HM Government

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Wiltshire Council

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

Wiltshire Health and Wellbeing Board Better Care Fund Narrative Plan

Contents

1. Cover

This plan was overseen by the Wiltshire Alliance Partnership Committee, which includes representation from a wide range of bodies including Wiltshire Council, BSW ICB, acute hospital trusts, community health and care providers, Healthwatch and the VCS. A full list of membership (consultees) is available in Appendix A.

This plan builds on the priorities previously developed with and agreed by the Wiltshire Health and Wellbeing Board, outlines the challenges and progress made in 2022-23 and identifies the plan for 2023-24 and 2024-25.

BCF is a high-profile vehicle for change in Wiltshire and the extensive programme of service reviews, tenders and operational feedback, alongside system wide ICB led development programmes are regularly reported to a wide range of stakeholders. Stakeholder's views are gathered year-round through formal and informal means. Table 1 gives an example of this involvement.

Table 1: BCF Plan Consultees

Consultee	Detail
Wiltshire Alliance Partnership Committee	Replaced Locality Commissioning Groups in July 2022. Enables the involvement of a range of stakeholders (Appendix A) to shape priorities for BCF funding and oversees submissions to the Health and Wellbeing Board (HWB).
Health and Wellbeing Board	Reviews and approves BCF spending and plans, creates links with Joint Local Health and Wellbeing Strategy and Joint Strategic Needs Assessment which both inform Wiltshire BCF priorities.
Operational Services	Operational staff across health and social care are involved and consulted on BCF funded services performance and development. 2022-23 examples include therapy and social care involvement in the PW2 pilot (Appendix C), OT's and reablement staff in service improvement work on community equipment, Support workers in Mental health services and falls prevention etc
Healthwatch and Wiltshire Centre for Independent Living	Commissioned to mobilise engagement of Wiltshire residents. 22-23 – engaged users of discharge pathways for feedback, 23-24 – Use of TEC, discharge communications, understanding carers voices, co-production of ASC strategy etc
VCSE	Representatives attend the ICA and HWB, acting as a focal point for wider engagement across the voluntary sector. We also commission some BCF services through Voluntary sector organisations, such as the Home from Hospital service delivered through by Age UK who carry out service-user feedback as part of the contract monitoring.
Housing	Housing sits within the portfolio of the Director for Living and Ageing Well. The Director sits on the ICA and HWB and oversees the DFG expenditure. The Director works closely with the BCF commissioning team across the BCF workplan.

2. Governance

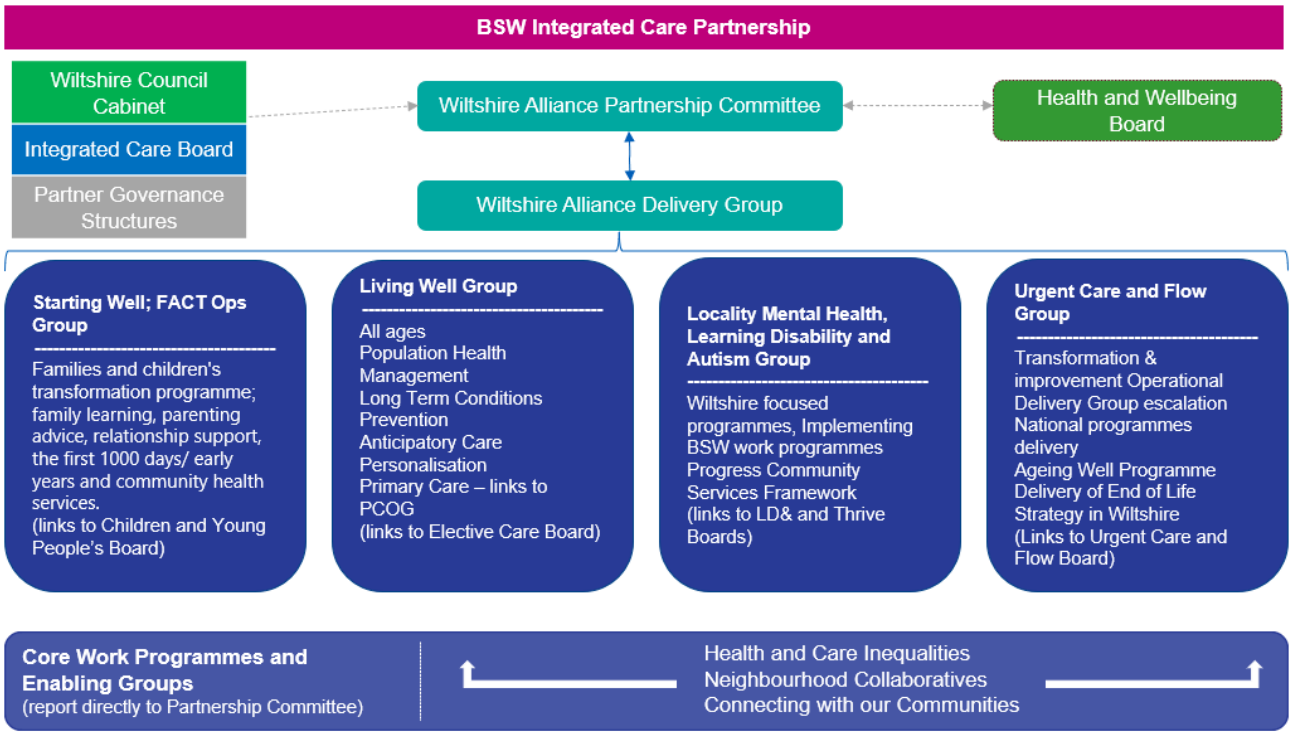
The strategic direction of travel is governed through several groups sitting under the BSW Integrated Care Partnership (see figure 1).

The findings of the Joint Strategic Needs Assessment (JSNA) 2022 directly informed the development of a co-authored Joint Local Health and Wellbeing Strategy (JLHWS). The JLHWS sets out 4 guiding priority themes for our work and these, together with the ICS Strategy and Wiltshire Council's social care strategies, priority objectives have set a clear pathway towards improving outcomes for and with our population, drawing on the combined resources and skills of Alliance partners.

At the highest level, the Joint Local Health and Wellbeing, Integrated Care System and Local Authority Strategies align with each other in scope and priorities, the clusters represent linked and related priority areas of work. Localisation and connecting with our communities are seen as integral to our way of working across all themes and objectives and aligns with the ICS Vision of "Listening and Working Effectively together to improve health and wellbeing and reduce inequalities". Public Health intelligence also influences BCF priorities.

Though each place is developing their own Better Care Fund Narrative Plan to address needs set out in their joint strategic needs assessment, Bath, Swindon and Wiltshire have formed a strong, collaborative partnership and work closely together, drawing on the arrangements that are possible within the BSW Integrated Care Board.

Figure 1: Alliance Partnership Committee and Delivery Sub-Group Structure



Clear metrics and targets are being set to monitor progress which provides oversight and assurance that we are delivering the benefits and managing spend as set out in the plan. Shared risks, information sharing protocols and robust governance arrangements are in place to support whole system ownership for the delivery of the BCF.

3. Executive summary

The ambition of this plan is to consolidate the strong relationships and governance formed during the last 2 years, 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.

There are some key changes in this year's plan, including the introduction of further schemes funded under the Adult Social Care Discharge Grant and a greater focus on understanding our demand and capacity requirements across our local services.

We have also reviewed progress since last year's BCF plan. Key challenges for us to note were our higher-than-expected avoidable admissions to hospital and higher than expected admissions to care homes. This tells us that we have more to do to deliver alternative pathways to hospital and to provide a credible alternative to residential and nursing care through our pathway 2 offer, keeping people at home for longer. Our plan explains more about how we will achieve this.

Table 2: Wiltshire Priorities

	National conditions	Wiltshire 23/24 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 now secure recurrent service changes made at pace to deliver the joint strategic aims

	National conditions	Wiltshire 23/24 Priorities
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 maintain investment in supporting adult social care. There has been significant investment in the Wiltshire Support at Home Service with in-house domiciliary care capacity to prevent hospital admission and aid hospital discharge in complex cases. This came from a recognition of our challenges in domiciliary care capacity and the market position.
3	Invest in NHS commissioned out-of-hospital services	Continue with added impetus to develop the anticipatory care and urgent response community-based services. Deliver improvement as required against the High Impact Change model for transfers of care. Falls prevention is an area for review and improvement Deliver joint plans and funding for End-of-Life care and prevention of hospital admissions Commission a new carer support service Develop and implement housing and technological strategies for independent living. Secure recurrent investment in community-based care services, recognising the significant investment already made.
4	Implementing the BCF policy objectives	Enable people to stay well, safe and independent at home for longer Provide the right care in the right place at the right time As part of this national condition, commissioners will agree how services delivered via BCF funding sources will support these objectives. This includes continued implementation of the High Impact Change Model for Transfers of Care, which is integral to meeting BCF requirements around supporting discharge. Wiltshire will agree and submit a plan showing expected demand for intermediate care services in the second half of the financial year and expected capacity across the ICA area to meet this. These capacity and demand plans will need to be submitted at the same time as main BCF plans. BSW is conducting demand and capacity work for community services, with support from WSP. Outcomes from this work will be closely reviewed as part of checking BCF investments are supporting the systems discharge pathways at the right level Planning will continue to understand and address Health inequalities as defined in the Equality Act and for the NHS Core20Pluss Development of Health Equity audits and use of HEAT to assess Better Care Plan Services Development of Wiltshire Alliance Neighbourhood collaboratives

A review of our original HICM self-assessment was carried out, focusing on those areas self-identified as 'to note' or 'opportunities'.

