Working in partnership with
Wiltshire Council
Where everybody matters

NHS
Wiltshire
Clinical Commissioning Group

## Appendix 2

# Outline commissioning intentions – Better Care Plan 2016/17

Detailed proposed commissioning intention for the Better Care for 2016/17 is outlined below and each is mapped against the high level strategic intentions outlined in the covering document.

| **Recommendation** | **How we will deliver** |
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| **Specific Objectives** | |
| **Living well with complex comorbidities and maintaining our population in our normal place of residence** | |
| **Systematic, targeted case-finding. This includes using risk stratification, electronic case-finding tools and screening within primary and community settings.**<br>(*New approach*)- link to prevention work stream | • Risk stratification in practice, together with input from the Integrated Teams to identify vulnerable patients- can this be rolled our more widely across Wiltshire and link into social care.<br>• Getting value out of our risk stratification approach is of high importance and connecting with wider system for prevention and case management benefit.<br>• There is a real opportunity through the BCP and joint commissioning to ensure this approach aligns with social care and proactive link with the prevention agenda. |

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| **Proactive comprehensive geriatric assessment (CGA) and follow-up.**<br>(*Continuation*)- link to crisis management , admission and integrated teams | Maintain 3 community geriatricians in place and expand areas of coverage to;<br>• Community hospitals.<br>• Front door admission avoidance.<br>• Pull model of discharge planning.<br>• Case management with integrated teams |
| | • Recognising we have cohorts of patients admitting with multiple morbidities – there is a need for more integrated case management. More will be required out of community matrons, nurses and the integrated teams.<br>• Establishing a framework for comprehensive geriatric assessment is critical to the integration agenda and these principles need to endure beyond the specialist roles to ensure proactive management of high risk frail elderly. |
| **An identified keyworker who acts as a case manager and coordinator of care across the system.**<br>(*New approach*)- link to integrated teams | All practices have care co-ordinators although roles vary across the County- need to ensure this is aligned with the discharge management strategy in Wiltshire being taken forward under the Better Care Plan. |

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| **Carers are offered an independent assessment of their needs and signposted to interventions to support them in their caring role.**<br>(*Will be accelerated as part of the Care Act work*) | • Offer assessments and support to carers and by commissioning an information portal that has within it a self-assessment tool for carers that enable them to access the care they need, when they need it.<br>• The Care Act will encourage all carers to come forward for assessment.<br>• Work with Practices through integrated teams to hold registers of carers and ensure linkage in terms of case management and follow up care.<br>• More formal involvement of the voluntary sector in the provision of care. This is subject to the commissioning review being undertaken. |
| **Progress the personalised commissioning agenda.**<br>(*New approach*)- link to the prevention agenda | • The presence of personal budgets in Wiltshire and the revised national direction on personalisation requires us to look at how we can expand our approach to personal budgets and the personalisation agenda.<br>• There is an opportunity to link this in with the work of identified voluntary sector organisations. |

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| **A comprehensive service for those with dementia must be available and accessible.**<br>(*Continuation but needs more spread)- link to crisis management , prevention and early intervention* | Dementia strategy and action plan has been developed, but we need to target the gaps in care and need to ensure a more community focused /crisis intervention based model of care. Through the Better Care Plan we are already looking at;<br>• Care Home Liaison services.<br>• Focused support to AWP in relation to discharge planning.<br>• Acute "in reach" and ESD programmes for dementia.<br>Dementia diagnosis rates have increased across the county – need to ensure that once patients are diagnosed they are moved to appropriate service for ongoing care and management. The registers have to serve a purpose and provide a platform for future case management.<br>There is also a need through our workforce development and training programme to establish a dementia training programme given the level of occurrence and the impact this has on service provision. |

| Rapid Response and admission avoidance | |
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| **Single point of access available to facilitate access to community services to manage crisis at home with specialist opinion and diagnostics.** (*Continuation*)-admission avoidance and crisis management | • Access to Care single telephone number has been established. Further opportunities to commission community geriatrician and local diagnostics through this route should be explored.<br>• Also Access to Care and Urgent Care at home model is being expanded to include EOL care and mental health crisis (this will need further expansion. |
| **A comprehensive geriatric assessment initiated rapidly, seven days a week.** (*Continuation but will need to expand to 7 days a week)- admission avoidance /crisis management and integrated teams* | • Community geriatrician coverage across Wiltshire, need to link in more formally with established community teams. It is also recognised that our admission avoidance approach needs to be consistent across a 7 day period.<br>• Urgent care at home model planning case management /intervention of high risk patients.<br>• Consider as part of the community hospital review and the new community contract how we maximise use of community hospitals, |

