NHS
Wiltshire
Clinical Commissioning Group

Wiltshire CCG

Operational Plan: 2017 - 2019

FINAL VERSION – 23 December 2016

Contents

Executive Summary

The objective of this plan

This Operational Plan for 2017 to 2019 sets out how Wiltshire CCG with our partners in Wiltshire Council and the wider care system across BaNES and Swindon, progress on our journey to transform care for people in Wiltshire and beyond. This was originally set out in our strategy of February 2014 and now augmented by our participation in the BSW STP.

Our strategic objectives

In that strategy, our vision was that Health and Social Care services in Wiltshire should support and sustain independent healthy living.

Wiltshire CCGs three key strategic objectives

- Increased investment and support into developing and maintaining personal responsibility - focus on education, prevention and support to develop and maintain healthy and independent living
- Enhanced and integrated community care with a broader range of services provided in a local setting
- Improved productivity and effectiveness of care with a reduced reliance on bed-based solutions

Working with our partners in the STP

In early 2016, we joined with our care partners across the health and social care system in BaNES and Swindon on this journey.

We are now all working together through the Sustainability and Transformation Plan (STP) process to implement transformational change across the health and care system that will achieve our joint strategic priorities, which are aligned with Wiltshire's local priorities.

BSW joint strategic priorities

- Create locally integrated teams supporting primary care
- Shift the focus of care from treatment to prevention and proactive care
- Redefine the ways we work together to deliver better patient care
- Establish a flexible and collaborative approach to workforce
- Design our strategy to further enable collaboration and sustainability

Meeting the nine "must do's" – in Wiltshire and the wider care system

At the heart of this Operational Plan is our response to NHS England's requirement for us to meet the nine "must do's" set out in the planning guidance.

The summary below shows how we successfully address the nine "must do's" from the Wiltshire CCG perspective by delivering CCG level objectives and targets through our CCG level plans, as well as highlighting areas where our plans support the STP to deliver our wider system level priorities.

How our plan successfully addresses the nine "Must Do's"

Must Do	How addressed in our Operational Plan
1 STPs	▪ Our strategic objectives are closely aligned with the STPs strategic priorities, so the direction of travel for developing and transforming services is the same between the CCG and STP ▪ We have been working at the heart of the BSW STP since its inception and in some areas, for example in Planned Care, leading the development of initiatives across the STP ▪ Our approach is to be an active partner in the BSW STP, whether we lead or contribute to the change that the BSW STP will deliver by 2021
2 Finance	▪ We will meet the business rules for CCGs in 2017/18 and 2018/19, achieving £14.5m of QIPP which will support the BSW system to achieve the control total for the STP ▪ We plan to achieve constitutional standards, working proactively with providers to identify likely pressure points and put in place plans to address issues identified ▪ We have also formulated plans to reduce demand in both elective and non elective care at CCG level which support STP plans to manage demand at a system level
3 Primary Care	▪ We recognise the central role that Primary Care plays in access to and the delivery of high quality care. Our Primary Care Offer (PCO) is designed to move away from providing care through a transactional activity driven model based on individual practices towards place based commissioning and development of locality working to deliver Primary Care at scale. ▪ The PCO therefore directly supports the development of new integrated care models centred on accountable care, through alignment and integration of Primary Care with expanded Out of Hospital care. ▪ We are also developing a detailed plan for the implementation of the GP Forward View, which will include a range of investment such as from the Estates and Technology Transformation Fund ▪ Our local investment for enhanced services and Transforming Care for Older People (TCOP) is £9.44m in 2016/17. Alongside this we have set up a series of workforce projects to address workforce and workload issues in Primary Care. ▪ We are also improving access to Primary Care by linking together with broader initiatives designed to improve patient flow through the care system, for example through single point of access.
4 Urgent & Emergency Care	▪ Our providers are currently not planning to achieve the A&E standard. We will continue to challenge and support them to develop and put in place remedial action to improve performance. ▪ Wiltshire CCG are working in partnership with the wider system that has adopted a highly structured programme approach to bring together plans for Urgent and Emergency care that include the four hour standard, the four elements of the A&E improvement plan, the four priority standards for seven day hospital services for urgent network specialist services. ▪ Our focus in Urgent and Emergency care covers both physical and mental health. We already co-commission mental health liaison services across the STP with our three principal providers and have received pump priming funds to expand the opening hours for mental health liaison services and to progress towards the 24 hour core standards. ▪ Our procurement of an Integrated Urgent Care service for Wiltshire will deliver a more functionally integrated service, which will bring further improvements in care from April 2018, when the new service is planned to go live ▪ We continue to build on our well established partnership with Wiltshire Council through the Better Care Plan, which already delivers a range of successful outcomes including reducing avoidable admissions, reducing longer term placements in nursing and residential homes and a high level of patient and carer satisfaction.

Must Do	How addressed in our Operational Plan
5 Referral to Treatment Times and Elective Care	▪ We are committed to meeting constitutional standards for Referral to Treatment times and proactively monitor provider performance to identify areas where their performance is deteriorating and standards may not be met. We then work with providers to develop remedial action plans and hold them to account for the timely and complete delivery of those plans. ▪ Wiltshire CCG is leading system wide redesign of planned care for the BSW STP, concentrating on selected specialties where there is scope to streamline care pathways. We are also rolling out Patient Initiated Follow Ups to avoid unnecessary follow ups.
6 Cancer	▪ Wiltshire 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, which includes: ▫ Implementing the national taskforce report ▫ Promoting early diagnosis to improve survival rates ▫ Implementing follow up pathways for breast cancer patients ▪ These developments are being implemented 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, not just for Wiltshire's patients ▪ We will also work with providers to successfully meet the NHS constitution 62 day cancer standard
7 Mental Health	▪ Mental Health service development is a key priority areas for Wiltshire CCG. We plan to deliver in full the 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. ▪ We expect to achieve the 50% IAPT recovery target in 2017/18 and 2018/19 ▪ We will increase baseline mental health spend to facilitate delivery of the Mental Health Investment Standard. ▪ Our Local Transformation Plan for Children and Young People's Mental Health and Wellbeing has put in place a range of investments in community services that will reduce demand for costly hospital admissions for self harm and mental health conditions for 11 to 18 year olds, with a planned reduction of 3.5% in 2017/18 increasing to 6.5% by 2020/21. ▪ We are working closely with our partners in the STP so that our developments are tied into the workstreams and project plan being developed through the STP. This will ensure that mental health services operate at scale across the STP to deliver system wide pathways of care. ▪ From December 2016, Operational leads from each CCG, Public Health and Local Authorities will be working together to operationalise the plans agreed by all parties in the STP.
8 People with Learning Disabilities	▪ We continue to work through our partners in health and Local Government in both Swindon and Wiltshire to develop and improve services for people with Learning Disabilities. ▪ The key themes of this cross sector working include: ▫ Enhancing community provision by building on our track record of community solutions, which includes the rollout of Care Programme Approach by June 2017 and the implementation of the Blue Light Protocol by April 2018 ▫ Reducing the number of people in long term inpatient placements from 10 to 4 before the target date of March 2019 ▫ Continuing to improve access, so by 2020, 75% of people with LD and/or Autism on a GP register are receiving an annual health check

Must Do	How addressed in our Operational Plan
9 Improving quality in organisations	▪ Improving quality remains a fundamental priority for Wiltshire CCG and is an integral element of the services we commission. Our Quality Schedules for 2017/18 and 2018/19 set out our expectations for quality improvements including: ▫ Improvements in early warning by providers ▫ Practical learning from incidents in both inpatient and community settings ▫ Improvements in stroke performance so the service is at least a "B" level ▪ We work with providers to improve quality through a consistent focus on continuous improvement and learning, to embed change and improve patient outcomes, holding them to account for the implementation of these plans ▪ Wiltshire CCG actively promotes and monitor providers' improvement in the efficient use of staffing resources to ensure safe sustainable and productive services ▪ We also continue to actively participate in system wide groups including the Wiltshire Workforce Action Group, the Community Education Provider Network and the Academic Health Science Network to promote system wide learning, action and quality improvement

Section 1 - STPs

Summary

1. This section of the Operational Plan sets out our approach to working with the STP, which is designed to ensure our Operational Plan is integrated with and delivers the STP within BSW. Wiltshire CCGs strategic objectives are closely aligned with the STPs strategic priorities, so the direction of travel for developing and transforming services is very similar between the CCG and STP

2. We also discuss how we will achieve the STP requirements set out in NHS planning guidance in these areas:

    - Implementing agreed STP milestones
    - Achieving agreed trajectories against the STP core metrics

Our approach to working with the STP

3. We have been working at the heart of the BSW STP since its inception and in some areas, for example in Planned Care, leading the development of initiatives across the STP. Our approach is to be an active partner in the BSW STP, whether we lead or contribute to the change that the BSW STP will deliver by 2021.

How our governance supports system level working (C6)

Key Line of Enquiry C6

How do governance processes ensure clarity as to how the CCG contributes to an agreed system way of working, how progress will be tracked, and how they will work with other organisations to manage transformational activity?

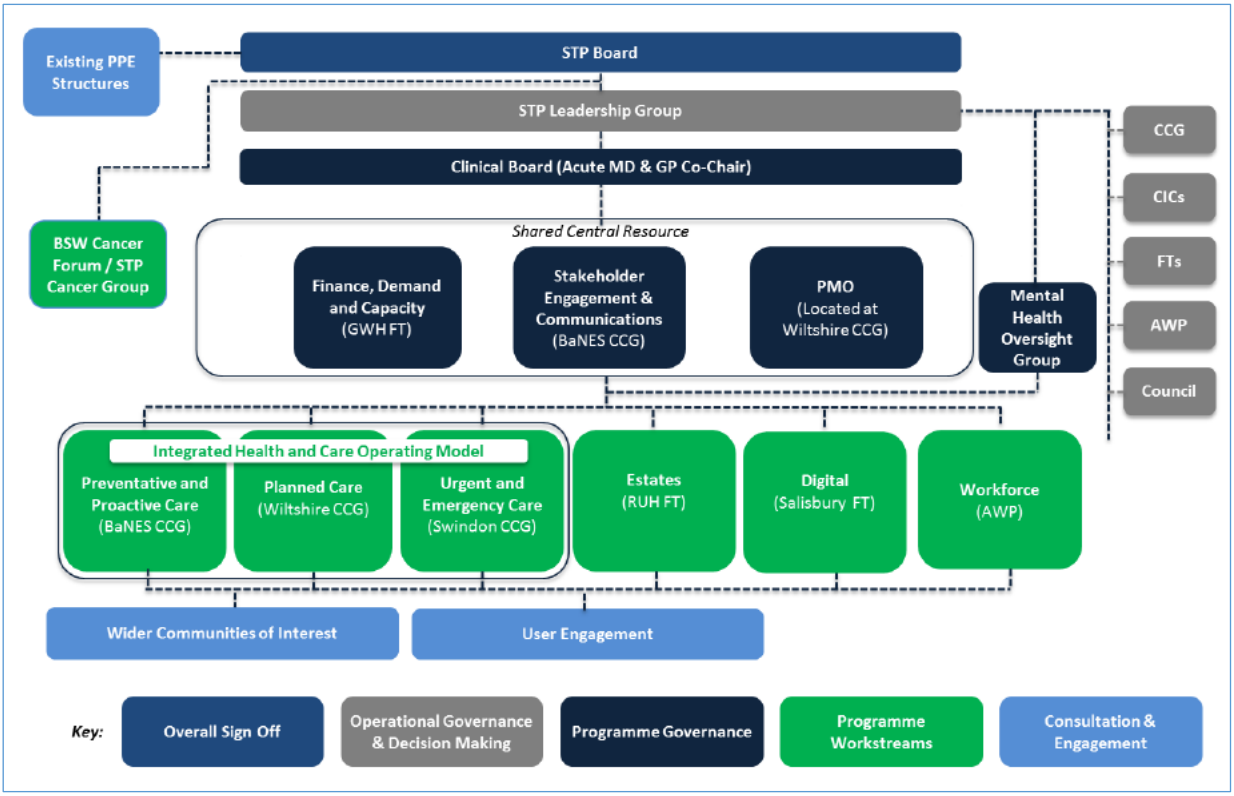
4. The BSW STP has an established governance framework so all stakeholders are represented and can participate through a series of working groups. The diagram below shows:

    - The STP Board supported by a Leadership Group and a Clinical Board to provide both clinical and organisational leadership to the STP
    - Six workstreams that are delivering the detailed projects that underpin transformational change across the STP
    - A shared central resource to provide the support needed for each workstream and project

5. Organisations across BSW work through this governance framework, with the workstreams and project groups providing a team based focus to manage and deliver the various elements of transformational change within the STP in an open and collaborative way. Naturally, via internal governance, our Governing Body are regularly engaged, briefed and invited to endorse the direction of travel (See KLOE C7 and for more details of clinical engagement within Wiltshire CCG).

6. This governance structure therefore provides clarity around the part each organisation plays in the STP and is developing an effective system way of working, so all partners work together in an agreed way to achieve the objectives set out in the BSW STP. We are an active partner in this collective way of working, which helps us achieve our objectives that are aligned with the developing STP.

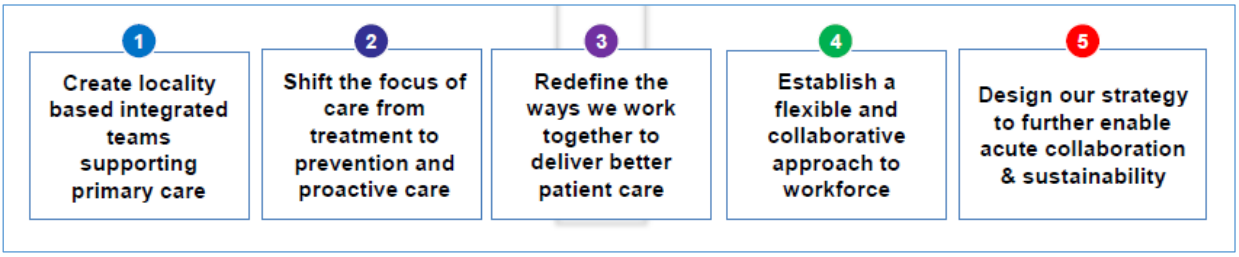
BSW STP governance framework



The STPs strategic priorities and how they link to Wiltshire CCGs strategic direction

7. The governance framework shown above provides the structure for Wiltshire CCG and the other stakeholders in the BSW system to work together. BSW have also agreed that what the STP will do will be structured around achieving five strategic priorities.

Five strategic priorities identified in June's STP



8. These priorities are reflected in the seven initiatives that will be pursued by the STP and its partners in 2017/18 and 2018/19.

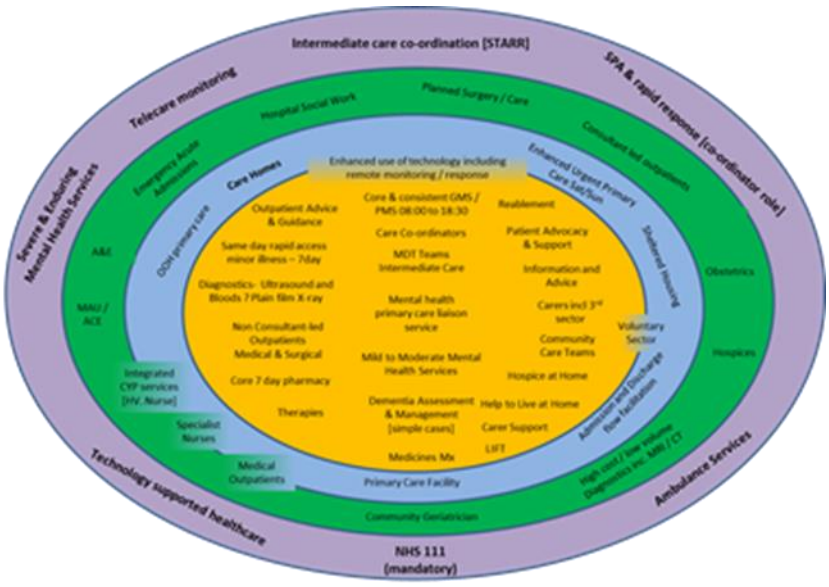
Seven STP initiatives for 2017 – 2019

1. Confirm the new models of care that support the sustainability of primary care.
2. Redesign the initial access points for urgent care – tailoring to each CCG / Council locality to ensure best fit with the population based care models.
3. Standardise elective care pathways to reduce variation in quality for patients.
4. Develop the organisational capacity to deliver systems change – particularly for engagement and capacity planning.
5. Agree and implement solutions to the workforce capacity constraints, particularly in social care support provision and within identified acute specialties.
6. Improve the inter-operability between clinical IT systems so clinicians from different organisations can access and share patient information.
7. Develop a single Estates strategy for the footprint.

9. The STPs strategic priorities which were agreed earlier this year are also strongly aligned to the three strategic objectives set out in Wiltshire CCGs Strategy developed in 2014:

- Increased investment and support into developing and maintaining personal responsibility - focus on education, prevention and support to develop and maintain healthy and independent living
- Enhanced and integrated community care with a broader range of services provided in a local setting
- Improved productivity and effectiveness of care with a reduced reliance on bed-based solutions

Wiltshire CCGs strategic approach – delivering a range of care services, tailored to people's individual needs



10. This means that the objectives we are pursuing as a CCG are aligned with those agreed by the BSW STP, so as we deliver our CCG objectives, we also deliver the STP objectives.

STP and CCG strategic alignment with the HWB

11. The STPs approach to health and social care integration, is to continue with the agreed direction of travel of working through the mechanisms of the Better Care Plan. This is already in place across the STP, with a joint plan and pooled budget in place between CCGs and the Council. These arrangements drive the strategy of integrating services at the point of need.

12. Whilst we currently have three statutory plans in this regard, there is much commonality in terms of approach and potential for complete health and social care integration across the STP.

13. The three CCGs within BSW are all pursuing integration although aspects of that integration are at different levels of development. Wiltshire has a well established Better Care Plan, nationally acclaimed and led by a jointly appointed Director of Integration, which already delivers good outcomes.

14. The STP, HWB and CCG plans themselves are aligned because they all reflect six common approaches:

- Integrating services at the point of need
- Progressing the home first discharge model and improving system flow
- Implementing admission avoidance and case management
- Maximising Independence of the service user and reducing demand on statutory services
- Integrating Information
- Enhancing the impact of public health and prevention

How we are jointly developing our plans

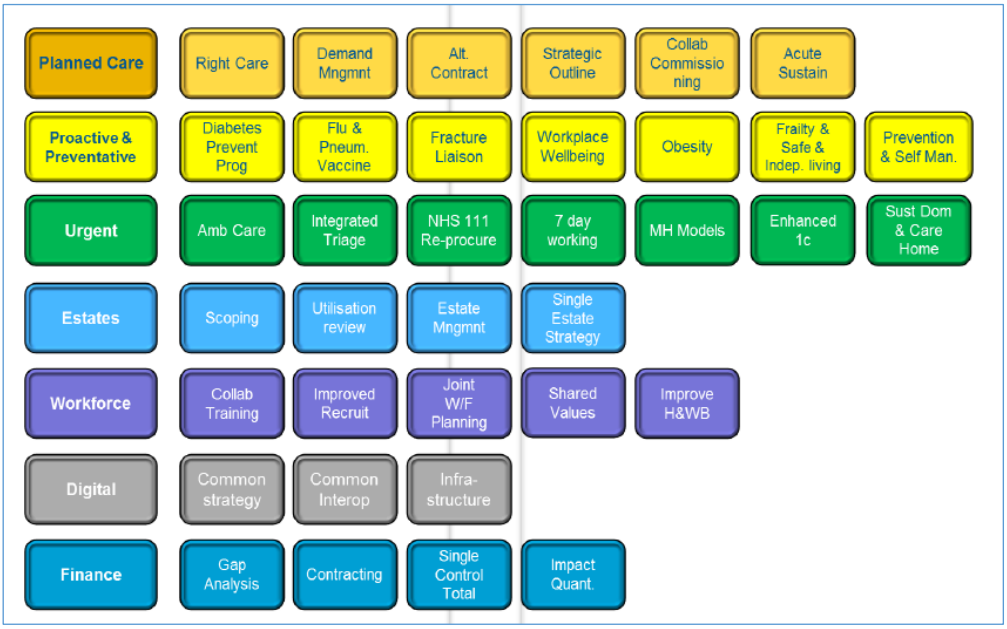
Developing our plans on an open book basis (C1)

Key Line of Enquiry C1

What is the evidence of the plan being based on a shared, open-book process to deliver performance and improvement?

15. The Programme and project structure shown below sets out the seven functional programmes and the projects that support each theme. Each of the partners within the BSW STP is participating in transformational work to deliver performance improvement through this structure, and all work is undertaken collaboratively on an open book basis to design and deliver the change projects.

BSW STPs Programme and project structure



16. The Finance, Demand and Capacity Group, which includes representatives from all STP organisations, provides a mechanism for making sure that:

- The impact of the Programmes and Projects are identified
- The quantification is robust and includes activity as well as finance
- The impacts by Programme/Project/Organisation are brought together so there is a consistent system wide appreciation of the impact of transformation

Governance arrangements to support effective delivery

17. Governance arrangements are also being strengthened as the STP moves into delivery mode. Arrangements are in place to manage the delivery of a broad range of projects across stakeholder organisations. Business cases and requests for investment will need to be approved by:

- The STP Leadership Group
- The STP Clinical Board (if clinical)
- Individual Organisation Boards

18. Once all approvals are in place, they will be reported to the STP Board for information. This is part of a planning and monitoring mechanism that has been put in place to facilitate and support effective delivery at all stages of the project lifecycle, which includes

- A business case sign off process, so all projects are supported by a robust business case that identifies amongst others, clear objectives and benefits, which must support the direction of travel for the STP. This means that at initiation and approval, projects are robust and are aligned with the STPs strategic objectives
- A planning group that meets monthly where project managers report in detail on progress. This mechanism helps to ensure that there is effective detailed management of projects and that potential synergies across projects are identified and exploited, whilst potential clashes are avoided
- A leadership group, comprising SROs that meets fortnightly to provide oversight across projects and programmes, to ensure projects and programmes are on track. The group also provides a higher level forum for effectively resolving system "blockages" that are slowing down progress

19. The approach is therefore completely open book, with analysis and quantification for each project shared across organisations, for example through the Planned Care Programme Board and included within the financial model that gives a whole system perspective for the BSW STP.

Making sure the Operational Plan and STP align (C2)

Key Line of Enquiry C2

How does the operational plan align with STP objectives and planning assumptions? Do they share the same 'direction of travel'? What is the CCGs contribution to achieving the STPs overall reduction in activity?

20. Wiltshire CCGs Operational Plan aligns with the BSW STP because:

- The STP and Wiltshire CCG share the same direction of travel as our strategic objectives summarised in the diagram shown above for KLOE C6, are aligned with the five key priorities defined by the STP
- We have used the same planning assumptions as the STP, which is confirmed in the sections on finance and activity, KLOE A1 below.

- The transformational initiatives developed at STP and Wiltshire CCG level are rooted in the same approach of using an evidence base (notably Right Care and best practice across England) to identify the scope for increased efficiency and reduction in activity growth

21. The contribution to the overall STPs activity reduction for planned and unplanned care is set out in detail in Appendices A and B, demonstrating how Wiltshire CCGs plans contribute to the overall reduction in activity in BSW STP.

The nature of our transformation and efficiency plans (C5) and enablers

Key Line of Enquiry C5

How do transformation and efficiency plans in the operational plan, including activity growth moderation plans, relate to the STP? Does the contribution of each organisation deliver the STP?

22. Transformation and efficiency measures in the Operational Plan relate directly to the STP. The table below shows key highlights of the STP and our CCG plans, which are focused on reducing activity across both planned and unplanned care through specific plans as well as our broader programme of transformational work within the CCG, that draws on RightCare and a range of best practice. This comparison shows:

- **In Planned Care**, plans are completely aligned, with our actions in Wiltshire a direct subset of STP plans of which demand management is a primary focus
- **In Unplanned Care**, we are already making good progress in several areas identified by the STP. Wiltshire CCG are ahead of other partners in the system, with a very successful Better Care Fund. Further, our Transforming Care for Older People Programme and Primary Care Offer provides support for older people in the community to reduce unnecessary non-elective admissions and extension of ambulatory care. We are also pursuing initiatives that align with the STP such as improved ED triage and further extension of ambulatory care pathways. The focus for 2017/18 will continue to be on curtailing growth, where we have achieved success over the past two years.

23. The activity and financial impact of transformation and efficiency plans has been quantified and discussed with providers during the contracting round. These plans have not yet been completely finalised, so there are likely to be some changes in the coming weeks.

24. For Wiltshire CCGs three principal providers, QIPP/Transformation risk will rest with the CCG, although we have agreed contract mechanisms with providers so successful implementation of transformational plans will be reflected in lower contract payments at the end of the financial year. This approach will also help providers manage their cash flow through the financial year.

25. Once all plans have been finalised, they will be aggregated by the STP to understand the extent to which the sum of partners' plans achieves the STP planned outcomes.

How key transformation and efficiency plans are linked

Area	STP highlights	WCCG highlights
Planned Care **(WCCG Impact £3m)**	▪ Standardised clinical policies to reduce referrals and procedures ▪ Demand management to reduce referrals for planned care ▪ MSK – reduction in first outpatients and surgical interventions ▪ Cardiology – reduction in first and follow up outpatient attendances ▪ Rheumatology – reduction in first outpatients	We have developed action plans at a CCG level for: ▪ Clinical policies ▪ Demand management ▪ A mix of advice and guidance, referral reduction, alternative community provision and self care in MSK, Cardiology, Ophthalmology, Pain, Gastroenterology and Rheumatology ▪ Using Patient Initiated Follow ups in most specialties as a default

Area	STP highlights	WCCG highlights
Unplanned Care **(WCCG Impact £3m)**	▪ Integrated Emergency and Urgent Care/Triage ▪ Extension of ambulatory care ▪ Seven Day Working – delivery of clinical standards ▪ Development of models of care – MH Liaison and Crisis Services ▪ Care home and domiciliary care provision ▪ Enhanced primary care model	We are already making progress on: ▪ TCOP and PCO (augmented by the Care Home LES) focusing on older people to increase admissions avoidance ▪ Extension of ambulatory care ▪ Seven Day Working ▪ MH Liaison and Crisis Services The focus of CCG plans will be on: ▪ Continuing with TCOP initiatives ▪ Extending BCF initiatives ▪ Focusing on Community based initiatives such as high intensity care at home and older people's assessment hubs

Workforce and estates as enablers for transformational plans and their links to clinical models

26. Workforce and estates are key enablers for transformation and efficiency plans. The approach to the development of transformation plans includes:

- Periodic workshops with representatives for all workstreams across the system to update on progress and development, including clinical models
- Clinicians embedded into project teams to provide clinical and service expertise on development of plans to deliver clinical models
- A Clinical Reference Group to provide clinical oversight of the whole service transformation programme

27. This will be part of an ongoing cycle of development, with actions at each stage followed by a process of bringing the system together to understand the workforce and estates implications of plans and to develop these enablers. Although this process is still at a relatively early stage, the main steps are:

- As clinical models develop for individual projects, the service changes are understood, which highlights the estates and workforce changes required to implement the transformation proposals
- The estates and workforce groups are being developed to offer advice and support to each clinical/service group to understand the implications of the transformational change and develop plans to address the workforce and estates impact of plans
- These individual elements will then be brought together into overall STP level workforce and estates plans, that will be managed at scale

How the STP interoperability solution interacts with these plans and how the risks are managed

28. These plans will be supported by the STPs interoperability solution, which means that different information technology systems and software applications deployed by STP partners will be able to communicate, exchange data, and then use the information that has been exchanged. In practical terms:

- The system wide digital solutions that support transformation are set out in the Digital High Level Programme Plan
- The Universal Capabilities are a subset of the STP Plan, which are embedded in Wiltshire's Local Digital Roadmap (LDR)

- The LDR directly supports the QIPP/Transformation plans within this Operational Plan – this is shown in more detail in section 10 of this plan under KLOE K2 (table - ***How UCs support this Operational plan***)

29. The Wiltshire Interoperability Programme will deliver:

- Jan 2016 to Mar 2018 –Basic information exchange across stakeholder systems
- Apr 2016 to Mar 2019 – Enablement of shared care planning
- Apr 2017 to Mar 2020 – Development of interactive patient access to shared care records

30. Projects underway include:

- Implementation of TPP Viewer for social care supports the extension of ambulatory care
- Implementation of the TPP Care Home module supports care home and domiciliary care provision
- Network infrastructure enhancements, for which funding has been approved, will support seven day working and enhanced primary care models

31. Planning for Phase 2 and 3 of the Wiltshire Interoperability Programme includes submitted applications for funding for:

- Single Sign On solutions in GP practices
- Implementation of TPP Hubs to support federated working
- Patient Wi-Fi services
- Integration software solution(s) to mitigate the risk of a heavy reliance on a single system supplier.

32. These proposals support the five strategic priorities included in the BSW STP June submission. If these bids are not successful, the STP may apply for other funding offered by NHS England in 2017, for example, the Digital Maturity Fund, GP Forward View Fund, and the Urgent and Emergency Care Fund.

33. Membership of the Wiltshire Interoperability Programme Board includes key providers serving the BSW STP footprint, and the SRO is also a member of the BSW STP Digital work stream. The Board has proposed that it could reasonably become the BSW STP Interoperability Delivery Board, building on well established collaboration between partners, some additional membership, and revised terms of reference. This proposal is currently under consideration by the BSW STP Digital work stream.

34. This demonstrates that Wiltshire developments are meshed into the STPs Digital High Level Programme Plan (October 2016 STP, page 18) and will facilitate implementation of the system wide transformation plans described above, through digital solutions.

35. We have identified a number of risks relating to Wiltshire's digital plans, however, we have also identified appropriate mitigations to address these risks:

Risks and mitigations for Wiltshire's digital developments

Potential risk	Proposed mitigation
Failure to attract funding	A number of bids have recently been submitted to attract ETTF funding from NHS England e.g. £120K has been bid for purchase of an integration engine, but if this bid is not successful other funding sources are being offered by NHS England in 2017, such as the GP Forward View Fund, the Digital Maturity Fund and the Urgent and Emergency Care Fund
Heavy reliance on a single system supplier (TPP)	Pursuing interoperability solutions delivered by other suppliers e.g. other suppliers' integration engine solutions; national solutions such as Summary Care Record and GP Connect; pursuing opportunities for leveraging TPP and other system suppliers in the locality to enable sharing between systems

Potential risk	Proposed mitigation
Insufficient collaboration between multiple STP partners	Manage through Interoperability Board and development of champions across organisations supported by STP leadership
Insufficient staff resources to support successful delivery of projects	Maintain close links between WCCG IM&T leads and STP work streams to identify opportunities for using shared resources and rationalising delivery across the BSW footprint; funding bids to include cost of staff resources where permissible
Compatibility of information sharing protocols across the three CCGs	Project resource has been allocated to develop an approach to information sharing which is fit for Wiltshire and may be offered for adoption by key stakeholders in BaNES and Swindon
Resistance by patients and clinicians to wider sharing of patient information which would support improved care	Heavy emphasis placed on stakeholder engagement within the information sharing protocols work stream

Other transformational programmes

36. As well as the initiatives in planned and unplanned care we have other transformational change programmes in train. These also align to the STP through the aim of delivering more services in the community; at or close to home, relying less on services being delivered in a hospital setting.

37. We have already made major strides in setting the conditions for success in this area, most notably with the effective procurement and award of new long term contracts for both Adults' and Children's Community Health Services. These are both fundamental to the successful implementation of our strategic vision, and working with the new providers in the future offers us a genuine opportunity to deliver our aspirations.

