Bath and North East Somerset, Swindon and Wiltshire Together

BSW ICP Meeting in Public - Agenda

10 July 2024, 13:00-16:00, Kennet Meeting Room, County Hall, Bythesea Road, Trowbridge BA14 8JN

Timing	No	Item title	Lead	Action	Paper ref.
13:00	1	Networking with colleagues			
Opening Business					
14:00	2	Welcome and Apologies	Chair ICP	Note	Verbal
	3	Declarations of Interests	Chair ICP	Note	Verbal
	4	Minutes from last meeting 12 March 2024	Chair ICP	Approval	ICP/24-25/001
	5	Public Questions	Chair ICP	Note	Verbal
Business Items					
14:15	6	**BSW Together strategy Fairer Health and Wellbeing Outcomes** Introduction and overview of the session and governance of inequality programme delivery	Steve Maddern	Discuss/ Note	Verbal/ Presentations
14:20		Progress update on the BSW inequality strategy objectives: • Making inequality everybody's business • Training and education with the BSW Academy • Children and Young People • Data update (cover in earlier item) • System and place action • Core 20+5 clinical area benchmarking and progress	Abbey Mulla		
14:40		Locality based Inequality Projects Overview – summary of projects underway and showcase of key projects	Emma Kain / Sam Perry / Sarah Heathcote		
15:40		Discussion How do we celebrate success? • Further embedding in key ICB workstreams and future resourcing	Chair		
Closing Business					
15:55	7	Chairs summary and direction	Chair ICP	-	Verbal

Bath and North East Somerset, Swindon and Wiltshire Together

DRAFT Minutes of the BSW Integrated Care Partnership Meeting

Tuesday, 12th March 2024, 1400hrs, Trowbridge County Hall and MS Teams

Attending:

Richard Clewer	ICP Chair
Stephanie Elsy	ICP Deputy Chair
Sue Harriman	BSW ICB Chief Executive
Richard Collinge	BSW ICB Chief of Staff
Stephen Ladyman	Wiltshire Health and Care Chair
Alison Ryan	RUH Board Chair
Charlotte Hitchings	AWP Chair
Pam Webb	CEO Voluntary Action Sindon
Alan Mitchell	Chair Healthwatch Wiltshire
Julian Kirby	BSW ICB NED for Public and Community Engagement
Gordon Muvuti	BSW ICB Director of Place Swindon
Rebecca Reynolds	Director of Public Health BaNES
Kate Blackburn	Director of Public Health Wiltshire
Ian Green	Chair Salisbury Foundation Trust
Sam Wheeler	BSW ICB Assistant Director of Business Intelligence – System Architecture and Transformation
Abbey Mulla	BSW ICB Head of Inequalities & Prevention Programme
Lucy Heath	BSW ICB Swindon Health and Care Professional Director
Nicole Williamson	BSW ICB Assistant Board Secretary (Minutes)

Apologies:

Samantha Mowbray	CEO Swindon Borough Council
Will Godfrey	CEO BaNES Council
Gill May	Chief Nurse ICB
Amanda Webb	BSW ICB Chief Medical Officer
Terence Herbert	CEO Wiltshire Council
Amber Skyring	CEO Wessex Community Action
Fiona Slevin-Brown	BSW ICB Director of Place Wiltshire
Steve Maddern	Director of Public Health Swindon
Rachael Backler	BSW ICB Chief Delivery Officer
Liam Coleman	GWH Board Chair
Laura Ambler	BSW ICB Director of Place BaNES
Kevin Guy	Leader BaNES Council Cabinet

1. Welcome and Apologies

1.1 The Chair welcomed members and officers to the meeting and noted apologies. Introductions to the group were made and the meeting was declared quorate.

2. Declarations of Interest

2.1 No declarations of interest were declared that related to agenda items

3. Minutes from 24 October 2023

3.1 The minutes from the meeting held on the 24th October 2023 were approved as an accurate record of the meeting.

4. Public Questions

4.1 No public questions were raised prior to the meeting or during the meeting.

5. BSW Together Strategy Prevention and Early Intervention led by BaNES (Bath and North East Somerset)

5.1 Rebecca Reynolds, Director of Public Health BaNES, opened the meeting with an introduction the session. The session would focus on Objective one of the BSW Together Strategy Prevention and Early Intervention and how we would move forward as part of the strategy to work collaboratively. As part of the session several slide decks would be presented to the meeting.

5a. Wider context of the three places and contributions from system partners to improving health

5a.1 Abbey Mulla, BSW ICB Head of Inequalities & Prevention Programme, presented to the meeting the Wider context of the three places and contributions from system partners to improving health.

5a.2 The following was highlighted to the meeting:

- The varying demographic, population and life expectancy statistics for Bath, Swindon and Wiltshire
- BSW has a combined population of approximately 941,000 people
- BSW population is likely to exceed one million, with one in five people - or more than 200,000 - aged over 65 years

5a.3 There are areas of concern within BSW which include:

- 180,000 people have some form of mental health condition
- 156,000 people have three or more long-term conditions
- Nearly 6% of the population has diabetes
- 85,000 people aged 65+ receive ten or more regular prescriptions for medicines
- 100,000 adults are smokers

5a.4 The Integrated Care Alliances in BaNES, Swindon and Wiltshire have responsibility for oversight and assurance of the delivery of the relevant parts of the Integrated Care Strategy and the Local Health and Wellbeing Strategy

5a.5 The meeting discussion noted there are several nuisances with covering the Bath, Swindon and Wiltshire area noting that each area poses their own challenges. There is ongoing work to develop collaboration with the local health and wellbeing boards who will feed into the ICP and the wider strategy. It is noted that the ICAs (Integrated Care Alliances) will hold a critical role to utilise knowledge in providing mitigations to the challenges presented for each area. The current ICP (Integrated Care Partnership) strategy and implantation plan considers the view of BSW including the population and key stakeholders understanding that due to the uniqueness of each locality there will be separate delivery.

5a.6 The discussion further noted, all priorities of the plan are evidenced based and are an overall view of common narratives through the BSW plan noting that each locality will have a specific strategy, priority and need for their population.

5a.7 There is an overall importance to ensure we are conforming to the strategy and reviewing data as it becomes available to measure performance and to understand the direction of travel required, there would be a benefit to utilising the population health data to provide this.

5b. ‘Prevention’: what do we mean by the term in the context of improving health

5b.1 Rebecca Reynolds, Director of Public Health BaNES, presented ‘Prevention’: what do we mean by the term in the context of improving health to the meeting.

5b.2 The aim is to look at prevention through a variety of lens’s including:

- Hospital Admission
- Social Care
- Improving Population Health

The utilise this, there is a need to look at the 4 areas of prevention, Primary prevention, Secondary prevention, Tertiary prevention, and Wider determinants of

health. The is assurance to involve all including individuals and their families, Community healthcare providers, the use of Community Pharmacy, Third sector and Local Authorities.

5b.3 The discussion noted there would need to be a focus on education as part of prevention to assist the population in taking action for their own health outcomes and to keep well. As BSW has different communities and population a focus on education is a key priority, currently Wiltshire has two apprentices working towards being health advocates for their area due to the local knowledge they hold.

5b.4 It is noted that prevention will often assist with costs in earlier age but not those heading towards or in the end of their life. The latest CMO (Chief Medical Officer) report details healthy aging and is clear on what actions can be taken to save money and assist the population with aging well and the best quality of life. There is ongoing reviews of budgets and finances within the system on prevention understand that no cost savings will be immediate. There is a noted national dilemma to fund prevention spending but there is available guidance to the BSW system.

5c. Delivery against BSW Integrated Care Strategy Outcome One (Prevention and Early Intervention) 23-24

5c.1 Lucy Heath, BSW ICB Swindon Health and Care Professional Director, presented to the meeting Delivery against BSW Integrated Care Strategy Outcome One (Prevention and Early Intervention) 23-24.

5c.2 Each Local Authority area has developed a whole systems approach to obesity and work is progressing. At an ICS level this is being joined up with a focus on weight management pathways for adults and children. Mental wellbeing is embedded in the ICSs Mental Health Programme with a focus on improving community MH services, a new model of CYP MH in Swindon, improving talking therapies provision and preparing a new Local Enhanced Service for GPs providing annual physical health checks for people with SMI.

5c.3 The next key steps outlined to measure the impact of what is being done to help with future prevention and early intervention understanding that there would be no immediate impact on non-criteria to reside or ambulance delays. The work has reflected the need to continue to invest in prevention and early intervention to see those changes in time. There are several factors to why the changes are not addressing the pressure, these include:

- A national post pandemic aftermath
- Long standing issues which were identified pre covid
- Public demands on the services

- Additional reviews in prevention for attending the acute settings.

The factors highlighted display the need for the system to work together across the BSW (Bath, Swindon, and Wiltshire) area.

5d. Moving forward: the Prevention Strategy group - a refreshed approach to providing strategic direction to prevention and early intervention

5d.1 Rebecca Reynolds, Director of Public Health BaNES, presented Moving forward: the Prevention Strategy group - a refreshed approach to providing strategic direction to prevention and early intervention.

5d.3 The BSW Prevention Strategy Group will have a main/initial focus on the health and care system including on responsibilities which sit at a system level and on system prevention activity which can best add value to work done at Place within BSW. The group will use population health analysis and evidence in relevant workstreams and aims to eventually combine with the BSW Inequalities Strategy Group of the BSW PHB (Population Health Board). The BSW Prevention Strategy Group will work with BSW Primary and Community Services Delivery Group and BSW Children and Young People's Programme Board.

5d.4 There are 6 proposed workstreams for the BSW Prevention Strategy Group which includes:

- Lead on one agreed priority system prevention programme
- Funding shift towards prevention
- Organisational culture and workforce for health improvement
- Influence the plans of identified BSW Delivery Groups to strengthen focus on prevention
- Oversee delivery of identified BSW-wide prevention programmes
- Have oversight of delivery of Prevention and Early Intervention commitments in the BWS Together Integrated Care Strategy

5d.5 The meeting discussion noted, there are several different forums within BSW including the ICA's, Population Health Board and Health and Wellbeing board which would be able to assist with developing the viewpoints of the ICP.

5d.6 There is money ringfenced within the system budgets for prevention and early intervention, the Population Health Board has oversight and decision-making capabilities for this funding.

5e. Early proposed key deliverables for 24-26 against BSW Integrated Care Strategy Outcome One (Prevention and Early Intervention)

5e.1 Lucy Heath, BSW ICB Swindon Health and Care Professional Director, presented to the meeting Early proposed key deliverables for 24-26 against BSW Integrated Care Strategy Outcome One (Prevention and Early Intervention)

5e.2 There will be a focus to look at the funding and resources on prevention rather than treatment, this includes:

- The Population Health Board continue to focus on defining and understand what we spend on prevention as a system.
- Complete procurement of Integrated Community Based Care and ensure continued focus on prevention as part of this contract.
- Effectively using the increased investment in preventative measures.
- ICS Investment Committee will implement a revised prioritisation framework with and increased weighting on preventing future illness or complications of current conditions and addressing health inequality or health equity.

5e.3 There will be a focus on different wellbeing groups which include physical wellbeing, mental wellbeing, and smoking. With specific targets for each area. In addition a look at Identifying ill health early (secondary prevention), Slowing or stopping disease progression (tertiary prevention) and the wider determinant of health.

5f. The role of Population Health Management underpinning this work

5f.1 Sam Wheeler BSW ICB Assistant Director of Business Intelligence – System Architecture and Transformation and Kate Blackburn Director of Public Health Wiltshire presented the role of Population Health Management underpinning this work.

5f.2 There will be a focused approach to using PHM (Population Health Management) data to drive the change.

5f.3 The meeting discussion noted, the presentation highlighted several statistics which would be beneficial in ongoing work for prevention and early intervention. Any measurable results would take time to reflect in the system, the workforce review could see outcomes and measurables within 6-12months and Health Outcomes is over a longer projected time frame. The reports could measure a variety of data including acute admissions to better understand the high level of admissions to each acute and subsections to why.

5f.4 There is some noted difficulties with measuring base line finances and spend but has been achieved by other ICS's (Integrated Care Systems) and so the methodology would be reviewed and adopted where possible.

5g. The role of the ICP to help support and drive this work going forward

5g.1 The next steps of objective one is to set up the financial workstreams associated to the prevention and early intervention. The ICP would need to look to sign up to one focus, hypertension, and continue to have support from the ICB Board.

5g.2 The meeting noted the work that had been undertaken as part of Objective One and the importance to review early stages of health outcomes to better prevent attendance to acutes and emergency departments.

6. Chairs summary and direction

6.1 Richard Collinge, BSW Chief of Staff reminded the meeting of the upcoming objectives for the ICP meetings:

- ICP Reviewing Strategy Objective 2 led by DPH Swindon – 10 Jul 24
- ICP Reviewing Strategy Objective 3 led by ICB CDO – 26 Nov 24

6.2 There being no further business the chair closed the meeting at 16:06hrs

Next ICP Meeting to be held on:
10th July 2024
County Hall, Trowbridge and MS Teams

Bath and North East Somerset,
Swindon and Wiltshire Together

Report to:	BSW Integrated Care Partnership	Agenda item:	6
Date of Meeting:	10 July 2024		

Title of Report:	Approach to tackling health inequalities in Swindon
Report Author:	Dr Emma Kain, Consultant in Public Health
Board / Director Sponsor:	Steve Maddern, Director of Public Health
Appendices:	

Report classification	Please indicate to which body/collection of organisations this report is relevant. *Only one of the below should be selected* (x)
ICB body corporate	
ICS NHS organisations only	
Wider system	X

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Group/Forum/Board that systems and processes are in place, or to advise a gap along with a remedy	X
Noting	For noting without the need for discussion	

BSW Integrated Care Strategy Objective(s) this supports:	Select (x)
1. Focus on prevention and early intervention	
2. Fairer health and wellbeing outcomes	X
3. Excellent health and care services	

Previous consideration by:	Date	Please clarify the purpose

1	Purpose of this paper
The aim of this paper is to update the BSW Integrated Care Partnership on 10 July 2024, to share Swindon's approach to tackling health inequalities, including an update on the spending of the Health Inequalities grant funding.	

2	Summary of recommendations and any additional actions required
The BSW Integrated Care Partnership is asked to note the contents of the paper and share any feedback.	

3	Legal/regulatory implications
This work is in line with our Legal duty to reduce inequalities as part of the Public Sector Equality Duty.	

4	Risks

5	Quality and resources impact
Please outline any impact on Quality, Patient Experience and Safeguarding: The initiatives in this report aim to improve patient and public experience and access to healthcare services. Finance: This report provides an update on grant funding that has been allocated.	
Finance sign-off	

6	Confirmation of completion of Equalities and Quality Impact Assessment

7	Communications and Engagement Considerations

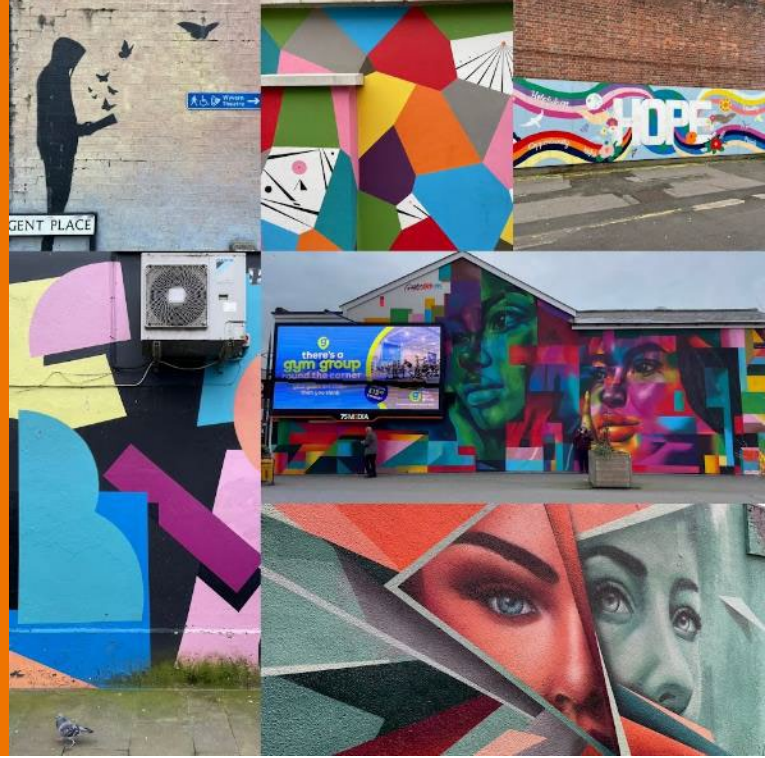
8	Statement on confidentiality of report
This report is for review by members of the board only.	

