Better Care Plan

Wiltshire Locality 2021/22

Final Version for submission to NHS England

28 October 2021

Bath and North East Somerset,
Swindon and Wiltshire Partnership
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Contents

4. Foreword and Introduction

4.1. Wiltshire Council and Wiltshire Clinical Commissioning Group (CCG) are pleased to present their Better Care Fund (BCF) Plan for the period 2021/22.

4.2. During the period since the previous plan, the impact of the COVID 19 pandemic with its necessary policy and delivery changes tested the Wiltshire system, but the strong culture of joint working and governance provided a stable platform to meet the challenges.

4.3. In March 2020, the Wiltshire health and social care system began operating within the context of the COVID 19 pandemic and the national DHSC pandemic response. The system was flexible to respond to the pressures in the acute hospitals and operated effectively as an alliance including streamlining hospital discharge processes, increasing discharge to assess capacity in the community, integrating Council and CCG brokerage functions, commissioning designated units in the community. This included significantly investing in Home First and Reablement capacity. The staffing pressures in the home care and care home market, the return of full elective service and evidence of increasing complexity of need will be pressures across the system in 2021/22.

4.4. The Hospital Discharge and Community Support Policy and Operating Model released on 7 July 2021 (updated 19th October 2021) sets out the aim to embed the D2A model actioned during the COVID 19 response. There is an expectation that performance continues to reduce the length of stay for people in acute care, improve people's outcomes following a period of rehabilitation and recovery and minimise the need for long-term care at the end of a person's rehabilitation.

4.5. In response, the Wiltshire Better Care Plan 21/22 is based on a review of priorities and funded schemes in the context of the new operating environment and recovery post pandemic:

- Increased pressure on primary care capacity due to COVID 19 response and vaccine
- The impact of workforce shortages in domiciliary care and qualified nurses
- Capacity constraints in Discharge to Assess (D2A) Pathway 2 (PW2) beds caused by increased length of stay in beds based in care homes due to closure, outbreaks or lack of home care capacity in the community. We still have significantly higher commissioned and funded capacity than pre-COVID19 levels
- The hospital 'Criteria to Reside' national guidance has had a substantial impact on the discharge pathway for those at the end of life. In Wiltshire in 2020/21, an average of 20% of people discharged from hospital into PW2 beds died there
- Many people are likely to need more support post COVID 19 due to the impacts of deconditioning and long COVID. Prolonged sedentary enforced lifestyle has particularly impacted older people, accelerating decline in social, physical, mental health and wellbeing. This increases potential to need social care support, including residential support services earlier than would have originally been anticipated
- Increased cost of care in the community due to staffing shortages, increased provider costs (fuel, food, insurance, utilities) and the impact of COVID infection prevention and control measures. In 2020/21 this is supported by the continuation of HDP funding, but we are working as a system to have a robust three year funding plan with secure recurrent funding in-place for all BCF plans.

4.6. The ambition of this plan is to consolidate the strong relationships and governance formed during pandemic response, and to use the BCF as an integration enabler to maximise the opportunities for people to remain independently well at home, and, in the event of hospital admission, return home for recuperation and rehabilitation as soon as possible.

5. Better Care Plan Context

Wiltshire Joint Strategic Needs Assessment

5.1. The Wiltshire Recovery Joint Strategic Needs Assessment outlines the impacts of the pandemic on a variety of thematic areas referred to as chapters. Data has been gathered from a broad range of sources to achieve this.

Local demography and the Needs of Wiltshire's Population

5.2. Wiltshire is a large, predominantly rural and generally prosperous county. Wiltshire Council and Wiltshire Alliance are coterminous and the registered and resident populations are therefore largely the same.

5.3. The population of Wiltshire is served by three main acute trusts, only one of which is in the County. Around 35% of Wiltshire residents use Salisbury Foundation Trust (SFT), 31% use the Royal United Hospital (RUH) in Bath with the balance (around 29%) attending the Great Western Hospital (GWH) in Swindon. This distribution of activity and service demand adds complexity to admission avoidance and discharge planning

5.4. Almost half the population lives in towns and villages of fewer than 5,000 people and a quarter live in villages of fewer than 1,000 people. Approximately 90% of the county is classified as rural and there are significant areas with a rich and diverse heritage of national and international interest, such as Stonehenge and Salisbury Cathedral.

Table A illustrates the scale of the challenge facing the County. Taken from the Wiltshire Joint Strategic Needs Assessment (JSNA), it shows a 7.1% rise in overall population to 2030 but with an increase in the same period of 26.7% for over-65s and around 60% for over-85s (although significantly fewer in terms of numbers alone). In the same period, the working-age population is projected to reduce by 1.7%, making an urgent case for resilient communities and a sustainable health and social care system. These ageing changes are greater in Wiltshire than in other systems in the South West or in England[1].

Table A: Wiltshire demographic forecast

Table: Population	Mid-year estimate		Population Projection			
	2014	2017	2018	2019	2020	2030
Total Population	484,560	496,043	498,500	503,600	510,100	531,500
Under 20	114,609	115,852	116,200	117,200	118,700	117,800
Ages 20-64	273,123	276,425	275,700	277,400	280,100	271,800
Aged 65 & over	96,828	103,766	106,400	108,800	111,100	141,900
Age 65+ (% of total pop)	20.0%	20.9%	21.3%	21.6%	21.8%	26.7%
Aged 85 & over	13,283	14,193	14,500	14,900	15,300	22,600

5.5. An additional challenge, particularly in the South of the County is that recruitment of care staff remains difficult in an area with low unemployment and where house prices are higher. The pandemic and reduction in European workforce availability have exacerbated the

[1] Source: ONS Sub-National Population Projections, 2016
2 Source : Wiltshire Council Adult Social Care Team, 2018/19.

situation, with increasing competition for staff in a large, predominantly rural and generally prosperous county.

5.6. We know that high levels of social isolation can lead to admission to hospital and greater levels of care. Levels of social isolation, as measured by the annual client and biannual carers' survey, are higher than we would like to see within Wiltshire, and the pandemic has exacerbated this. The Wiltshire Older People's Collaborative reviewed the impact of social isolation and identified areas at high risk of social isolation. This led to the development of the prevention service to support the signposting of people to local community assets which can help reduce the levels of social isolation across the county.

5.7. Current performance on the 91 days at home after reablement is an improving trend as the year progresses, as set out in Table B

Table B % people remaining at home at 91 days after reablement

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Reablement	70%	68%	69%	82%	76%	78%
Home First	66%	72%	68%	79%	75%	86%
AVG	68	70	69	81	76	82

6. Better Care Plan (BCP) Strategic Priorities for 2021/22

6.1. Following full consideration of the national planning requirements, the priorities for the Wiltshire 2021/22 Better Care Plan have been jointly agreed with partners across Wiltshire and are set out below in Table C. Each priority is aligned with national conditions. Work on these priorities is progressing and is monitored at the Locality Commissioning Group and key elements feed into the Wiltshire Alliance Programme Board.

