NHS
Wiltshire
Clinical Commissioning Group

OPERATIONAL RESILIENCE AND CAPACITY PLAN

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1 STATEMENT OF ASSURANCE

At the meeting of 18th September 2014 the Wiltshire System Resilience Group reviewed the operational resilience and capacity plan and supporting investment tables that identified the allocation of £6.876m to support health and social care provision in 2014/15

Based on this information, a peer review of provider resilience presented at the meeting, knowledge of historic provider performance during times of increased demand and an awareness of current provider challenges Wiltshire SRG have applied a confidence factor of 80% for the delivery of the 4 hour Accident and Emergency target at Salisbury Hospitals NHS Foundation Trust.

This has been arrived at by Wiltshire SRG applying a confidence factor against individual provider delivery and weighting this against each provider's impact to whole system delievry.

Provider	Wiltshire SRG confidence factor of provider delivery of performance	Weighting applied to importance of provider delivery to support system resilience	Weighted Average
Arriva	85%	0.70	0.079
AWP	70%	0.40	0.037
Care UK NHS 111	75%	0.60	0.060
GWH Community	75%	0.80	0.080
H2L@H	50%	0.60	0.040
Medvivo	95%	0.90	0.114
Primary Care	80%	0.80	0.085
SFT	85%	1.00	0.113
SWASFT	90%	0.90	0.108
Wiltshire Council	75%	0.80	0.080
		7.50	**80%**

2 INTRODUCTION

2.1 Current issues that need to be addressed

2.1.1 The Joint Strategic Assessment (JSA), developed by our partners at Wiltshire Council, provided the CCG with detailed information about the population across the County.

2.1.2 Wiltshire is a large, predominantly rural and generally prosperous County with a population of 479,992. Almost half of the population resides in towns and villages with less than 5,000 people and a quarter live in villages of fewer than 1,000 people. The rural nature of the County has implications for the planning and provision of health and social care services, particularly with a shift towards more provision of services in the community.

2.1.3 The CCG's current population is 479,992 (2013), and forecast to grow by an additional 3.3% (15,603) by 2018, and by 5.3% (25,423) to 505,416 by 2021. This excludes some additional 10,000 people because of military restructuring and developments in the County. By 2021 there will be proportionately more children & young people (+5533) and less working age adults (-632). People over 65 make up 20% of the County's population and will make up 22.5% of the County's population within the next 7 years, and the number of older people is rising much faster than the overall population of the County (+20,253 by 2021).

2.1.4 The implications of an ageing population are great in terms of people living longer into older age, with an increased demand for health services, a higher burden of chronic disease and susceptibility to the negative impacts of social isolation. Older people are more likely to need health and care services and we know that nearly half of Wiltshire's NHS financial resources (47.4%) are used by people aged over 65. Much of this resource is needed for frail and vulnerable older people.

2.1.5 The conclusion is that the resource consumption of over-65 age group is significantly higher per head that that of other age groups and that the impact of population changes will therefore have a profound impact on the CCGs future resource needs.

2.1.6 The challenge will be to focus on the over 65 group - particularly over 75s - as without this type of fundamental change through a shift in the balance of care, relying less on reactive acute services and more on proactive community care, the CCG's ability to meet its commissioning intentions for the healthcare needed by people in Wiltshire will be compromised.

2.1.7 Our provider sector is dominated by acute providers who make up 56% (£274.4m) of service expenditure. Non acute care, which includes community and mental health services makes up the second largest element of expenditure, 22% (£107.2m) of overall service expenditure. We have identified scope for improving resource utilisation in a number aspects of acute provision, such as non-elective length of stay, higher than expected levels of non-elective activity and scope for redesigning care pathways to deliver elements of planned care that are more in line with best practice norms, all of which form part of the CCG two year delivery plan.

2.1.8 The CCG will need to continue to address services that are too heavily focussed upon the acute sector and bed-based hospital services by continuing to develop further community and home based services as credible high quality alternatives to the current default of acute inpatient care and ensure that continued local investment and joint working with Wiltshire Council and the utilisation of the Better Care Fund supports this goal.

2.1.9 The CCG is faced with the juxtaposition of supporting strategic objectives around care closer to home whilst recognising increasing demand across the whole provider landscape. We are aware that as of end of May 2014/15 ambulance activity for emergency response is up 7%, Out of Hours activity is up on average 24%, A&E attendance is also showing demand pressures with all of our acute providers are showing an increase in non-elective activity.

2.1.10 We have further analysed data to month 2 year to date 2014/15, and have found, (see charts 1 to 5), that;

- Emergency calls with an 8 minute response are up 7%, although conveyance rates to an emergency department (all calls) are down 2.7%
- NHS 111 calls are up 16% and Out of Hours telephone advice volume and home visits are up 35% and 17% respectively
- Whilst the A&E attendance for the CCG is down at -4%, there is a broad spread across various providers, (GWH -4%, RUH +10%, SFT +1%, MIU's -2% and SWIC +9%
- Non elective spells for SFT is flat with a 2% increase at RUH and a 7% increase at GWH

Chart 1

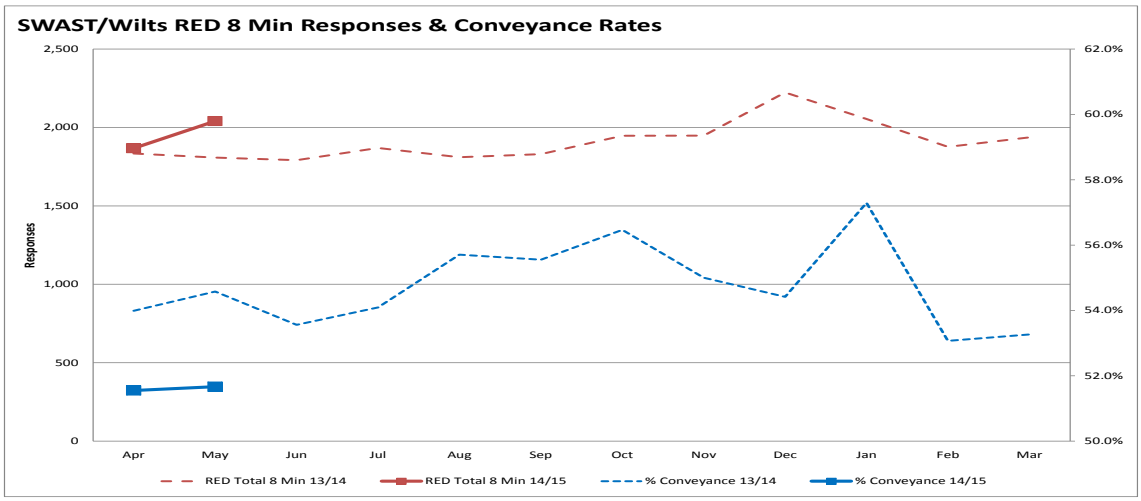


Chart 2

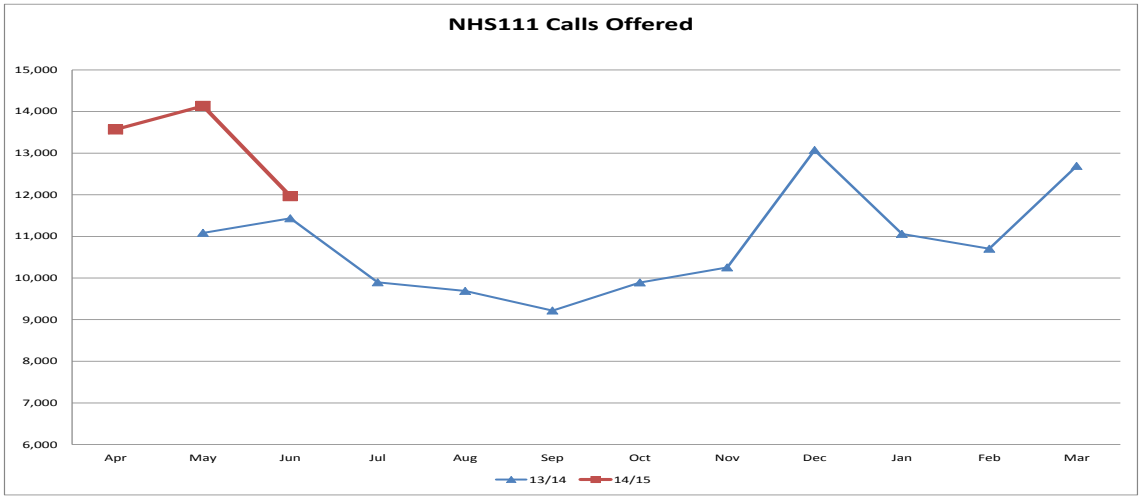


Chart 3

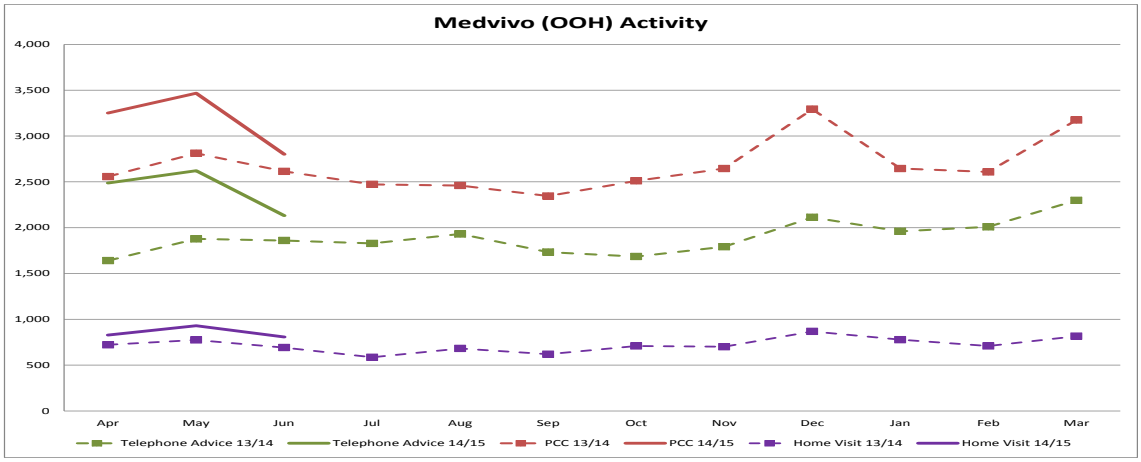
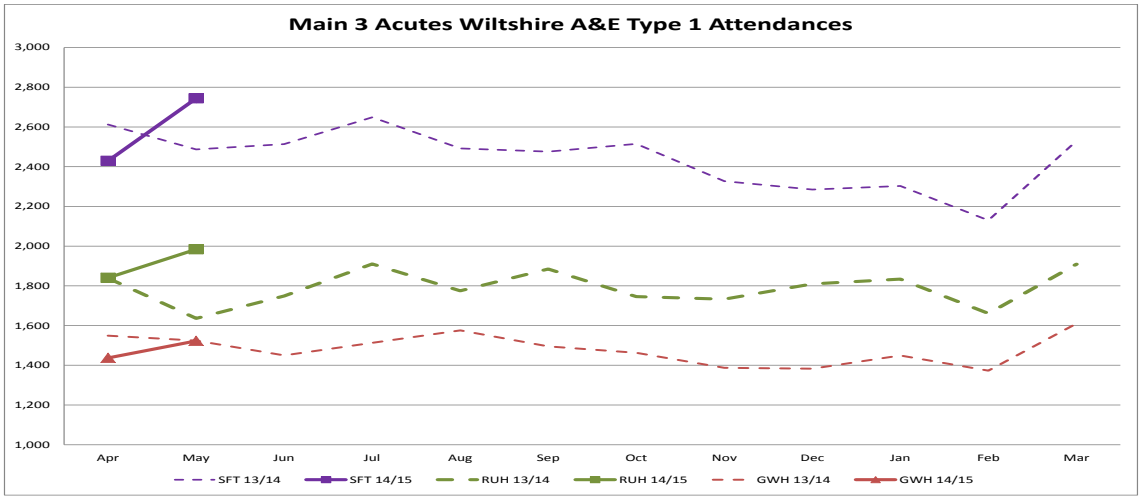


Chart 3



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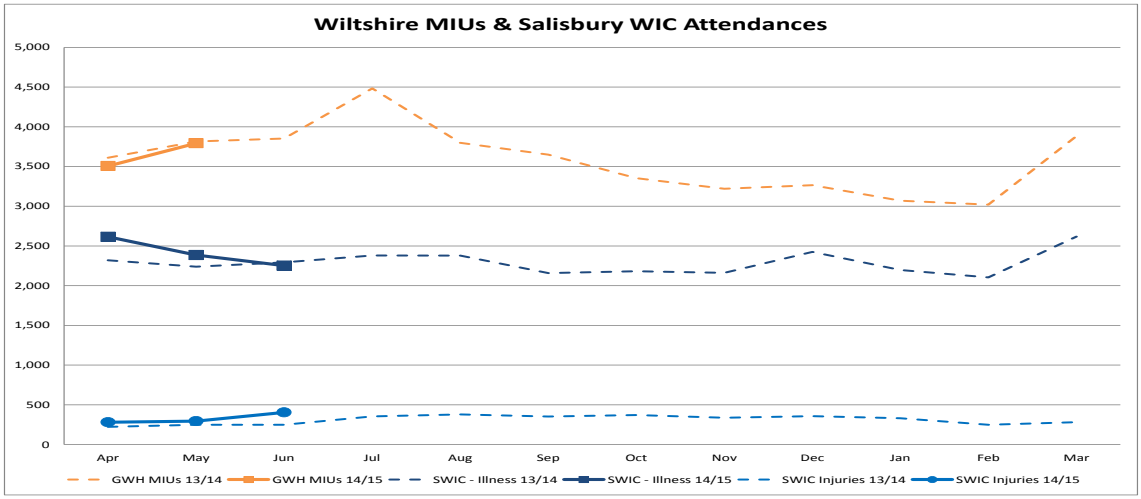

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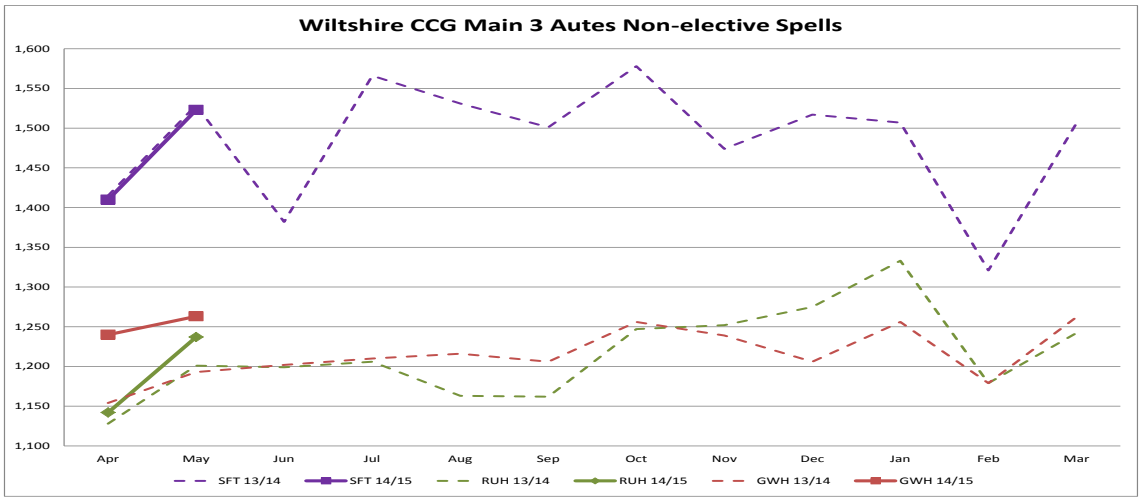
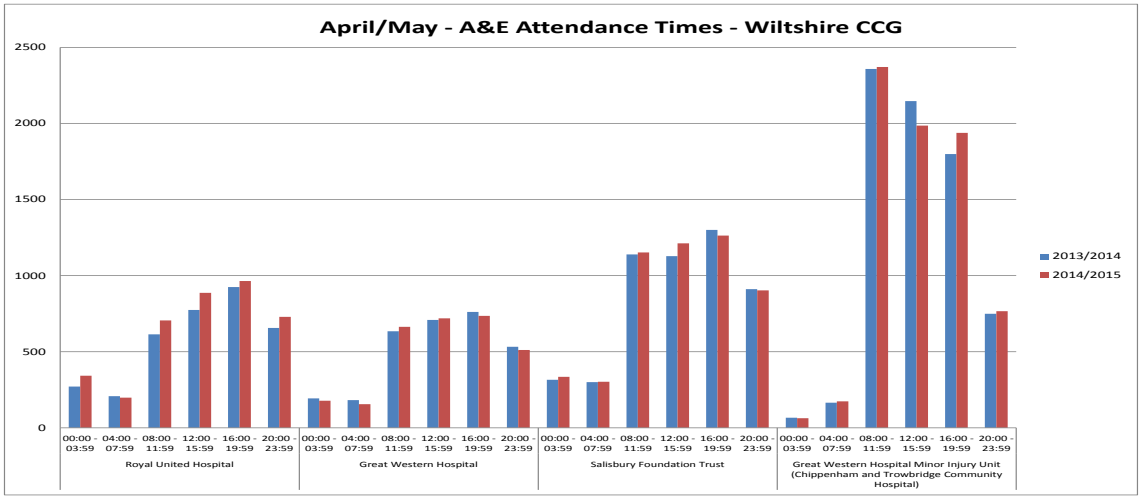


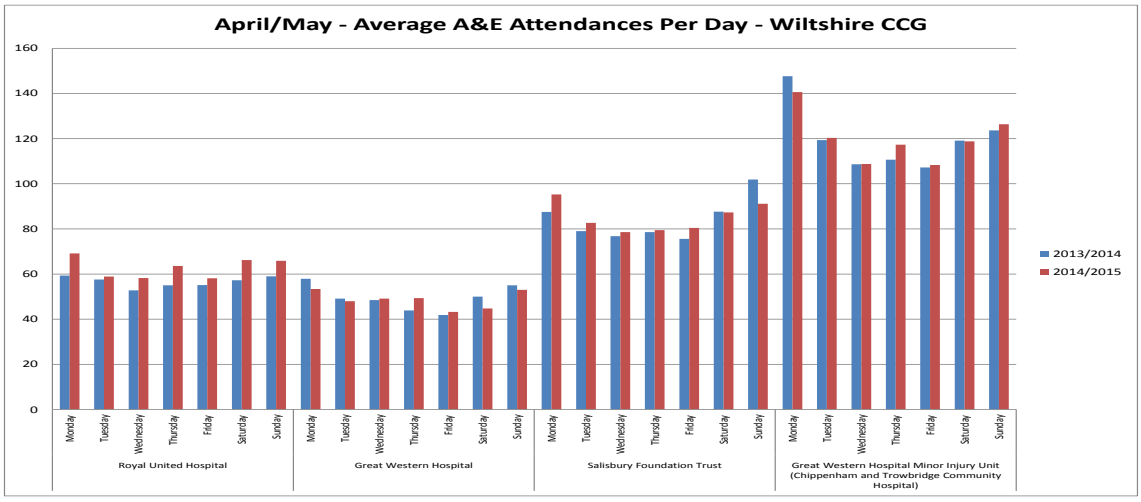
2.1.11 Additional analysis of time and day of arrival for ED and MIU attendances was undertaken for the same period to attempt to identify any patterns. Banding the time of arrival into 4hr blocks the greatest proportion of ED arrivals was late afternoon / early evening, whilst MIU attendance was at its greatest in the morning, (chart 6).

Chart 6



2.1.12 The 'Average A&E attendances Per Day' show average attendances on each day of the week adjusted for the differing numbers of each day in the month for each year. (eg in April 2013 there were 5 Mondays but only 4 in April 2014). Mondays are the busiest day at all sites. Over the 2 month period the day with the greatest increase in average attendances is Thursdays for RUH, GWH and MIUs whereas it is Mondays at SFT, (chart 7).

Chart 7



2.1.13 The non-recurrent funding for operational resilience for 2014/15 has been allocated to CCGs on a fair shares basis; Wiltshire CCG's allocation is £2,763,138. Wiltshire CCG's view is that we want to continue focusing on the services that we have put in train which are funded through the Better Care Programme or the specific reserves within Wiltshire. This includes the investment around expanding our community teams which is being driven through the Optimising Community Teams; Simple Point of Access and rapid response/urgent care at home services; intermediate care; and Transforming Care of Older People schemes across the CCG localities in developing pro-active care focussing on reducing avoidable admissions of frail elderly patients.

2.1.14 However, through joint working with Swindon and BaNES SRG's we have agreed a number of joint investments, linked to provider requests, to ensure that Wiltshire patients are not disadvantaged.

2.2 Governance and performance arrangements

2.2.1 In June NHS England confirmed to the CCG the requirements that need to be put in place to ensure operational resilience during 2014/15 for both urgent and planned care. http://www.england.nhs.uk/wp-content/uploads/2014/06/op-res-cap-plan-1415.pdf

2.2.2 This guidance moved beyond planning for urgent care over winter, and brought together planned care into the system wide year round resilience framework This wider remit was partly informed by the recent pressures that have been seen in delivery of the referral to treatment (RTT) standard, but was primarily driven by the principle of good local healthcare planning being equally focussed and resilient across planned and urgent care.

2.2.3 In response the CCG has reviewed the functionality of the Urgent Care Working Group, recognising that this will evolve into the Wiltshire System Resilience Groups (SRGs) with an expanded remit and become the forum where urgent and elective capacity planning and operational delivery across the health and social care system is co-ordinated. Bringing together both elements within one planning process underlines the importance of whole system resilience and that both parts need to be addressed simultaneously in order for local health and care systems to operate as effectively as possible in delivering year round services for patients.

2.2.4 In addition, the CCG has established an overarching strategic programme structure, of which urgent care is a key component, along with interdependent programmes focused on delivery of community transformation, additional primary care capacity through Transformation of Older People schemes, coordination of patient facing health and social care services through Simple Point of Access, increased capacity through intermediate care beds and patient flow initiatives within our three local acute hospitals.

2.2.5 The urgent care programme will report progress against key deliverables within a number of agreed projects through to the SRG. These projects also link into redesign processes being supported by BaNES and Swindon CCG, to ensure that the CCG remain sighted on any interdependent clinical redesign within those areas.

2.2.6 In addition a process will be established to ensure that the SRG is sighted on 'business as usual' activity. This will include, but not be limited to, activity around key core contracts supporting the ambulance service, Out of Hours and associated services and NHS 111 provision.

2.2.7 The SRG will report through to the Executive led CCG Programme Governance Group (PGG).

2.3 Links to Better Care Fund and Health and Wellbeing Board

2.3.1 The Health and Wellbeing Board will oversee the delivery of the Wiltshire Better Care Plan which is a key element in the implementation of the Wiltshire Health and Wellbeing Strategy, and ultimately our aspiration for a better integrated health and social care system.

2.3.2 Health providers all sit on our Health and Wellbeing Board as well as other partners such as Wiltshire Council, Wiltshire Police, NHS England and HealthWatch.

2.3.3 Supporting the Health and Wellbeing Board we have a well-established Joint Commissioning Board for Adults' Services (JCB) and many of the currently emerging service changes have been developed and overseen by this Board, which comprises key Executives from the CCG and the Lead Councillor & Officers of Wiltshire Council.