Approach to tackling health inequalities in Swindon

Presentation to BSW ICP July 2024

Dr Emma Kain

Consultant in Public Health



Swindon Borough Council

Putting inequality front and centre

Vision

Working together to tackle inequalities and empower all people in Swindon to live longer, healthier, fulfilling lives, supported by thriving and connected communities

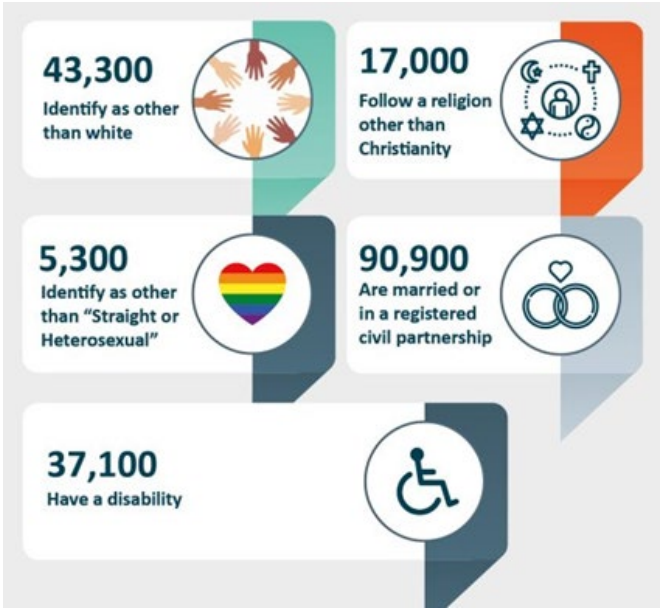
Swindon's health inequalities profile

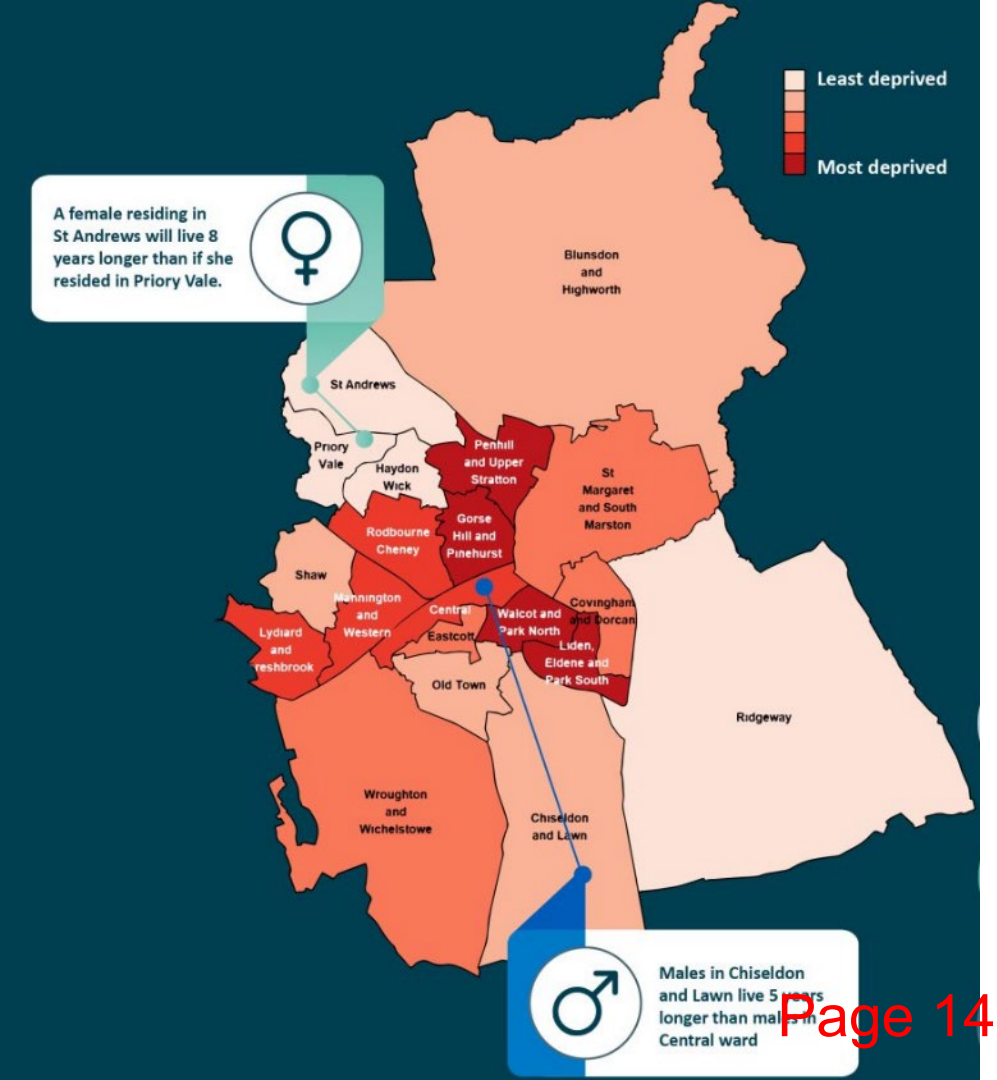
Nearly 223,000 people live in Swindon, projected to increase by about 5% between 2020 and 2030. The 2021 Census shows the number of people aged 50-64 has increased by 26% since 2011 with nearly 1 in 5 people in this age group.

Swindon overall is ranked as the 98th most deprived area out of 151 Upper Tier Local Authorities (UTLAs) in England but some smaller areas are in the 10% most deprived in the country.

One in three children aged 10-11 and one in four children aged 4-5 in Swindon are overweight or obese.

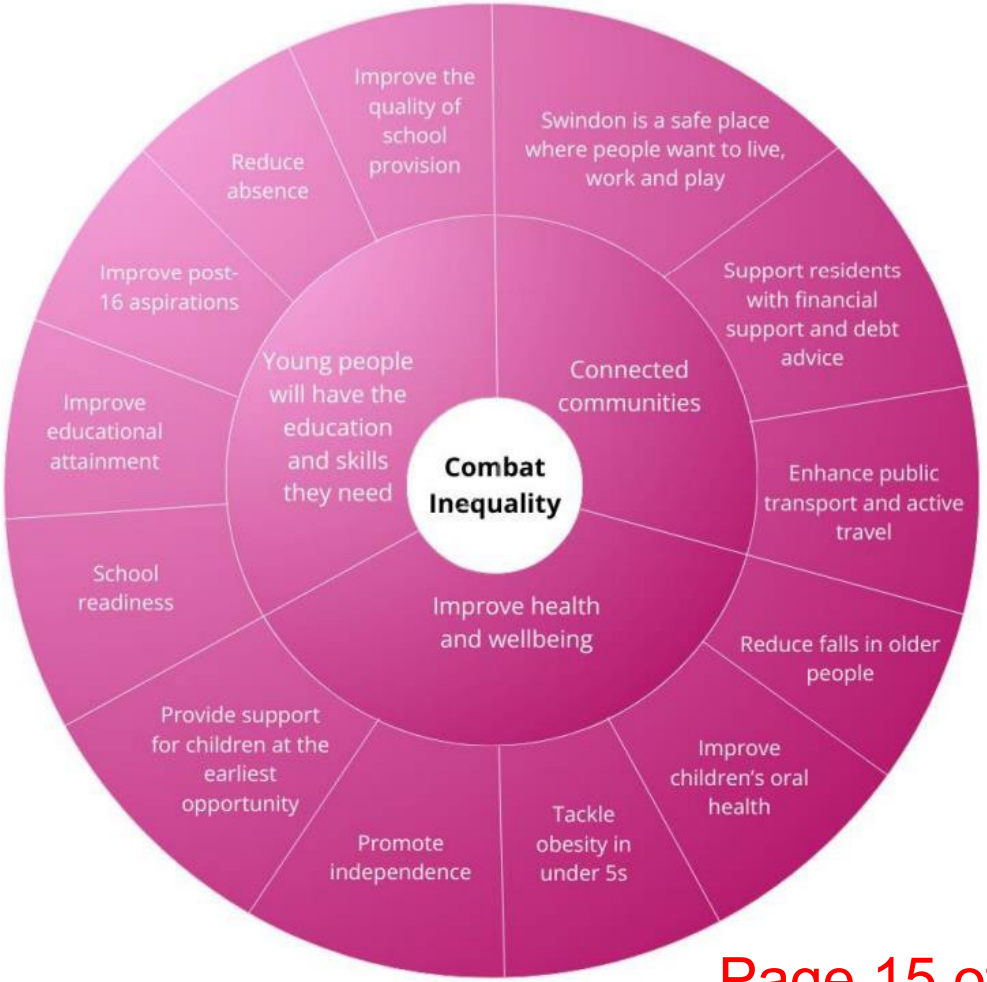
Around 86% of Swindon's population is estimated to be from a white ethnic background, with over 16,000 people from an Asian or Asian British background. Swindon has always celebrated its diversity and has partially strong Goan, Nepalese and Polish communities.





Deprivation

Ward	Number of LSOAs in most deprived 20% in Swindon
Walcot and Park North	5
Gorse Hill and Pinehurst	5
Linden, Eldene and Park South	4
Penhill and Upper Stratton	4



"Ensuring we make Swindon a fairer place, reducing disadvantage, make poorer areas richer and eliminate big disparities in life expectancy, education levels and social justice."

Our approach

Cost of living grants	Warm and Safe Wiltshire	Food advertising restrictions	Hot food takeaway policy
HEA weight management services	COVID/flu vaccination outreach	Targeted cancer awareness sessions	Stop Smoking advisor in substance misuse
Targeted oral health promotion	Play parks in deprived wards	Playing Out road closures	Community connections network

Health inequalities funding investment

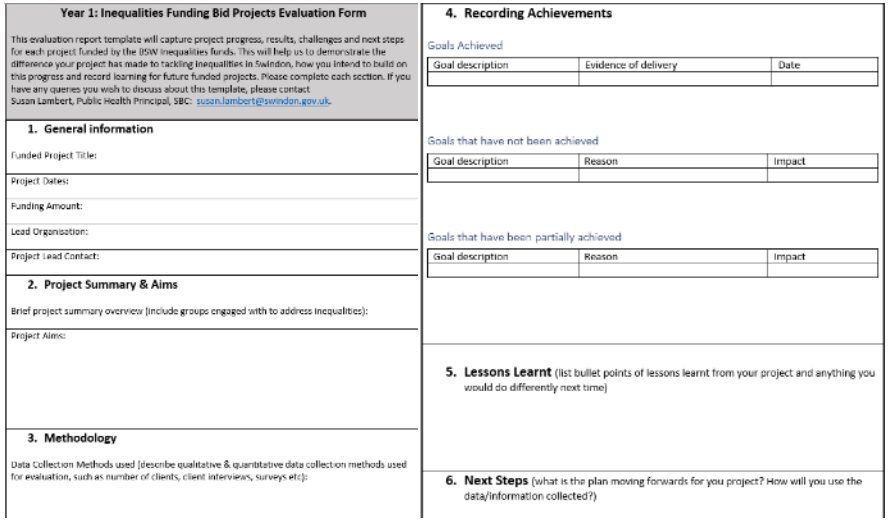
Approach

Funding used for small grants to support a range of projects, including grassroots community projects

Criteria

1. Population Health Management (PHM) to support understanding inequalities
2. Elective Recovery from the impacts of the Covid Pandemic
3. Core20PLUS5 interventions with a focus on prevention
4. Community engagement
5. Wider determinants

Evaluation



Year 1: Inequalities Funding Bid Projects Evaluation Form

This evaluation report template will capture project progress, results, challenges and next steps for each project funded by the BSW Inequalities funds. This will help us to demonstrate the difference your project has made to tackling inequalities in Swindon, how you intend to build on this progress and record learning for future funded projects. Please complete each section. If you have any queries you wish to discuss about this template, please contact
Susan Lambert, Public Health Principal, SBC: susan.lambert@swindon.gov.uk.

1. General information

Funded Project Title:

Project Dates:

Funding Amount:

Lead Organisation:

Project Lead Contact:

2. Project Summary & Aims

Brief project summary overview (include groups engaged with to address inequalities):

Project Aims:

3. Methodology

Data Collection Methods used (describe qualitative & quantitative data collection methods used for evaluation, such as number of clients, client interviews, surveys etc):

4. Recording Achievements

Goals Achieved

Goal description	Evidence of delivery	Date

Goals that have not been achieved

Goal description	Reason	Impact

Goals that have been partially achieved

Goal description	Reason	Impact

5. Lessons Learnt (list bullet points of lessons learnt from your project and anything you would do differently next time)

6. Next Steps (what is the plan moving forwards for you project? How will you use the data/information collected?)

Year one projects

Project Title	Duration
Primary Care Networks education and support for new parents (x4)	1 year from Nov 2023
Citizens Advice Swindon cost of living support	18 months from Oct 2023
Gateway Furniture Project - alleviating furniture poverty	3 years from Apr 2023
Changing Suits mental health awareness	2 years from Nov 2023
Integrated Neighbourhood Teams Swindon communities together	1 year
Central Swindon North Parish Council - multiagency project addressing food security	1 year from Jun 2023
Primary Care Networks tablets for translation (x7)	1 year - completed
GWH Hospital Population health management IT system	1 year - completed

Year two projects

Project Title	Duration
Kennet Furniture Refurbish supplying furniture	2 years
Ridge Green Medical Centre New Bilingual Parent Sessions	1 year
SBC Public Health/GWH Community Dentistry CYP Oral Health promotion	1 year
Brunel Health Group Heart Failure project	2 years
Brunel Health Group Atrial Fibrillation MDT clinics	1 year
Wyvern PCN Early Cancer Diagnosis BAME/LDA/LGBTQ+	1 year
The Platform Therapeutic Mentoring	2 years
Harbour Project refugee and asylum seeker health	1 year
Livewell Team Black and ethnic minority communities' health	14 months

Project in focus: Changing Suits

Working with the South Asian community to raise awareness of mental health, tackle stigma, and break down barriers to engaging with support services

Project in focus: Changing Suits

- Sahara Health Fairs
- Wellbeing Workshops
- Taboo!Talk
- Service Provider Awareness
- Changing Suits Podcast

Next steps

- Evaluation of inequalities grant funded projects
- Swindon Health Inequalities Summit
- Systematic approach to health inequalities across our work
- Focus on our Core20 areas
- Focus on wider and commercial determinants of health
- Support Build a Fairer Swindon Policy Development Committee

Thank you

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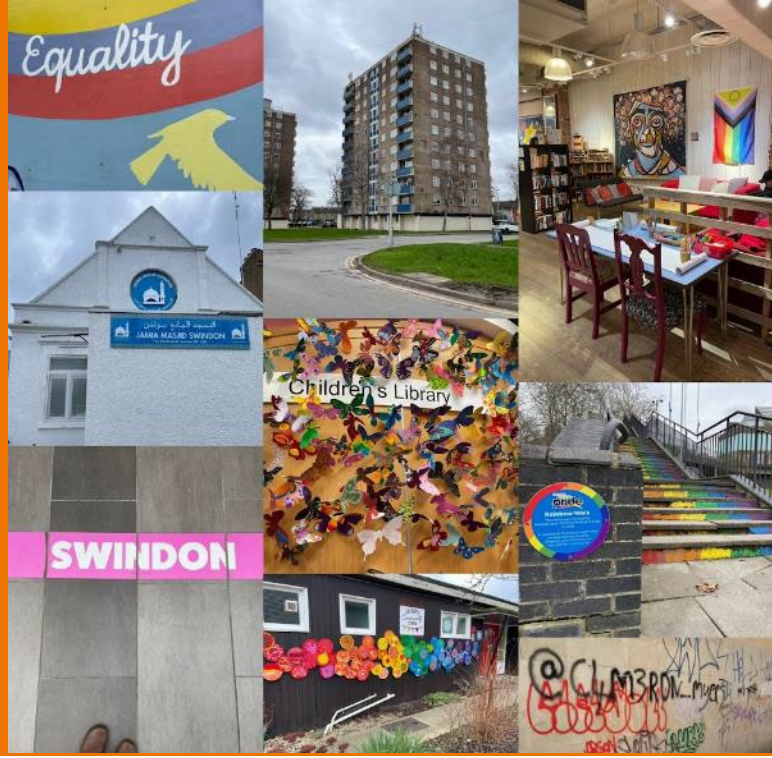

Swindon Borough Council

Appendices

1. Year 1 projects further information
2. Year 2 projects further information

Year one projects

Project Title	Duration	Details
Primary Care Networks education and suppo new parents (x4)	1 year from Nov 2023	The funding will be used for 4 part-time Patient Educators delivering obesity & smoking cessation education and support for each of the 4 PCNs involved
Citizens Advice Swindon	18 months from Oct 2023	Increasing capacity to provide extra cost of living support and integrating with Live Well
Gateway Furniture Project (GFP) now KFR	3 years from Apr 2023	Local support organisations to alleviate furniture poverty (includin beds) for the most vulnerable households in Swindon
Changing Suits	2 years from Nov 2023	Project to increase mental health awareness in South Asian communities
Integrated Neighbourhood Teams	1 year	Supporting the delivery of Swindon Communities Together
Central Swindon North Parish Council multiagency project addressing food security	1 year from Jun 2023	Partnership project addressing food poverty provision in the Centr Swindon North Parish area, supported by the Feeding Swindon Partnership Project officer (SBC) between Central Swindon North the Salvation Army, Nightshelter, Renew CIC, Stepping Stones (C Baptist Church), Penhill Community Café and FoodCycle
Primary Care Networks to implement IT soluti to support vulnerable groups (x7)	1 year - completed	Tablets for language translation
GWH Hospital	1 year - completed	Population Health Management IT investment

Year two projects

Project Title	Duration	Details
Kennet Furniture Refurbiz	2 years	Swindon Crisis Provision Fund. Recycled essential furniture and white goods to families and individuals in Swindon in most deprived area a experiencing extreme poverty and resulting health inequalities. Holistic referral routes
Ridge Green Medical Centre - New Bilingual Parent Sessions	1 year	
SBC Public Health/GWH Community Dentistry CYP Oral Health project	1 year	PH Specialist in Oral Health in post & work plan developed concentra on Core 20+5 specifically CYP
Brunel Health Group Heart Failure proje	2 years	Reducing heart failure mortality and improving titration of heart failure medication, addressing inequalities by targeting patients in the 20% deprived postcodes and patients from ethnic minority communities
Brunel Health Group - Atrial Fibrillation backlog	1 year	Addressing backlog of patients with Atrial Fibrillation through clinics v MDT prioritising the Core20 (20% most deprived) Plus (individuals fr ethnic minority backgrounds) 5 (Reducing risk of MI/Stroke) demogra Given that a substantial 20% of strokes are linked to Atrial Fibrillation
Wyvern PCN Early Cancer Diagnosis BAME/LDA/LGBTQ+	1 year	Focus on early cancer diagnosis by increasing uptake, education and awareness of Bowel, Prostate, Cervical and Breast screening in area BAME, other languages (not including English), Learning Disability p visually impaired and LGBTQ+ communities.
The Platform - Therapeutic Mentoring	2 years	Therapeutic mentoring of disadvantaged CYP experiencing range of issues - range of partnerships including schools.
Harbour Project	1 year	Health related advice and triage
Livewell Team - Black and ethnic minority communities Health	14 months	Health Expo targeting Black and ethnic minority communities. Dedicated Community Navigator working with targeted PCNs to increase access t health services, improve management of long term conditions.