Table C

	National conditions	Wiltshire 21/22 Priorities
1	A jointly agreed plan between local health and social care commissioners and signed off by the Health and Wellbeing Board	Consolidate the relationships and integrated working established during the pandemic and securing recurrent service changes made at pace
2	NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution	Continue to develop integrated services and investment into supporting adult social care maintained
3	Invest in NHS commissioned out-of-hospital services	Continue to develop the anticipatory care and urgent response community based services Deliver improvement as required against the High Impact Changes Falls prevention is an area for review and improvement as part of the development of rapid response services Secure recurrent investment in community based care services, recognising the significant investment already made.

	National conditions	Wiltshire 21/22 Priorities
4	Plan for improving outcomes for people being discharged from hospital	Continue to develop the discharge to assess model to ensure it meets the criteria for a D2A model and flexibly meets the needs of our staff and residents. Review and improve process and delivery on Pathways 1 and 2 Improve access to reablement 7 days a week Development plan for the joint brokerage service Support market capacity for home care Improve integrated performance reporting Develop live demand and capacity information

Changes and additions to the BCP 21/22

6.2. To ensure that we are targeting our resources to places of maximum benefit, key BCF schemes are currently undergoing strategic review to assess whether they are fit for purpose in the current operating context. The reviews are being reported through the Locality Commissioning Group (LCG). See table D below.

Table D

Service Area	Descriptor	Type of report	Review status	LCG Date
Carers	Wiltshire Carers	Review prior to Tender	In progress	December 21
BCF	Better Care fund	Dashboard	Complete	October -21
Home From Hospital	Home from Hospital Age UK service	Review	In progress	October-21
Brokerage	Integrated 7 day brokerage function	Report with dashboard	Completed, development of future options to enhance	Apr-21
Home First , PFH and co ordination	Pathway 1 discharges, including pathway and Patient Flow Hub	Full service review	In progress, specification drafted	February 22
Audit Hospital discharge flow Pathway analysis	Short term P2 funded audit	Project report	Completed	Jun-21
PW2 Beds	All temporary beds used for step up and step down plus associated services	Full service review	Completed	Jun-21
Trusted assessor	Trusted Assessment across the pathway	Full service review	Completed	Jun-21
Urgent community response	2 hour community rapid response to	Project report and performance	Completed	Jul-21

	prevent avoidable admissions			
Public Health fuel poverty	Public Health project	Short report	Jan-22	Feb -22
Mental Health Pilot	Crisis response pilot	Project report and dashboard	Complete	Sept-21
2 day reablement response	Part of the urgent community response standards	Project report	February 22	March -22
BCF Medvivo Contracts	All contract lines	Full service review	In progress	December -21

The strategic review of the BCF has led to the following changes:

- **Consolidating** an integrated commissioning function through the development of a dedicated BCF commissioning team
- **Support** for service improvements through BCF theme service improvement projects with the CCG e.g., P2 Bed Review and Pathway 1 review
- **Increased** funding for integrated personal and health care services at home
- **At scale** roll out of a fully integrated 2 hr Rapid Response service to prevent unnecessary hospital admissions
- **Integration** of the CCG and Council brokerage services, supporting personalised care
- **Increase** in services for complex mental health support for older people in the community e.g., Virtual ward rounds in care homes
- An Intensive Enablement Service was launched in March 2021 and focuses on maximising independence for people over the age of 18 who have complex needs and behaviour which challenges. This is designed to reduce escalation and maintaining individuals in community settings avoid admissions.
- **Increased funding** for at home and bedded reablement services
- **Increased support** to social care to enable smoother and more timely hospital discharge and flow from bedded reablement
- **Increased funding** for Trusted Assessment to enable faster discharge from hospital and bedded reablement facilities
- **Review** of service specifications across the hospital discharge service schemes to ensure synergy in key performance indicators

6.3. The existing programme of 33 schemes funded by the BCF continues to be implemented (taking into consideration the changes and reviews outlined above) with the objective of contributing to NHS England's 'high-impact changes' and our specific performance objectives.

6.4. Our ambition is to deliver the national High Impact Change Model HICM) which aims to support local care, health, and wellbeing partners to work together to prevent, delay or divert the need for acute hospital or long-term bed-based care. We recognise that while sometimes hospital is the most appropriate place for someone to be, most people want to be at home and independent for as long possible, and that this is generally the best place for them to recover.

6.5. To support the HICM, a self-assessment has been produced by the Local Government Association (LGA). As part of the development of the BCP, the Wiltshire system has together assessed delivery across the 5 key changes:

- Population health management approach to identifying those most at risk

- Target and tailor interventions and support for those most at risk
- Practise effective multi-disciplinary working
- Educate and empower individuals to manage their health and well-being
- Provide a coordinated and rapid response to crises in the community

6.6. The outcome of this self-assessment process has identified areas of strength and some for further improvement. The assessment has informed the development of our priorities and how we will work together to address them. We recognise that success in these priorities is contingent on how we align ourselves, work together, collaborate and share resources and information. An integrated approach is essential. Please see Appendix 2 for more detail on the Wiltshire Approach to Integration

7. How BCF Services support our approach to integration

7.1. It is important that the BCF schemes follow the agreed Wiltshire Alliance Principles (see Appendix 2) and maximise the opportunities that integrated working brings us. Accordingly, three of our major delivery vehicles in 2021/22 have been jointly designed and commissioned and delivered through the Wiltshire Alliance partners - The 2-hour crisis response service, Pathway 2 service delivery and Home First.

7.2. **2 hr crisis response service** Wiltshire Health and Care (WHC) Community Teams have integrated with Wiltshire Council and Medvivo to provide the core service model for 2 hr crisis response services. These services have been enhanced to enable response to all two-hour community crises with a full multidisciplinary approach. WHC Community teams will also be an important service to provide ongoing planned health care after the crisis has been attended to. Social care: Adult social care responding to Carer Breakdown are integral to supporting people to stay at home or in their usual place of residence and preventing hospital admission. Medvivo are integral in the provision of a Single Point of Access and providing Urgent Care at Home services. To support this the Alliance has also identified funding for a Wiltshire adult community overnight nursing service, recognising this as a clear community service gap and essential to support rapid response services to avoid admissions

7.3. **Pathway 2 (PW2) Bed review** Following a full review of discharge to assess bedded capacity, a new model is in development in order to address the discovered inequity and efficiency of current services.

7.4. The review found that the nature of the demand is often complex, the majority (over 75%) of all PW2 referrals meet the criteria for therapy assessment and the opportunity for rehabilitation which is largely not now conducted in hospital. Too many referrals for people with dementia are not successful, meaning they are denied rehabilitation assessment and opportunity for improvement. Our current arrangement of PW2 beds into D2A or IR creates an inequitable access to services.

