Integration and Better Care Fund

Narrative Plan Template 2017/19

Better Care Support Team

Area	Wiltshire
Constituent Health and Wellbeing Boards	Wiltshire
Constituent CCGs	NHS Wiltshire CCG

Contents

Introduction / Foreword

The Better Care Plan is well established across Wiltshire, leading schemes, managing the system in terms of flow and increased pressures and developing a consistent approach in relation to measurement, monitoring and delivery. The BCP plays a key role in managing pressure across the system and its impact continues to be monitored by the whole system with established system wide governance processes in place and this is being enhanced through a Joint Council & CCG Post encompassing the Director of Adult Social Care and CCG Accountable Officer role.

Several key schemes are being continued into 2017/18 and we would expect to see further improved performance in the next 12 months and a key commitment of all partners to maximise outcomes from existing schemes, priorities and expenditure. Enhancing the relative return on investment is of key importance during 2017/18 and into 2018/19 considering the challenging financial picture across health and social care and the requirements for improved performance and efficiency across the system.

Underpinning the continuation of key schemes is a commitment to deliver integrated care at the point of need and at as a local a level as possible. In addition, there is a need to maximise the opportunities that will be presented because of the integrated community services contract.

What is the local vision and approach for health and social care integration?

Our Better Care Plan is built upon our overriding vision of care as close to home as possible, with home always the first option.

This vision is delivered by a 2-stage transition;

Stage 1 – focus was very much on discharging people from hospital to home as soon as they are medically stable usually through an integrated package of care. This will enable the long-term independence of the service user.

Stage 2 retains the focus on long term independence with the aim being able to transition patients off package of care towards long term independence in their own home. Our performance during 2014/15 and 2015/16 demonstrated we are achieving this for the clear majority of the frail elderly population in Wiltshire and whilst we made further progress during 2016/17 we did, due to a range of factors, see a general increase in delayed transfers of care across our system. This is a key area of improvement during 2017/18 and 2018/19.

We are clear about the challenges facing us and know that without a change in the health and care system there is a significant risk that service quality will decline. The Better Care Plan has been the key driver for out of hospital care in Wiltshire and has provided a very strong case for change which is evidence based and recognised and understood by the whole system. The Better Care plan has been running for the last 3 years and has provided a strong framework for integration, transformation and system wide delivery across Wiltshire. Moving forward the Better Care Plan will be looking at prevention strategies both for the population to remain as healthy as possible but also through assistive technology as both will help the population remain out of hospital and reduce long term care needs.

Our vision for better care is based upon the outcomes which are set out in our Joint Health and Wellbeing Strategy and these are based on what our population tell us they want. These draw on the overarching definition of good integrated care, developed by National Voices, which looks at the delivery of care from an individual's perspective:

Care Planning and coordination "My care is planned by people who work together to understand me and my carer(s), put me in control, coordinate and deliver services to achieve my best outcomes"

My goals/outcomes: "All my needs as a person are assessed. Care planning: I work with my team to agree a care and support plan "

Communication:" I tell my story once. I am listened to about what works for me, in my life. Decision making including budgets: I am as involved in discussions and decisions about my care, support and treatment as I want to be."

Transitions: "When I use a new service, my care plan is known in advance and respected."

What difference will this make to patient and service user outcomes?

By 2020 we expect that the plan will have the following impact, as seen from a patient and service user perspective:

- ✓ My care is planned with people who are working together to understand my needs and those of my carers
- ✓ I will receive the highest standards of care in my own home
- ✓ I will not have to be unnecessarily admitted to hospital or stay there longer than I need to
- ✓ I am involved in all decisions about me and my care
- ✓ I am always kept informed and I always know who to contact if the need arises
- ✓ I am looked after in a place of my choosing
- ✓ I don't have to keep repeating myself to lots of different professionals
- ✓ I have a named person to go to when I need them
- ✓ I understand my condition and how it will affect me
- ✓ If things get worse I have a plan to help me cope
- ✓ I can have my care needs met in my place of residence
- ✓ I have good advice and sufficient information so I know how to look after myself and stay well
- ✓ I have a local support network around me that meets my wider (holistic) needs

Background and context to the plan

The Wiltshire Health & Wellbeing Board oversees the production of the Health and Wellbeing JSNA (http://www.intelligencenetwork.org.uk/health/jsa-health-and-wellbeing/) which is currently being updated and due to be published in November 2017. The following information is taken from the JSNA and where appropriate has been updated.

Wiltshire is a large, predominantly rural and generally prosperous county. Almost half of the population resides in towns and villages with less 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. The relationship between the city of Salisbury and the larger towns in Wiltshire and the rest of the county has a significant effect on transport, employment, travel to work issues, housing and economic needs.

Wiltshire's population is ageing more rapidly than England or the South West, reflected by growth of 17.5% in the number of people aged 65 or over between 2011 and 2016. This is substantially greater than the 13.2% increase in England or 14.0% increase in the South West. The table shows the population projection to 2030, given the levels of population growth for the over 65s

Wiltshire Population aged 65 and over, projected to 2030					
	2014	2015	2020	2025	2030
People aged 65-69	30,300	30,600	28,500	31,800	36,700
People aged 70-74	22,200	23,300	29,600	27,600	30,800
People aged 75-79	17,700	18,100	21,600	27,600	25,900
People aged 80-84	13,000	13,400	15,500	18,800	24,300
People aged 85-89	8,300	8,600	10,000	12,000	14,900
People aged 90 and over	5,100	5,300	6,700	8,700	11,300
Total population 65 and over	96,600	99,300	111,900	126,500	143,900

Table 1 – Age 65+ Population Growth

This represents growth of 48% in 15 years compared to England (41%) and South West (38%), there would be a significant cost associated with doing nothing, and as the evidence demonstrates the Better Care Plan in Wiltshire has been successful in reducing the hospital admission impact of such growth. Any future investment through the Better Care Plan needs to ensure it is targeted at the high risk, high cost cohorts and reduces ongoing demand on statutory services and demonstrates a clear return on investment. We are also looking at ways of integrating other wider services offered by the Council and the Voluntary Sector to support the wider

population. Initiatives like Warm & Safe Wiltshire which help insulate and update boilers in the homes of older people help to ensure existing homes remain a cost effective options for residents.

As graphs and data highlight that whilst there was a relative reduction in delayed transfers of care in 2015/16, there was a marked increase in delays during 2016/17 due to a series of service restrictions, significant increase in demand and reduced capacity. The key service priority for 2017/18 is to reduce the level of delays across the system. There also remains a strong ambition to transition more patients to full independence as quickly as possible to reduce reliance on statutory services. This remains a significant challenge when you consider the increase in the volume of patients over the age of 65 and the associated levels of frailty.

The graphs below highlight the scale of the challenge associated with an ageing population, increasing levels of frailty and complex comorbidities. As the projections below suggested we are likely to see an increase in our dependent population and highlights the need to ensure we mobilise and transition our elderly population to early independence ideally in a home setting in the community.

