NHS
Swindon
Clinical Commissioning Group

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Age of Consolidation

Operational Plan 2014-16

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Introduction

Swindon Clinical Commissioning Group (CCG) is part of the NHS, responsible to NHS England for identifying the local health and health service needs of 229,000 people registered with 27 GP practices in and around Swindon and is responsible for buying (commissioning) £228m of local health services in 2014-2015 and 2015-2016.

We work with local clinicians, patients and the public in the design of health services, prioritising investment in local healthcare, planning sufficient capacity and capability to meet local health and health care needs. To achieve this we will work in partnership with other organisations to improve local health, and managing the performance of community and hospital services.

Background to our commissioning plan for April 2014 to March 2016

This document explains how Swindon CCG plans to use the funding we receive from NHS England to improve care for patients by commissioning the best quality and most cost effective healthcare over the next 12 months.

We also set out our commitment and approach towards buying health care and improving health through a range of providers, voluntary, charitable, public and private sectors, collectively putting into action our mission **to optimise the health of the people of Swindon and Shrivenham**.

Our aims for 2014-16

We will continue to work with all partners to commission services that focus on delivering high quality care and the achievement of excellent outcomes for patients and that are better able to meet the health needs of the future. As a commissioner we will work with all qualified providers whether from the voluntary, private or public sector, to improve the health and prolong active life of Swindon citizens, reducing reliance on healthcare services, improving the quality and productivity of services for patients, whilst encouraging innovation and providing more care outside of hospital.

What we already know

We know that:

- Our population growth and an ageing population will see demand outstrip resources UNLESS we use our resources wisely
- The current configuration of services is the right configuration – it is how we use local services that needs to change

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- We must use the new resources we have received in 2014-2016 wisely – to invest in new ways of working not the current. This is a one off opportunity

Our clinical priorities for 2014-16

Our clinical priorities remain broadly the same as when we consulted in 2013-2014 and have been recently endorsed by a survey of our clinical membership:

- Urgent Care
- Cancer
- Self-care and prevention
- Carer support
- Children
- Long term conditions
  - Chronic obstructive pulmonary disease (COPD)
  - Dementia
  - Diabetes
  - Heart failure
- End of life
- Mental health and Learning disability services

Many of the changes we made in 2013 will start to reap dividends in 2014

One Swindon: One Vision (Our Five Year Plan)

Our Operational Plan needs to be seen in the context of our five year plan, which we set out in One Swindon: One Vision. Below we summarise the key programmes of change within that strategy:

- Supporting **self-care** and **life long planning for care**
- **Neighbourhood plans** as the foundation for self-care, building our investment around what is already available to households in their own community
- Shifting from dependence to **self reliance** with investment in primary care and the voluntary sector, together with the roll out of primary care based urgent care centres, home visiting and Link Workers to support people develop their life-long health plans
- Shifting towards greater use and support of **informal carers, the voluntary and third sector**
- Shifting from care being provided in a disjoined way with delays each time a patient's care moves form one provider to another and towards the patient's care flowing seamlessly both within and between providers (**best patient flow)**
- Shifting from providing care for patients as if they only had one condition when many present with **many conditions** <u>at the same time</u> and need services to be better joined up therefore

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- **Commissioning** services based on the improvement we wish to make for the whole of Swindon (our **programmes of care**) rather than buying a single type of operation or treatment and then having to join these all up in order to improve the overall health of the people in Swindon eg commissioning a complete diabetes services for Swindon rather than buying foot care through one provider, outpatient appointments from another, inpatient or emergency care from a third

- **Redesigning current services** with the Public, Patients, our Partners, our Providers and our member Practices in order to ensure we are using the resources we receive wisely, delivering improved quality, encouraging innovation, achieving better productivity and shifting the balance of delivery towards prevention

- **Bringing services into the town** where people in Swindon must travel great distances and a local service can be provided economically, sustainably and safely eg radiotherapy

- Whilst Swindon is well-equipped to survive and grow through any extended recession, there was a developing concern over the **inability to recruit and retain staff** in key roles in Swindon whilst at the same time there is a growing pool of local talent (but with no healthcare experience) upon which we should be able to draw. Our five year plan is heavily dependent on having a joined up approach to recruiting and developing our workforce that contributes positively to the local economy

