



Version 8 : 25 4 2016

## Better Care Fund planning 2016-17

### 1) PLAN DETAILS

#### a) Summary of Plan

Local Authority	<b>Swindon</b>
Clinical Commissioning Groups	<b>Swindon</b>
Boundary Differences	<b>CCG area covers Shrivenham, the community health services for Shrivenham are excluded from this plan</b>
Date agreed at Health and Well-Being Board:	<b>March 2016 by Chair of Health and Wellbeing Board</b>
Date submitted:	<b>21 March 2016</b>
Minimum required value of BCF pooled budget 2016-17	<b>£12,150,000 CCG contribution £897,000 LA contribution</b>
Total agreed value of pooled budget 2016-17	<b>£14,458,700</b>
2016-17	<b>£12,150,000 CCG contribution £2,308,700 LA contribution Total £14,458,700</b>

#### b) Authorisation and sign off

<b>Signed on behalf of the Clinical Commissioning Group</b>	Swindon CCG
<b>By</b>	Dr Peter Crouch
<b>Position</b>	Clinical Chair
<b>Date</b>	March 2016

<b>Signed on behalf of the Council</b>	Swindon Borough Council
<b>By</b>	Cllr Brian Mattock
<b>Position</b>	Deputy Leader of the Council
<b>Date</b>	March 2016

<b>Signed on behalf of the Health and Wellbeing Board</b>	Swindon
<b>By Chair of Health and Wellbeing Board</b>	Cllr David Renard

<b>Date</b>	March 2016
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**c) Related documentation**

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

<b>Document or information title</b>	<b>Synopsis and links</b>
Health and Wellbeing Strategy	Statutory Plan to improve the health and well-being of the people in Swindon <a href="http://www.swindon.gov.uk/sc/sc-healthmedicaladvice/Pages/sc-healthmedicaladvice-Health-and-Wellbeing-Strategy.aspx">http://www.swindon.gov.uk/sc/sc-healthmedicaladvice/Pages/sc-healthmedicaladvice-Health-and-Wellbeing-Strategy.aspx</a>
JSNA 2013-2022	Joint Strategic Needs Assessment for Swindon <a href="http://www.swindonjsna.co.uk/">http://www.swindonjsna.co.uk/</a>
One Swindon	The Community Strategy and Vision for Swindon <a href="http://www.oneswindon.org.uk/cs/Pages/default.aspx">http://www.oneswindon.org.uk/cs/Pages/default.aspx</a>
Adult Care Strategy	Our strategy for managing demand for adult services <a href="http://ww5.swindon.gov.uk/moderngov/mgConvert2PDF.aspx?ID=46045">http://ww5.swindon.gov.uk/moderngov/mgConvert2PDF.aspx?ID=46045</a>
Strategy for care (CCG)	The vision how care and support needs to change to improve the health of people in Swindon <a href="http://www.swindonccg.nhs.uk/media/file-browser/Swindon%20CCG%20Strategy%20for%20care.pdf">http://www.swindonccg.nhs.uk/media/file-browser/Swindon%20CCG%20Strategy%20for%20care.pdf</a>
CCG One Year Operational Plan 2016/17	Swindon CCG Operational Plan 2016/17 <a href="http://www.swindonccg.nhs.uk/index.php/list-of-events/attend-a-governing-body-meeting/governing-body-papers">http://www.swindonccg.nhs.uk/index.php/list-of-events/attend-a-governing-body-meeting/governing-body-papers</a>
Joint Commissioning Intentions and update 2015/16	Swindon Health & Wellbeing Board meeting 27 <sup>th</sup> May 2015 <a href="http://ww5.swindon.gov.uk/moderngov/ieListDocuments.aspx?CId=933&amp;MId=6849&amp;Ver=4">http://ww5.swindon.gov.uk/moderngov/ieListDocuments.aspx?CId=933&amp;MId=6849&amp;Ver=4</a>  Health & Wellbeing Board Meeting 9 <sup>th</sup> December 2015 <a href="http://ww5.swindon.gov.uk/moderngov/ieListDocuments.aspx?CId=933&amp;MId=6889&amp;Ver=4">http://ww5.swindon.gov.uk/moderngov/ieListDocuments.aspx?CId=933&amp;MId=6889&amp;Ver=4</a>

## 2) VISION FOR HEALTH AND CARE SERVICES

- a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20
- b) What outcomes are we striving to achieve?

We have combined the requirements for section a and b in the following analysis and description of our vision

### 1. Vision

Our joint vision for people in Swindon is enshrined in the Health & Wellbeing Strategy

***To ensure that everyone lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities***

***Our plan supports the CCG mission***

***To optimise the health of the people of Swindon and Shrivenham***

We have aligned our joint resources to support the health, wellbeing, mental health, education and care of children, families and adults in the community to achieve the mission of both organisations.

This Plan is also aligned with the work being progressed by the One Swindon Board.

We have been involved in discussions with the public, patients, GP practices, providers, voluntary sector, other stakeholders, children and young people, and the Youth Forum in the development of the documents referred to above. The Better Care Fund Plan is a summary of jointly agreed areas of priority. Specific service redesign workshops were held on mental health, carers and community based support for older people.

Service users stated that their priorities are:

- Improved advice and information about services for carers and parent carers
- A simplified assessment process for service users and carers
- Community support for people discharged by specialist mental health services and a seamless link between voluntary and third sector providers and specialist services
- Support for older people who are isolated
- Improved patient flow within the hospital discharge process

The findings have been incorporated into this plan.

We have a long history of integrated commissioning and integrated service delivery for health and social care. Our future plans will now be revised in light of the Five Year Forward Plan.

Our vision for the Better Care Fund builds on our successful integration and is part of the forthcoming Sustainability and Transformation Plan for Swindon and the new planning footprint including Wiltshire and Bath & North East Somerset.

We are a single unitary local authority (Swindon Borough Council), one CCG (Swindon

CCG, representing 26 member practices in Swindon and Shrivenham), a single acute Trust in the Town (Great Western Hospitals NHS Foundation Trust), one mental health provider (Avon and Wiltshire Mental Health Partnership NHS Trust, who have established a clinical directorate that just serves Swindon), one emergency patient transport provider (South Western Ambulance Service NHS Foundation Trust) and one network of voluntary sector organisations (Voluntary Action Swindon or VAS).

Swindon Borough Council is the Local Housing Authority.

Our track record in providing integrated commissioning and delivery has been recognised in Swindon becoming one of 10 members of the national Public Service Transformation Network Areas.

We have jointly commissioned services through National Health Services Act 2006 Section 75 Agreements since 2008. The Agreement renewed in 2015 comprises total funding of £47m from the CCG and £89m Swindon Borough Council (SBC), a total of £136m. Services are commissioned through a joint commissioning team reporting to both the Accountable Officer in the CCG and the Director of Adult Social Care/Director Children's Services. All services are commissioned against an agreed Joint Commissioning Plan and monitored by a Joint Commissioning Board. The Better Care Fund is a separate pool within the S75 of £14.5m, with the balance of funding being within aligned pools.

Integrated services for children are established, bringing together community health, education and social care services in a single co-located service, managed in an integrated way within Swindon Borough Council.

We already have an established community provider providing integrated health and social care services, SEQOL, which was established in 2011.

We recognise that our demographic challenges as an expanding town with an ageing population mean we have to go further in the way that integrated services are commissioned and provided. In particular, we need to align the community and third sector closely to SEQOL and Great Western Hospital so that clear integrated pathways are in place for all our patients.

The contract for the community health and social care provider SEQOL comes to an end on 31<sup>st</sup> March 2016. In preparation, the CCG and Swindon Borough Council (SBC) started market engagement events, engagement with stakeholders, staff, voluntary sector, patients and the public in summer 2015.

In addition, the Local Government Association commissioned Newton Europe to undertake a diagnostic into further improvements in integration of health and social care in relation to reducing emergency admission, delayed discharges and improving patient flow.

The findings from this have been taken into consideration to shape the future provision of community health and social care services with closer integration with the acute pathway. Swindon Borough Council and the CCG took reports to the Governing Board and Cabinet to service notice and secure a new model in line with the Five Year Forward View.

A 12 months' notice was served on 16<sup>th</sup> February 2016 and an advert for the tender was published in March 2016.

In light of the strategic direction and the Special Educational Needs Reforms, Swindon Borough Council transferred Learning Disability social work services from SEQOL to the Council in October 2015 and wider social work services will transfer by February 2017

## **2. What will be different in 2020 for services and people?**

Swindon will have grown substantially by 2020 with a population of over 250,000 by 2026 (including Shrivenham) from a current population of 220,000. We already have a lot of community based health services that are delivered in the homes of residents, such as fluids, medication and antibiotics through our Virtual Ward and home visiting services. We will be delivering more services in the community, such as delivering health care in people's homes where this is safe to do through for example the Virtual Ward working closely with care homes. At present, many older people do not have a health care plan addressing their long term health conditions.

Living in Swindon in 2020 will mean that you can expect to live longer than the English average, with less risk of avoidable death, in better health and with the support of your neighbourhood and community. More of your integrated health and social care provided by community nursing services, home care and social workers will be planned in advance as part of a new life-long health plan and will be preventative, replacing much that is currently emergency care and avoidable. This will be done in a coordinated way with primary care

By 2020 everybody in Swindon is working together with a common set of values and principles based on respect, giving people choice, collaboration and innovation, where people are encouraged to think what they can do themselves, what help they have within their family and community and what they still need help with. When people need help it will be personalised, offering choice and control.

Outcomes for service users and patients will improve

- Emergency hospital admissions will be avoided for specific groups of patients, particularly those suffering from diabetes and heart conditions
- More patients will be able to leave hospital without delay
- Fewer older people will be admitted to residential care, through support provided at home and flexible housing with care, reducing isolation amongst older people
- Reablement will be an integral part of all domiciliary care and will mean that fewer patients will be re-admitted to hospital
- More people with a learning disability will be able to find employment through support commissioned from the voluntary and third sector and in partnership with our Skills For Employment.

### **2.1 Prevention and self help**

We already understand the population of Swindon at a locality/ward area and at GP practice level. We have some preventative and self-help services in place such as a third phase of community navigators and befriending support for a small number of older people.

By 2020 preventative and self-help integrated services are in place locally to engage and

support individuals. In 2019 this will mean that for individuals:

- We will offer a genuine choice of care setting for those whose mobility, functionality or health is impaired or for those with serious and terminal illness who are preparing for death
- Home will mean your own home, with us using new practice and technology that enables you to be at home
- Our vision is to support you to live life to the full within your community despite the long term conditions you may have thus avoiding institutionalised care in a community setting.

In 2020 you, your parents and carers know where to access information and support in your community, services and online through My Care My Support and the Swindon Advice and Support Centre. Carers for people with support needs are well supported through joint investment in the Carers Centre and short term breaks.

If you are older, we want to support you in making a positive contribution to your community by encouraging you to help others. This could be helping in a playgroup or being a good neighbour. You are engaged in self-help groups, local activities and you are able to volunteer. Older people say that they feel safe in their community. Where possible the entrance to residential and nursing care is delayed and housing opportunities such as homes for life, supported housing and extra care housing are used extensively.

You will have access to a range of programmes designed to improve your health, from healthy eating and healthy exercise (ranging from cycling to sports activities and recreational swimming to walking and gardening schemes); to smoking cessation programmes; to cultural activities, all of which have been shown to benefit health and wellbeing and extend quality of life. We will encourage you to volunteer to help deliver these services and promote community health champions.

Most studies identify self-care as representing 98% of the total health care needed across a population at any given time. We have invested in self-care and self-management of patients through the Health Improvement Team and community navigators. We need to develop more support through the voluntary and community sector to support patients in managing their health conditions.

Public Health initiatives such as health ambassadors work well in promoting health and wellbeing, specifically healthy eating, exercise, smoking cessation and reduction in drug and alcohol misuse. By 2020 we want Public Health to be working closely with General Practice providing a short consultation that can lead to more people quitting smoking. Brief intervention has been particularly successful in smoking cessation and drug and alcohol misuse. Community navigators have demonstrated that they improve the quality of life of individuals, reduce isolation and avoid some health costs. During 2016 we will continue to develop and evaluate the model to determine its cost effectiveness.

### **An example of how life will be different in 2020**

#### **Self-care and prevention 2016**

Andrea is living in Penhill, one of the most deprived areas in Swindon. She has three children and an older mother suffering from diabetes living nearby. She is unemployed

and on a low income. Her middle child is overweight and the youngest child's speech development is poor. She has few friends or relatives and feels often low and depressed, caused by stress and anxiety.

### **Self-care and prevention 2020**

Andrea's children were supported by the health visitor from before birth. She receives information from My Care My Support which the Health Visitor pointed her to. The Health Visitor shows her what local parent led groups are available. In discussions with other parents, she has made new friends and joined adult learning activities. She has found a carers' support group run locally where she can discuss caring for her mother. Meeting new parents in the area and other carers means that she feels supported and part of her community.

## **2.2 Urgent care – moving from unplanned care to planned care**

We have community navigators linked to GP practices where if you are at high risk of a hospital admission, your GP or community nurse is able to refer you to review your health, social and emotional wellbeing and develop a plan with you.

The evaluation in January 2016 demonstrated that community navigators working with 235 clients. A cost benefit analysis has been completed demonstrating a small cost reduction on emergency admissions. The model will be extended until June 2017 with further evaluation before considering mainstreaming.

If you are a patient with a long term health condition and identified as at very high risk of hospital admission, your GP will draw up a health care plan with you rather than refer to a community navigator.

If you have need for rapid access to treatment for a minor illness and cannot treat this yourself through rest or use of medication, then this will be through a combination of your local pharmacy or by appointment through the urgent care centre, contacted through your GP surgery and open 0800 to 2000 seven days a week or within two GP led urgent care clinics (SUCCESS programme). These clinics operate 0800-2000 during weekdays but hours are being extended to include weekends from March 2016 for a trial period.

If you need a home visit this is available in future from a dedicated service able to offer a visit at any time 0800 to 2000, rather than as commonly happens now with home visits having to wait until the end of a GPs working day (again part of our SUCCESS programme)

If you need to access emergency services, then you may be seen by a 'GP at the scene' who will assess whether you can be safely treated at home. If you need to go to the local hospital you can expect to be seen and your treatment commence or to have been admitted within a maximum of four hours within either a GP/Nurse Led urgent care clinic or the Emergency Department at GWH. Patients will be directed to the right department depending on whether you need to see a GP urgently, have a minor injury, require an urgent diagnosis and outpatient appointment, require a medical assessment, require urgent treatment, need to be admitted, need resuscitation or immediate surgery or need to be kept under observation and review. Within this we have developed a new model of care - our 'Fix Me Hub' (urgent care centre on the acute hospital site). The 'Fix Me Hub'

is fully established and has significantly prevented admissions. Between April and January 2016, 19,765 patients used the Urgent Care Centre, an average of 65 patients a day and 23,454 patients have accessed services operating as part of the SUCCESS programme.

There are strong links between the provider of integrated community health and social care services and all partners, particularly the local hospital, care homes, voluntary sector and primary care. We have invested in My Care, My Support website at <http://www.mycaremysupport.co.uk/> giving advice and information about health and social care as well as a community based advice service. As explained above we have also worked to improve urgent care.

By 2020 advice and information will have been fully available to all for a number of years, so that patients are well informed and know where to find health care urgently. We will have increased capacity in the Virtual Ward and extended the treatment of relevant medical conditions within the community (minor illness) in order to prevent admission to hospital. There is more to do to improve urgent care.

Currently we still have issues with patient flow as well as discharge processes. Over the past year the delays in health services have reduced but delays due to social care increased. We know that delays are due to length spent on completion of assessment, waiting for domiciliary care, residential and nursing care. Our additional capacity is used by prescription of high care packages. In December 2015 the delays due to social care increased to 9.1 per 100,000. However this includes delays in mental health which accounted for 40% of delays.

In the next 12 months, through the Delayed Discharge Programme, we will have reviewed and revised admission and discharge management processes and invested in systems to reinforce clinical decision making at point of admission. Discharge from hospital will be better-co-ordinated. Nursing homes and care homes will have well-trained staff and will provide community based nursing interventions, reducing the need for hospital admissions. Nursing homes and residential homes work together with health and social care to facilitate speedy hospital discharge. A new contract will be in place for domiciliary care.

### **An example of how life will be different in 2020**

#### **Urgent care 2016**

Patrick lives at home. He is 85 years old and his health is poor, suffering from high blood pressure and heart disease. When his health deteriorates due to an infection, he is admitted to hospital and given antibiotics intravenously. He is isolated and visits his GP frequently.

#### **Urgent care 2020**

All GPs in Swindon know of community services and the referral process. Patrick is identified at high risk of hospital admission. The community services meet him and discuss his health, his regular drinking and how he can better look after himself. Using My Care My Support, Patrick is allocated a volunteer to befriend him. A plan is made so that if he has another infection he can be given antibiotics intravenously with the help of a community nurse. This means that when Patrick suffers from an infection, he is cared for at home and not admitted to hospital.



## 2.3 Long term conditions

In 2020 if you have one or more long term conditions you will have support from those with the same condition. Informed through primary care, community services and web based information, you will be encouraged to take control of your condition whilst being routinely monitored by your primary care team which will include support from your community and the voluntary sector. You will have rapid access to specialist healthcare (including community based specialists, out of hospital and community care and outpatient clinics at the hospital) to avoid the need for emergency care and hospital admission.

Currently we have people living in areas of Swindon such as Penhill, Pinehurst, Parks, Toothill, Gorse Hill and Moredon with high levels of poor health and little access to advice and information. From our data we know that many people in those areas prefer information given to them face to face. We know that the number of older people with long term conditions will rise substantially from 35,000 now to approximately 40,000 by 2020 (see section 3).

In 2020 those people who live in the most deprived areas will be receiving additional signposting and support through community champions so that they are better able to care for themselves and able to seek the most appropriate support at the right time.

Recognising increased demand and priority of dementia care, in 2015/16, the CCG has worked with GPs to manage more routine diagnosis and management of those with dementia. Performance against the national 28 day diagnosis target has been reduced to 4-6 weeks. Currently we know that we have 2,000 people diagnosed with dementia and that this is due to double to almost 4,000 by 2030.

By 2020 Swindon will be a dementia friendly community. Older people suffering from dementia have good diagnosis in place with support groups operated in the community and more use of dementia cafés and activities. Community and social care providers support people suffering from dementia and are skilled and sensitive to their needs.

End of Life care in the community will be established as currently too many people die in hospital and patients have told us they would prefer to be at home.

We currently have a good nursing service which supports children with long term health needs in the community and at home. However, our admissions for children to hospital are high. In 2015/16, a review of Children's Services in the Acute, Community and Mental Health services will be taking place. A review of urgent care in paediatrics has informed changes in operational structure and care delivery in 2015/16. Urgent care for paediatrics will be part of an overall review in 2016/17, supporting a new model of care delivery.

During 2015/16, the key focus for community services has been progress towards maintaining sustainable services which support people in the community and prevent hospital admissions.

By 2020 children and young people with long term health needs are supported in the community by refocusing the hospital children's outreach team to work closer with GPs and community health services so children can be at home. Parents are able to access

enhanced primary care services (Children's and Young Person Clinic commissioned 0800 – 2000 in the SUCCESS centre) so that hospital admissions are prevented.

### **An example of how life will be different in 2020**

#### **Living with dementia in 2016**

Doris lost her husband 3 years ago. She lives on her own and her son and his family are a 2 hour drive away. Doris is a member of her local church but has only a few friends. Following a fall when she broke her arm, Doris returns home after 3 weeks in hospital. Over the next few months her son notices that Doris becomes more forgetful, seems more anxious and does not participate as much in activities. After 4 months she is diagnosed with dementia and becomes very isolated. She deteriorates rapidly. Her son increases the care package.

Doris has another fall and is found by a neighbour wandering outside. Her son is becoming increasingly concerned about her safety. In discussing the situation with Doris, Doris moves into residential care near her son's family.

#### **Living with dementia in 2020**

Swindon has an active network of locally based groups and the churches play a very active part with dementia champions. Following the loss of her husband, the local church volunteer visits Doris and encourages her to continue to come to church functions. The volunteer collects Doris for the weekly lunch and women's group. Doris's son is aware of the church volunteer. He notices Doris getting more forgetful. He contacts the local advice and information service about activities in her area. Doris maintains her independence for another two years.

As she seems to be significantly more forgetful Doris is diagnosed with dementia. Her son is able to access information online and discuss help with Doris. Following deterioration in her health, Doris is not able to manage living on her own in her house as she starts wandering. Her son is able to make a referral for extra care housing through the advice and information service. A care team is on site and support is tailored to her needs. The church volunteer continues to collect Doris from her extra care flat and take her to church groups. Doris is able to live with support in extra care housing and admission to residential care is delayed.

## **2.4 Mental Health & Learning Disability**

In 2020 if you have a learning disability and are supported by social workers you will have a personalised plan and personal budget in place. You and your carers have fully participated in the plan and own the outcomes to be achieved. You will be supported to be the best you can be with skill development, education, training and employment opportunities identified and pursued. Where possible you are living within the community in supported housing with local support. Community support through volunteers and wellbeing coordinators will support you if you do not require specialist social work support.

If you have a learning disability or mental illness you are enjoying leisure and culture and have opportunities for employment. More of you say that you feel safe.

Carers say that they have been fully involved and are positive about the quality of support and services they receive.

We currently have a diverse sector of voluntary and community groups which have not been as effectively coordinated as we would like. This means that we have a gap in offering individual support for those recovering after specialist mental health support, a gap in services reducing isolation and a gap in offering employment support for those with a learning disability. We support about 667 people with a learning disability through social care. 192 of those live in residential care, a proportion higher than in other areas. The number of people with a learning disability is expected to rise by 30 people each year as life expectancy rises and a larger number of young people become the responsibility of adult social care each year.

In 2020 the voluntary and community sector provision for people with a learning disability and those with mental ill health has been reshaped and implemented so that support is preventing conditions from getting worse and more people access employment and training opportunities. Links with specialist learning disability and mental health services are well established. The principle for services will be wellbeing coordination, therapeutic and volunteer support.

In 2020 we will have reduced the number of people with mental illness being admitted to an acute ward when presenting with mental health problems and we will have built on the many services in the local community that are amongst the best in the country and need to continue to be supported. Mental health services will be delivered locally with a strong focus on early intervention and recovery. We will have wellbeing coordinators working in voluntary organisations, bringing together specialist and community services for people being discharged and those at risk of mental illness and learning disability

### **An example of how life will be different in 2020**

#### **Mental health 2016**

Diana has suffered from depression for a number of years. She has been referred and allocated to the specialist mental health services three times in the past. The usual pattern is that she is discharged after a period of months when she has stabilised. Once discharged she only has access to her GP. She is re-admitted to mental health services after 6 months.

#### **Mental health 2020**

As part of the discharge process, mental health workers start discussing with Diana how she copes at home and what causes the deterioration in her mental health. Well before discharge, the mental health worker discusses the wellbeing co-ordinator role with Diana. Diana meets the wellbeing coordinator with her mental health worker. Together they establish a plan around how the three of them will work together before and after Diana's discharge. The wellbeing co-ordinator introduces Diana to a job club and Diana works as a volunteer three mornings a week after discharge. Her mental health improves through the new friendships she makes as a volunteer. Her mental health improves and she is not re-admitted to mental health services.

## **2.5 Being a carer**

In 2020 as a carer, you will have been made aware by your GP, your health visitor or social worker about the support offered by the Carers' Centre. You will have been offered an assessment to discuss with you what help you may need. You or your family can complete a self assessment questionnaire on line. You have been offered short term breaks to help you with caring and you feel valued and supported. Your GP has discussed your health with you and you know that you can receive a health check in the community. As a parent carer you know that advice and information is available and you are supported by a multi-agency team. In your local area there are groups that support you. Support through short term breaks and community groups is flexible and based on what you need.

The Census 2011 estimated that there are 19,500 carers in Swindon. We currently commission support for carers from the Swindon Carers Centre and there is an increasing number of short term breaks. We have a system in place which ensures that carers can give all the care details of their loved one. This is called the Emergency Card. If a carer is ill or unable to care, the social work teams have access to the care needs of the individual.

From April 2015, the Care Act means that all carers can request an assessment of their needs. We have invested additional resources into the Carers' Centre to give advice, complete assessments and offer group and individual support. Carers will be able to do this online or through skilled support from the Swindon Carers' Centre as well as SEQOL, and the Mental Health provider Avon and Wiltshire Mental Health Trust. Carers will have support that is flexible, outside of Monday to Friday. A personal budget enabling carers to have choice and control is offered. Informal support is available in local areas. We recognise that as carers of people with a learning disability become older, we need to review the support they are offered to support them.

By 2020 we will have evaluated the Carers Strategy and implemented new actions taking account of the views of carers through their involvement, involvement of the carers centre and the analysis of our data.

## **b) What outcomes are we striving to achieve? –**

In Section A we have already outlined the difference service users will experience, using illustrative examples and referring to evidence within the JSNA. We have engaged public and patients in a range of workshops which are described in section 8. Our work on the Adult Care Strategy, the Joint Commissioning Plan 2014/15 and the Five Year Strategic Plan for the CCG were all based on discussions with the Patient and Public Forum. This led to the following priority outcomes:

- **Enhancing quality of life for people with long term conditions** (such as diabetes and dementia) by commissioning services that appropriately support patients' and carers' needs and help them manage their own conditions and maintain them to live in their own homes for as long as possible and avoid unnecessary hospital admissions.
- **Helping people to recover following illness** through better patient flow to ensure that people are given the care and support required in the most efficient and appropriate care settings at the right time, across health and social care. This will also

mean commissioning direct access to planned care seven days a week.

- **Improving patient experience and safety** improving access, quality and safety of services.
- **Reducing health inequalities** in Swindon working with other partners e.g. One Swindon, Health and Wellbeing Board, Swindon Borough Council and NHS England to ensure voluntary, private and public sectors are working together to support the most disadvantaged communities and households.
- **Preventing people from dying early** including preventing disease in the first place. Early diagnosis and appropriate treatment of disease can also reduce premature death.

- c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

We already have an integrated provider of community health and adult social care in place. The provider is jointly funded and its services in relation to reablement and community health will continue to be funded from the Better Care Fund.

#### **Community health and social care**

Community health services are part of social work teams. Care is coordinated around the individual. A Single Point of Access is already in place as well as integrated hospital discharge services, a rapid assessment service (DART) as well as the Virtual Ward and 'Fix Me Hub'. A joint contract is in place across Swindon CCG and Swindon Borough Council supporting carers as well as jointly funded carer's breaks.

Our ambition for our integrated care model is first and foremost driven by our daily appreciation of the delays and confusion in healthcare delivery caused by the current disintegrated model of care delivery, despite our best efforts to ensure the patient experience is right first time for everyone. The most common complaint from both patients and clinicians is that every pathway of care has too many points where care must be handed over to another organisation, that these handover stages cause confusion and delay, that delay results in poor healthcare and also discontinuity of provision, that the resulting communication between healthcare professionals and health and social care could be better and needs new systems to improve it.

The commissioning of the voluntary and third sector is led by the joint commissioning arrangements. This funding is also part of the Better Care Fund as well as support to carers.

DART was developed by the integrated discharge team to reduce length of stay in hospital of people who need support through equipment, reablement or community nursing but don't need complex assessments. A review has taken place of the DART team in 2016, and a joint plan is being developed with DART to reduce delayed transfers of care. This will be implemented from April 2016.

Through DART and the Integrated Hospital Discharge team, social work services are available 7 days a week supported by the brokerage and contracts team in adult commissioning.

A range of public health initiatives such as smoking cessation, health ambassadors, work with black and ethnic minority communities are already in place and will be strengthened through our joint community capacity work targeting healthy lifestyles and a reduction in risk taking behaviour such as alcohol and drug misuse.

The Better Care Fund will build on the work that Swindon has already started and comprise the following schemes in 2016-17:

All services are delivered within the community and in community based locations.

### **Urgent care**

An Urgent Care Programme Board was established in February 2016, where GWH Trust, community provider, Swindon Borough Council and Swindon CCG meet fortnightly to resolve pressures within the system and ensure that the target is met. The Senior Reporting Office for the Urgent Care Programme Board is the Executive Nurse Director at the CCG.

The Aim of 2015/16 in the CCG Operational Plan were to develop a number of initiatives which would help to manage capacity and consider how these initiatives would work within a more integrated model if proven successful. This has included a stronger triage model for minor illness and minor injury through analysis. A pilot of a Rapid Response Unit (RAU), a service with enhanced diagnostic capability to treat ambulant patients supporting admission and attendance avoidance at ED has been completed.