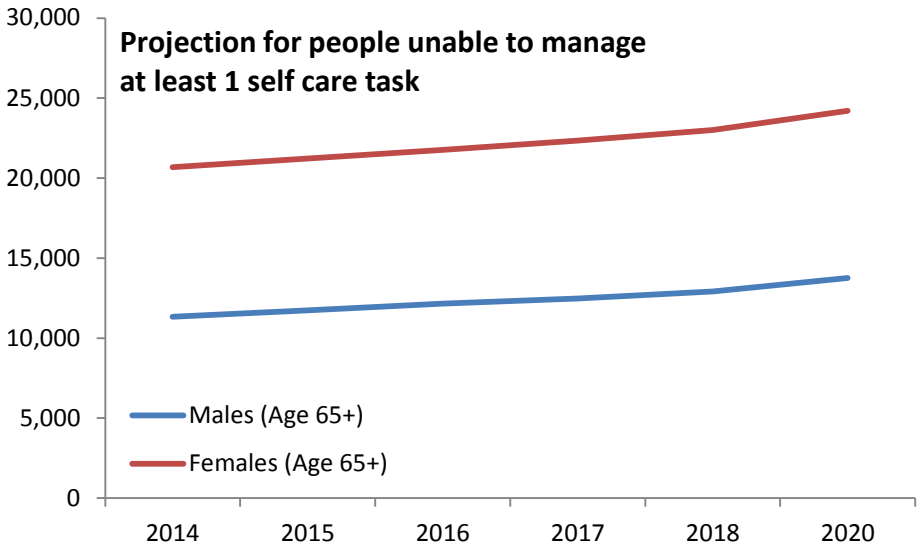

Figure 1 – Projection for people unable to manage at least 1 self-care task

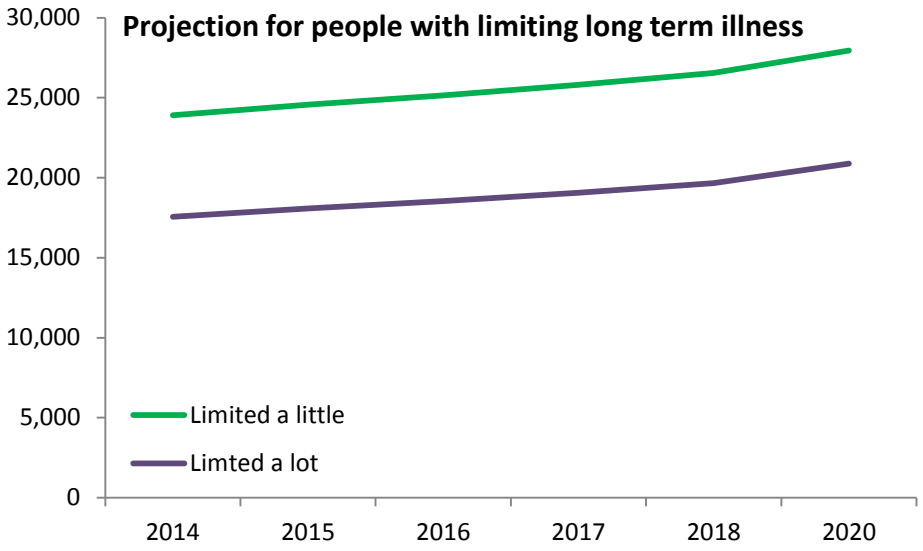

Figure 2 – Projection for people with limiting long term illness

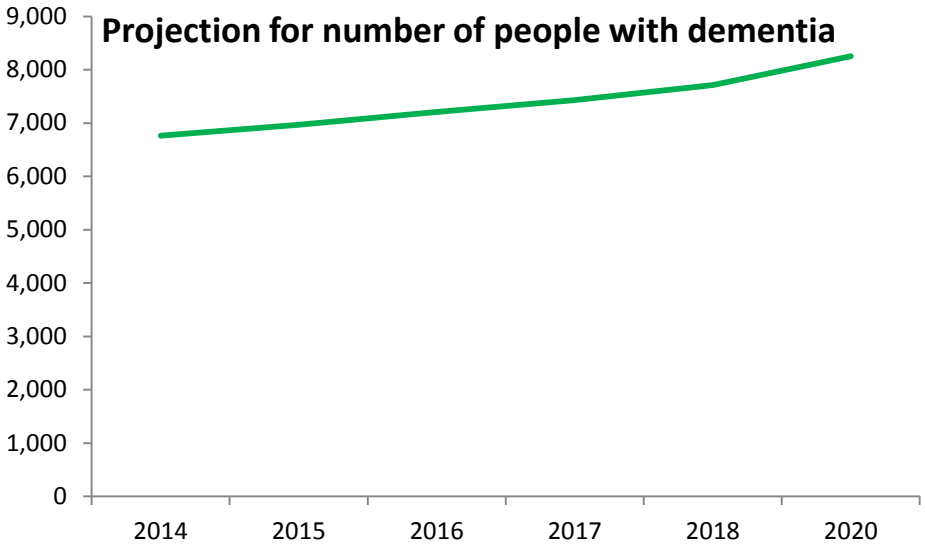

Figure 3 – Projection for People with Dementia

The Better Care Plan for Wiltshire will continue to have associated admission avoidance and length of stay reduction targets. Underpinning the continuation of key schemes must be the commitment to deliver integrated care at the point of need at as local a level as possible as well as maximise the opportunities that will be presented because of the integrated community services contract. There is an emerging linkage between the Better Care Plan and the STP process across Wiltshire and the key schemes within this programme are crucial in ensuring the long-term sustainability of the health and care system during this challenging period of austerity. As a result, we would expect to see a clear return for all investment made and develop a system wide process which reviews all schemes and areas of investment.

The Adult Community Service contract is now mobilised and fully operational in its first full year of delivery in 2017/18, the Wiltshire Health and Care Model plays a

critical role in delivering operationally the aims and ambitions of the Wiltshire Better Care plan and programmes led by Wiltshire Health and Care such as the High Intensity Care Programme and Home First will play a key role in managing crisis reducing demand across the system and improving flow

The Prevention Board has been refocused and has a very ambitious work plan to deliver in line with the key recommendations from the Wiltshire Older Persons Review. This approach will ensure that we reduce dependency as we transition patients through various pathway stages and ensure more residents will be maintained in their own home for longer. We will deliver this with targeted prevention programmes, signposting and navigation services, education programmes for patients and carers and bespoke training and support for staff across Wiltshire.

Progress to date

The following provides a summary of the progress made by the Better Care Plan during 2016-17, this is the foundation on which our priorities are based for 2017/18.

Activity and Outcomes

Non-elective admissions have grown by around 4.0% (1,657 admissions), growth in those aged 65 and over was 2.3% (464 admissions) which is less than might have been expected given demographic growth. The population aged 65 and over has grown by 11,000 people since 2013-14, if admission rates had stayed as they were this would have resulted in an extra 2,000 admissions in 2015-16 and there was an increase of around 1,000 admissions.

This represents a reduction in potential admissions of around 1,500. The Wiltshire rate of emergency admissions in the population aged 65 and over remains lower than the average for England. This is also reflected in the national integration dashboard which shows Wiltshire has the 10th lowest rate of admission for those aged 65 and over.

