Local Government Association

NHS England

Better Care Fund planning template – Part 1 version 9

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Swindon**
Clinical Commissioning Groups	**Swindon Clinical Commissioning Group**
Boundary Differences	**Shrivenham and this is included in health service provision**
Date agreed at Health and Well-Being Board:	**Discussion of draft plan 8th January 2014**
Date submitted:	
Minimum required value of pooled budget: 2014/15	**£3,394,293**
2015/16	**£12, 675,000**
Total agreed value of pooled budget: 2014/15	**£3,394,293 Section 256**

2015/16	**£12,675,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Swindon
By	Dr Peter Crouch
Position	Clinical Chair
Date	14.2.2014

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	Swindon
By	Gavin Jones
Position	Chief Executive
Date	14.2.2014

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	Swindon
By Chair of Health and Wellbeing Board	Leader of the Council David Renard
Date	8.1.2014

<Insert extra rows for additional Health and Wellbeing Boards as required>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

The service redesign programme is the main means of engagement with providers attending a range of events to address a number of Swindon specific priorities. Swindon Strategic Change Forum brings together the Clinical Commissioning Group, Swindon Borough Council, SEQOL (provider of community health and social care) and Great Western Hospital. This plan builds on the agreed priorities of

- Health & Well-Being Strategy
- The draft 5 year Plan for CCG and Swindon Borough Council
- The Commissioning Intentions 2014/15, which have been discussed with providers and have been developed jointly with Swindon Borough Council;
- The Joint Commissioning Plan which brings together the priorities for both the CCG and Swindon Borough Council. The priorities of this plan have also been shared and discussed with the voluntary and community sector.

In developing the plan there was a need to engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. As part of the planning process for 2014/15 and the 5 year strategic plan we will need to assess future capacity and workforce requirements across the system.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

The service redesign programme is the main mechanism for engagement in Swindon with patients, carers, service users and the public. In July 2013, in response to **A Call to Action**, we accelerated this redesign programme and developed it further to include the six emerging themes: **prevention**, **mental and physical health and wellbeing**, **learning from the best**, putting the **patient in control**, developing and testing **future scenarios**, and enhancing the quality of life for **people with long term conditions.**

The draft plan builds on engagement which has led to the Health & Well-Being Strategy, the 5 year Strategy, commissioning intentions 2014/15 and the Joint Commissioning Plan 2013/14. The draft plan has been discussed with the Public and Patient Forum of the Clinical Commissioning Group as part of the discussions on the Commissioning Intentions 2014/15. Feedback from service users and the voluntary and community sector for adult social care has led to priorities for

- improved advice and information;
- increased prevention, personalisation and self-help and self-management;
- improved support for carers

e) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**
Health and Wellbeing Strategy	Statutory Plan to improve the health and well-being of the people in Swindon http://www.swindon.gov.uk/sc/sc-healthmedicaladvice/Pages/sc-healthmedicaladvice-Health-and-Wellbeing-Strategy.aspx
JSNA 2013-2022	Needs assessment for Swindon http://www.swindon.gov.uk/sc/sc-healthmedicaladvice/jsna/Pages/sc-jsna.aspx
One Swindon	The Community Strategy and Vision for Swindon http://www.oneswindon.org.uk/cs/Pages/default.aspx
Adult Care Strategy	Our strategy for managing demand for adult services http://ww5.swindon.gov.uk/moderngov/mgConvert2PDF.aspx?ID=46045
Strategy for care (CCG)	The vision how care and support needs to change to improve the health of people in Swindon http://www.swindonccg.nhs.uk/media/file-browser/Swindon%20CCG%20Strategy%20for%20care.pdf
The Five Year	NHS required vision under a call to action

draft Plan	
Pioneer Bid 'Shoulder to Shoulder	Vision for integrated commissioning and integrated working for Swindon
Commissioning Intentions 2013/14 and Joint Commissioning Plan 2013/14	Joint commissioning priorities http://www.swindon.nhs.uk/Library/Publications/About_us/Business/Organisational_Development_Plan_2008-13.pdf

2) VISION AND SCHEMES

a) Vision for health and care services
Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

1. Vision
Our joint vision for people in Swindon is enshrined in the Health & Wellbeing Strategy

To ensure that everyone lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities

Our plan supports the CCG mission
To optimise the health of the people of Swindon and Shrivenham

We have aligned our joint resources to support the health, wellbeing, mental health, education and care of children, families and adults in the community to achieve the mission of both organisations.

This plan is also aligned with the work being progressed by the One Swindon Board as part of the Public Service Transformation network.

We have been involved in discussions with public, patients, GP practices, providers, voluntary sector, other stakeholders, providers, children and young people, and the Youth Forum in the development of the documents referred to above. The Better Care Fund Plan is a summary of jointly agreed areas of priority.

We have a long history of integrated commissioning and integrated service delivery for health and social care. This was outlined in detail in our bid 'Shoulder to Shoulder' to become and integration pioneer. Our vision for the Better Care Fund builds on our successful integration and the Five Year Strategic Plan for swindon.

***2.* What will be different in 2019 for services and people?**
Swindon will have grown substantially by 2019 with a population of close to 250,000 including Shrivenham. We will be delivering more services in the community.

Living in Swindon 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 integrated 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.

Everybody in Swindon is working together and to a common set of values and principles for how we work where people are encouraged to think what they can do themselves, what help they have within their family and community and what they still need help with.

Outcomes for service users and patients will improve

- Emergency hospital admissions will be avoided for specific groups of patients
- More patients will be able to leave hospital without delay
- Fewer older people will be admitted to residential care
- Fewer patients will be re-admitted to hospital through reablement services
- More people with a learning disability will be able to find employment

2.1 Prevention and self help

We understand the population of Swindon well down to each local area and at GP practice level. Preventative and self-help integrated services are in place locally engage and support you.

