Wiltshire Integrated Better Care Plan
IBCF/BCF 2017-2019

Version	Sign off	Date
Draft Submission	To the Health and wellbeing Board	
BCF Final	Submitted to NHSE	29 September 2017

Contents:

Glossary

BCF	Better Care Fund
DToC	Delayed Transfer of Care
IBCF	Improved Better Care Fund
NEL	Non-elective admission
STP (ACS)	Sustainable Transformation Partnership (Accountable Care System)

Section 1: Vision and priorities

Background and Wiltshire context

Current state of the health and adult social care market

Health and social care is facing challenging times. In Wiltshire the population is ageing and by 2020 those of 65years will account for 4.8% of the Wiltshire population, the prevalence of long term conditions is increasing and the demand for health and social care services is growing.

At the same time the aspirations and needs of the community are also changing as people expect more personalised services and more choice and control over how their individual needs are met. The current financial climate also places a greater imperative on the CCG and the Council to develop models of care within available resources that are both robust and sufficiently flexible to be responsive to changing needs, aspirations and technological advances over the next decade and beyond. Within this climate, the care market in Wiltshire is also facing a number of challenges, which are reflective of those being faced across the country. This includes the recruitment and retention of adequate numbers of appropriately skilled, experienced staff (including nurses for nursing homes).

Shared Vision for 2020

In Wiltshire, our local vision is set out in the Joint Health and Wellbeing Strategy and a recently agreed Statement of Intent on health and social care integration. Our vision is that health and social care services in Wiltshire should work seamlessly together to support and sustain healthy, independent living.

Our two key aims are:

- **Healthy Lives** – which means encouraging and supporting Wiltshire communities, families and individuals to take on more responsibility for their own health and wellbeing through a range of health promotion, protection and preventive activities.
- **Empowered Lives** – which means care should be personalised and delivered in the most appropriate setting, wherever possible in the community and at, or closer to home. We want the people of Wiltshire to be supported and empowered to live independently, healthily and for longer.

Delivering our two key aims and the vision of supporting and sustaining healthy, empowered living will require increased integration and cooperation between public health and primary, secondary and specialist health services – together with social care and other council teams. Our JHWS sets out how this integration needs to happen at local level by developing multi-disciplinary teams; in the way services are commissioned at a countywide level; and by joint working on issues such as workforce development and estates (enablers).

Over the past three years we have made very significant progress in the production and mobilisation of our shared Better Care Fund (BCF) plan, the successful establishment and functioning of both Health and Wellbeing Board and the supporting Joint Commissioning Board, and the appointment of a shared Director overseeing BCF developments. We have also made strong progress in agreeing the structure and composition of a shared team with responsibility for Mental Health and Learning Disabilities. Building on this, Wiltshire Council and Wiltshire Clinical Commissioning Group, and our partners, have made the commitment to further enhance their collaboration to create a sustainable health and social care system that promotes health and wellbeing and sets high service standards to achieve good outcomes for the local population. This places prevention at the heart of our vision to increase the healthy and productive life years of people living in Wiltshire. It will be delivered through an integrated approach, based on sound evidence with a focus on population needs; better prevention, self- care, improved detection, early intervention, proactive and joined up responses to people that require care and support across organisational and geographical boundaries.

Shared Vision for 2020

Wiltshire Council, Wiltshire CCG and our partners in the acute and mental health sectors and Wiltshire Health and Care (which brings together our three acute hospitals to deliver community care) have agreed to combine leadership to:

- Align strategies and plans with an emphasis on shifting the focus from acute to primary and community care and, in turn, to prevention and population health;
- Share the risks and rewards of investment locally, moving over time to commissioning on the basis of whole population health outcomes rather than a system which rewards increased contact;
- Have a shared and transparent governance structure;
- Establish joint outcomes and evidence based provision;
- Provide a multi-skilled and joined up workforce.

This will transform the way in which our business is done and will help to deliver the triple aim of improved population health, improved quality and experience and reduced cost per capita. The immediate next steps to deliver this vision are:
Appoint a joint Chief Accountable Officer / Corporate Director (DASS). The current situation whereby both the Wiltshire CCG Accountable Officer post and the Council Director of Adult Services (DASS) are vacant, provides an opportunity for Wiltshire to take the next step on the integration journey, and appoint a single individual to fill both roles.
Align budgets and commissioning intentions to develop whole place commissioning. A single source of commissioning intentions will provide more efficient, effective and coherent services to our population enabled by a single source of strategic commissioning intentions. We will test and develop arrangements for capitated budgets & outcomes based commissioning.

The steps described will deliver a transformation in the way that health and social care services are designed in Wiltshire. To deliver the work, Wiltshire has brought together an accountable care alliance, reporting to the Health and Wellbeing Board. From inception, the Board has included our acute providers, mental health trust, ambulance trust and local medical committee and the alliance is the next iteration of the strong relationship between providers and commissioners in Wiltshire. Our key providers also strongly support the steps outlined in this Better Care Plan for Wiltshire to deliver sustainable change.

The Contribution of the Better Care Plan to the Shared Vision for 2020

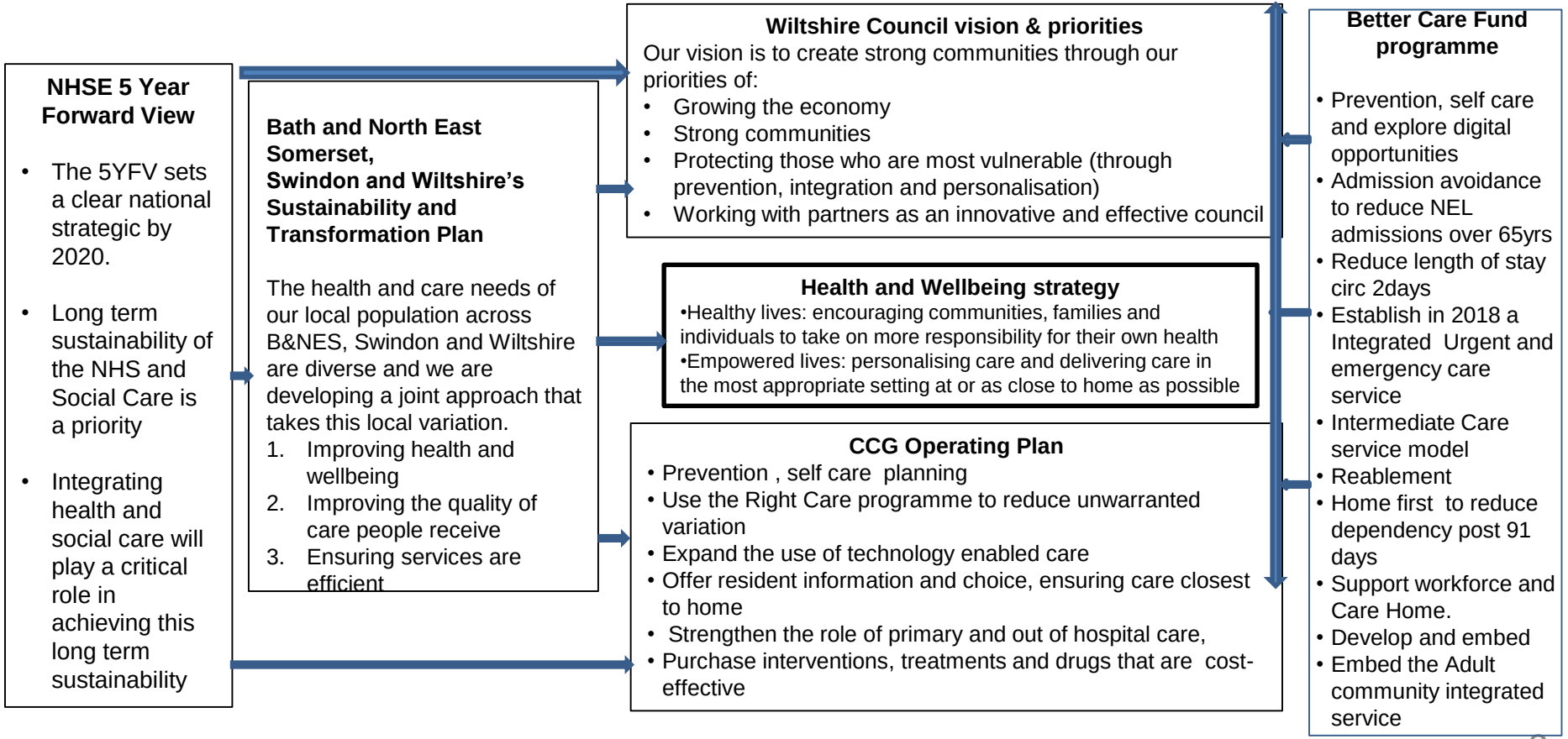
The Better Care Plan will continue to play a key role in managing pressure across the system, monitored by established system wide governance processes; and will help to deliver the vision for enhanced health and social care in Wiltshire for 2020 through demonstrating a commitment to enhance and embed a sustainable system that promotes health and wellbeing. This work, which has the full support of our acute partners, will deliver a greater emphasis on upstream prevention and focus on self-management and signposting. We will commission the third sector to deliver an increased emphasis on prevention, early intervention and to empower individuals to be more independent. This will be complemented with investment in community focused provision, the development of locality based integrated teams, supporting primary care, and continued joint commissioning of an integrated urgent care service and Home First to avoid admissions, reduce length of stay and support discharge.

The Better Care plan has been running for the last 2 years and has provided a strong framework for integration, transformation and system wide delivery across Wiltshire. The BCP statement of intent for 2017/18 and 2019 outlines our ambition to further enhance and transform Wiltshire with the additional investment from the Adult Social Care (£5.8m in 2017/18) IBCF which will enable the strengthening of work streams to improve flow and the integration and transformation of services aligned to the JSNA, CCG operational plan and Health and Wellbeing board vision for the population of Wiltshire. This will deliver by 2020 the vision of a one service delivery infrastructure underpinned in part by the BCF and IBCF. A new S75 agreement for 2017-19 reflecting this is set for completion in Q4 2017/18. As part of the aim to develop community resilience and market capacity, ensuring people are discharged from hospital in a safe and timely manner, the focus of the additional, non-recurring, resources will be on wider transformation of adult social care (including front door services), developing a reablement service that supports Home First, increasing capacity in the domiciliary care market, redesigning the hospital discharge process and tackling National Living Wage pressures.

These steps will be critical for delivering change on the ground, in line with Wiltshire's Joint Health and Wellbeing Strategy, so that people can say: ***My care is planned with people who work together to understand me and my carer(s), put me in control, co-ordinate and deliver services to achieve my best outcomes***. We will use this and the other 'National Voices' outcome statements and work with Healthwatch Wiltshire to test these with patients, service users and staff to measure our success in delivery.

Vision and priorities

The Better Care Fund programmes delivers the council and CCG vision and priorities, which are informed by the local and BANES STP strategy/priorities and the NHSE 5 Year Forward Plan.



Better Care Plan is built upon our overriding vision of care

Our Better Care Plan is built upon our overriding vision of care as close to home as possible, with home always the first option. This vision is delivered by a 2-stage transition;
Stage 1 – focus was very much on discharging people from hospital to home as soon as they are medically stable usually through an integrated package of care employing Home First and reablement. This will enable the long-term independence of the service user.

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

- The Better Care Plan has been the key driver for out of hospital care and has provided a very strong case for change which is evidence based and recognised and understood by the whole system.
- The Better Care plan has been running for the last 3 years and has provided a strong framework for integration, transformation and system wide change.
- The Better Care Plan will further strengthen the prevention strategies both for the population to remain as healthy as possible but also through assistive technology as both will help the population to remain out of hospital and reduce long term care needs.
- Our vision for better care is based upon the outcomes which are set out in our Joint Health and Wellbeing Strategy and based on the strategic joint needs assessment to be led and informed by Wiltshire residents.