7.5. In order to address the inequity, the review proposes a change of bed model for PW2 which removes the artificial boundary of IR and D2A beds in care homes and creates one access route to one set of beds called PW2 beds. These beds will have GP, social care and therapy support which will be commissioned as part of PW2 bed commissioning. The commissioning of medical, clinical, and professional support needs to be consistent and aligned to the commissioning of the PW2 beds, with a single commissioning lead for both provision of the beds in care homes and clinical cover

7.6. The centres will also accommodate step up beds for use by rapid response and 2 day bedded reablement. Here, integration will also develop at a micro level, not just organisationally, with care home staff trained in a reablement approach, and KPIs for each team. PW2 bedded units will need additional support and training in dementia and older person's mental health needs, and end of life care

7.7. **Home First services**, although operated by two different providers, Wiltshire Health and Care and Wiltshire Council, the service shares a joint pathway, joint MDTs and has a monthly shared dashboard to monitor overall performance and effectiveness.

8. Joint Priorities for 21/22

8.1. Since its first iteration, the BCP has provided a strong framework for integration, transformation, and system wide delivery across Wiltshire. In 2021/22, post pandemic, the BCF has been a main enabler in the design of the urgent changes required to deliver hospital discharge services, aid recovery, and manage pressure across the system.

8.2. The table below sets out how the BCF is delivering effective improvements for our population in the key BCF theme areas, against our identified Priorities.

Priority for 21/22	BCF theme	Actions in 21/22
Continue to develop effective preventative services in the community	Anticipatory care and Out of hospital services	Implementation of the Safe and Warm project. The Centre for Sustainable Energy is funded by BCF to employ a Community Caseworker to work closely with the Wiltshire Council Re-ablement Team to support their clients with fuel poverty related advice
Deliver the action plan to improve the flow and outcomes from PW2 beds	Hospital discharge	Implement new PW2 bed model
Implement the changes required following the PW1 and 2 reviews	Hospital discharge	Service improvement plans to decrease length pf stay in hospital
Continue to develop end of life care services outside of hospital	Anticipatory care and Out of hospital services Hospital discharge	Implementation of 24 hr community nursing 2 hr rapid response, early supported discharge and enhanced support to care homes
Continue to develop support to carers	Anticipatory care and Out of hospital services Hospital discharge	Review of local needs and Tender services
Continue to develop the integrated technology, reablement and housing services for Wiltshire	Anticipatory care and Out of hospital services	recruitment of a project lead and refresh the strategy

8.3. The BCF-led reviews of the hospital discharge service pathways have identified that circa 50% of referrals to pathway 1 and 2 services originated from a fall at home leading to a hospital admission. 2021/22 will see the key stakeholder groups developing an enhanced approach for falls prevention, starting early and in the community.

8.4. As part of the aim to develop community resilience and market capacity, ensuring people are discharged from hospital in a safe and timely manner, the focus of the additional, non-

recurring, resources will be on the continued wider transformation of adult social care (including front door services) to support the NHS.

8.5. We will continue to develop an integrated offer for support at home and hospital discharge services as part of the integrated discharge pathway, along with continued efforts to increase capacity in the domiciliary care market through our Alliance framework.

8.6. These are important steps for delivering tangible change in line with the Joint Health and Wellbeing Strategy, so people can say their care is planned with people who work together to understand them and their carers, put them in control, and co-ordinate and deliver services to achieve best outcomes for them.

9. Changes to existing Better Care Plan Schemes

9.1. Our vision is for better care aligned to the outcomes in our JHWS and on the Recovery JSNA (see Appendices 4,5 and 6) that is led and informed by the people of Wiltshire. The principle of 'care as close to home as possible' is embedded in all our thinking with home being the first option. This vision is delivered through the joint principles of discharging people home as soon as they are medically fit and a focus on long-term independence.

9.2. The BCP has been the key driver for out of hospital care and has provided a very strong case for change that is evidence-based and recognised and understood by the whole system. The BCP has been running for the last five years and has provided a strong framework for integration, transformation, and system wide change.

9.3. Taking into consideration the changing context and backdrop against which we need to deliver, there are some key changes to the BCF-funded schemes which are set out in the following table:-

Table E below sets out the main changes to BCF schemes for 21/22

Schemes	Change to scheme in 21/22
Therapy Support Intermediate Care	New PW2 model; access to therapy support for all who are assessed to need it
Acute Trust Liaison	Review in progress to improve efficiency of these roles which are employed by Medvivo and assigned to each acute Trust
Access to Care (SPA)	Review in progress to ensure this is an effective service which meets the purpose of a Single Point of Access
Patient Flow Hub	In 2020/21 extended to 7 days a week, 8-8 and is Hospital Discharge SPA, triage and coordination point for D2A. Continued development of a single co-ordination point for Wiltshire
Step Up/Step Down Beds	New bed model for PW2 beds to be implemented in 2021/22, ensuring we have the 'right beds in the right places'
Home First Plus	Increased funding to meet increased demand
GP & ANP Cover for Intermediate Care	Redesigned and recommissioned jointly with the new bed model to meet increased complexity
Trusted assessor	Trusted assessor increased funding to cover all 3 Acute sites
End of Life Care: 72-hour Pathway	Under review with a view to redesign

Self-Funder Support	Integrated health and social care Brokerage Service
Finance, Performance & PMO	BCF Commissioning Team recruited

10. Supporting Hospital Discharge

10.1. Our approach to improving outcomes for people being discharged from hospital is based on the national policy of Discharge to Assess, as outlined in the Hospital Discharge and Community Support Policy and Operating Model, NHS. All operational teams work to integrated discharge pathways, with oversight by the weekly Wiltshire Discharge Review group, reporting to the weekly Wiltshire Urgent Care & Flow Operational Group.

The principles for the service are:

i. Unified vision that brings system partners together
ii. Simplify and standardise as far as possible.
iii. Use services for diversion and admission avoidance as well as discharge
iv. No discharge destination determined from the ward
v. Coordinate the use of voluntary sector at all decision points
vi. Outcomes and whole person journey are a key indicator of success not just flow data
vii. Understanding our demand, capacity and outcomes

10.2. A BCF Dashboard has been developed and is an important performance management tool to measure our improvement - it is a reference for all decision making points.

How the BCF Schemes support hospital discharge

10.3. The table below (Table F) sets out the BCF hospital discharge schemes and the support they offer to the system and our population.

