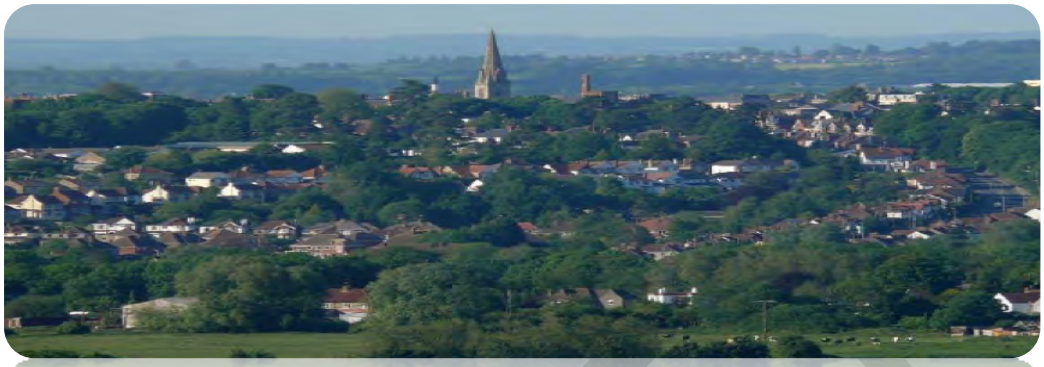
NHS
NHS Swindon
Shadow Clinical Commissioning Group



ONE SWINDON: ONE VISION

Five Year Strategic Plan 2014-2019

Swindon Clinical Commissioning Group

February 2014

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Foreword

Swindon Clinical Commissioning Group (CCG) came into operation from the 1st April 2013, with a mission to optimise the health of 229000 people registered with 27 GP practices in and around Swindon, and to be responsible for commissioning just over £230m of local health services.

One Swindon: One Vision sets out our five year vision and our ambitions for Swindon health and health services. *The Age of Consolidation* then provides a more detailed analysis of the changes we will make over the next two years (2014-2016). Both documents are supported by a number of templates issued by NHS England and which provide the detailed activity and financial analysis to demonstrate that Swindon CCG has a sustainable plan going forwards.

At the heart of this strategy are the following aims:

To increase the life expectancy of people living in Swindon and Shrivenham

To reduce health inequalities within Swindon and Shrivenham

To increase our self reliance and support self care

To increase the support we offer to those with long term conditions

To reduce emergency admissions and make the shift from unplanned to planned care

To use new technology and practice to improve the efficiency and productivity of local health services

To improve the patient's experience of local health services

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OUR VISION

Living in Swindon and Shrivenham in 2019 will mean that you can expect **to live longer** than the English average, with **less risk of avoidable death**, in **greater health** and **with the support of your neighbourhood and community**. More of your care will be planned in advance as part of a **life-long health plan** and **be preventative**, replacing much that is emergency care at present and avoidable.

You will have access to a number of programmes designed **to improve your health**, ranging from healthy eating (including incentives with leading retailers to swap to healthy choices of food) and healthy exercise (cycling to sports activities and recreational swimming to walking and gardening schemes) to smoking cessation programmes (our local programme has saved the second most lives of any programme in England but we are aiming for the top slot) to library and cultural activities, all of which have been shown to benefit health and wellbeing and extend quality of life.

If you have one or more **long term conditions** you will have the support of those with the same condition, informed through expert patient programmes, web based information and seven day call centres, you will be encouraged to take control of your condition whilst being routinely monitored by your primary care team which will include those expert in navigating you to support from your community and the voluntary sector. You will have rapid access to specialist healthcare (including community based specialists, out of hospital and community care and outpatient clinics at the hospital) to avoid the need for emergency care and hospital admission.

If you have need for **rapid access for minor illness** and cannot treat this yourself through rest or use of medication, then you will be able to access a combination of your local pharmacy or make an appointment with one of five primary care urgent care centres, contacted through your GP surgery and open 0800 to 2000 seven days a week (our SUCCESS programme).

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

If you need to **access emergency services**, then you will often be seen by a GP on the ambulance who will assess whether you can be safely treated at home. If you need to go to the local A&E you can expect to be seen and your treatment commence or to have been admitted within a maximum of four hours with a new A&E being built in Swindon that will navigate you to the right department depending on whether you need to see a GP urgently, have a minor injury, require an urgent diagnosis and outpatient appointment, require a medical assessment, require urgent treatment, need to be admitted, need resuscitation or immediate surgery or need to be kept under observation and review. We are calling this new unit our Fix Me Hub.

If you need surgical or medical treatment at a hospital as part of a plan you have agreed with your GP in order to improve your health (**planned care**) then you will have a choice as to which provider you wish to be treated at, can expect to be treated promptly with waiting times continuously improving, to be given information about your treatment before, during and afterwards and to be contacted afterwards to ensure your treatment has been successful. Any home care or community

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support you require after your hospital stay will have been arranged before you leave hospital and will commence on the first day you leave whilst your GP will have been kept fully informed of the treatment you have received and its outcome during your stay and immediately at the point at which you leave hospital.

In the case of both emergency and planned care, you will be kept in hospital for as long as is necessary to ensure when you go home you do not need to return to hospital but equally all agencies will work together and with you **to avoid any delay** in your going home or to a community centre as we wish to minimise the risk of complication, fall and infection that a prolonged hospital stay can lead to.

In the case of services for rare conditions or those needing the care of the most **specialist centres**, you will be able to access the top centres in the country in London, Oxford and Bristol, all of whom are working with the local hospitals to bring as much as possible into Swindon but under the umbrella of their specialist teams and where it is both safe and economic to do so. For example, in future you can expect to receive radiotherapy in Swindon but provided by the Oxford University Hospital, where before you will have travelled to Oxford.

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

The chart overleaf sets out the healthcare support you can then expect when you visit your GP practice, book an appointment at one of the primary care urgent care centres (serving c50,000 people), go to your local hospital (serving c350,000 people) or a specialist centre (serving a million population or more).

The table on pages 7-8 summarises our five year vision.

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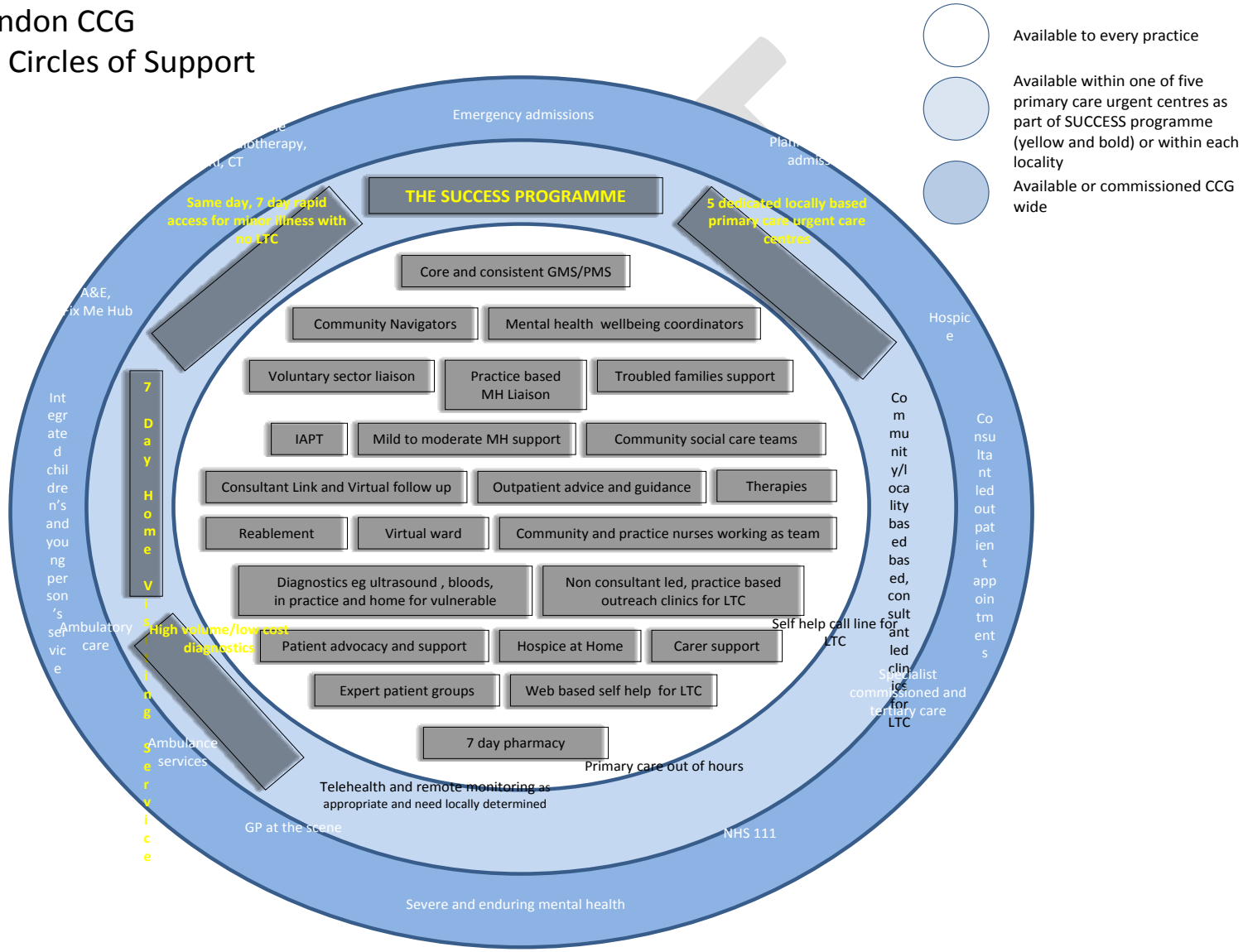
Swindon CCG
The Circles of Support



Available to every practice

Available within one of five primary care urgent centres as part of SUCCESS programme (yellow and bold) or within each locality

Available or commissioned CCG wide

ONE SWINDON: ONE VISION 2014-2019 (SUMMARY)

Mission	Aims	Underpinning (Existing) Strategies	Foundations	Planning hierarchy
To optimise the health of the people of Swindon and Shrivenham 229000 people in 27 practices growing to over 252000 by 2019 Above average and improving Health (life expectancy male and overall and avoidable deaths) but also average use of hospital care below average numbers with long term condition feel supported and PYLL	Maximising benefit of primary care 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 **Working as One** or **Being One** for benefit of patients and community	Health and Wellbeing JSNA 2013-2022 and 2014-2023 Adult Care Strategy "Doing the Basics Brilliantly" "Our Health in Our Hands" "Shoulder to Shoulder" "Time to Reflect" "Sustainabilty, Capacity and Choice" "One Swindon: One Voice" "One Swindon: One Vision"	SUCCESS programme Risk stratification Building healthy partnerships Transformation Network Social Investment Integrated Transformation Fund One Swindon Programme of Change Joint Commissioning Plan and Board S75 pooled budgets (Better Care Plan) 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	**Assumptions (per annum)**	**Transformation Priorities**	**Configuration**	**Transformation Opportunities**
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	Population growth 1.3% Demand growth 2.8-3.2% Pay and price inflation: 2.3% Funding growth: 1.7% Primary care: impact of new contract Community and secondary care: in price efficiencies (4%) Impact of Better Care Fund: 24 hour working Accelerated discharge Impact of H&WB Strategies: healthy eating smoking cessation healthy exercise Net Transformation required: £60m over 5 years	Releasing primary care time for long term conditions and to manage planned care Strengthening household and neighbourhood capacity Expert patient programmes supported by on line and telephone advice 24/7 Redesigned pathways of care Shift from services to programmes of care being commissioned including greater use of block contracts Re-focused voluntary sector contribution Outcome based contracts linked to pooled budgets and over longer term Integration OR Integrated working	AWP no longer fit for purpose and may break up GWH threatened by potential loss of community services SEQOL – small and little opportunity for market growth Most likely scenario: AWP splits and SEQOL picks up some opportunity from this GWH will be long term sustainable through acute growth driven by population growth and demand, improved patient flow, and planned care expansion along M4 corridor	**Primary care** -5 GP urgent care centres - Home visiting service **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

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Self care	Primary care	Community	Secondary care	Other
Community Navigator initiative Troubled families scheme Mental health and well being coordinators Healthy Eating strategy and schemes Healthy Exercise strategy and schemes Enhanced smoking cessation programme Alcohol prevention and support Small community schemes eg Nepalese, Goan initiatives 24/7 condition line Roll out single point of access for long term conditions On line third sector directory of service Enhanced expert patient programme (includes prescribed training in condition)	SUCCESS programme - immediate single consultations to urgent care centres releasing GP team time for long term condition management - home visiting service smoothing arrivals at ED Joint AT and CCG support programme for areas of poor performance Links with community services eg 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, therapists, psychiatric liaison	Enhance admission avoidance roles of Virtual Ward, SWICC, telehealth, GP at the scene, home visiting Develop locality based community models in conjunction with third sector eg leg club model Expand above to multiple conditions Shift model of community and third sector delivery towards locality and practice attached teams in support of primary care configuration Ongoing development of reablement and accelerated discharge schemes	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 resuscitation 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 link into primary care and use of virtual clinics and consultation	Mental health: revisit local capacity model, protect and enhance IAPT model, strengthen crisis resolution and MH liaison with both primary and secondary care, implement health and wellbeing coordination Learning disability: shift towards supportive living model by stimulating local market and expanding employment, occupational and educational opportunities Paediatrics: reduction of emergency admissions through locality based urgent care alternatives eg hot tot clinics, stream cases away from adult ED

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OUR POPULATION

Swindon is classified as a prospering town and has benefitted from a strong economy with above average growth in our total population. The 2001 census showed a bulge in both the 0-9 and working age adult population approaching retirement but we were below both regional and national averages for those over 60. Forecasts between 2001 and 2011 were however that we would see the over 85 populations grow at a much faster rate than the rest of our population due to increased life expectancy.

Indicator	Value	England	Region	England Min	Spine chart	England Max
ONS Cluster	Prospering UK	n/a	n/a			
Registered population	226,465	266,525	287,999	69,778		904,301
IMD 2010 score	16.4	22.1	16.1	5.8		47.4
% of Population age 0-9	12.8	11.7	11.2	8.9		18.3
% of Population age 10-19	11.5	11.5	11.6	8.0		15.7
% of Population age 20-29	13.0	13.9	12.5	8.7		26.8
% of Population age 30-39	14.9	13.8	12.6	9.2		25.3
% of Population age 40-49	16.1	14.9	15.0	10.6		17.4
% of Population age 50-59	12.6	12.3	12.8	7.0		14.7
% of Population age 60-69	9.4	10.6	11.6	3.9		16.5
% of Population age 70-79	5.9	6.8	7.5	2.7		11.1
% of Population age 80+	3.9	4.5	5.3	1.4		8.3

The 2011 Census saw Swindon buck the national trend (which saw population estimates revisited downwards in many parts of England). Population growth continued at the same pace overall in Swindon with an average of 1.3-1.4% per annum. At the local plan enquiry in December 2013, the estimates for future population in Swindon were considered by the Inspector to be potentially understated by as much as 7000 people (a further 2% growth by 2019).

The 2011 Census also identified a significant increase in non White British population to 15% and in those in schools for whom English was not the main language up to 13%, whilst the actual growth in the over 85 population was 4.9% per annum (3.6% per annum for the over 95 age group). Average expenditure for these two age groups was £11794 in 2012 compared with an average allocation per head for the whole population of £1003.

The population pyramid from the 2011 Census is shown overleaf. The red and blue lines show how this is forecast to change in Swindon by 2019.

The key changes are the growth in the over 85 age group, mainly in the male population, and the fact that the male population will overtake the female population by 2019. The 16-25 age group is also forecast to increase which may see Swindon start to develop specific services for this age group particularly around renal and cancer (this age group being the only cohort that has seen survival rates for cancer decline in the last ten years with evidence from UK specialist centres and from Europe of the need for specific services for the adolescent and young adult). The other material growth is in our working age adult population approaching retirement (45-65), offset to a degree by a much smaller 65-75 population proportionately than the English average.

