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

- 65 to 74
- 75 to 84
- 85+

Year:
- 2014: 11.9
- 2015: 14.4
- 2016: 17.0
- 2017: 19.6
- 2018: 22.2
- 2019: 24.8
- 2020: 27.4
- 2021: 30.0
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
- 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”

Integrated Discharge Teams: Acute Hospital sites; 7 days a week working

Integrate Therapy Services in the Acute: Community, Social Care and Housing Settings

Single view of the customer Truly integrated information system across the public sector

“I want the right care first time”

Discharge to Access

Non Acute Bed Provision: Step down & Step up; Consultant and GP support; Integrated Care Centres; Extra Care; Rehab Units; Community Hospital beds; Private Residential and Nursing bed provision

Integrated locality working Access to multi-disciplinary teams coordinated by the GP, including mental health/dementia/learning disability; Risk; Stratifying patients; Anticipatory

Crisis Response Services; Access to shared Anticipatory Care Plans by the Ambulance service, Enhanced Rapid Response, Enablement Services and Voluntary Sector based

Comprehensive geriatric assessment and crisis management whatever the location
The Aims (some!)

- 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.
Case example – how will a new system impact?

<table>
<thead>
<tr>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. B 86, previously physically fit</td>
<td>Mr. B referred to SPA</td>
</tr>
<tr>
<td>Sole carer for his wife who has dementia</td>
<td>Integrated reablement at home which included assessment of mobility</td>
</tr>
<tr>
<td>Previously declined social care significant strain on Mr. B</td>
<td>Visit also included assessment of couples care needs</td>
</tr>
<tr>
<td>Mr. B own mobility was beginning to decline, high risk of fall</td>
<td>Mr. B underwent a 6 week course of reablement</td>
</tr>
<tr>
<td>Recently seen by GP</td>
<td>Mr. B remains independent, improved mobility at home and accesses respite care</td>
</tr>
<tr>
<td><strong>Patient identified and discussed by cluster MDT</strong></td>
<td><strong>Outcomes</strong></td>
</tr>
<tr>
<td></td>
<td>Maintained independence in community</td>
</tr>
<tr>
<td></td>
<td>Avoided an average of 1 admissions and 2 readmissions for this cohort</td>
</tr>
<tr>
<td></td>
<td>Avoided/prolonged transfer to a nursing and residential home</td>
</tr>
</tbody>
</table>
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>

Wiltshire Council
Clinical Commissioning Group
Ambition into action

THE CLINICAL MODEL, THE SYSTEM REVIEW AND THE 100 DAY CHALLENGE
The Challenge

Creating capacity here
To fund capacity
Here/harness experienced resources here

Scaling up and creating the space to achieve change

Patient/Service User
Family
Community

A&E and hospital settings
Nursing and residential care

Care clusters
Intermediate care beds
Ambulatory care
Simple point of access
Wider MDT including Community
Geriatrician/Matron/Pharmacy/SWs/MH/
Third Sector/Therapies

Patient/Service User
Family
Community
The Clinical Model
Systems thinking and the “Check stage”
Ambition into action

THE 100 DAY CHALLENGE
What is the 100 Day Challenge?

• Going live from the 1st September, this will be 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 focussing 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.
- 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
Ambition into action
GOING FURTHER
Going further (1)
LEADING ACROSS THE SYSTEM
Propositions

• We are looking for significant changes in behaviour on the part of professionals and the public; relationships are a critical factor in behaviour change.

• We are working with a “complex” social system - main features:
  • Self-organising; order from following simple rules; understanding the system comes from looking at collective behaviour.
  • Some failure is inevitable and can’t be avoided through system design; it can only be managed e.g. by giving discretion to front line staff.
  • Small changes can have big impact (feedback loops, networks, cascade effects, varied timescales); cause and effect is very hard to identify.
  • Have an identity, expressed through traditions, symbols, rituals, language, stories, practices and behavioural norms;
  • Use past experience to determine how to react to change; seek to preserve themselves, so “temporary” change resisted or avoided; however if change is seen as permanent then the system will adapt to survive.
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

After Ralph Stacey
Going further (2)

EMBEDDING THE RISK SHARE APPROACH
The risk share approach

- The Better Care Fund is underpinned by a set of metrics set at national level:
  - Admissions to residential and care homes
  - Effectiveness of reablement
  - Delayed transfers of care
  - Avoidable emergency admissions
  - Patient and service-user experience
  - Local metric

