



Integration and Better Care Fund

Narrative Plan Template 2017/19

Swindon 2017 v4 8.9.2017

Area	SWINDON
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Introduction / Foreword

Swindon has a long and well established history of joint commissioning and integrated working for health and social care. This plan sets out our ambitions for the Better Care Fund for 2017-2019. It provides a joined up vision for all partners working with individuals, carers and local communities to transform the quality of care provided and improve levels of health and wellbeing for people living in Swindon. Local health and social care partners are committed to work together to improve the delivery of integrated community and acute pathways. This plan continues to progress our integration journey and endorses a shared responsibility for the current pressures across Swindon's health and social care system.

The plan describes how we will work together with a common set of values and principles. We recognise we need to find new and better ways of responding by building on the support that people can find amongst their families, friends and communities, by making more use of technology to help people remain independent, and by helping earlier and more effectively to stop people's circumstances getting worse. Where people do need additional help, we will ensure it is personalised and offers choice and control. Our BCF plan focusses on delivering the following outcomes:

- avoiding emergency hospital admissions for specific groups of patients, particularly those suffering from diabetes and heart conditions
- Enabling more patients to leave hospital without delay.
- Fewer patients being re-admitted to hospital by embedding reablement into domiciliary care
- Fewer older people being admitted to residential care through the provision of timely and effective reablement, making better use of preventative services in the voluntary and third sector and flexible housing with care, and reducing isolation amongst older people
- Enabling more people with a disability to live as independently as possible and to access paid employment through ongoing investment in technology and the voluntary and third sector.

The plan details the specific schemes and actions the partnership has identified to deliver these outcomes and provides confirmation of the agreed funding contributions and areas of spend for implementing the Care Act, provision of Carers Support and Short Term Breaks, Reablement, Social Care and Improved Better Care Fund. Clear metrics and targets have been set to monitor progress which will provide oversight and assurance that we are delivering the benefits and managing spend as set out in the plan. Shared risks, information sharing protocols and robust governance arrangements are in place to support whole system ownership for the delivery of the BCF Plan.

Local vision for health and social care integration

1. Vision

Our joint vision for people in Swindon is enshrined in the Health & Wellbeing Strategy

To ensure that everyone lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities

We have aligned our joint resources to support the health, wellbeing, mental health, education and care of children, families and adults in the community to achieve the mission of both organisations. This Plan is also aligned with the work being progressed the Sustainable Transformation Plan Partnership and Accountable Care. We have been involved in discussions with the public, patients, GP practices, providers, voluntary sector, other stakeholders, children and young people, and the Youth Forum in the development of the documents referred to above and the development of Accountable Care.

The Better Care Fund Plan is a summary of jointly agreed areas of priority and serves as our plan for integrated working and joint commissioning. Specific service redesign workshops were held on mental health, carers and community based support for older people as well as developing plans for an Accountable Care System.

The following priorities identified by service users have been incorporated into this plan:

- Improved advice and information about services for carers and parent carers
- A simplified assessment process for service users and carers
- Community support for people discharged by specialist mental health services and a seamless link between voluntary and third sector providers and specialist services
- Support for older people who are isolated
- Improved patient flow within the hospital discharge process
- Preventing hospital admissions by improving streaming and preventative care

Swindon has a long history of joint commissioning and integrated working for health and social care. Our future plans have now been revised in light of the Five year Forward plan next Steps and the Sustainable Transformation Partnership Plan, Accountable Care and the refreshed Health and Wellbeing Strategy 2017 – 2022.

We are a single unitary local authority (Swindon Borough Council), one CCG (Swindon CCG, representing 26 member practices in Swindon and Shrivenham), a single acute Trust in the Town (Great Western Hospitals NHS Foundation Trust), one mental health provider (Avon and Wiltshire Mental Health Partnership NHS Trust, who have established a clinical directorate that just serves Swindon), one emergency patient transport provider (South Western Ambulance Service NHS Foundation Trust) and one network of voluntary sector organisations (Voluntary Action Swindon or VAS). Swindon Borough Council is the Local Housing Authority.

We have jointly commissioned services through National Health Services Act 2006 Section 75 Agreements since 2008. We have jointly commissioned services through National Health Services Act 2006 Section 75 Agreements since 2008. The Agreement renewed in 2015 comprises total funding in 2017-18 of £17.8m from the CCG and £101m Swindon Borough Council (SBC), a total of £118.8m. Services are commissioned through the Joint Commissioning

Group with representation of the Executive Nurse of the CCG, the Director of Adult Social Care and Director of Children's Services. For 2017–18 services are commissioned against this Better Care Fund Plan and monitored by the Joint Commissioning Group reporting to the Health & Wellbeing Board. The Better Care Fund is a separate pool within the S75 of £22.8m, with the balance of funding being within aligned pools.

We have increased the amount of money pooled in the BCF so that we are able to show the total spent against the schemes we are jointly commissioning through the BCF and IBCF. The excel document sets out the financial arrangements.

Integrated services for children are established, bringing together community health, education and social care services in a single co-located service, managed in an integrated way within Swindon Borough Council.

We recognise that our demographic challenges as an expanding town with an ageing population. Following a detailed diagnostic by Newton Europe in 2015, the community health services and community equipment services were tendered in 2016 with the aim of improving independence, reducing emergency admissions and improving the health and wellbeing of the population. The contract was successfully awarded to Great Western Foundation Trust who we are working with to develop a new model of care in line with the Five Year Forward View.

On 1 October 2016, 400 staff that had previously provided care services in Swindon on behalf of SEQOL (the independent employee-owned social enterprise company) transferred to the Council following financial difficulties experienced by SEQOL. All services were transferred smoothly and there have been no complaints from staff or service users. A new management structure has been established and we have successfully recruited to a Head of Transitions post, Head of Commissioning, Head of Social Work and Regulated Services Manager. At the same time community health services transferred to Great Western Hospital earlier than planned under a 'care taker arrangement'. A new contract for community health services is now in place.

2. What will be different in 2020 for services and people?

Adults and Older people

Swindon will have grown substantially by 2020 with a population of over 250,000 by 2026 (including Shrivenham) from a current population of 220,000. We already have a lot of community based health services that are delivered in the homes of residents, such as fluids, medication and antibiotics through our Virtual Ward and home visiting services. We will be delivering more services in the community, such as delivering health care in people's homes where this is safe to do through for example the community health services working closely with care homes. At present, many older people do not have a health care plan addressing their long term health conditions.

Living in Swindon in 2020 will mean that you can expect to live longer than the English average, with less risk of avoidable death, in better health and with the support of your neighbourhood and community. More of your integrated health and social care provided by community nursing services, home care and social care workers (including social work and occupational therapy) will be planned in advance as part of a new life-long health plan and will be preventative, replacing much that is currently emergency care and avoidable. This will be done in a coordinated way with primary care.

By 2020 everybody in Swindon is working together with a common set of values and principles based on respect, giving people choice, collaboration and innovation, where people are encouraged to think what they can do themselves, what help they have within their family and community and what they still need help with. When people need help it will be personalised, offering choice and control.

Outcomes for adult service users and patients will improve:

- Emergency hospital admissions will be avoided for specific groups of patients, particularly those suffering from diabetes and heart conditions
- More patients will be able to leave hospital without delay Fewer older people will be admitted to residential care, through improved reablement service, good use of preventative services in the voluntary and third sector, flexible housing with care and reducing isolation amongst older people
- Reablement will be an integral part of all domiciliary care and will mean that fewer patients will be re-admitted to hospital
- More people with a learning disability will be able to find employment through support commissioned from the voluntary and third sector and in partnership with our Skills for Employment.
- More people with a learning disability will live in well-designed supported living

Children and Families

We want children in Swindon to have the best start in life and to be safe, healthy and to grow up in supportive, confident and resilient families and communities. We want children to grow up in loving and stable families where the relationship between children and parents is good. If you need help we will be offering support to families and children to achieve a best start in life. This includes support where parents have lost confidence in their parenting ability or where relationships come under pressure to adapt to a potentially new situation. We want to achieve a different balance weighted towards practical, direct and targeted support when parents need help the most, and to support parent carers so that disabled children are supported at home or live in supported accommodation where possible.

We will be working together to protect children from harm, abuse and exploitation. Young people will be kept safe, living in supportive and appropriate environments. Children in care will live in stable families or in specialist placements where that is necessary, have access to good education and become successful and confident adults.

There are 48,604 children and young people aged 0-18 living in Swindon and we want to ensure that they are all able to take advantage of the benefits of living here. Most do, but there are some children and young people who cannot, or who need help to do so. Swindon is a town of geographical inequality and poverty. The place we are born, or the place we live, is likely to dictate our life chances, unless actions are taken to change this.

Ante-natal support, early attachment and parent-child interactions, language development, family support at the earliest stage of difficulties are essential for effective early intervention with children.

In March 2017, 64% of Swindon children living in one parent families are living in poverty. This contrasts sharply with children living in two parent families; where the rate of poverty of just 9%. This means that a child living in a lone parent family is almost seven times more likely to be living in poverty than a child living in a two parent household. If the child also has special educational needs, latest evidence (Selwyn 2016) suggests that a child receiving free school meals, with special needs has a '70% likelihood of been referred to social services in the future'. Early intervention has a big part to play to ensure we proactively work with these families before they hit crisis to avoid having to access statutory and often costly social care interventions later in the child's life.

Early intervention is already established as a core principle in many areas of working and there is substantial commitment and energy to support and work with families. However, there is a sense that early intervention could be more coordinated and that the strategic direction could better channel early intervention and prevention work to make the most of strong partnerships, existing good practice and further targeted investment supporting early intervention.

Outcomes for children and families will improve:

- A more coordinated approach to prevention and early intervention which builds on community strengths and resilience
- More guidance, advice and support available digitally to children and families through smart phone apps and better interactive websites
- A whole family approach will be adopted by all stakeholders working with children, young people and families
- Early intervention and prevention will be an integral part of the support available to children and families
- More children will have Early Help Records and Plans
- There will be less statutory intervention with fewer children on a Child protection register or becoming looked after

2.1 Prevention and self help

We already understand the population of Swindon at a locality/ward area and at GP practice level. We have some preventative and self-help services in place such as a third phase of community navigators and befriending support for a small number of older people.

By 2020, preventative and self-help integrated services will be in place locally to engage and support individuals. This will mean:

- Genuine choice of care setting for those whose mobility, functionality or health is impaired or for those with serious and terminal illness who are preparing for death
- Home will mean your own home, with us using new practice and technology that enables you to be at home
- You will be supported to live life to the full within your community despite the long term conditions you may have thus avoiding institutionalised care in a community setting.
- You, your parents and carers know where to access information and support in the community, services online through My Care My Support, and the Swindon Advice and Support Centre.
- Carers for people with support needs will be well supported through joint investment in the Carers Centre and short term breaks.

- If you are older, we will support you in making a positive contribution to your community by encouraging you to help others. This could be helping in a playgroup or being a good neighbour. You may be engaged in self-help groups, local activities or be a volunteer.
- Where possible moving to residential and nursing care will be delayed and housing opportunities such as homes for life, supported housing and extra care housing will be used extensively.
- You will have access to a range of programmes designed to improve your health, from healthy eating and healthy exercise (ranging from cycling to sports activities and recreational swimming to walking and gardening schemes); to smoking cessation programmes; to cultural activities, all of which have been shown to benefit health and wellbeing and extend quality of life. We will encourage you to volunteer to help deliver these services and promote community health champions.

Most studies identify self-care as representing 98% of the total health care needed across a population at any given time. We have invested in self-care and self-management of patients through the Health Improvement Team and community navigators. We need to develop more support through the voluntary and community sector to support patients in managing their health conditions.

Public Health initiatives such as health ambassadors work well in promoting health and wellbeing, specifically healthy eating, exercise, smoking cessation and reduction in drug and alcohol misuse. By 2020 we want Public Health to be working closely with General Practice providing a short consultation that can lead to more people quitting smoking. Brief intervention has been particularly successful in smoking cessation and drug and alcohol misuse. Community navigators have demonstrated that they improve the quality of life of individuals, reduce isolation and avoid some health costs.

2.2. Early help

Swindon's commitment to Early Help to improve outcomes for children, young people and families is reflected in the strategies, plans and commissioned services. By 2020, all services and activities across the partnership will be working together more effectively to prevent problems occurring, promote positive outcomes, and support people to reduce problems escalating. We will have developed community projects to build resilience and help families connect to their communities and reduce social isolation. Our Early Help offer will be addressing inequalities of health and wealth by providing the right kind of help and support at the right time to the local communities who need it. We will be using predictive analytics to identify and plan for future need. By 2020, our Early Help offer will:

- Provide Swindon children with a good start in life, whatever their background and wherever they live by listening to their needs and aspirations.
- Invest early to prevent harm, helping families build lifelong resilience and self-reliance involving friends, communities and professionals.
- Act swiftly when children and young people are at risk of harm and protect them by listening to them and acting on their behalf to restore their rights – stability, permanence, security, education, health and wellbeing.
- Be inclusive and respect difference and recognise that even the most vulnerable children and young people are participating, shaping and enriching the life of the town.
- Make sure that whether at the start of life, or on the way through, children who need help will be able to access early help support services that become predominantly proactive rather than reactive.

- Work with the resources in the system rather than provide support directly using the community, universal services and digital help.
- Test innovative new early help models to bring new solutions more quickly as well as solutions that change children and family outcomes for the better whilst reducing the costs per intervention.

How self-care, prevention and early help will be different in 2020

2017

Andrea is living in Penhill, one of the most deprived areas in Swindon. She has three children and an older mother suffering from diabetes living nearby. She is unemployed and on a low income. Her middle child is overweight and the youngest child's speech development is poor. She has few friends or relatives and feels often low and depressed, caused by stress and anxiety.

2020

Andrea is able to access early help family support services delivered from the Family Service in Penhill where services are designed to enable Andrea to be as healthy as she can be; to start well, stay well and age well. Staff at the centre will work across services and in the wider community to offer support to Andrea so that she can access the job market, housing, environment and education she needs to be healthy, happy and independent.

Andrea can attend weekly parent support groups and parent led stay and play sessions which will help Andrea to meet new friends from her community and feel less isolated. The centre will host adult and community courses such as cooking healthily on a budget as well as sessions to help Andrea to get back into work or access training to boost her self-esteem and confidence. Parenting courses will also be available to give Andrea the tools and strategies to support her young children and her own mental wellbeing.

Andrea can access self-help from the council web pages that will provide links to additional local and national support. Andrea will also be able to sign up for digital apps using her smart phone 24 hours a day for immediate information on a raft of health and wellbeing services as well as early help and education support to help her as her children transition from nursery to school. All early help services will be working together to give Andrea the support she needs whilst only having to tell her story once.

2.3 Urgent care – moving from unplanned care to planned care

We have community navigators linked to GP practices where if you are at high risk of a hospital admission, your GP or community nurse is able to refer you to review your health, social and emotional wellbeing and develop a plan with you. The evaluation in January 2017 indicated the community navigators were demonstrating a small cost reduction on emergency admissions and long term care. The model has now been revised and extended to focus on patients with long term health conditions continuing to link to GP practices and the voluntary and community sector. If you are a patient with a long term health condition and identified as at very high risk of hospital admission, your GP will draw up a health care plan with you rather than refer to a community navigator.