Table 3: Updates to 2022 HICM self-assessment

Change	Issues noted	Progress
1. Population health management approach to identifying those most at risk	Single shared truth, driven by 'live' data not yet possible across many services	HomeFirst dashboard now established and a good example of joint activity and performance data collection. JSNA good example of population, it's health and challenges to service delivery. **2023-24 Plan:** Developing a system-wide dashboard to inform service delivery across Wiltshire.

		Build on the BI 'Population Insight Tool' developed to inform the Falls work into other health areas for more targeted interventions.
	Little evidence of risk modelling at the system level	Still progress needed but signs of developing a shared risk approach shown in the PW2 re-model which used locality-based stratification tools. **2023-24 Plan:** PW1 modelling has been started with plans for PW3 in 2023-25.
2. Target and tailor interventions and support for those most at risk	System is reactive and focused on hospital discharge pathways rather than a more holistic and planned approach to meeting needs	Work in 2022-23 and into 2023-24 has focused on maintaining independence (PW2, community equipment, an independent living centre review. **2023-24 Plan:** There will continue to be a focus on embedding the Rapid Response, 24hr nursing and Intensive Enablement Services as well as implementing Virtual Wards.
	No clear baseline to assess against	HF and PW2 baselines identified and monitored against. Demand and capacity work prioritised and KPIs under development. **2023-24 Plan:** To use the developed system-wide dashboard to inform service delivery across Wiltshire.
	Lack of 24hr community nursing	This service is now operational. **2023-24 Plan**: Monitor service delivery to assess it's impact on hospital avoidance.
	Opportunity to explore use of technology in supporting public health	TEC commissioning team fully recruited to in 2022-23 and strategy under development which will shape work plan for 2023-25. **2023-24 Plan:** Influence Tec applications to support targeted intervention on identified groups
3. Practise effective multi-disciplinary working	MDTs often formed informally without structured TORs	Formal MDT's now fully embedded and 'business as usual' across the system. Daily MDTs for every pathway are now established. **2023-24 Plan:** Continue to monitor the effectiveness of the MDTs.
	Insufficient evidence on; family and carer involvement in assessments;	Dedicated resource has resulted in a revised Carers Strategy and improvement in the collection of data to ensure evidence-based decision-making. Hospital Carer teams provide dedicated support in acute settings, ensuring more carer involvement in discharge decisions. **2023-24 Plan:** Continue to monitor the effectiveness of the service.
	Training and skills mix	Skills for care training modules **2023-24 Plan:** Continue to monitor the number/type of training and its impact on services.
	Understanding impact of inequalities	JSNA, Public Health and the Core20PLUS5 provides a clear picture of health inequalities and impacts across Wiltshire. **2023-24 Plan:** Clearly link service developments to specifically support groups most affected.
4. Educate and empower people to manage their own health and wellbeing	Strategy to develop TEC not yet complete	TEC commissioning team fully recruited to in 2022-23 and strategy under development which will shape work plan for 2023-25. **2023-24 Plan:** Influence Tec applications to support targeted intervention on identified groups and how better use of TEC across services can support people's independence.
5. Provide a coordinated and rapid response to	There are some gaps in the current level of services including 24/7 support, community nursing cover and emergency weekend cover	**2023-24 Plan:** will continue to be a focus on embedding the Rapid Response, 24hr nursing and weekend emergency cover.

crises in the community	Recruitment and retention issues in ensuring appropriate levels of service	2022-23 say ongoing recruitment issues across services. The ASCDF investment showed significant benefits for both recruitment and retention figures (as high as 4 times higher than same time in previous year). **2023-24 Plan:** To review what we can apply from this learning in 2023-25 to continue the benefits to service provision. .
	Issues in allocating dom care packages to patients ready to be discharged from services. A reflection of a lack of available provision in the market.	A re-tender in 2022-23 has resulted in capacity now meeting demand. Overnight nursing, 24/7 Rapid response and county-wide weekend brokerage services are also embedded. **2023-24 Plan:** Embed the new Dom care flexible framework in Wiltshire and monitor impact on hospital discharges in particular.

4. National Condition 1: Overall BCF plan and approach to integration

Partners across the health and care system share a common aim to keep people independent and healthier for longer, keeping people in their own homes where possible. Where people do need additional help, we will ensure it is person centred, strength based and offers choice and control. Our BCF Plan submission priorities for 2023/2025 are an added layer of detail to our ICA Delivery Plan. Our core ICA principles for working together are:

Table 4: Wiltshire Alliance Collaboration Principles

The 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.

In Wiltshire, a jointly funded BCF commissioning team works together across services on demand and capacity modelling and actively seeking models of care than bring operational services together in a patient-focused way. The Neighbourhood Collaboratives (Appendix D) are an example of an approach to understanding where we are and where we want to go – and how we might get there.

The planning template details the specific schemes and actions the partnership has identified to deliver our priorities and provides confirmation of the agreed funding contributions. The schemes align with the BSW Operational Plan submission and the UEC Recovery Plan. Each of these plans has common themes around understanding demand and capacity, creating flow and keeping the person at the centre of decision-making. Often services such as Virtual Wards will meet objectives across several plans.

Table 5: Summary of BCF Schemes

Scheme	National Condition 2	National Condition 3
Assistive Technologies and Equipment – Telecare and community based equipment	☐	

Carers Services – Respite, and Carers advice and support	☒	
Community Based Schemes – Community Health Services Contract		☒
DFG related schemes – Adaptations (including statutory DFG grants)	☒	
High Impact Change Model for Managing Transfer of Care – Hospital based Social Work teams	☒	☒
Home Care or Domiciliary Care – Domiciliary care packages, and care packages to support HomeFirst discharges		☒
Integrated Care Planning and Navigation – Assessment teams/joint assessment	☒	
Bed Based Intermediate Care services – with reablement /therapy to support discharge	☒	☒
Home Based Intermediate Care services – with reablement to support discharge	☒	
Urgent Community Response	☒	
Residential Placements – Extra Care, Care Home, Nursing Home and Short term residential care (without reablement or rehabilitation)		☒
Trusted Assessor Service		
Rapid Response Service	☒	☒
Voluntary Sector Contracts	☒	☒
Prevention/early Intervention – Social Prescribing	☒	
Intensive Enablement Service (Mental Health/LD/Autism)	☒	☒
Care Act Implementation		☒
Overnight Nursing		☒
Mental Health Liaison		☒
End-of-life 72 hr pathway discharge service		☒
Community Services – Integrated neighbourhood services	☒	☒

Wiltshire Council and the ICB work closely together. A jointly funded BCF commissioning team oversees the Lead Commissioning, brokerage, and contract management of services on behalf of the ICB and work with the ICB throughout the commissioning process. Third sector commissioning within the Section 75 is also managed under a pooled budget by Wiltshire Council on behalf of both partners, with reporting and oversight provided by the Locality Commissioning Group. Wiltshire Council and the ICB will continue to explore options for further joint commissioning across the period of this plan.

The governance structure ensures support across the system for multi-disciplinary working which is core across services. One example of this is the HomeFirst review (appendix E), where the optimal model is being developed with a central notion of multi-skilled staff reducing handovers and making the service more efficient. It also ties in closely with wider system work on changes to the domiciliary care framework, which ensures capacity to support individuals both during and after receiving the service.

Interventions for health inequality populations are determined locally through a variety of means. One example is the Neighbourhood Collaboratives (appendix D) that is working with system partners and residents (already identified as a health inequalities group) to agree the type of support that is appropriate. Marginalised groups as identified by the Wiltshire Core20Plus 5, such as gypsy, Roma and boating communities will be engaged with in a similar manner, utilising experienced community engagers such as the Wiltshire Independent Living Centre.

Further analysis of individual scheme Equality Impact assessments give important insights which need incorporating into commissioning specifications and the development of new metrics. We intend to assess ourselves against the Health Equity Assessment Tool (HEAT) In 2023-24.