Wiltshire, integrated care delivery model

The Better Care plan has provided a strong framework for integration, transformation and system wide delivery across Wiltshire. The model of care for Wiltshire which has been put in place and needs to be supported and maintained, will include the following;

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

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

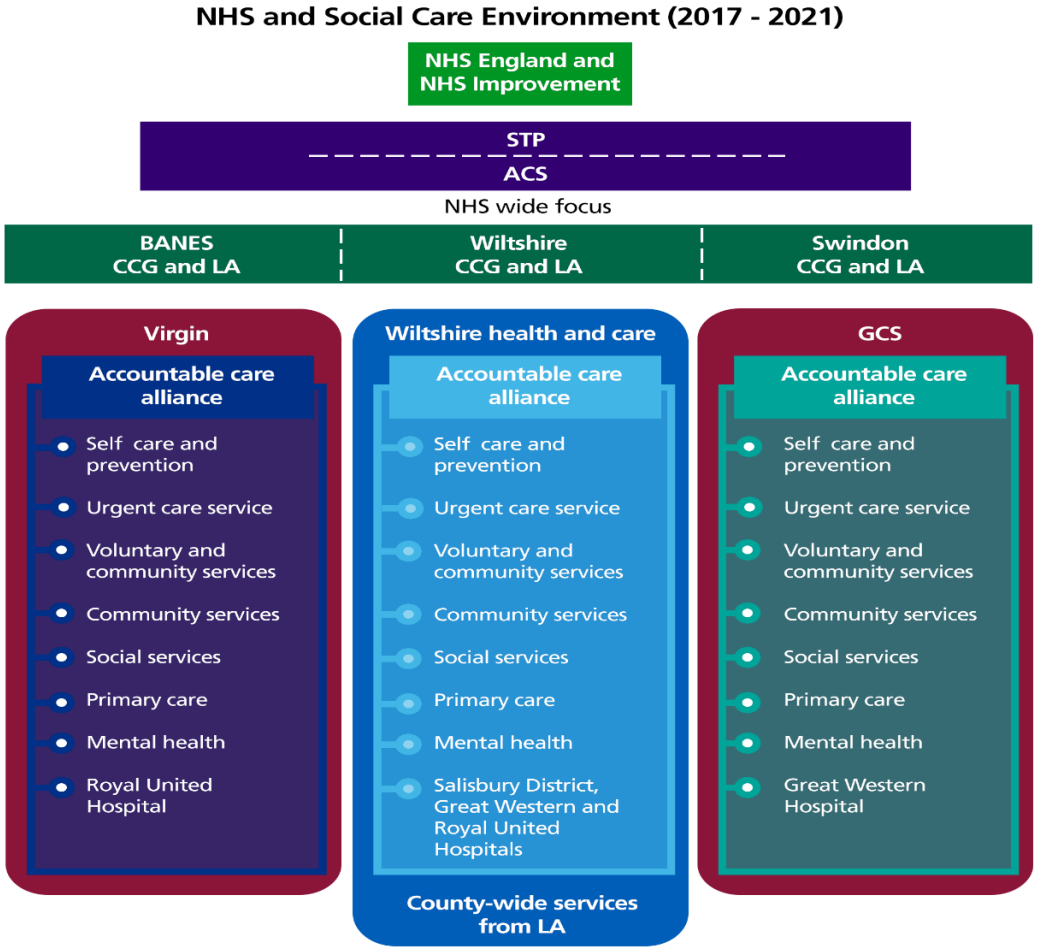
Leadership and culture change

Wiltshire is committed to strengthening the current collaborative ways of working to appoint a joint adult and social care and Accountable officer post in 2018/19. This is a key role to take forward at pace the accountable care system and new ways of working.
Wiltshire Council and Wiltshire Clinical Commissioning Group seek to work in ways that achieve high levels of output that produce good outcomes in partnership with others and at a cost the local community can afford.

The Council's approach is aligned to the strategic leadership in Wiltshire CCG. There are great synergies between the drive and commitment from the Council's strategic leaders and board at the CCG. The culture developed in the inception of the Better Care Fund and more recently in the Improved Better Care Fund provide a platform to further build on the work completed over the previous 3 years. .

The two strategic partners possess a complementary vision of our BCF programme which is innovative and flexible in its approach. Rather than just looking for new projects the BCF board seeks to identify, from an evidence base, what local projects and delivery outcomes can be expanded or amend to deliver more; what projects are delivering outcomes; and or the wider footprint of BaNES STP.

Our vision 2017-2020 of an Accountable Care System



Wider services such as mental health, ambulance, patient transport services, continuing healthcare and specialised

Definitions

Requirement setting, regulation and assurance. Targetted support.Accountability for strategic vision and outcomes. Strategic commissioning activities. Responsibility for system design and delivery. Back office shared function. STP: STP partnerships

Local strategiccommissioning at LA level

- s75 pooled budgets
- Public health (JSNA)
- Influencing of public policy
- Prevention
- Strategy and vision
- Resources prioritisation and allocation
- Required outcomes
- PPE
- Market stimulation
- Procurement
- Contracts
- Performance management and QA
- Functions across STP for wider services and with other STPs for MH, Specialised and Ambulance
- Workforce planning

ACA system elements

- High quality sustainable acute services - and improvement of
- Integrated urgent and emergency care services
- Primary care at scale
- Integrated CYP service
- Population based HWB offer
- Integrated H&SC services
- Physcial and mental health
- Vibrant market/VCSE
- Integrated personal commissioning

Questions:

- NHS only business learning?
- Networks outside of STP?

Sustainability and Transformation Plan (STP)

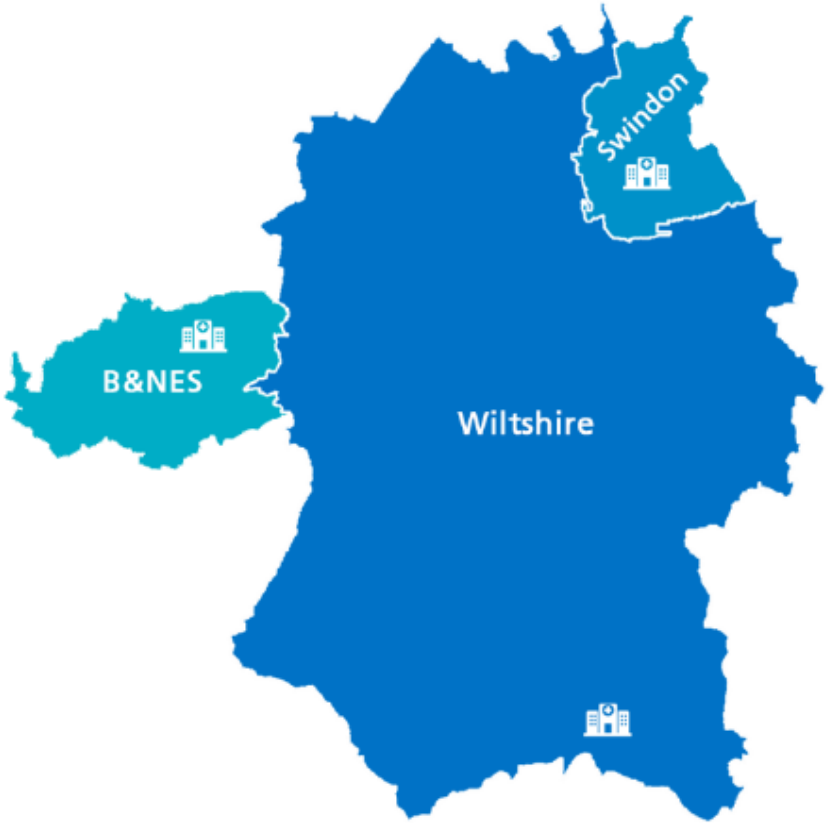
The Wiltshire Better Care Fund Plan carries forward elements of the B&NES, Swindon, Wiltshire (BSW) Sustainability and Transformation Plan (STP) which has established 5 key priorities that are set out below.

In particular, the priority to focus on prevention, create locality based integrated teams and focus on workforce and capacity issues such as the domiciliary care workforce and care home capacity are strong themes running through the local BCF as well. The BCF Plan complements the STP Urgent and Emergency Care Delivery Plan, particularly the national priority on hospital to home services.

STP Priorities

1. Create locality based integrated teams supporting primary care
2. Shift the focus of care from treatment to prevention and proactive care
3. Redefine the ways we work together to deliver better patient care
4. Establish a flexible and collaborative approach to workforce
5. Design our strategy to further enable acute collaboration & sustainability

STP (BSW) operating boundary



Organisations within the footprint:

Bath & North East Somerset CCG
Swindon CCG
Wiltshire CCG
Bath & North East Somerset Council
Swindon Borough Council
Wiltshire Council
Great Western Hospital Foundation NHS Trust
Royal United Hospitals Bath NHS Foundation Trust
Salisbury NHS Foundation Trust
Avon & Wiltshire Mental Health Partnership NHS Trust
Wiltshire Health & Care
South Western Ambulance Service NHS Foundation Trust
Wessex Local Medical Committee
West of England Academic Health Science Network
Health Education England
Health and Wellbeing Boards (B&NES, Swindon, and Wiltshire)

Section 2: Demographics and population needs

The needs of our population

The Joint Strategic Needs Assessment (JSNA) indicates that there will be a 1.7% rise in the population to 501,300 by 2020, by 2030 the population of Wiltshire is expected to rise by 6.4% higher with a population of around 524,300.

For those aged 65 and over the estimates show an increase of 4.8% by 2020 to 111,700 and 34.6% by 2030 to 143,500. For those aged 85 and over the increase is 74% by 2030 to 24,800.

Our working age population is expected to reduce by 3.6% or 10,000 people by 2030, making the case for resilient communities and a sustainable health and social care system even greater.

This will be explored further within this section.

Demographics

Table: Population	2014	2017	2018	2019	2020	2030
Total population	483,300	492,700	496,200	498,600	501,300	524,300
Under 20	114,500	114,300	114,400	114,500	114,900	116,300
20-64	271,900	274,300	275,200	274,900	274,700	264,500
Aged 65 and over	96,900	104,100	106,600	109,200	111,700	143,500
population aged 65+ as a % of total population	20.0%	21.1%	21.5%	21.9%	22.3%	27.4%
Aged 85 and over	13,300	14,500	14,900	15,300	16,000	24,800
Population 85+ as a % of total population	2.8%	2.9%	3.0%	3.1%	3.2%	4.7%

Wiltshire Council and NHS Wiltshire are broadly coterminous and the registered and resident populations are broadly similar.

Wiltshire is a large, predominantly rural and generally prosperous county. Almost half of the population resides in towns and villages with less than 5,000 people and a quarter live in villages of fewer than 1,000 people. Approximately 90% of the county is classified as rural and there are significant areas with a rich and diverse heritage of national and international interest, such as Stonehenge and Salisbury Cathedral. The relationship between the city of Salisbury and the larger towns in Wiltshire and the rest of the county has a significant effect on transport, employment, travel to work issues, housing and economic needs.

Wiltshire's population is ageing more rapidly than England or the South West, reflected by growth of 17.5% in the number of people aged 65 or over between 2011 and 2016. This is substantially greater than the 13.2% increase in England or 14.0% increase in the South West. The table shows the population projection to 2030, which shows further growth for the over 65s of 7.3% from 2017 to 2020. At the same time the working age population is broadly unchanged.

The population of Wiltshire is served by 3 main Acute trusts, only one of which is actually in the County. Around 35% of the activity goes to Salisbury Foundation Trust in Wiltshire. Roughly the same percentage attend the Royal United Hospital in Bath and around 25% attend the Great Western Hospital in Swindon. This distribution of activity and service demand adds complexity to the admission avoidance and discharge planning for patients.

Older people

Table 1: Population	2017	2018	2019	2020
Aged 65 and over	104,100	106,600	109,200	111,700
65+ as a % of total population	21.1%	21.5%	21.9%	22.3%
Aged 85 and over	14,500	14,900	15,300	16,000
85+ as a % of total population	2.9%	3.0%	3.1%	3.2%

Table 2: Support arrangements	2017	2020	2025	2030
Total population aged 65 + unable to manage at least one self-care activity* on their own	34,651	37,585	43,573	50,522
Total population aged 65+ unable to manage at least one domestic task** on their own	42,243	45,954	53,352	61,743
People aged 65 + **providing unpaid care** to a partner, family member or other person, by age, projected to 2030	14,894	15,882	17,788	20,113
Total population aged 65 + **living in a care home** with or without nursing	3,277	3,635	4,395	5,313

Wiltshire has a large older, 65+, population, see table 1, 21.1%. This is expected to rise to 22.3% within the next three years. The older population continues to be healthy, with average life expectancy at age 65 higher than national average at 19.4 years for men (vs. 18.7yrs nationally) and 21.7 years for women (vs. 31.1yrs nationally) The Wiltshire BCF vision is to support the increase in demand for services that support residents remaining independent. We support Carer Support Wiltshire who undertake carer reviews, provide respite care and have a voluntary emergency care which enables early identification of a carer to provide alternative support in an emergency.

Whilst independence remains the aim some of our residents, see table 2, some of our residents need to live in residential or nursing home environments. There are a substantial number of nursing and residential care homes, 204, in Wiltshire delivering over 5,000 beds . This brings a range of challenges, for instance high number of ‘self-funders’ who revert to local authority support when their resource expires – but are expensive placements and do not want to move; demand for high volume of social care workforce – in a area where employment rates and high and house prices are many times the average salary.

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

Social Isolation and mental health

Social Isolation

Levels of Social Isolation as measured by the annual client and biannual carers survey are higher than we would like to see within Wiltshire. We know that high levels of social isolation can lead to admission to hospital and greater levels of care. The Wiltshire Older Peoples collaborative is working with the Council, CCG, Providers and the Voluntary Sector to identify areas at high risk of social isolation and support the signposting of people to local community assets which can help reduce the levels of social isolation across the county.

Mental Health

Local dementia diagnosis rates are around 65%, slightly below the national target level of 67%, with some outstanding individual GP practice performance, but the impact of dementia on long term care needs for families and care home capacity is continuing to rise. The BCF work on training care homes employees is seeking to ensure residents remain in the home rather than be transferred to hospital. A Dementia strategy and action plan has been developed, but we need to target the gaps in care and need to ensure a more community focused /crisis intervention based model of care. Through the Better Care Plan, we are already looking at;

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

Long term conditions and frailty

In 2014 Wiltshire Council published its first Older Persons Joint Strategic Assessment, this led onto an Older Peoples Service Review which was published in 2015. The key recommendations of this review were:

- Supporting Independence
- Healthy Active Ageing
- Support for living with health problems
- Understanding co-morbidity
- Rapid support close to home in times of crises
- Good discharge planning and post discharge support and reablement
- End of life care

The Better Care Fund has been supportive in delivering the recommendations of the review which includes the Urgent Care at Home service and Step Up Beds in the community and our 72 hours end of life care pathway. In 2017-19 we will continue to develop our existing and new services in line with the recommendations of the review.

The Older Persons JSNA analysis is currently being updated and due for publication in December 2017 and this will be used to support the tailoring of current schemes to meet the evolving needs of this population.

The ongoing Adult Social Care transformation programme, funded by the iBCF monies is primarily about delivering effective reablement support both in the community and post hospital discharge one of the main recommendations of the Older Persons review in Wiltshire.

