NHS
Wiltshire
Clinical Commissioning Group

QIPP plans 2017-19

Project Outlines: Planned and Unplanned care

16 December 2016

'The right healthcare for you, with you, near you.'

WORKING FOR CARERS

QIPP plans - Planned Care (Summary)

Initiative		Overview	Executive Lead
1.	**Demand Management**	*Reducing activity through Referral Management Centre implementation for all referrals.*	Lucy Baker
2.	**Clinical Policies**	*Full year impact of existing polices and STP wide single suite of policies.*	Lucy Baker
3.	**MSK**	Implementation of an ESP interface service, including redesign of existing community physio resources and processes.	Mark Harris
4.	**Rheumatology**	Addressing variation in adoption of patient initiation on biosimilars and switching from biologics. Roll out of dose optimisation clinics.	Lucy Baker
5.	**Gastroenterology**	Single referral form. Review of referral criteria and advice and guidance services. Scope opportunity for community services.	Lucy Baker
6.	**Ophthalmology**	*Triage service developing into community based services. Implement high cost drug policy.*	Lucy Baker
7.	**Follow Ups**	*Patient Initiated Follow Up expansion and developing STP vision of reduced contact based secondary care follow up activity.*	Lucy Baker

Title : Planned Care - Demand Management

Ref : **PLC-A-1**

Description : To reduce demand in secondary care by 2.5% in 17/18 and a further 2.5% in 18/19 by creating a single point of referral access and uniformed referral management services. This includes three key areas:-

- Reducing duplicate demand
- Reducing urgent /expedite requests
- Identifying alternative settings of care

All referrals will be electronic and via the ERS. The vision includes referrals being returned to primary care which do meet criteria or are not made via ERS.

Dependencies:

Clinical policies, Service redesign work streams.

Scope:

All providers of secondary acute care where Wiltshire CCG is the lead or associate to a CCG contract within the STP.

Gross benefit (contract adjustments):

PYE (Subject to phasing review) £284K

Investment requirement (recurrent /non recurrent)

Additional clinical and administration in RMC £177K

Net benefit:

PYE £107K

Project Lead : Lucy Baker, Acting Director of Acute of Acute Commissioning?

Clinical Lead : Dr Andy Hall

Director Lead : Lucy Baker, Acting Director of Acute of Acute Commissioning

Commencement date : 1/4/17

Status: Mobilisation

Delivery Plan / Key Milestones :

Date	*Action / Decision*	*Lead*
31/12/17	Vision agreed across all STP organisations	LB
06/1/17	Mobilisation and implementation plan	LB
13/1/17	Development and agreement of comms and engagement plan	LB
01/02/17	Comms and engagement commences	LB
01/03/17	Refresh of phasing by CCG	LB
01/04/17	Go Live ENT	LB
01/09/17	Full roll out	LB

Title : Planned Care – Clinical Policies

Ref :* *PLC-A-2

Description :

Full year impact of revised clinical polices and planned revisions to policies being enacted fully by referrers and providers. Supported by Trust Access policies and full utilisation of Referral Management Centre. Enforced through contractual challenge for Prior Approval policies and audit of Criteria Based Access policies.

Co-ordination of clinical policies across STP area to form one single suite of policies with standardised processing and provider challenges.

Dependencies: *Prior Approval /Exceptions Team Capacity; Contract Challenge Process; Demand management work stream (Referral Management Centre); STP work stream to align clinical policies.*

Scope: All existing clinical policies across all providers of secondary acute care where Wiltshire CCG is the lead or associate to a CCG contract within the STP.

Gross benefit (contract adjustments):

FYE £200K

Investment requirement (recurrent /non recurrent)

Use of existing budgeted staff resource.