Bath and North East Somerset, Swindon and Wiltshire Together

Report to:	BSW Integrated Care Partnership	Agenda item:	6
Date of Meeting:	10th July 2024		

Title of Report:	Wiltshire Health Inequality Activity
Report Author:	Gemma Brinn, Public Health Consultant and Sam Perry, Public Health Specialist - Inequalities
Board / Director Sponsor:	Kate Blackburn, Director of Public Health, Wiltshire
Appendices:	PPT – Wiltshire Health Inequalities

Report classification	
ICB body corporate	
ICS NHS organisations only	
Wider system	[X] Wiltshire Council, Salisbury Foundation Trust and BSW Integrated Care Board

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Group/Forum/Board that systems and processes are in place, or to advise a gap along with a remedy	
Noting	For noting without the need for discussion	x

BSW Integrated Care Strategy Objective(s) this supports:	Select (x)
1. Focus on prevention and early intervention	x
2. Fairer health and wellbeing outcomes	x
3. Excellent health and care services	

Previous consideration by:	Date	Please clarify the purpose
NA	NA	NA

1	Purpose of this paper

The aim of this paper is to update the BSW Integrated Care Partnership Board on Health Inequalities activity in Wiltshire in 22/23 and 23/24.

The financial information in this paper and slide set has previously been presented to the BSW Population Health Board for the purposes of financial approval for the allocation of the Health Inequalities Funding 23/24.

2	Summary of recommendations and any additional actions required

The BSW Integrated Care Partnership is asked to note this report detailing locality health inequality work in Wiltshire.

Investments of Health Inequality Funding will continue to be monitored through the BSW Population Health Board through a collated report by the BSW Inequalities Strategy Group. Locality oversight is coordinated by the Wiltshire Health Inequalities Group.

3	Legal/regulatory implications

Investment in inequalities contributes towards compliance with the requirements of the Public Sector Equality Duty, section 149 of the Equality Act 2010. Compliance with a number of sections of the 2006 Act (amended by the 2022 Act) where duties are placed on the ICB to secure health services in an integrated way, and to improve the quality of those health services and reduce inequalities between persons with respect to their ability to access those services and with respect to the outcomes achieved.

4	Risks

This programme of work will help reduce the risk that we do not effectively combat health inequalities within our population and therefore do not achieve one of the main aims of an integrated care system.

Health inequalities funding is coordinated by the Integrated Care Board, who own contracts and project monitoring oversight for investment and delivery, including risk management. As with all fixed term budgets, there is potential uncertainty for the future financial allocations for locality health inequalities work.

No specific risks on project delivery are noted at the time of presenting this report.

5	Quality and resources impact

Quality, Patient Experience and Safeguarding: The outcomes of this programme are aimed at improving the life.
expectancy and more importantly healthy life expectancy of the BSW population.
Finance: Wiltshire Health Inequalities Funding allocation 22/23: £600k, 23/24: £816,127.42
Workforce: Investment includes a number of fixed term roles across a range of organisations.
Sustainability/Green agenda: It is expected that this work will have a positive impact on BSW's sustainability plans.

Finance sign-off	NA

6	Confirmation of completion of Equalities and Quality Impact Assessment
All investments are contracted in line with standard NHS grant agreements incorporating EQIA considerations.	

7	Communications and Engagement Considerations
ICB communications team are aware of the investments included in this report and projects are aware of on the communication requirements of the ICB in relation to Health Inequalities Fund investment.	

8	Statement on confidentiality of report
NA	

Wiltshire Health Inequalities Update

1. Introduction

1.1. The purpose of this paper is to inform the Board of activity in Wiltshire under the workstream of Reducing Health Inequalities, utilising Health Inequalities Funding (HIF) during 2022/23 and 2023/24.

1.2. This paper explains the work of the Wiltshire Health Inequalities Group, the process and outcome of HIF allocation and provides a spotlight on one project to demonstrate impact the investment has had on tackling inequalities.

2. Background and wider context

2.1. BSW ICB has a legislative requirement to:
(a) Reduce inequalities between person with respect to their ability to access health services and
(b) Reduce inequalities between patients in respect to the outcomes achieved

2.2. To support the prioritisation of tackling Health Inequalities, NHS England (NHSE) included an additional £200m in the national allocations for 22/23. In 23/24, this funding is not ringfenced, but still formed part of system allocations. As stated by the Integrated Care Board meeting 18th May 2023, the BSW ICB intends to make a five-year commitment to ringfence funds to support health inequalities of £2m per annum. The board delegated prioritisation and first line oversight of the funding to the BSW Population Health Board.

2.3. The Wiltshire Health Inequalities group (WHIG) was established in November 2022, co-chaired by Public Health Consultant, Wiltshire Council and Associate Medical Director, Salisbury Foundation Trust. The group oversees local inequalities activity, including the allocation of Health Inequality Funding (HIF) investment.

2.4. HIF investments were approved by the WHIG on a rolling basis in 2022/23, before being ratified by the Wiltshire Integrated Care Alliance. Investments in 22/23 were:

- Health Inequalities Staffing (approved September 2022).
- Winter warmth packs (approved December 2022)
- Five to Thrive training for communities (approved February 2023)
- GRTB outreach with Julian House (approved October 2022)

2.5. HIF investments in 2023/24 were managed through an open bidding process, coordinated by a Steering Group reporting to the WHIG, with membership from Public Health, Salisbury Foundation Trust and BSW ICB. Investments were approved by the WHIG on 17th October 2023 and consequently by the BSW Population Health Board on 25th October 2023. 14 projects received funding from the Wiltshire HIF 23/24 allocation:

- Neighbourhood Collaboratives
- Wiltshire Council business focussed health coaches
- Acorn Community Bank financial support for people suffering ill health
- Wiltshire MIND targeted counselling services for routine and manual workers
- KidzLoveFit Under 5's health club in Bemerton Heath, Salisbury
- Wiltshire Community Foundation small grants programme
- Carers support crisis avoidance project
- HCRG learning disability support in dental care
- Public Health research on military health and wellbeing
- Wiltshire Community First mindfulness collaborative
- Wiltshire Council FUEL – school holiday activity club expansion
- Julian House outreach with GRTB communities
- Centre for Sustainable Energy fuel poverty and prevention project
- HCRG CYP Neurodevelopment Assessment

3. Wiltshire Health Inequalities Team (HIT)

3.1. Since January 2023 utilising HIF, Wiltshire Public Health have hosted a team of 4 (one Public Health Specialist and three Public Health Practitioners) as the locality Health Inequalities Team (HIT). The team have had three priority areas of work:

- Collaborate with PCNs to drive forward change and champion reducing health inequalities;
- Reduce health inequalities through supporting interventions and incentives;
- Be proactive in raising awareness and profile of health inequalities work across Wiltshire

3.2. The team have formed trusted relationships with PCNs awareness raising of population health approaches, wider determinants, and locally informed health inequalities (HI) as per the Tackling Neighbourhood Inequality DES contractual obligations through an array of platforms (e.g. PCN mangers meetings, GP practice meetings). The team act as a directory of engagement, signposting and providing connections between system and place, Acute and VCSE

colleagues to promote collaboration and shared practice enhancing outcomes for the community. An example of this is drawing on Wiltshire's Community Conversations colleagues to support clinical improvements in 'hard to reach' groups.

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3.3. The team operate an outreach plan, mirroring the 3 phased approach of the BSW inequalities strategy, to provide support and guide the piece across the locality whist ensuring a system level understanding through regular contact with BSW/ICB colleagues.

3.4. The HIT have developed and continue to evolve a PCN dashboard which reflects the 'Health Inequalities situation' across the locality; sharing information on points of contact, engagement work and projects, training received, challenges faced, promoting interconnectivity and progress monitoring. The team review available data sources supporting PCNs in their understanding of the interconnectivity of the wider determinants of health and how these serve to impact our communities – sharing scope and understanding with stakeholders and partners and using this to support with interventions: 3 PCNs have undertaken pilot interventions aimed at addressing health inequalities within their patient populations;

- Hypertension in the most deprived areas within Sarum Cathedral PCN;
- A dementia day with Calne & Yatton Keynell PCN focussing on unpaid carers and those with a diagnosis living in areas of deprivation;
- A project addressing hypertension within Chippenham, Corsham and Box in collaboration with Neighbourhood Collaboratives.

3.5. The team continue to play a significant role in the BSW HIF local processes, supporting with the HIF steering group, proforma making, creating a SharePoint collaboration site, shortlisting, and outcomes administration. The team have an administrative role in overseeing the feedback back to the ICB on financial and outcomes management basis for all HIF investment.

4. Discussion; Spotlight on GRTB focussed project

4.1. To illustrate impact of investment, the HIF awarded to Julian House in both 22/23 and 23/24 has been selected for noting.

4.2. Gypsy Roma Travellers and Boaters experience some of the starkest health inequalities of any population group. They form one of the Core20PLUS5 inclusion groups due to these inequalities and are included in the Plus groups for Wiltshire as a priority within the Wiltshire Health and Wellbeing JSNA.

National and local data evidence that people in GRTB communities experience significantly worse outcomes than the general population:

- Twice the levels of smoking
- Life expectancy are 10-12 years shorter
- Higher levels of poor mental health
- Twice as likely to be carers
- Higher rates of miscarriage and maternal deaths
- Lower average birth weights and lower levels of breastfeeding
- Almost half living with long-term health conditions
- Lower uptake of screening and immunisations

4.3. A Wiltshire Health Needs Assessment for GRTB communities in 2018 indicated that in the 2011 census 757 people identified themselves as Gypsy or Traveller – this is likely to be a gross underestimate and there is no reliable data for those living on boats on the Kennett and Avon Canal. National data suggests 0.2% of Wiltshire's population is from GRT communities – equating to around 1020 people. This suggests a growing population of those who identify as GRT.

4.4. The Julian House Gypsy Roma Traveller Boater (GRTB) Outreach Service has been run since 2019, with an overriding purpose to reduce the stark inequalities and poorer health outcomes faced by this community. It also seeks to provide evidence of the broad needs of these communities and the type of support required. Through its work, cross-organisational connections established have included: Housing & Commercial, Communities, Public Health, Families and Children's, Adult Social Care, Planning, Education and Skills, Highways and Environment.

5. Risks

5.1. Health inequalities funding is coordinated by the Integrated Care Board, who own contracts and project monitoring oversight for investment and delivery, including risk management. As with all fixed term budgets, there is potential uncertainty for the future financial allocations for locality health inequalities work. No specific project delivery risks are noted at the time of presenting this report. A total of 308 people have been supported in 23/24, including intervention engagement preventing risk of an estimated 10 boaters from becoming homeless.

6. Stakeholder engagement including patient and public consultation

6.1. The Wiltshire Health Inequalities Group is the stakeholder group where organisations serving Wiltshire convene to be sighted on Wiltshire health

inequality projects and activity. Group membership includes Wiltshire Council, Salisbury Foundation Trust (who operate as Co-Chairs), Avon and Wiltshire Mental Health Partnership NHS Trust, BSW ICB, Primary Care, Wiltshire VCS Leadership Alliance, Healthwatch and Wiltshire Police and Crime Commissioner.

7. Impact on equalities

7.1. Investment in inequalities contributes towards compliance with the requirements of the Public Sector Equality Duty, section 149 of the Equality Act 2010. Compliance with a number of sections of the 2006 Act (amended by the 2022 Act) where duties are placed on the ICB to secure health services in an integrated way, and to improve the quality of those health services and reduce inequalities between persons with respect to their ability to access those services and with respect to the outcomes achieved.

8. Next steps

8.1. HIF projects submit quarterly reporting to the ICB, commencing Q1 2024/25. These reports will be reported to the BSW Inequalities Strategy Group to the BSW Population Health Board. Projects are also invited to attend the WHIG to showcase activity and network.

8.2. The Health Inequalities team in Wiltshire, funded on a two-year basis from HIF, will cease in January 2025, with coordination of HIF projects being led by the ICB and locality involvement continuing to operate through the Wiltshire Health Inequalities Group chairs and members.

8.3. Future HIF will be managed at the direction of the ICB, utilising experience and expertise from locality health inequality leads, with activity coordinated through the BSW Health Inequalities Strategy Group.

9. Recommendations

9.1. The board are asked to note the activity in the Wiltshire locality on health inequalities, in particular the range of projects funded through NHS England Health Inequalities allocations in 22/23 and 23/24.

Locality Health Inequalities Activity Update: Wiltshire

Sam Perry
Public Health Specialist - Inequalities

Contents

Acknowledgements

This report has been compiled by Gemma Brinn (PH consultant), Samantha Perry (PH Specialist; Inequalities) with GRTB content supplied by Vicki Lofts (PH Specialist).




Population and deprivation: Indices of multiple deprivation

There are **285** Lower Layer Super Output Areas (LSOAs) or small areas of geography, in Wiltshire

Of which **8** are in the 20% most deprived nationally.

The table below details each of these LSOAs and the 2019 IMD national decile in which it falls.

LSOA	2019 IMD national decile
Trowbridge John of Gaunt - Studley Green	1
Chippenham Queens - East	2
Salisbury Bemerton - West	2
Salisbury Bemerton - South	2
Salisbury St Martin - Central	2
Melksham North - South West	2
Melksham North - North East	2
Trowbridge Drynham - Lower Studley	2

Indices of multiple deprivation: LSOA's in Wiltshire in the 20% most deprived nationally, by their 2019 IMD national decile

These 8 LSOAs are all classified as 'Urban city and town' under the Rural-Urban classifications produced by the Department for Environment, Food and Rural Affairs (DEFRA), and are located in the following towns in Wiltshire:

- Trowbridge
- Chippenham
- Salisbury
- Melksham

The total population living in these 8 LSOAs is **13,924**

which is **3%** of Wiltshire's total population

0 -19 year olds: 27%
20 – 64 year olds: 56%
65+ year olds: 17%

Compared to the overall Wiltshire population, there is a higher proportion of younger people aged 0 – 19 living in these LSOAs, and a lower proportion of those aged 65+.

NHSCore20PLUS5 (Adults): Defining target populations

Wiltshire

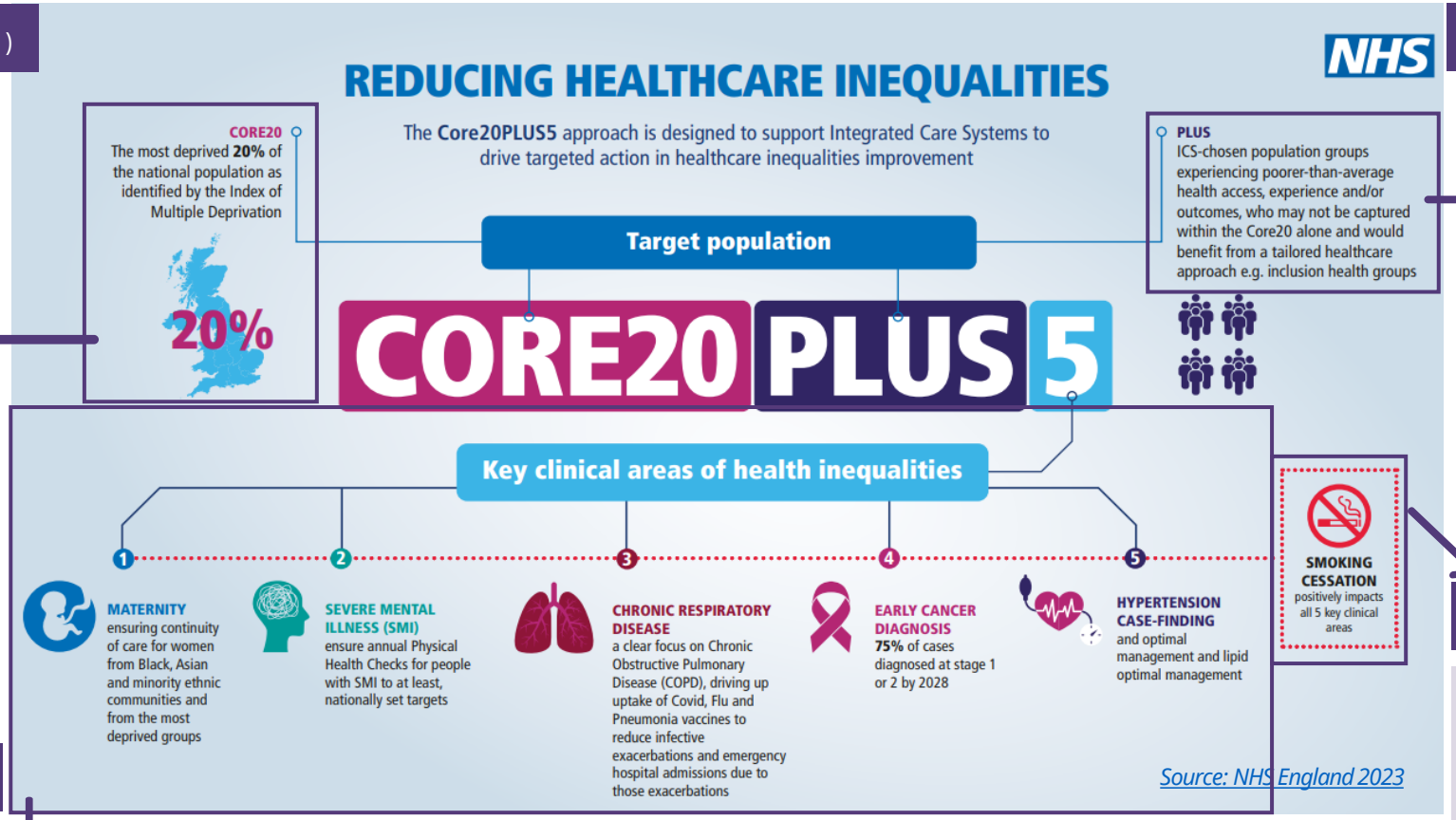
20% Most Deprived (1)

Trowbridge

Chippenham

Salisbury

Melksham



Wiltshire PLUS Groups (2)

Routine and manual workers, specifically those in minority groups

Gypsy, Roma, Traveller and Boater communities

The most **deprived 20% of the national population** - with a focus on rurality and accessibility

Smoking

Wiltshire smoking prevalence (18+) **10.2%** (4).

Government plan to create a smokefree generation Smokefree by 2030 (prevalence of **5%** or less) (5).