2.3.4 Delivery of the Better Care Plan is integral to delivering system change to services that will be better able to support improved demand and capacity management. We have agreed new joint arrangements for project management and oversight, including the establishment of a bespoke Better Care Fund Programme Governance Group as a subcommittee of the JCB.

2.3.5 This group will have a similar remit to the CCG's established PGG, and bring the same level of scrutiny and control to all those projects within the Better Care Fund. Many of these are inter-dependent on projects arising from the CCG, and accordingly we are committed to working with our Council partners to work smartly and collaboratively to deliver the best possible effect without duplication of staff effort.

3 GOOD PRACTICE

3.1 Principles

3.1.1 In December 2012 The NHS Commissioning Board (NHS CB) published *Everyone Counts: Planning for Patients 2013/14*. This helped local clinicians plan and deliver more responsive health services, focused on improving outcomes for patients and against which to measure improvements. It outlined five themes: moves toward seven-day a week working for routine NHS services; greater transparency and choice for patients; more patient participation; better data to support the drive to improve services: and higher standards and safer care.

3.1.2 In addition, in January 2013 NHS CB announced a *Review of Urgent and Emergency Services in England*. As well as seven-day working, the review set out to help CCGs find the right balance between provision of excellent clinical care in serious complex emergencies and maintaining or improving local access to services for less serious problems.

3.1.3 It set out the different levels and definitions of emergency care, ranging from top-level trauma centres at major hospitals to local accident and emergency departments and facilities providing access to expert nurses and GPs for the treatment of more routine but urgent health problems.

3.1.4 It stresses that the pattern of urgent and emergency care, including the number and location of services, will continue to be developed locally to meet the different needs of urban and rural communities.

3.1.5 A recent update presented by Professor Keith Willets and his team suggested that in addition to ensuring the tiered systems of care to support those with life threatening emergency needs are in place, that systems must evolve to deliver care to those with urgent, but non- life threatening needs. This should include;

3.1.5.1 Better support for self-care through accessible information about self-treatment options

3.1.5.2 Helping people get the right advice in the right place first time through an enhanced NHS 111 service

3.1.5.3 Faster convenient enhanced services, including same day every day access to primary care, 24/7 decision support for general practice, co-location of community based urgent care services, and improved utilisation of paramedic skills within the community.

3.1.5.4 Establishing strategic and operational system resilience groups

3.1.6 The CCG recognises that the principles currently captured within the 5 Year Strategic Plan and supported through current investment and use of the Better Care Fund fully align with the themes emerging from the Review of Urgent and Emergency Services in England.

3.2 Community Urgent Care Review Project

3.2.1 The Wiltshire CCG 5 Year Strategic Plan identified a need to review the urgent care system, including the Salisbury Walk In Centre (SWIC); Chippenham and Trowbridge Minor Injury Unit's (MIU) and Minor Injury (MI) GP Local Enhanced Services to define an optimum service pathway for patients.

3.2.2 The community urgent care review has commenced and will incorporate the Urgent and Emergency Care review design principles making it simpler for patients to access and navigate urgent care services, integrating with a primary care team around and an agreed twenty thousand population cluster.

3.2.3 The project will conduct a full review of activity and associated cost, identifying if the current model matches the current need of the population. This will be completed through three separate task and finish groups concentrating on the three units (Trowbridge, Chippenham and Salisbury). These groups will also provide recommendations for potentially aligning the provision of community urgent care across the health economy to ensure equity of service is provided for all registered patients as well as identify any potential savings.

3.2.4 The project will also highlight future model recommendations and identify if activity could be managed elsewhere, aligning with the CCG's strategy of providing care closer to home and resulting in an optimum service pathway to ensure patients are seen by the most appropriate clinician in the most appropriate setting at the most appropriate time providing equity of access across the CCG and not just to those patients residing close to the units or registered with those practices.

3.2.5 Recommendations will be produced before December 2014 to allow for any suggested changes to run alongside the community contract procurement process.

4 WIDER CONSIDERATIONS

4.1 Better Care Plan.

4.1.1 The CCG and Wiltshire Council recognise that delivering a joint vision will involve significant changes to the way services are designed and delivered, and that those changes are already underway.

4.1.2 The integrated pooled budget supporting the better care fund for 2014/15 is £22.37m rising to £31.91m in 2015/16 and in discussion with stakeholders, including health and social care providers; the National Voices definition of good integrated care has been adopted

4.1.3 Providers have been engaged in a number of ways:

- Through a Health and Wellbeing Board hosted event on the Better Care plan (14th January 2014) attended by Acute Trusts, Community Health Provider, Social Care providers, Mental Health provider and voluntary sector
- Through work with the Wiltshire Care Partnership, the membership organisation for social care providers
- Through the Health and Wellbeing Board itself – the Board is made up of a range of stakeholders, including the 3 district general hospitals serving Wiltshire People, the mental health trust and the ambulance trust.
- Through the work underway on the CCG's 5 Year Plan. The 5 Year Plan has been developed jointly with council colleagues and has involved extensive provider engagement. The information gathered at these events is also informing our Better Care Plan.

4.1.4 Wiltshire Healthwatch will be leading on all user engagement as part of the Better Care Plan and will undertake user focused qualitative analysis. Additionally, other user led organisations will be engaged and consulted about service change with the established Local Area Boards.

4.1.5 The Better Care Plan also reflects a number of existing programmes of joint work which have engaged with health, social care and voluntary sector providers as active participants. Examples include

- Engagement on the Joint Health and Wellbeing Strategy
- Engagement on the CCG's Community Transformation Programme
- Workshops with providers on a whole system workforce strategy
- A Steering Board for the development of intermediate care services (STARR)

4.2 Discharge to Assess

4.2.1 Discharge to Assess (D2A) is a pilot project to establish capacity and process for a new pathway designed to move care closer to home and reduce unnecessarily prolonged stays in acute hospital beds.

4.2.2 At any one time there are a number of people in an acute hospital bed, whose medical episode is complete, but who are unable to manage without support at home or in a residential home. Rather than wait in hospital for further assessment of their long term care needs, the challenge is to move people into a more appropriate setting, improving hospital flow and maximizing people's capacity for independent living, increase the number able to remain living at home and reduce the total who are permanently admitted to care.

4.2.3 The CCG and Wiltshire Council are supporting a pilot to implement a discharge to assess model. This aims to proactively ensure that frail elderly people only stay in an acute hospital when they require a 24/7 specialist service and once medically stable they are supported to remain at home where further assessments (therapy, equipment etc) can take place, followed by a period of rehabilitation and/or reablement as required.

4.2.4 The project will look at the possibility of delivering a fully integrated and streamlined service, which will both speed up hospital discharge times and improve outcomes for older people. The pilot will operate as two parts. Pilot A will operate for patients whose home address is Warminster, Chippenham or Corsham and will support people largely in their own homes. Pilot B will operate for patients who are discharged from Salisbury Hospitals NHS Foundation Trust and will support people largely within a short-term care home placement.

4.2.5 There will be potentially three pathways of which discharge to assess will focus on the third;

1. Restart of an existing pathway and discharge home to previous situation, without any additional support required
2. Rehabilitation or reablement to existing pathway via Community Hospital, Community Health Team or Social Care initial support
3. A significant change or increase in need (e.g. potential care home placement) that requires an alternative service to enable safe discharge from hospital. Most people will be able to return home for further joint assessment, although a small percentage of patients may need a community assessment bed

4.2.6 The principles of the discharge to assess pilot will be based upon;

- Clear and understandable pathways
- No patient to be in hospital for longer than clinically required
- No decision about long-term care to be made whilst the patient is in hospital
- On admission, every patient who may appear to have a support need upon discharge will have a discussion about what is likely to happen upon discharge
- The aim will be to discharge every patient to a discharge to assess pathway within 24 hours of the patient being clinically fit for discharge
- Going home to be the default option for every patient

4.2.7 Discharge to assess will encompass STARR, HTLAH providers, care home providers, community health, locality social care, GPs, community geriatrician, mental health specialist support, telecare services and voluntary and community sector, as required

4.2.8 Every patient on D2A and or their carer will agree their care plan (including escalation) to better cope with their symptoms and develop strategies for dealing with difficult periods in the management of their rehabilitation.

4.2.9 Clinicians, social workers and carers will ensure that customers and their carers are central to decision making and will provide holistic support and care respecting their beliefs, values, dignity and choice at all times. The aim will be to maximise independence and wellbeing for older people and those with long term conditions. The model will support proactive case finding in hospital – a 'pull' model with community based health and social care identifying people who can be discharged from acute care and will also utilise step down intermediate care beds (Community Hospital and STARR) for people who cannot go home for assessment and will include patients from all three local acute providers, whose home address is within the 2 Somerset Care HTLAH areas (either Chippenham/Corsham or Westbury/Warminster) who meet the requirement of pathway 3 above – i.e. medically fit, with an increase in care needs and / or rehab requirement.

4.2.10 Both pilot area A and B involve commissioning a range of community-based services to proactively ensure that frail elderly people only stay in an acute hospital bed when they require a 24/7 specialist service and once medically stable they are supported to return home, whenever possible, if not possible then the individual will be supported in a care home environment until they are able to return home, or make an informed decision for their future care. Pilot B will rely on short-term care home beds whilst the HTLAH Provider in South Wiltshire (Mears) increases their carer capacity to undertake discharge to assess at home.

4.2.11 The Pilot will run from the beginning of September 2014 to the end of March 2015 and report through the intermediate care steering group within the overall CCG and Wiltshire Council governance arrangements.

4.3 Transforming Care for Older people – Phase 2

4.3.1 With a reduction in headroom funding the CCG has been required to identify investment in primary care to the sum of £5 per head of registered patient population. This equates to £2.35m in total throughout the CCG practices.

4.3.2 The CCG has invited practices and or groups of practices to submit a business case for utilisation of these funds based on;

- Strategic fit
- Clarity of the problem
- Clarity of the solution
- Return on investment
- Implementation plans

4.3.3 Eleven cases have been supported at the CCG Governing Body, although some require additional data on affordability and the recruitment challenge prior to implementation.

4.3.4 These initiatives are replicated across a number of practices and include but are not limited to;

- Release of primary care capacity through back fill of emergency care practitioners and elderly care clinical assistants to support delivery of proactive care and support planning.
- Proactive telephone triage of at risk patients, including the development of 'additional support lists' for weekend crisis prevention.

4.3.5 Locality leads will work with applicants to complete these due diligence checks related to cost breakdown and impact / benefit, with a target date 31st July 2014.

4.3.6 Following due diligence a process has been agreed for transactional finance arrangements / audit trail for payments etc. with a target date of 30th September 2014 for completion.

4.3.7 Due diligence checks related to cost breakdown and impact / benefit were completed by the end of August 14. Where no significant issues were raised during due diligence in terms of affordability / deliverability, plans are now progressing to recruitment / implementation planning stage with a target go live date of October 14.

4.3.8 Recognising the recruitment challenge providers experience from a limited clinical pool, the CCG, GP practices and SWASFT are having joint discussions to explore the opportunity for shared working of ECP's or paramedics to support the objectives within the bids of increased GP capacity by provision of alternative assessment models.

4.3.9 The Transforming Care for Older People panel will review progress at the September 2014 prior to the Primary Care Programme Board taking over accountability for on-going monitoring, evaluation and continued funding recommendations.

5 BUILDING ON EXISTING WORK

5.1 Learning From Last Year

5.1.1 2013/14 gave the CCG opportunity to resource and plan system changes and this undoubtedly had a major bearing on local performance improvements. Looking three ways has always provided the CCG with a degree of complexity and we recognised our responsibility to ensure that our patient population was not disadvantaged by where they live within the county. To that end we supported investment right across the health system, working closely with commissioning and provider colleagues.

5.1.2 We are clear that supporting a key theme of keeping people out of hospital had a positive impact on the health system. We introduced 23 wte. care co-ordinators across practice clusters to provide a safety curtain for complex patients within the community, working closely with risk stratification tools to ensure patients were readily identified and appropriately supported. This principle of admission avoidance strategies was also enhanced by additional GP capacity at weekends to help prevent patient urgent admissions and support early discharge and by increasing GP resources to support patients within Nursing Homes

5.1.3 Our Out of Hours operator performed exceptionally well and we continue to see the benefits that this has on the wider system as they have been able to flexibly upscale to meet planned and unplanned demand. Their provision of a joint Council and CCG funded initiative to deliver an Urgent Care at Home Service (Rapid Response) aimed at preventing inappropriate hospital admissions by putting in place support packages within 1 hour proved to be hugely beneficial. The investment within a Single Point of Access had the benefit of being a single conduit for orchestrating the delivery and co-ordination of the Access to Care, In reach and the UC@H services which worked well to support both admission avoidance and early discharge. Access to step up and step down beds (STARR) performed well, often at times of reduced staffing, and the referral criteria was relaxed within the parameters of patient safety to offer far in excess of budgeted capacity during times where secondary care were under pressure.

5.1.4 We funded the OOH provider to support the local Health Care Professional line, reducing admissions by providing clinicians with access to medical expertise, and during public holidays they were also been able to take call streaming from NHS 111 to help with predictable activity surges.

5.1.5 We worked with Swindon CCG in their delivery of additional nursing home beds and also continued to invest in the expansion of community beds to support escalation at Savernake and Warminster for RUH and SFT patients

5.1.6 Some of our biggest challenges for the CCG were supporting pan service providers, as they play a vital part to system integration and performance. We worked closely with SWASFT during the winter to support their consolidated action plan, designed to deliver their contracted response performance. Whilst this had overall benefits, we were aware that the rural nature of our county continued to present them with operational and performance challenges.

5.1.7 Likewise NHS 111, critical to flowing callers to OOH, ED and the ambulance service had a number of service challenges in 2013/14, not least the volumes of referrals to an emergency department and the ambulance service remained too high, which impacted upon downstream providers. We continue to work with neighbouring CCG and Care UK to address this problem, but Care UK staffing levels continue to inhibit performance improvements.

5.1.8 The implementation of a new PTS contract at the beginning of the traditionally busy period was less than ideal, and there were some early operational challenges with trusts becoming familiar with the parameters within the new contract.

5.1.9 The investment and service redesign that took place within 2013/14 provided the CCG with an excellent platform to continue to work with commissioner and provider colleagues to ensure that the local health and social care systems in place are able respond to capacity and demand challenges.

5.2 Optimising Community Teams

5.2.1 Traditionally community teams (currently neighbourhood teams) have cared for patients in their own home only. More recently the teams provide care in the patient's home setting where ever this may be. Services are also delivered from a number of clinics. The current community teams operate as eleven teams, clustered around groups of GP practices, covering Amesbury, Tidworth and Ludgershall; Corsham, Calne and Box; Chippenham; Salisbury City; Devizes; Malmesbury; Marlborough; Melksham and Bradford on Avon; Wilton and Tisbury; Trowbridge; and Warminster, Westbury and Mere.

5.2.2 The community teams are multi-disciplinary community teams comprising community matrons (specialist support for people with a long term condition), community nurses, physiotherapists, occupational therapists, and health care support workers supported by administrative staff to provide nursing and therapy to patients at home or in care homes. Each team has a community team leader.

5.2.3 The current community teams vary in size and work alongside colleagues from primary care, social care and Medvivo who also provide 'Access to Care' services for the management of non-complex referrals. Currently the links are not well established with the community mental health teams.

5.2.4 It is intended that existing neighbourhood teams will be replaced by Community Care Teams with each team being centred around a cluster of GP Practices. The teams will be sized and staffed in accordance with the projected demand for a revised set of community services and each team tailored to the requirements of the population it serves.

5.2.5 The Community care teams are currently being transformed from 11 to 20 teams and additional recruitment to further enhance these teams has commenced following the investment approved by the CCG of £366,000 for 2014/15 with a full year effect impact of £1.6m in 2015/16. These new teams will have an enhanced capability supported by a training programme. The new teams will be wrapped around clusters of GP practices working directly with them in an integrated and flexible way on a day to day basis.

5.2.6 Concurrently as the cluster teams are forming and the CCG will be rolling out the concept of the Extended Primary Care Team (EPCT) which is the ultimate goal across Wiltshire for the provision of integrated community services.

5.2.7 The EPCT will have even greater capacity from the integration of social care, mental health, domiciliary care functions and voluntary services into the teams. Further training and recruitment is required to enable this and to encourage multi-agency working and to develop a new culture of joint working. The aim is to provide a total care environment in the community where the patient receives the care and support they need in a seamless way to enable them to continue to, live in their local community for as long as possible. The wider EPCT, with the leadership of the cluster GPs will develop a culture of integrated joint working that recognises the need for and delivers the care required to achieve that aim.

5.3 Right Care, Right Time, Right Place (RC2)

5.3.1 National guidance suggests that the current system of urgent and emergency care is unaffordable and unsustainable and is consuming NHS resources at a greater rate every year. The number of emergency admissions to hospitals continues to rise at a time when NHS budgets are under significant pressure and there is a clear need to adopt a whole system approach to commissioning more accessible, integrated and consistent urgent and emergency care services.

5.3.2 The Urgent and Emergency Care Review led by Sir Bruce Keogh, positioned the ambulance service as one of the most important gateways into the health and social care system and an integral part of urgent and emergency care provision. Within the there is an explicit recognition that the ambulance service has a vital role to play in addressing the challenges within urgent and emergency care, ensuring all patients get the right care, in the right place, at the right time. South Western Ambulance NHS Foundation Trust has a relatively unique set of characteristics that will support this enhanced role through the local implementation of its Right Care, Right Time, Right Place programme as part of the 2014/15 contract.

5.3.3 As at month 4 year to date 2014/15 the conveyance rate to emergency department is at 40.86%, which places the county in a strong position when compared across the contracted area, and conveyance percentage to alternative destinations has also increased along with the percentage of patients who are treated at scene.

5.3.4 The CCG will continue to work with the trust through the contract management arrangements to ensure that RC2 becomes embedded within the local health and social care community.

5.4 Intermediate Care Beds

5.4.1 Intermediate care is defined as a range of integrated services that promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care thereby avoiding admissions.

5.4.2 It covers the care / treatment of patients who are not ill enough to warrant admission to an acute care setting, who require several days of support / intervention for an exacerbation of an existing condition or who are at risk of an emergency admission, and can be supported to recovery and returned to the community setting. The care is person-centred, focused on rehabilitation and usually delivered by a combination of professional groups

5.4.3 The Better Care Plan for Wiltshire places a strong emphasis on ensuring patients are cared for as close to home as possible with home being the priority. Intermediate care will also plan to increase the volume of patients (within an agreed cohort) that can be cared for at home, with the core elements of the intermediate care strategy being;

5.4.3.1 Provision of effective step up beds of an appropriate volume to ensure we avoid target number of avoided admissions.

5.4.3.2 Reduction on the reliance on STARR beds moving forward by ensuring more patients will receive care at home

5.4.3.3 Increase in the use of home care packages and increase effectiveness of them (this will also include packages of care such as Help to Live at Home).

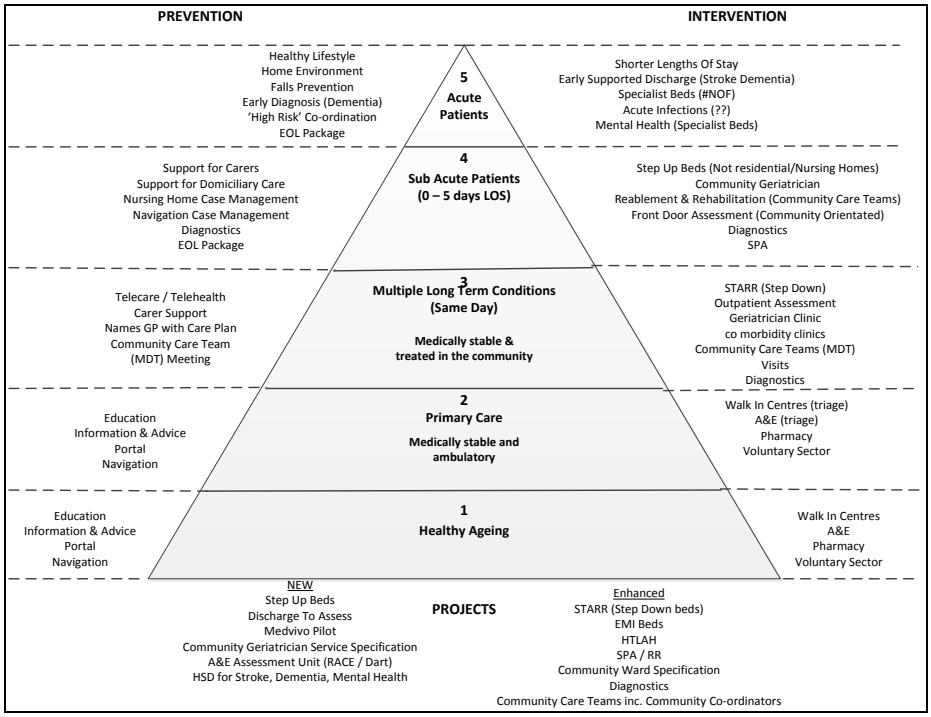
5.4.3.4 Enhancing the effectiveness of community crisis response in a range of different settings

5.4.4 The focus is effectively of 3 elements of bed transition with the development of step up beds being the first stage of this transition as recent analysis has suggested that there is not a consistent model of step up intermediate care across Wiltshire with variances in referrals routes , lengths of stay and discharge outcomes.

5.4.5 The step up beds will be provided within a community hospital working with the relevant providers of additional care to provide a holistic assessment of health and social care need; care planning, intervention and review and to avoid an unnecessary admissions to a hospital setting and ensure we maximise opportunities to manage crisis in a community setting

5.4.6 The team (nurses, therapists, GPs, community geriatrician) will provide high quality, equitable care and will have access to current community health resource e.g. AWP mental health services (Community Matrons, Community Neurological team, Tissue Viability, etc.)

5.4.7 The revised Intermediate Care clinical model is outlined below.



5.4.8 The team will ensure that patients and their carers are central to decision making and will provide holistic support and care respecting their beliefs, values, dignity and choice at all times. The team will work in partnership with statutory and non-statutory organisations to support the social care need of patients in the community, minimising admission to an acute hospital, maximising independence and well-being and improving outcomes for older people and those with long term conditions.

5.4.9 Currently the model is based on 25 beds at Warminster Hospital 15 of which will be reserved as step up beds and 10 will remain as step down beds. The use of those remaining step down beds will be reviewed during the programme. The pilot will run from the beginning of September 2014 to the end of March 2014 and focus on the sub-acute medically stable cohort of patients aged over 65.

5.4.10 Community geriatricians will support the step up beds along with staff provided by GWH, resident medical cover provided by Medvivo Group Limited, and patient's GP input. Arriva Transport Solutions Limited will provide the community transport facilities under a variation in contract and identified social workers will be assigned to address social care needs

5.4.11 The key success factors for the pilot will be;

- Trial the concept in a small controlled environment to ensure success can support this new approach.
- Test whether an average length of stay of <10 days is achievable for step up beds and aim for a reduction to 7 days
- Test the process of GPs and other identified health care professionals such as hospital consultants and emergency care practitioners referring directly into an intermediate care bed

- Enhance use of existing STARR beds by increasing occupancy levels, increasing access over a 7 day periods and reducing length of stay
- Identify and quantify the reduction in use of step up STARR beds that can be used as evidence to justify full adoption of the approach
- Identification of the likely reduction in admissions to secondary care if this approach is rolled out
- Quantify the improvement in efficiency resulting from patients being all in one setting
- Establish the improvements in quality of care both within the bed stay and overall quality of life and independence

5.5 Access to Care and Rapid Response

5.5.1 Access to Care (AtC) is the Single Point of Access (SPA) which includes the provision of the Acute Trust Liaison Service and the Urgent Care at Home Service.