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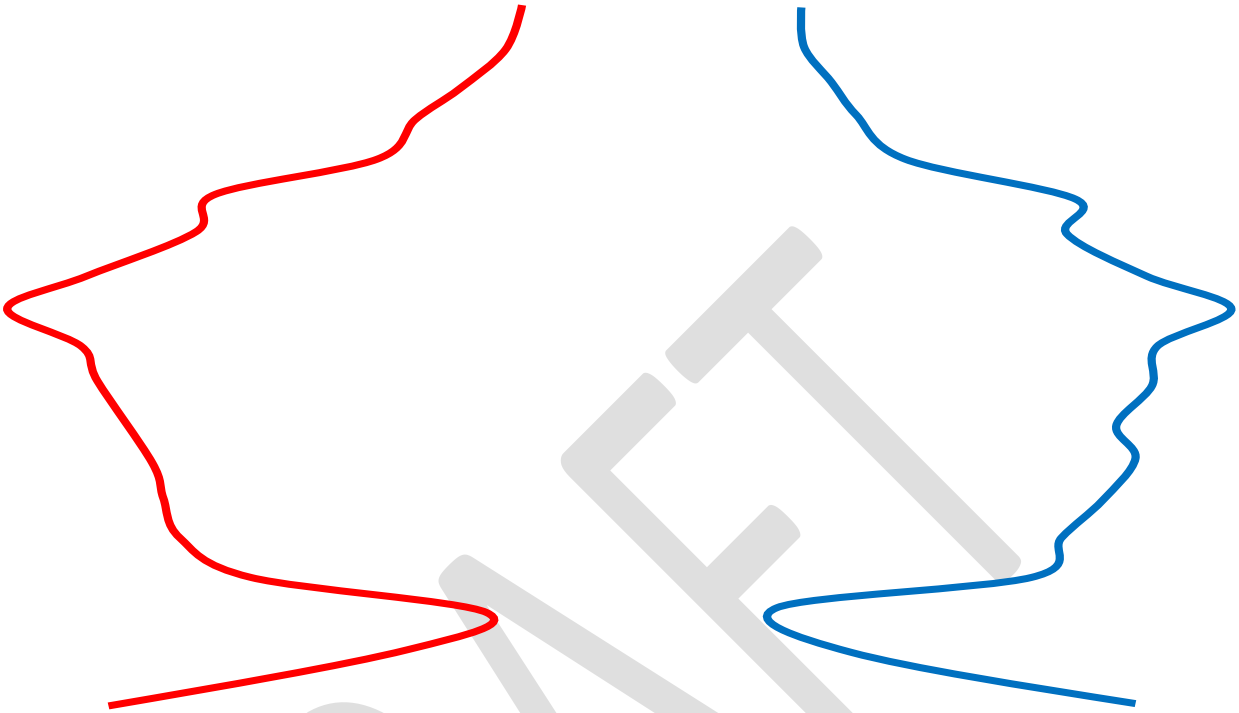
Population Pyramid 2011 with 2019 projection shown as lines



Life expectancy

Swindon residents can now expect to live nearly 3 years longer than when the Census was undertaken in 2001. Female life expectancy is much closer to the English average and both male and overall life expectancy are above the English average. Potential years of life (PYLL) that could be saved for women has increased ie gone the wrong way, and is above the English average in 2012 for the first time in a decade, indicating there is far more that we can do locally to further increase female life expectancy.

In 2012, our JSNA spoke of Swindon being healthier than the English average with above English average life expectancy for our population as a whole (but with female life expectancy reported as below the English average at 80.2 years compared with 80.7 years). Hospitalisation rates were reported as higher than the English average and rising faster than the rest of England.

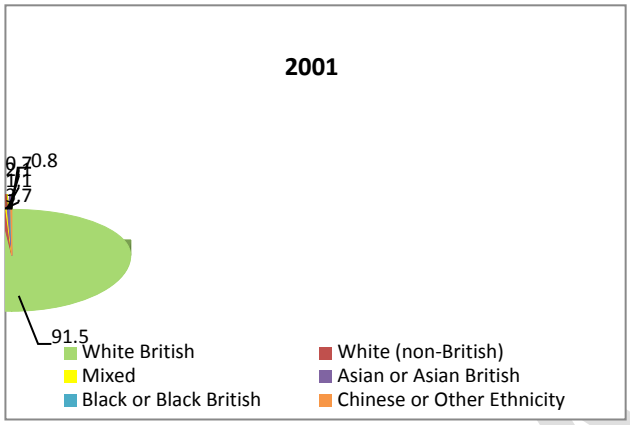
Based on the 2011 Census and 2013 hospitalisation rates, the situation has improved in most regards with the exception of potential years of life lost (see below). Hospitalisation rates are now in line with the English average with key health determinants such as female life expectancy coming much closer to the English average (82.7 years compared with 82.9 years). Life expectancy for both men and women in Swindon has improved at a much faster rate than the English average and are both better than the English average.

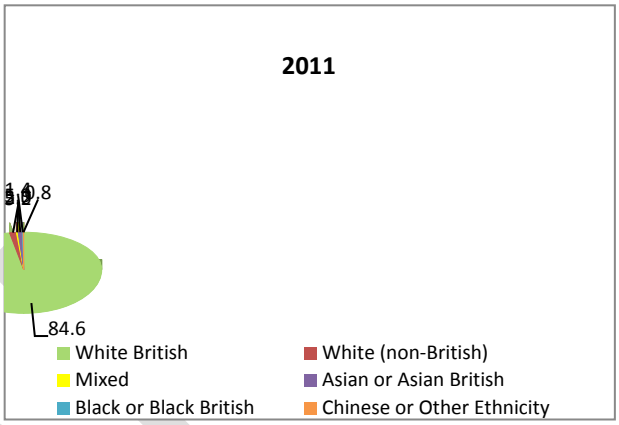
Meanwhile, the **gap** in life expectancy between the least and most deprived has reduced significantly amongst the female but risen slightly amongst the male population. In our last JSNA,

the gap for the overall population was over 8 years between the least and most disadvantaged and was growing at the rate of one year in every ten years. The gap is now under 8 years, so has steadied (and indeed fallen for the first time since 1801, although the gap is still concerning at just under 9 (8.9) years for men). Reducing health inequalities for men remains a top priority.

Minority groups

The growth between 2001 and 2011 in minority groups is shown in the two pie charts below:





This growth places even greater emphasis on the development of approaches to healthcare design and delivery that reach out to and are guided by our new communities. The greatest growth has been in communities who are also vulnerable to diabetes, respiratory and cardiovascular disease (which are priorities for new interventions in 2014-2019 therefore).

Reducing health inequalities

Improving health, particularly female health, and reducing health inequalities between the least and most disadvantaged amongst our male population remain the top priorities with the launch of our Health and Wellbeing strategy in 2013.

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

Long term conditions

Meanwhile, in 2001, 27476 people reported having a long term condition which limited them in some way. A similar question was asked in the census in 2011 and the reported figure has risen to

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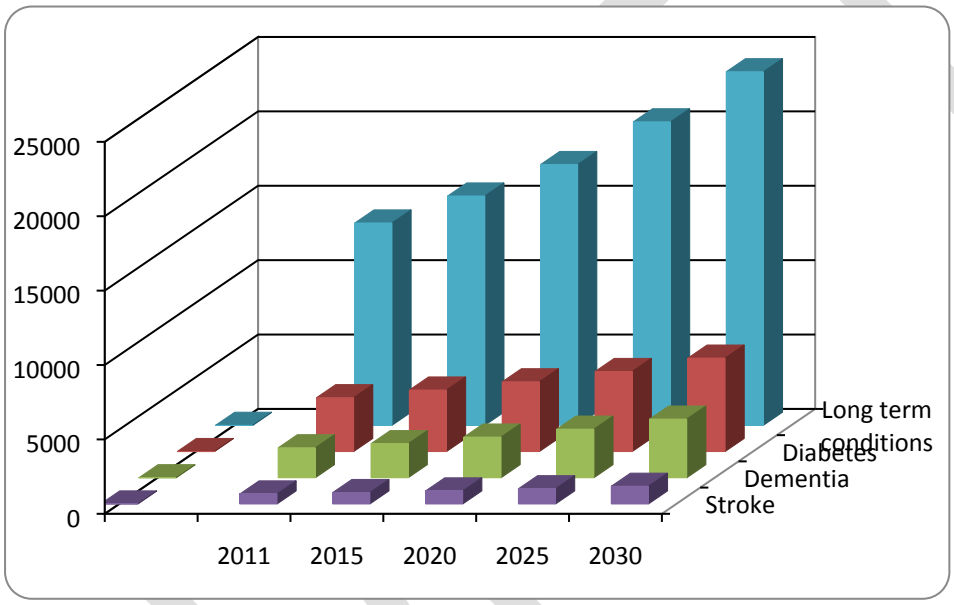
32302. This is a very slight rise *in percentage terms* from 15.2% to 15.3%, suggesting that, despite a significant change in the age demographics between 2001 and 2011 (48.6% growth in the over 85 age group), this has had little if any impact on the overall prevalence of those with long term limiting illness. The key impact of our ageing population has been in the number of residents who have **multiple conditions** and their **degree of debilitation**, neither of which is collected as part of the Census, but information on both is now available through our investment in risk stratification.

Growth in demand due to forecast changes in our population

Whilst the overall number of Swindon residents living with a long term condition has increased in line with our overall population, some conditions such as diabetes and respiratory disease have grown faster than that due a a near doubling of minority groups where the prevalence of these conditions is higher, whilst other conditions such as dementia and stroke are forecast to increase at a faster rate than our population due to the faster rate of growth of our older population



The forecast growth rate for these conditions is significantly faster at 4-5% per annum 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 networks. Those with a long term limiting condition are two to three times more likely to also develop depression.

From 2016 onwards, the resources coming into Swindon for health services will match our population growth but fall below the level of demand from our population as we see the over 85 age group grow at 4.9% per annum and the above increase in chronic illness.

Our response is a combination of the following:

- Managing long term conditions differently in primary care through investment in urgent care centres and home visiting that will release primary care time
- Investment in greater community support for individuals and households to help the development of self care and coping strategies
- Investment in health promotion and prevention
- Greater coordination of and better navigation to the voluntary, primary care and community support that exists

- Placing the patient in control of their condition trough access to better information about conditions using web and social media and also investing in expert patient programmes and peer support networks

The vast majority with long term conditions are being managed effectively in primary care by GPs and their teams including practice and district nurses. However, not all patients receive the same level of care nor are achieving the same level of outcomes and the volume of urgent care is saturating all of our member practices, reducing the time that can be spent on those patients with long term conditions.

We will work with primary care teams to support them as they reduce the level of variation in outcome principally by streaming the large numbers of patients requesting one off consultations for minor ailments through our five GP Urgent care centres and thus releasing more time in primary care for patients to have their long term conditions assessed, monitored and managed.

People who have long term conditions can also have reduced mobility and thus become housebound or isolated. This can lead in turn to depression, anxiety and frailty. We will develop a dedicated home visiting service therefore as part of our SUCCESS programme, work with local communities and the voluntary sector to avoid isolation within our communities, and with primary care and community teams to support people's physical and mental health needs.

Trends in hospital admissions

Since 2002, the number of admissions to hospital care in Swindon has grown at a faster rate than our population (with us seeing typically 3-5% annual growth in admissions 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 eg 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 has been in emergency admissions since 2011 and the marginal rates that apply to this activity are less than the actual cost of treatment). Our health system will silt up with emergency care unless we invest in self care, prevention and alternative pathways that see rapid access to planned care and ambulatory care for those with long term conditions.

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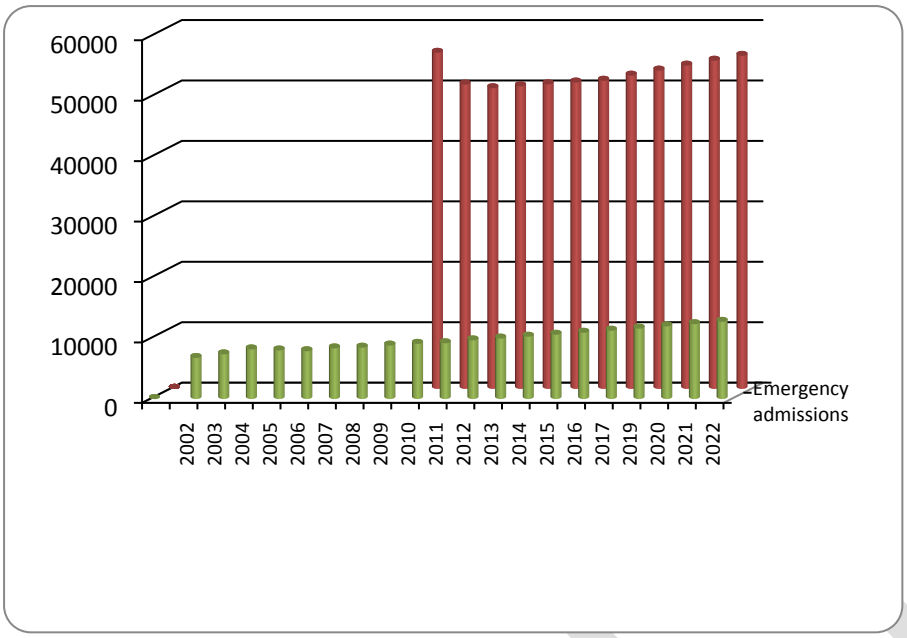
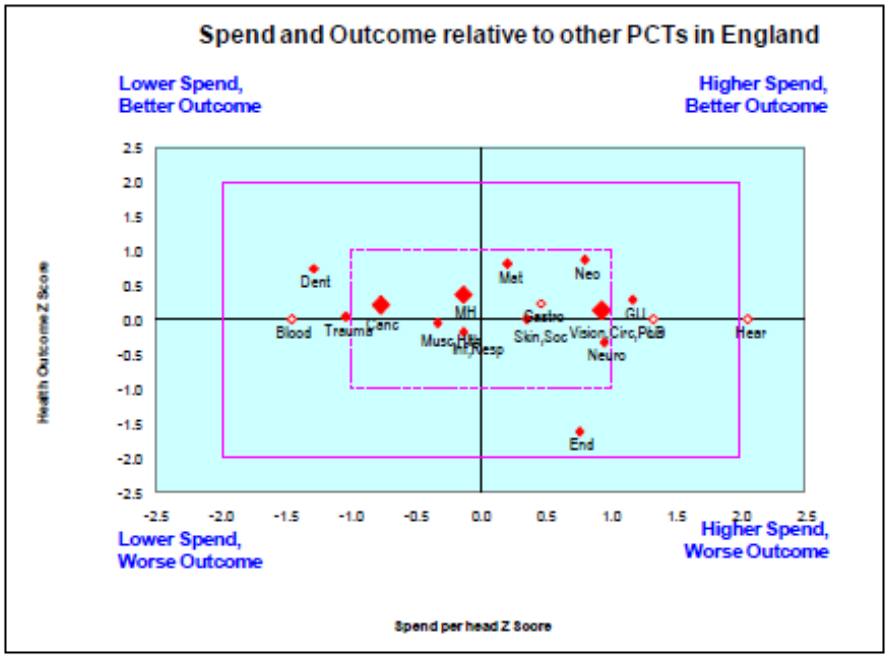


Whilst the overall level of admissions is not forecast to rise above the position in 2011 (which represents a peak in the total of admissions), the rise in emergency admissions at 3-4% per annum and (as of equal concern) the higher proportion of emergency admissions compared to planned care since 2011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

At the same time, if we look at our overall level of investment by programme of care ie we group what we spend by condition, disability or disease such as mental health or circulatory problems etc, we see within our Joint Strategic Needs Assessment that there is little correlation between spend, activity and outcome. Essentially, our historic spending pattern has not always been **paying for results**.

Figure 6.8 Swindon's position on a matrix of health spending and outcomes, compared to England, 2010/11.



This chart shows how our various programmes of spend cluster based on investment compared to the English average and performance compared to the English average. Mental health and cancer which are key priorities are shown to be cost effective and both have also had to address both service change and growth in demand. 30% of our programmes have above average investment and are not achieving above average performance.

In assessing the likely growth in **demand** for healthcare, therefore, we have gone back to our population and the impact we predict from population growth on each of our programmes of spend.

