Better Care Fund Plan- Wiltshire

Case Study

August 2014

Wiltshire Better Care Fund Plan: Case Study

1. Risk Stratification

Methodology

- To mitigate risks and minimise the costs, a risk share framework has been put in place as part of the section 75 agreement. There are four levers that the risk-share framework is built upon:
  - Scheme Tier – i.e. what services are being delivered.
  - 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.
- The key factors influencing the risk share agreement include understanding of the intended impact of the BCF and who is accountable for delivering the schemes.
- The framework allows for risk sharing between the CCG and Local Authority to be agreed for each scheme, with detailed risk ownership for specific activities within each scheme to be determined, assessed and agreed.

Learning

- A review of the approach to risk stratification is being undertaken in a number of different ways:
  - Applying frailty scores to the risk stratification model.
  - Developing a joint risk stratification tool for health and social care (a new system is in the process of being procured).
  - Take a more preventative approach by identifying those patients who (through agreed criteria) could become high risk and reach crisis in 18-24 months unless preventative interventions were put in place now.
- With the procurement of a new system there is an opportunity to change approach in this respect.
- Determination of risk and benefit sharing could be made more efficient via use of an outcome matrix covering CCG and council interests.

Evidence

- The risk stratification is applied to each of the individual Schemes and overall BCF metrics.
- The financial impact of non-delivery of the Better Care Plan objectives in relation to length of stay and reduced admissions is £3m for the CCG in 2014/15. The impact will approximately double in 2015-16 if growth cannot be contained and the Better Care Plan and other initiatives do not deliver.
- Risk stratification is applied to a range of data sources with particular emphasis on GP, acute , community and social care systems and our ambitious Single View of the customer programme.
- We have identified that at least 2% of the 120,000 risk stratfied are at high risk of emergency admissions unless proactive intervention is put in place.

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2. Case for Change

Methodology

- Health and Social care providers all recognise that significant changes are needed to the way services are designed and delivered, and that those changes are already underway.
- Existing programmes of joint work, in engaging with health, social care and voluntary sector has informed a Joint Strategic Needs Assessment. Examples include:
  - Joint Health and Wellbeing Strategy.
  - Wiltshire Care Partnership.
  - CCG's five year plan and Community Transformation Programme.
  - Wiltshire Healthwatch.
  - Workshops with providers on a whole system workforce strategy.
  - A Steering Board for the development of intermediate care services.

Learning

- As part of the wide reaching " system review ", "persona profiles " are being undertaken as in detail reviews of patient journeys through the system . For example, process mapping a patients journey through a number of health and social services and presenting this to a number of different forums . This approach was extremely powerful in identifying key areas of focus and opportunity as well as helping to determine where key schemes should apply there focus.
- As a result of this work, Healthwatch are being engaged to undertake similar reviews of patient journeys in the future.
- There is scope for gathering wider knowledge using the Atlas of Variation, RightCare, Any Town CCG Guidance principles and the Commissioning for Value Atlas in order to inform other areas for scheme identification that have not been considered for 2015/ 16.

Evidence

- Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.
- 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. Older people are more likely to need health and care services and we know that nearly half of Wiltshire's NHS resources (47.4%) are consumed by people aged over 65. Much of this resource is needed for frail and vulnerable older people.
- Whilst the rate of growth of the total population is below the south west and national average, the rate of growth in the older population in Wiltshire exceeds the rate of growth in the rest of the south west, and exceeds the England average.

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3. Using the Evidence Base to Select Appropriate Interventions

Methodology

- The vision for better care is based upon the four priority outcomes set out in the Joint Health and Wellbeing Strategy:
  - I will be supported to live healthily, I will be listened to and involved, I will be supported to live independently and I will be kept safe from avoidable harm.
- The focus for the Better Care Fund is upon frail older people due to the high rate in growth in the number of elderly people in Wiltshire placing a burden on care budgets, creating financial pressures and capacity issues for health and social care. We know that if this is not addressed, the impact will be felt by people of all ages.
- This was informed by the extensive provider engagement activities and Joint Strategic Need and as a result of this approach a number of interventions were deemed to be of limited effectiveness.
- The Wiltshire wide system review was commissioned to identify where services " breakdown " and what schemes should be commissioned.