If you have need for rapid access to treatment for a minor illness and cannot treat this yourself through rest or use of medication, then this will be through a combination of your local pharmacy or by appointment through the urgent care centre, contacted through your GP surgery or within two GP led urgent care clinics (SUCCESS programme). These clinics operate 0800-2000 during weekdays but hours are being extended to include weekends

If a patient needs a home visit, this will be available in the future from a dedicated home visiting service able to offer a visit at any time 0800 to 2000. Currently home visits are commonly arranged at the end of a GPs surgery (this is part of our Extended Primary Care Access Service – called SUCCESS). If you need to access emergency care, then you may be seen by an urgent care GP who will assess whether you can be safely treated at home or you need to go to the local hospital.

Depending on urgent care needs the patient will be directed to the appropriate service to meet there needs. This may be within either a GP/Nurse Led urgent care clinic or the Emergency Department at GWH. Wherever the patient presents in community or on the acute hospital site, sign-posting will be used to maximise effective use of all care services so that the best possible care can be delivered. Our care services are configured and developing to provide high quality care closer to home.

There are strong links between the provider of integrated community health and social care services and all partners, particularly the local hospital, care homes, voluntary sector and primary care. We have invested in My Care, My Support website at <http://www.mycaremysupport.co.uk/> giving advice and information about health and social care as well as a community based advice service.

By 2020 advice and information will have been fully available to all for a number of years, so that patients are well informed and know where to find health care urgently. We will have increased capacity in the Virtual Ward and extended the treatment of relevant medical conditions within the community (minor illness) in order to prevent admission to hospital. There is more to do to improve urgent.

Currently we still have challenges with patient flow at the health and social care interface. The Delayed Discharge Programme continues to focus on admission and discharge management processes as well as ensuring staff are trained to deliver community based nursing interventions. Nursing homes and residential homes are working together with health and social care to facilitate speedy hospital discharge. The new contract is in place for domiciliary care.

How urgent care will be different in 2020

2017

Patrick lives at home. He is 85 years old and his health is poor, suffering from high blood pressure and heart disease. When his health deteriorates due to an infection, he is admitted to hospital and given antibiotics intravenously. He is isolated and visits his GP frequently.

2020

All GPs in Swindon know of community services and the referral process. Patrick is identified at high risk of hospital admission. The community services meet him and discuss his health, his regular drinking and how he can better look after himself. Using My Care My Support, Patrick is allocated a volunteer to befriend him. A plan is made so that if he has another infection he can be given antibiotics intravenously with the help of a

community nurse. This means that when Patrick suffers from an infection, he is cared for at home and not admitted to hospital.

2.4 Long term conditions

There will be a number of health improvement programmes designed to support children, young person, adults or older person. These range from healthy eating and healthy exercise (ranging from cycling to sports activities and recreational swimming to walking and gardening schemes); to smoking cessation programmes; to cultural activities, all of which have been shown to benefit health and wellbeing, reduce isolation and loneliness, and extend quality of life. We will encourage people to volunteer to help deliver these services and promote community health champions.

In 2020 if you have one or more long term conditions you will have support from those with the same condition. Informed through primary care, community services and web based information, you will be encouraged to take control of your condition whilst being routinely monitored by your primary care team which will include support from your community and the voluntary sector. You will have rapid access to specialist healthcare (including community based specialists, out of hospital and community care and outpatient clinics at the hospital) to avoid the need for emergency care and hospital admission

Currently we have people living in areas of Swindon such as Penhill, Pinehurst, Parks, Toothill, Gorse Hill and Moredon with high levels of poor health and little access to advice and information. From our data we know that many people in those areas prefer information given to them face to face. We also know that the number of older people with long term conditions will rise substantially from 35,000 now to approximately 40,000 by 2020.

In 2020 those people who live in the most deprived areas will be receiving additional signposting and support through community champions so that they are better able to care for themselves and able to seek the most appropriate support at the right time.

Dementia care is a key priority with an increasing aging population. The CCG has worked with GPs to manage more routine diagnosis and management of those with dementia. Performance against the national 28 day diagnosis target has been reduced to 4-6 weeks. Currently we know that we have 2,000 people diagnosed with dementia and that this is due to double to almost 4,000 by 2030. By 2020 Swindon will be a dementia friendly community with community support groups and more dementia friendly cafés and activities. Community and social care providers who support people suffering from dementia will be skilled and sensitive to their needs.

An example of how Living with dementia will be different in 2020

2017

Doris lost her husband 3 years ago. She lives on her own and her son and his family are a 2 hour drive away. Doris is a member of her local church but has only a few friends. Following a fall when she broke her arm, Doris returns home after 3 weeks in hospital. Over the next few months her son notices that Doris becomes more forgetful, seems more anxious and does not participate as much in activities. After 4 months she is diagnosed with dementia and becomes very isolated. She deteriorates rapidly. Her son increases the

care package. Doris has another fall and is found by a neighbour wandering outside. Her son is becoming increasingly concerned about her safety. In discussing the situation with Doris, Doris moves into residential care near her son's family.

2020

Swindon has an active network of locally based groups and the churches play a very active part with dementia champions. Following the loss of her husband, the local church volunteer visits Doris and encourages her to continue to come to church functions. The volunteer collects Doris for the weekly lunch and women's group. Doris's son is aware of the church volunteer. He notices Doris getting more forgetful. He contacts the local advice and information service about activities in her area. Doris maintains her independence for another two years.

As she seems to be significantly more forgetful Doris is diagnosed with dementia. Her son is able to access information online and discuss help with Doris. Following deterioration in her health, Doris is not able to manage living on her own in her house as she starts wandering. Her son is able to make a referral for extra care housing through the advice and information service. A care team is on site and support is tailored to her needs. The church volunteer continues to collect Doris from her extra care flat and take her to church groups. Doris is able to live with support in extra care housing and admission to residential care is delayed.

End of Life care in the community will be established as currently too many people die in hospital and patients have told us they would prefer to be at home. We currently have a good nursing service which supports children with long term health needs in the community and at home. However, our admissions for children to hospital are high. Children's Services in the Acute, Community and Mental Health services are being transformed following a recent review. A review of urgent care in paediatrics led to changes in operational structure and care delivery. Urgent care for paediatrics was part of an overall review in 2016/17 to support new models of care delivery. The key focus for community services is to maintain sustainable services which support people in the community and prevent hospital admissions.

By 2020 children and young people with long term health needs will be better supported in the community with the hospital children's outreach team working closer with GPs and community health services so children can remain at home. Parents will be able to access enhanced primary care services (Children's and Young Person Clinic commissioned 0800 – 2000 in the SUCCESS centre) so that hospital admissions are prevented.

2.5 Learning Disability & Mental Health

We currently have a diverse sector of voluntary and community groups which have not been as effectively coordinated as we would like. This means that we have a gap in offering individual support for those recovering after specialist mental health support, a gap in services reducing isolation and a gap in offering employment support for those with a learning disability. We support about 680 people with a learning disability through social care. 192 of those live in residential care, a proportion higher than in other areas. The number of people with a learning disability is expected to rise by 30 people each year as life expectancy rises and a larger number of young people become the responsibility of adult social care each year.

In 2020 if you have a learning disability and are supported by social workers, you will have a personalised plan and personal budget in place. You and your carers will have fully participated in developing and influencing the outcomes in your plan. You will be supported to achieve the

skills, education, training and employment opportunities identified through the planning process. Where possible, you will be supported to live in the local community in supported housing. If you do not require specialist social care support, community support will be available through volunteers and wellbeing coordinators. If you have a learning disability or mental illness, you will access and enjoy leisure and culture and have opportunities for paid employment. Carers will be fully involved and feel positive about the quality of support and services they receive.

In 2020 we will have reduced the number of people with mental illness being admitted to an acute ward when presenting with mental health problems and we will have built on the many services in the local community that are amongst the best in the country and need to continue to be supported. Mental health services will be delivered locally with a strong focus on early intervention and recovery. We will have wellbeing coordinators working in voluntary organisations, bringing together specialist and community services for people being discharged and those at risk of mental illness and learning disability

An example of how life living with Mental Health problems will be different in 2020

2017

Diana has suffered from depression for a number of years. She has been referred and allocated to the specialist mental health services three times in the past. The usual pattern is that she is discharged after a period of months when she has stabilised. Once discharged she only has access to her GP. She is re-admitted to mental health services after 6 months.

2020

As part of the discharge process, mental health workers start discussing with Diana how she copes at home and what causes the deterioration in her mental health. Well before discharge, the mental health worker discusses the wellbeing co-ordinator role with Diana. Diana meets the wellbeing coordinator with her mental health worker. Together they establish a plan around how the three of them will work together before and after Diana's discharge. The wellbeing co-ordinator introduces Diana to a job club and Diana works as a volunteer three mornings a week after discharge. Her mental health improves through the new friendships she makes as a volunteer. Her mental health improves and she is not re admitted to mental health services.

2.6 Being a carer

Carers provide very important unpaid care to a child, relative, parent or friend needing help and support. At the 2011 Census, 19,140 people in Swindon (9.4%) reported they were providing some level of unpaid care. This is a similar percentage to the national average for the population overall (10.4%). As of 31st March 2017, there were 3950 carers registered with Swindon Carers Centre caring for a total number of 3875 dependents. Amongst the total carers registered, 58% are Adult Carers (2322), 16% are Parent Carers (655), 21% are Young Carers (827) and 3% are Young Adult Carers (146). We currently commission support for carers from the Swindon Carers Centre but we will be re-procuring the service in December 2017. We have invested additional resources into the Carers' Centre to give advice, complete assessments and offer group and individual support. Carers also have access to an online assessment tool. Carers have support that is flexible, outside of Monday to Friday. A personal budget is also available enabling carers to have choice and control over the best way to meet their support needs. Informal support is available in local areas. We recognise that as carers of people with a learning disability become older, we need to review the support they are offered to support them. We also have a system in place which ensures that carers can give all the care details of their loved one. This is called the Emergency Card. If a carer is ill or unable to care, the social work teams have access to the care

needs of the individual. We are developing a needs assessment of carers and refreshing the Carers Strategy taking account of the views of carers.

An example of how life being a Carer will be different in 2020

In 2020 as a carer, you will have been made aware by your GP, your health visitor or social worker about the support offered by the Carers' Centre. You will have been offered an assessment to discuss with you what help you may need. You or your family can complete a self-assessment questionnaire on line. You have been offered short term breaks to help you with caring and you feel valued and supported. Your GP has discussed your health with you and you know that you can receive a health check in the community. As a parent carer you know that advice and information is available and you are supported by a multi-agency team. In your local area there are groups that support you. Support through short term breaks and community groups is flexible and based on what you need.

2.7 Children in need, child protection and children in care

There are approximately 50,000 children under the age of 18. Children from Black and Minority Ethnic (BME) communities and diverse backgrounds account for 20% of all school age children. 117 languages are spoken in Swindon schools. Swindon has the highest proportion of children with English as an additional language in the South West.

There is fast growing population and service demand has increased over the past 3-4 years placing additional pressure on children services. A higher number of teenagers are needing additional support to address challenges such as poor mental health, exploitation, substance misuse and family breakdown.

As at December 2016, approximately 22% (11040) of children were in receipt of early help services, and 3.7% (about 1,700 children) receive specialist social care support. Children under five are supported by health visitors and the Family Nurse Partnership. There are 632 families identified as part of the Troubled Families programme. This programme provides targeted intervention for families with multiple problems including crime, anti-social behaviour, mental health problems, domestic abuse, unemployment and mental health. Of these families, just over half of them (329) live in one of the 30% most deprived areas in England.

Swindon has been historically lower than comparators in terms of the number of children in need, however the increase over the last 2 years now places Swindon above the statistical neighbour and national average. The number of children in need (excluding child protection and children in care) has reduced slightly to 1174 in February 2017 compared to 1250 for the same period last year.

Once a child protection investigation has taken place, a decision is firstly taken whether to hold a child protection conference which then decides whether a child needs a child protection plan. At the end of February 2017, there were 253 children subject to a child protection plan, similar number to the same period last year (258). This is above the national average (211) and statistical neighbour average (233) for 2015/16.

The number of children in care has risen. At the end February 2017, there were 323 children in care, an additional 41 children compared to the same period last year. Nineteen of these are Unaccompanied Asylum Seeking Children. Swindon's rate for children in care is 66 per 10K children which is above the national (60 per 10K) and statistical neighbour average rates (61 per 10K) for 2015/16.

Our aim is for children to have stable and secure long term placements. The percentage of children looked after for more than 2.5 years who have been in the same placement for at least 2 years or placed for adoption was 64.18% as at February 2017. This is an improvement on our year end position in 2015/16 (59.4%) but slightly lower than both the national average (68%) and SW average for 2015/16. 85.8% of care leavers live in suitable accommodation and 45.68% were not in education, training or employment in February 2017.

2.8 Children with special educational needs

During 15/16 academic year, 16.5% of Swindon pupils had a statutory plan of SEN (statement or EHC plan) or received SEN support. This compares to an average of 15% across the SW. 3.8% of Swindon pupils have a statements or education, health and care plans (

The number of requests for statutory assessment remains high, and latest data (December 2016) shows the rate of EHCP/Statements issued per 10,000 under 18 population is 45.5, which is significantly higher than the 2016 national comparator (23.9) and Statistical neighbour (20.5). The total number of children with a statement of special educational needs has risen in the past 12 months to 1597. The main category of need identified for children with SEND is moderate learning difficulties.

Many of our children with special educational needs are placed in one of 6 special schools in Swindon. The proportion of pupils with a statement of SEND that achieved at 5 A*-C GCSE, including English and maths remains consistently below national benchmarks. To date, locally, we have relied heavily on specialist services and recognise the need to raise the aspirations for disabled children.

We continue to embed the new duties to improve provision and support for children and young people with special educational needs and /or disabilities. Our Local Offer is well established providing advice and information on services. Our children and young people are having their needs identified through Education, Health and Care Assessments and Reviews, and we are focussing our efforts on improving transition planning for young people through the multi-agency Transitions Programme.

2.9 Paediatric Speech and Language

We are seeing a consistent year on year increase in accepted referrals for children requiring speech and language therapy intervention. In April 2013 the service had 1,896 children who required the speech and language therapy service compared with 2,379 in September 2016. This upward trend has put pressure on the service, however, recent funding has been secured to recruit 2.25 FTE additional speech and language therapists to work with children and young people with Autistic Spectrum Disorder in schools and community clinics.

The national trend shows a significant rise in the number of children diagnosed with Autistic Spectrum Disorder (ADS) with diagnosis more than doubled since 2004. In March 2017, the average waiting time for ASD diagnosis in Swindon is 41.8 weeks. 55 children are waiting for OT support and 64 children are waiting for speech and language support. CCG has invested additional £330,610 to increase capacity and reduce waiting times.

In 2020 we will have improved communication and information sharing across the partnership by having better joint systems and processes. We will be better at intervening early through the provision of a range of universal, targeted and specialist services which are focussed on preventing problems from escalating and helping families build resilience. We will continue to be responsive in identifying and supporting children who need protection enabling them to live with their families whenever possible, or seek good quality alternative care in a timely manner if the need arises. The Healthy Child Programme will continue to support every family with a new baby ensuring their child is supported to be school ready. Children and families with additional special needs (e.g. disability, learning, health, behaviour, emotional development, youth offending) will be receiving the right support to enable them to maximise their own functioning independence enabling them to enjoy a full and rewarding life within their families, peer groups and the wider community. Our workforce will be outcomes focused and person-centred and this will be at the heart of their practice.

