

**NHS Swindon Clinical Commissioning
Group**

Swindon Borough Council

**Draft Joint Commissioning Intentions
2016/17**

Version 01, June 2016

1.0 Executive Summary

In this document, Swindon Clinical Commissioning Group (CCG) and Swindon Borough Council set out their joint commissioning intentions for 2016/17

Swindon Clinical Commissioning Group (CCG) aims to improve the health of 220,000 people registered with 26 GP practices in and around Swindon, and be responsible for commissioning £257 million of local health services in 2016/17.

Swindon Borough Council as a local authority commissions and provides services for people in Swindon and has an annual net budget of approx. £135m in 2016/17.

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.

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 this agreed Joint Commissioning Plan and monitored by the Joint Commissioning Board. The Better Care Fund is a separate pool within the Section 75 of £14.5m, with the balance of funding being within aligned pools.

Opportunities to increase joint commissioning between the CCG and SBC will be considered in 2016/17. As a minimum, the intention is to continue to jointly commission services using the Section 75 and the Better Care Fund as the governance route for joint commissioning. This is overseen by The Joint Commissioning Group who report into The Health and Wellbeing Board and The CCG Governing Body.

In order to develop a single budget for Swindon and in line with the Spending Review and the Better Care Fund, Swindon Borough Council and the CCG will be working to develop a pooled budget, which will also include some of the Public Health funding in order to support the prevention agenda. The pooled budget will be set against the agreed vision of the Health & Wellbeing Strategy and Better Care Fund plan to 2020.

The pooled budget will enable commissioners to use funding flexibly to achieve the improvement in outcomes for the population shifting an emphasis towards prevention. A detailed workstream will be established to determine the strategic plan and outcomes to be achieved by 2020, the governance

arrangements and financial modelling to achieve the medium financial plan goals of the CCG and the Council.

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

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

We have been involved in discussions with patients, GP practices, providers, carers, voluntary sector, other stakeholders, children and young people, and the Youth Forum in the development of the topics included in this plan.

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. The views of service users, carers and parents have also been gathered through our work on Joint Strategic Needs Assessments led by Public Health.

Alongside these Joint Commissioning Intentions, the Better Care Fund Plan 2016/17 outlines our joint plans for improving the health and social care for adults. The Better Care Fund Plan is part of the forthcoming Sustainability and Transformation Plan for Swindon and the new planning footprint including Wiltshire and Bath and North East Somerset.

The Joint Commissioning Intentions provide the framework for the resources both organisations have aligned within the National Health Services 2006 Section 75 Agreements. It is a summary of jointly agreed areas of priority based on the:

- Health & Wellbeing Strategy
- NHS Five Year Forward View
- CCG Operating Plan 2016/17
- Better Care Fund Plan 2016/17
- Public Health Outcomes Framework

- A review of the Joint Commissioning Delivery Plan 2015/16

We have a well established history of integrated commissioning and integrated service delivery for health and social care. 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.

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

Seqol is the community provider for integrated health and social care services in Swindon. The contract with Seqol comes to an end on 31st 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 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.

Swindon Borough Council is the Local Housing Authority.

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 serve notice and secure a new model in line with the Five Year Forward View.

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 / Adult Social Care and Great Western Hospital so that clear integrated pathways are in place for all our patients.

2.0 Our Vision

We want children in Swindon to have the best start in life and to be safe, healthy and to grow up in supportive, confident and resilient families and communities. We want children to grow up in loving and stable families where the relationship between children and parents is good.

If you need help we will be offering support to families and children to achieve a best start in life. This includes support where parents have lost confidence in their parenting ability or where relationships come under pressure to adapt to a potentially new situation. We want to achieve a different balance weighted towards practical, direct and targeted support when parents need help the most, and to support parent carers so that disabled children are supported at home or live in supported accommodation where possible.

We will be working together to protect children from harm, abuse and exploitation. Young people are motivated and safe, living in a supportive and appropriate environment. Children in care live in stable families or in specialist placements where that is necessary, have a good education and become successful and confident adults.

Living in Swindon and Shrivenham in 2020 will mean that you can expect to live longer than the England average, with less risk of avoidable death, in greater health and with the support of your neighbourhood and community.

More of your adult 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.

You will have access to a number of programmes designed to support you as a child, young person, adult or older person 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, reduce isolation and loneliness, and extend quality of life. We will encourage you to volunteer to help deliver these services and promote community health champions.

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.

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.

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.

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 skills 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.

Whoever provides your care in the future, you can expect the same **high quality outcomes**, with providers being offered as a choice to you only if they can demonstrate high levels of satisfaction and if they are meeting national safety and performance standards when delivering care and support.

3.0 Strategic Context

Section Summary

This section sets out the strategic issues that influence the Joint Commissioning Plan. These are:

- Population growth in Swindon is rising above the national average
- A rising demand for care services across adults and children due to increasing identification of children suffering from abuse and neglect and a rising population of older people, those with long term health conditions including dementia
- Health inequalities across Swindon
- A growing burden of lifestyle related ill-health, particularly related to obesity, physical inactivity and smoking
- Higher than average admission rates to hospital
- High number of people with a learning disability living in residential care outside of Swindon.
- Low rates of people with a learning disability in employment
- The financial allocation for health, care and wellbeing
- The quality of our services

The main changes to our population are analysed through the Joint Strategic Needs Assessment (JSNA) for Swindon. The JSNA provides the evidence

and insight from both a quantitative and qualitative perspective for commissioners on what the needs of the local community are.

The JSNA is constantly reviewed, with the 2015/16 JSNA Summary providing useful updated information on a wide range of areas including Dementia, Diabetes and Long Term Conditions, as well as wider determinants of health such as Housing, Community Safety and Mental Wellbeing. The full JSNA, along with a number of detailed needs assessments can be found on the Swindon JSNA website at: <http://www.swindonjsna.co.uk>.

The following section is a summary of the main changes in population.

3.1 Strategic Context - Population growth in Swindon

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.

We recognise that Swindon Clinical Commissioning Group also covers the area of Shrivenham. However, the data presented here is for the Borough of Swindon, and will be influenced by changes in the new homes building rates.

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.

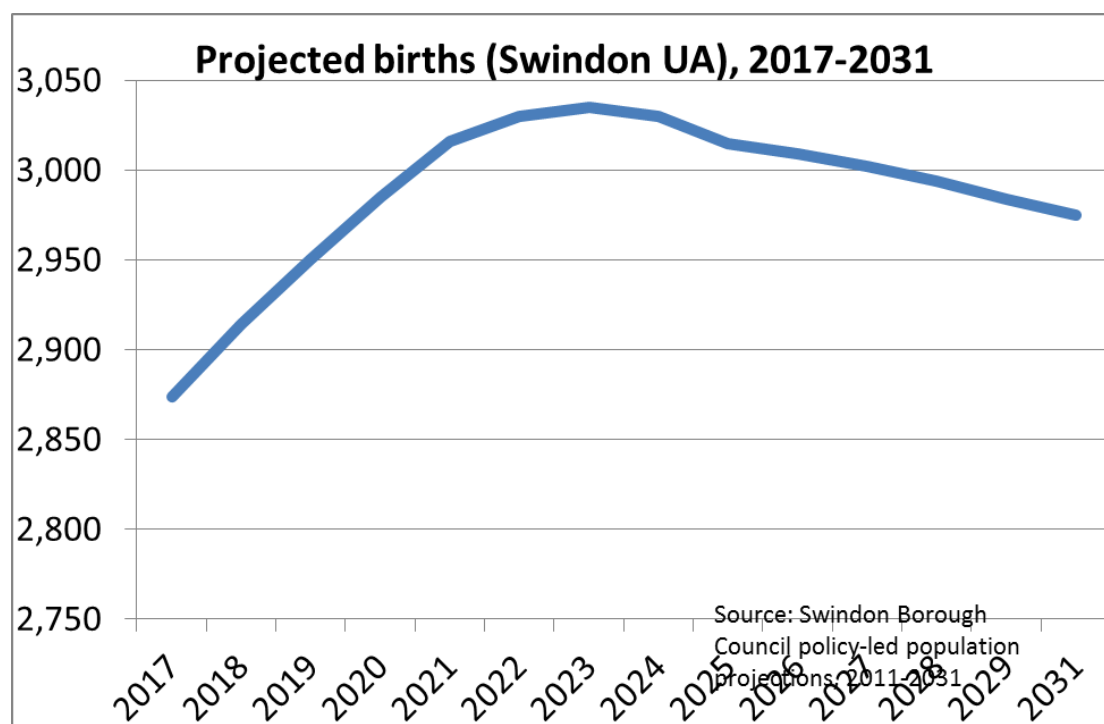
- The population of school-age children aged 5-18 is projected to grow from 34,900 in 2011 to 43,000 in 2031, and overall, the population of children aged 0-18 will grow from 49,100 in 2011 to 58,300 in 2031.
- Overall, the age structure of the population is projected to change with significantly higher 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.