Both of these services, coupled with support for *on the day* demand through the SUCCESS programme in primary care has managed overall urgent care demand successfully through 2015/16. It is believed that each of these services have delivered compound effect and has helped to inform a new urgent care model. This has maintained flat growth in Urgent Care demand to Emergency Department throughout the year.

The new model is based on fewer points of access into what is a large, diverse and skilled set of services which are currently used in an integrated way to manage demand. The new model is based on rapid sign posting from a single access point to treat patient in the right place within the system rapidly to avoid escalating need. This model has been jointly developed with provider in community and the hospital.

The aims for management in urgent care will build on this work:

- Developing the initial phases of implementation for the new model of single point of access
  - More management of minor injuries / illness within community settings
  - Greater utilisation of alternatives to admission for all presentations to ED
  - Development of integrated models of ambulatory care between hospital and community through RAU and the ambulatory care unit
  - Specialist consultations pulled to patient need to support community treatment
  - Development of Right Care II framework for Ambulance services to support the new model
  - Development of the SUCCESS model relative to *on the day* demand
- Work with providers to articulate a new workforce model which supports overall

demand and shared resources between providers

- Contractual arrangements so all aspects of commissioned capacity can be used flexibly
- Development of estates and facilities to support the implementation of the new model
- Rapid access developed for End of Life care which is highly responsive to patient need and choice
- Mental health services local targets will be changed to better reflect Parity of Esteem and support for overall system. This in both Mental Health Liaison and the Intensive Service
- Working with the hospital to develop the *Right Care, Right Bed* initiative
- CQUINs this year with focus on capacity and demand management across system and promote integrated working moving toward becoming an Accountable Care Organisation in Swindon

The Urgent Care Target for 2016/17 is 98% of people will be seen and discharged from A&E within 4 hours.

### **Long term conditions**

Review of care pathways for Diabetes, Dementia, cancer, heart failure, stroke, COPD through on-going redesign process so that services appropriately meet the demand created through better diagnosis and increased awareness for dementia, better treatment for cancer, diabetes and COPD.

The increasing prevalence of LTCs is highlighted within the JSNA. The financial pressures facing health and social care into the future indicates a radically new approach is required to tackle this trend.

Respiratory/COPD: A Quality Improvement Plan has been developed for 2016/17, this will include working with providers to review;

- the diagnosis and management pathway in general practice according to NICE clinical guidelines.
- the local COPD Oxygen and Pulmonary Rehabilitation services.
- identifying improvements on how acute care can integrate closer with the COPD community service with patients experiencing frequent exacerbations who need more pro-active management.
- use of overtreatment with inhaled corticosteroid when used above the optimal level.

Diabetes: Following a clinically-led service review which took place in the acute trust in November 2015, a comprehensive report detailing key recommendations that should be considered in 16/17. The opportunity to move towards developing and adopting a community-led model of care that incorporates the whole system will be a priority for the CCG and providers. By delivering this model of patient care, this will not only manage patients appropriately with the right care provider and in the right setting at the right time, but also support primary care. A “community-led” model of care in this context is defined as one that comprises a community of healthcare stakeholders across acute, primary, community and voluntary care to respond to the health needs and inequalities

experienced by the Swindon diabetes population. In such a model of care, this type of community leadership is maintained irrespective of care settings.

### **Self-care and prevention**

During 2014/15 Swindon CCG and Swindon Borough Council (SBC) submitted a bid to the national Transformation Challenge Award (TCA) to expand the CN team in 2015/16. Following approval by the Governing Body on 22nd January 2015 to continue the pilot for a second year, arrangements were made to commission the Health and Well Being Team at Swindon Borough Council to provide 14 Community Navigators (CN) for all 26 practices, emphasising the need to promote and enable self-care and management for those patients with long term conditions and to facilitate engagement with existing voluntary services available including Swindon Circles of Support.

Indications from the patient feedback suggests that this phase of the pilot has contributed to the improvement in the health and well-being of the individuals and empowered them to access other sources of support to help them manage their condition and reduce their social isolation.

Feedback from the Community Navigators and the Provider Management Team suggests that this phase of the pilot has been well structured and supported, and whilst the variable engagement of practices has been disappointing, the CN's remain positive about the impact and changes they have made to individuals in terms of the management of their long term condition and life styles.

Reshaping of provision in the voluntary and third sector to improve health and well-being is being undertaken. Advice and information service as well as a website offering information is in place. Voluntary sector organisations supporting those with a learning disability, mental illness, carers and support services are co-located in the centre of Swindon. We will continue to promote the advice and information service so that people can make plan and make choices for themselves.

**Reducing a growing burden of lifestyle related ill health and cancer** particularly due to physical inactivity, obesity and smoking that we want to address through increasing community capacity to tackle the wider determinants in relation to housing and employment. Swindon has higher rates of smoking, alcohol consumption, physical inactivity and obesity in areas of disadvantage, which in turn leads to higher incidence of heart disease and diabetes in those communities. We continue to invest in initiatives that tackle health inequalities throughout the life course. We will be commissioning volunteer befriending and engagement services to reduce social isolation so older people remain linked to their communities for as long as possible.

**Improving the health of children** by reducing child obesity to below 19% in year 6 to prevent long term ill health, improving children's emotional health, reducing paediatric admissions and will ensure targeted support for children and families.

A review of Children's Services in the Acute, Community and Mental Health services will be taking place. A review of urgent care in paediatrics has informed changes in operation structure and care delivery in 2015/16. This review has suggested, in a similar way to overall urgent care delivery, the rapid response and integration with community urgent care successfully supports demand management. Urgent Care for paediatrics will be part



of an overall review in 2016/17 supporting a new model of care delivery.

Key tasks which will be completed:

- Continuation of SUCCESS children's clinic to support *on the day* demand
- The monitoring of specialist advice line for primary care and community clinicians and its effect on admissions / attendance
- Re-design of the urgent care pathway between Urgent Care Centre, Paediatric ED and PAU
- An overall service review of children's services to inform new models of care.
- Rapid End of Life care pathway response and increased care options for children and their families

Children's Mental Health Care: A review of CAMHS / TAMHS provision under the Joint strategic needs assessment has informed changes and a transformation plan which will be carried out over the next five years in line with the national review of Children's Mental Health Services. This service re-design will make the service more responsive and create measures which give more clarity around outcomes.

**Improving mental health** through wellbeing co-ordination and improved work between voluntary and third sector mental health services and secondary mental health services.

Dementia: Recognising increased demand and priority of dementia care, the CCG have worked with General Practitioners to manage more routine diagnosis and management of those with dementia. Performance against the national 28 day diagnosis target has been challenging in recent years, however we have now secured a new model of care which will support ongoing delivery in the future. Within the dementia strategy there is a model for specialised treatment and management of more chronic and specialist requirements. This is being delivered now via a Specialist Dementia Team in AWP.

**Improving health, social and emotional development of people with a learning disability** so that health outcomes improve, people live and are supported locally and find suitable employment and training.

**Supporting Carers:** Developing an extended assessment and information sharing supporting carers including young carers. Reviewing all services to ensure they adequately provide for the needs and rights of carers and ensuring carers are aware of support and short term breaks available to them.

Swindon Clinical Commissioning Group and Swindon Borough Council already have a National Health Services Act 2006 Section 75 Agreement in place. As the Better Care Fund is largely funds from existing budgets, many of the services are already funded. If the Better Care Fund was not in place then the following community based services could be at risk:

- Community health services
- 7 day working in adult social care
- Reablement support and accelerated discharge from hospital through access to care packages 7 days a week

### 3) CASE FOR CHANGE

**Please set out a clear, analytically driven understanding of how care can be improved by integration in your area**, explaining the risk stratification exercises you have undertaken as part of this.

The Better Care Fund Plan is based on a thorough analysis of need of the population in Swindon. It addresses the key challenges, which are evidenced below:

- Reducing emergency admissions to hospital by strengthening our urgent care plans
- Reducing delayed transfers of care across health and social care by 50% , in particular due to completion of assessment, admission to residential and nursing care and access to domiciliary care
- Reducing emergency admissions and improving health of those with long term conditions through community based support, advice & information, community based support, community navigators
- Strengthening reablement services for those discharged from hospital including 7 day working in social care and health
- Improving locally based support for people with a learning disability
- Improving advice, information, assessment and support for carers
- Addressing the needs of an ageing population and improving health inequalities.

The vision, priorities and schemes are based on an analysis of data from the JSNA, literature search and best practice nationally. The schemes were also identified in Swindon's application to become a Health Pioneer. As we already have joint commissioning plans in place, the majority of schemes were already referenced in the Joint Commissioning Plan 2015/16. New schemes have been included in the CCG One Year Operational Plan 2016/17.

We are a single unitary local authority (Swindon Borough Council), one CCG (Swindon CCG, representing 26 member practices in Swindon and Shrivenham), a single acute Trust in the Town (Great Western Hospitals NHS Foundation Trust), one mental health provider (Avon and Wiltshire Mental Health Partnership NHS Trust, who have established a clinical directorate that just serves Swindon), one emergency patient transport provider (South Western Ambulance Service NHS Foundation Trust) and one network of voluntary sector organisations (Voluntary Action Swindon or VAS).

Integrated services for children bringing together community health, education and social care services in a single co-located service and managed in an integrated way.

The data below outlines the challenges in detail which we will continue to address in an integrated way through the schemes outlined in Section 4 of this plan.

Swindon faces significant population growth over the next 10 years as the data below shows. We will see a larger rise than nationally amongst children under five and older people with long term conditions, both of whom are high users of primary and secondary health services. Looking at our demographics, we can see the unique consequences of the growth in our industries in the 1980s and 1990s with a materially larger proportion of our people being in the 30-64 age groups. Forecasts between 2001 and 2011 also show

that we would see the over 85 population grow at a much faster rate than the rest of the population due to increased life expectancy.

Risk stratification has identified those patients most at risk of admission and services are in place to provide enhanced support. In addition national data shows that Swindon has high rates of unplanned admissions for asthma and diabetes, and an increasing mortality rate for respiratory diseases. Programmes of work are in place to work with patients with diabetes with a focus on self-management, improved foot care and ophthalmology screening. Respiratory patients self-management, increased capacity for tele health services and specialist community support services

### **Population changes**

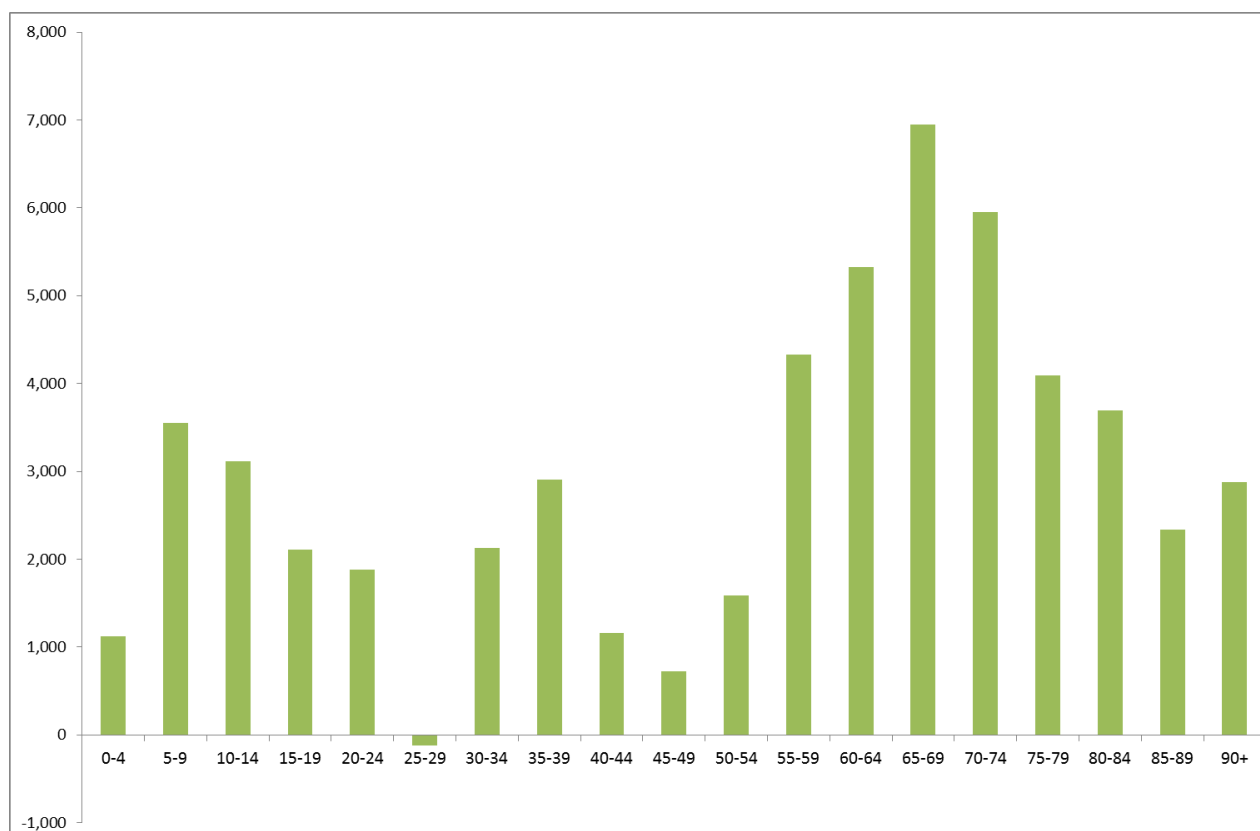
The population of Swindon by mid-2011 was estimated to be 209,700, an increase of approximately 29,600 persons from 2001 representing a growth rate of 16%, the highest in the South West. In Swindon, to take account of the planned additional 25,000 new homes between 2012 and 2026 policy-led projections were produced based on population data from the Office for National Statistics (ONS) and Swindon District's housing targets to 2026 from the Local Plan.

The key facts from these projections are:

- Swindon's population could increase to 240,000 persons by 2021, and 265,400 by 2031, equivalent to growth of approximately 14% from 2011 to 2021, and a further 10% from 2021 to 2031.
- From 2011 to 2031, births are projected to average approximately 2,900 per year, deaths approximately 1,700 per year, and net migration approximately 1,800 per year.
- The largest increase in persons will be in the 65 to 74 age group, projected to be 12,900 more by 2031. However, the 85+ age group will have the largest growth rate at approximately 136%.
- By 2031 the population aged over 65 is projected to grow by 25,900 persons to reach a total of 55,000 by 2031, accounting for 46% of total population growth.
- The working age population (16-64) is also projected to grow by approximately 21,600 persons to reach a total of 160,800 by 2031, accounting for 39% of total growth.
- The age group from 0-4 is projected to grow by 1,100 to reach a total of 15,300 by 2031.
- The population of school-age children aged 5-18 is projected to grow from 34,900 in 2011 to 43,000 in 2031, and overall, the population of children aged 0-18 will grow from 49,100 in 2011 to 58,300 in 2031.
- Overall, the age structure of the population is projected to change with significantly higher growth in the older age groups than in the younger groups. This will result in an increase in the ratio of children and older people to working age people so that by 2031 for every one person under the age of 16 or aged 65+ there will be

1.5 persons of working age instead of 2 persons of working age in 2011.

**Chart 1: Projected change by 5 year age group from 2011 to 2031**



# Population Forecast

Age Group	2010	2015 Projection	2022 Projection
People aged 0 to 4 years	14,805	14,926 +0.8% from 2010	15,437 + 4.3% from 2010
People aged 65+ years	28,857	32,944 +14.2%	38,721 +34.2%
People aged 75+ years	13,892	15,556 +12%	19,391 +40%
People aged 85+ years	3,865	4,681 +21.1%	6,161 +59.4%
Total Population	201,053	211,102 +5%	231,867 +15.3%

## Future Projections for Population 65 +

Number of over 65s in Swindon projected to have:-	2011	2015	2020	2025	2030	% Increase 2011 to 2030
• Dementia	2,014	2,289	2,734	3,265	3,941	95.7%
• A long-standing health condition caused by a stroke	673	767	877	1,023	1,191	77.0%
• A limiting long-term illness	13,599	15,412	17,526	20,397	23,762	74.7%
• A fall leading to the need for support	7,716	8,777	10,119	11,698	13,786	78.7%
• A BMI of 30 or more	7,582	8,670	9,717	11,057	12,835	69.3%
• Diabetes	3,617	4,133	4,686	5,379	6,279	73.6%

Based on national population projections, which are show less growth in Swindon's elderly population because they don't take new housing into account, the following projections of the number of over 65s projected to have certain conditions have been calculated. These numbers can be regarded as conservative estimates if the prevalence of these conditions remains unchanged in future years. Many elderly people will have more than one of the above conditions.

Number of over 65s in Swindon projected to have:	2015	2020	2025	2030	% increase 2015 to 2030
Dementia	2,280	2,727	3,259	3,979	75%
A long standing health condition caused by stroke	766	890	1,042	1,228	60%
A long-term illness limiting day to day activities a lot	7,745	9,005	10,694	12,653	63%
An admission to hospital because of a fall	677	792	957	1,124	66%
A BMI of 30 or more	8,683	9,927	11,398	13,272	53%
Type 1 or Type 2 diabetes	4,135	4,787	5,525	6,494	57%

The proportion of BME people in Swindon UA, in approximate terms, doubled from 8.5% (15,344 people) in 2001 to 15.4% (32,128 people) in 2011. The broad BME proportion reported in Swindon in the 2011 Census varied greatly from 48.2% in Central to 5.6% in Blunsdon & Highworth. Among school children in 2014, the proportion of children from a minority ethnic group in Swindon was 21.7%, more than the 11.3% in the South West and but less than the 27.8% in England. Maternity data supplied by the Great Western Hospital NHS Trust for births to women resident in Swindon, in the 2 years up to 31st October 2014, showed that 28% were to women from a minority ethnic group.

Using the provisional outturn 2014/15 data, Swindon is spending £508.55 per older person on Physical Support and Sensory Support (PS&SS) 65+ social care. This is in line with the South West average of £508.38. The actual proportion of Adult Social Care (ASC) spend on PS&SS in Swindon at 25% is lower than the South West average at 31% but this is due to Swindon having a smaller 65+ population. The actual amount we spend per person on the 65+ population is in line with the average.

### **Life expectancy**

In Swindon, in 2012-14, life expectancy is 79.5 years for males and 83.0 years for females, which is similar to England. Males in Swindon will spend 80.7% of their lives in good health, to around 64 years, whereas women will only spend 75.8% in good health, to around 63 years. At age 65, life expectancy for males in Swindon is an additional 18.5 years compared to 21.1 years for females. However, there is almost no difference between sexes in the remaining length of time spent in good health (9.4 years compared to 9.8 years). Causes of premature mortality in Swindon are changing. In 2001-03, 36% of deaths under 75 were from cancer and 30% from cardiovascular disease (CVD) but by 2012-14, 41% were from cancer and 23% from CVD.

Meanwhile, the gap in life expectancy between the least and most deprived has reduced significantly amongst the female population but risen slightly amongst the male population. In the most deprived areas of Swindon, men die on average 9.7 years earlier and women 4.0 years earlier than those in the least deprived areas. Reducing gender related health inequalities remains a top priority.

The growth in people from Black and Minority Ethnic Communities to 15% places even greater emphasis on the development of approaches to healthcare design and delivery that reach out to and are guided by our new communities. The greatest growth has been in communities who are also vulnerable to diabetes and cardiovascular disease in the Asian community (both of which are priorities for new interventions in 2014-2019 therefore).

In addition, we have undertaken significant analysis of our population and our demand for

health and social care. Based on analysis from Public Health we know that:

- At the end of 2014/15, 24,147 people aged between 40 and 74 had taken up the offer of a NHS Health Check, 39.6% of those eligible (England average 37.9%) - The NHS Health Checks programme is monitored monthly and improvements identified to improve take up based on regional best practice. A new service specification for GP practices is being developed including surveys of health check effectiveness by patients which can then be used to develop the service.
- Cancer Screening coverage – cervical cancer 72.4% (England average 73.5%) - The Public Health team link to Public Health England campaigns to boost uptake as well as working with providers locally to look at ways to improve coverage.
- Mortality from communicable diseases 74.1 per 100,000 population (England average 63.2) – This includes the number of deaths from certain infectious and parasitic diseases as well as from influenza and pneumonia. SBC have initiatives to reduce fuel poverty and provide grants for improvements to heating for those on low incomes. The CCG also sent out a Keeping Well and Staying Safe booklet to every household this winter with advice on reducing winter illness and the risks of respiratory disease.
- Preventable sight loss – age related macular degeneration (124.4 per 100,000 age 65+) and sight loss certifications (41.1 per 100,000) – It is difficult to know whether low rates of certification and prevalence are due to genuine lack of need or lack of services / access to services. The JSNA Steering Group commissioned a JSNA which looked at sight loss to understand the local need more fully.
- Incidence of TB – 10.1 per 100,000 (England average 13.5). This is expected as higher rates tend to be concentrated in larger cities.

Improving health, particularly female health, and reducing health inequalities between the least and most disadvantaged amongst our male population remain the top priorities as described in the Joint Health and Wellbeing Strategy 2013-16.

### **Population analysis and use of services**

Our analysis of Experian Mosaic has identified that five of the 69 categories are significant users of healthcare, namely elderly living in isolation, elderly in social care housing in isolation, families with young children on benefits, in social housing or in overcrowded conditions. These same groups also present as major users for other agencies within Swindon, hence our One Swindon joint programme of transformation. These groups are often clustered at street level rather than ward level and live in households in every ward in Swindon. The need to deliver more support to those who are most disadvantaged in our communities at household level has seen the development of schemes in support of families as well as the community navigator and mental health and wellbeing coordinator interventions.

Full analysis at household level shows that there are particular groups who use adult services most.

### **Adult Social Care**

Data was provided on SBC's Adult Social Care services, from November 2010 – April 2014. This included all community care packages (broken down by type of package/service), as well as average weekly costs of care at a household level. The top 5 customer types for Adults Social Care are E18, G29, F23, M59, and E19.

**Table 4: Adult's Social Care (ASC), top 5 customer types (by service type)**

Mosaic Type	Day Care	Direct payment	Domiciliary	Equipment/Adaptations	Other	Personal Budget	Professional Support	Residential Perm
E18	£10,799	£773	£12,856	£22,974		£373	£19,832	£17,324
G29	£18,337	£567	£11,634	£2,822		£880	£1,672	£34,154
F23	£14,403	£5,716	£5,459	£1,364	£12	£783	£3,291	£31,454
M59	£7,902	£1,387	£30,324	£8,139	£563	£8,051	£1,686	£359
E19	£9,759	£2,475	£22,386	£12,024	£82	£4,633	£754	£2,668

*Pink cells indicate the top 5 highest average weekly cost by service type*

E18 people are classified as having moderate incomes, typically occupying large inter-war semi-detached properties. They are less resilient in the face of recessions with one or both parent possibly losing income during these times. They are internet savvy and this could help them to access services where needed. E18 are not appearing as the 'top' type for any other service, so it would be worth exploring why they are so prevalent for Adult Care.

G29 occupy larger terraces but lead busy professional lives. With high internet usage they will access services they need for their families. Both G29 and E18 are accessing Adult Social Care services far higher than their modelling would indicate – whether this is due to increasing need combined with awareness of what is available to them should be the focus of further in depth research.

F23 looks to be accessing ASC services for two distinct age groups – young people with difficulties and the elderly (likely to be parents of the type rather than the type itself). This type are, again, very internet savvy, and are early middle aged parents living in relatively large housing.

M59 is one of the most heavily deprived elderly types with extremely high levels of need. This type would probably be expected to be top of this category; however, the address matching process has not been able to match people to residential care homes. Even without the 'full' match it has still entered the top 5 for need.

E19 is very similar to E18; vulnerable during recessions but with higher levels of education and experience than 18 so possibly more likely to retrain and return to the job market.

The chart showing the type of service required by age holds no surprises with learning disabilities predominant at younger age ranges, mental health concentrated between the young and old and physical disabilities dominating heavily for the elderly. The extremely large numbers for this last category show quite clearly the large volume of service requests, yet the overall highest financial pressures occur due to learning disabilities – this is therefore was a priority for the Better Care Fund in 2014/15.

## SEQOL

SEQOL provided data on all patient contacts and episodes, between November 2010 and April 2014. There could be many contacts to a patient episode, much like there could be many episodes to patient spells in secondary care activity, but usually only one referral per episode. Data on costs was not provided.

The top 5 types for SEQOL are M59, J45, B05, L54 and M56.

**Table 5: SEQOL, top 5 customer types (by age)**

Mosaic Type	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99	100+	Total	% HH	Expected	High/Low
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														Visits	
M59			42	8	96	103	427	135	235	686	15		1.85	8261	41343
J45	43	271	267	655	687	158	353	103	107	284	85	31497	5.08	22687	8810
B05	64	46	147	225	364	743	131	606	151	444	38	28611	2.74	12247	16364
L54	13		6		96	448	234	731	129	344	50	26631	2.06	9199	17432
M56	41	31	13	192	217	598	231	874	882	466	37	25681	1.67	7484	18197

*Pink cells indicate the top 5 highest instances by age*

It is interesting that 'E18 and 19' do not feature in SEQOL's list, despite being the top group for Adult Social Care.

M56, M59, B05 and L54 are all elderly types and looking at the dominant age ranges it is no surprise that these are the prime requesters of SEQOL services (although M59 dominates).

J45 are white collar workers likely to have suffered ill health as a result of work/working practices. Data on service type was also provided; community/district nurse is by far the key service type with a huge number of visits compared to any other area. All types are using these services higher than the modelled percentage would indicate but this is likely to be due to the direct need of these more elderly types. Therefore our advice and information services will use this information to target information in such a way that these groups of people receive information to manage their health and social care needs in a way that corresponds to their preferences

## GWH

GWH provided data on all hospital admissions *that require a stay* between November 2010 and November 2013. This does not include day visits. The data provided included principal ICD (international classification of diseases) codes, to enable us to draw out some analysis on primary condition alongside customer type. Full costs at household level were provided.

Due to having such a comprehensive dataset, this is best seen as a top 10 rather than a top five. The top 5 (10) types for GWH are: J45, H35, E19, B05, J47 (K51, E21, M59, M56, O68). Appendix 5 shows the breakdown by age and by condition.

**Table 6: GWH Hospital admissions, top 10 customer types (by cost)**

Mosaic Type	Total	% HH	%HH/Spend	High/Low
J45	£9,686,184	5.08%	£6,978,493	£2,707,691
H35	£8,482,290	9.38%	£12,899,093	-£4,416,803
E19	£7,621,444	4.72%	£6,482,606	£1,138,838
B05	£6,081,844	2.74%	£3,767,244	£2,314,600
J47	£5,738,012	2.54%	£3,493,755	£2,244,257
K51	£5,479,954	3.22%	£4,422,417	£1,057,537
E21	£5,403,529	4.08%	£5,606,537	-£203,008
M59	£5,225,330	1.85%	£2,541,049	£2,684,281
M56	£4,712,106	1.67%	£2,302,121	£2,409,985
O68	£4,482,675	2.70%	£3,717,656	£765,019

J45 present as the highest cost customer type to the hospital. Typically low income but

low unemployment, this is a relatively deprived group. Analysis by age shows it is patients aged 66 – 85 that are triggering the highest costs.

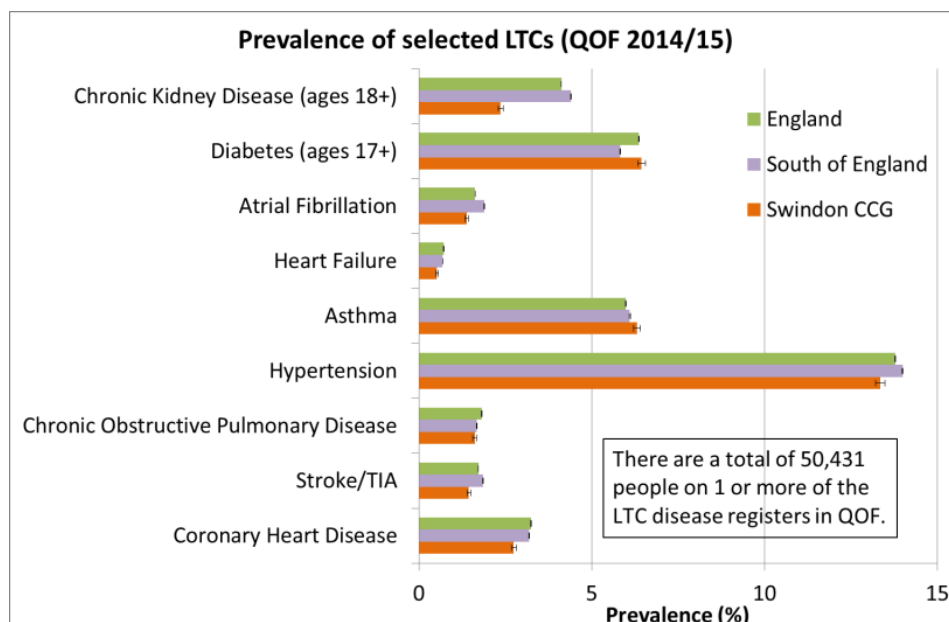
By age, costings break down into two main groupings – pregnancy-related stays, therefore young adults plus children, in types H35 and O68 and the elderly, who make up the other types. This is also reflected in the principal ICD codes, which have several codings to do with pregnancy and several for lung, heart problems, fitting of pace makers etc. Interestingly, one of the other principal categories relates to dental care which has some implications for overall service provision/take-up.

