NHS
Wiltshire
Clinical Commissioning Group

Wiltshire Council
Where everybody matters

29th August 2014

County Hall
Bythesea Road
Trowbridge
Wiltshire
BA14 8JN

**FAO: Anthony Kealey**
Sent by email

Dear Anthony

We are delighted to submit a revised Better Care Plan as a national Exemplar and see this as an excellent opportunity to show case the work we are undertaking in Wiltshire and sustain the momentum we are generating across the system . Please find attached the completed templates and we look forward to working with you to refine our approach as a national fastrack site.

We see the Better Care Fund as a driver for stimulating the integration of health and social care services and both the council and the CCG are investing additional resources in the Better Care Fund, starting in 2014-15. We have a range of ambitious targets and also see the Better Care Fund as enabling us to meet the challenges of increasing demands and expectations. We anticipate, for example, that the impact of the Care Act on the whole system will be on a scale of between £16.9m and £24.4m.

We are pleased to say that the whole health and social care economy in Wiltshire has been engaged in the development of the Better Care Plan and continue to be involved in its delivery. We now enter a key part or our implementation with the launch of our 100 day challenge, which we have articulated in our plan and is real opportunity to make positive change as an integrated health and social care system

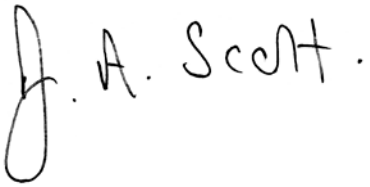
We understand the challenges ahead in delivering on the Better Care Plan and have embedded a robust governance structure. Acute and other health and social care providers are involved in each work stream of our Better Care Plan. We have developed a monitoring framework that will give us information about spend, return on investment and impact on performance and we are now moving this into a daily focus through our 100 day challenge. This approach has the full support our acute trust partners

As you will see from our plan, we intend to make the biggest impact in years one and two of the Better Care Plan, as the Council and CCG move to reduce average length of stay and non-elective admissions from a challenging baseline, the next stage will then be to sustain these improvements against the backdrop of increasing demand and even more challenging demographics, the impact of which is outlined in our submission.

Please be aware that the performance metrics in our plan have been completed to ensure the forward looking plans agree with our original submission. Therefore, the planned metrics for avoidable admissions has not been revised to reflect the change in baseline data mentioned in Section 5c of the guidance notes and we are amending further guidance from the department to enable us to address this. Please also note that the metrics for residential admissions have not been revised to reflect the new definition of ASCOF 2a (permanent admission) as published in the ASCOF handbook last week.

We look forward to working with you and your colleagues in future months in order to assure our delivery of better care for people in Wiltshire.

Yours sincerely



Jane Scott (OBE), Chair, Wiltshire Health and Wellbeing Board
Dr Steve Rowlands, Vice-chair, Wiltshire Health and Wellbeing Board

**Updated July 2014**

# Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

## 1) PLAN DETAILS

### a) Summary of Plan

| | |
|---|---|
| Local Authority | **Wiltshire** |
| | |
| Clinical Commissioning Groups | **Wiltshire** |
| | |
| Boundary Differences | **n/a** |
| | |
| Date agreed at Health and Well-Being Board: | |
| | |
| Date submitted: | **29/08/2014** |
| | |
| Minimum required value of BCF pooled budget: 2014/15 | **£11.58m** |
| 2015/16 | **£29.5m** |
| | |
| Total agreed value of pooled budget: 2014/15 | **£22.37m** |
| 2015/16 | **£31.91m** |

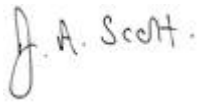
### b) Authorisation and signoff

| | | |
|---|---|---|
| **Signed on behalf of the Clinical Commissioning Group** | Wiltshire CCG | <Name of ccg> |

| | | |
|---|---|---|
| **By** | Dr Steve Rowlands | <Name of Signatory> |
| **Position** | Wiltshire CCG Chair | <Job Title> |
| **Date** | 29/08/2014 | <date> |

<Insert extra rows for additional CCGs as required>

**Signed on behalf of the Council** Wiltshire Council

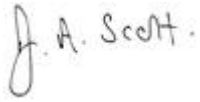


**By** Jane Scott OBE

**Position** Leader of the Council
**Date** 29/08/2014

<Insert extra rows for additional Councils as required>

**Signed on behalf of the Health and Wellbeing Board** Wiltshire Health and Wellbeing board



**By Chair of Health and Wellbeing Board** Jane Scott OBE
**Date** 29/08/2014

<Insert extra rows for additional Health and Wellbeing Boards as required>

**c) Related documentation**
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

| **Document or information title** | **Synopsis and links** |
|---|---|
| Joint Strategic Assessment (JSA) | A joint assessment of population needs, produced for different audiences, including a local community area information<br>http://www.intelligencenetwork.org.uk/joint-strategic-assessment/ |
| Joint Health and Wellbeing Strategy (JHWS)<br>Pioneer Application, June 2013 | Setting out the priority outcomes and actions for the year ahead<br>http://www.wiltshire.gov.uk/healthandsocialcare/jointhealthandwellbeingstrategy.htm |
| Wiltshire Council Business Plan | The Plan sets out priorities for the next four years, as follows:<br>• Protect those who are most vulnerable<br>• Boost the local economy<br>• Bring communities together to enable and support them to do more for themselves<br>http://www.wiltshire.gov.uk/council/howthecouncilworks/plansstrategiespolicies.htm |
| Wiltshire Clinical Commissioning | The Plan sets out priorities up to 2014-15. It will be updated |

| | |
|---|---|
| Group, The Right Healthcare for you, with you, near you (High Level Strategic Plan) | by the 5-Year Plan, developed alongside the Better Care Fund Plan<br>http://www.wiltshireccg.nhs.uk/publications/reports-and-strategies |
| Health and Social Care Integration Update Report | This update paper was presented to the CCG Governing Body and the Health and Wellbeing Board in November 2013, providing a summary of current initiatives to integrate health and social care commissioning and provision<br>http://www.wiltshireccg.nhs.uk/tuesday-26th-november-2013 |
| Joint submission for Local Vision: Systems Leadership programme | This document elaborates on our intention to improve urgent care, through the story of Gwen Wiltshire, a persona developed to illustrate the current and future system to reduce inappropriate hospital admissions |
| Community Campuses in Wiltshire | A series of documents describing the Council's proposals for innovative community campuses across the county. Campuses will help deliver services which are value for money, tailored to local need and influenced by local people and partners. They are a key opportunity for health and social care integration at a community-level.<br>http://www.wiltshire.gov.uk/communityandliving/communitycampuses.htm |
| Help to Live at Home Service: an outcomes approach to social care | This paper by Professor John Bolton of the Institute of Public Care, describes Wiltshire Council's approach to developing its Help to Live at Home Service for older people. The approach has focussed on the outcomes older people wish to gain from social care and involved an overhaul of care management and contracting within the Council.<br>http://ipc.brookes.ac.uk/publications/index.php?absid=691 |
| Wiltshire Dementia Strategy 2014-2021 | This is a joint strategy, currently out to consultation. The aim of the strategy is that all people with dementia in Wiltshire are treated as individuals and are able to access the right care and support, at the right time so that they can live well with dementia and can remain independent and living at home for as long as possible within supportive communities<br>http://cms.wiltshire.gov.uk/ieListDocuments.aspx?CId=141&MId=7216&Ver=4 |
| NHS Wiltshire CCG Five Year Plan and 2 Year Plan | Plans have been developed in parallel and complement the Better Care Fund Plan |

# 2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

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

We are clear about the challenges facing us and know that without a change in the health and care system there is a significant risk that service quality will decline

**Context**
Our Joint Strategic Needs Assessment provides us with the detailed information we need to inform our vision. Overall health and life expectancy in Wiltshire are well above the national average. People over 65 make up 20% of the county's population and will make up 22.5% of the County's population within the next 7 years and the number of older people is rising much faster than the overall population of the county. Older people are more likely to need health and care services and we know that nearly half of Wiltshire's NHS resources (47.4%) are consumed by people aged over 65. Much of this resource is needed for frail and vulnerable older people. Dementia in particular can affect people of any age, but is most common in older people. One in 14 people over 65 have a form of dementia and one in six people over 80 have a form of dementia.

The prevalence of dementia in Wiltshire is predicted to rise because of this ageing population. Oxford Brookes University and the Institute of Public Care (2013) estimate that there are approximately 6,538 people with dementia. It is predicted that this number will increase by 27.8% by 2020 – equating to an additional 1,800 people with dementia and will nearly double by 2030 to 11,878 people. It is also estimated that there will be an increase in those people with severe dementia from approximately 800 in 2012 to 1,600 in 2030.
Whilst increased life expectancy is a cause for celebration, the high rate in growth in the number of elderly people and people with dementia in Wiltshire is placing a burden on care budgets, creating financial pressures and capacity issues for health and social care.

Table 1 show that whilst the rate of growth of the total population is below the south west and national average, the rate of growth in the older population in Wiltshire exceeds the rate of growth in the rest of the south west, and exceeds the England Average.

TABLE 1 – RATE OF POPULATION GROWTH – WILTSHIRE COMPARISON

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

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

resources required. Table 2 illustrates that the biggest impact is of the increase in numbers of people aged 85 and over.

TABLE 2 – THE IMPACT OF POPULATION GROWTH ON RESOURCE REQUIREMENTS – ALL AGE GROUPS

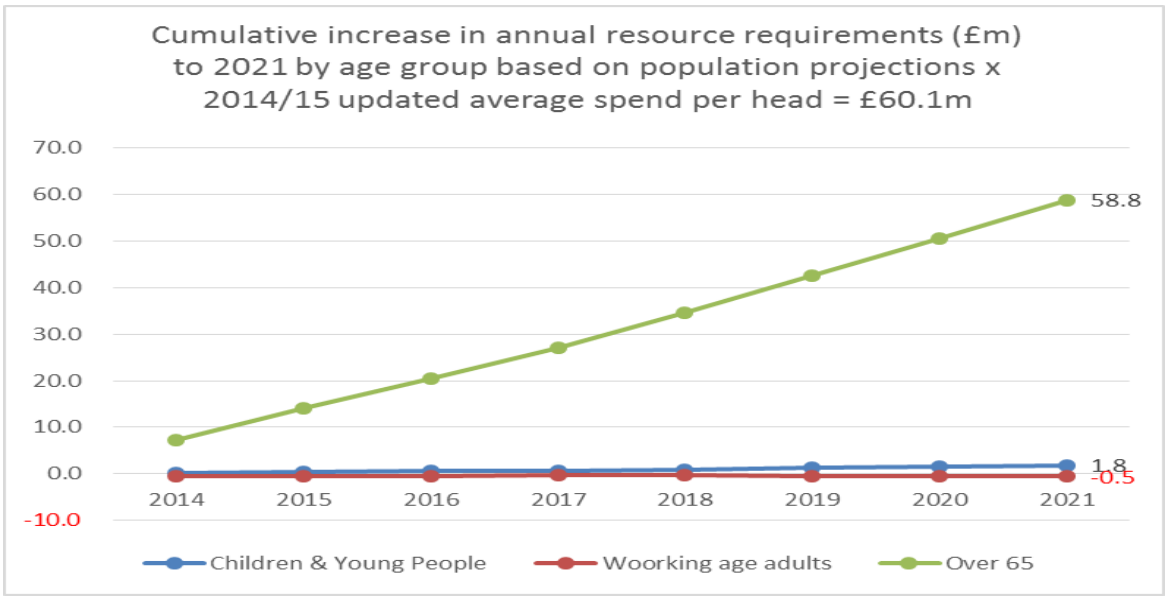
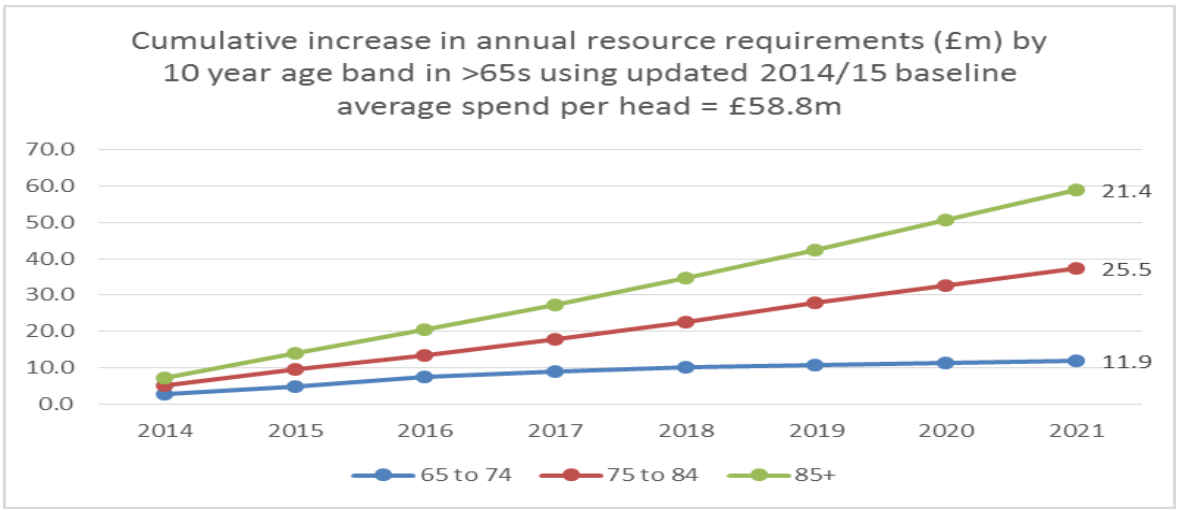



TABLE 3 – THE IMPACT OF POPULATION GROWTH ON RESOURCE REQUIREMENTS – OLDER PEOPLE




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

- Care and support is fragmented, so people experience gaps in care and patients are treated as a series of problems rather than as a person. Care and support plans do not link together, which is inefficient and frustrating for people on the receiving end of our services. People have to repeat their stories to different agencies and are not always kept informed. We are committed to integrating at the point of need and ensuring that the service user experiences no distinction between services when they receive the service they need.
- The health and care system gives a higher priority to treatment and repair rather than prevention or early intervention. Often, people are not eligible to receive services until

they reach a point of crisis, when a little support earlier may have avoided the crisis from developing. Through a more proactive risk stratification approach we are committed to identifying and managing those patients who could become high risk in the future without intervention and system wide case management being put in place now.

- Acute hospitals, specialist hospitals, including mental health hospitals, and emergency departments are under pressure, with unacceptably high levels of delayed transfers of care and extended lengths of stay in hospital. We have focused on the development of system wide action plans and schemes addressing the high number of delayed transfers of care.
- Too many people make a decision about their long-term care and support whilst they are in hospital, and this may result in frail elderly people being rushed into decisions and possibly an unnecessary admission to a residential or nursing home. From September we will be looking to roll out our ambitious " discharge to assess " programme across Wiltshire

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

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

**I will be supported to live healthily**
For example

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

**I will be listened to and involved**
For example

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

**I will be supported to live independently**
For example

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

**I will be kept safe from avoidable harm**
For example

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

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

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

Within the next 5 years, we expect that the plan will have the following impact, as seen from a patient and service user perspective:

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

**Our key metrics**

We are suggesting the following measures of success, and expect to test these with people who use services

- % of people who feel confident in their supporting community care team to help them to manage their condition when needed
- % of people with long-term condition who know how to contact/are in contact with others in the locality with the same condition (*peer support is a key element to effective self-management*)
- % of people with long-term condition admitted to hospital as non-electives for a reason directly related to their condition (*should be decreasing*)
- % of people who feel capable of managing their condition on a day-to-day basis (*feeling that you can actually cope*)
- % of people that have received help/support to adapt their home and/or have received specialist equipment (*should be increasing if more people are being supported to cope at home?)*
- % of people receiving home care
- Number of older people who are receiving support from carer support services
- No of carer assessments completed
- % of people over 75 who report being included and consulted in discussions about their own care
- % of positive responses to: Are you happy with the quality of your health and life?
- % of positive responses to: Do you feel that you have been treated with dignity?
- % of people living in their own accommodation who have daily contact with others both by leaving their own home or having friends and relatives visit them in their home (*should be increasing*)
- % of people who feel that they have had to repeat the same information to 3 or more people (*other than basic info to identify themselves*)
- % of people who feel that agencies are working in a disjointed or uncoordinated manner (*opposite of integrated care*)
- % of people who feel that they have been given advice that has been inconsistent or contradictory from different services
- % of people who do not feel safe and adequately supported

By April 2016, we expect to see some shift towards achieving all of these outcomes.

In addition to this, we would expect to see a significant reduction in the number of people whose discharge from acute care is delayed and an increase in the volume of patients who can have their condition managed in a community settings. This commitment is recognised by the health and social care community in Wiltshire and there is clear ambition through each workstream to deliver on this

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

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

- Care will be as **close to home** as possible, with home always as the first option
- We will shift our services from being paternalistic to ensuring that **services are designed for and with the people who use them.**
- We will focus **care around the person**, building from communities of approximately 20,000 people.
- We will join up care at a local level and will **work with communities** to integrate care around clusters of GP practices and other community settings
- We will ensure that **care is coordinated** for all older people, particularly to support those at risk of deterioration and hospital admission
- We will create a team around the person, with someone to coordinate care between all the professionals and agencies involved, so that the person at the receiving end feels in control.
- We will build on the Council's work with local communities on the development of **campuses** to incorporate health and care facilities
- We will support individuals and communities to take more **personal responsibility** for their own health and wellbeing
- We will ensure that **carers are supported** and that contingency plans are in place, to recognise when informal care arrangements may break down
- We will develop our **intermediate care services** so that more people can be supported to be independent and ensuring that patients can be " stepped up " to appropriate care in community settings when they reach crisis point.
- We will ensure people have access to the right support when they need it, even if this is **24/7**
- We will take a holistic approach, with locally accessible services to support **mental health needs**
- We will ensure that people with dementia can remain independent and living at home for as long as possible within **supportive communities.**

- People with **dementia** will be diagnosed early, so that the most appropriate treatment and support is provided to maintain independence for as long as is possible and to allow people and their carers to plan for the future

- We will continue to develop **outcomes-focussed commissioning**, based on the principles of our Help to Live at Home services

- We will reduce duplication of assessments and support plans, so that there are **shared assessments and support plans** owned by the individuals they support.

- We will **minimise delays**, with a focus on reducing high numbers of delayed transfers of care across the system.

- We will invest in the capacity and competency of the health and care **workforce**, so that people with complex needs can be supported safely in their communities.

