Bath & North East Somerset Council

Improving People's Lives

Health and Wellbeing Board

Date: Tuesday, 24th January, 2023
Time: 10.30 am
Venue: Kaposvar Room - Guildhall, Bath

Members: Councillor Dine Romero (Bath and North East Somerset Council), Paul Harris (Curo), Laura Ambler (Integrated Care Board), Councillor Alison Born (Bath and North East Somerset Council), Sophie Broadfield (Bath & North East Somerset Council), Cara Charles Barks (Royal United Hospital), Jayne Davis (Bath College), Sara Gallagher (Bath Spa University), Will Godfrey (Bath and North East Somerset Council), Julia Griffith (B&NES Enhanced Medical Services (BEMS)), Nicola Hazle (Avon and Wiltshire Partnership Trust), Mary Kearney-Knowles (Bath and North East Somerset Council), Amritpal Kaur (Healthwatch), Ronnie Lungu (Avon and Somerset Police), Alice Ludgate (University of Bath), Kate Morton (Bath Mind), Rachel Pearce (NHS England), Sue Poole (Healthwatch BANES), Rebecca Reynolds (Bath and North East Somerset Council), Nikki Rice (Avon Fire and Rescue Service), Val Scrase (Virgin Care), Richard Smale (Integrated Care Board) and Suzanne Westhead (Bath and North East Somerset Council)

Observers: Councillor Robin Moss (Bath and North East Somerset Council)

Other appropriate officers
Press and Public

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NOTES:
1. **Inspection of Papers:** Papers are available for inspection as follows:

Council's website: https://democracy.bathnes.gov.uk/ieDocHome.aspx?bcr=1

Paper copies are available for inspection at the Guildhall - Bath

2. **Details of decisions taken at this meeting** can be found in the minutes which will be circulated with the agenda for the next meeting. In the meantime, details can be obtained by contacting as above.

3. **Recording at Meetings:-**

The Openness of Local Government Bodies Regulations 2014 now allows filming and recording by anyone attending a meeting. This is not within the Council's control. Some of our meetings are webcast. At the start of the meeting, the Chair will confirm if all or part of the meeting is to be filmed. If you would prefer not to be filmed for the webcast, please make yourself known to the camera operators. We request that those filming/recording meetings avoid filming public seating areas, children, vulnerable people etc; however, the Council cannot guarantee this will happen.

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4. **Public Speaking at Meetings**

The Council has a scheme to encourage the public to make their views known at meetings. They may make a statement relevant to what the meeting has power to do. They may also present a petition or a deputation on behalf of a group.

Advance notice is required not less than two full working days before the meeting. This means that for meetings held on Thursdays notice must be received in Democratic Services by 5.00pm the previous Monday.

Further details of the scheme can be found at:

https://democracy.bathnes.gov.uk/ecCatDisplay.aspx?sch=doc&cat=12942

5. Emergency Evacuation Procedure

When the continuous alarm sounds, you must evacuate the building by one of the designated exits and proceed to the named assembly point. The designated exits are signposted. Arrangements are in place for the safe evacuation of disabled people.

6. Supplementary information for meetings

Additional information and Protocols and procedures relating to meetings

https://democracy.bathnes.gov.uk/ecCatDisplay.aspx?sch=doc&cat=13505

Health and Wellbeing Board - Tuesday, 24th January, 2023

at 10.30 am in the Kaposvar Room - Guildhall, Bath

A G E N D A

1. WELCOME AND INTRODUCTIONS

2. EMERGENCY EVACUATION PROCEDURE

   The Democratic Services Officer will draw attention to the emergency evacuation procedure.

3. APOLOGIES FOR ABSENCE

4. DECLARATIONS OF INTEREST

   At this point in the meeting declarations of interest are received from Members in any of the agenda items under consideration at the meeting.

   (a) The agenda item number in which they have an interest to declare.

   (b) The nature of their interest.

   (c) Whether their interest is a **disclosable pecuniary interest** or an **other interest** (as defined in Part 4.4 Appendix B of the Code of Conduct and Rules for Registration of Interests).

   Any Member who needs to clarify any matters relating to the declaration of interests is recommended to seek advice from the Council's Monitoring Officer or a member of his staff before the meeting to expedite dealing with the item during the meeting.

5. TERMS OF REFERENCE (Pages 7 - 12)

   To remind the Board of the Terms of Reference in considering the following agenda items.

6. TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR

7. PUBLIC QUESTIONS AND STATEMENTS

8. MINUTES OF PREVIOUS MEETING (Pages 13 - 24)

   To confirm the minutes of the above meeting as a correct record.

9. UPDATE ON ACTIONS FROM PREVIOUS MEETING - HEALTH AND HOUSING

   (10 minutes)

   Paul Harris to give a verbal update on his meeting with Laura Ambler and Graham Sabourn to discuss health and housing.

ITEMS FOR COMMENT/SIGN OFF

10. HEALTHWATCH CARE QUALITY COMMISSION (CQC) (Pages 25 - 74)

(25 minutes)

Sue Poole/Ann-Marie Scott (Healthwatch) to give a presentation on the findings of the CQC work on the experience of accessing health and social care services by those struggling with mental ill health during the pandemic.

The report includes Healthwatch findings and recommendations and the ask from the Board is to respond to these recommendations.

11. HEALTH AND WELLBEING STRATEGY- FINAL PRIORITIES (Pages 75 - 80)

(15 minutes)

To agree the final priorities of the Health and Wellbeing Strategy in advance of the Strategy being signed off at the March meeting.

Fedalia Richardson

12. BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE (BSW) INEQUALITIES STRATEGY (Pages 81 - 118)

(20 minutes)

To consider the Board's role in delivering Bath and North East Somerset elements of the Inequalities Strategy.

Paul Scott/Annette Luker

13. BETTER CARE FUND UPDATE

(15 minutes)

To update the Board on the Adult Social Care Discharge Grant.

Gary Guest/Judith Westcott

14. DEVELOPMENT OF THE BSW INTEGRATED CARE PARTNERSHIP'S INTEGRATED CARE STRATEGY

(15 minutes)

Richard Smale (IICB) to give a verbal update with key asks for the Board.

Richard Smale

The Democratic Services Officer for this meeting is Corrina Haskins who can be contacted on 01225 394357.

Bath and North East Somerset Health and Wellbeing Board – Terms of Reference and Procedure

TERMS OF REFERENCE

1. Background

1.1 Health and Wellbeing Boards were required to be established in all local authorities under the Health and Social Care Act 2012 as a key mechanism for driving joined up working at a local level.

1.2 Health and Wellbeing Boards are committees of the local authority.

1.3 The legislative framework for Health and Wellbeing Boards is within the Health and Social Care Act 2012 and the Health and Care Act 2022.

2. Vision

2.1 Together we will address inequalities in Bath and North East Somerset so people have the best start in life, live well and age well in caring, compassionate communities, and in places that make it easier to live physically and emotionally healthy lives

2.2 BaNES local authority works with local partners, in partnership with Swindon and Wiltshire as part of the Integrated Care System and with other local authority partners in the West of England Combined Authority to ensure that those services that are shared across a wider population meet the requirements.

3 Functions

3.1 The Board must undertake the following statutory functions:

- Prepare and publish a Joint Health and Wellbeing Strategy (JHWS) for B&NES, setting the vision for desired population level outcomes, strategic direction and high-level priorities for system partners to operationalise, to meet needs identified in the Joint Strategic Needs Assessment (JSNA), referred to locally as the Strategic Evidence Base.

- Prepare and publish a JSNA (Joint Strategic Evidence Base) of current and future health, care and wellbeing needs of the population and ensure this informs the B&NES JHWS and the B&NES, Swindon and Wiltshire (BSW) Integrated Care Strategy.
- Encourage integrated working between health and social care commissioners, and the use of the Health and Care Act 2022 and the NHS Act 2006 flexibilities to increase joint commissioning, pooled and aligned budgets (where appropriate), to support the effective delivery of the JHWS.

- Encourage closer working in planning, commissioning and delivery of services to improve the health and wellbeing of the population of B&NES and reduce health inequalities.
- Prepare and publish a Pharmaceutical Needs Assessment for pharmaceutical services in B&NES.
- Receive and respond to the draft/revised joint forward plan of the BSW Integrated Care Board.
- Be the accountable partnership for the Better Care Fund.

3.2 Achieving the vision and fulfilment of the statutory functions will be supported by the following actions. The Board will:

- Be visible and influential, championing the improvement of health and wellbeing and reduction in inequalities as important strategic issues. It will influence organisations and partnerships both within and external to the B&NES locality and wider Integrated Care System in reflecting this in their operational and commissioning plans.
- Develop strong links with and influence developments in wider services that impact on health and wellbeing including planning, transport, housing, environment, economic development, education and community safety in order to address the wider determinants of health, wellbeing and inequalities, and ensure a focus on mental well-being in conjunction with good physical health.
- Ask partners to show how they embed and deliver meaningful action against the priorities in the Health and Wellbeing Strategy.
- Periodically refresh the Health and Wellbeing Strategy in line with evidence from the Joint Strategic Evidence Base.
- Monitor progress of implementation of the Health and Wellbeing Strategy, and ensure action is taken to improve outcomes when monitoring or performance indicators show that plans are not working.
- Ensure there are effective and sufficient mechanisms and resource to communicate, engage on and co-produce Health and Wellbeing Strategy priorities with local people and stakeholders, working closely with the Third Sector.
- Consider the Integrated Care Partnership's Integrated Care Strategy when preparing or revising its Health and Wellbeing Strategy; and be active participants in the development of the Integrated Care Strategy.
- Consider whether the ICB's joint forward plan (previously the CCG's commissioning plan) has given due regard to the Health and Wellbeing Strategy.
- Strengthen its attention on community resilience and on identifying and building on community assets.
- Work closely with the B&NES Healthwatch and Third Sector partners to ensure appropriate engagement, involvement and feedback with residents, patients and service users.

- Encourage partners to consider sufficient resourcing, both fiscal and human, of the prevention and inequality agendas.
- Seek to secure collaboration in the system to reduce duplication and make best use of available resources.
- Receive a copy of the ICB's joint capital resource plan outlining planned capital resource use, so to help align local priorities and provide consistency with strategic aims and plans.
- Provide strategic oversight and direction to ensure that the approaches adopted for health and wellbeing services are aligned with the aspirations of local partners to operate in a sustainable manner and to address the climate emergency.
- Produce an annual report presented to Cabinet/full Council outlining achievements of the Board in respect of the improvement of health and wellbeing, a reduction of health inequalities for the population of B&NES and influencing Council priorities on the wider determinants of health.

2.3 Responsibility for the scrutiny of health and wellbeing will continue to lie with the Council's Policy Development and Scrutiny Panels.

3. Scope

3.1 The Board's scope shall be set out within the Joint Health and Wellbeing Strategy.

3.2 The Health and Wellbeing Board may consider services beyond health and social care enabling the Board to look more broadly at factors affecting the health and wellbeing of the B&NES population.

4. Accountability

4.1 Those stakeholders with statutory responsibilities will retain responsibility for meeting their individual duties and responsibilities.

4.3 The Board will establish on-going and short lived sub-groups as needed that will report to it. Subgroups established will reflect the priorities of the Health and Wellbeing Board such as children and young people, JSNA, updating the Health and Wellbeing Strategy etc.

4.4 Accountability for safeguarding lies with the B&NES Community Safety and Safeguarding Partnership (BCSSP)

PROCEDURE

5. Membership

5.1.1 The Membership of the Board is:

- B&NES Council x 7 (Cabinet Member for Adult Services, Cabinet Member for Children's Services, Chief Executive, Director of Adult Social Care,

Director – Children and Young People, Director of Public Health, Director of Sustainable Communities)

- B&NES Swindon and Wiltshire Integrated Care Board x 2 (ICB Place Director, nominated ICB Executive Officer)
- Healthwatch B&NES x 1
- Avon and Somerset Police x 1
- Avon Fire and Rescue x 1
- Housing provider representative x 1
- Higher and further education representative x 3
- Health and social care provider and Third Sector representatives x 5 (acute care, community care, primary care, mental health service, and voluntary, community and social enterprise sector)
- NHS England x 1

5.2 The Board will be chaired by a Cabinet Member nominated by the Leader of the Council and supported by a Vice Chair agreed by the Board.

5.2.1 The Council will provide secretariat support to the Chairperson in setting dates for meetings, preparing agendas, and minuting meetings

5.3 In the event of a vote on a substantive matter, the quorum for the meeting will be:

- 3 members of the Council
- 1 member of the Integrated Care Board
- 1 member of Healthwatch B&NES
- 1 health and social care provider or Third Sector representative
- 1 member from either of Avon and Somerset Police or Avon Fire and Rescue
- 1 member from either Higher and Further Education or Housing

5.4 Board members may nominate a named substitute from an appropriate member of their organisation or service.

6. Wider engagement

6.1 By working together the Health and Wellbeing Board will proactively embed good public and patient engagement within the day-to-day business of the Board through adhering to the following principles:

- Taking responsibility for good public engagement
- Clarity about purpose
- Harnessing a range of engagement methods
- Engaging with everyone

- Committed to cultural change
- Providing access to information
- In partnership with Healthwatch B&NES and 3SG
- Feeding back engagement results
- Evaluating engagement

6.2 The Board will seek to engage all stakeholders (including key health and social care providers) on the JHWS and commissioning plans.

6.2 The Council's policy development and scrutiny function offers an opportunity for broader engagement on key issues.

6.3 It is intended that one representative of each Political Group on the council, not currently represented on the board, be invited to formal Board meetings in an observer capacity.

7. Business management

7.1 The Board is a statutory committee of the Council and will be treated as if it were a committee appointed by the Council under section 102 of the Local Government Act 1972.

7.2 The Board will act in accordance with the Council's committee procedures.

7.3 Formal Board meetings shall be held in public. The Board may resolve to hold closed sessions in accordance with the Access to Information rules.

7.4 The Board will develop a work programme framed by the HWS which will guide its work.

7.5 The Board will meet at least 5 times per year in public as a minimum, with the flexibility for development sessions and agenda planning meetings held in private.

Approved by B&NES Health and Wellbeing Board 29/11/2022
Approved by B&NES Council 17/11/2022
Review date: November 2023

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Bath and North East Somerset Council

HEALTH AND WELLBEING BOARD

Minutes of the Meeting held

Tuesday, 29th November, 2022, 10.30 am

Councillor Dine Romero	Bath and North East Somerset Council
Councillor Alison Born	Bath and North East Somerset Council
Will Godfrey	Bath and North East Somerset Council
Rebecca Reynolds	Bath and North East Somerset Council
Suzanne Westhead	Bath and North East Somerset Council
Mary Kearney-Knowles	Bath and North East Somerset Council
Richard Smale	Integrated Care Board
Laura Ambler	Integrated Care Board
Sue Poole	Healthwatch BANES
Ronnie Lungu	Avon and Somerset Police
Julia Griffith	B&NES Enhanced Medical Services (BEMS)
Paul Harris	Curo
Val Scrase	Virgin Care
Kate Morton	Bath Mind
Jocelyn Foster	Royal United Hospital Bath NHS Trust

23 WELCOME AND INTRODUCTIONS

The Chair, Councillor Dine Romero, Cabinet Member for Children, Young People and Communities welcomed everyone to the meeting.

Members of the Board and officers introduced themselves.

24 **ELECTION OF VICE-CHAIR**

RESOLVED that Paul Harris be elected Vice-Chair of the Health and Wellbeing Board.

25 **EMERGENCY EVACUATION PROCEDURE**

The Democratic Services Officer drew attention to the emergency evacuation procedure.

26 **APOLOGIES FOR ABSENCE**

Apologies had been received from
Cara Charles-Barks, Chief Executive, RUH
Rachel Pearce, NHS England Area Representative
Amritpal Kaur, Healthwatch,
Sophie Broadfield, Director of Sustainable Communities, B&NES
Alice Ludgate, Bath University,
Sara Gallagher, Bath Spa University
Jayne Davis, Bath College

Joss Foster, Director of Strategy (RUH) attended as substitute for Cara Charles-Barks.

27 **DECLARATIONS OF INTEREST**

Sue Poole declared an interest in the agenda item concerning Healthwatch update and confirmed that she would leave the meeting before that item was considered.

28 **TO ANNOUNCE ANY URGENT BUSINESS AGREED BY THE CHAIR**

There was no urgent business.

29 **PUBLIC QUESTIONS AND STATEMENTS**

There were no public questions or statements.

30 **MINUTES OF PREVIOUS MEETING**

RESOLVED that the minutes of the meeting of 27 September 2022 be approved as a correct record and signed by the Chair.

31 **PRESENTATION ON HOUSING**

Graham Sabourn and Ann Robbins gave a presentation on Housing and Health and Wellbeing issues as summarised below:

<u>Housing, Health & Wellbeing</u>

- Well established causal relationship between physical housing defects and poor physical health outcomes.

    - Estimated £2.5b annual cost to NHS.
    - 63,000 excess winter deaths (1/3 due to cold homes).
- Developing evidence that non-physical housing factors can also have a significant and negative impact on mental health and wellbeing.
    - Harder to quantify but linked to depression, stress and anxiety.
    - Control, autotomy, status & empowerment all affected and linked to health & wellbeing.

Local Housing Challenges

- Supply challenges
    - Older poor-quality housing
    - Large (and unbalanced) private rented sector
    - Large numbers of HMO
    - AirBnB usage (2,000+ units) having impact
    - Land limited
- Affordability challenge
    - 12.4x lower quartile house price to average earnings
    - 78% of all first-time buyers unable to afford an average terraced property
    - £1,200 mean 2-bed rent (LHA £847)
- Demand challenges
    - 6,000 households on Homesearch & 474 homes available (2021/22)
    - 58 households in temporary accommodation (100% increase in 3 yrs)
    - Trend of complication: homelessness casework, disabled adaptations, rough sleeping all getting more complicated & resource intensive
    - Challenging financial climate

More Homes

- Enabling activities:
    - Delivered 1,848 affordable homes in past 10yrs
    - Facilitating delivery of 100% AH schemes
    - Enhanced Empty Property CPO/enforced sale process
    - Refreshing housing needs evidence base to support Local Plan update (
    - Developing overarching Housing Strategy
- Direct Delivery
    - B&NES Homes Programme, comprising supported housing, shared-ownership & social rent
    - 26 units completed, 21 on site, 208 in medium-term pipeline
    - Energy efficient: Shared-ownership EPC A rated EPC; Grosvenor House reduced energy consumption by over 40%; Theobald air-source heating
- Supported Housing
    - Pemberley Place Extra Care Scheme; 72 flats mixture of social rent & shared-ownership
    - Delivered 24 units of accommodation for former rough sleepers; on site for 14 units of temporary accommodation; working up planning application for 16 units for LD clients
    - In partnership with Adults, Children & Families developing Supported Housing Strategy

Better Homes

- Regulation & Enforcement
    - Enforcement of housing conditions across 33,000 rented homes
    - Proactive HMO Licensing scheme
    - Improved 364 properties through enforcement action

    - Commissioning house condition survey & post 2023 licensing position
- Adaptation Services
    - Deliver, commission or fund range of adaptation services: disabled facilities grants; hospital discharge service; rails contract; home improvement agency.
    - Recently incorporated the Community Equipment Store providing specialist community equipment to residents.
    - Urgent repair grants
- Affordable Warmth
    - Energy at Home Service provides advice, signposting and financial assistance to low-income residents.
    - Work with Public Health team and Sustainability team on promotion and targeting to vulnerable groups
    - With BCC/SG successful HUG bid to assist 170+ households living in fuel poverty (£3m for B&NES).

<u>Happy and Healthy Lives</u>

- Housing Options
    - 2,000 approaches p.a. with 40-50% homeless/threatened with homelessness
    - 60% of prevention duties successful helped by Homefinders & Supported Lodgings Scheme
    - Households in temporary accommodation increasing (100% increase in 3 years to 58) but low compared to national rate
- Homesearch
    - Single access point for 85%+ of social housing in district
    - 6k households on scheme & 474 vacant homes in 2021/22
    - Urgent & high priority households waiting 44 & 70 weeks to be housed (2021/22)
    - But, demand/supply ratios very high at 18yrs & 186yrs for 3bed & 4bed properties.
- Rough Sleepers
    - Cohort of around 60 individuals who fall in/out of rough sleeping
    - Comprehensive range of local services, including direct access hostel, floating support, reconnection service, mental health etc.
    - £2m NSAP bid provided move-on accommodation; £1.3m DLUHC bid providing further expansion of services; inc. Housing First, specialist women worker etc.

<u>A Last Few Thoughts</u>

- The challenges are likely to get worse in the short-term
    - Squeezed household incomes
    - More landlords exiting residential market & rising rents
    - Funding & recruitment challenges
    - Housing supply likely to reduce in short-term & planning reform challenges
    - Increasingly frustrated and agitated clients
    - Trend of complication likely to continue
- Locally we are better positioned and more resilient than we have ever been
    - Covid has provided a number of learning experiences
    - We better understand where we can add value & where our partners add value

- More ambitious and willing to intervene where perceived market failure
- Partnership working, both internally and externally, continues to improve
- Opportunity to further simplify housing commissioning arrangements

The Board were asked to contact the Housing Team if they were aware of clients with housing condition issues, require adaptations or likely to become homeless.

The following comments were raised:

1. Kate Morton referred to Section 21 notices and stated that there was a need for more effective alignment between social care, housing and the third sector and that she welcomed the experience of the Council in this area.
2. Paul Harris referred to the case in Rochdale of a child who had died after extensive exposure to damp and mould and stated that this was not just a housing issue but a health and poverty issue. He stated that overcrowding was an issue faced by housing providers and Curo were getting more GP letters on behalf of clients requesting appropriate housing. He concluded that there was a need for better joint working to help people into appropriate housing and made the following suggestions:
    a. A scheme such as the one in the Forest of Dean where heating vouchers were given out to help with ventilation. This would save money in terms of the cost to the NHS associated with poor housing.
    b. The best use of existing housing stock, such as encouraging under-occupiers to move by offering good quality alternatives.
3. Cllr Alison Born asked if there was retrofitting funding available to source dehumidifiers to help with damp/mould problems. Graham Sabourn responded that the Council did not offer de-humidifiers but there was the HUG scheme money to assist households living in fuel poverty and there was also a new Government Eco Plus scheme which would help householders with insulation.
4. Joss Foster also emphasised the importance of joint working to meet the short-term risks over the winter period. It was noted that there was a Winter Pressure Plan but there was also a need for a system wide approach to look at opportunities around preventative measures.
5. Ronnie Lungu referred to the issue of overcrowding in accommodation and the pressures on young people which may force them to spend a lot of time on the streets and be at risk of anti-social behaviour. He suggested that it would be useful to offer incentives e.g., vouchers to attend gyms to offer young people positive alternatives.
6. Cllr Alison Born asked if there were any schemes to encourage elderly people with extra space to rent rooms to students. Ann Robins confirmed that this had been considered in the past but too many barriers had been identified to make the scheme viable, however it was something that could be revisited.
7. Concern was expressed about the increasing number of AirBnbs and the impact on the availability of housing and the Board questioned whether anything could be done to address this issue.

It was agreed that Graham Sabourn, Laura Ambler and Paul Harris would meet to discuss the issues raised in more detail and would report back to the next meeting of the Board.

The Board **RESOLVED** to;

1. Note the presentation.
2. Agree that Graham Sabourn, Laura Ambler and Paul Harris meet to discuss the issues raised in more detail and report back to the next meeting of the Board.

32 HEALTH AND WELLBEING BOARD TERMS OF REFERENCE

Becky Reynolds reported that the amended terms of reference had been circulated to members of the Board for comment and in principle agreement prior to approval by Council on 10 November.

It was noted that members of the public were not participating in HWB meetings and there may be issues that needed considering such as venues and accessibility to improve engagement. Paul Harris, Kate Morton and Laura Ambler undertook to discuss this issue in more detail.

Paul Harris questioned whether quoracy should be reconsidered at a future review. It was noted that members had the opportunity to send substitutes from their organisation if they were unable to attend.

The Board **RESOLVED** to;

1. Note the proposed changes to the Health and Wellbeing Board's Terms of Reference, which include changes to the Board's vision and membership in particular.
2. Note the addition of the Bristol, Swindon and Wiltshire Integrated Care Board to its membership, as part of the statutory requirements of the 2022 Health and Care Act.
3. Approve the updated Terms of Reference for the B&NES Health and Wellbeing Board.

33 BSW INEQUALITIES STRATEGY

The Board **RESOLVED** to;

1. Note that the BSW Inequalities Strategy will be on the agenda for the January meeting of HWB.

34 DRUG AND ALCOHOL STRATEGY 2022

Celia Lasheras gave a presentation on the Drug and Alcohol Strategy as summarised below:

Alcohol and Drug Abuse impacted on a wide range of local priorities:

- Health, Wellbeing and Social Care
- Prosperity and Attainment
- Criminal Justice

National Strategy:

- From Harm to Hope: A 10-year Drugs Plan to Cut Crimes and Save Lives was published by the Central Government in December 2021. The strategy committed the whole of government and public services to work together to:

    - Break drug supply chain
    - Deliver a world-class treatment and recovery system
    - Achieve a shift in the demand for recreational drugs
- The national Alcohol Strategy also committed to combine nation-wide interventions and policies with locally developed approaches to reduce harmful drinking and the impact on the population.

Funding for local areas:
- Supplemental Grant Funding (2022 – 2025) £950,438. Supplementary to the treatment grant, which would help improve B&NES drug and alcohol treatment and recovery systems.
- RSDATG (2022 – 2024) £1,393,508. Focussed on improving access and engagement of rough sleepers or those at risk of rough sleeping engaging with drug and alcohol treatment.

Translating national strategy to local needs
- High levels of drug and alcohol related hospital admissions
- High levels of people not in treatment
- Drug-related death rate now above national average
- Increasing complexity (mental health and social needs)
- An ageing treatment population with increasing long-term conditions
- Children in need assessments identify parental substance use disorder as a factor (21-23%)

Development of the Strategy
- B&NES Drug and Alcohol Partnership Group
- Consultations:
    - Online consultation for stakeholder networks
    - Focus groups with adult service users and front-line workers
    - Online and paper feedback from young people with P28
    - Stakeholder events at Bath Council in July and September
    - Engagement events with housing, education, treatment services
    - Strategic forums
- Multi-agency collaborative work

Core Vision:
- To work together to enable people from B&NES to grow up and live free from the harms of substance use.

Core Aims:
- To focus on prevention alongside early intervention, and support those that experience difficulties with substance use by having an effective treatment and recovery support system.

Priorities:
1. Reduce demand for substances in the B&NES population
2. Support more adults and young people to access and benefit from treatment and recovery services
3. Prevent and reduce harms from drugs and alcohol, including preventing drug and alcohol-related deaths
4. Support the health and social needs of adults and young people with complex lives

Next Steps:

1. **Action planning** to deliver the strategy *(in process)*
2. Implementation will be overseen by the Bath and North East Somerset Drug and Alcohol Partnership with supporting governance
3. Outcomes for monitoring the strategy and action plan will be informed by national guidance (awaited 2022), with locally agreed indicators informed by the priorities and data discussed

The Board were asked to champion the strategy within their organisations to ensure that it did not sit in isolation to other work programmes.

