NHS
Swindon
Clinical Commissioning Group

ONE SWINDON: ONE VISION

Five Year Strategic Plan 2014-2019

Swindon Clinical Commissioning Group

April 2014

FOREWORD

Swindon Clinical Commissioning Group (CCG) has a mission to optimise the health of quarter of a million people registered with 26 GP practices in Swindon & Shrivenham. We are responsible for commissioning £235m of health services for the people of Swindon & Shrivenham.

We consulted our membership through December 2013 and January 2014 and have received their endorsement for the direction of travel of our commissioning intentions.

One Swindon: One Vision sets out our five year vision and our ambitions for Swindon health and healthcare services.

The document entitled *The Age of Consolidation* provides a more detailed analysis of the changes we will make over the next two years (2014-2016). Both documents are supported by a number of NHS England templates and analysis by Ernst Young which provide the detailed activity and financial analysis to demonstrate that Swindon CCG has a set of sustainable plans.

Following further input from NHS England, The Health & Wellbeing Board and wider public consultation, this document will be further refined between now and June 2014 for final submission. It has been presented to our Governing Body and will be presented to The Health and Wellbeing Board at this stage to indicate the proposed direction of travel for health and health services locally over the next five years and to invite comments and respond to any suggested changes.

At the heart of this strategy are the following aims:

- To **increase the life expectancy** of people living in Swindon and Shrivenham
- To **reduce health inequalities** within Swindon and Shrivenham
- To **increase our self-reliance** and **support self-care**
- To **increase the support we offer to those with long term conditions**
- To **reduce unnecessary emergency admissions** and **promote a shift from unplanned towards planned care**
- To **promote the use of new technology and practice** to **improve the efficiency and productivity of local health services**
- To **improve the patient's experience of local health services**

As the elected Clinical Chair of the Swindon Clinical Commissioning Group Governing Body, I have pleasure in presenting our considered Five Year Strategic Plan.

Dr Peter Crouch

Clinical Chair
Swindon Clinical Commissioning Group

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OUR VISION

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

You will have access to a number of programmes designed **to improve your health**, ranging from **healthy weight** (including incentives with leading retailers to promote a swap to healthy choices of food) and **healthy exercise** (cycling to sports activities and recreational swimming to walking and gardening schemes) to further promotion of smoking cessation to increasing access to library and cultural activities, all of which have been shown to benefit **health and wellbeing, reduce isolation and loneliness** and **extend and enhance quality of life**.

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

If you cannot treat yourself through rest or use of over the counter medication and advice from your community pharmacist then you will be able to make an appointment with a network of local primary care Urgent Care Centres (open 0800 to 2000 seven days a week) booked through your GP surgery or out of hours service (our SUCCESS programme).

If you need a **home visit** this will be available in future from a dedicated service able to offer a house visit without home visits having to wait until the end of a GPs morning, afternoon or evening surgeries (our SUCCESS programme).

If you need **access to emergency services**, then you may be seen by a GP working closely with the ambulance service 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 within a maximum of four hours using services that will navigate you to the right department (our **Fix Me Hub)**.

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

Any **home care or community support** you require after a hospital stay will have been arranged before you leave hospital and will commence on the first day you leave whilst your GP will have been kept fully informed of the treatment you have received immediately at the point at which you leave hospital.