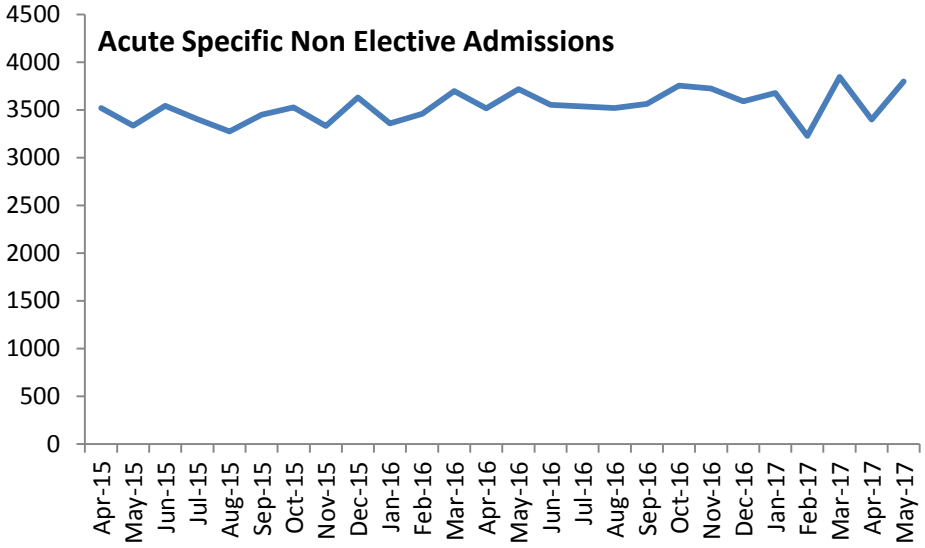

Figure 4 – Trend in Acute Specific Non Elective admissions

Avoidable Emergency admissions are showing a reduction of 4.8% on the levels seen in 2015-16. This suggests admission avoidance activity in the community is supporting patients before admission becomes necessary and causing increased acuity of admissions in hospital. This resonates with messages from the 3 acute hospitals in Wiltshire who have all experienced an increase in complexity and acuity of admissions through A&E.

Our Urgent Care at Home scheme supports admission avoidance and discharge facilitation, the graph shows the trend in activity for this scheme

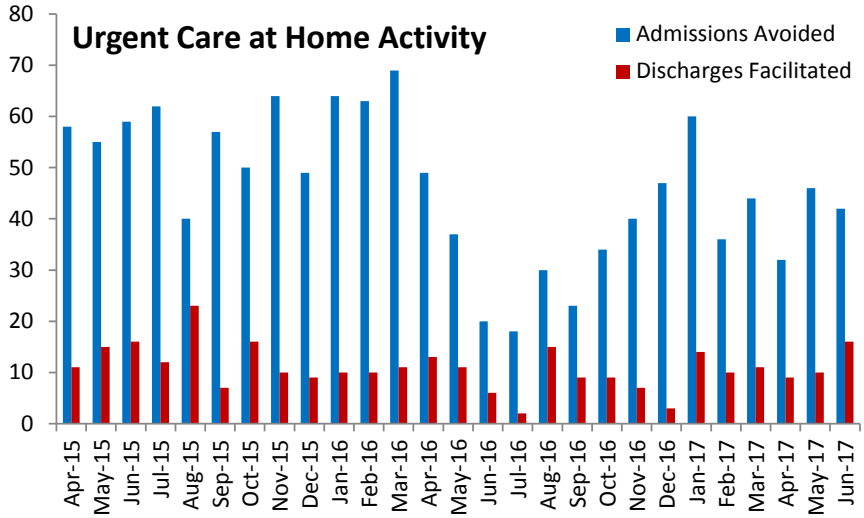

Figure 5 – Trend in Urgent Care at Home Activity

The provider of this scheme was subject to CQC restriction in early 2016-17 which is why activity levels dipped in the middle of 2016. Following the restriction we re-tendered the service and have a new provider who is currently looking to increase the number of session available on this scheme. In terms of admission avoidance activity performance remains strong with around 80% of those referred not going to hospital.

The figure shows that Delayed Transfers of Care have increased back to the levels seen in 2014-15, in part due to issues with CQC restrictions on one of the BCF schemes which limited our workforce for admission avoidance and discharge support as well as demand exceeding supply, increased complexity and inappropriate referrals. This has in effect negated the significant progress we made in reducing delayed transfers of care in 2015/16 and led to more beds being used than planned. The average number of daily delayed days in 2015-16 was 49.0, in 2016-17 this increased to 73.8 as a result of the issues outlined above.

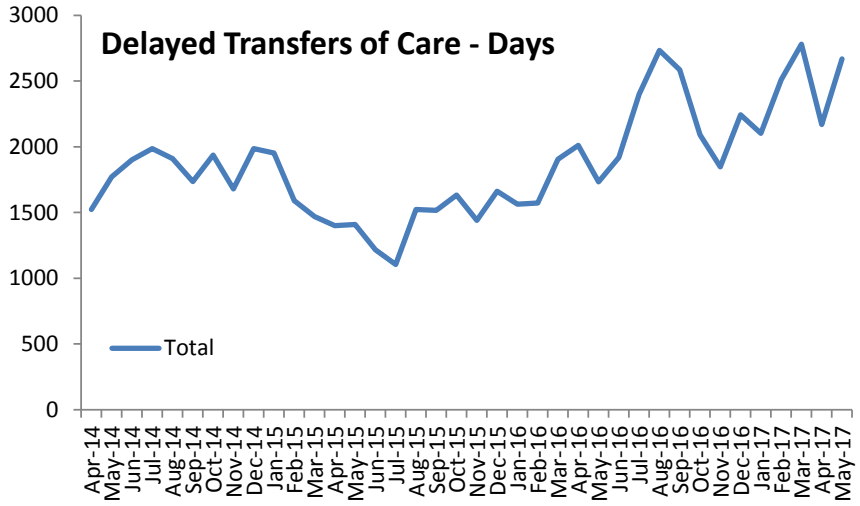

Figure 6 – Trend in Delayed Transfer of Care

The percentage of patients at home 91 days' post discharge from hospital (reablement indicator) has reduced slightly to around the 80% target, though the nationally reported figure is lower due to issues with data collection. The figure shows the trend up to the latest available data.

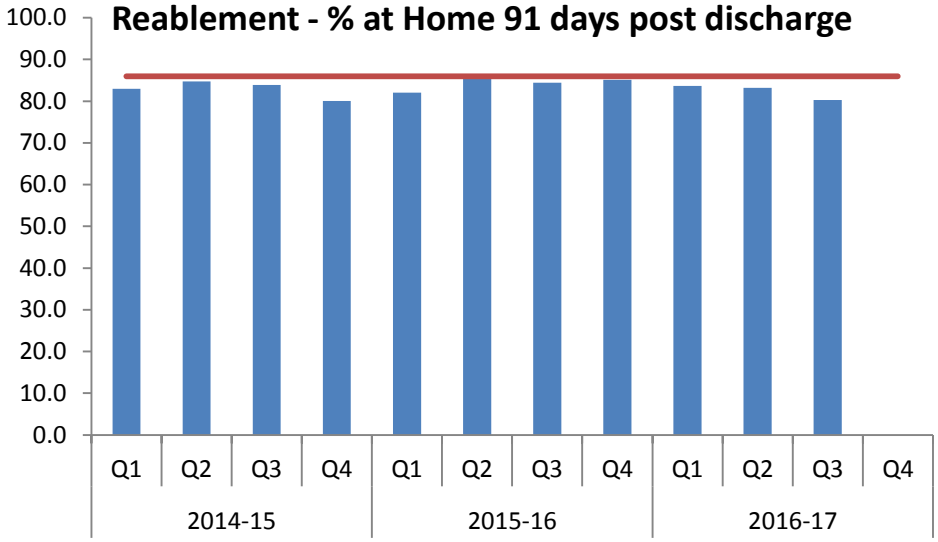

Figure 7 – Trend in % of people at home 91 days post discharge from Hospital

Permanent Placements to care homes for those aged 65 and over remain comparatively low and falling. While this is a success for the system it is likely to increase the pressure on the demand for care at home.

