Delayed Transfer of Care Action Plan 2017 - 2019

1.0 Overview

The aim of the document is to provide an overview of the system wide DTOC action plan for Wiltshire. This is developed in line with the recent NHS England guidance to reduce DTOC to 1,450 bed days in September 2017 from 1,999 in April 2017. However, it was recognised by the Wiltshire system this was not achievable so agreed a realistic trajectory to deliver 1,325 bed days from December 2017 led by A&E Locality Boards supporting the Wiltshire population.

The plans relate to our 3 main acute hospitals and 1 community hospital:

- Salisbury Foundation Trust
- Great Western Hospital Foundation Trust
- Royal United Bath Hospital Foundation Trust
- Wiltshire Community Health
- Avon Wiltshire Partnership

It should be noted that both Swindon CCG and Banes CCG have separate DTOC actions in place but there is a clear commitment through the various A&E Delivery Board forums and the BSW STP to join up approaches where relevant. This plan also covers all community services commissioned by Wiltshire CCG, home care commissioned by Wiltshire Council and intermediate care and urgent care services jointly commissioned by Wiltshire Council and Wiltshire CCG under the auspices of the Better Care Plan. The Wiltshire system model will expand from Q1 2018/19 when the new reablement service and recommissioned Urgent and Emergency Care service models commence. The commitment demonstrated in Wiltshire is defined in the Better Care Plan in support of reducing DTOC, length of stay and maximising capacity appropriately for the right patients at the right time.

2.0: Governance and Performance Management

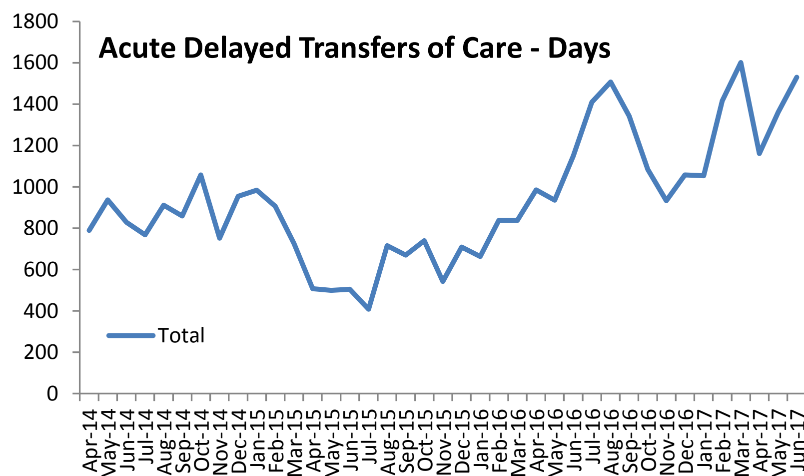
Within Wiltshire we have an established system wide DTOC Board to support the development and implementation of the action plan. The role of the DTOC Board is to oversee the plans delivery and be taken through the A&E Locality Boards to improve delivery during 2017/18 and sustain that in 2018/19. The DTOC Action plan will also be reviewed and monitored by the Wiltshire A&E Delivery Board with a focus on SFT and we also report directly to the Banes A&E Delivery Board and the Swindon A&E Delivery Board which has an integrated DTOC Governance Model (to be ratified in October 2017).

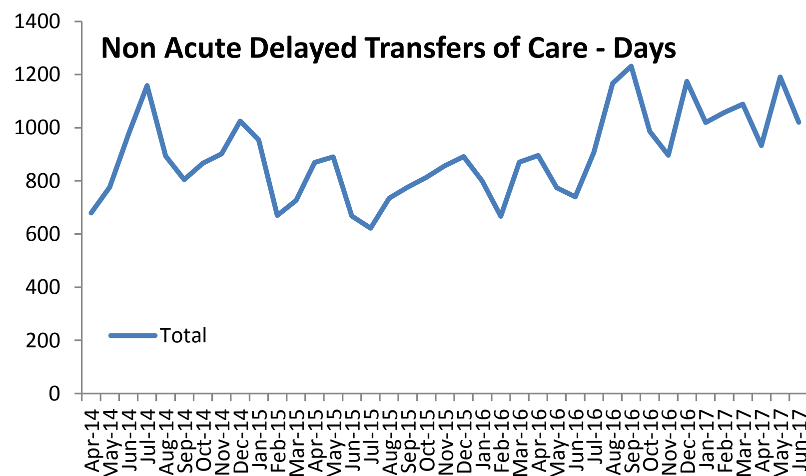
The Wiltshire wide Health and Wellbeing Board and Joint Commissioning Board will also receive regular updates and review system performance alongside the Better Care Programme and performance monitored through the BCP performance dashboard.

