Implementing the **100 day challenge** across Wiltshire

Draft Briefing Slides

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+ Context

- Ambitious but challenging admission avoidance and financial targets
- Activity reductions + cost savings not being achieved = **Increased pressure**
- Differing patient and practitioner experiences
- Not all stakeholders behind the message
- A Range of new schemes due to go live in September
- Need to enhance delivery focus and daily performance management
- Alternative models of care have to be credible , integrated and deliver
- ? Are we making a difference ?
- Expectations from Centre include *detailed risk assessments / commitment to expected reductions and an early implementer approach.*
- Wiltshire's enhanced fastrack status increases profile
- Need to clearly define our integrated delivery model and establish an accurate view on delivery

Ambition into action

THE 100 DAY CHALLENGE

What is the 100 day challenge ?

- Going live from the 1st September , this will be a system wide approach aiming at reducing the number of attendances and admissions for frail patients in Wiltshire and reduce the amount of time they spend in hospital.
- Includes all health and social care partners in Wiltshire
- Focusing on preventing avoidable admissions for a wider range of conditions
- Under the launch of a range of new innovative schemes and maximise /priorities the use of these schemes delivering ***right care in the right place***
- Requires full commitment and collaboration across the system
- Need for system to combine our approaches to care for frail individuals and help them stay home for longer.

+ Focus of the 100 day challenge

Case Management

- Enhanced 7 day management of the high risk 2 % underpinned by frailty scores
- Community Geriatrician identification and monitoring of the highest risk patients from acute wards
- Focused discharge to assess programmes supporting transfer from wards
- System management of the EOL register
- Community geriatrician and multi morbidity clinics combining

Primary care management

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

Focus of the 100 day challenge

Access and referral routes

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

Managing crisis

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

Managing sub acute patients in a community setting

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

Focus of the 100 day challenge

Reducing length of stay and improving discharge processes

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

Ongoing Measurement /Monitoring and action

- System review check stage to go live at the same time ensuring ongoing review and action
- Launch of the **M**ulti **A**gency **V**iew across general practice.
- New performance management process in place across system with new indicators
- CCG to launch daily system dashboard
- Daily exec leads monitoring performance
- Daily bed state reports
- Weekly issue logs / reports and formal monthly evaluations

What next ?

- Agree outline scope by 1st August 2014
- Update and request for support ay HWB on 31st July
- Outline communication plan to be drafted by 31st July
- Draft performance Dashboard in place by 1st August
- Commence system wide comms by 8th August

Whats needed

- Full commitment and focus all stakeholders
- Alignment with prioritisation
- Operational and challenge mindset
- Clear message to providers
- Clear organisational message