

Sustainability and Transformation Plan 2016-2021

Update for H&WBB May 2016

DRAFT

BSW footprint

- The BANES, Swindon and Wiltshire (BSW) plan is being led by James Scott, Chief Executive of Royal United Hospital in Bath, a position he has held since 2007. James will oversee and coordinate a team drawn from the leaders of each of the health and social care organisations included in our STP 'footprint' area. During this time, James will continue with his responsibilities as CEO of the RUH.
- The BSW plan brings together our three hospitals (Royal United Hospital, Great Western Hospital and Salisbury Foundation Trust), the three Clinical Commissioning Groups; BANES, Swindon and Wiltshire Councils, South West Ambulance Service and Avon and Wiltshire Mental Health Partnership Trust. The providers of our community services – Wiltshire Health and Care, SEQOL and Sirona and the Wessex Local Medical Committee (representing GPs from across the BSW area) complete our organisational grouping.
- Working together to cover a combined population size of approximately one million people, the BSW grouping will bid for and receive a transformation fund from 2017/18 onwards, which will be used to pay for health and social care services for people living in our area.

Contents

- Outline of national guidance – slides 4 – 10
- BSW draft STP submission – slides 11 - 23
- Swindon process slides 24 - 34

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The background of the slide features a photograph of two individuals, likely healthcare professionals, in a clinical setting. They are both wearing white lab coats. The person on the left is an older woman with short grey hair and glasses, looking down at a document. The person on the right is a man with glasses, also looking down. The image is overlaid with a semi-transparent blue geometric pattern. The main title is centered over this image in a large, white, sans-serif font.

Developing Sustainability and Transformation Plans

Preparing for 15 April and beyond

March 15 2016

STPs are an opportunity to develop a local route map to an improved, more sustainable, health and care system

44 STP footprints have been agreed

- Each will be convened by a local leader, backed by national bodies
- Footprints are not statutory boundaries – they are vehicles for collaboration
- Planning will still need take place at different levels - subsidiarity is a key principle

A good STP focuses on the big questions and early action

- Get going on some early actions rather than waiting for the plan to be complete
- As 'umbrella' plans, STPs can be a way of making sense of competing priorities
- Think about populations, not institutions or organisational form
- Spend time on identifying the practical opportunities and solutions, not endlessly debating the scale of the challenge

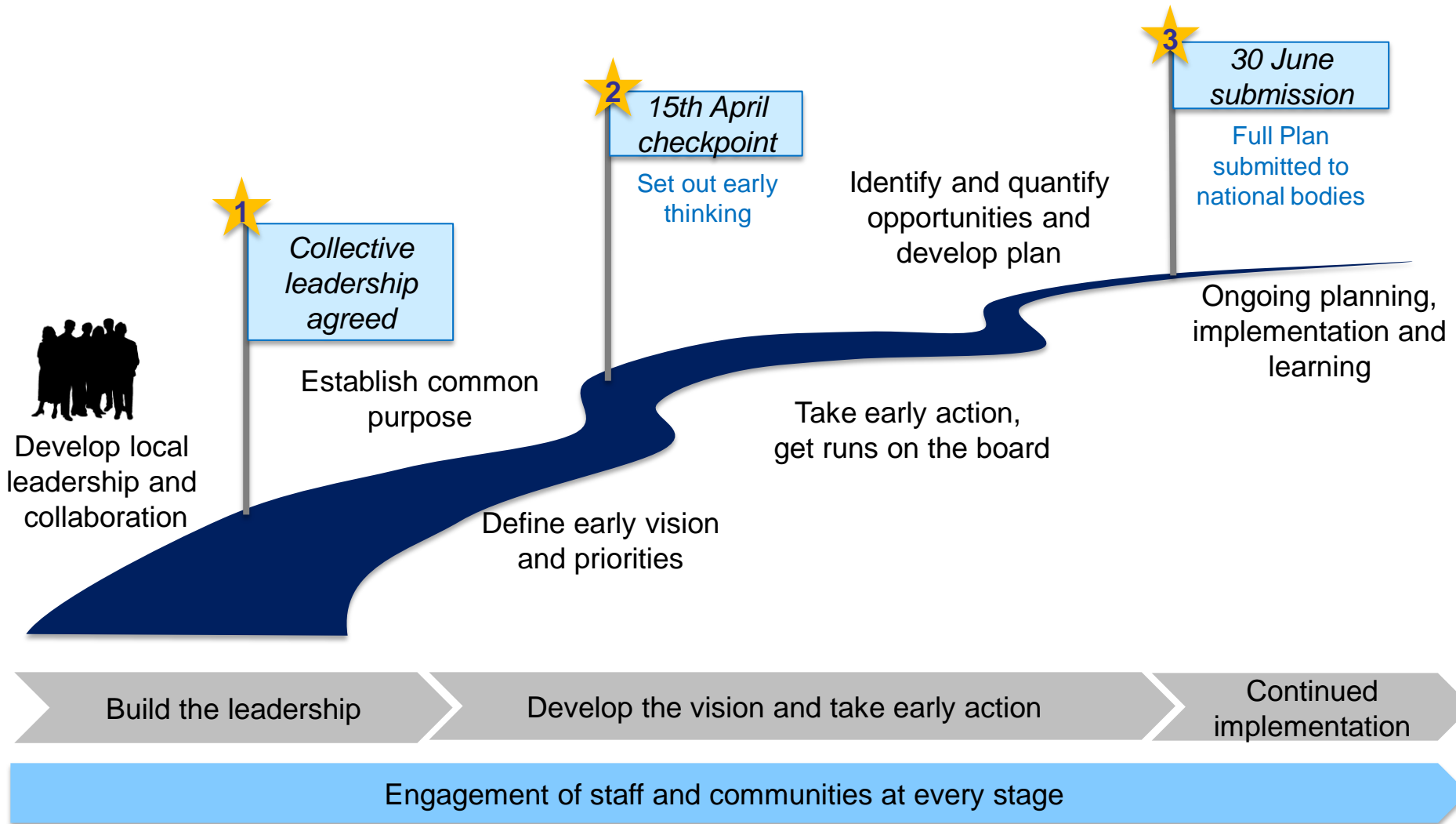
It won't be easy

- There will be technical challenges, e.g.
 - Cross-footprint flows and boundaries
 - Incentives that pull in different directions
- Non-technical challenges, e.g.
 - Building meaningful relationships
 - Freeing people to focus on the long-term
 - Moving quickly, whilst ensuring buy-in

This is an opportunity to build or strengthen relationships

- Across health, social care and local government – but also with patients, communities, staff and the voluntary sector
- STPs aren't all about writing the plan: building energy, relationships and collaborative leadership is even more important
- Trust and ownership is crucial for implementation

Overview of the process



The April 15th checkpoint: Summary

Each STP area is asked to make a submission by 15 April focusing on the following **two questions**:

- a. What leadership, decision-making processes and supporting resources you have put in place to make progress?
- b. What are the major areas of focus and big decisions you will need to make *as a system* to drive transformation?

A short template to fill in and submit to england.fiveyearview@nhs.net is provided in the annex.

Different areas will be starting from different places

- Many areas will have already undertaken considerable amounts of work. Where this is the case, you should of course build on this work – we are not asking areas to redo what they've already done, although there may be gaps to fill.

The April 15th checkpoint: agreeing areas of focus for your STP

A full STP will need to be underpinned by

- an understanding of your current major local challenges against the '3 gaps' (health and wellbeing, care and quality, and finance and efficiency);
- how those challenges are expected to evolve over the next 5 years in a 'do nothing scenario';
- emerging hypotheses for what is driving the gaps and therefore the action needed.

National priorities and local challenges

- The STP process is intended above all to be a process for partners across a footprint to work together to identify, agree and address significant challenges. **It is not a checklist exercise.**
- In order to support this effort, and drawing on commitments from the mandate to NHS England and the shared planning guidance, on the following pages we have set out 10 key areas where we know we need to make progress across the health and care system.
- Reflecting on these 10 areas, for the April submission we would expect footprints to be identifying key local priorities for transformation through the remainder of the STP process.

10 big questions – what are your priorities? (1/2)

Given your local circumstances, where do you need to focus in order to allow you to deliver the priorities for the health and care system by 2020/21?