The Board **RESOLVED** to;

1. Approve the B&NES Drug and Alcohol Strategy 2022 – 2027

2. Support development and implementation of the accompanying Action.

3. Plan to deliver on the strategic priorities and commitments.

35 B&NES COMMUNITY SAFETY AND SAFEGUARDING PARTNERSHIP (BCSSP) ANNUAL REPORT

Mary Kearney Knowles drew attention to the BCSSP Annual report and asked members to email any queries or suggestions to her/Suzanne Westhead.

The Board **RESOLVED** to;

1. Note the Annual Report and Executive Summary for the BCSSP.

2. Forward any queries or suggestions of additional areas for consideration for BCSSP to Mary Kearney Knowles and Suzanne Westhead.

36 BETTER CARE FUND

Suzanne Westhead and Laura Ambler gave an update on the Better Care Fund and drew attention to the following:

- The Government had confirmed that the £500 million Adult Social Care Discharge Fund would be pooled into local Better Care Fund plans and Section 75 agreements.
- Funding would be provided through grants to Local Authorities (40% of the national fund) and allocations via ICBs (the remaining 60%).
- Use of funding would be agreed locally between the ICA and Local Authority.
- The money would be released in two tranches, the first in early December and the second in January.
- ICBs would need to confirm the agreed distribution of their allocations across the HWBs in their area via submission of 2 plans:
    - ***ICB Level*** – Used to confirm how funding allocated to ICB's would be distributed across the HWB BCF plans that the ICB contribute to

- ***HWB Level*** – Used to confirm how the funding in each HWB's BCF would be spent and the expected activity.

- Submission deadline for plans had been set as 16th December 2022.
- The NHS B&NES, Swindon and Wiltshire allocation was confirmed as £6,247,209.87 and the allocation to the B&NES area would be agreed locally.
- The B&NES Council allocation was £608,127.
- The money needed to be spent by the end of March 2023 and there were proposed schemes in place.

It was agreed that Paul Harris be included in future discussions with Suzanne Westhead and Laura Ambler about proposed schemes.

The Board **RESOLVED** to**:**

1. Note the Better Care Fund Update.

37 HEALTH AND WELLBEING BOARD STRATEGY

Fedalia Richardson gave a presentation on the Health and Wellbeing Strategy Update. She advised that draft priorities had been informed by the first phase of consultation, feedback from engagement sessions and the Strategic Evidence Base.

Draft Priorities:

1) Improving access to health services
2) Mental health and emotional wellbeing of children, young people and adults
3) Low-income families (housing, food security, fuel poverty, access to education, training and skills)
4) Chronic disease prevention with a focus on the four main behavioural risk factors (tobacco smoking, physical inactivity, unhealthy eating, and the harmful use of alcohol)
5) The health and wellbeing needs of rural communities (inequality and different accessibility needs, isolation and loneliness)
6) Improved quality of life for people with dementia (this priority may change as the needs of older people coming through the engagement process and SEB are further explored)
7) Access to nature and leisure facilities

Next Steps:

1) The Health and Wellbeing Strategy Steering Group will provide feedback on the identified priorities.
2) The Health and Wellbeing Strategy Team will meet with key partnership groups to sense-check the draft priorities.
3) The Health and Wellbeing Strategy Team will meet with colleagues within the public health team and council to:
    i. discuss whether these are the right priorities
    ii. discuss interventions already in place to tackle identified priorities

Board Members raised the following comments:

1. Kate Morton stated that the priorities should not be seen in isolation, e.g., there was a crossover between mental health and a number of other

priorities.

2. Mary Kearney-Knowles suggested that there was a need to look at what individual organisations and the ICB did differently and how resources could be moved around e.g., to support children and young people. She suggested identifying 3 areas and looking at current impact and then reviewing this at a future date.
3. Richard Smale referred to the ICB transformation work which was looking at how to deliver services differently.
4. Cllr Dine Romero suggested that social prescribing should be a future agenda item for the Health and Wellbeing Board.

The Board **RESOLVED** to;

1. Note the findings from the public consultation and feedback from stakeholder engagement sessions with third sector organisations.
2. Note the proposed priorities for the new Joint Health and Wellbeing Strategy 2023-2030.

38 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2021-2022

Becky Reynolds gave a presentation on the contents of the Public Health Annual Report 2021-22 as summarised below:

Chapter 1 – Impact of Covid 19
Summarised the far-reaching impact of the pandemic on the population, giving voice to local people and organisations that responded to the challenge.

Chapter 2: The Health of Children, Young People and Families
An overview of health and wellbeing indicators, summarising challenges including the impact of COVID-19 and the cost of living crisis, and providing examples of action taken to improve the lives of children, young people and families and reduce inequalities.

Chapter 3: The Importance of Our Places
Gives examples of innovative ways in which partners have worked together to further strengthen health and wellbeing through developing the places in which we live.

Chapter 4: Recommendations:

1) Implement the B&NES Living Safely and Fairly with COVID-19 Plan
2) Further strengthen the targeted action to support children, young people and families outlined in the Children and Young People's Plan
3) Ensure that the new B&NES Local Plan and the B&NES Economic Strategy that are being developed, both maximise their potential to reduce inequalities and make it easier for people to live healthy lives
4) Update and implement the B&NES Health and Wellbeing Strategy, ensuring it has a strong focus on addressing inequalities
5) The NHS to increasingly embed prevention and inequalities action into its priorities, and be helped to increasingly support social and economic development in B&NES
6) All partners of the Health and Wellbeing Board, the Integrated Care Alliance, and the Future Ambitions Board, commit to and deliver on action to improve

health and reduce the inequalities that previously existed and have been highlighted as a result of the pandemic

Indicators

- The report contained a list of indicators taken from Public Health Outcomes Framework and other key sources
- Indicators were particularly chosen to show the areas of greatest challenge
- These would inform identification of priorities in the Joint Health and Wellbeing Strategy

The following comments were raised by Board Members:

1. Val Scrase referred to the indicators in relation to hospital admissions for children and young people and stated that Health providers had identified this as an area of concern.
2. Paul Harris commented that the report did not refer to long covid and asked how this would be addressed. It was noted that there were long covid clinics in B&NES, but in terms of looking forward, the Local Authority would need to consider how to support people suffering from long covid.
3. There was only 1 positive indicator listed. There were other positive indicators, but the report focused on areas for improvement.
4. The report would need to feed into the ICA to consider the implementation of the recommendations and Laura Ambler undertook to speak to Becky Reynolds about how the priorities would flow into the wider system.

The Board **RESOLVED** to;

1. Receive the report.
2. Support dissemination and implementation of the recommendations in the report.

39 **HEALTHWATCH CONTRACT**

The Board noted the Healthwatch Contract Update.

ACTIONS ARISING FROM THE MEETING

Issue	**Action**	**Action Lead**
Housing and Health	Graham Sabourn, Laura Ambler and Paul Harris to meet to discuss the issues raised in more detail and report back to the next meeting of the Board.	Graham Sabourn/ Laura Ambler/ Paul Harris
Public Participation in Health and Wellbeing Board meetings	Paul Harris, Kate Morton and Laura Ambler to discuss.	Paul Harris/ Kate Morton/ Laura Ambler
Community Safety and Safeguarding Partnership (BCSSP) Annual Report	Any queries or suggestions of additional areas for consideration for BCSSP to Mary Kearney Knowles/Suzanne Westhead.	All Board Members
Social Prescribing	Social Prescribing to be included as	Kate Morton/

	an agenda item for a future meeting of the Health and Wellbeing Board.	Laura Ambler
Adult Social Care Discharge Fund	Paul Harris to be included in future discussions with Suzanne Westhead and Laura Ambler about proposed schemes.	Suzanne Westhead/ Laura Ambler/ Paul Harris

The meeting ended at 12.45 pm

Chair .....

Date Confirmed and Signed .....

Prepared by Democratic Services

healthwatch Bath and North East Somerset

healthwatch Swindon

healthwatch Wiltshire

How did people living with mental ill health access services during the pandemic?

Contents

Report summary

What is this report about?

Over the last few years, mental health has been discussed as a key issue nationally and locally across Bath and North East Somerset (BaNES), Swindon and Wiltshire (BSW). This project is a joint project between Healthwatch Swindon, Healthwatch Bath & North East Somerset and Healthwatch Wiltshire.

We worked with the Care Quality Commission (CQC), the independent regulator, to support the delivery of a continuous programme of engagement to hear the experiences of people accessing a named health and/or social care service while suffering with severe mental ill health.

What did we do?

The project was carried out during March 2022, and included an online survey, paper questionnaire and direct engagement sessions in BaNES and Swindon. The majority of data collected during this period provided a snapshot of people's feedback.

We also used information collected from a range of different projects during 2021 and the first quarter of 2022, from across all three areas.

The description of 'severe mental ill health' was not used throughout the data collection process as there is no clear definition of this and it was thought it may deter people from sharing their experiences. It was noted from feedback to the surveys and engagement that the thresholds for accessing care and support are high and can be a barrier to getting help. In this way, people could decide for themselves whether to participate in the survey.

It should be noted that the short timescale allowed for engagement meant that some partner organisations were unable to respond in time and Covid restrictions further impacted our engagement in patient settings in BaNES and Swindon.

The first part of this report looks at key findings and recommendations from across the BSW area, followed by a more detailed review of each of the three localities.

What were the key findings?

Key findings across BSW included:

- The most common theme was people living with mental ill health are unable to access mental health services.
- People feel that mental health services should be preventative rather than reactive.
- Access is reliant on very high thresholds for receiving care; ongoing support should be provided that is more tailored to the individual.
- Waiting lists are very long and people felt they 'get lost' in the system.
- Some people reported that they found their mental health issues made it more difficult

to access services, particularly when they were in crisis.
- The transition from children's to adult services is problematic, with a perception that you have to start again.
- Carers feel they are not being listened to and as a result their own mental health is being adversely affected, which can impact negatively on the person they are caring for.
- Care coordinators are overstretched, with a high turnover, which further impacts on unpaid carers and service users.
- Feedback about individual services or types of service was very mixed. Voluntary and community organisations providing support services had more positive feedback, while health service providers received more negative feedback. GP services received a very mixed response. Many people recognised the lack of resources and staffing as the problem rather than a lack of will or intention.

Feedback also highlighted gaps in services:

- There is a gap in mental health services for people with autism and/or learning disabilities.
- It was felt that better mental health support is needed across the area for LGBTQ+ people.
- There is a gap in children's mental health support, with long waiting lists, little or no support while waiting to be seen, home educated children falling through the gaps, and children under five not being catered for.
- People with eating disorders and those suffering from trauma/PTSD are getting limited support.
- The rural nature of Wiltshire and BaNES meant these areas had unique issues, with the bulk of the services not being available outside of the urban areas leading to isolation and a lack of access to services.

We also noted comments on the CQC's feedback process, with people finding questions off-putting, too formal and challenging to complete.

Conclusions and recommendations

The feedback we have collected clearly shows that mental health services are insufficient in meeting the needs of the populations of BaNES, Swindon and Wiltshire and our recommendations reflect this. We recommend that significant training and additional support is provided, particularly across the less well-served areas, such as children's services, eating disorders, and for people suffering from trauma.

Introduction and background

Healthwatch champions the views of the public for health and social care. We are an independent statutory body, with the power to make sure NHS leaders and other decision makers listen to feedback and improve standards of care.

This report focuses on the findings of a survey and engagement looking at the experiences of people with mental ill health in accessing health and social care services across Bath and North East Somerset, Swindon and Wiltshire (BSW) region.

Healthwatch BaNES, Healthwatch Swindon and Healthwatch Wiltshire worked with the Care Quality Commission (CQC), the independent regulator of health and social care in England, to support delivery of a continuous programme of engagement to hear the experiences of people accessing a named health and/or social care service while suffering with severe mental ill health.

Over the last few years, mental health has been discussed as a key issue nationally and locally across BSW.

The CQC's new strategy outlines its ambition to regulate services driven by people's needs and tackle inequalities in health and care.

A key aim of this strategy is to hear from those "experiencing the greatest health inequalities and most likely to face barriers in accessing care and poorer health outcomes" by encouraging them to share their experiences through trusted local intermediaries — such as Healthwatch — in a way that is accessible to them.

What did we do?

We reached out to people who experience mental ill health and organisations working within the BSW area, asking them to share their experience of health and social care throughout 2021 using a number of different engagement methods.

We developed and ran a survey for four weeks to gather feedback based on the CQC questions and shared it on our websites and social media channels. It was also shared by charities across Swindon and BaNES. We received a total of 109 responses to the survey.

In Swindon and BaNES, we engaged with statutory and third sector organisations, and with their clients and service users, by joining their events and organising additional groups.

In Wiltshire, feedback came from a variety of sources, including the Wiltshire Mental Health Open Forum, a monthly online meeting room where service users and carers can talk directly to Avon and Wiltshire Mental Health Partnership Trust (AWP), as well as community engagements between January 2021 and March 2022, such as a Wiltshire Parent Carer Council event.

Healthwatch Wiltshire worked with Wiltshire Service Users' Network (WSUN) to hear the views of 43 people with autism and 49 carers on services. In August 2021, we heard the views of 28 young people who identify as LGBTQ+ (Lesbian, Gay, Bisexual, Transgender and Questioning) about the support available to them in Wiltshire. In May 2021, we published our report into the Bluebell Unit, a Place of Safety, where we asked people living with mental health illness about their experiences of accessing services and help.

We also used existing data that had been collected across BSW in 2021 including KS2's What's Going On event and a previous joint Healthwatch project, What local organisations think of mental health support.

Who did we hear from?

We heard from a range of people including service users, carers, community and voluntary organisations and health and care service providers.

The survey we ran in Swindon and BaNES received 109 responses, we also engaged through events and regular meetings with:

- 15 organisations in BaNES, including KS2, AGE UK Bath and North East Sommerset, Julian House, and Bath and North East Somerset Carers Centre.
- 10 organisations in Swindon, including Swindon and Gloucestershire Mind, Swindon Carers, Swindon SEND Family Voice and Swindon Advocacy Movement.
- 8 organisations in Wiltshire, including Avon and Wiltshire Mental Health Partnership NHS Trust (AWP), Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group (BSW CCG), Wiltshire Service Users Network (WSUN), Wiltshire Parent Carer Council (WPCC), Rethink Mental Illness, Alabaré, Wiltshire MIND, Bluebell Unit Place of Safety.

A full list of organisations can be found in the Appendix.

Locality reports for BSW

What people told us in Bath & North East Somerset (BaNES)

Feedback came from our survey and from one-to-one conversations during engagement sessions we attended.

We also collected feedback from Healthwatch BaNES' community pot funded projects with KS2, a peer support group for carers of people with mental ill health, and Youth Connect South West, a charity providing a range of targeted and open access services supporting young people aged 11-25.

Key findings

- Mostly positive comments on voluntary and community sector services.
- More mixed and negative comments on health and care providers.
- Long waiting lists.
- Difficulty getting an appointment.
- Issues accessing services from rural areas.
- Lack of training and support for eating disorders.
- Lack of training and support for trauma.
- Shortage of Care Coordinators (who coordinate and navigate care and support across health and care services, particularly for the frail elderly, or people with long term conditions).

Feedback about voluntary sector services was largely positive, with these services often being seen as a "lifeline", providing a safe space either in small groups with other people who also experience mental ill health, or through one-to-one support.

> Groups have been amazing, gives me a focus – Bath Mind open opportunities, Creativity Works writing group, wellbeing walks, Carers Centre groups. If at home in four walls, it would be different.

> KS2 (carers peer support group) has been really supportive and AWP are improving the way they work with carers.

Feedback about health and care services was far more mixed. There was significant negative feedback concerning the difficulty in accessing mental health support in general, and in relation to specific services. Feedback about GP services as the first point of contact to mental health support was very mixed.

> It's soul destroying trying to get help for mental health. To ask for help is so hard and then to get pushed around services makes you feel like giving up and that you shouldn't seek help in the first place. Mental health professionals in AWP are generally really lovely people, but the system is inefficient and unhelpful.

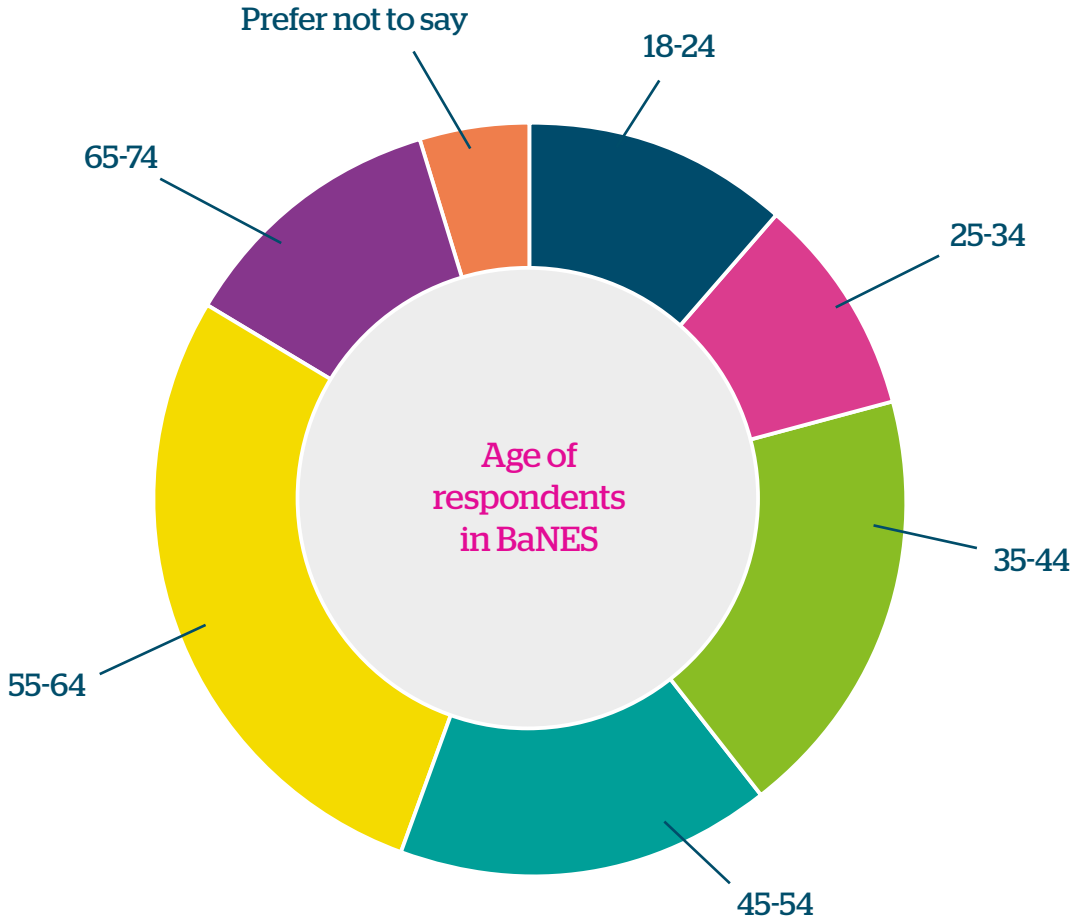
Feedback from our survey

45 people in BaNES responded to our survey.

- 83% were female, 12% were male, 5% were non-binary.
- 93% of respondents were White British.

When we asked people about accessing support during 2021, 30 people said they had and 15 said they hadn't. For those who did access services six people had a positive experience, 17 were mixed, and 17 were negative.

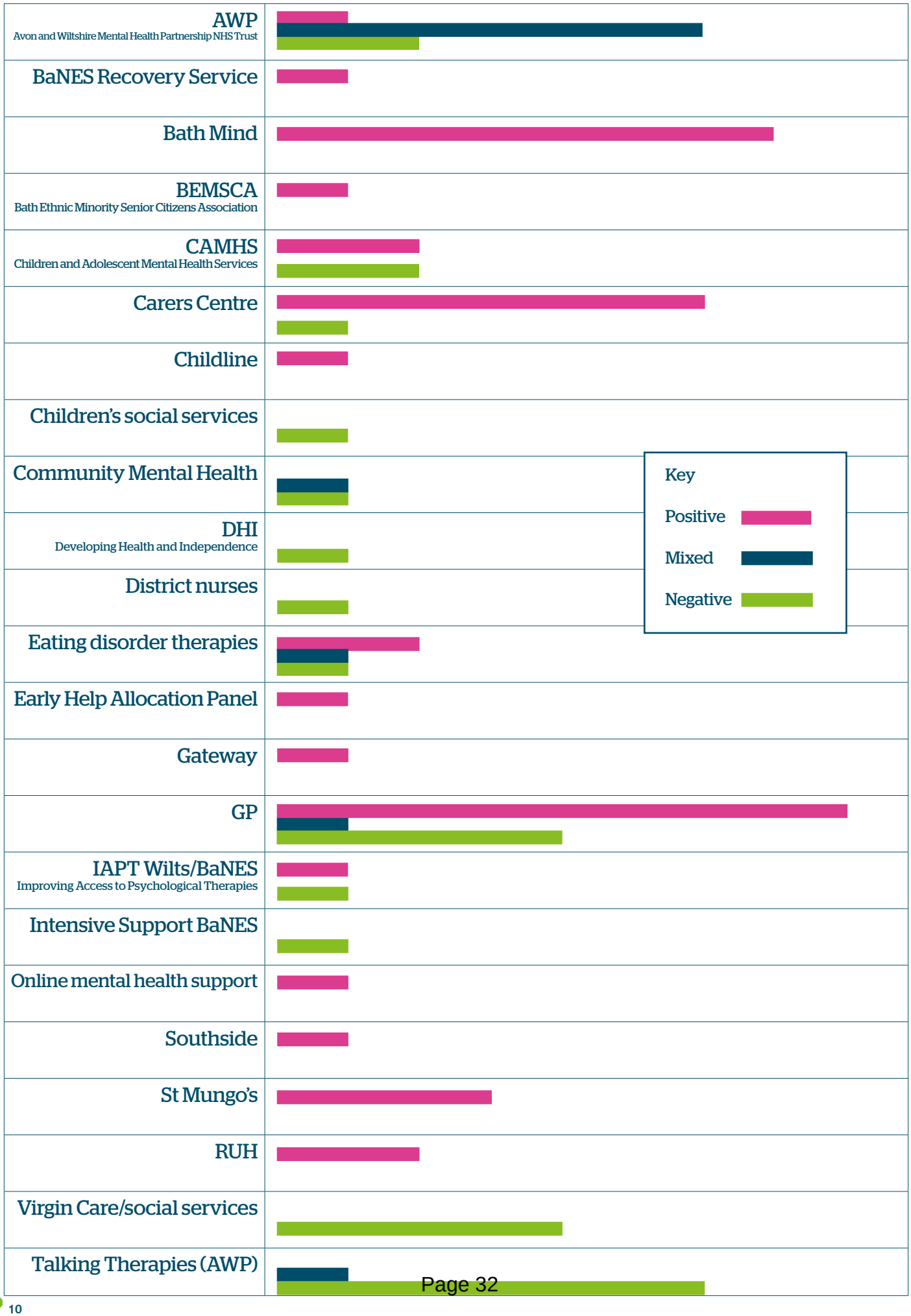
Twelve people shared their experience with the organisation they were accessing but 24 did not.



The graph on the next page illustrates the feedback received about services in BaNES, and whether the feedback was positive, negative or mixed.

Full demographics can be found in the Appendix.

Feedback on services in BaNES



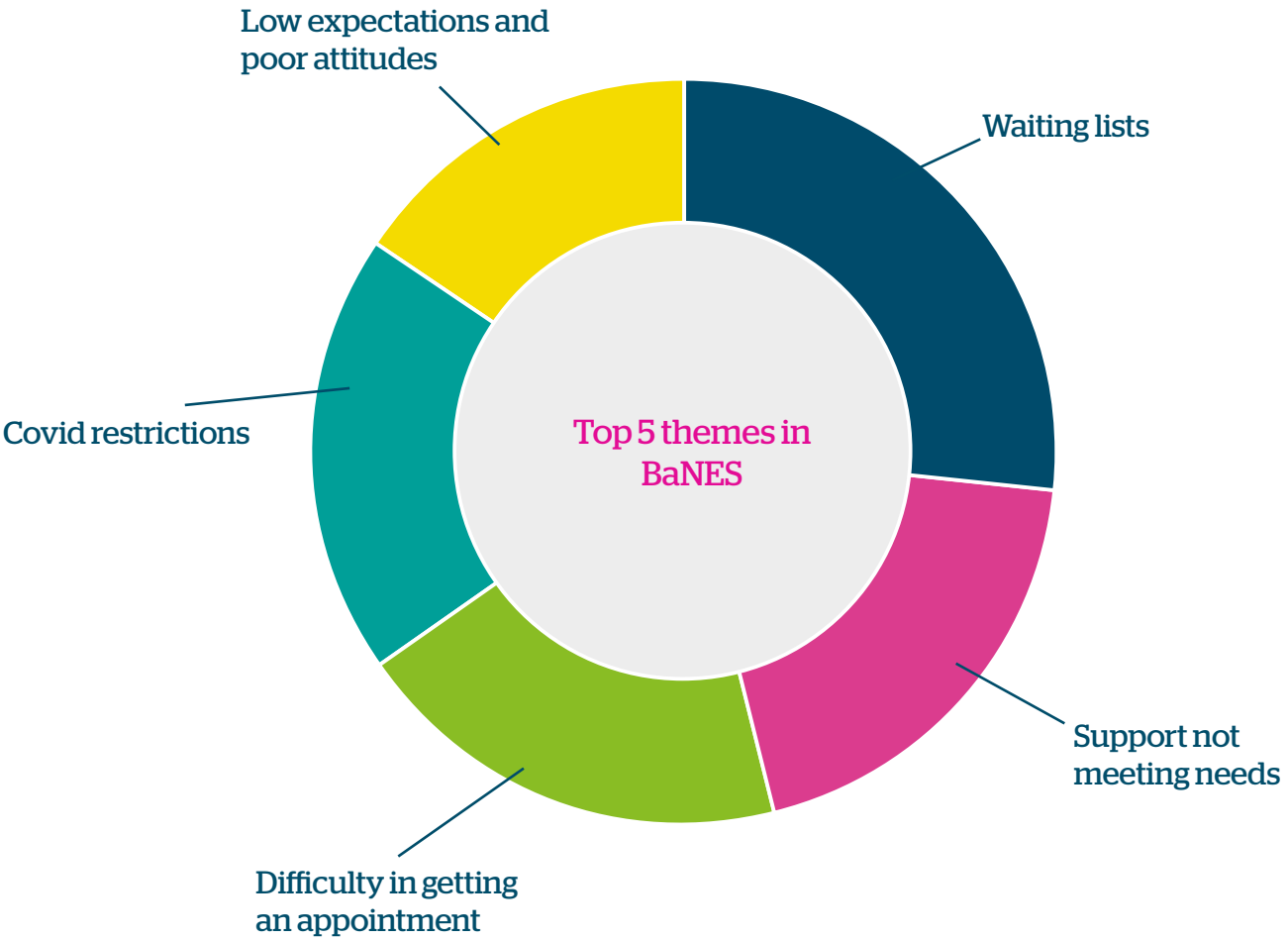
A number of comments were received via the survey from people who had experience of complex Post Traumatic Stress Disorder (PTSD) about the need for trauma informed care and the impact of trauma not being recognised or being dealt with in a trauma informed way.

