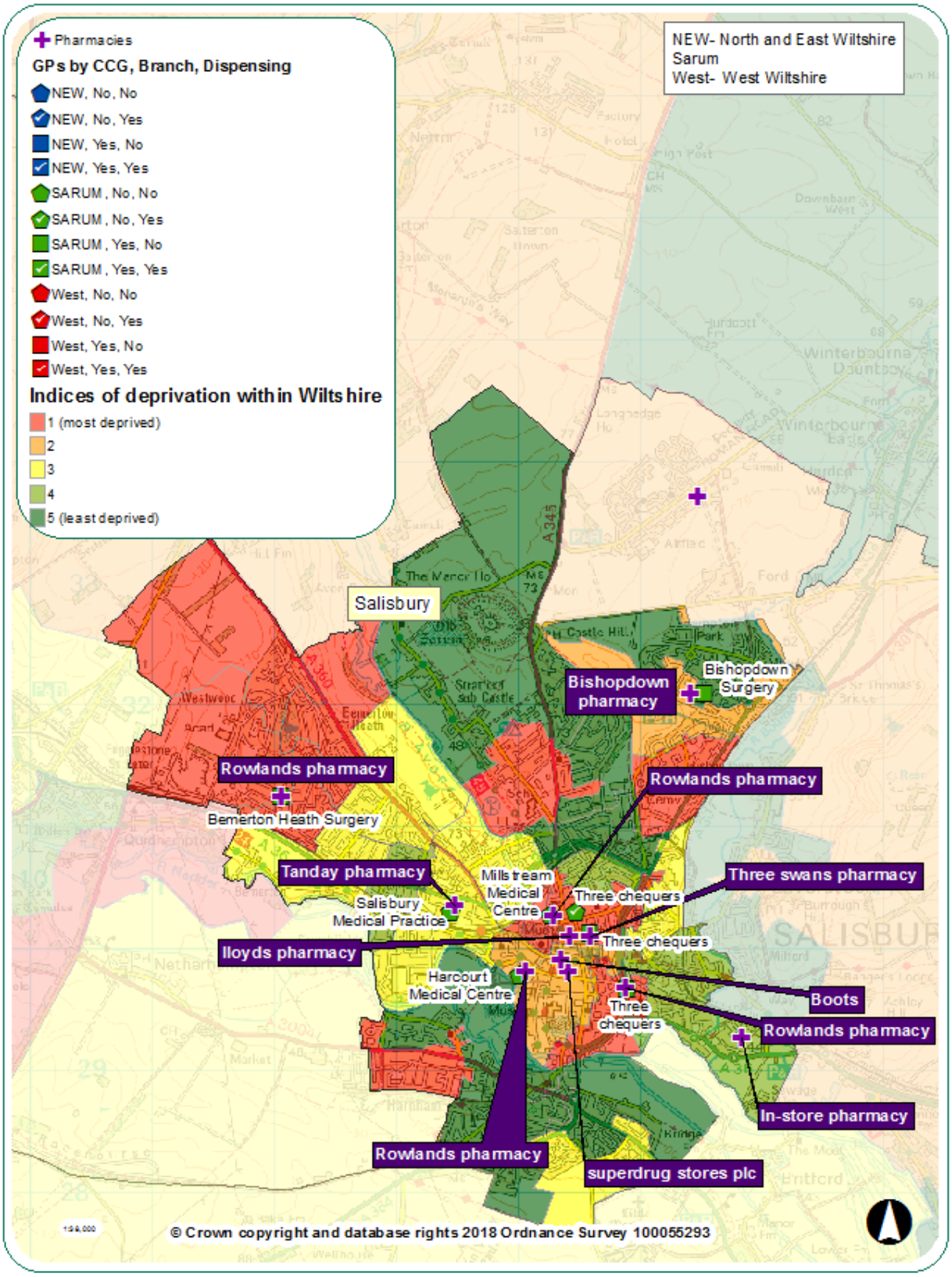
Number of Community Pharmacies	• Eleven Community Pharmacies (plus one distance selling pharmacy), of which 10 responded to the contractor survey (non-responders highlighted in red below) Boots Salisbury 41-51 Silver Street Salisbury SP1 2NG Lloyds Pharmacy 4-6 Minster Street Salisbury SP1 1UA Superdrug Salisbury 12-14 Old George Mall Salisbury SP1 2AG Rowlands Pharmacy Avon approach Salisbury SP1 3SL Rowlands Pharmacy 82 St Ann Street Salisbury SP1 2PT Rowlands Pharmacy Harcourt Medical Centre Cranebridge Road Salisbury SP2 7TD Rowlands Pharmacy Pembroke Road Bemerton Heath Salisbury SP2 8DJ Three Swans Pharmacy Rollestone Street Salisbury SP1 1DX Tanday Fisherton House Fountain Way Wilton Road Salisbury SP2 7FD Tesco Salisbury Bourne Centre Southampton Road Salisbury SP1 2NY Medicine Clinic Bishopdown Surgery 28 St Clements Way Bishopdown Salisbury SP1 3FF Dispensing Appliance Contractor: Fittleworth Medical, Units 12-14, Barnack Business Park, Salisbury, SP1 2LP
Number of GP surgeries	• Five main GP surgeries and one branch surgeries • In addition, there is a NHS Walk In Centre in Salisbury • As of April 2017 Endless Street, Three Swans and St Anns practices merged to become the Three Chequers Medical Practice
Number of Dispensing GPs	• One dispensing GP

Access to Community Pharmacies	• Five Community Pharmacies are willing to provide a Care Home service • Six provides a home delivery service. • Two with evening opening. • Seven are open on Saturdays. • Two are open on Sundays.
SPECIFIC DISEASES	
Cardiovascular disease (CVD)	• No significant difference in CVD mortality rate when compared to County • Wiltshire does not commission any of the community pharmacies in the area to offer specific CHD medicines management or Vascular Risk Assessment Service (NHS Health Check).
Diabetes	• Close to the Wiltshire average for Diabetes hospital admissions rate. Ranks 6th highest of the 20 Community Areas. • No Community Pharmacies offer diabetes screening (non-commissioned) and all state that they would be willing to if commissioned.
Chronic Obstructive Pulmonary Disease (COPD)	• Third highest Community Area rate for COPD hospital admissions. • Wiltshire does not commission any of the community pharmacies in the area to offer specific COPD medicines management.
Asthma	• 6th highest Asthma hospital admissions out of the 20 Community Areas. • None of the Community Pharmacies in the area states that they currently offer specific Asthma medicines management. Eight stated that they would be willing to if commissioned with training.
LIFESTYLE FACTORS AND AVAILABLE SERVICES	

Drug misuse & alcohol	• Six Community Pharmacies offer a needle/syringe exchange service (commissioned) and a supervised administration service (commissioned).
Sexual health	• Three of the Community Pharmacies are commissioned to deliver the No Worries! Service. This provides testing for Chlamydia and treatment for those who test positive, emergency hormonal contraception, pregnancy testing and free condoms. • The community based chlamydia screening programme diagnosed 30 young people with the infection in 2016 which was 6.6% of those that tested compared to a Wiltshire average of 8.4% •
Smoking	• Fourth highest smoking prevalence compared to Wiltshire average. • Five Community Pharmacies in the area are commissioned to deliver a Support to Stop Smoking Service.
Obesity	• One of the Community Pharmacies in the area would be willing to provide the service if commissioned with training.
BORDERING AREAS	
	• The following Community Areas in Wiltshire border Salisbury - Amesbury, Wilton and Southern Wiltshire.

Wiltshire Council
Where everybody matters

Salisbury Community Area
Pharmacies and GP locations



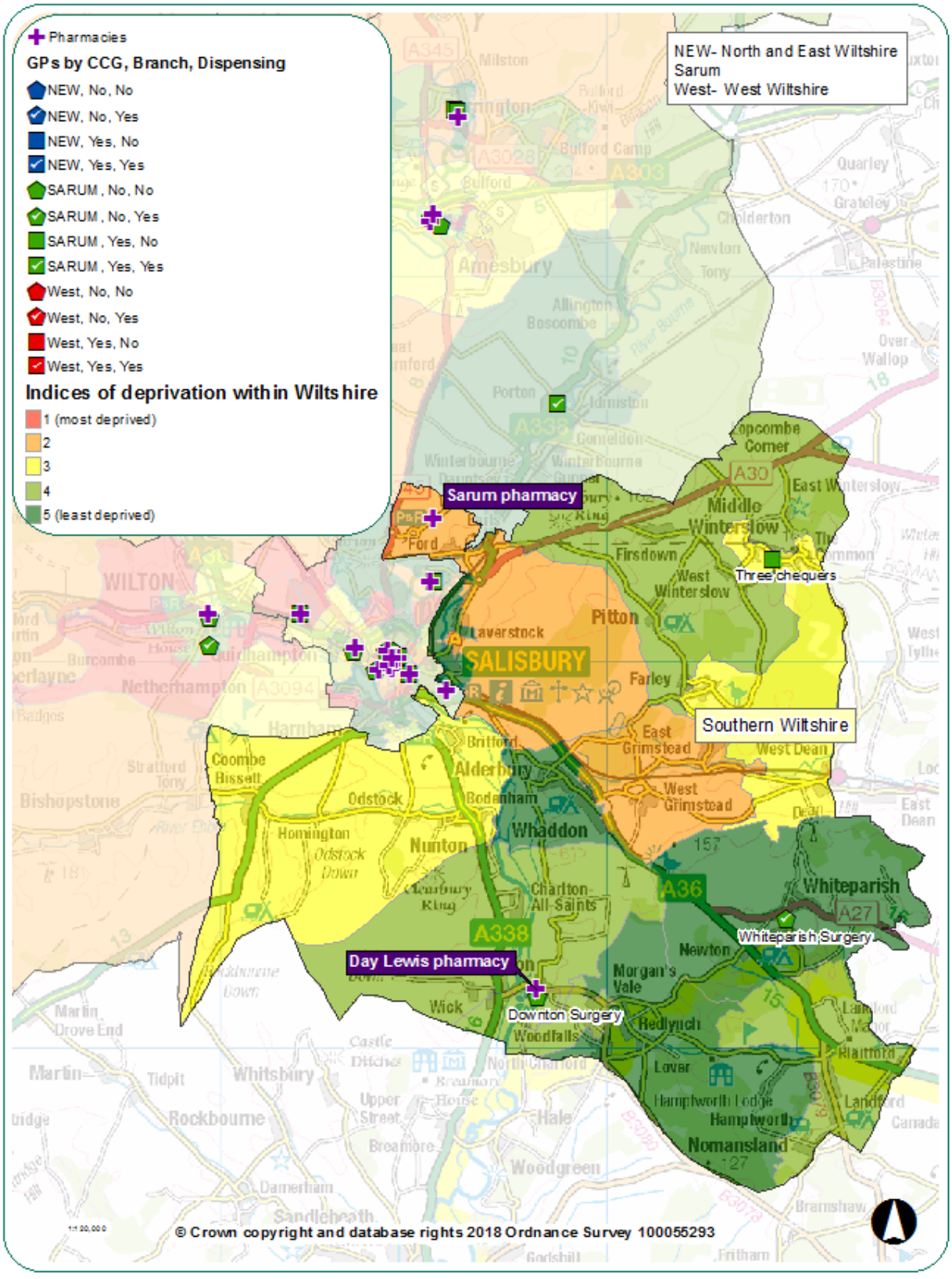
SOUTHERN WILTSHIRE COMMUNITY AREA	
POPULATION	
Demography	• Total population is 23, 156 • In relation to the other 19 community areas, Southern Wiltshire Community Area has 2nd lowest proportion of males in the 20-64 age group (47.7% of this age group are male)
Number of LSOA which are within 20% most deprived in England	• Southern Wiltshire has 13 LSOAs of which none are in England's 20% most deprived.
SERVICE PROVISION	
Change in Community Pharmacies since 2015 PNA	• None
Number of Community Pharmacies	Downton Pharmacy – Day Lewis 5 High Street Downton Salisbury SP5 3PG Distance-selling but also provide services to local patients Sarum Pharmacy Portway Centre Old Sarum Salisbury, SP4 6EB
Number of GP surgeries	• Two main surgeries and one branch surgery
Number of Dispensing GPs	• Two dispensing GPs
Access to Community Pharmacies	• One Community Pharmacy does not offer a home delivery service (non-commissioned). • Neither are commissioned to offer a Care home service. • Open on Saturdays but not Sundays. • No evening opening.

SPECIFIC DISEASES	
Cardiovascular disease (CVD)	• Significantly lower rate of CVD mortality compared with the Wiltshire average. • The Community Pharmacy is not commissioned to offer specific CHD or hypertension medicines management or Vascular Risk Assessment Service (NHS Health Check).
Diabetes	• Close to County average for Diabetes hospital admissions rate ranking 7th lowest out of the 20 Community Areas. • The Community Pharmacy is not commissioned to offer Diabetes screening or specific Diabetes Type I or II medicines management.
Chronic Obstructive Pulmonary Disease (COPD)	• COPD hospital admissions rate ranking 3rd lowest out of the 20 Community Areas. • The Community Pharmacy is not commissioned to offer specific COPD medicines management.
Asthma	• Similar to the Wiltshire average for the Asthma hospital admissions rate and ranks 12th highest out of the 20 areas. • The community pharmacy in the area is not currently commissioned to offer specific Asthma medicines management.
LIFESTYLE FACTORS AND AVAILABLE SERVICES	
Drug misuse & Alcohol	• The Community Pharmacy offers a needle/syringe exchange service (commissioned), and supervised administration(commissioned)
Sexual health	• No Community Pharmacy is commissioned to provide the No Worries! Service, which includes providing testing for Chlamydia and treatment for those who test positive, emergency hormonal contraception, pregnancy testing and free condoms. • The community based chlamydia screening programme diagnosed 13 young people with the infection in 2016 which was 7.8% of those that tested compared to a Wiltshire average of 8.4%
Smoking	• Second lowest estimated percentage of smokers (1.7%) out of all the Community Areas. • The Community Pharmacy is commissioned to offer a Support to Stop Smoking Service.
Obesity	• The Community Pharmacy is not commissioned to offer an obesity management service.

BORDERING AREAS	
	• The following Community Areas in Wiltshire border Southern Wiltshire - Wilton, Salisbury and Amesbury. There are also pharmacies in Hampshire which are accessible from Southern Wiltshire.

Wiltshire Council
Where everybody matters

Southern Wiltshire Community Area
Pharmacies and GP locations



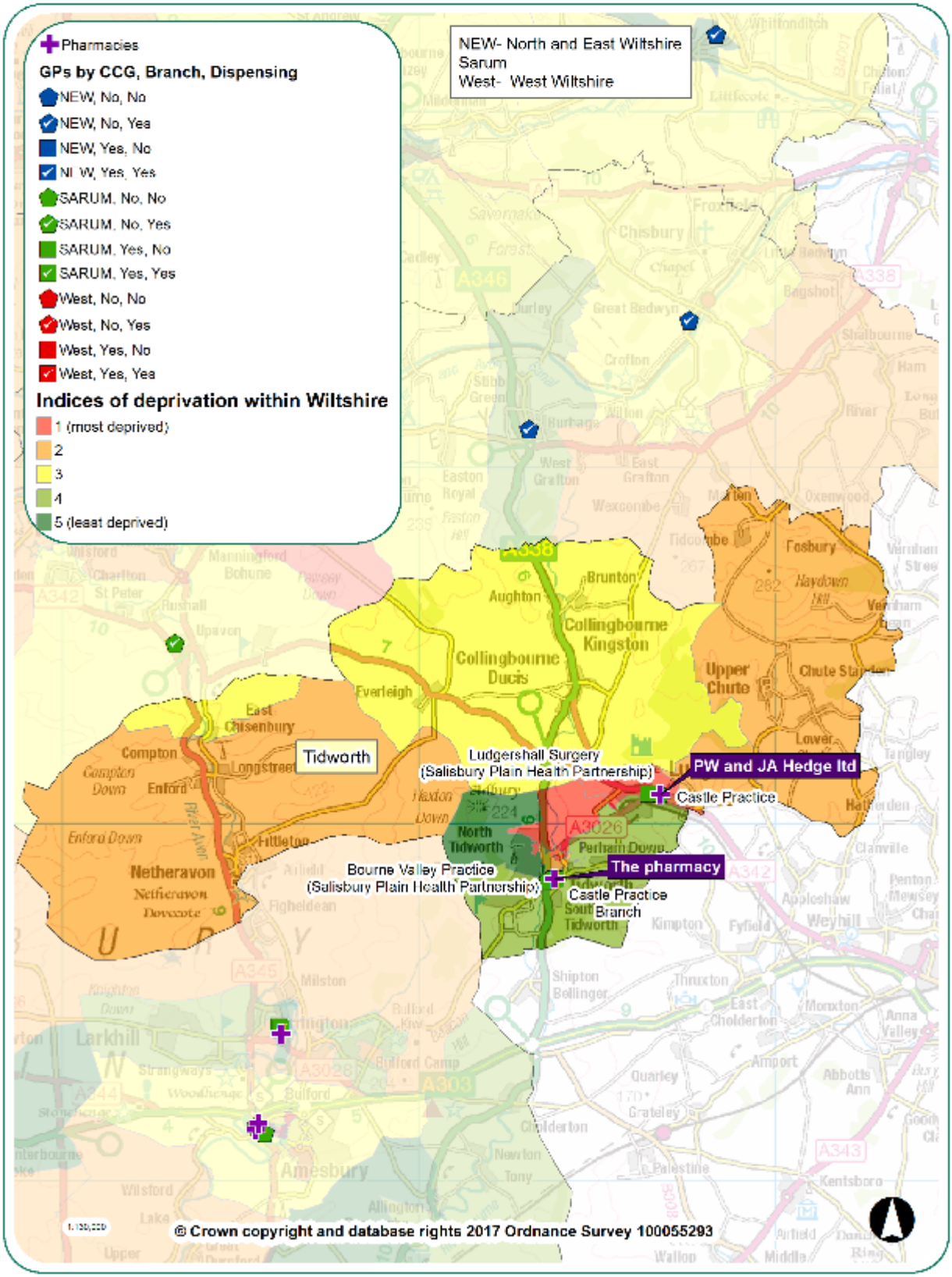
TIDWORTH COMMUNITY AREA	
POPULATION	
Demography	• Total population is 21, 236 • Highest proportion of males in the 20-64 age group (59.5% of this age group are male). Also, highest proportion of males in 65+ bracket (48.7%) and 2nd highest proportion of males in u20s (53.0%)
Deprivation	• Tidworth has 11 LSOAs of which none are in England's 20% most deprived.
SERVICE PROVISION	
Change in Community Pharmacies since 2015 PNA	• None
Number of Community Pharmacies	PW & JA Hedge The Pharmacy Dummer Lane Tidworth SO9 7FH PW & JA Hedge The Pharmacy Central Street Ludgershall SP11 9RA
Number of GP surgeries	• Two main surgeries and two branch surgeries.
Number of Dispensing GPs	• No dispensing GPs
Access to Community Pharmacies	• No pharmacy provides a care home service but one willing if commissioned. None offer delivery. • No evening opening (one is open until 7pm on weekdays) • Both are open on Saturdays. • One is open on Sundays.
SPECIFIC DISEASES	
Cardiovascular disease	• Similar to the Wiltshire average for CVD mortality. Lowest CA for CVD hospital admissions • NHS Wiltshire does not commission either of the community pharmacies in the area to offer specific CHD or hypertension medicines management or Vascular Risk Assessment Service (NHS Health Check).

Diabetes	• Close to the Wiltshire average for Diabetes hospital admissions rate and ranks 10th highest out of the 20 areas. • The Community Pharmacies in the area are not commissioned to offer specific Diabetes Type I or II medicines management but both would be willing to if commissioned. • Two would offer Diabetes screening (non-commissioned) if commissioned with training.
Chronic Obstructive Pulmonary Disease	• Similar to the Wiltshire average for COPD hospital admissions rate. • Community Pharmacies in the area are not commissioned to offer specific COPD medicines management.
Asthma	• Close to the the Wiltshire average for the Asthma hospital admissions rate and ranks 11th lowest out of the 20 areas. • Community Pharmacies in the area are not commissioned to offer specific Asthma medicines management but two would be willing to if commissioned with training.
LIFESTYLE FACTORS AND AVAILABLE SERVICES	
Drug misuse & Alcohol	• One Community Pharmacy offers a needle/syringe exchange (commissioned) and sharps disposal and a supervised administration service • Similar to the Wiltshire average of hospital inpatient admissions due to alcohol related causes.
Sexual health	• Ludgershall & Perham Down and Tidworth wards all have a higher than average teenage conception rate. • One of the Community Pharmacies in Tidworth is commissioned to deliver the No Worries! Service. This provides testing for Chlamydia and treatment for those who test positive, emergency hormonal contraception, pregnancy testing and free condoms. • The community based chlamydia screening programme diagnosed 29 young people with the infection in 2016 which was 9.2% of those that tested compared to a Wiltshire average of 8.4%

Smoking	• Lower than the Wiltshire average for estimated smoking prevalence. • There are no community pharmacies in the area is commissioned to provide a stop smoking service
Obesity	• Neither of the Community Pharmacies in the area are commissioned to offer obesity management but one would be willing to if commissioned with training.
BORDERING AREAS	
	• The following Community Areas in Wiltshire border Tidworth - Pewsey and Amesbury. There are also community pharmacy services available in nearby Andover (Hampshire).

Wiltshire Council
Where everybody matters

Tidworth Community Area
Pharmacies and GP locations

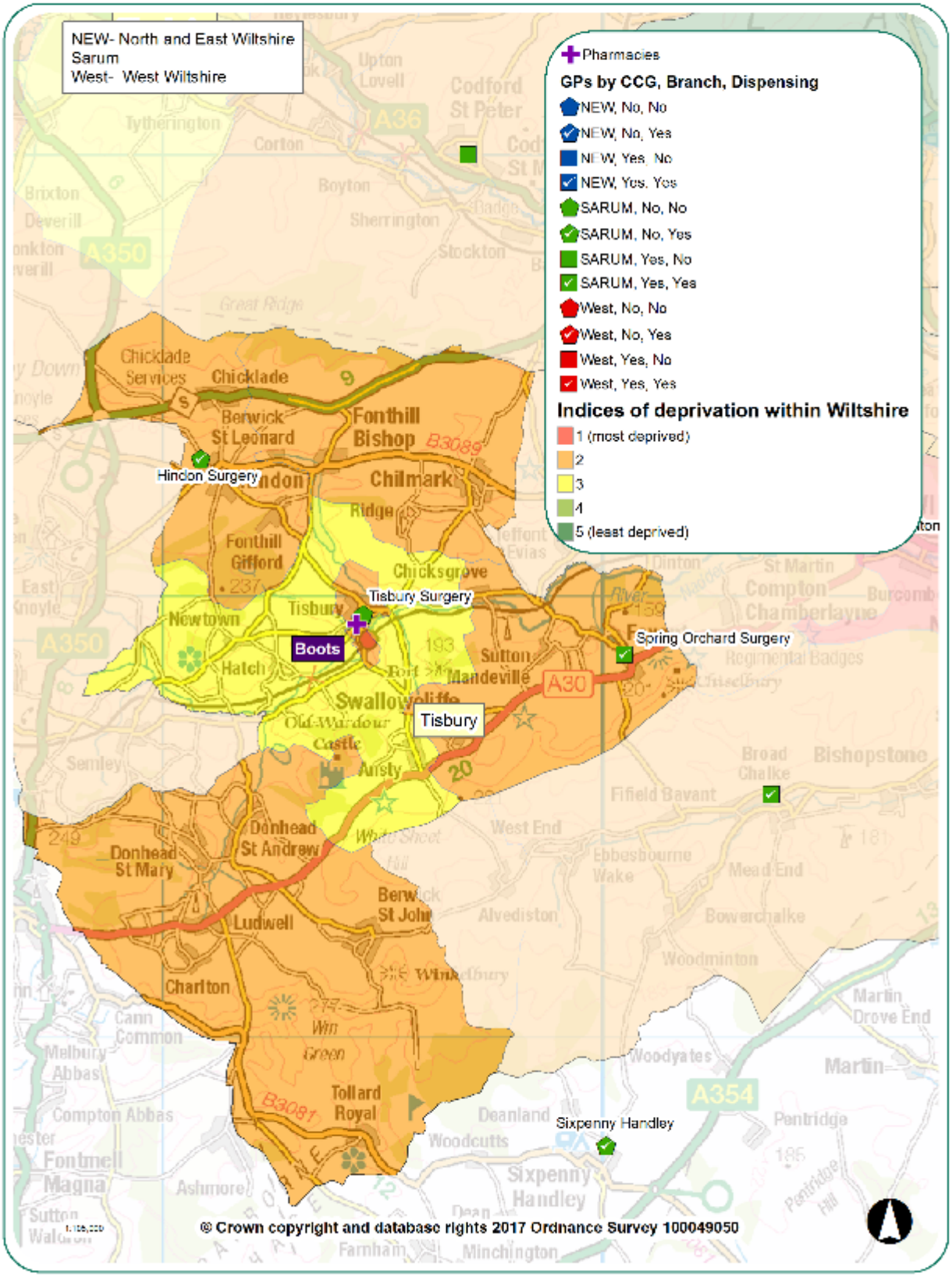


TISBURY COMMUNITY AREA	
POPULATION	
Demography	• Total population is 7,316 • Compared to the other 19 community areas, Tisbury Community Area has the lowest proportion of males in the 20-64 age group (47.3% of this age group are male)
Number of LSOA which are within 20% most deprived in England	• There are four LSOAs in the Tisbury Community Area of which there are no areas among the 20% in England with the highest percentage of households experiencing three or four types of deprivation.
SERVICE PROVISION	
Change in Community Pharmacies since 2015 PNA	• None
Number of Community Pharmacies	Boots – Tisbury High Street Tisbury Salisbury SP3 6LD
Number of GP surgeries	• Two main surgeries and one branch
Number of Dispensing GPs	• Two dispensing GP
Access to Community Pharmacies	• The Community Pharmacy is open on Saturdays. • Not open on Sundays. • No evening opening. • No care home services or home delivery
SPECIFIC DISEASES	
Cardiovascular disease	• Higher than the Wiltshire average for the CVD Mortality. • The Community Pharmacy is not commissioned to offer specific CHD or hypertension medicines management or Vascular Risk Assessment Service (NHS Health Check).

Diabetes	• Low rate of Diabetes hospital admissions, ranking 15 out of the 20 Community Areas. • The Community Pharmacy in the area is not commissioned to offer Diabetes screening or specific Diabetes Type I or II medicines management and not willing to be commissioned.
Chronic Obstructive Pulmonary Disease (COPD)	• Low rate of COPD hospital admissions ranking 7th lowest out of the 20 Community Areas. • The Community Pharmacy in the area is not commissioned to offer specific COPD medicines management.
Asthma	• Fifth lowest rate of Asthma hospital admissions out of the 20 Community Areas. • The Community Pharmacy is not commissioned to offer specific Asthma medicines management and not willing to be commissioned.
LIFESTYLE FACTORS AND AVAILABLE SERVICES	
Drug misuse & Alcohol	• The Community Pharmacy is commissioned to provide supervised administration. • The Community Pharmacy is not commissioned to provide a needle/syringe exchange service or sharps disposal
Sexual health	• Nadder and East Knoyle wards have a higher than average teenage conception rate. • No Community Pharmacy is commissioned to provide the No Worries! Service, which includes providing testing for Chlamydia and treatment for those who test positive, emergency hormonal contraception, pregnancy testing and free condoms. • The community based chlamydia screening
Smoking	• Second lowest in terms of smoking prevalence compared to the other Community Areas. • There is no current commissioned pharmacy offering a Support to Stop Smoking Service.
Obesity	• The Community Pharmacy is not commissioned to offer obesity management currently but states that they would be willing to if commissioned.
BORDERING AREAS	
	• The following Community Areas in Wiltshire border Tisbury - Mere, Warminster and Wilton.

Wiltshire Council
Where everybody matters

Tisbury Community Area
Pharmacies and GP locations



TROWBRIDGE COMMUNITY AREA	
POPULATION	
Demography	• Total population is 44, 414 • Compared to the other 19 community areas, 17.9% of its residents aged 65+
Number of LSOA which are within 20% most deprived in England	• There are 22 LSOAs in the Trowbridge Community Area of which three are among the 20% in England with the highest percentage of households experiencing three or four measured types of deprivation.
SERVICE PROVISION	
Change in Community Pharmacies since 2015 PNA	• One pharmacy closure (Lloyds Pharmacy, 33-34 Fore Street, Trowbridge). • Both Launder and Gamlin pharmacies are now owned by Cohen's • Boots at Adcroft service relocated to Trowbridge health centre • Cohens moved from 60A Bradford road to 68 Brook Street

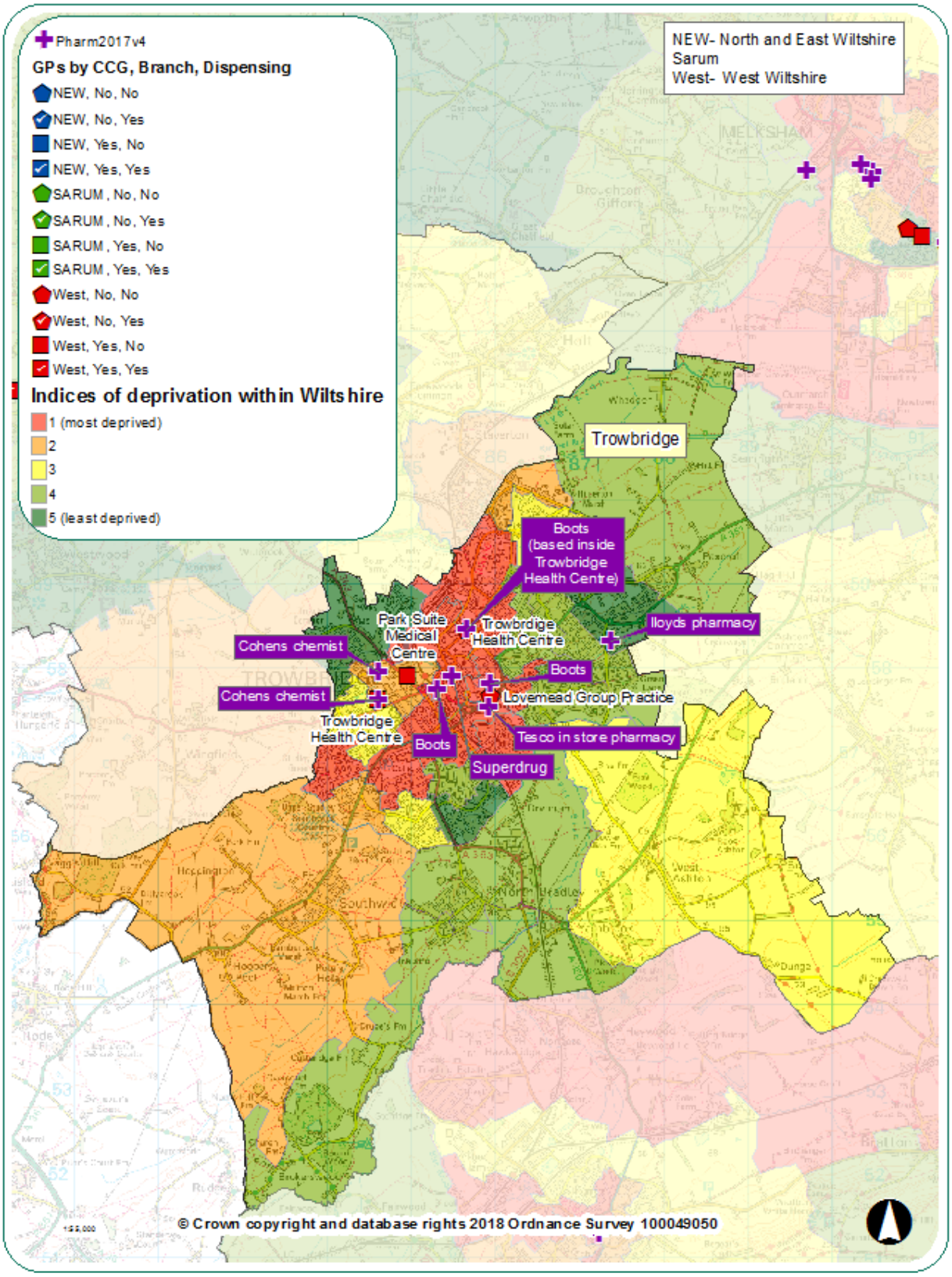
Number of Community Pharmacies *denotes 100 hour pharmacy	Boots – Trowbridge Roundstone Surgery Polebarn Circus Trowbridge BA14 7EG Boots Unit G Local Centre Trowbridge Health Centre Trowbridge BA14 7GW Boots Trowbridge* The Shires Gateway 32-34 Bythesea Road Torwbridge BA14 8FZ Tesco Trowbridge* County Way Trowbridge BA14 7AQ Lauder and Gamlin Park Suite 68 Brook Street Trowbridge BA14 9AR Lauder and Gamlin 74 Wingfield Road Trowbridge BA14 9EN Lloyds Trowbridge Hacketts Place Hilperton Superdrug Trowbridge Unit 28 The Shires Trowbridge BA4 8AT
Number of GP surgeries	• Two main GP surgeries and two branches • Adcroft and Bradford Road practices merged to form Trowbridge Health Centre
Number of Dispensing GPs	• No dispensing GPs
Access to Community Pharmacies	• One Community Pharmacy in the area provide a Care Home Service. Two state that they would be willing and able to provide. • Five pharmacies provide home delivery. • One is open early mornings, from 6.30am Tuesday – Saturday. • Two are open late evenings • Eight are open on Saturdays. • Three are open on Sundays.
SPECIFIC DISEASES	

Cardiovascular disease (CVD)	• Higher than the Wiltshire average for CVD mortality. • Wiltshire does not commission any of the community pharmacies in the area to offer specific CHD or hypertension medicines management or Vascular Risk Assessment Service (NHS Health Check).
Diabetes	• Trowbridge community area has the ranks 14th highest for diabetes related hospital admissions • Three pharmacies provide Diabetes screening (non-commissioned). • Wiltshire does not commission any of the community pharmacies in the area to offer specific Diabetes type I or II medicines management. Four were willing to provide this service if commissioned with training. One pharmacy provides a type 2 service.
Chronic Obstructive Pulmonary Disease (COPD)	• Close to the Wiltshire average for COPD hospital admissions rate and ranks 9th highest out of the 20 areas. • Wiltshire does not commission any of the community pharmacies in the area to offer specific COPD medicines management.
Asthma	• Close to the the Wiltshire average for the Asthma hospital admissions rate and ranks 9th highest out of the 20 areas. • Wiltshire does not commission any of the community pharmacies in the area to offer specific Asthma medicines management. Four would be willing to be commissioned with.
LIFESTYLE FACTORS AND AVAILABLE SERVICES	
Drug misuse & Alcohol	• Five community pharmacies are commissioned to provide a needle/syringe exchange service. • Six are commissioned to provide a supervised administration service.
Sexual health	• Trowbridge and Adcroft wards both have a higher than average teenage conception rate. • Two of the Community Pharmacies are commissioned to deliver the No Worries! Service. This provides testing for Chlamydia and treatment for those who test positive, emergency hormonal contraception, pregnancy testing and free condoms. • The community based chlamydia screening programme diagnosed 77 young people with the infection in 2016 which was 8.8% of those that tested compared to a Wiltshire average of 8.4%

Smoking	• Highest estimated smoking prevalence rate out of 20 Community Areas. • Seven Community Pharmacies are commissioned to provide a Support to Stop Smoking Service.
Obesity	• No Community Pharmacy is commissioned to offer obesity management. • One stated that they would be willing to provide this service if commissioned with training.
BORDERING AREAS	
	• The following Community Areas in Wiltshire border Trowbridge - Bradford on Avon, Melksham and Westbury. There is also availability of community pharmacy across the border in Somerset.

Wiltshire Council
Where everybody matters

Trowbridge Community Area
Pharmacies and GP locations



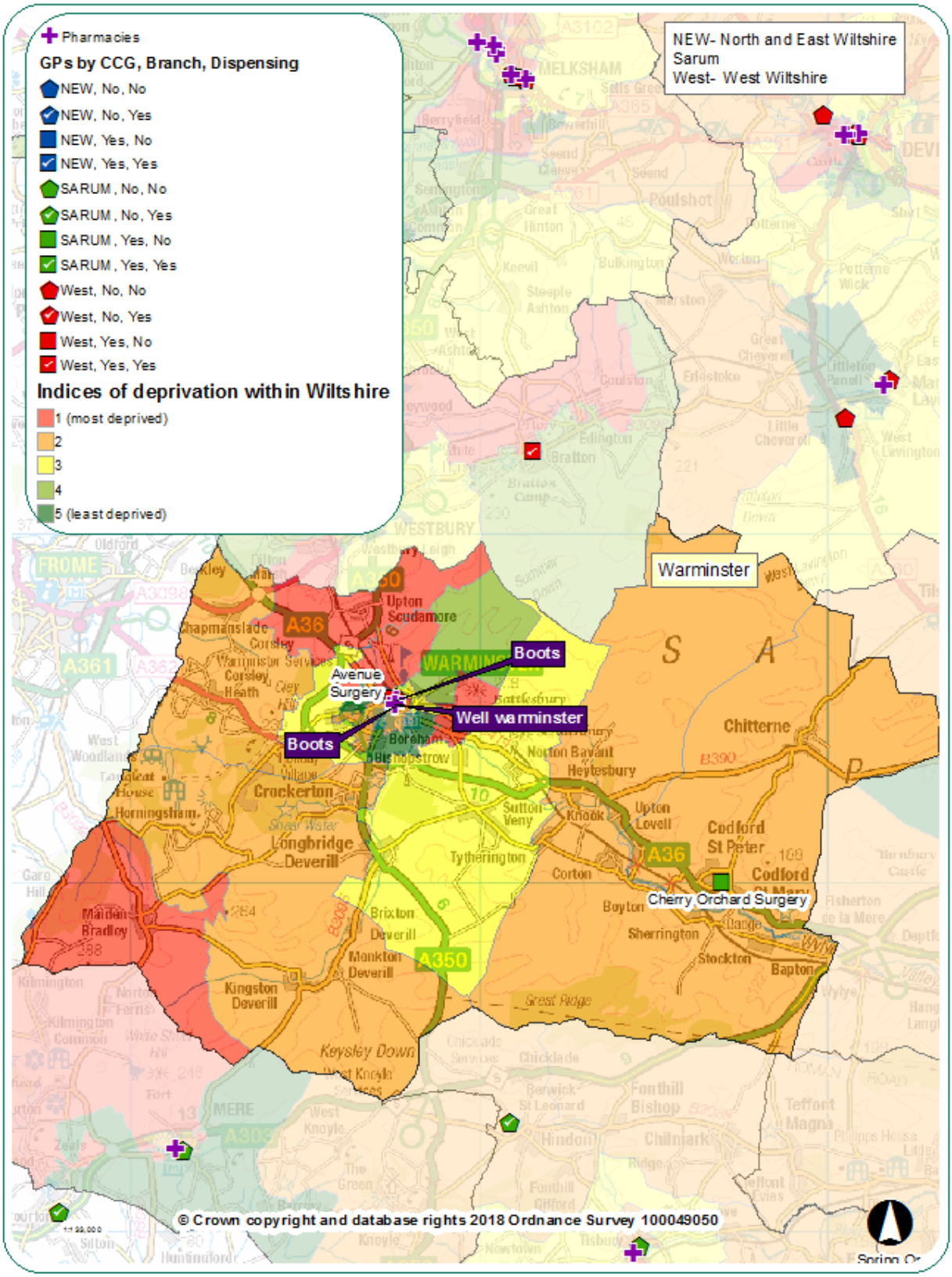
WARMINSTER COMMUNITY AREA	
POPULATION	
Demography	• Total population is 24,752 • Compared to the other 19 community areas, Warminster Community Area has the sixth highest 65+ population.
Number of LSOA which are within 20% most deprived in England	• There are 18 LSOAs in the Warminster Community Area of which none are within the 20% in England with the highest percentage of households experiencing three or four types of deprivation.
SERVICE PROVISION	
Change in Community Pharmacies since 2015 PNA	• No changes
Number of Community Pharmacies	Boots Warminster 14-16 The Avenue Warminster BA12 9AA Boots Warminster 39 Market Place Warminster BA12 9AZ Well Pharmacy 10 Cornmarket Warminster BA12 9BX
Number of GP surgeries	• One main surgery and one branch surgery • Smallbrook practice ceased trading
Number of Dispensing GPs	• No dispensing GPs

Access to Community Pharmacies	• None of the Community Pharmacies are commissioned to offer a home delivery service or Care home service; one offers a home delivery service. • None are open evenings. • Two are open on Saturdays. • One is open on Sundays.
SPECIFIC DISEASES	
Cardiovascular disease	• Lower than the Wiltshire average for CVD mortality rate. • Wiltshire does not commission any of the community pharmacies in the area to offer specific CHD or hypertension medicines management or Vascular Risk Assessment Service (NHS Health Check).
Diabetes	• Similar to the Wiltshire average for Diabetes hospital admissions rate, ranking 5th highest out of the 20 areas. • Wiltshire does not commission any of the community pharmacies in the area to offer specific Diabetes screening or specific Diabetes Type I or II medicines management but one would be willing to if commissioned with training.
Chronic Obstructive Pulmonary Disease (COPD)	• Similar to the Wiltshire average for the COPD hospital admissions ranking 6th. • Wiltshire does not commission any of the community pharmacies in the area to offer specific COPD medicines management.
Asthma	• Similar to the Wiltshire average for Asthma hospital admissions rate. Third lowest rate (ranking 17th out of 20 areas). • Wiltshire does not commission any of the community pharmacies in the area to offer specific Asthma medicines management but one would be willing to if commissioned.
LIFESTYLE FACTORS AND AVAILABLE SERVICES	
Drug misuse & Alcohol	• One of the Community Pharmacies offers a needle/syringe exchange service (commissioned). • Three offer supervised administration (commissioned). • Lower to the Wiltshire average for alcohol related hospital admission rate.