- 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 your own or family home, **kept as your home**, with us using new practice and technology that maintains the home environment.
- Supporting you to live at home when mobility, functionality or health is impaired does not mean leaving you to be bed bound nor placing your home with a clinical environment.
- Our vision is to support you **to live to the full** within your community despite the long term conditions you may have THUS to avoid institutionalised care in a community setting

You, your parents and carers know where to access information and support in your community, services and online. Carers for people with support needs are well supported through joint investment in the Carers Centre and short term breaks.

If you are older you are encouraged to engage with younger children and make a positive contribution. You are engaged in self- help groups, local activities and able to volunteer. Older people say that they feel safe in their community. Where possible the entrance to residential and nursing care is delayed and housing opportunities such as homes for life and extra care housing are used extensively.

You will have access to a range of programmes designed **to improve your health**, ranging from healthy eating and healthy exercise (ranging from 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 cultural activities, all of which have been shown to benefit health and wellbeing and extend quality of life

Self-care will be increasingly important. The vast majority of health care is either self-administered or a consequence of our body's ability to heal itself. Most studies identify self-care as representing **98%** of the total healthcare needed across a population at any given time.

Self-care can be supported in the home or the local community through informal routes

such as family, friends and carers, or by more formal routes for advice from pharmacists, Swindon Borough Council Localities, the voluntary and third sector, self-help groups, and the local integrated community health and primary care teams.

Public health initiatives and work is closely aligned to the community and third sector with a common message on promoting health and wellbeing, specifically healthy eating, exercise, smoking cessation and reduction in drug and alcohol misuse. Public health with work closely with General Practice as a short consultation can lead to more people quitting smoking and brief intervention has been particularly successful in smoking cessation and drug and alcohol misuse. Time banking is well established enabling everybody who is able to volunteer and participate in helping others in their community.

Children and young people have the best start in life and children's centres work closely with health visiting, maternity services and paediatric services so that children are healthy, have a good start at school and the need for hospital admission is reduced. Children's health & well-being is supported through excellent targeted mental health and specialist mental health services.

We will understand the economics of and constraints in, our health system such that investment can be better made in the right care in the right place at the right time.

Case study

Self-care and prevention 2013
Andrea is living in Penhill, one of the most deprived areas in Swindon. She has three children and an older mother suffering from diabetic living nearby. She is unemployed and on a low income. Her middle child is overweight and the youngest speech development is poor. She has few friends or relatives and feels often low and depressed caused by stress and anxiety.

Self-care and prevention 2019
Andrea's children are registered with the local children's centre when they were born. She receives information from the centre and as they offer to discuss managing behaviour and diet, she attends a local support group. In discussions with other parents, she has made new friends and joined adult learning activities. The centre introduced her to My Care, My Support website where she has found a carers support group run locally where she can discuss caring for her mother. Meeting new parents in the area and carers means that she feels supported and part of her community

2.2 **Urgent care – moving from unplanned care to planned care**

If you are at high risk of a hospital admission then your GP is able to refer to to a **community navigator** who will review your health and social and emotional well-being and develop a plan with you

If you have need for **rapid access for minor illness** and cannot treat this yourself through rest or use of medication, then this will be through a combination of your local

pharmacy or by appointment through 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 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.

There are strong links between the provider of integrated community health and social care services and all partners, particularly the local hospital, care homes, voluntary sector and primary care. We will have increased capacity in the virtual ward, extended the treatment of relevant medical conditions within the community (minor illness) in order to prevent admission to hospital. The 'Fix Me Hub' is fully established and has significantly prevented admissions.

Ambulatory care is good and existing programme to cover all major urgent conditions has been rolled out and linked to primary care developments.

Patient flow has improved as well as discharge processes. We have review and revise admission and discharge management processes and invested in systems to reinforce clinical decision making at point of admission. Discharge from hospital is well-co-ordinated. Nursing homes and care homes have well-trained staff and provide community based nursing interventions reducing the need for hospital admissions. Nursing homes and residential homes work together with health and social care to facilitate speedy hospital discharge.

Case study

Urgent care 2013
Patrick lives at home. He is 85 years old and his health is poor, suffering from high blood pressure and heart disease. When his health deteriorates due to an infection, he is admitted to hospital and given antibiotics intravenously. He is isolated and visits his GP frequently

Urgent care 2019
All GP's in Swindon know of community navigators and the referral process. Patrick is identified at high risk of hospital admission. The community navigator meets him and discusses his health, drinking regularly and looking after himself. Using My care My Support, Patrick is allocated a volunteer to befriend him. A plan is made so that if he

has another infection he can be given anti- biotics intravenously. This means that when Patrick suffers from an infection, he is cared for at home and not admitted to hospital.

2.3 Long Term conditions

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

Those people who live in the most deprived areas will be receiving additional signposting and support so that they are better able to care for themselves and be able to seek the most appropriate support at the right time.

Swindon is a dementia friendly community. Older people suffering from dementia have good diagnosis in place with support group operated in the community and more use of dementia café's and activities. Community and social care providers support people suffering from dementia and are skilled and sensitive to their needs

End of Life care in the community is well established. Providers are working together to ensure people are able to be supported in the place they want to live.

Children and young people with long term health needs are supported in the community. Parents are able to access enhanced primary care services evenings and weekends so that hospital admissions are prevented.

Living with dementia in 2013
Doris lost her husband 3 years ago. She lives on her own and her son and his family are a 2 hours' drive away. Doris is a member of her local church but has only a few friends. Her son has organised a local Befriending service to support her four hours a week. Following a fall when she broke her arm, Doris returns home after 3 weeks in hospital. Over the next few months her son notices that Doris becomes more forgetful, seems more anxious and does not participate as much in activities. After 4 months she is diagnosed with dementia. Her son increases the care package.