3.0: Overview of Performance 2016/17

The Wiltshire system has taken a proactive integrated approach to the reduction of delayed transfer of care over the last 3 years and the following graphs provide an overview of the key performance issues and the strong foundation we have moving forward.

Delayed transfers of care delays – Acute & Non Acute





There were challenges with capacity during 2016-17 which saw the number of delayed days at acute hospitals increase substantially during 2016-17. While our non-acute delayed days increased, they did not increase as substantially as the acute delays. We have analysed the reasons for the increase in delays and this has been used to create greater resilience into schemes and services which relate to DTOC reduction.

4. Our core principles 2017-19

- Aim of the Better Care Plan during 2017-19 is to transition more patients off package towards long term independence, this will require a further reduction of packages of care, a reduction in ICT length of stay and acute hospital length of stay
- Integrated discharge teams include GP practices; Help to Live At Home (HTLAH) and to strengthen the models.
- One single point of entry for discharge planning across the whole system (this will be embedded across the Home First approach)
- Joint management of risk
- Focus on reducing dependency as we transition patients through the pathway focusing on an asset approach
- Stronger focus on “front door turnaround and discharge planning “
- Integrated discharge teams need to be operational 7 days a week and there is a need to significantly increase the volume of discharges on the weekend
- Functional integration of therapy teams across the whole system.
- Long term care decisions where possible and appropriate are not made in the hospital
- Integrated community teams are the key platform for our integrated discharge and “home first “principles
- Focus on outcomes rather than hours
- Transition towards business as usual in the following ways
- Home first should be mainstreamed within integrated teams – i.e. social care, HTLAH and community health working together with a list of patients to make best use of the capacity.
- Reablement and Home First is a core element of integrated working.
- Align prevention to self-management
- Ensure we deliver an workforce development strategy that enables staff to embrace these key principles and meet the demographic challenges and the complex needs of service users

5.0: HIGH IMPACT CHANGES FOR MANAGING TRANSFERS OF CARE

We have undertaken a self-assessment under the high impact changes model, this is currently in draft and is being reviewed across the system.

Change 1: Early Discharge Planning – MATURE

Systems are in place in all 3 acute hospitals (Royal United Hospital Bath, Great Western Hospital Swindon and Salisbury Foundation Trust) to identify people who may require discharge planning. This is managed and monitored through Integrated Discharge teams based within each of the 3 acute hospitals, Adult Social Care, adult community, MH provider supported by discharge to assess for routine and complex discharge home.

Actions:

Early Discharge Planning	Lead	*Completion Date*
1.1 SAFER Bundle Produce a plan to get to 100% Full implementation 1.2 Explore the use of prefect week and red and green days to reduce DToC and improve LOS	Acute trust Acute trust, community and Mental Health	Q3 test status to inform winter plan and DTOC plan 2018/19
1.2 Explore development of system wide response to further reduce readmission post 91 days. 1.3 Establish a task and finish group to explore opportunities to develop a locality base response – membership Health watch, providers, CCG and PH. 1.4 Test assumptions and evidence base to inform Salisbury locality project. 1.5 Active membership of BaNES STP Board and three A&E Boards.	WC/WCCG/Providers	Q1 2018/19 Q3 2018 Q3 2018 On-going
1.6 Develop and consultant on a Wiltshire model detailing a patient-centred discharge model and delivery structure that is used to brief and support patients and partners. 1.7 Develop the model incorporating the asset based approach 1.8 Scope new pathway models to include prevention, admission avoidance, reduce LoS and improve DTOC/Stranded patients	WC, WCCG/Providers	End Q4

Measurement of Success: Reported DTOC reduction in accordance with trajectory and where required actions to mitigate risk is implemented in a timely way

Change 2: Systems to Monitor Patient Flow – ESTABLISHED

System leaders monitor patient flow, daily and when the Trust and or system are in OPEL escalation within the 3 acute hospitals and across the system to enable early in the day discharge and to escalate where action is required for those who are medical ready for discharge or designated as a Delayed Transfers of Care.
Overarching actions:

Performance reports/dashboards and delivery of trajectories are monitored through A&E delivery Boards.