- 1 How are you going to prevent ill health and moderate demand for healthcare?** Including:
 - A reduction in childhood obesity
 - Enrolling people at risk in the Diabetes Prevention Programme
 - Do more to tackle smoking, alcohol and physical inactivity
 - A reduction in avoidable admissions
- 2 How are you engaging patients, communities and NHS staff?** Including:
 - A step-change in patient activation and self-care
 - Expansion of integrated personal health budgets and choice – particularly in maternity, end-of-life and elective care
 - Improve the health of NHS employees and reduce sickness rates
- 3 How will you support, invest in and improve general practice?** Including:
 - Improve the resilience of general practice, retaining more GPs and recruiting additional primary care staff
 - Invest in primary care in line with national allocations and the forthcoming GP 'Roadmap' package
 - Support primary care redesign, workload management, improved access, more shared working across practices
- 4 How will you implement new care models that address local challenges?** Including:
 - Integrated 111/out-of-hours services available everywhere with a single point of contact
 - A simplified UEC system with fewer, less confusing points of entry
 - New whole population models of care
 - Hospitals networks, groups or franchises to share expertise and reduce avoidable variations in cost and quality of care
 - health and social care integration with a reduction in delayed transfers of care
 - A reduction in emergency admission and inpatient bed-day rates
- 5 How will you achieve and maintain performance against core standards?** Including:
 - A&E and ambulance waits; referral-to-treatment times

10 big questions – what are your priorities? (2/2)

Given your local circumstances, where do you need to focus in order to allow you to deliver the priorities for the health and care system by 2020/21?

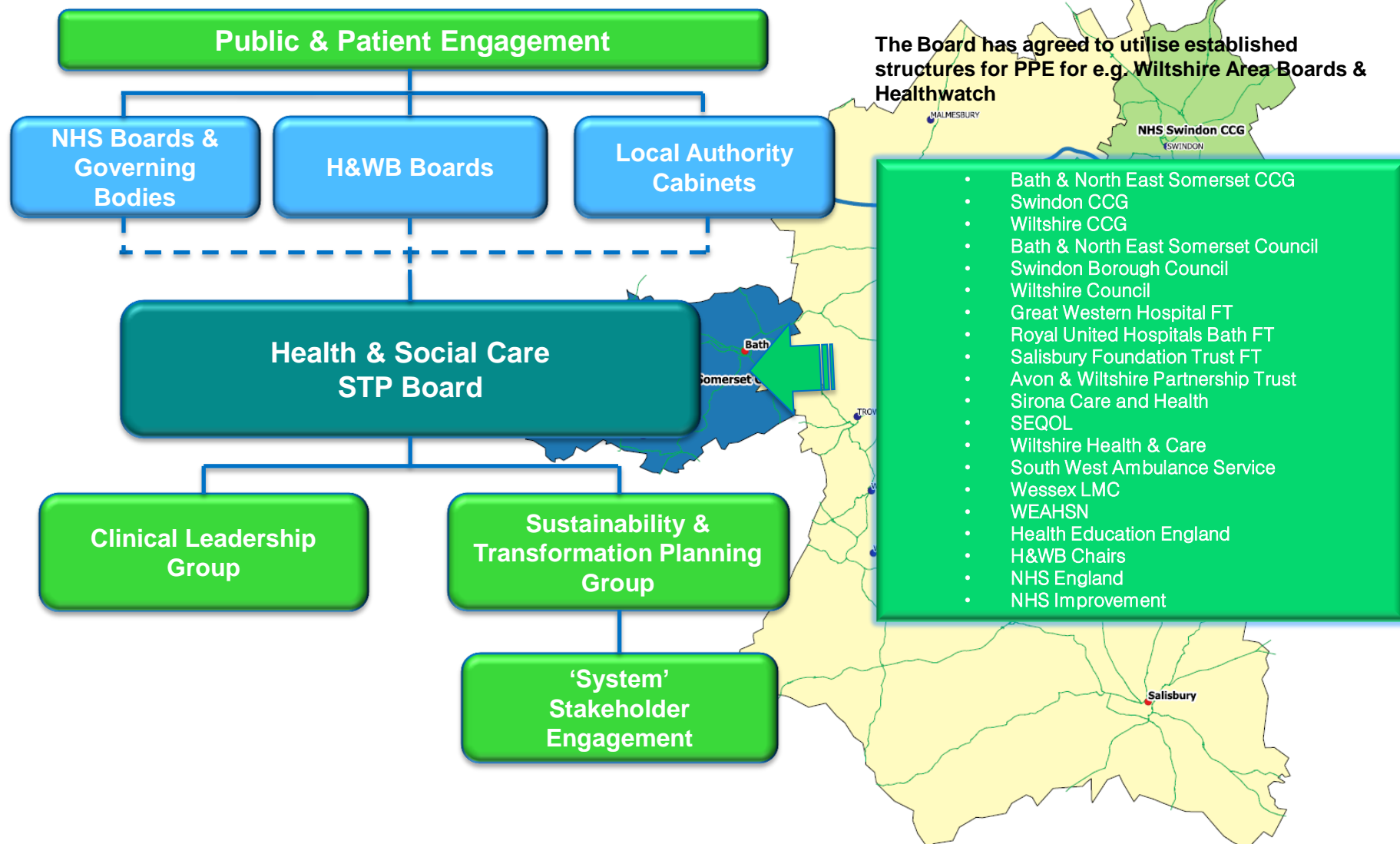
- 6 How will you achieve our 2020 ambitions on key clinical priorities?** Including:
 - Achieve at least 75% one-year survival rate (all cancers) and diagnose 95% of cancer patients within 4 weeks
 - Implement two new mental health waiting time standards and close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole, and deliver your element of the national taskforces on mental health, cancer and maternity
 - Improving maternity services and reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries
 - Maintain a minimum of two-thirds diagnosis rate for people with dementia
- 7 How will you improve quality and safety?** Including:
 - Full roll-out of the four priority seven day hospital services clinical standards for emergency patient admissions
 - Achieving a significant reduction in avoidable deaths
 - Ensuring most providers are rated outstanding or good– and none are in special measures
 - Improved antimicrobial prescribing and resistance rates
- 8 How will you deploy technology to accelerate change?** Including:
 - Full interoperability by 2020 and paper-free at the point of use
 - Every patient has access to digital health records that they can share with their families, carers and clinical teams
 - Offering all GP patients e-consultations and other digital services
- 9 How will you develop the workforce you need to deliver?** Including:
 - Plans to reduce agency spend and develop, retrain and retain a workforce with the right skills and values
 - Integrated multidisciplinary teams to underpin new care models
 - New roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice
- 10 How will you achieve and maintain financial balance?** Including:
 - A local financial sustainability plan
 - Credible plans for moderating activity growth by c.1% pa
 - Improved provider efficiency of at least 2% p.a. including through delivery of [Carter Review recommendations](#)

BANES, Swindon & Wiltshire draft STP submission

11 April 2016

DRAFT

Leadership, governance & engagement



Programme Infrastructure

Central Leadership Team

Senior Responsible Officer
James Scott

Programme Director
David McClay

Programme Assistant
TBC

Commissioned Packages - TBC

**Wiltshire
CCG**

STP Planning
Lead
David Noyes

**Swindon
CCG**

STP Planning
Lead
Tess Green

**BaNES
CCG**

STP Planning
Lead
Julie-Anne Wales

Workstream Leads

Health & Wellbeing Workstream

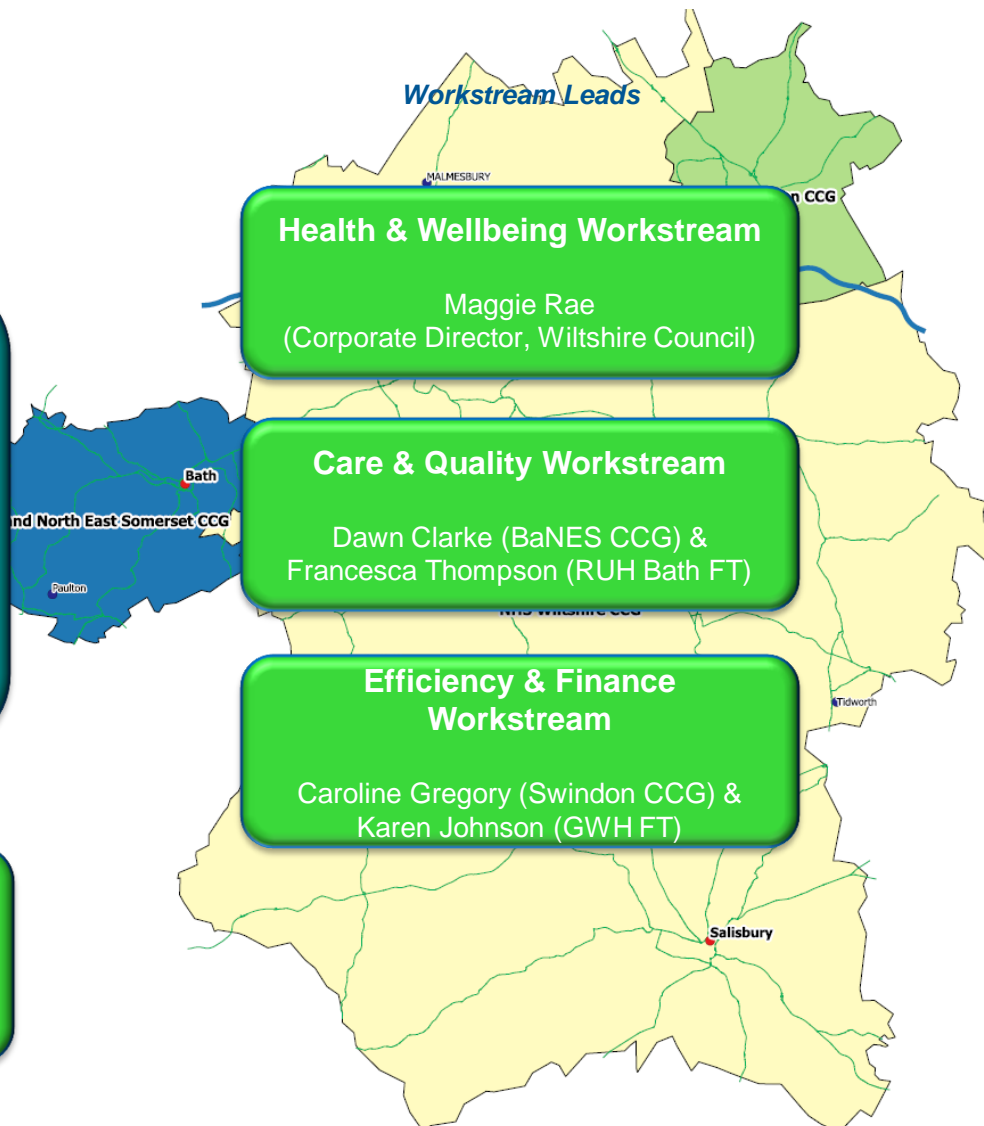
Maggie Rae
(Corporate Director, Wiltshire Council)