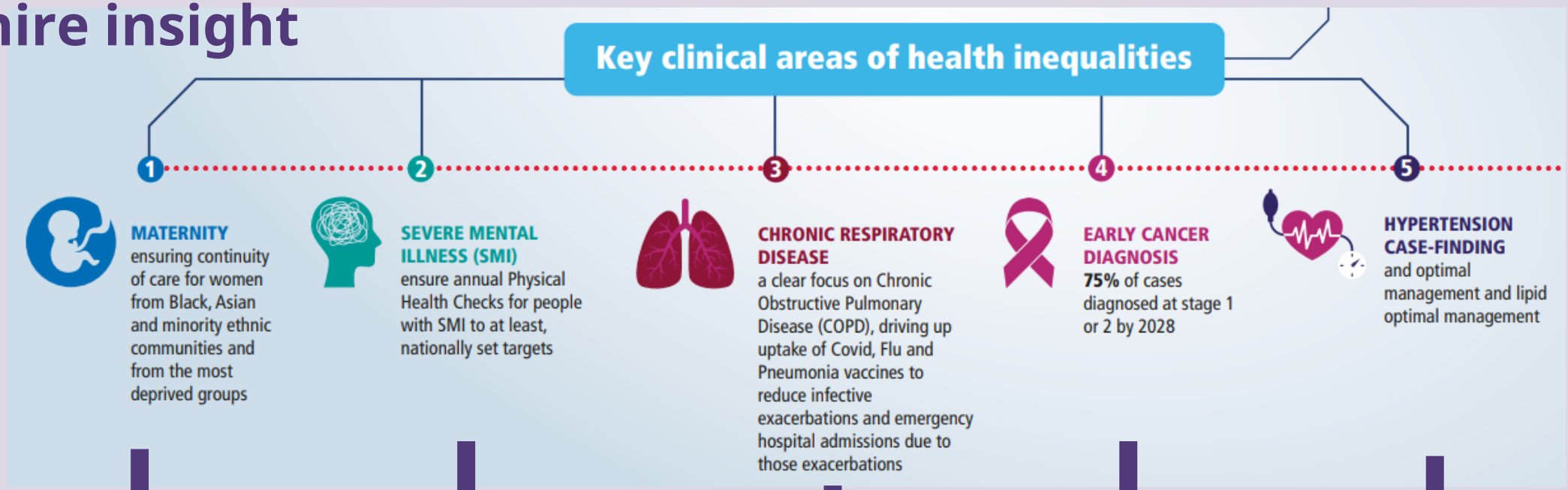
Key clinical areas (3)

There are **5 key clinical areas of focus** which require accelerated improvement

Depression, obesity & hypertension are 3 LTC's with the highest QOF prevalence in Wiltshire

Depression 11.8% | **Obesity 11.3%** | **Hypertension 16%**

Wiltshire insight



Examples of inequalities work:

Antenatal pathway for boaters

Baby steps (targeted perinatal parenting programme)

Depression QOF prevalence 11.8%

COPD QOF prevalence 1.8%

Cancer screening coverage:
Breast cancer - 70.5%
Bowel cancer – 77.4%
Cervical cancer (25-49) – 74.7%
Cervical cancer (50-64) – 77.4%

Hypertension QOF prevalence 16%

Key local documents

BSW Reducing Inequalities Strategy
The CORE20PLUS5 provides the framework.

Local PLUS groups are:

- **Adults**: Routine and manual workers (specifically those in minority groups, e.g. polish speakers) and Gypsy, Roma and Traveller communities

- **Children and Young People:** Children from Gypsy, Roma, Boater and Traveller communities

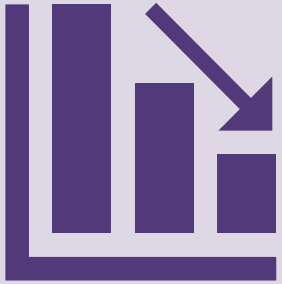
- For Children and Young People, the BSW 'PLUS' groups are:
    - **Children with Special Educational Needs and Disability (SEND)**
    - **Children with excessive weight and living with obesity**
    - **Children Looked After (CLA) and care experienced CYP**
    - **Early Years** (with a focus on school readiness)
    - **Children and Young People with Adverse Childhood Experiences (ACE**; with a focus on delivering trauma informed services)

Wiltshire Health Inequalities Group

Supporting workstream of:

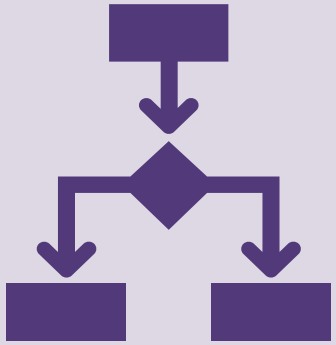
- **Wiltshire Integrated Care Alliance Partnership Committee**
- **BSW Inequalities Strategy Group.**

WHIG Meets monthly with alternating focus across Healthcare and Partnership agendas.



NHS England Health Inequality Funding commenced in 2022. Projects funded report outcomes to the Wiltshire Health Inequalities Group, up to the BSW Inequalities Strategy Group providing assurance at place and system level.

Established December 2022, the Group brings together partners across Wiltshire to collaborate on tackling the drivers of inequalities **across Phase 2 and Phase 3 of the BSW strategy**; Healthcare inequalities and Wider Determinants



Uses **local data and evidence** to inform practice and make connections to deliver against the BSW strategy on reducing inequalities.

Provides a **network** for sharing good practice.

WHIG activities

Sharing best practice and local activity

- PCN population health fellow project presentations
- Neighbourhood collaboratives
- Treating Tobacco Dependency and the launch of the Wiltshire Tobacco Control Alliance
- The role of the Wiltshire and Swindon Police and Crime Commissioner
- Whole systems approach to obesity

Monitoring of Health Inequality Funded projects

- Annual reporting of progress and outcomes
- Network for support and learning, identifying challenges and successes in implementation
- Future reporting framework under development across BSW

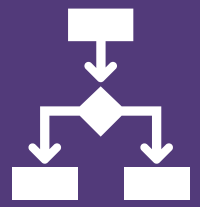
Population Health data and insights

- JSNA launch workshop
- Introduction and launch demonstrations of Population Health Management tools
- Working alongside the system delivery of Phase 1 of strategy – understanding inequality

Acute Trust Activity

- Treating Tobacco Dependency
- Sustainability at Salisbury Foundation Trust
- Supporting patients with Learning Difficulties
- Veteran patient pathways
- Partnership working

Wiltshire Health Inequalities Funding (HIF) Oversight

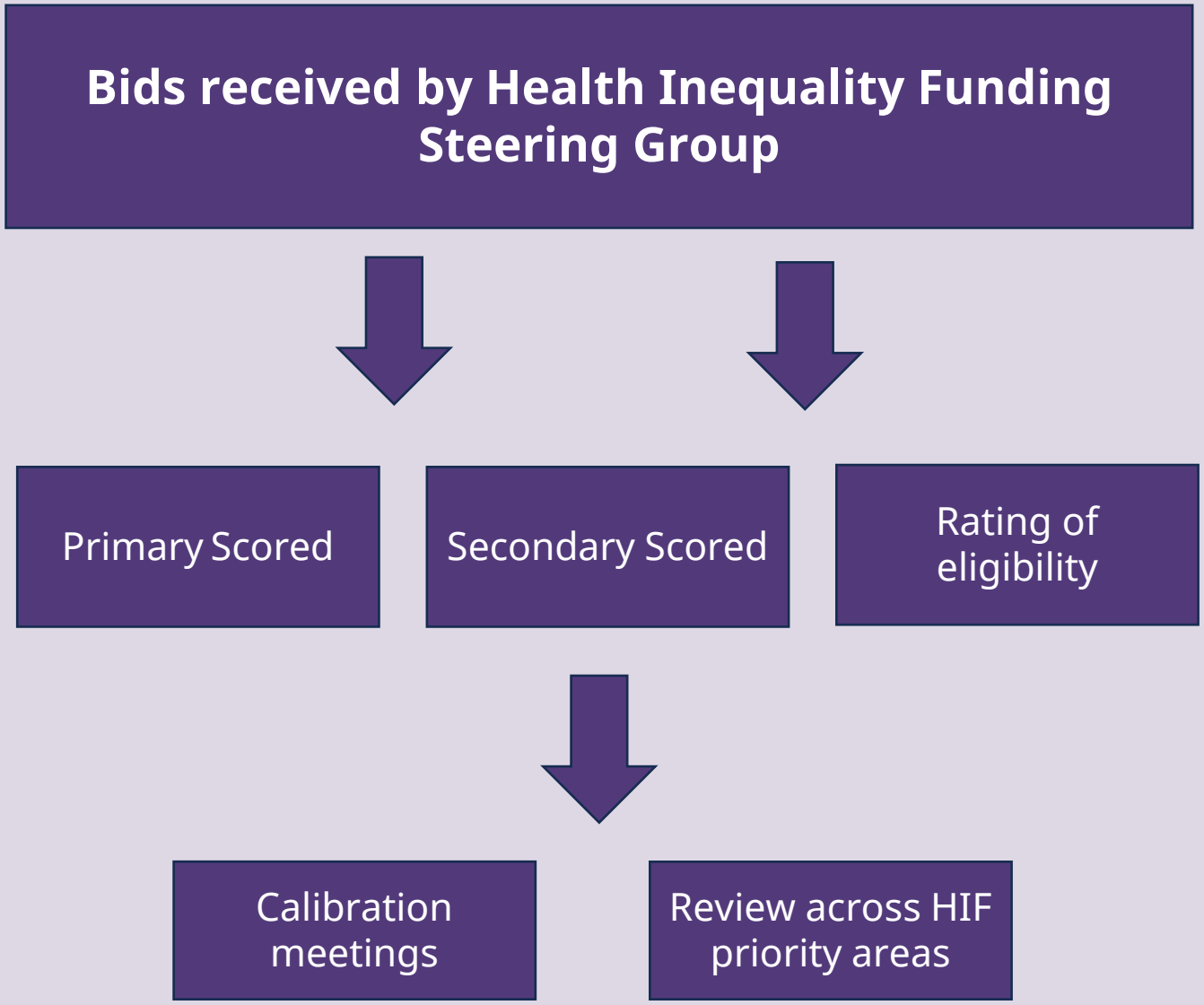





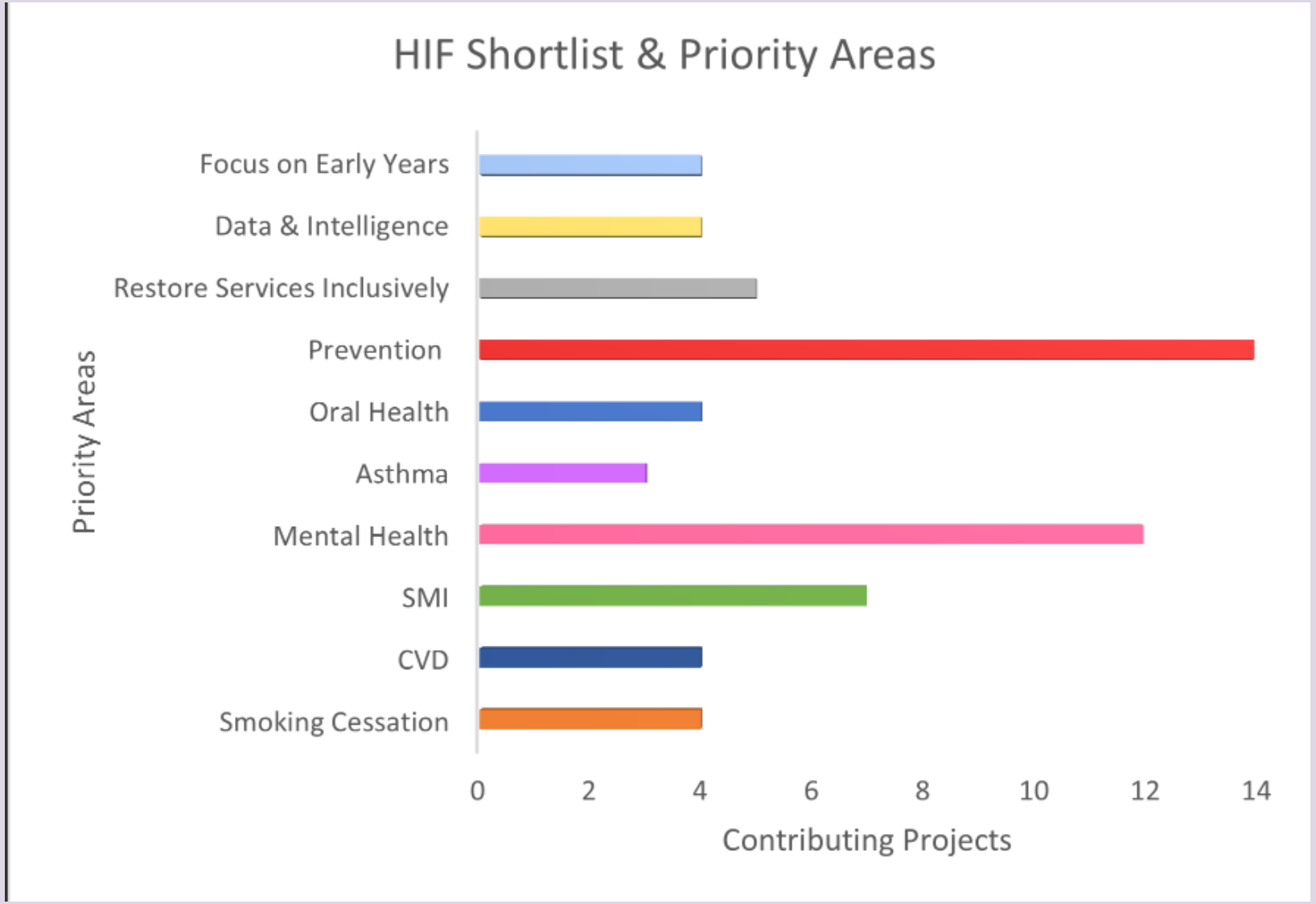
Project investment 22/23 Health Inequalities Funding		Amount
Health Inequalities Staffing	One Public Health Specialist, supported by three public health practitioners, hosted by Wiltshire Council Public Health Team to progress the inequalities agenda to support primary care with their implementation of the BSW Inequalities Strategy and Tackling Neighbourhood Inequalities Directed Enhanced Service	£400,000
GRTB outreach	Support for outreach work to include cost of living support, vaccine targeting and wider outreach work with GRT&B	£100,000
Five to Thrive – Community	Community based training support for 20 community areas in Wiltshire around children and young people's mental health using the Five to Thrive: Attachment, Trauma and Resilience model.	£30,000
Wiltshire Warm and Safe	Service enhancement to Wiltshire Warm and Safe to assist in fuel poverty. Investment in Warm Packs for distribution via outreach workers	£24,000
Unallocated – rolled forward to 23/24 allocation		£46,000

HIF scoring process 23/24

- Funding criteria, launch and scoring overseen by a steering group consisting of:
  - Public Health
  - Salisbury Foundation Trust
  - Integrated Care Board
- Max £100k investment, with scoring criteria recognising partnership working, evidence base, coproduction and outcome measurement
- Each bid primary and secondary scored for quality and rated against eligibility criteria of fund
- Conflicts of interest managed by excluding organisations from scoring/rating projects where CoI declared
- Longlisted projects discussed at two face to face calibration meetings for in-depth review
- Each calibration meeting had lay observers to provide challenge/critique of process
- WHIG consulted throughout process and sighted on key decision points



HIF funding against priority areas



Project	Lead Bidder	Summary	£
Development of neighbourhood collaborative programme.	Emma Higgins, BSW ICB	Engagement and training (30k), delivery (40k) and programme coordinator post (30k)	100,000
Financial support for people experiencing life changing experiences due to ill health	Clive Henley, Acorn Community Bank	Financial inclusion officers, providing tailored support around financial wellbeing	63,700
Business Focused Health Coach	Guy Sharp, Public Health – Wider Determinants	Health coach to lead on workplace health, specifically focussed on routine and manual workers	60,000
Sustaining work - targeted counselling service for R&M workers	Guy Sharp, Public Health – Wider Determinants	Work with Wiltshire MIND to deliver mental wellbeing support for routine and manual workers	10,000
U5 Health Club - Bemerton & St Marks	Alex Taylor, Kidz Love Fit	Delivery of 6 week course on physical activity and nutrition for families in areas of higher deprivation	19,425
Wiltshire Health inequalities small grants programme	Margaret Firth, Wiltshire Community Foundation	Small grants programme for smaller VCSE activity aligned with health inequalities priorities	100,000
Crisis avoidance project	Anna Sibbald, Carers support Wiltshire	Workshop and toolkit development for carers, low level crisis avoidance and focus on carer health and wellbeing	37,890
LD nursing support in dental care	Sam Davies, HCRG Care Group	additional nursing capacity and develop resources to support and educate parent/carers and CYP with a learning disability and/or autism.	34,000
Research report for military personnel	Mike Rose, Public Health – Wider Determinants and Intelligence	research report to investigate the health and support requirements of serving military personnel and their families in Wiltshire.	10,000
Mindfulness Collaborative	Lynn Gibson, Wiltshire Community First	Navigator, resources (online and material) mental health and wellbeing	71,600
FUEL programme	Jacqui Radford, Wiltshire Council	Expansion of holiday activity clubs for children in receipt of free school meals	100,000
Julian House Outreach	Vicki Lofts, Public Health	increase capacity within Outreach team for GRTB communities to address needs of those living roadside in vans, on sites, and in bricks and mortar housing.	80,000
Fuel Poverty and prevention	Jonathan Twomey, Centre for sustainable energy	Caseworker, working with primary care, focus on keeping warm and well and disease prevention	94,400
CYP Neuro development assessment	Alison Burge, HCRG Care Group	Enhanced personalised needs led advice and support for CYP requiring neuro development assessment and their families	78,600