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

Forecast growth in demand based on age profile of users of services and indicative programme spend

Programme	Spend £ms (includes specialist services)	%	Annual growth estimate	Projected spend			
				2013-2014	2014-2015	2015-2016	2016-2017
Mental health	37.2	14.10%	3.83	38.6	40.1	41.6	43.2
Circulation	26.8	10.10%	4.05	27.9	29.0	30.2	31.4
Genito urinary	18.0	6.80%	4.04	18.7	19.5	20.3	21.1
Gastrointestinal	16.5	6.20%	1.39	16.7	17.0	17.2	17.4
Cancer	16.4	6.20%	4.11	17.1	17.8	18.5	19.3
Neurological	16.3	6.20%	3.62	16.9	17.5	18.1	18.8
Musculoskeletal	16.0	6.10%	4.04	16.6	17.3	18.0	18.7
Respiratory	14.8	5.60%	3.44	15.3	15.8	16.4	16.9
Learning disability	14.5	5.50%	0.00	14.5	14.5	14.5	14.5
Maternity	13.3	5.00%	5.54	14.0	14.8	15.6	16.5
Endocrine and metabolic	11.0	4.20%	3.87	11.4	11.9	12.3	12.8
Social care	10.4	3.90%	1.39	10.5	10.7	10.8	11.0
Dental	10.1	3.80%	1.39	10.2	10.4	10.5	10.7
Trauma and injuries	10.1	3.80%	2.01	10.3	10.5	10.7	10.9
Vision	8.8	3.30%	4.04	9.2	9.5	9.9	10.3
Skin	7.5	2.80%	1.01	7.6	7.7	7.7	7.8
Infectious diseases	4.4	1.70%	1.39	4.5	4.5	4.6	4.6
Poisoining	3.9	1.50%	1.11	3.9	4.0	4.0	4.1
Neonatal	3.8	1.40%	0.00	3.8	3.8	3.8	3.8
Hearing	2.6	1.00%	2.01	2.7	2.7	2.8	2.8
Blood disorders	1.9	0.70%	1.11	1.9	1.9	2.0	2.0
Totals	264.3			272.4	280.9	289.6	298.8
Overall growth in demand (%)				3.10	3.12	3.10	3.18

OUR OUTCOMES AND PERFORMANCE

Outcomes

We have set improvement targets over the next five years for every outcome in all 5 domains against which the CCG will be monitored by NHS England. Two outcomes in particular require additional attention and intervention: **Potential Years of Life Lost**, and **Avoidable emergency admissions** (including unplanned admissions for chronic conditions that can be treated through ambulatory care).

Indicator	Value		England	Region	England Min	Spine chart	England Max
▼ Outcomes - domain 1							
Potential Years of Life Lost amenable to healthcare - female	2,222	↑	1,911	1,712	1,098		3,071
Potential Years of Life Lost amenable to healthcare - male	2,182	↑	2,267	1,911	1,568		4,039
Under 75 Mortality from CVD	63.4	↑	66.9	56.1	35.6		124.0
Under 75 Mortality from respiratory disease	32.6	↑	28.3	23.0	12.7		67.9
Emergency admissions for alcohol released liver disease	21.3	↑	25.7	18.2	5.8		83.9
Under 75 Mortality from cancer	121.4	↓	123.8	115.5	87.0		174.5
▼ Outcomes - domain 2							
% of patients with LTCs who feel supported	74.8		72.8	75.5	59.7		80.5
Unplanned admissions chronic ACS conditions	905.0	↑	826.5	630.5	211.1		1,711.1
Unplanned hospitalisation for asthma, diabetes and epilepsy in under ...	371.9	↑	338.6	287.0	70.4		723.9
▼ Outcomes - domain 3							

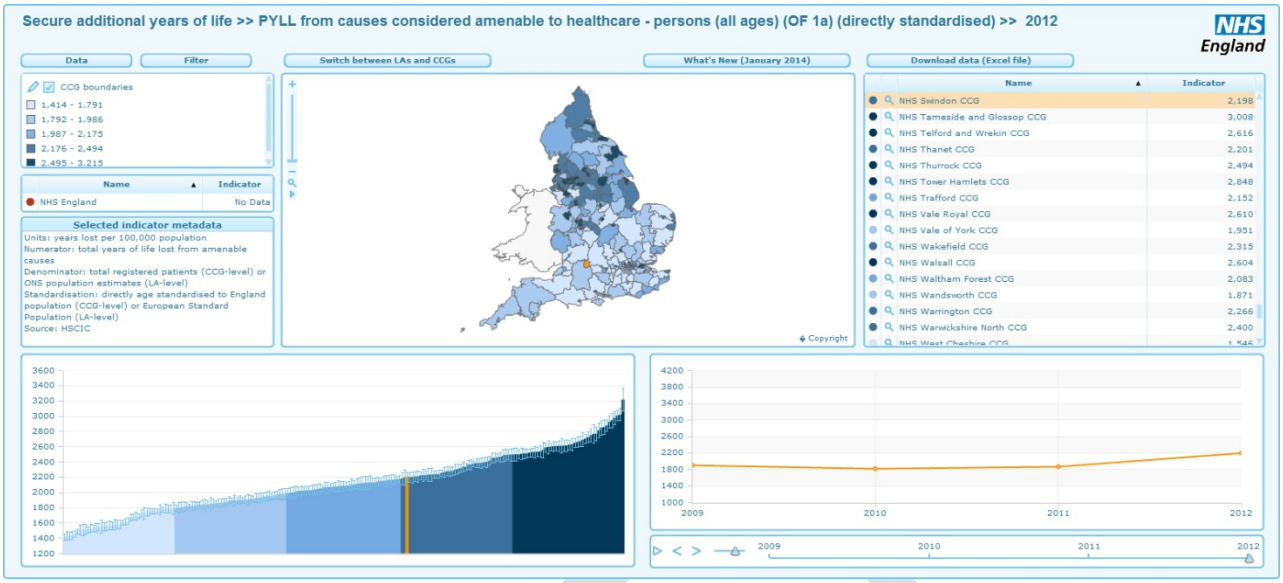
Indicator	Value		England	Region	England Min	Spine chart	England Max
▼ Outcomes - domain 3							
Emergency admissions for acute conditions that should not usually r...	1,227.7	↑	1,217.9	979.7	289.3		2,188.6
Emergency readmissions within 30 days of discharge from hospital	11.8		11.8	11.3	8.1		13.8
Hip replacement casemix adjusted health gain	0.43	↑	0.41	0.43	0.28		0.45
Knee replacement casemix adjusted health gain	0.29	↑	0.30	0.30	0.20		0.37
Groin hernia casemix adjusted health gain	0.11	↑	0.09	0.09	-0.03		0.14
Emergency admissions for children with lower respiratory tract infecti...	276.3	↓	406.1	396.5	79.0		731.5
▼ Outcomes - domain 4							
Patient experience of GP out-of-hours services	63.6	↓	70.8	72.9	51.5		84.3
▼ Outcomes - domain 5							
Incidence of healthcare-associated infection - C.Difficile	18.01		27.88	28.55	7.96		58.46
Incidence of healthcare-associated infection - MRSA	1.35		1.77	1.70	0.00		5.81

Potential years of life lost (PYLL) and saved

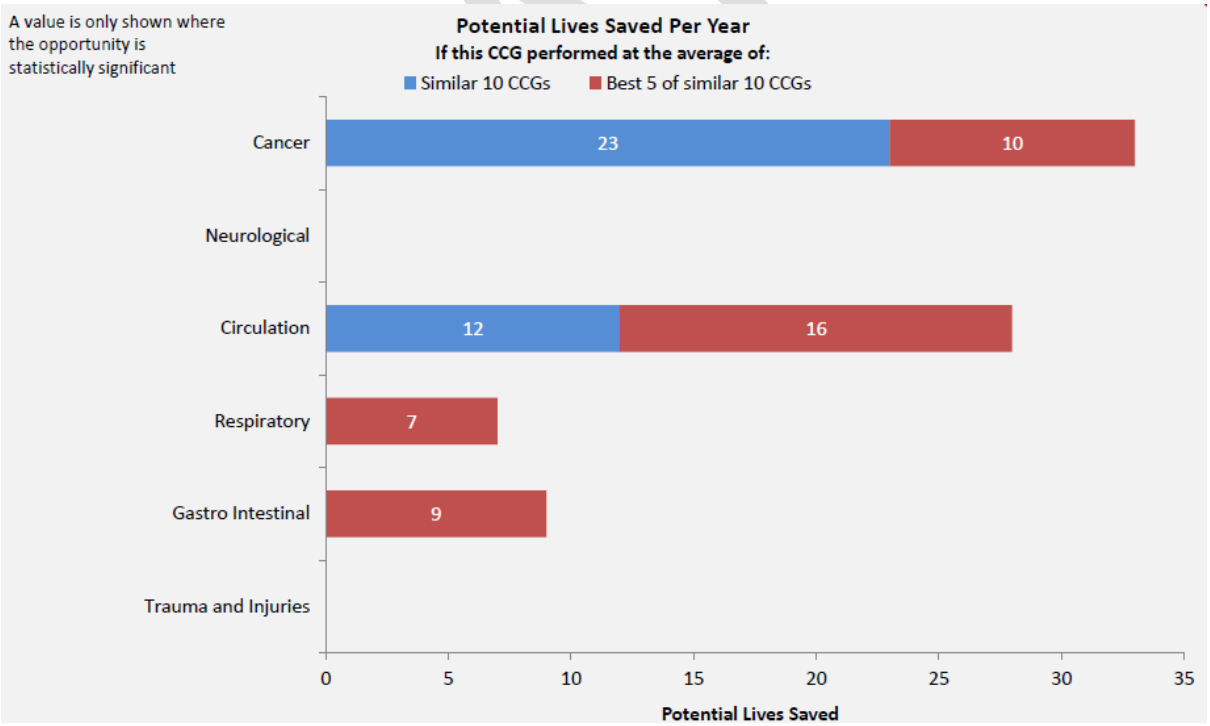
Swindon's PYLL has moved from being best tertile to worst tertile in the single year of 2012 and our ambition is to return to the best tertile position at 1819 or where the local community was in 2010.

With the exception of diabetes (female deaths working age) and respiratory disease (under 75 for both genders), mortality through avoidable deaths are fewer in Swindon than the English average.

In 2009 (the latest year for which we have national statistics with which to compare), less than one per cent of the Swindon population died with the main causes of death being: RTA amongst children followed by congenital abnormalities; suicide was the main cause of death in the 15 to 34 age group; then coronary heart disease for men from 35 onwards and for women over the age of 65. For women aged between 35 and 64, breast cancer was the leading cause of death.



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



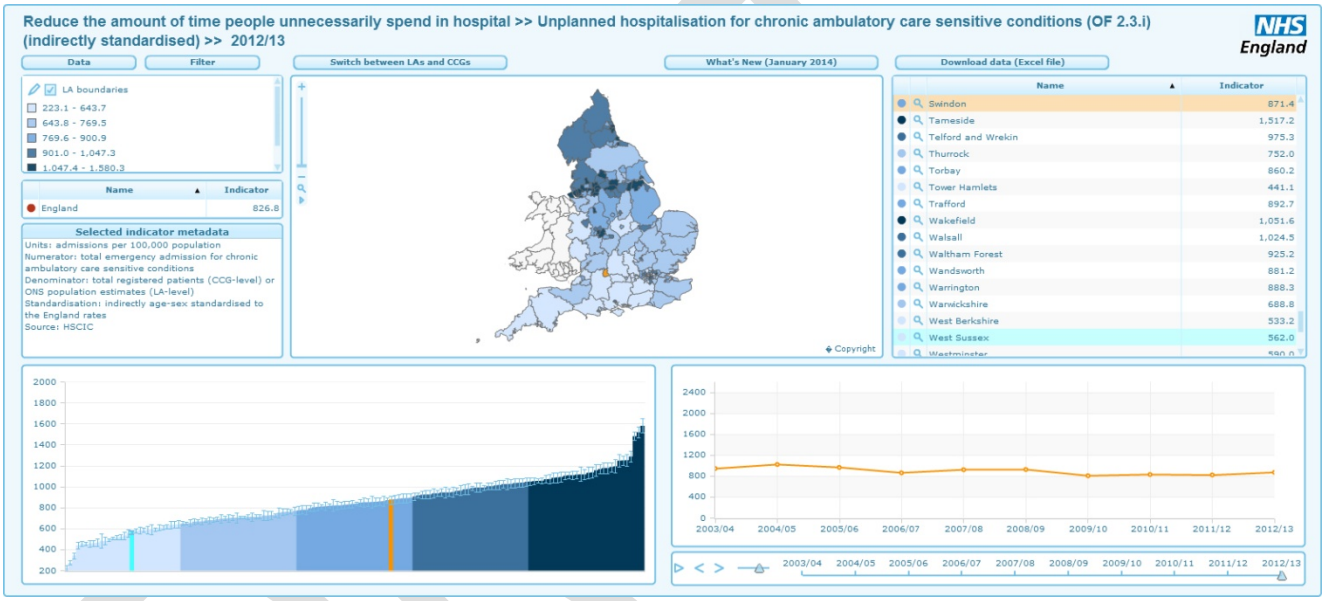
Avoidable emergency admissions

Although the Swindon comparative and actual admission rate for emergencies has improved over the last nine months and in the period 2007 to 2011 (during which period Swindon saw one of the biggest reductions in the emergency admission rate in the country), our admission rate deteriorated in 2012 (note: this may be due to the classification of ambulatory care) and so there remains a

significant opportunity when comparing the CCG with its peer group and with all CGGs (with potentially just over £1.5m savings in circulatory and respiratory diseases alone).

The CCGs ambition is to restrict growth in demand in emergency care at a maximum of 1.3% which is 1.5% per annum below our age adjusted annual growth in demand. However, our interventions would also see a further switch from unplanned care to planned and ambulatory care of 1.5% to 2% per annum as part of the change in management of urgent care and long term conditions.

The overall gross change (when combining the admissions avoided altogether and those shifting to ambulatory care) would therefore be a 15.5% reduction in unplanned care over the 5 years of this strategy.



Redesigning local health services

Our programme of public and patient engagement in redesigning local health services has identified a number of opportunities to improve the support we offer to those with **long term conditions**, **urgent care** and for key conditions such as **joint pain**. Below we summarise some of the findings from our service redesign programme in 2013.

As a general finding, the support currently offered is regarded as difficult to access or to navigate through, often confusing, with many people in Swindon (and some of our GP members) not aware of the full offering of support local residents can receive and finding the names given to some services confusing or unhelpful. In all instances, both the workshops and our surveys of members identified the need to engage with and make greater use of the local voluntary sector and to provide greater support for informal carers.

Web and social media are not seen as being used well whilst expert patient programmes appear to have disappeared or gone into retreat. Many patients would welcome knowing far more about their condition and also about where to go for advice in addition to or as an alternative to their local GP

surgery and hospital. Many also feel that when they have developed more than one condition, the way in which the health service treats each condition separately is neither helpful nor efficient.

Summary from Swindon's service redesign programme in 2013

Dementia

Two workshops have been run so far and these identified the need for carer support and earlier diagnosis together with a revised pathway for access to secondary care support and investment in the Community Navigator model. Three pathways are being reviewed (as provided by national lead on dementia) for implementation in 2014. In the meantime additional investment continues for memory clinics until the new pathways have been implemented. The Community Navigator model has been implemented already and will be expanded to include support for those with dementia and their carers in 2013-2014.

Diabetes

Two workshops have been run together with the launch of a Diabetes Network to oversee the delivery of our local programme of improvement in diabetic care. The CCG has committed to six key changes:

- development of better information for patients as part of expert patient and peer support programme, training programmes for those with diabetes and for healthcare professionals, supported by social media and web based information;
- need for better information in practices about voluntary sector contribution supported by expert navigator (pilot has gone live);
- improvements in foot screening and footcare including using the standardised checklist developed by Roche, reviewing the priority given by podiatry, exploring the Kingston model, ensuring all footcare inspections included an inspection of the foot and avoiding amputations through better use of the local vascular network;
- improvements in primary care monitoring through support from community specialist services with a number of practices with plans in place to improve their QoF scores on diabetes;
- retinal screening where a back log has built up during the transition between providers and still needs to be addressed but where there has been significant improvement in the last quarter of data available;
- and ophthalmology where issues over waiting list management have seen priority cases missed or delayed in being seen and is now being addressed following a review by the RCoOph

Joint pain

The recommendations from this workshop on knee replacement are covered in more detail when we look at our progamme of change for planed care. The current pathway and complex offering is not understood by local residents and many services are by-passed or not referred to eg MATS. The RMS further complicates the process and can lead to incomplete information being sent to surgeons for review. Discrepancies in diagnosis in primary care have led to mis-diagnosis of knee and hip pain.