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

> *"**there are no gaps in my care, and I don't need to worry about who is paying for my care, I contact one person and it's all sorted"***
>
> ***"I am always kept informed, and I always know who is in charge of my care and who to contact"***
>
> ***"I don't have to keep repeating myself to lots of different professionals"***
>
> *"**The people who support me provide a good quality of service"***
> ***"If things get worse, I have a plan to help me cope, to make sure I stay at home and don't go to hospital or to a care home"***
>
> ***"I know that services provide good value for money".***

**Our future health and care system model**
The diagram below shows how we expect that health and care services will wrap around the person to support them at the appropriate level. We want to personalise our interventions to the service user and the service practionner The diagram below outlines how our care model will be set up is made up of rings of support wrapped around the individual
**The extended primary Care team (Amber Ring- 20,000 population)**

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

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

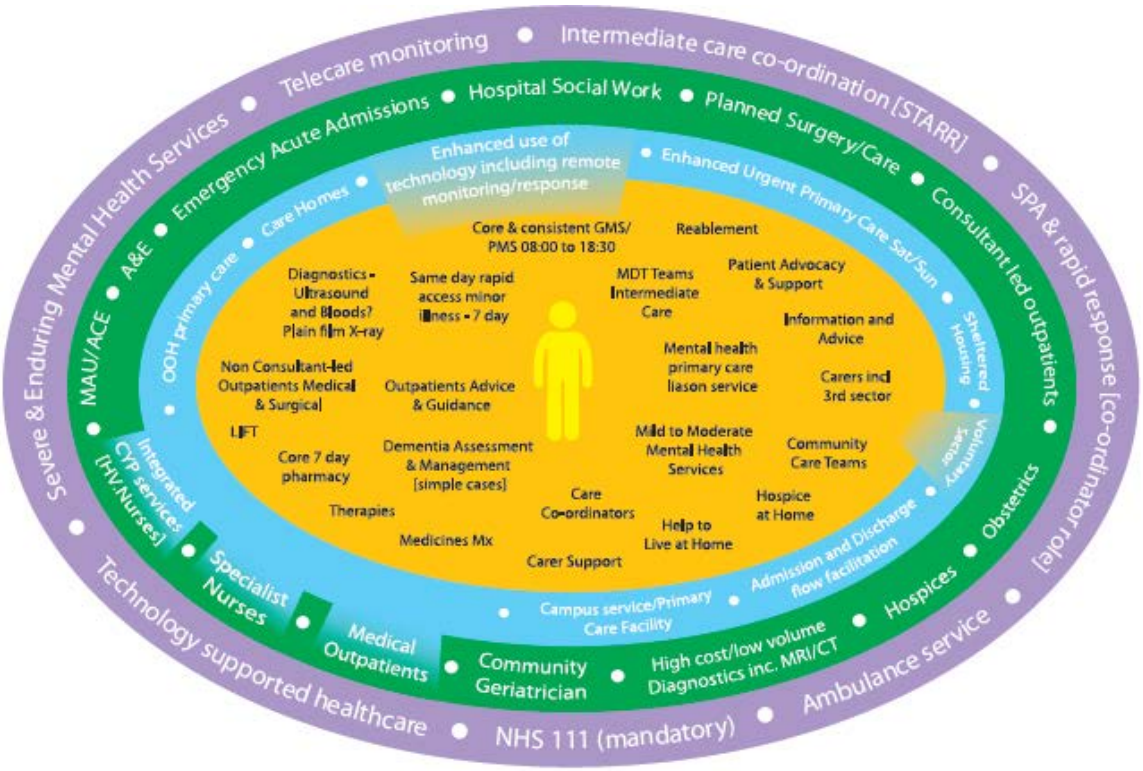
These services include those available in the community covering the 7 day period provided for a market town and may include out of hours access for minor injuries and ailments, services for nursing and care homes and frail elder people in their own homes, support for rapid admission and discharges to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

**Expected Service Provision for a Group Area (Green Ring-100,00 + population)**

These are more specialist services provided within a maximum travel time of 1 hour. These services would include obstetrics and accident and emergency units, ambulatory and medical assessment units and hospice services. There should also be access to most surgical and intervention services and complex diagnostics, specialist nursing and outpatients and outreach advice from consultants in elderly medicine, dementia and long term conditions.

**Services provided on whole Wiltshire scale (Lilac ring)**

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



# 3) CASE FOR CHANGE

**Please set out a clear, analytically driven understanding of how care can be improved by integration in your area**, explaining the risk stratification exercises you have undertaken as part of this.

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

- Joint commissioning
- Joint service delivery - Coordinated pathways of care and coordinated services
- Joined up governance
- Joined up processes and staff structures

**Joint commissioning**

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

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

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

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

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

**Joint service delivery**

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

| Our principle | Our objectives for integration | Our measures |
|---|---|---|
| **We will shift our services from being paternalistic to ensuring that services are designed for and with the people who use them.** | People will be involved in the redesign of integrated services | • Patients and service users will be involved in pathway reviews, service specifications and tendering. |
| **Care will be as close to home as possible, with home always as the first option**<br>**We will focus care around the person, building up from communities of approximately 20,000 people**<br>**We will join up care at a local level and will work with communities to integrate care around clusters of GP practices and other community settings** | We will create multi-disciplinary teams, wrapped around primary care clusters, providing integrated, accessible care in local communities. These teams will work across community health services, social care, mental health, voluntary sector, commissioned Help to Live at Home providers and other community resources such as sheltered housing. Services will match levels of needs in each community and existing inequalities in levels of service provision in some parts of the county will be levelled out. | • Emergency attendances and admissions to acute hospitals will not increase<br>• Long-term care home admissions will be reduced<br>• Activity levels of community health services will increase<br>• Patient and customer experiences of services will improve |
| **We will ensure that care is coordinated for all older people, particularly to support those at risk of deterioration and hospital admission.** | We will create a team around the person, with someone to coordinate care between all professionals and agencies involved, so that people at the receiving end feel in control. | • Emergency attendances and admissions to acute hospitals will not increase<br>• Every older person will have a named GP and a coordinated support plan<br>• It will be possible to share information between professionals so that care is more effective, more timely and more safe |
| **We will build on the council's work with local communities on the development of campuses** | Within the next 5 years, we will see an accessible location within each community bringing together services such as primary and community health with leisure, library and other council services and the voluntary sector. Facilities can be used imaginatively as a resource to promote health and wellbeing and provide treatment. | • Patient and customer experiences of services will improve. |
| **We will support individuals** | We will focus our investment in | • Reliance on urgent and |

| | | |
|---|---|---|
| **and communities to take more personal responsibility for their own health and wellbeing** | voluntary and community services, working towards a shift in investment towards more preventative services and more accessible information and advice to promote self-care and independence | crisis services will reduce.<br>• Patient and customer experiences of services will improve – people will feel more in control of their care |
| **We will ensure that carers are supported** | We will continue to use our carer's pooled budget to provide options for carers and we will plan for new responsibilities to carers under the Care and Support Bill. We will offer carers personal budgets to allow them more choice and control over their support | • Carers' experiences of services will improve |
| **More people will be supported to remain independent** | We will develop our intermediate care services to prevent hospital admission and provide a 'stepping stone' for people recovering from a hospital stay.<br>Intermediate care for people with mental health and dementia needs will be strengthened<br>We will seek to implement a system wide approach to Discharge to Assess | • Delayed transfers of care will be reduced<br>• Emergency attendances and admissions to acute hospitals will not increase<br>• Decisions about long term care will not be taken in hospital and admissions to long term care will be reduced<br>• Activity levels of community health services will increase |
| **We will ensure that people have access to the right support when they need it**. | People with complex health conditions, including dementia, often need support in the middle of the night or at weekends, and we believe community health and support services should be available 24/7 | • People will access new out-of-hours services and unnecessary admissions to acute hospitals will be avoided |
| **We will take a holistic approach, with locally accessible services to support mental health needs** | We will integrate mental health and dementia care into our local services and we will support communities to be dementia friendly.<br>We will seek to provide specialist care in community settings<br>We will improve the joint management of the patient s across acute and community care. | • Long-term care home admissions will be reduced for people with dementia<br>• People with mental health needs will not be delayed in hospital |
| **We will ensure that people with dementia can remain independent and living at home for as long as possible within supportive communities.** | | • A toolkit for dementia friendly communities will be available for Area Boards to use<br>• A Neighbourhood Return scheme will be trialled to support people with memory problems who |

| | | |
|---|---|---|
| | | go missing |
| **People with dementia will be diagnosed early, so that the most appropriate treatment and support is provided to maintain independence** | | • Diagnosis of dementia within primary care will increase |
| **We will continue to develop outcomes-focussed commissioning, based on our Help to Live at Home model of commissioning** | We will commission service providers, including care homes, to focus on outcomes for individuals, in order to give people the maximum independence and choice. | • Care providers will work to contracts with incentives to deliver the best outcomes for individuals<br>• This will reduce the reliance on both acute and community beds |
| **We will reduce duplication of assessments and support plans** | We will develop shared assessments and support plans, with appropriate information-sharing systems, and support plans owned by the individuals that they support.<br><br>We will develop our IT systems | • The number of people with their own single support plan will increase<br>• Patients and customers will say they are be better informed about services |
| **We will minimise delays, with a focus on reducing high numbers of delayed transfers of care across the system** | We will review processes for discharge from hospital to minimise delays.<br>The Improvement plan for DTOCs will be overseen by the Integration Director as part of the Better Care Programme<br><br>We will invest in capacity planning and in 'surge' capacity for community-based services so that our services can better cope when demand is greatest.<br>We will put in place system wide solutions such as the Discharge to Assess programme with home as the default once patient is medically stable<br><br>We will develop a culture of '7-day discharge' | • The number of delayed transfers of care will be reduced<br>• |
| **We will invest in the capacity and competency of the health and care workforce** | We will increase the capacity of the community-based workforce, and ensure they have the skills to support people with complex needs.<br>We will develop a skills academy approach to model | • The objectives of our workforce plan will be met, including increased competencies, improved recruitment and retention of care and support staff.<br>• The workforce will say |

| | | |
|---|---|---|
| | and address the supply challenge we are facing.<br>We are benefitting from a systems leadership review which will inform the type of skills, competencies and leadership model we seek to develop in the future. | they feel valued<br>• The domiciliary care workforce will have a structured career path and zero hour contracts will be minimised |

# 4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

## Investing in transformation

***During 2014-15***

- We will establish a joint integration programme team, using new capacity (a programme director who is now appointed) and existing resources from within the Council and the CCG. This team will lead the implementation of joint commissioning and joint delivery and ensure we achieve the objectives set out within this plan.
- We will undertake a systems review of the pathway of care for older people. This will tell us where different organisations invest and what outcomes are achieved. It will allow us to see a shift in investment from repair to preventative services that can make the biggest difference. This programme has now commenced and is entering the "Check stage "
- We will use the systems review to prioritise the areas for development in 2015-16 and beyond. The first area for development will be hospital discharge and a range of core initiatives have been identified and will be accelerated during 14/15
- The system review has the full support of each acute hospital
- In line with the system review we will be launching the " 100 day challenge " for Wiltshire where as a system there will be a joint commitment to prioritising the development of our " out of hospital model " , launching all key schemes and measuring through a daily dashboard the impact of each intervention. More detail of the 100 day challenge for Wiltshire is provided later in the document.

## Joint commissioning

***During 2014-15***

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

***During 2015-16***

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

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

***During 2014-15***

- We will commission an information and advice portal to support healthy lifestyles, independent living and self-care
- We will support informal carers in their caring role, listen to their views and realign the services funded through our Carers Pooled Budget. .
- We will review our existing investment in preventative services and maximise the opportunities for joint commissioning of voluntary and community sector services
- We are developing a joint risk stratification process across health and social care and will map demand so our commissioning priorities are aligned with greatest need

***During 2015-16***

- We will continue to invest in preventative services so that we can more intervene in a integrated way to prevent exacerbation of condition and patients becoming " high risk"

## Supporting care closer to home

***During 2014-15***

- We will review processes for hospital discharge so that people do not make a decision about their long-term care arrangements in an acute hospital. This will reduce delays in hospital. The flagship scheme in this respect will be Discharge to Assess which will be going live in September.
- We will implement our model of local multi-disciplinary team working, moving staff and services into local clusters. We will establish 3 demonstrator sites for integrated teams.
- We will realign investment in community health services to ensure we address inequity of provision across the county
- We will review the provision of bed-based care in the county, including the commissioning of care home beds. We will re-commission care home beds using an outcomes-based approach to ensure that all care takes a re-abling approach and achieves the right outcomes to maximise independence. The council and the CCG will ensure care home beds are commissioned in a consistent way
- We will develop a pool of " step up " intermediate care beds as an alternative to an acute admissions for identified cohorts of patients
- With a proactive community geriatrician service working in partnership with integrated teams we will ensure that more crises can be managed in community settings
- We will make the best use of telecare and telehealth services to increase the range of equipment used and the number of people benefitting
- We will increase investment in capacity and skills for intermediate care and reablement in the community. This will be through a review of our existing STARR step up and step-down bedded scheme with a view to moving more of the investment from beds to support in people's own homes.
- We will review the implementation of Help to live at Home processes to improve outcomes for intermediate care.
- We will ensure the availability of additional capacity within intermediate care services for escalation beds in the community, when the whole system is under pressure, for example, over the winter period.
- We will work explicitly with NHS England to develop capacity in General Practice in

Wiltshire
- We will develop a culture of 7 day discharge

***During 2015-16***

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

## The right support when people need it

***During 2014-15***

- We will continue to invest in 24/7 rapid response services
- As part of the 100 day challenge we have simplified practitioner access into a range of admission avoidance services through one number (the access to care line) which is accessible 24/7.
- We will continue to invest in acute liaison services to support hospital discharge at weekends
- Our pathway review will help us determine where to invest in 24/7 services to get the best outcomes.
- We will enhance our community geriatrics model
- We will develop extended community teams in identified areas

***During 2015-16***

- We will implement 24/7 and weekend working, as determined by our pathway review and ensure we have a culture of 7 day discharge

## Shared assessments and support plans

***During 2014-15***

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

***During 2015-16***

- We will implement a single assessment and support plan
- We will implement information sharing systems through our ambitious Single View of the Customer.

b) Please articulate the overarching governance arrangements for integrated care locally

We see strong joint governance as a key step towards integration.

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

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

We are developing a **joint integration programme team**, led by a jointly-appointed programme director and including specialist capacity from the Council's System's Thinking Team and information management team.

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

**Providing effective oversight and coordination**

There will be bi-monthly update reports on the delivery of Better Care and the use of the pooled funds to our Joint Commissioning Board. The Joint Commissioning Board has developed a **dashboard of performance outcomes** which it monitors at every meeting. This dashboard will be expanded to include they key performance outcomes for the Better Care Fund.

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

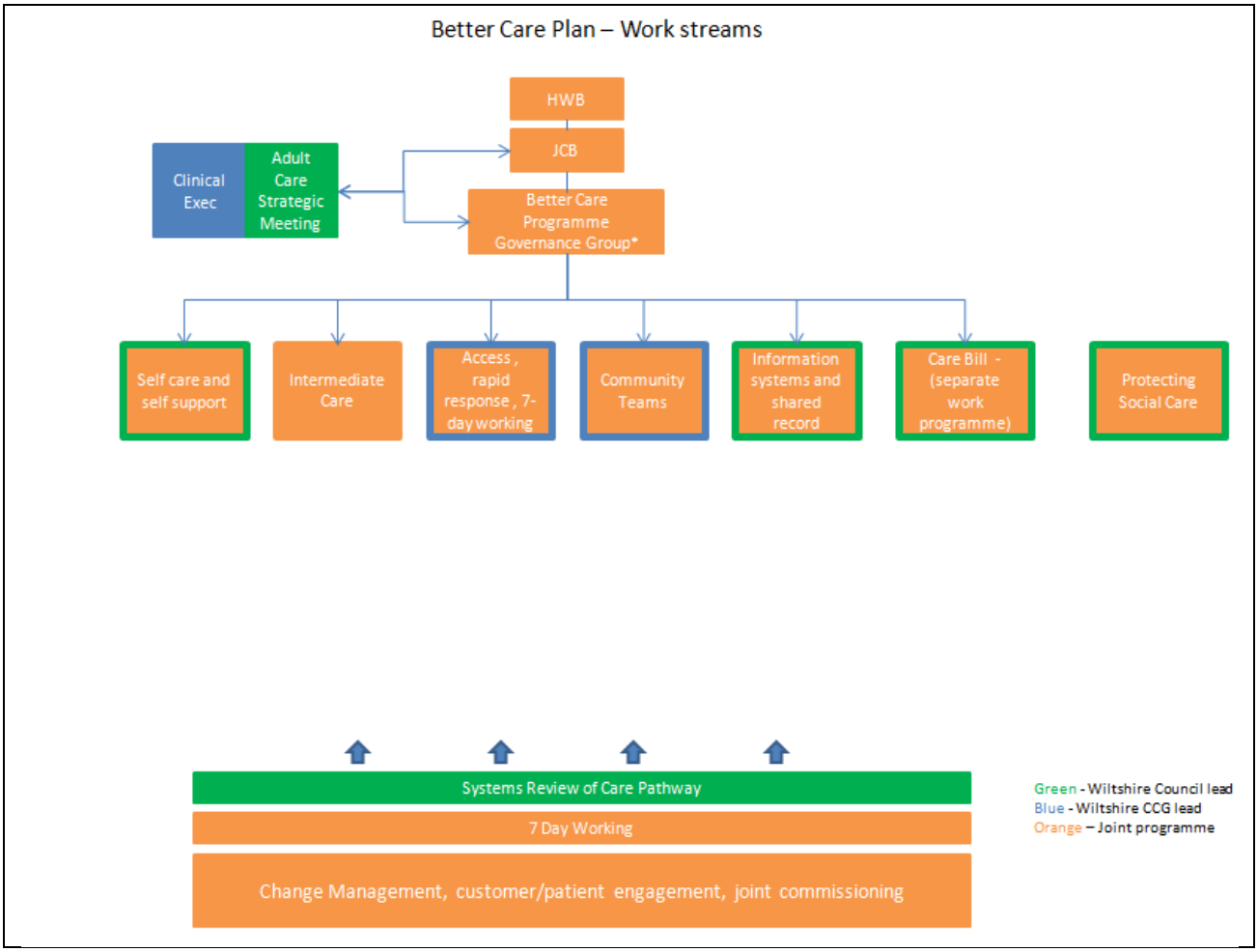
We will also ensure that the public are informed of progress, both through the publication of six-monthly reports and through regular updates in the *Wiltshire Magazine*. We will work with our Older People's Reference Group and with Healthwatch Wiltshire to ensure that we develop our patient and customer feedback and can respond to people's views. We will be presenting at each of the 28 Local Area Boards in Wiltshire ensuring the key messages and priorities of our better care plan are heard as widely as possible

We will also as part of the 100 day challenge for Wiltshire be undertaking

- A 6 month system review
- A daily dashboard of key indicators
- Detailed monthly reviews of all schemes
- Focused reviews of user experience through direct engagement of Wiltshire Healthwatch and other user networks

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

There are also strong linkages between the Better Care Plan Governance Group and the Wiltshire Health and Well Being Board as outlined below.




c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

## There is strong oversight of the Better Care Plan in Wiltshire

- At its highest level the plan is reported on and has been signed off at the Health and Well Being Board in Wiltshire which includes all key stakeholders across health and social care in Wiltshire. This has the full and active involvement of all acute providers. The Health and Well Being Board receives an update on all the key issues relative to the plan and a report outlining the key risks and issues
- Both the CCG Board and the relevant Cabinet Committee in the council receive regular updates on the plans progress
- There is an established Better Care Plan Governance Group with full involvement of Health and Social Care Commissioners which is chaired by the Integration Director and is tasked with overseeing the implementation of the plan and monitoring the performance and delivery of each work stream. The Governance Group will also review any areas of under performance and request that remedial action plans are put in place
- There is an established Better Care Plan performance dashboard which is reported on monthly to the Joint Commissioning Board.
- Integration Director meets formally with each provider on a 6 weekly basis to discuss key issues and resolve risks, representatives from the providers are at Director of Operations and Director of Finance level.
- Each of the 7 work streams has an established steering group in place and delivery plan. The membership of each work stream is reflective of the system with identified representatives from each key health and social care organisation.
- As part of the 100 day challenge we will be launching a daily performance management

| |
|---|
| dashboard overseeing each key scheme ensuring strong focus on delivery. This includes a range of key performance indicators ( with an example attached) |

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

| Ref no. | Scheme |
|---|---|
| 1 | - All key schemes are listed in table C section 8 |
| 2 | |
| 3 | |
| 4 | |
| 5 | |
| 6 | |
| etc | |

# 5) RISKS AND CONTINGENCY

### a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

| **There is a risk that:** | **How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely* | **Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact*<br><br>*And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)* | **Overall risk factor** *(likelihood *potential impact)* | **Mitigating Actions** |
|---|---|---|---|---|
| The introduction of the Care Act will result in a significant increase in demand for assessments and an increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and Plans | 3 | Financial impact from April 2016 could be as high as £15m, increasing to £40m by 2020 | 3 | Use of agreed national model with local variations to understand full impact to 2034 |
| The expected shift to more community-based services will not deliver the expected benefits, for example because of the acuity levels of | 2 | The impact of the risk will be that the capacity in the acute sector will be under pressure and the system will be unable to realise the savings anticipated. £3m in 2014-15 | 3 | Each element of our Better Care Plan will be monitored and project-managed, with timeframes for delivery and early evaluation. Service developments will be flexible to reflect evidence of what is |

| | | | | |
|---|---|---|---|---|
| people requiring services | | | | working or not working well. Contingency plans will be in place for all new service developments.<br><br>A methodology and templates for monitoring Return on Investment have been developed. |
| Care Act – the Residential Care market is unbalanced by the changes related to the funding reforms form April 2016 | 3 | Increase to costs of residential care of 10% would lead to a budget pressure of £5-10m | 4 | Discussions with care providers about modelling the cost of care and what that means to existing block and framework contracts |
| A lack of high quality and meaningful local key performance indicators will make it difficult to monitor outcomes | 2 | Difficulty in demonstrating success | 3 | The integration programme will work with the Council's Research Team and will commission Healthwatch to work on some patient/service user led outcome measures.<br>We will work with service providers on outcomes-based commissioning specifications<br><br>We are also as part of the 100 day challenge launching a daily performance dashboard of key indicators |
| Operational pressures will restrict the ability of our workforce to deliver the required investment and associated | 3 | The impact of the risk will be that the capacity in the acute sector will be under pressure and the system will be unable to realise the savings anticipated. | 3 | We will work together to implement our workforce strategy, including joint recruitment, retention and workforce development plans. |

| | | | | |
|---|---|---|---|---|
| projects to make the vision of care outlined in our Better Care Fund submission a reality. | | | | |
| The extent of cultural and behavioural change required of the public and of professionals working in the system will not be achievable. | 2 | The impact of the risk will be that the capacity in the acute sector will be under pressure and the system will be unable to realise the savings anticipated. | 2 | We are participating in the LGA Systems Leadership Programme which will support our culture/behaviour change work<br><br>The use of personalised care plans for people with long term conditions and/or at risk of hospital admission will also help reassure people that services are coordinated and information is shared in order to support them safely and in the best place. |

## b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

| |
|---|
| The CCG have limited reserves to mitigate over performance of the acute sector in 2014-15 and 2015-16.<br><br>Performance of the whole system, including the delivery of BCF schemes, will be monitored closely through the year. The Better Care Programme Governance Group may decide that it is e necessary to hold-back or re-direct some of the one-off investment in the Better Care Fund for 2014-15 to fund increase in acute hospital activity.<br><br>To support this approach we are developing a local process to the review and management of return on investment to critically review each of our programmes to assess outputs and whether |

ongoing investment should be prioritised.