Data analysis shows:

- The proportion of our population with long term conditions has remained static at around 15%
- The proportion of BME people in Swindon Unitary Authority, in approximate terms, doubled from 8.5% (15,344 people) in 2001 to 15.4% (32,128 people) in 2011.
- 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, whereas women will only spend 75.8% of their lives in good health.
- 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. People in the most deprived groups have more admissions to hospital before retirement age and more long term illness
- The number of children in care is roughly in line with the most recent national average
- The number of children on protection plans is now above the national average.

On the whole Swindon is a successful town economically and socially and the social determinants of health (education, employment, good mental health, poverty, obesity, smoking and alcohol) are captured in our strategies. Some indicators compare unfavourably: harm from alcohol, self-harm, educational attainment at the ages of 16 and 19 and the number of young people aged 18 not in education, training or employment.

We are seeing an increase in the birth rate in Swindon. Swindon is steadily attracting young families seeking employment and is a town that is expanding. With this will come a boom in the birth rate from 2016-2022.



3.2 Strategic Context - Older people and long term health and care needs

The number of older people is set to rise significantly and with this comes an increasing number of people with long term health issues. In 2015 the population of over 65s in Swindon was estimated to have risen by 14.2% from 28,857 in 2008 to 32,944 in 2015. The numbers of over 85s is forecast to rise by 21.1% or 816 people.

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 increase in long term conditions and increasing older age is often reflected in increased emergency hospital admissions and planned admissions for people with long term conditions.

As the population is getting older, with more complex health conditions, we are expecting a rising demand for adult care services. The number of older people receiving support from adult social care has seen a 6.6% increase in 2015/16 to 3,628 during the year whilst those with physical disabilities saw an increase of 7.4% to 838.

Older people admissions to residential care in 2015/16 were 220 people similar to those in 2014/15.

When longer term support is required, we know that when people have a clear understanding of the money that is available to them to meet their assessed needs, and they are given the ability to choose what to do, and who is going to provide the services, the support they choose is likely to be different from the traditional style services that have previously been available. This approach is known as personalisation.

We want people to have the right support around them to be as independent as they can be. We want to enable everyone, including those who are sourcing their own support, or just looking for activities or guidance within their area, to have the information to make the right choices for themselves and their loved ones, and to be able to directly access services available in their communities, rather than having to be re-directed by us.

Our aim is that all older people supported by adult social care have choice and control in the services they need, this is measured through the percentage of people with a personal plan and budget.

We have improved the percentage of people with a personal budget to 82.6% but remain below the target of 100%.

Maintaining good health, an active lifestyle and thereby reducing isolation and loneliness so they are able to live at home for as long as this is possible and appropriate is also a priority.

3.3 Strategic Context - Rising demand in children in need, child protection and children in care placed with independent providers

There are approximately 50,000 children under the age of 18. Children from Black and Minority Ethnic (BME) communities and diverse backgrounds account for 20% of all school age children. 117 languages are spoken in Swindon schools. Swindon has the highest proportion of children with English as an additional language in the South West.

There is fast growing population and service demand has increased over the past 3-4 years placing additional pressure on services. Higher numbers of teenagers are needing additional support to address challenges such as poor mental health, exploitation, substance misuse and family breakdown.

At any time about 10% of children will be in receipt of early help services, and 3.1% (about 1,600 children) receiving specialist social care, or support through permanent exclusion or drug user treatment services. Children under five are supported by health visitors and the Family Nurse Partnership.

Swindon was invited by the Department for Communities and Local Government (DCLG) to be an Early Starter local authority for Troubled Families and began the roll out of phase two of the programme in January 2015. In phase one SBC had a target of working with 370 families and outcomes were met for 96% of cases (354). 57.1% (202) families continued to sustain their outcomes and did not meet any phase two criteria. Phase two of the Troubled Families Programme retains the current programme's focus on families with multiple high cost problems and continues to include families affected by poor school attendance, youth crime, anti-social behaviour and unemployment. However, it also reaches out to families with a broader range of problems, including those affected by domestic violence and abuse, with younger children who need help, where crime and anti-social behaviour problems may become intergenerational and with a range of physical and mental health problems. 227 families were identified in 2015/16, 81% of the target, and the service is confident that that the target will be met. The target is to increase the number of troubled families engaged on the programme to 1,270 families by 2020.

Swindon has been historically lower than comparators in terms of the number of children in need, however the increase experienced in the last 2 years now places Swindon above the statistical neighbour and national average.

The number of children in need (excluding child protection and children in care) has stayed essentially static in 2015/16, at 1,279.

There has been an increase in the number of open cases (including child protection and looked after children) to 1,799 open cases at March 2016. This is above the statistical and national averages, but in line with the South West.

The number of children subject to a child protection plan has increased from 213 in March 2015 to 238 at end March 2016. At end March 2016, there were 292 children in care, an increase from 246 at end of March 2015.

Priorities for 2016/17 include:

- to increase the percentage of looked after children who are placed inside the Borough boundaries from 83.5% now to 93% by 2019
- to increase the percentage of care leavers going into employment, education and training in line with the national average by 2018/19 from 41.7% to 17% in 2016
- to reduce the % of children becoming subject of a child protection plan for the second or subsequent time to be in line with the national average by 31st March 2017, from the current level of 17.9% to 16.6%.

Number of Initial Child Protection Conferences and children with a child protection plan

Once a child protection investigation has taken place, a decision is firstly taken whether to hold a child protection conference which then decides whether a child needs a child protection plan.

At the end of 2015/16, there were 238 children subject to a child protection plan, an increase from 213 at the end of 2014/15.

80% of Initial Child Protection Conferences (266 out of 344) were held within 15 working days. This is an Improvement from 69.5% in 2014/15.

Number of children in care

The number of children in care has risen, and at the end of 2015/16, 292 children were in care. This is an increase from 252 at the end of March 2015.

This equates to a rate of 60.1 per 10,000 children and is in line the national average of 60 per 10,000 in 2014/15.

Our aim is for children to have stable and secure long term placements. The percentage of children looked after for more than 2.5 years who have been in the same placement for at least 2 years or placed for adoption was 59.4% (38 out of 64 children). This is down from 66.1% at the end of 2014/15 and relates to a number of children leaving care having achieved permanency.

18.8% of children looked after are placed more than 20 miles from home.

87.5% of care leavers live in suitable accommodation and 48.9% were in education, training or employment which is slightly higher than the England average in March 2015.

3.4 Strategic Context - Children with special educational needs

The prevalence of SEN in Swindon's school population is decreasing, from 22.7% in 2009 to 16.9% in 2015, and is now similar to the prevalence in the South West (16.2%), although slightly higher than the national average (15.4%). However, the proportion of children and young people with a statement of SEND in Swindon continues to remain high at 3.8% which is significantly above the national average (2.8%).

Although the number of requests for statutory assessment remains high (250 requests made in 2015), 39 fewer statements were issued this year. However, the total number of children with a statement of special educational needs has risen in the past 12 months to 1,376.

The main categories of need identified for children with SEND are: Moderate learning difficulties (23%); Social, Emotional and Mental Health (18%); Specific learning difficulty (15%); and Speech, language and communication needs (15%). The proportion of children in need with a disability also increased this year (19.9%) and is above the national average (13%). Almost 24% of these children have a learning disability, 28% have autism and 32% have a mobility disability. Although the proportion of children with autism has increased by 12% compared to last year, 6% fewer children are recorded as having a learning difficulty.

Many of our children with special educational needs are placed in one of 6 special schools in Swindon. The proportion of pupils with a statement of SEND that achieved at 5 A*-C GCSE, including English and maths remains consistently below national benchmarks. In 2014-15, 5% of pupils with a statement/EHCP achieved the benchmark standard compared to 9% nationally. To date, locally, we have relied heavily on specialist services and recognise the need to raise the aspirations for disabled children.

We continue to embed the new duties to improve provision and support for children and young people with special educational needs and /or disabilities. Our Local Offer is well established providing advice and information on services. Our children and young people are having their needs identified through Education, Health and Care assessments and reviews, and we are focussing our efforts on improving transition planning for young people.