> Virgin Care, mental health services all under-resourced and with staff who aren't adequately trained to deal with people who have complex PTSD. These services have re-traumatised me and I now I'm planning an assisted suicide at Dignitas because it is easier to get an assisted suicide on a bureaucratic level than to get help from BaNES services.

38 people responded to our question about the barriers they faced if they did not access services in 2021 and these were grouped under common themes.

The top 5 themes from the survey were:

- Long waiting lists impacting on the balance between people's ability 'to maintain positive aspects of their life over 'unhelpful coping strategies'. (7)
- The support on offer not meeting needs (gaps or lack of options in service). (5)
- Difficulty in getting in contact with services or making appointments. (5)
- Covid restrictions. (5)
- A combination of low expectations and poor previous experience with (perceived) poor attitudes of staff. (4)



Feedback from engagement

Feedback from other engagement ,including KS2 and Youth Connect South West reports, highlighted similar themes.

KS2 worked with homeless charity St Mungo's to carry out research into the experience of carers and those with mental ill health in accessing services. They gathered data from questionnaires and focus groups between August and October 2021, and led the What's Going On conference in November 2021 (funded by Healthwatch BaNES).

Feedback from the KS2 report highlighted 'being bounced around services' and having to 'keep retelling their story' as the biggest barriers. One respondent made this suggestion:

> A way in which the patient could upload information they want to share with multiple agencies so that they don't have to keep repeating themselves and waiting for initial appointments — would speed up the process and prevent some wasted time.

Youth Connect South West, carried out a project facilitated by young people with lived experience in acting as 'mental health inspectors' and produced a report of their findings.

Feedback included comments from young people about accessing services around mental ill health including the availability of information and preventive support.

> They need to be more friendly and welcoming, offer regular appointments and long-term support.

> More help for urgent/crisis mental health issues.

> I would like someone to talk to who isn't family, friends or school.

> Needs to be spoken about a lot more in schools.

> We need more help and more education surrounding help and where to find it.

Child and Adolescent Mental Health Services (CAMHS) was criticised by young people taking part in the Youth Connect South West project. They saw the wait to access the service in BaNES being very long, and Keynsham (where the local CAMHS is based) wasn't viewed as being easy to get to. Young people also expressed concern about confidentiality.

The Youth Connect South West report also raised issues around accessibility, signposting and referrals, high thresholds for accessing care and support and transition from children's services to adult services. Many of the negative comments referred to feeling unheard, being a burden or people not properly listening to them and just being asked a 'tick list' of questions. Conversely, there were positive comments about services, and comments that problems were due to a lack of resourcing and services being overwhelmed.

Issues and gaps

Travel within rural areas and digital accessibility

Transport was a particular concern of young people who were reliant on public transport. Generally, accessibility was an issue for people living in rural areas outside Bath. There was a desire to maintain options for virtual support.

> Not to assume everyone is Bath based or lives in an urban area. Keep remote/online appointments. Transport help (for rural areas).

> Video sessions as opposed to via telephone (no face to face due to Covid). Preferred having my sessions in the comfort of my own home.

Signposting and referrals (including self-referrals)

The Youth Connect South West report noted that there are a lot of mental health and wellbeing services offered to children and young people in BaNES but people said it was difficult to find the right services for the user and find what support is needed.

> Support is needed for those with mental health issues to transition from mental health support groups and services to mainstream groups...There seems to be a real gap in this type of support and it can keep you feeling trapped in a mental health system... Treading water to survive life, rather than feeling able to move forward and thrive.

> I self-harmed and ended up in A&E, RUH. The mental health staff were very helpful. They said they'd inform Social Services about my needs and I was referred to the Wellbeing Service. It took five months, but they helped me to find the Bath Mind open opportunities group.

> Didn't know who to contact, didn't feel like my difficulties were "serious" enough.

Waiting times

These were integral to much of the feedback received.

> Instant support, not waiting months where things get a lot worse.

High thresholds for accessing care and support

Being 'not ill enough' was a common theme, with carers also reporting this in relation to the person they care for. One person said their partner only began to access the support needed after a safeguarding issue was raised for themselves. The issue was also raised in feedback concerning accessing eating disorder services.

> People go from one crisis to the next. Can only get in hospital now if you're sectioned.
>
> *KS2 report*

> If you're too ill for Improving Access to Psychological Therapies (IAPT), you're on a waiting list (10 months for a therapy service).

> For individuals with deep rooted trauma, more trauma informed-care is needed.
>
> *KS2 report*

Lack of eating disorder services in BaNES

Specific feedback was received about the shortfall in local eating disorder services:

> Fantastic support at Southmead (Bristol), but why does an 18 year old have to get severely underweight and unwell before action is taken.

> My experience of Southmead was vastly better than RUH in its approach to treating eating disorders... at the RUH they were understaffed, under skilled in how to approach mental health issues... Only two dietitians in the entire hospital and again, they had no knowledge on treating eating disorders and could not appreciate it as a mental health condition with physical side effects.

> The RUH needs to be more geared towards eating disorder provision. Essentially the Bath area should have an eating disorder unit and outpatients service.

Individual and one to one services

There were a number of comments that highlighted the lack of individualised services, including Talking Therapies, that met people's needs but it was recognised that resources are limited.

> Would like a more holistic, person-centred approach from psychiatrists, ie less medication (because of the side effects and the positives being over stated) and more emphasis on other outcomes – work, housing, peer support, etc.
>
> *KS2 report*

Lack of care coordinators/lack of beds

> For Community Mental Health Team to have more care coordinators that know about person centred care as well as Dialectical Behavioural Therapy [a type of talking therapy]. Clear pathways. Not having to wait until you're in crisis to get support (which often makes things worse).

What organisations in BaNES told us

Key findings

- People with mental ill health represented 32% of families receiving support from Southside (family support and play).
- Challenges with the transition from children's to adult services.
- Lack of social prescribing for children and young people.
- An increase in number of children and young people showing signs of mental ill health.
- An urgent need for more trauma informed services, with a doubling in referrals for specialist trauma therapy from 2021-22.
- Gaps in access to clinical mental health services for serious mental ill health among homeless and Gypsy, Roma, Traveller and Boater communities.
- Carers tell us they were traumatised during Covid by the burden of caring without support services.

The themes identified during our engagement included the extent of mental ill health experienced by their service users, with particular reference to the impact of trauma, and issues around both the range of services available and the need for better information and accessibility to those services.

3SG (the third sector support group for BaNES), who carried out their annual survey from October to November 2021, found that the top three unmet needs, from the 97 organisations responding, were "mental health, isolation and loneliness and access to support and advice", all relevant in the context of the findings of this report.

One of the respondents commented that in relation to the level of need that they were "more complex needs than anticipated, made worse by Covid-19".

Southside, who provide family support and play, including support for people experiencing domestic abuse and mental ill health in particular in the more deprived areas, reported that in 2021, 25% (125) of the 501 new referrals to their Family Support and Play project included mental ill health as an issue; and, that 32% of people/families receiving support in 2021 (including those carried over from 2020) were dealing with mental ill health issues. When assessments were included for people experiencing mental ill health, the figures included 262 people in 2021 experiencing emotional domestic abuse and 98 with a mental health problem.

Issues raised by **Children and Young People's Network** (CYPN) when discussing the mental health needs of children and young people included:

- The transition from children's to adult services, with this being particularly difficult for care leavers and for those with an SEND diagnosis (Special Educational Needs) where there can often be a 'cliff edge' where a young adult goes from a high level of support as a child to zero support as an adult.
- The impact of an official diagnosis of a learning difficulty or autism, which prevents access to mainstream mental health support even where this is separate to the learning difficulty.
- The lack of data available in BaNES about the extent of early childhood trauma, in part due to the lack of services and also due to a lack of means for early diagnosis.
- A large increase in 'school refusers' over the past two years, primarily related to mental ill health and at least in part an impact of Covid, and a corresponding increase in home schooling with a subsequent lack of access education based mental health support.

Youth Connect South West highlighted the lack of social prescribing for children and young people, and an emphasis on medication as the first offer from GPs. Youth Connect suggested that if social prescribing was extended to children and young people it could provide 'pre-CAMHS' support while children and young people were waiting for a higher level of assessment and support. They also flagged up a large increase in Educational Health and Care Plans for those with mental health needs. Youth Connect's report summarises the issues identified and makes recommendations for support for young people.

Bath Mind provide a wide range of services across Bath and North East Somerset, for adults and for children and young people aged 16+, with an additional project for children moving from primary to secondary school. They found that during the pandemic, new lockdown announcements or changes tended to trigger surges in calls and emails. For example, there was a 50% increase in referrals for counselling in November and December 2021. They also reported that economic factors also had a big impact on calls for support related to people's mental ill health such as cost of living increases and the ending of the uplift in Universal Credit — and that these also impacted on safeguarding concerns.

Breakthrough provide specialist trauma therapy and psychotherapy groups for adults from their support centre in Twerton, Bath, as well as training for organisations. They highlighted the complex, deep seated and long-lived adverse issues that can arise from unidentified and untreated trauma, and that if trauma is recognised and treated quickly, the likelihood of recovery and prevention of future adverse impacts is much greater.

Breakthrough reported a doubling of new referrals (to 240) in 2021 for specialist trauma therapy compared to 2020, and are doubling their provision of group sessions in 2022. Their view was that there is an urgent need for more trauma-informed services both within and outside health services, as the more organisations are aware of, and can help identify the signs of, trauma — whether in schools, businesses, the criminal justice system or voluntary organisations — the more people can be diagnosed and effectively supported to recovery.

Genesis Trust - Gateway Centre provides a range of support services to vulnerable people, including the Life Course, designed to support people to move from addiction or poor mental health to living well in recovery through a 10 week programme.

They told us that 96% of people coming in to the Gateway Centre have experienced early childhood trauma and that as the AWP's Talking Therapies is not suitable for people in crisis, they frequently receive referrals from Talking Therapies and GPs to support people in crisis through this particular course. They reported that there is a constant waiting list and the course is not suitable for everyone, with gaps around people with learning difficulties and also those with addictions.

Julian House provides a wide range of services including the direct access hostel in Bath city centre, homelessness outreach, and support for the Gypsy, Roma, Traveller and Boater communities.

During engagement with Healthwatch, managers reported that while physical health services for people experiencing homelessness were generally good with a GP and nurse operating out of the Manvers Street hostel, and that a mental health nurse was available for outreach, the main gap was around access to clinical mental health services, including clinical psychologists able to deal with serious mental ill health in particular, underlying trauma, which impacted on 100% of hostel residents.

It was reported to us that health professionals from AWP often assumed that if someone was

homeless or resident in the hostel that their primary issues related to substance misuse, and that these issues needed to be addressed before support could potentially be provided.

BaNES has a large **boater community** of around 500 people with additional Gypsy, Roma and Traveller communities. Julian House operates a GRTB project in support of these communities. The project manager said that the impact of a lack of a settled address, and the No Fixed Abode status created an additional barrier to accessing the mental health services, such as counselling and psychotherapy.

Feedback collected from engagement between Healthwatch and carers at **Bath Carers Centre** echoed the responses to our survey, mainly that carers' mental health was negatively impacted by the pandemic with many saying that their experience in 2021 was worse than in 2020.

A number of carers reported being traumatised by the experience of caring during the pandemic when support services were reduced, schools shut down, and having reduced family support.

Engagement with **Avon and Wiltshire Mental Health Partnership NHS Trust** (AWP) was limited to an in-depth one to one conversation with the partner carer of an AWP patient. The individual outlined the lack of health and social care for their partner. With a number different mental health conditions, they've had to pay privately for a carer because there is no support available to them.

What people told us in Swindon

People across Swindon provided feedback through March 2022 via the online and paper questionnaire and from engagement events across Swindon, including a pop-up mental health survey in Swindon town centre.

Key findings

- Barriers to accessing support was a key theme.
- Health providers received more negative feedback, with feedback about voluntary services more positive.
- There is a lack of support for children and young people, with many feeling lost in the system, particularly as they transition from child to adult services.
- Waiting times are too long, and were exacerbated by the pandemic.
- There is a lack of understanding and support for people with complex mental health needs.
- There is a lack of information and signposting to services available.

Feedback from our survey

62 people in Swindon responded to our survey.

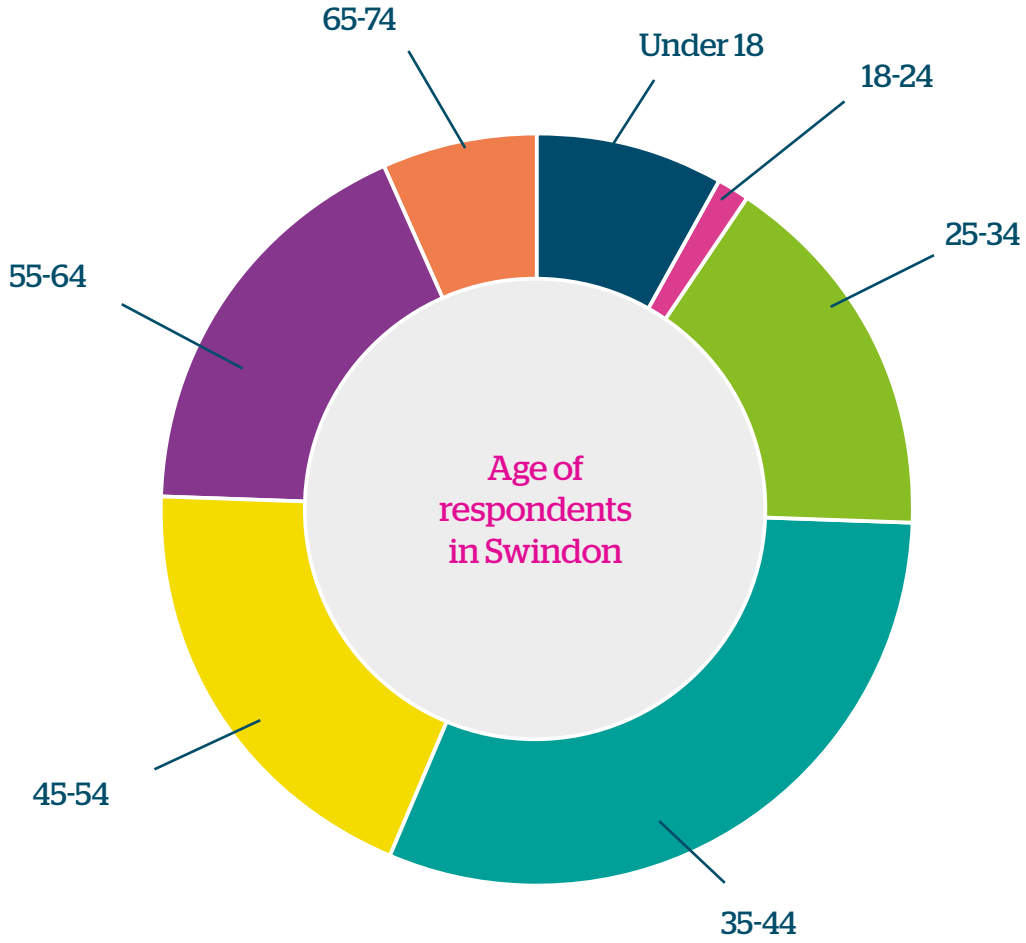
15% were male, 78% were women and 7% were non-binary.
83% of respondents were White British.

51 people said they had accessed support in 2021 and 11 said they hadn't. Ten people had a positive experience, 30 gave mixed feedback, and 20 said they had had a negative experience.

19 people shared their experience with the organisation they were accessing but 24 did not.

When we asked people in Swindon if they consider themselves a carer, 41 said yes and 37 said no. 63 people told us they lived with mental ill health or cared for someone who did. 26 said their mental health had been impacted as a carer. Half of the respondents said they or the person they cared for had a disability.

Full demographics can be found in the Appendix.



Feedback about specific voluntary services who provide one to one and specialist support was mostly positive, with particular reference to Shine, a charity supporting postnatal depression, (PND) and IPSUM (a mental health and wellbeing centre in Swindon). We also heard positive feedback about the support in schools, including play therapy.
Feedback about health services was far more mixed, while still receiving positive feedback

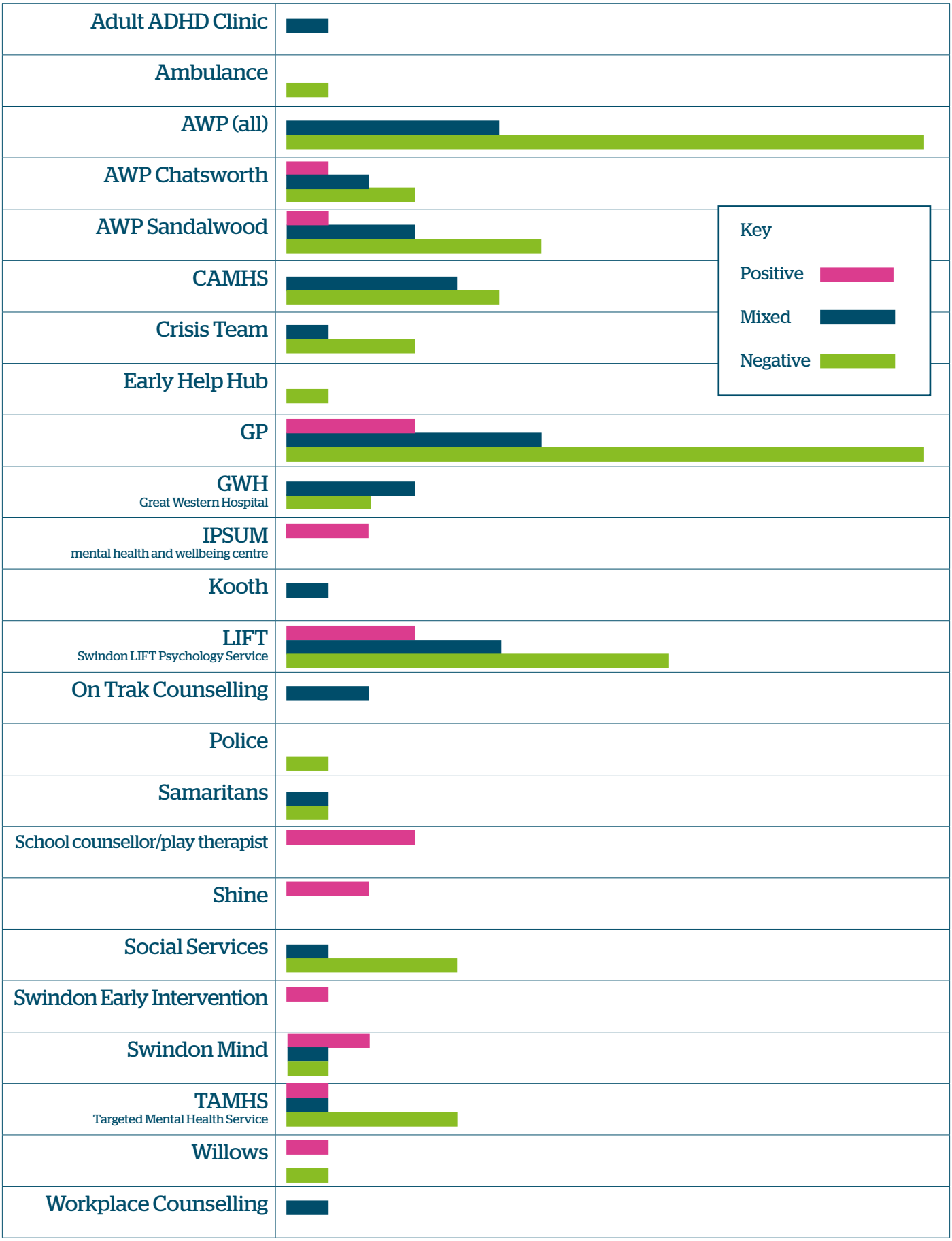
> My son was having a very difficult time, school organised play therapy straight away which helped improve his mood and behaviour both at home and at school.

> Shine is fantastic, honestly saved me 10/10.

there was a significant amount of negative feedback relating to the difficultly of accessing mental health support through GPs and about specific services including AWP, LIFT Psychology (part of AWP), GP surgeries and CAMHS.

The graph on the next page illustrates the feedback received about services in Swindon, and whether the feedback was positive, negative or mixed.

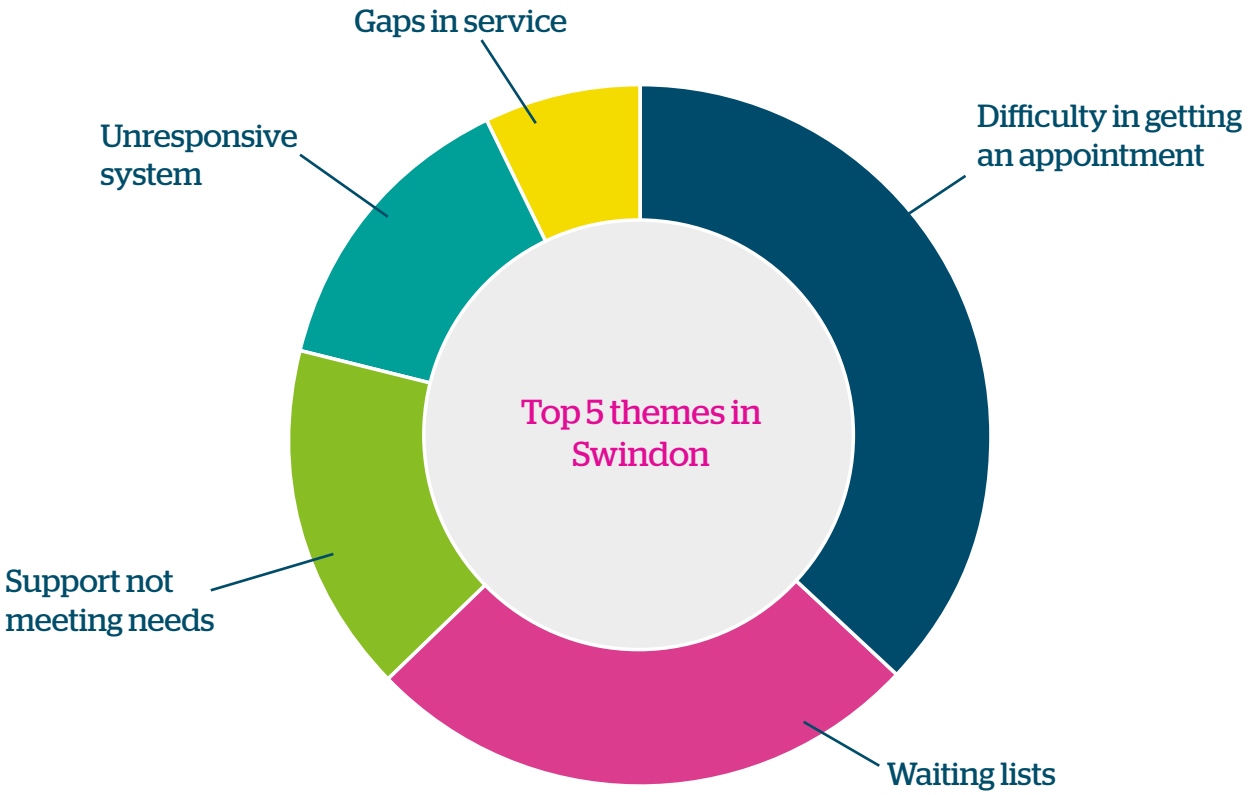
Feedback on services in Swindon



We received 52 responses to our question about the barriers people faced if they did not access services in 2021.

The top 5 themes from the survey were:

- Difficulty in getting in contact/appointments (16)
- Waiting lists (11)
- The support on offer not meeting needs (gaps or lack of options in service) (7)
- An unresponsive system (going round in circles) (6)
- Lack of staff/gaps in service (3)



> My GP practice told me they were "unwilling to throw any more medication at this" and told me to access LIFT. I tried but could not get booked onto a session. This had a detrimental affect on me. The work-based counselling service was excellent but could only offer a limited number of sessions.

> The waiting time is a huge challenge, people are reaching out for help and it doesn't come soon enough.

> TAMHs/CAMHS one year wait. There needs to be something in place in the interim. Partnership working could provide advice and support. Allocated support workers, linking with the community navigators.

> Referred by GP for Mental Health (MH) assessment, MH team failed to call me back, failed to arrange appointments, failed to treat me like a person. When I had a bad evening, I rang the intensive team and got hung up on. I have since decided not to seek help from AWP/ NHS and suffer alone, in silence.

Issues and gaps

Examples of responses highlighting the gaps and issues are set out below.

Children's and Young People's services (CYP)

> Parents and carers lots of help and advice aimed at adults or specific pathway but there are blocks in the way for children. No one takes accountability to help them.

> How do home educated children access mental health support? There is nothing.

> Not enough support in school or services to support parent/family and child support. Personally found results are better when family-child counselling is offered.

> Young people are diagnosed but then not offered the tools/services to support them.

> Family/carers are often getting lost. It needs to be people first.

> Under 5's often 'not allowed' to use services. Need to be more preventative and talk to the families from pre-school.

Transition from CYP to adult services

> Young people on the brink, needing service but get overseen because the support process is too slow and then get lost as they transition in to adult care.

> When someone reaches 18 moves to adult services and the transition doesn't work. Have to start again.

> Need to bridge the support, from younger people to 16+ etc.

Waiting times

> Lack of support for wife, who suffers from depression, anxiety and PTSD, from GP and LIFT.

It is a minimum 5 months' wait to access services.

GP too quick to prescribe medication, people often need something more therapeutic, need more social prescribing.

Service user has found IPSUM and Mind really helpful. During 2021, Covid didn't make anything worse, it just highlighted how hard things are for mental health support.

Covid stopped a lot of the service user groups early 2021. But as the year progressed, Live Well really helped to find new groups to join and has been a great pillar of support.

Just wanted counselling and couldn't find a service that could offer it, without having to pay. Covid made this even harder and still not managed to find someone.

During 2021, the service user reached out for help with their depression and was told it wasn't bad enough to need help.

Gaps in services

Lack of understanding of specific conditions. Adults with brain injury often feel there is no one out there to help manage situation, there are gaps.

DASH [Diagnostic, Assessment and Stabilisation Hub] – adult diagnosis the delays are huge; it can be years. Upskill and more resource for this. Need support coming to terms with diagnosis.

People who are transitioning in their sexuality don't have a lot of support avenues in Swindon.

An ex military veteran expressed the opinion that they received no support for their complex mental health needs in Swindon. The only people that could support them were Help for Heroes and they had to travel. The two respite beds that were offered to people from the area have now gone.

Service user experienced a break down, felt unable to ask for help at first and then has been unsuccessful in finding counselling. Mind has offered some support, but feels like she's bounced around from one place to the next, just looking for someone to talk to.

> Person has ADHD [Attention Deficit/Hyperactivity Disorder] and living with autism. He has experienced delays in assessment and then support/provision of services.

> One size does not fit all.

> Pre Covid-19 I was using the Active Life services of AWP Swindon out at Sandalwood Court. The services are no longer available to those who accessed them from the community, I know this from personal experience. The issue needs re-addressing and reconsideration applied for better mental health all round.

Lack of signposting and barriers for carers

> Unless you know services are out there it's hard to access them. Need a central resource library for all services.