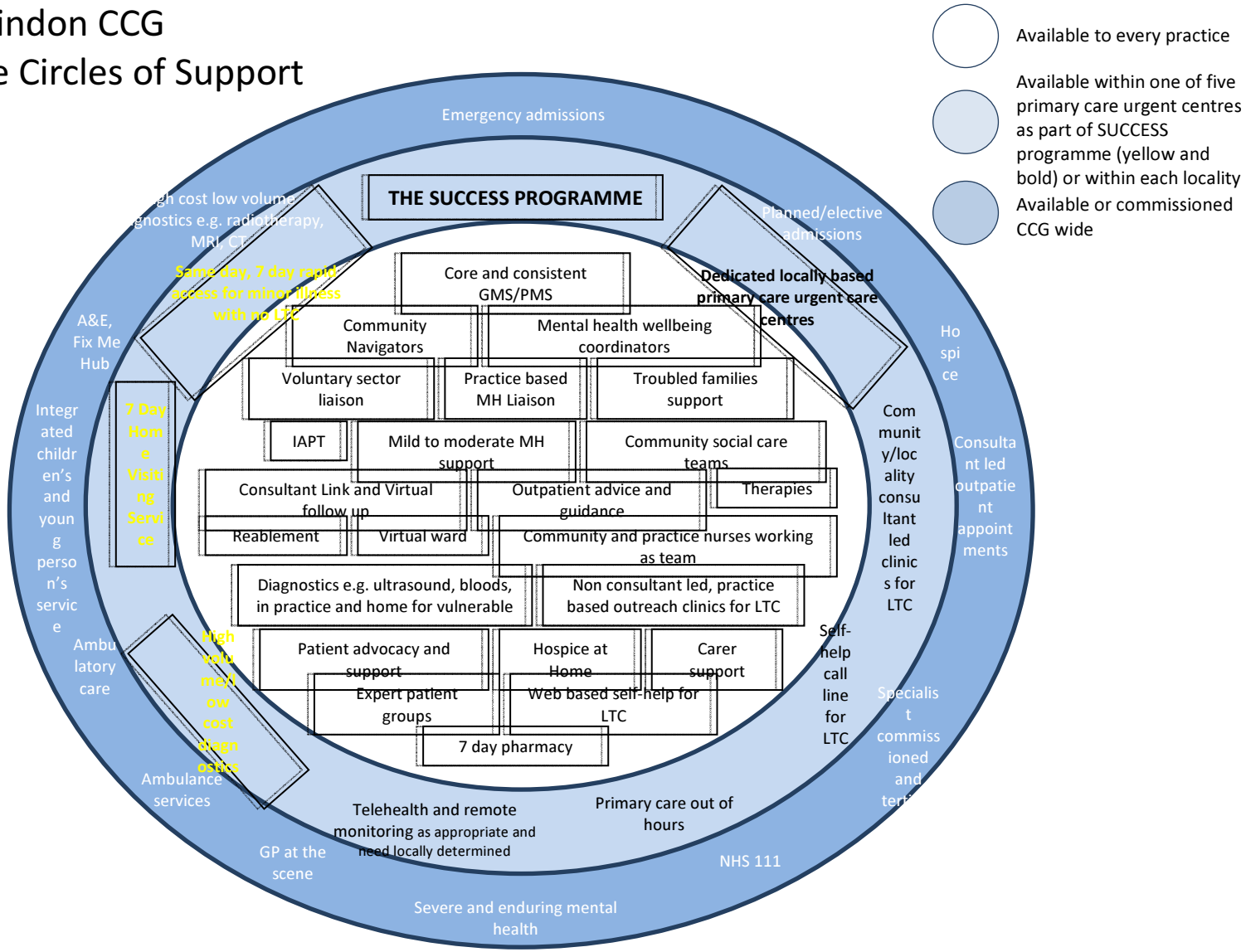
In the case of both **emergency and planned care**, you will only remain in hospital for as long as is strictly necessary and after care will be planned to help ensure when you go home you do not need to return unnecessarily. All agencies will work together and with you to avoid any unnecessary delay in you returning home safely.

In the case of services for rare conditions or those needing the care of the most **specialist centres**, you will be able to access **specialist centres or the services of specialist centres delivered locally in Swindon.** For example, in future you can expect to receive radiotherapy locally in Swindon provided by the Oxford University Hospital, avoiding unnecessary repeated travel to Oxford.

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

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

Swindon CCG
The Circles of Support



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ONE SWINDON: ONE VISION 2014-2019 (SUMMARY)

Mission	**Aims**	**Underpinning (Existing) Strategies**	**Foundations**	**Planning hierarchy**
To optimise the health of the people of Swindon and Shrivenham 229,000 people in 26 practices growing to over 25,2000 by 2019 Above average and improving Health (life expectancy male and overall and avoidable deaths) but also average use of hospital care below average numbers with long term condition feel supported and PYLL	Maximising benefit of primary care Dependence to self-reliance Unplanned care to planned care Single condition to multiple conditions Earlier intervention based on risk stratification Improved patient flow through community and secondary care Enhanced third sector contribution **Working as One** or **Being One** for benefit of patients and community	Health and Wellbeing • JSNA 2013-2022 and 2014-2023 • Adult Care Strategy • "Doing the Basics Brilliantly" • "Our Health in Our Hands" • "Shoulder to Shoulder" • "Time to Reflect" • "Sustainability, Capacity and Choice" • "One Swindon: One Voice" • "One Swindon: One Vision"	SUCCESS programme Risk stratification Building healthy partnerships Transformation Network Social Investment Integrated Transformation Fund One Swindon Programme of Change Joint Commissioning Plan and Board S75 pooled budgets (Better Care Plan) Integrated health and social care provider Research networks National Innovation Hub	Delivery of **National** frameworks and priorities **Swindon** statutory sector priorities, performance and capacity Strengthening the individual, household, **Neighbourhood** and community Linking National, Swindon wide, locality and Neighbourhood plans JSNA identified needs
Priorities	**Assumptions (per annum)**	**Transformation Priorities**	**Configuration**	**Transformation Opportunities**
Self-care and prevention Primary care development and consistency Long term conditions: - diabetes - dementia - cancer - COPD - heart failure - stroke Mental health Learning disability Children Carer support	Population growth 1.3% Demand growth 3.2% Pay and price inflation: 2.3% Funding growth: 1.7-2.0% Primary care: impact of new contract Community and secondary care: in price efficiencies (4%) Impact of Better Care Fund: 24 hour working Accelerated discharge Impact of H&WB Strategies: healthy weight policy tobacco control healthy exercise stress management Net Transformation required: £60m over 5 years	Releasing primary care time for long term conditions and to manage planned care Strengthening household and neighbourhood capacity Expert patient programmes supported by on line and telephone advice 24/7 Redesigned pathways of care Shift from services to programmes of care being commissioned including greater use of block contracts Re-focused voluntary sector contribution Outcome based contracts linked to pooled budgets and over longer term Integration OR Integrated working	GWH will be long term sustainable through acute growth driven by population growth and demand, improved patient flow, and planned care expansion along M4 corridor **Risks** GWH potentially threatened by loss of community services SEQOL – small and limited opportunity for market growth	**Primary care** - GP urgent care centres & home visiting service **Patient flow** - **reduced flow** at front end of secondary care - **increased flow** within hospital and community sector - **eliminate flow** due to readmissions and complications **Technology** Use of monitoring technology Use of communication technology to reduce need for outpatient consultation Use of new medications and surgical techniques to avoid unnecessary admission, reduce stay, avoid complication, save life or limb