5.5.2 Access to Care provides a single point of access for the Wiltshire health community. Born from the need for a referral mechanism to support the community teams and the community hospital bed management process, AtC provides a comprehensive 24 hour referral management system.

5.5.3 Historically, AtC has utilised Adastra as the primary information management system but is currently reviewing system transfer options, including SystemOne, in an attempt to improve information sharing with local primary care providers. The Capacity Management System Directory of Services is also used. In excess of 3,500 referrals are processed each month by AtC's clinical support administrators and clinical advisors.

5.5.4 AtC plays a key role in supporting the health and social care community in managing pressure by offering clinicians the opportunity to refer via the call centre in order to access alternative pathways to secondary care, to support timely discharge in order to release acute capacity and in providing an overview of the 'whole syste'.

5.5.5 Acute Trust Liaison Service clinicians from Access to Care are currently working in a variety of clinical areas within each of the local acute trusts, seven days week. This role encompasses much more than the traditional 'liaison' role by facilitating discharge across the whole system. Support is provided to hospital staff in identifying the type of patient who can be managed at home and the resources available to enable this.

5.5.6 Medvivo Group Ltd has been commissioned to deliver an integrated rapid health & social care response service for service users in crisis in their own home. Depending on the most appropriate pathway for the service user, the service focuses on supporting service users to;

- Access appropriate assessments in the right place at the right time
- Remain at home with additional support
- 'Step up' to a community hospital or STARR bed (intermediate care bed)
- Expedite return to home with additional support following acute assessment

5.5.7 The SPA Team assess and coordinate support for service users who have been directly referred to the service or have been identified as appropriate within other pathways. If required, they coordinate an UC@H crisis response, within one hour from receipt of referral, who can assist with further assessment and actively support the patient in the short term.

5.5.8 Initially the team will always refer into 'traditional' care pathways such as the Community Team and H2L@H provider. The SPA then coordinates further crisis support in order to "hold" the patient in the community until standard care & support provision can commence. The SPA arrange and coordinate any required assessments e.g. a visit from the service users own GP, and actively refer onwards for any continuing assessments or support required.

5.5.9 Where it is not appropriate for service users to be supported at home, the SPA arrange their 'step up' admission into a STARR bed, a community hospital or an acute hospital. Where a service user has required acute assessment the SPA team will, where appropriate, utilise the above methods to expedite their return home.

5.5.10 The SPA team can also coordinate an UC@H crisis response, within one hour, who will support the service user for up to 2 hours. This is provided by the Medvivo Telecare Response Team operating from three bases spread across the county. The SPA will then coordinate the required crisis support until standard provision can take over (up to 72 hours).

5.5.11 At present this includes a dedicated care team provided by MiHomecare and coordinated by the SPA. Support available ranges from one off support visits up to 24 hour care

5.5.12 Medvivo Group Ltd is the sole provider of telecare monitoring services for Wiltshire Council customers providing 24/7 telecare monitoring service The service is also purchased privately by individuals. Telecare customers are able to access a 24/7 response service, which provides a home visiting crisis response service.

5.5.13 Reassurance call support is provided to vulnerable people in a number of ways e.g. through regular telephone contact or routine home visits.

5.5.14 Access to Care holds details of service users and their carers who have registered with this scheme. In the event of an unforeseen crisis, staff refer to a predetermined manage plan to offer support and access additional help.

5.6 The 100 Day Challenge

5.6.1 The CCG recognises that in order to maximise system efficiencies within the wider health and social care context that there has to be a degree of seamless integration within the redesign initiatives being implemented.

5.6.2 Linked to this, and the challenging position of appropriate admission / admission avoidance are key system and financial pressures which demand rapid implementation and roll out if success is to be achieved.

5.6.3 In September the CCG and Wiltshire Council will launch the 100 Day Challenge. This will be a system wide approach aimed at reducing the number of attendances and admissions for frail patients in Wiltshire and reduce the amount of time they spend in hospital.

5.6.4 It will include all health and social care partners within the County and will focus on preventing avoidable admissions for a wider range of conditions.

5.6.5 This will require full commitment and collaboration across the system in order to combine approaches to care for frail individuals and help them stay home for longer. It will primarily focus on;

5.6.5.1 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 programs supporting transfer from wards
- System management of the EOL register
- Community geriatrician and multi morbidity clinics combining.

5.6.5.2 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

5.6.5.3 Managing crisis

- Enhanced HTLAH services.
- 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 domiciliary care programmes
- Enhanced specialist input in community settings by the community geriatrician

- Geriatrician led discharge from ED with connection to existing front door models

5.6.5.4 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
- Re-launch of STARR and delivery of new intermediate care action plan
- Community nursing " step up " services to be prioritised and expanded

5.6.5.5 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 intermediate Care Beds model (formally STARR) accessible 7 days a week.
- Focused review of conversion rate and outlier volume.

5.6.5.6 Ongoing measurement / monitoring and action

- System review check stage to go live at the same time ensuring ongoing review and action
- 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

5.6.6 The timetable is ambitious and includes the agreement of the Health and Wellbeing Board, development of a wider communications plan to maximize awareness and the cascading of clear information, and the development of an integrated data dashboard to support visibility of system performance and pressures.

5.6.7 The CCG has a Delayed Transfer of Care Group, made up of representation from all acute and social care providers. A subset of this group has established an agreed definition of G2G and works through individual patient level issues to support flow through the system on a daily basis.

5.6.8 The overarching group is chaired by the joint CCG and Council appointed Director of Integration, who is also leading the 100 day Challenge. Currently weekly DTOC reporting shows individual provider DToC numbers split between health and social care. As part the data dashboard being developed this will be available on a daily basis.

5.7 Mental Health

5.7.1 The 2014 Mental Health Crisis Care Concordat commits to 'working together to improve the system of care and support so people in crisis because of a mental health condition are kept safe and helped to find the support they need – whatever the circumstances in which they first need help – and from whichever service they turn to first.'

5.7.2 There have long been concerns about the way in which health services, social care services and police forces work together in response to mental health crises. Where there are problems, they are often as a result of what happens at the points where these services meet, about the support that different professionals give one another, particularly at those moments when people need to transfer from one service to another.

5.7.3 Every day, people in mental health crisis situations find that our public services are there when they need them – the police officers who respond quickly to protect people and keep them safe; the paramedics who provide initial assessment and care; the mental health nurses and doctors who assess them and arrange for appropriate care; and the Approved Mental Health Professionals, such as social workers, who coordinate assessments and make contact with families. These services save lives, but we must also recognise that in too many cases people find that the same services do not respond so well.

5.7.4 The complexity of crises may mean that individuals need support for several aspects of their crisis. This means having their mental health issues understood within the context of their family, cultural or community setting and other urgent needs, such as self-harm, alcohol or drug misuse, or pregnancy.

5.7.5 People should be able to expect a whole system response and Wiltshire CCG are leading a multi-agency review based on the 2014 Mental Health Crisis Care Concordat. This will identify how contributing agencies, can work together to deliver a high quality response when people of all ages with mental health problems urgently need help.

5.7.6 Following the review a joint statement of intent and common purpose, and an understanding about the roles and responsibilities of each service will be agreed. This will help to make sure people who need immediate mental health support at a time of crisis get the right services they need and get the help and support to move on and stay well.

5.7.7 Core principles and outcomes will be access to support an individual before a crisis point. This may be an early intervention via a single point of access, access to a multidisciplinary mental health team or a joined up response from services with strong links between agencies

5.8 Joint arrangements with local Clinical Commissioning Groups

5.8.1 The CCG recognise it is necessary to ensure that service developments being put in place through agreed investment with neighbouring CCG's or by neighbouring CCG's independently do not disadvantage patients within Wiltshire, based on where they receive their treatment.

5.8.2 As such we ensure that there is cross representation across all SRG's, at an Executive or Director level and at any urgent care provider forum or similar. This representation ensures that there is discussion around co-ordinated local investments that support operational resilience that reduces the risk that any one investment may jeopardise the benefit of an initiative elsewhere within the wider system. This is particularly relevant where investment proposals rely on recruitment of clinical staff groups, which seem to be in limited supply.

5.8.3 Although the CCG has continued to support the current investments in place, we have also been receptive to requests for new investments through both Swindon and BaNES SRG's and has jointly agreed and aligned a number of these.

5.8.4 The accompanying financial table files provide details of the correlated investments that have been agreed by Wiltshire at both BaNES and Swindon SRG's based on a far share allocation.

5.8.5 We believe that through joint representation on each SRG, close monitoring of the supported initiatives and their impact on system delivery, and being able to jointly respond to capacity and demand challenges through strategic and operational discussions we will ensure that the CCG has in place the most appropriate health and social care process for Wiltshire patients without adversely impacting investment or service redesign elsewhere

5.9 Supporting ECIST recommendations locally

5.9.1 The CCG will continue to invest in a number of schemes based around service improvements recommended by ECIST at both Royal United Hospitals NHS Trust (RUH) and Great Western Hospital NHS Foundation Trust (GWH). The funding into RUH is in its second year of a joint agreement made with BaNES CCG for £940,000 and is supporting improved service delivery through increased clinical staffing within the emergency department, establishing a Rapid Access Consultant Evaluation Unit, Surgical Assessment Unit and other redesign principles originally detailed with the agreed business case and noted with the 2013/14 CCG winter plan. Following a recent ECIST review at GWH a number of redesign principles were identified and the CCG is supporting the establishment of a Discharge Assessment and Referral Team to support patient flow, discharge planning and multiagency coordination to the sum of £234,000.

5.9.2 In addition the CCG may consider low cost, high impact non-staff related initiatives on request

5.9.3 These investments and delivery of agreed performance indicators are monitored within the CCG programme management structure previously described.

5.10 Data Sharing and Joint Assessment

5.10.1 Through the 'Single View of the Customer' programme, we will scope requirements for information systems to allow people to share information at a local level about patients and service users.

5.10.2 This work will be informed by the systems review. The aim is to develop a single view of the customer across the public sector, with a particular emphasis on sharing across health and social care.

5.10.3 The work on the 'Single View' will include a range of public sector organisations in Wiltshire. The first phase will concentrate on a single view of the Over 65s, and will include:

- System 1 (primary care)
- Adastra (out of hours primary care)
- Ambulance Service systems
- Acute Patient Administration Systems
- Wiltshire Council CareFirst (social care)
- Wiltshire Council Geographic Information System
- Wiltshire Council revenue and benefits system
- Medvivo (out of hours and single point of access)
- Avon and Wiltshire Partnership Mental Health systems

5.11 Elective Care – Referral To Treatment (RTT) Standard

5.11.1 Funding has been allocated to NHS England Area Teams to support the delivery of additional elective activity to improve performance on RTT standards, clear backlog and reduce the number of long wait patients. The Area Teams will then agree its use with CCGs and local providers. The funding will be used to ensure that:

- All three RTT operational standards are met at a national level.
- This is achieved in the September 2014 RTT data (published in November 2014)
- Reducing backlog by focusing additional activity on patients that are waiting more than 16 weeks for treatment; and
- Reducing the total number of patients waiting over 16 weeks by 115,000 nationally, bringing us back to the level of over 18 week waiters seen in January 2013.

5.11.2 The return requested from providers requires a split of additional activity into completed pathways (1) up to 18 weeks and (2) over 18 weeks. This will enable the impact of additional activity on the RTT operational standards to be assessed. The CCG will review the provider returns and assure them in partnership with the Area Team.

5.11.3 The CCG has received returns through Unify in relation to all provider submissions where it is the responsible commissioner. These have been iterated with the Area Team and providers, and the Area Team are co-ordinating a revised version to fit with the Area Team financial allocation and list reduction requirements across its area. The CCG has assured that its lead provider; Salisbury Hospitals NHS Foundation Trust can flag this activity separately, and will be signing off the activity completed on behalf of the Area Team via submissions from providers. The CCG has in this process risk assessed the creation of a "bow wave" of additional unfunded activity through any heavy provider focus on non-admitted wait times that may convert to procedures. The Area Team in its proposed revisions to the provider returns is looking to focus on the admitted pathways.

5.11.4 It will be for Regional and Area Team colleagues to determine the criteria for assuring that the activity commissioned is appropriate and sufficient to achieve the aim of reducing the number of long waiters. However, if and when plans are submitted and activity aggregated to a national level, it is found that this amount of activity is insufficient to reduce the number of long waiters; we will need to work together to agree which plans can go further.

6 COMMUNICATIONS

6.1 Winter Communications Strategy

6.1.1 The CCG's communications strategy will be based on NHSE's four part pla,

- Communications across the system when winter pressures escalate
- Public information campaign about how to access urgent care services
- Three key marketing campaigns
- Internal communications

6.1.2 The three significant marketing campaigns are;

- ***The Earlier, The Better*** starting Mon 27th Oct until Fri 5 Dec (6 weeks)
- ***Flu Jab Campaign*** starting on Mon 6th Oct, a four week campaign being led by Public Health and NHSE Area Team
- ***Treat Yourself Better*** campaign led by PAGB (Proprietary Association of Great Britain)_and Pharmacy Voice, starting very soon

6.1.3 The focus in previous winters has been on reducing attendances at A&E by all demographics. New evidence suggests that the main cause behind winter pressures is the number of frail and elderly being admitted and blocking up the system through delayed discharge.

6.1.4 It is suggested that many frail and elderly don't want to be a burden on the system when they're feeling a "bit" unwell and so they don't take any action. This often results in an exacerbation of their condition before they seek medical advice.

6.1.5 As a result, The Earlier The Better campaign will specifically target the over 65 population and promote better and earlier self-care and more use of community pharmacies.

6.1.6 The campaign is not about avoiding the GP but about catching problems (especially respiratory illnesses) much earlier before they develop into something more serious.

6.1.7 The target audience will be;

- Frail and elderly over the age of 65 although the term "over 60" in will be used in national materials
- Carers, age 45yrs to 64yrs, who are predominantly female.

6.1.8 The communication channels will be;

- Friends, family and carers will be directed to a microsite on the NHS Choices website for more information.
- F&E will be targeted in their local pharmacies through posters and advertising on pharmacy bags
- Over 75s are harder to reach as they spend more time indoors and do not use digital media, and they will be targeted through local support groups, charities, churches, local councillors etc.
- Evidence shows that the more channels where the message is seen, the better the results. This could include posters/screens in waiting rooms, adverts in local media, billboards etc.
- Messages need to be circulated to all staff as well so that they can help to spread the message to friends and family

6.1.9 Locally, the CCG will have access to a wide range of centrally produced materials to help spread the messages that will be marketed nationally.

6.1.10 NHSE recognise that it is difficult to evaluate the results of a campaign based on the number of attendances at A&E, and so their focus will be on measuring people's awareness of the campaign and asking what action they would take in different scenarios.

6.1.11 The CCG communications lead will attend the SRG. In addition it was agreed that a joint communication's group for the BGSW NHSE area will be established that will allow communication leads to share their thinking on winter campaigns, agree joint messages and pool budgets to maximise impact.

7 RISKS AND MITIGATIONS

7.1 Risk Management

7.1.1 The CCG has established a corporate programme management structure and all projects that link to service redesign or service improvement are managed through this methodology that includes local identification of project specific risks and mitigating actions.

7.1.2 The individual risk profiles are escalated through to the CCG programme governance group where the profile exceeds the agreed threshold. This group will then authorise and monitor any remedial action.

7.1.3 Similar processes exist for joint CCG and Wiltshire Council projects that link through to the Better Care programme governance group.

7.1.4 Local provider projects are managed through reporting into the CCG urgent care programme, via CCG project managers

7.1.5 The Wiltshire system resilience group will receive updated risk data relating to project delivery.

7.1.6 The Wiltshire system resilience group will undertake a peer review of provider resilience plans within scheduled meetings and hold providers to account for service delivery at times of increased surge and demand.

7.1.7 A significant risk that will reduce the impact of the successful delivery of local resilience plans will be the impact of increased non elective activity across the health system. This CCG receives activity data through weekly summary reporting supplied by Central Southern Commissioning Support Unit, and will use this information to support system resilience through established escalation processes.

7.1.8 In addition, routine contract management systems and procedures support the CCG to remain aware of system critical performance in areas such as the emergency services and NHS 111.

7.1.9 National / local weather forecasting is noted through receipt of information from the Met. Office Forecast Service. Pertinent information is then cascaded through to provider organisations and noted within CCG EPRR system management as required.

7.1.10 The CCG is a member of the Flu Immunisation Planning and Oversight Group.

8 ALLOCATION OF OPERATIONAL RESILIENCE FUNDING

8.1 Financial Data

8.1.1 Non recurrent funding for 2014/15 has been made available to support the successful delivery of system wide operational resilience, whilst ensuring that quality, access and financial balance are of equal importance and maintained.

8.1.2 Urgent care funding of £2,763,138.00 allocated to the CCG on a fair-shares basis has been shared amongst local systems though the system resilience group, and the CCG has assured itself that the overall strategic plan for continued support and delivery of current initiatives fully utilises the funding in totality.

8.1.3 These plans build on the good work undertaken throughout last year, and include the use of primary care, community and secondary care as well as social services to support patients with urgent care needs or to help avoid such urgent episodes altogether.

8.1.4 Additional details are provided within the financial template appendices, but include;

8.1.4.1 Additional funding for RUH support increase in non-elective medical bed capacity, increased radiology capacity, increased evening clinical capacity within ambulatory care, additional capacity to support weekend discharges and additional capacity on core speciality wards.

8.1.4.2 Additional funding for GWH to extend ambulatory care opening, creation of a 8 bed frail elderly unit, support for improved secondary / primary care communications, increased therapist support at ED and the introduction of trauma coordinators.

8.1.4.3 Additional funding for GWH community escalation beds to deal with urgent care demand.

8.1.4.4 Overnight Nursing Teams to support patients in the community who require out of hours urgent nursing care. This is specifically targeted at those patients with an end of life care need, known long terms conditions, or those who would otherwise require a hospital admission.

8.1.4.5 Part year impact of expansion of community services staffing to deliver a shift to the agreed community cluster model.

8.1.4.6 Extension of the healthcare professional line to provide Wiltshire facing clinicians with a direct link into the Out of Hours Service rather than having to be routed via NHS 111.

8.1.4.7 Additional funding for GWH Discharge Assessment Referral Team (DART) to facilitate more timely assessment and discharge in support of patient flow

9 ANALYTIC REVIEW

9.1 Introduction.

9.1.1 Wiltshire SRG recognise the complexity of ensuring that data flow from our three secondary care providers is captured and shared in a meaningful way to support operational resilience. We believe that the development and distribution of the 100 Day Challenge Dashboard, together with the opportunity to share data flows being produced neighbouring SRG's will support not only system resilience, but also increase the visibility of where service transformation is having a positive impact.

9.1.2 The CCG through CSCSU receive weekly and monthly activity data from the three secondary care providers. This has been used to help inform the CCG of its investment intentions in respect of not only the non-recurring ORCP funding, but also wider funding streams.

9.2 The levels and Drivers of increased demand (Salisbury Hospital NHS Foundation Trust)

9.2.1 Month 4 analysis of elective data at Salisbury Hospitals NHS Foundation Trust shows that there has been an increase in 2014/15, with a particular spike in GP referrals in July 2014. Closer analysis of the top five referring practices indicate an average increase of 5.0%, with a range from -7.8% to 27.9%.

9.2.2 Elective activity indicates annual elective growth is at 0.6%. Day cases have increased by 2.6%, with the majority being in gastroenterology. Further casemix analysis shows this is mainly for endoscopy examination. Elective inpatient activity shows a decrease of 6.9%

9.2.3 Waiting list pressure continues to increase. As at month four both the waiting list size (1,656) and the number of over 18 week waits (24) have increased. This is despite extra RTT activity taking place.

9.2.4 Non elective pressures continue to increase, currently at 7.7% , with the majority of growth within general medicine (27%) and gynaecology (25%). Both of these increases are significantly above 2014/15 plan.

9.2.5 Emergency department attendance is up 1.8% YTD, with May and June seeing the most significant percentage increase (up to 25% for week 9), although activity has decreased since the end of July

9.3 Whether acuity and complexity has actually increased (Salisbury Hospital NHS Foundation Trust)

9.3.1 The elective growth is predominately in day cases and in endoscopies which are lighter case-mix

9.3.2 Reviewing outcomes from Emergency Department attendance it appears that the growth in attendances is mirrored by an increase in patients discharged with no further follow-up, suggesting an increase in minor ailments. However the HRG analysis of ED attendances shows the majority of the increased 2014/15 attendances are attracting a medium/high HRG ED casemix.

9.3.3 This has been reviewed at contract performance meeting and the view from the trust is that this is due to an increase in diagnostics that is increasing the ED intervention rate, but containing the A&E admissions rate.

9.3.4 Non-electives HRG trends shows that much of the non-elective activity growth is seen with more minor casemix as the growth sits in HRGs without complications or complexity. However non-elective length of stay has not reduced due to continued high levels of delayed transfers of care and the local reduced help to live at home capacity.

9.4 Whether there is a redistribution of demand (Salisbury Hospital NHS Foundation Trust)

9.4.1 Two of the three operational localities with the CCG, (Sarum and WWYKD) refer in to Salisbury Hospitals NHS Foundation Trust

9.4.2 Elective referral analysis by GP practice shows a reduced flow from WWYKD practices with referral growth mainly coming from Sarum based practices.

9.4.3 ED growth is greater from the WWYKD practices (+4.6%) than Sarum's (+3.4%) annual growth, whilst non-elective activity shows that at month 4, Sarum is up 5.9% and WWYKD is up 12.8%. Whilst this shows a disproportionate growth from WWYKD, it should also be noted that they have increased at Royal United Hospitals NHS Trust.

9.4.4 Thus elective pressure is disproportionately from local Sarum practices but non-elective pressure to SFT is high from WWYKD

9.5 Changes in the volatility of demand (Salisbury Hospital NHS Foundation Trust)

9.5.1 There is some evidence of changes in the volatility of demand. Planned care has shown a spike in referrals for July 2014 and unplanned care is now levelling off after a large increase in months 2 and 3.

9.6 Reduced Capacity in trusts to meet demand (Salisbury Hospital NHS Foundation Trust)

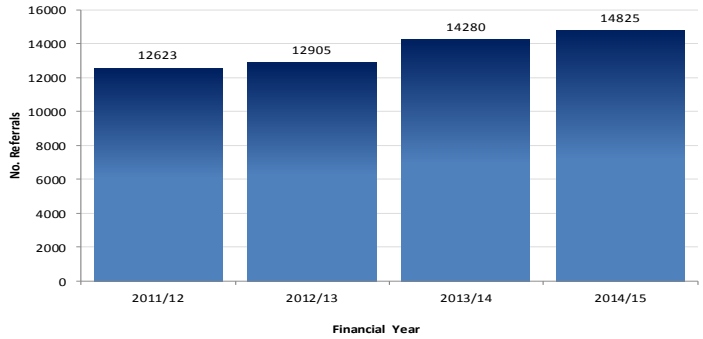
9.6.1 The trust has clinical staff pressures in within the dermatology speciality that have led to reduced capacity.