38. Our Adult Community Services are now delivered by Wiltshire Health and Care, a new Limited Liability Partnership formed by a strategic alliance between our three major Acute care providers, who plan to recruit three local GPs to the Board. This is extremely helpful in terms of sharing strategic aspirations and the long-term sustainability of health planning. One of the key elements which we seek from Wiltshire Health and Care is for them to act as an integrator of services across our system.

39. There are several examples of other local transformational initiatives which are already delivering well in very local settings.

Examples of other local transformational initiatives

- We have established 20 Multidisciplinary teams across the county. These fully integrated patient centred local multi-disciplinary teams (comprising community nursing staff, therapists, mental health workers and often social workers) based in our communities are a fundamental building block of our strategy. They build on the existing strength of primary care across the county, with the teams designed to wrap around primary care practices, being led and co-ordinated by our GPs. We have also worked up and agreed a high level concept paper of how these teams should operate and guide their outputs to provide a level of consistency of offer.
- We have also successfully recruited and established Care Co-ordinators county wide, delivering one of the CCG's very early aspirations. The coordinators, based in GP practices, help to reduce unnecessary admissions into hospital or care home. They act as a point of contact to bring together the medical and social care services that may be available to someone who needs just that little extra support to stay at home.
- We are seeing good progress arising from our initiatives to implement integrated discharge across the system, and have recently agreed significant additional investment in a Rehabilitation Support Worker embedded in the community teams to support early discharge and augment the service delivery to patients in their first 7-10 days post discharge; this will also help improve their ability to sustain independent living shortly after discharge. This should impact favourably on the DTOC target in the early part of 2017/18.
- Wiltshire Health and Care have migrated their IT support solution by rolling out the community module of TPP system One, which greatly helps with interoperability with primary care, and they are investing in mobile technology and scheduling to help improve the productivity and effectiveness of their services.

40. To implement our vision of delivering better integrated out of hospital services, we have also formulated a ground breaking Primary Care Offer. This three year programme which began in 2016/17 is designed to transform the commissioning, delivery and monitoring of enhanced services from our GP practices; it supports the development of locality working, and should support the sustainability of primary care at the same time as enhancing the quality of the services delivered from primary care.

41. Active discussions are underway regarding the opportunities for federation of primary care, and we are also exploring the opportunities for primary care to operate and work at scale across the county. We are working closely with our LMC to formulate achievable milestones on the path to implementing the GP Forward View.

42. We have utilised the funding provided under the Transforming Care of Older People (TCOP) programme to encourage local innovation to improve support to the frail and elderly cohort of our population, and have a scheme live under this programme in every part of the county. Using this, we are encouraging empowerment of non GP clinicians to free up GP capacity, extended hours and provision of locally tailored support targeted to meet the specific needs of our largely rural communities, and are delivering localised plans, tailored to the specific needs of communities to achieve this. We also have an aspiration to enhance primary care provision to include greater access to urgent care services without recourse to Accident & Emergency units by enhancing care at the interface with our high intensity care programme being launched in the community.

43. We have also worked with our Council colleagues to reinvigorate the commissioner relationship with the voluntary sector in the county, and aspire to ensure that this important and valuable resource is integrated into our care model. Included in this is a project to further develop and integrate a referral management service for voluntary sector services

Improving operational productivity (C7)

Key Line of Enquiry C7

Is there evidence that improvements in operational productivity are being accelerated at an individual organisational level to reduce unwarranted variation in quality and costs?

Using RightCare to address unwarranted variation

44. We are committed to commissioning and delivery of high quality care. As we commission service from three principal providers, we have an ongoing focus to ensure that we address unwarranted variation in both quality and costs.

45. We have used Right Care information for several years to help us identify aspects of care where there is unwarranted variation and used this to focus on aspects of care where there is scope for improvement. In last year's operational plan (see paragraph 80 and Appendix B of 2016/17 plan) we highlighted the use of Right Care and in our current plans Right Care has also helped us identify areas of focus. We will actively participate in Wave 2 of RightCare, which starts in November 2016, to continue so we can, where possible, both extend and accelerate our use of Right Care.

46. Our plans for 2017/18 and 2018/19 that are built on the opportunities identified through Right Care, drawing on examples of best practice across England include:

- Specialty specific projects in planned care such as MSK and Cardiology
- Cross specialty initiatives such as Patient Initiated Follow Ups and referral reduction measures
- Avoidable admissions in Unplanned Care

47. We have also followed up the Right Care analysis for each provider so that the action plans we generated are focused on the particular circumstances facing each provider and actions tailored to maximise improvement at provider level, rather than a generic target across providers.

How RightCare links to the STP

48. Our work to improve operational productivity is also linked to the STPs work on acute sustainability that is part of the suite of projects under the planned care workstream. The STP will provide additional impetus for cross provider work to address unwarranted variation in quality and costs through systems based solutions.

49. The Planned Care clinically led specialty focused workstreams, set out in Appendix A1, are identifying unwarranted variation to improve access and quality for our patients.

Clinical Engagement

50. Wiltshire clinicians are deeply involved in the development and implementation of QIPP/Transformation initiatives:

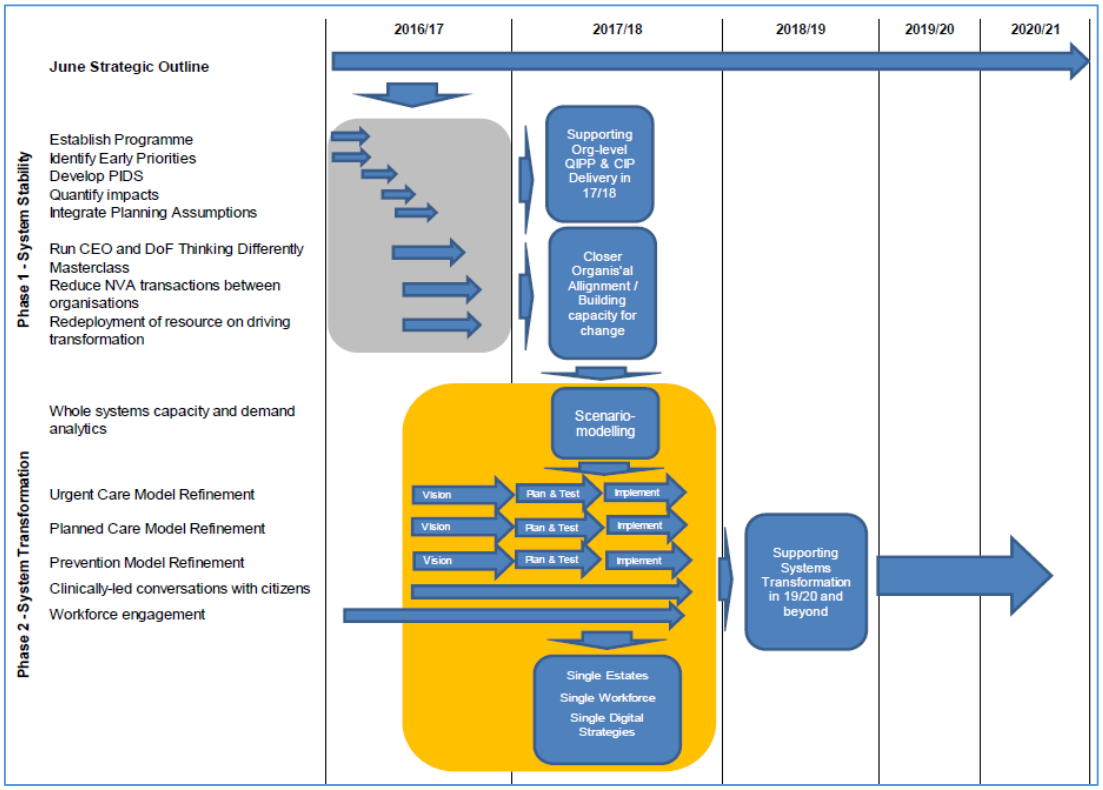
- Wiltshire CCGs Chair and the three locality chairs all sit of the STPs Clinical Reference Group
- The Governing Body is clinically led and each meeting includes an STP briefing so there is ownership and buy in to the Transformation plans being developed and executed
- The Governing body is also updated with the development and implementation of our Operational Plan. As QIPP/Transformation initiatives are operationalised, the GPS involved in the various initiatives also report back on progress to the Governing Body

Implementing agreed STP milestones (KLOE C3)

NHS England planning requirement 1.1
Implement agreed STP milestones, so that we are on track for full achievement by 2020/21
Key Line of Enquiry C3
Has the plan clearly articulated how the CCG will support delivery of their STP, including clear and credible milestones?

51. The STP has set out high level milestones for core work around transformation.

High level timeline for system transformation within the STP



52. We actively support these programme areas, which are broadly on track to meet the milestones set out above. The principal transformational areas from the STP are:

- **Planned care –** Wiltshire CCG are leading the STPs Planned Care workstream, working collaboratively with our partners - CCGs and providers. There are now project plans in place with quantified target benefits at CCG and STP level, so these areas should be on track
- **Unplanned care** – we are participating in this workstream and have also formulated our CCG level plans to support CCG QIPP delivery in 2017/18, so we should be on track to meet the STP milestones.
- **Preventative and proactive care** – we are participating in this workstream, building on our track record of collaborative working with Wiltshire Council's Public Health function and the BCP Prevention Programme Board

53. Work is also progressing on collaborative projects to ensure acute services are clinically sustainable through the Acute Sustainability Workstream, which also has links with the Planned Care Workstream, which is led by Wiltshire CCG. Two projects, Pain and Gastro, have already been transferred into the

Planned Care Workstream for implementation and there is an assessment planned to confirm whether the Care of the Elderly project should also now move into the Planned Care Workstream.

54. The Acute Sustainability Workstream is also examining referral patterns to assess the scope for creating sustainable services within the STP as an alternative to Out Of Area referrals. This will also cover the use of clinical support services such as diagnostics.

55. The STP is also examining flows across STPs for example though BNSSG, looking at flows into AWP.

Achieving agreed trajectories against the STP core metrics (KLOE C4)

NHS England planning requirement 1.2
Achieve agreed trajectories against the STP core metrics set for 2017-19
Key Line of Enquiry C4
Does the plan identify the CCGs contribution to achieving the agreed trajectories against the STP core metrics set for 2017-19?

56. The September 2016 planning guidance sets out the nine core baseline metrics that will, at a minimum, be the baseline STP metrics, however, no guidance has yet been issued that finalises the metrics.

57. It is also not clear what role BSW should take in performance managing the areas suggested in the draft metrics, because:

- There has not been system wide sign up to an STP level plan for each of the nine draft metrics
- It is not clear whether it is appropriate for the STP to manage and be accountable for performance for each of the nine metrics on a system wide basis

58. The table below sets out the current position on each of the draft indicators. This will evolve over the coming year as there is more certainty over the indicators themselves and the role of the STP is clarified. Once this has been done, partners will need to develop and agree appropriate monitoring/performance management mechanisms for each indicator.

Our current approach to the draft STP core metrics

STP area	Core Metric	Approach
Finance	*Performance against organisation-specific and system control totals*	▪ Wiltshire CCG is committed to meeting its financial control totals. The actions set out in Section 2 of this plan are designed to facilitate this ▪ There is currently no formal agreement on working to a single system control total. There are ongoing discussions between partners within BSW to explore the options and benefits around working to a single system control total and the mechanisms for managing this, but there is currently no agreed position on this within the system
Quality	*A&E performance*	▪ Each CCG is working with individual providers to agree trajectories for A&E performance – see Section 2 of this plan ▪ An STP aggregate trajectory has been developed and system 4 hour performance is reviewed at STP level however the focus remains on CCG-level 4 hour performance through the 4 Hour Delivery Board.
	RTT performance	▪ Each CCG is working with individual providers to agree trajectories for RTT performance – see Sections 2 and 5 of this plan ▪ CCG trajectories have been aggregated to STP level however in-year monitoring and performance management focus is likely to remain at CCG for 2017/18.

STP area	Core Metric	Approach
Health outcomes and care redesign	*Progress against cancer taskforce implementation plan*	▪ The metrics are likely to include % of cancers diagnosed at stage 1 or 2; 62 day waits; one year cancer survival rates; and overall patient experience ▪ The Cancer Taskforce implementation plan is managed through system wide groups including three Cancer Alliances; the STP Cancer Group and the Living With and Beyond Cancer Board – see Section 6 and Appendix E of this plan ▪ These groups are at a relatively early stage of development, still formulating their plans and have not yet begun the process of bidding for funds to support those plans ▪ Once the groups and plans have matured, there should be scope for the STP Cancer Group to work as a forum for reporting progress across BSW, but this has yet to be discussed and agreed by partners
	Progress against Mental Health Five Year Forward View implementation plan	▪ The metrics are likely to include IAPT recovery rate; EIP two week waits; and Out of Area Placements ▪ Section 7 and Appendix F of this plan set out how we are managing the Mental Health Five Year Forward View implementation plan ▪ We are also working closely with our partners in the STP so that our developments are tied into the workstreams and project plan being developed through the STP. This will ensure that mental health services operate at scale across the STP to deliver system wide pathways of care ▪ From December 2016, Operational leads from each CCG, Public Health and Local Authorities will be working together to operationalise the plans agreed by all parties in the STP ▪ At this stage, there is not enough detailed co-ordination to make it practical for the STP to report overall system level progress, but this is likely to be developed during 2017/18
	Progress against the General Practice Forward View	▪ The metrics are likely to include access to extended access appointments; time to 3rd next available appointment; and patient satisfaction with opening times ▪ Each of the CCG partners in BSW faces different challenges in Primary Care within their geographies. Whilst the partners have agreed common principles for developing Primary Care, the implementation plans will be different for each area. ▪ Wiltshire's plan for the GPFV is set out in Section 3 and Appendix D of this document. As the plans for the GPFV have only just been completed, there has been no work done to see if there is scope for the STP to report on progress at system level ▪ This will be discussed further and is likely to be simply some form of aggregation of the current position within each CCG across standard agreed metrics
	Hospital total bed days per 1,000 population	▪ This could be a useful metric to help understand differences in utilisation of both planned and unplanned care across the system and be used to support some of the transformation plans being developed for both planned and unplanned care ▪ Although this has not been agreed as a standard metric within BSW, we will explore how this could be used within our transformation programmes and how we could report this at a system level

STP area	Core Metric	Approach
	Emergency hospital admissions per 1,000 population	▪ This could be a useful metric to help understand differences in utilisation of emergency care across the system and be used to support some of the transformation plans being developed for urgent and emergency care ▪ Although this has not been agreed as a standard metric within BSW, we will explore how this could be used within our transformation programmes and how we could report this at a system level

Communication and engagement

59. Effective communication end engagement is a key enabler of the effective development and delivery of change that is included in both the STP and this operational plan. This section of the Operational Plan discusses:

- The STPs principles and engagement messages
- The two phases of communication and engagement.

Principles and messages

60. All communication and engagement through the BSW STP, as well as around the change programmes within this operational plan are underpinned by three messages:

61. The three messages set out and explain the context of the change that will happen in the system by 2020 to develop and deliver new models of care that are sustainable, affordable and improve people's health and wellbeing. The emphasis is on integration, prevention and personal responsibility as well as involvement and co-production – people and organisations working together to find the best solutions to the challenges the system faces.

62. The development and implementation of change will be in line with six principles agreed by the Five Year Forward View People and Communities Board. These common principles will be used across the system as well as within Wiltshire, for communication and engagement.

Common messages and principles we will use in communication and engagement

Three key messages	Six common principles
1) All health and care partners are working together across organisational boundaries to improve everyone's health and wellbeing, to improve service quality and to deliver financial stability 2) For services to be sustainable, we need to get better at preventing disease, not just treating it, and encourage everyone to take responsibility to manage their own care 3) Together we can identify the common challenges and opportunities for innovation across our footprint and adopt a joint approach to remove variation in care and treatment	1) Care and support is personalised, coordinated and empowering 2) Services are created in partnership with citizens and communities 3) Focus on equity and narrowing health inequalities 4) Carers are identified, supported and involved 5) Voluntary, community, social enterprise and house sectors are key partners 6) Volunteering and social action are recognised as key enablers

The first phase of communication and engagement – promoting the STP and the need for change

63. The first phase of communication and engagement is underway. It began in August 2016, designed to promote the messages of the emerging STP by setting out the context for change and promoting the need for change, highlighting that to do nothing is not a viable option and that the process of change needs to start now.

64. This phase of engagement has three main elements, encompassing a wide spectrum of stakeholders, including patients, the public, organisations and staff involved in care.

Promoting the STP as the vehicle for change across Wiltshire

Who we engaged with	What we did
Patients and the public	Between September and December 2016, we engaged with patients and the public through: • **Sessions with Healthwatch Wiltshire** who provided us with useful feedback on the emerging messages from the STP, which helped us shape our public facing engagement • **Engagement sessions with 55 Patient Participation Groups (PPG),** using joint briefing sessions with a number of groups at once to help us develop a common understanding of the key messages and to get useful feedback and reaction of participants. Our experience of working with PPGs has been positive because of their dual role of "critical friend" to GP practices and advocates for our strategy for change • **Public facing sessions** – across the Wiltshire geography, including Devizes, Melksham, Trowbridge and Warminster, reflecting the range of geographies and care needs across the CCG, to set out the challenges we are facing – especially those in primary care - and the concept of the STP as the vehicle to deliver system wide change
Voluntary and Private sector providers	In September 2016, we held a series of briefing sessions for both Voluntary and Private sector providers in Wiltshire, briefing them on the challenges as well as the opportunities that new models of care would open up
Staff across primary and acute care	In August 2016, Wiltshire CCGs Communication and Engagement staff participated in an STP wide series of briefings for people, involved in care delivery, which included: • CCG staff • GPs involved in the CCG • Clinical staff in acute settings • Primary Care staff These sessions will evolve into an ongoing programme of communication and engagement that will roll into the second phase of communication and engagement that is discussed below

65. To support this programme of work, we have held media briefings with Wiltshire press and radio, reiterating the context and setting out the common messages that are being promoted across the whole of the BSW STP. This ensures that whilst we acknowledge the specific care needs of people in Wiltshire, all our communication is consistent with and promotes the common and agreed STP messages and principles.

The second phase of communication and engagement – helping develop and deliver the change

66. The second phase of communication and engagement is designed to help develop and deliver the change planned through the STP, with a series of the service changes being led by Wiltshire CCG staff, for example through their participation in the Urgent Care and Planned Care workstreams, and are included in this operational plan.

67. KLOE C6 above sets out the five strategic priorities of the STP, with the details of the programmes and projects supporting the five priorities shown in KLOE C1, which gives the structure for the changes to the structure and delivery of care between now and 2020.

68. Because the programmes and projects are still at a relatively early stage of development, the STP is not yet able to show the milestones for implementation including public-facing communications, engagement and consultation needed ahead of delivery timeline for projects that represent specific pathways or services.

69. However, we do have clarity on the approach we will adopt from the start of 2017 to make sure that communication and engagement is developed for our change programme. This includes:

- **Developing in more detail the approach we will use** for communication and engagement depending on the nature of the change being proposed
- **Formulating communication and engagement priorities** by identifying the sequence of pathway and service projects being rolled out so we can develop a timetable. We will also look to group projects where there is commonality or a dependency between projects and identify where statutory public consultation might be required
- **Setting up broader stakeholder engagement** that is not linked to specific changes, but still needed to continue promoting the STP and the need for change

70. The December issue of the STP shows how communication and engagement is woven into all five priority areas. There is also a clear commitment to co-production – involving patients, the public and other stakeholders in the design process, rather than simply engaging with stakeholders to ask for approval once detailed plans have been completed.

71. This programme of activity will be delivered by the communications leads for each partner organisation in the STP with Wiltshire taking an active part in this process. The programme will be assured by CCG PPI lay members, Healthwatch, and where applicable, patient and public forums and committees. Our communications representatives and Healthwatch will work closely with STP workstream leads to identify where formal public consultation will be required on major service change and ensure there are realistic timescales and resources for this to happen.

72. Healthwatch will play an important part in the process, connecting us with patients whose care needs are most relevant to the specific piece of engagement that is being undertaken.

73. We will work through the existing STP governance structure, particularly:

- **The STP Communication and engagement workstream**, so all activities mesh into a single overarching plan for the system
- **The Leadership Group**, to ensure that SROs for programmes and projects are sighted on and actively support and promote communication and engagement for there are of responsibility
- **The Planning Group**, to ensure that communication and engagement activity for a particular project is correctly aligned to the project plan and confirm which partner organisation is leading the communication and engagement for that project

74. This second phase of communication and engagement will therefore be:

- **Structured and aligned to the programme of work** being developed and rolled out by the STP
- **Comprehensive** by including a wide range of stakeholders particularly patients and the public
- **Effective in support the change process**, with the emphasis on involving stakeholders in designing new services, not just asking for approval once plans are completed

Making it happen

75. The BSW STP has developed quickly. We are now working through established governance structures in the STP and relationships are deepening across NHS organisations as well as with social care partners, which is helping to accelerate system wide change.

76. The October STP submission demonstrated that we are making real progress in BSW, not simply in articulating our problems, but by developing common, agreed solutions to those problems.

77. Our CCGs plans clearly support the delivery of STP objectives in a range of areas and our experience in areas such as Right Care has helped to develop STP level plans as well as our own CCG plans.

78. We have signed up to common STP objectives, approaches and plans with our BSW partners, which will deliver real change in our care system. We will work to continue to deepen relationships in BSW as well as practical joint working to make the planned transformational improvements happen both within Wiltshire and across BSW.

Section 2 – Finance and activity

Summary

79. This section of the Operational Plan sets out how we will achieve the key finance related requirements set out in NHS planning guidance:

- Deliver financial control totals
- Undertake robust activity planning
- Implement local STP plans
- Implement demand reduction measures
- Increase provider efficiency

Delivering financial control totals

NHS England planning requirement 2.1

Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals. At national level, the provider sector needs to be in financial balance in each of 2017/18 and 2018/19. At national level the CCG sector needs to be in financial balance in each of 2017/18 and 2018/19

80. Our financial and activity process is designed to develop a plan for Wiltshire CCG to achieve its financial duties. Our plan also is aligned with the financial analysis set out in the STP.

Current financial position

81. NHS England requires CCGs to:

- Deliver a cumulative 1% surplus, with CCGs also needing to deliver an in year surplus position
- Hold a 1% uncommitted headroom (which may only be released in conjunction with NHS England/Treasury approval) - 50% of this is to be held as system risk reserve with other 50% available for investment

82. During 2016/17 we faced financial pressures, principally from acute services growing faster than plan, plus an overspend on Funded Nursing Care (FNC) due to a 40% increase in FNC rates payable backdated to the start of April 2016.

83. Our forecast for the end of 2016/17 includes other risks, which have been set against a series of identified mitigations.

84. Overall, our projection is that we will comply with NHS England's business rules for CCGs.

Our projections show we will meet the business rules for CCGs in 2017/18 and 2018/19

Business rule	Meeting the rules in 2017/18	Meeting the rules in 2018/19
Achieve a 1% surplus	Our planned surplus is £5.9m which is 1% of £591.5m of allocated resources for 2017/18	Our planned surplus is £6.1m which is 1% of £605.4m of allocated resources for 2018/9
Minimum contingency of 0.5%	£3.0m = 0.5%	£3.0m = 0.5%
Non-recurrent spend of 1% of programme baseline allocation	£5.8m = 1%	£6.0m = 1%
No overspend on running costs	Running costs not overspent	Running costs not overspent

Approach to financial planning for 2017/18 and 2018/19

85. Our approach to financial planning is aligned with the STP. We are actively participating in the STP finance group to share information, confirm assumptions and report on the results of financial planning. This will provide transparency for partners within the STP and produce a consolidated system level position that all partners are signed up to.

86. In Wiltshire CCG, our planning is based on our Medium Term Financial Plan (MTFP), which projects forward five years to give us a longer term perspective of finance and activity than that from one or two year plans. The details shown in this section of the Operational Plan are drawn from years 2017/18 and 2018/19 within the latest MTFP.

87. In our financial planning, we continue to comply with the business rules for CCGs for 2017/18 and 2018/19, in line with broader system wide themes established in 2016/17:

- **The system is overtrading** - we are spending more money than is or will be available; the cost of the system is greater than the income available
- **We need to reduce demand** - the system delivers care which is not always appropriate or necessary so we need to focus our resources on care that delivers good outcomes for patients
- **All parts of the system should change the care they deliver** - care at home or the community is an affordable, safe and effective alternative to inpatient care in hospital
- **Overall costs need to fall** - this means that fewer people will be employed to deliver care in the future; in the acute sector this means fewer beds and fewer heads

88. Although our CCG has received an increase in resources of for 2017/18 and 2018/19, there is a financial shortfall across the STP system estimated at some for £100 to £200m between 2017/18 and 2018/19, which is shown in the table below

Change in CCG resources compared to STP system level shortfall in resources

	2017/18	2018/19
CCG increase in resources	£13.9m (2.4%)	£14m (2.37%)
STP system shortfall (do nothing)	£100m	£200m

89. Financial modelling within the STP is based on the aspiration that all STP partners achieve all their QIPP, CIP and transformation plans for the STP to achieve its system control totals in 2017/18 (£19.4m surplus) and 2018/19 (£28m surplus).

Headlines of the financial plan for 2017/18 and 2018/19

90. We are planning to meet the NHS business rules between 2017 and 2019.

Our projections show we will meet the business rules for CCGs in 2017/18 and 2018/19

Area	Description	£m	
		2017/18	2018/19
Sources	Baseline	-577.5	-591.4
	Growth	-13.9	-14.0
	Surplus b/f	-5.9	-5.9
	Total	-597.3	-611.4
Applications	Baseline	573.4	584.2
	Net inflation	1.2	1.2
	Demographic and non-demographic growth	16.2	19.9
	Investments	15.1	15.1
	QIPP	-14.5	-15.0
	Total	591.4	605.3
(Surplus) / Deficit position per annum		**-5.9**	**-6.1**
(Surplus) / Deficit position per annum as a % of resources		**1%**	**1%**

91. Our financial plan for 2017/18 and 2018/19 has been developed by working with providers to formulate a financial settlement that gives an equitable and practical balance between:

- Providing additional funding
- Incentivising providers to reduce both activity and costs

92. The headlines of the plan are:

- A provider baseline that reflects the full recurrent outturn for 2016/17 with any fines and reduced CQUIN delivery added back into the position. This position will include adjustments to take account of HRG4+, the 30% marginal rate adjustment for non-elective activity and readmissions adjustments with both being based on 2016/17 values. Modelling is ongoing to prove whether the national assumptions around cost neutrality of HRG4+ are valid for Wiltshire CCG
- Inflation increases of 2.1% for acute and non-acute NHS activity, 2% for other non acute activity and 2% for prescribing, all offset by a 2% efficiency requirement
- A 0.6% increase to the recurrent outturn position to reflect demographic growth. We have used IHAMS assumptions for non demographic growth (recognising the application of the growth across patient types and specialties will vary).
- The RTT backlog is assumed to be funded over and above this offer, after taking into account any current elements of non recurrent funding to deal with the backlog

93. We will therefore be making significant investments in services outside the acute sector, particularly investment in mental health services that will be 2.4% in 2017/18 and 2.4% in 2018/19, which meets the Parity of Esteem requirement of growth in Mental Health funding being at least the value of annual growth in CCG allocations

94. If extra activity is required over and above contracted activity levels, this will need to be delivered by improved efficiency in line with the NHS transformational challenge. Work will also be focused on achieving a sustainable level of supply and demand which is affordable and delivers the constitutional access targets. We will undertake additional activity and capacity modelling with providers to ascertain whether demand growth can be managed within existing NHS capacity. If not, we will continue to use Independent Sector capacity to make up any shortfall.

95. During the contracting round, we have worked with providers to identify the RTT backlog. The CCG is assuming that the backlog will either be covered from within existing capacity that will be funded from additional QIPP savings or contingency funding. If both assumptions cannot be delivered, then this will represent a significant risk to the CCG and its financial plans

96. This approach is underpinned by activity planning which is discussed below so that:

- The QIPP requirement for unplanned and planned care of £6m is accounted for within activity plans and then into agreed financial plans
- Parity of Esteem investments and any additional activity required to meet NHS Constitution targets are include within the overall quantum of planned activity for 2017/18

Assessment of financial risks in 2017/18 and 2018/19

97. The financial plan has identified financial risks that have been assessed as the following:

- RTT backlog - the CCG has funded a total of £0.6m non recurrently in the last quarter of 2016/17 across the three principal acute providers to target RTT backlogs by March 2017. Therefore, by April 2017, principal providers are expected to start the year with and to maintain a manageable RTT "tail"
- Assessment of the current QIPP schemes – we will undertake risk monitoring of our QIPP schemes each month to confirm the level of risk. Currently, we do not have an estimate of the level of risk because of the relative maturity of our QIPP plans
- There are issues around the growth in the number of births at the RUH. Therefore, there is risk around the Maternity pathway that could result in a financial risk as the current modelling is only able to forecast on 4 months' data (£0.1m)
- Should the national policy position contained in the NHS contract for readmissions be renegotiated then the CCG would lose an income stream for funding reablement services which is embedded into the BCF (£1.7m)
- At this point, there are no material issues on start points and contract proposals, however, the major risk to the system is on QIPP and being able to take costs identified in QIPP out of the system.

98. Our ongoing monitoring and evaluation of risks through analysis of prior year trends and emerging issues mean that we have identified high level risks. Contingency plans are in place to offset these, and we will develop additional options and actions if our analysis indicates that risks outweigh mitigations.

QIPP

99. Our MTFP has identified a £12.6m QIPP gap in 2016/17, which will be addressed through:

- Planned Care - £3m
- Unplanned Care - £3m
- Prescribing - £1.8m
- Other including running costs, slippage, quality premium and additional measures - £2.3m
- Unidentified QIPP - £2.5m

100. We will review the overall QIPP position after all contracts have been agreed and expect that the unidentified QIPP will reduce. We will then work to identify additional measures to address the remaining QIPP gap.

101. The breakdown of QIPP plans for Planned Care, Unplanned Care and Prescribing are set out in Appendices A, B and C plus accompanying slides

Undertaking robust activity planning

102. We have sound processes to produce robust activity plans. Our activity planning uses common tools and assumptions across the STP footprint. There is an aggregation process in place to bring together activity baselines, growth and changes arising from transformation and QIPP to produce an aggregate system level position.

103. This means there is a clear trail from modelling and planning at CCG level through to the STP, with changes and the overall system level position expressed as both activity and finance.

How our activity plans link to the STP (A1)

Key Line of Enquiry A1

Does the activity submitted with the operational plans directly reflect years 2 and 3 of the relevant STP?

104. Wiltshire CCG and BSW STP use IHAM as a common planning tool and adopt common assumptions for IHAM, as set out in the table below.

