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.

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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

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

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

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 **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

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:

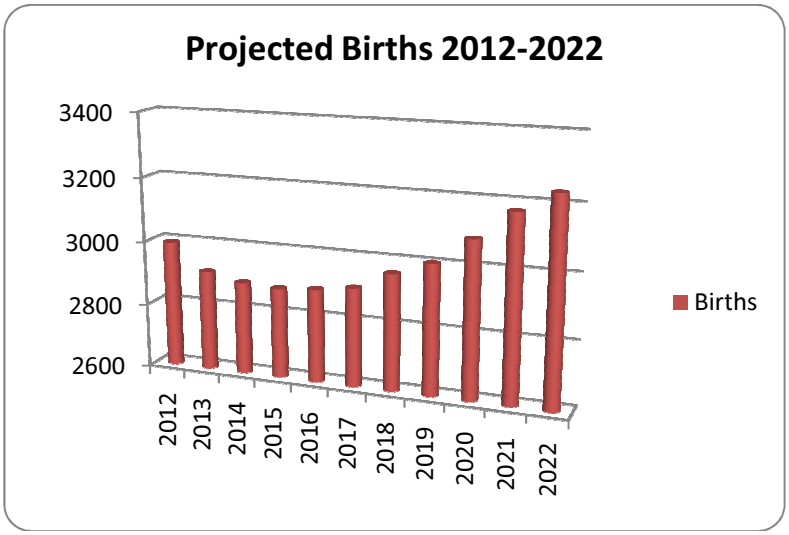
- Population growth in Swindon is rising above the national average
- Additional healthcare funding is due to increase at below population growth
- Higher than average admission rates to hospital
- Healthcare staffing levels are below national and regional average
- No correlation between investment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

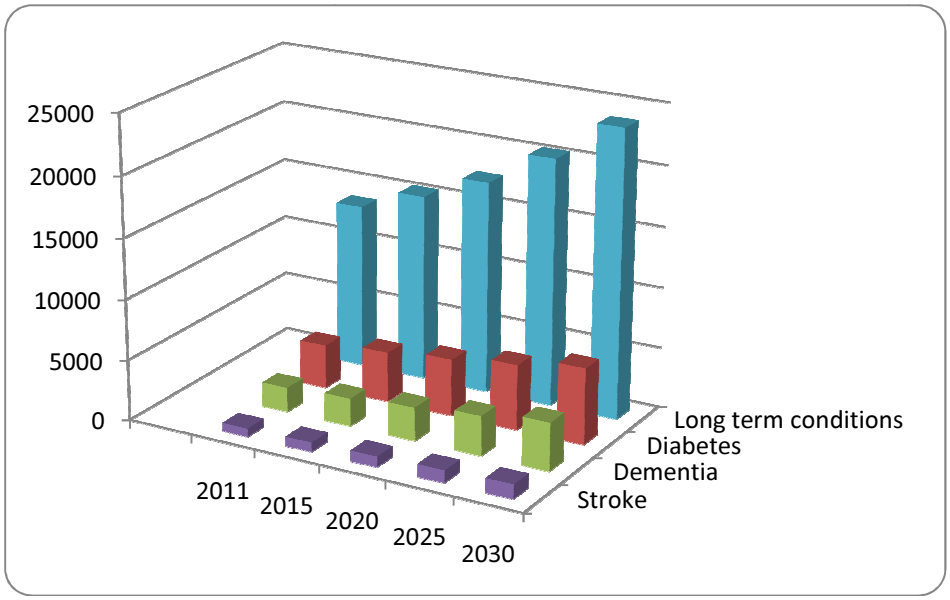
Swindon Borough is the most populous authority in Wiltshire and is growing amongst the fastest rates in England. The 2011 census had a population of 209,000 for Swindon (including the towns of Highworth and Wroughton). This is an increase of 16% since 2001. Residents are predominantly based in the town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

