An update from Wiltshire

James Roach
Integration Director, Wiltshire Clinical Commissioning Group and Wiltshire Council

The Kings Fund > Ideas that change health care
integrating care

Twitter: #integratedcare
Integration and the Better Care Plan

The Wiltshire approach
Context

• Ambitious plan with strong platform for delivery
• National exemplar site and growing profile
• Focusing on the growing demographic challenge
• Focus on DTOCs/independence post discharge /hospital admissions and admissions to nursing and residential care.
• £27 million as the driver for integration
  • Care as close to home/priority being home
  • Create a bottom up vision with our public
  • Delivering innovative integrated services
  • "hearts and minds“-enhancing the individuals experience
  • Courage and space to experiment and challenge
  • Health and well being board reflective of the system
The impact of population growth on resource requirements (older people)- Cumulative

Cumulative increase in annual resource requirements (£m) by 10 year age band in >65s using updated 2014/15 baseline average spend per head = £58.8m
Recognising our challenges

• Care and support is fragmented, so people experience gaps in care and patients are treated as a series of problems rather than as a person. Care and support plans do not link together, which is inefficient.

• The health and care system gives a higher priority to treatment and repair rather than prevention or early intervention. Often, people are not eligible to receive services until they reach a point of crisis, when a little support earlier may have avoided the crisis from developing.

• Providers are under pressure, with unacceptably high levels of delayed transfers of care and extended lengths of stay in hospital.

• Too many people make a decision about their long-term care and support whilst they are in hospital.
What will change deliver?
2 Views on Integration

**The Person**
- Care coordinated across organisations
- Clear joined up pathways for carers
- Person centered
- Joint outcomes
- No gaps in care

**The System**
- Joint budgets
- No distinction
- Joint teams and sharing the risk
- Joint commissioning and smarter provision
“The no distinction challenge “

<table>
<thead>
<tr>
<th>“I want the right care first time “</th>
<th>“No duplication and ease of access”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated discharge teams – 7 days a week</td>
<td>Single view of the customer – truly integrated information approach across health &amp; social care</td>
</tr>
<tr>
<td>Early mobilisation – integrated therapy teams across the system</td>
<td>Integrated locality working – access to multi disciplinary teams coordinated by the GP encompassing mental health, dementia and learning disabilities. A focus on risk stratifying patients and developing anticipatory approaches to care.</td>
</tr>
<tr>
<td>Comprehensive geriatric assessment and crisis management whatever the location</td>
<td>Crisis response services – ensuring access to shared anticipatory care plans by the ambulance service, rapid response, enablement services and the wider range of voluntary sector</td>
</tr>
<tr>
<td>Discharge to assess – once the patient is medically stable</td>
<td>Self funders – clear pathways and provision of care</td>
</tr>
<tr>
<td>Non acute bed provision – step up and step down. - transitioning towards more care at home, integrated care centers (our community campus) and assisted living</td>
<td></td>
</tr>
</tbody>
</table>
Key Aims

- Patient centered care, Appropriate holistic care
- Communicating better with patients, carers and families (reducing uncertainty /anxiety/ mixed messages)
- Integrated working with social care and mental health
- More Seamless working between acute trusts and community.
- Managing crises better in more appropriate places of care delivery.
- More efficient use of resources: managing demand maximising efficiency: working SMARTER.
- Improving patient outcomes – e.g. quality of care, patient experience, reducing dependency where possible.
Some key outcomes from the BCP

<table>
<thead>
<tr>
<th>Metrics</th>
<th>Desirable patient outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in daily average of occupied bed days</td>
<td>Prevent premature avoidable decline through proactive care and earlier intervention</td>
</tr>
<tr>
<td>Reduction in emergency bed day use for patients 65</td>
<td>Better care experiences 7 days a week</td>
</tr>
<tr>
<td>Eradicate DTOC’s</td>
<td>Support for carers and family</td>
</tr>
<tr>
<td>Financially responsible for fewer people aged over 65</td>
<td>Decisions made on commissioning needs not service dimensions</td>
</tr>
<tr>
<td>Correlated increase in use of Home Care Services</td>
<td>Empowering our service users</td>
</tr>
<tr>
<td>Increase diagnosis rate for dementia</td>
<td></td>
</tr>
</tbody>
</table>
Ambition into action
THE CLINICAL MODEL, THE SYSTEM REVIEW AND THE 100 DAY CHALLENGE
The Challenge

Scaling up and creating the space to achieve change

Creating capacity here

To fund capacity here/harness experienced resources here
The Clinical Model
Ambition into action

THE 100 DAY CHALLENGE
What is the 100 Day Challenge?