Impact of increasing demand on the Paediatric Speech and Language Therapy Service

We are seeing a consistent year on year increase in accepted referrals for children requiring speech and language therapy intervention. In April 2013 the service had 1,896 children who required the speech and language therapy service compared with 2,392 in April 2016. This is an overall increase of 26.16% in the last three years. This is an upward trend that is continuing and continues to exacerbate pressure on the service.

The increasing referrals and workload have been absorbed by the service until now and the target of offering an initial assessment to 80% of cases within 13 weeks was achieved in 2014/2015 with an overall rate of 81% of cases seen within 13 weeks. However, as this referral rate continues to steadily increase, the number of referrals seen within 13 weeks has dropped to 74.7% in 2015/2016 overall. In March 2016, 68.5% of referrals were seen within 13 weeks.

There has been a 191% increase in the number of children and young people on the three Autistic Spectrum Disorders (ASD) speech and language therapy caseloads from March 2013 to March 2015 (from 72 to 210 children and young people). This has led to increased waiting times for assessment and diagnosis of ASD for children and young people from an average of 10 weeks in 2012/13 to 20 weeks in 2014/15 and now rising to 26-30 weeks in 2015/16.

There are currently 34 (June 2016) children and young people waiting for assessment on the diagnosis pathway. In addition there are pressures on delivery of therapy for both the pre -school service and to children and young people in school.

The paediatric speech and language service is now unable to function effectively without additional resources. A funding request to the CCG for £68,430 at 2015/16 costs was submitted to provide 1.8 Speech and Language Therapists to work across the core clinical service and the ASD caseloads. As additional funding has not been agreed to meet demand, there will be a need for the CCG to agree areas for service reduction to manage the service within the available resources.

3.5 Strategic Context - People with a learning disability

Based on the Joint Strategic Needs Assessment there are over 2,000 people with a low, moderate and high level of a learning disability living in Swindon. At 31st March 2016, Adult Social care supported 665 people with a learning disability and all of these will have a moderate to high degree of disability.

The number of people with a learning disability in nursing or residential placements at this date was 200, therefore the percentage of these clients in residential or nursing placements was 30%, down from 40% in 2014/15. Many are in Wiltshire and further afield. We anticipate that we will have more people with learning disabilities reaching adulthood and older age and we want more people to live locally within communities and find supported employment.

The Learning Disability Social Work Team returned to the Council from Seqol in 2015.

People with learning disabilities are still not getting the opportunities they need to lead full lives and realise their potential. We are working to improve our person-centred long term planning to help people and their families to think creatively about their solutions and take more control over their lives.

3.6 Strategic Context - Health Inequalities, obesity, smoking and drug and alcohol misuse

The Joint Strategic Needs Assessment Summary 2015 continued to highlight health inequalities across Swindon with higher rates of people suffering from diabetes, heart disease and hospital admissions in areas of disadvantage. This leads to a gap in life expectancy across Swindon. 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. People in the most deprived groups have more admissions to hospital before retirement age and more long term illness. Risky behaviours including smoking, excess alcohol intake, lack of exercise and unhealthy eating all increase the risk of developing a long term condition and increased dependency. 80% of heart disease and strokes are preventable by addressing these risky behaviours and an estimated 40% of cancers. Evidence now also suggests that adopting a more healthy lifestyle can reduce the risk of dementia.

We know that people in more deprived areas tend to follow less healthy lifestyles than their more affluent peers, for example, being more likely to smoke, to consume more alcohol and to have an unhealthy weight. People living in least affluent areas probably need more help in pursuing a healthy way of life and in using health services, but may be less likely to gain access to available support. We will also need to bear in mind the needs of other vulnerable groups.

Obesity

Obesity remains a significant health risk with an estimated 70% of the Swindon population overweight or obese and only 55% of adults physically active. Being obese can increase the risk of many potentially serious health conditions, including type 2 diabetes, high blood pressure and high cholesterol. Stroke is the largest cause of adult disability in England.

In Swindon over 20% (2 in 10) children in reception class at school (aged 4 – 5 years old) are overweight or obese (approx. 580 children). In year 6 at school (aged 10 – 11 years old) over 34% (3 in 10) are overweight or obese (approx. 830 children). Swindon Borough Council has a Healthy Weight and a Physical Activity Strategy (and implementation plans) which aim to reduce the prevalence of obesity across the whole population over time. Influencing the built environment so that being physically active becomes an easy choice is a key element.

Smoking

Smoking is the single biggest contributor to shorter life expectancy and health inequalities. Although overall smoking prevalence in Swindon in 2014 was 17.8% (Eng average 18%), down from 21.5% in 2012 smoking rates in some of our more deprived communities are more than double the average rate for Swindon. The majority of smokers started smoking in their teens and a priority continues to be to reduce the uptake of smoking by young people.

Alcohol and drug misuse

The NHS measures alcohol related admissions to hospital and admissions in Swindon were lower for men than the national average whilst those for women were in line with the national average.

We have a high number of children living with families receiving treatment for alcohol misuse and 32% of clients in drug treatment has a child living with them at least some of the time. Work by the NSPCC and alcohol and drug treatment services ensures that the needs of children are identified and addressed. The increasing use of Novel Psychoactive Substances (legal highs) continues to be a concern.

In summary, if we do not address these health issues, we may be faced with increasing numbers of people who are living longer, but who need more assistance in coping with ill-health and disability, which might have been prevented.

3.7 Strategic Context - Mental Health and Wellbeing

Good mental health is important in enabling people to live fulfilling lives and able to access and maintain training and employment. There are an estimated 22,000 – 29,000 people with depression or common mental health problems living in Swindon.

Data indicates that rates in Swindon are higher than the national average. Swindon also has the third highest rate of prescribing anti-depressants in the South West. Hospital admission rates due to self-harm are also high.

3.8 Strategic Context – Carers

Carers provide very important unpaid care to a child, relative, parent or friend needing help and support. The 2011 census indicated that there were 19,450 people in Swindon providing unpaid care, a 23% growth since 2001. An estimated 1,000 people have multiple caring roles and 161 young carers under the age of 25 were identified. This figure is likely to be much higher and Swindon Carers' Centre is providing support to 702 young people (number at 31 March 2016). Carers who provide care to an adult receiving adult social care services are entitled to an assessment of their needs.

In 2015/16, 1,369 carer's assessments were completed, which is 89.9%.

From April 2015, all carers can ask for an assessment of their needs and we are working with Swindon Carers Centre, SEQOL and Avon and Wiltshire Mental Health Services to improve our assessment and support.

3.9 Strategic Context - Admission rates to hospital

Providers are expected to work with commissioners and partner organisations to support the development of services and resilience in the community.

Overall unplanned hospital admissions continue to rise and cause significant demand on the acute hospital. Accidents and injuries account for 13% of emergency hospital admissions.

The admission rate amongst our most deprived population is materially different, with those in the greatest poverty being the highest users of hospital services and the lowest users of the alternatives including GP surgeries and community based health services. Analysis of MOSAIC data 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.

The Swindon Clinical Commissioning Group (SCCG) Urgent Care Programme represents a number of projects commissioned to support implementation of the Urgent Care Strategy. Collectively, they aim to reduce pressure on Swindon's urgent care system and support achievement of a number of national performance indicators, in particular, the four-hour target (95% of patients discharged, admitted or transferred within four hours of arrival in A&E). Additionally, they will support implementation of a number of recommendations as identified through internal and external reviews and national/local policy and strategic drivers:

- Newton Europe diagnostic (June 2015)
- CQC GWH inspection (2015/16)
- Recommendations from the NHS England investigation into delayed discharges in Swindon
- Review and learning from Christmas/New Year and January escalation and impact
- Swindon CCG Urgent Care Strategy (2016)

3.10 Strategic Context - Housing, employment and skills

Swindon Borough Council retains a large housing stock and the provision of low cost and social housing is a priority. Sussex Place is expected to be completed by the end of 2016, which will provide 26 more homes to rent and 10 for sale.

Around 1,000 homes are built in Swindon each year, and there is a shortfall of 600 against Local Plan projections which is being addressed.

165 households were accepted as homeless in 2015/16, and 324 households were in temporary accommodation.

Educational attainment is an important element of enabling young people to make a successful transition into training, higher education and employment. In 2015, 53% of young people achieved 5 or more GCSEs A*-C including English and Maths, which is below the national average of 57%, and down from 58% in 2014.