Doris has another fall and is fund by a neighbour wondering outside. Her son is becoming increasingly concerned about her safety. In discussing the situation with Doris, Doris moves into residential care near her son's family.

Living with dementia in 2019
Swindon has an active network of locally based group and the churches play a very active part. Following the loss of her husband, the local church volunteer visits Doris and encourages her to continue to come to church functions. The volunteer collects Doris for the weekly lunch and women's group. Doris son is aware of the church

volunteer. He notices Doris getting more forgetful. He contacts the local advice and information service about activities in Doris area. Doris is diagnosed with dementia. Her son is able to access information online and discuss help with Doris. Following deterioration in her health, Doris is not able to manage living on her own in her house as she starts wondering. Her son is able to make a referral for extra care housing through the advice and information service. A care team is on site and support is tailored to Doris needs. The church volunteer continues to collect Doris from her extra care flat and take her to church groups. Doris is able to live with support in extra care housing and admission to residential care is delayed.

2.4 Mental health & Learning Disability

If you have a learning disability and upported by social workers will have a personalised plan and personal budget in place. You and your carers have fully participated in the plan and own the outcomes to be achieved. You will be supported to to be the best you can be with skill development, education, training and employment opportunities identifies and pursued. Where possible you are living within the community in supported housing with local support.

If you have a learning disability or mental illness you are enjoying leisure and culture and have opportunities for employment.

Carers say that they have been fully involved and are positive about the quality of support and services they receive. More of you say that they feel safe.

The voluntary and community sector provision for people with a learning disability and those with mental ill health has been reshaped and implemented so that support is preventing conditions from getting worse and more people access employment and training opportunities. Links with specialist learning disability and mental health services are well established

We will have reduced people with mental illness being admitted to an acute ward when presenting with mental health problems than we should and we will have built on the many services in the local community that are amongst the best in the country and need to continue to be supported. Mental health services will be delivered locally with a strong focus on early intervention and recovery. We will have evaluated and extended the concept of well-being co-ordinators bringing together specialist and community services for people being discharged and those at risk of mental illness.

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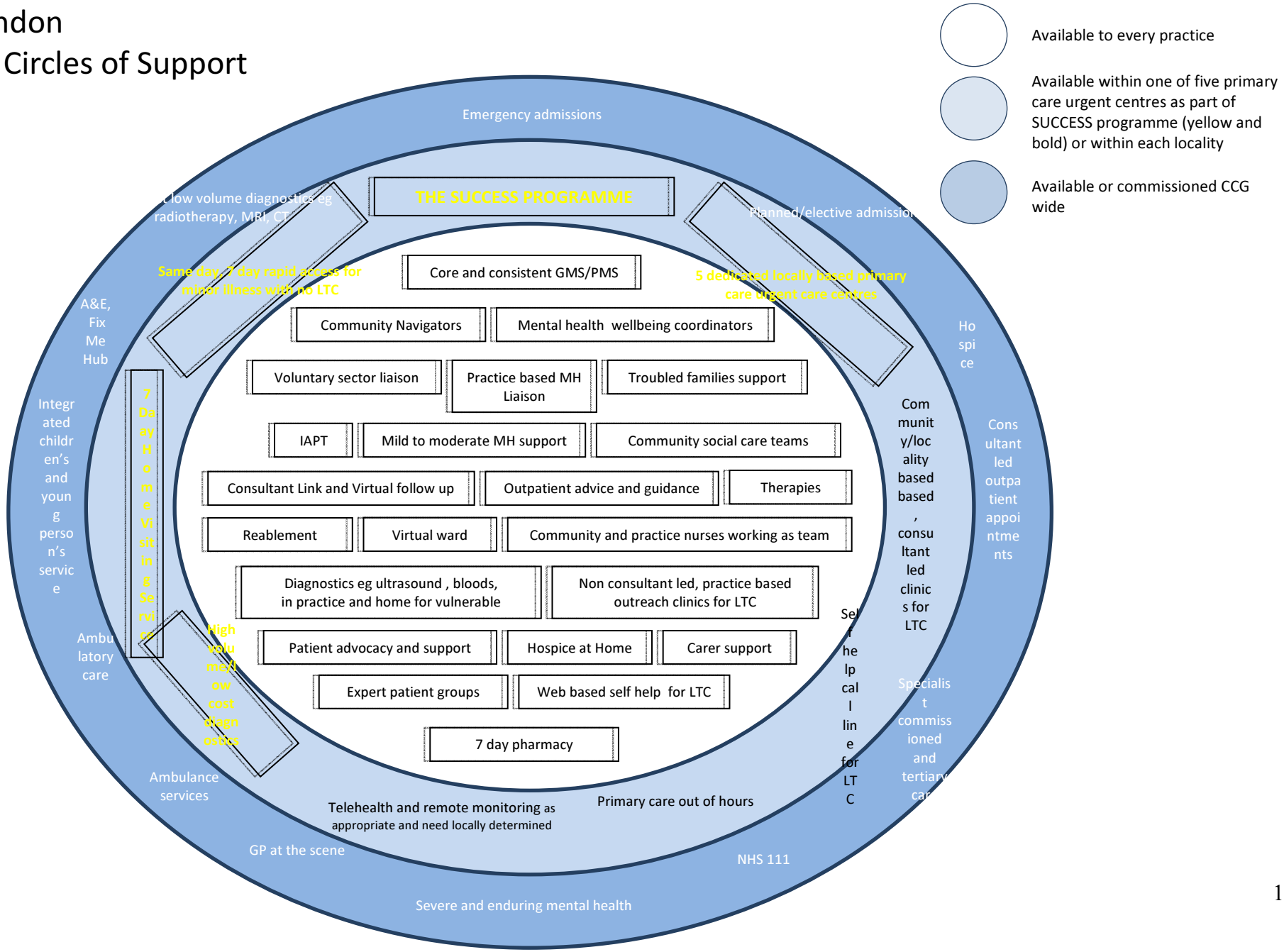
Case study