Table F

BCF Hospital Discharge Schemes	How the scheme supports safe, timely and effective discharge
Hospital Discharge Service performance and commissioning	A dedicated commissioner within the BCF commissioning team oversees performance of the schemes against local and national targets and monitors capacity in all hospital discharge services, with direct commissioning of beds and domiciliary care, enabling early identification of issues and rapid flex of capacity.
Home First Plus	The aim of the service is to provide short-term reablement for recover at home safely following discharge from hospital. Home First teams identify the support needed and using strength-based approaches encourage independence at home. This service is also used for admission avoidance.
Social work teams	This dedicated hospital discharge team supports triage and social care support to people who require it on hospital discharge. The service case manages individuals until they get safely home, when there is hand over to community teams if required.
PW2 Beds	When people required bedded support for discharge if they are still poorly or unable to manage or be safe at home even with support packages of care

BCF Hospital Discharge Schemes	How the scheme supports safe, timely and effective discharge
GP and AHP support to PW2 beds	Dedicated GP support based on an agreed specification. The additional support is required to support sub-acute hospital discharges and manage readmissions from PW2 beds, due to the increase in complexity following the implementation of criteria to reside standards. The team also includes Nurses, Occupational Therapists, Physiotherapists and Pharmacy review.
Housing support	Hospital discharge teams work closely with Housing support including use of the Disabled Facilities Grant (DGF) to support people with housing issues at discharge. In 201/22 BCF commissioners are planning to develop an action plan with housing and other with key stakeholders to include equipment and Technology as an enabler of independence at home.
Equipment and technology	OTs are able to access support for equipment and technology from an integrated service to enable discharge home, particularly focused on those people at risk of falls who live alone, and early dementia
Integrated Brokerage	The integration of the brokerage service has enabled the sourcing all care post assessment, including the hospital to home service, discharge to assess pathways, continuing healthcare and end of life provision. The approach also offers enhanced brokerage and care navigators to support self-funders to reduce delays. Multidisciplinary team (MDT) case management and frailty pilots are showing significant cost and quality benefits. Brokerage has also moved from being a 5 to 7 day service
Rehabilitation Support Workers	The rehab support workers enable the required capacity for reablement at home
DFLG	Three OTs are funded through and also Kingsbury Square emergency homelessness service has been funded through to assist with hospital discharge and disabled placement
Trusted Assessor	When the discharge process was altered during the pandemic, it provided sound evidence of the positive impact the role can have on increasing the efficiency and timeliness of hospital discharges. While the pandemic occurred just as the TA was beginning to become established, the evidence shows 152 process days were saved during the early weeks of the pandemic when hospitals were urgently trying to discharge as many patients as was safely possible in preparation for the peak of the outbreak. Funding has been agreed to extend the current TA role and recruit an additional TA to extend coverage across the county.
Patient Flow Hub (PFH) SPA	The Wiltshire Patient Flow Hub is the single point of access for all supported hospital discharge, currently pathways 1-3. The flow hub MDT team triage referrals and allocate to a discharge destination, home or bedded support. It operates 8-8, 7 days a week
End of life care - 72-hour pathway	This service supports the early discharge of patients requiring hospital discharge home with end-of-life care needs. it is a 7 day a week service
Acute Trust Liaison	This is an in-reach service to support discharge issues such as access to voluntary sector support

11. Helping People to Remain in Their Own Home

11.1. Wiltshire Council brings together Health, Care and Housing services to support people to remain in their own home through adaptations and other activity to meet the housing needs

of older and disabled people. There are several mechanisms through which we work to do this.

11.2. The Disabled Facilities Grant (DFG) is managed as a component of the BCF, ensuring a whole system approach to prevention and reablement. DFG supports people to live at or as close to home as possible and is a key enabler to increase the number of people living in their own homes, avoiding longer residential or other support costs. Allocation of funding from the DFG is based on need, which varies month to month depending on the case load and professional assessment of need. There is strong collaboration between Health, Public Health and the Council in order meet the housing needs of older and disabled people

11.3. We value working with Planning, Policy and Public Health teams, in addition to Housing and Health colleagues, to exploit the potential to secure new housing built in Wiltshire is fit for purpose for older and disabled people, through strategic working and medium to long term planning. We see the potential of innovative housing solutions, such as cohousing, to create intentional communities that incorporate health and wellbeing into the design, leading to less reliance on Health and Social care as the members of these communities are able to provide support to one another

11.4. Public Health funds an exercise class (across the Council's leisure centres) to contribute to falls prevention, on referral from the reablement. They are looking at how prescribed medication may have a side effect that may contribute to the risk of fall and how changes in practice and behaviour can reduce the number and severity of falls - e.g., standing blood pressure checks vs seated and promotion of care home residents getting up and walking across the room to collect or order a drink, rather than it being brought to them, ensuring movement and confidence improve. The home assessment links to the therapists in Housing to ensure any adaptations required to maintain independence are in place in a timely way.

11.5. There are Occupational Therapists in the Private Sector Housing Team that provide advice for anyone who requires adaptations, to either consider if a property would be suitable for adaptation before they move or can be adapted for those who are already living in the properties. Consequently, the Occupational Therapists link in with Housing Allocations (from the Housing Register – Homes 4 Wiltshire), the Homelessness Team and Tenancy Services Term – demand for the housing OTs are very high.

11.6. There is also a Rough Sleeper Outreach Team within the Homelessness Team and health is a big issue. Through grant funding there are various officers with specific support links to the Drug and Alcohol and Mental Health service provision as these are two significant areas of need when looking at rough sleepers' health issues.

11.7. The Wiltshire Housing Residential Development Team has spoken with Public Health to discuss their requirement for more green space on developments. The team are supportive of this approach; however, it isn't secured by planning policy and it contradicts the Housing Management and Maintenance Team's requirement of reduced green space (due to the maintenance liability), therefore there are conflicts to resolve in the long term

11.8. There is a current tender process to find a modern methods of construction (MMC) manufacturer for the next 3 years. The M4(2) and M4(3) provision sets out the level of accessibility of the proposed homes. The teams are also seeking a price from the MMC suppliers for an additional "Pod" that can be added to the 2- or 3-bedroom house designs to provide a downstairs bedroom and bathroom that can turn a traditional family home into an adapted home that will work for families in need of downstairs space. This pod can be adapted to the individual needs of the family. Also involved in this project to ensure provision meets future requirements are Homes for Wiltshire and Whole Life Commissioning.

11.9. Wiltshire Housing Principal Development Officers (Negotiate Planning Applications) currently aim to negotiate 10% adapted (M4(2)) units on all schemes with 10 or more Affordable Housing units. If there is a specific need identified for a customer whose needs are proving difficult to meet through adaptation of existing stock, the PDOs aim to negotiate a bespoke adapted unit and would liaise with the relevant OT.

When aware of an unusual (non-standard) adapted unit coming forward (e.g., large wheelchair accessible bungalows) they inform the Housing OTs and Allocations Team know that the scheme is progressing and likely to start on site.

Through the Local Plan Review Process the PDOs have been involved in trying to secure a requirement in the Local Plan to provide a percentage of all homes as adapted – mostly to M4(2) but possibly with some to M4(3) standards. Inclusion of this requirement will be dependent on the viability testing of the policies.