Care & Quality Workstream

Dawn Clarke (BaNES CCG) &
Francesca Thompson (RUH Bath FT)

Efficiency & Finance Workstream

Caroline Gregory (Swindon CCG) &
Karen Johnson (GWH FT)



Improving Health & Wellbeing (1/2)

Using Public Health intelligence the Health & Social Care STP Board has identified the current key priorities across the three commissioning localities on both prevention and narrowing the gap on Health Life Expectancy.

A key tenet of the plan will be the focus on providing focused, intensive services to those parts of our population that need them most.



Priority/Topic area	Swindon	BaNES	Wiltshire
Healthy Life Expectancy – narrowing the gap	<ul style="list-style-type: none"> Increasing the length of time and percentage of life spent in good health and reducing the inequality in life expectancy 	<ul style="list-style-type: none"> Focusing on groups with the worst outcomes (people experiencing deprivation, mental illness, disability) 	<ul style="list-style-type: none"> Increasing the length of time and percentage of life spent in good health is a key priority in closing the health and well-being gap
Prevention	<ul style="list-style-type: none"> Prevention of Long Term Conditions. Independent and active lives. 	<ul style="list-style-type: none"> Keeping prevention strong. Focusing on groups with the worst outcomes (people experiencing deprivation, mental illness, disability). Empowering people to look after their health 	<ul style="list-style-type: none"> Reducing early deaths from major causes of mortality; reducing child mortality; keeping people healthy, active and independent longer and improving people's quality of life.

Improving Health & Wellbeing (2/2)

Healthy Life Expectancy – Narrowing the gap

Life Expectancy and healthy life expectancy reflect the focus not only on how long we live, but also on how well we live, at all stages of our lives.

Increasing the length of time and percentage of life spent in good health is a key priority in closing the health and wellbeing gap.

Attention will be paid to the gap in healthy life expectancy between the most and least deprived areas, focusing targeted attention on areas of deprivation with poor health outcomes in addition to the provision of good quality universal services for all.

Prevention

A radical upgrade on prevention over the next five years will help to reduce early deaths from major causes of mortality; reduce child mortality; keep people healthy, active and independent longer and improve people's quality of life.

Intervening before the development of disease and disability through prevention is key to improving life expectancy and healthy life expectancy. Investment in improving the wider determinants of health will help achieve this.

Our belief is that patients and communities have a key role to play in achieving these outcomes and this will be set out within our June submission.

The following ten priorities have been identified by Public Health Intelligence teams and approved by the STP Board

H&WB 10 Priority Areas



Improving Care & Quality of Services (1/2)

Care & Quality Workstream

Lead nurses and senior quality representatives from across the footprint have identified the current major local challenges and have developed an emerging hypothesis on the causal factors.

Key themes are as follows:

- ✓ Ensuring the right number of people with the right skills are employed in the right place at the right time.
- ✓ Comprehensive redesign of urgent care services
- ✓ A need to maximise the value a patient / user derives from their own care and treatment.
- ✓ The need to make dramatic improvements in mental health services, and in particular in support for children, young people and their families.
- ✓ Strengthening primary care as an agent in reducing health inequalities.
- ✓ Comprehensive support for people with dementia, their carers, families and friends.
- ✓ Expand Personal Health budgets beyond CHC.
- ✓ Improve value through standardised pathways and systematic approach to quality improvement.

The following ten priorities have been identified by the Wiltshire Public Health Intelligence team and approved by the STP Board

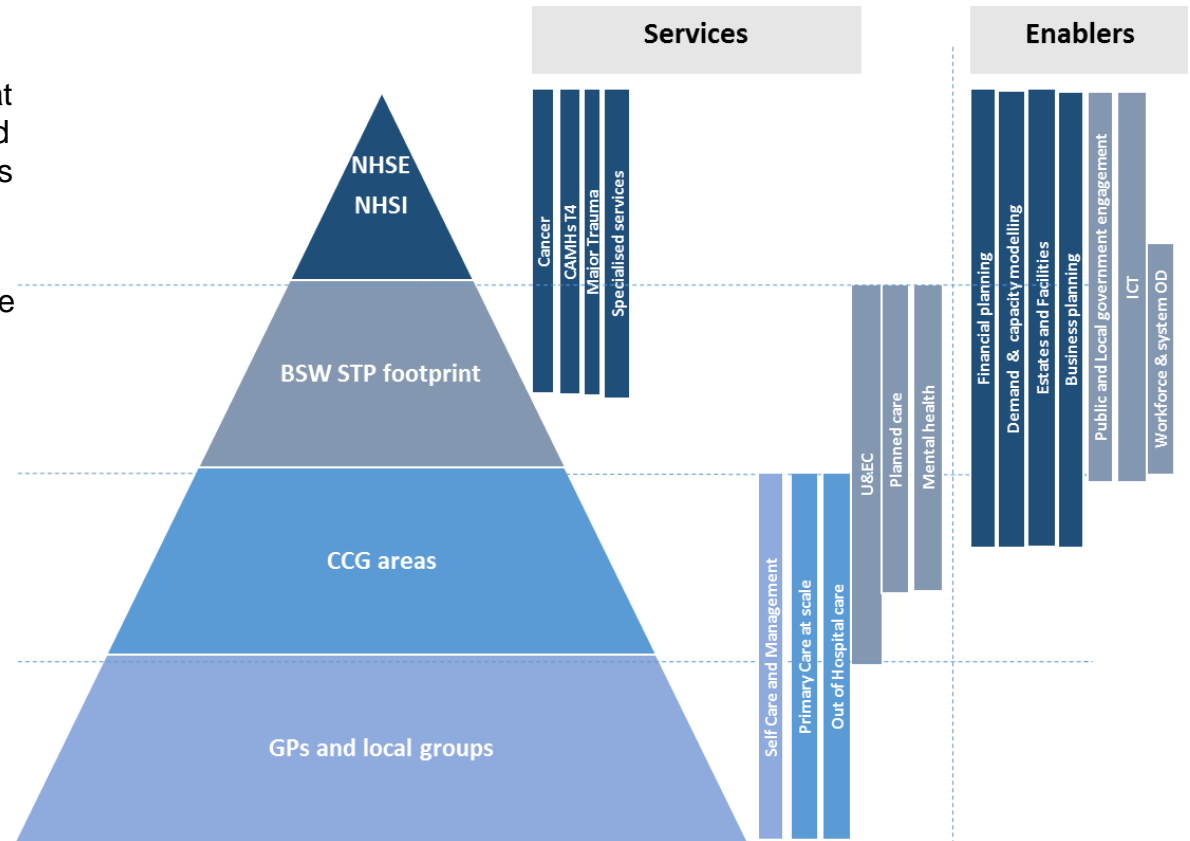
Care & Quality 10 Priority Areas



Improving Care & Quality of Services (2/2)

Intended approach

- This model looks to demonstrate that the national planning focus, STP and local priorities must be considered as a whole not as separate entities.
- The approach is layered to reflect the importance of place based planning and delivery balanced with opportunities to improve health outcomes, quality, and economics more effectively at scale.
- The diagram is colour coded to indicate at which layer planning and delivery should be led from.



Improving Productivity & Closing the Financial Gap



Bath, Swindon & Wiltshire STP

Financial Challenge facing Commissioners, Providers and Local authorities annually over the next five years is over £100m. Note, that local authority figures have not been included for 2020/21 because they work on a four year financial settlement.

Cumulatively, the STP system is looking at an overall financial pressure of £490m.