Mental health 2013
Diana has suffered from depression for a number of years. She has been referred and allocated to the specialist mental health services three times in the past. The usual pattern is that she is discharged after a period of months when she has stabilised. Once discharged she only has access to her GP

Mental health 2019
As part of the discharge process, mental health workers start discussing with Diana how she copes at home and what causes the deterioration in her mental health. Well before discharge, the mental health worker discusses the well-being co-ordinator role with Diana. Diana meets the well-being coordinator with her mental health worker. Together they establish a plan how the three of them will work together before and after Diana's discharge. The well-being co-ordinator introduces Diana to a job club and Diana works as a volunteer three mornings a week after discharge.

Swindon
The Circles of Support



b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

4. Our Aims

To improve the outcomes for people in Swindon through the joint investment in high quality services so that we are

- **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 and maintain them to live in their own homes for as long as possible
- **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.

5. In order to achieve our vision, our service development priorities are:

- **Urgent care:** locally enhanced service models need to be put in place to ensure the roll out of risk stratification. Supporting primary care through SUCCESS model with urgent care centres in as well as increased home visiting and joint work between community and acute services (Fix Me Hub); supporting the implementation of a lead GP for each patient over the age of 75 years
- **Long term conditions:** Diabetes, Dementia, cancer, heart failure, stroke, COPD review of care pathways through on-going redesign process so that services appropriately meet the demand created through better diagnosis and increased awareness for dementia, better treatment for cancer, diabetes and COPD
- **Self-care and prevention** locally enhanced service models on a pilot basis to be put in place to test the N.E. London case worker model for long term conditions including older people. Reshaping of provision in the voluntary and third sector to improve health and well-being, improved advice and information so that people can make plan and make choices for themselves
- **Reducing a growing burden of lifestyle related ill health and cancer** particularly due to physical inactivity, obesity and smoking that we want to address

through increasing community capacity to tackle the wider determinants in relation to housing and employment. Swindon has higher rates of smoking, teenage pregnancy, alcohol consumption, physical inactivity and obesity in areas of disadvantage, which in turn leads to higher incidents of heart disease and diabetes in those communities. We continue to invest in initiatives that tackle heath inequalities throughout the life course

- **Improving the health of children** by reducing child obesity to prevent long term ill health, reducing paediatric admissions and ensure targeted support for children and families
- **Improving mental health** through wellbeing co-ordination and improved work between voluntary and third sector mental health services and secondary mental health services
- **Improving health, social and emotional development of people with a learning disability** so that health outcomes improve, people live and are supported locally and find suitable employment and training.
- **Supporting Carers:** Developing an extended menu of support for carers. Reviewing all services to ensure they adequately provide for the needs and rights of carers and ensuring carers are aware of support and short term breaks available to them

6. Measuring aims and objectives

National indicators subject to payment by result (TBC)

- Avoidable emergency admissions reduce by 1.5 % by March 2015. Baseline data April to September 2013 showed 2,022 avoidable admission which we aim to reduce by 1.5% for a six month period.
- Delayed transfers of care from hospital per 100,000 population reduce by 5% by June 2015. Baseline data shows 3,151 bed days in delay over 6 months, which we aim to reduce to 3,110 over 6 months.
- Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 (100k) population reduce by 9% by March 2015 from the baseline of March 2014. The current year forecasts 200 admissions by March 2014 leading to a rate of 660 per 100k population, which we aim to reduce to a rate of 594 per 100k population
- Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services improved to 85% by March 2015 from a current baseline of 80%
- Patient / service user experience - awaiting national detail.

Local indicators for consideration on which one is to be selected (TBC)

- Increase the number of those with a learning disability in employment and training by 40% to 28 people which will enable us to also move people to supported living in Swindon rather than residential care

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

7. Integrated health and social care

An integrated Health and Social Care Social Enterprise (SEQOL) is already in place with a joint contract with a total value of approx. £28m. SEQOL provides integrated learning disability and older people social work teams. Community health services are part of social work teams. Care is co-ordinated around the individual. A Single Point of Access is already in place as well as integrated hospital discharge services, a rapid assessment service (DART) as well as the Virtual Ward and 'Fix Me Hub'. A joint contract is in place across Swindon CCG and Swindon Borough Council supporting carers as well as jointly funded carers breaks.

DART was developed by the integrated discharge team to reduce length of stay in hospital of people who need support through equipment, reablement or community nursing but don't need complex assessments. Following a successful pilot in the summer, the service is now commissioned. The service started on 1st November and in the first 12 days of operation, the team were able to demonstrate a 2.2 day reduction in length of stay in the Great Western Hospital.

Through DART and the Integrated Hospital Discharge team, social work services are available 7 days a week supported by brokerage and contracts team in adult commissioning.

A range of public health initiatives are already in place and will be strengthened through our joint community capacity work targeting healthy lifestyles and a reduction in risk taking behaviour such as alcohol and drug misuse.

The Better Care Fund will build on the work that Swindon has already started and comprise the following schemes in 2014/15

8. Schemes funded from Better care Fund 2014/15 and delivered 2014/15

8.1 Integrated Crisis and rapid response

Crisis support to prevent admission to hospital and enable those who leave hospital to with access to assessment facility for people discharged from hospital linked to reablement so that length of stay in hospital reduces and people are able to regain their skills as quickly as possible.

