Wiltshire
HEALTH AND CARE

NHS

Delivery Plan

2017 - 2019

Introduction

This document sets out the Delivery Plan for adult community health services in Wiltshire for the period spanning 2017-18 and 2018-19. The priorities and strategic direction span both delivery years. Given the nature of planning in an environment that is changing constantly, there is more detail on plans for 2017-18 than for 2018-19. The plan should be viewed as a further step towards long term sustainable change, rather than a series of short term initiatives. This aligns to Wiltshire Health and Care's ambition to ensure that community services in Wiltshire play their full part in a sustainable health and social care system of the future.

Our purpose

Wiltshire Health and Care is a partnership formed by the three Foundation Trusts that serve Wiltshire, Great Western Hospitals NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust and Salisbury NHS Foundation Trust. The partnership has been responsible for the delivery of adult community health services in Wiltshire since 1 July 2016.

The overall purpose of Wiltshire Health and Care is to achieve seamless care and to remove the barriers to achieving it. Continuing to transform adult community health services is a vital part of fulfilling our overall purpose.

Our five year programme of change

At the formation of Wiltshire Health and Care, we set out the themes for a five year programme of change for Wiltshire adult community services. These themes have guided our change programme so far. Since July 2016, a Sustainability and Transformation Plan has been developed to guide the long term change of all health and care services across the Bath and North East Somerset, Swindon and Wiltshire areas. The change priorities of Wiltshire Health and Care match very closely with the emerging five year priorities of the STP:

Wiltshire Health and Care Five Year Programme of Change Themes	STP 5 Year Priorities
A service delivered in partnership*. Teams with a 'can do' approach and the networks to draw in support from other agencies and specialist advice when required. Real time communication and access to patient records to reduce duplication and the need to tell their story again. Working together as part of a multi-disciplinary local teams which include primary care, social care, mental health community services and the voluntary sector.	**1.Create locality-based integrated teams supporting primary care**
Higher intensity care. Offering comprehensive higher intensity community care, whether in a patient's own home or in a community inpatient bed. This will mean more people supported to stay in their own home at times of escalating need, reducing the need for a secondary care admission.	
Best practice: normal practice. We want Wiltshire to have the best possible care in the community. In many areas, we will lead the way and be an example of best practice. In others, we will learn from elsewhere and implement changes over the 5 year period to ensure that all aspects of services are consistently the best they can be	
Healthy, independent lives. Promoting health and prevention is part of the day job for community services, making use of every opportunity to inform and coach patients, carers and their families. Our services don't exist to do things for people that they can do for themselves, but will offer support and give them the confidence to take control.	**2. Shift the focus of care from treatment to prevention and**

Wiltshire Health and Care Five Year Programme of Change Themes	STP 5 Year Priorities
This needs to include tapping into technology to promote self-management e.g. secure video conferencing, remote monitoring at home, apps and web based support	**proactive care**
Community based urgent care. Making stronger links between urgent primary care, the current provision of minor injury units and adding strong links to Emergency Departments to develop an innovative response for the people of Wiltshire. A comprehensive urgent care offer in the community	
Leading the way. Transforming the use of technology to support patient care and collaboration of professionals in a way that supports rather than replaces a human voice and hand. Adopting evidence based technology and systems available to all industries, then innovating beyond that. From paper based and travel dependent solutions to connected and enabled	**3. We will develop an efficient infrastructure to support new care models**
Broadening skills. Extending the skills of everyone who cares for patients. Broadening horizons by enabling cross working across multiple settings of care and increasing availability of specialist knowledge, advice and enhancing trust	**4. Establish a flexible and collaborative approach to workforce**
More for your money. Community services will only play their full part in responding to increased demand on health and care services if they are fit for the future. We will reduce waste and duplication and proactive shifting of resources to allow investment in the community	**5. Enable better collaboration between acute providers**

*This priority theme has been adjusted from the original wording to emphasise the importance of broad partnership working in creating local integrated teams.

This business plan therefore demonstrates how Wiltshire Health and Care's priorities and change programme will play its part in achieving the high level objectives which exist across the wider local health and care economy.

In addition to priorities for adult community health services set out in this Delivery Plan, Wiltshire Health and Care will also be part of developing longer term approaches to broader system change. This will include:

- Increasing the extent to which health and social care services can be integrated. We will be working closely with Wiltshire Council to scope the opportunities to bring separate operational services more closely together with the aim of increasing collaboration and reducing unnecessary duplication;

- Playing a full part in the development of an accountable care system in Wiltshire. As part of the Sustainability and Transformation Plan, This type of approach can take many forms but is likely to involve building a broader partnership of health and care providers, operating under a single vision and aims and associated pooling of budgets and changes to contractual arrangements. Wiltshire Health and Care will take an active role in the design and development of a new approach, in partnership with commissioners and other providers