Post-16 activities of young people: NEET, participation in Learning and Youth Unemployment

March 2016 figures show that the proportion of 16-17 year-olds **in learning** (education or training) activities in Swindon is 89%, down on the previous year (91%). This represents a difference of approximately 160 young people, out of a possible 5,200. The learning rate is now below the national average (91.5%), but especially so for 17 year-olds. A major contribution to the drop in learning is the increase in the number of young people declaring work as their main activity. When employment is taken into account, the difference between Swindon and England in terms of 16-17 year-olds participating in positive activities is almost non-existent.

Local authorities have a statutory duty to track young people's post-16 activities, with the primary aim of identifying those not participating so that support can be provided for those to take on positive activities. With this in mind, the proportion of young people in '**unknown**' activities was 4.1% (213) for 16-17 year-olds in March 2016, twice as high as in the previous year, at 1.9% (99 young people). This is above national (3.3%) and regional averages (3.6%).

The proportion of 16-18 year-olds that was **NEET** in Swindon as at March 2016 was 4.6% (329 young people), lower than last year's figures of 5.6% (421), but slightly higher than England's 4.3%.

Youth unemployment related figures show a positive picture for the wider young people cohort (up to 24 year-olds). The Youth Unemployment rate (those working out of all those 'available' for work) was on average 11% during 2015, compared to 16% in 2014, and this compares favourably to a national average of 14% and regional average of 12%. However, latest figures show a similar number of 18-24 year-olds in Swindon claiming JSA - 2.6% (430) as at March 2016 – than in the previous year (2.6%, 440 young people). Although this is in line with the national average of 2.6%, Swindon is not following the low JSA rates in the South West (1.9%), with Swindon ranked 14th out of 15 local authorities.

4.0 Financial Allocation

For 2016/17 there has been funding growth within the Clinical Commissioning Group whilst local authority resources remain significantly stretched under the public sector austerity measures. There will continue to be a focus on ensuring that all providers work with commissioners on delivering the outcomes and quality indicators agreed for each contract.

The budget for Adult Social Care (net of Supporting People and specific external grants) totals £52.2m in 2016/17, the same as 2015/16. External specific grant support has fallen by £0.7m (£5.8m down to £5.1m) and this has reduced gross funding available accordingly.

The budget for Children and Families will increase by £2.580m from £20.932m in 15-16 to £23.512m. The additional Council investment is directed at meeting pressures on child placements and front line staffing.

The budget for the Clinical Commissioning Group increased by £10.3m or 4.19% as part of a review of NHS funding allocations to £257.3m.

The budget for Public Health (ring fenced grant) will be £10.635m, this is a net reduction of £0.867m on the funding available in 15-16.

Swindon Borough Council and Swindon Clinical Commissioning Group currently have two National Health Services act 2006 section 75 Agreements, which were brought together in 2015 including the Better Care Fund Plan.

The following allocations are now in place for 2016/17:

Children:

Clinical Commissioning Group: £3.3m

Swindon Borough Council: £24.6m

Adults including Better Care Fund (BCF):

Swindon Clinical Commissioning Group: £27.2m

Swindon Borough Council: £55.0m

Public Health:

Swindon Borough Council £10.6m

5.0 The quality of services

We recognise the importance of ensuring quality, safety and effectiveness at the heart of our business. We aim to commission services that are:

- Safe
- Effective
- Caring
- Well led

- Responsive to peoples need (timeliness)

5.1 What service users, patients, children and young people say about their needs and services

During 2015/16, the Swindon CCG Communications and Engagement team undertook a number of pieces of work which resulted in direct and indirect improvements to programmes including changes to commissioning plans, increased support for new interventions, and increased public engagement in partner and community events. In the next year the CCG communications and engagement team will carry out the following pieces of work:

- Working closely with our providers and commissioning partners to deliver integrated campaigns that encourage healthier lifestyles, and more appropriate access to health and social care services
- Closer working on key interventions to ensure that projects have the right level of planning and support to achieve meaningful and timely patient engagement
- Continued support of local community and voluntary services such as Healthwatch Swindon and the Swindon Carers' Forum, by working closely with these organisations and the voluntary sector commissioning team.
- To ensure the PPI Committee operates effectively to achieve its three key functions as a subcommittee of the Governing Body
- Developing more opportunities for patient reference groups, where these have both public and professional support.
- Supporting the primary care team with communications and engagement activity to ensure that General Practices are well supported and build strong relationships with their PPGs.
- Further development of a new CCG public website – which will increase the accessibility for patients and the public to key information
- Closer working with young people on targeted opportunities for engagement
- Public engagement in the development of future community services
- Taking a leading role in the evaluation of services by delivering comprehensive and targeted patient surveys and interviews
- Identifying and articulating relevant and timely patient stories to the Governing Body meetings
- To ensure the CCG localises any national campaigns
- To further develop excellent relationships with key partners and stakeholders, ensuring they have access to the information they need
- To continue to promote our successes, achievements and activities proactively both inside and outside the organisation, inspiring confidence in local NHS services.
- To support our staff and GP membership in their role through proactive communication of achievements of both the organisation and individuals
- To develop a communication and education strategy to enable patients to benefit from strategic changes.

The survey of adult social care service users showed that those who receive Adult social care services rate their quality of life just above the national average. The provision of good quality information and advice scored slightly below the national average in 2014/5 of 74.3% and has improved to 75% in 2015/16.

Service users also say that the provision of services makes them feel safer. The following areas surveyed in Swindon in 2015/16 have improved and are now above the last published national average in 2014/15:

- The percentage of service users who feel safe
- The percentage of service users who say they have as much social contact as they would like
- The overall satisfaction with the quality of services provided
- Access to good advice and information

Swindon has a Youth Council, a Member of Youth Parliament, two Deputies, Thought Tank - a dedicated participation group for young people with disabilities, and our Young Inspectors programme.

The MYPs, Youth Council and Thought Tank give young people the chance to express their ideas, opinions and needs to decision makers and regularly present to Elected Members and the Children's Health, Social Care and Education Overview & Scrutiny Committee.

Young Inspectors visit services that work with and impact upon children and young people to assess and evaluate how well they are meeting their needs; advise on improvements and report on their findings.

The Members of Youth Parliament and Youth Council priorities:

- Improving support around emotional well-being, and reducing the stigma associated around mental health in children and young people. Whilst ensuring children and young people with additional needs are supported in education
- Improving health choices for children and young people; making sure there are cheaper and accessible leisure facilities for the young, disabled and disadvantaged so everyone to access fitness
- As part of their work, the Members of Youth Parliament and Youth Council embrace wider consultation with schools, youth organisations and specialist groups working with hard to reach young people to ensure they reflect the true voice of Swindon's young people.

5.2 Law and Policy

5.2.1 Children and Family Act

The Children and Family Act places a duty on local authorities to improve the approach to the assessment and support for children with Special Educational Needs. Since September 2014, children should have an Education, Health, Education and Care Plan which will last until a young person is 25 years old if required, instead of a Statement of Educational Needs. Following a review, all

children should transfer to a new EHC Plan. Swindon has published improved advice and information as part of the Local Offer. Parents and carers participated in the introduction of EHC Plans we continue to work with them.

5.2.2 Care Act 2014

The Care Act 2014 introduced new duties in relation to Adult Social Care. The focus is on care and support, which is clearer and fairer, promotes people's wellbeing, enables people to prevent and delay the need for care and support, and carers to maintain their caring role, puts people in control of their lives so they can pursue opportunities to realise their potential.

The Care Act includes eligibility criteria for Adult Social Care, and an improved advocacy service for all service users who need help and do not have the capacity to participate in an assessment. All carers can ask for an assessment of their needs. The definition of safeguarding is widened to include self neglect. All users of Adult Social Care can ask for a deferred payment to meet their care costs.

5.2.3 NHS 5 Year Forward View

NHS England 'Five Year Forward View' (2014). It sets the strategic direction for health services and commits to joint commissioning of health and social care services with an increasing focus on prevention, quality, managing demand and improved access to primary care in order to reduce the need for admission to hospital and thereby reducing demand. The Five Year Forward View notes the traditional divide between primary care, community services, and hospitals is a barrier to personalised and co-ordinated care, adding that long term conditions require the NHS to partner with patients over the long term rather than providing single unconnected 'episodes' of care.