• This goes live on the 1st September, this is a system wide approach aiming at reducing the number of attendances and admissions for frail patients in Wiltshire and reduce the amount of time they spend in hospital.
• Includes all health and social care partners in Wiltshire.
• Focusing on preventing avoidable admissions for a wider range of conditions.
• Under the launch of a range of new innovative schemes and maximise/priorities the use of these schemes delivering *right care in the right place*.
• Requires full commitment and collaboration across the system.
• Need for system to combine our approaches to care for frail individuals and help them stay home for longer.
Focus of the 100 Day Challenge

Case Management

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

Primary care management

• Initiatives across all 58 GP Practices focusing on proactive care and support planning for frail elderly.

• For the more vulnerable patients and those with co-morbidities, there is evidence that these ‘high risk’ patients are best managed by a multi-disciplinary team who can work with the patient’s GP to assess, plan and deliver a personalised plan of care, including assessing falls risk, reviewing and reconciling medications, screening for depression and social isolation, and documenting patient wishes for care at the end of life.
Focus of the 100 Day Challenge

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

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

**Managing sub acute patients in a community setting**
- Launch of step up beds in community settings for a range of clinical conditions with average LOS of circa 7 days
- Relaunch of STARR and delivery of new intermediate care action plan
- Community nursing “step up“ services to be prioritised and expanded
Focus of the 100 Day Challenge

Reducing length of stay and improving discharge processes

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

Ongoing Measurement /Monitoring and action

- System review check stage to go live at the same time ensuring ongoing review and action
- Launch of the Multi Agency View across general practice.
- CCG to launch daily system dashboard
- Detailed patient pathway mapping informing actions
- Daily exec leads monitoring performance
- Daily bed state reports
- Weekly issue logs / reports and formal monthly evaluations
# Daily Measurement

## Wiltshire Health and Social Care System
### Emergency Dashboard

<table>
<thead>
<tr>
<th>Metric</th>
<th>Basis</th>
<th>Target</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
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<td>271</td>
<td>662</td>
<td>533</td>
<td>256</td>
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<td>98.8%</td>
<td>96.8%</td>
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### STARR Step Up Beds

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### STARR Step Down Beds

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### Interim Care

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<td>0</td>
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<tr>
<td>No. &gt;7 days LoS</td>
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<td>3</td>
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### Warminster & Savernake Step Up Beds

<table>
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<tr>
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<th>56</th>
<th>61</th>
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<th>67</th>
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<tbody>
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<td>158</td>
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### SWAST Wilts

<table>
<thead>
<tr>
<th>Metric</th>
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</table>

The table above provides a summary of daily measurements including call volumes, referral rates, and other critical metrics for Wiltshire Health and Social Care System emergency services. The data is organized by various categories such as 'Calls', 'Answered <60 Secs %', 'Ambulance Referral %', and more, with specific values and targets listed for each category. The 'Actual' column reflects the actual numbers observed for each service and period.
100 Day Challenge – coverage

The 100 Day Challenge Dashboard is published each weekday to 70 key staff across the Wiltshire Community.

Analysis of 1\textsuperscript{st} month of the 100 Day Challenge Dashboard.

- Data Quality/completeness issues identified
- Daily Trends analysed for each indicator
- Number of spikes in pressure cut by service type and individual indicator.
- Comparisons of differential activity pressures at the 3 main Acutes
What does it feel like for the patients?
## Step up Intermediate Care

<table>
<thead>
<tr>
<th>Referrer</th>
<th>GP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time/Day of Referral</strong></td>
<td>Tuesday 14:30</td>
</tr>
</tbody>
</table>
| **Presenting Complaint** | 91 year old gentleman living at home with his daughter  
Urinary Tract Infection  
Falls |
| **Referral/Assessment Process** | Initially a referral was made by the patient’s GP for an Intermediate Care Bed (formerly STARR). The patient was normally independent and but was now requiring assistance of one to two with mobility and personal care. An ATC Clinician completed an assessment over the telephone with the patient’s GP and the patient’s daughter. |
| **Outcome** | It was agreed that the first appropriate step would be to try and keep the patient at home with additional support and to see if his condition would improve over the next 24 hours following the commencement of antibiotics. The ATC Team reassessed the following day but unfortunately the patient’s condition had not improved. The ATC Team then arranged for the patient to be directly admitted into a ‘step-up bed’ at Warminster Community Hospital (with the agreement of the patient, his daughter and his GP). Transport was booked by the ATC Clinician at 1030 and the patient was admitted to Longleat Ward at 1330. Whilst on the ward the patient had further antibiotic treatment and an intensive period of physiotherapy. He was discharged home after 4 days, having returned to his previous level of independence. |
## Options following a 999 call

