Wiltshire Council
Where everybody matters

AGENDA

Meeting:	**HEALTH AND WELLBEING BOARD**
Place:	**Kennet Room, County Hall, Bythesea Road, Trowbridge**
Date:	**Thursday 29 March 2018**
Time:	**10.00 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.
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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:

Cllr Ben Anderson	Portfolio Holder for Public Health and Public Protection
Bill Bruce-Jones	Avon & Wiltshire Mental Health Partnership
Dr Gareth Bryant	Wessex Local Medical Committee
Tracy Daszkiewicz	Director of Public Health
Tony Fox	Non-Executive Director - South West Ambulance Service Trust
Terence Herbert	Corporate Director - Children and Education
Linda Prosser	Wiltshire Clinical Commissioning Group
Kier Pritchard	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

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AGENDA

1 **Chairman's Welcome and Introduction**

2 **Apologies for Absence**

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

To confirm the minutes of the meeting held on 25 January 2018.

4 **Declarations of Interest**

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

5 **Chairman's Announcements** *(Pages 15 - 16)*

- Salisbury
- CQC review in March
- Local Area SEND Inspection Outcome

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 **Thursday 22 March 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 **Monday 26 March 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 **Safeguarding Adults Reviews** *(Pages 17 - 24)*

To update the Board on the implications of these reviews

Responsible Officers: Richard Crompton
Report author: Emily Kavanagh

8 **End of Life Care Implementation Plan for Children** *(Pages 25 - 36)*

To review the implementation plan for end of life care for children, following input from local hospices.

Responsible Officer: Susan Tanner/ Ted Wilson
Report author: Myfi Champness

9 **Maternity Plan** *(Pages 37 - 94)*

To consider the transformation plan for maternity ahead of consultation.

Responsible Officer: Linda Prosser
Report author: Lucy Baker

10 **Delayed Discharges** *(Pages 95 - 118)*

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: Tony Marvell

11 **Better Care Plan** *(Pages 119 - 134)*

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: Tony Marvell

12 **Wiltshire Information Sharing Charter (WiSC)** *(Pages 135 - 146)*

An update on the rollout of Single View and the requirement for additional information sharing protocols

Responsible Officers: Carlton Brand, Linda Prosser
Report author: Ian Baker, Liz Creedy

13 **Preventative Mental Health Concordat** *(Pages 147 - 152)*

A presentation seeking agreement for Wiltshire's participation in the PHE Mental Health Concordat.

Responsible Officer: Tracy Daszkiewicz
Report author: Karen Spence

14 **Mental Health Crisis Care Concordat** *(Pages 153 - 160)*

A presentation on progress with the action plan, places of safety and the pathways review.

Responsible Officers: Ted Wilson
Report author: Georgina Ruddle

15 **Date of Next Meeting**

The next meeting will be on 17 May 2018

16 **Urgent Items**

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Wiltshire Council
Where everybody matters

HEALTH AND WELLBEING BOARD

DRAFT MINUTES OF THE HEALTH AND WELLBEING BOARD MEETING HELD ON 25 JANUARY 2018 AT THE KENNET ROOM - COUNTY HALL, TROWBRIDGE BA14 8JN.

Present:

Cllr Baroness Scott of Bybrook OBE (Chair), Dr Toby Davies, Dr Andrew Girdher, Christine Graves, Angus Macpherson, Cllr Laura Mayes, Cllr Ian Thorn, Cllr Jerry Wickham, Cllr Ben Anderson, Linda Prosser, Andy Hyett and Dr Anna Collings

1 **Chairman's Welcome and Introduction**

The Chair welcomed all to the meeting.

2 **Apologies for Absence**

Apologies were received from Chief Insp. Mike Veale, Nerissa Vaughan, Dr Andy Smith, and Dr Bill Bruce-Jones, James Scott and Cara Charles-Barks.

3 **Minutes**

The meeting considered the minutes of the meeting held on 9 November 2017.

Resolved

To approve as correct record for signing by the Chair the minutes of the meeting held on 9 November 2017.

4 **Declarations of Interest**

There were no declarations of interest.

5 **Chairman's Announcements**

The Chairman drew the meeting's attention to the following announcements detailed in the pack:

- CQC inspection in March
- Mention the Ofsted inspection of SEND
- Progress on integration

6 **Public Participation**

There were no public questions or statements received.

7 **Sustainability and Transformation Partnership Update**

Chris Bown gave a presentation, appended to these minutes, regarding the current priorities for collaborative working, and to introduce the board to the new senior responsible officer for the Sustainability and Transformation Partnership (STP).

Matters highlighted in the course of the presentation and discussion included: the overview of the national picture and the context in which the STP had been drawn up; the need for better engagement with local government; that a plan was established in 2016 and focused on the 5 year forward view; the 44 STPs in England and the desire to become accountable care systems (now retitled as integrated care systems); the focus on improving health outcomes for the population, particularly narrowing the gap on life expectancy between those living in more deprived areas; that there are 20 plus partners involved in delivering the aspirations; the desire to reduce duplication and variation with the intention of making the system more efficient and less confusing to the individual; the five key focuses of the plan: proactive and preventative care, planned/consistent care; acute collaboration; digital and workforce issues; the key role of the Health & Wellbeing Boards in providing strategic leadership along with the STP; the key areas for future work: mental health and well-being, a greater emphasis on self and community care; and better integration with social care; that some services should be commissioned or transformed at STP level where appropriate; the desirability of an update on maternity at a future meeting, the need to address the financial challenge of a projected deficit of £110m (without savings across the STP); how cost improvement programmes are developed; the importance of developing a workforce and estates strategy; the complexities of the geography in Wiltshire; the work to provide greater emphasis on children's services; the piloted approaches in areas of deprivation; and the further discussion required on governance.
The Chairman thanked Mr Bown for his presentation, and welcomed the opportunity to continue discussions.

8 **Winter Pressures - Update**

Jo Cullen gave a presentation, appended to these minutes, on the implementation of winter planning measures, the additional funding announced in the budget and to consider the current situation across the system.

Matters highlighted in the course of the presentation and discussion included: that this was an interim update which presented some of the lessons learnt from experiences so far this winter; the increase in ambulance demand compared to the previous year; the variance in attendances at the three acute centres and the

reasons for this; the impact of Christmas events on demand; how actual demand matched with predicted demand on 111 services; the symptoms of people presenting at 111 and how they can be appropriately diverted to self-care and pharmacy when routine services aren't available; the volume of calls for out of hours services; how extra demand was managed with additional resources; that care homes that had been seeking repeat prescriptions over weekends had been identified and were targeted for action; the services provided by walk-in centres; that average length of stay in acute settings had reduced; the integrated control centre in Wiltshire, supported by partners, to enable capacity can be managed; and the lessons learnt and the interim actions already taking place.

The Chairman asked the thanks of the Board to all staff supporting the system be recorded.

9 **Delayed Discharges**

Jeremy Hooper presented an update on the latest figures for delayed discharges (DTOC).

Matters highlighted in the course of the presentation and discussion included: that DTOC numbers were being brought down; that some further work was required including regarding mental health partners; the greater focus on increasing weekend working to facilitate 7 days a week discharges; the work of the JCB, the discussion of equipment provision and the implementation of the choice policy and the further work required; that further work on the efficacy for dementia strategy was required; and the thanks to the teams for their continued hard work.

Resolved

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

10 **Better Care Plan**

Jeremy Hooper presented an update, appended to these minutes, on the delivery of the Better Care Plan for Wiltshire and emerging plans for 2018/19.

Matters highlighted in the course of the presentation and discussion included: that non-elective admissions were higher than last year across all age bands; the changes to the model of home care; the activity on intermediate care beds; the new governance arrangements, and the changes made to better manage the number of projects that need to be

delivered; and that the project board would be meeting the following month and establishing a deliver group.

Resolved

1. **To note the new Better Care Fund Dashboard**

2. **To note the Better Care Fund Risk Register 2017/18**

3. **To consider the emerging plan for 2018/19**

4. **To 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).**

11 **Pharmaceutical Needs Assessment**

Steve Maddern presented the report which asked the Board to agree the final Pharmaceutical Needs Assessment (PNA), following recent consultation.

Matters highlighted in the course of the presentation and discussion included: that the draft was considered at a previous meeting; that issues raised in the consultation had been addressed in the revised draft; that young peoples' needs have been highlighted; and that officers had been providing response to the PNAs from neighbouring areas.

The Chairman thanked Steve and his team for their hard work**.**

Resolved

1. **To note the public consultation feedback in the draft PNA document.**

2. **To approve the final PNA 2018 document to come into effect as of 01 April 2018.**

12 **CCG Local Transformation Plan (CAMHS) Refresh**

Ted Wilson presented the report which asked the Board to approve the refresh of the CCG's local transformation plan for child adolescent mental health services in 2018/19.

Matters highlighted in the course of the presentation and discussion included: that the plans expanded upon the plan from 2015; the relevance of the green paper of 2017 from DoE and DfH and the links to those ambitions; the improved resources available to schools; that twelve secondary schools now had dedicated workers; how officers were leading on STP-wide work looking at the

reprocurement of CAMHS services; that there is now a single point of access for self-referral and for professionals; the welcome expansion of online counselling service, and that 2000 individuals had accessed this service; the work of Healthwatch and the training of Young Listeners, the increasing levels of self-harm and the aim increase early intervention; that work was ongoing to reduce relatively high waiting times; and that officers were pleased with the progress made so far.

Councillor Laura Mayes expressed her thanks for the progress made, and gave examples of the positive feedback received from young people.

In response to a question from Angus MacPherson, it was noted that all secondary schools had welcomed the offer of new services, but there was a concern that those with school nurses may see the expanding service as a way how making cut backs to their own provision. It was also hoped to expand the offer of services to primary settings.

Dr Toby Davis gave an example from his practice which showed a marked improvement in the services available.

In response to a question raised by Christine Graves, it was noted that further training to be given to all teachers so that they are confident in signposting children to support.

Resolved

1. **To note the progress to date on the implementation of the CCG local transformation plan for children and young people's mental health and wellbeing;**

2. **To endorse the refreshed and expanded plan including its commissioning intentions, local priorities and updated budget proposals;**

3. **To encourage partner agencies to consider contributing their views to the green paper on improving mental health support for children and young people.**

13 **Wiltshire CCG Care Operating Model**

Mark Harris gave a presentation, appended to these minutes, regarding the proposed care operating model for Wiltshire.
Matters highlighted in the course of the presentation and discussion included: the services included in the model; the basis on how the capital investment is made; the different groups within each geographical footprint and what can be expected in which footprint; and the vision of having GP practices working together at hubs.

The Chairman thanked the officers for the presentation and requested that a further discussion take place at a future meeting.

14 **Domestic Abuse**

Tracy Daszkiewicz presented the report which gave an update on domestic abuse strategy, the needs assessment and contract award.

Matters highlighted in the course of the presentation and discussion included: how the needs assessment was undertaken and published; the procurement process undertaken; that the new strategy had been developed in line with the national strategy; that there were approximately 15,000 people at risk or suffering from domestic abuse; that addressing this was a key priority; and that about 50% of children in contact with children's services are affected by domestic abuse; how support can be integrated with housing policies; that services are available to all victims so that there is no discrimination based on gender; the links to substance abuse and how the work is partnered; and the work with police and fire service partners.

Resolved

To note the report

15 **Adult Social Care Transformation Programme**

Catherine Dixon presented the report which provided an update on the delivery of the programme.

Matters highlighted in the course of the presentation and discussion included: how the funding had been used to develop the model of prevention; the work to promote reablement and increasing capacity in the market; that the project had looked at local area co-ordination; the proposed links to the STP and how this might be reflected in the CCG plans; the desire to include partners in steering group; the commissioning intentions and developing strategies for services for adults with learning difficulties; that there would be further work on co-production to bring partners; that an innovation grant was awarded to look at workforce capacity; the changes to staffing structures and setting up own reablelment services; that the project would be continuing to look at services and looking at elderly and mental health in stage two; and how the project is monitored through transformation board.

Resolved

To note the progress made

16 **Health and Wellbeing Board progress report 2017**

David Bowater presented the report that provided an update on progress in delivering the joint health and wellbeing strategy. Matters highlighted included: the importance of highlighting the progress made against the public strategy; that some issues could be looked at in the future e.g. personal health budgets; and the effectiveness of taking a partnership approach to shared problems.

Resolved

To note the progress made in delivering key objectives over the last year.

17 **Date of Next Meeting**

It was noted that the date of the next meeting would be the 29 March 2018.

18 **Urgent Items**

There were no urgent items.

(Duration of meeting: 9.00 - 11.17 am)

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

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Chairman's announcements

Salisbury

A brief verbal update on the response to the situation in Salisbury will be provided.

CQC Health and Wellbeing Local System Review

As part of a 14 week review, 12 inspectors were on site in Wiltshire visiting a range of health and social care organisations during the week of 12-16 March.

On completion of the system review CQC's findings will be made available to the Health and Wellbeing board during May/ June, 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 continues to 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.

Local Area SEND Inspection

Ofsted and Care Quality Commission inspect local areas' effectiveness in identifying and meeting the needs of children and young people who have special educational needs and/or disabilities (SEND). An inspection took place in Wiltshire during the week of 29 January 2018.

The report is to be published on the Ofsted website and a brief verbal update summarising this and the next steps will be provided at the meeting.

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Wiltshire Council

Health and Wellbeing Board

29 March 2018

Subject: Safeguarding Adults Reviews (SAR)

Executive Summary

The Chair of the WSAB is attending the Health and Wellbeing Board on 29 March to provide members with an update on:

- Two Safeguarding Adults Reviews the Board has undertaken following the unrelated death of two adults at risk in Wiltshire
- The learning from those reviews that will help us more effectively safeguard vulnerable adults in the future
- The Board's business plan for 2018-2019

The primary statutory duty of the Board is to carry out a Safeguarding Adults Review (SAR) when:

"an adult in its area dies as a result of abuse or neglect, whether known or suspected, **and** there is concern that partner agencies could have worked more effectively to protect the adult (s.14.133)"

The purpose of a SAR is not to hold any individual or organisation to account but to allow local organisations to learn lessons from the past.

Until 2017 the WSAB had not completed such a review since 2014 when it looked at the care offered to residents of a small residential service in Wiltshire. This year the Board has completed two reviews allowing us to re-examine how effectively our multi-agency system works to safeguard adults.

At the time of writing this report these two reviews, and the Board's business plan, are in draft format. However, in order to ensure that the Health and Wellbeing Board and kept informed of the work of WSAB to assess the quality of the multi-agency safeguarding system this report:

- Summarises the circumstances that prompted these statutory reviews
- Includes the **draft** multi-agency recommendations that are likely to be made in these reviews
- Details how our WSAB Business Plan for 2018-2019 will ensure that learning from these reviews will help to improve how adults in Wiltshire are safeguarded

An action plan will be developed by the WSAB to share learning from the two SARs and to ensure that the recommendations made in these reports lead to the necessary changes being made to safeguard vulnerable adults.

Proposal(s)

It is recommended that the Board:

i) Notes the outcome of the 2018 Safeguarding Adults Reviews relating to Adult A and to Adult B
ii) Ensures that this learning has an impact on the work of its member agencies
iii) Asks the WSAB to share the finalised action plan with HWB to ensure that the recommendations of the two SARs and the learning from these reviews are shared and effect change
iv) Supports the necessary partnership resources to ensure that action plan can be delivered effectively
v) Acknowledges the aims of the WSAB's business plan for 2018-2019 and continues to support the work of the Board to safeguard vulnerable adults in Wiltshire

Reason for Proposal

The Wiltshire Safeguarding Adults Board is accountable to the Health and Wellbeing Board for its work as a partnership to protect all adults in its area who have needs for care and support and who are experiencing, or at risk of, abuse or neglect against which they are unable to protect themselves because of their needs. The WSAB's work is directly related to improving health and wellbeing outcomes for vulnerable adults across the county.

Presenter name: Richard Crompton
Title: Independent Chair,
Organisation: Wiltshire Safeguarding Adults Board

Wiltshire Council

Health and Wellbeing Board

29 March 2018

Subject: Safeguarding Adults Reviews (SAR)

Purpose of Report

1. To report to the Health and Wellbeing Board:
   - The outcome of two Safeguarding Adults Review (SAR) completed by the Wiltshire Safeguarding Adults Board (WSAB) in March 2018 and which are due to be published by the Board in April 2018.

2. Safeguarding Adults Board **must** arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, **and** there is concern that partner agencies could have worked more effectively to protect the adult (s.14.133).

   SABs **must** also arrange a SAR if an adult in its area has not died, but the

   SAB knows or suspects that the adult has experienced serious abuse or neglect. In the context of SARs, something can be considered serious abuse or neglect where, for example, the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect. SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support (s.14.134).

   The adult **must** have needs for care and support, but does not have to have been in receipt of care and support services for a SAR to be considered.

3. The purpose of such a review is not to reinvestigate or to apportion blame, it is:
   - To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk;
   - To review the effectiveness of procedures (both multi-agency and those of individual organisations);
   - To inform and improve local inter-agency practice;

Safeguarding Adults Review – Adult A

Background

- Adult A was admitted to hospital in December 2016 after having been found on the floor of her flat by the attending paramedics. There were

concerns raised by the paramedics about the state of the flat and possible self-neglect. The paramedics also raised a safeguarding alert as they suspected Adult A had been financially abused by a carer.

- Adult A was admitted to hospital but in the absence of any physical problems associated with the fall was released to an ICT bed. During this time Adult A exhibited some concerning behaviours and during an assessment was found to have a degree of confusion.

- In mid-January Adult A activated her life line, the paramedics who attended reported that she was found in a situation of serious self-neglect sitting in a cold dark flat and was severely hypothermic. There was no fresh food in the flat and it appeared that Adult A had not been talking her medication.

- Adult A died in hospital in January. The coroner noted the that at time of death was suffering from hypothermia, broncho-pneumonia, left ventricular hypotrophy, hypertension, diabetes, kidney disease and dementia. The coroner's report also stated that he did not think adequate preparation had been made to ensure Adult A had provisions and support on discharge.

- The coroner concluded that Adult A would not have died at that time had Adult A not been discharged home. The review identified a number of issues, some of which may not have resulted in significant harm if they had occurred in isolation. The professionals that were interacting with each other did not challenge decisions that were made in other agencies. There was no evidence of escalation when referrals were not receiving the expected response.

- Whilst the review concluded that it could be considered that ultimately, it was the discharge planning that was the final layer of defence that failed. That, however, relied on all the other elements being effectively applied to understand what exactly needed to be part of the discharge plan and future interventions. If these had been applied robustly, Adult A may well not have been discharged at all at that time. There were many layers of protection in the system that failed at the same time culminating in a catastrophic outcome for Adult A.

Draft multi-agency recommendations

- WSAB should produce Multi Agency Self Neglect guidance to support practitioners in managing self-neglect.

- WSAB must assure itself that agencies can evidence how they will address the shortfalls in understanding and applying the Mental Capacity Act that this review has evidenced.

- WSAB should provide a learning briefing to all agencies regarding all the learning points from the review.

- WSAB should seek patient stories showing evidence of the effectiveness and safety of discharge planning processes.

Safeguarding Adults Review – Adult B

Background

- Adult B was diagnosed with a degenerative and progressive disease of the brain. Adult B lived in the community in independent living accommodation and was able to maintain a degree of independence.

- Adult B died in late 2016 in a road traffic accident after walking a significant distance from home. Prior to this fatal accident Adult B had been found on a separate occasion wandering at a considerable distance from home in a state of undress. A number of agencies were aware of Adult B and his tendency to walk long distances and become disorientated had been reported to other agencies by the police.

- Other SARs regarding people with dementia who walk, have identified people with dementia walking and subsequently dying as a result even when they have been subject to 24 hour care provision. However the WSAB review relating to Adult B concluded that with more robust communication, coordination and assessment alongside application of statutory processes and respectful challenge and escalation, Adult B might have benefitted from a safer and more secure care package.

Draft multi-agency recommendations

- WSAB should seek assurance that agencies consider the elements of NICE Guidance for supporting people with Dementia that would have made a difference in this case. In particular, that there should be an agreed approach to identifying a lead worker role when multiple agencies are working with an individual at risk and an agreed approach to shared care planning.

- WSAB Quality Assurance sub group should seek information from commissioners regarding their assessment of the risk resource and capacity issues pose to the safety and well-being of Adults with Care and support needs who are at risk of harm. There should be an expectation and an agreed process for commissioners to escalate any significant risk to the Board Chairman.

- WSAB should assure itself that all agencies and providers have robust structures in place for support and supervision of staff.

- WSAB should consider the learning from this review and undertake to ensure that there is guidance to all agencies on the importance of professional curiosity and challenge and of escalation where required to mitigate risk. This may be undertaken by the following approaches:

    - By way of a briefing note.
    - By review of the Safeguarding Procedures that include an escalation section.
    - As part of the Operating Procedures for the Adult MASH.

- An agreed multi-agency approach is required for managing risk in adults who have care and support needs. WSAB should seek assurance that this approach is developed and embedded through audit.
-
- WSAB should add the learning from this review regarding understanding and application of the Mental Capacity Act, to the previously made recommendation in the Adult A SAR.

Wiltshire Safeguarding Adults Board Business Plan 2018/2019

During 2017-2018 Wiltshire Safeguarding Adults Board has focused on reviewing the wider system that aims to safeguard vulnerable adults in Wiltshire. We have done this by:

- Carrying out two independent reviews after receiving referrals regarding two adults at risk in the county who died (in unrelated circumstances), to learn how partner agencies could have worked more effectively to protect those adults
- Undertaking a self-assessment audit of our Board members and identifying areas where we can improve the way local organisations work together
- The work of our Quality Assurance group to examine local data and to seek reassurance from those organisations that practice is continually improving to protect adults at risk
- Regularly meeting with service users and carers through our reference groups to learn from their experience
- Discussions at Board Meetings and with key partners have about how changes to legislation, to demand on our member agencies and to service delivery are impacting on how effectively our members can work together

The Board is required to publish a strategic plan and in 2016 we published a three-year plan for 2016-2018. This report sets out what progress has already been made against that plan and what actions will be taken during 2018-19. In 2016 we set out three aims, which were to:

- Improve Board Effectiveness
- Develop the ethos and practice of Making Safeguarding Personal
- Develop and improve our preventative and responsive practice.

Since that time we have done much to improve the effectiveness of our Board. In Wiltshire, we have introduced an innovative model that brings together support for WSAB, our Local Safeguarding Children Board and the local Community Safety Partnership. This allows us a unique opportunity to examine how we are protecting vulnerable people from childhood into adulthood from neglect and abuse and from wider harms. We have also agreed a new business model for 2018-2019 which will see a smaller WSAB executive group meeting more often. This will allow us to increase the progress we are making to identify risk and weaknesses in the system and to act early to protect adults at risk.

Having made these changes our renewed focus in 2018-2019 will be on both Making Safeguarding Personal, on developing and promoting preventative practice and to:

- Share learning and provide assurance that learning from experience leads to improvements

As a Board our focus in Wiltshire must be on providing assurance. This work has progressed in 2017-2018 but we need to be able to more clearly identify and articulate levels of assurance relating to key safeguarding arrangements

In the last year we have also learned much from a regional study of Safeguarding Adults Review carried out by Professor Michael Preston-Shoot and from a review carried out in Somerset into the mistreatment and abuse of residents at Mendip House, a care home for adults with autism near Highbridge run by the National Autistic Society (NAS). In 2018-2019 we will be working to gain assurance in relation to how Wiltshire commissioners monitor the quality of internal and external placements, and crucially, how external commissioners monitor the quality of placements in Wiltshire.

A more detailed summary of what we have learnt through review of the system and the changes we hope to see made are set out in the Board's Business Plan for 2018-2019. This provides a framework by which our members and partners can measure success over the course of the next year. Our next three-year strategy will be published in 2019 and will report and build on the essential work we undertake this year.

Presenter name: **Richard Crompton**
Title: **Independent Chair**
Organisation: **Wiltshire Safeguarding Adults Board**

Report Authors: Emily Kavanagh
Wiltshire Board Manager
01225 716693

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Wiltshire Council

Health and Wellbeing Board

29 March 2018

Subject: End of Life Care Implementation Plan for Children

Executive Summary

I. Following a multi-agency review of End of Life care for Wiltshire children against NICE guidelines, this paper summarises:
- Priority areas of work to improve compliance with guidelines
- Demand on end of life service for Wiltshire children
- Next steps

Proposal(s)

It is recommended that the Board:

i) Reviews the enclosed paper and notes the findings of the review and associated resulting actions.

Reason for Proposal

Following development of the Wiltshire End of Life Strategy for adult services, a request was made to better understand End of Life Care for children and any actions required to improve services for Wiltshire.

Susan Tanner
Head of Commissioning and Joint Planning
Wiltshire Council

Purpose

The need to review end of life care for Wiltshire children was highlighted following presentation of the Wiltshire End of Life strategy, which does not specifically address the needs of children, at the Health & Wellbeing Board. Opportunity for review also arose following publication of the NICE guidelines: End of life care for infants, children and young people with life-limiting conditions: planning and management, in December 2016 and their subsequent associated Quality Standard in September 2017. This paper aims to summarise the key findings from this review, as well as priority areas that have been identified for further action, and next steps. For the purposes of this paper the term 'children and young people' refers to everyone under the age of 18, including neonates and infants.

Background

No one provider or professional group is ultimately responsible for provision of palliative care for children and young people across Wiltshire. Instead there is a complex landscape of organisations which may be involved, to varying extents, at different points within the palliative care pathway. The principal organisations involved in provision of palliative care for Wiltshire patients have been summarised within Appendix 1. For the purposes of this review and ongoing work we have opted to exclude tertiary providers; Wiltshire patients predominantly feed into three tertiary centres, although some children will go on to access services from tertiary centres even further afield. Each tertiary centre will provide care to children from many counties other than Wiltshire and so it was not seen as feasible to request any significant involvement on their part, and instead tertiary centres will be kept informed of any changes to practice that may impact on them as a result of work undertaken within Wiltshire. All other identified organisations have been engaged with and representatives from each have been identified and invited to take part in an initial review of services and ongoing strategy work to address key priorities. The primary aims of the review were to:

- Develop an understanding of end of life care for Wiltshire children currently, the organisations involved and their respective roles and responsibilities within the overall context of delivering an optimum level of care for children and their families;
- Identify any gaps in service provision across Wiltshire or areas for further development;

- Understand whether services for children in Wiltshire are compliant against NICE guidelines;
- Enable networking and communication across organisations with a common goal of improving palliative care for children across Wiltshire.

Demand

In order to provide some context, the data from the Wiltshire Child Death Overview Panel report have been summarised within Appendix 2. In summary however, there are an average of 28 child deaths per year in Wiltshire. The majority of children are in their first year of life when they die (64%) and most child deaths take place in a hospital setting (average of 19 deaths per year). Further analysis of data has been identified as a key priority in order to better understand the potential demand for end for life care across Wiltshire and plan capacity accordingly. Existing data enables us to make assumptions around the proportion of child deaths that may have been as a result of life limiting conditions and so may have had the opportunity to receive end of life care outside of hospital, versus those that were are a result of trauma or unexpected. For example, 28% of deaths were unexpected and so it is likely that these children would not have been on a palliative care pathway. Numbers of children requiring end of life care are thankfully small and provision is sporadic in its nature, the result of which is that our acute and community providers do not generally have designated capacity in place for end of life provision, but instead work to create capacity as and when it is required. Feedback is that when a family choose to go home providers will do all that is required to enable this to happen however it is acknowledged that this puts significant strain on services and we must do whatever we can to identify other resources that can support and make the best use possible of this highly specialist resource.

Review findings

Each provider was given the opportunity to present a summary of their service provision and any issues that they felt they have in relation to fulfilling the NICE guidelines. It was clear from this that there is significant variation in service models across providers, and there was acknowledgement that there can be differences in end of life provision for children within oncology services, which generally has a higher level of palliative care resource, than for children with non-oncological conditions. All providers felt that they were compliant with NICE guidelines for the elements for which they were responsible albeit in some cases as a result of staff going ‘above and beyond’ rather than it being within their job plans. Participants felt that it was very useful to hear more about how each service operates in order to best match the needs of the child and their family to the organisation. Some specific issues were relayed by individual providers however there was a strong consistency between all organisations and the group was able to agree a number of key priorities for provision of end of life care for children across Wiltshire:

1. Access to 24/7 medical cover:

The NICE guidelines state that children and young people receiving end of life care at home should have access to advice from a consultant in paediatric palliative care at any time (day and night). This is extremely challenging for providers to deliver against, both in terms of the specialism in paediatric palliative care at consultant level and the 24 hour provision. Whilst some hospices are able to offer 24/7 consultant medical telephone cover, other providers are unable to meet this expectation. With the numbers outlined in appendix 2 it is very difficult to make this provision viable and so as a county we need to explore other means of accessing medical support, particularly out of hours.

2. The role of the GP:

There were reports of variable engagement from GPs around children's end of life care. Some have been involved throughout a child's palliative and end of life pathway; often enabling care to be delivered at home if that is the family's wish, whilst others have not seen this as part of their role. GPs potentially have a vital role to play both in the delivery of some medical support for end of life provision out of hospital but also in the ongoing support of the whole family after the child's death, and the group identified the need to seek engagement from GPs in future work so that this role could be further defined. It was acknowledged that GP representation on the group had not been sought but was important and this has now been rectified with two GPs identified to participate in the working group going forwards.

3. Workforce planning & training:

In addition to the medical workforce children with life-limiting conditions or receiving end of life care need access to a number of other professionals with specialist palliative care experience including but not limited to: nurses, pharmacists, psychologists, allied health professionals, chaplains, social care and educational professionals. Within each of these staff groups, a specialism in palliative care is relatively rare and providers are often competing with each other for a relatively small staffing pool. In order to manage this situation the group needs to consider how it might communicate or even develop training and development opportunities in order to nurture staff with an interest in palliative care for the future. Some particular staffing groups, such a psychology, were identified as particular gaps by certain providers.

4. Data:

The Wiltshire and Swindon Child Death Overview Panel has been in place since April 2008 and it reviews the deaths of every Wiltshire and Swindon child under 18 years with a particular focus on whether there were any modifiable factors which may have contributed to the death and what, if any, actions could be taken to avoid future such deaths. Within this capacity they collect a significant amount of data on behalf of Wiltshire which would enable us to better understand how end of life care is currently being delivered and whether this was in line with

children and families wishes. This will in turn help the group to better plan services for the future and so the need to collect and analyse this data on behalf of Wiltshire patients was identified as a priority for the group.

Next steps

Strategically the group is keen to explore opportunities in working alongside the adult End of Life Programme Board to understand synergies and identify shared priorities. It is the view of the group that many of the high level strategic aims in end of life care will be shared between children and adults and the group is keen to find a way of aligning the strategic focus of end of life care as much as possible, whilst recognising that there will be some factors which are unique to provision of end of life care for children and young people.

The Children's End of Life Group has agreed to meet quarterly in the capacity of a 'working group' in order to progress against the priority areas outlined within the review findings above. NICE suggests that organisations work within clinical networks to develop and improve children's End of Life Care and the working group will be well placed to deliver against this recommendation. Below is an illustration of the actions that the group is currently working to:

Action	Status
Identify a GP representative to sit on the group	Complete
Identify a representative from the out of hours GP provider to join the group	Complete
Make contact with the Rainbow Trust and engage in future activities	Complete
Develop a directory of all services providing input to end of life care for children across Wiltshire, including geographical areas and patient groups covered	Complete, See Appendix 3
Schedule a meeting for February to begin work on identified priority areas of work	Complete
Develop list of exceptional data requests for CDOP	Complete
Explore option of developing a children's palliative care template within the GP system Ardens	May 18
Consider how children's 'fast-track' continuing care referrals might be aligned with end of life pathways	April 18
Agree how the children's end of life group will feed strategically into wider end of life discussions at the CCG	Mar 18
Agree process for sharing Advance Care Plans and Symptom Management plans with all relevant staff involved in provision of end of life care	May 18
Develop a simple 'off the shelf' guide for GPs and out of hours services on children's end of life pathways, key documents and principle providers	May 18
Compile a training directory for staff who may have an interest in this area, or who feel that it is an area in which they need further development. Also consider as a group of providers whether there might be some work that we can do together to upskill discreet groups such as the clinical hub within the 111 service	April 18

Appendix 1

Table of stakeholders:

Tertiary centres*	Bristol Children's Hospital (RUH tertiary provision)
	John Radcliffe Hospital Oxford (GWH facing)
	Southampton Children's Hospital (SFT facing)
Acute hospitals trusts	Great Western Hospital Swindon
	Royal United Hospital Bath
	Salisbury General Hospital
Hospices/ voluntary sector organisations	Naomi House & Jacksplace , Winchester
	Julia's House, Devizes
	Helen & Douglas House, Oxford
	Children's Hospice South West (Charlton Farm), Bristol
	Jessie May, hospice at home
	Rainbow Trust South West Family Support Team, Chippenham
Children's Community Services	Virgin Care
Primary Care	Family GP
	Medvivo (out of hours)

*A number of children may access tertiary services via other specialist centres for example Great Ormond Street.

Appendix 2

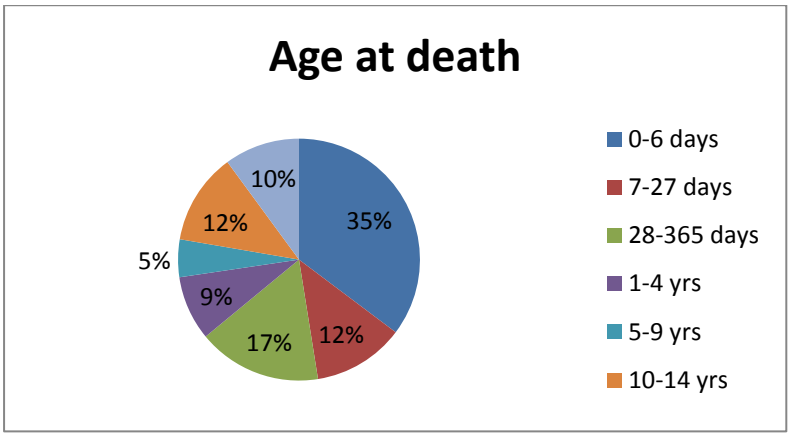
Some of the key data from the 2016/17 CDOP annual report are summarised below. Unless otherwise stated numbers relate to the period 1st April 2012 – 31st March 2017.

1. Number of child deaths notified in Wiltshire:

Year	**Number of child deaths**
2012-13	39
2013-14	32
2014-15	28
2015-16	17
2016-17	23
TOTAL	**139**

2. Age at death:

The greatest proportion of notifications (47%) were for babies dying in the neonatal period (under one month of age). This figure increases to 64% when all deaths under one year are grouped together.



3. Location of death

Home/ private residence	32
Royal United Hospital, Bath	15
Salisbury District Hospital	14
St Michael's Hospital, Bristol	14
Princess Anne Hospital, Southampton	13
Other hospital	13
Bristol Children's Hospital	10
Hospice	9
Great Western Hospital, Swindon	8
Southampton General Hospital	6
Other	5

Grouped locations:

Hospital- tertiary/ out of area	56
Hospital- in area	37
Home/ private residence	32
Hospice	9
Other	5

4. Expected and unexpected deaths

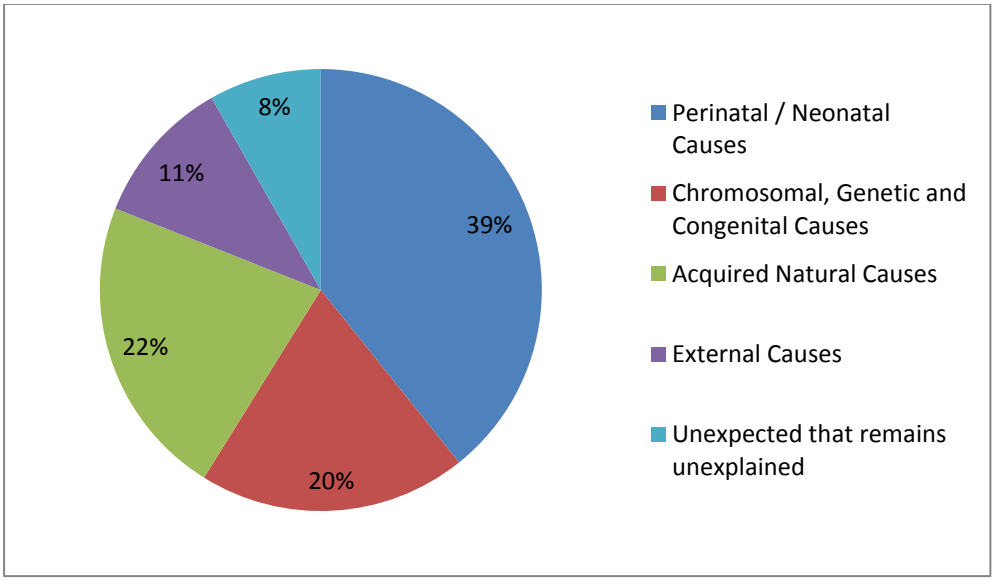
An unexpected death is defined as the death of a child which was not anticipated as a significant possibility 24 hours before the death or, where there was a similarly unexpected collapse or incident leading to or precipitating the events that led to the death. During the reporting period 2012 – 2017, 39 deaths (28%) of children were unexpected. The remaining 100 were expected child deaths of children with known illnesses or life-limiting conditions.