The CCG acute team monitor delivery of NHS Constitutional targets and daily performance and risk mitigation for DTOC, supported by OPEL framework and OSRP. The Associate Director (ASC) undertakes daily monitoring of DTOC. The DASS and Lead Member undertake weekly monitoring, any additional resources needed to increase the flow are agreed by the Associate Director.

Systems to Monitor Patient Flow	**Lead**	***Completion Date***
2.1 Timely access to appropriate shared data for stakeholders daily. Governance in place to support OPEL and risk mitigation	CCG/WC	Completed
2.2 The Wiltshire system have an agreed process to enable timely decision making led by health and social decision makers to enable barriers and delays to be removed. 2.3 Review completed following winter to share learning and ensure the communication and escalation processes are responsive	CCG/WC Wiltshire system	Completed Q2 2018/19
2.4 DTOC to include those designated as ‘stranded patients’ is undertaken daily. 2.5 Wiltshire exploring a senior decision making meeting, to explore blocks/barriers for these complex patients using evidence base from other regions.	CCG/WC/Providers CCG/WC/Providers	Q3 2017 Q4 2018
2.6 Proactive review of patients out of area and weekly planning repatriation planning meetings for those with ongoing health or care needs.	CCG	Completed

Measurement of success: Discharges happen on the planned discharge date and a LOS reduction for MFFD patients.

Change 3: Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector. – ESTABLISHED

Integrated Discharge Teams operate within the 3 acute hospitals and are co-located with staff from Health and Social Care. The team consist of staff from the acute and community and work in collaboratively with private care providers and voluntary sector agencies.

Multidisciplinary Discharge Teams	Lead	*Completion Date*
3.1 Review the current MDT model to ensure it has the appropriate membership and are a key member of Board rounds to enable timely discharge.	CCG/WC/Providers	Q4 2017/18
3.2 To monitor and review the model in order to continuously improve, take learning from other regions to test new delivery models	WC/CCG/Providers	Q4 2017/18
3.3 Undertake an evaluation of the step up and step down pathways and access criteria for beds. Align the home first methodology and admission avoidance to ensure that individuals are supported to remain in the community and receive care close to home. 3.4 Ensure the Integration between the community and acute nursing, therapy and social care teams is strengthen with the commencement of the trust assessor role to facilitate safe and speedy discharge.	WC/CCG/Providers	Q3 2017 Q4 2017/18
3.5 Focus on simple discharges to improve patient's health outcomes and improve flow. 3.6 Explore the learning from those that could have received support or had their needs met outside of the acute setting.	WC/CCG/Providers/IDT	Q4 2017/18

Measurement of success: Wiltshire DTOC reduce lost bed days to a sustainable level. A reduction in escalation beds and step up beds used to support admission avoidance.

Change 4: Home First/Discharge to Access. – ESTABLISHED

Wiltshire Council and CCG are working with Wiltshire Health and Care, acute hospitals and supporting services to strengthen the Home First/ Discharge to assess service.

The home first model is supported by a current reablement service and will be further strengthen by a planned integrated reablement service and the increase in domiciliary care workforce model in 2018/19.

The model is in the early stage of implementation but is based on 4 discharge pathways agreed across the whole system in Wiltshire, to simplify the discharge pathways and delays due to assessments, or waiting for pre-determined follow on care.

