Department of Health & Social Care

Department for Levelling Up, Housing & Communities

Local Government Association

NHS England

Wiltshire HWB
Q2 Report Feedback
Responses

Integration and Better Care Fund

Feedback-Wiltshire 1/2

Area	Metric
Metrics	**Avoidable Admissions–slightly over Q1 but on track.** Emma Matthews, Virtual Wards Lead, NHSE: note focus on step down in the model. How does this link with Wiltshire health and care frailty model and how could pathways be maximised to support frailty and respiratory virtual wards in the alternatives to admission space are you linking with Gemma Pugh in WHC? The NHS@Home service has patients referred approximately 50/50 step up/down. Patients are mostly frailty and respiratory related conditions. UCR and NHS@H are an integrated service and therefore patients who are unwell and need hospital level care are referred to one another to avoid admission to hospital wherever possible. Julia Cutforth, Urgent Community Response Lead, NHSE: note UCR referral expected capacity decreased from 900 to 596/month – CSDS notes last 5/12 of data – average referral rate of 818 and continue not to meet their target to reach >70% within 2 hours – average target for last 5/12 is 55.6%. How will Wiltshire meet the 70% target when not achieved previously on a demand between 400-600? Is their demand data accurate as reality would appear much higher and not being met already? Eg: Nov 23 = 596 but CSDS for Sept 23 = 795 – Wiltshire not consistently able to meet this demand The UCR service has been performing at 71-74% since September 2023 with average referral numbers of 807/month. A data quality issue was identified and work completed to review records and rectify the performance reporting.

Feedback-Wiltshire 1/2

Area	Metric
Metrics	***Falls-good performance against target on Q1 and on track.*** *Emma Matthews, Virtual Wards Lead, NHSE: we can see you are linking with falls programme across ICB and Wiltshire. How does this care homes work link with urgent community response and virtual wards if people are acutely unwell. How is this linking to alternatives to admission pathways and are there areas you could support?* *Julia Cutforth, Urgent Community Response Lead, NHSE: falls programme underway – purchase of equipment and training in care homes: is there a sustainable programme of training? What has been impact? Have you evaluated their care homes with maximum conveyance rates?* The WH&C Urgent Care Response service has undertaken a programme of work that has delivered targeted staff training alongside revised Falls policies and operating procedures. The training on handling falls included Band 3 staff which, when supported with clear escalation routes has increased the capacity of the service to respond to falls. The result has been an improvement in the performance in terms of falls response times and capacity to manage non-injurious falls within a community setting. Averaging 30 UCR falls responses per month prior to training (Jan-Nov 2023) being fully embedded and averaging 45 in the last two months – this also reflects a busier period over winter as well so is not likely solely attributed to training. Prior to training averaging 77% of UCR Falls responses meeting 2-hour response target, in last 2 months have met target for 89% of responses. ICB funded additional Raizer chairs and alongside existing Mangar Camels and the additional training has led to an increased capacity to manage non injurious falls in the community and has reduced admissions to hospital. 377 UCR falls responses in 2023, 46 admitted to hospital, 313 kept in the community, 14 referrals where response was closed prior to outcome (e.g. patient declined care, another service arrived before us, service not appropriate) . This is an alternative to admission, which the outcome figures demonstrate. Any ‘long-lie’ patients are automatically referred to the NHS@Home/Virtual Ward service for review and whether further support or monitoring is required. The person will also stay on the UCR caseload and will receive therapy support if needed. This process continues to be reviewed and working with system partners to capture most effective way of keeping people in the community with additional monitoring. The team are also beginning to focus on falls prevention work within the county. At present people are referred via GP’s and offered therapy support on an ad hoc basis but the team are working on falls prevention with a targeted cohort of high-risk residents as part of the Melksham and Bradford-on-Avon neighbourhood Collaborative work. It is recognised that the rural nature of the county where we have a high percentage of elderly and frail residents (I’ll get exact figures from the JSNA) is likely the reason why we have a high fall rate in comparison to the rest of the Southwest. The focus on falls prevention is in recognition of this. Regarding the Care Home training outcomes an evaluation is pending and will be shared in the year-end reporting.