8.2 Enhanced Reablement

People will regain skills and quickly as possible without the need for on-going support. This will be provided from an integrated service including OT and therapists with direct referrals from the Hospital Discharge team to enable speedy discharge from hospital.

8.3 Community navigators and enhanced voluntary sector capacity

Community navigators will provide advice and information and targeted voluntary and third sector capacity. The role of the community navigator will be to coordinate a holistic pan for patients at high risk of hospital admission. A plan is put in place with the support from various sectors and agencies to deliver this package of assistance. Patients with

long term conditions are identified through risk stratification which is in place in all GP surgeries. Community navigators are now being piloted in 4 GP practices from January 2014.

In addition to community navigators, mental health well-being co-ordinators are introduced through the commissioning of mental health third and voluntary sector contracts. Process re-designs and training is in place and piloted from November 2013.

To support the above, the second strand of the project is the development of a single database **My Support, My Care** that can be accessed by the patient and the link worker in assembling the package of support. Alongside the link workers, we need to ensure that investment in the voluntary and third sector is aligned to support those in most need of self-care.

In particular we will commission voluntary and community based support linked to localities and GP practices. Supporting volunteers reduces the need for some targeted and specialist services. Community and voluntary sector groups provide important flexible services either informally or as part of local contracts. There needs to be greater emphasis on direct work and practical help because patients often need advice and help outside of normal working hours and we will invest in community based volunteering (TImebank) and, dementia and befriending services. The main voluntary sector organisation providing support to those with mental health, advice and information services and support for carers will be co-located.

8.4 Community Rehabilitation Scheme (**Fessey**)
We will be funding nursing assessment beds with enhanced health care so that patients can be discharged from hospital more quickly. Process has been designed and additional staffing introduced. Discharge from hospital into Fessey implemented in December 2013.

8.5 Enhanced hospital discharge
We will continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible. We will ensure access to brokerage and verification services so that there is speedy access to social care packages seven day a week. Integrated discharge team comprising of health and social care is in place. Since September 2013 a Discharge Assessment and referral team (DART) has also been in place to avoid admission and discharge as early as possible. Both services operate 7 days a week and work closely with hospital clinicians. We will be reviewing home from hospital support so that any delay is avoided and a community support package is in place. The Virtual ward will be working closely with the hospital discharge services and the Single Point of access to both avoid admissions and enable speedy discharge

8.6 Learning disability:
We will re-commission services by shifting towards supportive living model by stimulating local market and expanding both occupational and educational opportunities. A project team is in place from January 2014.

***9.* Schemes funded from Better Care Fund 2015/16 onwards**

In addition to the schemes above we will develop the following areas

9.1 community navigators and enhanced voluntary sector capacity

Following a formal review and evaluation, we will roll out the scheme to all GP practices across Swindon based on initial projections in reducing hospital admissions. Link workers will work closely with services provided in the voluntary and community as well as community health and social care services provided by SEQOL, so that a community self-help package is in place overseen by clinicians. The target population is patients with long term conditions with frequent hospital admissions.

9.2 Enhanced Patient Expert programme

Enhanced Expert Patient Programme (includes prescribed training in condition)

9.3 Single Point of Access for Long term Conditions
Roll out single point of access for long term conditions.

9.4 Mental health
For mental health: revisit local capacity model, protect and enhance IAPT model, strengthen crisis resolution and MH liaison with both primary and secondary care.

9.5 Carers Support
A joint carers contract is already in place which was tendered in 2012/13. The Carers centre provides advice and information for carers, welfare benefits advice as well as support groups. Young carers support is provided by the same voluntary organisation and was part of the same tender. Outcomes for carers continue to improve. Additional investment was made available in April 2012 for short term breaks for carers and the investment has been maintained. This has resulted in additional support for carers in their caring responsibilities. Two carers support groups operate through the localities work.

9.6Capital allocations
Capital allocations fund the joint Integrated Community equipment Store for children and adult services as well as investment in tele health and telecare. We will continue investment in technology to support self-care and prevention and enable for this a disability to live an independent as possible.

9.7 Implementation of new responsibilities under the care and support system
We will be implementing the required systems under the health & Social Care Bill and prepare systems for an increase in financial assessments and self assessments. Wherever possible we will be investing in new technology to automate processes as quickly as possible.

9.8 Alternative community based health services preventing hospital admissions

Continued development and enhancement of a range of community based support such as the Single Point of Access,

9.9 Supporting independence and reducing length of stay in hospital
Virtual Ward, Intermediate Treatment beds (SWICC), Hospital discharge services and 7 day working for clinicians

9.10 Integrated services for people with a learning disability

10. Alignment to existing strategies integration and JSNA

The vision, priorities and schemes are based on an analysis of data from the JSNA, literature search and best practice nationally. The schemes were also identifies in Swindon's application to become a Health Pioneer. As we already have joint commissioning plans in place, the majority of schemes are already references in the Joint Commissioning plan 2013/14. New schemes will be included in the refresh of the CCG Commissioning Intentions 2014/15 and the Joint Commissioning Plan.

Swindon is strongly placed to build on its existing delivery of integrated care with an existing Section 75 agreement in place for health and social care comprising a total aligned fund of £16m CCG and £55m SBC (total £72m). We already have an established community provider providing integrated health and social care services, SEQOL. We are 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 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 (South Western Ambulance Service) and one network of voluntary sector organisations (Voluntary Action Swindon or VAS).

Integrated services for children bringing together community health, education and social care services in a single co-located and managed in an integrated way.

One Swindon is a partnership of all statutory organisations working with the private sector to deliver a single vision for Swindon which:

- Benefits the people of Swindon
- Celebrates the successes of Swindon
- Sees One Swindon working as one and is part of the national Public Service Transformation Network as one of nine local authority areas to be designated and already has earned the reputation for delivery of joined up services and change with 12 new business cases developed for implementation during 2014.