Background and context to the plan

The previous section describes our vision for health and integration for different groups of service user. It provides illustrative examples of how services will be different in 2020. The vision has been informed by what service users and the public have told us as well as evidence arising from our JSNA. This has shaped the following outcomes which have informed our joint commissioning priorities:

- Ensuring that children are protected from harm and their welfare promoted
- Increasing the social and emotional wellbeing of children and young people
- Increasing the healthy life expectancy of people living in Swindon
- Reducing health inequalities of people in Swindon
- Increasing our resilience and support self care
- Increasing the support we offer to children and adults with long term conditions
- Reducing unnecessary emergency admissions and promote a shift from unplanned to planned care
- Improving the experience and safety of children and adults
- Preventing people from dying early

Community health and social care – older people

Local health and social care partners have committed to work together to improve the delivery of integrated community and acute pathways. We have already made major strides in setting the conditions for success, most notably with the successful procurement and award of a new integrated contract for Community Services. This is fundamental to the successful implementation of our strategic vision, by developing integrated services for our population, and is the first phase of developing Accountable Care in Swindon aimed at:

- A shift of focus towards whole population and prevention particularly for those with a Long Term Condition
- Services wrapped around primary care to improve resilience
- Integration of acute and community pathways
- Strengthening of governance, integrated leadership and collaborative partnerships
- Improved quality and increased patient satisfaction

As our vision is for Accountable Care solutions at CCG/Council level, the development of new models for both primary care and the wider care models for each locality will continue to be led by CCGs. The STP will provide an enabling role in sharing learning and progress across the footprint seeking to accelerate progress towards completion.

Adult social care has reviewed the delivery of social work and occupational therapy services following the transfer to Swindon Borough Council. The diagnostic found that

- More older people could benefit from reablement as part of hospital discharge as well as when first referred to adult social care. The reablement service can be re-designed to increase efficiency and outcomes. This would also reduce high cost care packages and overutilization of residential and nursing care and ensure the residential rehabilitation beds are used to be best effect
- There is a need to improve flow of patients into social care from the hospital and reduce delays in particular due to social work assessment

- There is an opportunity to improve the links between social care and the voluntary sector so that more older people receive advice and support from community based agencies and carer support improves
- There is an opportunity to reduce the paperwork and improve the efficiency in the social work and occupational therapy assessment and review process

Great Western Hospital has reviewed how the flow of patients can be improved through integration of the patient flow team and processes and the Discharge Assessment and Referral Team

Our commissioning intentions

Our priorities that will help us to align our ways of working for better patient care and increased efficiency include:

- Create locality-based integrated teams supporting primary care and care coordinated around the individual
- Shift the focus of care from treatment to prevention and proactive care
- We will develop an efficient infrastructure to support new care models
- Establish a flexible and collaborative approach to workforce
- Enable better collaboration between acute providers
- Implement a new way of working, assessment and review for adult social care social work and occupational therapy
- Re-design and implementation of Reablement Services including Fessey
- Re-design and implementation of Hospital Social work services alongside hospital discharge services
- Re-design and implementation of front door services for social care seeking closer alignment with voluntary sector
- Implement a new process for patient flow and the Discharge Assessment and Referral Team

Please see Bath and North East Somerset, Swindon and Wiltshire's Sustainability and Transformation Plan (STP) A short guide: <http://www.wiltshireccg.nhs.uk/wp-content/uploads/2016/04/STP-short-guide.pdf>

Urgent care

The Urgent Care strategy sets out the vision for the future of Urgent Care services in Swindon. It outlines the operational challenges facing urgent care in Swindon and a response to support, manage and improve urgent care over the next five years from 2016-2021.

Our commissioning intentions

There are several work streams which are required to achieve this new model including:

- A move towards meeting demand across appropriate seven day services, (including holiday periods), provision in community and inpatient services to support demand management and avoid ebb and flow of discharge
- A reduction of hospital admissions through specialty support for clinical management in the community, working closely together with community services.
- A review of minor presentations across ED and Urgent Care Centre for the last five years, and a clear and concise understanding of likely demand over the next five years. This will

then be skill matched to existing provision within urgent care resources and a plan created for using resources differently to treat all minors outside of the ED.

- Strong links for the front door services to alternatives to admission such as Virtual ward, rapid response, step up beds (short term), tele-health, Community IV services and District Nursing
- A parallel pathway through to the ED for ambulance services and emergency self-presentations
- An incentivised model to support admission avoidance
- A local publicity campaign to help Swindon people understand the changes in urgent care easily and understand local provision; and in collaboration with Public Health, a stay well and know how to access the educational and support infra-structure in their neighbourhoods.

These new service structures will be supported by BCF, governed by clear outcomes, making it simpler and easier for the public to understand where to get support from to we can be assured we are providing the best care, in the right place, from the right person every time.

The A&E Improvement Plan continues to drive the strategic and operational discussion (through the A&E Delivery Board and Urgent Care Working Group) to support the 5 mandated areas to deliver on the 4-hour A&E standard.

The Urgent Care Working Group, established during 2016, comprises key stakeholders including local providers, GWH Trust, Swindon Community services, Swindon Borough Council, Primary Care and Swindon CCG. This group meets monthly to resolve pressures within the urgent care system to ensure the Urgent Care strategy and A&E Improvement Plan are delivered, escalating issues to AE Delivery Board when required.

The CCG has also developed a stakeholder-owned Delayed Transfer of Care (DToC) action plan incorporating a number of key actions to support a reduction in delayed discharges and delayed transfers of care.

The Urgent Care strategy, A&E Improvement Plan and DToC action plan incorporate the High Impact Changes that will prompt change to the pattern and configuration of services (e.g. 7 days services, front door, Integrated Discharge Services, Care Homes) during the coming years in order to meet strategic ambitions. The BCF will support delivery of this.

Long term conditions

A key strategic objective for Swindon CCG is to increase the support we offer to those with long term conditions. Care pathways for Diabetes, Dementia, cancer, heart failure, stroke, COPD are being reviewed and processes redesigned to assist with better diagnosis and greater awareness for dementia, and improved treatment for cancer, diabetes and COPD. The increasing prevalence of Long Term Conditions is highlighted within the Joint Strategic Needs Assessment (JSNA). The financial pressures facing health and social care requires a new approach to tackle the rising trend.

Our Commissioning Intentions

Dementia - Post-diagnosis care and support community initiatives are in place. A Dementia Specialist Team has been established to offer support in addition to the Memory Clinic services, linking between secondary care, primary care and, community initiatives and care homes.

Initiatives are underway to support the development of a dementia Friendly community for Swindon.

Respiratory/COPD: COPD Integrated Model of Care was established in April 2017 which includes:

- ✓ the diagnosis and management pathway across the health system
- ✓ the local COPD Oxygen and Pulmonary Rehabilitation services
- ✓ identifying improvements on how acute care can integrate closer with the COPD community service with patients experiencing frequent exacerbations who need more pro-active management
- ✓ use of overtreatment with inhaled corticosteroid when used above the optimal level

Diabetes: Swindon 6 model of care being implemented within GWH Acute Diabetes services since April 2017. This includes an integrated Community Led Diabetes Model to increase support to GP Practices through:

- ✓ The Diabetes Transformation Programme and the 5 work streams, (diabetic foot, structured education, integrated community-led model, patient reference group and medicines optimisation) which has been formally approved by Clinical Leadership Group (CLG)
- ✓ A dedicated public access website for Swindon patients and HCPs to access best practice guidelines and up-to-date information
- ✓ Supporting primary care to improve diabetes service delivery through improved access to the community integrated diabetes team, including consultant outreach. Named GP Diabetes Lead identified
- ✓ CCG working with NHSE to support primary care to offer practice nurses access to continued professional development

Self-care and prevention

Swindon CCG has identified its key intentions to release further time for care alongside what is already in place. This includes increasing aspects of self-care (including web and app-based portals), consultations through the share learning from Physician Assistants, further roll-out of the Clinical Pharmacist pilot, Community Navigators, and the development of Federated Practices in Swindon. The CCG will spread awareness of any innovations that release time for care. The above examples fit with the 'Releasing Time for Care' programme and demonstrate a willingness to collaborate in service redesign ideas, knowledge exchange, using technology, training, and it encourages Practices who may wish to go further in implementing changes.

We have utilised national transformation monies awarded to the CCG and Borough Council to trial a Community Navigator scheme which links patients to their communities to gain support for improving their health and wellbeing, alongside this a service delivered by the voluntary sector – circles of support. We are beginning to see some excellent outcomes from these initiatives.

Reshaping of provision in the voluntary and third sector to improve health and well-being is being undertaken. Advice and information service as well as a website offering information is in place. Voluntary sector organisations supporting those with a learning disability, mental illness, carers and support services are co-located in the centre of Swindon. We will continue to promote the advice and information service so that people can make plan and make choices for themselves.

Our Commissioning Intentions

- Implementation of a revised operating model for Community Navigator service, building on the success of existing scheme, and incorporating further utilisation of information of risk stratification of tools to identify patients at risk of admission
- Use of technology, on-line appointment booking, the Prescription Ordering Direct scheme
- Implementation of release Time to care Programme

Reducing a growing burden of lifestyle related ill health and cancer

We want to address ill health particularly due to physical inactivity, obesity and smoking through increasing community capacity to tackle the wider determinants in relation to housing and employment. Swindon has higher rates of smoking, alcohol consumption, physical inactivity and obesity in areas of disadvantage, which in turn leads to higher incidence of heart disease and diabetes in those communities.

Swindon CCG are already actively working to develop and implement the cancer services transformation planning requirements both within the CCG and across the wider care system through the Cancer Alliance and the STP cancer group (Bath, Wiltshire & Swindon Cancer Group), which means that our transformation work improves the quality of patient care in the wider system. We will also work with providers to successfully meet the NHS constitution cancer standards. This includes working closely with our main tertiary provider Oxford University Hospitals NHS FT, who are developing a new radiotherapy unit on Great Western site.

Our Commissioning Intentions

- Commissioning of weight reduction, smoking cessation and alcohol and drug misuse services
- Implementing the national taskforce report on cancer
- Promoting early diagnosis to improve survival rates
- Implementing follow up pathways for breast cancer patients

Improving the health of children by reducing child obesity to below 19% in year 6 to prevent long term ill health, improving children's emotional health, reducing paediatric admissions and will ensure targeted support for children and families. A review of Children's Services in the Acute, Community and Mental Health services and Urgent Care for paediatrics will support a new model of care delivery. It is anticipated demand can be better managed through rapid response and integration with community urgent care.

Our Commissioning Intentions

- Continuation of GP and nurse led children's clinic to support *on the day* demand
- The monitoring of specialist advice line for primary care and community clinicians and its effect on admissions / attendance
- Re-design of the urgent care pathway between Urgent Care Centre, Paediatric ED and PAU
- An overall service review of children's services to inform new models of care.
- Rapid End of Life care pathway response and increased care options for children and their families

Improving mental health

Mental Health service development is a key priority area. We plan to achieve the 50% IAPT recovery targets and are piloting the national model to support patients identified with LTCs. We will increase baseline mental health spend to facilitate delivery of the Mental Health Investment Standard.

We are working closely with our partners in the STP so that our developments are tied into the work streams and project plan being developed through the STP as well as the BCF plan. This will ensure that mental health services operate at scale across the STP to deliver system wide pathways of care.

Our Commissioning Intentions

- Implementation plan for the Mental Health Five Year Forward View for all age groups alongside access and quality standards so there is genuine parity of esteem within our services.
- A joint service commissioned across the STP footprint, enabling more joined up approaches through joint commissioning arrangements of one provider. The contract starts in April 2018.
- Implementation of a single point of access in place for TAMHS/CAMHS services to ensure a seamless service provision. For Eating Disorders, the CAMHS service accepts direct referrals from any professional or parent/carers

Learning Disabilities and Autism

The Swindon and Wiltshire Transforming Care Plan (TCP) is in its first year of implementation. There is multiagency responsibility for delivery and robust governance and performance structures in place to ensure this is successful. A SMART project plan with milestones is in place which will be monitored over its 4-year period by a multiagency project team and the NHS E LD Assurance Manager. Our Transforming care Plan interprets the local actions required to ensure the national requirements for Transforming Care for people with LD and/or Autism are delivered.

The Plan encompasses actions to ensure processes are in place to support unnecessary hospital admissions and lengthy hospital stays; embed workforce development to ensure staff have the right skills in the right place; ensure people and their families have more choice and more say in their care with options for accessing innovative i.e. through Personal Health Budgets; ensuring more care can be provided in the community (including positive daily activities e.g. employment) and in providing more intensive support for those who need it, so that people can stay close to their home.

Swindon performs exceptionally well in ensuring the avoidance of inpatient admissions. A review of the national CTR Policy and Blue Light Protocol has been locally interpreted and we have developed a local policy which ensures timely, consistent, proactive and high quality co-productive reviews where people are presenting as at risk of admission due to escalating behaviour.

Swindon has a higher number of people with a learning disability living in residential care and high costs supported housing. Our analysis of social work assessments and plans has also found that there is a need to be outcome and progression focused so that people learn new skills. A

pilot has been undertaken with Wiltshire on the implementation of progression planning. A programme is in place across children and adult services so that we continue to ensure a positive move from children to adult services, increasing people's independence and reducing reliance on residential care.

Our Commissioning Intentions

- Implementation of progression and strength based social work assessments
- Implementation of Transition programme from children to Adult services
- Development of new housing and support for people with a learning disability
- Case reviews and collaboration with other local authorities and CCGs to reduce the number of people in residential care where appropriate
- Understanding the position of people with autism who have received a health check and have a health action plan in place. This will include assessing current rates of health screening and local mortality rates

Supporting Carers

Supporting carers remains a priority for us in Swindon. Additional funding has been made available for short term breaks, advice and information and support to carers as part of hospital discharge. Support to young carers is in place through a dedicated services

Our Commissioning Intentions

- Develop extended assessment and information sharing to support all carers.
- Review all services to ensure they adequately provide for the needs and rights of carers and ensure carers are aware of the support and short term breaks available
- Re-commissioning of the contract for carers support and young carers so that young carers are protected from inappropriate caring responsibilities

Joint Commissioning

Swindon Clinical Commissioning Group and Swindon Borough Council already have a National Health Services Act 2006 Section 75 Agreement in place. As the Better Care Fund is largely funds from existing budgets, many of the services are already funded. If the Better Care Fund was not in place then the following community based services could be at risk:

- Community health services
- 7 day working in adult social care
- Reablement support
- Accelerated discharge from hospital through access to care packages 7 days a week
- Carer Support

PROGRESS To Date (MARCH 2017) - Key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Swindon already has integrated joint commissioning and delivery in place. This is supported by Section 75 Agreements for adult social care, community health and mental health services. These agreements were revised in 2014 so that a new Section 75 is in place with a schedule for the Better Care Fund from 1st April 2015 for five years. The Better Care Fund is a schedule of the section 75 agreement and this Plan will form part of the schedule for 2017.