Table 6 sets out protected characteristics where there is inequity from our current service EIA and actions to address:

Table 6: Protected characteristics

Protected characteristic	Inequity	Addressing the inequity

Age	Barriers for access to services based on rural location and lack of transport. Also, digital inequity Barriers are fear of statutory assessment, lack of access to information about next steps in hospital discharge pathway, separation from family during rehabilitation	Improving transport is a priority are for Wiltshire. Action is being taken for individuals and also service providers which will make services more available to those living in remote locations – eg paying travel costs for domiciliary carers. The new PW2 model, by reducing length of stay and exploring communication with Healthwatch to assess needs. ICA communication work group
Ethnicity	Disproportionate levels of homelessness, less likely to ask for support as carers. Access to information	Refreshed Carer's strategy and recommissioning of services to include KPI's to address inequity. Neighbourhood collaborative to review issues and address priority local issues. Review all communication across all BCF pathways
Disability	From our Brokerage analysis, people with greater disability are more likely to have delays in leaving hospital and accessing care at home	Escalation processes and MDT approach to develop individual solutions
Religion or belief	People with faiths who require designated areas for worship are not accommodated in some parts of the discharge bedded pathway	PW2 recommissioning addresses this in the specification
Sexual orientation	LGBTQIA+ impacts are: • Limited transport to other areas of Wiltshire and England to attend events with likeminded individuals. • Stigma within health services • Lack of support in schools	Raise profile of issue within all services, address through specification, priority transport already identified for Wiltshire. Education and Training in H&SC workforce Training to GP surgeries and hospitals about the LGBTQIA+ community will ensure to abolish the stigmas and change the culture around languages and treatment to people in the LGBTQIA+ community. Counselling services in schools, colleges, and universities to include dedicated services for the LGBTQIA+ community Working with services in Wiltshire to hold more LGBTQIA+ events in local areas Working with carer contract holder to create dedicated carers cafes for carers in the LGBTQIA+ community Working with carer contract holder to dedicate educational sessions to parents of children in the LGBTQIA+ community
Carers	Key barrier to working age unpaid carers accessing suitable employment was insufficient social care services	Include workplace support services including support with recruitment. Targeted approach to minority groups and areas to offer respite and SC support

The plan has yet to be developed to describe how the BCF provides for inclusion health populations? As noted in the draft plan (page 17), HWB partners expect to develop the plan to gain visibility of those accessing BCF-funded services by deprivation quintile to understand equity of access, with ambitions to also demonstrate how services are

being targeted at the most deprived groups/areas across the county? In baselining equity of access, it would be helpful to include drilldowns by protected characteristics as defined in the Equality Act 2010.

Rather than simply looking for new schemes to initiate, this plan seeks 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.

It is important that the BCF schemes follow the agreed Wiltshire Alliance Principles and maximise the opportunities that integrated working brings. Accordingly, three of our major delivery vehicles in 2023/24 have been jointly designed and commissioned and delivered through the Wiltshire Alliance partners (table 7).

Table 7: Wiltshire BCF Major Delivery Vehicles 2023-24

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. Enables a 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 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. Recognising a service gap - further investment in a Wiltshire adult community overnight nursing service supports the Rapid Response service to avoid admissions. Now an established 7-day a week service
PW2 'Hub' Model	Using evidence-based analysis of patient outcomes and an integrated approach to piloting and commissioning a service Wiltshire has a new 'hub' model for pathway 2 that provides targeted rehabilitation for patients discharged from hospital with the aim of retaining independence at home (see Appendix A. Case Study 1).
HomeFirst 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. A service review is underway in 23/24 to reduce length of stay and improve access for PW1 (see appendix E. Case Study 3)

Reducing inequalities (see also health inequalities section): Wiltshire partners have established a Wiltshire Health Inequalities Group (WHIG) to coordinate Population Health Inequalities improvement across the NHS Core20PLUS5, BSW Reducing Inequalities Strategy and Salisbury Hospital 'Improving Together' work programme. Gypsie, Roma, Traveller and Manual Workers (specifically those in minority groups) have been identified as the Wiltshire Plus Groups.

The Alliance Living Well Delivery Subgroup has been established to support this work, as well as addressing priority improvements around Long-Term Conditions and Anticipatory Care. Partnership working with VCSE sector colleagues will be essential is promoting prevention and co-production and reducing our health inequalities. Neighbourhood collaboratives will also tackle inequalities (appendix D).

Hospital Discharge: Urgent Care and Flow Transformation. Aligned with our Better Care Fund Programme, a comprehensive programme of work across our Alliance is focussed on improving flow across services and reducing unnecessary hospital admissions and delayed discharges. Work programmes under this heading include reducing length of stay in community and care home settings, maximising capacity of the HomeFirst service, increasing the number of people returning to their own home following a hospital admission and improving hospital discharge communication to improve service users experience.

Avoidable Admissions: The Urgent Care and Flow Transformation work aims to deliver improvement in 2hr Rapid Response times and expand same-day emergency care to support a reduction in avoidable admissions. We also work

with primary care and communities to identify opportunities to support early preventative and intervention, for example leg lunch clubs, strength and balance classes based in community venues. We also work with acute trusts to increase assessment at the front door and turnaround through both health and social care interventions.

5. National Condition 2: Enabling people to stay well, safe and independent at home for longer.

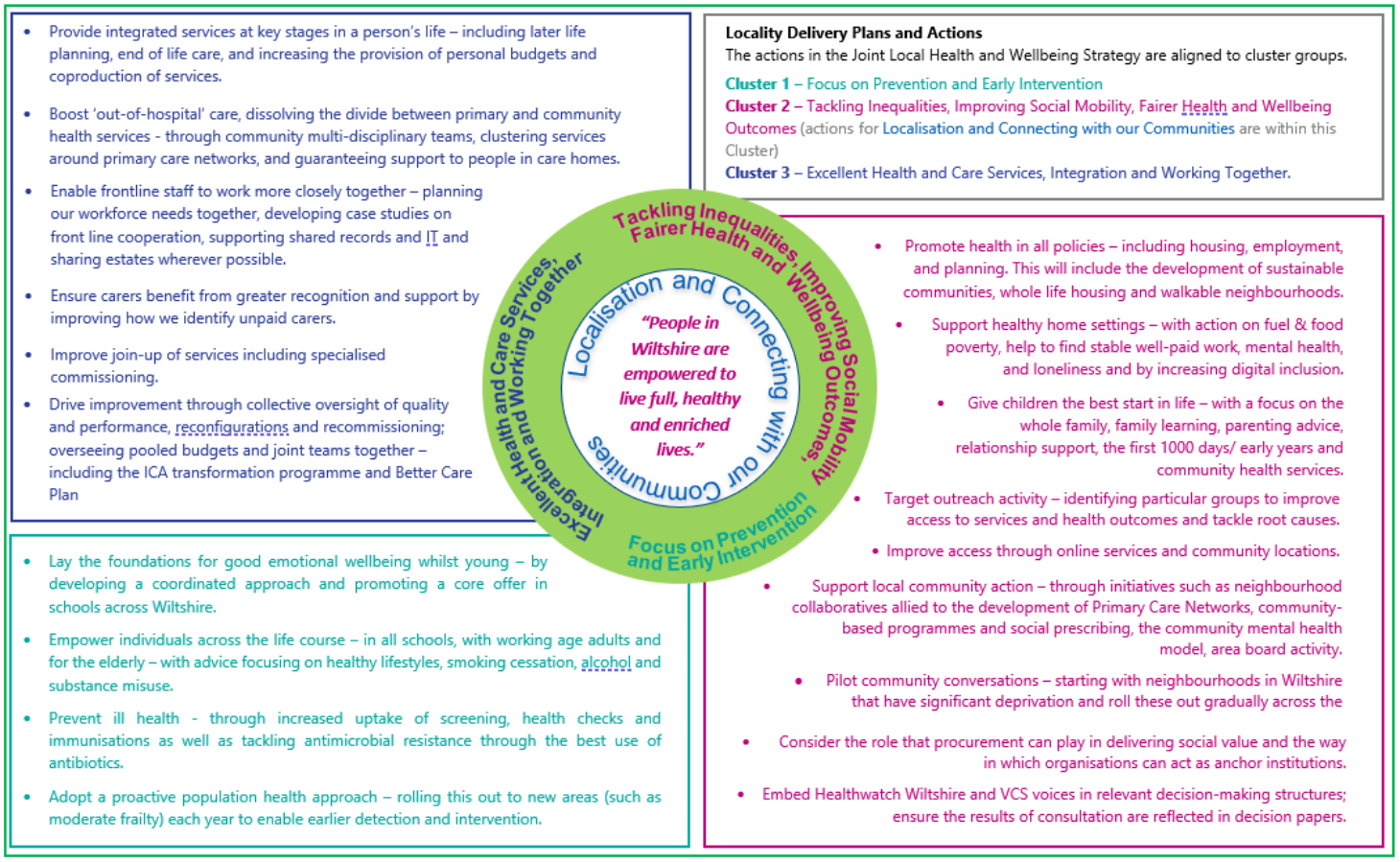
Delivering all the actions in the JLHW Strategy will require intense effort across many parts of the Wiltshire system and Wiltshire ICA has a key part to play. Embracing the opportunities that partnership working and our Alliance now bring, a structure of ICA Partnership Subgroups and additional delivery programme structures across the locality has been established to help drive the change that the JLHW and ICS Strategies have set out, as well as ensuring delivery against national and local aims, improvement work and standards.

The Subgroups will embed links to ICS Programme Boards, acting as a key link with the wider system across BSW. Once fully operational, each group will own delivery against key national and local indicators for health and wellbeing improvement for the Wiltshire population and will drive some of the actions in the JLHW Strategy. Membership of each group represents the broad Alliance partnership and engages the resources across our organisations. The groups are accountable to the Wiltshire ICA Partnership Committee, with close relationships to the Health and Welling Board which monitors achievement against the JLHW Strategy.