> Lots of people with mental health issues stop engaging with services but if they have a carer and the person with issues stops, they lose the support too. It might help equip the family to help and maybe get the person to reengage.

What organisations in Swindon told us

Key findings

- There was an increase in referrals to mental health services in Swindon in 2021.
- Local police told us that mental health was one of the biggest issues they faced in 2021.
- There is a need for advocacy support for people with learning difficulties and autism.

Swindon SEND Family Voice, which is run by parents of children with additional needs, reported on the requests for support they had received from January to December 2021. They told us they have had 127 mentions of support around mental health in this period, with 92 cases that mentioned parent support. Most were seeking signposting to services that could help them or act as a listening ear. The overall picture was that mental health is something that carers and young people themselves raise and ask for support with.

Swindon and Gloucestershire Mind, which provides mental health advice and support, said they had seen an increase in referrals and requests for support around mental health in 2021, with the largest increase in Quarter 3 of 2021 (July to September) with 88 referrals in 2020/2021 and 199 for the same quarter in 2021/2022.

Swindon Police told us one of their biggest issues over the last year was mental health, with people calling the police for support due to lack of out of hours support elsewhere, or calling in a crisis because the dedicated crisis service can't see them for a week. Ambulance staff also call to say they can't get to a patient in need and ask the police to help.

Within the last three years (March 2018-March 2021) **Swindon Advocacy Movement** (SAM) have had 93 referrals for their Adult Community Mental Health Advocacy Project, which supports people moving from inpatient mental health services to living independently, and to help reduce an individual's need for mental health support.

52 of those referrals were self-referrals, 15 were from health services (AWP/NHS/GP/hospital), seven were through Swindon Borough Council, five were from the mental health charity Mind, four were done internally within SAM, two were from family members, and the rest were other services and organisations (Rethink, Swindon Carers Centre, TWIGS, Turning Point, Wiltshire Wildlife Trust, Catch-22 College, Mountford School, Together for Mental Wellbeing).

The Community Mental Health Advocacy Project is currently working with 22 people, but there is only one advocate working on this project. A service user described having an advocate as a "sense of safety" and "looking out for my interests". They went on to say there were a lot of things they have "struggled with" and that "thankfully you have been there".

> I like you and feel safe with you... having your support keeps my anxiety levels lower.

SAM's findings from their drop-in sessions for autistic people highlight the need for a better understanding of autism and how a diagnosis, or a lack of one, can impact on those living with autism. Here is some of the feedback they gathered:

- A participant felt things 'got worse' after being given their diagnosis. She felt it was 'too late' since she was 30 years old. There was emphasis placed on the diagnosis but not on support being offered.

- One participant assumed having the diagnosis would help her in other areas of her life and this felt it should have been explained it is not true. They were having issues at their workplace including bullying and thought having the diagnosis would fix this.
- Other participants agreed they were also diagnosed too late in life (40/50 years old), and the diagnosis should have been given when they were at school. They too thought things would be different once they had their diagnosis but felt they weren't because autism wasn't well known or understood.

> I was medicated for years for depression when it was autism and once a month I used to have terrible mood swings resulting in a hysterectomy which in fact I now know to have been 'meltdowns' exacerbated by constant stress, lack of support and monthly hormones. It took me seven years to get my son diagnosed because I did not know how to get the help he needed and my son really suffered during that time resulting in three breakdowns in three schools and eventually home schooled. Speech and Language Therapy, behavioural classes (he didn't need), schools rejecting him because of funding issue.

> We NEED fulltime advocacy, a louder voice, better protection, and longer appointment times at doctors and hospital appointments. That is crucial to our health and human rights to be listened to and have long enough to be heard and fully understand what is going to happen to us, not a rushed 10 minute appointment over the telephone.

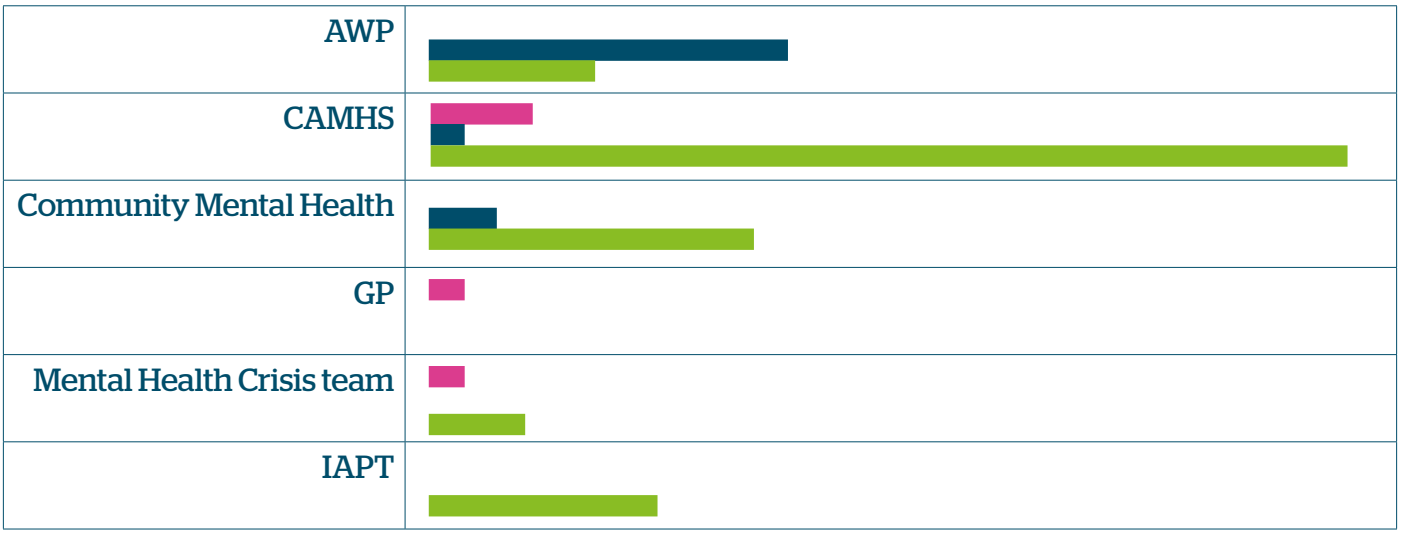
What people told us in Wiltshire

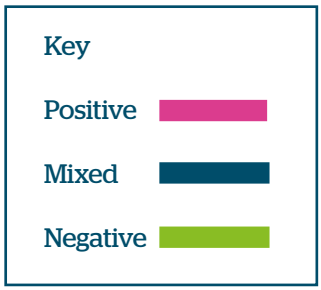
The majority of feedback from people in Wiltshire was about health providers including CAMHS (mainly negative), Improving Access to Psychological Therapies (IAPT) which is part of AWP, and the Wiltshire Community Mental Health Team, and was mixed.

Key findings

- People found it difficult to get the support they needed when facing a mental health crisis.
- There are gaps in support services for people with autism and people in the LGBTQ+ community.
- Concerns were raised around long waiting lists, with people often feeling abandoned.
- Children transitioning to adult services were met with high thresholds, or support being removed.
- Carers felt there was little support for them, and felt left out of conversations on support being delivered to their loved ones.
- People felt there was a need for more preventative help to reduce an the risk of a crisis and for more ongoing support after someone has been discharged from a service.

Feedback about services in Wiltshire





Issues and gaps

Getting help before a mental health crisis

As part of a project into Places of Safety, where people can be taken when suffering a mental health crisis, we asked people who were suffering from mental illness if they had tried to get help before they were taken to the Place of Safety. Just under half (46%) said that they had not.

Attempts to get help were made for 54% of those we spoke to, with 38% of our participants trying to get help themselves, and for 16% of participants a family member or carers tried to get help for them. They described difficulties encountered by themselves and their families in getting the support that they needed. Some people were not clear about who they had contacted, and some said by the time they reached someone, their mental health had deteriorated to a point where they were not able to engage with the support offered.

> Tried GP five times but got no positive response — told to book an appointment, having explained I was thinking of ending my life. I tried two surgeries.

> It was lockdown and I couldn't get help so I took a drug overdose. I have had PTSD for many years.

> I rang the intensive team, couldn't get help because busy. When finally able to get in touch was too overwhelmed.

Support for people with autism

There is a gap in mental health support services for people with autism, learning disabilities (LD) and neurodiverse conditions such as ADHD. While autism is not a mental health illness, feedback from both carers and service users states that the anxiety and distress that can arise from this condition is not well understood or provided for and can lead to difficulties.

> There is still a gap between autism diagnosis and mental health care. We were bounced about a lot, that we could not access mental health care as "he is autistic, he will always be like that". A person with autism can still have mental health difficulties, and this can be due to their different view of the world caused by autism. This does not mean they are beyond mental health help. Getting the autism diagnosis seems to just slam doors shut, which is not helpful, both at child and adult level.

> There is a definite 'gap' in services. Patients with autism/learning disabilities would probably answer in the affirmative, giving the impression that all was generally ok with them, because they do not have capacity to break down what it is they are feeling or going through. A carer would know what to pick up on. The patient themselves, not so much. A view of where an autistic/LD patient really was with their mental health could not be established by the Access Team from an E to A paper scale. Carers should be more involved/part of the full conversation in these incidences.

> There is a waiting list for ADD [Attention Deficit Disorder]/ADHD services in Wiltshire of between 18 months and 2 years.

In addition to difficulties with accessing support for their autism and possible mental health issues, 49% of people with autism who responded to our survey (43 people) in 2021 told us that they found it difficult or very difficult to make a GP appointment.

51% found it difficult or very difficult to explain the reason for their visit and more of them found it difficult to understand their diagnosis and the information given than found it easy.

The short length of the appointment made them anxious and did not provide enough time to tell the GP or clinician about their problem. A longer appointment and having the information written down would make a big difference for them.

They also mentioned their difficulty in coping with busy waiting rooms at GP surgeries and hospitals and that a quiet area and a map of the hospital to help them find their way would be helpful. In terms of accessing social care, help with information on community activities and support with claiming benefits and housing would be welcomed as this is a struggle for them.

Gaps in services

There is also a gap in support services for the LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Questioning) community, particularly around sexual health and access to mental health support, for those with co-existing substance misuse, those who self-harm and for those with PTSD (Post Traumatic Stress Disorder) outside of the military.

The challenge of living in a rural location with poor public transport connections to main service centres was also highlighted frequently.

> There aren't any Mental Health services for LGBTQ+ in Wiltshire.

> People that are marginalised or disadvantaged in some way (homeless, drug/alcohol issues) are usually not given access to proper long-term mental health support.

> There are no self-harm support groups in Wiltshire, only the national website, HARM for example. It was mentioned that LGBT and PTSD groups were also communities having no support [in Wiltshire]."

> PTSD... took me over a year to be diagnosed, then no help from GP or CPN [Community Psychiatric Nurse] very difficult when you are very rural!... no groups locally unfortunately.

Members of the local boating community who are experiencing mental health problems, exacerbated by Covid lockdowns and restrictions, expressed frustration at the difficulties they have faced in accessing GP services and other services. They were frequently told by GP receptionists that without a fixed address they could not register with a GP practice. This is incorrect and NHS GP Access cards were provided to help them understand their rights.

When visiting a Gypsy/Roma Traveller site, we heard that none of the families living there had access to a dentist, and they found it difficult to get repeat prescriptions and medication. Mental health is a big issue, and we have since asked Rethink if they could prepare a presentation to help signpost people, as they hadn't been able, or didn't know how to, access mental health services.

Waiting lists

Concerns have been raised around waiting lists for the Improving Access to Psychological Therapy (IAPT) service with waiting times of 12 months or more.

> IAPT waiting list is currently a year in Wiltshire - this is too long (six weekly wellbeing calls are offered but this is not enough, and things can change hugely in six weeks).

> IAPT — can seem like a 'plaster on a dam' for those who have higher needs. Better access to initial mental health services/support mechanism is needed, before the process to Intensive/Inpatient Services. Waiting times too long and could be 12 to 18 months. A big need for counselling/ talking therapies for higher needs.

Staffing issues

A high turnover, or lack of staff have left service users feeling abandoned.

> I lost my care co-ordinator/support last month — still waiting for support... feeling deserted.

> Counselling backlog — counsellor left after 4 sessions and then the counselling stopped. Told you are still on the list but haven't heard any more.

> My new care coordinator knows nothing about me and it's kind of stressing me out. I know they are understaffed. It's just no good as not connecting with her and not helping me with my therapy.

> I have had four CPNs [Community Psychiatric Nurse] when the notes went to the new CPN the notes were misinterpreted and caused me significant problems.

Concerns over delivery of services

Mental health services not delivering on their promises was also raised as a concern.

> Services should do what they say they are going to do without me having to chase them constantly. If my son was being better supported, then I could access better support myself.

> We had a client that had a plan to commit suicide, the CMHT [Community Mental Health Team] said they would come out and they didn't.

> I was in crisis and had a plan. I felt not listened to. Someone was supposed to turn up and no one turned up. I didn't get any help whatsoever. They just tell you to do all these things but when you are ill you can't. I have a care coordinator. She told me not to ring her.

> Consistent and reliable communication – when a professional says they will call the next day and then they don't it can have a very negative impact.

> I would end my life rather than ringing the Intensive Service. They have let me down so many times.

Transition from child to adult services

The transition from children's to adult mental health services was also as an issue, with thresholds being seen as too high.

> The transition from child to adult mental health services was a nightmare. My daughter did not meet the threshold to adult services. I Had to get in touch with my M.P to help get adult services.

> Transition between CAMHS [Child and Adolescent Mental Health Services] and adult mental health is non-existent, children are being missed. No support for adults with ASD [Autism Spectrum Disorder].

> Some young people are too ill for community mental health services but do not meet the need for secondary care. For example, a child could go to A&E five times after attempted suicide. This is what we are hearing from parent carers.

Carers feeling less involved

Carers told us that they were often left out of conversations about the care being delivered to their loved ones and that there was a lack of support for them to continue their caring responsibilities.

Feedback from the Wiltshire Mental Health Open Forum repeatedly emphasises the need to have carers involved in planning and accessing health and care support and services for their loved ones. People living with mental illness are often unable to communicate with services either because of the method used, anxiety, inability to engage at the time or a need for someone to speak on their behalf.

> Include carers when attempting to engage the person with mental health. Do what you say you are going to do as a service, without people having to chase.

> The impact on me as a carer over the last six years has not been acknowledged, and my own mental health is failing as a result of the ongoing stress from trying to manage my son's illness.

> My son has had 20 years of psychotic episodes and the impact it has on families when acute is enormous — there is very little support.

Lack of flexibility

The lack of flexibility in services meant that help was not available when someone was in crisis.

> It's very difficult to access support in a crisis (particularly out of hours).

> Although there now is a crisis support telephone line set up during the pandemic, I know that some people have found at times the crisis support has been dependent on who the person on the end of the telephone is. Some have found talking to the person supportive and helpful, and others have felt the person was dismissive and unhelpful.

> Mental health is 24/7 and doesn't fit a 9 to 5 schedule.

> Lack of services around the weekend. Relying on ambulance services, hospitals, or the police. Rather than a more specific targeted service.

> Users sometimes resort to calling emergency services as they don't know who else to call. They may just need someone to talk to.

Need for preventative help

People felt that good mental health support should be preventative and provide low level support to stop escalation to crisis point.

> Focus on prevention and mild to moderate mental health and wellbeing issues.

> Services that are accessible whatever level of mental health issue you have, preventing escalation.

> Provide my son with the ongoing proven support he needs, physically, mentally and socially and stop waiting for each crisis to happen before stepping in.

Need for ongoing support

Ongoing support should also be provided when out of services, or when discharged from hospital, to prevent a relapse.

> Sometimes packages of support are not put into place when they leave, so they have a period where they are unsupported, and this can cause relapse. Too many people are signposted to places and not actively supported when discharged, and so they relapse as no one is there to promote them communicating with services.

> People are being discharged without any follow-up. No ‘soft landing’. If you don’t have a personal support network in place, you can be left isolated, and it feels abrupt.

> I think when in hospital there should be more support to find positive things to do on discharge, such as wellbeing arts groups, peer support etc, to gain support in the community and build improved ways to manage own mental health.

Training for emergency services

The use of emergency services to deal with a crisis was also raised with calls for more training in mental health for paramedics and the police.

> Police are called to so many section 136s [of the Mental Health Act] where the person is drunk and psychotic. Society cannot manage these people, and these emergency services are overused. They should be used as a last resort. There needs to be a community mental health service, so other services are not called. Police and ambulance are not specialists to deal with mental health issues.

> Typically, the only professionals you will see at the scene for someone in a mental health crisis is a paramedic and/or a police officer; mental health services are nowhere to be seen.

> Police are overly heavy handed and don't talk to you. You try to communicate with them, but they ignore you. Non-confrontational training needed.

> Police very reactive using a baton to press my head into concrete.

Conclusions and recommendations

The feedback we have collected clearly shows that mental health services are insufficient in meeting the needs of the populations of Bath and North East Somerset, Swindon and Wiltshire and our recommendations reflect this.

We recommend that significant training and additional support is provided, particularly across the less well-served areas, such as children's services, eating disorders and for people suffering from trauma.

It is also apparent from our research that people living with mental illness feel that they have difficulty in accessing the health and care services that they need to support them in their daily lives.

We recommend the following:

- Enable better access to initial mental health services/support and engage early to prevent escalation.
- Improve transition from child to adult mental health services and develop consistent thresholds to facilitate transition.
- Involve carers in discussions and decisions wherever possible to achieve the best outcomes for the patient.
- Provide better out of hours cover: mental health crises do not fit a 9-5pm schedule.
- Ensure provision across rural as well as town areas.
- Continue to offer a choice of online/virtual as well as face to face appointments and services.
- Provide better follow-up post discharge to avoid recurrence of issues and make the patient feel supported.
- Improve GPs' use of mental health support and social prescribing.
- Engage more with people from ethnic minorities, as there is a perceived reluctance to discuss mental health or access the services.
- Provide more appropriate training on mental health, such as Oliver McGowan Mandatory Training for autism, to paramedics, emergency services and GP staff.
- Improve training and support for eating disorders, an area of mental health that is currently poorly served locally, resulting in people being placed away from their families and loved ones.
- Improve support for people who experience trauma, and provide specific trauma training for staff at all levels.
- Further review children's mental health provision to meet the increase in demand.

We also recommend that the CQC increases engagement with members of the public to develop a more accessible and user friendly feedback from.

Next steps

This report provides an important overview of local peoples' experiences of accessing mental health support and services in 2021. This report will be shared with commissioners for each area, statutory bodies including the Care Quality Commission, Bath and North East Somerset, Swindon and Wiltshire NHS Integrated Care Board (BSW ICB, formerly the Clinical Commissioning Group), NHS England and NHS Improvement, and third sector providers of health and social care in the BSW region.

We will share our findings with people who took part in the survey and will keep them updated on what has happened as a result of sharing their experiences with us. We will share this report with the organisations who contributed, publish it on our websites and share key messages about our findings on our social media channels.

Each Healthwatch will work with local services and organisations to ensure our recommendations are considered, monitor how they implemented, and provide updates on their progress. We are committed to carrying out any follow-up work required to support local services in delivering the best experience possible for everyone.

Thank you!

This report was written by the teams at Healthwatch Bath and North East Somerset, Healthwatch Swindon, and Healthwatch Wiltshire.

Thank you to our volunteers David Evans, for data analysis, and Harry Dale and Phillip Murphy, for supporting the Swindon Pop-up Café. And thank you to all the organisations who contributed to this report and to the people who took the time to talk to us.

Appendix

Where we visited and who we spoke to

Organisation/group	Description
Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)	Provides healthcare for people with serious mental illness, learning disabilities and autism across BaNES, Swindon and Wiltshire, Bristol, North Somerset and South Gloucestershire.

Bath and North East Somerset

Organisation/group	Description
Age UK BaNES	Charity supporting older people.
BaNES Carers Centre	Charity supporting unpaid carers.
Bath Mind	Local independent mental health charity.
BEMSCA (Bath Ethnic Minority Senior Citizens Association)	Provides a range of activities, support and information for older people from black and minority ethnic groups within the area.
Breakthrough	Supports survivors of trauma and provides training.
Children and Young People's Network	Supporting voluntary and community sector organisations working with children and young people.
Dorothy House	Provides palliative care.
Genesis Trust – Gateway Centre	Provides support to move people from addiction or poor mental health to living well in recovery through a 10-week programme.
Julian House	Supports vulnerable and at-risk individuals and Gypsy, Roma, Traveller and Boater communities.
Kooth	Online mental wellbeing community for young people.
KS2	Voluntary peer support group for carers of people with mental ill health.
Southside Family Centre	Family support and play.
Swallow	Charity enabling teenagers and adults with learning disabilities to live as independently as they wish.
Youth Connect South West	Charity supporting young people aged 11-25.
3SG	Network of charities, social enterprises and community groups.

Swindon

Organisation/group	Description
Headway	Supporting adults with traumatic and acquired brain injury, their families and carers.
Live Well and Public Health	Helping people access opportunities and services which can help improve their health and wellbeing.
New College Swindon	Offering academic, vocational and technical qualifications, higher education and degree-level courses, apprenticeships and business training courses, across two campuses.
Swindon Advocacy Movement	Free advocacy service for people with care and support needs.
Swindon Carers	Charity supporting unpaid carers.
Swindon and Gloucestershire Mind	Local independent mental health charity.
Swindon Hub	Accessible friendly space run by the community, for the community.
Swindon SEND Family Voice	Supports parents of children with additional needs.
Voluntary Action Swindon	Charity which supports other charities and coordinates voluntary activity in the local area.
Willows	Charity that provides counselling for people and training for counsellors.

Wiltshire

Organisation/group	Description
Wiltshire College	College courses, apprenticeships, degree level courses, evening classes, and distance learning across five campuses.
Wiltshire Mental Health Open Forum	Run by Healthwatch Wiltshire and AWP, the forum offers an opportunity for people to speak directly to those who run mental health services.
Wiltshire Parent Carer Council	Focuses on improving services for children and young people with special educational needs and/or disabilities.
Wiltshire Police (Swindon)	Local police force.
Wiltshire Virtual Carer Group	Part of Carer Support Wiltshire, a charity supporting unpaid carers.
Wiltshire Hearing Voices Group	Provides a safe and non-judgemental space for people with unusual sensory experiences.

Healthwatch Swindon Mental Health Survey

Your experiences over the last year

Healthwatch Swindon gives you the chance to say what you think about how local services are run. Your experience matters to us.

We are reaching out to people who experience mental ill health to share their experience of health and social care throughout 2021.

We want to hear your stories and work with those who commission and design services, to champion for change and improvements. Helping to ensure health and social care services are more inclusive and accessible to everyone.

By completing this survey, you consent to the information you provide to be used by Healthwatch and shared with the Care Quality Commission and NHS England, confidentially and anonymously unless instructed otherwise by yourself. The information you provide will not only help to improve services but also to ensure we are hearing from people of all ages and backgrounds.

1. Do you or someone you care for suffer from mental ill health

- [ ] Yes
- [ ] No

2. Did you or the person you care for need to access/receive additional support during 2021?

- ◯ Yes
- ◯ No

3. If you or the person you care for did NOT receive any additional support for their health, can you please explain any reasons or factors that may have prevented you receiving help?

4. If yes, would you consider your experience:

- [ ] Positive
- [ ] Mixed
- [ ] Negative

5. Can you please list the service(s)/organisation(s) you have accessed? for e.g. Old Town Surgery, Swindon

6. If you feel able too, can you please share your experience of this service/services?

7. What about the service(s) could be improved or worked well for you?

8. When did this happen?
(if it is more than one incident please add as many dates as needed)

9. Do or did you work or volunteer for this service (s)/organisation (s)?

Yes	
No	
Which service(s)/organisation(s)?	

10. Have you shared this with the service(s)/organisation(s)?

- [ ] Yes
- [ ] No
- [ ] If Yes Which service(s) /organisation(s) did you share it with?

11. Have you told the authorities?

This is asked in case what you've told us is about abuse or neglect. When we read your feedback, we'll decide if we think someone is at risk. If we think they/you are at risk, we'll need to contact the police or council. It helps if we know who you've already told

- ◯ The Police
- ◯ The Council Safeguarding Team
- ◯ Both the police and the council safeguarding team
- ◯ Neither of these

12. Did you hear about this survey through a charity?

- ◯ Yes
- ◯ No

13. If Yes, please name

14. Can we contact you for more information?

Name	
Organisation (if applicable)	
City/Town	
Postal Code	
Email Address	
Phone Number (optional)	

15. Do you consider yourself to be a carer?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

16. Do you consider yourself or the person you care for to have a disability?

- ◯ Yes
- ◯ No
- ◯ Prefer not to say

17. If you are a carer are you

- ☐ Paid
- ☐ Unpaid
- ☐ Prefer not to say

18. If you are a carer has your mental wellbeing been impacted in the last year?

- [ ] Yes
- [ ] No

If yes in what way?

19. While supporting the person you care for were your thoughts and feelings considered by the health & social care service providers?

- [ ] Yes
- [ ] No
- [ ] Not applicable

Any comments

20. Gender: How do you identify

- ◯ Man
- ◯ Women
- ◯ Non-binary

Prefer to self describe

21. What is your age?

- ◯ Under 18
- ◯ 18 to 24
- ◯ 25 to 34
- ◯ 35 to 44
- ◯ 45 to 54
- ◯ 55 to 64
- ◯ 65 to 74
- ◯ 75 or older
- ◯ Prefer not to say

22. What is your Ethnicity?

- [ ] Asian/Asian British – Chinese
- [ ] Asian/Asian British – Bangladeshi
- [ ] Asian/Asian British – Indian
- [ ] Asian/Asian British – Pakistani
- [ ] Asian/Asian British - Any other Asian background
- [ ] Black or Black British – African
- [ ] Black or Black British – Caribbean
- [ ] Black or Black British - Any other Black Background
- [ ] Any other Ethnic Groups – Arabic
- [ ] Any other Ethnic Groups – Iranian
- [ ] Any other Ethnic Groups - Iraqi
- [ ] Any other Ethnic Groups – Kurdish
- [ ] Any other Ethnic Groups – Turkish
- [ ] Any other Ethnic Groups - Any other Ethnic background
- [ ] Mixed/multiple ethnic groups - White and Asian
- [ ] Mixed/multiple ethnic groups - White and Black African
- [ ] Mixed/multiple ethnic groups - white and Black Caribbean
- [ ] Any other mixed/multiple background
- [ ] White – British
- [ ] White - Eastern European
- [ ] White – Gypsy
- [ ] White – Irish
- [ ] White - Irish or Scottish Traveller
- [ ] White – Roma
- [ ] Any other white Background
- [ ] Prefer not to say

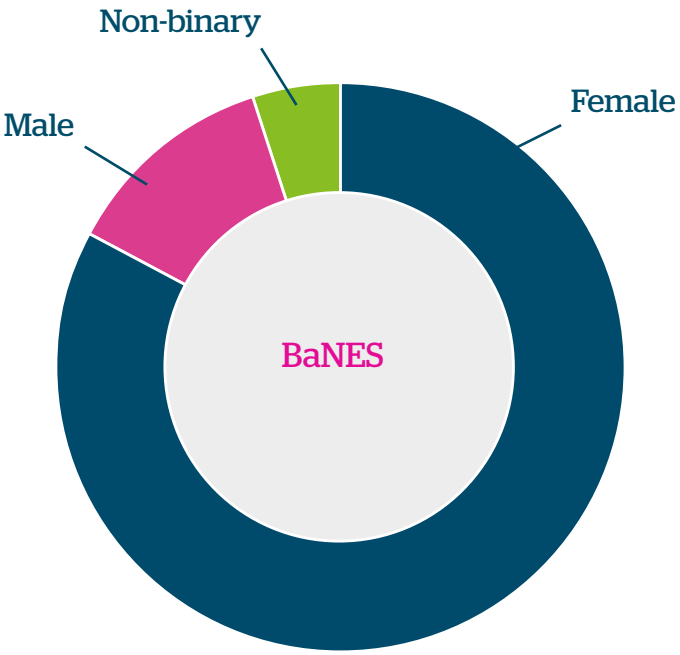
23. What is your religion?