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at March 2017
1	<p>Integrated crisis and rapid response</p> <p>Crisis support to prevent admission to hospital and enable those who leave hospital. Access to assessment facility for people discharged from hospital linked to reablement so that length of stay in hospital reduces and people are able to regain their skills as quickly as possible.</p>	<p>Review use of Discharge to Assess beds alongside Fessey rehabilitation beds to reduce length of stay in Fessey</p> <p>Commission rapid response as part of re-commissioning of community and</p>	<p>Implement findings from review to assist with rehabilitation and start re-commissioning process for Fessey</p> <p>Commission rapid response as part of re-</p>	<p>Complete re-commissioning process for rehabilitation at Fessey, crisis and rapid response services</p> <p>Complete commission rapid response as part</p>	<p>Implement new service model</p>	<p>Fessey beds length of stay was reviewed and reduction achieved in year to an average of 6 weeks.</p> <p>The Service was insourced 1.10.2016 to the local authority due to the financial difficulties with SEQOL.</p> <p>Service continuity was maintained.</p> <p>The reshaping of the service alongside rapid response and reablement will now take place in 2017/18 supported by an</p>

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at March 2017
		social care services, publication of process	commissioning of community and social care services	of re-commissioning of community and social care services	Implement new service model	external improvement partner. A new regulated service manager for the services is in post
2	<p>Reablement Service and Telecare</p> <p>People will regain skills as quickly as possible without the need for on-going support. This will be provided from an integrated service including OT and therapists with direct referrals from the Hospital Discharge team to enable speedy discharge from hospital.</p>	Maintain reablement capacity at 29 patients and £28 per hours and include principle in domiciliary care tender	Complete domiciliary care tender	Implement mobilisation of new model for domiciliary care including enabling patients to gain new skills	Implement new contract including enabling patients to gain new skills	<p>The reablement Service was insourced to the local authority following financial difficulties with SEQOL on 1.10.2016.</p> <p>The reablement Service was reviewed by Newton Europe as part of their diagnostic into adult social care services.</p> <p>In 2017/18 the service will be re-designed alongside Fessey and domiciliary care from hospital to achieve greater efficiency and make reablement available to service users seeking support from adult social care rather than a discharge service from hospital only with</p>

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at March 2017
						capacity increasing to 900 patients in a full year once re-designed. This will support admission avoidance
3	<p>Enhanced voluntary sector capacity</p> <p>Commission voluntary and community based support linked to localities and GP practices. Supporting volunteers reduces the need for some targeted and specialist services. Community and voluntary sector groups provide important flexible services either informally or as part of local contracts.</p> <p>Mental health wellbeing co-ordinators have been introduced through the commissioning of mental</p>	<p>Re focus community navigator scheme</p> <p>Shape specification for home from hospital, befriending and reducing isolation contracts</p> <p>Amend specification for mental health in the voluntary sector</p>	<p>Monitor community navigator scheme</p> <p>Tender home from hospital, befriending and reducing isolation services</p> <p>Complete implementation of new specification</p>	<p>Monitor community navigator scheme</p> <p>Complete tender home from hospital, befriending and reducing isolation services and mobilise for new service</p> <p>Monitor implementation of amended mental health specification</p>	<p>Evaluation of community navigator completed and decision made about future service</p> <p>Monitor first quarter performance of new service</p> <p>Monitor performance of amended mental health specification</p>	<p>The community navigator scheme was refocused with a smaller number of navigators and has been evaluated positively showing savings as well as positive outcomes for patients with long term health issues.</p> <p>The mental health services in the voluntary sector now offer one to one support for people with dual diagnosis and autism. 10 people have benefitted from the service following re-design.</p> <p>Funding has been secured for Circles of</p>

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at March 2017
	health third and voluntary sector contracts.	to include autism and dual diagnosis				Support and community navigator for 2017/18 from health and social care to focus on patients with 3+ long term health conditions. The tender for reducing isolation will take pace in 2017
4	<p>Community and residential rehabilitation and Discharge to Assess</p> <p>Funding nursing assessment beds with enhanced health care so that patients can be discharged from hospital more quickly. This programme is now established.</p>	Review use of Discharge to Assess beds alongside Fessey rehabilitation beds to reduce length of stay in Fessey	Implement findings from review to assist with rehabilitation and start re-commissioning process for Fessey	Complete re-commissioning process for rehabilitation at Fessey, crisis and rapid response services	Implement new model	<p>The Service was insourced 1.10.2016 to the local authority due to the financial difficulties with SEQOL.</p> <p>Service continuity was maintained. The service will be reviewed in 2017/18 as outlined above.</p> <p>Additional Home to assess capacity was funded from November 2016 – march 2017 to facilitate speedier discharge of patients to the community. So far the service is showing to</p>

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at March 2017
						reduce NHS delays at GWH
5	<p>Preventing hospital admissions and effective discharge</p> <p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible.</p> <p>Ensure access to brokerage and verification services so that there is speedy access to social care packages seven day a week.</p>	<p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible.</p> <p>Ensure access to bridging and D2A at weekend so that there is speedy access to social care packages seven day a week.</p>	<p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible.</p> <p>Ensure access to bridging and D2A at weekend so that there is speedy access to social care packages seven day a week.</p>	<p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible.</p> <p>Bridging principle part of mobilisation of domiciliary care tender</p>	<p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible.</p> <p>Bridging principle part of new domiciliary care service</p>	<p>The DART team and the Integrated Discharge team (social care) were reviewed and refocused in 2016 to ensure reduction in DTOC numbers. Social work and OT service run 7 days a week with access to domiciliary care services at the weekend. Domiciliary care bridging service has been maintained.</p> <p>The domiciliary care tender will be re-issued in 2017 following review to ensure continuity of service</p> <p>Tender for community health and social care</p>

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at March 2017
	<p>Integrated Discharge Team comprising of health and social care is in place. Since November 2013 a Discharge Assessment and Referral Team (DART) has been in place to avoid admission and discharge as early as possible. Both services operate 7 days a week and work closely with hospital clinicians.</p> <p>The Virtual Ward will be working closely with the hospital discharge services and the Single Point of Access to both avoid admissions and enable speedy discharge. Virtual Ward, Intermediate Treatment beds (SWICC), Hospital Discharge services and 7 day working for clinicians.</p>	<p>Implement findings from review of DART/IDT</p> <p>Re-commissioning of community and social care services, publication of process</p>	<p>Start plan of transferring management of social work to SBC and monitor implementation of DART processes</p> <p>Tender evaluation of re-commissioning of community and social care services</p>	<p>Start Transfer social work and social care staff to SBC</p> <p>Complete tender of community health and social care services</p>	<p>Complete Transfer social work and social care staff to SBC</p> <p>Implementation of new models of care following completion of tender</p>	<p>services was completed in July 2016. GWH was identified as the new provider. The local authority insourced all social care services including social work from SEQOL on 1.10.2016. the services have been reviewed and a re-design programme has started in march 2017</p> <p><u>Delayed Transfer of Care (DTOC)</u></p> <p>The DTOC programme was established in 2016 and has reduced delays across health and social care, albeit not by 50%.</p> <p>The current performance as of end of December 2016 was ranked 71st in England for the BCF indicator.</p> <p>A Board and project teams with work streams</p>

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at March 2017
	<p data-bbox="219 371 546 467"><u>Additional Scheme for 2016-17 - Delayed Transfer of Care Programme</u></p> <p data-bbox="219 563 546 802">Sustainable reduction in number of DTOC and non-DTOC delays across the health and care system by 30.9.16, with planned reduction of current numbers by at least 50%.</p> <p data-bbox="219 898 546 1177">Agreed programme of work with clear outcomes and timelines for implementing the Newton Europe recommendations as these apply to delayed discharges and prevention of admission</p>	<p data-bbox="577 443 808 683">Implement delayed discharge programme with fortnightly project team and Programme Board meetings.</p> <p data-bbox="577 762 831 890">Implement work streams from Newton Europe and urgent care Programme</p>	<p data-bbox="862 802 1122 978">Complete delayed discharge programme with fortnightly project team and Programme Board meetings.</p> <p data-bbox="862 1137 1160 1305">Implement work streams from Newton Europe and urgent care Programme with work streams and monitor performance</p>	<p data-bbox="1198 778 1496 1058">Monitor completed delayed discharge programme with monthly project team and Programme Board meetings. Add and adjust work streams to maintain performance</p> <p data-bbox="1198 1090 1496 1337">Implement work streams from Newton Europe and urgent care Programme with work streams and monitor performance. Adjust programme based on</p>	<p data-bbox="1523 738 1809 1018">Monitor completed delayed discharge programme with monthly project team and Programme Board meetings. Add and adjust work streams to maintain performance</p> <p data-bbox="1523 1114 1809 1361">Implement work streams from Newton Europe and urgent care Programme with work streams and monitor performance. Adjust programme based on</p>	<p data-bbox="1843 371 2141 762">are in place and have been refreshed across Swindon and Wiltshire. Implementation of learning from newton Europe was delayed due to community and social care tender and subsequent tupe of staff to GWH and the local authority</p>

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at March 2017
				evaluation of performance	evaluation of performance	
6	<p>Carers' Support</p> <p>A joint carers' contract is already in place which was tendered in 2012/13. The Carers' Centre provides advice and information for carers, welfare benefits advice as well as support groups. There is a GP outreach post. Young carers' support is provided by the same voluntary organisation and was part of the same tender. Outcomes for carers continue to improve. Additional investment was made available in April 2012 for short term breaks for carers and further investment has been made to deliver the requirements</p>	<p>Monitoring of carers contract and implementation of new carer post in hospital discharge process</p> <p>Testing of online carer assessment</p>	<p>Monitoring of carers contract and implementation of new carer post in hospital discharge process</p> <p>Training and start implementation of online carer assessment</p>	<p>Monitoring of carers contract and implementation of new carer post in hospital discharge process</p> <p>Training and start implementation of online carer assessment</p>	<p>Monitoring of carers contract and implementation of new carer post in hospital discharge process</p> <p>Training and start implementation of online carer assessment</p>	<p>The carer's contract has been monitored quarterly and shows good performance. A carer support post is working in GWH supporting carers whose relatives are being discharged from hospital</p> <p>The online carer assessment is in test</p>

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at March 2017
	of the Care Act. Development of improved assessment process for carers and improved access to health checks.					
7	Capital Grant adult social care Capital allocations fund the disabled facilities grant scheme which is operated by Swindon Borough Council. It also funds large items of social care equipment required through the joint Integrated Community Equipment Store for children and adult services as well as investment in telehealth and telecare.	Continue investment in technology to support self-care and prevention and enable people with a disability to live as independently as possible.	Continue investment in technology to support self-care and prevention and enable people with a disability to live as independently as possible.	Continue investment in technology to support self-care and prevention and enable people with a disability to live as independently as possible.	Continue investment in technology to support self-care and prevention and enable people with a disability to live as independently as possible.	Swindon Borough Council has continued to invest in technology and used all capital allocations plus a top up from the local authority of £300k
8	Community Health aimed at reducing emergency admissions					Community health services moved to GWH on 1.10.2016 and GWH was awarded the contract following a successful

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at March 2017
	Continued development and enhancement of a range of community based support such as the Single Point of Access, SUCCESS, nurse home visiting	<p>Evaluation of Rapid response, single point of access and commission as part of community and social care tender</p> <p>Evaluate SUCCESS and rapid response to determine future funding</p>	<p>Complete tender of Rapid response, single point of access and commission as part of community and social care tender</p> <p>Evaluate SUCCESS and rapid response to determine future funding</p>	<p>Complete tender of Rapid response, single point of access and commission as part of community and social care tender</p> <p>Evaluate SUCCESS and rapid response to determine future funding</p>	<p>Mobilisation and implementation of new contract</p> <p>Evaluate SUCCESS and rapid response to determine future funding</p>	<p>tender. The services have been reviewed and a re-design programme will commence for community health services alongside social care services. A joint programme board will ensure that we continue to develop services together whilst staff are managed and employed separately. Confident professional health and social care staff are required so that future integrated working is able to succeed</p>
9	<p>Managing increase in demand for adult social care</p> <p>Increase in care packages due to demographic pressure leading to</p>					<p>Care packages have continued to increase and the local authority has spent an additional £3m on supporting older people in 2016/17 including significant</p>

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at March 2017
	reduced length of stay in hospital. Work with residential and nursing providers to increase access to health care within homes so that admissions to hospital reduce	Continue to improve social work decision making on care packages by implementing vulnerable adults programme and demand management. Share demand data with HWB Provider Forum	Continue to improve social work decision making on care packages by implementing vulnerable adults programme and demand management	Continue to improve social work decision making on care packages by implementing vulnerable adults programme and demand management	Continue to improve social work decision making on care packages by implementing vulnerable adults programme and demand management	investment in hospital discharge A re-design programme across all social care services will ensure an effective and efficient service in 2017
	<p>Implementation of new responsibilities under the Care Act 2014</p> <p>The funding provided within the Better Care Fund has contributed towards the cost of implementing the requirements of the Care Act. These include carers' support, advocacy and safeguarding. We have implemented the required systems under the Health &</p>	Continue to increase adverts and advice and information on My care My Support, mobilise voluntary sector to give advice and support. Tender advocacy service ,	Continue to increase adverts and advice and information on My care My Support, mobilise voluntary sector to give advice and support. Complete tender advocacy service ,	Continue to increase adverts and advice and information on My care My Support, mobilise voluntary sector to give advice and support. Mobilise for new advocacy service ,	Continue to increase adverts and advice and information on My care My Support, mobilise voluntary sector to give advice and support. Monitor new advocacy	<p>The care Act has been fully implemented with additional support for</p> <ul style="list-style-type: none"> - Carers - Advocacy - Safeguarding team - Advice and information including co-location of the voluntary sector - Online assessment tested with social workers

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at March 2017
	Social Care Bill. We have invested in new technology to allow on line self-assessment and information and advice through www.mycaremysupport.co.uk	implement online assessment	implement online assessment	implement online assessment	service , implement online assessment	

Evidence base and local priorities to support plan for integration

The Better Care Fund Plan is based on a thorough analysis of need of the population in Swindon. It addresses the key challenges, which are evidenced below:

- Reducing emergency admissions to hospital by strengthening our urgent care plans.
- Reducing delayed transfers of care across health and social care by 50%, in particular due to completion of assessment, admission to residential and nursing care and access to domiciliary care.
- Reducing emergency admissions and improving health of those with long term conditions through community based support, advice & information, community based support, community navigators.
- Strengthening reablement services for those discharged from hospital including 7 day working in social care and health.
- Improving locally based support for people with a learning disability.
- Improving advice, information, assessment and support for carers.
- Addressing the needs of an ageing population and improving health inequalities.

The data below outlines the challenges in detail which we will continue to address in an integrated way through the schemes outlined in this plan.

Swindon faces significant population growth over the next 10 years as the data below shows. We will see a larger rise than nationally amongst children under five (8% compared to 2%) and older people (32% compared to 22%), many of whom will have long term conditions. Both of these population groups are high users of primary and secondary health services. Looking at our demographics, we can see the unique consequences of the growth in our industries in the 1980s and 1990s with a materially larger proportion of our people being in the 30-64 age groups (48% compared to 45% nationally). Forecasts also show that between 2011 and 2031 the over 85 population will grow at a much faster rate than the rest of the population due to increased life expectancy.