5. Categorisation of death for cases reviewed by CDOP

As part of the Child Death Review process each death reviewed by the panel is categorised by the most likely cause of death based on a set of pre-defined CDOP categories. As the numbers within these categories remain quite small despite the use of aggregate data, they can be grouped into wider categories as follows:

Pre-defined CDOP categories	**Wider Category**
Perinatal / Neonatal Event	Perinatal / Neonatal Causes
Chromosomal, genetic and congenital anomalies	Chromosomal, genetic and congenital anomalies
Malignancy Acute medical or surgical condition Chronic medical condition Infection	Acquired natural causes
Deliberately inflicted injury, abuse or neglect Suicide, or deliberate self-inflicted harm Trauma and other external factors	External causes
Sudden, unexpected, unexplained death	Unexpected that remains unexplained

The assignment of categories to child deaths across Wiltshire is summarised below. It is possible from this information to make some assumptions about what kind of demand there might be for hospices or end of life care at home. For the purposes of these projections it would be sensible to discount those deaths that are attributable to External and Unexpected causes, as in their nature these deaths are likely to have been sudden or not attributable to long term or pre-existing life limiting illness. These children account for 19% of child deaths.



Appendix 3

A summary of organisations involved in the provision of End of Life Care for infants, children and young people in Wiltshire with life limiting conditions.

Acute Providers:

In the first instance, the majority of children across Wiltshire will be managed clinically by one of three acute trusts: the Royal United Hospital Bath, Great Western Hospital Swindon and Salisbury Hospital. Children and families can exercise choice as to which trust they would like to access care from, however in the main the county splits fairly equally three ways depending on proximity to hospitals from home. If more specialist intervention or oversight is required then these three acute trusts will link into Bristol Children's Hospital, Oxford Radcliffe and Southampton Children's Hospital respectively. Other tertiary hospitals may be accessed as required by the child's condition or as capacity, for example within paediatric intensive care, dictates. Acute providers outlined will support children with a range of life limiting or life threatening conditions, covering specialties such as: Paediatric oncology, neurology, respiratory, cardiology, and neonatal care. Children with complex needs may sit under a range of acute clinicians and specialties; however one primary clinician should be nominated as the lead for that child and their management. In most circumstances the acute trust will commence the child's Advance Care Plan and Symptom Management Plan, and will be responsible for its ongoing review.

Community provider:

Our children's community healthcare services in Wiltshire are provider by Virgin Care, who provide a range of services that may be involved in the delivery of care for children with life limiting of life threatening conditions including but not limited to: community nursing, continuing care, community paediatrics, integrated

therapies, speech & language and paediatric continence. Children or young people with life limiting conditions will have a lead community nurse, and the community nursing team will work closely with acute hospital to enable a family to go home to receive end of life care if that is their wish. This will involve establishing a rota for provision of nursing support in the home.

Voluntary sector organisations:

Below is a summary of the hospices and other voluntary sector organisations involved in provision of services for infants, children and young people with life limiting and life threatening conditions. It is important to recognise that within children's services involvement with these organisations is not limited to end of life care, but that children and their families may receive ongoing care and services throughout their lives. Hospices listed below are all able to provide care at the end of a child's life if that is the choice of the family or young person. As such, the organisations below all aim to work in partnership with other professionals and organisations surrounding the child and their family including acute hospitals, schools, social care and community providers. Referrals can either be made by professionals or the families themselves.

Children's Hospice South West (Charlton Farm, Bristol)
Charlton Farm Hospice will usually cover West Wiltshire and provides ongoing support for children up to the age of 18 and their families, including end of life provision. The hospice employs a multidisciplinary team including paediatric nurses, therapists, social workers, teaching staff and medical support through GPs and paediatricians. Referral information: https://www.chsw.org.uk/what-we-do/our-care/make-referral

Helen & Douglas House, Oxford
Helen & Douglas House most commonly receive referrals for families living in the North West area of Wiltshire, typically being managed via Great Western Hospital. The Hospice comprises Helen House, caring for babies and children up to the age of 18, and Douglas House, who look after young people and adults, aged 16 – 35. Referral information: https://www.helenanddouglas.org.uk/our-care/how-to-get-help/

Jessie May, Bristol
Providing nursing care at home for children and young people with life limiting conditions who are not expected to live beyond the age of 19. Nurses will go into the family home to provide care and support, providing parents or carers with some much needed free time. Referral details:
https://www.jessiemay.org.uk/help-support/do-you-need-our-help/

Naomi House & Jacksplace, Winchester
Predominantly taking referrals for children and families from the South of Wiltshire, Naomi House offers respite care, day visits and end of life care for children up to the age of 18.The multi-professional team is led by a specialist paediatric palliative care consultant. Jacksplace will accept referrals for young

people from 16 – 35 years. Referral details: https://www.naomihouse.org.uk/about-us/referrals

Julia's House

Julia's House is a Children's Hospice caring for children from 0-18 years across the whole of Wiltshire. We provide practical and emotional support for families caring for a child with a life-limiting or life-threatening condition, providing frequent and regular support in their own homes, in the community or at our hospices where day and occasional overnight care can be provided- wherever it is needed. This can include 24 hour support for children at the End of Life. The family support service provides holistic whole family support enabling family members to build their resilience and confidence this includes specialist play and complementary therapy. https://www.juliashouse.org/contact-us

Rainbow Trust

The Rainbow Trust is a non-clinical organisation that provides outreach support to children, parent carers, siblings and grandparents where a child has a life threatening or terminal illness. This may include practical support for example with taking siblings to and from school or helping to prepare meals, helping to liaise with hospitals regarding appointments and advice as well as emotional and bereavement support. Referral information: https://rainbowtrust.org.uk/support-for-families/ask-for-support

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Wiltshire Council

Health and Wellbeing Board

29th March 2018

Subject: Maternity Plan

Executive Summary

A Local Maternity System (LMS) has been created across our STP footprint to help the system respond to the nationally mandated Better Birth recommendations and further improve the experience for our local women and families. The LMS has co-created, with service users and partner stakeholders, a Maternity Transformation Plan (MTP) to create a strategic vision for the future. This plan is at **Appendix 1**. Previous briefings on the development of the plan and next steps have been provided to the Health Select Committee.

One of the key work streams for the LMS is the delivery of personalised care and choice. This work stream has been aligned with a project commenced by the RUH to review the delivery of antenatal, birth and postnatal pathways. A shortlist of options is being co-created with service users and stakeholders by the end of March 2018 in line with the required NHSE service reconfiguration process. These options will be shared with the Board as soon as they are confirmed.

Proposal(s)

It is recommended that the Board:

i) Notes the Maternity Transformation Plan
ii) Notes the development of options for anticipated formal consultation from June 2018

Reason for Proposal

To keep the Health and Wellbeing Board informed of maternity transformation and provide early information in relation to formal public consultation expected to commence in June 2018 in relation to delivery of antenatal, birth and postnatal pathways.

Lucy Baker, Acting Director of Acute Commissioning, STP Programme & Director for Maternity, Wiltshire CCG
Fiona Coker, Head of Midwifery and lead STP midwife, SFT
Sarah Merritt, Head of Nursing and Midwifery, RUH
Sandra Richards, Project midwife, GWH and WCCG
Sally Johnson, Head of service 0-5, Wiltshire Council

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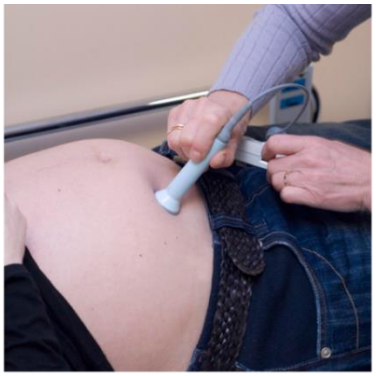
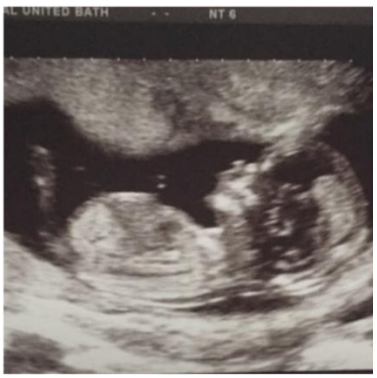








Our Local Maternity Transformation Plan

BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE LOCAL MATERNITY SYSTEM (LMS)

January 2018

Foreword

Our ambitious goal is that every woman in our region will have an equally positive experience regardless of her personal circumstance, whether she is a lone parent, a young parent supported by Family Nurse Partnership, a woman in a same sex relationship and any other pregnant woman in our diverse communities.

Birth is a special experience for all, from the women and their babies, to their partners and families through to the midwives and other birth attendants who have the privilege of being with women during this miracle of new life. This is the birth of a family too, who need to be supported so that all new parents have the confidence to take care of themselves and their new baby.

This letter reflects the care and support that we want every new mother to have. It is the unique experience of one woman, her baby and her partner.

A letter to my baby

As I watch you sleep deeply and safely, I reflect on the love I have for you and the joy you have brought me and your father.

You have had the best start in life and your dad and I have been fully supported to bring you into the world safely. We feel confident that we will be the best parents you could wish for. We thank all our carers for their support.

The health visitors continue to support us and give us information that is consistent with what we learned from our team of midwives to ensure you are developing and thriving. In partnership with my GP they also help me take care of my emotional wellbeing and knowing they are close at hand helps me feel protected, safe and confident to care for you.

Health professionals have been skilled at supporting me to nurture and sustain you by bringing you to the breast and continuing to breastfeed. Their partners in the community, such as children centres and others, are also available for us if we need extra support on our journey as new parents and to ensure we have a positive experience during this transition in our lives.

I chose your place of birth to be the safest and most relaxing place for us. During your birth, midwives enabled me to feel empowered and to be guided by my own instinct. The encouragement of family, friends and health professionals on the day gave your dad the confidence to be an amazing birth partner. Your birth felt private, safe and secure and I felt cared for, listened to and treated respectfully. I was able to follow my body's cues and make informed decisions about our care in labour and if I needed additional support, obstetricians and paediatricians were on hand.

There was much preparation leading up to your birth. I was confident in my decision about where to birth following open and informed discussion with my midwife. There were also opportunities for your dad to be involved in this. During my pregnancy with you I felt your movement, we talked about it at my antenatal checks, and my team of midwives measured and prodded me to check you were developing properly. I felt cared for, and as parents to be, contact with our midwifery team and antenatal classes prepared us for your birth and parenthood. We also built a social network along the way meeting other new parents.

When your dad and I felt ready for new beginnings, we prepared ourselves for conception, ensuring we were as healthy as possible and able to give you the best start in life.

Those nine months of us being together as one were an unforgettable journey as you developed from an egg to an infant. I look forward to our life as a family and feel blessed that we have received the best care possible.

Forever Yours

A New Mother

This is an exciting time for our maternity services and for women and families in B&NES, Wiltshire and Swindon. Service user representatives have been centrally involved in developing our local transformation plan, working alongside key stakeholders, sharing information, considering needs, identifying gaps and shaping services that have women and their families at the centre.

We begin this transformation from a strong base with well-established relationships across the local maternity system (LMS); good engagement from all parties; and a shared passion and commitment from all stakeholders to change our services for the better. It is now time to put our well thought out plans into action and drive forward our vision for “all women to have a safe and positive birth and maternity experience and to be prepared to approach parenting with confidence.”

Trudi Webber (MSLC Vice Chair) on behalf of service users

1. Introduction

Bath and North East Somerset, Swindon and Wiltshire (BSW) maternity services have increasingly been working together to improve services for women. Strong relationships have developed between the three hospital Trusts and commissioners. We welcome the publication of "Better Births, Improving outcomes of Maternity Services in England" as it provides a vision and framework for us to progress. The national blueprint for maternity as described in the Five Year Forward View has also been used to form this plan.

The providers and commissioners within BSW are active participants in the South West Maternity Clinical Network, which benchmarks providers and facilitates quality improvement initiatives. We are well placed to build on the success of this established network to transform our local maternity services through clinical leadership.

We will proactively engage with women, fathers, families and communities to ensure safe births, positive experiences and equity for all women. As organisational boundaries blur, staff and services will be enabled to improve communication and continuity of care. We will work together with partner agencies to develop seamless pathways that enable women and their families to access services to further enhance their physical, emotional and mental health in pregnancy and support the transition to parenthood ensuring the best possible start for babies.

We recognise that the commitment and ideas from staff provide the foundation of any transformation and we will ensure that their feedback informs and shapes our plan as it develops. Through embedding a continuous quality improvement approach, we will further develop the existing safety culture that is evidenced by transparent reporting and sharing of learning from serious incidents. We are committed to sharing and learning from each other when things go wrong as well as when celebrating success.

The current national pilot projects underway will provide additional learning and guidance which we are keen to adapt for our Local Maternity System as the evidence becomes available. This is an exciting time for maternity services in England, and we are looking forward to not only implementing our local plan but also being part of the country wide transformation that aims to make maternity care amongst the best in the world.

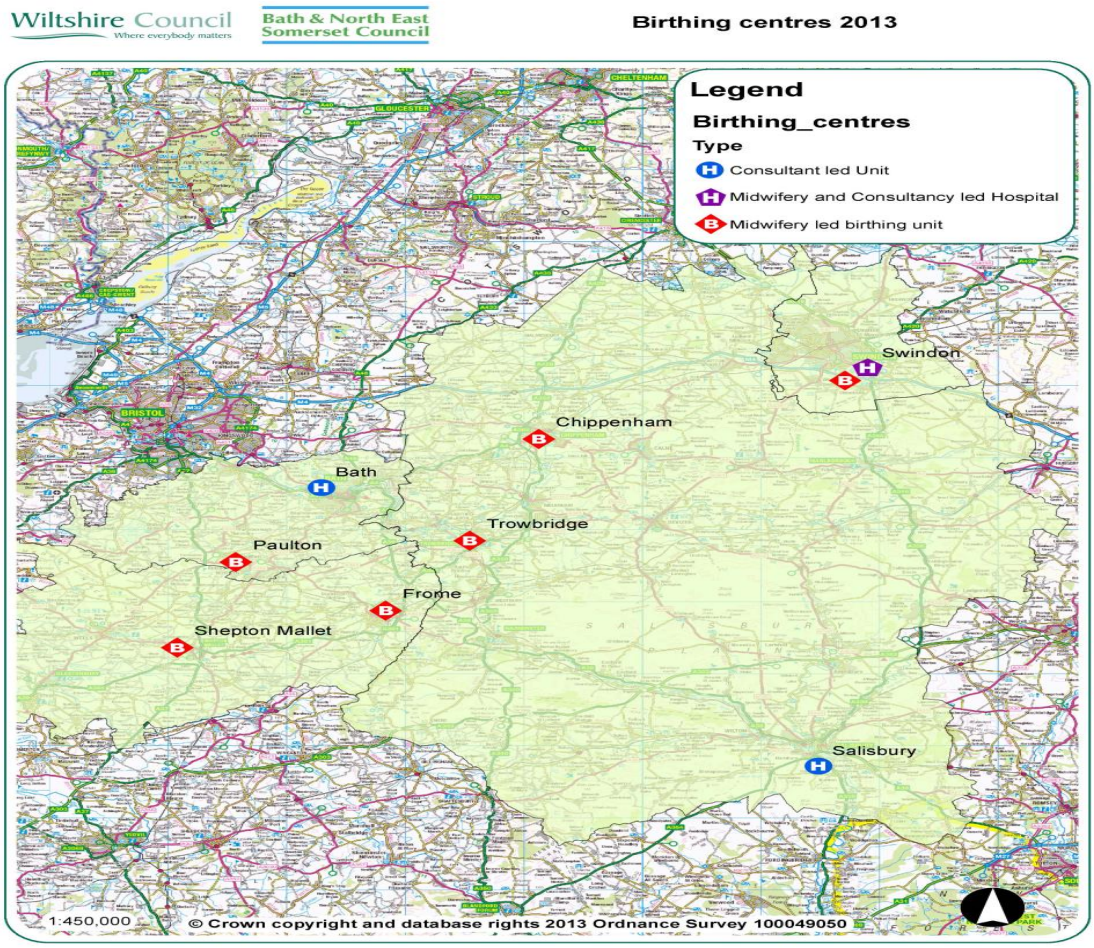
2. Our Local Maternity System

A Local Maternity System (LMS) has been created across the Bath and North East Somerset, Swindon and Wiltshire (BSW) Strategic Transformation Partnership (STP) footprint. The LMS is hosted by Wiltshire Clinical Commissioning Group (CCG) and includes service users and all providers and commissioners across the maternity pathway.

Our LMS has an extremely varied demographic structure and geography, which poses challenges to the delivery of maternity services. It features large rural areas (particularly the mid-Wiltshire Salisbury plain area) as well as urban centres. The main acute providers and larger towns are located on the periphery of the STP footprint. The footprint incorporates a largely affluent population but there are pockets of deprivation (6.4% of the population falls within the most deprived quintile).

The maps below detail birthing locations across the LMS.

Map 1: Birthing locations as per 2013*



**Note: Shepton Mallet now provides antenatal and postnatal care only.*

Map 2: Better Births Initiatives Mapping – Live birth density:

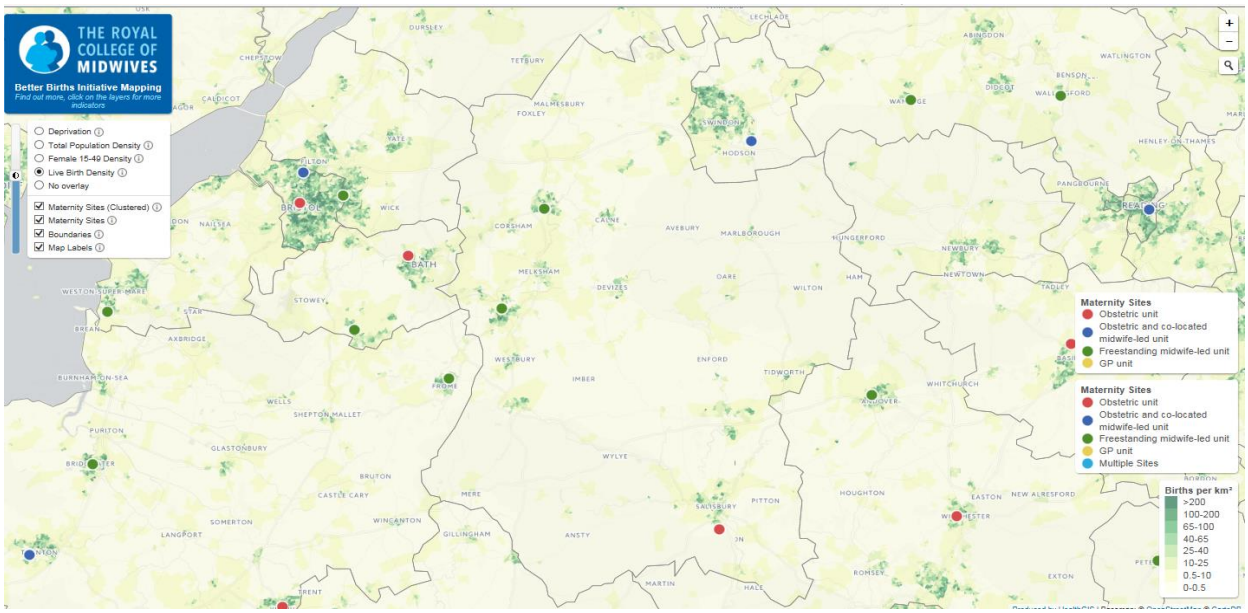
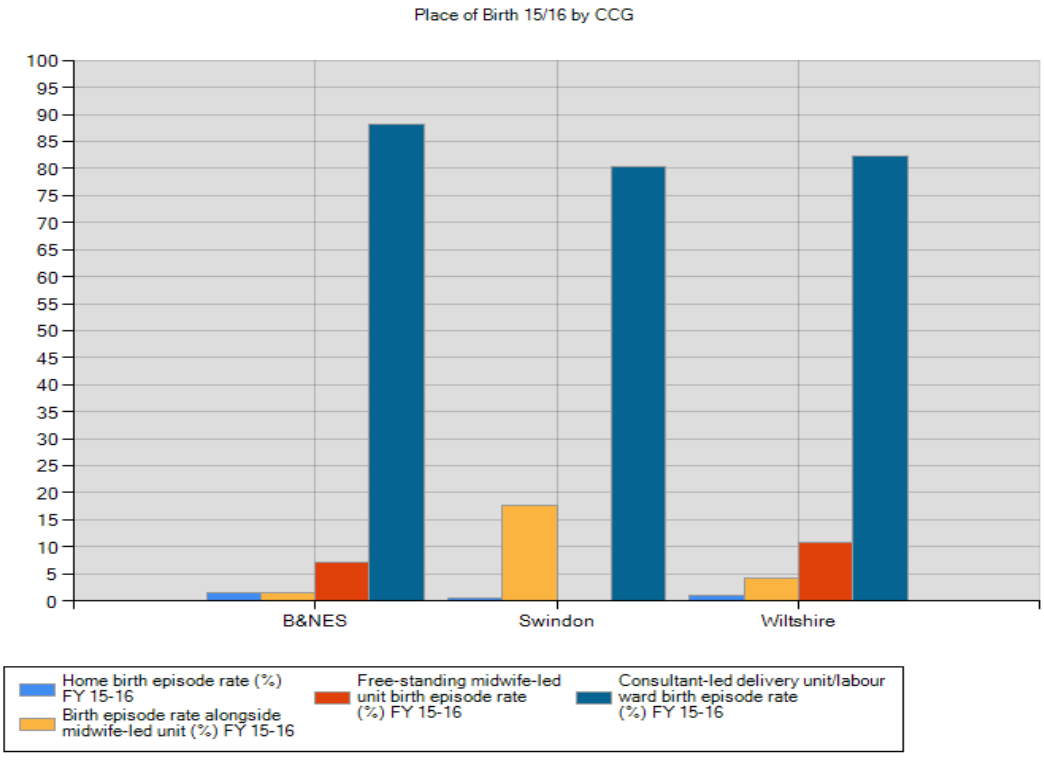


Table 1: Current maternity provision across the STP footprint:

Organisation	Maternity care and birth provision				
	Antenatal and postnatal care	Hospital based consultant care	Home birth	Standalone birth centre	Co-located birth centre
Royal United Hospitals Bath NHS Foundation Trust	√	√	√	Trowbridge Chippenham Frome Paulton	
Great Western Hospitals NHS Foundation Trust	√	√	√		√
Salisbury Hospitals NHS Foundation Trust	√	√	√		

Salisbury are currently exploring the option of a co-located birthing unit linked to military repatriation and associated demographic growth. It is our vision that all women will have access to the full range of antenatal, postnatal and birth choice options across the LMS footprint. An acute services redesign process has been commenced to review current choice and develop future options, which will be subject to a full public consultation exercise. Further details of this process feature in section 5.1. The maternity provision naturally affects the choices women make around where they birth. Figure 1 below illustrates this variation across the LMS.

Figure 1: Place of Birth 15/16 by Clinical Commissioning Group



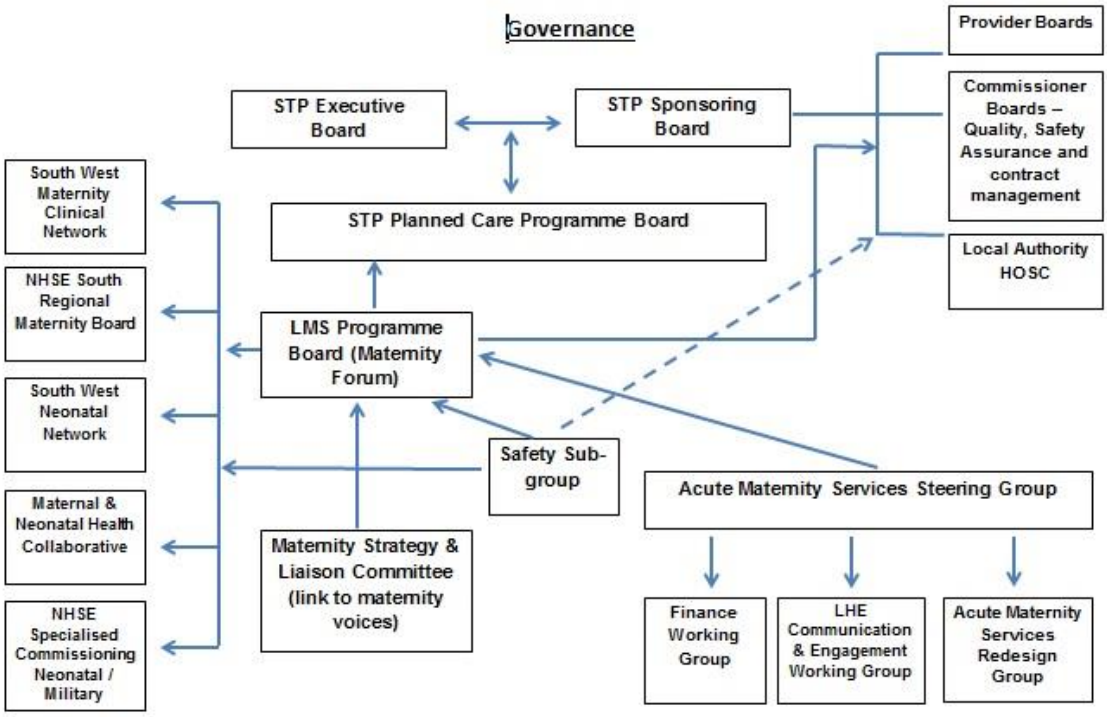
Source: SWSCN

2.1 Governance

The Local Maternity System (LMS) consists of the Local Maternity System Programme Board and the Maternity Strategy Liaison Committee. The Maternity Strategy Liaison Committee (MSLC) is the multi-disciplinary strategic arm of the LMS that drives the strategic direction for services across the maternal care pathway and is accountable to the LMS Programme Board. It is informed by national policy and local agendas. Its work includes reviewing national policy, such as the Better Birth Recommendations and responding to local needs and agendas. It is chaired by Public Health and is attended by a range of stakeholders including service users (See Appendix 1 for core membership). Ensuring providers and commissioners take account of the views and experiences of women and their families who use maternity services is a key function of the group. Maternity services are commissioned by B&NES, Swindon and Wiltshire CCGS and quality and safety assurance is provided through CCG Contract Quality Review meetings and processes. Maternity measures are included in the CCG Internal Assurance Framework (IAF). This data is reviewed at the LMS Programme Board. The LMS has strong links into the South West Clinical Network and the NHS Improvement maternity and neonatal safety collaborative.

A dedicated Acute Maternity Services Steering Group has been created to support the service reconfiguration aspects of our choice work stream. This is supported by finance, redesign and communication and engagement working groups. Further detail can be found on page 21.

Fig 2: The LMS Governance framework



The development of a local Maternity Voices Partnership is being discussed with current service user representatives at the MSLC. The above framework will be amended to reflect developments in this area in due course.

Our LMS has defined and appointed key roles, which feature in the table below:

SRO	Chief Officer, Wiltshire CCG
Programme Director Lead Commissioner	Director, Wiltshire CCG
STP/ LMS lead midwife	Head of Midwifery, SFT
STP / LMS lead public health representative	Wiltshire Council
Lead service user rep	MSLC vice chair
Project Midwife	LMS (appointed Jan 2018)
Lead Consultant	RUH/SFT
Lead GP	BaNES CCG
Quality lead	Associate Director of Quality, Wiltshire CCG
Finance lead	Deputy Chief Finance Officer, Wiltshire CCG
Comms and engagement lead	RUH/ WCCG
Project manager (service reconfiguration)	RUH

2.2 The LMS and Accountable Care Organisations

Accountable care is about bringing organisations in an defined area together to work towards a common goal of helping the local population to live healthy, independent lives in which the right health and social care is available when needed.

Providers and commissioners are being encouraged to join forces in a way that will enable woman and their families to access, and staff to provide, care that is more integrated and free from the organisational barriers that can often cause delay, confusion and frustration to many. The organisations will include local councils, health care providers and social services.

Sustainability and Transformation Partnerships (STP) will need to co-ordinate with the Accountable Care Organisations within their area to influence the agenda.

Co–design approach to identifying key streams and priorities including engagement events with staff and service users will set priorities for areas of focus relevant to the needs of the population that the Accountable Care Organisation covers.

The LMS will liaise closely with neighbouring Accountable Care Organisations and STPs to ensure that priorities are shared and discussed to ensure the maternity agenda has influence and a voice.

3. An understanding of the local population and its needs for maternity services

It has not been feasible within the time limitations to conduct a full maternal health needs assessment across the LMS to inform this plan. Nevertheless, all available data has been reviewed from a range of sources including Public Health England, the South West Clinical Network Maternity Dashboard and RightCare and some conclusions drawn.

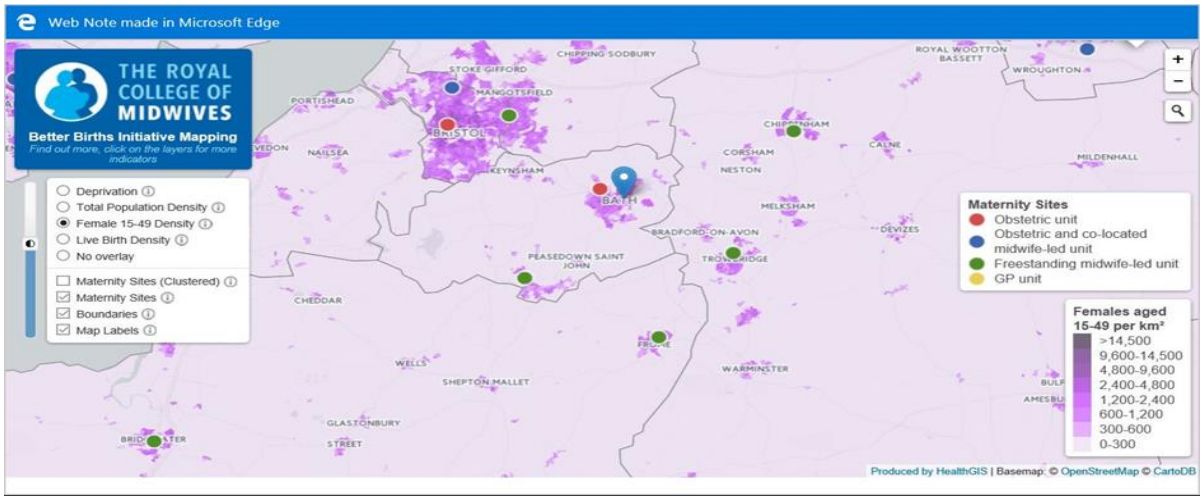
3.1 Geography and population

Wiltshire, Swindon and B&NES span a large geographical area of 3,875 km^2 with a total population of 894,065 based on ONS 2016 mid-year estimates. Each area has distinctively different geographies and demographics which are important to consider when transforming maternity services locally.

Wiltshire is a predominantly rural area covering an area of 3,485 km^2 and population density averages 140 people per km^2. It is largely white-British population with few people from ethnic minorities. Access to maternity services varies considerably for women living in different parts of Wiltshire.

Swindon is a large town covering an area of only 40 km^2 and the average population density is 5,447 people per km^2. The 2011 Census showed population growth to be faster in Swindon than the England average and the population from minority ethnic groups nearly doubled in ten years. B&NES area contrasts greatly in terms of density and diversity of population. The City of Bath accounts for approximately half the population and is 12 times more densely populated that the remainder of North East Somerset. About 10% of the population are non-white-British. In terms of deprivation B&NES is one of the least deprived authorities in the country, ranking 247 out of 326. The density of female population aged 15 to 49 is reflected in map 3 below. The LMS will undertake further work to analyse the data that informs the map and consider the implications.

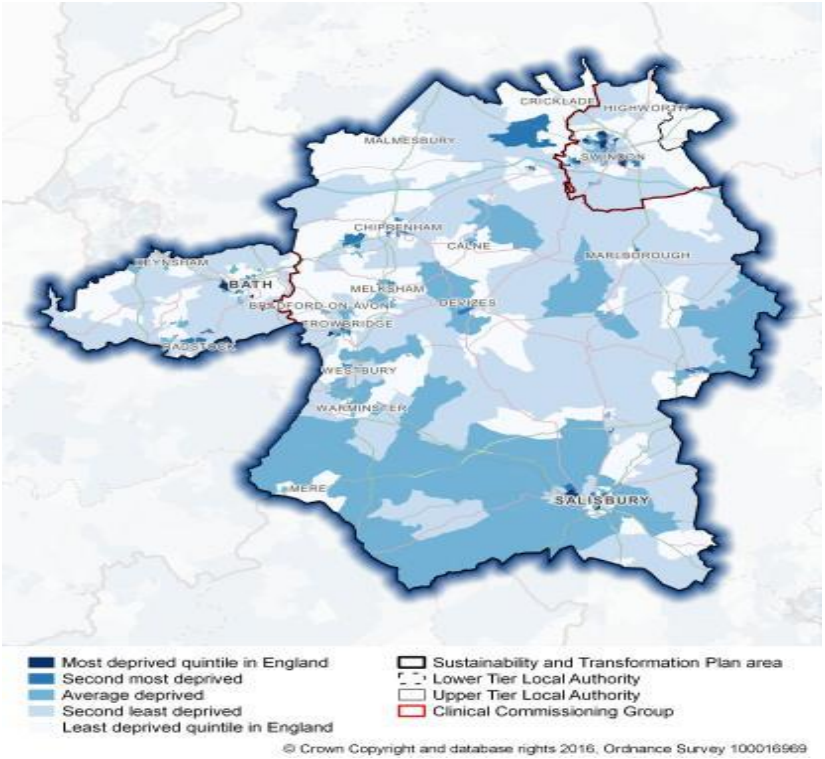
Map 3: Better Births Initiative Mapping – Female 15-49 Density



3.2 Deprivation

The Index of Multiple Deprivation (IMD) ranks the 32,844 Lower Super Output Areas (LSOAs) in England in terms of deprivation. LSOAs contain about 1,500 people. Wiltshire and B&NES are considered to be generally prosperous areas; however, there are hidden pockets of deprivation as illustrated in Map 4. Based on 2015 IMD data, 12 LSOAs in Wiltshire are within the 20% most deprived LSOAs in England and five in B&NES. Deprivation is more evident in Swindon with 19 LSOAs within the 20% most deprived nationally and eight of those are in the 10% most deprived.

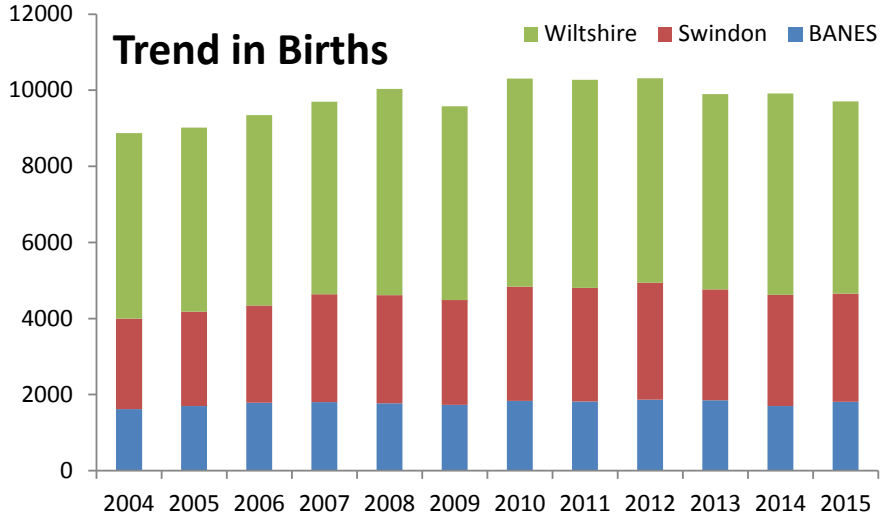
Map 4: Deprivation quintile map 2016



3.3 Number of live births

Over the last 12 years there has been some variation in the overall number of births with a low of just under 9,000 in 2004 to a high of over 10,300 in 2012. There has been little variation, however, in the proportion of births in each of the three areas during the same period (Figure 3). Most recently (2015), just over half the births were to women who lived in Wiltshire (53%), just under a fifth were to women who lived in B&NES (18%), and just under a third were to women who lived in Swindon (29%).

Fig 3: Trend in Live Births



Source: ONS

Although the number of births in each area has fallen slightly in recent years (Table 2), the latest ONS projections forecast a gradual increase in the number of births for each area. Local policy-led projections sometimes present a different picture (Figure 4). Swindon Borough Council's policy-led projection forecast a slightly bigger rise in Swindon births. In Wiltshire, a combination of plans to increase housing, as set out in the Core Strategy, and the army rebasing programme are expected to impact on birth numbers. An initial crude estimate suggests this could result in over 700 additional births across Wiltshire. The LMS recognise the importance of closely monitoring population changes to ensure the vision outlined in this MTP can be delivered effectively.