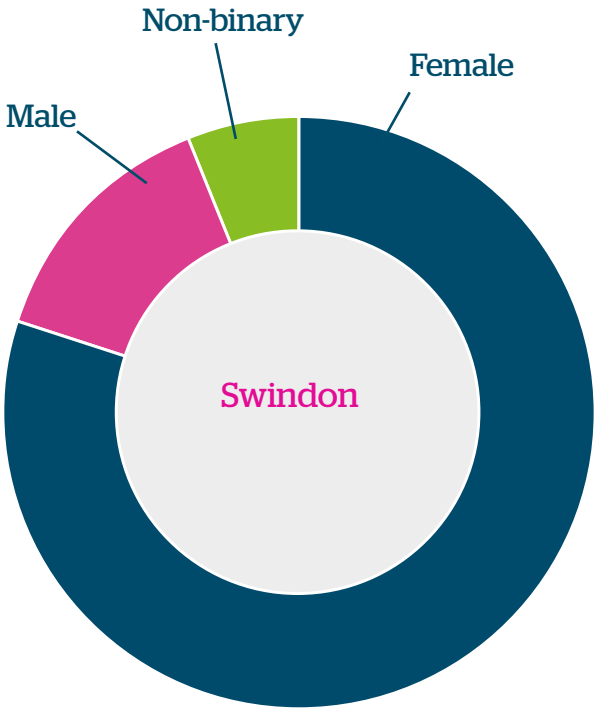
24. We may use your first name and quote your story when publishing our findings. If you would prefer to remain anonymous, please indicate below.

- [ ] Don't use my first name

Demographics for BaNES and Swindon survey

Gender

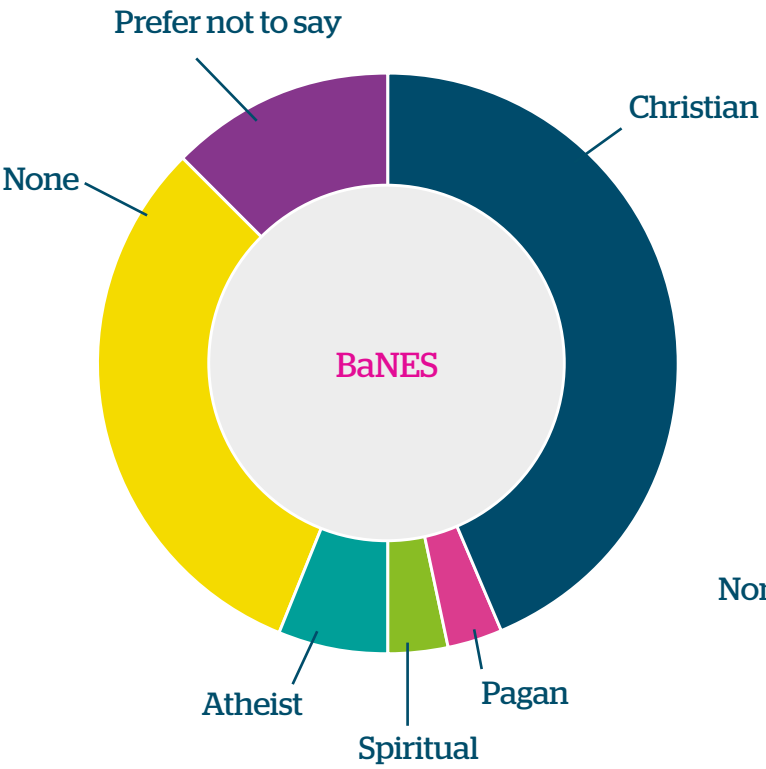


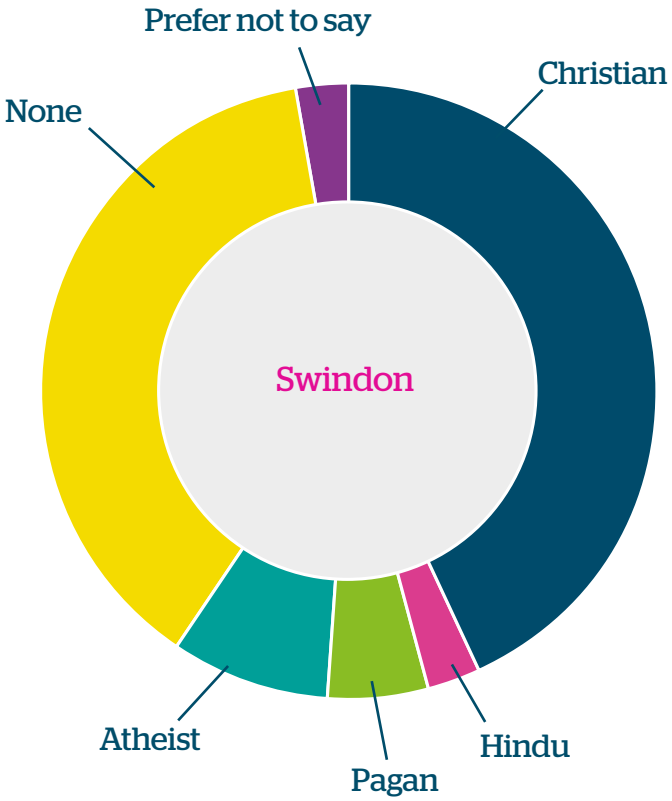


Ethnicity

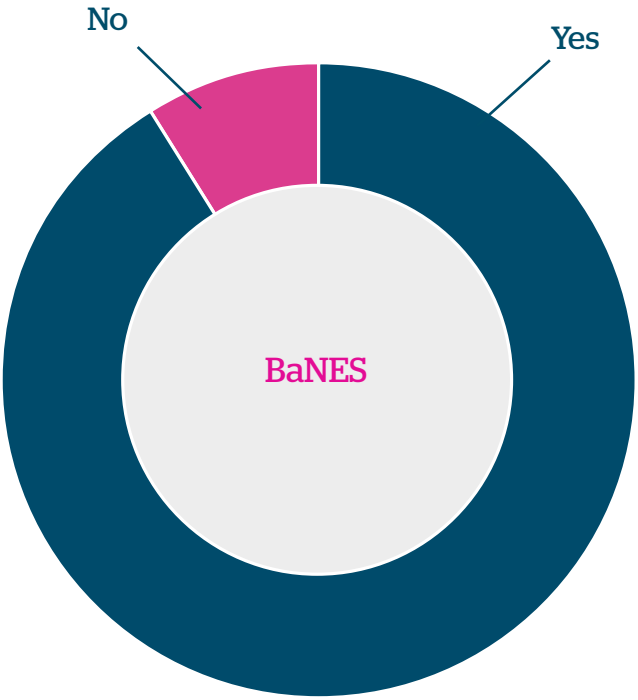
Ethnicity	BaNES	Swindon
Asian/Asian British Indian	0	2
Asian/Asian British – Any other Asian Background	1	1
Iranian	0	1
Black or Black British Caribbean	1	1
Mixed multiple Ethnic Groups – white & Black African	1	0
White Irish	1	0
White British	40	51
White Roma	0	1
Any other white Background	0	2
Prefer not to say	3	4

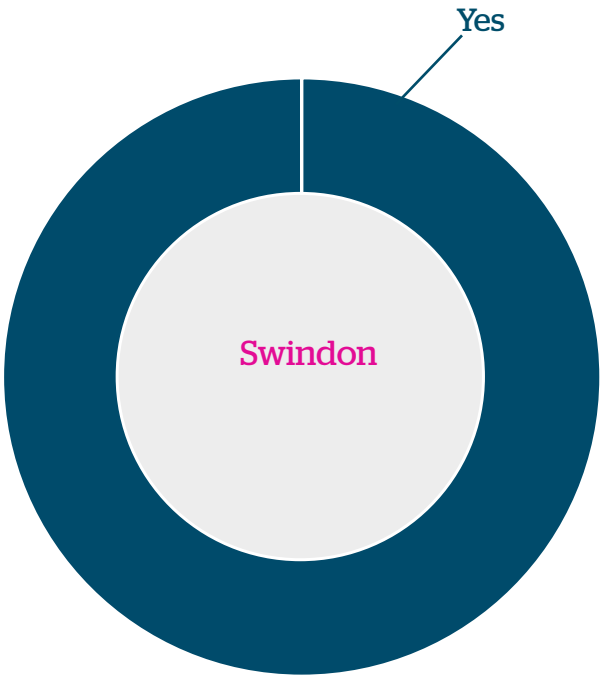
Religion


Prefer not to say
Christian
None
BaNES
Atheist
Spiritual
Pagan

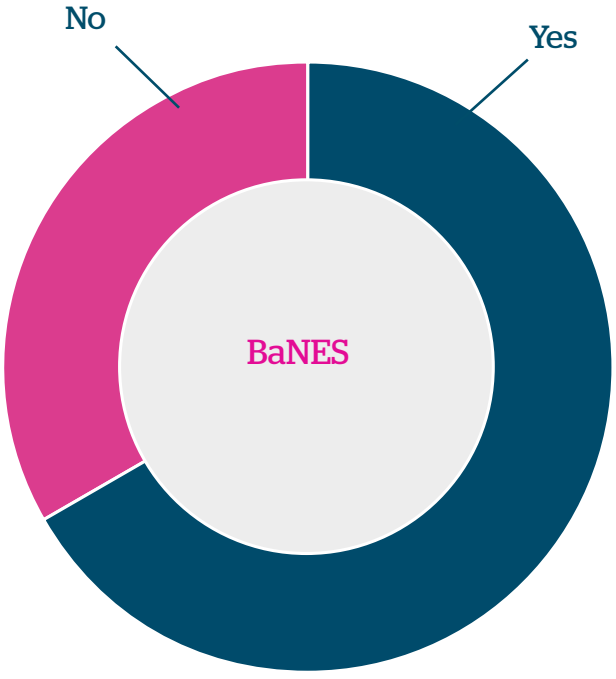

Prefer not to say
Christian
None
Swindon
Atheist
Pagan
Hindu

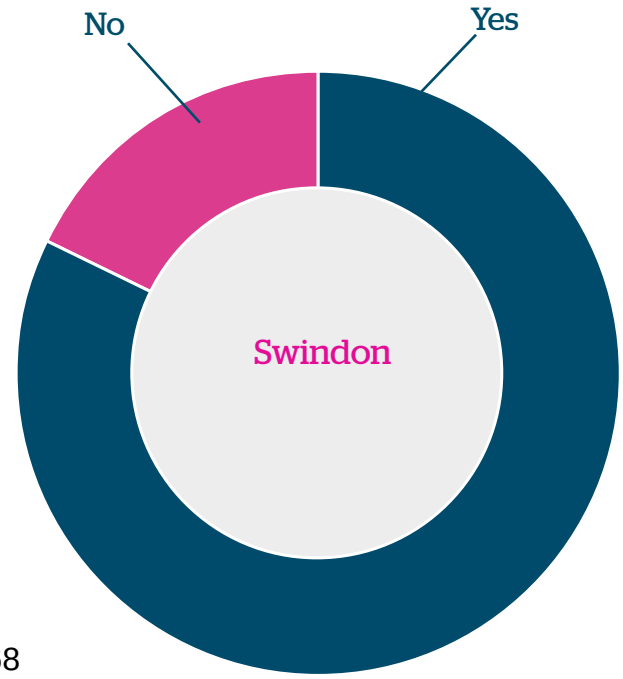
Do you or someone you care for suffer from mental health?





Did you or the person you care for need to access support in 2021?

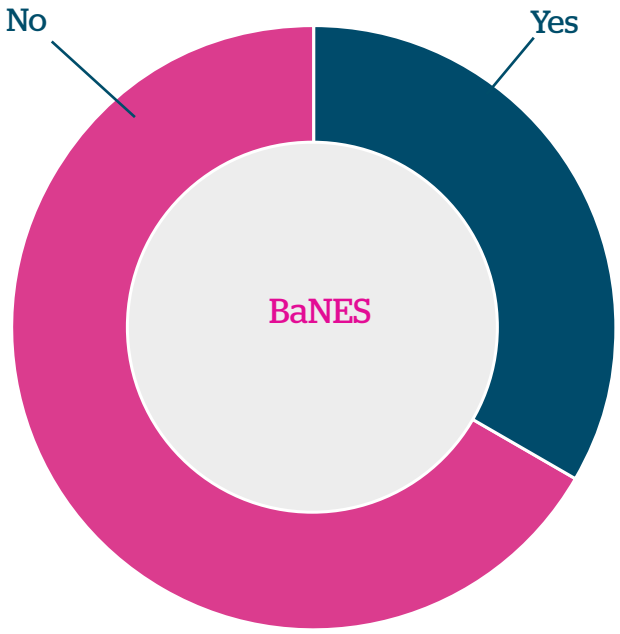


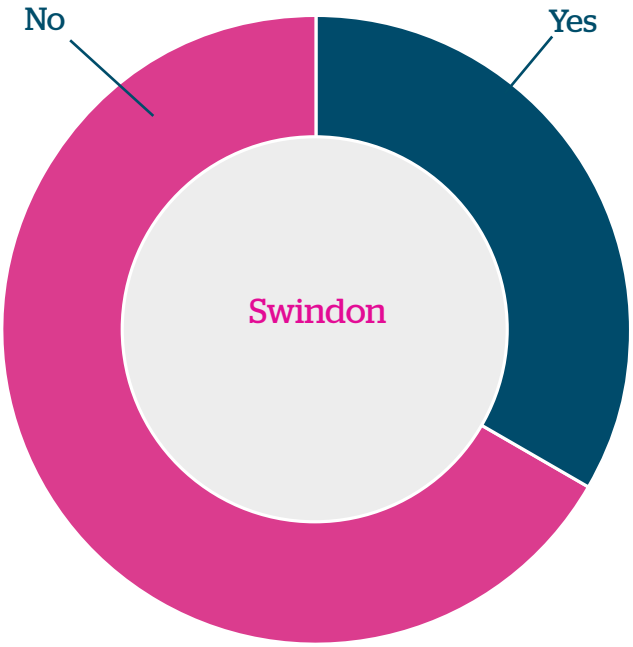


How do you consider your experience accessing services?

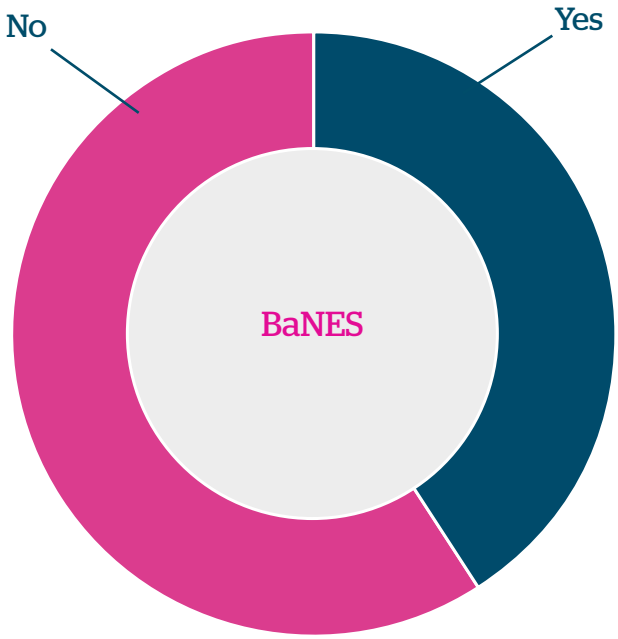
Experience	BaNES	Swindon	Wiltshire
Positive	6	10	5
Mixed	17	30	16
Negative	17	20	52
Total	40	60	73

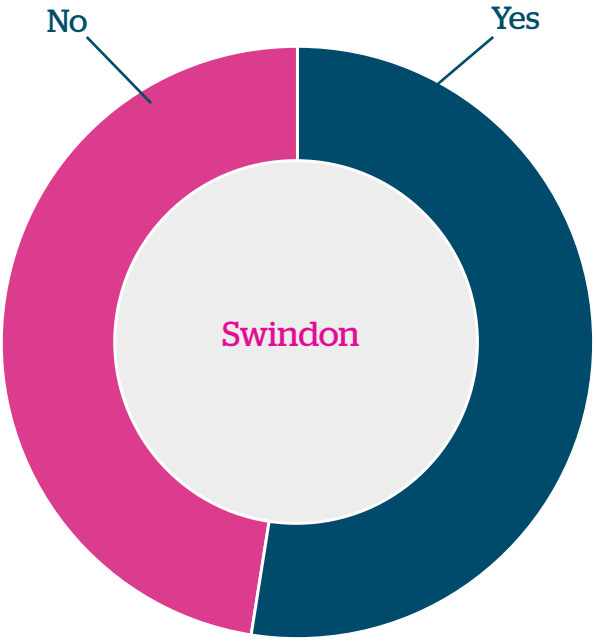
Have you shared your experiences with the organisation?



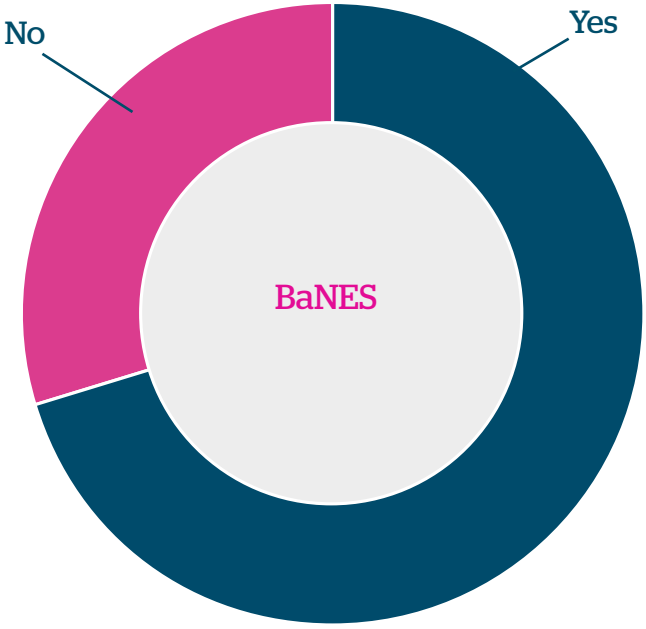


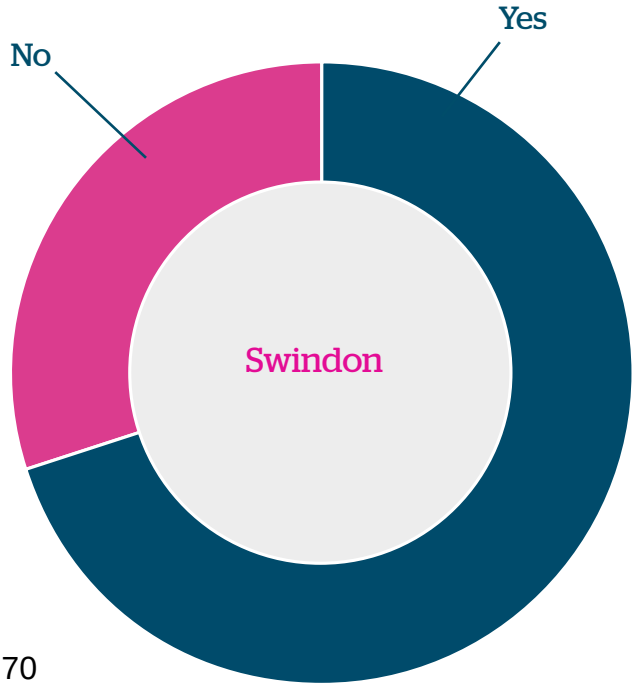
Do you consider yourself a carer?



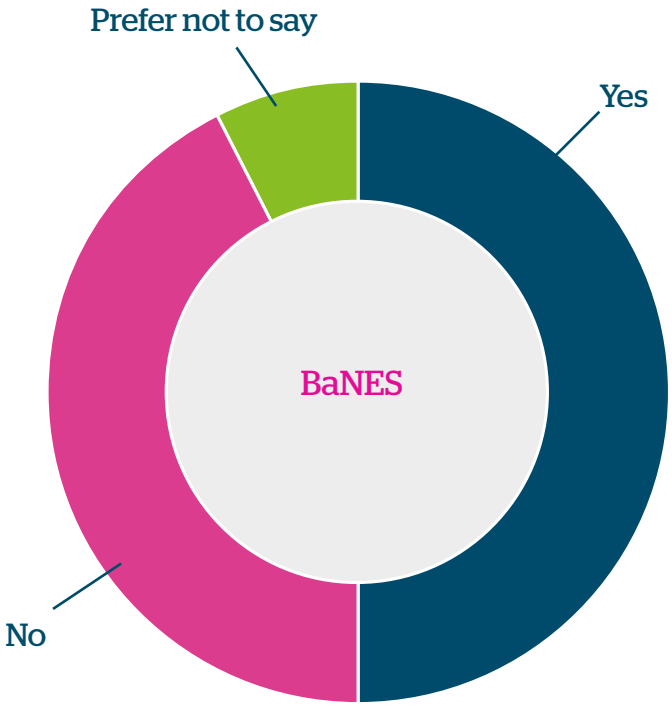


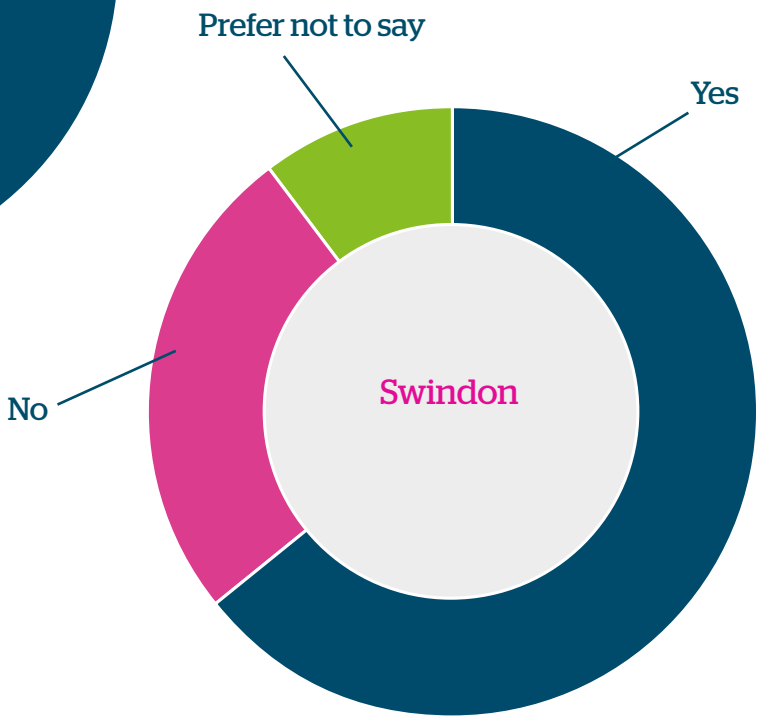
Has your mental health been impacted as a carer?





Do you consider yourself or the person you care for to have a disability?





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HealthwatchWiltshire

healthwatchwiltshire

Bath & North East Somerset Council	
MEETING/ DECISION MAKER:	**Health and Wellbeing Board**
MEETING DATE:	**24 January 2022**
TITLE:	**Health and Wellbeing Strategy Priorities – For Sign Off**
WARD:	All
AN OPEN PUBLIC ITEM	
List of attachments to this report:	

1 THE ISSUE

1.1 The Bath and North East Somerset (B&NES) Joint Health and Wellbeing Board has a statutory duty to develop a Joint Health and Wellbeing Strategy for the local population. The Health and Wellbeing Strategy Team began work to create a new Joint Health and Wellbeing Strategy in June 2022. The Strategic Evidence Base for Bath and North East Somerset, published in June 2022, is the primary source of evidence being used to decide health and wellbeing priorities for the new strategy. The public consultation phase ran from September 29 – October 31, 2022. This gave people who live and work in B&NES the opportunity to help determine the strategy's key priorities. We have evaluated the findings from the public consultation and stakeholder engagement phases. Using evidence from the Strategic Evidence Base, the findings from the public consultation and stakeholder engagement sessions, the priorities for the new Joint Health and Wellbeing Strategy 2023-2030 have been drafted, sense checked with the necessary partners and are now being brought to the Health and Wellbeing Board for sign off.

2 RECOMMENDATION

The Board is asked to;

2.1 Sign off on the proposed priorities for the new Joint Health and Wellbeing Strategy 2023-2030.

3 THE REPORT

3.1 The health and wellbeing strategy team has continued to make progress in developing the new health and wellbeing strategy following the public consultation period which ran from 29th of September to 31st of October 2022.

3.2 To guide the process, the Health and Wellbeing Strategy Steering Group (drawn from Health and Wellbeing Board members and other stakeholders) continues to meet monthly to review strategy related documents and discuss the overall progress of the strategy development. The steering group uses these meetings to discuss challenges, potential risks and key achievements.

3.3 Following the public consultation and drafting of identified priorities, the health and wellbeing strategy team met with the steering group and discussed the alignment of the priorities with the evidence, and public consultation findings. A decided action from that meeting was the need to ensure that identified priorities are the right ones through further meetings and engagement with related partnerships and partners in the form of sense checking.

3.4 The sense check meetings served to ensure that Health and Wellbeing Board partners and others, were aware of the identified priorities and could help to tailor priorities to be in line with their departmental and organisational goals. In these meetings, we discussed current and future plans and considered what would be achievable during the life span of the strategy.

3.5 During these meetings, priorities were consistently updated following each meeting, taking into consideration the views of the various partners. They were then fed back to the steering group members for further comments and changes.

3.6 The Strategic Evidence Base (SEB), the primary source of evidence for the new strategy, is being used to guide the strategy development process. During the priority identification and sense checking processes, the SEB was referenced to ensure an evidence-based approach was consistently being utilised as we reframed the priorities based on the feedback.

3.7 The health and wellbeing strategy team began writing the new joint Health and wellbeing strategy in December 2022.

3.8 An implementation plan is being drafted to sit under with the Health and Wellbeing Strategy. This will further map out actions to be taken under the four priorities to improve health and reduce inequalities.

3.9 The priorities being proposed for the new Joint Health and Wellbeing Strategy are:

1. **Ensure that children and young people are healthy and ready for learning and education**

   1.1 Strengthen family resilience to ensure children and young people can experience the best start in life.

   1.2 Improve timely access to appropriate family and wellbeing support.

1.3 Reduce the existing educational attainment gap for disadvantaged children and young people.

1.4 Ensure services for children and young people who need support for emotional health and wellbeing are needs-led and tailored to respond and provide appropriate care and support (from early help to statutory support services).