Net benefit:

FYE £200K

Project Lead : Nadine Fox, Head of Medicines Management
Clinical Lead : Dr Helen Osborn
Director Lead : Lucy Baker, Acting Director of Acute Commissioning

Commencement date : 1/4/17

Status: Mobilisation

Delivery Plan / Key Milestones :

Date	*Action / Decision*	*Lead*
23/12/16	Harmonisation of policies phase 1	NF
30/01/17	Decision by SCCG on use of WCCG team	AF
30/01/17	Harmonisation of policies phase 2	NF
30/01/17	Standard challenge approach agreed	NF
24/2/17	Harmonisation of policies phase 3	NF
01/04/17	Go live of standard policies	NF

Title : Planned Care - MSK

Ref : PLC-B-3

Description :
Implementation of an ESP interface service, including redesign of existing community physio resources and processes. Supplemented by additional demand management via the Referral Management Centre.
Redesign principles are underpinned by greater emphasis on self management and shared decision making to reduce unnecessary secondary care diagnostics, procedures and follow ups towards Right Care benchmark level. Phased implementation throughout 2017/18.

Dependencies:
Wiltshire Health & Care Mobilisation and recruitment, existing secondary backlogs. Demand Management (RMC).

Scope:
All providers of secondary acute care where Wiltshire CCG is the lead or associate to a CCG contract within the STP.

Gross benefit: (contract adjustments)
PYE £490K

Investment requirement (recurrent /non recurrent)
PYE £500K

Net benefit:
PYE (£10K)

Project Lead : Jill Whittington
Clinical Lead : Dr Tim King
Director Lead : Mark Harris, Chief Operating Officer

Commencement date : 1/6/17

Status: Development

Delivery Plan / Key Milestones :

Date	Action / Decision	Lead
9/1/17	Revised specification agreed	JW
27/1/17	Mobilisation/ delivery plan agreed*	JW
1/4/17	Recruitment for phase 1 complete*	JW
1/6/17	Go live phase 1*	JW
1/9/17	Ongoing phases mobilise*	JW

*indicative, subject to provider response

Title : Planned Care - Rheumatology

Ref :
PLC-B-6

Description :
Addressing variation in adoption of patient initiation on biosimilars and switching from biologics. Roll out of dose optimisation clinics.

Project Lead : Nadine Fox (Biologics) *STP lead - B . Alexander BaNES CCG
Clinical Lead : TBC
Director Lead : Lucy Baker, Acting Director of Acute Commissioning

Commencement date : 1/4/17

Status: Mobilisation

Dependencies:
STP wide approach to addressing high cost drug use.

Scope:
All providers of secondary acute care where Wiltshire CCG is the lead or associate to a CCG contract within the STP.

Gross benefit (contract adjustments)
(Biologics component only) FYE £240K

Investment requirement (recurrent /non recurrent)
FYE £0

Net benefit:
FYE £240K

Delivery Plan / Key Milestones :

Date	***Action / Decision***	***Lead***
30/01/17	Analysis of biologics and biosimilar initiation complete	RHo
17/02/17	Trust level action plans	RHo
28/02/17	Dose optimisation business cases	NF
28/02/17	Community base options appraised	BA
01/04/17	Trust actions go live – initiation and switching	RHo
01/06/17	Dose optimisation clinics go live	NF
01/06/17	Community options business case	BA

Title : Planned Care - Gastroenterology

Ref :* *PLC-B-2

Description :
Reduce demand in secondary care for OPD and diagnostics. Creation and implementation of pan Wiltshire single referral form. Review of referral criteria and advice and guidance services. Scope opportunity for community services.

Project Lead : Lucy Baker, Acting Director of Acute Commissioning
Clinical Lead : Dr Richard Sandford-Hill
Director Lead : Lucy Baker, Acting Director of Acute Commissioning

Commencement date : 1/4/17

Status: Mobilisation

Dependencies:
Demand management work stream.