Figure 1 shows the Alliance delivery structure and relationships to other groups and programmes of work. This ensures maximised resources and limits duplication whilst affording a line of sight across the matrices in which we now function, both at neighbourhood, locality and broader system.

Further to this the Wiltshire ICA Delivery Plan Actions align across the common priorities.

Figure 2: Wiltshire ICA Delivery Plan



The Wiltshire JSNA 2022[1] highlights how by 20240 Wiltshire's 65+ population is estimated to increase by 43%, and the 85+ population by 87%. We must therefore ensure we commission schemes to mitigate the impact of this on health and social care services. The ICB have developed a suite of population health tools, making use of integrated care records, which will provide further assistance in analysing and improving population health and be preventative in our approach. We will feed into the community area JSNA which is being written this year to ensure key indicators, such as falls data, are included enabling us to make informed commissioning decisions and develop more targeted proactive interventions.

Multidisciplinary teams (MDTs) are core to the Alliance principles of working (see table 4); 'Work as one: partners collaborate sharing expertise, data and resources in the interest of our population'. Many services already use MDTs as standard practice, but it is also widely used across management within the system. Examples of this include the Homefirst review (appendix E) where a MDT of Alliance partners jointly developed the optimal HomeFirst model, aligning a true D2A model with interdisciplinary teams. This will result in a multi-skilled workforce and less handovers of care. It is also closely aligned with a recent re-launch of the domiciliary care framework. The Alliance approach and close working relationships resulted in key services being in place to support a homefirst goal. The Pathway two hub model beds are also an example of effective interdisciplinary team development and working (appendix C).

5.1 How work to support unpaid carers and deliver housing adaptions will support this objective.

Supporting parent carers through activities such as the 'healthy movers programme' (supporting young children with physical literacy) it trains parent carers to support their own children. It builds confidence, provides a forum to create support networks, helping their emotional wellbeing and resilience.

Training is provided to Carer Support Wiltshire on 'five to thrive' trauma training which equips them to support young carers with trauma. It allows them to support the young person going through trauma with a quick response time and allowing the young person the safe space to talk. Knowing that there is a professional who is trained in understanding what they are going through and can support them with techniques leaves the young person at a lower risk of self-harm or becoming diagnosed with anxiety or depression.

Carers themselves are also offered training opportunities, for example training in manual handling or understanding autism and how to safeguard yourself. Equipping carers with the right tools enables carers to help the diagnosed navigate through life easier. Advice is also provided for carers about safeguarding themselves, for example advising carers about services like legal power of attorney allows them to support the cared for legally.

Carer input to service development and feedback on existing services is gathered across numerous carer engagement events and these feed into several contracts/projects and strategies, for example the Dementia and Carer's Strategies. Developing services while taking into consideration the carer and cared for we can show commitment to both to support them in a happier, healthier life.

This work supports preventative care, ensuring the carer is supported and able to care while maintaining their own health and wellbeing.

Also see unpaid carers section of this plan.

5.2 Demand and capacity for intermediate care to support people in the community and hospital discharge.

Intermediate care services in Wiltshire

Service	Description

[1] Population and deprivation Wiltshire Intelligence

HomeFirst	Supporting people to return home following hospital discharge. The service provides assessment within a person's home to ensure they are supported to carry out daily activities required to be independent.
Wiltshire Support at Home	Providing domiciliary support in domestic settings; supporting people on discharge from hospital as well as long-term. Also supports HomeFirst and Reablement services with additional capacity when required.
Rapid Response	Support within two hours to help people to remain at home and avoid hospital admission.
Reablement	a short-term service within a person's home from specially trained social care staff, including occupational therapists and reablement workers, enabling people to regain independence. The service is available to adults who normally live independently at home, but who might have lost physical ability or confidence in carrying out their day-to-day living tasks.

Wiltshire's intermediate care services sit within a system with a shared vision to promote independence and shift care away from hospitals and other bedded care. We are aware that the HomeFirst service will need to plan for increasing demand over the coming years and a review is under way (appendix E) to understand the improvements that could be made to increase efficiency and capacity with this service. The recent launch of a newly commissioned dom care framework has resulted in an increase in available packages of care in the community. The resulting reduction (or in some cases removal) of waiting times has assisted both discharge and hospital avoidance intermediate care services. The ambition is to continue to look to ways to better integrate services, strengthen the existing multi-disciplinary team approach and continue work to develop performance dashboards that reflect services as single delivery mechanisms.

Wiltshire ICB has recently undertaken a detailed analysis of demand and capacity across its health and social care system. The aim of the modelling was:

- A clear Plan for the ICA which aligns to respective system and Wiltshire strategies, and which includes a phased implementation plan, and clear risk mitigating actions for the transition period to the future state.
- Sustained reduction in non-recurrent spend from 2023-24 on spot purchasing and high cost bedded care
- Investment in an ICA model that improves our ability to deliver and flex to sustain a default "Home First" offer.
- The Wiltshire ICA has the optimal number and types of Community and D2A capacity to meet the needs of the population, and deliver improved performance across sectors (financial and qualitative)

Since the modelling work started in January 2023 the following has been achieved:

- Assessed the proposals to reduce non-recurrent spend and risk assess the impact on Wiltshire flow
- Started to develop a mitigation plan for 2023-24, identifying key improvement areas
- Scoped the size of the backlogs on P1 and P2 and quantified.
- Modelled the Pathway 2 demand and capacity across each Trust geography and evidenced this can be accommodated in the proposed P2 bed model (appendix C)
- Demonstrated Capacity and Demand of -/+ 65yrs against John Bolton and National Guidance
- Provided progress update towards final phase of modelling (P1 and P3)

Our next steps will be to carry out a Home First Review (appendix E) and create an Urgent Care and Flow Group

The work has resulted in predicted demand being fully scoped and a full year 'plan on a page' has been developed (appendix B). The Wiltshire Ageing Well and Urgent Care Group are responsible for monitoring and delivery of actions.

5.3 Learning from 2022-23

Our work on the PW2 development included analysis of referrals and outcomes (appendix x) using the NHSE stratification model we found that our then Intensive Rehabilitation beds were not achieving the desired outcomes because people were not being properly aligned to the correct pathway. There were cohorts of patients that would have been better placed in end-of-life, long-term bedded accommodation or pathway 1. The analysis supported a wholescale review and re-modelling of pathway 2 (appendix C). Early feedback from the new hub model that started in April 2023 shows an overall reduction in length of stay and more appropriate alignment of customers.

Unplanned admissions to hospital for chronic ambulatory care sensitive conditions:

We did not meet our plans for 2022-23 avoidable admissions – we were approximately 1000 higher than planned. We have several actions in place that we hope to have a positive impact on avoidable admissions. This includes:

- A significant programme of work to reduce falls. This includes the work done to identify those at risk of falls but who have not yet fallen, making used of health and population data from across system organisations.
- Rapid Response and Overnight Nursing services will continue to be rolled out across Wiltshire.
- In 2022-23 the Wiltshire system reporting 3,207 unplanned admissions against a target of 2,261. Rapid Response and Overnight Nursing services continue to be rolled out across Wiltshire and once at full complement we expect to see them having an impact on these figures. Further analysis of avoidable admissions per acute trust has found significant differences between Trusts. Of these, 42% are into RUH, 31% into SFT and 19% into GWH. In recognition of this we used the ASCDF to increase in-reach roles in EDs across acute trusts. We expect to see an impact on discharges in 2023-24. We will complete further analysis in quarter 2 of 2023-24 to better target discharge resources.

Discharge to usual place of residence:

The PW2 model (see Appendix C) is an example of providing focussed rehabilitation to patients on discharge with the sole aim of enabling them to return home (with or without packages of care). Patient criteria is strict to ensure those able to are offered a multi-agency support to get them home and as independent as possible, as quickly as possible post hospital discharge.

The HomeFirst service across Wiltshire also supports pathway 1 discharges for a finite period to assist people to remain independent in their homes.

The BCF funded Home from Hospital service supports people being discharged on pathway 0 that need some support and minimal intervention in the early days of discharge. This support can range from the provision of meals to HELP boxes that provide essentials such as food and toiletries for the initial days at home. This enables people to have the time they need to then coordinate shopping etc from their own homes, rather than while in hospital.

The BCF funded Intensive Enablement Service supports provides time-limited care, enabling support for people with mental health needs, learning disability and/or autism who are at risk of hospital admission and/or for people being discharged from acute psychiatric hospital and/or rehab. It provides outreach-based support in people's own homes (where appropriate). This new service is like the Council's existing Reablement team working with older adults focusing on maximising independence for people with complex needs.