9.6.2 Within unplanned care the discharge to assess numbers remain high as a consequence of reduced capacity in the local help to live at home service.

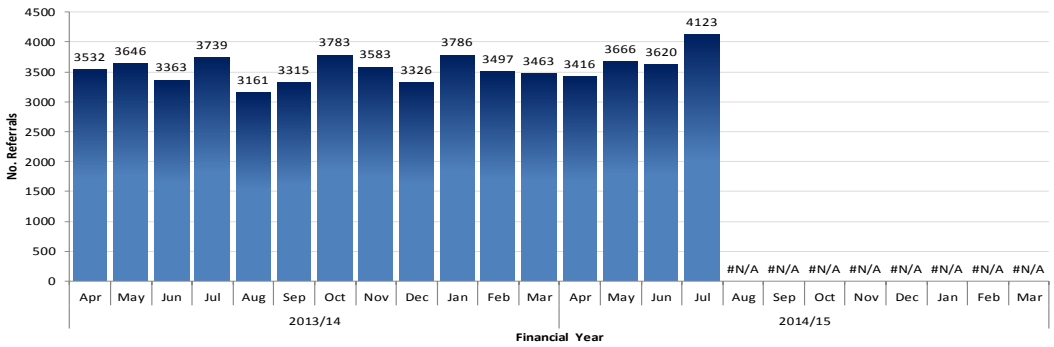
9.6.3 There are longer than planned length of stays seen in step up & step down intermediate care beds with a shortage of STARR beds in the south of the county. There are ongoing issues with the responsiveness of the contracted patient transport service. Currently this is set at four hours, but it is being recognised that a increased response time would better support the urgent care requirements. Discussions are ongoing to resolve this.

NHS Wiltshire CCG - SFT Referral Trend Summary - Month 4

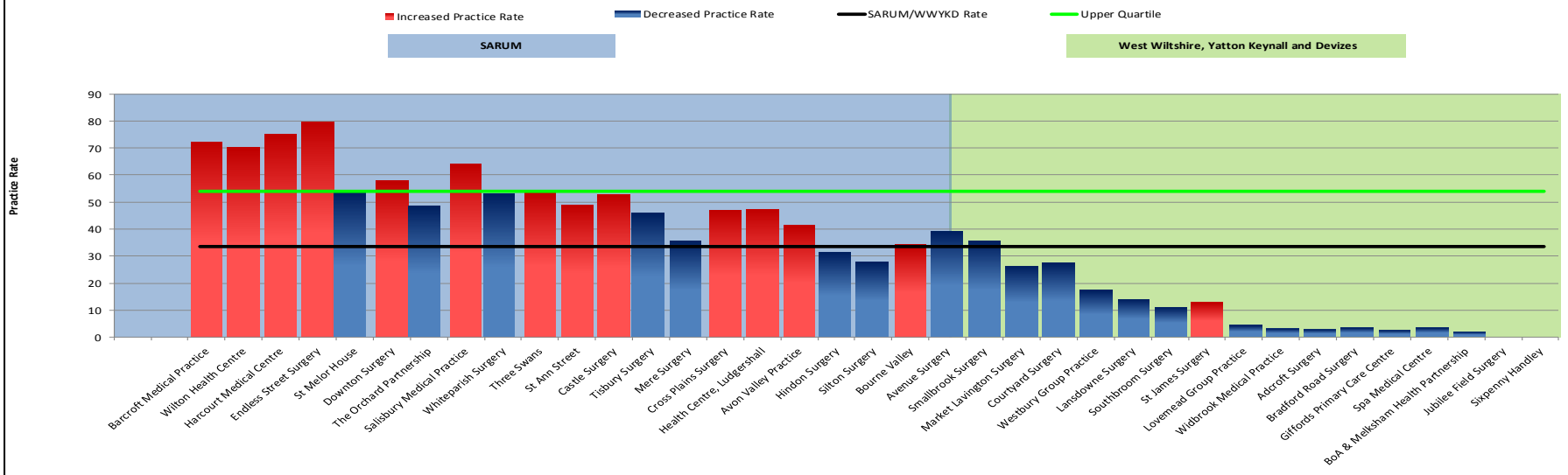
YTD Referrals by Year

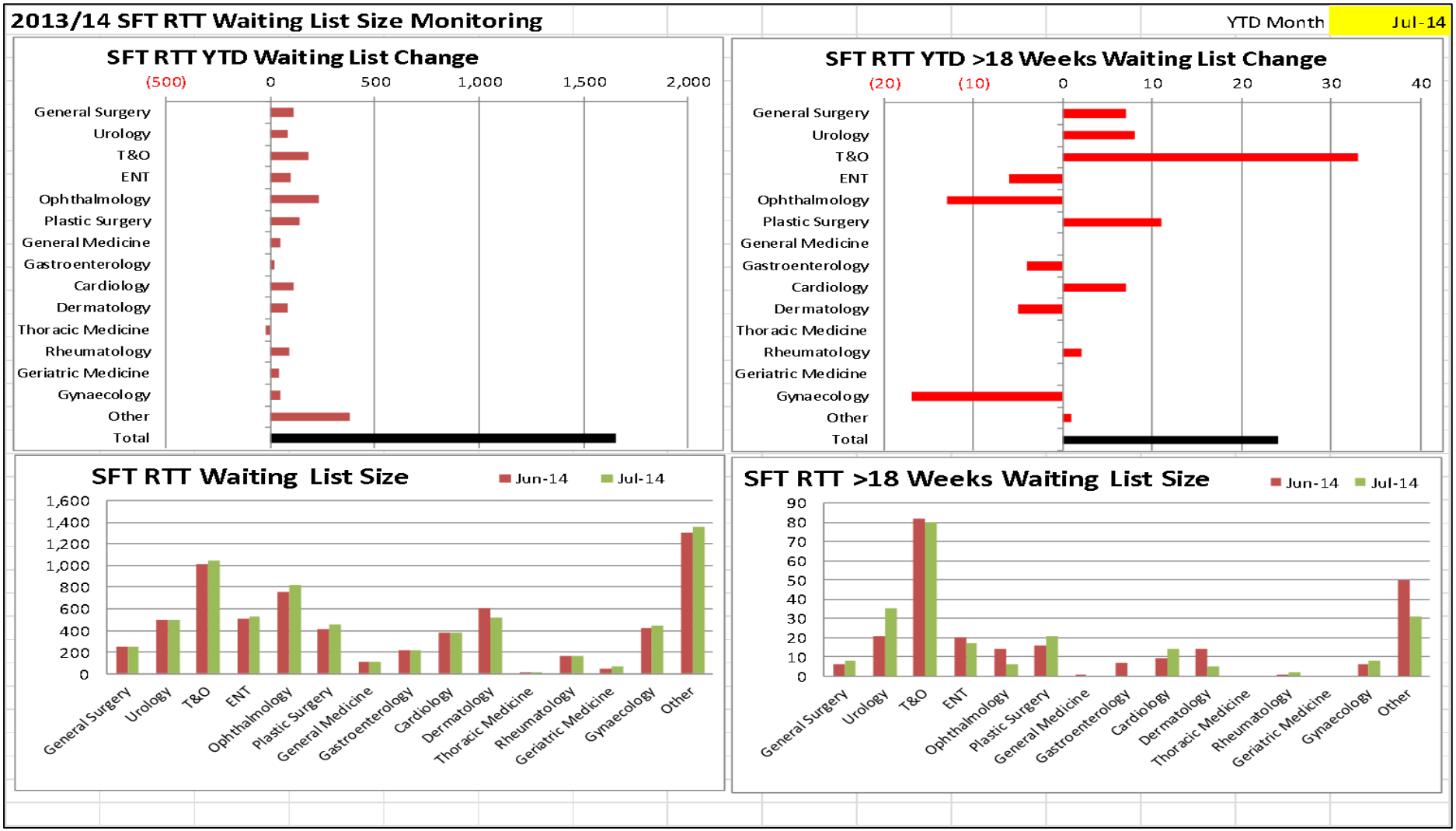


Referrals by Month



SFT Referrals per 1,000 Weighted Population by GP Cluster/Practice 13/14 YTD




2013/14 SFT RTT Waiting List Size Monitoring
YTD Month
Jul-14
SFT RTT YTD Waiting List Change
(500)
0
500
1,000
1,500
2,000
General Surgery
Urology
T&O
ENT
Ophthalmology
Plastic Surgery
General Medicine
Gastroenterology
Cardiology
Dermatology
Thoracic Medicine
Rheumatology
Geriatric Medicine
Gynaecology
Other
Total
SFT RTT YTD >18 Weeks Waiting List Change
(20)
(10)
0
10
20
30
40
SFT RTT Waiting List Size
Jun-14
Jul-14
1,600
1,400
1,200
1,000
800
600
400
200
0
SFT RTT >18 Weeks Waiting List Size
90
80
70
60
50
40
30
20
10
0

SFT Weekly A&E Access

	Local Target = 95%					Local Target = 95%					Local Target = 95%					Local Target = 95%					Local Target = 95%			
Week ending	Wk	Attends	Breaches	Rate	Week ending	Wk	Attends	Breaches	Rate	Week ending	Wk	Attends	Breaches	Rate	Week ending	Wk	Attends	Breaches	Rate	Week ending	Wk	Attends	Breaches	Rate
04/04/2010	1	794	6	99.2%	03/04/2011	1	810	28	96.5%	01/04/2012	1	854	35	95.9%	07/04/2013	1	905	101	88.8%	06/04/2014	1	859	23	97.3%
11/04/2010	2	761	12	98.4%	10/04/2011	2	836	33	96.1%	08/04/2012	2	841	25	97.0%	14/04/2013	2	878	97	89.0%	13/04/2014	2	813	46	94.3%
18/04/2010	3	753	17	97.7%	17/04/2011	3	791	14	98.2%	15/04/2012	3	822	24	97.1%	21/04/2013	3	876	77	91.2%	20/04/2014	3	840	23	97.3%
25/04/2010	4	817	39	95.2%	24/04/2011	4	841	9	98.9%	22/04/2012	4	756	10	98.7%	28/04/2013	4	894	36	96.0%	27/04/2014	4	822	39	95.3%
02/05/2010	5	851	13	98.5%	01/05/2011	5	883	18	98.0%	29/04/2012	5	767	13	98.3%	05/05/2013	5	919	41	95.5%	04/05/2014	5	891	26	97.1%
09/05/2010	6	824	13	98.4%	08/05/2011	6	846	36	95.7%	06/05/2012	6	825	25	97.0%	12/05/2013	6	862	22	97.4%	11/05/2014	6	943	32	96.6%
16/05/2010	7	796	15	98.1%	15/05/2011	7	837	9	98.9%	13/05/2012	7	801	13	98.4%	19/05/2013	7	837	5	99.4%	18/05/2014	7	899	43	95.2%
23/05/2010	8	811	14	98.3%	22/05/2011	8	836	22	97.4%	20/05/2012	8	834	29	96.5%	26/05/2013	8	802	11	98.6%	25/05/2014	8	882	38	95.7%
30/05/2010	9	789	5	99.4%	29/05/2011	9	815	16	98.0%	27/05/2012	9	881	10	98.9%	02/06/2013	9	743	1	99.9%	01/06/2014	9	927	71	92.3%
06/06/2010	10	803	11	98.6%	05/06/2011	10	859	32	96.3%	03/06/2012	10	932	4	99.6%	09/06/2013	10	850	6	99.3%	08/06/2014	10	912	41	95.5%
13/06/2010	11	794	3	99.6%	12/06/2011	11	792	14	98.2%	10/06/2012	11	904	10	98.9%	16/06/2013	11	830	13	98.4%	15/06/2014	11	930	48	94.8%
20/06/2010	12	884	8	99.1%	19/06/2011	12	766	16	97.9%	17/06/2012	12	863	26	97.0%	23/06/2013	12	859	3	99.7%	22/06/2014	12	976	40	95.9%
27/06/2010	13	852	23	97.3%	26/06/2011	13	800	24	97.0%	24/06/2012	13	888	15	98.3%	30/06/2013	13	897	10	98.9%	29/06/2014	13	951	50	94.7%
04/07/2010	14	837	12	98.6%	03/07/2011	14	862	41	95.2%	01/07/2012	14	852	16	98.1%	07/07/2013	14	864	6	99.3%	06/07/2014	14	893	44	95.1%
11/07/2010	15	836	7	99.2%	10/07/2011	15	849	17	98.0%	08/07/2012	15	874	28	96.8%	14/07/2013	15	926	11	98.8%	13/07/2014	15	907	52	94.3%
18/07/2010	16	826	12	98.5%	17/07/2011	16	847	12	98.6%	15/07/2012	16	807	11	98.6%	21/07/2013	16	960	53	94.5%	20/07/2014	16	948	49	94.8%
25/07/2010	17	894	16	98.2%	24/07/2011	17	856	23	97.3%	22/07/2012	17	843	13	98.5%	28/07/2013	17	902	51	94.3%	27/07/2014	17	954	53	94.4%
01/08/2010	18	788	28	96.4%	31/07/2011	18	819	25	96.9%	29/07/2012	18	850	8	99.1%	04/08/2013	18	852	15	98.2%	03/08/2014	18	885	30	96.6%
08/08/2010	19	855	28	96.7%	07/08/2011	19	792	26	96.7%	05/08/2012	19	882	28	96.8%	11/08/2013	19	802	23	97.1%	10/08/2014	19	881	46	94.8%
15/08/2010	20	737	24	96.7%	14/08/2011	20	845	20	97.6%	12/08/2012	20	852	27	96.8%	18/08/2013	20	739	15	98.0%	17/08/2014	20	855	36	95.8%
22/08/2010	21	755	19	97.5%	21/08/2011	21	727	5	99.3%	19/08/2012	21	872	65	92.5%	25/08/2013	21	868	28	96.8%	24/08/2014	21	834	22	97.4%
29/08/2010	22	789	36	95.4%	28/08/2011	22	755	8	98.9%	26/08/2012	22	833	26	96.9%	01/09/2013	22	969	52	94.6%	31/08/2014	22	880	47	94.7%
05/09/2010	23	834	24	97.1%	04/09/2011	23	840	6	99.3%	02/09/2012	23	878	51	94.2%	08/09/2013	23	832	17	98.0%	07/09/2014	23	843	19	97.7%
12/09/2010	24	776	21	97.3%	11/09/2011	24	817	3	99.6%	09/09/2012	24	832	31	96.3%	15/09/2013	24	831	24	97.1%	14/09/2014	24	470	6	98.7%
19/09/2010	25	814	40	95.1%	18/09/2011	25	829	5	99.4%	16/09/2012	25	827	14	98.3%	22/09/2013	25	778	22	97.2%	21/09/2014	25			
26/09/2010	26	806	56	93.1%	25/09/2011	26	808	8	99.0%	23/09/2012	26	885	15	98.3%	29/09/2013	26	850	33	96.1%	28/09/2014	26			
03/10/2010	27	798	33	95.9%	02/10/2011	27	857	9	98.9%	30/09/2012	27	862	22	97.4%	06/10/2013	27	852	47	94.5%	05/10/2014	27			
10/10/2010	28	840	49	94.2%	09/10/2011	28	865	5	99.4%	07/10/2012	28	902	64	92.9%	13/10/2013	28	836	24	97.1%	12/10/2014	28			
17/10/2010	29	816	13	98.4%	16/10/2011	29	896	13	98.5%	14/10/2012	29	839	25	97.0%	20/10/2013	29	819	21	97.4%	19/10/2014	29			
24/10/2010	30	750	31	95.9%	23/10/2011	30	807	13	98.4%	21/10/2012	30	817	15	98.2%	27/10/2013	30	819	55	93.3%	26/10/2014	30			
31/10/2010	31	779	8	99.0%	30/10/2011	31	808	8	99.0%	28/10/2012	31	865	26	97.0%	03/11/2013	31	742	10	98.7%	02/11/2014	31			
07/11/2010	32	721	4	99.4%	06/11/2011	32	777	6	99.2%	04/11/2012	32	795	28	96.5%	10/11/2013	32	802	18	97.8%	09/11/2014	32			
14/11/2010	33	759	2	99.7%	13/11/2011	33	823	15	98.2%	11/11/2012	33	793	39	95.1%	17/11/2013	33	825	34	95.9%	16/11/2014	33			
21/11/2010	34	719	8	98.9%	20/11/2011	34	723	7	99.0%	18/11/2012	34	816	44	94.6%	24/11/2013	34	790	26	96.7%	23/11/2014	34			
28/11/2010	35	717	21	97.1%	27/11/2011	35	810	14	98.3%	25/11/2012	35	743	16	97.8%	01/12/2013	35	827	51	93.8%	30/11/2014	35			
05/12/2010	36	742	27	96.4%	04/12/2011	36	754	7	99.1%	02/12/2012	36	791	8	99.0%	08/12/2013	36	794	60	92.4%	07/12/2014	36			
12/12/2010	37	771	31	96.0%	11/12/2011	37	777	15	98.1%	09/12/2012	37	817	18	97.8%	15/12/2013	37	789	21	97.3%	14/12/2014	37			
19/12/2010	38	692	11	98.4%	18/12/2011	38	782	32	95.9%	16/12/2012	38	799	31	96.1%	22/12/2013	38	765	27	96.5%	21/12/2014	38			
26/12/2010	39	663	25	96.2%	25/12/2011	39	694	9	98.7%	23/12/2012	39	773	18	97.7%	29/12/2013	39	719	26	96.4%	28/12/2014	39			
02/01/2011	40	804	28	96.5%	01/01/2012	40	802	8	99.0%	30/12/2012	40	761	18	97.6%	05/01/2014	40	745	23	96.9%	04/01/2015	40			
09/01/2011	41	752	39	94.8%	08/01/2012	41	811	14	98.3%	06/01/2013	41	655	28	95.7%	12/01/2014	41	695	43	93.8%	11/01/2015	41			
16/01/2011	42	684	4	99.4%	15/01/2012	42	737	8	98.9%	13/01/2013	42	734	22	97.0%	19/01/2014	42	732	28	96.2%	18/01/2015	42			
23/01/2011	43	707	17	97.6%	22/01/2012	43	757	9	98.8%	20/01/2013	43	660	18	97.3%	26/01/2014	43	819	50	93.9%	25/01/2015	43			
30/01/2011	44	695	14	98.0%	29/01/2012	44	776	22	97.2%	27/01/2013	44	764	23	97.0%	02/02/2014	44	815	37	95.5%	01/02/2015	44			
06/02/2011	45	751	7	99.1%	05/02/2012	45	769	12	98.4%	03/02/2013	45	828	49	94.1%	09/02/2014	45	775	46	94.1%	08/02/2015	45			
13/02/2011	46	806	34	95.8%	12/02/2012	46	772	23	97.0%	10/02/2013	46	806	42	94.8%	16/02/2014	46	797	30	96.2%	15/02/2015	46			
20/02/2011	47	736	16	97.8%	19/02/2012	47	821	40	95.1%	17/02/2013	47	783	55	93.0%	23/02/2014	47	748	19	97.5%	22/02/2015	47			
27/02/2011	48	723	11	98.5%	26/02/2012	48	830	24	97.1%	24/02/2013	48	828	32	96.1%	02/03/2014	48	804	31	96.1%	01/03/2015	48			
06/03/2011	49	721	17	97.6%	04/03/2012	49	864	15	98.3%	03/03/2013	49	810	22	97.3%	09/03/2014	49	834	51	93.9%	08/03/2015	49			
13/03/2011	50	721	13	98.2%	11/03/2012	50	802	36	95.5%	10/03/2013	50	804	24	97.0%	16/03/2014	50	881	14	98.4%	15/03/2015	50			
20/03/2011	51	848	8	99.1%	18/03/2012	51	822	42	94.9%	17/03/2013	51	830	31	96.3%	23/03/2014	51	831	17	98.0%	22/03/2015	51			
27/03/2011	52	827	23	97.2%	25/03/2012	52	852	42	95.1%	24/03/2013	52	820	17	97.9%	30/03/2014	52	845	25	97.0%	29/03/2015	52			
			996					918		31/03/2013	53	822	32	96.1%										
		40618	996	97.5%			42146	918	97.8%			43572	1339	96.9%			43025	1607	96.3%			20995	924	95.6%