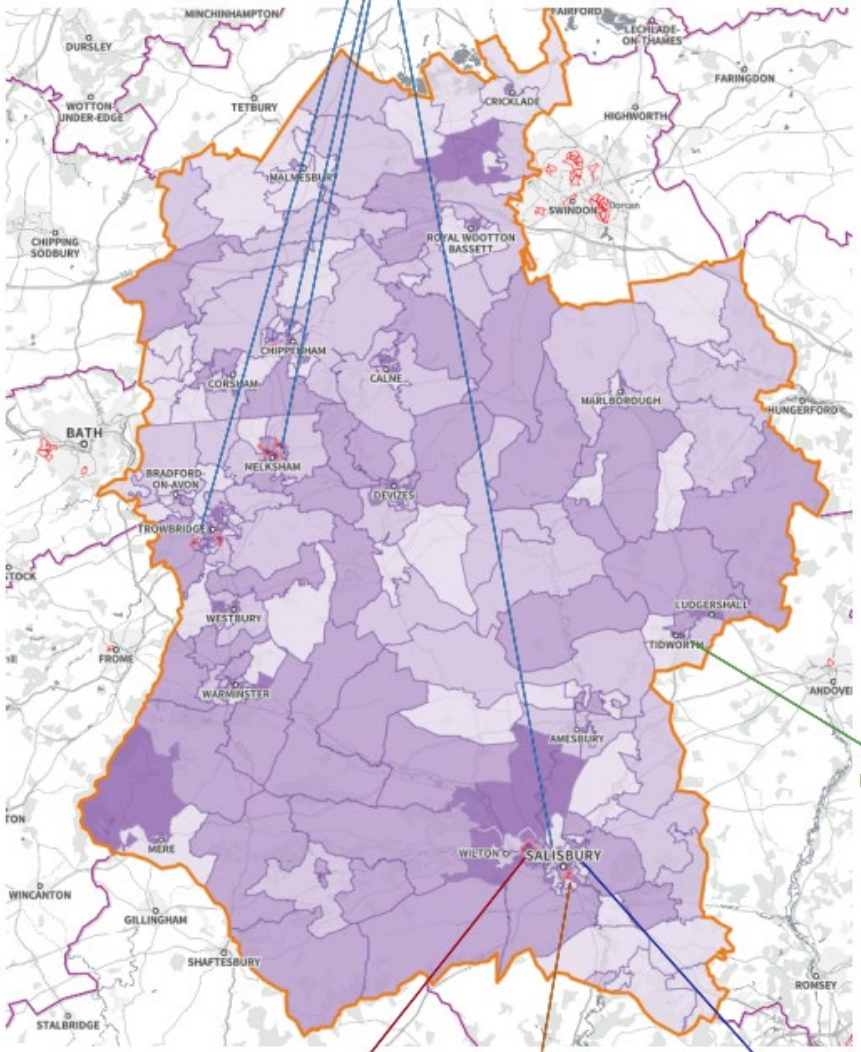
Map of 23/24 investment

Pan-Wiltshire bids with a focus on the Core20 areas in Trowbridge, Chippenham, Salisbury & Melksham:

00_20MF: Wiltshire Health inequalities small grants programme
00_24JR: FUEL programme
00_26EH: Development of neighbourhood collaborative programme
00_36JV: Fuel poverty and prevention

Pan-Wiltshire bids:

00_28GS: Business Focused Health Coach
00_29GS: Sustaining work - targetted counselling service for R&M workers
00_16AS: Crisis avoidance project
00_37SD: LD nursing support in dental care
00_32AB: CYP Neuro development assessment
0_3VL: Julian House Outreach



Bid 00_23MR: Research report for military personnel

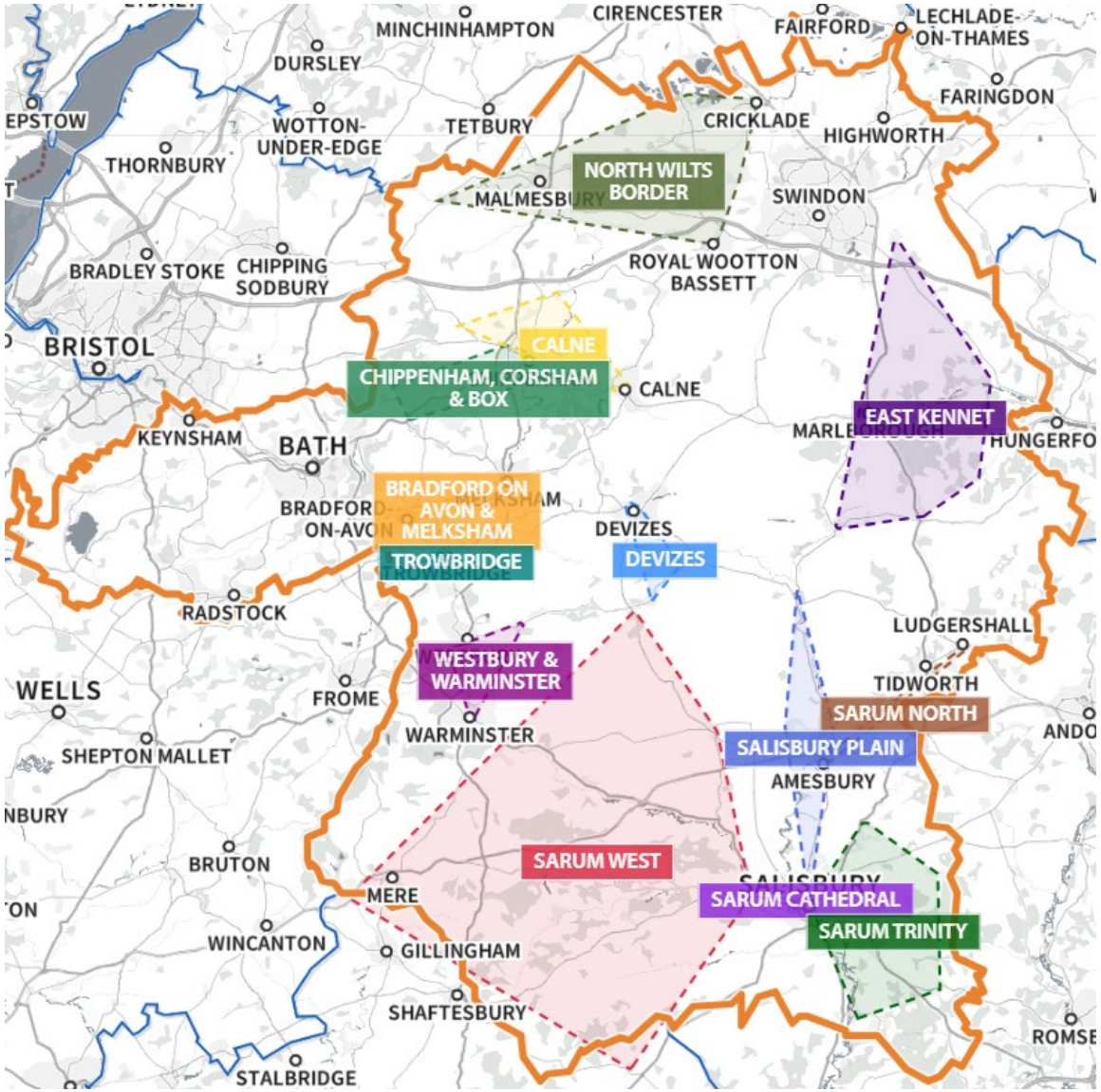
Bid 00_14AT: U5 Health Club - Bemerton & St Marks

Bid 0_9CH: Financial support [illegible] experiencing life changing events due to ill health

Bid 00_10LG: Mindfulness Collaborative [illegible] most deprived wards and rurally isolated areas surrounding Salisbury)

Wiltshire Inequalities Team Working with PCNs to reduce inequalities

Working with 13 PCNs across Wiltshire



(Source: SHAPE 27.03.24. NHS England Digital. April 2024 (19)

Working with Primary Care Networks to:

- Increase awareness, education & training in the use of Population Health Managagement tools
- Collaborate with PCN's to drive forward change & champion reducing health inequalities
- Reduce health inequalities through supporting interventions & incentives (incorporating a business as usual approach where possible)
- Be proactive in raising awareness & profile of health inequalities work accross Wiltshire

Priority Objective: increase awareness, education and training in use of POP health tools

Data tools used to support PCNS:

Shape Atlas Tool *

Office for National Statistics (ONS) – Census data

NHS Digital

Fingertips – Public Health Data

JSNA

*Requires free registration

Other tools available:

OHID – Local Inequalities Explorer tool 2023

PAPI *

Cervical Screening tool

Priority Objective – Collaborate with PCNs to drive forward change and champion reducing health inequalities

Raising the profile of the wider determinants of health - Population health profiles

Aligning Health inequalities agenda at system level (BSW inequalities strategy) to support
BAU contractual outcomes at PC level:

- DES Tackling neighbourhood inequalities
- Fuller stocktake outcomes
- BSW inequalities strategy
- NHS long term plan
- Language and reframing

Working with Primary Care and BSW colleagues to recognise challenges with tackling the Health inequalities agenda and support with PH cross cutting agendas and models of engagement.

Collaborating with ICB colleagues to drive the **neighbourhood collaboratives** agenda supporting PC to move to a population health approach to prevention for those experiencing health inequalities.

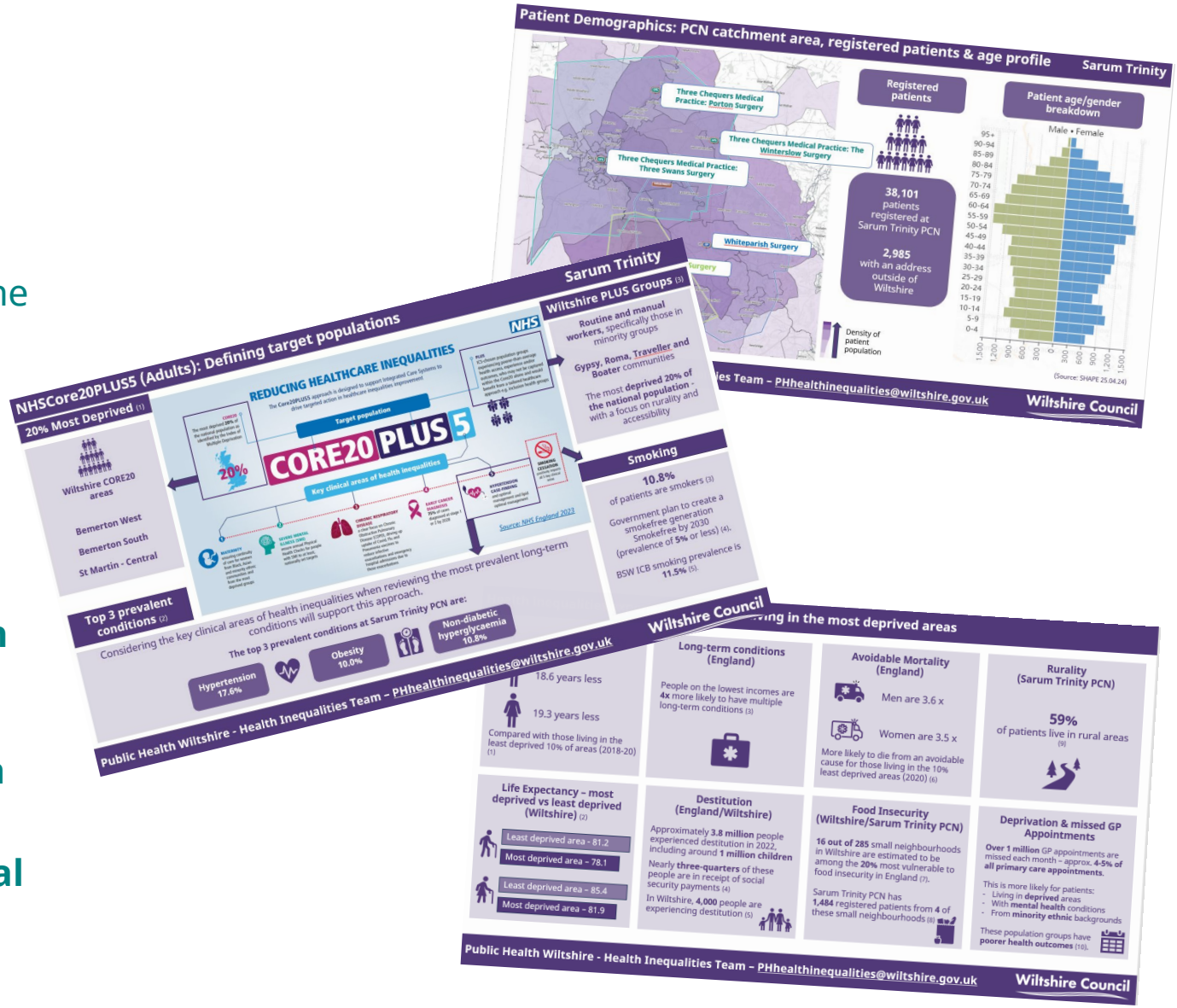
Bespoke PCN Population Profile per PCN in Wiltshire – 13 packs in total

The bespoke PCN profile aims to:

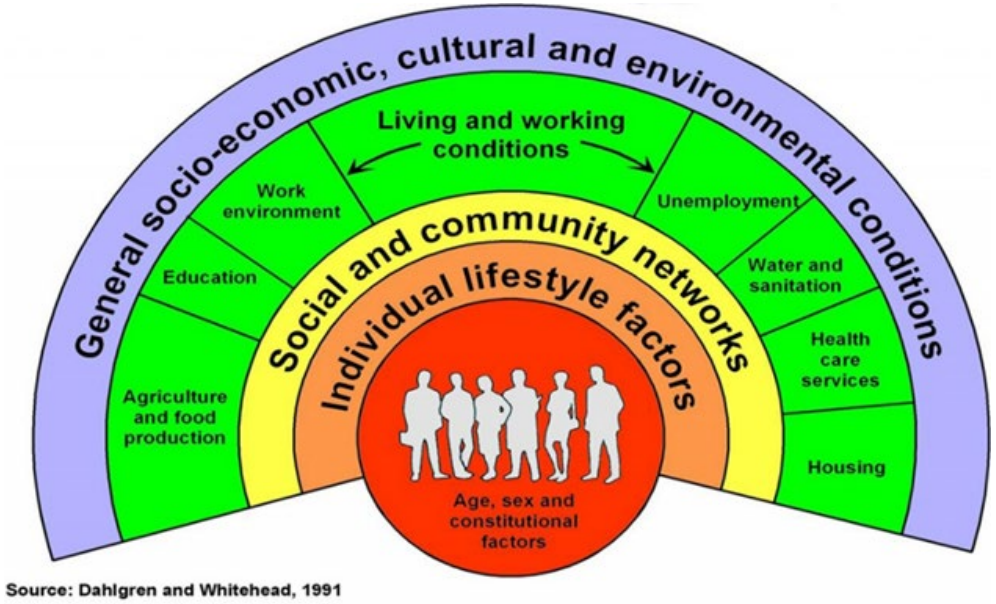
- Demonstrate **where health inequalities exist** and the **impact on health outcomes**, with local and national data comparatives.
- Draws on the NHS Core20PLUS5, BSW Inequalities Strategy and aligns with NHS population health approaches.

With the objective to support PCN's to:

- **Identify target groups** experiencing **adverse health outcomes** including the impact of the social determinants of health.
- Review current services and provision and **consider a health inequalities** lens.
- **Provide opportunities for PCNs to explore potential action** and outlines the support available.



Wider determinants of health & health inequalities - Reframing



Source: Dahlgren and Whitehead, 1991

In Wiltshire between 2019/20 – 2023/24 , **80.7%** of people aged 40-74 were **invited** to an NHS health check, **29.9%** had **received** health check (18).

Alex was invited for an NHS Health Check and has **not responded** to the invite letter or text.

The diagram on the right provides insight to some of the challenges & barriers patients may face which can lead to non-attendance or response to service provision.

Collaborating with ICB colleagues to support the **neighbourhood collaboratives** model avoiding duplication and signposting population health as a preventative approach to action

Data informed practice using Primary Care sources, population health tools to recognise change and improvements to practice to enhance services.

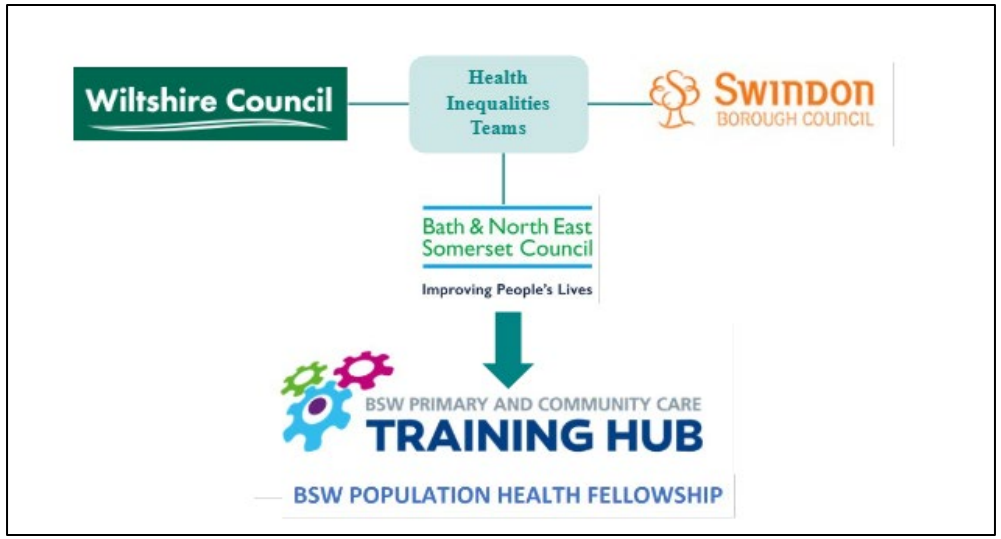
- SM Practice - obesity & Accurx example

Flexible model

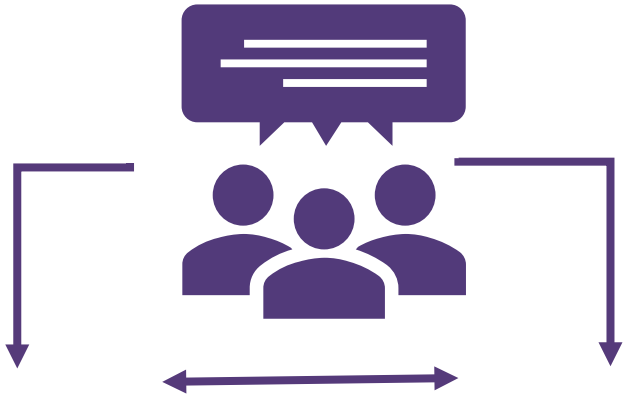
- Informed conversations
- Asset based
- Data informed
- Co-design
- Population health impact

Seeking opportunities

Engagement with GP fellowships to support with project work, avoiding duplication and recognising cross cutting agendas across both system/place.

