## Swindon Borough Council

# Health and Wellbeing Board

## Wednesday, 8 May 2013

Committee Room 6, Civic Offices (Anticipated meeting room)

At 2.00 p.m.

**Contact Officers:**
Alison Smith (Committee Officer), 01793 463612, alsmith@swindon.gov.uk
Cherry Jones (Deputy Director of Public Health), 01793 444681, cherry.jones@swindon.gov.uk

Swindon Borough Council can be contacted at the Civic Offices, Euclid Street, Swindon, SN1 2JH (Telephone 01793 445500)

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## AGENDA

1. **Apologies for Absence**

2. **Declarations of Interest**
   Members are reminded that at the start of the meeting they should declare any known interests in any matter to be considered, and also during the meeting if it becomes apparent that they have an interest in the matters being discussed.

3. **Public Question Time**
   See explanatory note below. Please phone the Committee Officer whose name and number appears at the top of this agenda if you need further guidance.

4. **Minutes** (Pages 1 - 4)
   To receive the minutes of the Shadow Health and Wellbeing Board meeting held on 13th March 2013.

5. **Healthwatch Swindon Update** (Pages 5 - 8)

6. **Terms of Reference for the Health and Wellbeing Board** (Pages 9 - 18)

7. **Developing the Joint Strategic Needs Assessment (JSNA)** (Pages 19 - 28)

8. **Health and Wellbeing Draft Strategy** (Pages 29 - 46)

9. **Clinical Commissioning Group's Commissioning Plan for 2013-14 - A Clear and Credible Plan** (Pages 47 - 88)

10. **Dates of Future Meetings**
    10th July 2013 2 – 4pm
    11th September 2013 2 – 4pm
    13th November 2013 2 – 4pm

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| 8th January 2014 | 2 – 4pm |
| 12th March 2014 | 2 – 4pm |
| 7th May 2014 | 2 – 4pm |

**Date of Despatch:** 30 April 2013

***Public Question Time*** *- Swindon Borough Council is committed to increasing its accountability to the public and to promoting active citizenship. Up to 15 minutes will be allowed at the start of all Council meetings for questions to the Chair from members of the public about the work of the Committee (except for confidential matters and specific planning applications). Questions must be relevant, clear and concise. Because of time constraints Public Question Time is not an opportunity to make speeches or statements. Prior notice of a question to the Director of Law and Democratic Services is desirable - particularly if detailed background information is needed.*

***Access Arrangements -*** *The venue is wheelchair accessible and an infrared receiver hearing system is provided. If you would wish to attend the meeting but have any special requirement to enable you to do so please contact the Committee Clerk, whose name appears at the top of this agenda, as soon as possible prior to the date of the meeting.*

If you would like to receive any of the pages contained in this agenda in a larger print size please contact the Committee Officer whose name appears on the first page of this agenda.

# SHADOW HEALTH AND WELLBEING BOARD

**WEDNESDAY, 13 MARCH 2013**

**Note of Meeting**

**Present:** Councillor Roderick Bluh (Leader, Swindon Borough Council), Gavin Jones (Chief Executive, Swindon Borough Council), John Gilbert (Group Director, Children & Adults Services), Dr Jose Ortega (Director of Public Health), Kathleen Aitken (LINk representative (Manager of Swindon MIND), Julia Davison (NHS Commissioning Board), Tony Ranzetta (Clinical Commissioning Group), Cherry Jones (Deputy Director of Public Health) and Councillor Ray Ballman.

**Apologies:** Councillor Brian Mattock and James Griffin.

| 1. | **Welcome and Introduction** | |
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| | Councillor Bluh welcomed everyone to the meeting and explained that this would be his last meeting as he would be standing down as Leader of the Council in April. He added that this would also be the last meeting for Kathleen Aitken and Dr Jose Ortega and he thanked them for their input into the development of the Health and Wellbeing Board. He also thanked Moira Shields for her work in clerking the Shadow Board. | |

| 2. | **Minutes of the Previous Meeting and Matters Arising** | |
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| | The minutes of the meeting held on 9th January 2013 were agreed as an accurate record.<br><br><u>Matters arising</u><br><br>**National Consultation on National Specialised Commissioning (Min 9) –** PB to consider response to the national consultation on specialised consultation following further discussion with JO. PB/JO will review policies and agree a response on behalf of the Clinical Commissioning Group. | PB/JO |

| 3. | **Joint Strategic Needs Assessment Update (JSNA)** | |
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| | Dr Jose Ortega (Joint Director of Public Health) reported on the Joint Strategic Needs Assessment (JSNA) work plan for 2013 and explained that clarity around the intended population would be fully explained for each area of work. The Learning Disabilities (adult) bulletin had now been signed off by the steering group and was available on the website. Clarification around the next steps and a revision date were also included within the bulletin. Members of the Shadow Board agreed that as this had an impact upon a significant number of people, future bulletins needed to contain information on what actions were to be undertaken, by whom and by when. It was agreed that all JSNA bulletins would be signed off by members of the Health and Wellbeing Board before being published. | |

| 4. | **Clinical Commissioning Group (CCG) Plans - update** |
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| | Tony Ranzetta (Clinical Commissioning Group) presented the draft NHS Swindon Clinical Commissioning Plan for 2013/14 that identified local clinical priorities such as self-care and prevention and explained that the objective was to shift the balance to localised support. The detailed plan would be presented to the governing body on 27th March 2013 and a consultation process would be run over Easter to mid-May. It was agreed that a presentation outlining the details of the plan be given to members of the Board during April before being submitted to the first meeting of the Health and Wellbeing Board in May 2013. | TR |

| 5. | **Health and Wellbeing Strategy Development** | |
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| | Cherry Jones (Deputy Director of Public Health) presented the Health and Wellbeing vision and explained that formal consultation with stakeholders was currently underway with a view to launching in June 2013. Members of the Shadow Board agreed that the vision mirrored the ambitions of the Board and it was agreed that each organisation should link their commissioning plans to the vision in order to identify any gaps and to ensure that there is a connection between the vision and delivery.<br><br>The Chair commented that consideration should be given to the wellbeing elements of the Board and how links could be made between localisation, neighbourhood planning and the work of the Health and Wellbeing Board. Some discussion took place around the work of the One Swindon Board and the Health and Wellbeing Board and the need to ensure there was no duplication in their activities and that organisations' were enabled to develop a culture in which the wellbeing of individuals was considered alongside their health needs. | |

| 6. | **Swindon Healthwatch - update** | |
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| | Mark Feeny (Contract and Commissioning Officer) explained that the local Healthwatch would take over the work of the Local Involvement Network (LINk) from April 2013. This would be a national, legally constituted body with local representation and, following a tendering exercise, the agreed provider for Swindon was chosen as Parkwood. The contract would be with Swindon Healthwatch (a social enterprise) and Parkwood would be the parent company. The local representative had not yet been appointed. | |

| 7. | **Establishing the Health and Wellbeing Board as a Committee of the Council** | |
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| | Cherry Jones (Deputy Director of Public Health) introduced the proposed terms of reference for the Health and Wellbeing Board. She explained that a report would be considered by Cabinet on March 20th to approve the appointment of the Health and Wellbeing Board as a Committee of the Council and to endorse the draft terms of reference for submission to full Council.<br><br>With regards to the membership of the Board, it was agreed that Tony Ranzetta (Accountable Officer) would be the Clinical Commissioning Group (CCG) representative and that a request be made that an additional clinical | |

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| | member be appointed from the CCG. John Gilbert (Board Director, Commissioning) stated that it would be useful to include within the terms of reference a statement regarding the Health and Wellbeing Board receiving regular updates from the Safeguarding Boards. Cherry agreed to amend the terms of reference and circulate to members of the Board. She also agreed to speak to David Wray regarding the development of a fair and equitable process for nominating and appointing representatives to the Health and Wellbeing Board. | CJ |

| **8.** | **Board Development** | |
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| | It was agreed that a Board Development session would be held in April to consider commissioning plans and how these contribute towards the vision. It was also agreed that all commissioners should be invited to this development session. | ALL |

| **9.** | **Board Risk Register** | |
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| | Members of the Shadow Board agreed that the risks associated with the development of the Health and Wellbeing Board were no longer valid and could now be closed down and that any future risks identified would be submitted to the Board for their consideration. | |

| **10.** | **Future meetings at the Civic Offices - (2nd Wed every 2 months)** | |
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| | Future meetings of the Health and Wellbeing Board would be held on:-<br><br>8th May 2013 2 – 4pm<br>10th July 2013 2 – 4pm<br>11th September 2013 2 – 4pm<br>13th November 2013 2 – 4pm<br><br>Members of the Shadow Board also agreed that it would be useful to hold alternate meetings at community venues. | |

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# Healthwatch Swindon Update

**Health & Well Being Board** **Date: 08/05/2013**

Author: Clare Davis, Operations Manager, Parkwood Healthcare

Wards: All

Locality Affected: All

Parishes Affected: All

## 1. Purpose and Reasons

1.1 Update on Healthwatch Swindon, since contract start on the 1st April 2013

1.2 Healthwatch Swindon has a statutory place on the Health and Well Being Board. This is the first meeting since Healthwatch started, a chair person has not been recruited at this stage, but an update on activities is still needed.

## 2. Recommendations

The Committee is recommended to:

2.1 Accept the update and suggest any additional key priorities.

## 3. Detail

Activities so far

3.1 Healthwatch Swindon started on 1st April 2013, and its delivery is being supported by Parkwood Healthcare. Although a bank holiday the website and email address were both live in readiness for any possible enquiries.

3.2 Two members of staff are currently employed, they moved to Healthwatch Swindon under TUPE regulations, and were previously working for the Local Involvement Network (LINk).

3.3 It is important that positive working relationships are built between all key stakeholders and Healthwatch Swindon, and to start this a representative from Parkwood Healthcare has already attended the Learning Disability Partnership Board, the final LINk meeting, the Health and Well Being Strategy workplan development meeting as well as meeting key individuals including the Citizens Advice Bureau and Jo Ash (Head of Policy and Performance, Service Delivery).

These activities will continue over the next few months.

3.4 Recruitment for the Chair and Board of Directors has started, interviews are scheduled for the 10th May and 17th May 2013 respectively.

3.5 Staff are currently working on producing a community engagement plan, communications plan and development plan.

Further information on the subject of this report can be obtained from Clare Davis, Direct Dial 07803 028046, Clare.Davis@parkwoodhealthcare.co.uk

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In addition, staff are undertaking a mapping exercise of relevant meetings and groups which Healthwatch needs to have a presence at, identifying who will be the most appropriate person to represent Healthwatch Swindon at them.

3.6 Parkwood Healthcare has developed a bespoke Healthwatch database, for the capturing and reporting of qualitative and quantitative data. This is being populated and will be readily available to staff as part of their day to day work.

3.7 Key performance indicators and reporting requirements are currently being agreed with the council.

3.8 Any live advocacy cases are being continued by SEAP (Support, Empower, Advocate, promote - the outgoing provider). This is to ensure continuity for current clients. Future cases will be looked after by a local advocate, who will be appointed by Parkwood Healthcare.

3.9 Key milestones have been met during Healthwatch Swindon's first month, with the next significant milestones being the successful appointment of a chairperson and board of directors.

**4. Alternative Options**

4.1 There are no alternative options.

**5. Implications, Diversity Impact Assessment and Risk Management**

Financial and Procurement Implications

5.1 Healthwatch is an independent champion for consumers and users of health and social care in England. In Swindon the Healthwatch service is commissioned by Swindon Borough Council (Commissioning Children and Adults) as lead commissioner.

5.2 The contract to provide a Healthwatch service was awarded to Parkwood following an open tender exercise. The contract being for an initial 3 years with an option to extend by 2.

5.3 The Healthwatch contract is funded from within the 2013/14 adults voluntary organisations budget.

Legal and Human Rights Implications

5.4 The Health and Social Care Act 2012 sets out that local Healthwatch will be established from April 2013. The aim of the local Healthwatch will be to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. As such, the local Healthwatch will have a seat on the Health and Wellbeing Board.

Further information on the subject of this report can be obtained from Clare Davis, Direct Dial 07803 028046, Clare.Davis@parkwoodhealthcare.co.uk

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All other implications (including Staff, Sustainability, Health, Rural, Crime and Disorder

5.5 A local Healthwatch is an independent organisations and able to employ its own staff and volunteers. It has a role in promoting public health, health improvements and in tackling health inequalities.

Links to One Swindon, Strategic Objectives, Plans and Policies

5.6 Healthwatch will contribute to improving the health and wellbeing of local people and in ensuring people live healthy lives.

Diversity Impact Assessment

5.7 A Diversity Impact Assessment has not been completed for this report. This is because it relates to the establishment of the local Healthwatch, with no changes to staffing, budget or service eligibility criteria.

Risk Management

5.8 No specific risks have been identified at this stage for this report.

**6 Consultees**

6.1 The Board Director Finance, Revenues, Benefits and Property (Section 151 Officer) and the Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

**7. Background Papers**

7.1 None

**8. Appendices**

8.1 None

Further information on the subject of this report can be obtained from Clare Davis, Direct Dial 07803 028046, Clare.Davis@parkwoodhealthcare.co.uk

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# Health and Wellbeing Board Terms of Reference

**Health and Wellbeing Board** **Date: 8th May 2013**

Author: Director of Public Health
Wards: All
Locality Affected: All
Parishes Affected: All

## 1. Purpose and Reasons

1.1 To determine the Terms of Reference of the Health and Well Being Board. The Shadow Health and Wellbeing Board, established in September 2011, became a substantive Committee of the Council April 2013.

## 2. Recommendations

The Committee is recommended to:

2.1 Agree the Terms of Reference for the Health and Wellbeing Board.

## 3. Detail

3.1 The Health and Social Care Act 2012 brought about significant reform of existing health structures. These changes included the transfer of public health accountabilities from the NHS to local authorities; the abolition of Primary Care Trusts (PCTs) and, in the place of PCTs, the establishment of GP led Clinical Commissioning Groups (CCGs). It also established the creation of patient champion groups Healthwatch in place of Local Involvement Networks (LINks) and the introduction of Health and Wellbeing Boards to provide an opportunity to deliver improved health outcomes, through closer working relationships between the council, local GPs and the health community.

3.2 The ambition behind the introduction of Health and Wellbeing Boards is to build strong and effective local partnerships, which improve the commissioning and delivery of services across NHS and local government, leading in turn to improved health and wellbeing for local people. The health and wellbeing boards function is to set a strategic direction for health, wellbeing and social care providing a sense of place, bringing together the key health and social care commissioners and the local Healthwatch.

3.3 The 2012 Act states that the Health and Wellbeing Board has various functions. These include those conferred on it directly, such as the duty to encourage integrated working. It also includes duties conferred jointly on the local authority and its partner Clinical Commissioning Groups (CCGs) but which must be discharged by the board. These joint duties include the preparation and publication of Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS).

Further information on the subject of this report can be obtained from Cherry Jones, 01793 444681, Cherryjones@swindon.gov.uk.

3.4 Health and Wellbeing Boards are a key part of the broader plans to modernise the NHS. Their role is to:

3.4.1 Ensure stronger democratic legitimacy and involvement around the health agenda,

3.4.2 Strengthen working relationships between health and social care,

3.4.3 Encourage the development of more integrated commissioning of services, and

3.4.4 Ensure that commissioners have regard to the JSNA and the Health and Wellbeing Strategy when making commissioning decisions.

3.5 The regulations relating to health and wellbeing boards make provision for the disapplication and modification of certain enactments relating to local authority committees appointed under section 102 of the Local Government Act 1972, insofar as they are applicable to a health and wellbeing board established under section 194 of the 2012 Act. The regulations aim to provide local areas with the flexibility and freedom to shape their health and wellbeing boards as best fits with local circumstances. In particular:

3.5.1 Health and wellbeing boards will be free to establish sub-committees and delegate functions to them;

3.5.2 Voting restrictions have been lifted so that non-elected members of a health and wellbeing board (i.e. CCG representative, local Healthwatch, Directors of Public Health, Children's Services and Adult Social Services and any wider members) could vote alongside nominated elected representatives on the Board.

3.5.3 Political proportionality requirements have been lifted so that the question of political proportionality of health and wellbeing board membership is left to local determination.

3.6 Health and Wellbeing Boards must include six statutory members which are:

- at least one councillor, who will be (or be nominated by) the Leader
- the Director of Adult Social Services of the local authority
- the Director of Children's Services of the local authority
- the Director of Public Health of the local authority
- a representative of Local Healthwatch
- a representative of the Clinical Commissioning group (CCG)

3.7 The Board and the local authority have the power to appoint additional members as they see fit.

3.8 The proposed membership of the Swindon Health and Wellbeing board is as set out in the draft Terms of Reference - Appendix One.