The financial impact of non-delivery of the Better Care Plan objectives in relation to length of stay and reduced admissions is £3m for the CCG in 2014/15. The impact will approximately double in 2015-16 if growth cannot be contained and the Better Care Plan and other initiatives do not deliver.

**Better Care Fund – Wiltshire - Risk share framework**

It is recognised across Wiltshire that Appropriate risk share between the CCG and LA is fundamental to protecting investment of both organisations into the Better Care Fund. There is a system-wide risk that even with a strong contract and performance management in place with provider organisations, the benefits might not be achieved. Failure to meet the targets has financial consequences as the cost of any additional services that have not met the targets will need to be covered by either CCG or LA.

The individual BCF schemes have been set up so that as in aggregate the targets for metrics (admissions to residential and care homes, effectiveness of reablement, delayed transfers of care, avoidable emergency admissions, patient and service-user experience and local metrics) are met over 2014 – 2016.

There are also a number of ground rules that are in the process of being agreed in Wiltshire as part of the risk-share arrangements under section 75, these include;

- Will BCF have the right of first refusal for any reduction in BCF metrics over other in-flight initiatives (e.g. QIPP)
- Who bears the risk and cost of BCF underperforming
- Who benefits if BCF targets are exceeded
- How will the penalty payment be used (if a consequence of breach was that a percentage of provider payment was withhold, what will happen to the withhold cash - will it remain in BCF or be shared between the commissioners)
- Where services within the BCF are existing services that have already been contracted by either CCG or LA, there are a number of other considerations that will impact on risk sharing. These include:
    - Who is the current host commissioner
    - Who provides the existing services and what arrangements are in place
    - Whether changes to existing provider arrangements will have direct and indirect impact on non-BCF services currently provided
    - Whether current contract management arrangements are fit-for-purpose

To mitigate the risk and minimise the costs, we have put in place a risk share framework as part of the section 75 agreement and this is described below. The key factors influencing the risk share agreement include understanding of the intended impact of the BCF and who is accountable for delivering the schemes. Possible metric achievement outcomes are detailed below along with required agreements between CCG and Local Authority or possible agreed actions for handling these

| | BCF metrics | |
|---|---|---|
| | Achieved | Not achieved |
| Provider metrics achieved | ■ BCF objectives met<br>■ Agreement required if targets are exceeded and there are additional savings realised | ■ BCF objectives not met<br>■ Agreement required how the failure cost will be shared between LA and CCG |
| Provider metrics not achieved | ■ BCF objectives met however agreement necessary how to share the withheld payment amount between Local Authority and CCG | ■ BCF objectives not met<br>■ Withheld payment can be used to fund some of the failure cost |

There are four levers that the risk-share framework is built upon:

- Scheme Tier – i.e. what services are being delivered
- Delivery provider – who will be responsible for delivery of the services
- Benefit realisation – i.e. where will the savings / benefits be realised
- The source of funds – i.e. who is funding the contribution and in what proportion

In addition to the consideration of benefit realisation, CCG and Local Authority will consider the downstream impact if the scheme fails to deliver outcomes – i.e. where the failure will be managed. E.g. if reablement programmes do not deliver the intended outcomes, hospitals will see an increase in readmission rates.
Each of the four levers above have been assessed against each of the BCF schemes so that a sliding scale of responsibility between the CCG and LA can be clearly presented and agreed, as detailed below (content to be agreed).

**Reviewed against the 4 levers:**

- Tier
- Delivery provider
- Benefit realisation
- Source of funds

**Tiers:**

0 – Lifestyle promotion
1 – Low intensity prevention
2 – Primary care
3 – Community Health & Social Care

**Lever analysis is indicative and should be re-applied when all schemes have been scoped out in detail.**

| | Scheme Name | Contribution £ '000 | Tier | Delivery | | Benefit realisation | | Source of funds | | Risk share | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Health | Social | CCG | LA | CCG | LA | CCG | LA |
| 1 | Intermediate care | 15,064 | 3 | | | | | | | | |
| 2 | 7-day working, Rapid Response and discharge Coordination | 10,280 | 3 | | | | | | | | |
| 3 | Protecting Social Care Services | 18,366 | 3 | | | | | | | | |
| 4 | Care Act Requirements | 2,500 | 3 | | | | | | | | |
| 5 | Supporting Communities to be more resilient | 3,944 | 1 | | | | | | | | |
| 6 | Data sharing and joint assessments | 1,200 | 3 | | | | | | | | |
| 7 | Service user feedback and involvement | 200 | 3 | | | | | | | | |

The above model allows for risk sharing between the CCG and Local Authority to be agreed for each scheme, with detailed risk ownership for specific activities within each scheme to be determined, assessed and agreed. The level of risk will be determined through a joint CCG/Local Authority risk assessment process.

## Financial Governance arrangements for the Better Care Plan 2014/15 and 2015/16

### Financial Governance Arrangements

- The overall responsibility for operational and financial delivery associated with the Better Care Programme will be the Wiltshire Health and Wellbeing Board.

- The Wiltshire Health and Wellbeing Board will delegate the responsibility for delivery of the Better Care Programme objectives to the Joint Commissioning Board which has Council and CCG Directors and Managers as members. The Joint Commissioning Board will be responsible for overseeing the performance of the delivery of the 7 schemes and will be responsible for reporting performance and delivery to the Wiltshire Health and Wellbeing Board.
- The 7 schemes will be led by either a CCG Director, a Wiltshire Council Officer or the Director of Integration in line with the agreed Better Care Programme – Governance, Programme Management Arrangements and Initial Scoping Paper (20 March 2014). These programme leads will be responsible for the delivery of the program objectives within the allocated resources.
- A Better Care Programme Governance Group has been set up to monitor the performance and delivery of the Better Care Programme including the adherence and support to the governance arrangements for the Better Care Programme.
- The Joint Business Agreement between Wiltshire Council and Wiltshire CCG will provide the legal framework for the Better Care Programme in the form of Section 75 and Section 256 Arrangements. Section F (Payment and Financial Management) and Appendix 2 (Financial Arrangements) of that Joint Business Agreement set out the details for accounting, charging and payment arrangements.
- Given the additional contributions made by the CCG for 2014/15 it is agreed that any underspend on the pool will be used to reduce the additional contribution that the NHS has committed in 2014/15 unless it can be evidenced that the underspend relates to the specific Wiltshire Council additional funding.
- For 2015/16 the Better Care Programme will be operated as a pooled budget and will be subject to the full guidelines of the Joint Business Agreement agreed between the CCG and the Council.

**The Scheme of Delegation for then Better Care Programme**

The following responsibilities describe the delegated limits that will be set for the administration of the Better Care Programme:

- The Wiltshire Health and Wellbeing Board will approve the annual Better Care Programme financial plan
- The Wiltshire Health and Wellbeing Board will be required to approve new commitments over and above £500k that sits within the approved financial plan.
- Wiltshire Health and Wellbeing Board voting members will be required to gain assurances from their respective organisations on whether they can approve such expenditure. Every effort should be made by members of the Joint Commissioning Board to ensure that all organisations and agencies have been consulted with before an investment decision is made by the Wiltshire Health and Wellbeing Board.
- In the spirit of partnership and ownership it is envisaged that expenditure commitments under the £500k level will also be discussed and agreed informally within the respective organisations.
- For the CCG the Governing Body will be required to agree any investment over £500k and the Clinical Executive / Accountable Officer being responsible for any investment under £500k.
- For the Council the Cabinet Member for Health and Community Safety in consultation with the Corporate Director will be required to agree any investment over £500k. This will be

reported to Council through budget monitoring, and decisions over £1 million will be taken by Cabinet.

- The Wiltshire Health and Wellbeing Board will approve any in year budgetary virements between schemes and will need to gain assurance on the impact of the overall scheme objectives. The Wiltshire Health and Wellbeing Board will seek assurance from the Joint Commissioning Board on the delivery against the Better Care Programme objectives. Any overspends on a specific scheme will need to be managed within the Better Care Programme funds and will need to be clearly reported to the Joint Commissioning Board and the Wiltshire Health and Wellbeing Board. Assurances will need to be received on how the overspend will be managed.
- If the Better Care Programme is predicted to overspend within a financial year then the Wiltshire Health and Wellbeing Board will be responsible for seeking agreement between Wiltshire Council and Wiltshire CCG on how the overspend will be funded in line with the financial principles that will be described later in the document. It is envisaged that the Joint Commissioning Board will resolve most overspend issues within its delegated responsibility.

**Managing Financial Performance**

The following section describes how the financial position of the Better Care Programme will be managed in line with the delegated responsibilities.

- Schemes are expected to operate within the financial resources that have been allocated to them.
- Programme Directors will be accountable and held responsible for ensuring that their programme expenditure remains within the budget provision. However, they are not delegated authority to commit expenditure above £500k as laid out in section 3.8.2. Any change to the required resources will have to be agreed by the respective Boards in line with the agreed Governance Arrangements.
- Program Leads will need to consider the full year effect of the commitments that they are making to ensure that the allocated budgets are not exceeded in future years.
- The program leads will be responsible for the budgets that have a number of pre-commitments. It will be essential that the Programme Leads gain assurance on any pre-commitments and to work with colleagues to ensure that the Better Care Programme resources are used effectively and efficiently.
- Program Leads will need to ensure that all of the commitments are supported by formalised contractual arrangements where appropriate e.g. contract with Medvivo for Telecare Support and Response Service. These arrangements will include clear service specifications, financial commitments, contractual activity and key performance indicators (KPIs).
- All future commitments will need to be supported by a service specification and a contract with clear financial values, activity targets and KPIs where appropriate.
- For the financial year 2014/15 any underspend on the budgets funded by the CCG will in the first instance be used to reduce the non-recurrent funding commitment that is being made by the WCCG. The CCG will consider using any slippage on its investments on overspends from other parts of the Better Care Programme schemes. Approval of this transfer will be via the CCG Governing Body / CCG Clinical Executive
- For 2015/16 the resources will be held as a pooled budget. The Wiltshire Health and Wellbeing Board will be responsible for approving virements between scheme budgets

and any re-investment of any slippage on the Better Care Programme resources must be reviewed by the Joint Commissioning Board and approved by the Wiltshire Health and Wellbeing Board.

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# 6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

There is strong alignment with the 2 year operating strategy and 5 year strategic plan of the CCG. All other key areas and initiatives relating to care and support are included within the Better Care Plan and has a focus and priority within the relevant individual work streams. For example the Care Act Programme Board will take into consideration a range of key areas relating to the implementation of the care act and other relevant Local Government Planning Proposals

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

**Part 1 – CCG 2 Year operating and 5 year strategic plans**

Within Wiltshire, given the close working relationship between Wiltshire Council, the Clinical Commissioning Group and NHS Providers in the county, it was natural that we would evolve and develop both the Better Care Plan and the CCG 5 year strategic/2 year operational plan in a fully coherent manner. We identified this opportunity early so planning workshops and events were held jointly, and inclusively of providers and co-commissioners, and culminated in Health and Wellbeing Board endorsement of both plans. The Health and Wellbeing Board recognise that together these plans represent the roadmap to the achievement of the overarching Wiltshire Health and Wellbeing Strategy. Joint governance and performance reporting arrangements have also been developed and implemented to build upon the strong foundation of integrated working laid by the Health and Wellbeing Board and the supporting Joint Commissioning Board. Furthermore, our consultation, engagement and communication is ongoing in a collaborative manner.


**Vision**

In Wiltshire we are wholly committed to developing a truly integrated system. Our vision that **Health and Social Care services in Wiltshire should support and sustain independent healthy living** and the design of our future system is based on three key principles:

- People encouraged and supported to take responsibility for, and to maintain / enhance their well-being
- Equitable access to a high quality and affordable system, which delivers the best outcome

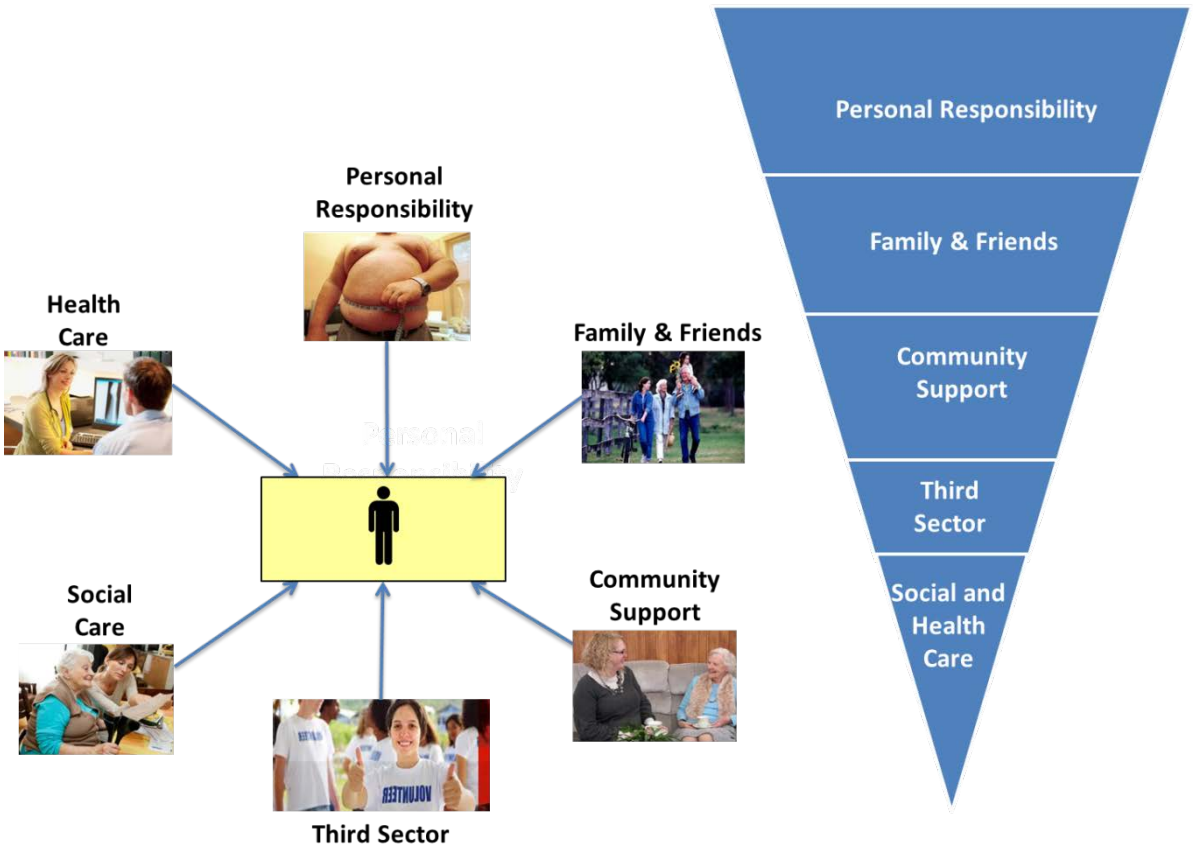
for the greatest number

- Care should be delivered in the most appropriate setting, wherever possible at, or as close to home
    - Where acute care is one-off or infrequent, there should be formal and rapid discharge
    - Where care in on-going (e.g. chronic conditions) the default setting of care should be primary care

The financial and quality drivers mean that more of the same is not an option for us. We have been transparent with our partners about the challenges that lie ahead and have developed a common understanding of the need for radical transformation and a shared responsibility to deliver the system change and manage the associated risks.

We know from our public and stakeholder work that the people in Wiltshire want more joined up services available in their communities and, at the same time, we know we cannot sustain the current proportion of our expenditure that is spent on acute hospital services. We therefore want to support people to be well and independent, and to take control of their own care. When intervention is needed we want this to be provided in people's homes, in primary care or in the community. Only when there is a good reason why this should not be the case should care be provided in our local acute hospitals. In the future we envisage that all services in Wiltshire will be delivered in an integrated way, led by primary care working with our social care partners, and to the highest standards of safety, quality and safeguarding.

In the future we will see increased investment and support to develop and maintain healthy and independent living. The starting point for our future model of care is personal responsibility with people supported to be more in control of their lives and increasingly confident to draw on their personal resources and those of their families and communities.



In developing this model, we are aware that we need to look at the traditional health and care system differently, refocussing our investment, giving greater priority to prevention, early intervention, shared decision making and self-care.

We recognise that the wider determinants of health, including isolation, housing, and lifestyle choices can be equally, if not more, important that the health and care services in terms of keeping people well and healthy.

To ensure we can provide the population of Wiltshire with access to the high quality, responsive and sustainable health and care services they need to manage ill-health or address a care need within our available resources, we will shift the focus of our investment towards tackling the root causes of demand and support people to establish and sustain wellness and independence.

Alongside our commissioned services we will seek to develop healthy community networks and promote well-being by moving away from a medical model of care, promoting a sense of community, as well as signposting support and activities in the community which are available and may be more appropriate for themselves and those they care for.