Learning

- Greater emphasis could have been placed on benchmarking with other health and social care economies.
- Could of undertaken more specific clinical audits in a range of areas , this is being negated by recent involvement in the national Intermediate audit.
- Further engagement activities with patients and service users (as per the case for change) would assist in the identification of needs that are not currently highlighted (or which have emerged since) in the prior JSNA.
- In a commissioning environment of the near future based on outcomes, current priorities may change rapidly, although there has been little scope to test this hypothesis.
- Increased use of data (via CSU support) could be sought to provide critical challenge to the validity of aligning schemes to the JSNA.

Evidence

- Assumed reductions in finance in 2015-16 is £5.7m.
- Improve access to intermediate care step-up beds in community settings. 25 step up beds with average length of stay of 7 days. Assume admission avoidance of 25 patients per week x 85% occupancy. Risk adjusted for length of stay variance. This will reduce bed days by 940 per year.
- Improve access to intermediate care step-down beds- speed up discharge by 1 day per step-down patient. This will reduce bed days by 600 per year.
- Introduce Discharge to Assess – assume 3 discharges per acute hospital per week, shortening length of stay by 3 days per patient. Will reduce bed days by 1404 per year.

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4. Modelling the Impact of Interventions on Activity

Methodology

- The biggest impact is expected in year one of the BCF as the CCG and Council move to reduce the average length of stay experienced by patients.
- The CCG is planning for a reduction in the average length of stay by 20% (approximately 2 days). This will be achieved by improving the flow through the acute hospitals by enhancing the services on the front of the emergency system as well improving the discharge process through a series of targeted programmes such as Discharge to Assess .
- We would be seeking to get average length of stay down to targeted levels in 14/15 and then seek to maintain this during 15/16. We would be applying the same approach to our community beds to ensure we have improved flow, reduced delays and occupied bed days across the whole system.

Learning

- Ambition is considered to be moderate, given that schemes are expected to deliver against these criteria. There are a number of potential risks that require close scrutiny and mitigation (as outlined in our plan) in order to assure feasibility.
- The speed of change is rapid, given that this is a new way of working for both the CCG and Council, however the links established via the HWB are expected to allow length of stay targets in year one to be met.
- Use of clear risk sharing and governance arrangements will make achievement more viable.

Evidence

- The CCG and Council are also expecting to see a reduction in non-elective admissions of 3.5 % in 2014/15 and 3.5% in 2015/16.
- This is clearly profiled and outlined in appendix 2 of the BCF submission.
- The system will be applying a daily challenge and review of the data with the launch of the 100 day daily dashboard, this will enable tracking of the impact of new schemes , pressure on the system and ensure risks and issues are being managed in a more proactive way.

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4. Modelling the Impact of Interventions on Activity (Cont.)

Metric	Definition	% change 14/15	% change 15/16	What is the rationale for this target?	How will schemes contribute to this?
Non Elective Admissions	Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	-3.75%	-3.75%	Building on baseline activity and in reviewing growth and the type of admissions to hospital (acuity), it is believed there is a further opportunity to reduce admissions to hospital through a range of new schemes This relates to 1460 admissions in 2014/15 and 1416 admissions to be avoided in 2015/16	• Intermediate care scheme will reduce avoidable admissions with an enhanced focus on step up intermediate care • 7-day working, Rapid Response and Discharge Coordination scheme will support people who are in crisis and reduce avoidable admissions.
Residential admissions	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	2%	0%	Over the last few years there has been a decrease in permanent residential admissions and the aim is to make further improvements to get the system to a more sustainable position	• Intermediate care scheme will reduce permanent care home admissions with a focus on rehab and reablement • We will also be rolling out the discharge to assess programme in 3 localities across Wiltshire • Enhancing existing HTLAH arrangements
Delayed transfers of care	Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	-7%	-3%	There is a stated aim to reduce the average length of stay in each acute hospital by 2 days and this the % change in volume of delays required to achieve this	• Intermediate care scheme will reduce length of stay for non elective patients. • 7-day working, Rapid Response and Discharge Coordination scheme will improve discharge planning, reduce length of stay and increase weekend discharges. • Protecting Social Care Services scheme will reduce delayed transfers of care and maintain eligibility criteria and flow in the system. • Our flagship scheme for reducing delayed transfers of care is the Discharge to Assess Programme is being rolled out across each acute hospital

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4. Modelling the Impact of Interventions on Activity (Cont.)