Common IHAM planning assumptions used across BSW STP

		2016/17	2017/18	2018/19	2019/20	2020/21
Wiltshire	Outpatient attendances	4.1%	4.0%	4.1%	4.1%	3.9%
	Elective admissions	2.3%	2.3%	2.4%	2.3%	2.1%
	Non elective admissions	2.4%	2.3%	2.6%	2.6%	2.4%
	A&E attendances	2.2%	2.2%	2.4%	2.3%	2.3%
BaNES	Outpatient attendances	3.3%	3.4%	3.7%	3.6%	3.1%
	Elective admissions	1.5%	1.6%	1.8%	1.7%	1.3%
	Non elective admissions	1.6%	1.6%	2.2%	2.0%	1.2%
	A&E attendances	2.0%	1.8%	2.2%	2.1%	1.6%
Swindon	Outpatient attendances	4.3%	4.3%	4.3%	4.5%	4.1%
	Elective admissions	2.5%	2.6%	2.5%	2.7%	2.3%
	Non elective admissions	2.6%	2.4%	2.6%	2.5%	2.3%
	A&E attendances	2.8%	2.5%	2.8%	2.6%	2.5%
England	Outpatient attendances	3.8%	3.9%	3.9%	3.8%	3.8%
	Elective admissions	2.0%	2.1%	2.1%	2.0%	1.9%
	Non elective admissions	2.1%	2.2%	2.2%	2.2%	2.1%
	A&E attendances	2.3%	2.3%	2.3%	2.3%	2.3%

105. Our approach is to:

- Confirm the baseline using month 4 year to date, measured at month 5
- Flex the baseline forward to develop a forecast outturn
- Adjust the forecast to take account of requirements for 2017/18 and 2018/19 such as winter pressures, RTT requirements and the impact of Transformation/QIPP schemes

106. The IHAMS modelling was applied across the BSW footprint. There was also be local flexibility for Transformation/QIPP schemes to reflect:

- The part year effect of Transformation/QIPP schemes at a system level – starting times
- The impact at CCG level – differential impact

107. This approach is designed to ensure that CCG and STP level plans reflect realistically the impact of Transformation/QIPP across the whole system as we aim to achieve financial balance and the financial system control total.

Activity modelling (A5)

Key Line of Enquiry A5

Is there clear evidence of activity modelling that supports the plan?

108. The activity modelling discussed above is reflected in:

- A common commissioner plan model created by the CSU, which is used across the BSW footprint
- Analysis reviewed by the STP finance group to understand the commissioning position across the STP footprint

109. This reflects an open book approach to contract plans and activity projections, with:

- Commissioner level contract plans discussed and shared openly with commissioners across the footprint
- Plans shared with Providers through the contract process. Our plans were shared before 4 November in line with the national contracting timetable, making the contracting process open and transparent at an early stage. Going forward, details will be included within the national contract tracker which will provide a point of reference on the plans.

110. We also comply with the NHS England planning requirements by submitting the templates pre-populated with SUS activity data provided by NHS England.

Key planning assumptions (A2 and A3)

Key Line of Enquiry A2

Does the plan set out clear and reasonable growth assumptions, using IHAM as a default starting point?

111. The starting growth assumptions used are the IHAMS assumptions, which are used at point of Delivery (POD) level for each provider to give the granular accuracy the IHAMS model is designed for. The detailed assumptions at POD level are set out in table shown in paragraph 104 above.

112. For local contract planning we have made a series of local adjustments, which are reflected in the waterfall chart in NHS England's Plan Submission Template. These adjustments take account of:

- Population changes
- Known data recording issues in SUS
- Transformation/QIPP schemes
- Policies such as Seven Day Working

Key Line of Enquiry A3

Does the plan clearly describe the evidence and assumptions that enable activity to be reduced from the 'do nothing' scenario and the impact of transformational change (e.g. BCF, vanguard, local contractual changes)?

113. During the third quarter of 2016/17 we worked with providers to agree the 2016/17 outturn to facilitate a focus on redesign, which was agreed with two of our three principal providers and we continue to engage with our third principal provider on this.

114. The Planned and Unplanned Care service redesign plans, developed at both CCG and STP level form the basis of QIPP values embedded into contract and are the principal means to reduce activity from the do nothing scenario.

115. We have also implemented specific actions in 2016/17 to prepare for the planned reduction of activity in 2017/18 and 2018/19. One example is the work with Wiltshire Health and Care where we have agreed to implement the Rehab Support Worker model, which will facilitate earlier discharge from acute care into community or home based settings. This model of care will be in place from January 2017.

116. The Transformation/QIPP initiatives included in this Operational Plan and incorporated into our activity plans are evidenced in Appendices A and B plus accompanying slides. The detailed plans include the following information for each initiative:

- Projections of the financial and activity impact for 2017/18 and 2108/19
- Evidence that was used to make the projections
- Timing so that part year effect is accounted for

How planned activity relates to performance (A4)

Key Line of Enquiry A4

How will planned activity enable performance to be delivered and how are risks related to deviating from the activity plan mitigated? Does planned activity enable achievement of constitutional standards and reflect agreed trajectories?

117. Our planning worked through stages so that our plans are set up to achieve constitutional standards, and we are confident that we are planning to commission sufficient activity across our system:

- We have reviewed RTT backlogs with providers to confirm the extent of non-recurrent activity that was needed in plans to achieve constitutional standards. This included both additional activity as well as reductions in activity, where we have commissioned activity in non-acute settings (for example community hernia services)
- We assessed our ongoing analysis of "hotspots" to identify here additional activity might be needed in areas where we know there are breaches of standards and where we have been working with providers to address them. Examples of where we know there have been performance issues and are working with providers to monitor plans to address "hotspots" include:

- Gastroenterology and Dermatology
- RTT incomplete pathways at RUH and tertiary providers
- A&E standards – RUH (now being monitored through a weekly commissioner meeting; SFT (have submitted a trajectory that is non compliant, so remedial plans are being developed)
- Cancer 2 week wait – a deep dive investigation to understand the disproportionate growth in referrals at RUH will continue in 2017/18

- We identified specific areas within IAF that indicated where there might be additional activity/action needed. The most significant example of this was IAPT recovery rates
- We also undertook activity modelling to identify areas where IHAMS understates population pressures unique to Wiltshire

118. All these aspects were included in our planning and discussions with providers so that agreed contract plans contained sufficient activity to meet demand and meet constitutional standards. These plans were reflected in agreed trajectories to meet standards in cases where standards were not being met.

119. Our approach to managing risks in these areas is to:

- Monitor closely trajectories to ensure constitutional standards are met. This is undertaken as part of our BAU, where we already have a good understanding of existing and developing risks and pressures
- Where standards are not met or there is deviation from trajectories, work closely with providers to develop and monitor the implementation of recovery plans

How we align our plans with provider plans (A6)

Key Line of Enquiry A6

What is the evidence that activity has been jointly mapped with commissioner and provider and that capacity is available?

120. Commissioner and Provider plans are aligned by comparing demand and supply through the contracting process where:

- We as the Commissioner set out our demand plans to main NHS and Independent Sector providers through our contract offers. As part of this process we highlighted areas where we expect activity reductions through Transformation/QIPP plans so that these initiatives are understood and taken account of in the contract process
- Providers responded with their capacity plans and highlights of capacity “hotspots”
- Discussions to confirm proactive focus areas where:
  - We have agreed to use IS or other NHS capacity to meet demand pressures
  - Providers have agreed to address capacity constraints through internal measures

121. This approach has confirmed that capacity is either available or will be made available through shifting activity to alternative providers or through provider efficiency measures.

122. We have contracted with our providers on the basis that they will have sufficient capacity available to meet current levels of demand plus agreed growth. Provider capacity will be proactively monitored and where providers have insufficient capacity, we will address this through contract variations to facilitate changing referrals to different providers where there is capacity available.

Capacity needed to meet constitutional standards (A7)

Key Line of Enquiry A7

Where capacity in the NHS cannot meet demand, what actions are in place to source additional capacity?

123. We continually monitor demand and capacity so we can ensure there is sufficient capacity available to meet demand. Alongside this we have put in place a standard pre-referral process which helps us identify scope for using IS acute providers, where there is pressure on NHS capacity – see also KLOE B5 below.

124. There is now a single point of access for a series of pathways which involves community based triage, that directs patients to community based alternatives to acute care – for example in podiatry and for hernias. If there is no community alternative, then patients are directed straight to an acute IS provider, where clinically appropriate and improve both patient access and experience.

125. Our Referral Management service also supports this process by directing patients, where possible and respecting patient choice, to the provider with the shortest waiting times. This helps to match demand and capacity, to make better use of NHS capacity by reducing some of the pressure on NHS providers.

126. See KLOE A4 above for further details.

How we manage activity risks (A8)

Key Line of Enquiry A8

What is the evidence to show that risks in relation to activity been jointly identified (commissioner and provider) and mitigated through agreed contingency plan and show consistency between activity, workforce and finance plans?

127. Key activity risks were identified during contracting discussions to match commissioner offers and provider capacity projections. Examples of risk areas identified and addressed included some Providers have raising coding and accounting issues that impact upon the initial baseline. These are currently being discussed as part of the contracting process and should be addressed by checkpoint 2 in the national contracting timetable.

128. We also identified specific workforce issues through contract discussions with providers, for example in challenged specialties such as Dermatology where staff shortages have resulted in capacity restrictions that have impacted on ability to meet demand and achieve constitutional targets. This has been managed through a mix of provider actions to address staff shortages and proactive management of referrals to use alternative capacity in both the NHS and IS.

How we integrate our activity and finance plans (A9)

Key Line of Enquiry A9

Is there a clear link between finance and activity plans, is planned activity budgeted for and affordable?

129. We adopted an iterative process to make sure finance and activity are aligned:

- We confirmed the envelope of available resources, which is £597.3m for 2017/18 and £611.4m for 2018/19
- We identified the initial gap between resources and cost of services of £14.5m in 2017/18
- We also identified target cost reductions in care areas, principally in planned and unplanned care that would be incorporated into initial contract offers

- Through activity planning we identified the level of demand for each provider, and incorporated our target cost reduction areas through Transformation/QIPP which formed the initial contract offers
- We priced service offers at the beginning of November before discussions with providers so we understood the resource implications of contract offers
- We iterated our contract offers to produce the final agreed contract position, which were expressed in both activity and finance

130. This approach meant that we:

- Identified the cost of our activity proposals early in the process, linking activity and finance
- Related the cost of contract proposals back to our resource envelope, so activity was all budgeted
- Developed additional QIPP plans to produce a balanced position, so our contracted activity is shown to be affordable

131. The approach for Ambulance and mental health services was different because these services are not based on PBR but contracted through a block arrangement:

- For Ambulance services, we triangulated activity and finance by agreeing the outturn position and anticipated growth using reported activity trends as the evidence base for future activity
- For the past two years, our mental health provider has shared information mapping that breaks out expenditure and activity by commissioner, relating this to income received. This resource mapping was the basis of contracts in 2016/17 and was planned to be used for future contracts. Unfortunately, AWP have refused to use this mechanism to set contract values, which would have ensured an equitable and correct match between income and activity across the system. Despite this we believe that this approach will be helpful in future as we develop contracts that are based on mental health tariffs

132. KLOE C5 above discusses how we are holding the risk on QIPP/Transformation, with contract mechanisms in place to reduce contract payments for successful QIPP/Transformation delivery.

Meeting constitutional standards

133. We continue with our commitment to meet constitutional standards. The 2016/17 position reflects a range of pressures being experienced across England, which have impacted on organisations' ability achieve the constitutional standards.

134. In 2017/18 and 2018/19 we will continue to work closely with providers to manage instances where constitutional standards are not being met through support and monitoring of actions plans where remedial action is needed.

Trajectories to meet constitutional standards (B1 and B2)

Key Line of Enquiry B1

From current baseline does the CCG have a trajectory agreed with providers to meet all constitution standards in 2017/18?

135. We have agreed actions and trajectories with all providers to meet constitution standards in 2017/18 and are developing a system wide approach to meeting constitutional standards as part of our system level management.

Areas for remedial action to meet constitutional standards

Standard	Current position	2017/18 Plan Target	Action for 2017/18
Diagnostics (≥99% under 6 Weeks)	Sleep studies: being managed through STP wide workstream for GWH and RUH	Achieve ≥99% under 6 Weeks	Focus on commissioning alternatives for historic sleep study services Review increasing risk around Cardiology diagnostics linked to a known workforce issue
RTT incomplete pathways (≥92% under 18 Weeks)	RUH – position improved from August to September, but still not achieving the standard Virgin Care – breached due to legacy patients – recovery trajectory in place Tertiary providers – expect these to be cleared in 2016/17	Achieve ≥92% under 18 Weeks)	The CCG is planning monthly 92% achievement. However, there is a risk because RUH will not be planning achievement but the CCG hopes to make up the shortfall from the Independent Sector, as they continue to over achieve their plans For Wiltshire, the RUH backlog will be dealt with by RMS referral transfers to alternative providers. It is unlikely the STP-wide trajectory will achieve because of the RUH materiality on the BaNES plans
RTT >52 Week waits	GWH – assurance around remedial action on breaches obtained at RTT steering Board NBT – part of larger ongoing recovery plan for spinal patients, expected to be completed in 2016/17	Zero >52 week waits	Continue to monitor performance through established mechanism of monthly RTT delivery meetings to ensure recovery to achieve the standard is made and sustained
A&E standards (≥95% under 4 Hours)	RUH have not achieved this standard in 2016/17, although performance improved from 79% in August to 91% in October GWH have also not achieved the target in 2016/17, showing performance of 89% in August falling to 84% in Octobers SFT's position in August was 93%, which fell to 92% in October These figures are based on average weekly totals	Achieve ≥95% under 4 Hours	SFTs trajectory shows that the Trust will not achieve the target in 2017/18. RUHs trajectory shows that the Trust will not achieve the target in 2017/18. GWH will only achieve the standard during two summer months in 2017/18 We will continue to work with all providers to develop and implement appropriate remedial action to recover the position through demand management and service improvement and where possible achieve the standard

Standard	Current position	2017/18 Plan Target	Action for 2017/18
Cancer 2 week wait (≥93%)	RUH – Deep dive underway to identify cause of 21% increase in 2ww attendances, with review at November RTT delivery group. GWH - Dermatology recovery plan being developed - recovery is expected to be achieved within a matter of weeks and maintained thereafter	Achieve 2 week wait (≥93%)	Expect all issues identified in 2016/17 to be resolved by the end of March 2017. Ongoing monitoring to ensure the standard is achieved and maintained
DToC (3.5% of population cohort)	Excess DToCs at all principal providers in August 2016. Improved performance in September and October. Rollout of Integrated Discharge Scheme expected to improve the position further.	Achieve <3.5% of population cohort	Plans have been agreed to reduce the DTOC rate to 3.5% by March 2017. The actions below are designed to maintain this position from April 2017: a) 70 cohorted ICT beds across 9 locations, providing active rehabilitation and support for patients between hospital and home b) Urgent care at home programme to support patients flow through the system 24/7 c) Integrated discharge programme and strategy - integrated discharge teams in each of the three acute hospitals. d) Launch rehab support workers programme in partnership with Wiltshire Health and Care to increase care resource in the community e) Relaunch of the DART programme at GWH f) Enhanced discharge support through the 72 hour pathway for patients who are palliative or end or end of life
Dementia diagnosis (66.67%)	September actual is 65.2%, improvement from August. The recently submitted a revised plan trajectory that is expecting the 66.67% standard to be achieved by Feb 2017	Meet the 66.67% standard in 2017/18	Dementia diagnosis performance will slip back in the 1st 4 months of each year because of the annual revised denominator, which means we need to identify newly diagnosed patients on top of the normal attrition rates Support is being offered to practices where there is still a significant gap in terms of numbers between the target and the numbers with a diagnosis or where diagnosis rates have declined. The Dementia LES is specifically designed to improve the rate of diagnosis by providing the most appropriate incentives, support and management of dementia diagnosis. ***See Section 7 Planning Requirement 7.4 for detail***

Standard	Current position	2017/18 Plan Target	Action for 2017/18
MSA	GWH – reported breaches in September	Zero breaches	Ongoing monitoring and remedial plans where required

Key Line of Enquiry B2

Are trajectories realistic, reflecting past performance, seasonality and planned changes?

136. We assess the position on constitutional standards as part of our ongoing monitoring with specific pressures and issues identified through "hotspot reporting".

137. Our trajectories and action plans use information from our monitoring so that we understand patterns of past performance and the impact of seasonality or non recurrent factors, therefore trajectories and plans agreed with providers are as robust as possible. The CCG trajectories reflect the timing of Easter and the reduced number of elective days in 2017/18.

Managing risks around constitutional standards (B3)

Key Line of Enquiry B3

What is the level of risk that they will not be delivered and how will this risk be mitigated?

138. Risks have been identified through action plans agreed with providers. Mitigations include:

- Deep dive into underlying reasons for increases in referrals for cancer, to identify any opportunities for clinically appropriate demand management. This will be balanced in relation to the national drive to increase 2ww for cancer to improve early diagnosis rates
- Internal actions by providers to increase capacity to reduce historic backlogs
- Referrals to other NHS providers through proactive outsourcing at pre referral stage (see KLOE A7 above)
- Using IS capacity as an alternative to NHS provision
- STP workstreams to drive operational efficiency and pathway improvements to support improvements in demand management

Using independent sector capacity (B5)

Key Line of Enquiry B5

What independent sector capacity has been identified to support delivery of constitutional standards?

139. The CCG has encouraged a plural independent market which is used to proactively redirect clinically appropriate cases. Areas of growth in demand have been supported by commissioning additional community surgical services and pre referral demand management schemes so available IS capacity is utilised fully.

140. We commission services from a range of IS providers which means that our approach to capacity is flexible and we are not tied to one IS provider or are only able to access limited IS capacity

141. We work collaboratively with neighbouring CCGs, acute NHS providers and the IS to maximise our capacity as a system and improve access for patients. This another example of how system wider working in BSW is developing in practice.

142. Our use of IS capacity will continue to be reviewed strategically via the STPs RTT Group which meets bi monthly and operationally via the established RTT steering and delivery groups. IS usage is viewed

monthly and we proactive refer at source to the IS, in collaboration with NHS providers and neighbouring CCGS.

143. The STP work streams, particularly the demand management and clinical policy work stream, include planning of non-NHS capacity. Speciality level work streams also include service redesign strategies to transition clinically appropriate services from acute NHS to IS and community provision – this includes pain and dermatology within the first phase.

144. The STP planned care work streams link across all providers, so there is a strategic STP wide view of IS use on an ongoing basis.

Collecting performance data (B4)

Key Line of Enquiry B4

Does the CCG have in place monitoring system to collect the necessary performance data for current and new standards?

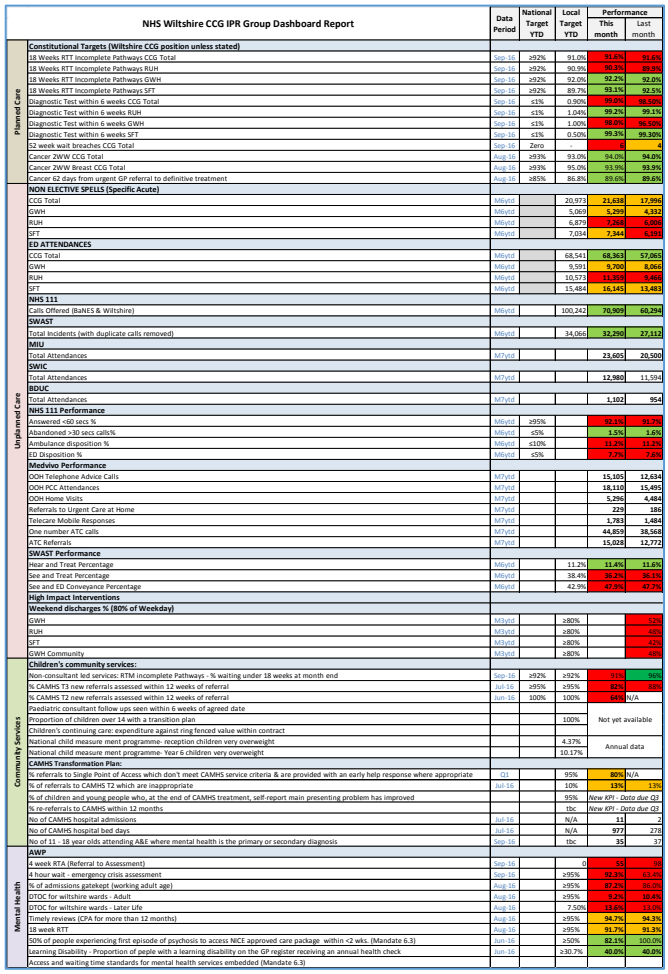
145. We have robust systems and processes in place to collect, report on and monitor performance data for current standards. These have been shown to be effective and we have no known issues around data reporting and monitoring for current standards.

146. We use dashboards for regular monitoring, that show:

- The Organisation level position in Planned Care, Unplanned Care, Community Services and Mental Health, including aggregate and provider level status
- The Group level position, showing key performance risks; performance against finance, QIPP, activity and constitutional targets; provider level performance and status of key developments projects.

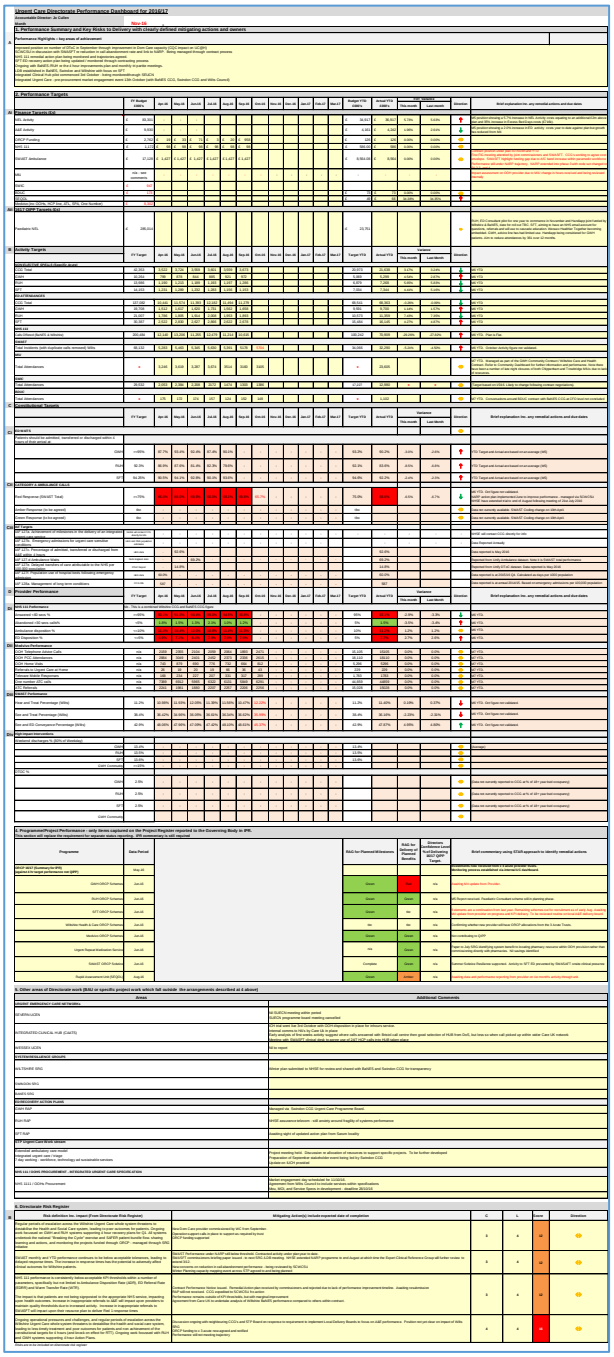
Examples of our dashboards

Organisation level dashboard



NHS Wiltshire CCG IPR Group Dashboard Report		Data Period	National Target YTD	Local Target YTD	Performance This month	Last month
Planned Care	**Constitutional Targets (Wiltshire CCG position unless stated)**					
	18 Weeks RTT Incomplete Pathways CCG Total	Sep-16	≥92%	91.0%	91.6%	91.6%
	18 Weeks RTT Incomplete Pathways RUH	Sep-16	≥92%	90.9%	90.3%	89.9%
	18 Weeks RTT Incomplete Pathways GWH	Sep-16	≥92%	92.0%	92.2%	92.0%
	18 Weeks RTT Incomplete Pathways SFT	Sep-16	≥92%	89.7%	93.1%	92.5%
	Diagnostic Test within 6 weeks CCG Total	Sep-16	≤1%	0.90%	99.6%	98.50%
	Diagnostic Test within 6 weeks RUH	Sep-16	≤1%	1.04%	99.2%	99.1%
	Diagnostic Test within 6 weeks GWH	Sep-16	≤1%	1.00%	98.6%	96.50%
	Diagnostic Test within 6 weeks SFT	Sep-16	≤1%	0.50%	99.3%	99.30%
	52 week wait breaches CCG Total	Sep-16	Zero	-	0	0
	Cancer 2WW CCG Total	Aug-16	≥93%	93.0%	94.0%	94.0%
	Cancer 2WW Breast CCG Total	Aug-16	≥93%	95.0%	93.9%	93.9%
	Cancer 62 days from urgent GP referral to definitive treatment	Aug-16	≥85%	86.8%	89.6%	89.6%
Unplanned Care	**NON ELECTIVE SPELLS (Specific Acute)**					
	CCG Total	M6ytd		20,973	21,638	17,996
	GWH	M6ytd		5,069	5,290	4,332
	RUH	M6ytd		6,879	7,268	6,006
	SFT	M6ytd		7,034	7,344	6,191
	ED ATTENDANCES					
	CCG Total	M6ytd		68,541	68,363	57,065
	GWH	M6ytd		9,591	9,700	8,066
	RUH	M6ytd		10,573	11,359	9,466
	SFT	M6ytd		15,484	16,145	13,483
	NHS 111					
	Calls Offered (BaNES & Wiltshire)	M6ytd		100,242	70,909	60,294
	SWAST					
	Total Incidents (with duplicate calls removed)	M6ytd		34,066	32,290	27,112
	MIU					
	Total Attendances	M7ytd			23,605	20,500
	SWIC					
	Total Attendances	M7ytd			12,980	11,594
	BDUC					
	Total Attendances	M7ytd			1,102	954
	NHS 111 Performance					
	Answered <60 secs %	M6ytd	≥95%		92.1%	91.7%
	Abandoned >30 secs calls%	M6ytd	≤5%		1.5%	1.6%
	Ambulance disposition %	M6ytd	≤10%		11.2%	11.2%
	ED Disposition %	M6ytd	≤5%		7.7%	7.6%
	Medvivo Performance					
	OOH Telephone Advice Calls	M7ytd			15,105	12,634
	OOH PCC Attendances	M7ytd			18,110	15,495
	OOH Home Visits	M7ytd			5,296	4,484
	Referrals to Urgent Care at Home	M7ytd			229	186
	Telecare Mobile Responses	M7ytd			1,783	1,484
	One number ATC calls	M7ytd			44,859	38,568
	ATC Referrals	M7ytd			15,028	12,772
	SWAST Performance					
	Hear and Treat Percentage	M6ytd		11.2%	11.4%	11.6%
	See and Treat Percentage	M6ytd		38.4%	36.2%	36.1%
	See and ED Conveyance Percentage	M6ytd		42.9%	47.9%	47.7%
	High Impact Interventions					
	Weekend discharges % (80% of Weekday)					
	GWH	M3ytd		≥80%		52%
	RUH	M3ytd		≥80%		45%
	SFT	M3ytd		≥80%		42%
	GWH Community	M3ytd		≥80%		43%
Community Services	**Children's community services:**					
	Non-consultant led services: RTM incomplete Pathways - % waiting under 18 weeks at month end	Sep-16	≥92%	≥92%	91%	96%
	% CAMHS T3 new referrals assessed within 12 weeks of referral	Jul-16	≥95%	≥95%	82%	81%
	% CAMHS T2 new referrals assessed within 12 weeks of referral	Jun-16	100%	100%	64%	N/A
	Paediatric consultant follow ups seen within 6 weeks of agreed date					
	Proportion of children over 14 with a transition plan				100%	Not yet available
	Children's continuing care: expenditure against ring fenced value within contract					
	National child measure ment programme- reception children very overweight				4.37%	Annual data
	National child measure ment programme- Year 6 children very overweight				10.17%	
	CAMHS Transformation Plan:					
	% referrals to Single Point of Access which don't meet CAMHS service criteria & are provided with an early help response where appropriate	Q1		95%	80%	N/A
	% of referrals to CAMHS T2 which are inappropriate	Jul-16		10%	13%	13%
	% of children and young people who, at the end of CAMHS treatment, self-report main presenting problem has improved			95%	*New KPI - Data due Q3*	
	% re-referrals to CAMHS within 12 months			tbc	*New KPI - Data due Q3*	
	No of CAMHS hospital admissions	Jul-16		N/A	11	7
	No of CAMHS hospital bed days	Jul-16		N/A	377	278
	No of 11 - 18 year olds attending A&E where mental health is the primary or secondary diagnosis	Sep-16		tbc	35	37
Mental Health	**AWP**					
	4 week RTA (Referral to Assessment)	Sep-16			0	35
	4 hour wait - emergency crisis assessment	Sep-16		≥95%	92.3%	61.4%
	% of admissions gatekept (working adult age)	Aug-16		≥95%	87.2%	86.0%
	DTOC for wiltshire wards - Adult	Aug-16		≥95%	9.2%	10.4%
	DTOC for wiltshire wards - Later life	Aug-16		7.50%	13.6%	13.9%
	Timely reviews (CPA for more than 12 months)	Aug-16		≥95%	94.7%	94.3%
	18 week RTT	Aug-16		≥95%	91.7%	91.3%
	50% of people experiencing first episode of psychosis to access NICE approved care package within <2 wks. (Mandate 6.3)	Jun-16		≥50%	82.1%	100.0%
	Learning Disability - Proportion of peple with a learning disability on the GP register receiving an annual health check	Jun-16		≥30.7%	40.0%	40.0%
	Access and waiting time standards for mental health services embedded (Mandate 6.3)					

Group Level Dashboard



Urgent Care Directorate Performance Dashboard for 2016/17

Accountable Director: Jo Cullen

Month: Nov-16

1. Performance Summary and Key Risks to Delivery with clearly defined mitigating actions and owners

Performance Highlights / key areas of achievement

2. Performance Targets

3. Activity Targets

4. Operational Targets

5. Provider Performance

6. Programmes/Project Performance - only those captured on the Project Register reported to the Governing Body in IPR.

7. Other areas of Directorate work (BAU or specific project work which fall outside the arrangements described at 6 above)

8. Directorate Risk Register

147. The new performance standards are principally related to Mental Health and Learning Disabilities as well as Primary Care. When the final definitions are confirmed, national guidance will be issued for all the standards.

148. For Mental Health and Learning Disabilities, the standards focus on psychosis and CAMHS. We will work with AWP who are our principal provider of these services to ensure that they collect and report performance data to the required standards. These requirements will be incorporated into the contract schedules so there is a formal requirement for providers to comply with the standards and reporting requirements.

The CCG Improvement and Assessment Framework (B6)

Key Line of Enquiry B6

Does the plan reference the CCG IAF position and identify and describe improvements to achieve the standards?

149. We monitor our IAF position and have put in place actions to address any areas where improvement is needed to achieve the standards.

Wiltshire CCG IAF areas requiring improvement at end October 2016

IAF area	Current position	Action for 2017/18
Diabetes patients that have achieved all the NICE recommended treatment targets: Three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children	The CCG position is 37.7%, with that for England being 39.8% This data is from 2014/15	The 2015/16 audit data is due out imminently. Once this comes through, the Wiltshire CCG Programme Board will be analysing it to come up with action plans that specify how the CCG will work with practices that are not achieving those targets (***See KLOE N2a in KLOE Excel file***).
Improving Access to Psychological Therapies recovery rate	The CCG position is 34.9%, with that for England being 48.9% This data is from June 2016	Our most up to date figures show that the 50% target was not met in Q1 2016/17, although in October 2016, our performance showed we had achieved the 50% target in month. This has been achieved by implementing the recommendations of the external review of the IAPT service and we expect to achieve or exceed the 50% target in 2017/18 and 2018/19
Delayed transfers of care per 100,000 population	The CCG position is 23.3 per 100,000 population with that for England being 14.1 This data is from August 2016	See action on Constitutional standards under KLOE B1 and B2 above

IAF area	Current position	Action for 2017/18
People eligible for standard NHS Continuing Healthcare	The CCG position is 19.4, with that for England being 46 This data is from Q1 2016/17	We are actively working to ensure that all people who are entitled to relieve CHC are considered for screening. This includes, widely communicating CHC criteria to all stakeholders; training to health and social care professionals to refer appropriately; reviewing all submitted checklists whether positive or negative to ensure consistent application of CHC criteria; undertaking rigorous internal quality assurance that ensures criteria have been correctly applied; and dissemination of any learning from NHS England Independent Review Panels, complaints and local resolution meetings to improve processes
Effectiveness of working relationships in the local system	The 2015/16 assessment shows our position is 61.9	We will continue to develop our relationships for cross system working both through the STP and individual initiatives agreed with partners

Meeting Operational Plan targets that are not part of the NHS Constitution

150. We are also planning to meet operational plan targets that are not part of the NHS Constitution.

E referral

151. We are not currently meeting the 80% target for e-referrals in 20161/7. The target will change to: 100% in April 2018.

