DRAFT BETTER CARE FUND PLAN 2014-2016 (SUMMARY) V0.5 **Appendix 2**

5 year Vision	5 year Aims	Underpinning (Existing) Strategies	Existing Foundations	Planning hierarchy
To ensure that everyone lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities 223000 people in 27 practices and 7 Localities growing to over 250000 by 2019 Above average Health (life expectancy and avoidable deaths) but also above average use of hospital care and health inequalities	To improve the outcomes for people in Swindon through the joint investment in high quality services so that we are changing Dependence to self reliance Unplanned care to planned care Single condition to multiple conditions Earlier intervention based on risk stratification Improved patient flow through community and secondary care Enhanced third sector contribution Maximising benefit of primary care **Working as One** or **Being One** for benefit of patients and community	Health and Wellbeing Stratgey JSNA 2013-2022 One Swindon Adult Care Strategy "Doing the Basics Brilliantly" "Our Health in Our Hands" "Shoulder to Shoulder"/Joint Commissioning Plan "Time to Reflect" "Sustainability, Capacity and Choice" "One Swindon, One Voice" "Safely in Swindon"	Risk stratification Building healthy partnerships Transformation Network Social Investment Integrated Transformation Fund One Swindon Programme of Change Joint Commissioning Plan and Board S75 aligned budgets Integrated health and social care provider Research networks National Innovation Hub	Delivery of **National** frameworks and priorities **Swindon** statutory sector priorities, performance and capacity Strengthening the individual, household, **Neighbourhood** and community Linking National, Swindon wide, locality and Neighbourhood plans
Priorities Sequencing of developments over 5 years – 2014 - 2016 priorities Self care and prevention Primary care development and consistency Long term conditions: - diabetes - dementia - cancer - COPD - heart failure stroke Mental health Learning disability Children Carer support Reducing a growing burden of lifestyle related ill health	Assumptions (per annum) CCG Population growth 2.8-3.2% CCG Pay and price inflation: 2.3% CCG Funding growth: 1.5% LA net investment of £550k learning disability and £500k older people packages against LA settlement of -10% 2014/15 Primary care: impact of new contract Community and secondary care: in price efficiencies Impact of Transformation Fund: 7 day working Accelerated discharge Impact of H&WB Strategies: healthy eating no smoking healthy exercise Net Transformation required	Transformation Priorities (joining of schemes) 2014- 2016 Strengthening household and neighbourhood capacity Redesigned pathways of care Re-focused voluntary sector contribution Integration and Integrated working Increased community based support for those with a learning disability, mental health and children 2016 – 2019 TBC Expert patient programmes supported by on line and telephone advice 24/7 Shift from services to programmes of care being commissioned Outcome based contracts linked to pooled budgets	National Conditions 2014 - 2016 Net investment by LA in learning disability packages and in care packages for older people. 7 day working in hospital social work team 7 day access to verification and brokerage Data sharing and use of NHS number in place, Information Governance in place Risk stratification across GP in place, GP LES in place, 5% of patients allocated to community matron/district nurse. Community link worker for patients in 4 practices based on risk stratification	Transformation Opportunities over 5 years Patient flow - **reduced flow** at front end of secondary care - **increased flow** within hospital and community sector - **eliminate flow** due to readmissions and complications Technology Use of monitoring technology eg diabetes Use of communication technology to reduce need for outpatient consultation Use of new medications and surgical techniques to avoid admission, reduce stay, avoid complication, save life or limb

Self care	Primary care (needs timescals)	BCF funded schemes	Secondary care (needs timescales)	Outcomes and baseline
2014 - 2016 Mental health and well being coordinators Small community schemes On line third sector directory of service and advice and information service On line self assessment for social care services Supported housing to maintain people with learning disabilities Work with care homes and nursing homes on preventing hospital admission (focus group) Healthy Eating strategy and schemes Healthy Exercise strategy and schemes Enhanced smoking cessation programme Alcohol prevention and support 2016 TBC onwards 24/7 condition line Roll out single point of access for long term conditions Enhanced expert patient programme (includes prescribed training in condition)	Single vision & approach to performance management of primary care co-developed by AT and CCG Links with community services & link worker, virtual ward, community matron Locality based developments eg enhanced diagnostics, leg club model Specific developments eg monitoring through use of technology Developments in response to risk stratification eg renal, and greater support for medication review Capacity enhancement eg therapists, psychiatric liaison Development of three locality hubs for enhanced services	2014/15 (£3.3m) Ongoing development of reablement and accelerated discharge schemes, Fessey beds, Crisis support (2.1m) Carers support and short term break (LA) £540k Clinical waste £30k Accelerated discharge and access to care packages (460k) 7 day working in social care and community health services (150k) Link Worker initiative (community navigators) Shift model of community and third sector delivery towards locality and practices (100k) 2015/16 (potentially £12.675m) In addition to the above Capital for health and social care Enhance admission avoidance roles of Virtual Ward, SWICC, telehealth, GP at the scene (targeting of residential/nursing homes) Potential Expand Link worker initiative (community navigator following evaluation) to multiple conditions Capital Schemes Carers Support	New "Fix Me" Hub serving wider and growing catchment population c350,000 Single point of entry and initial navigation to appropriate stream within Fix me Hub Streams to include resus. and major, minor, ambulatory and walk in diagnostic, urgent GP and nurse led, medical triage and assessment, surgical assessment, social issues and care Planned care to include clinics for multiple conditions and rapid access and review clinics for specific long term conditions to avoid admission, use of technology to expand consultant links into primary care and use of virtual clinics and consultation	Delayed discharge ASCOF 2C (1) 8.4 per 100k (Comparator 8.1) 2012/13 ASCOF 2C (2) – 4.5 per 100k 2012/13 (Comparator 2) Hospital admission rate Admission to residential care 392.2 per 100k ASCOF 2A (2) October 2014 (612 2012/13, Comparator 715) Readmission to hospital within 90 days following reablement – effectiveness of service ASCOF 2.B (1) 80% 2012/13 (Comparator 84%) People offered reablement following discharge ASCOF 2.B (2) 1.6 2012/13 (Comparator 3.6) Satisfaction with services ASCOF 3A 63.2% (Comparator 64.5%) Outcome measures to also reflect community capacity and self care