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| | Can we widen remit in areas such as;<br>• Frailty units<br>• Extended community diagnostics<br>• Community IV and transfusions<br>• Targeted discharge for areas with high excess bed days<br><br>Developing robust "interface" care with each acute hospital , enhancing the ATL model and diverting appropriate patients to established models of care in the community (for discharge and admission avoidance). |
| **Alternative emergency pathways available 7 days a week in an out of hospital setting**.<br>(*Continuation but need to expand to 7 days – funding dependent*)- crisis management and admission avoidance ) | **Urgent care at home**<br>Continued commissioning of Urgent care at home available through Access to Care.<br>Although there is a need to standardise our approach to jointly managing the Medvivo contract.<br><br>**Step Up Intermediate care**<br>Continue to commission existing community hospital step up pathway, need to consider extension to another site such as Chippenham.<br><br>**Step up care at home**<br>The Wiltshire HomeFirst programme will provide an element of "step up" care and crisis management I the patient's home. |

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| | ***Community IV***<br>There is a need to finalise a strategy for community IV in Wiltshire and agree a Business Case process. This was identified as a key priority during the 100 day challenge and has not yet been progressed.<br><br>**End of life 72 hour pathways**<br>As outlined below<br><br>**Comprehensive Geriatric assessment and case management**<br>As outlined above<br><br>**Referral management**<br>With the multiple number of schemes in Wiltshire it is imperative we have a very clear consistent message in relation to the out of hospital alternatives, key areas of focus include;<br>• Continuation of the one access number<br>• Revisiting referral pathways with GPs<br>• Widening pool of referrers into schemes, for example detailed liaison with SWAST has commenced looking at how they utilise UCAH and step up. Also opportunities for nursing and residential homes to use pathways.<br>• Focused communication<br>• Focused training and support with the highest referring practices parts of the system. |

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| **Enhancing care at the "interface".**<br>(*Continued scheme* )- mobilisation , independence and admission avoidance | • Following successful pilots, the aim during the second half of 15/16 and beyond is to develop established pathways for admission avoidance and discharge planning at each acute hospital. This will build on the existing Access to Care Model with hospital clinical leadership.<br>• In relation to mental health crisis, a review has been undertaken of acute mental health liaison and any recommendations from this need to have a presence in commissioning intentions. |
| **Mental health services should contribute with specialist mental health assessments, if appropriate and support to care homes and other service providers.**<br>(*Continuation but needs further scope*)- crisis management and early mobilisation | • Care Home Liaison team to be re-commissioned and BCP remains as the funding stream.<br>• Mental health advice and support within the urgent care at home model, which will also increase support to SWAST in relation to the management of mental health crisis.<br>• Continued leadership to the Mental Health system flow programme (with a focus on acute beds at AWP). |
| **Rapid access ambulatory clinics available in acute and community hospital settings for the provision of rapid access to specialist advice from the multi-disciplinary team.**<br>(*New approach*)- crisis management and admission avoidance | Following the review of community hospitals and the development of 24 hour pathways into intermediate care, need to consider whether these clinics, day care of frailty units are to be provided in community hospitals within Intermediate Care Units and acute settings. |

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| **There are shared care protocols with ambulance organisations that can enable older people to remain at home.** | To be developed. |
| **Good discharge planning and post-discharge support:** | |
| **A key priority of the Better Care Plan is to ensure that more residents can have their longer term care provided for in a home setting.**<br>(Continuation with roll out during 2016/17)- mobilisation and discharge planning<br><br>Increase the volume discharges home from an acute hospital. | Roll out of the Wiltshire Home First initiative, building in the discharge to assess concept this was recognised as one of the key system priorities in the 15/16 commissioning round.<br><br>**There is an urgent need to clarify the scope of the service extension, the impact on beds required in the system and the principles assumed in relation to funding.**<br><br>Key lessons from the proof of concept need to be incorporated in the extension of the programme as well as ensuring we consistently review the appropriateness of existing packages of care. **We have embed a focus on transitioning patients from package of care to long term independence (phase 2 of the strategy).** |

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| **Patient, carers and families are involved in decision making from admission.**<br>(*Continued approach*)- discharge , early mobilisation and supporting social services | • To be inserted into all contracts.<br>• Acute hospitals to establish a single point of referral for complex discharges.<br>• The Choice Policy is a key policy to be relied upon and its use has to be embedded in key provider contracts and audited.<br>• Review the current discharge support to self- funders and enhance the existing service provision.<br>• Continue to respond to the new requirements of the Care Act.<br>• Maintain the existing support to Adult Social Care. |
| **Discharge to an older person's normal residence should be possible within 24 hours, seven days a week – unless continued hospital treatment is necessary.**<br>(*Continued approach*) | This will be a key priority of the Wiltshire Home First Programme. |