Home First/ Discharge to Assess	**Lead**	***Completion Date***
4.1 Evaluate the Home First and Discharge to access model currently in place in order to extend, review and use learning towards establishing a sustainable scheme. This will include: •Ensure sufficient range, flexibility and capacity within services to manage the needs of our patients. •Identify role, responsibility and skills set required by staff to enable them to facilitate discharge to assess at home. •Implementation timetable to mobilise discharge to assess for all appropriate discharges across localities. •Relevant Continuing Healthcare protocols. •Clear key performance indicators and base line to evaluate the project	WC/CCG	Q3 2017/18
4.2 Evaluate the community based Integrated Care beds and map their contribution to working with hospital discharge to support a discharge to assess model.	CCG/WC/Providers	Q3 2017/18
4.3 Explore the opportunities assistive technology can provide to support independent living, as part of the Wiltshire response to digital solutions.	CCG/WC	Q4 2017/18

Measurement of success: Increased numbers of Wiltshire patients accessing Home First and a reduction in the use of alternative services. Increase in number of patients accessing reablement from social work teams and reduction in use of residential care from hospital

Change 5: Seven-Day Service. – PLANS IN PLACE

NHS Trusts: Salisbury FT has delivered against the four clinical standards outlined in the 2020 FYFV, in March 2017, Royal United Hospitals FT trajectory IS March 2018 and GWH by March 2020.

Independent Sector social workers are 7 days however plans to enable seven days for social workers is under discussion to move beyond 6 days a week within the acute hospitals.

Seven Day Services	Lead	***Completion Date***
5.1 Wiltshire CCG to test compliance with the seven day services 4 clinical standards, delivery plan and supporting trajectories within contract meetings. 5.2 Wiltshire to map compliance with seven days ambition to identify risk and actions.	WC/CCG	Monthly Q3/4 2017/18
5.23 Wiltshire system to explore within the integrated work force plan opportunities meet the workforce challenges in 2017/18 – 2018/19	WC/WCCG	Q3/Q4 2017/18

Measurement of Success: Improved flow across the health and social care system, Improved timely discharges within the Trust and a reduction in length of stay, improved ED 4hour wait time performance and patients going to the right place first time.

Change 6: Trusted Assessors. – PLANS IN PLACE

Training is established for Health and Social Care.
A co-ordinated approach is supported through the IDS.
A single assessment form is being produced to enable a one voice approach.
Care Home Forums have been re-established focusing on building productive relationships to enable the move to more trusted assessments.
The CCG is developing a proposal for Trusted Assessor and LES for GP weekly ward round in identified care homes.

Trusted Assessment	**Lead**	***Completion Date***
6.1 Development of a clinically led trusted assessment process on behalf of multiple partners across health, social care and the independent sector.	CCG	Q4 2017
6.2 A recognised trusted assessment process with standard documentation and a mandated remit to undertake on behalf of whole system.	CCG	Q4 2017
6.3 Develop a common suite of documentation, including assessment template and communication protocol to in-taking care providers (e.g. email, teleconference, or face to face for complex patients).	CCG	Q4 2017
6.4 Implement an appropriate crisis response to wrap around the trusted assessment process in the event that the care package breaks down within the first 48 hours.	CCG	Q4 2017

Measurement of success: Assessments are integrated and timely.

Change 7: Focus on Choice. – PLANS IN PLACE

Choice policies are in place in 3 acute hospitals, community hospitals and Intermediate Care beds. Wiltshire has adopted a system wide choice policy and supported by a training package for partners to ensure consistent implementation, this is being rolled out. To test compliance a planned audit will be undertaken in 2017/18

Focus on Choice	Lead	*Completion Date*
7.1 Undertake an audit with system partners to test compliance to the choice policy,	Providers	Q4 2017/18
7.2Followin audit develop a plan 7.3 share learning from the audit as appropriate	Acute Trust/providers	Q4 2017/18 and into Q1 2018/19
7.4 Test the communication plan to support of residents, including self-funders, vulnerable individuals are fully informed. 7.5 Explore an independent provider model to communicate the choice options, for those that do not receive the self-funder service.	WC/WCCG/Provider WC/WCCG	Q4 2017/18 Q1 2018/19

Measurement of success: Choice Policy referred in accordance with national guidance for choice.

Change 8: Enhancing Health in Care Homes. – PLANS IN PLACE

Wiltshire Council has a Quality Assurance team who support Care Homes to improve quality.
The CCG have prepared a proposal to establish care homes support service that incorporates community nursing and health service.
The CCG pilot for red Bag Scheme proposal is in development to be supported by nominated care homes.
The CCG fund AWP to provide a mental health liaison team to support Care Homes, particularly around the care of patients with dementia.