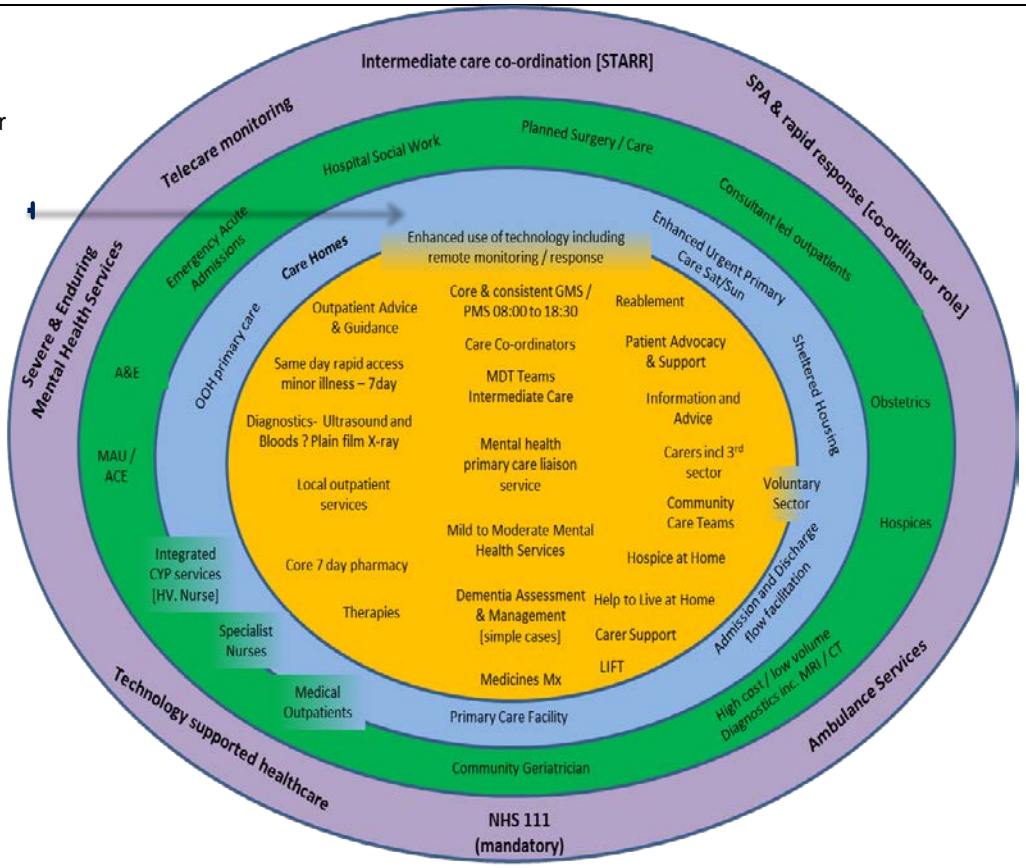
**Future Health and Care Service Model**

Where interventions from Health and Social Care are required, our integrated Primary, Community and Social Care services will be wrapped around the individual, accessed and co-ordinated through Integrated Extended Primary Care Teams, delivering a proactive and preventative approach to healthcare.

The diagram below sets out, at-a-glance, the key features of our future vision for wellbeing, care and health across Wiltshire. Due to the large, rural nature of our County, we have focussed upon using building blocks of 20,000 people as the core of our model (a very broad average list size for a GP Practice). The outer layers of the model then progressively move up towards a market town level (40,000 population), a wider locality level consistent with the county being divided into three natural geographical areas defined by the watershed and a County-wide level. In this way we have brought together health and care services to work with stakeholders in mapping out the most sustainable way to deliver the outcomes we aspire to over the next five years:

Potential locations for "Market Town" 40,000-level population:

- Chippenham
- Malmesbury
- Bradford on Avon
- Tisbury
- Warminster
- Trowbridge
- Melksham
- Marlborough
- Tidworth
- Salisbury
- Devizes




**Characteristics of a high quality, sustainable health and care system**

Together, our Better Care Plan and the CCG Five Year Plan build on, and take lessons from, our existing work to develop and improve integrated services provided as close to home as possible across Wiltshire.

In order to realise our vision we are aware of the need to extend and enhance our primary care services. Primary Care will play a key role in the leadership, co-ordination and provision of services across Wiltshire. This will require investment in workforce development, investment in technology to support innovative care delivery, improved utilisation and development of our community estate infrastructure and education and refocus patients' behaviour. This will require a step change in the way in which services are designed, commissioned and provided.

Our plans place Primary Care, alongside patients, at the centre of the health and social care economy. The aim being that not only will Primary Care continue to lead the design of the healthcare system via clinical commissioning, but also provide a greater range and improve the quality and safety of services delivered to patients and to support our plans for integration, moving care out of hospital and our reconfiguration of community services. The development of primary care is required due to a wide range of national and local drivers which include demographic pressures, rising prevalence of chronic disease, rising demand for primary care services, constrained funding growth and rising patient expectations.

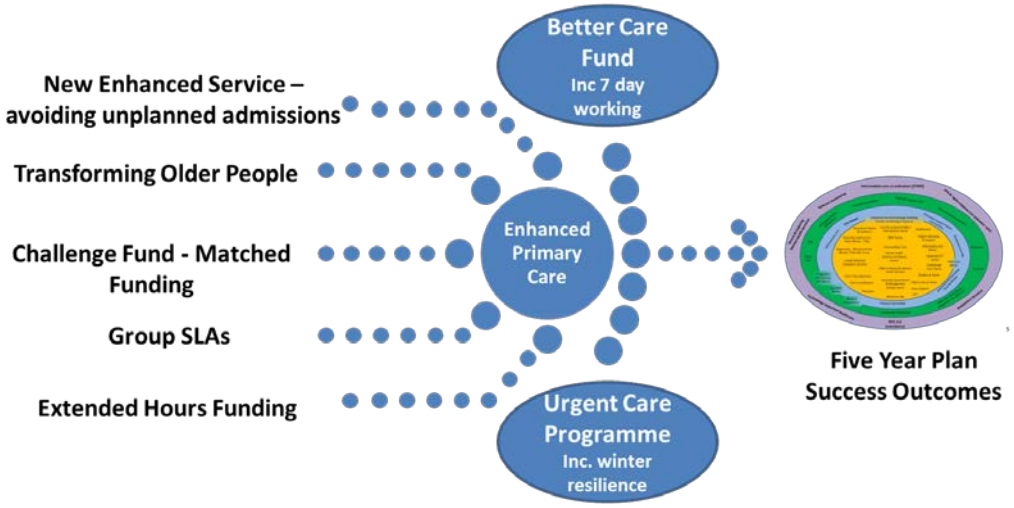
A coordinated, care system with services wrapped around the patient using integrated care services and support accessed and co-ordinated by Primary Care teams is the foundation stone for our strategic vision.

As a system we envisage the Better Care Fund supporting the development of integrated

community health and care services and further wish to use the opportunities afforded through Primary Care co-commissioning to further strengthen our transformational programme and deliver at greater pace and scale.

Given the central role that primary care will play in the successful implementation of our strategic plans, we feel that the ability to shape the local primary care strategies including workforce development and premises will represent significant leverage to the achievement of our joint strategy.

We also believe that the allocation of primary care funding, over and above core contracts, into individual streams, each with their own set of outcomes, risks duplication and limits the systems potential to deliver maximum return on investment and we see delegated local power to influence and align the primary care funding streams with our local transformational change investment as key to optimising the patient and public benefits derived from wrapping community services around extended primary care teams.




Our aim is that not only will Primary Care continue to lead the design of the healthcare system via clinical commissioning, but also provide a greater range and improve the quality and safety of services delivered to patients and to support our plans for integration (community, social care, mental health), moving care out of hospital and our reconfiguration of community services.

A coordinated, care system with services wrapped around the patient using integrated care services and support accessed and co-ordinated by Primary Care teams is the foundation stone for our strategic vision.

The Health and Wellbeing Board will oversee the delivery of the Wiltshire Better Care Plan and has endorsed this plan, since delivery will be a key element in the implementation of the Wiltshire Health and Wellbeing Strategy, and ultimately our aspiration is for a better integrated health and social care system. Health providers all sit on our Health and Wellbeing Board as well as other partners such as Wiltshire Council, Wiltshire Police, NHS England and HealthWatch. Supporting the Health and Wellbeing Board we have a well-established Joint Commissioning Board for Adults' Services and many of the currently emerging service changes have been developed and overseen by this Board, which comprises key Executives from the CCG and the Lead Councillor & Officers of Wiltshire Council.

Indeed for delivery of the Better Care Plan, which is naturally coherent with the CCG 5 year plan, we have agreed new joint arrangements for project management and oversight, including the establishment of a bespoke Better Care Fund Programme Governance Group as a subcommittee of the JCB. This group will and bring scrutiny and control to all those projects within the Better Care Fund. These are coherent and inter-dependent on projects arising from the CCG 5 year/2

year plan, and accordingly we are committed to working within the integrated system to work smartly and collaboratively to deliver the best possible effect without duplication of staff effort. Each project has a team working together to deliver on objectives, drawn from across health and social care. Teams are led either by commissioners from the Council or the CCG (work streams have been allocated on the basis of which organisation is likely to have the most professional/clinical expertise in the area in question) and will engage with existing service providers (e.g. acute hospital trusts, social care, Help to Live at Home providers, out-of-hours services etc) to ensure that new arrangements can be co-produced to get the best results.

**Part 2- Alignment with Local Government planning documents**

In line with planning for the Care Act and the associated implications we have put in place a Care Act Programme Board with the main areas of focus being;

- Commissioning / market shaping
- Workforce practice, policies, procedures and development (assessments, personalisation, support planning)
- Finance and funding reform
- Early intervention and prevention (inc information and advice)

**Purpose of the Care Act Programme Board is**

- to ensure that the Council and CCG is prepared and ready to respond to the Care Act when it passes through Parliament
- to interface with the Better Care Plan being developed with the CCG
- to ensure implementation of the Care Act is done with suitable input and involvement from key stakeholders
- to resolve and manage risks and issues around implementation of the Care Act
- to share and identify links to other work programmes and developments across the Council and CCG
- to agree and approve recommendations from workstreams before going to appropriate governance groups.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

This is covered in part 1 of the above section

# 7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

### a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

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

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

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

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Funding which is currently allocated within the Social Care 'Health Gains' transfer and Reablement transfers has been used to enable the local authority to meet increased demands for services and sustain the current level of eligibility. This has been through investment in 2013-14 on the following

**Direct care provision**

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

**Capacity to support discharge from hospital**

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

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

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

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The Better Care Fund will include the existing Carers Pooled Budget. This is £1.472m in 2014-15 and a range of priorities have been established underpinning this

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

A Care Act Implementation programme has been established within the Council to provide a governance structure for implementation and manage the different workstreams that will be required. A lead officer has been appointed to manage the programme.

The Better Care Fund includes £2.5m in 2015/16 to fund the additional activities around

- Carers assessments and any support that will be required
- Information and advice systems
- Early assessments for self-funders
- Capacity required in commissioned services affected by the Care Act
- Information sharing and ICT systems required for creating the Care Account

The Council has already made considerable progress in moving towards personalisation in its care management processes, following implementation of the Help to Live at Home service. This means we have an established outcome focused assessment and support planning process already in place that can be reviewed in light of the new regulations.

The immediate priority is

- Modelling the financial impact of the changes
- preparing for the impact of changes to Carers rights
- talking to residential care providers about the impact of the funding reforms.
- Ensuring the voluntary sector play a key role in our service solutions

v) Please specify the level of resource that will be dedicated to carer-specific support

£2.5 million from 2015/16

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

The Councils overall budget for adult care was developed with consideration of the Better Care Plan and underpinned by joint working with health partners. Regular monitoring of both individual partner budgets and Better Care Fund monies has not identified further pressures. The council continues to assess the cost consequences of the care act and the sufficiency or not of the fund to cover potential costs. Overall work with heath partners is focusing on moving to meet these objectives within the BCP and includes systems thinking analysis which is assessing the total cost of care and the options in place to deliver improved value for money. This approach has led to an improvement in management information and the ability to forecast costs. As such at this stage there is no overall impact on the council's budget known or forecast and this position will continue to be monitored.

We have undertaken a detailed assessment of the impact of the Care Bill for Wiltshire and are developing a Return on Investment toolkit for health and social care which we are looking to launch in November 2014.

## b) 7 day services to support discharge

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

In the last year, we have used NHS Health Gains transfer to enhance our 24/7 tele care response service and provide with an urgent domiciliary care response. We will sustain this funding and evaluate this service in early 2014 to determine future investment.
We have increased capacity for 24/7 nursing care services and weekend community discharge liaison staff based in 3 acute hospitals.

The CCG has used Winter Pressures funds to pilot 7-day working in primary care. Some practices have evidence of reduced emergency admissions and the CCG are currently considering plans to roll-out successful pilots across the county.
The Council used Winter Pressures funds to pilot social care 7-day working in acute hospitals. The results of this pilot were reported in our Winter Plan, and demonstrated to us that social work alone cannot make a difference to weekend discharges. The whole system, including therapy, discharge liaison, transport, pharmacy etc. needs to be geared to full 7-day working.

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

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

There is a system wide commitment to the concept of Discharge to Assess which will be operational across all bed based units 7 days a week.

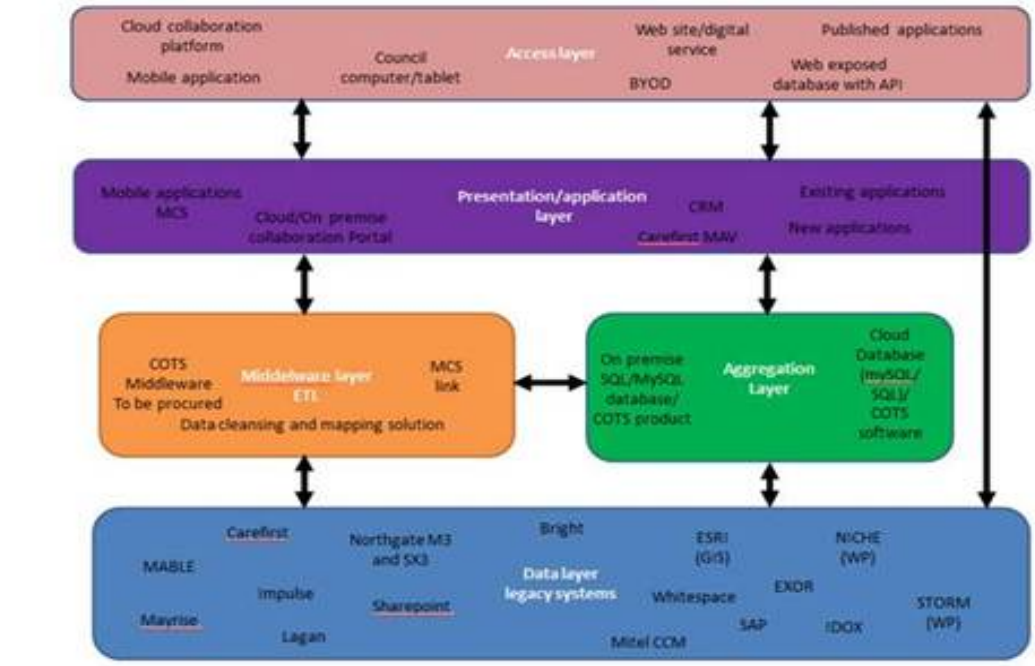
We are also maximising appropriate discharges through our established services 7 days a week.

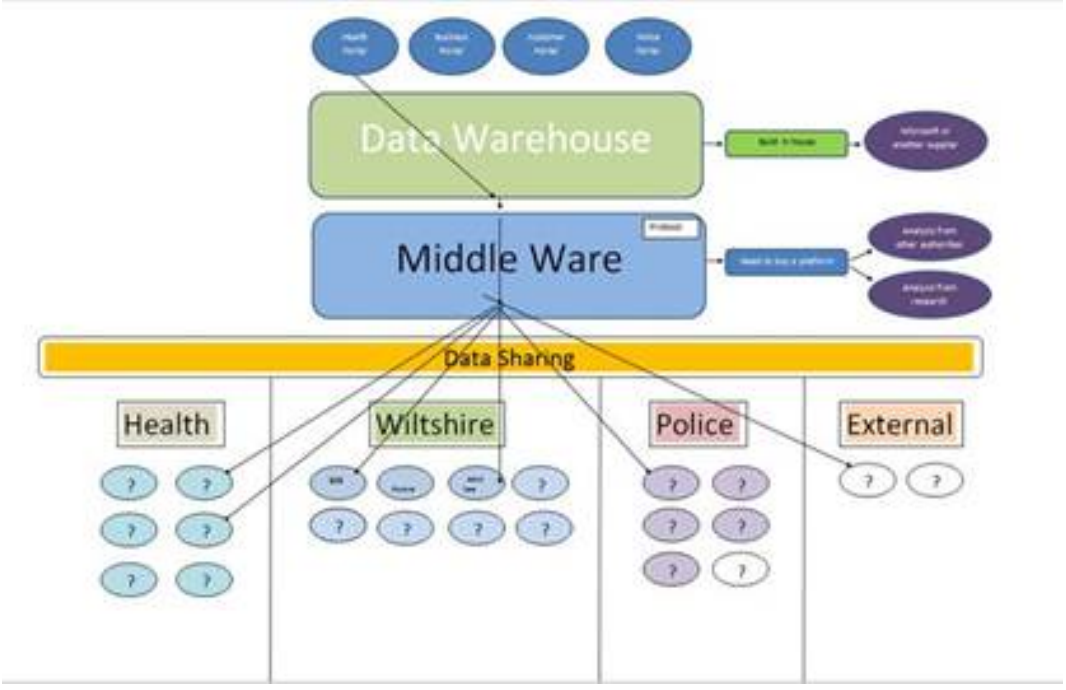
## c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

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

We are currently in discussion with the ICO about how Wiltshire can maximise data sharing opportunities, this will form a key part of our Single View of the Customer approach and workstream. The diagrams below are high level views of the proposed solution to data sharing across the public sector in Wiltshire.




The NHS number will be the primary identifier by April 2015.

In relation to our Single View of the Customer Programme we have a system launch (including all key health and social care partners on the 2nd September and we have been shortlisted for the national technology fund award which we will be interviewed for on the 11th September

iii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

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

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

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

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

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

The Devon Risk tool is utilised by Wiltshire GPs to identify patients at risk. It is intended to add the Social Care module to further improve the risk stratification process and ensure we have a joint approach to risk stratification and case management.

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

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

confidentiality rules are followed

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

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

**d) Joint assessment and accountable lead professional for high risk populations**

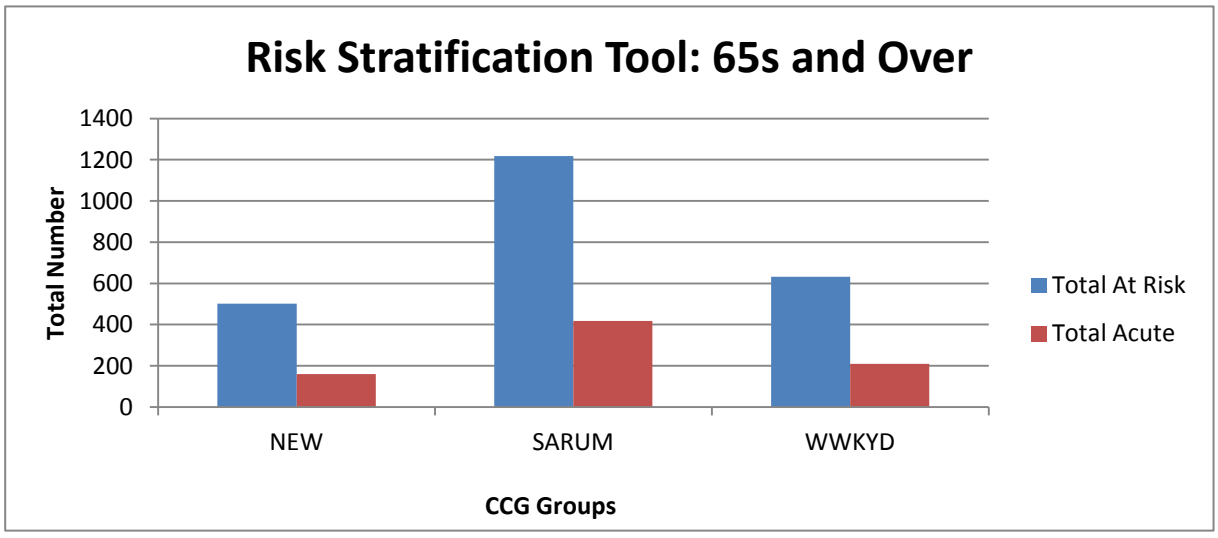
i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

TABLE 6 –PEOPLE AGED 65 AND OVER WITH A LONG TERM HEALTH PROBLEM OR DISABILITY

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

(Census, 2013)

TABLE 7 PEOPLE AGED 65 AND OVER WHO ARE INDICATED AS AT RISK THROUGH THE USE OF RISK STRATIFICATION



*ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population*

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

Wiltshire CCG and the Council's Public Health Team have developed data to segment the older population according to risk. This has been presented as a report: "Quantifying the number of vulnerable older people in Wiltshire" – prepared in January this year by a Public Health Consultant. The report acknowledges the high number of indicators for vulnerability which makes it difficult to define a cohort that is not duplicated. It uses a number of proxy measures to estimate the population. Table 4 below shows census data, whilst Table 5 shows the work undertaken by using the Devon Risk Tool to produce a risk score for patients aged 65 and over.