Section 3 - Better Care Plan

Lessons learnt from the Better Care Plan

The evaluation of BCP Schemes has highlighted the following themes, which have been developed into a transformational programme of work.
Phase One of this transformation is listed in the table below and provides a foundation for Phase Two.
Phase Two will focus on the further integration of the health and social care economy.

- Greater focus on prevention and self-management incorporating adult social care front door transformation and information and advice
- Better managing demand across the system, **Right Place First time** for the residents of Wiltshire
- Ensuring greater stability in the local care market.
- Improving reablement and the alignment of reablement and the Home First model future model
- Increased workforce capacity including domiciliary care market and flexible use of the workforce, moving towards an integrated workforce within our ACS
- Developing integrated commissioning to use our resources effectively across the system
- Increasing innovation, including better use of technology advances
- Further improvements to hospital discharge planning and reductions of delayed transfers of care (which are set out in the High Impact Change Model and Delayed Transfers of Care Plan – Appendix I DTOC plan and Appendix 2 High Impact Changes.
- Stakeholder engagement building upon the JSNA

Wiltshire's Better Care Plan

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

The Adult Community Service contract is now mobilised and fully operational in its first full year of delivery in 2017/18, the Wiltshire Health and Care Model plays a critical role in delivering operationally the aims and ambitions of the Wiltshire Better Care plan and programmes led by Wiltshire Health and Care such as the High Intensity Care Programme and Home First will play a key role in managing crisis reducing demand across the system and improving flow.

Explore new opportunities to strengthen Wiltshire`s person centred approach through an assets based assessment, and integrating the wider social model in communities and across the Wiltshire system

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

The total spend on Better Care is £44.083m. For a full breakdown of the BCF schemes, see Appendix 55,56 and 57

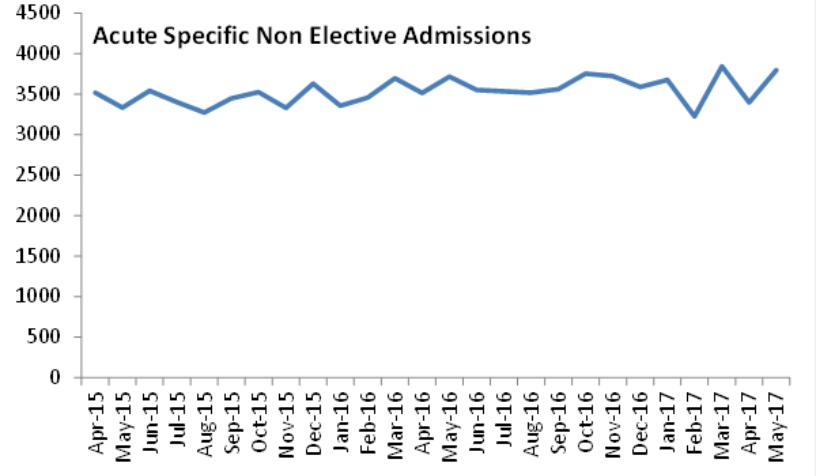
Performance to date

The following provides a summary of the progress made by the Better Care Plan during 2016-17, this is the foundation on which our priorities are based for 2017/18. Utilising the analyst of data, Better Care Plan work streams and new service models explore further the opportunities to ensure Wiltshire residents appropriately access the right service first time in there community and closer to home.

Activity and Outcomes

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

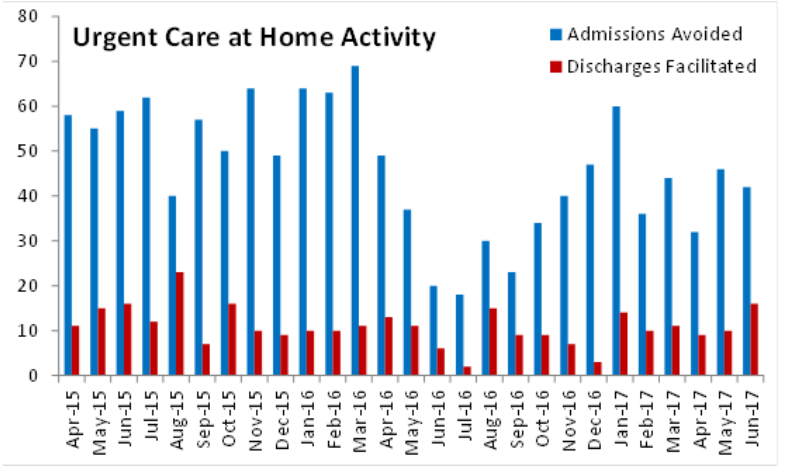
This represents a reduction in potential admissions of around 1,500. The Wiltshire rate of emergency admissions in the population aged 65 and over remains lower than the average for England. This is also reflected in the national integration dashboard which shows Wiltshire has the 10th lowest rate of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



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

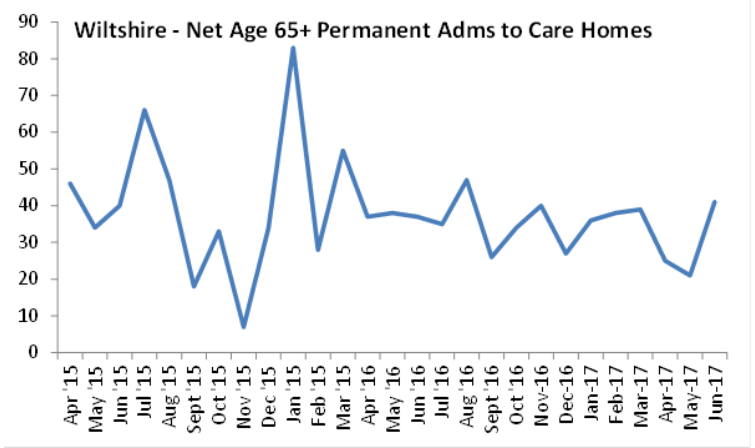
Performance to date

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



Effectiveness of Reablement:
The percentage of patients at home 91 days' post discharge from hospital (reablement indicator) has reduced slightly to around 80% which is under target, the ASC transformation programme is aimed at ensuring greater reablement activity and better outcomes.

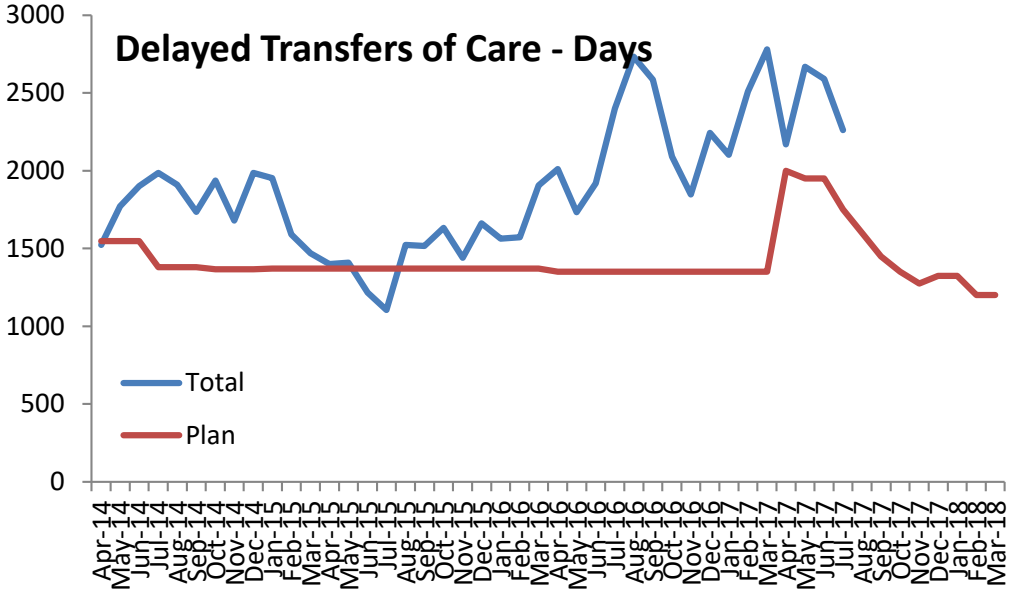
Permanent Care Home Admissions:
Permanent Placements to care homes for those aged 65 and over remain comparatively low and falling. While this is a success for the system it is likely to increase the pressure on the demand for care at home.



Dementia Diagnosis:
Dementia Diagnosis rate is now less than 1% below target and the CCG is working with GP practices to achieve the national target by year end. Wiltshire achieves good outcomes when patients are diagnosed with dementia with 88.3% having a care plan reviewed face to face in the last 12 months compared to an England average of 83.8%. It also does better on DEM05 achieving 86.3% compared to an England average of 84.6%.

Performance to date

Delayed Transfers of Care:
The figure shows that Delayed Transfers of Care have increased back to the levels seen in 2014-15, in part due to issues with CQC restrictions on one of the BCF schemes which limited our workforce for admission avoidance and discharge support as well as demand exceeding supply, increased complexity and inappropriate referrals. This has in effect negated the significant progress we made in reducing delayed transfers of care in 2015/16 and led to more beds being used than planned. The average number of daily delayed days in 2015-16 was 49.0, in 2016-17 this increased to 73.8 as a result of the issues outlined above. In 2017/18 and into 2019 our 100% commitment to sustainably improve flow and the experience of people who use our services will be established and continuously monitored to strengthen the Wiltshire integrated system



Section 4 - Managing the Market

Market Position

The domiciliary care market in Wiltshire reflects the pressures experienced in many other parts of the country where recruitment and retention issues impact upon capacity and availability where required.

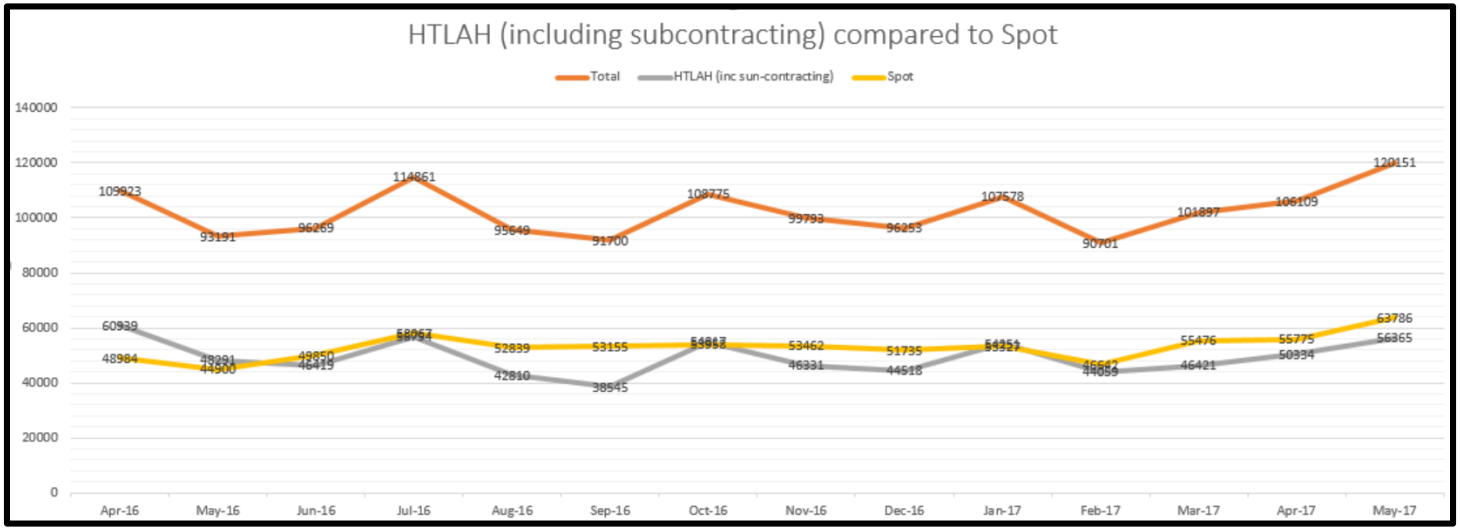
There has been a significant shift from purchasing within a block framework to spot purchasing with the latter raising the unit cost of care and creating a reactive rather than strategic market which does not respond to the commissioning priorities of the Council

Reablement forms an integral element of the contract but is ineffective in its delivery thereby increasing demand into the system and reducing domiciliary care capacity

There is an over reliance upon residential care services as a consequence as service users remain too long in hospital, intermediate care and respite services as community based provision is insufficient or inappropriate to presenting needs

The table on slide 28 describes the shift from block to spot purchasing and the need to invest in the market to stabilise it whilst Transformation initiatives are undertaken

Market Position



Market Position

A key national and local priority is to ensure that there are no delays in acute hospitals for patients who require social care. Wiltshire's performance in this area is currently in the lowest 15% nationally as measured by the NHS/Social Care performance dashboard published by the government.

The lack of an effective reablement service is impacting on our ability to support patient discharges from the three acute hospitals that serve Wiltshire (Royal United Hospital, Great Western Hospital and Salisbury Foundation Trust) and the three smaller community hospitals in Chippenham, Marlborough and Warminster. Increasingly patients are moving into care home beds as a temporary measure as services to support them in their own homes are not available. Individuals often become further deconditioned with functional loss which means they never return home.

Investment is required to create a dedicated reablement service to address the above market pressures and to mitigate demand for services and maintain peoples independence.

The over reliance on residential care also applies to specialist services and in particular, Learning Disabilities where the average cost of care is higher than many other Councils in the South West Region. National Data shows that Wiltshire spend above average amounts on support for learning disabled adults being the 3rd highest spenders per 10,000 of population.