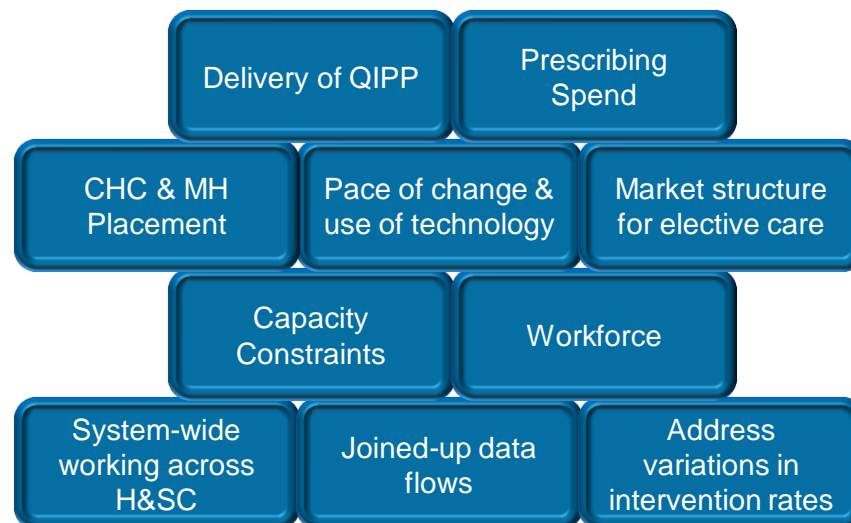
	2016/17	2017/18	2018/19	2019/20	2020/21	TOTAL
	£m	£m	£m	£m	£m	£m
Commissioners	30.40	22.54	21.34	17.62	8.51	100.41
Providers	51.21	45.41	51.83	53.45	33.20	235.09
Local authorities	31.63	37.54	48.64	37.19	-	154.99
	113.23	105.49	121.81	108.26	41.71	490.49

STP Financial Challenge Over 5 Years

490.49

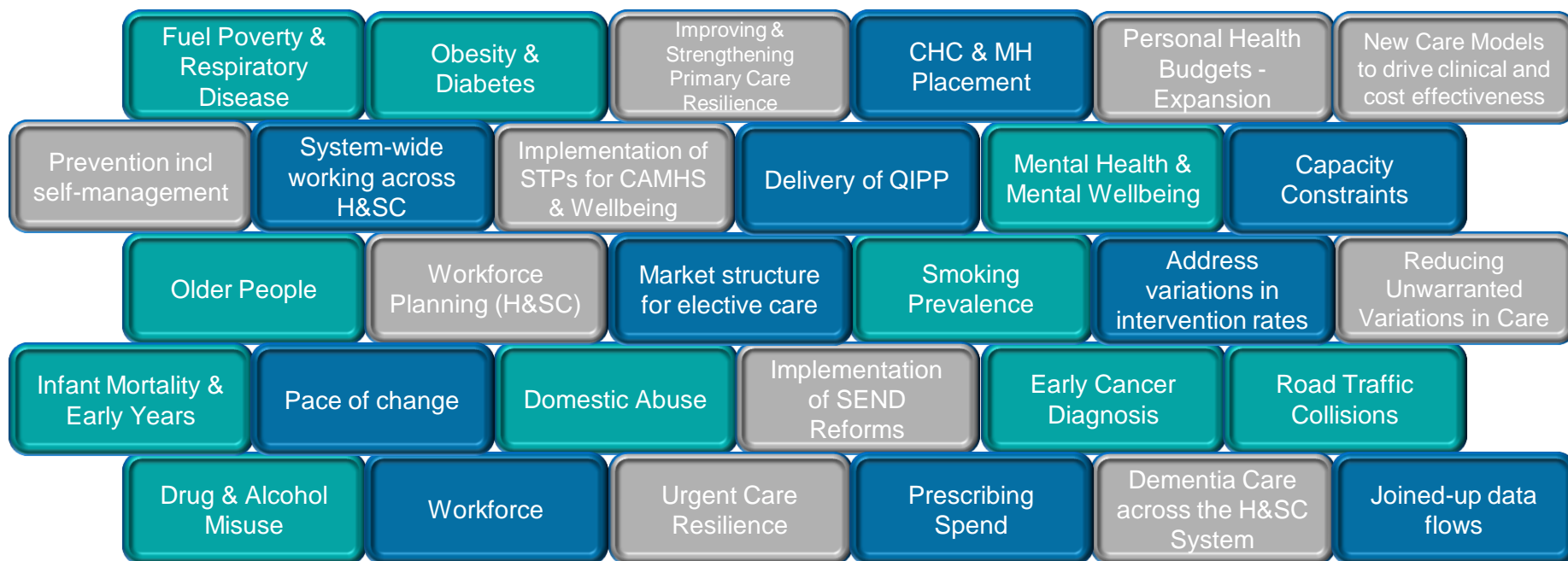
The following ten priorities have been identified by the finance teams across the footprint:

Improving Productivity & Financial Performance 10 Priority Areas



Emerging Priorities – the long list

Having identified and collated the top 30 emerging priorities, key member of the STP Board undertook a prioritisation exercise that sought to identify the high impact areas that would drive system improvement. The group also sought to combine and align priorities where it was prudent to do so.



Emerging Priorities – the short list

Obesity & Diabetes

Addressing childhood and adult obesity; promoting active and healthy lifestyles for the public and our workforce.

Workforce across the system

Workforce plans that address the strategic issues across organisational boundaries; reduction in agency; spread specialist skills across the system and address primary care challenges

Clinical & Cost effective new models of care

Redesigning models of care based on clinical and cost effectiveness (including Mental Health) as current models unaffordable; developing prevention agenda; reducing unwarranted variation; use of technology as fundamental enabler.

Capacity Constraints (inc capital)

Capacity & demand insight & real time monitoring; greater collaboration across the system in managing demand; developing comprehensive infrastructure plan.

Older People

Reducing isolation and focusing on aligning services focused at caring for older people; adding value – as defined by them; enhanced dementia care.

Urgent Care Resilience

Variations in patterns of admission for ambulatory care sensitive conditions; review quality and outcome measures used by SRGs

Social Care Capacity

Right-sizing social care capacity to enable users to be cared for in the most appropriate setting for their needs

Drug & Alcohol Misuse

Address underlying causes of drug and alcohol misuse; early support for users and integrated intensive support to those prone to admission.

Programme Priorities

Relationship building; cementing the infrastructure; goal alignment across the footprint; Developing a shared narrative on current and future state; Prioritising the priorities

10 Early Priorities for the Programme

1. Further liaison with Healthwatch and established engagement bodies to dovetail plans.
2. Detailed working with the AHSN to understand how we maximise their involvement in bringing innovative solutions to the patient safety challenges facing the footprint.
3. Engagement with statutory and non-statutory bodies to align and integrate agenda's, including assessing the offer of the Severn Urgent and Emergency Care Network (SUECN).
4. Undertaking / collating more detailed public health needs analysis to correctly identify sections / groups within our communities that require intensive input and high impact areas.
5. Mapping current interoperability plans / digital roadmaps to identify gaps and overlaps.
6. Defining optimal catchments for service planning and improvement – particularly for cancer pathways (building on the Cancer Alliance discussions).
7. Developing cohesion within the STP leadership team through facilitated sessions.
8. Establishing the overall programme infrastructure – including the working groups that will oversee our response to the 8 priorities, develop our communications strategy and formal approach to consultations.
9. Consideration of how we ensure STP agenda is woven into Board agenda's within the footprint to ensure strong governance links with STP Board.
10. Planning for clinical and stakeholder engagement events across May and June. Planning for wider community engagement event in June.

Emerging thinking – national and regional support

National barriers:

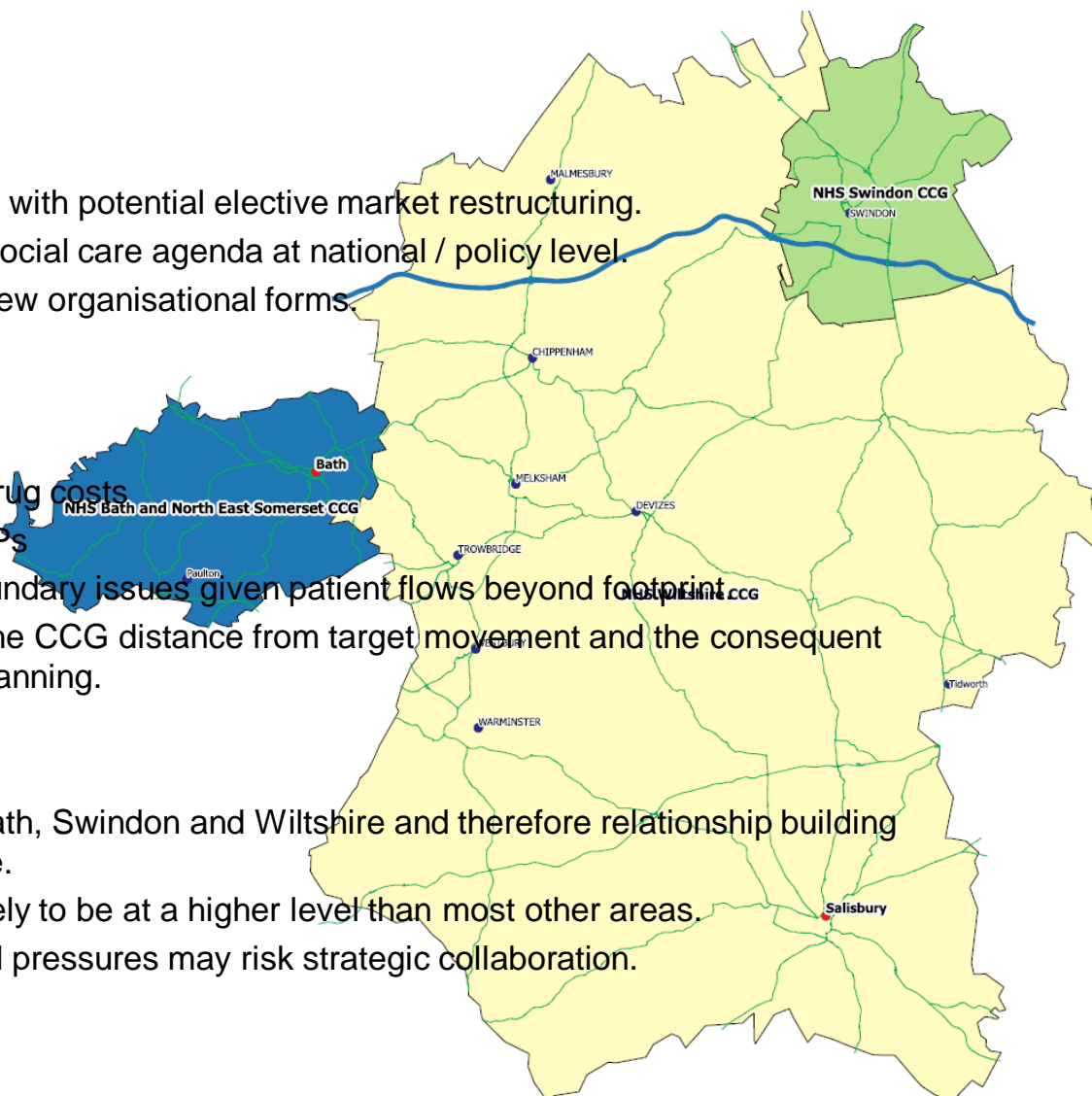
- Choice and procurement conflict with potential elective market restructuring.
- Closer alignment of health and social care agenda at national / policy level.
- Barriers to the development of new organisational forms.

Regional/National support:

- Spread of STP best practice.
- National progress on reducing drug costs
- Early clarity on future role of STPs
- Support / guidance on cross-boundary issues given patient flows beyond footprint
- The pace of change applied to the CCG distance from target movement and the consequent impact on short term financial planning.

Risks:

- STP is a new footprint across Bath, Swindon and Wiltshire and therefore relationship building and goal alignment will take time.
- June submission is therefore likely to be at a higher level than most other areas.
- Current operational and financial pressures may risk strategic collaboration.



Swindon Sustainability and Transformation Plan

Two workshops have been held to begin to develop a model of care for Swindon. The outputs from this are in the following slides.

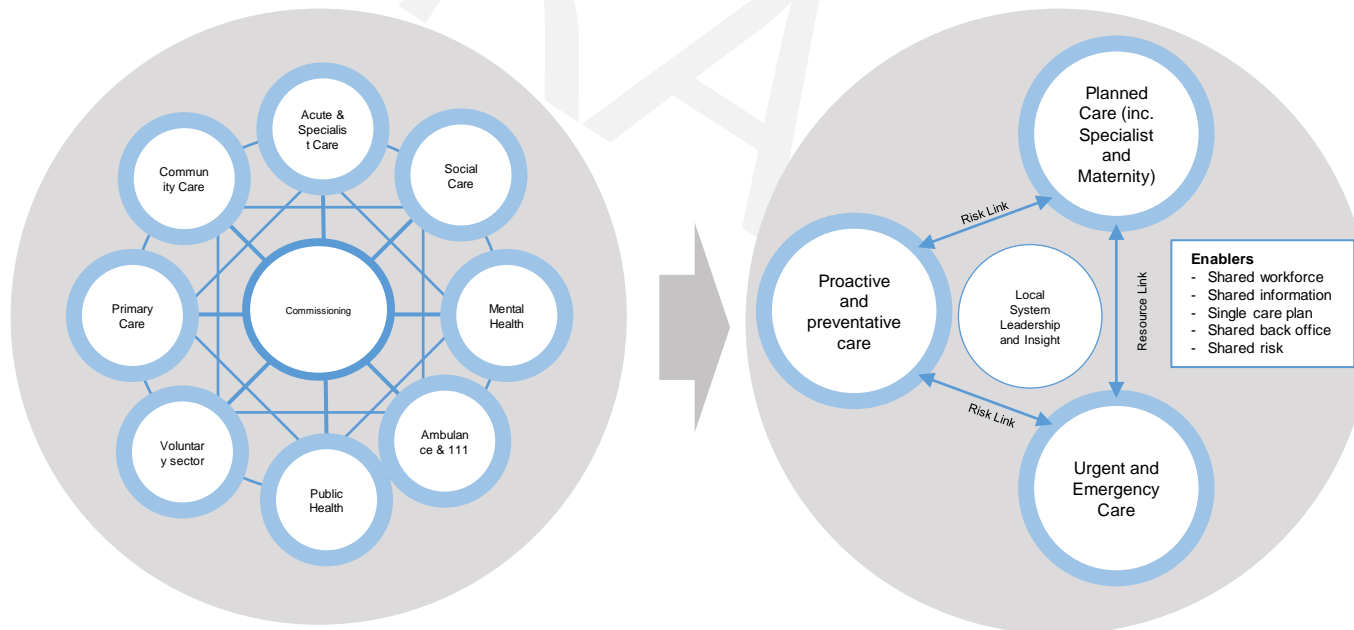
Adopting a whole system view for transformation

Traditionally the NHS has been organised around organisations delivering separate parts of a patient's pathway. Each organisation had control over part of the patient but not the whole. This system has been characterised by fragmentation and competing incentives. Swindon aims to adopt a whole system model that focuses on value. This will require us to develop a different model that is both coherent, integrated and focuses on population health and system value.

The diagram below summarises a shift in care that views population health and care needs through three lenses;

- Proactive and preventative – supporting patients to stay well and to manage their condition
- Urgent and emergency – incorporating the full range of urgent and emergency care it provides services when people need them most
- Planned care – (1) an optimised planned care services providing effective and efficient elective care and, (2) people being able to access services in a planned way through early interventions to prevent longer-term issues

There remains a need to provide local system leadership, insight and co-ordination. However, this will also need to change in order to delivery the local transformation required.



Five 'big shifts' were identified during the workshop

Focus on system value

System value can be defined as delivering improved patient outcomes and quality at a lower cost. There should be a single view of value across the system that cuts across organisational boundaries and reflects the true cost of provision. This includes sharing resources across organisations (such as a shared back office) and developing a system view of financial sustainability.

A population based approach to health and care services

Services should be organised around patients with similar needs. Budgets and payments should reflect this to enable the system to deliver greater value. Organisations, and care professionals, will have joint accountability for patient outcomes and are focused on prevention where possible. Lessons should also be drawn from the healthy towns model.¹

Care management supported by effective risk stratification

Risk stratification will be used to identify patients based on needs. Services will be tailored to each group. Those groups requiring greater support will be proactively managed. This would take place within neighbourhoods and enabled by separation of functions in primary care.

Integrated delivery supported by information and data

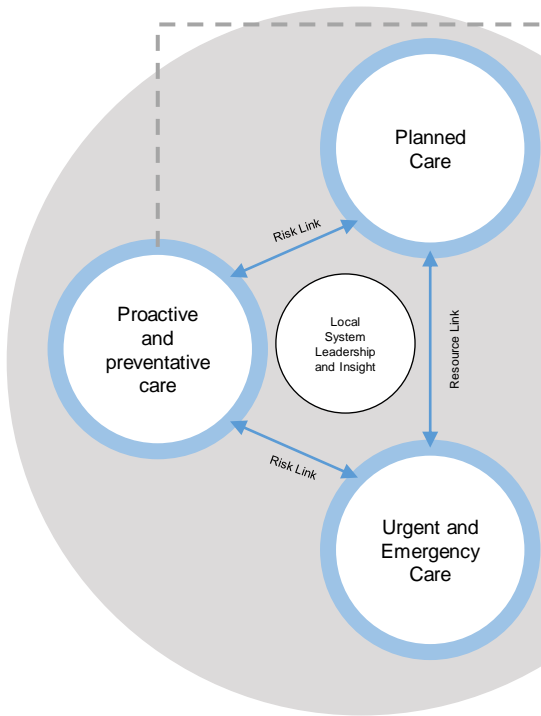
Patients – particularly those with complex needs – should be known across all parts of the system. In this model *no patient is unknown* to a provider. The ambition should be to move to an integrated workforce capable of supporting the different needs of patients who are working from a single, shared, care plan. This will reduce duplication, enable scarce resources to be directed appropriately and promote the shared ownership of patients. Achieving this will require a single source of information and enhanced means of communication across the system.