Scope:
All providers of secondary acute care where Wiltshire CCG is the lead or associate to a CCG contract within the STP

Gross benefit (contract adjustments):
FYE (Excludes unscoped community service opportunity) £30K

Investment requirement (recurrent /non recurrent)
£0

Net benefit:
FYE £30K

Delivery Plan / Key Milestones :

Date	*Action / Decision*	*Lead*
08/12/16	Referral form circulated across STP	LB
08/12/16	Referral form live in Wiltshire CCG	LB
06/01/17	Review of form uptake	LB
30/01/17	RMC commence discussions at practice level where referrals not made on form.	AH
30/01/17	Draft IBD and IBS templates to be circulated	LB
03/02/17	Review BaNES pilot for community IDA clinic to assess wider roll out opportunities	JW
01/03/17	Indicative date for business case completion	JW

Title : Planned Care - Ophthalmology

Ref :
PLC-B-7

Description :
Implementation of permanent triage process following pilot of triage with Evolutio. Roll out across STP and development of further community based capacity to remove activity at source and manage stable follow up conditions.

Alongside this adherence to cataract policy and high cost drugs policy (injectables).

Dependencies: *Contract Challenge Process; STP work stream for Ophthalmology; existing secondary care backlogs.*

Scope: All providers of secondary acute care where Wiltshire CCG is the lead or associate to a CCG contract within the STP. All optician referrals where the optician is based in Wiltshire.

Gross benefit (contract adjustments): *(*Triage FYE £101K, Cataracts FYE £75K EST, Community Management £150K EST, High Cost Drugs £50K)
£376K

Investment requirement (recurrent /non recurrent)
(Triage £70K, Community Management £75K EST) £145K

Net benefit:
Est PYE £231K

Project Lead : Ashley Windebank-Brooks
Clinical Lead : Dr Andy Hall
Director Lead : Lucy Baker, Acting Director of Acute Commissioning

Commencement date : 1/4/17

Status: Development

Delivery Plan / Key Milestones :

Date	***Action / Decision***	***Lead***
30/1/17	Identification of STP wide patient and service needs.	AWB
27/3/17	High cost drug policy introduced	RHo
29/5/17	STP model identification complete	AWB
29/5/17	Referral methodology complete	AWB
29/6/17	Community model mobilisation starts	AWB
1/9/17	Community model live	AWB

Title : Planned Care – Follow Ups (including Patient Initiated Follow Ups)

Ref :
PLC-B-5

Description :
Reduction in follow up activity through redesigned clinical model for follow ups (at STP level). Standardising existing practice for Patient Initiated Follow Ups and further expansion including application to hold files; and alongside this developing alternatives for acute face to face follow up care.

Dependencies:
Existing secondary care backlogs and hold files. Implementation time and resource for any community alternatives identified.

Scope: All providers of secondary acute care where Wiltshire CCG is the lead or associate to a CCG contract within the STP. Excludes ophthalmology as covered in separate project.

Gross benefit:
FYE £540K

Investment requirement (recurrent /non recurrent)
TBC

Net benefit:
FYE £540K

Project Lead : Ashley Windebank-Brooks
Clinical Lead : Dr Andy Hall
Director Lead : Lucy Baker, Acting Director of Acute Commissioning

Commencement date : 1/4/17

Status: Mobilising

Delivery Plan / Key Milestones :

Date	Action / Decision	Lead
30/01/17	Complete PIFU analysis stage	AWB
30/01/17	Non PIFU follow up actions scoped	AWB
30/01/17	Approach to hold files for PIFU agreed	AWB
27/3/17	Provider PIFU reporting in place	AWB
29/02/17	Non PIFU Business case	AWB
01/06/17	All providers delivery existing PIFU consistently	AWB
01/09/17	Phased roll out of extension of PIFU starts	AWB
01/09/17	Non PIFU model go live	AWB

QIPP plans - Unplanned Care (Summary)

Initiative		Overview	Executive Lead
1.	**Better Care Fund (BCF)**	*Programmes that reduce unplanned admissions by delivering integrated health and social care to patients.*	James Roach
2.	**Transforming Care of Older People (TCOP)**	*Schemes designed to avoid unplanned admissions by delivering high quality care to the >75 population in the home or community setting.*	Jo Cullen
3.	**Other Community/ Out of Hospital initiatives**	*Initiatives that aim to reduce demand for unplanned care by providing high quality care and rehabilitation services in a community setting.*	Ted Wilson

1. Better Care Fund: Assumptions

Assumptions:

- The projection baseline is 2016/17 plan.
- We are assuming recurrent impact for 2017/18 and 2018/19.
- The cost impact is calculated based on the average NEL admission cost from the SFT M7ytd SLAM which is £2,043. This cost includes excess bed days, readmissions and MRET.
- All programmes are covered by BCF funding so we are not putting additional costs into the system.