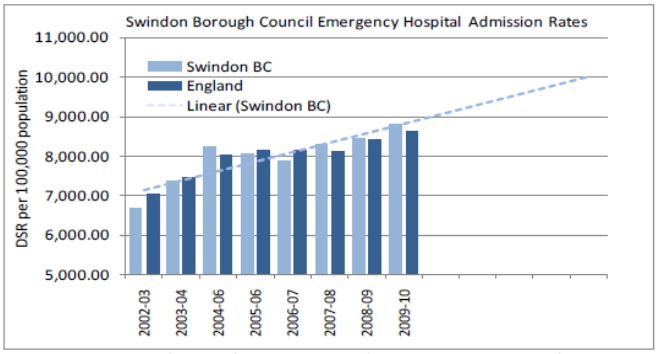
Admission rates

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 Reduce risky behaviours (e.g. Smoking, drinking) amongst our children and young people Keep all children and young people safe Improve educational attainment of children and young people Reduce the number of young people not in education, employment or training	*Continuous improvement in the health of our young* *Self care and prevention* *Early start strategy*	*Continuous improvement in the health of our young* Section 5. Public health and Children's sections	JSNA 2011 child health review HOSC feedback on JSNA Child obesity and diabetes from JSNA and diabetes steering group 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 **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	*Moving towards steady state in terms of our hospital admission rate* *Focusing on key long term conditions*	*Moving towards steady state in terms of our hospital admission rate* *Focusing on key long term conditions* Section 5 on Urgent Care and Long term Conditions	Admission rate analysis from JSNA Programme spend analysis from JSNA ROPE 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** 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**	*expectancy between our least and most deprived populations* *Targeting pockets of poverty and deprivation*	*expectancy between our least and most deprived populations* *Targeting pockets of poverty and deprivation* Section 5 on Public health	Experian Mosaic GP survey One Swindon Public Event Comparative admission rates Locality champions feedback
Improved mental health, wellbeing and resilience for all	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 (e.g. 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**	*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* Section 5 on Mental Health	JSNA Identified in top 5 from GP surveys National strategy 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**. 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 and encourage permeability within communities	*Workforce strategy, responding to the economic downturn, building sustainable communities* *Targeting the hard to reach community through gateway workers and risk stratification* *Targeting pockets of poverty and deprivation*	*Targeting pockets of poverty and deprivation* Section 5 on Public health	JSNA Part of self care agenda 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

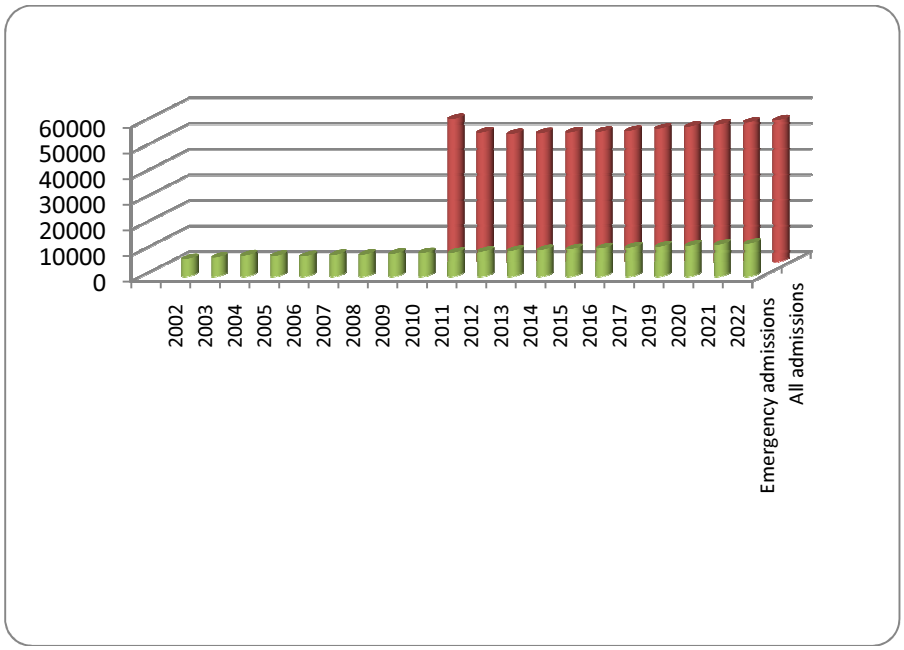
This section summarises the underlying growth and demand for health services based on population growth.