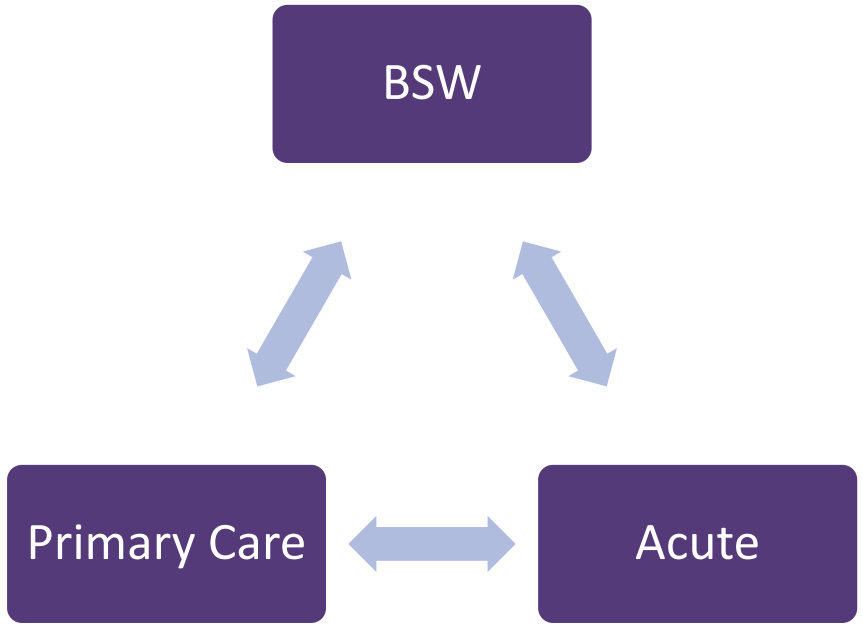


Priority Objective: be proactive in raising awareness and profile of health inequalities work across Wiltshire



Externally Facing **Internally Facing**

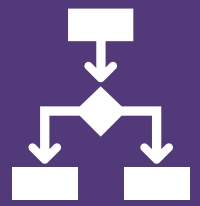
- WHIG
- Community of Practice
- BSW strategy Group
- BSW Health Inequalities group
- PCN managers meeting
- Practice managers meetings
- NC steering groups/working groups
- Population health national delivery forum
- Learning disability and autismm forum
- Warm and safe Wiltshire
- CCB, Devizes, M&BOA Neighbourhood collaboratives working group



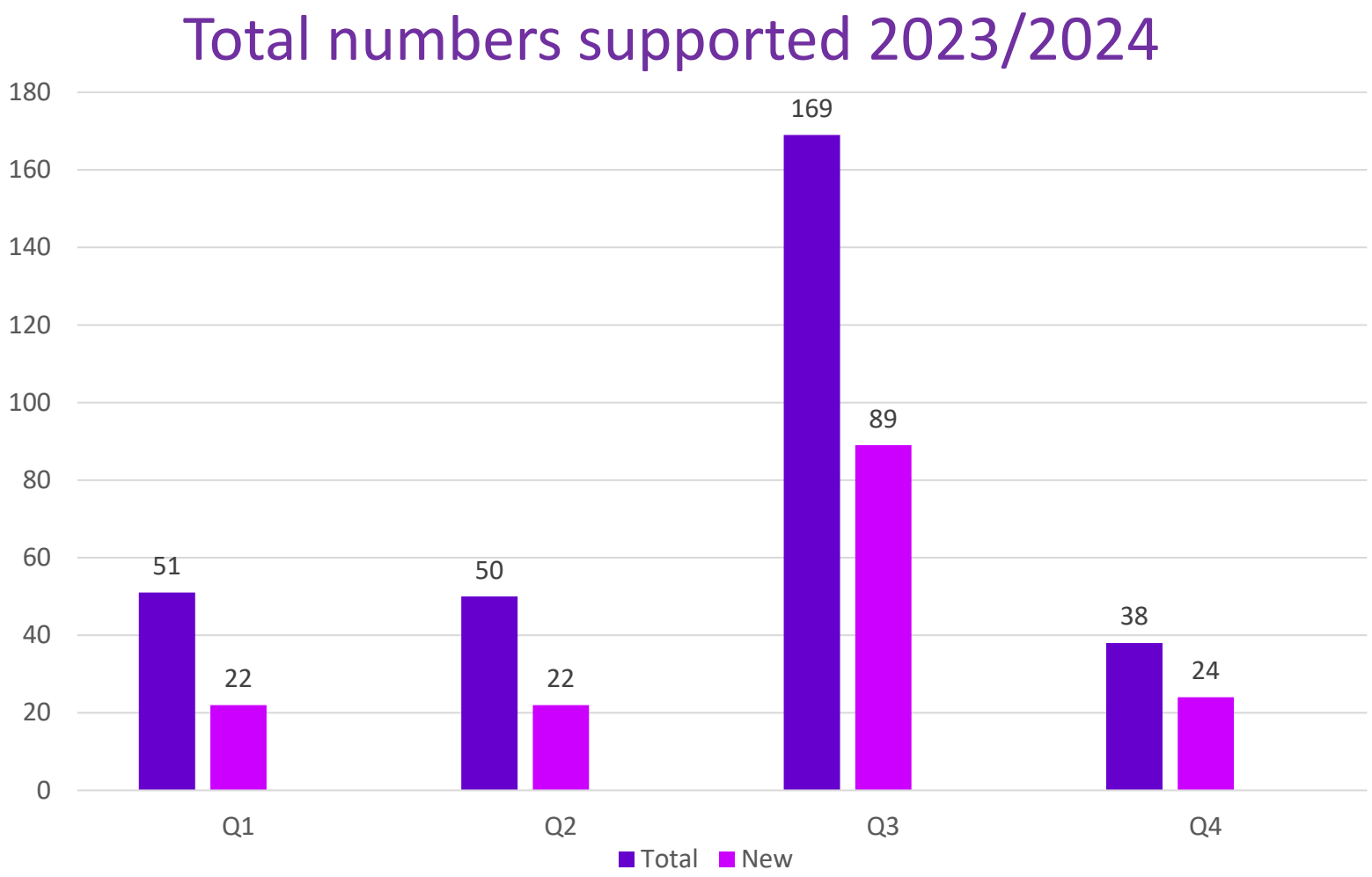
HIT representation at both place and system level allows for the effective dissemination of strategy and ambition to be shared encompassing an informed local lens.
Information, best practice, learning can be shared across multiple platforms avoiding duplication, promoting a joined-up approach.

A working example of this is the HIF funding.

GRTB Outreach & Engagement 2023-24 summary





Communities Supported	Numbers in 2023-24
Boaters	**251**
New Traveller	**45**
Irish Traveller	**2**
Other	**10**
Total	**308**

- N.b. Q3 increase due referrals for Wiltshire **'Warm & Safe Funding'**
- Additional HI-Funding has expanded the contract in 2024/25
- We anticipate numbers of 'non-boaters' being supported to increase through **2 new team members** in post

Type of Support	Q3	Q4
GP registration	2	4
Attending Health Appts	3	2
Benefits Application	18	7
Vaccinations	0	1
School Attendance	1	1
Accessing MH Services	9	2
HSF Funding applications	164	14
CRT Licencing Adjustments	6	3

We began to collect this breakdown of information in Q3

CRT Licencing adjustments

This complex work involves protracted negotiation with the Canal & River Trust to **preclude boaters becoming homeless**

Key Developments

308

People Supported

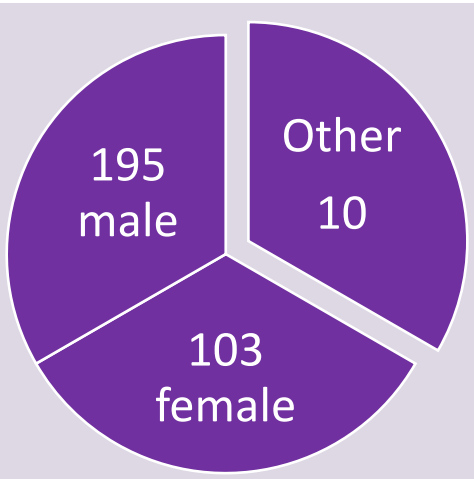
Improved links with:

- WC Enforcement Team
- Adult Social Care
- Primary Care Networks
- Rough Sleeper Team
- DWP
- Canal & River Trust
- Social Prescribers

Worked with **LMNS Maternity & Neonatal Voices** project to ensure 'voice of boaters' was represented in service planning

Provided **'drop ins'** for Boaters at the Hubs

- Bradford on Avon and;
- Caen Hill Marina



Developed improved pathways to other services:
Adult Social Care
Local Welfare Provision
Primary Care
Warm & Safe

Identified gaps in provision and contributed to planning to close them:
Local Welfare Provision

Prevented an estimated **10 boaters** from becoming homeless; by advocating for them to have licence conditions altered

Feedback – what we liked most.

"The fact that Travellers are working with Travellers makes the relationship with staff relatable. The outreach workers understand the lifestyle as they have lived it so I trust them and that they understand the issues we face."

All of the team have been approachable, organisationally & individually. Really lovely that the Team all try to respond as quickly as possible,, it has been so valuable. Friendly & relaxed.

"Being able to talk to someone who doesn't judge me and knows about living on a boat"

The general friendliness of the team and all the help we were given in a non judgemental way.

"Being made aware of support and grants that are available was extremely helpful and definitely got me through the winter"

Feedback – what we liked least.

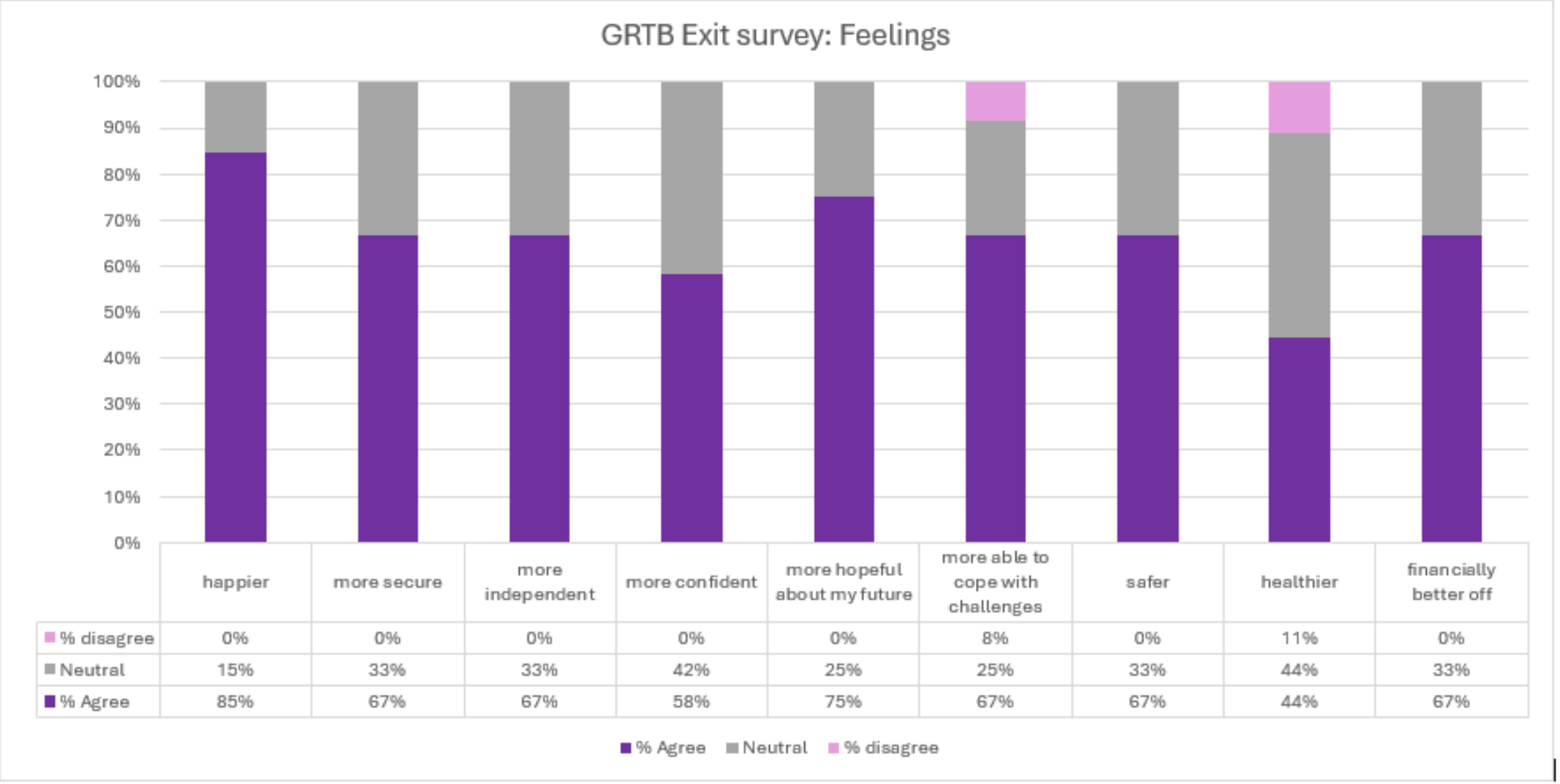
"A dislike talking on the phone - preferred method of method contact face to face but understands that you cannot always get out to we help & I feel relief from the barrier by being the team being so approachable."

"They are always so busy that it's not always possible to see them when I need them"

"Nothing really it has been very helpful."

"Nothing - you run a brilliant service."

Feedback – Exit Survey - Feelings

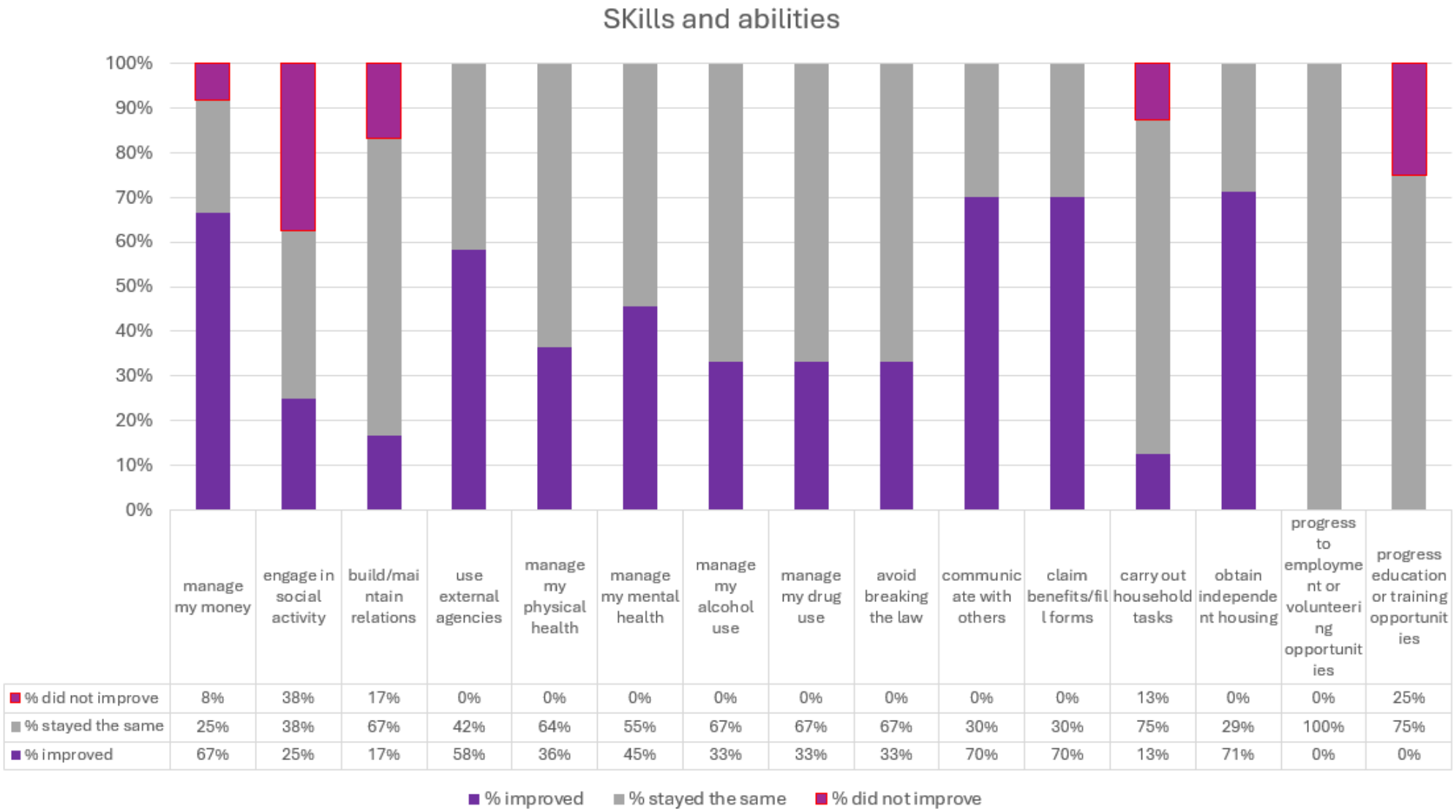


	happier	more secure	more independent	more confident	more hopeful about my future	more able to cope with challenges	safer	healthier	financially better off
% disagree	0%	0%	0%	0%	0%	8%	0%	11%	0%
Neutral	15%	33%	33%	42%	25%	25%	33%	44%	33%
% Agree	85%	67%	67%	58%	75%	67%	67%	44%	67%

Majority of service users indicated a **positive change** in their feelings at the end of support

Most felt '**happier**'

Feedback – Exit Survey – Skills and abilities



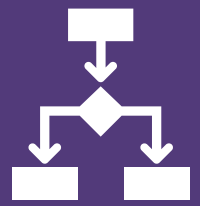
	manage my money	engage in social activity	build/maintain relations	use external agencies	manage my physical health	manage my mental health	manage my alcohol use	manage my drug use	avoid breaking the law	communicate with others	claim benefits/fill forms	carry out household tasks	obtain independent housing	progress to employment or volunteering opportunities	progress education or training opportunities
% did not improve	8%	38%	17%	0%	0%	0%	0%	0%	0%	0%	0%	13%	0%	0%	25%
% stayed the same	25%	38%	67%	42%	64%	55%	67%	67%	67%	30%	30%	75%	29%	100%	75%
% improved	67%	25%	17%	58%	36%	45%	33%	33%	33%	70%	70%	13%	71%	0%	0%

Largest increases seen in money management, communicating with others and claiming benefits.

