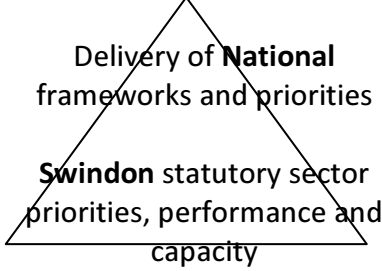


<p>5 year Vision To ensure that everyone lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities</p> <p>223000 people in 27 practices and 7 Localities growing to over 250000 by 2019</p> <p>Above average Health (life expectancy and avoidable deaths)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

<p>Self care 2014 - 2016</p> <p>Mental health and well being coordinators</p> <p>Small community schemes</p> <p>On line third sector directory of service and advice and information service</p> <p>On line self assessment for social care services</p> <p>Supported housing to maintain people with learning disabilities</p> <p>Work with care homes and nursing homes on preventing hospital admission (focus group)</p> <p>Healthy Eating strategy and schemes</p> <p>Healthy Exercise strategy and schemes</p> <p>Enhanced smoking cessation programme</p> <p>Alcohol prevention and support</p> <p>2016 TBC onwards</p> <p>24/7 condition line</p> <p>Roll out single point of access for long term conditions</p> <p>Enhanced expert patient programme (includes prescribed training in condition)</p>	<p>Primary care (needs timescales)</p> <p>Single vision & approach to performance management of primary care co-developed by AT and CCG</p> <p>Links with community services & link worker, virtual ward, community matron</p> <p>Locality based developments eg enhanced diagnostics, leg club model</p> <p>Specific developments eg monitoring through use of technology</p> <p>Developments in response to risk stratification eg renal, and greater support for medication review</p> <p>Capacity enhancement eg therapists, psychiatric liaison</p> <p>Development of three locality hubs for enhanced services</p>	<p>BCF funded schemes 2014/15 (£3.3m)</p> <p>Ongoing development of reablement and accelerated discharge schemes, Fessey beds, Crisis support</p> <p>Carers support and short term break (LA)</p> <p>Accelerated discharge and access to care packages</p> <p>7 day working in social care and community health services</p> <p>Link Worker initiative (community navigators)</p> <p>Shift model of community and third sector delivery towards locality and practices</p> <p>2015/16 (potentially £12.675m)</p> <p>In addition to the above</p> <p>Capital for health and social care</p> <p>Enhance admission avoidance roles of Virtual Ward, SWICC, telehealth, GP at the scene (targeting of residential/nursing homes)</p> <p>Potential Expand Link worker initiative (community navigator following evaluation) to multiple conditions</p> <p>Capital Schemes</p> <p>Carers Support</p>	<p>Secondary care (needs timescales)</p> <p>New “Fix Me” Hub serving wider and growing catchment population c350,000</p> <p>Single point of entry and initial navigation to appropriate stream within Fix me Hub</p> <p>Streams to include resus. and major, minor, ambulatory and walk in diagnostic, urgent GP and nurse led, medical triage and assessment, surgical assessment, social issues and care</p> <p>Planned care to include clinics for multiple conditions and rapid access and review clinics for specific long term conditions to avoid admission, use of technology to expand consultant links into primary care and use of virtual clinics and consultation</p>	<p>Outcomes and baseline</p> <ul style="list-style-type: none"> • 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 to 1,993 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 • 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
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