1. Better Care Fund: Overview

Background:

- Demographic trends show that population growth is only really seen in those aged 65+.
- Over the four years between 2013-14 and 2016-17 we saw growth of approximately 11,000 people in this age band (split almost 50:50 male female) or around 11.6% (12% males and 10% females).
- Given that the average rate of emergency admissions in this age group is around 200 per 1,000 this would suggest an increase of around 2,200 admissions in a "do nothing" scenario.
- However, we have been successful in restricting growth of admissions. Through a number of schemes, including those covered by the BCF, we have been decreasing the rate of admissions among this age group by 3.6% or 7 per 1,000. This has kept admission growth to 1% per year for this age band, versus the 3.9% average admission growth per year that we would expect based on demographic growth. In a "do nothing" scenario, average admission growth per year would have suggested 700 more admissions in 2015-16 and 200 more admissions in 2016-17. As at 2015-16, Wiltshire's emergency admission rate for the 65+ population is significantly below the England average.

Our ambition for 2017-18 and 2018-19:

- To continue to restrict emergency admission growth to 1% per year for the 65+ population in 2017-18 and 2018-19 (as compared to a "do nothing" scenario which would see emergency admission growth of 3.9% per year).
- To continue to reduce average length of stay for emergency admissions of the 65+ population in 2017-18 and 2018-19. Over the last two years, we have achieved an average 1.5 day reduction and our ambition is to achieve a 2 day reduction in 2017-18 and 2018-19.

1a. Better Care Fund – Step up community hospital beds

The aim of this scheme is to avoid hospital admissions by managing a greater volume of patients in a step up community ward. The scheme utilises pre-existing community wards. The main focus is frail elderly 65+ admissions and certain conditions with the aim being to avoid crisis and exacerbation of existing conditions.

Development status

The project has been live since 2014 and is well established within the contract with Wiltshire Health and Care. At present, 25% of community hospital beds are step up, and our aim is to get to 50% by April 2017.

Future view

Within the community contract, the aim is to transition to 50% of community hospital beds being step up. We are currently at 25% and aim to get to 50% by April 2017. This will create greater admission avoidance benefit in the future.

Who will change impact upon

The patient groups it will impact on are all patients over the age of 65 with a sub acute condition or illness. The average age of patients being managed through step up is 84 years (more frail end of the pathway).

What needs to happen

The service is well established. It has been in place since September 2014, the service will continue into 2017/18.

We will need to transition beds to get to our 50% target in line with the plan.

Impact on activity and costs

Across all beds we aim to avoid 30 admissions per month with an admission avoidance rate of 85%. Our total target reduction is 306 admissions per annum in 2017/18 and 2018/19. Assuming £2,043 unit cost per NEL admission, this would translate into a cost impact of £625,158 each year.

In Q2 2017/18, we will review the impact of transitioning to 50% of community hospital beds being step up, to see if we exceed the target of avoiding 30 admissions per month. We will track this through monthly performance reports from the provider and the quarterly clinical audit we receive. If we do exceed the 30 admissions avoided target, we will re-define plans and targets in line with this.

***Project manager** – James Roach*

1b. Better Care Fund – ICT beds (70 cohort beds manage discharges)

Since 2015, we have commissioned 70 cohorted Intermediate Care (ICT) beds in 9 care homes with the aim to provide rehab and rehabilitation support for frail elderly. The ICT beds enable improved patient flow, reducing length of stay and supporting earlier discharge to ensure patients transition to independence as quickly as possible.

Development status

The project has been live since 2015 and is well established within contracts.

Future view

We have just re-tendered for another 2 years for the same number of beds (70 beds).

