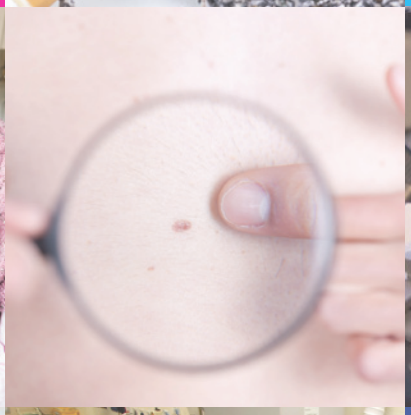
Better Care Plan












NHS
Wiltshire
Clinical Commissioning Group

Wiltshire Council
Where everybody matters

2014 – 2016

Welcome

This document sets out our shared vision for Better Care and provides details about how the Wiltshire Health and Wellbeing Board expects the Better Care Fund to act as a catalyst for change.

Approximately £800m is spent in Wiltshire on health and social care. We see the £27m of Better Care funding as a driver for stimulating the integration of health and social care services. Both the council and the Clinical Commissioning Group (CCG) are investing additional resources in the Better Care Fund in 2014/15, and we will see a move to increasing pooled budgets in future years.

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

We can also demonstrate that the Better Care Fund will help us deliver on the national conditions and our local priority; such as:

- protecting social care services – through increased investment in social care services to meet the requirements of demography and of the Care Bill
- 7-day services to support discharge from hospital – through increased investment across the whole system
- data Sharing – through working together on new systems and developing our ability to share information not just between health and social care, but more widely with other public sector services
- joint assessments and accountable lead professional – through local joint working and the development of patient/service user-held records
- ensuring services support people to remain at home or in their community.

We are confident that the priority schemes set out in our plan will enable us to maintain and improve performance in relation to the national outcomes. We understand the need to achieve balance between each of these areas of performance and will not allow performance against one indicator to outweigh our ability to achieve improvements against all five:

- Admissions to residential and nursing care
- Success of reablement and rehabilitation
- Delayed transfers of care
- Avoidable emergency admissions
- Patient and service user experience

We are clear that the governance of the Better Care Fund sits with the Wiltshire Health and Wellbeing Board and see that the Wiltshire Health and Wellbeing Board, as systems leaders, will play a key role in ensuring each of the partners delivers on our plan.

This plan must focus on services for adults – specifically on older people, because we know that this is where the Better Care Fund can have the greatest impact. However, the Wiltshire Health and Wellbeing Board believes that many of the changes described in the plan will be of benefit to everyone in Wiltshire, including disabled children, disabled adults and people with mental health needs. We therefore intend to expand the vision document for better care to ensure it encompasses everyone in Wiltshire and will publish that shared vision in the next few months.

We are proud to be launching our Better Care Plan at a Health Fair event in Trowbridge on 12 February and it will then be submitted, as a draft, for ministerial approval on 14 February. The final version of the Better Care Plan will be available by 31 March 2014.

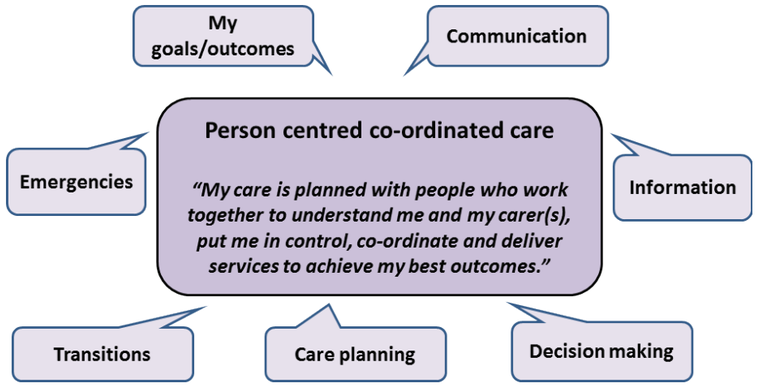
Jane Scott OBE,
Chair,
Wiltshire Health and Wellbeing Board

Dr Steve Rowlands,
Vice-chair,
Wiltshire Health and WellBeing Board

Engagement with the service provider

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

In discussion with stakeholders, including health and social care providers, we have adopted the National Voices definition (2) of good integrated care:



Health and social care providers all recognise that delivering our vision will involve us in significant changes to the way services are designed and delivered, and that those changes are already underway.

We have engaged providers in a number of ways:

- Through a Health and Wellbeing Board hosted event on the Better Care Plan (14 January 2014) attended by Acute Trusts, community health social care and mental health, providers and the voluntary sector
- Through work with the Wiltshire Care Partnership, the membership organisation for social care providers
- Through the Health and Wellbeing Board itself – the board is made up of a range of stakeholders, including the three district general hospitals serving Wiltshire people, the Mental Health Trust and the Ambulance Trust
- Through the work underway on the CCG's Five Year Plan. The Five Year Plan has been developed jointly with council colleagues and has involved extensive provider engagement. The information gathered at these events is also informing our Better Care Plan.

The Better Care Plan also reflects a number of existing programmes of joint work which have engaged with health, social care and voluntary sector providers as active participants. Examples include:

- engagement on the Joint Health and Wellbeing Strategy
- engagement on the CCG's Community Transformation Programme
- workshops with providers on a whole system workforce strategy
- a steering board for the development of intermediate care services (STARR).

Engagement Patient, service user and public

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Our vision is set out below. It is based upon what people have told us is most important to them.

We have developed this vision with the public, patients and service users in a number of ways:

- Wiltshire Council area board meetings. All area boards have run engagement sessions on the Joint Strategic Assessment, which has created a public debate on priorities for each community. To reinforce the health and wellbeing focus of area boards, all meetings are attended by a CCG Group Director and have an aligned GP. The CCG uses the area boards as an opportunity to listen and respond to local issues and to be informed about local priorities
- Consultation events on the Joint Health and Wellbeing Strategy
- NHS Wiltshire CCG Stakeholder Assemblies
- Work on a Home Truths project which involved a survey of older people about their care choices and discussions with patients in GP surgeries about access to social care
- Adult Social Care customer reference group which assists with service development, the contract review process and gathers service user feedback on our behalf
- A wide group of stakeholders (70+ individuals) attended our workshop on Better Care hosted by the council on 14 January 2014. The workshop focussed on principles and priorities for the Better Care Fund. Attendance included user-led organisations, voluntary and community sector organisations, scrutiny councillors, health and social care providers and more.

Throughout March, we will continue to run stakeholder engagement events on our Better Care Plan. We will work with the Wiltshire Care Partnership to discuss the plan in more detail with social care providers. The Better Care Plan is likely to be a theme at our Skills for Care Partnership conference. Throughout April and May we will work with Wiltshire's area boards to generate local debate and local actions in support of our Better Care Plan in each of our 20 community areas most important to them.

Throughout the life of the Better Care Plan, we intend to strengthen our patient and service user involvement in service development. We will use the council's research team and will also commission Healthwatch to understand what people really think about current services and what they want to see in the future.

We will use National Voices outcome statements and test these with patients, service users and staff to develop our own "I statements" (e.g. "I was always kept informed about what the next steps would be."; "I always knew who was the main person in charge of my care.") and patient stories that reflect our aspirations for better co-ordinated care. We will use these "I statements" and stories to measure our success in delivery.