Metric	Definition	% change 14/15	% change 15/16	What is the rationale for this target?	How will schemes contribute to this?
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	2%	0%	Resubmitted performance for this indicator for 13/14 and as a result the % increase in performance has been reduced to 2%	• Intermediate care scheme will improve outcomes of rehabilitation and reablement. • Protecting Social Care Services scheme will reduce long-term placements.
Patient/Service User metrics	% of patients who express satisfaction with integrated services	70%	85%	Local target has been developed	• Supporting communities to be more resilient scheme will improve patient and customer experience. • Service user feedback and involvement scheme will ensure all changes are based on views of patients and service users.
Local metric	% estimated diagnosis rate for people with dementia	55%	67%	Local target has been developed, previous years performance was at 44%	• A range of community services have been developed in partnership with the mental health provider, local GPs and community services • Dementia strategy launched at July HWB

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5. Translating the Impact into Financial Benefit

Approach to capturing financial benefits

Methodology

- We provided *estimates* of future performance, based on historical figures – depending on the metric, this is based either on historic average activity or a simple 'straight line' projection approach.
- Financial benefit will be monitored against plan through multiple data points such as:
  - Admission Avoidance data from Simple Point of Access.
  - NEL admission data from acute contracts.
  - Community bed days data.
  - Nursing home bed days data.
  - A&E attendance data from acute contracts.
  - Short stay admissions data from acute contracts.
- A planned Social Return on Investment (RoI) approach is also being considered to capture non-financial benefits and also to monetarise these through the use of proxies.

Learning

- Commenced the development of a return on investment toolkit at an earlier stage.
- Use of a social ROI is a worthwhile activity, particularly to shift the BCF plans to a focus on outcomes for patients/ service users. This has raised challenges that would be expected such as:
  - Time required to select appropriate proxy financial benefits.
  - Need for in-depth review and use of social ROI techniques affecting both health and social care.
  - Determination of financial savings applicable to social benefits that may not have been anticipated.
- As estimates of future performance have been relied upon, a future approach would benefit from a more sophisticated approach that reduces any dependence on straight line projections (ie a non-linear forecast).

Evidence

- The CCG is planning for a reduction in the average length of stay by 20% (approximately 2 days).
- The CCG and Council are also expecting to see a reduction in non-elective admissions of 3.75% in 2014/15 and 3.75% in 2015/16. This takes into consideration growth and converts to admissions in of 1460 admissions avoided in 2014/15 and 1414 admissions avoided in 2015/16 respectively
- The Council and CCG have developed a methodology and templates for assessing and monitoring RoI and this work is owned by the Better Care Governance Group. For each of the schemes, this includes, profiled and committed monthly spend along with benefits and KPI tracking by month.

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5. Translating the Impact into Financial Benefit (Cont.)

Contracting and provider sign-up plans

Methodology

- By grouping together multiple schemes, several organisations will be involved in delivering these initiatives.
- These will be managed through the following options:
  - Lead Provider Arrangement.
  - Alliance Arrangement.
  - Formal Joint Venture.
- Providers have been engaged through:
  - Health and Wellbeing Board and an event it hosted on the Better Care Plan and attended by Acute Trusts, Community Health Provider, Social Care providers, Mental Health provider and voluntary sector.
  - Wiltshire Care Partnership, the membership organisation for social care providers.
  - CCG's five year plan.
  - Wiltshire Healthwatch.
- The Better Care Plan also reflects a number of existing programme of joint work which have engaged with health, social care and voluntary sector providers as active participants:
  - Joint Health and Wellbeing Strategy.
  - CCG's Community Transformation Programme.
  - Workshop on a whole system workforce strategy.
  - Steering Board for the development of intermediate care services.

Learning

- The advantages and disadvantages of differing contractual methods could have been explored in more detail by:
  - Understanding the readiness of providers to manage particular contracts (eg Lead Provider) and the readiness of those sitting within the arrangement.
  - Recognition of the legal ramifications of each option, including exit strategies where appropriate.
  - Considering international examples of success and failure.
- Providers could be managed more effectively to an extent if the BCF plan is accompanied by clear articulation of the impact on provider sustainability, including:
  - How activity changes are likely to affect the provider income.
  - Potential benefits to provider cost base.
  - Impact on provider staff morale/ dependency on agency staff.