2017-2019: Change plan for adult community health services

WHC theme	STP Priority	2017-19 Delivery Objectives	We will…
A service delivered in partnership	Create locality-based integrated teams supporting primary care	Standardise and systemise to reduce variation	• Continue roll out of Higher intensity care project • Embed consistent frailty scoring • Deliver requirements of assessment of wounds CQUIN
		Respond to increased demand and maintain performance	• Support response to growth in adult continence, speech and language and orthotics services • Expand diabetes workforce
Higher intensity care		Improve system flow	• Complete implementation of Home First pathway • Further development of Home First • Commence the ESD for stroke pathway • Contribute to system-wide proactive and safe discharge CQUIN
Best practice: normal practice		Bring community provision together	• Develop joint provision between services, such as dietetics as part of diabetes education programmes.
Healthy independent lives	Shift the focus of care from treatment to prevention and proactive care	Implement new approaches to promote self management and proactive care	• Agree a new approach to community musculo-skeletal services • Invest in a SMS text based support system • Deliver the personalised care and preventing ill health CQUINs • Develop a falls strategy that includes prevention • Develop a dementia strategy
		Review services	• Align and integrate with new urgent care services • Participate in CCG review of learning disabilities and implement
Community based urgent care		Develop and strengthen partnerships	• Start a new partnership with the Stroke Association • Establish and facilitate a Delivery Partners Forum • Work increasingly closely with social care teams • Make connections to emerging models of primary care at scale • Achieve closer alignment with community mental health services
Leading the way	Develop an efficient infrastructure	Plan for change in estates	• Prepare for the planned transfer of community estate and maintain access to facilities management • Develop high level estates framework • Work with commissioners estates solutions as part of STP work
		Transform use of technology	• Continue to develop SystmOne • Bid to move minor injury units and inpatient wards to SystmOne • Embed and expand mobile working • Review all network capacity / speed • Scope telephone solutions to offer future flexibility • Contribute to system- wide interoperability projects
Broadening Skills	Establish a flexible and collaborative approach to workforce	Design the workforce for the future	• Use our partnership to make early progress as part of STP plan • Develop and embed a workforce strategy • Improve workforce planning to provide a longer term view • Grow the supply of flexible workforce • Review skill mix and safer staffing models in community wards • Upgrade our e-roster system
		Implement values and behaviours	• Implement values and behaviours • Support the health and wellbeing of staff as measured in CQUIN
		Develop career pathways	• Utilise the Apprenticeship Levy system • Participate in the Trainee Nursing Associate programme • Continue support for existing development opportunities • Provide opportunities for staff across our partnership to work and train across a range of services and settings • Encourage newly qualified staff to seek community careers • Ensure leaders are equipped with development 'tool kit'.
More for your money	Enable better collaboration	Connect acute and community pathways	• Be part of the consolidation of back office arrangements • Implement simplified discharge pathways at all 3 acute sites • Implement with SFT & primary care a common frailty approach • Learn from the Active Recovery Team pilot with RUH • Improve patient flow information sharing with GWH.

A quality focus
Deepening quality improvement
Strengthening quality assurance

A public and patient engagement plan
Better communication
Feedback for Board
Broaden sources of feedback

Good use of resources
Simplifying financial and contractual mechanisms
Understanding costs
Investing to save

Standardise and systemise to reduce unnecessary variation

One of the key strengths of community services is the ability of team members to think on their feet and respond to rapidly changing situations. Whilst maintaining and encouraging this individual clinical judgement and flexibility, there is also need to develop - in some areas – more standardisation and systemisation. The benefits of doing so is that it gives colleagues in other care settings more certainty of what the standard approach will be, reducing variation. It also allows more measurement of outcome and effectiveness of care, which provides a more solid foundation on which to base further investment and development.

We will:

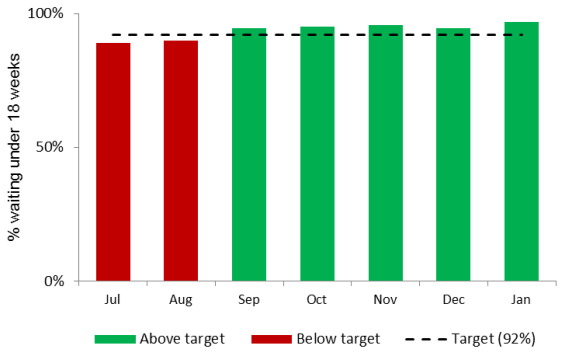
- Continue to deliver the Higher Intensity Care project, to put in place the necessary systems and processes to support defined periods of higher intensity care, whether delivered in patients' own homes, an intermediate care bed or community bed. Further details of this project are set out in Appendix 1
- Continue the roll out and embedding of frailty scoring – a common method of assessing how frail somebody is - achieving at least 90% of over 65s care for by community teams having a frailty score
- Deliver the requirements of the 'Improving the Assessment of Wounds' CQUIN
- Expand and design new standard procedures where they will improve patient care and increase consistency

Supporting services to respond to increased demand and maintain performance

Wiltshire Health and Care is responsible for the delivery of a wide range of community services for adults. Whilst pursuing the strategic change set out in this plan, we will also ensure that services are able to respond to the increased demand on their services and that performance is maintained.

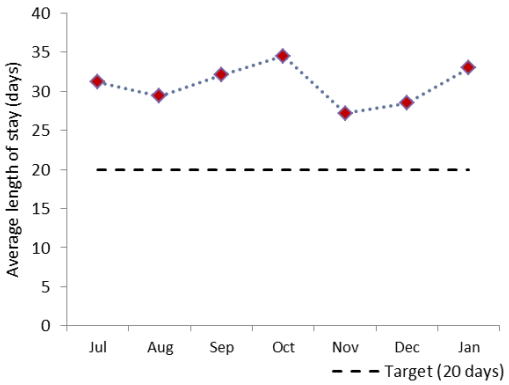
Our expected performance against key performance targets during 2017-19 is as follows:

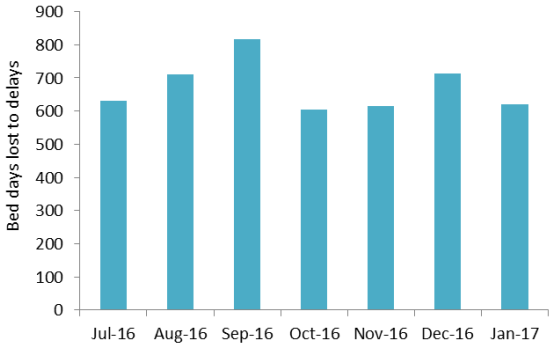
- <u>Referral to Treatment for planned referrals:</u> Our target is to have at least 92% of people waiting less than 18 weeks from the point of referral for planned treatment in the community. In July 2016, our performance was below target at 89%. Performance has risen to 97% in January 2017. We expect to sustain performance above 92% for the duration of this plan