The level of knee replacement being commissioned is below the needs assessed for Swindon.

There is evidence of unnecessary delay and also of unnecessary follow up with no protocol based discharge process. Smoking cessation and weight loss prior to surgery are not being promoted as fully as they could be, with risks not being consistently communicated to the patient.

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A new pathway is being developed with greater use of virtual follow up and protocol based discharge. A review of MATS has commenced looking at whether there is a real benefit or does it delay treatment?

Joint pain web site for patients is to be developed. Need for practice based navigator (pilot has gone live). Use of Optimise will continue to be encouraged within primary care and is supported by membership in recent survey.

Finally, the local spinal pathway and clinical threshold were reviewed in 2013 as comparatively Swindon was at the high end of surgical intervention. A new threshold was introduced since the workshop, which has seen a reduction of £0.2m per annum in overall investment in spinal surgery across the CCG by introducing new guidance based on NICE recommendations.

Urgent care

Four workshops resulted in a six point plan:

- community navigators to aid self care (gone live)
- GPs at the scene and on the ambulance to divert at first point of contact (gone live)
- a new Fix me Hub which streams patients on arrival between primary care, minors, ambulatory, majors, resuscitation, specialist clinics and rapid access, observation etc
- better patient flow across the system and within the hospital supported by protocol driven decisions with the same criteria and information being used by all parts of the health and social care system;
- a single point of discharge (gone live)
- and better communication and coordination of care post discharge to prevent readmission

Cancer

There is clear evidence of growth in need and demand but also poor performance against the 31 day cancer target and a significant proportion of those with cancer being identified for first time following an Emergency Department attendance. Under 75 cancer mortality rates are also high in Swindon.

Radiotherapy within Swindon is a priority for investment given the 1 hour travel time to our nearest centre in Oxford.

The result of two workshops was support for radiotherapy investment and the business case from Oxford University Hospital for radiotherapy to be brought to Swindon, support for further centralisation of cancer services on the Great Western Hospital campus wherever possible, and support for the co- development with Marie Curie of a Survivorship programme. Investment in cancer services generally is predicted to grow at above the 1.3% average population growth and a refreshed JSNA on cancer is to be produced and published by the end of 2014

Paediatrics

The first workshop was on the day of the national pledge and saw the CCG publicly endorse the pledge. Swindon is slightly above the English average on hospitalisation and spending, but just below on avoidable deaths. However, the English average is not a good place to be with amongst the worst avoidable death rates and hospitalisation rates in Europe combined with the second highest spend per capita in Europe.

Key themes to emerge were the development of a hot tots out of hospital care model, together with a 7 day urgent care model for minor ailments as part of the SUCCESS programme for primary care, supported by evidence from 800 interviews of those attending ED of the reasons why parents attend with their children and the opportunity to divert by offering immediate appointments at primary care based urgent care centres. The second workshop concentrated on the detailed pathway design for the above services.

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COPD

A number of patients were identified as being routinely admitted to hospital for observation and care. A revised pathway was implemented in January 2014 and funded through a CQUIN. A successful out of hospital model including virtual ward and also one of the best no smoking programmes are to be extended over the next two years as both are proven to deliver real health outcome and economic benefits.

End of life

The recommendations were:

- to move towards life-long health planning to include preparing for the final stages of life;
- whole community access to summary care record;
- change our vision for end of life such that the choice of dying at home includes the choice of dying in one's own bed with one's partner etc and not in a hospital environment within the home;
- exploring technology, practice and approach to care in the home so that we don't preclude those with narrow staircases or other reasons commonly given for not being able to offer someone their preference

The future will see everyone receiving their preference for where they wish to be cared in the last stages of life and we will accommodate both our practice and the equipment we use to enable this.

Cardiology and Heart Failure

Three models emerged from our workshop, all of which will have benefits for patients not just in cardiology but in other conditions as well: the concept of consultant link (immediate telephone access substituting for outpatient clinics, successfully piloted in Bristol with huge patient experience gains and savings with 68% of outpatient appointments reducing from £200 to £65); Expert GPs in cardiology at locality or CCG level presented by a GP already working this model in the North of England, with potential for further clinic reduction; and the introduction of MTAU and new protocol for admission through rapid access chest pain pathway based on clinical audit, reducing admissions where indicators stabilise naturally in six hour period gone live in January 2014

Long term conditions

Emerging from all of our workshops was a common approach to supporting those with long term conditions. Our strategy is targeted at addressing the five main healthy support areas that improve the health of all of those with life-long conditions (healthy eating and exercise, smoking cessation, reducing alcohol abuse and stress), and doing so in a way that places us as patients in control of our conditions and health at various stages of life from Starting Well to Working Well to Preparing for Death Well. Key is ensuring that everyone with a life-long condition can access advice and support from a variety of sources, ranging from media to others with the same condition to their own family friends, colleagues and neighbours.

Being navigated to the best advice, but also being helped to put together the life-long health plan that will enable each of us to cope with our conditions is essential and this is why Swindon CCG has placed considerable stock in the development of our SUCCESS programme (releasing primary care team time to review patients with long term conditions) and the Community Navigator role within every primary care team, based on the models that have been successful in the US, France, Italy and Germany, and more recently piloted in NE London.

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Addressing immediate areas of poor performance

In addition to the key improvements above, our strategy also addresses long term **and sustainably** the current areas of poor performance in:

- access to radiotherapy
- control of infection
- long waits for planned care (52 weeks or longer)
- access to stroke beds
- and A&E 4 hour performance

We have included within our two year plan (*The Age of Consolidation*), the rectification plans to address poor performance immediately within the first year of this strategic plan (2014-2015) in control of infection, stroke, over 52 week waiters and 4 hour wait in A&E. Our cancer rectification plan is to a large degree tied to our investment in additional radiotherapy capacity to be located in Swindon in 2015-2016.

Sub domain	Reference	Short Description	Target	Performance						Trend	Direction to improve
				In period		Direction	Year to date		Year end forecast		
Treating and caring for people in a safe environment	CB_A15	Healthcare acquired infection (HCAI) measure (MRSA)	0	0	G	⇔ Dec	3	R	4		⇩
	CB_A16	Healthcare acquired infection (HCAI) measure (c. difficile)	0	3	R	⇔ Dec	44	R	59		⇩
Waiting times	CB_S5i	Mental Health Measure- Improved access to psychological services - The proportion of people who have depression and/or anxiety	0%	0%		Apr	3%		14%		⇧
	CB_S5ii	The proportion of people who complete treatment who are moving to recovery	0%	0%		Apr	48%	R	48%		⇧
	CB_B1	i. The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period on an	90%	96%	G	⇧ Dec	95%	G	95%		⇧
	CB_B2	ii. The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period	95%	97%	G	⇧ Dec	97%	G	97%		⇧
	CB_B3	iii. The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period	92%	95%	G	⇩ Dec	95%	G	95%		⇧
	CB_S6iii	Number of 52 week RTT incomplete pathways greater than 52 weeks for patients on incomplete pathways at the end of the	0	0	G	⇩ Dec	23	R	31		⇩
	CB_B4	Diagnostic test waiting times - over 6 week waits	1.00%	0.40%	G	⇩ Dec	0.57%	G	0.57%		⇩
	CB_B5iii GWH	A&E Department - % of A&E attendances under 4 hours (GWH)		92%	A	⇩ Dec	95%	G	95%		⇧
	CB_B6	All Cancer 2 week waits	93%	96%	G	⇩ Nov	96%	G	96%		⇧
	CB_B7	Two week wait for breasts symptoms (where cancer was not initially suspected)	93%	94%	G	⇩ Nov	94%	G	94%		⇧
	CB_B8	Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of	96%	96%	G	⇧ Nov	96%	G	96%		⇧
	CB_B9	31-day standard for subsequent cancer treatments-surgery	94%	95%	G	⇩ Nov	95%	G	95%		⇧
	CB_B10	31-day standard for subsequent cancer treatments-anti cancer drug regimens	98%	100%	G	⇔ Nov	100%	G	100%		⇧
	CB_B11	31-day standard for subsequent cancer treatments-radiotherapy	94%	80%	R	⇩ Nov	80%	R	80%		⇧
	CB_B12	All cancer two month urgent referral to first	85%	85%	A	⇩	85%	A	85%		⇧

Designed and Produced by Health Intelligence Analytics CSCSU

OUR AMBITIONS

Our ambitions by 2019 are to have achieved the following outcomes:

- reducing the potential years of life lost in Swindon to 1819 (17.5% improvement) thus increasing female life expectancy to above the English average
- reducing the gap in life expectancy between the most and least advantaged of our male population to below 8 years
- meet the specific health needs of our growing population from minority groups and also reducing the health inequalities experienced by those who provide informal care for others
- shift an average of 1.5% of emergency admissions each year into planned or ambulatory care
- reducing our emergency hospitalisation or admission rates by 1.5% per annum
- provide greater support to those with long term conditions such that at least 80% of those for whom we care feel supported
- reducing the norm for medical length of stay by 10% by 2019
- reducing the percentage of patients who are ready to leave hospital but yet to go by 60%
- increasing the number of patients who when surveyed say their experience of local healthcare was neutral to positive to 90%
- ensuring through the commissioning of specialist services that at least 95% of patients are offered the choice of a specialist centre for their care if they require a specialist service

Improving local health outcomes

The key opportunities for improvement locally are:

- Increasing the **potential years of life saved** for our female population, with our ambition being to return to the top tertile nationally (see section on Outcomes and Performance)

- **Avoiding unnecessary emergency admissions**, (see section on Outcomes and Performance) for which we have three inter-linked ambitions:

  i. **reducing** our standardised admission rate for emergencies. In 2007-2011 we had one of the lowest rates of growth in England (indeed we saw an annual reduction in unplanned care of just under 1% per annum in that period)
  ii. **increasing** our access to ambulatory care and thus shifting the balance of unplanned care towards planned care. Our uptake on ambulatory care has been one of the fastest in England bit there is still a significant opportunity to do more
  iii. **reducing** readmissions, which are particularly high in general medicine, to a maximum of 1.5% in all specialties

- Increasing the percentage of those with **long term conditions who feel supported**. We are currently above the English average but have set ourselves the target of getting to 80% by 2019 which is close to the current English maximum. Our vision and programme for long term conditions includes considerably more support at every level from self care to public

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information and expert patient groups to more time in primary care to rapid access to outpatient consultation so we are moderately confident that a shift from 75% to 80% in a population of 32000 is achievable over five years

Reducing health inequalities

The opportunity to reduce health inequalities lies in the following four main areas:

- The gap between the least and most disadvantaged men in terms of their life expectancy is currently 8.9 years and we will seek to actively reduce this to below 8 years through targeting households and the work place and expanding on successful exercise, leisure, no smoking and healthy eating programmes

- Older carers have a lower life expectancy whilst younger carers have a higher level and burden of stress than the general population and we will invest in and refocus our support for carers to meet these needs

- We have a growing population from minority groups who also have a much higher proportion of carers than the general population for Swindon and have higher incidence of some long term conditions eg diabetes, asthma and other respiratory diseases

- Those households with lowest incomes and/or with people living in isolation or over-crowded conditions are significantly more likely to access hospital care than the rest of the population and also have lower life expectancy and self assess themselves to be in poorer health (based on Census 2011 and 2011 and analysis of Mosaic)

Key interventions include: our SUCCESS programme, Community Navigator, Early Start, Carer Support, Mental Health and Wellbeing, Healthy Eating, Healthy Exercise, Smoking cessation, and Supporting those with Long Term Conditions programmes

Key supporting strategies include: our Health and Wellbeing strategy 2013; Self Care strategy 2013, Healthy Eating strategy 2014, Healthy Exercise strategy 2014, *One Swindon: One Voice, 2013*

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OUR PROGRAMME OF CHANGE

Commissioning for Value

Swindon CCG is ranked in the best tertile in terms of value already realised through commissioning. The summary data pack identifies some £8m of opportunity split approximately 50% in planned care, 25% in medicines optimisation and 25% in avoidable emergency admissions.

Some of the data is from 2012-2013 and has already been used by the CCG to inform the 2013-2014 QIPP programme and so has been discounted to avoid any double count. In the case of Musculoskeletal spend, the detailed data underneath the summary (and a subsequent NHS England report) do not support the high level benchmark analysis so this saving opportunity has also been discounted.

This leaves £4m of opportunity that is being pursued. In planned care most of the opportunity appears to be in reducing outpatient activity and we have a number of key interventions such as consultant link and virtual follow up clinics that we will roll out across specialties to reduce both new and follow up appointments.

Savings carried forward from 2013-2014

In addition, we have the full year effect of schemes implemented within 2013-2014, particularly opening the GP Urgent Care Centre (£0.47m), GP at the Scene (£0.28m), Community Navigator (£1.08m), changes to the local spinal threshold (£0.10m), SAU (£0.04m), ISTC use (£0.80m) and COPD (£0.16m), totalling £2.93m carried forward.

One Swindon

One of the major savings opportunities within the Swindon health system is the delivery of the One Swindon agenda. This is in three parts:

12 Transformation Projects

12 business cases have been approved by the One Swindon Board and supported by both HM Treasury and the national Transformation Network of nine organisations pioneering integrated working nationally. These range from a single procurement hub to new and integrated workforce initiatives to investment in reducing alcohol and domestic violence related crime, abuse and

hospitalisation to support for troubled families, those with mental health problems and the Community Navigator scheme.

The overall benefit has been assessed by HM Treasury, the national Transformation Support Unit and Ernst & Young as in the range of £16m to £90m per annum across the partners. Conservatively, the CCG has only assumed the lower range of benefits from three schemes: the Community Navigators (£1.08m), Mental Health and Wellbeing Coordinators (£0.3m) and Early Start (Troubled Families) initiative (£0.08m) but the health economy as a whole should benefit from 9 of the 12 business cases in 2014-2017.

Social and charitable investment including bonds

In addition, and on the back of being a national pilot for the Building Healthy Partnerships initiative, Swindon CCG is on target to go to market for between £10m and £40m social and charitable investment as grants over seven years to support further transformation concentrating on four areas: urgent care, end of life care, learning disabilities and domestic violence. The feasibility study (funded by the Cabinet Office but originally under-written by the CCG) is due in March 2014 and will identify the order in which we should go to market together with any other opportunity areas, such as social and older people isolation (compare the five Worcestershire and Herefordshire CCGs social investment bond).

One Swindon Transformation Hub

Finally, and in support of the transformation agenda faced y the CCG, we will be part-funding a joint Transformation Hub which has been set up and supported by HM Treasury (funding of £1.5m over 2013-2015 and more on offer) as well as One Swindon partners to deliver a cost:benefits ratio of 1:2.14 ie for every £1 invested by a partner non-recurrently, there is a payback through transformation of £2.14 recurrently by the end of 2015-2016. Most of this benefit will come from exploring and then locally implementing the schemes developed and evaluated in the other eight of the nine National Transformation Network pioneers.

Planned care

Our strategy is ultimately to increase the level of planned care as we reduce the level of unplanned care. Our vision is that a crisis in bed management should be exceptional because the level of emergency care (and the peaks and troughs in predictable and unpredictable demand) have been reduced and smoothed throughout the day and the week. Our SUCCESS programme, coupled with our programmes for Urgent Care, supporting those with long term conditions and promoting self care and prevention, will deliver this change but on the assumption that there will be more rapid access to planned and ambulatory care.

In the period 2007-2011, we saw annual growth in the range of 4-5% in planned care, paralleled by one of the largest year on year *reductions* in unplanned care in England. 2011-2013 has seen this position reverse. It has also seen a reduction in GP referral rates.

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Our SUCCESS programme starts to address what appears to be the consequence of primary care becoming saturated with immediate demand for one off consultations with low levels of underlying pathology, dissipating our ability to manage long term conditions and planned care. We have achieved the shift from unplanned to planned care **before** (and need to do so again) but this time it will be driven by releasing the time in primary care to manage that shift.

This does not remove the need to also make efficiency savings within planned care.