Our objectives for 2014-16

- **Preventing people from dying early** including preventing disease in the first place. Early diagnosis and appropriate treatment of disease can also reduce premature death
- **Enhancing quality of life for people with long term conditions** (such as diabetes and dementia) by commissioning services that appropriately support patients' and carers' needs and help them manage their own conditions
- **Helping people to recover following illness** through better patient flow to ensure that people are given the care and support required in the most efficient and appropriate care settings at the right time, across health and social care. This will also mean commissioning direct access to planned care seven days a week
- **Improving patient experience and safety** improving access, quality and safety of services
- **Reducing health inequalities** in Swindon working with other partners e.g. One Swindon, Health and Wellbeing Board, Swindon Borough Council and NHS England to ensure voluntary, private and public sectors are working together to support the most disadvantaged communities and households

National Imperatives

The NHS Outcomes Framework includes the following which we covered in Back to basics, which we published in January 2013:

- ensuring people in Swindon and Shrivenham receive the standards that are their right under the NHS Constitution;
- ensuring we are offered a choice of provider;
- delivering a year on year improvement in productivity
- ensuring the services we provide are increasingly developing local sustainability
- supporting and encouraging research and innovation
- developing our local capacity to deliver care in periods of peak demand

- planning for and developing the local workforce
- supporting education and training
- and delivering equality within the NHS

Outcome Ambitions

The seven outcome ambitions relevant for Swindon have defined proposed attainment by 2019 in the Strategy and the proposed trajectory for the first two years is detailed below.

Ambition area	Metric	Proposed attainment by 2016
Increased life expectancy through realising potential years of life saved	PYLL	Reduce to 1819 PYLL by 2019 and 2046 by 2016
Reduce health inequalities in particular the gap in male life expectancy	Difference in life expectancy: least and most advantaged male decile	Reduce to 8.7 years from 8.9 years by 2016
Reduce health inequalities in particular to meet the growing and specific health needs of minority groups in Swindon	Type 2 diabetes in Asian population	Reduce by 2% by 2016
Reduce avoidable emergency admissions and hospitalisation rates	Standardised admission rate for emergency inpatients Ambulatory care rate for chronic conditions	Reduce SAR by 3% Shift 3% of admissions to planned or ambulatory care Reduce readmissions to 3% maximum as part of delivery of the above
Greater support for those with long term conditions	% with LLI, LTLI, declaring they feel supported	77.5% of those with a long term condition feel supported
Reducing avoidable deaths due to patient care	Avoidable deaths due to NHS care	Awaiting Swindon/ CCG data
Reducing the time spent in hospital through better patient flow	Norm for length of stay Delayed transfers of care	Norm for medical length of stay reduces by 4% % of patients ready to leave hospital still in hospital reduces by 20%
Improve patient experience within our hospitals	Number of negative responses per 100 patients	<10% of responses are poor
Improve patient experience outside of our hospitals	(waiting national metric)	
Ensuring the most specialist care is provided under the clinical management of specialist centres	% of specialist commissioned care offered at a specialist centre	95%

NHS Constitution

The CCG is meeting the requirements of the NHS Constitution, with the exception of:

- A&E four hour targets
- Cancer waiting times
- 52 week waits

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- MRSA/C Diff targets

Rectification plans are attached for these which are being managed by CCG through its contracts with providers.

Quality and Safety

Quality and safety is at the heart of all of our plans. We are proactively working to ensure that all providers offer safe and high quality services. Where they do not, we will intervene including removing services from being offered as a Choice and terminating contracts.

We monitor and challenge providers through our own inspections, third party reviews, independent inspections by regulatory bodies, monthly quality and standard reports, contract management meetings and the review of complaints and incidents. We also have a programme of clinical audits with each provider and all of this information comes to a monthly governance meeting (our Commissioning for Quality Forum) as well as to our Governing Body, which meets in public to discuss the quality and safety of our providers every month.