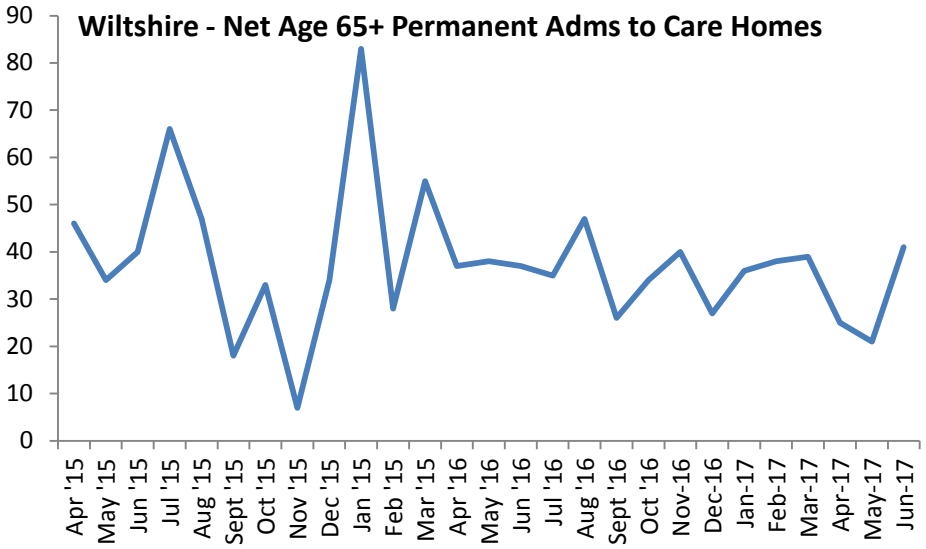

Figure 8 – Trend in number of new, Age 65+ permanent admissions to a care home

Dementia Diagnosis rate is now less than 1% below target and the CCG is working with GP practices to achieve the national target by year end.

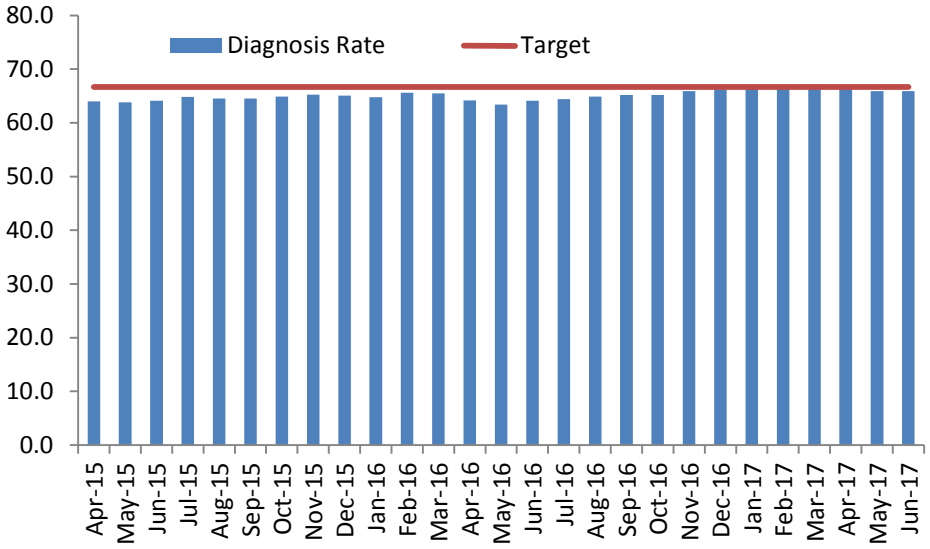

Figure 9 – Trend in Dementia Diagnosis Rate

Wiltshire achieves good outcomes when patients are diagnosed with dementia with 88.3% having a care plan reviewed face to face in the last 12 months compared to an England average of 83.8%. It also does better on DEM05 achieving 86.3% compared to an England average of 84.6%.

Better Care Fund plan

High level aims and ambitions for the Wiltshire Better Care Plan are outlined below

- Continue to develop and implement new models of provision and new approaches to commissioning, which maximise the opportunities and outcomes for integration. Our ASC Market Position Statement is currently being updated as part of the ASC transformation programme to ensure it reflects the innovative approaches being developed by the programme.
- Deliver measurable, evidence based improvements to the way our citizens and communities experience integrated care and support.
- Increase the capacity, capability and sustainability of integrated services, so that professionals and the public have confidence that more can be delivered in the community in the future.
- Seeking to Support the reconfiguration of services from acute to community settings in line with: BSW STP New models of care.
- Manage an effective and efficient pooled budget which is widened across the partnership to deliver the integration programme.
- Develop Wiltshire's "medium term integration plan" including our approach to organisational forms and alignments

The key development for 2017-18 is the development of the Home First initiative with Rehab Support Worker scheme previously agreed by this Board. Work has commenced to recruit workers and the maximum allocation for 2017-18 has been proposed at £1.2 million. It is proposed that expenditure and activity be reviewed during the financial year 2017-18 to establish whether the scheme is delivering the required outcomes in support of the overall better care plan. During 2017-18 the CCG will be tendering for Integrated Urgent Care and we will ensure this aligns with the ASC Transformation Programme and other BCF Programme.

The community equipment budget is currently operated as an aligned budget outside of the BCF but is incorporated within the current Joint Business Arrangement between the council and the CCG. In 2016-17 the total community equipment budget is £4.477 million. It is proposed that from 1 April 2017 the community equipment budget is incorporated within the BCF pooled budget. This would be on a non-risk transfer basis, i.e., each partner would continue to have responsibility for their own element of the budget in respect of year end variances.

In making this change it is anticipated that efficiencies can be achieved through improved joint management of the spend. There is some work to do to clarify the elements of the budget spent on Children's Services.

Due to the capacity to amend the current legal agreements it is proposed that the management of the community equipment budget will be moved in to the BCF from 1st April 2017 and that the Joint Business Agreement and Section 75 Agreement will be amended at the earliest opportunity to formalise this position.

What will also be managed as part of the Better Care Plan for 2017/18 is the additional £5.8 million investment into adult social care from the Integrated BCF.

The tables outline the jointly agreed commissioning intentions for 2017-19. The targets for 2018-19 are set at the same level as 2017-18 and will be reviewed and amended accordingly in light of in year performance and impact.

Care Services (bed based and non-bed based) ***Strategic Intention – Maintaining independence and Integrated teams***				
Description	**Provider Impact**	**Baseline**	**Target 2017/18**	**Target 2018/19**
Deliver county wide intermediate care services enabling proactive discharge from our 3 acute hospitals and integrated case management (70 Beds) – this includes both step up and step down services	WCC/WHC	50 admissions per month 600 admissions per annum	60 admissions a month 720 admissions per annum	60 admissions a month 720 admissions per annum
Expanding the role and impact of integrated teams (co located health and social care teams) in relation to -Systematic, targeted case-finding. -management of high risk patients -supporting discharge from acute hospitals -working with intermediate care homes to deliver trusted assessment models - joint training and development programmes with each intermediate care	WHC/GPs	N/A	N/A	N/A
An identified keyworker who acts as a case manager and coordinator of care across the system All GP practices have care co-ordinators although roles vary across the County- need to ensure this is aligned with the discharge management strategy in Wiltshire being taken forward under the Better Care Plan.	GP, s	N/A	N/A	N/A
Adequate and flexible provision of step up and step-down home-based and bed based rehabilitation and re-ablement services with enough capacity and responsiveness to meet the needs of everyone who might benefit. (continued approach), this will be delivered by 70 ICT beds Community integrated teams (incorporating HTLAH) Rehab support workers	WHC	See Below	See Below	See Below