3.9 All members of the Health and Wellbeing Board will be subject to Swindon Member's Code of Conduct when acting as a member of the board and will be subject to the standard requirements regarding declarations of interests.

3.10 The Health and Wellbeing Board will align with the One Swindon Board and support the delivery of the One Swindon strategic priorities

3.11 The draft Terms of Reference for the Health and Wellbeing Board are attached as appendix One. These have already been approved by Cabinet at the meeting held on 20th March 2013 and adopted by Full Council at the meeting held on 11th April 2013.

**4. Alternative Options**

4.1 The Health and Wellbeing Board could seek to include additional members onto the Health and Wellbeing Board.

4.2 The Health and Wellbeing Board could decide on a different frequency of meetings

**5. Implications, Diversity Impact Assessment and Risk Management**

Financial and Procurement Implications

5.1 There are no direct financial implications arising from the establishment of the Health and Wellbeing Board. However the statutory duties of the board will provide the opportunity to promote integrated commissioning and pooled budget arrangements across the NHS, social care and public health.

5.2 Although not a commissioning board in its own right, the Health and Wellbeing Board will have strategic influence over commissioning decisions across health, public health and social care. It will strengthen democratic legitimacy through the involvement of democratically elected representatives and patient representatives in commissioning decisions alongside commissioners across health and social care. It provides a local forum for challenge, discussion and the involvement of local leaders.

Legal and Human Rights Implications

5.3 Legal and Human rights have been taken fully into account in compiling this report. It is considered that the recommendations within this report are compatible with Convention Rights.

5.4 In consideration of any future guidance and an understanding of best practice from elsewhere, the council will work with the NHS and other partners in order to

ensure that equalities and a respect for human rights are at the heart of the work of the Health and Wellbeing Board, and that everyone in Swindon has fair access to services and are free from discrimination

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

5.5 The establishment of the Health and Wellbeing Board provides opportunity to improve the health outcomes of the people of Swindon and reduce health inequalities that exist across Swindon

5.6 There should be no significant staffing or other implications arising from this report

Links to One Swindon, Strategic Objectives, Plans and Policies

5.7 The Health and Wellbeing Board will align with the One Swindon Board and support the delivery of the One Swindon strategic priorities

Diversity Impact Assessment

5.8 A Diversity Impact Assessment has been completed on the establishment of the Swindon Health and Wellbeing Board and is available on request.

Risk Management

5.9 No specific risks identified at this stage for this report.

**6. Consultees**

6.1 The Board Director Finance, Revenues, Benefits and Property (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

**7. Background Papers**

7.1 None

**8. Appendices**

8.1 Appendix One – Health and Wellbeing Board draft Terms of Reference

Further information on the subject of this report can be obtained from Cherry Jones, 01793 444681, Cherryjones@swindon.gov.uk.

# Swindon Health and Wellbeing Board

## Terms of Reference

## 1 Introduction

The Health and Social Care Act 2012 establishes health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.

The Swindon Health and Wellbeing Board is made up of a collection of people from different organisations (including the NHS, the local authority officers and elected members, the Clinical Commissioning Group and the voluntary sector), who will work together on issues to do with being healthy and feeling well. The board aims to find out what people in Swindon need to be healthy and feel well and work together to agree a strategy (plan) that will make things happen. The health and wellbeing strategy will help the Health and Wellbeing Board plan services to do with being healthy and feeling well and that make it easier for everyone to get the care they need. The board also aims to reduce the health differences between poorer and better off groups across Swindon (health inequalities).

The Health and Wellbeing Boards primary role is to provide strategic leadership to improve the health and wellbeing of Swindon's population (both adults and children) and to reduce the inequalities in health experienced by some communities. It aims to:

- ensure delivery of improved outcomes for the people of Swindon bringing together national health and social care policy in conjunction with local priorities.
- achieve democratic legitimacy and accountability, and empower local people to take part in decision-making about local health and wellbeing.

## 2 Purpose

The purpose of the board is to improve the health and wellbeing of people of all ages in Swindon and to reduce health inequalities in Swindon.

## 3 Underlying Principles

- shared leadership of a strategic approach to the health and wellbeing of our local communities
- a commitment to driving real action and change to improve services and outcomes
- parity between board members in terms of their opportunity to contribute to the board's deliberations, strategies and activities
- shared ownership of the board by all the members (with commitment from their nominating organisations) and accountability to the communities it serves
- openness and transparency in the way that the board carries out its work

- inclusiveness in the way it engages with patients, service users and the public
- Recognition of safeguarding (adults and children) as everyone's business and a cross cutting theme ensuring that all people in Swindon are safe and their wellbeing protected

## 4 Key responsibilities

The key responsibilities of the Board are;

- To provide collective leadership, set strategic direction, prioritise local activity and present comprehensible plans of what will be done locally to address needs and improve health and wellbeing in alignment with the One Swindon priorities, outcomes and principles

- To prepare the Swindon Joint Strategic Needs Assessment which identifies the local health and wellbeing needs of our population ensuring
    - effective and meaningful engagement and dialogue with local communities and service users
    - joined up intelligence from local partners and stakeholders
    - Inclusion of comprehensive safeguarding data analysis

- To prepare the Swindon Joint Health and Wellbeing Strategy

- To promote partnership and integration of commissioning and service delivery across health, social care, public health and other service areas including but not limited to housing, leisure and transport in conjunction with One Swindon and the Health and Wellbeing Strategy

- To ensure that the plans of local and regional commissioners, including the Clinical Commissioning Group commissioning plan, support delivery of the Swindon Joint Health and Wellbeing Strategy

- To monitor, evaluate and annually report on the Clinical Commissioning Group performance as part of the Clinical Commissioning Groups annual assessment by the national Commissioning Board

- To measure progress against local plans including the Clinical Commissioning Group plans, the Joint Health and Wellbeing Strategy and other supporting plans and ensure action is taken to improve outcomes when monitoring indicators show plans or initiatives are not working

- The One Swindon Partnership Board will be accountable for ensuring that One Swindon and the One Swindon Delivery Plan support the delivery of the Swindon Joint Health and Wellbeing Strategy.

- The Board will advise the One Swindon Partnership Board on strategic matters of health and wellbeing.

- The Board will ensure that commissioning decisions support the delivery of the Swindon Joint Health and Wellbeing Strategy

- The Board will refer the Commissioning Plans back to the Clinical Commissioning Group or to the NHS Commissioning Board if they do not take sufficient account of the Swindon Joint Health and Wellbeing Strategy

- Board members are accountable to each other for mobilising and co-ordinating partners and sharing resources to deliver agreed priorities.

The work programmes of the Swindon Health and Wellbeing Board, Health Overview and Scrutiny Committee (HOSC) and Swindon Healthwatch will be shared and loosely aligned to create pathways for influence, whilst maintaining independence and the role of scrutiny.

## 5 Role of the board

In order to deliver its responsibilities, the board may decide to establish a subcommittee and delegate functions to them.

The board will do the following:

**Coordinate partnership working**

- Bring together NHS, public health and social care leaders with members of the local population and democratically elected representatives.
- Integrate the business action plans of partner organisations.
- Coordinate information sharing across partners
- Coordinate commissioning decisions to reflect the priorities identified by the board including the use of joint commissioning and pooled budgets where appropriate.
- Report to the One Swindon Partnership Board.
- Consult with service users and carers about service developments which will affect them.
- Work with the Local Safeguarding Children and Adult Boards to ensure all partners promote the safety and welfare of children and young people and receive an annual report from the LSCB and the LSAB and the SCTB.
- Maximise effective and efficient working to avoid partner organisations duplicating each others' work.
- Link with the voluntary, community and social enterprise sector

**Identify local needs**

- Lead the development of the Joint Strategic Needs Assessment which identifies local health and wellbeing needs and priorities.

**Set strategic direction and prioritise and communicate actions**

- Prioritise actions, based on the agreed strategic direction, joint commissioning strategies and Joint Strategic Needs Assessment, to meet the needs of the current population without compromising the wellbeing of future generations.
- Communicate actions in publically available action plans.

**Performance monitor**

- Evaluate performance against locally agreed priorities.
- Evaluate performance against nationally set outcomes frameworks for the NHS, public health and social care.
- Scrutinise any major service redesign of the NHS.

- Produce annual reports of progress in relation to above action plans, in order that the board is publically accountable for delivery of these actions.

## 6 Membership

The membership will consist of:
The Leader of the Council (Chair)
Chief Executive of Swindon Borough Council
Cabinet Member for Health and Social Care
Shadow Member for Health and Social Care
Director of Adult Social Care/ Children's Services
Director of Public Health
Swindon Healthwatch representative
Swindon Clinical Commissioning Group (CCG) Accountable Officer
NHS Commissioning Board representative
Third Sector representative
General Practitioner Representative

In accordance with the regulations all members of the Swindon Health and Wellbeing Board are voting members and as such will be governed by Swindon Borough Councils code of conduct

All members or co-opted members must notify the council's monitoring officer of disclosable pecuniary interests and are prohibited from participating in discussion or voting on any matter relating to their interest

## 7 Procedures

Meetings of the shadow board will be chaired by the Leader of the Council and held every two months.

A quorum shall be four members. Each member is required to attend at least four of the six scheduled Health and Wellbeing Board meetings per year. Board members of the board will nominate a deputy who will attend in their absence and have delegated authority to make decisions. Nominated deputies will form part of the quorum

The Board will operate in accordance with the council's existing decision-making framework and normal council budget setting processes. A decision to exercise any further local authority functions by the Health and Wellbeing Board would therefore need to be taken by the appropriate decision-making body (e.g. cabinet or council), and a further report would be required for this

## 8 Review Arrangements

The Swindon Health and Wellbeing Board Chair will lead an annual effectiveness review with the initial review being undertaken by March 2014.

**APPROVED:**

**DATE OF REVIEW OF TERMS OF REFERENCE:**

**NEXT REVEW:**



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**REVIEW HISTORY:**

| | |
|---|---|
| **Inaugural Terms of Reference:** | **Approved** |
| **First Review:** | **Approved Date** |
| **Second Review:** | **Approved Date** |

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# Joint Strategic Needs Assessment (JSNA) Work Plan

**Health and Wellbeing Board** **Date: 8th May 2013**

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| Author: | Acting Director of Public Health |
| Wards: | All |
| Locality Affected: | All |
| Parishes Affected: | All |

## 1. Purpose and Reasons

1.1 To determine the on-going development of the Swindon Joint Strategic Needs Assessment (JSNA).

1.2 The JSNA is an objective analysis of current and future health and wellbeing needs of the population encompassing a wide range of data. As such it is the primary process for identifying key health issues and the current and future impact of social, environmental, economic and lifestyle factors on health and wellbeing.

## 2. Recommendations

The Committee is recommended to:

2.1 Note and agree the Joint Strategic Needs Assessment development plan.

2.2 Authorise the established Joint Strategic Needs Assessment Steering Group to lead the on-going JSNA process.

2.3 Review the JSNA development as a standard agenda item at future Health and Wellbeing Board meetings.

## 3. Detail

3.1 The Health and Wellbeing boards function is to set a strategic direction for health, wellbeing and social care providing a sense of place, bringing together the key health and social care commissioners.

3.2 At the heart of the health and wellbeing board's role in joining up commissioning across health and social care, is the development of a Joint Strategic Needs Assessment (JSNA).

3.3 The 2012 Act states that the Health and Wellbeing Board has various functions. These include those conferred on it directly, such as the duty to encourage integrated working as well as a number of duties conferred jointly on the local authority and its partner Clinical Commissioning Groups (CCGs) but which must be discharged by the board. These joint duties include the preparation and publication of Joint Strategic Needs Assessment (JSNA).

Further information on the subject of this report can be obtained from Cherry Jones, 01793 444681, Cherryjones@swindon.gov.uk.

3.4 The JSNA Steering Group was established February 2012, comprising representatives of key stakeholders to undertake the task of on-going review and development of the JSNA.

3.5 The aim of the steering group is to lead and oversee the JSNA process in Swindon, ensuring that it produces high quality evidence to guide all strategy and commissioning processes that impact on population health and wellbeing.

3.6 The JSNA is not one single document but a suite of information, data, insights and intelligence.

3.7 The JSNA Steering Group meet on a monthly basis to:

3.7.1 Develop a comprehensive annual JSNA work programme to deepen understanding of population health, wellbeing and inequalities in Swindon.

3.7.2 Allocate leads, resources and support to specific JSNA projects as required and to ensure that all JSNA work is undertaken on time and to a high standard

3.7.3 Facilitate the involvement of relevant groups and individuals living or working in Swindon in the JSNA process, ensuring that local views are taken into account

3.7.4 Identify health and wellbeing priorities from JSNA work and ensure that these are communicated to (and understood by) the Health and Wellbeing Board and other relevant groups to guide their strategic and commissioning work

3.7.5 Ensure that the outcomes of JSNA work are more widely communicated through various media including the JSNA website, meetings and other means

3.7.6 Ensure that all legislation and guidance relating to JSNA is complied with.

3.8 The Swindon JSNA can be found on the following webpage; http://www.swindon.gov.uk/healthandwellbeing

3.9 The Health and Wellbeing Board use the JSNA to agree overarching priorities in order to inform the development of the Joint Health & Wellbeing Strategy (JHWS). The strategy will, in turn, inform local health and social care commissioning plans

3.10 The Joint Strategic Needs Assessment development plan is attached as Appendix One.

**4. Alternative Options**

4.1 The Health and Wellbeing Board could request a revised programme of work for the JSNA steering group.

**5. Implications, Diversity Impact Assessment and Risk Management**

Financial and Procurement Implications

5.1 There are no direct financial implications arising from the development of the JSNA work plan.

5.2 The JSNA will have strategic influence over commissioning decisions across health, public health and social care. It will strengthen democratic legitimacy through the involvement of democratically elected representatives and patient representatives in commissioning decisions alongside commissioners across health and social care.

Legal and Human Rights Implications

5.3 Legal and Human rights have been taken fully into account in compiling this report. It is considered that the recommendations within this report are compatible with Convention Rights.

5.4 In consideration of any future guidance and an understanding of best practice from elsewhere, the council will work with the NHS and other partners in order to ensure that equalities and a respect for human rights are at the heart of the development of the Swindon JSNA and that everyone in Swindon has fair access to services and are free from discrimination

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

5.5 The development of the JSNA work plan provides opportunity to improve the health outcomes of the people of Swindon and reduce health inequalities that exist across Swindon

5.6 There should be no significant staffing or other implications arising from this report

Links to One Swindon, Strategic Objectives, Plans and Policies

5.7 The JSNA informs our local strategic plans and strategies including the Health and Wellbeing Strategy.

Further information on the subject of this report can be obtained from Cherry Jones, 01793 444681, Cherryjones@swindon.gov.uk.

Diversity Impact Assessment

5.8 A Diversity Impact Assessment has been completed for the JSNA and is available on request.

Risk Management

5.9 No specific risks identified at this stage for this report.

**6. Consultees**

6.1 The Board Director Finance, Revenues, Benefits and Property (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

**7. Background Papers**

7.1 None

**8. Appendices**

8.1 Appendix One – Joint Strategic Needs Assessment development plan

Further information on the subject of this report can be obtained from Cherry Jones, 01793 444681, Cherryjones@swindon.gov.uk.

