

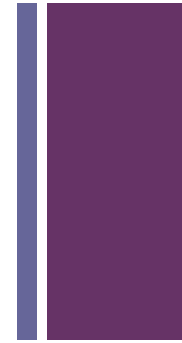
Implementing the **100 day challenge** across Wiltshire

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

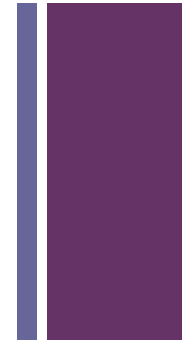
- An enhanced simple point of access with one number to call for services /professionals
- Detailed directory and clinical triage processes
- Improved connection to acute hospitals
- Ensuring complete access to services 7 days a week

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 **Multi Agency View** 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