152. Wiltshire CCG is leading an STP wide demand management scheme working collaboratively across providers and commissioners to reduce elective referral variation. E-referrals will be the enabler for this work stream with the subsequent aim of delivering the required e-referral national requirements.

153. The STP workstream, which involves an expanded Referral Management process and ending paper referrals, is being trialled in ENT from April 1st 2017 and planned to roll out across all specialities in September 2017. The phases of this project are integral to the delivery of the e-referral percentage and hence the trajectory has been set to align with the agreed project milestones.

154. Our current trajectory is to:

- Achieve 80% in October 2017
- Achieve 100% in March 2018
- Continue to achieve 100%from April 2018

Wheelchairs for Children

155. The new target is that children should wait for no longer than 18 weeks for a wheelchair, which will be met in 2017/18 and 2018/19. The plan for managing performance against this target is to:

- Advise Wiltshire Health and Care (WHC) of the new requirement for the CCG to report performance against this figure- current WHC performance against this measure is 93% which exceeds the target being set for 2017/18.
- Amend the Wheelchair service specification for 2017/18 to include the measure articulated in the return around children's wheelchairs. This will be done as part of WHC Contract negotiation process currently underway
- Manage WHC performance against the 2017/18 target (92%) through the formal contract management process

- Amend the SDIP for 2017/18 to stipulate that WHC are to develop a plan for how they will achieve 100% against this KPI in 2018/19. This will be done as part of the SDIP development process currently underway. The recent introduction of SystmOne in the wheelchair service will support this.

Personal health budgets (PHBs)

156. The target is based on offering PHBs to 0.04% of the CCGs population by the end of 2018/19. For Wiltshire CCG, this represents 196 PHBs, which will be met by the end of quarter four in 2018/19.

157. We are building on our work to extend the offer of PHBs during 2016/17, where we focused primarily on patients with:

- Long term conditions
- Mental Health conditions
- LD and/or Autism
- Adult and Child CHCs

158. We are currently waiting for national guidance to help us target our extended offers in 2017/18 and 2018/19. Our current approach, subject to national guidance, will be to target, patients:

- At End of life
- Who use wheelchairs

159. This extension of PHB offers will be managed through a formal structure to support the delivery of this target. This may include partners from the Voluntary Sector as well as provider organisations.

GP extended access

160. The implementation of this standard will be dependent on funding, and we already have a pilot underway, which should deliver 20% compliance for quarters 3 and 4 in 20171/8.

161. Once the pilot has been completed we expect the system to go live at the start of 20181/9, at which point we expect 100% compliance at Quarters 1 and 2 in 20181/9 and to be maintained at 100% thereafter.

Implementing local STP plans

162. NHS England's planning requirement 2.2 asks organisations to implement local STP plans that:

- Achieve local targets to moderate demand growth
- Increase provider efficiencies

Implementing demand reduction measures

NHS England planning requirement 2.3

Demand reduction measures include: implementing Right Care; elective care redesign; urgent and emergency care reform; supporting self care and prevention; progressing population-health new care models such as multispecialty community providers (MCPs) and primary and acute care systems (PACS); medicines optimisation; and improving the management of continuing healthcare processes

163. We continue to implement a range of demand reduction measures in both planned and unplanned care, that will be delivered at both CCG and STP level.

How we are implementing demand management measures

Demand reduction measure	How we are implementing these measures
Implementing Right Care; elective care redesign; urgent and emergency care reform	▪ We use Right Care to help us identify areas with most scope for care redesign in both elective and urgent care. We will also use the Right Care Wave 2 work to accelerate and extend our work to manage demand and reduce unwarranted variation – see KLOE C7 above ▪ We have also developed plans in both elective and unplanned care to implement service redesign that will improve quality and cost efficiency as well as reducing unwarranted variation between providers – see KLOE C5 above ▪ In addition, there is an STP wide review of clinical policies and procedures to drive greater consistency across the system in the number and type that are normally funded
Supporting self care and prevention	▪ **STP priority number 2 seeks to shift the focus of care from treatment to prevention**. By embedding these changes into new care models, we will unlock the transformative potential of a shift from treatment to prevention through behavioural change. These developments build on the prevention work being undertaken in partnership with Wiltshire Council's Public Health function, with Wiltshire's Director of Public Health sitting on the STP group that is delivering Priority 2. ▪ The STPs work will cover three broad areas and will be linked to place based approaches to development of care that are set out in Priority 1 of the STP: ▫ **Ageing well** – Developing and implementing consistent processes to identify and support people to live independently using a single assessment framework for Safe and Independent Living, harnessing the voluntary sector's consistent approach to assessing frailty, including mental frailty across the footprint. We will also commission fracture liaison services from acute trusts based on national evidence bas ▫ **Tackling obesity** – Implementing a footprint-wide approach to commissioning weight management services – tier 2 to tier 4, starting with tier 4 and including a review of thresholds and the evidence base. Adopting Workplace Wellbeing Charter in all organisations within the footprint, working with other employers and agencies to adopt the initiative. ▫ **Proactive management of Long Term Conditions** – Embedding prevention and self-management along identified LTC pathways, including diabetes, recognising the needs of people with multi-morbidities, and drawing on the support of 'expert' peers within the voluntary sector. Collective campaigns for flu and pneumococcal vaccinations using social marketing to achieve behaviour change ▪ There are also a range of other prevention measures in place that we are expanding and accelerating: ▫ We have successfully bid as an STP to be part of the National Diabetes Prevention Programme, so we are better able to improve prevention measures in this expanding area. ▫ Specific programme areas undertaken through Public Health include cancer, particularly malignant melanoma, alcohol, smoking, dementia, obesity/physical inactivity, diabetes and self harm ▫ Through the Better Care Plan Prevention Programme Board, we also work with partners to develop and deliver interventions for self-management and promote the use of the Wiltshire 'Your Care Your Support' information portal through primary care ▪ Work undertaken by Public Health in Wiltshire is related to local needs which are identified through 20 Local Area Assessments (LAA), based around local market towns and surrounding villages. These "slices" of the JSA identify specific local health and wellbeing needs that can then be addressed through detailed public health plans. The LAAs are also used to develop and target our TCOP actions so they are relevant and impactful at a locality level (See ***Planning 2-3 (NEW)_HIS Service Plan 2017_18 V2-Extract*** and ***Planning 2-3 (NEW)_Service Plan Template Substance misuse CCG***)

Demand reduction measure	How we are implementing these measures
Progressing population-health new care models such as multispecialty community providers (MCPs) and primary and acute care systems (PACS)	▪ The approach within Wiltshire CCG and the STP is to for care to be place based and tailored to the particular needs of population groups. ▪ The development of new care models, whether PACS or MCP will be undertaken through the STP and work is currently at a relatively early stage, although for Wiltshire the direction of travel is very firmly based on MCP ▪ A key feature of new care models that is in place is the focus on high intensity care and care management of patients, so we proactively manage the care needs of patients with extensive and ongoing care needs
Medicines optimisation	▪ We have an ongoing programme of work on medicines optimisation. In 2016/17 we implemented a prescribing incentive scheme and trained over 100 practice staff in measures to reduce unnecessary repeat prescriptions. This resulted in a reduction in cost by Month 5, which showed negative year on year growth ▪ We will continue with the incentive scheme for 2017/18 onwards and work across the STP to reduce duplication and increase consistency ▪ Across the STP there is a proposal to move to a common formulary which will further reduce variation ▪ Area Prescribing Committee (APC) anticipated to be developed from April 2017 to replace three local formularies to further improve prescribing consistency
Improving the management of continuing healthcare processes	▪ We have strong and robust processes to ensure there is appropriate and meaningful engagement with all stakeholders including the Local Authority and most importantly individuals and all their representatives throughout the process of determining eligibility. ▪ However, we acknowledge and are committed to improving the timeliness of positive screening to decision, reflecting the 28 day timescale. This is already a key area of focus for the CCG, which will be further supported through the Quality Premium. ▪ Our ambition is to engage with our Local Authority partners to ensure that there is sufficient capacity within the Council to support each stage of the CHC assessment process and we have jointly funded a dedicated Social Worker to further support improvement. This will continue to be a key area of focus for the CCG during 2017/18 and 2018/19.

164. Our investments in Mental Health will also play their part in reducing demand, for example:

- The extension of Mental Health Liaison services, will help to reduce admissions, particularly for older people (evidence from Royal College of Emergency Medicine, February 2013)
- The implementation of local priorities and investment for Children and Young People in community services will have a positive impact on reducing demand for costly CYP hospital attendances and admissions (See Appendix F for detail)

Increasing provider efficiency

NHS England planning requirement 2.4

Provider efficiency measures include implementing pathology service and back office rationalisation; implementing procurement, hospital pharmacy and estates transformation plans; improving rostering systems and job planning to reduce use of agency staff and increase clinical productivity; implementing the Getting It Right First Time programme; and implementing new models of acute service collaboration and more integrated primary and community services.

165. The relevant areas for Wiltshire CCG are:

- New models of service collaboration
- Integrated primary and community services

New models of service collaboration

166. STP priority number 5 covers acute collaboration, to develop acute services that are sustainable. We are actively participating in this STP workstream, with CCG staff involved in projects that includes:

- Improving resilience in capacity for challenged specialties by collaboratively redesigning care models – this has started across six specialties and will be an ongoing programme of work we are involved in
- Increased resilience opportunity for out of hours clinical support functions supporting the delivery of high quality services and seven day working
- Back office redesign – we are actively involved in the estates workstream as well as investigating wider options for sharing back office support functions, which is facilitated by discussions on how the system can exploit the Lead Provider Framework to extend and accelerate changes in back office functions
- Workforce, which includes developing shared bank and e-roster for acute providers and developing a whole system understanding of the impact on workforce arising from the introduction of new models of care

167. This workstream will also include elements of the Carter Review, with providers expected to meet the challenges of the Carter Review to identify ways of driving down the cost of service delivery, which will include measures around back office redesign and workforce initiatives set out above.

Integrated primary and community services

168. Both the STP and Wiltshire CCG are pursuing greater integration of primary and community services. The key priorities identified by the STP are to:

- Support and grow the primary care workforce
- Improve access to general practice in and out of hours
- Transform the way technology is deployed and infrastructure utilised
- Better manage workload and redesign how care is provided
- Implement the GP Forward View (including the plans for Practice Transformational Support, and the ten high impact changes).
- Ensure local investment meets or exceeds minimum required levels.
- Extend and improve access in line with requirements for new national funding, by no later than March 2019
- Support general practice at scale, the expansion of MCPs or PACS, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes.
- Take a system wide approach with a focus on inequalities within our footprint rather than regional comparisons and take into account key groups (e.g. people with learning difficulties)

169. Our developments in primary care are aligned with these objectives, which are being delivered through our Primary Care Offer, which is designed to:

- Move away from providing care in a transactional activity driven model at individual practice level to a more efficient and effective use of resources.
- Develop a single CCG framework incorporating and aligning all the currently commissioned local enhanced services
- Include patient-focussed quality measures and responsive services;
- Incentivise and drive quality initiatives to reduce unnecessary variation across and between practices' individual clinicians

170. We have already completed transformational developments in primary and community services which are discussed above as part of KLOE C5. Further details on the development of primary care services is in the next section of this plan.

Making it happen

171. We have well developed approaches to financial planning and control that have been shown to be effective. Our annual activity planning process is supported by ongoing management of demand and capacity with hotspot monitoring and deep dive reviews of problem areas so remedial action, where required, is addressing the root cause of problems.

172. We have also made operational changes such as implementing a suite of demand management measures and the introduction of referral management to help smooth peaks and troughs in demand and capacity, where possible using IS providers to help balance workload across the care system.

173. These systems and processes will help us work positively with providers and other partners so that we meet constitutional targets. We acknowledge that in some cases there are challenges in meeting targets. We believe that our systems and processes will help us to work positively with providers, challenging them, as well as supporting them, so they do meet targets and standards.

Section 3 – Primary Care

Summary

174. We recognise the central role that Primary Care plays in access to and the delivery of high quality care. Our Primary Care Offer (PCO) is designed to move away from providing care through a transactional activity driven model based on individual practices towards place based commissioning and development of locality working to deliver Primary Care at scale.

175. The PCO therefore directly supports the development of new integrated care models centred on accountable care, through alignment and integration of Primary Care with expanded Out of Hospital care.

176. We are currently developing the first year of our plan to deliver the GP Forward View, which will be supported by the planned move to delegated commissioning to allow us to drive forward our primary care strategy.

177. Our local investment for enhanced services and Transforming Care for Older People (TCOP) is £9.44m in 2016/17. Alongside this we have set up a series of workforce projects to address workforce and workload issues in Primary Care.

178. We are also improving access to Primary Care by linking together with broader initiatives designed to improve patient flow through the care system, for example through single point of access.

Sustainability of General Practice

NHS England planning requirement 3.1

Ensure the sustainability of general practice in your area by implementing the General Practice Forward View, including the plans for Practice Transformational Support, and the ten high impact changes

Sustaining General Practice through the Wiltshire Primary Care Offer (PCO) 2016-19

179. The Wiltshire Primary Care Offer (PCO) is a proposal to move to a different and more flexible way of commissioning enhanced services from member GP Practices in Wiltshire from April 2016.

180. We believe that moving away from providing care in a transactional activity driven model at individual practice level will result in a more efficient and effective use of resources. Developing a single CCG framework incorporating and aligning all the currently commissioned local enhanced services gives an opportunity to provide more robust, locality based commissioning with patient focussed quality measures and responsive services

181. This approach adds improved incentives and will drive quality initiatives to ensure a reduction in unnecessary variation across our constituent practices and between individual clinicians.

The PCO proposal

The PCO proposal is to:

- Develop a three year programme 2016-2019 (allowing for transition and some pace of change);
- Transform the commissioning, delivery and monitoring of the CCG commissioned enhanced services from GP Practices in Wiltshire, over and above core GMS/PMS services to deliver responsive, safe and sustainable services;
- Move towards “placed based commissioning” and the CCG vision of integrated out of hospital services;
- Support the development of locality working to deliver primary care services at scale to support increased efficiencies, and to address issues of recruitment and retention of a competent, capable and resilient primary care workforce to deliver high quality services;
- Move towards a "block contract" type arrangement - setting out the total funding available for 2016 to cover the specified services to be delivered to meet the needs of their locally registered population in return for meeting the outcomes required (moving from year 1 with KPIs and agreed metrics towards a full outcome based model by year 3);
- Use 2016/17 as a shadow transition year before delegated commissioning of primary medical services from April 2017.

182. A GP Resilience Board has been established led by Executive GPs and supported by LMC to prioritise resilience issues for GP practices across Wiltshire and have oversight of the GP resilience programme and associated funding and GP Development Programme and Transformational Support. (***See Planning 3-1_v1.6 Primary Care Extract JC; Planning 3-1_22.03.16 Governing Body Paper Primary Care Offer; Planning 3-1_Primary Care Update - briefing forPCJCC***).

183. The Board will:

- Work closely with the CCG as a membership organisation to ensure the views and expertise of GPs as providers are heard
- Provide the forum/conduit for the Wiltshire Community Education Provider Network to link with for primary care
- Provide a local co-ordinated approach to practices struggling with workforce issues
- Provide Executive GP leadership of this programme.

Local investment

NHS England planning requirement 3.2

Ensure local investment meets or exceeds minimum required levels

184. The funding for Enhanced Services and TCOP for 2016/17 is £9.44m at the CCG weighted list size of 487,843, giving an indicative price of £19.36 per registered patient (above core contract) [***See Planning 3-1_v1.6 Primary Care Extract JC; Planning 3-1_Primary Care Update - briefing forPCJCC***].

185. All GP practices in Wiltshire have signed up to and delivering all elements within the PCO in 2016/17. Specific working groups are under review such as drug monitoring, leg ulcer management, Care Homes and dementia.

186. Our plans for investment in 2017/18 and 2018/19 were discussed in detail at the Governing Body Seminar in December 2016. Plans include:

- GPIT
- A range of Sustainability and Transformation Package investments
- Funding to improve access to General Practice Services
- The Estates and Technology Transformation Fund (ETTF)

187. The details of the investments are set out in the report to the Governing Body [***See App D2 (NEW) Paper 6 – GP Forward View.pdf***] which details the investments as well as the work of the Community Education Provider Network (CEPN) as well as a comprehensive package of support available to Practices set out in the Primary Care Support Pack.

188. Our intentions for 2017/18 were discussed at our Clinical Executive in December 2016, which included recommendations from the PCO working Groups (drug monitoring, leg ulcers, dementia, care homes and Secondary Care Initiated Procedures), PMS premium reinvestment and GP Access [***See App D3 (NEW) Item 4.1 Clinical Exec PCO Plan 2017-18***]

Workforce and workload

NHS England planning requirement 3.3

Tackle workforce and workload issues, including interim milestones that contribute towards

- increasing the number of doctors working in general practice by 5,000 in 2020,
- co-funding an extra 1,500 pharmacists to work in general practice by 2020,
- the expansion of Improving Access to Psychological Therapies (IAPT) in general practice with 3,000 more therapists in primary care, and
- investment in training practice staff and stimulating the use of online consultation systems

189. We recognise the need to tackle workforce and workload issues in Primary Care [***See Planning 3-1_Primary Care Update - briefing forPCJCC***]. Wiltshire has been allocated £84,000 in 2016/17 to set up a CEPN and to deliver a series of workforce projects that will address workforce and workload issues by:

- Supporting workforce planning
- Responding to local workforce need
- Coordinating educational programmes
- Developing a faculty of trainers
- Supporting development of the existing workforce and foster innovation

190. Two localities are delivering the Clinical Pharmacy Scheme pilots in 2016/17. They are the Devizes locality practices and the SARUM North locality practices in Salisbury. Having shared their experience and learning with their colleagues, a number of other GP practices have expressed interest in bidding for funding for the scheme when it is rolled out in 2017/18.

191. In NEW, this includes practice in the Chippenham locality, and practices in Calne, Corsham and East Kennet. The Westbury/Warminster locality practice have declared their interest in the scheme in West Wiltshire. They have been joined by a central Salisbury practice and a more rurally situated one in SARUM.

Improving access

NHS England planning requirement 3.4

By no later than March 2019, extend and improve access in line with requirements for new national funding

192. Improving access to Primary Care is an important local priority, and one which we are linking to broader initiatives designed to improve patient flows through the system. CCGs are responsible for commissioning to expand capacity ensuring plans in general practice dovetail with plans for single point of contact to integrated urgent care with access with OOH and reformed 111 and clinical hubs over 7 days. Procurement is now live (advert 1st November) for an Integrated Urgent Care Service (with BaNES CCG, Swindon CCG and Wiltshire Council) [***See 3-1_v1.6 Primary Care Extract JC***].

193. An Integrated Urgent Care Access, Treatment and Clinical Advice Service is being piloted in Wiltshire (started 3rd October 2016) to offer patients access to a wide range of clinicians, both experienced generalists and specialists. This is being reviewed monthly, via Severn UECN [***see Planning 3-4_Wiltshire Integrated Clinical Hub Trial***].

194. Wiltshire CCG did not receive any PMCF funding in wave 1 or 2, so we are not anticipating receiving any additional funding until 2018/19. We will meantime be exploring scope to improve access through the comprehensive package of primary care support we are offering to practices [See embedded report 2 in ***App D2 (NEW) Paper 6 – GP Forward View.pdf***]

General Practice at scale and new models of care

NHS England planning requirement 3.5

Support general practice at scale, the expansion of Multispecialty Community Providers or Primary and Acute Care Systems, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes.

How the PCO supports the development of General Practice at scale

195. The PCO moves to a different and more flexible way of commissioning enhanced services from member GP Practices in Wiltshire, which will facilitate the development of General Practice at scale.

196. The underlying rationale was that moving away from providing care in a transactional activity driven model at individual practice level would result in a more efficient and effective use of resources as well as giving an opportunity to provide more robust, locality based commissioning with patient focussed quality measures and responsive services; adding improved incentives and driving quality initiatives to ensure a reduction in unnecessary variation across constituent practices and between individual clinicians.

197. The Offer also supports general practice at scale by commissioning certain services to be provided at scale not by individual practices e.g. leg ulcer care, care homes, and Transforming Care of Older People (TCOP)

How the PCO supports the development of new integrated care models

198. The FYFV anticipated the development of new care models centred on the concept of accountable care – integrated care focused on the needs of local populations.

199. Wiltshire's PCO supports these developments by initiating the move to a full "locality offer" in Primary Care over the next three years, based on capitated or place based budgets including 7 day services, same day urgent primary care hubs, clinical integrated pathways, and agreed estates solutions aligned across the county i.e. not 56 practices, and integrated with other out of hospital services. This

integration provides direct support to the growth of new care models built on the concept of accountable care.

200. Additionally, the PCO supports the development of collaborative organisations with general practice at their heart, such as groups of practices, localities, networks or federations – for a resilient new model of primary care service delivery, whilst maintaining the independent contractor status to improve outcomes for patients [***see Planning 3-1_v1.6 Primary Care Extract JC; Planning 3-4_Wiltshire Integrated Clinical Hub Trial***].

Implementing the GPFV

201. Our Primary Care Offer is the vehicle for implementing the GPFV, with some of the plans discussed above. Our detailed plans for implementing the GPFV are set out in Appendix D.

Making it happen

202. We have strong practice level buy in to the principles of the Primary Care Offer, which will be one of the biggest drivers of change in primary care. The PCO will help primary care in Wiltshire to move away from a transactional activity driven model focused in individual practices to one focused on localities and people's needs within that locality.

203. The changes delivered by the PCO will drive improvements in quality, reduce unnecessary variation and with support from additional investment through the GPFV, help redesign care to improve access, address workforce and workload challenges as well as improving practice infrastructure to facilitate these changes.

Section 4 – Urgent and Emergency Care

Summary

204. Our providers are currently not planning to achieve the A&E standard. We will continue to challenge and support them to develop and put in place remedial action to improve performance.

205. Wiltshire CCG are working in partnership with the wider system through the Wiltshire Local Delivery Board, which has adopted a highly structured programme approach to bring together plans for Urgent and Emergency care that include the four hour standard, the four elements of the A&E improvement plan, the four priority standards for seven day hospital services for urgent network specialist services.

206. We are also working through the Severn Urgent and Emergency Care Network to develop an Integrated Urgent Care Clinical Hub across 999/111/OOH services.

207. Our focus in Urgent and Emergency care covers both physical and mental health. We already co-commission mental health liaison services across the STP with our three principal providers and have received pump priming funds to expand the opening hours for mental health liaison services and to progress towards the 24 hour core standards.

208. We continue to build on our well established partnership with Wiltshire Council through the Better Care Plan, which already delivers a range of successful outcomes including reducing avoidable admissions, reducing longer term placements in nursing and residential homes and a high level of patient and career satisfaction.

Urgent and emergency care standards

NHS England planning requirement 4.1

Deliver the four hour A&E standard, and standards for ambulance response times including through implementing the five elements of the A&E Improvement Plan.

Meeting standards through the Wiltshire LDB

209. Our providers are currently not planning to achieve the A&E standard. We will continue to challenge and support them to develop and put in place remedial action to improve performance.

210. Following the transition of the SRG into the Local A&E Delivery Boards (LDB) from September 2016, it was agreed that there will be three Local Delivery Boards across the STP footprint, each facing one of our three hospitals – and so for Wiltshire, the Delivery Board will now be solely focused on Salisbury.

211. The LDB in Wiltshire has been established with focus to ensure that 4-hour performance is delivered and to oversee the delivery of the nationally mandated A&E Rapid Implementation Guidance for Local Systems issued to Commissioners and Providers at the end of August. The LDB meets monthly with every statutory body, including Local Authorities, having a seat and represented at executive level with the authority to commit to decisions on behalf of their organisation.

STP level co-ordination through the STP Programme Board

212. An Urgent and Emergency Care STP Programme Board has been established with wide stakeholder representation across the footprint. Providing an overview assurance function for the current identified work streams and priorities, the Programme Board meets monthly with fortnightly telephone conference calls between the three CCGS in between to ensure momentum is maintained.

213. The current work stream priorities, identified through a series of workshops earlier this year, incorporate and focus on the delivery of the key “must dos” that feature within existing and the recently published 2017-19 Operational Planning and Contracting Guidance.

214. Work within the STP for Urgent and Emergency Care is and will continue to add value to the existing work currently targeting the delivery of these "must do's" (in particular implementation of the five A&E rapid improvement initiatives) and continuous effort is being made to ensure that duplication of reporting is minimised as a collaborative and information sharing approach across the Footprint is established.

215. Recognising that Wiltshire CCG has significant contractual relationships for system assurance within the BaNES and Swindon health economies, the CCG has director level representation on the LDB's supporting these areas and senior management representation on operational subgroups

216. Wiltshire CCG is also participating in the National Ambulance Response Programme. Consequently, ambulance response times are not included within the CCG contractual framework and are not reported by us [***See Planning 4-1_A&E IMPROVEMENT_WINTER PLAN; Planning 4-1_STP Footprint A&E Local Delivery Board; Two additional documents to come: A&E Improvement in 2016/17 – Rapid Implementation Guidance for Local Systems; Salisbury NHS Foundation Trust – ED Delivery Board Update (October 2016)***].

Priority standards for seven day services

NHS England planning requirement 4.2

By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services

217. We are working to meet the four priority standards by November 2017

- Standard 2: Time to Consultant Review
- Standard 5: Access to Diagnostics
- Standard 6: Access to Consultant-directed Interventions
- Standard 8: On-going Review

Progress at all our principal providers

218. Our three principal providers are currently developing plans to implement these four priority standards for seven day working:

- **At GWH** a business case has been presented to October's Executive Committee, which indicates an overall financial risk of £2.3m. Key priorities have been identified as
  - Securing relevant workforce for MAU 7/7 with 8-8 consultant cover with twice daily reviews
  - Supplementing cardiology workforce to deliver true 7/7 cover
  - Removing respiratory and endocrinology from medical take to provide weekend ward commitment
  - Aligning D&O support service with the three above priorities
- **GWH** have also identified the opportunity of 'caretaking' SEQOL services which will also support further transformation and integration of acute and community services, to support 7 day working. The Trust are also developing innovative workforce approaches to consider new and extended roles for clinical and non-clinical staff. To address lower staffing levels at weekends. A focus on junior doctor workforce is underway with advanced nurse practitioners and a review of prescribing pharmacists is to follow
- **At SFT**, the latest national survey has been completed and benchmark scorers are due from NHS England. The Trust believe they score well across the four highlighted domains and will continue to

develop their plan once they have received the benchmarking results from NHS England, which will confirm the priority development areas

- **At RUH** – the Trust meets the standard with 10 out of 10 relevant clinical areas in the trust report that patients were seen by a consultant within 14 hours 90% or more of the time; 12 out of 14 diagnostic services are available seven days per week and 9 out of 9 consultant directed interventions are available seven days per week

Diagnostics

219. The CCG is working via service redesign work streams to review diagnostic capacity and pathways. The CCG is continuing to commission the Independent Sector for routine activity to release capacity for 2ww. Currently 65% of endoscopy activity is being commissioned from the IS. The CCG is working with acute and primary care clinicians to review GP direct access including MRI and gastroscopies

Priority clinical standards

220. Wiltshire CCG is also working across the STP to analysis the impact of the proposed recommendations from the hyper stroke and STEMI heart attack reports. The CCG has already fed back its concerns regarding the impact on our local population. We will continue to work across the STP so the services being developed are sustainable. This issue is being reviewed by the STP clinical leadership group to develop a forward-facing strategy for 2017/18.

221. Ongoing monitoring of progress and performance against the four priority standards will continue via the contract performance meeting process, as most of the elements are reported through the SDIP. Mortality data is monitored separately, through six monthly reports that include identification of weekday versus weekend trends. Updates have already been requested via this process for 2016/17. Formal updates in relation to the 2020 timeframes will be requested quarterly from 2017/18 onwards. Areas of concerns will also be fed into the relevant Local ED delivery board.

Implementing the urgent and emergency care review

NHS England planning requirement 4.3

Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls.

Improving care by procuring an Integrated Urgent Care service for Wiltshire

222. Wiltshire Clinical Commissioning Group is seeking to procure an Integrated Urgent Care service for Wiltshire. The procurement is driven by the need to secure NHS 111 and GP Out of Hours services for Wiltshire as both contracts will end in March 2018. The contract for the Salisbury Walk in Centre has also been varied and aligned to end at the same time. Nationally and locally, current providers within the emergency and urgent care services are challenged in meeting their contractual requirements and constitutional targets.

223. Maintaining the current service models and specifications within separate contracts does not provide the CCG with any opportunity to manage or improve this performance across the whole system, and thus the clinical outcomes for our patients and whole system resilience are affected.

224. The CCG therefore has an opportunity to commission an integrated solution for urgent care in line with national and local requirements, and ensure a service which is safe, sustainable and that provides consistently high quality in line with the recommendations of the Urgent and Emergency Care Review.

225. The national review states, for those people with urgent care needs, we should provide a highly responsive service that delivers care as close to home as possible, minimising disruption and inconvenience for patients and their families. For those people with more serious or life threatening

emergency care needs, we should ensure they are treated in centres with the very best expertise and facilities to maximise their chances of survival and a good recovery.

Key objectives of the procurement

226. The key objective for us in the procurement is to deliver a more functionally integrated Urgent Care Access, Treatment and Clinical Advice Service model by aligning existing service specifications for NHS 111 and the GP OOH service, in line with the national direction. It is not simply the bolting together of existing services (NHS 111 and GP Out of Hours) but in fact the introduction of a new, functionally integrated service that includes a new clinical advice element: the clinical hub.

227. This model will offer patients who require it, access to a wide range of clinicians, both experienced generalists and specialists. It will also offer advice to health professionals in the community, such as paramedics and emergency technicians, so that no decision needs to be taken in isolation.

228. The clinicians in the hub will be supported by the availability of clinical records such as Special Notes, Summary Care Record (SCR) as well as locally available systems; and co-ordination of health and social care resources, OOH, community and social care beds, palliative care, acute trust liaison, and Health Care Professionals.

229. The procurement will therefore include all the aspects set out in planning requirement 4.3 above [***See Planning 4-3_Governing Body_Integrated Urgent Care Procurement; Planning 4-3_SUECN_Integrated Clinical Hub (ICH) Trials and next steps– August; Planning 4-3_Wiltshire Urgent Care Procurement_High level***].

999 calls and avoidable transportation to A&E

NHS England planning requirement 4.4

Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department.

230. SWASFTs performance in this area is good as they have the second highest rate in England for resolving:

- Calls that receive a telephone or face-to-face response, by telephone advice (Hear and Treat) – SWASFT = 14.1%; England 9.4%
- Calls that receive a face-to-face response from the ambulance service, managed without need for transport to Type 1 and Type 2 A&E (See and treat) – SWASFT = 48.7%; England 38.3% (*https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-quality-indicators-data-2016-17/ - Ambysis Indicators, September 2016, Calls closed without transport)*

231. The CCG as part of the collaborative commissioning arrangements in place with SWASFT are working to further increase Hear and Treat and See and Treat rates. The implementation of NHS Pathways within SWAST North Division should improve these rates.