Enhancing Health in Care Homes	**Lead**	***Completion Date***
8.1 Wiltshire Council has a Quality Assurance team who support Care Homes to improve quality with a expectation WCCG as part of integration will further enhance the current model. 8.2 The CCG are prepared a proposal to establish care homes support service that incorporates community nursing and health service.	WC/WCCG WCCG	Q1 2018/19 Q4 2017/18
8.3 Develop a proposal for a Red Bag scheme	WCCG	Q3 2017/18
8.4 Evaluate the Mental Health Service Model	WCCG	Q1 2018/19
8.5 Explore opportunities to support admission avoidance through locality based engagement	WCCG/WC	Q3 2017/18

Measurement of success: Reduced attendances and admissions to hospital; reduced LoS; delayed discharges (DToC) for care home patients; increased weekend discharges; improved communication and relationships between hospital and care homes

Wiltshire system DTOC Action Plan

Outlined below is the more detailed DTOC action plan for Wiltshire by ensuring business as usual is embedded in 2017/18 and to sustain into 2019. Appendix 1: DTOC trajectories 2017-19, Appendix 2: Provider ambition for December 2017 and Appendix 3 Wiltshire break down by reason for the delay

There is a comprehensive reporting structure in place for delayed transfers of care which is underpinned by the Better Care Plan Performance Dashboard. The key indicators include;

- DTOC delayed bed days (all beds)
- Readmission rates (28 days)
- 91day indicator
- Average LOS per NEL bed
- Average LOS community hospital bed and ICT
- Green 2 Go (G2G) patients per acute trust AND % of beds (Stranded patients)
- Number of DTOCs per acute trust
- Volume of weekend discharges
- Average time on caseload
- Average LOS between medical stability (G2G) and actual discharge
- Volume of discharges before midday against plan
- Volume of assessments and discharges within 24 hours
- Volume of activity per scheme vs. plan.
- SPC for current year using previous year activity as the baseline (to be explored)

Wiltshire Council ambition for 2018/19

- Redesigning the hospital discharge process
- Developing a reablement service that supports Home First
- Increasing capacity in the domiciliary care market
- Wider transformation of Adult Social Care (including front door)
- Responding to demand pressures within SEND/LD
- Home First operational pathway lead National Living Wage pressures

Better Care Fund Programme plan 2017-19

Service Area	Action required	KPIs, Delivery date and owner of project	Risk
Workforce Strategy	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, this is underpinned by the Wiltshire Workforce Strategy.	Ongoing training with care homes to instil a reablement philosophy within homes	
Admission avoidance		• 2017-18 restrict admission to 1% growth for 65+ and 2018-19 reduction of 306 admissions per annum. Baseline 2, 2000 admissions (200 per 1,000). • Avoid 30 admissions per month and 85% admission avoidance. Test to increase in 2018/19	
Readmission	Identify support to reduce readmissions.		
Community geriatrics	Community geriatrician coverage across Wiltshire, need to link with established community teams consistent across a 7-day period. Developing "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 aim will be to reduce LOS and admission avoidance through early intervention and support in the community.	
Wiltshire High Intensity Care programme	**Roll out of the High Intensity care programme, 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		
Front Door Avoidance Rapid assessment (streaming)		Community teams link to specialist teams	
Step Down ICT Beds – care homes	60 beds in 9 identified homes across the county. Confirm criteria for ICT beds. LoS reduction	To enable 60 admissions a month and 720 admissions per *annum*	
Step Up ICT Beds – care homes	10 beds in 2 identified care homes in the south of the county and a GP Led delivery model	To support admission avoidance in the South.	
Community Hospital – Step Down	Confirm criteria for community hospitals beds.	*To enable an additional 25 patients Per month 300 patients per annum*	
Step Up Intermediate care (Community Hospitals).	Access across a 7 day period Access to a wider pool of referrers (such as SWAST) Sign off agreed referral pathways from hospital front doors **Community Hospital Beds and Intermediate Care beds** The main reasons for DTOCs in community hospital beds remain - Delays in awaiting care package at home - Delays in waiting long term residential and nursing care. - Choice delays - Increased length of time moving patient to " MDT " ready for discharge, this is in effect getting patients to " green to go " status . - Poor referral management with patients being discharged	WC/WCCG November 2017 2017-18 50% of community beds to be step up compared to 25%. The aim is to achieve an additional 15 discharges a month from CH beds. This will provide an additional 180 discharges per annum over and above current levels 12 patients a month 144 patients a year	If flow is not maintained it will impact on LOS, DTOC and excess bed days