Schemes such as Consultant Link and Virtual Follow Up have huge transformational and economic potential, with 60% plus outpatient consultations in cardiology, for example, avoided through the pilot scheme in Bristol – each Link consultation saving £140 and over £0.4m savings being made for one CCG in one speciality alone.

Our vision for the future is for a predominantly **immediate** or instant consultation with secondary care in the GP surgery with the patient present, avoiding any need for an outpatient clinic in 50-65% of occasions, depending on specialty, and with less than 15% of current follow up appointments being face to face.

So whilst the volumes of surgical intervention and referral for specialist advice will increase (in some cases faster than average population growth given the ageing nature of our population), the models of delivery we propose to introduce will significantly reduce the wait for consultation (50-65% will be immediate in future), the number of face to face consultations (by 50-65% for new and 85% for follow up), and the average cost per consultation (by 50-75% per consultation).

The corollary will be that we will wish to use some of the capacity released through these changes to establish multi specialty clinics capable of addressing the most common combinations of conditions in a single consultation, rather than (as happens at present) providing a succession of uncoordinated clinics, each independently operating on a single specialty basis and resulting in GPs and patients having to navigate very complex systems of referral and follow up.

In 2013-2014, we addressed issues over the surgical intervention for spinal surgery. The next major qualitative and surgical threshold area is **knee replacement**, with a significantly worse PROMS result in Swindon than the English average. This was the subject of one of our most productive service redesign workshops in 2013. The key findings and feedback from patients and clinicians were:

(1) we can offer a wide choice for patients locally for surgery below the knee and for knee replacement with good feedback from patients on the benefits of surgical intervention

(2) the volume of knee replacements commissioned is below various needs assessment for the Swindon population

(3) our RMC and MAT services are causing delay in the surgical pathway that is not justified by the benefit of either intervention

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(4) initial diagnosis of joint pain needs to improve with not all joints on a leg being examined where pain is identified in one joint (NICE guidance. Early diagnosis of knee pain as hip pain is not uncommon but causes delay in local treatment (sometimes for years) and can be eliminated through the greater use of Optimise

(5) inconsistent pain management and mobilisation whilst waiting for care and a lack of public awareness of what is on offer whilst waiting for surgery eg the MATs service

(6) when knee surgery has been undertaken (and there are very few adverse comments about the actual surgery) poorly coordinated post discharge care, especially equipping the home with aids and wound care, have been highlighted as further areas of concern. Variability in wound care is a major concern and addressing this became a CQUIN for 2013-2014

(7) replacement knees now last longer and so the age at which the first knee replacement can be made has come down but this is not being consistently applied, leaving many of working age unable to work independently

(8) MRI provides an in-exact science in circumstances where a long term tear of the cartilage has not self-repaired or where the knee joint has de-stabilised in its natural state but has to be re-assembled and supported to take the MRI

(9) Eliminating smoking, addressing weight, managed exercise and therapy are all essential to avoiding complications and ensuring a knee replacement does not require revision as well as avoiding a readmission. Yet these are not promoted for NHS care of the knee *as actively* as with the private sector. The risk of heart failure during or immediately after surgery, for example, is ten times that for a smoker compared to a non smoker whilst length of stay due to wounds taking longer to heal is up by 20% for the smoker. Every patient has a right to know this as these are material differences in outcome

There is some evidence of possible price movement: *intermediate* knee procedures comes up for example as having increased significantly above our population requirement with minor knee operations reducing by a commensurate amount. Similarly we have seen the number of procedures classified as "with complications" increase since 2012. During each year of our five year plan we will undertake external coding and activity reviews to ensure there is no "price drift", that is the movement of activity into more expensive tariffs in order to deliver internal income targets as part of a provider CRES programme.

In 2013-2014, we set an ambitious target for switching activity towards our local ISTC, who have spare capacity for Swindon residents and whose contract is currently under-utilised by us. The switch proved difficult given the location of the ISTC and the range of alternative providers we can offer nearer to or in Swindon.

However, given the need to allow the local ophthalmology service in Great Western Hospital to review its waiting list management on the back of an external review by the Royal College of Ophthalmology (it was recommended in their report that the current service should temporarily

cease to be offered as a local choice for new referrals and that use should be made of the private sector to buy the local service the space to get its act in order), we anticipate an increase in demand for the ISTC in 2014-2015.

On that basis, we plan to increase our use of the ISTC and have identified an opportunity for savings in 2014-2015 of £0.9m (with a full year effect of nearer £0.8m given that there may be some additional activity going through in 2013-2014 but unlikely to be greater than £0.1m).

Mental health and learning disability services

In addition to the admissions that will be avoided through our mental health and wellbeing coordinators, we were successful in making £0.3m savings in 2013-2014 through the reduction of mental health placements outside of Swindon and have plans in place to make similar savings every 2 years during the life of our strategy, equating to an average of £0.15m per annum.

A further opportunity lies in our hospitalisation rate for those with mental health problems and whom are admitted into Great Western Hospital. Our hospitalisation rate is currently over twice that of the English average and (given our prevalence of mental health is significantly below the English average) this is hard to justify or to support as the acute setting is the wrong environment. Over half of those being admitted to the local hospital should not be going into an acute hospital setting but rather being offered different support in their home or in other settings.

In the case of services we commission for those with learning disabilities, a proportion of the savings made by the Borough Council in moving from residential care to supportive living arrangements will accrue to Swindon CCG wherever there is aligned health spend. The total savings that will be released across both organisations will be in the region of £7-8m over the life of our strategy, with potentially 5% of that deriving as healthcare savings or in the region of £0.08m per annum.

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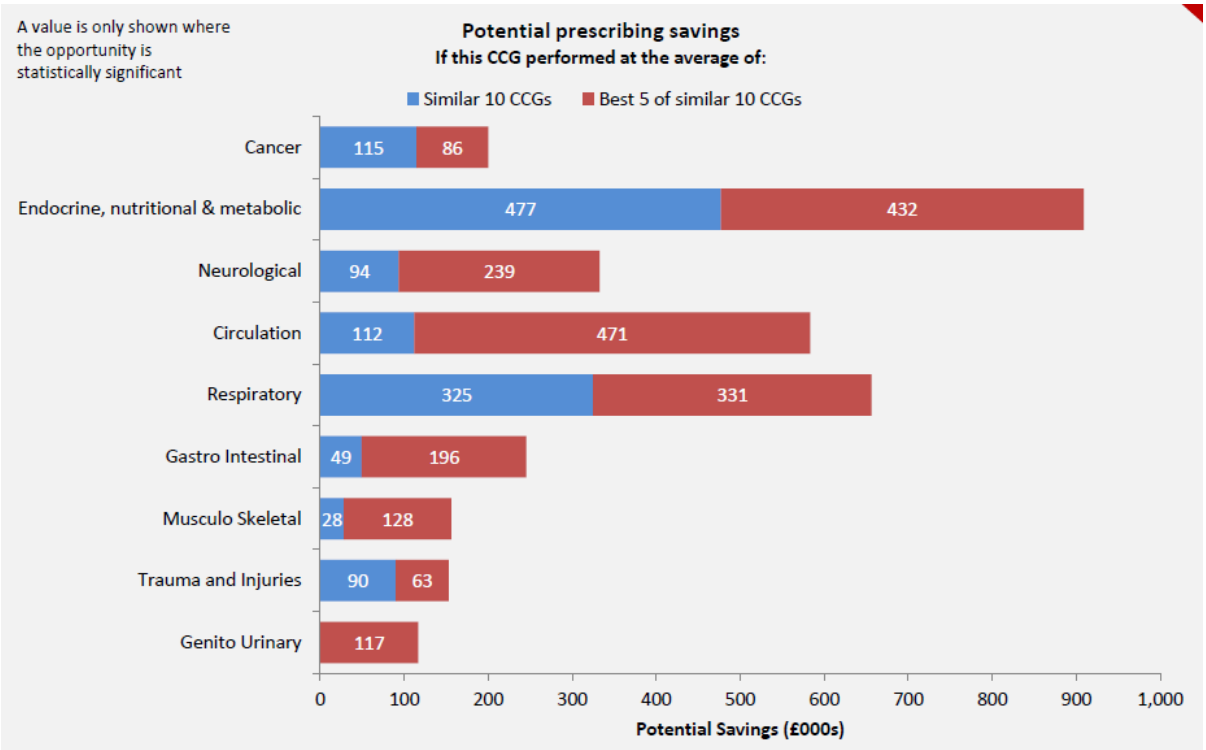
Medicines optimisation

The CCG's lead on medicines optimisation (and his approach to supporting our member practices) has seen two successive years of cost reduction in prescribing, delivering savings equivalent to those identified in the NHS England Commissioning for Value pack and so our programme has targeted £1m before growth and £1.5m after growth in each year of the strategy as achievable:

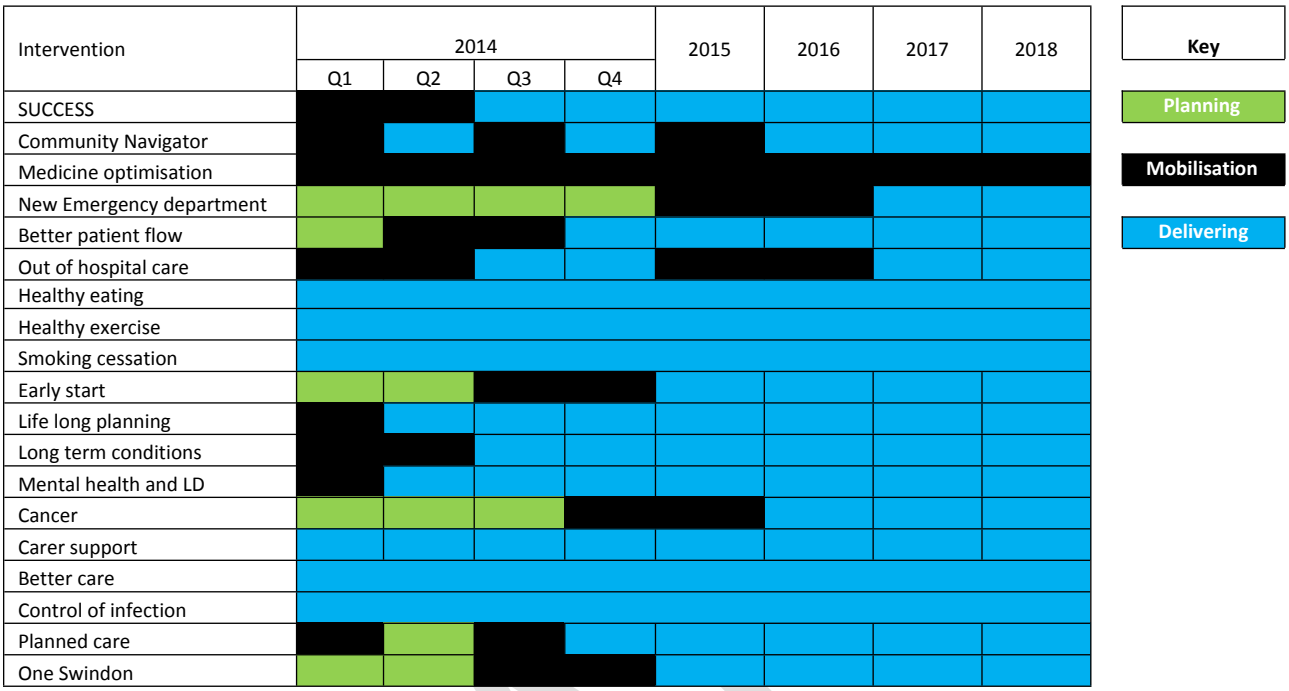


Our Priority Interventions

Our vision has been developed around the delivery of nineteen key interventions, each of which has its own business plan or forms part of one of our clinical priorities as identified by our membership: Urgent care, Cancer, Self care and prevention, Long term conditions (diabetes, dementia, COPD, asthma, stroke and heart failure), Children, Carer support, End of life care, Mental health and wellbeing, Support for those with learning disability. The interventions are:

- SUCCESS programme
- Community Navigator programme
- Medicines optimisation
- Fix Me Hub (new Emergency department)
- Better Patient Flow
- Out of Hospital Care strategy
- Healthy eating strategy
- Healthy exercise strategy
- Smoking cessation programme
- One Swindon Transformation
- Early Start programme
- Life long planning and end of life
- Long term conditions programme
- Mental health and learning disability
- Cancer strategy
- Carer support programme
- Better Care Fund
- Control of Infection programme
- Planned care programme

Mobilisation timeline



Benefits realisation (financial)

Intervention	2014 Q1	2014 Q2	2014 Q3	2014 Q4	2015	2016	2017	2018
Carry forward 2013-2014 *	-0.26	-0.26	-0.26	-0.27				
SUCCESS **								
Community Navigator			-0.27	-0.27	-0.81	-0.81		
Medicine optimisation	-0.40	-0.40	-0.40	-0.38	-1.59	-1.59	-1.59	-1.59
New Emergency department								
Better patient flow			-0.09	-0.18	-0.36			
Out of hospital care ***	-0.13	-0.13	-0.26	-0.26	-0.25	-0.25		
Healthy eating								
Healthy exercise								
Smoking cessation								
Early start					-0.08			
Life long planning		-0.21	-0.31	-0.32	-0.23			
Long term conditions			-0.11	-0.16	-0.55	-0.55	-0.55	
Mental health and LD	-0.14	-0.14	-0.14	-0.14	-0.23	-0.23	-0.23	-0.23
Cancer								
Carer support	-0.07	-0.07	-0.08	-0.08	-0.30	-0.30	-0.30	-0.30
Better care								
Control of infection								
Planned care	-0.21	-0.21	-0.31	-0.31	-1.25	-1.25	-1.25	-1.25
One Swindon					-0.30	-0.30		
Technical adjustments ****	-0.25	-0.25	-0.25	-0.25	-1.54	-1.02	-1.02	-1.02
Run rate								
Finance	-1.46	-1.67	-2.48	-2.62	**-7.49**	**-6.30**	**-4.94**	**-4.39**

* excludes Community Navigator and ISTC which are in SCCG2 and SCCG 18
** 2014-2015 assumed to be funded through PM Challenge Grant otherwise scheme does not proceed **in full** but would be part funded through Transformation reserve – for this reason these costs have not been added through to the finance total in the bottom row.
*** includes NHS111/NHS Direct savings from original business case
**** includes managing CHC budget within 0 inflation, contract challenges and fines at 0.2%, Running cost savings, other technical adjustments

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Summary of activity changes (2014-2019)

Summary of activity changes	Outpatient new	Follow up	Planned care admits	MH placement	LD residential care	MH admissions	ED Attend	Emergency admits
2014-15	-726	-1912	-96	-1	-1	-23	-7795	-3576
2015-16	-5082	-13385	-157	0	-1	-46	-12575	-4055
2016-17	-9437	-24857	-157	-1	-1	-46	-13711	-5390
2017-18	-13793	-36330	-157	0	-1	-46	-14847	-7265
2018-19	-18149	-47802	-157	-1	-1	-46	-14847	-7265
Total	**-46461**	**-124285**	**-628**	**-3**	**-4**	**-207**	**-55980**	**-27551**

Workforce

In *Doing the Basics Brilliantly*, we summarised out strategic vision for the local workforce. Our strategy is to develop and enhance the support in primary and community care and thus shift the balance of care towards self care, prevention and the management of long term conditions. This strategy is heavily dependent on:

- our ability to attract professionals into local primary care teams through being innovative in the design and delivery of the local model of primary acre (Our SUCCESS programme) and through continuing to be successful in the delivery of primary care based research programmes;
- changes in the way the voluntary and community-based public sector operate in a more coordinated fashion focused on the delivery of programmes of care that promote self-reliance or substitute for existing care in a more economic and effective manner;
- our ability to move existing secondary care professionals from the hospital to primary care or community settings as we effect the shift toward more out of hospital care;
- and our ability to recruit in the local labour market

We have developed our out of hospital care strategy and one of the early pieces of our analysis highlighted that as much as 25% of acute medicine could shift out of hospital based care to a comprehensive model of care in the community. Such a shift, however, 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 Australia, as the only country to publish results showing real savings, is dismantling their out of hospital care programme because it destabilised their hospital sector.

Huge and ambitious targets for shifts from hospital to out of hospital care are not helpful therefore as they lead to uncertainty in the hospital sector, whilst also outstripping the ability of the community sector to recruit. Our strategy assumes a 1% shift per annum from hospital care to out of hospital care as part of our overall vision to hold demand for secondary care at 1.39% rather than the 2.8% to 3.2% growth in demand we forecast if we do not continue to take action to develop alternatives to hospital care.