Normalising the actual service usage against the Mosaic household percentage shows that again H35, whilst using a lot of services, is under represented whilst others are heavily over represented.

Given the nature of the conditions affecting the elderly further work investigating how to interact with health promotion activities before they reach this age range may prove highly beneficial and will be incorporated into the community capacity scheme of the BCF.

### Long term Conditions

Meanwhile, in 2001, 27,476 people reported having a long term condition which limited them in some way. A similar question was asked in the census in 2011 and the reported figure has risen to 32,302. This is a very slight rise *in percentage terms* from 15.2% to 15.3%, suggesting that, despite a significant change in the age demographics between 2001 and 2011 (48.6% growth in the over 85 age group), this has had little if any impact on the overall prevalence of those with long term limiting illness. The number of patients on a long-term conditions disease register with a Swindon GP was 50,431 in 2014/15<sup>1</sup>. The key impact of our ageing population has been in the number of residents who have **multiple conditions** and their **degree of debilitation**, neither of which is collected as part of the Census, but information on both is now available through our investment in risk stratification.



Whilst the overall number of Swindon residents living with a long term condition has increased in line with our overall population, some conditions such as diabetes and respiratory disease have grown faster than that partly due to near doubling of minority

<sup>1</sup> QOF data

groups where the prevalence of these conditions is higher, whilst other conditions such as dementia and stroke are forecast to increase at a faster rate than our overall population due to the faster rate of growth of our older and minority populations. The above increases will put additional pressure on individuals, households, their families, carers and support networks. Those with a long term limiting condition are two to three times more likely to also develop depression.

Our investment in community nursing, SUCCESS, community navigator and support for older people through voluntary and third sector organisations are part of our plan to address this. More detailed information is included in the CCG 5 Year Strategic Plan.

### **Demands on adult social care**

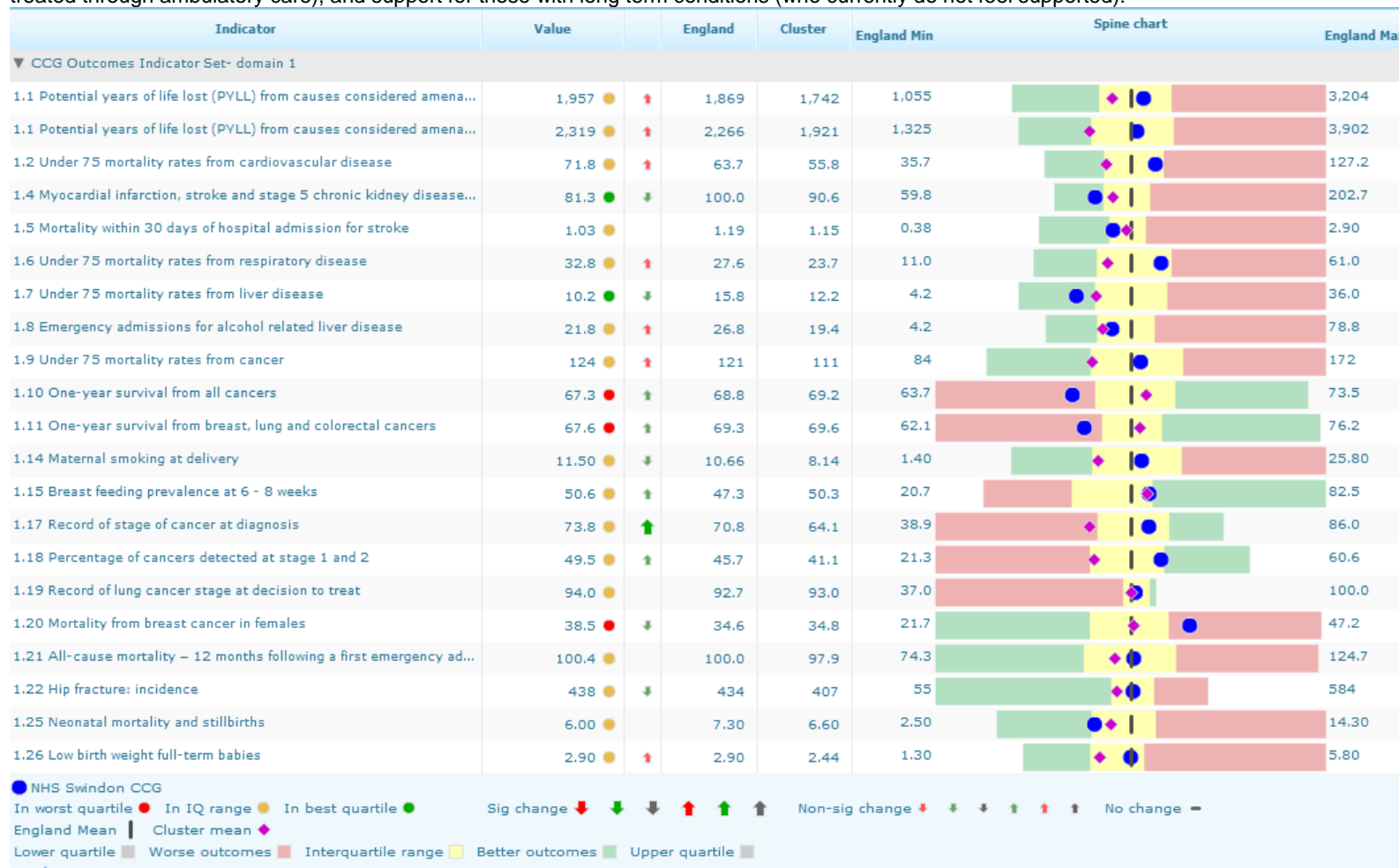
There were 676 people with a learning disability supported by Adult Social Care in January 2016 and 1,200 older people. Modelling by Swindon Borough Council on increases in demand estimates an additional 60 older people for 52 weeks of the year each year until 2016. Thereafter, it is likely that this number increases due to the demographic changes outlined above. We are also experiencing more complex health needs for Older People and in 15/16 have seen a significant increase in the value of packages of care. An additional £1.6m has been allocated in the 16/17 budget to meet increased demand for Older People.

Our spend on older people is the lowest amongst similar authorities at £992 per head of population. We support more people living at home and similar numbers in residential care.

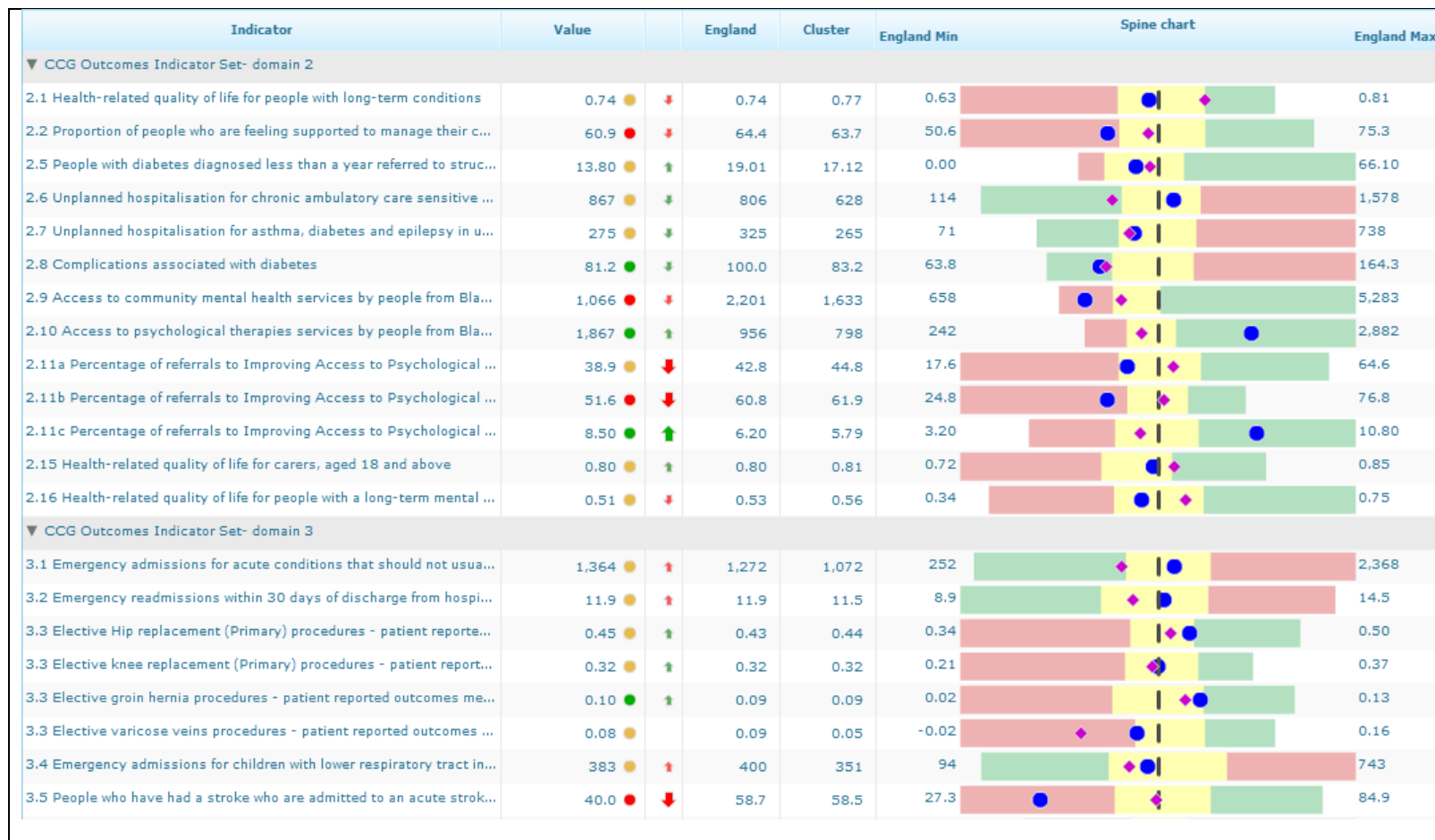
When we examine the satisfaction rates, we have a higher proportion of older people saying they feel isolated. Reducing isolation is therefore a priority for our work with older people.

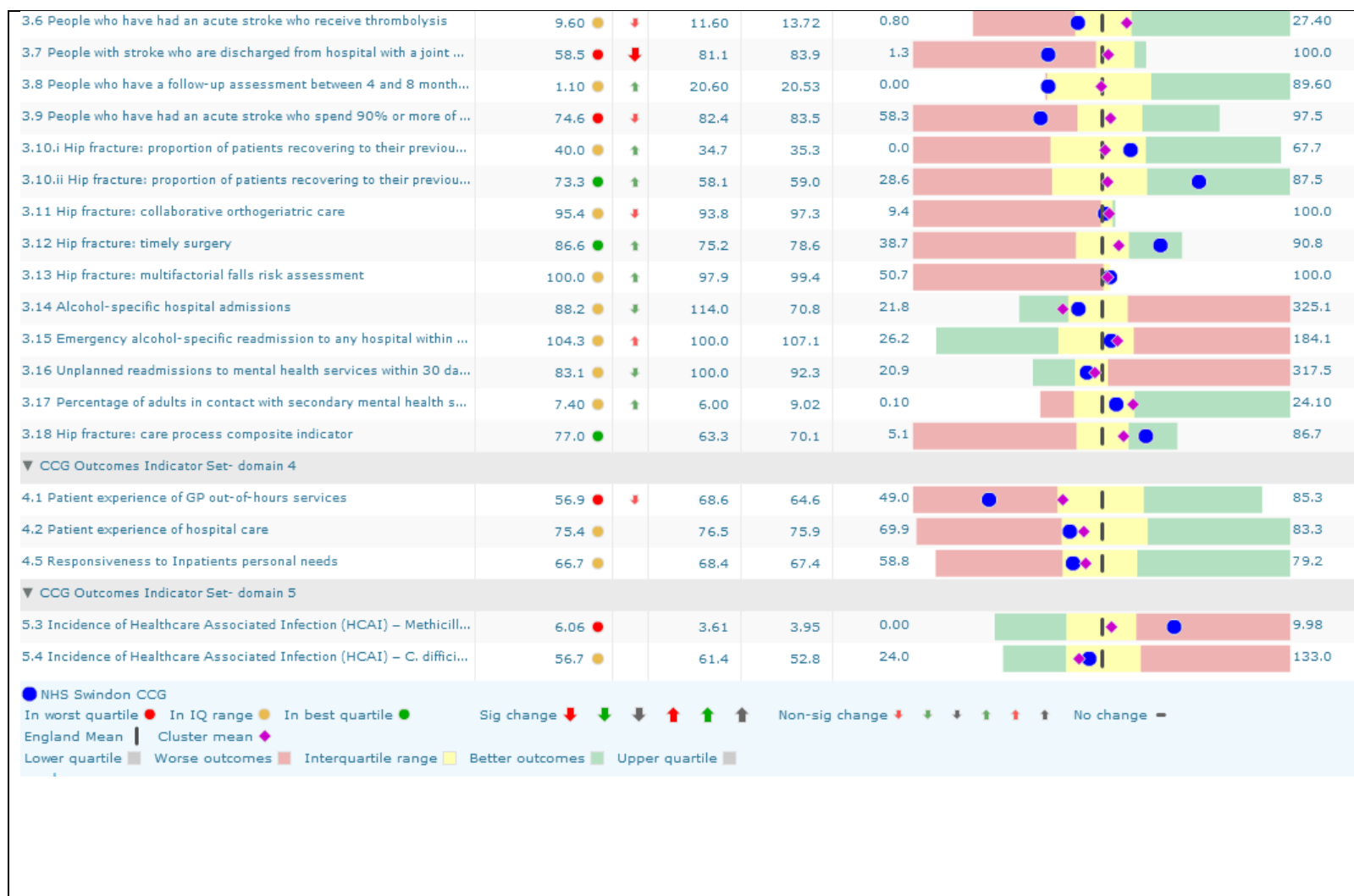
## OUR POPULATION AND PERFORMANCE<sup>2</sup>

We have set improvement targets over the next five years for every outcome in all 5 domains but 3 in particular require additional attention and intervention: **Potential Years of Life Lost**, **Avoidable emergency admissions** (including unplanned admissions for chronic conditions that can be treated through ambulatory care), and support for those with long term conditions (who currently do not feel supported):



<sup>2</sup> From tools on this NHS England website: <https://www.england.nhs.uk/resources/resources-for-ccgs/ccg-out-tool/> accessed 4/3/16

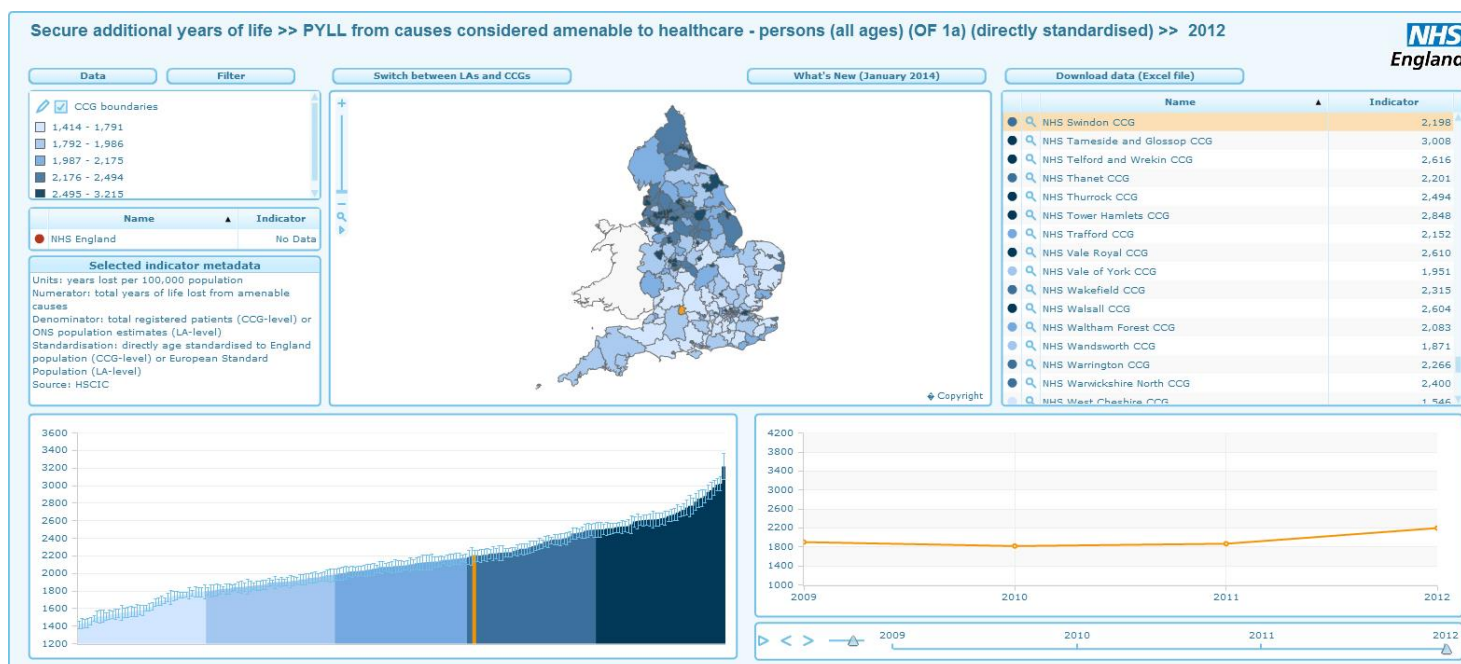




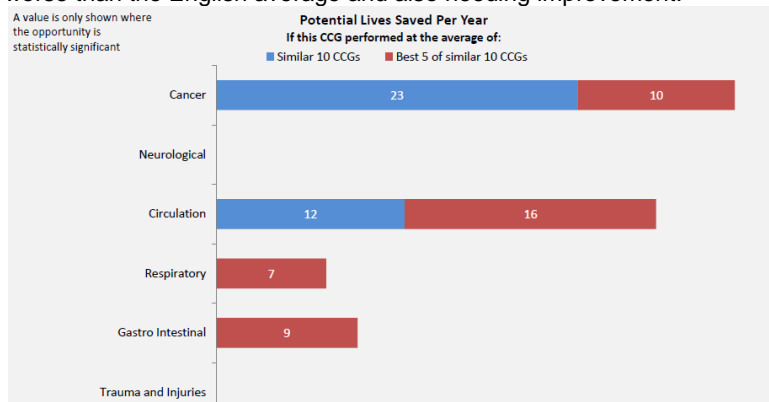
## AREAS FOR IMPROVEMENT

### Potential years of life lost (PYLL) and saved

**Swindon's PYLL** has moved from being best tertile to worst tertile in the single year of 2012 and our ambition is to return to the best tertile position at 1800 or where the local community was in 2010. With the exception of diabetes (female deaths working age) and respiratory disease (under 75 for both genders), mortality through avoidable deaths are fewer in Swindon than the English average. In 2009 (the latest year for which we have national statistics with which to compare), less than one per cent of the Swindon population died with the main causes of death being: RTA amongst children followed by congenital abnormalities; suicide was the main cause of death in the 15 to 34 age group; then coronary heart disease for men from 35 onwards and for women over the age of 65. For women aged between 35 and 64, breast cancer was the leading cause of death.



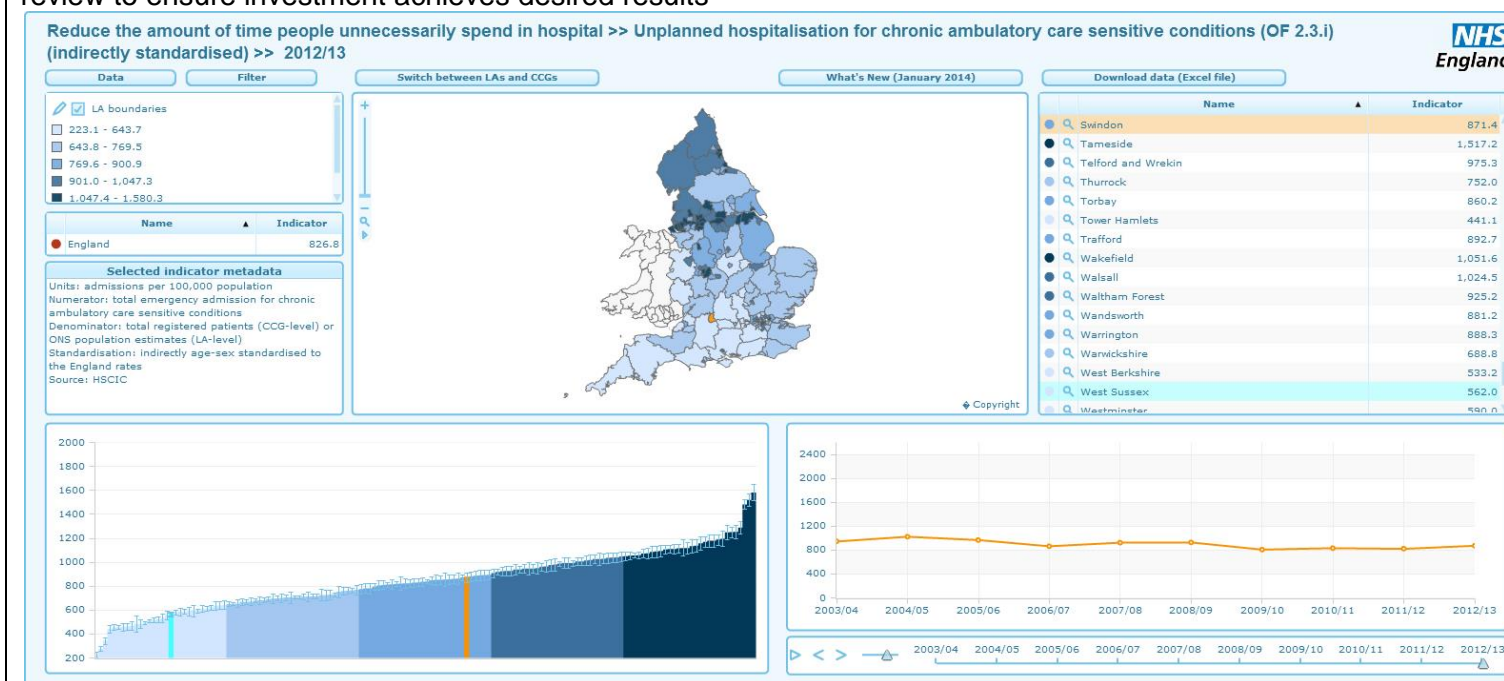
The main opportunities for intervention are in cancer and circulatory disease (see below) with under 75 mortality from respiratory disease being worse than the English average and also needing improvement:





### Avoidable emergency admissions

The Joint Strategic Needs Assessment spoke of a growth in admissions but did not differentiate between unplanned and planned admission. Recently in 2013/14 our emergency admissions have grown. Our GP referral rate has averaged around 5% between 2007-2014 and this has seen a growth in planned admission of 5% as well per annum, the overall impact is a growth slightly higher than our population growth, which is unaffordable in the long term. The CCG 5 year strategy supported by the Better Care Fund is an ambitious programme of change for both referral management and greater use of technology to allow specialist consultation to happen within primary care and the community to achieve a 15% reduction in emergency admission over 5 years. The CCG 5 year strategic plan also analyses spent by condition, disability and disease as our spent is not achieving the improvement in outcomes we aspire to. This is an area of work for review to ensure investment achieves desired results





In assessing the likely growth in **demand** for healthcare, we have gone back to our population and the impact we predict from population growth on each of our programmes of spend, the impact of additional housing investment in the latter years of our strategy and the potential impact of changes in our demography and levels of deprivation.

Some conditions will see more growth than others due to the forecast age distribution of our population and this is shown in the table below. Taking mental health as an example, we have assumed significant growth in Dementia at 5.03% growth per annum and built this into our mental health programme, as well as factoring in a growth in depression in those living longer with a limiting or chronic illness, but this is partly offset by our assumption of nearly zero population driven growth in demand in the young and working age population. We acknowledge the Parity of Esteem initiative and will work with our providers to achieve this.

## Forecast growth in demand and indicative programme spend

This is based on age profile of users of services

Programme	2011-2012 (%)	2012-2013 (%)	Annual growth estimate	Projected spend before inflation, developments and efficiencies					
				2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019
Mental health	14.69%	14.05%	3.83	37.3	37.3	38.7	40.2	41.7	43.3
Circulation	10.52%	11.56%	4.05	31.8	33.1	34.4	35.8	37.3	38.8
Genitourinary	7.08%	7.05%	4.04	19.5	20.2	21.1	21.9	22.8	23.7
Gastrointestinal	6.46%	6.68%	1.39	17.9	18.2	18.4	18.7	19.0	19.2
Cancer	6.46%	6.33%	4.11	17.5	18.2	19.0	19.7	20.5	21.4
Neurological	6.46%	5.20%	3.62	14.3	14.8	15.4	15.9	16.5	17.1
Musculoskeletal	6.35%	7.70%	4.04	21.2	22.1	23.0	23.9	24.9	25.9
Respiratory	5.83%	6.19%	3.44	17.0	17.5	18.2	18.8	19.4	20.1
Learning disability	5.73%	2.35%	0	14.5	14.5	14.5	14.5	14.5	14.5
Maternity	5.21%	5.37%	1.39	15.0	15.2	15.4	15.6	15.9	16.2
Endocrine	4.38%	4.43%	3.87	12.2	12.6	13.1	13.6	14.1	14.7
Dental	3.96%	4.34%	1.39	11.7	11.8	12.0	12.2	12.3	12.5
Trauma and injuries	3.96%	4.80%	2.01	13.0	13.2	13.5	13.8	14.0	14.3
Vision	3.44%	3.62%	4.04	10.0	10.4	10.8	11.2	11.7	12.2
Skin	2.92%	3.74%	1.01	10.0	10.1	10.2	10.3	10.4	10.5
Infectious diseases	1.77%	1.99%	1.39	5.4	5.4	5.5	5.6	5.7	5.8
Poisoning	1.56%	1.26%	1.11	3.3	3.4	3.4	3.4	3.5	3.5
Neonatal	1.46%	1.36%	0	3.6	3.6	3.6	3.6	3.6	3.6
Hearing	1.04%	0.99%	2.01	2.7	2.7	2.8	2.8	2.9	2.9
Blood disorders	0.73%	0.99%	1.11	2.6	2.7	2.7	2.7	2.7	2.8

### Remove maternity, neonatal, mental health and LD

Totals (including specialist services)	209.9	216.5	223.4	230.4	237.8	245.4
Overall growth in demand (%)		3.15	3.15	3.17	3.18	3.19

#### 4) PLAN OF ACTION – PROGRESS AT MARCH 2016 - Key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Swindon already has integrated joint commissioning and delivery in place. This is supported by Section 75 Agreements for adult social care, community health and mental health services. These agreements were revised in 2014 so that a new Section 75 is in place with a schedule for the Better Care Fund from 1<sup>st</sup> April 2015 for five years. The Better Care Fund is a schedule of the section 75 agreement and this Plan will form part of the schedule for 2016.