# Joint Strategic Needs Assessment (JSNA) development 2013

25th April 2013

| | |
|---|---|
| confirmed | |
| completed | |

| JSNA/PROFILE | Jan 2013 | Feb | Mar | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan 2014 | Feb | Mar | April |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Learning Disabilities adults - JSNA | | Complete | | | Easy read version | | | | | | | | | | | |
| Dementia JSNA | | | | | | 21st June Service redesign workshop | | | | | | | | | | |
| Demography Profile | | | | | | | | | | | | | | | | |
| Children and Young People – Domestic Violence JSNA | | | | | | Interim report | | | | | | | | | | |
| Mental Health adults - JSNA (inc mental wellbeing) | | | | | Interim report<br>15th & 21st Workshop | | | | | | | | | | | |
| Probation Mental Health JSNA | | | | | | | | | | | | | | | | |
| Diabetes Profile | | | | | | | 10th work shop | | | | | | | | | |
| Hepatitis B & C JSNA | | | | | | | | | | | | | | | | |
| JSNA health data summary | | | | | | | | | | | | | | | | |
| Cancer | | | | | Scoping | 6th work shop | | | | | | | | | | |

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Paediatric admissions | | | | | Scoping | | 26th work shop | | | | | | | | | |
| Employment and Economy | | | | | Scoping | | | | | | | | | | | |
| Housing | | | | | Scoping | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |

Future considerations include:

- Orthopaedics
- Ophthalmology
- Respiratory conditions
- Dermatology
- Mental Health (children) start Sept 2013 – Feb 2014
- PNA (Pharmaceutical Needs Assessment) – April 2015

http://www.pcc-cic.org.uk/article/pharmaceutical-needs-assessments-right-service-right-place

# Joint Strategic Needs Assessment (JSNA) development 2013

25th April 2013

| Topic Area | Existing local supporting reports | Selection criteria | Lead | Approved brief | Progress to date | Key Milestones/Timeline |
|---|---|---|---|---|---|---|
| **Learning Disabilities Adults JSNA** | LD Health equity audit.<br>Disability Equity Scheme 2006. | Support the Demand Enquiry work | Public Health | Agreed Oct 2012 | JSNA and Bulletin complete.<br><br>Easy read version to be drafted. | Published Feb 2013<br><br>Easy Read version May 2013 |
| **Dementia JSNA** | Building on work in JSNA Review | Support Social Care services and Demand Enquiry.<br><br>Growing public health problem. Identified in the JSNA 2012 Review | Public Health | Agreed Nov 2012 | Draft circulated to stakeholders for comments/feedback - April 2013.<br><br>Final version to JSNA Steering Group for ratification May 2013 | Ratification by JSNA steering group (SG) May 2013<br><br>Submission to HWB end May 2013<br><br>Publish May 2013 |
| **Demography Profile** | Building on work in JSNA Review | Census data published in 2012 and 2013; new SBC projection model required | Public Health | Agreed | Initial Scoping underway.<br><br>Final version to JSNA Steering Group for ratification June 13 | Ratification by JSNA SG June 2013<br><br>Submission to HWB July 2013<br><br>Publish July 2013 |

# Joint Strategic Needs Assessment (JSNA) development 2013

25th April 2013

| Topic Area | Existing local supporting reports | Selection criteria | Lead | Approved brief | Progress to date | Key Milestones/Timeline |
|---|---|---|---|---|---|---|
| **Children and Young Person's JSNA - Domestic Violence** | Child Poverty Needs Assessment 2011.<br><br>Infant mortality 2010.<br><br>Maternity needs assessment 2008. | Impact of Domestic Violence on families – support and inform the Domestic violence Strategy and implementation plan. | Public Health | Agreed Dec 2012 | Scoping completed<br><br>First draft underway<br><br>Strategy and Implementation plan workshop scheduled June 2013 | Publish Aug 2013<br><br>Interim report April 2013 |
| **Diabetes Profile** | Local Diabetes Profile | Rise in obesity. Cost of diabetes. Poor disease management.<br><br>Identified in the JSNA 2012 Review | Public Health | Agreed Feb 2013 | Update of 2010 local diabetes profile. | Publish June 2013 |
| **Mental Health and Wellbeing Adults JSNA** | Building on CAMHS report and Suicide audit (Excluding drugs and alcohol) | Identified in the JSNA 2012 Review | Public Health | Agreed Dec 2012 | | Interim report May 2013<br><br>Publish August 2013 |

# Joint Strategic Needs Assessment (JSNA) development 2013

25th April 2013

| Topic Area | Existing local supporting reports | Selection criteria | Lead | Approved brief | Progress to date | Key Milestones/Timeline |
|---|---|---|---|---|---|---|
| **Probation Mental Health JSNA** | Supports the wider mental health JSNA | Working with Wiltshire Public Health & Wiltshire & Swindon probation services | Public Health | Agreed | | First draft May 2013<br>Publish June/July 2013 |
| **Hepatitis B & C JSNA** | Building on previous equity audit and Drugs Needs Assessment | Publication of new NICE Guidelines and anticipated National Liver Strategy | Public Health | Agreed | | Publish July 2013 |
| **Learning Disability (Children) JSNA** | Building on work from Adult JSNA | | Public Health | Yet to be scoped | | Dates to be confirmed - 2014 |
| **Cancer** | Scoping document available May 2013 | | | | | |
| **Paediatric Admissions** | Scoping document available May 2013 | | Commissioning Support Unit (CSU) | | | |
| **Employment and Economy** | Scoping document available May 2013 | | | | | |

## Joint Strategic Needs Assessment (JSNA) development 2013

25th April 2013

| Topic Area | Existing local supporting reports | Selection criteria | Lead | Approved brief | Progress to date | Key Milestones/Timeline |
|---|---|---|---|---|---|---|
| **Housing** | Scoping document available May 2013 | | | | | |
| **Future considerations include:**<br>• **Orthopaedics**<br>• **Ophthalmology**<br>• **Respiratory conditions**<br>• **Dermatology**<br>• **Mental Health (children) start Sept 2013 – Feb 2014**<br>• **PNA (Pharmaceutical Needs Assessment) – April 2015** | | | | | | |

# Health and Wellbeing Draft Strategy

**Health and Wellbeing Board** **Date: 8th May 2013**

| | |
|---|---|
| Author: | Acting Director of Public Health |
| Wards: | All |
| Locality Affected: | All |
| Parishes Affected: | All |

## 1. Purpose and Reasons

1.1 This report presents the first draft of the Swindon Health and Wellbeing Strategy (HWS).

1.2 The Health and Social Care Act 2012 set out a new vision for the leadership and delivery of public services and supports the principle of local clinical leadership and democratically elected leaders working together to deliver the best health and care services based on the best evidence of local needs.

1.3 The Health and Wellbeing Board has a duty to produce a Health and Wellbeing Strategy (Health and Social care Act 2012) informed by the needs of its population outlined in its Strategic Needs Assessment (JSNA).

1.4 Clinical Commissioning Groups (CCG's), the NHS Commissioning Board (NHS England) and local authorities plans for commissioning services are expected to be informed by the JSNA and HWS.

1.5 The CCG must demonstrate that their commissioning plans have taken proper account of the JSNA and HWS and consult on them with the Health and Wellbeing Board. When consulted the Health and Wellbeing Board must give a view, and their final opinion must be included in the CCG's final commissioning plan.

## 2. Recommendations

The Committee is recommended to:

2.1 Note the progress in the development of the Swindon Health and Wellbeing Strategy.

2.2 Authorise the Acting Director of Public Health to update the draft strategy taking on board the various feedback and comments from the contributions of the various stakeholders involved in the engagement process to date of developing the strategy

2.3 Authorise the Acting Director of Public Health to launch a consultation on the revised version of the draft Health and Wellbeing Strategy.

Further information on the subject of this report can be obtained from Cherry Jones, 01793 444681, Cherryjones@swindon.gov.uk

**3. Detail**

3.1 The Swindon Health and Wellbeing Strategy will set the overarching framework for health and care commissioning plans across the borough. The Health and Wellbeing Board has a duty to produce a Health and Wellbeing Strategy (Health and Social care Act 2012) informed by the needs of its population outlined in its Joint Strategic Needs Assessment (JSNA)

3.2 Swindon's Health and Wellbeing draft strategy was commissioned by the Swindon Shadow Health and Wellbeing Board and aims to improve the health and wellbeing of children and adults in the borough and to reduce the health inequalities that exist across our community.

3.3 A Health and Wellbeing Strategy development working group was established with membership from the local authority, the shadow CCG, the Swindon LINk and Public Health.

3.4 The draft Strategy has been developed informed by the Swindon Joint Strategic Needs Assessment and aligned with the One Swindon priorities, the national and local frameworks and feedback from various stakeholders following a widespread and on-going engagement process.

3.5 The vision for the draft strategy was agreed by the Shadow health and Wellbeing Board as ***Everyone in Swindon lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities***.

3.6 Five outcomes have been identified for the strategy along with a number of related priorities

3.6.1 Every child and young person in Swindon has a healthy start in life

3.6.2 Adults and older people in Swindon are living healthier and more independent lives

3.6.3 Improved health outcomes for disadvantaged communities

3.6.4 Improved mental health, wellbeing and resilience for all

3.6.5 Creation of sustainable environments in which communities can flourish

3.7 A revised iteration of the strategy is underway taking on board all the comments and feedback gathered during the engagement process with the intention to have a final version available for public consultation at the end of May.

3.8 Following consultation the final version will be presented to the Health and Wellbeing Board for ratification July 2013.

Further information on the subject of this report can be obtained from Cherry Jones, 01793 444681, Cherryjones@swindon.gov.uk

**4. Alternative Options**

4.1 Not to have a further consultation process.

**5. Implications, Diversity Impact Assessment and Risk Management**

Financial and Procurement Implications

5.1 There are no direct financial implications arising from the development of the Health and Wellbeing Strategy.

5.2 The Health and Wellbeing Strategy will have strategic influence over commissioning decisions across health, public health and social care. It will strengthen democratic legitimacy through the involvement of democratically elected representatives and patient representatives in commissioning decisions alongside commissioners across health and social care.

Legal and Human Rights Implications

5.3 Legal and Human rights have been taken fully into account in compiling this report. It is considered that the recommendations within this report are compatible with Convention Rights.

5.4 In consideration of any future guidance and an understanding of best practice from elsewhere, the council will work with the NHS and other partners in order to ensure that equalities and a respect for human rights are at the heart of the development of the Swindon Health and Wellbeing Strategy and that everyone in Swindon has fair access to services and are free from discrimination

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

5.5 The Health and Wellbeing Strategy provides opportunity to improve the health outcomes of the people of Swindon and reduce health inequalities that exist across Swindon.

5.6 There should be no significant staffing or other implications arising from this report

Links to One Swindon, Strategic Objectives, Plans and Policies

5.7 The Health and Wellbeing Strategy will align with and contribute to the delivery of One Swindon and the SBC Corporate objectives.

Diversity Impact Assessment

5.8 A Diversity Impact Assessment has been completed for the Health and Wellbeing Strategy and is available on request.

Further information on the subject of this report can be obtained from Cherry Jones, 01793 444681, Cherryjones@swindon.gov.uk

Risk Management

5.9 No specific risks identified at this stage for this report.

**6. Consultees**

6.1 The Board Director Finance, Revenues, Benefits and Property (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

**7. Background Papers**

7.1 Health and Social Care Act 2012

7.2 The Swindon JSNA

**8. Appendices**

8.1 Appendix One. Swindon's Draft Health and Wellbeing Strategy 2013 - 2016

Further information on the subject of this report can be obtained from Cherry Jones, 01793 444681, Cherryjones@swindon.gov.uk

# SWINDON'S DRAFT HEALTH AND WELLBEING STRATEGY 2013 - 2016

*Swindon's Health and Wellbeing Board*

# Swindon's draft Health and Wellbeing Strategy

## Introduction

Leaders from across the community have come together to form Swindon's Shadow Health and Wellbeing Board. The focus of the board is on improving health and wellbeing so that individuals and communities are able to live healthier lives, and to ensure that everyone in Swindon has a positive experience of the health and care system. Health and wellbeing is more than the absence of disease; it is the ability for everyone to fulfil their potential, make a contribution and to be resilient to life's challenges. With that in mind, we have adopted the approach that health and wellbeing is the ability to adapt and to self-manage in the face of social, physical, and emotional challenges and to function with fulfilment and a feeling of wellbeing.

The Health and Social Care Act 2012 places health and wellbeing boards at the centre of planning to transform health and social care and achieve better population health and wellbeing. Health and wellbeing boards have been given a number of core responsibilities. These include assessing the health and wellbeing needs of the local population through the Joint Strategic Needs Assessment (JSNA) and preparing a Health and Wellbeing Strategy.

The Shadow Health and Wellbeing Board commissioned a health and wellbeing strategy steering group with representation from the Swindon LINk, the Clinical Commissioning Group, Swindon Borough Council, NHS Swindon and Public Health to develop a draft strategy. This process has included a series of discussions and workshops, engaging with a wider stakeholder audience, to identify and agree our local priorities.

This is the first Health and Wellbeing Strategy for Swindon and sets out the vision and the long term improvements in local people's health and wellbeing that we want to achieve in Swindon. It also sets out our priorities for action and indicators that will help us measure progress. (See Appendix One for a summary table). The strategy will be monitored and reviewed by the Swindon Health and Wellbeing Board (currently in shadow form) every six months and revised annually informed by and reflecting the latest JSNA findings.

The Health and Wellbeing Board's vision is that everyone in Swindon lives a healthy, safe, fulfilling and independent life supported by thriving and connected communities. The aim is to improve health and wellbeing outcomes especially for those communities and groups who experience the poorest health. Health and wellbeing in Swindon is improving and we must make sure that it continues to improve. We believe by working together we can make significant differences to everyone's health and wellbeing.

This strategy comes at a time of huge challenges for Swindon from:

- An ageing population.
- A growing burden of lifestyle related ill-health, particularly due to physical inactivity, obesity and smoking.
- A growing need for savings across the public sector finances, including health and social care services.
- Significantly poorer health in our most disadvantaged communities.

This strategy sets the context for other health and wellbeing plans and for commissioning of integrated NHS, public health, social care and related children's services. The Board will work with all partners to help align policies, services, resources and activities with the Health and Wellbeing Strategy and to ensure joined up action to tackle issues that will benefit from multi agency working.

The Health and Wellbeing Board will expect that the commissioning plans of the Local Authority, the Clinical Commissioning Group and the local NHS are consistent with the Strategy, as required by the Health and Social Act 2012.

## Swindon's Vision

Everyone in Swindon lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities.

## Purpose of the strategy

The Health and Wellbeing Strategy for Swindon is aligned with the Swindon Sustainable Community Strategy and the One Swindon framework to deliver our health and wellbeing vision. It focuses on the health and social care issues for everyone living in Swindon, but also recognises the wider factors that affect health and wellbeing including education, employment, housing and leisure, all of which are under pinned by other more detailed strategies and plans.

To achieve our vision we must work together across organisations and alongside our community, building on strengths of our communities, to improve the quality of life and wellbeing for all. Everyone in Swindon has to play their part if we are to succeed. The vision is about improving the experience of people throughout their lives in terms of health and wellbeing, enabling individuals to make positive choices to lead healthier lifestyles and about reducing inequalities.

The purpose of this strategy is to:

- Set out the vision of what we want to achieve for health and wellbeing in Swindon
- Identify the key priorities for improving health and wellbeing
- Drive and influence the delivery of health care
- Provide an integrated framework that aligns with other local strategies
- Improve health and wellbeing for everyone and reduce health inequalities
- Maximise the opportunities local assets afford us
- Engage with local partners and communities to ensure local needs are being met

## Swindon's Priorities

The strategy builds on a number of collaborative pieces of work undertaken in Swindon with a wide range of stakeholders that focus on working together to improve people's health and wellbeing in Swindon (One Swindon, The Swindon Sustainable Communities Strategy – A Shared Vision for Swindon 2008 -2030). In developing this strategy we have agreed five high level outcomes for Swindon. The health and wellbeing priorities have been chosen based on a set of criteria outlined in Appendix two. Work done to agree these priorities drew upon evidence from the Swindon Joint Strategic Needs Assessment (JSNA) and following engagement with organisations and groups who work in the area of health and wellbeing.

## Outcomes:

1. Every child and young person in Swindon has a healthy start in life
2. Adults and older people in Swindon are living healthier and more independent lives
3. Improved health outcomes for disadvantaged and vulnerable communities (including adults with long term conditions, learning disabilities, physical disabilities or mental health problems)

4. Improved mental health, wellbeing and resilience for all
5. Creation of sustainable environments in which communities can flourish

## OUTCOME 1

## Every child and young person in Swindon has a healthy start in life

All children and young people in Swindon deserve the best start in life and we want them to enjoy life, to achieve, to stay safe from harm, to be healthy and to grow up to reach their full potential making a positive contribution to society. We know that health in later life is strongly influenced by childhood experiences and focusing now on ensuring that they have the best opportunities early in life will not only improve their individual health but also that of the whole family. Helping our young people to prepare, from an early age, to be self-sufficient and develop a network of support will enable them to live independent and healthy lives.

Focussing on the first few years of a child's life (especially those who are more disadvantaged and vulnerable) will ensure that every child is given the best possible start in life and benefit them for the rest of their lives. We will continue to review and build on our services using an evidence based approach to target early intervention and preventative programmes that will ensure our young people have the best start in life and prepare them for adulthood.