Sexual health	• One of the Community Pharmacies is commissioned to deliver the No Worries! Service. This provides testing for Chlamydia and treatment for those who test positive, emergency hormonal contraception, pregnancy testing and free condoms. • The community based chlamydia screening programme diagnosed 32 young people with the infection in 2016 which was 9.3% of those that tested compared to a Wiltshire average of 8.4%
Smoking	• Estimated smoking prevalence is higher than the Wiltshire average (5th highest). • One is commissioned to offer a Support to Stop Smoking Service.
Obesity	• No community pharmacy in the area is commissioned to offer obesity management but one state they would be willing to if commissioned with training.
BORDERING AREAS	
	• The following Community Areas in Wiltshire border Warminster - Westbury, Devizes, Amesbury, Tisbury and Mere. There is also availability of community pharmacy across the border in Somerset.

Wiltshire Council
Where everybody matters

Warminster Community Area
Pharmacies and GP locations



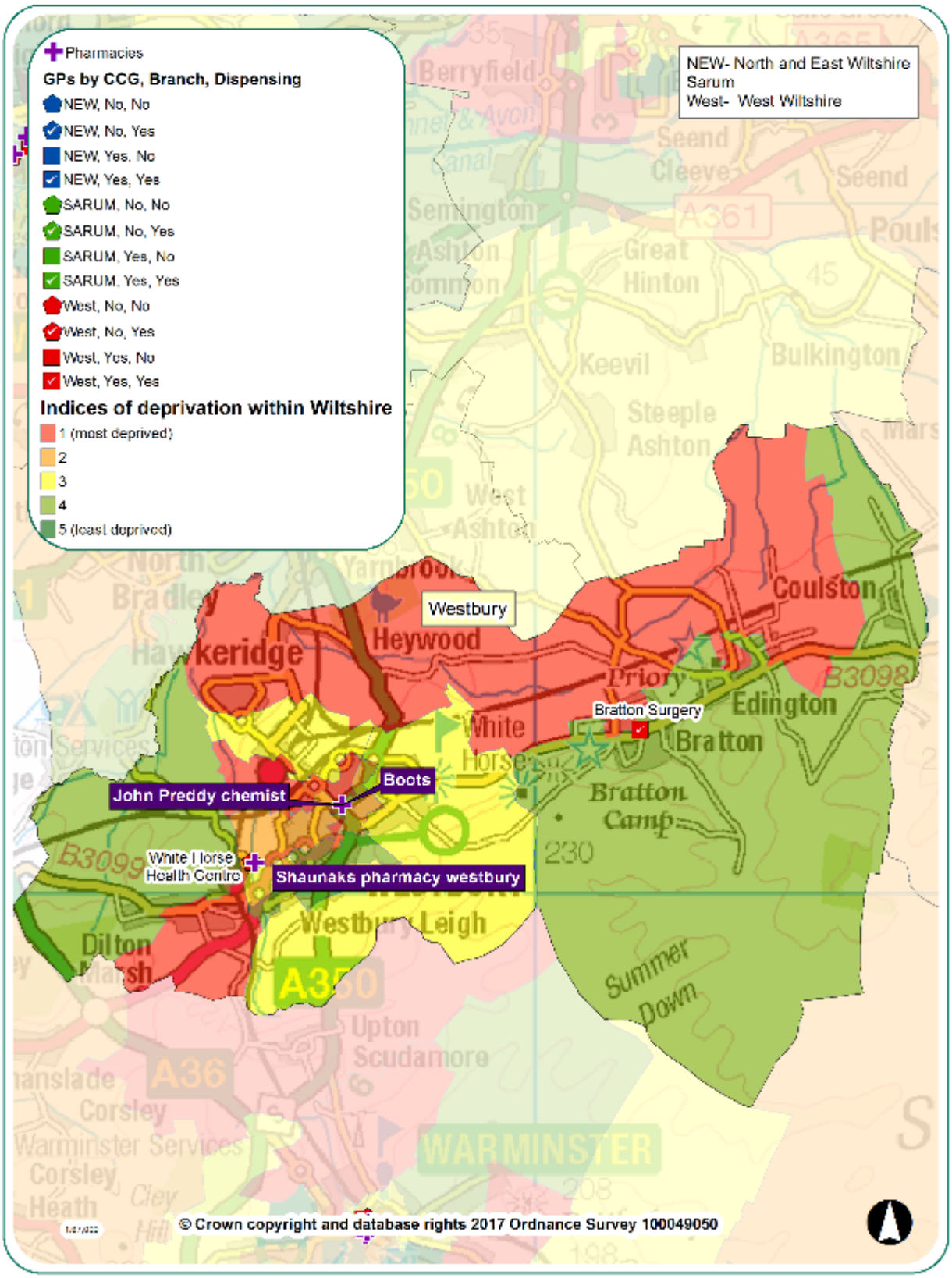
WESTBURY COMMUNITY AREA	
POPULATION	
Demography	• Total population is 20, 198 • Compared to the other 19 community areas, Westbury Community Area has the5th lowest percentage of its total population over the age of 65 years.
Number of LSOAs which are within 20% most deprived in England	• There are 11 LSOAs in the Westbury Community Area of which one is among the top 20% in England with the highest percentage of households experiencing three or four types of deprivation as measured in the 2011 Census.
SERVICE PROVISION	
Change in Community Pharmacies since 2015 PNA	• Pharmacy in White Horse Medical Centre is now delivered by Shaunaks pharmacy
Number of Community Pharmacies	John Preddy & Co 29-31 High Street Westbury BA13 3BN Shaunaks Pharmacy (formerly Octopus Healthcare) White Horse Health Centre Mane Way Westbury BA13 3FQ Boots Westbury 9-11 High Street Westbury BA13 3BN
Number of GP surgeries	• One main surgery and one branch
Number of Dispensing GPs	• Two dispensing GP
Access to Community Pharmacies	• Two Community Pharmacies would offer a Care Home service with training. • One offers a home delivery service. • None is open late evenings. • 3 four are open on Saturdays. • None is open on Sundays.

SPECIFIC DISEASES	
Cardiovascular disease	• Slightly higher than the Wiltshire average rate of CVD mortality. • Wiltshire does not commission any of the community pharmacies in the area to offer specific CHD or hypertension medicines management or Vascular Risk Assessment Service (NHS Health Check).
Diabetes	• Similar to the Wiltshire average for Diabetes hospital admissions rate. • No Community Pharmacy offers Diabetes screening (non-commissioned) and the others state they would be willing to if commissioned. • Wiltshire does not commission any of the community pharmacies in the area to offer specific Diabetes Type I or II medicines management but three already provides this service (non-commissioned) and two state they would be willing to if commissioned.
Chronic Obstructive Pulmonary Disease	• Similar to Wiltshire average for the COPD hospital admissions rate, ranking 11th highest out of the 20 community areas. • Wiltshire does not commission any of the community pharmacies in the area to offer specific COPD medicines management.
Asthma	• Similar to the Wiltshire average for the Asthma hospital admissions rate, ranking 7th highest out of the 20 areas. • Wiltshire does not commission any of the community pharmacies in the area to offer specific Asthma medicines management but one is providing and two would be willing to if commissioned.
LIFESTYLE FACTORS AND AVAILABLE SERVICES	
Drug misuse & Alcohol	• Two Community Pharmacies offer a needle/syringe exchange service (commissioned). • Three offer a supervised administration service (commissioned).

Sexual health	• One of the Community Pharmacies is commissioned to deliver the No Worries! Service. This provides testing for Chlamydia and treatment for those who test positive, emergency hormonal contraception, pregnancy testing and free condoms. • The community based chlamydia screening programme diagnosed 25 young people with the infection in 2016 which was 8.2% of those that tested compared to a Wiltshire average of 8.4%
Smoking	• Estimates show that the percentage of people in Westbury that smoke is higher than the Wiltshire average and ranks Westbury 2nd highest out of the 20 Community Areas. • Two of the Community Pharmacies are commissioned to offer a Support to Stop Smoking Service and the other one states that they would not be willing to if commissioned.
Obesity	• None of the Community Pharmacies in the area are commissioned to offer obesity management but one stated that they would provide the service if commissioned with training.
BORDERING AREAS	
	• The following Community Areas in Wiltshire border Westbury - Trowbridge, Melksham, Devizes and Warminster.

Wiltshire Council

Westbury Community Area
Pharmacies and GP locations

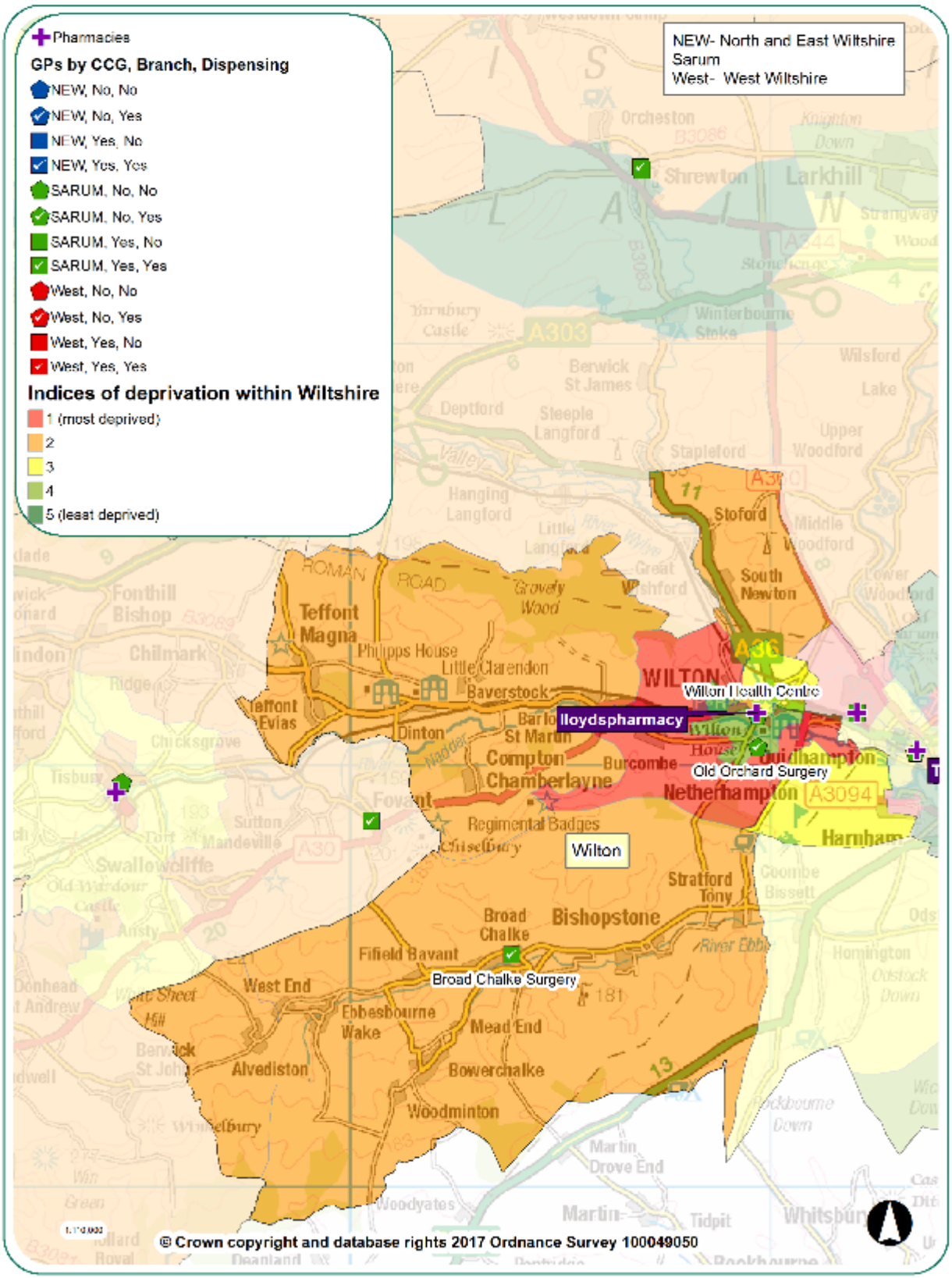


WILTON COMMUNITY AREA	
POPULATION	
Demography	• Total population is 9,050 • Compared to the other 19 community areas, Wilton Community Area has the 2nd lowest proportion of males in the u20 age group (49.0% of this age group are male)
Number of LSOA which are within 20% most deprived in England	• Wilton Community Area has five LSOAs, of which none are amongst the 20% in England with the highest percentage of households experiencing three or four types of deprivation.
SERVICE PROVISION	
Change in Community Pharmacies since 2015 PNA	• None
Number of Community Pharmacies	Lloyds Wilton 3 North Street Wilton Salisbury SP2 0HA
Number of GP surgeries	• Two main surgeries and one branch
Number of Dispensing GPs	• Three dispensing GPs
Access to Community Pharmacies	• The Community Pharmacy offers a home delivery service (non-commissioned) • They are not commissioned to not offer a Care home service but state they would be willing to if commissioned. • Open Saturdays but not Sundays. • No evening opening.
SPECIFIC DISEASES	
Cardiovascular disease (CVD)	• Slightly higher than the Wiltshire average rate for CVD mortality. • Wiltshire does not commission the community pharmacy in the area to offer specific CHD medicines management or Vascular Risk Assessment Service (NHS Health Check). • They offer a specific hypertension medicine management service (non-commissioned).

Diabetes	• Similar to the Wiltshire average for Diabetes hospital admissions rate, ranking 7th highest out of the 20 areas. • The Community Pharmacy offers Diabetes screening and specific Diabetes Type II medicines management (non-commissioned).
Chronic Obstructive Pulmonary Disease (COPD)	• Highest Community Area rate for COPD hospital admissions. • Wiltshire does not commission the community pharmacy to offer specific COPD medicines management.
Asthma	• Higher than the Wiltshire average for Asthma hospital admissions rate, ranking 2nd lowest highest out of the 20 areas. • The Community Pharmacy is not commissioned to offer specific Asthma medicines management.
LIFESTYLE FACTORS AND AVAILABLE SERVICES	
Drug misuse & Alcohol	• The Community Pharmacy is not commissioned to offer a needle/syringe exchange service • They are commissioned to provide a supervised administration service.
Sexual health	• No Community Pharmacy is commissioned to provide the No Worries! Service, which includes providing testing for Chlamydia and treatment for those who test positive, emergency hormonal contraception, pregnancy testing and free condoms. • The community based chlamydia screening
Smoking	• Lower than the Wiltshire average for smoking prevalence, rank at 10th position. • The Community Pharmacy is not commissioned to offer a Support to Stop Smoking Service.
Obesity	• The Community Pharmacy in the area is not commissioned to offer obesity management currently.
BORDERING AREAS	
	• The following Community Areas in Wiltshire border Wilton - Southern Wiltshire, Salisbury, Amesbury and Tisbury.

Wiltshire Council
Where everybody matters

Wilton Community Area
Pharmacies and GP locations



11 GLOSSARY

100 hour service	Pharmacy open for 100 hours a week over 7 days
Advanced Pharmacy Service	Can be provided by contractors once accreditation requirements are met
AUR	Appliance Use Review
BME	Black and Minority Ethnic
Community Area	Wiltshire Council has twenty community areas
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular Disease
DACS	Dispensing Appliance Contractors
DH	Department of Health
Dispensing Group Practice	GPs who have been approved to dispense medicines to specific patients on their lists
EHC	Emergency Hormonal Contraception
Enhanced Pharmacy Service	Commissioned by the PCT in response to the needs of Wiltshire population
ESPLPS	Essential Small Pharmacy Local Pharmaceutical Service
Essential Services	Provided by all pharmacy contractors
GP	General Practice
IMD	Indices of Multiple Deprivation
JSNA	Joint Strategic Needs Assessment
LD	Learning Disabilities
LLTI	Limiting Long Term Illness
LMC	Local Medical Committee
LPC	Local Pharmaceutical Committee
LPSs	Local Pharmacy Service Contracts
LSOA	Lower LSOA

LTC	Long Term Condition
MDS	Monitored Dosage System
MUR	Medicines Use Review
NCMP	National Child Measurement Programme
NHS	National Health Service
ONS	Office for National Statistics
PCT	Primary Care Trust
PNA	Pharmaceutical Needs Assessment
PSSG	Pharmaceutical Services Strategy Group
SAC	Stoma Appliance Customisation
SHA	Strategic Health Authority
SOA	LSOAs

12. List of dispensing practices (practices & branches)

Practice Name	Branch Surgery	Address 1	Address 2	Town
Avon Valley Practice	No	Fairfield	Upavon	Pewsey
Bradford on Avon & Melksham Partnership	No	Health Centre	Station Approach	Bradford on Avon
Bratton Surgery	Yes	The Tynings	Bratton	Westbury
Burbage Surgery	No	9 The Sprays	Burbage	Marlborough
Cricklade Surgery	Yes	113 High Street	Cricklade	Swindon
Cross Plain Surgery (Salisbury Plain Health Partnership)	Yes	84 Bulford Road	Durrington	Salisbury
Downton Surgery *	No	Moot Lane	Downton	Salisbury
Three Chequers	No	72 Endless Street		Salisbury
Hindon Surgery	No	The Surgery	Hindon	Salisbury
Jubilee Field Surgery	No	Yatton Keynell		Chippenham
Marlborough Medical Practice	No	George Lane		Marlborough
Mere Surgery *	No	Dark Lane	Mere	Warminster
Old School House Surgery	No	Church Street	Great Bedwyn	Marlborough
Old Orchard Surgery	No	South Street	Wilton	Salisbury
Patford House Surgery	No	8A Patford Street		Calne
Porton Surgery	Yes	32 Winterslow Road	Porton	Salisbury
Ramsbury Surgery	No	Whittonditch Road	Ramsbury	Marlborough
Silton Surgery	No	Gillingham Road	Silton	Gillingham
Spring Orchard Surgery	Yes	High Street	Fovant	Salisbury
Three Chequers	No	82 St Ann Street		Salisbury
Sutton Benger Surgery	Yes	Chestnut Road	Sutton Benger	Chippenham
The Surgery	Yes	Ashton Keynes Village Hall	Ashton Keynes	Swindon
Till Orchard Surgery	Yes	High Street	Shrewton	Salisbury
Tolsey Surgery	No	High Street	Sherston	Malmesbury
Wanborough Surgery	Yes	3-5 Ham Road	Wanborough	Swindon
White Horse Health Centre	No	Mane Way	Leigh Park	Westbury
Whiteparish Surgery *	No	Common Road	Whiteparish	Salisbury
Wilton Health Centre	No	Market Square	Wilton	Salisbury
Winsley Surgery	Yes	73A Tyning Road	Winsley	Bradford on Avon
Sixpenny Handley	No	Dean Lane	Sixpenny Handley	Salisbury
Broad Chalke Surgery	Yes	Doves Meadow	Broadchalke	Salisbury

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Appendix 2: Summary of Changes

Page	Change
4	Total pharmacies changed from 74 to 73 of which 2 are distance-selling pharmacies
4	28 dispensing practices amended to 25
5	Additional paragraph added to the conclusion: Although current provision is deemed reflective of population need, future provision maybe required in line with the NHS (pharmaceutical services and local pharmacy services) regulation 2013. The reader should bear these regulations in mind when deciding future pharmacy provision as a result of demographic or population size changes or changes in the health and wellbeing needs of the local populations change. The actual/potential merger of primary care services may or may not cause gaps in local pharmaceutical services but requests from pharmacies to change location or hours of business may cause gaps.
6	NHSUMS has been commissioned to 30 Sept 2018 (not 31 March 2018)
7	PNA correct at time of writing amended to January 2017
12	PCT changed to 'NHS and local commissioners'
13	Final paragraph reworded to read: Wiltshire HWB consulted formally on the draft PNA from September to December 2017. The consultation closed 01 December 2017 and feedback was reviewed and incorporated into the final PNA document which is scheduled for the Wiltshire HWB in January 2018 for approval prior to publication.
17-18	Changes to military population in Wiltshire updated to read: Military personnel in Wiltshire constitute around 3.3% of the total population, and including dependants the total is estimated to be around 30,000 people. Locally, military personnel and their dependents are estimated to constitute over 20% of the total population in some wards (e.g. Tidworth, Bulford, Durrington, Upavon, Warminster East, and Lyneham). Increases in the numbers of military personnel and their dependents in the south of the county will take place during the lifetime of the PNA, which may have implications for local health services. A major impact on south Wiltshire in particular will be felt from the Army's transformation under the 'Army 2020' concept and the Army Basing programme. The changes to the Army's structure, reorganisations, and relocations will result in an estimated increase of approximately 4,000 uniformed personnel, and an estimated 3,200 dependants, living and working in Wiltshire. All unit moves are planned to be complete by December 2019 following completion of the building of additional single living and service families' accommodation. Following its closure as a RAF station, MOD Lyneham has become a key defence technical training site for electronic and mechanical engineering. Part of the Defence College of Technical Training, MOD Lyneham has around 1,500 military

	and 700 civilian personnel as students and staff. Additionally a regular Army unit of approximately 500 personnel will be based at MOD Lyneham from 2019. The Ministry of Defence medical centres provide primary healthcare for service personnel and some families. Tidworth, Larkhill, Bulford, Lyneham and Warminster military sites all have access to a Medical Centre with a dispensary staffed by a Pharmacy Technician on site. Corsham personnel have access to a Medical Centre on site where prescriptions are faxed to a local Lloyds pharmacy for dispensing. In addition, all Military Medical Centres have access to a MOD Regional Pharmacist and pharmacy technician based at the Regional Headquarters of Defence Primary Health Care Central and Wessex Region, based in Tidworth. Wiltshire's Health and Wellbeing Board will ensure that as part of the planning for army re-basing the provision of pharmaceutical services will be reviewed on an ongoing basis and supplementary statements to this PNA will be issued when necessary.
22	Dispensing Appliance Contractors details added: Fittleworth Medical (Salisbury) is the only noted DAC in Wiltshire.
23	NUMSAS is now commissioned until 30 September 2018
25	Work with the Acute hospitals last paragraph reworded: In a bid for integrated working between community pharmacy and Acute settings, a IT system called PharmOutcomes is being used to facilitate this integrated working across all Acute Trusts and community pharmacies. This includes the Royal United Hospital using the referral service to provide discharge summaries for patients who have medicines packaged into weekly dosage systems. Salisbury Foundation Trust have this functionality and is using it to provide discharge summaries for patients with weekly dosage systems. Great Western Hospital use similar functionality to refer patients starting on anticoagulant medicines for further support.
25-26	Core strategy reworded: The anticipated increase in each community area over the next three year period until 2020/21 would not have a significant impact on provision of, or access to pharmaceutical services
27	Military, sentence added: Military families / dependants may access NHS services and community pharmacies in the areas in which they live.
38	Alcohol screening and brief interventions service removed from 'locally commissioned pharmacy services' and added to non-commissioned service
41	Changed from 19th largest to 2nd smallest population
43	Removal of teenage pregnancy data, as no longer hotspot areas

45	Changes since last PNA: both pharmacies now run by Day Lewis
46	Removal of teenage pregnancy data, as longer hotspot area
48	Map refreshed to detail practice merger
49	Noorani and Sons renamed 'Pharmacy at Northlands'
51	Teenage pregnancy data removed, as area is no longer hotspot area
53	Pharmacy in Sainsbury's renamed to 'Lloyds in Sainsbury's
55	Teenage pregnancy data removed, as area is no longer hotspot area
57	Pharmaxo moved from 'new changes' section into body of pharmacy details as a distance selling pharmacy Dispensing GPs, changed to one. This is a branch surgery in Colerne, but the practice belongs to Bath and North-East Somerset.
60	Corsham map updated
61	All pharmacies had responded to provider survey
67	Teenage pregnancy data removed as area is no longer a hotspot area
69	Only one pharmacy is open on Saturdays (not both as previously stated)
73	Sainsbury's pharmacy is changed to Lloyds in Sainsbury's
75	Teenage pregnancy data removed as no longer identified as hotspot area
76	Map updated
78	Teenage pregnancy data removed as no longer identified as hotspot area
85	Lloyds Pharmacy and CLM Jones and Partner (RWB) are now under ownership of 'Cohen's Chemist. A new pharmacy has opened up in Lyneham.
87	Teenage pregnancy data removed as no longer identified as hotspot area
88	Map updated
89-91	• Lloyds premises change from 47 Market Place to 4-6 Minster Street • Rowlands Pharmacy premises change from 41 Castle Street to Avon Approach • Imman Ltd change of ownership to Medicines Clinic • Dispensing Appliance Contractor@ FlittleWorth Medical added • Practice merger: Endless Street, Three Swans and St Anns merged to become Three Chequers Medical Practice. And dispensing practices reduced from 2 to 1.
92	Teenage pregnancy data removed as no longer identified as hotspot area

93	Map updated
94	Distance-selling community pharmacy Sarum pharmacy added to main pharmacist listings as it also provides community services
97	Map updated
105	• Both Launder and Gamlin pharmacies are now owned by Cohen's • Boots at Adcroft service relocated to Trowbridge health centre • Cohens moved from 60A Bradford road to 68 Brook Street • Two main GP surgeries and two branches • Adcroft and Bradford Road practices merged to form Trowbridge Health Centre
107	Only Trowbridge and Adcroft wards both have a higher than average teenage conception rate.
109	Map updated
110	• One main surgery and one branch surgery • Smallbrook practice ceased trading
112	Teenage pregnancy data removed as no longer identified as hotspot area
113	Map updated
116	Teenage pregnancy data removed as no longer identified as hotspot area
119	Teenage pregnancy data removed as no longer identified as hotspot area
123	St Anns and Endless Street changed to 'three chequers'

Appendix 3: Cross-Border PNA responses

Wiltshire HWB have a responsibility to respond to those PNAs of our neighbouring authorities. HWBs must also consult with other HWBs areas with which they border, for which Wiltshire borders with B&NES, West Berkshire, Hampshire, Gloucestershire, South Gloucestershire, Somerset, Dorset, Swindon and Oxford and similarly each HWB may consult with ours. The responsibility for responding to these consultations was delegated to the PNA lead, public health consultant, Steve Maddern to respond on behalf of the HWB. Below is a summary of the feedback provided in response to neighbour HWB PNAs.

PNA	**Comments provided as part of consultation**
South Gloucestershire Responded: 01.10.2017	Page 61, section 7.2.9 refers to PCTs (now defunct). A paragraph states that residents of South Glos can access sexual health and smoking cessation services across the border in Wiltshire pharmacies. This is not the case - only Wiltshire residents can access these services from a Wiltshire pharmacy.
Hampshire Responded: 30.10.2017	Requirement for maps to be titled appropriate and that the reader is signposted to correct maps if not on the same page. Recommend to provide an overarching conclusion of the PNA and not just a conclusion per community area.
West Berkshire Responded: 02.11.2017	Page 41 states "the current provision of pharmaceutical services in West Berkshire means that there are 18 pharmacies and dispensing practices per 100,000 population. In March 2016, there were 22 pharmacies per 100,000 population. Has pharmacy provision reduced and if so why? – this has not been clearly explained. Page 43 - mixed use of percentages and numbers on the population survey results are a bit confusing, probably suggest that % is used in the figures to make them more meaningful in context with the narrative.
Swindon Responded: 21.11.2017	There is little / no mention of cross-border issues. As a neighbour that does border onto Swindon, there needs to be some reflection of the potential cross border issues (or not). It may be worth mentioning prescribing habits – e.g. we know in Wiltshire that 97% of prescriptions are dispensed within the county but the bulk of the remaining 3% are dispensed in Swindon and Hampshire. The Swindon PNA highlights some of the growth to housing stock in South Swindon, but does not seem to consider growth to Wiltshire housing stock (or other bordering authority) which may impact on Swindon pharmaceutical service delivery.
BANES Responded: 11.12.2017	Given that BANES is a neighbour with about 5 other LA areas, including Wiltshire, although a nod has been given to this, it is felt that a further sentence or two around any border-issues (or not) could have been given. E.g. We know in Wiltshire around 97% of our prescriptions are dispensed within the county with much of the remainder being dispensed in Swindon and Hampshire, so we don't identify any cross-border issues with BANES

	It would be suggested that the end of the document needs a concluding paragraph to draw the document to a close, effectively saying, that there is sufficient provision and there are no identified gaps etc. The PNA currently reads as if the document just ends. The document was a little difficult to read in parts, especially when there were multiple references on certain pages and also additional bracket references. But overall it was very comprehensive and reads well.
Gloucestershire Responded: 28.12.2017	Gloucestershire is a neighbour with other LA areas, including Wiltshire, although a nod has been given to this, it is felt that a further sentence or two around any border-issues (or not) could have been given. E.g. We know in Wiltshire around 95% of our prescriptions are dispensed within the county with much of the remainder being dispensed in Swindon and Hampshire, so we don't identify any cross-border issues with Gloucestershire.

Wiltshire Council

Health and Wellbeing Board

25 January 2018

Subject: Local Transformation Plan for Children and Young People's Mental Health and Wellbeing 2017-18 refresh

Executive Summary

Improving mental health services for children and young people continues to be a national priority and is providing a perhaps once in a lifetime opportunity to deliver large scale service transformation that should significantly enhance the life chances for children, young people and their families.

The importance of this agenda is highlighted by the publication of a recent joint Green Paper (December 2017) by the Department for Education and Department of Health which sets out the ambition that children and young people who need help for their mental health can get it when they need it. Proposals include earlier intervention and prevention, particularly in and linked to schools and colleges.[1]

By 2020/21, the national aspiration is that significant expansion in access to high quality mental health care will result in at least 70,000 additional children and young people receiving treatment each year – representing an increase in access to NHS-funded community services to meet the needs of at least 35% of those children and young people with a diagnosable mental health condition.

To realise the national ambition for improvement (Future in Mind and Mental Health Five Year Forward View) the Wiltshire CCG has expanded, refreshed and republished its Local Transformation Plan for Children and Young People's Mental Health and Wellbeing. The plan details how the CCG will utilise the funds and commit to this agenda, to support Wiltshire's goals for change across the whole child and adolescent mental health system. This builds on progress made since the first publication of the Transformation Plan in 2015. Some of our key achievements over the last twelve months have included:

- Significantly improving access to emotional wellbeing and mental health support by reducing waiting times and strengthening pathways for the most vulnerable children;
- Building closer partnerships between education and CAMHS through our trailblazing Thrive Hub programme, expanding the number of secondary schools with CAMHS link workers from six to twelve as well as providing Wiltshire College with a dedicated CAMHS worker;
- Rolling out Youth Mental Health First Aid training to adults who work with and care for children, young people and families;

[1] https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper

- Successfully re-commissioned a modern CAMH Service across Swindon, Wiltshire and Bath and North East Somerset, to go live on 01 April 2018, with a much bigger focus on early intervention, improved access and reflective of the national THRIVE model (an updated model for CAMHS). An estimated 200+ individuals (including children, young people and parents/carers) helped shape the new service.

Considering these developments and the latest views and needs of children and young people, the Wiltshire CCG has reviewed the priorities within the Local Transformation Plan. Underpinned by the following strategic objectives, these guide how the CCG will make use of the funding available to drive further improvements.

- **Promoting good mental health, building resilience and identifying and addressing emerging mental health problems early on;**
- **Providing children, young people and families with simple and timely access to high quality support and treatment;**
- **Improving the care and support for the most vulnerable and disadvantaged children by closing critical service gaps, improving support at key transition points and tailoring services to meet their needs.**

Key priorities for the next twelve months will include:

- launching the new integrated CAMH service;
- strengthening transparency and accountability of the delivery of the Local Transformation Plan and local performance to ensure improved outcomes and value for money;
- developing a clear and funded collaborative commissioning plan across Bath and North East Somerset, Swindon and Wiltshire with NHS England Specialised Commissioning to improve crisis care and reduce the number of children and young people being placed far from home and/or in adult wards; and
- developing an effective joint agency workforce development plan to ensure the right workforce is in place to make sure children and young people get the right help they need when and where they need it.

Proposal(s)

It is recommended that the Board:

i) Notes the progress to date on the implementation of the CCG local transformation plan for children and young people's mental health and wellbeing;

ii) Endorses the refreshed and expanded plan including its commissioning intentions, local priorities and updated budget proposals;

iii)	Encourages partner agencies to consider contributing their views to the green paper on improving mental health support for children and young people.

Reason for Proposal

NHS England requires Wiltshire CCG to work with key partners (including schools, the voluntary and community sector and importantly children, young people and those who care for them) to review the local transformation plan and ensure it is reflective of local needs and is delivering improvements.

Presenter name: Ted Wilson
Title: Community and Joint Commissioning Director and Group Director – North and East Wiltshire Group
Organisation: Wiltshire CCG

Wiltshire Council

Health and Wellbeing Board

25 January 2018

Subject: Local Transformation Plan for Children and Young People's Mental Health and Wellbeing 2017-18 refresh

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Purpose of Report

1.1 To meet national expectations set out by NHS England and the Department of Health, this report provides a summary of the expanded, refreshed and republished local transformation plan for children and young people's mental health and wellbeing. In doing so, it sets out the Wiltshire CCG's commissioning intentions, local priorities and budget proposals which aim to deliver tangible improvements to local child and adolescent mental health services.

1.2 A copy of the full transformation plan can be found by using the following link http://www.wiltshireccg.nhs.uk/wp-content/uploads/2017/11/WiltshireCCGLTPRefreshDRAFT2017-23-11-17.pdf An updated child and youth friendly version of the plan is currently being developed with children and young people and will be published in February 2018.

Background

National focus on children and young people's mental health

1.3 Nationally, there continues to be a high-profile emphasis on the child and adolescent mental health agenda (Future in Mind Report and NHS Mental Health Five Year Forward View), with the Government committed to making substantial improvements in services by 2020. This commitment is supported by additional investment and focuses on driving improvement across the following key themes:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

1.4 The Government's ongoing commitment to this agenda was recently highlighted by the publication of a new green paper which sets out the ambition that children and young people who need help for their mental health are able to get it when they need it. Jointly developed by the Department for Education and Department of Health, the paper includes proposals to improve mental health support for children and young people. These include a focus on earlier

intervention and prevention, especially in and linked to schools and colleges. Draft plans include:

- Creating a new mental health workforce of community-based mental health support teams;
- Every school and college to be encouraged to appoint a designated lead for mental health;
- A new 4-week waiting time for NHS children and young people's mental health services to be piloted in some areas.

1.5 The government is asking people for their views on the green paper with the consultation closing at midday on 02 March 2018. The link to the paper is https://www.gov.uk/government/consultation/transforming-children-and-young-peoples-mental-health-provision-a-green-paper

Local Transformation Plans

1.6 Improvement and transformation is being led by local areas and to support local leadership and accountability, NHS England requires Clinical Commissioning Groups (CCGs) to work with commissioners and providers across health, education, social care, youth justice and the voluntary sector, to develop Local Transformation Plans for Children and Young People's Mental Health and Wellbeing (LTPs).

1.7 LTPs were first published in 2015 and set out how local services will invest resources to improve children and young people's mental health across the 'whole system'. In respect of Wiltshire CCG, the potential funding available to support the implementation of the LTP (excluding eating disorders) is £1.39m however this funding is not ring-fenced, neither is it yet confirmed within the 2018/19 CCG financial plan. At a national level, the non-ring-fenced allocation will continue to increase year on year until 2020/21, and will be included (on a non-ring-fenced basis) within the growth element of CCG allocations. NHS England monitors whether planned spend on the LTP matches the revised budget allocation each year.

1.8 LTPs are 'living documents' and CCGs are required to refresh and republish them on their websites annually. Assurance of the plan is via the CCG planning framework and plans should be signed off by the Health and Wellbeing Board. Working with the local authority and its partners (including children and young people), Wiltshire's refreshed and expanded LTP, sets out a number of local priorities for improvement underpinned by the following strategic objectives:

- **Promoting good mental health, building resilience and identifying and addressing emerging mental health problems early on;**

- **Providing children, young people and families with simple and timely access to high quality support and treatment;**
- **Improving the care and support for the most vulnerable and disadvantaged children by closing critical service gaps, improving support at key transition points and tailoring services to meet their needs.**

1.9 The ongoing development and implementation of the plan is overseen by the multi-agency Children's Trust Emotional Wellbeing and Mental Health Sub Group, with accountability to the Children's Trust Commissioning Executive, Wiltshire CCG and Health and Wellbeing Board. Shaped by the needs and views of children and young people and building on progress made since the plan's initial launch, key achievements over the last twelve months have included:

- Almost 10,000 children and young people from 95 school and college settings took part in a wide-ranging survey about their health and wellbeing;
- Significantly improving access to emotional wellbeing and mental health support by reducing waiting times for both assessment and treatment as well as strengthening pathways for the most vulnerable children;
- Building closer partnerships between education and CAMHS through our trailblazing Thrive Hub programme, expanding the number of secondary schools with CAMHS link workers from six to twelve as well as providing Wiltshire College with a dedicated CAMHS worker;
- Boosted the Kooth online counselling service for teenagers from 100 to 154 hours per month. In 2016/17, nearly 2,000 young people registered for the service;
- 118 schools engaged with the Wiltshire Healthy Schools programme, which supports them to take a whole school approach to emotional wellbeing and mental health;
- Rolling out Youth Mental Health First Aid training to adults who work with and care for children, young people and families with 91 staff trained so far across 70+ primary and secondary schools.
- Successfully re-commissioned a modern CAMH Service across Swindon, Wiltshire and Bath and North East Somerset, to go live on 1 April 2018, with a much bigger focus on early intervention, improved access and reflective of the national THRIVE model (an updated model for CAMHS). An estimated 200+ individuals (including children, young people and parents/carers) helped shape the new service.