Engagement Related documents

Please include information/links to any related documents such as the full project plan for the scheme and documents related to each national condition

The following list is a current synopsis of some of the key published source documents that have informed this plan.

Joint Strategic Assessment (JSA) www.intelligencenetwork.org.uk/joint-strategic-assessment	A joint assessment of population needs produced for different audiences, including local community area information.
Joint Health and Wellbeing Strategy (JHWS) www.wiltshire.gov.uk/healthandsocialcare/jointhealthandwellbeingstrategy.htm	Setting out the priority outcomes and actions for the year ahead.
Pioneer Application, June 2013	Wiltshire was unsuccessful in its application for pioneer status. However, the application sets out our emerging vision for integrated care and support.
Wiltshire Council Business Plan www.wiltshire.gov.uk/council/howthecouncilworks/plansstrategiespolicies.htm	The plan sets out priorities for the next four years, as follows: • Protect those who are most vulnerable • Boost the local economy • Bring communities together to enable and support them to do more for themselves.
Wiltshire Clinical Commissioning Group, The Right Healthcare for you, with you, near you (High Level Strategic Plan) www.wiltshireccg.nhs.uk/publications/reports-and-strategies	The plan sets out priorities up to 2014/15. It will be updated by the Five-year Plan, developed alongside the Better Care Fund Plan.
Health and Social Care Integration Update Report www.wiltshireccg.nhs.uk/tuesday-26th-november-2013	This update paper was presented to the CCG Governing Body and the Health and Wellbeing Board in November 2013, providing a summary of current initiatives to integrate health and social care commissioning and provision.
Joint submission for Local Vision: Systems Leadership programme	This document elaborates on our intention to improve urgent care, through the story of Gwen Wiltshire, a persona developed to illustrate the current and future system to reduce inappropriate hospital admissions.
Community Campuses in Wiltshire www.wiltshire.gov.uk/communityandliving/communitycampuses.htm	A series of documents describing the council's proposals for innovative community campuses across the county. Campuses will help deliver services which are value for money, tailored to local need and influenced by local people and partners. They are a key opportunity for health and social care integration at a community-level.
Help to Live at Home Service: an outcomes approach to social care www.ipc.brookes.ac.uk/publications/index.php?absid=691	This paper by Professor John Bolton of the Institute of Public Care, describes Wiltshire Council's approach to developing its Help to Live at Home Service for older people. The approach has focussed on the outcomes older people wish to gain from social care and involved an overhaul of care management and contracting within the council.
Wiltshire Dementia Strategy 2014-2021 www.cms.wiltshire.gov.uk/ieListDocuments.aspx?CId=141&MId=7216&Ver=4	This is a joint strategy, currently out to consultation. The aim of the strategy is to ensure that all people with dementia in Wiltshire are treated as individuals and are able to access the right care and support, at the right time so that they can live well with dementia and can remain independent and living at home for as long as possible within supportive communities.
NHS Wiltshire CCG Five Year Plan and Two Year Plan	First drafts are being developed in parallel, and linked, to the Better Care Fund Plan.

Vision for Health and Care Services

Please describe the vision for health and social care services for this community for 2018/19 – what changes will have been delivered in the pattern and configuration of services over the next five years? What difference will this make to patient and service user outcomes?

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

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.

Context

Our Joint Strategic Needs Assessment provides us with the detailed information we need to inform our vision. Overall health and life expectancy in Wiltshire are well above the national average. **People over 65 make up 20% of the county's population and will make up 22.5% of the county's population within the next seven years** and the number of older people is rising much faster than the overall population of the county. Older people are more likely to need health and care services and we know that nearly half of Wiltshire's NHS resources (47.4%) are consumed by people aged over 65. Much of this resource is needed for frail and vulnerable older people. Dementia in particular can affect people of any age, but is most common in older people. One in 14 people over 65 has a form of dementia and one in six people over 80 has a form of dementia.

The prevalence of dementia in Wiltshire is predicted to rise because of this ageing population. Oxford Brookes University and the Institute of Public Care (2013) estimate that there are approximately 6,538 people with dementia. It is predicted that this number will increase by 27.8% by 2020 – equating to an additional 1,800 people with dementia and will nearly double by 2030 to 11,878 people. It is also estimated that there will be an increase in those people with severe dementia from approximately 800 in 2012 to 1,600 in 2030.

Whilst increased life expectancy is a cause for celebration, the high rate in growth in the number of elderly people and people with dementia in Wiltshire is placing a burden on care budgets, creating financial pressures and capacity issues for health and social care. Table 1 shows that whilst the rate of growth of the total population is below the South West and national average, the rate of growth in the older population in Wiltshire exceeds the rate of growth in the rest of the South West, and exceeds the average for England.

Table 1 – rate of population growth – Wiltshire comparison

Area	Growth in 65 or older population	Growth in 85 or older population	Growth in all age population	% growth in 65 or older population	% growth in 85 or older population	% growth in all age population
Wiltshire Unitary Authority	27,981	5,161	31,097	32.4%	42.4%	6.6%
South West	264,085	53,491	442,388	25.3%	34.5%	8.3%
England	2,057,457	459,573	4,580,615	23.6%	38.5%	8.6%

For NHS services, we have estimated that without transformational change, we would need an additional £60.1m by 2021 – of that 97.85% (£58.8m) would be required for people aged 65 and over. Tables 2 and 3 below show the impact of the growth in population of older people on resources required. Table 2 illustrates that the biggest impact is of the increase in numbers of people aged 85 and over.

Table 2 – The impact of population growth on resource requirements – all age groups

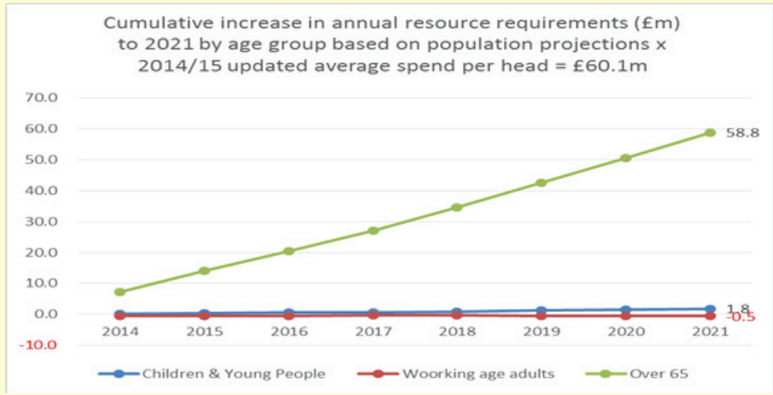
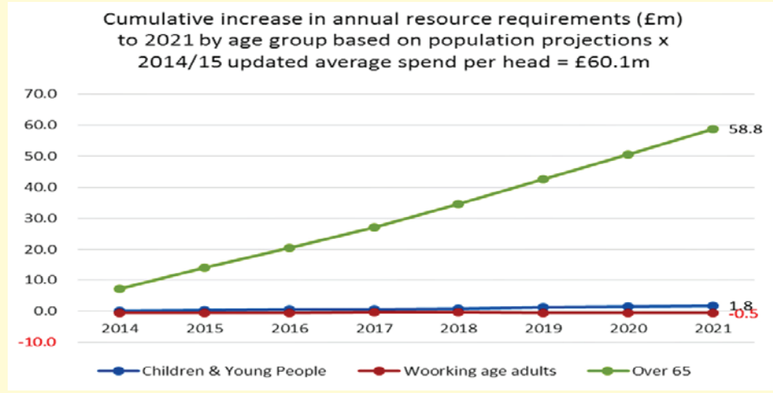