Wk	10/11	11/12	12/13	13/14	14/15	Diff		Wk	10/11	11/12	12/13	13/14	14/15	Diff
1	794	810	854	905	859	(46)	(5%)	1	99.2%	96.5%	95.9%	88.8%	97.3%	-7.1%
2	761	836	841	878	813	(65)	(8%)	2	98.4%	96.1%	97.0%	89.0%	94.3%	-8.1%
3	753	791	822	876	840	(36)	(4%)	3	97.7%	98.2%	97.1%	91.2%	97.3%	-5.9%
4	817	841	756	894	822	(72)	(8%)	4	95.2%	98.9%	98.7%	96.0%	95.3%	-2.7%
5	851	883	767	919	891	(28)	(3%)	5	98.5%	98.0%	98.3%	95.5%	97.1%	-2.8%
6	824	846	825	862	943	81	9%	6	98.4%	95.7%	97.0%	97.4%	96.6%	0.5%
7	796	837	801	837	899	62	7%	7	98.1%	98.9%	98.4%	99.4%	95.2%	1.0%
8	811	836	834	802	882	80	10%	8	98.3%	97.4%	96.5%	98.6%	95.7%	2.1%
9	789	815	881	743	927	184	25%	9	99.4%	98.0%	98.9%	99.9%	92.3%	1.0%
10	803	859	932	850	912	62	7%	10	98.6%	96.3%	99.6%	99.3%	95.5%	-0.3%
11	794	792	904	830	930	100	12%	11	99.6%	98.2%	98.9%	98.4%	94.8%	-0.5%
12	884	766	863	859	976	117	14%	12	99.1%	97.9%	97.0%	99.7%	95.9%	2.7%
13	852	800	888	897	951	54	6%	13	97.3%	97.0%	98.3%	98.9%	94.7%	0.6%
14	837	862	852	864	893	29	3%	14	98.6%	95.2%	98.1%	99.3%	95.1%	1.2%
15	836	849	874	926	907	(19)	(2%)	15	99.2%	98.0%	96.8%	98.8%	94.3%	2.0%
16	826	847	807	960	948	(12)	(1%)	16	98.5%	98.6%	98.6%	94.5%	94.8%	-4.2%
17	894	856	843	902	954	52	6%	17	98.2%	97.3%	98.5%	94.3%	94.4%	-4.1%
18	788	819	850	852	885	33	4%	18	96.4%	96.9%	99.1%	98.2%	96.6%	-0.8%
19	855	792	882	802	881	79	10%	19	96.7%	96.7%	96.8%	97.1%	94.8%	0.3%
20	737	845	852	739	855	116	16%	20	96.7%	97.6%	96.8%	98.0%	95.8%	1.1%
21	755	727	872	868	834	(34)	(4%)	21	97.5%	99.3%	92.5%	96.8%	97.4%	4.2%
22	789	755	833	969	880	(89)	(9%)	22	95.4%	98.9%	96.9%	94.6%	94.7%	-2.2%
23	834	840	878	832	843	11	1%	23	97.1%	99.3%	94.2%	98.0%	97.7%	3.8%
24	776	817	832	831	470	(361)	(43%)	24	97.3%	99.6%	96.3%	97.1%	98.7%	0.8%
25	814	829	827	778				25	95.1%	99.4%	98.3%	97.2%		-1.1%
26	806	808	885	850				26	93.1%	99.0%	98.3%	96.1%		-2.2%
27	798	857	862	852				27	95.9%	98.9%	97.4%	94.5%		-3.0%
28	840	865	902	836				28	94.2%	99.4%	92.9%	97.1%		4.2%
29	816	896	839	819				29	98.4%	98.5%	97.0%	97.4%		0.4%
30	750	807	817	819				30	95.9%	98.4%	98.2%	93.3%		-4.9%
31	779	808	865	742				31	99.0%	99.0%	97.0%	98.7%		1.7%
32	721	777	795	802				32	99.4%	99.2%	96.5%	97.8%		1.3%
33	759	823	793	825				33	99.7%	98.2%	95.1%	95.9%		0.8%
34	719	723	816	790				34	98.9%	99.0%	94.6%	96.7%		2.1%
35	717	810	743	827				35	97.1%	98.3%	97.8%	93.8%		-4.0%
36	742	754	791	794				36	96.4%	99.1%	99.0%	92.4%		-6.5%
37	771	777	817	789				37	96.0%	98.1%	97.8%	97.3%		-0.5%
38	692	782	799	765				38	98.4%	95.9%	96.1%	96.5%		0.4%
39	663	694	773	719				39	96.2%	98.7%	97.7%	96.4%		-1.3%
40	804	802	761	745				40	96.5%	99.0%	97.6%	96.9%		-0.7%
41	752	811	655	695				41	94.8%	98.3%	95.7%	93.8%		-1.9%
42	684	737	734	732				42	99.4%	98.9%	97.0%	96.2%		-0.8%
43	707	757	660	819				43	97.6%	98.8%	97.3%	93.9%		-3.4%
44	695	776	764	815				44	98.0%	97.2%	97.0%	95.5%		-1.5%
45	751	769	828	775				45	99.1%	98.4%	94.1%	94.1%		0.0%
46	806	772	806	797				46	95.8%	97.0%	94.8%	96.2%		1.4%
47	736	821	783	748				47	97.8%	95.1%	93.0%	97.5%		4.5%
48	723	830	828	804				48	98.5%	97.1%	96.1%	96.1%		0.0%
49	721	864	810	834				49	97.6%	98.3%	97.3%	93.9%		-3.4%
50	721	802	804	881				50	98.2%	95.5%	97.0%	98.4%		1.4%
51	848	822	830	831				51	99.1%	94.9%	96.3%	98.0%		1.7%
52	827	852	820	845				52	97.2%	95.1%	97.9%	97.0%		-0.9%
53	0	0	822	0										
		18904	19511	19866		355								
			3.2%	1.8%										

RNZ/99N SLAM Non Elective Activity

Mth: 4 Excluded Specialties =314, 315, 422, 426, 501 & 560

		99N												99N												YTD				M4 YTD	Diff	%
Code	Specialty	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	13/14	14/15	14-15 Diff		Plan		
100	Gen Surg	113	129	120	151	134	125	158	135	133	119	102	117	112	125	118	135									513	490	(23)	(4%)	507	(17)	(3%)
101	Urology	41	39	35	47	41	44	39	41	44	38	47	28	43	41	44	47									162	175	13	8%	157	18	11%
103	Breast Surg							1				1			1												1	1		1	0	34%
104	Colorectal			1						4			2			1	1									1	2	1	100%	2	0	10%
105	Hepatobiliary & Pancreatic Surgery																1										1	1			1	
106	Upper GI											1				1											1	1		0	1	194%
107	Vas Surg			1				2	1			1	1	2												1	2	1	100%	2	0	3%
110	T&O	76	95	73	87	73	74	76	65	70	68	55	70	79	85	86	96									331	346	15	5%	314	32	10%
120	ENT	19	20	15	13	9	16	9	11	19	18	16	17	14	25	17	13									67	69	2	3%	60	9	14%
130	Ophthal		1	2	1	1		2	2			1	1				3									4	3	(1)	(25%)	3	0	14%
160	Plastics	35	36	33	38	51	32	45	41	32	38	31	36	20	53	40	34									142	147	5	4%	150	(3)	(2%)
180	A&E	132	157	129	172	161	141	157	155	170	169	148	140	124	145	133	157									590	559	(31)	(5%)	553	6	1%
191	Pain Management									1																				0	(0)	(100%)
214	Paed T&O	4	1		1		2		1						1		1									6	2	(4)	(67%)	4	(2)	(52%)
215	Paed ENT								1	1							1										1	1		1	0	76%
217	Paed Max-Facial		1	1										1			1									2	2			1	1	203%
263	Paed Diabetic		1	1	2		1										2									4	2	(2)	(50%)	1	1	101%
300	Gen Med	348	368	319	346	367	367	384	352	356	443	380	413	438	448	418	451									1381	1755	374	27%	1288	467	36%
301	Gastro	29	22	22	34	33	30	57	24	39	37	26	49	35	30	25	25									107	115	8	7%	131	(16)	(12%)
302	Endocrin	6	5	5	5	7	3	3	5	4	2	3	4	5	3	1	5									21	14	(7)	(33%)	17	(3)	(18%)
303	Cl Haem	2	12	7	2	3	5	2	3	4	4	2	4	1	7	6	9									23	23			17	6	34%
307	Diabetes																															
320	Cardiology	28	34	48	46	46	36	41	40	40	33	25	29	33	45	37	51									156	166	10	6%	151	15	10%
328	Stroke	29	33	18	23	19	18	13	21	23	16	7	13	12	11	13	11									103	47	(56)	(54%)	74	(27)	(36%)
329	TIA																															
330	Derm		1				1		1						1											1	1			1	0	25%
340	Thoracic	1	1	3	2		1	2	1				1	4		1	1									7	6	(1)	(14%)	4	2	41%
370	Med Oncol		2		1			1		3	4	1			1											3	1	(2)	(67%)	3	(2)	(70%)
410	Rheum			1		1			1		1			2												1	2	1	100%	1	1	62%
420	Paeds	63	49	58	77	73	91	85	95	111	86	57	108	77	68	77	58									247	280	33	13%	275	5	2%
430	Elderly Care	18	17	30	12	10	9	6	14	10	9	4	7	9	5	2	10									77	26	(51)	(66%)	51	(25)	(49%)
501	Obstetrics																															
502	Gynae	36	36	33	33	38	29	39	37	33	36	27	41	44	47	22	59									138	172	34	25%	114	58	51%
503	Gynae Oncology		1																							1		(1)	(100%)	1	(1)	(100%)
800	Cl Oncol	1	4	2		2	2	1		1	1															7		(7)	(100%)	5	(5)	(100%)
811	Int Radiology	11	12	10	8	10	12	5	11	11	5	11	3	14	13	13	3									41	43	2	5%	43	0	0%
Total		**992**	**1077**	**967**	**1101**	**1079**	**1039**	**1128**	**1058**	**1109**	**1127**	**946**	**1084**	**1069**	**1155**	**1055**	**1175**									**4137**	**4454**	**317**	**7.7%**	**3932**	**522**	**13.3%**
Year on Year % increase														7.8%	7.2%	9.1%	6.7%										4421					
																										N-pbR	33					
	Non-PbR Total	13	10	13	31	10	8	18	16	8	8	12	3	10	10	3	10									67	33	(34)	(51%)			
	PbR Total	979	1067	955	1072	1069	1031	1110	1042	1101	1119	935	1092	1059	1145	1052	1165									4073	4421	348	9%			

RNZ/99N SLAM Elective Activity

Mth: 4

Excluded Specialties = 422

POD	Code	Specialty	99N Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	99N Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD 13/14	14/15	14-15 Diff		M4 YTD Plan	Diff	%
DC	100	Gen Surg	42	31	36	20	33	37	27	41	37	37	30	37	24	31	19	39									129	113	(16)	(12%)	132	(19)	(15%)
	101	Urology	69	71	70	77	105	74	77	77	68	59	60	84	65	72	44	73									287	254	(33)	(11%)	312	(58)	(19%)
	103	Breast Surg	12	7	14	13	10	7	17	8	7	7	8	10	20	14	11	8									46	53	7	15%	42	11	25%
	104	Colorectal	168	150	96	139	132	134	146	135	122	165	146	133	108	121	86	110									553	425	(128)	(23%)	551	(126)	(23%)
	105	Hepatobiliary & Panc Surg	12	13	11	5	7	11	8	4	11	5	8	12	8	12	11	15									41	46	5	12%	39	7	17%
	107	Vas Surg	10	7	8	6	3	6	7	8	5	10	10	9	6	7	8	8									31	29	(2)	(6%)	28	1	3%
	110	T&O	120	84	114	103	84	115	105	101	86	109	80	101	65	89	110	115									421	379	(42)	(10%)	272	107	39%
	120	ENT	33	24	22	25	24	33	22	37	17	24	25	19	32	26	31	27									104	116	12	12%	110	6	5%
	130	Ophthal	101	84	102	136	88	63	143	102	96	98	128	83	101	122	119	150									423	492	69	16%	394	98	25%
	160	Plastics	72	95	78	82	66	79	97	83	65	83	83	76	78	53	62	90									327	283	(44)	(13%)	258	25	10%
	215	Paed ENT	1			1											1										2	1	(1)	(50%)	1	0	7%
	219	Paed Plastic		1																							1		(1)	(100%)	1	(1)	(100%)
	300	Gen Med	30	51	38	45	58	79	54	46	56	49	26	31	73	51	42	89									164	255	91	55%	210	45	22%
	301	Gastro	258	276	256	274	265	251	311	293	280	262	278	339	342	296	303	373									1064	1314	250	23%	1043	271	26%
	302	Endocrin	2		3	2		1	3	1	1	1	3	2		3	1	2									7	6	(1)	(14%)	6	0	7%
	320	Cardiology	73	57	69	73	62	69	70	62	64	70	63	69	82	73	72	76									272	303	31	11%	277	26	9%
	330	Dermatology	12	22	26	29	17	19	29	23	18	19	18	9	10	6	17	22									89	55	(34)	(38%)	59	(4)	(7%)
	340	Respiratory Med	7	10	6	6	4	9	10	5	11	7	7	6	27	10	13	10									29	60	31	107%	31	29	95%
	361	Nephrology					2																								1	(1)	(100%)
	370	Medical Oncology									1																				0	(0)	(100%)
	410	Rheum	37	67	58	65	65	60	65	55	52	61	49	41	48	64	66	62									227	240	13	6%	236	4	2%
	420	Paeds										2		1	1													1	1		0	1	114%
	430	Elderly Care			1	1												3									2	3	1	50%	1	2	349%
	502	Gynae	71	66	46	45	60	49	43	57	38	60	35	53	44	64	68	66									228	242	14	6%	218	24	11%
	503	Gynae Oncol	1	6	10	12	8	13	5	2	4	3			3	4	6	7									29	20	(9)	(31%)	34	(14)	(41%)
	811	Int Radiology	34	31	22	23	21	20	23	27	18	22	2	2	6	3	3	3									110	15	(95)	(86%)	93	(78)	(84%)
	Total		**1165**	**1153**	**1086**	**1182**	**1114**	**1129**	**1262**	**1167**	**1057**	**1153**	**1059**	**1117**	**1143**	**1121**	**1093**	**1348**									**4586**	**4705**	**119**	**2.6%**	**4350**	**355**	**8.2%**
	Year on Year % increase														-2%	-3%	1%	14%															
	Combined Surgery (DC)		244	208	165	183	185	195	205	196	182	224	202	201	166	185	135	180									800	666	(134)	(17%)	792	(126)	(16%)
IP	100	Gen Surg	21	21	21	12	23	22	22	14	25	23	26	30	27	14	21	19									75	81	6	8%	83	(2)	(3%)
	101	Urology	41	41	57	48	50	41	45	51	47	33	38	43	39	47	46	39									187	171	(16)	(9%)	166	5	3%
	103	Breast Surg	13	17	10	9	6	13	2	9	6	14	13	10	19	13	9	12									49	53	4	8%	44	9	19%
	104	Colorectal	10	21	14	12	16	15	16	6	10	12	12	16	10	11	6	10									57	37	(20)	(35%)	59	(22)	(38%)
	105	Hepatobiliary & Panc Surg	6	8	3	5	7	12	8	10	4	4	5	8	4	7	3	9									22	23	1	5%	28	(5)	(18%)
	106	Upper GI Surg	1	1	1	4	2	8	1	2	5	2	4		1	1		2									7	4	(3)	(43%)	10	(6)	(61%)
	107	Vas Surg	5	4	1	4	1		2	2	6	2	4	1	4	3	1	3									14	11	(3)	(21%)	10	1	10%
	110	T&O	63	86	79	92	74	73	62	77	70	80	63	85	57	72	63	91									320	283	(37)	(12%)	297	(14)	(5%)
	120	ENT	18	24	27	16	27	19	22	19	15	10	15	18	22	15	16	27									85	80	(5)	(6%)	84	(4)	(5%)
	130	Ophthal	2		1			1		1				1	1	1	1										3	3			2	1	23%
	160	Plastics	33	38	26	34	31	36	38	51	37	20	38	26	29	35	26	47									131	137	6	5%	124	13	11%
	211	Paed Urology					1																								1	(1)	(100%)
	214	Paed T&O	2	1		3		1		2	2	2															6		(6)	(100%)	4	(4)	(100%)
	215	Paed ENT	4	6	3	2	2	1	2	3	5	1	8	4		9	2	5									15	16	1	7%	15	1	8%
	219	Paed Plastic	3	2		1	1	1	2		1	1			3	1	1										6	5	(1)	(17%)	5	(0)	(3%)
	300	Gen Med	13	7	5	1	7	3	5	6	1	2	2	2	3	4	5	5									26	17	(9)	(35%)	22	(5)	(24%)
	301	Gastro	3	7	5	7	10	11	10	5	8	4	8	7	9	4	9	8									22	30	8	36%	31	(1)	(2%)
	302	Endocrin	1																								1		(1)	(100%)	0	(0)	(100%)
	303	CI Haem		3	3		2	2	2	2	2	4	5	5	5	7	4	5									6	21	15	250%	7	14	189%
	320	Cardiology	3	4	4	10	5	6	7	11	9	5	11	6	5	10	4	8									21	27	6	29%	22	5	21%
	340	Respiratory Med					1									1												1	1		1	0	46%
	370	Med Oncol	1		2				2					3	1												3	1	(2)	(67%)	3	(2)	(62%)
	410	Rheum				1																					1		(1)	(100%)	1	(1)	(100%)
	420	Paeds		1	1	8	1	2	1	1		2	2	1	2	1											10	3	(7)	(70%)	8	(5)	(61%)
	430	Elderly Care	1							1																	1		(1)	(100%)	1	(1)	(100%)
	502	Gynae	20	24	25	25	24	17	32	32	21	21	25	23	21	21	19	32									94	93	(1)	(1%)	90	3	4%
	503	Gynae Oncol														1												1	1			1	
	800	CI Oncol		1	1		1	1	1		1	2	2	1		1	1										2	2			3	(1)	(30%)
	811	Int Radiology	9	10	8	9	9	11	11	12	7	3	4	7	4	7	4	2									36	17	(19)	(53%)	32	(15)	(47%)
	Total		**273**	**327**	**297**	**303**	**301**	**296**	**293**	**317**	**282**	**247**	**285**	**297**	**266**	**286**	**241**	**324**									**1200**	**1117**	**(83)**	**(6.9%)**	**1153**	**(36)**	**(3.1%)**
	Year on Year % increase														-3%	-13%	-19%	7%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%							
	Combined Surgery (ELIP)		56	72	50	46	55	70	51	43	56	57	64	65	65	49	40	55									224	209	(15)	(6.7%)	235	(26)	(11.0%)
DC & ELIP Combined			1438	1480	1383	1485	1415	1425	1555	1484	1339	1400	1344	1414	1409	1407	1334	1672									**5786**	**5822**	**36**	**0.6%**	**5502**	**320**	**5.8%**
Year on Year % increase															-2%	-5%	-4%	13%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%		5818					
																												-4				

9.7 The levels and Drivers of increased demand (Royal United Hospitals NHS Trust)

9.7.1 Month 4 analysis of elective data at Royal United Hospital NHS Trust shows that there has been any increase in 2014/15, although GP referrals are flat and the growth seems to be in consultant to consultant and ED referrals. Gastroenterology, Cardiology and Dermatology specialities are seeing most growth. Closer analysis of the top five referring practices indicates an average increase of just 2.0%, with a range from 9.8% to 48.1%.

9.7.2 Elective activity indicates annual elective growth is at -2.0%%. Day cases have decreased by 3.0%%, with the majority being in gastroenterology and oncology. Elective inpatient activity shows an increase of 3.0% which is within orthopaedics.

9.7.3 There has been a 55% reduction in elective excess bed days this year

9.7.4 Waiting list pressure is broadly static. As at month four both the waiting list size (+28) and the number of over 18 week waits (-44) have decreased. This is despite extra RTT activity taking place. Extra RTT backlog activity is being undertaken to reduce the tail still further however long waits for Gastroenterology remain.

9.7.5 Emergency department attendance is up 5.0% YTD, despite some activity being undertaken by the bath urgent care centre since April 2014. There was a spike in activity in May 2014 (1984 cases) but July was below the same month in 2013/14.

9.8 Whether acuity and complexity has actually increased (Royal United Hospitals NHS Trust)

9.8.1 The elective growth is high in diagnostic spells including endoscopies which are lighter casemix. There is also a marked increase in cancer spells.

9.8.2 Reviewing ED attendance outcomes, it appears that the growth in attendance is mirrored by an increase in patients admitted from ED, suggesting an either a casemix rise or a lowering of admission thresholds. However the HRG analysis of ED attendances shows some increases in the higher levels of intervention within ED

9.8.3 HRG trends analysis shows that much of the non-elective activity growth is seen with more minor casemix as the growth sits in HRGs without complications or complexity. Cardiac activity analysis shows significant growth in just a handful of HRGs.

9.8.4 Non-elective average length of stay has reduced from 5.7 to 5 days this year with over 2 day stays down from 10.8 to 9.5 days.

9.9 Whether there is a redistribution of demand (Royal United Hospitals NHS Trust)

9.9.1 Two of the three operational localities with the CCG, (WWYKD and NEW) refer in to Royal United Hospital NHS Trust

9.9.2 Elective referral analysis by practice shows increased referrals from both WWYKD and NEW clusters. There is greater elective growth flowing to Circle Bath, BMI Bath Clinic and Care UK ISTCs suggesting there is increased elective flow away from the RUH.

9.9.3 A&E- RUH growth is greater than that seen at the MIUs, however the planned BUCC impact is not leading to the expected reduction in RUH attendances.

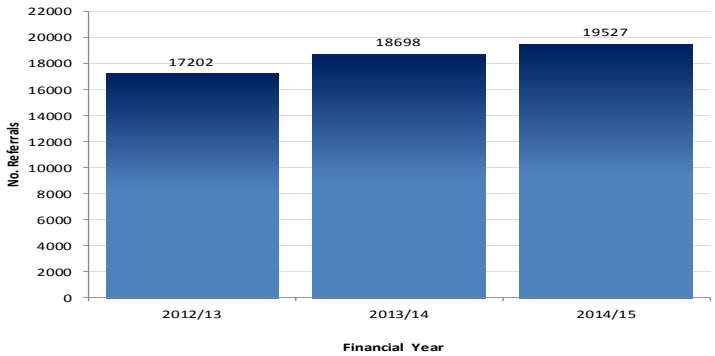
9.9.4 Non-electives – Total activity at the RUH has increased since the maternity transfer since June 2014.

9.10 Changes in the volatility of demand (Royal United Hospitals NHS Trust)

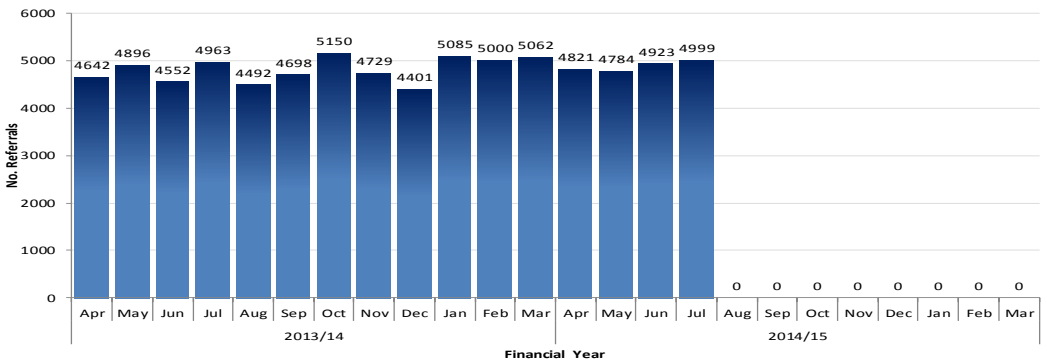
9.10.1 There is some evidence of changes in the volatility of demand. Planned care has seen a spike in referrals in June 2014 but this reverted close to planned levels in July 2014. Unplanned care has seen a large spike in activity in May 2014 with smaller increases since then. There has been a material unplanned increase in readmissions in 2014/15.