The individual BCF schemes have been set up so that as in aggregate the targets for the above metrics are met over 2014 – 2016. There is a system-wide risk that even with a strong contract and performance management in place with provider organisations, this will might not be achieved. Failure to meet the targets has financial consequences as the cost of any additional services that have not met the targets will need to be covered by either CCG or LA. To mitigate the risk and minimise the costs, a risk share framework should be put in place as part of the section 75 agreement.
The risk share approach

- There are four levers that the risk-share framework is build upon:
  - Scheme Tier – i.e. what services are being delivered (outlined in appendix 1)
  - Delivery provider – who will be responsible for delivery of the services
  - Benefit realisation – i.e. where will the savings / benefits be realised
  - The source of funds – i.e. who is funding the contribution and what in what proportion

In addition to the consideration of benefit realisation, CCG and Local Authority might want to consider the downstream impact if the scheme fails to deliver outcomes – i.e. where the failure will be managed. E.g. if reablement programmes do not deliver the intended outcomes, hospitals will see an increase in readmission rates.
The risk share approach

- There are also a number of ground rules that need to be agreed as part of the risk-share arrangements under section 75.
  - Will BCF have the right of first refusal for any reduction in BCF metrics over other in-flight initiatives (e.g. QIPP)
  - Who bears the risk and cost of BCF underperforming
  - Who benefits if BCF targets are exceeded
  - How will the penalty payment be used (if a consequence of breach was that a percentage of provider payment was withhold, what will happen to the withhold cash - will it remain in BCF or be shared between the commissioners)
- Where services within the BCF are existing services that have already been contracted by either CCG or LA, there are a number of other considerations that will impact on risk sharing. These include:
  - Who is the current host commissioner
  - Who provides the existing services and what arrangements are in place
  - Whether changes to existing provider arrangements will have direct and indirect impact on non-BCF services currently provided
  - Whether current contract management arrangements are fit-for-purpose
Risk share framework – Wiltshire Lever Analysis

- Reviewed against the 4 levers:
  - Tier
  - Delivery provider
  - Benefit realisation
  - Source of funds

- Tiers:
  - 0 – Lifestyle promotion
  - 1 – Low intensity prevention
  - 2 – Primary care
  - 3 – Community Health & Social Care

- Lever analysis is indicative and should be re-applied when all schemes have been scoped out in detail. Can also be converted to percentage risk allocated.

<table>
<thead>
<tr>
<th>Scheme Name</th>
<th>Contribution (£’000)</th>
<th>Tier</th>
<th>Delivery</th>
<th>Benefit realisation</th>
<th>Source of funds</th>
<th>Risk share</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate care</td>
<td>15,064</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7-day working, Rapid Response and discharge Coordination</td>
<td>10,280</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protecting Social Care Services</td>
<td>18,366</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care Act Requirements</td>
<td>2,500</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supporting Communities to be more resilient</td>
<td>3,944</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data sharing and joint assessments</td>
<td>1,200</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service user feedback and involvement</td>
<td>200</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Going further (3)

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
# The Impact Map

## Social Return on Investment – The Impact Map

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives</td>
<td>Date</td>
</tr>
</tbody>
</table>

### Scope

- Activity
- Contract/Funding/Part of organisation
- Objective of Activity
- Time Period
- Purpose of Analysis
- Forecast or Evaluation

### Stage 1

- Stakeholders
- Intended/unintended changes
- Inputs
- Outputs
- The Outcomes (what changes)

### Stage 2

- Description
- Indicators
- Source
- How did you describe the change?
- How would you measure it?
- How much change was there?

### Stage 3

- Duration
- Financial impact
- Value of the information
- What happened without the activity?

### Stage 4

- Impact
- Action Plan

<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Intended/unintended changes</th>
<th>Inputs</th>
<th>Outputs</th>
<th>The Outcomes (what changes)</th>
<th>Dead-weight %</th>
<th>Displacement %</th>
<th>Attribution %</th>
<th>Drop Off %</th>
<th>Impact</th>
<th>Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who do we have an affect on? Who has an affect on us?</td>
<td>What do you think will change for them? What do they invest? Value it</td>
<td>Summary of activities in numbers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

The table above outlines the key elements for understanding the impact of a social return on investment project. Each stage of the map is designed to help track and assess the various inputs, outputs, and outcomes, along with the factors that influence their impact and displacement.