Information on further accomplishments can be found at the front of the Local Transformation Plan.

1.10 By 2020/21, the national target for NHS England is to reach at least 70,000 additional children and young people each year who will receive evidence based mental health treatment. This is expected to deliver increased access from meeting around 25% of those with a diagnosable condition locally, based on current estimates, to at least 35%. These additional children and young people will be treated by NHS-funded community services. The expectation is that the implementation of local transformation plans will help deliver this objective.

1.11 Within the context of national policy developments, local progress and challenges and importantly the latest needs and views of children, young people, parents/carers and professionals, Wiltshire's updated plan details how the CCG will use resources in the best way to drive continuous improvement across the whole system in collaboration with the local authority and other partners.

Transformation funding

1.12 Overall local expenditure on CAMHS has increased from £5.7m in 2014-15 to £6.9m in 2016-17 (this includes funding from the CCG, the local authority and NHS England Specialised Commissioning). The figures mean that Wiltshire spends around £60 per head of the 0-19 child and youth population (as per the Office for National Statistics 2015 mid-year estimates). The increase in funding is the direct result of additional resource that has been made available to CCGs from NHS England to support the delivery of Local Transformation Plans.

1.13 Wiltshire CCG has been allocated the following funding from NHS England. The non-ring-fenced funding is recurrent, grows year on year until 2020 and is included within the overall CCG budget allocation. The table below provides a summary of this funding, its intended purpose and forecasted uplift (please note the figures from 2017/18 are draft and are subject to confirmation from NHS England).

	2015/16	**2016/17**	**2017/18**	**2018/19**	**2019/20**
Early Intervention	£ 610,565.00	£ 973,840.00 (59% uplift)	£ 1,149,131.00 (18% uplift)	£ 1,390,449.00 (21% uplift)	£ 1,557,303.00 (12% uplift)
Eating Disorders	£ 243,924.00	£ 245,000.00	£ 245,000.00	£ 245,000.00	£ 245,000.00

1.14 In addition to the transformation funding, Wiltshire CCG has also been successful in securing funding from the NHS England Health and Justice Commissioner to address gaps in service provision for children and young people in contact with directly commissioned health and justice services. These are Liaison and Diversion, Secure Children's Homes and Sexual Assault Referral Centres.

- £40k per annum is being used to support a joint project with Bath and North East Somerset CCG to improve psychological support from Oxford Health CAMHS for children and young people who display harmful and/or problematic sexual behaviours.

- £50k per annum is supporting Oxford Health CAMHS to provide better assessment, triage and support for children and young people who come into contact with the Swindon and Wiltshire Sexual Assault Referral Centre (SARC). This is a joint Swindon and Wiltshire CCG project.

Assurance of funding

1.15 NHS England will assure CAMHS transformation funding through the CCG planning framework. Commissioning intentions, local priorities and budget proposals shall be reflected within the CCG Operational Plan as well as the Bath & North East Somerset, Swindon and Wiltshire Sustainability and Transformation Plan. The CCG will be required to submit regular returns to NHS England regarding progress and compliance with national expectations.

1.16 NHS England requires CCGs to clearly demonstrate how CAMHS transformation plans and funding are linked with other services and support that are being provided for children and young people locally. In short, they want to be assured that the CCG is working with the local authority and its partners across the whole system to progress change. Within this context, the CCG will continue to ensure that CAMHS funding is linked with other income streams, including Early Intervention in Psychosis, Parity of Esteem, as well as local authority and school funding.

1.17 In addition to funding for CCGs to improve local services, NHS England has invested significant monies nationally to:

- Fund expansion of the Children and Young People's Improving Access to Psychological Therapies (IAPT) programme;
- Deliver improvements to perinatal mental health care;
- Improve inpatient services for children and young people;
- Build workforce capacity;
- Support innovation and development of online support;
- Specifically support the mental health needs of children with learning disabilities and those in the youth justice system.

Main Considerations

1.18 The local transformation plan and its refreshed priorities have been developed in response to the needs and views of children, young people, parent's carers and professionals. A summary of key challenges from their perspective is given below.

Key challenges

- *Moving from an out of date fragmented system to a modern integrated model of coherent support that provides the right help at the right time in the right place, including a shift in culture where CAMHS is seen as a whole system that is made up of a variety of agencies and organisations working together.*

- *Improving outcomes for children and young people and achieving better value for money by directing more resources upstream on early intervention and prevention. To include providing better access to early help and support in schools and other community settings.*

- *Too many referrals to CAMHS do not meet the service criteria. Better information and training is therefore needed for professionals so that they are able to refer or signpost children and young people to right help they need.*

- *Demand for services is rising. Without additional investment and capacity in the system the right help for children, young people and their families cannot be provided when and where they need it. A key issue is providing the right help and support for teenagers who make up the bulk of demand in respect of CAMH services.*

- *As is the case across the country waiting times are continuing to increase – reducing waits for assessment and treatment is perhaps the biggest challenge locally.*

- *Improving transitions for young people to adult mental health services.*

- *Reducing the need for mental health related hospital attendances and admissions and length of stay. To include addressing the shortage in the local supply of the right Tier 4 CAMHS inpatient beds to stop children and young people having to be treated far from home.*

- *Ensuring appropriate emotional wellbeing and mental health support is available for the most vulnerable children and young people.*

- *Putting an end to children and young people in mental health crisis being detained in custody.*

<u>Local priorities</u>

1.19 The following local priorities have been developed to respond to the local challenges and align with the recommendations set out in the Mental Health Five Year Forward View and Future in Mind.

- **Mobilise and implement a new integrated CAMH Service** across Bath and North East Somerset, Swindon and Wiltshire in line with the THRIVE model. To include:
    - A single point of contact
    - Closer partnership working with schools and multi-agency children's services teams

    - A whole system approach with better joint working and information sharing
    - Provision of talking therapies
    - No more declined referrals
    - Community based interventions and treatment
    - Good quality digital service offer

- Finalise and begin the implementation of a Bath and North East Somerset, Swindon and Wiltshire wide **multi-agency workforce development plan** detailing how we will build capacity and capability across the whole CAMHS system, including provision of a dedicated budget to enable continued investment in the Children and Young People Improving Access to Psychological Therapies Programme.

- Develop a comprehensive and **coordinated offer of parenting support** to help parents/carers better meet the emotional wellbeing and mental health needs of their children.

- Develop and present a business case to Wiltshire CCG with the aim of placing **counselling from large GP surgeries** in areas of greatest need on a sustainable financial footing from 1 April 2018.

- Establish a clear **all-age joint-agency sexual assault referral pathway** for emotional wellbeing and mental health across Swindon and Wiltshire.

- **Improve transition** from CAMHS to adult mental health services by providing a more flexible offer to children and young people aged 16+ through Bath and North East Somerset, Swindon and Wiltshire wide review of the transitions pathway and associated protocols.

- Develop a Bath and North East Somerset, Swindon and Wiltshire wide **collaborative commissioning plan** between tier 3 and tier 4 CAMHS with the aim of reducing hospital admissions and out of area placements. To include:

    - Fully embedding an enhanced CYP mental health liaison model in all three acute hospitals across Bath and North East Somerset, Swindon and Wiltshire
    - Submission of a bid to the Department of Health Beyond Places of Safety Grant scheme to establish an out of hours psychiatric assessment centre for children (and potentially adults) for Bath and North East Somerset, Swindon and Wiltshire with the aim of avoiding inpatient admissions
    - Improve joint working between health, education and social care as well as enhance community CAMHS home treatment to enable a shift from placements to the provision of community packages of support where possible
    - Consider the development of a Swindon and Wiltshire Children and Young People Crisis Care Concordat to provide a more coordinated response to CYP in crisis

- **Improve access to community based treatment** through increased investment in Oxford Health CAMHS as part of re-commissioning as well as ensuring requirements to flow data to the national Mental Health Services Dataset are included within all CCG funded service contracts.

- Continued focus on **driving down waits** for both referral to assessment and referral to treatment.

- Undertake a review of how we provide the **right emotional wellbeing and mental health support offer to primary age children** and those in the early years.

- Take positive and helpful steps to **support schools to provide a more consistent and equitable good quality offer of counselling**.

- Continued focus on prevention and promotion of positive wellbeing and further **action to tackle stigma and discrimination** through ongoing development of the Wiltshire Healthy Schools Programme, OnYourMind website, Anti-bullying initiatives and through children and young people's participation and involvement.

- Further enhance the **OnYourMind website** to help people understand what services and support are available and how these can be accessed.

- Work across CAMHS and social care to develop a more robust **emotional wellbeing and mental health pathway for Looked After Children** and children and young people at risk of Child Sexual Exploitation as well as Unaccompanied Asylum Seekers.

- In the context of the STP and having one shared CAMHS provider, consider the **closer alignment of priorities and resources across Bath and North East Somerset, Swindon and Wiltshire**, with the potential development of a BSW Local Transformation Plan for Children and Young People's Mental Health and Wellbeing in 2018.

Draft budget subject to review following CCG budget setting process

1.20 Details of the use of transformation funding to support local priorities are given below.

Planned Income (£)

Transformation funding for early intervention	997,212.00
Transformation funding for eating disorders	245,000.00
Health and Justice funding	90,000.00
Total	**1,332,212.00**

Planned Expenditure (£)

Joint agency workforce training and development	25,000.00
Primary CAMHS	1,036,649.00

Community based eating disorder service	245,000.00
Digital service developments	16,000.00
Other service developments	10,000.00
Total	**1,332,649.00**

Recommendations

1.21 The Board is invited to approve the following recommendations:

i) Notes the progress to date on the implementation of the CCG local transformation plan for children and young people's mental health and wellbeing;

ii) Endorses the refreshed and expanded plan including its commissioning intentions, local priorities and updated budget proposals;

iii) Encourages partner agencies to consider contributing their views to the green paper on improving mental health support for children and young people.

Presenter name: Ted Wilson

Title: Community and Joint Commissioning Director and Group Director – North and East Wiltshire Group

Organisation: Wiltshire CCG

Report Authors:

James Fortune, Lead Commissioner, Children's Services, Wiltshire Council

Date: 09 January 2018

Wiltshire Council

Health and Wellbeing Board

25 January 2018

Subject: Domestic Abuse

Executive Summary

This report provides an updated overview of the domestic abuse reduction agenda in Wiltshire.

Proposal(s)

It is recommended that the Board notes the report.

Reason for Proposal

The domestic abuse health needs assessment has been completed and work on the new strategy had commenced in the autumn. Procurement of the new domestic abuse and independent sexual violence advisory (ISVA) service started in September. The new model includes a range of services addressing the needs of those in the county who are affected by domestic abuse and sexual violence.

Tracy Daszkiewicz
Director of Public Health
Wiltshire Council

Wiltshire Council

Health and Wellbeing Board

25 January 2018

Subject: Domestic Abuse

Purpose of report

1. This report provides an updated position on the domestic abuse reduction agenda in Wiltshire.

Background

2. Current contract arrangements for the existing domestic abuse support services expire 31 March 2018. To support Wiltshire's understanding of the prevalence and impact of domestic abuse and to inform the development of a new service model, the Wiltshire Community Safety Partnership commissioned a health needs assessment.

Wiltshire Domestic Abuse Health Needs Assessment

3. The Domestic Abuse health needs assessment has been completed. It provided an epidemiological, corporate and comparative assessment that will help further understanding of need around domestic abuse in Wiltshire. Recommendations have been identified to strengthen future service provision and strategy development. The health needs assessment has been published on the Wiltshire Intelligence Network: http://www.intelligencenetwork.org.uk/health/adults/

Wiltshire Domestic Abuse and Sexual Violence Strategy

4. The current strategy expired in March 2017. The findings from the domestic abuse health needs assessment have been used to inform and shape the next strategy. This document reflects Wiltshire's strategic vision for domestic abuse and sexual violence. The governance for the strategy is with the joint WCSP/WSCB Domestic Abuse Sub group.

Procurement of Domestic Abuse and ISVA Services

5. Following cabinet's endorsement in June 2017, procurement of the new domestic abuse and ISVA services commenced in September. The work has been developed jointly through a multi-agency commissioning group,

with representation from Wiltshire Council's Public Health, Housing strategy, Children's services and commissioning, and the Office for the Police and Crime Commissioner. It will be co-funded through Wiltshire Council and the Police and Crime Commissioner.

6. To support the service development, Wiltshire hosted a Stakeholder consultation event in May and a Provider's market event in July. Both were well represented, with over 40 participants to each, covering a breath of agencies and service areas.

7. Wiltshire Council is commissioning an innovative and reconfigured range of services to address the needs of those who are affected by domestic abuse and sexual violence. The new service brings together services for victims and their families that were previously separately commissioned. There will be a single access point meaning that all Wiltshire victims of domestic abuse and sexual offences will be provided with a tailored specialist support service(s) appropriate to their risk and need.

8. The vision of the service is to significantly reduce domestic abuse and sexual violence and the harm caused by it through effective prevention and early intervention. Service delivery will consist of four intertwined strands;

    - Victim focussed support addressing both domestic abuse and sexual violence
    - Support for children and young people living with the impacts of domestic abuse
    - Work to address perpetrator behaviour, as part of a whole family approach
    - Provision of safe, flexible accommodation accessed to all at greatest risk fleeing domestic abuse

9. The procurement process (including the standstill period) has now been completed. The contract award is to be made to the lead provider Splitz Support Service in a partnership bid with Greensquare Housing Group, Salisbury Refuge and the Nelson Trust. The new service will commence 1st April 2018.

Tracy Daszkiewicz
Director of Public Health
Wiltshire Council

Report Author:
Hayley Mortimer
Public Health Specialist Vulnerable Communities, Wiltshire Council

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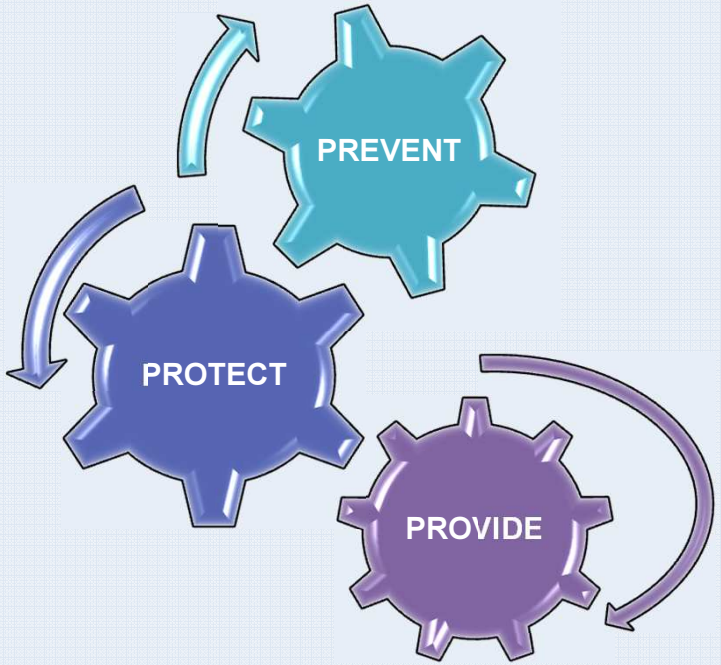

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Domestic Abuse and Sexual Violence Strategy 2017-2020

Introduction

This is the first Wiltshire domestic abuse and sexual violence strategy setting out our vision, aims and objectives for tackling domestic abuse and sexual violence and the outcomes we expect to see.

The key groups intended to benefit from this strategy are:

- Victims (direct and indirect) and survivors of domestic abuse and/or sexual violence
- Children and young people who have witnessed or experienced domestic abuse and/or sexual violence
- Perpetrators or those at risk of perpetrating, to work to reduce the ongoing harm caused by domestic abuse and/or sexual violence
- Partner agencies working to support adults, children and young people affected by domestic abuse and/or sexual violence

National Strategy

The Government's Violence Against Women and Girls Strategy 2016-2020 published in March 2016 continued with the 2010 pillar approach of:

- Prevention
- Provision of services
- Partnership working
- Pursuing perpetrators

Wiltshire has recently completed a health needs assessment (HNA) on domestic abuse.

The health needs assessment and the national strategy have been used to provide the strategic framework to inform Wiltshire's approach.

Definitions

What is domestic abuse?

Home Office Definition	**Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality.** *(HO, 2013)*

This can encompass, but is not limited to, the following types of abuse:

Physical, Emotional, Sexual, Financial and/or Psychological

Controlling Behaviour	A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.
Coercive Behaviour	An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim." This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and it is clear that victims are not confined to one gender or ethnic group.

Whilst the definition applies to young people aged 16yrs and above, it is critical to acknowledge that domestic abuse can have far reaching impacts on children and young people under 16.

What is sexual violence?

Sexual Violence Definition	**Any behaviour of a sexual nature, which is unwanted and committed against someone without that persons freely giving consent.** *(Centres for Disease Control and Prevention,2014)*

This can encompass, but is not limited to, the following types of abuse:

Sexual Abuse within families

Sexual Exploitation by individuals and/or groups

Online Sexual Abuse such as online grooming and/or sharing images of sexual violence on the internet.

Sexual Offences	Sexual offences including sexual activity with a child under 16 years of age are governed by the Sexual Offences Act 2003 (England and Wales).

The sexual offences act (2003) includes:

Rape

Sexual Assault

Serious Sexual Assault

Sexual Activity with a Child under 16years

National context - domestic abuse and sexual violence

Each year an estimated

1.9 million people in the UK suffer form domestic abuse

1.2 million women

700,000 men

85,000 women and 12,000 men are raped each year

2 in 4 UK rapes are committed by a current or ex-partner

1 in 5 women (16-59) has experienced some form of sexual violence since the age of 16

Each year more than **100,000** adults are at HIGH risk of being murdered or serious injury as a result of domestic abuse

Over 130,000 children live in these homes

The UK cost of domestic abuse each year

£15.8 billion

plus a further £9.9 billion on emotional and human costs

The cost of domestic abuse to health services £1.73 billion

4 in 5 victims of domestic abuse don't tell the police

Only 15% who experience sexual violence choose to report to the police

90% of those raped will know the perpetrator

85% of victims sought help five times on average the year before they got effective help

30% of DA starts or escalates during pregnancy

Wiltshire Council

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Local context - domestic abuse and sexual violence

15,300
adults in Wiltshire are believed to be living with domestic abuse

9,400 women

5,900 men

80% Female
20% Male

Underreporting is a real issue

3,300
incidents of domestic abuse were reported to Wiltshire Police in 2015/16

403
rapes recorded to Wiltshire police in 2016/17

reports of other sexual offences **925**

referrals to the ISVA service **563**

9% of cases referred for ISVA support were Male victims

A recent review identified of 128 rape investigations **half** were DA related

Both court mandated and community programmes have low completion rates

110 in 2015/16
refusals "Support needs too high"

Wiltshire currently provides **0.7** refuge units per 10,000 population

Flexible accommodation needed

1,000 Cases

Over 50% of Children's Services' cases **involved Domestic Abuse in 2015/16**

An additional **1,500** Children's Services' contacts were made that include domestic abuse

Wiltshire Multi-Agency Risk Assessment Conference discussed

500 cases in 2015/16

including over **650** children and young people in the HIGH risk household

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Strategic Framework

Our vision is to significantly reduce domestic abuse and sexual violence and the harm caused by it, to keep our communities safe and encourage healthier, happier lives

This will be supported by three key aims of prevention, protection and service provision.

Wiltshire aims to:

- Prevent domestic abuse and sexual violence from happening in the first place, challenging behaviours and attitudes and intervening earlier to prevent it from continuing, reoccurring or escalating.
- Reduce the risk and impact on victims, children and young people and vulnerable adults, by holding perpetrators to account and support them to change their behaviour.
- Work together in partnership to provide appropriate levels of support where abuse occurs.

Wiltshire's priorities (objectives) are to:

- Target activity on education, training and earlier intervention to prevent abuse/violence from occurring, continuing, re-occurring or escalating.
- Identify, assess and reduce risk to victims, children and young people and vulnerable adults.
- Protect victims across all levels of risk through access to appropriate interventions
- Provide appropriate support to adults, children and young people living with the effects of domestic abuse and/or sexual violence to reduce its impact.

Wiltshire domestic abuse and sexual violence strategy - overview

Our Vision	To significantly reduce domestic abuse and sexual violence and the harm caused by it, to keep our communities safe and encourage healthier, happier lives

	Strategic Aim	Outcomes
PREVENT	Prevent domestic abuse and sexual violence from happening in the first place by challenging the attitudes and behaviours which foster it, and intervening early where possible to prevent it from continuing, recurring or escalating.	Victims, perpetrators and their children are identified early and provided with the appropriate level of support to break cycles of domestic abuse and sexual violence and overcome the impact it has on their lives.
		Communities and professionals understand what domestic abuse is, and know how to respond. Challenging attitudes or behaviours to reduce its prevalence.
		Increased reporting of domestic abuse and sexual violence to the police and reducing the number of repeat victims.
		Training is delivered to all relevant practitioners, organisations and businesses.
PROTECT	Reduce the risk and impact on victims, children and young people and vulnerable adults, by holding perpetrators to account and support them to change their behaviour.	Children and young people at risk of harm are identified and referred appropriately.
		Victims are safer and have improved resources to remain safe.
		Victims have increased access to justice and perpetrators are held to account through the policing and justice system.
		Perpetrators of domestic abuse and sexual violence are supported to change their behaviour and improve their overall wellbeing., reducing the risk of repeat perpetration.
PROVIDE	Work in partnership to provide appropriate levels of support where abuse occurs	Victims have access to responsive services through coordinated pathways, which support sustained recovery, mitigating the risks of further abuse.
		All identified victims are offered an equally accessible service which meets their needs.
		Victims report improved health, wellbeing and resilience for themselves and their families.
		Effective sharing of lessons learned through service evaluations and domestic homicide reviews

Domestic Abuse Needs Assessment

June 2017

Part of the JSA family

Wiltshire Council
Where everybody matters

Needs Assessment/Report prepared by:
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Public Health Specialist Vulnerable Communities
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Executive Summary

Background

Domestic Abuse (DA) is a complex issue that represents a major public health concern, which cuts across all geographic and cultural groups.

Domestic Violence and Abuse has been defined as:

> *"Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial and / or emotional".*

The impact on those living with its effects can be devastatingly long and lasting. DA occurs across all levels of society regardless of age, gender, race, sexuality, wealth and geography. To tackle this agenda effectively requires a sensitive, multi-disciplinary approach.

There is no single factor that explains why some individuals have an increased tendency for domestic abuse or why domestic abuse is more prevalent in some communities than others. The socio-ecological model considers the complex connections of the impact and risks of domestic abuse across four layers (individual, relationship, community and societal) and it can be used to develop a framework for preventative interventions. This framework can help to promote the development of cross-sectoral policies and programmes by identifying links and interactions between different levels and factors.

Purpose, Scope and Methodology

This needs assessment is an epidemiological, corporate and comparative needs assessment. It will be used to further the understanding of need around domestic abuse in Wiltshire. It will also underpin the commissioning of a new domestic abuse service for the county and be used to shape future strategy.

Local Need

Demographics

Wiltshire is a predominantly rural county with a population of 486,000. In the next 25 years the population is expected to grow by 13% to 547,000. Military rebasing is a significant driver of this population growth. The population has a higher proportion of over 65s than the national average, and a BME population that is proportionally one third of that observed nationally. The county is relatively affluent although there has been an increase in relative deprivation since 2004. There are some localised pockets of significant deprivation.

Risk and Protective Factors:
This health needs assessment looks at the risk and protective factors associated with both experiencing and also perpetrating domestic abuse, and there is often significant overlap between them.

At the individual level, factors such as previous exposure to violence, long term physical or mental health conditions and drug and alcohol abuse are found to be risk factors. Young people and females are over represented as victims.

At the relationship level, educational disparity, relationship dissatisfaction and low socio economic status are associated with increased risk of domestic abuse.

At the community and societal level, relative deprivation, weak community sanctions, rural living, social norms supportive of violence and traditional gender norms are found to be associated with increased risk of domestic abuse.

The strength of research evidence around these findings is variable and it is difficult to quantify how these factors are distributed within Wiltshire.

Prevalence of Domestic Abuse in Wiltshire
Applying national estimated prevalence rates for domestic abuse we would expect 9,374 women and 5,891 men to be experiencing domestic abuse in Wiltshire. The actual number of domestic abuse incidents reported to Wiltshire police in 2015/16 was 3,354, which is significantly lower than the projected volume and suggests a culture of non-reporting and signals a large unmet need.

In four out of five incidents reported to the police in Wiltshire the victim is female, which broadly reflects the national picture. Of those who go on to receive domestic abuse service support, 95% are female. Almost two thirds are in the 20-39 age group, although referrals in older populations are growing.

Nationally, the NSPCC have estimated that around 20% of girls and 10% of boys experience domestic abuse.

In Wiltshire there were 652 children recorded as being in the household at the time of a high risk domestic abuse incident that resulted in a referral to the Multi-Agency Risk Assessment Case Conference (MARAC) in 2015/16. In 2014/15 Children's Services record a large number of contacts (4,553) and referrals (406) where domestic abuse was recorded as a 'topic of concern'.

Local Demand

Adult Victim Services
Adult victim services cover a spectrum of risk. The MARAC seeks to safeguard the highest risk victims and their families, through a coordinated partnership approach and targeted action plans to reduce immediate risk. Independent domestic violence advisors provide specialist high risk support and advice and through the provision of housing, including refuges, ensure victims and their families can live in a place of safety.

Moving down the risk spectrum, domestic violence protection orders facilitate moving the perpetrator away from the victim, the domestic violence disclosure scheme allows partners to know of previous history of domestic violence and early sharing of information through the domestic abuse conference helps safeguard victims. In addition, a community-based 'outreach' support service for victims, offers longer term interventions through domestic abuse support workers.

Demand for services from service users with complex needs, including alcohol, drugs and mental health is felt to be increasing and service provision needs to be flexible enough to manage this.

Children and Young People's Services
A Children's Support Service provide both a one to one and group work service for young people aged 11-16 years living in a household where high risk DA has been identified, which is aimed at improving young people's understanding and awareness of domestic abuse. There is a high demand for these services and significant waiting lists. This service is currently operating with interim funding and is delivered via Thrive Hubs.

Children's Centre's provide a venue for family support programmes such as the Freedom Programme, Making Changes and You and Me Mum which are offered to families experiencing domestic abuse. Demand for these programmes is increasing.

A universally targeted healthy relationships programme "Teenztalk" is delivered by Splitz Support Service in schools to years 9 and 10. It is acknowledged that there is a gap in support provision for 5-11 year olds.

Perpetrator services
Wiltshire currently provides limited perpetrator services offering a voluntary community programme and a court-mandated programme. The voluntary community programme has seen a recent drop in referrals and less than 50% of those who are referred complete the programme (around 35 a year). The court-mandated programme, Building Better Relationships is delivered by the Community Rehabilitation Company (CRC) and around 40 people a year complete the programme. The number of people completing perpetrator programmes is very low compared to the number of domestic abuse incidents occurring in the county.

Universal Services
As well as specialist domestic abuse services a number of other agencies such as health services, also offer support to those experiencing domestic abuse.

Support Currently Offered
Support services are arranged to be in line with the national Violence against Women and Girls Strategy 2016-2020. The support currently available is combination of nationally provided services and locally commissioned and voluntary sector services.

Evidence Review of What Works
Evidence supports a co-ordinated approach to prevent violence and abuse in the first place and to make sure those experiencing it, access appropriate support. The

national focus is supporting professionals to identify and recognise the earliest signs of domestic abuse, preventing escalation through a greater focus on early intervention. There is evidence around supporting children and young people who live with domestic abuse and nascent evidence around working with perpetrators to stop abuse at its source.

Recommendations

A number of recommendations to strengthen future service provision arise from this report and are summarised at the end of each section. They include ways to tailor service provision to meet the changing demographic needs of the county, address service provision gaps and find ways to ensure data is captured to allow effective monitoring and evaluation of domestic abuse service provision going forward.

Contents

Glossary of Terms

Acronyms Used

AWS / UWS	Army Welfare Service / Unit Welfare Service
C&YP	Children and Young People
CiN	Child in Need
CP	Child Protection
CQC	Care Quality Commission
CRC	Community Rehabilitation Company
CSC	Children's Social Care
DA	Domestic Abuse
DACC	Domestic Abuse Conference Call
DASH RiC	Domestic Abuse, Stalking and Harassment and Honour Based Abuse Risk Identification Checklist
DHR	Domestic Homicide Review
DV	Domestic Violence
DVA	Domestic Violence and Abuse
DVDS	Domestic Violence Disclosure Scheme
DVPN/O	Domestic Violence Protection Notice/Order
FGM	Female Genital Mutilation
FM	Forced Marriage
HBV	Honour Based Violence
HMIC	Her Majesty's Inspectorate of Constabulary
HMIP	Her Majesty's Inspectorate of Probation Services
IDVA	Independent Domestic Violence Advisor
IPV	Intimate Partner Violence
IRIS	Identification and Referral to Improve Safety
JTAI	Joint Team Area Inspection
MARAC	Multi Agency Risk Assessment Conference
NPS	National Probation Service
NSPCC	National Society for the Prevention of Cruelty to Children
PH	Public Health
SDVC	Specialist Domestic Violence Courts
SV	Sexual Violence
SVA	Sexual Violence Assault
VAWG	Violence against Women and Girls
WCSB	Wiltshire Safeguarding Children's Board
WSAB	Wiltshire Safeguarding Adult's Board
WSCP	Wiltshire Community Safety Partnership

Background

Violence remains a major contributor to death, disease and disability, as well as a host of other health and social consequences at a global level[1].

Domestic Abuse (DA) is a complex issue that presents a major public health issue, which cuts across all geographic and cultural groups. The impact on those living with its effects are long lasting and devastating. DA occurs across society regardless of age, gender, race, sexuality, wealth and geography. To effectively tackle this agenda requires a sensitive, multi-disciplinary approach.

Domestic Violence and Abuse (DVA)
Wiltshire adopted the 2013 cross-government definition[2] for domestic violence and abuse as;

> *"Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological, physical, sexual, financial and / or emotional".*

'Controlling behaviour' is; a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

'Coercive behaviour' is; is an act or pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish or frighten their victim.

This new definition was widened to include those aged 16-17yrs following government consultation.

There are cross-overs with other agendas including:

Honour Based Violence/Abuse (HBV/A)
Whilst there is no specific offence of 'honour based crime', it is an umbrella term that encompasses various offences covered by existing legislation. HBV/A can be described as a collection of practices used to control behaviour within families or other social groups to protect perceived cultural, religious beliefs or honour. Such violence can occur when perpetrators perceive a relative has shamed the family or community by breaking their honour code[3]. Wiltshire have adopted the term Honour Based Abuse (HBA) to reflect a broader understanding of issues and for consistency with the DA term used.

[1] WHO (2014) *Global status report on violence prevention 2014*. WHO
[2] Home Office (2013) *Cross government definition of domestic violence and abuse and violence* https://www.gov.uk/domestic-violence-and-abuse
[3] The Crown Prosecution Service, "Honour Based Violence and Forced Marriage," [Online]. Available: http://www.cps.gov.uk/legal/h_to_k/honour_based_violence_and_forced_marriage/#a04

Forced Marriage (FM)
A forced marriage is when one or both persons have not consented to the marriage, or where duress has been a factor in their decision making. The duress put on a person could be physical or sexual violence, financial pressure, emotional or psychological abuse etc[3].

Prior to 16th June 2014 Forced Marriages were not a specific offence, instead existing legislation such as false imprisonment, kidnapping and offences of violence were used to prosecute perpetrators. Forced Marriage is now a specific offence under s121 of the Anti-Social Behaviour, Crime and Policing Act 2014 and came into force on 16 June 2014[3].

An arranged marriage is not the same as a forced marriage. In an arranged marriage the couple getting married have consented to the marriage, whilst the families can take a leading role in arranging the partners, they are still free to accept or decline the marriage and partner.

Female Genital Mutilation (FGM)
Female Genital Mutilation refers to the procedures that intentionally change, injure or remove the female genital organs for non-medical purposes. FGM has no medical or health benefit and can often cause a severe physical and emotional impact on the female. FGM can also cause long term problems including possible infertility or child birth problems[4].

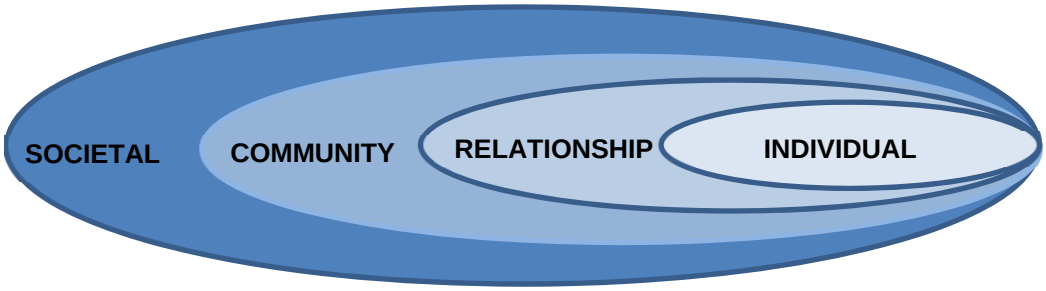
Modern-Day Slavery
Modern Slavery encompasses slavery, servitude, forced and compulsory labour and human trafficking. Traffickers and slave drivers coerce, deceive and force individuals against their will into a life of abuse, servitude and inhumane treatment. Victims may be sexually exploited, forced to work for little or no pay or forced to commit criminal activities against their will. Victims are often pressured into debt-bondage and are likely to be fearful of those who exploit them, who will often threaten and abuse victims and their families. All of these factors make it very difficult for victims to escape[5].

Domestic Abuse and the Socio-Ecological Relationships
There is no single factor that explains why some individuals have an increased tendency for violence or why violence is more prevalent in some communities than others. Krug (2002)[6] discusses that violence is the result of a complex interplay of individual, relationships, social, culture and environments factors. Having a greater understanding of the influence of these factors, are crucial in unpinning a collaborative response to the agenda.

The socio-ecological model (figure 1) was introduced in the late 70's in the context of child abuse and has more recently been used to understand intimate partner violence.

[4] The Crown Prosecution Service, "Female Genital Mutilation," [Online]. Available: http://www.cps.gov.uk/legal/d_to_g/female_genital_mutilation/
[5] HM Government (2014) *Modern Slavery Strategy* [online] available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/383764/Modern_Slavery_Strategy_FINAL_DEC2015.pdf
[6] Krug, E., Dahlberg, L., Mercy, J., Zwi, A. and Lozano (2002). *World report on violence and health*. WHO.

Figure 1 Socio-Ecological Model to understand the impact of Domestic Abuse



Individual level: encompasses biological, beliefs and attitudes, and personal history factors that influence an individual's likelihood of experiencing DSVA.
Relationship level: reflects how an individual's close social relationships influence the risk of DSVA.
Community level: relates to the settings of social relationships, such as neighbourhoods, workplaces, organisations and schools, and characteristics of those environments that contribute to or protect against DSVA.
Societal level: refers to those underlying conditions of society that either encourage or inhibit DSVA.

The model considers the complex connections of the impact and risks of domestic abuse across four layers, which include individual, relationship, community and societal and it can be used to develop a framework for preventative interventions. This framework can help to promote the development of cross-sectoral policies and programmes by identifying links and interactions between different levels and factors.

Purpose, Scope and Methodology

The Domestic Abuse Needs Assessment is an epidemiological, corporate and comparative assessment that aims:

- To understand and describe the population of Wiltshire.
- To understand and describe the risk and protective factors associated with domestic abuse and consider them in the Wiltshire context where possible.
- To understand and describe the prevalence of domestic abuse in Wiltshire.
- To map current domestic abuse service provision and identify potential service gaps.
- To assess demand upon current services.
- To determine whether the current domestic abuse service provision meets the identified needs and demands of the local population.
- To understand and describe inequalities experienced by those experiencing domestic abuse and consider how these may be addressed.

In addition this domestic abuse needs assessment comes at a time where it can help inform the commissioning of a new domestic abuse service for the county.

The traditional model of epidemiological, corporate and comparative healthcare needs assessment was developed by Stevens and Rafferty[7]. This health needs assessment draws on all three approaches. The epidemiological need considers the severity and size of the domestic abuse problem. Corporate need looks at the perceptions of the service providers, commissioners and users while comparative need looks at the data in comparison to other localities/sub groups and national targets[8]. Given the time constraints it was not possible to engage directly with service providers.

Limitations of the data

Domestic abuse is a complex area and the data are often patchy unreliable. This is in part due to the complexity of the service provision and data collection. We have attempted to bring together multiple sources of data, with valuable local data helping to create a more comprehensive picture of domestic abuse in Wiltshire. However, as identified throughout the document, the data available is at times imperfect.

[7] Stevens A. Rafferty J. Health Care Needs Assessment: The Epidemiologically Based Needs Assessment Reviews, Vol. 1. Oxford: Radcliffe Medical Press

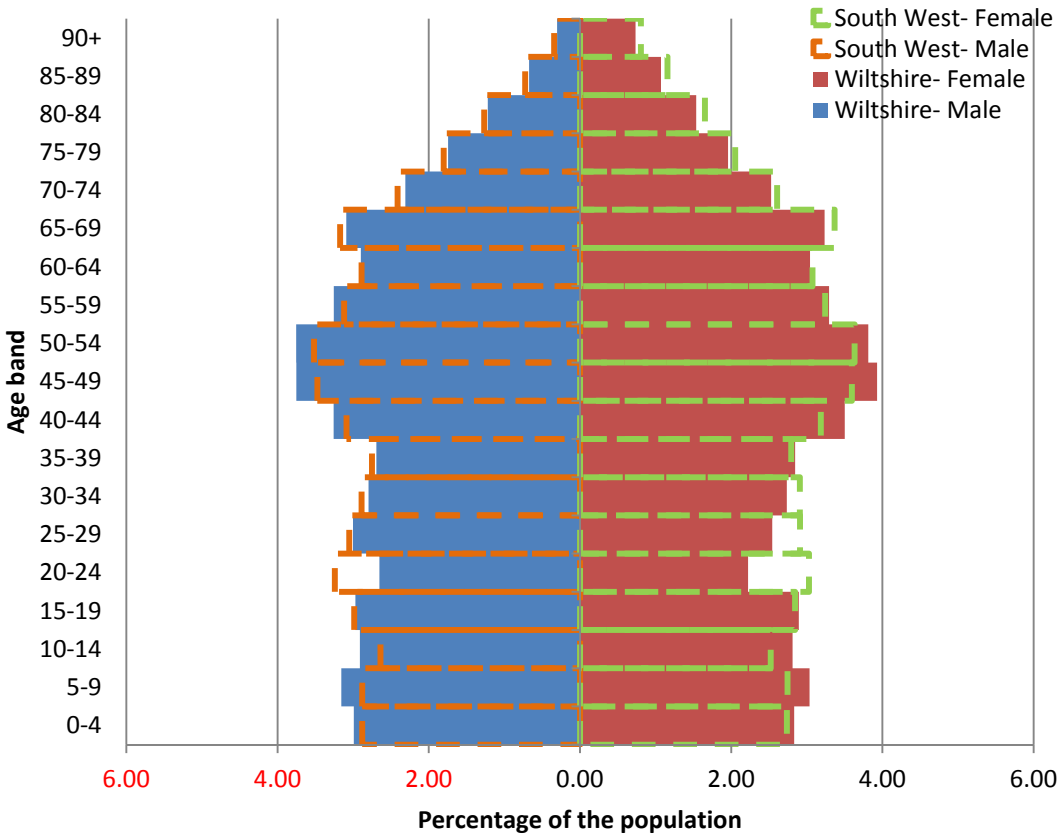
[8] Hooper J, Longworth P. Health needs assessment workbook. Health Development Agency. January 2002

Local Health Needs

Local demographics

There are an estimated 486,000[9] people living in the Wiltshire Local Authority area. 51% of the population is female. Wiltshire is predominantly White British (93%). Figure 2 depicts the most recent population pyramid of Wiltshire and the South West region.