11.10. This year's BCP aims to see closer working between housing, health and care commissioners to evaluate the impact of DFG schemes and to strengthen the links between DFG, Community Equipment services and Assistive Technology.

12. Risk

12.1. Four significant risks have been identified in relation to the Wiltshire Better Care Plan. These are known and shared risks and issues which have been set out, together with summary level actions to give assurance that there are plans in place to reduce these risks as much as possible.

Maintaining stability across the whole local health and care system

12.2. The local health and social care system faces significant operational, clinical and financial challenges with all partners including providers coming under increasing financial, capacity and quality pressures. Demand management programmes have been implemented with some level of success however it is not clear that this will continue in the face of these unprecedented challenges. There are significant workforce recruitment and retention issues across health and social care, and commissioners face significant affordability pressures, with community provision not yet fully expanded to meet demand, and the requirement to pump prime community-based services against a continuing requirement for acute bed capacity to manage elective recovery.

12.3. With significant pressures in funding across health and social care, integration is essential to support sustainability. Opportunities for joint commissioning, avoiding duplication and maximising value for money, are continuously being developed across Wiltshire as we work towards the ICS and Wiltshire Alliance.

12.4. Our finances need to flow across the system in a way that appropriately pays providers and helps all organisations achieve long term financial balance by unlocking efficiencies in different parts of the system.

12.5. Transformational programmes and the opportunities offered through the Alliance, will allow us to remove some of the traditional tariff and contract barriers according to patient need, by placing the money in the part of the systems where it is needed. Money will be able to follow the patient/customer and by renewing our focus on self-care and prevention, the pressure on the whole system will be better managed.

Financial risks

12.6. In the first four years of the BCF programme, no overspends occurred across the pooled fund but increasing demographic demands do present a continuing risk to the pooled fund, which may have an adverse effect on services that have been commissioned through the BCF.

12.7. It is therefore important to mitigate this risk through the close financial monitoring of the BCF through the new governance structures, which will continue to receive monthly financial monitoring reports, at Local Commissioning Group (LCG). Where pressures on services are identified, the LCG will need to identify and implement solutions to ensure that the programme delivers within the available funding.

12.8. The Section 75 agreement has clearly set out the principles for managing any overspends.

Programme Risks

12.9. Risks relating to the funding or performance of any scheme are managed through a risk log and raised at the LCG at the earliest opportunity to allow for transparent conversations and shared problem solving. In the event of the Group not being able to remedy this action, the issue will be escalated to the HWB. The Alliance Delivery Group and Programme Board also receive programme reports relating to the key schemes that are shared in the Alliance Work Programme. This provides an opportunity to identify and share risks and collectively work to resolve them.

Workforce

12.10. Wiltshire has a specific risk in terms of workforce due to a lower-than-average number of people of working age within the local demographic. High levels of employment in the county also makes recruitment to care roles more difficult. A separate workforce task group has been established by the BSW Partnership, which is focusing on addressing the challenges in the local system. There is a particular emphasis on the role of colleges in supporting the development of a local social care workforce through new courses and apprenticeships.

12.11. We have shared the vacancies and recruitment challenges with the BSW People Group which is developing a system-wide strategy for closing some gaps by working across a larger footprint. In Wiltshire we have agreed as partners that we will avoid competing against each other for workforce wherever possible.

13. Programme Governance

13.1. There are robust governance arrangements in place which provide assurance regarding the management and oversight of the BCP and the Alliance work programme.

13.2. The development of the BaNES, Swindon and Wiltshire integrated Care System (BSW ICS) and the Wiltshire Integrated Care Alliance (ICA) has seen governance arrangements refreshed, and system leaders from health and social care are committed to working together to build on the closer relationships made in order to delivery recovery from the pandemic and improved outcomes for their population, at scale.

13.3. The Wiltshire Alliance is part of the Bath and North East Somerset, Swindon and Wiltshire (BSW) Integrated Care System (ICS) Partnership and works to improve the health and wellbeing of the population of the Wiltshire.

13.4. It is a collection of partners which includes among others, Wiltshire Council, BSW Clinical Commissioning Group, Wiltshire Health and Care, Salisbury Foundation Trust, the Royal United Hospital Bath Foundation Trust and Primary Care Networks across Wiltshire. We work closely with third sector organisations and other health and social care providers.

13.5. Two principles underpin the BSW ICS governance arrangements which flow through into the Locality arrangements. Appendix 1 illustrates the BSW integrated care system governance map. The map is embedded in the Alliance Programme Governance Framework, which was approved by partners in June 2021,

- Decisions are made at system- or locality-level and taken by the partner organisations – leaders at system and locality levels come together and form agreements in principle and by consensus, then take these to their sovereign organisations for ratification.
- We aim to make and take decisions at the most appropriate level and as close to local level as possible.

Wiltshire CCG Governing Body and Wiltshire Council Cabinet:

13.6. As the executive bodies of the two organisations pooling budgets, these are responsible for signing off the s75 agreement and agreeing the procurement of significant new initiatives (above the limits set out in the respective organisations' scheme of delegation).

13.7. Elements of the BCP that require key decisions will, as appropriate, be reviewed by the CCG Governing Body and to the Council's Cabinet.

Wiltshire Health and Wellbeing Board

13.8. Strong joint governance is central to effective integration and transformation. The Health and Wellbeing Board (HWB), which includes lead members and chief officers from the Wiltshire health and social care system, continues to oversee the delivery of the BCP. The HWB is also responsible for signing the s75 agreement and for gaining system-wide buy-in to the BCP. The HWB receives standing updates on progress against the high-level BCP outcomes and on the delivery of new schemes to ensure that the leadership of the CCG (the Wiltshire Alliance from April 2022) and the Council have clear, shared visibility and accountability in relation to all aspects of the BCF.

Locality Commissioning Group

13.9. The Locality Commissioning Group (LCG) is a joint decision-making group with delegated authority from the council and BSW CCG. This includes overseeing the management of existing joint investments and initiatives alongside a targeted programme of activities that maximises opportunities where greater coordination and alignment are beneficial. In accordance with the BSW CCG's Constitutions and Standing Orders, the BSW Governing Body established this Wiltshire Locality Commissioning Group (the Committee). The BSW CCG's Delegated Financial Limits, and Scheme of Reservations and Delegations, apply.

13.10. The Committee may operate in common with relevant Committees of other organisations in the interests of integration

13.11. The Committee is accountable to the BSW CCG Governing Body and Wiltshire Cabinet. The Committee will, where appropriate, act as an advisory and decision-making body, to the two commissioning organisations, making recommendations to the CCG for change in commissioned services, and making decisions within the remit of the ToR.