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

The next stage will be to include social care information within the risk stratification process. Care coordinators are working with every practice in Wiltshire to case find those patients at highest risk of hospital admissions or care home admission by using a clinical risk stratification tool and Care First (The social care management system). A proactive care plan is then developed for each patient together with the GP with a range of lower level interventions also considered such as signposting to the voluntary sector through to changes in medication and management of long term conditions.

The development of the role of the care coordinator within primary care, and the use of multi-disciplinary team meetings on high risk patients will increase that number of patients with a care plan to approximately 85%. We are also looking to enhance the risk stratification process with the inclusion of the frailty index.

Taking all of these key factors and issues into consideration, the CSU on behalf of the CCG is now putting in place a new risk stratification tool which will go live in October.

*iii) Please state what proportion of individuals at high risk already have a joint care plan in place*

5670 individuals have a joint care plan in place.

# 8) ENGAGEMENT

## a) Patient, service user and public engagement

Our vision is set out below. It is based upon what people have told us is most important to them. We have developed this vision with the public, patients and service users in a number of ways:

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

Throughout March, we held stakeholder engagement events on our Better Care Plan. Throughout April and May we worked with Wiltshire's Area Boards to generate local debate and local actions in support of our Better Care Plan in each of our community areas.

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

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

We will be launching the revised Better Care Plan in early September and commencing direct engagement with the public about the key schemes and priorities though a range of meetings with each of the 26 area boards in the Wiltshire area.

## b) Service provider engagement

*Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans*

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


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

We have engaged providers in a number of ways:

- Through a Health and Wellbeing Board hosted event on the Better Care plan (14th January 2014) attended by Acute Trusts, Community Health Provider, Social Care providers, Mental Health provider and voluntary sector
- Through work with the Wiltshire Care Partnership, the membership organisation for social care providers
- Through the Health and Wellbeing Board itself – the Board is made up of a range of stakeholders, including the 3 district general hospitals serving Wiltshire People, the mental health trust and the ambulance trust.
- Through the work underway on the CCG's 5 Year Plan. The 5 Year Plan has been developed jointly with council colleagues and has involved extensive provider engagement. The information gathered at these events is also informing our Better Care Plan.
- Wiltshire Healthwatch will be leading on all user engagement as part of the Better Care Plan and will undertake user focused qualitative analysis. We will also be engaging other user led organisations and consulting about service change with the established Local Area Boards.

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

- Engagement on the Joint Health and Wellbeing Strategy
- Engagement on the CCG's Community Transformation Programme
- Workshops with providers on a whole system workforce strategy

A Steering Board for the development of intermediate care services (STARR)

### i) NHS Foundation Trusts and NHS Trusts

We have engaged directly with NHS Foundation Trusts in the area in a number of ways

***Active involvement and engagement at the Wiltshire Health Well Being Board***

Each of our acute providers are active members of the Wiltshire Health and Well Being Board and were involved in the development and subsequent sign off of the Better Care Plan , its submission and subsequent re submission for the Fastrack process.

***Individual meetings with Each Acute Provider***

The Integration Director has established strong relationships with each of the Acute Trust s and meets with key Trust Board members on a regular basis to update on

- Progress against plan
- Key risks and issues
- Key operational issues
- Review of scheme impact
- Plans for the future

***Active engagement at workstream level***

There is strong provider representation on each of the 7 workstreams this includes both managerial and clinical leads. These representatives are fully engaged in each programme and involved in the scoping of key schemes and its implementation. At a recent discharge to assess workshop held in Wiltshire there were over 45 attendees from the 3 acute trusts in the area.

***Rising to the challenge***

Each of the 3 acute Trusts is fully engaged in the Wiltshire 100 day challenge and have demonstrated a real commitment to work in partnership on the development of the out of hospital model and daily monitoring of impact through the launch of a system wide daily performance dashboard

### ii) Primary care providers

**Primary care providers are fully engaged in the programme in a different ways to include ;**

- GP Lead representation at the Health and Well Being Board
- Active involvement in each of the 7 workstreams with primary care providers taking the lead on a number of key schemes such as the Access to Care Number
- Commitment to case managing in partnership with community and social care practionners the highest risk patients
- Each of the £ 5per head bids for primary care were assessed against key Better Care Plan Criteria
- Regular attendance at each of the monthly provider meetings

**iii) Social care and providers from the voluntary and community sector**

Social care is fully involved and takes the joint leadership of the programme and this is clearly highlighted within the detail of the Better Care Plan.

The voluntary sector are actively engaged in the Better Care Plan and Programme in a number of ways including

- Leading a number of key schemes such as the recently established home from hospital pathway , this is being taken forward in partnership with age concern and other voluntary sector organisations
- Membership of the Early Intervention and Integration work stream
- Development of an information signposting tool for the Wiltshire population
- Health watch have been commissioned to lead on the engagement process for the Better Care Plan and as part of the system review in Wiltshire are undertaking qualitative reviews of patient pathway and measuring the user experience
- Full involvement in the Wiltshire wide system review and the 100 day challenge

## c) Implications for acute providers

*Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:*

- *What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?*
- *Are local providers' plans for 2015/16 consistent with the BCF plan set out here?*

The Chief Executives of the 3 Acute Trusts serving Wiltshire's population are members of the Wiltshire Health and Wellbeing Board. They have participated fully in the development and sign-off of this Better Care Plan. Beyond the plan they are actively involved in the following ways ;

- Sign up to the systems review
- Appropriate representation at each of the key Better Care Plan Programme Workstreams
- Working with the CCG and Local Authority in developing a range of operational solutions

The CCG and Council have assessed the impact on the local acute system. There is agreement that the system impacts associated with the BCF will see a reduction in the number of bed days utilised by emergency admissions and the total number of emergency patients admitted into the acute hospitals. This is set against the current context of increased acuity that is being experienced by the 3 Acute Hospitals in terms of the case mix related to the admissions.

The biggest impact is expected in year 1 of the BCF as the CCG and Council move to reduce the average length of stay experienced by patients. The CCG is planning for a reduction in the average length of stay by 20% (approximately 2 days). This will be achieved by improving the flow through the acute hospitals by enhancing the services on the front of the emergency system as well improving the discharge process through a series of targeted programmes such as Discharge to Assess. We would be seeking to get average length of stay down to targeted levels in 14/15 and then seek to maintain this during 15/16. We would be applying the same approach to our community beds to ensure we have improved flow, reduced delays and occupied bed days across the whole system.

The CCG and Council are also expecting to see a reduction in non-elective admissions of 3.75% in 2014/15 and 3.75% in 2015/16. This reduction is assumed after the impact of annual activity

growth of approximately 2%.

**Table A – Assumed reductions in activity and finance**
Note – 2015-16 figures assume management of 2% growth in activity

| | RUH | GWH | SFT | Others | CCG Total |
|---|---|---|---|---|---|
| 2013/14 Outturn | 13,501 | 9,188 | 13,607 | 2,840 | 39,136 |
| 2014/15 Plan | 13,265 | 9,027 | 13,369 | 2,790 | 38,541 |
| 2015/16 Plan | 13,033 | 8,869 | 13,135 | 2,741 | 37,778 |
| 14/15 Change compared to 13/14 outturn | - 467 | - 388 | -501 | -104 | - 1460 |
| 15/16 Change compared to planned 14/15 outturn | -488 | -332 | -492 | -102 | - 1414 |
| How many non-elective admissions for the CCG is the BCF planned to prevent in 14-15? | | | | | - 1460 (3.75%) |
| How many non-elective admissions for the CCG is the BCF planned to prevent in 15-16? | | | | | - 1414 (3.75%) |

**This assumes 2% growth less 3.75% reduction**

**Table B – Detail of schemes and impact on acute care and social care**

| Hospital | RUH | GWH | SFT | RUH | GWH | SFT | RUH | GWH | SFT |
|---|---|---|---|---|---|---|---|---|---|
| | Reduced Bed days | | | Bed Reductions | | | Average LoS Reduction | | |
| | | | | | | | | | |
| Length of Stay Reduction | 13,094 | 7,566 | 12,720 | 34 | 20 | 33 | 2.1 | 2 | 2.3 |
| | | | | | | | | | |
| Admissions Reductions | 936 | 638 | 944 | 2 | 2 | 2 | | | |
| | | | | | | | | | |
| **Total** | **14,030** | **8,204** | **13,664** | **37** | **21** | **36** | | | |

**Performance against admission avoidance assumptions**

Through the Better Care Plan there is a commitment to reduce non elective admissions in Wiltshire by a minimum of 3.5% during 14/15 and 15/16. A range of schemes have been scoped and are due to go live during the 100 day challenge which commences from September 2014. The key schemes are outlined earlier in the document. The 100 day challenge has the full support of all providers and there is a commitment to make this work driven by a necessity to

reduce demand and reduce volume of delayed transfers of care. This commitment is underpinned by the development of a daily dashboard which will monitor impact of all new schemes moving forward.

There are high levels of un-coded data reporting in 2014/15. This makes is difficult to conduct a full case mix analysis of spells growth. Therefore the spells growth has used only the month 2 year-to-date spells SUS data. One of the Better Care Fund measures is to monitor the level of avoidable emergency admissions based on a selection of diagnosis codes. The indicator reports on the emergency admission rate for acute conditions that should not usually require hospital admission, such as influenza, pneumonia, urinary tract infections and cellulitis. These are conditions that should usually be managed without the patient having to be admitted to hospital. Analysis of these shows a decrease from 686 to 642 on 2014/15 at CCG total level as shown in table 7 below. But this is below our planned trajectory for avoidable admissions YTD and there is a commitment to further reduce volume of admissions through the launch of all key schemes from September under the umbrella of the 100 day challenge and beyond.

Within this area it should be recognised that acuity of admissions has increased and we have had an increase in admissions for more complex conditions (such as heart attacks, strokes) which cannot be managed in a community setting and a more detailed analysis can be provided.

| Provider | 13/14 M2ytd | 14/15 M2ytd | Diff | % change |
|---|---|---|---|---|
| GWH | 165 | 176 | 11 | 6.7% |
| RUH | 275 | 256 | -19 | -6.9% |
| SFT | 206 | 178 | -28 | -13.6% |
| Main 3 sub-total | 646 | 610 | -36 | -5.5% |
| Others | 40 | 32 | -8 | -20% |
| **Total** | **686** | **642** | **-44** | **-6.4%** |

The key aim following the launch of the 100 day challenge is to ensure ongoing delivery of the plan and to reduce admissions by 3.5% moving forward.

We are also beginning to make some early “in roads “into reducing Non elective length of stay with an overall reduction of length of stay from 5.9 days to 5.0 days and reductions at 2 of our main acute providers. We would expect to make further impact following the launch of our flagship discharge scheme which is Discharge to Assess which will be rolled out during September.

**System wide benefits**

The data outlined above provides an overview of the anticipated cumulative impact of all the schemes on volume of avoided admissions, subsequent financial savings and associated reduction in bed days. We believe all of our schemes together will deliver this benefit through:

- Addressing a range of different patient cohorts identified through risk stratification
- Ensuring crisis is managed in a range of different settings in the community
- Enabling the involvement of a wide range of practitioners across health and social care
- Targeting those patients with the greatest need
- Providing a range of different treatment options and locations such as crisis management in a community setting, diagnostics in the community and rehabilitation and re-ablement in a home setting.

There is a joint commitment across the system to ensure we deliver on our shared vision. Table D below and Table E set out the approach to change and to the enablers for change.

For social care, Wiltshire already performs well in that care home placements for older people are low. However, we believe that the whole system initiatives will help maintain, if not improve this performance, whilst reducing delayed transfers of care. Each long term care placement avoided will save the Council on average £21,000 (net) per year, which can be reinvested in alternative support services to maintain people's independence at home for longer. The council is already forecasting growth in demand per year of c£4m in adult care. This is drawing resources from other areas of the council and is why the Council, and CCG, see this as a vital programme of action to firstly contain cost increased and then move to greater prevention to manage future costs.

**Table D – Scaling up and creating the space to achieve change**

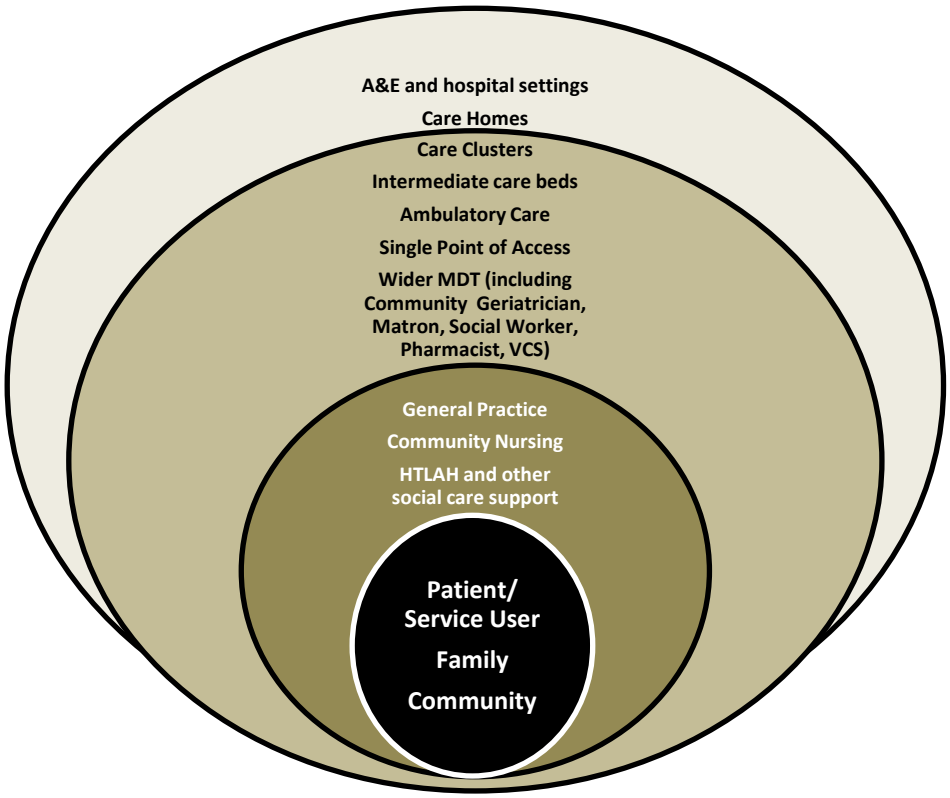


**Table E – Enablers for integration**

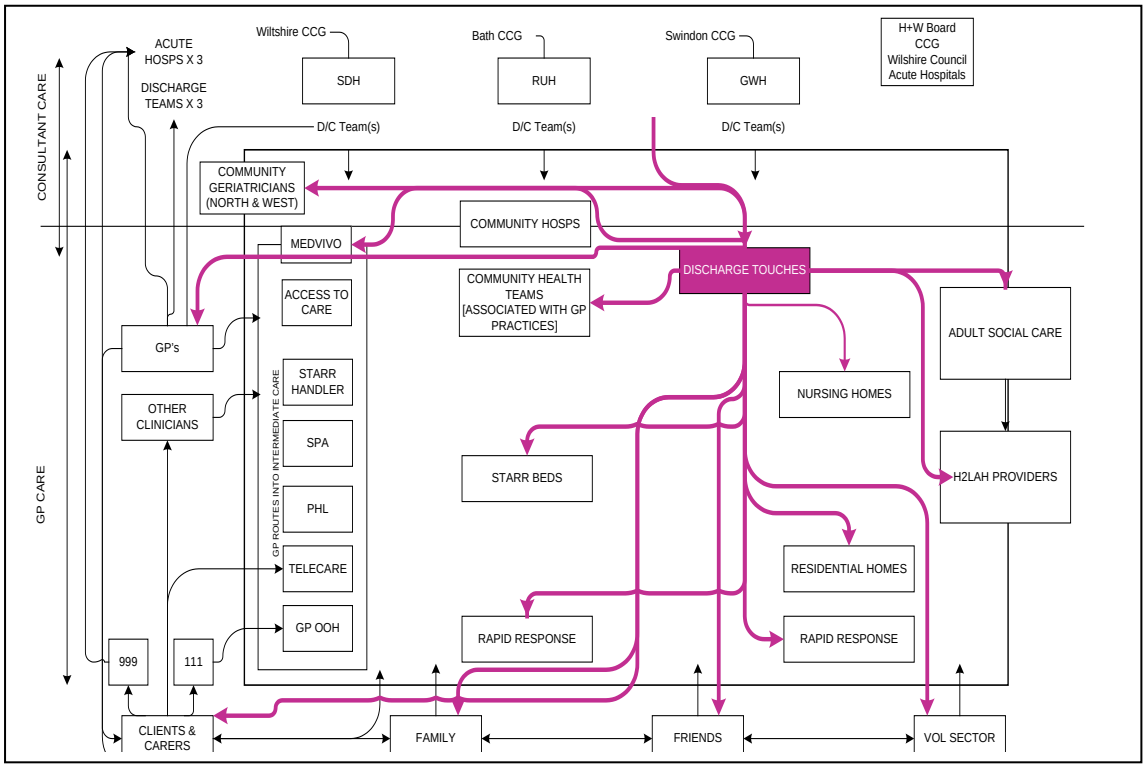
| IM&T | Estates |
|---|---|
| • **Information governance systems that allow better linkages**<br>• **Prioritising the work around single view**<br>• **Effective identification of candidates for early discharge**<br>• **Joint access to effective risk stratification to support targeting of services** | • **Joined up innovative estates management should include all health and social care estates**<br>• **Buildings designed around models of care should be the focus**<br>• **Focus on how innovative estates management across health and social care can facilitate change required** |
| **Finance and contracting**<br>**What areas are we considering -**<br>• **Year of care**<br>• **Prime contactor**<br>• **Joint Venture**<br>• **Alliance contract**<br>• **Longer term strategies for joint commissioning and procurement** | **Workforce**<br>**Implementing new ways of working**<br>• **7-day working**<br>• **Are traditional ways of working still dominating the provider landscape**<br>• **The " big supply " challenge**<br>• **Skills academy approach**<br>• **Clinical and practitioner mindset shift** |

**The Better Care Systems Review**

Our approach in delivering a system view on benefit has been underpinned by the approach we have taken across the health and social care system in Wiltshire in undertaking a system wide review. This review underpins the ambition across health and social care for collective efforts delivering outcome and service change for the people of Wiltshire.

Our current pathways have been mapped and indicate the complexities of the 'out-of-hospital system as it currently stands. Table F below is an outline of that system.
The next stage of the systems review is to undertake the 'check' stage which will be led by the Council's systems thinking team with participation from front-line staff and clinicians from social care, community and acute NHS services, independent care providers and the voluntary sector. This stage will provide us with the analysis of the current system and evidence for where change could have the biggest impact.

**Table F – the current system for intermediate care**




## The 100 day challenge in Wiltshire

The 100 day challenge was launched at the Health and Well Being Board in July, This is an ambitious system challenge which underpins all of the key objectives of the Better Care Plan for Wiltshire and requires health and social care staff to work together more collaboratively to reduce unnecessary admissions to hospital through better use of new and existing community based services as well as increase independence and reduce the amount of time our service users spend in hospital.

During the 100 day challenge there will be a particular focus on the following four areas

1. Access and referral routes
2. Managing crisis in community settings
3. Managing a greater number of patients in a community setting
4. Reducing length of stay and improving discharge process.

As much as this process aims to " sharpen " the operational focus this is also a listening and learning experience and we keen to measure success through feedback through key metrics . The system will operate a daily dashboard to monitor performance and there will be weekly issue logs /reports and more formal monthly evaluation.