Table 3 – The impact of population growth on resource requirements – older people



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

We are aware of other challenges within the health and care system:

- Care and support is fragmented, so people experience gaps in care and patients are treated as a series of problems rather than as a person. Care and support plans do not link together, which is inefficient and frustrating for people on the receiving end of our services. People have to repeat their stories to different agencies and are not always kept informed.
- The health and care system gives a higher priority to treatment and repair, rather than prevention or early intervention. Often, people are not eligible to receive services until they reach a point of crisis, when a little support earlier may have avoided the crisis from developing.
- Acute hospitals, specialist hospitals, including mental health hospitals, and emergency departments are under pressure, with unacceptably high levels of delayed transfers of care and extended lengths of stay in hospital.
- Too many people make a decision about their long-term care and support whilst they are in hospital, and this may result in frail elderly people being rushed into decisions and possibly an unnecessary admission to a residential or nursing home.

Developing our vision

Our focus for the Better Care Fund must therefore be upon frail older people. We know that if we do not, the impact will be felt by people of all ages.

We want people in Wiltshire to say...

> "There are no gaps in my care, and I don't need to worry about who is paying for my care, I contact one person and it's all sorted"

Our vision for better care is based upon the four priority outcomes which are set out in our Joint Health and Wellbeing Strategy

I will be supported to live healthily

For example

- through health promotion and prevention activities
- through the provision of appropriate information and advice
- through treating me as a person, not just a set of conditions.

I will be listened to and involved

For example

- through services working together to treat the person, not the condition
- through having to tell my story only once, rather than repeat it to different organisations
- through involving me in my care arrangements
- through involving me in how services are developed.

I will be supported to live independently

For example

- through the right care being provided in the right place and at the right time
- through helping me recover from any episode of injury or illness
- through supporting my network of family, friends and neighbours to help me.

I will be kept safe from avoidable harm

For example

- through a culture that treats people the way we would all like to be treated ourselves
- through care being joined up, with appropriate sharing of information
- through providing me with a plan to help me cope if things get worse.

Our Pioneer Bid helped us consolidate our vision for a clear and simple system of care closer to home. It set out a vision for healthy, resilient communities.

Our vision is based upon the overriding principles of care closer to home, with health care led by local GPs. We have adopted the following principles:

- Care will be as close to home as possible, with home always as the first option.
- We will shift our services from being paternalistic to ensuring that **services are designed for and with the people who use them.**
- We will focus **care around the person**, building from communities of approximately 20,000 people.
- We will join up care at a local level and will **work with communities** to integrate care around clusters of GP practices and other community settings.
- We will ensure that **care is co-ordinated** for all older people, particularly to support those at risk of deterioration and hospital admission.
- We will create a team around the person, with someone to co-ordinate care between all the professionals and agencies involved, so that the person at the receiving end feels in control.
- We will build on the council's work with local communities on the development of **campuses** to incorporate health and care facilities.
- We will support individuals and communities to take more **personal responsibility** for their own health and wellbeing.
- We will ensure that **carers are supported** and that contingency plans are in place, to recognise when informal care arrangements may break down.
- We will develop our **intermediate care services** so that more people can be supported to be independent.
- We will ensure people have access to the right support when they need it, even if this is **24/7.**
- We will take a holistic approach, with locally accessible services to support **mental health needs.**
- We will ensure that people with dementia can remain independent and living at home for as long as possible within supportive communities.
- We will launch **dementia** friendly communities and towns where people can feel safe and looked after.
- People with dementia will be diagnosed early, so that the most appropriate treatment and support is provided to maintain independence for as long as is possible and to allow people and their carers to plan for the future.
- We will continue to develop **outcomes-focussed commissioning,** based on the principles of our Help to Live at Home services.
- We will reduce duplication of assessments and support plans, so that there are **shared assessments and support plans** owned by the individuals they support.
- We will **minimise delays,** with a focus on reducing high numbers of delayed transfers of care across the system.
- We will invest in the capacity and competency of the health and care **workforce**, so that people with complex needs can be supported safely in their communities.

We want people in Wiltshire to say...

> I know that services provide good value for money

In future, we want people in Wiltshire to say things like:

"There are no gaps in my care, and I don't need to worry about who is paying for my care, I contact one person and it's all sorted out."

"I am always kept informed, and I always know who is in charge of my care and who to contact."

"I don't have to keep repeating myself to lots of different professionals."

"The people who support me provide a good quality of service."

"If things get worse, I have a plan to help me cope, to make sure I stay at home and don't go to hospital or to a care home."

"I know that services provide good value for money."

Our future health and care system model

The diagram shows how we expect that health and care services will wrap around the person to support them at the appropriate level. The diagram is made up of rings of support wrapped around the individual.

The extended Primary Care Team (Amber ring – 20,000 population)

These services are those that are wrapped immediately around the patient and are accessed and co-ordinated through the extended Primary Care Team. Each team serves a population of approximately 20,000 people (typically, one or two GP practices). Enhanced General Practitioner Services will be supported by 'wrap-around' community nursing teams, care co-ordinators, primary care mental health liaison and psychological therapies, memory nurses, access to intermediate care, therapies and reablement, carer support, etc. Enablers will include multi-disciplinary team working, health stratification tools, care co-ordination, personalised care planning and enhanced interconnectivity of personal data across organisational boundaries.

Expected additional services provided for a market town population (Blue ring – 40,000 population)

These services include those available in the community covering the 7-day period provided for a market town and may include out-of-hours access for minor injuries and ailments, services for nursing and care homes and frail elderly people in their own homes, support for rapid admission and discharges to local District General Hospitals and access to community-based rapid response via the single point of access.