13.12. Approve and ensure implementation of policies as may be required to support integrated / collaborative / joint commissioning, following consultation with Cabinet, and ensuring alignment and compliance with Wiltshire Council policies

13.13. The Committee has delegated authority from the BSW CCG Governing Body and Cabinet to make decisions on all matters related to areas within the pooled budget and where there is joint funding between the CCG and Local Authority. The Committee represents the partnership of health and social care commissioners across Wiltshire to build on a shared vision for the commissioning and development of services, taking into account:

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

The members of the Committee will ensure that any of their commissioning decisions are:

- Evidenced based
- Co-produced and co-ordinated around the individual

- Based on continuous engagement and collaboration with population
- Sustainable, productive and affordable
- Outcome-focused
- Improving patient access and egress to/from services at the right time
- Improving customer experience, individual to tell their story only once
- Improving operating consistency
- alignment and/or integration of resources can lead to improved outcomes and efficiency.

Wiltshire Alliance Programme Board

13.14. The Wiltshire Alliance Programme Board (WAPB) is an oversight group Membership includes all key stakeholders within Wiltshire. the Better Care Programme is a key area of work within the Alliance Work Programme. The Board reports to the Wiltshire Alliance Leadership group which also oversees financial decisions are made at LCG and recommendations made via ADG.

Wiltshire Alliance Delivery Group

13.15. The Wiltshire Alliance Delivery Group (ADG) is accountable to the Alliance Leadership Group and provides a forum for leaders and experts across the health and social care system to focus on design and delivering the Wiltshire vision of integrated health and social care based on the outcome and specifications set jointly by health and social care commissioners. The scope of responsibilities of this group expands to areas of integrated care, urgent care, primary care, secondary, voluntary services, community services, mental health and disabilities.

13.16. The Wiltshire Ageing Well Board oversees the schemes and service improvement agenda for BCF at an operational level and makes recommendations to the LCG and Alliance Programme Boards.

13.17. Wiltshire Council is an active member of the South West ADASS and supports the benchmarking of adult social care performance on a quarterly basis.

13.18. BSW CCG contracts the services of the SCW CSU and Commercial organisations to help understand performance and capture best practice ideas from across the country and internationally to understand how they can relate to Wiltshire and whether there is learning that can be transferred to our system.

14. Closing Summary

14.1. This paper has set out the Better Care Fund Plan for 2021/22 within the context of the challenges for Wiltshire in continuing to respond to the consequences of the COVID 19 pandemic and the population health challenges both now and in the years to come.

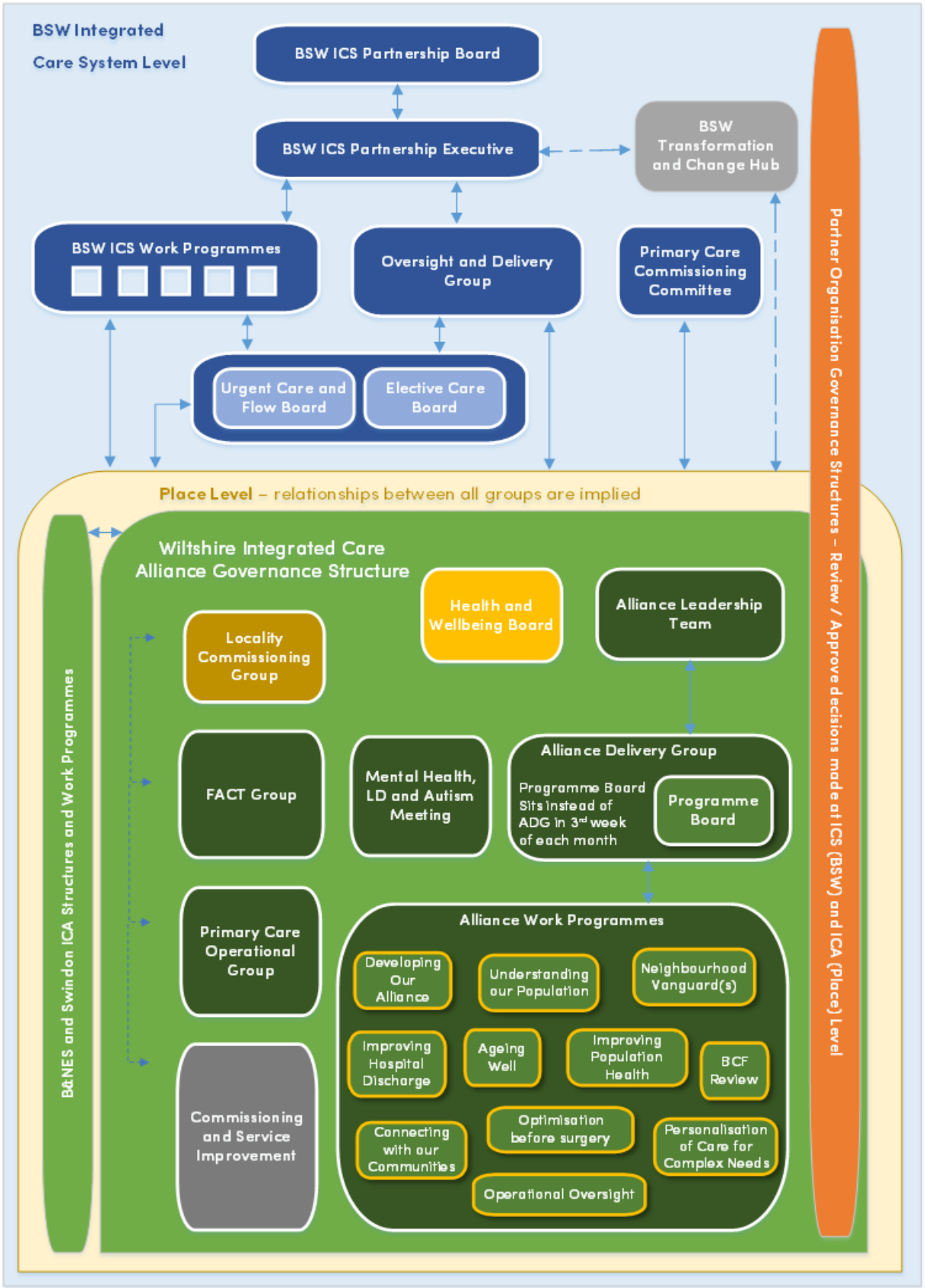
14.2. It has set out the priorities, associated schemes and amendments to the schemes which are aligned to our strategy and aimed at addressing the identified challenges and gaps.

14.3. The mechanisms for oversight of the BCP have been described to provide assurance regarding decision-making, performance monitoring and assurance.

14.4. These mechanisms also monitor the identified risks and we work collaboratively without partners to reduce the risks and to deliver the priority parts of the plan.