Team works on short term interventions and further follow up may be needed to capture progress in areas such as volunteering or education, training and employment.

Thank you

Questions?



Bath and North East Somerset,
Swindon and Wiltshire Together

Report to:	BSW Integrated Care Partnership	Agenda item:	6
Date of Meeting:	10 July 2024		

Title of Report:	B&NES Locality Inequality Projects Overview
Report Author:	Paul Scott, Associate Director of Public Health and Sarah Heathcote, Health Inequalities Manager, Public Health and Prevention, B&NES Council
Board / Director Sponsor:	Becky Reynolds, Director of Public Health B&NES
Appendices:	Implementing the BSW Together Integrated Care Strategy Objective 2 – *Fairer health and wellbeing outcomes* – in B&NES

Report classification	Please indicate to which body/collection of organisations this report is relevant. *Only one of the below should be selected* (x)
ICB body corporate	
ICS NHS organisations only	
Wider system	X

Purpose:	Description	Select (x)
Decision	To formally receive a report and approve its recommendations	
Discussion	To discuss, in depth, a report noting its implications	
Assurance	To assure the Group/Forum/Board that systems and processes are in place, or to advise a gap along with a remedy	X
Noting	For noting without the need for discussion	

BSW Integrated Care Strategy Objective(s) this supports:	Select (x)
1. Focus on prevention and early intervention	
2. Fairer health and wellbeing outcomes	X
3. Excellent health and care services	

Previous consideration by:	Date	Please clarify the purpose
BSW PHB	29/05/24	Assurance - Deep Dive – B&NES Health Inequalities Work Programme
B&NES ICA	23/05/24	Approve - 2024/24 progress report and future governance proposal

BSW PHB	25/10/23	Approved - Recommended B&NES HI Funding (BHIF) 2023 24 proposals for funding by BSW PHB
B&NES ICA	October 2023	Approve the recommended proposals.
B&NES ICA	June 2023	Approve delegation of responsibility to a task and finish group, for allocation of HI funding

1	Purpose of this paper

The purpose of the attached report is to provide the Integrated Care Partnership (ICP) with an overview of the locality based health inequalities work programme in Bath and North East Somerset (B&NES).

It demonstrates how this links to implementation of the BSW Integrated Care Strategy (ICS) Objective Two *'Fairer health and wellbeing outcomes'*.

The report outlines progress and key projects underway showing outputs and early impact that contribute to this strategic objective.

2	Summary of recommendations and any additional actions required

We would like to invite the BSW ICP to consider the work presented in the report and to endorse the partnership and network based approach to place based health inequalities in B&NES, as well as our governance locally through the B&NES ICA and to the ICB via the BSW Inequalities Strategy Group.

3	Legal/regulatory implications

There is a legal requirement for ICBs to:

- reduce inequalities between person with respect to their ability to access health services and
- reduce inequalities between patients in respect to the outcomes achieved for them by the provision of health services.

4	Risks

We have been hugely appreciative of the funding provided to date by NHSE and BSW ICB. This has enabled us to build a network of posts and plans across key organisations and to fund specific projects for our most disadvantaged communities.

Uncertainty regarding future funding beyond 2024/25 is a potential risk to current delivery, longer term legacy of the work, and reputation (which was already bruised after the 23/24 funds were shifted to 24/25 meaning that discussions with local organisations about funding available in 24/25 were all stopped). Indicative amounts have been shared, which is very encouraging, but following a significant financial change at very short notice in 23/24 this leaves some degree of uncertainty.

It would be helpful to have assurance on funding available for work in 2025/26.

5	Quality and resources impact

Please outline any impact on
Quality, Patient Experience and Safeguarding:
Addressing accessibility and acceptability of services ensuring inclusivity is a key priority for having impact in reducing inequality

Finance: There are no additional resources being requested in this paper (beyond assurance about the existing recurrent inequalities funds allocated through the BSW Inequalities Group and signed off to date in B&NES by the ICA).

Workforce: To note the B&NES Inequalities Core Network Team are funded to March 2025 through an allocated inequalities budget. Discussions are underway to maintain the sustainability of those roles though a number of routes including the recurrent NHSE / ICB inequalities funding.

Sustainability/Green agenda: The B&NE Health Inequalities Work programme including BHIF funding criteria is underpinned by the Marmot principles for health equity including '*Create and develop healthy and sustainable places and communities'.*

Finance sign-off	Funding agreements to date have been signed off through the B&NES ICA with operational financial oversight by Wiktoria Pabianczyk, Finance Analyst at BSW ICB.

6	Confirmation of completion of Equalities and Quality Impact Assessment

Consideration of equality is a core part of the work programme and was included in the criteria and scoring process for BHIF applications. Projects needed to demonstrate how they are addressing inequalities in relation to Core20PLUS5 particularly through innovative approaches for people who may otherwise face marginalisation, barriers and experience worse outcomes.

7	Communications and Engagement Considerations
	Information about the opportunity to submit proposals to the BHIF were shared widely through partnerships and to the Third Sector through 3SG in B&NES. The application scoring criteria included detail on how projects would address community/service user engagement and co-production. The BSW ICB Communications Guidance has been shared with BHIF projects and project leads are encouraged to link with ICB communications colleagues as appropriate. Project leads are providing 'pen portraits' in response to request by ICB Communications and Engagement team.

8	Statement on confidentiality of report
	There is no sensitive information in the paper in relation to people and patient confidentiality.

B&NES Locality based Inequality Projects Overview

1. Introduction

1.1 The attached report sets out the how the B&NES health inequalities work programme has developed and is being implemented. It contains information about inequalities in our population, our network approach, funding allocations and how the work is supporting implementation of the ICS objective 2 (*Fairer health and wellbeing outcomes*) as well as delivery of the BSW Inequalities Strategy. An example project is described which exemplifies our network approach.

2. Risks

2.1 Risks relating to the work are described on page 3 above.

3. Recommendations

3.1 We would like to invite the BSW ICP to consider the work presented in the report and to endorse the partnership and network based approach to place based health inequalities in B&NES, as well as our governance locally through the B&NES ICA and to the ICB via the BSW Inequalities Strategy Group.

Implementing the BSW Together Integrated Care Strategy Objective 2 *Fairer health and wellbeing outcomes in B&NES*

July 2024

1. Overview of the Health Inequalities Funding Investment
2. B&NES Health inequalities profile
3. Local implementation of the three phases of the BSW Inequalities Strategy B&NES
4. Spotlight Project – Pennard Court, A LD Care Home in Core 20 neighbourhood

Bath & North East Somerset Council
Improving People's Lives

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

NHS
Royal United Hospitals Bath
NHS Foundation Trust

BEMS

1. Health Inequalities (HI) Funding Investment Overview 2022/23 to 2023/24

2022-23 Investment - Establishment of the B&NES Health **Inequalities Network** Team

The health inequalities (HI) team was established in May 2023 with NHSE inequalities funding which BSW ICB allocated to Place in **2022-23** (£302k per annum, for 2 years). The configuration of posts reflects the desired approach in B&NES to develop a 'network' to support different parts of the local system. The posts are fixed term to April 2025.

- HI Manager at B&NES **Council** (the Network Lead)
- HI Lead at Royal United **Hospital** in Bath
- 2* x HI and Population Health Management (PHM) Facilitators based with **primary care** organisation (BEMS)
- **Community Wellbeing Hub** Outreach Coordinator and improved data infrastructure
- Part of the funding was allocated to support data analysis and this has been redirected to support Core20PLUS5 projects in primary care

** One Health Inequalities and PHM Facilitator left December 2023 and funds have been redeployed to secure wider primary care expertise from GP, programme support, etc.*

Health Inequalities Fund 2023/24

B&NES received an additional allocation of NHSE health inequalities funding (HIF) from BSW ICB in **2023/24** to further action on addressing healthcare inequalities.

A multi-agency task and finish group formed to develop criteria, application, scoring and moderation process to oversee this B&NES Health Inequalities Fund (BHIF). Funding allocation from the ICB was deferred to 2024/24.

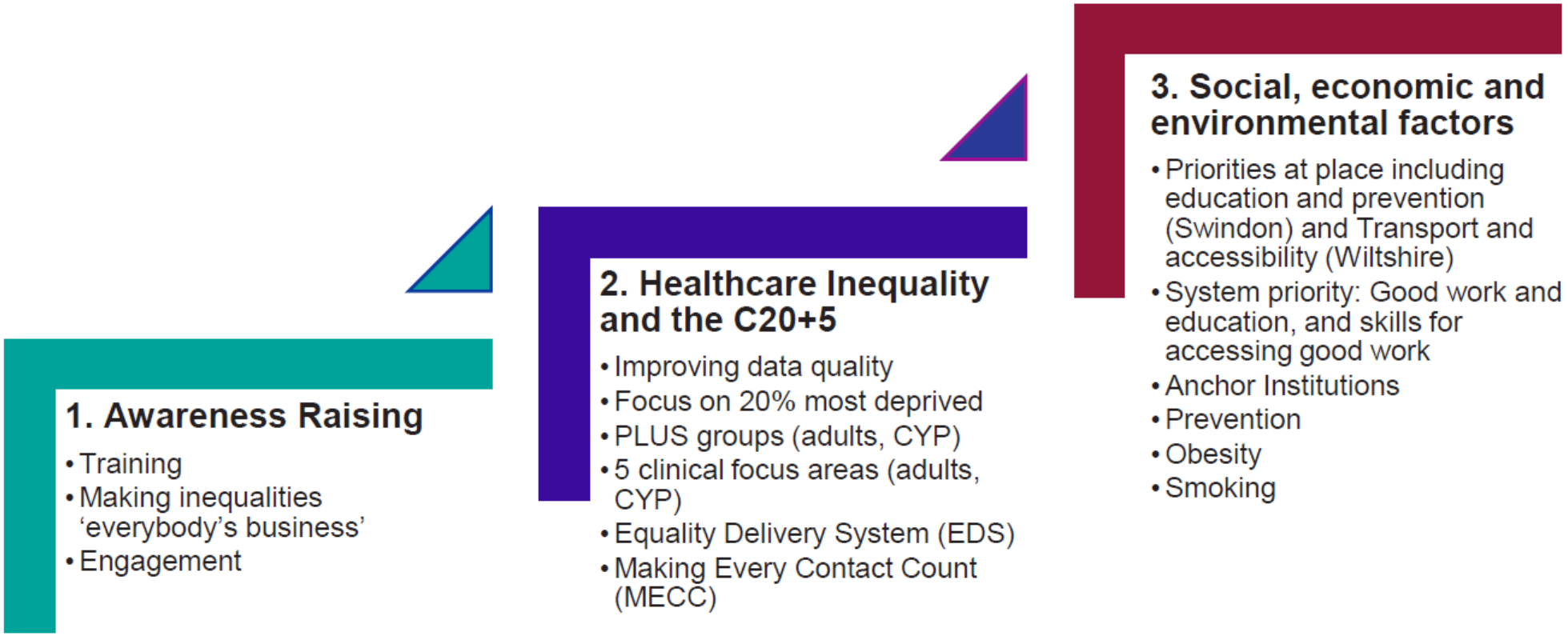
Twelve projects were selected reflecting a range across adult and children and young people healthcare inequality priority areas. The projects have mobilised January-April 2024. **(See details of projects on slide 11)**

2. B&NES Health Inequalities Profile

- B&NES remains one of the less deprived local authorities in the country
- Two areas are within the most deprived 10% nationally – Twerton West and Whiteway.
- Life expectancy in these 'Core 20' areas is significantly lower than England average
- Premature mortality from all causes is closely associated with deprivation across the whole district
- Female life expectancy (LE) gap narrowed between 2010-12 to 2018-20
    - Mainly due to improvements for females in most deprived decile
- Male life expectancy (LE) gap narrowed between 2010-12 to 2018-20
    - With a fall in LE in the least 2 deprived deciles and rise in LE in the more deprived deciles, particularly in the most recent 2018-20 period
- B&NES has highest excess under 75 mortality rate in adults with severe mental illness (SMI) in England (Plus group)
- B&NES has a higher number of rough sleepers relative to its population size compared to Swindon and Wiltshire, with much lower life expectancy than general population for people sleeping rough (Plus group)
- Education Attainment gap between children eligible for free school meal (FSM) and non-FSM pupils at key stage 2 (Plus Group)

3. How the HI network is supporting implementation of the three phases of the BSW Inequalities Strategy in B&NES

The BSW Inequalities Strategy will be delivered in three phases from 2021-2024:



Phase One: Awareness Raising & Making Inequalities Everyone's Business

Health Inequalities Network Approach – Legacy

- Establishment of a health inequalities working group and steering group at the RUH Chaired by Deputy Chief Medical Officer. Health inequalities also incorporated into RUH staff accreditation programme.
- Influencing existing networks for sustained focus on HI (including PCN networks, RUH, Future Ambitions Board, professional networks). Health inequalities are now a standing agenda item at PCN network meetings.
- With colleagues in Swindon and Wiltshire we have established a BSW HI Network which is a useful forum for collaboration, information exchange and progressing shared priority areas
- Coordination of the B&NES Health Inequalities Funding (BHIF) allocation has created opportunities for raising awareness about health inequalities through all elements of the application process.
- Instituted a network of reporting leads and sponsors, ensuring addressing inequalities is core to implementation of the B&NES Joint Health and Wellbeing Strategy (JHWS)
- Ensured that addressing HI is central to the new B&NES Whole Systems Health Improvement Framework
- Inequalities are embedded within the commissioning process (incorporating reference to HI in service specifications and inclusion of KPIs as part of the B&NES Community Services Review, and recent B&NES Healthwatch tender process)
- Establishing a B&NES Health Inequalities Group (BHIG) to guide and oversee the work ensuring a sustained focus on HI

Training and Learning

Reviewing and sharing HI resources on the BSW Academy website

Currently updating training needs analysis and developing an implementation plan for a rolling programme

Supported co-design of Health Inequalities training programme (OHID SW LKIS) for NHS analysts and clinical leads

Sharing HI resources on professional/organisational websites

Delivery of learning sessions on health inequalities for staff groups including all local authority staff; primary care and clinical executive groups at the RUH

Delivery of HI awareness raising campaigns at the RUH for staff who don't have time to attend training

Phase One: B&NES Health Inequalities Dynamic Delivery Plan

We are developing our delivery plan which aligns with key priorities as outlined in existing plans and strategies including:

B&NES	Joint Health and Wellbeing Strategy (JHWS)
BSW	Integrated Care Strategy
BSW	Inequalities Strategy

The plan includes:

Improving data intelligence and evidence base quality and addressing key HI issues identified through PHM including addressing ‘gaps’ in our understanding

Implementation of a B&NES health inequalities training and awareness raising plan

Oversight of NHSE BSW ICB health inequalities funding allocation including delivery, monitoring and reporting on the 12 BHIF projects 2024/25 and additional inequality projects

Continued work with PCNs to agree and delivery on HI clinical priorities including - uptake of cancer screening, smoking cessation, immunisations, targeted work e.g. with people with SMI

Inclusion of RUH Health Inequalities Lead work programme including digital inclusion, Treating Tobacco Dependence and developing the RUH as an anchor institution

Ensure inclusion of community voice and co-production

Support PCNs to undertake PHM activity based on local understanding and analysis of need

Contribute to an evidence base of ‘what works’

Ensure Social, economic, and environmental determinants of health are addressed in line with Marmot principles for health equity

Legacy planning for a sustained priority focus on addressing health inequalities in B&NES

Phase Two: Tackle Healthcare Inequalities – 5 NHS Priorities

Implementing the NHS 5 Key priorities

1. Restore service inclusively
2. Mitigate against digital exclusion
3. Ensure datasets are timely and complete
4. Accelerate preventative programmes
5. Leadership and accountability.