This above average spending is not explained by above average customer numbers, nor by high levels of deprivation. Market development work is required to ensure that provision is both appropriate and value for money

Market Development

Across the wider system, the commitment by the Health and Wellbeing Board is to move beyond the integration of health and social care bringing together a wide range of partners to influence the wider determinants of health including housing, education, regeneration and economic development and build on the assets of our people and communities. The reengineering of the health and social care system, building on Wiltshire Council and Wiltshire CCG commitment to secure better outcomes and ensure a more sustainable system for the future. The Joint Commissioning Board (JCB) is actively working towards establishing joint strategies across the market to ensure a whole system approach to commissioning and to maximise opportunities for collaboration, achieve economies of scale and remove duplication. This will include:

- A joint approach to commissioning the Third Sector with an increased emphasis on prevention, early intervention and empowering individuals to be more independent;
- Joint commissioning of an integrated Urgent Care Service;
- A further shift of investment from acute and specialist health services to support investment in community-focused provision.

Market Development

The Adult Social Care Market Position Statement (MPS):

The social care market positon statement is currently being refreshed to reflect the changes envisaged by the ongoing transformation project, the latest data from the JSNA (set for agreement at November HWB), the progress the Council has made with respect to extra care housing and alternatives to residential provision across all service user groups. This will be completed and further work will be undertaken to address any gaps identified by the MPS following its completion.

Work undertaken through the Transformation Programme and the JCB has identified opportunities for further integration across health and social care to combine strategies and jointly develop the market.
These strategies will inform the MPS and engagement events are being held with key stakeholders to assist in the creation and delivery of the joint priorities identified.

Two key papers from the Transformation Board will go to cabinet in December outlining a new approach to the domiciliary care market and reablement, both of which are crucial to managing demand and creating capacity to minimise flow into and maximise flow out of the acute sector into the community.

A new post of Service Director for Commissioning will bring together commissioning for adult care and children's services within the Council, providing opportunities for combining strategies across a whole life-span.

Market Development

The Care Act 2014 and Commissioning:

In order to fulfil our new duties of Market Shaping under The Care Act, the Council and the CCG have undertaken the following:

- **Supported the development of the Wiltshire Care Partnership** (membership organisation representing social care providers) to act as the relationship lead with independent providers.
- **Strengthened the Quality Assurance function** to support providers to improve and maintain standards within the market.
- Market mapping and gap analysis to inform joint health and social care strategies and understand interdependencies across the system including the financial sustainability of key providers.
- **Co-production of new BCF schemes** with providers including Home-First.
- **The launch of a Progression Model for people with learning Disabilities** – working towards greater independence to complement work being undertaken on **Asset Based Assessment** and Reviews and combined with a transparent approach to the cost of care with providers
- **Establishment of a workforce sub-group to the JCB** to progress initiatives which enhance the workforce and to reflect the changing demands of the market
- **Further developing community resilience strategies** including Local Area Co-ordination to support and develop local resource. Working with local Health and Well Being Boards to inform them about Adult Social Care Transformation and target and develop local solutions that make best use of local assets.

Section 5: Ongoing projects

Intermediate Care – Care Homes

Existing **Budget 2017-18: £5.22 m** **Budget 2018-19: £5.22m**

Scheme Description:

- 70 intermediate care beds (step down beds county-wide and step-up beds in the South of the county)
- Physiotherapy and occupational therapy input
- Social work input
- Primary care input
- Programme Management

Outcomes in these beds are improving slowly in terms of throughput and outcomes (getting people home) but with the additional training which has been provided to these homes we expect to see further improvements in outcomes.

Outcomes 2017-18: 60 admissions per month
Outcomes 2018-19: 60 admissions per month (to be reviewed following project evaluation).

Intermediate Care – Community Hospitals

Existing Budget 2017-18: £0.86m Budget 2018-19: £0.86m

Scheme Description:

Phase 1

Continue to commission existing 15 community hospital beds for the step up pathway in the North and West of the County at Warminster and Savernake. This needs to be underpinned by a clear system strategy and commitment to step up by Wiltshire Health & Care.

Phase 2

Wiltshire Health and Care have committed in their contract to convert 50% of community hospital bed capacity to step up, transition to this level will commence during 2017/18.

Outcomes 2017-18: 25 admissions per month
Outcomes 2018-19: 25 admissions per month (to be reviewed following project evaluation

End of Life Care

Existing **Budget 2017-18: £0.31m** **Budget 2018-19: £0.31m**

Scheme Description:

Within Wiltshire it is recognised that 30 % of all hospital non-elective admissions are for patients with a life limiting diagnosis. To support admissions avoidance and improve quality of life for these patients we need to;

1. Improve identification of patients who have <12 months to live.
2. Progress implementation of treatment escalation plans across system.
3. Reshape role of the community end of life team (Wiltshire Health & Care) to ensure they take a more proactive case management approach to patients on an end of life pathway.
4. Continue commissioning of the 72 hour EOL pathway.
5. Review and agree future role of hospices in the EOL agenda.

Outcomes 2017-18: 16 cases per month
Outcomes 2018-19: 16 cases per month (to be reviewed following project evaluation)

Mental Health Liaison

Existing **Budget 2017-18: £0.2m** **Budget 2018-19: £0.2m**

Scheme Description:

Avon & Wiltshire Partnership provides support to Care Homes through training and individual management plans for specific patients. This helps the homes to manage patients with complex dementia in the home environment rather then requiring admission to an acute hospital.

Outcomes 2017-18: project evaluation to be completed Q3
Outcomes 2018-19:TBA

Community Geriatrics & Services

Existing **Budget 2017-18: £4.48m** **Budget 2018-19: £4.48m**

Scheme Description:

- Community geriatrician coverage across Wiltshire is provided through a Community Geriatrician at each of the 3 acute trusts to support discharge planning and provide advice in the community. In 2017-18 we need to link this capacity in more formally with established community teams.

- Contribution to the Community Health Services contract (Wiltshire Health and Care)

- Developing robust “interface” care with each acute hospital, enhancing the Acute Trust Liaison model and diverting appropriate patients to established models of care in the community (for discharge and admission avoidance).

- We are also looking at the role of community nurses, matrons and therapists in the high intensity care programme to ensure effective roll out of the High Intensity care programme, led by Wiltshire Health and Care and which will focus on
  - Step up care in the patient’s home
  - Acute geriatric pathways in the community
  - Frailty hub approach at community hospitals
  - Integrated team approach

Outcomes 2017-18: Project evaluation to be completed Q3
Outcomes 2018-19: TBA

Urgent Care at Home & Access to Care

Existing **Budget 2017-18: £1.59m** **Budget 2018-19: £1.59m**

Scheme Description:

- Urgent care at home is a service to provide admission avoidance and additional bridging domiciliary and nursing care support across a 7-day period to support further discharges from the acute hospitals. There is an explicit target for UCAH to move back to performance levels delivered in 15/16 which was circa 80 cases per month management for admission avoidance and discharge facilitation.
- Domiciliary care services to support the delivery of rehabilitation delivered by Wiltshire Health and Care

Outcomes 2017-18: 80 cases per month for Urgent Care at Home
Outcomes 2018-19: 80 cases per month (to be reviewed following project evaluation)

Maintaining Social Care

Existing **Budget 2017-18: £9.18m** **Budget 2018-19: £9.5m estimate**

Scheme Description:

This money is used to support and maintain the adult social care activities of Wiltshire Council including complex packages of care to allow clients to remain at home for as long as possible.

In addition we have strengthened our work and links with providers to provide greater assurance on the quality of the care provided.

Care Act

Existing **Budget 2017-18: £2.5m** **Budget 2018-19: £2.5m**

Scheme Description:

This money is used to support and maintain the adult social care activities of Wiltshire Council generated by the implementation of the Care Act 2014. This includes the impact of new duties in relations to carers assessments and services.

Prevention, including services for carers

Existing **Budget 2017-18: £1.76m** **Budget 2018-19: £1.76m**

Scheme Description:

There are over 47,000 unpaid carers in Wiltshire. 2,700 of them are young adult carers aged between the age of 16 and 25 who look after siblings or parents. Carer Support Wiltshire helps them to access support, services, education and training, and breaks from their caring role. Ensuring carers have a voice in policy making and planning for services, and we work with health and social care professionals and employers to develop best practice.
The services cover the whole of Wiltshire and are available to anyone who is aged 16 or over.

This work stream also funds a fracture liaison service at Salisbury Foundation Trust, this was initially funded for 12 months and following a successful initial evaluation has been extended for another year, we will now also be looking at how this service can be rolled out across the other 2 acute trusts which serve the Wiltshire population.

As part of our prevention work we have also undertaken training with care homes which was physiotherapist led to help train care home staff in reablement and aids and equipment which might be useful in helping people retain their independence for longer. We have also undertaken Health Coaching Training for over 150 medical professionals in the South of Wiltshire which is in the process of being evaluated and we hope to undertake in the North and West of the County in the coming year.

Outcomes 2017-18: to be established following a stocktake and evaluation
Outcomes 2018-19: TBA

Integrated Discharge Support

Existing **Budget 2017-18: £2.66m** **Budget 2018-19: £2.66m**

Scheme Description:

- Our Home First Pilot recognised the benefit of an integrated team of social workers, hospital discharge staff and domiciliary care staff working on the discharge of patients with ongoing care needs. An integrated discharge team is now established across all 3 acute trusts in Wiltshire.
- The integrated discharge teams are supported by our single number access to care service which facilitates the provision of the ongoing support or care needs.
- For self funders we also offer a service through the Care Home Select organisation to support facilitate the finding of both Care at Home or a Placement.
- Telecare support to maintain people independently at home

Outcomes 2017-18: 80 cases per month
Outcomes 2018-19: 80 cases per month (to be reviewed following project evaluation)

Healthwatch Service User Engagement

Existing Budget 2017-18: £0.1m Budget 2018-19 tbc

Healthwatch have been commissioned in 2017/18 to undertake engagement with Wiltshire population related to projects held within the BCF, these are:

- **Information for the public** – evaluate the current provision of information for the 5 most prevalent LTC in Wiltshire as identified in 2016 Joint Strategic Needs Assessment (JSNA)
- **Sound Doctor** available via Your Care Your Support Wiltshire, evaluate the set of patient information videos for those with LTC, unpaid carers and sub set of health and care professionals, (slide 51)
- **Home First** transferring patients out of a setting once medically fit, to their own home, in a timely fashion over 65yrs and rehabilitation workers who provide additional capacity to facilitate early discharge. To evaluate the effectiveness of these initiatives and improvement opportunities from the point of view of the patient, relatives, staff and stakeholders
- **Higher Intensity Care team** to capture from patients, unpaid carers and staff experiences of the service and potential future developments,
- **Choice Policy** to evaluate discharge by capturing patients and staff experiences of preparing for hospital discharge
- **SFT Fracture femur**, early supported discharge service, facilitate a focus group and collate responses into a report to inform the BCP learning and future projects
- **Single View** to gather views to inform the development, evaluate the impact of the pilot

Disabled Facilities Grant

Existing **Budget 2017-18: £2.79m** **Budget 2018-19: £3.03m**

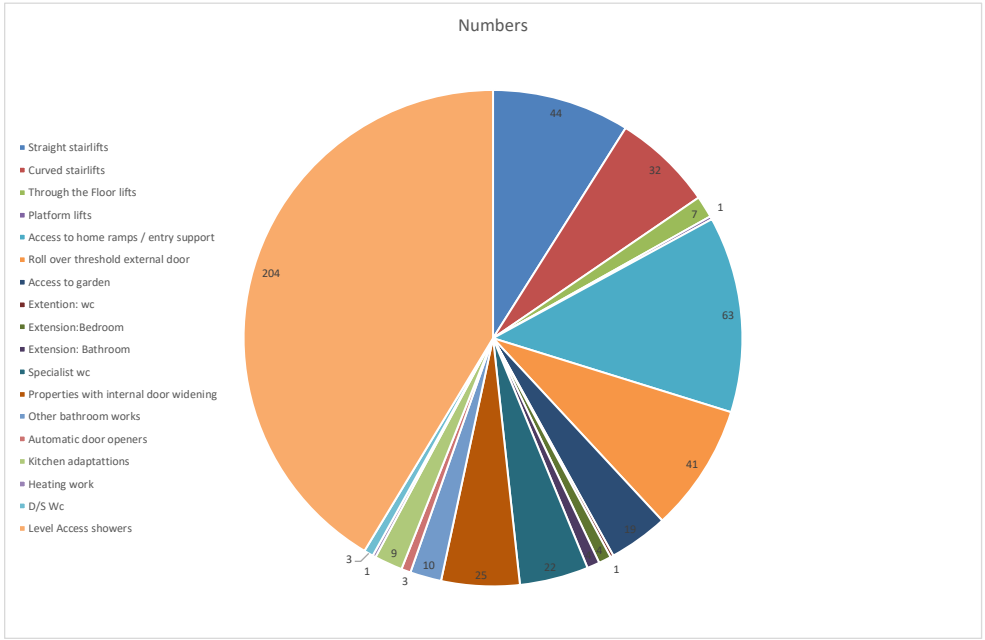
Scheme Description:

The Council proactively worked with the CCG to ensure a whole systems approach to prevention and reablement, and as such volunteered the inclusion of the Disabled facilities Grant (DFG) into the BCF pool ahead of the transfer by DCLG. The purpose being to recognise that by seeking to increase people staying living in their own homes and avoiding longer residential or other support costs, we need to ensure those residents are able to live in their homes. As such the DFG allocation is for aids and adaptations to homes for this purpose. The Council has topped up the Government allocation every year for the last 7 years as part of this commitment and strategy.

Further detail can be provided on the top up per annum on request and is reported to the Council's Cabinet as part of the capital programme.