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The evidence worldwide is consistent that a well-developed out of hospital care model is successful at reducing growth in emergency admissions and reducing length of stay by providing earlier intervention and the opportunity for prevention as well as accelerated discharge.

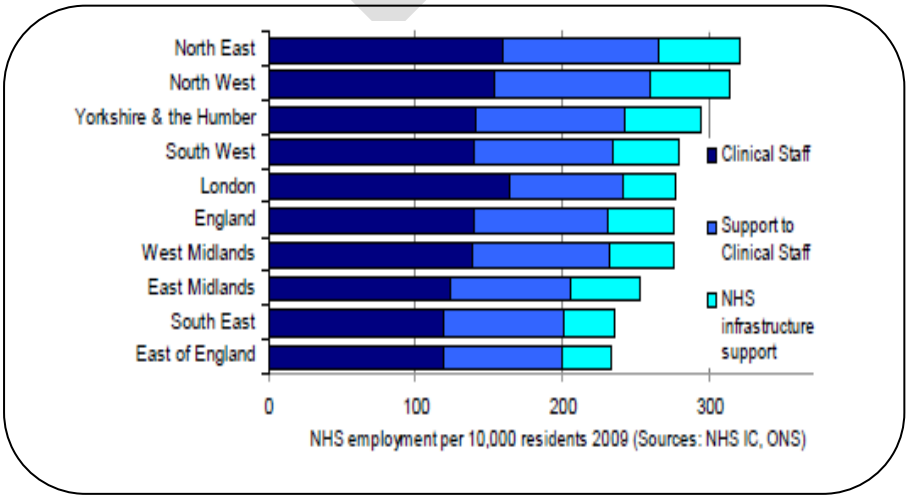
Where other health systems in England have embarked on such a quantum of shift into the community, they have seen the total caseload for their community providers almost double. This can be offset in part by changing the model of delivery of existing community services and thus achieving some productivity 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.

In addition, our local community provider SEQOL has achieved significant productivity and quality gain through providing staff with the incentive of sharing in the success of their social enterprise. This is a model of personal incentive that some of the best and most efficient healthcare providers in the world, such as John Hopkins or Kaiser Permanente, have also implemented.

Even the above approaches, however, are unlikely to meet more than 20-30% of the need for additional capacity in community services over the life of our strategy. The primary, voluntary and community sector workforce will need to increase ... which presents a challenge.

Our region is higher than the English average in terms of employment of NHS staff per head of population. Somerset, Wiltshire and Swindon, however, are all significantly **below** the regional and English position. A combination of distance from target funding and the historical gravitation of NHS professionals towards the larger teaching and research centres in Bristol, Southampton, Plymouth, Oxford and London, has seen Swindon healthcare provide support to our local residents through a much higher level of consultations per professional.

This is at its most stark in primary care, where the average number of consultations per GP is **19.2%** higher than the age adjusted English average (with four practices at 60-70% higher).



The South West region has a higher proportion of NHS staff per capita than London and the English average. Only London has a higher proportion of clinical to non clinical staff than our region

The figures exclude GPs and primary care teams however the IC ONS for GPs shows a comparatively similar position for the region

Delivering our vision will require more staff in new roles, with all professionals promoting health and self-reliance as a core professional responsibility. Coordination and continuity of care will see many roles combine. Swindon will need to attract new professionals into the area at a time when there are already significant vacancies for healthcare professionals and those seeking work locally have different qualifications and background.

Professional, technical and personal service occupations are currently the only areas where there are more opportunities than those seeking work. The traditional employment areas in Swindon, such as process and plant operatives, administration and sales, all have an already saturated labour market, with job seekers therefore looking to retrain.

Our strategy invites the whole health economy to look collectively at the opportunities we will be offering for employment and to design our training and development approaches to meet a likely gap in the labour market that may require in excess of 1000 new community and voluntary sector staff as well as a 5-10% increase in the size of primary care teams.

In particular, we want to build on the successful models of development and recruitment that have been developed within both SEQOL and Great Western Hospital with both organisations growing their own internal talent through training and succession planning and thus releasing roles in junior positions and entry grades that are suitable for the local labour market to consider as new careers with some re-training.

We are actively working through One Swindon and local Employment Services to develop a joint business case for investment in both promoting and providing development opportunities for those seeking to start a new career in health and social care, as well as reviewing the outcome of the pioneer scheme in Scotland for accelerated qualification to become a primary care assistant practitioner or general practitioner.

SUCCESS programme

This programme forms a key part of our Urgent Care, End if Life and Long Term Condition strategies and sees two key developments:

- the establishment of five GP Urgent care centres offering same day appointments for those requiring a one off consultation for a minor ailment or minor treatment and with no underlying long term condition, operating 0800 to 2000 hours seven days per week

- the implementation of a dedicated GP home visiting service operating 0800 to 2000 seven days per week as an enhancement of our existing and successful GP at the Scene scheme which sees GPs working with the ambulance service to avoid residents needing to be conveyed to hospital

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The above are supported by a workforce development and recruitment programme, investment in information sharing software to enable the development of and access to MYHealthMYLife summary care records, and an underpinning estates programme.

The SUCCESS programme will not only achieve a reduction in both emergency attendances and admissions in its own right but also is the key enabler for our self care, end of life and long term condition programmes (see below).

The first three centres will open in April to May 2014, with the fourth and fifth centres opening by the end of the summer 2014, subject to a successful bid against the PM Challenge Fund which will be announced in March 2014.

Community Navigator programme

Based on the North east London and Paris models of community gateway workers , evaluated by HM Treasury and funded through the national Transformation Network, this scheme went live as a pilot in four practices in January 2014 and has already delivered a reduction in emergency admissions and nursing home placements by working with households and neighbourhoods on developing personalised coping strategies around self care and prevention but tapping in to the social capital within each street and community as well as providing practical advice on health and guiding people towards further advice and peer support.

It has delivered savings in its first month equivalent to a cost: benefits ratio of 1:9. The scheme will be rolled out to all member practices requesting it in 2014-2015.

Medicines optimisation

The CCG is in to the third year of its medicine optimisation programme which has seen good quality practice based information and advice on the opportunity to change medicine practice where there is both a qualitative AND economic gain move the CCG from being the highest spender per capita on medicines in the region to the lowest. The approach of putting good, expert, timely information that balances outcome and economy into the hands of GPs and practices to determine for themselves what action to take has proven to be incredibly successful - far more so than attempts elsewhere to performance manage primary care on its medication spend.

Opportunities still exist to improve both outcome and keep growth in medication spend to around the growth in our population as identified in the Commissioning for Value pack but also as identified through risk stratification (where the need for a medication review is one of the most frequent interventions indentified for those who were the highest users of healthcare). The level of wasted or prescribed but unused drugs runs at 40% in Swindon, the average scripts per capita is over 20 per annum, and spend on medication represents approximately 15% of the CCG's allocation per head of population or an average of just over £150 per head per annum.

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Fix Me Hub (new Emergency department)

As part of our Urgent Care strategy, we propose to develop a new Emergency department in 2015-2016, subject to business case approval, which will enable patients arriving at the Emergency department in future to come through a single entrance and then be triaged by a senior clinical decision maker before being streamed immediately to any of the following, each of which will be separate units thus avoiding the Emergency department itself silting up:

Resuscitation
Emergency Treatment Centre
GP Urgent Care Centre
Minor Injuries Unit
Ambulatory Care and Diagnostic Centre
Observation Unit
Rapid Access Clinics (for key conditions)

We have already demonstrated the success of part of this model when opening our GP and Nurse led Urgent Care Centre in the former Clover unit, which has successfully managed to maintain the level of emergency attendances within the normal range of 122-151 per day during the winter peak months, by seeing 500-550 patients per month who would otherwise have gone to the Emergency department.

Better Patient Flow

Maintaining good patient flow was identified as the second highest priority after maintain safe staffing levels in Sir Bruce Keogh's recent report on what differentiates between safe and unsafe hospitals. The key characteristics of good patient flow are maintaining normal bed conditions for as long as possible and recovering from any peak back to normal within the shortest time possible. To achieve this there are some basic business rules that need to be applied to the allocation of beds, the definition of when a patient is ready to go home, their admission and discharge management, ensuring a patient is in the right setting at all times. These rules include reducing both outliers and bed occupancy, maintaining rapid turnaround of patients in the MTAU, SAU and MAU and eliminating avoidable re-admissions as these all have the impact of reducing the efficient use of beds.

Research undertaken by UCL in 2013 of the top ten performing Trusts in England against the A&E standard identified that 9 out of 10 of those Trusts had adopted the same approach to patient flow (pioneered in the US and across Europe by Dr Jess Brown) and reinforced through the use of online analytical (OLAP) clinical decision making tools that sit at ward level and feed from existing information systems. This approach won West Middlesex Hospital the EH Innovation award in 2012.

International research, the experience of Kaiser Permanente, and a review by the East of England Public Health Network published in the Bandolier shows that the conventional wisdom that changes to flow can be delivered through cultural change and business rules alone has no evidence base. Any change to business rules, unless it also leads to the immediate change of the systems used daily

by clinicians, will not last longer than the first occasion they log on. System investment needs to go hand in hand with training, development, protocol and process redesign.

Based on the independent evaluations of the models in use elsewhere, the benefits of using a recognised clinical decision support tool that manages admissions and discharges against agreed clinically determined business rules will include:

- Reductions in re-admissions, outliers and bed occupancy
- Reductions in hospital acquired infection
- Reductions in length of stay
- Reduction in delays in discharge
- Reductions in the hospital standardised mortality rate

This approach to bed management, pioneered in both Oxford and Cambridge University Hospitals, is the only approach to be independently evaluated AND to have delivered improvements in both bed efficiency, readmissions and quality markers such as mortality rates and infection rates.

For that reason, Sir Bruce Keogh has already invited PwC (in partnership with Dr Jess Brown and benefitting from over one million hours of underpinning clinical research into the protocols they will use) into two of the 20 Trusts he identified in his report and the approach has been bought into by all of the hospitals in Wales.

Our vision is to use this proven approach locally and to invest in the acknowledged market leader in OLAP bed management tools in conjunction with the local Trusts investment in an upgrade to its Medway PAS which will enable information to become available real time.

Out of Hospital Care strategy

Out of hospital care can mean many things, but in the context of our strategy, we are referring to the comprehensive model of delivering services in the community as an alternative to secondary or hospital care. This out of hospital care definition was first written up in Paris in 1961, piloted in this country in Peterborough in 1978, and was further developed in the US during the 1990s in California and Pittsburgh (made famous by both Medicare and then Kaiser Permanente). Most recently it has re-emerged through the site assessments made by the Department of Health Intensive Support Team, and the Department of Health Intermediate Care reviews in 2000, 2006 and 2010.

As Peterborough demonstrated, for the model to be effective it has to be bought into in its entirety, it cannot be developed piece-meal, as a series of initiatives, but rather has to be comprehensive and coordinated across primary and community care from day one.

Our aim is to develop out of hospital care as a single model of delivery that is primary care led but interfacing with community and voluntary sector providers. We are open to any organisation that is prepared to offer some or all of our proposed model provided they are also prepared to enter into community partnership with other providers to ensure the resulting delivery of care is seamless and accessed through primary care.

What we are seeking is the following:

1961 model[1]

- Services from different agencies working together on an integrated basis across primary, secondary, community and local authority boundaries
- Hospital at home scheme to accelerate discharge for planned care
- Hospital at home scheme to prevent acute admissions
- Rapid response service to prevent acute admission or A&E attendance
- Intensive community rehabilitation team
- Rapid response and hospital at home service for children
- Carer and family support including respite care to maintain informal care for the vulnerable
- Coordination of voluntary sector support including mobility transport and meals
- Halfway house schemes that enable rapid discharge whilst patients are assessed for further community based care

To which we add from the 1990s model:

- Ensuring 24/7 cover and added capacity for peaks such as winter[2]
- Telemedicine and telehealth[3]
- Portable life signs monitoring[4]
- Smart and assisted housing models[5]
- Call centres, help lines and mutual aid groups for the vulnerable[6]
- Expert patient initiatives[7]
- Specific pathways for dementia and end of life care with dedicated teams and settings[8]
- Targeted programmes in the community to avoid readmissions and frequent attendances[9]

To which we add from the most recent models from 2000-2012:

- Risk stratification[10]
- GP led Urgent care centres as the front door to A&E or majors alongside the development of ambulatory care diagnostic centres as alternatives to traditional A&E[11]

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[1] The Paris and Bayonne model as introduced into the UK in Peterborough in 1978

[2] 1999, Preparing for Millennium guidance, NHS Executive, May 1999

[3] Telemedicine pilots in Ipswich and Gateshead, 1996, Nurse led telemedicine scheme wins Queens Award, 1999

[4] US Medicare pilots in 1997, made famous in episode of Frasier in 2004

[5] First world wide pilot was remote monitoring by Ipswich community services of housing estate in Gateshead, pilot run by BT, 1998

[6] Part of Medicare initiatives in 1994-1995 and rolled out to Peterborough and Ipswich in 1994, including development of first two leg clubs and similar condition based self help clubs in rural communities (1994-1995)

[7] See note 19. Evaluation of Our Healthier Nation in 1997 picked up this development which became the Expert Patient programme in 2000 on the back of the NHS Plan

[8] PHRU at University of Kent publishes its guidance for commissioners on dementia care and the components in the ideal pathway, 1998. Warns of silting up of acute medicine unless alternatives are purchased

[9] Confronting the challenge, 1997

[10] Conceptually sound but beleaguered by poor information. Understanding the likelihood that a patient might be at risk of acute admission is important in targeting resources and the evidence from reviews of existing out of hospital care is consistent that targeted use of out of hospital care does have a financial benefit whereas whole population services may not

[11] Central Middlesex and St Charles model pioneered this in UK in 1995, Andy Black going on to develop this model for consumption across UK. First GP led urgent care centre opened in Northumberland in 1996 with emergency practitioner models opening in Scotland in 1998 and becoming part of Scottish emergency care strategy at same time. Current model is based around pioneer schemes that opened in

- GP or community organisations managing the A&E department or the front door of A&E[12]
- Pathways of care for long term conditions that prevent health deterioration and avoid acute episodes[13]
- Specific pathways for the management of complex discharges including directly commissioning housing provision[14]
- Early supported discharge[15]
- Community based chemotherapy[16]
- Real time patent monitoring in hospitals[17]
- The concept of constant added value along complete pathway of care[18]
- Digital TV[19] and continuous patient monitoring

Healthy eating strategy

This strategy was re-launched by Swindon Borough Council in February 2014 with specific initiatives and recommendations regarding diet for different conditions and cultural backgrounds, supported by a schools promotional programme, media and communications campaigns and the proposal to develop all care staff in their awareness of the beneficial impact of understanding diet and its consequences.

The launch coincides with Jamie Oliver's visit to Swindon and ALDI's launch of their Swap to Healthy campaign. Roche are also working with the CCG on diet leaflets for different cultures whilst we have put a proposal together to pilot a mentorship scheme regarding diet for those from minority groups with diabetes and have won an award for our diabetes programme for the local Goan pupation which includes specific information on healthy eating,

It is hard to assess the impact of such a strategy but it is the case that Swindon has moved to just above the English average from just below for child obesity and thus the need to raise the profile of healthy eating has become all the more important.