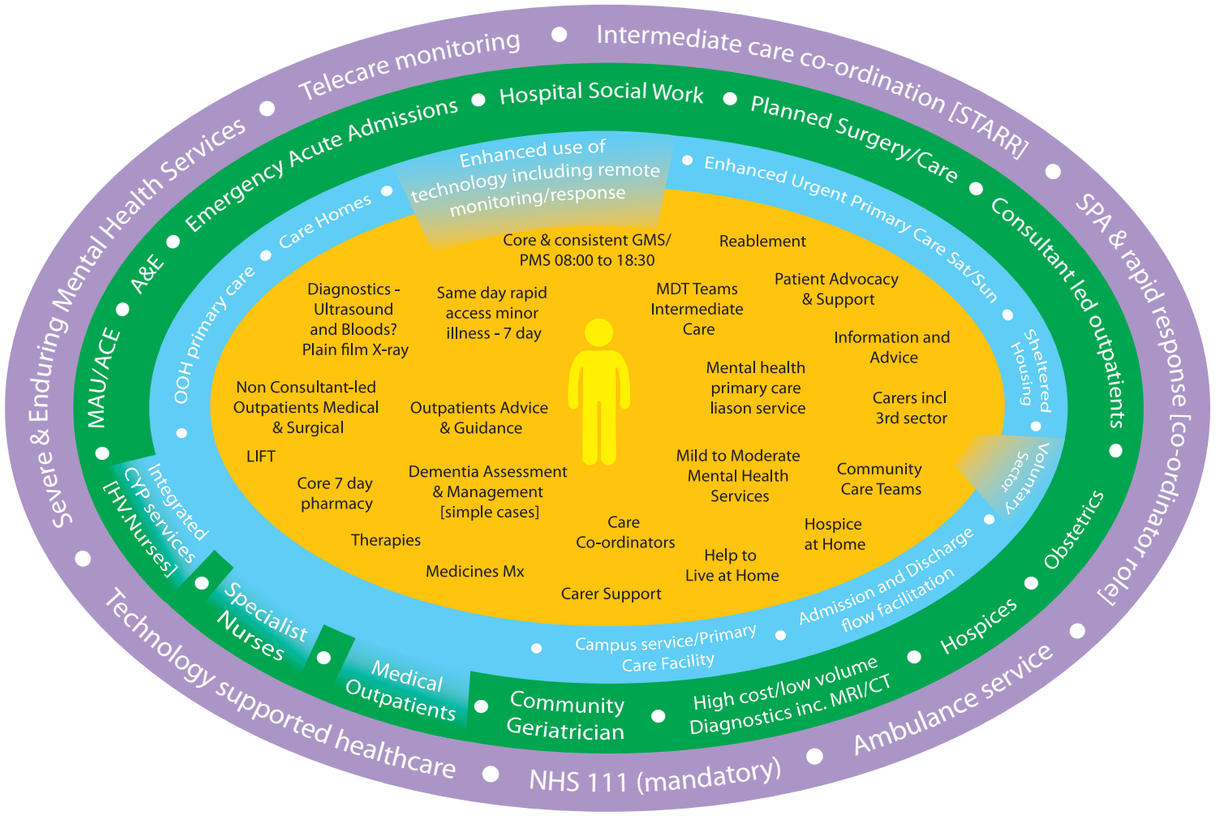
Expected service provision for a group area (Green ring-100,00 + population)

These are more specialist services provided within a maximum travel time of one hour. These services would include obstetrics and accident and emergency units, ambulatory and medical assessment units and hospice services. There should also be access to most surgical and intervention services and complex diagnostics, specialist nursing and outpatients and outreach advice from consultants in elderly medicine, dementia and long-term conditions.

Services provided on whole Wiltshire scale (Lilac ring)

To cover the whole of the county, a simple point of access will be provided which will work for professionals to co-ordinate and facilitate rapid access to services 24 hours, 7-days a week. This will include co-ordination of intermediate care and hospital discharge. Ambulance services and access to NHS 111 will also be co-ordinated at this level. There will be greater use of technology to support health and social care delivery and there will be access to health and care records across the system. It is at this level that we will co-ordinate services for people with severe and enduring mental health difficulties.

Table 4 – Our future health and care model



Integration aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the Better Care Fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated care system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

We understand that in order to secure improved outcomes, we must address integration through a number of routes:

- Joint commissioning
- Joint service delivery – co-ordinated pathways of care and co-ordinated services
- Joined-up governance.

Joint commissioning

We believe that integrated services are based on joint commissioning and our Joint Commissioning Board agreed the following principles in July 2013:

- We will take account of local needs and priorities, as set out by the Wiltshire Health and Wellbeing Board through the Joint Strategic Assessment and the Joint Health and Wellbeing Strategy.
- We will take account of an evidence base of what works to deliver the best outcomes for local people.
- We will focus on early, creative preventive approaches, based in local communities.
- We will adopt a shared understanding of risk.
- We will improve information, advice and signposting about services available to people.
- We will acknowledge the national direction and national outcomes frameworks for the NHS and social care.

We expect to see joint commissioning teams, based upon the above principles, implemented from 2015.

We expect commissioners to be managing and tracking outcomes through the intelligent use of data. We will be developing systems to track total activity and cost data across health and social care, for individuals and for whole segments of our local population.

We will develop information systems to identify people who incur the greatest health and social care costs and use this information to identify interventions that could have made a difference earlier to achieve better outcomes and reduce overall costs and to begin to shift the allocation of funding towards more early intervention and prevention.

We believe that integrated services are based on joint commissioning and key principles

Integration aims and objectives

Joint service delivery

We expect our principles for better care to be translated into integrated services and better outcomes for people who use services. We have summarised these in the table below:

Our principle	Our objectives for integration	Our measures
We will shift our services from being paternalistic to ensuring that services are designed for and with the people who use them.	People will be involved in the redesign of integrated services.	• Patients and service users will be involved in pathway reviews, service specifications and tendering.
Care will be as close to home as possible, with home always as the first option. We will focus care around the person, building up from communities of approximately 20,000 people. We will join up care at a local level and will work with communities to integrate care around clusters of GP practices and other community settings.	We will create multi-disciplinary teams, wrapped around primary care clusters, providing integrated, accessible care in local communities. These teams will work across community health services, social care, mental health, voluntary sector, commissioned Help to Live at Home providers and other community resources such as sheltered housing. Services will match levels of needs in each community and existing inequalities in levels of service provision in some parts of the county will be levelled out.	• Emergency attendances and admissions to acute hospitals will not increase. • Long-term care home admissions will be reduced. • Activity levels of community health services will increase. • Patient and customer experiences of services will improve.
We will ensure that care is co-ordinated for all older people, particularly to support those at risk of deterioration and hospital admission.	We will create a team around the person, with someone to co-ordinate care between all professionals and agencies involved, so that people at the receiving end feel in control.	• Emergency attendances and admissions to acute hospitals will not increase. • Every older person will have a named GP and a co-ordinated support plan. • It will be possible to share information between professionals so that care is more effective, more timely and safer.
We will build on the council's work with local communities on the development of campuses.	Within the next five years, we will see an accessible location within each community bringing together services such as primary and community health with leisure, library and other council services and the voluntary sector. Facilities can be used imaginatively as a resource to promote health and wellbeing and provide treatment.	• Patient and customer experiences of services will improve.
We will support individuals and communities to take more personal responsibility for their own health and wellbeing.	We will focus our investment in voluntary and community services, working towards a shift in investment towards more preventative services and more accessible information and advice to promote self care and independence.	• Reliance on urgent and crisis services will reduce. • Patient and customer experiences of services will improve – people will feel more in control of their care.
We will ensure that carers are supported.	We will continue to use our carers pooled budget to provide options for carers and we will plan for new responsibilities to carers under the Care and Support Bill. We will offer carers personal budgets to allow them more choice and control over their support.	• Carers' experiences of services will improve.