Discharge planning and post-discharge support				
Description	**Provider Impact**	**Baseline**	**Target 2017/18**	**Target 2018/19**
Full roll out of the Wiltshire wide rehab support workers programme (30 additional rehab support workers across the system) from 1st April	WHC /Acute Trusts	Full scheme roll out from 1st April 2017	21 discharges a week 1091 discharges per annum	21 discharges a week 1091 discharges per annum
Continued delivery of integrated discharge teams and processes at each of the 3 acute hospitals in Wiltshire	System wide	TBC	Core business levels at circa 1200 discharges per annum from the acute trusts	Core business levels at circa 1200 discharges per annum from the acute trusts
Building on the existing urgent care model (referenced below in the admission avoidance section) provide additional bridging support across the system, this is pending the improvements in general care provision	Medvivo and acute trusts	The aim is to provide 6 additional care shifts across a 24/7 period	See numbers below	See numbers below
Continued commissioning of 70 intermediate care beds across the system to support discharge planning and rapid access to reablement and rehabilitation in the community	WHC /WCC	As above	See numbers above	See numbers above
Improve flow and reduce length of stay in community bedded capacity (Community hospital beds and ICT). Key areas of focus include - Review of staffing models - Alignment of HTLAH support - Relaunched service action plans - Twice weekly escalation and performance management calls	WHC	Currently in scoping stage	The aim is to achieve an additional 15 discharges a month from CH beds. This will provide an additional 180 discharges per month over and above current levels	The aim is to achieve an additional 15 discharges a month from CH beds. This will provide an additional 180 discharges per month over and above current levels

Crisis management and admission avoidance				
Description	**Provider Impact**	**Baseline**	**Target 2017/18**	**Target 2018/19**
Urgent care at home Continued commissioning of Urgent care at home available through Access to Care. This will need to be underpinned by the provision of additional domiciliary care bridging resource to support demand from all parts of the system and increase the volume of discharges. There will be an explicit target for UCAH to move back to performance levels delivered in 15/16 which was circa 80 cases per month management	Medvivo /WHC /Acute Trusts	65 cases per month 780 cases per annum	80 cases per month 960 cases per annum	80 cases per month 960 cases per annum
Step Up Intermediate care (Community Hospitals) Phase 1 Continue to commission existing community hospital step up pathway in Warminster and Savernake but this needs to be underpinned by a clear system strategy and commitment to step up. (15 beds) **Phase 2** Wiltshire Health and Care have committed in their contract to convert 50% of community hospital bed capacity to step up, transition to this level will commence during 2017/18	WHC	15 patients per month 180 patients per annum	25 patients Per month 300 patients per annum	25 patients Per month 300 patients per annum
Step-up intermediate care in South Wiltshire (Care Home based) Given the lack of community hospital beds in the south, 10 step up beds are commissioned through a care home provider, this will continue in 2017/18 with a new provider and GP led delivery model	WHC /GPS	8 patients a month 104 patients a year	12 patients a month 144 patients a year	12 patients a month 144 patients a year
Enhancing Care at the interface We have developed and should continue to resource pathways for admission avoidance and discharge planning at each acute hospital. This will build on the existing Access to Care Model with hospital clinical leadership. AWP in reach for dementia has been reviewed and will be strengthened in 2017/18 in relation to the care home liaison programme.	AWP/ WHC /3 acute trusts	N/A	This will need to be scoped with AWP and Wiltshire Health and Care	

There is also a need to ensure greater linkage to and platforming of the frailty hub programme being progressed by Wiltshire Health and Care				
Community geriatrics and the Wiltshire High Intensity Care programme Community geriatrician coverage across Wiltshire, need to link in more formally with established community teams. It is also recognised that our admission avoidance approach needs to be consistent across a 7-day period. Developing robust "interface" care with each acute hospital, enhancing the ATL model and diverting appropriate patients to established models of care in the community (for discharge and admission avoidance). The role of community nurses, matrons and therapists in the high intensity care programme also need to be clarified and defined Roll out of the High Intensity care programme, this will be led by Wiltshire Health and Care and will focus on - Step up care in the patient's home - Acute geriatric pathways in the community - Frailty hub approach at community hospitals - Integrated team approach	WHC /3 acute trusts	Need to be agreed with WHC	Need to be agreed with WHC	
Equitable access to specialist palliative care services for frail older people. Need to recognise that 30 % of all hospital non-elective admissions are for patients with a life limiting diagnosis. Need to; 1. Improve identification of patients who have <12 months to live. 2. Progress implementation of treatment escalation plans across system. 3. Reshape role of the community end of life team (GWH Community services) ensure they take a more	Dorothy House Hospice and Salisbury Hospice	10 cases per month 120 cases per annum	16 cases per month 192 cases per annum	16 cases per month 192 cases per annum

proactive case management approach to patients on an end of life pathway. 4. Continue commissioning of the 72 hour EOL pathway. 5. Review and agree future role of hospices in the EOL agenda.				
Single point of access available to facilitate access to community services to manage crisis at home with specialist opinion and diagnostics. (continuation)	Medvivo /3 acute trusts and WHC	As part of UCAH	As part of UCAH	As part of UCAH

Prevention and early intervention			
Description	**Provider Impact**	**Baseline**	**Status**
Ensure a preventative based approach is taken at all stages of an older person's pathway of care The key priorities in 2017/18 are to • Implement key recommendations from the Older Persons Review • Implementation of falls strategy and action plan (led by the Wiltshire wide Bones Health Group) • Signposting, navigation and roll out of the Information Portal in partnership with voluntary sector and Health watch. • Working with health watch explore ways to educate and inform patients of service developments • Continue with the fracture liaison service at SFT and following Pilot end in November 2017 consider whether this should be rolled out across Wiltshire	WCC	n/a	n/a
Workforce development strategy Adequate clinical training for care home staff; both registered and non-registered workers learning together on-site as part of an overall quality improvement programme. (continued approach), this is being delivered by the underpinning Wiltshire Workforce Strategy which is detailed below	Whole system	n/a	n/a

Supporting core social services and integration			
Description	**Provider Impact**	**Baseline**	**Status**
Shared assessments Shared assessment frameworks across health and social care should lead to a Personalised care plan for everyone, where the individual and their careers are key participants in any decision made,	WCC	n/a	n/a
Integration of information Continued development of the Single View of the Customer approach across Wiltshire in 2017/18 to further ensure that adequate and timely information is shared between services whenever there is a transfer of care between individuals and services	WCC	n/a	n/a
Carers support Carers are offered an independent assessment of their needs and signposted to interventions to support them in their caring role. (Will be accelerated as part of the care act work). Offer assessments and support to carers and by commissioning an information portal that has within it a self-assessment tool for carers that enable them to access the care they need, when they need it. Work with Practices through integrated teams to hold registers of carers and ensure linkage in terms of case management and follow up care. More formal involvement of the voluntary sector in the provision of care. There is a need to ensure we derive maximum benefit from commissioned voluntary and 3rd sector services	WCC	n/a	n/a
Personalised commissioning The presence of personal budgets in Wiltshire and the revised national direction on personalisation requires us to look at how we can expand our approach to personal budgets and the personalisation agenda. There is an opportunity to link this in with the work of identified voluntary sector organisations. Roll out of personal health budgets to be accelerated during 2017/18	WCC	n/a	n/a

Dementia services A comprehensive service for those with dementia must be available and accessible this will include Dementia strategy and action plan has been developed, but we need to target the gaps in care and need to ensure a more community focused /crisis intervention based model of care. Through the Better Care Plan, we are already looking at; • Care Home Liaison services. • Focused support to AWP in relation to discharge planning. • Acute "in reach "programmes for dementia. Dementia diagnosis rates have increased across the county – need to ensure that once patients are diagnosed they are moved to appropriate service for ongoing care and management. The registers must serve a purpose and provide a platform for future case management.	AWP		

The Better Care plan has provided a strong framework for integration, transformation and system wide delivery across Wiltshire.