Self-care	Primary Care	Community Care	Secondary Care	Other Care
Community Navigator initiative Troubled families scheme Mental health and wellbeing coordinators Healthy weight strategy and schemes Healthy Exercise strategy and schemes Enhanced smoking cessation programme Alcohol prevention and support Small community schemes e.g. Nepalese, Goan initiatives 24/7 condition line Roll out single point of access for long term conditions On line third sector directory of service Enhanced expert patient programme (includes prescribed training in condition)	SUCCESS programme - immediate single consultations to urgent care centres releasing GP team time for long term condition management - home visiting service smoothing arrivals at ED Joint AT and CCG support programme for areas of poor performance Links with community services e.g. link worker, virtual ward, community matron Locality based developments e.g. enhanced diagnostics, leg club model Specific developments e.g. monitoring through use of technology Developments in response to risk stratification e.g. renal, and greater support for medication review, therapists, psychiatric liaison	Enhance admission avoidance roles of Virtual Ward, SWICC, telehealth, GP at the scene, home visiting Develop locality based community models in conjunction with third sector e.g. leg. club model Expand above to multiple conditions Shift model of community and third sector delivery towards locality and practice attached teams in support of primary care configuration Ongoing development of reablement and accelerated discharge schemes	New “Fix Me” Hub serving wider and growing catchment population c350,000 Single point of entry and initial navigation to appropriate stream within Fix me Hub Streams to include resuscitation and major, minor, ambulatory and walk in diagnostic, urgent GP and nurse led, medical triage and assessment, surgical assessment, social issues and care Planned care to include clinics for multiple conditions and rapid access and review clinics for specific long term conditions to avoid admission, use of technology to expand consultant link into primary care and use of virtual clinics and consultation	Mental health: revisit local capacity model, protect and enhance IAPT model, strengthen crisis resolution and MH liaison with both primary and secondary care, implement health and wellbeing coordination Learning disability: shift towards supportive living model by stimulating local market and expanding employment, occupational and educational opportunities Paediatrics: reduction of emergency admissions through locality based urgent care alternatives e.g. hot tot clinics, stream cases away from adult ED

OUR POPULATION

In this section we set out the changes in the shape of our population since the last Joint Strategic Needs Assessment in August 2012. In general our population size has increased in line with the forecasts made in, based on the 2001 Census. The 2011 Census has highlighted the following:

- Our overall population growth is faster than the average in England

- The growth in the over 75 and over 85 age groups has continued at a faster rate than any other age group (4-5% per annum)

- The proportion of our population with long term condition has remained static at 15%

- The proportion of our population from minority groups has nearly doubled in ten years

- The gap in life expectancy between the most and least deprived has decreased

- Life expectancy overall is better than the English average BUT the potential years of life lost for our female population is amongst the worst in England

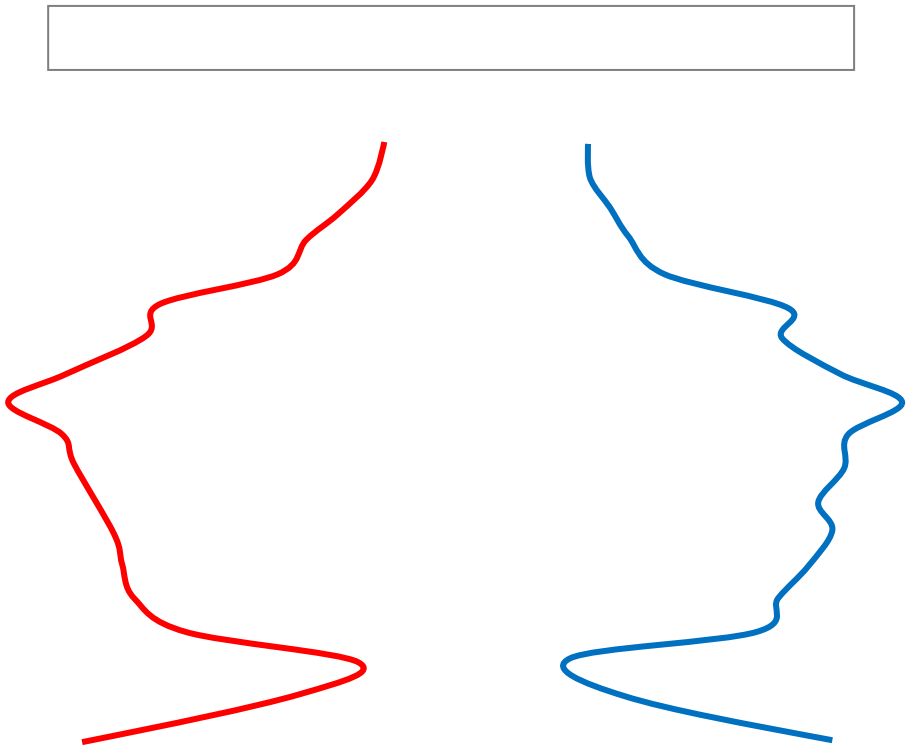
Swindon is classified as a prospering town and has benefitted from a strong economy with above average growth in our total population. The 2001 census showed a bulge in both the 0-9 and working age adult population approaching retirement but we were below both regional and national averages for those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