The Five Year Forward View document lays out a number of different provider models, the main emphasis is on greater integration across acute, community and primary care. These organisations are seen as early 'Accountable Care Organisations'. An Accountable Care Organisation is either a single provider or group of providers which are accountable for the whole needs of a person. This creates a greater incentive for co-ordinated care and integrated working.

The CCG Governing Body took the decision in January 2016 to commission a different provider model which integrates acute and community pathways, incentivised to shift the emphasis of treatment to effective prevention and management of patients, particularly those with Long Term Conditions and the Frail Elderly. This will be supported by new contract and payment models which are currently being explored.

Notice has been issued to the incumbent provider and a Programme Board has been convened to manage the procurement of a new service. This is a major programme of work for the CCG in 2016/17.

6.0 Commissioning aims and priorities

Section Summary

This section sets out the benefits of joint commissioning and our approach to commissioning services. We expect all services to be safe, effective, caring, well led and responsive delivered by well trained, supported and skilled staff.

6.1 Our Aims

To improve the outcomes for people in Swindon through the joint investment in high quality services so that we are

- Ensuring that children are protected from harm and their welfare promoted
- Increasing the social and emotional wellbeing of children and young people
- Increasing the healthy life expectancy of people living in Swindon
- Reducing health inequalities of people in Swindon
- Increasing our resilience and support self care
- Increasing the support we offer to children and adults with long term conditions
- Reducing unnecessary emergency admissions and promote a shift from unplanned to planned care
- Improving the experience and safety of children and adults

6.2 Our quality expectations

There is an expectation that Swindon Borough Council and the CCG as commissioners will:

- Treat all providers equitably and ensure that all providers:
- Commit to the quality imperatives within the contract
- Offer social value
- Can demonstrate value for money and increased productivity
- Can demonstrate innovation
- Can demonstrate services are safe
- Can demonstrate services are green and sustainable
- Are resilient and have business continuity plans
- Proactively promote prevention and healthier lifestyle choices

6.3 In order to achieve our vision, our commissioning and service development priorities are:

6.3.1 For children, children in need, children with a child protection plan and children in care and leaving care

- Deliver a range of universal, targeted and specialist services to support children and families when they need it - aiming to intervene early

wherever possible and prevent problems from escalating and for families to build their resilience

- Keeping children safe – identifying and responding to children who need protection or need to be supported and enabled to live with their families, or where children can't continue to live with their families to offer the best alternative care possible and longer term permanence in a timely manner.
- Deliver the Healthy Child Programme through health visiting and school nursing - we will support every family with a new baby up to school entry and support children at school with health needs
- Deliver a range of targeted services to support families with identified additional needs e.g. disability, learning, health, behaviour, emotional development, youth offending

Throughout the functions listed above, Swindon Borough Council Children's Services will work in partnership with other agencies to ensure good communication and effective information sharing to help parents and carers to achieve the best outcomes for children and young people.

This will be achieved by implementing the following plan:

Educational attainment in Swindon for adults, children and young people improves

- Supporting improved school attendance
- Improving outcomes for children with SEN
- Tracking children missing from education

The gap in attainment between children in receipt of free school meals/looked after children and other children decreases at all key stages

- Strengthen the Looked After Children Education Service (LACES), embedding across all services the importance of schools and learning in the lives and future outcomes for looked after and other vulnerable children
- Further enhance the role of the Council as a Corporate Parent to increase opportunities for care leavers to progress into further / higher education or employment.

Youth unemployment reduces

- Children and young people have greater access to apprenticeships – Develop a Pathway to enable routes to employment for Children in Care and Care Leavers which will include opportunities to gain the skills and experience required and progression into Apprenticeships.
- Improving attainment of young people at age 16 and 19, narrowing the gap for pupils eligible for the pupil premium, reducing NEETs and increasing the number of young people participating in learning post 16 (in particular children in care and care leavers)

Parents are able to provide adequate levels of care for their children

- Further embed Early Help Record and Plan
- Further strengthen the quality of core social work, ensuring timely and authoritative intervention with the most vulnerable children
- Drive up quality of outcomes for vulnerable children through Improved assessment, plans and interventions
- Further strengthen management oversight of social workers
- Implementing the enhanced Quality Assurance Plan

Children and vulnerable adults are cared for in Swindon

- Implement the Looked after Children Strategy incorporating Strategy for Placements. This includes a stronger emphasis on local placement and supporting more young people in the community, targeted recruitment to improve placement choice and diversity for teenagers and permanence planning
- Planning is timely for children on the edge of care and needing care

People choose healthy lifestyles and are as well as they can be both mentally and physically

- Drive up quality of outcomes for vulnerable children through implementing the rapid improvement plan to improve the health of looked after children
- Implement Call to Action for Health Visiting to improve recruitment and retention of Health Visitors
- Strengthen the recording compliance of health visitors
- Further develop commissioning strategy for children's emotional wellbeing services

Support is targeted at the most vulnerable

- To achieve full accreditation in Unicef Baby Friendly status.
- We will need to adjust further the 'front door' of our service to consider how aspects of a MASH can be further developed offering quicker support, less duplication and exemplary information sharing between agencies and services.
- Development of preventing offending and re-offending – focusing on early interventions and development of the integrated offender management scheme

People are able to help themselves and develop their own solutions, promoting independence, reducing dependency and demand on services

- Deliver Phase 2 of Troubled Families Programme

Services are reshaped at a lower operating cost and are sustainable within the budget now and in the light of potentially significantly reduced budgets in the future

- Placement sufficiency (including recruitment of in-house foster carers & supportive lodgings providers) strategy is implemented
- Workforce Development Strategy in relation to social workers and health visitors is implemented

- ICT, ICS & Governance development and improvement to help support front line workers and enable the QAF to function effectively

6.3.2 Commissioning and service development priorities **Children with special educational needs**

- Strengthen further the strategic overview and commissioning for SEND, based on a rigorous analysis and monitoring of outcomes
- Build capacity across the system, particularly in mainstream schools
- Develop the workforce so that being outcomes focused and person-centred is at the heart of their practice
- Refresh SEND/EHCP processes, focusing particularly on the SEND Banding descriptors and the role of the SEN Panel
- Promote innovative responses to the SEND of children and young people, by working together with families to design the kind of help and support they need to exercise greater control over their lives.

6.4 Commissioning and service development priorities **To improve the health and wellbeing of people in Swindon**

6.4.1 Reducing emergency hospital admissions and improved discharge

Urgent Care – New Model

Aims of 2015/16 in Urgent Care 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 also 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 2015/16.

The new model is based on fewer points of access into what is a large, diverse and skilled set of services which are not currently used in an integrated way to manage demand. The new model is based on rapid signposting from a single access point to treat patients in the right place within the system, rapidly, to avoid escalating need. This model has been jointly developed with the 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 toward becoming an Accountable Care Organisation in Swindon

Paediatrics

A review of Children's Services in the Acute, Community and Mental Health services will be taking place in 2016/17. 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, that 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.

Key workstreams include:

- Dedicated resources for assessment at front door to assess all routine referrals within two weeks
- Transition arrangements which monitor joint working from 17 years of age for ongoing care
- Focused work for Deliberate self-harm and rapid case review for any child with multiple attendance to ED
- The introduction of new creative solutions panel to support care delivery locally (where possible) for looked after children
- A new joint model for care delivery which is void of Tiers of delivery between CAMHS and TAMHS and operational review which informs future commissioning structures

Delayed Transfers of Care

We 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.

Delayed Transfer of Care Programme 2016/17

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

The target is a sustainable reduction in number of DTOC and non-DTOC delays across the health and care system by 30th September 2016, with planned reduction of current numbers by at least 50%.

6.4.2 Children and adults with long term health conditions

Community Health and Wellbeing

We are investing in self-care and lifelong health planning, preventative care and health promotion including the five main contributors to good health, namely healthy weight and exercise, smoking cessation, reducing substance abuse (including alcohol abuse) and reducing stress, and ensuring primary care monitoring and management of long term conditions, navigating people to support from within their community, the third sector and the health service, developing patients as experts in their own conditions.

We are reviewing services to provide support for those with multiple conditions, with specific programmes for those minority groups where the incidence of long term conditions is higher than the population average.

Community Navigator - Patient activation and self-management: Community Navigator

During 2014/15, Swindon CCG and Swindon Borough Council (SBC) submitted a bid to the national Transformation Challenge Award (TCA) to expand the Community Navigator 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 Wellbeing Team at Swindon Borough Council to provide 14 Community Navigators (CN) for all 26 GP 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 suggest that this phase of the pilot has contributed to the improvement in the health and wellbeing 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.