Figure 2: Population pyramid for Wiltshire and South West region



The age structure of Wiltshire is similar to the South West region. However, Wiltshire has a slightly smaller proportion of 20 to 24 year olds which might be a reflection of a lack of a University. It is thought that the population pyramid in Wiltshire will become top heavy with a larger proportion of elderly and that in 2026 the number of people over the age of 65 will for the first time outnumber those under the age of 20.

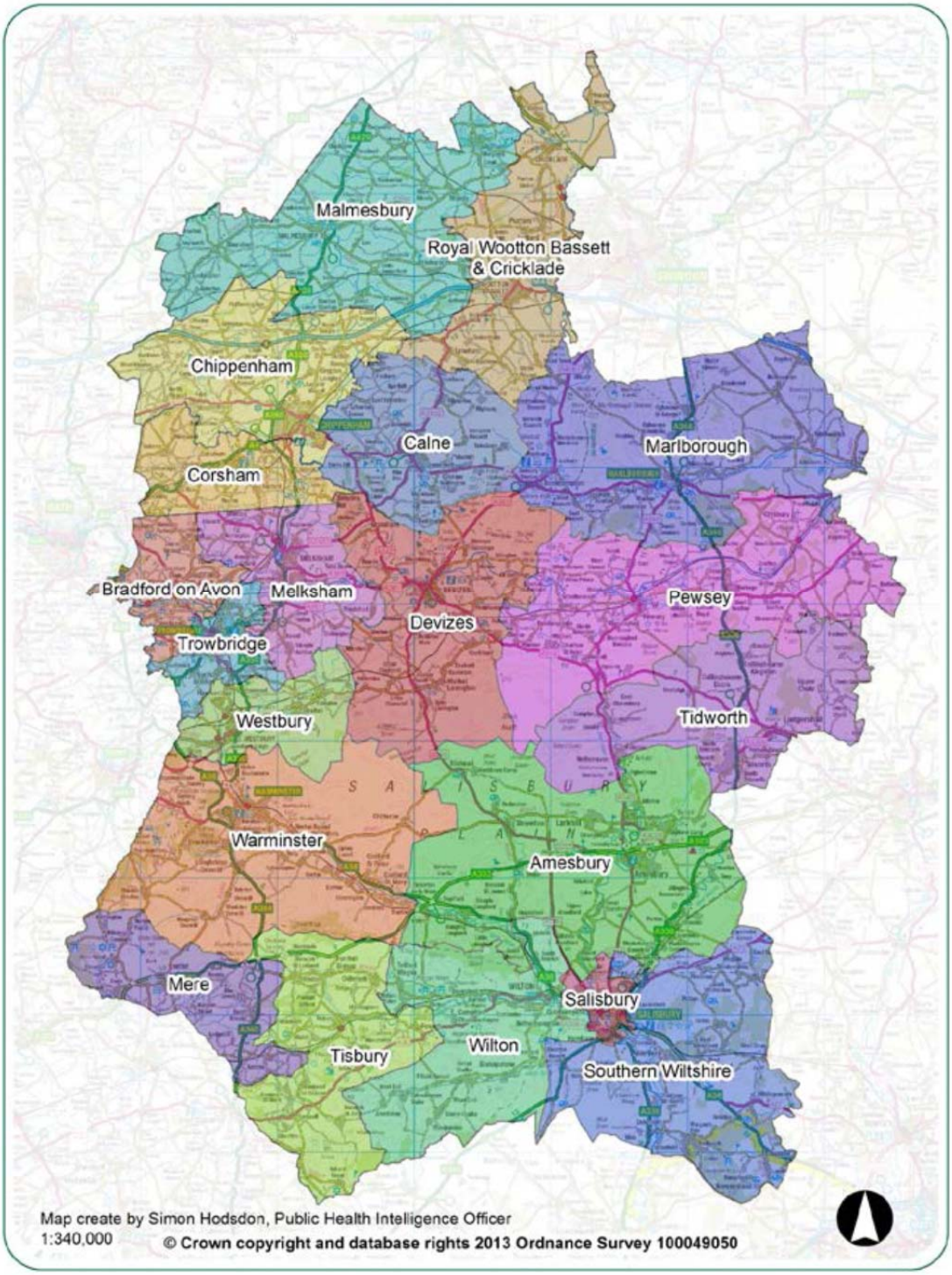
In terms of overall deprivation level, Wiltshire compares favourably against the national benchmark. However, the county has seen an increase in relative deprivation since the 2004. For the first time, Wiltshire now has one geographic region in the 10% most severely deprived in England (Salisbury St Martin – Central).

Within Wiltshire, the Council and local partners have identified twenty Community Areas, forming eighteen Local Area Boards. A map of the community areas is given below.

[9] Office of National Statistics [ONS] mid-year 2015

Wiltshire Council
Where everybody matters

Wiltshire's Community Areas



Sex

51% of the population is female. The table shows the breakdown of the population by sex and broad age bands. In line with national trends, due to different life expectancies there are significantly more women aged 65+ than men.

Table 1 showing Wiltshire population split by sex

People	Wiltshire		South West		England	
	Number	% of Pop	Number	% of Pop	Number	% of Pop
Age 0-17	104,046	21.4	1,082,081	19.8	11,677,856	21.3
Age 18-64	282,861	58.2	3,220,145	58.9	33,396,899	61.0
Age 65+	99,186	20.4	1,168,954	21.4	9,711,572	17.7
Total	486,093	100	5,471,180	100	54,786,327	100

Males	Wiltshire		South West		England	
	Number	% of Pop	Number	% of Pop	Number	% of Pop
Age 0-17	52,906	22.0	553,785	20.6	7,053,719	22.0
Age 18-64	141,992	59.1	1,602,476	59.6	19,768,448	61.6
Age 65+	453,95	18.9	531,835	19.8	5,252,278	16.4
Total	240,293	100	2,688,096	100	32,074,445	100

Females	Wiltshire		South West		England	
	Number	% of Pop	Number	% of Pop	Number	% of Pop
Age 0-17	51,140	20.8	528,296	19.0	6717,154	20.3
Age 18-64	140,869	57.3	1,617,669	58.1	19,959,546	60.4
Age 65+	53,791	21.9	637,119	22.9	6,358,889	19.3
Total	245,800	100	2,783,084	100	33,035,589	100

Black Asian and Minority Ethnic Groups[10]

Ethnicity has been defined as:

> *"The social group a person belongs to, and either identifies with or is identified with by others, as a result of a mix of cultural and other factors including language, diet, religion, ancestry and physical features traditionally associated with race"[11].*

Wiltshire is predominantly White British (93%). People in minority groups are often not present in Wiltshire in sufficient numbers to form recognisable groups. According to 2011 Census figures, ethnic minorities make up 6.6% of the population (31,256 people). Wiltshire has a lower proportion of ethnic minorities than the South West region as a whole (6.6% vs 8.2%) and a considerably lower proportion than for England as a whole (6.6% vs 20.2%). The proportion of the population from ethnic minority groups in Wiltshire has increased by 129% between 2001 and 2011 compared to 114% in the South West and 74% in England. Obtaining accurate information on ethnicity between censuses is difficult.

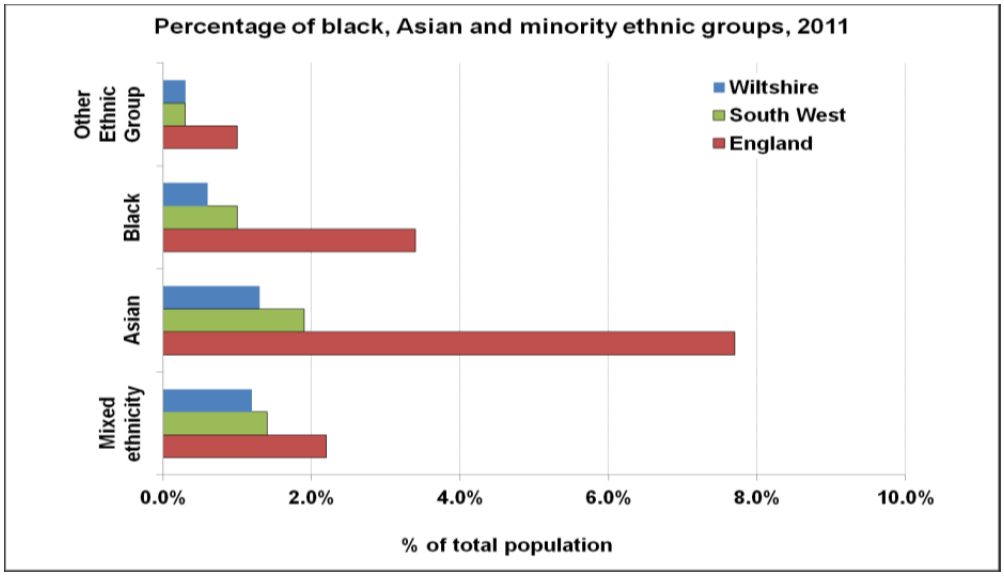
The relatively small size of the BME population in Wiltshire is an important point to consider in relation to domestic abuse. At the national level it has been flagged that there are some specific risks associated with BME groups including honour-based

[10] Data sourced from Wiltshire JSA health and wellbeing 2013/14 demographics: ethnicity
[11] (Bhopal R. Glossary of terms relating to ethnicity and race: for reflection and debate. Journal of Epidemiology Community Health 2004:58:441-445)

violence, female genital mutilation and forced marriage, as well as barriers to accessing mainstream services including issues over cultural understanding, fears of racism and language barriers. The BME population is a diverse group and the levels and types of risk will vary between groups of differing cultural or religious backgrounds.

The national strategy has a strong focus on working with BME populations. While this nationally driven focus clearly remains important, the smaller size of the BME population in Wiltshire may require different approaches to ensure that locally the inequality is addressed appropriately.

Figure 3 showing Black, Asian and Minority Ethnic groups in Wiltshire and the South West



Source: 2011 Census Table KS201EW, ONS

Table 2 to show estimated population change by ethnic group 2001-2011

Area	Total population	White	Mixed	Asian	Black	Other
Wiltshire	+9%	+7%	+96%	+180%	+181%	+32%
South West	+7%	+5%	+92%	+132%	+137%	+68%
England	+8%	+1%	+85%	+68%	+64%	+157%

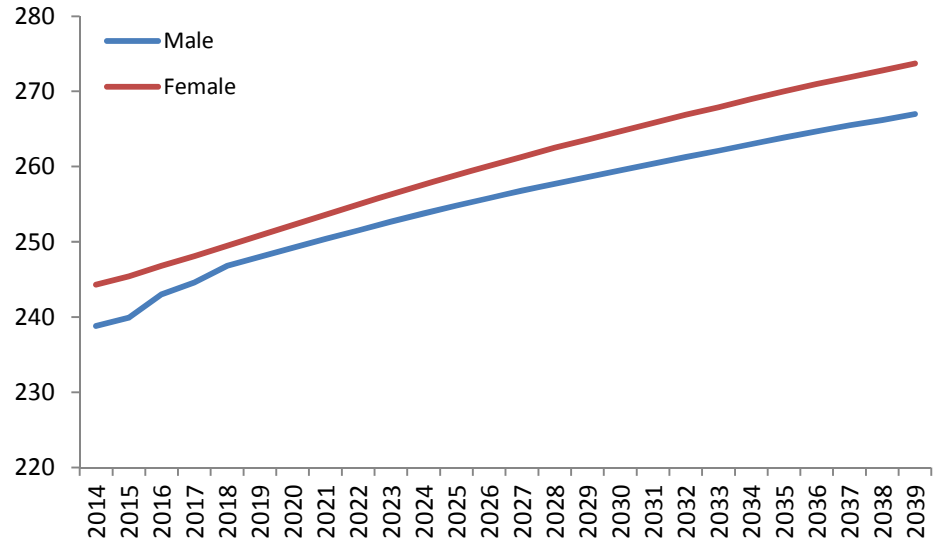
Source: Key Statistics interface tool, ONS. url: www.ons.gov.uk/ons/rel/census/2011-census/key-statistics-for-local-authorities-in-england-and-wales/index.html

Projected Population Growth and the Military

Over the next 25 years the population of Wiltshire is expected to grow by around 12%, an addition 58,000 people. This is illustrated graphically in figure 4.

The steeper rise of the male population between 2014 and 2019 reflects the impact of the military rebasing that is expected to occur. The ONS projections have not adjusted for accompanying spouses and children, and so are likely to be an underestimate of the true population. It is locally estimated there will be around 1,400 spouses and 1,800 children. Including additional military spouses and families would take the projected increase in population from 12% to at least 13%, or an additional 61,000 people in total.

Figure 4 showing projected population growth for Wiltshire.



The fact that a significant proportion of the Wiltshire population is military and the rapid growth of this population is of importance in the context of domestic abuse.

National and international research indicates that domestic abuse is a significant issue for military personnel and their families[12,13]. There are a number of factors that influence the fact that military families may be more affected by domestic abuse than the general population. These include:

- isolation of families on or near to bases;
- frequent house moves of military families disrupting a support networks;
- the risk of losing the family home if the victim is not entitled to military housing in their own right;
- careers involving control and power may be attractive to perpetrators;
- the close-knit nature of the regiment or squadron and
- fears about the impact on a military career from reporting domestic abuse.

Overall, Wiltshire is a relatively affluent county of around 486,000 people. Compared to the national picture there are fewer black and ethnic minority people and the overall population is older than the national average. In addition, the high proportion of military and ex-military personnel has an impact on the population composition, and rebasing will have a considerable impact on population growth over the next decade. These Wiltshire specific demographic characteristics influence many of the areas of need discussed in the rest of this needs assessment.

Recommendations arising from this section

- Use knowledge of the local demographic profile to inform service planning and allow for future proofing of services. Particular attention needs to be paid to the local ethnic profile and the need of the substantial and growing military presence.

[12] MacManus, D. et al. 'Violent behaviour in UK military personnel returning home after deployment', Psychological Medicine,

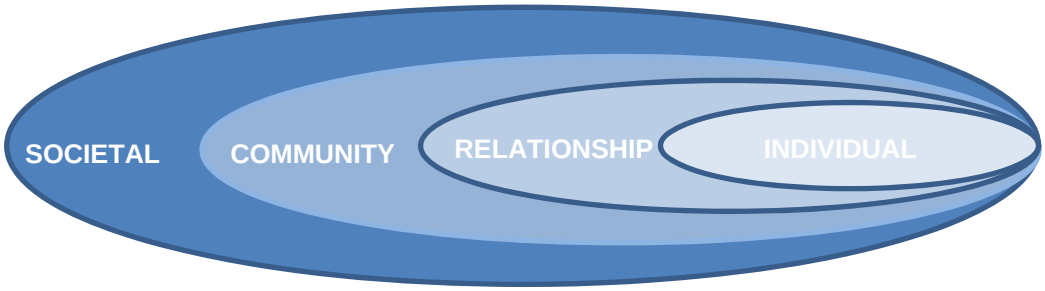
[13] Trevillion K, Williamson E, Thandi G, *et al.* A systematic review of mental disorders and perpetration of domestic violence among military populations. *Soc Psychiatry Psychiatr Epidemiol* 2015;**50**:1329–46. doi:10.1007/s00127-015-1084-4

Risk and protective factors associated Domestic Abuse

Overview[14]

The socioecological model introduced in the background section recognises that domestic abuse and related issues result from the complex interplay of various pre-disposing risk factors at the individual, relationship, community and societal level.

Figure 5 Socio-Ecological Model to understand the impact of Domestic Abuse



The review of risk and protective factors provided here will consider the main risk factors grouped into the levels outlined above. There are two recent systematic reviews that seek to identify the risk and protective factors for sexual violence and intimate partner violence, and much of the following discussion is based on the finding of these papers[15,16]. Supplementary evidence is informed by the findings of a systematic, rapid evidence review of 15 publications carried out in late 2016 by Devon County Council[17].

There are a wide range of risk and protective factors that operate at all levels of the socio-ecological model. These factors include non-modifiable factors such as gender and age, as well as modifiable factors such as acceptance of violence and harmful use of alcohol. There is substantial cross-over in the risk and protective factors and evidence of significant interaction between risk factors operating at different levels of the socio-ecological model. This suggests that broad, wide-reaching prevention strategies are likely to be most effective in tackling the root causes of the problem. There are significant gaps in the evidence specifically relating to certain population groups who appear to have an increased risk of domestic abuse and violence. These groups include prisoners, military personnel, and lesbian, gay, bisexual and transgender individuals (LGBT). Furthermore, there is a lack of research evidence from the UK regarding the risk factors in adolescent and young adult populations.

While the information is not yet available to facilitate the provision of a Wiltshire specific population profile of the distribution of risk and protective factors locally available evidence will be discussed under each subheading.

[14] Source data: Centres for Disease Control and Prevention https://www.cdc.gov/violenceprevention/intimatepartnerviolence/riskprotectivefactors.html
[15] Tharp A, DeGue S, Valle L. A systematic qualitative review of risk and protective factors for sexual violence perpetration. , *Violence, Abus* Published Online First: 2013.http://tva.sagepub.com/content/14/2/133.short
[16] Capaldi D, Knoble N, Shortt J, *et al.* A systematic review of risk factors for intimate partner violence. *Partner Abuse* Published Online First: 2012.http://www.ingentaconnect.com/content/springer/pa/2012/00000003/00000002/art00005
[17] Devon County Council, Who is most at risk of becoming a victim of DVSA or perpetrating DVSA, Sept 2016

Individual Risk Factor

The table below illustrates some of the key factors associated with domestic abuse.

Table 3 show the individual level factors associated with domestic abuse perpetration and victimisation

Perpetration	Victimisation
Age	Age
Low education/low income	Low education/low income
Gender	Gender
Ethnicity	Ethnicity
Sexual abuse	Separated/divorced marital status
Stress	Pregnancy
Intra-parental violence	Intra-parental violence
Antisocial personality	Sexual abuse
Harmful use of alcohol	Mental disorder (anxiety, depression, post-traumatic stress disorder)
Illicit drug use	Harmful use of alcohol
Acceptance of violence	Illicit drug use
Unemployment	Acceptance of violence
Self-esteem	Exposure to prior abuse/victimisation
Past history of being abusive	Long term conditions e.g. disability, eating disorder

There is considerable crossover between factors associated with being a perpetrator or a victim.

Age:

Young age is consistently shown as a risk factor for perpetration and victimisation of domestic abuse. Although adolescent experiences of dating violence in the UK have not yet received the same degree of attention as in places like the USA, survey data from the NSPCC identifies partner violence in adolescent relationships as a significant concern for young people's wellbeing[18].

Socioeconomic status, income education and employment:

Deprivation is a consistently reported risk factor for perpetration and victimisation of DA, with rates of reported incidents higher in more deprived areas and in the unemployed. However, there is conflict as to the relative contribution and robustness of income, education and employment as individual risk factors. Furthermore, there are suggestions that socio-economic status may interact with other risk factors such as age and gender. In females, a low level of education is a risk factor for victimisation. It is thought that low education mediates its effect through reducing exposure and access to resources, and increased acceptance of violence and unequal gender norms. Furthermore, many of the observed associations between DA and SES are attenuated once more proximal factors such as alcohol intake, stress and relationship conflicts are controlled for.

In the Wiltshire context, as a country the region generally enjoys higher than average levels of educational achievement and income and lower than average levels of

[18] Barter C, Mccarry M, Berridge D, *et al.* Partner exploitation and violence in teenage intimate relationships. Published Online First: 2009.www.nspcc.org.uk/inform

unemployment and socioeconomic deprivation. However, when looked at the sub-county level there are pockets of the region (e.g. Salisbury St Martin - Central) that perform lower than the national and county average in these factors.

Ethnicity:
There is some evidence that being a member of a minority ethnic group is a risk factor for DA; however, it is rarely the sole focus of a study. Furthermore, the bulk of the research is conducted in the USA and therefore generalisability to the UK is not known.

In the Wiltshire context the county has lower than national or regional average population proportions of ethnic minorities.

Childhood abuse:
Exposure to sexual and physical violence in childhood increases the likelihood of DA perpetration and victimisation in adulthood. It is hypothesised that early exposure to violence may increase violence acceptance in future relationships. A meta-analysis conducted in sex offenders also provides evidence for the role of sexual abuse history in increasing the risk of perpetration.

In the Wiltshire context as in the rest of the Country, it is hard to quantify or identify those who have suffered childhood abuse as it commonly goes unreported.

Stress:
There is evidence from cross-sectional studies that financial and work-related stress is predictive of DA perpetration. In the local context, this is a factor that is hard to quantify at a population level but the risk can be assessed at the individual level.

Harmful use of alcohol:
Harmful use of alcohol has been shown to be strongly associated with the perpetration and victimisation of DA. It is hypothesised that alcohol is a risk factor for DA due to its disinhibitory effects on aggression. In terms of SVA much of the research has been conducted in well-defined populations such as college students or military personnel and therefore may not be generalisable to the wider population. Furthermore, there is ongoing debate as to the direction of causality; it may be both a cause and an effect of DA. There is also evidence of interaction between harmful alcohol use and illicit drug use and an interaction with gender is also apparent with alcohol being associated with increased aggression in males more than females.

More information on the harmful use of alcohol and illicit drug abuse can be found in the Wiltshire Council Adult Emotional Wellbeing and Mental Health Needs Assessment and in the Adult Drug and Alcohol Treatment Needs Assessment.

Antisocial personality:
Several longitudinal studies have explored the role of antisocial behaviour as a developmental risk factor for Intimate Partner Violence (IPV). There is evidence to suggest that the cluster of problem behaviours related to conduct problems and antisocial behaviour are a substantial risk factor for later IPV involvement. Studies suggest that individuals with antisocial behaviour characteristics are more likely to disregard social norms and have a tendency to become more aggressive. The research evidence for the role of personality disorders in Sexual Violence Assaluts

(SVA) is more mixed which probably reflects the wide variety of factors that have been examined in each category, making comparison between studies difficult.

More information on personality disorders in the local context can be found in the Wiltshire Adult Emotional Wellbeing and Mental Health Needs Assessment.

Acceptance of violence, Exposure to intra-parental violence and past history of victimisation:

Attitudes to violence are correlated with both perpetration and victimisation. Males who believe it is acceptable to beat their wives have an increased risk of perpetration while women's acceptance of violence is also positively associated with experiencing abuse. Acceptance of violence may be driven by witnessing it from an early age or experiencing it in the past but much of the evidence around this is only based on retrospective reporting.

Mental disorder:

The evidence base for the role of mental disorder such as depression and anxiety in IPV is mixed and suggestive of an interaction by gender. Results from one systematic review[19] and meta-analysis suggest that the risk of experiencing IPV is increased by more than 3 fold in women with depressive disorders, anxiety disorders and post-traumatic stress disorder compared to women without mental disorders. Findings from an alternative review suggest that depressive symptoms are associated with IPV perpetration and victimisation, with the effect apparently stronger for women than for men.

A fuller discussion of mental health and domestic abuse in the Wiltshire context can be found in the Wiltshire Council Adult Emotional Wellbeing and Mental Health Needs Assessment.

Pregnancy:

There is some disagreement in the literature as to whether the prevalence of IPV and SVA increases during pregnancy. In one review it was concluded that men with a history of violent or abusive behaviour were more likely to exhibit this behaviour in future relationships, especially during pregnancy.

Disability:

Results from a meta-analysis of 16 pooled studies suggest that the relative risk for victimisation of SVA of children with disabilities was 2.88 (95% CI 2.24-3.69). However, the review acknowledged a lack of robust evidence, poor standards of measurement of disability and SVA and concluded that there were gaps in the knowledge which need to be addressed.

Relationship Factors

At the relationship level there are a number of factors that can be identified as increasing the risk of domestic abuse. These are outlined in the table below. These are not factors that can easily be mapped at the Wiltshire population level and so the discussion considers the factors in their broader context.

[19] Trevillion K, Williamson E, Thandi G, *et al.* A systematic review of mental disorders and perpetration of domestic violence among military populations. *Soc Psychiatry Psychiatr Epidemiol* 2015;**50**:1329–46. doi:10.1007/s00127-015-1084-4

Table 4 show the relationship level factor associated with domestic abuse perpetration and victimisation

Perpetration	Victimisation
Multiple partners/infidelity	Educational disparity
Low resistance to peer pressure	Number of children
Association with troubled peers	Association with troubled peers
Conflict/discord	Marital dissatisfaction/discord
Marital status	Marital status
Low SES	Low SES

Multiple partners/infidelity:

Men who report multiple partners are more likely to perpetrate DA and infidelity is also shown to be a risk factor for both perpetration and victimisation. Much of the evidence to underpin this finding has been conducted in low and middle income countries which may affect the generalisability of the findings to the UK.

Relationship status:

There has been much research on the role of relationship status on risk for DA with suggestions that marriage was a protective factor for DA. The evidence points towards separated women as being particularly vulnerable to experiencing DA.

Association with troubled peers:

Association with troubled peers is a strong risk factor for a range of problem behaviours in adolescents particularly including delinquency and disruptive behaviour. This also appears to be true for IPV with data from both cross-sectional and longitudinal studies demonstrating an association between involvement with aggressive peers and IPV. High friendship quality in adolescence appears to offer protection against IPV.

Relationship discord and dissatisfaction:

Marital or relationship conflict is a robust risk factor for DA, with higher levels of DA present in couples who have more frequent disagreements. Low relationship satisfaction is also shown to be a risk factor for DA in men and women, but is thought to be mediated through relationship discord and conflict. There is also some evidence for an interaction between relationship dissatisfaction and problem alcohol consumption.

Community Factors and Societal Factors

In general the evidence base for community level factors is weaker than for individual factors due to methodological difficulties in measuring factors at the level of the community or society. A summary of factors believed to be influential at the community or society level is given in the table below.

Table 5 shows the community and societal level factors associated with domestic abuse perpetration and victimisation

Perpetration	Victimisation
Community level factors	
Poverty	Poverty
Weak community sanctions	Weak community sanctions
Neighbourhood characteristics (poverty, unemployment, educational context, male literacy, acceptance of violence, high proportion of households that use corporal punishment)	Neighbourhood characteristics (high proportion of poverty, high proportion of unemployment, educational context high proportion of female literacy, acceptance of violence, low proportion of women with higher education)
School context (perceived school safety, school attachment, school bonding, and school economic disadvantage)	Social support
Rural living	Rural living
Alcohol outlet density	Poverty
	Alcohol outlet density
Societal level factors	
Traditional gender norms and social norms supportive of violence	Traditional gender and social norms supportive of violence
	Divorce regulations by government
	Lack of legislation on IPV within marriage
	Protective marriage law

Poverty:

While DA occurs in all socio-economic groups, women living in poverty are disproportionally affected by victimisation. Much of the research has been conducted in low and middle-income countries and the generalisability to the UK is not well known. However, poverty is known to be a cause of stress, frustration and a sense of inadequacy which may be contributing factors to the observed inequality. Wiltshire experiences below average levels of poverty but there are a few pockets of the county that do experience high levels of deprivation.

Rural living:

There is some evidence that rural living is associated with risk of perpetration and victimisation of DA. Much of the evidence is based on work done in the USA and more work is needed to identify how this may be relevant in the UK.

In the Wiltshire context this may be significant as much of the county is rural and people may dwell in relatively isolated rural areas. The inequality may be exacerbated by poor access to services.

School context:

There is emerging evidence that school context may be a risk factor for IPV in adolescent populations. For example, lower school bonding has been shown to be associated with both perpetuating peer and dating violence. However, there are suggestions that the influence of school context may differ by gender and may also interact with other factors such as deprivation and parental involvement.

Alcohol outlet density:

A recent review suggested neighbourhood factors such as alcohol outlet density to be associated with risk of IPV[20]. The effect is hypothesised to occur through an increased number of alcohol outlets promoting problem alcohol use among at-risk couples. However, measurement of geographical data is difficult and more research is needed to understand how exposure to alcohol outlets may influence behaviour. This is an interesting factor to consider as unlike many others it can be influenced by local and national government policy.

Weak community sanctions and broader societal factors

This can refer to a lack of legal sanctions or moral codes of practice and these factors are shown to be associated with DA. In a comparison of 16 societies, those with the lowest levels of IPV were those which had strong community sanctions against it. Community factors such as social support may also offer protection against IPV. The extent to which beliefs in male sexual entitlement are entrenched in society is related to the likelihood of DA and other forms of sexual violence.

There is a lack of empirical evidence for the role of societal factors in DA in high income countries. One of the most consistently reported risk factors for perpetration of IPV is traditional gender norms and male dominance within society. These factors interact with other factors at the level of the individual, relationship and community to magnify issues.

Community and societal norms are unlikely to differ significantly from those in the rest of the county. Nationally there is an increased awareness of the issues around domestic abuse and a growing understanding that it is unacceptable. This national trend is likely to benefit Wiltshire.

Recommendations arising from this section

- Ensure prevention strategies are broad and can encompass the wide spectrum of multi-level and interconnected risk and protective factors.
- Grow the evidence base around local risk and protective factors and consider qualitative work to research the societal and community factors which operate locally and could be used to focus prevention interventions.
- Ensure this knowledge is used to inform multi-agency activity in the area.

[20] Cunradi CB. Neighborhoods, alcohol outlets and intimate partner violence: addressing research gaps in explanatory mechanisms. *Int J Environ Res Public Health* 2010;**7**:799–813. doi:10.3390/ijerph7030799

Prevalence of Domestic Abuse in Wiltshire

This chapter includes

- A discussion of the volume of Domestic Abuse being recorded and;
- The local communities who are affected and living with its impact.

Overview

Domestic Abuse has far reaching consequences across our local populations irrespective of age, gender, ethnicity, sexuality or economic status. Domestic Abuse can be experienced by both men and women; however evidence reports that there are higher levels of Domestic Abuse experienced on women by men, and that women are more likely to experience multiple incidents of abuse[21].

The latest figures published using data from the Crime Survey for England and Wales published in 2014 highlight 7.1% of women and 4.4% of men were estimated to have experienced domestic abuse; equating to an estimated 1.2 million females and 700,000 male victims in England and Wales[22]. Such is the scale of the issue that three women a fortnight are killed by a partner or former partner[23].

Data around Reported Domestic Abuse Incidents

Countywide data

Using national figures captured by the Crime Survey for England and Wales, we can calculate the projected number of Domestic Abuse victims in Wiltshire. This is shown in the table below.

Table 6 Projected Volume of Domestic Abuse in Wiltshire

Source Crime Survey England and Wales

	ONS mid-year population estimates 2015 (ages 16-59) **FEMALES**	Applying CSEW estimate of 7.1% of female victims of domestic abuse	ONS mid-year population estimates 2015 (ages 16-59) **MALES**	Applying CSEW estimate of 4.4% of male victims of domestic abuse
Wiltshire	**132,023**	**9,374**	**133,882**	**5,891**

Thus, we would expect 9,374 women and 5,891 men to be experiencing Domestic Abuse in Wiltshire.

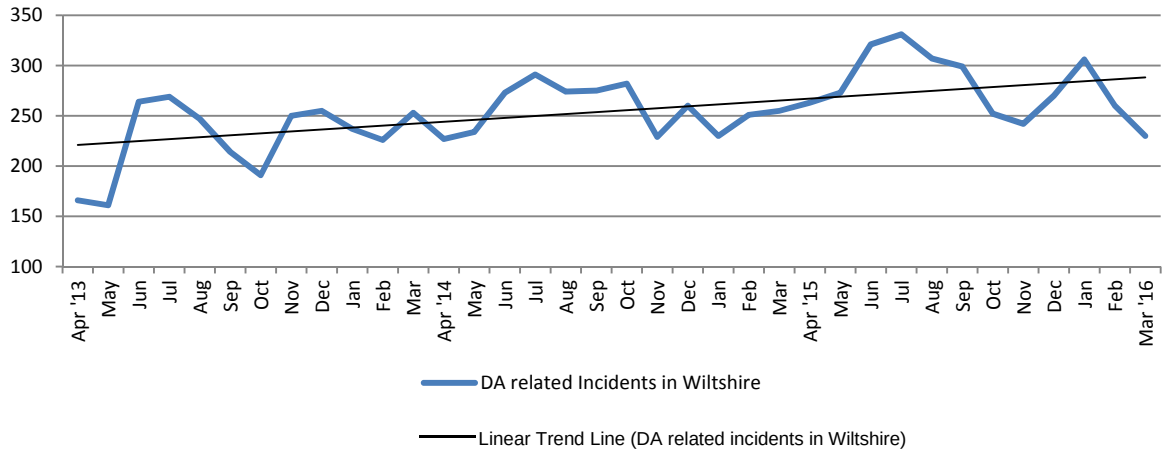
The actual number of Domestic Abuse incidents reported to Wiltshire police was 3,354 (2015/16), which is significantly lower than the projected volume. The reports to the police show an 8% increase (273 incidents) compared to the previous year. This increase could be due to a number of potential influencing factors which include increased levels of public awareness raising of domestic abuse, as well as changes to police recording practices. Figure 6 presents the volume of domestic abuse incidences reported to the police over time. It enables the seasonal variations to be identified, including peaks in summer months June/July and Dec/Jan.

[21] Walby, S & Allen, J (2004). Domestic violence, sexual assault and stalking: Findings from the British Crime Survey. London

[22] Office for National Statistics (2014) *Chapter 4 – Intimate Personal Violence and Partner Abuse* 13 February 2014 http://www.ons.gov.uk/ons/dcp171776_352362.pdf

[23] HMIC. (2014). Everyone's business: improving the police response to DA. *HMIC*

Figure 6 DA related Incidents reported to Wiltshire Police
Source Wiltshire Police



There has been a noticeable increase in the volume of recorded crime for Domestic Abuse in Wiltshire in 2015-16 compared to previous years (represented in the table below).

Table 7 Comparable trend data for Wiltshire

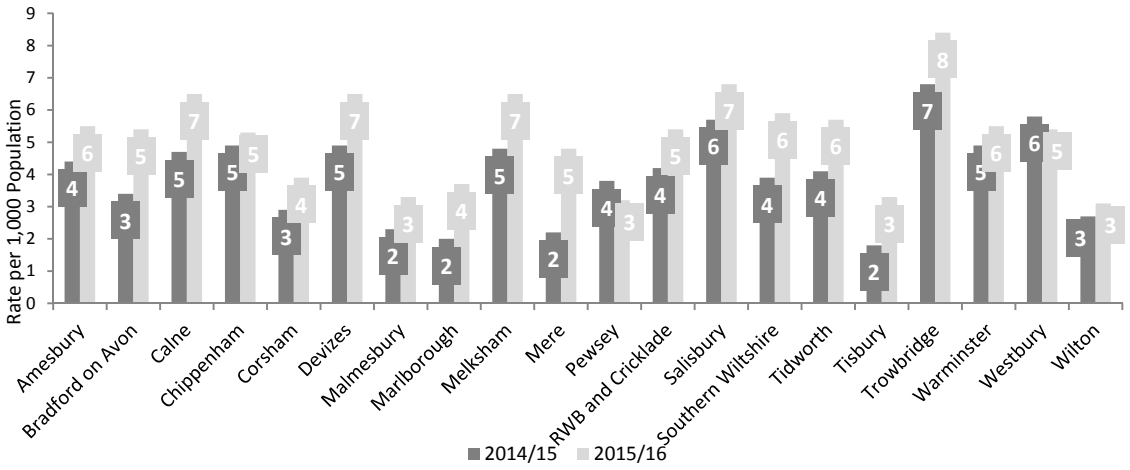
	2011-12	2012-13	2013-14	2014-15	2015-16
DA Incidents	1963	N/A	2733	3081	3354
DA Related Crimes	1192	1421	1851	2036	2725

Source Wiltshire Police

Community area data

In 2015/16 reports of domestic abuse increased across all Wiltshire Community Areas with the exception of Pewsey and Westbury (figure below).

Figure 7 Incidents of Domestic Abuse (Rate per 1,000) by Wiltshire Community Area 2014/15 - 2015/16
Source Wiltshire Police

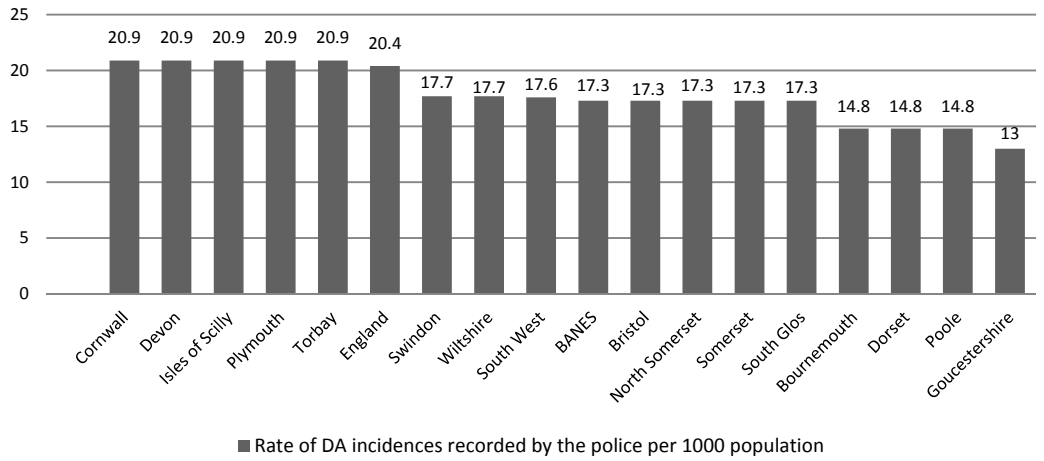


Comparative data

The Public Health Outcome Framework (PHOF) compares the rate of Domestic Abuse incidences recorded per 1,000 populations across the South West region.

Wiltshire recorded a rate of 17.7 Domestic Abuse incidences per 1000 population (figure 8 below), compared against the South West range of a high of 20 and a low of 13 Domestic Abuse incidences per 1,000 populations.

Figure 8 Public Health Outcome Framework for Domestic Abuse 2014-15
Source Public Health Outcome Framework



Data on the demographic profile of those experiencing domestic abuse

Data captured for the 2014 Police Problem Profile; a dip sample from domestic abuse incidents reported to the police between 1st January and 30th June 2014, identified 1,428 victims, of which 4% of incidents linked to more than one victim.

Of the 1,428 victims; 21% (n.304) were male, with 79% (n. 1,122) female, which broadly reflects the national picture reported[24]. However, the data captured through the commissioned Domestic Abuse support service showed in 2015-16, the majority of their service users were female with 95% and just 5% being male.

Due to the complex nature of Domestic Abuse consideration should be given to 'counter-allegations' of abuse. This can involve reports of DA from both parties presenting as a victim. Such cases have been identified and discussed through the Wiltshire MARAC and require careful consideration. The commissioned support services support both male and female victims of DA, however due consideration is given to referrals involving counter-allegations and advice sought from the national helpline RESPECT, with referrals made where appropriate.

The two tables below (8 and 9) detail the age profile of service users accessing the commissioned Domestic Abuse Support Services. The greatest volume of service users to both services were aged between 20-49yrs.