NHS Wiltshire CCG - RUH Referral Trend Summary - Month 4

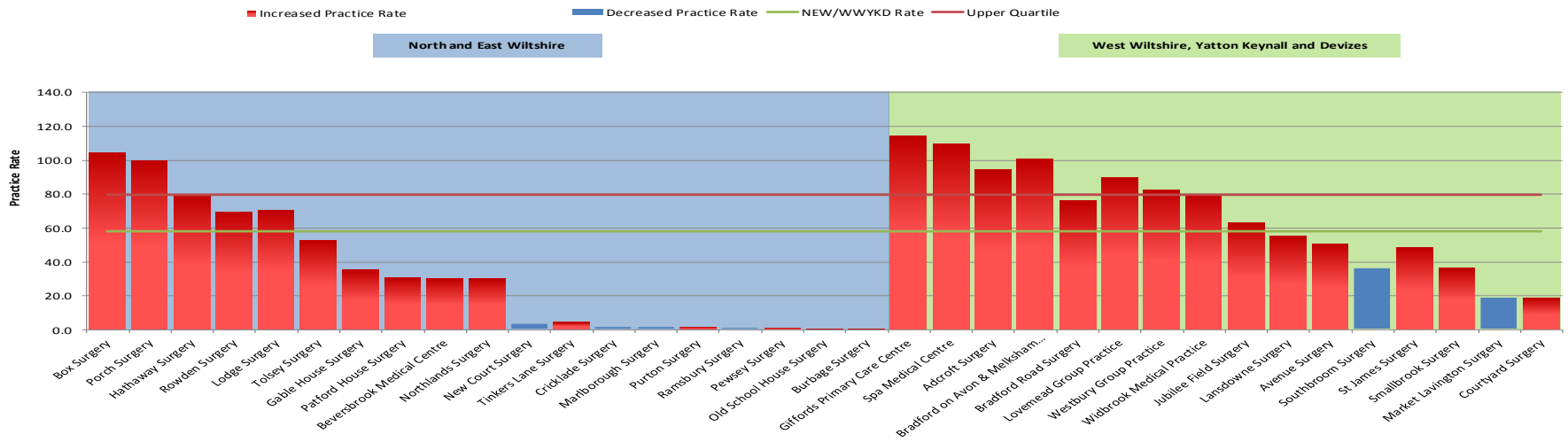
YTD Referrals by Year



Referrals by Month



RUH Referrals per 1,000 Weighted Population by GP Cluster/Practice 14/15 YTD



RUH SLAM Elective Spells Trends Mnth 4

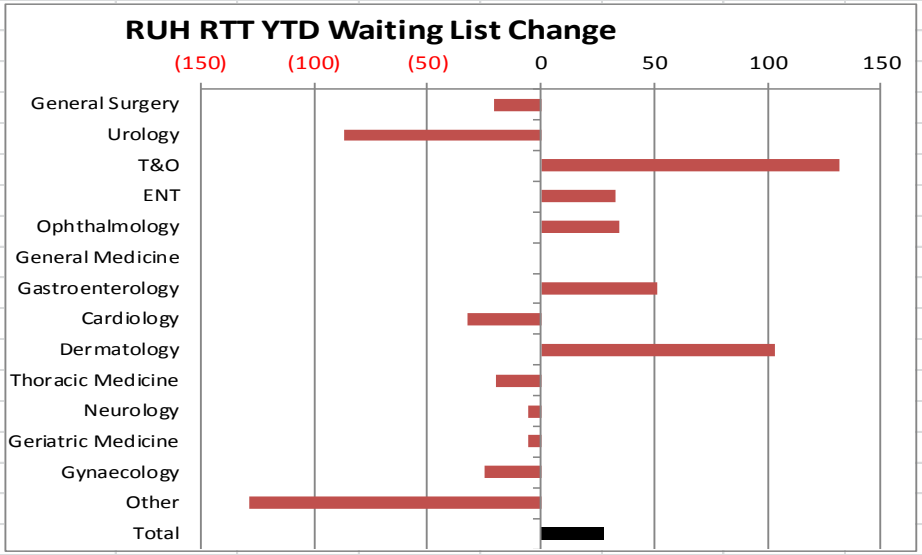
CCG Code 99N

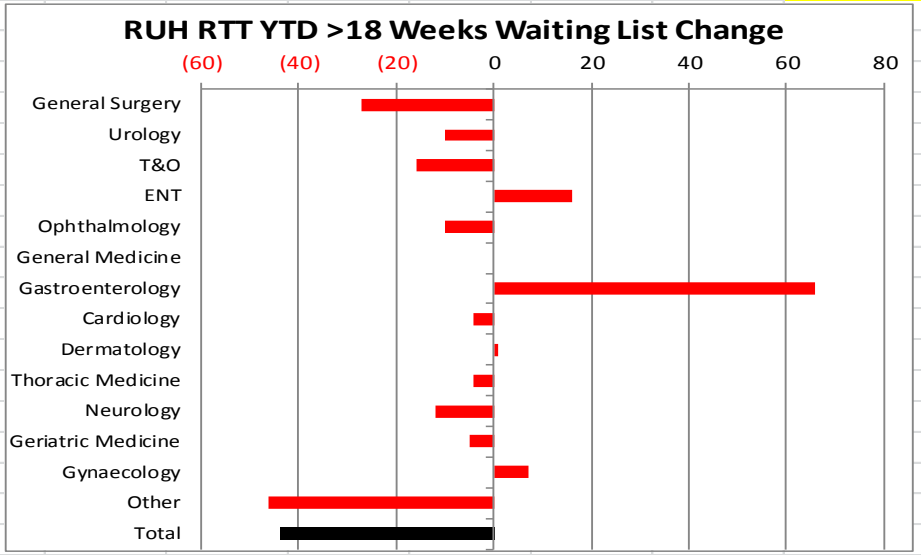
Update

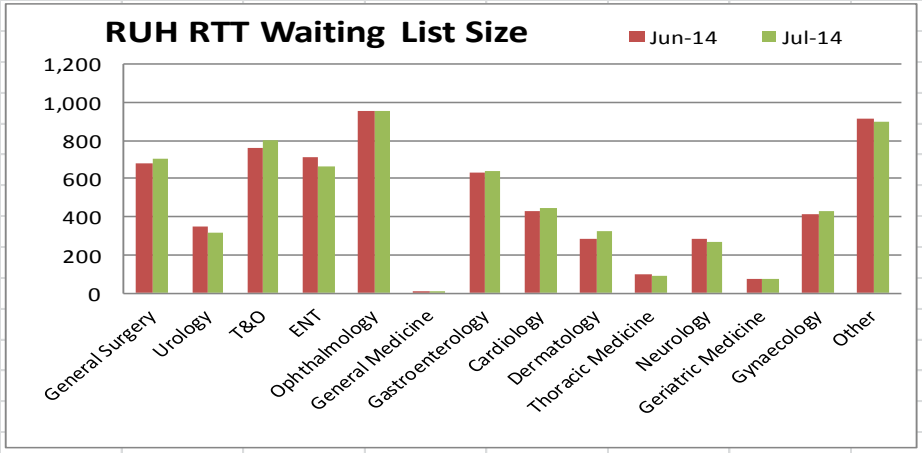
Sum of ActivityActual			2013/14												2014/15												13/14	14/15	2014-15		YTD				Unplanned YTD			
POD	SpecCode	SpecDesc	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	OT	FOT	Growth		13/14	14/15	Diff	%	Plan	Actual	Diff	%
	BSP	Bowel Screening Program (FoC)	17	15	19	13	16	11	16	13	15	18	13	9	20	14	18	22									175	222	47	27%	64	74	10	16%		74	74	
DC	100	General Surgery	56	37	59	54	26	36	43	41	51	61	61	72	38	37	68	41									597	552	(45)	(8%)	206	184	(22)	(11%)	188	184	(4)	(2%)
	101	Urology	34	38	29	38	27	25	40	28	29	45	32	40	28	34	34	36									405	396	(9)	(2%)	139	132	(7)	(5%)	132	132	0	0%
	103	Breast Surgery	6	12	9	6	5	9	7	10	10	11	7	9	9	11	13	10									101	129	28	28%	33	43	10	30%	33	43	10	29%
	104	Colorectal Surgery			1	3		1	1	1	2	2		1	1												12	3	(9)	(75%)	4	1	(3)	(75%)	4	1	(3)	(77%)
	106	Upper Gastrointestinal Surgery																																				
	107	Vascular Surgery	3	3	6	6	3	1	1	1	7	1	2	8		3		3									42	18	(24)	(57%)	18	6	(12)	(67%)	14	6	(8)	(58%)
	110	Trauma & Orthopaedics	41	61	44	54	48	47	48	64	60	65	66	62	52	41	47	53									660	579	(81)	(12%)	200	193	(7)	(4%)	211	193	(18)	(8%)
	120	ENT	32	42	42	45	20	30	49	44	29	31	28	30	32	33	47	42									422	462	40	9%	161	154	(7)	(4%)	151	154	3	2%
	130	Ophthalmology	74	66	79	91	70	73	85	82	86	75	85	83	86	67	84	85									949	966	17	2%	310	322	12	4%	314	322	8	2%
	171	Paediatric Surgery	2		1		2		2	3			2	1	7	1	3	1									13	36	23	177%	3	12	9	300%	4	12	8	171%
	180	Accident & Emergency								1																	1		(1)	(100%)					0		(0)	(100%)
	191	Pain Management	76	78	63	54	56	50	67	87	54	69	48	56		1		4									758	15	(743)	(98%)	271	5	(266)	(98%)	265	5	(260)	(98%)
	211	Paediatric Urology	5	3	5	2	1	3	3	3	2	4	2	2	7	6	6	4									35	69	34	97%	15	23	8	53%	12	23	11	88%
	263	Paediatric Diabetic Medicine									1																1		(1)	(100%)					0		(0)	(100%)
	300	General Medicine	50	39	34	34	45	35	20	24	21	30	26	29	43	36	48	47									387	522	135	35%	157	174	17	11%	137	174	37	27%
	301	Gastroenterology	224	195	173	227	207	228	224	195	195	227	185	215	225	244	225	292									2,495	2,958	463	19%	819	986	167	20%	859	986	127	15%
	302	Endocrinology			1	1		2	4	3	2	4	1	2	2	5	5	4									20	48	28	140%	2	16	14	700%	6	16	10	177%
	303	Clinical Haematology	76	95	57	86	86	91	81	83	101	94	86	89	109	93	87	84									1,025	1,119	94	9%	314	373	59	19%	348	373	25	7%
	306	Hepatology													1													3	3			1	1			1	1	
	307	Diabetic Medicine							1			1			1	1											2	6	4	200%		2	2		0	2	2	488%
	316	Clinical Immunology																																	0		(0)	(100%)
	320	Cardiology	26	36	32	34	17	25	29	29	17	22	25	31	18	30	23	28									323		(323)	(100%)	128	99	(29)	(23%)	111	99	(12)	(11%)
	330	Dermatology			1		1		1	1	2	2		2		2		1									10	9	(1)	(10%)	1	3	2	200%	3	3	0	10%
	340	Respiratory Medicine	17	16	13	22	11	11	14	16	16	21	21	19	19	22	26	27									197	282	85	43%	68	94	26	38%	61	94	33	54%
	370	Medical Oncology	19	12	13	18	17	12	20	14	10	15	9	12	12	18	10	11									171	153	(18)	(11%)	62	51	(11)	(18%)	64	51	(13)	(21%)
	400	Neurology		1	1	1	1											5									4	15	11	275%	3	5	2	67%	9	5	(4)	(46%)
	410	Rheumatology																																				
	420	Paediatrics	2	6	6		3	2	2	3	3	6	3	2	5	4	1	6									38	48	10	26%	14	16	2	14%	13	16	3	27%
	421	Paed Neuro																																				
	422	Neonatology																																				
	430	Geriatric Medicine									1		1			1											2	3	1	50%		1	1		0	1	1	194%
	502	Gynaecology	35	51	61	57	44	45	49	43	38	45	41	39	46	36	63	50									548	585	37	7%	204	195	(9)	(4%)	192	195	3	2%
	503	Gynaecological Oncology	1		1				1		1					1		1									4	6	2	50%	2	2			2	2	0	18%
	800	Clinical Oncology	22	22	15	24	16	11	21	17	13	13	17	11	13	9	4	14									202	120	(82)	(41%)	83	40	(43)	(52%)	76	40	(36)	(47%)
	812	Diagnostic Imaging																																				
	MED																																					
	SURG																																					
DC Spells Total			**801**	**813**	**746**	**857**	**706**	**737**	**813**	**792**	**752**	**844**	**748**	**815**	**754**	**736**	**794**	**849**									**9,424**	**9,399**	**(322)**	**(3%)**	**3,217**	**3,133**	**(84)**	**(3%)**	**3,212**	**3,133**	**(79)**	**(2%)**
EL	100	General Surgery	16	22	26	40	23	26	25	15	22	18	24	20	18	22	16	25									277		(277)	(100%)	104		(104)	(100%)	123		(123)	(100%)
	101	Urology	17	25	24	26	23	30	29	30	27	25	29	18	25	32	38	32									303		(303)	(100%)	92		(92)	(100%)	101		(101)	(100%)
	103	Breast Surgery	9	6	8	12	10	6	5	11	11	11	12	13	17	14	12	11									114		(114)	(100%)	35		(35)	(100%)	37		(37)	(100%)
	104	Colorectal Surgery	11	8	9	15	11	9	10	8	10	10	12	9	8	5	8	8									122		(122)	(100%)	43		(43)	(100%)	37		(37)	(100%)
	107	Vascular Surgery	11	11	9	10	11	10	7	9	5	19	8	11	9	9	7	7									121	96	(25)	(21%)	41	32	(9)	(22%)	38	32	(6)	(16%)
	108	Spinal Surgery														1												3	3				1	1		1	1	
	110	Trauma & Orthopaedics	41	58	63	59	62	71	60	71	50	54	69	79	59	57	53	70									737	717	(20)	(3%)	221	239	18	8%	250	239	(11)	(4%)
	120	ENT	12	11	13	13	8	11	9	4	13	14	11	9	13	12	13	13									128	153	25	20%	49	51	2	4%	43	51	8	18%
	130	Ophthalmology							1	1		1			1		1	1									3	9	6	200%		3	3		2	3	1	47%
	171	Paediatric Surgery																																	0		(0)	(100%)
	191	Pain Management								1					1												1	3	2	200%		1	1			1	1	
	192	Critical Care Medicine													1													3				1				1		
	211	Paediatric Urology							1	2			1	1													5		(5)	(100%)					1		(1)	(100%)
	263	Paediatric Diabetic Medicine									1																1		(1)	(100%)								
	300	General Medicine	1					3	1		3		1	1													10		(10)	(100%)	1		(1)	(100%)	2		(2)	(100%)
	301	Gastroenterology		7	3	1	2	1	1	4	6	14	3	1	1	2	6	1									43	30	(13)	(30%)	11	10	(1)	(9%)	9	10	1	13%
	302	Endocrinology						1	1			1															3		(3)	(100%)					2		(2)	(100%)
	303	Clinical Haematology	2	1	3	1	2	9	7	3	3	2	3	7	5	2	1	1									43	27	(16)	(37%)	7	9	2	29%	14	9	(5)	(35%)
	307	Diabetic Medicine								1							1										1	3	2	200%		1	1			1	1	
	320	Cardiology	14	14	17	17	14	13	8	15	5	22	14	20	16	16	14	13									173	177	4	2%	62	59	(3)	(5%)	61	59	(2)	(4%)
	328	Stroke Medicine																																				
	340	Respiratory Medicine		2			1				1		5	1	1		1										10	6	(4)	(40%)	2	2			1	2	1	96%
	370	Medical Oncology		1	2	1		2			1					1	1									7	6	(1)	(14%)	4	2	(2)	(50%)	8	2	(6)	(74%)
	400	Neurology																1										3	3			1	1			1	1	
	420	Paediatrics	5	3	1	5	2	2	3	1	1	2	1	2	3		1	3									28	21	(7)	(25%)	14	7	(7)	(50%)	8	7	(1)	(14%)
	422	Neonatology																																				
	430	Geriatric Medicine			1	1			1																		3		(3)	(100%)	2		(2)	(100%)	2		(2)	(100%)
	502	Gynaecology	25	19	30	35	27	25	26	29	19	27	25	27	20	31	26	36									314	339	25	8%	109	113	4	4%	111	113	2	2%
	503	Gynaecological Oncology								4	2		1	1	1		1	1									8	9	1	13%		3	3			3	3	
	800	Clinical Oncology	1	3	2	4	3	4	1				2				2										20	6	(14)	(70%)	10	2	(8)	(80%)	10	2	(8)	(80%)
	812	Diagnostic Imaging																																				
	SURG																																					
EL Spells Total			**165**	**191**	**211**	**240**	**199**	**223**	**196**	**208**	**180**	**220**	**221**	**221**	**199**	**204**	**202**	**223**									**2,475**	**2,484**	**(867)**	**(35%)**	**807**	**828**	**21**	**3%**	**860**	**537**	**(323)**	**(38%)**
	XBDs		148	71	144	84	47	80	14	123	22	22	12	57	140	2	13	44.6									966	599	(367)	(38%)	447	200	(247)	(55%)	330	200	(130)	(39%)
Total EL (Spells & XBDs)			313	262	355	324	246	303	210	331	202	242	233	278	339	206	215	268									3,299	3,083	(1,734)	(53%)	1,254	1,028	(226)	(18%)	1,190	737	(453)	(38%)
Total Elective Spells (DC & EL)			**966**	**1004**	**957**	**1097**	**905**	**960**	**1009**	**1000**	**932**	**1064**	**969**	**1036**	**953**	**940**	**996**	**1072**									**11,899**	**11,883**	**(16)**	**(0%)**	**4,024**	**3,961**	**(63)**	**(2%)**	**4,072**	**3,670**	**(402)**	**(10%)**
															-1%	**-6%**	**4%**	**-2%**																				
	Gross Gen Surgery		47	47	52	77	55	51	47	43	48	58	56	53	152	142	171	158									634	1,869	1,235	195%	223	623	400	179%	480	623	143	30%

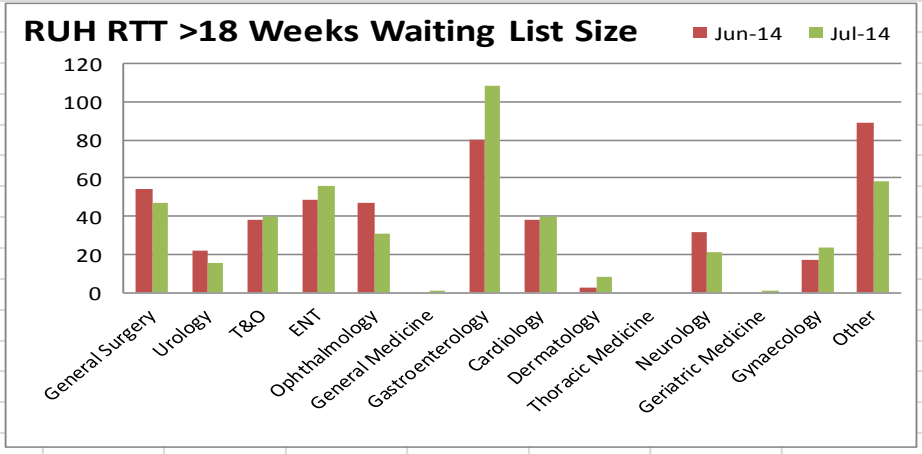
2013/14 RUH RTT Waiting List Size Monitoring

YTD Month Jul-14









NHS
Wiltshire
Clinical Commissioning Group

CCGCode 99N Mnth 4

Sum of ActivityActual			2013/14												2014/15												13/14	14/15	2014-15		YTD				Unplanned YTD			
POD	Code	SpecDesc	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	OT	FOT	Growth		13/14	14/15	Diff	%	Plan	Actual	Diff	%
Total NE	100	General Surgery	103	150	143	159	133	158	145	151	128	148	128	113	158	136	128	135									1,659	1,671	12	1%	555	557	2	0%	356	557	201	57%
Adjusted	101	Urology	14	20	19	23	23	28	20	25	20	15	20	14	17	31	18	16									241	246	5	2%	76	82	6	8%	86	82	(4)	(5%)
for	103	Breast Surgery		1							1					1											2	3	1	50%	1	1			1	1	(0)	(25%)
Readmits	104	Colorectal Surg			2	1	3	1	1			1	1		2	1	3	3									10	27	17	170%	3	9	6	200%	4	9	5	145%
NEL,	106	Upper GI Surg						1	1																		2		(2)	(100%)					1		(1)	(100%)
NELNE,	107	Vascular Surgery	7	9	18	4	4	5	2	2	2	3	6	3	4	3	5	3									65	45	(20)	(31%)	38	15	(23)	(61%)	34	15	(19)	(56%)
NELSD,	110	T&O	77	87	82	77	83	72	66	59	82	73	58	78	66	84	89	81									894	960	66	7%	323	320	(3)	(1%)	285	320	35	12%
NELST	120	ENT	12	15	16	19	11	21	17	25	25	22	21	15	15	17	17	14									219	189	(30)	(14%)	62	63	1	2%	59	63	4	6%
	130	Ophthalmology		1					1	1	3			1	4		3	2									7	27	20	286%	1	9	8	800%	2	9	7	285%
	171	Paed Surgery		1							1		1		1												3	3			1	1			0	1	1	199%
	180	A&E	120	128	133	132	133	125	139	114	133	131	108	124	126	111	119	123									1,520	1,437	(83)	(5%)	513	479	(34)	(7%)	504	479	(25)	(5%)
	191	Pain Mgmt	5	1	2	2	1	1	6		2	4	4	4	3	3	3	1									32	30	(2)	(6%)	10	10			9	10	1	11%
	192	Critical Care Med	2	5	5	1	2	3	3	7	4	9	4	2	5	2	3	7									47	51	4	9%	13	17	4	31%	16	17	1	6%
	211	Paed Urology	1				1					2				2	1	1									4	12	8	200%	1	4	3	300%	1	4	3	299%
	263	Paediatric Diabetic Medicine				3			1																		4		(4)	(100%)	3		(3)	(100%)	1		(1)	(100%)
	300	General Med	288	321	329	332	328	316	359	311	336	409	340	354	342	374	376	372									4,023	4,392	369	9%	1,270	1,464	194	15%	1200	1,464	264	22%
	301	Gastro	22	33	30	19	32	31	28	23	31	34	20	26	39	37	37	33									329	438	109	33%	104	146	42	40%	119	146	27	23%
	302	Endocrinology	38	16	14	24	23	20	21	20	14	22	20	23	22	15	18	23									255	234	(21)	(8%)	92	78	(14)	(15%)	100	78	(22)	(22%)
	303	Clinical Haem	2	1	5	1	1	4	9	9	2	5	4	3	3	1	7	3									46	42	(4)	(9%)	9	14	5	56%	15	14	(1)	(9%)
	307	Diabetic Med	17	25	18	23	19	9	18	18	15	24	13	17	20	33	21	18									216	276	60	28%	83	92	9	11%	63	92	29	46%
	320	Cardiology	40	41	30	42	37	40	32	37	39	42	48	43	35	50	47	34									471	498	27	6%	153	166	13	8%	141	166	25	18%
	321	Paediatric Cardiology			1					1							1										2	3	1	50%	1	1			0	1	1	199%
	328	Stroke Medicine	22	28	32	31	27	23	23	31	32	34	30	30	25	35	23	34									343	351	8	2%	113	117	4	4%	112	117	5	4%
	329	TIA			1		1				1		1		1												4	3	(1)	(25%)	1	1			1	1	0	50%
	340	Respiratory Med	20	26	26	34	39	35	29	21	28	23	34	30	31	39	32	36									345	414	69	20%	106	138	32	30%	97	138	41	42%
	370	Med Oncology	5	1	2	8	6	3	8	5	6	5	3	1	3	2	4	6									53	45	(8)	(15%)	16	15	(1)	(6%)	15	15	(0)	(0%)
	400	Neurology												1				1									1	3	2	200%		1	1			1	1	
	420	Paediatrics	158	144	154	134	117	154	143	221	188	147	141	164	139	161	123	138									1,865	1,683	(182)	(10%)	590	561	(29)	(5%)	608	561	(47)	(8%)
	421	Paed Neurology																																				
	422	Neonatology		3	3	1		2	2	5	5	4	3	4	4	3	6	5									32	54	22	69%	7	18	11	157%	11	18	7	63%
	430	Geriatric Med	105	61	51	65	58	58	80	71	79	89	73	73	89	101	73	96									863	1,077	214	25%	282	359	77	27%	239	359	120	50%
	501	Obstetrics			1							1		1													3		(3)	(100%)	1		(1)	(100%)				
	502	Gynaecology	17	18	25	24	19	14	29	24	17	19	23	29	18	22	22	32									258	282	24	9%	84	94	10	12%	91	94	3	3%
	503	Gynae Oncology	1				1		2																		4		(4)	(100%)	1		(1)	(100%)	2		(2)	(100%)
	658	Orthotics							1																		1		(1)	(100%)					0		(0)	(100%)
	800	CI Oncology	6	5	4	4	7	3	3	7	5	10	9	5	5	3	2	1									68	33	(35)	(51%)	19	11	(8)	(42%)	15	11	(4)	(28%)
	Total SPELLs		**1082**	**1141**	**1146**	**1163**	**1109**	**1127**	**1189**	**1188**	**1199**	**1276**	**1113**	**1158**	**1177**	**1267**	**1181**	**1218**									**13,891**	**14,529**	**638**	**5%**	**4,532**	**4,843**	**311**	**7%**	**4190**	**4,843**	**653**	**16%**
NELXBD,	XBDs		693	932	537	555	553	676	910	936	436	647	411	417	510	716	510	416									8,929	6,455	(2,474)	(28%)	2,717	2,152	(565)	(21%)	2496	2,152	(345)	(14%)
NELNEXBD	Adult Critical Care		111	100	170	85	94	128	110	140	77	125	69	133	43	10	2	70									1,395	374	(1,021)	(73%)	466	125	(341)	(73%)	33	125	92	281%
	Grand Total		1886	2173	1853	1803	1756	1931	2209	2264	1712	2048	1593	1708	1730	1993	1693	1703									22,936	21,358	(1,578)	(7%)	7,715	7,119	(596)	(8%)	6719	7,119	400	6%
	Gross Gen Surgery		110	161	163	164	140	165	149	153	132	152	136	116	116	165	141	136									1,741	1,674	(67)	(4%)	598	558	(40)	(7%)	396	583	187	47%