Table 2: Number of live births by local authority

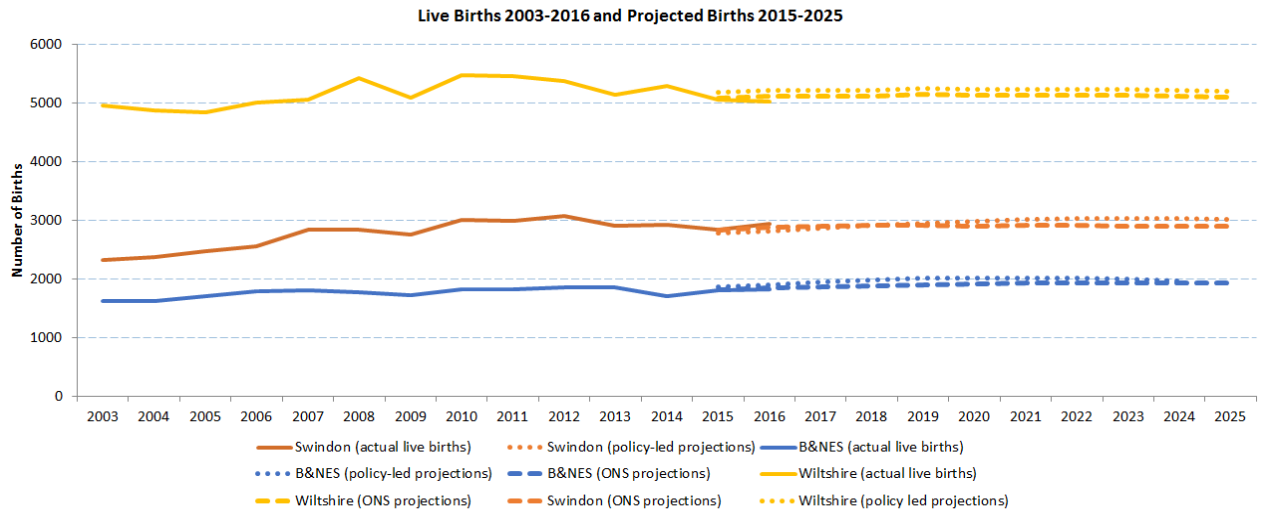
	Swindon	B&NES	Wiltshire
2012	3,073	1,867	5,378
2013	2,911	1,854	5,133
2014	2,923	1,702	5,290
2015	2,847	1,808	5,050

Source: ONS

Figure 4 illustrates the following birth projections for our footprint working from a baseline of 9,790 births

- 2018/19 - 10,127
- 2019/20 - 10,213
- 2020/21 - 10,238

Figure 4: Projected number of births



Source: ONS, BANES, Wiltshire and Swindon Borough Councils

3.4 Early booking

It is recommended that women have access to maternity services for a full health needs assessment ideally by 10 weeks of pregnancy (NICE, 2008). Late booking and late access to antenatal care is a known risk factor. In B&NES, Swindon Wiltshire ≥90% of women book early in pregnancy in line with the South West median is 92%.

3.5 Flu vaccination in pregnancy

The Public Health England influenza immunisation programme aims to offer protection to those who are most at risk of serious illness or death should they develop influenza. Preventing flu in pregnancy plays an important part in preventing maternal deaths (MBRRACE, 2014).

Table 3 provides data on flu vaccination uptake in pregnancy and shows a small increase across the LMS in 2016/17 compared with 2015/16. Increasing the uptake flu vaccinations in pregnant women is a priority for the LMS and flu clinics were introduced in some maternity services across the footprint in 2016/17 as a pilot approach. All maternity services have repeated this model for the 2017/18 flu season. Improved access for pregnant woman at scheduled screening appointments commenced in October 2017.

Table 3: Provisional cumulative uptake data for England for vaccinations in pregnancy given from 1 September 2016 to 31 January 2017

	Pregnant women	
Area	**2015/16**	**2016/17**
B&NES	44.0%	45.7%
Swindon	46.7%	46.9%
Wiltshire	42.9%	43.9%
Gloucestershire	43.9%	46.7%
BGSW	44.2%	45.8%
England	42.3%	44.8%

Source: ImmForm website, registered patient GP practice data (PHE)

The national expectation is to deliver flu vaccinations to 75% of the pregnant population therefore further work is required to achieve this.

3.6 Complex needs

The following risk factors are known to increase a mother and baby's vulnerability to adverse events: booking late in pregnancy (early booking data is routinely collected to monitor this); maternal age where risks are higher for younger women and older women; language barriers; smoking in pregnancy; obesity in pregnancy; maternal mental health; multiple births. Data related to these risk factors is presented in Table 4 with the exception of maternal mental health for which robust data is not yet available.

Table 4: Women with complex needs in pregnancy by CCG area (2015-16)

	Swindon	B&NES	Wiltshire	South West median
Early booking in pregnancy rate (1)	86.4%	91.9%	90.0%	90.0%
Birth rate from under 18 conceptions	4.0%	1.2%	2.4%	1.4%
Birth rate in women aged 40 or over (1)	1.4%	1.3%	2.4%	2.4%
% of babies born to mothers born in the Middle East and Asia (2014) (2)	10.5%	3.2%	2.7%	3.25%
Smoking at birth rate (1)	10.9%	7.4%	9.8%	10.9%
Obesity –BMI 30+ (1)	20.2%	17.2%	21.2%	21.0%
Multiple births (per 1000) (2015) (2)	20.4	14.5	14.2	14.9

Source: (1) South West Clinical Network Maternity Dashboard / (2) PHE Public Health profiles

Wiltshire has a higher percentage of women over 40 years birthing than in the other areas, but not exceptionally high for the South West. The difference in ethnicity of mothers is very apparent in Swindon with over 10% of babies born to mothers from the Middle East and Asia, reflecting the greater ethnic diversity in Swindon. Smoking rates are highest in Swindon and lowest in B&NES which may be related to levels of deprivation in the respective areas. Maternal obesity is lowest in B&NES and similar to the South West median in both Wiltshire and Swindon. Swindon has a notably higher rate of multiple births than B&NES and Wiltshire.

RightCare Maternity and Early Years data comparing Wiltshire, Swindon and B&NES each with their 10 most demographically similar CCGs also highlights smoking in pregnancy as an area of 'opportunity' for improvement. Overweight and obesity rates in children aged 4-5 are also notably high compared with demographically similar CCGs suggesting there is opportunity for improvement. Babies born to obese mothers are at greater risk of becoming obese children which highlights the importance of working to ensure women adopt healthy lifestyles before and during pregnancy and to support and enable more women to breastfeed. The RightCare data for all CCGs within the LMS was presented and discussed at the Maternity Forum on Thursday 25 May 2017 and the above priorities identified.

The LMS Programme Board will be reviewing complexity data during quarter one 2018 to establish a baseline which will be used to aid future planning and service requirements. This will include complexity classification as used in Maternity Pathway Payments and complex social needs.

3.7 Perinatal mental health

Perinatal mental illness refers to a range of mental health problems of varying severity that can affect women during pregnancy and in the year after birth including anxiety, depression and postnatal psychotic disorders. Such problems affect up to 20% of women at some point during pregnancy and for the first year after birth and can have a significant negative impact on the mother, family and her developing child. Mental illness is one of the leading causes of maternal death in the UK and the number of new mothers committing suicide has not fallen over the past decade. Babies born to mothers experiencing perinatal mental health illness are at increased risk of prematurity, low birth weight, infant mortality, suboptimal growth, illnesses, neurodevelopmental problems and long-term cognitive outcomes.

Table 5 provides an estimate of perinatal mental illness across the LMS broken down by area and shows the potentially large numbers of women to suffer from mild to moderate mental illness during the perinatal period. Research indicates that there will also be a proportion of fathers who develop mental health difficulties during this period.

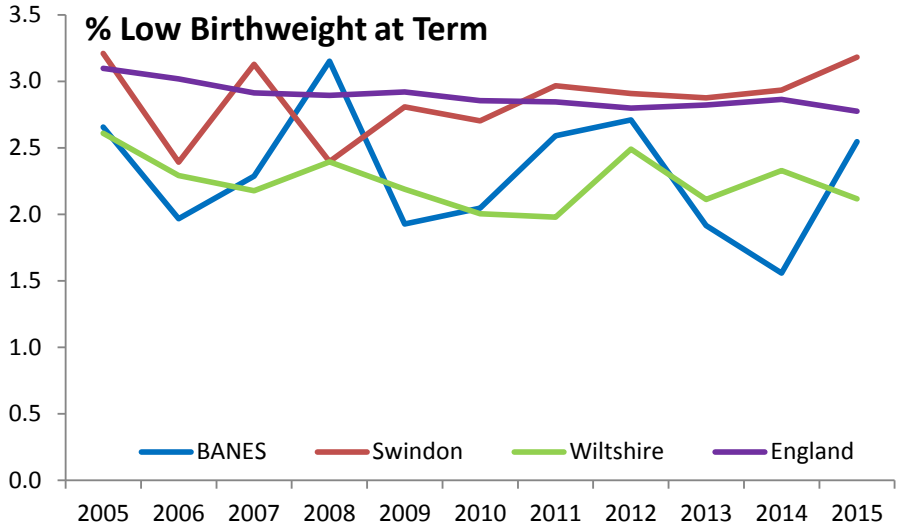
Table 5: Perinatal Mental Health Projections taken from the Chi Mat tool

Perinatal Mental Health Projections	NHS Wiltshire	NHS B&NES	NHS Swindon
Estimated number of women with postpartum psychosis (2013/14)	10	5	10
Estimated number of women with chronic SMI (2013/14)	10	5	10
Estimated number of women with severe depressive illness (2013/14)	140	55	90
Estimated number of women with mild-moderate depressive illness and anxiety (lower estimate) (2013/14)	460	180	290
Estimated number of women with mild-moderate depressive illness and anxiety (upper estimate) (2013/14)	685	270	435
Estimated number of women with PTSD (2013/14)	140	55	90
Estimated number of women with adjustment disorders and distress (lower estimate) (2013/14)	685	270	435
Estimated number of women with adjustment disorders and distress (upper estimate) (2013/14)	1,370	540	865

3.8 Low birth weight babies

Low birth weight (babies born weighing less than 2.5kg) is a major determinant of mortality, morbidity and disability in infancy and childhood and also has a long-term impact on health outcomes in childhood and adult life. Low birth weight of full term babies is obviously of most concern and routinely monitored. Figure 5 shows the trend across the LMS and compares with England.

Figure 5: Trend in percentage of low birth weight at term babies



Source: ChiMat

The average percentage of low birth weight babies at term has been falling in England as has the percentage in both Wiltshire and B&NES. In Swindon the percentage has been rising and is now higher than the England average.

3.9 Caesarean births

Unnecessary caesarean (not medically indicated) births carry additional risk of complication to both the mother and baby as well as increased health care costs. The latest data available locally (Table 6) shows the percentage of caesarean births broken down by NHS Trust and by CCG area in 2016-17. The data ranges from 22.9% at the Royal United Hospital NHS Foundation Trust, significantly lower than the South West median of 24.9%, to 27.6% at the Great Western Hospital NHS Foundation Trust, significantly higher than the South West median.

Table 6: Caesarean births rates by NHS Trust and CCG area (2016-17)

	Caesarean birth (1)
NHS Trust	
Royal United Hospitals Bath NHS Foundation Trust	22.9%
Great Western Hospitals NHS Foundation Trust	27.6%
Salisbury Hospitals NHS Foundation Trust	23.1%

CCG	
B&NES	Data not available
Swindon	27.6%
Wiltshire	23.6%
South West median	24.9%

Source: (1) South West Clinical Network Maternity Dashboard

Work has commenced across the LMS to explore caesarean birth rates. This includes a dedicated research project at GWH being supported by the University of West of England.

3.10 Breastfeeding

Breastfeeding reduces the risk of infant infection and mortality and confers protection for the mother from breast cancer. There is also some evidence that breastfed babies have lower incidence of Sudden Infant Death Syndrome (SIDS), are less likely to be obese as children and have a higher IQ. Table 7 shows the latest annual data and a more up to date snapshot from the regional maternity dashboard.

Table 7: Breastfeeding initiation by area

Breastfeeding initiation by area	Breastfeeding initiation		
	1415 (1)	**1516 (2)**	**1617 (2)**
Swindon	84.1%	84.4%	79.2%
B&NES	76.3%	84.4%	no data
Wiltshire	80.1%	76.3%*	74.4%*
South West	79%	77.4% (median)	77.9% (median)
England	74.3%	n/a	n/a

*Source: (1) Department of Health Statistical releases / (2) South West Clinical Network Maternity Dashboard / *affected by data quality issues*

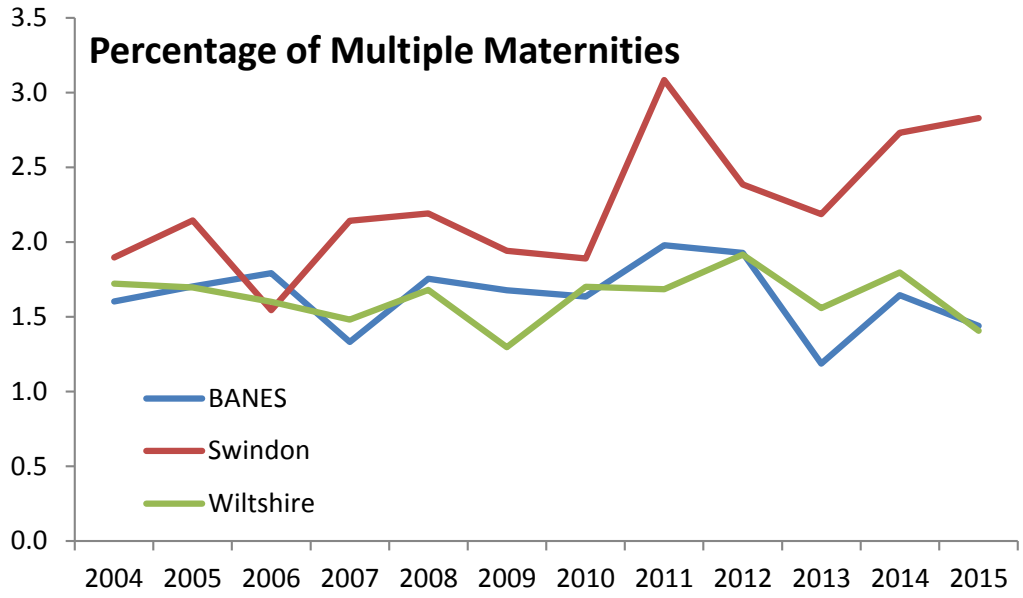
Breastfeeding initiation rates in Swindon, B&NES and Wiltshire have been higher than the national and regional averages for many years. This continues to be the case although data quality issues have affected the ability to monitor progress accurately over the last 12 months.

However, a closer look at the data reveals variation in relation to age and deprivation. Breastfeeding initiation rates are lower in more deprived areas and breastfeeding initiation among young mothers (under 25 years of age) is statistically significantly lower than any other age group.

Despite a high percentage of women initiating breastfeeding, historic data suggests that many women cease breastfeeding in the early weeks. Due to changes in the way 6-8 week breastfeeding data is collected recent data quality is variable across the LMS and, therefore, not included. As data quality improves breastfeeding drop-off rates will be monitored and analysed to ensure women are being supported to sustain breastfeeding.

3.11 Multiple births

Figure 6: Trend in multiple births which carry risks for both the mother and baby



Source: ONS Vital Statistics

The trend for both B&NES and Wiltshire is generally consistent and the same. The trend in Swindon is increasing and is now higher than both B&NES and Wiltshire.

3.12 Infant mortality and stillbirth

Wiltshire, Swindon and B&NES MSLC maintains regular oversight and scrutiny of infant mortality and stillbirth data to enable it to fulfil its key function of ensuring maternity care is of the highest quality. Infant mortality is well recognised as an indicator of population health; the wellbeing of infants, children and pregnant women; and of progress towards addressing inequalities. Most infant deaths occur in the first 27 days of life and stillbirths and infant deaths are associated with a number of complex risk factors, including obesity, smoking, maternal age and inequalities.

It is well recognised that many of the risk factors that impact on low birth weight, infant mortality and stillbirth are disproportionately represented in the most deprived communities. Local data supports this.

The Wiltshire, Swindon and B&NES Stillbirth and Infant Mortality Report (2017) looked in detail at births, stillbirths, perinatal and infant mortality across the LMS and associated risk factors over the last ten years. In summary:

- **Infant mortality rates** in B&NES and Swindon are reducing while in Wiltshire the trend is relatively flat.
- The **stillbirth rates** are broadly similar in all areas although the trends vary. There is an upward trend in B&NES, a downward trend in Swindon and a fairly consistent trend in Wiltshire.

The stillbirth baseline rate is 5.6 per 1000 which is estimated to reduce to 5 per 1000 (2019), 4.8 (19/20), 4.6 (20/21).

Perinatal mortality rates are similar for all areas. The trend in Swindon is reducing; for B&NES and Wiltshire the trend is flat.

3.13 Key Challenges

Based on the factors set out in this section, the key challenges facing the LMS are as follows:

- Improve maternal nutrition and reduce maternal obesity levels.
- Reduce smoking in pregnancy to 6% by 2022.
- Increase the uptake of the flu in pregnancy vaccination to better protect women.
- Increase breastfeeding rates with a particular focus on young mothers and those from more deprived communities.
- Maintain implementation of the NHSE *Saving Babies' Lives* care bundle and monitor progress.
- Improve the care pathway for women with maternal mental health difficulties, including those with chronic low-level problems.
- Developing continuity of carer and appropriate staffing levels in the context of a rising birth rate and increasing complexity within existing resources.
- Managing the expectations of staff, service users, their families and communities.
- Ensure equity of maternity provision across the LMS whilst ensuring services are able to respond to demographic variations and the differing needs of the population.
- Ensure we have sustainable workforce across our system with robust planning.
- Ensure we continue to consult and co-create our vision and future delivery of our services with our population.
- Ensure we balance improving the overall health of the maternal population with targeting interventions effectively to address the health inequalities that exist.

4.0 The views of women

In April 2017 Public Health professionals worked together with service user representatives from the MSLC to develop and implement an online Place of Birth Survey. The survey focussed on what and/or who informs women's decision about where to birth their baby and was targeted at women who were currently pregnant and those who had given birth within the last year. The week long survey received 850 responses.

The respondents were from a fairly representative sample in terms of deprivation and there was a 50:50 split between those pregnant and those who had given birth in the last 12 months. The data was analysed, themes drawn out and the following recommendations made:

- Develop ways of engaging with partners and ensuring they have access to unbiased information to inform decision making around place of birth.

- Ensure unbiased information and discussion that includes the risks and benefits of all birthing options is offered to all expectant parents consistently across the Local Maternity System. To include identifying and agreeing use of an online tool, e.g. Which Choices.

- Actively promote positive birth stories and experiences to expectant parents and the wider community to promote positive birthing generally and to help break down misconceptions about certain birthing choices, such as birthing in the community.

- Engage with service users to gain a more detailed and deeper understanding of what aspects of birth environment affect their decision about where to birth.

- Adopt a similar methodology in the future to gather feedback from a representative sample of service users on issues related to maternal health and care.

Maternity services have a variety of tools to gather patient experience and feedback including Friends and Family Test (FFT), CQC Maternity Picker Survey, Birth Reflections, Compliments and Complaints. This information is regularly triangulated to gather themes, both positive and areas for improvement, to ensure priorities align with what our women and their families are telling us.

Local themes include:

- Quality of care – kindness, compassion, listening.
- Continuity of Carer – antenatal and postnatal.
- Better communication between teams / other health professionals.
- Emotional wellbeing and support in the post-natal period.

There are clear similarities to the national picture and the priorities of Better Births: Safer Care, Personalised Care, and Continuity of Carer, Working across boundaries, Multi-professional working and Better Postnatal and Perinatal Mental Healthcare (Better Births). All maternity services have facilitated or are planning to run 'Whose Shoes' workshops. The word cloud below features an example from one of our Trust's.

5.0 Better Births Gap Analysis

All maternity providers completed a self-assessment against the Better Births recommendations. These assessments were reviewed at the MSLC and common themes drawn together to help shape the priorities of this transformation plan.

Themes from the 'Better Births' analysis from 2016

There are seven areas that each provider within the B&NES, Swindon and Wiltshire LMS measured themselves against. This self-assessment was formulated as a GAP analysis.

Red – unlikely to achieve this recommendation without significant investment or service transformation, which has not yet been agreed.

Amber – have a good possibility of achieving this recommendation within the national time-frame.

Green – already meet this recommendation or can realistically achieve it by March 2017.

Table 8: Themes from the 'Better Births' analysis from 2016

Work stream	Positives	Challenges	Overall RAG rating
Personalised care and choice	**All 3 providers currently looking at ways of giving unbiased information**	• **2 providers have 3 out of 4 birth place choices.** • **Personalised plans not fully implemented.**	**Red**
Continuity of Carer	**In some areas there is evidence of continuity of in the antenatal period**	• **All providers have a high number of midwives that have chosen to work part time.** • **None of the three maternity services have continuity within the maternity workforces.**	**Red**
Better Postnatal and perinatal mental healthcare	**Perinatal infant mental health pathway is being developed across the LMS footprint and all providers are engaged with this development**	• **Post natal care provision is patchy and there is little consistency in the post natal offer.** • **There is a variation in availability of community mental health services.**	**Amber**
Working across boundaries	**All providers are involved with local systems- MSLC and planned maternity forum**	• **There are no shared policies and pathways between the providers.** • **Digital systems are not compatible between providers.** • **Community hubs are**	**Amber**

		not yet a consideration.	
Safer care	**All providers site a culture of learning and continuous improvement Duty of Candour in place in all organisations All providers are signed up to the National Maternity and Neonatal Health safety Collaborative**	**The rapid redress scheme is an expectation but this has not been outlined nationally**	**Green**
Multiprofessional working	**All providers have teams that train and learn together**	• **Peer reviews not yet in place** • **No systems in place to learn across the region**	**Amber**
Payment System		**National system not yet in test**	**Red**

5.1 Personalised Care and Choice

Our vision for personalised care and choice is:

- Women and their families will be fully informed and receive unbiased information. They will be actively involved in co-creating their care plan and feel listened to throughout this process.
- Women and their families will enjoy positive experiences and feel safe.
- There is recognition that pregnancy and beyond is a dynamic pathway so as an LMS we need to be responsive and iterative and ensure there is “time to talk and time to listen”.
- Staff across the LMS are confident and skilled to undertake their roles, feel supported to provide the care they want to, and have the time and capacity to provide a partnership role throughout the pregnancy journey and beyond.

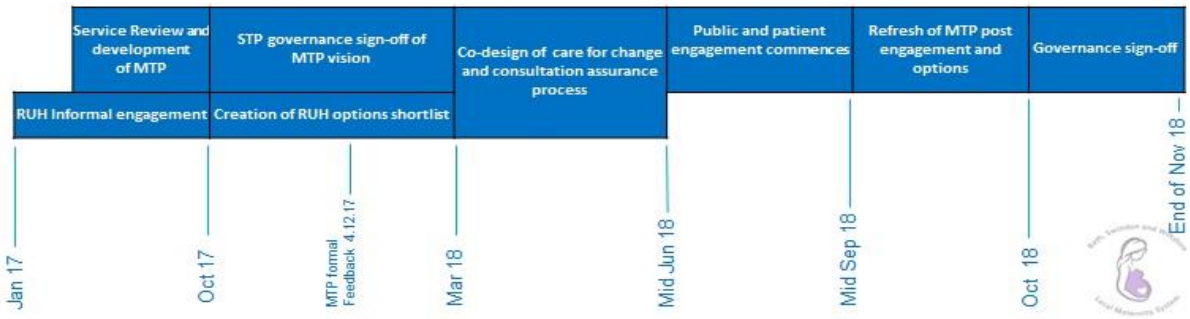
All three providers currently provide individual care planning to women through historically delivered models. This process begins from the booking appointment and continues through the maternal journey to postnatal care. The LMS will be reviewing this process to ensure parity of process and patient experience across the STP footprint via the MSLC to include users and other providers across antenatal and postnatal care. The next stages are detailed in the action plan on page 33.

A dedicated Programme Board utilising a full PMO (project management) approach has been developed to support the choice work stream. Informal staff and public engagement began in January 2017 and a shortlist of options for redesign will be agreed by March 2018. This may require formal public and staff consultation depending on the agreed shortlist. This redesign work will cover provision of antenatal, postnatal and labour care as well as consideration of the number and

location of maternity clinical hubs and will reflect the priorities set out in Better Births. The following table demonstrates the proposed timeline for this work, which has been mapped across the revised NHS service reconfiguration model. We are currently working on stage one of this process. We are currently working on stage one of this process with an expected Stage 1 NHS reconfiguration meeting timetabled for April 2018. As a result of the mandated revised service reconfiguration requirements, our initial project plan timetable has been revised.

Next Steps + Programme Delivery

Action	Date	Status
1. Co-creation of strategic Maternity Transformation Plan (MTP) **stage one**	July - September 2017	Complete
2. Draft MTP submitted – **stage one**	October 20th 2017	Complete
3. RUH informal engagement commenced – **stage one**	January 2017	In progress
4. RUH informal engagement long list of options scored – **stage one**	September – November 2017	In progress
5. Identification of short list options to inform LMS plan – **stage two**	December 2017	
6. Co-design of LMS proposal (Including RUH elements) – **stage two**	January - February 2018	
7. Discussion, Assurance and Approvals for recommendations for change (inc. NHSE, Clinical Senate, HOSC, Boards etc.) – **stage three/four**	February 2018	
8. Development of consultation plan and materials – **stage three/four**	February – March 2018	
9. Formal public and patient engagement and / or consultation – **stage five**	March 2018 – June 2018	



A Clinical Senate Review is also planned for the end of April 2018 as part of the assurance process.

A dedicated Maternity Redesign Steering Group is in place supported by a Project Manager. The Acute Maternity Services Steering Group will sign off the case for change for wider approval and sign off, which will include:

- Nationally led improvement work e.g. Better Births.
- Local drivers – LMS Transformation Plan, RUH Maternity Services Redesign.

The rationale for this redesign work is that the current choice of place of birth for women and families is resulting in:

- Underutilisation in some care settings
- Mismatch between workloads and staffing levels
- Current variation in LMS provision and birth environments

The key aims of this programme are:

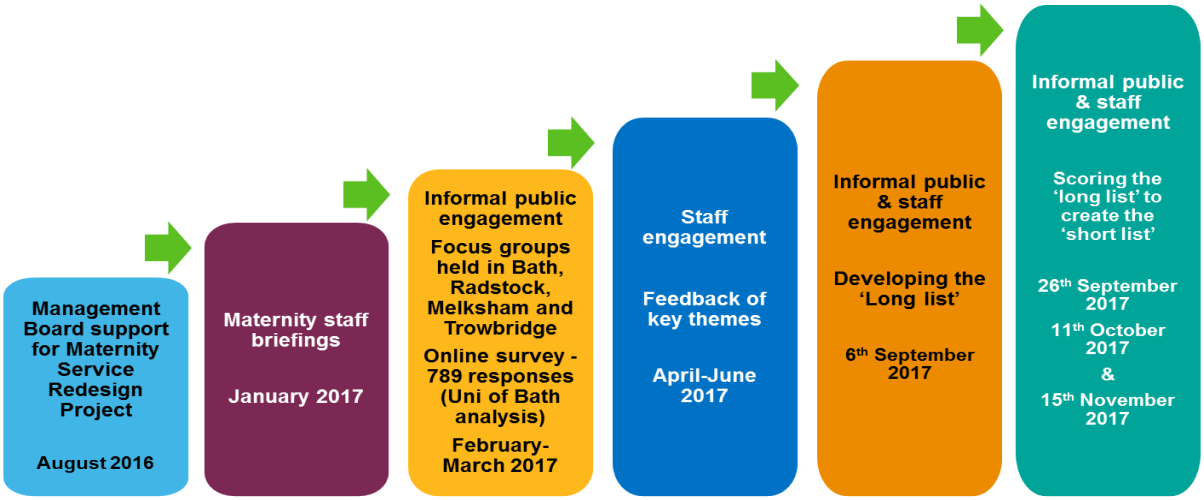
- Improved outcomes and experience across STP
- Safe and consist service
- Parity of access
- Value for money

The sign-off process for any change proposals will include the BSW STP, HOSCs, CCG Governing Bodies Acute Provider Boards and will follow the defined NSHE Service reconfiguration process.

Communications and engagement activities will be overseen by the LHE Communication and Engagement Working Group, reporting into the Acute Maternity Services Steering Group.

The LMS recognises that there is the opportunity to further improve maternity services, to focus on safety and equity, and to be responsive to the choices that women are making. Before developing any options for service change, there has been a period of informal engagement to help understand what matters most to our maternity service users, what families want from our maternity services and what drives the choices they are making in relation to their care and decision making around where to have their baby. Informal engagement also sought to understand what service users feel is good about current service provision and what they would like to see improved.

To gather this information, in January 2017 the RUH launched informal patient and public engagement activity to broadly outline the need for change and to gather feedback on what matters most to women and families when choosing where to give birth. Over the period of 3 months they had feedback from over 800 people including staff, mums and stakeholders, via questionnaires and discussion groups. A summary of engagement activities is set out in the diagram below.



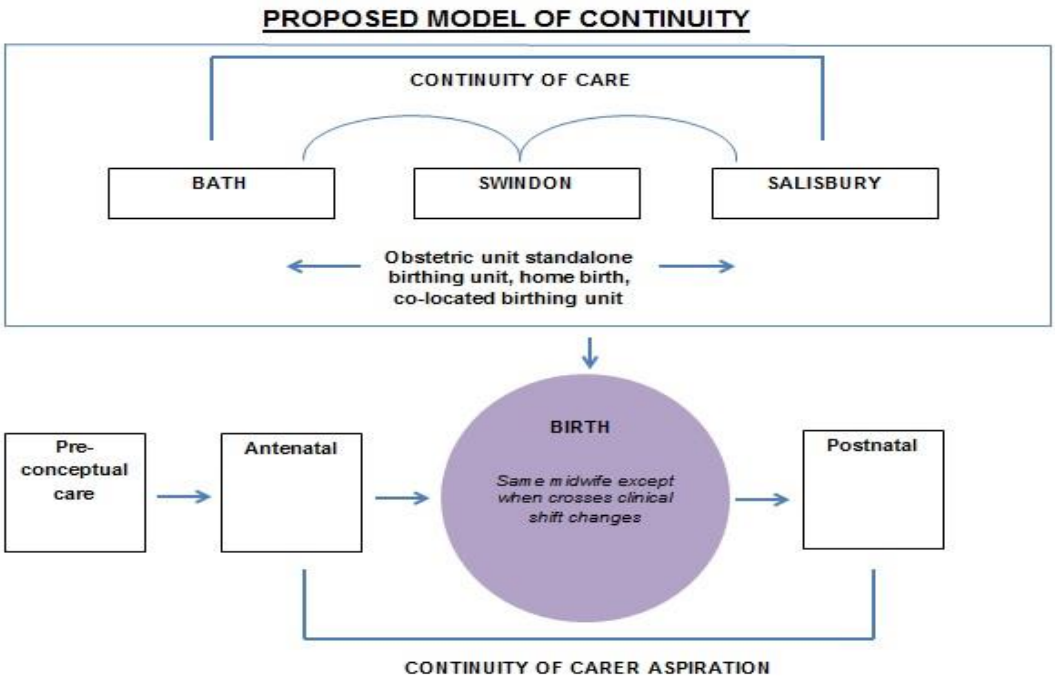
Outputs from this informal engagement work have been used to support the development of a long list of options which is in the process of scored against defined criteria to create a short list of options. Any proposed service changes will be preceded by a period of formal consultation or engagement as appropriate which will be supported by a full communication and engagement plan.

In parallel the MSLC undertook a place of birth survey to understand the views of women and families. In two weeks, over 850 responses were received and this rich data will also be used to inform our case for change.

5.2 Continuity of Carer

The LMS is exploring a pilot approach to delivering the continuity of carer agenda. The diagram below details the potential options of delivering continuity of care for antenatal and postnatal pathways across the STP footprint.

Figure 7: Proposed Model of Continuity



Our vision is that in the next 5 years women will be cared for by a team of professionals throughout their pregnancy, birth and postnatal journey that they know and trust.

It has been acknowledged that one of our key enablers will be workforce transformation. The LMS has agreed that we will target our initial pilots on vulnerable women and families.

Our key actions are:

1) For each provider to undertake as a QI pilot project prior to June 2018.
2) To engage the existing workforce.
3) To focus initially on providing continuity across ante-natal and post-natal pathways. On call options will be explored as part of this model.
4) For obstetric teams within our providers to review continuity.
5) To undertake a full workforce review informed by the evaluation of QI pilot projects. This will link in with our planned HEE supported local workforce review.
6) To develop key messages to support expectations of both women, families and staff.
7) To ensure revised models of care are supported by the appropriate protocols and infrastructure, such as agreements for staff to work across geographical and organisational boundaries.

5.3 Safer Care –

A clinically-led multidisciplinary Maternity Safety Sub-Group has been developed; membership includes healthcare providers, commissioners, stakeholders and service users. This sub group will report directly into and will be accountable to the LMS Programme Board and ultimately to the Commissioner and Provider Boards and Networks. The first meeting of this group was held in

January 2018 and will be chaired by a Head of Nursing and Midwifery from within the LMS. Quality and safety assurance is currently provided through commissioner contractual processes with each Trust. Performance of this sub group will be measured through key agreed indicators and through review of the provider dashboards.

The vision for the Maternity Safety Sub Group is for all women, babies and their families, across all care settings within the LMS, to receive the safest, highest quality care and experience with the best possible outcome. This will be achieved through a collaborative approach with consistent and effective care.

The focus for the Maternity Safety Sub Group will be one of safe systems and processes. The group will initially focus on the development of a combined Safety Improvement Plan, supported by the Maternal and Neonatal Heath Safety Collaborative programme. Areas of priority within this plan will be the introduction of external peer review in the event of a serious incident, standardising the approach to root cause analysis and the introduction of a human factors approach to incident investigation, consistency across the LMS with red flag reporting and incident reporting triggers, particularly in the event of a serious incident.

Other key areas of priority for the safety sub group is benchmarking against national audits such as the Mothers and Babies Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK), the National Perinatal Epidemiology Unit (NPEU) and the National Maternal and Perinatal Audits (NMPA); Each Baby Counts. The focus will be on any barriers to implementing recommendations with the aim of meeting the ambition to reduce the rate of stillbirths, neonatal and maternal deaths in England.

Incident investigation, complaints and claims will be shared to ensure LMS wide peer learning takes place. The group will also study thematic reviews and trends and will receive and seek feedback from local, regional and national clinical networks through joint membership.

In November 2017, the Secretary of State for Health announced a new maternity safety strategy detailing plans for the Healthcare Safety Investigation Branch (HSIB) to undertake around 1,000 independent safety investigations into avoidable baby deaths and incidents of harm nationally. These investigations are expected to start in April 2018, and will focus on cases that meet the Each Baby Counts (EBC) criteria for intrapartum stillbirth, neonatal deaths and severe brain injuries, as well as all maternal deaths. The EBC is a dedicated programme, established by the Royal College of Obstetricians and Gynaecologists, to gather intelligence and information from local serious incident investigations and build a picture of national issues.

The aim is to bring a standardised approach to maternity investigations without attributing blame or liability and to ensure that families are involved throughout the investigation. The HSIB maternity implementation team are working through the finer details around approach and methodology but each investigation will:

- Identify the factors that may have contributed towards death or harm;
- Use evidence-based accounts to establish what happened and why;
- Produce concise reports in the shortest time possible

Our LMS supports this approach and will fully cooperate with any investigations that the HSIB may initiate within our LMS.

Key area for Safety focus with LMS Plan

Based on current quality assessment frameworks, benchmarking information, national and local audits and reports, there are a number of areas within the safety domain that we will focus on as part of the Maternity Safety Improvement Plan. These include:

- Reducing the number of still births and neonatal and maternal deaths in line with national targets – Each baby counts / Saving babies lives care bundle/NHSR
- Meeting the National Perinatal & Maternity Audit (NPMA) recommendations
- MBRRACE Saving Lives, Improving Mothers' Care lessons learned
- Transitional Care - reducing unnecessary separation of term babies (ATAIN) – NHSi Ambition to reduce admissions of full term babies to neonatal units by 20%
- Participation in the Maternity and Neonatal Health Safety Collaborative – a three year programme to improve quality and safety in maternity and neonatal units
- Health Education England funding to improve training within maternity services - multi-professional training recommendations from the 2016 National Maternity Review report: 'Better Births
- NICE Guidance
- Ensuring women and their family's concerns are heard and acted upon to implement service improvements in relation to safety and quality. This would include drawing on learning from complaints, compliments, birth reflections services and sharing with and across LMS.

CQC Assessments – Maternity & Gynaecology Services

Below is a summary of the Maternity & Gynaecology CQC ratings for the three provider organisations within the LMS. Services are currently rated as Good overall; however, all three were rated as requires improvement in the Safety domain. This is for a variety of reasons including bereavement facilities, staffing levels, maintenance and provision of equipment.

Table 9: Maternity & Gynaecology CQC ratings

Hospital	**Safe**	**Effective**	**Caring**	**Responsive**	**Well Led**	**Overall**	Date of inspection
RUH	Requires improvement	Good	Good	Good	Good	Good	Mar-16
GWH	Requires improvement	Good	Good	Good	Good	Good	Oct-16
SFT	Requires improvement	Good	Good	Good	Good	Good	Dec-15

Each Provider has a local action plan to address recommendations from the CQC inspections and good progress has been made in a number of areas in light of the CQC Reviews.