Following consideration of an interim evaluation report for the 15/16 scheme at Governing Body in January 2016, funding was subsequently identified from the National Transformation Challenge Fund (from where this current model has been funded in 2015/16) to extend the service for a further 12 months until June 2017. The operating model will remain largely similar to that provided in 2015/16, with small revisions to the model (determined by the

remaining funding available) including a reduced number of Community Navigators from the current WTE of 11 to 8, and the introduction of a single point of access for those practices who choose not to engage in the programme with a named Navigator, but may identify individual patients who could benefit from the service.

Reshaping of provision in the voluntary and third sector to improve health and well-being, improved advice and information so that people can make choices

A single database, My Care My Support has been developed at <http://www.mycaremysupport.co.uk/>. The website can be accessed by the patient and their community navigator in assembling the package of support.

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. There needs to be greater emphasis on direct work and practical help because patients often need advice and help outside of normal working hours and we will invest in community based volunteering and, dementia and befriending services. The main voluntary sector organisations providing support to those with mental health, advice and information services and support for carers will continue to be co-located.

Dementia

Recognising increased demand and priority of dementia care, the CCG have worked with GPs 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 through a Specialist Dementia Team in AWP.

Reducing a growing burden of lifestyle related ill health

This is particularly in relation 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, teenage pregnancy, alcohol consumption, physical inactivity and obesity in areas of disadvantage, which in turn leads to higher incidents of heart disease and diabetes in those

communities. We will continue to invest in proactive prevention and initiatives that tackle health inequalities throughout the course of life.

6.4.3 Support for Carers

Carer support is essential for those with long term conditions and often neglected especially at the point of discharge from hospital when carers are being asked to support a loved one, family member or friend who is suddenly appreciably less able or less well, without the preparation to do so. A pilot project has been undertaken with Great Western Hospital to provide support for carers when patients are discharged from hospital.

Additional staff were recruited to undertake carer's assessments as identified in the Care Act. Advice and Information is provided on My Care My Support. A new carer's assessment will be introduced with the Swindon Carers Centre and additional financial support for work on short term breaks and crisis support. We are developing a Parent Carer Assessment in line with the Care Act and Children and Families Act.

We will continue to work with carers to improve our services and devise new solutions with them, including developing an extended menu of support for carers, including parent carers, and health checks for all 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. We will continue to invest in supporting young carers so that they are protected from inappropriate caring responsibilities.

6.4.4 Older People

- We will fund new advice and information services delivered through the Citizens Advice Bureau at Swindon Support and Advice centre including a new online self-assessment for adult social care
- We will fund an improved advocacy service and additional Home from Hospital support and befriending services
- Older people supported through community navigators will have access to a volunteer led service through Circles of Support
- We will offer an improved Deferred Payment system and train staff in this
- We will increase and simplify the access to domiciliary care and reablement for patients leaving hospital

6.4.5 Mental health and wellbeing

We will work to improving the mental health of adults through wellbeing co-ordination and improved work between voluntary and third sector mental health services and secondary mental health services. Continue the development of family working so that the needs of children are identified in adult services and vice versa. Continue to work with providers of secondary mental health services to support the recovery of patients with mental ill health and support general well-being through commissioning additional

psychological therapies (particularly aimed at those with a long term condition). We will ensure that patients are placed in a safe place and not in a police station, and continue to implement the Mental Health Crisis Concordat.

Improving mental health of children through targeted mental health services for children, timely access to child and adolescent services for children in care and additional financial support to improve access to counselling,

Swindon CCG and the other five main CCG commissioners of Adult Mental Health services from Avon & Wiltshire Mental Health Partnership NHS Trust (AWP) have been in discussion with AWP regarding the development and implementation of an Acute Care Pathway to transform services to improve effectiveness and patient outcomes in a safe and sustainable way.

The AWP Delivery Plan for this work is monitored through CCG contract governance arrangements.

Choice in mental health services has been in place in Swindon and allows individuals to choose where they would go for their assessment of need. Our main provider AWP continues to be instructed to make a choice of initial assessment clear on referral and the assessment post completion. The providers of choice are then conveyed clearly back to AWP to initiate if there are identified needs beyond local services this is escalated to the CCG for consideration.

A new mental health pathway has been implemented with our main provider resulting in the following outcomes:

- Local whole pathway contracts focused on outcomes and sustained recovery with high level scrutiny measures
- An emergency response better than outlined within Parity of Esteem and Crisis Concordat
- A model which is empathetic to pressure in Primary care and does not add to it by increasing availability of specialism locally
- A nonlinear pathway which reduces demand on primary care and empowers self-management and uses pull to support genuine recovery
- Far better whole systems understanding
- System integration to focus on Mental Health and Physical Health care simultaneously fulfilling national ambition, delivering better outcomes, more synergies, using less or same resources

Psychiatric Liaison Services: There is a service in place at the Great Western Hospitals NHS Foundation Trust. A review of this has taken place, with a particular emphasis on the requirements of patients to dementia to identify what further development is required. This also links into the Urgent Care Model and an intention to site the Crisis Response Service and the Psychiatric Liaison Service within the Urgent Care Centre. Work is required for those who re-attend with self-harm and self-poisoning.

6.4.6 People with a learning disability

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.

In 2013, a Joint Strategic Needs Assessment of the 546 residents of Swindon who were registered with a learning disability and live or have lived within the borough showed that a high proportion lived in residential care (32) at least twice the expected proportion compared to the reference sites we used and many of these did not have a personalised care assessment. This is now a local performance indicator in line with The Better Care Fund initiative.

6.4.7 Health promotion and healthy lifestyles, wider determinants of health

- Effective support for people suffering from alcohol and drug misuse as well as continued development of sexual health services. Continue the development of whole family working so that the needs of children are identified in adult services and vice versa.
- Reshaping of supported housing options so that a range of appropriate models are in place for young people, families and adults to live locally and avoid admissions to specialist and inpatient placements
- Continue to develop strategic approaches to primary prevention of long term conditions and the promotion of NHS Health Checks. Development and commissioning of services to increase physical activity, promote healthy weight, reduce smoking prevalence and improve mental wellbeing.
- Increase uptake of adult and children's immunisation screening programmes.

7.0 Measuring aims and objectives

7.1 Children

A number of key performance indicators have been selected as part of the Councils 'dashboard' measures, including:

- Increase the percentage of care leavers going into employment, education or training to be in line with the national average by 2018/19. Current level: 41.7%. March 2016 target: 47%.
- To reduce the percentage of children becoming the subject of a child protection plan for a second or subsequent time to be in line with the national average by 31 March 2017. Current level: 17.86%. March 2017 target: 16.6%.

- Increase the number of troubled families engaged in the programme to 1,270 families by March 2020. Current level: 208 families. March 2020 target: 1,270 families.
- Increase the percentage of looked after children who are placed inside the Borough boundaries to 93 % by March 2019. Current level: 83.5%. March 2019 target: 93%.

7.2 National indicators including those subject to Better Care Fund

- Avoidable emergency admissions
 - Meet the four hour target of 95% of patients discharged, admitted or transferred within four hours of arrival in A&E from March 2016 through the delivery of the Urgent Care Programme.
- Delayed transfers of Care from hospital (DTC)
 - Target: sustainable reduction of DTC and non DTC delays across the health and care system by end September 2016, with planned reduction of current numbers by at least 50%
- Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 (100k) population
 - The forecast for 2015/16 is 736.8 per 100,000 population, and the target for 2016/17 is to maintain that at 735.5 per 100,000 population. Residential Care Admissions continue to be challenging
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
 - The forecast for 2015/16 is 92.9%, and the target for 2016/17 is 92.9%. The current performance in relation to reablement is above the national average, so it is not feasible to increase the target further.
- Learning Disability clients received a review to establish potential to move out of residential care
 - Target: 70% in 2016/17. We wish to ensure 70% of service users have a review in the year to reduce high cost packages across all service users with learning disabilities.
- Increase the number of carers assessments
 - In 2015/16 89.95% of carers assessments and reviews were completed, a total of 1,369. The target for 2016/17 has not yet been set.
- % of patients discharged or admitted from A&E within 4 hours
 - Target for 2016/17 is 98%

- Patients will be seen for routine elective care within 18 weeks
- Mortality from cardiovascular disease in under 75 year olds
- Mortality from cancer in under 75 year olds
- Mortality from respiratory illness in under 75 year olds
- Suicide rate

7.3 Quality measures

- Delivery of Quality Assurance Framework in Children's Services
- Findings from Serious Case Reviews and Local Case Reviews in Children's and Adult Services.
- Patient safety measured through Patient Safety Report
- Quality of clinical practice measured through Quality Effectiveness Report
- Patient/service user experience report measuring complaints and compliments
- Increase the number of service users who say they have access to advice and information
- The percentage of carers who say they have access to advice and information
- Improve the percentage of older people with social contact
- Patient / service user experience – quality of life

Workforce Plans

Swindon Borough Council Children's Services

Swindon Borough Council Children's Services is delivering a significant programme of work, the Safeguarding Children and Supporting Families Programme May 2016-March 2019, which includes a workstream focused on workforce.