Risk stratification has identified those patients most at risk of admission and services are in place to provide enhanced support. In addition, Swindon has a higher prevalence of asthma and diabetes than England and comparable CCGs and a mortality rate for respiratory diseases that is no longer decreasing. Programmes of work are in place to work with patients with diabetes with a focus on self-management, improved foot care and ophthalmology screening. Respiratory patients self-management, increased capacity for tele health services and specialist community support services.

Population changes

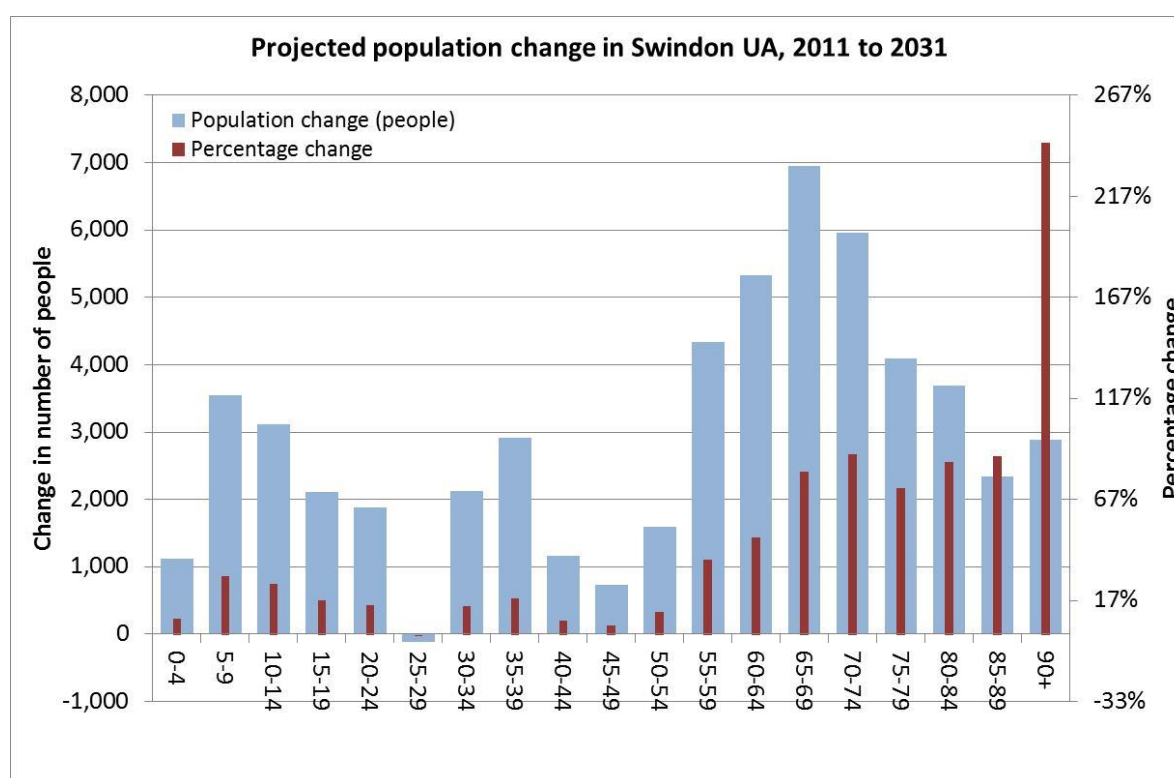
The population of Swindon by mid-2011 was estimated to be 209,700, an increase of approximately 29,600 persons from 2001 representing a growth rate of 16%, the highest in the South West. In Swindon, to take account of the planned additional 25,000 new homes

between 2012 and 2026 policy-led projections were produced based on population data from the Office for National Statistics (ONS) and Swindon District's housing targets to 2026 from the Local Plan.

The key facts from these projections are:

- Swindon's population could increase to 240,000 persons by 2021 and 265,400 by 2031, equivalent to growth of approximately 14% from 2011 to 2021, and a further 10% from 2021 to 2031.
- From 2011 to 2031, births are projected to average approximately 2,900 per year, deaths approximately 1,700 per year, and net migration approximately 1,800 per year.
- The largest increase in persons will be in the 65 to 74 age group, projected to be 12,900 more by 2031. However, the 85 plus age group will have the largest growth rate at approximately 136%.
- By 2031 the population aged over 65 is projected to grow by 25,900 persons to reach a total of 55,000 by 2031, accounting for 46% of total population growth.
- The working age population (16 to 64) is also projected to grow by approximately 21,600 persons to reach a total of 160,800 by 2031, accounting for 39% of total growth.
- The 0 to 4 age group is projected to grow by 1,100 to reach a total of 15,300 by 2031.
- The population of school-age children aged 5 to 18 is projected to grow from 34,900 in 2011 to 43,000 in 2031, and overall, the population of children aged 0 to 18 will grow from 49,100 in 2011 to 58,300 in 2031.
- Overall, the age structure of the population is projected to change with significantly higher growth in the older age groups than in the younger groups. This will result in an increase in the ratio of children and older people to working age people so that by 2031 for every one person under the age of 16 or aged 65 plus there will be 1.5 persons of working age instead of 2 persons of working age in 2011

Chart 1: Projected change by 5 year age group from 2011 to 2031



Source: SBC projections, 2011-2036

Based on national population projections, which show less growth in Swindon's elderly population because they don't take new housing into account, the following projections of the number of over 65s projected to have certain conditions or limitations have been calculated. These numbers can be regarded as conservative estimates if the prevalence of these conditions remains unchanged in future years. Many elderly people will have more than one of these conditions or limitations.

Number of over 65s in Swindon projected to have certain conditions or limitations

	2015	2020	2025	2030	% increase 2015 to 2030
Dementia	2,280	2,727	3,259	3,979	75%
A long standing health condition caused by stroke	766	890	1,042	1,228	60%
A long-term illness limiting day to day activities a lot	7,745	9,005	10,694	12,653	63%
An admission to hospital because of a fall	677	792	957	1,124	66%
A BMI of 30 or more	8,683	9,927	11,398	13,272	53%
Type 1 or Type 2 diabetes	4,135	4,787	5,525	6,494	57%

Source: Projecting Older People Population Information System (POPPI)

The proportion of Black and Minority Ethnic (BME) people in Swindon UA, in approximate terms, doubled from 8.5% (15,344 people) in 2001 to 15.4% (32,128 people) in 2011. The broad BME proportion reported in Swindon in the 2011 Census varied greatly from 48.2% in Central to 5.6% in Blunsdon and Highworth. Among school children in 2016, the proportion of children from a minority ethnic group in Swindon was 25%, more than the 13% in the South West and but less than the 30% in England. Additionally, births data shows that in 2015, 28.2% of babies born to Swindon residents were to non-UK born mothers, which is very similar to England overall (28.4%).

Life expectancy and health outcomes

In Swindon, in 2013-15, life expectancy is 79.6 years for males and 82.8 years for females, which is similar to England. Males in Swindon will spend 80.5% of their lives in good health, around 64 years, whereas women will only spend 74.4% in good health, around 62 years. At age 65, life expectancy for males in Swindon is an additional 18.5 years compared to 20.9 years for females. However, there is little difference between sexes in the remaining length of time spent in good health (12.2 years compared to 11.2 years). Causes of premature mortality in Swindon are changing. In 2001-03, 36% of deaths under 75 were from cancer and 30% from cardiovascular disease (CVD) but by 2012-14, 41% were from cancer and 23% from CVD.

Meanwhile, the gap in life expectancy between the least and most deprived has reduced significantly amongst the female population but risen slightly amongst the male population. In the most deprived areas of Swindon, men die on average 9.7 years earlier and women 4.0 years earlier than those in the least deprived areas. Reducing gender related health inequalities remains a top priority.

The growth in people from BME Communities to 15% places even greater emphasis on the development of approaches to healthcare design and delivery that reach out to and are guided by our new communities. The greatest growth has been in communities who are also vulnerable to diabetes and cardiovascular disease in the Asian community (both of which are therefore priorities for new interventions in 2014-2019).

In addition, we have undertaken significant analysis of our population and our demand for health and social care. Based on analysis from Public Health we know that:

- At the end of 2016/17, 20,365 people aged between 40 and 74 had taken up the offer of a NHS Health Check in the past 4 years, 31.9% of those eligible (England 36.2%). The NHS Health Checks programme is monitored monthly and improvements identified to improve take up based on regional best practice. A new service specification for GP practices is being developed, including surveys of health check effectiveness by patients, which can then be used to develop the service.
- Cancer screening coverage: cervical cancer 72.4% (England - 72.7%); bowel cancer 54.1% (England – 57.9%). The Public Health team link to Public Health England campaigns to boost uptake as well as working with providers locally to look at ways to improve coverage. A multi-stranded bowel cancer campaign is planned for 2017 targeted at raising uptake in the 60 year old age group.

- Mortality from communicable diseases 14.1 per 100,000 population (England average 10.5). This includes the number of deaths from certain infectious and parasitic diseases as well as from influenza. SBC have initiatives to reduce fuel poverty and provide grants for improvements to heating for those on low incomes. The CCG also sent out a Keeping Well and Staying Safe booklet to every household this winter with advice on reducing winter illness and the risks of respiratory disease.
- Excess weight in adults – 70.8% of Swindon adults are obese or overweight compared to 64.8% in England overall. The ‘Get Swindon Active Strategy’ 2015-2020 sets out the vision for Swindon to get ‘everybody active, every day’ by making active lives the norm not the exception.
- HIV late diagnosis – 61.1% of people diagnosed with HIV in Swindon were diagnosed at a late stage. Late diagnosis is the most important predictor of morbidity and mortality among those with HIV infection. Those diagnosed late have a ten-fold risk of death compared to those diagnosed promptly and is essential to evaluate the success of expanded HIV testing.
- Improving health, particularly female health, and reducing health inequalities between the least and most disadvantaged amongst our male population remain the top priorities as described in the Joint Health and Wellbeing Strategy 2017-22
- Reducing isolation continues to be a priority for our work with older people. The national indicator that measures social isolation in adults who use social care services has improved from 43.6% in 2014/15 to 48.7% in 2015/16 and this is above the national average of 45.4% in 2015/16.

Long Term Conditions (LTC)

The Swindon LTC JSNA estimates that 32.2% of Swindon people have one or more LTC, this amounted to 69,820 persons in 2015. In all, 21.0% had only one condition (45,580), 7.2% (15,699) had two conditions, while 3.9% (8,540) had three or more conditions. Thus, approximately one third of people with any recorded condition were in a state of multi-morbidity, having co-morbidities alongside their main condition. With regard to people aged 65 years or over, 69.3% of people were estimated to have at least one LTC (2,917 in all). These estimates triangulate information from the 2011 Census, General Practice disease registers (QOF) and modelled figures. They contain both people with a clinical diagnosis of a LTC, some of whom may feel they are not limited by it and also those who are limited in the day to day activities but do not have a clinical diagnosis of a specific condition.

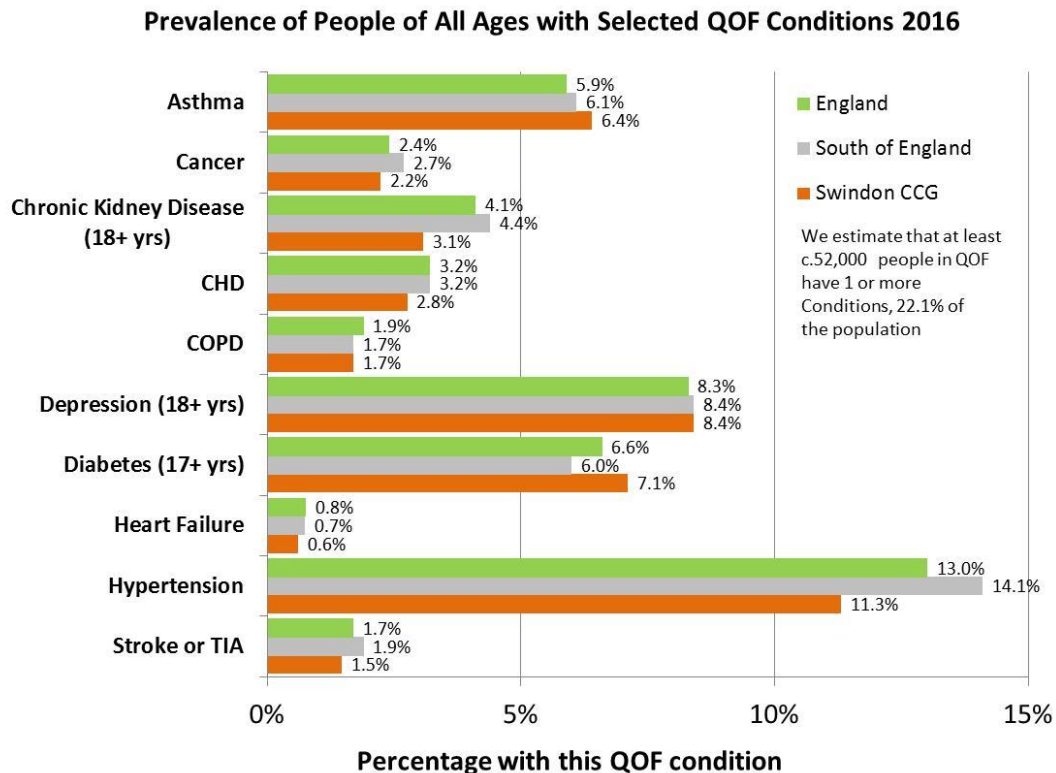
More affluent people might have milder forms of LTCs and/or have better resilience, better coping strategies, better social and family networks and a greater ability to gain benefit from the health and caring services. Thus, more affluent people do not necessarily avoid the LTCs experienced by their less well-off peers, but they are more likely to be in the group of “Ageing Well” people, coping better with their situation (and sometimes without LTCs at all.)

People who live in deprived areas and have three or more LTCs are known to be at greater risk of requiring Social Care services. It is estimated there are around 6,000 people in this

group in Swindon and their most common conditions are hypertension, coronary heart disease, diabetes, cancer and stroke.

A key task of the Health and Care community is to help older people to move into the “Ageing Well” segment (while remaining there as long as possible), and to prepare middle-aged people for a later life which builds on “Ageing Well” principles. This task involves mental health as much as physical health. People in deprived areas have the most to gain from such initiatives.

Prevalence of selected long-term conditions, 2015/16



Source: Quality and Outcomes Framework (QOF), 2015/16

Whilst the overall number of Swindon residents living with a long term condition has increased in line with our overall population, some conditions such as diabetes and respiratory disease have grown faster. This is partly due to a near doubling of minority groups where the prevalence of these conditions is higher. Other conditions such as dementia and stroke are forecast to increase at a faster rate than our overall population due to the faster rate of growth of our older and minority populations. The above increases will put additional pressure on individuals, households, their families, carers and support networks. Those with a long term limiting condition are two to three times more likely to also develop depression.

Our investment in community nursing, SUCCESS, community navigator and support for older people through voluntary and third sector organisations are part of our plan to address this. More detailed information is included in the CCG 5 Year Strategic Plan.