Simplify points of contact across the system

A joined up model of care will support patients to access the right part of the system when they need it. The aim will be to simplify the points of contact for the population, and support those who need it to navigate the system. This will be supported through the development of a single workforce across all settings of care.

1. <https://www.england.nhs.uk/ourwork/innovation/healthy-new-towns>

Proactive and preventative care



Proactive and preventative care focuses on keeping people well and providing ongoing support to those patients and service users who need it. Delivery is characterised by integrated teams that bring together different professionals involved in a person's care. This includes both health, social and other forms of care. This type of care will focus on reducing demand and pressure on more expensive parts of the system – namely the number of people going to A&E and/or hospital. If patients experience an emergency or need a planned procedure, the co-ordination of their care will continue through improved management and dialogue. It combines primary prevention (e.g. public health initiatives) and secondary prevention (e.g. case management for high-risk patients).

Key features:

- **Patient segmentation:** Patient cohorts will be segmented into coherent groups with similar needs. This will enable the appropriate provision of services to meet the needs of those groups. This will be supported by improvements in digital and informatics capabilities.
- **Management of complex patients:** Patients with complex needs will be proactively managed within primary care. This function will co-ordinate a patient's care and act as a single point of contact regardless of where the patient is in the pathway. This will be achieved by separating routine primary care – those patients who have a health need but are otherwise healthy – and those patients who need extra management and support.
- **Drawing on a range of community assets to support patients with different needs:** Ability of health and care professionals to draw on a range of community based assets and resources to help people live healthy lives. This will be supported by a comprehensive director of services and stronger local communities that can be self supporting.
- **Underpinned by self-management:** Across all contact points, patients will be encouraged and supported to manage their condition. This will be a key focus for those professionals proactively managing complex patients.
- **Multi-disciplinary teams focused on delivering services around the patient:** Further integrate teams to support the full range of patients needs both before and after a hospital admission. This will include the integration of social care.
- **Prevention initiatives will underpin delivery:** Primary prevention initiatives focusing on issues such as child obesity and the wider determinants of health will be delivered across Swindon. Local providers will understand these services and proactively recommend these to different patient groups.

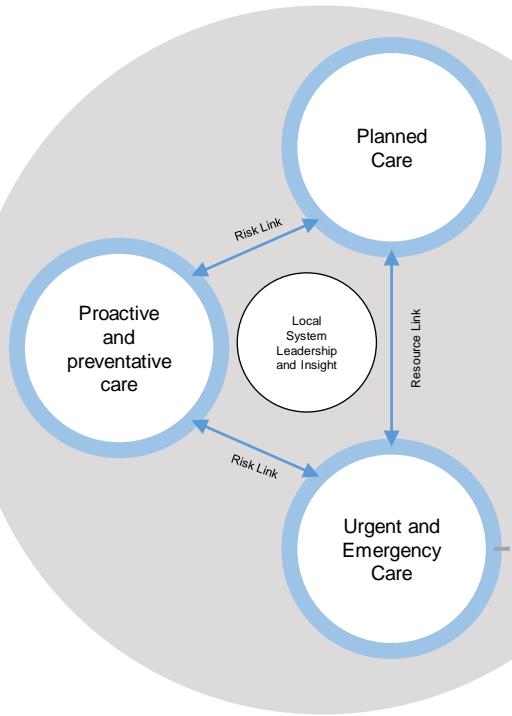
Enablers:

- Primary care operating at scale to provide sufficient workforce and capacity to meet additional needs
- Enhanced out of hospital estates centred around primary care / out of hospital hubs / campuses
- Risk stratification and segmentation tools
- Digital and shared workforce
- Integrated social care

Further areas/ questions for consideration:

- Plan for primary care at scale and estate to support separation of functions
- Population segmentation methodology
- Contracting and performance
- Investment in IT and risk stratification
- Practical integration of social care

Urgent and Emergency Care



Further areas/ questions for consideration:

- Plan for primary care at scale and OOH estates plan
- How to integrate U&EC services particularly those services across boundaries
- Development of the hospital 'front door'

Urgent and Emergency Care (U&EC) is a fundamental component of the NH. However, its use should be seen as a failure of the local health system to keep patients well. While proactive and preventative care aims to reduce demand for these services, patients will continue to experience crises. Therefore, patients should have access to the appropriate support when they need it. The high-cost of these services means that duplication should be avoided. Access should be simple and reflect the national direction for U&EC facilities and the move towards integrated delivery.¹ Overall, we should expect to see peoples reliance on this part of the system reduce over time.

Key features:

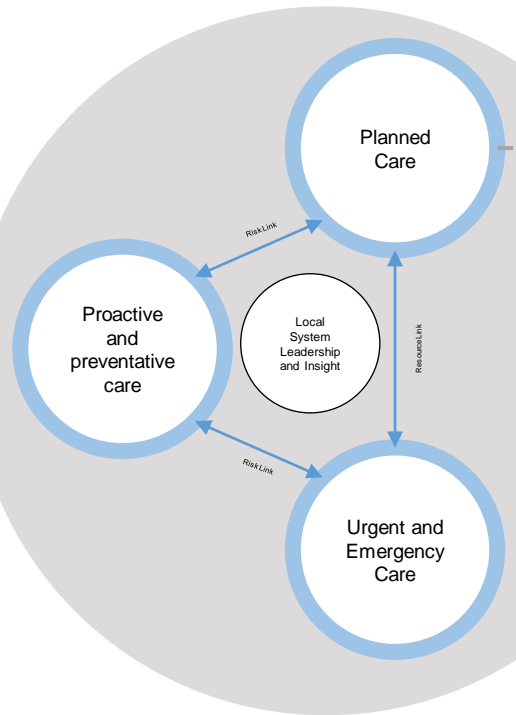
- **Coordinated U&EC provision:** Integrated and joined up Urgency and Emergency system bringing together existing resources under a common governance. This includes Pharmacy.
- **Simplified access:** Patients should be given clear messages about how to access care in a crisis. At the same time access points across the system should be clear. In this context Using A&E physical locations as a legitimate way to access a range of services is viewed as a positive way to use existing assets and streamline provision – although patients will need to be effectively 'streamed' at the front door.
- **Improved access in primary care:** Patients will have increased access to appointments in primary care. Patients in each neighbourhood will have access to extended hours throughout the week facilitating on-the-day appointments. Where appropriate, these will be located in hubs/campuses across Swindon including the hospital. This will help to move decision-making nearer the patient and break down barriers between organisations.
- **Integrated IT and communication:** IT should be integrated across settings enabling instant access to information on patients – particularly those with complex conditions. This will enable each setting to identify complex patients and enable effective communication between teams.
- **Access to specialist opinion, advice and support:** In order to prevent unnecessary admissions or A&E attendances, some health and care professionals will need access to specialist advice and opinion. This should be supported by integrated health records and care plans – particularly for higher risk patients.
- **Identifying which U&EC services should be provided at scale:** Some urgent and emergency care should be delivered at scale across CCG boundaries. This could include Ambulance services and 111. Where this is the case these services will need to be integrated into the local U&EC network.
- **Supported by efficient flow through the system:** A focus of the system will be to ensure patients move through the system as efficiently as possible. This will result in more time spent out of hospital.

Enablers:

- Primary care operating at scale to provide enhanced access
- Passport of training (e.g. I am an advanced nurse and can practice here and everywhere)
- Communication and education

1. <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>
<http://www.nhs.uk/NHSEngland/keogh-review/Pages/published-reports.aspx>

Planned Care



Further areas/ questions for consideration:

- Development of a single workforce
- Opportunities for delivering lower costs services (workforce, estate?)
- What, if any, planned care services should be delivered at scale beyond Swindon?
- How to improve productivity (across whole system)

Planned Care will be delivered as effectively and efficiently as possible, underpinned by effective co-ordination across the system. Patients will be supported in the most appropriate setting with high-levels of patient satisfaction and only interact with the 'system' for as long as is clinically required. At the same time patients will be supported to access their care in a planned way through earlier intervention where appropriate

Features:

- **Adopting an effective client management system:** This will co-ordinate patients' care across the system and along the planned care pathway.
- **Shared understanding of thresholds across the system:** Mechanisms need to be in place to push back on inappropriate referrals and increase understanding of referrals – this will include education, advice and training rather than referral management centres.
- **A focus on outcome:** Using aids such as a patient decision tool, health and care professionals will work with patients to consider the most effective and appropriate intervention to help them achieve their preferred outcome.
- **Planned and co-ordinated discharge:** Care should be provided seamlessly via end-to-end integration of care from the point of referral through discharge and recovery.
- **'In-reach' supported by a single workforce:** When patients find themselves in hospital, workforces from across the system should be able to access them. This will be supported by the concept of an '*NHS Swindon workforce*'.
- **Early intervention:** Patients will be supported to access planned care earlier in the pathway where it will help them achieve their preferred outcome and reduce longer term consequences of their condition
- **Shifting unplanned to planned care:** Patients and service users should be supported to access the system in a planned way through earlier intervention and improved management of conditions.
- **Prioritising resources:** Develop a shared understanding of resources, services and initiatives across the system. This will inform decision-making about what to prioritise for patient groups.