A Workforce Plan has been established, including progression and succession, training and development, career progression, skills development and demographics, and a focus on ensuring the smooth and timely recruitment and retention of social workers.

Swindon Borough Council Adult Services

A Workforce Plan for Adult Services is being developed, with particular emphasis on supporting the workforce around Transitions. This Plan will be in place by the end of 2016.

CCG

During 2015/16 and in response to requests from local membership practices, the CCG supported the development of the 'Primary Care Workforce Development Project'. This project sought to engage constructively with all stakeholders to agree, prioritise and establish actions to support the primary care workforce in Swindon and improve recruitment and retention rates. The

project outcomes were consistent with short, medium and long-term aspirations for the primary care workforce as follows:

- To manage increasing demand in primary care
- To support practice to work together, share ideas & best practice
- To improve perception of Swindon
- To increase recruitment & retention of all staff groups
- To improve morale in all staff groups
- To develop different models of care / skills mix of professional groups
- To support training for all staff groups
- To ensure appropriate premises/accommodation is available for service
- To increase funding available to support primary care services and workforce

A number of projects have been delivered successfully and the programme will be continued in 2016/17 with the following key priorities, supported by all stakeholders:

- To quantify workforce pressures and provide consistent reporting
- To continue to provide a Retainer Scheme for doctors
- To evaluate the 'Swindon Area Primary Care Network' website
- Maintain intranet sites for Practice Managers and Practice Nurses to aid collaboration, to work together to share ideas & best practice
- To continue to provide on-line training resources for all primary care staff
- To attend regional events to promote Swindon and workforce development opportunities

This work will be overseen by the Swindon Community Education Provider Network (CEPN). The CEPN will be led by primary care providers (i.e. groups of GPs and GP provider practices) and supported by the Deanery, Local Education Trust, CCG and other stakeholders, such as Universities, community service provider, Pharmacy representative, LMC, Local Community Practice leads for Nursing and patient representatives.

Overall the aims of the CEPN are consistent with those of the Primary Care Workforce Development Project, as both seek to support workforce planning, education and development locally. The CEPN will also report to the Swindon Workforce Steering Group. The CCG has developed a Workforce Steering Group to take a local oversight role in ensuring HR strategy, structures, systems and processes across the health system are in place and functioning to support current and future workforce needs. The WSG will oversee that national policy recommendations are being implemented (e.g. Shape of Caring) and brings together commissioners, education, acute, primary, social and community care providers to enable workforce discussions and ensure a collective approach to deliver what patients need now and in the future. The WSG will ensure an in-depth understanding of local current and future workforce across all health and social care including recruitment, retention and ongoing professional development and aligning education and training to enable delivery of the CCG's commissioning plan and overarching strategy.

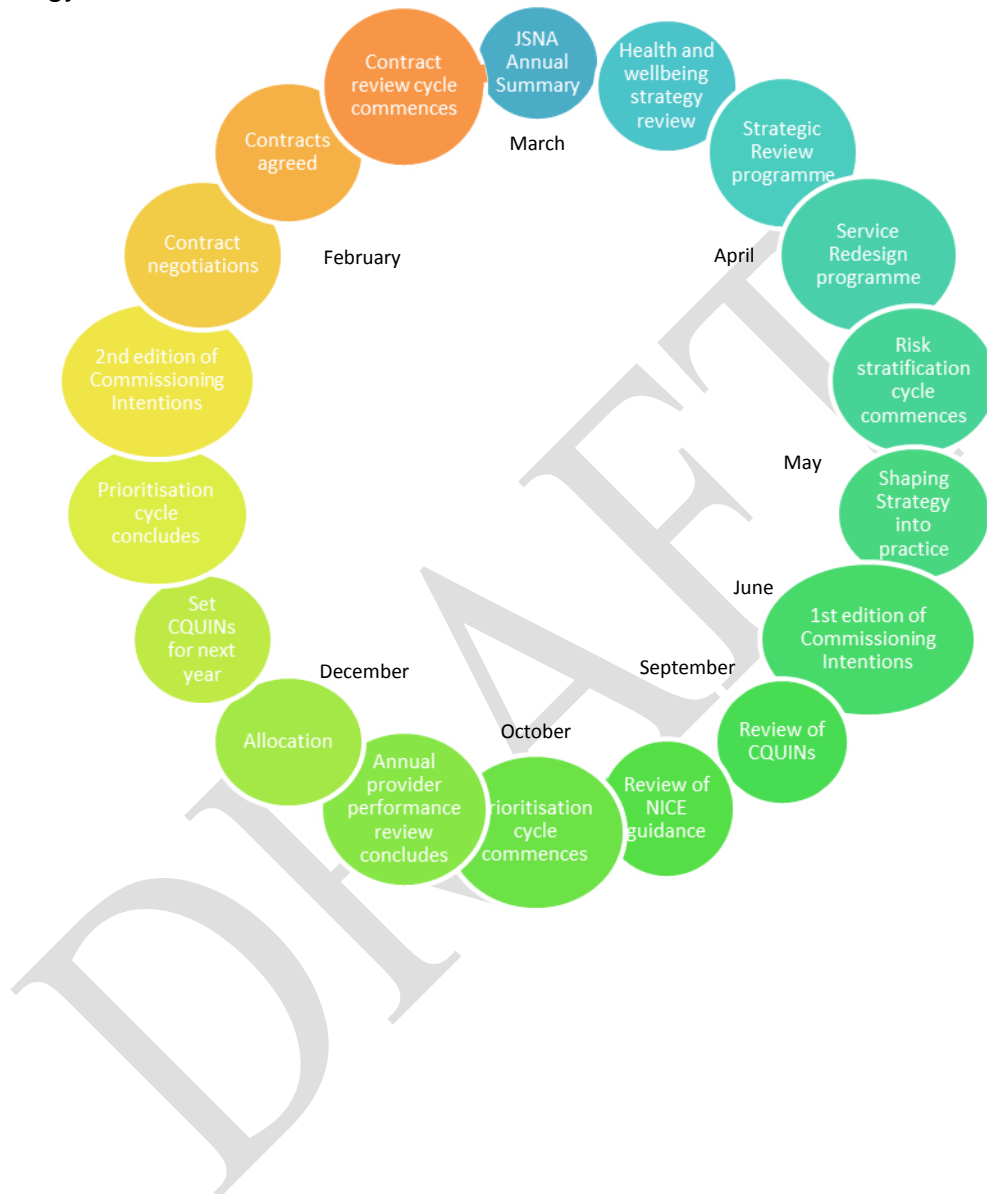
The key areas of work during 2016/17 include:

- Designing and profiling future workforce on a population health basis;
- Ensure sustainable and flexible local workforce planning in collaboration with LETBs, HEE and LGA;
- Testing models of an integrated workforce across health organisations; Addressing barriers (e.g. employment contracts) to allow the workforce to work flexibly across Swindon geography;
- Identifying gaps in the current workforce that may impede new ways of working.