Disabled Facilities Grant 1/3

The detailed plan for spend is fluid as it is based on need, and that can vary month to month depending on the case load and professional assessment of need to re-enable clients to maintain a health and high quality of life in their own homes. The following slide notes the process and governance around award and monitoring of the fund. The following is a breakdown of the types of equipment provided 2016/17, this is not untypical:

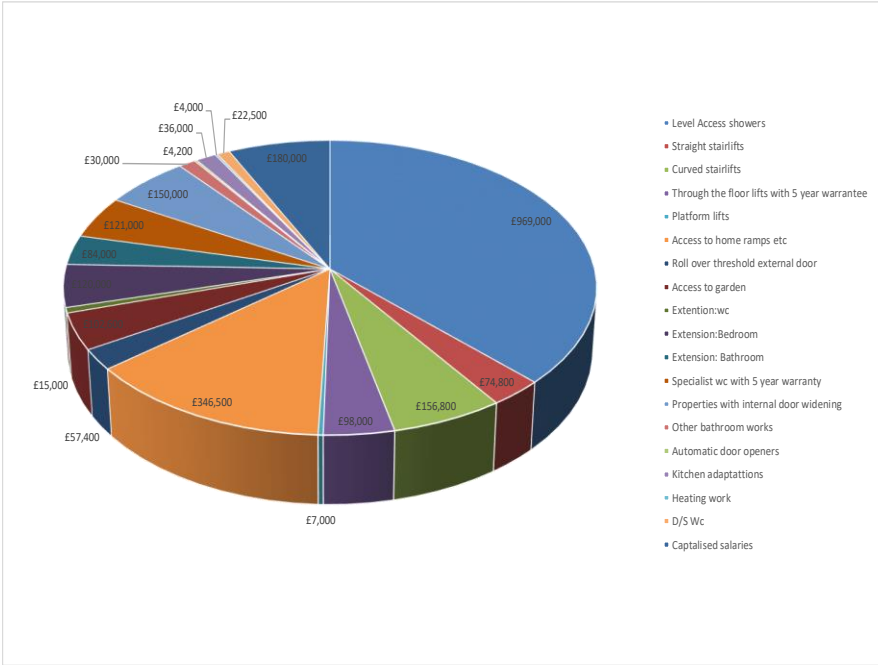


Type of adaption	Numbers
Straight stairlifts	44
Curved stairlifts	32
Through the Floor lifts	7
Platform lifts	1
Access to home ramps / entry support	63
Roll over threshold external door	41
Access to garden	19
Extention: wc	1
Extension:Bedroom	4
Extension: Bathroom	4
Specialist wc	22
Properties with internal door widening	25
Other bathroom works	10
Automatic door openers	3
Kitchen adaptattions	9
Heating work	1
D/S Wc	3
Level Access showers	204

Disabled Facilities Grant 2/3

The full DFG grant that is included within the BCF Pool was spent in 2016/17, and continues to be in 2017/18, on DFG items only supporting reablement

Type of DFG spend	Total (£)
Level Access showers	£969,000
Straight stairlifts	£74,800
Curved stairlifts	£156,800
Through the floor lifts with 5 year wa	£98,000
Platform lifts	£7,000
Access to home ramps etc	£346,500
Roll over threshold external door	£57,400
Access to garden	£102,600
Extention:wc	£15,000
Extension:Bedroom	£120,000
Extension: Bathroom	£84,000
Specialist wc with 5 year warranty	£121,000
Properties with internal door wideni	£150,000
Other bathroom works	£30,000
Automatic door openers	£4,200
Kitchen adaptattions	£36,000
Heating work	£4,000
D/S Wc	£22,500
Captalised salaries	£180,000
Total	**2,578,800**



Disabled Facilities Grant 3/3

Disabled Facilities Grants are provided to enable disable household members to access essential facilities in their home. For example, but not exclusively, they include work to provide access to their home and from their home into the community, adaptation for the purpose of bathing and toileting, provision to provide access to a room for sleeping, for preparing a meal and access to the garden. The provision of such facilities allow the disabled person to live and function in their home creating increasing their independence and personal well being allowing them to remain in living at home. In turn the impact on family members who provide caring roles is eased as is the input required by the local authority to provide a person centred care package. Safe access in and around the home and to facilities also reduces the risk of falls.

A typical customer journey would involve an assessment by an Occupational Therapist who will make a referral to housing outlining the person's needs. On that day following a provisional financial assessment by Housing and agreement of the disabled person the details are sent to an agent usually the Local Home Improvement Agency who help put together a specification, monitor the work and put together an application. Housing staff work closely with the Agent and the Occupational Therapist to ensure the work specified meets the needs and that a successful application made, with a focus on reablement. The authority to agree individual DFG applications sits with the Private Sector Housing Manager under the scheme of delegation. There is a limit to the DFG funding so each application of £30,000 and the majority are far less than this. There are statutory eligibility criteria for DFGs and they are a mandatory grant so if an applicant meets the statutory criteria as assessed by an OT it is our duty to agree the award of a grant to enable the applicant to procure the adaptation. Also attached is the detailed criteria which is lifted from the legislation http://www.legislation.gov.uk/ukpga/1996/53/part/I/chapter/I/crossheading/disabled-facilities-grants para 23.

The process is monitored closely to ensure that works progresses in a timely fashion. The budget, spend and potential spend is monitored closely by the budget holder in consultation with social care re upcoming need / accruals. This is reported to the Cabinet through the Capital Programme, as well as the HWBB and JCB through the BCF plan monitoring. Any over commitment is subject to budget monitoring and decision making based again on need.

BCF Management and administration 2017/18

Existing **Budget 2017-18: £0.32m** **Budget 2018-19 £0.32m**

The Council and CCG recognise that there is a need to administer the BCF and iBCF to be able to both monitor, evaluate and service the various returns. As such this budget and spend reflects dedicated resources to administer this grant effectively. This is less than 1% of the overall BCF/iBCF, but the CCG and Council continue to review these costs and has taken action to manage these costs down slightly going forward.

Section 6: New Projects

Home First/Rehab Support Workers

New for 2017-18. **Budget 2017-18: £1.2m** **Budget 2018-19: TBA**

Scheme Description:

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

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

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

The success of the scheme will be evaluated during 2017-18 and if successful funding will be continued into 2018-19.

Outcomes 2017-18: to support additional 21 discharges per week

Outcomes 2018-19: TBA to ensure alignment with new reablement service 2018/19

Integrated Equipment Services

New for 2017-18. **Budget 2017-18: £5.10m** **Budget 2018-19: £5.10m**

Scheme Description:

Wiltshire Council currently spends around £1.8m and NHS Wiltshire CCG spends around £3.3m on providing equipment in the community. The community equipment budget is currently operated as an aligned budget outside of the BCF but is incorporated within the current Joint Business Arrangement between the council and the CCG.

Outcomes 2017-18: Based on need
Outcomes 2018-19: Based on need

Adult Social Care Transformation 1/2

New for 2017-18. **Budget 2017-18: £5.81m** **Budget 2018-19: £7.21m**

Scheme Description: In Wiltshire, the Council, CCG and all NHS providers agreed to utilise the non-recurring iBCF to transform adult social care to deliver a sustainable service model to effectively meet current and future demand. This builds upon the lesson learnt to develop and enhance our focus to deliver the key priorities within the BCF objectives

The programme is focused on:

- Developing a model of prevention
- Developing a reablement service that complements Home First
- Increasing capacity in the domiciliary care market
- Reviewing the residential and nursing care home capacity
- Redesigned customer journey

The funding also has to strike the balance between transforming asap and providing market stability and capacity whilst the change occurs, as such the next slide sets out some of this impact in more detail as a breakdown of spend by catergory:

The Wiltshire Adult Social Care Transformation Programme will deliver against five key objectives

1. To manage demand more effectively, including investing in prevention, and be financially sustainable
2. To ensure all services are structured efficiently and effectively across the whole system to improve flow and access to the right care at the right time in the right place.
3. To ensure Wiltshire has a robust and effective workforce to meet the needs of our customers now and into the future.
4. To work more efficiently and effectively with our partners utilising integrated systems and technology
5. To ensure value for money

Outcomes 2017-18: outlined in the business cases (commercial sensitive) appendix x

Outcomes 2018-19: TBA

IBCF

The additional funding in Wiltshire (£5.8m 2017/18) has been specifically allocated as follows:

	Type of work funded	£m
A	**Sustainable Transformation:** Project team to support the transformation to recognise the need to provide capacity, capability and drive to push forward transformation and maintain focus on delivery and analysis of KPIs	0.409
B	**Providing stability and extra capacity in the local care systems:** Wiltshire has allocated iBCF to maintain social services in a period of transition by providing market stability to enable the council to provide stability and extra capacity in local care systems. This need has arisen due to the ongoing pressures on providers to maintain financial viable services. In 2017/18 the Council has had an additional increase of £1m above its projected costs arising from letting of new contracts for care for additional demand and increased complex reassessments. To not have let or moved to spot purchase would have destabilised the market further. We have also faced a £840k pressure from the stability of the market arising from cessation of three Learning Disability Providers in the last 3 months. In addition, there is a pressure of £350k within this on intermediate care within the BCF that will be covered within this amount. This is a critical factor in the need to change the current market and transform. This is thus different from business as usual and is clearly ensuring a stable market, and takes account of local pressures which if not addressed would have reduced the market capacity and would have had an adverse impact on DTOCs.	2.200
C	**Improving Reablement:** Wiltshire has allocated iBCF to deliver its Vision to create a reablement service and front door, which will impact positively on DTOCs. Detailed business cases for the transformation and a more detailed breakdown of this spend are available on request, but are commercially sensitive.	2.352
D	**Immediate interventions:** Wiltshire has recruited additional capacity to support targetted development where the greatest focus on immediate action to address DTOCs is needed, including more intermediate care beds and reablement domicilary care capacity. Hospital based OT to faciltate discharge	0.847
	Total	**5.808**

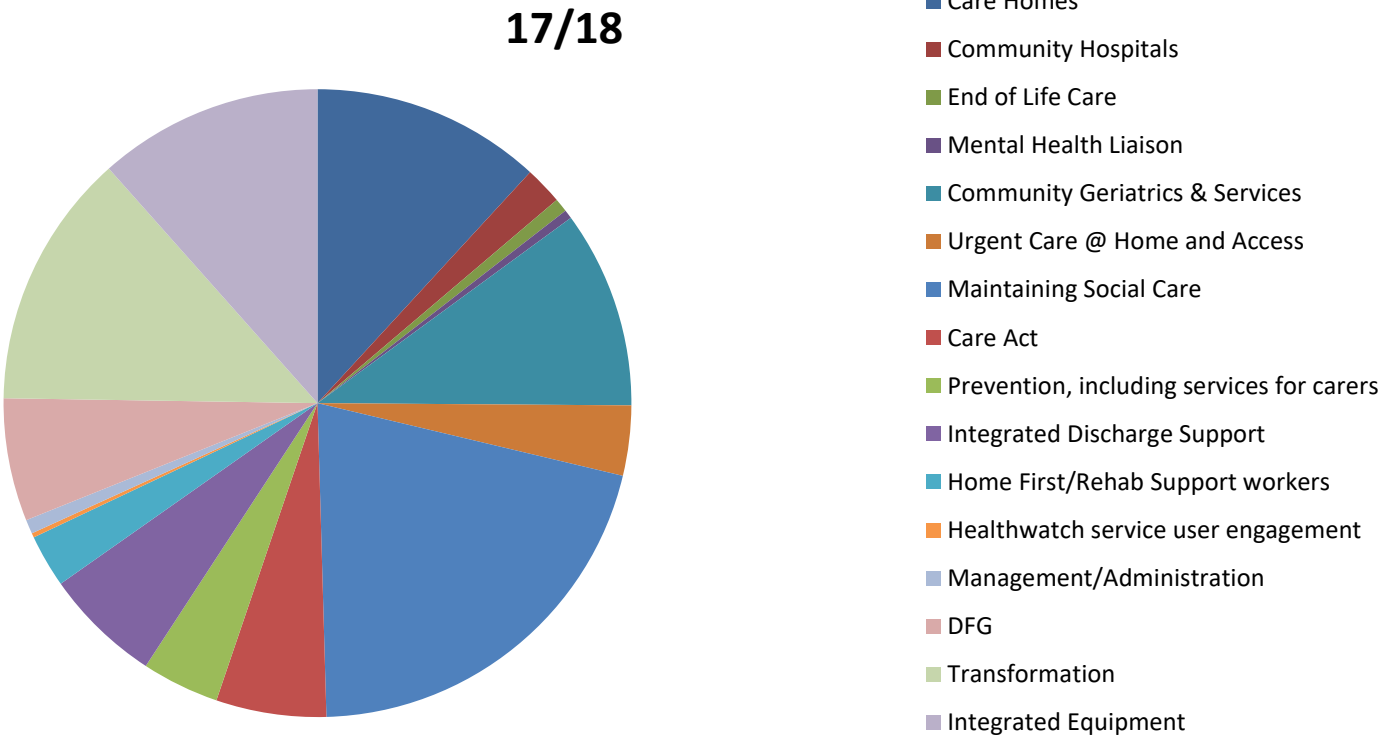
Reablement Outcomes

- Nationally modelled reablement impact assumptions to current activity and average hours of service for Adult Social Care in Wiltshire upon demand and capacity pressures as shown below. It is anticipated that the creation of a directly provided reablement function that is aligned to Home First rehabilitation will have the single most significant investment impact to ameliorate flow pressures within the Wiltshire Health and Social Care economy.