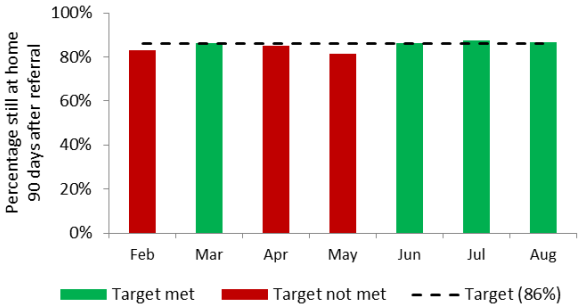
- <u>Length of stay in community inpatient wards.</u> We have a target to keep average length of stay at or below 20 days on our 3 rehabilitation wards. Performance has been consistently higher than target, and is heavily influenced by a high number of our Delayed Transfers of Care position. Since July 2016, we have lost an average of 673 bed days per month to delays in discharging patients. System changes

described later in this plan are intended to have a positive impact on this position. Given these changes, we expect to see improvement to these indicators over the period of this plan

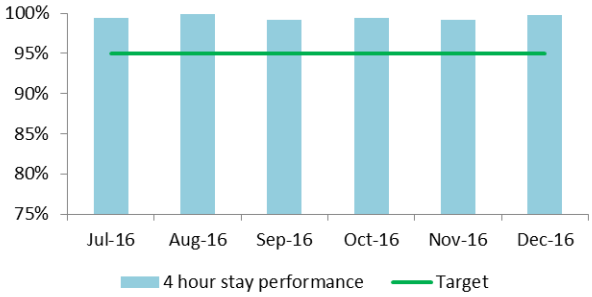




- Reablement at home 90 days. We monitor where a patient is living 90 days after referral in to our community teams for short term support following a discharge from hospital. It helps quantify the effectiveness of the Community teams in supporting patients to stay in their homes. We currently have a target of 86% for this measure. We expect to maintain performance at or above target



- Minor Injury Unit performance. Our two Minor Injuries Units consistently meet their target to see patients within 4 hours. This consistent performance will continue



All of our services are facing increasing demands and increasing complexity. Many of the improvements we will pursue are designed to change the way that services work so that they can adapt to the changing picture of demand. In addition, to this ongoing service development, we will also support some additional capacity for services which have experienced exceptional levels of growth in demand in the last and previous years. These services include Orthotics, Adult Continence and Speech and Language Therapy.

+7% year on year

Speech and Language therapy and orthotics referrals have increased around 7% year on year since 2011.

For each of these services, we will:

- Understand the growing demand for the service including sources of referrals and provision of complimentary services across other teams and services
- Develop and agree the scope and pathways for service provision
- As necessary, support the delivery of additional capacity

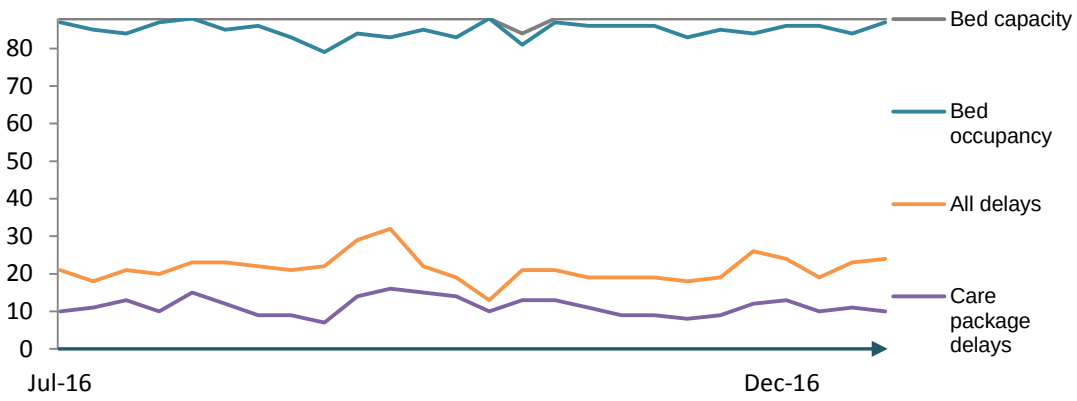
+20%

1318 referrals to the adult continence service between July to December 2016; up 20% on the same period in the year before.

We will also expand our diabetes workforce during 2017 -18, in line with the additional commissioned activity. This will enable the service to provide a Wiltshire wide structured education programme (EXPERT), to support Wiltshire Health and Care's focus on self-management; provide virtual clinics to support improved access, and develop pathways associated with diabetes such as diabetic foot clinics.

Improving system flow

The problems associated with poor system flow within the health and care system are well documented. These issues affect the whole system , including community services. For example, the following graph illustrates the number of community hospital beds available in Wiltshire and the number of them that were used for people who could have been in another setting given alterative provision, in particular those that could have been at home if a package of care could have been found.



