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NHS Wiltshire Clinical Commissioning Group

Better Care Plan 2017/18
APPENDIX 2- Commissioning intentions

Outline commissioning intentions Better Care Plan 2017/18

The information below provides a summary of the outline commissioning intentions of the Better Care Plan in Wiltshire for 2017/18. These have been reviewed and discussed at the February JCB and the CCG Governing Body in March.

For purposes of reference schemes are colour coded as follows

- **Green** for schemes under the direct commissioning and delivery responsibility for the Better Care Plan
- **Amber** for schemes led by other contracts and programmes but act as key enabler for the Better Care Plan Programme

Intermediate Care Services (bed based and non-bed based) ***Strategic Intention – Maintaining independence and Integrated teams***			
Description	**Provider Impact**	**Baseline**	**Target 2017/18**
Deliver county wide intermediate care services enabling proactive discharge from our 3 acute hospitals and integrated case management (70 Beds) – this includes both step up and step down services	WCC/WHC	50 admissions per month 600 admissions per annum	60 admissions a month 720 admissions per annum
Expanding the role and impact of integrated teams (co located health and social care teams) in relation to -Systematic, targeted case-finding. -management of high risk patients -supporting discharge from acute hospitals -working with intermediate care homes to deliver trusted assessment models - joint training and development programmes with each intermediate care	WHC/GPs	N/A	N/A
An identified keyworker who acts as a case manager and coordinator of care across the system All GP practices have care co-ordinators although roles vary across the County- need to ensure this is aligned with the discharge management strategy in Wiltshire being taken forward under the Better Care Plan.	GP, s	N/A	N/A

Adequate and flexible provision of step up and step-down home-based and bed based rehabilitation and re-ablement services with enough capacity and responsiveness to meet the needs of everyone who might benefit. (continued approach), this will be delivered by 70 ICT beds Community integrated teams (incorporating HTLAH) Rehab support workers	WHC	See below	See below

Good discharge planning and post-discharge support			
Description	**Provider Impact**	**Baseline**	**Target 2017/18**
Full roll out of the Wiltshire wide rehab support workers programme (30 additional rehab support workers across the system) from 1st April	WHC /Acute Trusts	Full scheme roll out from 1st April 2017	21 discharges a week 1091 discharges per annum
Continued delivery of integrated discharge teams and processes at each of the 3 acute hospitals in Wiltshire	System wide	TBC	Core business levels at circa 1200 discharges per annum from the acute trusts
Building on the existing urgent care model (referenced below in the admission avoidance section) provide additional bridging support across the system, this is pending the improvements in general care provision	Medvivo and acute trusts	The aim is to provide 6 additional care shifts across a 24/7 period	See numbers below
Continued commissioning of 70 intermediate care beds across the system to support discharge planning and rapid access to reablement and rehabilitation in the community	WHC /WCC	As above	See numbers above
Improve flow and reduce length of stay in community bedded capacity (Community hospital beds and ICT). Key areas of focus include - Review of staffing models - Alignment of HTLAH support - Relaunched service action plans - Twice weekly escalation and performance management calls	WHC	Currently in scoping stage	The aim is to achieve an additional 15 discharges a month from CH beds. This will provide an additional 180 discharges per month over and above current levels

Crisis management and admission avoidance			
Description	**Provider Impact**	**Baseline**	**Target 2017/18**
Urgent care at home Continued commissioning of Urgent care at home available through Access to Care. This will need to be underpinned by the provision of additional domiciliary care bridging resource to support demand from all parts of the system and increase the volume of discharges. There will be an explicit target for UCAH to move back to performance levels delivered in 15/16 which was circa 80 cases per month management	Medvivo /WHC /Acute Trusts	65 cases per month 780 cases per annum	80 cases per month 960 cases per annum
Step Up Intermediate care (Community Hospitals) **Phase 1** Continue to commission existing community hospital step up pathway in Warminster and Savernake but this needs to be underpinned by a clear system strategy and commitment to step up. (15 beds) **Phase 2** Wiltshire Health and Care have committed in their contract to convert 50% of community hospital bed capacity to step up, transition to this level will commence during 2017/18	WHC	15 patients per month 180 patients per annum	25 patients Per month 300 patients per annum

Step up intermediate care in South Wiltshire (Care Home based) Given the lack of community hospital beds in the south, 10 step up beds are commissioned through a care home provider, this will continue in 2017/18 with a new provider and GP led delivery model	WHC /GPS	8 patients a month 104 patients a year	12 patients a month 144 patients a year
Enhancing Care at the interface We have developed and should continue to resource pathways for admission avoidance and discharge planning at each acute hospital. This will build on the existing Access to Care Model with hospital clinical leadership. AWP in reach for dementia has been reviewed and will be strengthened in 2017/18 in relation to the care home liaison programme. There is also a need to ensure greater linkage to and platforming of the frailty hub programme being progressed by Wiltshire Health and Care	AWP/ WHC /3 acute trusts	N/A	This will need to be scoped with AWP and Wiltshire Health and Care