14.5. Further information and detail is available within the appendices which follow.

15. Appendix 1 - BSW Governance Process



16. Appendix 2 - Our overall approach to integration

16.1. Wiltshire, as part of the Bath and North East Somerset, Swindon and Wiltshire Integrated Care System (BSW ICS) is currently working towards a place-based integrated care alliance (ICA) – "Wiltshire Alliance". The Alliance brings together partners across Wiltshire to work in a collaborative and integrated way. It will become a formal entity in April 2022. In the new Alliance, the Health and Wellbeing Board will continue its role in identifying our priority areas for improvement.

16.2. Our vision for our Wiltshire population is set out in the Joint Health and Wellbeing Strategy (JHWS):

"People in Wiltshire live in thriving communities that empower and enable them to live longer, fulfilling healthier lives."

16.3. Additionally, the specific approach to integration within the JHWS is as follows:

"Ensuring health and social care is personalised, joined up and delivered in the right place, at the right time and as close to home where possible."

16.4. To deliver this vision, the Health and Wellbeing Board strategy set out four core themes:

- **Prevention** – Improving health and wellbeing by encouraging and supporting people to take responsibility for improving and maintaining their own health.
- **Tackling Inequalities** - Addressing the wider determinants of health, the conditions in which people are born, grow, live, work and age, to improve health outcomes.
- **Localisation** – Enabling communities to be stronger and more resilient and recognising that, across Wiltshire, different approaches will be required to deliver the best outcomes for all our population.
- **Integration** – Ensuring health and social care is personalised, joined up and delivered at the right time and place, and as close to home as is possible.

16.5. Delivery of the JHWS requires increased integration and cooperation between public health, primary care, secondary care and specialist health services, social care and other teams through multi-disciplinary teams. This affects how services are jointly commissioned at a countywide level and the development of joint working on enablers, such as workforce and digital.

16.6. The local health and care system remains under pressure and can be confusing for patients, families and carers. As our populations get older and more people develop long-term health conditions, our system is under greater pressure to cope with the changing needs and expectations of the people it serves. This leads to higher demand for social care and increasing pressure on carers and community health services. The pandemic has exacerbated longstanding inequalities. In order to evaluate and identify inequalities post pandemic, a Recovery JSNA for Wiltshire has been developed

The Wiltshire Approach to Integration

16.7. Wiltshire's health and care system leaders have placed engagement, leadership and cultural change at the heart of their programme of transformation. Governance arrangements have been refreshed and there is significant alignment of drive and commitment.

16.8. An in-depth understanding of the issues faced by the population is essential to the development of a plan that is going to have the strongest impact. Stakeholder engagement is core, and in the Terms of Reference of each decision making board reflect this. The development of the ICS and ICA has further strengthened Stakeholder engagement through whole day events and workshops, further strengthening relationships between partners.

16.9. The Alliance Leadership Group receives reports from the Alliance Delivery Group. the Principles for working together have been agreed in early 2021:

Wiltshire Alliance Principles

1. Work as one: partners collaborate sharing expertise, data and resources in the interest of our population
2. Be led by our communities: decisions are taken closer to, and informed by, local communities
3. Improve health and wellbeing: we take an all-age population health approach to improve physical and mental health outcomes and promote wellbeing
4. Reduce inequalities: we focus on prevention and enhancing access to services for population groups who are in poorer health or challenging social circumstances
5. Join up our services: we develop integrated and personalised service models around the needs of individuals
6. Enable our volunteers and staff to thrive; we support ongoing learning and development, and work collectively to ensure well-being is prioritised

16.10. The Alliance Delivery Group allows full and integrated engagement across all stakeholders, the list of whom is included in Appendix 2.

16.11. Engagement with stakeholders and communities is embedded into service specifications.

16.12. In addition, partners across Wiltshire Alliance are participating in the Optum Project which brings together data sources in an area to analyse them in new ways, identifying population health gaps and then working to address them. The Alliance will work to share the learning from this project both in terms of *how* the data was analysed as well as the outcomes so that we are able to embed this approach across Wiltshire.

Rather than simply looking for new schemes to initiate, the new governance arrangements seek to identify and challenge, from an evidence base, those local schemes and delivery outcomes that can be expanded or amended to deliver better outcomes and value for money, and to ensure that the wider footprint of the BSW Partnership is aligned to create appropriate economies of scale.

16.13. A joint Wiltshire BCF commissioning team offer the advantage of a dedicated and integrated commissioning resource. It provides oversight on the major initiatives of BCF and thus opportunities for identifying synergies and improved value for money. The team has close links with housing and in 2021/22 will further develop the already strong relationship.

16.14. Whole-place commissioning will be achieved by aligning budgets and, where appropriate, pooling budgets and integrating staff. Commissioning intentions are to provide more efficient, effective and coherent services leading to developing arrangements for capitated budgets and outcomes-based commissioning.

Since the first BCP was first produced in 2014, there has been significant progress in the development of joint-working, including the Health and Wellbeing Board (HWB) and the supporting Wiltshire Locality Commissioning Group. This is set up as a joint committee and so governance is effectively managed within the establishment of a strong Wiltshire Alliance governance structure.

16.15. With the development of the BSW ICS, the Wiltshire partnership works at scale where it makes sense to do so. Wiltshire shares learning with our geographical neighbours, while simultaneously realising opportunities to work more specifically to better meet the needs of our local population, now more than ever.

The BSW Partnership system partners are currently working together to identify the most effective ways of delivering as an ICS and a place-based ICA. The Partnership has embedded and continues to develop new way of working. The BCF has enabled a successful partnership structure on which to build tangible service improvements.

The Wiltshire BCP carries forward elements of the BSW partnership, which has established the following five key priorities:

- Improving the health and wellbeing of our population
- Reduce health and care inequalities
- Reform quality and experience of care
- Increase staff wellbeing and retention and deploy an inclusive, engaged and flexible workforce
- Reduce per capita cost of healthcare and protect environmental, social and economic resources

16.16. Prevention, locality-based joint health and care teams (the integration of process rather than structure) and a focus on workforce and capacity issues, such as the domiciliary care workforce and care home capacity, are strong themes running through the local BCP as well. The BCP also complements the Partnership's reform priorities for urgent and emergency care, particularly the national priority on hospital to home services.

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Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care

16.17. A strength- or asset-based approach to care acknowledges a person's disability and/or illness etc. but shifts the focus to 'the positive attributes of individual lives and of neighbourhoods, recognising the capacity, skills, knowledge and potential that individuals

and communities possess. It is based on the fundamental premise that the social work relationship is one of collaboration, and that people are resourceful and capable of solving their own problems if enabled and supported to do so'.

Wiltshire Council has several services that aim to address the prevention remit which focus on a strengths-based approach to promote independence and resilience and encourage the individual to make choices and have control about their wellbeing.

Frontline social work staff have had training to ensure a consistent approach to working with people and considering their strength and capabilities and what support might be available from their wider support network within the community and what else can be considered other than formal care services to assist the person in meeting their outcomes. This strength-based culture is driven by the Operational Directors as well as the Corporate Director of People.