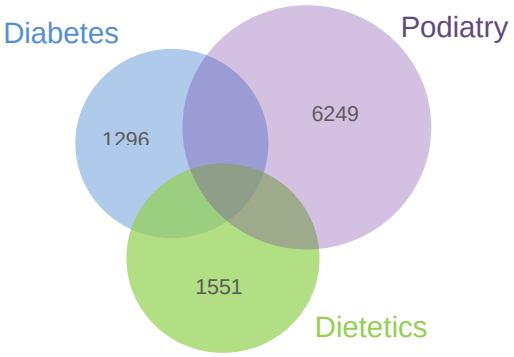
We will:

- Complete the implementation of the Home First pathway. This will include embedding simplified discharge pathways at each of the three acute sites, and implementing the HomeFirst pathway in phases. Further information on the remaining stages of the project are attached in Appendix 1
- Work closely with Wiltshire Council and Wiltshire CCG on the options for further development of the Home First pathway, improving links and developing a comprehensive approach to rehabilitation and reablement

- Commence the Early Supported Discharge for stroke pathway, adding additional support for discharge home following a stroke. Further details on this project can be found in Appendix 1
- Deliver the community services contribution to the system-wide 'Supporting Proactive and Safe Discharge' CQUIN targets during 2017/18 and 2018/19

Bringing Community Provision Together

As people that are looked after in the community have more complex needs it is becoming increasingly common that they access more than one of the services that Wiltshire Health and Care provides. As an example of this, the diagram below shows the overlap between diabetes, podiatry and dietetics.



Number of Patient Contacts, per service, July to Dec 2016

It is important to ensure that the delivery of services meet the needs of people rather than making people fit around the structure of services. We will therefore pursue service improvements which bring services more closely together.

This will include:

- Increased use of our clinical software, SystmOne, between different community teams to communicate and plan care
- Developing joint provision between services e.g. diabetic foot clinics
- Developing joint dietetic provision with diabetes education programmes.

Implement new approaches that support self-management and proactive care

Promoting health and prevention is part of the day job for community services, making use of every opportunity to inform and coach patients, carers and their families. A large proportion of our services have the privilege of delivering care in people's own homes, which is the ideal setting for reinforcing that the clinician is not in charge and that person led, empowering models of care are promoted. We will:

- Work with commissioners to agree a new approach to community musculo-skeletal services and advice which will have the support of self-management at its heart. Further details are set out in Appendix 1
- Invest in a SMS text based support system, which has been used in other areas of the country to support self-management and monitoring
- Increase the use of patient set goals, recorded on our clinical software. This will be part of achieving the 'Personalised Care and Supporting Planning' CQUIN
- Implement changes on our inpatient wards as part of delivering the 'Preventing Ill health by risky behaviours – alcohol and tobacco' CQUIN
- Develop a falls strategy that includes prevention
- Develop a dementia strategy which supports both people with dementia and their carers/ family

Planned reviews/ changes to services

Our priorities for 2017-19 include the review and development of revised services to ensure that the needs of patients and growing populations can continue to be met. These developments will include patient and public engagement to ensure that new services or pathways are co-designed.

<u>Urgent Care Services</u>

Wiltshire Clinical Commissioning Group and Wiltshire Council are currently re-commissioning a range of urgent care services, in collaboration with Bath and North East Somerset and Swindon CCGs. This process will determine the future delivery arrangements for services such as 111, GP out of hours services and a range of local Wiltshire services.

Wiltshire Health and Care is already responsible for the delivery of two Minor Injury Units in Wiltshire. Our vision for the future is that they should take their place within an integrated urgent care system, acting as local Urgent Care Centres. There are also other aspects of core work within community teams that need to be aligned with approaches to responding to urgent needs as a system. Wiltshire Health and Care will therefore await the outcome of this tendering process – which is expected later in 2017 - before commencing work to achieve as close an alignment and integration for Wiltshire services as possible.

Learning Disability services

Wiltshire CCG have recognised that there are significant gaps in provision for individuals with a learning disability and/or autism and has committed to:

- Understanding the gaps in the whole service pathways for people with a learning disability and/or autism, in particular exploring commissioned specifications against service activity, and benchmarking of service delivery against best practice recommendations
- Commissioning a clinical audit of pathways associated with the learning disabilities service across all providers

We will participate in this review during 2017-18 and plan to implement services changes agreed as a result.

Develop and strengthen partnerships

Good care and responsive services are reliant on partnership working. Teams who know other teams; people who know people. This guides our approach, rather than strict adherence to contractual or organisational boundaries and barriers As Wiltshire Health and Care moves into its first full delivery year, we want to strengthen our partnerships with delivery partners. We will:

- Start a new partnership with the Stroke Association from April 2017, to provide advice and guidance for people recovering with stroke as part of our stroke pathways
- Establish and facilitate a Delivery Partners Forum, as a provider forum for Wiltshire, focused on services delivered in the community
- Ensure operational teams work increasingly closely with social care operational teams, co-locating where possible, regular communication where not.
- Make connections to emerging models of primary care at scale to develop new approaches to locality working
- Achieve closer alignment and communication between adult community services and mental health services delivered in the community

A plan for change in estates

The physical and information technology infrastructure supporting community services in Wiltshire has not, historically, been a focus for investment and improvement. This means that services are increasingly being delivered within or from estate that is not best suited for modern healthcare and is need of modernisation and review. Wiltshire Health and Care services form one of multiple uses of most community estate. As such, Wiltshire Health and Care needs to be ready to participate and shape any changes planned and proposed by commissioners and landlords.