**The local issues**

- GCSE attainment is significantly worse than the average for England with just under 50% achieving 5+GCSE's or equivalent A* to C including English and Maths (England average is 55.2%)
- The number of young people who are not in education, employment or training is high
- 6,786 children aged 0-15 were known to be living in poverty 2010
- Swindon has a high rate of hospital admissions for alcohol specific conditions for under 18 years old compared with the England average (94.9 per 100,000 compared with 61.8 for England)
- Nearly 15% of pregnant women continue to smoke throughout their pregnancy
- Over 17% of 10 to 11 year olds in Swindon are obese
- Nearly 50% of mums stop breastfeeding at the 6 to 8week stage - Swindon has one of the highest drop off rates in the country for breastfeeding
- 17% of primary school children are from Black and Minority Ethnic groups (15% of secondary school children) with 11% of school children have English as their second language
- There are rising numbers of children in care in Swindon
- High rates of hospital admissions for self-harm amongst children under 18 years old.
- Younger children have high support needs indicated by the high numbers of children in need and the small increase seen in children coming into care due to neglect
- 370 families with complex needs live in Swindon
- Children in local authority care are more at risk of having poor emotional health and wellbeing

**Our Priorities**

- Improve the mental wellbeing of children and young people
- Reduce risky behaviours (e.g. smoking, drinking) amongst our children and young people
- Keep all children and young people safe
- Improve educational attainment of our children and young people
- Reduce the number of young people not in education, employment or training

## OUTCOME 2

## Adults and older people in Swindon are living healthier and more independent lives

The age structure of our local population means that Swindon will see a very big increase in the number of older people in the future. Many people will have long term health conditions such as diabetes or heart disease in middle age, but there is scope to prevent ill health and disability in people - early action would improve their quality of life and slow down the future growth in health and social care requirements for older people. Everyone has a role to improve their health and wellbeing and that of their families and to take responsibility for their own health and wellbeing. Lifestyle choices can have a direct impact on health and wellbeing and changing behaviours such as stopping smoking, eating and drinking more healthily and being more physically active can prevent the onset of some diseases and prevent premature death from diseases such as cancer and heart disease.

Older people make a valuable contribution to the communities across Swindon and it is important to support, expand and grow this asset ensuring that older people with energy, skills and time to give play a role and contribute to the local community.

We want to enable people to stay independent and safe and enjoying the best possible quality of life. The changing age structure in Swindon will also mean more people will be living with Dementia. This priority sets out our aim to improve the quality of life and not just extend life and also highlights the need to support carers and their role in the community.

Older people often need care and support from a number of different services following an illness or admission to hospital and we need to ensure an integrated service provision that works together and focuses on regaining and

promoting independence working with local communities and social networks to help people remain in their own home for as long as possible.

**The local issues**

- Average male and female life expectancy has increased over the years and is now 78.6 years for men and 83.1 years for women
- Population projections show an expected increase of 14% in people aged 65 years or more by 2015 rising to a 34% increase by 2022- that's an extra 4,000 people over 65 by 2015 and an extra 9,800 by 2022
- 21.8% of adults smoke in Swindon
- In 2010/11 172 people over 65 years old had a hip fracture
- 2,014 people over 65 years old are estimated to have dementia in Swindon and this is expected to increase by over 95% by 2030
- 3,617 people over 65 years old are estimated to have diabetes and this is expected to increase by over 73% by 2030
- Currently in Swindon the use of hospital services almost doubles from the 45 to 64 age group to those aged 65 to 74
- Nationally the number of people aged 65+ with some disability is projected to increase by 40% by 2022, in Swindon the projected increase is 74% (from 24,800 in 2001 to 43,177 in 2026)

**Our Priorities**

- Strengthen integrated working between health and social care
- Reduce the number of people suffering from long term conditions through the promotion of healthy lifestyle choices
- Promote independence and reduce the need for hospital services and long term care
- Ensure that carers needs are met

## OUTCOME 3

## Improved health outcomes for disadvantaged and vulnerable communities (including adults with long term conditions, learning disabilities, physical disabilities or mental health problems)

There is a strong link between poverty and health; the poorer you are the unhealthier you are likely to be. This is caused by many things, including

differences in housing conditions, diet, levels of smoking and drinking, access to sport and leisure, social and support networks as well as barriers to accessing healthcare (such as language and literacy barriers).

We experience significant differences in life expectancy in Swindon between people living in our more affluent areas compared to those living in our less affluent areas. We also know that some of our more vulnerable communities (including those with learning disabilities, mental health issues and from our black and minority ethnic communities) will experience poorer health outcomes and that they are less likely to access health services.

Focusing on prevention and early detection of the conditions most strongly related to health inequalities such as cardio vascular disease, cancer, respiratory disease and diabetes will help to reduce the gap in life expectancy that we have in Swindon. It is important to prevent people becoming ill and developing these long term conditions. We can do this by addressing some key lifestyle factors which we know are more prevalent in the less affluent areas of Swindon as well as addressing the wider determinants of health (housing, educational attainment, employment).

**The local issues**

- Life expectancy in our less affluent areas is significantly less that our most affluent areas with women living on average
- In 2009 a total of 14.3% of the borough's resident population belonged to black and ethnic minority (BME)
- 11% of Swindon school pupils have English as a second language (up from 7% in 2010), with a total of 104 languages being spoken
- 7,285 children were classed as living in poverty in 2009
- 16.3% of Swindon adults aged 60 and over (approx. 6,800) were identified as
- People living in the most deprived areas of Swindon were almost four times as likely to be admitted to hospital for alcohol-specific reasons than people living in the least deprived areas
- On average 21.8% of the adult population smoke but a recent survey conducted in Penhill showed that nearly 50% of people questioned were smokers

**Our Priorities**

- Ensure access to information and advice that supports choice and control
- Ensure people from disadvantaged groups receive good quality care for their physical health

- Local economic and social policies are developed to strive to narrow social inequalities rather than widen them
- Prevent early death and disease through healthier lifestyle choices, early detection and screening

## OUTCOME 4
## Improved mental health, wellbeing and resilience for all

We want everyone in Swindon to enjoy the best possible mental health and wellbeing and have a good quality of life. This would mean that everyone has a greater ability to manage their own lives, a sense of belonging within their communities, the skills they need for living and working and a greater sense of purpose. Good mental health is fundamental to physical health, relationships, education and training, employment and to fulfilling ones potential. Mental health problems such as depression are more common in people with physical illness and having both physical and mental health problems will impact upon recovery from both. We know that people with poor mental wellbeing are more likely to smoke, drink unhealthily, be obese, eat unhealthily and be less physically active - all of which contribute to their physical health and longer term health outcomes.

Effective collaboration between many agencies is vital to ensure that a wide range of community resources are available to promote recovery, dispel the stigma and discrimination around mental health and support and sign post people appropriately.

**The local issues**

- At least one in four people will experience a mental health problem at some point in their life
- An estimated 29,000 people in Swindon have a common mental health disorder
- There was an average of 317 hospital admissions a year for self-harm of Swindon people aged 15+ between 2001/02 to 2008/09
- The highest admission rates for self-harm in Swindon were amongst women in the 15-29 and 30-44 age groups
- An average of 16 Swindon residents a year died of suicide or undetermined causes from 2001 to 2009, with three quarters of these being men
- There are strong links with deprivation and social fragmentation for both suicide and self-harm
- There are estimated to be 532 injecting drug users in Swindon

**Our Priorities**

- Develop effective pathways for people with mental health problems
- Increase the opportunities for people with mental health problems to access support services and community facilities aimed at promoting recovery ( eg education, debt management, housing, leisure services, health promotion)
- Promote positive mental health and recognise that mental health is everyone's business
- Reduce the stigma and discrimination associated with mental ill health

## OUTCOME 5

## Creation of sustainable environments in which communities can flourish

We will focus on developing communities that have a positive impact on the way people live and how they feel about their neighbourhood. We know that well connected and vibrant communities provide a resilient and supportive local environment.

It is important to appreciate and mobilise individual and community talents, skills and assets and not just focus on problems and needs. This helps to empower communities to use their own resources and skills and helps combat the idea that people are passive recipients of services.

Community assets are more than just the physical assets such as parks, leisure facilities, open spaces but are also the skills of local residents, the power of local associations and the supportive functions of local institutions. Local assets can be considered to be the primary building blocks of sustainable community development and as such have a vital contribution to make to the health and wellbeing of the community. Drawing upon existing community strengths will ensure the building of stronger more sustainable communities for the future.

It is recognised that transport, green spaces and the built environment play a key role in determining our health and wellbeing. Sustainable communities are places in which people want and are able to live and work, now and in the future. They meet the diverse needs of existing and future residents, are sensitive to their environment and contribute to a high quality of life. They are safe and inclusive, well planned, built and run, offering equality of opportunity and good services for all.

**Our Priorities**

- 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.
- Work with our local communities to develop creative solutions for local issues
- 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
- Promote the use of green, open spaces and activities such as walking and cycling
- Maintain effective public transport and transport networks which ensure access to services and activities, encourage permeability within communities

## Next steps

This is the first draft of the Swindon Health and Wellbeing Strategy and draws upon the JSNA evidence base highlighting the issues and needs of our local population.

The next steps in the development process are:

- Wider stakeholder engagement and feedback
- Ratification of the strategy by the Shadow Health and Wellbeing Board

**References**

Swindon community Strategy
http://www.talkswindon.org/politics/leaflet_archive/2008%2001%2001%20Rod%20Bluh%20-%20Vision%20For%20Swindon_2008-2030.pdf

JSNA 2012 Review
http://www.swindon.gov.uk/sc/sc-healthmedicaladvice/Pages/sc-jsna.aspx

One Swindon
http://www.swindonsp.org.uk/draft_del_plan_app_2_-_cab_report_-_27.5.pdf

DRAFT

Appendix One. Summary

# Vision

**Everyone in Swindon lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities**

| Outcomes | Priorities |
|---|---|
| *Every child and young person in Swindon has a healthy start in life* | **1.** Improve the mental wellbeing of children and young people<br>**2.** Reduce risky behaviours (e.g. Smoking, drinking) amongst our children and young people<br>**3.** Keep all children and young people safe<br>**4.** Improve educational attainment of children and young people<br>**5.** Reduce the number of young people not in education, employment or training |
| *Adults and older people in Swindon are living healthier and more independent lives* | **6.** Strengthen integrated working between health and social care<br>**7.** Reduce the number of people suffering from long term conditions through the promotion of healthy lifestyle choices<br>**8.** Promote independence and reduce the need for hospital services and long term care<br>**9.** Ensure that carers needs are met |
| *Improved health outcomes for disadvantaged and vulnerable communities* | **10.** Ensure access to information and advice that supports choice and control<br>**11.** Ensure people from disadvantaged groups receive good quality care for their physical health<br>**12.** Local economic and social policies are developed to strive to narrow social inequalities rather than widen them<br>**13.** Prevent early death and disease through healthier lifestyle choices, early detection and screening |
| *Improved mental health, wellbeing and resilience for all* | **14.** Develop effective pathways for people with mental health problems<br>**15.** Increase the opportunities for people with mental health problems to access support services and community facilities aimed at promoting recovery (e.g. education, debt management, housing, leisure services, health promotion)<br>**16.** Promote positive mental health and recognise that mental health is everyone's business<br>**17.** Reduce the stigma and discrimination associated with mental ill health |
| *Creation of sustainable environments in which communities can flourish* | **18.** 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.<br>**19.** 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<br>**20.** Promote the use of green, open spaces and activities such as walking and cycling<br>**21.** Maintain effective public transport and transport networks which ensure access to services and activities and encourage permeability within communities |

Appendix two.

## Criteria for prioritisation

The priorities outlined in this Health and Wellbeing Strategy have been chosen because they:

- deliver the most benefit to our population
- impact upon health inequalities
- have the potential to improve health and wellbeing
- affect a large number of people across all age ranges
- require strong leadership and coordinated action across organisations and our communities in order to secure change
- are informed and based on evidence identified by our JSNA and the views of stakeholders

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# Commissioning Plan

**Health & Well-being Board** **Date: 8 May 2013**

Author: Paul Bearman, Executive Director of Commissioning,
NHS Swindon Clinical Commissioning Group

Wards: All

Locality Affected: All

Parishes Affected: All

## 1. Purpose and Reasons

1.1 The Commissioning Plan sets out the approach by the Swindon CCG to the procurement of health services to deliver the 2013/14 Commissioning Intentions.

1.2 The Commissioning Plan is prepared as part of the NHS Commissioning process.

## 2. Recommendations

The Health & Well-being Board is recommended to:

2.1 Agree the Commissioning Plan.

## 3. Detail

3.1 The Commissioning Plan 2013-14, A Clear & Credible Plan, is the document that brings together the 'Commissioning Intentions' and the 'Strategy for Care' into an operational plan and we are now consulting on the plan.

3.2 The Plan outlines the approach and progress made by the CCG in the 2013/14 contracting round with its healthcare providers. The plan includes the activity assumptions for 2013/14, proposed contract values with the main Swindon providers and the anticipated savings from the Quality, Innovation, Productivity and Prevention Programme. These figures will be further refined as the contracting round is concluded and the business cases to support the QIPP programme are developed.

3.3 Additional work will be completed during 2013/14 to fully understand the workforce requirements for the future and also on modelling the financial and activity consequences of the population growth in Swindon.

3.4 Assuming that the Health & Well-being Board formally agree the Swindon Clinical Commissioning Group's Plan for 2013-14 and a statement will be included within the Plan detailing the support of the Health & Well-being Board in ensuring that the Commissioning Plan contributes towards the delivery of the Swindon Joint Health & Well-being Strategy.

Further information on the subject of this report can be obtained from Paul Bearman, Direct Dial 01793 444603, executivedirectorcommissioning@swindonccg.nhs.uk.

**4. Alternative Options**

4.1 None

**5. Implications, Diversity Impact Assessment and Risk Management**

Financial and Procurement Implications

5.1 The Commissioning Plan outlines the proposed investments and commitments to improving health and healthcare for the people of Swindon & Shrivenham.

Legal and Human Rights Implications

5.2 None

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

5.3 None

Links to One Swindon, Strategic Objectives, Plans and Policies

5.4 The Commissioning Plan does link to the Health & Well-being Strategy and the One Swindon and Strategic Objectives.

Diversity Impact Assessment

5.5 To be completed for specific service redesign projects.

Risk Management

5.6 The implementation of the Commissioning Plan is considered in the CCG Board Assurance Framework.

**6. Consultees**

6.1 The Commissioning Plan is being circulated to a range of shareholders prior to being finalised and approved by the NHS Swindon CCG Governing Body.

Further information on the subject of this report can be obtained from Paul Bearman, Direct Dial 01793 444603, executivedirectorcommissioning@swindonccg.nhs.uk.

NHS
NHS Swindon
Shadow Clinical Commissioning Group

# SWINDON CLINICAL COMMISSIONING GROUP

## A Clear and Credible Plan

**Commissioning Plan for 2013-2014**

5th April 2013

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## Foreword

Swindon Clinical Commissioning Group (CCG) was authorised from the 1st April 2013 with one condition (the production of a clear and credible plan), at which point we took on our mission to improve the health of 220,000 people registered with 26 GP practices in and around Swindon, and be responsible for commissioning just over £235m of local health services in 2013-2014.

This document sets out our commissioning plan for 2013/14 to procure health care and health improvement from a range of providers who will take forward our mission **to optimise the health of the people of Swindon**.

It should be read in the context of two further documents: 'Strategy for Care' and the 'Commissioning Intentions for 2013/14' which set out the longer term vision for commissioning and our proposals for 2013/14 respectively. These documents summarised the priorities for health and health service improvement that we have jointly agreed with our partners in One Swindon as part of our Joint Strategic Needs Assessment and Health and Wellbeing Strategy.

The Commissioning Intentions set out our investment proposals to deliver significant and measurable improvement in each of those areas over the next twelve months. Finally, they set out our assumptions for general growth or reduction in activity, inflation and cost pressures, and quality, innovation productivity and performance improvement.

This Commissioning Plan demonstrates how the strategy and the commissioning intentions will be implemented for 2013/14.

This Commissioning Plan will be considered by the Swindon Health and Wellbeing Board once the contracting negotiations with our providers has been concluded.