Our principle	Our objectives for integration	Our measures
More people will be supported to remain independent.	We will develop our intermediate care services to prevent hospital admission and provide a 'stepping stone' for people recovering from a hospital stay. Intermediate care for people with mental health and dementia needs will be strengthened. We will open a new Extra Care scheme in Malmesbury in 2015/16 and will commence work on a similar scheme in Devizes in 2015/16. This is part of our programme to ensure all market towns offer appropriate supported housing for frail elderly people.	• Delayed transfers of care will be reduced. • Emergency attendances and admissions to acute hospitals will not increase. • Decisions about long term care will not be taken in hospital and admissions to long term care will be reduced. • Activity levels of community health services will increase. • The option of extra care housing will be available in more communities in Wiltshire.
We will ensure that people have access to the right support when they need it.	People with complex health conditions, including dementia, often need support in the middle of the night or at weekends, and we believe community health and support services should be available 24/7.	• People will access new out-of-hours services and unnecessary admissions to acute hospitals will be avoided.
We will take a holistic approach, with locally accessible services to support mental health needs.	We will integrate mental health and dementia care into our local services and we will support communities to be dementia friendly.	• Long-term care home placements will be reduced for people with dementia. • People with mental health needs will not be delayed in hospital.
We will ensure that people with dementia can remain independent and living at home for as long as possible within supportive communities.		• A toolkit for dementia friendly communities and towns will be available for area boards to use. • A Neighbourhood Return scheme will be trialled to support people with memory problems who go missing.
People with dementia will be diagnosed early, so that the most appropriate treatment and support is provided to maintain independence.		• Diagnosis of dementia within primary care will increase.
We will continue to develop outcomes-focussed commissioning, based on our Help to Live at Home model of commissioning.	We will commission service providers, including care homes, to focus on outcomes for individuals, in order to give people the maximum independence and choice.	• Care providers will work to contracts with incentives to deliver the best outcomes for individuals.
We will reduce duplication of assessments and support plans.	We will develop shared assessments and support plans, with appropriate information-sharing systems, and support plans owned by the individuals that they support. We will develop our IT systems.	• The number of people with their own single support plan will increase. • Patients and customers will say they are be better informed about services.
We will minimise delays, with a focus on reducing high numbers of delayed transfers of care across the system.	We will review processes for discharge from hospital to minimise delays. We will invest in capacity planning and in 'surge' capacity for community-based services so that our services can better cope when demand is greatest.	• The number of delayed transfers of care will be reduced.
We will invest in the capacity and competency of the health and care workforce.	We will increase the capacity of the community-based workforce, and ensure they have the skills to support people with complex needs.	• The objectives of our workforce plan will be met, including increased competencies, improved recruitment and retention of care and support staff. • The workforce will say they feel valued. • The domiciliary care workforce will have a structured career path and zero hour contracts will be minimised.

Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme.

We recognise that achieving our vision will mean change across the whole of our current health and care landscape. All providers of health and care services will need to change how they work and how they interact with their patients, customers or service users and with each other.

Investing in transformation

During 2014/15

- We will establish a joint integration programme team, using new capacity (a programme director) and existing resources from within the council and the CCG. This team will lead the implementation of joint commissioning and joint delivery and ensure we achieve the objectives set out within this plan.
- We will undertake a systems review of the pathway of care for older people. This will tell us where different organisations invest and what outcomes are achieved. It will allow us to see a shift in investment from repair to preventative services that can make the biggest difference.
- We will use the systems review to prioritise the areas for development in 2015/16 and beyond. The first area for development will be hospital discharge.

Joint commissioning

During 2014/15

- We will plan for joint commissioning teams for specialist services (learning disabilities and mental health).
- We will scope the potential for further pooled budget arrangements.
- We will evaluate options for joint commissioning of community health and care services.
- We will build on developing systems to share information to support commissioning. This will inform us how investment decisions across the whole system can be changed to get the best overall outcomes.
- We will start the implementation of a joint workforce strategy, which has been developed across acute, community and social care providers.

During 2015/16

- We will implement joint commissioning teams for learning disabilities and mental health.
- We will implement further pooled budgets as scoped in 2014/15.

We will implement joint commissioning teams for learning disabilities and mental health

Supporting individuals and communities to take more responsibility for their own health and wellbeing

During 2014/15

- We will commission an information and advice portal to support healthy lifestyles, independent living and self care.
- We will support informal carers in their caring role, listen to their views and realign the services funded through our carers pooled budget.
- We will review our existing investment in preventative services and maximise the opportunities for joint commissioning of voluntary and community sector services.

During 2015/16

- We will continue to invest in preventative services.

We will support informal carers in their caring role, listen to their views and realign the services funded through our carers pooled budget

Description of planned changes

Supporting care closer to home

During 2014/15

- We will review processes for hospital discharge so that people do not make a decision about their long-term care arrangements in an acute hospital. This will reduce delays in hospital.
- We will implement our model of local multi-disciplinary team working, moving staff and services into local clusters.
- We will realign investment in community health services to ensure we address inequity of provision across the county.
- We will review the provision of bed-based care in the county, including the commissioning of care home beds. We will re-commission care home beds using an outcomes-based approach to ensure that all care takes a enabling approach and achieves the right outcomes to maximise independence. The council and the CCG will ensure care home beds are commissioned in a consistent way.
- We will make the best use of telecare and telehealth services to increase the range of equipment used and the number of people benefitting.
- We will increase investment in capacity and skills for intermediate care and reablement in the community. This will be through a review of our existing STARR step up and step-down bedded scheme with a view to moving more of the investment from beds to support in people's own homes.
- We will review the implementation of Help to Live at Home processes to improve outcomes for intermediate care.
- We will ensure the availability of additional capacity within intermediate care services for escalation beds in the community, when the whole system is under pressure, for example, over the winter period.
- We will work explicitly with NHS England to develop capacity in General Practice in Wiltshire.

During 2015/16

- We will implement new contracts for care home beds.
- We will continue to increase investment in community-based therapy and support for rehabilitation and re-ablement and further shift to more re-ablement at home rather than in hospital or care home beds.

The right support when people need it

During 2014-15

- We will continue to invest in 24/7 rapid response services
- We will continue to invest in acute liaison services to support hospital discharge at weekends
- Our pathway review will help us determine where to invest in 24/7 services to get the best outcomes.

During 2015-16

- We will implement 24/7 and weekend working, as determined by our pathway review.

Shared assessments and support plans

During 2014/15

- We will develop and pilot a single support plan record which is held by the patient/service user.
- We will scope requirements for information systems to allow people to share information at a local level about patients and service users. This will avoid the need for people to repeat their story to different agencies.

During 2015/16

- We will implement a single assessment and support plan.
- We will implement information sharing systems.

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plans/s for social care

The Health and Wellbeing Board will assure that organisations are working together and in line with the Joint Strategic Assessment and the Joint Health and Wellbeing Strategy.

Our schemes for integration will be reported for information to the Wiltshire Urgent Care Board. This board will ensure alignment to other services such as 111, ambulance and out-of-hours GP services.

We will use the Systems Leadership Local Vision Programme to support the Health and Wellbeing Board to meet the challenges of implementing the Better Care Plan and working effectively as a system. The programme will focus on understanding roles and responsibilities at different levels and in different organisations, and of what organisations can expect and need from others.

Wiltshire Council's Business Plan (2013–2017) is based on a vision to create stronger and more resilient communities. One of the council's priorities is to continue to protect the most vulnerable in its communities. Within the plan, Outcome 5 focusses on people having healthy, active and high quality lives, whilst Outcome 6 is focussed on ensuring people are as protected from harm as possible and feel safe. The priority actions set out in the plan are fully consistent with the vision and objectives of the Better Care Plan.

The Clinical Commissioning Group's Two Year Plan and Five Year Plan are framed on the principles set within the Wiltshire Health and Wellbeing Strategy. Our joint working on these plans over the coming months will ensure that we are driving a coherent approach on our shared vision, building on work already achieved within the community transformation programme.