Ref no.	Scheme	Milestones Q1/2 2014/15	Milestones Q 3/4 2014/15	Milestones Q1/2 2015/16	Milestones Q3/4 2015/16	Progress at March 2016
1	<b>Integrated Crisis and rapid response</b> Crisis support to prevent admission to hospital and enable those who leave hospital. Access to assessment facility for people discharged from hospital linked to reablement so that length of stay in hospital reduces and people are able to regain their skills as quickly as possible.	Urgent care workshop to reduce length of stay in hospital	Review of Crisis and Single Point of access in view of care Act requirements Implement 7 day working in therapy services at the front door linked to rapid response services through additional OT and therapy services	Ensure Crisis services and rapid response use on line self assessment process for social care so that there is a speedy assessment process	Improve e-communication between secondary, primary and community care (crisis support, carer support, hospital discharge schemes, reablement, social care support 24/7)	Crisis and reablement services have been integrated and released additional capacity. Self assessment tool has been tested and roll out started in customer services. 7 day social work and OT services in place in hospital with access to domiciliary care bridging services at weekend.
2	<b>Enhanced Reablement</b> People will regain skills as quickly as possible without the need for on-going support. This will be provided from an integrated service including OT and therapists with direct referrals from the Hospital Discharge team to enable speedy discharge from hospital.	Analysis of end of year data for reablement 2013/14 completed with 330 people supported during the year	Additional £70k investment in reablement services to increase capacity  Research into older people social care services commissioned to identify future commissioning priorities	Continue investment in reablement services Implement findings from audit of reablement services and determine whether research into older people needs changes the service model	Implement findings from audit of reablement services and determine whether research into older people needs changes the service model	Additional investment in reablement, Fessey made. Review of reablement completed and shared with SEQOL. Reablement principles to be included in domiciliary care tender published March 2016

Ref no.	Scheme	Milestones Q1/2 2014/15	Milestones Q 3/4 2014/15	Milestones Q1/2 2015/16	Milestones Q3/4 2015/16	Progress at March 2016
3	<p><b>Community navigators and enhanced voluntary sector capacity</b> The role of the community navigator will be to coordinate a holistic plan for patients at high risk of hospital admission. Patients with long term conditions are identified through risk stratification which is in place in all GP surgeries.</p> <p><b>Wider community capacity</b> Commissioning of mental health third and voluntary sector contracts to support demand for health and social care services</p>	<p>Development and establishment of community navigator project</p> <p>First evaluation of community navigator pilot</p> <p>Tendering of community based mental health services</p>	<p>Second evaluation of community navigator to be completed to establish potential for roll out and cost effectiveness of the model</p> <p>Risk stratification implemented</p> <p>Roll out to further GP practices in Locality 2 Implementation of over 75 year old funding to GP practices to establish care plans for all frail older people</p> <p>Community based mental health services through voluntary and third sector in place</p> <p>Commissioning of home from hospital enhanced service</p> <p>Circles of Support supporting older people on low care packages</p>	<p>Further development dependent on second evaluation of community navigator</p> <p>Older people workstream commences to explore community based support and reduce admissions to residential care</p> <p>Tendering of befriending services for older people</p> <p>Testing of advocacy specification for older people, mental health and learning disabilities</p>	<p>Implementation of new befriending service</p> <p>Community navigator supporting 220 patients with individual care plans identified through risk stratification at the end of Q3. Some reduction in emergency admissions has been seen from this cohort</p> <p>Tendering of advocacy specification for older people, mental health and learning disabilities</p> <p>Evaluation of home from hospital services</p>	<p>Community navigator evaluated and extended to June 2017</p> <p>Tender on befriending delayed so it could be coordinated with GWH commissioned service.</p> <p>Befriending services in place through Red Cross, Age UK and Circles of Support. Meeting with voluntary sector to reduce fragmentation and scope new tender</p> <p>Advocacy service extended in 2015 to meet care Act requirement. New tender April 2016</p> <p>Evaluation completed and new tender late spring 2016</p> <p>Circles of Support supporting 50 older people</p>

Ref no.	Scheme	Milestones Q1/2 2014/15	Milestones Q 3/4 2014/15	Milestones Q1/2 2015/16	Milestones Q3/4 2015/16	Progress at March 2016
3 cont..	The development of a single database <b>My Care, My Support</b> that can be accessed by the patient and workers in development of support	Co-location of voluntary and community sector and launch of 'My Care My Support'  Advice and Information services for adult social care and community health services in place, meeting requirements of Care Act	Development of online self assessment lined to My care My Support for service users	Implementation of online self assessment	Evaluation of use of online self assessment for service users in first 6 months	My Care My Support live at <a href="http://www.mycaremysupport.co.uk/">http://www.mycaremysupport.co.uk/</a> Self assessment questionnaire live in hospital social work team and review team.
4	<b>Community Rehabilitation Scheme (Fessey)</b> Nursing assessment beds with enhanced health care so that patients can be discharged from hospital more quickly.	Implementation of residential reablement services	Additional 16 discharge to assess beds to support patient flow with additional therapy to support regaining of skills	Evaluate discharge to assess models and determine future funding into 2015/16		Evaluation of Fessey and Discharge to Assess beds completed and part of Delayed Discharge Programme. Additional D2A beds have been in place since July 2015.
5	<b>Enhanced hospital discharge</b> We will continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible. We will ensure access to brokerage and verification services so that there is speedy access to social care packages seven day a week.	Re-design workshops: mental health, carers, diabetes, COPD, and dementia	Implementation of ECIST findings with improved hospital discharge service  Urgent care workshop to promote patient flow	Review and revise admission and discharge management processes and invest in systems to reinforce clinical decision making at point of admission	Implement any findings from reviews to ensure speedy discharge from hospital and reduce delayed discharge	7 day social work funded, additional manager post funded, DART model evaluated and report shared with SEQOL and GWH. New system to be implemented 1.4.2016  Delayed discharge of care have continued to be high for social care. The main reasons are completion of

Ref no.	Scheme	Milestones Q1/2 2014/15	Milestones Q 3/4 2014/15	Milestones Q1/2 2015/16	Milestones Q3/4 2015/16	Progress at March 2016
						<p>assessment, awaiting domiciliary care and residential and nursing care. An additional 1,500 domiciliary care per week (20% increase) has been purchased by social care as well as additional beds in residential care. NHS England completed a diagnostic in December 2015. In response a programme of work has been established with several work streams to reduce delays. Weekly meetings of CCG and GWH are taking place at executive level to resolve barriers to discharge. Weekly operational meetings are taking place to resolve operational barriers with daily discussions on individual patients.</p> <p>Delays due to social care for GWH and SWICC Intermediate care based on days lost were:</p> <p>October 2015: 268 days  November 2015: 261 days  December 2015: 287 days</p> <p>A target has been set to reduce days lost by 50% by 31.3.2017</p>

Ref no.	Scheme	Milestones Q1/2 2014/15	Milestones Q 3/4 2014/15	Milestones Q1/2 2015/16	Milestones Q3/4 2015/16	Progress at March 2016
6	<b>Learning disability</b> We will re-commission services by shifting towards a supportive living model by stimulating the local market and expanding both occupational and educational opportunities. A project team is in place from January 2014.	Learning disability workstream established  Enhanced learning disability transition planning implemented	Learning disability research commissioned to determine improved transition planning and reduction in use of residential care  Development of community based housing support to reduce use of residential care	Implementation of improved transition process from children to adult services for those with a disability  Establishment of action plan to address findings from commissioned research	Re-commission community based support and supported accommodation for people with learning disabilities	Learning disability work stream completed, service transferred to SBC. Five transition link workers recruited. Transition working group to be evaluated
7	<b>Carers Support</b> in place to ensure good assessment and support services are in place	Carers workshop on current provision and planning for care Act completed  Steering Group to implement requirements of Care Act established	Development of common assessment process for carers  Development of on line carers assessment  Increased capacity for carers assessment through work with carers centre	Implementation of carers assessment on-line	Implementation of carers support in relation to Care Act duties  Monitor and assess impact of online self assessment for carers	Carer assessment in line with Care Act implemented, additional capacity funded in carers centre, increase in carers' assessments delivered, additional support for carers funded.  Carers' self assessment designed, awaiting implementation of IT solution.
8	<b>Capital allocation for social care</b>		Contract for on line self assessment for service users agreed	Capital used to support implementation of care act duties in relation to financial systems	Capital used to support implementation of care act duties in relation to financial systems	Capital programme delivered
9	<b>Implementation of new responsibilities under the</b>		Development and	Implementation of social	Implementation of	Care Act implementation

Ref no.	Scheme	Milestones Q1/2 2014/15	Milestones Q 3/4 2014/15	Milestones Q1/2 2015/16	Milestones Q3/4 2015/16	Progress at March 2016
	<b>Care Act 2014</b> We will be implementing the required systems under the Health & Social Care Bill and prepare systems for an increase in financial assessments and self-assessments. Wherever possible we will be investing in new technology to automate processes as quickly as possible.		implementation of Care Act requirements in relation to carers and assessments  Workforce development workshops on personalisation and Care Act  Business case for 7 day working in social care agreed and implemented	care self-assessment on-line  Development of financial assessment systems in relation to Care Act  Workforce development implementation to meet new duties	financial systems in relation to Care Act  Continued workforce development in relation to the Care Act	delivered, safeguarding single point of access established in SBC, care Act training delivered, new assessment Care Act compliant. Workforce development delivered.
10	<b>Supporting independence and reducing length of stay in hospital</b> Virtual Ward, Intermediate Treatment beds (SWICC), Hospital discharge services and 7 day working for clinicians	Schemes already fully implemented	Dementia Strategy action plan in place  Dementia ward opened in GWH	Continued improvements to patient flow across the health system	Continued improvements to patient flow across the health system	Dementia team established and operational 1.12.2015. Dementia Strategy in place, steering group established, Diagnosis waiting time reduced to 6 weeks.
11	<b>Alternative community based health services preventing hospital admissions</b> Continued development and enhancement of a range of community based support such as the Single Point of Access, SUCCESS, nurse home visiting	Development and initiation of SUCCESS centres  Development of business case for 'Fix Me Hub'  Development of ambulatory pathways for the frail elderly	Full operation of the SUCCESS Centre  Implementation of personal health budgets  GP led initiatives for older people over the age of 75 years with care planning and nurse led services in place	Continued operation of SUCCESS model	Delivery of community based support for older people with long term health conditions including rapid access clinics and live telephone consultations  Implementation of schemes to mitigate	SUCCESS centres delivered with increased appointments. 10,047 SUCCESS appointments, 675 of which were home visits in Q3. All practices are now able to book electronic appointments for SUCCESS



Ref no.	Scheme	Milestones Q1/2 2014/15	Milestones Q 3/4 2014/15	Milestones Q1/2 2015/16	Milestones Q3/4 2015/16	Progress at March 2016
		Out of hospital strategy developed			<p>demand for 2016/17 based on data analysis under taken in 2014/15</p> <p>Rapid Assessment Unit - 464 patient contacts in Q3, new pathways operational from October 2015 which increase flows of patients</p>	<p>ALL GP practices able to book electronic appointments</p> <p>Urgent Care Programme Board established with workstreams to reduce hospital admissions, including maximising home based support</p> <p>Front Door model for ED has been reviewed and patients attending with a minor illness are streamed to neighbouring Urgent Care Centre (from Dec 2015)</p> <p>Communications Strategy developed and commenced December 2015 which supports prevention messages and public understanding of alternative services.</p>
12	<p><b>Adult social care support for older people and those with a learning disability</b></p> <p>Increase in care packages due to demographic pressure. Work with residential and nursing providers to increase access to health care within</p>		Data analysis of demand by older people for acute and residential care services and responding action plan	Implement recommendations from research to manage demand for older people services	<p>Extend lifelong health planning to planning for retirement</p> <p>Implement recommendations from research to manage demand for older people services</p>	<p>Service insourced and additional management recruited. Caseload reviewed and reshaped, training delivered. Exception panel continued. Transition to be evaluated</p> <p>Older people work stream established to manage</p>

<b>Ref no.</b>	<b>Scheme</b>	<b>Milestones Q1/2 2014/15</b>	<b>Milestones Q 3/4 2014/15</b>	<b>Milestones Q1/2 2015/16</b>	<b>Milestones Q3/4 2015/16</b>	<b>Progress at March 2016</b>
	homes so that admissions to hospital reduce					demand which increased by 205 in 2015/16

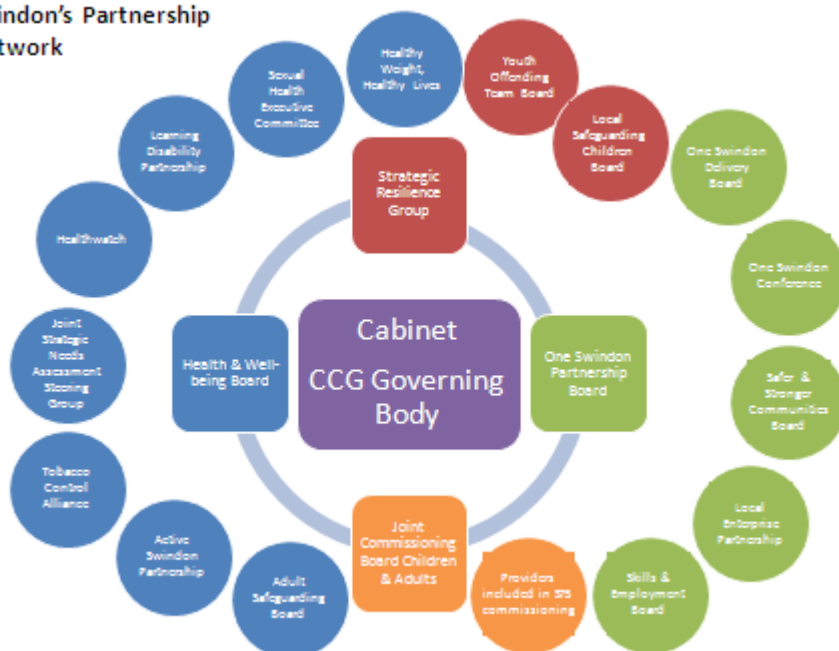
## b) Please articulate the overarching governance arrangements for integrated care locally

Swindon has two National Health Services Act 2006 section 75 Agreements for the commissioning of adult health and social care services including mental health and commissioning of health, education and social care services for children. A joint commissioning plan bringing together all our joint priorities as well as a delivery plan is in place. These are reviewed six monthly and renewed annually by the Joint Commissioning Group referred to below.

Governance arrangements to monitor the section 75 Agreements are already in place through the Joint Commissioning Group (JCG). The CCG and Swindon Borough Council, including Public Health are members of the JCG. Meetings of the Group take place monthly. The Group reports through to the Health and Wellbeing Board at every meeting. The Better Care Fund sits as a pooled fund within the Section 75 Agreement and is monitored by the JCG. The existing Section 75 Agreements have been refreshed to take account of the new arrangements.

The Joint Commissioning Group Terms of Reference have been amended to provide a link to the Health & Wellbeing Board who agreed the Better Care Fund. There are also links between the Better Care Fund and the Operational Resilience and Capacity Plan and the Swindon Strategic Systems Resilience Group which is the new whole system network designed to bring together multiple stakeholders from across Swindon and Wiltshire and replaces the Strategic Change Forum.

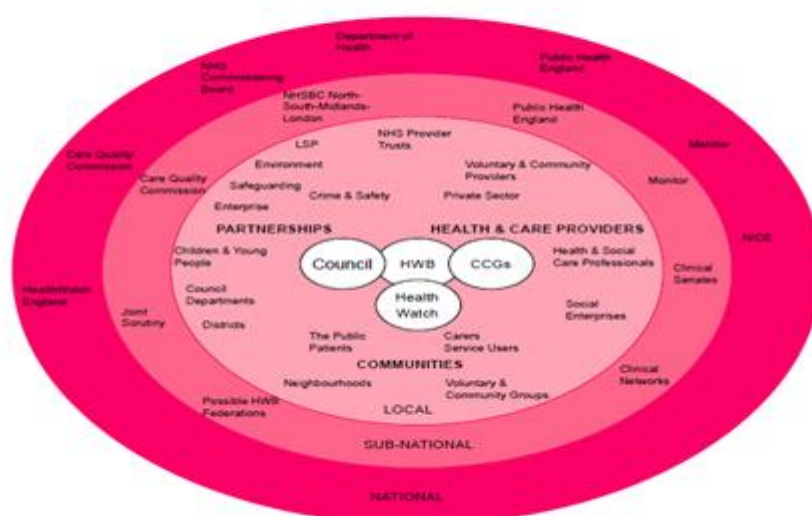
**Swindon's Partnership Network**



## Purposeful partnerships

Partnership	Purpose
Health and Well-being Board	<ol style="list-style-type: none"> <li>1. Assess the needs of the local population and lead the Joint Strategic Needs Assessment</li> <li>2. Develop a joint Health and Well-being Strategy based on the Joint Strategic Needs Assessment</li> <li>3. Promote integration and partnership across areas, including through promoting joined-up commissioning plans across the NHS, social care and public health</li> <li>4. Support joint commissioning and pooled arrangements where all parties agree this makes sense</li> </ol>
One Swindon Partnership Board	<ol style="list-style-type: none"> <li>1. Develop and work towards the shared long term vision for Swindon</li> <li>2. Focus resources on achieving the shared medium term outcomes for Swindon</li> <li>3. Promote effective multi-agency working across Swindon</li> <li>4. Understand Swindon's people and places and make the strategic changes required to realise the shared vision and outcomes e.g. a community budget</li> </ol>

## Health & Well-being Board: key relationships



c) Please provide details of the management and oversight of the delivery of the Better Care Fund plan, including management of any remedial actions should plans go off track

Operationally, the delivery of the Better Care Fund Plan is through the CCG Executive Management Team and the Joint Commissioning Group. Joint membership of both groups is in place. Joint reports go to the Joint Commissioning Group as well as progress reports against the Joint Commissioning Plan. A progress report has been submitted to the JCG and the Health and Wellbeing Board in November 2015.

Each of the Better Care Fund schemes is part of either the CCG Interventions or the Adult Demand Programme. Project managers and workstream leads are in place for each scheme. New workstreams were established for Carers development in partnership with the Carers' Centre. This has resulted in a revised Care Act compliant Carers Assessment, a streamlined process for carers' breaks, and carers post within the hospital discharge team.

The delivery of joint community health and social care services is monitored through a monthly contract meeting. There are contractual arrangements in place for escalating performance issues.

GPs are provided with real time information from SEQOL that will inform practices on the activity of the community health service that has been involved in for their patients.

Delivery of workstream targets is reported to the Joint Commissioning Group and CCG executive team. Delivery issues and risks are reported to the relevant Board where remedial actions will be agreed.

d) **List of planned BCF schemes for 2016-17**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme	Governance
1	<b>Integrated Crisis and rapid response</b> Crisis support to prevent admission to hospital and enable those who leave hospital. Access to assessment facility for people discharged from hospital linked to reablement so that length of stay in hospital reduces and people are able to regain their skills as quickly as possible.	SEQOL contract management and reports to the Joint Commissioning Group.
2	<b>Reablement Service and Telecare</b> People will regain skills as quickly as possible without the need for on-going support. This will be provided from an integrated service including OT and therapists with direct referrals from the Hospital Discharge team to enable speedy discharge from hospital.	As above.
3	<b>Enhanced voluntary sector capacity</b> In particular we will commission voluntary and community based support linked to localities and GP practices. Supporting volunteers reduces the need for some targeted and specialist services. Community and voluntary sector groups provide important flexible services either informally or as part of local contracts.  Mental health wellbeing co-ordinators have been introduced through the commissioning of mental health third and voluntary sector contracts.  A website has been developed, <a href="http://www.mycaremysupport.co.uk/">http://www.mycaremysupport.co.uk/</a> , to provide information and advice to the public, staff and voluntary sector partners.	Joint workstream CCG Reports to the Joint Commissioning Group. Vulnerable Adults Programme Board
4	<b>Community and Residential Rehabilitation and Discharge to Assess</b> We are funding nursing assessment beds with enhanced health care so that patients can be discharged from hospital	Vulnerable Adults Programme Board

	more quickly. This programme is now established.	
5	<p><b>Preventing Hospital Admission and effective discharge</b></p> <p>We will continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible. We will ensure access to brokerage and verification services so that there is speedy access to social care packages seven day a week. Integrated discharge team comprising of health and social care is in place. Since November 2013 a Discharge Assessment and Referral Team (DART) has been in place to avoid admission and discharge as early as possible. Both services operate 7 days a week and work closely with hospital clinicians. We will be reviewing home from hospital support so that any delay is avoided and a community support package is in place. The Virtual Ward will be working closely with the hospital discharge services and the Single Point of Access to both avoid admissions and enable speedy discharge. Virtual Ward, Intermediate Treatment beds (SWICC), Hospital Discharge services and 7 day working for clinicians.</p> <p><b><u>Additional Scheme for 2016-17</u></b></p> <p><b>Delayed Transfer of Care Programme</b></p> <p>Sustainable reduction in number of DTOC and non-DTOC delays across the health and care system by 30.9.16, with planned reduction of current numbers by at least 50%.</p> <p>Agreed programme of work with clear outcomes and timelines for implementing the Newton Europe recommendations as these apply to delayed discharges.</p>	<p>CCG Interventions Programme DTOC Programme Board and Vulnerable Adults Programme Board</p> <p>DTOC Project Board reports to DTOC Programme Board (Swindon Borough Council, Swindon CCG, Wiltshire Council and Wiltshire CCG, Great Western Hospital NHS Trust, SEQOL)</p> <p>DTOC Programme Board reports to System Resilience Group</p>
6	<p><b>Carers' Support</b></p> <p>A joint carers' contract is already in place which was tendered in 2012/13. The Carers' Centre provides advice and</p>	Joint Commissioning Group

	<p>information for carers, welfare benefits advice as well as support groups. There is a GP outreach post. Young carers' support is provided by the same voluntary organisation and was part of the same tender. Outcomes for carers continue to improve. Additional investment was made available in April 2012 for short term breaks for carers and further investment has been made to deliver the requirements of the Care Act. Development of improved assessment process for carers and improved access to health checks.</p>	
7	<p><b>Capital Grant Adult Social Care</b> Capital allocations fund the disabled facilities grant scheme which is operated by Swindon Borough Council. It also funds large items of social care equipment required through the joint Integrated Community Equipment Store for children and adult services as well as investment in telehealth and telecare. We will continue investment in technology to support self-care and prevention and enable people with a disability to live as independently as possible.</p>	Joint Commissioning Group
8	<p><b>Community Health aimed at reducing emergency admissions</b> Continued development and enhancement of a range of community based support such as the Single Point of Access, SUCCESS, nurse home visiting</p>	CCG Interventions Programme and SEQOL contract management
9	<p><b>Managing increase in demand for adult social care</b> Increase in care packages due to demographic pressure leading to reduced length of stay in hospital. Work with residential and nursing providers to increase access to health care within homes so that admissions to hospital reduce</p>	Vulnerable Adults Programme Board
10	<p><b>Implementation of new responsibilities under the Care Act 2014</b> The funding provided within the Better Care Fund has contributed towards the cost of implementing the requirements of</p>	Joint Commissioning Group



	<p>the Care Act. These include carers' support, advocacy and safeguarding. We have implemented the required systems under the Health &amp; Social Care Bill. We have invested in new technology to allow on line self assessment and information and advice through <a href="http://www.mycaremysupport.co.uk">www.mycaremysupport.co.uk</a></p>	
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## Better Care Fund Plan 2016/17 Action Plan

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at June 2016
1	<b>Integrated crisis and rapid response</b>  Crisis support to prevent admission to hospital and enable those who leave hospital. Access to assessment facility for people discharged from hospital linked to reablement so that length of stay in hospital reduces and people are able to regain their skills as quickly as possible.	Review use of Discharge to Assess beds alongside Fessey rehabilitation beds to reduce length of stay in Fessey  Commission rapid response as part of re-commissioning of community and social care services, publication of process	Implement findings from review to assist with rehabilitation and start re-commissioning process for fessey  Commission rapid response as part of re-commissioning of community and social care services	Complete re-commissioning process for rehabilitation at Fessey, crisis and rapid response services  Complete commission rapid response as part of re-commissioning of community and social care services	Implement new service model  Implement new service model	
2	<b>Reablement Service and Telecare</b>  People will regain skills as quickly as possible without the need for on-going support. This will be provided from an integrated service including OT and therapists with direct referrals from the Hospital Discharge team to enable speedy discharge from hospital.	Maintain reablement capacity at 29 patients and £28 per hours and include principle in domiciliary care tender	Complete domiciliary care tender	Implement mobilisation of new model for domiciliary care including enabling patients to gain new skills	Implement new contract including enabling patients to gain new skills	

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at June 2016
3	<b>Enhanced voluntary sector capacity</b>  Commission voluntary and community based support linked to localities and GP practices. Supporting volunteers reduces the need for some targeted and specialist services. Community and voluntary sector groups provide important flexible services either informally or as part of local contracts. Mental health wellbeing co-ordinators have been introduced through the commissioning of mental health third and voluntary sector contracts.	Re focus community navigator scheme Shape specification for home from hospital, befriending and reducing isolation contracts  Amend specification for mental health in the voluntary sector to include autism and dual diagnosis	Monitor community navigator scheme  Tender home from hospital, befriending and reducing isolation services  Complete implementation of new specification	Monitor community navigator scheme  Complete tender home from hospital, befriending and reducing isolation services and mobilise for new service  Monitor implementation of amended mental health specification	Evaluation of community navigator completed and decision made about future service  Monitor first quarter performance of new service  Monitor performance of amended mental health specification	
4	<b>Community and residential rehabilitation and Discharge to Assess</b>  Funding nursing assessment beds with enhanced health care so that patients can be discharged from hospital more quickly. This programme is now established.	Review use of Discharge to Assess beds alongside Fessey rehabilitation beds to reduce length of stay in Fessey	Implement findings from review to assist with rehabilitation and start re-commissioning process for Fessey	Complete recommissioning process for rehabilitation at Fessey, crisis and rapid response services	Implement new model	

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at June 2016
5	<p><b>Preventing hospital admissions and effective discharge</b></p> <p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible.</p> <p>Ensure access to brokerage and verification services so that there is speedy access to social care packages seven day a week.</p> <p>Integrated Discharge Team comprising of health and social care is in place. Since November 2013 a Discharge Assessment and Referral Team (DART) has been in place to avoid admission and discharge as early as possible. Both services operate 7 days a week and work closely with hospital clinicians. The Virtual Ward will be working closely with the hospital discharge services</p>	<p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible.</p> <p>Ensure access to bridging and D2A at weekend so that there is speedy access to social care packages seven day a week.</p> <p>Implement findings from review of DART/IDT</p> <p>Re-commissioning of community and social care services, publication of process</p>	<p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible.</p> <p>Ensure access to bridging and D2A at weekend so that there is speedy access to social care packages seven day a week.</p> <p>Start plan of transferring management of social work to SBC and monitor implementation of DART processes</p> <p>Tender evaluation of re-commissioning of community and social care services</p>	<p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible.</p> <p>Bridging principle part of mobilisation of domiciliary care tender</p> <p>Start Transfer social work and social care staff to SBC</p> <p>Complete tender of community health and social care services</p>	<p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible.</p> <p>Bridging principle part of new domiciliary care service</p> <p>Complete Transfer social work and social care staff to SBC</p> <p>Implementation of new models of care following completion of tender</p>	

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at June 2016
	<p>and the Single Point of Access to both avoid admissions and enable speedy discharge. Virtual Ward, Intermediate Treatment beds (SWICC), Hospital Discharge services and 7 day working for clinicians.</p> <p><u>Additional Scheme for 2016-17 - Delayed Transfer of Care Programme</u></p> <p>Sustainable reduction in number of DTOC and non-DTOC delays across the health and care system by 30.9.16, with planned reduction of current numbers by at least 50%.</p> <p>Agreed programme of work with clear outcomes and timelines for implementing the Newton Europe recommendations as these apply to delayed discharges and prevention of admission</p>	<p>Implement delayed discharge programme with fortnightly project team and Programme Board meetings.</p> <p>Implement workstreams from Newton Europe and urgent care Programme</p>	<p>Complete delayed discharge programme with fortnightly project team and Programme Board meetings.</p> <p>Implement workstreams from Newton Europe and urgent care Programme with work streams and monitor performance</p>	<p>Monitor completed delayed discharge programme with monthly project team and Programme Board meetings. Add and adjust workstreams to maintain performance</p> <p>Implement workstreams from Newton Europe and urgent care Programme with work streams and monitor performance. Adjust programme based on evaluation of performance</p>	<p>Monitor completed delayed discharge programme with monthly project team and Programme Board meetings. Add and adjust workstreams to maintain performance</p> <p>Implement workstreams from Newton Europe and urgent care Programme with work streams and monitor performance. Adjust programme based on evaluation of performance</p>	
6	<p><b>Carers' Support</b></p> <p>A joint carers' contract is already in place which was</p>	Monitoring of carers contract and	Monitoring of carers contract and	Monitoring of carers contract and	Monitoring of carers contract and	

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at June 2016
	tendered in 2012/13. The Carers' Centre provides advice and information for carers, welfare benefits advice as well as support groups. There is a GP outreach post. Young carers' support is provided by the same voluntary organisation and was part of the same tender. Outcomes for carers continue to improve. Additional investment was made available in April 2012 for short term breaks for carers and further investment has been made to deliver the requirements of the Care Act. Development of improved assessment process for carers and improved access to health checks.	implementation of new carer post in hospital discharge process Testing of online carer assessment	implementation of new carer post in hospital discharge process Training and start implementation of online carer assessment	implementation of new carer post in hospital discharge process Training and start implementation of online carer assessment	implementation of new carer post in hospital discharge process Training and start implementation of online carer assessment	
7	<b>Capital Grant adult social care</b>  Capital allocations fund the disabled facilities grant scheme which is operated by Swindon Borough Council. It also funds large items of social care equipment required through	Continue investment in technology to support self-care and prevention and enable people with a disability to live as independently as	Continue investment in technology to support self-care and prevention and enable people with a disability to live as independently as possible.	Continue investment in technology to support self-care and prevention and enable people with a disability to live as independently as possible.	Continue investment in technology to support self-care and prevention and enable people with a disability to live as independently as possible.	