232. SWASFT have a clinician with the CARE UK NHS 111 service reviewing ambulance dispositions and CARE UK have additional clinical models in place to review low acuity ambulance dispositions. We are in discussion with SWASFT for MiDos to be made available to paramedics to allow them to access alternative services from their electronic patient record device, rather than transporting patients to A&E as the default approach [***See Planning 4-4_Ambulance Response Programme Comm Briefing; Planning 4-4_Call Answering Performance Briefing***].

Waiting time standard for people in mental health crisis in urgent care

NHS England planning requirement 4.5

Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis.

Approach to meeting the standard

233. To meet the waiting time standard for urgent care for those in a mental health crisis, the focus has been on implementing robust mental health liaison (MHL) services within A&E departments. This has been done across the STP patch and the three CCG teams collaborate and share best practice through the Mental Health Liaison network which meets quarterly.

Actions to meet the standard

234. Wiltshire CCG Commission and co-commission three mental health liaison (MHL) services with respective CCGs:

- SFT MHL
- RUH MHL (BANES CCG)
- GWH MHL (Swindon CCG).

235. Wiltshire CCG conducted a review of the three MHL services in 2015/2016. The recommendations of the review reflected PLAN accreditation and Royal College of Psychiatry Standards for MHL services, and aimed to achieve parity in service provision for Wiltshire residents across each of the services [***See Planning 4-5_DRAFT Acute Mental Health Liaison Service Review***].

236. The recommendations of the review were supported by the CCG and have been implemented by the services enabling parity in response times for emergency, urgent and routine referrals, and A&E presentations.

237. Furthermore, Wiltshire CCG worked in partnership with respective CCGs and submitted a successful proposal to NHSE for pump priming funds to expand MHL operation hours and to progress towards Core 24 service standards, with expansions based upon A&E activity. The operational hours of services are now as follows:

- SDH 8-8 core service, 8-midnight Thursday to Sunday, matched against activity. OOH emergency assessments completed by SWIDS. Review of extended hours impact commenced, due for presentation at Dec MH & D JCB, this will determine whether further extension is warranted.
- GWH 8-10 7 days a week. Swindon Intensive Team to be based in ED from 10pm until 8am. Commencing from 1/11. The success of this will be reviewed after three months
- RUH 8-8 core hours, commence extension until midnight Q3 2016. OOH emergency assessments completed by BANES Intensive team. The success of this will be reviewed after three months

238. From December 2016, the SFT MHL team will respond to all Emergency referrals within 1 hour. GWH and RUH are working towards this standard during 2017/18.

239. As the extended hours of operation has been implemented in SFT since June 2016 the impact of this is currently being reviewed by the CCG to determine whether additional expansion is required. This review will be presented to the Mental Health and Disabilities Joint Commissioning Boards 20/12/2016.

240. MHL performance is monitored through quarterly steering groups and Local CQPMs as requested.

Better Care Fund

241. We have a well established Better Care Plan, led by a jointly appointed (between Council and CCG) Director of Integration, which already delivers good outcomes.

Examples of successful improvements in outcomes delivered by the BCF

Focus area	Improved outcome
Patients being cared for in the right location	• Rate of avoidable admissions admitting to hospital at its lowest for the last 2 years for frail elderly. We are maximising opportunities to case manage and admission avoid. This aligns with a message there has been an increase in high acuity admissions to our hospitals. • 11% reduction in emergency admissions from care homes • Reduction in the number of deaths in hospital which is currently 37.8% (lowest in region)
Longer term independence for our service users	• Volume of long term placements to nursing and residential care continue to fall and is below the BCF target • More Wiltshire residents remain independent 91 days post discharge, performance through our Integrated Teams is currently 87.5% • Throughput and outputs in ICT remain strong
Higher level of patient and carer satisfaction	• Over 80% of Wiltshire residents surveyed said they were very satisfied with the service they have received

242. Going forward, our work facilitated by the BCF focuses on seven key areas, with a key theme of enhancing Out of Hospital capacity, for example through Intermediate Care, Urgent Care at Home and Wiltshire Integrated Discharge Service.

Forward developments facilitated by the BCF

Focus area	Actions underway
Intermediate care	• A new model of 70 cohorted intermediate care hospital beds have been launched and length of stay in these beds has been sustained, which improves patient flow. • A process of trusted assessment between providers has been initiated with dedicated community therapists working on an 'in reach basis' in the acute hospitals serving Wiltshire patients
Admissions avoidance	• Focus has been maintained on the 'front doors' of acute hospitals by partner providers engaged in the BCF with the aim of preventing unnecessary admissions
Step up care	• A new model of step up beds has been introduced. The model provides an enhanced level of care to that delivered to patients in their own homes and prevents unnecessary admission to acute hospitals
Urgent care at home	• Through the provision of services by the providers of adult community services and general practice out of hours, more patients in need of urgent care in their own home are better able to access the services they require over a seven day period
Community geriatrics	• Close working with consultants at the three acute hospitals serving Wiltshire has led to enhancements in the provision of geriatric care in the community

Focus area	Actions underway
Wiltshire Home First	• Wiltshire is supporting the roll out of an Integrated Discharge service model being adopted across the county by our 3 acute providers in partnership with our community provider, adult social care and other key stakeholders. The model aims to identify patients earlier in the acute setting for discharge home under the care of an appropriate community resource. • The service is having a number of key benefits which include improved MDT working, changes to existing culture of integrated working and reducing dependency and increasing longer term independence of clients once we discharge them home
72 hour pathway for end of life care	• The out of hours general practice provider continues to work in partnership with the hospices serving Wiltshire to provide an enhanced Urgent Care @ Home Service for patients at the end of their life. Initially Dorothy House and Prospect Hospice are providing an additional carer to the pool of staff available for the UC@H service. • They are available twenty four hours a day, seven days a week and are providing care for palliative patients (patients within the last year of life).

Improving patient flow and reducing delayed transfers of care

243. Across the BCP there is commitment to reduce the amount of time people spend in hospital by discharging them quickly ideally to their own place of residence. We believe that patients recover better and transition to independence quicker in their own homes and our aim is to move patients from hospital as soon as they medically fit and ensure that no decisions around long term care are made in a hospital setting.

244. To deliver on this ambition we have put in place a number of initiatives:

- 70 cohorted ICT beds across 9 locations. Providing active rehabilitation and support for patients between hospital and home
- The urgent care at home programme that supports patients flow through the system 24/7
- The integrated discharge programme and strategy which is in place across Wiltshire and has led to the development of integrated discharge teams in each of the 3 acute hospitals.
- Launch of the Rehab Support Workers programme in partnership with Wiltshire Health and Care. Rehab Support Workers, which will provide a full assessment and rehabilitation programme so that people discharged from an acute hospital, a community hospital or from an Intermediate care bed will be helped to improve their health and well-being, reducing their long term dependency on care, avoiding readmission to hospital or admission to a care setting
- Relaunch of the DART programme at GWH
- Enhanced discharge support through the 72 hour pathway for patients who are palliative or end or end of life

Making it happen

245. We are building on our track record of improvement in urgent and emergency care to continue to drive down demand. Our partnership with Wiltshire Council through the Better Care Fund, plus our continuing programme of Transforming Care for Older People initiatives mean we have an established approach with underpinning plans and commitments to change and improve the way care is provided by shifting care into Out of Hospital settings.

246. We have the Primary Care Offer in place across all Wiltshire GP practices, which is supporting general practice at scale with the development and enhancement of services across the localities. The focus on resilience in general practice is key to ensure the ability of primary care to support the out of hospital strategy

247. These changes have already improved care and the further expansion of Out of Hospital care will have a positive impact across the care system for example through focus on issues such as DTOCs.

248. Our procurement of an Integrated Urgent Care service for Wiltshire will deliver a more functionally integrated service, which will bring further improvements in care from April 2018, when the new service is planned to go live.

249. The key objective for us in the procurement is to deliver a more functionally integrated Urgent Care Access, Treatment and Clinical Advice Service model by aligning existing service specifications for NHS 111 and the GP OOH service, in line with the national direction. It is not simply the bolting together of existing services (NHS 111 and GP Out of Hours) but in fact the introduction of a new, functionally integrated service that includes a new clinical advice element: the clinical hub. This model will offer patients who require it access to a wide range of clinicians, both experienced generalists and specialists. It will also offer advice to health professionals in the community, such as paramedics and emergency technicians, so that no decision needs to be taken in isolation

250. Our partnerships – working through Wiltshire and other Local Delivery Boards, service trials through the Severn and Wessex UECN and co-commissioning of Mental Health Liaison services demonstrate an ongoing programme of collaborative action that will continue to drive improvement in urgent and emergency care.

Section 5 – Referral to Treatment times and Elective Care

Summary

251. We are committed to meeting constitutional standards for Referral to Treatment times and proactively monitor provider performance to identify areas where their performance is deteriorating and standards may not be met. We then work with providers to develop remedial action plans and hold them to account for the timely and complete delivery of those plans.

252. Wiltshire CCG is leading system wide redesign of planned care for the BSW STP, concentrating on selected specialties where there is scope to streamline care pathways. We are also rolling out Patient Initiated Follow Ups to avoid unnecessary follow ups.

NHS Constitution standards

NHS England planning requirement 5.1

Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT)

253. Current plans show that in Wiltshire the aggregate position for all providers against the constitutional standards shows that the 92% standard will be achieved, despite the RUH underperforming for seven months during 2017/18. The remedial action being developed with the RUH has been discussed previously under KLOE B1.

254. Wiltshire CCG is leading STP wide work on developing RTT trajectories for the next year to deliver the 92% standard. The initial aim will be to ensure Trust and organisational wide delivery – concentrating on three specialities where delivery will not be at 92% for 2017/18 due to a combination of operational, workforce and financial pressures. The three specialties are:

- SFT – T&O, plastics and oral
- GWH – T&O, gastroenterology and general surgery
- RUH – T&O, gastroenterology, dermatology)

255. This will allow focus in all other specialities to support delivery. These trajectories will be drafted by November 2016 and will link with STP demand and capacity intelligence.

256. The CCG has a suite of actions in place regarding pre-referral demand management and commissioning of alternative pathways to deliver the constitutional target. This will roll forward into the next financial year. Such actions include the commissioning of community surgical services and creation of a single point of access for all referrals (see Section 2, KLOE B1).

Outpatient appointments

NHS England planning requirement 5.2

Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018.

257. Wiltshire CCG is leading the STP demand management work stream. This includes E-referrals and identification and mobilisation of actions to achieve the 100% trajectory by April 2018.

258. Wiltshire CCGs current trajectory for e-referrals is to:

- Achieve 80% in October 2017
- Achieve 100% in March 2018
- Continue to achieve 100% from April 2018

259. Patient choice is also a focus for this work stream with early agreement that all elective referrals will flow through a referral management process where the choice discussion will take place. E-referrals have been confirmed as the enabler for the demand management work stream with processes being defined for rejection of paper referrals.

260. Compliance is being reviewed at organisational and GP practice level with Directory of Service discussions ongoing. The STP demand management group will oversee compliance and delivery of actions linking into required contract and locality meetings.

Elective care pathways

NHS England planning requirement 5.3

Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups

261. Wiltshire CCG has key service redesign work streams in place linked to the STP wide planned care programme. These include MSK, Cardiology, Rheumatology, Gastroenterology, Pain and dermatology (Appendix A)

262. The CCG has also rolled out Patient Initiated Follow Ups (PIFU) in surgical pathways across providers by use of the contractual measures. It is planned that volumes of PIFU will be extended next year to encompass additional specialities.

National maternity service review "Better Births"

NHS England planning requirement 5.4

Implement the national maternity services review, Better Births, through local maternity systems

263. We are leading the Maternity Forum which has been established across the STP footprint. Meetings have commenced and the terms of reference and membership of the group have been drafted. This Forum will link directly into the STP Planned Care Programme Board.

264. There is increased focus on maternity services via the Improvement and Assessment Framework and the four key areas of focus for the STP group are:

- Neonatal and still birth
- Maternal smoking at time of delivery
- Women's experience
- Choice in maternity services

265. In addition to these four areas, the forum is asking for the opportunity to evaluate the services provided across the STP more generally to identify ways to work together across the patch to improve maternity services. There is a range of local and national drivers for change which have highlight areas of inconsistency in service provision and practice across maternity services.

266. The next stage of this work will include engagement of local people in some early evaluation work which has already started. Our aim will be to ensure that the services we offer can sustainably meet the needs of our women, families and staff and are equitable and appropriate across the STP footprint. This forum is being used as the vehicle to review the self-assessments following the better birth recommendations and STP wide action plan developments.

267. The initial focus for the Maternity Forum will be reviewing opportunities in relation to the triage of woman in labour and reviewing how we offer choice.

Making it happen

268. As a CCG, we have an ongoing focus on Referral to Treatment times and improvement of planned care. We will continue to develop and implement plans not just at CCG level but also at STP level to improve operational performance in planned care as well as changing the way planned care is delivered through service redesign across multiple pathways, which will improve speed of access and treatment.

269. This builds on previous service redesign work where we have worked with providers to improve care delivery, which will now be scaled up to cover a wider range of specialties and a wider geography, encompassing the whole STP area.

Section 6 - Cancer

Summary

270. Wiltshire 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.

271. We are part of 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, not just for Wiltshire's patients.

272. We will also work with providers to successfully meet the NHS constitution 62 day cancer standard

Implementing the cancer taskforce report

NHS England planning requirement 6.1

Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report

How we work across the system

273. Wiltshire CCG will continue to work actively with commissioning and provider colleagues in the three cancer alliances to which we have patient flows (Somerset, Wiltshire, Avon and Gloucestershire [SWAG], Wessex, and Thames Valley) under agreed STP arrangements, to help deliver the requirements of the national cancer strategy [***See Planning 6-1_SWAG Cancer Alliance Board Meeting; Planning 6-1_Wiltshire CCG Cancer Strategy Implementation Approach***]. A CCG has been designated as the STP representative for each of the three alliances:

- B&NES CCG will represent the STP in the SWAG Alliance
- Swindon CCG will represent the STP in the Thames Valley Alliance
- Wiltshire CCG will represent the STP in the Wessex Alliance

274. Wiltshire CCG represents the STP in the Wessex Alliance (See ***Planning 6-1 (NEW)_Wessex Cancer Alliance - form and function***), which meets on a quarterly basis. A total of sixteen members make up the Wessex Alliance, with selection designed to represent the key stakeholders required to deliver on the Cancer Strategy:

- Local primary and secondary care trusts
- CCGs
- Health Education Wessex (HEW)
- Public Health
- NHS England

275. A local cancer patient chairs the Wessex Alliance on a voluntary basis, to ensure the Alliance adopts a patient-centred approach in its work.

276. Wiltshire CCG has signed a Memorandum of Understanding (MOU) with NHS England (Wessex) (See ***Planning 6-1 (NEW)_20160722 Memorandum of Agreement_Wessex Cancer Alliance - Wiltshire CCG***). The MOU confirms that the Wessex Alliance will not have executive powers, but will instead support the STP in the delivery of the Cancer Strategy objectives, with a focus on:

- Patient-centred cancer service planning
- Pathway design across the patch
- Provision of support for service improvement
- Measuring outcomes (done through the CCG Assessment Framework and integrated Cancer Dashboard)
- Public engagement for effective communication around service change

Moving from planning to delivery

277. Care is being taken to ensure we build on what is already being done and avoid duplication. We have an agreed Alliance-specific action plan aimed at delivering the cancer strategy. Our quarterly meetings are designed to track progress against those actions and define next steps (See ***Planning 6-1 (NEW)_Wessex Cancer Alliance - Action Plan July 2016*** and ***Planning 6-1 (NEW)_Wessex Cancer Alliance - national 96 recommendations summary***).

278. The requirements of the taskforce report are set out in the NHS England Guidance for Cancer Alliances and the National Cancer Vanguard. These requirements are being implemented by our Cancer Alliances. The Alliances are gearing themselves up to deliver the local recommendations as defined in Annex A of the Guidance. We are awaiting a final version of the Guidance and the Alliance will adapt its structure and determine its work as required by the Guidance once published.

279. In line with provisional NHS England Guidance for Cancer Alliances and the National Cancer Vanguard, the Alliances are working to have local action plans approved by the three respective Cancer Alliance Boards and the relevant STP leads. The local action plans will be submitted to NHS England by March 2017 [see ***Planning 6-1 (NEW)_DRAFT guidance for Cancer Alliances and the National Cancer Vanguard***].

280. Action plans will detail how we will deliver on each of the five cancer taskforce report priority areas:

- Prevention
- Early diagnosis
- Treatment and care
- Living with and beyond cancer
- Enablers

281. We will also will continue to work with providers using Cancer Alliance expertise to identify opportunities for pathway redesign to align with national guidance and best practice through both formal and informal collaboration. Examples might include:

- Prostate (MRI first)
- Colorectal (straight to test)
- Lung (national optimal pathway)

282. Each Action Plan will include the five dimensions requested in NHS England guidance:

- The vision driving the local plan
- The governance arrangements overseeing the plan's delivery

- The specific delivery actions over the period 2017/18 – 2020/21
- The 2017/18 financial and resourcing plans and requests underpinning delivery
- Whether we will bid for further Cancer Transformation Funding to support delivery

283. Once these plans are agreed, we will monitor and report on performance against the plans in line with NHS England Guidance which is expected shortly.

284. The national cancer vanguard is not relevant to Wiltshire CCG because Wiltshire is not working within the national cancer vanguard programme.

NHS Constitution cancer standard

NHS England planning requirement 6.2

Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity and the other NHS Constitution cancer standards

285. Cancer standards performance will continue to be monitored monthly and areas of concern will be addressed with providers via the RTT Assurance Meetings. This is covered in detail in the previous section of this document which shows how we plan to meet constitutional standards (***See Section 2, KLOE B1***).

286. Provision of diagnostic capacity is a national and cancer alliance priority which we will continue to actively support.

Survival rates

NHS England planning requirement 6.3

Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

287. Wiltshire CCG's Cancer strategy 2016-2020, which was developed in early 2016, details the approach to delivering this target by promoting early diagnosis to identify cancers earlier, when the benefit of treatment is greatest (See ***Planning 6-3 (NEW)_Cancer Strategy - V0.2***)

288. Implementation of the CCG's cancer strategy, which is based on the national strategy, will support improvement in one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission [***See Planning 6-1_Wiltshire CCG Cancer Strategy Implementation Approach***]. Actions supporting this requirement mainly fall under the Working Area "Early diagnosis" within the attached Implementation Plan, which tracks progress against each. Wiltshire CCG plays either a supportive or leading role in each case. Actions fall under three main headlines:

Actions to improve cancer diagnosis rates

Headline	Action
Intelligence gathering and monitoring	Measure activity and conversion data to evaluate "Be Clear on Cancer" campaign (which is designed to encourage patients to visit their GPs if they experience a range of defined symptoms that could indicate cancer) Monitor providers against national targets and follow up with RAPs when appropriate

Headline	Action
Pathway re-design	Engage practices and gather their views on work needed to support pathway re-design for direct access diagnostics Support efforts to re-design pathways to achieve earlier diagnosis and meet the four-week diagnostic standard, including through implementing standardised two week wait referral proformas which ensure patients are seen in a timely way and within the appropriate setting
GP education, advice and guidance	Consider GP Advice & Guidance services specific to Cancer Run education events focused on reducing variation in referral behaviour across GP practices, including through encouraging use of the standardised two week wait referral proformas

289. Increasing the % of cancers diagnosed at stage 1 or 2, and decreasing the amount of cancers diagnosed following an emergency admission, are two existing nationally reported measures. However, the data reporting has a time lag of 2.5 years or more. Therefore, it is not currently possible to record the impact of year-on-year improvement arising from recent actions.

290. SWAG Alliance is taking this up with NHS England to get faster data reporting. In parallel, the CCG has requested Trusts to investigate whether they can record and report this information faster at a local level.

291. The requirement for a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission is part of the emerging workplan for the SWAG Cancer Alliance and the Bath Swindon Wilts STP Cancer Group. Data to show the improvement will also form part of the SWAG Cancer Alliance dataset for regular performance reporting.

Follow up pathways for breast cancer

NHS England planning requirement 6.4

Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types.

292. Provisional NHSE Guidance for Cancer Alliances and the National Cancer Vanguard states that all breast cancer patients should have access to stratified follow up pathways of care in 2017/18. Depending on evidence from pilots, this should be extended to prostate and colorectal cancer patients from 2018/19.

293. This will be developed as part of cancer alliance guided work to implement these requirements within provider Trusts, informed at RUH by the Living With and Beyond Cancer board, supported via the STP cancer group (Bath Wilts & Swindon Cancer Group) and in line with national cancer strategy and planning guidance.

294. Wiltshire is represented on the SWAG Cancer Alliance, Thames Valley Cancer Alliance and lead STP representative on Wessex Cancer alliance, where meetings are now being planned and this issue is on provisional work plans.

295. Wiltshire CCG is represented on the RUH Living with and Beyond Cancer Board, which has already met twice and will put stratified follow up pathways into practice within nationally defined timeframes once these are confirmed in the revised NHS England Guidance.

296. Wiltshire CCG is also a leading member of BSW Cancer Group taking rotational chairing of that working group and is working towards the same aim [See ***Planning 6-1_SWAG Cancer Alliance Board Meeting; Planning 6-1_Wiltshire CCG Cancer Strategy Implementation Approach; Planning 6-4_Bath and Wiltshire Cancer Forum Notes and Actions - June 2016; Planning 6-4_RUH LWBC Project Board Notes and Actions - July 2016***].

297. Finally, the stratified follow up pathway requirement is being captured in contracts with providers for 2017/18 as part of a workstream to implement patient initiated follow-ups, which seeks to ensure that follow-up appointments are only held where necessary.

Commissioning the recovery package

NHS England planning requirement 6.5

Ensure all elements of the Recovery Package are commissioned, including ensuring that

- All patients have a holistic needs assessment and care plan at the point of diagnosis;
- A treatment summary is sent to the patient's GP at the end of treatment; and
- A cancer care review is completed by the GP within six months of a cancer diagnosis

298. Commissioning all elements of the Recovery Package will be developed as part of Cancer Alliance guided work to implement all elements of the Recovery Package within provider trusts. At RUH, this will be informed by the Living With and Beyond Cancer board, supported via the STP cancer group (Bath, Wiltshire & Swindon Cancer Group) and in line with national cancer strategy and planning guidance [***see Planning 6-1_SWAG Cancer Alliance Board Meeting; Planning 6-1_Wiltshire CCG Cancer Strategy Implementation Approach; Planning 6-4_Bath and Wiltshire Cancer Forum Notes and Actions - June 2016; Planning 6-4_RUH LWBC Project Board Notes and Actions - July 2016***].

299. NHS England Guidance for Cancer Alliances and the National Cancer Vanguard outlines the availability of national funding to support the cancer transformation programme over the next four years. Details of how to bid for funding are yet to be provided. However, the purpose of the fund is to support the development and delivery of Cancer Alliance plans and thereby the achievement of the national cancer "must-do's" including early diagnosis, survival rates, recovery package, etc. Once details of how to bid are confirmed by NHS England this will be taken forward on a CCG/STP/Cancer Alliance basis.

Making it happen

300. We are committed to working with our providers to deliver the NHS Constitution 62 day cancer standard to make current services provision as effective as possible. We are also working actively with our partners, both commissioners and providers within Wiltshire and across the wider STP to improve services along the whole care pathway.

301. This active partnership will improve care from diagnosis to treatment to follow up aftercare. By shifting elements of care into out of hospital settings, people will also receive more holistic care that is more accessible and convenient to them.

Section 7 - Mental Health

Summary

302. Mental Health service development is a key priority area for Wiltshire CCG. We plan to deliver in full the implementation plan for the Mental Health Five Year Forward View for all age groups alongside access and quality standards.

303. We will increase baseline mental health spend to facilitate delivery of the Mental Health Investment Standard.

304. Our Local Transformation Plan for Children and Young People's Mental Health and Wellbeing has put in place a range of investments in community services that will reduce demand for costly hospital admissions for self harm and mental health conditions for 11 to 18 year olds, with a planned reduction of 3.5% in 2017/18 increasing to 6.5% by 2020/21.

305. We are also working closely with our partners in the STP so that our developments are tied into the workstreams and project plan being developed through the STP. This will ensure that mental health services operate at scale across the STP to deliver system wide pathways of care. From December 2016, Operational leads from each CCG, Public Health and Local Authorities will be working together to operationalise the plans agreed by all parties in the STP.

Psychological therapies

NHS England planning requirement 7.1a

Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with physical healthcare

Current performance

306. Wiltshire CCG's monthly performance report shows that services are already delivering above the 19% target access rate: 19.2% in July 2016, 22% in August 2016 and 23.1% in September 2016. The trend is expected to continue.

307. In terms of the IAPT recovery rate, our most up to date figures show that the 50% target was not met in Q1 2016/17, although in October 2016, our performance showed we had achieved the 50% target in month. Following a comprehensive review, NHSE's Intensive Support Team made recommendations which were integrated into Wiltshire CCG's Service Innovation Initiative Plan (SIIP) document. These recommendations also informed the reconfiguration of the service model which was introduced into the contract in April 2016.

308. We are confident that we will comply with or exceed the IAPT target of 50% for recovery rates in 2017/18 and 2018/19 [***see Planning 7-1a_NHS Wiltshire CCG Final Oct16; Planning 7-1a_Service Improvement Initiative plan***].

Reconfiguring services

309. The reconfiguration is focused on delivering NICE compliant IAPT services, enabling a more robust referral and treatment pathway through IAPT.

310. The service reconfiguration is also one part of the response to the workforce challenge which Wiltshire is grappling with. The challenge – which is nationally recognised - relates to high turnover and retention and recruitment of workforce: particularly lower intensity therapists. These recruitment and retention issues have reduced the capacity of the service. The CCG is working with the service to reduce, through a phased approach, the range of services offered (41 different courses) to the pure IAPT service model of 8 standard courses from April 2016, and to introduce a centralised booking system.

Recruitment and retention

311. The recruitment and retention issue is also being actively addressed through the 2016/17 contract refresh round.

312. This will be monitored via the multi-lateral contract management governance arrangements and the local AWP contract management governance arrangement. These arrangements will include establishing a Workforce Review Working Group to drive forward the recruitment programme for AWP and will feed into the local AWP contract management structure. AWP are also linking with STP-level workforce group and Wiltshire-based WAG group to address these workforce challenges.

313. We are actively tracking recruitment and retention through our monthly monitoring meetings with AWP, using a comprehensive action plan that includes details of vacant posts, adverts placed and interviews planned. The plan also encompasses contractual changes and training which are designed to address staffing and recruitment issues.

314. In December, AWP will submit a plan that details recruitment trajectories to fill the posts identified in the recruitment and retention action plan. This will remain a focus of monthly monitoring meetings and if plans do not address recruitment issues, then further measures will be put in place during 2017/18 so staffing shortfalls are resolved.

315. The SIIP also encourages greater integration with physical health care through a range of training schemes.

Services for children and young people

NHS England planning requirement 7.1b

More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of Children and Young People Improving Access to Psychological Therapies (CYP IAPT) by 2018

Building capacity and capability across the overall CAMHS system (including system transformation delivered through the CYP IAPT)

316. Through the implementation of our refreshed Local Transformation Plan for Children and Young People's Mental Health and Wellbeing (See ***Planning 7-1b (NEW)_Draft Wiltshire CCG LTP CYP Mental Health and Wellbeing 2016 2017cf 4***), we aim to meet the 32% target in 2018-19 (currently projected to reach 32.2%). Wiltshire CCG's estimates indicate that we are working from a 2016-17 baseline of 25%, and our Transformation Plan is geared towards expanding access to evidence-based services by 7% in real terms in each of 2017-18 and 2018-19. We are endeavouring to reach 35% by 2020-21. To succeed, we will focus on workforce development, enhancing early intervention, embedding CYP IAPT, implementing enhanced 24/7 crisis resolution, liaison and home treatment.

317. Wiltshire's CAMHS provider, Oxford Health NHS Foundation Trust is the lead service partner within the CYP IAPT Oxford and Reading Collaborative. Through the delivery of primary and specialist mental health services for children and young people, the Trust provides access to a range of evidence-based/NICE approved treatments and interventions, including Cognitive Behavioural Therapy (including Dialectical Behavioural Therapy and CBT-E), Multi-Family Therapy; Systemic Family Therapy and Interpersonal Therapy. Routine Outcome Monitoring has been rolled out to all Wiltshire CAMHS teams.

318. IAPT training is currently limited to professionals working in CAMHS. In 2017, as part of its refreshed Local Transformation Plan for Children and Young People's Mental Health and Wellbeing, Wiltshire CCG will work with the CYP IAPT Oxford and Reading Collaborative and the CYP IAPT South West Collaborative to extend IAPT training to those professionals within Local Authorities, schools, and the voluntary and community sector working with children and young people (e.g. school and community

based counsellors, educational psychologists, health visitors and school nurses). A dedicated budget has been allocated to CYP IAPT training for 2017-18.

319. We will begin monitoring take-up of the training and seeking feedback from professionals receiving this training in 2018. Success will be measured in terms of the degree of training take-up and the extent to which professionals report feeling more confident in delivering low level interventions as a result. If our approach is successful, we would expect to see less referrals and admissions to specialist mental health services by 2021. This is in line with the national vision and will be monitored using Public Health indicators.

320. The ultimate objective of developing and delivering a joint agency workforce strategy including IAPT training provision, is to build more capacity and capability within CAMHS overall. The strategy's development is overseen by the local Workforce Action Group. A draft version of the strategy is attached (See ***Planning 7-1b (NEW)_CAMHSworkforceplandraftv1.0***), and a detailed five-year Workforce Strategy will be completed by April 2017. Building capacity and capability into CAMHS is key to meeting and maintaining performance against the target of at least 32% of children with a diagnosable condition being able to access evidence-based services by April 2019, including all areas being part of CYP IAPT by 2018. Our workforce strategy is a fundamental component of this capacity and capability building.

Treatment for first episode of psychosis

NHS England planning requirement 7.1c

Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral.

Current compliance with the standard

321. Against the 50% referral to treatment target, the Wiltshire EIP team achieved 80% compliance for November 2015. Between July and October 2016, the compliance rate ranged between 84.6% to 100%. Due to the small numbers of people accessing the service and the fact that it is subject to monthly review, the service is vulnerable to breaches (fluctuations can lead to large % changes reflecting small numbers). AWP's current performance (October 2016) is 91.7% in this area.

322. Based on performance over the past year, we expect to achieve or exceed the 50% referral to treatment target.

Developing early intervention services

323. Wiltshire CCG ring-fenced £104,000 parity of esteem funding in 2015/16 to work with AWP to develop the Early Intervention in Psychosis service to meet national guidelines by enhancing workforce capacity and therapeutic skills.

324. As of December 2015, the team introduced a duty rota system which will enable assessments to be offered within 72 hours of referral receipt, and therefore the allocation of care co-ordinator to take place. Achievement of the referral to receipt of assessment and care co-ordination allocation occurring within two weeks will still be at risk from delays caused by delayed identification of psychosis by other teams, and delayed onwards referral to EIP. However, the team remain confident that they will sustain achievement of, and exceed, the 50% target due to their robust allocation system.

325. Since the new rota system was put in place, AWP have either met or exceeded the 50% target.

326. With the introduction of the duty system and recruitment of two additional band 5 care co-ordinators to the team, the capacity of those with NICE compliant skills and ability to deliver NICE compliant interventions has increased. The team can deliver in excess of 1,800 CBT sessions (over 3 years), and 1,280 are required to support their full caseload. [***see Planning 7-1c_05 Early Interventions for***

Psychosis Implementation Plan 2016a; Planning 7-1c_21.10.16 AWP CI Framework letter 2017-18 FINAL signed PDF].