CCG 99N Mnth 4

Sum of ActivityActual			2013/14												2014/15												13/14	14/15	2014-15	
POD	HRGCode	HRGDesc	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	OT	FOT	Growth	
AandE	UZ01Z	Data invalid for grouping								1																	1		(1)	(100%)
	SAUIN99N	WILTS SAU (ECIST ADJ)																												
	SAUOUT99N	WILTS SAU OUT (ECIST ADJ)																												
	VB01Z	Any investigation with Cat 5 treatment	6	5	3	5	8		3	4	6	3	4	2	5	2	1	5									49	39	(10)	(20%)
	VB02Z	Cat 3 investigation with Cat 4 treatment	32	27	25	23	25	28	27	30	24	36	34	33	41	34	53	40									344	504	160	47%
	VB03Z	Cat 3 investigation with Cat 1-3 treatment	88	74	73	97	76	76	85	93	79	96	84	92	85	84	87	80									1,013	1,008	(5)	(0%)
	VB04Z	Cat 2 investigation with Cat 4 treatment	249	222	253	264	253	265	255	254	268	371	298	307	346	417	368	384									3,259	4,545	1,286	39%
	VB05Z	Cat 2 investigation with Cat 3 treatment	91	79	63	83	74	68	83	79	80	109	98	85	72	63	62	55									992	756	(236)	(24%)
	VB06Z	Cat 1 investigation with Cat 3-4 treatment	51	31	41	47	52	58	44	53	44	31	29	40	38	35	41	33									521	441	(80)	(15%)
	VB07Z	Cat 2 investigation with Cat 2 treatment	295	259	260	285	282	318	259	236	302	298	282	304	232	252	215	263									3,380	2,886	(494)	(15%)
	VB08Z	Cat 2 investigation with Cat 1 treatment	497	428	530	545	506	560	495	463	476	477	434	544	570	601	605	590									5,955	7,098	1,143	19%
	VB09Z	Cat 1 investigation with Cat 1-2 treatment	396	405	385	417	368	396	402	385	394	315	294	362	335	368	309	308									4,519	3,960	(559)	(12%)
	VB10Z	Dental Care																												
	VB11Z	No investigation with no significant treatment	133	106	116	144	131	116	93	135	137	98	104	140	115	128	98	92									1,453	1,299	(154)	(11%)
	AVG																													
Grand Total			1838	1636	1749	1910	1775	1885	1746	1733	1810	1834	1661	1909	1839	1984	1839	1850									21,486	21,487	1	0%

YTD				Unplanned YTD			
13/14	14/15	Diff	%	Plan	Actual	Diff	%
			-	0		(0)	
				10		(10)	(100%)
				- 63		63	(100%)
19	13	(6)	(32%)	18	13	(5)	(27%)
107	168	61	57%	115	168	53	47%
332	336	4	1%	320	336	16	5%
988	1,515	527	53%	1,007	1,515	508	50%
316	252	(64)	(20%)	313	252	(61)	(19%)
170	147	(23)	(14%)	178	147	(31)	(17%)
1,099	962	(137)	(12%)	1,115	962	(153)	(14%)
2,000	2,366	366	18%	2,107	2,366	259	12%
1,603	1,320	(283)	(18%)	1,018	1,320	302	30%
499	433	(66)	(13%)	307	433	126	41%
7,133	7,512	379	5%	6,446	7,512	1,066	16.5%

9.11 The levels and drivers of increased demand (Great Western Hospitals NHS Foundation Trust)

9.11.1 Elective Pressure – GWH have been unable to supply a complete patient level referral dataset since New Medway PAS went live in May 2014.

9.11.2 Elective activity indicates annual elective growth is at +2%%. Day cases have increased by 6.3%, with the majority being within urology (+15%), ENT (+58%) and general medicine (+8). Elective inpatient activity shows a decrease of 13.8%%

9.11.3 Waiting list pressure continues to increase. As at month four both the waiting list size (1,136 or 36%). However this is not a 'Real' increase but a consequence of the Trust not capturing all clock stops due to a backlog of outpatient attendance reporting. The number of over 18 week waits (161) have increased and extra RTT backlog activity is being undertaken to reduce the tail and the trust is prioritising PTL validation.

9.11.4 Non elective pressures continue to increase, currently at +7.7%, (219 spells) with the majority of growth within general surgery (+37%), combined general medicine (+6%) and obstetrics (+14%). There is a reporting issue where some outpatient outcomes have been reported as NEL spells in error that is being investigated

9.11.5 Emergency department annual attendance growth is up 1.4% with a reduction in lower value HRGs and a rise in mid-tariff HRGs. There was a spike in June 2014 attendances after a slow start in April

9.12 Whether acuity and complexity has actually increased (Great Western Hospitals NHS Foundation Trust)

9.12.1 The Elective growth is high in ENT and diagnostic spells including Endoscopies which are lighter case-mix. There is also a marked increase in cancer spells

9.12.2 Reviewing ED attendance outcomes at it appears that the growth in attendances is seen in the middle to higher intervention HRGs with fewer minors.

9.12.3 Non-electives – HRG Trends shows much of the non-elective activity growth is seen in maternity where the Trust has coded outpatient outcomes as admissions in error. This is due to be corrected next month. There is an increase in cardiac HRGs and UTIs. However non-elective average length of stay has remained close to last year's level after a spike in April 2014.

9.13 Whether there is a redistribution of demand (Great Western Hospitals NHS Foundation Trust)

9.13.1 Two of the three operational localities with the CCG, (WWYKD and NEW) refer in to Royal United Hospital NHS Trust

9.13.2 Using 1st outpatient growth as a proxy for referral shows some limited increased flow from WWYKD practices whilst it is flat from NEW practices that are seeing increased flow to Care UK ISTCs.

9.13.3 Emergency department case-mix analysis of MIU attendances has been impossible due to all attendances showing as U codes so far in 2014/15. This is due to be corrected in the next SUS/SLAM submission.

9.13.4 Non-electives – Total activity at the trust has decreased since the transfer of maternity services in June 2014.

9.14 Changes in the volatility of demand (Great Western Hospitals NHS Foundation Trust)

9.14.1 There is some evidence of changes in the volatility of demand. Planned care has shown a spike in referrals for June 2014 but has since reverted closer to planned levels in July 2014.

9.14.2 Within unplanned care data recording issues has made it difficult to understand the drivers of reported non-elective spell increases.

GWH SLAM - Elective Inpatients & Daycase

Day Cases (PbR only)		2013/14												2014/15												YTD			
Speciality	Spec Desc	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	13/14	14/15	Diff	%
100	GENERAL SURGERY	112	106	76	92	86	91	114	112	91	88	72	85	88	94	100	94									386	376	(10)	(3%)
101	UROLOGY	61	66	39	91	73	87	71	73	90	94	77	70	72	71	73	80									257	296	39	15%
103	BREAST SURGERY																									0	0	0	
110	TRAUMA & ORTHOPAEDICS	96	76	78	70	65	81	93	63	59	103	69	60	93	73	65	74									320	305	(15)	(5%)
120	ENT	14	21	27	19	17	22	33	28	23	32	36	33	29	32	34	33									81	128	47	58%
130	OPHTHALMOLOGY	39	56	46	43	52	43	47	27	23	37	41	44	44	50	46	48									184	188	4	2%
191	PAIN MANAGEMENT	12	8	6	10	11	7	8	4	6	8	5	8	9	8	7	8									36	32	(4)	(11%)
290	COMMUNITY PAEDIATRICS																									0	0	0	
300	GENERAL MEDICINE	132	119	113	128	120	122	122	108	119	138	103	139	0	1	1	1									492	3	(489)	(99%)
301	GASTROENTEROLOGY													110	142	120	141									0	513	513	
302	ENDOCRINOLOGY	1	2	1					1	1	3	1	1	2	3	3	2									4	10	6	150%
303	CLINICAL HAEMATOLOGY	65	40	42	55	45	45	52	51	40	77	56	57	58	56	60	75									202	249	47	23%
320	CARDIOLOGY	18	20	33	18	22	14	24	21	19	27	26	23	29	29	23	32									89	113	24	27%
330	DERMATOLOGY																1									0	1	1	
340	RESPIRATORY MEDICINE													5	7	3	2									0	17	17	
341	RESPIRATORY PHYSIOLOGY																									0	0	0	
370	MEDICAL ONCOLOGY	40	41	24	49	52	57	71	52	57	57	43	40	34	25	26	18									154	103	(51)	(33%)
400	NEUROLOGY													1	0	0	0									0	1	1	
410	RHEUMATOLOGY	12	12	12	18	11	16	15	17	15	19	11	10	19	12	12	18									54	61	7	13%
420	PAEDIATRICS	1	1		2	2	1	1		1	3		5	1	4	0	4									4	9	5	125%
502	GYNAECOLOGY	14	28	16	22	20	19	30	17	13	13	15	22	11	25	24	16									80	76	(4)	(5%)
715	OLD AGE PSYCHIATRY	4	5	1					1																	10	0	(10)	(100%)
800	CLINICAL ONCOLOGY	8	12	6	12	10	24	13	18	18	12	12	17	15	12	13	20									38	60	22	58%
	Grand Total	**629**	**613**	**520**	**629**	**586**	**629**	**694**	**593**	**575**	**711**	**567**	**614**	**620**	**644**	**610**	**667**									**2,391**	**2,541**	**150**	**6.3%**
	Yearly Variance													-1.4%	5.1%	17.3%	6.0%											**18**	

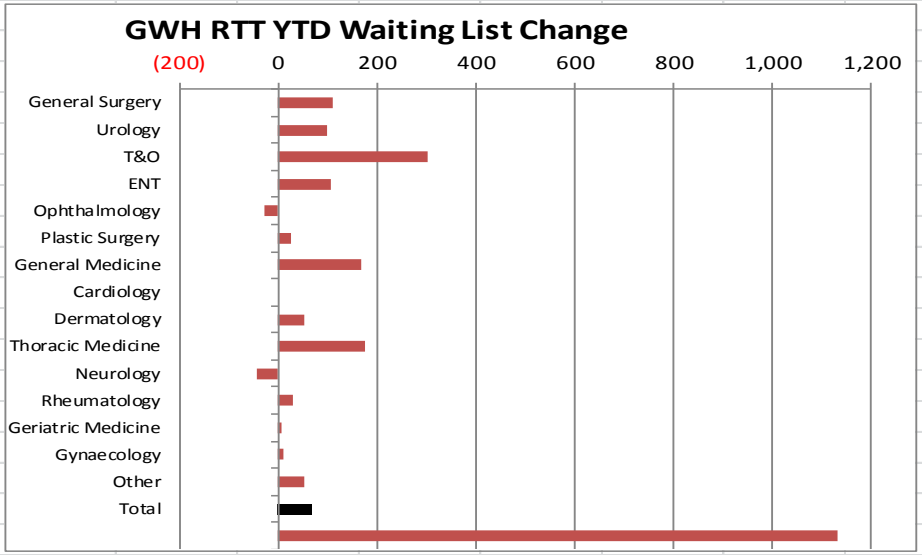
PAS upgrade in June 14 now has more granularity in specialities. In 14/15 General Medicine has been split into General Med, Gastro and Respiratory Medicine.

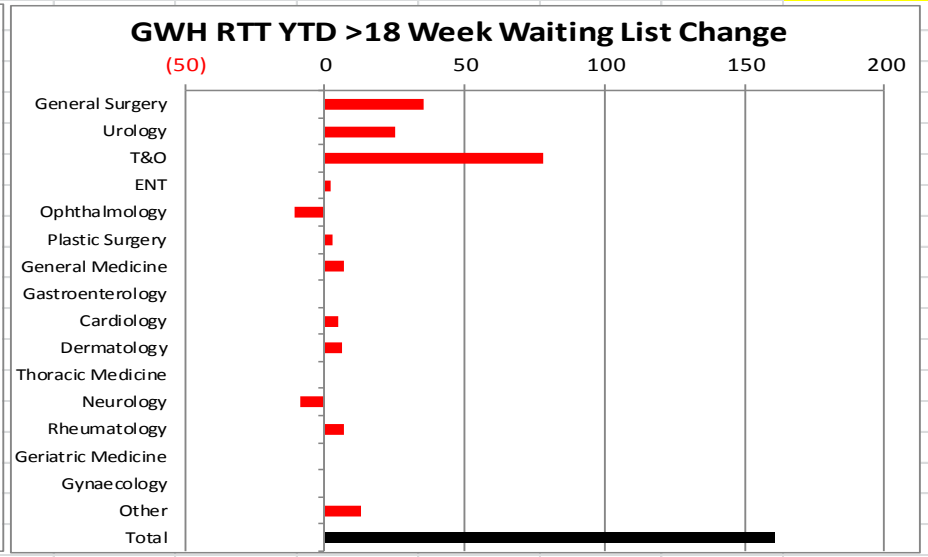
Gen Med, Gastro & Resp Med Total	132	119	113	128	120	122	122	108	119	138	103	139	115	150	124	144	0	0	0	0	0	0	0	0	492	533	41	8%
Total Excl Haem & Oncol	***516***	***520***	***448***	***513***	***479***	***503***	***558***	***472***	***460***	***565***	***456***	***500***	***513***	***551***	***511***	***554***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***1,997***	***2,129***	***132***	***6.6%***

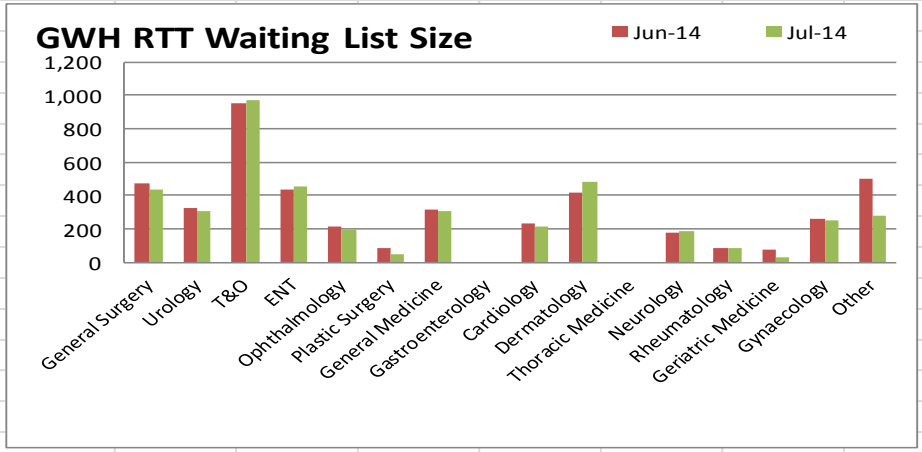
Elective Inpatients (PbR only)		2013/14												2014/15												YTD			
Speciality	Spec Desc	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	13/14	14/15	Diff	%
100	GENERAL SURGERY	32	28	30	33	19	26	24	35	24	46	32	31	21	17	26	24									123	88	(35)	(28%)
101	UROLOGY	22	16	15	17	19	12	23	6	19	15	17	16	17	12	9	23									70	61	(9)	(13%)
103	BREAST SURGERY													0	1	0	0									0	1	1	
110	TRAUMA & ORTHOPAEDICS	53	55	63	63	47	64	62	58	49	73	43	54	47	47	40	48									234	182	(52)	(22%)
120	ENT	6	11	11	7	15	6	11	11	15	11	13	12	12	14	18	16									35	60	25	71%
130	OPHTHALMOLOGY	1	2		1		6		2		1	2	2	0	3	1	4									4	8	4	100%
290	COMMUNITY PAEDIATRICS								1																	0	0	0	
300	GENERAL MEDICINE	10	7	10	6	7	4	10	8	8	9	6	9	0	0	0	0									33	0	(33)	(100%)
301	GASTROENTEROLOGY													3	3	10	8									0	24	24	
302	ENDOCRINOLOGY	1				1					1		1													1	0	(1)	(100%)
303	CLINICAL HAEMATOLOGY	2	1	1		3	1	1		3	2	3	2	2	1	1	1									4	5	1	25%
320	CARDIOLOGY	6	4	4	8	5	3	8	9	2	6	6	7	4	7	5	4									22	20	(2)	(9%)
340	RESPIRATORY MEDICINE													1	5	10	11									0	27	27	
341	RESPIRATORY PHYSIOLOGY	11	6	8	9	12	10	11	11	9	11	5	11	10	6	3	0									34	19	(15)	(44%)
370	MEDICAL ONCOLOGY		1	1			1			2	1		1	0	0	1	0									2	1	(1)	(50%)
410	RHEUMATOLOGY			1			1							0	1	0	0									1	1	0	0%
420	PAEDIATRICS	5	4	1	2	7	3	4	1		3			4	0	2	2									12	8	(4)	(33%)
430	GERIATRIC MEDICINE	1																								1	0	(1)	(100%)
501	OBSTETRICS					1				1		1														0	0	0	
502	GYNAECOLOGY	21	17	22	15	18	17	19	16	18	15	15	11	16	14	14	10									75	54	(21)	(28%)
800	CLINICAL ONCOLOGY		1										1	1	1	0	1									1	3	2	200%
	Grand Total	**171**	**153**	**167**	**161**	**154**	**154**	**173**	**158**	**150**	**194**	**143**	**158**	**138**	**132**	**140**	**152**									**652**	**562**	**(90)**	**(13.8%)**

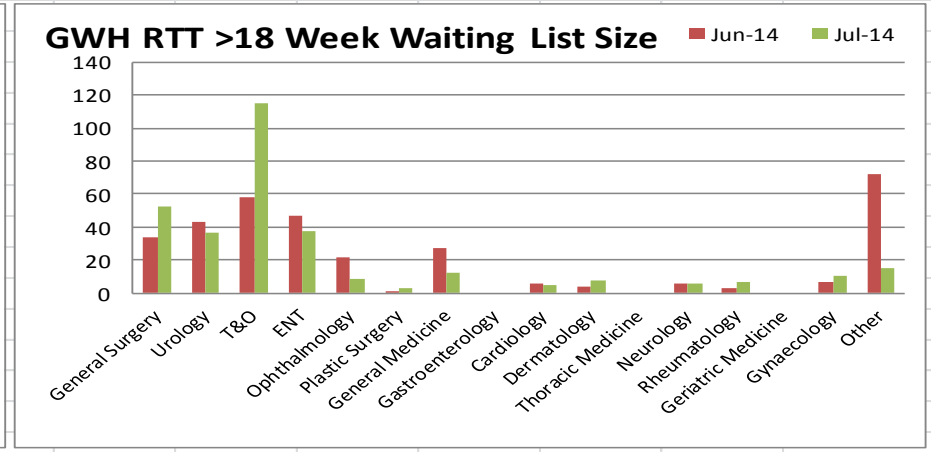
2013/14 GWH RTT Waiting List Size Monitoring

YTD Month Jul-14









GWH SLAM - Non-Elective Inpatient

Non-Electives (PbR only)		2013/14												2014/15												YTD			
Speciality	Spec Desc	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	13/14	14/15	Diff	%
100	GENERAL SURGERY	79	87	96	109	109	102	99	103	109	97	81	107	84	104	146	174									371	508	137	37%
101	UROLOGY	1	4	4	3	4	5	2	4	2	10	4	5	4	2	1	5									12	12	0	0%
103	BREAST SURGERY																									0	0	0	
110	TRAUMA & ORTHOPAEDICS	62	58	61	54	62	59	58	50	49	36	58	45	49	45	35	71									235	200	(35)	(15%)
120	ENT	13	12	11	9	7	6	7	8	14	13	5	9	5	7	12	9									45	33	(12)	(27%)
130	OPHTHALMOLOGY		4		2	6	2	1						0	1	0	2									6	3	(3)	(50%)
180	ACCIDENT & EMERGENCY	47	66	66	73	62	59	60	67	43	59	41	44	42	57	59	47									252	205	(47)	(19%)
191	PAIN MANAGEMENT							2						0	1	0	0									0	1	1	
290	COMMUNITY PAEDIATRICS										1			1	0	0	0									0	1	1	
300	GENERAL MEDICINE	347	354	387	374	417	347	350	345	366	406	374	416	359	380	357	372									1,462	1,468	6	0%
301	GASTROENTEROLOGY													14	17	17	10									0	58	58	
302	ENDOCRINOLOGY			1					1		1	1		2	1	3	3									1	9	8	800%
303	CLINICAL HAEMATOLOGY	2		2	2		1		2	3			1	1	0	2	0									6	3	(3)	(50%)
315	PALLIATIVE MEDICINE						1						1													0	0	0	
320	CARDIOLOGY	33	19	20	31	15	22	25	28	32	22	16	28	25	20	18	33									103	96	(7)	(7%)
326	ACUTE INTERNAL MEDICINE													0	2	0	0									0	2	2	
340	RESPIRATORY MEDICINE													4	12	6	5									0	27	27	
341	RESPIRATORY PHYSIOLOGY			1								1	1													1	0	(1)	(100%)
370	MEDICAL ONCOLOGY							1			1			0	0	0	1									0	1	1	
400	NEUROLOGY																									0	0	0	
410	RHEUMATOLOGY																									0	0	0	
420	PAEDIATRICS	106	73	97	81	69	111	99	119	139	113	92	97	73	91	98	66									357	328	(29)	(8%)
430	GERIATRIC MEDICINE	3	4	2	3	1	18	20	20	24	25	16	26	28	21	15	15									12	79	67	558%
501	OBSTETRICS	56	67	69	59	64	72	65	65	60	71	67	73	67	81	74	66									251	288	37	15%
502	GYNAECOLOGY	11	20	6	15	7	14	6	10	14	12	14	14	13	19	11	13									52	56	4	8%
560	MIDWIFE EPISODE	14	14	16	19	16	20	15	19	12	14	13	16	18	11	20	22									63	71	8	13%
653	PODIATRY																1									0	1		
715	OLD AGE PSYCHIATRY		2																							2	0	(2)	(100%)
800	CLINICAL ONCOLOGY												1													0	0	0	
810	RADIOLOGY											1														0	0	0	
	Grand Total	**774**	**784**	**839**	**834**	**839**	**839**	**810**	**841**	**867**	**881**	**784**	**884**	**789**	**872**	**874**	**915**									**3,231**	**3,450**	**219**	**6.8%**
	Yearly Variance													**1.9%**	**11.2%**	**4.2%**	**9.7%**												