The 2011 Census saw Swindon buck the national trend (which saw population estimates revisited downwards in many parts of England). Population growth continued at the same pace overall in Swindon with an average of 1.3-1.4% per annum. At the local plan enquiry in December 2013, the estimates for future population in Swindon were considered by the Inspector to be potentially understated by as much as 7000 people (a further 1.83% growth by 2019).

The 2011 Census also identified a significant increase in Non-White British population to 15% and in those in schools for whom English was not the main language up to 13%, whilst the actual growth in the over 85 population was 4.9% per annum (3.6% per annum for the over 95 age group). Average expenditure for these two age groups was £11,794 in 2012 compared with an average allocation per head for the whole population of £1,003.

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

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



Life expectancy

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

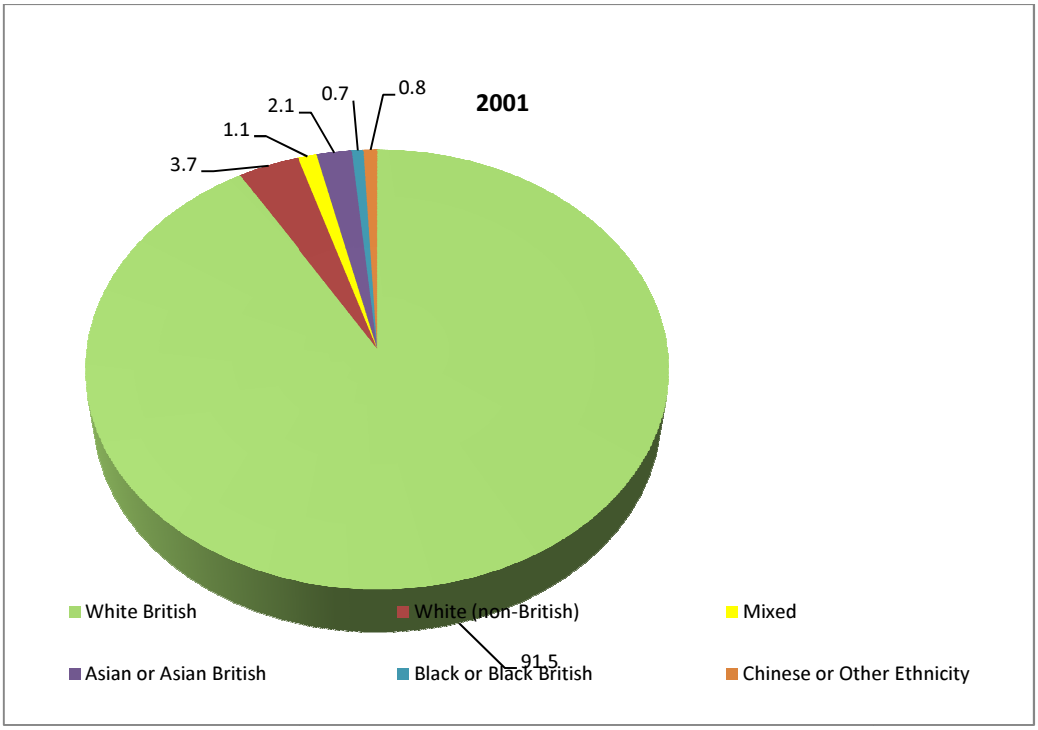
In 2012, our JSNA spoke of Swindon being healthier than the English average with above English average life expectancy for our population as a whole (but with female life expectancy reported as below the English average at 80.2 years compared with 80.7 years). Hospitalisation rates were reported as higher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