The CCG's Two Year and Five Year Plan are framed on the principles set within the Wiltshire Health and Wellbeing Strategy

Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The biggest impact is expected in year one as the CCG and council move to reduce the average length of stay experienced by patients

Supporting care closer to home

We have assessed the impact on the local acute system which includes the Royal United Hospital, Bath, NHS Trust (RUH), Great Western Hospitals NHS Foundation Trust (GWH), and Salisbury Hospitals NHS Foundation Trust (SFT). The innovation and transformation that the BCF strategy sets out aims to reduce Wiltshire's dependency on acute hospital bed capacity as a result of reducing the average length of stay that Wiltshire's patients currently experience as well as reducing the number of inappropriate admissions to the acute sector. This will allow the three trusts to reduce their bed occupancy rates therefore making the acute system far more sustainable. It will increase their ability to manage future fluctuations in emergency activity demand. This impact will only materialise once the service changes set out in this plan have been delivered and the acute hospitals have experienced the impact.

Our shared ambition is to reduce the average length of stay of emergency admissions by 20% (approximately two days) over the next two years. This will be achieved by improving the flow through the acute hospitals by enhancing the services on the front of the emergency system as well improving the discharge process.

We are also expecting to see a reduction in non-elective admissions of 4.5% in 2014/15 and for 2015/16 commissioners are setting an ambition of minimising the impact of demographic growth which equates to approximately 2%. This will be achieved by reducing the level of inappropriate admissions through the enhancement of health and social care services to support people more effectively in the community. This will include the enhanced community response to supporting clients in crisis situations.

The CCG and council have modelled the potential impact of the Better Care Plan on the three trusts for 2014/15 and have set an ambition of reducing the demand on acute bed capacity by 20%. For patients who stay longer than two days this will equate to approximately 37,000 bed days by reducing the average length of stay by two days. Table 5 represents the potential impact across the three acute hospitals.

Table 5 – The impact of reducing the average length of stay across the three acute hospitals

Hospital	RUH	GWH	SFT	RUH	GWH	SFT	RUH	GWH	SFT
	Admissions			Reduced bed-days			Average LoS reduction		
Length-of-Stay (LoS) reduction	0	0	0	13,094	7,566	12,720	2.1	2.0	2.3
Admissions reductions	538	424	471	1,076	848	942			
Total	**538**	**424**	**471**	**14,170**	**8,414**	**13,662**			

The Length-of-Stay (LoS) reductions will benefit both commissioners and the acute trusts, with the greatest impact on the trusts which will be expecting to reduce the number of beds in the three hospitals. In reality the trusts will be able to close escalation beds that have been opened in 2013/14 allowing them to reduce their cost base and contribute to the delivery of the annual 4% efficiency challenge set by the Department of Health.

The results for commissioners will be some reduced numbers of 'excess bed days', although it is not possible to quantify the detailed impact due to the changes in the nationally defined 'trim points'. The CCG will work in partnership with the three acute trusts and has made a committment that there will be no contractual changes with the acute hospitals that stipulate a bed day reduction, providing assurance to the three trusts that they will not be financially disadvantaged by the impact of the Better Care Fund.

The impact of not delivering our Better Care Plan objectives

We will work in partnership with the acute hospitals to reduce length of stay and the non-elective admission reductions will have a number of effects. We know that the result of not doing this would be as follows:

- Hospitals would struggle to expand their current bed capacity as growth of 3.3% or more would impact on the acute system in 2014/15 and 2015/16. The predicted extra number of required beds could be as many as 15 beds per year across the three acute hospitals.
- The CCG would experience 'over performance' on the three acute hospital contracts as non-elective QIPP targets would not be deliverable. The financial impact of non-delivery of the Better Care Plan objectives in relation to length of stay and reduced admissions is £3m for the CCG in 2014/15. The impact would approximately double in 2015/16 if growth could not be contained and the Better Care Plan and other initiatives did not deliver. The CCG will have only limited reserves to mitigate this over performance in 2014/15 and 2015/16 due to the creation of the Better Care Fund.
- The result of longer stays in hospital will mean there will be a rise in care home admissions. The Better Care Fund includes a growth prediction of £1.8m over and above the Wiltshire Council funded growth. If the objectives of the Better Care Plan are not delivered, then the £1.8m will be required for care home placements, and will have a recurrent impact in 2015/16.

The Better Care Fund includes a growth prediction of £1.8m over and above the Wiltshire Council funded growth of £2.5m

Governance

Please provide details of the arrangements in place for oversight and governance for progress and outcomes.

We see strong joint governance as one of the routes to integration

We see strong joint governance as one of the routes to integration.

The **Wiltshire Health and Wellbeing Board** will oversee the delivery of Better Care and has already taken an active interest in the development of our plans. Health providers are all represented on the Health and Wellbeing Board.

Elements of our plan that require key decisions will, as required, be reported to the **CCG Governing Body** and to the **Wiltshire Council Cabinet.**

We have a **Joint Commissioning Board** for adult services and many of the emerging service changes have been developed and overseen by this board.

We have a number of existing joint arrangements between the council and the CCG, including pooled budgets for carers' services. These agreements sit within a single overarching **Joint Business Agreement** which is overseen by the Joint Commissioning Board. We will expand this agreement to cover the Better Care Fund pooled budget.

We are developing a **joint integration programme team**, led by a jointly-appointed programme director and including specialist capacity from the council's system thinking team and information management team.

The host arrangements for the pooled budgets are still to be determined. The Joint Commissioning Board will be responsible for monitoring the pool and taking any in-year decisions to manage the budget. The Better Care Fund will be allocated against areas for investment and a manager with accountability will be identified for each area of investment.

Providing effective oversight and co-ordination

There will be bi-monthly update reports on the delivery of Better Care and the use of the pooled funds 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 the key performance outcomes for the Better Care Fund.

There will be six-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.

We will also ensure that the public are informed of progress, both through the publication of six-monthly reports and through regular updates in the Your Wiltshire Magazine. We will 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.

National conditions Protecting social care services

Please outline your agreed local definition of protecting social care services.

...we expect the Better Care Fund to help focus an investment in information, advice, preventative services and re-ablement in order to improve outcomes and provide more choices for self funders

Protecting social care services in Wiltshire means ensuring that those in need within our local communities continue to receive the support they need in a time of growing demand and budgetary pressures. We expect to maintain our current eligibility criteria for social care services, but also expect to develop more alternatives to support people to remain healthy and well and have the maximum independence. This will benefit individuals but also delay the need for more intensive, and more expensive services.

Wiltshire is a county with a large percentage of 'self funders' – people who do not currently meet the financial threshold for support from the council for their social care needs – we expect the Better Care Fund to help focus an investment in information, advice, preventative services and re-ablement in order to improve outcomes and provide more choices for self funders.

The new Care Bill will bring, amongst other things, major changes for eligibility, assessment and support planning and an element of the Better Care Fund will help the council meet additional demand. We will use the next year to assess additional demands for social care services and the likely impact upon the Better Care Fund.

Please explain how local social care services will be protected within your plans

The financial appendix for this plan sets out how much of the Better Care Fund is invested in social care services.

Funding currently allocated within the social care 'Health Gains' transfer and reablement transfers have been used to enable the local authority to meet increased demands for services and sustain the current level of eligibility. This has been through investment in 2013/14 on the following

Direct care provision

- Admissions to care homes
- Help to Live at Home services
- Care for people with complex needs (delegated healthcare)
- Step up and step down beds (STARR)
- Telecare response service
- Services for carers.