The proposed daily dashboard is attached at appendix c

***The key areas of focus for the 100 day challenge are as follows***

**Case Management**

- Enhanced 7 day management of the high risk 2 % underpinned by frailty scores
- Community Geriatrician identification and monitoring of the highest risk patients from acute wards
- Focused discharge to assess programmes supporting transfer from wards with enhanced social care support
- System management of the EOL register

- Community geriatrician and multi morbidity clinics combining

**Primary care management**

- Initiatives across all 58 GP Practices focussing on proactive care and support planning for frail elderly.
- For the more vulnerable patients and those with co-morbidities, there is evidence that these 'high risk' patients are best managed by a multi-disciplinary team who can work with the patient's GP to assess, plan and deliver a personalised plan of care, including assessing falls risk, reviewing and reconciling medications, screening for depression and social isolation, and documenting patient wishes for care at the end of life.

**Access and referral routes**

- An enhanced simple point of access with one number to call for services /professionals
- Detailed directory and clinical triage processes
- Improved connection to acute hospitals
- Ensuring complete access to services 7 days a week

**Managing crisis**

- Enhanced HTLAH within the first 72 hours
- 72 hour pathway for EOL patients
- Commitment from ambulance trusts to convey to non-acute locations
- Continued delivery of the successful care home support and dom care programmes
- Enhanced specialist input in community settings by the community geriatrician
- Geriatrician led discharge from ED with connection to existing front door models

**Managing sub-acute patients in a community setting**

- Launch of step up beds in community settings for a range of clinical conditions with average LOS of circa 7 days
- Relaunch of STARR and delivery of new intermediate care action plan
- Community nursing " step up " services to be prioritised and expanded

**Reducing length of stay and improving discharge processes**

- Green to go for Wiltshire to be launched
- System DTOC actions to be activated for each acute hospital
- Roll out of discharge to assess across the system
- Extended home from hospital pathways commissioned by social care
- Commitment to consultant review within 24 hours
- Improved and enhanced ICB model ( formally STARR ) accessible 7 days a week
- Focused review of conversion rate and outlier volume ( agree targets )

**Ongoing Measurement /Monitoring and action**

- System review check stage to go live at the same time ensuring ongoing review and action
- Launch of the **M**ulti **A**gency **V**iew across general practice to give access to social care records.
- New performance management process in place across system with new indicators
- CCG and Council to launch daily system dashboard
- Daily exec leads monitoring performance including social care
- Daily bed state reports, including STARR beds
- Improved workforce capacity monitoring to ensure appropriate use of existing resources
- Weekly issue logs / reports and formal monthly evaluations

The 100 day challenge has the full involvement and endorsement of the health and social community in Wiltshire and will drive forward the ambition of the Better Care Plan; this programme will go live on the 1st September.

We have identified a range of key operational metrics which we will be monitoring on a daily basis through the daily dashboard approach. An outline of the daily dashboard is attached to this

document at appendix C

**Risks**

The impact of non-elective admissions in 2015/16 will be negligible as further length of stay reductions will be difficult to achieve as the patients that are required to be admitted to hospital will have an increased acuity.

The length of stay reductions will benefit both commissioners and Trusts although the greatest impact will be seen on the Trusts who will be expecting to reduce the number of beds in the 3 hospitals. In reality the Trusts will be able to close escalation beds that have been opened in 2013/14. The commissioner impact will result in reduced numbers of excess bed days however it is impossible to quantify due to the changes in the nationally defined trim points.
The risk of not delivering the length of stay and the non-elective admission reductions will have a number of effects.

- Firstly the hospitals will struggle to expand their current bed capacity as growth of 3.3% or more will impact on the acute system in 2014/15 and 2015/16. The predicted extra number of required beds could be as many as 15 beds per year across the 3 acute hospitals.
- The second impact will be on the CCG who will experience over performance on the 3 acute contracts due to the non-delivery of the non-elective QIPP targets associated with some of the BCF services. The CCG will only have limited reserves to mitigate this over performance in 2014/15 and 2015/16 due to the creation of the BCF. The financial impact of non-delivery of the BCF objectives around length of stay and reduced admissions is £3m for the CCG in 2014/15. The impact will approximately double in 2015/16 if the same growth persists and the BCF and other initiatives do not deliver.
- The third consequence will see a rise in care home placements as patients lose their ability to be discharged back to their own homes due to diminishing levels of independence as they experience longer stays in the acute sector. The BCF includes a growth prediction of £1.8m over and above the Wiltshire Council funded growth of £2.5m. If the BCF does not deliver then the £1.8m will be required and will have a recurrent impact in 2015/16.

The Council and the CCG have developed a methodology and templates for assessing and monitoring Return on Investment and this work is owned by the Better Care Governance Group. For each of the Better Care work streams, this includes:

- Profiled monthly spend
- Committed monthly spend
- Benefits tracking by month – reduced admissions and attendances, reduced length of stay, excess bed days, reduced care home admissions and length of stay, reduced delayed transfers of care.
- KPI tracking by month.

# ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Within this section we have provided more detail on the key schemes that are focusing on ensuring we deliver;

- Reduced admissions to hospital
- Reduced readmissions , attendances and unnecessary conveyances to hospital
- Reduced average length of stay in acute and community hospitals
- More integrated services at the point of need
- Increased volume of service users who can be supported to live in their own home
- Increased independence in community settings post discharge from hospital
- Increased number of sub-acute patients being managed in community settings
- High quality preventive focused services which avoid premature decline of our frail elderly.
- An increased focus on presentation
- High quality services and interventions for all our service users who need them.

The key schemes are outlined in more detail below

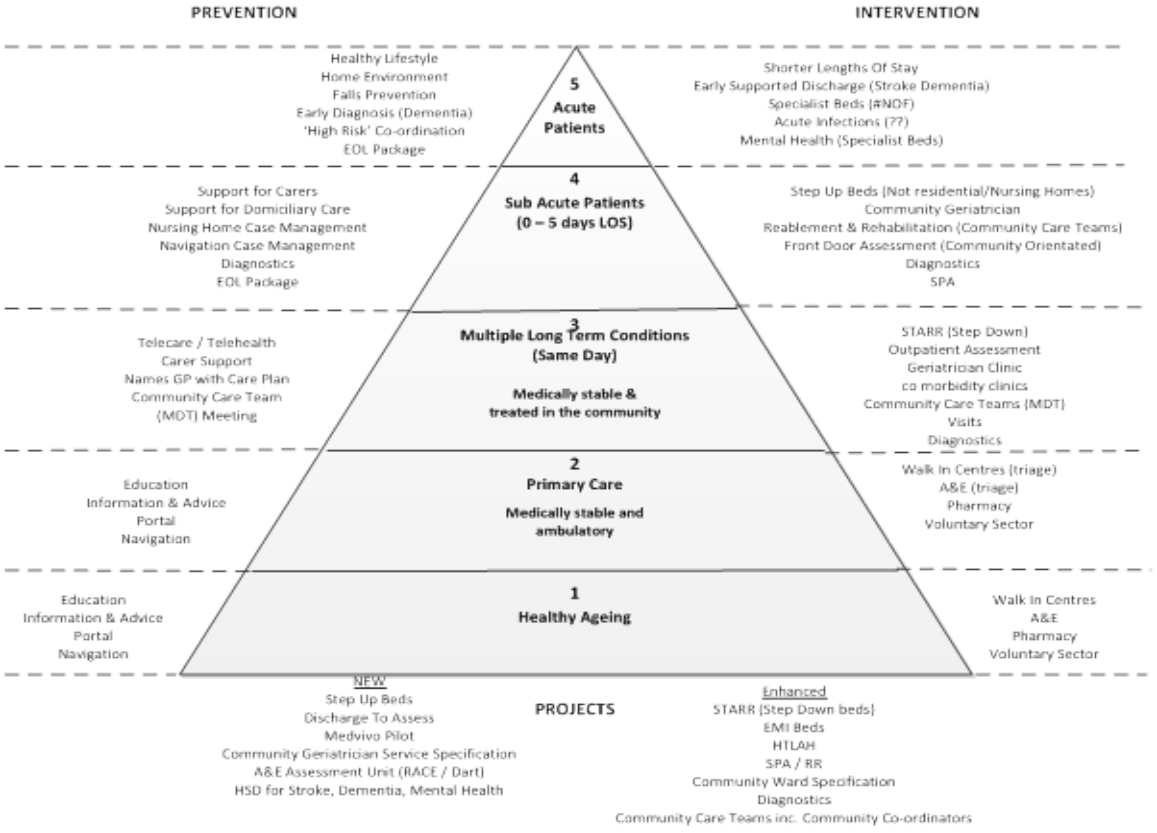
| **Scheme ref no.** |
|---|
| Scheme 1 |
| **Scheme name** |
| Intermediate Care |
| **What is the strategic objective of this scheme?** |
| The main strategic objectives of the scheme are to<br>- Increase the number of patients who can be managed in a community setting when they reach crisis point , through a mix of bedded and non-bedded alternatives<br>- Ensure decisions about long term care are made in non-acute settings through the development of a discharge to assess scheme where the focus is on discharging patients once they are medically stable<br>- Increase the number of patients whose care needs are provided for in a home settings through the enhancement of our Help to Live at Home Programme. |
| **Overview of the scheme**<br>Please provide a brief description of what you are proposing to do including:<br>- What is the model of care and support?<br>- Which patient cohorts are being targeted? |
| Intermediate care is a key scheme in place across health and social care which is central to development of a robust out of hospital model and ensuring a higher number of appropriate admissions are avoided by providing robust care and crisis management in a community setting. The evidence base suggests there are a number of sub – acute patients who are currently being cared for in hospital settings who could be cared for in the community if appropriate capacity such as step up was in place. This view is clinically endorsed and supported by GPs and Community Geriatricians in the Wiltshire area.<br><br>Within Intermediate care the focus is on the following<br><br>- Reducing reliance on acute beds (those avoiding admission and readmission) through the development of Step up intermediate care in existing community wards. We believe that by converting up to 40 existing community hospital beds to step up we have the opportunity to avoid in excess of 1000 admissions per annum. The key transition here will |

be managing an identified cohort of patients in a community setting who are currently admitting to hospital.

- Enhancing existing intermediate care (step down ) and help to live at home (reablement and care/support in the patient's own home ) to reduce the volume of readmissions , ensuring longer term independence post discharge , reduce length of stay in acute settings and increase the volume of service users who can have their care needs provided for at home . A key priority of the Better Care Plan is to support as many people to remain independent at home. The key transition here will be managing more patients at home who are currently having their care needs provided for in nursing /residential homes or step down intermediate care
- Reducing average of length of stay in acute hospitals and reducing current high volume of delayed transfers of care. Within the Better Care Plan there is a stated aim to reduce the current average length of stay in acute hospitals by 2 days and the bed day impact this generates is outlined elsewhere in this document. This we believe will be achieved through the roll out of our Discharge to Assess scheme. The discharge to assess programme will support each of the acute providers and community hospitals and will enable the discharge of patients once they are medically stable so their longer term care needs and rehab /reablement can be provided for in an out of hospital setting .

Within Wiltshire we have an ambitious vision for intermediate care which is clinically driven and endorsed and aims to target a range of patient groups both from prevention and an intervention perspective. The clinical model is outlined below and provides an overview of how care will be provided in each of the identified patient risk levels.

**The Intermediate care clinical model**




The Typical patient cohort that is being targeted through this work are

- high risk patients over the age of 65 identified through our coordinated case management and risk stratification
- In relation to step up patients would be classed as those who are "sub-acute "and whose condition could be managed in a community setting with appropriate care in place. These

are patients who typically present with conditions such as UTIs, off legs, falls, exacerbations of long term conditions, breakdown in care package /plan.
- In relation to "discharge to assess "the typical patient cohort would be patients 65 + who are medically stable and have rehab potential.

**The delivery chain**
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The strategy and vision for intermediate care has been set by the System Wide Intermediate Care Steering Group (which is one of a number of key schemes within the Better Care Plan Programme). This group is chaired by the Integration Director and has membership from the following organisations.

-CCG ( managerial and finance )
-council ( Managerial and finance )
-GP Leads
-hospital Clinical leads
-Each acute provider
-community provider
Medvivo ( our key OOH and single point of access provider )
-Arriva ( who lead on patient transport )
-local mental health trust

All plans and strategies are consulted on at this forum and need to be signed off by the Steering Group before they can commence.

An example of the key milestones for the programme is included below.

**The evidence base**
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

**Local evidence base**

*System review of intermediate care*

In Wiltshire we have invested in a system review of intermediate care over the last 6 months ( detail of this programme of work is outlined above ) and within this we undertook a focused review of the patient pathway ( including mapping a number of patient journeys ) ,reviewing admission data at each of the acute hospitals and interviewing key stakeholders. This helped to "spotlight the breakdown" in service provision, identify the key opportunities and challenges and develop guidance on a target patient cohort. This review had the involvement of all key stakeholders in the area with outcomes being presented at CCG Boards, Provider Boards and Council Cabinet committees.

*Bed capacity review*

In 2013/14 the CCG commissioned a review/audit of hospital admissions (both community and provider) and this advised on the number of beds the system would require moving forward and supported the need to develop more direct referral options in community settings for GPs and other practioners. This further drove and supported the need for "step up "intermediate care in Wiltshire. It also identified that that there is currently a cohort of patients being cared for step down intermediate care who could be appropriately cared for at home.

*System wide DTOC(delayed transfers of care ) workshops*

During 2014/15 , we have held a number of system wide workshops with each acute provider in relation to delayed transfers of care and this helped to develop the system wide action plan and identify the need for a discharge to assess programme in Wiltshire

**National Evidence Base**

In relation to Discharge to Assess we have reviewed the successful pilots that were undertaken in Warwickshire, Oxford and Sheffield including undertaking a site visit to Oxford.

Participation in the National Audit of Intermediate Care has helped to shape further thinking in this area.

**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan- *this is outlined in part 2*

**Impact of scheme**
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The key outcomes for this workstream are as follows

- Reduction in acute admissions
- Reduction in acute attendances
- Reduction in volume of admissions to nursing and residential care
- Reduce average length of stay on identified acute and community wards.
- Reduction in volume of occupied bed days for patients over the age of 65 and associated excess bed days
- Reduction in care and nursing home length of stay
- Reduced number of delayed transfers of care (DTOCs )
- Increased quality of care
- Increased number of appropriate patient contacts through alternative admission avoidance schemes
- Increased in the volume of high risk patients who are jointly managed by health and social care
- Increased volume of care assessments made in an out of hospital environment

**Feedback loop**
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

There are a number of approaches that are being taken.

1. System review " check stage "

The ongoing check stage of the system review ( core team of health and social care practionners) who continue to review the impact of schemes on the ground , identify issues and put in place contingencies should schemes not be delivering to plan. This team has a presence across the health and social care infrastructure in Wiltshire.

2. The 100 day challenge

As outlined earlier in the plan the 100 day challenge provides an excellent opportunity to prioritise the key schemes and ensure we keep a system wide focus on delivery. This will also provide a useful listening , feedback and communications opportunity for front line staff and key referrers ( such as GPs ) to outline any key issues , concerns or barriers. We have established a central e mail which will be reviewed regularly for all feedback and concerns.

3. Daily performance dashboard

As part of the 100 day challenge and beyond we have established a daily performance dashboard which will track a range of key indicators focused on system demand and activity that is being undertaken (volumes of referral and impact of the schemes that have been put in place. This dashboard is system wide and will ensure a daily focus on a range of key indicators which will help to determine the impact we are having and any changes we need to make. There will be assigned executive leads for this process across the system so concerns can be dealt with in a timely proactive way. There is a commitment from providers to provide this data on a daily basis.

4. Ongoing reporting

Through the Better Care Plan Governance Process there is also a monthly performance report which enables us to monitor performance against a the key Better Care Plan indicators for Wiltshire. Each workstream also has to provide informal fortnightly and formal monthly scheme updates.

5. Ongoing assessment of impact

As outlined elsewhere in the document we have directly engaged Healthwatch Wiltshire to undertake the ongoing qualitative assessment of our service provision and ensure we continue to take the views of patients and users into account.

**What are the key success factors for implementation of this scheme?**

**Clinical expertise and knowledge**

The scheme the full involvement of the appropriate clinical lead from primary care and secondary care as well as the involvement of senior social care practionners . There is 3 assigned GP Leads for the scheme

**Operational expertise and leadership**

Given the importance of this scheme to the overall delivery of the out of hospital model, this workstream is chaired by the Integration Director and has Director level leadership input from the CCG and the main providers in the area.

**Partnership working**

There is a strong history of partnership working and this approach builds on the networks that were previously in place and has been strengthened with enhance clinical involvement.

**ongoing engagement and communications**

There is regular communications to all staff on this scheme, key changes and updates.

**Ongoing measurement and evaluation**

As outlined above there is a range of key performance indicators in place which monitor and measure the impact of the scheme on an ongoing basis.( i.e. the daily dashboard and feedback loop for staff )

**Ongoing development of our workforce**

There is an assigned OD lead for this work stream with a clear work plan in this area.

**Scheme ref no.**

Scheme 2

**Scheme name**

Urgent care, 7 day working and rapid response

**What is the strategic objective of this scheme?**

The main strategic objectives of the scheme are to

- Increase the number of patients who can be managed in a community setting when they reach crisis point, through a mix of bedded and non-bedded alternatives.
- Ensure patient care is provided for 7 days a week and out of hours
- Improve and simplify access routes to a range of services through once single number 7 days a week
- Ensure delivery against the 4 hour A&E target and reduce emergency pressures across the system
- Ensure GP led case management of the highest risk patients 24/7
- Develop robust alternatives to A&E attendance and admission either through the development of alternatives in a community setting or through enhancing rapid assessment at the front end of A&E
- Ensure referral needs are dealt with in an urgent manner (where appropriate) through development of robust rapid response and urgent care services across health and social care.
- Increase the number of patients whose care needs are provided for in a home settings through the enhancement of our Help to Live at Home Programme.

**Overview of the scheme**

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

This programme is a key scheme in place across health and social care which is central to development of a robust out of hospital model and ensuring a higher number of appropriate admissions are avoided by providing robust care and crisis management in a community setting. Alongside creating alternative pathways and models of care the aim is to ensure that response is rapid ( within a defined period of time ) to prevent conveyance and subsequent admission to an acute hospital and ensuring care can be provided quickly when patient reaches crisis point The evidence base suggests that opportunities are being missed to maintain patients in community settings because either (a) the alternative services are not in place or (b) the response of the services are not timely enough to avoid ongoing referral to the acute hospitals . There is also a recognition that increased demand in acute settings is not sustainable and a wider range of alternative /rapid services should be put in place

Within this workstream the focus is on the following

**<u>Simplifying and enhancing access 7 days a week</u>**

- An enhanced simple point of access with one number to call for services /professionals
- Detailed directory and clinical triage processes
- Improved connection to acute hospitals through simple point of access
- Ensuring complete access to services 7 days a week
- Developing robust rapid assessment processes at the front end of each acute hospital ensuring that patients are not inappropriately admitted and can be assessed and re-directed out to a community setting on a more regular basis.

**Managing crisis**

- Enhanced help to live at home within the first 72 hours

- 72 hour pathway for end of life patients
- Commitment from ambulance trusts to convey to non-acute locations
- Continued delivery of the successful care home support and dom care programmers
- Enhanced specialist input in community settings by the community geriatrician
- Geriatrician led discharge from ED with connection to existing front door models

The Typical patient cohort that is being targeted through this work are

- high risk patients over the age of 65 identified through our coordinated case management and risk stratification
- Patients with minor health and social care needs who often admit to an acute hospital during evenings or weekends .
- Patients who require home care over night
- In relation to patients who we would seek to crisis manage these would be classed as those who are "sub-acute "and whose condition could be managed in a community setting with appropriate care in place. These are patients who typically present with conditions such as UTIs, off legs, falls, exacerbations of long term conditions, breakdown in care package /plan.
- Patient who choose to attend A&E ( The self-presenters )that could have their care needs provided for in a non-acute setting

**The delivery chain**

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The strategy and vision for Urgent Care has been set by the System Wide Urgent Care Working Group (which is one of a number of key schemes within the Better Care Plan Programme). This group is chaired by a CCG Director and is an existing Urgent Care Working Group that was established in Wiltshire during 13/14 and has provided to be successful. This group sets the direction and strategy for urgent care in Wiltshire and has the following membership;

-CCG ( managerial and finance )
-council ( Managerial and finance )
-GP Leads
-hospital Clinical leads
-Each acute provider
-community provider
Medvivo ( our key OOH and single point of access provider )
-Arriva ( who lead on patient transport )
-local mental health trust

All plans and strategies are consulted on at this forum and need to be signed off by the Steering Group before they can commence.