Emergency hospital admissions following a fall for people over the age of 65:

Wiltshire has seen a reducing trend since 2021-22 with a maintained improvement of 2%. This is due to increasing our focus on helping people to stay in their own homes and improving therapy available on hospital discharge. The ICA are making use of the national funding to support a reduction in hospital admissions because of non-injurious falls. This includes amongst other things, working with community teams and care home providers to purchase and utilise new equipment. In addition, our Neighbourhood Collaboratives Programme (appendix D) is rolling out across Wiltshire. Recognising that we have responsive services in place and good outcomes in preventing second falls following an initial event, the Pathfinder site, working through a prevention lens, is focussed on identifying people at

risk of a first fall (i.e., they are not known to be at risk of a fall and are not receiving support or prevention advice) and working with them to reduce that risk. The developed population insight tool pulled together public health, primary care and other population data which was reviewed against an agreed set of filters. Through this new approach to data collection and analysis 154 people have been identified in the Pathfinder area who have been defined as being highly likely to fall within the next 12-24 months if we do not intervene – we are now at the stage of working with them to understand their needs and develop our plan. Lessons from this work will be shared across the system to support rapid adopt and spread of any successful activities.

The number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population:

Some of the 2023-24 ICB element of the Winter discharge funds is committed to Wiltshire Support at Home; to increase capacity in the home care market and support more people returning home. The focus on our BCF funded HomeFirst service with a review (Appendix E) will further drive efficiencies and supporting discharge flows. The new PW2 'hub' model (Appendix C) brings therapy, social care and triage services together to provide targeted support to patients with rehabilitation that supports independence and a return home.

We have gaps in bed based and community care for specialist dementia services. We are working with providers and conducting analysis with public health specialists and ICB analysts to predict demand and capacity and have incorporated findings into our Market Sustainability planning.

Changes and new schemes in 2023-25: (Some suggestions to include)

- In-reach teams in the acute settings, supporting discharge flows
- PW2 model (Appendix C)
- Service improvement work on community equipment service (to support rehab and greater independence)
- 7-day brokerage function now established
- HomeFirst review (appendix E)

The BCF also funds carer support in Wiltshire to further support people to remain at home. Please see the Carers section for more information.

6. National condition 3: Provide the right care in the right place at the right time.

Aligned with our Better Care Fund Programme, a comprehensive programme of work across our Alliance is focussed on supporting people to remain in their own homes, improving flow across services and reducing unnecessary hospital admissions and delayed discharges. Over the next 12 months the HWBJS locality plan's 'Integration and working together subgroup' will deliver: -

- Reduced Length of Stay in Care Homes (to achieve 28 days by July 2023)
- Achievement of the 70% 2-hour Urgent Care Response target (by June 2023)
- Delivery against Virtual Ward development targets, (reaching 136 'beds' by December 2023 and 180 by March 2024)
- Reduced length of stay in community hospitals (to reach 35 days across all wards by July 2023)
- Reducing hospital trust lengths of stay.
- Maximising capacity of Home First services
- Complete Discharge Communications Project to improve patient, family and carer experience and reduce discharge delays (resources launching July 2023, full impact September 2023)
- Increasing the number of people returning to their own home after a hospital admission (% increase TBC once modelling completed).
- Implementing new End of Life care provision model, ensuring people are supported to die in the place of their choosing (launch new model October 2023).
- Increased 0-day lengths of stay

- Same Day Emergency Care expansion.

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. 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:

- Unified vision that brings system partners together
- Simplify and standardise as far as possible.
- Use services for diversion and admission avoidance as well as discharge
- No discharge destination determined from the ward
- Coordinate the use of voluntary sector at all decision points
- Outcomes and whole person journey are a key indicator of success not just flow data
- Understanding our demand, capacity and outcomes
- The BCF Dashboard is an important performance management tool to measure our improvement - it is a reference for all decision-making points. In 2023-24 it will undergo review and it will incorporate contextual and key ICB required data so ensure it is it is 'fit for purpose' across the system.

Table 8: Hospital Discharge Schemes

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
VCS	Age UK Bath are commissioned to support hospital discharge and Pathway 1 discharges. A transformation project will look at how we can more effectively level community and VCSE resource
PW2 Beds	When people required bedded support for discharge if they are still unwell or unable to manage or be safe at home even with support packages of care
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 (DFG) to support people with housing issues at discharge. In 22/23 BCF commissioners are working with housing and other with key stakeholders to include equipment and Technology as an enabler of independence at home.
Intensive Enablement Service	The service provides time-limited care, enabling support for people with mental health needs, learning disability and/or autism who are at risk of hospital admission and/or for people being discharged from acute psychiatric hospital and/or rehab. It provides outreach-based support in people's own homes (where appropriate). This new service is like the Council's existing Reablement team working with older adults focusing on maximising independence for people with complex needs.

BCF Hospital Discharge Schemes	How the scheme supports safe, timely and effective discharge
Equipment and technology	OTs can 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 and also Kingsbury Square emergency homelessness service have been funded 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.
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. Fast track offer is under review with a proposed way forward for Wiltshire to be approved in 22/23 by BSW ICB.
Acute Trust Liaison	This is an in-reach service to support discharge issues such as access to voluntary sector support

6.1 How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

The Wiltshire locality was granted approval for proposed schemes to support hospital discharges during the winter period December 2022- March 2023. The total pooled budget was £4,265,220. The schemes implemented in the Wiltshire locality were developed in partnership with health colleagues and mobilised and demonstrated an increase in capacity to support discharges. The schemes were varied and took a multi-faceted approach to supporting discharges; including staff retention, the purchase of additional capacity in existing services, work to release existing roles to focus on discharge etc. The funds supported the following types of discharge support.

45% of the funding went to providers – either through the purchasing of additional bedded care or through direct support via a grant to support recruitment and retention.

50% funded additional key roles in hospital discharge services or funded agency staff to free capacity in existing roles.

Table 9: ASCDF Spend 2022-23 1

Type	Total	% of total
Recruitment and Retention	**£1,647,000**	**39**
Additional Capacity (bedded care)	**£1,412,000**	**33**
Market Support	**£500,000**	**12**
Other spend to increase staff capacity		
Care Act Ax backlog	**£375,000**	**9**

VCS offer - Meals	**£85,000**	**2**	

Table 10 highlights some of the learning from the 2022-23 ASCDF:

Table 10: Learning from ASCDF 2022-23 1

Learning from the 2022-23 ASCDF
The benefit of using voluntary sector to support discharge support services. We engaged voluntary services to deliver meals that also acted as welfare checks, to release Reablement staff to support additional hospital discharges. This was a cost-effective means of increasing capacity within an established service and was well-received by service-users.
Increasing in-reach team capacity in Emergency Departments at the acute Trusts serving Wiltshire residents: Salisbury, Bath and Swindon. These teams liaise with patients; supporting them and their families to be proactive and ensure timely discharge.
Staff recruitment and retention – The staff incentive and recruitment bonuses have had a significant impact on both the level of applications and the number of roles filled. January applications across all three services (Wiltshire Support at Home, Reablement and Outreach and Intensive Enablement Service was 2.5 times higher than the same period the previous year with February applications almost four times higher than the same period the previous year.

Team	**Jan-22**	**Jan-23[1]**	**Feb-22**	**Feb-23**
Wiltshire Support at Home	12	32	18	29
Reablement	31	36	8	32
Outreach & Intensive Enablement	6	49	2	45
Total:	**49**	**117**	**28**	**106**

[1] Jan 23 data is from 10th-31st January.

In 2023-24 we have identified the following schemes that will support capacity in hospital discharge pathways:

Table 11: ASCDF 2023-24 Schemes 1

	Scheme	**Detail**
1	Supporting community equipment	Provides additional funding to support the increase in demand for community equipment associated with increased number of patients being discharged to their homes.
2	Wiltshire Support at Home	Providing additional capacity in domiciliary care to provide the required increase in packages of care
3	Risk pool for PW3 beds and domiciliary care provision	To provide additional capacity across the care market to support winter pressures.
4	Micro-provider Support	Funds to support recruitment and retention within the smallest providers to support market capacity.
5	VCSE and Carers Support	Using the voluntary sector to support hospital discharge and provide additional capacity to support carers with discharge planning.

6.2 Using BCF funding to ensure that duties under the Care Act are being delivered.

Better Care Fund investment is being used in a variety of ways to ensure that Care Act related duties are being delivered:

Health and social care integration: The Better Care Fund will be used to support the integration of health and social care services to ensure that patients receive the care they need in a coordinated and timely manner through integrated commissioning of services, delivering the right care in the right place at the right time.

Care planning: We will use Better Care Fund money to support the development of care planning for individuals, ensuring that their care needs are identified and met at the earliest opportunity, with service user engagement where possible and that they receive the appropriate services and support.

Care coordination: The Better Care Fund will be used to support the coordination of care services for individuals, including the provision of care journey coordinators who will help individuals to access the services they need and through community wellbeing hub interventions who will connect service users and their relatives to a range of community services that can assist with a range of discharge and ongoing care support services.

Training and development: The Wiltshire system will use funding to support the ongoing training and development of health and social care staff, particularly via our ongoing BSW commitment to the Skills for Care Partnership. This partnership leads on several duties including bidding for Skills for Care funding and advising providers on the minimum standards of training which staff are required to have to do their job effectively under the Care Act whilst improving outcomes for people who use our services. The BSW Academy supports domiciliary care agency workers through the provision of co-production training, supporting the personalisation of care.