Swindon is therefore already delivering integrated care supported by the fact that organisations currently providing local health and social care services are dealing with the same patients and communities.

We will built on existing models for integration of sources of funding, resource allocation and provision across adults and children with a particular focus on enhancing the role of community based health and social care support, community navigators and community based support through the voluntary and third sector. 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 - it certainly will not reflect the level of ambition that the ITF seeks to achieve. We see the opportunity presented by the Better Care Fund as a step in a journey that we describe below.

Our ambition for our integrated care model is first and foremost driven by our daily appreciation of the delays and confusion in healthcare delivery caused by the current disintegrated 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 confusion and delay, that delay results in poor healthcare and also discontinuity of provision, that the resulting communication between healthcare professionals is also poor and needs new systems to improve it, and that having two different definitions of choice operating along teach pathway i.e. social care and health care definitions are differently applied, only adds to the confusion.

Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Swindon faces significant population growth over the next 10 years as the data below shows. We will see a larger rise than nationally amongst children under five and older people with long term conditions, both of whom are high users of primary and secondary health services. Looking at our demographics, we can see the unique consequences of the growth in our industries in the 1980s and 1990s with a materially larger proportion of our people being in the 30-64 age groups. Forecasts between 2001 and 2011 also show that we would see the over 85 populations grow at a much faster rate than the rest of the population due to increased life expectancy

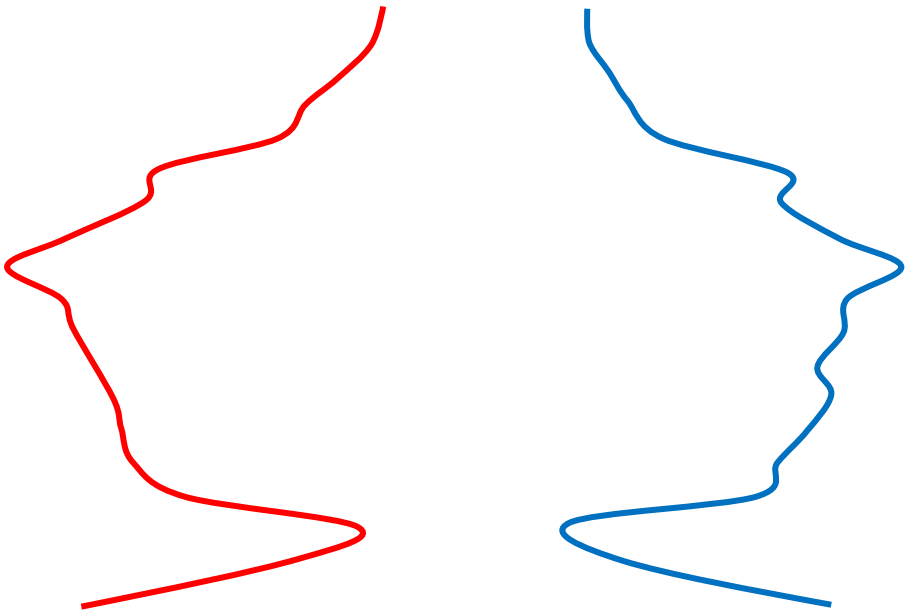
This means that our opportunities for reducing hospital admissions are challenging and cannot easily be compared to the national average.

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 with an average of 1.3-1.4% per annum and indeed 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. 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.

Swindon residents can now expect to live nearly 3 years longer than when the Census was undertaken in 2001. Female life expectancy is almost at the English average and both male and overall life expectancy are above the English average. Potential years of life that could be saved for women has increased, however, to 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.

Population Pyramid 2011 with 2019 projection shown as lines



Based on the 2011 Census and 2013 hospitalisation rates, this is no longer the case. Hospitalisation rates are now on 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.

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 the male population remains a top priority.

The growth in people from Black and Minority Ethnic and Diverse Communities to 16% 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 and cardiovascular disease in the Asian community (both for which are priorities for new interventions in 2014-2019 therefore).

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.

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 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.

OUR POPULATION AND PERFORMANCE

We have set improvement targets over the next five years for every outcome in all 5 domains but 3 in particular require additional attention and intervention: **Potential Years of Life Lost**, **Avoidable emergency admissions** (including unplanned admissions for chronic conditions that can be treated through ambulatory care), and support for those with long term conditions (who currently do not feel supported):