An example of the key milestones for the programme is included below.

**The evidence base**

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

**Local evidence base**

*System review of intermediate care*

In Wiltshire we have invested in a system review of intermediate care over the last 6 months ( detail of this programme of work is outlined above ) and within this we undertook a focused review of the patient pathway ( including mapping a number of patient journeys ) ,reviewing admission data at each of the acute hospitals and interviewing key stakeholders. This helped to "spotlight the breakdown" in service provision, identify the key opportunities and challenges and develop guidance on a target patient cohort. There has also been an extensive review of *" what happens to patients out of hours*" and this has helped to inform thinking in relation to the key schemes This review had the involvement of all key stakeholders in the area with outcomes being presented at CCG Boards , Provider Boards and Council Cabinet committees .

*System wide urgent care strategy*

This plan was developed in 13/14 for NHS England and underpinned the development of the Wiltshire Urgent Care Working Group. This strategy provides clear direction in terms of clear schemes, operational priorities and the management of emergency pressures.

*System wide DTOC(delayed transfers of care ) workshops*

During 2014/15 , we have held a number of system wide workshops with each acute provider in relation to delayed transfers of care and this helped to develop the system wide action plan and identify the need for a discharge to assess programme in Wiltshire as well as identifying further key opportunities within urgent care.

*Emergency Care Intensive support Team reviews (ECIST)*

Due to poor A&E performance during 2013/14, ECIST undertook reviews of processes in 2 of the acute trusts in Wiltshire (Great Western Hospital and Royal United Hospital Bath). The subsequent reports from these reviews have helped to shape the urgent care strategy for each organisation and the system as a whole as well as endorsing the approach we are taking in Wiltshire in relation to the Better Care Plan.

**Investment requirements**

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan- *this is outlined in part 2*

**Impact of scheme**

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The key outcomes for this workstream are as follows

- Reduction in acute admissions
- Reduction in acute attendances
- Reduction in volume of admissions to nursing and residential care
- Reduce average length of stay on identified acute and community wards.
- Reduction in volume of occupied bed days for patients over the age of 65 and associated excess bed days
- Reduction in care and nursing home length of stay
- Reduced number of delayed transfers of care (DTOCs )
- Increased quality of care
- Increased number of appropriate patient contacts through alternative admission avoidance schemes

- Increased in the volume of high risk patients who are jointly managed by health and social care
- Increased volume of care assessments made in an out of hospital environment

**Feedback loop**
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

There are a number of approaches that are being taken.

System review " check stage "

The ongoing check stage of the system review ( core team of health and social care practionners) who continue to review the impact of schemes on the ground , identify issues and put in place contingencies should schemes not be delivering to plan. This team has a presence across the health and social care infrastructure in Wiltshire.

The 100 day challenge

As outlined earlier in the plan the 100 day challenge provides an excellent opportunity to prioritise the key schemes and ensure we keep a system wide focus on delivery. This will also provide a useful listening , feedback and communications opportunity for front line staff and key referrers ( such as GPs ) to outline any key issues , concerns or barriers. We have established a central e mail which will be reviewed regularly for all feedback and concerns.

Daily performance dashboard

As part of the 100 day challenge and beyond we have established a daily performance dashboard which will track a range of key indicators focused on system demand and activity that is being undertaken (volumes of referral and impact of the schemes that have been put in place. This dashboard is system wide and will ensure a daily focus on a range of key indicators which will help to determine the impact we are having and any changes we need to make. There will be assigned executive leads for this process across the system so concerns can be dealt with in a timely proactive way. There is a commitment from providers to provide this data on a daily basis.

Ongoing reporting

Through the Better Care Plan Governance Process there is also a monthly performance report which enables us to monitor performance against the key Better Care Plan indicators for Wiltshire. Each workstream also has to provide informal fortnightly and formal monthly scheme updates.

Ongoing assessment of impact
As outlined elsewhere in the document we have directly engaged Healthwatch Wiltshire to undertake the ongoing qualitative assessment of our service provision and ensure we continue to take the views of patients and users into account.

**What are the key success factors for implementation of this scheme?**

**Clinical expertise and knowledge**
The scheme the full involvement of the appropriate clinical lead from primary care and secondary care as well as the involvement of senior social care practionners . There is 3 assigned GP Leads for the scheme

**Operational expertise and leadership**

Given the importance of this scheme to the overall delivery of the out of hospital model , this workstream is chaired by the Director Lead for urgent care in the CCG and has Director level leadership input from the council and the main providers in the area.

**Partnership working**

There is a strong history of partnership working and this approach builds on the networks that were previously in place and has been strengthened with enhance clinical involvement.

**ongoing engagement and communications**

There is regular communications to all staff on this scheme, key changes and updates. There are also bi-monthly urgent care seminars that are held in Wiltshire

**Ongoing measurement and evaluation**

As outlined above there is a range of key performance indicators in place which monitor and measure the impact of the scheme on an ongoing basis.( i.e. the daily dashboard and feedback loop for staff )

**Ongoing development of our workforce**

There is an assigned OD lead for this workstream with a clear work plan in this area.

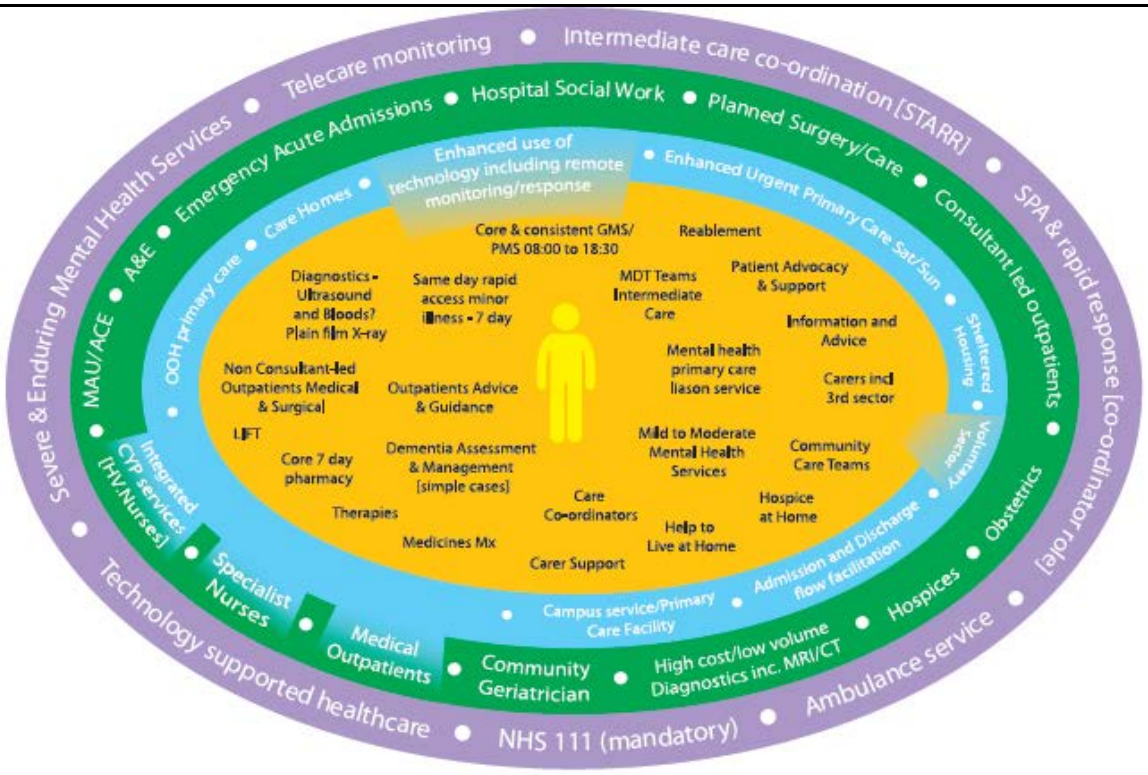
| **Scheme ref no.** |
|---|
| Scheme 3 |
| **Scheme name** |
| Developing our community services and enabling full integration of health and social care |
| **What is the strategic objective of this scheme?** |

The main strategic objectives of the scheme are to

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

**The extended primary Care team (Amber Ring- 20,000 population)**

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




- Increase the number of patients who can be managed in a community setting when they reach crisis point, through a mix of bedded and non-bedded alternatives.
- Ensure GP led case management of the highest risk patients 24/7
- Develop robust alternatives to A&E attendance and admission either through the development of alternatives in a community setting or through enhancing rapid assessment at the front end of A&E
- Increase the number of patients whose care needs are provided for in a home settings through the enhancement of our Help to Live at Home Programme.
- Care coordinators are working with every practice in Wiltshire to case find those patients at highest risk of hospital admissions or care home admission by using a clinical risk stratification tool and Care First (The social care management system). A proactive care plan is then developed for each patient together with the GP with a range of lower level interventions also considered such as signposting to the voluntary sector through to changes in medication and management of long term conditions.

**Overview of the scheme**

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The core model of care is outlined above , the key aims within this work programme are to

- Embed the development of integrated teams at a local level across health and social care with the ultimate aim being to wrap services and care around the patient. The ambition is provide proactive care at a local level working at a population level of circa 20,000. Integrated locality teams will be the foundations on which the delivery of the Better Care Plan in Wiltshire will be built and there is commitment to piloting fully integrated services in 3 identified localities in Wiltshire by the end of 2014.
- Enhanced case management through the provision of care coordinators to GP practices in Wiltshire
- Roll out of the Community Geriatrician approach ensuring that more specialist care is provided in community settings.

- Revised risk stratification approach at GP practice level with an emphasis on identifying patients who are at " high risk " of crisis now or could become high risk in 18 -24 months' time unless proactive planning is put in place.
- For the more vulnerable patients and those with co-morbidities, there is evidence that these 'high risk' patients are best managed by a multi-disciplinary team who can work with the patient's GP to assess, plan and deliver a personalised plan of care, including assessing falls risk, reviewing and reconciling medications, screening for depression and social isolation, and documenting patient wishes for care at the end of life.
-
-

The Typical patient cohort that is being targeted through this work are

- High risk patients over the age of 65 identified through our coordinated case management and risk stratification
- Patients with minor health and social care need who often admit to an acute hospital during evenings or weekends.
- Patients who require home care over night
- In relation to patients who we would seek to crisis manage these would be classed as those who are "sub-acute "and whose condition could be managed in a community setting with appropriate care in place. These are patients who typically present with conditions such as UTIs, off legs, falls, exacerbations of long term conditions, breakdown in care package /plan.
- Patients who are currently at level 1 or 2 of the risk pyramid who have been identified as benefiting from proactive intervention now to prevent decline or crisis in the future
-

**The delivery chain**

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The strategy and vision for the development of community services is well established in Wiltshire with the Community Transformation Programme being launched in 2013 and the key elements of this being a central part of the CCGs 5 year strategy. As such the governance for this workstream is well established with a Optimising Community Teams Board ( chaired by a lead GP ) and the Optimising Community Teams Sub Group which has membership as follows

-CCG ( managerial and finance )
-council ( Managerial and finance )
-GP Leads
-hospital Clinical leads
-Each acute provider
-community provider
-Medvivo ( our key OOH and single point of access provider )
-Arriva ( who lead on patient transport )
-local mental health trust

All plans and strategies are consulted on at this forum and need to be signed off by the Steering Group before they can commence.

**The evidence base**

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

**Local evidence base**

*System review of intermediate care*

In Wiltshire we have invested in a system review of intermediate care over the last 6 months ( detail of this programme of work is outlined above ) and within this we undertook a focused review of the patient pathway ( including mapping a number of patient journeys ) ,reviewing admission data at each of the acute hospitals and interviewing key stakeholders. This helped to "spotlight the breakdown" in service provision, identify the key opportunities and challenges and develop guidance on a target patient cohort. There has also been an extensive review of " *what happens to patients out of hours*" and this has helped to inform thinking in relation to the key schemes This review had the involvement of all key stakeholders in the area with outcomes being presented at CCG Boards , Provider Boards and Council Cabinet committees .

*Community Transformation Programme*

In 2013 the CCG launched an ambitious community transformation programme which outlined the vision for the development of community services in Wiltshire and put in place a number of key schemes. The strategy document was published in 2014 and was supported by an ambitious organisational development strategy. From April 2014 the Community Transformation Programme became part of the Wiltshire Better Care Programme but the evidence base and consultation from this programme of work was crucial in shaping the future direction of integrated and community services in Wiltshire

**Investment requirements**

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan- *there is no additional investment for this programme of work but it is a key scheme in terms of the overall Better Care Plan*

**Impact of scheme**

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The key outcomes for this workstream are as follows

- Reduction in acute admissions
- Reduction in acute attendances
- Reduction in volume of admissions to nursing and residential care
- Reduce average length of stay on identified acute and community wards.
- Reduction in volume of occupied bed days for patients over the age of 65 and associated excess bed days
- Reduction in care and nursing home length of stay
- Reduced number of delayed transfers of care (DTOCs )
- Increased quality of care
- Increased number of appropriate patient contacts through alternative admission avoidance schemes
- Increased in the volume of high risk patients who are jointly managed by health and social care
- Increased volume of care assessments made in an out of hospital environment

**Feedback loop**

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

There are a number of approaches that are being taken.

System review " check stage "

The ongoing check stage of the system review ( core team of health and social care practionners) who continue to review the impact of schemes on the ground , identify issues and put in place contingencies should schemes not be delivering to plan. This team has a presence across the health and social care infrastructure in Wiltshire.

Community Transformation programme

As a result of the work that was undertaken in 2013/14 there remains a strong network across all providers and an opportunity to raise issues and feedback.

The 100 day challenge

As outlined earlier in the plan the 100 day challenge provides an excellent opportunity to prioritise the key schemes and ensure we keep a system wide focus on delivery. This will also provide a useful listening , feedback and communications opportunity for front line staff and key referrers ( such as GPs ) to outline any key issues , concerns or barriers. We have established a central e mail which will be reviewed regularly for all feedback and concerns.

Daily performance dashboard

As part of the 100 day challenge and beyond we have established a daily performance dashboard which will track a range of key indicators focused on system demand and activity that is being undertaken (volumes of referral and impact of the schemes that have been put in place. This dashboard is system wide and will ensure a daily focus on a range of key indicators which will help to determine the impact we are having and any changes we need to make. There will be assigned executive leads for this process across the system so concerns can be dealt with in a timely proactive way. There is a commitment from providers to provide this data on a daily basis.

Ongoing reporting
Through the Better Care Plan Governance Process there is also a monthly performance report which enables us to monitor performance against key Better Care Plan indicators for Wiltshire. Each workstream also has to provide informal fortnightly and formal monthly scheme updates.

Ongoing assessment of impact
As outlined elsewhere in the document we have directly engaged Healthwatch Wiltshire to undertake the ongoing qualitative assessment of our service provision and ensure we continue to take the views of patients and users into account.

**What are the key success factors for implementation of this scheme?**

**Clinical expertise and knowledge**
The scheme the full involvement of the appropriate clinical lead from primary care and secondary care as well as the involvement of senior social care practionners . There is 3 assigned GP Leads for the scheme

**Operational expertise and leadership**

Given the importance of this scheme to the overall delivery of the out of hospital model , this workstream is chaired by the Director Lead for urgent care in the CCG and has Director level leadership input from the council and the main providers in the area.

**Partnership working**

There is a strong history of partnership working and this approach builds on the networks that were previously in place and has been strengthened with enhance clinical involvement.

**Ongoing engagement and communications**

There is regular communications to all staff on this scheme, key changes and updates. There are also bi-monthly urgent care seminars that are held in Wiltshire

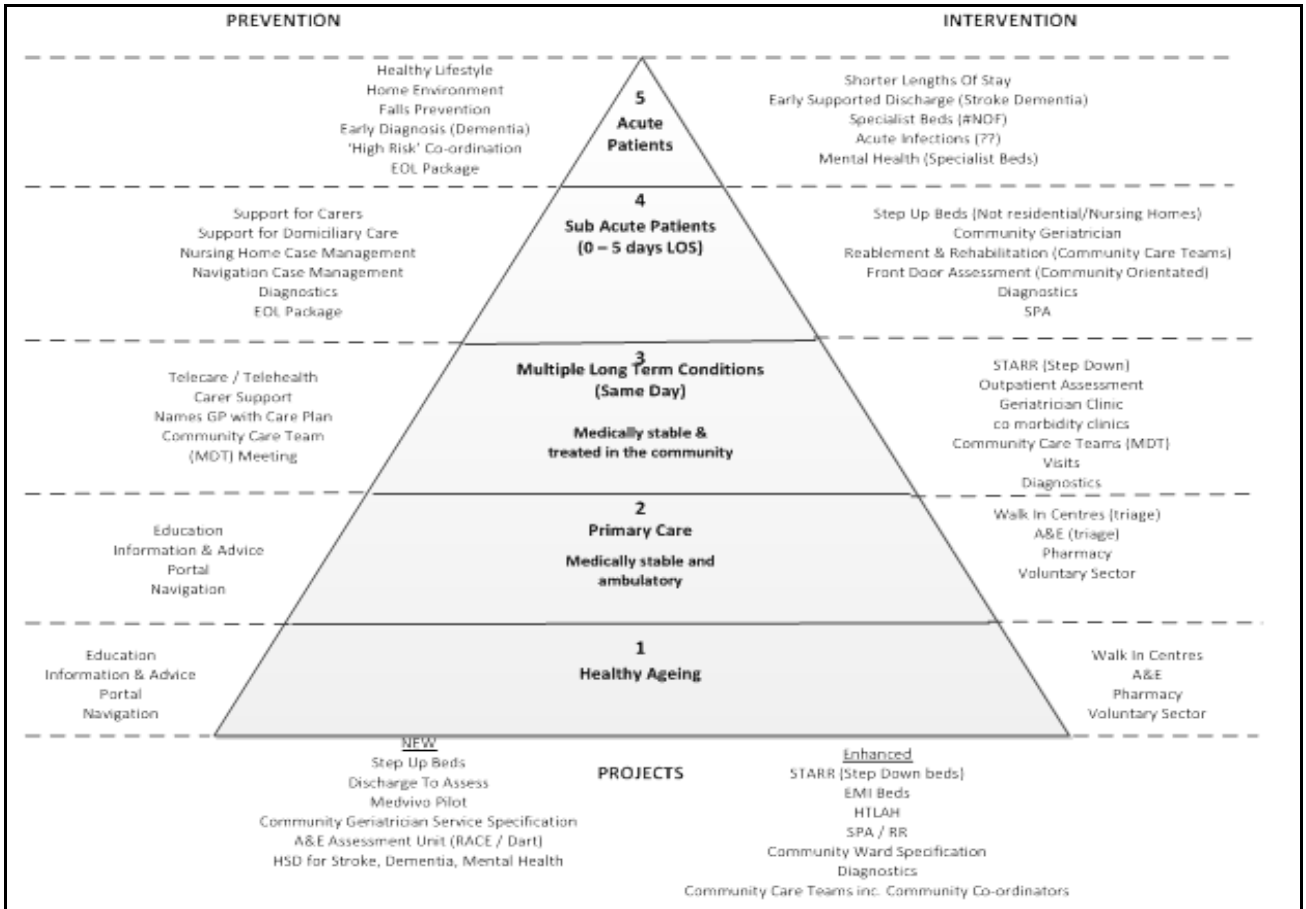
**Ongoing measurement and evaluation**

As outlined above there is a range of key performance indicators in place which monitor and measure the impact of the scheme on an ongoing basis.( i.e. the daily dashboard and feedback loop for staff )

**Ongoing development of our workforce**

There is an assigned OD lead for this workstream with a clear work plan in this area.