6.3 Supporting unpaid carers.

These services are jointly commissioned in Wiltshire. The BCF funds the 'Carers Support Wiltshire contract and Wiltshire Council provide a team of commissioners to support carers in the county. The carers strategy, 'Carer Friendly Wiltshire – all age carers strategy 2023-28' is currently in final draft stage. The work that carers do to support those they look after is invaluable to the health and social care system in Wiltshire. The strategy explains the vision of a career friendly Wiltshire, describes the outcomes carers have told us they would like to achieve, describes the new service offer that will help meet carer's needs, and identifies the tools to measure our progress against expected outcomes.

- 42,262 people in Wiltshire are caring for a family member, friend or neighbour.
- In 2021 8.6% of Wiltshire residents provided unpaid care and support.

Wiltshire has a draft development plan – a support offer for all carers. The following is an outline of key services provided by Carers Support Wiltshire.

- Improving carer awareness across health, social care, education, and the wider community, recognising that people do not always know what they need or what is available to support them and that carers may not identify with the term as carer. This includes offering carer awareness training across health and social care and other statutory partners, a General Practice Accreditation Scheme and a School Accreditation Scheme.
- Operating a Reduce, Prevent, Delay (RPD) model of service delivery, which includes information, advice, intelligent signposting, and onward referral.
- Facilitating carer involvement and ensuring that the voice of carers is heard when decisions are made about how their own needs and the needs of those they care for are met. The provider facilitates and supports both the Council and the ICB with engagement with carers. A Carers Forum is in place and regular engagement events are help. Carers are key to informing strategy development and involvement takes place in a variety of ways e.g., focus groups, carer cafes, surveys and engagement events.
- The provider has delegated responsibility for undertaking Care Act compliant carers' assessments for carers aged 18+. They operate a two-level function: primarily undertaking health and wellbeing assessments that result in a RPD support plan and a secondary function of 'Statutory Carer Assessments' that lead to the provision of commissioned services either through a Direct Payment or a brokered support service. These services include the commission of replacement care or respite services for the cared for.
- Undertaking health and wellbeing assessments of parent carers of disabled children and offering support through carer cafes, information, advice, and signposting.
- Undertaking young carer and parent carer transition assessments.
- Organising carer break activities that provide opportunity to meet others in a comparable situation and who share the same interests, which helps to build a network of peer support.
- Supporting access to and organising training for carers to support them to provide care and support safely (e.g., manual handling), maintain their own wellbeing and build resilience.
- Providing emotional wellbeing support.

- Supporting opportunities for carers to get into volunteering, which adds value to the service as well as an opportunity, particularly for those whose caring role has ended and who are seeking a return to employment.
- Supporting Carers to plan for emergencies. This includes administering and supporting registration to a carers' emergency card scheme.

Young carers are one of the hardest to reach and are vulnerable due to age but also without being correctly supported to achieve whilst caring could end up on relying social care support later in life. Carer Support Wiltshire has also recently brought the young carers service (5-18) back 'in-house', ensuring a whole life approach to carer support. They have also recently employed a family key worker to this end and link with commissioned support provisions in the council to reach more vulnerable groups of people. For example, Julian House is contracted to support people who do not have a fixed address (travelling families), the Early Help team are commissioned to support families of which their first language is not English, the corporate team support resettled families in Wiltshire and our LGBTQIA forum has several resources to support community engagement. With these tools we can support carers in different communities and engage with them when needed

6.4 Disabled Facilities Grant (DFG) and wider services

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 to meet the housing needs of older and disabled people.

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 can provide support to one another.

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.

The council has a statutory duty to provide means-tested Disabled Facilities Grants to adapt the homes of disabled occupiers to make them more suitable for their needs. Residents are assessed by an Occupational Therapist who makes recommendations. DFG Priority 1 adaptations are high priority major adaptations, and DFG 2 refer to other or standard adaptations. Wessex Loans are for essential repair and maintenance work to properties or to pay for adaptation where the cost is above the Disabled Facilities Grant, or the person doesn't qualify for a grant. Adaptations made to council owned properties are funded through the Housing Revenue Account. Housing colleagues within the council work closely with BCF commissioned hospital discharge services such as Reablement and Home from Hospital (voluntary sector) to enable timely adaptations that support efficient discharges.

Adaptations made to households in Wiltshire saw a decrease in 2020/21, where the impact of the pandemic had a negative impact on timescales and number of completions. Planned works had to be delayed due to restrictions and shielding requirements, and the need to introduce new health and safety measures.

There is also a Rough Sleeper Outreach Team within the Homelessness Team and health inequality 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. In

2022-23 three homeless hostels were refurbished. These were specifically used to facilitate and support homeless people on discharge from hospital. In 2023-24 a further two flats will be refurbished, doubling the capacity for homeless discharge support.

This year's plan 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. A TEC commissioning team was recruited to in 2022-23 and is in the final stages of a strategy which will identify plans for 2023-24. It is the ambition that TEC solutions that support independence are trialled and applied across a range of services to support people to be independent at home.

6.5 Additional information (not assured)

Discretionary grants provide a top up to the Disabled Facilities Grant where the cost of essential works exceeds the maximum grant. If eligible. Wiltshire Council will fund a top up to the DFG to a maximum of £10,000. The type of work includes extensions and other significant adaptation work.

Due to inflation and other cost increases work it has become increasingly challenging to complete required works within the maximum DFG grant (£30,000). There has, therefore been a corresponding increase in the use of the discretionary grant in recent years (table 12).

Table 12: Discretionary Grants 1

Year	No. Cases	Cost
2020-21	2	£32,586
2-21-22 (covid)	0	£0
2022-23	4	£70,979
2023-24 (to date)	5 cases committed	£48,196

7. Equality and Health inequalities

2022-23 saw Wiltshire move toward a more strategic, population-based approach to determining our priorities. Local priorities for health inequalities have been set in two main ways. At a strategic level, the BSW Reducing Inequalities Strategy requires each BSW Place to set place-based priority groups. For Wiltshire, our Adult PLUS group (The PLUS is the CORE20PLUS5) is Gypsy Roma Traveller and Boater (GTRB), and routine and manual workers. For Children and Young People, the PLUS group is GRTB children. Phase three of the strategy requires a wider determinant priority for the county, which the Wiltshire Alliance Delivery Group agreed to be Transport and Connectivity. At an operational level, the Wiltshire Health Inequalities Group held a workshop in March 2023 setting themselves some draft 1- and 5-year priorities. These are being reviewed and will be used to inform spend of the Health Inequalities funding in 2023-24.

The projects funded through the health inequalities fund are chosen to align with the CORE20 – in that they must all focus on reducing the impact of inequalities for those people in the nationally most deprived 20% of areas. For Wiltshire we only have a small number of areas in this group, notably, Bemerton Health and Studley Green, where the council are doing targeted work through Community Conversations. The PLUS groups (as above) are priorities for all health inequality spend and the 5 clinical areas are overseen by the ICB clinical leads.

Neighbourhood collaboratives as a new approach to identifying and tackling inequalities (appendix D).

8. Approval and sign off

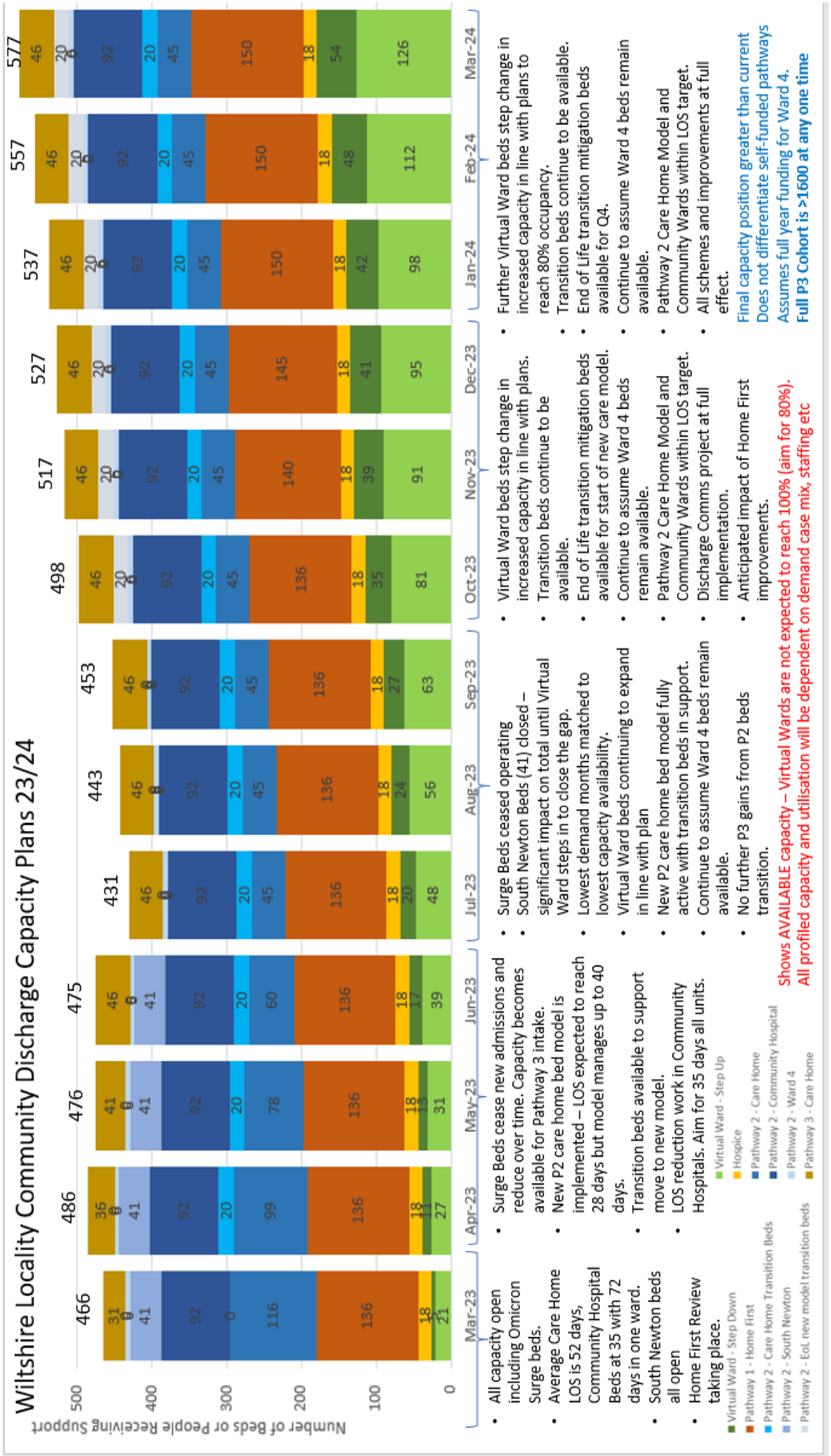
This plan has been created in partnership with all organisations detailed in section 1.0 and has been signed off by the Health and Wellbeing Board delegated authority, before formal sign off by the HWB on 20th July 2023.