Community geriatrics and the Wiltshire High Intensity Care programme Community geriatrician coverage across Wiltshire, need to link in more formally with established community teams. It is also recognised that our admission avoidance approach needs to be consistent across a 7-day period. Developing robust "interface" care with each acute hospital, enhancing the ATL model and diverting appropriate patients to established models of care in the community (for discharge and admission avoidance). The role of community nurses, matrons and therapists in the high intensity care programme also need to be clarified and defined Roll out of the High Intensity care programme, this will be led by Wiltshire Health and Care and will focus on - Step up care in the patient's home - Acute geriatric pathways in the community - Frailty hub approach at community hospitals - Integrated team approach	WHC /3 acute trusts	Need to be agreed with WHC	Need to be agreed with WHC

Equitable access to specialist palliative care services for frail older people. Need to recognise that 30 % of all hospital non- elective admissions are for patients with a life limiting diagnosis. Need to; 1. Improve identification of patients who have <12 months to live. 2. Progress implementation of treatment escalation plans across system. 3. Reshape role of the community end of life team (GWH Community services) ensure they take a more proactive case management approach to patients on an end of life pathway. 4. Continue commissioning of the 72 hour EOL pathway. 5. Review and agree future role of hospices in the EOL agenda.	Dorothy House Hospice and Salisbury Hospice	10 cases per month 120 cases per annum	16 cases per month 192 cases per annum
Single point of access available to facilitate access to community services to manage crisis at home with specialist opinion and diagnostics. (continuation)	Medvivo /3 acute trusts and WHC	As part of UCAH	As part of UCAH

Prevention and early intervention			
Description	**Provider**	**Baseline**	**Status**
Ensure a preventative based approach is taken at all stages of an older person's pathway of care The key priorities in 2017/18 are to • Implement key recommendations from the Older Persons Review • Implementation of falls strategy and action plan (led by the Wiltshire wide Bones Health Group) • Signposting, navigation and roll out of the Information Portal in partnership with voluntary sector and Health watch. • Working with health watch explore ways to educate and inform patients of service developments • Continue with the fracture liaison service at SFT and following Pilot end in November 2017 consider whether this should be rolled out across Wiltshire	WCC	n/a	n/a
Workforce development strategy Adequate clinical training for care home staff; both registered and non-registered workers learning together on-site as part of an overall quality improvement programme. (continued approach), this is being delivered by the underpinning Wiltshire Workforce Strategy which is detailed below	Whole system	n/a	n/a

Supporting core social services and integration			
Description	**Provider**	**Baseline**	**Status**
Shared assessments Shared assessment frameworks across health and social care should lead to a Personalised care plan for everyone, where the individual and their careers are key participants in any decision made,	WCC	n/a	n/a
Integration of information Continued development of the Single View of the Customer approach across Wiltshire in 2017/18 to further ensure that adequate and timely information is shared between services whenever there is a transfer of care between individuals and services	WCC	n/a	n/a

Carers support Carers are offered an independent assessment of their needs and signposted to interventions to support them in their caring role. (Will be accelerated as part of the care act work). Offer assessments and support to carers and by commissioning an information portal that has within it a self-assessment tool for carers that enable them to access the care they need, when they need it. Work with Practices through integrated teams to hold registers of carers and ensure linkage in terms of case management and follow up care. More formal involvement of the voluntary sector in the provision of care. There is a need to ensure we derive maximum benefit from commissioned voluntary and 3rd sector services	WCC	n/a	n/a
Personalised commissioning The presence of personal budgets in Wiltshire and the revised national direction on personalisation requires us to look at how we can expand our approach to personal budgets and the personalisation agenda. There is an opportunity to link this in with the work of identified voluntary sector organisations. Roll out of personal health budgets to be accelerated during 2017/18	WCC	n/a	n/a

Dementia services A comprehensive service for those with dementia must be available and accessible this will include Dementia strategy and action plan has been developed, but we need to target the gaps in care and need to ensure a more community focused /crisis intervention based model of care. Through the Better Care Plan, we are already looking at; • Care Home Liaison services. • Focused support to AWP in relation to discharge planning. • Acute "in reach "programmes for dementia. Dementia diagnosis rates have increased across the county – need to ensure that once patients are diagnosed they are moved to appropriate service for ongoing care and management. The registers must serve a purpose and provide a platform for future case management.	AWP		