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at June 2016
	the joint Integrated Community Equipment Store for children and adult services as well as investment in telehealth and telecare.	possible.				
8	<b>Community Health aimed at reducing emergency admissions</b>  Continued development and enhancement of a range of community based support such as the Single Point of Access, SUCCESS, nurse home visiting	Evaluation of Rapid response, single point of access and commission as part of community and social care tender  Evaluate SUCCESS and rapid response to determine future funding	Complete tender of Rapid response, single point of access and commission as part of community and social care tender  Evaluate SUCCESS and rapid response to determine future funding	Complete tender of Rapid response, single point of access and commission as part of community and social care tender  Evaluate SUCCESS and rapid response to determine future funding	Mobilisation and implementation of new contract  Evaluate SUCCESS and rapid response to determine future funding	
9	<b>Managing increase in demand for adult social care</b>  Increase in care packages due to demographic pressure leading to reduced length of stay in hospital. Work with residential and nursing providers to increase	Continue to improve social work decision making on care packages by implementing vulnerable adults programme and	Continue to improve social work decision making on care packages by implementing vulnerable adults programme and demand management	Continue to improve social work decision making on care packages by implementing vulnerable adults programme and demand management	Continue to improve social work decision making on care packages by implementing vulnerable adults programme and demand management	

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at June 2016
	access to health care within homes so that admissions to hospital reduce	demand management. Share demand data with HWB Provider Forum				
	<b>Implementation of new responsibilities under the Care Act 2014</b>  The funding provided within the Better Care Fund has contributed towards the cost of implementing the requirements of the Care Act. These include carers' support, advocacy and safeguarding. We have implemented the required systems under the Health & Social Care Bill. We have invested in new technology to allow on line self assessment and information and advice through <a href="http://www.mycaremysupport.co.uk">www.mycaremysupport.co.uk</a>	Continue to increase adverts and advice and information on My care My Support, mobilise voluntary sector to give advice and support. Tender advocacy service , implement online assessment	Continue to increase adverts and advice and information on My care My Support, mobilise voluntary sector to give advice and support. Complete tender advocacy service , implement online assessment	Continue to increase adverts and advice and information on My care My Support, mobilise voluntary sector to give advice and support. Mobilise for new advocacy service , implement online assessment	Continue to increase adverts and advice and information on My care My Support, mobilise voluntary sector to give advice and support. Monitor new advocacy service , implement online assessment	



## 5) RISKS AND CONTINGENCY 2016/17

### a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	How likely is the risk to materialise? <i>Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely</i>	Potential impact <i>Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact</i>  <i>And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)</i>	Overall risk factor <i>(likelihood *potential impact)</i>	Mitigating Actions
<b>Risk 1:</b> Demand at a higher rate than population growth assumption of 2.8 - 3.2%	4	5 Not achieving reduction of 3.5% will result in a CCG pressure of £1m. The schemes within BCF are already part of SEQOL block contract. Therefore CCG will allocate funding for over performance for acute health care from 2016/17 allocation (CCG risk).	20	Focus on self-care and prevention through My Care, My Support and Voluntary sector commissioning – Acting Director Adult Social Services by 31 3 2017 A range of health led interventions addressing unplanned admission to hospital outlined in CCG 5 year Sustainable Transformation Plan – Lead Accountable Officer CCG by June 2016
<b>Risk 2:</b> Community based self-care pilots too small to impact on demand	5	4 No financial impact as community navigator for 2016/17 will be funded from national transformation fund. If there is over performance in adult social care (SBC risk) or acute health care (CCG risk) then these will be funded by core budget from SBC and	20	Link of community navigator and mental health wellbeing coordination schemes to maximise impact, Acting Head of Adult Social Services. SUCCESS scheme and nurse led home visiting services funded by CCG core budget. Lead

		CCG core budget outside of BCF respectively		Accountable Officer CCG June 2016
Risk 3 Demand outstrips capacity in reablement services	4	3 £1.7m allocated for demand in older people by SBC for 2016/17.SBC risk	12	Spot purchasing of bridging packages through Better Care Fund allocation from BCF. Re-commissioning of domiciliary care services through prime contractor model Head of Commissioning Children & Adults (start April 16)
Risk 4 Patients continue to go to A&E rather than community alternatives leading to increased hospital admissions	5	4 Not achieving reduction of 3.5% will result in a CCG pressure of £1m. the schemes within BCF are already part of SEQOL block contract. Therefore CCG will allocate funding for over performance for acute health care from 2016/17allocation (CCG risk)	20	Communication strategy, close work between GP practices and community health services. Distribution of information materials, promotion of online advice and information and targeted media using MOSAIC data– April 2016 Associate Director of Commissioning (Out of Hospital)
Risk 5 Political resistance to change	2	5 No measurable financial impact	10	Cross Party Lead Member Advisory Group in place monitoring adult change programme. Good political ownership and multi-agency ownership of vision and strategy through Health & Wellbeing Board and JCG from April 16- Interim (DASS) and Clinical Chair

Risk 6 Cultural change required from staff across public sector	4	4 No measureable financial impact	16	Multi agency workforce development programme across Swindon on managing expectation and managing change through redesign workshops and workforce development. Actions throughout 2016/17 Head of Commissioning Children & Adults
Risk 7 Capacity to drive pace of change under developed	4	4 No measurable financial impact as all schemes have project management allocated already	16	Additional programme management in place for urgent Care and DTOC Programmes from January 2016
Risk 8 NHS Provider viability - Potential risk to small and medium size providers during tendering of services and the potential of service disruption	3	3 Likelihood assessed as remote – no financial risk quantified (CCG risk)	9	Publication of tender for community services and social care as well as domiciliary care in March 2016 following soft market testing and provider engagement in 2015

### **b) Contingency plan and risk sharing**

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

There is a formal risk sharing process in place between the CCG and Great Western Hospital linked to the delivery of QIPP schemes and over performance against the contract. Mitigating schemes continue to be developed to ensure that we are able to

manage the demand for unscheduled care and the Swindon Strategic Resilience Forum will review this on a monthly basis.

Swindon Borough Council agrees to undertake work with those care homes in Swindon that have been identified with the highest hospital admissions based on data to be supplied by Swindon CCG. Further discharge to assess capacity will be secured if patient flow issues are identified by sourcing additional nursing beds in care homes locally.

In developing and quantifying the projected financial and service benefits from the programme of schemes a full PMO process has been followed. Operational risk is managed by the organisation sponsoring the scheme, with an executive officer being accountable for delivery of each scheme. Risk registers are in place for every scheme and are regularly monitored and reviewed both during the formation and implementation phases.

In identifying schemes, and quantifying the potential benefits, a structured approach has been followed and a standard methodology used to risk assess the potential financial benefits and risks. Third party evidence has been used wherever possible to support changes proposed and where lacking, financial benefits have been risk adjusted. For example, activity prices and volume shifts are based on local systems experience and historical data.

Standard tools have been used to ensure that any proposed benefits are probability weighted and projects are treated objectively. Although much of this has been process driven, management judgement has also had to play its part. The expected benefits of schemes are monitored and reported against on a monthly basis so remedial actions can be taken in a timely fashion.

Each partner takes the risk for over performance in the areas as follows:

If targets for admission to residential care are not achieved in 201/17 for adult social care, then the Council's core budget will cover an increase in demand. This is not likely as data analysis has shown that although more people were admitted, the length of stay reduced and therefore there are no adverse financial impact

- Additional £200k has been allocated from the BCF for discharge to assess. Demand over and above this figure will be met by Swindon Borough Council. SBC has committed through the DTOC Programme to reduce delays due to social care by 50% in 2016/17 based on bed days in GWH.
- The CCG has allocated growth funding for GWH from its core budget including additional demand for emergency admissions. The CCG allocation of the better care fund excluding capital is 60% compared to 40% for social care related schemes. Swindon Borough Council agreed to this figure which is less than 50% so that the potential 10% could be aimed at reducing emergency admissions. Swindon Borough Council agrees that if emergency admissions rise over target that the CCG share of BCF of 60% can be used to fund demand for hospital care. If the target of 3.5% reduction in hospital admission is not met, then the CCG will budget for over performance from its allocation as schemes within the BCF form part of the SEQOL block contract.

## 6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

This plan links closely to the strategies and plans referenced in Section 1 of this document.

The Urgent Care Programme, the DTOC Programme and CCG Interventions include community navigators, the SUCCESS scheme, Rapid Assessment Unit and Urgent Care Centre. These interventions will contribute to the reduction in emergency admissions to hospital.

As explained elsewhere the Better Care Fund brings together schemes which are part of the SEQOL contract, CCG Interventions and the Vulnerable Adults Programmes. It develops the schemes further to address our joint priorities. These schemes are also aligned with the Swindon Operational Resilience and Capacity Plan.

Personal budgets in social care have been implemented with over 63% of the population in receipt of a personal budget.

### Personal Health Budget (PHB)

In conjunction with SBC the CCG has developed a plan for implementing Personal Health Budgets (PHBs). This should support the NHS England objectives of there being between 50,000 and 100,000 people having a PHB in place by 2020/21. Specifically the plan will have milestones for improving patient choice by 2020 using PHBs.

Phase One - (January 2016 to May 2016) is proposed to be used to support the procurement process of a new CHC provider, to develop CCG operating and governance processes and procedures and to ensure the CCG has in place its Local Offer by 1st April 2016. This Phase will also be used to work with SBC in identifying around 20 individuals (adults and/or children) in receipt of CHC/CC who would benefit from a PHB. Support from NHS England will be utilised in assessing the current cost of CHC/CC care packages for these 20 against PHB care packages calculated using an agreed budget tool (e.g. budget the Manchester Decision Support Tool (DST), and in progressing these people onto a PHB. Early indications are that financial efficiencies could be achieved through PHB's whilst outcomes for individuals improve.

This Phase would also be used to commission third party brokerage support (e.g. DHI Swindon) in the full PHB set up with individuals including Direct Payment set up, support planning, budgeting etc. Individuals requesting a PHB during Phase One will be managed through the existing CHC team within SBC.

During this Phase, it is expected that a low number of individuals will be suitable or choose to take up a PHB although the finance resource required to manage these within the CCG will be high. Therefore, and whilst CCG systems and processes are being developed, this Phase proposes that the third party also manages the finance responsibilities associated with each PHB on behalf of the CCG. The CCG shall retain its full responsibility for all decisions relating to the PHB.

To support accelerating PHB implementation, a specialist - currently supporting the

national IPC programme - has been successfully secured from NHS England (South West) at no cost to the CCG. This specialist will provide expert PHB advice and support to both the CCG and individuals identified for a PHB and those who choose to have a PHB. In addition, free support from Enham Trust has been offered in the provision of brokerage support although this is likely to be limited to two or three individuals. For subsequent roll out of the PHBs the CCG will need to procure brokerage support.

Phase Two - It is expected that Phase Two will run concurrently to Phase One from March onwards. In the main, this Phase will incorporate the appointment of a new CHC provider and third party brokerage service. Phase Two will have all CCG operating and governance processes and procedures in place and a plan established that supports PHB rollout. Further expansion beyond individuals in receipt of CHC/CC shall be covered during Phases Two and Three.

It is expected that during Phase Two, the new CHC provider will be managing requests for a PHB and in identifying individuals who would benefit from a PHB. The CCG will continue to oversee progress of PHB implementation and the numbers of individuals requesting and receiving a PHB and in meeting its statutory obligations.

Phase Three - Work is required to understand how expansion of PHBs can be achieved among other health groups (e.g. Learning Disabilities, Mental Health, Long Term Conditions, End of Life) and, in particular, how monies can be released from block contracts and placed into a PHB. Further, understanding of Integrated Personal Commissioning (IPC's) – an approach to joining up health and social care and education for children and capitated payments – is also required. Development around these will be covered in Phase Three.

During all Phases, the CCG will be part of the NHS England (South West) networking membership and will access training and support in regard to all areas of development.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

This plan builds on the agreed priorities of:

- Health & Wellbeing Strategy
- The 5 year Strategic Plan 2014- 2019 for CCG and the CCG Operational Plan for 2016/17
- Swindon Borough Council Vision, Priorities and Pledges 2015-2030
- The Commissioning Intentions 2015/16, which have been discussed with providers and have been developed jointly with Swindon Borough Council;
- The Joint Commissioning Plan which brings together the priorities for both the CCG and Swindon Borough Council. The priorities of this plan have also been shared and discussed with the voluntary and community sector.

There are no discrepancies between the BCF plan and the CCG 1 and 5 year plans.

They are aligned in terms of their priorities and key deliverables.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The CCG submitted an expression of interest in co-commissioning primary care. The main impact that co-commissioning would have on the BCF schemes is in respect of how primary care is commissioned to ensure that enhanced services are aligned with the priorities of the health and social care community in Swindon.

Schemes are discussed with primary care at Locality Forums, and GPs were involved in the development of services to support patients identified through risk stratification. There are GP representatives in the Urgent Care Working Group and schemes are discussed at the CCGs clinical Leadership Group.

Work on the management of patients at risk of an emergency admission; the role of the accountable GP and the development of care plans can also be considered as part of the co-commissioning work.

## 7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

### a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Swindon Borough Council uses its core budget allocation and the additional funding of the Better Care Fund to promote integrated working across health and social care. We are joint partners in the National Health Services Act 2006 section 75 Agreements with Swindon Clinical Commissioning Group.

We have an annual Joint Commissioning Plan which sets out our joint priorities and funding of services included in the Section 75 Agreements. The Joint Commissioning Plan's priorities are refreshed in light of the JSNA and the Health & Wellbeing Strategy annually. The Joint Commissioning Plan is reviewed annually and demonstrates the outcomes that have been achieved across health and social care for the benefit of the people of Swindon.

We are defining the protection of adult social care as maintaining eligibility criteria for adult social care in line with the Care Act 2014.

Funding from the Better Care Fund for increase in demand is used to protect adult social care as well as investment in existing schemes. Eligibility criteria are described in detail

on My Care My Support website accessible for carers, patients and service users.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Swindon Borough Council is proposing an investment of £1.6m in care packages for older people in its core budget for 2016/17. Savings have been identified against supported housing schemes, transport costs, and efficiencies within the Social Enterprise. Additional funding of £935k has also been provided for Older People residential care and domiciliary care to fund the cost of the increase in the minimum wage and pension implications.

Swindon already has a joint health and social care integrated social enterprise. Funding from the Better Care Fund has been used to increase care packages to meet demographic growth in 2015/16. Specific schemes to protect adult social care are support for carers, crisis support and integrated care, community capacity building and increase in care packages to support hospital discharge. Schemes protecting adult social care account for £4,986 revenue funding including the allocation for the implementation of the Care Act.

An advice and information service has been launched as well as a service directory on line (My Care My Support) to give the public and patients access to up to date information. This is aimed at promoting independence and choice. The voluntary and third sector is commissioned to improve self-help and prevention for carers, those at risk of mental ill health and older people.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services.

We confirm that £4,986k has been allocated for schemes which protect spending in adult social care but also supports effective hospital discharge. In particular, the schemes protect adult social care funding for crisis intervention, 7 day working, effective discharge from hospital, reablement services and telecare. £929,954 has been allocated to meet the growth in demand for older people services in adult social care (Schemes 1, 2, 4, 5, 9). The capital allocation is in addition to this of approximately £930k, so that the total for adult social care is £5.8m

£460k was allocated within the BCF in 2015/16 to contribute to the implementation of the Care Act. This funding is still included within the 16/17 BCF and has now been increased to £468,800 as per the scheme below. This includes Safeguarding Team, Advocacy, Carers' Support and Advice and Information.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Investment by the Local Authority in advice and information web based information and



an Advice and Support Service at Sanford House commissioned from Swindon CAB. An online self-assessment has been developed and is currently being used by staff before being rolled out to the public, including self funders in 2016. Increases in demography in social care have been modelled through the Adult Demand programme and the analysis was published in papers to the Health Overview and Scrutiny Committee in September 2013 and December 2013 [www.swindon.gov.uk](http://www.swindon.gov.uk).

Workstreams were established for the implementation of the Care Act for carers, self-assessment, workforce development and financial planning. This work has been completed and necessary changes in policies and procedures adopted. Additional funding has been allocated for safeguarding duties, advocacy, deferred payment system has been revised as well as increase in workforce development so that care Act duties are met

v) Please specify the level of resource that will be dedicated to carer-specific support

£809,570 has been identified within the BCF to support carers. A contract is already in place to provide community based support. This was based on best practice and developed with carers. A budget for the provision of short term breaks, emergency access to support and emergency card details are in place. A workshop was held with carers to develop the menu of support and ensure the assessment process is developed in partnership. A workstream in relation to carers is in place as part of the Care Act implementation and reports into the Adult Demand programme and CCG Interventions.

The Carers' Centre has GP liaison workers and will be based in the Swindon Advice and Support centre raising awareness amongst the voluntary and third sector of carers needs. Additional scheme to support carers in hospital discharge process and carer support have been developed as part of the carers workstream.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

In 2016/17 additional funding of £200k has been provided within the BCF to provide for inflation and also some additional funding (£115k) to contribute toward the increase in demand that is being experienced. This is particularly in relation to hospital discharge and more complex social care needs. If funding is not allocated to the schemes agreed then there is likely to be an impact on reablement services, delayed discharge, 7 day working in social care and support to carers and eligibility criteria for social care.

**b) 7 day services to support discharge**

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

The Better Care Fund investment for adult social care is used to fund 7 day working for social care within the hospital discharge teams. Social workers, verification and access to care packages are now in place 7 days a week. Community health services are accessible 7 days a week. 7 day working is also in place for OT and community health services within the hospital discharge team, reablement services and in the intermediate care services (SWICC).

7 day working is also identified as part of a discharge CQUIN with our health providers and is recognised as a key piece of work identified by the ECIST review of GWH and is included in the Operational Resilience and Capacity Plan.

**c) Data sharing**

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

We are using the NHS number as primary identifier for correspondence across health and social care services. SEQOL is a joint health and social care provider and the NHS number is used and recorded on the Social Care Information system (SWIFT) and Capita One. SWIFT and Capita One are owned by Swindon Borough Council so that commissioners and providers have access to the NHS number for both children and adults. A project manager has been employed by Swindon Borough Council to lead on system development in relation to social care and supporting information governance work so that the NHS number is used consistently.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We will be adopting Open API and Open Standards as part of the SUCCESS project we have commissioned an interoperability platform that allows communication between different primary care systems, secondary care and social care systems. This is not Open API but is secure provider interface technology which is being developed locally through bespoke software. The Digital Roadmap submitted to NHSE by CCG outlines our detailed work on digitalisation.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit

requirements, and professional clinical practice and in particular requirements set out in Caldecott 2.

Information sharing protocols will be in place. Consent will be asked for by SEQOL for all patients and social care service users so that information can be shared. SEQOL, SBC and CCG will all meet relevant information governance requirements.

**d) Joint assessment and accountable lead professional for high risk populations**

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

GP will be the lead professional for all patients over the age of 75. Assessing patients according to need continues to be a vital component of our Long Term Conditions (LTC) generic model and key to the delivery of good LTC management. By using a risk prediction approach it is possible to identify those people who are the most regular users of health services (both primary and secondary care) and are at risk of re-admissions to hospital), then stratify them according to complexity of need and commission cost effective interventions to meet those needs. NHS Swindon made an investment in implementing a risk stratification tool in all GP surgeries. GP practices will be involved in identifying opportunities for commissioning interventions that could reduce the risk of a hospital admission. Community matrons prioritise patients with long term conditions for care management in the community which are the top 5% of patients identified by risk stratification

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

All patients with long term conditions and identified as high risk through risk stratification tool will be on the Community Matron caseload. GP LES in place supporting risk stratification.

As part of the GP contract, the GP practices are identifying the accountable GP for the over 75s and those patients identified with complex needs. The risk stratification tool is being used by practices to identify those patients that need a care plan.

The over 75s funding is supporting the roll out of support to patients identified at risk and needing support through their care plan.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

Risk stratification will identify patients in need of case management supported by community matrons, practice attached community navigators who are supported by a database of available community, voluntary sector and neighbourhood support.

5% of patients identified in risk stratification have a plan in place and all over 75 year olds with long term conditions have a joint care plan.

Care Line provides holistic information for care and refers all requests for service to

SEQOL. Detailed advice and information for service users is in place through My Care, My Support. SEQOL provide joint community health and social care teams and there is a single assessment process already in place with a single SEQOL professional allocated to meet health and care needs.

## **Workforce development**

Having the right staffing numbers, skills and values are fundamental to fulfilling our commitment to provide a safe, compassionate, high quality and responsive urgent and emergency care system. Ensuring this presents challenges though, in particular, national and local shortages of healthcare workers, people are living longer with a range of long term conditions putting greater demands on health services, the shift from hospital centric to community based, person-centred care and the increased focus on the provision of NHS services across the 7 day week. However, these challenges will be factored into the plans to deliver this strategy.

Supporting this strategy, the CCG has established a Workforce Steering Group which will oversee that national policy themes and recommendations relating to workforce are being implemented. The Workforce Steering Group brings together commissioners, education, acute, primary, social and community care. The key areas of work during 2016/17 include:

- Whole system sight of health and social care provider workforce plans and identifying gaps in the current workforce that may impede new ways of working
- Scoping of the Community and Urgent Care workforce model so they are patient-centric, not service-led, ensuring full patient engagement and participation
- Addressing barriers (e.g. employment contracts) to allow the workforce to work flexibly across Swindon geography
- Testing models of an integrated workforce across health organisations
- Designing and profiling the future workforce based on population health needs
- Ensuring sustainable and flexible local workforce planning and access to Continuing Professional Development opportunities in collaboration with our Local Education and Training Board, Health Education England (HEE) and Local Government Association
- Establish the Community Education Provider Network (CEPN) from HEE funding that will bring Primary Care organisations and its workforce together (e.g. GPs, Nurses, Pharmacists) to access multi-professional education and training as well as inter-professional working and learning.

The Workforce Steering Group, reporting to the Systems Resilience Group, shall measure and evaluate workforce planning progress against a number of its objectives to improve recruitment and retention, reduce agency staff, reduced gap between health and care assistant roles and the graduate nurse, joint training across providers

## 8) ENGAGEMENT

### a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

**Our service users, patients, carers and public have been involved in the run up to, and the complete development of the better care fund plan. We have involved each group in different stages of the above commissioning cycle by:**

Across Swindon and Shrivenham, mechanisms are in place for engagement with patients, service users and the public through a number of events, meetings and surveys, examples include:

- The CCG attending Swindon youth partnerships events, which offered the opportunity to hear from those working directly with youth groups, and their experience to date within Swindon.
  - Swindon Borough Council Carer's engagement event Swindon Borough Council convened the second of its Carer's engagement events, which the CCG participated in. Carers and other voluntary groups were updated on work and progress around carers support.
  - Community Navigator patient review and the Community Optometry pathway patient feedback.
  - The CCG's AGM for 2014/15 took place in July 2015. It was well attended by a good cross section of the Swindon population with 40 members of the public and representatives from in and around Swindon. The second part of the meeting was dedicated to seeking the audiences' experiences with community services which kick started a two month engagement exercise looking at the Community Service Provision in Swindon. This was the first of many engagement events for the provision of community services engagement programme.
1. Provision of Community Services Engagement: Swindon Borough Council and the CCG engaged with a range of organisations, the public, patient and carer groups to gain feedback on their experiences of community health and social care services. We were keen to hear from all individuals who have experience of using Swindon Community Services or other local community providers to capture detailed feedback on what works well, and what improvements could be made to services in the future.
  2. The CCG is in the second year of delivering its five year Communications and Engagement Strategy. The strategy is reviewed on a yearly basis to ensure it is still relevant and to report on achieved activities.
  3. GP member practices receive a fortnightly newsletter providing them with information and areas where they need to undertake actions.
  4. The CCG's Governing Body has a lay member for patient and public involvement and this person also chair's the CCG's Patient and Public

Involvement Forum. Representatives from Swindon Borough Council are also members of the Governing Body.

5. Seeking wide representation of local groups and patients to take part in the CCG's Patient and Public Involvement Forum (this is a committee of the CCG's Governing Body), this group provides continual positive challenge and improvement to the way we operate, and engage with our local population. It seeks to assure the Governing Body that the CCG is effectively engaging with a wide range of groups and individuals. The Forum meets on a monthly basis and is looking to hold more of its meetings in different community settings.
6. Working closely with our local GP Patient Participation Groups (PPG), to seek feedback on healthcare in Swindon for primary care users, and their experience of hospital, community and mental health services in Swindon.
7. Working closely with Healthwatch Swindon, to seek feedback on Healthcare in Swindon and jointly taking part in engagement roadshows.
8. Listening to our providers and third sector groups, as a result of this we are seeking to increase the access to services. Examples include working closely with the Carer's Centre in Swindon regarding the rollout of the Better Care Fund and the development of a CQUIN with SEQOL to target the hard to reach populations of Swindon.
9. The CCG produces a monthly Patient and Public Involvement Newsletter which provides the organisation with the opportunity to promote national campaigns such as Be Clear on Cancer and the Shingles vaccination. SCCG also shares local health news and updates from the organisation.
10. The CCG has updated its [website](#) to make it more user friendly and provide increased information on patient and public involvement activities. There is now a facility on the website for the text to be translated into different languages.
11. Gap analysis work is continuing to take place to identify equality and diversity gaps with the population we serve.
12. The CCG has invested in a free post address, this will allow the CCG to receive a greater amount of public feedback, and will also encourage people to take part in our patient surveys when we are carrying out evaluations throughout the year.
13. My Care My Support was developed with service users as well as the development of the advice and information service. Personalisation training has been held with staff. Support to carers was increased through a new contract and additional funding. The carers' assessment was simplified and supported with access to short term breaks.

**c) Implications for acute providers**

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The main acute provider for Swindon CCG is Great Western Hospitals NHS Foundation Trust (GWH), Swindon commissions circa 60% of their activity.

GWH and the wider health economy has worked closely with the Emergency Care Intensive Support Team (ECIST), Newton Europe and the NHS England review of delayed Discharge to identify the key areas of focus to build resilience into the urgent care system within Swindon.

Scheme	Commencement date	Additional capacity impact	BCF/ORCP/QIPP
Integrated crisis and rapid response	Commenced	No additional capacity impact as modelled into the table above	BCF
Reablement service and telecare			BCF
Enhanced voluntary sector capacity			BCF
Community and residential rehabilitation and Discharge to Assess			BCF
Preventing hospital admissions and effective discharge			BCF
Carers' support			BCF
Capital Grant Adult Social Care			BCF
Community health aimed at reducing emergency admissions			BCF
Community navigator	Pilot in place, roll out additional practices 1/10	Reduction of 200 admissions per month	
Practice over 75's schemes	1 October		
SUCCESS model			

Safer 7 day working bundle		ORCP being reviewed by CCG with new proposals to be published in finalised 1 Year Operational Plan 2016/17	ORCP
7 day front door physiotherapy, OT and social work service (ED)			ORCP
Frail Elderly pathway – include 8 bedded unit, hotline for GPs and therapy services			ORCP
Expansion of SEQOL Urgent Care Centre to stream minors away from ED			ORCP
Pharmacy service to provide drugs to an extended hours IV service			ORCP
Increased hospice at home capacity			ORCP

The impact of schemes will be reviewed on a monthly basis by the Swindon Strategic Resilience Group (executive level group with representation from all partners); where concerns are identified mitigating schemes will be agreed. One area already identified which could be mobilised to support management of any increased demand, is the purchase of further 'discharge to assess' beds, and this has been agreed with Swindon Borough Council. A scheme to work with nursing homes has already been identified and mobilised during 2015/16.

Schemes are supportive to meet the parity of esteem for mental health, community navigator is an example of a scheme that will benefit those with a mental health problem, supporting them to negotiate the system in relation to their physical health issues.

The Better Care Fund is one strand of how system resilience and service redesign will be delivered, this plan is consistent with the Operational Resilience and Capacity Plan and QIPP (as demonstrated in the table above).