Services in Wiltshire specifically focused on this include:

- A new Prevention and Wellbeing Team is working with people deemed at risk to holistically support them with their skills, ambitions and priorities in the community
- Carers Support Wiltshire is working with Carers to support people to remain at home when it is possible to do so. They also increased capacity to the hospital discharge hub to prevent discharge breakdown
- Expanded Reablement Services which work with people to promote independence and help people to achieve their outcomes and reduce the reliance on formal care services
- The Intensive Enablement Team works with people with Mental Health, Learning Disabilities and Autism who may be at risk of crisis, at risk of hospitalisation, risk of placement breakdown or may require a period of enablement to build on their independent living and problem-solving skills.
- Rapid Response is an integrated service supporting people at times of crisis as a result of illness or injury to remain at home and avoid a hospital admission, these people can be supported beyond the crisis to regain independence and confidence.
- There is also the Wiltshire High Intensity Users (HIU) service, commissioned to be provide by Wiltshire CIL, support those people who present often to services and working on strategies to support them to live independently.

17. Appendix 3 – Wiltshire Alliance Delivery Group Membership

- Wiltshire Locality Director of Commissioning, BSW CCG (Chair)
- Wiltshire Locality Clinical Chair, BSW CCG
- Wiltshire Locality Chief Operating Officer, BSW CCG
- Wiltshire Associate Director of Primary Care, BSW CGG
- Director Adult Care Delivery, Wiltshire Council
- Director of Adult Care Operations, Learning Disability & Mental Health Services
- Commissioning Director, Wiltshire Council
- Public Health Consultant, Wiltshire Council
- Managing Director, Wiltshire Health and Care
- Chief Operating Officer, Wiltshire Health and Care
- Director of Transformation, Salisbury NHS Foundation Trust (SFT)
- Associate Director Strategy, Salisbury NHS Foundation Trust
- Chief Operating Officer, Royal United Hospitals NHS Foundation Trust (RUH)
- GP representative , North and East Locality
- GP representative, West Locality
- GP representative, Sarum Locality
- Associate Director of Quality, Wiltshire Locality, BSW CCG

- Informatics Lead, Wiltshire Locality, BSW CCG

18. Appendix 4 - Health Inequalities

18.1. Existing health and social inequalities have been exacerbated during the pandemic. In response, Wiltshire has developed a Recovery Joint Strategic Needs Assessment (JSNA) to evidence the impact of the pandemic on our communities and to identify areas where we need to work together to mitigate against the detrimental effects we have seen. .

18.2. During a year where most of our time was spent in our homes, the need for a stable and safe environment to live in has never been so important. The quality and condition, stability and security, and affordability of housing can all have an impact on health and the COVID-19 pandemic has highlighted this. It is also known that groups that experience health inequalities are disproportionately represented in poor-quality homes.

18.3. Social impacts have been seen as a result of the pandemic, with most people spending the majority of their time in their houses during the most restricted points of the lockdown. A lack of outside space, loneliness, feeling unsafe, and safety issues (for example with repairs needed in rented properties) were all key issues.

18.4. Tackling health inequalities in Wiltshire requires our health and social care services to work with communities to address the wider determinants of health in the county, including social isolation and loneliness, poor housing, poor educational attainment, poverty, unemployment and family breakdown.

18.5. The increased needs of particular groups such as disabled people, carers, the military, those in prison, Gypsies, Travellers and Boaters - and the way these needs are met - can also affect the inequality gap. The Joint Health and Wellbeing Strategy sets out ways in which we are addressing health inequalities as a system. The Director of Public Health is a member of the Locality Commissioning Group that oversees the BCP in Wiltshire. The great joint working on Covid-19 vaccination yielded significant learning for engaging with particular groups and how we can involve them in the work of the Wiltshire Alliance.

18.6. Overcrowding in housing has been increasing over the years for private and social renters and in 2019-20, 9% of social renters and 7% of private renters lived in overcrowded accommodation. Overcrowding is less prevalent among owner occupiers, 1% of whom live in overcrowded accommodation. COVID 19 has further highlighted overcrowding as an issue, as it makes it more difficult for household members to self-isolate and can lead to an increased risk of viral transmission.

19. Appendix 5 - Equity of access - Mental Health and Dementia

19.1. Local dementia diagnosis rates are around 66%, very close to the national target level of 67% with some outstanding individual GP practice performance. However, the impact of dementia on long term care needs for families and care home capacity is continuing to rise.

19.2. The BCP work on training care home employees seeks to ensure residents remain at home safely rather than be transferred to hospital when this is not appropriate. A dementia strategy and action plan has been developed, although gaps in care and need must be targeted to ensure a more community-focused /crisis intervention-based model of care. Through the BCP, we are already looking at:

- Care Home Liaison services
- Focused support to AWP in relation to discharge planning
- Acute in-reach programmes for dementia

19.3. Demand for autism support services is also increasing.

19.4. The Wiltshire Joint Strategic Needs Assessment (JSNA) and other national and pathway-specific benchmarking tools are used to prioritise resources.

20. Appendix 6; The Adult Social Care market in Wiltshire

20.1. The care market in Wiltshire is facing several capacity and availability challenges that reflect those faced across the country, including recruitment and retention of adequate numbers of appropriately skilled and experienced staff. The majority of social care users in Wiltshire fund their own care, and this high percentage of 'self-funders' has influenced how the market has developed in the county.

20.2. The way home care is commissioned has changed with the development of Home First Plus, the Council's in-house reablement service to help manage demand and a move from purchasing care from a small number of lead providers to developing a Help to Live at Home Alliance that provides a framework to influence the market and manage price. The Alliance has attracted additional providers into the county and has allowed commissioners to develop workforce initiatives, including workforce capacity grants for providers and a Proud to Care workforce programme to support recruitment and retention. The Alliance Board, which includes provider representatives, has agreed a work programme with the priorities of workforce, process improvement and financial sustainability.

20.3. Rising costs form the pandemic, sharply rising energy and food costs have an impact on provider resilience, and commissioners are working with providers to support management of these risks.

20.4. Historically, the lack of home care capacity has led to an over-reliance on care home beds to support hospital discharges and there is more to do to stimulate the home care market, particularly in more rural parts of the county.

20.5. The voluntary sector is commissioned to provide 'Home from Hospital' services which support people who may need a little support, for example with shopping or confidence-building.

20.6. There is a mixed domiciliary care market in Wiltshire with a range of small and large providers. High levels of employment in the county make it difficult for providers to recruit and retain staff in care roles. Rurality is also an issue and it is difficult to secure provision in some more isolated parts of the county.

20.7. Providers are struggling with severe workforce issues which have developed during the pandemic, and the Alliance has developed integrated contingency plans for provider failure.