[24] ONS, (2015), *Chapter 4: Violent Crime and Sexual Offences – Intimate Personal Violence and Serious Sexual Assault*

Table 8 Age Profile; Victims Referred to Outreach Service 2015-16
Source Splitz Support Service

Age	No.	%
16-19	28	4%
20-29	253	36%
30-39	169	24%
40-49	127	18%
50-59	77	11%
60+	49	7%
	703	**100%**

Table 9 Age Profile; Victims Referred to High risk Service 2015-16
Source Splitz Support Service

Age	No.	%
16-19	20	3%
20-29	271	47%
30-39	138	24%
40-49	73	13%
50-59	48	8%
60+	8	1%
Not Recorded	20	3%
	578	**100%**

The Support Service has reported an increasing trend in referrals from older populations experiencing Domestic Abuse particularly in referrals to the Outreach Service (7%). Feedback from the Service advised that patterns of referrals will be as a result of victims seeking support following many years of systematic abuse. National research on the prevalence of Domestic Abuse in older populations is limited and remains a hidden problem. National awareness campaigns have tended to target a younger audience, which all supports a false assumption that Domestic Abuse ceases to exist beyond a certain age[25].

Recommendations arising from this section

- Explore further the impact of Domestic Abuse on older populations

Data on Domestic Abuse Prosecutions

This section discusses data recorded by the Crown Prosecution Service (CPS). It details the successful outcome rate for Domestic Abuse cases, which is the proportion of successful convictions secured at court. In CPS terminology "successful" refers to a conviction being recorded in a case they felt there was good evidence of guilt.

Wiltshire reports a successful outcome rate of 76.8% for domestic abuse related cases heard at Court (2014-15), which is a slight reduction compared to the previous year (82.2%). This change could be attributed to an increase in the overall volume of cases heard at court in 2014-15.

The highest reason for an unsuccessful outcome was due to 'no evidence offered' (74), followed by 'discontinued' (36) and 'dismissed after full trial' (30); this is an area to note, as the cost incurred for a case in terms of time and emotional impact, to then be dismissed following a full trial is significant.

[25] SafeLives (2016), Safe Later Lives: Older People and domestic abuse. Bristol. http://safelives.org.uk/sites/default/files/resources/Safe%20Later%20Lives%20-%20Older%20people%20and%20domestic%20abuse.pdf

Specialist Domestic Violence Courts

The accreditation of Specialist Domestic Violence Courts (SDVCs) was introduced under the Home Office National Delivery Plan (2008). Its purpose was to offer an improved service and pathway through the court process to victims of Domestic Abuse, in recognition that they required a different approach.

Wiltshire had attainted Specialist Domestic Violence Courts (SDVCs) accreditation by the Ministry of Justice in 2008. However, over more recent years the SDVC process in Wiltshire has had a lesser focus. Recent discussions have once again highlighted the role of the court process and the impact it has on victim's decision-making to pursue a criminal prosecution. This has been recently picked back up by the Wiltshire Criminal Justice Board Victims and Witness Sub Group.

Recommendations arising from this section

- Revisit the role of the Specialist Domestic Violence Court (SDVC) process in Wiltshire and review the victim's journey through the court process.

Data on prevalence of Children at risk of living with Domestic Abuse

An estimated 130,000 children in the UK live in a household with HIGH risk domestic abuse[26] and around 6% of all children are estimated to be exposed to severe domestic abuse between adults in their homes at some point in their childhood[27].

Children identified at risk of Domestic Abuse in Wiltshire

MARAC

The Wiltshire MARAC records data of all referrals received where children were present in the household.

In 2015-16, there were 652 children recorded in the household at the time of a high risk Domestic Abuse incident resulting in a referral to the Multi-Agency Risk Assessment Case Conference (MARAC), of which 97 children were identified in the household where further repeat incidents of DA occurred (table 10). Cases discussed at MARAC included 15 high risk victims who were pregnant (21 previous year) at the point of the MARAC referral.

Table 10 Breakdown of MARAC referrals and Children

Source LA Wiltshire – Public Health

	Total Referrals	No. of children in Household	No. of repeat cases with Children	Total No. of Children in household in a Repeat Case	No. of Victims Pregnant at point of referral
2015-16	**494**	**652**	**54**	**97**	**15**
214-15	**424**	**575**	**52**	**112**	**21**
2013-14	**368**	**662**	**N/A**	**N/A**	**2**

[26] CAADA (2012), *CAADA Insights 1: 'A place of greater safety'*. Bristol

[27] Radford, L., Corral, S., Bradley, C., Fisher, H., Basset, C., Howatt, N. and Collishaw, S. (2011), '*Child abuse and neglect in the UK today'.* London: NSPCC

Children's Services

In this section data has been collated by Wiltshire's Children's Services, identifying those children and young people that have been identified at risk of or living with the impacts of Domestic Abuse. While absolute prevalence cannot be determined, the data provides an indication of the scale of the issue for local children and young people.

Data collated for the CiN (Children in Need) Census reported the following domestic-related factors identified at the end of an assessment over 2013-2016 (illustrated below).

Of the initial contacts, 4,553 (27%) identified Domestic Abuse in some context between Sept 2014-Aug 2015 (table 12).

Table 11 15 CiN Census – Domestic related factors
Source LA Wiltshire – Children Services

2013-14	2014-15	2015-16	Number of completed assessments
494	509	683	Domestic Violence; child subject
934	1178	1539	Domestic Violence; parent/carer subject
225	305	421	Domestic Violence; another person subject
3834	4460	5403	Number of Assessments

Table 12 Initial contacts notified as 1st Sept 2014 to 31st Aug 2015
Source LA Wiltshire – Children Services

Initial contacts notified	Children or Young People	Of initial contacts – No. where incident had been identified as DA	% identified as DA out of initial contacts
16,703	10,313	4,553	27%

Over the same time period, 406 referrals were authorised that had Domestic Abuse recorded as the 'topic'; of which 34 were then subject to a Child Protection Plan (table below).

Table 13 Referrals authorised (where DA recorded as the Topic) as of 1st Sept 2014 to 31st Aug 2015[28]
Source LA Wiltshire – Children Services

Outcome of referral	
Access to records	1
Closed – referral to CAF	2
Closed at referral	14
Single Assessment	385
Transfer in Case	4
	406

Of the 406 referrals authorised, 34 became subject to a Child Protection Plan

Of a sample of 363 Common Assessment Frameworks (CAFs)[29] reviewed, Domestic Abuse was identified in 29% of cases.

Table 14 Presenting Factors Identified in CAF review (Apr 15-May 16)
Source LA Wiltshire – Children Services

CAFs registered Apr15-Mar16 (363 in total)	No.	No	%	%
Domestic Abuse - CHILD SUBJECT TO	20		5.5%	
Domestic Abuse - PARENT SUBJECT TO	78	106	21.5%	29%
Domestic Abuse - OTHER SUBJECT TO	8		2.2%	

[28] Due to changes in recording ; DA is no longer identified as an Outcome, and therefore comparable data no longer available (as of April 2016)
[29] For the period February 2014-May 2016

Cases involving domestic abuse are often complex and involve multiple other factors. Further analysis of how domestic abuse presents in the context of other issues is presented in the two tables below. In CAFs it co-occurs most frequently with behaviours issues, mental health issues, emotional neglect and financial instability. On single assessments, domestic abuse is found in 60% of emotional abuse cases.

Table 15 Other factors (top 10) present on CAFs with identified domestic abuse as Presenting Factor (PF) (Feb 14-May 16)

Source LA Wiltshire – Children Services

		SAMPLE of 179 CAFs reviewed Feb-14 to May-16				
	Top 10 Presenting Factors:	**No. DA CAFs with this PF**	**% of DA CAFs with this PF**		**% of all Factors**	**Cumul % of all Factors**
1	Behaviour (Home/ Community)	73	40.8%		11%	11%
2	Mental Health - PARENT	64	35.8%		10%	21%
3	Possible Low Level Emotional Neglect	43	24.0%		7%	28%
4	Financial concerns	42	23.5%		6%	34%
5	Mental Health - CHILD	39	21.8%		6%	40%
6	Non-school Attendance	38	21.2%		6%	46%
7	Behaviour (school/ setting)	37	20.7%		6%	51%
8	Alcohol Misuse - PARENT	30	16.8%		5%	56%
9	Housing/ Homeless	30	16.8%		5%	61%
10	SEN or Disability	23	12.8%		4%	64%

Table 16 Other factors (top 10) present on Single Assessment with identified domestic abuse as Presenting Factor (PF) (Apr 15-Mar 16)

Source LA Wiltshire – Children Services

		SAMPLE of 599 SA's with DV outcome CIN (Apr-15 to Mar-16)				
	Presenting Factor:	**No. SAs with this PF**	**% of SAs with this PF**		**% of all Factors**	**Cumul % of all Factors**
	Domestic Abuse - CHILD SUBJECT TO	**226**	**37.70%**			
	Domestic Abuse - PARENT SUBJECT TO	**488**	**81.50%**			
	Domestic Abuse - OTHER SUBJECT TO	**133**	**22.20%**			
1	Emotional Abuse	360	60.10%		20.00%	20.00%
2	Mental Health - PARENT	227	37.90%		12.60%	32.50%
3	Physical Abuse	160	26.70%		8.90%	41.40%
4	Alcohol Misuse - PARENT	143	23.90%		7.90%	49.30%
5	Neglect	123	20.50%		6.80%	56.20%
6	Mental Health - CHILD	104	17.40%		5.80%	61.90%
7	Socially Unacceptable Behaviour	85	14.20%		4.70%	66.60%
8	Drug Misuse - PARENT	81	13.50%		4.50%	71.10%
9	Mental Health - OTHER	55	9.20%		3.00%	74.20%
10	Learning Disability - CHILD	50	8.30%		2.80%	76.90%

Work is currently underway to develop the Wiltshire Safeguarding Children's Board (WSCB) dataset for Domestic Abuse and children.

Data around Experience of Domestic Abuse in Children and Young People

The NSPCC undertook the first national study of its kind in the UK in 2009[30], looking to understand the incidence and impact of Domestic Abuse on teenage partner violence. 1,353 young people aged 13-17yrs from England, Scotland and Wales participated in the survey and 91 young people took part in in-depth interviews. The findings are reflected in figure 9.

Figure 9 Headlines from NSPCC findings

Source NSPCC (2009)

Wiltshire Children and Young People's Health and Wellbeing Survey[31]

In 2015, Wiltshire Council commissioned the Wiltshire Children and Young People's Health and Wellbeing survey, to gain a better understanding of our young people's experiences of life, both inside and outside of school.

The survey was carried out in 64 primary schools, secondary schools and colleges from January to April 2015; a total of 6,912 pupils completed the survey. The questions covered a wide range of aspects including healthy lifestyles, learning experience, relationships, wellbeing, safety, aspirations and support requirements. The survey explored young people's experience of domestic abuse. The majority of respondents from secondary (92%) and post-secondary (86%) schools reported that either 'they or someone in their immediate family had not been a victim of domestic abuse'. However, 14% did report that they or someone in their immediate family had experienced domestic abuse, with a higher proportion of girls reporting experiencing domestic abuse.

Recommendations arising from this section

- Explore the underlying factors that drive the disparity between the high volume of cases where Domestic Abuse is being identified by Children's Services and the numbers that receive an intervention or support.
- Further develop the WSCB's dataset to provide greater context of the Domestic Abuse issue, rather than just the prevalence.
- Explore options to gather further qualitative data on the impact of Domestic Abuse and attitudes of Young People.

[30] Barter C, McCarry M, Berridge D and Evans K (2009) *Partner exploitation and violence in teenage intimate relationships* NSPCC
[31] Foster and Brown Research limited

Local Demands

Domestic Abuse Support Services Activity

Wiltshire has a wide range of services available to support victims of Domestic Abuse. This chapter provides an overview of the services and support.

Adult Victim Services

There are several aspects to supporting victims of Domestic Abuse. These include

- The use of multi-agency risk assessment conferences (MARACs) to safeguard victims and their families at highest risk, through a coordinated approach and targeted action plans to reduce immediate risk.
- Provision of housing including refuges to ensure victims, and their families, can live in a place of safety.
- Provision of a specialist high risk support service, using dedicated Independent Domestic Violence Advisor (IDVA) roles to support victims.
- A range of supportive measures used to safeguard victims at risk of Domestic Abuse through the temporary removal of the perpetrator from the home (Domestic Violence Protection Orders), early disclosure of previous partner offending behaviour to enable informed, safe decisions to be made (Domestic Violence Disclosure Scheme) and the early sharing of information facilitated through the Domestic Abuse Conference Call (DACC).
- Provision of a community-based 'Outreach' support service to victims, offering longer term interventions through Domestic Abuse Support workers.
- The performance of statutory domestic homicide reviews to ensure that issues that led to domestic homicide can be identified and that lessons learned can be fed back to contribute to a process of continuous improvement in services.
- To work under the Care Act (2014) to identify and safeguard adults at risk, which includes Domestic Abuse.
- Recognising and addressing the wider issues of Domestic Abuse, which include supporting victims at risk of Honour Based Violence (Abuse), Forced Marriage, Female Genital Mutilation and other at risk communities including Gypsy and Traveller groups.

Each of these areas will be discussed in more detail in the rest of this section.

Reports to the Wiltshire Multi-Agency Risk Assessment Conference (MARAC)

MARACs are multi-agency meetings that specifically focus on ensuring the safety of high risk victims of DA. They provide a forum for sharing information and taking action to reduce harm to the victim. The primary focus of the MARAC is to safeguard the adult victim. However, the MARAC will also make links to other fora to safeguard children, as well as to manage the behaviour of the perpetrator. Each MARAC is attended by key agencies from both the statutory and voluntary sector and the outcome of each meeting is a coordinated action plan to facilitate victim safety.

MARACs are not a statutory requirement but they are cited as best practice by national strategy and policy documents and are also referred to in the Statutory Guidance for Domestic Homicide Reviews. The Wiltshire MARAC has been running since 2007.

Wiltshire co-ordinates two area MARACs (North and West; East and South), which each run fortnightly. Meetings are generally well attended by agencies, and many have embedded MARAC as part of their core function. The meetings regularly review representation and look to seek new membership where appropriate

The agencies currently involved in the Wiltshire MARAC are listed in the table below;

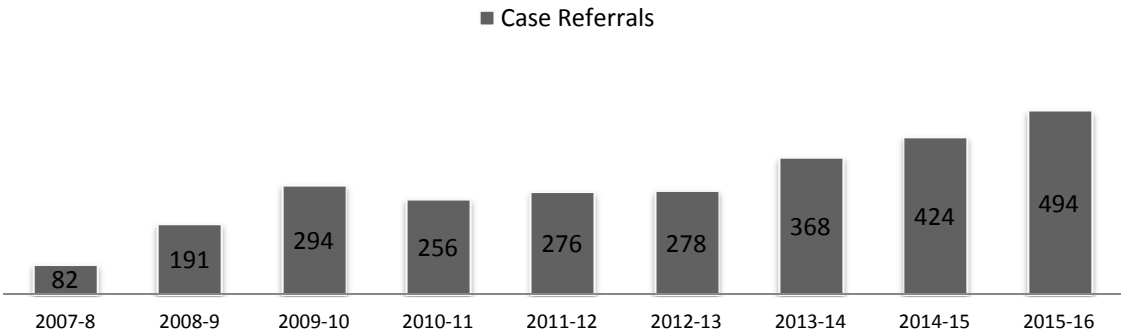
Table 17 Agencies participating in MARAC

Agencies	
Wiltshire Police	**National Probation Service**
Community Rehabilitation Company (Bristol, Gloucester, Somerset and Wiltshire)	**Domestic Abuse Support Service** Splitz Support Service
Avon and Wiltshire Mental Health Partnership	**Refuge Providers** GreenSquare Aster Living Salisbury Women's Refuge Advance
Wiltshire Council Children's Services Housing Allocations and Options Children's Centres CAF (Common Assessment Framework) Coordinators Adult Social Care Early Years – Education Welfare Early Years – Youth Offending	**Health Services** **Salisbury Foundation Trust** Maternity Services Names Nurse Safeguarding Children Salisbury Hospital – Emergency Department **Great Western Hospital, Swindon** Emergency Department Midwifery **Royal United Hospital, Bath** Emergency Department Midwifery **CAMHS (Child and Adolescent Mental Health Service)** **Virgin Care** **Medvivo (GP Out of Hours Service)**
Army Welfare Service	**Wiltshire Substance Misuse Service**
Case Dependant	
Wiltshire Council Public Protection Officers – Anti-Social Behaviour	**Registered Social Landlords** Curo Radian Selwood Aster Living GreenSquare

A continued area for development is to strengthen the links with Mental Health Services, whose availability to attend has fluctuated over recent months. As discussed earlier in this document, poor mental health can be both a cause and effect of domestic abuse, with high rates of co-occurrence. As a result, mental health services have an important role around the table.

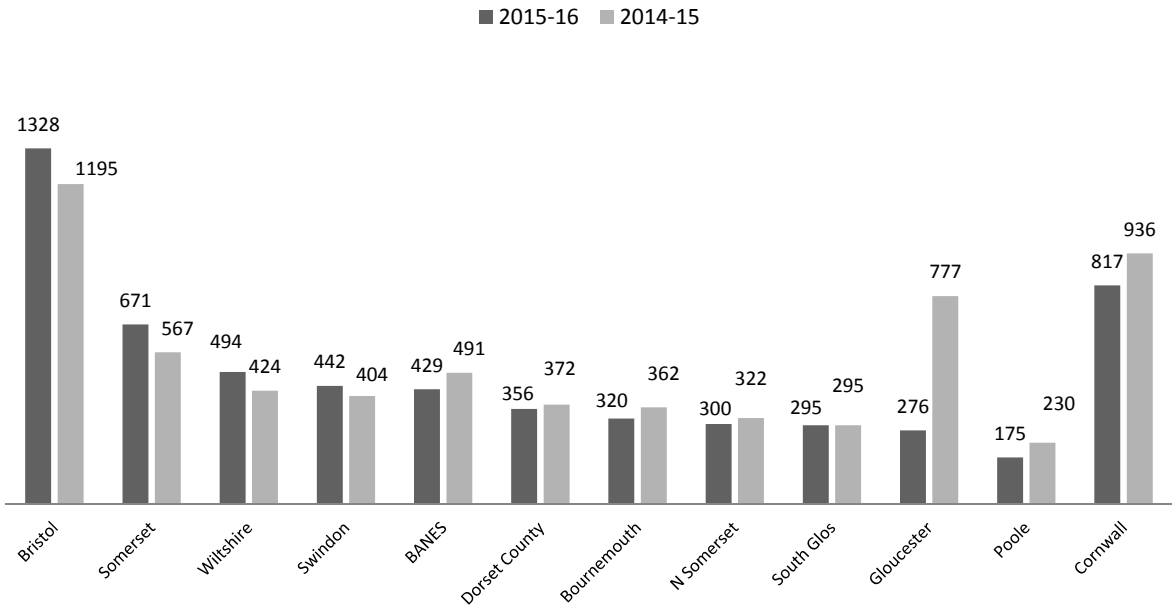
The volume of MARAC referrals has continued to increase, with just under 500 referrals received in 2015/16. Figure 25 shows the increase in volume of referrals to Wiltshire MARACs and figure 10 (below) shows how this compares to other areas in the South West.

Figure 10 Volume of MARAC Referrals 2007-2016
Source LA Wiltshire MARAC data



In Wiltshire there has been a 500% increase in referrals in the eight years since 2007. This is encouraging as it probably reflects positive changes in case reporting and referrals following awareness campaigns and the multi-agency training programme. To cope with increasing volumes, Wiltshire MARAC meetings were made fortnightly in 2015 and capacity continues to be an area that needs close monitoring.

Figure 11 South West * Comparison of MARAC Referrals in2015-16 and 2014-15
Source LA Wiltshire



* Data has not been provided for Devon Areas, and therefore not represented

In the South West region, Figure 11 (above) shows that there is no clear trend in the volume of cases referred into MARACs when comparing 2014/15 with 2015/16. There were reported increases in volume in Bristol, Somerset, Wiltshire and Swindon; with the other areas reporting a reduction in referrals. It is of note that Gloucestershire shows an apparent large decrease in referrals. However, during this

time period they instigated a change in practice whereby all cases are discussed via MASH and in a teleconference. Following these discussions only those requiring the additional input of a full MARAC discussion were referred. The Charity SafeLives are leading work nationally to review the best model for MARACs going forward.

Within Wiltshire, the North/West Wiltshire MARAC sees a larger number of cases when compared to the South/East. This is consistent with general levels of reported incidents/crimes recorded by the police and the support services. The breakdown of MARAC activity in table 18, shows that Wiltshire continued to record a higher than national non-police referral rate of 41% (against 36% national average). Wiltshire also compares favourably to other areas in the South West on this parameter. This may reflect a positive effect of the domestic abuse training that has been delivered to many non-police agencies on MARAC referral pathways.

Table 18 2015-16 Wiltshire MARAC data collation
Source SafeLives Dataset 2015-16

	National figure	Most similar force group	SafeLives benchmark parameters	Police Force Area	Wiltshire MARAC area	North West Wiltshire	South East Wiltshire
Number of MARACs	282	39	-	3	2	1	1
Cases discussed	81,764	9,751	-	944	494	302	192
Children in household	103,404	12,101	N/A	1,351	649	373	276
Repeat cases	25%	25%	28% - 40%	33%	23%	22%	25%
Police referrals	64%	69%	60% - 75%	66%	59%	58%	57%
Referrals from Non-Police Referrals	36%	31%	25% - 40%	34%	41%	42%	43%

The full range of sources of referrals to MARAC meetings is illustrated below. There has been an increasing trend in the number of referrals being recorded under the 'other category'. A breakdown of the 'Other' category referrals in 2015-16 showed that 44 (out of the 49 referrals) were received from 'Out of Area' agencies (mostly MARAC-to-MARAC referrals) as a result of clients fleeing into Wiltshire.

Figure 12 MARAC Referrals by Source in 2015-16
Source LA Wiltshire MARAC

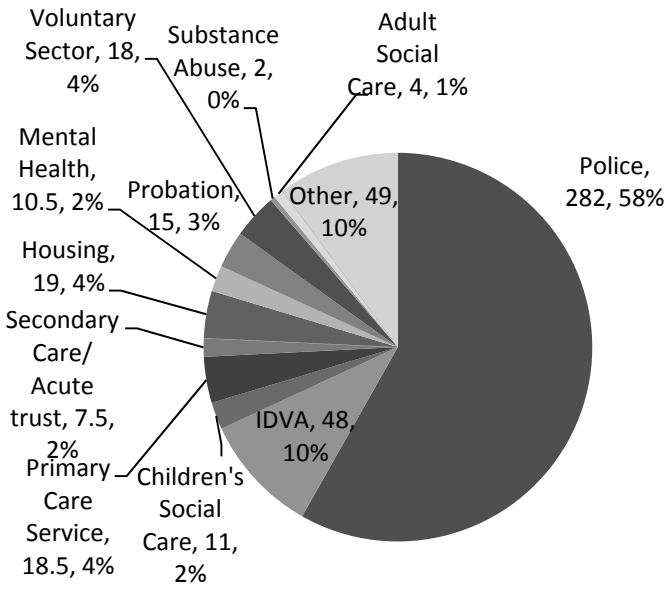


Figure 13 below, illustrates a comparison between data recorded at a national level, most similar force area and for Wiltshire, recording the percentage of cases that have been referred to MARACs from the identified vulnerable groups.

Figure 13 % of Referrals from Vulnerable in 2015-16
Source SafeLives Dataset 2015-16

Interpreting Wiltshire's performance against these national benchmarks is complex. In Wiltshire ethnic minorities make up 6.6% of the population compared to a South West regional average of 8.2% and 20.2% nationally. Thus, it might be that the lower proportion of BME domestic abuse referrals in Wilshire is simply a reflection of the lower proportion of BME individuals in the Wiltshire population. Alternatively, the lower value may be due to those Wiltshire residents who come from ethnic minorities experiencing structural or cultural barriers that make reporting abuse harder than for the majority white population. The discrepancy between national and local reporting figures for men and people with disabilities are less likely to be due to differences in the composition of the local population compared to the national population. In the LGBT community there is

some suggestion that fewer people locally may feel comfortable self -identifying as LGBT locally in part due to the lack of a recognised community support systems.

A recent audit was completed (Oct 2016) reviewing how the MARAC process identifies and addresses risks to children. A report of the findings was produced for Children's Social Care. Ensuring that these findings are used to improve child safeguarding structures will continue to be important.

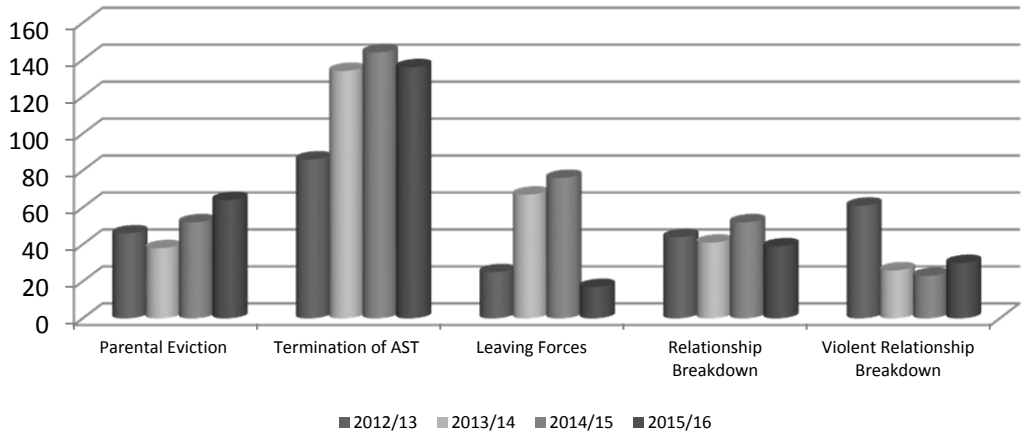
Recommendations arising from this section

- Review Wiltshire MARAC process to ensure it incorporates recent research into best practices, and is robust enough to deal with any further increases in referral volumes
- Ensure appropriate agency representation at meetings by continuing to strengthen engagement with mental health services, army welfare services and drugs and alcohol service.
- Explore future opportunities to ensure appropriate representation of "hard to reach" vulnerable communities in referrals to MARAC.

Refuge – Supported Accommodation

The Local Authority's Housing Option's team offer housing advice and assistance to people looking to secure suitable and affordable accommodation. The top 5 reasons for homelessness in Wiltshire between 2012 and 2016 are shown below in Figure 14. These are in line with national findings. Violent relationship breakdown has a significant role in precipitating homelessness and can affect both victim and perpetrator. In 2015/16, housing recorded 30 approaches to them for re-homing due to fleeing domestic abuse compared to 23 the year before.

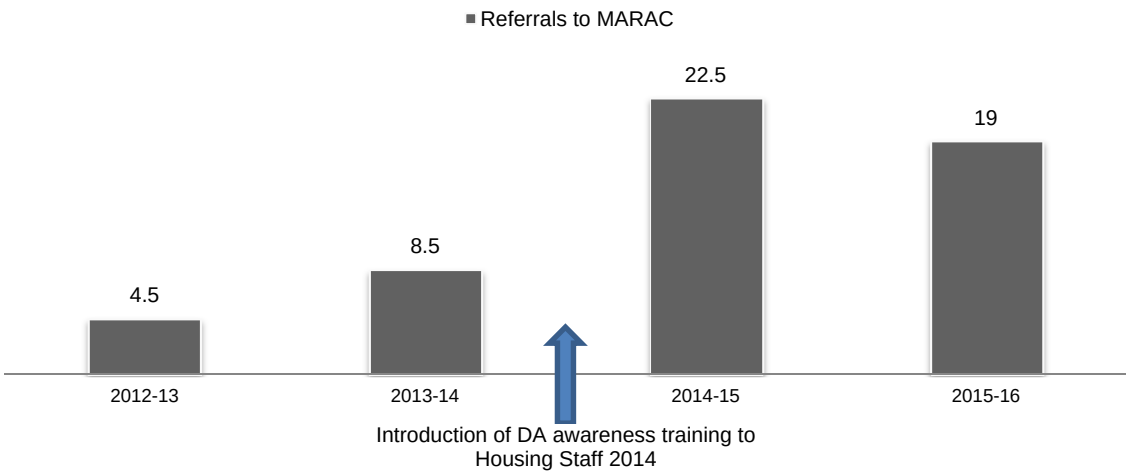
Figure 14 Reasons for Homelessness as reported to Wiltshire Council
Source LA Wiltshire – Housing Options



Strong links between domestic abuse support workers and frontline housing staff have been forged over recent years. Housing Options attend the Wiltshire MARACs and participate in the DA Conference Call (DACC). Domestic abuse awareness training started in 2014 to Housing frontline staff. As a result, the number of referrals made by Housing to MARACs has steadily increased over the past 3 years from 4.5 to 22.5[32] in 2014/5 and 19 in 2015/16 (figure below).

[32] NB. 0.5 of a referrals represents that referral has been received by more than one agencies

Figure 15 Housing referrals to MARAC
Source LA Wiltshire MARAC



Referrals to Women's Refuge

In some cases, the victim of domestic abuse cannot be safely accommodated in traditional housing and requires a more specialist option. A refuge is safe accommodation for people who have suffered and are fleeing violence or abuse. Its purpose is to safeguard service users. The accommodation should provide both a confidential address, to protect women and their children as well as access to emotional and practical support.

Wiltshire has 35 rooms of accommodation, provided through five refuge premises, across the four Wiltshire geographic hub areas, delivered by four current providers:

- Advance Housing Association (West)
- Greensquare Housing Association (North)
- Aster Living Housing Association (East)
- Salisbury Women's Refuge Ltd (South)

Table 19 Breakdown of Refuge Provision
Source Wiltshire Refuge Providers

Wiltshire Women's Refuges	Rooms of Accommodation
Salisbury Women's Refuge	11[33]
West Wiltshire Refuge	7
North Wiltshire Refuges *(Two Properties)*	10
Kennet Refuge	7
TOTALs	**35**

The current level of service is funded through legacy Supporting People funding (table above). Refuge provision accounts for 12.5% of the supported allocated

[33] Anomaly in data provided; contract was varied in 2013 for refuge to reduce bedspaces to 7; Salisbury Refuge advises that WC's 7 units are funded through legacy SP grant and the other units through rent / HB

housing budget in Wiltshire; which is roughly comparable to the total number of units which stands at 10% of total supported housing stock.

Until now, Wiltshire Council Housing has directly managed the contracts for refuge provision. The current contract expires in March 2018. Consideration should be given to the benefits and efficiencies of incorporating the supported housing provision into the overarching domestic abuse service. This could provide significant added value, both in terms of budget efficiencies and most importantly service efficiencies.

The regional distribution is summarised in the table below. When looking at adequacy of refuge provision at the population level it is appropriate to consider the number of units per 10,000 population rather than simply looking at units per se. A benchmark level of 1 refuge unit per 10,000 population has been suggested as an optimal level of provision[34]. Table 19 below details the refuge provision across the South West region from areas that participated in a recent survey[35]. Wiltshire currently has a level of provision of 0.7 per 10,000 population, which is below the suggested national level and places us in the bottom half of the region in terms of provision level.

Table 20 Refuge provision Comparison Data for South West
Source Data collected by Somerset County Council on behalf South West Domestic Abuse Network

Area	No. of refuges	No. of Units in refuge	No. of Safe Houses/ Units	Total Units	Population (mid-year 2014)	Ratio - 1: unit per 10000 populations
Poole	1	18	0	18	150,109	1.2
Bournemouth	-	22	0	22	191,390	1.1
Bristol	5	38	0	38	442,474	0.9
Plymouth	1	11	13	24	261,546	0.9
Gloucester	1	8	3	11	125,649	0.9
Torbay	1	7	5	12	132,984	0.9
Swindon	1	20	0	20	215,799	0.9
North Somerset	1	14	2	16	208,154	0.8
Wiltshire	4	35	0	35	483,143	0.7
South Glos	3	16	0	16	271,556	0.6
Dorset	2	19	1	20	418,272	0.5
Cornwall	4	29	0	29	545,335	0.5
Somerset	2	23	6	29	541609	0.5

Regionally only Bournemouth and Poole reach the national target although Bristol, Plymouth, Swindon, Torbay and Gloucestershire are close at 0.9 per 10,000 population.

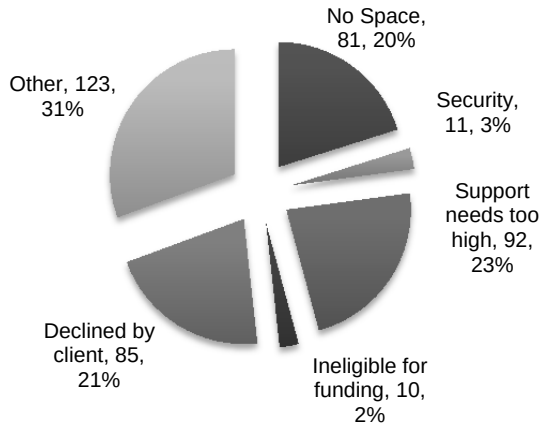
In 2015-16 there were 529 referrals to Wiltshire Refuges, with a breakdown of 205 referrals to South Wiltshire, 151 in the West, 119 in the North and 54 in East Wiltshire. The recent Housing Review identified that in 2015/16 the average length of stay in a refuge was 81days.

[34] Best Value Performance Indicator 225
[35] Completed by Somerset County Council – August 2016

The relationship between referrals and final placement is complex. Often women will be referred to several refuges in the expectation that at least one refuge will offer a place, and in the event that multiple places are available the most suitable can be taken up. In addition, it is important to note that often victims need to be placed out of area away from perpetrators and their networks for their own protection. Refuge providers nationally therefore accept referrals from outside their local area as well as locally where appropriate. This means it is often the case that Wiltshire residents will optimally be placed in refuge accommodation outside Wiltshire, and non-Wiltshire residents in Wiltshire refuges. For this system to work efficiently it is important that refuge accommodation provision is considered in terms of units per head of population and that these are met nationally to ensure total population need is covered.

Refuges do not accept all referrals they receive. Sometimes this will be because the refuge is full, but there are other frequently occurring reasons. In 2015/16, 110 women were formally refused accommodation in Wiltshire refuges. The most frequent reason recorded was that the client's needs were too high (n=92), followed by lack of space (n=81) (figure 16). "Too high needs" can refer to the client having issues like mental health disorders, drug and alcohol abuse or other complex health or social issues.

Figure 16 2015-16 Breakdown of Refusals
Source Wiltshire Refuge Providers



It is noted that Salisbury and West Wiltshire refuges have also refused to accept referrals based on the client having physical access requirements they could not meet due to structural issues with the properties.

Having a disability or having substance misuse problems are all known to be associated with increased risk of experiencing domestic abuse. Thus the fact refuges cannot accommodate those with complex needs or physical disabilities are a serious concern. Such clients often represent a large proportion of victims and are often those with high levels of need.

Another area of concern is that, across all four schemes, the void rate is high with 359 void unit weeks recorded in 2015/16. The high void rate in combination with one of the main reasons for refusal being 'lack of space' (n=81) represents an interesting

issue. The Housing Review identified that refuges were refusing referrals, as they only had small rooms available, which were insufficient for the client's needs.

There are also disparities across the services in terms of acceptance criteria; some refusing to accommodate service users who have teenage boys (13yrs+) as part of the family makeup, whereas others will review on a case-by-case basis. This further increases the barriers to women fleeing domestic abuse. In addition, the current refuge provision is not able to offer accommodation to male victims of Domestic Abuse.

Recommendations arising from this section

- Include the future refuge provision within the upcoming domestic abuse commissioning process.
- Review options for ensuring refuge provision matches expressed need in terms of unit size and accessibility.
- Review options around how best to ensure that those with complex social and health needs can access refuge accommodation
- Work with local and national colleagues to ensure overall provision of refuge units for men and those fleeing with teenage male children is adequate

Commissioned Support Services for Victims of Domestic Abuse

As from October 2015, Wiltshire has had a single service provider, to deliver the commissioned support to victims of Domestic Abuse across all risk thresholds (standard to high risk). Prior to this, there were two providers. Following the procurement process in 2015, the support service for victims is provided by Splitz Support Service.

Splitz deliver two elements of support:

- High Risk Support (Independent Domestic Violence Advisors – IDVAs) and;
- Outreach (Paloma) Community-Based Support.

High Risk Support Service

The High Risk Domestic Abuse Support Service provides an easy to access service, offering a range of short-term crisis interventions, including working across a range of services to support access to alternative accommodation, safety planning, and healthcare services. Working to reduce immediate risk and supporting individuals to stay safe remain the priorities for the service. Support will be provided to anyone at high risk of Domestic Abuse aged 16yrs or above irrespective of disability, ethnicity, sexuality or gender.

The current contract commenced on 1st October 2015 and will expire 31st March 2018. The service includes the provision of five qualified (accredited) IDVAs.

The volume of referrals for high risk support has continued to increase year-on-year (figure 17). Referrals have increased by 60% since 2012. The greatest source of

referrals is received from the police, but there remains a wide range of referring agencies to the service (figure 18).

Figure 17 Referrals received to High Risk Support Service 2012-2016
Source LA Wiltshire - Public Health

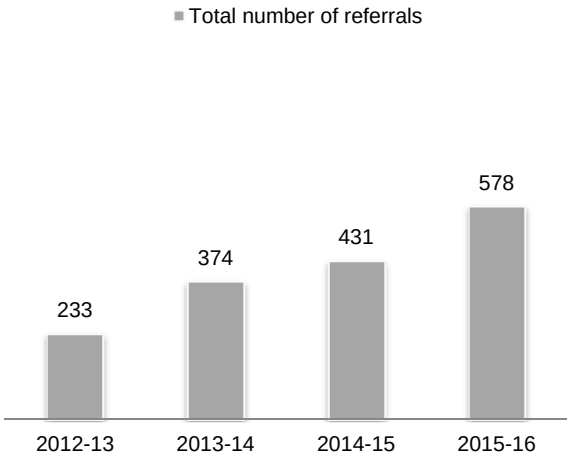
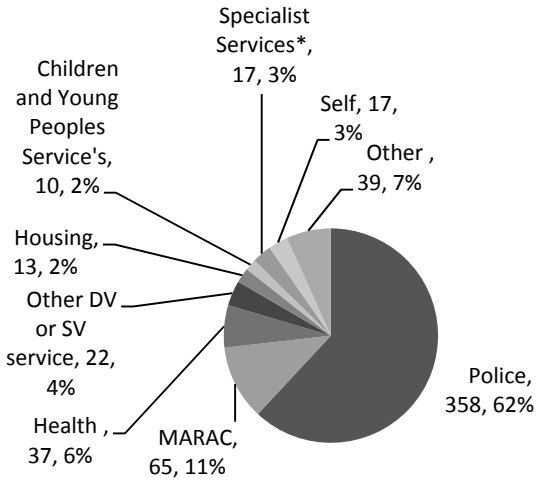


Figure 18 Source of Referrals to High Risk Service in 2015-16
Source Splitz Support Service



The engagement rate has steadily increased year-on-year; with the service recording a current engagement rate of 72% in 2015-16 (figure 19 below), which is within the national (SafeLives) guidelines of 60-80% engagement rate for services.

Figure 20 records referrals for some of the areas of vulnerability that have been identified, although it is recognised that there are further vulnerable groups that need to be supported. Of the referrals received to the service from identified vulnerable groups they have recorded an increase (with the exception of clients that are pregnant).