The above is complimented by a fortnightly review of all risks to identify any emerging quality or safety themes and has been supplemented by mystery shopping and moving some providers onto more intense and frequent scrutiny (even to the point of monitoring key safety standards every fifteen minutes in the case of one provider).

In 2013 the public enquiry into Mid Staffordshire NHS Foundation Trust and the subsequent publication of the Keogh Review and Berwick Report demonstrated the commitment made by the NHS to patient safety. That commitment forms part of the job description, objectives and appraisal of every member of staff in the CCG and the wider healthcare service (on the ward, in a GP surgery, in every community service).

The key findings of the Keogh report were that all parts of a health system must understand if staffing and patient flow are working well and take immediate action if not, as these were highlighted as the two consistent failings in poorly performing organisations.

Swindon CCG is fully committed to the recommendations made and pledges to ensure that all contracts include quality performance requirements and expected core standards of care. All providers are and will continue to be challenged to make continuous improvements in the quality of care and the patient experience they offer.

Financial position

We believe in and are committed to a clear and transparent process for how we determine the priorities for investment each financial year.

We have been informed of our income (financial allocation) for 2014-15 and 2015-16. The basis for the calculation of the allocation has changed to ensure that funding considers the fact that our local population has been and will continue to grow at a rate faster the rest of England as well as taking account of health inequalities and the impact of an aging population on demand for healthcare. For us the allocation for 2014-15 is £229m, an increase of 4% on 2013-14.

Our medium term financial plan

This 5 year financial plan for the CCG is based on the latest set of planning assumption guidance received from NHS England. This assumes a roll forward financial baseline with additional growth in line with the latest allocations published for each CCG from NHSE. There is an expectation of a net tariff deflator after taking account of the need to continue to achieve a 4% efficiency gain. There is a requirement to fund:

- Pay inflation which is expected to run in excess of 2% over the next five years and non-pay
- Prescribing at 5.5% which is consistent with previous years
- CQUIN at a static rate of 2.5%

Demographic growth averaging 1.39% annually plus a specific fund which Swindon will look to set aside to meet the higher than average levels of local activity demand at 0.65%. There is still an expectation that CCG's set aside:

- Non recurrent funding to pump prime strategic change initiatives though this will reduce from the current 2% to 1.5% for 2014/15 and then 1% thereafter
- Call to Action as a 1% fund in 2014/15 with the focus again being on local health systems using this to fund non recurrent transformational projects which can deliver longer term recurrent savings
- Contingency of 0.5%
- Achieve a surplus equivalent to 1%

Running Costs allowance will increase slightly in 2014/15; however 2015/16 will see a sizeable decrease with each CCG demonstrating that they can reduce this by circa 10% (for Swindon this will equate to over £500k saving).

The transfer of funding from health to social services will increase growth of 0.3% to be ring fenced for the Social Services Better Care Fund in 2014/15, rising to 3% in 2015/16.

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	Plan	Outturn	Plan				
	2013/14	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Opening Baseline	(217.98)	(217.96)	(219.88)	(228.00)	(234.91)	(239.13)	(243.20)
Growth	(5.00)	(5.00)	(9.04)	(6.91)	(4.22)	(4.07)	(4.12)
Specialist Commissioning		2.10	0.80				
Notified recurring adjustments		0.03					
Closing Baseline	**(222.98)**	**(219.86)**	**(228.08)**	**(234.91)**	**(239.13)**	**(243.20)**	**(247.32)**
Running cost allocation	(5.46)	(5.46)	(5.49)	(4.57)	(4.55)	(5.02)	(5.04)
Other sources	(2.32)	(2.35)					
	(230.77)	(227.67)	(233.48)	(239.88)	(244.13)	(248.22)	(252.36)
Opening Commitments	217.61	210.17	220.22	226.72	232.66	236.74	240.77
Activity demand	1.57	1.57	0.00	0.00	0.00	0.00	0.00
Demographic and other growth	2.94	2.94	2.29	2.24	2.17	2.65	2.73
Inflation	6.47	6.47	6.62	7.07	10.22	8.05	7.96
CRES in tariff	(8.12)	(8.12)	(8.79)	(8.57)	(8.98)	(7.10)	(7.22)
Outturn pressures		7.20					
	220.47	220.23	223.49	229.45	235.15	241.34	245.22
Strategic change fund	4.46		2.42	2.39	2.39	2.43	2.47
Call to Action Fund			2.20	0.00	0.00	0.00	0.00
National initiatives	2.91	1.35	2.30	1.20	1.20	1.20	1.20
Local initiatives	2.90	0.41	0.60	0.60	1.00	0.60	0.60
	229.51	**221.98**	**231.59**	**233.50**	**240.78**	**245.47**	**249.49**
Impact of Key Interventions	(8.03)		(7.55)	(2.29)	(5.40)	(6.10)	(5.97)
Running costs	5.46	5.46	5.88	5.14	5.17	5.21	5.24
Contingency	1.12		1.14	1.17	1.20	1.22	1.24
(Surplus)/Deficit	(2.28)	(0.23)	(2.28)	(2.32)	(2.29)	(2.42)	(2.47)