Healthy exercise strategy

This strategy was launched in February 2014 by Swindon Borough Council and includes an increase in investment in sports and leisure facilities, support for sports clubs and voluntary groups with an

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England in 2005-2007 but model already proven in rural parts of Scotland by 2002 and the Scottish health plan of that year. Primary Care Foundation, Urgent Care, 2012. Primary Care Foundation, Ambulatory Care, 2012 (both reports on the Primary Care Foundation website)

[12] New Zealand model advocated by Professor Ham introduced in Imperial and Royal Free in London, with variant at Whipps Cross where PCT managed triaging GPs at front door, evaluated by the Kings Fund, delivered a 15.4% switch away from ED at Imperial in two years

[13] Department of health guidance on long term conditions following NHS Institute publication of ten high impact changes, 2002

[14] Robertson et al, 2009

[15] Proven initiative in place in all acute Trusts for some conditions but needs to be rolled out for all of the 48 conditions where benefit shown

[16] For an existing and evaluated case study go to Bristol (78% savings delivered but none went to the providers who made the change – all of benefit was to commissioners)

[17] For an existing and evaluated case study go to EHI Innovations site or RealTime Solutions Ltd's web site

[18] DH emergency care IST, Ian Sturgess, Clinical director, 2011. http://www.youtube.com/watch?v=FS5KwFu7vu4

[19] 1991 saw the start of the first pilot to use Digital TV as the interface for patients to not only book care direct but also to have access to key information about their condition and advice on navigating to the right setting. The pilot was probably ahead of its time but worth resurrecting, not least as on the back of that pilot the first airport booking system allowing all GPs to book outpatient appointments at the piloting hospital from their GP systems was introduced, resulting in a 480% growth in one year in GP referrals to that Trust. Audit Commission Management Letter to Chief Executive of the NHS Management Executive, Department of Health on performance of NHS trusts in 1991-1992, September 1992

exercise dimension, further investment in cycling routes, rambling, dog walking and gardening clubs and maintaining the successful prescribed exercise initiative.

Smoking cessation programme

Run successfully by SEQOL this programme saved the second most number of lives of any programme in the country (top was the programme in Westminster but with twice the investment per person entering the programme compared to Swindon). Given it only takes 20 minutes for someone with asthma or COPD to benefit from stopping smoking, it is never too late and always of benefit to push for cessation

It is also the case that smog has serious secondary effects or anyone undergoing surgery as it prolongs length of stay, reduces wound healing rates, increases the risk of wound infection, and increases the risk of death following strategy by material amounts.

The CCG will look to increase its support for this programme as part of its plan to reduce potential years of life lost, but also in the knowledge that this programme has also been successful in reducing admissions amongst those with heart disease, COPD and asthma.

Early Start programme (also known as the Troubled Families initiative)

Swindon has an active programme of investment funded from central Government for "Troubled Families" that is those families who present with a range of need for support from different agencies and for whom a joint approach to enable them to become self-reliant is required and as importantly to allow the children in that family to have the same opportunity for educational attainment, health and well-being as other children. Two of the top five mosaic groups that are the highest presenters or users of local hospital care are those who also meet the definition of being a "Troubled Family".

This programme provides support to the whole family including economic and welfare support, support to get one of the family members at least into employment, support in addressing debt or any criminal record and the risk of repeat offending, support in addressing any issues of neglect or domestic violence and abuse, and support in addressing any issues of drug or alcohol abuse.

The intent is to create a secure, safe and economically sound environment in which the children in a household can then be brought up, with the ultimate endpoint being the household becomes economically able to support itself through a least one earner.

The impact in health terms can be measured in a number of ways. There is a clear correlation between high hospitalisation rates and low income/high levels of deprivation. This mosaic group uses hospital care at twice the rate of the Swindon average for example. The assumption that improving household income and reducing deprivation will reduce hospitalisation rates however has yet to be proven (the experience of German unification gives us a case study that showed the reverse happen for ten years) but there is a clear correlation between improving levels of deprivation and life expectancy gain.

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Nonetheless, given a key part of the programme is looking at the health and wellbeing of this cohort of Swindon residents and that they represent some of our largest users of healthcare, we anticipate some benefit in reducing admissions and have assumed for this submission of our strategy that 1 in 20 households will see one admission avoided over the life of the strategy. We will revisit this for our March submission with more evidence of what has actually been achieved in 2013-2014.

Life-long planning and end of life

This programme sees the CCG deliver the following during 2014-2015 with benefits running over the following four years for the just over 2000 Swindon and Shrivenham residents who will die each year, nearly 3500 who will be in the last stages of life and need support, and over 24000 residents who will be touched in some way or another by the death of a loved one

- to move towards life-long health planning to include preparing for the final stages of life;
- whole community access to summary care record;
- change our vision for end of life such that the choice of dying at home includes the choice of dying in one's own bed with one's partner etc and not in a hospital environment within the home;
- exploring technology, practice and approach to care in the home so that we don't preclude those with narrow staircases or other reasons commonly given for not being able to offer someone their preference
- developing the delivery of the hospice at home model with Prospect Hospice, Marie Cure and SEQOL

Our vision will see everyone receiving their preference for where they wish to be cared in the last stages of life and we will accommodate both our practice and the equipment we use to enable this. As a consequence, we would expect to see a significant reduction (c90%) in those admitted to our local acute hospitals to die.

Long term conditions programme

The local NHS in Swindon developed its approach to long term conditions in 2011 with particular emphasis on diabetes where a number of key indicators identified the local health service as failing to support or meet the needs of local residents. Recent surveys, such as the national Diabetes audit, indicate that little progress has been made to change the way residents feel about the support they receive. Particular areas of concern have also been highlighted through the series of workshops run by the CCG during 2013.

The support currently offered is difficult to access or to navigate through, often confusing, with many people in Swindon (and our GP members) not aware of the support they could receive and finding the names given to services confusing or unhelpful. Web and social media are not used well whilst expert patient programmes appear to have disappeared or gone into retreat. Many patients would welcome knowing far more about their condition and also about where to go for advice in addition to or as an alternative to their local GP surgery and hospital. Many also feel that when they have developed more than one condition, the way in which the health service treats each condition separately is neither helpful nor efficient.

Our programme looks at:

- self care and life long health planning
- preventative care and health promotion including the five main contributors to good health, namely healthy eating and exercise, smoking cessation, reducing substance abuse (including alcohol abuse) and reducing stress
- primary care monitoring and management of long term conditions
- navigating people to support from within their community, the third sector and the health service developing patients as experts in their own conditions
- reviewing services to provide support for those with multiple conditions
- targeting those who need support through risk stratificaton
- releasing time to provide additional support in primary care through the SUCCESS programme
- using existing voluntary sector, charitable and peer support groups and social media to improve the information we provide regarding the most common conditions
- specific programmes for those minority groups where the incidence of long term conditions is higher than the population average
- providing rapid access to specialist clinicians and secondary care consultation including outreaching specialist nurses and consultants into primary care at practice or locality level depending on the volumes
- carer support is essential for those with long term conditions and often neglected especially at the point of discharge from hospital when carers are being asked to support a loved one, family member or friend who is suddenly appreciably less able or less well, without the preparation to do so

Key is ensuring that everyone with a life-long condition can access advice and support from a variety of sources, ranging from media to others with the same condition to their own family friends, colleagues and neighbours.

Our vision is that everyone with a long term condition will have access to someone who is also a member of their community, familiar with the same condition and can navigate to the best advice, but also help to put together the life-long health plan that will enable each of us to cope with our conditions.

This is why Swindon CCG has placed considerable stock in the development of our SUCCESS programme (releasing primary care team time to review patients with long term conditions), the Community Navigator role within every primary care team, based on the models that have been successful in the US, France, Italy and Germany, and more recently piloted in NE London, \and the mentorship scheme that sits alongside the Community Navigator team and is to be piloted in the first quarter of 2014-2015.
There are then specific concerns relating to diabetes care which is one of our top priorities. Generally, there is concern in Swindon over footcare, foot assessments, retinography screening and the slow uptake of new technology and practice. There are active peer support groups that feel frustrated at how little engagement there is between the support they can offer and primary and

secondary care. The vast majority of feedback about any care or treatment received is positive, but there remains a general feeling that support other than face to face contact with a GP, consultant or specialist nurse, is lacking. The vast majority of those with diabetes want to get on with their lives and not be over-medicalised.

Most also remain concerned at the stigma associated with diabetes and its constant link in the public mind with obesity when less than one third of those with type 2 diabetes are obese.

The new vascular network, run by Royal Gloucestershire Hospitals Foundation Trust provides a major opportunity to set up the multi disciplinary teams (MDTs) needed to ensure we look at every surgical intervention **other than** amputation for Swindon residents and has already prevented a number of amputations through arterial bypass operations. But it is important that by the end of quarter 1 of 2014-2015 we have addressed not only the inconsistencies in footcare assessment and referrals for amputation but also the need for a new set of web based information, formally reviewed with NHS England what is happening regarding retinography screening, and continue to ensure there is rapid access to ophthalmology for this at risk group of residents.

Mental health and learning disability

The level of mental health admissions per capita is comparatively low in Swindon, our reported outcomes are relatively good and overall investment is below national average.

The number registered with mental health problems in primary care in Swindon is considerably below the English average and in the latest survey of our membership, whilst Mental Health was still highlighted as a priority area, it was in the middle of the pack whereas in the previous surveys it had been consistently near the top of the rankings as a priority.

One contributor to this change in the sense of priority was highlighted by a number of members, namely that Swindon benefits from having the best IAPT service in the country with its model of open access to psychology being supported by all practices. One area of omission in the current service offering that came up time and again was the need to have practice attached mental health liaison.

The next two years see a number of key developments:

First the CCG wishes to support and grow the current model of IAPT and the current service provision. We will support the current service provider in moving from Avon and Wiltshire Partnership Trust to another organisation if there is any detrimental change to the current model of delivery and service.

Second, we will implement both mental health liaison with primary care and mental health and wellbeing coordinators to assist in the prevention of both admissions and re-admissions to secondary care mental health services

Third, we will review the present pathways of care with particular attention to metal health liaison with the local acute hospital and crisis resolution.

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Finally, we are still assessing the changes that follow the release of the new national mental health strategy last month and will update our Strategic Plan to reflect the national strategy at the next submission.

The net impact of the changes we are proposing should be to reduce the admissions at Great Western Hospital and also out of area residential placements.

Learning disability

In 2013, a Joint Needs Assessment of the 546 residents of Swindon who are registered with a learning disability and live or have lived within the borough showed that a high proportion live in residential care (at least twice the proportion compared to the reference sites we used) and without a personalised care assessment.

Our aim is simple and is shared with the Swindon Borough, with whom we jointly commission the care for these residents. We seek to move towards every one of these 546 very vulnerable people having a personalised care assessment, and then to meet the ongoing support needs that will arise, providing many with their own home, rather than continuing to care for them in institutions set in the community, sometimes at some considerable distance from Swindon.

The net impact we predict over the life of this Strategic Plan is that at least 55 and potentially 75 Swindon registered patients could return to live in Swindon under supportive living arrangements.

Cancer strategy

Our strategy for cancer services is six-fold and has emerged from two service redesign workshops involving Swindon and Wiltshire CCGs, two sets of specialist commissioners, public, patients, voluntary and charitable sectors, practices, providers and Swindon Borough:

- Promotion of the screening and awareness programmes being run nationally in coordination with NHS England (but also timed to avoid periods of peak demand in primary care)
- Development of a local Survivorship programme in partnership with Marie Curie
- Investment at above population average growth in Cancer services the next five years but targeted towards delivering new pathways of care that also see a higher number of those with cancer identified/diagnosed earlier and by the fast track route rather than in A&E
- Investment to bring radiotherapy into Swindon at a new centre on the Great Western Hospital campus
- The co-location of the rest of cancer services as far as is possible within the current estate at the Great Western Hospital
- A review of our model of care and delivery for the 15-25 age group

The target is to deliver a net improvement in our under 75 mortality rate for cancer

Carer support programme

This sees a joint investment of £1m per annum over the life of the plan for the delivery of £0.3m savings per annum, principally in reducing re-admissions although there will also be some

emergency and planned care admission avoidance opportunity based on national studies and as a result of the introduction of Health Checks for carers. The savings will be re-evaluated once we have the results of a complete 12 months of implementation of the programme.

Better Care Fund

This Plan has been submitted as an attachment to the Strategic and Operational Plans and sets out how £12.74m of pooled resources under s75 agreements between the CCG and Swindon Borough Council and other Local Authorities will be deployed to deliver reablement, admission avoidance schemes such as hydration advice in nursing homes, virtual ward and telehealth, discharge acceleration schemes such as a single point of discharge, investment in halfway house and discharge to assess schemes and the movement towards 24/7 coverage from social care and community teams.

It contributes to the delivery of our ambitions of a 15.5% reduction in emergency admissions over the life of the Strategic Plan as well as the reduction by 10% in medical length of stay by 2019.

Control of Infection programme

Attached to our Two Year Plan (*The Age of Consolidation*) is a detailed plan setting out our programme of delivering the national target maximum for C diff cases and zero cases of MRSA for our population in each year. The plan is heavily reliant on good patient flow and bed allocation within the acute Trust with a high correlation between escalation beds being open, high numbers of outliers and the risk of infection. The plan demonstrates a high level of scrutiny by the CCG and needs to be seen in conjunction with what we wish to achieve regarding patient flow.

We have assumed no net impact on bed efficiency from this programme but the reality is that Great Western Hospital lost 24-30 beds in winter peak months in two of the last three winters and so any improvement in control of infection will benefit the Trust and also reduce the need for winter pressures funding from the CCG.

Planned care programme

This is covered in the earlier section on our Programme of Change

One Swindon Transformation

This is covered on detail in the earlier section on our Programme of Change

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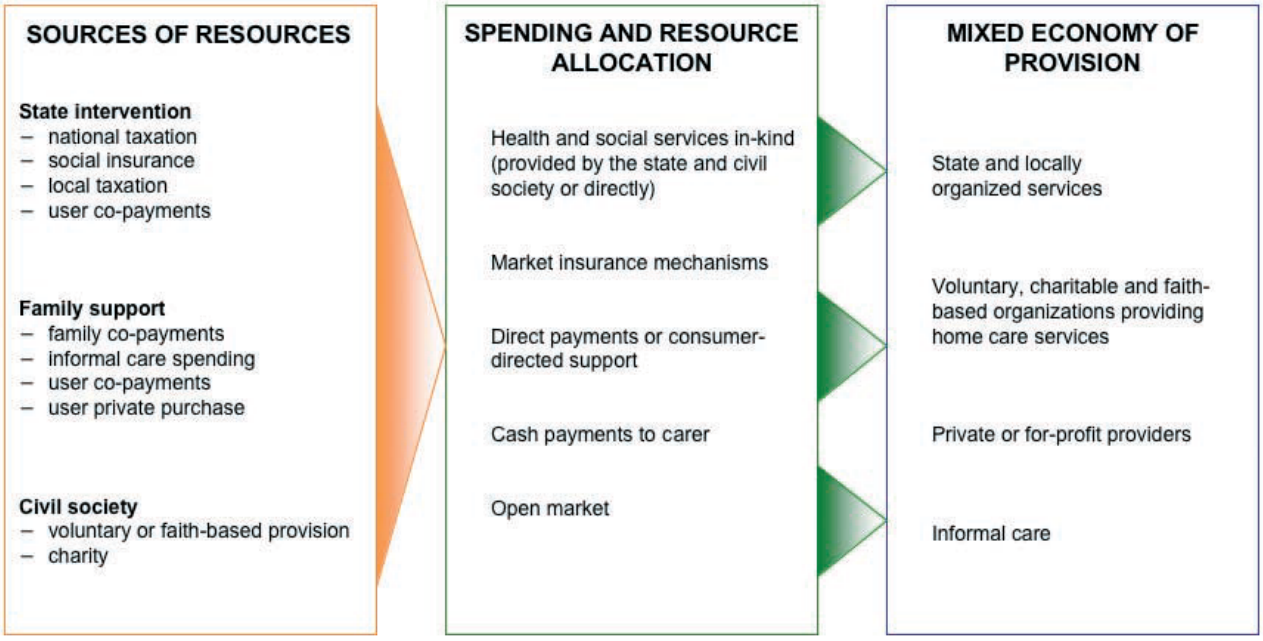
OUR PARTNERS

Swindon is strongly placed to deliver integrated care. It has a single unitary local authority (Swindon Borough Council), one CCG (Swindon CCG, representing 27 member practices in Swindon and Shrivenham), a single acute Trust in the Town (Great Western Hospitals NHS Foundation Trust), one community health provider (SEQOL, one of the leading Social Enterprises in the country), one mental health provider (Avon and Wiltshire Partnerships NHS Trust, who have already set up a clinical directorate that just serves Swindon), one ambulance service provider and one network of voluntary sector organisations (Voluntary Action Swindon or VAS). Integrated services for children already bring together community health, education and social care services, co-located and managed as part of a single Trust. Swindon CCG is therefore strongly placed to work with its partners to test new models of joint working and integration given that **the organisations currently providing local health and social care services are dealing with the same patients and communities.**

We have already undertaken an extensive literature search on the opportunities presented through integration (particularly in the delivery of out of hospital care) and a summary of this informed our Out of Hospital Care strategy. We have also made contact with the policy leaders in the delivery of integrated care in the US, France, Spain and Germany in order to establish a Peer Review panel for our proposals on joint working.