- New customers into the system will go through a reablement phase and 60% will exit without the need for further ongoing services. The remaining 40% will have a reduced level of service moving from an average of 13 hours to 11 hours per week expressed as a service cost equivalent across the system.
- 15% of existing customers who have reablement potential will be put through a period of reablement giving a reduced need to the 11 hours average described above.
- 15% will be diverted customers who would otherwise have gone into residential care and will follow the new reablement pathway
- 20% will be diverted customers who would otherwise have gone into intermediate care and will follow the new reablement pathway outcomes

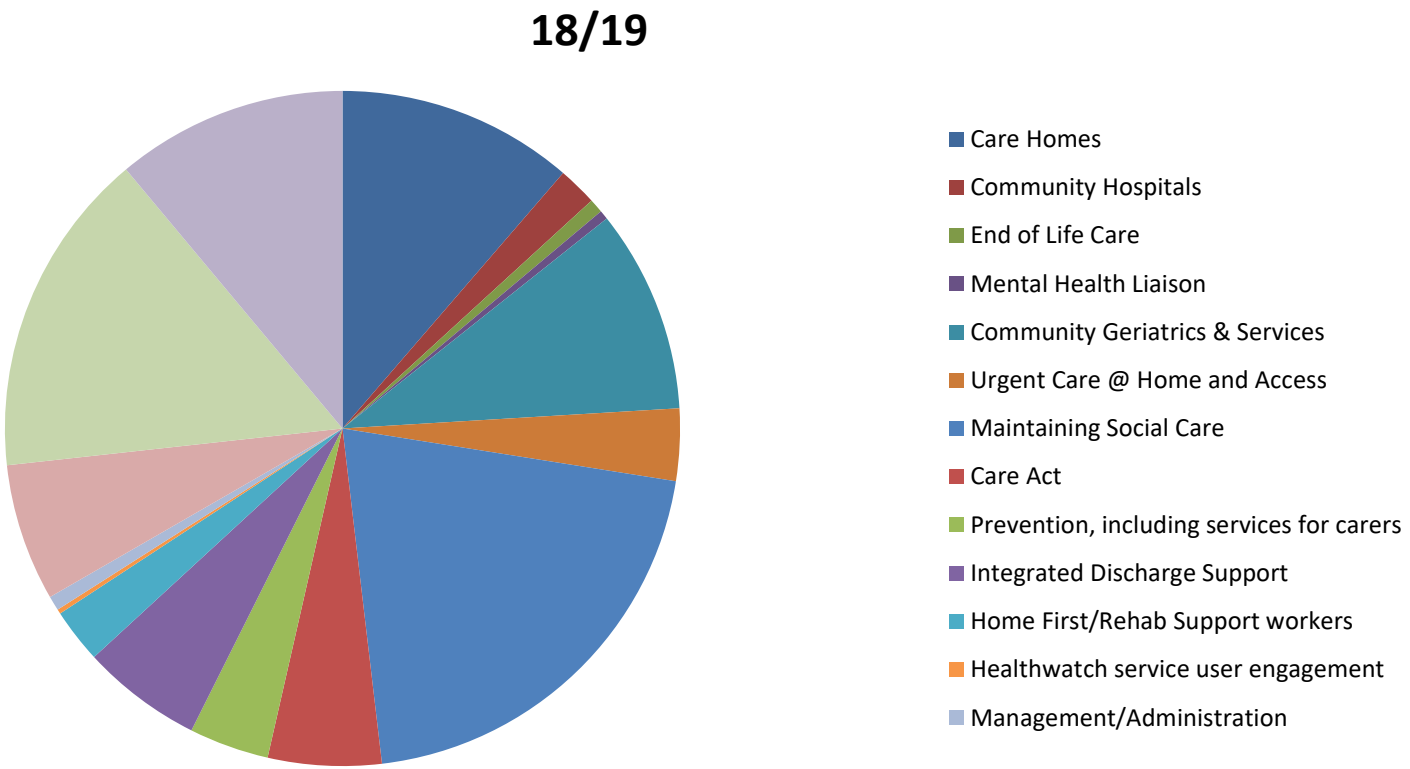
Overview of Better Care Budget Spend by Scheme Type (2017-18)

The funding contributions for the BCF, including agreement on identification of funds to be finalised in the Section 75 2017-19 and defined in the finance template.
The summary overview is set out below.
Funding levels for 2017/18 for existing schemes, to enable stability in ongoing schemes and to maximise the fund for new integration and transformation schemes in 2017/18 and beyond.



Overview of Better Care Budget Spend by Scheme Type (2018-19

The funding contributions for the BCF as set out in the finance template . The summary overview is set out below.



Section 7: National conditions supporting evidence

National Condition 1 – Jointly Agreed Plan

National Conditions For The Better Care Fund 2017-18	Does your BCF plan for 2017-18 set out a clear plan to meet this condition?	Issues and/or actions that are being taken to meet the condition, or any other relevant information.
1) Plans to be jointly agreed	Has the area produced a plan that all parties sign up to, that providers have been involved in, and is agreed by the health and well being board?	The Health & Wellbeing Board met in May 2017 and agreed the budget and commissioning intentions for the Better Care Fund for 2017-18. The board also agreed to delegated authority to the Chair and Vice Chair of the Health & Wellbeing Board (HWB) to approve any required submission if it was unable to bring this to a full meeting of the Board. The HWB Board meeting held on the 19th September 2017, ratified the submission in accordance with the delegated powers, the subsequent submission on the 11 October 2017 has been signed off within our formal delegated powers. The local Joint Commissioning Board, which includes representation from the Council, CCG and Providers has reviewed and approved the plan and targets. In addition the DTOC trajectory has been reviewed, approved and monitored by the 3 A&E delivery boards which cover the main providers for the Wiltshire population.
	In all areas, is there a plan for DFG spending? And, in two tier areas, has the DFG funding been passed down by the county to the districts (in full, unless jointly agreed to do otherwise)?	The DFG monies funds adaptations to a disabled persons property that are both necessary and appropriate for the needs of the disabled person and reasonable and practicable in relation to the property to remain independent in their own homes. See slide 47. Spending is aligned to the Health & Wellbeing Board and Better Care Fund objectives.

National Condition 2 – Maintain ASC

National Conditions For The Better Care Fund 2017-18	Does your BCF plan for 2017-18 set out a clear plan to meet this condition?	Issues and/or actions that are being taken to meet the condition, or any other relevant information.
2) Maintain provision of social care services (not spending)	Does the planned spend on Social Care from the BCF CCG minimum allocation confirm an increase in line with inflation* from their 16/17 baseline for 17/18 and 18/19	The Council has recognised that it needs to transform its Adult Social Care services to ensure a more responsive service that maximises independence. The integration agenda will impact on how all services are delivered in the future and there is a need to ensure that Adult Social Care is fit for purpose and able to respond to the opportunities for integration. There are challenges in respect of domiciliary care which impact on safe and timely discharges from hospital. There is limited capacity currently in the market, impacting on DTOC rates and requiring spot purchasing to increase capacity in accordance with demand. HTLAH provides a very limited reablement service in its current form however there is scope to further enhance the models of care to manage demand and promote independence in 2018/19. The effectiveness of Home First is dependent on capacity within the domiciliary care market, without this flow Home First will be unable to deliver the agreed outcomes. The Council and health partners recognise a short-term pragmatic spend to respond to crisis whilst a robust sustainable model is being established. In summary the additional funding for adult social care provides an opportunity to develop and implement a transformation plan for the adult social care service; invest in development of reablement services in the county and further develop the domiciliary care market to ensure adequate capacity in the market to enable people to maximise their independence and remain at home. This work will help to improve the flow from the acute providers and throughout the whole system.

National Condition 2 – Maintain ASC

National Conditions For The Better Care Fund 2017-18	Does your BCF plan for 2017-18 set out a clear plan to meet this condition?	Issues and/or actions that are being taken to meet the condition, or any other relevant information.
2) Maintain provision of social care services (not spending)	Does the planned spend on Social Care from the BCF CCG minimum allocation confirm an increase in line with inflation* from their 16/17 baseline for 17/18 and 18/19	The analysis shows that we are committed and have approved the year on year increase which meets the minimum requirement condition as set out in our quarterly submissions.

National Conditions 3 – NHS Out of Hospital

National Conditions For The Better Care Fund 2017-18	Does your BCF plan for 2017- 18 set out a clear plan to meet this condition?	Issues and/or actions that are being taken to meet the condition, or any other relevant information.
3 : NHS commissioned Out of Hospital Services (Policy Framework)	Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?	The key development for 2017-18 is the embed the Home First scheme across Wiltshire. It is proposed that expenditure and activity be reviewed during the financial year 2017-18 to establish whether the scheme is delivering the required outcomes in support of the overall better care plan. The Home First Scheme is lead by Wiltshire Health and Care (WHC) providing Rehabilitation Support Workers (RSW) employed directly as part of the Core Community Teams. This should be seen as part of the wider initiatives to enable discharge to assess, maintain independence and enable our over 65years residences to return to their home and be supported in the community. **Evidence base:** The Home First model has a strong evidence base and builds on the benefits of the Homefirst initiative trialled in 2015-16 which demonstrated a number of benefits in particular: • The importance of an integrated discharge approach • That discharging a patient home as soon as medically fit and rehabilitating the patient in their own home. • That prescribed care needs are often reduced on discharge and a patient transitions towards full independence or a marked reduction in care needs sooner **New model:** The RSWs will be trained to meet agreed therapy and domiciliary care needs of patients discharged from hospital as soon as they are medically fit. There is an opportunity for this 'intermediate care at home' immediately following an early discharge to be provided for a limited period of time by additional rehab/care staff. This additional capacity will work with OTs and community physios to assess the needs of the patients in their homes and provide early intense rehab and domiciliary care. This removes the need to assess in the hospital and allows a speedier discharge to a home setting into the care of clinicians who are more used to coping and managing patients with complex care needs. A number of options on how this can additional capacity can be provided are reviewed below. In 2017-18 we have tender for an Integrated Urgent Care Service which will bring together our out of hospital urgent care services under one umbrella to ensure we can maximise A&E attendance avoidance. The ASC Transformation programme established in Wiltshire Council will maximise and strengthen the prevention opportunities across health

National Conditions 4 – Transfers of Care

National Conditions For The Better Care Fund 2016-17	Does your BCF plan for 2016-17 set out a clear plan to meet this condition?	Issues and/or actions that are being taken to meet the condition, or any other relevant information.
4. Implementation of the High Impact Change Model for Managing Transfers of Care	**Is there a plan for implementing the high impact change model for managing transfers of care?**	A key focus is to reduce delayed transfers of care back to the levels of 2015/16 in the first instance and then progress towards further improvements. Our commitment in December 2017 is to achieve 1,325 lost bed days, and sustain thereafter. Our key schemes in 2017-18 and 2019 focuses on early mobilisation, transfer and ensuring longer term independence. This is seen as a system wide approach to include prevention, admission avoidance using digital solution to enable care to be provided in community. The Wiltshire Home First programme enables patients to return home as soon as they are “medically stable” with enhanced domiciliary and health care in the patient’s own home. The model, expenditure and activity for 2017/18 financial year will be evaluated to ensure alignment with the planned reablement service in 2018-19 to strengthen delivery of an outcomes based service, learn to accelerate delivery of the out of hospital model in support of the overall better care plan. This will commitment the discharge earlier in the acute pathway (A&E and AMU assessment areas) and working with providers ensure internal tracking and monitoring of the estimated discharge date, improvement methodologies such as red and green actions are established alongside the safer buddle for discharge and the seven day clinical standards are met. The programmes that support this are acute trust liaison, urgent care at home and the rehab support workers programme. Wiltshire has established a patient Choice policy and has seen a reduction in choice related delays and has been adopted as an area of good practice by our neighbouring CCGs. The Choice Policy will be reviewed in 2018/19 to ensure it is being consistently applied and learning from the implementation is incorporated in the evaluation. IBCF is targeted at reducing demand thereby improving flow and increasing capacity in the domiciliary care market place.

Reducing Delayed Transfers of Care High Impact Changes Appendix 2

The need to adopt new approaches to meet the new national performance targets (submitted on 21 July 2017) is recognised however Wiltshire trajectory proposes Dec 2017 (lost bed days of 1325). A forward action plan is being developed collaboratively using 'High Impact change Model'.

The DTOC plan is taken forward by the A&E Locality Boards encompassing the three hospitals, CCG's, Adult Social Care, Community providers and Mental Health provider. The overall responsibility for delivery of the plans remains with the STP (ACS) A&E delivery board.

Wiltshire assessment of the High Impact change Model for transfers of care as summarised in table 1

	Hi Impact Change 1	High Impact change2	High Impact change 3	High Impact change 4	High Impact change 5	High Impact change 6	High Impact change 7	High Impact change 8
	Early discharge Planning	Systems to Monitor Patient flow	Multi disciplinary/ agency discharge teams	Discharge to Assess	Seven day service	Trusted Assessor	Focus on choice	Enhancing health in care homes
Self assessment	Mature	Established	Established	Established	Plans in Place	Plans in Place	Plans in Place	Plans in Place

The following slides set out a summary of the current approach and high level actions for each pillar and embrace the integrated, whole system approach which is needed to deliver transformation and are not exclusively aligned to BCF funding streams or projects. Appendix 3: DTOC Milestone tracker

The outcome will be to improve the transfer of patients to the right place, with the right care and support without avoidable delays. Residents will stay for a shorter time in hospital once their necessary medical care is complete. Initial support needs are met and assessments are completed in a settled environment, ensuring people feel safe to live the life they want with support to manage their risks, build independence, health and wellbeing.

Previous National Conditions

The Better Care Fund in Wiltshire still recognises the importance of the conditions attached to earlier years of the Better Care Fund remains committed to plans which will help achieve those conditions.