6.0 Financial Case for Change

The Local Maternity System has not identified any prescribed financial savings as part of its development of this transformation plan. This has been acknowledged by the STP leadership group. However, this plan aims to deliver safe and efficient services, which reduce duplication and explore transformation opportunities. As these opportunities arise, full cost benefit analysis will be undertaken with a view to reinvesting any achieved savings in areas of service improvement to support a cost neutral approach. A potential example of this is a review of the triage process for woman in labour to standardise model of care, improve consistency and reduce duplication across the three providers.

As and when the early adopters' feedback on progress with personal budgets, the LMS will review its position and agree next steps and timeframes.

6.1 LMS Maternity Contracts

Currently the LMS has standard PBR contracts across all providers in line with the national Maternity Pathway.

6.2 Current Spend

The tables below details current spend on maternity services across the STP footprint:

Table 10a: Wiltshire CCG:

1617		1718 FOT	
RUH	£9,604,700	RUH	£10,620,455
GWH	£3,642,372	GWH	£3,696,852
SFT	£6,237,010	SFT	£7,303,294
Total	**£19,484,083**	**Total**	**£21,620,601**

Table 10b: Swindon CCG

1617		1718 FOT	
GWH	£3,878,552	GWH	£5,646,916
OUH	£25,225	OUH	£37,464
NBT	£13,792	NBT	£9,189
Total	**£3,917,569**	**Total**	**£5,693,569**

Table 10c: BANES CCG

1617		1718 FOT	
RUH	£6,594,755	RUH	£6,997,123
UHB	£883,242	UHB	£687,362
NBT	£123,775	NBT	£154,212
Total	**£7,601,772**	**Total**	**£7,838,697**

A Finance Working Group has been developed with its first meeting in January 2018 to commence costings of the shortlisted models of service provision. Due to the timeframes of our service reconfiguration, further data of future costings are not available at this time.

6.3 National LMS funding

The LMS has reviewed the use of its nationally allocated ring-fenced funding. The table below provides detail for the 17/18 allocation with indicative values also provided for 18/19 planning:

Table 11a: 17/18 allocation

Scheme	Value	Lead
1. Appointment of Project Midwife (band 8a 1wte) 2. Equipment for project midwife	£10,117k £2k (including mileage)	Programme Director/ Lead Midwife
3. Clinical sessions to support service reconfiguration (includes primary care)	£37.883k	Provider leads
4. Development of Maternity APP	£9k	RUH
5. Implementation of engagement with fathers – investment in Dads Pad app across STP	£14k	Public Health
6. Development of Maternity voices and public engagement	£4k	
Total	**£77K**	

Table 1b: 18/19 allocation (to be confirmed)

Scheme	Value	Lead
1. Appointment of Project Midwife (band 8a 1wte)	FYE	Programme Director/ Lead Midwife
2. Clinical sessions to support service reconfiguration (includes primary care)	0.4wte FYE	Provider leads
3. Development of Maternity APP	FYE	RUH
4. Extension of Dads Pad	FYE	Public Health
5. Development of VBAC DVD	£5k	Swindon CCG
Total	£144k	

7. Local Maternity System Vision for 2021

Our co-created LMS vision is that:

"All women to have a safe and positive birth and maternity experience, and be prepared to approach parenting with confidence."

Our work plan is underpinned by four core commitments:

a. Women and their chosen support networks will be partners in care

Women will receive unbiased, timely information to enable them to participate fully in personalised care planning, and they will be encouraged to explore and question available options. Services will reflect on the language they use, focusing on the women's experience. Above all women will be listened to.

b. Maternity services and organisational partners within the LMS will work collaboratively

Woman will receive a service that is seamless and joined up irrespective of where they access their care. Women will receive personalised care and staff will be enabled to provide continuity.

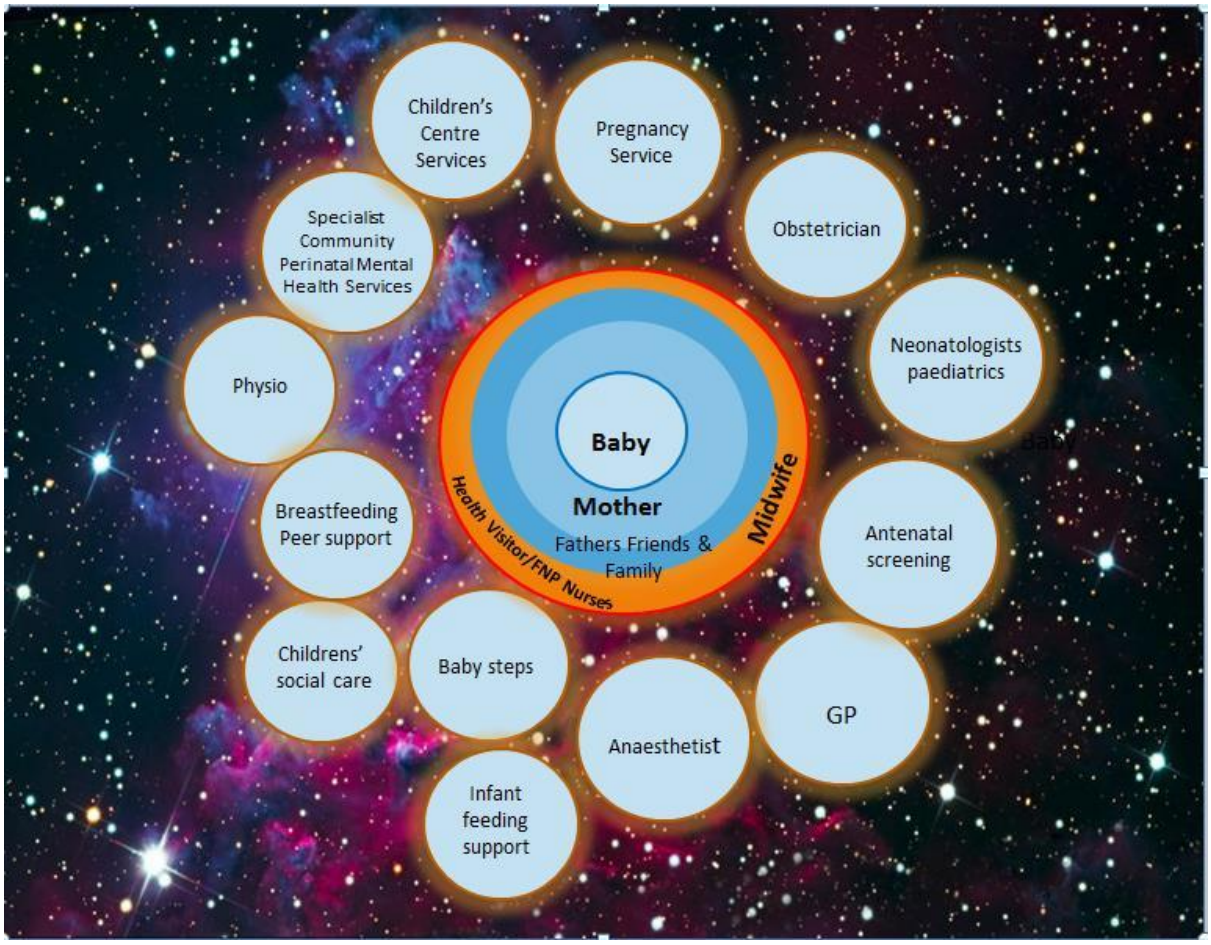
c. We will enhance safety through assisting all women to experience the best birth possible for their personal circumstances.

Woman will be supported to make informed decisions, ensuring risks and benefits are assessed, discussed and managed proportionality. We will adopt an approach that works with the physiology of labour and optimises physical and mental good health. Learning will be shared across organisations and multidisciplinary teams will learn together.

d. Woman, partners and their families will be supported and enabled to optimise their health in preparation for pregnancy, birth and parenthood.

Ensuring staff have the skills and confidence to deliver consistent and effective public health interventions that positively impact on outcomes for women and children.

The diagram below illustrates the range of services that are available for woman and families during their maternity journey dependent on their level of need.



7.1 Implementing the vision

The action plan below was informed by a series of stakeholder workshops and is working document that identifies the direction of travel. This action plan will be developed further by our LMS and will be flexible to meet agreed objectives. Our focus has been on co-creation of the actions.

It is envisaged that organisations will take a lead on individual elements of the action plan. The allocation of these work streams and subsequent co-creation will take place during November 2017 and the action plan will be updated to include timescales, risks, mitigation and leads.

7.2 Trajectories and ambitions

There are a number of key national ambitions that this plan is expected to impact on. These are set out below. Where data is available local trajectories have been set to help us clearly monitor progress. Where baseline data is not yet available the LMS will prioritise identifying a baseline in the coming months so that milestones can be set.

Birth projections (detailed in section 3.3) that underpin this are summarised below.

Table 13: Birth Projections

Number of births and projection for each year				
	Local baseline	**2018/19**	**2019/20**	**2020/21**
BSW LMS	9,790	10,127	10,213	10,238
Percentage growth	-	3.4%	0.8%	0.2%

Ambitions and Trajectories				
Ambition	**Local baseline**	**Trajectory March 2019**	**Trajectory March 2020**	**Trajectory March 2021**
1. To improve the safety of maternity care so that by 2020/21 significant progress has been made towards the ambition of halving the rates of stillbirth and neonatal death, maternal death and brain injuries during birth by 50% by 2030				
Stillbirths and neonatal deaths	5.6 per 1,000 = 60 (2013-15)	55	51	48
Intrapartum brain injuries	Baseline to be set			
2. To roll out personalised care planning				
Number of personalised care plans	Baseline to be set			
3. To improve choices available so that all women are able to make choices about their maternity care as envisaged in Better Births. This includes antenatal care, postnatal care and type and place of birth.				
Number of women able to choose from three places of birth	50%	60%	75%	95%
4. To improve continuity of the person taking care of women during pregnancy, birth and postnatally				
Number of women receiving continuity of carer	Baseline to be set			
5. To enable more women to give birth in midwifery settings (at home and in midwifery units)				
	RUH	**GWH**	**SFT**	**Total**
Number of women giving birth in all settings	**4,578**		**2,318**	
Consultant led	**3,761**			
Alongside midwife led	**0**		**0**	
Free standing midwife led	**680**		**0**	
Home birth	**137**		**67**	
Other	**0**		**0**	

7.3 Shaping our LMS future and timeframes

The LMS has reviewed its detailed action plan for implementing our Maternity Transformation Plan. This features in table 14. We have also co-produced a high level summary of what will look different in 6 months, 12 months and two years. The delivery of these ambitions will be monitored by our dedicated project midwife who was appointed on January 25th 2018.

Six month ambitions

- Our Dad Pad – to support Dad's and help signpost to services – will be rolled out across the LMS and developed as an App.
- The LMS will have commenced the development of a dedicated Maternity App.
- The LMS will have commenced a Plan Do Study Act (PDSA) review of booking appointments and would have started trailing alternative models. The current data collection requirements will be reviewed to improve the experience of women and staff.
- The LMS will have developed and mobilised a 'Welcome Pack' to support women and families. This work will include a review and improvement of patient information such as greater signposting to the Which? Choice tool.
- Our dedicated Safety Group will be mobilised.
- The LMs will commence exploring procurement opportunities.
- The LMS will have improved our postnatal continuity of care/r (within existing resources)
- The LMS will develop an STP approach to Perinatal and Infant Mental Health
- The LMS will have created a platform for working across boundaries – this will include IG solutions.
- The LMS would have commenced local workforce mapping linking with HEE.

12 month ambitions

- The LMS will deliver a revised choice offer for women and families.
- The dedicated Maternity App will be online and mobilised.
- The LMS will have confirmed a standardised role for Maternity Support Workers.
- The LMS will introduce group supervision to create a safe place for midwifes to discuss issues and concerns.
- The LMS will have improved capture and subsequent learning from patient experience linking in with maternity voices partnership.
- The LMS will have developed plans to improve the triage of women in labour.
- A QI and associated framework model for transformation will be implemented.
- Delivery of pilots for new continuity of carer models – focused on vulnerable women.
- The LMS will be ensuring and delivering full women and family involvement in our service reconfiguration and transformation journey.

Two year ambitions

- The LMS will be delivering improved continuity of carer to a broader cohort of women.
- The LMS will be delivering all our safety ambitions and trajectories.

- The LMS will have delivered and will be measuring the impact of a consistent parenting pathway for vulnerable groups.
- The LMS will have created and be delivering our clinical/ community hubs.
- The LMS will have created and delivered transitional care.

Table 14: Actions, current position and next steps

	Action	Current Position	Next Steps	Lead and timeframes
1	**Personalised care and choice**			
1.1	Share local policies and agree common language and protocols around maternity care. Align/standardise policies as much as possible.	LMS planning workshops have included discussions on common language. Non standardised language at present but each Provider already working with staff to discuss language used. Policies and protocols similar as based on national guidance but require review to identify differences that could be discussed as LMS.	• Set up LMS Policy Group • Consider drop box or other method of sharing guidelines. • Heads of Midwifery Services (HOMs) to lead standardised language work stream. • Place of birth Choice leaflet to be agreed across LMS area by Providers, LMS Programme Board and MSLC.	• Project Midwife lead August 2018 • LHE Comms and Engagement Group lead Draft by July 2018
1.2	Provide welcoming, consistent, unbiased, informed, timely information to women and their partners regarding their maternity care	Standardised information for women tailored to individual clinical areas available within each Trust but not in a central location for LMS.	• Project lead to procure webpage for LMS. • To consider facility for booking care and appointments online across LMS. • Draw on findings from local Place of Birth user survey to ensure women and their partners are consistently informed about the	• Project midwife to lead with support of LHE Comms and Engagement • Welcome pack to be drafted by HOM and LHE Comms and Engagement group by May 2018

			risks and benefits of all birth options in a way that is meaningful to them. • Review and where appropriate redesign provision of choice across LMS • Development of education programme to support choices	
1.3	Align to public health strategies and be mutually supportive	Variations in public health strategies that support maternity and neonatal services.	• Redesign project group to map variation across LMS. • Baby steps evaluations to be shared across LMS. • Consider alignment of public health initiatives that impact on Maternity services across LMS area to avoid inconsistencies in care provision	• Redesign project group August 2018
2	**Antenatal and Postnatal care**			
2.1	Standardise antenatal and postnatal pathways for all women, ensuring timely access to the support or help needed.	Most pathways similar but require review to identify inconsistencies across LMS	• LMS and Safeguarding Specialist Midwives to agree Cross boundary policy about how vulnerable women will be identified and alerted across LMS area. • Consider central Safeguarding email address. • Review antenatal and post-natal care pathways across LMS.	• Safeguarding specialist midwives to lead linking with 6.6 June 2018 • Redesign Project Group October 2018

2.2	Consider adopting elements of the Stepping up to Public Health (PH) resources to empower women and to enable staff to personalise maternal public health	No current mapping of provision of Stepping up to PH resources. Women do not routinely complete their own notes. Women not routinely asked to identify "what is important to you or what do you want to know about or ask".	• Redesign project group to review evidence and identify pilot sites for agreed elements of Stepping up to PH resources. • Redesign project group to formulate proposal and present at MSLC.	• Redesign Project group June 2018 • Sept 2018
2.3	Infant feeding leads and breastfeeding strategy leads to work together to contribute to Joint Strategy Needs Assessments (JSNAs) and ensure consistency of provision and messages across LMS	There are specialist infant feeding leads in all maternity and health visiting services as well as commissioning leads in each CCG. But there are differences in breast feeding policies which need to become more aligned. Although all services are Breastfeeding Friendly Initiative (BFI) accredited, women can still receive inconsistent messages from different professionals, including neonatal feeding guidance.	• Infant feeding leads currently meet quarterly and are becoming more aligned due to the SWSCN work. • Ensure governance of BFI accreditation is linked to Early Help Boards as well as contract management of services. • Work together across STP to ensure consistency in data collection and recording. • GPs and Paediatricians also need to provide consistent messages - Health visitors best placed to influence.	• Maternity and Health Visiting Services Infant Feeding Leads Sept 2018
2.4	Standardise transitional care pathways across the LMS, with a focus on keeping mothers and	There is variation between and across maternity services in how care is provided to new babies	• Acute trusts evaluating pilots. • All units to participate in the ATAIN programme to keep	• Provider leads (one for each Trust) November 2018

	babies together, smooth transitions and effective communication between services at all times and appropriate on-going care in the community	who need additional monitoring and/or interventions. Acute Trusts are working collaboratively towards a transitional care model Communication between maternity, Paediatrics, SCBU/NICU, GPs and health visitors, infant feeding specialists is not always consistent.	mothers and babies together. • Commissioners raising payment issues around transitional care at regional and national levels. • Need to develop and adopt a procedural pathway to ensure all relevant communication (including finance) and discharge summaries are completed in a timely manner.	
2.5	Adopt a consistent approach to routinely offering all women and families the opportunity to reflect on their birth experience, particularly in the early postnatal period (link to 5.4)	Each maternity provider offers the opportunity for mothers to reflect on their birth experience with a midwife and/or obstetrician. Nevertheless, the opportunity is not currently promoted/ provided routinely.	• The services will expand to offer each woman the opportunity to talk about the birth – not just those with a negative experience. Pathways to be formalised between IAPT and maternity services to ensure women are receiving the right support at the right time.	• Reflection service leads and IAPT lead Sept 2018
2.6	To ensure women and their partners are empowered and confident making the transition to parenthood and preparing for any subsequent pregnancies, actively promote preparation for parenthood and support positive	Delivery of antenatal education and transition to parenthood varies across the LMS (health visiting and maternity services) both in terms of content and reach. This applies to both universal provision and targeted	• Review and collate current provision in each area including support for parents who have very premature babies. • Review learning outcomes/ take up (including fathers/ partners) and evaluate user feedback.	• MSLC to lead Sept 2018

	parenting throughout the maternal care pathway (MSLC priority).	programmes, such as Baby Steps. Access to self-funded and voluntary sector provision is also varied. IAPT group based programmes are also inconsistently provided across the area.	• Continue to align midwifery and health visitor universal antenatal education offering and ensure sessions are accessible to and meet the needs of those vulnerable families who need them most. • Raise awareness of other providers for those who can self-fund. • Consider business proposal for Baby Steps in B&NES.	
3	**Perinatal and infant mental health**			
3.1	Implement local PIMH plans and ensure synergies across LMS where appropriate (links to MSLC priority 1.3)	There are many similarities in the pathways in each area, e.g. a well-being plan is given at all bookings, but also variations e.g. the midwives screening tool questions vary. There are named MH support MWs at each acute hospital but they are not MH specialists. The adult MH provider (AWP) is the same across the STP but, there are local variations in referrals to, and provision from, Improving Access to Psychological Therapies (IAPT) and Primary Care Liaison Services	• To develop an STP approach to PIMH • To develop and launch one PIMH strategy across the STP area. • An STP bid for 2018/19 'pump priming' for a new specialist community PIMH service is being prepared ready for submission to NHS England in late 2017.	• May 2018 • PIMH project manager to lead August 2018

		(PCLS). There is a lack of specialist community perinatal MH services across the STP.		
3	**Workforce transformation**			
3.1	Ensure our workforce is designed to meet the needs of the MTP and LMS	Providers have carried out some workforce planning	• Identify and work with workforce modelling experts to progress via HEE local team	• Provider divisional director leads and project midwife April 2018
3.2	Ensure we have a workforce that is equipped and enabled to take forward the transformation agenda through a QI methodology e.g. PDSA	As above	• Develop HR processes to support cross boundary working • Learn from national initiatives (project midwife) • Agree QI methodology • Agree approach i.e. listening into action • Plan training and release of staff • Develop clear outcome measures	• LMS Programme Board and AHSN support June 2018
4	**Continuity of carer**			
4.1	Define what continuity of carer is for our LMS	Not currently in place but each provider is mapping opportunities to provide continuity	Ambition to be designed at workshop	Lead midwife January 2018 ACTIONED

4.2	Draw on lessons learnt from early adopter sites to model continuity of carer locally	The providers within the LMS are evaluating schemes that have most relevance to their demographic	PDSA pilots to be created to explore options for continuity of carer delivery Obstetric teams to review continuity	Lead and project midwife June 2018
4.3	Link with workforce transformation work stream to develop model for achieving continuity of carer through the maternity journey in response to women's local needs	This will be mapped, evaluated and actioned through the LMS Programme Board	Full workforce workforce review following evaluation of Q1 project in each provider area. focus on giving continuity AN & PN Revie won call arrangements	Lead and project midwife August 2018
5	**Working across boundaries / multi-agency working**			
5.1	Standardise maternity notes across LMS including personalised care plans	RUH and GWH use same notes. SFT have different notes. Aim for all areas to use the same notes.	• HOM Salisbury to discuss with Clinical Governance and agree standardised records. • To obtain and implement revised notes for Salisbury (until such time as digital records can be shared across LMS (or nationally).	• HOM SFT lead July 2018
5.2	Identify common digital platform for professionals and women, partners and families	No common digital platform- Each Maternity Service uses a different electronic records system which do not communicate.	• Project lead to co-ordinate support from national digital team • Learn from other areas that may have already progressed this action. • Use digital platform to promote a	• Project Midwife lead August 2018

		No one source of information for service users	wide range of positive birth stories to expectant parents and the wider community	
5.3	Implement LMS triage system	No standard triage system at present. Background work being undertaken by midwifery representative from each Acute Trust. Expressions of interest submitted to SW Hub project.	• Working group led by Project lead to be set up by December 2018. • Share Wessex Unscheduled care pathways to use as basis for discussion of protocols. • Working group to evaluate potential use of SW Hub as LMS triage for all LMS Providers of Maternity Care with standardised triage tools.	• Project midwife to lead December 2018
5.4	Standardise birth reflections and VBAC (Vaginal Birth after Caesarean) services across the STP and feedback key themes or learning into the Safety subgroup (links to 2.5)	All areas provide Birth reflections services. No current sharing of trend analysis from Birth reflections across LMS. VBAC support services require mapping for each provider	• Each Provider to identify VBAC /positive birth champions (Midwife and Obstetrician). • To set up quarterly meeting for champions for positive birth reflections and VBAC services. • Map Positive Birth reflections services for LMS by Project lead. • Map VBAC services across LMS by project lead. • Development of educational DVD for women	• Project Midwife May 2018 • Swindon CCG Commissioning Lead July 2018
5.5	Ensure consistent public health messaging, use of online resources	Local currently – with variation	• Public health to be an agenda item at LMS Programme Board –	• MSLC

	and signposting for information across LMS		link to national programme. • Consultation with service users re needs / approach. • Review BANES Early Help App – consider adopting this across LMS with local information. • Flu jabs first messages required. • Project plan campaigns with a timeline including identification of resources available / media type.	Dec 2018
5.5	Invite appropriate early years(0-5 year) partners to discharge planning meetings and formalise MW-CC link role	Obstetricians not fully aware	• Each Trust to identify lead liaison role. • Identify Children's centre contacts. • Raise awareness of CC services across wider maternity services & locally. • Identify what meetings they are required to attend - all/ selected by invitation? • To be in place by February 2018.	• LMS public health lead August 2018
5.6	Establish mechanisms to enable midwives to work across organisational boundaries	Not in place – required to aid recruitment & staffing shortfalls and spread shared practices	• Dialogue with university training schools of nursing required. Consider rotational posts. • Consult existing staff in each Trust to seek expressions of interest / suggestions on way forward. • Share learning from new LMS /	• Project midwife June 2018

			SWAST Midwife role – set up (October 2017) and implementation/practice (2017/18).	
5.7	Develop a collective vision for community hubs across services involved in the maternal care pathway to ensure families across the STP receive a service that is as seamless	Not in place	• Share learning from Swindon Accountable Care model to be implemented 2018/19 (Team Swindon) model). • Identify what services are required in the hub to support maternity services? • Identify the expected benefits of community hub & outcome success measures?	• Lead and project midwife via LMS Programme Board June 2018
5.8	Ensure Early Help /Early Intervention strategies are linked to ensure a whole system approach across the STP.	Each CCG / Local Authority area has different arrangements for delivering the early years agenda and varying degrees of sign up from agencies.	• To review strategic early years arrangements and working processes across the STP.	• LMS public health lead Sept 2018
6	**Safer Care**	**Current Position**	**Next Steps**	
6.1	Deliver against Maternal and Neonatal Health Safety Collaborative priorities.	Great Western Hospital is in Wave 2 and Salisbury and Royal United Bath are in Wave 3 of the Maternal and Neonatal Health Safety Collaborative, a three year programme to support	• Each organisation will receive a wide-ranging support over the life of the programme. This includes tailored resources and networks, in the meantime learning from Wave 1 organisations will take	• HOMs/ quality lead April 2018

		improvement in the quality and safety of maternity and neonatal units across England.	place via clinical networks and will feed into the newly formed Maternity Safety Sub Group. • A combined Safety Improvement Plan will be developed across the LMS which will set the priorities and framework within which the Maternal Safety Sub Group will work.	
6.2	In conjunction with the South West Clinical Network develop a joint safety improvement plan across the LMS	Individual Trusts have benchmarked against Better Births and have locally agreed priorities for Maternity Safety Improvement Plan (MSIP).	• Collaborate across the LMS to develop joint MSIP. • Introduce external peer review for SI's. • Standardise approach to SI investigation using RCA and Human Factors approach. • Ensure consistency in reporting trigger framework.	• HOMs/ Quality lead May 2018
6.3	Review implementation of maternity based clinics to increase uptake of vaccination in pregnancy (MSLC priority)	Each Trust in LMS has developed its own local plan for delivering vaccination in pregnancy.	• Maternity Safety Sub Group will focus on safe systems and processes across the LMS which will include sharing ideas for implementing public health initiatives such as delivery vaccination clinics and any barriers or difficulties experienced. • Review 2016/17 data and update	• HOMs ACTIONED for 17/18 MSLC discussion April 2018 to confirm plans for 18/19

			at maternity forum on uptake of vaccinations rates to date and agree strategies to promote including supporting across LMS. Agreed and in place for 17/18.	
6.4	Benchmarking against national audits such as MBRRACE, NPEU, NMPA and EBC and sustain implementation of recommendations such as implementation the Stillbirth Care (MSLC priority)	Each Trust within LMS has implemented the Stillbirth Care Bundle and monitors incidence of stillbirth on a monthly basis: % of women identified as smokers at booking referred to a specialist stop smoking service Proportion of women having a CO test at booking Number of unexpected SGA babies born % of intrapartum CTG interpretations reviewed by a midwife / doctor hourly during labour No. of still births (>=24 weeks)	• Monitor and maintain through the Maternity Safety Sub Group a reduction in stillbirths and share good practice across the LMS. • Benchmark that there is consistency across the LMS of monitoring and reporting of Stillbirth interventions and outcome measures. • Prescribe, monitor and maintain safe clinical systems and processes across the LMS to ensure women who meet the criteria for a more intense level of care are identified early and a personalised care plan is developed in partnership with them.	• HOMs/ Quality lead June 2018
6.5	Monitor the impact of programmes to improve health in pregnancy, share learning and identify gaps in	Health in Pregnancy programmes are available in some Trusts (B&NES and Wiltshire) with demographic data collected to	• Need to identify current position, some Trusts are able to offer focused health improvement programmes as a result of	• HOMs/ Quality lead/ Lead LMS public health Via LMS programme Board

	provision (MSLC priority)	plan services and determine efficacy. Percentage of mothers recorded as smoking at time of booking Percentage of mothers recorded as smoking at time of delivery Percentage of women with BMI 30 to 34.9 at booking Percentage of women with BMI 35 to 39.9 at booking Percentage of women with BMI 40 to 49.9 at booking Percentage of women with BMI 50+ at booking	commissioning priorities.	June 2018
6.6	Improve understanding of the definition and prevalence of vulnerabilities in pregnancy across the STP and work to improve engagement and support for vulnerable women and their families (MSLC priority) links to 5.8	Baseline data is currently being collected across the LMS for the period 2016/17 and Q1 2017/18 which includes: Vulnerabilities: <20 years / substance misuse / perinatal mental health /	• Review the data to establish the current picture across the LMS and develop strategy in response. • Ensure consistent application of vulnerability criteria across maternity, health visitor and Children's Centre services which is consistent with the LSCB	• Public health lead and HOMs June 2018 • Sept 2018

		homeless or housing issues / domestic abuse / recent arrival as a migrant / asylum seeker or refugee / English as a second language / concealed pregnancy Method: % of pregnant women with one of the vulnerability factors listed above (total of all pregnant women as denominator) at booking % of pregnant women with 3 or more of the above vulnerability factors at booking % of pregnant women at booking with the 'toxic trio' at booking	thresholds. • Review and update maternity and health visitor liaison pathway as part of LMS work.	
6.7	Ensure commissioners and maternity services are responding to demographic changes among women of childbearing age and considering the needs of particular vulnerable groups, including Syrian refugees, European migrants and military families (MSLC priority)	Not yet started	• Work with commissioners and provider business analysts to agree the data set to be collected across the LMS to enable personalised care is planned in response to demographic needs.	• LMS Programme Board April 2018

6.8	Ensure effective supervisory mechanisms are in place to support midwives locally (MSLC priority)	Each individual Trust has developed a plan to support implementation of the AEQUIP Professional Midwifery Advocate role.	• To scope whether there is a need to provide cross boundary cover across the LMS.	• Lead and project midwife May 2018
6.9	Clinicians from each provider to actively participate in the Strategic Clinical Network to drive continuous improvement	Membership already established	Joint membership will be in place across the LMS within clinical networks and Maternity Safety Sub Group.	• HOMS and quality lead Ongoing
6.10	Work closely with neonatal network to align strategies	Already established	Joint membership will be in place across the LMS within clinical networks and Maternity Safety Sub Group.	• HOMS and quality lead Ongoing

7.3 Co-production of the Plan

A Maternity Transformation Plan (MTP) planning event was held in June 2017 for service users, leads and staff from maternity and early years' services to reflect on the Better Births report and identify key areas for action locally. A small task and finish group came together afterwards to pull together the ideas generated on the day and formulate a draft plan. A subsequent event was organised in September 2017 to present the draft MTP to those who attended the June event to obtain feedback. The opportunity was also taken to begin work on an area for action identified in June, namely to change some of the language used during pregnancy and birth to become more user friendly and create more positive perinatal experiences for women and their partners. A further workshop was held in January 2018 to co-produce and finalise our mobilisation action plan, which features in table 14.

7.4 MTP Co-ordination and implementation

Our LMS is developing a proposal to use assigned national ring-fenced funds to appoint a dedicated Project lead midwife and obstetrician time to help deliver the actions assure progress and support clinical engagement and ownership.

It is envisaged that each provider will identify leads for the key themes of the plan within their teams who will liaise with each other and with the MTP Project Lead to ensure actions are implemented effectively and equitably across the LMS where appropriate.

A detailed communication and engagement strategy will be developed as part of this plan. This will build on the RUH Maternity redesign programme, which commenced in January 2017 prior to the conception of the Local Maternity System. The communication and engagement strategy will be co-designed with providers and stakeholders by mid June 2018.

8 The role of service users and opportunities to provide feedback

There are a range of opportunities for women accessing maternity care and those supporting them to feedback on their experience including social media, real-time feedback, 'Friends and Family', and provider surveys.

Service users have been centrally involved in the local MSLC for several years, providing the user perspective at meetings and taking forward discreet pieces of work, such as a birth environment audit and more recently, developing a place of birth user survey to which over 800 service users responded.

It is recognised there is more to be done to improve how services engage with women accessing maternity care and those supporting them and how we as an LMS listen and respond appropriately. Ideas for improvement include:

- collating service user feedback that providers and user representatives are gathering across the LMS in a way that can inform service improvement
- pro-actively seeking feedback from a representative sample of service users, not just relying on those who are confident at voicing their experiences

- ensuring we are engaging with the wider community, especially partners and families including those from harder to reach groups within our demographic

Plans are in place to work with current MSLC user representatives and others expressing an interest to be involved in maternity service improvement to take forward this work. The development of a Maternity Voices Partnership is being discussed to build on the good work to date engaging service users.

Each provider and commissioner has a documented and advertised complaints process to support woman, families and carers when things go wrong.

9 Risks

Table 15 details current identified risks. This will be expanded and the level of risk scored by the MOS by the end of Nov 2017.

Table 15: Risks

Focus	Risk	Mitigations
Workforce	Due to the staffing models recommended by Better Births, there is a risk that they cannot be fully implemented without additional investment.	Involvement of national team to develop models of care that is deliverable and sustainable.
	Due to the shortage of skilled midwives, there is a risk that insufficient staff can be recruited / retained to implement the new models of care.	Link with HEE work, STP workforce plan etc. Share successful strategies
	Due to proposed significant changes to working practices, there is a risk that staff availability will decline.	Ensure staff involvement and engagement with Better Births recommendations.
LMS and Accountable Care organisational development	Due to the large number of agencies involved, there is a risk that agreeing shared goals and objectives will be difficult and time consuming	Regular maternity forum and MSLC meetings with attendance by appropriate decision makers.
	Due to operational /financial issues with identifying host or new buildings, there is a risk that Community Hubs cannot be established	Primary focus is on shared care approach during transition period to National transformation of Health and Social Care.
Service Performance	Due to the proposed changes to established models of care, there is a risk of unintended consequences resulting in deteriorating performance.	Use of robust Quality Improvement methodology to inform change strategies. Continuous monitoring of outcomes with benchmarking against SW and national key performance indicators.
Service Users	Due to national developments there is a risk that women will request personal budgets for their maternity care and a decision has been made by the LMS to defer this offer.	The Maternity Transformation Plan will clearly set out what women and their families can expect.

10 Conclusion

This document sets out the initial strategy as co-created by the LMS and wider stakeholders. It is envisaged that it will inform the basis of improvements to our services for our women, babies and families. It is recognised that it will evolve in line with national maternity transformation developments.