Figure 19 Engagment Data for High Risk Cilents in 2012-16
Source LA Wiltshire – Public Health and Splitz Support Service

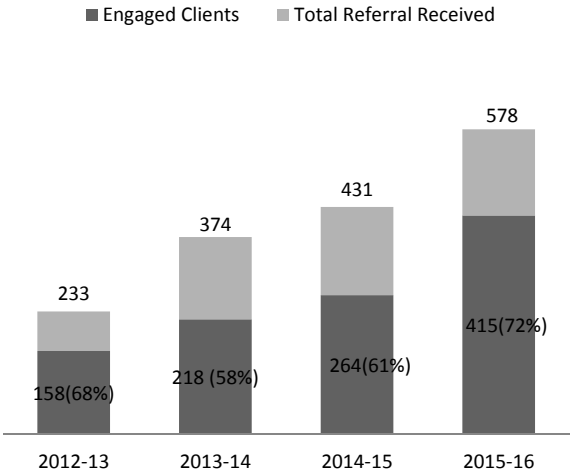
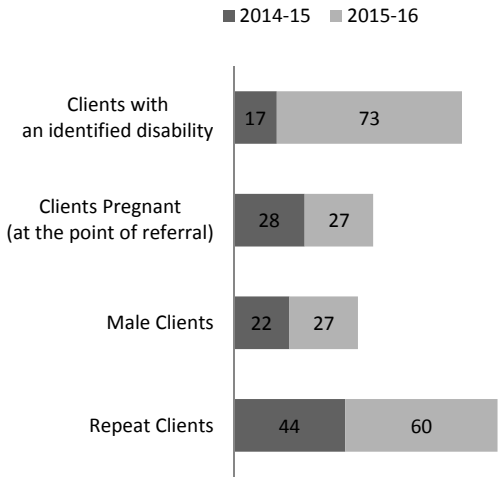


Figure 20 Vulnerable Referrals (high risk): 2014-16
Source LA Wiltshire - Public Health ande Splitz Support Service



Following an internal Review by Splitz, they introduced a new process aimed to support the increasing demand on their services.

The high risk service of 5 IDVA (qualified) staff work with high risk DA cases scoring a DASH Risk Indicator Checklist (RIC[36]) of 14 or higher. Contact will be made between 24-48hrs of the referral by an IDVA.

Cases that are assessed as (high) medium risk cases, with a DASH RIC of 10-14, will also be supported by an IDVA from the high risk service. Contact will be made between 3-5 working days by an IDVA.

Outreach (Paloma) Support Service

The Outreach Service (Paloma) supports victims of Domestic Abuse whose immediate risk has reduced (Medium and Standard risk) and are in a position to engage in further support to re-build confidence, encourage peer support, and work towards enabling positive behaviour change. The service will also deliver Making Changes workshops, group sessions which deliver a programme of support and understanding healthy relationships.

The service includes a manager and four Outreach Domestic Abuse Support workers (30hr contracts). The service supports victims that are at standard to medium risk (DASH RIC 5-9).

Service users will expect to receive contact within 3-5 days by a Support Worker.

The volume of referrals received to the service has continued to increase. The highest number of referrals was received in 2015-16 with 864 (figure 21 below). Self-referrals continues to be the greatest source of referrals, which supports the work and relationship building that the service has developed in local communities (Figure 22).

Figure 21 Volume of Referrals to Paloma 2012-2016
Source Splitz Support Service

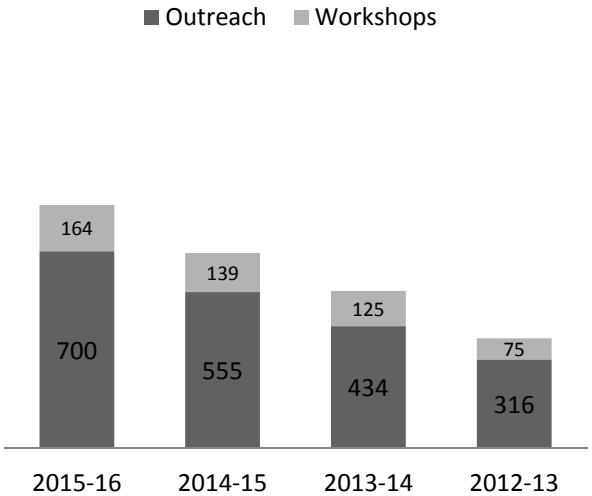
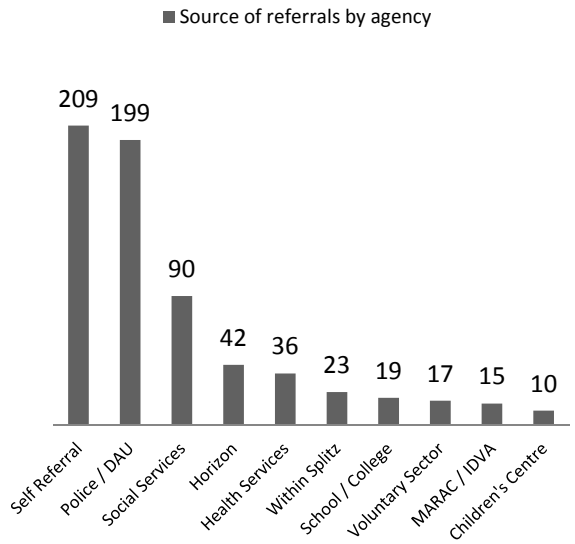


Figure 22 Referrals by Source to Outreach in 2015-16 *(top 10)*
Source Splitz Support Service



Service Accessibility

The evidence-base acknowledges Domestic Abuse remains a hidden crime and will often go un-reported. It is believed that only one in five incidences is being reported

[36] DASH – Domestic Abuse Stalking and Harassment and Honour Based Violence Rick Indicator Checklist

to the police. Awareness raising and accessibility of key support services plays an integral role.

Included as part of the current specification for the commissioned services is an expectation to work alongside partner agencies contributing to the wider awareness raising in local communities. This includes raising the profile of the services they provide and how they can be accessed. This is achieved through a variety of awareness opportunities including training sessions, briefings and developing relationships with other services.

The transition to a single service provider introduced a single contact point, simplifying the point of entry for service users.

Wiltshire Council hosts a webpage of supporting information for the public to access. This is promoted through the URL www.wiltshire.gov.uk/speakout. This includes a range of services both nationally and locally which can offer support.

Recommendations arising from this section

- Review options as part of the new service model to address the capacity pressures on accessing supporting services.
- Address the 'un-met' need of those hidden victims who are not already in the system, through earlier identification.

Address the issue around ownership of data in future contracts, to prevent data gaps in the event of a change of provider, to support the continued understanding regarding the prevalence of the wider agenda.

Wiltshire has a suite of supportive measures offering further protection to victims, including

- Domestic Violence Protection Notices/Orders
- Domestic Violence Disclosure Scheme
- Domestic Abuse Conference Call

Each of these areas will be covered in this section.

Domestic Violence Protection Notices/Order (DVPN/Os)

Under the 'Policing, Crime and Private Security Act 2010 Section 21-30' a Domestic Violence Protection Notice (DVPN) can be granted for 48hrs. Its purpose is to create a protective space for the victim, enabling access to appropriate support, through the removal of the perpetrator from the home and prohibiting them from returning for 48hrs. This period can be extended for up to 28 days, following a Domestic Violence Protection Order (DVPO) being granted by a Magistrate.

Figure 23 Volume of DVPN/O's in Wiltshire (area only)
Source Wiltshire Police

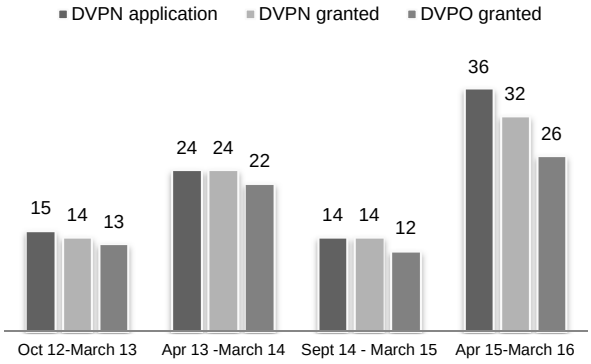
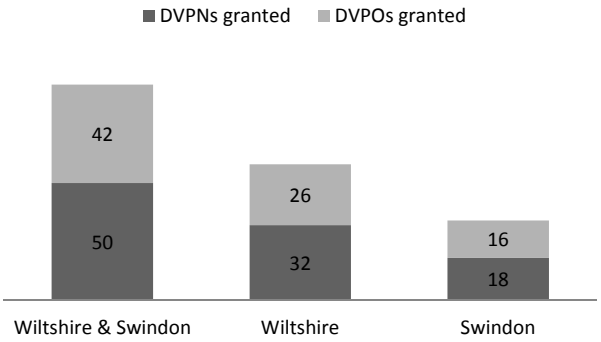


Figure 24 Volume of DVPN/Os Granted in 2015-16
Source Wiltshire Police



The volume of DVPN/O applications remains low in Wiltshire, with a total of 36 applications made in 2015-16, although this is the highest volume since its introduction. The use of DVPN/Os could be considered disproportionately low in comparison to the total volume of DA incidences being reported in Wiltshire.

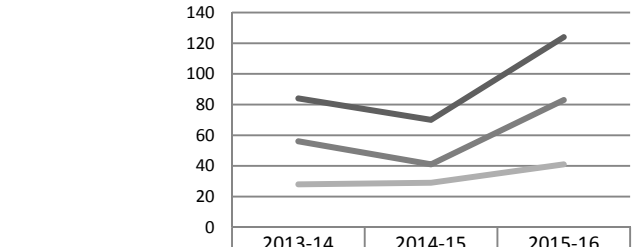
Despite the low numbers, the conversion rate into a successful application remains high 89% (DVPNs) and 81% (DVPOs.

Nationally there is concern regarding insufficient penalties being given for breaches of a DVPN/Os. There have been examples of low monetary fines being used as sanctions, undermining the effectiveness and victim confidence in the power of the tool. There remains a gap in addressing the perpetrator's behaviour with this scheme, with the interventions being focused on the victim.

DVPOs are a tool to offer support to victims, but it is accepted that they are not the only tool. Police will utilise bail conditions, where applicable in DA cases, which again can provide prohibiting conditions to safeguard the victim.

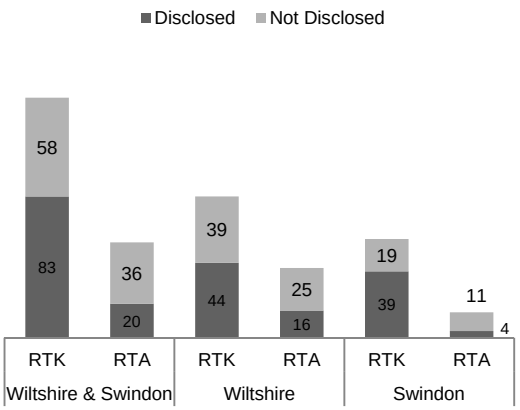
Domestic Violence Disclosure Scheme (DVDS)
DVDS is a process enabling the police to disclose to individuals, information about previous violent offending by a new or existing partner where this may help protect them from further violent offending and help them to make informed choices, using 'right to know' and 'right to ask' legislation.

Figure 25 Wiltshire Volume of DVDS Applications
Source Wiltshire Police



	2013-14	2014-15	2015-16
Total Applications	84	70	124
Total RTK	28	29	41
Total RTA	56	41	83

Figure 26 Breakdown of Disclosures for Right to Know & Right to Ask in 2015-16
Source Wiltshire Police



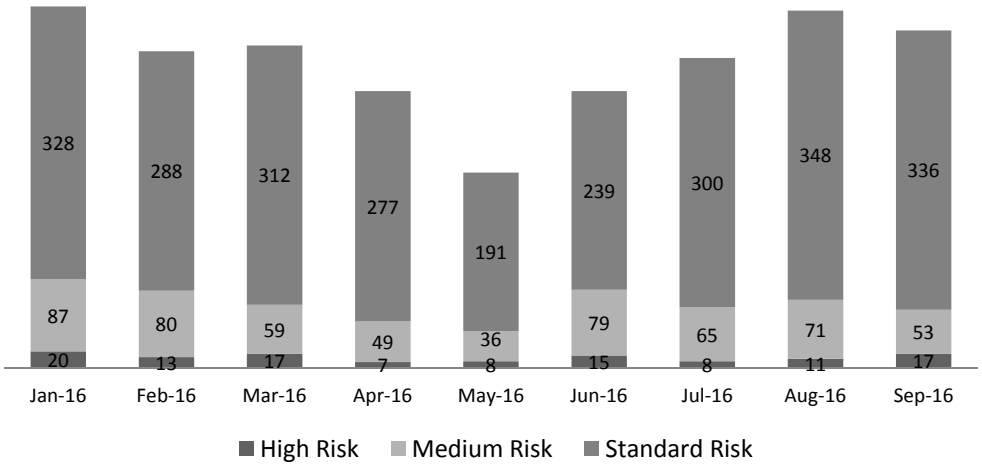
In 2015-16, there were a total of 124 applications received an increase of 44% on the previous year. Wiltshire has always recorded a greater volume of applications in comparison to Swindon, with a higher proportion of 'right to ask' (RTA) applications (83). However, disclosure is only happening in around 50% of applications; which has dropped compared to previous years; therefore further work could be considered to look at the 'type' of application being received and in light that only 50% result in a disclosure it may support the need for further awareness raising of the subject area.

Wiltshire adopted a policy of disclosures being made jointly between the police and the high risk support service, to optimise the safeguarding of the victim whilst the disclosure is being made. This process can be lengthy and time consuming for both parties, having knock-on-effects on service provision.

Domestic Abuse Conference Call (DACC)
The DACC is a daily, weekday conference call between participating agencies, discussing the previous 24hrs (or 72hrs on a Monday) reported domestic abuse incidents notified to Wiltshire Police. The purpose is to increase the timeliness of sharing appropriate and proportionate information to safeguard victims at risk of Domestic Abuse.

The DACC was introduced in Wiltshire in October 2014. The role of the DACC in facilitating early information sharing for Domestic Abuse cases was recognised as good practice in the recent Joint Targeted Area Inspections.

Figure 27 DACC breakdown of cases Jan 2016 - Sept 2016
Source Wiltshire Police



Agencies participating in the Wiltshire DACC regularly include Children Social Care, LA Housing and Splitz; meetings are chaired by the Police. In addition, National Probation Service will receive the DACC case list, with the purpose to review and identify cases known to them, which triggers the police to share PPD1[37] (Public Protection Department 1form).

There were 3,327 cases discussed by DACC (Jan-Sept '16) of which 2,007 cases identified children.

DACC will refer standard cases to the Horizon Victim and Witness Care team, of which 1544 referrals were made. The Horizon team followed up contact with victims to see if they wished to be referred to a support service (Splitz).

Recommendations arising from this section

- Re-visit the awareness and promotion of the use of DVPN/Os.
- Explore future opportunities to address perpetrator behaviour through the DVPN/O process.
- To further build on the DACC role to share information through increasing agency participation in the process.

Statutory Domestic Homicide Reviews

Domestic Homicide Reviews (DHRs) were established on a statutory footing under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011. The governance for the DHR process is cited within the Wiltshire Community Safety Partnership and there are local terms of reference for the DHR.

Domestic homicide reviews are a process whereby cases that resulted in death (or suicide in one recent case) are examined to try to identify lessons that can be leant to improve future practice.

[37] PPD1 form is the Police record of any domestic-related incident

Since 2012, Wiltshire has commissioned seven domestic homicide reviews. The average length to complete a DHR in Wiltshire is 17days[38]; with the range being 14days – 20days.

To date, the cost associated with the completion of the DHRs in Wiltshire has exceeded £42,500, with the average cost per review in the region of £6,000. The principle cost is to fund an Independent chair for the review and an author. To date the costs have been largely paid for from the Local Authority Public Health budget, with one review being a joint investigation with NHS England, where the costs were shared. Currently, there is no identified budget to support future DHRs.

The administrative support required by the process is large. This has frequently, and inappropriately, been absorbed by the local authority instead of being seen as part of the chair/author remit. Lack of clarity in working group structure has meant that administrative efforts have been duplicated resulting in unnecessary staff pressures.

The lessons learned and action plans produced are monitored and reviewed through a Local Quality Assurance process. It is apparent that in all cases there have been multiple and complex needs identified for both the victim and the perpetrator, often requiring access to multiple agencies for support and advice. Significant links to mental health risks and alcohol dependencies have been identified.

There have been ongoing discussions in the DA Sub group around developing a vehicle to consider lesson's learned on those significant cases that were 'near misses'. However, it has been hard to obtain good data. In addition, the DHR guidance recommends Local Areas to consider commissioning reviews for domestic abuse incidents that resulted in suicide. In 2015, Wiltshire commissioned one such review following a suicide. This process was found to be incredibly informative by those agencies that participated, suggesting there was much that could be learned from it. Further work could be carried out to investigate the feasibility of these options.

Recommendations arising from this section

- Establish how future DHRs will be delivered, developing policy to reflect local and national learning.
- Explore the inclusion of "near misses" into local DHR policy.

Adults at risk

An Adult at risk is defined in the Care Act (2014) as an adult aged 18 and over whom;

- Has care and support needs, whether or not they are met by the local authority;
- Is experiencing or is at risk of experiencing abuse or neglect or;
- As a result of those needs is unable to protect themselves from the risk or experience of abuse or neglect

[38] Assuming a working day 8hrs

Domestic Abuse has now been included explicitly within the *types* of abuse or neglect.

> *"Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances. Professionals should work with the adult to establish what being safe means to them and how that can be best achieved. Professionals and other staff should not be advocating 'safety' measures."* The Care Act statutory Guidance. HM Gov. 2016

From 2015, data now records domestic abuse as one of the types of abuse identified[39], comparison data is provide in the figures below.

Figure 28 Jul 14 - Jun 15
Source LA Wiltshire Adult Social Care

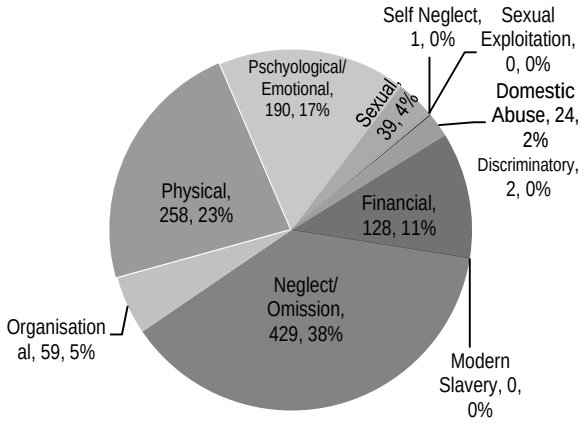
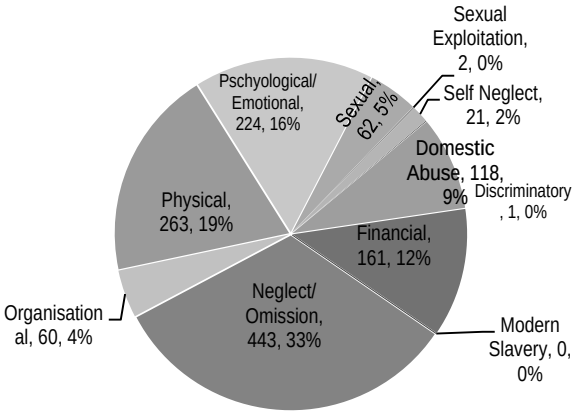


Figure 29 Jul 15 - Jun 16
Source LA Wiltshire Adult Social Care



The Safeguarding Adult Team (SAT) would be the initial point for identifying Domestic Abuse. To support this identification staff are required to complete an e-learning training package, which includes Domestic Abuse awareness. A further training session was delivered in 2015 on Domestic Abuse Risk Assessment and MARAC referral pathways and is set to be re-visited in Spring/Summer 2016 as a refresher.

Subject to the level of risk and concern, action is identified through the Safeguarding Adult team and a referral (if required) to MARAC would be generated. The number of referrals made to MARAC in 2015-16 was 4.

Recommendations arising from this section

- Continue to develop relationship across the services interface to increase the earlier recognition and identification of Domestic Abuse.

[39] Clients can be identified as having experienced multiple 'types' of abuse and not restricted to just one. The Care First system will only track the 'primary' concern; therefore could be a higher volume experiencing DA.

Vulnerable Communities

The definition of Domestic Abuse includes the wider issues of Honour Based Violence (Abuse), Forced Marriage, Female Genital Mutilation and Modern-Day Slavery. The nature of Domestic Abuse and its impact can be even more hidden in some communities including Visible Minority Ethnic and Gypsy Traveller groups, increasing vulnerabilities of these communities.

Honour Based Violence (HBV), Forced Marriage (FM) and Female Genital Mutilation (FGM)

The Forced Marriage (Civil Protection) Act 2007 seeks to assist victims of Forced Marriage and those threatened with Forced Marriage, by providing civil remedies.

Wiltshire Police confirmed a nil return for no crimes recorded of Female Genital Mutilation, Forced Marriage and Honour Based Violence (Abuse) in 2015-16.

There have been 15 referrals made to the Wiltshire MARAC for Honour Based Violence (Abuse).

Multiple Complex Needs

Domestic Abuse will rarely sit in isolation and cuts across a wide range of agendas including substance misuse and mental health issues, often collectively referred as the 'toxic trio'[40].

Wiltshire agencies and services are anecdotally reporting concerns about the increasing levels of complex issues presenting in their caseloads and service users. Families are now living and experiencing increasingly chaotic lifestyles and are requiring a multi-disciplinary response. Often health issues such as alcohol dependency and poor mental health need to be considered at the same time as ensuring immediate safety concerns are addressed. As this area continues to emerge, we need to understand the prevalence and impact further through improved data collection.

Recommendations arising from this section

- Explore future training and awareness on the wider issues included under the Domestic Abuse definition to both professionals and wider public campaigns.
- Develop improved data recording on the impact and prevalence of substance misuse and mental health in Domestic Abuse caseloads, to increase the understanding around the issue.
- Ensure future service provision addresses the issues of being able to support service users with multiple complex needs.

[40] Ofsted (2010) Learning lessons from serious case reviews 2009 – 2010, Manchester: Ofsted

Children and Young People Services

Overview

The prevalence of domestic abuse on Wiltshire's Children and Young people has been covered in an earlier chapter. This section looks to review:

- The local support available for children and young people witness and living with the effects of domestic abuse.
- Discuss the context of current children's services;
- Report the recent findings from the Joint Team Area Inspections (JTAI).

Context of Children's Support Arrangements

Historically in Wiltshire Children's Support services were independently funded and delivered through the voluntary sector. Splitz Support Service started the Children's programme in 2004, supporting a wider age range (7-16yrs) of children affected by domestic abuse. However, at this time several other organisations were also funded to provide support to children under 11yrs e.g. Barnardo's' Tapestry project and NSPCC. Therefore with limited funding Splitz took the decision to focus on supporting young people aged 11-16yrs. Up until September '16, this work had primarily been funded by Comic Relief and Children in Need.

The service provided by Splitz Support Service supported children and young people aged between 11-16years living in Wiltshire, across two geographic areas;

- South and East Wiltshire (SplitzKidz) and;
- North and West Wiltshire (KidzPace).

The service provided both one to one and group work and aimed to improve young people's understanding and awareness of domestic abuse and that they are not at fault for the abuse being experienced between their parents.

Over the past 3 years, in the South of Wiltshire (1 FTE worker) 97 individuals received support. The average waiting time for support has been 90 days and the waiting list has been closed on several occasions. In North Wiltshire, over the past 3 years (0.9 FTE worker) offering a different model, with more time limited support has worked with 270 young people. The average waiting time for support was 50 days. Figure below provides a breakdown of the volume of referrals by area in 2014-15. An evaluation of the outcomes of the two models could be considered.

Figure 30 Referrals to Support Services for Young People affected by Domestic Abuse in 2014-15
Source Splitz Support Service

This service ended in September ’16, as a result of the external grants finishing.

Support for Children Witnessing/Living with Domestic Abuse

Children’s Domestic Abuse Support Service

An interim Children’s Support Service was funded through Wiltshire Council’s Public Health and Children’s Social Care (CSC) from October 2016. The service is delivered by Splitz Support Service and works with children and young people (11-16yrs) identified through CSC at threshold levels 3 and 4 (CiN and CP). It provides 55hrs of support per week. The service is delivered out of the ‘Thrive Hub’ areas, to maximise the support time available (reducing travel time). The service projects to support 130 children a year.

Over the first 6mths of the Service (Oct ’16 – Mar ’17) a total of 90 referrals were received, of which 84 received support (6 not eligible as were under the age threshold). 24 cases have been closed to date, 18 of which needs were deemed to be met and 6 due to non-engagement.

The interim arrangement does differ to the previously independently funded children’s work for the County. The funding for this expired September 2016, so to prevent a gap in service provision Wiltshire Council agreed to fund an interim intervention, to support those deemed at greatest risk of harm. Current work is ongoing regarding a future procurement exercise for domestic abuse services, of which Children’s Support work will be included.

In addition, Splitz currently deliver a TeenzTalk programme to secondary schools in Wiltshire. A healthy relationships programme aimed at Year 9 and 10 students. This service has independently secured three year funding (Blagrave Trust). The funding will deliver the service to 27 schools over the 3 years until September 2018. The first programme is free and then any subsequent programmes initiate a charge of £100 per student.

Wiltshire Children’s Centres

The Wiltshire Children’s Centre provision is delivered by two voluntary organisations Spurgeons and The RISE Trust. Children’s Centres aim to target specific vulnerable groups, including children living with domestic abuse.

In 2015/16 the number of families seen at Children Centre’s in Wiltshire who had disclosed domestic abuse was 927 (up 64% on 2014/15).

Children’s Centres deliver and encourage participation in programmes for families experiencing domestic abuse. In 2015/16, 140 families accessed domestic abuse programmes (mainly the Freedom Programme and Making Changes from Splitz), an increase of 146% since 2014/15 (source: eStart).

A recent development, includes delivering the Women’s Aid programme ‘You and Me Mum’, a 10 week programme for new mother’s identified through the children’s

centre and other referring agencies who have experienced domestic abuse and have children aged 0-5yrs. An evaluation of this programme is planned.

In addition, Children Centre's have regular representation at the Wiltshire MARAC arrangements.

Joint Targeted Area Inspection (JTAI) Findings

Between 31 October and 4 November 2016, Ofsted, the Care Quality Commission (CQC), HMI Constabulary (HMIC) and HMI Probation (HMI Probation) undertook a joint inspection of the multi-agency response to abuse and neglect in Wiltshire. This inspection included a 'deep dive' focus on the response to children living with domestic abuse.

In preparation, Wiltshire collected evidence demonstrating the outcomes and impact for families exposed to domestic abuse. This overview can be viewed in full in the supporting documents.

The overall findings were positive, with inspectorates reporting that

> *"Organisations across Wiltshire have worked together well to overcome issues that have been raised in inspections conducted by the different inspectorates over the last few years. Significant progress has been made in all areas to ensure that children and families receive a well-coordinated and helpful response when difficulties are identified. This is clearly evident in the work undertaken to support children who are experiencing domestic abuse."*

Key multi-agency strengths identified included:

- A strong and committed partnership dedicated to improving outcomes for vulnerable children, including those experiencing domestic abuse.
- Multi-Agency Safeguarding Hub (MASH) arrangements.
- Management oversight in agencies and challenge between partners.
- Wiltshire Safeguarding Children Board and the domestic abuse sub-group promote, coordinate and prioritise the work of statutory partners effectively in relation to domestic abuse.
- Partners remain committed to drive the agenda forward and implement actions identified to ensure continuous learning and improvement is achieved in the safeguarding of Wiltshire's vulnerable populations.

Recommendations arising from this section

- Build on a collaborative approach to safeguard the next generation; strengthening the relationships between partner agencies.
- Include the children's support work as part of the proposed DA procurement process.
- Address the gap of support at the lower risk threshold; considering opportunities to embed an early intervention model.
- Address the gap in support provision for children aged 5-11yrs.
- Further work is required on communicating a clear referral pathway for accessing children's support service.
- Explore future working models and opportunities to identify driving factors between the high volume of single assessments completed in Wiltshire and those actually in receipt of specialist domestic abuse support.
- Continue to deliver on the JTAI recommended areas.

Perpetrator Services

This section provides an overview on current services available to support and address perpetrator behaviour through both;

- Community-based (voluntary) programmes.
- Court-Mandated programmes and;
- Consideration of identified gaps.

Overview

Unless work is targeted at addressing perpetrator's behaviour, the cycle of abuse will never be broken.

The 2014 HMIC reports[41] shone a spotlight on the policing response to domestic abuse and put it into the public domain. In addition, the latest VAWG Strategy (2016) continues to emphasise the need for effective criminal justice responses to tackle this agenda and build on the recommendations from HMIC.

The long-term effectiveness of perpetrator programmes has been subject to much research, most recently as part of Project Mirabal. Its findings concluded that whilst researchers were optimistic about the role of domestic violence perpetrator programmes in ending DV, they warned they are not a panacea, as individual men ranged from minimal change to considerable improvement[42].

Wiltshire Community Perpetrator Programme – Turnaround

The community perpetrator programme in Wiltshire is delivered through Splitz Support Service. It is independently funded through a range of external grants secured until 2018. Splitz first started delivering the programme in 2005.

Turnaround is a 25 week (5 modules) voluntary programme for male perpetrators of domestic abuse, who are looking to change their abusive behaviour. A women's safety worker works alongside the programme, offering support to the partner. Programmes are delivered in both Trowbridge and Salisbury.

The aims include to:

- Promote safety of victims and their children,
- Mitigate and prevent the risk of reoffending,
- Promote change in abusive/harmful behaviour and;
- Work collaboratively with other agencies to manage risk.

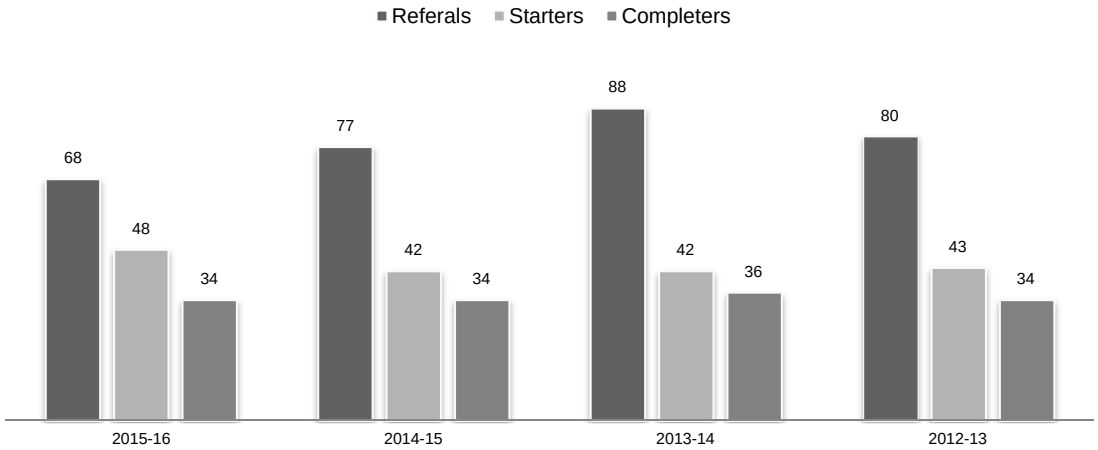
The programme is one of 10 nationally to be accredited by Respect.

Since 2013-15, the number of referrals have reduced year on year (figure below); with the lowest referrals received in 2015/16 (n=68). The service now only accepts Wiltshire referrals. 70% of those starting completed the programme.

[41] HMIC (2014) *Wiltshire Police's approach to tackling domestic abuse* https://www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/2014/03/wiltshire-approach-to-tackling-domestic-abuse.pdf
[42] Kelly, L. and Westmarland, N.(2015) Project Mirabal; Domestic Violence Perpetrator Programmes Steps Towards Change https://www.dur.ac.uk/resources/criva/ProjectMirabalfinalreport.pdf

Anecdotally the service reported fewer self-referrals, which could be as a result of a change to the referral process. As from January 2016, if an agency is involved with the family e.g. Children Social Care, Army/Unit Welfare Services etc, that agency is required to complete the referral form.

Figure 31 Wiltshire Turnaround Programme 2012-2016
Source Splitz Support Service



The service has recently introduced the 'Daphne Outcome Measuring' toolkit[43], completed by men and their partners (if engaged with the women's safety worker). This involves data collation at the start, middle and at the end of the programme.

The service has just commenced a 3yr external evaluation with effect from 1st January 2016.

Court-Mandated programme – Building Better Relationships[44]

As part of the government's reform of probation services, the Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company (CRC) was formed in June 2014.

The CRC is responsible for the management of low and medium risk offenders who have been sentenced to serve their order in the community. Additionally, CRC manage low and medium risk offenders released from prison on license, as well as offenders sentenced to less than 12months in custody.

Data provided by the National Probation Service (NPS) identified in 2015-16:

Table 21 Breakdown of Offenders as perpetrators / victims of DA

No. of Male Offenders identified as Perpetrators of DA by Probation Service	118
No. of Female offenders identified as perpetrators of DA by Probation Service	4
No. of Male offenders identified as VICTIMS of DA by Probation Service	25
No. of Female offenders identified as VICTIMS of DA by Probation Service	6

Source National Probation Service

[43] The DAPHNE IMPACT project; provides a monitoring framework for perpetrator programmes to (self) monitor the results of their work http://www.impact.work-with-perpetrators.eu/index.php?id=16

[44] Data Source; Wiltshire Community Rehabilitation Company Limited

Specific to domestic abuse, the CRC work with people who have been violent or abusive towards their partners or have been identified at risk of doing so. They deliver the 'Building Better Relationships' programme, an accredited group to reduce re-offending by adult male perpetrators of intimate partner violence. It aims to enable men to acknowledge the abuse they have perpetrated and its effects on others, and to build understanding and strategies for appropriate behaviour and responses in the future. The programme runs for 24 group sessions, held once or twice a week, plus up to five one-to-one sessions.

Table 22 Building Better Relationships Programme data 2013-16

	2013-14			2014-15			2015-16		
	Total	Rural (Wiltshire)	Swindon	Total	Rural (Wiltshire)	Swindon	Total	Rural (Wiltshire)	Swindon
Men made subject to BBR	84	37	47	95	41	54	77	38	39
Men completing DA Programme (IDAP/BBR)*	25	-	-	29	-	-	34	-	-

Source CRC
**Nb. Of the completions – not all will come from Orders made in the same year, due to the time period for completing programme IDAP (Integrated Domestic Abuse Programme) was phased out 2013-14 and replaced with BBR (Building Better Relationships)*

The above table depicts the volume of cases referred to Building Better Relationships and the numbers completing. In 2015/16 there were 77 men subject to the Building Better Relationship programme; 38 were men residing in the Wiltshire (county) area. Across the year, a total of 34 men completed the programme[45]. The completion rate has numerically increased, with more men completing in 2015-16, compared to previous years.

Young perpetrator programmes

The recognition of young people as victims and/or perpetrators of domestic abuse was seen as one of the major additions to the Home Office definition (2013).

The needs assessment sought to include data from young offenders who have been identified as perpetrating or at risk of perpetrating domestic abuse, through Wiltshire Council's Youth Offending team. Young people are assessed in terms of relationships and the 'asset assessment' looks both from the perspective of them being a victim or perpetrator. However at this stage it was not possible to extract this information from the systems[46].

Data available from the Wiltshire MARAC reported in 2015-16 that there were 4 referrals received (north/west MARAC) involving perpetrators who were aged 17 or below.

To support and further understand the prevalence of the domestic abuse and young people, the Wiltshire DA Sub group has commissioned an audit to focus on young people perpetrating or at risk of perpetrating DA, due the end of 2016-17.

There remains little support available to address young people perpetrating or at risk of perpetrating domestic abuse in the County.

[45] Note. Not all of the 2015-16 completers, would have come from orders made in the same period, with some rolling over from the previous year.
[46] Source: Youth Offending

Recommendations arising from this section

- Consider undertaking a review to address the disparity between the high volumes of DA being perpetrated in Wiltshire compared against the low number of perpetrators in receipt of support interventions.
- Consideration to be given to including an element of perpetrator intervention into the future procurement offer, currently not being addressed.
- Explore alternative options used in other areas of short-term interventions for behaviour-change led programmes with perpetrators.
- Future consideration to be given to addressing the identified gap of available support for both young perpetrators, as well as female perpetrators.
- To support the young perpetrator audit and consider any future findings or recommendations.

Universal Services and their role in supporting those experiencing domestic abuse

Overview

The domestic abuse (DA) agenda has continued to gather significant momentum over recent decades. It is now recognised as a key public health priority, affecting women and children across the world (WHO, 2014)[47]. As well as the more specific and specialist services discussed above there are a number of ways in which universal services also support those who experience domestic abuse.

Health Services Based Activities

Domestic abuse often inflicts injuries on victims that require the attention of medical services. The health effects of domestic abuse are known to include acute and chronic conditions, such as physical injury[48], complications pre/post pregnancy as well as significant long-term mental and emotional health problems[49].

Families live with domestic abuse for a significant period before getting effective help; on average 2.6 years for high-risk abuse, and three years for medium-risk[50]. During this time they may well come into contact with health services and so this represents a stage at which help could be offered earlier.

47 World Health Organisation. (2014). *Violence against women; intimate partner violence against women* Factsheet No. 239 [online] World Health Organisation available from http://www.who.int/mediacentre/factsheets/fs239/en/ (accessed 23 October 2016)

48 Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet* [online]. pp. 359, 9314, 1331-1336 available from: http://search.proquest.com.ezproxy.uwe.ac.uk/docview/199005269?pq-origsite=summon (accessed 05 November 2016)

49 Lazenbatt, A., Taylor, J., and Cree, L. (2009). A healthy settings framework: an evaluation and comparison of midwives' responses to addressing domestic violence. *Midwifery* [online]. 25, 6, pp. 622-636 available from http://www.sciencedirect.com.ezproxy.uwe.ac.uk/science/article/pii/S0266613807001398 (accessed 05 November 2016)

50 SafeLives, (2015). *Getting it right first time*. SafeLives. http://www.safelives.org.uk/sites/default/files/resources/Getting%20it%20right%20first%20time%20-%20complete%20report.pdf

Health professional associations have published guidelines on how to identify and respond to women experiencing domestic abuse[51]. The purpose of screening in a healthcare setting is to identify women with current or past experiences of abuse, to enable referral to appropriate support and interventions to encourage improved outcomes[51]. However, studies have confirmed that domestic abuse screening is very complex; domestic abuse remains a complex social phenomenon rather than a disease, which impacts of the barriers for disclosure and the effectiveness of screening tools and interventions.

Findings from the 2014 systematic review[51] show that while screening is likely to increase identification of DA in healthcare settings, rates of identification remain relatively low in comparison to prevalence of abuse.

Local Health Service Activity

Over recent years, the involvement of health services in the domestic abuse agenda in Wiltshire has grown with key representation at both strategic and operational groups. There has been continued strong representation at the Wiltshire MARAC arrangements involving both primary and secondary health services. Health services have also contributed to all the domestic homicide reviews commissioned in Wiltshire and as a result some local health service policies have been changed.

- When patients present with mental health issues if they hold a gun licence the information is now shared with the police so they can temporarily revoke the licence.
- Patient files can now be flagged to denote domestic abuse to enable the health provider to take informed decisions.

In addition, local health services continue to show an appetite for domestic abuse training.

While the above are to be welcomed there are still a number of areas where improvements could be made. There is a lack of data collection at the health service level to allow evaluation of interventions and to contribute to the research base around the wider impacts of domestic abuse.

There are IDVAs in only two out of the three major hospital that serve Wiltshire. The Royal United Hospital in Bath and Great Western Hospital in Swindon both have IDVAs while Salisbury Foundation Trust does not. This represent a health inequality in provision which may exacerbate other inequalities; Salisbury hospital serves the more rural and deprived communities in the south of the County, both of these factors are known to be associated with increased rates of domestic abuse.