Peter Crouch
Chair
Swindon Clinical Commissioning Group

Paul Bearman
Executive Director of Commissioning
Swindon Clinical Commissioning Group

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## Glossary

### Key definitions and explanation of terms / abbreviations

| | |
|---|---|
| **Acute care** | Often referred to as emergency care, this is treatment or diagnosis needed so immediately or urgently that not to do so might be life threatening |
| **Admission** | When treatment or diagnosis requires someone to stay in hospital rather than be treated at home or in the community, they are "admitted" to that hospital |
| **Admission rate** | The number of people in a local population who are admitted to hospital in any year compared with the rest of the country |
| **Aim** | A medium to long term goal i.e. something that we plan to do over the life of our strategy. If you don't aim then you are likely to miss! |
| **Ambulatory care** | Rapid access, fast access, immediate and urgent care where the patent can walk in to a centre and be seen or be directly referred by a doctor, nurse or therapist to avoid the need to admit a patient |
| **Assurance** | The policies, procedures, systems and arrangements by which the public, those partners and external bodies to whom Swindon CCG is accountable, and its own Governing Body can be reassured that we are doing what we say we will do and in the way in which we said we would do it |
| **Austerity and austerity measures** | Long term savings plans and other changes brought in as a consequence of reductions in income |
| **Baseline assumption** | This is the money that an organisation will assume it has as a minimum |
| **Business cycle** | The annual timetable of plans, guidelines and publications. See also Commissioning Cycle |
| **Care Quality Commission (CQC)** | Reviews all providers to ensure that they meet the standards set out in law to provide safe healthcare of an acceptable quality. CQC has the power to close a service or to require immediate action to avoid closure, when their inspections find a service to be below standard |
| **Chronic illness** | A condition which a patient has for a considerable time and which can be referred to as a long term or even life-long condition. An illness that takes time from which to recover and/or can be permanently disabling |
| **Clinical Commissioning Group (CCG)** | An authorised body that is part of the NHS and has the responsibility for improving health and for planning and contracting for healthcare on behalf of a local population |

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|---|---|
| **Commissioning** | The task of defining the health service needs of a local population and then contracting with an appropriate range of providers to allow both choice and the safe, effective, accessible and timely delivery of healthcare to meet those needs |
| **Commissioning cycle** | The annual process of strategic development, contract review, management and negotiations with key deadlines set by the Department Of Health each year, and informed by the annual publication of planning and priorities guidance, usually in December of each year. |
| **Community care** | Care delivered in a local neighbourhood and in the home. |
| **Consensus building** | where there is early disagreement on which of a number of change options is best, continuously refining the options until everyone is prepared to accept the same proposed solution |
| **Constraints theory** | A management theory that makes systems of care more effective and efficient by concentrating on where there are blocks or delays in progressing care and eliminating these |
| **Consulting** | providing people with information on a proposed change in services and its impact; encouraging them to comment and make alternative suggestions |
| **Critical mass** | A volume of care, activity or service that is sufficient to ensure that those who are providing care are sufficiently practised to offer safe care. Similar to the minimum number of air miles a pilot must do each year to retain a licence, usually only applied to specialist and rare healthcare |
| **Demography** | The analysis of population by age, gender and other factors that can influence health |
| **Discharge Planning** | The process of preparing for a patient to leave hospital |
| **End state vision** | What services or providers will look like once all proposed changes have been implemented fully. Important in ensuring there are no unintended consequences of individual changes |
| **Engaging** | actively seeking people to become informed and involved |
| **Finished Consultant Episode** | A completed episode of hospital care. This is one way of measuring the number of patients who have been admitted to hospital |

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|---|---|
| **Governance** | The policies, procedures, systems and management arrangements by which Swindon CCG ensures we deliver our strategies and plans within the rules and regulations with which we must comply. |
| **Governing Body** | The Governing Body is the Board of a CCG comprising principally local clinicians drawn from general practice (GPs, nurses, and practice managers), and from local hospital and other health services. The Governing Body can also appoint lay members and experienced finance, strategy, commissioning or similar experts, but should remain predominantly clinical in its membership. |
| **GVA or Gross Value Added** | A way of measuring business growth in an area |
| **Health** | A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity |
| **Health and Wellbeing Board** | A joint committee of Swindon Borough Council, Swindon PCT and Swindon CCG with the responsibility for developing a single "Health and Wellbeing Plan" for improving health across Swindon |
| **Health economy or health system** | The collection of health care organisations in an area which together represent the totality of healthcare and health service investment serving the same community. For example, all of the healthcare providers and the PCT/CCG in Swindon would together be known as the Swindon health economy or health system |
| **Health services** | Individuals, teams, departments or organisations whose role is to provide healthcare |
| **Healthcare** | The provision of nursing, therapy, medical, surgical diagnostic, drug, consultations, counselling and other care, intervention and treatment designed to improve health, prevent the onset of illness, address disease and illness, remedy harm and injury or recuperation following a period of poor health or injury |
| **Healthwatch** | To replace LINk (Local Involvement Network) from April 2013 but with additional powers and responsibilities including a place on the Health and Wellbeing Board, also taking on PALS (Patient Advice and Liaison Service) and ICAS (Independent Complaints Advisory Service )responsibilities, and with the ability to escalate local issues to Healthwatch England (who have direct links to Monitor, the NHS Commissioning Board, the Care Quality Commission and Secretary of State for Health) |
| **Hospitalisation rate** | Hospitalisation rate then measures if more or less patients than comparable elsewhere are being admitted to hospital |

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|---|---|
| **ICAS** | Independent Complaints Advisory Service assists patients with complaints, especially those which are complex or where the complainant needs assistance in order to articulate their concerns |
| **Informing** | giving people information |
| **Innovation** | A new approach or way of doing something |
| **Intelligent commissioner** | A body that plans and contracts for healthcare informed by the best information on health and health risks, provider performance, pathways of care, future workforce requirements, local population needs and the capacity needed to meet these local health priorities and the best means to respond |
| **Involving** | providing people with the opportunity to be part of an activity (whether planning or designing services, choosing where money should be spent or reviewing the performance of local services) |
| **Joint Strategic Needs Assessment** | An analysis of our community's health and wellbeing, looking at life expectancy, life circumstances, diseases, employment, housing, poverty and other wider determinants of health in Swindon. Formulation of a JSNA helps to inform the creation of an agreed set of priorities for improvements in health shared by Swindon Borough Council, Swindon PCT and Swindon CCG |
| **LEAN methodology** | A management theory that removes variation in the way in which services are delivered and promotes the concept of "right first time". Successful in many other industries, it has seen the delivery of quality as an important factor for the delivery of value for money, (since much waste is due to the need to redo poor quality work) |
| **LINk** | Local Involvement Network. An independent network of thousands of individuals and local groups with the single and important aim of improving local health and social care (see also Healthwatch above) |
| **Locality** | Used in two senses in this document: the CCG is split into 3 localities of GP practices; Swindon Borough has 7 localities with Locality workers and forums |
| **Long term conditions** | Illnesses which we have for long periods of time or even for the rest of our lives, for example diabetes. (See also Chronic Illness above) |
| **MAU**<br>**Medical Assessment Unit** | A unit in a hospital where patients will be assessed for periods of usually up to 12 hours before either being admitted onto a ward, being referred to ambulatory care or being sent home with support. |
| **Mission** | One organisation's contribution towards delivering a Vision e.g. *we will be the first to put a man on the moon* |
| **Monitor** | Oversees the performance of NHS Foundation Trusts |

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|---|---|
| **NHS Commissioning Board** | Responsible for planning and contracting for specialist services (specialist healthcare often not provided by local health services so planned for on a regional basis) and for the performance and conduct of CCGs, including their authorisation |
| **NHS Trust** | A provider of health care, either an NHS Trust (being phased out) or more commonly an NHS Foundation Trust. Trusts are separate legal bodies from CCGs but both are part of the NHS |
| **Objective** | A more detailed definition of an aim, setting out how the aim will be achieved, the timescales and the resources needed to do so |
| **One Swindon** | A strategic partnership of the largest organisations in Swindon , bringing together Swindon Borough Council, the NHS in Swindon and its largest industries and retailers under a single vision and with the purpose of developing joint strategies that continue to see Swindon prosper and remain at the leading edge of growth and innovation |
| **Optimise** | A referral Management system developed in Swindon which assists GPs by establishing commonly agreed thresholds for referral for hospital and other care. |
| **Out of Hospital care** | An approach to providing care out of hospital and in community based clinics or the home |
| **PALS** | Patient Advice & Liaison Service. PALS role is to assist the public in finding or registering with the right service and to assist in the early handling of patients' concerns |
| **Partners** | Used in this document to cover those third parties with whom Swindon CCG is working towards a common agenda such as our shared health priorities or public and patient involvement and engagement. We do not use it to mean a formal partnership i.e. a legal entity in its own right, but rather a strong and mutually beneficial relationship |
| **Patient Participation Group** | A group set up to allow patients to become involved in the design and delivery of their healthcare or to become more informed about their condition and better able to deliver self care |
| **Planned care** | Consultations, diagnosis, treatments and surgery where the attendance at hospital is pre-planned and an appointment is therefore made to be seen in clinic or to be admitted to a bed |
| **Practice Participation Group** | Similar to the above but set up at GP Practice level |
| **Prevalence** | The rate of incidence of a particular disease or condition in a community |

| | |
|---|---|
| **Primary care** | First point of contact with healthcare. Usually with your General practitioner but also includes dentists and pharmacists |
| **Primary Care Foundation** | An organisation which supports your local CCG with advice and audits |
| **Primary Care Trust (PCT)** | Currently responsible for planning and contracting for local health services but being phased out to be replaced by Clinical Commissioning Groups (CCGs) |
| **Principle** | Defines the *way* in which we will do things to ensure we deliver the benefits of what we set out to do |
| **Priority** | The outcomes, tasks or activities that are regarded to be most important and those which we will seek to achieve first |
| **Productivity** | Measuring how much activity per person or per £ invested in order to ensure & demonstrate that value for money is being provided |
| **"Providerscape"** | A description of the whole spectrum of providers in an area – a shorthand version of "the provider landscape" |
| **Public Health** | A department and discipline of healthcare that involves trained professionals, usually senior clinicians, researchers or doctors, in the analysis of health and health indicators and the development and delivery of programmes to address health concerns and improve health generally, including screening and surveillance programmes. |
| **Quality** | Definitions range from the standards expected of a service to that additional component that differentiates a good service from a bad service. |
| **Recession** | A period during which business growth, public sector finances and taxation are all standing still or reducing |
| **ROPE** | A locally developed healthcare feedback system that allows the continuous capture of patient, patient family, carers and visitors experience of GP, hospital and community services |
| **Self-care** | When we look after ourselves through accessing over the counter medication, following publicised advice for management of self-limiting illness. |
| **SEQOL** | Swindon based social enterprise providing community and home based health and social care |
| **Spell** | Another method of measuring the number of patients who have been admitted into hospital |

| | |
|---|---|
| **Swindon Borough** | Swindon town and neighbouring villages and rural communities. |
| **Supply induced demand** | Where the demand for activity arises as a consequence of there being too much capacity in a local area |
| **System simulation** | A management technique that allows hypothetical patients to be run through computer software that mimics and reproduces the operational processing of a local health system. This allows changes to be tested for unintended consequences before implementation and also allows different healthcare solutions to be compared |
| **Third sector** | Voluntary, charitable and not-for-profit organisations and networks, so called as the private and public sector represent the first two sectors, but both are reliant on an active and coordinated voluntary and charitable sector. |
| **Unemployment Stress** | A measure of how much impact will be had on an area, authority or Borough due to unemployment |
| **Urgent care** | Care required to treat a condition, disease, harm or injury that requires rapid attention. |
| **VAS** | Voluntary Action Swindon. The coordinating body for voluntary groups and organisations in Swindon |
| **Vision** | A long term aspiration or desired outcome that will benefit a community or society at large. |
| **Voluntary sector** | The collective term for voluntary groups and organisations. Voluntary groups and organisations are those where people have undertaken to support for or care for others without being employed. The Voluntary Sector provide their time and expertise at no cost (save sometimes for expenses and administrative support) and for no profit |
| **Ward deprivation** | A ward is the collection of households that vote for their local councillor. Ward deprivation measures the degree of local poverty and other indicators that might lead to a local community being less advantaged in terms of health, education, housing, employment, the environment, access to services and benefits, crime and fear of crime, the local economy |
| **Well being** | A contented state of being happy, healthy and prosperous |

Other terms should be explained within the main body of this document but we welcome any queries regarding the terminology we have used, particularly if any terms are unclear. We will endeavour to update this document in response to all such feedback.

## EXECUTIVE SUMMARY

In this document, Swindon Clinical Commissioning Group (CCG) sets out its commissioning plan for its first year of operation in 2013-2014.

Our mission is to "Optimise the health of the people of Swindon"

This Commissioning Plan has been developed under the auspices of Swindon Primary Care Trust (PCT) and before the CCG has had the opportunity to fully develop its approach to public, patient, clinician, provider and partner engagement.

We have involved GP practices through our Locality Forums, the work undertaken with the Primary Care Foundation and elected practice representatives on our Clinical Leaders Group, Commissioning for Quality Forum and Governing Body.

We have involved the public by engaging them in an open public event in October 2012

We have been involved in contract management meetings with our providers and shared our commissioning intentions through this forum. For specific priorities, such as diabetes or dementia, we have involved patients as service users as well as clinicians in the design of new ways of working.

Above all, we are committing ourselves to the delivery of shared priorities, outcomes and objectives with our partners in One Swindon and the other co-signatories to our Health and Well-being Strategy, which includes Swindon Borough Council.

But we recognise this is only the start, and we undertake to do far more to engage front-line clinicians and the people of Swindon in preparing our Commissioning Intentions and plan for 2014-2015.

Our task is to plan, design and then contract for a portfolio of healthcare provision for the benefit of the people of Swindon, to offer local people the best choice of providers, and to seek continuous improvement in quality, encourage innovation, and drive forward better productivity.

We have £235m to deploy on behalf of just over 220,000 people registered with 26 practices in Swindon, Shrivenham and surrounding areas. This document sets out our plan of how we propose to use that funding to make a difference and to commission the best healthcare. A summary of our plan is included as **Appendix 1.**

# 1. Strategic Context

Section Summary

This section sets out the five strategic issues that will influence the commissioning plan in Swindon CCG. These are:

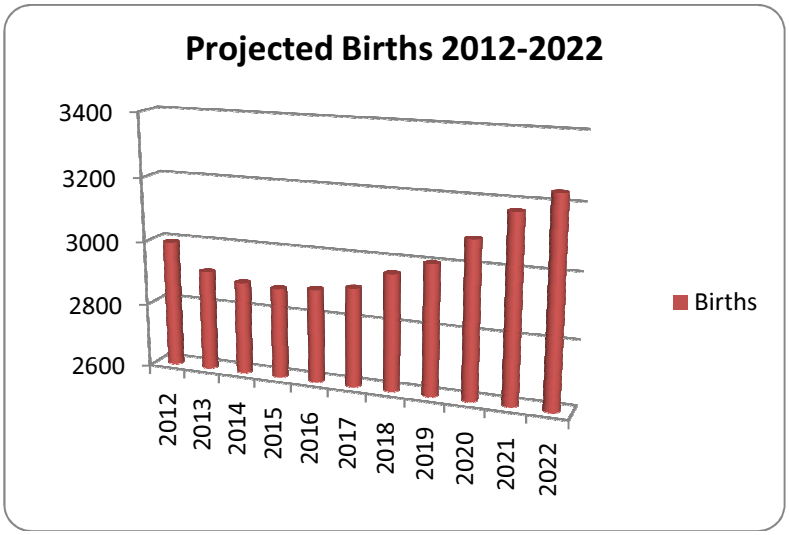
- Population growth in Swindon is rising above the national average
- Additional healthcare funding is due to increase at below population growth
- Higher than average admission rates to hospital
- Healthcare staffing levels are below national and regional average
- No correlation between investment and health outcomes

## Population growth in Swindon

**Ensure that population growth is properly recognised in this contracting round based on the JSNA assessment of age adjustment and applying differential population growth depending on the age profile of those receiving each service.**

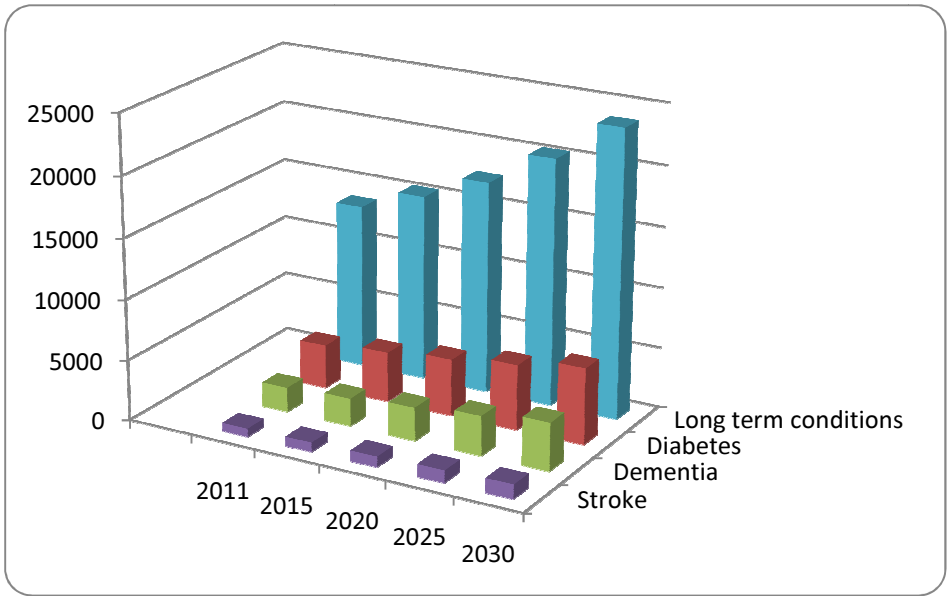
Swindon Borough is the most populous authority in Wiltshire and is growing amongst the fastest rates in England. The 2011 census had a population of 209,000 for Swindon (including the towns of Highworth and Wroughton). This is an increase of 16% since 2001. Residents are predominantly based in the town of Swindon with the remainder residing in the surrounding rural areas.