In order to participate in this work, we will clarify the type of physical infrastructure that is required for delivering community services in future. This will include:

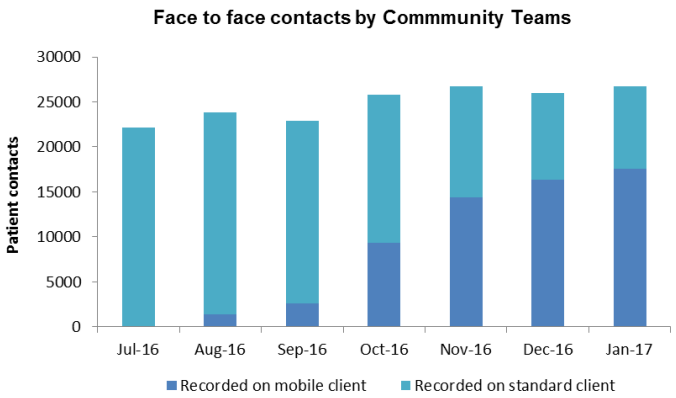
- Bookable space in publicly accessible healthcare facilities for visiting clinicians to deliver clinic based services
- Increasing access to bookable space in non-healthcare facilities such as leisure centres, community centres and village halls to support group sessions and education sessions aimed at supporting people to live with long term conditions
- Permanent facilities in modern healthcare facilities to deliver fixed-location services, such as inpatient care, urgent care centres and some fixed location clinical services
- Community bases from which mobile teams can collect equipment, plan and organise their workload and be supported while delivering services in people's homes, providing advice and guidance remotely using technology or delivering care across multiple locations. These bases do not need to be located alongside publicly accessible healthcare facilities, but they do need good access to transport links and excellent IT infrastructure. We will work with partners so that similar service needs can be co-located
- Some general administrative space, delivered in line with market rates for office spaces. This will mean reducing the amount of publicly accessible healthcare space used to house administrative functions

We will:

- Prepare for the planned transfer of ownership of community estate from Great Western Hospitals NHS Foundation Trust to NHS Property Services, ensuring that the new arrangements provide flexibility for Wiltshire Health and Care to make more efficient use of estate over time
- Ensure that Wiltshire Health and Care services have appropriate access to facilities management services following the transfer
- Develop high level estates framework to feed into the wider health economy estates planning work
- Work with commissioners on planning of estates solutions for Devizes, Trowbridge, Chippenham and Melksham, in line with the STP plans

Transforming technology

Our plans for community services are reliant on transforming the way in which technology is used. We have already made excellent progress, by implementing mobile working across all of our core community teams within six months. However, the pace of further transformation of services is being affected by the capacity and capability of information technology infrastructure. We will focus, therefore, on the opportunities for investment and improvement to ensure that technology can be the enabler of change.



The rollout of mobile devices to our community teams started in August 2016. By January 2017, at least 66% of face to face contacts were recorded using the mobile client.

We will:

- Continue to develop our clinical record, SystmOne, to support effective, consistent and safe clinical care
- Bid for funding to allow the Minor Injury Units to use SystmOne as the clinical record, enabling more information sharing with primary and community services
- Bid for funding to allow the four community inpatient wards to move to using SystmOne as the clinical record, enabling more information sharing with primary and community services
- Procure mobile devices/laptops to allow community specialist services who require mobile access to be able to record electronically during patient facing contacts.
- Undertake a review of all network capacity / speed on community sites and identify solutions where network speed is impeding efficiency
- Scope telephone solutions that will offer flexibility to deliver service change in the future
- Embed mobile working, following the completion of the mobile working project in 2016-17
- Contribute to system-wide efforts to improve interoperability between different systems

Design the workforce for the future

Our people are our most important and valuable asset. Developing and supporting staff to feel engaged, valued and empowered will have a positive impact on the quality of care delivered and this improves patient experience and positive patient outcomes. Ensuring that we have a sustainable workforce is the essential building block to delivering quality care that is safe and effective. Establishing a flexible and collaborative approach to workforce is one of the main priorities of the Sustainability and Transformation Plan. The unique partnership which lies behind Wiltshire Health and Care means that we can make early progress on increasing flexibility and collaboration across a workforce that spans multiple settings of care. We will:

- Use our partnership to make early progress on a flexible and collaborative workforce, as part of the STP plan
- develop and embed a workforce strategy that supports a healthy and happy workforce delivering quality care. The focus of the strategy will be to **R**etain, **R**ecruit, **R**eward and **R**espect all staff groups
- improve workforce planning to provide a longer term view of workforce challenges
- grow the supply of flexible workforce, including the use of flexible retirement options, in order to increase our flexibility at times that teams are stretched
- review the skill mix and safer staffing models that apply to our community inpatient wards to ensure that they continue to reflect the model of care delivery in community hospital settings
- upgrade our e-roster system to improve the way in which day to day staffing rotas are planned and organised. Further details of this project can be found in Appendix 1

Implementing values and behaviours for Wiltshire Health and Care

During our first nine months of operation, we have reviewed the values and behaviours that should apply to everyone who is part of delivering services for Wiltshire Health and Care. The work has involved a cross-section of front line staff and volunteers from Healthwatch to provide external challenge and scrutiny.

The agreed values and behaviours are:

Building and Strengthening Partnerships

- Effective Communication
- Leadership
- Involvement and Team-working

Quality Care for All

- Compassion
- Patient Centred
- Culture of Learning

Adapting in a Changing Community

- Service Development
- Wellbeing
- Proactive Approach

Demonstrating Integrity in All We Do

- Open and Honest
- Professionalism
- Respect

We will:

- Implement our revised set of values and behaviours during 2017-18
- Support the health and wellbeing of staff, as measured by the 'Improving staff health and wellbeing' CQUIN target for 2017-18 and 2018-19

Developing career pathways

We know that central to attracting and retaining staff is the offer of career pathways. Some of these pathways will mean that staff are able to stay in the same location or service for longer; others will mean that staff will move between settings of care and be supported to do so, in order to ensure that their expertise is retained in the broader health and care system. We will:

- Utilise the Apprenticeship Levy system by identifying and supporting the delivery of different career pathways. This will include liaising with Health Education England to adopt new pathways within the apprenticeship levy arrangements
- Testing new types of roles by participating in the Trainee Nursing Associate programme and recognise its value in the community workforce
- Continue support for development opportunities including advanced practitioners in therapy and nursing, Specialist Practitioner Qualification and Assistant Practitioners
- Provide opportunities for staff across our partnership to work and train across a range of services and settings
- Develop pathways to encourage newly qualified staff to seek careers in the community
- Ensure our leaders are equipped with the right 'tool kit' to enable them to manage and develop their staff

Work as a partnership to connect acute and community pathways

Our unique partnership has been a catalyst for closer collaboration between the three Foundation Trusts that serve Wiltshire. Our work as a partnership results in tangible benefits for community services and the wider system. It also means that brings broader benefits – relationships between operational teams, understanding of the challenges along a whole pathway and the ability to share ideas quickly.

We will:

- Be part of the consolidation of back office arrangements. This stream of work will bring benefits to community services, making it easier to support a geographically dispersed workforce with streamlined back office arrangements. In doing so, community services will improve the specification and service standards it requires from back office services

- Implement simplified discharge pathways at each of the three acute sites, which maximise the opportunities for simple and effective discharge;

- Work with Salisbury NHS Foundation Trust and primary care colleagues in the South of Wiltshire to implement a single frailty approach across acute, community and primary care

- Work with Royal United Hospitals Bath NHS Foundation Trust to learn from the Active Recovery Team pilot in 2016-17 and apply lessons to the HomeFirst pathway

- Work with Great Western Hospitals NHS Foundation Trust to improve information sharing in relation to real time patient flow

A quality focus

The quality of services is an intrinsic part of our plans to develop services. Indeed, many of the delivery objectives and priorities already set out in this plan are about improving the quality of services. In addition to achieving these changes, it is important that there is a focus on the overall assurance of quality and the right environment for encouraging continuous improvement. Data drives improvement and the integrated use of data is core to our work.

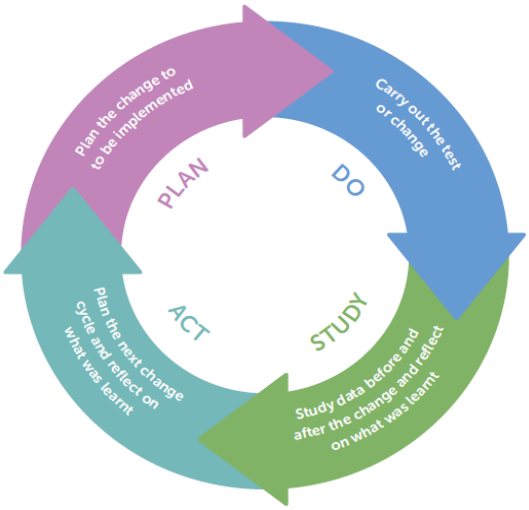
Strengthening quality assurance

We will strengthen our assurance of quality by:

- Sustaining an internal governance structure, to ensure that effective arrangements are in place to continuously monitor and improve the quality of health care provided;
- continuing to improve information about the quality of services and ensure that it supports service development.
- Reviewing and revising the risk management system to inform current and future risks to quality.
- Continuing to build a positive learning culture and ensure organisational/ system learning from all events and incidents.
- Reviewing the Root Cause Analysis process to ensure it is supporting the learning culture.
- Pursuing continuous review of new pathways of care to ensure safe delivery.
- Continuing to support the role of safeguarding practice influencers to raise the profile safeguarding and the implementation of the Mental Capacity Act.

Deepening quality improvement

This Delivery Plan sets out a wide range of delivery objectives and the direction of travel for change in community services. In addition to these larger scale plans, we will create an environment that supports innovation within the organisation. Innovation is a vital part of the Wiltshire Health and Care culture and is critical to the future.



In encouraging innovation, we will:

- Work with the West of England Academic Health Science Network to support the integration of quality improvement methods
- Ensure a continued focus on clinical audit to support and lead change
- Broaden the quality improvement culture throughout Wiltshire Health and Care and the implementation of quality improvements by 'Plan Do Study Act' cycles of change.
- Ensure that 'failure risk' is managed proportionately

A public and patient engagement plan

Engagement of patients, their families and unpaid carers is a vital part of improving services and designing new services. It is something that we want to develop further and improve. We will:

- Develop a comprehensive engagement plan for Wiltshire Health and Care,
- Broaden sources of feedback beyond existing sources
- Ensure our board makes decisions with the benefit of hearing the voice of patients and carers. Our 'patient voice' non executive member, appointed from April 2017, will tap into local networks to ensure that this is happening
- Increase our communication capacity, to support more conversations and information sharing
- Increase the amount of co-design of change when considering new pathways or changes to services
- Evaluate changes we have made, using patient and carer feedback. For example, we are engaging Healthwatch to help us gather feedback on our Higher Intensity Care pathway, early in 2017-18

97.8% of patients likely to recommend our services to family and friends

Good use of resources

Our delivery and development of services is only possible if The organisation aims to deliver an underlying breakeven income and expenditure position for the next three financial years. This will mean that any available resources are re-invested into the delivery of services. The accounts of the partnership will be submitted annually to Companies House.

We will ensure good use of resources by:

- **Investing to save.** We will prioritise investment from any financial headroom into areas that will make services more efficient in the future
- **Understanding costs.** As Wiltshire Health and Care prepares for possible future changes to the way in which services are funded and commissioned, it is necessary to build a better understanding of the detailed costs of delivery. This allows informed choices to be made in future about the best way of meeting increased demand with limited resources

Simplifying financial and contractual mechanisms. We will pursue a programme of simplification of historic contractual and financial flows that have developed over time into an overly complex set of arrangements. By doing so, this will reduce the amount of management time associated with dealing with unnecessary complexity.