Demands on adult social care

There were 717 people with a learning disability supported by Adult Social Care during 2016/17 and 4106 older people. The demographic changes outlined above indicate the demand will continue to increase. We are also experiencing more complex health needs for Older People and over the last few years we have seen an increase in the value of packages of care. In response to the financial pressures on adult social services, the Council has already taken a number of steps to transform the adult social care system which should improve outcomes for residents over the coming year. These include: increasing the Adult Social care budget from £60.4m in 2016/17 to £67.3m in 2017/18; improving the delivery of the reablement services to increase capacity so more people benefit from the service; re-designing the way the hospital social work team works to enable timely discharge of patients and reduce delays, particularly due to social work assessment and admission to residential and nursing homes; re-designing the 'front door' of adult social care to provide strong links to the voluntary and third sector; and review the way we work so that Occupational Therapy and social care assessments are timely and promote independence.

Better Care Fund Plan 2017/19 Action Plan

Integrated services and commissioning underwent significant changes in 2016/17 as the SEQOL contract came to an end, a STP plan was published and we developed our approach to Accountable Care. In order to reflect those changes we have reviewed our schemes and adjusted funding accordingly without impacting on investment in social care, carers support, and the Care Act Both Swindon CCG and Swindon Borough Council have invested additional resources in reablement as the reshaped service has already provided improved outcomes in 2017/18 Quarter 1. We have also cross referenced the High Impact Changes in our schemes set out below (set out in red)

Ref no.	Scheme	Milestones Quarter 1/2 2017/18	Milestones Quarter 3/4 2017/18	Milestones Quarter 1/2 2018/19	Milestones Quarter 3/4 2018/19	Progress at March 2018
1	<p>Prevention of Hospital admission including rapid response</p> <p>Crisis support to prevent admission to hospital and enable those who leave hospital. Implementation of Urgent Care Programme</p> <p>Support at the front door social care to prevent hospital admission and</p>	<p>Re design rapid response and front door of adult social care to reduce admission to residential and nursing care</p> <p>Development of clinical model for patients with long term conditions to prevent ED</p>	<p>Implement new front door and rapid response as part of re-design of adult social care services</p>	<ul style="list-style-type: none"> • Complete implementation and monitor impact • Evaluation and contract 	<ul style="list-style-type: none"> • Review effectiveness of new model and determine savings achieved • Evaluation and contract 	

Ref no.	Scheme	Milestones Quarter 1/2 2017/18	Milestones Quarter 3/4 2017/18	Milestones Quarter 1/2 2018/19	Milestones Quarter 3/4 2018/19	Progress at March 2018
	<p>admission to residential and nursing care</p> <p>Therapy services at the front door of ED</p> <p>IBCF Prevention of hospital admission (therapy, crisis support £135k)</p>	<p>attendances and admission</p> <p>Implement therapies at the front door with new KPI and specification</p>	<p>Monitor KPIs and implementation of</p> <ul style="list-style-type: none"> clinical model for patients with long term conditions to prevent ED attendances and admission therapies at the front door with new KPI and specification 	<p>management of KPI's for</p> <ul style="list-style-type: none"> clinical model for patients with long term conditions to prevent ED attendances and admission Implement therapies at the front door with new KPI and specification Establish need for step down capacity from therapy at the front door 	<p>management of KPI's for</p> <ul style="list-style-type: none"> clinical model for patients with long term conditions to prevent ED attendances and admission Implement therapies at the front door with new KPI and specification 	
2	<p>Reablement Service and Telecare, telehealth</p> <p>People will regain skills as quickly as possible without the need for on-going support with access to support from hospital as</p>	<p>Re- design reablement service linked to bridging service to improve</p>	<p>Implement redesign with at least 200 more people benefitting from the service and 60% not requiring ongoing package or reduced package</p>	<ul style="list-style-type: none"> Monitor implementation of new model for reablement and domiciliary care including move to 	<ul style="list-style-type: none"> Evaluate new model of reablement and monitor development of domiciliary care service 	

Ref no.	Scheme	Milestones Quarter 1/2 2017/18	Milestones Quarter 3/4 2017/18	Milestones Quarter 1/2 2018/19	Milestones Quarter 3/4 2018/19	Progress at March 2018
	well as front door of social care IBCF Reablement (therapy £130k)	efficiency and effectiveness Principle of enablement in domiciliary care tender Telehealth targeted at patients with chronic illness and monitoring of KPIs in new contract	Complete domiciliary care tender and mobilisation Telehealth targeted at patients with chronic illness and monitoring of KPIs in new contract	support planning by provider • Telehealth targeted at patients with chronic illness and monitoring of KPIs in new contract	• Telehealth targeted at patients with chronic illness and monitoring of KPIs in new contract	
3	Enhanced voluntary sector capacity Commission voluntary and community based support linked to localities and GP practices. Supporting volunteers reduces the need for some targeted and specialist services. Community and voluntary sector groups provide important flexible services either informally or as part of local contracts. Ensure voluntary sector links to	Carer support available within hospital setting through carers centre Re focus community navigator scheme and integrate with Circles of Support to patients with 3+ health conditions Link voluntary sector and My care My	Evaluate community navigator scheme and circles of support model Monitor voluntary sector contracts to support adult social care and health priorities Tender relevant voluntary sector services to meet children, health and social care priorities	• Monitor community navigator scheme • Monitor voluntary sector contracts to support adult social care and health priorities • Tender relevant voluntary sector services to meet health and social care priorities	• Evaluation of community navigator completed and decision made about future service • Evaluation and monitoring of voluntary sector contracts	

Ref no.	Scheme	Milestones Quarter 1/2 2017/18	Milestones Quarter 3/4 2017/18	Milestones Quarter 1/2 2018/19	Milestones Quarter 3/4 2018/19	Progress at March 2018
	front door and My care My support	support closely to adult social care front door Tender of carer support service	Implement front door services with link to advice and information in the voluntary sector	<ul style="list-style-type: none"> Monitor new front door and link to voluntary sector and MCMS 	<ul style="list-style-type: none"> Evaluation of front door and MCMS 	
4	Discharge to Assess – residential rehabilitation	Re design use of Fessey rehabilitation beds to reduce length of stay in Fessey, facilitate discharge but also prevent admission by linking to rapid response team Evaluation of Home to Assess model which will inform future commission and remit	Implement findings from re-design so that discharge to assess and rehabilitation beds enable older people to regain their skills and return home, reduce delays due to residential care admissions Home to assess model if implemented will complement reablement/residential discharge to assess/rehabilitation (Fessey)	<ul style="list-style-type: none"> Monitor KPIs and outcomes of discharge to assess and rehabilitation beds enable older people to regain their skills and return home reduce delays due to residential care admissions Home to assess model if implemented Mobilisation of new domiciliary care 	<ul style="list-style-type: none"> Monitor KPIs and outcomes of discharge to assess and rehabilitation beds enable older people to regain their skills and return home Home to assess model if implemented Domiciliary care contracts so that delays due to domiciliary care reduce 	

Ref no.	Scheme	Milestones Quarter 1/2 2017/18	Milestones Quarter 3/4 2017/18	Milestones Quarter 1/2 2018/19	Milestones Quarter 3/4 2018/19	Progress at March 2018
		Domiciliary care bridging service remodelled to enable older people to regain skills	Include bridging service requirement in domiciliary care tender and award tender	contract including bridging		
5	<p>Effective discharge (early discharge, 7 day working, multi-disciplinary teams, Choice Policy)</p> <p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible.</p> <p>Care package support for hospital discharge</p> <p>Implementation of integrated discharge services across 7 day</p>	<p>Re-design social work services within GWH and link to new Integrated Discharge services (IDS) to ensure patient flow</p> <p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be.</p> <p>Fund additional care package capacity to facilitate discharge</p> <p>Early engagement with families to</p>	<p>Implement effective re-design of social work services to reduce delays due to assessment and admission to nursing homes</p> <p>Full implementation of IDS leading to improved patient flow and reduction in length of stay</p> <p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be</p>	<ul style="list-style-type: none"> Monitor new ways of working in GWH for health and social care across integrated discharge services <p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be</p>	<ul style="list-style-type: none"> Monitor and review integrated discharge services <p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be</p>	

Ref no.	Scheme	Milestones Quarter 1/2 2017/18	Milestones Quarter 3/4 2017/18	Milestones Quarter 1/2 2018/19	Milestones Quarter 3/4 2018/19	Progress at March 2018
	<p>including social care Swindon and Wiltshire</p> <p>Sustainable reduction in number of DTOC and non-DTOC delays across the health and care system by with planned reduction of current number and no more than 13 beds per day by March 18 (17 September 2017)</p> <p>Winter contingency Fund in place</p>	<p>reduce delays due to patient choice and full implementation of choice policy</p> <p>Implement delayed discharge programme with fortnightly project team and monthly Programme Board meetings.</p> <p>Winter contingency Fund in place</p>	<p>Monitor delays due to patient choice and take corrective action</p> <p>Fortnightly team and monthly Programme Board meetings.</p>	<p>Monitor delays due to patient choice and take corrective action</p> <p>Monitor and review completed delayed discharge programme with monthly project team and Programme Board meetings. Add and adjust work streams to maintain performance</p> <p>Evaluate use of winter contingency fund</p>	<p>Monitor delays due to patient choice and take corrective action</p> <p>Monitor and review completed delayed discharge programme with monthly project team and Programme Board meetings. Add and adjust work streams to maintain performance</p>	

Ref no.	Scheme	Milestones Quarter 1/2 2017/18	Milestones Quarter 3/4 2017/18	Milestones Quarter 1/2 2018/19	Milestones Quarter 3/4 2018/19	Progress at March 2018
	<p>IBCF Winter contingency (£100k)</p> <p>Contingency (£229k)</p>		<p>Winter contingency Fund in place</p>			
6	<p>Carers' Support</p> <p>A joint carers' contract is already in place which was tendered in 2012/13. The Carers' Centre provides advice and information for carers, welfare benefits advice as well as support groups. There is a hospital carer support post in GWH. Young carers' support is provided by the same voluntary organisation and was part of the same tender. Development of improved assessment process for carers and improved access to health checks.</p>	<p>Develop engagement with a view to tender carers support service in 2017</p> <p>Monitoring of carers contract and implementation of new carer post in hospital discharge process</p> <p>Testing of online carer assessment</p>	<p>Tender carers support service 2017</p> <p>Monitoring of carers contract and review of new carer post in hospital discharge process</p> <p>Training and start implementation of online carer assessment</p> <p>Tender for carers services with new service from April 2018</p>	<p>Implement new contract</p> <p>Monitoring of carers contract and of new carer post in hospital discharge process</p> <p>Monitoring and evaluation of online carer assessment</p>	<p>Monitoring of carers contract and implementation of new carer post in hospital discharge process</p> <p>Monitoring and evaluation of online carer assessment</p>	

Ref no.	Scheme	Milestones Quarter 1/2 2017/18	Milestones Quarter 3/4 2017/18	Milestones Quarter 1/2 2018/19	Milestones Quarter 3/4 2018/19	Progress at March 2018
7	<p>Capital Grant adult social care</p> <p>Capital allocations fund the disabled facilities grant scheme which is operated by Swindon Borough Council. It also funds large items of social care equipment required through the joint Integrated Community Equipment Store for children and adult services as well as investment in telehealth and telecare.</p>	Continue investment in technology to support self-care and prevention and enable people with a disability to live as independently as possible.	Continue investment in technology to support self-care and prevention and enable people with a disability to live as independently as possible.	Continue investment in technology to support self-care and prevention and enable people with a disability to live as independently as possible.	Continue investment in technology to support self-care and prevention and enable people with a disability to live as independently as possible.	
8	<p>Out of Hospital care aimed at reducing emergency admissions (Community health services and Enhanced Health in Care Home, trusted assessor)</p> <p>Wrap around community nursing around primary care</p>	<p>Development and early implementation of</p> <ul style="list-style-type: none"> • Wraparound community nursing in primary care • Virtual ward • IV therapy in patients home 	<p>Evaluation of</p> <ul style="list-style-type: none"> • Wraparound community nursing in primary care • Virtual ward • IV therapy in patients home • Enhanced care home model with trusted 	<p>Full implementation based on benefits realisation and evaluation of pilots including role out of</p> <ul style="list-style-type: none"> • Wraparound community nursing in primary care 	Contract monitoring of the established KPI's and delivery of specification of	

Ref no.	Scheme	Milestones Quarter 1/2 2017/18	Milestones Quarter 3/4 2017/18	Milestones Quarter 1/2 2018/19	Milestones Quarter 3/4 2018/19	Progress at March 2018
	<p>Implementation of virtual ward</p> <p>IV therapy in patients home</p> <p>Enhanced care home model including trusted assessor</p>	<ul style="list-style-type: none"> Enhanced care home model with trusted assessor pilot and GP LES 	<p>assessor pilot and GP LES</p> <p>Developing plans to pilot Red bag model in care homes with admission to hospital</p>	<ul style="list-style-type: none"> Virtual ward IV therapy in patients home Enhanced care home model with trusted assessor pilot 	<ul style="list-style-type: none"> Wraparound community nursing in primary care Virtual ward IV therapy in patients home Enhanced care home model with trusted assessor pilot 	
9	<p>Managing increase in demand for adult social care</p> <p>Increase in care packages due to demographic pressure leading to reduced length of stay in hospital. Work with residential and nursing providers to increase access to health care within homes so that admissions to hospital reduce, redesign social</p>	<p>Continue to improve social work decision making on care packages by re-designing social work ways of working to improve decision making, assessment</p>	<p>Implement new models of working for social work, assessment and review to improve social work decision making on care packages</p>	<p>Monitor new model of social work ways of working , assessment and review</p>	<p>Monitor and evaluate new model of social work ways of working, assessment and review to determine success in improved social work</p>	

Ref no.	Scheme	Milestones Quarter 1/2 2017/18	Milestones Quarter 3/4 2017/18	Milestones Quarter 1/2 2018/19	Milestones Quarter 3/4 2018/19	Progress at March 2018
	<p>work services to focus on prevention and improved decision making</p> <p>IBCF funding of £2m older people care packages</p>	<p>and review. Share demand data with HWB Provider Forum</p>			<p>decision making on care packages</p>	
10	<p>Implementation of new responsibilities under the Care Act 2014</p> <p>The funding provided within the Better Care Fund has contributed towards the cost of implementing the requirements of the Care Act. These include carers' support, advocacy and safeguarding. We have implemented the required systems under the Health & Social Care Bill. We have invested in new technology to allow on line</p>	<p>Continue to increase adverts and advice and information on My care My Support, mobilise voluntary sector to give advice and support. Implements and develop advocacy service , implement online assessment</p>	<p>Continue to increase adverts and advice and information on My care My Support, mobilise voluntary sector to give advice and support. Monitor advocacy service , implement online assessment</p>	<p>Continue to increase adverts and advice and information on My care My Support, mobilise voluntary sector to give advice and support. Monitor and review advocacy service and online assessment</p>	<p>Continue to increase adverts and advice and information on My care My Support, mobilise voluntary sector to give advice and support. Monitor and review advocacy service , and online assessment</p>	-

Ref no.	Scheme	Milestones Quarter 1/2 2017/18	Milestones Quarter 3/4 2017/18	Milestones Quarter 1/2 2018/19	Milestones Quarter 3/4 2018/19	Progress at March 2018
	self-assessment and information and advice through www.mycaremysupport.co.uk					
11	Workforce development and transformation IBCF Additional change and social care capacity (£320k)	Testing of new ways of working in hospital social work team and reablement, KPIs agreed and reported monthly Testing and implementing new front door for adult social care	Implementation of new ways of working in hospital social work, reablement, adult community team social care Implementing new front door for adult social care	Monitor implementation and outcomes of new ways of working in hospital social work, reablement and adult community teams Monitor new front door for adult social care	Monitor implementation and outcomes of new ways of working in hospital social work, reablement and adult community teams and front door	

National Conditions

National condition 1: jointly agreed plan

This plan has been jointly agreed by the Health & Wellbeing Board and Swindon Borough Council and Swindon CCG. The draft Plan was circulated to the A & E Delivery Board and IBCF discussed with them. The IBCF use of funding was agreed by the Health & Wellbeing Board including Swindon CCG on 24th May 2017. The distribution of the funding was shared with partners. The Disabled Facilities Grant is retained by the Council and will continue to be part of the BCF.