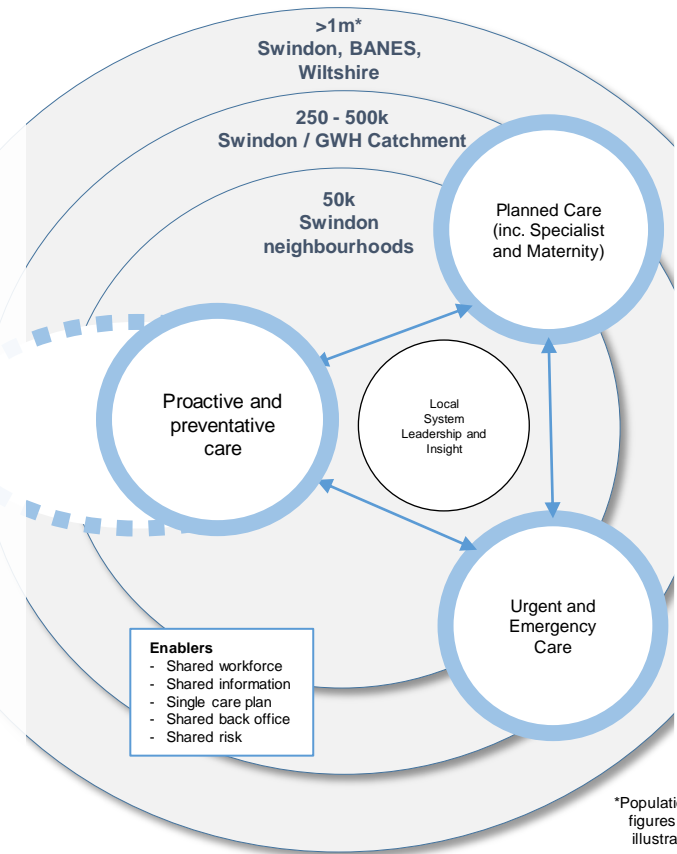
Enablers:

- Dialogue between settings of care to manage referrals
- Review thresholds for some services
- Effective care plans
- Patient decision tools focused on outcomes

Services will be aligned to different geographies

A place-based model suggests that care needs to be organised around different geographies and population groupings. This reflects the need to deliver local, joined up care for different patient groups as well as the need to manage some services across a wider geography due to scarcity of resources, workforce or demand. This page considers the different levels of provision that may be required within Swindon and across neighbouring geographies.

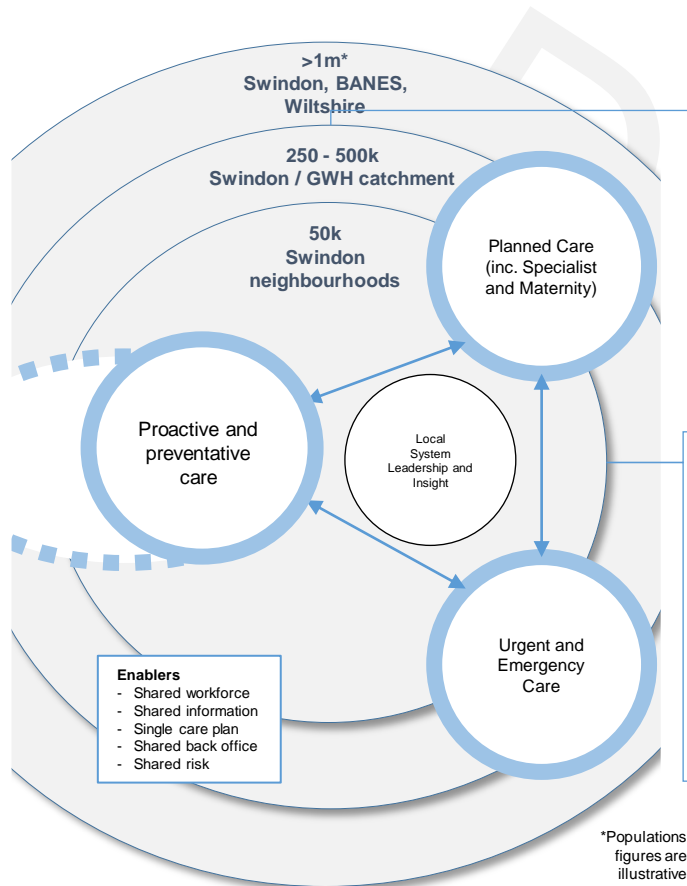
- Tier 1: circa 50,000 population:** The majority of health and care provision will be organised around populations of around 50,000. This will support a patient-centric model and enable care management and co-ordination for complex patients. Evidence¹ suggests that this size of population enables services to be delivered at some scale whilst enabling a personalised patient experience. At the same time, this scale enables alternative payment models to be used if required². Some U&EC care will take place at these levels including access to pharmacy and WICs or UCCs. While care is delivered within neighbourhoods there should be standardisation across system (tier 2) in terms of segmentation, access and links to broader services.
- Tier 2: circa 250,000 - 500,000 populations:** At a scale of circa 500,000 the majority of planned care and U&EC services will become viable although some service may still operate as a hub and spoke model with neighbouring hospitals. While services are delivered at this scale they should be fully integrated with other areas of provision.
- Tier 3: Over 1m population:** Some services, as is currently the case, will need to be delivered on a much wider scale. This would include tertiary services where complexity and volume require such a scale. It may also include specialist/acute Mental Health services and Ambulance Services. In addition, some preventative/public health services will take place across the wider geography.
- System leadership and delivery architecture:** Systems will need to develop a single delivery architecture that operates across these tiers. A single delivery architecture will enable organisations to fully utilise the assets, tailor services for different populations and enable feedback loops between settings of care. There are a number of mechanisms to achieve this; for example, Alliances and Accountable Care organisations.



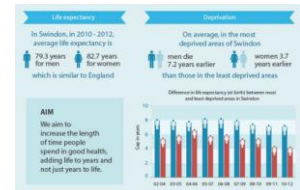
1. For example Patient Centred Medical Homes in the USA

2. <https://www.gov.uk/government/publications/supporting-innovation-in-the-nhs-with-local-payment-arrangements>

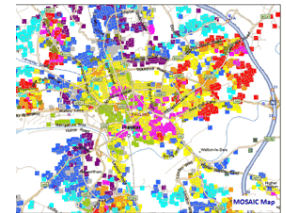
Population needs will be mapped at different levels within Swindon



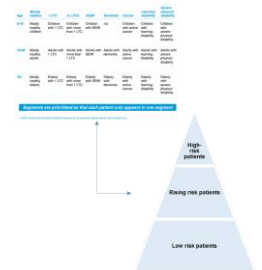
Population health and wellbeing: There is a developed understanding of health and wellbeing needs across the population. Factors include clinical and care needs, demographic and behavioural. This will draw on existing material just as the JSNA (<http://www.swindonjsna.co.uk/>). and reflect the wider planning footprint as required. An understanding of service usage and patient flow across Swindon and the wider footprint will also support planning.



Neighbourhoods informed by demographic analysis: Using Mosaic analysis it is possible to identify a number of distinct neighbourhoods around which care can be organised. At a system level care can be prioritised based on need and flexed to respond to changes in over time. Within these neighbourhoods people will have different needs, behaviours and wants. This can be used to inform the allocation of resources based on need.