References

South West Clinical Network Maternity Dashboard: http://maternitydashboard.swscn.org.uk/

PHE Public Health Pregnancy and Birth profile: https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-pregnancy

Universal health visiting service: mandation review:

https://www.gov.uk/government/publications/universal-health-visiting-service-mandation-review

Wiltshire, Swindon and Bath and North East Somerset Stillbirth and Infant Mortality Report (2017)

Appendix 1: Current membership of the core LMS (Maternity Forum and MSLC)

Acting Director of Acute Commissioning (Programme Director for Maternity STP)	Wiltshire CCG
STP/ LMS lead midwife	SFT
STP / LMS lead public health representative	Wiltshire Council
Project Midwife	LMS
Lead Consultant	RUH/SFT
Lead GP	Banes CCG
Quality lead	Wiltshire CCG
Finance lead	Wiltshire CCG
Comms and engagement lead	RUH/ WCCG
Project manager (service reconfiguration)	RUH
Associate Director for Quality	Wiltshire CCG
Commissioning lead	B&NES CCG
Commissioning lead	Swindon CCG
Consultant Obstetrician and Gynaecologist	Royal United Hospitals Bath NHS Foundation Trust,
Community and Acute Matrons	Royal United Hospitals Bath NHS Foundation Trust,
Head of Nursing and Midwifery, Women & Children's Division	Royal United Hospitals Bath NHS Foundation Trust,
Women and Children's Divisional Manager	Royal United Hospitals Bath NHS Foundation Trust,
Acute and Community Midwifery representation	Royal United Hospitals Bath NHS Foundation Trust,
Infant Feeding Specialist	Royal United Hospitals Bath NHS Foundation Trust,
Senior Midwifery Matron	Royal United Hospitals Bath NHS Foundation Trust,
Consultant Obstetrician	Great Western Hospitals NHS Foundation Trust
Community Midwife	Great Western Hospitals NHS Foundation Trust
DAU Midwife (lead for Diabetes in DAU)	Great Western Hospitals NHS Foundation Trust
Consultant Obstetrician and Gynaecologist	Great Western Hospitals NHS Foundation Trust
Clinical Midwifery Manager	Great Western Hospitals NHS Foundation Trust
Maternity Support Worker	Great Western Hospitals NHS Foundation Trust
Consultant Paediatrician (special interest in SCBU)	Great Western Hospitals NHS Foundation Trust
Head of Midwifery	Great Western Hospitals NHS Foundation Trust
Head of Maternity and Neonatal Services	Salisbury NHS Foundation Trust
Consultant obstetrician and gynaecologist (Head of Obstetrics and Gynaecology Service.	Salisbury NHS Foundation Trust
Labour Ward Manager	Salisbury NHS Foundation Trust
Community Midwifery Manager	Salisbury NHS Foundation Trust
Safeguarding Midwife	Salisbury NHS Foundation Trust
Antenatal Services Manager	Salisbury NHS Foundation Trust

Infant Feeding Lead	Salisbury NHS Foundation Trust
Midwife	Salisbury NHS Foundation Trust
Midwife	Chippenham Birthing Centre
Head of Service, Health Visiting	Bath and North East Somerset Community Health & Care Services
Family Nursing Partnership	Bath and North East Somerset Community Health & Care Services
Infant Feeding Lead	Bath and North East Somerset Community Health & Care Services
GP	Wiltshire CCG
Quality Manager	Wiltshire CCG
Quality Manager	Swindon CCG
Principal Officer – Health & Wellbeing	Swindon Council
Public Health Commissioning & Development Manager, Children and Young People	B&NES Council
CAMHS and Maternity Commissioning Project Manager	B&NES CCG
Lead Commissioner	Wiltshire Council
Acting Director of Public Health	Wiltshire Council
Assistant Director for Children and Young People's Service	Wiltshire Council
Head of Service (Conception to 5 years)	Wiltshire Council
Screening & Immunisation Coordinator	NHS England
Patient Safety Programme Director	West of England Academic Health Science Network
South West Maternity and Children's Clinical Network Manager	NHS England
Quality improvement Lead, South West Clinical Network	NHS England
NCT Antenatal Teacher and NCT Doula	NCT
Service User Representatives	
Health watch representative	
Children Centre Representatives	B&NES, Swindon and Wiltshire Children Centre's Services
Health Visiting Team Leaders	B&NES, Swindon and Wiltshire Health Visiting Services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Maternity Strategy
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NHS
Bath and
North East Somerset
Clinical Commissioning Group


NHS
Swindon
Clinical Commissioning Group


NHS
Royal United Hospitals Bath
NHS Foundation Trust


NHS
Great Western Hospitals
NHS Foundation Trust


NHS
Salisbury
NHS Foundation Trust


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SWINDON
BOROUGH COUNCIL


Bath & North East
Somerset Council

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BETTER CARE PLAN

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BCF January DTOC Summary

8th March 2018

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January DTOC Delayed Days - Summary

- Wiltshire delayed days increased 29.8% (482 days) in January 775 days higher than the trajectory (1,325).
- NHS delays (1,306):
  - Increased in January by 26.4% over trajectory by 511 days.
  - GWH RUH & WH&C have the largest number of delays
- ASC delays (657):
  - Increased in January by 37.1% over trajectory by 236 days.
  - SFT & WH&C have the largest number of delays
  - Acute delays account for around 65% of ASC delays

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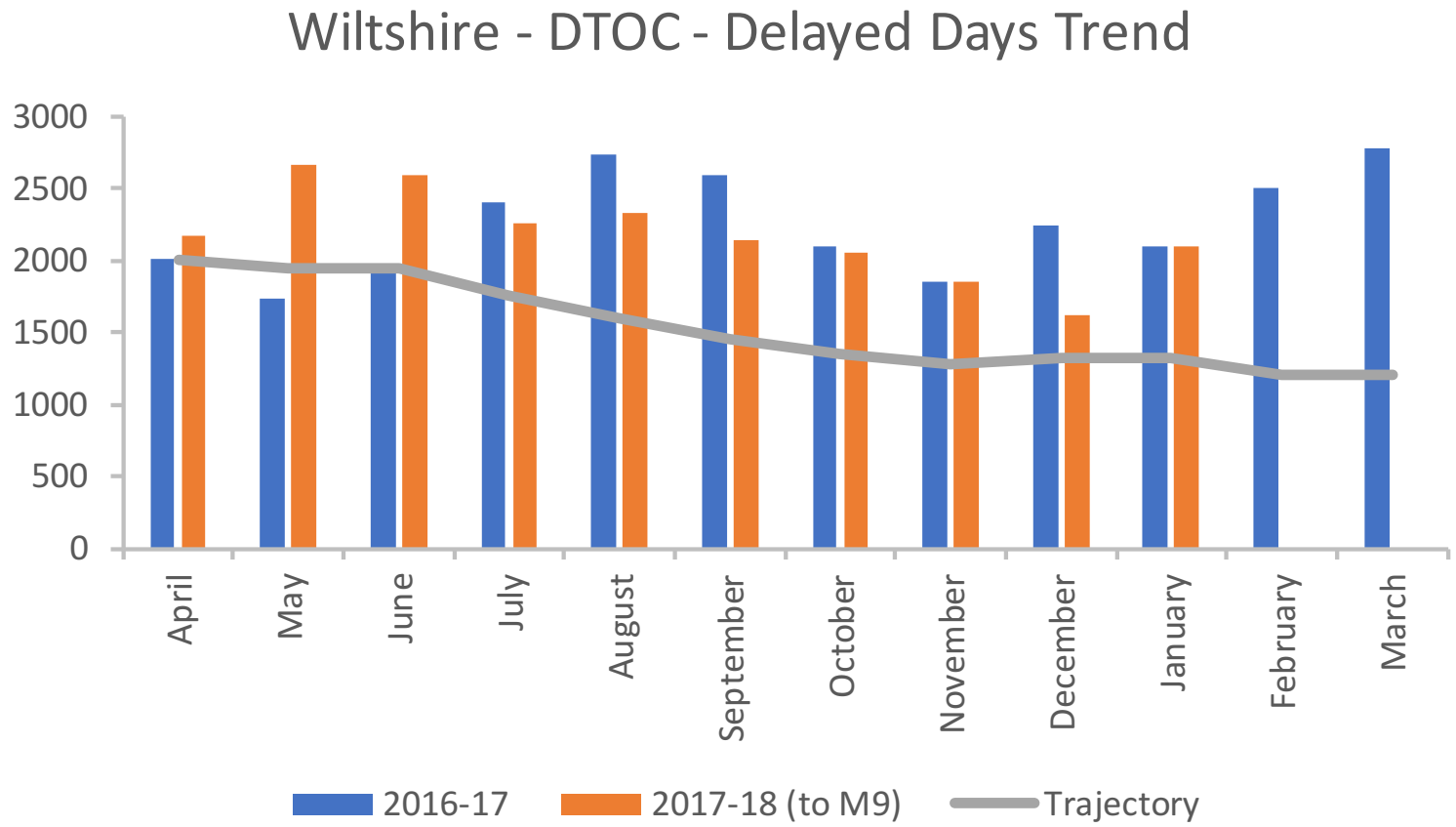
Comparison Trend for All Delayed Days



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December DTOC Delayed Days

	NHS	ASC	Both	Total	Trajectory
Wiltshire	1,306	657	137	2100	1,325
GWH	396	88	8	492	150
RUH	330	50	0	380	200
SFT	136	287	0	423	250
AWP	115	2	116	233	200
WH&C	269	207	0	476	475
Others	60	23	13	96	50

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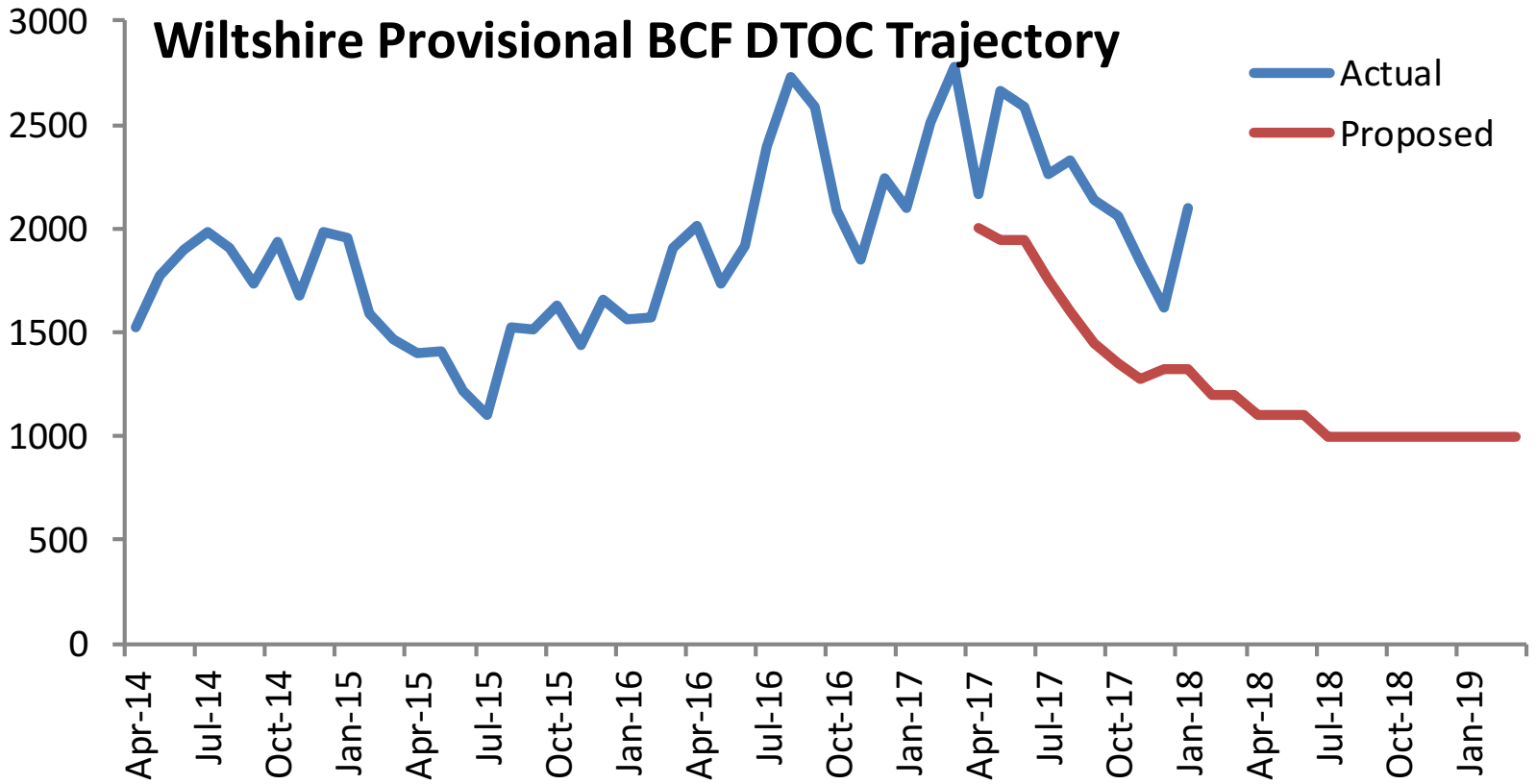
Trend for All Delayed Days



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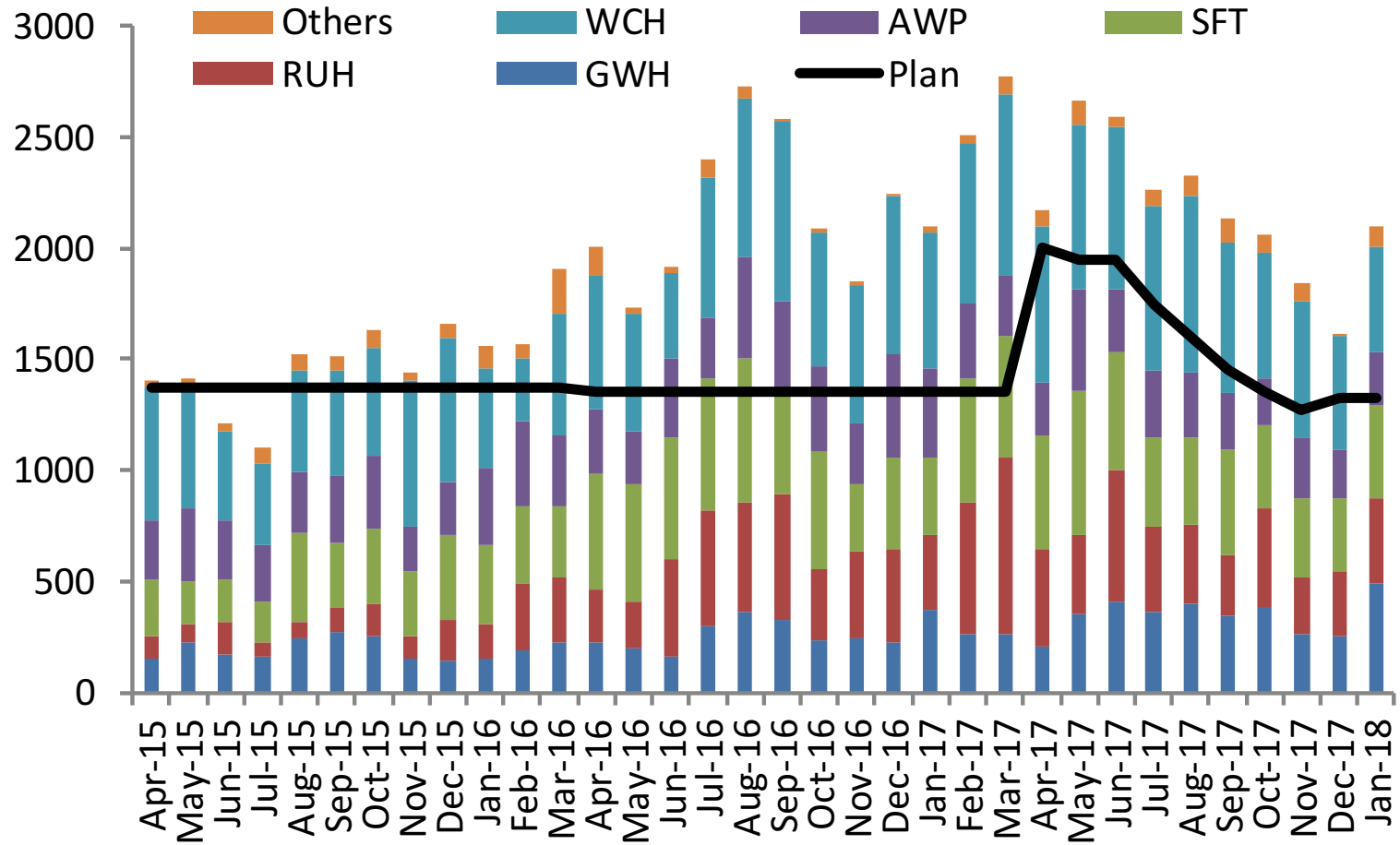
Trend for All Delayed Days by Provider



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Reason for All Delayed Days

Reason	2015-16	2016-17	2017-18 (to M10)	Jan 2018
Assessment	36.6	53.2	78.1	162
Public Funding	10.2	8.0	26.2	14
Non Acute transfer	299.0	447.3	299.6	387
Residential home	191.2	301.3	300.1	237
Nursing home	343.2	378.5	442.4	248
Dom Care	435.2	795.3	682.3	582
Equipment/ adaptations	39.8	76.7	104.1	165
Patient/ family choice	88.0	128.2	202.9	248
Disputes	9.7	14.0	3.2	17
Housing	42.8	43.3	37.9	40

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December NHS DTOC Delayed Days

	NHS	Trajectory	Gap	% of GAP
Wiltshire	1,306	794	512	64.5
GWH	396	126	270	214.3
RUH	330	159	171	107.5
SFT	136	143	-7	-4.9
AWP	115	56	59	105.4
WH&C	269	286	-17	-5.9
Others	60	23	37	160.9

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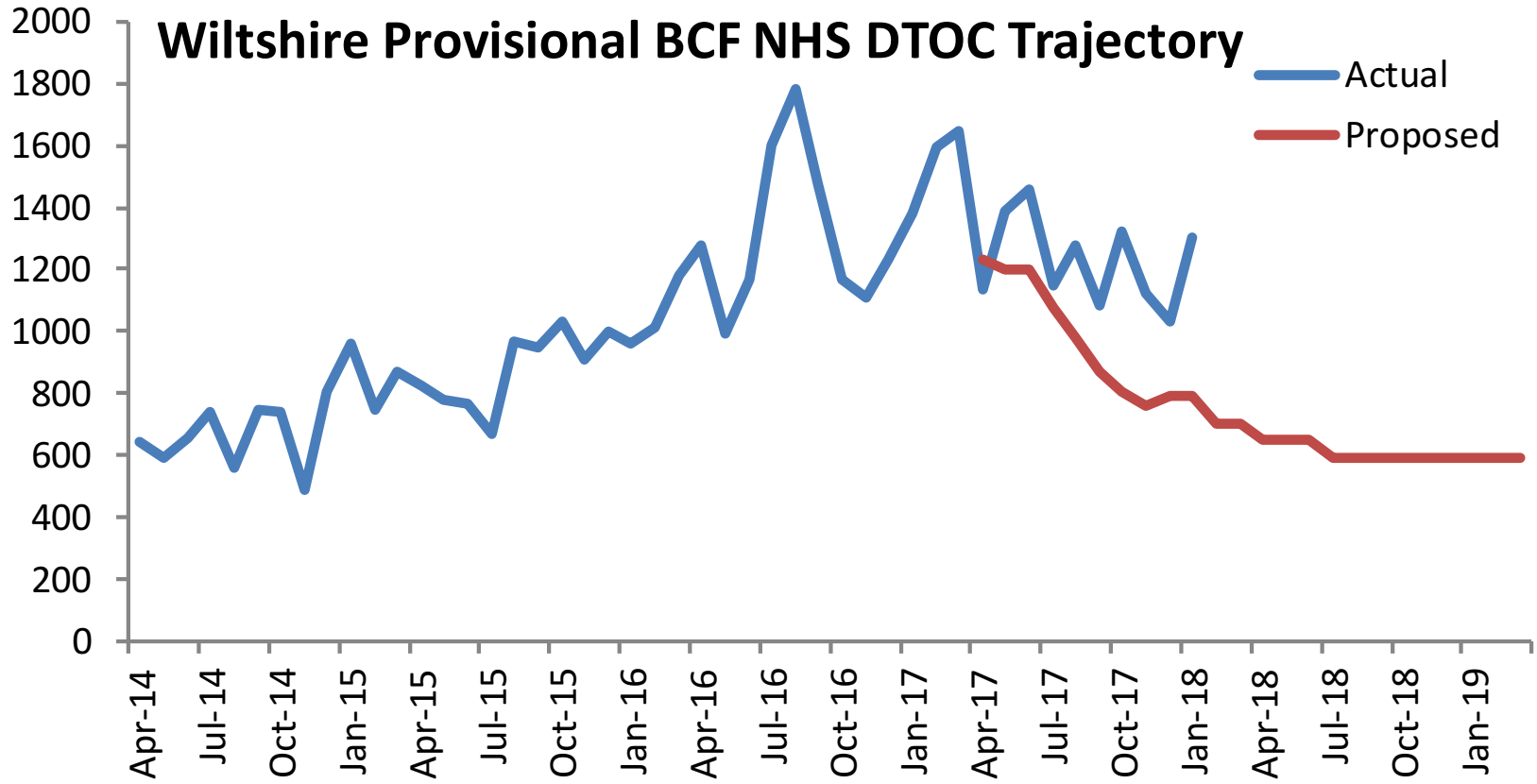
Trend for NHS Delayed Days



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December ASC DTOC Delayed Days

	ASC	Trajectory	Gap	% of GAP
Wiltshire	657	421	236	56.1
GWH	88	23	65	282.6
RUH	50	40	10	25.0
SFT	287	103	184	178.6
AWP	2	56	-54	-96.4
WH&C	207	181	26	14.4
Others	23	18	5	27.8

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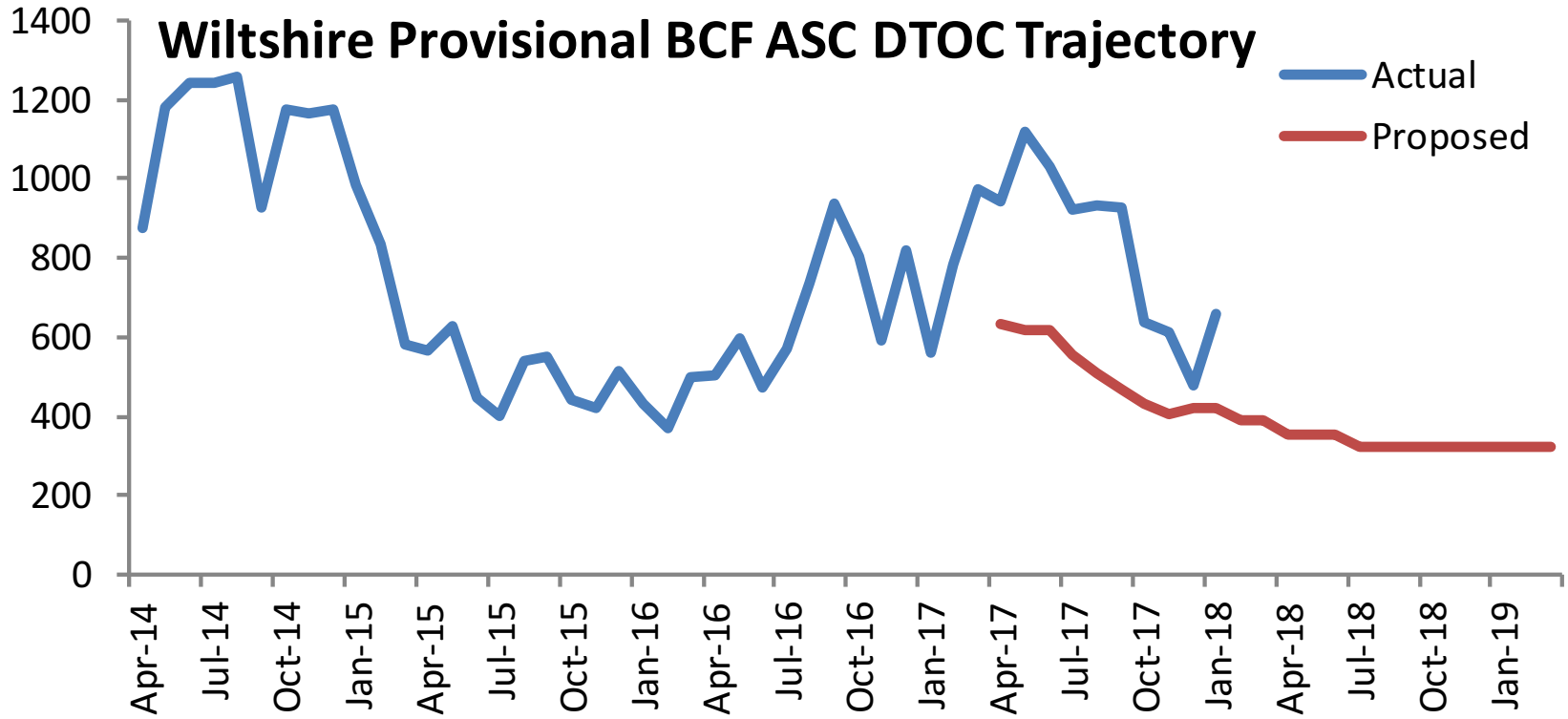
Trend for ASC Delayed Days



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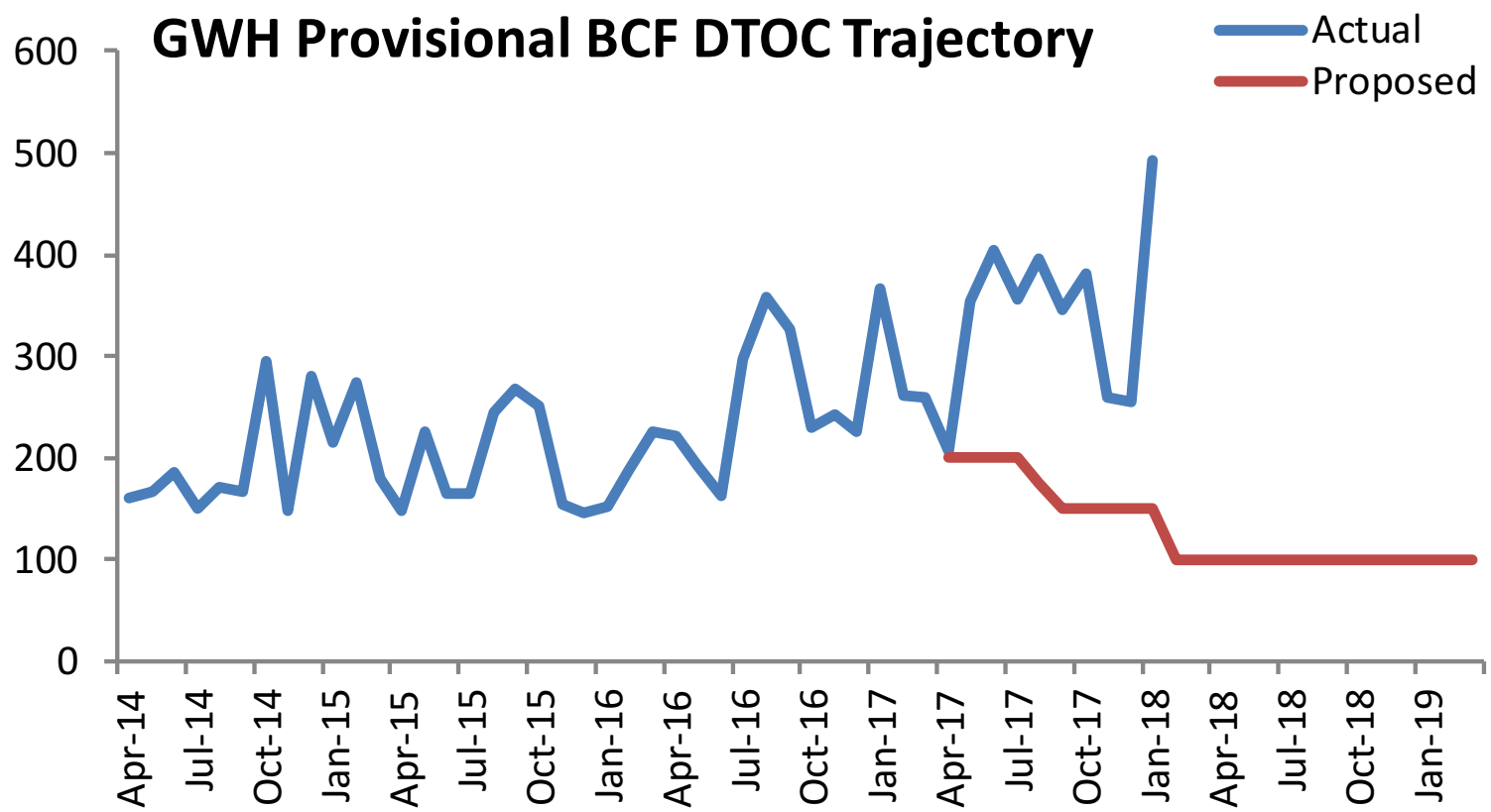
Trend for GWH Delayed Days



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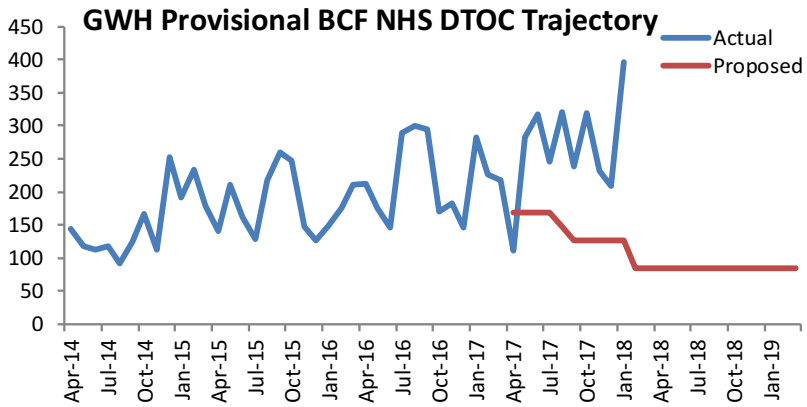
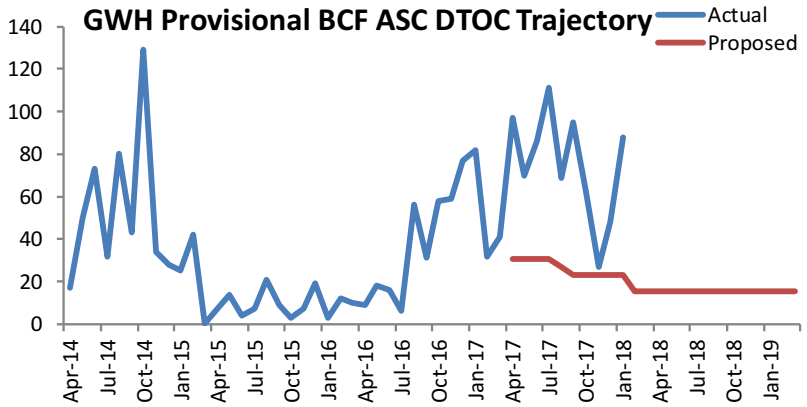
Trend for GWH Delayed Days





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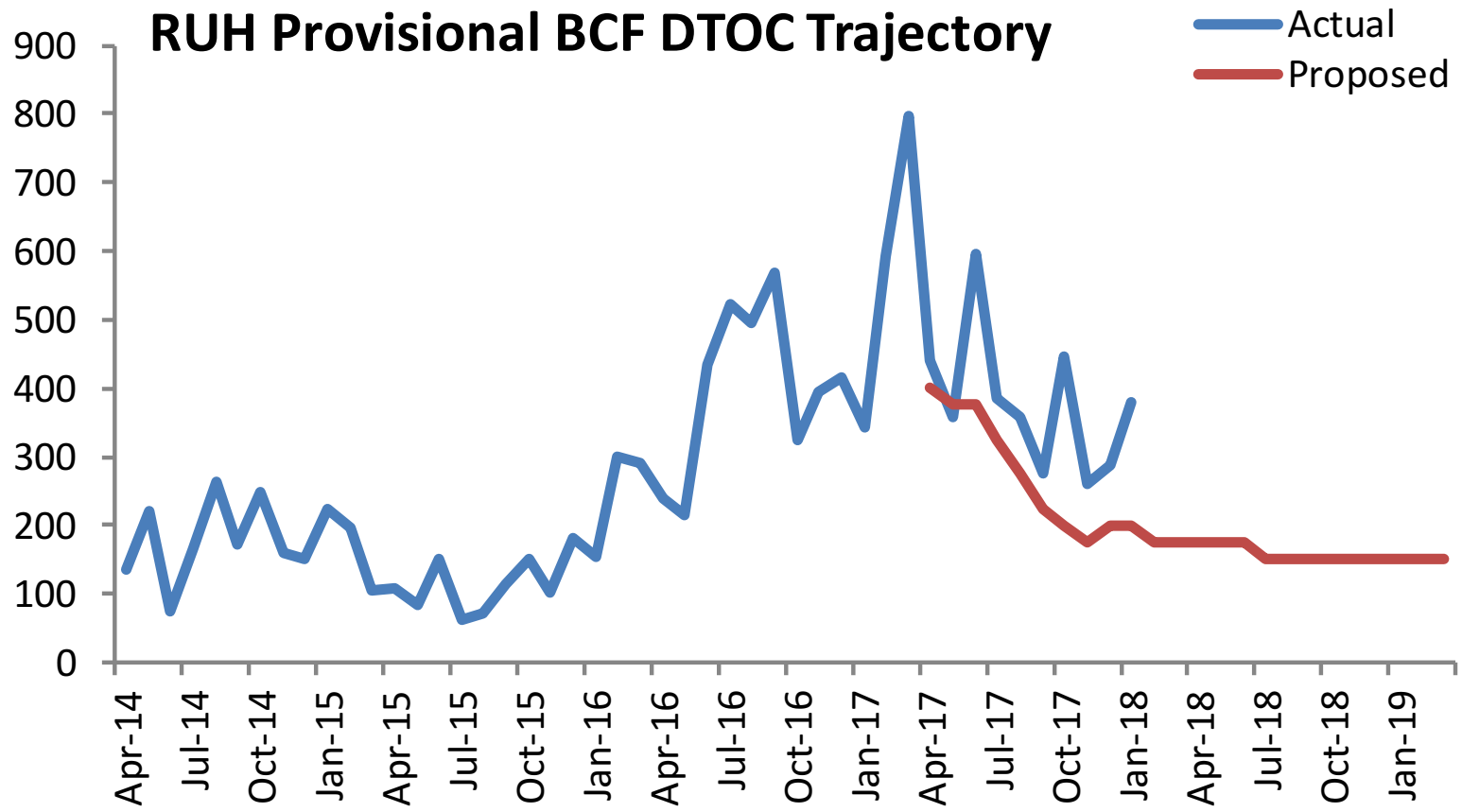
Trend for RUH Delayed Days



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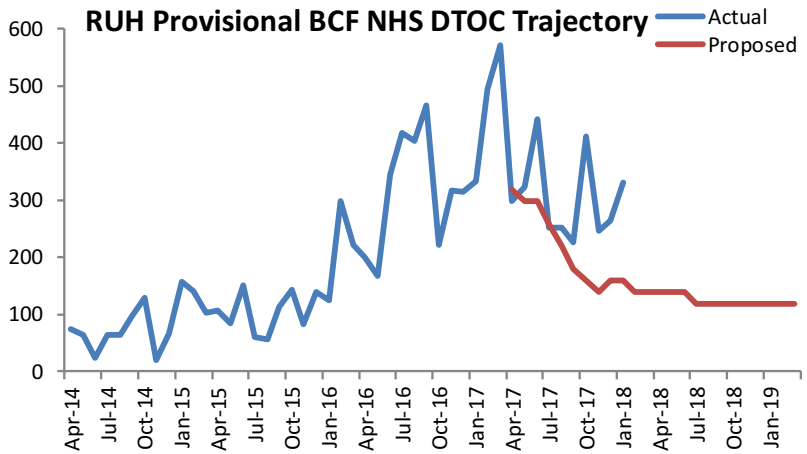
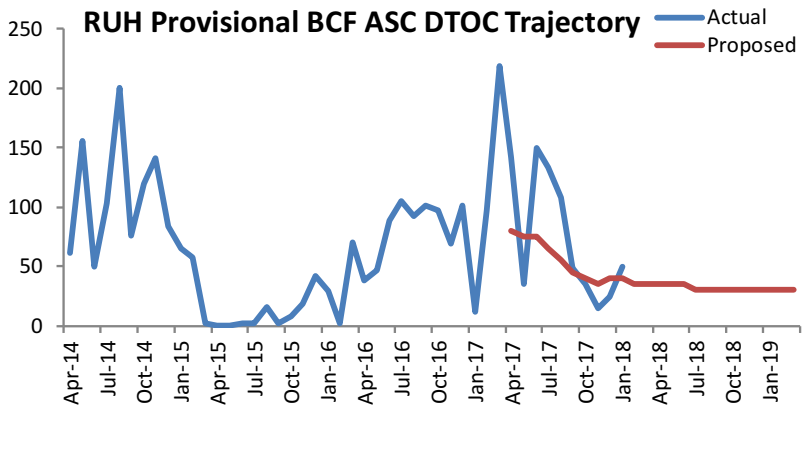
Trend for RUH Delayed Days





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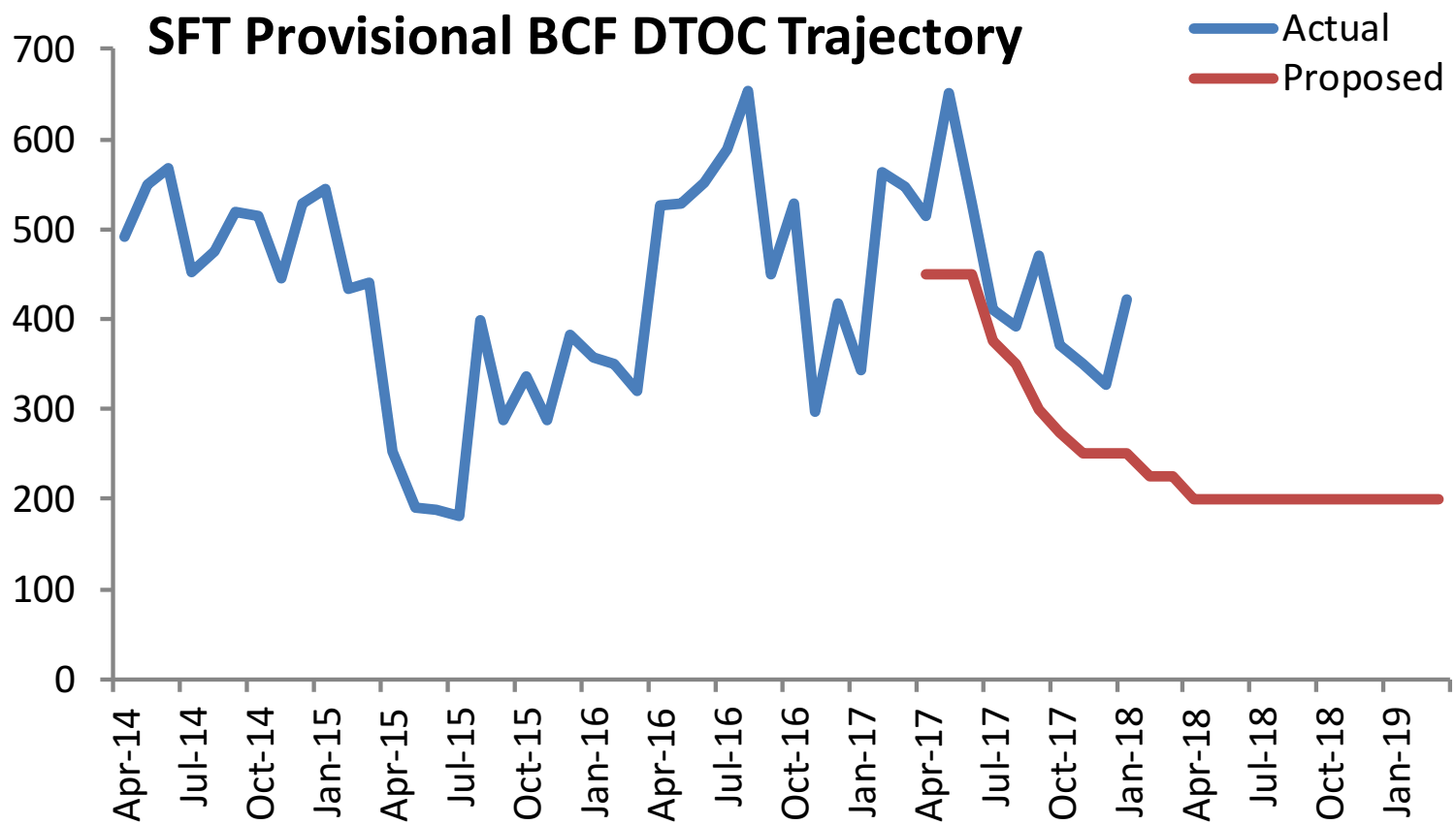
Trend for SFT Delayed Days