National Conditions (continued)

National condition 2: social care maintenance

We are defining the protection of adult social care as maintaining eligibility criteria for adult social care as defined by the Care Act. Funding from the Better Care Fund has been allocated to fund the increase in demand, is used to protect adult social care as well as investment in existing schemes. Eligibility for social care is described in detail on My Care My Support website accessible for carers, patients and service users.

The funding below sets out how the different schemes in the BCF will be funded. The minimum funding for adult social care has been maintained as well as funding for carers, care act and out of hospital care. Due to changes to the community provider, allocations have been changed to reflect the changes. In addition Swindon Borough Council has added funding to the BCF for jointly funded schemes to show the full cost of the schemes. Reablement has benefitted from being reshaped to increase the number of patients benefitting from the service as well as additional investment.

Specific schemes to protect adult social care are support for carers, learning disabilities, crisis support and integrated care, community capacity building and increase in care packages to support hospital discharge. Schemes protecting adult social care account for £4.4m revenue funding in addition to the allocation for the implementation of the Care Act

An advice and information service has been commissioned as well as a service directory on line to give the public and patients access to up to date information. This is aimed at promoting independence and choice. The voluntary and third sector is commissioned to improve self-help and prevention for carers, those at risk of mental ill health and older people. Further services in relation to breaking isolation have been commissioned in 2017.

The Health benefit of reablement has been evidenced with a reduction in re-admission to hospital from 17% to 7% in quarter 1 2017/18. The domiciliary care bridging services and discharge to assess beds reduce delays in hospital.

Support to carers shows benefits through national research and Swindon CCG and the Council have signed the Memorandum for Carers

Investment by the Local Authority in advice and information web based information and an Advice and Support Service at Sanford House commissioned from Swindon CAB. An online information gathering tool is used by social workers as part of the streamlining of assessment. As part of the care Act additional advocacy, safeguarding and carer support is being funded and provided. In 2017 we have reshaped social work services for older people to increase use of community resources, give good advice and information and reduce the length of time service users wait for assessment and services.

We are using the NHS number as primary identifier for correspondence across health and social care services. The NHS number is used and recorded on the Social Care Information system (SWIFT) and Capita One. SWIFT and Capita One are owned by Swindon Borough Council so that commissioners and providers have access to the NHS number for both children and adults. Adult social care is currently procuring a new case management system stating inter-operability to NHS and My care My Support. We are part of the STP Digital work stream to develop a shared care record.

National condition 3: NHS commissioned out-of-hospital services

By using a risk prediction approach it is possible to identify those people who are the most regular users of health services (both primary and secondary care) and are at risk of re-admissions to hospital), then stratify them according to complexity of need and commission cost effective interventions to meet those needs. NHS Swindon made an investment in implementing a risk stratification tool in all GP surgeries. GP practices will be involved in identifying opportunities for commissioning interventions that could reduce the risk of a hospital admission. Those patients identified at high risk are allocated to a community navigator to develop a self-management plan. The scheme has received additional investment following a positive evaluation where health of the individual improved and health spent reduced.

Bespoke pathways for both Respiratory and cardiology have been developed locally to help with the management of repeat attendances to ED most commonly within winter periods.

These pathways combined with a developed Older Adult pathway will be supported by social care and provide more efficient care delivery within the community.

National Condition 4: Managing Transfers of Care

The DTOC Programme Board brings together Swindon CCG, Great Western Hospital, and Wiltshire Council to tackle the blockages leading to patients having their discharge from hospital delayed. Delayed discharge is a challenge nationally and regionally. . From April 2016 to March 2017, the hospital days lost due to DTOC for Swindon are 889 fewer compared to this time last year which places us as one of the top four performers in the South West. As in previous months, the main cause for delay in March 2017 was the availability and arrangement of Nursing Home Placements (29% compared to the national figure of 14%). From April 2016 to the end of March 2017, the delayed transfers of care attributable to social care in Swindon equates to a rate of 5.95 per 100,000 population. Although this is above our year-end target of 3.9, it is an improvement on last year's performance (8.3 per 100K population) and is better than the latest South West average of 8.79 and England average of 6.4 per 100,000 population.

Our DTOC performance deteriorated between April – June 2017. We believe this is due to a change in working in the hospital social work team and in Great Western Hospital. We have analysed our data and reviewed processes to improve patient flow.

Delays have been particularly high due to waiting for assessments, but there have also been delays due to awaiting nursing care in the community beds. Mental health delays have also increased. Across health and social care, we have committed to reducing the number of people delayed in hospital to an average of 17 per day by end of September 2017 (9 attributable to the NHS and 8 attributable to social care), 13 people per day by the end of March 2018 (7 attributable to NHS and 8 attributable to Social Care). The challenge of mental health delays is most likely to impact negatively on our ambitious target. In particular a very small number of patients with her high needs (challenging and potentially violent behaviour requiring safehold care).

The hospital based Integrated Discharge Team works jointly across health and social care staff; with a current focus on development of internal metrics to improve flow of timely assessment from inpatient acute care, assessment lead time and identification of need to improve function within the community.

These actions are intended to support reduced variation in daily discharge fluctuations to support the acute but also maximise opportunity to maintain independence and care within the home. These developed pathways will be developed jointly within local partners and social care and reported to the DTOC programme Board and Urgent Care working Group.

A detailed modelling exercise has already been completed to look at component responsibilities of partners to improve flow of simple and more complex discharge which makes best use of available resources.

Our DTOC data is monitored weekly in social care and monthly through the DTOC Programme. Newton Europe is supporting adult social care to reshape services to improve performance. Our Improved Better Care Fund Plan (IBCF) sets out our plans to use the additional funding from Central Government to reduce delays. We have a review of our DTOC plans with NHS and LGA through the national improvement team on 12th September 2017. Our work in social care focuses on: increasing capacity in reablement; better use of discharge to assess beds; reshaping the hospital social work team and to have full seven day working enshrined in staff contracts; reduction in permanent admission to residential and nursing homes; and to fully embed the health in care homes initiative.

Data for July and August shows improved delays transfers of care for social care.

Work continues to support expeditious and timely hospital discharge so that patients stay until their acute medical episode is finished, receive a high level assessment and then move to a more appropriate location for assessment of future needs. We are actively developing the frailty pathway with health to ensure patient flow is improved and creating a cohesive admission alternative pathway to meet the needs of local population including discharge to assess and step down and step up beds. We are also focussing our efforts on improving the effectiveness and maximising the capacity of reablement and rehabilitation services to up skill clients so they can live quality and independent lives. We are pro-actively engaging with the Care Home Forum to prevent avoidable admission to hospital from care homes, and ensure speedy discharge at the earliest opportunity. There is also a focus on reducing the discharge delays for patients who are medically fit and are the responsibility of other CCGS. The Repatriation policy has supported speedier discharge for out of area patients.

Our progress and actions against the High Impact Changes which forms our DTOC Action Plan is attached as Appendix 1

Overview of funding contributions

Briefly set out confirmation that the funding contributions for the BCF have been agreed and confirmed – including agreement on identification of funds for Care Act duties, reablement and carers breaks from the CCG minimum. These can be confirmed in the excel Planning Template

- Care Act 2014 – how funding for CA implementation is being used
- Reablement
- Carer's breaks
- Social Care
- if

We have agreed funding contributions for implementation of the Care Act, Carers Support and short term breaks, reablement, social care and IBCF. . The schemes set out below and in the action plan 2017-19 set out how the funding is used. Care Act funding is used specifically to fund further support to carers, advice and information, safeguarding and social work in ensuring care act compliance. Additional advocacy has also been funded. We have pooled all funding supporting carers including carer's breaks and support in the voluntary sector and carer's assessments. IBCF funding is split across managing demand, maintaining the market and funding the increase in the minimum wage as well as supporting hospital discharge. Swindon Borough Council has used its own resources in addition to IBCF to reshape social care, reablement and 7 day working in hospital social work team, reablement and rapid response.

The DFG is allocated within the local authority for capital spent and the Local Authority annually adds additional capital. The Public Health Directorate manages the spent. It is reported annually through the Joint Commissioning Group as part of our governance arrangements. The actual allocations and spent are detailed in the Excel planning template.

BCF and IBCF schemes 2017/19

Ref no.	Scheme	Governance
1	<p>Prevention of Hospital admission including rapid response Crisis support to prevent admission to hospital and enable those who leave hospital. Implementation of Urgent Care and therapies at the front door BCF and IBCF funding to enhance service</p>	Implementation DASS and Director of Nursing CCG – monitoring Joint Commissioning Group from April 2017
2	<p>Reablement and Telecare People will regain skills as quickly as possible without the need for on-going support. The reablement service will be re-designed with external support to increase capacity and efficiency. In future the service will take referrals from the hospital and social work services as well as Social care front door Funding BCF and IBCF transformation, therapy. Additional capacity funded so that 930 patients will benefit per year from a baseline of 330 in 2016/17</p>	Implementation DASS – July 2017, monitoring Do programme Board
3	<p>Enhanced voluntary sector capacity In particular we will commission voluntary and community based support linked to localities and GP practices. Supporting volunteers reduces the need for some targeted and specialist services. Community and voluntary sector groups provide important flexible services either informally or as part of local contracts. Circles of Support will be expanded to support patients with long term conditions A website is in place http://www.mycaremysupport.co.uk/ ,</p>	Implementation – DASS April 2017, monitoring through Joint Commissioning Group

	<p>to provide information and advice to the public, staff and voluntary sector partners. Funding BCF and core funding SBC</p>	
4	<p>Discharge to Assess including residential rehabilitation We are funding residential assessment and rehabilitation beds with occupational therapy so that patients can be discharged from hospital more quickly. An additional Home to Assess service is commissioned by the CCG Social care domiciliary care bridging capacity to ensure return home for complex assessments BCF and IBCF funded</p>	<p>Implementation DASS and Director of Nursing – July 2017</p>
5	<p>Effective discharge from hospital and delayed discharge from care</p> <p>Early discharge from hospital through ambulatory care, seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible. New multi-disciplinary Integrated Discharge Service in place across Wiltshire, GWH and Swindon Social care operating 7 days a week. Discharge coordinators in post to facilitate weekend discharges discharge. Virtual Ward, Intermediate Treatment beds (SWICC),</p> <p>Sustainable reduction in number of DTOC and non-DTOC delays across the health and care system to 17 beds per day 30.9.17 and 13 days by 31.3.2018</p> <p>Agreed programme of work with clear outcomes and timelines for implementing the Newton Europe recommendations as these apply to delayed discharges. Funding BCF and IBCF for transformation</p>	<p>Implementation DASS, Director of Nursing – from May 2017</p> <p>Monitoring through DTOC Programme Board (Swindon Borough Council, Swindon CCG, Wiltshire Council and Wiltshire CCG, Great Western Hospital NHS Trust, SEQOL)</p> <p>DTOC Programme Board reports to A & E Delivery Board</p>
6	<p>Carers' Support A joint carers' contract is already in place due to be re-tendered in 2017. The Carers' Centre provides advice</p>	<p>Monitoring -Joint Commissioning Group monthly from April 2017</p>

	<p>and information for carers, welfare benefits advice as well as support groups. There is a carer's support worker operating in GWH. Young carers' support is provided by the same voluntary organisation and was part of the same tender. Outcomes for carers continue to improve with more assessments being completed, support groups in place, short term breaks and improved access to health checks.</p> <p>Funding BCF</p>	
7	<p>Capital Grant Adult Social Care (Disabled Facilities Grant) Capital allocations fund the disabled facilities grant scheme which is operated by Swindon Borough Council. It also funds large items of social care equipment required through the joint Integrated Community Equipment Store for children and adult services as well as investment in telehealth and telecare. We will continue investment in technology to support self-care and prevention and enable people with a disability to live as independently as possible.</p>	<p>Monitoring Joint Commissioning Group monthly from April 2017</p>
8	<p>Out of Hospital Care through Community Health, enhanced Health in care Homes, trusted assessor aimed at reducing emergency admissions Reshaping of community health provision through new provider contract with GWH, pilot of Enhanced health in Care Homes and trusted assessor , continued development of Single Point of Access for GP's and new models of care</p> <p>Funding BCF</p>	<p>Director of Nursing – Urgent Care Board reporting into A & E delivery Board – July 2017</p>
9	<p>Managing increase in demand for adult social care Increase in care packages due to demographic pressure leading to reduced length of stay in hospital. Work with residential and nursing providers to increase access to health care within homes so that admissions to hospital reduce. Additional investment in care packages to</p>	<p>Implementation DASS, April 2017, Monitoring Joint Commissioning Group monthly</p>

	<p>improve availability of care for older people Funding BCF and IBCF</p>	
10	<p>Implementation of new responsibilities under the Care Act 2014 The funding provided within the Better Care Fund has contributed towards the cost of implementing the requirements of the Care Act. These include carers' support, advocacy and safeguarding. We have implemented the required systems under the Health & Social Care Bill. We have invested in new technology to allow on line self-assessment and information and advice through www.mycaremysupport.co.uk Funding BCF and IBCF</p>	<p>Monitoring Joint Commissioning Group monthly from April 2017</p>
11	<p>Workforce development and transformation Transformation and additional social work and staff funding to implement changes in hospital social work, reablement, adult social care community social work</p>	<p>Implementation DASS – April 2017, monitoring Joint Commissioning Group monthly</p>

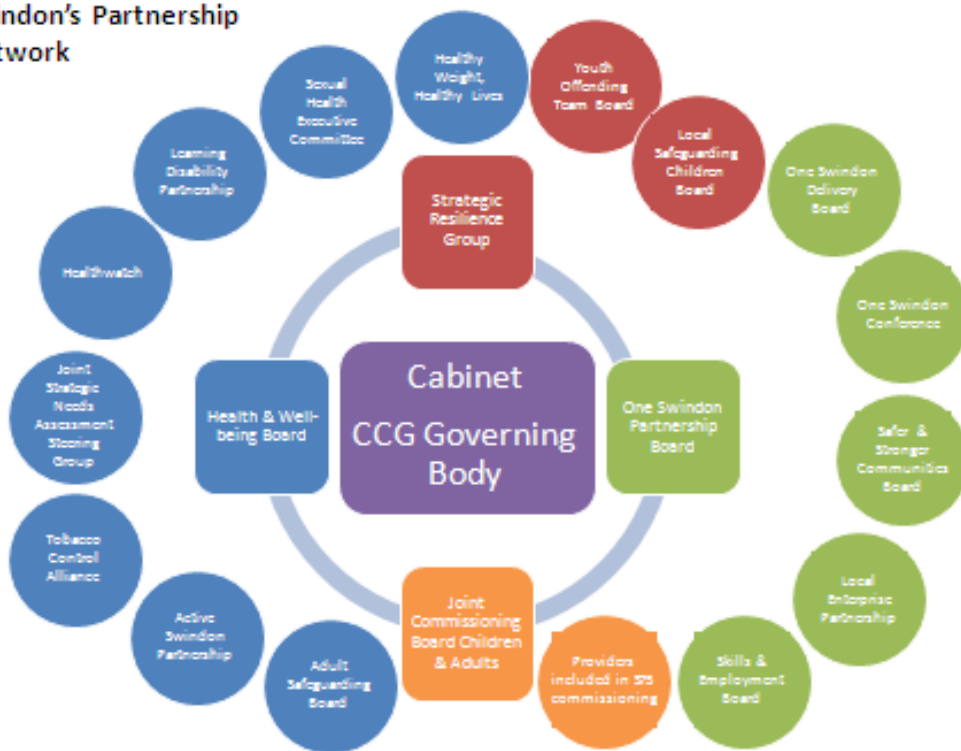
Programme Governance

Swindon has a National Health Services Act 2006 section 75 Agreements for the commissioning of adult health and social care services including mental health and commissioning of health, education and social care services for children. A joint commissioning plan bringing together all our joint priorities as well as a delivery plan has been in place for 2016/17 which will be replaced by this comprehensive BCF as well as the emerging **Market Position Statement (Appendix 2)**. These are reviewed six monthly and renewed annually by the Joint Commissioning Group referred to below.