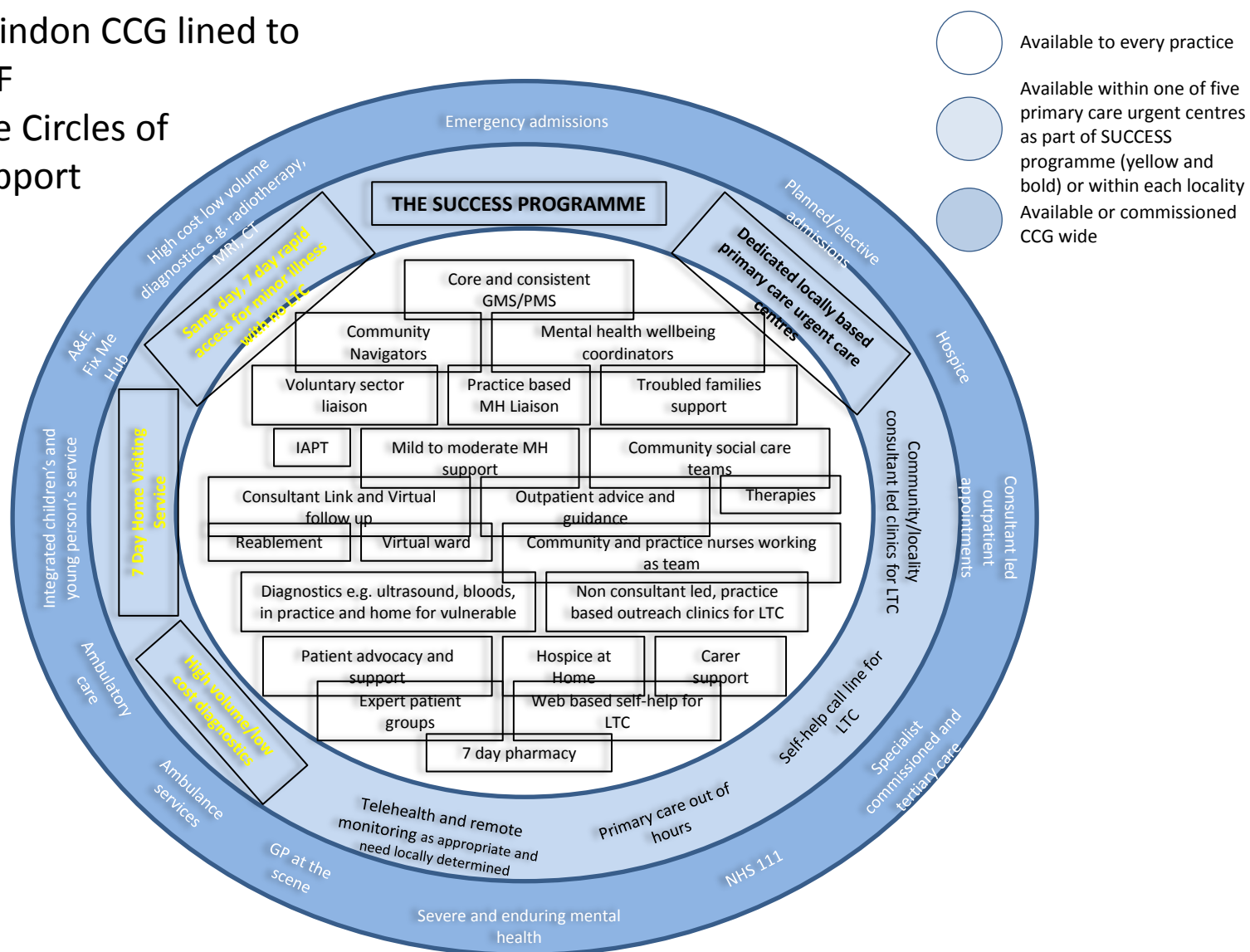
Outcome measures at provider level will include

- A contribution towards reduction in hospital admission so that admissions reduce by 3.5%.
- A contribution towards a reduction in admission to residential care to 736.8 per 100,000
- 50% reduction in DTOC delays by 31.3.17
- New elderly care ambulatory pathway in place with a 72 hour length of stay for agreed cohorts
- 4 hour NHS Constitution standard is met



# Swindon CCG lined to BCF

## The Circles of Support



The diagram above describes all of the initiatives in Swindon across the health and social care system to promote health and wellbeing reduce the reliance on acute hospital services and facilitate hospital discharge. Starting from the outside in dark blue are the Swindon wide commissioned services. In particular the GP at the scene supports the reduction in emergency admission . A GP is based with the ambulance service and treats those patients within primary care and the Virtual ward so that emergency admission is avoided.

The second ring in light blue includes the services provided through the SUCCESS programme. The SUCCESS centre started opening in Moredon in October 2014. GP practices across Swindon can book urgent appointments electronically for patients in the evening and weekends who cannot be seen in primary care thereby further reducing hospital admissions. The service works closely with Scheme 10 and 11 outlined below which are the community health and virtual ward services Scheme 10 and 11 are further supported by the nurse led home visiting services which started in November 2014 and are funded from the over 75 allocation of funding to GP practices.

All services in the inner ring are based around GP practices to promote the health and well-being of the population ranging from preventative services such as promoting well-being coordination to services supporting hospital discharge (scheme5) through Home from hospital.

## ANNEX 1 – Detailed Scheme Description for 2016/17

Scheme 1
<b>Scheme name: Integrated Crisis and rapid response</b>
<b>What is the strategic objective of this scheme?</b>
<p><i>Crisis support to prevent admission to hospital and enable those who leave hospital. Access to assessment facility for people discharged from hospital linked to reablement so that length of stay in hospital reduces and people are able to regain their skills as quickly as possible.</i></p> <ul style="list-style-type: none"> <li>• Reduction in emergency admissions by having 24/7 access support to social care at a time of crisis with access to social work support packages</li> <li>• Reduction in admissions to residential and nursing care through access to social work services and packages at a time of crisis and 24/7</li> <li>• The scheme will fund social care costs and protect social care services.</li> </ul>
<p><b>Overview of the scheme</b></p> <p>Please provide a brief description of what you are proposing to do including:</p> <ul style="list-style-type: none"> <li>- What is the model of care and support?</li> <li>- Which patient cohorts are being targeted?</li> </ul>

<ul style="list-style-type: none"> <li>• Single point of access to crisis support provided by SEQOL and based at Great Western Hospital. The team is staffed by qualified nurses and social workers as well as health and social care assistants. A telephone triage services directs referrals to the correct professional. Immediate access to assessment, crisis beds, care packages and overnight crisis support.</li> <li>• This service is part of the integrated health and social care services provide by SEQOL</li> <li>• The patients targeted as those with long term health conditions and social care needs who require support immediately to avoid hospital admission or long term nursing and residential care and patients who are at immediate harm without the provision of support</li> </ul>
<b>The delivery chain</b> Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioner: Swindon Borough Council, Provider: SEQOL with links to Great Western Hospital (GWH)
<b>The evidence base</b> Please reference the evidence base which you have drawn on <ul style="list-style-type: none"> <li>- to support the selection and design of this scheme</li> <li>- to drive assumptions about impact and outcomes</li> </ul>
Crisis support as part of the Single Point of access is regarded as good practice nationally so that social care service users can be supported as quickly as possible avoiding admission to permanent residential care and hospital. The majority of schemes within this plan are aimed at prevention and promoting integration. However, there remains a group of older people with long term health conditions who require support due to the number of complex health needs they have. As a crisis occurs it is important to have an integrated approach and access community health and social care so that a hospital admission can be avoided Audit Commission <i>Older people – independence and well-being</i> , 2012
<b>Investment requirements</b> Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan <b>£1,181,105</b>
<b>Impact of scheme</b> Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
<u>2016/17 benefits</u> <ul style="list-style-type: none"> <li>• A contribution towards reduction in hospital admission so that admissions reduce by 3.5%.</li> <li>• A contribution towards a reduction in admission to residential care to 736.8 per 100,000</li> </ul>
<b>Feedback loop</b> What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Monthly joint contract performance meeting with SEQOL and CCG, escalation of issues to Strategic Resilience Forum  
Quarterly report to Joint Commissioning Group

**What are the key success factors for implementation of this scheme?**

Existing scheme funded from NHS Transfer to LA  
Contribution 580 admission and readmission reduction in hospitals and admission avoidance of residential care.

## Scheme 2

### Scheme name: Reablement Service and Telecare

**What is the strategic objective of this scheme?**

- Reduction in admissions to residential and nursing care through access to reablement services
- Reduction in delayed discharge and thereby improving patient flow and reducing re-admission rates through reablement and access to telehealth and tele care
- The scheme will fund social care costs and protect social care services

**Overview of the scheme**

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

*People will regain skills as quickly as possible without the need for on-going support. This will be provided from an integrated service including OT and therapists with direct referrals from the Hospital Discharge team to enable speedy discharge from hospital*

- Our reablement service has two elements, a domiciliary service and a residential placement service, both are commissioned and provided through Seqol, who provide a reablement domiciliary care service in peoples own homes to help people regain skills lost through injury or illness.
- Single integrated reablement service staffed by OT, health and domiciliary care workers. The service is located at GWH close to SWICC (Intermediate Care Centre – step up, step down). Additional funding means that the service now operates 7 days a week and has additional staffing for winter pressure.
- The service is targeted at patients discharged from hospital to home where a package of support is likely to reduce the need for long term care and residential

care
<b>The delivery chain</b> Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioner: Swindon Borough Council, Provider: SEQOL with links to Great Western Hospital (GWH)
<b>The evidence base</b> Please reference the evidence base which you have drawn on <ul style="list-style-type: none"> <li>- to support the selection and design of this scheme</li> <li>- to drive assumptions about impact and outcomes</li> </ul>
<p>Reablement services have been successful in reducing the need for long term care packages by enabling individuals to regain their skills.</p> <p><u>Domiciliary Reablement</u>          From April to the end of December 2015, a total of 180 social care clients have received an episode of domiciliary reablement, helping them to build their own capabilities and helping them maintain independence. Of the clients who received reablement domiciliary care above, 80 accessed it following a hospital discharge, 88 came via a community/ other route and 10 were a diversion from hospital and 2 are not recorded. Of those 180 people, 150 were over the age of 75.</p> <p>At the end of March 2015, there were 186 patients on telehealth with over 56,000 monitored non-face to face contacts.</p> <p>This shows this prevention service is achieving the right outcomes in helping them maintain their own independence for as long as possible. There is a large body of research evidence supporting this approach Audit Commission, <i>Assistive Technology: independence and well-being</i>, 2004; Elkan R et al <i>Effectiveness of Home Based Support for Older People</i>, BMJ 2001; SCIE <i>At a Glance 52: Reablement</i>, March 2012</p>
<b>Investment requirements</b> Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan <b>£706,961</b>
<b>Impact of scheme</b> Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Existing scheme funded from £545k NHS Transfer to LA, £162k CCG Admission and readmission avoidance 240 patients supported by community navigators in 2015/16 and 100 older people through volunteering support. Contribution to the figures quoted in particular readmission reduction with 330 people

supported and 130 people through telehealth, discharge to assess beds of 19 in scheme 4. Creating better patient flow without necessarily resulting in a financial benefit

### **Feedback loop**

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Monthly joint contract performance meeting with SEQOL and CCG, escalation of issues to Strategic Resilience Forum  
Quarterly report to Joint Commissioning Group

### **What are the key success factors for implementation of this scheme?**

#### Measure/Metrics 2016/17:

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.

Actual 2014/16: 88.9%

Forecast 2015/16: 92.9%

Planned 16/17: 92.9%

Existing scheme funded from £545k NHS Transfer to LA, £162k CCG  
Admission and readmission avoidance 240 patients supported by community navigators in 2015/16 and 100 older people through volunteering support.  
Contribution to the figures quoted in particular readmission reduction with 330 people supported and 130 people through telehealth, discharge to assess beds of 19 in scheme Creating better patient flow without necessarily resulting in a financial benefit.

## **Scheme 3**

### **Scheme name: Enhanced Voluntary Sector Capacity**

#### **What is the strategic objective of this scheme?**

- Supporting people to lead independent and healthy lives for longer by reducing social isolation and providing community based support.
- Reduction in emergency hospital admission through access to community based support in the third sector such as befriending, time banks and community navigator support
- Improving quality of life for the population and users of social care and health services

### Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

*Commission voluntary sector and community based support linked to localities and GP practices. Supporting volunteers reduces the need for some targeted and specialist services. Community and voluntary sector groups provide important flexible services either informally or as part of local contracts.*

*Mental Health wellbeing coordinators have been introduced through the commissioning of mental health voluntary and third sector contracts.*

- All voluntary sector contracts across the CCG and Swindon Borough Council are joint for mental health and vulnerable adults.
- The model of care is community based support through the third and voluntary sector promoting health and well-being, mental health, support for people with a learning disability, befriending and reducing social isolation. In particular we will commission voluntary and community based support linked to localities and GP practices. Supporting volunteers reduces the need for some targeted and specialist services. Community and voluntary sector groups provide important flexible services either informally or as part of local strategy. Voluntary sector organisation providing advice and support, promoting mental well-being, advocacy, support for carers and support planning for those with a direct payment are co-located in the centre of Swindon. This also gives the opportunity for health checks in addition to advice and information
- All services are aligned to the CCG Strategic Plan and the Adult Demand Strategy.
- The role of the community navigator will be to coordinate a holistic plan for patients at high risk of hospital admission. Referrals will be made by GPs based on high risk patients including those over the age of 75 identified from risk stratification tool. The community navigator makes contact with the patient and agreed a joint plan. A plan is put in place with the support from various sectors and agencies to deliver this package of assistance.
- To support the above, the second strand of the project and meeting the Care Act requirements, is the development of a single database [www.mycaremysupport.co.uk](http://www.mycaremysupport.co.uk) that can be accessed by the patient and the link worker in assembling the package of support.
- Targeted support is commissioned from the council's Locality team to pilot Circles of support for older people and carers in order to reduce social isolation. A dedicated befriending service will be commissioned in 2015
- The cohort of service users targeted by the provision of community based support are taken from risk stratification and an analysis of adult social care customer cohorts using household level data from MOSAIC
  - Older people over the age of 75 with long term health needs
  - People suffering from mental ill health
  - People with a learning disability needing support in finding training and employment
  - Older people at risk of social isolation

### The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioner: Swindon Borough Council, CCG Provider: Voluntary and third sector
<b>The evidence base</b> Please reference the evidence base which you have drawn on <ul style="list-style-type: none"> <li>- to support the selection and design of this scheme</li> <li>- to drive assumptions about impact and outcomes</li> </ul>
<p>There is extensive evidence from Think Personal Act Locally as well as Joseph Rowntree Foundation that investing in community capacity and self-help increases the resilience of individuals to improve their health, JFR <i>Commissioning Care and Support for Older People</i>, July 2013; RSA 2020 Public Services Hub <i>The New Social Care Strength Based Approaches</i>, May 2013 Swindon is building on evidence from NE London on community navigators and has included this in the development of well-being co-ordinators in the recent tender of community mental health services provided by the third sector. Circles of support is funded by NESTA to develop community resilience and capacity through supporting older people on low care packages, RSA 2020 Public Services Hub <i>The New Social Care Strength Based Approaches</i>, May 2013 ; NIHR <i>Research Findings : Older people's prevention services: 2013</i></p> <p>A local evaluation of community navigators found that There was an overall reduction of the costs to health care for those older people included in the scheme based on a three months follow up leading to an £80,000 for 4 community navigators in the first year.</p>
<b>Investment requirements</b> Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan £ 1.003,800 BCF with an additional £1.411,700 from Swindon Borough Council core budget added to the BCF
<b>Impact of scheme</b> Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
<p>2015/16 benefits</p> <p>123 admissions avoided leading to a saving of £226,000 through primary care self help, nurse led home visiting. This is supported by Community Navigator each supporting 16 patients at any one time and 60 for each navigator per annum , leading to 240 patients in 2014/15. In 2015/16 a minimum of 240 patients will be supported.</p> <p>100 older people supported through Circles of Support in 2014/15 and 2015/16.</p> <p>Befriending service not yet established, so no baseline or anticipated number of beneficiaries as this would be agreed through tender.</p>



All community support services making a contribution to improving quality of life for individuals ASCOF 1A to reach 18.7 in 2015/16.

#### **Feedback loop**

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Monthly joint contract performance meeting with voluntary and third sector,  
escalation of issues to Strategic Resilience Forum  
Quarterly report to Joint Commissioning Group

#### **What are the key success factors for implementation of this scheme?**

Existing scheme funded from CCG and LA budgets. Good networks of voluntary sector provision will be key to success as well as co-location of the sector  
Admission and readmission avoidance 240 patients supported by community navigators in 2015/16 and 100 older people through volunteering support.

## **Scheme 4**

### **Scheme name: Community and Residential Rehabilitation and Discharge to Assess**

#### **What is the strategic objective of this scheme?**

- Reduction in admissions to residential and nursing care through access to residential reablement services
- Reduction in delayed discharge and thereby improving patient flow and reducing re-admission rates by using residential and nursing home beds as part of 'discharge to assess' models of care

#### **Overview of the scheme**

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

*Fund nursing and assessment beds with enhanced health care so that patients can be discharged from hospital more quickly. This programme is now established.*

- This is the residential and discharge to assess part of our reablement service, provided through Seqol, who provide a reablement domiciliary care service in people's own homes to help people regain skills lost through injury or illness.
- The service is targeted at patients discharged from hospital to assessment beds. It offers temporary placements to support those in need of a slower more

<p>intensive episode of support. This element of reablement has only been in place since the beginning of the 2014 and now has 19 beds. Additional beds are accessed in the private nursing sector during winter pressures</p> <ul style="list-style-type: none"> <li>• The service is targeted where a package of support is likely to reduce the need for long term care and residential care and a medical discharge is agreed but further assessment in the community is required to establish the correct nature of the on-going support package.</li> </ul>
<p><b>The delivery chain</b> Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved</p>
<p>Commissioner: Swindon Borough Council, Provider: SEQOL</p>
<p><b>The evidence base</b> Please reference the evidence base which you have drawn on</p> <ul style="list-style-type: none"> <li>- to support the selection and design of this scheme</li> <li>- to drive assumptions about impact and outcomes</li> </ul>
<p>Reablement services have been successful in reducing the need for long term care packages by enabling individuals to regain their skills.</p> <p>The residential reablement service was new in 2014 and supported 37 people in total to regain their independence. 89% of people were aged 75 or over, and again the majority (26 people) had no mainstream services prior to their episode of reablement, and of those, 22 (59.5%) needed no mainstream service following.</p> <p>From April to end of December 2015, there were 66 people who completed an episode of residential reablement equating to a total of 3,533 days of reablement. Of those people, 48 received residential reablement following a hospital discharge, 8 came via a community/other route, and 4 were a diversion from hospital and 6 were not recorded. 61 out of the 65 were over the age of 75.</p> <p>Discharge to assess and intermediate care schemes are now seen as a key element of good patient flow. The Audit Commission found that 9% of older patients in hospital who are fit to leave hospital remain in acute care; <i>SCIE Research briefing 12: Involving individual older people in the discharge process from acute to community care</i>, February 2005.</p>
<p><b>Investment requirements</b> Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan <b>£550,805</b></p>
<p><b>Impact of scheme</b> Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below</p>
<p>A contribution to a reduction in hospital admission by 3.5 % focusing on reducing re-</p>

<p>admissions through improved discharge to assess process A contribution to a reduction in delayed discharge by 1.2% using discharge to assess beds to improve patient flow</p> <p>There will be 19 discharge to assess beds throughout the year funded from BCF with the aim of rehabilitation and avoiding adult social care spent on residential care. The length of stay will vary depending on nature of complexity. In 2013/14 the length of stay was 19 days.</p>
<p><b>Feedback loop</b> What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?</p>
<p>Monthly joint contract performance meeting with SEQOL and CCG, escalation of issues to Strategic Resilience Forum Quarterly report to Joint Commissioning Group</p>
<p><b>What are the key success factors for implementation of this scheme?</b></p>
<p>Existing scheme funded from £551k NHS Transfer to LA.</p> <p>Admission and readmission avoidance 240 patients supported by community navigators in 2015/16 and 100 older people through volunteering support.</p> <p>Contribution to the figures quoted in particular readmission reduction with 330 people supported and 130 people through tele health, discharge to assess beds of 19 in scheme 4 Creating better patient flow without necessarily resulting in a financial benefit. Benefit is cost avoidance rather than cashable savings.</p>

## Scheme 5

**Scheme name: Preventing hospital admission and effective discharge**

**What is the strategic objective of this scheme?**

- Reduction in admissions to residential and nursing care through 7 day working in social care and community health services
- Reduction in delayed discharge and thereby improving patient flow and reducing re-admission rates by accessing care packages for older people and protecting adult social care spent

**Overview of the scheme**

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

- We will continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible. We will ensure access to brokerage and verification services so that there is speedy access to social care packages seven day a week. Integrated discharge team comprising of health and social care is in place. Since September 2013 a Discharge Assessment and Referral Team (DART) has also been in place to avoid admission and discharge as early as possible. Both services operate 7 days a week and work closely with hospital clinicians. We will be reviewing home from hospital support so that any delay is avoided and a community support package is in place. The Virtual ward will be working closely with the hospital discharge services and the Single Point of access to both avoid admissions and enable speedy discharge. Additional funding for care packages will be available to enable speedier discharge. Adult social care will be working 7 days a week as part of the Integrated Hospital discharge team and DART.
- The target group are patients with social care needs who require a care package. The majority of these are older people over the age of 75

#### Data for 2015/16 (at February 2016)

Adults admitted into permanent residential or nursing care per 100K population: 6 younger adult admissions, 1 person with physical disabilities, 1 person with learning disabilities and 4 younger adults with mental health issues. This is 7 fewer than in 2014/15.

Adults admitted into permanent residential or nursing care per 100K population: It is recognised that the admissions indicators are joint indicators with commissioning and both providers to ensure the strategies are in place and working to support only necessary and appropriate admissions. In 2014/15, there was a total of 169 admissions, 147 older people, 20 older people with mental health needs and 2 with a learning disability. This is an increase of 17 people up on the same period in the previous year.

#### [Further information on Additional Scheme for 2016-17 - Delayed Transfer of Care Programme](#)

#### **Progress and data July 2015 – December 2015**

Aim: Sustainable reduction in number of DTOC and non-DTOC delays across the health and care system by 30.10.16, with planned reduction of current numbers by at least 50% of days lost by Quarter 3 and Quarter 4 2016/17

Agreed programme of work with clear outcomes and timelines for implementing the Newton Europe recommendations as these apply to delayed discharges.

#### Background Data:

Delays due to social care and health for GWH and SWICC Intermediate Care based on days lost were:

July 2015 – December 2015 monthly average : 537 days (226 days NHS and 311

days Social care)

### Objectives

NHS England undertook an Enquiry regarding Delayed Transfers of Care in Swindon in December 2014 following high levels of delays at Great Western Hospital for health and social care. Commissioners and Providers are committed to ensuring that the NHS England Enquiry findings are considered in line with the detailed work undertaken with Newton Europe which has provided a comprehensive analysis of performance and detailed evidence base of issues around Delayed Transfers of Care in Swindon.

Delayed Transfers of Care have continued to be high for social care until December 2015. The main reasons are completion of assessment, awaiting domiciliary care and residential and nursing care.

Data on Delayed Transfers of Care is shared and validated weekly between SEQOL, GWH and Swindon Borough Council. The data is taken from GWH delays, Swindon Intermediate Care Centre (SWICC) and in patients at Avon and Wiltshire Mental Health Trust. All data is then reconciled monthly before being submitted to NHS England. Each patient is recorded individually with the reasons for delay and the number of days.

In summer additional domiciliary bridging services and pilot nursing beds were commissioned to help support the discharge process and reduce delays. Locally Swindon has increased provision of domiciliary care by 1,500 hours per week, a 20% increase.

The Better Care Fund Scheme has funded part of the increase in capacity but Swindon Borough Council also made additional investment available of £1.6m into older people care packages

### **DTOC Programme**

In order to achieve a sustainable reduction in delayed discharges and following the visit by NHS England which focused on the Swindon delays rather than Wiltshire, a DTOC Programme was established in January 2016, and is a joint programme between Swindon Borough Council, Swindon CCG, Great Western Hospital and SEQOL. Wiltshire are invited to the DTOC Programme as some service overlap. The programme focus on Great Western Hospital because this is where the highest levels of delays were identified in the summer and autumn 2015.

The DTOC Programme focuses on the short and medium term challenges of delayed transfers of care. Short term is defined as the next 3-5 months, and medium term 9 months. The work and its outputs provide the platform for the implementation of the recommendations that form the NHS England investigation into delayed transfers of care in Swindon and Newton Europe's system wide diagnostic work on Delayed Transfers of Care.

The DTOC Programme will improve system alignment, overall governance, structures and processes, and in doing so, ensure a sustainable reduction in delayed

transfers of care.

The Programme Board for the DTOC programme reports to the System Resilience Group (SRG) who use the data and information to support wider health and care work across Swindon. The accountability for strategic planning is with the SRG.

The DTOC Programme has 7 workstreams:

- Domiciliary Care Provision – to commission a new domiciliary care and community support service based on an outcomes model
- Delayed Discharge Out of Area – to reduce delays for discharge of patients who are the responsibility of other CCGs, agreeing a protocol and escalation processes
- Communication, Choice and Training – to ensure that all staff and managers across the system understand the discharge process, routes of escalation, roles and responsibilities, and menu of discharge options.
- Review of DART and IDT Team – to review the DART process so that there is clarity over roles and responsibilities and delays are minimised
- Reablement – to agree the shape of reablement service and a lower unit cost and thereby increase capacity, and to agree prioritisation of patients to ensure speedy discharge
- Discharge to Assess/Community Beds – ensure there is clarity over criteria and process for all bed based provision in the community so there is patient flow, and that a commissioning strategy is in place for community bed based provision
- Care Homes – to prevent avoidable admission to hospital from care homes and ensure speedy discharge at the earliest opportunity.

## **DTOC Programme Progress Report at April 2016**

As outlined above the delayed discharges were high in Quarter 1 – 3 2015/16. It has been challenging to analyse trends as data has fluctuated significantly month on month. For example, the lowest month in 2015 was April 2015 with 479 days whilst December 2015 was the highest number.

Since the establishment of the Programme Board in January 2016, the data shows that despite winter and high demands for non elective admissions, delayed discharges have reduced month on month in relation to Great Western hospital and SWICC due to active management by commissioners and providers of individual patients

In quarter 4 2015/16 delayed discharges for GWH and SWICC were as follows:

January 2016: 416 days  
 February 2016: 257 days  
 March 2016: 252 days

NHS England also measures the percentage of days lost at GWH across the system. The delayed Discharge Programme has also impacted on this data, particularly for Swindon as the table below demonstrates and percentage increases for Wiltshire and other areas which are outside of the remit of the BCF Plan. However overall the data for GWH is shows a downward trajectory :

<b><i>Patients at Thursday Daily DToC Snapshot</i></b>	<b>7-Jan</b>	<b>14-Jan</b>	<b>21-Jan</b>	<b>28-Jan</b>	<b>4-Feb</b>	<b>11-Feb</b>	<b>18-Feb</b>	<b>25-Feb</b>
Swindon	11	17	11	18	15	6	6	6
Wiltshire	5	5	15	9	8	12	11	11
Other	8	11	7	4	5	7	6	6
ALL	24	33	33	31	28	25	23	23
Acute beds occupied	468	467	465	470	454	458	447	447
% DTOC ALL	5.1%	7.1%	7.1%	6.6%	6.2%	5.5%	5.1%	5.1%
% DTOC Swindon	2.4%	3.6%	2.4%	3.8%	3.3%	1.3%	1.3%	1.3%
% DTOC Wilts	1.1%	1.1%	3.2%	1.9%	1.8%	2.6%	2.5%	2.5%
% DTOC Other	1.7%	2.4%	1.5%	0.9%	1.1%	1.5%	1.3%	1.3%

<b><i>Patients at Thursday Daily DToC Snapshot</i></b>	<b>3-Mar</b>	<b>10-Mar</b>	<b>17-Mar</b>	<b>24-Mar</b>	<b>31-Mar</b>
Swindon	10	10	6	5	7
Wiltshire	13	7	11	18	5
Other	7	4	13	13	9
ALL	30	21	30	36	21
Acute beds occupied on snapshot date	471	467	464	471	452
% DTOC ALL	6.4%	4.5%	6.5%	7.6%	4.6%
% DTOC Swindon	2.1%	2.1%	1.3%	1.1%	1.5%
% DTOC Wilts	2.8%	1.5%	2.4%	3.8%	1.1%
% DTOC Other	1.5%	0.9%	2.8%	2.8%	2.0%

The published data for delayed discharges nationally is adversely affected by mental health delays submitted by AWP without verification by the local authority.