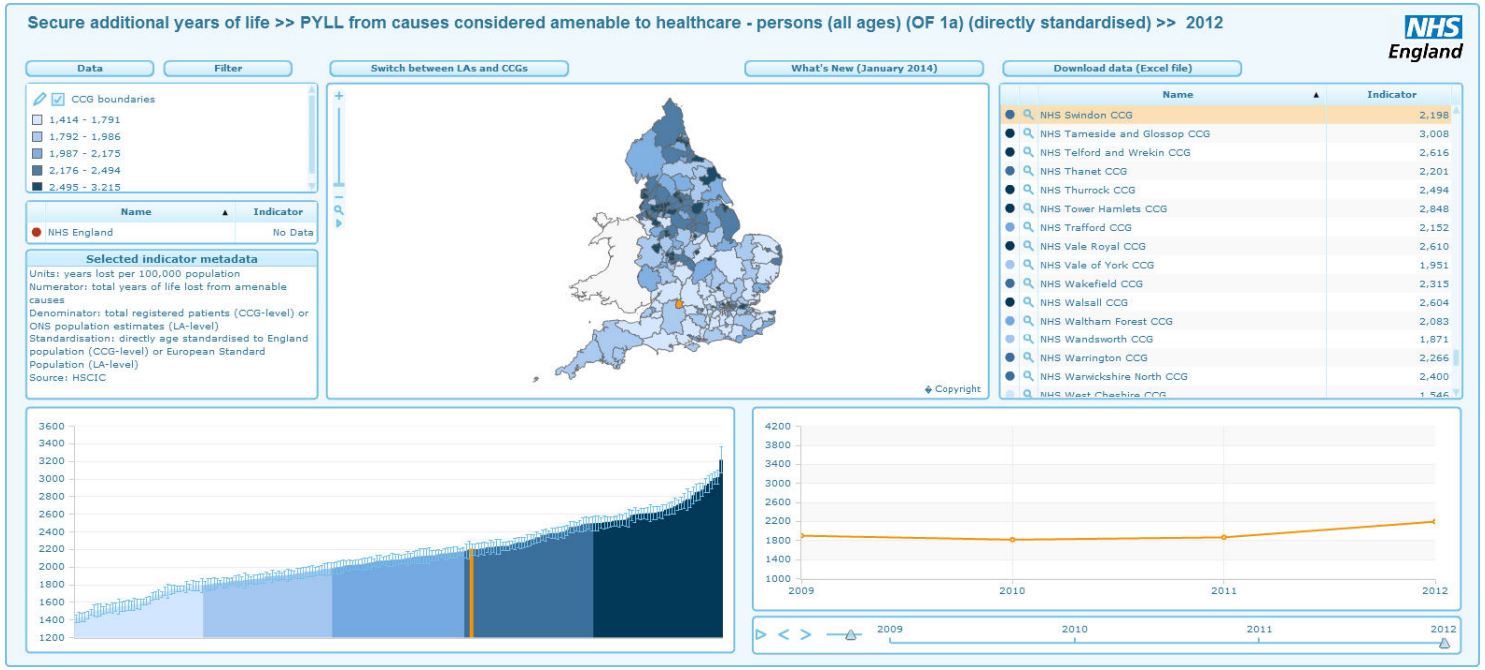
Indicator	Value		England	Region	England Min	Spine chart	England Max
▼ Outcomes - domain 1							
Potential Years of Life Lost amenable to healthcare - female	2,222	↑	1,911	1,712	1,098		3,071
Potential Years of Life Lost amenable to healthcare - male	2,182	↑	2,267	1,911	1,568		4,039
Under 75 Mortality 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

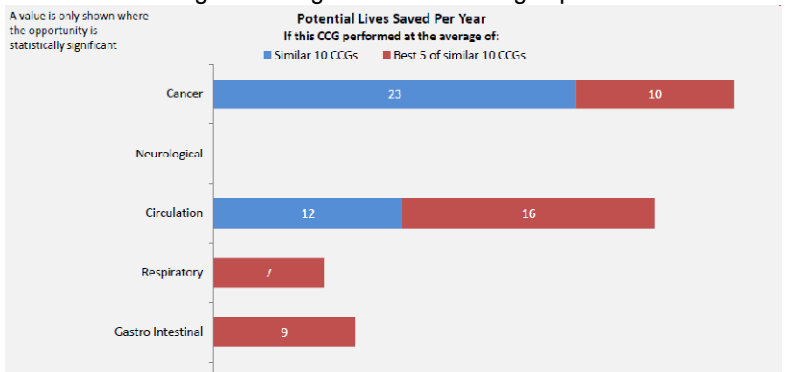
AREAS FOR IMPROVEMENT

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 1800 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.