Feedback-Wiltshire 1/2

Area	Metric
Metrics	**Discharge to Usual Place of Residence–on track but concern about increased acuity challenging rehabilitation and reablement services.**Emma Matthews, Virtual Wards Lead, NHSE: you note home 1st now BAU. What about people who do not meet criteria to reside but could be supported to be discharged sooner via a virtual ward have you consider pathways to reduce LoS in those cohorts (Resp and frailty pathways) The NHS@Home service has patients referred approximately 50/50 step up/down. Patients are mostly frailty and respiratory related conditions. UCR and NHS@H are an integrated service and therefore patients who are unwell and need hospital level care are referred to one another to avoid admission to hospital wherever possible. **Reablement –no formal data but informal data showing performance 10% above target (which is comparatively low)** Latest performance for Q3 shows us performing 2% below the regional average at 79% (regional average 22-23 was 81%). We have increased capacity within PW1 (see Q2 refreshed submission) and we will be monitoring performance across the supporting services. **Residential Admissions-no data – Wiltshire have set a comparatively low annual target.** As at Q3 we had exceeded the target (total of 499 admissions against a target of 370). We will revise the target for the 24-25 planning round.

Feedback-Wiltshire 2/2

<table>
<tr><th>Area</th><th>Metric</th></tr>
<tr><td>Capacity and Demand Plan</td><td>
Overall
• Noted revised plan signed off by HWB 30/11/2023. Q2 return re-submitted. ICB recently indicated in a return to NHSE that there were concerns around gaps in provision in Pathway 1 hospital discharge. Work underway to address and additional system funding in place enabling brokerage of additional domicillary care to support peaks in demand.
• Demand assessments will be checked as part of demand and capacity planning for 2024/25.
• All 5 questions answered in template.
• Note challenges in social care and mental health services to meet complex needs

Hospital Discharge
• Emma Matthews, Virtual Wards Lead, NHSE: how are your pathway 0 services supporting virtual wards in respiratory and frailty? Are you maximising opportunities for people to be discharged sooner with wrap around low level services to meet personalised need?

We fund a ‘Home from Hospital’ service from BCF funds. This supports around 150 people per month and referrals come from a range of services. The virtual wards are still not at full capacity – this is something that has increased over the past year as recruitment is successful. We would expect to see referrals from virtual wards to increase accordingly. Many people who are cared for through virtual wards also require some level of personal or domiciliary care. As a result, they are often known to our brokerage and/or ASC teams and can be referred to HfH service for support in signposting to other support resources, such as meal delivery services, befriending schemes etc.

Community
• Additional P0 support for the community reported in refresh.
• Julia Cutforth, Urgent Community Response Lead, NHSE: note UCR referral expected capacity decreased from 900 to 596/month – CSDS notes last 5/12 of data – average referral rate of 818 and continue not to meet their target to reach >70% within 2 hours – average target for last 5/12 is 55.6%. How will Wiltshire meet the 70% target when not achieved previously on a demand between 400-600? Is their demand data accurate as reality would appear much higher and not being met already? Eg: Nov 23 = 596 but CSDS for Sept 23 = 795 – Wiltshire not consistently able to meet this demandSee slide 2 for response
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<tr><td>Other-Advisories from BCF Planning</td><td>
I would be grateful if you could respond to the outstanding advisories from 23-25 BCF planning, outlined in the table below.

If you would like to access any support for Intermediate Care Capacity and Demand planning, we would be happy to pick this up in the new year.

<table>
<tr><th>PR</th><th>KLOE (shorthand)</th><th>Issue to resolve</th></tr>
<tr><td>4&6</td><td>C&D</td><td>Disconnect between narrative and template needs to be reviewed and resolved. NB REVISED TEMPLATE</td></tr>
<tr><td>4&6</td><td>C&D</td><td>DHSC comments to follow up. Is BCF Support offer</td></tr>
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