October 2015: 195 days  
 November 2015: 153 days  
 December 2015: 173 days

Discussions have taken place with AWP and an agreed discharge monitoring system has been put in place.

## Target 2016/17 BCF

### Target setting for the Better Care Fund has to be seen in the context of the DTOC Programme.

The Better Care Fund Plan sets a DTOC target for health and social care including mental health.

The target for 2016/17 is 5,100 bed days including mental health and 4,000 without mental health. The target for quarter 1 and quarter 2 2016/17 have been set linked to the reduction in delays for GWH (Appendix 2). A detailed monthly trajectory has been produced which links the BCF target to the DTOC Programme target and the GWH high risk monitoring and target. This means that appendix 2 models a monthly trajectory of all three targets:

- BCF target (target 3)
- DTOC programme target based on days delayed by reason (target 1)
- NHSE target of reducing delays at GWH to 3% (target 2)

The BCF (target 3) quarterly target is

Q1: 983.9 (1,700)

Q2: 787 (1,360)

Q3: 636.7 (1,100)

Q4: 572.2 (1000)

The DTOC Programme (target 1) as agreed with NHS England, is only based on delays for Health and Social Care in relation to GWH and Swindon Intermediate Care (SWICC). This means that the actual days are reduced to (see appendix 2) :

Q1: 1370

Q2: 1047

Q3: 826

Q4: 788

The aim is to flat line delayed discharges based on days to 266 days per month across Health and Social Care by end of October 2016 and to maintain this for winter 2016/17. The current data for quarter 4 outlined on the previous page demonstrates that this is realistic given current performance during winter and high demand for emergency care. Given the fluctuations in data due to small numbers, partners in Swindon have decided on an average percentage reduction in delays rather than trying to model a fluctuating picture which is unlikely to be accurate.

In addition the DTOC Programme will contribute to reducing the total percentage of days lost at GWH to 3% (target 2) recognising that Swindon used 60% of the beds leading to a rate of no more than 1.8% average for the month for Swindon.

The data in the table 86 shows that Swindon delays are reducing and that the swindon contribution to the 3% is achievable. There is a challenge for Wiltshire and other neighbouring CCGs to support this target with detailed plans for Wiltshire. We



would expect these to be reported to the SRG as the systems leadership group and within the Wiltshire BCF.

**The following outline below shows the achievement of the DTOC programme in Quarter 4 2015/16**

**Workstream 1: Re-commissioning of domiciliary care**

The tender will be published in April 2016. The due date for the completion of the tender is October 2016. This date was reviewed in line with legal advice. Clarification questions can be asked as part of process.

The model of Home First has been agreed with SEQOL and in consultation with Wiltshire, and consultation with existing providers has been completed.

Swindon CCG has agreed additional funding for adult social care as part of the Better Care Fund to enable investment into care packages.

**Workstream 2: DTOC Out of Area**

Meetings have been held with Berkshire and Oxfordshire CCG and Wiltshire CCG are actioning a meeting and liaison with Gloucestershire CCG. There is an agreement for clear points of escalation and increased attendance with GWH site management SILVER calls weekly to progress any blockages. The site team report the OOA repatriations and they have improved as a result and we are awaiting figures on this from the site team.

**Workstream 3: Communication, Choice and Training**

Key outcomes include implementation of a 'Choice' policy resulting in a reduction of delays due to choice by 50%, resolving issues identified by staff and having a documented resolution in place, ensuring there is consistent response to issues escalated and putting in place an agreed and signed off discharge protocol. An agreed discharge protocol has been signed off by GWH and SEQOL. An agreement has been reached on how a 'choice' policy will be disseminated to staff alongside a communication plan.

An integrated DTOC Governance Group has been established at GWH including representatives from DART, OT, Physiotherapy and Ward Matron to drive forward interdisciplinary communication and discharge planning and to monitor progress against agreed targets.

Daily DTOC reports and escalation process in place. This process needs to embed.

Daily coding agreed from 2nd week February, fully operation March 16. GWH, Seqol and SBC have set up a weekly oversight management group to ensure DTOC reporting process is embedded and operating.

Medway information system to provide baseline performance report on discharge timescales and DART referrals. Further work on Choice Policy and CHC process

identified.

GWH has created a new page on the Intranet to support the DTOC programme and to provide staff with resources and information to support patient flow and discharge: [http://gwh-intranet/unscheduled-care/patient-flow-and-discharge/delayed-transfers-of-care-\(dtoc\)-programme.aspx](http://gwh-intranet/unscheduled-care/patient-flow-and-discharge/delayed-transfers-of-care-(dtoc)-programme.aspx)

GWH DTOC Governance Group has identified need for further clarification on CHC and so a new action has been added. Confirmed list of F-Codes which are now on Medway to provide comprehensive feedback on reasons for delays. Lorraine Austen (LA) confirmed a meeting is scheduled for Tuesday 19<sup>th</sup> April. GWH website is being used to communicate changes and will include the monthly newsletter. GM will send the flow chart on CHC funding and decision making plan to LA. Will also be looking at putting on data around medically fit for discharge to actual day of discharge; the aim is to get the 'green to go number' down.

#### **Workstream 4: Review of DART and IDT team and process**

This workstream has incorporated a review of the social work function within DART to ensure patients are discharged home where possible. DART Review confirmed that DART would return to the original model. This will take to week of 25 April 2016. DART process will now remove the timescales of triage within 24 hours. Discussions have taken place between SW, HM and RR about taking out inbuilt delays – agreed that complex cases to go direct to social worker. SW confirmed that if someone is going back home to the same place with the same package of care, there is no need for an assessment to be carried out.

Action Plan being developed in response to DART review by Seqol. This will be circulated w/c 11.4.16

Rapid Response now has access to Bridging Services so that admissions can be avoided. Seqol also has a community nurse in the front door team and this will be reviewed.

Work to be done around DART and non-acute health delays. There are also delays around community services. Some work to be done in GWH to understand the referral pathway from the Seqol community position in order to aid social worker perspective.

GWH has made some internal changes to support patient flow. Now want to look at how patient flow and DART work together. There is a piece of work to be done on non-acute Health patients around clarification of discharge from the ward, through DART, and to the final destination. Alison Koster has been nominated from GWH, Louise Tapper as Health Commissioner and Jill Kick from DART.

#### **Workstream 5: Reablement Reshaping**

Progress included within Domiciliary Care specification, and workstream closed. Paper based audit of reablement undertaken and findings raised at Commissioner /

Provider meeting 2.3.16. Further work now required on how Seqol submit information.

Additional reablement hours now available through restructure but additional work still required to fully utilise funding.

#### **Workstream 6: Discharge to assess beds, residential reablement and SWICC**

- Plan to decrease number of private D2A further and link with closure of Florence House
- Discussions with Seqol to increase D2A provision in Fessey House and Fessey to become the only D2A provision. 2 delirium beds now available in Whitbourne.
- Contact and brokerage officers assigned to review usage of D2A service with a view to increase usage of Fessey and consolidate private sector beds to providers able to support discharge 7 days a week.
- Further workstream developed for further collaborative working between hospital social work, reablement, Bridging and D2A in the nursing sector.

#### **Workstream 7: Care Homes**

- March 2016 - Meeting with CCG Community Contract Lead, SEQOL continence nurse, GWH Urgent Care Matron and GWH Programme Director for Community Integration for advice around continence products as GWH do not have continence nurse specialty. Pathway will be for all new continence patients who are referred to SEQOL continence service as part of the patient's discharge arrangements.
- Seqol Continence service reviewing referral source from Care Homes, including whether patient went home via GWH to Care Home and then referred to the service. Review meeting mid-April.
- March 2016 - Identified Care Home issues, and action plan developed and discussed with Programme Board. New (reminder) generic pathway to access specialist nurses to be developed by 22nd April.
- March 2016 - IV pathway / training for Nursing Homes who want to pilot giving IV fluids or IV antibiotics in development. Specialist Nurse Lead (Jo Boyd) has started discussions with community nurses re communication flyer and access to Seqol services. Jo to update Louise Tapper 18.4.16. This will be shared with Wiltshire to ensure consistency.
- Seqol to confirm number of people in Nursing/Care homes with a Community Matron care plan.

#### **The delivery chain**

**Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved**

DTOC Project Team for delivery of each of the 7 workstream packages to an agreed set of deliverables and timetables. Each workstream has a nominated lead who is responsible for delivery of the work.

Reporting to: DTOC Programme Board with representatives from Swindon Borough Council, Swindon CCG, Wiltshire Council and CCG, Great Western Hospital NHS Trust, SEQOL who will oversee the changes to systems and services to deliver a sustainable reduction in delayed transfers of care.

Reporting to: System Resilience Group

Commissioner: Swindon Borough Council,  
Provider: SEQOL

### **The evidence base**

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Integrated hospital discharge is regarded as good practice. The team is located within GWH and is implementing the relevant findings from the recent ESIS review in 2014. ESIS review of Great Western Hospital was positive about the impact of the DART team in improving patient flow and reducing admissions to hospital. Adult social care commissioning works closely with the teams to ensure that there is no delay in accessing adult social care packages. Research has shown that many older people in hospital have multiple health issues and that the length of stay is directly related to the age and complexity of health and care needs Cornwell et al *Continuity of care for older hospital patients, a call for action*, Kings Fund March 2012. Integrated discharge planning within hospitals has been identified as good practice in order to prevent hospital re-admissions, for example Kings Fund *Continuity of care for older hospital patients, a call for action*, March 2012 ;

### **Investment requirements**

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan  
**£4.109,559**

### **Impact of scheme**

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan  
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Benefits 2016/17

A contribution to a reduction in hospital re-admission to 3.5%

A contribution to a reduction in admission to residential care to 736 per 100,000

The model cost for a care package for an older person is approx. £7,500 per annum, which means this scheme is able to support an additional 77 older people in 2015/16.

### **Feedback loop**

What is your approach to measuring the outcomes of this scheme, in order to

understand what is and is not working in terms of integrated care in your area?
<p>Monthly joint contract performance meeting with SEQOL and CCG, escalation of issues to Strategic Resilience Forum</p> <p>Quarterly report to Joint Commissioning Group</p>
<b>What are the key success factors for implementation of this scheme?</b>
<p>Targets: Delayed Transfers of Care per 100,000 population aged 18+ 2016/17 (BCF target 3)</p> <p>Q1: 983.9 (1,700) Q2: 787 (1,360) Q3: 636.7 (1,100) Q4: 572.2 (1000)</p> <p>This includes Mental Health and Community Health Services. The DTOC Programme as agreed with NHS England, is only based on delays for Health and Social Care in relation to GWH and Swindon Intermediate Care (SWICC). This means that the actual days are reduced to (BCF target 1):</p> <p>Q1: 1370 Q2: 1047 Q3: 826 Q4: 788</p> <p>50% in social care DTOC by 31.3.17 50% in delays by 31.3.17</p>

## Scheme 6

### Scheme name: Carer Support

#### What is the strategic objective of this scheme?

- Supporting carers so that their quality of life improves and they enjoy their caring role
- Carers feeling supported and are able to maintain their own health

#### Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

- A joint Carers' contract is already in place which was tendered in 2012/13. The Carers' Centre provides advice and information for carers, welfare benefits

<p>advice as well as support groups. Young carers support is provided by the same voluntary organisation and was part of the same tender. Outcomes for carers continue to improve. Additional investment was made available in April 2012 for short term breaks for carers and the investment has been maintained.</p> <p>Development of improved assessment process for carers and improved access to health checks. The Carers' Centre has a number of full time, part time and volunteer staff. There is now a GP liaison service and carers champions in GP surgeries. As part of the BCF we want to improve the number of carer assessments, short term breaks and hospital discharge through a dedicated resource.</p> <ul style="list-style-type: none"> <li>• All carers are targeted through this service which will be co-located with other voluntary sector service in the centre of Swindon</li> <li>•</li> </ul>
<p><b>The delivery chain</b></p> <p>Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved</p>
<p>Commissioner: Swindon Borough Council, CCG</p> <p>Provider: Carers' Centre and private sector</p>
<p><b>The evidence base</b></p> <p>Please reference the evidence base which you have drawn on</p> <ul style="list-style-type: none"> <li>- to support the selection and design of this scheme</li> <li>- to drive assumptions about impact and outcomes</li> </ul>
<p>.</p> <p>Extensive national research is available to support the evidence base for carer support. Carers' assessments support personalisation, helping to maintain the independence &amp; resilience of service users and their carers being supported within the community.</p> <p>As well as the two main community health and social care providers, the Swindon Carers Centre completes assessments, which are then validated by an SBC care manager.</p> <p>The target for the year was 30% Although we achieved just below at 29.2% which equates to 1374 carer's assessments being completed. In addition to these, 3.8% of carers were offered but declined an assessment during the year.</p> <p>Therefore we will be providing on line and face to face support to increase the number of carers assessments which are completed each year and thereby increasing appropriate support.</p> <p>Continuity of care for older people is important especially as part of the hospital discharge process. The Carers centre has a GP outreach post and GP's have carer Leads in all Swindon Surgery. The model of a carers workers within a hospital discharge services was evaluated positively in Leeds and cited as good practice in the Kings Fund <i>Continuity of care for older hospital patients, a call for action</i>, March 2012; SCIE Research briefing 12 <i>Involving individual older people patients and their carers in the discharge process</i>, February 2005, Carers Act 2004</p>
<p><b>Investment requirements</b></p>

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan <b>£809,570</b>
<b>Impact of scheme</b> Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
2015/16 benefits Improving the health and wellbeing of carers through assessment of needs and support in their caring role 750 carers assessments completed by SEQOL and AWP, 1000 carers assessments completed by Carers centre, SEQOL and AWP. Discharge post to support 250 carers per annum through hospital discharge process
<b>Feedback loop</b> What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Quarterly performance meeting with carers centre, escalation of issues to Strategic Resilience Forum Quarterly report to Joint Commissioning Group
<b>What are the key success factors for implementation of this scheme?</b>
Existing scheme funded from NHS Transfer to LA and CCG allocation Prevention schemes resulting in delay for care and improved quality of life for carers. Cost avoidance rather than cashable savings

## Scheme 7

**Scheme name: Capital Grant Adult Social Care**

**What is the strategic objective of this scheme?**

- Appropriate equipment and adaptations to support people living independently for as long as possible and ensure a good quality of life

**Overview of the scheme**

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

*Capital allocations fund the Disabled Facilities Grant scheme which is operated by Swindon Borough Council and meets our statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.*

Capital allocations contribute towards the joint Integrated Community Equipment Store for children and adult services as well as investment in telehealth and telecare through the funding of major items of equipment. We will continue investment in

technology to support self-care and prevention and enable for this a disability to live as independently as possible.
<b>The delivery chain</b> Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioner: Swindon Borough Council Provider: SEQOL  Disabled Facilities Grants are managed by Swindon Borough Council.
<b>The evidence base</b> Please reference the evidence base which you have drawn on <ul style="list-style-type: none"> <li>- to support the selection and design of this scheme</li> <li>- to drive assumptions about impact and outcomes</li> </ul>
Capital required to ensure equipment and / or adaptations to support hospital discharge and maintain people living at home is in place
<b>Investment requirements</b> Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan <b>£897k</b>
<b>Impact of scheme</b> Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Approximately 2,000 items of equipment are given to service users and carers each year. This is an existing funding scheme to support people at home and ensure care home have appropriate equipment to prevent injuries such as pressure sores and maintain their independence for as long as possible.
<b>Feedback loop</b> What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Monthly contract performance meetings with SEQOL, escalation of issues to Strategic Resilience Forum Quarterly report to Joint Commissioning Group
<b>What are the key success factors for implementation of this scheme?</b>
Existing scheme funded from capital allocation

## Scheme 8



<b>Scheme name: Community Health aimed at reducing emergency admissions</b>
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<b>What is the strategic objective of this scheme?</b>
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|---|
| <ul style="list-style-type: none"> <li>• Reduction in hospital re – admissions through use of step up and step down beds</li> <li>• Reduction in delayed discharge through use of step up and step down beds</li> <li>• This is one of the largest investments of the BCF into community health services because based on research these schemes have been effective in avoiding hospital admissions and reducing delayed discharge. In addition to the virtual ward, Swindon also invests in a number of urgent care schemes through CCG base budget funding.</li> </ul> |
|---|

<b>Overview of the scheme</b>
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Please provide a brief description of what you are proposing to do including:
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- |   |
|---|
| <ul style="list-style-type: none"> <li>- What is the model of care and support?</li> <li>- Which patient cohorts are being targeted?</li> </ul> |
|---|

<i>Continued development and enhancement of a range of community based support such as the Single Point of Access, SUCCESS, Nursing Home Visiting</i>
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<p>This scheme includes our existing provision of Virtual Ward, Intermediate Treatment beds (SWICC), Hospital discharge services and 7 day working for clinicians, single point of access.</p>
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<p>SWICC are two wards providing step up and step down beds in a separate building on the site of Great western Hospital. There are two wards. Forrest ward is a 30 bed unit taking hospital discharge patients with the aim of rehabilitation so that admission to residential and nursing care is avoided. At the Falcon Acute Stroke Unit at Great Western Hospital the specialist stroke multidisciplinary team, which includes physiotherapists and Occupational Therapists, work with patients on stroke therapy assessment and rehabilitation just days or weeks after the stroke has happened.</p>
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<p>Some people go to Forest Ward in-patient rehabilitation at SWICC, and its team skilled in stroke rehabilitation starts setting goals with people straight away. This includes planning for discharge, supported by our seven-days-a-week community stroke team, who assist people to adjust to the effects of having a stroke. Orchard ward is a 26 bed unit as a step up facility to avoid hospital admission.</p>
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<p>The virtual ward is supporting patients at home through a nurse led home visiting service. Over 1200 patients were discharged between April and June 2014 and thereby avoiding hospital admissions</p>
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<p>The target patients for Virtual Ward and Orchard are older people with long term health conditions, whose health has suddenly deteriorated but who can be supported outside an acute setting. The target population for Forrest is patients being discharged from hospital. Consultants support patient care in both wards if the need arises.</p>
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<b>The delivery chain</b> Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioner: CCG Provider: SEQOL,
<b>The evidence base</b> Please reference the evidence base which you have drawn on <ul style="list-style-type: none"> <li>- to support the selection and design of this scheme</li> <li>- to drive assumptions about impact and outcomes</li> </ul>
<p>.</p> <p>There is extensive research supporting the implementation of intermediate care and virtual ward environments. SCIE <i>Research briefing 12: Involving individual older people in the discharge process from acute to community care</i>, February 2005. 1,200 patients were discharged from the Virtual ward in the first quarter of 2014/15 with an average length of stay of 13 days against a target of 21 days. The bed occupancy in both Forrest and orchard has been 97% with an average length of stay in Orchard of 14 days and 32 days in Forrest. This demonstrates the effectiveness in the service to improve patient flow.</p>
<b>Investment requirements</b> Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan <b>£2,389,446</b>
<b>Impact of scheme</b> Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
<p>2015/16 benefits</p> <p>A contribution to a reduction in hospital re-admission by 3.5%</p> <p>A contribution to a reduction in delayed discharge by 1.2%</p> <p>The Virtual ward is estimated to have 4,800 discharges in a year. Orchard and Forest ward are estimated to have an occupancy of 97%. It is difficult to estimate the number of patients as length of stay varies depending on the needs of the patients.</p>
<b>Feedback loop</b> What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
<p>Monthly contract performance meetings with SEQOL, escalation of issues to Strategic Resilience Forum</p> <p>Quarterly report to Joint Commissioning Group</p>
<b>What are the key success factors for implementation of this scheme?</b>
<p>This is an existing scheme. Appropriate referrals from GPs are critical to the success of the virtual ward.</p>

Creating better patient flow without necessarily resulting in a financial benefit. Benefit is cost avoidance rather than cashable saving with 4,800 discharges and 97% occupancy.

## Scheme 9

### Scheme name: Managing Demand in Adult Social Care

#### What is the strategic objective of this scheme?

- Meeting the demand for increasing demographic growth in older people social care services and enabling people to live independently for as long as possible.

#### Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

- Increase in care packages due to demographic pressure leading to reduced length of stay in hospital. Work with residential and nursing providers to increase access to health care within homes so that admissions to hospital reduce
- Modelling showing due to population changes explained in section 3, an additional 60 older people per year in need of adult social care services and 30 people with a learning disability. The local authority is targeting work in learning disabilities to reduce demand and ensure efficient and effective delivery. This is planned to mitigate against demand by £3.2m for 2015/16. This additional funding of £800k from BCF is to ensure eligibility criteria can be maintained.

#### The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioner: Swindon Borough Council,  
Provider: SEQOL, Voluntary and Third Sector

#### The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Section 3 outlines the increase in population of older people and those with long term conditions which will increase demand for adult social care. This allocation is not a specific scheme but enables care packages to be delivered. Taking an average

cost of £7,500 per service user per year, then an additional 106 people can be supported.

#### **Investment requirements**

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

**£929,954**

#### **Impact of scheme**

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan  
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Maintaining people to live independently as long as possible. At a cost of £7,500 per care package per annum a total of 106 additional service users can be supported per annum, currently approximately 1,200 older people are supported per annum

#### **Feedback loop**

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Monthly contract performance meetings with SEQOL, escalation of issues to Strategic Resilience Forum  
Quarterly report to Joint Commissioning Group

#### **What are the key success factors for implementation of this scheme?**

New scheme, project management support for implementation of savings schemes, work force development so that community based resources are used to maximum capacity. Support for an additional 106 older people with potential to reduce delayed discharge.

## **Scheme 10**

**Scheme name: Implementation of Care Act 2014**

#### **What is the strategic objective of this scheme?**

- Personalisation, choice and support for people in need of adult social care so that they are able to lead fulfilling lives and reach their potential and their quality of life improves

#### **Overview of the scheme**

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

<p>.</p> <p>We will be implementing the required systems under the Health &amp; Social Care Bill and prepare systems for an increase in financial assessments and self-assessments. Wherever possible we will be investing in new technology to automate processes as quickly as possible. We will focus on</p> <ul style="list-style-type: none"> <li>• On line assessment</li> <li>• Carers assessment</li> <li>• Increased advocacy for older people</li> <li>• Advice and information and promotion of well-being</li> <li>• Deferred payment scheme</li> <li>• Preparation for changes to financial support</li> </ul>
<p><b>The delivery chain</b></p> <p>Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved</p>
<p>Commissioner: Swindon Borough Council, Provider: SEQOL, Voluntary and Third Sector</p>
<p><b>The evidence base</b></p> <p>Please reference the evidence base which you have drawn on</p> <ul style="list-style-type: none"> <li>- to support the selection and design of this scheme</li> <li>- to drive assumptions about impact and outcomes</li> </ul>
<p>.</p> <p>Statutory requirements of Care Act 2014</p>
<p><b>Investment requirements</b></p> <p>Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan</p> <p><b>£468,800</b></p>
<p><b>Impact of scheme</b></p> <p>Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan</p> <p>Please provide any further information about anticipated outcomes that is not captured in headline metrics below</p>
<p>Implementation of the Care Act and meeting statutory guidance. As guidance has not been finalised it is not possible to estimate the potential benefits. However, we have already implemented an advice and information web site and service as well as commissioning of carers support and assessment, We estimate that improving access to services for service users and carers through improved assessment, improved advice and information and 7 day working in social care will also improve the quality to life of individuals (ASCOF 1A to 18.7 in 2015/16)</p>
<p><b>Feedback loop</b></p> <p>What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?</p>
<p>Monthly contract performance meetings with SEQOL, escalation of issues to Strategic Resilience Forum</p> <p>Quarterly report to Joint Commissioning Group</p>

<b>What are the key success factors for implementation of this scheme?</b>
New scheme, project management support for implementation of new guidance, ICT infra-structure, work force development. Additional investment to meet Care Act requirements



**Joint document of Swindon Borough Council, Swindon CCG, Great Western Hospital,  
SEQOL and Wiltshire Council**

<b>Version</b>	<b>Modifications</b>	<b>Author</b>	<b>Date</b>
<b>V01</b>		Alan Rosenbach/Sue Wald	11/01/2016
<b>V02</b>	Additions by Gill May and Louise Tapper	Louise Tapper	14/01/2016
<b>V03</b>	Accepting changes	Sue Wald	15/01/2016
<b>V04</b>	SEQOL changes	Sue Wald/Heather Mitchell	18/01/2016
<b>V05</b>	GWH amendments	Adrian Griffiths	18/01/2016
<b>V06/7</b>	SRG amendments with NHS England	Sue Wald	20/1/2016
<b>V08</b>	DTOC Programme Team meeting	Victoria Guillaume	3/2/2016
<b>V09</b>	Amendments	Sue Wald	5/2/2019
	Final amendments		

<b>Project Initiation Document (Version 09)</b>	
<b>Project Name:</b> Delayed Transfers of Care Programme <b>Project Sponsor:</b> Sue Wald <b>Project Manager:</b> Louise Tapper/Victoria Guillaume <b>Start Date:</b> 18 <sup>th</sup> January 16 <b>Completion Date:</b> September 2016	
<b>Objectives</b>	
<p>The DTOC Programme will focus on the short and medium term challenges of delayed transfers of care (DTOC). Short term is defined as the next 3 – 5 months, medium term 9 months. The work and its outputs will provide the platform for the implementation of the recommendations that form the NHS England investigation into delayed discharges in Swindon and Newton Europe's system wide diagnostic work on Delayed Transfers of Care. The Programme Board for the DTOC Programme will report to the System Resilience Group who will use the information and data to support wider health and care work across Swindon. The accountability for strategic planning will be with the SRG and not this programme of work</p>	
<b>Anticipated Benefits</b>	
<ul style="list-style-type: none"> <li>– Reduction in delayed discharge for health and social care to 3 per 100,000 population each thereby halving the current rate and 50% of days lost due to health and social care</li> <li>– Reduction of non-DTOC delays to half of current numbers for GWH and Intermediate Care SWICC to</li> <li>– Strengthened relationships with care sector providers to prevent admission and ensure speedy discharge</li> <li>– Improved communication on system challenges, changes and improvements on Delayed Transfer of Care (DTOC) for both health and care staff</li> <li>– Delivery of safe, effective and resilient social care services</li> <li>– Reduced hospital length of patient stay and improved patient flow from the GWH ED; improved performance against the ED 4 Hour patient waiting time target</li> </ul>	
<b>Scope</b>	



**In scope:**

- Service models to ensure the speedy and safe discharge of patients thereby reducing delay and hand offs within discharge systems and processes
- Staffing challenges in the care sector including training and support to care home and home care sector

**Out of scope:**

- Strategic plans for housing
- Equipment Services
- Continuing Health Care arrangements
- Prevention of hospital admission included in urgent care programme
- Actions relating to single agencies only
- System Wide Five Year Strategic Plan
- Mental Health DTOC (This is part of a separate piece of work with AWP and commissioners)

**Deliverables/ Outcomes**

- Sustainable reduction in number of DTOC and non-DTOC delays across the health and care system by 30/9/16 (planned reduction of current numbers by at least 50%)
- Agreed programme of work with clear outcomes and timelines for implementing the Newton Europe recommendations as these apply to delayed discharges.

**Dependencies**

This work links to the following programmes:

- Link to SBC Transformation Programme; Meeting the Needs of Vulnerable People' with work streams reporting to both programme boards
- Link to programme of GWH programme 'Right Patient, Right Bed'
- Link to Urgent care programme focusing on prevention of hospital admission
- Link to commissioners' Urgent Care Strategy
- Link to 5 year Strategic Plan led by Swindon CCG

**Assumptions**

The working assumption is that the changes to be implemented and sustained will be made, as the CCG and SBC are recommending to Governing Body and Cabinet working towards greater integration of acute and community health services; the other assumption is that services and systems will be simplified and made easier for people using services and families.