Who will change impact upon

The patient groups it will impact on are all patients over the age of 65 with a sub acute condition or illness. The average age of patients being managed through step up is 84 years (more frail end of the pathway).

What needs to happen

The service is well established. It has been in place since September 2014 and will continue into 2018/19.

Impact on activity and costs

Our aim, at a minimum, is to maintain current performance of facilitating 55 discharges per month, that is, 660 discharges per annum, in 2017/18 and 2018/19.

The benefits will be reduced LOS at hospital and reduced DTOC numbers and excess bed days.

However the focus of this programme is less about releasing savings and more about maintaining flow. This scheme will support our ambition to reduce average length of stay by 2 days in 2017-18 and 2018-19.

Project manager *– James Roach*

1c. Better Care Fund – Urgent care at home

This service has been in place since 2014. It incorporates Single Point of Access, Acute trust liaison and urgent care at home.

The service provides rapid clinical and social support to avoid admissions and manage crisis.

Development status
The project has been in place since 2014 and is well established. It is in the contract with Medvivo and has established KPIs and targets. We have now successfully moved towards a weekly review of data and formal performance management.

Future view:
The service will continue into 2017/18 and will then form part of the new integrated urgent care service which we plan to launch in March 2018 (See Planning 4-3_Governing Body Integrated Urgent Care Procurement).

Who will change impact upon:
The patient groups it will impact on are all patients over the age of 65 with a sub acute condition or illness.

What needs to happen:
The service is well established. However we need to undertake a workforce and capacity analysis which will inform how we run the service in 2017/18. The workforce and capacity analysis will begin in January 2017.

Impact on activity and costs:
The target for 2017/18 is to increase throughput to 70 cases per month at an admission rate of 85%, resulting in 714 admissions avoided per annum.

Assuming £2,043 unit cost per NEL admission, this would translate into a cost impact of £1,458,702 each year.

***Project manager** – James Roach*

1d. Better Care Fund – Integrated discharge programme

The Better Care Plan leads on the development of the integrated discharge initiatives across Wiltshire. Our ambition is to create consistent referral routes and one joint team responsible for discharge across the hospital footprints (GWH , SFT and RUH). Our focus is on transferring the patient once they are medically stable and providing step down rehab care in the community or patients' own home.

Development status:
This programme incorporates all discharge initiatives across Wiltshire into one programme and builds on previous initiatives such as *Wiltshire Home First* and *Discharge to Assess*. It is now live in all 3 hospitals . 2017/18 is a key year for this programme (first full year).

Future view:
All 3 acute hospitals support the service and this will be further strengthened by:

- The launch of the rehab support workers programme led by Wiltshire Health and Care, which will provide an additional 30 WTE carers across Wiltshire.
- Additional bridging support being provided by Urgent Care at Home.

Who will change impact upon:
The patient groups it will impact on are all patients over the age of 65 with a sub acute condition or illness. The average age of patients being managed through step up is 84 years (more frail end of the pathway). The focus is improving flow and earlier discharge to ensure patients transition to independence as quickly as possible.

What needs to happen:

- Launch of rehab support workers programme in April 2017
- Additional bridging resource provided by Medvivo in April 2017
- Move rota from complement of 666 staff operating 24/7 to 996 staff operating 24/7 subject to recruitment.

Impact on activity and costs:
We are working on an additional 25 discharges per week across all 3 hospitals. If we take into consideration an 85% achievement rate for activity fluctuations and weekend access we would expect an additional 1,105 discharges to be managed through this programme.

This scheme will support our ambition to reduce average length of stay by 2 days in 2017-18 and 2018-19.

***Project manager** – James Roach*

1e. Better Care Fund – 72 hour pathway for end of life care

Working with 2 hospices in Wiltshire we have developed bespoke services to support patients in the last days of life. The aim of the services is to provide ongoing care and support for patients at home, avoiding the need for a hospital admission and ensuring dying at home in line with patients' wishes.