Appendix A:

Representatives from the following groups have either been consulted or directly input to the content of the Wiltshire BCF Plans.

Representative	Group(s)
Wiltshire Locality BSW ICB Executive Director for Place - Wiltshire Associate Director Finance Director of Locality Commissioning Health Care Professional Director BSW ICB Medical Director	Integrated Partnership Committee, Alliance Delivery Group
Wiltshire Council Corporate Director for People Director of Ageing and Living Well Director of Procurement and Commissioning Head of Finance	Integrated Partnership Committee, Alliance Delivery Group
Acute Trusts (SFT/RUH/GWH) CEO, COOs	Integrated Partnership Committee, Alliance Delivery Group
Community Services Managing Directors – children's and Adults	Integrated Partnership Committee
VCSE Leadership Alliance (voluntary services) Nominated individual	Integrated Partnership Committee
Healthwatch Organisation Deputy Chair	Integrated Partnership Committee, Alliance Delivery Group
Social Care Providers	Integrated Partnership Committee, Alliance Delivery Group
Mental Health Providers Locality leads for adults and children's. AWP and Oxford Health	Integrated Partnership Committee, Alliance Delivery Group
Public Health Consultant	Integrated Partnership Committee, Alliance Delivery Group
Housing Head's of Service – Wiltshire Council	Represented through Ageing Well Director's attendance at System-wide meetings as well as project specific meetings.

Appendix B: Wiltshire Locality Community Discharge Capacity Plans 2023-24



Appendix C. Case Study 1: Pathway 2 'Hub' model of care

Our Pathway 2 hospital discharge pathway has recently been re-modelled to ensure the provision of effective multi-disciplinary therapy to assist a return home for patients discharged from hospital. A number of issues were identified with the bed based care in pathway 2.

- Inequitable access to therapy
- Excessive lengths of stay
- provision not meeting patient needs
- Poor outcomes for patients

Table A shows the analysis of patient outcomes.

PW2 discharge outcomes	Average % (Oct 20-Mar 22)	Notes
Hospital readmission	17%	This is likely due to a worsening of an existing condition – whatever the reason, PW2 bed are not appropriate for this level of need.
Nursing home	18%	These customers would have been better suited to PW3 rather than a therapy-based bed
Residential home	14%	
Home independently	10%	This is the aim for most people being admitted to a PW2 therapy-based model
Home with Package of Care	16%	
Home First	12%	For those discharged with Home First it is assumed this could have been an option in the first instance. The bed review showed a high proportion of PW2 customers who, on clinical reassessment, were deemed to have been appropriate for Home First rather than a bedded facility.
End-of-life	13%	On many levels, this is not satisfactory, and alternative bedded provision should be found.

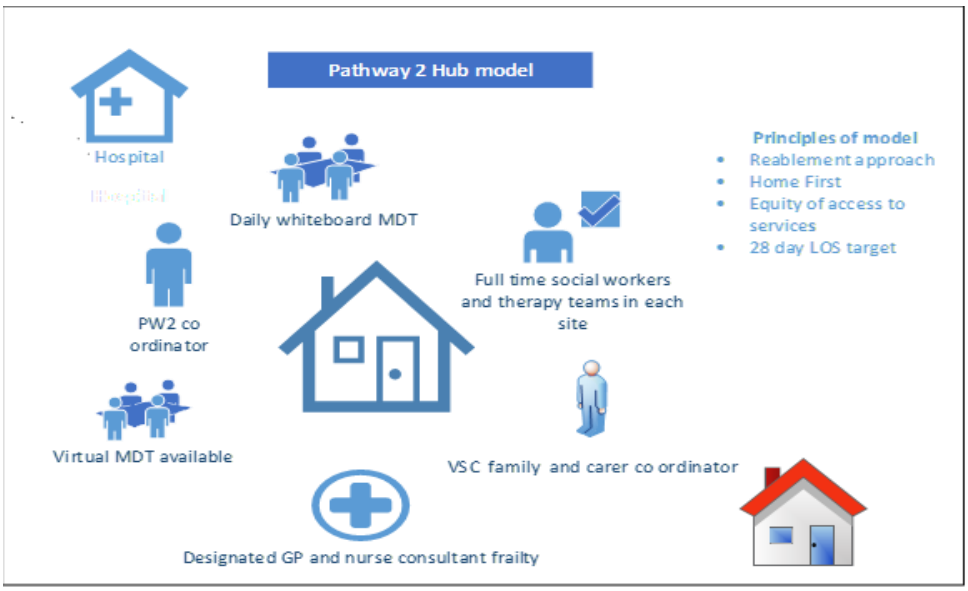
Further stratification was then conducted, using the NHSE Stratification model, along with

Due to this analysis of patient outcomes a stratification of the pathway was conducted collaboratively with colleagues from Wiltshire Health and Care, Adult Social Care, Integrated Care Board and the Better Care Fund as well as involvement from GP's, providers, and acute providers. This highlighted that if the correct patients are admitted into a therapy-based bed model, the Wiltshire system would require between 53 and 61 beds.

PW	**Definition**	**Current outcomes (Oct 21-Mar 22) as % of demand**	**Beds required**	**Beds required plus 15% capacity to aid system flow**
2a	Medically stable cognitively and physically able to participate in rehabilitation activities. Current dependency, rehabilitation or cognition mean not yet able to be managed in community	21%	22 PW2 Hub Model	25
2b	As per 2a plus: Higher rehab complexity (but not reaching requirement for NHSE&I Level 1 and 2 rehabilitation[5])	20%	21 PW2 Hub Model	24
2c	Clinical risk is too high to go home at this stage. relatively low rehab e.g., end of life care	16%	18 Nursing beds	21
2d	As per 2a plus; Both clinical risk and rehab requirements are high (but not reaching requirement for NHSE&I Level 1 and 2	10%	10 PW2 Hub Model (Complex)	12

	rehabilitation) delirium and complex MH with clinical complexity			
2e	Residing in P2 due to lack of P1 capacity	6%	6 HomeFirst Service	
2f	Residing in P2 due to other reasons (e.g., P3, Specialist capacity, other	11%	12 PW3	14
-	Hospital readmissions from PW2	20%	21 Community Hospital or clinical optimisation	24
Totals of PW2a, 2b and 2d suitable for PW2 'Hub' model			53	61

The review further identified areas where efficiencies could be made both to pathway 2 admissions and across other discharge pathways to enable a reduction in the overall number of pathway 2 beds. It was proposed that these beds could be delivered through a new 'hub' model.



The proposed organisational model is to establish specialist hubs – adaptable, equitable and able to deliver a short term, rapid, high-quality level of assessment and rehabilitation. A hub model provides economies of scale – enabling GPs, Social Care and therapy staff to concentrate support in one place.

Collaborative Approach

A pilot was conducted 1st September 2022 and 31st March 2023, to understand how best to identify suitable patients, test ways of collaborative working, how to affect a cultural shift in the provision of therapy to improve independence and a return to the individuals home and do all of this with a LOS at or around 28 days. The pilot tested:

1. GP Support	We will use existing support services to ensure medical support to the beds
2. Therapy Support	Qualified occupational therapists and physiotherapists will be available as part of the 'hub' team so access to this support is equitable across all the beds, including the more complex dementia and delirium cases.
3. Social Care support	Social workers will be part of the 'hub' teams and therefore able to be more reactive in terms of timely assessments etc.
4. Training to support a cultural shift toward reablement	Training for care home staff on the ethos and approach to reablement and increasing independence will be provided to support the service.