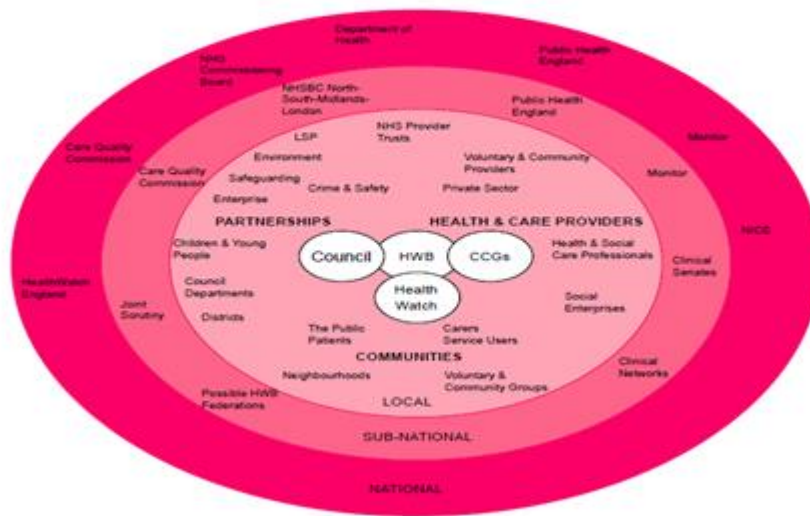
Governance arrangements to monitor the section 75 Agreements are already in place through the Joint Commissioning Group (JCG). The CCG and Swindon Borough Council, including Public Health are members of the JCG. Meetings of the Group take place monthly. The Group reports through to the Health and Wellbeing Board at every meeting. The Better Care Fund sits as a pooled fund within the Section 75 Agreement and is monitored by the JCG. The existing Section 75 Agreements have been refreshed to take account of the new arrangements.

The Joint Commissioning Group Terms of Reference have been amended to provide a link to the Health & Wellbeing Board who agreed the Better Care Fund. There are also links between the Better Care Fund and the A & E Delivery Board which is the new whole system network designed to bring together multiple stakeholders from across Swindon and Wiltshire.

Swindon's Partnership Network



Health & Well-being Board: key relationships



Operationally, the delivery of the Better Care Fund Plan is through the CCG Executive Management Team and the Joint Commissioning Group.

Joint membership of both groups is in place. Joint reports go to the Joint Commissioning Group as well as progress reports against the Joint Commissioning Plan. A progress report has been submitted to the JCG and the Health and Wellbeing Board in December 2016

Each of the Better Care Fund schemes is part of either the CCG Interventions or the Adult Change Programme. Project managers and work stream leads are in place for each scheme. New work streams were established for Carers development in partnership with the Carers' Centre. This has resulted in a revised Care Act compliant Carers Assessment, a streamlined process for carers' breaks, and carers post within the hospital discharge team.

A Transition Programme Board is in place for the new contract with GWH for community health services which is attended by Swindon Borough Council, Swindon CCG and GWH. There are contractual arrangements in place for escalating performance issues.

Delivery of work stream targets is reported to the Joint Commissioning Group and CCG executive team. Delivery issues and risks are reported to the relevant Board where remedial actions will be agreed.

Assessment of Risk and Risk Management

There is a risk that:	How likely is the risk to materialise? <i>Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely</i>	Potential impact <i>Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact</i> <i>And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)</i>	Overall risk factor <i>(likelihood *potential impact)</i>	Mitigating Actions
Risk 1: Demand at a higher rate than population growth assumption of 2.8 - 3.2%	4	5 Not achieving reduction of 3.5% will result in a CCG pressure of £1m. The schemes within BCF are already part of GWH block contract. Therefore CCG will allocate funding for over performance for acute health care from 2016/17 allocation (CCG risk).	20	Focus on self-care and prevention through My Care, My Support and Voluntary sector commissioning – Director Adult Social Services by 31 3 2018 A range of health led interventions addressing unplanned admission to hospital outlined in CCG 5 year Sustainable Transformation Plan – Lead Accountable Officer CCG by June 2018
Risk 2: Community based self-care does not impact on demand	5	4 No financial impact as community navigator for 2017/18 will be funded by CCG. If there is over performance in adult social care (SBC risk) or acute health care (CCG risk) then these will be funded by core budget from SBC and CCG core budget outside of BCF respectively	20	Link of community navigator, circles of support and healthy Lifestyles all delivered through a co-located dedicated team with a single manager responsible for collaboration and coordination. DPH SUCCESS scheme and nurse led home visiting services funded by CCG core budget. Lead Accountable Officer CCG June 2018
Risk 3 Demand outstrips capacity in reablement services	4	3 £1.7m allocated for demand in older people by SBC for 2017/18.SBC risk	12	Bridging packages through Better Care Fund allocation from BCF. Re-commissioning of domiciliary care services through prime contractor model Head of Commissioning (start February 2017)

Risk 4 Patients continue to go to A&E rather than community alternatives leading to increased hospital admissions	5	4 Not achieving reduction of 3.5% will result in a CCG pressure of £1m. The schemes within BCF are already part of GWH block contract. Therefore CCG will allocate funding for over performance for acute health care from 2016/17 allocation (CCG risk)	20	Communication strategy, in place including social media Primary care streaming implemented in urgent care Centre – April 2018 Associate Director of Commissioning (Out of Hospital)
Risk 5 redesign programme for adult health and care services not delivering transformation and change	3	5 Over performance creating financial risk to Swindon Borough Council Over performance in hospital admission creating financial risk for CCG	15	External support secured to drive re-design programme bringing additional capacity and evidence based change methodology (DASS) Continuous learning approach (Plan, Do, Study Act) – Quality approach – Executive Nurse April 2018
Risk 6 Cultural and behaviour change required from staff across public sector to develop Accountable Care	4	4	16	Multi-agency workforce development programme across Swindon on managing expectation and managing change through redesign workshops and workforce development. Actions throughout 2017/18 monitored by Accountable care Alliance Board
Risk 7 Capacity to drive pace of change under developed	4	4 No measurable financial impact as all schemes have project management allocated already	16	Programme management in place for urgent Care DTOC and Accountable Care Programmes throughout 2017 – Executive Nurse CCG

There is a formal risk sharing process in place between the CCG and Great Western Hospital linked to the delivery of QIPP schemes and over performance against the contract. Mitigating schemes continue to be developed to ensure that we are able to manage the demand for unscheduled care and the Swindon Strategic Resilience Forum will review this on a monthly basis.

Swindon CCG is developing a health in care homes pilot to reduce hospital admissions further discharge to assess capacity of domiciliary bridging services of over 800 hours per week, 12 discharge to assess beds, and 6 step up beds are funded from BCF (social care to improve patient flow). A winter contingency fund across CCG, Swindon Borough Council and GWH is in place of £300k for 2017/18 to support patient flow

In identifying schemes, we have ensured that High Impact Changes to reduce delayed discharges a structured approach has been followed and a standard methodology used to risk assess the potential financial benefits and risks. Third party evidence has been used wherever possible to support changes proposed and where lacking, financial benefits have been risk adjusted. For example, activity prices and volume shifts are based on local systems experience and historical data. The IBCF has been allocated to complement the existing investments in the High Impact Changes, stabilise the social care market, and invest in transformation and a winter contingency.

Standard tools have been used to ensure that any proposed benefits are probability weighted and projects are treated objectively. Although much of this has been process driven, management judgement has also had to play its part. The expected benefits of schemes are monitored and reported against on a monthly basis so remedial actions can be taken in a timely fashion.

Each partner takes the risk for over performance in the areas as follows:

If targets for admission to residential care are not achieved in 2017/18 for adult social care, then the Council's core budget will cover an increase in demand. This is not likely as data analysis has shown that although more people were admitted, the length of stay reduced and therefore there are no adverse financial impact.

- Additional funding has been allocated from the IBCF for demand into care packages as discharge to assess already funded. Demand over and above this figure will be met by Swindon Borough Council. SBC has committed through the DTOC Programme to reduce delays due to social care by 50% in 2017/18 based on bed days in GWH.
- The CCG has allocated growth funding for GWH from its core budget including additional demand for emergency admissions. Part of the allocation for social care also supports non elective admissions such as community navigator and home to assess care packages. If the target of 3.5% reduction in hospital admission is not met, then the CCG will budget for over performance from its allocation as schemes within the BCF form part of the SEQOL block contract.

National Metrics

Non Elective Admissions

We have established an ambitious target with GWH to reduce non elective admissions. The targets set in the BCF reflect the target set by the CCG in its operational delivery plan 2017/18. We have an overarching A & E Improvement Plan which sets our actions to be undertaken in reducing non elective admissions across the system. Additional CCG funding is resourcing the community navigator programme to further reduce non elective admissions. Risk stratification tools are being used to identify patients across GP surgeries for the service. Annual evaluations have shown that the service is effective in reducing non elective admissions. The Urgent Care Board Swindon reports into the STP wide urgent care work stream as well as the A & E Delivery Board. This ensures that Swindon shares its learning with our STP partners and vice versa.

Admission to nursing homes

Admissions to residential and nursing care have been effectively managed and remained below target for both younger adults (aged 18-64) and older adults (aged 65 and over). During 2016/17, 192 older people were admitted to permanent care: 102 to a nursing home placement and 90 to residential care. Amongst these first time permanent admission to care, 21 people were admitted with mental health needs, one with a learning disability and 170 people with personal care/physical support needs (older people). The target for the year was to admit no more than 228 older people (a rate of 689.52 per 100k population). Current performance is 580.65 per 100k population aged 65 and over which put us ahead of our year-end target. From April – June 2017 admissions to residential and nursing care are being effectively managed and remain below target for both younger adults (aged 18-64) and older adults (aged 65 and over). 21 older people were admitted to permanent care: 11 to a nursing home placement and 10 to residential care. Amongst these first time permanent admission to care, 5 people were admitted with mental health needs and 16 people were admitted with personal care/physical support needs (older people).

Given our strong performance, our target for 2017/18 for older people aged 65+ years is 577.1 per 100,000 population.

Effectiveness of re-ablement: How will you increase re-ablement?

Describe how the metric for re-ablement will be reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19?

In 2016/17 we increased our intermediate care provision, step up crisis support and bridging domiciliary care services to reduce hospital admission and facilitate appropriate hospital discharge. Nearly 90% of older people (65+) still at home 91 days after discharge from hospital into reablement/rehabilitation. We continue to perform well in this areas amongst our comparators.

There has been significant improvement in the reablement service with greater throughput, reduced length of stay and better outcomes. From April to June, 84 episodes of homecare reablement have been completed. The average number of days to re-able an individual has reduced from 27 to 21 days, and a greater proportion of people (88%) are gaining independence following the service and therefor no longer require ongoing support. We have also improved the number of people. Receiving reablement at any one time from an average of 16 to 27

We are monitoring the improved reablement service with a set of KPI's weekly in terms of admissions, discharges, length of stay and hospital people this has been achieved through changing staff rostering and working more efficiently. This will be reported into the Joint Commissioning group monthly.

We will be aiming to maintain 90% performance of patients at home 91 days after discharge.

Delayed transfers of care

Please provide evidence of agreement on local action plan to reduce DTOC and improve patient flow.

Provide a narrative on the metrics themselves (as laid out in your planning template, including how any amendments to the expectations for reductions in social care related and NHS related delays were agreed and a rationale for the amended split between NHS/social care/jointly attributable delays.

Set out the contribution that the BCF schemes will make to the target including an analysis of previous performance and a realistic assessment of the impact of BCF initiatives in 2017/19 towards meeting the ambitions set out for local areas by Government (for social care and jointly attributable delays) and NHS England (for NHS attributable delays)

Narrative plans should set out how the services commissioned will contribute to the local plan to achieve the ambition in the local system on reduction of delayed transfers of care.

From April 2016 to the end of March 2017, the delayed transfers of care attributable to social care in Swindon equates to a rate of 5.95 per 100,000 population. Although this is above our year-end target of 3.9, it is an improvement on last year's performance (8.3 per 100K population) and is better than the latest South West average of 8.79 and England average of 6.4 per 100,000 population.

Our DTOC performance deteriorated between April – June 2017. We believe this is due to a change in working in the hospital social work team and in Great Western Hospital. We have analysed our data and reviewed processes to improve patient flow and social work

Delays have been particularly high due to waiting for assessments, but there have also been delays due to awaiting nursing care in the community beds. Mental health delays have also increased. Across health and social care, we have committed to reducing the number of people delayed in hospital to an average of 17 per day by end of September 2017 (9 attributable to the NHS and 8 attributable to social care), 13 people per day by the end of March 2018 (7 attributable to NHS and 8 attributable to Social Care).

Approval and sign off

Provide confirmation of who has signed up to the BCF plan

Brian Mattock Chair Health & Wellbeing Board, Swindon

A handwritten signature in black ink, appearing to read 'B. Mattock', with a large, stylized flourish at the end.

Cabinet Member Adults: Councillor Brian Ford

A handwritten signature in black ink, appearing to read 'B. Ford', with a large, stylized flourish at the end.

Accountable officer, Swindon CCG: Nicki Millin

A handwritten signature in black ink, appearing to read 'N. Millin', with a large, stylized flourish at the end.

Provide the Date of Health and Wellbeing agreement (for the second submission of plan) 25th October 2017. BCF submission date was also raised on 24th July HWB

Delegated to Chair and Cabinet Member for sign off. Date of next health & Wellbeing Board