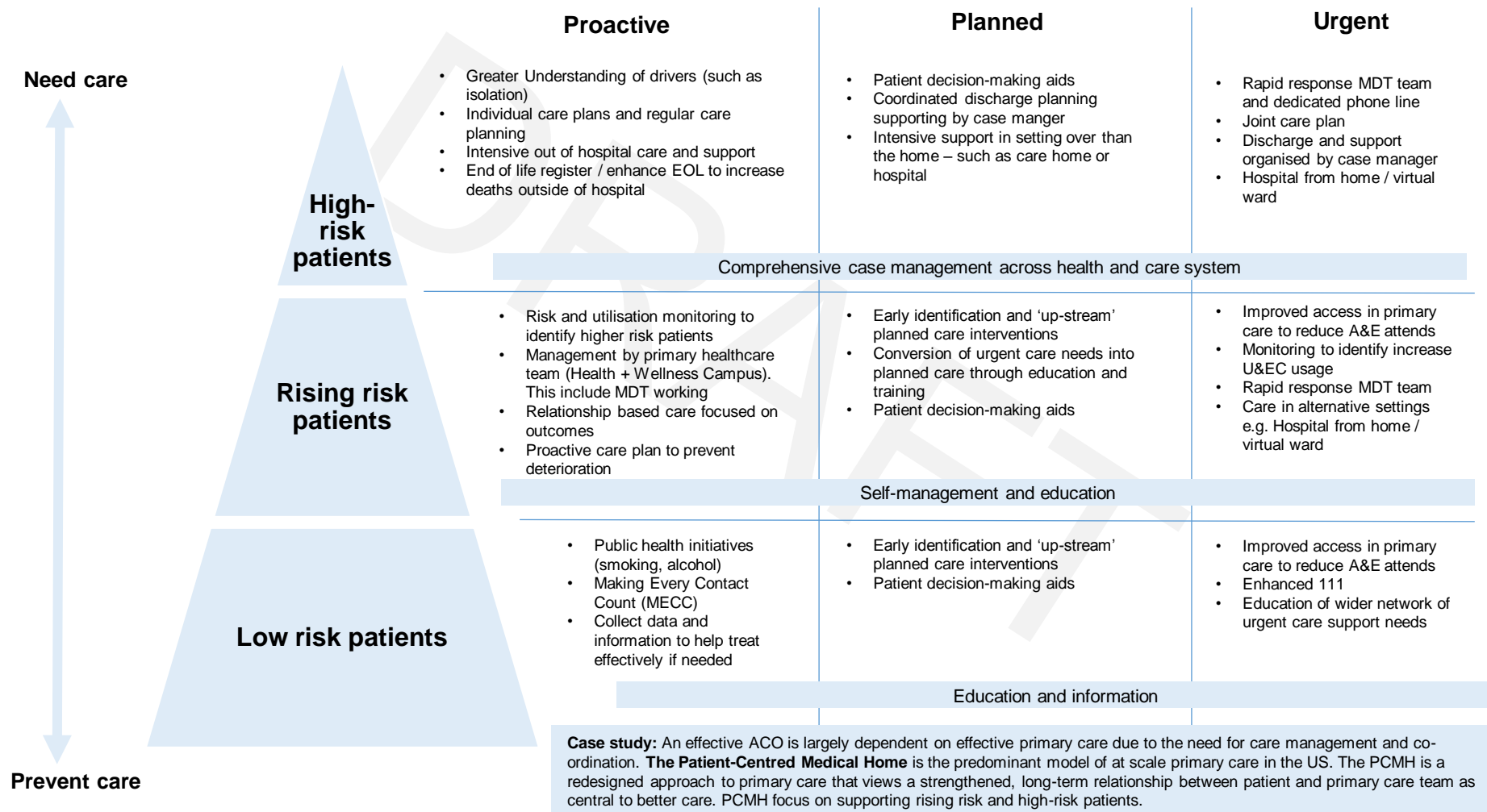


Patient segmentation to identify high risk/cost people: A consistent approach to population/risk segmentation will be developed across Swindon and used by all parts of the system/network. Patients will be risk



Neighbourhoods will be responsible to planning care for these individuals based on need. Segmentation looks at the drivers of need as well as current/recent usage

Attendees at the workshop considered the different needs for each group



Key features of enabling programmes

Workforce

- **Develop a single workforce:** Establish as single workforce across organisations. In the immediate term this may be 'virtual' but overtime may become more integrated.
- **A system workforce plan:** Collectively identify new roles across the system as well as training needs of the existing workforce to deliver the new models of care.
- **Increase access and communication:** Establish a culture of shared access and communication across the system. This will enable in-reach into acute settings and support in the community

IM&T

- **Shared analytics:** Develop a shared approach to management information and reporting. This includes the development of shared definitions and data gathering
- **Single view of population:** Develop a single view of the population that is shared across organisations to enable effective management of risk
- **Interoperable IM&T:** Develop an interoperable system that enables each part of the system to access real-time information

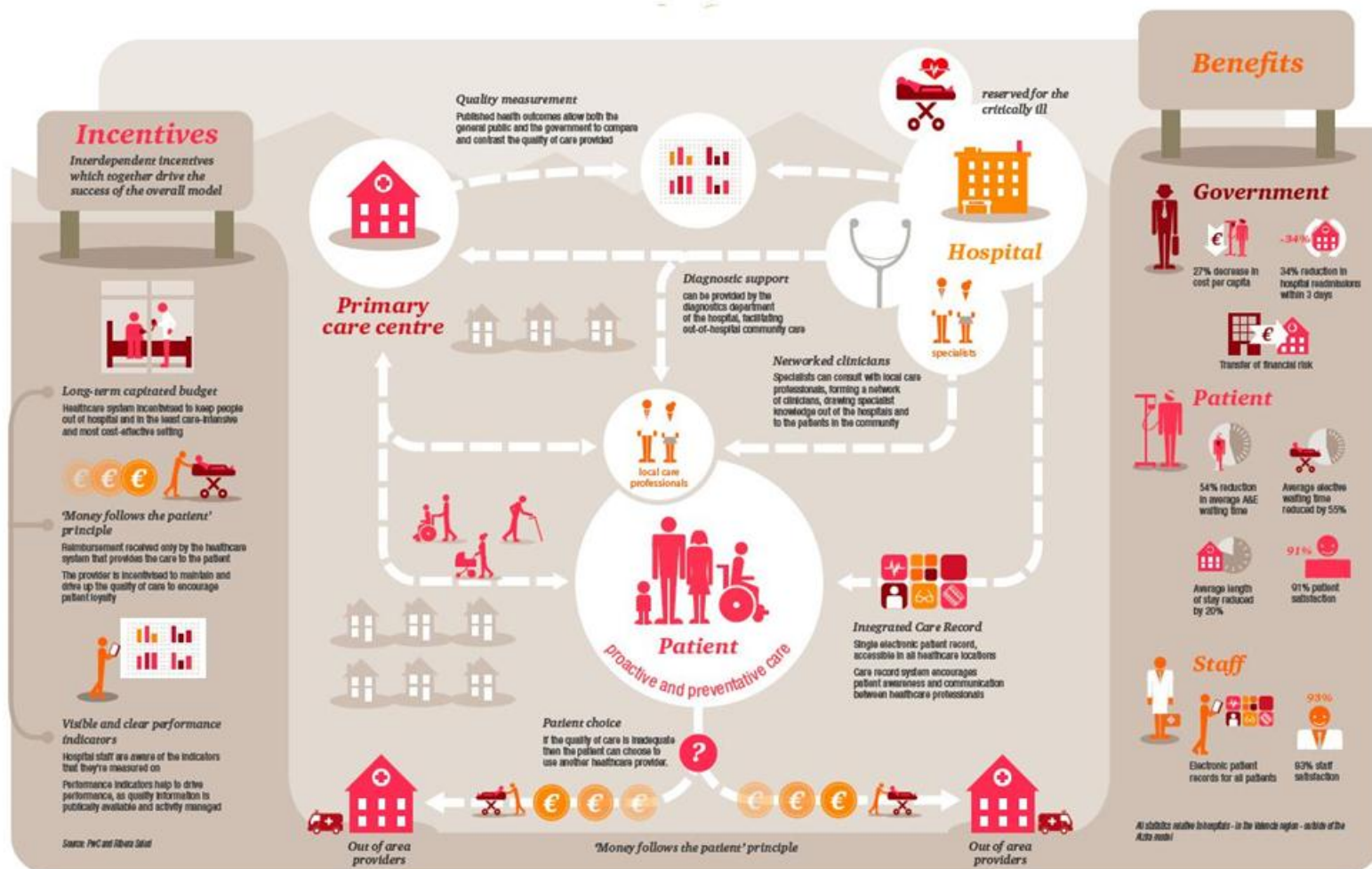
Estates (note – not discussed at workshop)

- **Shared understanding of capital investment:** Take a place-based view on capital investment decisions so that they optimise the existing health and care estate
- **Understand the current estate:** Understand the existing estate across the health and public service economy to inform decision-making. Development of health campus model across a number of acute and primary care sites.
- **Adopt a flexible approach to estates:** Consider how to use estate flexibly to optimise overheads and provide the right care across Swindon, recognising the need to optimise the use of the estate on the GWH site to ensure use of PFI financed facility is maximised.

Finance and commissioning

- **Align incentives to promote prevention:** Develop ways to change incentives in the system through alternative payment and reward mechanisms. This should flow through organisations and workforce
- **Joint financial planning:** To agree priority investments that benefit the system. This would form the basis of a place-based budget reflecting the need to demonstrate system financial balance.
- **Understand system baseline:** Collectively establish and agree the system baseline. Identify fixed and variable costs in the system

The aim should be to develop a coherent model focused on outcomes and value



Next steps for Swindon

A number of actions need to take place in the short-term to build on the principles and vision set out above.

Planning

- Develop a 5-year road map to accountable care organisation and new models of care
- Develop appropriate working groups to develop STP in key areas
- Establish joint team to focus on the work of the system

Model of care

- Further define the model of care – in particular an outline model for ‘health campus’ and primary care at scale that includes a description of the enablers required to support it