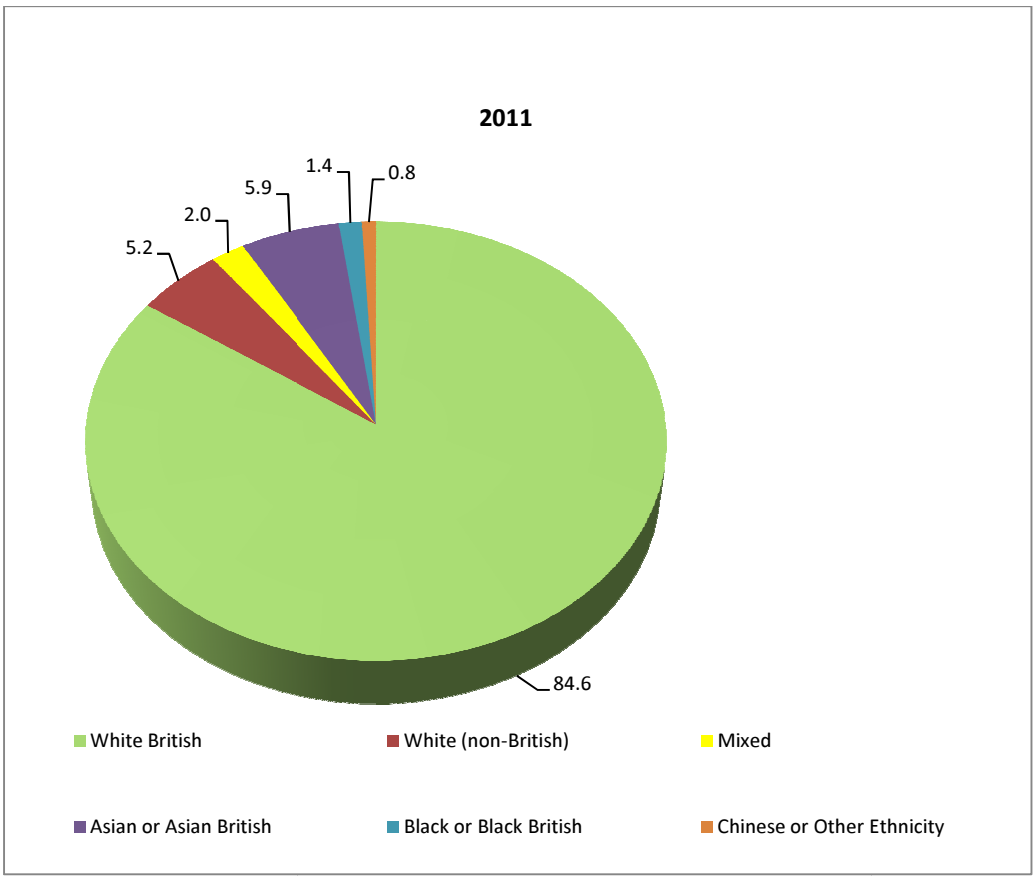
Based on the 2011 Census and 2013 hospitalisation rates, the situation has improved in most regards with the exception of potential years of life lost (see below). Hospitalisation rates are now in line with the English average with key health determinants such as female life expectancy coming much closer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

Meanwhile, the *gap* in life expectancy between the least and most deprived has reduced significantly amongst the female but risen slightly amongst the male population. In our last JSNA, the gap for the overall population was over 8 years between the least and most disadvantaged and was growing at the rate of one year in every ten years. The gap is now under 8 years, so has steadied (and indeed fallen for the first time since 1801, although the gap is still just under 9 (8.9) years for men). Reducing health inequalities for men remains a top priority.

Minority groups

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





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

Reducing health inequalities

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

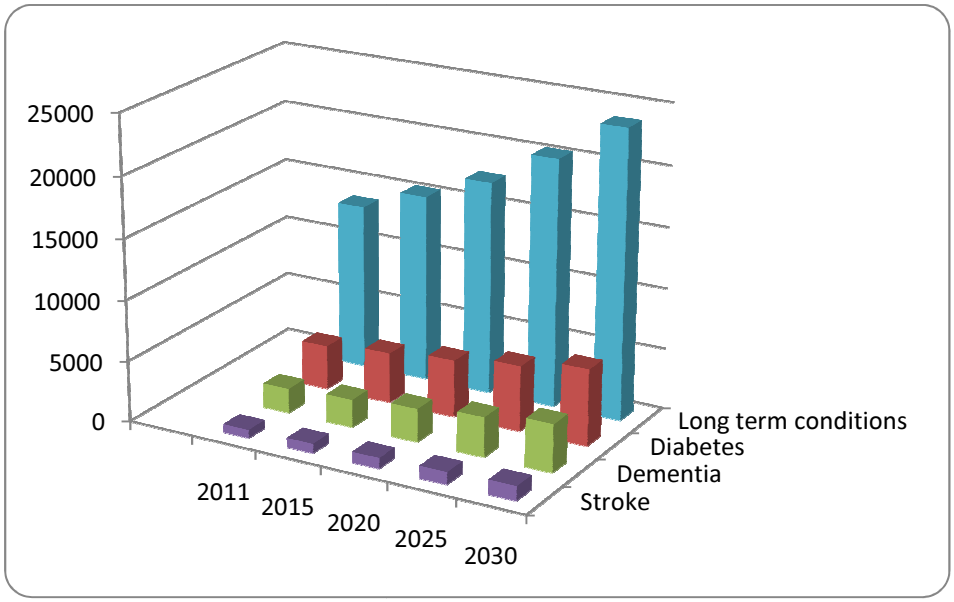
Our analysis of Mosaic has identified that five of the 69 categories are significant users of healthcare, namely elderly living in isolation, elderly in social care housing in isolation, families with young children on benefits, in social housing or in overcrowded conditions. These same groups also present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