Reviewing service performance

327. A service review was completed by Wiltshire CCG during 2016/2017, focusing on the services' performance against the Psychosis and Schizophrenia Quality Standards [QS 2015]. This informed a business case which presented an options case to enhance service capacity and workforce skill to a level predicted to enable compliance with the RTT and relevant quality standards. The business case also considered how to future proof the service by proposing capacity required to enable additional staff to attend accredited training courses. The preferred option within the business case was supported and additional staff are being recruited [***see Planning 7-1c_EIP Businesscase 23 6 2016 v2***].

Workforce risks

328. It is believed that at present the key risks for meeting the target are around workforce – and specifically ensuring that there are clinicians in place with the right skills to meet the standards. Additional staff have been enrolled in training courses (two people are taking the CBT course) to provide enough capacity over the coming two years as long as no one leaves in that time (it takes two years to qualify) and all staff are trained in family intervention course. There is, however, a potential future risk around the family intervention course as the NHS currently does not have plans to continue to provide this [***see Planning 7-1c_EIP Businesscase 23 6 2016 v2***].

329. AWP and WAG discussions around workforce challenges are ongoing.

EIP RTT standard developments

330. The EIP RTT standard has been set out in the 2017-2019 Commissioning Intensions letter. It is intended that an amended service specification will be agreed and part of the 2017-2019 Contract. EIP service performance is monitored at the monthly local AWP CQPM and Multi-lateral CQPM meetings.

331. The EIP team are actively participating in Matrix submissions for the South Region's EIP Programme, which measures the success of interventions.

332. Key highlights of the most recent Matrix Report [***see Planning 7-1c_AWP-Wiltshire EIP Summary Report***], are the "Outstanding" rating for RTT services, family interventions, employment and education and smoking cessation and "Good" rating in relation to CBT for psychosis. The two areas for improvement which were highlighted, Physical health and carer education programmes, will be addressed through the service expansion.

333. An AWP Trust wide EIP task and finish group was established in July 2016. Monthly meetings facilitate development of a system level approach in parity of compliance with standards, and recommendations to develop RiO recording and reporting of EIP activity against the required standards.

Individual placement support

NHS England planning requirement 7.1d

Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline

334. NHS England are conducting a baseline audit to confirm the 2017/18 baseline that is set out in the target. This work will be completed by the end of March 2017 and the results used to select STP areas that will receive target funding to increase access to individual placement support for people with severe mental illness in secondary care services. At the end of 2018/19, services will then be assessed to check for improvement against the 2017/18 baseline.

The IPS service

335. This IPS service started on 1st April 2016 (on a 5 year contract) and is commissioned by Wiltshire CCG and Wiltshire Council. The service MOU specifies delivery of a high fidelity IPS service exclusively to AWP's Wiltshire CMHT service users and WC Mental Health Social Care Teams.

336. The current IPS team is comprised of 5.6 wte employment support specialists, covering the geographical spread of Wiltshire in alignment with the CCG three sector split of WWYKD, SARUM and NEW

337. The Centre for Mental Health provide IPS expertise and oversee the service implementation as part of a wider national evaluation of IPS efficacy by the Dept. of Health.

338. Quarterly Commissioner contract review meetings will provide the mechanism to monitor success in increasing service access against the 2017/2018 baseline [***see Planning 7-1d_IPS Q Review Agenda for 10.10.16***].

339. WCCG plan to use the findings of the NHS baseline audit to inform service development locally, and will ensure the findings are triangulated with data collated from the local service to bid for any transformational funding which becomes available. Data will be utilised to improve access for those with SMI presentations by understanding service user need and capacity required, commissioners plan to work collaboratively with the provider to tailor service development through refinement to the service specification.

340. The Revised KPIs for Contract Monitoring (***see Planning 7-1d_Revised KPIs for Contract Monitoring***) demonstrates robust performance data recording and monitoring. This data will be submitted to provide the required 2017/18 baseline, so we can start monitoring the level of increase in access to IPS before the 2019 target date.

341. The IPS service will continually review referral source and capacity to ensure the service evolves to manage demand and meet service delivery requirements. Service performance and development is monitored on a quarterly basis (***see Planning 7-1d_TORs IPS Steering Group***).

342. The CCG is currently considering including within the DQIP a focus on how current data is presented as it not possible, at present, to look at performance as a % of the total population but rather performance on an individual patient by patient basis.

Eating disorders

NHS England planning requirement 7.1e

Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases

Overview of our service

343. We have enhanced our specialist community eating disorder service through a joint commissioning arrangement with Bath and North East Somerset and Swindon. Wiltshire CCG is the Lead Commissioner for the enhanced service across the STP which includes:

- A multi-disciplinary team in each base offering NICE-concordat treatment
- Eating Disorder parenting groups in 4 of 5 bases
- Links with acute paediatrics at DGHs
- Time-limited home re-feeding via CAMHS OSCA teams
- Twice yearly SWB ED network meetings
- Teaching and training to partner agencies

344. The service has a low rate of inpatient referral and in the latest data submission to NHSE (Q2), 79% of CYP had received treatment within 4 weeks for routine cases. 75% had received treatment within 1 week for urgent cases. We expect to achieve the 95% standard by 2020/21.

Improving our service

345. Capacity in the service was enhanced in 2015/16 with the number of WTE therapists growing from 12 to 23 WTE (by July 2016). This equated to 6.60 WTE for Wiltshire.

346. A Service Development Improvement Plan (SDIP) is in place as part of the Tier 3 CAMHS contract to improve performance further. Service developments that are in the process of being delivered include:

- Online referral forms
- Self-referral across the age range
- Enhanced involvement of families and young people in service development, implementation and monitoring
- Multi-dimensional outcome measurement and reporting
- Increase in capacity and standardisation of skill mix and expertise ensuring NICE concordat treatment is available in all localities
- Multi-family therapy

Reducing suicide rates

NHS England planning requirement 7.1f

Reduce suicide rates by 10% against the 2016/17 baseline

Partnership working to reduce suicide rates

347. The Public Health England Fingertips data shows Wiltshire experiences an average of 9 per 100,000 suicides (3 year average, 2013-2015 data), which is 2 below the average for the South Region (https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/0/gid/1938132828/pat/6/par/E12000009/ati/102/are/E06000054)

348. Suicide prevention is Public Health led and the CCG links with Public Health under the Crisis Concordat meetings. The local provider of specialist secondary care mental health services. AWP NHS Trust has a suicide prevention group which reports to the Quality & Standards Committee. The group is chaired by the Suicide Prevention Lead. Administrative support is organised through the Quality Academy. The group meets bi-monthly, with twice yearly invites to local authority public health/suicide prevention leads and CCG mental health leads. Each delivery unit is represented by either their Clinical Director or Head of Profession & Practice, or other identified lead [***see Planning 7-1f_20160406 Wiltshire Crisis concordat Action Plan DRAFT v6***].

Actions to reduce suicide rates

349. To improve the efficiency and effectiveness of mental health SMI, with the consequential intention to reduce suicide rates, a number of work streams have been developed or maintained:

350. The Wiltshire Crisis Care Concordat is a well-attended multi-agency meeting. During 2014/2015 attendees of the CCC completed a mapping exercise of crisis care pathways which enhanced the detail and efficacy of its action plan, resulting in development of services and pathways to enhance provision of early and effective crisis care. To further enhance the effectiveness of Crisis, care pathways Wiltshire and Swindon CCCs will collaborate through the Crisis Care Concordat framework from January 2017 [***see Planning 7-1f_Draft TOR V5***].

351. AWP were successful in their bid for capital funds from the Department of Health, which will enable increased capacity and improvements to the environments of the Places of Safety for the residents of Wiltshire and Swindon CCG. Pending the outcome of a staff consultation, the environmental works will commence in December 2016, completing by Feb/March 2017, with the service commencing with immediate effect upon completion [***see Planning 7-1f_Places of Safety - Wiltshire Application form v2 MP***].

352. The Mental Health Liaison expansion will also contribute towards efforts to further reduce suicide rates.

353. Wiltshire and Swindon CCGs and the Police fund and co-commission the Wiltshire and Swindon Street Triage service. Following an independent review, it has been agreed that the service operational hours will be extended to 24/7. This development has been approved and is in process [***see Planning 7-1f_SWST Report Finalv5***].

Reviewing our services

354. A CCG review of the Wiltshire Intensive teams has commenced, scheduled for completion in Q4 2016/2017. This review will assess service demand, capacity, performance and will benchmark service against other areas and examples of best practice. Recommendations will be made to improve service efficiency and effectiveness.

355. AWP conducted a Trust-wide review of their Acute Care Pathway during 2014/2015. A dedicated workstream has been established to enhance this work, with progress monitored by commissioners through the monthly multi-lateral and local CQPM meetings.

356. Wiltshire CCG set up a Commissioner led EUPD Integrated Care Pathway working group to review and improve service provision and pathways against best practice [***see Planning 7-1f_PD TOR v3 draft Nov2015***].

Mental health access and quality standards

NHS England planning requirement 7.2

Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.

Services provided

357. 24/7 cover is provided in each of the Acute hospitals by MHL teams as described earlier, and out of hours by the local Intensive Teams in the RUH and SFT for Emergency referrals to A&E. At GWH the Swindon Intensive Team will be based in the A&E department from November 2016, providing the OOH response for all A&E MH presentations.

358. Wiltshire CCG commissions the provision of two Wiltshire Intensive Teams (North and South Teams) from AWP who provide crisis interventions and home treatment 24/7. The teams can provide home treatment from 9am - 10pm, switching to telephone support from 10pm-9am and support MHA activity as required, except for the South based team who cover SFT A&E.

359. The imminent developments to the East PoS, as mentioned above, will provide 2 locations for OOH community based assessments.

360. The Swindon and Wiltshire Control Room Street Triage are to be extended to 24/7, and the business case is currently being drafted. The decision to extend the service was based upon the observed impact the service has achieved in appropriately reducing the number of section 136 detentions, and the improved conversion rate for s136, and the motivation to continue to enhance the Acute Care Pathway for local resident experiencing a Mental Health Crisis. The business case will be submitted for approval by CCG boards in December 2016.

Managing the service

361. Wiltshire CCG has worked with AWP over the past years to get more detailed reports (with DQIP forming part of contract negotiations) and this has been achieved. This has allowed for better monitoring and points to possible risks (e.g. capacity issues, quality of the environments). One of the main risks that has been identified relates to Places of Safety.

362. At present, changes to the Police and Crime Bill are in process (expected April 2017) and this has resulted in some pressure on the Wiltshire system from Bristol and Hampshire which have already implemented several provisions. To avoid this further reducing capacity for Wiltshire, there is work going on to address this, including an independent system-wide review being conducted with recommendations about changing pathways and provision to address service delivery and management of patient flow. In addition, when there are issues of capacity the local provider escalates that to the respective CCG to address the problem at root.

Mental health investment standard

NHS England planning requirement 7.3

Increase baseline spend on mental health to deliver the Mental Health Investment Standard

How we achieve the Mental Health Investment Standard

363. In line with the Parity of Esteem requirements as set out in the NHS Operational Planning guidance from 2015/16 onwards, the CCG is committed to increasing its investment in mental health services by at least the value of annual growth in CCG allocations [***details in Planning 7-3_Mental Health Investments draft 16 17***].

Planned Spend on Mental Health Services (Core and Other)

	2016/17	2017/18	2018/19
Planned Spend	£53.8m	£55.1m	£56.4m
% Increase	-	2.4%	2.4%

364. In 2017/18, the CCG expects to spend an additional £1.3m on mental health services in 2017/18 compared to 2016/17 and a further £1.3m in 2018/19 compared to 2017/18, on areas including Early Intervention in Psychosis, mental health liaison, control room triage and ADHD management

Investment headlines and expected outcomes 2017/18

365. The committed investments in 2017/18 make up 60% of the £1.3m additional investment for the year. These investments, together with the expected outcomes, are:

- **EIP**: This is an expansion and enhancement of an existing AWP community service provision. Through the additional investment of £309,000 per annum the team will be able to achieve and sustain delivery of a NICE compliant service from April of 2017
- **ADHD**: A new ADHD service (AWP), with an activity based contract value of £305,000 will commence from April 2017. This service will provide diagnostic assessment and post diagnostic care, which will include facilitation of GP shared care prescribing arrangements
- **Mental Health Liaison**: The additional investment of £192,000 across the three MHL service WCCG commissions and co-commissions in SFT, GWH and the RUH has enabled an expansion of core operational hours, ensuring parity of provision for Wiltshire residents, with all services now operating 9-5pm, 7 days a week.

366. There are a range of investments under consideration for 2017/18. These will be evaluated and shortlisted for funding from the remaining 40% of the addition al £1.3m of resources. The investments and their expected outcomes are:

- **IAPT Silver cloud** – the CCG have commissioned a pilot of the Silver cloud online guided self-help platform for individuals with mild-moderate anxiety and depression disorders, to be provided by the Wiltshire IAPT service. The pilot went live in Q2 2016/2017, and will be reviewed on a quarterly basis to determine the feasibility of commissioning this element of service provision on a recurrent basis.
- **Control Room Triage** – Wiltshire CCG co-commissions a Control Room Triage service in partnership with Swindon CCG and Wiltshire Police. Currently the service operates 8am-12am 7 days a week. This service has a positive impact upon reducing the number of 136 detainees the police make and on improving the appropriateness of the 136 detentions, which was demonstrated through the improved conversion rates. Commissioners have decided to extend the hours of operation to 24/7 but the funding options and level of funding commitment for each partner organisation have not yet been confirmed.

Investment headlines and expected outcomes for 2018/19

367. There are two main Investments under consideration for 2018/19:

- **Step 4 Psychology expansion/Therapeutic provision/Service for individuals with EUPD** –estimated range of investment £800k-£1.2m. Wiltshire Public Health are currently refreshing the Wiltshire Mental Health Needs Assessment which will inform a formal business case. Service level data from Wiltshire AWP, IAPT and A&E departments indicates there is a high level of need for service provision which can provide robust and effective therapeutic interventions for individuals with an Emotionally Unstable Personality Disorder; approximately 10% of patients supported by AWP community teams will have EUPD, which equates to. 199 people based on October snapshot data. Service users with EUPD are reported to require prolonged input from a range of MH services.
- **IPS** – Additional investment to expand workforce capacity will be required in 2018/19 to enable achievement of the required increased access target of 25% comparatively to baseline from 2017/18 for individuals with Serious mental illnesses. We will work with the service in 2017/18 to develop a business case to facilitate any required service developments.

Dementia diagnosis

NHS England planning requirement 7.4

Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and

Have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support

Improving the dementia diagnosis rate

368. The Dementia Diagnosis rate has improved significantly over the last three years. Wiltshire experienced the national decrease in diagnosis rate where the rate decreased marginally from 65.2% in November 2015 to 64.7% in January 2016. We are taking action especially with Practices that have the greatest shortfalls in delivery.

369. Our current trajectory is as follows, which shows we will achieve and then exceed the 66.7% standard by the end of 2016/17:

- October 2016 = 65.5% (4,340 patients)
- November 2016 = 65.9% (4,363 patients)

- December 2016 = 66.2% (4,386 patients)
- January 2017 = 66.6% (4,409 patients)
- February 2017 = 66.9% (4,432 patients)
- March 2017 = 67.0% (CCGs Quality Premium Target) (4,439 diagnosed)

370. The Dementia LES and Memory Service are currently undergoing reviews, and an audit of the Older Adults wards has been completed to understand current service effectiveness and efficiency. This will inform future service commissioning in Primary and secondary care, seeking to improve diagnostic practice, reduce service waiting times whilst improving access rates, and address service provision gaps i.e. crisis support for Dementia.

371. Support is being offered to practices where there is still a significant gap in terms of numbers between the target and the numbers with a diagnosis or where diagnosis rates have declined. Specific measures include the CCG working with GP surgeries across the county to ensure details of patients who are prescribed Dementia medications are appropriately recorded on the dementia register.

372. The Dementia LES is specifically designed to improve the rate of diagnosis by providing the most appropriate incentives, support and management of dementia diagnosis. The review is expected to be completed by quarter 3 of 2016/17 and the recommendations implemented by the Dementia Board work programme during 2016/17.

373. The CCG are also in the process of reviewing dementia services and pathways in primary and secondary care which will result in a service redesign proposal aiming to enhance service user experience and ensure access to evidence-based and holistic treatments. Proposals should be submitted during Q4 2016/17, with service redesign planned to commence during 2017/18.

374. Looking forward, in 2017/18 and 2018/19, the denominator for this standard will change at the start of each year to take account of population prevalence. For Wiltshire, this means that the denominator will increase, because of the growth in the elderly population. This increase in the denominator will result in a slight reduction in the diagnosis rate at the start of each year, but we plan to recover this within year so that we achieve the 66.7% target each year [***see Planning 7-4_Appendix A TOR v1.0; Planning 7-4_AS AN AUDIT PROPOSAL SUMMARY V2 DRAFT; Planning 7-4_Memory service review proposal 2016 draft v4***].

NHS Implementation guidance on dementia

375. With regard to improving post-diagnostic care and support for people with dementia in line with the forthcoming NHS implementation guidance, we have identified three principal areas of variation and are actively addressing these issues:

- **Equity of access in day care resources across Wiltshire** - we will ensure that the recent joint procurement exercise in re-commissioning of the Advocacy Service provides support for people with Dementia and will ensure they are able to have voice and choose the type of day care activity they wish to access and/ or participate in.
- **Improving waiting times for memory services** - a service review of the Memory Service is scheduled to take place in Quarter 3 in the new financial year, and findings of this review will establish how services will be redesigned over 2016/17 with the aim for new services to go live during the next financial year (2017/18).
- **DTOCs** - the Care Home Liaison service was expanded in February 2016 with the intent to enhance provision, working 7 days a week, of effective holistic post diagnostic care for those with Dementia in care homes, reducing placement breakdown and therefore the need for admission, and to reduce the length of stay for those admitted, facilitating timely discharge to care home placement to bring the level of DTOCs down further (***see Planning 7-4_2016 06 27 DToC Group - TORs MH&D JCB Approved; Planning 7-4_2016 07 21 DToC Driver Diagram***).

376. The trajectory showing when Wiltshire CCG expects to meet NHS dementia diagnosis rate targets has been submitted to NHSE using the data shown above.

Addressing dementia priorities in care homes

377. Dementia priorities are also being addressed in care home settings, together with measures to support upskilling of home care and care home workforce. Examples include:

- Establishing and rolling out the gold standard training in Dementia with Stirling University over this financial year targeting residential and nursing care homes across the county to participate
- The launch of the new Care Home Liaison Service has provided extra expert capacity for residential care and nursing care homes to support service users in their own residential setting. One of the key objectives for this new provision is to ensure more extensive coverage of residential care and nursing care homes in Wiltshire County that currently have a Wiltshire patient in their care [***see Planning 7-4_Care Home Liaison Service service spec DRAFT v3.1; Planning 7-4_CHLS July 2016***].

Dementia advisors

378. Our commissioning intentions include Dementia Advisors that are available to all GP practices, actions around EOL care, reviewing the range of respite available for carers and the Dementia Awareness Project, which provides an overarching approach to ensure that the Prime Minister's challenges are effectively met. Please refer to the Health Watch website for further information around our Dementia Engagement and Outreach work.

379. Nine Dementia Advisors currently work across the county. The joint contract is timetabled to be reviewed and recommissioned shortly. The review will be completed by end of quarter 2 of 2016/17 with recommendations to be prioritised and implemented through the Dementia Delivery Board and overseen by the Joint Commissioning Board.

DTOCs

380. Our current plan is to reduce DTOCs to below 7.5% of Wiltshire CCGs commissioned bed base by 1 April 2017. We recognise that this is a challenging target, based on recent performance where DTOCs have ranged between a low of 9% in December 2015 to a high of 18% in August 2016.

381. If we achieve the 7.5% target by the end of March 2017, our ambition is to sustain target performance in 2017/18 and 2018/19.

382. This will be achieved through:

- A weekly commissioner Chaired DTOC review meeting that provides a multi-agency forum to ensure focus and progress is maintained in managing and resolving Wiltshire DTOCs.
- An AWP Trust wide DTOC task and finish group which has been established to agree parallel processes and ensure a robust system wide management approach is taken to reducing DTOC numbers. (***see Planning 7-4_2016 06 27 DToC Group - TORs MH&D JCB Approved; Planning 7-4_2016 07 21 DToC Driver Diagram***)

Out of area placements for non-specialist acute care

NHS England planning requirement 7.5

Eliminate out of area placements for non-specialist acute care by 2020/21

Our current position on out of area placements

383. In terms of current performance, if out of area (OOA) is defined as out of trust, Wiltshire currently has one patient out of area and talks are underway to resolve this.

How we will eliminate future out of area placements

384. The AWP Trust-wide Acute Care Pathway will eliminate OOA placements for non-specialist acute care by enhancing process and practice to enhance provision and effectiveness of community based care, and similarly improving provision of inpatient care whilst aiming to reduce length of stay and DTOC (see attached ToR). A monthly commissioner attended ACP review meeting takes place where progress against the ACP project plan is monitored, this is then reviewed at the AWP Multi-lateral CQPM, ensuring AWP are held to account on delivery of projects, and trajectories for service and pathway improvements [***see Planning 7-4_2016 06 27 DToC Group - TORs MH&D JCB Approved; Planning 7-5_Acute Care Pathway Programme Board TOR***].

385. The Wiltshire CCG led Pathway and service reviews of the Dementia LES, Memory service and Older adult's admissions will contribute to the elimination of OOA by improving patient flow and service efficacy through the commissioning implementations of recommendations.

386. The recently expanded CHLS service will contribute to the elimination of OOA by reducing the need for admission, and improving LOS by facilitating timely discharge.

387. Commissioner led weekly DTOC meetings and the AWP DTOC task and finish group will also contribute to enhancing system flow and therefore capacity.

388. OOA numbers are monitored, and providers held to account through local monthly CQPM, and monthly multi-lateral CQPM and FIG.

389. We are confident that these measures will result in us meeting and sustaining the target of eliminating OOA placements.

Making it happen

390. In 2017/18 we will make significant additional investments of £1.3m (2.4%) over the 2016/17 baseline, with a further £1.3m investment in 2018/19. The mix of additional resources, strong partnerships and our ongoing commitment to achieving genuine Parity of Esteem will drive the delivery of improved Mental Health services across the board and for all age groups.

Section 8 – People with Learning Disabilities

Summary

391. We continue to work through our partners in health and Local Government in both Swindon and Wiltshire to develop and improve services for people with Learning Disabilities.

392. The key themes of this cross sector working include:

- Enhancing community provision by building on our track record of community solutions, which includes the rollout of Care Programme Approach by June 2017 and the implementation of the Blue Light Protocol by April 2018
- Reducing the number of people in long term inpatient placements from 10 to 4 before the target date of March 2019
- Continuing to improve access, so by 2020, 75% of people with LD and/or Autism on a GP register are receiving an annual health check

Transforming care partnership

NHS England planning requirement 8.1

Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism

393. Wiltshire has developed a robust Transforming Care Partnership delivery plan with its partner Swindon CCG [***see Planning 8-1_TCP - Service Model Plan - Swindon and Wiltshire FINAL v2; Planning 8-1_TCP Service Model Plan***].

394. The Wiltshire and Swindon partnership have tailored the plan to the local system's health and care needs based on provider landscape and demographics and health and social care contexts. However, the plan is consistent with the following principles:

- **Building the right support** and the **national service model** developed by NHS England, the LGA and ADASS (October 2015)
- **A shift in power**. People with a learning disability and/or autism are citizens with rights, who should expect to lead active lives in the community and live in their own homes just as other citizens expect to. We need to build the right community based services to support them to lead those lives, thereby enabling the closure of all but the essential inpatient provision. To do this people with a learning disability and/or autism and their families/carers should be supported to co-produce transformation plans, and plans should give people more choice as well as control over their own health and care services. An important part of this, is through the expansion of personal budgets, personal health budgets and integrated budgets
- **Strong stakeholder engagement**: providers of all types (inpatient and community-based; public, private and voluntary sector) should be involved in the development of the plan, and there should be one coherent plan across both providers and commissioners. Stakeholders beyond health and social care should be engaged in the process (e.g. public protection unit, probation, education, housing) including people with direct experience of using inpatient services.

395. For Wiltshire, the plan requires the delivery of a community focused complex needs care pathway that looks to deliver assessment and treatment in a community setting, avoiding the need where possible for inpatient admission. The plan focuses on people with learning disabilities and/or autism who have mental health and/or complex and challenging needs.

396. The plan remains on target with a current focus on the milestones set out below [***see Planning 8-1_TCP Milestone Tracker 08-16 v2 (002); Planning 8-1_TCP Service Model Plan***].

Plan highlights and targets to be achieved in 2017/18

Focus area	2017/18 and 2018/19 target
Risk register – Tracking people at risk of an inpatient admission	Implement risk stratification with a revised database by December 2016, to facilitate the rollout of Care Programme Approach by June 2017
Blue Light Pre Care and Treatment Review Protocol	Full implementation of Blue Light Protocol by April 2018
Transitions Process	New Transitions panel and Resolutions panel process in place by November 2017

Reducing inpatient bed capacity

NHS England planning requirement 8.2

Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population, and 20-25 in NHS England-commissioned beds per million population

397. Wiltshire continues to have low numbers of people in inpatient settings. Wiltshire does not currently provide any specialist learning disabilities beds in the local area. In preference we have developed a local complex needs care pathway where people are supported in the community or within local generic mental health beds when an inpatient admission is required.

398. The current number of people, both NHSE and CCG funded, in an inpatient setting is 10. Of this group, seven people are in long term out of area inpatient settings, three have been admitted this year. Of the three, two are in local inpatient settings, one is out of area.

399. There is already an active plan to reduce the number of people in long term inpatient placements from 10 to 4 before the target date of March 2019. One of the projects that supports this reduction is the Daisy, a brand new specialist residential home in Devizes, that will see at least three people return to Wiltshire from long term out of county inpatient placements. [***see Planning 8-2_TCP - activity and finance annexes (23rd Feb version)].***

Improving access to healthcare

NHS England planning requirement 8.3

Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check

400. The Transforming Care Partnership plan sets out clear milestones for the delivery of improved levels of health action planning for people with learning disabilities and/ or Autism.

401. 44.8% of people currently on the GP register have received a health check in 2013/14 (most recent available data). The plan has set an ambitious milestone for December 2017 to offer everyone, within the five cohorts groups across children's and adult services, identified in the Transforming Care plan a health action check.

402. There will be close monitoring of the level of take up and, if required, remedial action implemented, so the level of take up of health action checks after December 2017 will increase, so the 75% target is achieved by 2020 [***see Planning 8-1_TCP - Service Model Plan - Swindon and Wiltshire FINAL v2***].

Reducing premature mortality

NHS England planning requirement 8.4

Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability or autism.

403. A review of the learning disabilities care pathway will be completed by February 2017 and implemented as part of the Transforming Care agenda by 2019, A major focus of this review will be access to mainstream services for people with learning disabilities.

404. The recommendations will be implemented through the TCP action plan process, with an expectation that mortality rates will be in line with those of the general population by 2019.

405. Consideration will be given to how to roll out changes within the current pathway that support people to access mainstream health services and where necessary using the skills and expertise of specialist learning disabilities teams to support reasonable adjustments and changes within Wiltshire health provision.

406. The transforming Care Partnership plan will focus on the key areas around improving not only mental health but also the wider learning disabilities health agenda. For example, there will be:

- Workforce review – to look at training needs of carers and support teams
- Roll out of a consistent approach to positive behavioural support
- Review of the Autism pathway focusing on post diagnostic support [***see Planning 8-1_TCP - Service Model Plan - Swindon and Wiltshire FINAL v2***].

Making it happen

407. Our well established partnerships across health and Local Government, have given us the confidence to invest in enhanced community provision for people with LD and/or Autism. These arrangements will help us to continue to improve services by:

- Delivering more care in community settings
- Reducing inpatient admissions
- Increasing access to healthcare for people with LD and/or Autism

Section 9 – Improving Quality in Organisations

Summary

408. Improving quality continues to be a key priority for Wiltshire CCG, with our expectations set out in quality schedules in provider contracts, with performance against these standards evaluated through robust quality monitoring systems.

409. The quality schedules incorporate a range of measures related to workforce and staff wellbeing, complaints and incidents as well as mortality measures down to specific diagnostic cohorts. This range of indicators provides a balanced assessment of provider quality.

410. We also continue to actively participate in system wide groups including the Wiltshire Workforce Action Group, the Community Education Provider Network and the Academic Health Science Network to promote system wide learning, action and quality improvement.

Plans for improving the quality of care

NHS England planning requirement 9.1

All organisations should implement plans to improve quality of care, particularly for organisations in special measures.

Quality, patient safety and performance monitoring

411. Regular meetings are in place to monitor quality, patient safety and performance across all contracts. These meetings are held on either a monthly or quarterly basis (dependent on the size of the contract). Within these regular provider meetings key metrics in respect to quality, patient safety and performance are discussed in detail, and should there be any issues where further improvements are needed these are identified and appropriate actions, and timescales for remedial actions, agreed. If appropriate this process is reinforced with appropriate contractual levers.

412. In addition, when the CCG may have concerns about any specific patterns or trends in respect to any quality, patient safety and performance issue we have undertaken Quality Assurance visits or Themed Reviews to gather further assurances, or gain a greater understanding of issues. When we have identified where improvements could be made, we have required our providers to produce robust action plans to assure us that positive changes have been made and firmly embedded into day-to day practice.

Our expectations for quality in 2017/18 and beyond

413. We have clear expectations for quality in 2017/18 which is articulated through the quality schedules which have a consistent focus on continuous improvement and learning, to embed change and improve patient outcomes. These schedules are based upon performance in the previous year and the analysis of themes and trends which have been seen through feedback from patient experience, Primary care and review through our Quality and Clinical Governance Committee.

Examples of quality expectations and how these will be achieved

Expectation	What we will do to achieve this expectation
National Early Warning Score (NEWS)	This indicator has been included as a result of themes and trends arising in incident and complaints data. Working with the Academic Health Science Network (AHSN), the CCG has included an indicator in the schedule which requires providers to participate in the improvement work around NEWS and to evidence that this is embedded across the trust Building on work in previous years, the 2017/19 schedule will ensure that both accuracy and appropriate escalation are measured and improved, as well as the introduction of a Paediatric and Maternity version

Expectation	What we will do to achieve this expectation
Learning from Incidents	Through analysis of themes and trends in incident and audit data, the CCG identified a need to address the rising occurrence of falls within provider settings. Indicators were included in the 2016/17 schedule, which will be revised for the 2017/19 schedule, to ensure an in-depth review and analysis of learning from incidents, particularly around falls. This is also an area of particular focus with the community provider inpatient wards. In addition, providers will be asked to attend a collaborative meeting to identify and transfer good practice, and have been asked to put in place a falls action plan with regular progress updates

414. The CCG is committed to implementing a rigorous approach to achieving early identification of any trend which shows that standards have fallen below that expected and in gaining assurance that the provider has acted swiftly to mitigate further decline and address the concern. We have developed a risk profiling of vulnerable providers in 2016/17 and will work closely with both local and regional quality surveillance groups to identify early any areas of sub optimal quality.

415. The CCG's approach to early identification of themes and trends has been reviewed in 2016/17 and will be further developed and refined during 2017-2019. The CCG has established a dashboard, embedded in the Integrated Performance Report, which benchmarks indicators linked to safety, experience and effectiveness across planned care, community and mental health and urgent and emergency care services. This dashboard approach facilitates the identification of emerging themes and trends across the provider landscape.

416. The Quality Team works with the providers to obtain assurance regarding deteriorating standards and where appropriate, these are addressed in a collaborative way. The CCG Quality Team is building positive relationships with providers to develop an open and supportive approach to sharing information, so that the CCG becomes aware of potential issues at the earliest opportunity.