Recommendations arising from this section

- Build on the work done to date with health services. Consider how the new procurement of the Domestic Abuse Support Service 'offer' can include direct work with primary and secondary care health services.
- Explore options to have an IDVA worker in Salisbury Hospital to ensure geographical equity of service provision

[51] World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. WHO, 2013.

Cross agency domestic abuse capability raising

The health services are not the only services that come into contact with those experiencing domestic abuse. As part of Wiltshire's ongoing commitment to raising the awareness and understanding of domestic abuse, there has been a drive to deliver a combination of multi-agency and single-agency training sessions around the agenda.

The table below details the training delivered over a 12mth period. This has reached in excess of 400 Wiltshire practitioners from agencies as diverse as the police, health, CSC, housing, early years ASC, AWP, Probation, Drugs and Alcohol, Army Welfare, Midwifery, School Nurses, Schools and Children Centres.

Table 23 Training Schedule Delivered between October 2015-October 2016
Source Wiltshire Council – Public Health

Training Delivered	No. of Sessions Delivered	No. of Participants
WSCB Multi Agency Domestic Abuse and the Impact on Children	7	124
Multi Agency DASH Risk Assessment and Referral Pathway to MARAC	4	54
DASH Risk Assessment and referral to MARAC Training – bespoke to Selwood Housing Association	1	15
DASH Risk Assessment and referral to MARAC Training – bespoke to Childrens Social Care	3	32
DASH Risk Assessment and referral to MARAC Training – bespoke to Turning Point	2	27
DASH Risk Assessment and referral to MARAC Training – bespoke to AWP Mental Health	2	40
Domestic Abuse Awareness – for Early Years Settings	1	27
Multi Agency HBV/FM Briefing	1	26
HBV/FM/FGM Awareness Raising – bespoke to MASH Staff	2	34
HBV/FM Information Session to Wiltshire DA Forum	1	27
TOTAL		**406**

This training has helped people from these agencies feel better able to support those experiencing domestic abuse and has raised awareness of the issue across the county. There is a positive correlation between training delivered and the continued increases in MARAC referrals received from the wide range of non-police agencies. MARAC has a non-police referral rate of 41% in 2015-16 (against the national average of 36%).

Recommendations arising from this section

- Continue to raise awareness across agencies on the wider remit of domestic abuse.
- Deliver and evaluate the impact of cross agency domestic abuse training.

Support currently offered

Overview

To tackle Domestic Abuse it requires an integrated, multi-agency response that works across a combination of legal, criminal justice, health, housing, education and adult and children's safeguarding frameworks.

The evidence supports that no one agency can deal effectively and safely with the effects of domestic abuse, as the issue requires close partnership working between agencies and a collaboration which can have a profoundly positive effect on the lives and the safety of families[52].

Specialist service overview

National Response

Nationally, the Government launched in March 2016 the latest Violence against Women and Girls Strategy 2016-2020[53]. It continued to build on previous national strategy focusing on:

- Prevention,
- Provision of Services,
- Partnership working and;
- Pursuing Perpetrators.

Service provision to support the Domestic Abuse agenda at a national level remains limited and the continuing economic pressures have resulted in reductions in funding to services. Appendix 1 provides a breakdown of the national specialist services available supporting the wider Domestic Abuse (Violence against Women and Girls) agenda.

Local Response

The Wiltshire response to domestic abuse is governed and driven through a multi-agency arrangement, within the Wiltshire Community Safety Partnership and the Wiltshire Safeguarding Children's Board. Work continues to strengthen the links across the Wiltshire Safeguarding Adults Board agenda.

Wiltshire is committed to delivering a Domestic Abuse response across both adult and children's services, reducing silo working and encouraging a 'whole family approach'.

Agency commitment for the Domestic Abuse agenda remains high in Wiltshire, demonstrated through regular attendance at meetings by a wide variety of agencies and departments. This remains an area for continued review, further work could be beneficial to re-engage partners across the strategic and/or operational agenda including adult mental health services, children and adolescent mental health services and army welfare services.

Local service provision to support the Domestic Abuse has been detailed in Appendix 2, which includes specialist commissioned services and more general support services serving a wider universal need.

[52] Home Office. (2007). National Domestic Violence Delivery Plan: Annual Progress Report 2006/7. London
[53] HM Government (2016), *Ending Violence against Women and Girls Strategy 2016-2020*. HM Government.

Brief description of provision and range of non-specialist services (National and Local)

There are a range of local and national services that do not specifically have a domestic abuse remit but that none the less provide support to those experiencing domestic abuse. It is not possible to provide a comprehensive list of such services but it would be remiss not to highlight and acknowledge the role they can play in supporting people particularly in the early stages of help seeking. These services will include places such as the GP and other health workers, community and religious groups, third sector organisations such as the Citizens Advice Bureau and mental health charities.

Recommendations arising from this section

- Recognition of the National strategic direction for the Violence against Women and Girls agenda in future local Strategy development.
- Strengthen partnership working across agencies including adult mental health services, children and adolescent mental health services and army welfare services and drugs and alcohol services with the local DA strategic and operational agendas.
- Develop a Service Pathway 'map' to support awareness and accessibility of key services.

Evidence Review of What works

Overview

This chapter provides an overview of the most recent evidence-based practice across the agenda including:

- Health-Based interventions
- Support models for children and young people
- Efficacy of perpetrator programmes

Adult Victims

The Violence against Women and Girls Strategy (2016)[54] acknowledges the need for a co-ordinated approach to prevent violence and abuse in the first place and to make sure those experiencing it, access appropriate support. The national focus is supporting professionals to identify and recognise the earliest signs of Domestic Abuse, preventing escalation through a greater focus on earlier intervention.

Health-Based Interventions

Increasing evidence has supported the role of health in the earlier identification of Domestic Abuse. Victims of Domestic Abuse are more likely to present to a health service than any other service, for some this can be as many as up to 15 occasions[4]; representing missed opportunities for earlier intervention and reducing the risk of further harm.

The IRIS Model

IRIS (Identification and Referral to improve safety) provides support for GP practices in identifying and supporting victims of Domestic Abuse. A targeted intervention for

[54] HM Government. (2016). *Ending Violence against Women and Girls Strategy 2016-2020.*

female patients aged 16 and above experiencing current or former DA from a partner, ex-partner or adult family member. It provides care pathways for all patients living with domestic abuse and information and signposting for male victims and for perpetrators. IRIS was the first European randomised controlled trial of an intervention to improve the health care response to domestic violence and abuse[55]; taking place in 48 practices across Bristol and Hackney between 2007-10, below are the summarised findings:

- Women attending intervention practices were 22 times more likely than those attending control practices to have a discussion with their clinician about a referral to an advocate. This resulted in them being six times more likely to be referred to an advocate.
- Women attending intervention practices were three times more likely than those attending control practices to have a recorded identification of DVA in their medical record.
- The results also showed IRIS to be a cost effective intervention[56].
- Training and support programmes targeted at primary care clinicians and staff improved referral to specialist DA support services.

Project Themis- co-location of IDVA services in Hospital settings

This research project looked to explore the impact of co-location of IDVA services in hospital settings[57]. The research examined five hospitals, across four geographic areas that had adopted co-location of specialist domestic abuse services with their A&E and maternity units; compared against community-based Domestic Abuse support service. The key findings are represented in the table below:

Table 24 Findings of the Themis research Source SafeLives

Co-location of IDVA services within a hospital setting can significantly improve health and wellbeing outcomes for victims of domestic abuse; in addition to:	
Increased engagement of victims disclosing disclose high levels of complex/multiple needs in relation to mental health, drugs and alcohol.	Health setting was more conducive to disclosures; as seen as confidential, with a greater focus on wellbeing rather than the criminal justice issues.
Increased engagement of victims who are pregnant in hospital settings.	Increased timeliness for accessibility for support through earlier identification, than those in a community setting.
Improved links with safeguarding arrangements e.g. referrals to MARAC and improved information sharing.	'Golden window of opportunity' – for hospital IDVAs to support victims due to their setting.
56% of hospital victims had accessed A&E the previous year; prior to getting effective help, compared to 16% in the community. Reflecting missed opportunities for earlier intervention.	Improve victims safety and wellbeing through improved access to wider services; hospital IDVAs providing a gateway to other support interventions.

Recommendations arising from this section

- Consider the role of health-based interventions for DA in Wiltshire in particular IDVA presence at Salisbury Hospital and link-workers in GP surgeries

[55] Feder, G., Davies, R., Baird, K., *et al* (2011). *Identification and referral to improve safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial.* The Lancet. 2011; 378: 1788-95

[56] Norman, R., Spence, A., Eldridge, S. and Feder, G. (2010). *Sot-effectiveness of a programme to detect and provide better care for female victims of intimate partner violence*. Journal of Health Services Research & Policy.

[57] SafeLives. (2016). *A Cry for Health; why we must invest in domestic abuse services in hospitals*. SafeLives.

Children and Young People

Evidence base for the impact of domestic abuse on Children and Young People

There remains significant evidence supporting the overwhelming impact Domestic Abuse has on those children and young people that are exposed and living with its impacts. The table below reports the effects of Domestic Abuse on Children and Young People as described in a briefing by the Royal College of Psychiatrists (2004)[58]:

Table 25 Identified effects of DA on C&YP Source Royal College of Psychiatrists (2004)

Anxious or depressed	Difficulty sleeping
Nightmares or flashbacks	Easily startled
Complaints of physical symptoms e.g. tummy aches	Bed Wetting
Temper tantrums	Behaving younger than they are
Problems with school	Becoming aggressive
Withdrawing from other people	Low sense of self-worth
Older children may begin to play truant	Use alcohol or drugs
Self-harming	Eating disorder

Summary findings from the research include:

- Domestic abuse is a factor identified in over half of all Serious Case Reviews[59].
- Nineteen children and two women were killed by perpetrators of domestic abuse in circumstances relating to child contact (formally or informally arranged)[60].
- A third of children witnessing domestic abuse also experience another form of abuse[61].
- Children and young people may be significantly affected by living with domestic abuse, and impact can occur long after safeguarding measures have been taken to secure their safety[62].
- Witnessing inter-partner violence can have a negative effect on the child's emotional and behavioural development[63].
- At its most basic level, living with the abuse of their mother can be considered a form of emotional abuse, with negative implications for children's emotional and mental health and future relationships.
- Investing in early intervention services can bring about significant financial savings to both local and national government[64]. However, the current economic picture and reducing budgets are challenging for Local Authority

[58] Royal College of Psychiatrists (2004), cited by Women's Aid Website
[59] Sidebottom, P et al (2016) *Pathways to harm, pathways to protection; a triennial analysis of serious case reviews 2011 to 2014: final report*
60 Women's Aid, (2016) *Nineteen Child Homicides*. Bristol: Women's Aid
[61] Radford, L et al (2011) *Child Abuse and Neglect in the UK.* NSPCC
[62] Holt, S et al (2008) *The impact of exposure to domestic violence on children and young people: A review of the literature*. Child Abuse & Neglect Vol.32 Issue 8 pg. 797-810
63 Kolbo et al (1996) cited in Hester et al (2007) Making an Impact: Children and Domestic Violence. Second Edition. London: Jessica Kingsley Publishers.
[64] Munro, E., (2011). *The Munro Review of Child Protection*. Department for Education: London.

areas in continuing to preserve and have a focus on early intervention services (Action for Children, 2016[65]).

- Programmes providing non-judgmental advice, to build young people's resilience can make a positive difference and minimise the chances of long lasting harm (Public Health England, 2014[66]).
- Early intervention services haven't just helped them avoid crisis or get much needed support at difficult times, it has helped to set them on a path towards a better life.

Recommendations arising from this section

- Address the gap of support at the lower risk threshold; considering opportunities to embed an early intervention model.
- Address the gap in support provision for children aged 5-11yrs.

Perpetrators

Evidence Base of the efficacy of male perpetrator programmes

There remains a clear need to hold perpetrators of Domestic Abuse to account in and out of the criminal justice system.

Research on the effectiveness of perpetrator programmes is documented in 'Project Mirabal'[67]; a mixed method, longitudinal multi-site study of 11 British community-based (not criminal justice-mandated) DVPPs from 2009-2015. It studied the male perpetrators, their female partners and children and staff and other stakeholders. The table below documents the main findings.

Table 26 Project Mirabel - Research findings
Source Kelly, L. and Westmarland, N. (2015)

Programmes resulted in improvements in 6 outcome areas measured: respectful communication, expanded space for action (controlling behaviour), safety and freedom from violence and abuse for women and children, safe, positive and shared parenting, awareness of self and others (understands the impact of their actions) and safer, healthier childhoods.
The men found the experience mostly positive, the impact of being *held to account by their peers* and exploring *different ways of being men* were the heart of the programmes' success.
Overall the DVPPs contributed significantly to men taking steps to change, including *choosing* to change – men often had an initial view that attendance to tick boxes would then allow them to 'carry on as normal', meaning short, untested courses are not appropriate.
Physical and sexual violence was *ended* for the majority of women in the research but *everyday harassment was harder to curtail*.
Researchers were optimistic about the role of DVPPs in ending DV but warned they are not a panacea as individual men ranged from minimal change to considerable improvement.
Key recommendations included: • Improvements to group work for men, • *Increased dedicated support for the women and children*, • Acknowledgment of the tensions faced for DVPPs with challenging funding, • Increasing connections with children's services and;

[65] Action for Children, National Children's Bureau and The Children's Society (2016) *Loosing in the long run; trends in early intervention funding* https://www.actionforchildren.org.uk/media/5826/losing_in_the_long_run.pdf
[66] Public Health England (2014), *Building children and young people's resilience in schools.* Public Health England: London.
[67] Kelly, L. and Westmarland, N. (2015) *Domestic Violence Perpetrator Programmes: Steps Towards Change. Project Mirabal Final Report.* London and Durham: London Metropolitan University and Durham University.

• Conflict between sustainability and adherence to the original models of the DVPP
If the main referrers are children's' services and CAFCASS then pathways in to DVPPs for men who might self-refer or who are not fathers may be limited. Important to attract men who can see the DVPP as an opportunity rather than a hurdle.

Recommendations arising from this section

- Ensure that the local DA offer is fully benchmarked against evidence based best practice.

Recommendations

Key recommendations arising have been highlighted throughout the text. The following is a summary of all key recommendations by section.

Local health needs

Demographics

- Use knowledge of the local demographic profile to inform service planning and allow for future proofing of services. Particular attention needs to be paid to the local ethnic profile and the need of the substantial and growing military presence.

Risk and Protective Factors

- Ensure prevention strategies are broad and can encompass the wide spectrum of multi-level and interconnected risk and protective factors.
- Grow the evidence base around local risk and protective factors and consider qualitative work to research the societal and community factors which operate locally and could be used to focus prevention interventions.
- Ensure this knowledge is used to inform multi-agency activity in the area.

Prevalence of Domestic Abuse in Wiltshire

- Explore further the impact of Domestic Abuse on older populations.
- Revisit the role of the Specialist Domestic Violence Court (SDVC) process in Wiltshire and review the victim's journey through the court process.
- Explore the underlying factors that drive the disparity between the high volume of cases where Domestic Abuse is being identified by Children's Services and the numbers that receive an intervention or support.
- Further develop the WSCB's dataset to provide greater context of the Domestic Abuse issue, rather than just the prevalence.
- Explore options to gather further qualitative data on the impact of Domestic Abuse and attitudes of Young People.

Local Demands

Domestic Abuse Support Services

Adults

- Review Wiltshire MARAC process to ensure it incorporates recent research into best practices, and is robust enough to deal with any further increases in referral volumes.
- Ensure appropriate agency representation at meetings by continuing to strengthen engagement with mental health services, army welfare services and drugs and alcohol service.
- Explore future opportunities to ensure appropriate representation of "hard to reach" vulnerable communities in referrals to MARAC.
- Include the future refuge provision within the upcoming domestic abuse commissioning process.
- Review options for ensuring refuge provision matches expressed need in terms of unit size and accessibility.

- Review options around how best to ensure that those with complex social and health needs can access refuge accommodation.
- Work with local and national colleagues to ensure overall provision of refuge units for men and those fleeing with teenage male children is adequate.
- Review options as part of the new service model to address the capacity pressures on accessing supporting services.
- Address the 'un-met' need of those hidden victims who are not already in the system, through earlier identification.
- Address the issue around ownership of data in future contracts, to prevent data gaps in the event of a change of provider, to support the continued understanding regarding the prevalence of the wider agenda.
- Re-visit the awareness and promotion of the use of DVPN/Os.
- Explore future opportunities to address perpetrator behaviour through the DVPN/O process.
- To further build on the DACC role to share information through increasing agency participation in the process.
- Establish how future DHRs will be delivered, developing policy to reflect local and national learning.
- Explore the inclusion of "near misses" into local DHR policy.
- Develop relationships across adult services interface to increase the earlier recognition, identification and support of Domestic Abuse.
- Explore future training and awareness on the wider issues included under the Domestic Abuse definition to both professionals and wider public campaigns.
- Develop improved data recording on the impact and prevalence of substance misuse and mental health in Domestic Abuse caseloads, to increase the understanding around the issue.
- Ensure future service provision addresses the issues of being able to support service users with multiple complex needs.

Children

- Build on a collaborative approach to safeguard the next generation; strengthening the relationships between partner agencies.
- Include the children's support work as part of the proposed DA procurement process.
- Address the gap of support at the lower risk threshold; considering opportunities to embed an early intervention model.
- Address the gap in support provision for children aged 5-11yrs.
- Further work is required on communicating a clear referral pathway for accessing children's support service.
- Explore future working models and opportunities to identify driving factors between the high volume of single assessments completed in Wiltshire and those actually in receipt of specialist domestic abuse support.
- Continue to deliver on the JTAI recommended areas.

Perpetrators

- Consider undertaking a review to address the disparity between the high volumes of DA being perpetrated in Wiltshire compared against the low number of perpetrators in receipt of support interventions.

- Consideration to be given to including an element of perpetrator intervention into the future procurement offer, currently not being addressed.
- Explore alternative options used in other areas of short-term interventions for behaviour-change led programmes with perpetrators.
- Future consideration to be given to addressing the identified gap of available support for both young perpetrators, as well as female perpetrators.
- To support the young perpetrator audit and consider any future findings or recommendations.

Universal Services

- Build on the work done to date with health services. Consider how the new procurement of the Domestic Abuse Support Service 'offer' can include direct work with primary and secondary care health services.
- Explore options to have an IDVA worker in Salisbury Hospital to ensure geographical equity of service provision
- Continue to raise awareness across agencies on the wider remit of domestic abuse.
- Deliver and evaluate the impact of cross agency domestic abuse training.

Support Currently Offered

- Recognition of the National strategic direction for the Violence against Women and Girls agenda in future local Strategy development.
- Strengthen partnership working across agencies including adult mental health services, children and adolescent mental health services and army welfare services and drugs and alcohol services with the local DA strategic and operational agendas.
- Develop a Service Pathway 'map' to support awareness and accessibility of key services.
- Ensure that the local DA offer is fully benchmarked against evidence based best practice.

Acknowledgements

This report acknowledges the support and work of:

Wiltshire Community Safety Partnership

Wiltshire Safeguarding Children's Board

Wiltshire Safeguarding Adult's Board

Wiltshire's Domestic Abuse Sub Group

Members of the Task and Finish Needs Assessment Group

Data Provided by

Wiltshire Council departments:
- Public Health
- Housing Options
- Children Social Care
- Adult Social Care

Wiltshire Police

Splitz Support Service

Wiltshire Refuge Providers:
- Advance Housing Association (West)
- Greensquare Housing Association (North)
- Aster Living Housing Association (East)
- Salisbury Women's Refuge Ltd (South)

National Probation Service Wiltshire
Bristol, Gloucestershire, Somerset and Wiltshire Community Rehabilitation Company

Crown Prosecution Service

Appendix One National Specialist Services

24hr Freephone National Domestic Violence Helpline **(run in partnership between Women's Aid and Refuge)**	**Tel: 0808 2000 247 24 (24hr)** **Web: www.womensaid.org.uk**
Refuge	Tel: 0808 2000 247 24 (24hr) Web: www.refuge.org.uk
National Centre for Domestic Violence (NCDV) - *Free legal advice and support with injunctions*	Tel: 0844 8044 999 (24hr helpline)
Male Advice Line (MALE)	Tel: 0808 801 0327 Web: www.mensadviceline.org.uk
RESPECT	Tel: 0845 122 8609 Web: www.respect.gov.uk
Domestic Abuse National LBGT Helpline	Tel: 0800 999 5428 Web: www.galop.org.uk
Forced Marriage Unit	Tel: 020 7008 0151 Web: www.gov.uk/stop-forced-marriage
Karma Nirvana - *Supporting victims of Honour crimes and Forced Marriage*	Tel: 0800 5999 247 Web: www.karmanirvana.org.uk
Iranian and Kurdish Women's Rights Organisation (IKWRO) – *supporting middle eastern and afghan women and girls at risk of HBV, FGM and DV*	Tel: 0207 920 6460 Web: www.ikwro.org.uk
Paladin – *advocacy and support for victims of stalking*	Tel: 020 3866 4107 Web: www.paladinservice.co.uk

Source National Support Services Websites

NB. This list is not exhaustive and is subject to change

Appendix Two Wiltshire Domestic Abuse Support Services

COMMISSIONED SPECIALIST DOMESTIC ABUSE SUPPORT SERVICES	
SUPPORTING VICTIMS	
Splitz Support Service Wiltshire Commissioned provider of: High Risk DA support Outreach Support Provision including Making Changes programme	Tel: **01225 775 276 (helpdesk)** Web: www.splitz.org/wiltshire
Refuge Provision Four refuge providers operate across the County – offering emergency accommodation to victims fleeing DA	Tel: not for public release
SUPPORTING CHILDREN & YOUNG PEOPLE	
Splitz Support Service Support to Children living with the effects of DA (11-16yrs Level 3&4 risk)	Tel: **01225 775 276 (helpdesk)** Web: www.splitz.org/wiltshire
Children's Centres Spurgeons and The RISE Trust Supporting parents and children aged 0-5yrs Including: You and Me Mum, Freedom Programme	Web: http://www.wiltshire.gov.uk/child-care-childrens-centres

NON COMMISSIONED SPECIALIST DOMESTIC SUPPORT SERVICES	
SUPPORTING PERPETRATORS	
Splitz Support Service Turnaround – community perpetrator programme	Tel: **01225 775 276 (helpdesk)** Web: www.splitz.org/wiltshire
Wiltshire Community Rehabilitation Company – Building Better Relationships (BBR) programme Court-Mandated perpetrator programme	Web: www.bgswcrc.co.uk
SUPPORTING VICTIMS	
Splitz Support Service Buddy Scheme	Tel: **01225 775 276 (helpdesk)** Web: www.splitz.org/wiltshire

NON COMMISSIONED Universal Support Services	
Wiltshire Police	Tel: 101 In an emergency call 999 Web: www.wiltshire.police.uk
Victim Support Wiltshire Supporting victims of crime	Tel: 0808 281 0113 Web: https://www.victimsupport.org.uk/help-and-support/get-help/support-near-you/south-west/wiltshire

Source LA Wiltshire website and Stakeholder Event

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Wiltshire Council

Health and Wellbeing Board

18 January 2018

Subject: Adults Social Care Transformation Programme

Executive Summary

Adult Social Care supports people eligible under the Care Act 2014 who are over 18 years and have a learning disability, a mental health problem, a physical disability, a drug or alcohol problem or who are older and frail.

In Wiltshire, the Council, CCG and all health providers (GWH, SFT, RUH, WH&C, AWP) met on 5th April 2017 to agree the Adult Social Care Transformation programme and the use of the additional social care monies provided to Wiltshire Council. The partners agreed that this money should not be spent on additional IC beds, but on supporting people to stay in their own homes.

The ASC Transformation Programme aims to deliver sustainable services that support individuals to maximise their independence and build on their individual strengths and those of their families and communities.

Since the update in September 2017 progress has been made with regards to:

- a prevention model, to be piloted in three communities in Wiltshire
- strategies are being developed in Learning Disabilities and Autism, as well as an Older Persons and Accommodation Strategy, to inform the council's Market Position Statement
- changes to the Help to Live at Home contracts are being implemented with a view to establishing new contractual frameworks with providers and a new in-house reablement service alongside the existing Home First service, to manage demand and create market capacity within the County, supported by community services activities
- Developing new commissioning frameworks for Residential and Supported Living Services, both of which will come into effect in mid-2018, in the Learning Disability Market.

Proposal(s)

It is recommended that the Board notes the progress to date.

Reason for Proposal

To ensure that the Health and Wellbeing Board is fully informed of this significant transformation programme.

Graham Wilkin
Interim Director of Adult Social Services
Wiltshire Council

Wiltshire Council

Health and Wellbeing Board

16 July 2015

Subject:

Purpose of Report

1. For the Board to note progress on the Adults Social Care Transformation Programme since the last report in September 2017.

Background

2. The Council, CCG and all health providers (GWH, SFT, RUH, WH&C, AWP) first met on 5th April 2017 to agree the Adult Social Care Transformation programme and the use of the additional social care monies provided to Wiltshire Council.

3. The ASC Transformation Programme aims to deliver sustainable services that support individuals to maximise their independence and build on their individual strengths and those of their families and communities. The key areas of focus for Wiltshire Council in designing an appropriate service have been:
   - Developing a model of prevention
   - Developing a reablement service that supports Home First
   - Increasing capacity in the domiciliary care market
   - Reviewing the residential and nursing care home capacity
   - Redesigned customer journey

   Progress to date is set out below.

4. Developing a model of prevention

Wiltshire Council has conducted a Systems Thinking review of both how it manages demand at the 'front door' and the overall customer journey through the service. It recognises that customer outcomes for independent living would be better provided through improved early signposting to community support and that this will prevent escalation into more costly interventions in both health and social care. A number of models were considered and it was concluded that the most appropriate one for the Wiltshire setting is Local Area Coordination (LAC). Recognising the potential for benefits across the system, partners were invited to a presentation on the LAC in July 2017 and in December 2017 the STP agreed funding of £40k to assist the Wiltshire team to plan, implement and develop a LAC pilot, using expertise gathered from national schemes. Wiltshire Council has also agreed further funding to resource the implement of the LAC pilot and the establishment of

appropriate governance and project management of the scheme will commence early in 2018.

5. **Commissioning Intentions and market Position Statement**

   Additional capacity has been brought into commissioning to further develop current strategies in Learning Disabilities and Autism and work has commenced on the development of an Older Persons and Accommodation Strategy to meet the housing needs of people who are eligible for services. The strategies will form the building blocks for the Market Position Statement which will enable providers to better understand the strategic commissioning and procurement intentions of the Council.

6. **Domiciliary care market development**

   Cabinet approved in December a recommendation to cease all HTLAH contracts by the end of October 2018 and to establish new contractual frameworks with providers which are fit for purpose and better able to meet the needs of the Wiltshire community. Notices were served upon existing providers at the beginning of the month and extensive engagement activity is planned across Wiltshire to create a new contract and attract a much broader provider representation for the new contract commencing in November. The decommissioning of a contract of this size will undoubtedly carry some risks, but the attendant benefits in terms of creating a much broader and more vibrant market that is able to meet the supply demands and maintain people in the community, greatly outweigh these risks. Contingency activities through early market engagement, the creation of a new reablement service to reduce demand and release market capacity and an innovation grant to stimulate market growth and development are amongst a number of initiatives being deployed to achieve a seamless transition and create an infrastructure to accommodate new ways of working and support and encourage new providers within Wiltshire.

7. **Reablement and Customer Journey**

   Linked closely to this will be the establishment of a new in-house reablement service who will work alongside our strategic health partners, Wiltshire Health and Care (Home First service) to manage demand and create market capacity within the County.

   The community services activities described above are vital to the success of the new model for Adult Social Care in facilitating community resilience and service demand management through focusing activity much earlier within the customer journey and targeting resource on those areas most in need.

   Consultations will be happening with staff affected by the new model of social care.

8. **Learning Disability Market**

   Work is underway in a number of areas. The development of the commissioning strategies described above is further supported by the development of new commissioning frameworks for Residential and

Supported Living Services, both of which will come into effect in mid-2018. These will align with the overall vision of supporting individuals to maximise their independence. These will incorporate the current work that is being completed with the market around the cost of care using the Care Funding Calculator as well as the progression model, ensuring that people with learning disabilities live their life was independently as possible. Further market engagement will and the refresh of the market position statement will ensure that Wiltshire is able to accommodate and develop services that meet the needs of service users now and in the future.

Next Steps

9. It is intended that the redesigned Adult Social Care service, the reablement service and the increased domiciliary care capacity will go live in May 2018.

10. Phase 2 of the Transformation Programme will be scoped, to include specialist services and how to maximise benefits across the social care and health system following the existing Phase 1.

11. The Transformation Board will continue to meet monthly. It is responsible for monitoring progress against the programme plan and timeline. The Transformation Programme also reports to the Joint Commissioning Board.

Graham Wilkin
Interim Director of Adult Social Services
Wiltshire Council

Report Authors:
Paul Grubic, Transformation Consultant, Wiltshire Council
Catherine Dixon, Portfolio Manager, Programme Office, Wiltshire Council

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Wiltshire Council

Health and Wellbeing Board

25 January 2018

Subject: Joint Health and Wellbeing Strategy Progress Report

Executive Summary

The Progress Report outlines the progress made in delivering the objectives of the Joint Health and Wellbeing Strategy (2015-18) to the end of 2017. It follows the format and layout of the Strategy to enable easy comparison. Notable progress has been made in a range of areas across public health, children and adults' health and social care and integration of services generally.

Proposal(s)

It is recommended that the Board considers the progress made in delivering key objectives over the last year.

Reason for Proposal

A commitment to providing progress reports was made when the current Joint Health and Wellbeing Strategy (2015-18) was agreed by the Board.

Baroness Scott of Bybrook OBE — **Leader, Wiltshire Council**
Dr Richard Sandford-Hill — **Chair, Wiltshire CCG**
Chair and Vice Chair of Wiltshire Health and Wellbeing Board

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Wiltshire Health and Wellbeing Board 2017 Progress Report

NHS
Wiltshire
Clinical Commissioning Group

Wiltshire Council
Where everybody matters

Welcome

We are delighted to introduce this report, setting out some of our recent achievements against the priorities in Wiltshire's Joint Health and Wellbeing Strategy.

The current financial climate places a clear imperative on Wiltshire CCG and Wiltshire Council to develop models of care that are both robust and sufficiently flexible to be responsive to changing needs, aspirations and technological advances over the next decade and beyond.

We are pleased that a range of schemes have been implemented to provide greater emphasis on prevention, supporting people to manage their conditions and to improve signposting to preventative services. Alongside this, investment in community focused provision, the development of locality based integrated teams, support for primary care and continued joint commissioning of an integrated urgent care service and Home First to avoid admissions are all contributing to efforts to reduce length of stay in hospitals and support discharge.

A particular focus for the Board is how health and social care can work more closely together for the benefit of Wiltshire patients and service users. Over the next year we will be working on further enhancing our collaboration, placing prevention at the heart of our vision to increase the healthy and productive life years of people living in Wiltshire.

Our vision is that our services should work seamlessly together to support and sustain healthy, independent living. This report highlights the progress made during 2016 and 2017.

Baroness Scott of Bybrook OBE,

Chair, Wiltshire Health and Wellbeing Board Leader, Wiltshire Council

Dr Richard Sandford-Hill

Vice Chair, Wiltshire Health and Wellbeing Board

Chair, NHS Wiltshire Clinical Commissioning Group

Our aims for Wiltshire:

Aim 1: Healthy lives

Our first aim, healthy lives, means encouraging and supporting communities, families and individuals to take more responsibility for their own health and wellbeing through health promotion, protection and preventive activities.

Aim 2: Empowered lives

Empowered Lives means care should be personalised and delivered in the most appropriate setting, wherever possible in the community and at, or closer to home.

Aim one Healthy lives

Our first aim, healthy lives, means encouraging and supporting communities, families and individuals to take more responsibility for their own health and wellbeing through health promotion, protection and preventive activities.

Ongoing areas of delivery include:

Set out below are details of progress against the ongoing areas of delivery outlined in the Joint Health and Wellbeing Strategy for Wiltshire.

Children

Child Poverty reduction – Wiltshire's Reducing Child Poverty Strategy 2014-2020.

Child Poverty Community Area Profiles which have now been presented in all of Wiltshire's 20 community areas to engage local communities in tackling child poverty. The profiles include detailed information on the age breakdown of children living in low income households; health indicators relating to poverty; educational attainment; and information on worklessness and unemployment. The community engagement managers have played an important role in organising engagement activity and taking forward action from these dissemination sessions and there is now a range of activity taking place across Wiltshire to prevent, reduce and mitigate against the effects of child poverty.

In some areas local action has included the establishment of specific working parties and strategy groups to take forward a programme of work. Others have undertaken local service mapping and engaged with local services such as housing providers to develop youth projects. Some areas have used the profile

data to evidence needs to influence and inform decisions on grants and priorities. A number of Area Boards have also supported local schools to take part in Wiltshire Healthy Schools Programme. Almost all of the Community Areas, often in partnership with Town and parish Councils and Children's Centres now have smoke free playground signage. The signage protects children from exposure to cigarette smoke and from seeing adults smoking, helping to de-normalise smoking behaviour.

In addition, the Reducing Child Poverty Strategy steering group have held themed workshops on to engage wider partners in addressing the objectives of the strategy. One of these focused on housing, health and child poverty and another focused on narrowing the educational attainment gap and highlighted the importance of early intervention and also strengthened links with the Disadvantaged Learners Team.

A Wiltshire Child Poverty Summit took place in November 2017 to engage stakeholders and showcase local achievements and share learning across the County.

Local Transformation Plan for Children and Young People's Mental Health and Wellbeing

This plan replaces the children and young people's emotional wellbeing and mental health strategy and continues to bring Children's Trust partners together from across education, health and social care (including the voluntary and community sector) to implement new initiatives and services that are focused on making it easier and quicker for children and young people to access good quality emotional wellbeing and mental health support within their communities. With children and young people involved every step of the way, key achievements to date have included the successful launch of an online counselling services for teenagers and the co-location of mental health workers in many secondary schools.

A modern Child and Adolescent Mental Health Service is also being developed across Swindon, Wiltshire and Bath and North East Somerset, to go live on 1 April 2018. Key improvements shall include a bigger focus on early intervention and prevention, providing easier access to the right support and improving care for our most vulnerable children and young people. In 2016 the Local Transformation Plan was expanded and refreshed, setting out progress and local priorities for improvement. The plan was endorsed by the Health

and Wellbeing Board in December 2016. Developments are already beginning to transform and improve service provision, with Wiltshire performing well against many key performance indicators in a recent national report by the Education Policy Institute. Overall, Wiltshire is a good performing local authority area despite a modest per capita expenditure on CAMHS.

Child Health Improvement strategy

The Child Health Improvement Strategy (CHIS) has oversight of the delivery of the Healthy Child Programme 0-19 years and performance on health indicators relating to this. Health Visiting and Family Nurse Partnership continue to deliver the Healthy Child Programme 0-5s while School Nurses continue to deliver the 5-19s programme in school settings.

The CHIS also oversees specific streams of work relating to key health outcomes including injury prevention, healthy weight in children and developing young people friendly health services. There has been good progress on these and other areas over 2016/17. The multi-agency Wiltshire Young and Safe Group has developed and implemented an action plan to address prevention of unintentional injuries among 0-24 year olds. This has included provision of training for key frontline staff and related campaigns for example in relation to product safety and to prevent choking among young children.

Wiltshire's Life course Obesity Strategy was launched in 2016 and there has been good progress on implementing Strategic Priority 2 – ensuring children have the best start in life. Latest data from the National Child Measurement Programme (NCMP) where children are weighed and measured in Year Reception and Year 6 shows that levels of excess weight among children in Wiltshire are staying relatively stable despite national increases. This year has seen the launch of a specialist healthy lifestyles in pregnancy service which provides support to pregnant women to achieve and maintain a healthy weight. In addition the pilot of the Healthy Me healthy lifestyles and weight management programme for children aged 7-11 years has been very successful and is being rolled out across the county.

A new Wiltshire Young People Friendly (YPF) self-assessment pack has been produced for local services and rolled out to settings in 2016. In addition a quality assurance process has been developed for accreditation of services. No Worries GP practices, Sexual Health Services (CASH and GUM clinics) and School Nurse Drop-ins have been prioritised over 2016/17 and of these services most have achieved accreditation and those remaining should achieve this over the coming year. The YPF process has given settings an opportunity to reflect on their practice with young people, to ensure they have a well trained workforce,(some actively recruiting young people to support YPF) and the ability to offer a confidential and accessible health and wellbeing service, where young people are welcomed. Several settings have improved their offer and are sharing best practice.

Children's Community Health Services

Following a joint recommissioning exercise between Wiltshire Council, Wiltshire CCG and NHSE, Wiltshire Children's Community Health Services transitioned to Virgin Care as the new provider from April 2016. The new contract brought together a wide range of services and future plans include developing a single point of access for children and families. Public health nursing is a substantial part of the service and is commissioned to deliver the Healthy Child Programme, an evidence based programme designed to achieve positive outcomes for all children from pregnancy to 19 years. Services involved are Health Visiting, School Nursing and Family Nurse Partnership targeted at vulnerable first time parents.

Risky behaviours work (children)

The No Worries service offers a range of confidential sexual health services to young people aged 13 - 24. During 2016/17 974 young people were able to access these services through primary care centres who supported them in receiving a range of age appropriate services. 79.76% of respondents who were asked to rate the service reported it as excellent or very good, with a further 17.86% rating it as good. This feedback enables the service to review its objectives and continue to adapt to meeting the changing needs of young people.

Due to continued partnership working with a range of organisations the teenage pregnancy rate in Wiltshire continues to fall and is the lowest it has been since records began at a rate of 14.0 per 1,000 young women (below the national average of 23.0 per 1000 young women).

Using the cultural sector to engage young people

Chelsea's Choice is a powerful and engaging production highlighting the serious issue of sexual exploitation among young people through theatre. The production was commissioned and shared with schools and colleges in Wiltshire in 2016 and each production was followed by a plenary discussion session to enable young people to explore and discuss some of the themes raised in the play. The production was primarily targeted to under 16s thought but schools may have included older students in performances. Wiltshire College had a performance at each campus in November 2016. As a legacy of this work CSE continues to be addressed through the PSHE programme in schools and also there is information for young people on the Wiltshire council website.

There are a number of nationally recognised organisations supported by the Arts Council (NPO's): Wiltshire Music Centre, The Pound Arts Centre, Salisbury Arts (a new collective arts council funded project- Salisbury festival, Salisbury playhouse and Salisbury arts centre). Additionally, there are various independent and grant funded organisations across Wiltshire and beyond who deliver work regularly to a variety of groups of young people.

Example projects:

- Salisbury Playhouse- Inclusive Youth Theatre. All youth theatre groups embrace a mixed ability community of participants- additionally working with hospital settings. They are also working with military groups/ young people and building on this.
- Salisbury Playhouse-Partnership with local SEN School Exeter House and Performance Project. Prioritising opportunities for SEN students to perform on a professional platform
- Salisbury Festival- Young Carers Respite Days- Creative learning opportunities for NEET young carers, including Arts Award
- Zone Club with Wiltshire Music Centre and Salisbury Arts- A monthly music project supported SEN/D young people.
- Wiltshire Music Connect- Music Hub for the county have led and supported/funded work with young people across Wiltshire in a variety of settings- be it formal learning (school) or non formal settings.

Work with employers on workforce health strategies

The health trainer service support workplaces across Wiltshire including Royal Mail Depots, waste depots and several MOD sites. Specific campaigns have included the roll out of Public Health England's 'One You' campaign and also encouraging staff to participate in the annual 'Wiltshire Big Pledge' campaign.