Development status:
The project is well established and has shown encouraging outcomes since 2015. For example, in the period between December 2014 and now, we have seen 39% of patients supported to die at home within 72 hours, 35% in a hospice setting and the rest transitioned to mainstream care with only 3% admitting to hospital.
Overall deaths in the hospital have reduced and we have one of the lowest levels in the South West Region.

Future view:
There is need to maintain the programmes but to increase the volume and type of patients being managed. To do this requires changing the service specification and aligning the team within the integrated discharge service.

Who will change impact upon:
Those patients with a life limiting illness and in the last days of life. These are predominately patients over the age of 65.

What needs to happen:
The key action remaining is agreement on the funding position in order to expand the programme such that there is an increase in the volume and type of patients being managed.

The Palliative Care Steering Group in Wiltshire has approved the business case for the 72-hour pathway for end of life care subject to funding. The funding decision will be made in January 2017.

Impact on activity and costs:
20 palliative care admissions managed in a different (non-hospital) setting each month, or 200 palliative care admissions managed in a different (non-hospital) setting per annum.

Assuming £2,043 unit cost per NEL admission, this would translate into a cost impact of £408,600 each year.

Project manager *– James Roach*

Title : Unplanned Care – Transforming Care of Older People

TCOP encapsulates a range of schemes to avoid unnecessary hospital admissions by delivering high quality care to the >75 population in the home or community setting. The schemes are tailored to each area:

Ref :
URG-A-(1-20)

Schemes in operation

- SARUM West (6 practices) – Elderly Care Facilitator Scheme
- SARUM North(6 practices) – Wellbeing Clinics
- SARUM North (Castle Practice) – Elderly Care Clinic: Leg Ulcers
- SARUM Cathedral (3 practices) – Older Persons Team
- SARUM Clarendon (Whiteparish) – Individualised Management of Patients Over 75 with LTCs
- SARUM Clarendon (Downton) – Virtual Ward
- SARUM Clarendon (Three Swans, Endless Street, St Anns) – Carers Clinic, Carers Café and CHAT Worker Scheme
- WEST Warminster (Avenue) – Extended TCOP Under 75s / Falls WEST and UTIs
- WEST Westbury (White Horse Health Centre/Smallbrook) – Older Persons Public Health Specialist Nurse / Older Persons Specialist Nurse / Westbury Leg Club
- WEST BoA– BoA Older Persons Leg Club
- WEST BoA – Older Persons Nurse
- WEST Melksham (2 practices) – Older Persons Team
- WEST Trowbridge (4 practices) – Emergency Care Practitioner
- WEST Devizes (4 practices) – Leg Club
- WEST Devizes (5 practices) – ECP Visiting Scheme
- NEW North Practices (Calne locality, Chippenham locality) – Multi Morbidity Clinics
- NEW East Kennet Practices – Multi Morbidity Clinics
- NEW Rowden Surgery – Early Visits Scheme, Elderly Meds Management Scheme
- NEW RWB (4 practices) – Specialist Elderly Care Practitioner Scheme
- NEW Malmesbury / Tolsey (2 practices) – Multi Morbidity Clinics / Elderly Care Nurse / Health Questionnaires / Learning Review Sessions

Project Lead : Susan Rest
Clinical Lead : Mark Smithies
Director Lead : Jo Cullen, Director of Primary and Urgent Care

Commencement date : Live

Status: Live

Delivery Plan / Key Milestones :

Date	***Action / Decision***	***Lead***
28/2/17	Lead indicators / scheme capacity developed	SR
28/2/17	Evaluations completed and submitted to schedule	SR
28/2/17	Recruitment of Eldercare Facilitators in Sarum West and West Wiltshire	SR

2. Transforming Care of Older People [TCOP] (1)

TCOP encapsulates a range of schemes to avoid unnecessary hospital admissions by delivering high quality care to the >75 population in the home or community setting. The schemes are tailored to each area:

- **NEW: Localised multi-morbidity clinics where MDTs target vulnerable patients and Specialist nurses to coordinate holistic care**
  - Each GP practice runs a multi-morbidity clinic designed to meet local need e.g. East Kennet practices target patients with high frailty index scores, those at risk of falls, with Osteoporosis and partially sighted. Hathaway Surgery aligned its model with its enhanced support to care homes programme, as strong integrated care is known to reduce unnecessary hospital admissions.
  - In Malmesbury and Sherston locality and Royal Wootton Bassett, Cricklade and Purton locality, specialist nurses review urgent home visit requests, and work with MDTs supporting patients at home or in a community setting.
- **SARUM North: Elderly care wellbeing clinics focused on leg ulcers or dementia**
  - Involve social and educational activities aimed at improving patients' general well-being, which makes patients less dependent on medical services.
  - Based on MDT (GP, Pharmacist, Physiotherapist, Nurse and Care-coordinator) working, which has been shown to reduce unnecessary hospital admissions.
- **West Wiltshire: Leg Club and Emergency Care Practitioner (ECP) Visiting**
  - Devizes launched a Leg Club in 2016, aiming to manage complex cases in the primary care setting. This reduces the need for onward referral and provides social support to patients which makes them less reliant on medical services.
  - ECP visiting scheme involves a trained paramedic making home visits instead of GP. Launched in XXX, the scheme has been improved to include CPD and clinical supervision for the ECP and collecting patient feedback as of 2016.

***Project manager** – Jo Cullen*

Delivery progress

- Between 2014-2016, 19 schemes (mostly locality-based) have been supported and funded. Support and funding has been tied to the successful delivery of the agreed outcomes for >75 patient cohort.

- The 19 schemes cover all Wiltshire GP Practices.

- TCOP schemes have encouraged collaboration across practices and with wider MDTs. Evaluation has allowed us to identify where there is individual practice variation and share best practice. For example, in February 2016 a clinically-led TCOP educational event was organised to disseminate good practice among general practitioners.

- TCOP schemes are being evaluated on a range of dimensions, but KPIs have been designed to also assess schemes' impact on reducing unnecessary unplanned admissions. For example:

  - NEW practices' multi-morbidity clinics are evaluated by measuring the number of patients with a history of unplanned admissions reviewed and reduction in unplanned admissions in patients who have attended multi morbidity clinic appointments. Specialist nurse schemes are currently not evaluated. Evaluation will begin in the next six months.

  - SARUM practices' wellbeing clinics are evaluated by measuring levels of A+E admissions for patients in this cohort, focusing on practices with outlying emergency admissions levels.

2. Transforming Care of Older People [TCOP] (2)

Future view:

- There are plans in many localities to align and enhance TCOP services e.g. include population under 75 and merge as teams for older people.
- We will continue to evaluate TCOP schemes and enhance them, as well as share best practice and collaborate across the locality to scale what works. This is already being done. For example:

  - West Wiltshire's Devizes Leg Club: there are plans to integrate this with a monthly carers' club, formally organise staffing and volunteering and share lessons with BoA/ Melksham locality which also plans to set up a Leg Club scheme.
  - NEW practices with specialist nurses: This is the only scheme currently not evaluated, as it is new. Evaluation will take place over the next six months and there will be reflection on and sharing of lessons learnt to adjust the scheme if and as required and inform localities considering a similar scheme.
  - Following the successful TCOP GP-led learning event held in February 2016, a second one is planned for February 2017. This will also include dissemination of good practice but we will involve a wider variety of stakeholders, including the voluntary sector, to promote integrated care and partnership working.

Impact on activity and costs:

- "At the end of Q1 2016/17, the overall TCOP access rate for Non-Elective admissions over 75 years shows this is holding steady over 3 years, despite >75s showing the largest population growth in the area." (Source: Primary Care Update delivered to the Primary Care Joint Commissioning Committee on 27.09.16).

Impact on patient care and reduced need for further care:

- Qualitative and quantitative measures are showing positive impacts on care quality, including the important social advantages that schemes provide, increasing patients' morale, reducing isolation and improving general well-being. This has also reduced the need for further care, for example:
- Bradford on Avon Leg Club has seen healing rates for simple wounds fall from an average of 19 weeks to 11 weeks. This means that the need for follow-up care is reduced, which frees up capacity to treat more patients in the primary setting and prevent avoidable admissions.