	- inappropriately into community beds. - Patients over the age of 85 with co morbidities remains a challenge		
End of Life Care Pathway	30 % of all hospital non-elective admissions are for patients with a life limiting diagnosis. Actions to; Improve identification of patients who have <12 months to live. Progress implementation of treatment escalation plans across system. Reshape role of the community end of life team (GWH Community services) proactive case management approach for patients on an end of life pathway. Continue commissioning of the 72 hour EOL pathway? Review and agree future role of hospices in the EOL agenda.	Dorothy House Hospice and Salisbury Hospice. 16 cases per month 192 cases per annum	
Urgent care at home	Crisis response services have been reviewed and pathways standardised for each acute hospital.	Urgent care at home 80 cases per month 960 cases per annum Medvivo /WHC /Acute Trusts	
Care home liaison MH	AWP is launching the Care Home Liaison service for patients with dementia. Separate weekly performance management process in place across Wiltshire for mental health DTOCs?		
Dementia Services	A comprehensive service for those with dementia, Dementia strategy and action plan have been developed. However community focused /crisis intervention based model of care should be tested to ensure this meet demand. The Care Home Liaison services and discharge planning supported by Acute “in reach “programmes for dementia, now need to be tested.		

Integrated Discharge **Early Discharge Planning** **Capacity and demand reviews of** **Help to Live at Home (Dom care provision across Wiltshire)**	To strengthen the early discharge model to include WHC (pull model) Ensure Red and Green Days are embedded in acute and community hospitals. Consider Prefect Week Q3 and Q4 2017/18 Safer buddle – implemented and embedded. **Test** Care – coordinators These are in place at different levels across Wiltshire. Test if fully integrated within the discharge planning system across Wiltshire. • High risk patients being referred to integrated teams for ongoing management • Care – coordinators to be informed of discharge plan once patient is "medically stable ". Test: Early supported discharge pathways being developed for certain cohorts of patients	October 2017 – owned by Trusts Confirm roll out plan with implementation dates in Q3 – owned by Trusts. WCCG/WC/NHSI/Providers Trusts to confirm date for Q3 and Q4. Owned by Trusts supported by WCCG/WC/NHSI Supported by NHSI in Q3. WCCG/WC/NHSI	if not embed DTOC trajectory will not be delivered by Dec 2017 or sustained
Re-ablement **Rehab workers**	30 wte Carers to support Urgent care at home and improve 21 discharges a week 1091 discharges per annum.	New service model WC May 2018 – community teams Embed referral routes	Recruitment of workforce
Trusted Assessor		WCCG/WC/Providers implemented Q1 2018/19	

Systems to Monitor Patient flow Bed Management **Information Technology** **Single point of access**	Data to support daily management of patient flow – Daily calls and WC operational lead Wiltshire system daily dashboard used for daily review, escalation and action. Alignment to OPEL Boards to monitor progress against trajectories and actions (Dashboard for BCF projects) Single point of access available to facilitate access to community services to manage crisis at home with specialist opinion and diagnostics.	October 2017	Decision making will be impacted. DTOC increase impacting on performance
Multi-Disciplinary Multi-Agency Discharge Teams (Including Vol & Community sector)	Ensure MDT processes are reviewed to ensure they are robust and reflective learning is taken forward Confirm that - Community hospital teams held DTOC planning workshop and the key recommendations from this are being implemented - Confirm an expected date of discharge on admission to recorded - Development of the key worker role to coordinate patients to discharge - Target lengths of stay for conditions and profiles - Named and assigned social workers to all community hospitals - Direct access to domiciliary care at ward level - Improved reporting and tracking of delayed discharges	October 2017 on going Core business levels at circa 1200 discharges per annum from the acute trusts WC/WCCG providers	Communication impacted between providers