Appendix 1: Summary of projects in 2017-18

<table>
<tr><th colspan="4">Higher Intensity Care</th></tr>
<tr><td colspan="4">The aims of this project are aligned to our long-term strategy to:
Increase the capacity and capability of blended teams of community geriatricians, other medical resource specialists and general nursing to offer a higher intensity of care
Put in place the necessary systems and processes to support defined periods of higher intensity care, whether delivered in patients' own homes or in community beds
Support the delivery of higher intensity care through development of services delivered from community hospitals</td></tr>
<tr><th colspan="4">Progress in 2016/17</th></tr>
<tr><td colspan="4">Built the IT infrastructure to support recording for patients at home
Defined model of patient care and standard eligibility criteria
Agreed model for multi disciplinary team discussions
7 day working for clinical leads agreed following staff consultation
Procurement of 12 additional portable ECG machines
Agreed Ambulatory Care standard procedure for Cedar and Longleat wards
Introduced new MDTs in the south of the county, making and developing stronger links with Community Geriatrician, Dr Hugo Powell.
New pathway at home commenced March 2017</td></tr>
<tr><th colspan="4">2017-18 Project Plan summary</th></tr>
<tr><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td colspan="2">New 'at home' model live; collect agreed performance indicators to allow creation of baseline data and understand impact of the new ways of working.</td><td colspan="2" rowspan="3">Examine and analyse activity and decide on priorities for further development, which could include one or a combination of the following:
Greater intensification – offering more services in own home, but supporting broadly the same number of people
Maintaining capacity, shift development focus to proactive care to prevent needing higher intensity care
Expansion of pathway to cater for more people needing higher intensity care
As required, consider business case for future development and plan delivery for 2018/19.</td></tr>
<tr><td>7 day working for clinical leads in place (subject to successful recruitment)</td><td>Report on patient experience as tested in Melksham in Q1. Healthwatch Wiltshire have agreed to assist in the preparation of this</td></tr>
<tr><td colspan="2">Increase geriatrician support to Higher Intensity Care where required.</td></tr>
<tr><td colspan="2">Design revised clinical and medical cover arrangements for inpatient wards</td><td colspan="2">Revised arrangements for clinical and medical cover in inpatient wards implemented</td></tr>
<tr><th colspan="4">Project Benefits</th></tr>
<tr><td colspan="4">Reduced admission to secondary care, from more structured and visible management of higher intensity in community settings.
New process, backed by IT change, to allow collective review and management of identified cohort of higher intensity patients, increasing consistency.
The use of SystmOne by all clinicians will mean readily available and up to date information.</td></tr>
<tr><th colspan="4">Measuring Impact</th></tr>
<tr><td colspan="4">Total number of patients starting care with Higher Intensity Care at home
Number of patients starting care with Higher Intensity Care at home that do not go on to be admitted to hospital (to be used as a proxy measure for admission avoidance)
Number of inpatient admissions from the community (step up beds)
Link to system measure of non-elective admission for over 65s.</td></tr>
</table>

Home First

The Home First pathway aims to simplify discharge from hospital and direct support for the complex and intense post hospital period:

- Using a 'discharge to assess' approach – with full assessment happening when a patient is back in their own home rather than when in hospital
- Responsive care and rehabilitation while needs are rapidly changing
- Where required, arranging a managed transfer of care to Help to Live at Home providers on or before 10 days post discharge
- A managed transfer of case management when longer term needs can be assessed

The project was started in November 2016 after agreement from commissioners to invest in additional rehabilitation support workers to support the model.

Progress made in 2016-17

- The vast majority of the 30.6 WTE Rehabilitation Support Workers and the 3 WTE Occupational Therapists will have been appointed by the end of 2016/17.
- Agreement of performance reporting dashboard
- Development of Standard Operating Procedures and Referral Pathways out of acute hospitals and into local care agencies, reflecting requirements of local service providers
- Amendments to SystmOne to enable recording of Home First activity in the patient record

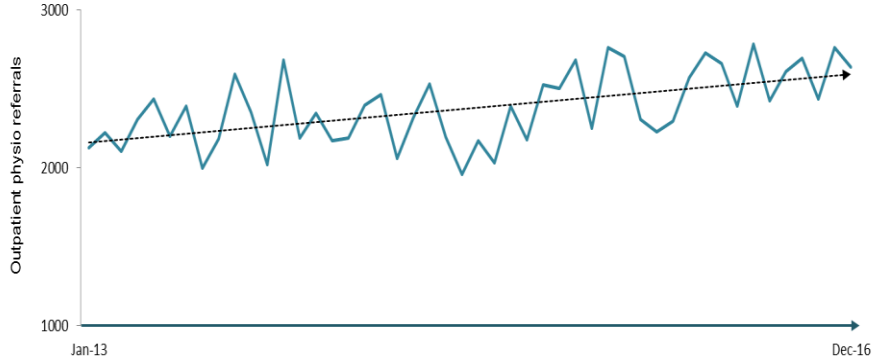
Q1	Q2	Q3	
Phase 1: Use increased workforce to help support speedier discharge using existing pathways Monitor impact of increased workload on ability for Help to Live at Home providers to be able to respond to a referral within 48 hours. Phase 2: Achieve sign up to new pathways and Standard Operating Procedures, and move to new pathway with commitment to handover times	Phase 3: Full pathway implemented	Evaluation and discussion of any further developments with commissioners	