Our older population is growing at a faster rate than the average for England and the number of projected births is also forecast to increase, from 2016 onwards. Life expectancy is steadily improving, and the number of people whose lives we save each year is also increasing.




*currently seeing a reduction*
*birth rate in Swindon.*
*er, Swindon is steadily*
*ing young families seeking*
*ment and is a town that is*
*ling. With this will come a*
*n the birth rate from 2016-*

One consequence of our growing and ageing population is that the number of Swindon residents living with a long term condition such as diabetes, dementia, stroke or respiratory problems or with some other limiting illness will also increase at higher rates than the English average.




*The forecast growth rate for these conditions is significantly faster than our overall population growth at just under 1.4% per annum*

The above increase will put additional pressure on individuals, households, their families, carers and support network. Those with a long term limiting condition are two to three times more likely to also develop depression.

Detailed work reviewing population growth is detailed in **Appendix 2**.

## Allocation

**Limited funding growth will mean there will be minimal opportunities for investment in 2013/14 and as part of the contracting round there will be a focus on ensuring that all providers work with commissioners on delivering QIPP schemes and identify internal cost improvement programmes.**

On 19th December 2012, we received our 2013/14 allocation and included within this is 2.3% growth funding. Population growth all but consumes most (if not all) of the allocation. Given the current allocation methodology, this is a particular challenge for fast growing populations such as Swindon. As a consequence, in contracting negotiations with providers we needed to develop a whole system QIPP programme to deliver savings, and this has been addressed in more detail in our draft Strategy for Care.

We are setting aside a small contingency, recognising the level of in year cost pressures that have arisen in previous years. We will also be required to make a surplus of 1%.

The CCG received notification of funding for 2013/14 on 19th December 2012 and this was for 2.3% growth which was in line with the level of growth received by all CCGs. This will have an impact on the opportunities for investment in Swindon in 2013/14; the scale of the

QIPP programme required for the health economy; and will create potential cost pressures which will impact on future plans beyond 2013/14.

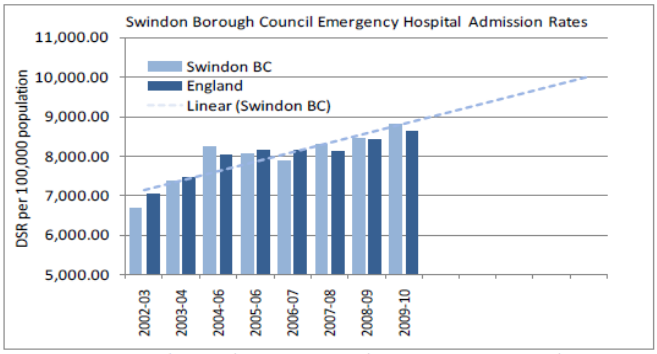
### Admission rates

**Providers will be expected to work with commissioners and partner organisations to support the development of services in the community.**

Our hospital admission rates again tend to be better than the English average BUT they continue to rise.

The admission rate amongst our most deprived population is materially different, with those of our people in the greatest poverty being the highest users of hospital services and the lowest users of the alternatives.

*Figure 6.5 Trend in the emergency admission rate in Swindon and England, 2002/03 to 2009/10*




Source: NHS Information Centre, published October 2011 (linear projection has been locally applied for illustration purposes only)

### Staffing levels

From workforce analysis the Swindon healthcare workforce has a below average number of staff compared to the level of activity. This is reflected in the low reference costs of our main acute provider and in the benchmarking analysis undertaken with our main community service provider.

### Programme budgeting marginal analysis

Work undertaken as part of the Joint Strategic Needs Analysis identified that for some clinical programmes there is significant spend in the local health economy but this does not necessarily correlate to outcomes. For example diabetes has been a high spend disease condition, but Swindon has had some of the poorest outcomes in the country.

In the table below we set out how the priorities within these Intentions match those in the strategy.

| Swindon Health and Wellbeing Strategy | | Doing the Basics Brilliantly; Doing the Brilliant Basically (Swindon CCG Strategy for Care) | Being Different, Being the Best (Swindon CCG Commissioning Plan) | Source of evidence to support |
|---|---|---|---|---|
| **Outcome** | **Priorities** | | | |
| *Every child and young person in Swindon has a healthy start to life* | Improve the mental wellbeing of children and young people<br>Reduce risky behaviours (e.g. Smoking, drinking) amongst our children and young people<br>Keep all children and young people safe<br>Improve educational attainment of children and young people<br>Reduce the number of young people not in education, employment or training | *Continuous improvement in the health of our young*<br>*Self care and prevention*<br>*Early start strategy* | *Continuous improvement in the health of our young*<br>Section 5. Public health and Children's sections | JSNA<br>2011 child health review<br>HOSC feedback on JSNA<br>Child obesity and diabetes from JSNA and diabetes steering group<br>GP survey identifies diabetes in top 5 |
| *Adults and older people in Swindon are living healthier and more independent lives* | Strengthen integrated working between health and social care<br>**Reduce the number of people suffering from long term conditions** through the promotion of healthy lifestyle choices<br>Promote independence **and reduce the need for hospital services** and long term care<br>Ensure that carers needs are met | *Moving towards steady state in terms of our hospital admission rate*<br>*Focusing on key long term conditions* | *Moving towards steady state in terms of our hospital admission rate*<br>*Focusing on key long term conditions*<br><br>Section 5 on Urgent Care and Long term Conditions | Admission rate analysis from JSNA<br>Programme spend analysis from JSNA<br>ROPE<br>Long term conditions identified in GP survey – dementia, respiratory, diabetes |
| *Improved health outcomes* | Ensure access to information and advice that supports choice and control | *Reducing the gap in life* | *Reducing the gap in life* | JSNA |

| | | | | |
|---|---|---|---|---|
| *for disadvantaged and vulnerable communities* | **Ensure people from disadvantaged groups receive good quality care for their physical health**<br>Local economic and social policies are developed to strive **to narrow social inequalities** rather than widen them<br>**Prevent early death and disease through healthier lifestyle choices, early detection and screening** | *expectancy between our least and most deprived populations*<br>*Targeting pockets of poverty and deprivation* | *expectancy between our least and most deprived populations*<br>*Targeting pockets of poverty and deprivation*<br>Section 5 on Public health | Experian Mosaic<br>GP survey<br>One Swindon Public Event<br>Comparative admission rates<br>Locality champions feedback |
| *Improved mental health, wellbeing and resilience for all* | Develop effective pathways for people with **mental health** problems<br>Increase the opportunities for people **with mental health problems to access support services and community facilities** aimed at promoting recovery (e.g. education, debt management, housing, leisure services, health promotion)<br>**Promote positive mental health** and recognise that mental health is everyone's business<br>**Reduce the stigma and discrimination associated with mental ill health** | *Increasing investment in mental health and reviewing our model of care for learning disability* | *Increasing investment in mental health and reviewing our model of care for learning disability*<br>Section 5 on Mental Health | JSNA<br>Identified in top 5 from GP surveys<br>National strategy<br>Key priority for Swindon Borough |
| *Creation of sustainable environments in which communities can flourish* | 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**.<br>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<br>Promote the use of green, open spaces and activities such as walking and cycling<br>Maintain effective public transport and transport networks which ensure access to services and activities and encourage permeability within communities | *Workforce strategy, responding to the economic downturn, building sustainable communities*<br><br>*Targeting the hard to reach community through gateway workers and risk stratification*<br><br>*Targeting pockets of poverty and deprivation* | *Targeting pockets of poverty and deprivation*<br>Section 5 on Public health | JSNA<br>Part of self care agenda<br>Picked up as priority through locality groups |

## 2. Commissioning Context and Themes

**Section Summary**

This section sets out our contracting approach and timetable. Working with our providers the CCG would expect to have sustainable and sensible agreements with a realistic QIPP target. We are also expected to ensure compliance with national standards.

The approach we have adopted with our providers is to have:

- Sustainable and sensible agreements
- Realistic QIPP and equitable target
- Minimal investment in developments
- Sought to agree 95% of contract value early
- By mid February 2013 know what needs to be resolved and how
- Updated our Commissioning Intentions during the contracting round
- Supported current provider configuration BUT
- Disengaged with those providers who do not work with us and
- Sought payment arrangements that move towards co-incentivisation

During the contract round we have ensured that our contracts reflect the six **national priorities** as set out within the most recent NHS Reforms:

- We must deliver value for money managing all our investment in local healthcare within the £235m per annum allocated to us
- We must invest in health promotion and healthcare services that prevent people from dying prematurely
- We must invest in a better quality of life for those with long term conditions
- We must invest in new pathways of care that help people to recover quicker from injury or ill-health
- We must commission local services in order to ensure people have a positive experience of their care
- We must ensure that people are treated and cared for in a safe environment protected from harm

The aims of our commissioning plan for 2013/14 are:

(1) To ensure no decision is taken concerning health improvement or healthcare delivery without the meaningful involvement and engagement of public, patients, practices, partners and providers
(2) To ensure that all providers of healthcare understand our priorities for improvement and are contributing towards optimising the health of the people of Swindon
(3) To develop health services that meet our communities' priorities for healthcare in a way that is most appropriately accessible
(4) To demonstrate our on-going commitment to the core principles of The NHS Constitution by offering an informed choice of provider wherever practicable.

Our objectives in the contracting round for 2013/14 are:

(1) To set out within a single framework the information that we and our providers require when planning for health care in 2013-2014 in sufficient time to allow providers to test their capacity and costs of delivering to the needs we have identified
(2) To provide a framework against which the CCG and local healthcare providers can identify priorities for investment or development
(3) To set out how we will invest £234m to derive the optimum benefit in terms of health care access and health gain for the people of Swindon
(4) To set out the starting point for health care services in terms of quality, standards and performance.
(5) To set out the framework for monitoring improvement against the above baseline including key performance indicators and critical success factors.

As part of the contracting round for 2013/14 the CCG's aim is to commission services that are:

| | |
|---|---|
| **Safe** | That not only meet minimum standards but also where there is evidence of a culture of continuous learning |
| **Appropriate** | Designed primarily to meet the clinical needs of the patient group served |
| **Responsive** | Continuously developing health care and also tailoring services to the individual needs of people in Swindon |
| **Flexible** | Adapting to new models of care and to changes in both demand and need |
| **Accessible** | Continuously reviewing location, hours and days of coverage to reflect patient needs |
| **Sustainable** | Have the right people, equipment, facilities and investment to provide services safely and continuously |
| **Social Value** | Ensuring that the services we commission improve the economic, social and environmental wellbeing of Swindon. Ensuring that the way we commission secures that improvement |
| **Add value** | Continuously reviewing costs and outcomes to be able to publicly demonstrate the added value of health care. Challenging individual and collective practice where there is no evidence of added value |

We aim to commission from providers who are:

| | |
|---|---|
| **Mature** | Understanding the priorities and the limitations on health care spending and work with commissioners to maximise health within available investment |
| **Putting patients first** | Viewing practices, policies, procedures and decisions from the perspective of the patient, trying to avoid unintended consequences and treating patients with courtesy and respect |
| **Promoting health** | Engaging with the wider community at addressing the root causes of poor health and design services to ensure there is equality of access for the most disadvantaged or hardest to reach |
| **Developing people** | Investing in training, developing, motivating, retaining and growing their staff, recruiting talented people and planning for their succession |

| | |
|---|---|
| **Effective** | Delivering the right care and treatment to the right people in the right place and setting at the right time to the right standards supported by the right information and equipment |
| **High quality** | Continuously seeking to deliver health care that is comparable with the standards, outcomes and reputation of the best |
| **Innovative** | Exploring new ways of delivering care, encouraging clinicians to challenge current practice and stimulating the rapid introduction of more efficient care |
| **Productive** | Reviewing existing practice for duplication and waste, ineffective activity, unnecessary care, avoidable delay, and develop models that deliver more care and better quality for the same (or less) cost |
| **Performing** | Consistently delivering to the quality, activity, productivity and performance standards set within our contracts |

We shall commission by being:

| | |
|---|---|
| **Clinically Led** | The CCG including our commissioning teams will be led by local clinicians with existing patient caseloads and elected by their peers. In addition the service redesign, planning and prioritisation activity of the CCG is also predominantly led by clinicians. |
| **Engaging** | Putting in place a range of opportunities for public, patient, practices, providers and partners to become involved in setting our intentions for future years |
| **Focused** | Ensuring that any investment is tested to ensure that it meets the agreed priorities within our Commissioning Intentions, as outlined by our Joint Strategic Needs Assessment. |
| **Informed** | As a CCG, having the information available to understand performance and how local services compare with the best |
| **Intelligent** | Having the people, skills and information to be able to analyse health needs and demands, provider performance and outcomes in order to identify opportunities for improvement |
| **Consistent** | Making clear decisions based on health needs assessment, our stated priorities and publicly accessible evidence |
| **Firm** | Not bowing to individual pressure groups or lobbying, ensuring there are no interests that will affect the impartiality of the CCG, and engaging the wider community of Swindon in the design of local health services. |

There is an expectation that the CCG as commissioners will:

- Treat all providers equitably
- Ensure all providers commit to **CQUINs** and to the quality imperatives within the contract
- Ensure all providers offer **social value**
- Ensure all providers can demonstrate **value for money** and **increased productivity**
- Ensure all providers can demonstrate **innovation**
- Ensure all providers can demonstrate services are **safe**
- Ensure all providers can demonstrate services are **green and sustainable**
- Ensure all providers are **resilient** and have **business continuity plans**

## 3. Priorities for investment

**Section Summary**

This section sets out a summary of the CCG's priorities for investment which providers need to consider during the contracting round for 2013/14.

- **Child obesity – as the key priority for investment by Swindon Borough Council using their public health funds.**
- **Risk stratification – locally enhanced service models need to be put in place to ensure the roll out of risk stratification and that investment is available to each practice to test and evaluate which interventions make a difference to overall population risk.**
- **Diabetes – the models of care within the approved business case need to be taken forward to complete implementation.**
- **Dementia – services need to be put in place to meet the demand created through better registration.**
- **Self-care and prevention/community coordination – locally enhanced service models on a pilot basis to be put in place to test the N.E. London case worker model for long term conditions.**
- **Paediatric admissions – investment in alternatives to admission.**
- **Urgent care – re-commissioning of urgent care pathway**
- **Cancer**

### Child obesity (using public health funding)

In 2011/12, data indicates that there was a general increase in the number of overweight and obese children in both Reception and Year 6. The only decrease occurred in the percentage of overweight Reception year children but this was only a 0.2% drop, from 14.2% in 2010/11 to 14.0% this year.