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Better Care Fund

£'000s	Plan 2013/14	Outturn 2013/14	Plan 2014/15	2015/16	2016/17	2017/18	2018/19
Income							
Current	2,753	2,753	2,753	2,753	2,753	2,753	2,753
Additional			641	448	426	426	426
Capital Grants	2,170	2,170	450	428	450	450	450
	4,923	**4,923**	**3,844**	**3,629**	**3,629**	**3,629**	**3,629**
Expenditure							
Current	2,753	2,753	2,753	2,753	2,753	2,753	2,753
Additional			641	448	426	426	426
Capital Grants	2,170	2,170	450	428	428	428	428
Carers Reablement Ex SCCG core			0	8,548	8,570	8,570	8,570
Disabilities Facilities Grant				498	498	498	498
	4,923	**4,923**	**3,844**	**12,675**	**12,675**	**12,675**	**12,675**
Variance	0	0 0	0	(9,046)	(9,046)	(9,046)	(9,046)
Funded from existing commitments in S75 with SBC				9,046	9,046	9,046	9,046
Net Impact to CCG				***0***	***0***	***0***	***0***

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How do we make decisions about which services to commission?

From the moment we became operational in January 2013, we made the decision that the public, service users and carers must be involved at every step of our commissioning of health services, moving away from single (and often poorly attended consultation meetings) and instead setting up a continuous programme of involvement from designing care pathways to evaluating the effectiveness of services. Various redesign workshops have taken place during the year which have focused so far on cancer, diabetes, dementia, orthopaedics, endoscopy, children's services, long term conditions, heart failure, end of life care, COPD, mental health, ambulatory and urgent care.

The priority programmes for 2014-16 were identified and developed from:

- What our members and stakeholders have told us (public, patients, professionals, partners, providers and GP practices) through a combination of service redesign workshops and surveys
- Benchmarking against other comparable areas and the review of national guidance
- Identifying opportunities to improve the quality, innovation, productivity or for prevention as identified by the clinical leaders from within our membership
- Working with the Health and Wellbeing Board to review the Joint Strategic Needs Assessments (the analysis of local population needs) each of which review has been set out as a published bulletin and

these include bulletins on mental health and learning disability, children's services, diabetes and cancer.

Our priorities for 2014-16

The following table highlights our priority programmes of work for 2014-2016.