The model of care for Wiltshire which has been put in place and needs to be supported and maintained, will include the following;

- Simplified access to core services through one number for the whole system.
- Effective Triage which increase use of alternatives such as assistive technology, rather than generate additional pressure
- Integrated service provision based on localities with appropriate clinical, community service, mental health and social care input to make them effective
- Services must make a difference in terms of intervention and be more responsive at point of need.
- Risk stratification and anticipatory care which deliver and make a difference.
- Ongoing development of credible alternatives which make a difference to acute hospital provision, there is a need to manage a higher level of acuity in community settings.
- Specialist provision and support in out of hospital settings underpinning the system ambition.
- Focus on discharging patient home first.
- Enhanced discharge arrangements with integrated community teams (which will aim to include both health and social care teams) being able to pull patients out of hospital once the patient is medically fit.
- Reliable intermediate care and care at home which gets patients to their normal place of residence more quickly.
- Reacting to what the data tells us and targets our interventions in the right area (care homes, multi morbidities, high referring practise, and wards with a high Length of Stay (LoS).
- A greater emphasis on upstream prevention and focus on self-management and signposting.
- Senior expert clinical opinion as early as possible in the pathway wherever the patient presents across the system.
- Building from the bottom up, ensuring that providers play a key part in the development of the integrated model of care.
- Increased responsibility for system change rests with providers.
- Forecasting financial commitments moving forward and establishing the social and economic return on investment.

These principles are inherent to the transformation approach in place across Wiltshire.

Risk

Demand on the acute care system is the health and social care economies biggest risk to sustainability as emergency admissions continue to be over plan with growth being experienced at a higher level in the 0-64 age groups.

The Wiltshire Better care plan can demonstrate positive impact in terms of reducing the volume of avoidable emergency admissions and managing the significant growth in the frail elderly cohort, however further progress is required to reduce demand and to reduce the increased levels of delayed transfers of care

A key focus for 2017/18 is to increase care capacity across the system and Home First will be a key scheme in this regard alongside the LA's development of a Reablement Service any additional actions that can be prioritised locally from the eight high impact changes self-assessment. However, this is not in itself going to address or resolve the significant workforce challenges we have at every stage of the pathway.

Financial allocations and the scale of financial pressures and savings required across the partnership will impact on the ability of partners to commit to new initiatives beyond the BCP, therefore it is critical that partners maintain delivery across the BCF plan metrics and national conditions as well as deliver a medium view of transformation for the next 2 years. To achieve this even more rigour will be applied to benefits realisation with more sophisticated, integrated and co-produced methodologies for risk modelling and reducing impact

There will need to be a further focus on developing a commissioning framework for integrated commissioning across LA and NHS partners which will involve identifying further joint savings and value for money in joint commissioning as well as ensuring quality and driving further innovation in integrated service delivery models.

Issues around Information Governance and the sharing of data predominantly for reporting purposes is a risk which we are actively working on. This builds on the work on the Single View of the Customer project which has been ongoing in Wiltshire for a couple of years.

National Conditions

National condition 1: jointly agreed plan

How we work together:

Commissioning, service delivery and transformation have been jointly developed by the council the CCG and provider partners and there is a strong commitment to delivering the key schemes, with all plans jointly agreed and signed off by the Wiltshire Health and Wellbeing Board.

The Wiltshire Health and Wellbeing Board have all provider organisations as members and this ensures a strong ongoing public commitment to the programme.

Our key aim remains to continue to reduce DTOCs across the system and to reduce NEL admissions, as well reducing LOS by circa 2 days.

How the plan was developed and agreed:

The Health & Wellbeing Board met in May 2017 and agreed the budget and commissioning intentions for the Better Care Fund for 2017-18. The board also agreed to delegated authority to the Chair and Vice Chair of the Health & Wellbeing Board to approve any required submission if it was unable to bring this to a full meeting of the Board. The next Board meeting is the 19th September 2017, so this submission has been signed off by HWB in accordance with the delegated powers.

The local Joint Commissioning Board, which includes representation from the Council, CCG and Providers has reviewed and approved the plan and targets. In addition the DTOC trajectory has been reviewed and approved by the 3 A&E delivery boards which cover the main providers for the Wiltshire population.

How our integration is developing

NHS Wiltshire CCG and Wiltshire Council and also actively pursuing closer integration of Health and Social care in the County with the joint appointment of a CCG Accountable Office and Director of Adult Social Care. This appointment will be responsible for realising the ambition outlined in the Joint Health & Wellbeing Strategy and the Better Care Plan.

The Council, CCG and all NHS providers are working together to develop an Accountable Care System for Wiltshire. Whilst, this is in the early stages there is strong commitment to progress at pace.

Wiltshire Council is currently reviewing its Accommodation Strategy; this will look at Nursing, Residential and Extra Care Housing provision.

National Conditions (continued)

National condition 2: social care maintenance

The Council has recognised that it needs to transform its Adult Social Care services to ensure a more responsive service that maximises independence. The integration agenda will impact on how all services are delivered in the future and there is a need to ensure that Adult Social Care is fit for purpose and able to respond to the opportunities for integration.

There are challenges in respect of domiciliary care which impact on safe and timely discharges from hospital. There is limited capacity in the market, impacting on DTOC rates. There is currently no framework for spot purchases and given the state of the market, other contracting arrangements will be considered. It should also be noted that HTLAH provides a very limited reablement service. There is scope to make more use of this vital element of a modern care service to manage demand and promote independence.

The development of Home First is dependent on capacity within the domiciliary care market to provide ongoing support to people post their period of Home First, without this flow Home First will be unable to deliver the agreed outcomes.

The Council and health partners recognise that there may be a need for short-term pragmatic spend to respond to crisis but that this should be avoided where ever possible to ensure the development of a sustainable model.

Additional funding for adult social care provides an opportunity to develop and implement a transformation plan for the adult social care service; invest in development of reablement services in the county and further develop the domiciliary care market to ensure adequate capacity in the market to enable people to maximise their independence and remain at home. This work will help to improve the flow from the acute providers and throughout the whole system.

In Wiltshire, the additional funding represents £5.8m for 2017/18, £5.1m for 2018/19 and £2.4m for 2019/20. This money is non-recurring. The importance of a strategic approach to the commissioning of services and for the extra resources for adult social care to be deployed as part of a whole systems economy is widely recognised.

As such, Wiltshire Council and Wiltshire CCG are working with strategic partners in health and in the third sector to create and develop a market economy that is sustainable and has its focus on community resilience and market capacity to meet the demographic demands placed upon it

As part of the aim to support the development of a sustainable whole system, ensuring people are discharged from hospital in a safe and timely manner it is proposed that the focus of the additional, non-recurring, resources is on:

- Redesigning the hospital discharge process
- Developing a reablement service that supports Home First
- Increasing capacity in the domiciliary care market
- Wider transformation of Adult Social Care (including front door)
- Responding to demand pressures within SEND/LD
- Home First operational pathway lead
- National Living Wage pressures

National condition 3: NHS commissioned out-of-hospital services

The key development for 2017-18 is the development of the Home First scheme previously agreed by this Board. Work has commenced to recruit workers and the maximum allocation for 2017-18 has been proposed at £1.2 million. It is proposed that expenditure and activity be reviewed during the financial year 2017-18 to establish whether the scheme is delivering the required outcomes in support of the overall better care plan.