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| **Older people should only be discharged from hospital with adequate support and with respect for their preferences.**<br>(*Continued approach*)- discharge , early mobilisation and supporting social services | • Wiltshire Home First and the system wide approach to discharge to assess to be commissioned.<br>• Integrated Team plus Help to Live at Home support.<br>• Commissioning of the 9 ICT MDTs across Wiltshire (as part of the block commissioning of 70 intermediate care beds). |
| | Care Home Selection to support self-funders by identifying appropriate care. (Future of this programme needs to be determined). |
| **Providing high quality Intermediate Care services supporting discharge.**<br>(*Continued approach*)- early mobilisation and independence | Phase 1 – retain the 70 ICT beds in the 9 homes identified<br>**NB – dependent on the roll out of HomeFirst it may be possible to reduce the number of ICT beds, this would need to link with capacity reductions elsewhere across the system.** |

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| **Adequate and timely information must be shared between services whenever there is a transfer of care between individuals or services.**<br>(*New approach*) | To be inserted into all contracts.<br><br>Single View of the Customer is being developed so that organisations in Wiltshire have access to appropriate information.<br><br>Access to TPP community module to be established in demonstrator sites. Need to determine how TPP will be utilised once fully rolled out across Wiltshire? |
| **When preparing for discharge, older people and carers should be referred to Social Work Team and/or the Home from Hospital service and offered details of local voluntary sector organisations, other sources of information, practical and emotional support including information on accessing financial support and re-ablement services.**<br>(*Continued approach*) | To be inserted into all contracts. |
| **Good rehabilitation and re-ablement after acute illness or injury:** | |
| **Shared assessment frameworks across health and social care should lead to a Personalised care plan for each individual, where the individual and their careers are key participants in any decision made.**<br>(*New approach*) | This is currently being progressed through the Integrated Demonstrator Sites and Wiltshire Home First – approach to Single Assessment needs to be standardised across Wiltshire.<br><br>Single View of the Customer will be the opportunity to share information systems to support a shared assessment. |

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| **Contracting and commissioning of services is done not on the basis of time periods and tasks, but on the outcomes desired for the person.** (*TBC*) | CCG community services procurement will be outcomes based.<br><br>Wiltshire Council Help to Live at Home contracts are outcomes based.<br><br>Care home commissioning will be outcome focused.<br><br>Need to agree how these contracts will be assessed and evaluated to get best value. |
| **Prevention –other areas of focus** | |
| **Alternatives should all be fully considered.**<br><br>**Telecare/Assisted Technology options considered and optimised before move to care home.**<br>(*New and continued*) | Telecare commissioned by Wiltshire Council and provided by Medvivo. Opportunities to be explored further. There is a more potential in this area that needs to be explored. |
| **Ensure a preventative based approach is taken at all stages of an older person's pathway.**<br>(*New approach*) | Implement key recommendations from the Older Persons Review.<br><br>Public Health team linkage with primary care. Implementation of a fracture liaison service at identified acute hospitals, service currently being commissioned at SFT and following proof of concept could be widened to other areas. Signposting, navigation and roll out of the of the Information Portal in partnership with voluntary sector and Healthwatch. |

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| **Adequate clinical training for care home staff; both registered and non-registered workers learning together on-site as part of an overall quality improvement programme.**<br>(*Continued approach*) | Being delivered through the Workforce strategy of the Better Care Plan. |
| **Low level prevention services including falls, continence, loneliness etc.**<br>(*Continued approach*) | By commissioning services including those provided by NHS and voluntary sector that deliver clearly defined preventive provisions, including self-management.<br><br>Falls continues to be a big reason for admission- so tackle this in a more proactive way in the community. |
| **Frail older people have access to services to prevent falls.**<br>(*Continued approach*) | Falls strategy and action plan has been developed – to be implemented.<br><br>Bones Health Group has been re-established. |
| **Choice, control and support towards the end of life:** | |
| **Structured approaches across the system in areas such as the Gold Standards Framework, with advance care plans, advance decisions and adequate choice, control and support towards the end of life.**<br>(*Continued approach*) | Use Group SLAs? |
| **Tools are used systematically to identify frail older people at the end of their life.**<br>(*Continued approach*) | Enhanced service in place. |

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| **Advance care planning is not seen as a one-off event; communication with patients and families is a continuous process and should be made available to patients with and without mental capacity, fully involving Carers/relatives in best interest decisions.**<br>(*Continued approach*) | Establishment of Treatment Escalation Plans and need to ensure implementation across the system. |
| **Equitable access to specialist palliative care services for frail older people.**<br>(Continued approach) | Need to recognise that 30 % of all hospital non elective admissions are for patients with a life limiting diagnosis.<br><br>Need to;<br>• Improve identification of patients who have <12 months to live.<br>• Progress implementation of treatment escalation plans across system.<br>• Reshape role of the community end of life team (GWH Community services) ensure they take a more proactive case management approach to patients on an end of life pathway.<br>• Continue commissioning of the 72 hour EOL pathway.<br>• Review and agree future role of hospices in the EOL agenda. |