From that literature search, what we observe is that the delivery of integrated care appears also to require the joining up of sources of funding, planning and commissioning, otherwise the inherent differences and competitiveness built into procurement and our different payment and reward regimes drive integrated pathways apart. We summarise the complexity of the current situation in the chart below:



As part of our vision for the next five years, we will implement models for the integration of **sources of funding**, **resource allocation** (our Better Care Plan and Fund) as well as **provision**. It is our belief, based on the evidence from other community health and social care systems around the world, that to merely seek to integrate the provision of care will result in unsustainable change.

We see the opportunity presented by Swindon and by the Better Care Fund as **a step in a journey** that we describe below. Above all we see further **integration as essential to the improvement of the patient's experience**.

Remember this is all about the Patient

Our ambition to deliver integrated care is first and foremost driven by our daily appreciation of the delays and confusion in healthcare delivery caused by the current model of care delivery, despite our best efforts to ensure the patient experience is right first time for everyone.

The most common complaint from both patients and clinicians is that every pathway of care has too many points where care must be handed over to another organisation, that these handover stages cause delay, that delay results in poorer health outcomes and also discontinuity that the resulting communication between healthcare professionals is also poor and needs new systems to improve it.

On a daily basis, in each ward a nurse will have to keep at least one patient in for an additional night (or over the weekend) because one or other service or professional involved in their care has not completed the tasks necessary for that patient to go home. That patient remains at risk of developing an infection, falling or other complications. If they are elderly, they will also become less self-reliant the longer they remain in hospital, placing a greater burden on their carer. Nearly two thirds of those who are then re-admitted to hospital return because their carers had not been prepared for the additional support they would need to provide when a patient is discharged.

One third of those treated in hospital will be discharged still needing a social care assessment but having had no referral to social care. Recent reports regarding ITU patients highlighted that this can delay someone in ITU returning to their original functionality by an average of two years. Most commonly, the length of stay of the patient is such that there was not time to make a referral to social care before discharge, again resulting in subsequent re-admission to hospital when patients are unable to cope at home.

Sometimes, social care needs are not identified during hospital stay and thus no referral is made. The consequences to the patients experience of being discharged without both health and social care needs being addressed in a coordinated way can be dramatic – if functionality or mobility is impaired, the once familiar home environment can become a place of risk and danger.

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Shoulder to Shoulder is a necessary next step in an existing journey for Swindon

Swindon already has a history of delivering integrated planning and commissioning of care and the integration of community services for adults and children. Prior to Transforming Community Services, Swindon had totally integrated its community health and social care teams supported by joint commissioning boards and teams for all aspects of out of hospital care. Children's health services transferred from the PCT to the local authority to form integrated services in 2011. Our vision is to re-establish a level of integration that was successful, but also to go further.

Level of alignment

Individual responsibilities	Partnership working	Building Healthy Partnerships	Community Budget Initiative	Shoulder to Shoulder
Separated commissioning and provision Separate primary, community and secondary care Separate health and social care Competitive market	Joint commissioning and planning Joint needs assessment Single Health and Wellbeing strategy	Joint initiatives between voluntary and statutory sector Training for volunteers Single information resource Shared bursary Greater engagement of voluntary sector in plannning and delivery of care	Joint initiatives across all sectors in Swindon Invest to Save schemes with large pay back in focused areas Initiatives require support in terms of removal of barriers, changes in rules or additional design and planning capacity	Joining care teams along conditions Unifying budgets into programmes of spend Providing social care free (where this reduces delay and saves whole system costs) Single information systems or databases Common core training for professionals Single point of access Co-location of professionals Joint Transformation Hub Single assessment and care planning Common funding and commissioning model which incentivises self care and out of hospital care Collaboration as the alternative to competitiveness
Swindon Borough Swindon CCG Great Western Hospital SEQOL Avon and Wiltshire Partnership Great Western Ambulance VAS BMI Ridgeway Independent Hospitals Group Range of small providers	Health and Wellbeing Board CCG Members Forum Swindon Strategic Change Forum Joint Commissioning Boards Joint Commissioners Joint service redesign programme Integrated pathways of care for some conditions eg diabetes		Short term (2 years) with large benefits. Community Navigator scheme Readmissions reduction Discharge management improvement Joint procurement initiative Troubled families scheme Mental health coordinators	Unified Health Board model replacing Health and Wellbeing Board
The Health Economy acting as a competitive market but with a duty of partnership working	**Joint Commissioning**	**Joint delivery across community and voluntary sectors**	**Joint initiatives that make significant savings**	**Integrated care that delivers sustainable savings and improved patient experience**

Level of integration and collaboration

Where Swindon is now

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Previous integration has been based on the planning and funding of **services**, but our vision for the future is to integrate the care we provide based on the **conditions** that require care with greater emphasis on all care professionals promoting self reliance, self care and prevention (see WHO recommendation on health promotion being a core, common and mandatory training requirement for anyone working in the care sector).

We will achieve our vision through the pooling of budgets, creating greater interoperability between our information systems, agreeing data sharing protocols, establishing common core or foundation training for our care professionals, implementing common assessment and care protocols and a single MYHealth:MYLife record accessible by those for whom we care, their informal carers and our care professionals, immediately available in any location or setting and at any time of the day or week.

We will work to eliminate the duplication of contacts, assessments and home visits caused by the current fragmentation of services and instead learn **to trust each other** to undertake assessments and home visits on our collective behalf, learning the lessons from the SAIL projects in Suffolk and Devon, and the discharge to assess schemes in Surrey and Kent.

We will also make much better use of our collective estate, co-locating care professionals to enable a single visit by those for whom we care to address as much of their care needs as possible. We will be supported in this by **One Swindon**, our local strategic partnership that brings together the leaders of the statutory, voluntary, charitable and private sectors in Swindon under a single shared vision and which has been successful in attracting HM Treasury funding to deliver the necessary transformation that will enable genuine and ambitious joint working: *"One Swindon Working as One".*

In five years' time the difference will be that there will be less services involved in the delivery of care, greater communication and faster patient flow between care professionals, greater consistency and clarity regarding the best care, patients and carers will be better informed about the care they can expect and will receive and be supported to be more self-reliant, less people will be delayed in going into or being discharged from hospital and less people will then be re-admitted when this could be avoided. More people will be supported to return to their own home when discharged from hospital, achieving the levels of home care of the best systems in the world such as the Dutch and German care systems. More people will be in control of the funding of their own care through personalised budgets and be expert in their own conditions, such that they can make informed choices over both improving their own health and health and social care interventions or treatments.

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OUR PROVIDERS

Our current provider-scape is one of our strengths with responsive services located accessibly in predominantly modern primary, community and secondary care facilities, supported by excellent tertiary care in Oxford and Bristol.

Overall, we are not forecasting a change in the configuration of providers nor that the changes we envisage in investment and new models of care will de-stabilise any of them. Rather, our vision is that the range of services each provides will change as they respond to new requests and new markets, which in turn substitute for the loss of income resulting from other services being removed.

There may be some small specialties whose level of activity could drop below the critical mass to remain viable, given the changes in our demography, but none that we have identified as yet. There will be other services, such as vascular, where we are already seeing the advantages of being part of a wider network of provision with the local specialist vascular centre, Royal Gloucestershire Hospitals Foundation Trust. There are also opportunities to bring specialist services into Swindon, such as radiotherapy, but under the umbrella of the local specialist cancer centre at Oxford University Hospitals Foundation Trust.

We envisage private sector provider competition increasing for some elective and diagnostic services, which we will encourage wherever we have performance concerns regarding current provision, but will need to manage carefully to ensure this does not de-stabilise the delivery of local emergency care.

Our vision is that the majority of secondary care will see volumes of activity remain broadly static to increase slightly at no higher than our forecast annual population growth of 1.39%. The impact of choice will see the actual level of growth at each provider vary around the average of 1.39% with material switches between providers due to choice observed in orthopaedics gynaecology and ophthalmology in 2012-2014.

There will be reductions in outpatient activity due to the introduction of new pathways and approaches to consultation, whilst the alternatives to urgent and emergency care are offset by the 1.39% average population growth per annum, the slightly higher than this growth in demand due to the age demography of our population, and an increase in planned and ambulatory care (a result of our shifting from unplanned to more rapid access to planned care as part of our strategy for supporting those with long term conditions).

Finally, we envisage new markets opening up for local providers from other commissioners (along the M4 corridor in particular and around Shrivenham).

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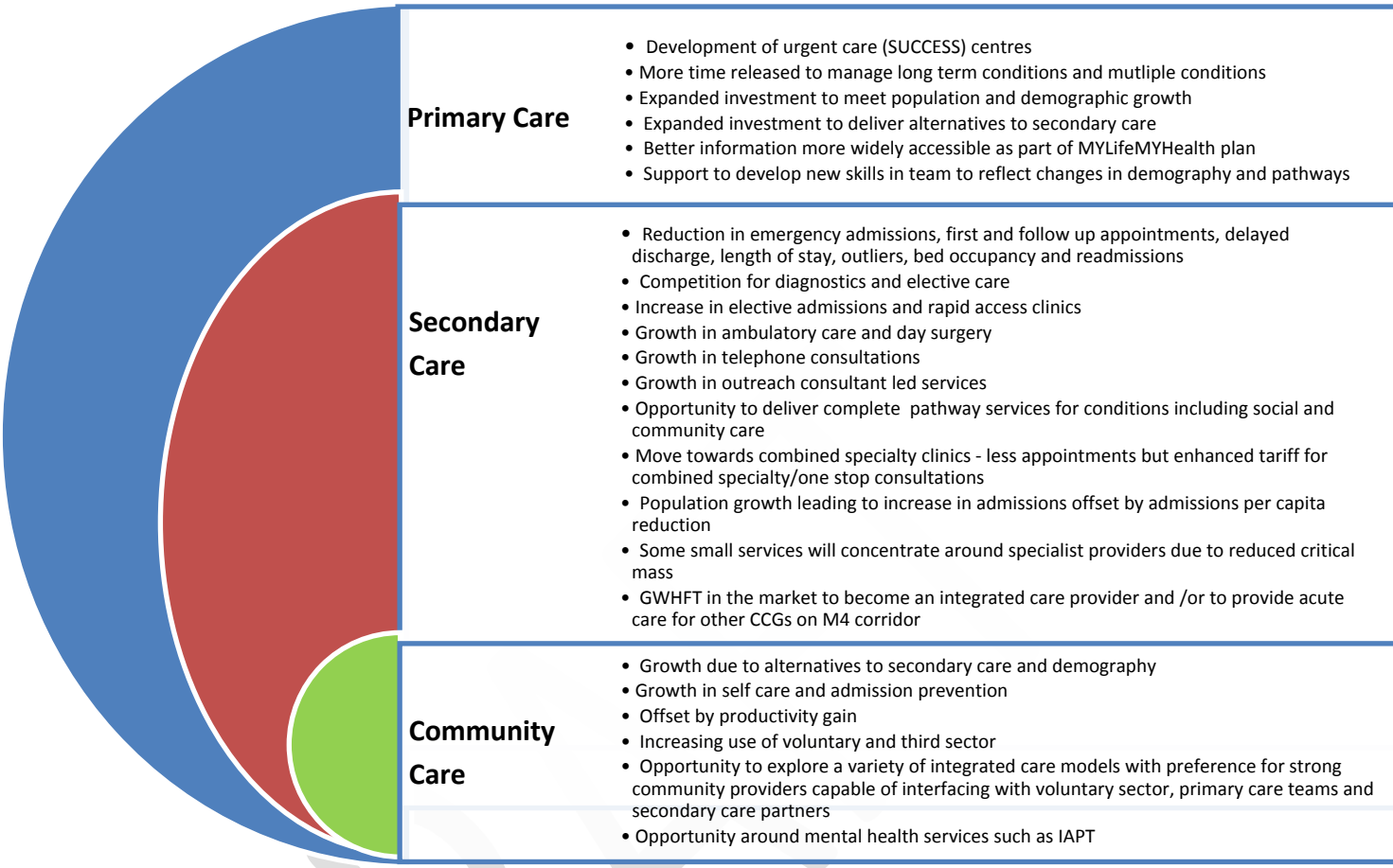

Primary care

will see demand for immediate one off consultations streamed to GP led Urgent care centres (SUCCESS centres) allowing greater time for consultation and the management of long term conditions and planned care referrals

will be supported by practice attached mental health liaison and social care "navigators" liaising with the voluntary sector, informal carers and schemes such as Troubled Families to help patients and households develop life-long health strategies that promote health, prevent the need for care and support self reliance

will grow in line with population growth with further local investment to enable primary care to develop alternatives to secondary care and to take on additional prevention roles

the greater emphasis on self care and continuity of care coupled with increased role in coordination of immediate community response possibly leading to integration of some community and primary care roles within primary care teams

outreach and specialist community services develop on a collaborative basis at locality level particularly in support of long term conditions (see Circles of Support)

Voluntary sector	*investment linked to outcomes, specifically reduction in demand for health care due to greater community support and self care*
	greater engagement in design of health care pathways with emphasis on role in developing coping strategies for self care, prevention and alternatives to health care
	greater integration and coordination to ensure services are targeted at those of greatest need in a way that does not confuse or conflict with other services
	greater focus on where there is evidence of proven health benefit
	longer term investment where benefits are proven to ensure stability of voluntary sector offering
	investment in VAS to support voluntary sector in bidding for funding, understanding local health and clinical priorities and developing approach to self care and prevention as part of programmes to support those with long term conditions, mental health and wellbeing and end of life, funded from Transformation reserve
Secondary care	*overall increase in income in line with annual population growth of 1.39% but reduction in urgent care and outpatient attendances (although less consultations the new model will see reinvestment in combined specialty clinics and outreach services) and increase un rapid access clinics*
	net productivity gain of 6% per annum in planned care and a reduction of 15.5% in emergency care in line with national assumptions including reductions in emergency admissions due to ambulatory care alternatives
	radiotherapy coping into Swindon and acting as the spur for further investment in the co-location of cancer services close to or alongside the new radiotherapy centre
	greater use of the acute hospital estate for other healthcare provision as the Great Western moves to become a Health campus and one stop shop for both health improvement and healthcare
	ongoing reductions in length of stay due to accelerated discharge and patient centred bed planning
	reductions in new follow up outpatient activity and move towards Consultant Link, virtual clinics and telephone follow up
	net increase in day surgical procedures with some moving into primary care but compensated for by all procedures moving to top quartile performance
	increase in admissions due to population growth but offset in part by decreases in admission rate due to prevention and alternatives to secondary care. Some conditions and services will increase at a faster rate than 1.39% including cancer, orthopaedics and maternity

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increase in admissions due to ageing population, also seeing an increase in length of stay due to greater co-morbidity offset by diversion of social care admissions and preventative management for long term conditions

increase in services that outreach into primary and community settings in order to aid self care and prevention strategies

opportunity to develop whole pathway services for long term conditions eg diabetes in partnership with SEQOL

Community care

increase in alternatives to secondary care resulting in greater community activity but offset in part by greater productivity

development of comprehensive out of hospital care model in partnership with voluntary sector and primary care teams to avoid admissions for emergency care buy providing rapid community access eg GP at the scene, extension of virtual ward and telehealth and other models within the Out of Hospital Care strategy

coordination of voluntary and community sector response providing important continuity, development and regulation of voluntary sector provision as part of out of hospital care model and in partnership with VAS

some integration of community models within primary care teams

integration of urgent care models with secondary care teams at front end of A&E, back door of A&E and in SAU, MTAU and MAU

integration of accelerated discharge models with secondary care teams

development of new models for end of life care in partnership with Prospect Hospice

opportunity to lead on behalf of the local health system access to new funds (such as Cabinet office, charitable and social bonds and European grants)

opportunity to be a partner in the delivery of services that promote the health outcomes funded by above grants eg extending successful employment schemes and health improvement programmes such as smoking cessation, the delivery of prescribed exercise and leisure schemes, further development of reablement, the implementation of combined voluntary and statutory sector schemes such as leg clubs etc

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