417. A continuous improvement approach is taken to resolving identified issues. Throughout 2017-2019, the CCG has planned a series of collaborative sessions to work with providers in addressing identified themes and trends across the system. These sessions will promote and sustain a clear methodology for Quality Improvement and will support providers to identify emerging issues within their own setting.

418. The CCG will utilise its dashboard to monitor progress and support providers to use tools such as the South West Clinical Network Maternity dashboard to benchmark their own progress and work with other providers to 'grow their own solutions'. An example of the initial focus of the collaborative meetings is the reduction in falls occurring across the provider landscape. This collaborative will include care home providers, mental health services, acute trusts, community services, primary care and the ambulance service.

Working across the system

419. We will ensure that we work closely with co-commissioners to agree a formal process for managing failing services and Trusts. We have commenced the development of enhanced quality assurance of care homes with Local Authority partners to identify those providers who require any additional support in advance of a regulatory inspection with the aim of preventing a poor outcome.

420. We are promoting a partnership working approach to the sharing of best practice and any quality initiatives across our providers to ensure that there is effective use of resource and less duplication in terms of quality improvement initiatives and to aid this, promote the involvement of providers in clinical networks.

421. The CCG is committed to developing relationships with providers which promote collaboration on specific quality work streams utilising networks such as the Academic Health Science Network to promote system wide learning and quality improvement. The CCG plans to set up a Wiltshire Forum to include our co-commissioners in our system footprint to address emerging concerns on a multi-provider

level. We will develop the Executive level contact for quality and promote an open and honest culture of information sharing.

Providers in special measures

422. If a provider has been identified to be in special measures, an action plan will be agreed and this will be monitored by the CCG and/or NHS Improvement or the Care Quality Commission. Updates in respect to any organisation considered to be in special measures, or subject to enhance surveillance, are shared with NHS England.

Meeting statutory safeguarding requirements

423. The *Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (2015)* sets out the roles and responsibilities of CCG's. CCG's are required to have appropriate systems in place to discharge their statutory duties in terms of safeguarding.

424. Wiltshire CCG successfully fulfils its statutory duties with the mechanisms set out in the table below.

How we fulfil our statutory safeguarding duties

Area	Mechanism for fulfilling duties in each area
Quality Assurance and Governance	a) Safeguarding Children and Adult standards are included in CCG contracts with commissioned services. This supports monitoring of the delivery of effective Safeguarding arrangements. b) There is a clear line of accountability within the CCG, with responsibility for safeguarding sitting in the portfolio of the Director of Quality. c) The Director of Quality is supported by the CCG Safeguarding team which includes: ▪ Head of Adult Safeguarding, Mental Capacity Act and Deprivation of Liberty ▪ Designated Nurse Safeguarding Children ▪ Designated Doctor Safeguarding Children ▪ Named GP Safeguarding Children ▪ Designated Nurse for Looked After Children ▪ Designated Doctor for Looked After Children d) Regular reporting to the CCG Governing Body and the Quality and Clinical Governance Committee. e) The CCG has in place an appropriate safeguarding policy. The safeguarding team actively contribute to the development and review of multi-agency policies, procedures and guidelines through membership of the Adults and Children's Safeguarding Boards. The CCG Safeguarding Leads also support provider named professionals in the development of their own safeguarding policies and procedures. f) The CCG's procedure for managing Serious Incidents includes the review of incidents against safeguarding criteria and evidence that the Duty of Candour has been applied. g) The CCG monitors reports and action plans resulting from CQC inspections and reviews and reports progress against these to the Quality and Clinical Governance Committee. h) As a member of the Wiltshire Safeguarding Boards, the CCG actively participates in the monitoring of action plans (health) from Serious Case Reviews (SCR) and other reviews which do not meet the SCR threshold. i) The CCG has a Quality Surveillance Group which meets regularly with the Local Authority and CQC to discuss providers of concern and attends the Regional QSG. Safeguarding is represented at these meetings

Area	Mechanism for fulfilling duties in each area
Training and supervision	a) Safeguarding training is incorporated into NHS Wiltshire CCG induction for all staff. Mandatory online Safeguarding training is provided for all staff at a level appropriate for their role. b) The CCG Safeguarding team provide training for primary care c) All GP practices have a nominated lead for safeguarding. d) The CCG Children's Safeguarding team facilitate three network meetings annually for provider safeguarding leads and GP practice leads. e) Regular supervisions are offered to provider safeguarding professionals to support them in fulfilling their roles and responsibilities.
Partnership working and information sharing	a) Wiltshire CCG is committed to inter-agency working and is a full member of both Wiltshire Children's and Adults safeguarding boards and is actively engaged in the sub-groups. b) The Wiltshire MASH provides a co-location of services which includes Children's Social Care, Police and Health and this allows information-sharing to be undertaken in a timely way to identify vulnerable children earlier. The CCG Designated Nurse is fully engaged in the support of the MASH

Planned safeguarding developments for 2017 – 2019

425. We also have a range of safeguarding developments planned for 2017/19, as part of our process of continuously improving the effectiveness of our safeguarding function:

- The development of a NHS Wiltshire CCG Safeguarding group as a sub group of the Quality and Governance Committee to provide strategic leadership and oversight of the safeguarding agenda across Wiltshire which support the new model of WSCB working locally
- Work with Public Health Wiltshire to deliver a domestic abuse strategy for Wiltshire
- Continue to support and improve primary care practice in safeguarding children
- Develop a training strategy for primary care including continuous professional development sessions
- Carrying out case learning reviews with practices
- Supporting GP practices that have been CQC inspected

How we understand and use patient experience to improve services

426. The CCG has built a sound quality assurance process by working with providers to seek patient experience. Understanding feedback from patients is used to:

- Improve patient experience and access to care
- Improve both the quality and equality of care

427. As part of the Quality Schedule, providers are required to undertake a number patient experience measures and report these, as well as the lessons learned and action plans to implement change, to the CCG.

428. Some examples of the reporting required are as follows;

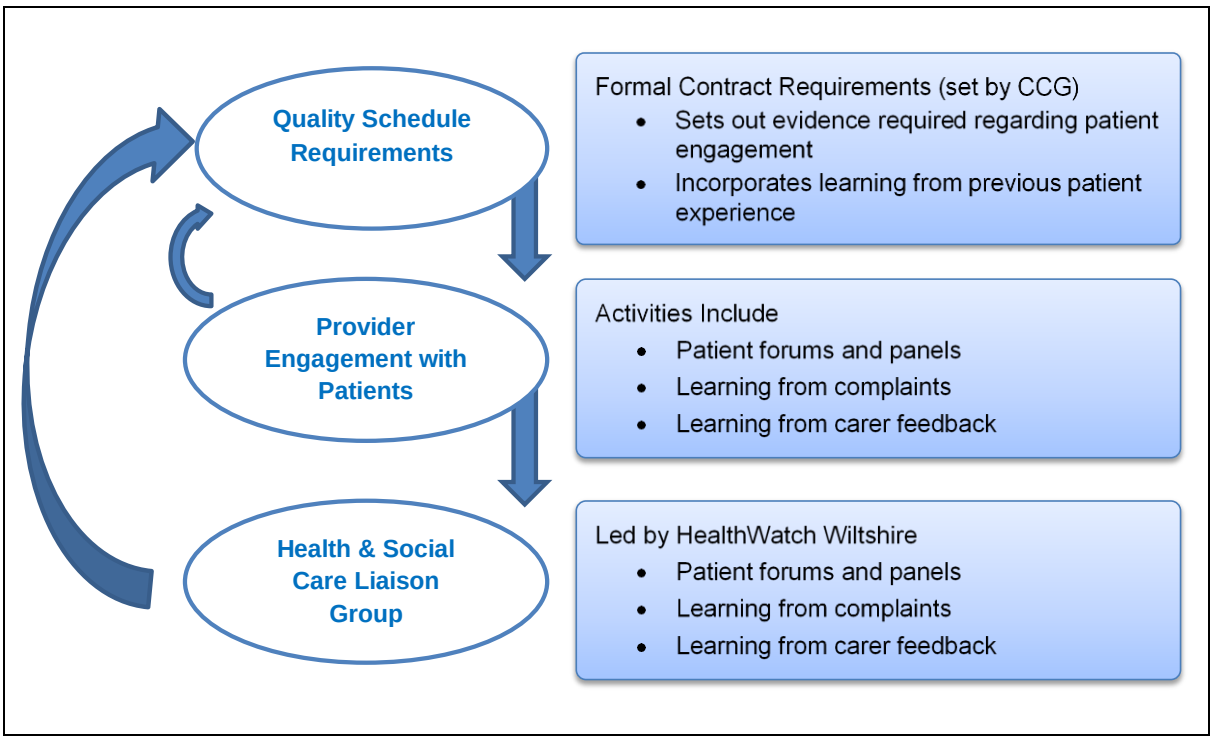
- Evidence that robust mechanisms are in place to ensure that development, monitoring and actions are embedded as a result of patient feedback
- Evidence that actions taken because of patient feedback is displayed in public places to demonstrate the actions that have taken place because of patient feedback
- Patient & carer stories or case studies
- Evidence of how patient forums feed into the board and inform decision making

429. This information is reviewed by the CCG and is discussed through different forums. These forums include the Healthwatch Wiltshire led 'Health and Social Care Liaison Group' as well as provider 'Clinical Quality Review Meetings' (CQRM).

430. The CCGs' internal Complaints and PALS function also feeds in to this process. The Complaints and PALS team liaise with patients regarding concerns or complaints they may have about CCG commissioned services. All complaints or PALS enquiries follow the CCG 'Compliments, Concerns and Complaints Policy' and are used to drive service improvements or identify potential commissioning gaps. The Complaints team produce a quarterly bulletin which identifies themes and trends of complaints. This is shared CCG wide and is taken to the Healthwatch Wiltshire led 'Health and Social Care Liaison Group.'

431. This process, which is summarised in the diagram below is designed to identify and address issues arising from patient feedback and by feeding this back into the ongoing development of the quality schedules, helps ensure that learning is embedded into the standards of care that we commission.

How our monitoring process embeds learning from patient experience into care delivery



Better use of staff resources

NHS England planning requirement 9.2

Drawing on the National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services.

432. Following review of the national guidance published by NHS England; '***How to ensure the right people, with the right skills, are in the right place at the right time'***, the CCG included requirements within its quality schedules to support focus on key areas related to workforce. The CCG will continue to evolve these indicators for inclusion in quality schedules from 2017 onwards.

433. We require providers to report upon:

- Provider progress against National Guidance: How to Ensure the Right People, with the Right Skills, Are in the Right Place at the Right Time (https://www.england.nhs.uk/wp-content/uploads/2013/11/nqb-how-to-guid.pdf)
- Evidence of compliance with NICE safer staffing guidance (for all inpatient units).
- Staff FFT results and action plan
- Anonymised summary and actions taken because of whistleblowing cases raised.
- Issues/trends relating to staff retention and skill mix and progress against Trust action plans/recruitment and retention strategies to address these.
- Progress towards Nurse revalidation including risks and mitigation

434. We will continue to actively monitor complaints and incidents as part of the 2017/18 quality schedules. The CCG review of these includes specific identification of issues related to workforce. In addition to this the CCG assess external publications of data which includes the national Inpatient Survey, Safer Staffing and staff Friends and Family Test.

435. Additionally, the CCG has implemented the Staff Health and Wellbeing CQUIN as part of the 2016/17 contracts. This included a mental health component for one particular provider. The CCG will continue to implement this CQUIN in line with national guidance for 2017 onwards.

436. In 2016/17 we participated in the following workstreams which are multi-organisation and system-wide:

- Wiltshire Workforce Action Group
- Community Education Provider Network (CEPN)
- HEE Transformation Funding
- Nurse Revalidation

437. During 2017-19 we will continue to actively participate in these workstreams and lead in identified priority areas

Findings from reviews of deaths

NHS England planning requirement 9.3

Participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare

438. The 2016/17 Quality Schedule includes KPIs to monitor mortality across the 7 day period and to provide the CCG with assurance regarding the specific diagnosis cohorts to address which are outside of expected levels.

439. We routinely monitor mortality data and uses this information to target audits required of providers to deliver assurance. The CCG has also required providers through the 2017-19 quality schedules to comply with the national developments in mortality reviews and reporting. All acute Trusts have confirmed that they are participating in the development of standardised mortality reviews and the CCG will continue to monitor participation in this work and identification of best practice.

440. For 2017-19 the focus will be the continued scrutiny on mortality with the purpose of reducing avoidable mortality. The CCG will continue to monitor Trusts and require action to address diagnosis groups which benchmark above expected mortality levels.

441. Mortality data is reviewed regularly and feeds into the evidence reviewed to select annual provider assurance audits required in the Quality Schedule. The CCG receives assurances on an annual basis from providers in relation to the Trusts' policy and process for carrying out Mortality Reviews.

442. The CCG is aware of the developing national level approach to mortality reviews and will be working with providers to ensure compliance with the new regime which evolves from this process.

Making it happen

443. We have clear expectations for quality in 2017/18 and beyond, which is articulated both in the Quality Schedules and a range of other work with partners and providers. These mechanisms are part of well established system and processes for working with co-commissioners and other partners as well as providers to embed quality within safe and sustainable services in Wiltshire as well as the wider BSW footprint.

Section 10 – Other developments

Summary

444. As well as meeting the nine Must Do's, we are actively addressing the development of our human and digital resources. This section of the plan shows how we are developing:

- Our leadership capabilities, so our leaders have the skills and capabilities to manage effectively in an increasingly constrained and challenging environment so that can deliver the best care possible to people in Wiltshire and the wider BSW system
- Our digital infrastructure, so we can take full advantage of the potential for improving care and increasing efficiency by implementing the Local Digital Roadmap. This will bring benefits to patients as LDR will facilitate improvements in care across care sectors, providers and professionals

Leadership development

445. The CCG has recognised that notwithstanding what future structures might look like, there is a significant leadership challenge ahead as we endeavour to modernise the NHS, implement both our own strategy, the STP and the Five Year Forward View, as well as delivering high quality services within increasingly constrained financial resources. Consequently, strong leadership capability is going to be essential if we are to build and deliver our ambitious aspirations for the people of Wiltshire.

Developing the next generation of leaders

446. The next generation of leaders will likely need to work differently:

- They will need to operate with an even deeper understanding of the critical success factors and key dependencies within our complex System
- Understand how to provide clear direction
- Monitor appropriately, mentor, coach and work more closely together and with key partners as they integrate processes from planning through to delivery.

447. To ensure that we have provided our current and future leaders with the best opportunity to thrive in this environment, we have recognised that we need to provide them with a toolkit on which to draw, and create an environment in which they can develop their personal capability to deliver our common goals.

448. Accordingly, we have designed and are implementing a structured progression approach, tailored to achieve this through career development stages at Initial, Intermediate, Advanced and Higher levels. Our concept is to develop a framework for leadership that starts with the newest and carries right through to the most experienced, with building blocks along the way at appropriate points in career progression.

449. The four stages envisaged encompass Initial, Intermediate, Advanced and Higher levels of training. The framework will recognise the importance of the larger multi-disciplinary team and provide constant challenge and support for all involved.

Our leadership development framework

450. At this stage, we have endeavoured to strike a balance between setting an ambitious approach, but containing the scale of our programmes to a size that we are able to manage with very taut support resource. Accordingly, currently the Initial and Advanced are primarily focussed on GP colleagues, and the concept for the Higher similar. Only the Intermediate has included from the outset the idea to have a more inclusive approach.

451. However, once programmes are established, and the administration settles, it is anticipated that we would seek to expand the catchment audience for each and include health professionals and managers from across the system, including nursing staff, pharmacists, therapists, Dental and eye professionals etc.

452. Over the past three years we have also worked very hard to establish and embed a values and competence based appraisal system, augmented by Personal Development Plans. Accordingly, selection to either the Intermediate or Advanced training level requires supporting evidence from this underpinning process. In this way, we are seeking to embed a culture in our people and leadership of through career development, augmented by matching investment and career planning/management

Resourcing the delivery of the workforce challenge

453. There is a considerable workforce capacity and capability challenge, and the complexity and creativity required to address this agenda across the health and care system requires dedicated skilled resources over and above the existing people working within organisations.

454. The CCG and Better Care Plan have recognised this and have recruited a fixed term senior workforce advisor to lead and support the delivery of system wide collaborative programmes. This unique role has already helped link a number of different work groups together to develop a consistent approach to workforce development initiatives and is also an active participant in the STP workforce agenda.

455. Other examples include:

- The successful bid for non recurring funds to develop a Community Education Provider Network have enabled the CCG to recruit a Project Manager to help deliver the work programmes for primary care workforce development as well as contributing to the funding of the Strategic Workforce Advisor and potentially other specialist support to a value of at least £84,000 to be used by March 2018.
- Similarly, non recurring funds are being made available from Health Education England to resource additional specialist staff to assist with the STP workforce agenda. A full time project manager for the Apprenticeships workstream will be hosted by the CCG and supervised by the Strategic Workforce Advisor, approximately 4 other posts are being recruited to in other providers to support other workforce work streams across the footprint.
- The Better Care Fund has also funded training programmes that previously would not have been available, for example in health coaching and in rehabilitation skills.

456. Commissioners are now discussing how best to raise the profile and gain some additional traction so that system wide collaboration on our common workforce challenges is given the priority it requires

within providers and they recognise the need to focus their resources collaboratively as well as internally.

Digital infrastructure – The Local Digital Roadmap (LDR)

Key Line of Enquiry K1

How does the operational plan support the objectives within the Local Digital Roadmap? How will critical technology projects identified in the STP be delivered?

How the Operational plan supports the LDR (KLOE K1)

457. The Operational Plan supports the LDR by identifying the implementation of the LDR and its constituent elements as an organisational priority. We do this by working through the STP with our health, social care and voluntary sector partners.

Delivery of critical technology projects (KLOE K1)

458. The October STP submission set out the agreed key objectives and project outputs. Technology projects are identified as critical insofar as they support these objectives and deliver these outputs. The objectives and outputs are shown below.

Digital Programme objectives and outputs

Project Objectives	• To support development of new ways of working via innovation • To improve efficiency and effectiveness of services through intelligent deployment of technology • To support people to manage their own health and wellbeing • To enable delivery of right care, right place, right time across organisations; including through easy professional access to records • To ensure joined up information to support patient care and reduce duplication of information collection • To extend the range of information available for the planning and delivery of services • To improve safety and quality of care • To improve staff flexibility and mobility • To deliver improved service and increase efficiency through collaboration between IT functions
Project Outputs	• Achieve paperless working at the point of care through increased levels of digital maturity • Ensure shared electronic patient record through information sharing and interoperability • Optimise patient portal and other citizen-facing digital services to increase patient and care team access, and drive patient self-care and activation • Improve and rationalise IT infrastructure and connectivity to drive delivery of STP digital objectives • Invest in population health analytics and real-time clinical intelligence to improve predictive modelling, demand and capacity analysis and benchmarking to reduce variation • Promote collaboration between IT departments across the footprint

459. A governance process has been set up to oversee the delivery of these projects. There are five groups in the governance structure which cover all aspects of digital development across the system:

- Corporate systems
- Interoperability
- IT infrastructure alignment
- Local Digital Roadmap delivery
- Data analytics

460. These five groups feed into the STP Digital Strategy Group, which in turn reports to the STP Leadership Board. The STP Digital Strategy Group's work is also aligned with the STPs service priorities of Planned care, Urgent care and Preventative care. This means that there are clear links between digital

developments and service transformation, so digital developments directly support service transformation.

461. STP partners have all signed up to the Digital High Level Programme Plan. Key highlights of the Plan are detailed in the October STP submission, including:

- eReferrals with estimated implementation by March 2018
- ePrescribing and Medicines Administration (ePMA) with estimated implementation by March 2018
- Systems Integration and Apps Development with estimated implementation by March 2020
- Health & Care Interoperability with estimated implementation by March 2019
- The implementation of the main IT infrastructure building blocks to support interoperability which is being staged over the three years (2017-2020).

462. Phase 1 interoperability project delivery is underway, with a focus on End of Life information and out of hours care. Phase 2 interoperability projects are currently in the planning stage and these will focus on shared care planning, to enable shared systems across health and social care [***see KLOE K1_LDR Appendices Wiltshire Oct 2016 v0.2; KLOE K1_LDR Report Wiltshire 20161031 v1.4; KLOE K1_LDR Submission Brief***].

How the delivery of Universal Capabilities supports this operational plan (KLOE K2)

Key Line of Enquiry K2

Does the operational plan include delivery of the Universal Capabilities required within the LDR programme and how do these support operational plans?

463. This Operational Plan includes delivery of the Universal Capabilities (UCs) required within the LDR programme. The table below shows how the UCs support a wide range of projects and initiatives contained within this plan [***see KLOE K2_Wiltshire Universal Capabilities Delivery Plan Oct 2016 V1.1 Draft; KLOE K2_Interop Timeline; KLOE K2_Wiltshire CCG EIA form - Interoperability options appraisal sept15***].

How UCs support this Operational plan

Universal Capabilities	How the UCs support this Operational Plan
A. Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions	• Enables more efficient emergency care since A&E and ambulance staff know what medicine has been prescribed and is being taken by the patient before treatment, which speeds up response and access times. • Expansion of community care, since the UC enables efficient interactions with patients as definitive medication information is instantly available, eliminating delays which would result from paper-based systems.
B. Clinicians in U&EC settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC)	• Facilitates more efficient emergency care as A&E and ambulance staff able to access key information (not just medication) for patients presenting, which speeds up response and access times.
C. Patients can access their GP record	• Supports increased take-up of self-care and self-management in line with CCG and STP priorities.

Universal Capabilities	How the UCs support this Operational Plan
D. GPs can refer electronically to secondary care	• More efficient care by speeding up the referral process and therefore improving RTT performance. • Enhanced care quality through supporting continuity of care along the pathway. • Facilitates choice, with links to referral management by highlighting providers with low wait times, balancing demand across providers to reduce peak demand where capacity is constrained, as well as reducing risk around loss of referrals, transcription errors
E. GPs receive timely electronic discharge summaries from secondary care	• Facilitates primary care picking up responsibility for care and having definitive information to do this. • Supports efficiency, as appointments are not wasted – this links to the GPFV objectives on workload and practice infrastructure • Facilitates reliability of GPs and primary care as principal healthcare provider after discharge supporting effectiveness of shift to out of hospital care.
F. Social care receives timely electronic Assessment, Discharge and Withdrawal Notices from acute care	• Facilitates integration of health and social care and ability to deliver plans through Better Care Fund (BCF) based on integrated working across Health and Social Care, designed to reduce inappropriate emergency attendances and admissions. • Facilitates expansion of out of hospital care as safe alternative to inpatient care.
G. Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly	• Facilitates a multi agency approach to child protection, all encounters are captured and any concerns shared
H. Professionals across care settings made aware of end-of-life preference information	• Supports quality of care, respecting and supporting patients' choice to die in setting of their choosing. • Care professionals both in and out of hours can provide appropriate care, reducing inappropriate hospital conveyance and admission into hospital – which is part of continuing improvement of EOL pathway.
I. GPs and community pharmacists can utilise electronic prescriptions	• Improves efficiency in primary care through paper free solution, time saving for clinicians (sign off), prevents loss of information, prescribing from a local formulary to reduce cost – this ties in with the GPFV priority of managing workload. • Improves pharmacy efficiency.
J. Patients can book appointments and order repeat prescriptions from their GP practice	• Improves patient experience, enabling them to book faster by reducing time taken to book due to busy receptionists. • Supports PIFUs since ease of access to GPs makes primary care a credible alternative to current default of face-to-face follow up with secondary care clinician.

Plans for data sharing, interoperable systems, data sharing agreements and consent models (KLOE K3)

Key Line of Enquiry K3

Do plans set out the CCG's approach to data sharing, developing interoperable systems, data sharing agreements and consent models?

464. We have plans in place that address data sharing, developing interoperable systems, data sharing agreements and consent models [***see KLOE K3_Information Sharing Framework Agreement_Wiltshire SV_Tier 1.docx***].

Plans that successfully address data sharing and interoperability

Elements	CCG approach
Data sharing	Single View (SV) is one element of data sharing across the system that will draw health information in to the council portal. SV is part of a collaboration between Wiltshire Council, Health partners, Police, Ambulance, which was implemented in July 2016. The aim of the SV is to: • Plan and design public services that match Wiltshire's needs • Provide clinical continuity and improve health and wellbeing (The Better Care Plan) • Save lives and protect the vulnerable (Police Service Delivery Plan) • Improve the customer journey by providing efficient and effective services (Wiltshire Council Business Plan) The SV development process is overseen by the Single View Information Governance Board (SVIGB) which: • Ensures sharing of information between partners is fair and lawful • Assures organisational processes and systems solutions for effective and secure handling of shared information, referencing HSCIC Information Governance Toolkit and ISO 27001. The SVIGB also reports to the Single View Programme Board about decisions, issues and risks. Wiltshire CCG is also developing its own interoperability approach based currently on TPP usage but likely to include national systems and an integration solution to wider STP partners for data sharing The Interoperability Programme Board which reports back to the STP Digital Group is steering this work
Interoperable systems	One of the groups feeding into the STP Digital Strategy Group is the Interoperability Group. As noted in our Digital High Level Programme Plan, the Group intends to deliver a patient portal, SCR and Summary Care with additional Information (SCR-AI), as well as population health and regional analytics by March 2018. Health and care interoperability is planned for delivery by March 2019. This is set out in the October STP submission, p. 18, Section 4.11 for the full Digital High Level Programme Plan.
Data sharing agreements	Set out in the Tier 1 Single View Information Sharing Framework Agreement. (Note that Tier 2 Single View Information Sharing Appendices are in place, to reflect specific arrangements for individual Product Cases).

Elements	CCG approach
Consent models	Set out in the Tier 1 Single View Information Sharing Framework Agreement, p. 7, sub-section "Fair Processing and Consent - Sharing Personal or Sensitive Personal Data" for details about the consent model being applied. The section outlines the alternative justifications for data sharing that may be considered in the absence of explicit informed consent from data subjects (e.g. 'to protect vital interests of data subjects' or due to the sharing of data being 'in substantial Public Interests') in accordance with the Data Protection Act and relevant Schedules. As the Agreement notes, Privacy Notices and Consent arrangements take due regard of the principle of proportionality to balance public interest and data subject interest. The Agreement also notes that where explicit consent is sought from a data subject, an "opt out" option should be available and that if the "opt out" option is selected, this should be made clear on the subject's records.

Making it happen

465. Our commitment to leadership development, particularly through the provision of tools, training and practical support means that we will develop a cadre of future leaders capable of leading and managing effectively in an increasingly constrained and challenged environment.

466. Our prioritisation of the implementation of the Local Digital Roadmap, particularly the Universal Capabilities, will support the effective implementation of many of the plans set out in this document. By working through the STP these initiatives will not only improve care for patients in Wiltshire, but for people across the whole of the BSW footprint.

…

Appendix A: QIPP plans - Planned Care summary

Our QIPP target for Planned Care is £3m, with plans to date for £2m of the total. Additional potential initiatives are under development in Audiology, Orthotics, Sleep Studies and Direct access MRI, to address the remaining £1m, although these have not yet been quantified

Our plans to date are well developed which will impact through a mix of mitigating the current overspend on planned care and reducing growth in 2017/18, which directly aligns with STP plans.

The detailed plans are set out in accompanying slides – ***App A and B (NEW) – QIPP slides***.

Area	Headlines	2017/18 impact (£000)
Demand management	▪ Referral reduction ▪ Advice and guidance ▪ Community single point of access for specific conditions	284
Clinical policies	▪ FYE of new policies (IVF) ▪ STP wide suite of policies ▪ Longer term impact of polices	200
MSK	▪ Community based MSK hubs ▪ Provider intervention rates	490
Cardiology	▪ Community heart failure and diagnostic clinics	TBC
Ophthalmology	▪ Referral triage ▪ Community alternatives to acute care ▪ Reduced use of high cost drugs	160
Gastroenterology	▪ Reduced referrals ▪ Reduced scopes	30
Rheumatology	▪ Self care and community care ▪ Dose optimisation and biosimilar switching	240
Follow ups including Patient initiated	▪ Reduce clinically unnecessary follow ups and move to PIFU as default where appropriate across all specialties	540

Appendix B: QIPP plans - Unplanned care summary

Our QIPP target for unplanned care in 2017/18 is £3m, a mix of mitigating the current overspend on unplanned care and reducing growth in 2017/18 and 2018/19

Our approach to containing Non- Elective Growth

We have in place a comprehensive approach, backed by significant investment, to contain non-elective growth, and utilise Right Care data to target our approach wherever possible:

- Our Better Care Fund, suite of TCOP schemes and Primary Care Offer are all well established and will continue to achieve sustained results by way of consistent application.
- Our new Adult Community Services provider, Wiltshire Health and Care, is also rapidly mobilising and is starting to focus upon some of the transformational change that was built into their service specification at contract award.
- In terms of system buy in, the fact that Wiltshire Health and Care is a joint venture co-owner in equal thirds by each of our main Acute providers, we have created the conditions to jointly drive towards the enactment of our out of hospital strategy, delivering both improved services to our population at or close to home and cost avoidance to the Acute sector, as well as easing acute capacity concerns.

Better Care Fund and Transforming Care of Older People Investment

Over the last 2 years the NHS Wiltshire CCG has invested substantially in the Better Care Fund (BCF) and Transforming Care of Older People (TCOP) to reduce the number of Emergency Admissions to Hospital in those aged 65 and over, that segment of our population which is growing the fastest.

Over this time period the population of Wiltshire has increased and the greatest percentage increase has been seen in the population aged 65 and over.

Trend in admissions

Figure 1 shows the trend in acute specific non elective admissions for those aged 65 and over.

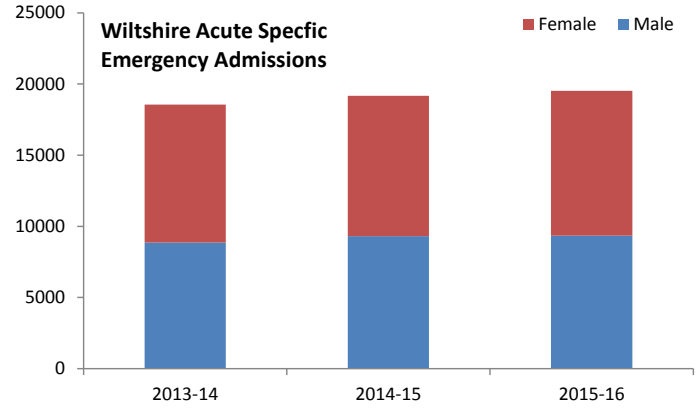


Figure 1 – Trend in acute specific emergency admissions for those aged 65 and over

Acute specific emergency admissions in the population aged 65 and over have increased from around 18,000 in 2013/14 to 19,000 in 2015/16. The 2016/17 forecast is an increase to around 20,000.

Trend in population

Figure 2 shows the trend in registered population for those aged 65 and over.

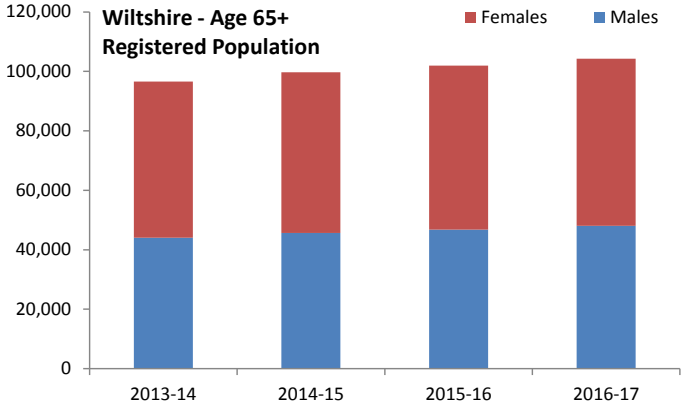


Figure 2 – Trend in the registered population aged 65 and over

This population group has grown from around 96,000 in 2013/14 to over 104,000 in 2016/17, that represents an increase of around 8,000 over the 4 years, with a rate of admission of around 200 per 1,000 population suggesting the increase in activity should be around 1,600 admissions.