2. Improve skills, good work and employment

2.1 Support and mentor individuals to engage in work opportunities.

2.2 Work with local employers to encourage, incentivise and promote good quality work.

2.3 Support the development of and access to an inclusive labour market, focusing on engaging our disadvantaged and vulnerable populations to support them to participate in meaningful work opportunities.

2.4 Prioritise inclusiveness and social value as employers, purchasers and investors in the local economy.

3. Strengthen compassionate and healthy communities

3.1 Continue to develop the infrastructure that encourages and enables individuals, organisations and networks to work together, with the shared aim of supporting people in need and building strong local communities.

3.2 Encourage proactive engagement in healthy lifestyle practices at all ages for good quality of life.

3.3 Develop a strategic approach to social prescribing to enable people to remain healthy and manage physical and mental health conditions.

4. Create health promoting places

4.1 Utilise the Local Plan as an opportunity to shape, promote and deliver healthy and sustainable places and reduce inequalities.

4.2 Improve take up of low carbon affordable warmth support for private housing; and encourage B&NES social housing providers to provide low carbon affordable warmth for existing social housing to help prevent damp and mould, and cold-related illnesses.

4.3 Maximise opportunities in legislation to facilitate targeted private rented sector inspection programme to ensure the minimum statutory housing and energy efficiency standards are met.

4.4 Improve access to physical and mental health services via the development of Integrated Neighbourhood Teams (INTs), community-based specialist services and our specialist centres.

3.8. Next Steps

(1) The Health and Wellbeing Strategy will be drafted and sent to the steering group for review.

(2) A near final version of the strategy will be taken to key groups for final review, including the Senior Management Team (SMT) in the council and the Integrated Care Alliance (ICA). The Health and Wellbeing Strategy will be brought to the Health and Wellbeing Board for final sign off in March 2023.

4 STATUTORY CONSIDERATIONS

4.1 The statutory considerations are set out in section 1 of this report.

5 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

5.1 The report contains 4 priorities and 15 objectives for the new Joint Health and Wellbeing Strategy. No specific resource implications are identified in this report.

6 RISK MANAGEMENT

A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

7 EQUALITIES

7.1 Priorities for the new strategy have been decided with an aim of reducing inequalities in B&NES, particularly to improve health and wellbeing outcomes for low-income households, vulnerable groups, and people with specific accessibility needs. An Equalities Impact Assessment (EQIA) was been carried out for the engagement process and updated now that this process is complete.

8 CLIMATE CHANGE

8.1 One of the cross-cutting themes of the strategy will be environmental sustainability, acknowledging that climate change is having a direct impact on the health and wellbeing of residents in B&NES due to rises in temperatures during summer months and extreme cold weather during the winter periods. Additionally, the identified priority - ‘Creating health promoting places’, aims to have a positive impact on the current climate position by encouraging the development of and access to green spaces in local neighbourhoods.

9 OTHER OPTIONS CONSIDERED

9.1 None. The creation of a new Joint Health and Wellbeing Strategy is a statutory duty of the Joint Health and Wellbeing Board.

10 CONSULTATION

10.1 The public consultation period ran from September 29th to October 31st, 2022.

Contact person	Fedalia Richardson, Health and Wellbeing Strategy Manager Fedalia_richardson@bathnes.gov.uk
Background papers	
Please contact the report author if you need to access this report in an alternative format	

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Bath & North East Somerset Council	
MEETING/ DECISION MAKER:	**Health and Wellbeing Board**
MEETING DATE:	**24 January 2023**
TITLE:	**Aligning work in B&NES with the implementation of the B&NES, Swindon and Wiltshire (BSW) Inequalities Strategy 2021-2024**
WARD:	All
AN OPEN PUBLIC ITEM	
List of attachments to this report: Please list all the appendices here, clearly indicating any which are exempt and the reasons for exemption. **B&NES, Swindon and Wiltshire (BSW) Inequalities Strategy 2021-2024**	

1 THE ISSUE

1.1 The Bath and North East Somerset, Swindon and Wiltshire Integrated Care Partnership (BSW ICP) has developed an Inequalities Strategy 2021-2024, published in May of 2022. It was brought to the B&NES Health and Wellbeing Board in November 2022 to note for information, due to the already committed agendas in the summer.

1.2 This report is the first chance for the Health and Wellbeing Board in B&NES to consider the strategy and in particular how local ambitions for reducing inequalities in life experience in B&NES can align with this wider work across the system in BSW.

1.3 The strategy is in the process of a refresh, which will incorporate recently published NHS guidance on reducing inequality, along with an implementation plan for Phase 1 of the strategy (more detail is given in section 3.1 below). Feedback from the Health and Wellbeing Board can be included in this refresh.

1.4 Reporting against the implementation plan will start in February 2023 with progress updates given to the BSW Population Health Board. The B&NES

Health and Wellbeing Board are invited to receive these progress updates if they wish to or may prefer a less regular update over a broader time frame.

2 RECOMMENDATION

The Committee is asked to;

2.1 Support the ambitions of the BSW Inequality Strategy

2.2 Provide any feedback for the refresh of the Strategy.

2.3 Consider the status of tackling inequalities as an objective or cross cutting principle in the forthcoming refresh of the B&NES Health and Wellbeing Strategy

2.4 Identify how best to align this BSW system wide strategy with B&NES partnerships and plans, including receiving updates on the Strategy's progress.

3 THE REPORT

3.1 The strategy is attached. It sets out the three phases of the work:

(1) To make inequality everybody's business through engagement and awareness raising

(2) To tackle healthcare related inequalities

(3) To focus on prevention, social, economic and environmental factors, also known as 'wider determinants'.

3.2 Each of these phases has more detailed objectives, as set out in the strategy.

3.3 Recent publication by NHSE of guidance on inequality and the Core 20 Plus 5 approach for children and young people has recently been published. The BSW Inequality Strategy is being updated in light of this. The focus is largely on clinical areas for particularly patient groups within young people.

3.4 In B&NES, the Integrated Care Alliance (ICA) has set out its priorities including one to 'Improve population health and reduce health inequalities'. Progress on putting the infrastructure in place to deliver this work has included a commitment that by Spring of 2023 we will have:

- Secured health inequality funding for new fixed term posts (a health inequalities coordinator, two posts within primary care and one at the RUH)
- Established a Health Inequality Network (organised by the health inequalities coordinator)
- Established Community Wellbeing Hub and spoke model at the RUH

3.5 B&NES has also led a workshop on identifying the key priorities for the wider determinants of health – which will support Phase 3, described above.

3.6 A recent Inequality Summit in B&NES also set out key local issues relating to the economy, education and health. Aligning next steps on that work with the work described above will be important to maintain focused and coordinated efforts rather than disparate programmes of work.

4 STATUTORY CONSIDERATIONS

4.1 The Public Sector Equality Duty places a responsibility on local organisations to eliminate discrimination, advance quality of opportunity and foster good relations for people with protected characteristics. Work to understand and tackle inequities in access to preventative or treatment services and inequalities in health and social outcomes supports achievement of this duty.

5 RESOURCE IMPLICATIONS (FINANCE, PROPERTY, PEOPLE)

5.1 The majority of resources involved in this work are fixed-term staff capacity, which will largely come from NHSE funding awarded to the BSW area.

5.2 In 2022/23 B&NES was able to access £600k from a £2.4m NHSE allocation to the ICS for health inequalities work. This was to support any or all of:

- Elective recovery from the pandemic (with a focus on inequalities)
- Wider determinants
- Population Health Management to support understanding inequalities
- Core20+5 with focus on prevention
- Community engagement

5.3 The aim in B&NES it to build a health inequalities network in B&NES by providing dedicated capacity, building system capability, supporting collection, analysis and utilisation of data, and coordinating activity across B&NES and with the BSW Integrated Care Board (ICB).

5.4 This will fund the following fixed term posts:

- Health Inequalities Coordinator and increased analytic capacity, employed by the Council
- Two project managers for population health management work employed in Primary Care Networks
- A project manager at the RUH focused on health inequalities

5.5 The funds will also support the Community Wellbeing Hub provision at the RUH.

5.6 Although the ICB has only been able to commit inequalities funding for 2022/23, the funding stream itself from NHSE to ICBs is being made recurrent in 2023/24 and conversations are ongoing with the ICB to discuss use of this funding and a

continued allocation to the three Places in the BSW Integrated Care System (ICS).

6 RISK MANAGEMENT

6.1 A risk assessment related to the issue and recommendations has been undertaken, in compliance with the Council's decision making risk management guidance.

7 EQUALITIES

7.1 The strategy will take forward a variety of programmes and actions that aim to promote equality in access to services and preventative programmes and in turn health and social outcomes. Individual projects that sit beneath the strategy will be reviewed within the new BSW ICB and ICS standard Equality and Quality Impact Assessment (EQIA) process.

8 CLIMATE CHANGE

8.1 Phase three of the Strategy (focusing on prevention, social, economic and environmental factors) considers climate change and the impact of the climate emergency on inequalities. This is indirectly addressed through the anchor institutions work, specifically on how these organisations will actively focus on their own environmental sustainability and ways to reduce their environmental impact within their community.

8.2 There is also overlap between health and environmental sustainability for example in increasing active travel to improve physical activity, mental health and improve air quality.

9 OTHER OPTIONS CONSIDERED

9.1 None

10 CONSULTATION

10.1 The work has been created by a multi-agency group but has not undergone public consultation.

Contact person	Paul Scott
Background papers	B&NES, Swindon and Wiltshire (BSW) Inequalities Strategy 2021-2024
Please contact the report author if you need to access this report in an alternative format	

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

BSW Inequalities Strategy

2021-2024

May 2022

Version control

Version	Date		Initials
Final	12/05/2022	Version 3.2 approved as final at PHCG 11/05/22	HSJ
3.2	11/04/2022	Updated following additional review inc. maternity lead	HSJ
3.1	05/04/2022	Updated following review with SRO Health Inequalities and CYP lead	HSJ
3	18/03/2022	Updated following feedback from ISG 04/03/22 and PHCG 09/03/22	HSJ
2	Feb 2022	Updated following feedback up to 09/02/22	HSJ
1	Jan 2022		HSJ

Contents

Vision

To work in partnership to tackle inequalities across the life course to ensure that every resident of Bath, North East Somerset, Swindon, and Wiltshire can live longer, healthier, happier lives.

What we committed to delivering against the following phases:

Phase 1

- To make inequality everybody's business through awareness raising, training and engagement with partners and communities

Phase 2

To tackle healthcare related inequalities by:

- Implementing the NHS Five 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.

- Implementing the *Core20PLUS5* programme. The programme focusses on the core 20% of most deprived areas PLUS communities at higher risk of inequality (e.g. those with black, Asian and minority ethnic backgrounds) focussing initially in five clinical areas:

    1. CVD
    2. Maternity
    3. Respiratory
    4. Cancer
    5. Mental Health (including. children and young people)

Phase 3

To focus on prevention, social, economic and environmental factors (known as 'wider determinants')

- To establish Anchor institution status at BSWs three hospitals
- To publish three place-based Joint Strategic Needs Assessments for BANES, Swindon and Wiltshire
- To establish local priorities that address public health and the social, economic, and environmental factors most affecting inequalities at place
- To plan and enable progress on prevention where outcomes will take longer to see
- Tackle life course obesity using a whole systems approach
- Tackle inequality linked to smoking using a whole systems approach

What will success look like?

Making Inequalities everybody's business

- All staff, partners, and communities to understand inequality and how we seek to address this in BSW

Tackling healthcare inequalities

- Work with commissioners and service providers to ensure robust and up-to-date data across the system on where inequalities are, and clear plans on how close the inequality gaps to offer exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes

- Achieving the Core20PLUS5 targets to reduce the inequality gaps identified in the five clinical areas

Tackling inequality by addressing social, economic, and environmental factors

- Establish and harness the potential of local anchor Institutions in our three acute hospitals and mental health trust to deliver positive change across all domains of anchor influence including employment, procurement, and environmental impact

- Halt and reverse obesity prevalence in children and adults across BSW

- Reduce smoking prevalence across BSW, with targeted focus on routine and manual occupations and smoking in pregnancy

- Demonstrate action on inequalities that spans from system to place through joined up strategy and planning

The BSW Inequalities Strategy aims to provide a framework for system activity to reduce health inequalities. The strategy has been developed from key guidance and policy relating to reducing healthcare inequalities, as well as recognising the need for close partnership working with colleagues at a place level to address wider determinants of health. This strategy aims to address inequalities across the life course, to include pregnancy, children and young people, adults and into old age.

Action on health inequalities requires improving the lives of those with the worst health outcomes, fastest.

What are health inequalities?

Health Inequalities are *unfair* and *avoidable* differences in health across the population, and between different groups within society. (The King's Fund, 2020). They arise because of the conditions in which we are born, grow, live, work and age. These conditions influence our opportunities for good health, and how we think, feel and act, and this shapes our mental health, physical health, and wellbeing.

Health inequalities have been documented between population groups across at least four dimensions, as illustrated in figure 1 below. It is important to note that these are overlapping dimensions with people often falling into various combinations of these categories.

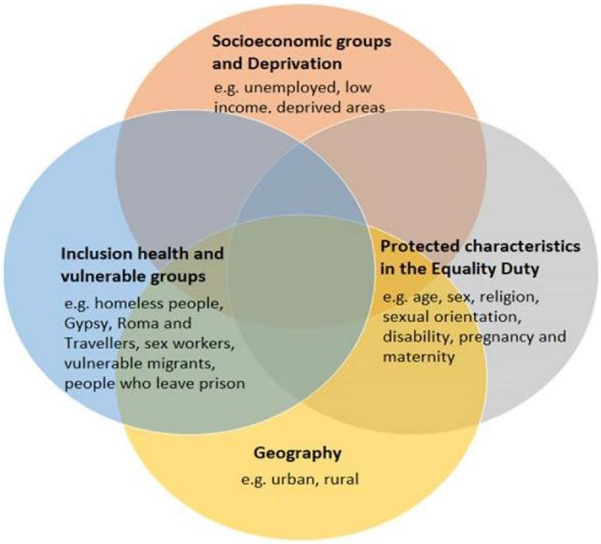

Figure 1 taken from: Health Equity Assessment Tool (HEAT): executive summary - GOV.UK (www.gov.uk)

Examples of the characteristics of people/communities in each of these groups are below (this is not an exhaustive list):

- Socio-economic status and deprivation: e.g. unemployed, low income, people living in deprived areas (e.g. poor housing, poor education and/or unemployment)
- Protected characteristics: e.g. age, sex, race, sexual orientation, disability
- Vulnerable groups of society or ‘inclusion health’ groups: e.g. vulnerable. migrants; Gypsy, Roma and Traveller communities; rough sleepers and homeless people; and sex workers
- Geography: e.g. urban, rural.

Inclusion Health Groups: Inclusion Health has been used to define a number of groups of people who are not usually well provided for by healthcare services, and have poorer access, experiences and health outcomes. The definition covers people who are homeless and rough sleepers, vulnerable migrants (refugees and asylum seekers), sex workers, and those from the Gypsy, Roma and Traveller communities.

Protected Groups: The protected characteristics covered by the Equality Act 2010 are: age, disability, gender reassignment, marriage and civil partnership (but only in respect of eliminating unlawful discrimination), pregnancy and maternity, race—this includes ethnic or national origins, colour or nationality, religion or belief—this includes lack of belief, sex, sexual orientation

People living in deprived areas: Evidence says that people living in our most deprived areas face the worse health inequalities in relation to health access, experiences and outcomes. When we talk about deprived areas, in relation to geography, this means we are working to address inequalities in urban and rurally deprived areas of England.

Health inequalities can involve differences in:

- health status, for example, life expectancy and prevalence of health conditions
- access to care, for example, availability of treatments
- quality and experience of care, for example, levels of patient satisfaction
- behavioural risks to health, for example, smoking rates
- wider determinants of health, for example, quality of housing

This strategy aims to address the unfair and avoidable differences in health by focusing on groups that suffer the greatest inequalities and those with the poorest health outcomes. This typically highlights deprivation and ethnicity as the most influential indicators of inequalities. The BSW Inequalities strategy takes this focus, rather than looking more broadly at all disadvantaged groups (e.g. across all protected characteristics). This is addressed through BSW Equality, Diversity, and Inclusion work, which ensures policies and measures meet the diverse needs of our service, population, and workforce, ensuring that none are placed at a disadvantage over others.

Children and Young People

Inequality affects people of all ages; however, there are some stages of the life-course at which inequality can have a particularly significant impact (Understanding Inequalities, 2022). Children and young people are often more affected by, and subject to, inequality than adults and they are often the least able to defend themselves against it. The impact of inequalities experienced in childhood can have a long-term effect across the life-course.

Intersectionality

Multiple sources of inequality produce intersectional identities which are affected by several discriminations and disadvantages. For example, more deprived areas have on average nine times less access to green space, higher concentrations of fast-food outlets and more limited availability of affordable healthy food than less deprived areas (The King's Fund, 2020).

Healthcare inequality

Healthcare inequality relates specifically to unfair and avoidable differences in how different groups access and experience *healthcare*, and the resulting outcomes. Health inequalities span across

several domains of influence, from the individual through to much wider social and economic conditions, as shown in figure 2. Healthcare inequalities have a narrower focus and are defined by the conditions which can be influenced more directly by healthcare services and the NHS.

Social, economic, and environmental factors

Our health is shaped by a complex interaction between many factors. These include the quality of health and care services, individual behaviours, the places and communities in which people live and wider determinants such as education, housing and access to green space. Health inequalities arise because of systematic variations in these factors across a population.

Sometimes referred to as the *wider determinants of health,* the social, economic, and environmental conditions in which people live that have an impact on health. They include income, education, access to green space and healthy food, the work people do and the homes they live in.

Inequalities in these factors are inter-related: disadvantages are concentrated in particular parts of the population and can be mutually reinforcing. Lower socio-economic groups, for example, tend to have a higher prevalence of risky health behaviours, worse access to care and less opportunity to lead healthy lives.

The interactions between different kinds of inequality, and the factors that drive them, is often complex and multidirectional. People can find it more difficult to move away from unhealthy behaviours if they are worse off in terms of a range of wider determinants of health. Access to green space, on the other hand, seems to weaken the relationship between income and health status in a complex way. We can influence health in other ways for example by improving air quality, improving the built and natural environment, access to work, education and skills, having quality housing and living conditions, access to benefits and addressing justice health.

Adapted from: Williams, Buck and Babalola (2020).

Figure 2: Dahlgren, G. and Whitehead, M. (1993) Tackling inequalities in health: what can we learn from what has been tried?

What are the consequences of these health inequalities?

The report '*Fair Society, Healthy Lives'* (Marmot, 2010) highlighted health inequality in England, and the consequences on the health and wellbeing of the population. Key findings include:

- People living in the poorest neighbourhoods in England will on average die seven years earlier than people living in the richest neighbourhoods

- People living in poorer areas not only die sooner, but spend more of their lives with disability - an average total difference of 17 years
- The Review highlights the social gradient of health inequalities - put simply, the lower one's social and economic status, the poorer one's health is likely to be
- Health inequalities arise from a complex interaction of many factors - housing, income, education, social isolation, disability - all of which are strongly affected by one's economic and social status
- Health inequalities are largely preventable. Not only is there a strong social justice case for addressing health inequalities, there is also a pressing economic case. It is estimated that the annual cost of health inequalities is between £36 billion to £40 billion through lost taxes, welfare payments and costs to the NHS
- Action on health inequalities requires action across all the social determinants of health, including education, occupation, income, home and community
- Early childhood is a critical time for development of later life outcomes, including health. Less positive experiences early in life, particularly experiences of adversity, relate closely to many negative long-term outcomes: poverty, unemployment, homelessness, unhealthy behaviours, and poor mental and physical health (Marmot, 2010, p. 17)

Evidence shows that the Covid-19 pandemic has exacerbated existing health inequalities. The 2020 update to the original 2010 Marmot report highlights those outcomes have got worse for those already suffering from inequalities in health. For example, ten years on:

- people can expect to spend more of their lives in poor health
- improvements to life expectancy have stalled, and declined for the poorest 10% of women
- the health gap has grown between wealthy and deprived areas
- relative child poverty has worsened, living in a household with less than 60 percent of median income, after housing costs will increase from 30 percent to 36.6 percent in 2021 in the UK (Marmot, 2010, p. 17)
- place matters – living in a deprived area of the North East is worse for your health than living in a similarly deprived area in London, to the extent that life expectancy is nearly five years less.

In addition to the effect on health and wellbeing and social injustice of these inequalities, there is an economic and societal cost to the widening gaps between population groups. For example:

- The extra costs to the NHS of health inequalities have been estimated as £4.8 billion a year from the greater use of hospitals by people in deprived areas alone.
- Health inequalities reduce employment and productivity - which has a cost for the national and local economies
- The burden of ill health and disability, as well as premature mortality, is disproportionately focussed on the most deprived populations. These sections of society are least equipped and resourced to make best and most appropriate use of services. If the ‘unmet need’ for preventive services and those for early detection and management is not addressed in those at greatest risk, a large part of the growing burden and cost will persist (NHS, 2018)
- It is also a legal requirement to take account of inequalities under the Health and Social Care Act (2012)
- The impact of inequality in childhood can last a lifetime and what happens during early years (starting in the womb) has lifelong effects and greatly influences health and well-being outcomes for adults

Inequalities in BSW

Demographics

Bath and North East Somerset, Swindon and Wiltshire has a combined population of around 923,000 people (BSW System Intelligence Report, 2021). Life expectancy across the three areas varies from 73 years to 91 years according to sex and geographical location.

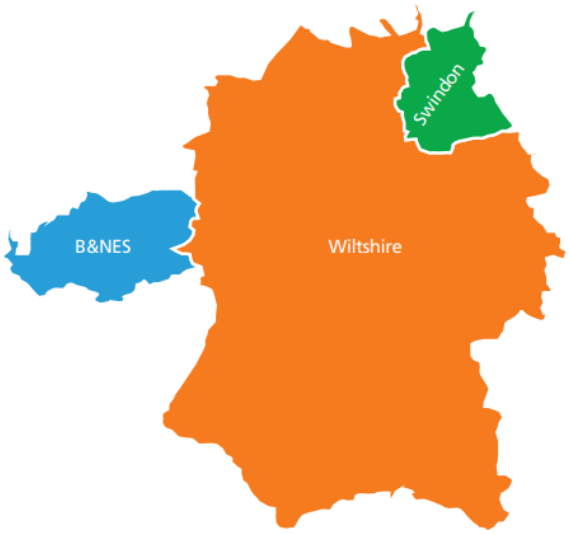

Figure 3 Map of Bath and North East Somerset, Swindon and Wiltshire taken from 'Our plan for health and care 2020-2024', BSW Partnership (2020)

Figure 4-6 (taken from *BSW system Intelligence Report*; BSW, 2021) highlights population sizes, breakdown by age group, life expectancy, healthy life expectancy, and inequality in life expectancy.

Inequality in life expectancy is represented by the slope index of inequality (SII), which is based on statistical analysis of how much life expectancy varies with area deprivation. The SII represents the range in years of life expectancy across the social gradient from most to least deprived.

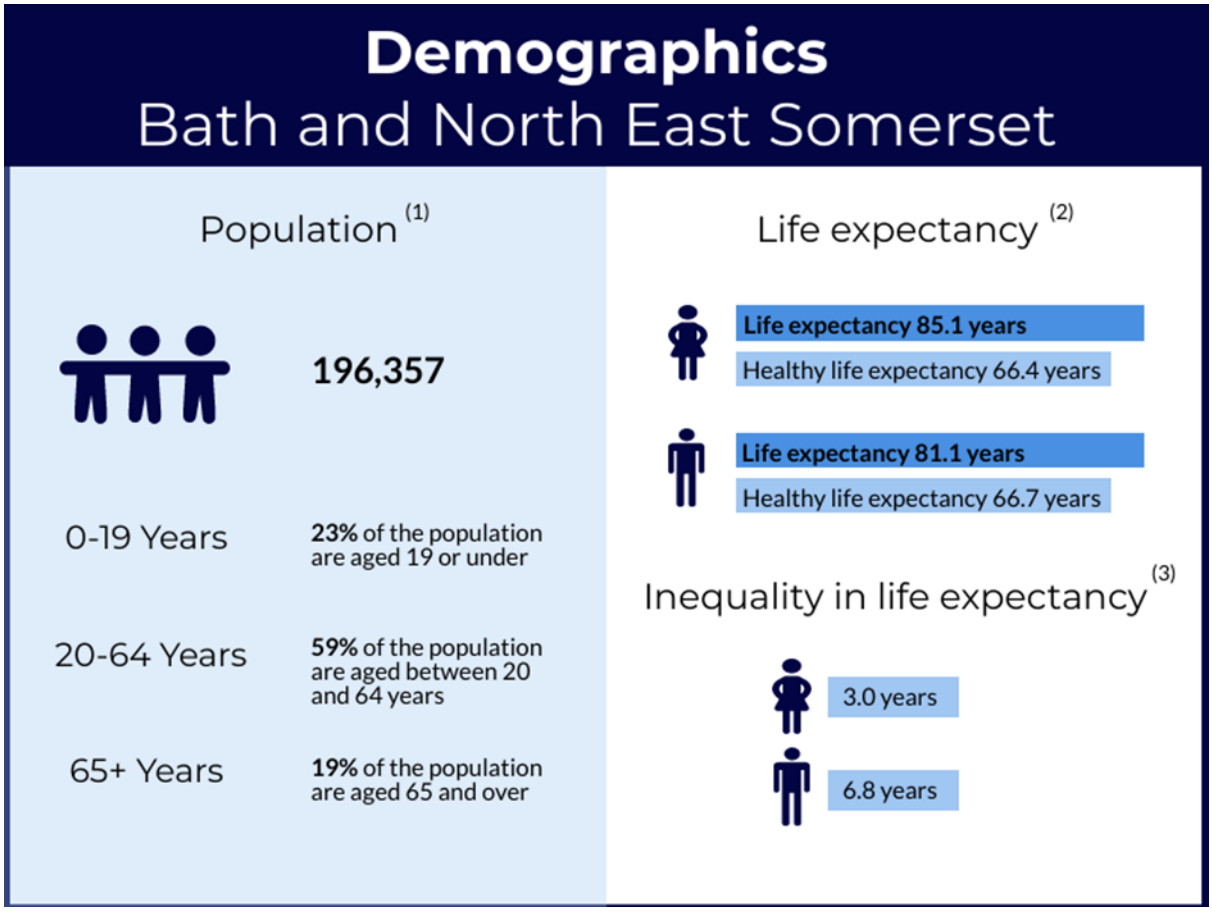

Figure 4 Demographics BANES (BSW Partnership, 2021)