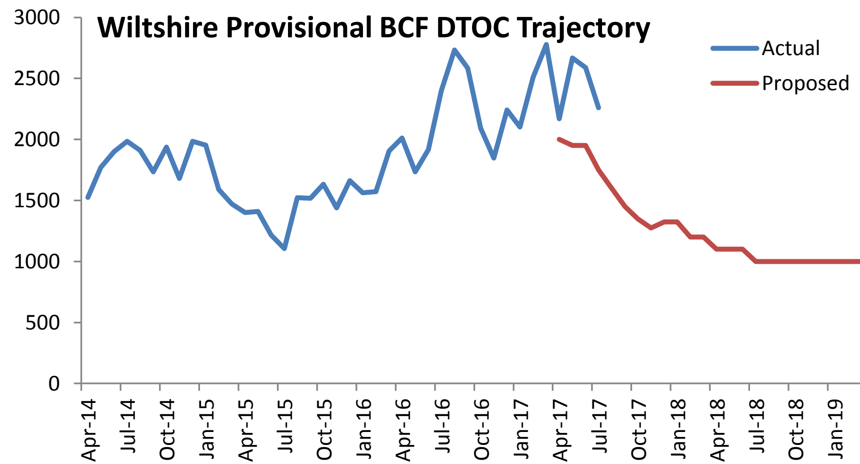
	- A greater focus on re-ablement gaining the patient's independence where there is no ICT provision. - Implementation of Wiltshire wide choice policy - Revised pathways criteria for acute referrals into beds - Enabling weekend discharges and admissions		
Home First **Discharge to Assess (D2A)**	Strengthen and roll out the model across acute and community settings in Q3 and Q4 however consider alignment to HTLAH and Re-ablement in Q4. Gap analysis – demand to capacity for HF/D2A/HTLAH Clarify domiciliary care capacity through Home First will ensure system beds are used appropriately	October to November 2017 finalise and commence rollout of plan SFT, GWH and RUH WHC/WC/WCCG owners WC/WCCG WHC/WC/WCCG	DTOC will not reduce to trajectory
PTS	Explore opportunities in current model and identify additional capacity	Q3 WCCG	Impact on discharge
Seven-Day Services	Model aligned to Health 7DS 4 clinical standards however assurance on WC 7DS offer for social care. Services implemented through the Better Care Plan and ORCP provide coverage across 7 days, supported by the 24/7 access to care /SPA led by MEDVIVO.	Providers WCCG and WC	Business Continuity Impact on DTOC and patient flow
Accessing specialist	CHC and fast test to ensure protocols are in place with each acute hospital. Fast-track pathways for stroke to dedicated and protected beds, MIs, and NoF.	Understand the impact on DTOC Q3 WC/WCCG/Providers	

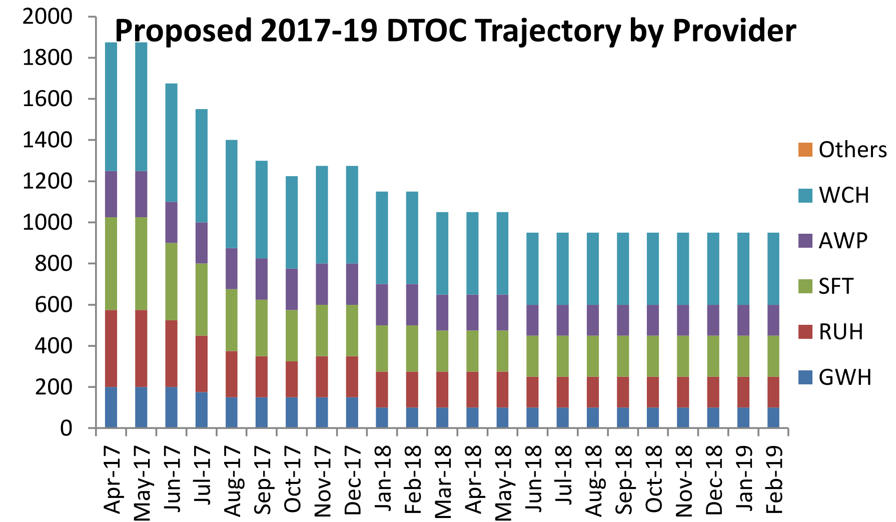
	Undertake a review ESD for stroke and discharge for spinal /trauma patients in SFT. Supported Hospital Discharge Service in place to facilitate discharges from the acute setting, review to be completed. Role of the voluntary sector in relation to discharge planning is being enhanced MH AWP Care Home Liaison EOL (72hr) rapid access pathways for end of life patients across Wiltshire.	AWP in reach for dementia – no measures? Test alignment to the frailty hub programme being progressed by Wiltshire Health and Care (17/18) EOL 20 admissions managed in a non-hospital setting at month.	
Choice Policy	Review policies within Trusts and system progress to ensure alignment and recording is consistent	Q3 – WCCG/WC owner working with acute and community hospitals	Risk to delivery and performance
Governance and planning	**System capacity and demand planning** Undertaken for the winter period and will be refreshed on a quarterly basis. This is underpinned by growth and disease projections and we have established monthly predicted demand levels and the amount of discharges required on daily basis to keep the system in balance and achieve the LOS /DTOC plan reductions		
Communication plan aligned to winter and escalation	Align Wiltshire Council and Wiltshire CCG winter plans - Launch of proactive comms for the period	CCG/WC, Medvivo /3 acute trusts and WHC	UEC Plan