Long term conditions

Meanwhile, in 2001, 27476 people reported having a long term condition which limited them in some way. A similar question was asked in the census in 2011 and the reported figure has risen to 32302. This is a very slight rise *in percentage terms* from 15.2% to 15.3%, suggesting that, despite a significant change in the age demographics between 2001 and 2011 (48.6% growth in the over 85 age group), this has had little if any impact on the overall prevalence of those with long term limiting illness. The key impact of our ageing population has been in the number of residents who have **multiple conditions** and their **degree of debilitation**, neither of which is collected as part of the Census, but information on both is now available through our investment in risk stratification.

Growth in demand due to forecast changes in our population

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



The forecast growth rate for these conditions is significantly faster at 4-5% per annum than our overall population growth at just under 1.4% per annum

The above increase will put additional pressure on individuals, households, their families, carers and support networks. Those with a long term limiting condition are two to three times more likely to also develop depression.

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

We expect to address this using a combination of the following:

- Managing long term conditions differently in primary care through investment in urgent care centres and home visiting that will release primary care time
- Investment in greater community support for individuals and households to help the development of self-care and coping strategies
- Investment in health promotion and prevention
- Greater coordination of and better navigation to the voluntary, primary care and community support that exists
- Placing the patient in control of their condition trough access to better information about conditions using web and social media and also investing in expert patient programmes and peer support networks

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

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

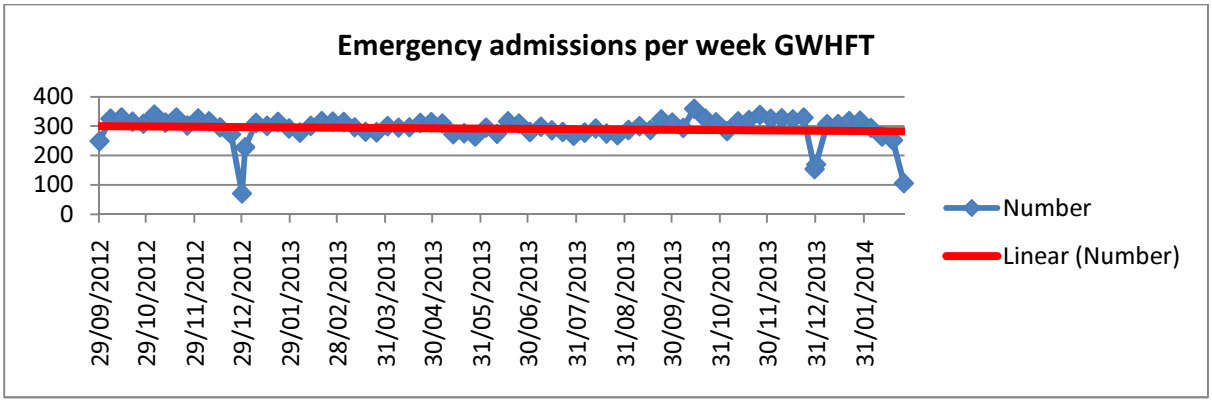
People who have long term conditions can also have reduced mobility and thus become housebound or isolated. This can lead in turn to depression, anxiety and frailty. We will develop a dedicated home visiting service therefore as part of our SUCCESS programme, work with local communities and the voluntary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