Appendix 1

Definition of Joint Commissioning (Department of Health):

‘The process in which two or more commissioning agencies act together to co-ordinate their commissioning, taking joint responsibility for translating strategy into action’



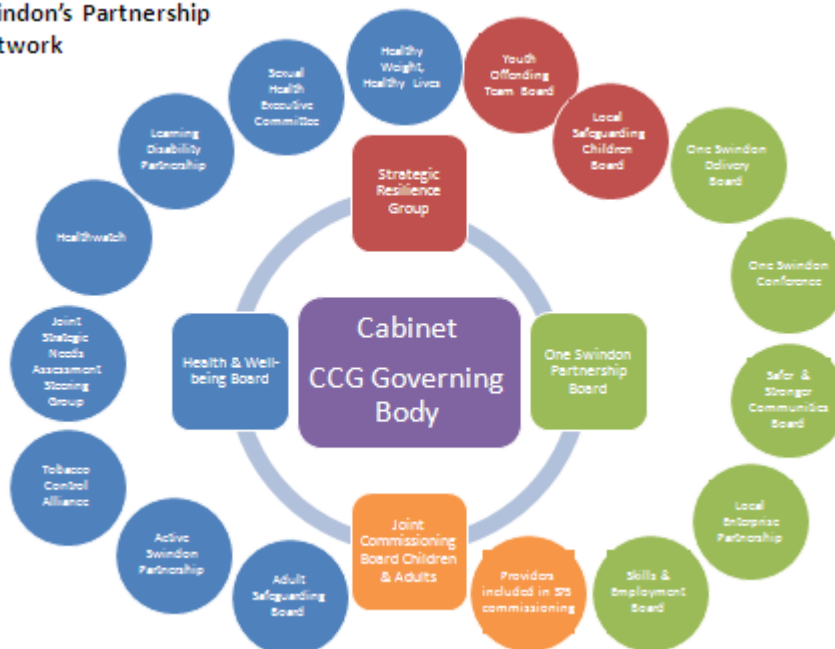
Partnership arrangements

Swindon has a 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.

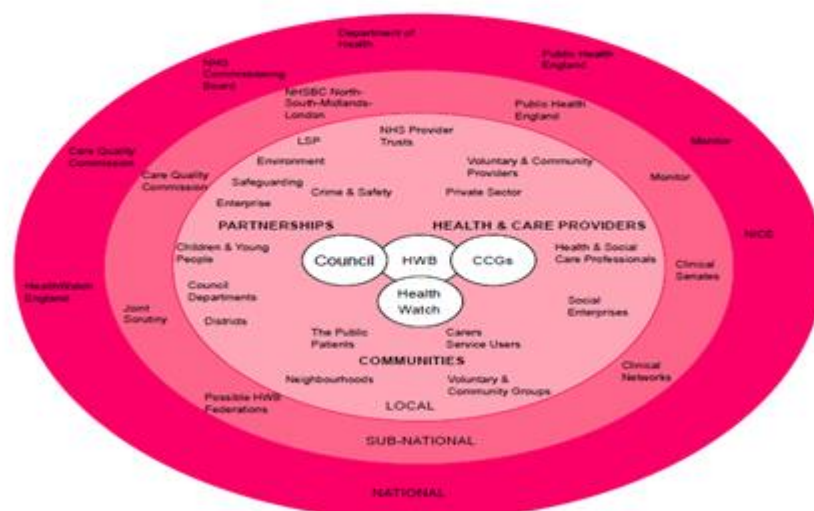
Governance arrangements to monitor the section 75 Agreements are in place through the Health and Wellbeing Board at a strategic level and operationally through the Joint Commissioning Group Children & Adults (JCG) reporting to the Health & Wellbeing Board. The CCG and Swindon Borough Council including Public Health are members of the JCG and the Health and Wellbeing Board.

The Joint Commissioning Group Terms of Reference provide a link to the Health and Wellbeing Board who monitor the implementation of the NHS Act 2006 Section 75 Agreements and these commissioning intentions. There is also a link to the Strategic 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.

Swindon's Partnership Network



Health & Well-being Board: key relationships



Appendix 2

In the table below we set out how the priorities within the Commissioning Intentions match those in the Health and Wellbeing Strategy

Swindon Health and Wellbeing Strategy		Joint Commissioning Intentions	Source of evidence to support
Outcome	Priorities		
<i>Every child and young person in Swindon has a healthy start to life</i>	<p>Improve the mental wellbeing of children and young people</p> <p>Reduce risky behaviours (e.g. Smoking, drinking) amongst our children and young people</p> <p>Keep all children and young people safe</p> <p>Improve educational attainment of children and young people</p> <p>Reduce the number of young people not in education, employment or training</p>	<p>High levels of compliance with all aspects of the core professional social work task</p> <p>Good quality interventions, ensuring no delay in reaching decisions about how best to safeguard and promote the welfare of children</p> <p>Ensuring that the right services are reaching the right children and families at the right time including support for Troubled Families</p> <p>High quality care planning, placement, permanence & pathway planning for children in care & care leavers,</p> <p>Co-producing good outcomes with our service users and our communities,</p> <p>Commissioning of Healthy Child Programme widening role of health visitor and Family Nurse Partnership.</p>	<p>JSNAs</p> <p>Inspection reports and annual self-assessment</p> <p>Performance reports to Children's Health, Social Care and Education Overview and Scrutiny Committee and Adults' Health, Adults' Care and Housing Overview and Scrutiny Committee and Health & Wellbeing Board</p>

Swindon Health and Wellbeing Strategy		Joint Commissioning Intentions	Source of evidence to support
Outcome	Priorities		
<i>Adults and older people in Swindon are living healthier and more independent lives</i>	<p>Strengthen integrated working between health and social care</p> <p>Reduce the number of people suffering from long term conditions through the promotion of healthy lifestyle choices</p> <p>Promote independence and reduce the need for hospital services and long term care</p> <p>Ensure that carers needs are met</p>	<p>Moving towards steady state in terms of our hospital admission rate</p> <p>Focusing on key long term conditions thorough community navigator, advice and information</p> <p>Implementation of the Care Act, befriending and advocacy services</p> <p>Use of assistive technology to help people self-manage their condition</p> <p>Ensure support to carers, flexible support, improved assessment, and local support groups</p> <p>Primary prevention supporting Healthier Lifestyle choices</p>	<p>Admission rate analysis from JSNA</p> <p>Programme spend analysis from JSNA</p> <p>Care Act 2014</p> <p>Long term conditions identified in GP survey – dementia, respiratory, diabetes</p>
<i>Improved health outcomes for disadvantaged and vulnerable communities</i>	<p>Ensure access to information and advice that supports choice and control</p> <p>Ensure people from disadvantaged groups receive good quality care for their physical health</p> <p>Local economic and social policies are developed to strive to narrow social inequalities rather than widen them</p> <p>Prevent early death and disease through healthier lifestyle choices, early detection and screening</p>	<p>Reducing the gap in life expectancy between our least and most deprived populations</p> <p>Targeting health promotion, healthy lifestyle and exercise programmes, smoking cessation, improved treatment for those with alcohol and substance misuse issues</p> <p>Increase uptake of immunisation and screening.</p>	<p>JSNA</p> <p>Experian Mosaic</p> <p>GP survey</p> <p>One Swindon Public Event</p> <p>Comparative admission rates</p> <p>Locality champions feedback</p>
<i>Improved mental health, wellbeing and resilience for all</i>	<p>Develop effective pathways for people with mental health problems</p> <p>Increase the opportunities for people with mental health problems to access support</p>	<p>Increasing investment in mental health and reviewing our model of care for learning disability</p> <p>Improved transition services</p>	<p>JSNA</p> <p>Identified in top 5 from GP surveys</p> <p>National strategy</p>

Swindon Health and Wellbeing Strategy		Joint Commissioning Intentions	Source of evidence to support
Outcome	Priorities		
	<p>services and community facilities aimed at promoting recovery (e.g. education, debt management, housing, leisure services, health promotion)</p> <p>Promote positive mental health and recognise that mental health is everyone's business</p> <p>Reduce the stigma and discrimination associated with mental ill health</p>	<p>Implement Special Educational Needs reforms, including Local Offer and Education, Health and Care Plan</p> <p>Improve access to mental health services for all children and those children in care and ensure whole family working</p>	Key priority for Swindon Borough
<i>Creation of sustainable environments in which communities can flourish</i>	<p>Build on the strengths of local communities, including the local voluntary sector, to enhance social cohesion, and promote social inclusion of marginalised groups and individuals.</p> <p>Work with our local communities to develop creating solutions for local issues</p> <p>Ensure that housing and development strategies for new and existing communities identify the health and wellbeing impacts for residents in the short and long term</p> <p>Promote the use of green, open spaces and activities such as walking and cycling</p> <p>Maintain effective public transport and transport networks which ensure access to services and activities and encourage permeability within communities</p>	<p>Workforce strategy, responding to the economic downturn, building sustainable communities</p> <p>Reducing NEETs and increasing the number of young people participating in learning post 16 (in particular children in care and care leavers)</p> <p>Commissioning Strategy for supported housing, review of sheltered housing schemes and placement strategy for children with complex needs and those at risk of sexual exploitation</p>	<p>JSNA</p> <p>Part of self-care agenda</p> <p>Picked up as priority through locality groups</p>