**Project Board Structure & Terms of Reference**

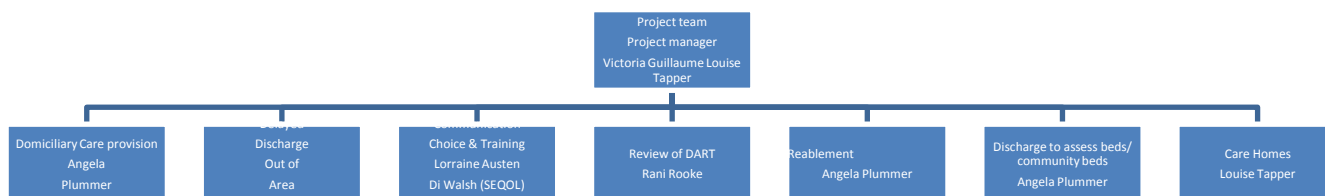
**System Resilience Group**



<p align="center"><b>Delayed Transfer of Care Programme Board Members</b></p> <p><b>Swindon SBC</b> - Sue Wald (Senior Responsible Officer SRO)  <b>Swindon CCG</b> – Gill May  <b>Wiltshire Council and CCG</b> - Carolyn Hamblett, James Roach  <b>Great Western Hospital NHS Trust</b> - Lorraine Austen  <b>SEQOL</b> - Heather Mitchell</p>
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<p align="center"><b>Terms of Reference</b></p> <p><b>Purpose</b>  The Board will oversee the changes for system and service changes to deliver a sustainable reduction in the delayed transfers of care.</p> <p><b>Aim</b>  To improve the system alignment, overall governance, structures and processes and in doing so to ensure a sustainable reduction of delayed transfers of care.</p> <p><b>Governance</b>  The Board will meet fortnightly over the next 9 months and report to the Strategic Planning Group fortnightly and SRG monthly and other key stakeholders. The Board will take the learning and ensure it is applied where relevant to other programmes where there are clear and obvious dependencies. The Board will also have an effective communication plan around its role, work and functions.</p>
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**Project Team and Work Packages (orange are existing SBC work streams)**



## Terms of Reference

### Purpose

The project team will be responsible for the delivery of the work packages to an agreed set of deliverables and timelines. Each work stream has a nominated lead who is responsible for the coordination of the work, produce fortnightly highlight reports

**Administrative support will be provided to each work stream.**

### Aim

The work packages will include all the key staff that can champion change and who can communicate the benefits for people using services, families and staff.

### Governance

The project team will meet fortnightly and report to the Programme Board on the on going progress linked to the work packages. The Team will also have an effective communication plan around its role, work and functions. Each work stream will have a detailed work plan in place, a summary of which is outlined below. The work stream lead will be responsible for the agreement of the detailed work plan against which **a fortnightly highlight report is produced.**

A summary report of progress against milestones, barriers and risks will be agreed by the project team and presented by the project manager to the Programme Board.

## Communication Updates

Name	Title	Organisation	Contact Details
Sue Wald	Interim DASS	SBC	swald@swindon.gov.uk

<b>Cost Estimates</b>			
<i>[Any significant expenditure that will be associated with delivering the project]</i>			

## DTOC Programme Workstreams

### **Workstream 1: Re-commissioning of domiciliary care** (Recommendation 8, 19, 29)

**Recommendation 8** - that the two Local Authorities (Wiltshire and Swindon) create a project, jointly with the CCGs to, where possible, align pathways and procedures in the light of known best practice. This project to be completed before October 2016.

**Recommendation 19** - that, subject to the Local Authorities confirming that they are using all financial levers available to them to maximise funding for Adult Social Care in general, and Home Care in particular, whole system partners urgently consider how to prioritise further expenditure (particularly within the Better Care Fund) on Home Care Commissioning for those areas where home care hours are still in short supply (a targeted approach to differential pay rates for different areas might help to make this affordable).

**Recommendation 29** - that the new specification for any retendered Home Care Services should specify the commencement of packages of care during the morning wherever possible.

**Workstream lead:** Angela Plummer ([aplummer@swindon.gov.uk](mailto:aplummer@swindon.gov.uk))

#### **Workstream members:**

SBC: Rani Rooke/Angela Plummer

GWH: Lorraine Austen

SEQOL: Sandie Parsley

Wiltshire Council: James Cawley

#### **Aim**

To establish the principles for bridging services working in partnership with Wiltshire Council to build on the 'Home First' model

To commission a new domiciliary care and community support service based on an outcomes model learning from Wiltshire experience

#### **Objectives**

Given the difficulties in commissioning domiciliary care capacity in the market and learning from the experience of Wiltshire Council of moving towards an outcome based contract, Swindon Borough Council wishes to commission a new model of domiciliary care through a new tender in 2016.

The requirement is for a prime contractor provider who will coordinate, manage and deliver both directly and indirectly domiciliary care and community support in Swindon, working with us to overcome barriers and deliver a new model of care and support.

Linking domiciliary care closely to community support by including the requirement to develop volunteering, befriending and initiatives to reduce isolation, support planning and review

All domiciliary care to be person centred and enabling service users to regain skills and maintain their

independence

**Key Outcomes to be achieved**

Improved capacity within domiciliary care to deliver hours required per week to meet need  
 Reduce admissions to residential and nursing care by maintaining people at home  
 Appoint prime provider for domiciliary care and support services

No	Milestone Description	Owner	Start and Due Date	Status
	Draft specification complete and gateway for tender	Angela Plummer	15.1.2016	G
	Route to procurement agreed	Angela Plummer	15.1.2015	G
	Model of Home First agreed with SEQOL and in consultation with Wiltshire	Rani Rooke	28.2.2016	
	Consultation with existing providers started	Angela Plummer	29.1.2016	G
	Publication of tender	Katey Magee	1.3.2016	
	Completion of tender	Katey Magee	30.8.2016	
	Cabinet budget setting for Council	Sue Wald	10.2.2016	G
	CCG to consider additional funding for adult social care as part of BCF to enable investment into care packages in discussion with Director of Social Services	Nicki Millin	1.3.2016	

**Workstream 2: Delayed Discharge Out of Area (Recommendation 9)**

**Recommendation 9** - that, within four weeks, summit meetings take place, with each of the surrounding Local Authorities, including all the relevant Chief Executives and backed by thorough data analysis, to agree optimal arrangements for avoiding DToC. Should such arrangements not be forthcoming as a result of those meetings, the matter to be escalated to the two relevant government departments for resolution.

**Workstream lead:** Thomas Kearney CCG (seniorcommissioningmanager@swindonccg.nhs.uk)

**Workstream members:**

CCG

Gloucestershire CCG

Oxfordshire CCG

Berkshire CCG

GWH: Emma Cavill and Linda Power

**Aim**

To reduce the delays for discharge of patients who are the responsibility of other CCGs

**Objective**

Agree protocol with each out of Area CCG to ensure patients are discharged within 48 hours of the patient's medically fit date.

Agree single point of contact with each CCG and point of escalation

GWH to share lost bed days information due to OOA DTOCs with lead CCG to monitor progress, identify themes and agree escalation process where required

**Key Outcomes to be achieved**

Reduction by 50% in the number of delayed patients and days from out of area placements  
Agreed protocol and escalation process

No	Milestone Description	Owner	Due Date	Status
	Issue invitation to neighbouring CCGs with patients at GWH	Thomas Kearney	15.2.2016	
	Establish number of patients delayed by month and by CCG for 2015 and number of bed days	Adrian Griffiths	22.2.2016	
	Agree immediate actions at meeting with CCGs to reduce delays	Thomas Kearney	28.2.2016	
	Agree protocol and escalation route for patients from those CCGs	Thomas Kearney	15.3.2016	

**Workstream 3: Communication, Choice and training** (Recommendation 6,10, 11, 30)

**Recommendation 6** - that the Executive Officers of GWH, whilst retaining their approach to devolved accountability to clinical operational teams, walk the wards on a daily basis in order to ascertain the effectiveness of that devolved approach in driving rapid change.

**Recommendation 10** - that there be an urgent review of the roll-out of the revised Choice policy to consider whether it can gain traction quickly enough, and to also consider whether additional alternatives should be commissioned.

**Recommendation 11** - that, within four weeks, a system is established to create a readily accessible 'Issues Log' so the staff at all levels can raise operational issues (not specific to a particular patient) and

receive feedback from an appropriate member of the executive as to how the issue is (or is not) being addressed. This Log to be a standing information item at the primary governance meeting for this pathway.

**Recommendation 30** - that the system for logging issues suggested in Recommendation 11 above should be used to collate examples of these different experiences with a view to establishing a common understanding.

**Workstream lead:** Lorraine Austen (lorraine.austen@gwh.nhs.uk)

**Workstream members:**

SBC: Rani Rooke

GWH: **Lorraine Austen/Emma Caville**

**SEQOL: Jill Kick/Val Timms**

### **Aim**

To ensure that all staff and managers across the system understand the discharge process, routes of escalation, roles and responsibilities and the available menu of discharge options including criteria for each provision including SWICC and discharge to assess options

To ensure all staff across the system are able to report issues hindering discharge so that these can be addressed and resolved by senior managers

To ensure the system escalation of silver and gold calls is reviewed to provide assurance to front line staff of timely and clear response to issues raised

### **Objectives**

Staff across the system are aware of the discharge options including those in the community and ward staff able to restart packages

The discharge protocol is clearly understood by all staff across the system involved in discharges  
There is clarity over capacity assessment, safeguarding and best interest decisions so that misunderstandings/interpretations do not delay a discharge

Staff are confident in the implementation of the choice policy and patients and families are involved in discussions at the earliest opportunity

Staff are able to report system wide issues and report that there has been a response to those issues  
All social work staff across GWH and SWICC work as a team with access to all assessments and plans so that workers on duty are able to deal with all discharge issues

There is a named point of escalation for all social work, acute health and community health during the week and at weekends to resolve issues

There is senior co-ordination of discharges across 7 days

The 5 day rolling forecast is used to support capacity planning and system flow.

### **Outcomes**

Choice policy effectively implemented resulting in a reduction of delays due to choice

Issues identified by staff have a documented resolution in place

Issues that are escalated result in a consistent response

Agreed discharge protocol in place and signed off

No	Milestone Description	Owner	Due Date	Status
	Final sign off of discharge protocol by GWH and SEQOL	Sue Wald	29.1.2016	Green complete
	Agreed communication plan with SEQOL and GWH of discharge protocol with front line staff	Lorraine Austen/Jill Kick	15.3.2016	
	Agreement how choice policy will be disseminated to staff and communication plan	Lorraine Austen/Jill Kick	15.2.2016	completed
	Safeguarding and mental capacity assessment briefing note to social work staff	Doug Bale/John Hughes with Victoria Guillaume	15.2.2016	
	Monthly commissioning newsletter	Victoria Guillaume	28.2.2016	
	Establishment of issue log process and dissemination (Patient Flow admin)	Lorraine Austen	15.2.2016	
	Monthly operational review of discharge process	Rani Rooke	10.2.2016 (start)	G
	Communication process agreed for messages from other work streams through project team meetings	Victoria Guillaume	3.2.2016	G

#### Workstream 4: Review of DART and IDT team and process (Recommendation 8, 12, 13)

**Recommendation 8** - that the two Local Authorities (Wiltshire and Swindon) create a project, jointly with the CCGs to, where possible, align pathways and procedures in the light of known best practice. This project to be completed before October 2016.

**Recommendation 12** - that, within two weeks, the Chief Executives of GWH and SEQOL with the Swindon ADASS consider the evidence, above, regarding the functioning of DART alongside any other evidence sought from their own staff, and agree, in writing 'one version of the truth' for dissemination to front-line staff. The purpose of this is to dispel inaccurate and negative stereotypes whilst at the same time identifying areas of dysfunction to be fixed immediately.

**Recommendation 13** - that, in line with the new electronic referral system, Key Performance Indicators are established for the various stages of referral and assessment within DART



**Workstream lead:** Rani Rooke (rrooke@swindon.gov.uk)

**Workstream members:**

SBC: Rani Rooke

GWH: Lorraine Austen

CCG: Louise Tapper

SEQOL: Jill Kick

Wilshire CCG/Council: Carolyn Hamblett

**Aim**

To review the DART process so that there is clarity over roles and responsibilities and delays are minimised; to ensure patient specific data, in terms of progress through the process, is readily available to the Trust and wider health and social care system

To develop KPIs to enable performance management of process delays

To achieve a 50% reduction in non DTOC delays attributed to DART services

To review the social work function within DART to ensure patients are discharged home where possible

That key communication leads are established for each hospital ward to liaise with DART

To review the role and responsibilities of GWH physio and occupational therapy teams to ensure effective interface with wards, DART and IDT to drive timely and safe discharge; to achieve improved integration of Trust, DART and therapy services

**Objectives**

To review the MDT and DART process and identify avoidable blockages, delays and hand offs to existing processes

To agree improvements to reduce identified built in process delays

To ensure clear communication about the DART process which is to be disseminated through work stream 4; to ensure visibility of patients' discharge via the DART process on Hospital whiteboards and at Board Rounds

To define the role and responsibilities of GWH occupational therapy and Physiotherapy teams

To agree across Swindon and Wiltshire the DART model and the role of social work within this. For Swindon this also includes social work in SWICC

To agree when new DART process can commence

To agree documentation, communication and managerial processes across 7 days

**Outcome**

DART process is agreed , documented and disseminated with clarity for patients who are responsibility of the ward and those who need to be triaged by DART

KPIs agreed, implemented and reported weekly and monthly, including patient delays and patient medically fit dates.

No	Milestone Description	Owner	Due Date (TBC)	Status
	Agree scope of review across all partners and how review will be conducted	Rani Rooke	22.1.16	G Review already underway
	Review actual service delivery against January 15 specification	Rani Rooke with AP and LT	8.2.16	G
	Review process complete including review of pathways to access other services	Rani Rooke	1.2.2016	G
	GWH to review the timeliness of ward based discharges that are not led by DART	Lorraine Austen	22.2.2016	
	Include requirement for 7 day working within DART and IDT and access to brokerage	Rani Rooke	22.1.2016	G
	Ensure real time information of patients within DART who had MDT, medically optimised and safe to discharge	Jill Kick	22.2.2016	
	Ward to be informed of Care Package availability in advance of 'on the day'.	Jill Kick	22.2.2016	
	Forecasting model to be rolled out for whole system to ensure faster capacity planning & discharge management.	Sharon Gerry Giles de Burgh	28.2.16	
	Review process complete including review of pathways to access other services	Rani Rooke	1.3.2016	
	Review Wiltshire DART model to understand difference between models	Rani Rooke	22.1.16	G completed
	Report review process to commissioners with action plan to address findings	Rani Rooke	1.3.16	
	Implement revised model	Rani Rooke	1.4.16	
	KPI agreed with monthly reporting agreed	Rani Rooke	7.3.2016	

**Workstream 5: Reablement reshaping (Recommendation 18)**

**Recommendation 18** - that, for Swindon, unless there is evidence that expansion would not reduce the Reablement waiting list, or would not significantly impact on downsizing Home Care packages, these services should be expanded as a matter of urgency. Between now and 1 April any such expansion will be at an additional cost which might reasonably be shared between all the whole system partners. From 1 April onwards the continued expansion of this team would need to be funded through a strategic approach to pathway redesign throughout the spring and summer, aligned with a commissioning plan to reduce spending, particularly next winter, with regard to hospital beds. For Swindon, this should happen irrespective of the decision about the future provider of community services.

**Workstream lead: Angela Plummer**

**Workstream members:**

SBC: Rani Rooke

CCG: Louise Tapper

SEQOL: Sharon Gerry

#### **Aim**

To agree shape of reablement service and a lower unit cost than the current £30 per hour and thereby increasing capacity

To agree prioritisation of patients onto reablement and review of patients to ensure speedy discharge from the service, particularly of self funders

To ensure that the reablement ethos is incorporated within the new domiciliary care specification to ensure all new service users are re-abled as standard.

Objectives: -

Reablement service is reshaped and business case received that is cost effective

Patients on reablement service with have timely reviews completed

Clear process for charging self funders is in place

#### **Outcomes**

Increase capacity within reablement so more than 29 patients can be supported at any one time

Ensure all self funders are charged the cost of the service once reablement episode has been completed

No	Milestone Description	Owner	Due Date	Status
	Receipt of business case by SEQOL to commissioners	Sharon Gerry	25.1.2016	Green complete
	Further review of specification and pathways for reablement and link with rapid response and RAU	Angela Plummer	12.2.2016	
	Review of domiciliary care specification to ensure reablement focus	Angela Plummer	18.1.2016	Green complete

	Agreement of funding if any by wider system	Caroline Gregory	1.3.2016	
	Agree with SEQOL process of charging patients on reablement once assessment is completed of future needs including full cost recovery of self funders who have refused an alternative on-going package – completed.			
	Protocol agreed by SEQOL for self funders and system implemented	Sharron Gerry	25.1.16	Ongoing, update requested

**Workstream 6 Discharge to assess beds, residential reablement and SWICC** (Recommendation 25, 26, 28)

**Recommendation 25** - that Swindon CCG jointly with Swindon Council, conduct (within four weeks) a review of the function and operating procedures of their locally commissioned community beds (other than residential and nursing homes) with a view to clarifying function (against a backdrop of near continual escalation) and, where necessary apply additional rehabilitation resources to secure better and faster Reablement.

**Recommendation 26** - that, over the next six months, a new Commissioning Strategy be produced (preferably jointly between Swindon and Wiltshire CCGs and Local Authorities) with a view to securing sufficient community beds of the various types (perhaps starting with dementia) over the next two, five, and 10 years. This would include the re-provision of those units that are no longer fit for purpose.

**Recommendation 28** – that Key Performance Indicators be established for D2A services.

**Workstream lead:** Angela Plummer

**Workstream members:**

SBC: Rani Rooke, Angela Plummer

CCG: Louise Tapper

SEQOL: Sharon Gerry

GWH: Lorraine Austen

### **Aim**

Ensure there is clarity over criteria and process for all bed based provision in the community so there is patient flow

Commissioning Strategy in place for community bed based provision

### **Objectives**

To ensure criteria for each community bed are clearly understood by wards and social work staff  
Commissioning strategy is developed which includes use of community beds and discharge to assess capacity

Review all current service users in receipt of D2A services and either move to mainstream services or home

Fessey House – reduce the number of current residential beds and purchase through private sector but develop Fessey or Whitbourne into all D2A

Completing the assessment for those service users in D2A beds, the intention is to reduce this capacity and evaluate the appropriateness of those who received the service. Review longer term use of Whitbourne House

KPI developed and agreed

### Outcomes

Agreed and implemented commissioning strategy with KPI agreed and monitored

The redesigned service is embedded within GWH MDT assessment and discharge planning

No	Milestone Description	Owner	Start and Due Date	Status
	Review with CCG the specification for SwICC	Angela Plummer /Louise Tapper	January 2016	Amber
	Review criteria for access to Fessey House reablement beds	AP/RR	Feb 16	Amber
	Review length of stay in all rehab/reablement units with onward destination to ensure best use of beds	AP	9 <sup>th</sup> Feb	Amber and awaiting full information from Seqol
	Analyse information on number of residential and nursing placements over the last 12 months and tender for block within appropriate settings	AP	2 <sup>nd</sup> Feb start with tender timescale to be agreed	Amber
	Review life span or Whitbourne House without significant investment – consider if D2A would be better in Whitbourne due to life span	AP	2 <sup>nd</sup> Feb	Amber
	Link potential future D2A beds with new provision in Swindon from June onwards	AP	18 <sup>th</sup> Jan	Amber
	KPI for community beds already in existence and reported in SEQOL contract meeting monthly		Completed	
	Access for care home managers to senior manager on call at	Lorraine Austen	4.2.2016	G Care homes

	GWH to resolve issues where re-admission can be avoided			to be briefed
	Clinical support from Rapid Assessment Unit, virtual ward and Out of Hours GP for patients in D2A beds	Louise Tapper	1.3.2016	
	Locum social worker in place that providers can ring directly to ensure timely social work assessment of patient	Rani Rooke	8.2.2016	G completed

**Workstream 7: Care homes****Workstream lead:** Louise Tapper**Workstream members:**

SBC: Rani Rooke

CCG: Louise Tapper

GWH: Lorraine Austen

SEQOL: Diane Blake

Care home members

**Aim**

To prevent avoidable admission to hospital from care homes and ensure speedy discharge at the earliest opportunity

**Objectives**

Identify with care homes issues that can be improved to prevent hospital admission

To agree the necessary protocols and implementation for IV fluids and antibiotics

To ensure that care homes receive the necessary discharge notes, medication and equipment for patients discharged from hospital

To agree the communication between wards and care homes so patients are able to return at the earliest opportunity

To design and implement the necessary training and support for care home staff

To liaise with CCG Care Homes project

Support care homes to understand the range of alternative services provided by SEQOL and others which will assist with preventing unnecessary admissions/attendances at GWH.

**Outcomes**

Reduction in delay in discharges to care homes from hospital

Improved awareness of out of hospital services,  
Increased use of community and voluntary based support,  
Patient's health and wellbeing has improved and they feel more in control.

No	Milestone Description	Owner	Due Date	Status
	Six weekly review meetings with care homes	Rani Rooke	2.2.2016	Green
	Written agreement between CCG, SEQOL and GWH over continence pads and continence assessments	Louise Tapper	15.2..2016	Green
	Set out protocol between community nursing and care homes on wound care and tissue viability services	Louise Tapper Di Blake SEQOL Carolyn Bell CCG	28.2.2016	
	Protocol to establish how IV fluids can be administered in nursing homes supported by the SEQOL CIVT Service.	Louise Tapper	15.3.2016	
	Protocol of how IV anti biotics can be administered in care homes supported by the SEQOL CIVT Service. Test protocol with Kingscourt	Louise Tapper	28.2.2016	
	Review the support offered by community nursing with patients in care homes including nursing homes in written protocol	Louise tapper Diane Blake	13.3.2016	
	Support to patients with long term conditions I care homes: - Business case to be developed for named matron for care homes to prevent hospital admission through training, oversight of antibiotics and proactive care plans. Consider role of community geriatrician in supporting care homes (End of life care delivered by Prospect hospice is preventing hospital stays and could be a model for this)	Louise Tapper with Diane Blake	30.4. 2016	

	Monthly dissemination of training opportunities offered by SEQOL and GWH for care home staff	Di Walsh and Lorraine Austen	December 2015 and monthly dissemination	Green completed. 20 nurses attended SEQOL training on revalidation
	Circulate format of a common nursing assessment to care homes to be recirculated	Angela Plummer	22.1.2016 8.2.2016	Completed and re-issued
	Agreed communication process of existing residents admitted to hospital from care homes so that care homes are informed throughout the stay of the resident. Starting point for care homes will be DART administration but then needs to be passed to wards for ongoing communication	Lorraine Austen	28.2..2016	
	Explore role of volunteers in supporting discharge to care homes	Lorraine Austen	1.3.2016	
	Contract between care homes and Rapid Response Team so patients have assessment and move on plan in place	Diane Blake	1.4.2016	
	Placement team to share with individual care home manager and area manager where there has been a delay in completing assessments by care homes on a case by case basis	Placement Team	Start 8.2.2016	

**Individual actions identified in NHS England report which will be reported to programme Board to ensure completion**

Recommendation	Milestone Description	Owner	Due Date	Status
<b>Recommendation 1 - that all parties bring together their planning resources for a very urgent reconciliation of all existing plans and sub-plans with regard to the Unplanned Care Pathway: within one week to produce a Transformation Plan which clearly identifies each task, its objectives, the additional resources to be</b>	Accountable Officer Swindon CCG to lead Strategic Plan for Swindon. Two Programmes for Discharge and Front Door established	Accountable Officer CCG	30.1.2016	G completed (PID)



brought to bear, the task owner, target milestones, and Key Performance Indicators of achievement (even if these are only inputs or outputs). For complex items to produce sub-plans identically structured within a further two weeks.				
2- That project managers be appointed either from within existing resources, or externally, in sufficient numbers to provide support and project acceleration for each project that requires a sub-plan (or some other indicator of project complexity).	Project managers identified and named in PID <b>Nicki to review</b>	CCG	18.1.2016	G completed
3 -That, if interagency relationships are considered sufficiently trusting to allow it, a Senior Responsible Officer at Chief Executive level is appointed to oversee all aspects of the new Transformation Plan and is given power to escalate quickly to fellow Chief Officers any matters, small or large, where milestones are not being met.	Identify SRO to oversee all aspects of new Transformation Plan Urgent Care Working Group becomes Urgent Care Programme Board	Sue Wald  Gill May	20.1.16	G completed
4 -That the existing hierarchy of meetings with regard to the Unplanned Care Pathway is subject to a two-week review with the aim of consolidating meetings to reduce time commitments, increasing added value, creating empowered chairpersons, flattening the structure, and ensuring that Very Senior Managers can be actively involved weekly, or fortnightly at least, in both the scrutiny of progress and driving change.	Hierarchy of Unplanned Pathway is subject to a two-week review  Fortnightly meetings for Strategic Planning to be reshaped to include report on both programmes (DTC and Urgent Care)	SRG monthly Strategic Planning Group fortnightly	20.1.16	G
5 -That, as far as possible, the timetable for exploring the commissioning of an 'Accountable Care Organisation' be compressed to move to a decision as quickly as possible.	Report to CCG Governing Body and Cabinet on future commissioning intentions for community services	Nicki Millin Sue Wald	21.1.2016 and 10.2.2016	G completed
7 - That the GWH workforce planning strategy is subject to a two-week review followed by an urgent presentation to the Trust's Board to secure support for	<b>Submission of Trust workforce plans to GWH Board; incorporation of specialty workforce plans</b>	Chief Operating Officer GWH/ Director of		G

<b>initiatives aimed at addressing the shortages early in 2016 with the objective of achieving a permanent workforce with normal vacancy rates before next winter.</b>	<b>within business plans.</b>	HR		
<b>14 - That, as part of 'Right Patient Right Bed' the Medical Director of GWH engages with Consultants to secure their immediate co-operation regarding the 'two patients per ward target', and a system for monitoring the achievement of that target.</b>	Right Patient Right Bed and implementation of two patients per ward target and monitored by GWH Programme Board  Maximise morning discharges, "home for lunch" use of discharge lounge, and prospective discharge planning at Board Rounds.	Chief Operating Officer GWH	Already established	G
<b>15 - That the two CCGs, either separately or preferably together, review and if necessary start a project to redesign, the Older Persons Urgent Care Pathway to incorporate the notion (in line with best practice) that where ever possible a patient's treatment should be completed in a setting other than GWH.</b>	Review of Older Persons Urgent Care Pathway -	Swindon and Wiltshire CCG's Gill May with GWH Geriatrician	Commenced.	
<b>16 - That the issue of End-Of-Life fast track should be escalated to a meeting between Chief Executives, with their advisers, within a week (in the evening if need be) to produce a solution that enables such care to be available within 48 hours. If this cannot be achieved it should be reported to the Governing Bodies of all the system partners at their next available meeting.</b>	End of Life working group have drafted end of life operational flow chart to support timely coordination and support to meet patients preferred choices and wishes as to where they wish to die and be cared for.	Gill May	30.1.2016	G
<b>17 - That Swindon urgently consider the merits of the Wiltshire approach to CHC check listing.</b>	Swindon CCG and SBC to consider the merits of the Wiltshire approach to CHC check listing	Paul Bearman Angela Plummer	22.2.16	
<b>20 - That any future plans regarding Integrated Working seek opportunities to utilise a different skills mix to create where possible more attractive jobs to meet intensive personal care needs.</b>	Workforce Steering Group established. Work plan in place to scope workforce review across care pathways and future scenario planning.	Gill May	Commenced follow up 4.2.2016	G
<b>22 -That an enlarged reviewing team</b>	Establish and implement	Angela	30.1.2016	G

revisit all existing Home Care packages, starting with the largest, to see if there is further scope for meeting patients' needs in other ways and thereby release some Home Care hours for new patients. This team may also be able to comment as to whether the packages were scoped correctly in the first place.		robust review process of high cost care packages and those on bridging. Workstream in place with SBC programme	Plummer		
23- That, within four weeks, Swindon's housing department receive, from NHS partners, case studies illustrating the time wasted on viewing inappropriate accommodation, and within a further two weeks, report to the relevant Overview and Scrutiny Committee (and back to the NHS partners) what they intend to do about this problem.		GWH and SEQOL to send case studies of patients with housing issues to SBC Housing department GWH to sign off protocol with Housing	Jill Kick/Emma Caville  Nick Kemmet with Lorraine Austen	15.2.2016	
24 - That the business case for additional Patient Flow Coordinators be prioritised for immediate completion but must take into account the need for this function to apply to in-county patients as well as out-of-county. That, assuming the business case is sufficient, implementation of growth should be prioritised using agency staff, and/or further secondments as necessary in the first instance.		Case for substantive recruitment of patient flow ward clerks to be developed.	Chief Operating Officer GWH	28 2 2016	
27 - that the use of the electric vehicle for transporting patients between GWH and SWICC be reinstated, or some similar cost-effective arrangement be put in place.		GWH and SEQOL to consider how to respond to suggestion of electric vehicle supported by SEQOL. To be part of GWH transport plan	Chief Operating Officer GWH/ CE SEQOL		
31 - That a more vigorous and planned approach be taken to the implementation of the national imperative for seven-day working.		GWH to develop plans for extended 7 day working by senior medical staff, pharmacy and therapy services. 7 day working in place for DART and social work. Brokerage 7 day working	Chief Operating Officer GWH Angela Plummer	18.1.2016	G for community services and social work/brokerage
Additional		DTOC CQUIN to be	Louise Tapper	31.3.16	

	developed for 2016-17			
Additional				