The BHIF (2023/24) guidance, application criteria, and allocation process addressed <u>all</u> 5 of these priority areas

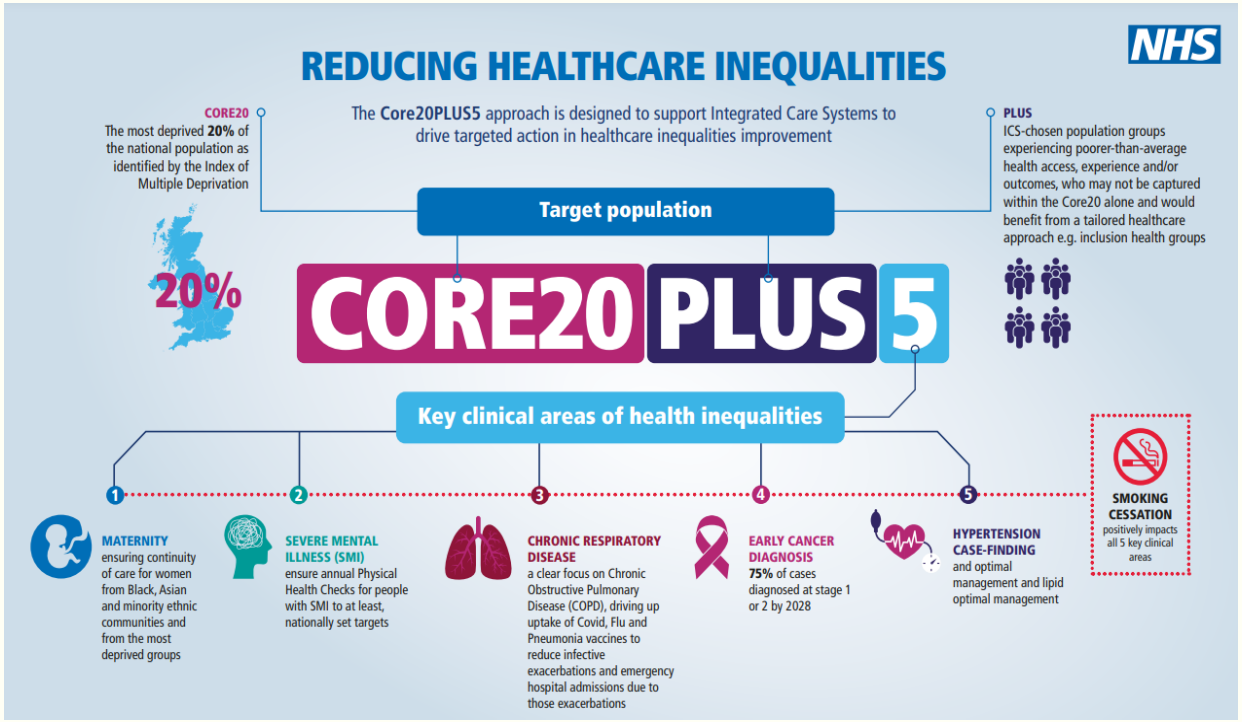
Other examples of actions to address the NHS 5 Key Priorities

1. Screening and vaccinations outreach work where uptake is low
2. The Health Inequalities Lead at the RUH is supporting a 2-year digital inclusion pilot to and recruiting to RUH Digital Navigator posts.
3. The HI and PHM facilitator has prepared population health packs for PCNs
4. Health Inequalities Lead has established the Treating Tobacco Dependence programme at the RUH taking an innovative holistic approach with the service run by Health Coaches adopting a MECC approach

Challenges

Primary care is very pressurised, QOF indicators relating to health inequalities are no longer in place making it difficult to incentivise prioritisation of health inequalities
Cost of living pressures will lead to widening inequality in the context of a vulnerable 3rd sector, wider system pressures and impact on Early Help and other discretionary services

Phase Two: Tackle Healthcare Inequalities – Core20PLUS5 Adults



Banes PLUS groups

- People from ethnic minority backgrounds
- People experiencing homelessness
- People living with severe mental illness

Actions to address Core20PLUS5

- The BHIF (2023/24) guidance, application criteria and allocation of funding
- RUH prioritising Core20Plus groups in all preventative initiatives e.g. TTD, and digital inclusion
- HI and PHM facilitator is working with primary care e.g. to address uptake of cancer screening among C20PLUS populations
- The network is prioritising smoking cessation which impacts all 5 clinical areas and negotiated new payment structure for GP surgeries to increase engagement
- Pennard Court (see spotlight case study)

Opportunities

- NHS Health Checks data modelling at BSW
- Targeted work with PLUS groups (e.g. living with SMI)
- Establishment of the BSW Prevention programme which is focusing on hypertension case finding
- Scoping potential placements for pharmacists completing training to have HI-focused placements

Phase Two: Tackle Healthcare Inequalities Children and Young People (CYP)

Actions to address Core20PLUS5

The BHIF (2023/24) application criteria and allocation process addressed Core20PLUS5 for CYP. Five of the 12 projects are focused on CYP

Work to address air quality and poor housing includes creation of a 0-5 air quality information leaflet and the B&NES Damp and Mould Charter (2024)

Opportunities

Oral health – BSW Primary Dental Services Plan (2024)

School survey this year will provide greater insights

Challenges and Gaps

Current lack of CYP EWMH commissioning lead

As the B&NES HI network we recognise the need to have a greater focus on children and young people in our delivery plan going forward

CYP Plus Groups in BSW

Children with Special Educational Needs and Disability (SEND); Children with excessive weight and living with obesity ; Children Looked After (CLA) and care experienced Early Years (with a focus on school readiness); Children and Young People with Adverse Childhood Experiences (ACE; with a focus on delivering trauma informed services) ; Additionally for B&NES, CYP PLUS groups are children eligible for free school meals

Phase 3 - Social, Economic and Environmental Factors

Some examples of Place-Based activity underway to address the wider determinants of health inequalities

- The **Active Way** three-year pilot is underway to increase active travel via social prescribing in the Somer Valley and areas/settings in B&NES with higher health and wellbeing needs. The Active Way is also a Community Wellbeing Hub (CWH) partner so that it can receive referrals from the many other partners that make up the Hub and including through multi-disciplinary meetings.
- The **Local Plan** is under development and is informed by community engagement work with residents often under-represented in public consultations such as residents with physical disabilities, black and ethnic minority residents, residents that attend children's centres, and older residents that attend luncheon clubs. A key priority for the Local Plan is to create healthy and sustainable places and reduce inequalities.
- Our research on **food insecurity** in B&NES highlights the importance of transport and localised support. B&NES Affordable Food Network, Public Health and Transport colleagues at B&NES Council are working with the University of Bath to develop bespoke toolkits to help transport and community level policy makers engage with experiences of food insecurity and identify where they can take-action.
- Housing (B&NES Council), with support from Public Health, have worked with social landlords across B&NES to develop a **Damp and Mould Charter** that many of our social landlords have signed up to in order to demonstrate their commitment to reducing damp and mould and associated inequalities in social housing in B&NES. They also now have access to a portal where they can continue to network and share good practice.

Future Opportunities – Developing the RUH as an anchor institution; progressing Marmot Region work in B&NES

The Twelve BHIF projects 2023-24 (deferred to 2024-25) *total value £357,897*

Bath City FC Foundation	Go Again, Health and lifestyle interventions at Bath City FC (1hr PA and one hour workshops)
Bath Rugby Foundation	Hi5! Inclusive afterschool clubs for children with SEND
BEMSCA	Community Connector at the Community Wellbeing Hub to support those from ethnic minority groups at hospital discharge
Bright Start Children's Centres	Perinatal Mental Health Support
DHI	Homeless Hospital Discharge (HHD) Service based at the Royal United Hospital. (1.0FTE)
Dorothy House	Develop new service/pathway for people experiencing homelessness to access palliative and EoL care
HCRG Care Group	Community LD nursing capacity to support children's oral health
Mental Health Motorbike	Community based mental health support for motorcyclists (MHFA training and support)
Off the Record	1-2-1 mental health/listening service for CYP in Twerton and Whiteway
Southside Family Project	Targeted family support worker for vulnerable families in Twerton
Soundwell Music Therapy	Music/art therapy for people with psychosis and/or schizophrenia
VOICES	Trauma informed recovery service for domestic abuse survivors

Progress to Date

All of the projects have mobilised and commenced delivery in line with their planned milestones. They have attended a webinar to support completion of agreed BSW project monitoring template

A network of BHIF projects has been created and e-newsletter produced to support collaboration.

It is too soon to identify clear outcomes but there are referrals across all services and early indications of impact are positive.
For example, Age UK B&NES is the lead partner for the Community Wellbeing Hub (CWH) Hospital discharge project and working closely with partners.
At the Annual CWH Partnership Review meeting (May 2024) it was reported that the BHIF funded Community Connector role with BEMSCA has resulted in more people from ethnic minorities accessing Age UK's services and vice versa as well as leading to a more culturally supported stay (e.g. food choices and products) in hospital

4. Spotlight Project

Pennard Court –
Outreach Wellbeing Events




Bath & North East Somerset Council

Improving People's Lives

Addressing Health Inequalities – Support for people with learning disabilities (LD)

Equality Act (2010) places obligation on health-care organisations to make ‘reasonable adjustments’ to reflect needs of disabled people. This is reinforced by Health and Social Care Act (2012) which requires that public authorities reduce inequalities in the benefits obtained from the health services.

However, as highlighted by a recent report from Nuffield Trust, people with learning disabilities are not always able to access the same preventative health and wellbeing support. The report highlights that people with learning disabilities have lower uptake of screening services, get diagnosed with cancer at a later stage than for the general population and these diagnoses are more often made during emergency presentations to hospital. Fingertips data suggests screening rates in Bath & North East Somerset (B&NES) are higher than the national average. However, they still do not meet national targets and rates for cervical screening have been decreasing over time.

This identified need, the mentioned legislation above and the commitment of the NHS to prevention and reducing inequalities , highlight a requirement for public services to support people with learning disabilities to engage in preventative health improvement activities.

https://www.legislation.gov.uk/ukpga/2010/15/contents
https://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
https://www.nuffieldtrust.org.uk/sites/default/files/2024-03/Nuffield%20Trust%20-%20Learning%20disability_WEB_FINAL_1.pdf
https://fingertips.phe.org.uk/profile/cancerservices/data
https://www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-and-health-inequalities/
https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/

The value of outreach: Pennard Court, innovative partnership project

Pennard Court is a 35 unit supported housing residence which is home to people with sensory (primarily hearing) impairment and/or learning difficulties. It is located in Twerton, one of the localities which is among the 10% most deprived nationally (IMD).

This was a multi-agency partnership project involving St Michaels surgery, BEMs, B&NES public health team, BSW ICB, The Active Way and BSL interpreters initiated by the HI and PHM facilitator which demonstrates the benefits of a network approach. The HI and PHM facilitator engaged with the local GP surgery to share data and agree shared priorities – the Practice highlighted the needs of their LD population and particularly low levels up uptake of vaccinations, screening and the annual health check.

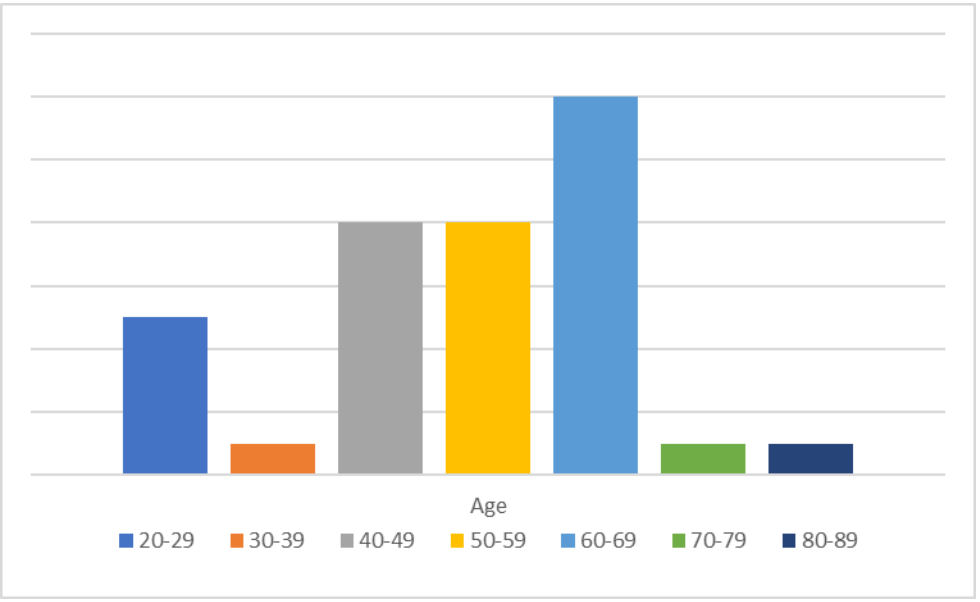
Two wellbeing events were held at the residence. These included flu and covid vaccination, NHS bowel cancer screening, NHS cervical cancer screening, annual LD health checks, MECC conversations and general health consultations, in addition the Active Way were able to engage residents in physical activity

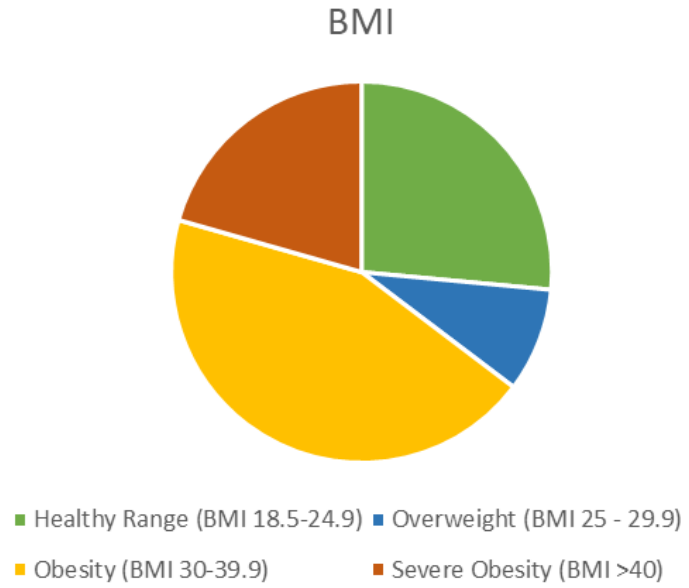
Taking the services out to the community was an entirely new way of working for the GP surgery staff and the partnership approach was well received and residents felt more comfortable engaging in their own familiar environment

A full evaluation has been undertaken and learning will be used to inform future projects and scale up across B&NES

Pennard Court

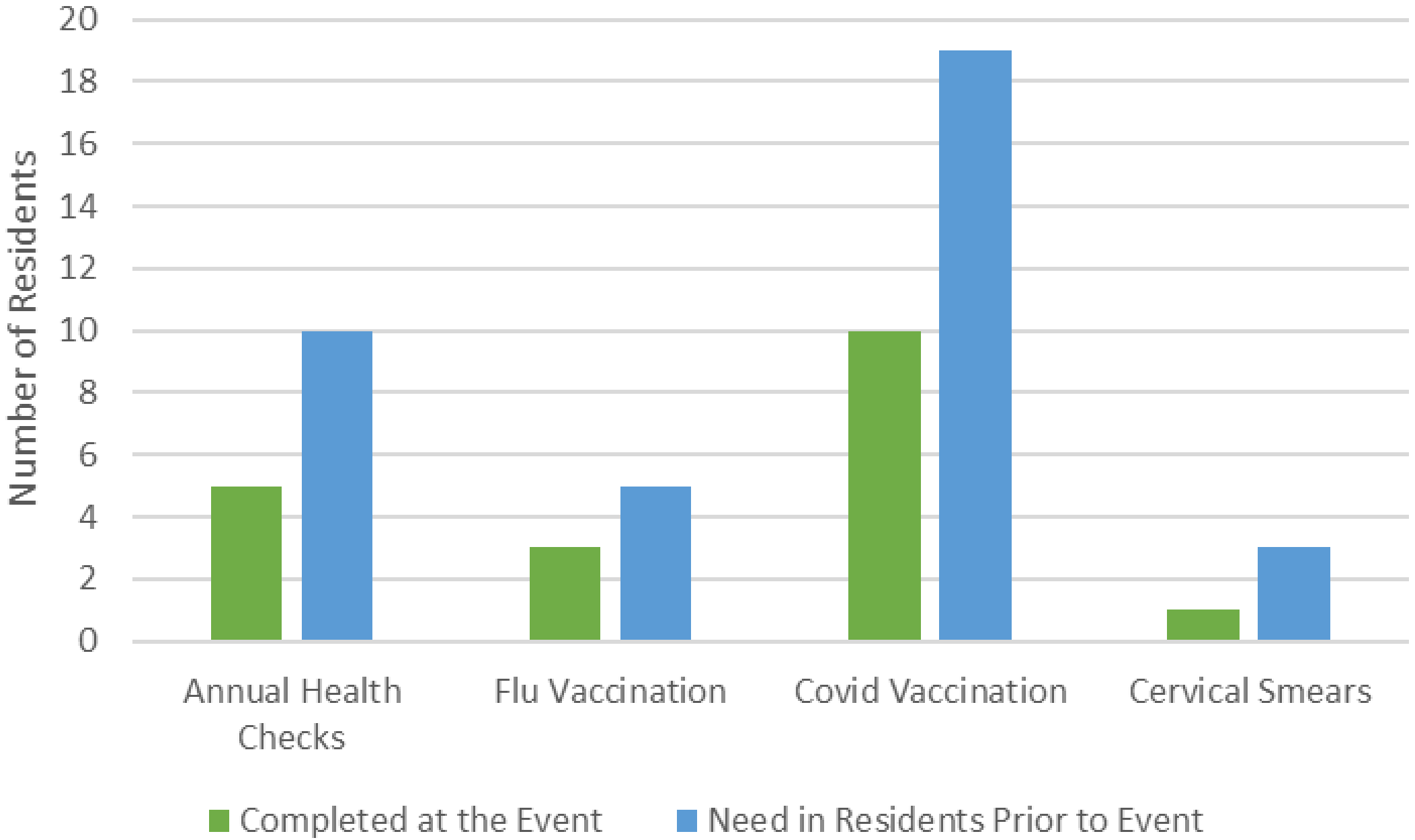
- 35 unit supported housing residence
- People with sensory impairment and/or learning difficulties
- Twerton





Two Wellbeing Events covering the following areas:

- Flu Vaccination
- The Active Way
- Annual Health Checks
- Covid Vaccination
- Cervical Screening
- MECC Conversations
- Bowel Screening
- General Health Consultations
- Interpreters


20
18
16
14
12
10
8
6
4
2
0
Number of Residents
Annual Health Checks
Flu Vaccination
Covid Vaccination
Cervical Smears
Completed at the Event
Need in Residents Prior to Event

Examples of success

Vaccination:
Two residents who were apprehensive about having vaccines came to the first well being event. Following discussions with the staff there at the second event they came back and had their vaccinations. They fed back it was due to the relaxed and non-judgemental approach which enabled them to build trust in the healthcare staff.

Bowel Screening:
Four residents ordered bowel cancer screening kits who hadn't previously considered this. Residents and staff had discussions about how to do this and some of the practicalities involved, making it more accessible for the residents.

Case Finding Hypertension:
Two residents were identified as hypertensive at the event and have already been followed up by their GP.

25 MECC Conversations

6 residents signed up for The Active Way

Recommendations based on the evaluation

- Hold annual themed events
- Determine ongoing funding for interpreters
- Ensure privacy and confidentiality is appropriate for services offered
- Consider other council departments that could also attend
- Explore other settings that could benefit from this style of event
- Review whether residents engaged with services initiated at event
- Build upon the relationship of residents with healthcare staff