- The greater capacity to treat complex cases in Primary Care has reduced recurrence rates to just over one-third of those registered two years ago: going from 75% in 2014/15 to 26% in 2016/17.
- The lower recurrence rates mean capacity to treat more new patients and reduce a greater volume of unplanned admissions.

What needs to happen:

- Recruitment of Elderly Care Facilitator (ECF) to support TCOP schemes in SARUM West and West Wiltshire.
- Closer collaboration with the Voluntary sector and community teams to strengthen TCOP schemes and deliver on integrated care.
- Evaluations completed and submitted to schedule with continuous sharing of lessons learnt to encourage collaboration across practices and scale what works.

Who will change impact upon:

- Patients
- GPs / Primary Care
- Secondary Care
- Adult Social Care
- Community Teams
- Voluntary sector

Title : Unplanned Care – High Intensity Care

Ref :
ACS-A-1

Future view – over the life of the 5 year contract:

- 100% increase in number of people managed intensely in own home
- Rapid access to appropriate diagnostics without need for admission
- Comprehensive geriatric assessment in the community
- Additional medical support to community beds
- More people kept close to home when inpatient stay required
- A faster more convenient alternative to inpatient services
- More people kept at home at times of increasing clinical need

What needs to happen:

- Consistent availability and resourcing of MDTs
- SystmOne to support a virtual ward model, with the ability for multi-professional teams to review active patients
- Increased mobile ECGs to support higher intensity care at home
- Weekend resilience within core teams
- Roll out of new process and pathway to all community team areas during 16/17
- 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 :

- 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.
- 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.

Project Lead : Neal Goodwin, Project Management through WH&C
Clinical Lead : Dr Toby Davies
Director Lead : Ted Wilson, Director of Community and Joint Commissioning

Commencement date : 1/4/17

Status: Development

Delivery Plan / Key Milestones :

Date	***Action / Decision***	***Lead***
30/12/16	Review of medical model in inpatient settings	WH&C
31/03/17	Offer of services to ambulant patients at Longleat and Cedar wards	WH&C
31/03/17	Wiltshire wide weekly MDT meetings in place	WH&C
31/03/17	Purchase of ECG machines	WH&C
31/03/17	Increased weekend resilience	WH&C
31/03/17	SystmOne changes for virtual bed model	WH&C
30/06/17	Testing of further developments in Melksham complete	WH&C

Title : Unplanned Care – Rehab Support Workers

Ref :
ACS-B-1

Future view – over the life of the 5 year contract:
A simpler and collaborative discharge decision process for complex patients

- A 'meet and greet', discharge to assess model for patients that are medically stable
- Provision of responsive care and rehabilitation in the early 'high risk' period following discharge when a patient's needs could be rapidly changing
- A simple all informed managed transfer of care to HTLAH
- Patients are supported to achieve maximum function, safety and confidence in order to reduce the likelihood of hospital or care home admission and / or long term dependency on a large package of care
- Partnership working between the community teams, the Integrated Discharge Teams in local acute hospitals, Access to Care, the HTLAH providers and Adult Social care
- To make the post hospital discharge care period:
    - Responsive
    - Patient centred
    - Rehabilitation focused
    - Simple and efficient
    - Transparent and accountable

What needs to happen:

- RSW's to be recruited
- Implementation Group to be established
- Project roll out to be managed by the Implementation group
- Reports on progress to be submitted as agreed

Project Lead : Neal Goodwin, Project Management through WH&C
Clinical Lead : Dr Toby Davies
Director Lead : Ted Wilson, Director of Community and Joint Commissioning

Commencement date : 1/4/17

Status: Mobilising

Delivery Plan / Key Milestones :

Date	***Action / Decision***	***Lead***
30/12/16	Rehab Support Programme approved by JCB	TW
31/03/17	Skeleton staff in place to begin pulling patients	WH&C
30/06/16	Full staff and full implementation of model	WH&C