GWH/NHSW SLAM - Accident & Emergency - *No data submitted by GWH in Month 4 SLAM for A&E at HRG Level*

		CCG (99N) - 2013/14												CCG (99N) - 2014/15												OT/FOT				YTD			
																														13/14	14/15	Annual Diff	
HRG	Description	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	13/14	14/15	Diff	Diff%	Actual	Actual	No.	%
VB01Z	Any investigation with category 5 treatment		1	1	1		1	1		1			1	1	2	3										7	18	11	157%	3	6	3	100%
VB02Z	Category 3 investigation with cat 4 treatment	5	8	6	10	9	6	13	16	9	14	12	9	11	8	21										117	120	3	3%	29	40	11	38%
VB03Z	Category 3 investigation with cat 1-3 treatment	79	97	75	71	103	88	85	94	106	91	111	116	109	80	82										1116	813	(303)	(27%)	322	271	(51)	(16%)
VB04Z	Category 2 investigation with cat 4 treatment	33	43	36	41	40	45	47	39	60	56	37	34	41	89	100										511	690	179	35%	153	230	77	50%
VB05Z	Category 2 investigation with cat 3 treatment	15	13	17	17	15	17	11	14	18	13	12	11	20	44	57										173	363	190	110%	62	121	59	95%
VB06Z	Category 1 investigation with cat 3-4 treatment	20	23	8	25	16	23	19	16	18	20	15	13	13	64	54										216	393	177	82%	76	131	55	72%
VB07Z	Category 2 investigation with cat 2 treatment	168	160	189	207	197	197	182	212	158	222	134	186	148	157	161										2212	1398	(814)	(37%)	724	466	(258)	(36%)
VB08Z	Category 2 investigation with cat 1 treatment	576	593	572	590	592	578	569	515	465	529	548	663	598	568	499										6790	4995	(1,795)	(26%)	2,331	1,665	(666)	(29%)
VB09Z	Category 1 investigation with cat 1-2 treatment	179	176	177	158	178	169	156	148	160	145	160	156	137	199	201										1962	1611	(351)	(18%)	690	537	(153)	(22%)
VB10Z	Dental Care																									0	0	0		0	0	0	
VB11Z	No investigation with no significant treatment	325	287	251	260	293	272	267	232	285	250	238	316	255	211	233										3,276	2097	(1,179)	(36%)	1,123	699	(424)	(38%)
	Sub Total	**1,400**	**1,401**	**1,332**	**1,380**	**1,443**	**1,396**	**1,350**	**1,286**	**1,280**	**1,340**	**1,267**	**1,505**	**1,333**	**1,422**	**1,411**	**1,431**									**16,380**	**16,791**	**411**	**3%**	**5,513**	**5,597**	**84**	**2%**
	Streamed Patients	149	123	118	133	133	99	113	101	103	109	106	105	103	105	173	143									1,600	1,572	(28)	(2%)	523	524	1	0%
	Grand Total	**1,549**	**1,524**	**1,450**	**1,513**	**1,576**	**1,495**	**1,463**	**1,387**	**1,383**	**1,449**	**1,373**	**1,610**	**1,436**	**1,527**	**1,584**	**1,574**									**17,772**	**18,363**	**591**	**3%**	**6,036**	**6,121**	**85**	**1.4%**
	Yearly Variance													(7.3%)	.2%	9.2%	4.0%																

10 SUMMARY OF PROVIDER RESILIENCE[i]

10.1 Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

10.1.1 AWP has a detailed 13/14 winter plan which will be used within Wiltshire that is due to be reviewed in Aug 2014

10.1.2 Priority will be given to maintenance of all key areas 24/7 services specifically inpatients at Green Lane Devizes and Fountain Way Salisbury Hospital sites.

10.1.3 There is a 24/7 crisis response from both North and South Intensive teams, however this team only serves functional mental health patients, and there is no crisis service for dementia patients or older people. In order to deliver this expanded service there is an increased resourcing requirement

10.1.4 AWP is an active partner in the urgent care networks and will develop shared plans as required with RUH, GWH and SFT.

10.1.5 Within the three acute hospitals AWP has acute liaison teams working in the emergency department and older peoples wards.

10.1.6 There is a care home liaison service working with Wiltshire Council STARR service and other care homes across the county.

10.1.7 Although not integrated, there is a continued close working relationship with Wiltshire social services regarding community work, mental health act assessments, and inpatients discharges. Shared protocols have been agreed and developed, for example delayed transfers of care (DTOC) reporting and section 136.

10.1.8 There is a specific issue in AWP Wiltshire beds regarding DTOCs which means that 20-30% of 81 MH assessment beds in Wiltshire are blocked on average. AWP are working with the WCCG/WC DTOC work stream to try to address this issue.

10.1.9 Out of hours intensive teams interface with the emergency duty team at Wiltshire Council and local police.

10.1.10 AWP will actively participate in discussions with and explore options for reprioritisation of admissions if extreme pressures in acute trusts. If activity levels increase there is no extra bed capacity in Wiltshire but depending in capacity pressures within the rest of AWP there may be other options for admission across the Trust.

10.1.11 Staffing levels of wards and teams will be adjusted for any anticipated peaks in demand. Safer staffing levels will be maintained at all times. At the moment this is via the use of bank and agency staff. This has been highlighted as a risk on the Wiltshire AWP risk register and options to resolve this issue are being explored.

10.1.12 The 2 Wiltshire intensive teams act as gate keepers for all functional acute mental health admissions and facilitate early discharge. The teams operate over 24/7 – 365 days of the year. The Wiltshire intensive teams will receive and respond to primary care referrals as necessary during weekends and bank holidays when the standard primary care liaison service is not available.

10.2 Wiltshire Council

10.2.1 The Council undertakes regular reviews of social care activity over a preceding 12 month period. This includes activity levels in acute hospital social care teams and STARR and the subsequent demand for services.

10.2.2 A daily capacity management system is utilised by the hospital social work teams and also by STARR.

10.2.3 The Council monitors acuity levels of the people it supports by identifying the average value of care packages made from hospital and the number of spot purchased specialist placements made from hospital.

10.2.4 Capacity modelling is undertaken utilising the above and builds in factors such as the nature and scale of demand in different geographical areas, and the time taken to complete different types of work. The Council also contributes to the community wide RCA exercises and implements lessons learned.

10.2.5 The placement team has now been moved into commissioning to provide a more strategic overview of demand for care home placements and allow for processes to be streamlined. This has led to consistency of commissioning activity and enhanced market oversight. It has also supported the enforcement of contractual obligations such as the requirement for providers to complete their assessment within 48hrs

10.2.6 The Council has provided additional management capacity for the hospital social work teams to manage escalation, capacity planning and demand management.

10.2.7 A capacity management early warning tool is also in place in relation to the hospital social work teams and STARR.

10.2.8 The capacity management system which is used by STARR has daily reporting of staffing levels, care home vacancies, referrals received and pending. This enables STARR to be used flexibly to respond to peaks in demand e.g. targeting staff at specific hospitals for in-reach as demand peaks; using CCG agreed funds to purchase additional spot contract beds; adjust STARR entry criteria to ease blockages elsewhere in the system. The information gathered as part of the STARR capacity management system is used strategically as part of the Wiltshire escalation teleconferences.

10.2.9 STARR now works to the nursing home framework rates, this increases the availability of beds/locations, as compared to the use of the block contract bed system.

10.2.10 A number of pilots have been undertaken to improve patient flows and pathways for discharge in the 3 acute hospitals. Additionally, a Single Point of Access pilot has been used to simplify pathways, reduce inappropriate admissions and support discharge planning. The Rapid Response pilot has prevented inappropriate admissions by providing a 1 hour response domiciliary care service.

10.2.11 The STARR management structure incorporates a Clinical Lead, Social Work Lead and Intermediate Care Strategic Lead who are together working to support the team's development towards intermediate care which will enhance the ability for people to be cared for in the community.

10.2.12 An independent service (Care Home Selection Services) has been commissioned to facilitate discharge of self-funded patients and provides information and advice and support to choose a care home.

10.2.13 The Help To Live At Home (HTLAH) providers are commissioned to deliver a service between 7am and 10.00pm 7 days a week to all customers within their contracted area (they can sub-contract). Capacity is monitored through an issues log where staff record any instances that the provider has not been able to deliver and this is reviewed at the monthly contract management meetings. Where a provider continues to experience difficulties in delivering and does not have a plan in place to address the problem the Council has the option of issuing a contract default notice.

10.2.14 The recruitment of social care staff in Wiltshire continues to be an issue and the workforce from which HTLAH draws its staff, comprises of workers who are often not well remunerated or rewarded. To address this, the Council and CCG are working with providers to develop an offer to this workforce of improved terms and conditions, a career pathway and improved training and career opportunities. This will result in a more stable workforce with improved retention. To date one provider has offered all its staff salaries instead of the usual hourly based remuneration, another provider has increased the payment for mileage and together they have developed an integrated care and support worker job description that will apply to all staff in their organisations. Other areas that are being considered are: exploring the opportunity for offering apprenticeships and offering staff a number of different employment options including night time care and live in care.

10.2.15 Care homes are required to staff to a level prescribed by the Care Quality Commission and, on the whole, have fewer problems with staff recruitment and retention with some exceptions. The use of agency staff is monitored at regular visits undertaken by the Council's commissioning team. The Council funds the Wiltshire Care Partnership that represents more than 50% of the total number of care homes for older people. This has improved communication with the sector as has the establishment of quarterly meetings with all care home providers in the CCG localities.

10.3 Care UK – NHS 111

10.3.1 The provision of NHS 111 services within the contracted area of the old Avon, Gloucestershire and Wiltshire geography and its incumbent CCG's is subject to close performance monitoring through weekly teleconferencing and submission of recovery plan updates, through to commissioner / BGSW NHSE discussions as a result of continued underperformance of key contractual requirements.

10.3.2 The current position is a direct result of insufficient staffing to meet rota fill demands that has left the service exposed since February 2014. Despite previous assurances and recruitment trajectories contained within the Care UK recovery plan, it is currently not possible for the CCG to retain a high level of confidence on an appropriate level of service resilience.

10.3.3 Care UK have in place a process to support resilience through integrated networking of their operational sites in an attempt to achieve call balancing through call flow management in and out of these locations. The aim is to operate around a 15% flow, although this can be increased at times of operational pressure or system failure at any one location. There is also the possibility to increase networking based on call answering times.

10.3.4 Care UK are also in developing a strategic relationship with a dedicated third party provider for resilience capacity (Conduit) and it is anticipated that they will approach commissioners for formal agreement to utilise this additional capacity once seamless information and data links have been established as this is necessary for commissioners to be able to monitor performance.

10.3.5 At times of unexpected increases in calls or a reduced rota fill Care UK have a robust internal clinical and operational escalation procedure. In additional to integrated networking Care UK are also take the following actions:

- Optimisation of the rota by rescheduling of breaks
- Remove any off phone activity that is non-core business critical.
- Increase the number of calls handled by the outsource provider (for sites using Conduit), this allows calls to be answered by the network for SWM who do not currently use Conduit resource.
- A text is sent to all staff requesting additional support at enhanced rate.
- Utilise support staff including trainers, coaches and Supervisors to take calls.
- Clinicians utilised to front end calls, although this can have a detrimental effect on availability to support call transfer from health advisors.

10.3.6 The CCG are aware of additional financial resources being managed via NHSE to further support operational resilience for NHS 111 services, but as yet are not aware of any substantive details. However as the key issue locally is based around recruitment challenges, the CCG will wish to closely monitor any impact of central support.

10.4 South Western Ambulance NHS Foundation Trust

10.4.1 SWASFT may experience periods of over capacity because of a variety of circumstances including major incidents, pandemics or any other unexpected or unplanned eventuality

10.4.2 The overriding principle is to ensure that SWASFT provides the highest level of patient care to the users of the service when capacity pressures are experienced. This is critical to the maintaining of clinical safety, public confidence and the good reputation of the service, as the Trust aims to provide a high quality, high performing right service, right place, right time

10.4.3 There are stages trigger points have been agreed which identify, as demand levels increase, the actions needed to supply the highest level of service within the resources available.

10.4.4 This response is predominantly applicable to the business activities of the A&E clinical hubs and so directly relates to the A&E control function. Therefore it has been developed on the A&E function roles and has not included trust 111 and UCS; however there could be times when consideration may be required for resources which can be called upon to assist A&E This provides a framework in which the business activities of the A&E clinical hubs may respond to periods of high pressure or on occasions where the capacity does not exist to absorb patient demand and to provide SWASFT managers a set of tactical options that are flexible and immediate to dynamically react to developing demand profiles where the provision of service cannot be met by the available resources

10.4.5 To ensure demand is managed effectively, there are 4 Action Cards relating to specific areas of demand (each with 3 Stages of demand management tactics):

- Action Card 1 – 999 Telephone Call Demand
- Action Card 2 – HCP Call Demand
- Action Card 3 – Unallocated Green Calls
- Action Card 4 – Unallocated Red Calls

10.4.6 **Stage 1** within the Action Cards (1-4) are tactics available to the Duty Managers/Control Officers, Dispatchers and Call Handling Supervisors to ensure they are being utilised to assist in the management of demand. This stage is Business as Usual options. If the Duty Manager (North / South) feels that actions and considerations in Stage 1 are not going to be effective or are not having the desired impact then he/she should escalate to the relevant Officer for Stage 2 considerations.

10.4.7 **Stage 2** within the Action Cards (1-4) are tactics available for Silver Commanders and Senior Clinical Hub Managers to consider. Some tactics may require authorisation of a Gold Commander

10.4.8 **Stage 3** within the Action Cards (1-4) are the potential tactics available for Gold Commanders to consider implementing or authorising to assist in the management of demand. Some tactics at this level may require authorisation at Director level

10.5 Great Western Hospitals NHS Foundation Trust

10.5.1 Awaiting documentation

10.6 Salisbury Hospitals NHS Foundation Trust

10.6.1 A local challenge in the health and social care community is the lack of health community provision which meets the needs of local patients in terms of supported discharge and timely establishment of packages of care, and this imbalance is being addressed by the strategic development of community services supported by the CCG.

10.6.2 The trust is reviewing the opportunity to develop an emergency nurse practitioner service to support minor injuries with the emergency department.

10.6.3 Frail elderly pathways are being reviewed as part of the Rapid Assessment and Consultant Evaluation (RACE) model in conjunction with the Medical Assessment Unit to ensure front loaded diagnostics and senior review at the earliest stages to speed up the patient pathway.

10.6.4 Review of trauma arrangements currently underway to ensure patients are managed in a timely, efficient and effective manner with enhanced recovery practice to improve discharge timeliness where applicable.

10.6.5 The trust is currently undertaking a review of its discharge process as part of the better care fund supported systems review. The internal review of discharge function and bed management should increase support to manage patients waiting for discharge.

10.6.6 The trust will input into the discharge to assess pilot being established within the better care fund from September 2014.

10.6.7 A full review of requirements for 7 days services is underway by the trust but is reliant on whole health and social care system being responsive 7 days per week for this to be fully effective.

10.7 Royal United Hospitals NHS Trust

10.7.1 RUH Operational Resilience and Capacity Plan for Urgent Care has been developed in parallel to planned care. The plan encompasses all year round elective as well as urgent and emergency care system delivery. The overall aim of the plan is to provide assurance that there is system resilience and robust planning to achieve and sustain the key acute trust performance targets.

10.7.2 The plan provides assurance that there is a robust Urgent Care Improvement Programme in place for 2014/15 at the RUH with a clear governance structure reporting into both the local Transformation Board and Management Board, and can demonstrate core membership of the three CCG System Resilience Groups and urgent care operational delivery groups. Programme performance monitoring is monthly against both project and trust wide KPI's and metrics as part of the agreed 2014/15 Urgent Care Improvement Programme. The 2014/15 programme also provides assurance of the 2013/14 programme delivery, sustainability of benefits in 2014/15 and current risks to delivery.

10.7.3 The RUH has undertaken a number of initiatives to improve the assessment and admission of emergency patients in the Emergency Department, Medical Assessment Unit and Surgical Assessment Unit. The operational arrangements within these areas to facilitate the assessment and admissions are detailed below;

10.7.4 Accident and Emergency Service

- 10 WTE Consultants the ED department has introduced Senior With A Team (SWAT) this is based on the recommendation from the ECIST to introduce a Rapid Assessment and Treatment model.
- ED co-ordinators and flow assistants to ensure that the patient pathway experiences minimal delay and that any issues are expedited.
- Patient flow in accident and emergency is monitored and escalation criteria have been incorporated into the new RUH Escalation policy to ensure a Trust wide response to support patient flow out of ED.
- Ambulance arrival screens provide up to date pre-arrival information. The RUH focus on ensuring that ambulance handover processes are efficient and support clear transfer of care maintaining high levels of patient safety and experience
- The rapid chest pain service operates seven days a week on MSSU for patients presenting to the Emergency Department
- The Emergency Department has access to an adjacent Observation Unit.
- Patients requiring admission may be transferred to one of the three Assessment Units (Medical, Surgical or Paediatric)
- The emergency department now have access to primary care records through TPP

10.7.5 Medical Assessment Unit

- The medical cover for the Medical Assessment Unit is provided by 6.7 WTE Consultant acute physicians during in week working hours (Monday – Friday 8am to 6pm). Supported by a physician and on-call consultant physician out of hours cover
- Ambulatory care is adjacent to MAU; all GP calls are received by the senior nurses in ambulatory care and signposted to the appropriate service. This service has significantly increased its capacity in 2013/14.
- It is the intention that patients stay a maximum of 12 hours only on the Medical Assessment Unit

10.7.6 Surgical Assessment Unit

- Consultant cover is provided by the general surgeon on call and the emergency surgical consultant.
- The Emergency Surgical Ambulatory Care Service was introduced in September 2013, this is reducing category C and D length of stay, avoiding ED attendance and reducing admissions.
- Evaluation as part of the 2013/14 urgent care programme has shown the service to be very successful; the lead surgeon has also been presenting this model of care nationally.
- All GP calls are received by the Medical Nurse Practitioner and signposted as appropriate.
- As with the medical assessment unit it is the intention that patients stay a maximum of 12 hours only on the Surgical Assessment Unit.
- Second locum surgeon appointed in May 2014

10.7.7 Emergency Admissions

- Stroke patients should be admitted directly from ED to the Acute Stroke Unit, normally via CT in line with national guidance. From April 2013 following the appointments of 2 additional consultants the stroke service now provides 7 day ward rounds and opening a 7 day TIA service.
- Patients with a fractured neck of femur are admitted directly to the trauma ward.

10.7.8 Site Management.

- Elective and emergency beds are managed by the clinical site management and bed management team with support from the clinical divisions
- Additional investment into the bed management team was made in 2013/14 so that a medical and a surgical bed manager are available on Monday to Friday early and late shifts and a day shift on Saturday and Sunday.
- The clinical site and bed management team access discharge information from the RUH Millennium (Patient Administration System) bed board which updates in real time from the patient administration system. This has now been rolled out and is live on all wards. All wards are asked to declare potential discharges via the bed board before 12pm.
- Daily bed planning meetings are held at 0900, 1300 and 1600 chaired by the clinical site manager with representation from the clinical divisions, discharge liaison and in reach teams.
- On a daily basis there is senior medical and surgical nurse coordinating ward staffing levels for the divisions. This is in line with the national safer staffing levels guidance

10.7.9 Planned Escalation: The RUH has identified three responses for planned escalation;

- Flexible capacity. The RUH has used the current bed model and demand model to agree the level of flexible capacity required throughout the year).
- Additional specialist medical ward capacity (OPU and Respiratory ward)
- Efficiencies gained from Urgent Care Improvement Projects

10.7.10 Unplanned Escalation**.** The RUH has identified two responses for unplanned escalation;

- Unplanned escalation bed capacity
- Transformation Board Green week escalation response

10.7.11 The escalation capacity that the trust would use to respond to demand surges, support the management of D&V outbreaks and respond to severe weather are clearly defined in the RUH Escalation policy and will be enacted by the clinical site team.

10.8 Arriva Transport Solutions Limited

10.8.1 Currently there are joint commissioner discussions with ATSL around contract activity and operational resilience.

10.9 Medvivo Group Limited

10.9.1 The capacity across the health and social care system in terms of beds and services is at an equivalent level to last year. While beds, in some areas, have reduced; resources have been re-allocated to community-based teams in order to meet national and local imperatives.

10.9.2 Medvivo has undertaken analysis of demand against last year's activity service delivery. This has contributed to the predictions for activity over the 2014/15 and takes into account 'whole system' demand including historical non-elective activity (emergency department attendance / admission), length of stay and referrals to primary care, all of which have an impact upon patient flow throughout the pathway.

10.9.3 Traditionally, activity has peaked in December, January and March. However, over the last three years a subtle change has been noted in that activity started to rise in October, with this increase continuing beyond the end of the winter period into the spring. This has been especially evident this year as escalation has continued into early summer.

10.9.4 All of Medvivo's service delivery areas have been primed to ensure staffing levels are optimised for those dates associated with high demand. Annual leave for staff has been reduced during the critical periods and staff training will be abandoned should contingency dictate.

10.9.5 Medvivo has an overarching Business Continuity Plan which is supported by Service Continuity Plans and a number of operational contingency procedures for each area of delivery. These documents underpin the organisations approach to capacity planning.

10.9.6 Robust contingency procedures have been developed which address the following for each area of service delivery;

- The Workforce.
- IM&T and Telecommunications.
- Fleet.
- Premises and Facilities.
- Whole System and Collaborative Working.

10.9.7 From an OOH perspective, the Adastra Hub is shared by the Wiltshire and Swindon services, this facilitates shared contingency plans and allows for mutual support. In the unlikely event of complete IT failure, Medvivo would implement full Disaster Recovery arrangements.

10.9.8 Early warning systems are in place and lines of communication well established and Access to Care's single point of access will continue to cascade escalation information across the local community. Using the single point of access in this way is valuable as it encourages thinking in terms of the 'whole system' and provides the opportunity to explore new models of managing capacity and demand for health and social services.

11 CONCLUSION

11.1 Summary

11.1.1 Wiltshire CCG through the establishment of the system resilience group and its participant members, the integration of strategic planning and service delivery with Wiltshire Council, the wider engagement with neighbouring system resilience groups and the wider joint contract management with key providers believes that it is well placed to support the local health and social care economy in delivering operational and system resilience.

11.1.2 Wiltshire CCG has established and supports a number of management and monitoring process to ensure that system pressures are shared and mitigating actions are implemented as necessary within existing system resources.

11.1.3 We believe that the local solutions either in place or being developed allow the best opportunity for the wider health and social care providers to maintain resilience within available resources and within predicted levels of activity.

[i] Copies of detailed provider operational and resilience plans received are available on request.