	- Focus on promotion of alternative services and access points - Signposting of services - Key public messages in relation to “ choice “ policy - Revised pathway and key service communications to GPs and other stakeholders in the system - Targeted community care homes (i.e. care homes, patients with LTC etc.) - Robust internal comms - Patient education and public health messages - Media plan (tbc) - On call comms arrangements - Promotion of the single number approach		
Prevention **Add other projects**	Ensure a preventative based approach is taken at all stages of an older. person’s pathway of care. Review to be undertaken post 2017/18.	WC 2017/18 review of SFT fracture clinic	
Supporting social services and health integration Shared assessment frameworks across health and social care should lead to a Personalised care Integration of information Continued development of the Single View of the Customer approach	**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, **Integration of information** Single View of the Customer to ensure that adequate and timely information is shared between services whenever there is a transfer of care between individuals and services.	WC BCF TBC	

              Carers Support **Personalised commissioning**	**Reviewing appropriateness of care packages across the system** Undertake a demand review of HTLAH utilisation with the aim of establishing ; - Very clear service thresholds - Upper limits / quotas - Clear referrals pathways and review points. To identify capacity flows to support the "home first /integrated discharge approach **Carers support** Carers are offered an independent assessment of their needs and signposted to interventions to support them in their caring role, as part of the care act. 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. **Personalised commissioning** Define the offer for personal budgets in Wiltshire in 2017/18 to identify the actions for 2018/19		

Appendix 1 Trajectory for Wiltshire





The trajectory was developed looking at the historic delayed days by trust and the split between Health and Adult Social Care delays. It is also based on what we believe the schemes outlined above are able to deliver. While we are currently over target, this is predominantly at GWH, AWP & WH&C, while SFT and RUH are both only marginally over the trajectory. Health delays are around the trajectory but Adult Social Care and Both delays remain well above the trajectory.

Phase 1
DTOC PLAN to reduce delayed bed days from 1,749 in July to 1,325 in December 2017

Phase 2
Reducing to around 1,100 from April 2018 to July 2018 and then sustainably deliver around 1,000 from August 2018. This represents an improvement on the previous performance across Wiltshire.

Appendix 2 Providers ambition for December 2017

Wiltshire Council

NHS Wiltshire Clinical Commissioning Group

Breakdown by Trust lost bed days

	2015-16	2016-17	2017-18 (July)	Dec Target
GWH	194.0	261.9	357	150
RUH	147.7	444.8	384	200
SFT	294.3	499.3	411	250
AWP	292.8	348.1	299	200
WHC	495.3	646.7	741	475
Others	71.3	45.1	68	50

Appendix 3 Lost bed days by reason

Wiltshire Council

NHS Wiltshire Clinical Commissioning Group

Breakdown by Reason

	15-16	16-17	17-18 (to M4)	Dec Target
Assessment	36.6	53.2	86.5	30
Public Funding	10.2	8.0	29.3	10
Non Acute transfer	299.0	447.3	314.8	250
Residential home	191.2	301.3	432.0	150
Nursing home	343.2	378.5	471.0	300
Dom. Care	435.2	795.3	776.3	400
Equipment/ adaptations	39.8	76.7	71.8	40
Patient/family choice	88.0	128.2	176.5	95
Disputes	9.7	14.0	0.0	10
Housing	42.8	43.3	63.3	40