The Home First Scheme is Wiltshire Health and Care (WHC) providing additional capacity in the form of Rehabilitation Support Workers (RSW) being employed directly as part of the Core Community Teams. The proposal has a strong evidence base and builds on the benefits of the Homefirst initiative trialled in 2015-16 which demonstrated a number of benefits in particular:

- The importance of an integrated discharge approach
- That discharging a patient home as soon as they are medically fit and rehabilitating the patient in their own home.
- That prescribed care needs are often reduced on discharge and a patient transitions towards full independence or a marked reduction in care needs sooner

The RSWs will be trained to meet agreed therapy and domiciliary care needs of patients discharged from hospital as soon as they are medically fit. There is an opportunity for this 'intermediate care at home' immediately following an early discharge to be provided for a limited period of time by additional rehab/care staff. This additional capacity will work with OTs and community physios to assess the needs of the patients in their homes and provide early intense rehab and domiciliary care. This removes the need to assess in the hospital and allows a speedier discharge to a home setting into the care of clinicians who are more used to coping and managing patients with complex care needs. A number of options on how this can additional capacity can be provided are reviewed below.

In addition during 2017-18 we will be tendering for our Integrated Urgent Care Services which will bring together our out of hospital urgent care services under one umbrella to ensure we can maximise A&E attendance avoidance. This tender process will take account of the ASC Transformation programme which is already ongoing in Wiltshire Council to ensure we can maximise prevention opportunities across health and social care.

National Condition 4: Managing Transfers of Care

Whilst excellent progress was made in 2015/16 in reducing the volume of delayed transfers of care and delayed days across Wiltshire, we have seen an increase in the number of delays during 2016/17 over the assumed plan. Therefore, a key focus in 2016/17 is to reduce delayed transfers of care back to the levels of 2015/16 in the first instance and then progress towards further improvements

Our key scheme relevant to DTOCs very much focuses on early mobilisation, transfer and ensuring longer term independence of the service user. As such the key schemes is the Wiltshire Home First programme which focuses on moving patients home as soon as they are “medically stable” with enhanced domiciliary and health care in the patient’s own home. This scheme commenced in Q4 2016/17 and there is a system wide commitment to ensure its success. Additional funding of circa £1.2 million per annum from the Better Care Plan has been provided. It is proposed that expenditure and activity be reviewed during the financial year 2017-18 to establish whether the scheme is delivering the required outcomes in support of the overall better care plan.

We have redesigned intermediate care provision in Wiltshire with a movement towards 70 contracted ICT beds in 9 identified homes across the county.

Where possible we will be looking to discharge patients earlier in the acute pathway whether that is in A&E and AMU assessment areas or as soon as the patient reaches medical fitness on an acute ward. Through programmes such as acute trust liaison, urgent care at home or the recently launched rehab support workers programme. We have also commissioned an enhanced urgent care at home service to provide additional bridging support across a 7-day period to support further discharges from the acute hospitals. We have also launched a new approach to managing patient Choice across Wiltshire which has overseen a reduction in choice related delays and has been adopted as an area of good practice by our neighbouring CCGs

The Transformation of Adult Social Care will deliver increased capacity in the market and establish a reablement service closely linked to Home First, improving the flow across the system.

The figure shows the level of ambition we are expecting to achieve with our plans to reduce delays in transfers of care.

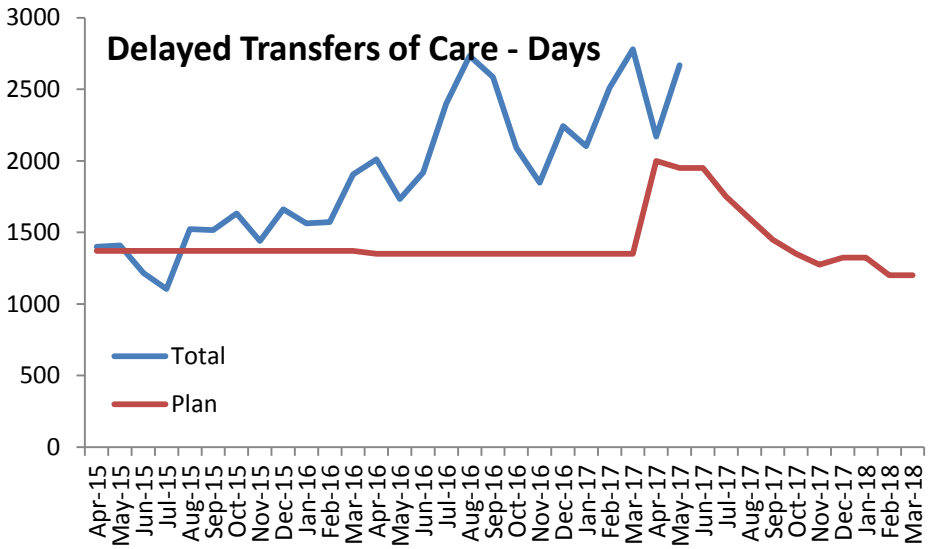

Figure 10 – Trend in Delayed Transfers of Care with Trajectory

Overview of funding contributions

Funding:

Source of Funding	2017-18	2018-19
CCG BCF Contribution (transfer to WC)	19,726,330	19,726,330
CCG BCF Contribution (schemes paid directly by CCG)	11,504,670	11,504,670
WC BCF Contribution	4,250,000	4,250,000
Disabled Facilities Grant	2,792,249	£3,033,313
Additional Adult Social Care Funding	5,810,000	£7,210,533
Total Funding	**£44,083,249**	**£45,724,846**

Expenditure by workstream

Analysis by Work Stream	2017-18	2018-19
Intermediate Care	18,207,385	18,200,000
Access, Rapid Response, 7-day working	3,828,724	3,900,000
Care Act	2,500,000	2,500,000
Self care, self support (prevention)	1,691,000	1,750,000
Protecting social care	9,183,000	9,250,000
Invest in Engagement (Healthwatch)	100,000	100,000
Other Council Schemes now in the pool	2,792,249	2,800,000
BCF Management and Administration	323,200	325,000
Integrated Community Equipment Services - ICES	5,102,000	5,100,000
Unallocated	355,691	1,799,846
Grand Total	**£44,083,249**	**£45,724,846**

The actual budgets for 2018-19 programmes will be agreed in Q4, following ongoing evaluations of the programmes and their outcomes.

Programme Governance

We see strong joint governance as a key step towards integration. The Wiltshire Health and Wellbeing Board will continue to oversee the delivery of Better Care. Health providers all sit on our Health and Wellbeing Board and have been fully involved in the development of the Better Care Plan and the scoping and implementation of the key schemes within the Better Care Plan for Wiltshire. The Health and Wellbeing Board has driven the implementation of the Better Care Plan across Wiltshire and developed a culture of collective responsibility and vision for change. Progress against the Better Care Plan is reviewed at the meeting and it is the forum where all key decisions in relation to the Better Care Plan are made. The effectiveness of the Wiltshire Health and Wellbeing Board is well recognised nationally - named as the Health and Wellbeing Board of the Year at the 2016 LGA awards.