There has been an increase in the number of obese children from 8.6% in 10/11 to 9.9% in 11/12. In Year 6, the percentage of overweight children

increased by 2.8%, from 13.9% to 16.7%, and the figure for obese children increased by 1.9%, from 17.3% to 19.2%. Swindon is higher than the national average (10/11) in all four aspects:

- Reception: 0.8% higher for overweight children; 0.5% higher for obese children
- Year 6: 2.3% higher for overweight children; 0.2% higher for obese children

Swindon has a Healthy Weight strategy and action plan, which involve a range of partners, including from Swindon Borough Council (including leisure services, Healthy Schools, children's services, Health Ambassadors, transport and planning), the voluntary sector, including CTC cycling charity, the NHS, including NHS Swindon, Great Western Hospital NHS Foundation Trust, Avon and Wiltshire Mental Health Partnership NHS Trust and specialist bariatric services provided outside Swindon, commercial weight management programme, such as Weight Watchers and the school sports partnership and an EU funded programme involving 5 other European countries.

### Risk stratification

Stratifying patients according to need continues to be a vital component of the Long Term Conditions (LTC) generic model and key to the delivery of good LTC management. By using a risk prediction approach it is possible to identify those people who are the most regular users of health services (both primary and secondary care) and are at risk of re-admissions to hospital), then stratify them according to complexity of need and commission cost effective interventions to meet those needs. NHS Swindon made an investment in procuring a risk stratification tool which will be implemented during 2013/14 and during the year GP practices will be involved in identifying opportunities for commissioning interventions that could reduce the risk of a hospital admission.

### Diabetes

In 2009/10 there were 8,880 people aged 17 years and older diagnosed with diabetes in NHS Swindon. This equates to 5.3% of the population aged 17 years and older in NHS Swindon which compares favourably to 5.1% in the South West region and 5.4% in England. In NHS Swindon there are an estimated 1,535 adults with diabetes who are currently undiagnosed. This is not particular to Swindon many people are estimated to be living with undiagnosed diabetes in England. NHS Swindon actually performs better than the English national average in identifying its diabetics (81.4% compared with 73% nationally).

Patients diagnosed with diabetes can be supported to manage their condition by their GP practice and during 2013/14 there are plans to increase the range of services provided by GPs to participate in an insulin initiation Local Enhanced Service.

### Dementia

The current estimated population of people with dementia in Swindon is 2232, of which approximately 44.2% have received a formal diagnosis. There has been a 0.7% reduction in the diagnosis of Dementia in Swindon from 2011-12 and currently the Alzheimer's Societies Mapping the Dementia Gap study identifies Swindon as ranking 108/178 in the diagnosis of Dementia when compared to other local health areas in the United Kingdom.

A range of initiatives have been progressed to improve dementia diagnosis rates and the care pathway. These will be further developed during 2013/14 and they include:

- GP lead to provide leadership and guidance
- Consultant psychiatrists providing training and awareness sessions
- Memory assessment service
- Mental health liaison services.

### Self care and prevention

The services commissioned by Swindon Borough and Swindon Commissioning Group will come under increasing pressure unless they can develop a coordinated approach to self care, preventative care and personalisation.

The key initiative for 2013/14 is to pilot the Community Navigator scheme that has been successful run in North East London, but also in the US, Germany, Italy and France. The pilot would run in six practices. The components of the pilot are as follows:
District nurses, community therapists, social care staff, supported by a Community Navigator, would be attached to six practices. Informed by the risk assessment of patients that derives from the CCG's risk stratification project (an assessment of the risk of health care intervention for all patients registered in a practice using the well-established John Hopkins model), the team will develop a coping strategy for those at risk of regular intervention, engaging with the patients household, family, friends, peers, local community, local voluntary sector and local community services.

The role of the Community Navigator will be to coordinate putting in place the support from various sectors and agencies to deliver this package of assistance, similar to the Mental Health Gateway Worker scheme. To support the above, the second strand of the project is the development of a single database that can be accessed by the patient and the Navigator in assembling the package of support. This will be further developed during 2013/14.

### Reducing paediatric admissions

The benchmarking data available to the CCG identified that there was scope to review the level of non-elective paediatric admissions to Great Western Hospital and during 2013/14 the intention is undertake a service redesign workshop on paediatric admissions. It is also acknowledged that during 2013/14 a new paediatric emergency department will be established at Great Western Hospital. Opportunities for new models of care will be explored including perhaps establishing some specific urgent care community based services.

### Revisit urgent care pathway

The continued increase in emergency admissions and attendances to the emergency department is a major concern for the CCG.

During 2013/14 there will be a series of service redesign workshops to work on urgent care and particularly the implementation of the risk stratification tool. A number of QIPP initiatives are in place to ensure that the current schemes such as the 'Joint Front Door'; the Swindon Intermediate Care Centre (SWICC); telehealth; and virtual wards. Opportunities to further enhance these and to develop other urgent pathways will be reviewed during 2013/14.

## Cancer

There is increasing demand for cancer services from the Swindon population and there is scope for improving services to

Swindon CCG will commission cancer services informed by the following:

- The National Cancer Action Team (NCAT) Strategy
- Thames Valley Cancer Network (TVCN) recommendations
- Informatics provided by the National Cancer Intelligence Network and Cancer Toolkit
- Wessex LMC
- The National Audit office which identifies areas for investment and disinvestment in terms of commissioning
- House of Commons report "Delivering the Cancer Reform Strategy 2011" which includes the highlight that 5,000 cancer deaths could be saved per year if we improved our performance to the European average.

Our aspirations are those of NCAT:

- Optimizing value for money
- Increasing awareness of Cancer
- Striving for earlier diagnosis by supporting Public campaigns and increasing GP awareness of cancer symptoms and referral criteria
- Improving quality of life for cancer patients and experience of care

Swindon CCG will commission services that:

- Deliver care in accordance with all 5 domains of the NHS Outcomes Framework
- Use profiling data supplied by TVCN that benchmarks cancer services and outcomes across our network and act on this information to work with Practices to improve effectiveness and efficiency of cancer services
- Support the development and use of Risk Assessment Tools
- Continue to work together with our Secondary Care Colleagues in our Local Cancer Implementation Group to effect best Practice
- Provide better access to diagnostics
- Encourage specialist services to be developed locally and safely through clinical networks
- Recognise and fund appropriately the inherent population based growth in many cancers, allowing the local provides to plan for the required capacity

# 4 CQUINs

**Section Summary**

This section summarises the CQUINS that the CCG would like to see in place with their providers for 2013/14.

## High impact innovations

For 2013/14 to achieve CQUINs there is a requirement for providers to meet 50% of the appropriate high impact innovations. The high impact innovations include:

- Increase the use of assistive technologies
- Implementation of the Oesophageal Doppler Monitoring (ODM) – already in place in Great Western Hospital NHS Foundation Trust
- Transforming wheel chair services
- Reducing inappropriate face-to-face contacts and switch to higher quality , more convenient, lower cost alternatives
- Commissioning services in line with NICE-SCIE guidance on supporting people with dementia

During the contracting round discussions held with the providers it was necessary to define which are the appropriate high impact innovations that would be the gateways to the CQUINS for 2013/14. The CCG view is that there was an expectation that a provider should be achieving at least 50% of the relevant innovations to benefit from CQUIN payments.

## National CQUINs

The key aim of the Commissioning for Quality and Innovation (CQUIN) framework for 2013/14 is to secure improvements in quality of services and better outcomes for patients, whilst also maintaining strong financial management.

The financial framework:

- CQUIN for 2013/14 is set at a level of 2.5 per cent value for all healthcare services commissioned through the NHS Standard Contract. One fifth of this value (0.5 per cent of overall contract value) is to be linked to the national CQUIN goals, where these apply.
- The full year financial value of a CQUIN scheme should be calculated as a percentage of the full year value for all healthcare services commissioned through the NHS Standard Contract.
- Providers should only be paid where they have achieved the agreed CQUIN goals.
- CQUIN payments should be made to providers in accordance with the detail set out in the NHS Standard Contract.
- Commissioners must set out clearly the proportion of payment associated with each CQUIN indicator and the basis upon which payment will be made.
- CQUIN monies remain non-recurrent.
- CQUIN monies should be used to incentivise providers to deliver quality and innovation improvements above the baseline requirements set out in the Standard Contract. Commissioners should plan to make challenging but realistic CQUIN

schemes available for providers, so that there is an expectation that a high proportion of commissioner CQUIN funding will be earned by providers in-year.
- Non-participation in any applicable national CQUIN scheme should result in non-payment of that proportion of CQUIN funding.

0.5 per cent of the value for all healthcare services commissioned through the NHS Standard Contract is to be linked to the national CQUIN goals, where these apply. There are four national CQUIN goals for 2013/14, which are:

- *Friends and Family Test* – where commissioners will be empowered to incentivise high performing Trusts;
- improvement against the *NHS Safety Thermometer* (excluding VTE), particularly pressure sores;
- improving *dementia* care, including sustained improvement in Finding people with dementia, Assessing and Investigating their symptoms and Referring for support (FAIR); and
- *Venous thromboembolism (VTE)* – 95 per cent of patients being risk assessed and achievement of a locally agreed goal for the number of VTE admissions that are reviewed through root cause analysis.

### Local CQUINs

The national guidance about local CQUINs was that at least 2 per cent of a provider's total contract outturn will be available for local CQUIN schemes, agreed between commissioner and provider. The number and content of local CQUIN schemes are entirely for local agreement. Where providers hold several contracts with commissioners, collaboration is encouraged to agree schemes across contracts where appropriate.

The approach adopted in Swindon has been to have local CQUINs which related to the following principles that were developed by the Clinical Leadership Group of the CCG.

- CQUINS that take forwards the CCG **strategic priorities** e.g. reducing emergency admissions, long term conditions (diabetes), child health (reduction in paediatric hospitalisation)
- CQUINS that promote **integrated working** e.g. diverting those with alcohol problems from A&E, and extended use of Optimise
- CQUINS that **promote and roll out innovation** and world class practice e.g. hydrant and addressing hydration generally
- CQUINS that are **enablers** e.g. OPTIMISE and ROPE

These principles have then been applied to the development of specific CQUINs as appropriate for the different providers:

- to promote the development of integrated and accelerated children care pathways with the objective of reducing paediatric admissions
- to promote the better coordination and most appropriate delivery and management of end of life care
- to promote a whole system approach to reducing admission from long term conditions or preventable events, specifically respiratory, UTI, malnutrition, dehydration, repeat admission from nursing homes or the collapse of informal carer support
- to promote self care, preventative care and personalisation of care

- to promote falls prevention programme
- to promote innovation in wound care
- to promote engagement in the fundamental information building blocks of OPTIMISE, ROPE, QUALITY DASHBOARD.

## 5. Quality, Innovation, Productivity and Prevention (QIPP)

Our approach to our QIPP programme has been as follows:

(1) Identify the opportunity to improve quality, innovation, productivity or prevention through benchmarking, reviews of the high impact changes and other research
(2) Quantify the opportunity, risk assess it and assign a likely lead time
(3) Require commissioning business cases for each QIPP workstream setting out the key milestones, responsibilities, risks, and benefits, having careful regard to where those benefits will be realised and how measured.
(4) Sign off of a QIPP programme by the whole health system Strategic Change Forum
(5) Weekly review by our PMO of deliverables against milestone and benefits plan (ABCD report: Achievements, Benefits, Concerns, Do Nexts)

Work is still in progress to define the level of the QIPP savings for specific schemes and the potential impact that the schemes will have on activity and the workforce. The CCG is in the process of introducing new project management arrangements for the QIPP work programme which includes establishing more detailed planning of schemes; better engagement from all stakeholders and improved risk assessment of schemes. Executive Directors are being given specific roles for QIPP programmes and Senior Responsible Officers are being identified for workstreams.

To support the QIPP programme the CCG is also establishing a programme of service redesign workshops during 2013/14.

The schedule of QIPP schemes detailed below will be further developed and will require commissioning business cases. Work also needs to be completed on risk assessing these schemes in terms of potential delivery and also in terms of when they are likely to be implemented in 2013/14.

The total financial savings from QIPP schemes will be scheduled to be phased although the intention is to deliver £8m savings in 2013/14

## *QIPP ANALYSIS*

*Planned Saving*

| | 2013-15 PLAN | 2013-14 RISK ASSESSED PLAN | *HEALTHCARE PROVIDERS* ACUTE | COMMUNITY & MENTAL HEALTH | AQP & OTHER | *PRIMARY CARE* | *PRESCRIBING* | *CCG* | *OTHER* |
|---|---|---|---|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| **Elective** | **2,961,676** | **2,060,586** | 1,898,854 | | 161,732 | | | | |
| **Non Elective** | **3,438,992** | **2,742,546** | 2,742,546 | | | | | | |
| **Community Services** | **2,237,000** | **869,000** | | 869,000 | | | | | |
| **Primary Care** | **617,300** | **186,523** | | | 4,000 | 182,523 | | | |
| **Other** | **2,190,000** | **1,200,000** | | | | | | 50,000 | 1,150,000 |
| **Prescribing** | **1,025,000** | **1,025,000** | | | | | 1,025,000 | | |
| **Total** | **12,469,969** | **8,083,655** | **4,641,400** | **869,000** | **165,732** | **182,523** | **1,025,000** | **50,000** | **1,150,000** |

## 6. Population growth

**Section Summary**

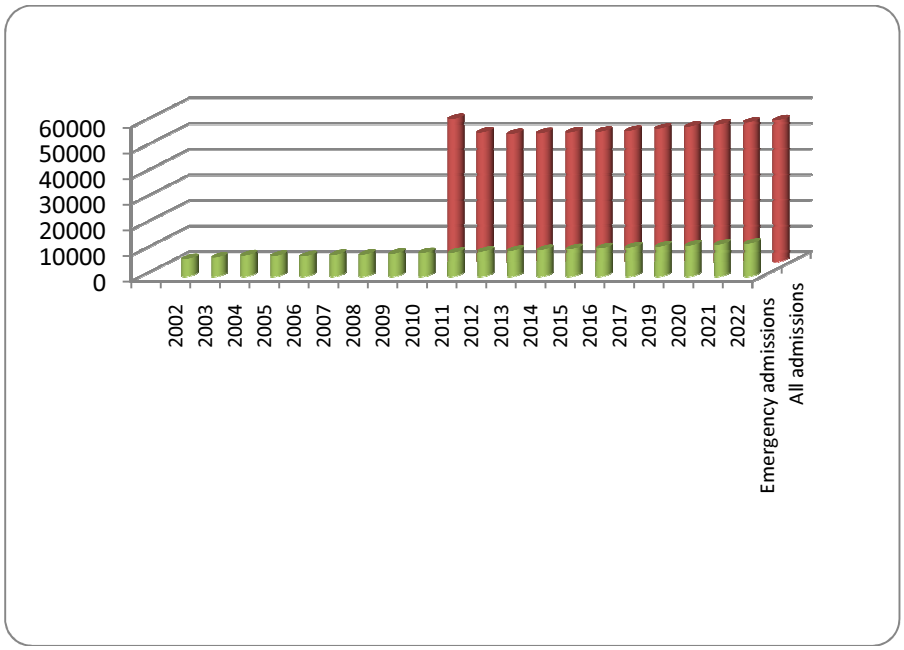
This section summarises the underlying growth and demand for health services based on population growth.

### Trends in hospital admissions

Since 2002, the number of admissions to hospital care has grown at a faster rate than our population (with us seeing typically 3-5% annual growth in admissions based on rolling averages compared to 1-2% growth in population). There are many factors that contribute to this, including:

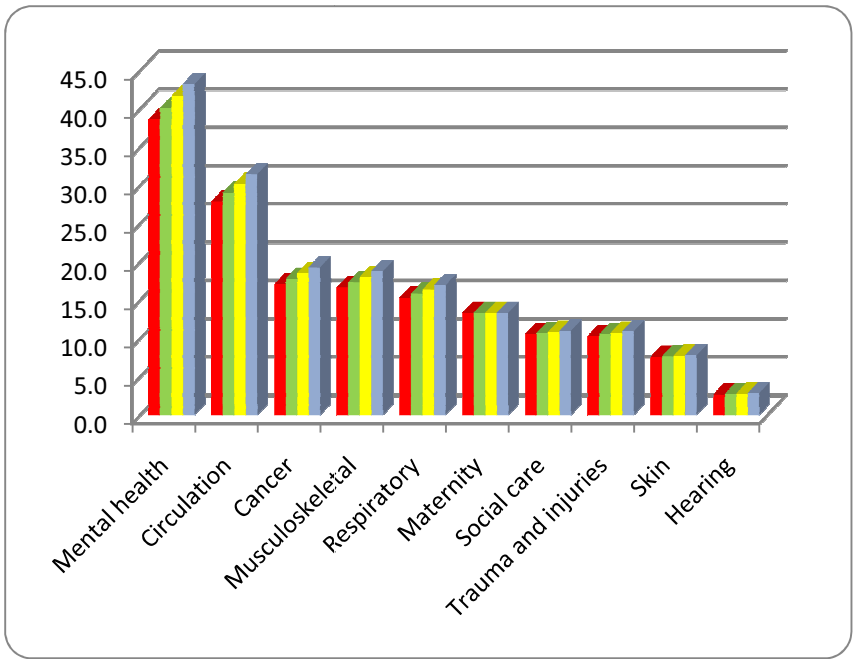
- New surveillance programmes that have identified previously unmet need e.g. cancers
- Increased hospital capacity and efficiency used to drive down waiting times
- Changes in the definition of an admission and better data collection
- New treatments and services becoming more accessible as they are brought locally

If we assume the current trend in the growth in admissions *continues* then we face an unaffordable position for both the Clinical Commissioning Group and our providers, as much of the growth is in emergency admissions and the national tariff for such is at below marginal rates. Our health system will silt up with emergency care unless we invest in self-care, prevention and alternative pathways.