<table>
<thead>
<tr>
<th>Referrer</th>
<th>Emergency Care Practitioner (ECP)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time/Day of Referral</strong></td>
<td>Thursday 19:50</td>
</tr>
</tbody>
</table>
| **Presenting Complaint** | 84 year old gentleman living at home with his wife  
General deterioration over previous 10-12 weeks  
Non-injury fall 3 weeks ago resulting in significant decrease in confidence and mobility  
No previous package of care but supported by his wife who was now unable to cope with the level of support required  
Requiring assistance of 2 for all transfers |
| **Referral/Assessment Process** | Call received from the ambulance service and an assessment was completed over the telephone by the ATC Clinician with the ECP. At the time of referral there were no Community Hospital Step Up Beds, Intermediate Care Beds (ICT) or overnight carer availability however there was carer capacity the following morning and the potential of step up or ICT bed availability. The clinicians jointly reviewed the options and agreed that the ECP would arrange for additional support to assist him to get the patient back into bed and the ATC team would follow up first thing the next morning to coordinate community services to prevent acute admission. |
| **Outcome** | The following day the ATC team arranged a review by the patient’s own GP and an urgent therapy assessment by the Community Team with a view to providing H2L@H support and continued therapy. Following this assessment the Community Team therapist advised that the patient required 24 hours support and would benefit from a period of intensive rehab in an intermediate care bed setting. There were no Intermediate Care Beds immediately available however a bed was available the following day therefore ATC put in 24 hour support via the Urgent Care at Home Service to support the patient at home until the patient could be admitted. The patient was transferred to an Intermediate Care Bed the following day. |
Ambition into action

GOING FURTHER
Going further (1)

LEADING ACROSS THE SYSTEM
Technical problems v adaptive challenges

- System Leadership
  - Focus on purpose, users, benefits
  - Saying ‘yes to the mess’; experiments; diversity; different perspectives; curious
  - Encouraging connections, conversation, relationships, building networks/coalition
  - Challenging habits and assumptions;
  - Reducing power differentials – those who do the work – do the change
  - Containing anxiety

- Ordinary Management
  - Technical/rational decision making
  - Simple structures
  - Effective procedures
  - Monitoring/co-ordination
  - Providing direction

Near to certainty — Far from certainty

Close to agreement — Far from agreement

After Ralph Stacey
Going further (2)

ARTICULATING THE SOCIAL RETURN ON INVESTMENT
Social Return on Investment (SROI)

• Stages in an SROI analysis:
  • Establishing scope and identifying key stakeholders
    • Setting clear boundaries about what the SROI analysis will cover
    • Identifying who will be involved in the process and how
    • For the Wiltshire BCF Plan this is included in the Detailed Scheme Descriptions
  • Mapping outcomes
    • Development of an Impact map showing relationship between inputs, outputs and outcomes
    • Cost of health insurance
    • Cost of gym membership
  • Establishing impact
    • Eliminating from consideration those aspects of change that would have happened anyway or are as a result of other factors
  • Calculating the SROI
    • Adding up all the benefits, subtracting any negatives and comparing the result to the investment
    • Sensitivity of the results can be tested
  • Reporting, using and embedding
    • Sharing findings with stakeholders and responding to them
    • Embedding good outcomes processes and verification of the report
Social Return on Investment (SROI)

- Evidence outcomes and giving them value
  - Identify data for each outcome and valuing/monetising them
  - Monitoring non-financial benefits through the use of proxies (social value expressed in financial terms)
- e.g.:
  - Residential and nursing care home cost
  - Hospital care cost
  - Hospital admission cost
  - Percentage of income normally spent on leisure
  - Cost of membership of a social club/network
  - Savings in time and travel costs
  - Home living costs
  - Cost of visiting private doctor clinic