The diagram shows the governance structure for the Better Care Fund in Wiltshire:

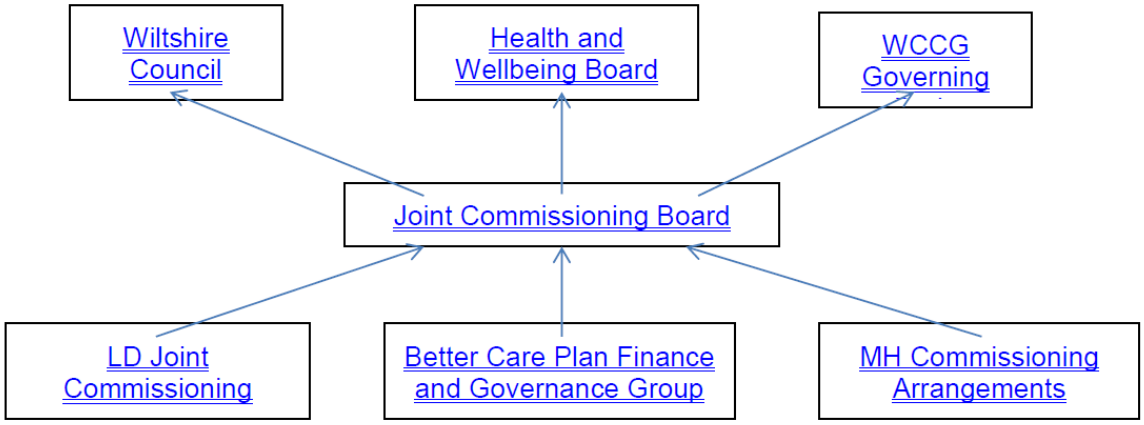

Figure 11 – Wiltshire BCF Governance Structure

Elements of our plan that require key decisions will, as required, be reported to the CCG Governing Body and to the Council's Cabinet. We have a Joint Commissioning Board for Adults' Services and many of the emerging service changes have been developed and overseen by this Board.

We have several existing joint arrangements between the Council and the CCG, including pooled budgets for carers' services. These agreements all sit within a single overarching Joint Business Agreement which is overseen by the Joint Commissioning Board. We have a joint integration programme team, led by a jointly-appointed programme director and including specialist capacity from the Council's System's Thinking Team and information management team.

The BCP Finance and Governance Group is chaired by the Finance Director of the Council or CCG on an annually revolving basis. The group meets monthly and

oversees the performance of the key work stream and the BCP budget. The Group will also prioritise areas for decision by the Joint Commissioning Board, providing effective oversight and coordination. Monthly update reports on the delivery of Better Care and the use of the pooled funds go to our Joint Commissioning Board. The Joint Commissioning Board has developed a dashboard of performance outcomes which it monitors at every meeting. This dashboard will be expanded to include they key performance outcomes for the Better Care Fund.

There will be bi-monthly public reports on the delivery of Better Care. These reports will be circulated to the Council's Cabinet, the CCG's Governing Body and the Health and Wellbeing Board. In this way, we will ensure that the leadership of the CCG and the Council have clear and shared visibility and accountability in relation to all aspects of the joint fund.

There has been effective engagement at the political interface with a BCP Task and Finish Group, this was a local authority member chaired scrutiny group and evaluates the performance of the plan on behalf of the Health Select Committee. This further enhanced the accountability of the better care plan and ensures a stronger connection with the local community it serves through their elected representatives which reported and made recommendations which are being acted on.

We also ensure that the public are informed of progress; we publish a monthly BCP Newsletter.

We also work with our Older People's Reference Group and with Healthwatch Wiltshire to ensure that we develop our patient and customer feedback and can respond to people's views. The work we have taken forward with Healthwatch Wiltshire has been recognised nationally as a good example of proactive patient engagement on the Better Care Plan.

We also continue to engage with each of the 18 Area Boards in Wiltshire ensuring the key messages and priorities of our better care plan are heard as widely as possible.

There is a commitment to action and ongoing evaluation across each of the key schemes and we will be moving the system to a daily review of core activity and performance indicators

The plan will then be monitored by NHS England through the quarterly review process. An established risk management framework is in place and the plan is also subject to review via the Board Assurance Framework.

The main target population impacted on by the Better Care Plan is the over 65 years' age group with the aim to ensure that there is accessible care in place for all who need it at the point they need it regardless of age, sex and religious denomination

National Metrics

Non-elective Admissions

Benchmarking data for Wiltshire shows we have one of the lowest rates of emergency admissions for the population aged 65 and over in England. As a result we are not setting targets for further reductions in admissions as part of the Better Care Fund. Some of the schemes funded by the Better Care Fund are designed to support other admission avoidance activity to help the CCG contain the growth in these admissions.

Admissions to residential care homes: How will you reduce these admissions?

Historically in Wiltshire we have had a low rate of permanent admissions to care homes, meaning substantial reductions are unrealistic. Our target is to continue a trajectory of small reductions in this target. Our aim is to continue with small reductions in the numbers which result in a decreasing rate due to our increasing elderly population. This will be achieved through the focus on prevention and the investment in Community Care.

Effectiveness of re-ablement: How will you increase re-ablement?

Additional funding for adult social care provides an opportunity to develop and implement a transformation plan for the adult social care service; invest in development of reablement services in the county and further develop the domiciliary care market to ensure adequate capacity in the market to enable people to maximise their independence and remain at home. This work will help to improve the flow fromthe acute providers and throughout the whole system. The target is to improve the proportion of people able to remain at home post discharge from hospital.

Delayed transfers of care (DTOC) plan

Whilst excellent progress was made in 2015/16 in reducing the volume of delayed transfers of care and delayed days across Wiltshire, we have seen an increase in the number of delays during 2016/17 over the assumed plan. Therefore, a key focus in 2017/18 is to reduce delayed transfers of care back to the levels of 2015/16 in the first instance and then progress towards further improvements

Our key scheme relevant to DTOCs very much focuses on early mobilisation, transfer and ensuring longer term independence of the service user. As such the key schemes is the Wiltshire Home First programme which focuses on moving patients home as soon as they are “medically stable” with enhanced domiciliary and health care in the patient’s own home. This scheme commenced in Q4 2016/17 and there is a system wide commitment to ensure its success. Additional funding of circa £1.2 million per annum from the Better Care Plan has been provided.

We have redesigned intermediate care provision in Wiltshire with a movement towards 70 contracted ICT beds in 9 identified homes across the county.

Where possible we will be looking to discharge patients earlier in the acute pathway whether that is in A&E and AMU assessment areas or as soon as the patient reaches medical fitness on an acute ward. Through programmes such as acute trust liaison, urgent care at home or the recently launched rehab support workers programme.

We have also commissioned an enhanced urgent care at home service to provide additional bridging support across a 7-day period to support further discharges from the acute hospitals

We have also launched a new approach to managing patient Choice across Wiltshire which has overseen a reduction in choice related delays and has been adopted as an area of good practice by our neighbouring CCGs.

We are in the process of establishing a Wiltshire wide DTOC Programme Board which will have representatives from the CCG, Council and Providers. This board will review progress on the DTOC Trajectory across Wiltshire which will then feed into the 3 A&E Delivery Boards which the Wiltshire System supports.

The Adult Social Care Transformation programme will increase capacity in domiciliary care, reablement and improve the flow across the system and represents a core element of strengthening care at home.

Approval and sign off

The Commissioning Intentions and Budget were approved by the Wiltshire Health and Wellbeing Board at its meeting on the 18th May 2017. The Board also agreed to delegate sign off the national submissions to the Chair and Vice Chair of the Board.

The September submissions relating to the Better Care Fund were approved by Cllr Baroness Scott (HWB, Chair) and Dr Peter Jenkins (HWB, Vice Chair)