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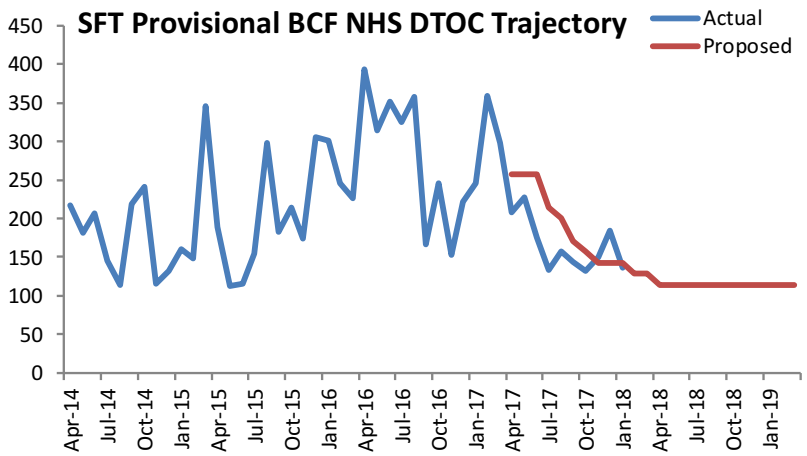
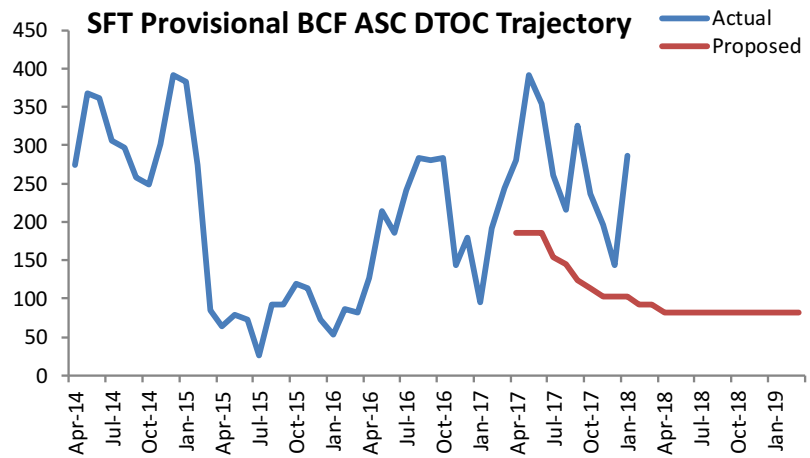
Trend for SFT Delayed Days





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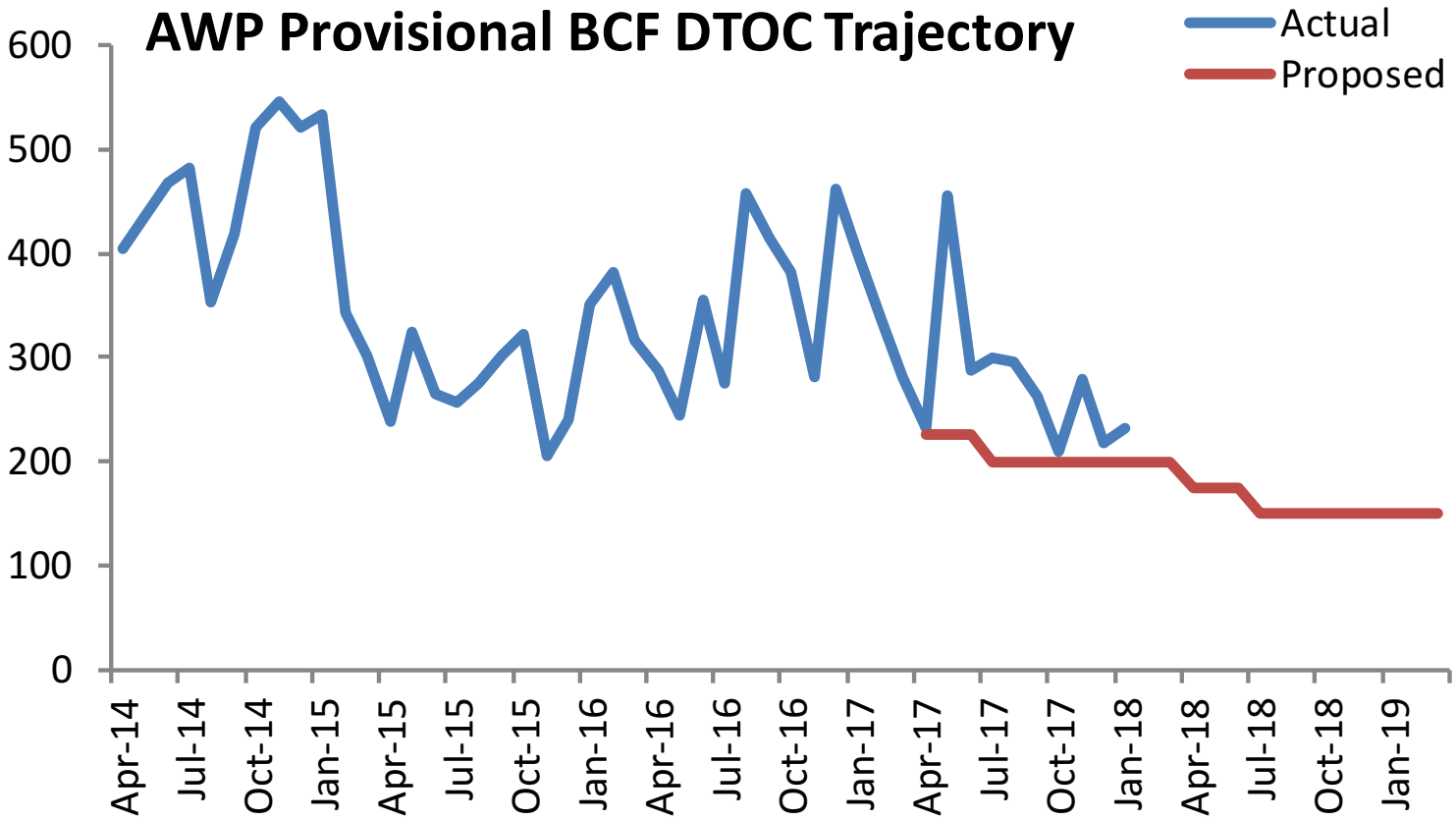
Trend for AWP Delayed Days



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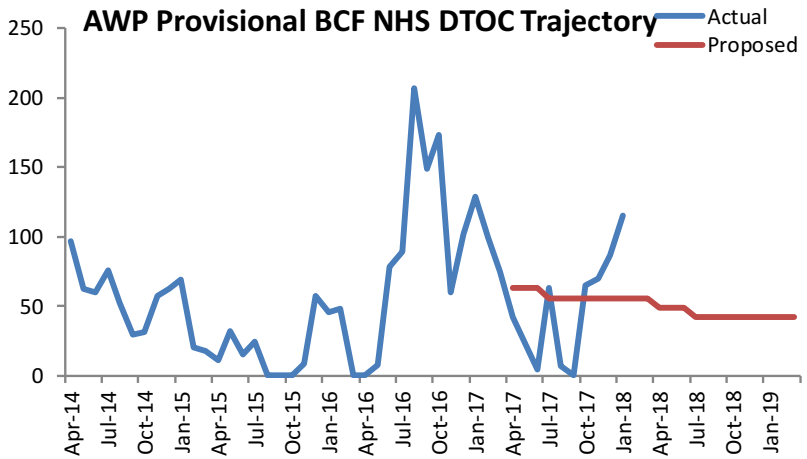
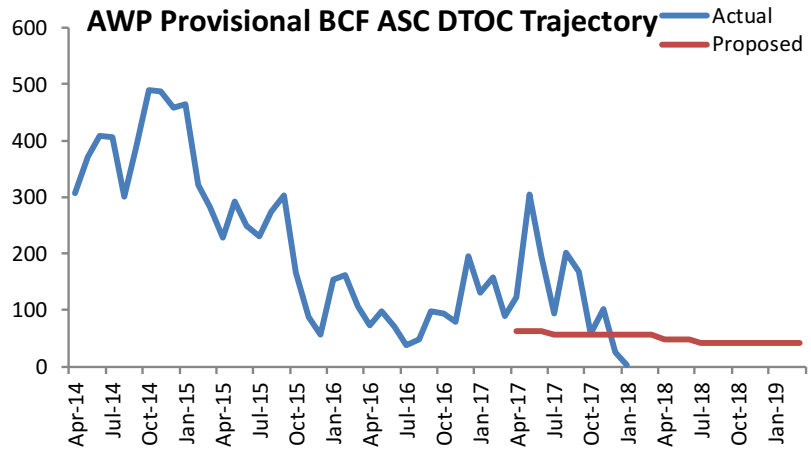
Trend for AWP Delayed Days





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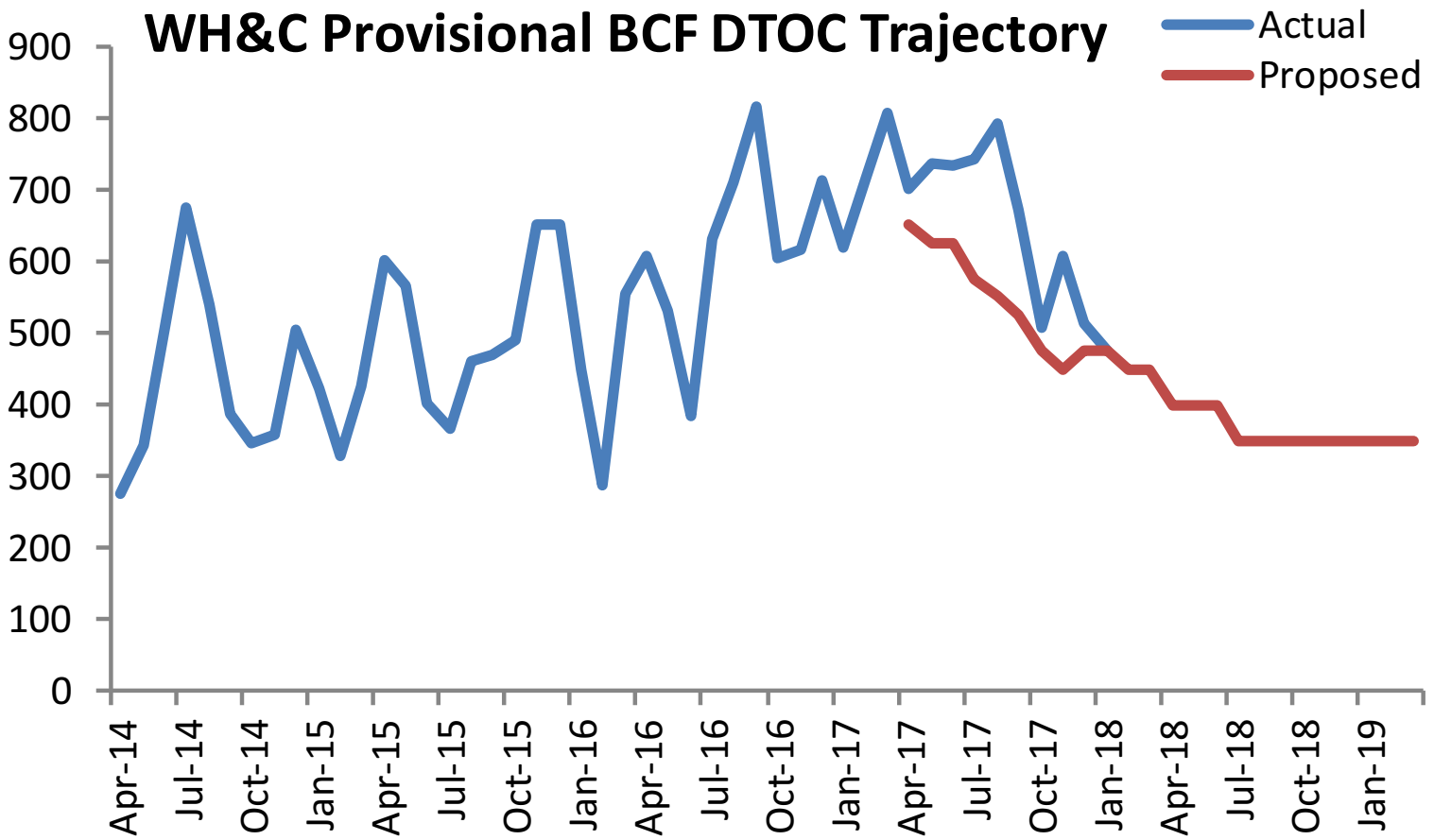
Trend for WH&C Delayed Days



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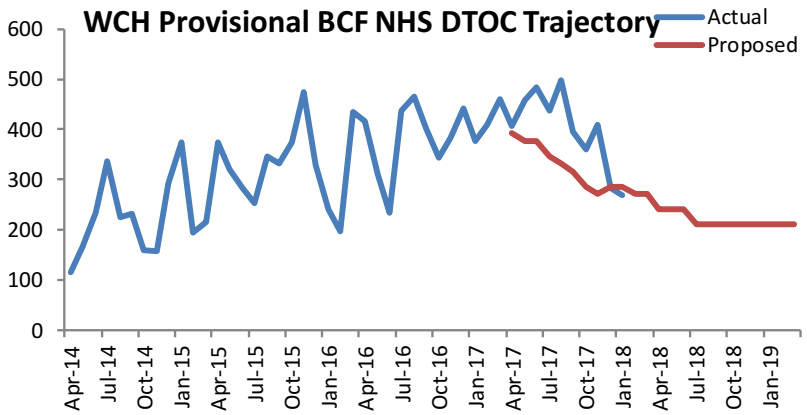
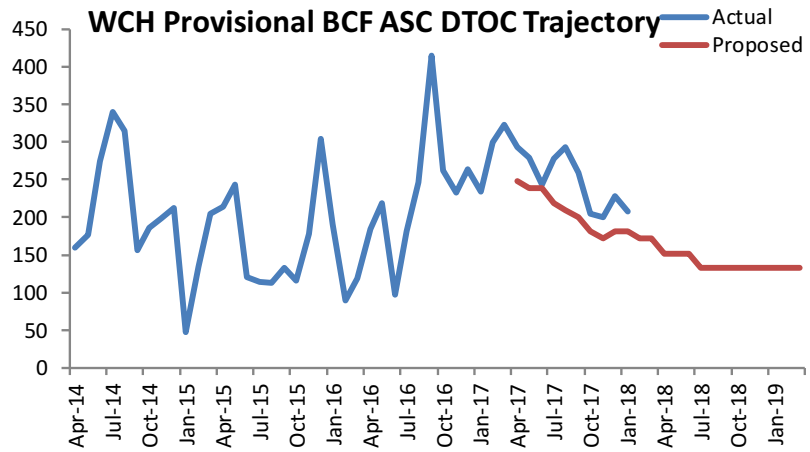
Trend for WH&C Delayed Days





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Clinical Commissioning Group

Benchmarking Performance

Table shows percentage increase or reduction in delayed days from December to January.

	NHS	ASC	Total
England	8.2%	0.5%	4.8%
South West	19.7%	5.3%	13.2%
Statistical Neighbours	11.4%	3.9%	9.6%
Wiltshire	26.4%	37.2%	29.8%

Wiltshire Council
Where everybody matters

NHS
Wiltshire
Clinical Commissioning Group

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	117	134	134
October 2017	133	120	131
November 2017	127	124	125
December 2017	124	113	124
January 2018	137	129	137

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Wiltshire Council

Health and Wellbeing Board

29 March 2018

Subject: Better Care Plan

Executive Summary

Non-elective admissions have increased when compared to last year but this is driven in the main by changes in coding at a couple of trusts and some transfer of responsibility from Specialised to CCG Commissioning.

The number of delayed transfer of care days (DTOC) increased in the latest January period, however we continue to see improvement in both NHS delays and ASC delays compared to earlier in the year.

There are some data quality issues surrounding the measurement of those people still at home 91 days after discharge which are being managed with a view to correcting the data from April onwards.

Urgent Care at Home has continued to see more referrals. Help to Live at Home has taken forward the person-centred model to enable individuals to have care that enables resilience and self-care. New permanent admissions to care homes remain at historically low levels

During 2018/19 the new market model for Wiltshire that supports the transformational change of delivering care closer to home or at home will be strengthened by domiciliary care market development, linking to Home First and the in house reablement service.

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 made a positive impact in relation to DTOC since April 2017 however we remain off trajectory, the pooled fund and associated schemes are currently being reviewed to ensure that improvement takes place at a system wide level through the adoption of national best practice models such as the high impact model of change.

Proposal

It is recommended that the Board:

i) Note the Performance levels contained in the Integration and Better Care Fund Dashboard and the completion of the Section 75 agreement

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.

Tony Marvell
Portfolio Delivery Manager - Integration
Wiltshire Council and Clinical Commissioning Group

Wiltshire Council

Health and Wellbeing Board

29 March 2018

Subject: Better Care Plan

Purpose of Report

1. To provide a status report for the Better Care Fund Programme, including an update on the Section 75 agreement.

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.

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 performance dashboard at **Appendix 1** shows that:
   - Overall non-elective admissions for Wiltshire are around 10.7% higher than last year, but this is driven in the main by changes in coding at a couple of trusts and some transfer of responsibility from Specialised to CCG Commissioning, without these changes the increase would be around 4.8%. Avoidable emergency admissions are down 1% and admissions from non-LD care homes are down nearly 3% on the same period last.
   - New permanent admissions to care homes remain at historically low levels due in part to availability of care homes.
   - The percentage of people at home 91 days post hospital discharge has reduced, data quality issues are causing issues with regards to the production of accurate performance information which is being managed to ensure reliable information for 2018-19.
   - The number of Delayed Transfers of Care days continue to fall and performance is improving on that seen earlier in the year, however our position remains above the planned trajectory.
   - Urgent care at home continues to see more referrals, with 72 in January, which is close to the target of 80 people, however the % of admissions avoided was lower at 75%

- Help to live at home activity increased in January for new cases, the total was 47 compared to 28 in December

- Urgent Care at home activity has increased 36% 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 at a level broadly similar to the same period last year but discharges are 2% higher. Domiciliary Care activity for new clients is 4.5% higher than the same period last year and ongoing support is 7.2% 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. A review of the schemes contained within the BCF pooled fund is in progress to ensure that schemes continue to contribute to the overall improvement of the whole health and social care system. This will ensure that the schemes for 2018/19 are clearly baselined and that benefits are reported and managed.

6. As reported to the last meeting the Section 75 agreement required a refresh to take account of the arrangement for 2017/19. The Section 75 has now been agreed by Wiltshire Council and The Clinical Commissioning Group.

7. Improvements to the governance for Integration and Better Care Fund are underway. A new Integration and Better Care Board is now in place to provide closer oversight and management of schemes, and to develop closer integrated working approaches.

   The board will report to the Joint Commissioning Board (JCB) on scheme delivery, reviewing business cases and will make recommendations to JCB for investment. The board will also evaluate existing schemes and make recommendations for mainstreaming or scheme closure.

Tony Marvell
Portfolio Delivery Manager - Integration
Wiltshire Council and Clinical Commissioning Group

Report Author: Tony Marvell
Portfolio Delivery Manager - Integration

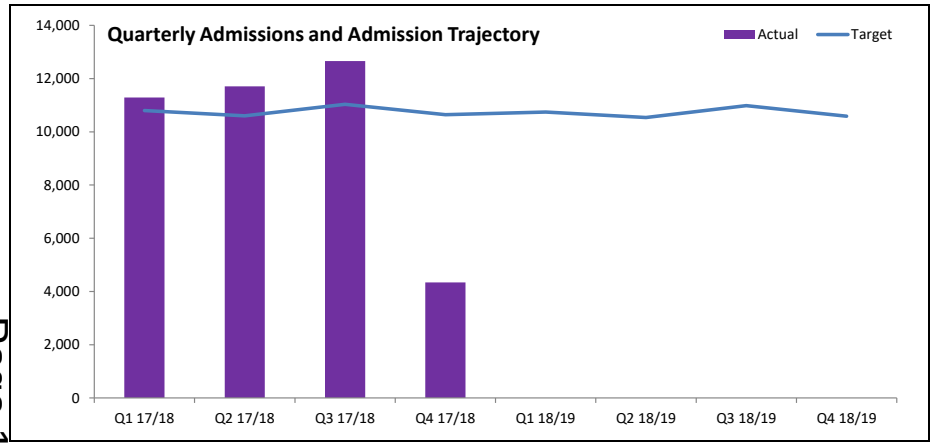
Appendices:
Appendix 1: BCP Dashboard

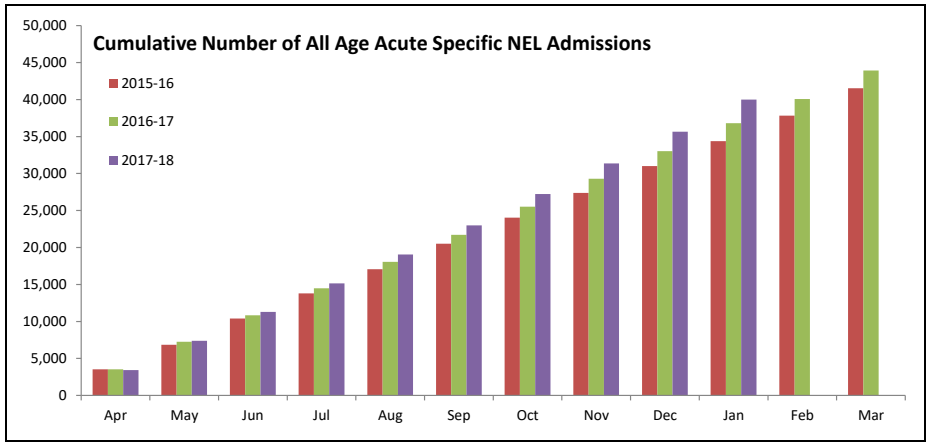
DTOC increased in the latest data but generally we are still seeing an improvement in both NHS delays and ASC delays than seen earlier in the year. Non-elective admissions have increased when compared to last year but this is driven in the main by changes in coding at a couple of trusts and some transfer of responsibility from Specialised to CCG Commissioning. 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 strengthened 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 embedded.

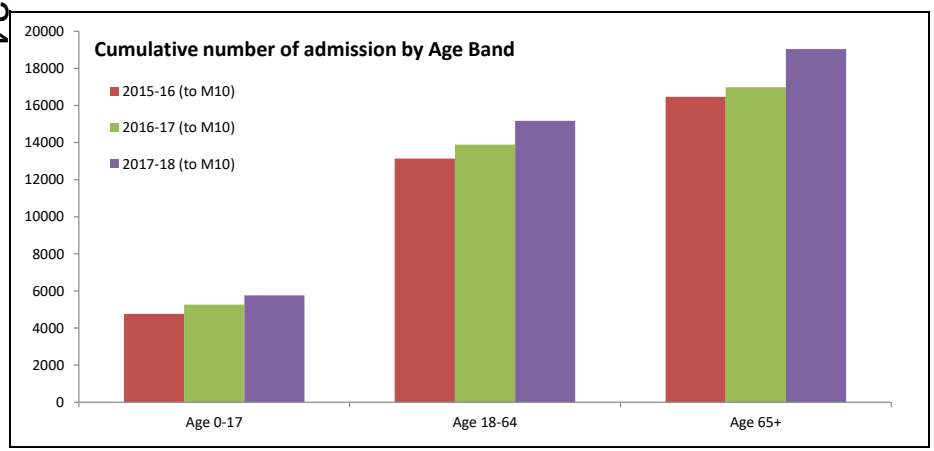
		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Red	Amber	Green
National Indicators																
	Specific Acute Non Elective Admissions	3,416	3,973	3,900	3,866	3,909	3,932	4,233	4,123	4,300	4,339			<3250	3250 or <375	>3750
	Permanent Admissions to Care Homes	300	276	348	474	518	496	423	423	433	432			>525	525 or >500	<500
	At Home 91 days post discharge with reablement		70.9			67.0								<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	1,618	2,100			>1500	1500 or >13	<1325
Wiltshire BCF Schemes																
	Intermediate Care Beds - Step Down	54	47	52	47	42	49	43	47	52	52	40		<45	>45 or <60	>60
	Intermediate Care Beds - Step Up	2	6	5	3	6	1	3	4	3	6	2		<7	>7 or <10	>10
	Community Hospital Beds - Admissions	79	72	72	70	74	79	78	81	89				<60	>60 or <80	>80
	High Intensity Care - Referrals	17	16	21	24	25	23	23	13	23				<12	>12 or <18	>18
	Urgent Care at Home	49	60	64	64	68	62	77	75	69	72			<60	>60 or <80	>80
	Rehab Support Workers	13	31	47	58	67	65	75	56	15				<60	>60 or <80	>80
	Community Geriatrics															
	Fracture Liaison															
	CHS															
Wiltshire iBCF Activity																
	20 Additional SD IC Beds															
	Admissions									8	9	7				
	Discharges										6	9				
	3 Specialist MH IC Beds															
	Additional RSW / UCAH Reablement															
	Housing Adviser															

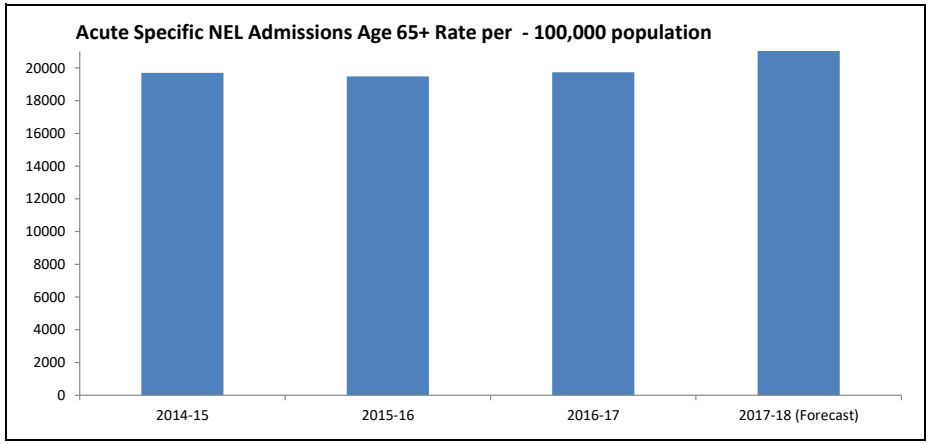
Acute Specific Non Elective Admissions

Activity has been increasing through the year and at M10 admissions are notionally 10.7% (3,858 admissions) higher than the same period last year. A large proportion of this increased activity is due to a change in coding practice at GWH and in addition some activity is now counted at CCG activity when previously it was NHS England specialised commissioning. As a result at this time the 2 years are not directly comparable.





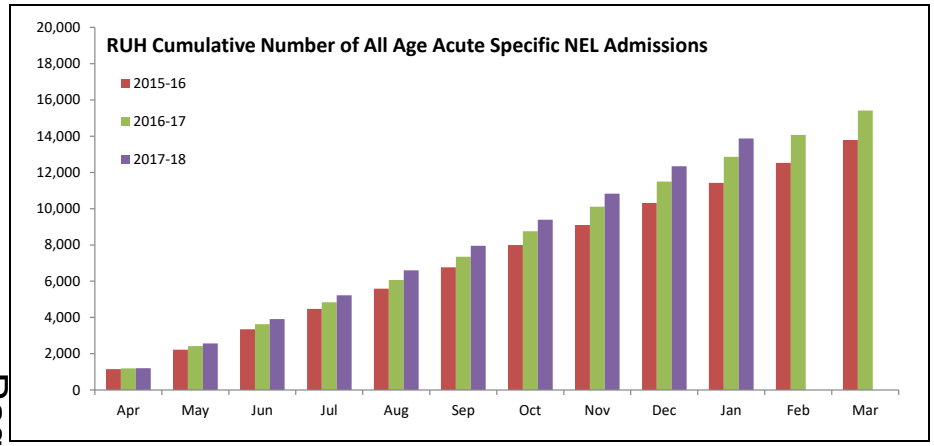


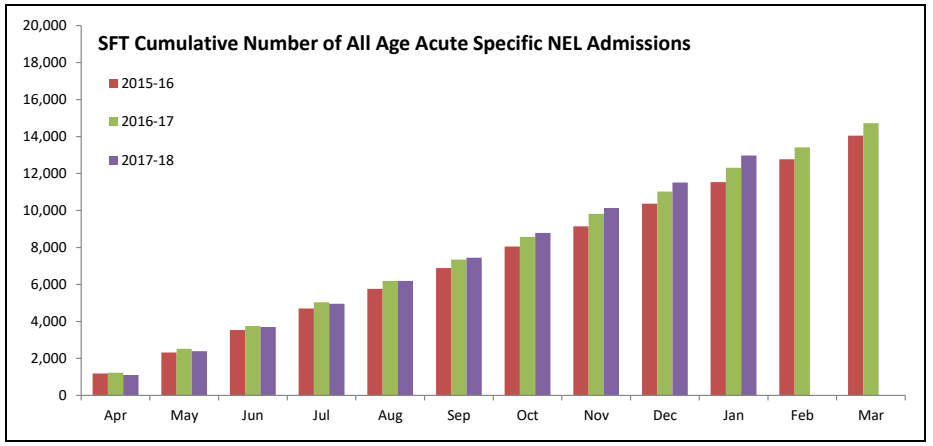


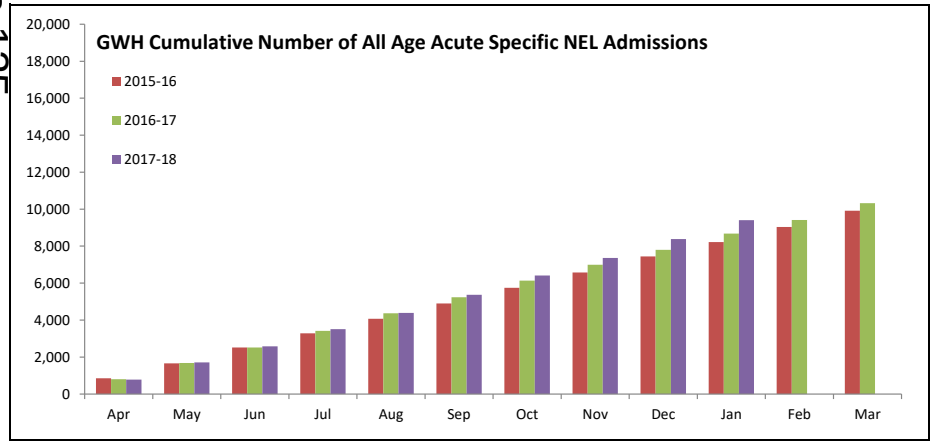
Source: CCG SUS Data

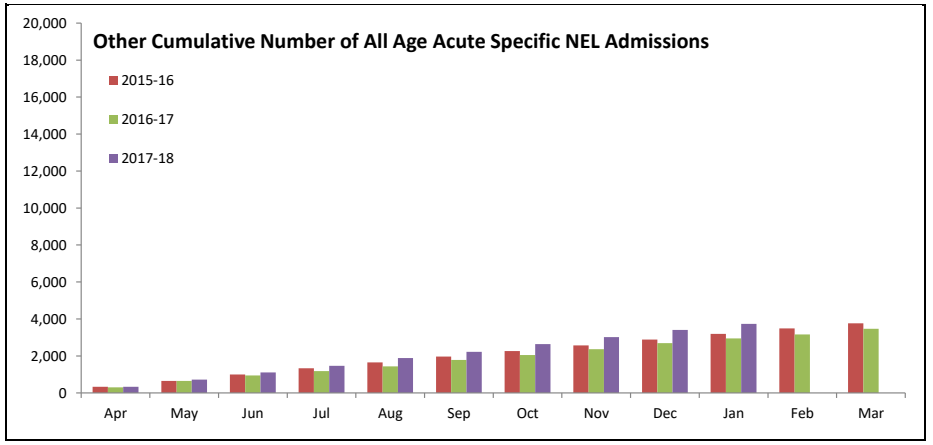
Acute Specific Non Elective Admissions

GWH has seen an increase of 11.5% (966 admissions) part of this is a change in coding practice, RUH & SFT have seen increases of 10.0% (1,259 adms) and 5.1% (632 adms) respectively this is believed to be driven by a transfer in responsibility from NHS E to CCG funding. Admissions out of area to other providers are also up on last year, partly explained by changes from WH&C and AWP.





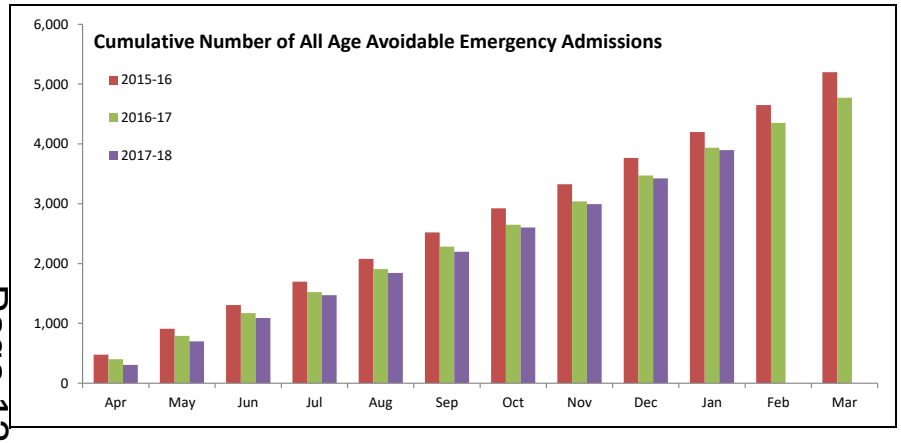


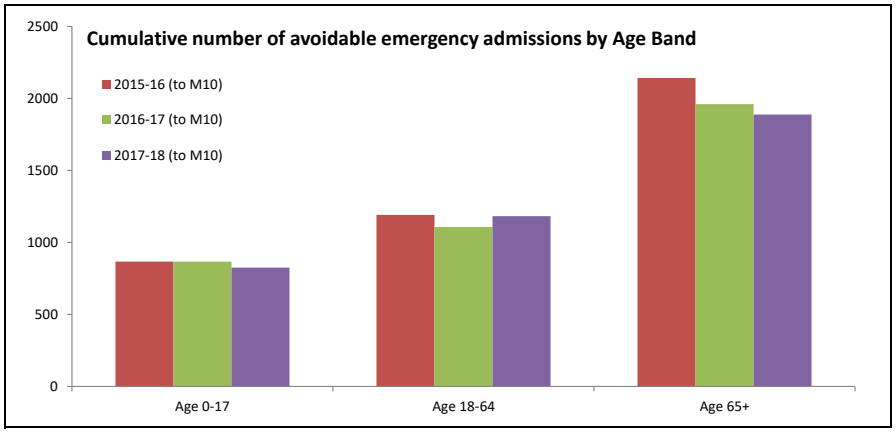


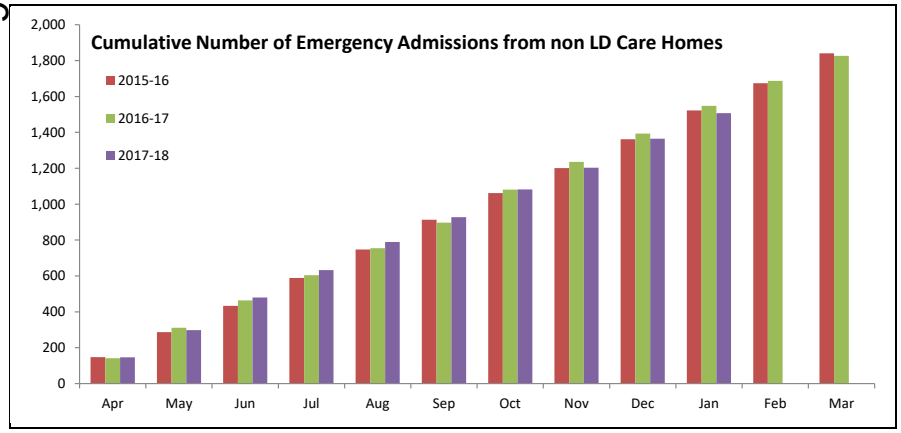
Source: CCG SUS Data

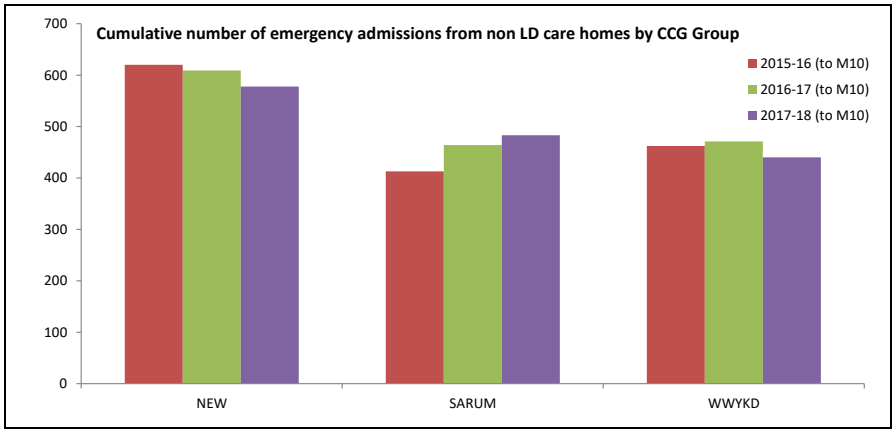
Avoidable Emergency Admissions & Admissions from Care Homes

Avoidable emergency admissions are 1% lower (40 admissions) lower than for the same period last year, although the cost of these admissions is around 9% 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 2.8% (43 admissions). When split by CCG group area we see a slight increase in the South, with a decrease in the West and North.