Moving to 7 day services
We continue to work with NHS providers and the Council to providing a genuinely 7 day service. The Better Care Fund continues to pay for additional Social Work Capacity to ensure that delays in accessing the right service are minimised. The national ambition to implement the 4 clinical standards within the acute setting has been met by Salisbury FT in March 2017, Royal United Bath FT have a trajectory for achievement in March 2018 and Great Western FT by 2020.

Data Sharing
The Wiltshire Single View project remains active and continues to develop business cases for the sharing of information across the county. The project has a pilot operational within a number of GP practices which provides combined information on a client to help ensure a holistic view of the patients care needs. The programme is exploring implementing the project into hospital settings in 2018/19 to enable timely discharge

Joint Assessments:
We continue to work with all providers on the development of a trusted assessment. This is underpinned by joint training and working groups to build confidence in the system.

Section 8: Programme governance and assurance

Programme Governance (1/2)

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

The diagram shows the governance structure for the Better Care Fund in Wiltshire and the terms of reference are held in appendix 1 (slide 80)

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

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

Programme Governance: (2/2)

The **BCP Finance and Governance Group** is chaired by the Finance Director of the Council or CCG on an annually revolving basis. The group meets monthly and oversees the performance of the key work stream and the BCP budget and prioritise areas for decision by the Joint Commissioning Board, providing effective oversight and coordination. A Better Care report and the use of the pooled funds is taken to the Joint Commissioning Board, monthly.

Joint Commissioning Board: BCF dashboard demonstrating performance outcomes is taken monthly and includes they key performance outcomes for the Better Care Fund. (Appendix 7: BCF Dashboard)

Bi-monthly public reports on the delivery of Better Care are 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, shared visibility and accountability in relation to all aspects of the joint fund.

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

Public engagement: is at the heart of the JSNA and there is a commitment to action and ongoing evaluation across each of the key schemes and we will be moving the system to a daily review of core activity and performance indicators..

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

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

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

Wiltshire's approach to evaluation

Evaluation of the performance of BCF Schemes is regularly reported to the Health and Wellbeing Board, specifically to demonstrate the impact of the BCF in terms of admission avoidance and systems flow.

The Joint Commissioning Board considers business cases for new schemes and recommendations for continuation or conclusion of schemes. In addition, the Council's Health Select Committee have established a specific task group to scrutinise the impact of BCF schemes.

The impact of BCF schemes is measured in terms of the following:

- **Performance against Key Performance indicators and BCF metrics** . For example, the Urgent Care at Home Scheme is monitored through contract review for admission avoidance, hospital discharges supported, and average length of stay; the HomeFirst scheme has a comprehensive performance dashboard which measures success against the original business case and is reviewed by commissioners each month; a monthly intermediate care report sets out the effectiveness of intermediate care beds in terms of numbers of people supported, numbers of hospital discharges supported and admissions avoided, average length of stay and delayed transfers home.

- **Performance against outcome measures**. For example, Quarterly outcomes reports from the provider of services to unpaid carers indicating how services address the outcomes set out in the Joint Carers Strategy. These reports include a variety of metrics, and also carer stories and case studies.

- **Customer feedback**. For example, the BCF has funded Healthwatch to undertake impact reports on patient experience, including hospital discharge services; services for unpaid carers; Home First pilots.

- **Full independent evaluation reports for specific schemes**. For example, a recent evaluation of the Fracture Liaison Service funded from the BCF

- **Annual stocktake, gap analysis and evaluation** of each work streams to inform commissioning intentions and planning for following financial year.

Inequalities & Equalities Act

Wiltshire Council and NHS Wiltshire CCG are firmly committed to the principles of equality and inclusion in both employment and service provision. We are keen to celebrate the diversity of people who live and work in Wiltshire. This means making our services accessible to all, treating people fairly and providing a fully inclusive working environment. Wiltshire is a relatively affluent county with a lower than average representation of BME communities, that said there are pockets of deprivation across Wiltshire. In establishing the Better Care Fund schemes we used data from the local JSNA to ensure that the schemes and services provided are available to all regardless of where they live, there gender, ethnicity or sexual orientation. The aim of the health and wellbeing strategy is to reduce inequalities across Wiltshire.

The JSNA in Wiltshire provides benchmarking information for Wiltshire against the England, South West and our ONS Statistical Neighbours, this provides good data to help understand where outcomes are better and where we might usefully learn from others. In developing the Home First scheme we have visited other local authority areas both regionally and nationally to understand how there schemes work and what aspects would work in Wiltshire and what aspects might struggle.

Wiltshire Council is an active member of the South West ADASS and supports the benchmarking of adult social care performance on a quarterly basis. NHS Wiltshire CCG uses the services of the SCW CSU and Commercial organisations to help understand performance and capture best practice ideas from across the country and internationally.

Section 9: Assessment of risk/risk management

Assessment of Risk/Risk Management

A separate risk register is in the Appendix 4. The most significant risks for the BCP can be summarised as:

Leadership and culture change to deliver integration is assessed as a risk. **The Wiltshire Better Care Plan receives full support from the organisations' leadership teams, the cabinet member for Adult Social Care, the Health and Wellbeing Board and the JCB**. Current vacant posts (DASS and CAO) are held by experience and stable interim postholders. A new joint leadership structure has been agreed and a plan is in place to recruit a joint DASS/CAO. **To support new operational models culture change will be required for staff at all levels**, including leadership, across partners, providers and the voluntary sector to influence a change in culture long term. Performance management frameworks for providers and employees will be adopted, as well as clear communications to service users to help facilitate change.

Demand on the acute care system is the health and social care economies biggest risk to sustainability as emergency admissions continue to be over plan with growth being experienced at a higher level in the 0-64 age groups. **The Wiltshire Better Care Plan** can demonstrate positive impact in terms of reducing the volume of avoidable emergency admissions and managing the significant growth in the frail elderly cohort, however further progress is required to reduce demand and to reduce the increased levels of **delayed transfers of care.** A DTOC plan has been developed and particular actions are underway impacting on acute and community settings.

The impact of demand upon capacity and the impact on the workforce. Pressures on recruitment and retention of appropriately skilled and experienced staff. A key focus for 2017/18 is to increase care capacity across the system and Home First will be a key scheme in this regard alongside the council's development of a Reablement Service to manage demand and release capacity any additional actions that can be prioritised locally from the eight high impact changes self-assessment. We are **developing a revised joint workforce plan** across the whole system.

Financial allocations and the scale of financial pressures and savings required across the partnership will impact on the ability of partners to commit to new initiatives beyond the BCP, therefore it is critical that partners maintain delivery across the BCF plan metrics and national conditions as well as deliver a medium view of transformation for the next 2 years. **To achieve this even more rigour will be applied to benefits realisation with more sophisticated, integrated and co-produced methodologies for risk modelling and reducing impact.** In addition, unexpected CQC related issues requiring alternative care arrangements could result in a financial pressure within the BCF and are being proactively managed through robust contingency planning and the adoption of a fair pricing mechanism in the market.

Assessment of Risk/Risk Management (2) Appendix

Issues around Information Governance and the sharing of data is a risk which we are actively working on. This builds on the work on the **Single View of the Customer project** which has been ongoing in Wiltshire for a couple of years.
Risks to delivery are currently identified and discussed at the most appropriate level, initially this would be the BCF Finance and Governance Group meeting; where this meeting is able to manage or mitigate the risk it will or it will escalate to the Joint Commissioning Board. If the Joint Commissioning Board requires further advice or authority the matter will be referred to the Wiltshire Health & Wellbeing Board.

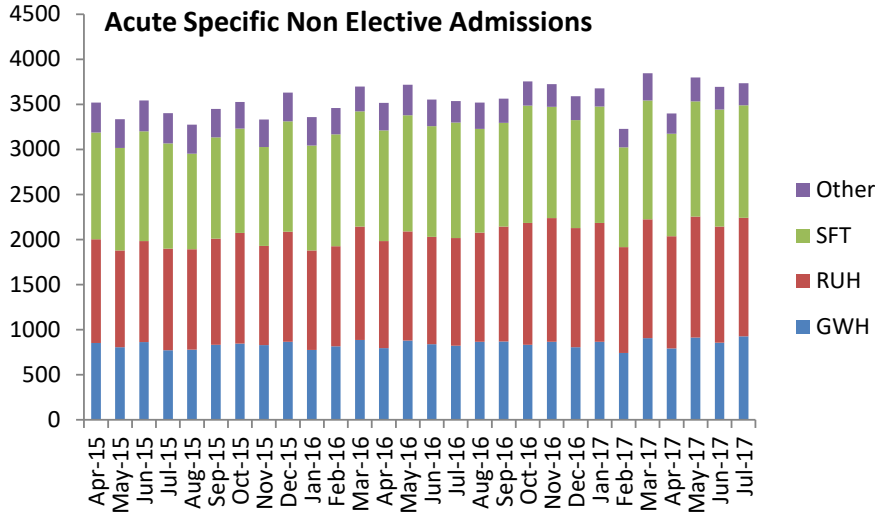
Going forward in 2017-18 the establishment of a integrated Programme Management Office (PMO) between the Council and CCG, is being explored. This office will then provide the understanding of project performance and associated risk and refer that to the relevant board for decision or management. In 2018-19 the integration of the PMO function will strengthen the governance going forward.

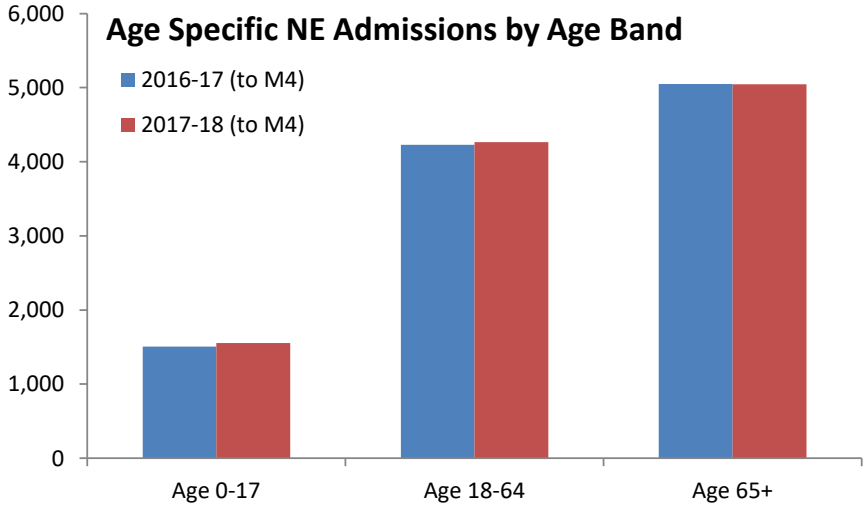
Building upon previous evaluations of schemes, a stocktake, gap analysis and evaluation of the Better Care schemes and Improved Better Care Schemes will be undertaken in 2017/18. Going forward the PMO will undertake a prince 2 function of the ongoing Better Care Fund and schemes. This will allow the Joint Commissioning Board and Health and Wellbeing Board to further evaluate the effectiveness of the scheme and approve changes to its scope and structure where this is felt appropriate. This team will be supported by Wiltshire Council, Public Health and Clinical Commissioning Group to ensure the reviews also look at the impact on inequalities.

Section 10: National metrics

National Metrics 1 – Emergency Admissions

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

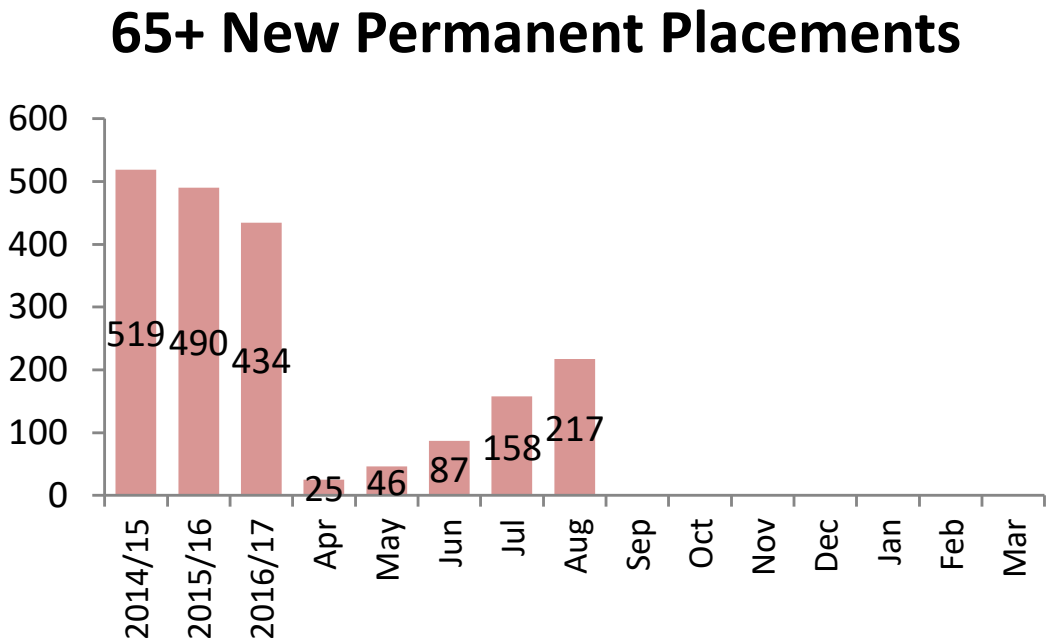




National metrics 2 – Care Home Admissions

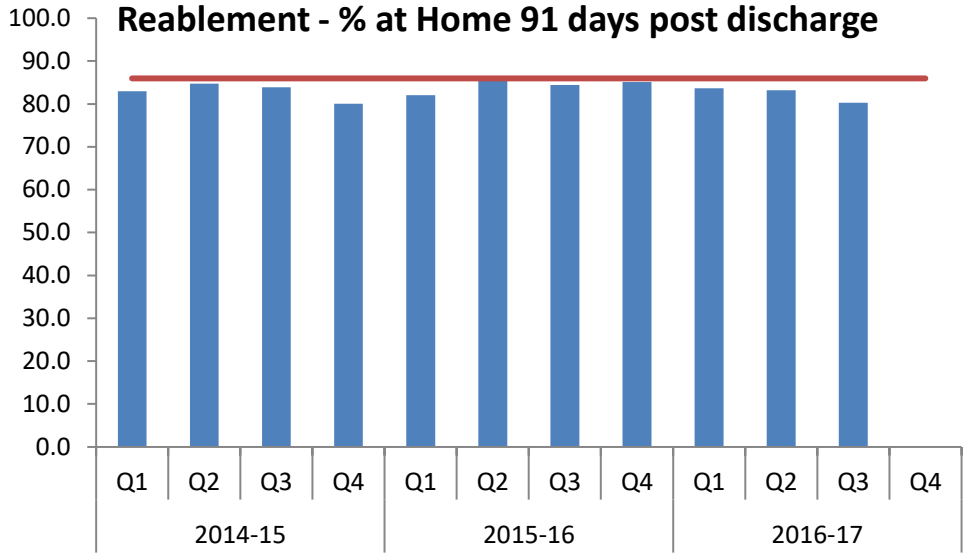
Historically in Wiltshire we have had a low rate of permanent admissions to care homes, meaning substantial reductions are unrealistic. Our target is to continue a trajectory of small reductions in this target. Our aim is to continue with small reductions in the numbers which result in a decreasing rate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