Project Benefits
• Simpler pathways and processes release therapy time currently taken up in organising and amending care, delivering more face to face therapeutic intervention • Implementation of a discharge to assess model – full assessment in own home, rather than inpatient setting, meaning it takes into account full context • Reduction in number of patients delayed whilst in inpatient care • Reduction in demand on care packages through a therapy led proactive assessment and rehabilitation approach in period immediately following discharge • Better system flow achieved when all parts of pathway are operating to agreed standards
Measuring impact
• Number of patients starting care with our Home First pathway • Number of bed days lost to delays in arranging packages of care each month • Average contact hours given per day to monitor impact on progression of care needs

Musculo-Skeletal Physiotherapy

Wiltshire Health and Care is proposing a move to a new model of care and is currently discussing these changes with Wiltshire CCG. Subject to agreement of the pathway and associated resources, we expect to be establishing a project during 2017-18 to implement the new pathway. The scope of this project is reliant on the CCG proposals being finalised.

These reforms will help to promote self management, ensure that secondary care services are being used appropriately and increase the convenience and access to a range of ways of supporting people manage their musculo-skeletal conditions. In doing so, it will also help to respond to a long term trend of increasing demand for physiotherapy outpatient services in the community. The graph below illustrates the steady increase in referrals that the service has experienced since 2013, which equates to a year on year increase in the region of 5%. This is against a backdrop of limited resources and more ambitious referral to treatment times in order to improve patient care.



Numbers of Referrals over time.

Project Deliverables

The priorities for the MSK project will therefore be:

- Work with WCCG to allow them to design, cost and commission an enhanced physiotherapy service model across, primary, community to enhance patient care and reduce trauma and orthopaedic surgery.
- Work with primary care and secondary care colleagues to implement the newly commissioned physiotherapy pathway in the community.

Q1	Q2	Q3	Q4
Agree scope with CCG Agree required additional resources	Recruitment of any agreed resources Estates and IT issues	Roll out of new pathway, in line with timelines agreed with CCG	

Project Benefits

- facilitate a reduction in referrals to trauma and orthopaedic services in acute hospitals
- a reduction in the number of appointments that are not attended without cancellation
- promote self management, to help meet increases in demand for treatment services

Stroke Early Supported Discharge

The aims of this project are aligned to our long-term strategy to support those who have suffered a stroke which will include:

- to provide rehabilitation to ESD eligible patients, at a level and intensity appropriate to individual patients and in line with what would have been received on an inpatient stroke rehabilitation unit.
- improved individual outcomes – reduced likelihood of on-going dependency on others for everyday activities
- aim to reduce demand on stroke rehabilitation units

Progress made in 2016-17

- Established patient pathway and supporting documentation
- Partnership working with Salisbury FT to strengthen links with specialist stroke ward
- Recruitment of additional resources –
    - Appointed additional stroke specialist staff in North and South Hubs
    - In the process of appointing Physiotherapist in South Hub
    - In the process of appointing Rehabilitation Support Worker in North Hub
- Built SystmOne mechanism for recording activity appropriately

2017-18 Project Plan summary

Q1	Q2	Q3	Q4
Launch of ESD service in North Hub Complete recruitment and launch of ESD service in South Hub Secure network connectivity to support service development in the North Hub.	Embed and consolidate new pathways – measure activity consistently to allow analysis in Q3.	Review outcomes and performance to assess areas for possible future development, which could include: ○ A wider team of professionals attributed to each Hub (including psychologists, dieticians, speech and language therapists) ○ Increased WTE of existing Hub staffing to enable more referrals to be accepted ○ Extended treatment sessions in terms of time allocated and professional group As required, consider business case for future development and plan delivery for 2018/19.	

Project Benefits

- Increased rehabilitation and recovery in own home
- Decreased demand on inpatient rehabilitation beds
- Improved individual outcomes – reduced likelihood of on-going dependency on others for everyday activities
- Two dedicated teams focusing on stroke rehabilitation at home
- Real time information via the use of SystmOne.

Measuring impact

- Number of patients starting care with our ESD service
- Days post-stroke at discharge from acute hospital
- Percentage of patients having first face to face contact within one working day of hospital discharge
- Percentage of patients with improvement in Barthel score between start and end of ESD care

Learning Disability services

Wiltshire CCG have recognised that there are significant gaps in provision for individuals with Learning Disabilities and has committed to:

- Understanding the gaps in the whole service pathways for people with a learning disability, in particular exploring commissioned specifications against service activity, and benchmarking of service delivery against best practice recommendations.
- Commissioning a clinical audit of Learning Disability services in Wiltshire

Wiltshire Health and Care will participate in this review and plan to implement services changes agreed as a result. A project will be established as part of implementing the recommendations of the review.

Q1	Q2	Q3	Q4
CCG to undertake clinical audit	CCG to redesign pathway and agree commissioning strategy to deliver it Providers and commissioners to work together to deliver short term solutions to any areas of high risk identified.		Implement permanent service changes as agreed in commissioning strategy

E Rostering System

One of the recommendations of the Lord Carter review in 2016 was for the NHS to implement an e-rostering system. The review acknowledged that an electronic system is significantly more efficient than staff producing manual rosters and contributes to a more effective and productive NHS.

Some of the teams in Wiltshire Health and Care already successfully use e-rostering and a project has been established to upgrade the e-roster software and implement this consistently throughout the remaining teams.

Q1	Q2	Q3	Q4
Produce training programme and start to roll out to operational teams.	Continue roll out to operational teams Start to produce, analyse and make management decisions based on information from e-rostering system	Complete roll out to operational teams	Roll out to support teams

Project Benefits

- Better use of clinical staff
- Reduced agency spend
- Reduced absenteeism
- More accurate and timely reporting which will support robust decision making