Trends in hospital admissions

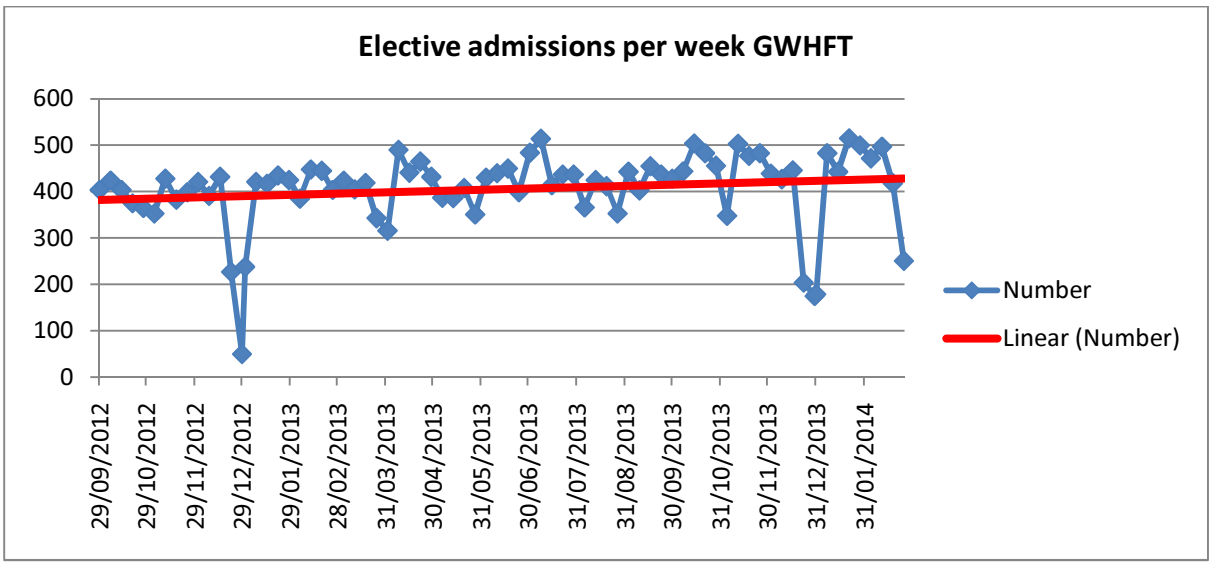
The Joint Strategic Needs Assessment (JSNA) in 2012 spoke of a growth in the number of admissions in Swindon. It did not differentiate in so doing between **unplanned** admissions and **planned** admissions. More importantly, it forecast a growth in emergency admission rate based on the last ten years. Since then, the CCG has had the opportunity to relook at that analysis. More importantly, the CCG also has trend analysis for 2013-2014 to add into the mix. The resulting message is very different from that within the 2012 JSNA and has changed the focus of our strategy towards the levels of urgent care within primary care, our GP referral rate, and our planned admission rate as a consequence.

Swindon CCG is one of 31 CCGs that have seen a steady reduction year on year in the emergency admission rate between 2007 and 2011. A 3.1% annual **reduction** compared to an average English position of annual **growth** of 1.8% (13th out of 202 CCGs). This reduction has brought the CCG to just below the national average standardised admission rate for unplanned care. See page 32, Outcomes Benchmarking Support Pack – Swindon CCG.

In 2011-2012, this changed due to the treatment of 0 day stay ambulatory care which was charged as short stay emergency admissions – the treatment of ambulatory care as emergency admissions is an aberration of the Monitor model for Foundation Trusts. The trend in 2012-2014 continued to be downward (see below):



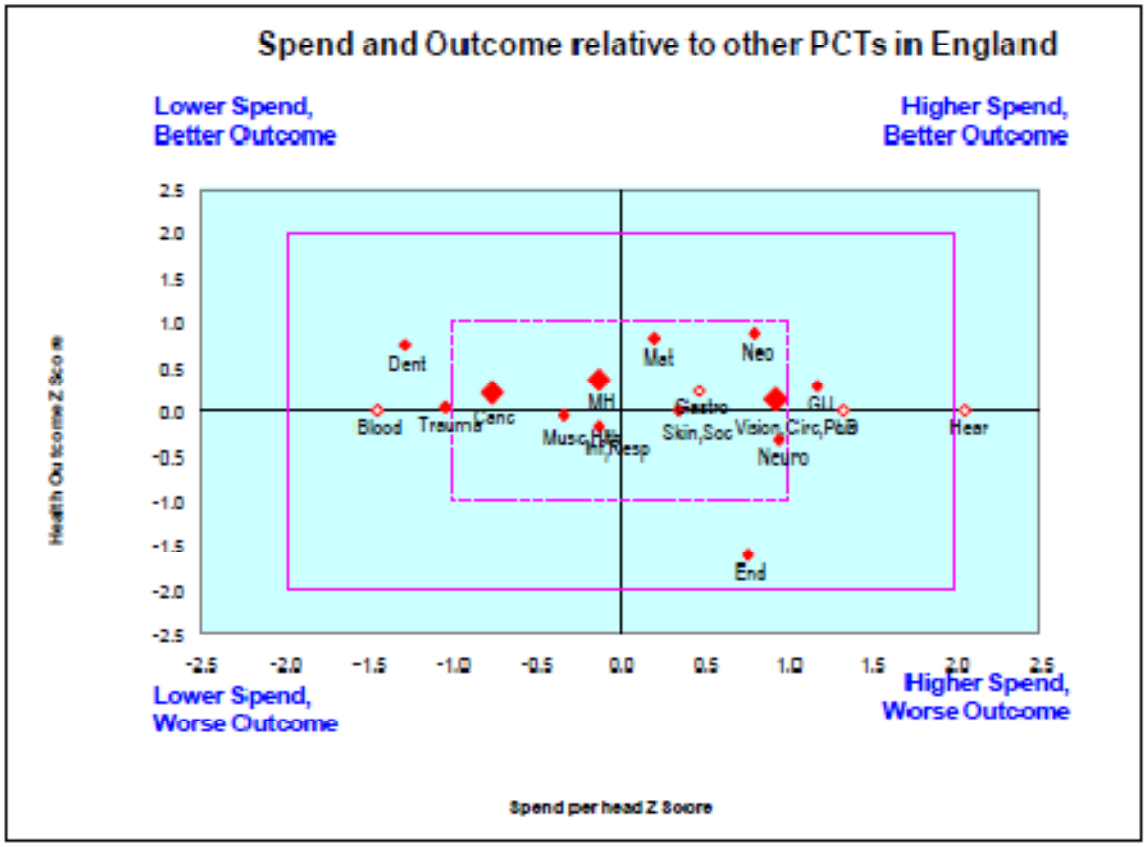
Admissions overall continue however to grow due to the growth in **planned admissions** both in the period 2007-2011 **and** 2013-2014. Our GP referral rate has averaged at around 5% in the period 2007-2011 and 2012-2014 and this has seen a growth in planned admissions at the same rate of approximately 5% per annum for both periods. Whilst the above figures are both still **below** the average for England, the overall impact is an annual growth in admissions at a slightly higher rate than our population growth, which is unaffordable in the long term.