Target 2017-18 – 525
Target 2018-19 – 500



National metrics 3 – Reablement effectiveness

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



National metrics (4)

Indicator1 &2	2017/18 Target and Target Basis	Notes & Key Drivers
Delayed Transfers of Care *(Delayed transfers of care from hospital per 100,000 population.)*	***2017/18 trajectory proposes delivery of 1,325 lost bed days in December 2017.*** *The High Impact Change Model plan will underpin the delivery plan and the new service models in 2018 provide a framework for sustaining delivery* Wiltshire is committed to improving the performance of transfers of care for our residents.	Has the metric taken into account performance to date and current trajectory and are schemes in place to support the target? Yes, recognising the risk to sustaining performance due to new integrated services planned for 2018 Have all partners agreed a metric for planned reductions in delayed transfers of care across the geography of the BCF plan? Does the metric take account of the indicative reductions in DToCs published by the Department of Health? Yes Have clear metrics been set for reductions in NHS attributable delays, Social Care attributable delays and jointly attributable delays that reflect the indicative reductions? Yes Does the narrative set out the contribution that the BCF schemes will make to the metric including an analysis of previous performance and a realistic assessment of the impact of BCF initiatives in 2017/19 towards meeting the ambition set out in the local A&E improvement plan? Yes Have NHS and social care providers been involved in developing this plan? Yes **Appendix 1 DTOC plan and Appendix 2 High Impact Changes**

17/18 DToC plans 21 July submission to NHSE (1)

The Better Care Plan has over the last 3 years taken the lead for:

- Co-ordinating system actions in relation to managing delayed transfers of care
- Developing the system DTOC Action Plan and the associated capacity management plan for Wiltshire
- Chairing the system wide DTOC Steering Group
- Commissioning and funding all the key operational services and initiatives relevant to this agenda. For example the Better Care Plan funds intermediate care, help to live at home, access to care and invest in the protection of core social care services.

It should be recognised this approach is one which is well established across the Wiltshire system establishing processes to manage any increased demand across the system and ensure we maintain high quality patient care in times of system challenge as well as a range of other associated services and programmes.

For Wiltshire our approach will build on what is currently in place and maximise capacity appropriately for the right patients at the right time.

The focus is very much “business as usual“ with the aim that our approach continues to be embedded into the day to day practice of all staff across the system tor bring identifiable benefit to patients even when the system is under pressure.

The Wiltshire system is in a strong position to respond to NHS England requirement for the development of a Wiltshire DTOC plan as we have taken a system wide approach since 2014 in relation to the reduction of delayed transfers of care and non-elective length of stay. This commitment is clearly demonstrated in our commissioning intentions and the approach we are taking to flagship schemes such as integrated discharge (home first approaches). The completion of the High Impact Challenges summary has provided the foundation to undertake a refresh of the DTOC plan in 2017/2018 (Appendix 1) and will be supported by a DTOC Board under development.

17/18 DToC plans 21 July submission to NHSE (2)

	Jul-17	Aug-17	Sept-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Total Delayed Days	1749.4	1599.5	1449.6	1349.6	1274.6	1324.6	1324.6	1199.7	1199.7
NHS Delayed Days	1,079.2	977.3	872.8	808.5	759.2	794.2	794.2	702.9	702.9
ASC Delayed Days	552.8	510.0	466.0	431.7	406.9	421.4	421.4	388.9	388.9
Both Delayed Days	117.4	112.2	110.7	109.4	108.6	109.1	109.1	108.0	108.0

This presents the high level trajectory submitted in July 2017 for Delayed Days, under pinning this is a detailed breakdown by provider and responsibility. Further analysis on reasons for delay is also being undertaken to provide information to support providers and commissioners to work together to ensure effective management of delays across the system.

Wiltshire BCF Performance Review – Dashboard Appendix 7

For the last 3 years we have developed and evolved a dashboard which covers the national BCF indicators, underlying metrics, such as admissions to hospital from care homes, which underpin the overall performance and performance of the main BCF funded schemes, such as Urgent Care at Home and Intermediate Care Beds. The dashboard provides a summary picture as well as detailed trend analysis and provider breakdown to allow for detailed discussions about issues with outcomes and performance to be discussed.

The dashboard is reviewed monthly at our Joint Commissioning Board, The BCF Finance & Governance Group meeting and the CCG Governing Body meeting, which also includes a summary report on performance and its links to the CCG QIPP schemes. This provides an opportunity for the Council, CCG and partners to consider the performance of the schemes and if they are continuing to deliver the outcomes which are expected. For new schemes, such as the Home First Pilot in Salisbury and the Fracture Liaison Service at SFT full evaluations were undertaken and considered at the Joint Commissioning Board which then decides on ceasing or continuing funding.

Code	Indicator Name	Defn.	RAG	Change	Current Value	Current Period	Last Value	Last Period	Last Updated	Target Value	Target Period	Commentry	Comments	BCF Scheme Impact	Source
National Metrics - Better Care Fund															
BCF 4.1	Specific Acute Non Elective Admission	Number of Specific Acute NE Admissions		➡	11,181	Jul '17 - Sept '17 (Based on July - 17 & Aug-17)	10,616	Jul '16 - Sept '16	09-Oct-17	10,599	Apr-17 to Jun-17	Overall for 2016-17 the CCG saw a 4.0% (1,658 admissions) increase in emergency admissions (excluding Maternity admissions). In 2017-18 to M5 there has been an increase of 1.2% (212 admissions)	To M5, growth is being seen in ICT (6.7%), GWH is broadly similar (0.8%) while SFT has seen a reduction (1.2%) as have other out of area hospitals. To M5 Under 18s are down 2.6% (69 admission), Age 18 to 64 are up 3.5% (247 admissions) while Age 65+ are similar at +0.4% (34 admissions),. RUH has seen the biggest rise 6.7% (412 admissions), GWH have seen a smaller rise of 0.8% (36 admissions) while SFT has seen a reduction of 1.1% (65 admissions)		SUS - Acute Specific Admissions
		Rate per 100,000 population of Specific Acute NE admissions		➡	2,321	Jul '17 - Sept '17 (Based on July - 17)	2,204	Jul '16 - Sept '16	09-Oct-17	2,200	Apr-17 to Jun-17	The rate of admission is slightly higher than target, reflecting the bigger increase in admissions than expected.			SUS - Acute Specific Admissions
BCF 4.2	Permanent admissions to residential or nursing homes.	Number of permanent admissions to care homes		⬆	248	Aug-17	217	Aug-17	05-Oct-17	525	2017-18	There was a net increase of 31 permanent admissions to care homes in September which is a reduction on the last couple of months and close to the monthly average seen during 2016-17 of around 36 which was slightly lower than that seen in 2015-16 (43). A simple forecast for year end based on the first 6 months would be around 500 which is close to the 525 target. Provisional work on the data suggests up to 20% of the current picture could be wrongly coded, it is envisaged we will get an updated picture			SALT Tables
		Rate per 100,000 population of permanent admissions to care homes		⬆	500	2017-18 (Simple FOT)	525	2017-18 (Simple FOT)	05-Oct-17	529	2017-18				
BCF 4.3	Reablement	% of people discharged to rehabilitation who are still at home 91 days post discharge.		⬇	78.8	Jan '17 to Mar '17 Discharges	81.5	Oct '16 to Dec '16 Discharges	05-Oct-17	86%	2016-17	This represents all discharges supported by the Neighbourhood Teams, ISP Clients and IC bed patients discharged from hospital Jan to March 2017. This shows a further slight reduction in the percentage to last quarter and is under the BCF target. The number of deaths in all areas suggest this might not reflect those genuinely being offered reablement. Due to issues with obtaining the detailed data from the Community Health Teams the actual ASCOF submission will reflect just IC and	Q4 (Q3) NT - 80.3 (83.7) IC - 70.7 (66.1) ISP - 78.6 (65.0)		NT & Care First
BCF 4.4	Delayed transfers of care (Days)	Average number of delayed days in the month.		⬆	6,780	Jul-17 to Sept-17 (Based on Jul-17)	7,425	Apr-17 to Jun-17	14-Sep-17	4,800	Apr-17 to Jun-17	This is the latest data as published by NHS England, which showed 2,589 delayed days in July compared to 2,588 in June. The forecast for the quarter shows the total number of delayed days would be around 2,000 higher than the BCF target of 4,800. The main reason for people being delayed in hospital remains the capacity within the domiciliary care market. Wiltshire Council commissioners are actively looking at this. Wiltshire Health and Care have now recruited to majority of their Rehabilitation Support Worker Posts and are starting to implement the Home First Model.	In July SFT was under the target but all other Trusts were over the target.		NHS England
		Rate per 100,000 population of		⬆	19	Jul-17 to Sept-17 (Based on Jul-	21	Apr-17 to Jun-17	14-Sep-17	14	Apr-17 to Jun-17				NHS England

Highlights | Summary | NE Admns by Provider | BCF2 - Reablement by Provider | BCF3 - Overall DTOC by Provider | Detail DTOC by Provider

Wiltshire DTOC Plan 2017/18

NHS Wiltshire CCG and Wiltshire Council has substantial amounts of activity at 3 major Acute Trusts, Wiltshire support the A&E delivery boards at each of those trusts and develops specific support for each trust to maximise the opportunity to reduce delayed transfers of care.

At this time we are currently supporting (not exclusive list) the trusts in the following ways:

- Continuing to support Integrated Discharge Service
- Working with Help to Live at Home provider to secure additional packages of care
- Establishing Home First Model in Q3 2017 and moving into 2018
- 9 extra step down intermediate care beds to support patients no longer in need of acute care and awaiting care at home or placement.
- Additional Reablement Domiciliary Care Capacity for 9 months specifically to support the hard to isolated outlying areas which have always been a difficult area to provide adequate home care.
- Age UK Home from Hospital Service
- Additional private ambulance transport to support people getting home

This additional support over and above the business as usual and response to winter designed to ensure our focus remains on achievement of the DTOC trajectory while we await the system wide ASC transformation and establish the new reablement model in 2018-19.

Section 12: Appendices

Appendix 1: Delayed Transfers Plan
Appendix 2: High Impact Changes Assessment
Appendix 3: DTOC milestone tracker
Appendix 4: Risk Register
Appendix 5: Key documents and Hyperlinks
Appendix 6: Joint Commissioning Board ToR
Appendix 7: BCF Dashboard

Appendix 5: Key documents and links

Documents policies and journals accessed through the hyperlinks are set out below:

Slide Number	Narrative section	Hyperlink
Slide 3-14	Vision & priorities	• Health and Wellbeing Strategy (http://www.wiltshire.gov.uk/downloads/1621)
Slide 13	BSW STP	• http://www.bathandnortheastsomersetccg.nhs.uk/assets/uploads/2016/04/BSW-STP-Final-14-12-16.pdf
Slide 15-20	JSNA Demographics	• HWB JSNA (http://www.intelligencenetwork.org.uk/health/jsa-health-and-wellbeing/) • Community Area JSA () http://wiltshirejsa.org.uk/
	JSNA/ Population profile	• Wiltshire Health profile 2017 (http://fingertipsreports.phe.org.uk/health-profiles/2017/e06000054.pdf) • Wiltshire PHOF Aug 2017 (http://fingertipsreports.phe.org.uk/public-health-outcomes-framework/e06000054.pdf)
	Protecting Social Care Services	• https://www.gov.uk/government/publications/adult-personal-social-services-revenue-funding-2017-to-2018
Slide 55,56,&57	iBCF funding contributions	• https://www.gov.uk/government/publications/the-allocations-of-the-additional-funding-for-adult-social-care
	Health &Wellbeing ToR	• http://cms.wiltshire.gov.uk/mgCommitteeDetails.aspx?ID=1163
	Joint Commissioning Group	• Ratified 20 September 2017 (attached in body of submission)
	Integrated Performance and Governance Group (BCF)	• ToR to be provided -