| **Scheme ref no.** |
|---|
| Scheme 5 |
| **Scheme name** |
| Prevention and self-intervention ( supporting communities to become more resilient ) |
| **What is the strategic objective of this scheme?** |
| The main strategic objectives of the scheme are to<br>- Increase the number of patients who can be managed in a community setting when they reach crisis point, through a mix of bedded and non-bedded alternatives.<br>- Develop robust alternatives to A&E attendance and admission either through the development of alternatives in a community setting or through enhancing rapid assessment at the front end of A&E<br>- Increase the number of patients whose care needs are provided for in a home settings through the enhancement of our Help to Live at Home Programme.<br>- Elevate the role of the voluntary sector and other 3rd sector organisations in the provision of care and support in Wiltshire<br>- Develop more effective prevention approaches in this area<br>- Improve use of services through effective signposting and information<br>- Ensure we continue to take the views of users and their family /carers into consideration when planning service provision. |
| **Overview of the scheme**<br>Please provide a brief description of what you are proposing to do including:<br>- What is the model of care and support?<br>- Which patient cohorts are being targeted? |
| In Wiltshire we believe that given the growing demographic challenges there is need to increase investment and focus on prevention. With the involvement of public health and senior practionners across health and social care we have outlined in line with the risk pyramid the type of prevention services which should be provided. |




Key areas of focus in this area are clearly highlighted at each stage of the risk pyramid /level of risk. The public health team at Wiltshire Council are fully engaged in this area of work and are taking the lead for this across Wiltshire. Other key areas of focus include;

- A joint health and social care pathway to facilitate people to manage their own care through the provision of appropriate information, skills, support and services to enable them to do this.
- A preventive and early intervention strategy/ Ageing Well Strategy leading to a commissioning plan.
- A review of user led organisations and re-commissioning of those services based on outcomes
- Re-commissioning of services to reflect the new approach
- More people (self-funders) able to access information and support they need to enable them to continue to remain independent.
- More people with long term conditions able to manage their own care.
- Reduction in inappropriate admissions or use of statutory services
- Improved support for carers leading to fewer crisis interventions

The other key areas of focus in this area include ;

- The commissioning of an information and signposting portal for the public and voluntary groups
- The commissioning of a home from hospital pathway in partnership with Age Concern and Age UK providing care and befriending services for patients in their own home
- Developing a robust commissioning and contracting strategy for the voluntary sector

**The delivery chain**
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

A system wide working group for prevention and early intervention has been established and meets on a monthly basis. This group has a wider membership base than some of the other working groups and includes representation from Heath watch, care providers, public health and a range of voluntary sector organisations. The group also includes representation from the CCG and the local authority

All plans and strategies are consulted on at this forum and need to be signed off by the Steering Group before they can commence.
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**The evidence base**
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

**Local evidence base**

*JSNA*

The JSNA for Wiltshire has identified the scale of the demographic challenge in Wiltshire and the key areas of focus and this plays a key role in driving the work of this workstream

*Wilsthire specific data*

A range of evidence highlights a need for such an approach , this includes ;

- 96,000 people over 65
- 17,000 people over 65 with a limiting long term illness
- 8,200 older people projected to have depression, of whom 2,600 have serious depression
- 6,700 over 65's people have dementia
- 4,700 projected to have a long standing health condition as a result of a heart attack
- 2,200 projected to have a long standing health condition as a result of a stroke
- 25,500 projected to have a fall of whom 1,900 admitted to hospital
- 15,700 projected to have a continence problem at least once a week
- 8,300 have a visual impairment
- 18% of older people live in rented accommodation
- 585 older people were admitted to care homes last year
- 3,600 older people live in care homes
- 40,000 have a hearing impairment
- 17,500 unable to manage an activity on their own
- 25,000 with a BMI or 30 or more
- 12,000 predicted to have diabetes
- 45% of over 75's live on their own
- 47,600 unpaid carers

**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan- *this is outlined in part 2*

**Impact of scheme**
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Through early intervention and support for patients with dementia aim to reduce long term institutionalisation by 20%
- Through focused carer support and counselling look to reduce ( for an identified cohort ) reduce care home placements by 25%
- Reduce volume of falls by 32 % ( for an identified cohort)
- Increased independence for patients with a diagnosis of dementia enabling them to be maintained in their own home for longer.

**Feedback loop**
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

There are a number of approaches that are being taken.

System review " check stage "

The ongoing check stage of the system review ( core team of health and social care practionners) who continue to review the impact of schemes on the ground , identify issues and put in place contingencies should schemes not be delivering to plan. This team has a presence across the health and social care infrastructure in Wiltshire.

The 100 day challenge

As outlined earlier in the plan the 100 day challenge provides an excellent opportunity to prioritise the key schemes and ensure we keep a system wide focus on delivery. This will also provide a useful listening , feedback and communications opportunity for front line staff and key referrers ( such as GPs ) to outline any key issues , concerns or barriers. We have established a central e mail which will be reviewed regularly for all feedback and concerns.

Daily performance dashboard

As part of the 100 day challenge and beyond we have established a daily performance dashboard which will track a range of key indicators focused on system demand and activity that is being undertaken (volumes of referral and impact of the schemes that have been put in place. This dashboard is system wide and will ensure a daily focus on a range of key indicators which will help to determine the impact we are having and any changes we need to make. There will be assigned executive leads for this process across the system so concerns can be dealt with in a timely proactive way. There is a commitment from providers to provide this data on a daily basis.

Ongoing reporting

Through the Better Care Plan Governance Process there is also a monthly performance report which enables us to monitor performance against the key Better Care Plan indicators for Wiltshire. Each workstream also has to provide informal fortnightly and formal monthly scheme updates.

Ongoing assessment of impact

As outlined elsewhere in the document we have directly engaged Healthwatch Wiltshire to undertake the ongoing qualitative assessment of our service provision and ensure we continue to

take the views of patients and users into account.

**What are the key success factors for implementation of this scheme?**

**Clinical expertise and knowledge**
The scheme the full involvement of the appropriate clinical lead from primary care and secondary care as well as the involvement of senior social care practionners . There is 3 assigned GP Leads for the scheme

**Operational expertise and leadership**

Given the importance of this scheme to the overall delivery of the out of hospital model , this workstream is chaired by the Director Lead for urgent care in the CCG and has Director level leadership input from the council and the main providers in the area.

**Partnership working**

There is a strong history of partnership working and this approach builds on the networks that were previously in place and has been strengthened with enhance clinical involvement.

**ongoing engagement and communications**

There is regular communications to all staff on this scheme, key changes and updates. There are also bi-monthly urgent care seminars that are held in Wiltshire

**Ongoing measurement and evaluation**

As outlined above there is a range of key performance indicators in place which monitor and measure the impact of the scheme on an ongoing basis.( i.e. the daily dashboard and feedback loop for staff )

**Ongoing development of our workforce**

There is an assigned OD lead for this workstream with a clear work plan in this area.

# ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

| | |
|---|---|
| **Name of Health & Wellbeing Board** | Wiltshire health and Well Being Board |
| **Name of Provider organisation** | Great Western Hospitals, NHS Foundation Trust<br>Royal United Hospital Bath, NHS Trust<br>Salisbury NHS Foundation Trust |
| **Name of Provider CEO** | Nerissa Vaughan (GWH)<br>James Scott (RUH)<br>Peter Hill (SFT) |
| **Signature (electronic or typed)** | |

**Provider 1- Salisbury Foundation Trust**

| | Question | Response |
|---|---|---|
| **1.** | **Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?** | We recognise the ambition behind the plan and the system commitment to deliver it. We don't fully recognise all the numbers because the anticipated impact has not yet been met. However we are committed to the Better Care Fund Initiative and are supporting the council and the CCG on the various schemes |
| **2.** | **If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?** | During 2014/15 we have experienced growth in A&E attendances and admissions above plan and we have seen an increase in the acuity of some of the admissions. As a result of this we are working with the Integration Director to review the baseline against which to measure the performance of the BCF and ensure it is correct moving moving forward.<br><br>We have also experienced at this stage a higher level of delayed transfers of care than anticipated and an increase in the volume of patients who are classified as "green to go "from an acute clinical perspective. This has resulted in a range of operational pressures and escalation.<br><br>We welcome and recognise the new actions that are being introduced in September through the BCP in particular the 100 day challenge with a range of new schemes going live including the discharge to assess scheme and the effect of |

| | | |
|---|---|---|
| | | the initiative and others and the effect of this initiative and others will be important in understanding whether the BCF approach will deliver sustainable benefits and reduced acute activity. We will then be in a better position to verify proposed reductions in activity as shown in the data and we welcome the commitment to move to daily reporting through the 100 day challenge as this will help us to determine both the impact and what we need to deliver as a system to realise the key benefits . We recently held a successful discharge to assess workshop in the hospital and will commence this scheme from the 1st September |
| **3.** | **Can you confirm that you have considered the resultant implications on services provided by your organisation?** | Discussions about the implications for services are on-going and we are working closely with partner organisations to understand this better. There are proposals to change the management arrangements for South Wiltshire community services, which are currently managed by GWH in Swindon, and this should help to support more integrated working in the medium term. We also and will continue to meet regularly with the Integration Director to understand the potential implications on service delivery and ensure we have a clear strategy to plan for future service provision in Salisbury |
| **4** | **Name and position of response lead**<br><br>**Signature** | Malcolm Cassells<br>Deputy Chief Executive/Finance Director Salisbury Foundation Trust / on behalf of Peter Hill CEO (Who has seen the response ) |

**Provider 2- Great Western Acute Trust and Great Western Community Services**

| | Question | Response |
|---|---|---|
| 1. | **Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?** | Yes, once the bed reductions are amended to 18. |
| 2. | **If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?** | n/a |
| 3. | **Can you confirm that you have considered the resultant implications on services provided by your organisation?** | Yes, the Trust has considered the impact on both the community service, in particular<br>• the use of community working with partners to implement step up/step down<br>• workforce implications by specialty service lines for the expansion of 7 day working shifting setting of care and the impact this will have on the acute beds, the Trust had all available acute beds open in 2013/14, the improvements in LOS and<br>• shifting setting of care will reduce the pressures on acute beds and enable the Trust to contain activity within the existing bed base. The bed reduction will contribute to a predicted shortfall of 55 that would occur if no system change happened. The balance of the bed shortage is expected to be achieved for Swindon CCG commissioned services. |
| | | |
| 4 | **Name and position of response lead** | Maria Moore<br>Deputy Chief Executive/Finance Director<br>GWH Acute Trust and GWH Community Provider |

| | | |
|---|---|---|
| | **Signature** | |

## Annex 3 – Wiltshire Better Care Plan Daily Dashboard

| **Wiltshire Better Care Plan Daily Dashboard**<br><br>*NB – the information included below is for demonstration purposes* | | | | | | | | | =Test data | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | **Actual** | **Day Before** | **2 Days Before** | **3 Days Before** | **4 Days Before** | **5 Days Before** | **6 Days Before** |
| | | | **Basis** | **Target** | **Thu** | Wed | Tue | Mon | Sun | Sat | Fri |
| **NHS111** | Calls | | C | | **224** | 250 | 245 | 200 | 210 | 230 | 240 |
| | Answered <60 Secs % | | C | 95% | **97.3%** | 95.3% | 94.2% | 96.3% | 97.2% | 92.3% | 91.2% |
| | Abandoned >30 Secs Calls % | | C | 5% | **0.0%** | 2.0% | 3.0% | 6.0% | 4.0% | 1.0% | 6.0% |
| | Ambulance Referral % | | C | 10% | **11.1%** | 8.1% | 68.0% | 72.0% | 68.0% | 75.0% | 67.0% |
| | A&E Referral % | | C | 5% | **9.0%** | 7.8% | 5.1% | 4.9% | 4.7% | 5.3% | 5.2% |
| **Medvivo** | Telephone Advice Calls | | C | | **80** | 85 | 75 | 80 | 84 | 90 | 88 |
| | PCC Attendances | | C | | **75** | 73 | 78 | 80 | 76 | 70 | 78 |
| | Home Visits | | C | | **24** | 20 | 30 | 35 | 23 | 20 | 22 |
| | Referrals to urgent care at home | | C | | | | | | | | |
| | Referrals to extended EOL service | | C | | **4** | 1 | 0 | 2 | 1 | 0 | 3 |
| | Telecare mobile responses | | C | | **4** | 3 | 2 | 3 | 3 | 1 | 3 |
| | One number SPA calls | | C | | **4** | 3 | 2 | 3 | 3 | 1 | 3 |
| **SPA** | Referrals | | C | | **5** | 4 | 6 | 4 | 5 | 7 | 6 |
| **STARR** | Step Up Beds | Admits | C | | **6** | 5 | 4 | 2 | 7 | 8 | 5 |
| | | Discharges | C | | **5** | 6 | 3 | 4 | 5 | 9 | 6 |
| | | Occupancy Rate | C | | | | | | | | |
| | | No. > 7d | C | | **8** | 7 | 5 | 9 | 8 | 7 | 9 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | ays LoS | | | | | | | | | |
| | Step Down Beds | Admits | C | | **6** | 5 | 4 | 2 | 7 | 8 | 5 |
| | | Discharges | C | | **5** | 6 | 3 | 4 | 5 | 9 | 6 |
| | | No. > 6Wk LoS | C | | **8** | 7 | 5 | 9 | 8 | 7 | 9 |
| | | Total No. of clients | C | | | | | | | | |
| **SWAST** | Red (1&2) Incidents | | C | | **102** | 105 | 110 | 95 | 97 | 100 | 105 |
| | Total Incidents | | C | | **239** | 250 | 245 | 200 | 210 | 230 | 240 |
| | ED Conveyance | GWH | P | | **46** | 44 | 48 | 50 | 45 | 42 | 49 |
| | | RUH | P | | **32** | 35 | 38 | 32 | 28 | 27 | 30 |
| | | SFT | P | | **17** | 16 | 18 | 20 | 17 | 14 | 15 |
| | | A&E %Conveyance Rate | C | | **40.6%** | 45.0% | 40.0% | 38.0% | 39.0% | 42.0% | 37.0% |
| **A&E** | GWH (A) | Attend | P | | **230** | 201 | 220 | 225 | 215 | 230 | 220 |

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|---|---|---|---|---|---|---|---|---|---|---|---|
| | | ances | | | | | | | | | |
| | | Admits | P | | **50** | 48 | 55 | 57 | 48 | 50 | 49 |
| | | %A&EAdmits | P | | **22%** | 24% | 25% | 25% | 22% | 22% | 22% |
| | | <4HrRate | P | >95% | **90.0%** | 89.0% | 88.0% | 92.0% | 94.0% | 93.0% | 92.0% |
| | | Handovers>30Mins | P | | **1** | 0 | 2 | 5 | 0 | 2 | 3 |
| | RUH | Attendances | P | | **230** | 201 | 220 | 225 | 215 | 230 | 220 |
| | | Admits | P | | **65** | 68 | 64 | 62 | 70 | 75 | 68 |
| | | %A&EAdmits | P | | **28%** | 34% | 29% | 28% | 33% | 33% | 31% |
| | | <4HrRate | P | >95% | **90.0%** | 95.0% | 96.0% | 97.0% | 96.0% | 92.0% | 92.0% |
| | | Han | P | | **0** | 0 | 2 | 1 | 0 | 1 | 0 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | d overs > 30 Mins | | | | | | | | | |
| | SFT | Attendances | P | | **121** | 115 | 130 | 142 | 133 | 120 | 115 |
| | | Admits | P | | **26** | 26 | 28 | 26 | 25 | 28 | 22 |
| | | % A&E Admits | P | | **21%** | 23% | 22% | 18% | 19% | 23% | 19% |
| | | < 4 Hr Rate | P | >95% | **97.5%** | 96.0% | 96.5% | 97.3% | 92.1% | 94.5% | 96.7% |
| | | Handovers > 30 Mins | P | | **0** | 0 | 1 | 2 | 0 | 0 | 1 |
| | GWH (C) | MIU Attendances | P | | **116** | 120 | 125 | 120 | 105 | 108 | 110 |
| | Bath UCC | Attendanc | P | | **116** | 120 | 125 | 120 | 105 | 108 | 110 |

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| | | es | | | | | | | | | |
| **APL** | GWH (A) | Emergency Admits | C | | **27** | 32 | 38 | 37 | 32 | 36 | 38 |
| | | Emergency Discharges | C | | **36** | 34 | 36 | 32 | 34 | 38 | 39 |
| | | Net Bed Flow | C | | **(9)** | (2) | 2 | 5 | (2) | (2) | (1) |
| | | No. > 14 day LoS | C | | **50** | 45 | 48 | 47 | 49 | 52 | 50 |
| | | Medical outliers | P | | **4** | 3 | 2 | 5 | 4 | 1 | 2 |
| | | Green to Go | C | | **20** | 18 | 16 | 15 | 14 | 17 | 18 |
| | | Disc | C | | **5** | 4 | 6 | 3 | 4 | 2 | 3 |

| | | | | | | | | | | | |
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| | | hargetoassess | | | | | | | | | |
| | | DToCs | C | | **5** | 3 | 4 | 2 | 5 | 6 | 4 |
| | RUH | EmergencyAdmits | C | | **35** | 32 | 38 | 37 | 32 | 36 | 38 |
| | | EmergencyDischarges | C | | **36** | 34 | 36 | 32 | 34 | 38 | 39 |
| | | NetBedFlow | C | | **(1)** | (2) | 2 | 5 | (2) | (2) | (1) |
| | | No.>14dayLoS | C | | **50** | 45 | 48 | 47 | 49 | 52 | 50 |
| | | Medicaloutl | P | | **4** | 3 | 2 | 5 | 4 | 1 | 2 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | iers | | | | | | | | | |
| | | Green to Go | C | | **20** | 18 | 16 | 15 | 14 | 17 | 18 |
| | | Discharge to assess | C | | **5** | 4 | 6 | 3 | 4 | 2 | 3 |
| | | D To Cs | C | | **5** | 3 | 4 | 2 | 5 | 6 | 4 |
| | SFT | Emergency Admits | C | | **35** | 32 | 38 | 37 | 32 | 36 | 38 |
| | | Emergency Discharges | C | | **36** | 34 | 36 | 32 | 34 | 38 | 39 |
| | | Net Bed Flow | C | | **(1)** | (2) | 2 | 5 | (2) | (2) | (1) |
| | | No. > 14 | C | | **50** | 45 | 48 | 47 | 49 | 52 | 50 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | day LoS | | | | | | | | | |
| | | Medical outliers | P | | **4** | 3 | 2 | 5 | 4 | 1 | 2 |
| | | Green to Go | C | | **20** | 18 | 16 | 15 | 14 | 17 | 18 |
| | | Discharge to assess | C | | **5** | 4 | 6 | 3 | 4 | 2 | 3 |
| | | D To Cs | C | | **15** | 16 | 14 | 12 | 9 | 14 | 16 |
| | GWH (C) | Emergency Admits | C | | **7** | 8 | 6 | 5 | 4 | 3 | 6 |
| | | Emergency Discharges | C | | **6** | 7 | 7 | 7 | 6 | 2 | 4 |
| | | N | C | | **1** | 1 | (1) | (2) | (2) | 1 | 2 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | et Bed Flow | | | | | | | | | |
| | | No. > 14 day LoS | C | | **25** | 24 | 26 | 25 | 23 | 26 | 27 |
| | | Green to Go | C | | **8** | 7 | 9 | 6 | 7 | 5 | 6 |
| | | D To Cs | C | | **14** | 16 | 15 | 12 | 14 | 13 | 15 |
| | AWP | D To Cs | C | | **14** | 16 | 15 | 12 | 14 | 13 | 15 |
| **Social Care** | Funded Packages - Care Home | Started | C | | **5** | 3 | 4 | 2 | 0 | 0 | 3 |
| | | Ended | C | | **4** | 3 | 5 | 3 | 0 | 1 | 3 |
| | | Current | C | | **50** | 48 | 46 | 48 | 45 | 43 | 49 |
| | Funded Packages - H2LAH | Started | C | | **5** | 3 | 4 | 2 | 0 | 0 | 3 |
| | | Ended | C | | **4** | 3 | 5 | 3 | 0 | 1 | 3 |
| | | Current | C | | **50** | 48 | 46 | 48 | 45 | 43 | 49 |
| | | N | C | | **4** | 3 | 5 | 3 | 0 | 1 | 3 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | e w initial support | | | | | | | | | |
| **PTS** | Total PTS journeys planned | | P | | | | | | | | |
| | Total discharges planned | | P | | | | | | | | |
| | Collections before midday | | P | | | | | | | | |
| | Discharges booked >1 day ahead | | P | | | | | | | | |