5. Revised eligibility criteria	To ensure only those with rehabilitation or reablement potential are admitted to the beds.
6. Reducing Length of Stay	Length of stay in Wiltshire across all D2A and IR pathways are on average more than twice the national standard of 28 days. In some instances, there are stays in D2A and IR of over 180 days. This has the biggest impact on current capacity. Delays in discharge from these beds will be addressed through the pathway 1 review. A hub model will also result in the right expertise, such as social care on site to enable timely assessment of individuals. Any reduction in length of stay, even on an incremental basis, to allow the system to calibrate and increase resources where needed, will be transformative.
7. Access to a consultant geriatrician and a virtual MDT	Support of a weekly virtual MDT and consultant geriatrician will support providers in making decisions on residents' care and ensure appropriate support of individuals.

To create the collaborative working environment social work staff, home staff and therapists shared office space to promote conversation regarding patients' needs as well as triaging referrals together and attending weekly MDT's.

The outcomes of the pilot;

• Reduced LOS • Staff reported greater job satisfaction with the model, citing a more holistic view of the patient.	• Improved outcomes (increase in the number of patients returning home) • Patient has regular input and oversight from a range of professionals. • A quicker turnover of patients.

As a result of the positive outcomes being shown it was collaboratively agreed to change the model to the one used during the pilot. It ended with a successful tender for the new service model which is currently in the first months of mobilisation.

Appendix D. Case Study 2: Collaborative Neighbourhoods

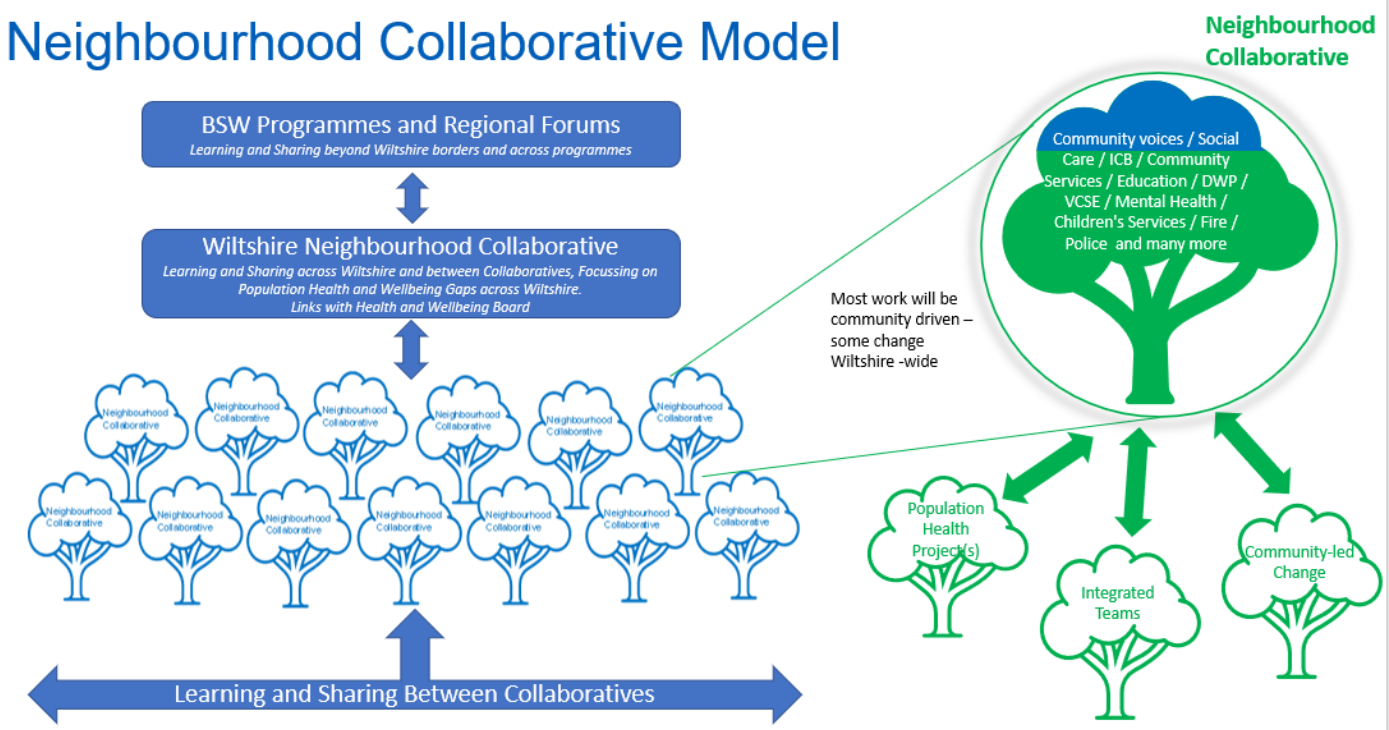
Integrated and explicit in the Joint Local Health and Wellbeing Strategy (2023) for Wiltshire, The Neighbourhood Collaborative programme has been co-designed by Integrated Care Alliance members to enable partnership working to flourish across services, organisations and community groups within areas loosely defined by each of the Primary Care Network footprints. Once established there will be 12 to 13 Collaboratives across Wiltshire.

Each Collaborative will connect partners from health and Social Care, Voluntary Community Social Enterprise, Local Authority partners, (including Area Boards, Education and Housing), Police, Fire and many Community Groups who will offer their resources and share their expertise and assets to enable solutions to be developed that can tackle health inequalities and promote health and wellbeing within their local community. Community views and engagement will be the key to success.

Each Neighbourhood Collaborative will be grown from the ground up, which means they may be structured differently to each other, and partner staffing models may look different depending on what works for each area. They will establish their own needs and priorities.

The six Principle Areas are:-

- Partnership working
- Co-production
- Community-led approach for health & wellbeing
- Working as one using data analysis
- Enabling volunteers and staff to thrive
- Creating a movement for change



The Collaborative approach aligns with guidelines set out in the recent Fuller Primary Care Stocktake report (2022) and has been integrated into the Joint Local Health and Wellbeing strategy, and aligns with the BSW Care Model and ICS Strategy. The programme also supports other key areas of focus within Area Boards, Families and Childrens Transformation and Community Conversations and Mental Health, LD and Autism.

Over the next 12 months, the Collaborative programme aims to:-

Milestone	Progress and Next Steps

1	Complete Pathfinder site (Melksham and Bradford on Avon) development and initial project area, feeding learning into the full programme structure.	• February to April 2023 – Collaborative group in one neighbourhood on a 'fast track' launched to gather early learning to add to the initial pilot findings. • May 2023 - Engagement work with Collaborative cohort, focussing on prevention. • June – Define and agree Collaborative structure and leadership. Publish First report. • July 2023 – Co-production training delivered with MBoA teams. Start working directly with an identified group of patients • September -2023 – Progress update • December – Progress updates
2	Deliver Initial Readiness Review and Launch Programme. (June '23)	Onboarding Launch programme agreed and online portal established. Full programme pathway agreed (indicates place and pace of Collaboratives launching). Currently establishing sites in Devizes, and in discussion with two other areas for full set up.
3	Hold first Wiltshire Collaborative event. (August '23)	Design Wiltshire Collaborative model with the Steering Group. Hold first Wiltshire Collaborative group – aiming for August but dependant on site development – may move to Autumn. Release Programme Update report.
4	Establish Neighbourhood Collaborative in each area of Wiltshire (April '24)	By April 2024 all neighbourhood areas will be on their collaborative journey at different points of maturity and will have completed or commenced the Launch programme. Initial impact results will be available for multiple collaboratives areas.

Appendix E. Case Study 3: HomeFirst Service Review

Since 2018 Wiltshire has commissioned two providers –Wiltshire Health and Care (WHC) and Wiltshire Council Reablement (WC) to deliver Home First, working within an integrated delivery pathway. Other providers also contribute to delivery - Wiltshire Support at Home (WSAH) and independent providers in the domiciliary care sector.

Despite multiple developments and innovations, Wiltshire has struggled since the pandemic to maintain its ability to rapidly meet demand, both in terms of volume and complexity. The time is right to undertake a full review of the Wiltshire Home First Service. The review is working to deliver a report to the ICA Partnership Committee by the end of July 2023:

- Identify a proposed optimal Home First Pathway for all people discharged with support needs (excluding those at the end of their lives).
- Undertake a gap analysis against the proposed Home First Pathway, making recommendations for service change, including workforce needs.
- Provide an assessment of current performance against best practice indicators and requirements, identifying future performance measures and implementing a shared minimum data set.
- Identify current and future capacity and demand and an assessment of service capacity and funding to meet needs.
- Identify a current cost per case for all service lines, and a cost per case for the proposed optimal pathway.
- Establish if we have the correct assurance systems in place for PW1
- Proposed recommendations for consideration at the ICA Partnership Committee, identifying immediate opportunities for improvement and those requiring further consideration and approval.