What we have found	What we propose to do
URGENT CARE ❑ Pressure on primary care to deal with high volumes of urgent care with no underlying pathology that will not resolve itself has grown significantly ❑ Our market assessment identified five cohorts of people in Swindon (segments) all of whom require urgent for different social reasons ❑ 32-54% depending on segment, need not have gone to primary care or an acute setting for their care ❑ We offer very little by way of alternative out of hours or home visiting ❑ What we do offer eg NHS 111, increases hospitalisation and the use of acute settings ❑ We set out seven key changes and have already successfully piloted schemes to test our approach ❑ 2014-2016 is about supporting primary care (the SUCCESS programme) and scaling up those developments to reap the benefits	❑ SUCCESS programme ➢ 5 new primary care urgent centres ❑ Link workers (Community navigator project) ➢ Roll out from 4 to 26 practices ❑ At the scene care ➢ Move to 18/7 and provide home visiting ❑ Consolidated Fix Me Hub ➢ Develop business case for single door ❑ Ambulatory care ➢ Roll out existing programme to cover all major urgent conditions ➢ Link to SUCCESS programme ❑ Patient flow ➢ Review and revise admission and discharge management processes ➢ Invest in systems to reinforce clinical decision making at point of admission ❑ Post discharge care ➢ Improved e communication between secondary, primary and community care ➢ Crisis support ➢ hospital discharge schemes ➢ reablement ➢ social care support 24/7
CANCER ❑ The numbers presenting with cancer or cancers is growing at 5-6% per annum ❑ The number surviving cancer is growing faster than English average ❑ At present those requiring radiotherapy must travel to Oxford – for many a journey of an hour or more ❑ A significantly high proportion of local patients have their cancer picked up through the Emergency Department rather than through contact with primary and community care ❑ Great Western Hospital has established excellent links with the top cancer centres in Oxford and	❑ Bringing radiotherapy to Swindon ❑ Survivorship programme ❑ National standard is travel time to radiotherapy is 45 minutes maximum ❑ SUCCESS programme ❑ Centralise cancer services underpinned by single cancer Strategy and Plan with radiotherapy as the catalyst

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London and thus can offer may services locally – the exception is radiotherapy ❑ Cancer services in Great Western are not in one place	
SELF CARE ❑ Swindon sees more consultations per doctor, more visits to the hospital, more people stay in hospital per head of population than the English average ❑ Swindon's life expectancy, potential years of additional life and survival with common diseases are all higher than English average and improving faster ❑ Swindon's population is growing at the third fastest rate in the country ❑ Swindon has a disproportionately high number of people about to retire or in late retirement and thus demand on services will be greater still	❑ Healthy eating, healthy exercise, volunteering and no smoking programmes (the latter saved more lives in 2013 than any other programme in UK) ❑ SUCCESS programme creating space in primary care ❑ Improved links with Neighbourhoods and Neighbourhood planning capitalising on what communities can do to support themselves ❑ Greater engagement of and investment in voluntary sector in preference to statutory sector, with a focus on befriending and reducing isolation schemes ❑ Link worker initiative is just the beginning ❑ Expert patient programme needs resurrecting ❑ Lifelong health planning – planning for retirement
CARER SUPPORT ❑ Swindon has a very active support network for carers of all age groups ❑ Swindon has an active voluntary sector ❑ The demands on informal carers is growing and is especially important for those presenting with dementia, as part of survivorship programmes, and in support of those with learning disability or significant physical disability ❑ When an informal carer's health and well being is not supported then this materially affects the health and well being of the person for whom they care ❑ No two carers' need the same support – carer support must be personalised and tailored in the same way as all care must be	❑ Reviewing all services to ensure they adequately provide for the needs and rights of carers ❑ Using the opportunities presented by the new Better Care Fund to target additional support for carers, including intermediate and short term breaks ❑ Ensuring informal carers are aware of the support they can receive through Link Workers and existing support network for carers
CHILDREN ❑ Swindon sees more children proportionately attend hospital than the English average and this is growing ❑ Swindon has a slightly lower death rate with the exception of 16-25 age group ❑ English average is NOT a good place to be: ○ Worst death rate in Europe	❑ Supporting key households and families through One Swindon ❑ Providing dedicated services for children ❑ Looking at adolescent services where there are shown to improve outcomes eg Cancer ❑ Providing a dedicated service for children with high temperature but where the most