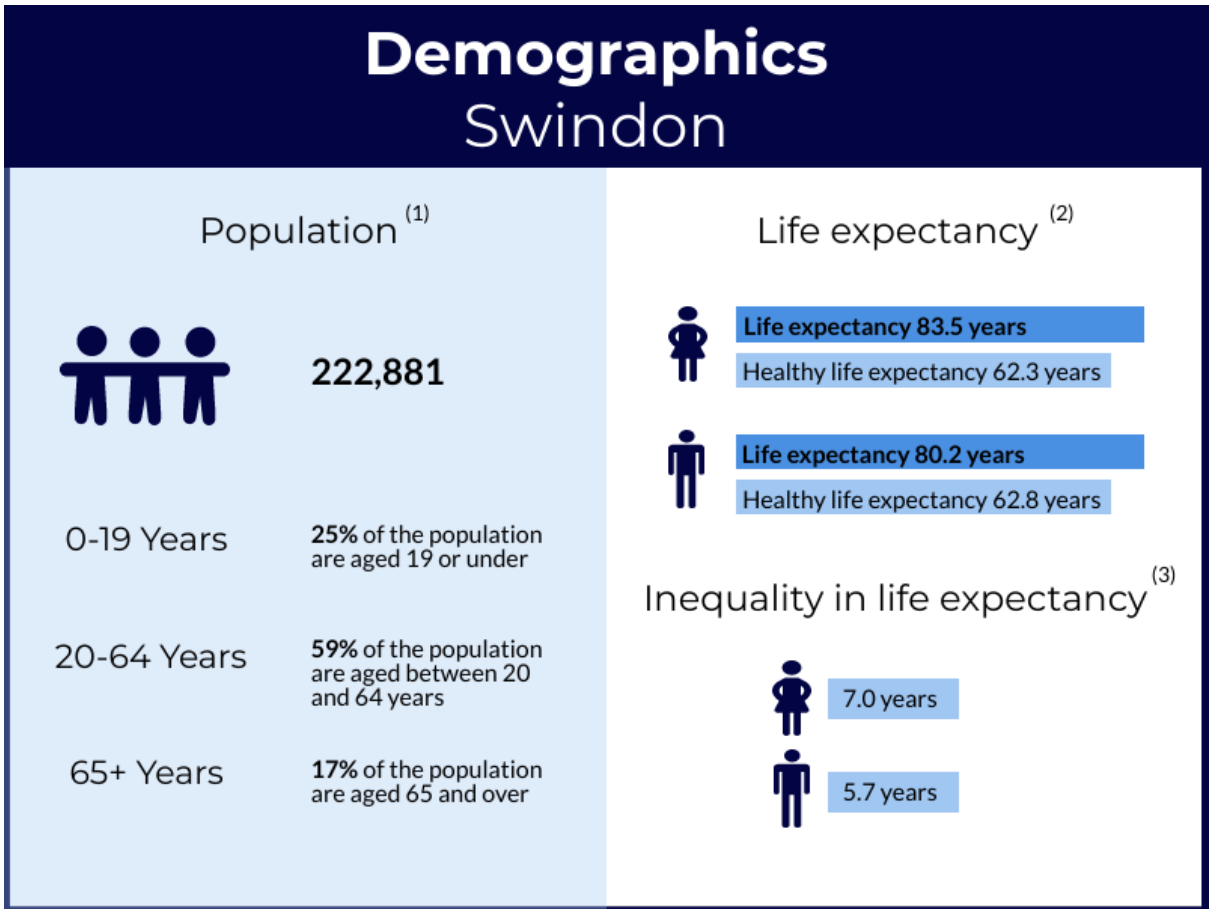

Figure 5 Demographics Swindon (BSW Partnership, 2021)

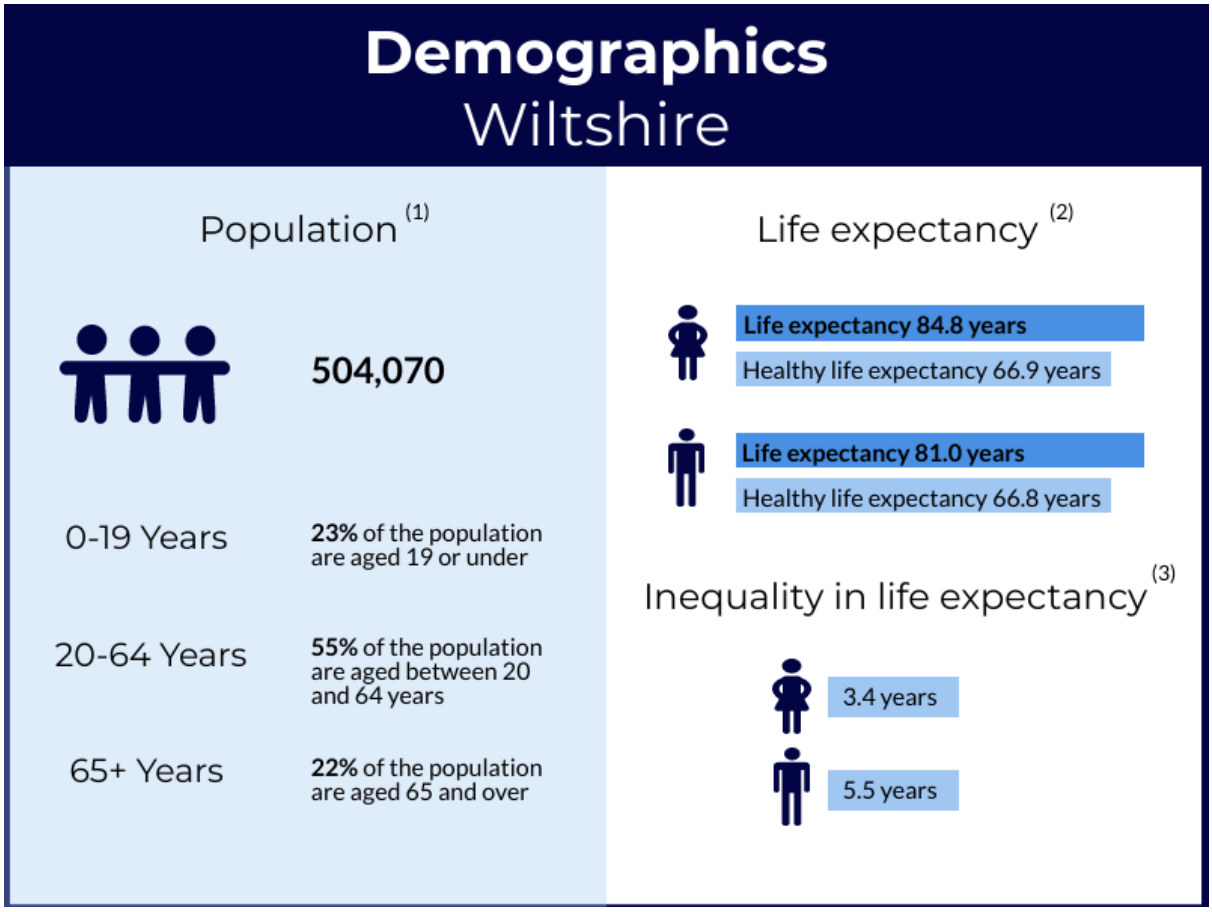

Figure 6 Demographics Wiltshire (BSW Partnership, 2021)

In BANES and Wiltshire, and nationally, the social gradient in life expectancy is steeper for males. In Swindon, however, the social gradient in life expectancy is steeper for females.

There are further variations in life expectancy between neighbourhoods in BSW. For example, a female in Bathavon South, BANES, can expect to live for 91 years, whereas a male from Trowbridge Central, Wiltshire, can expect to live for 73 years (BSW Partnership, 2021).

Deprivation

People living in deprived areas on average have poorer health and shorter lives. Research shows that socioeconomic inequalities result in increased morbidity and decreased life expectancy. The UCL Institute of Health Equity estimates 1.3 to 2.5 million potential years of life lost annually due to inequalities (Marmot, 2010). Males living in the most deprived tenth of areas can expect to live 9 fewer years compared with the least deprived tenth, and females can expect to live 7 fewer years (Public Health England, 2017).

What defines whether an area is a deprived area is based on a number of characteristics included in the Index of Multiple Deprivation (IMD) – Income Deprivation, Employment Deprivation; Education, Skills and Training Deprivation; Health Deprivation and Disability; Crime; Barriers to Housing and Services; Living Environment Deprivation.

According to the IMD (2019), Bath, North East Somerset, Swindon, and Wiltshire remains one of the least deprived parts in the country. However, this overall average masks pockets of deep deprivation and inequality within each area, including two neighbourhoods within the most deprived 10% nationally. Swindon has a higher level of deprivation compared to Wiltshire and Bath and North

East Somerset. See appendix two for detailed breakdown of deprivation by neighbourhood across BSW.

Quintiles: Best | Worst | Not applicable

Recent trends: – Could not be calculated | No significant change | Increasing | Decreasing

Deprivation score (IMD 2019) 2019 — Score

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	21.7	-	-
South West region	–	-	18.2	-	-
Torbay	–	-	28.1	-	-
Plymouth	–	-	26.6	-	-
Bristol	–	-	26.4	-	-
Cornwall	–	-	23.1	-	-
Swindon	–	-	18.6	-	-
Somerset	–	-	18.6	-	-
Bournemouth, Christchurch and Poole	–	-	18.2	-	-
Devon	–	-	16.6	-	-
North Somerset	–	-	15.8	-	-
Dorset	–	-	15.7	-	-
Gloucestershire	–	-	14.9	-	-
Wiltshire	–	-	13.4	-	-
Isles of Scilly	–	-	12.0	-	-
Bath and North East Somerset	–	-	11.7	-	-
South Gloucestershire	–	-	11.7	-	-

Table 1: Office for Health Improvement & Disparities (2022).

As there is variation in deprivation across the South West region, there is also variation within the local authorities as exemplified here across the wards in Swindon.

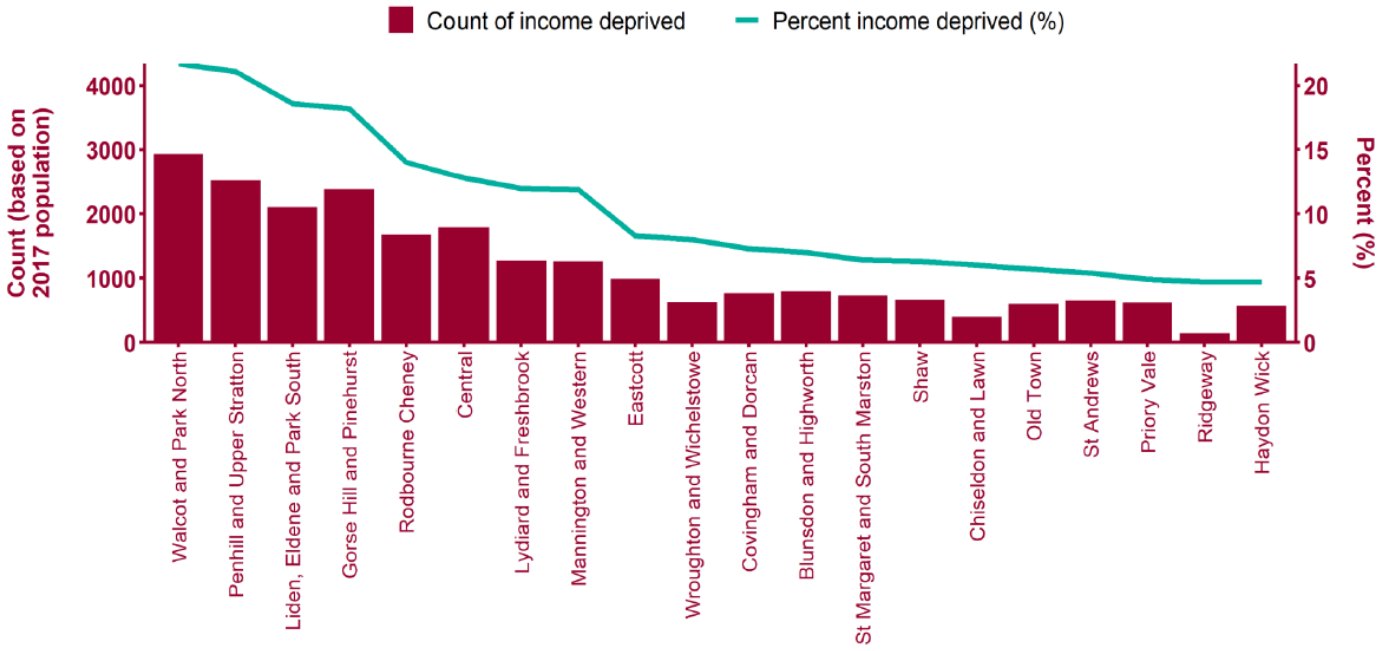

Figure 7 Income deprivation by ward in Swindon (IMD, 2019; taken from presentation by Maddern and Arulrajah, 2021)

During the pandemic there have been disproportionate deaths from COVID-19 between those living in the most deprived areas and those living in the least deprived areas. These mirror higher mortality due to other causes, in line with social gradient (Dodge and Owolabi, 2021).

Ethnicity

Ethnicity also has a large and complex effect on health. In England, inequality is experienced when comparing ethnic minority groups and those from white ethnic groups, and between different ethnic minority groups (Robertson et al., 2021). The infographic below (figure 8) highlights just some of the stark health inequalities related to ethnicity in the UK.

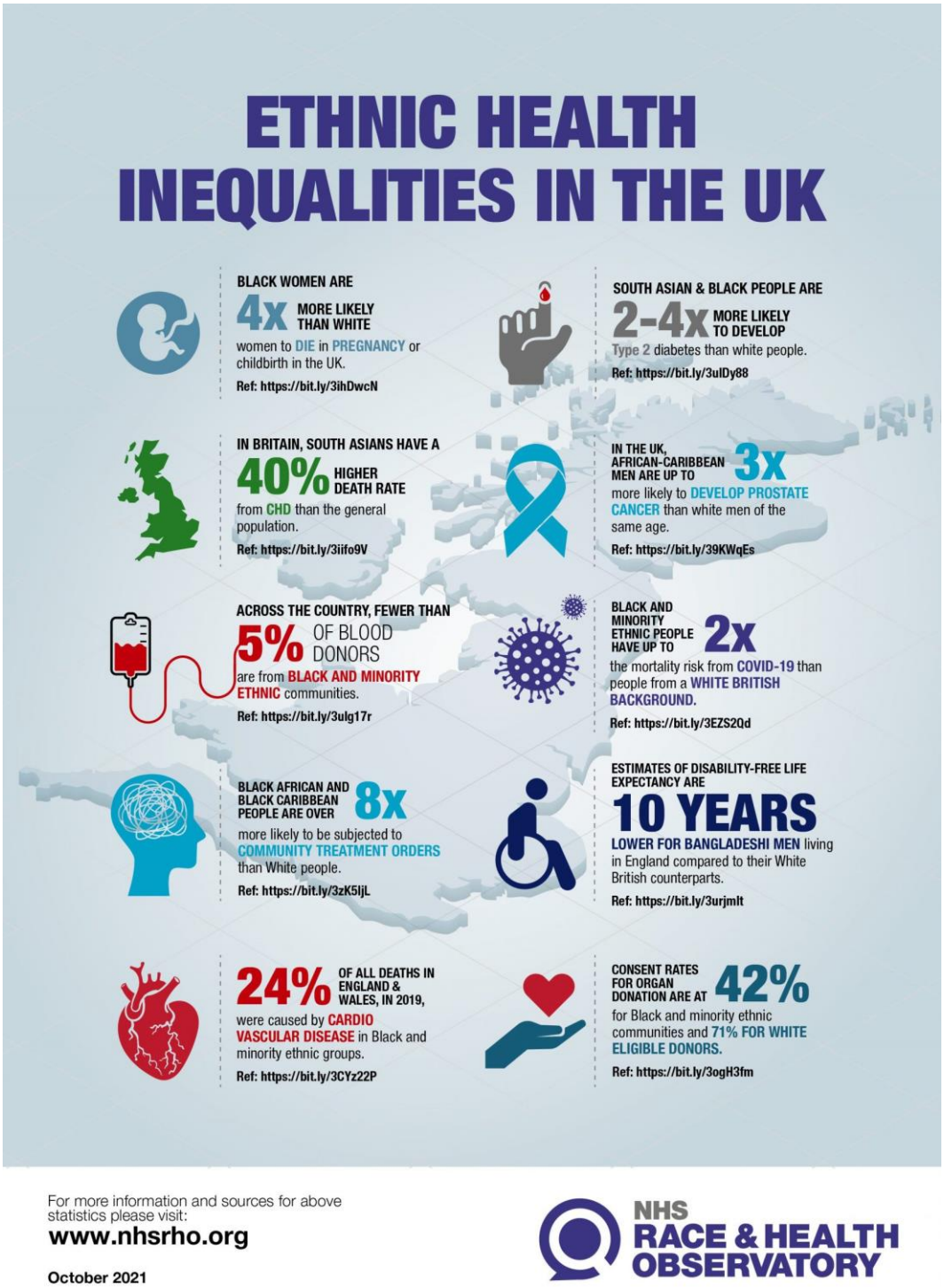

Figure 8 Taken from NHS - Race and Health Observatory (2021)

Nationally, the Covid-19 pandemic has had a disproportionate impact on ethnic minority communities, who have experienced higher infection and mortality rates than the white population.

Geography, deprivation, occupation, living arrangements and health conditions such as CVD and diabetes accounted for a large proportion, but not all, of the excess mortality risk of Covid-19 in ethnic minority groups (Raleigh and Holmes, 2021). It is important to understand the distribution of different ethnic groups across BSW as health outcomes, attitudes and beliefs, as well as health service accessibility and usage can vary.

There are approximately 100,000 people from Black and Minority Ethnic (BME) communities living in BSW (ONS, 2017). Swindon has significantly more residents from a black and ethnic minority group: 10.2% in Swindon, compared to 5.4% in BANES and 3.4% in Wiltshire (ONS, 2011). In BANES and Wiltshire, 'All other white' group is the largest ethnic group after 'White British', whereas in Swindon it is 'Asian/Asian British'.

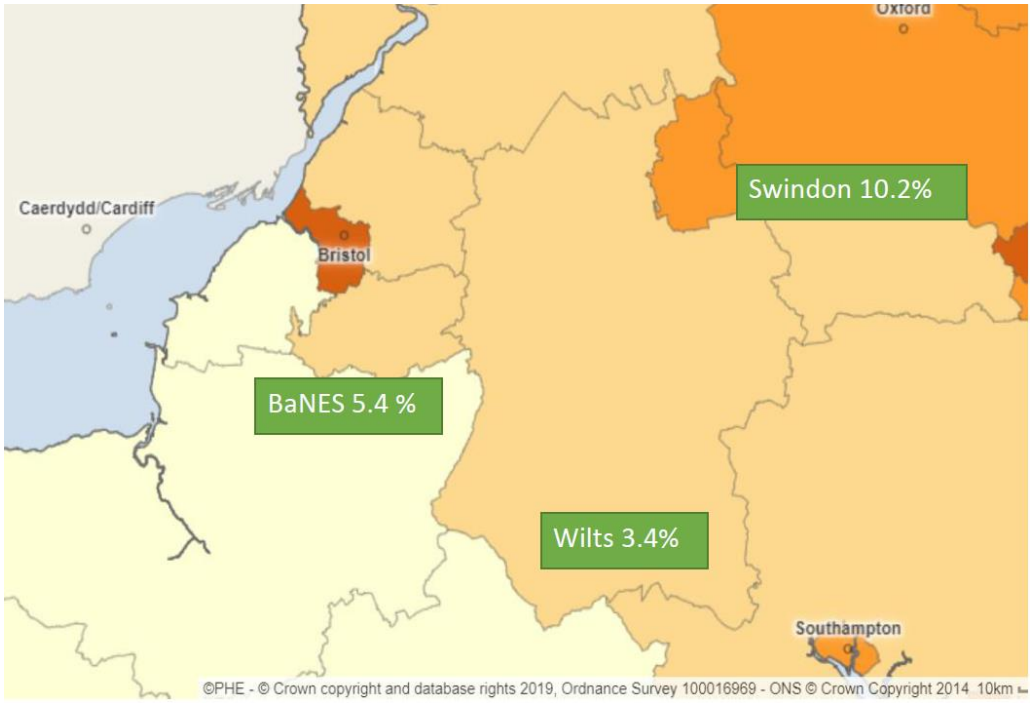

Figure 9 BSW Black and Ethnic Minority Population, 2011

Preventable risk factors

Although inequalities are broad and intersectional, it is clear there is strong evidence that people from socio-economically deprived populations and certain ethnic minority groups experience poorer health than the rest of the population, so it is particularly important to focus preventative services on these groups.

Ill health and premature mortality is considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could potentially be avoided by public health interventions in the broadest sense.

Smoking is the single largest driver of health disparities between the most and least affluent quintiles. Obesity is the next biggest preventable risk factor and obesity in children has seen a major increase during the pandemic, especially in the least well off (NHS, 2022). In BSW, this is supported by figure 10, showing the contribution to the gap in life expectancy in the most and least deprived groups by broad cause of death.

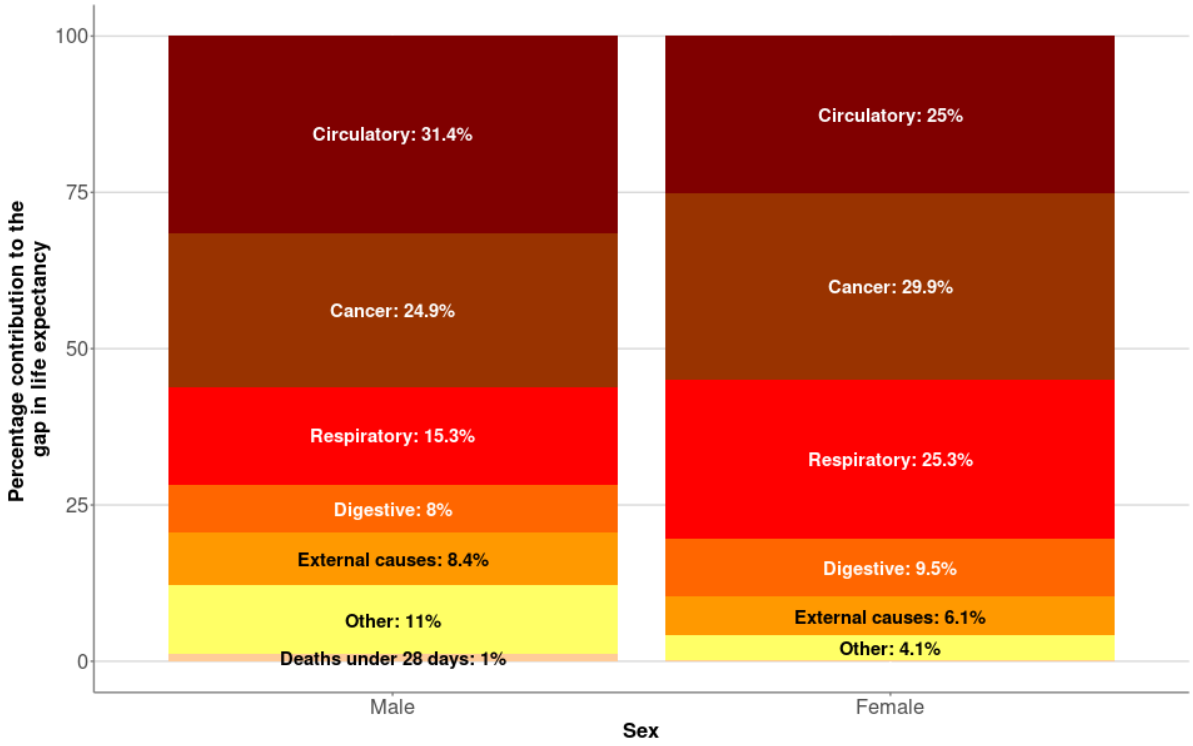

Figure 10 Scarf chart showing the breakdown of the life expectancy gap between the most deprived quintile and least deprived quintile of Bath and North East Somerset, Swindon and Wiltshire, by broad cause of death, 2015-17.

Smoking

Smoking is the leading cause of preventable illness and premature death in England, with about half of all lifelong smokers dying prematurely, losing on average around 10 years of life (Public Health England, 2019). There are around 128,000 smokers in BSW. This has increased since 2019, due to population growth and a slight increase in smoking prevalence in BANES and Wiltshire (BSW Partnership, 2021).

The decline in smoking prevalence in the last few decades has been more prominent in affluent groups, meaning that inequalities in smoking prevalence have widened (Mackenbach, 2011). Smoking is a key mediator of the effect of socioeconomic deprivation on mortality and therefore an important driver of health inequalities.

Smoking Prevalence in adults (18+) - current smokers (APS) 2019

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	6,144,703	13.9	13.6	14.1
South West region	–	633,500	14.0	13.3	14.7
Plymouth	–	38,738	18.5	15.8	21.2
Bristol	–	66,358	18.0	15.2	20.7
Cornwall	–	69,931	15.2	12.6	17.7
Torbay	–	16,590	15.0	12.6	17.3
Wiltshire	–	57,527	14.6	12.2	17.0
Somerset	–	64,912	14.4	11.8	17.0
Bournemouth, Christchurch and Poole	–	44,330	13.9	11.8	15.9
Devon	–	88,461	13.5	11.2	15.7
Swindon	–	22,505	13.1	10.7	15.5
Bath and North East Somerset	–	20,484	13.0	10.5	15.6
Gloucestershire	–	65,858	13.0	10.7	15.2
North Somerset	–	19,276	11.3	9.0	13.5
South Gloucestershire	–	25,299	11.2	8.8	13.6
Dorset	–	31,530	10.1	7.8	12.5
Isles of Scilly	–	.	.	.	.

Table 2 Office for Health Improvement & Disparities (2022).

In all three local authority areas, the prevalence of smoking for people in routine and manual occupations is over double the prevalence for people in managerial and professional occupations. In BANES and Wiltshire, over a quarter of routine and manual workers are current smokers.

In all three local authority areas, the prevalence of smoking for people in social housing is over four times the prevalence for people who own their home outright. Smoking inequalities by housing tenure are greatest in Swindon, where 40% of people who rent from a local authority or housing association are current smokers, compared with 6% of people who own their house outright.

Taken from BSW Partnership 'NHS Long Term Plan - internal intelligence briefing' 2021.

Obesity

Obesity does not affect all groups equally, it increases with age, and is more common in middle aged adults, people with low incomes, some BME groups and people with mental health issues, learning or physical disabilities (Batterham, 2020).

For children and adults, obesity and poor diet are linked with type 2 diabetes, high blood pressure, high cholesterol, and increased risk of respiratory, musculoskeletal, and liver diseases.

Increasingly, children with obesity are being diagnosed with a range of health conditions previously seen almost exclusively among adults. Obesity in childhood can also result in serious psychological difficulties (Childhood Obesity Foundation, 2014). In the *NHS Long Term Plan*, the UK Government has pledged to halve childhood obesity and significantly reduce the gap in obesity between children from the most and least deprived areas by 2030 (NHS England, 2019).

People with obesity are also at increased risk of certain cancers, including being three times more likely to develop colon cancer (NHS, 2019). The risk of developing type 2 diabetes is up to six times higher in certain Black, Asian and Minority Ethnic (BAME) groups.

Around two-thirds of adults in Swindon and Wiltshire live with excess weight or obesity, which is similar to the national average. BANES is significantly below the national average for overweight or obesity, but still over half of adults are affected.