*Whilst the overall admissions is not forecast to rise above the position in 2011 (which represents a peak in the total of admissions), the rise in emergency admissions at 3-4% per annum and (as of equal concern) the higher proportion of emergency admissions compared to planned care will be unaffordable for both our providers and the CCG.*

Some conditions will see more growth than others due to the ageing of our population and this is shown in the graph below. For example, we have assumed significant growth in dementia at 5.03% growth per annum and built this into our mental health programme, as well as factoring in a growth in depression in those living longer with a limiting or chronic illness, partly offset by our assumption of nearly zero population growth in the young and working age population.




*his graph shows the variance likely activity growth by ifferent programmes of end, with some rising arply and other rogrammes likely to be asonably flat.*

During 2013/14 further work will be undertaken with Public Health to fully understand the implications of the population growth experienced in Swindon.

## 7. Financial assumptions

On the 19th December 2012, Swindon Clinical Commissioning Group received its revised allocation for 2013-2014. The assumptions set out in that allocation and the further assumptions we have made in response are laid out below:

- We have received growth at 2.3% on a base allocation of £217m
- Financial plans have been drawn up on the basis of national guidance on resource availability
- We have created a contingency reserve of £1m, representing 0.5% of our resource allocation
- We will deliver a surplus in line with national requirements (1% for 2013-2014)
- We have assumed 2.8% underlying growth in activity based on our growing and ageing population but will also seek to mitigate this through our QIPP programme
- Running costs have been funded at £5.46m and the costs of the CCG, the Commissioning Support Unit, our Referral Management Centre and those services provided by Swindon Borough Council for the CCG are all contained within this
- We have assumed 4% CRES within tariff, but that inflation and provider cost pressures will absorb this
- We have assumed the following investments as required by the operating financial framework for the national mental health strategy, carers support, NICE and similar national mandatory initiatives:

| 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|
| £4.1m | £3.6m | £3.5m | £3.5m |

- In order to invest in self care and preventative care we have assumed a development fund of 0.6% with a view to delivering at least that benefit in reduction in demand in first year
- We have continued to assume a whole system QIPP requirement, but based on earlier years' actual achievement have set this at 2.5%. In order to deliver 2.5% in year, we will need to plan for 3.5% full year effect.

The table below summarises the initial position that the CCG entered to in the contracting round with health providers for 2013/14.

## CCG Income and expenditure

| | Assumed % | 2013-2014 £'m | 2014 -2015 £'m | 2015-2016 £'m |
|---|---|---|---|---|
| Baseline allocation | | (218.0) | (223.0) | (228.1) |
| Growth in Funding | 2.30% | (5.0) | (5.1) | (5.2) |
| | | (223.0) | (228.1) | (233.3) |
| Other sources | | (6.6) | (6.7) | (6.7) |
| | | (229.6) | (234.8) | (240.0) |
| Runnning cost allocation | | (5.5) | (5.5) | (5.5) |
| | | (235.1) | (240.3) | (245.5) |
| Commitments | | 211.3 | 217.6 | 220.8 |
| - strategic change fund | 2.00% | 4.5 | 4.6 | 4.7 |
| - activity demand | | 3.2 | 3.2 | 3.2 |
| Demographic and other growth | | 1.8 | 2.3 | 3.1 |
| Inflation | | 8.1 | 8.1 | 8.1 |
| CRES in tariff | | (8.4) | (8.5) | (8.5) |
| Cost pressures | | 5.3 | 3.7 | 4.0 |
| New Developments | | 2.7 | 4.0 | 4.7 |
| Operating framework imperatives | | 5.8 | 5.3 | 5.4 |
| | | 234.3 | 240.3 | 245.5 |
| QIPP programme | | | | |
| - Bfwd | | (3.2) | (2.5) | (2.5) |
| - in year | 2.50% | (4.8) | (6.4) | (6.4) |
| | | (8.0) | (8.9) | (8.9) |
| Running costs | | 5.5 | 5.5 | 5.5 |
| Contingency | 0.50% | 1.1 | 1.1 | 1.2 |
| **Surplus/(deficit)** | 1.00% | 2.2 | 2.3 | 2.3 |

For 2013/14, the contracting round is due to be concluded by the 31 March 2013. The contract values below are the current position with our providers for 2013/14, but these may still be subject to some changes such as clarification on whether elements of specialist commissioning are included or excluded from the contract negotiations.

| **Provider** | | **Baseline £000s** | **CQUIN £000s** | **Contract Value £000s** |
|---|---|---|---|---|
| BMI | | 2,944 | 74 | 3,018 |
| Prospect | | 950 | 24 | 973 |
| Oxford Uni Hosp | | 3,625 | 91 | 3,715 |
| Ambulance | | 5,831 | 146 | 5,977 |
| Gloucs Hosp | | 880 | 22 | 902 |
| Southern Health | | 350 | 9 | 359 |
| IHG | | 742 | 19 | 760 |
| SEQOL | | 15,734 | 393 | 16,127 |
| GWH* | | 102,297 | 2,673 | 104,971 |
| S75 Mental Health | | | | |
| | - AWP | 14,904 | 360 | 15,264 |
| | -CAMHS | 145 | 0 | 145 |
| | - SBC | 1,083 | 0 | 1,083 |

| | | | |
|---|---|---|---|
| CHC and MH Placements | 14,100 | 0 | 14,100 |
| Prescribing | 33,100 | 0 | 33,100 |
| CCG Running Costs | 5,500 | 0 | 5,500 |
| Other ** | 26,906 | 0 | 26,906 |
| | **229,091** | **3,810** | **232,900** |

** GWH figures are inclusive of QIPP (value prior to QIPP including CQUIN is £109.6m)*
*** This incorporates other contracts, non contracted activity, contingency and strategic change fund*

## 8. Activity

For planning purposes the activity is being modelled to reflect the financial position; population growth and the potential impact. As contracts are finalised and QIPP Schemes further refined activity will change. Appendix 2 details the summarised activity schedule for 2013/14 as at 18 March 2013.

## 9. Workforce

Our strategy for developing primary and community support and thus shifting the balance of care towards self care and prevention is heavily dependent on: changes in the way the voluntary and community-based public sector operate; our ability to move existing secondary care professionals from the hospital to primary care or community setting; and our ability to recruit in the local labour market.

We are currently developing our out of hospital care strategy and one of the early pieces of our analysis has highlighted that as much as 25% of acute medicine could shift out of hospital based care with investment in a comprehensive model of care in the community. Such a shift may or may not be less expensive than the existing service model (Northern Ireland is committed to making huge savings from such a shift, for example, but other countries have seen very little by way of savings and the only country to publish results showing real savings, Australia, is dismantling their out of hospital care programme).

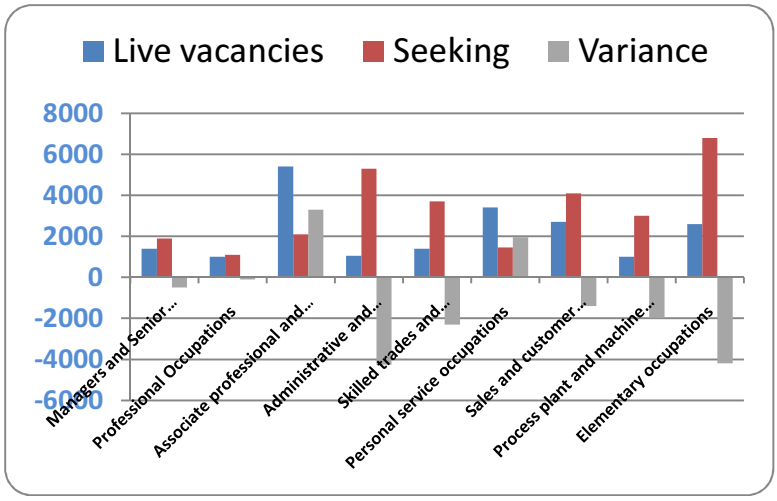
Where other health systems in England have embarked on such a quantum of shift into the community, they have seen the total caseload for their community providers almost double.

This can be offset in part by changing the model of delivery of existing community services and thus achieving some productivity gain through: integration with primary care team roles; increasing the number of patients seen at home per day to the levels in countries such as Belgium or Germany by concentrating purely on clinical intervention in the home; or by reducing the level of home based care and replacing it with community clinic based models where the evidence supports this being more effective and efficient as well as promoting greater independence and mobilisation, and a reduction in those living in isolation.

The concern we highlight in these intentions is that the local labour market is saturated with unqualified labour and those seeking to change career, thus requiring re-training. There is a shortage of professional nursing and therapists. For new models of care to be developed, we will need to be innovative in our approach to the labour market, developing the talent

within Swindon and avoiding over-professionalising roles where there is an opportunity for people with transferable skills to be recruited.

During 2013/14 the CCG will assess the impact of QIPP Schemes on work force and will engage in more workforce modelling with providers.




*The only areas where the number of vacancies are greater than the numbers seeking employment are in the professional and technical (which includes nursing and therapies) and personal service (which includes primary, social and home care) categories. Note: GPs, hospital and community doctors are classified as professional occupations.*

## 10. Governance and Decision Making

Swindon CCG has arrangements in place in preparation to operate as an effective statutory body including governance arrangements, processes for making effective decisions and for working with other partners and stakeholders.

The NHS Reforms establishes a number of new organisations in addition to the CCG. The CCG has refined the arrangements which have previously been outlined in its constitution and subsequently in the documents presented during the CCG authorisation process, in order to reflect these relationships, but also to recognise it is a small organisation of 22 staff. It will continue to review its arrangements once these other new bodies are established.

The key relationships the CCG has are detailed below along with their relevance to the commissioning intentions.

**Public and patients** (including groups representing and engaging with the population served by the CCG). Further details on how we engage public and patients are detailed in 'One Swindon – One Voice: Strategy for the Involvement and Engagement of patients and public'.

**CCG member practices**. The commissioning intentions are informed by the feedback received from practices either directly from the practice: from quarterly on-line surveys, Locality and Borough-wide meetings.

### Implementation of the NHS Commissioning Outcome Framework

The NHS Outcome Framework set outs national outcome goals. The NHS Commissioning Board (NHSCB) will translate these into outcomes and indicators that are meaningful at local level in the Commissioning Outcomes Framework. The NHSCB will use the Commissioning Outcomes Framework to drive local improvements in quality and outcomes for patients, to hold clinical commissioning groups to account and so that there is clear, publicly available

information on quality of healthcare services commissioned by commissioning groups and progress in reducing health inequalities.

The Commissioning Outcome Framework will become operational from April 2013, as CCGs take on full responsibility for commissioning. The NHS CB has published the final set of indicators for 2013/14 to further inform clinical commissioning groups in planning for 2013/14. The indicators cover the NHS Outcome Framework five domains referred to in Section Two and repeated below:

- Preventing people from dying prematurely
- Enhancing quality of life for people with long term conditions
- Helping people recover from episodes of ill health or following injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

## Annual Commissioning Cycle and Timetable

The 2013-2014 commissioning timetable has been finalised by the NHS Commissioning Board. The outline timetable below is based on the latest timetable published by the NHS Commissioning Board on 24th December 2012. Key dates are as follows:

### Outline Timetable

| Task | Start | Finish | Complete |
|---|---|---|---|
| Publication of CCG financial allocations | 19 12 12 | 19 12 12 | Yes |
| Publication of national planning and priorities guidance (the operational plan) | 19 12 12 | 19 12 12 | Yes |
| Publication of Commissioning Intentions (includes financial allocation) | 24 12 12 | 28 12 12 | Yes |
| Publication of first draft Strategy for Care | 24 12 12 | 28 12 12 | Yes |
| Review of CQUIN performance in 2012-2013 | 17 12 12 | 21 12 12 | Yes |
| Publication of January edition of Commissioning Intentions *(includes CQUINs and Re-modelled growth plus results of tariff)* | 20 01 12 | 25 01 13 | Yes |
| First cut activity, workforce and financial plans | 25 01 13 | 25 01 13 | Yes |
| Commence contract negotiations | 28 01 13 | 08 02 13 | Yes |
| Agree heads of terms | 12 02 13 | 31 01 13 | Yes |
| Further negotiation, conciliation and arbitration | 13 02 13 | 28 03 13 | Yes |
| Second cut of financial, activity and manpower returns to NHS Commissioning Board | | 27 03 13 | Yes |
| Sign off contract schedule with Governing Body | 08 03 13 | 27 03 13 | Yes |
| Final negotiation and sign off | 08 03 13 | 30 04 13 | |
| CCG Plan shared with NHS CB AT | 05 04 13 | | |
| CCG prospectus issued to local population | | 31 05 13 | |

## Commissioning Cycle

Below is the commissioning cycle we will look to work to for the next twelve months, as always subject to the national timetable dates once published.

## Appendix 2

Based on the QIPP programme and the financial allocation that we need to work within, we have analysed the predicted activity for 2013/14. This has been summarised below: (As at 18 March 2013

| | | | Activity | % growth |
|---|---|---|---|---|
| | 2012/13 FOT CCG | 2013/14 Plan CCG | 2013/14 Plan on 2012/13 FOT | |
| **Non-elective Admissions G&A (FFCEs)** | 21,260 | 20,784 | (476) | -2.2% |
| **GP Written Referrals from GPs for a first outpatient appointment in general & acute specialties** | 41,043 | 41,748 | 705 | 1.7% |
| **Other referrals for a first outpatient appointment in general & acute specialties** | 16,226 | 16,675 | 449 | 2.8% |
| **Total Referrals** | 57,269 | 58,423 | | 2.0% |
| **First Outpatient Attendances (consultant-led) following GP Referral in general & acute specialties** | 33,818 | 37,229 | 1,154 | 10.1% |
| **All first outpatient attendances (consultant-led) in general and acute specialties** | 52,785 | 56,727 | 3,411 | 7.5% |
| **All Follow-up outpatient attendances (consultant-led) in general and acute specialties** | 67,488 | 62,644 | 3,942 | -7.2% |
| **Elective Admissions - Day Cases (FFCEs)** | 20,195 | 19,628 | 3,942 | -2.8% |
| **Elective Admissions - Ordinary Admissions (FFCEs)** | 4,833 | 4,915 | (567) | 1.7% |
| **Total Elective FFCEs** | 25,028 | 24,543 | 82 | -1.9% |
| **A&E** | 93,443 | 94,132 | (485) | 0.7% |

| Movements in 2013/14 | Baseline | Population/Need @ 2.8% | QIPP Total |
|---|---|---|---|
| **Total planned reductions** | **2013/14** | **2013/14** | **2013/14** |
| Non-elective Admissions G&A (FFCEs) | 21,260 | 595 | (1,066) |
| GP Written Referrals from GPs for a first outpatient appointment in general & acute specialties | 41,043 | 1,149 | (437) |
| Other referrals for a first outpatient appointment in general & acute specialties | 16,226 | 454 | 0 |
| Total Referrals | 57,269 | 1,604 | (437) |
| First Outpatient Attendances (consultant-led) following GP Referral in general & acute specialties | 33,818 | 947 | 2,470 |
| All first outpatient attendances (consultant-led) in general and acute specialties | 52,785 | 1,478 | 2,470 |
| All Followup outpatient attendances (consultant-led) in general and acute specialties | 67,488 | 3,379 | (7,321) |

| | | | |
|---|---|---|---|
| Elective Admissions - Ordinary Admissions (FFCEs) | 4,833 | 135 | (48) |
| Elective Admissions - Day Cases (FFCEs) | 20,195 | 565 | (1,128) |
| Total number of G&A elective FFCEs in the period | 25,028 | 701 | (1,176) |
| A&E | 93,443 | 2,616 | (1,921) |