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○ Highest hospitalisation rate ○ Amongst the highest spend ❑ The care we provide being the second highest cause of child death	likely outcome is that this will settle ❑ Investing in support for households where there is a regime of neglect or domestic violence ❑ Linking schemes supporting those households where a member has an addiction to alcohol or other substance
LONG TERM CONDITIONS ❑ Swindon faces a significant growth in demand for those with **Diabetes, Dementia, COPD** and **Heart failure** ❑ In the case of diabetes services we have high historical levels of investment for poor outcomes and must change every aspect of the pathway of care ❑ Our analysis of current activity also shows variability in the management of waiting lists for planned care ❑ We offer very little by way of support to enable patients to take control of their conditions ❑ There are huge opportunities to reduce the use of secondary care through developing the time within primary care to manage patients with single and multiple long term conditions (the SUCCESS programme), expert patient programmes supported by peer and voluntary networks, training programmes, live information on web and other publications ❑ Reducing the pressure on primary care due to urgent care demand will release time for longer patient consultations for people with long term conditions, consultant link and virtual follow up clinics providing much more rapid, timely consultation opportunities that benefit both the patient and the GP ❑ There is a wealth of information available on healthy eating, smoking cessation and exercise but this information is not always put in front of patients when they need it ❑ The current pattern of referrals for planned care is not standardised and this leads to variations in practice and response from secondary care that is unaffordable and a waste of limited resources that could be better used supporting people with long term conditions	❑ Increasing time available in primary care to review those with long term conditions (shifting the balance of urgent and planned GP consultations) ❑ Helpline and other access to immediate information on self help ❑ Expert patient programme ❑ Standardised pathways of care for those with multiple conditions ❑ Standardised pathways of care for those with planned care needs ❑ Rapid access clinics for those with long term conditions ❑ Greater use of live telephone consultation ❑ Revised referral management system that meets the needs of GPs ❑ Increase diagnostic capacity based in localities or practices depending on economies of scale

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❑ Too many services are set up to manage a single condition when those presenting have multiple conditions	
MENTAL HEALTH AND LEARNING DISABILITY ❑ Our analysis of current activity shows that we see 1.5 times to twice as many residents being admitted to an acute ward when presenting with mental health problems than we should ❑ IAPT in the local community is amongst the best in the world and needs to continue to be supported ❑ We have developed an excellent model for supporting mental health and wellbeing for those who have already been in contact with mental health services and need to roll this out ❑ We need to improve the links between mental health, primary care and acute care to prevent admissions or offer alternatives ❑ The demand on primary care from those who need counselling and advice on social and welfare problems is growing ❑ Our model of support for those with learning disabilities is over reliant on residential care and costing us £7-8m per annum more than if we offered local supportive living arrangements for c75-125 residents who need this	❑ Roll out mental health and wellbeing coordinators ❑ Roll out Link Workers aligned with health and community centres and with schools and libraries ❑ Supporting the local IAPT service, maintaining open access model ❑ Developing better liaison with primary care ❑ Rapid access to alternatives to acute admission ❑ Further development of alcohol support services through One Swindon ❑ Re-commission community based support and supported accommodation for people with learning disabilities
END OF LIFE AND LIFE LONG HEALTH PLANNING ❑ End of life support needs to be seen as part of life long health planning and not a referral to services dedicated in terminal care ❑ Our vision is to offer a range of support that encourages independence for as long as possible ❑ We will offer a genuine choice of care setting for those whose mobility, functionality or health is impaired or for whom death is a possibility that needs preparation ❑ Home will mean a person's own or family home, kept as their home, with us using new practice and technology that maintains the home environment. ❑ Supporting people to live at home when	❑ Rapid access to pain relief supported by primary care consultants in palliative care ❑ Expert patient programme encouraged and supported by Link Workers ❑ Carer support and family breaks ❑ New practice and technology that is designed around the home ❑ Rapid access to clinics for presenting conditions cf cancer 14 day pathway ❑ Life long care plans including last 3 years of life and 18 months post death support for family and friends

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mobility, functionality or health is impaired does not mean leaving a person to be bed bound nor placing them in a clinical environment within their home. ❑ Our vision is to support people to live to the full within their community despite their condition THUS to avoid institutionalised care in a community setting	

Stakeholder Engagement

The CCG is committed to an on-going engagement exercise throughout January and February 2014, to allow patients and the public as full an opportunity as possible to comment and provide feedback on our Intentions. The feedback will then be reflected in the next edition of our commissioning intentions which go to the Health and Wellbeing Board and CCG Governing Body in March 2014 for consideration. The view have also been sought from healthcare providers; the third sector and from the CCG member practices.

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