Capacity to support discharge from hospital

- Additional social work capacity
- Liaison services to support discharge teams
- Information services to support self-funders.

We will sustain these funding allocations for 2014/15 to protect social care services. However, our review of the pathway for frail older people, and review of hospital discharge arrangements will allow us to refocus this investment to ensure that there is a shift from placements to care at home and intermediate care services.

The financial appendix for this plan sets out how much of the Better Care Fund is invested in social care services. We have agreed that Wiltshire's fund includes an additional £1.833m investment by Wiltshire Council.

National conditions 7-day services to support discharge

Please provide evidence of the strategic commitment to providing 7-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy).

In the last year, we have used NHS Health Gains transfer to enhance our 24/7 telecare response service and provide with an urgent domiciliary care response. We will sustain this funding and evaluate this service in early 2014 to determine future investment.

We have increased capacity for 24/7 nursing care services and weekend community discharge liaison staff based in three acute hospitals.

The CCG has used Winter Pressures funds to pilot 7-day working in primary care. Some practices have evidence of reduced emergency admissions and the CCG are currently considering plans to roll-out successful pilots across the county.

The council used Winter Pressures funds to pilot social care 7-day working in acute hospitals. The results of this pilot were reported in our winter plan, and demonstrated to us that social work alone cannot make a difference to weekend discharges. The whole system, including therapy, discharge liaison, transport, pharmacy etc needs to be geared to full 7-day working.

We are therefore proposing to invest an element of the Better Care Fund to pump-prime 7-day working across the whole health and social care sector.

Please describe your agreed local plans for implementing 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

Our systems review of the pathway for frail elderly people and of processes for hospital discharge will allow us to see where 7-day services will be best targeted to get the best outcomes. We will then produce a costed plan for 7-day services across the whole system.

National conditions Data sharing

Please confirm that you are using the NHS Number as a primary identifier for correspondence across health and care services.

All health services use the NHS number as the primary identifier. The adult social care system records the NHS number and the council subscribes to the national tracing service. 84% of all current social care customer records have a validated NHS number. We are committed to increasing the percentage and ensuring the NHS number's use in all correspondence between agencies.

If you are not currently using the NHS number as primary identifier for correspondence please confirm your commitment that this will be in place and by when.

The number will be the primary identifier by April 2015.

Please confirm that you are committed to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are committed to adopting systems based upon Open APIs and Open Standards. This is being reflected in the forthcoming ICT Strategy being compiled for Wiltshire CCG by Central Southern Commissioning Support Unit (CSCSU) and in relevant ICT tender requirements. A cross organisational IT Forum is in operation that reviews and ratifies technical proposals and designs concerning transfer of and access to information between partners.

Primary care uses System One, a clinical computer system that allows service users and clinicians to view information and add data to their records; 98% of GP practices in Wiltshire use System One.

Social care uses Carefirst 6, a software solution from OLM, that provides a range of functionality and content for both adult and children's social care. GPs are being given access to a 'cut down' view in the form of a system called Multi Agency View (MAV) for adult care information. It is the intention that this will be rolled out further over the next 12 months.

The council is investing resources and expertise into developing shared information systems to create a single view of the customer – bringing together information from council systems, including revenue and benefits, housing, social care, and from the police. There is potential to develop this work further to include health data from a range of sources and to form the basis of a shared record.

An electronic based modelling tool will be developed that provides a statistical description of need, demand, provision, capacity and outcomes in Wiltshire. It will contain pseudo-anonymous data supplied by social care, data from the acute hospitals and from community health systems and primary care, mental health and out of hours' services. This will form the basis of good commissioning intelligence.

The Devon Risk tool is utilised by Wiltshire GPs to identify patients at risk. It is intended to add the social care module to further improve the risk stratification process.

Primary care uses System One, a clinical computer system that allows service users and clinicians to view information and add data to their records; 98% of GP practices in Wiltshire use System One

Please confirm that you are committed to ensuring that the appropriate IG controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and, in particular, requirements set out in Caldicott2.

We are committed to maintaining five rules in health and social care to ensure that patient and service user confidentiality is maintained:

- Confidential information about service users or patients should be treated confidentially and respectfully.
- Members of a care team should share confidential information when it is needed for the safe and effective care of an individual.
- Information that is shared for the benefit of the community should be anonymised.
- An individual's right to object to the sharing of confidential information about them should be respected.
- Organisations should put policies, procedures and systems in place to ensure the confidentiality rules are followed.

A cross organisational Information Sharing Group is in operation, composed primarily of IG Managers/Caldicott Guardians, to review and ratify any proposed changes to information sharing. An overarching AWG Information Sharing Core Principles document is in place with level 2 protocols (Data Deposit Agreement and Commercial Data Sharing Agreement) created to underpin the statistical modelling tool.

Wiltshire Council is IGSOC compliant and utilises N3 network connectivity when sharing data with health partners.

National conditions Joint-assessments and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional.

Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Wiltshire CCG and the council's public health team have developed data to segment the older population according to risk. This has been presented as a report: "Quantifying the number of vulnerable older people in Wiltshire" – prepared in January this year by a public health consultant. The report acknowledges the high number of indicators for vulnerability which makes it difficult to define a cohort that is not duplicated. It uses a number of proxy measures to estimate the population. Table 6 shows census data, whilst Table 7 shows the work undertaken by using the Devon Risk Tool to produce a risk score for patients aged 65 and over.

GPs have used the Devon Risk Tool to identify the top 5% of people at risk in their practice (21,000 people across the county). A GP Local Enhanced Scheme is in place to support risk stratification. We are working towards at risk individuals having a joint care plan and an accountable professional. At the end of December 2013, 27% of patients receiving care co-ordination had a care plan in place and 43.9% of identified patients had an identified clinician supporting them.

The next stage will be to include social care information within the risk stratification process.

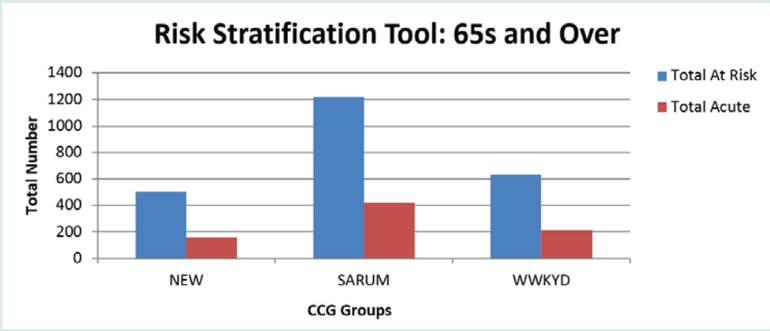
The development of the role of the care co-ordinator within primary care, and the use of multi-disciplinary team meetings on high risk patients will increase that number of patients with a care plan to approximately 85%.

Table 6 – People aged 65 and over with a long-term health problem or disability

Age	All categories: General health	Very good or good health	Fair health	Bad or very bad health
Age 65 and over	85,488	48,156	27,849	9,483

(Census, 2013)

Table 7 – People aged 65 and over who are indicated as at risk through the use of risk stratification



	At risk (score 60-80)	Acute (score 80+)	Both
Overall total	2,351	787	3,138

The intention is to commission services to support the numbers of people in at risk groups and strengthen the clinical pathways associated, providing services in a more holistic way across health and social care rather than by disease.