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:

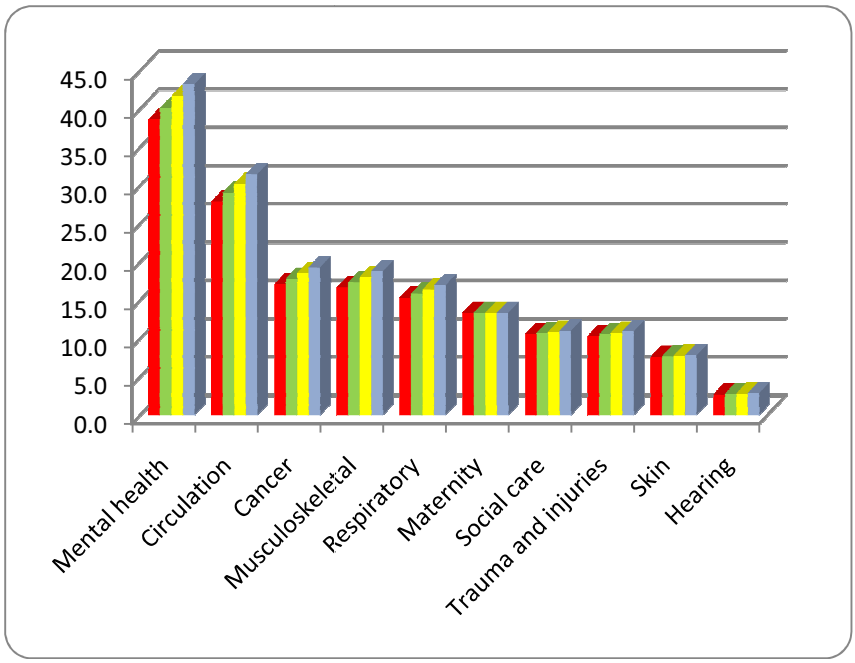
- New surveillance programmes that have identified previously unmet need e.g. cancers
- Increased hospital capacity and efficiency used to drive down waiting times
- Changes in the definition of an admission and better data collection
- New treatments and services becoming more accessible as they are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

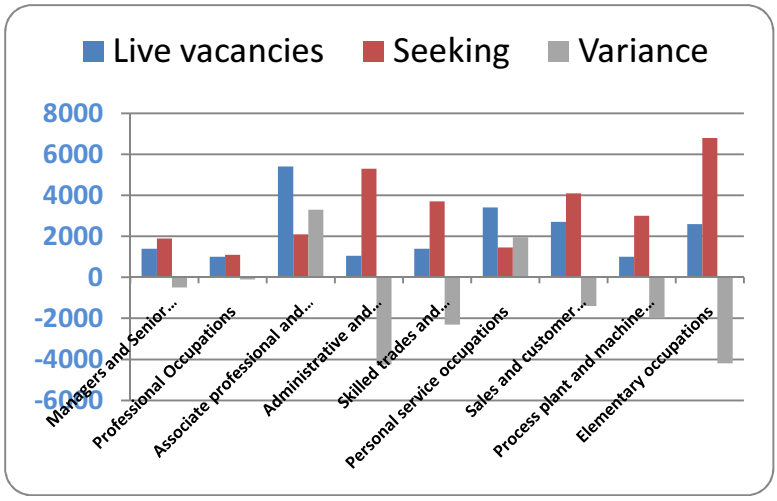
Where other health systems in England have embarked on such a quantum of shift into the community, they have seen the total caseload for their community providers almost double.

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)