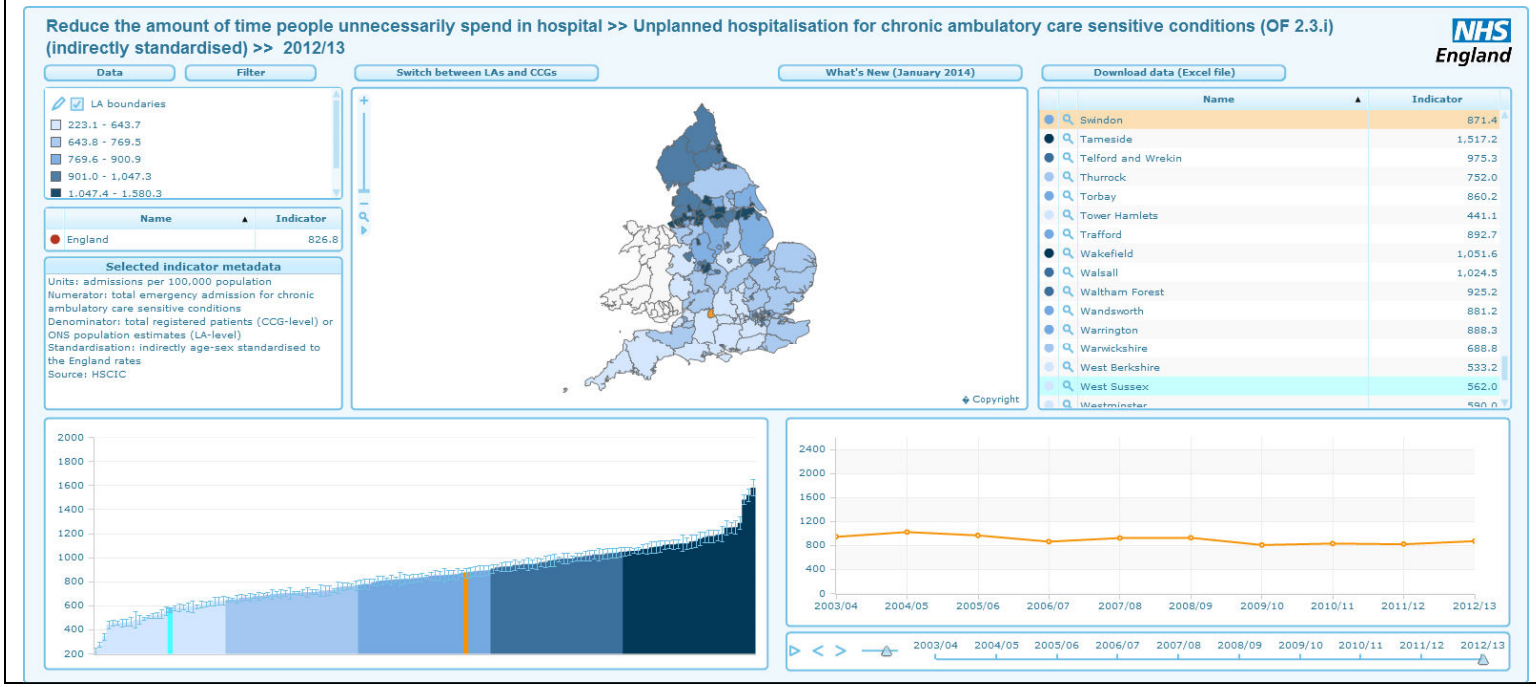


The main opportunities for intervention are in cancer and circulatory disease (see below) with under 75 mortality from respiratory disease being worse than the English average and also needing improvement:



Avoidable emergency admissions

Although the Swindon comparative and actual admission rate has improved over the last nine months and in the period 2009 to 2011, it deteriorated slightly in 2012 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 age adjusted annual growth (2% below the three year rolling average growth over the last ten years). However, the interventions proposed in this plan 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.



d) Governance
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

12. Governance

Swindon has two national Health Services Act 2006 section 75 Agreements for the commissioning of adult health and social care services including mental health and commissioning of health, education and social care services for children. Governance arrangements to monitor the section 75 Agreements are already in place through the Joint Commissioning Board Children & Adults. The CCG and Swindon Borough Council are members of the JCB. Meetings of the Board take place quarterly and are open to the public. The Board is a subcommittee of Cabinet and the Clinical Commissioning Board. The new Better Care Fund will sit as a pooled fund within the Section 75 Agreement and will be monitored by the JCB. The existing Section 75 Agreements will be refreshed to take account of the new arrangements.

13. NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Swindon Borough Council uses its core budget allocation and the additional funding of the Better Care Fund to promote integrated working across health and social care. We are joint partners in the National health Services Act 2006 section 75 Agreements with Swindon Clinical Commissioning Group. We have an annual joint commissioning plan which sets out our joint priorities and funding of services included in the Section 75 Agreements. The Joint Commissioning plan's priorities are refreshed in light of the JSNA and the heath & Well-Being Strategy annually. The Joint Commissioning plan is reviewed twice a year and demonstrates the outcomes that have been achieved across health and social care for the benefit of the people of Swindon.

Please explain how local social care services will be protected within your plans.

Swindon Borough Council is proposing a net investment of £550k in care packages for people with a learning disability and £500k in care packages for older people. Savings have been identified against supported housing schemes, limiting the rise of inflation and remodelling short term residential breaks for people with a learning disability. Swindon already has a joint health and social care provider in SEQOL. There are no plan to change eligibility criteria

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

In addition to the net increase in investment outlined above, the growth of investment of the Better Care Fund for adult social care will be used to fund 7 day working for social care within the hospital discharge teams. Social workers, verification and access to care packages will be in place 7 days a week. Community health services will be accessible 7 days a week.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

We will be using the NHS number as primary identifier for correspondence across health and care services

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

N/A

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We are committed to Open API and Open Standards

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practise and in particular requirements set out in Caldecott 2.

Information Governance is in place

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

GP will be the lead professional for all patients over the age of 75. Assessing patients according to need continues to be a vital component of our Long Term Conditions (LTC) generic model and key to the delivery of good LTC management. By using a risk prediction approach it is possible to identify those people who are the most regular users of health services (both primary and secondary care) and are at risk of re-admissions to hospital), then stratify them according to complexity of need and commission cost effective interventions to meet those needs. NHS Swindon made an investment in implementing a risk stratification tool in all GP surgeries. GP practices will be involved in identifying opportunities for commissioning interventions that could reduce the risk of a hospital admission

All patients with long term conditions and identifies as high risk through risk stratification tool will be on the Community matron caseload. GP LES in place supporting risk stratification.

Risk stratification will identify patients in need of case management supported by practice attached community navigators/link workers, supported by a database of available community, voluntary sector and neighbourhood support

3) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Risk 1: Demand at a higher	High	Focus on self-care and

rate than population growth assumption of 2.8 - 3.2%		prevention
Risk 2: Community based self-care pilots too small to impact on demand	High	Link of community link worker and mental health well-being coordination schemes to maximise impact
Risk 3 demand outstrips capacity in reablement services	Medium	Spot purchasing of reablement packages
Risk 4 patients continue to go to A&E rather than community alternatives leading to increased hospital admissions	medium	Communication strategy, close work between GP practices and community health services. Distribution of information materials, promotion of online advice and information
Risk 5 Political resistance to change	Low	Cross Party Lead Member Advisory Group in place monitoring adult change programme. Good political ownership and multi agency ownership of vision and strategy
Risk 6 Cultural change required from staff across public sector	Medium	Multi agency work force development programme across Swindon on managing expectation and managing change
Risk 7 Capacity to drive pace of change under developed	Medium	One Swindon Transformation Hub to support change programmes in adults and children
Risk 8 NHS Provider viability - Potential risk to small and medium size providers during tendering of services and the potential of service disruption	Medium	Publication of commissioning intentions and potential tendering with significant lead in time for tendering of services