Multi-Agency training for improving skills to intervene with a person at risk of suicide:

The Public Health team have been involved in a regional programme [funded by Health Education England] to provide ASIST suicide intervention skills courses for individuals from a wide range of organisations. This internationally renowned course is designed to improve the skills of people in communities who may come into contact with someone at risk of suicide and give course participants the confidence to take proactive steps to help. Four courses have been delivered in Wiltshire during 2016/17 to 72 members of staff and volunteers. Feedback has been positive and many participants have been called upon to put their new skills into practice very shortly after attending their training course

Active Travel and Air Quality Management

Wiltshire Council is continuing to work towards improving air quality across the county. The Air Quality Strategy has been refreshed and will be going out to public consultation this summer and the dedicated air quality website, which includes the 'Know and Respond' text alert service continues to provide valuable and up to date information and monitoring data. Many opportunities to promote 'Active Travel' as a means of improving air quality and people's health and wellbeing are taken, most recently with the trial of the 'HomeRun' app which has been sponsored by local area boards for 9 schools across the county. This initiative is designed to help parents with car sharing and active travel to and from school.

An active travel group has been formed to ensure that collectively teams within Wiltshire Council are working together to support active travel planning and help promote both internally within the council and externally.

Stop Smoking Strategy

A comprehensive plan is in place to reduce smoking prevalence and tackle tobacco control in Wiltshire. In 2016-17 General adult population smoking prevalence has further reduced 13.9% compared to 14.3% in the previous year and is the lowest smoking prevalence on since records began.

9.7% of women were smoking in pregnancy in Wiltshire at the end of 2016-17 compared with 10.8% for England. Local maternity services are commissioned to provide specialist intensive support to pregnant women to stop smoking.

Families, Adults and Older People

NHS Health Checks

Wiltshire achieved 50% uptake in 2016/17 for the NHS Health Check Programme, which was a 9% increase on the previous year. The NHS Health Check programme is delivered by GPs and provides a cardiovascular disease risk assessment every five years for eligible residents aged 40-74 resulting in a tailored package of healthy lifestyle interventions to improve health and wellbeing and reduce risk of cardiovascular disease.

Sexual health

Access to effective methods of contraception is important to ensure that everyone is able to have healthy sexual relationships, facilitating positive choices for them and their lives. The Public Health team worked closely with primary care sites across Wiltshire to enable women to access various forms of Long Acting Reversible Contraception (LARC) methods in additional to the more traditional methods such as 'the pill'. During 2016/17 4,406 women were fitted with a LARC device which lasts for at least five years.

Infection prevention and control and medicines management

Work continues on raising awareness of flu and the importance of getting immunised. Different ways of delivering this message before the flu season have been trialled, including vaccinations in pharmacies and working with nursing homes. A new immunisation programme has been introduced for children in primary years 1 and 2. This will be undertaken in the schools themselves using school nurses.

Within Wiltshire Council, 913 members of staff were vaccinated last year, compared to 674 in the previous year. In preparation for winter, Wiltshire Council has facilitated a Pandemic Flu exercise involving all health care providers in Wiltshire and Swindon, social care and other members of the Local Resilience Forum (LRF)

Arts and cultural interventions in health and social care contexts

There is a growing body of evidence that shows that by increasing access to and participation in arts and cultural activities we can improve people's overall wellbeing, bring communities together and reduce isolation for those most at risk. Our 'ArtLift' arts on prescription scheme was first established in 2014 and has since been running in five 'pilot' GP practices across the county. The programme operates through health professionals referring patients affected by mild anxiety or depression for an 8 weekly art sessions. The project has an innovative approach to sustainability involving 'move on' groups established and run by the participants themselves once their initial funded programme is complete. Two of the GP

practices involved have secured further funding from alternative sources enable them to continue referring new participants when the funding for the pilot comes to an end. Independent research by the University of Gloucestershire has shown that participants have a statistically significant increase in their wellbeing after completing the course.

Community centred approaches – action planning, volunteering, peer support groups, befriending initiatives, social prescribing

The Volunteer strategy (2017-2021) has been updated to support volunteering in the community.

The Leg club model is set up in several locations and continues to be a success, also identifying issues of loneliness and mental health problems. The groups have also led to other activities such as 'Falls prevention' exercise classes.

Encouraging people to be more responsible for their own health

Community health trainers have been based in all our community areas to help people to eat more healthily, to attain a healthier weight, to stop smoking, to get more active, to drink less alcohol or to generally improve their wellbeing. Health trainers help clients to develop healthy habits that will improve their lives. In 2016-17 community health trainers helped around 800 clients to make positive lifestyle changes.

The latest activity survey data for England shows that Wiltshire has one of the lowest rates of physical inactivity in the country and is the most active upper tier authority area. Through these programmes Wiltshire has continued to increase participation in attendance at leisure centres to 3.3 million a year, grown swim school memberships by 21% to over 6,100 members and increased fitness memberships by 41% to over 8,600 members.

Active Health is the Wiltshire Council service in leisure centres that provides physical activity opportunities for those referred by a medical professional. There can be many different reasons for referral and different exercise programmes are available across the county in leisure centres, at a reduced rate. The programmes include general exercise programmes, cardiac rehabilitation, exercise after stroke, and falls prevention, together with specialised support for a number of other long term health conditions.

Annually over 3,100 people are referred into the Active Health service by health care professionals. 26% are from the most deprived population, 38% are aged over 60. Although not necessarily the primary reason for referral, many of those referred are overweight or obese, and 70% of participants lose weight. The Active Health specialist exercise after stroke classes were reviewed independently by Glasgow Caledonian University which found that people with a history of stroke (some from quite a long time ago) could still improve their functional abilities and reduce their falls risk significantly within 14 weeks.

Get Wiltshire Walking is a Wiltshire Council service provided by volunteer walk leaders which aims to ensure every community within the county has access to a free weekly led walk. Walking is the lowest risk of all physical activities yet produces massive benefits to physical fitness and mental wellbeing. There are 31 weekly led walks in 18 locations throughout the county, with 157 volunteer walk leaders and over 2,400 registered walkers. The volunteer walk leaders benefit from the challenge and purpose offered. Walkers benefit from reduced social isolation, decreased depression, and help with weight loss and control of their blood pressure.

Wiltshire's Big Pledge activity challenge in 2016 had a 'Road to Rio' theme with over 18,100 participants, including 47 schools. Some schools continue to undertake their 'Daily Mile' activity and have more children walking, scooting or cycling to school.

A new, shorter and more accessible breastfeeding peer support training programme was developed and implemented in 2016-17 and over 60 new volunteers were trained. The service provides an important source of social and peer support that complements advice and support provided by health professionals to help women establish breastfeeding.

Warm and Safe Wiltshire has created a single point of contact cold homes referral service, to support people living in cold homes and with health conditions exacerbated by cold and damp conditions (including those discharged from hospital) to receive in-depth advice and grant aided heating and insulation measures. The project has successfully supported residents across Wiltshire with in-depth advice and case work on a wide range of topics

including heating and insulation improvements, switching energy providers, signing up to Scottish and Southern Electricity Network's (SSEN) Priority Services Register (PSR), claiming the Warm Home Discount and other grants as well as onward referrals to the Fire Service, Citizen's Advice and other relevant support services. The service also collaborated

with the Royal College of General Practitioners and local GP practices, contributing to a system wide, integrated approach to reducing fuel poverty and excess winter deaths in Wiltshire.

The Safe and Independent Living (SAIL) project has been implemented in partnership with Dorset & Wiltshire Fire and Rescue Service. The aim of SAIL is to provide a multi-agency referral approach to enabling access to signposting, support, and services, which are particularly beneficial to those who are aged 50+ or experiencing vulnerability. SAIL provides access to information, services, and support which will ensure preventative measures are accessed as early as possible, and promote health and well-being.

Health in all policies

The public health implications of all of Wiltshire Council's key policies are now taken into consideration before decisions are made. The public health team have engaged with academics and the spatial planning team through topic specific workshops to consider the delivery of best practice in planning for healthier environments. Wiltshire CCG is also developing quantifiable ambitions for improving public health through their work.

Strategy Development in 2016-17

Update the obesity strategy

Wiltshire's Obesity Strategy was launched in September 2016 and was supported by a comprehensive implementation plan that was launched at the Obesity Summit in July 2017.

Update Children and Young People's plan

The high level 3 year refreshed Children and Young People's Plan builds on previous achievements and sets out how multi-agency partners will continue to work together to achieve positive outcomes for children and young people – to be healthy, safe, enjoy and achieve, make a positive contribution and achieve economic wellbeing. Although Children's Trust arrangements are no longer mandatory, in Wiltshire we have made a collective decision to continue to work together to make a difference. Key progress in the last 12 months includes:

- Transformation of Child and Adolescent Mental Health Services to improve access to the right support
- Continued development of early help services and troubled families work with a specific focus on the early years. The local Early Help Strategy is currently being updated and an Early Years Board has been established
- Children's community health services have been brought together under one provider to improve children's health and development
- Improving support for children with SEN/disabilities, including short breaks, development of the children's learning disability nursing service and expanding post-16 provision
- Working with schools to improve attainment of disadvantaged learners

Delivery plan for Early Help Strategy

The Early Help Strategy 2014-2017 sets out the expectations for delivering effective early help to all vulnerable children and young people living in Wiltshire, including children living in 'troubled families'. Having achieved many of this strategy's objectives, work has now begun to review the strategy for 2018-2021. The focus will be on complex families and the parenting provision that is available to them. There will be a strong emphasis on a multi-agency approach, supported by service transformation in line with the Troubled Families initiative. The Troubled Families initiative encourages close working between Job Centre Plus and the local authority, two employment advisers are funded by the JCP to work with eligible families, as the focus continues to be on employment and the benefits that it offers.

Within Wiltshire Council the Children's Service Integration project aims to deliver an increased focus on prevention and seamless outcomes focused and family focused services. The first phase is concentrating on the blending of council Early Help and Safeguarding & Assessment. The second phase will be about exploring, with staff, partners and service users, the best way of delivering truly integrated, family-focused provision looking at all those council children's services which were not in scope for phase 1. Phase 1, currently being implemented, involves:

A. A whole-family, relationship-based model of practice will be introduced with training.

B. A single front door into operational children's services.

C. Blended Teams (across early help and social care) for higher need cases. Wherever possible it is proposed that workers at all levels will stay with the child throughout their journey to minimise handovers and enable strong relationships with the family to be formed.

D. The introduction of a new keyworker role to work directly with families and remain with them through different levels of need, assisting them to set family goals and referring to experts and specialists where appropriate. It is proposed that these keyworkers will work in pods alongside social workers and will drive the shift to a holistic family based model of practice.

E. A geographical hub and pod-based dispersal of staff with local allocation of resource and workflow; local, high quality advice and guidance that can be offered for all referrals not meeting thresholds.

Update the Anti-Bullying Strategy (schools)

An Anti-Bullying Charter was developed in consultation with young people and distributed to all Wiltshire schools during 2017. We continue to work with a range of local and national agencies to enable schools to access training and support to address bullying. Almost 10,000 children and young people from 95 schools were surveyed about their experience of bullying during 2017 which will inform future activities. Young people are developing a series of podcasts for Anti-Bullying Week in November 2017 to support the theme of 'All Different, All Equal' and highlighting good practice in coping with bullying behaviour; these will be available online.

Update the Domestic Abuse Strategy

The domestic abuse health needs assessment has been completed and work on the new strategy began in 2017. Procurement of the new domestic abuse and independent sexual violence advisory (ISVA) service started in September. The new model includes a range of services addressing the needs of those in the county who are affected by domestic abuse and sexual violence. The new service brings together services for victims and their families that were previously separately commissioned. There will be a single access point meaning that all Wiltshire victims of domestic abuse and sexual offences will be provided with a tailored specialist support service(s) appropriate to their risk and need. Service delivery will consist of four intertwined strands:

- Victim focussed support addressing both domestic abuse and sexual violence
- Support for children and young people living with the impacts of domestic abuse
- Work to address perpetrator behaviour, as part of a whole family approach
- Provision of safe, flexible accommodation accessed to all at greatest risk fleeing domestic abuse

Update on Alcohol Delivery Plan

The Wiltshire Alcohol Strategy was approved in April 2015 and sets out four key themes of prevention, intervention, treatment and engagement. To move the strategy forward multi-agency meetings have developed an implementation plan with ongoing monitoring of its delivery. A communication plan has been developed and delivered alongside an increased focus on outreach promoting positive public health measures and offering support to hard to reach groups. Examples of this include the attendance of Turning Point at Wiltshire festivals like Womad:

Engagement has taken place with Area Boards to help make links with the over 55 population, to encourage responsible drinking and to improve access to community activities not linked to alcohol.

A pilot has also taken place with the Multi Agency Safeguarding Hub, placing a substance misuse recovery worker within the team.

Update Volunteering Strategy

Wiltshire's Volunteering Strategy was updated in 2017. It shows the areas of the council where volunteers assist and details community engagement involvement and the concept of using 'project banks' to set up projects in the 18 community areas.

Ongoing areas of delivery include:

Children

Services for looked after children, young people and care leavers

Placement stability for looked after children is good with more children in long-term placements and, where required, children placed more quickly with adoptive families. More foster families are needed to enable looked after children to remain living in Wiltshire; we have a strategy in place to recruit additional in-house foster carers. The range of housing options available to our care leavers has improved and the number actively engaged in education or employment compares well to national averages. We are working to produce a Care Leaver Covenant (a set of promises to care leavers) with services provided via the Council, other statutory bodies, the voluntary sector and local industry. The Covenant will be launched early in 2018.

Families, Adults and Older People

Whole family support

The Troubled Families Programme in Wiltshire continues to offer support to families through early help services, such as children's centres and family support and also where more intensive support may be needed. There is a stronger focus in Phase 2 on families with younger children so that early intervention can be facilitated. We now have two full time Employment Advisers funded by Job Centre Plus who work with parents to encourage them into work by developing their CVs and sourcing volunteering as well as employment opportunities. The programme is about whole service transformation and we will shortly be assessing our local progress in implementing the Troubled Families Programme against the standards recently developed by the Troubled Families Unit. Links are being made between the Troubled Families Programme and the Council-led Children's Services Integration project.

Joint health and social care assessments and plans

The adult care transformation programme is working on streamlined processes and assessments, including trialling an approach to much more simple assessments.

Employment support for those with a long term conditions

Work has progressed since the last report. The models in Wiltshire across all groups have continued to move away from the previous models of preparing and training people to enter into work, and are now placing people with an employer, and then training them in the job. Mapping of available employment support for people has been undertaken to enable services to link up and avoid duplication and this is working well.

Seven day services

Most social care services are provided 7 days a week, and more work has been undertaken to allow new services to start at weekends, rather than waiting for a weekday. This includes admission to intermediate care beds, and extended provision of Urgent Care at Home.

Urgent care at home and intermediate care in the community

Urgent care at home is available 24/7 to prevent an inappropriate hospital admission and support hospital discharge. Since the service started in November 2013, nearly 2,514 people have been supported by the service and over 2,073 hospital admissions avoided. The

service receives, on average 61 referrals per month. 66% of these will avoid an unnecessary admission to hospital, and 34% will support someone to be discharged from hospital.

There are 70 intermediate care beds jointly commissioned across 10 care homes in the county. These deliver short-term support and rehabilitation to avoid an unnecessary admission to hospital, or to support people following a stay in hospital. Approximately 50 people are admitted to these beds each month and 60% of people who are discharged from an intermediate care bed return to be independent in their own home.

A new short-term rehabilitation service called Homefirst is being provided by Wiltshire Care and Health community NHS services. This service will support people who are discharged from hospital to regain independence. It will be evaluated over the coming year.

However, delayed transfers of care (DTOC) are a significant issue for Wiltshire. A transformation programme implemented across Adult Social Care will improve flow and the rates of bed days lost. Short term solutions for winter are an increase in domiciliary care capacity, increase in intermediate care beds capacity, Social care Occupational Therapists based in hospital social care teams. A DTOC task and finish group has been established between the Council and CCG to ensure we are responding at pace to the current issues.

Telecare

Telecare provides an important part of the offer to help people remain independent at home. The council currently supports over 2,500 through the Telecare service made up of a mixture of people in sheltered accommodation or in their own homes. The service also supports around 450 people who have bought the service privately. The call monitoring service receives approximately 10,000 calls per month and the response service makes, on average, 280 home visits per month.

Information portal – Your care your support and the Local Offer

Yourcareyoursupportwiltshire.org.uk is the adult social care information and advice portal. Nearly 8,000 people have visited the site in the last 3 months (May-Jul 2017), looking at 38,301 different pages. The average time on the site is just over 3 minutes. The most popular pages are:

1. Do I have to pay for care and support services?
2. How do I get care and support in Wiltshire?
3. The interactive guides section
4. Health and social care in Wiltshire
5. The services directory

Feedback on the website is mixed, and the search function is limited. The Council will be replacing yourcareyoursupportwiltshire.org.uk during 2017-18 with a site which is easier to use and gives much more local results. The new site will also allow customers to undertake their own financial assessments and receive more specific and tailored information about services.

Personal budgets and personal health budgets

From 2014, patients eligible for NHS continuing health care (including children's continuing care) have the right to request a personal health budget. From the 1 April 2015, those patients with a long term condition (including mental health conditions; aged 18+) have also had the right to request a personal health budget. A phased rollout of personal health budgets is being implemented on a test and learn basis. Wiltshire CCG is completing a detailed analysis to understand how personal health budgets can support patients to take greater control of their own care, and in the future hope to increase the numbers of patients with their own personal health budgets. Whilst it is not always possible to provide a personal health budget which results in direct payment; NHS professionals work with individuals to identify ways to create a personalised care plan, putting individuals at the heart of their own healthcare decision making. A goal detailed within the NHS Planning Guidance is that 50-100,000 people nationally should have a PHB by 2020. Wiltshire CCG has undertaken to implement their share of their residents on a pro-rata basis.

As at July 2017, 99% of people with funded support at home from Wiltshire Council now have a personal budget for social care.

Strategy Development

Rollout integrated Education, Health and Care plans (EHC)

The Council's SEND Service continues to work closely with health partners to ensure that existing Statements of Special Educational Need are converted into Education, Health and Care Plans which have a strong focus on understanding need, the child/young person's wishes and feelings, and the level and type of support required to meet these.

Develop a Primary Care Strategy for Wiltshire

Wiltshire CCG recognises the pivotal role of Primary Care, which is provided by GP practices, in the access to and the delivery of high quality care. The CCG developed a three year programme, beginning in 2016, called the Primary Care Offer (PCO), which is designed to move away from providing care through the traditional model based on transactional activity. Instead, individual practices now work to a model of place based commissioning, which means working across larger localities, to deliver Primary Care services at scale. Wiltshire CCG has invested £3 per registered patient through the PCO since 2016/17, to encourage and support practices and localities to be able to use resources in a more efficient and effective way and, in some cases, to combine income streams to deliver improved outcomes for patients.

Good examples of this are demonstrated in the way teams now work together to support older people, and the success of the popular 'Leg Clubs'. The PCO directly supports the development of new integrated care models, aligning and integrating primary care services with other services which are delivered away from a traditional hospital setting.

In April 2016 NHS England published the NHS General Practice Forward View (GPFV). The GPFV sets out specific, practical and funded steps against five programme areas: investment, workforce, workload, infrastructure and care redesign.

In Wiltshire, investment in the development of a local Community Education Provider Network (CEPN) is progressing. A major focus of this programme, which is led by clinicians, is on supporting GP practices to identify their future training needs, so they can be in a position to collaborate, develop new staffing models and identify and commission training to suit the needs of their staff. Many practices are now sharing clinical staff, and some have plans to share staff across other functions such as administration and finance, through practice mergers and federations, locality working and older persons teams amongst others.

Wiltshire CCG is adopting the general principle of 'recruit, retain and train' to support practices whilst

they are developing these new ways of working. Practices have been able to bid form funding through a Clinical Pharmacy Pilot, and many GP practice now have pharmacists based within their own practice, supporting medications reviews, reviewing prescribing activity and dealing with patient queries and support. Innovative schemes funded by the CCG through the Primary Care Offer include specialist older person's teams, specialist nurses and emergency response practitioners, supported by apprentices across the fields of clinical care, administration data support and IT. Learning is shared across Wiltshire and the network of localities, and there is increasing interest in these more specialist and varied roles.

From 1 April 2017, NHS England delegated responsibility of primary medical services to Wiltshire Clinical Commissioning Group (CCG). This offers the opportunity to align incentives with wider health and social care planning and provide many more integrated services in the community.

Wiltshire CCG has also led a recent procurement for an Integrated Urgent Care service. This will deliver a more functionally Integrated Urgent Care Access, Treatment and Clinical Advice service model, aligning existing service specifications for NHS 111 and the GP Out of Hours service, in line with the national direction set out by NHS England. Specifically, the new service includes a new clinical advice element: the clinical hub. This model will direct patients to a wide range of clinicians, both experienced generalists and specialists, when they require their support. It will also offer advice to health professionals in the community, such as paramedics and emergency technicians, so that no decision needs to be taken in isolation. The service will commence in May 2018.

Action plan for the Wiltshire Mental Health and Wellbeing Strategy

The Joint Mental Health and Wellbeing Strategy (CCG and Council) was published in May 2015. The initial implementation plan to deliver on its aims was developed by the Mental Health and Wellbeing Partnership Board and detailed the action we planned to take during the first two years of the strategy. Considerable progress has been achieved against the actions in this plan, and these were outlined in progress reports presented to the Health and Wellbeing Board in October 2016 and May 2017. A refresh of the implementation plan has recently been commissioned and will be an opportunity to ensure that the action for the next 2 years reflect the recommendations of the NHS Five Year Forward View for Mental Health and the evidence presented in the recently completed Mental Health Needs Assessment for Wiltshire.

Suicide prevention

In Wiltshire, a suicide audit is undertaken every three years to identify any themes or priorities across the county which alongside the national priorities for suicide prevention assist on the development of a multi – agency suicide prevention plan.

Implement whole family and joint health and social care assessments and plans

The Council works closely with Carer Support Wiltshire who undertake assessments for carers and social care and will provide flexible packages of care which can support the whole family.

Review the Voluntary and Community Sector Strategy

In the Autumn of 2016, commissioners responded to request from the sector and facilitated an initial Voluntary Health & Social Care Forum. The Forum was set up to ensure the third sector were engaged as a strategic partner and at the centre of developing an integrated care and support system for people living in Wiltshire. A Strategic Executive group was formed with three elected representatives from the third sector and senior representatives from the public sector including Wiltshire Council, CCG and Public Health. A VCSE Forum took place on 8 September 2017 and the VCSE strategy has been updated in light of this.

Put Mental Health Crisis Action Plan in place

Significant work has taken place reviewing s136 pathways in Wiltshire, winning additional funds for investment in improved places of safety and delivering closer working with Swindon and partners elsewhere to reduce referrals from outside the area. The Board has received regular updates on progress.

Update the Learning Disabilities Joint Commissioning Strategy

The Joint Learning Disabilities Commissioning Strategy is being refreshed to cover 2016 – 2019. It is structured around four strategic aims to: improve choice and control; reduce health inequalities; increase access and availability of local housing options; and strengthen quality. Included in the strategy is the Transforming Care plan which came out of the Winterbourne View investigation.

Following a consultation with all key stakeholder groups, these are the four areas rated as most important;

1. choice and control
2. strengthen quality
3. use of health care services are equal for all and provide for people with learning disabilities
4. increase access and availability of local housing to enable people with learning disabilities to live as independently as possible.

This 'live' strategy will be reviewed frequently, to take account of the changing national policy agenda, and local developments informed by what we know about the changing needs and requirements of individuals.

Update the Autism Joint Commissioning Strategy

The Wiltshire Adult Autism Strategy 2017 – 2020 is an update of the 2010 – 2013 Joint Commissioning Strategy for Adults with Autism in Wiltshire. This refreshed strategy includes the views of people on the autistic spectrum. This strategy has been written after consulting with people in Wiltshire, to find out what they think the most important priorities are and what other improvements could be made over the next three years, 2017-2020.

This strategy will be implemented in the context of reduced public funding; our strategic aims will need to be delivered using existing and reduced resources, so the focus is on reshaping existing services to deliver any planned improvements. Together the priorities and proposed actions will support all adults on the autistic spectrum in Wiltshire to live within a society that accepts and understands them. The Wiltshire Autism Partnership currently supported by Wiltshire & Swindon Users Network (WSUN) continues to be active in Wiltshire working through the agreed action plan.

Aim two Empowering lives

Action plan for the Wiltshire Dementia Strategy

An Information Dementia Road Map/ Pathway Steering Group is underway to develop a formal 'route' of support. This will be used by professionals as well to ensure that there is consistency in referral to dementia advice and signposting services.

There was large scale publicity during Dementia Awareness Weeks; GP Surgeries - Dementia Advisors increased presence. The Dementia Aware Project has 4500 members of the public who are now dementia friends in Wiltshire – 265 GP practice Staff, all Wiltshire Council leisure and all library staff are dementia friends. The project has facilitated and supported Area Boards and local groups to become Dementia Friendly Communities (Dementia Action Alliances).

Update the Carers Strategy

Consultation on the new Carers' Strategy has been completed and an implementation plan is in place. The strategy identifies the following priorities: to maintain carers' health to enable them to continue caring (should they wish to); to holistically identify the needs of carers and the person they care for; to continue to invest in early intervention and prevention services; to improve the identification of young carers, carers of people suffering from mental health issues and carers of people who misuse substances such as alcohol and drugs; to support communities to become more carer aware and supportive of carers living within them.

A new Carers Service is being commissioned from April 2018 and many aspects of the implementation plan will be incorporated into the new service.

In October 2017, the Health and Wellbeing Board members signed a Memorandum of Understanding in support of an integrated approach to the identification and assessment of carers' health and wellbeing needs.

Integrated working

Delivering our two key aims and the vision of supporting and sustaining health, empowered living will require increased integration and cooperation between public health and primary, secondary and specialist health services – together with social care and other council teams. Progress on this is set out below.

Integration and Cooperation

Progress has been made in a number of areas:

- Integrated Care Teams have been rolled out across 20 locality areas in Wiltshire.
- Wiltshire Health and Care (a new organisation shared between the three major acute providers) is using well established and robust relationships, in order to deliver community services that work together and deliver better services and outcomes
- Children's centres services have been redesigned, integrating effectively with health visitor teams

In addition to the Active Health service provided in leisure and health and wellbeing centres across Wiltshire (covered elsewhere in this report), the leisure service is working closely with NHS primary and community health care services to improve access to health care services. The community cardiac service provides support to patients with heart failure from the Five Rivers health and wellbeing centre and other venues. NHS community physiotherapists also provide specialist classes in leisure centres to help patients manage their lower back pain.

Sustainability and Transformation Plan

A Sustainability and Transformation Plan has been developed with our partners in Swindon and Bath & NE Somerset. A short guide is available highlighting areas we are cooperating on. Wilts/BANESccg.nhs.uk/STP-short-guide-2017

Adult Social Care Transformation (ASC)

In February 2017, the LGA undertook a Peer Review, focusing on commissioning within Adult Social Care. The feedback from this review, coupled with an internal diagnostic, identified several areas for improvement and subsequently a transformation programme was established to redesign the service. The ASC Transformation Programme aims to deliver sustainable services that support individuals to maximise their independence and build on their individual strengths and those of their families and communities. The key areas of focus are:

- Developing a model of prevention
- Developing a reablement service that supports Home First
- Increasing capacity in the domiciliary care market

- Reviewing residential and nursing care home capacity
- Redesigned customer journey

This work is being undertaken alongside other activity in the Better Care Plan for Wiltshire.

Area Board activity on health

The Joint Strategic Assessment (JSA) programme is Wiltshire's partnership approach to the delivery of comprehensive and coordinated data and intelligence across public services in the local authority area. To improve the health and wellbeing of residents sustainably, Community Area JSAs were used by both communities and partner organisations to identify local priorities and reduce inequalities. This programme forms part of Wiltshire Council's approach to building stronger and more resilient communities.

During this process mental health was identified as a top priority for all community areas and this has emphasised the need to raise awareness of both the signs and symptoms of mental ill health and the things that individuals and communities can do to look after their own emotional health and that of others. The Public Health team has been working with area boards and community engagement managers to offer a one hour awareness raising session in communities. To date, this has been delivered to over 100 people in four community areas with further sessions planned for the remainder of this year.

Wiltshire Community Safety Partnership

The CSP is a multi-agency partnership, bringing together Wiltshire Council, Police, CCG, Fire and Rescue, Probation and others to create safer communities. Priorities during 2016/2017 included improving the response to domestic abuse, reducing crime and reoffending, tackling radicalisation, tackling hate crime, promoting cyber awareness to reduce crime and possible exploitation, reduce alcohol and drug related harm. The completion of the Wiltshire substance misuse needs assessment earlier in the year was undertaken to inform the required procurement process. One key finding was that there were areas of the county that had service needs but were not accessing treatment. This influenced a change to the existing model, which builds on the current successes made in providing treatment with increasing accessibility and having a focus on prevention and early engagement. The delivery model has further reach with the collaboration with Swindon and the inclusion of supported housing. The new specification introduces a new model entitled PACT which represents 4 key themes; Prevention, Accessibility, Collaboration and Treatment. This model was developed following a wide range of stakeholder events including service users, CCG Mental Health Commissioning, NHS England (Pharmacy), PHE, Children Services, Adult Care, Domestic Abuse Services, Maternity Services, Stop Smoking Services, Sexual Health, National Probation Service, Community Rehabilitation Company, Wiltshire Police and Wiltshire Office of the Police Crime Commissioner (OPCC).

Enabling Integration

Workforce Strategies

Delivery of the Wiltshire Workforce Strategy is well underway. In July 2017 a recruitment promotion website - www.proudtocarewiltshire.org.uk was launched. This promotes jobs in health or care organisations across Wiltshire, including the voluntary sector. The website links with each organisation's jobs pages so it provides central links for someone wishing to work in care but unsure about what sort of roles are available. It also links with a local authority initiative across the south west of England - Proud to Care - which has advertising and social media presence from July 2017. We are now expanding that collaborative approach to attending recruitment and career fairs during 2017/18 as Proud to Care Wiltshire representatives.

The Wiltshire Workforce Action Group, continues to meet and widen its membership as more representatives meet together to collaborate on joint initiatives. It has also been promoting the free, high quality resources available on the Care Certificate, required to be undertaken by all new recruits to care roles. Workforce development across the many GP Practices in Wiltshire is also being enhanced at pace through the Wiltshire Community Education Provider Network (CEPN) which is enabling practices to work together on training initiatives, including developing more placements for students – something which we know helps encourage recruitment of newly registered professionals.

During 2016/17 two new programmes of training took place across health and care in Wiltshire, including for new staff working in care homes and domiciliary care; and for coaching training to 162 staff. Across the wider footprint new initiatives promoting staff health and wellbeing have just begun and a network has also been established to support health and care organisations. Joint procurement of new education providers for apprenticeships has begun, as has some 'myth busting' about the opportunities the new apprenticeships give to new and existing staff.

Single View

Single View is sharing data electronically, between the partnership of Wiltshire Council, the CCG, the three acute hospitals, AWP and the Fire, Police and Ambulance services. Wiltshire Council ICT have developed a system where specific data from different systems and organisations is available to specific partnership across Single View.

The initial focus has been to support joint health and social care assessments and support plans from Wiltshire Council's Adult Social Care. ACIS (Adult Care Information Sharing) has been available to a number of GP Surgeries since first being piloted in earlier this year and is now being rolled out across all of Wiltshire's GP Surgeries. ACIS has been very well received:

"Single View has saved our Older Person's Team 3-4 hours a week. It reduces the phone calls we have to make to (the Council's) Adult Social Care team as we can find out about our patients' care packages through Single View. It's very easy to use and now a valuable tool for our staff"

The Bradford on Avon and Melksham GP Partnership.

"Single View is a definite improvement in patient care. Wiltshire Council has ensured it was set up with no fuss, that key staff have adequate training and that robust data sharing agreements are in place"

"We would not be without Single View's ACIS, it's invaluable"

Beversbrook Medical Centre.

Other data sharing has been setup; Wiltshire Police is sharing access to their Firearms Licencing data with Avon and Wiltshire Mental Health Partnership. This enables the Intensive Care Teams to search if their patients have access to firearms, thus ensure the patient's wellbeing and safety are appropriately managed. The Acute and Community hospitals are also interested in accessing ACIS when planning for the discharging of their patients.

In April, Single View was picked up Gold at the IESE 2017 Awards 2017, for "Transforming through Technology".

Market Position statements

Wiltshire Council are currently reviewing commissioning strategies and Commissioners will be working with providers over the next year to update Market Position Statements.

Shared plans for better use of estates and delivery of extra care housing

Wiltshire CCG is undertaking a large programme of work to ensure that the health estate is fit for purpose for the years ahead. Currently, many of the existing health facility buildings are ageing and in poor repair, and there is a growing space requirement for GP practices and other primary care services. Two major schemes are under development via the NHS England Estates and Technology Transformation Fund (ETTF), which is being invested in infrastructure and buildings in Devizes and Trowbridge (linked to the One Public Estate initiative supported by Wiltshire Council). In addition to estates infrastructure, the CCG is developing GP IT infrastructure to link to the Local Digital Roadmap.

A Strategic Healthcare Planning review in North West Wilts (specifically the towns of Chippenham, Melksham and Trowbridge) has been published to help determine options for effective and productive clinical models, patient pathways and appropriate clinical accommodation for the North West Wiltshire area. This work is a response to the scale of the large capacity gap currently existing in primary care estate, and has been facilitated by the approval of funds from the ETTF scheme to support requirements in Trowbridge. The CCG has decided to expand this strategic view wider via through a Strategic Outline Programme across all of Wiltshire to ensure the estates needs of the whole county are captured.

Needham House, a brand new 47 Unit Extra Care scheme in Devizes, and Nadder Close, a refurbished sheltered scheme in Tisbury, were both recently completed. Both of these schemes provide innovative and vibrant communal facilities that are aimed at serving the residents of the schemes and the

wider community. Another strand of Wiltshire Council's new build programme has been the design and construction of bungalows in rural communities to accommodate older people who require level access to their homes and showering facilities. In total the Council is building 5 new bungalow schemes, of which 2 have again been recently completed in East Knoyle and Rowde. These bungalows provide independent living for older people so they can stay within their local communities and/ or release family accommodation to younger people.

Work has also started on another 60 unit Wiltshire Council owned and managed scheme in Amesbury, plus we are looking to develop with our partners further Extra care schemes in Chippenham and Salisbury

Finally, Wiltshire Council is working with key housing partners to review the majority of existing sheltered schemes across the County to ensure they are fit for purpose and

continuing to meet the needs of the local communities. As a result, a number of these schemes will see investment to improve communal facilities, accessibility and the promotion of more independent living.

Cross Cutting Themes

Inequalities – Equality Impact Assessment training has been provided to both Wiltshire Council and the CCG staff to ensure compliance with the Public Sector Equality Duty (PSED). Over the last year we have also worked to reduce health inequalities further and improve health outcomes through targeted work with communities.

Involvement

Healthwatch Wiltshire play a significant role in ensuring public engagement and involvement informs the delivery of health and care services in Wiltshire. Their 2016/17 annual report details the work they have achieved through the "You said, we did" model of engagement.

https://www.healthwatchwiltshire.co.uk/wp-content/uploads/2017/04/you-said-we-did-final-report.pdf

Safeguarding

NHS and social care organisations have statutory obligations to provide safe, high quality care. As well as obligations on individual organisations, Wiltshire's Safeguarding Children Board and Wiltshire's Safeguarding Adult Board (which has statutory powers) play an important role in delivering these aims through collaborative working. Wiltshire's Health and Wellbeing Board have considered the implications of Wiltshire's Safeguarding Boards' annual reports and any particular investigations they have undertaken; as well as providing input to emerging business plans.

Wiltshire Safeguarding Adults Board Annual Report
www.wiltshiresab.org.uk/support-wsabs-work

Wiltshire Safeguarding Children Board Annual Report
www.wiltshirescb.org.uk/home/annual-report

Wiltshire Safeguarding Children Board

Wiltshire Safeguarding Adults Board

healthwatch Wiltshire

Indicators for success

Overall

Life and healthy life expectancy	2016/17	66.8 years (F) 64.8 years (M)	◆	Overall life expectancy continues to increase. Healthy Life expectancy for females has remained the same and is well above the England average of 64.1 years. This is within the top 20% nationally and ranks 24/150. Healthy Life expectancy for males has decreased in the last 2 years from 68.9 years however it is still above the national average of 63.4 years. Variations in life expectancy across Wiltshire continue as set out in detail in the JSA.

Healthy lives

Air Pollution Level in Wiltshire	Sep-17	2 out of 10	▼	In the UK most air pollution information services use the index and banding system approved by the Committee on Medical Effects of Air Pollution Episodes (COMEAP). The system uses 1-10 rating with the lower the number the better. At March 2016, Wiltshire had a low level rating of 3/10 which was considered the top performing quartile in the scoring system. This data is measured at different five points across Wiltshire. IT has improved to 2/10 in September 2017.
Early years development	As at Q2 15/16	66%	▲	% of children achieving a good level of development in Foundation Stage Profile in 2015. This compares with a national average of 66% for 2014/15.
Numbers on protection plans	As at June 2017	335	◆	This is a minor increase on this time last year (333)
Children in Care	As at June 2017	428	◆	Within expected range.
Disadvantaged pupils	Academic Year 15/16	35%	▲	In 2016 32% of children in care achieved 5 or more A*-C GCSEs including English (35%) and Maths.
Obesity	2016/17	29.10%		Below the national average

Indicators for success

Healthy lives

Number of Self Directed Support – Clients	As at Sep 2017	2200 (99%)	▲	99% of clients in adult social care have Self Directed Support
Number of Self Directed Support – Carers	As at Sep 2017	492 (69%)	▲	69% of carers have Self Directed Support
Number of personal health budgets	As at Mar 2016	13	▲	This has increased from 9 to 13 people receiving personal health budgets for continuing health care. Plans are being developed to increase this further to achieve the 2020 target levels for personal health budgets.
Admissions to hospital	As at July 2017 (YTD)	14,602	▲	Hospital admissions (Emergency Acute Specific): 14,602 to July 2017 which is 281 (2%) higher than the same 4 months in 2016-17
Admissions to hospitals from care homes	As at Jun 2017 (YTD)	446	▼	Admissions from Care Homes: 446 to June 2017 which is 21 (5%) lower than the same 3 months in 2016-17
Average Delayed transfers of care	As at March 2017	29	▲	This measure has now (March 2017) changed following a change in reporting methodology by the NHS. The number has increased from the same position as last year, however more recent provisional figures demonstrate a decrease.
Dementia diagnosis rates	As at August 2017	65.60%	▼	The Primary Care Dementia Diagnosis Rate reduced from 65.9% in July 2017 to 65.6% in August 2017. The CCG currently has 77 fewer diagnosis than target
Health based places of safety are available for those experiencing a mental health crisis (proxy measure: numbers held in police custody)	2016/17	19	▼	During 2016/17 financial year, a total of 19 individuals experiencing mental health crisis were taken to police custody having been detained under S136 MHA (9 to Melksham custody, 10 to Swindon custody). Whilst this is a reduction on the previous year, there is still work to do as not all of the 19 cases may fall within the 'exceptional circumstances when a police station may be used' defined within the Policing and Crime Act which came into force in April 2017. The reasons for using police custody were: 9 due to no capacity at all at health based places of safety; 6 due to violent behaviour of the detainee; 3 because staff at the place of safety refused to accept; 1 other.

Living healthily for longer and enjoying a good quality of life in Wiltshire

NHS Wiltshire Clinical Commissioning Group

Wiltshire Council
Where everybody matters

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