Key risks

The table below provides an overview of some of the key risks identified through the co-design process to date. A full risks and mitigations log is being produced.

Ref	Risk	Status	Mitigating actions
R1	The introduction of the Care Bill, currently going through Parliament and expected to receive Royal Assent in 2014, will result in a significant increase in demand for assessments and an increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.	High	We are undertaking an initial impact assessment of the effects of the Care Bill and will continue to refine our assumptions around this as we develop our final Better Care Fund response, and begin to deliver upon the associated schemes. We have identified a specific sum within the Better Care Fund for 2015/16 to be held against this risk until the impact assessment has been completed. We believe there will be potential benefits that come out of this process, as well as potential risks.
R2	The expected shift to more community-based services will not deliver the expected benefits, for example because of the acuity levels of people requiring services.	High	Each element of our Better Care Plan will be monitored and project-managed, with timeframes for delivery and early evaluation. Service developments will be flexible to reflect evidence of what is working or not working well. Contingency plans will be in place for all new service developments.
R3	A lack of high quality and meaningful local key performance indicators will make it difficult to monitor outcomes.	High	The integration programme will work with the council's research team and will commission Healthwatch to work on some patient/service user-led outcome measures. We will work with service providers on outcomes-based commissioning specifications.
R4	Operational pressures will restrict the ability of our workforce to deliver the required investment and associated projects to make the vision of care outlined in our Better Care Fund submission a reality.	High	Our 2014/15 schemes include specific non-recurrent investments in the infrastructure and capacity to support overall organisational development. We will use expertise within Wiltshire Council's transformation team to build on integration and transformation work already undertaken with other services, including the police.
R5	Improvements in the quality of care and in preventative services will fail to translate into the required reductions in acute and nursing/care home activity by 2015/16, impacting on the overall funding available to support core services and future schemes.	High	We have modelled our assumptions using a range of available data, including metrics from other localities. We will use data from a number of existing pilot projects. 2014/15 will be used to test and refine these assumptions, with a focus on developing detailed business cases and service specifications.
R6	Recruitment and retention of health and care staff is challenging. This is due to the population profile in the county, high employment and high cost of living. This may impact upon our ability to increase capacity of community health and care services.	High	We will work together to implement our workforce strategy, including joint recruitment, retention and workforce development plans.
R7	The extent of cultural and behavioural change required of the public and of professionals working in the system will not be achievable.	High	The public and professionals must be given confidence in the quality and competence of all the options for care delivery, wherever they are provided. This will be achieved through rigorous monitoring and through a robust communications strategy. The use of personalised care plans for people with long term conditions and/or at risk of hospital admission will also help reassure people that services are co-ordinated and information is shared in order to support them safely and in the best place.

Appendix 1: Financial Plan

Note – All schemes to report to Health and Wellbeing Board in first quarter 2014/15 to agree detail of investment, delivery and expected outcomes.

Ref	2014/15 £m	2015/16 £m	Detail
Scheme 1 - Intermediate Care			
Intermediate Care Schemes to avoid hospital admission and reduce delayed transfers of care.	6.80	8.30	4.3m currently committed to STARR + 0.5m to support community services. Assume £2m new investment in intermediate care in 14/15 and further £1.5m in 2015/16.
Scheme 2 – 7-day working			
Single Point of Access, Rapid Response, Telecare, services to support hospital discharge over days.	3.39	6.89	Additional 3m in 2016/17 for whole system working 7/7. Investment priorities will be determined by a systems review of the pathway for frail elderly - allowing us to target changes in areas to make the biggest difference.
Scheme 3 – Protecting social care services			
Maintaining services for vulnerable people, including demographic growth.	9.18	9.18	Includes Wiltshire Council investment in adult care £1.833m.
Scheme 4 – Care Bill requirements			
Anticipated additional demand for assessments and services.	0.13	2.50	0.13m in 14-15 for carers assessments in advance of Care and Support Bill.
Scheme 5 – Supporting communities to be more resilient			
Carers services and increased investment in communities.	1.47	2.47	0.89m in carers pool from CCG. 0.58m in carers pool from Wiltshire Council. Additional investment in 2015/16 in community capacity.
Scheme 6 – Data sharing and joint assessments			
Shared records and information portal.	1.20		New commitment. Includes Wiltshire Council investment of 0.7m non recurring funds.
Scheme 7 – Service user feedback and involvement			
Investment in involvement.	0.10	0.10	New commitment.
Total investment	**22.28**	**29.44**	
New investment recurrent and non-recurrent	**6.93**	**8.00**	

Funds available	2014/15 £m	2015/16 £m
Better Care Fund	11.58	27.10
CCG non recurring funds	7.68	
Wiltshire Council growth	1.83	1.83
Wiltshire Council adult care contribution to carers	0.58	0.58
Wiltshire Council non recurring funds	0.70	
Total	**22.37**	**29.51**

Signed

Jane Scott OBE,
Chair,
Wiltshire Health and Wellbeing Board

Dr Steve Rowlands,
Vice-chair,
Wiltshire Health and WellBeing Board

Metric		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment	Assumption
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population.	Metric Value	609	N/A	613	
	Numerator	550		594	Ambition of maintaining placements at 13-14 estimated levels.
	Denominator	90345		96870	
		(April 2012 - March 2013)		(April 2014 - March 2015)	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services.	Metric Value	83%	N/A	88%	Ambition of increasing patients over 65 in reablement by 5%.
	Numerator	1005		1095	
	Denominator	1205		1244	
		(April 2012 - March 2013)		(April 2014 - March 2015)	
Delayed transfers of care from hospital per 100,000 population (average per month).	Metric Value	378		125	Ambition to reduce DTOC by 66%.
	Numerator	1419		475	
	Denominator	375265		380,383	
		(April 2012 - March 2013)	(April - December 2014)	(January - June 2015)	
Avoidable emergency admissions (composite measure).	Metric Value	1.6%	0.8%	0.8%	Assumes increase in avoidable admissions of 4.5% as per CCG QIPP plan.
	Numerator	7718	4033	4033	
	Denominator	479992	483069	486230	
		Oct 2012 - Sept 2013	(April - September 2014)	(October 2014 - March 2015)	
Patient/service user experience Use national metric [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used].			N/A		
		(insert time period)		(insert time period)	
Improvement in the rate of dementia diagnosis.	Metric Value	57.1%	67.0%	67.0%	
	Numerator	3835	4590	4590	
	Denominator	6714	6851	6851	
		(insert time period)	(insert time period)	(insert time period)	

Better Care Plan
2014 – 2016

NHS Wiltshire
Clinical Commissioning Group

NHS Wiltshire
Clinical Commissioning Group
Southgate House
Pans Lane
Devizes
Wiltshire SN10 5EQ

Telephone: 01380 728899
Email: WCCG.info@nhs.net
Web: **www.wiltshireccg.nhs.uk**

Wiltshire Council
Where everybody matters

Wiltshire Council
County Hall
Bythesea Road
Trowbridge
Wiltshire BA14 8JN

Telephone: 0300 003 4566
Email: PublicHealth@wiltshire.gov.uk
Web: **www.wiltshire.gov.uk/healthandsocialcare/publichealthwilts**