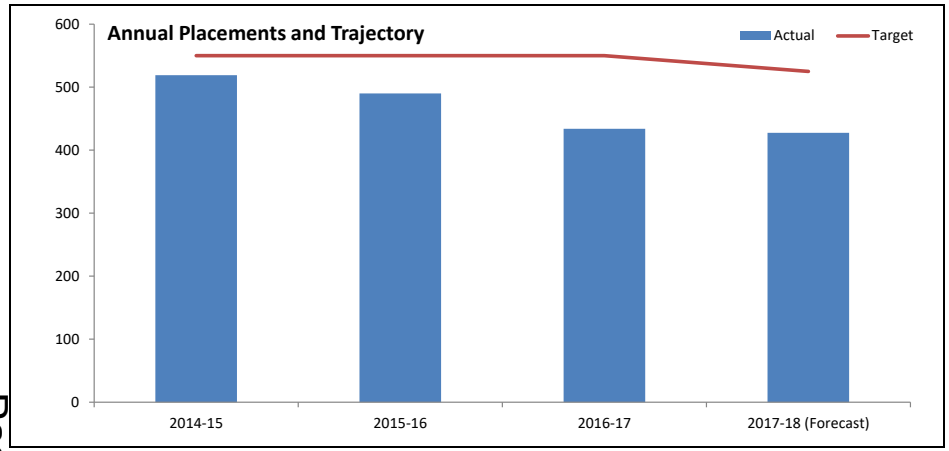


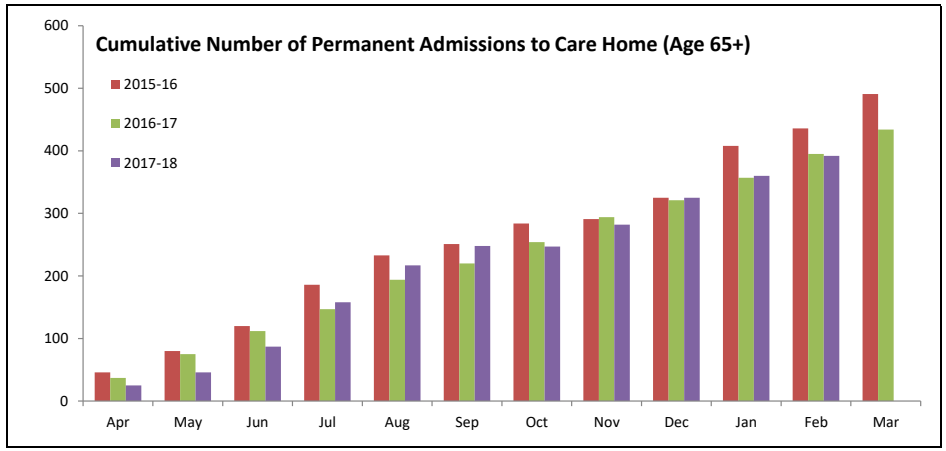


Source: CCG SUS Data

Permanent Admissions to Care Homes

There was a net increase of 32 permanent placements in January, this is slightly lower 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.

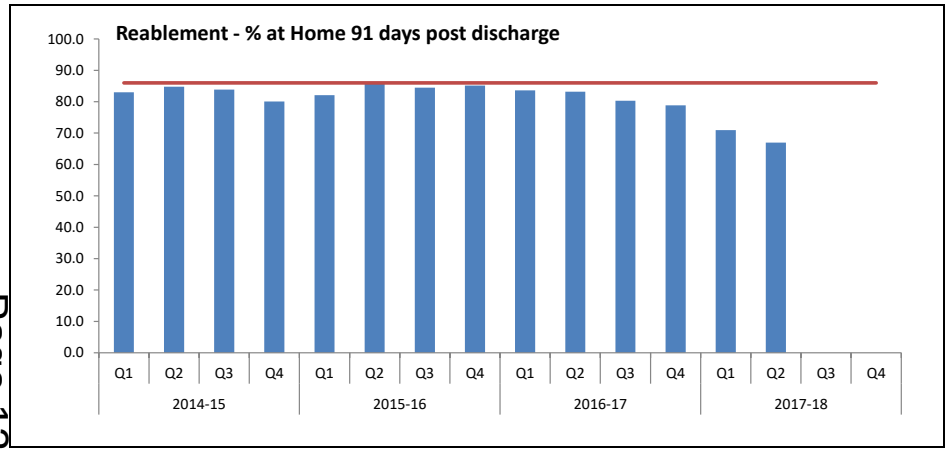


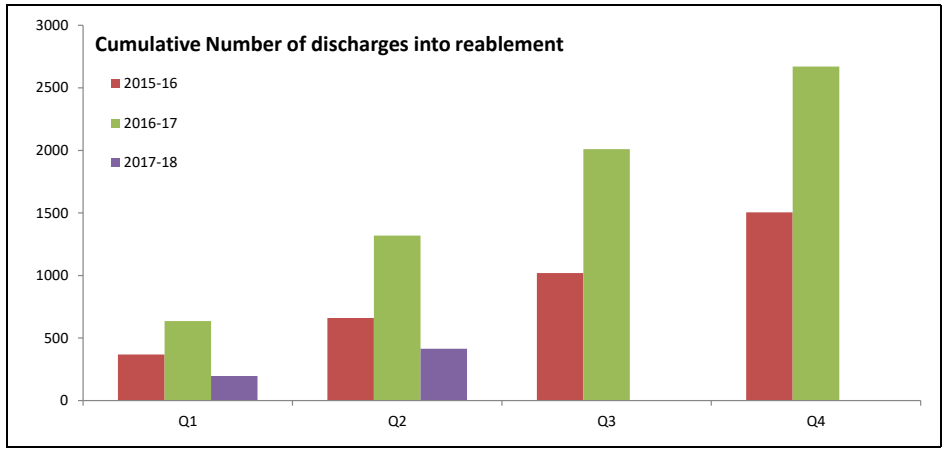


Source: ASC Performance Team

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.

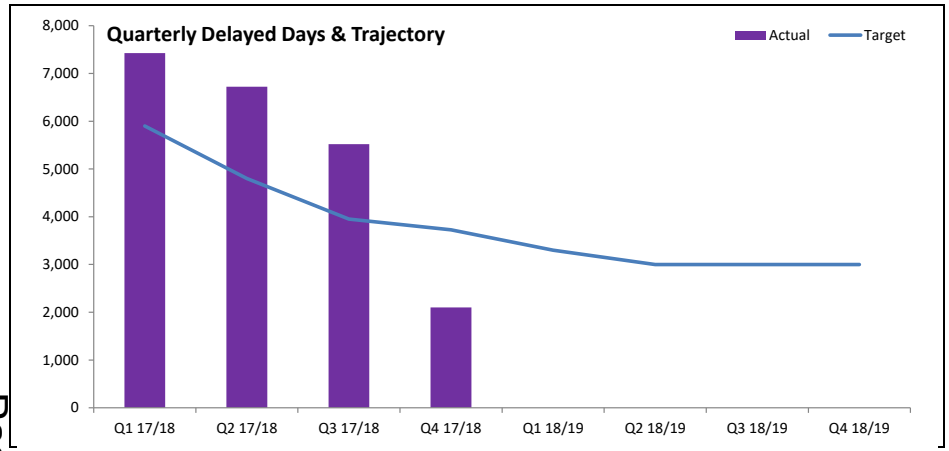


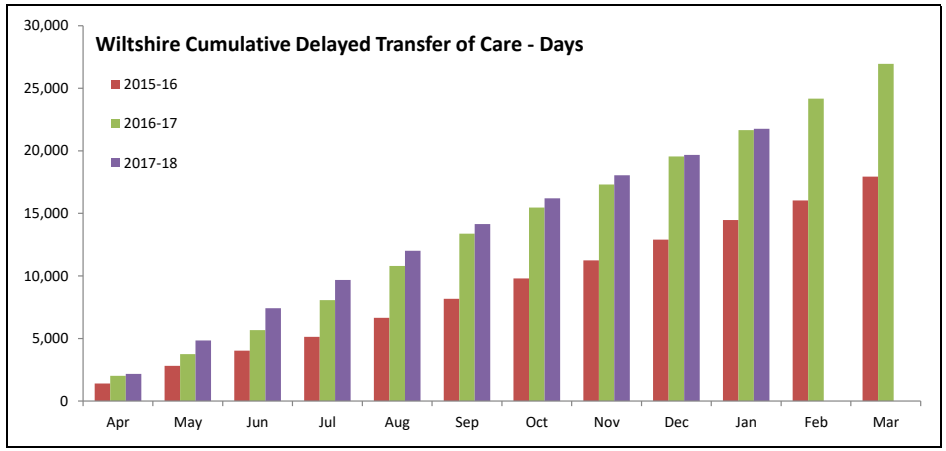


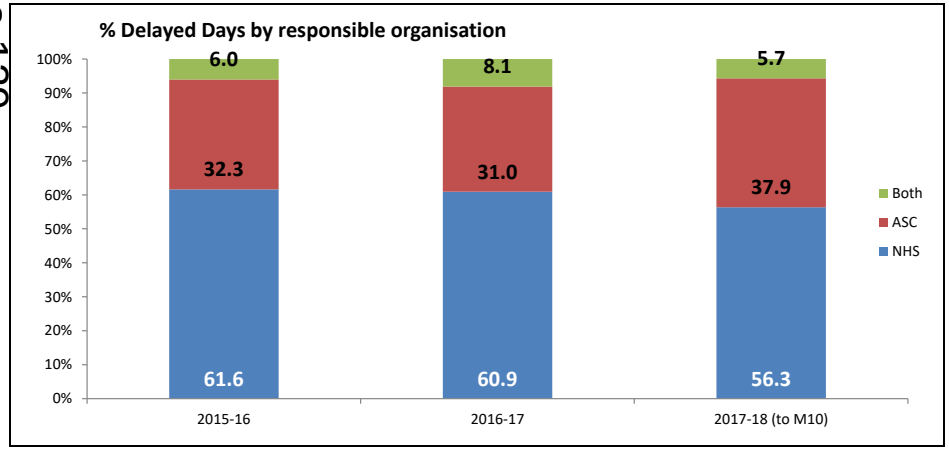
Source: ASC Performance Team & WH&C

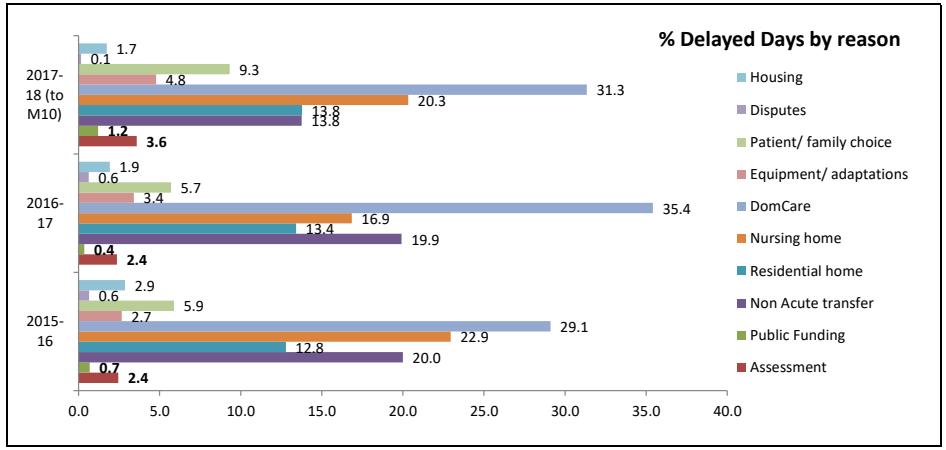
Delayed Transfers of Care - Delayed days

The number of delayed days increased by 29.8% (482 days) in January to 2,100 and remains well above the trajectory target of 1,325. Both NHS and ASC attributable delays increased in January. Waiting for Packages of Care and Placements accounted for 50% of the delayed days.





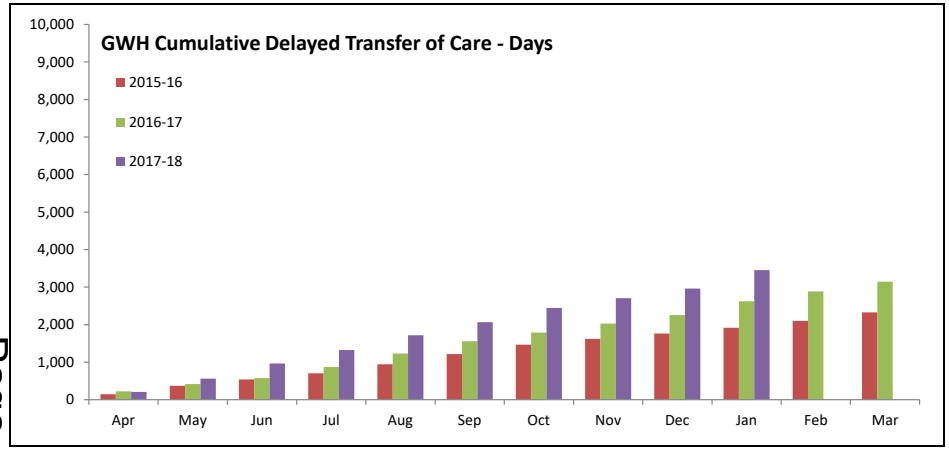


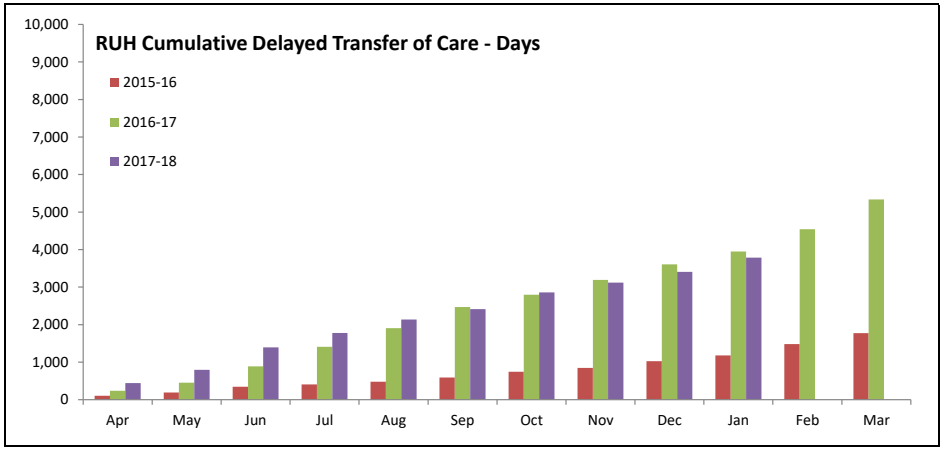


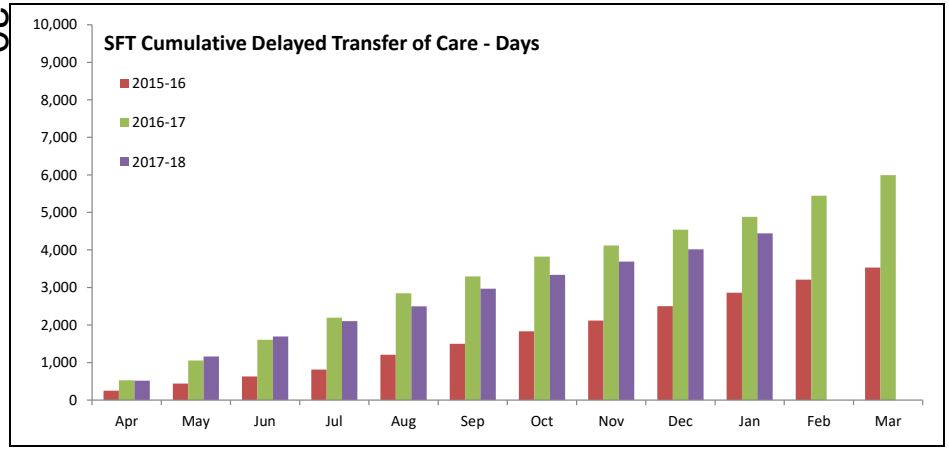
Source: NHS England Monthly Data

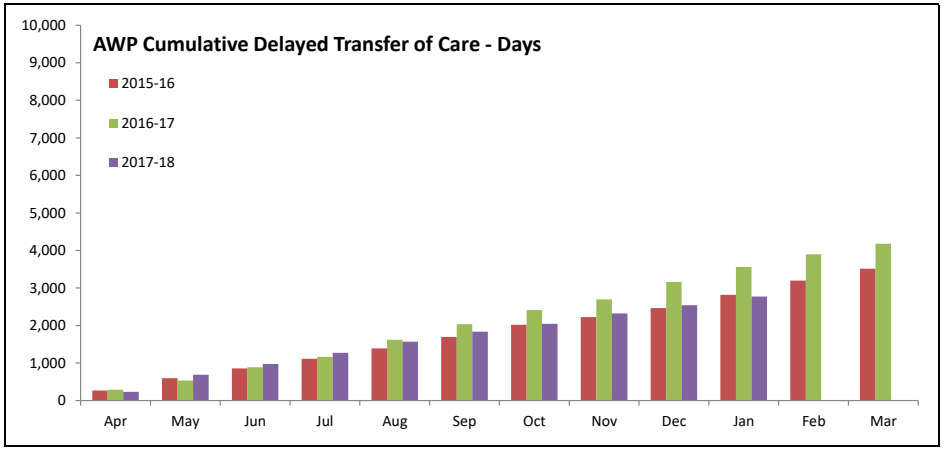
Delayed Transfers of Care - Delayed Days

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





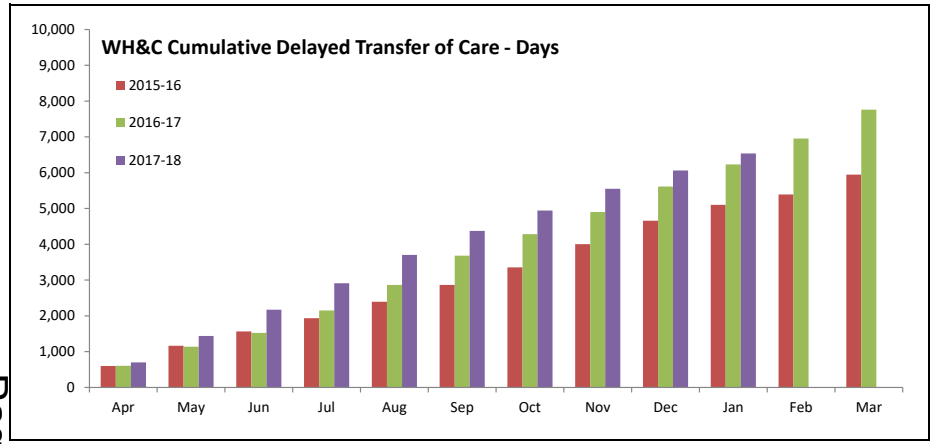


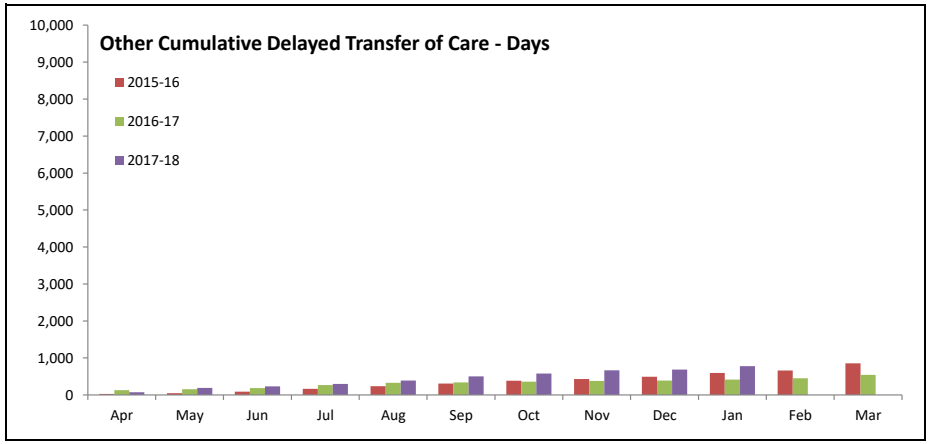


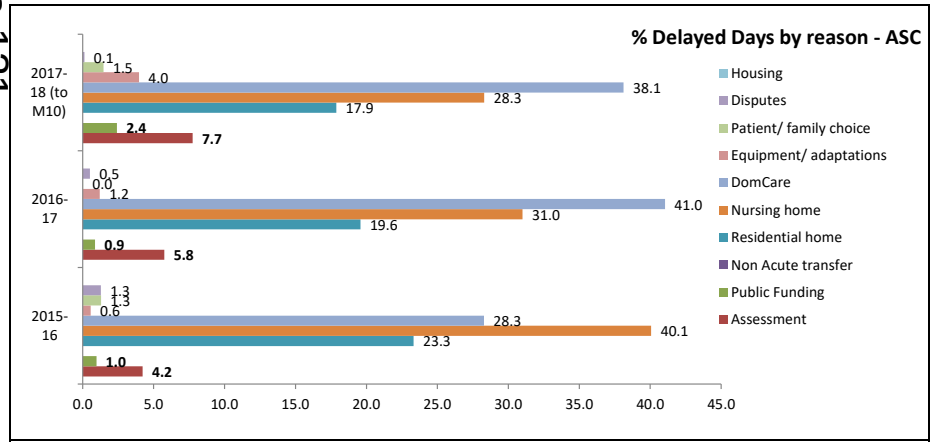
Source: NHS England Monthly Data

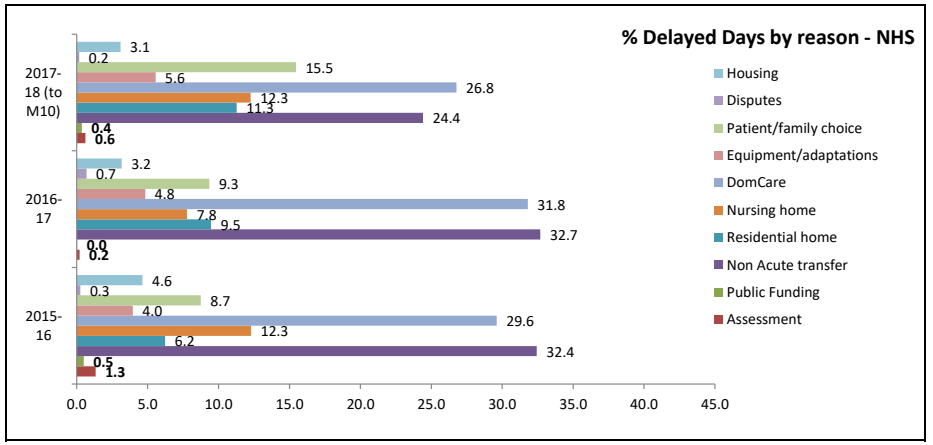
Delayed Transfers of Care - Delayed Days

Delays in Community Hospital and in Out of Area Hospitals have increased compared to the same period last year.
For NHS delays there has been an increase in the percentage of delays due to choice and waiting for a residential home. For ASC delays the percentage of delays associated with assessment and waiting for a package of care have increased.





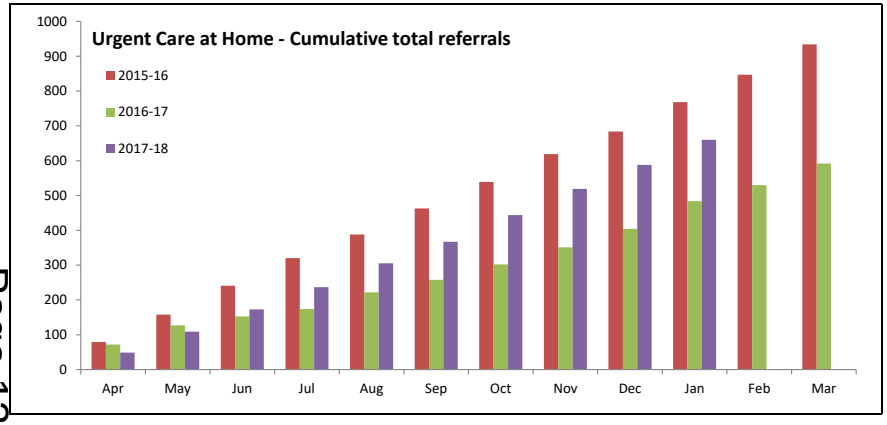


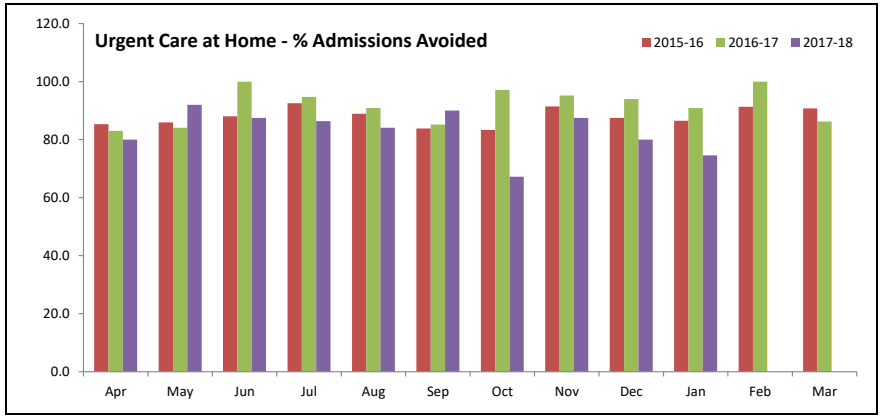


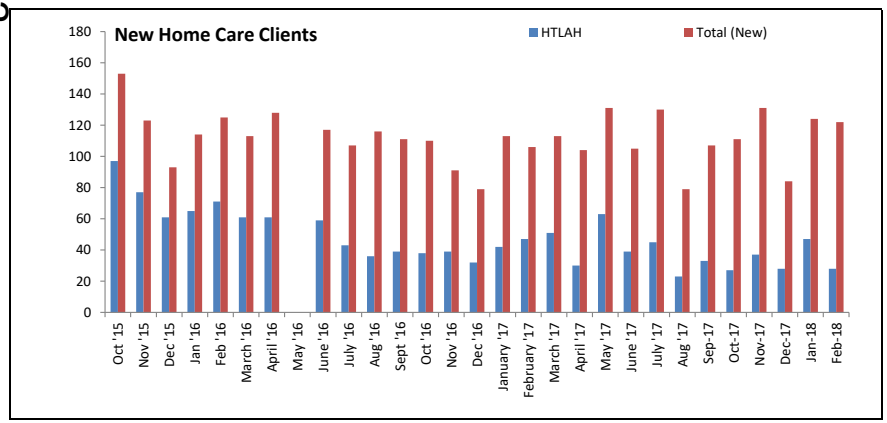
Source: NHS England Monthly Data

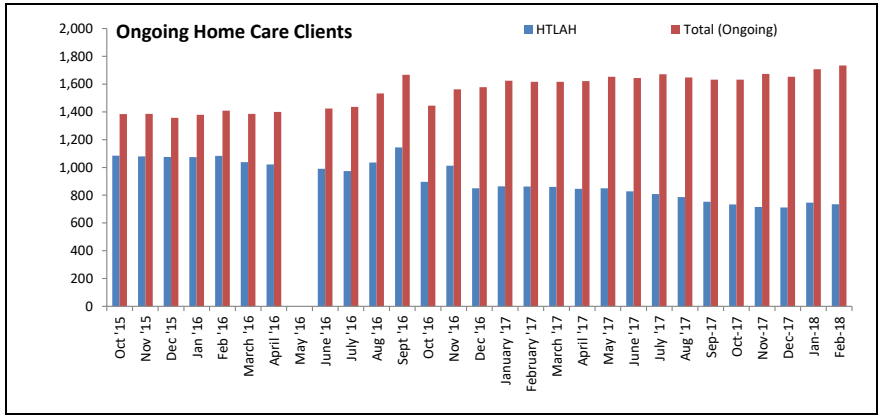
Home Care and Urgent Care at Home Activity

Urgent Care at Home referrals were 72 in January, which is close to the 80 target, however the % of admissions avoided was lower at around 75%. The average number of referrals to M10 is now around 66 per month which is higher than the 2016-17 of 50. The average percentage of admissions avoided is around 82%. The average number of referrals to support discharge is now around 15, this is higher than 2016-17 (9) and 2015-16 (12).
New Help to live at Home activity increased in January for new cases the total was 47 compared to 28 in December for ongoing cases it was 747 clients in December compared to 712 in December. Overall total clients (including SPOT purchase) increased from 1,653 in December to 1,707 in December.





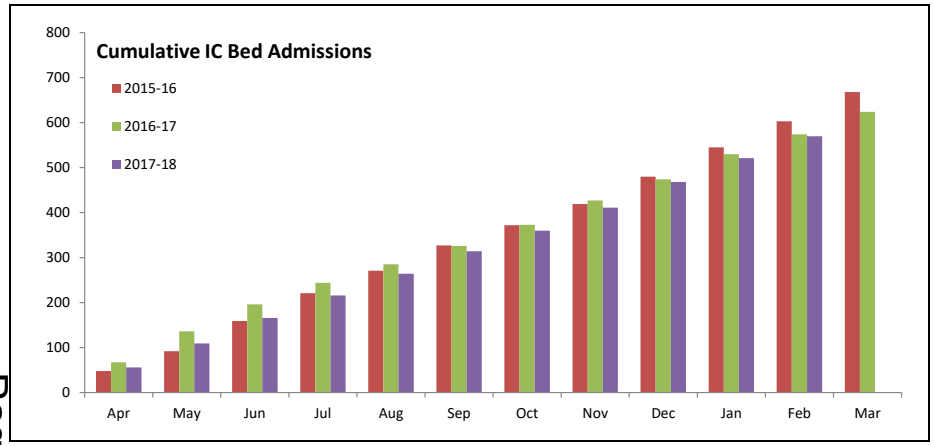


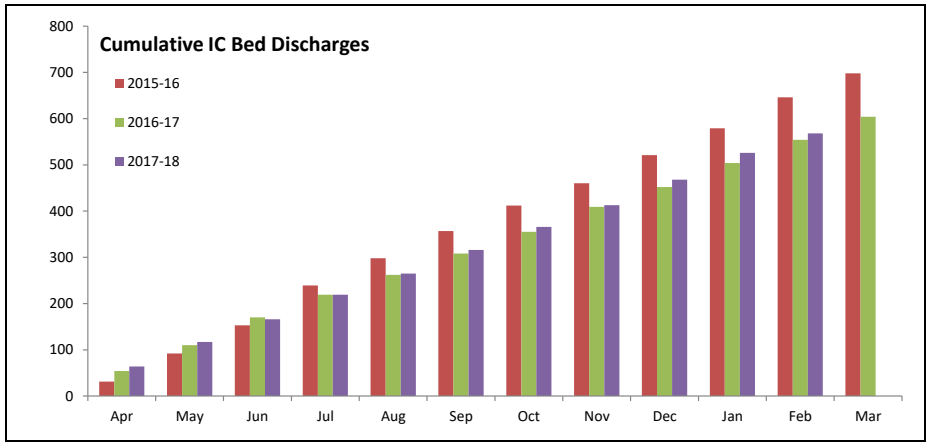


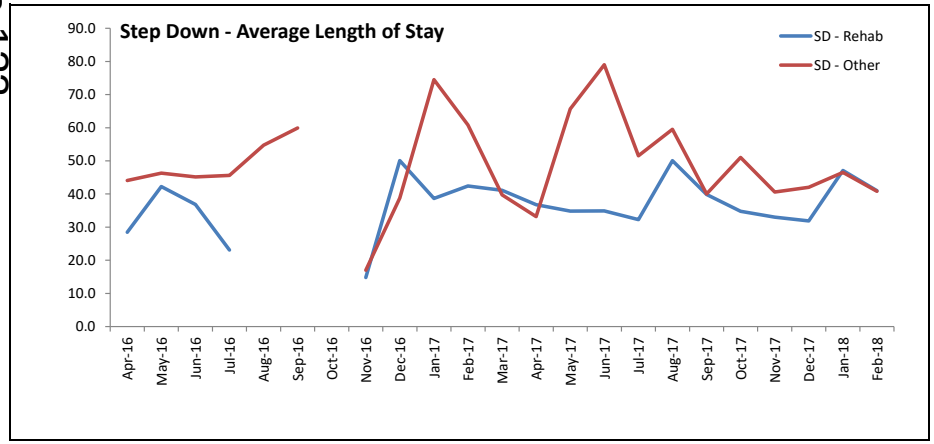
Source: Home Care Data, Wiltshire Council ASC Performance Team. UC@H Data, MEDVIVO

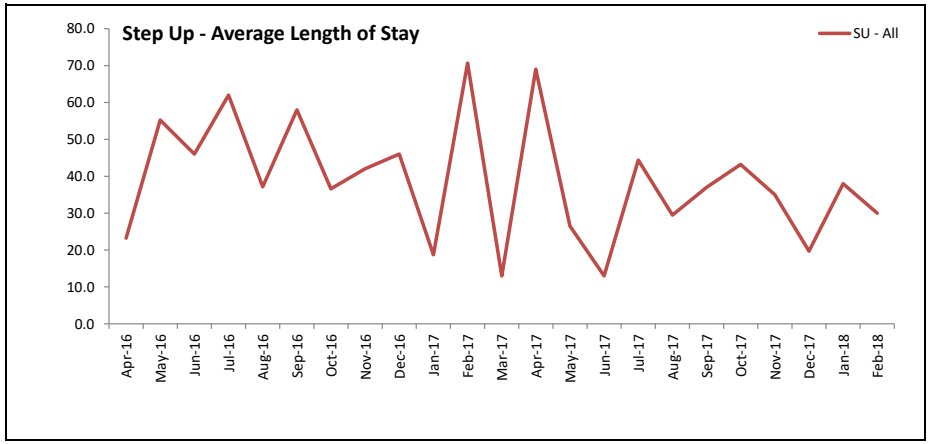
Intermediate Care Beds

Length of stay for rehab reduced in February to 41.0 days, for non rehab patients the length of stay is around the same at 40.8 days. Admissions have been maintained despite one of the homes is on the Council "red list" due to a poor CQC inspection, increased SPOT purchase has been used to help maintain flow. Step up bed admissions were similar in February to January.









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	75	69	72		
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	52	46		
	LoS	37.5	40.8	35.0	36.7	46.4	38.8	37.3	34.4	33.2	47.0		
IC Beds - SU (South)													
	Admissions	2	6	5	3	6	1	3	4	5	7		
	LoS	40.3	26.5	13.0	44.4	29.5	37.0	43.2	35.0	19.7	38.0		
Therapy provision for Intermediate Care Beds													
Step Up Beds (WHC)													
High Intensity Care (WHC)													
	Admissions	17	16	21	24	25	23	23	13	23			
	LoS	28.6	30.7	22.2	43.7	23.3	34.7	26.8	48.5	20.6			
Care Home Liaison													
East Kennet SHARP													
Community Geriatricians													
Home First (Rehab Support Workers Initiative)		13	31	47	58	67	65	75	56	15			
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												

Wiltshire Council

Health and Wellbeing Board

29 March 2018

Subject: Wiltshire Information Sharing Charter (WiSC)

Executive Summary

The paper seeks approval to implement a single over-arching data sharing charter that will replace a number of existing agreements where partner organisations have a common obligation or desire to provide services within Wiltshire.

Proposals

It is recommended that the Board Members:

i) Agree to progress the implementation of and sign up to the Wiltshire Information Sharing Charter (WiSC)

ii) Nominate an information governance lead from their organisation who can assist in establishing a single Information Governance (IG) Board to sit across the whole of Wiltshire, so progressing the implementation and continuation of the Wiltshire Information Sharing Charter.