Percentage of adults (aged 18+) classified as overweight or obese 2019/20

Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	62.8	62.6	63.0
South West region	–	-	62.0	61.2	62.8
Plymouth	–	-	67.5	63.0	72.0
Torbay	–	-	67.0	62.3	71.4
Swindon	–	-	66.1	61.7	70.6
South Gloucestershire	–	-	66.0	61.5	70.5
Dorset	–	-	65.9	61.1	70.4
Cornwall	–	-	65.9	61.4	70.5
Wiltshire	–	-	63.9	59.3	68.5
Somerset	–	-	62.5	60.2	64.8
Bournemouth, Christchurch and Poole	–	-	62.2	57.4	66.7
Gloucestershire	–	-	61.4	59.5	63.3
North Somerset	–	-	60.5	55.7	65.1
Devon	–	-	59.3	57.7	60.9
Bristol	–	-	57.3	55.0	59.7
Bath and North East Somerset	–	-	55.4	50.8	60.0
Isles of Scilly	–	-	52.5	44.7	60.2

Table 3 Office for Health Improvement & Disparities (2022).

The BSW Inequalities Strategy

The BSW Inequalities Strategy offers a framework to build a foundation for our shared understanding of health inequalities as a system, bringing together existing strategy and local data and intelligence and focusing this on the CORE20PLUS5 population.

Core framework that formed this strategy:

- NHS Health Inequalities Improvement Programme Policy Drivers
- NHS Long Term Plan – Chapter 2
- Covid Pandemic Phase 3 Letter – Eight Urgent Actions
- NHSE/I 21/22 Operational/Implementation Planning Guidance – 5 Key Priorities
- NHS 2021/'22 (Q1&2) Health Inequalities Priorities for Systems and Providers Health Inequalities Improvement
- NHS England » 2022/23 priorities and operational planning guidance
- Healthcare Inequalities 2022/23 Planning Guidance Advisory Note February 2022
- Health Equity in England: The Marmot Review 10 Years On - The Health Foundation
- NHS Race and Health Observatory: Supporting named leads for health inequalities on NHS boards
- Building healthier communities: the role of the NHS as an anchor institution - The Health Foundation

NHS Strategic priorities

COVID-19 has highlighted the urgent need to prevent and manage ill health in groups that experience health inequalities, as outlined in the NHS Long Term Plan. To help achieve this, NHS England and NHS Improvement issued guidance as part of its 'phase 3' response to the COVID-19 pandemic, setting out eight urgent actions for tackling health inequalities.

Systems were asked to focus on five priority areas in the first half of 2021/22, distilled from the eight actions. The 2022/23 NHS guidance outlines a requirement to continue efforts to implement the five priority areas as set out in March 2021 guidance.

Figure 11: The NHS Five Priorities (national)

Priority 1: Restore NHS services inclusively

At national level, the decline in access amongst some groups during the first wave of the pandemic broadly recovered in later months. Insight work has, however, highlighted that in some cases pre-existing disparities in access, experience, and outcomes, have been exacerbated by the pandemic. It is therefore critical that systems use their data to plan the inclusive restoration of services, guided by local evidence. This approach should be informed by NHS performance reports that are delineated by ethnicity and deprivation, as evidence suggests these are the areas where heath inequalities have widened during the pandemic.

Priority 2: Mitigate against digital exclusion

Systems are asked to ensure that:

- providers offer face-to-face care to patients who cannot use remote services
- more complete data collection is carried out, to identify who is accessing face-to-face, telephone, or video consultations, broken down by relevant protected characteristic and health inclusion groups
- they take account of their assessment of the impact of digital consultation channels on patient access.

Priority 3: Ensure datasets are complete and timely

Systems are asked to continue to improve the collection and recording of ethnicity data across primary care, outpatients, A&E, mental health, community services, and specialised commissioning. NHS England and NHS Improvement will support the improvement of data collection across all settings, including through the development of the Health Inequalities Improvement Dashboard, which will contain expanded datasets where there is currently a relative scarcity of intelligence, e.g. for people experiencing post- COVID syndrome.

Systems should also implement mandatory ethnicity data reporting in primary care, to enable demographic data to be linked with other datasets and support an integrated approach to performance monitoring for improvement.

Priority 4: Accelerate preventative programmes that proactively engage those at greatest risk of poor health outcomes

Uptake of the COVID and flu vaccination has increased significantly across all groups, but inequality has also widened, particularly by deprivation and ethnicity. Systems and providers should take a culturally competent approach to increasing vaccination uptake in groups that had a lower uptake than the overall average as of March 2021. Preventative programmes and proactive health management for groups at greatest risk of poor health outcomes should be accelerated, as set out in the main 2021/22 planning guidance, including:

- Ongoing management of long-term conditions
- Annual health checks for people with a learning disability
- Annual health checks for people with serious mental illness
- In maternity care, implementing continuity of carer for at least 35% of women, with the proportion of Black and Asian women and those from the most deprived neighbourhoods meeting and preferably exceeding the proportion in the population.

Priority 5: Strengthen leadership and accountability

Supporting PCN, ICS and Provider health inequalities SROs to access training and wider support offer, including utilising the Health Inequalities Leadership Framework, developed by the NHS Confederation.

Core20PLUS5 – An approach to reducing health inequalities

Core20PLUS5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

Core20

The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

PLUS

- Integrated Care System (ICS)-determined population groups experiencing poorer than average health access, experience and/or outcomes, but not captured in the 'Core20' alone. This should be based on ICS population health data.

- Inclusion health groups can include: ethnic minority communities, coastal communities, people with multi-morbidities, protected characteristic groups, people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups.

- In BSW, the 'PLUS' population was defined at place using public health data to determine which population groups were experiencing the worst health outcomes in addition to the 'Core20'. These are:

    - BANES: **Socially excluded groups, migrants, vulnerable children, rural communities**
    - Swindon: **Black, Asian, and minority ethnic communities**
    - Wiltshire: **routine and manual workers**, specifically those in minority groups (e.g. polish speakers). This is due to higher smoking prevalence. For example, latest data from 2019 showed 27.9% of smokers in this occupation group for Wiltshire compared with 23.2% nationally. This is also in support of the evidence that smoking is the main driver of inequalities and ties into prevention. With a significant predicted growth in older population of Wiltshire, tackling working age now has more potential long term benefit for the health and social care system.

'5'

The final part sets out five clinical areas of focus. Governance for these five focus areas sits with national programmes; national and regional teams coordinate local systems to achieve national aims.

1. **Maternity:** ensuring continuity of care for 75% of women from Black, Asian and minority ethnic communities and from the most deprived groups.

2. **Severe mental illness (SMI):** ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in learning disabilities).

3. **Chronic respiratory disease**: a clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

4. **Early cancer diagnosis:** 75% of cases diagnosed at stage 1 or 2 by 2028.

5. **Hypertension case-finding**: to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

The clinical areas have been funnelled directly from the NHS LTP commitments on tackling health inequalities in addition to Global Burden of Disease data and Public Health England contributions. National data shows Cardiovascular Disease, Chronic Respiratory Disease (in particular COPD) and Cancer as the biggest contributors to the gap in life expectancy between the most and least deprived populations. Furthermore, the NHS LTP has highlighted maternity services and annual health checks for SMI as key areas of wide inequitable disparities.

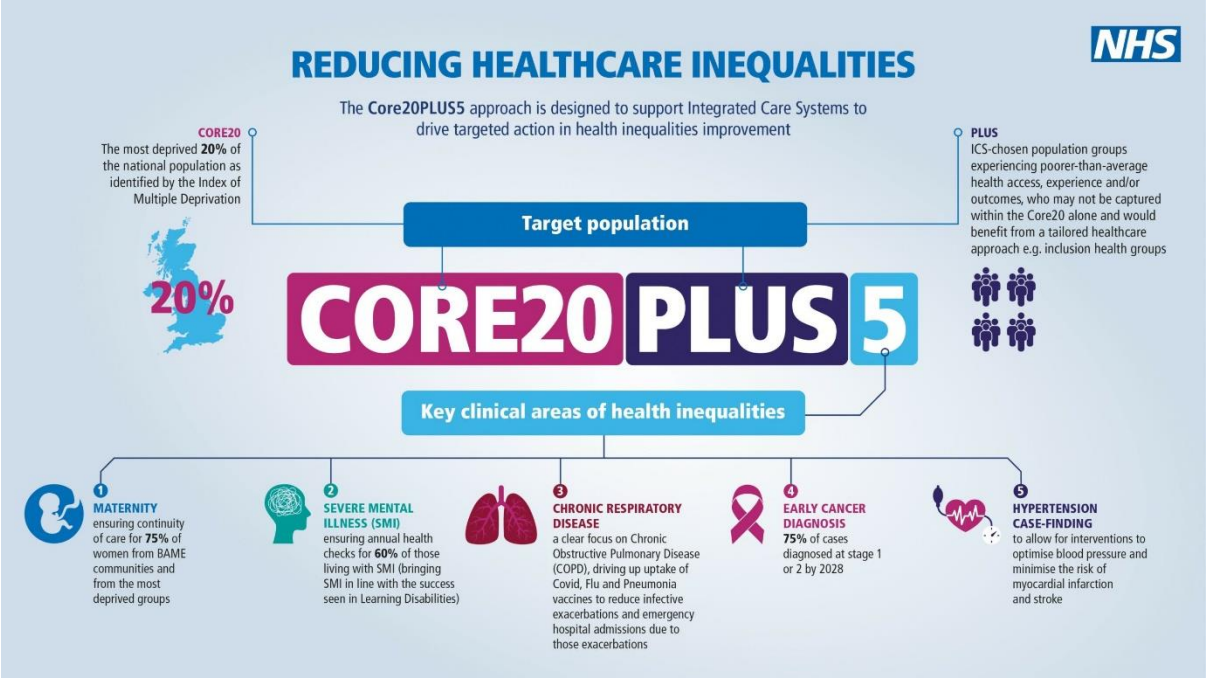

Figure 12 taken from: NHS England » Core20PLUS5 – An approach to reducing health inequalities

Prevention

Tertiary prevention	Softening the impact of an ongoing illness or injury that has lasting effects. This is done by helping people manage long-term, often-complex health problems and injuries (e.g. chronic diseases, permanent impairments) in order to improve as much as possible their ability to function, their quality of life and their life expectancy.
Secondary Prevention	Systematically detecting the early stages of disease and intervening before full symptoms develop – for example, prescribing statins to reduce cholesterol and taking measures to reduce high blood pressure.
Primary Prevention	Taking action to reduce the incidence of disease and health problems within the population, either through universal measures that reduce lifestyle risks and their causes or by targeting high-risk groups.
Wider determinants	These are the social, economic or environmental factors affecting health, such as housing, employment, education, or parks and green spaces.

Figure 13 Definitions of prevention, adapted from: Prevention | Local Government Association

Healthcare represents an important driver to reduce overall health inequalities, but this strategy seeks to encompass the broader role of prevention and the wider determinants of health. To support progress on this, BSW will also include action that take a broader view of prevention. These additional areas will be determined as data supporting this strategy from the updated BSW Joint Strategic Needs Assessments (JSNA) are published in 2022-2023, and form phase two of implementation planning.

Whilst this data will refine work needed to target on prevention and the wider determinants of health, this strategy will focus on **smoking** and **obesity** as key areas for prevention.

Anchor Institutions

Anchor institutions are "*large, public-sector organisations that are unlikely to relocate and have a significant stake in a geographical area*" (The Health Foundation, 2019). The size, scale and reach of the NHS means it influences the health and wellbeing of communities simply by being there.

In addition to its core purpose of delivering health care services, the NHS has the potential to influence the conditions in which people live, learn, work and age (The Health Foundation, 2019). We know that health care itself has a limited impact on the health of our communities and therefore on addressing health inequalities.

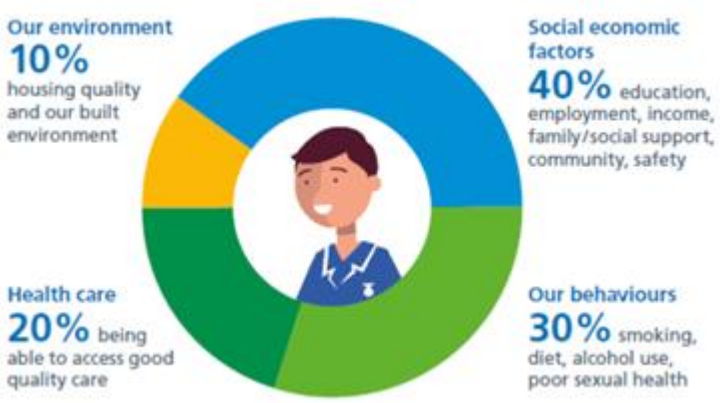

Figure 14 Adapted from University of Wisconsin Population Health Institute. County Health Rankings Key Findings 2014

However, as an employer of 1.4 million people, with an annual budget of £114 billion in 2018/19, the health service creates social value in local communities. Some NHS organisations are the largest local employer or procurer of services at place.

The infographic below (figure 15; The Health Foundation, 2019) indicates some of the ways in which NHS organisations in particular can leverage greater social value from our activities. The term anchor institution reflects that these organisations are rooted in their 'place', unlikely to move and therefore able to align their long term plans with the interests of their local communities in a way other entities cannot. Anchor institutions are large, non-profit local organisations that can choose to use their resources differently in order to drive greater health and wellbeing, and in a targeted way to address health inequalities through tackling some of the wider determinants of health. Specifically in BSW these are likely to be hospitals and universities or colleges, noting that the implications of the widening gaps in healthy life expectancy place an even greater impetus on hospitals to adopt these approaches. This can be done collectively with local authority or educational partners at ICA level or across the ICS as an NHS collaboration.

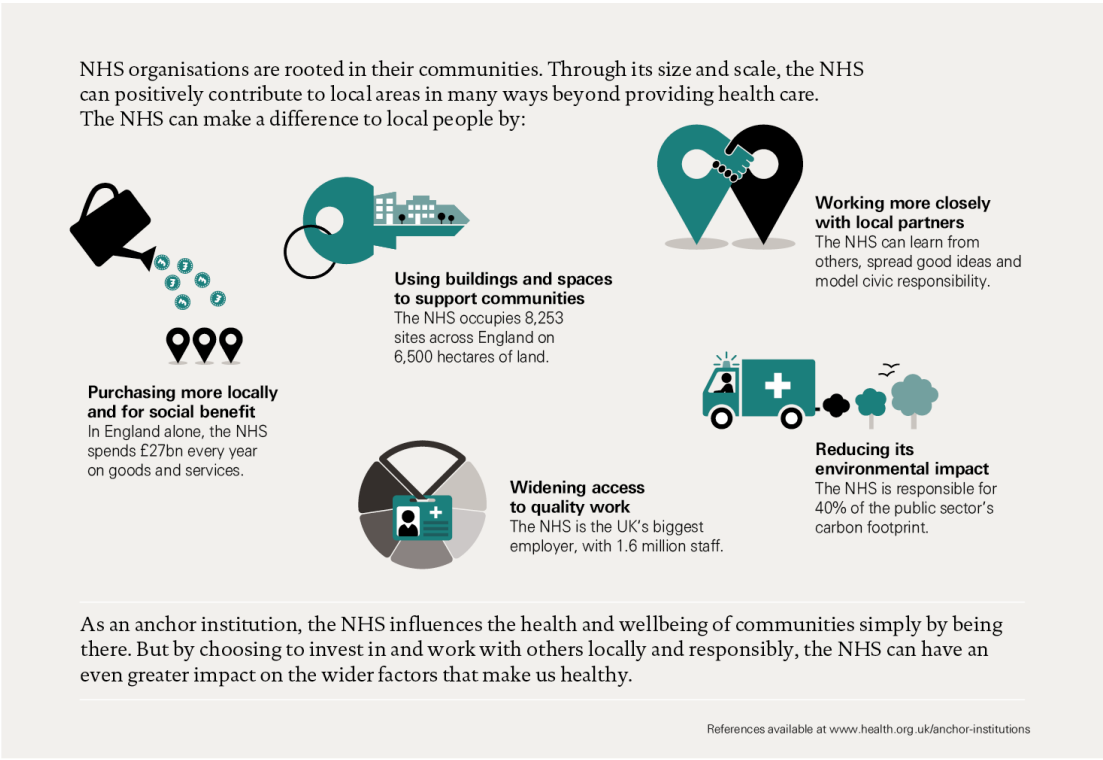

Figure 15 Image taken from: Building healthier communities: the role of the NHS as an anchor institution, The Health Foundation (2019).

The NHS Long Term Plan (2019) sets out the ambition to work with sites across the country to identify more of this good practice that can be adopted across England. The BSW Inequalities strategy includes the target to form anchor institutions as a lever to support change in the wider determinants of health. The example below shows how hospitals or health systems in the US, as anchor institutions have sought to improve community health.

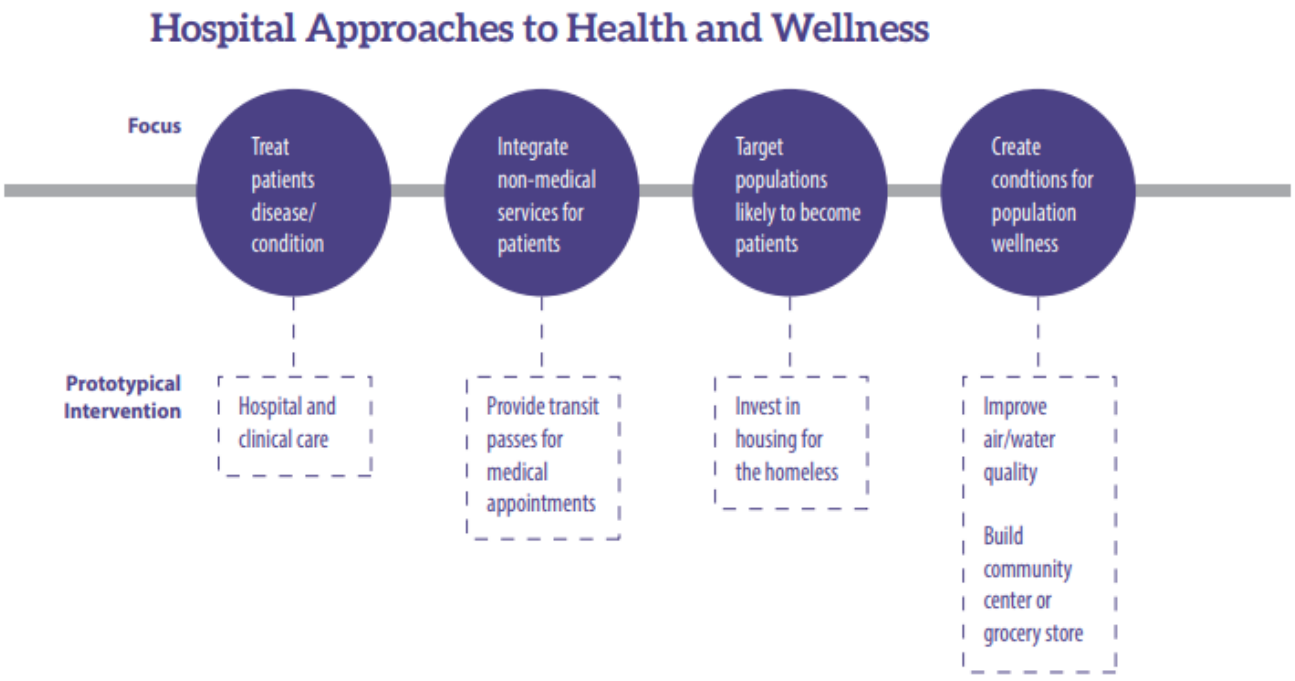

Image adapted from Robin Hacke, et al, "Improving Community Health by Strengthening Community Investment: Roles for Hospitals and Health Systems."[2]

Figure 16 (referenced above)

Domains of anchor influence

The Health Foundation (2019) identifies five ways in which NHS organisations act as anchor institutions:

- employment
- procurement and commissioning for social value
- use of capital and estates
- environmental sustainability
- as a partner in a place

Setting targets and measuring progress

Arising from the five NHS priorities and the CORE20PLUS5 approach, there are a set of defined targets to deliver. There are specific metrics arising from these targets to measure how we progress against them (see appendix 2). Each phase of the strategy will have an implementation plan developed to refine detailed action plans, metrics, and reporting.

How we will deliver

Targets for this strategy have been identified over key themes: awareness raising; healthcare inequality and the Core20PLUS5; and prevention and wider determinants.

Figure 17 Three phases of the BSW Inequalities Strategy - summary

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

Figure 18 Three phases of the BSW Inequalities Strategy

Implementation

Implementation, development, and evaluation of the inequalities strategy and action plan will be driven by the BSW Inequalities strategy group. This group will include members from across the system including local authority, public health, local commissioned services, and Avon and Wiltshire Partnership Trust.

Working in partnership, an implementation plan will be developed for each phase which will detail specific objectives, timelines, and the identified lead organisation. Building on existing work, detailed action plans will be in place for each work area. Various groups, including task and finish groups and local communities will be involved in the implementation of the strategy.

Governance

This strategy is governed by the Population Health and Care group through the Inequalities Strategy Group which will monitor an action plan.

Not all interventions will be directly under the governance of the inequalities strategy as they will report through their own governance arrangements. However, bringing the contributions together under the BSW Inequalities Strategy will ensure coherence and progress of action. There will also be a need that the inequalities agenda and strategy is linked to other allied strategies and vice versa.

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Appendix 1 - One page summary

Phase 1: Awareness Raising

Phase 2: Healthcare Inequality

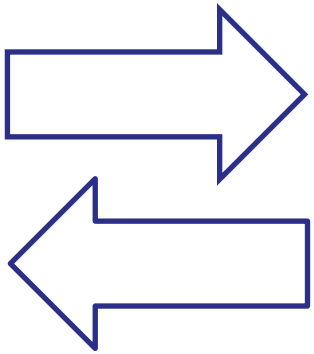
NHS Five Key Priorities

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

Core 20 Plus 5

- Core 20% of most deprived areas
- PLUS Groups (defined at place):
  - Black, Asian, and Minority Ethnic groups (Swindon)
  - Routine and Manual workers (Wilts)
  - Socially excluded and vulnerable groups including looked after children and migrants (BANES)
- Five clinical areas

1. CVD
2. Maternity
3. Respiratory
4. Cancer
5. Mental Health (inc. CYP)



Phase 3: Prevention and social, economic, and environmental factors

Priority Areas:

- Anchor institutions
- Publish three place-based Joint Strategic Needs Assessments for BANES, Swindon, and Wiltshire
- Establish local priorities that address public health and the social, economic, and environmental factors most affecting inequalities at place
- Plan and enable progress on prevention where outcomes will take longer to see

Committed areas of focus

- Whole system approach to Obesity
- Whole system approach to Smoking

Cross-cutting themes: Population Health Management (PHM); Equality, Diversity, and Inclusion (EDI); Workforce; Prevention; Personalised care

Appendix 2 – Draft Metrics

Phase		Vision	Metrics	Restore Services Inclusively	Mitigate against digital exclusion	Ensure datasets are timely and complete	Accelerate Preventative Programmes	Leadership and Accountability
1	Making inequalities everybody's business	All staff, partners, and communities to understand inequality and how we seek to address this in BSW	20 sessions delivered by April 2023					✓
			50% increase of staff network trained by April 2024					✓
			Resource library to be available and distributed by **September 2022**					✓
			All staff to have access to Health Inequalities storytelling by **December 2023**					✓
2	Healthcare inequalities and CORE20+5	Work with commissioners and service providers to ensure robust and up-to-date data across the system on where inequalities are, and clear plans on how close the inequality gaps to offer exceptional quality healthcare for all through equitable access, excellent experience, and optimal outcomes	Increased access across the system to data segmented by ethnicity and deprivation (as standard)	✓				
			Performance reports will be broken down by patient ethnicity and IMD quintile, focusing on:	✓				
			Identifying who is accessing different modes of consultation by collecting data on patient age, ethnicity, disability status, condition, IMD quintile		✓			
			Improved data collection on ethnicity across primary care, outpatients, A&E, mental health, community services, specialised commissioning			✓		
			Increased understanding of equity of access, experience and outcomes for priority groups as shown through patient engagement	✓				
			Engagement in digital supported self-management services				✓	
			Continuity of care for 75% of women from BAME communities and most deprived groups	✓			✓	
		Achieving the Core20PLUS5 targets to reduce the inequality gaps identified in the five clinical areas	Annual health checks for 60% of those living with with severe mental illness and learning disabilities	✓			✓	
			Increase in flu and Covid-19 vaccine uptake				✓	
			75% of cancer cases diagnosed at stage 1 or 2 by 2028				✓	
			Increase in hypertension case finding				✓	
			Prevalence of current smokers in BSW				✓	
3	Tackling inequality by addressing social, economic, and environmental factors	Reduce smoking prevalence across BSW, with targeted focus on routine and manual occupations and smoking in pregnancy	Prevelance of current smoking with routine and manual occupations				✓	
			Prevelance of people smoking in pregnancy				✓	
			Proportion of smokers received smoking cessation support within hospital				✓	
			Proportion of pregnant smokers offered support in maternity settings				✓	
			Uptake of lifestyle services– exact metric tbc				✓	
		Halt and reverse of obesity prevalence in children and adults across BSW	Engagement in NDPP				✓	
			Engagement in Digital Weight Management Programme				✓	
			All three acute hospitals in BSW achieve chartered anchor institution status by 2025				✓	✓
		Establishing and harnessing the potential of local anchor Institutions in our three acute hospitals and mental health trust to deliver positive change across all domains of anchor influence including employment, procurement, and environmental impact	Increased number of local hires				✓	✓
			Increased number of apprenticeships				✓	✓
			Increased recruitment representative of local demographic data				✓	✓
			Increased local vs. central spend where possible				✓	✓
			Increased community use of NHS estates				✓	✓
			Increased support for NHS staff to access affordable housing				✓	✓
			Increase in accessible community green space				✓	✓
			Decreased carbon output through improved energy efficiency, increased sustainable travel options				✓	✓
			Reduced waste and water consumption				✓	✓
			Develop and support anchor collaboratives/networks (e.g. AWP, Local authorities, campuses, leisure centres)				✓	✓

Appendix 3 – Decile rankings for domains of deprivation in BSW neighbourhoods

Taken from BSW Partnership. (2021). NHS Long Term Plan - internal intelligence briefing: November 2021. Lower-layer Super Output Areas (LSOA) that are in the most deprived decile nationally (IMD, 2019).

1	= Most deprived decile
2	= 2nd most deprived decile
3	= 3rd most deprived decile

Neighbourhoods (LSOA) in most deprived decile overall	Domain of deprivation						
	Income	Employment	Education	Health & Disability	Crime	Barriers to Housing & Services	Living environment
BANES							
Twerton West	2	1	1	1	2	7	10
Whiteway	1	2	1	2	2	5	9
Swindon							
Penhill East	1	1	1	1	2	7	6
Penhill North	1	1	1	1	1	7	4
Penhill Central	1	1	1	1	1	6	6
Upper Stratton South East	2	1	1	1	3	4	8
Pinehurst West	1	1	1	1	1	5	7
Pinehurst South	2	2	1	2	1	4	6
Park North North	1	2	1	1	2	5	6
Walcot East East	2	2	1	3	1	4	4
Walcot East South West	2	2	2	1	1	5	4
Walcot East North West	1	1	1	2	1	6	4
Park South Central	1	1	1	1	1	7	6
Park South South West	1	1	1	2	3	2	5
Wiltshire							
Studley Green	1	1	1	3	3	5	8