Trend in crude rate of admissions

Figure 3 shows the trend in the crude rate of admission per 1,000 population.

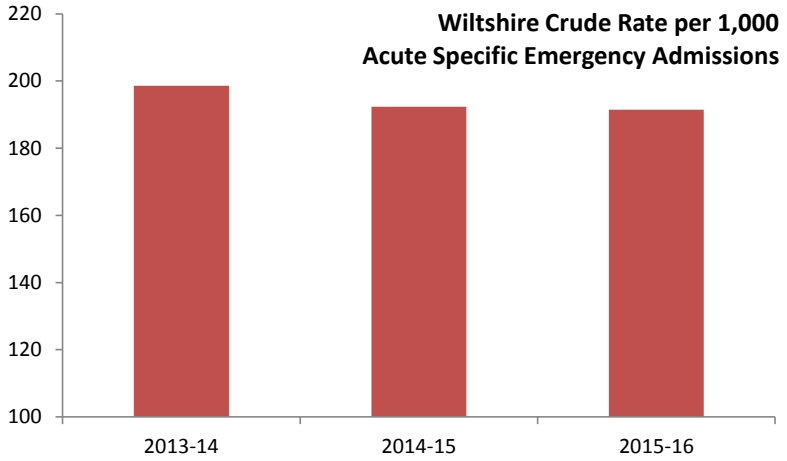


Figure 3 – Trend in age 65 and over crude rate of acute specific emergency admissions

The crude rate of admissions has fallen by around 3.5% from around 200 per 1,000 population to around 190 per 1,000 population. This suggests that there has been a positive impact in reducing the rate of admission for the population at which the BCF and TCOP activity was aimed.

Primary Care Offer and Care Home LES

From April 2016, the Wiltshire Primary Care Offer (PCO) was approved by the Governing Body to support a more flexible way of commissioning enhanced services from member GP practices.

The intention of the PCO was to move to a different and more flexible way of commissioning enhanced services from member GP Practices in Wiltshire from April 2016, believing that moving away from providing care in a transactional activity driven model at individual practice level will result in a more efficient and effective use of resources.

Developing a single CCG framework incorporating and aligning all the currently commissioned local enhanced services gives an opportunity to provide more robust, locality based commissioning with patient focussed quality measures and responsive services; adding improved incentives and driving quality initiatives to ensure a reduction in unnecessary variation across our constituent practices and between individual clinicians.

By investing in and allowing local initiatives to thrive in this way, we have enabled primary care to configure itself locally to deliver improved services and avoid admissions.

We also have invested in a Care Home LES to suppress admissions from the older cohort of our population.

Enhancing Community Services

Wiltshire Health and Care have committed as part of their first year service developments to provide higher Intensive support in the community to enable more people to be cared for at home or nearer to home. They will offer comprehensive community step up care whether in a patient's own home (via a 'virtual ward), in a community hospital bed or an assessment facility.

This will include the creation of older person assessment areas in community hospitals providing medical, nursing, therapy and comprehensive geriatric assessments and treatments, increasing the number of step beds to 50% of current bed capacity, Consultant led Multi Disciplinary Teams in the community and higher intensity 'virtual' wards supported by community geriatricians and managed by the community teams

By delivering sophisticated and complex health care at home and managing higher intensity patients in an out of hospital setting more people will be supported to stay in their own home at times of escalating need, reducing the need for secondary care admission and enabling earlier discharges.

5 months into the contract with WHC a detailed model for the delivery of Higher Intensity Care at home has now been developed. A key part of this was a review of the medical and senior nursing resources dedicated to the inpatient wards. The next step is to work on options to deliver medical care differently to support the resourcing of Advanced Nurse Practitioners. Work is also underway to develop the adaptations required in TPP SystmOne to support higher intensity care pathways.

The implementation plan going forward in 2016/17 includes:

1) Higher intensity care at home
    - Consistent availability and resourcing of MDTs to support review of higher intensity patients.
    - Implementation of the necessary system changes on SystmOne to support a virtual ward model, with the ability for multi-professional teams to review active patients
    - Increased number of mobile ECGs to support higher intensity care at home
    - Adding weekend resilience within core teams to support higher intensity patients
    - Roll out of new process and pathway to all community team areas during 2016/17
    - Test of further increases to intensity of care in Melksham to provide evidence and inform future phases of change.

Higher intensity beds in community hospitals

As part of the HIC project this year we will:

- Focus on the design of a new model for delivery of medical cover in a way that enables resources to be released to increase the availability of Advanced Nurse Practitioners.
- Ambulatory services in community hospitals
- Development of defined pathways for which ambulant patients can be offered a more convenient setting to receive follow up care.
- Begin implementation of ambulatory care provision in two community hospitals, accessed by patients already on a consultant caseload.

The detailed schemes are set out in slides - ***App A and B (NEW) – QIPP slides***

Appendix C: QIPP plans - Prescribing

The QIPP target for Prescribing in 2017/18 is £1.8m

The approach is part of a three year programme shown below that includes work on prescribing incentive schemes and continuing work on rebates

The plan is closely linked with the STP through system wide work to develop a more widely used formulary, which will reduce duplication and increase consistency of prescribing

2016/17	2017/18	2018/19
▪ Prescribing Incentive Scheme implemented across Wiltshire CCG with 55/55 practices participating ▪ Repeat Prescription workshops provided training for >100 practice staff ▪ GPs provided monthly updates on progress ▪ Month 5 data showing negative growth year on year (cost) ▪ Continued discussion/support/interventions with practices who demonstrate growth	▪ Programme continues into next financial year ▪ Continued progress with all GP practices to work towards achieving spend in line with budget within 3 years over gradual revision of processes and prescribing reviews ▪ Natural growth cycle may start to show an increase from July 2017 (decrease started July 2015)	▪ Continued progress with all GP practices to work towards achieving spend in line with budget within 3 years over gradual revision of processes and prescribing reviews
▪ STP level work initiated on Formulary	▪ Working across STP to reduce duplication and increase consistency ▪ Area Prescribing Committee (APC) anticipated to be developed from April 2017 to replace 3 local current formularies	▪ APC in place will allow much simpler implementation of any agreed guidelines across CCG and more consistent prescribing according to formulary
Rebates – ongoing programme of work on rebates		

Appendix D: General Practice Forward View planning requirements

There are three documents that show our response to the GPFV planning requirements:

- A summary setting out the requirements which is cross referenced to CCG reports – ***see App D1 (NEW) – GPFV Ops Plan Guidance DRAFT 20161215***
- Two CCG reports that discuss in detail how we will implement the GPFV – **see *App D2 (NEW) Paper 6 – GP Forward View.pdf*** and ***App D3 (NEW) Item 4.1 Clinical Exec PCO Plan 2017-18***

Appendix E: Cancer services transformation planning requirements

Wiltshire CCG are already actively working to develop and implement the cancer services transformation planning requirements. We are part of 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, not just for Wiltshire's patients.

Our response to a number of the requirements has been covered in the body of this plan and is also shown in this section to demonstrate the complete picture of our ambition and efforts

Requirement for 2017/18	Requirement for 2018/19	How we meet the Cancer services transformation planning requirements
AppE1 Strengthen existing tobacco controls and smoking cessation services, in line with reducing smoking prevalence to below 13% nationally by 2020	As 2017/18	Wiltshire CCG will continue to support Public Health initiatives to reduce smoking, in line with national and Wiltshire CCG cancer strategies and Alliance work programmes
App E2 Increase uptake of breast, bowel and cervical cancer screening programmes	As 2017/18	Wiltshire CCG will continue to support Public Health initiatives to improve screening uptake, in line with national and Wiltshire CCG cancer strategies and Alliance work programmes
App E3 Drive earlier diagnosis by: A. Implementing NICE referral guidelines, which reduce the threshold of risk which should trigger an urgent cancer referral B. Increasing provision of GP direct access to key investigative tests for suspected cancer	As 2017/18	NICE referral guidelines are incorporated into revised referral proformas developed by SW cancer network site specific cancer groups, and which are being adopted at RUH and SFT and have been shared with GWH (noting GWH is part of the Thames Valley Alliance) GP direct access to diagnostics is dependent on the availability of sufficient appropriate diagnostic capacity. Providers are expecting to be able to bid for additional funding from the national diagnostic fund to enable increased provision. At the time of writing it is not clear whether any local providers will be successful in any funding requests. Thereafter, appropriate protocols, based on capacity and test type, will need to be established to ensure the efficient use of any such capacity that is available on a Direct Access basis. The CCG will work with providers as necessary to support this process.

Requirement for 2017/18	Requirement for 2018/19	How we meet the Cancer services transformation planning requirements
App E4 Commission sufficient capacity to ensure 85% of patients continue to meet the 62 day standard by: A. Identifying any 2017/18 diagnostic capacity gaps B. Improving productivity or implementing plans to close these immediate gaps	Commission sufficient capacity to ensure 85% of patients continue to meet the 62 day standard and to begin to meet the 28 day faster diagnosis standard by: A. Identifying any 2018/19 diagnostic capacity gaps. B. Improving productivity or implementing plans to close these immediate gaps	Cancer standards performance will continue to be monitored monthly and areas of concern will be addressed with providers via the RTT Assurance Meetings. This is covered in detail in the previous section of this plan which shows how we plan to meet constitutional standards (Section 2, KLOE B1) Provision of diagnostic capacity is a national and cancer alliance priority which We will continue to actively support.
App E5 Ensure all parts of the Recovery Package are available to all patients including: A. Ensure all patients have a holistic needs assessment and care plan at the point of diagnosis and at the end of treatment B. Ensure that a treatment summary is sent to the patient's GP at the end of treatment C. Ensure that a cancer care review is completed by the GP within six months of a cancer diagnosis	As 2017/18	Commissioning all elements of the Recovery Package will be developed as part of Cancer Alliance guided work to implement all elements of the Recovery Package within provider trusts; informed at RUH by the Living With and Beyond Cancer board; supported via the STP cancer group (Bath, Wiltshire & Swindon Cancer Group) and in line with national cancer strategy and planning guidance (Section 6, Planning Guidance 6.5).

Requirement for 2017/18	Requirement for 2018/19	How we meet the Cancer services transformation planning requirements
App E6 Ensure all breast cancer patients have access to stratified follow up pathways of care and prepare to roll out for prostate and colorectal cancer patients	Ensure all breast, prostate and colorectal cancer patients have access to stratified follow up pathways of care	This will be developed as part of cancer alliance guided work to implement these requirements within provider trusts; informed at RUH by the Living With and Beyond Cancer board; supported via the STP cancer group (Bath Wilts & Swindon Cancer Group) and in line with national cancer strategy and planning guidance. Wiltshire is represented on the SWAG cancer alliance, Thames Valley Cancer Alliance and lead STP representative on Wessex Cancer alliance, where meetings are now being planned and this issue is on provisional work plans. Wiltshire CCG is a representative RUH Living with and Beyond Cancer Board, which has already met twice and is working towards delivering this deliverable within nationally defined timeframes. Wiltshire CCG is also leading member of BSW Cancer Group taking rotational chairing of that working group and is working towards the same aim (Section 6, Planning Guidance 6.4)
App E7 Ensure all patients have access to a clinical nurse specialist or other key worker	As 2017/18	This will be developed as part of Cancer Alliance guided work that will be implemented in provider trusts; informed at RUH by the Living With and Beyond Cancer board; supported via the STP cancer group (Bath Wiltshire & Swindon Cancer Group) and in line with national cancer strategy and planning guidance.

Appendix F: Mental Health transformation planning requirements

Deliverable	Key action for commissioners and providers	How we meet the Mental Health transformation planning requirements
App F1 Increase access to high quality mental health services for an additional 70,000 children and young people per year.	• Implement local transformation plans to expand access to CYP services by 7% in real terms in each of 2017/18 and 2018/19 (to meet 32% of local need in 2018/19). • Ensure that all areas take full part in the CYP IAPT workforce capability programme and staff are released for training courses. • Commission 24/7 urgent and emergency mental health service for children and young people that can effectively meet the needs of diverse communities, and ensure submission of data for the baseline audit in 2017.	**Local Transformation Plan for Children and Young People's Mental Health and Wellbeing** Our expanded, refreshed and republished Local Transformation Plan for Children and Young People's Mental Health and Wellbeing sets out how we will use extra funding to support ambitions for change across the whole system. Local expenditure on CAMHS (including expenditure by Wiltshire CCG, Wiltshire Council and NHS England Specialised Commissioning) has increased from £5.7m in 2014-15 to £6.5m in 2015-16. It is projected to reach £7m for 2016-17. We have made good progress to date to facilitate improved access to the right help. In 2015/16 we recruited an additional 13.6 whole time equivalent (WTE) CAMHS therapists and plan to recruit a further 9.5 WTE in 2016/17. We have invested in the provision of early help within local communities by establishing closer links between specialist CAMHS and schools as well as expanding the provision of face to face and online counselling. Through the delivery of our refreshed transformation plan we will continue to improve access to evidence based mental health wellbeing services by: • Building capacity and capability across the whole children's workforce to identify and respond to the emotional wellbeing and mental health needs of children and young people; • Continuing to enhance early intervention and prevention in our schools, early years and primary care settings; • Making better use of digital services to improve information and access to the right help as well as tackle stigma and discrimination; • Enhancing the provision of evidence based talking therapies and interventions including counselling; • Re-commissioning a modern fully integrated community Child and Adolescent Mental Health Service without tiers and that is more visible in local communities; • Enhancing 24/7 CYP mental health liaison and support within Accident and Emergency Departments; • Rolling out self-referral to CAMHS across the county; • Improving pathways and provision for children and young people who are more at risk of developing mental health problems including Looked After Children. • Implementing initiatives to reduce waiting times for treatment by 10% by 31 March 2017. • Embedding our enhanced community based eating disorder service; • Working in partnership with NHS England Specialised Commissioning to reduce CAMHS Tier 4 admissions and length of stay. This will include the development of a Collaborative Commissioning Plan with NHS England Specialised Commissioning to ensure the right supply of inpatient CAMHS Tier 4 beds, enhance community-based treatment services, reduce admissions and reduce length of stay.

<table>
<tr><th>Deliverable</th><th>Key action for commissioners and providers</th><th>How we meet the Mental Health transformation planning requirements</th></tr>
<tr><td>App F1 continued</td><td></td><td>The implementation of these local priorities and investment in community services will have a positive impact on reducing demand for costly CYP hospital attendances and admissions. Targets for reducing 11-18 year old hospital admissions for self-harm and mental health conditions over the next 4 years are given below:
<table>
<tr><th></th><th>% reduction</th><th>No of admissions</th><th>Estimated saving</th></tr>
<tr><td>2017/18</td><td>3.5%</td><td>20</td><td>£15,900</td></tr>
<tr><td>2018/19</td><td>4.5%</td><td>25</td><td>£19,875</td></tr>
<tr><td>2019/20</td><td>5.5%</td><td>31</td><td>£24,640</td></tr>
<tr><td>2020/21</td><td>6.5%</td><td>36</td><td>£28,620</td></tr>
<tr><td colspan="2">TOTAL</td><td>112</td><td>£89,040</td></tr>
</table>
Our local CAMHS provider Oxford Health NHS Foundation Trust is the lead provider for the Oxford Reading Collaborative. Through the provision of primary and specialist CAMHS Oxford Health provide access to a range of evidence-based/NICE approved treatments and interventions. Routine Outcome Monitoring has been rolled out to all CAMHS teams and continues to be embedded in clinical practice.
Wiltshire CCG will continue to invest in and embed CYP IAPT principles by establishing a dedicated training and development fund; submitting a bid to Health Education England for Psychological Wellbeing Practitioner posts; taking advantage of new training modules; and improving service user involvement. We will bring this together through the development of a multi-agency workforce plan which sets out how we will build capacity and capability across the whole children’s workforce.</td></tr>
</table>

Deliverable	Key action for commissioners and providers	How we meet the Mental Health transformation planning requirements
App F2 Community eating disorder teams for children and young people to meet access and waiting time standards	CCGs should commission dedicated eating disorder teams in line with the waiting time standard, service model and guidance. Commissioners and providers should join the national quality improvement and accreditation network for community eating disorder services (QNCC ED) to monitor improvements and demonstrate quality of service delivery.	We have enhanced our specialist community eating disorder service through a joint commissioning arrangement with Bath and North East Somerset and Swindon. Wiltshire CCG is the Lead Commissioner for the enhanced service across the STP which includes: • A multi-disciplinary team in each base offering NICE-concordat treatment • Eating Disorder parenting groups in 4 of 5 bases • Links with acute paediatrics at DGHs • Time-limited home re-feeding via CAMHS OSCA teams • Twice yearly SWB ED network meetings • Teaching and training to partner agencies The service has a low rate of inpatient referral. In the latest data submission to NHSE (Q2), 79% of CYP had received treatment within 4 weeks for routine cases. 75% had received treatment within 1 week for urgent cases. We expect to achieve the 95% standard by 2020-21. Capacity in the service was enhanced in 2015-16 with the number of WTE therapists growing from 12 to 23 WTE (by July 2016). This equated to 6.60 WTE for Wiltshire. A Service Development Improvement Plan (SDIP) is in place as part of the Tier 3 CAMHS contract to improve performance further. Service developments that are in the process of being delivered include: • Online referral forms • Self-referral across the age range • Enhanced involvement of families and young people in service development, implementation and monitoring • Multi-dimensional outcome measurement and reporting • Increase in capacity and standardisation of skill mix and expertise ensuring NICE concordat treatment is available in all localities • Multi-family therapy All providers are expected to be part of the national quality improvement and accreditation network for community eating disorder services (QNCC ED). Oxford Health is part of that network. Commissioners from the CCG are linked into the QNCC ED through the South West Strategic Clinical Network.

Deliverable	Key action for commissioners and providers	How we meet the Mental Health transformation planning requirements
App F3 Increase access to evidence-based specialist perinatal mental health care.	Commission additional or expanded specialist perinatal mental health community services to deliver care to more women within the locality. Ensure staff are released to attend training or development as required.	Commissioning the PIMH service ▪ The Wiltshire PIMH integrated care pathway was launched in September 2015 (see attached ToR). ▪ The PIMH proposal was submitted to NHS E, however this submission was not successful. Feedback will be requested and BSW. Commissioners and partnership organisations will submit a follow up proposal for the wave 2 opportunity (i.e. within the next five years). PMIH training ▪ The Wiltshire PIMH network is a multi-agency meeting to review, monitor and develop the Wiltshire Integrated PIMH pathway. All agencies signed up to ensuring relevant staff have the skills and have attended appropriate training enabling effective support for those with PIMH related needs. ▪ AWP are currently reviewing their staff learning tree to ensure appropriate courses, or sections of training are embedded. This is an ongoing piece of work and there are currently no deadlines to contractually hold the AWP to but they have committed to doing this. The ability to commission additional or expanded specialist perinatal mental health community services to deliver care to more women within the locality is dependent on the future availability of funding. See: ▪ ***App F3_20160219 PIMHN Draft ToR*** ▪ ***App F3_Perinatal MH CSDF Application Wiltshire BANES Swindon FINAL 16 9 2016*** ▪ ***App F3_PIMH AWP pathway working group TOR v2 17 12 2015*** ▪ ***App F3_REVISED PMH Screening tool from pathway (Oct 16)*** ▪ ***App F3_REVISED Wiltshire PIMH pathway phase 1 (Oct 16)***

Deliverable	Key action for commissioners and providers	How we meet the Mental Health transformation planning requirements
App F4 Commission additional psychological therapies for people with anxiety and depression, with the majority of the increase integrated with physical healthcare.	CCGs should commission additional IAPT services, in line with the trajectory to meet 25% of local prevalence in 2020/21. Ensure local workforce planning includes the number of therapists needed and mechanisms are in place to fund trainees. From 2018/19, commission IAPT services integrated with physical healthcare and supporting people with physical and mental health problems. This should include increasing the numbers of therapists co-located in general practice by 3000 by 2020/21.	**IAPT for people with anxiety and depression is discussed in Section 7 under requirement 7.1[a]** Additional IAPT services ▪ Wiltshire CCG will continue ambitiously aspiring to offer the best service for its local citizens by implementing a robust strategic commissioning framework and collaborative partnership approach with other neighbouring CCGs to meet the mandated national guidelines. ▪ The commissioning and procuring of IAPT services to meet the 25% access rate for local prevalence of anxiety and depression disorders by 2020/21 will be a priority on the local strategy agenda aligned with the Implementation of The Five Year Forward View for Mental Health. Our SIIP should increase capacity to the level needed to meet the trajectory IAPT as part of integrated physical and mental health services ▪ The WCCG Mental Health strategy already placed the parity of esteem on its day to day business operations and this will remain as a normative service delivery approach. The focus is currently on the primary care service to embrace the integrated system. This will be monitored via the GP data monitoring process for the parity of esteem from 2017/18 data. The afore-mentioned is already contained within our service contract with AWP Trust. Support will be granted through our robust contract negotiations for our provider(s) to increase the numbers of therapists co-located in general practice based on the Wiltshire local IAPT needs by 2020/21. This will be informed by the JSA (Joint Strategic Assessment) in collaboration with the Wiltshire Public Health Services, which is expected end of November 2016. ▪ The SIIP deals with a range of training and upskilling for staff to support people with physical and mental healthcare problems. The SIPP specifically addresses increasing the number of therapists co-located in general practice by 2020/21

Deliverable	Key action for commissioners and providers	How we meet the Mental Health transformation planning requirements
App F5 Expand capacity so that more than 50% of people experiencing a first episode of psychosis start treatment within two weeks of referral with a NICE-recommended package of care.	• Commission/provide an early intervention service that provides NICE-concordant care to people aged 14-65 years, meeting the relevant access and waiting time standards in each year. • At least 25% of EIP teams should meet the rating for 'good' services in the CCQI self-assessment by 2018/19	**Treatment for first episode of psychosis is discussed in Section 7 under requirement 7.1[c].** Commissioning the service: ▪ Service expansion is currently underway (See Service Improvement plan submitted). Wiltshire CCG takes part in CCQI and Matrix submissions and is working with AWP data teams to ensure correct activity can be captured through the AWP Trust-wide EIP task and Finish group. ▪ The service for 14-65 year olds is commissioned to meet the access and waiting times standards. Providers are on target to receive a good rating by 2018/19 and monitored through monthly CCGI meetings and submissions EIP service rating ▪ An AWP Trust wide EIP task and finish group was established in July 2016. Monthly meetings facilitate development of a system level approach in parity of compliance with standards, and recommendations to develop RiO recording and reporting of EIP activity against the required standards
App F6 Reduce suicides by 10%, with local government and other partners.	• CCGs and providers should contribute fully to local multi-agency suicide prevention plans, following the latest evidence and PHE guidance	**Reducing suicide rates is discussed in Section 7 under requirement 7.1[f].** Actions undertaken through The Crisis Care Concordat (CCC), which is a multi-agency arrangement: ▪ Multi-agency crisis meetings are held in the north and south of Wiltshire. They meet monthly, and can meet more often if required. If someone is escalating quite often into crisis this meeting is called and (if possible with the support of person in crisis) a "My Crisis Plan" is agreed on. ▪ The meetings would involve: AWP (secondary care MH provider), adult social care for MH, police, on occasion the fire service, the ambulance provider (SWAST), an A&E consultant, emergency duty service who provide out-of-hours AMP cover, the individual's GP, and as and when required Turning Point (the local substance misuse service). ▪ NHSE guidelines are covered through these meetings as well as the CCC

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App F7 Commission effective 24/7 Crisis Response and Home Treatment Teams as an alternative to acute admissions.	• Commissioners must have conducted a baseline audit of CRHTTs against recommended best practice and have begun to implement a funded plan to address any gaps identified. • Providers must routinely collect and monitor clinician and patient reported outcomes and feedback from people who use services.	**This topic is also covered in Section 7 under requirement 7.2** CRHTT baseline audit ▪ A review is currently underway to identify gaps in service provision to assess how best to reconfigure services to address those gaps. The review will report in by March 2017, with plans to implement the recommendations thereafter ▪ The review will be both a review of services and a review of the KPIs used to assess the services. A deeper level of data looking at patient outcomes is sought which would address both commissioner and provider actions listed. Recording outcomes ▪ For routine collection of outcomes, the CCG monitors performance of outcomes through CQPN. The quality team also monitors performance from Family & Friends surveys.
App F8 Eliminate of out of area placements for non-specialist acute care.	• Commissioners and providers must deliver reductions in non-specialist acute mental health out of area placements, in line with local plans, with the aim of elimination by 2020/21 • Commissioners must ensure routine data collection and monitoring of adult mental health out of area placements, including bed type, placement provider, placement reason, duration and cost.	**Eliminating out of area placements is discussed in Section 7 under requirement 7.5.** Routine data collection ▪ Detail regarding placement type cost is collated by Finance and reviewed in monthly AWP FIG meetings, this data is triangulated from CQPM reports, and monitored in monthly meetings. ▪ All indicators listed in the second action point listed are covered in, and monitored through, the above reports.

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App F9 Deliver integrated physical and mental health provision to people with severe mental illness.	CCGs should commission NICE-recommended screening and physical health interventions to cover 30% of the population on GP register with severe mental illness (SMI), and 60% in 2018/19. • Providers to meet the physical health SMI CQUIN requirement.	A dedicated Community Mental Health support worker has been deployed to review the results of the screening and escalate to a mental health nurse if necessary As part of the service expansion through the SIIP the CCG is ensuring that there will be sufficient and appropriate capacity to meet NICE Quality Standards
App F10 Ensure that 50% of acute hospitals meet the 'core 24' standard for mental health liaison as a minimum, with the remainder aiming for this level	• Commissioners and providers must implement funded service development plans to ensure that adult liaison mental health services in local acute hospitals are staffed to deliver, as a minimum, the 'Core 24' service specification. • Funding will be made available for mental health liaison via a two-phase bidding process. The first phase of bidding will be run in autumn 2016 for funding in 2017/18 (wave 1) and 2018/19 (wave 2). The second phase of bidding will be run in autumn 2018 for funding in 2019/20 (wave 3) and 2020/21 (wave 4). A&E Delivery Boards (formerly known as System Resilience Groups) will be invited to bid in late October	**Mental health access and quality standards are discussed in Section 7 under requirement 7.2.** Core 24 services: ▪ The review of ED activity and impact of extended hours was conducted to determine the need for further expansion. The report will go to Board on 20th December. ▪ The GWH MHL received working PLAN accreditation. This was labour intensive and required investment. Other teams are seeking to learn from GWH experience to pursue this. ▪ The aspiration is to enhance RUH and GWH to core 24; therefore, exceeding the 50% target. ▪ There are currently no plans to expand Salisbury DH beyond existing staffing compliment owing to activity flow not warranting this. However, service operation is in line with best practice and the service aspire to work towards PLAN Accreditation pending the learning from GWH. Funding ▪ Wiltshire CCG will pursue any bidding opportunities to develop service provision in MHL teams. The CCG is prepared to engage with any bidding opportunities owing to access to service performance data and commissioning understanding of service delivery.

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App F11 Increase access to Individual Placement Support for people with severe mental illness	• Using local findings from the national IPS baseline audit, CCGs should plan for improving access to IPS employment support for people with SMI across their STP area from 2018/19. • STP footprints will be invited to bid for transformation funding in autumn 2017, with bids submitted by December 2017.	**Individual Placement Support for people with severe mental illness is discussed in Section 7 under requirement 7.1[d].** IPS is not currently included in system wide plans through the STP, however, the CCG and partners within the Council will assess how to improve access to IPS employment support for people with SMI during the coming months and develop a plan for 2017/18
App F12 CCGs will continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia	• Achieve and maintain a diagnosis rate of at least two-thirds, making sustained gains towards the national ambition with a view to halving the number of CCGs not meeting the ambition by March 2019. • Increase the number of people being diagnosed with dementia, and starting treatment, within six weeks from referral; with a suggested improvement of at least 5% compared to 2015/16 (subject to local agreement).	**The dementia diagnosis rate is discussed in Section 7 under requirement 7.4.** Improvement target ▪ The 5% improvement target is perceived as achievable through the implementation of pathway and service reviews recommendations; assuming this is to be monitored through improvements to RTA breaches, as not all individuals will require secondary care services. ▪ The 4-week RTA is monitored through Local and Multi-lateral CQPM monthly meetings. ▪ It should be noted that the 4-week target is currently not being met. The October snapshot shows 14 breaches, with the main bottlenecks being at the Memory Service. The cause was presented by Memory Service as relating to staff vacancies which are now resolved. ▪ Wiltshire CCG is currently following up with Memory Service to improve quality of reporting to be able to better monitor progress in achieving targets.

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App F13 Ensure data quality and transparency.	• Commissioners must assure that providers are submitting a complete, accurate data return for all routine collections in the MHSDS, IAPT MDS and to any ancillary UNIFY collections. • Providers must engage with CCQI to complete and submit self-assessment tools and subsequent validation in relation to all evidence-based treatment pathways. • Ensure a locally agreed suite of quality/outcome measures is in place which reflects mental, physical and social outcomes, in line with national guidance.	Provider submissions ▪ Currently our provider (AWP Trust) submits Access, Recovery, DNAs, Waiting list and other data monthly, as per contractual agreement. As the quality of data was not up to standard, a remedial action plan was devised by the Intensive Support Team (NHSE) and a Service Improvement Initiative plan (SIIP) Action plan is in place to address the identified outstanding issues, with various milestones tabulated to be achieved under each heading. ▪ As a result, all providers now provide the data required and are compliant. Engagement with CCQI ▪ The provider engages with CCQI to complete and submit self-assessment tools and subsequent validation in relation to all evidence-based treatment pathways. ▪ The contract is in place which covers a locally agreed suite of quality/outcome measures under schedule 5 and 6 of the NHS Contract document. - (see IAPT contract doc.) ▪ To improve data recording for the early intervention service it was necessary to improve electronic clinical data. All commissioners who commission AWP emphasised the importance of having "one version of the truth" from AWP. As a result, there is now only one report provided to commissioners without discrepancy (as opposed to previously when there was a discrepancy in the data presented between the local and multilateral service meetings). ▪ There will be a records management audit, and revision to the records management tool in 2016. Quality and outcome measures ▪ All service contracts have a suite of quality/outcome measures is in place which reflects mental, physical and social outcomes, that are tailored to the specific serviced delivered. (Evidence – care home contract) ▪ Examples of specifications that are currently being updated and plan to be included in the AWP contract for 2017/18 are attached as examples (See ***App F13 (NEW)_Care Home Liaison Service service spec DRAFT v1 2016*** and ***App F13 (NEW)_Wiltshire CCG EIP Service specification -Draft version2 Dec 2016***)

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App F14 Increase digital maturity in mental health.	• Commissioners should support full interoperability of healthcare records ensuring mental health services are included in local digital roadmaps, plans and sufficient investment is made in functionalities and capabilities • Commissioners should support further expansion of e-prescribing across secondary care mental health services.	***Interoperability and the LDR is encompassed in the LDR work which is discussed in detail in Section 10 above*** e-prescribing ▪ This is currently being progressed and will be added to the SDIP for the AWP contract for 2017/18 and 2018/19 ▪ The contract will include a requirement for e-prescribing to be phased in using a structured project management approach that sets out the requirements and timelines through a clear scope and project plan in year 1, followed by implementation in year 2 ▪ The aim is to have full coverage by the end of 2018/19