Reason for Proposals

To introduce the potential of a single overarching information sharing charter to the board members and seek their endorsement and support in the adoption of the charter throughout Wiltshire, so resulting in an integrated service for residents.

Ian Baker, Head of Programme Office, Wiltshire Council
Liz Creedy, Head of Policy Partnerships & Assurance, Wiltshire Council

Purpose of Report

1. To provide information on the single over-arching data sharing charter that it is proposed will replace a number of existing agreements where partner organisations have a common obligation or desire to share information to facilitate the provision of services within the community.

Background

2. In late September 2017, the Single View Information Governance Board recognised the need to revise the Single View Tier 1 Sharing Agreement in preparation for GDPR (General Data Protection Regulation) that will be enshrined in UK law in May 2018. The Board reviewed the existing overarching data sharing agreements already used across the Country and concluded that an adapted Dorset Information Sharing Charter would meet the needs for the county's public services. The Dorset Information Sharing Charter has proved successful and has over 100 members. Some of the signatories also provide services in Wiltshire e.g. Dorset and Wiltshire Fire and Rescue.

3. A draft of the Wiltshire Information Sharing Charter (WiSC) was agreed by the Single View Information Governance (IG) Board and also by Wiltshire Council's IG Board in January 2018. This will now be progressed and signed by the Single View partners for use within the context of this programme. A copy of the draft charter is attached for reference.

4. The Single View Board has recognised the opportunity the WiSC presents to be an overarching data sharing agreement across all public services across Wiltshire. This would enable removal of a number of existing data sharing agreements within one and at the same time introduce a consistent set of principles and protocols.

5. The benefits of this charter will be to provide Wiltshire partner agencies with a robust overarching framework which allows for the legal and secure sharing of personal information between partner organisations. It will enable the ability to meet the statutory obligations and share information safely supporting better integrating service provision within the Wiltshire community. The sharing of information will be standardised with an agreed set of templates using a common theme.

6. One overarching IG partnership board would need to be established in order to oversee the introduction and maintenance of the WiSC. This would replace the need for several IG boards throughout Wiltshire e.g. the Single View Board

7. The WISC will meet the General Data Protection Regulation (GDPR) legislation scheduled for 25th May 2018. Existing safeguards on privacy will be maintained in accordance with the Data Protection Act.

8. Tier 2 sharing agreements, i.e. specific data sharing agreement between specific organisations with full details of the information to be shared will still be required between the organisations who are information sharing.

9. By partners signing up to the WiSC, they will agree to accept the principles of the charter as the foundation for sharing information with each other and in line with legislation. Signatories/approval should be at the highest level, e.g. CEO / SIRO and a charter membership list will be created, detailing all organisations who have joined.

10. The concept of this charter was received positively at the Sustainability and Transformation Partnership (STP) Digital meeting in December 2017, along with the Wiltshire CCG. Wiltshire Council's IG board is fully supportive of the WiSC and Wiltshire Police has also provided agreement. There is a definite appetite for a county wide charter as this will provide a unified basis for information sharing.

Ian Baker, Head of Programme Office
Liz Creedy, Head of Policy Partnerships & Assurance, Policy Partnerships & Assurance

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Report Authors:
Lisa McKeigue, Project Officer, Programme Office, Corporate Services and Digital

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Wiltshire Information Sharing Charter

Contents Page

1. Introduction

1.1 This charter aims to provide Wiltshire partner agencies with a robust foundation for the lawful, secure and confidential sharing of personal information between themselves and other public, private or voluntary sector organisations that they work, or wish to work in partnership with. It will enable all partner organisations to meet their statutory obligations and share information safely to enable integrated service provision across the county and better care outcomes for its residents.

2. Charter Principles

2.1 The principles of this charter are to:

(a) identify the lawful basis for information sharing;
(b) provide the framework for security of information and the legal requirements associated with information sharing;
(c) address the need to develop and manage the use of Personal Information Sharing Agreements (PISAs);
(d) encourage flows of personal data and develop good practice across integrated teams;
(e) provide the basis for Pan Wiltshire processes which will monitor and review data flows; and information sharing between partner services
(f) reduce the need for individuals to repeat their story when receiving an integrated service.

3. Scope

3.1 This charter considers the requirements for all personal information processed by partner organisations that is shared because of partnership and integrated working in order to provide a more seamless service to the individual.

3.2 This charter regards all identifiable personal information relating to an individual as confidential that should only be shared if there is a legitimate purpose, statutory obligation or lawful basis and is covered by associated procedures and/or agreements to this document between partners and/or specific services within that provide services to the public.

3.3 In line with the General Data Protection Regulation 2016, (and the proposed UK data Protection Act 2018) the term “personal data” refers to any information relating to an identified or identifiable natural person, processed wholly or partly by automated means or as part of a filing system.

3.4 This charter defines processing as any operation or set of operations which is performed on personal data or on sets of personal data, whether or not by automated means, such as collection, recording, organisation, structuring, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transmission, dissemination or otherwise making available, alignment or combination, restriction, erasure or destruction, in writing or through electronic medium including images and photographs.

3.5 The GDPR and domestic legislation further define certain classes of personal information as ‘special category data', for which additional conditions must be met to ensure the information is processed lawfully. All partners under this charter are expected to treat special category data in line with conditions as set out.

3.6 This charter applies to all persons within the partner agencies who manage, share and/or use information as part of established partnership working arrangements and integrated teams or services. It also applies to anyone working in a voluntary or contracted capacity within those arrangements.

4 Partner Commitment

4.1 By becoming a partner to this charter, all organisations are making a commitment to:

(a) accept the principles of this charter as the foundation for sharing information with each other and promote awareness to all staff
(b) share information in line with legislation and associated information sharing agreements where the purpose and necessity to share information has been agreed by all parties
(c) ensure the sharing of information is agreed as proportionate to meet the purpose
(d) ensure all persons working with personal information on behalf of their organisation do so in line with the principles of this charter
(e) delegate authority to a nominated lead for their organisation who will act on their behalf for decision making
(f) provide a nominated lead to assist the governance of this charter and associated information sharing agreements where required or link with a like-minded partner
(g) support on going participation for better information sharing in accordance with the governance protocol. Ensure groups are properly represented and representatives are supported with decision making
(h) support the production of shared guidelines and literature associated with information sharing for both staff and the public
(i) support the development and provision of joint cross agency training where appropriate
(j) provide all staff the appropriate training and support to be able to share information safely and legally as part of their normal duties.
(k) Confirm that all staff sharing information under this charter possess the appropriate knowledge and authority and are aware of the legislative and lawful basis requirements.
(l) ensure their DPA notification to the Information Commissioner covers the arrangements established under this charter and any associated PISAs
(m) follow the Caldicott and/or Data Protection principles
(n) understand that the sharing of information under this charter without lawful justification or consent places them at risk of prosecution
(o) ensure appropriate organisational policies and procedures are in place to cover the security, storage, retention and destruction of personal information under this charter.

4.3 It is understood that signatories to this charter are committing their entire organisation to fully support the principles and carry out their commitments to the full. Any organisation, that for whatever reason is unable to continue their commitments, will be removed as a partner and signatory to this charter. Only partner signatories to this charter will be able to benefit from any integrated agreements, joint development, support and universal resources available.

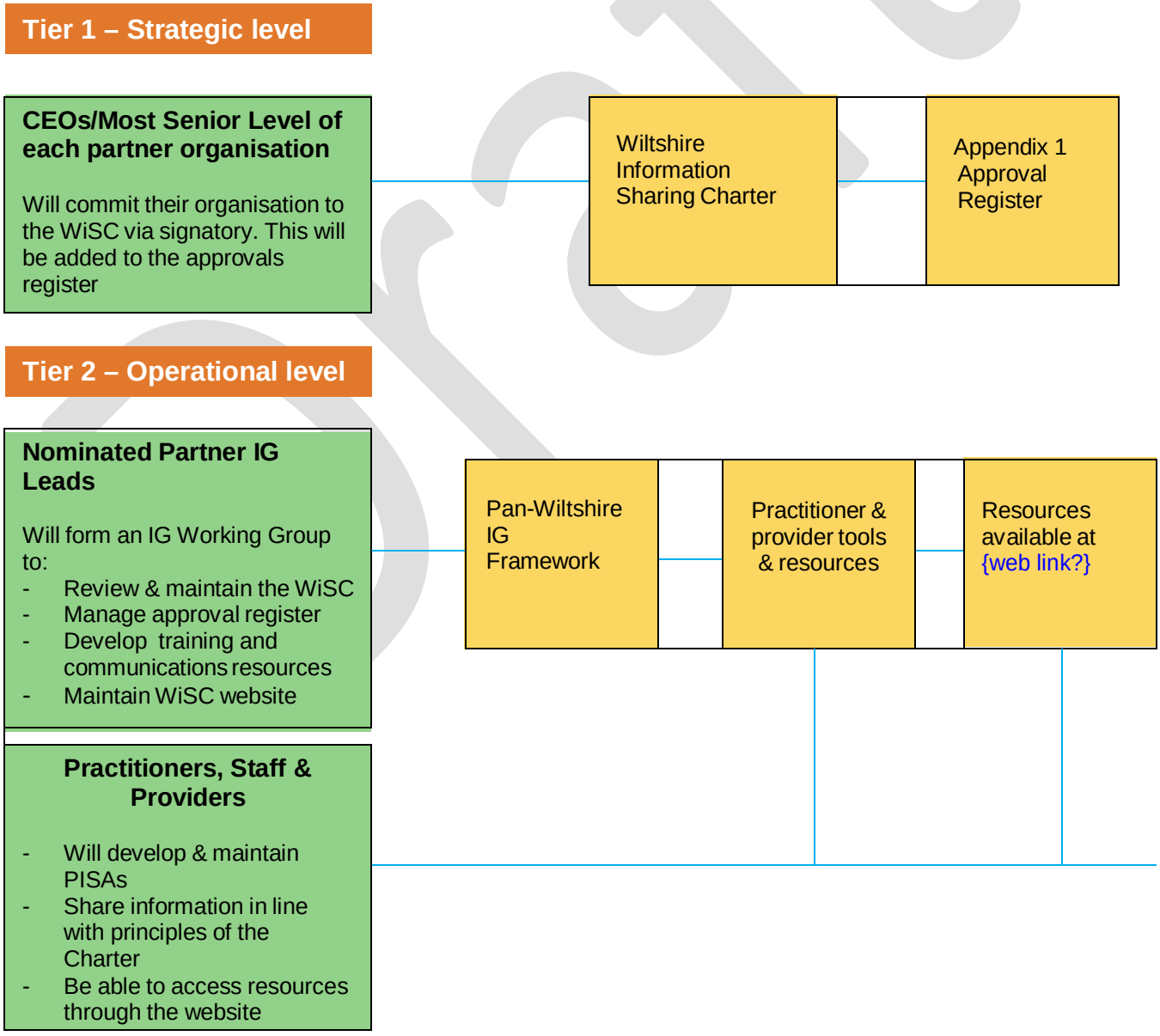
5 Governance

5.1 A governance framework will be put in place to manage this charter and monitor associated procedures and PISAs on behalf of all partners.

5.2 The framework will cover:

- Review and monitoring of the overarching charter and PISAs
- Approval of information sharing procedures and protocols associated to the charter
- Production of shared guidance and literature
- Data Privacy Impact Assessments
- Principles of good practice for information sharing
- Management of appropriate registers and logs, e.g. data breaches
- Structure and Terms of Reference for nominated lead persons
- Information sharing complaints

A two-tier structure is proposed and explained below:



5.3 By approving the charter, Tier 1 members grant delegated authority to their nominated leads to act on their behalf for management of this charter and all associated operational documents.

5.4 Tier 2 is the operational level, where the day to day information sharing decision making and IG support to organisations will operate on behalf of Tier 1 by delegated authority. The governance structure will also provide an overarching assurance role on behalf of all partners to the charter.

6 The Lawful basis and Legal Requirements

6.1 Principle legislation and guidance governing the protection and use of personal information is:

a. General data protection Regulation 2016
b. Data Protection Act 1998, as superseded by Data Protection Act 2018
c. Human Rights Act 1998 (article 8)
d. The Common Law Duty of Confidentiality
e. Caldicott Principles

All partners commit to respect the rights of individuals in line with legislation and the principles of this charter.

7 Personal Information Sharing Agreements (PISAs)

7.1 PISAs will be required by any partners that have a need to share specific personal data between their services in order to improve the customer journey and continuity of care. They are intended to define the procedural requirements to share agreed information in accordance with the principles of this charter.

7.2 PISAs need to be agreed between participating partners and their nominated lead person. These need to be shared with the Pan Wiltshire IG Group who will provide an assurance role on behalf of all partners to the charter.

7.3 Existing PISAs prior to partner agreement of this charter will remain valid until their review date where they must be updated in line with this charter and approved through the agreed governance procedure. However, for good practice and to maintain a consistent approach existing PISAs should ideally be reviewed and updated in line with this charter at the earliest opportunity.

7.4 The governance procedures associated to this charter will define agreed processes for the management and monitoring of all PISAs on behalf of partners. However, it will be the responsibility of nominated lead persons to undertake the review and updating of their respective PISAs.

8 Review of the Charter

8.1 It is intended that the overarching charter contains high level principles and partner commitments only. It will be reviewed every 5 years by the governance group.

Partners and signatories to the charter will be expected to sign up for the remaining term of the charter at the point of signing.

Subject to there being no significant changes, the charter may be extended by a further 5 years without seeking further approval or new signatures. However, any significant changes will require the full approval process and re-launch.

The planned review dates are: [5years] and [10years]

8.2 In addition and as part of their assurance role, the governance group will undertake annual 'light touch' reviews to ensure the charter is up to date and accounts for any changes in government legislation and requirements. These reviews will not require further partner approval unless the principles of the charter and partner commitments are significantly affected.

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Wiltshire Council

Where everybody matters

Better Mental Health: Implementing the Prevention Concordat

Health and Wellbeing Board

29th March 2018

Tracy Daszkiewicz.

Director Public Health and Public Protection,
Wiltshire Council

Prevention Concordat

- The concordat is a shared commitment by a wide range of national organisations
- Launched by Public Health England (PHE) as an ambition of the Five Year Forward View (5YFV) for Mental Health, to support the objective that all local areas have a prevention plan in place by 2017/18
- It includes:
  - promoting good mental health and wellbeing
  - preventing mental health problems and suicide
  - improving the lives of people experiencing and recovering from mental health problems

PHE propose:
5 Key steps to create a local prevention plan for better mental health

1. Needs and assets assessment
2. Partnership and alignment
3. Translating need into deliverable commitments
4. Defining success outcomes
5. Leadership and accountability

5 Key steps – Wiltshire Snapshot

- We already have a lot of knowledge about needs and assets:
  - have completed both adult and Children and Young People's Needs Assessments for mental health in last 2 years
- We have a Joint Mental Health and Wellbeing Strategy for adults and an Emotional Wellbeing and Mental Health Strategy for children and young people
- We have established a multi-agency partnership board responsible for implementing action and driving progress against the strategy
- We have an elected member Mental Health Champion
- Working to see what additional benefit can be achieved with regard to prevention with our B&NES & Swindon Sustainability & Transformation Partnership (STP) MH 5YFV Delivery Plan.
  - Including launch of A Year of Mental Health across the STP

Leadership

- We will be asking the Health and Wellbeing Board to take a lead role by:
  - Signing up to an agreed concordat
  - raising the profile of this work
  - inviting partners and other groups to account for progress
  - supporting coordination across the system

- The Health and Wellbeing Board might identify, in its priorities, one or two specific preventative initiatives to promote good mental health and wellbeing in Wiltshire.

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Wiltshire CCG – Mental Health Crisis Care Concordat Update

NHS Wiltshire Clinical Commissioning Group

- Combined Wiltshire and Swindon Crisis Care Concordat meetings held Bi-monthly.
- Wiltshire and Swindon Places of Safety – transition to GLH commenced through Feb & March 2018. Unitary PoS on the Greenlane Hospital site now in operation.
- S12 doctors: Business case supported by Wiltshire and Swindon CCGs. Extended s12 rota commenced 19/03/2018. Recruitment of additional Consultant Psychiatrist to operate from the Bluebell PoS Unit, Devizes. Enhanced s12 provision will ensure timely access, and will contribute to compliance with the PoCA 24 hr standard.
- BSW Place of Calm Café Bid submitted Jan 2018: Proposal requesting £450,000 Capital funding to develop a community based alternative place of safety, and purchase of vehicles to facilitate access across the footprint. Bid completed in partnership with Alabare.
- WCCG working with AWP to prioritise investments in 18/19 across services to address increase growth and acuity of MH service users.

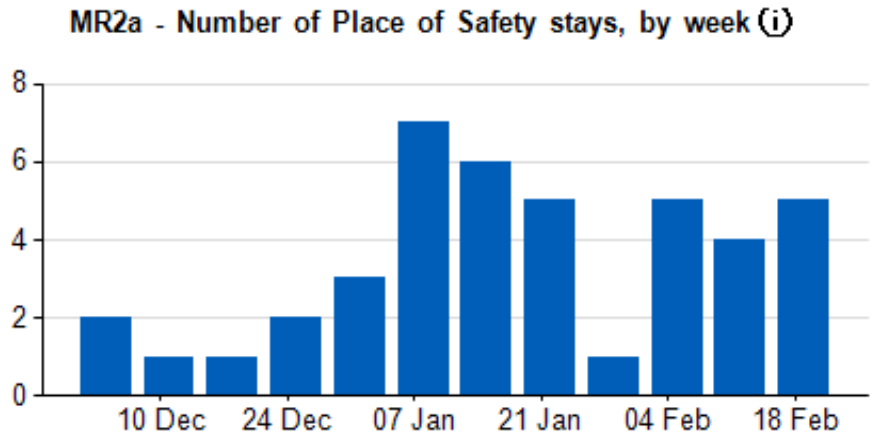
'The right healthcare for you, with you, near you.'

WORKING FOR CARERS

Wiltshire CCG – Mental Health Crisis Care Concordat Update:

Wiltshire 136 Activity 01/12/17-28/2/18

NHS Wiltshire Clinical Commissioning Group



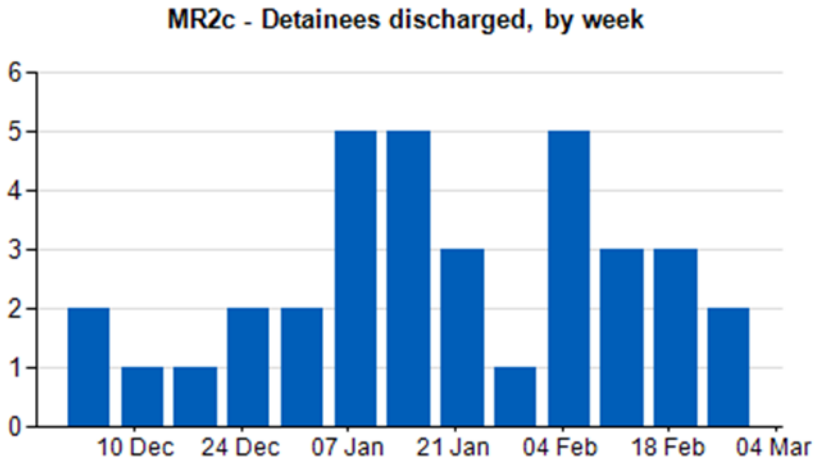
	MR3 - Length of Stay by Place of Safety			
Place of Safety	0-12 hours	12-24 hours	24-48 hours	Total
Mason Unit	0	2	0	2
Green Lane	8	7	1	16
Fountain Way	8	9	0	17
Sandalwood Court	1	3	1	5
External	0	2	0	2
Total	17	23	2	42

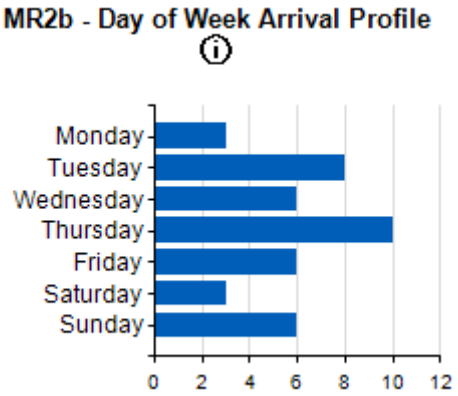
Since the change in legislation to regulate the length of time someone can be detained in a place of safety from 72 hrs to 24 hrs, there have only been two breaches, one was actually with an agreed extension to 36 hours to complete an assessment following drug and alcohol intoxication.

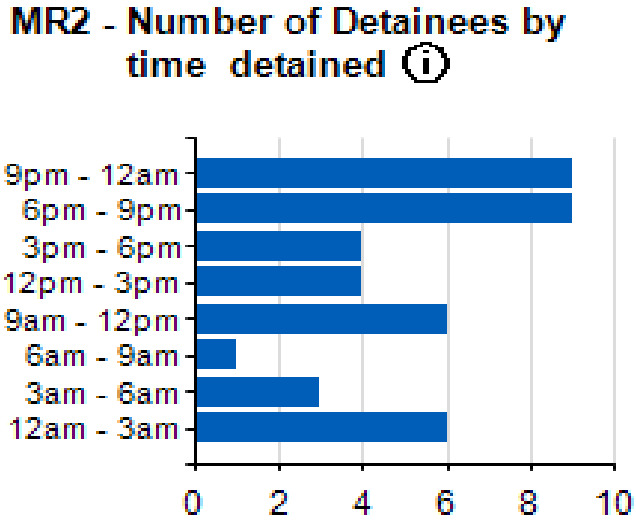
'The right healthcare for you, with you, near you.'

WORKING FOR CARERS

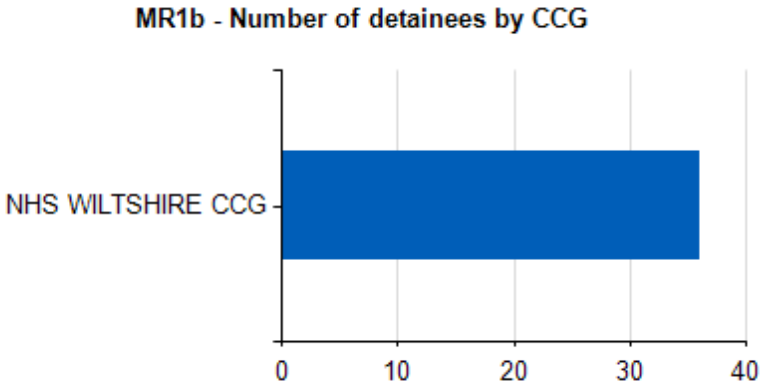
Wiltshire Detainees

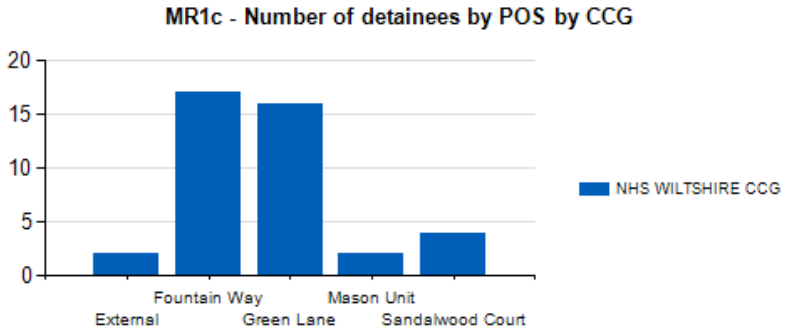


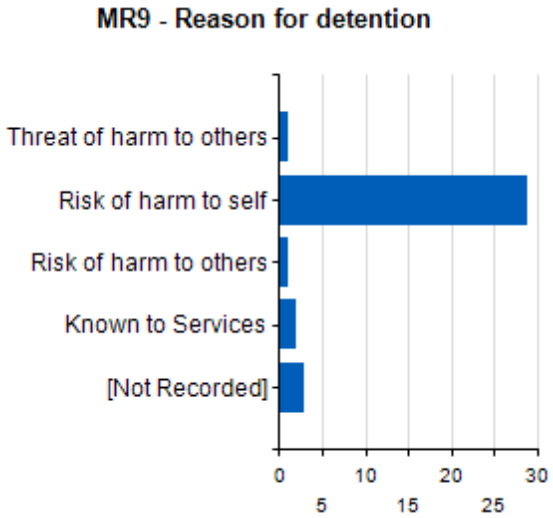


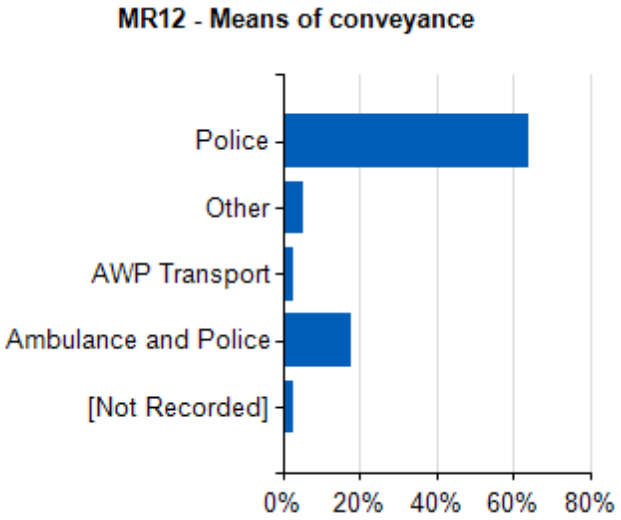


Detainees

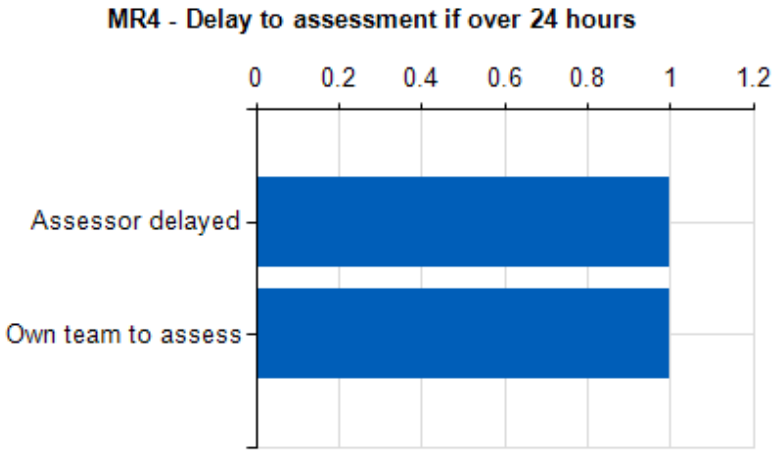

MR1b - Number of detainees by CCG
NHS WILTSHIRE CCG
0
10
20
30
40

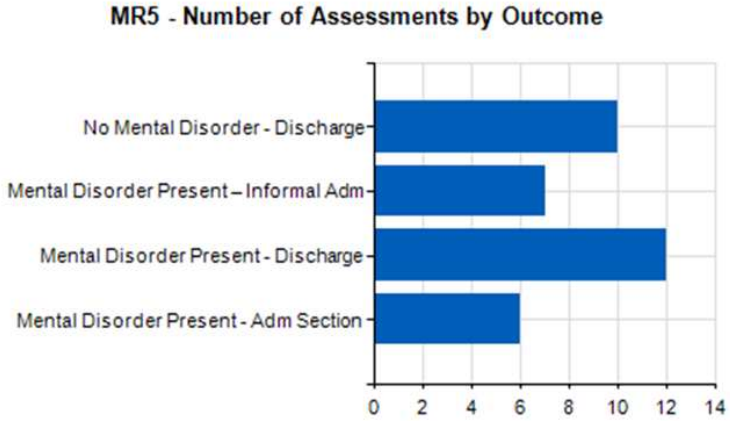

MR1c - Number of detainees by POS by CCG
20
15
10
5
0
External
Fountain Way
Green Lane
Mason Unit
Sandalwood Court
NHS WILTSHIRE CCG

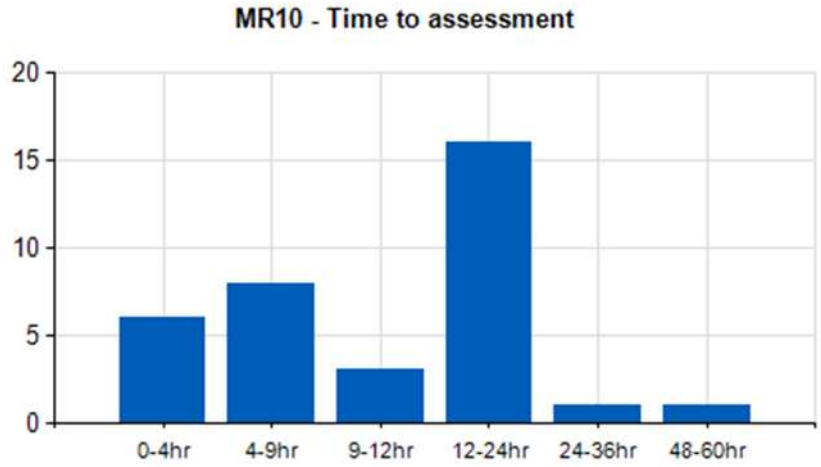

MR9 - Reason for detention
Threat of harm to others
Risk of harm to self
Risk of harm to others
Known to Services
[Not Recorded]
0
5
10
15
20
25
30

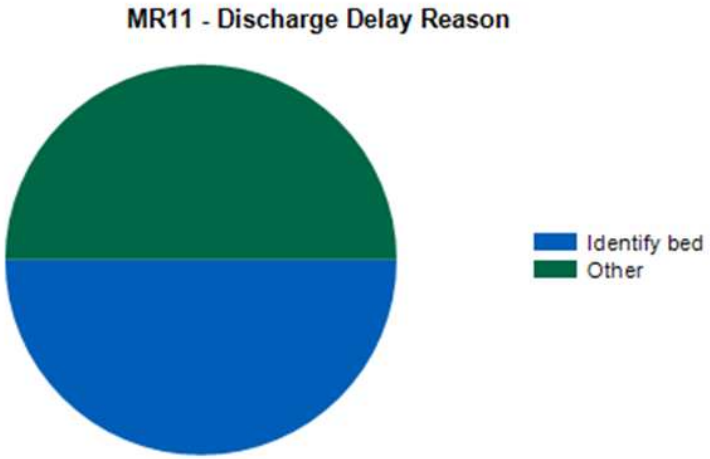

MR12 - Means of conveyance
Police
Other
AWP Transport
Ambulance and Police
[Not Recorded]
0%
20%
40%
60%
80%

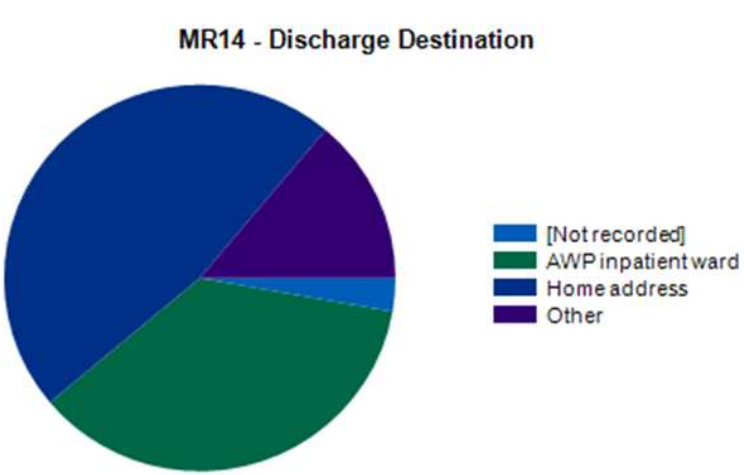
MR3 - Length of Stay by Place of Safety				
Place of Safety	**0-12 hours**	**12-24 hours**	**24-48 hours**	**Total**
Mason Unit	0	2	0	**2**
Green Lane	8	7	1	**16**
Fountain Way	8	9	0	**17**
Sandalwood Court	1	3	1	**5**
External	0	2	0	**2**
Total	**17**	**23**	**2**	***42***

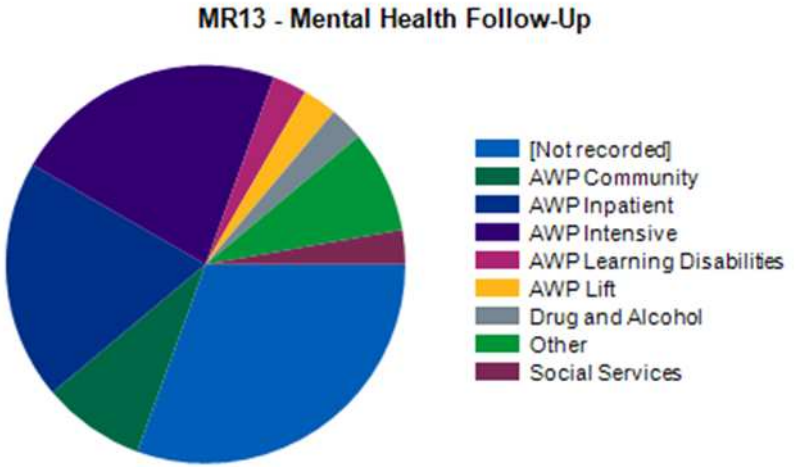


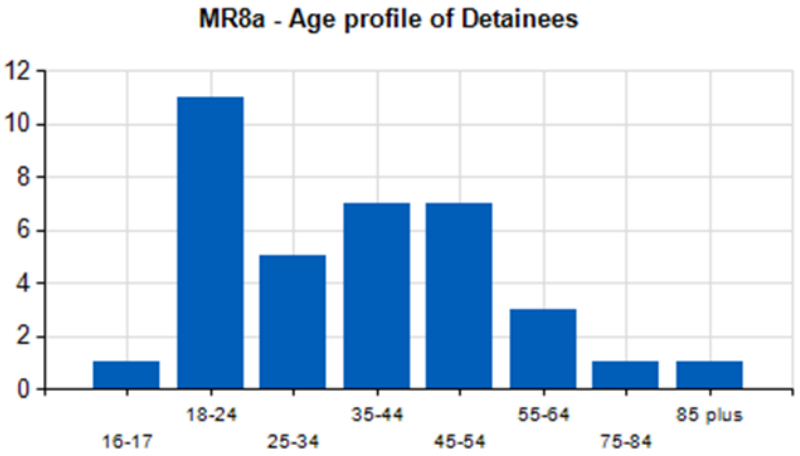


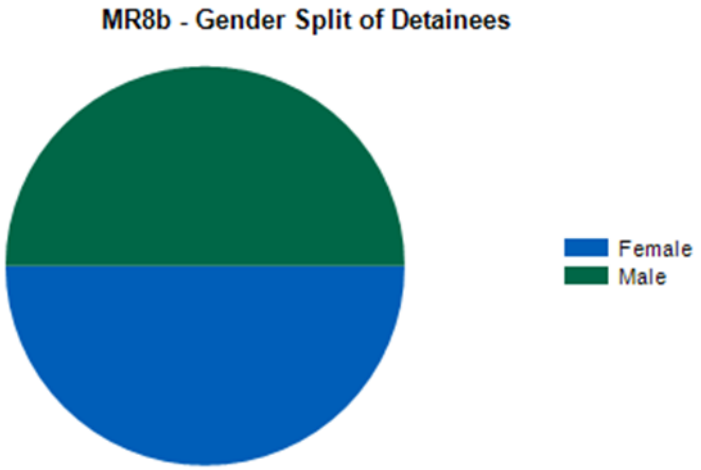


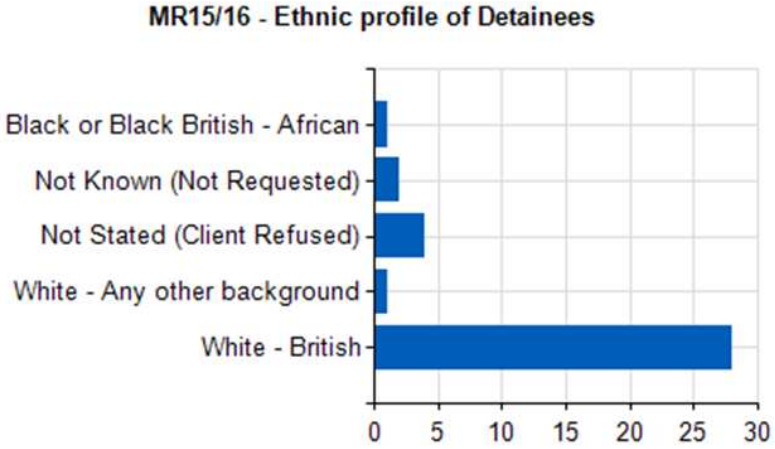

MR11 - Discharge Delay Reason
Identify bed
Other


MR14 - Discharge Destination
[Not recorded]
AWP inpatient ward
Home address
Other


MR13 - Mental Health Follow-Up
[Not recorded]
AWP Community
AWP Inpatient
AWP Intensive
AWP Learning Disabilities
AWP Lift
Drug and Alcohol
Other
Social Services


MR8a - Age profile of Detainees
12
10
8
6
4
2
0
16-17
18-24
25-34
35-44
45-54
55-64
75-84
85 plus


MR8b - Gender Split of Detainees
Female
Male


MR15/16 - Ethnic profile of Detainees
Black or Black British - African
Not Known (Not Requested)
Not Stated (Client Refused)
White - Any other background
White - British
0
5
10
15
20
25
30

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