One Swindon One Vision therefore sets out an ambitious programme of change for both referral management and also for the way we will commission secondary care consultation with much greater use of technology to allow specialist consultations to happen within primary care and the community, rather than within a secondary care setting. Managing the growth in planned care in line with our overall population growth i.e. annual growth of 1.3-1.5% is key to our local health system remaining financially stable.

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

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



This chart shows how our various programmes of spend cluster based on investment compared to the English average and performance compared to the English average. Mental health and cancer which are

Key priorities are shown to be cost effective and both have also had to address both service change and growth in demand. 30% of our programmes have above average investment and are not achieving above average performance.

In assessing the likely growth in **demand** for healthcare, therefore, we have gone back to our population and the impact we predict from population growth on each of our programmes of spend, the impact of additional housing investment in the latter years of our strategy and the potential impact of changes in our demography and levels of deprivation.

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

Forecast growth in demand and indicative programme spend

This is based on age profile of users of services

Programme	2011-2012 (%)	2012-2013 (%)	Annual growth estimate	Projected spend before inflation, developments and efficiencies					
				2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019
Mental health	14.69%	14.05%	3.83	37.3	37.3	38.7	40.2	41.7	43.3
Circulation	10.52%	11.56%	4.05	31.8	33.1	34.4	35.8	37.3	38.8
Genitourinary	7.08%	7.05%	4.04	19.5	20.2	21.1	21.9	22.8	23.7
Gastrointestinal	6.46%	6.68%	1.39	17.9	18.2	18.4	18.7	19.0	19.2
Cancer	6.46%	6.33%	4.11	17.5	18.2	19.0	19.7	20.5	21.4
Neurological	6.46%	5.20%	3.62	14.3	14.8	15.4	15.9	16.5	17.1
Musculoskeletal	6.35%	7.70%	4.04	21.2	22.1	23.0	23.9	24.9	25.9
Respiratory	5.83%	6.19%	3.44	17.0	17.5	18.2	18.8	19.4	20.1
Learning disability	5.73%	2.35%	0	14.5	14.5	14.5	14.5	14.5	14.5
Maternity	5.21%	5.37%	1.39	15.0	15.2	15.4	15.6	15.9	16.2
Endocrine	4.38%	4.43%	3.87	12.2	12.6	13.1	13.6	14.1	14.7
Dental	3.96%	4.34%	1.39	11.7	11.8	12.0	12.2	12.3	12.5
Trauma and injuries	3.96%	4.80%	2.01	13.0	13.2	13.5	13.8	14.0	14.3
Vision	3.44%	3.62%	4.04	10.0	10.4	10.8	11.2	11.7	12.2
Skin	2.92%	3.74%	1.01	10.0	10.1	10.2	10.3	10.4	10.5
Infectious diseases	1.77%	1.99%	1.39	5.4	5.4	5.5	5.6	5.7	5.8
Poisoning	1.56%	1.26%	1.11	3.3	3.4	3.4	3.4	3.5	3.5
Neonatal	1.46%	1.36%	0	3.6	3.6	3.6	3.6	3.6	3.6
Hearing	1.04%	0.99%	2.01	2.7	2.7	2.8	2.8	2.9	2.9
Blood disorders	0.73%	0.99%	1.11	2.6	2.7	2.7	2.7	2.7	2.8

Remove maternity, neonatal, mental health and LD

Totals (including specialist services)	209.9	216.5	223.4	230.4	237.8	245.4
Overall growth in demand (%)		3.15	3.15	3.17	3.18	3.19

OUR OUTCOMES AND PERFORMANCE

In this section we look at our outcomes and performance and identify the priorities for change driven by those areas where we seek improvement.

In most areas, Swindon CCG compares well against the rest of the country and in some cases has seen significant improvement over the last ten years, notably on life expectancy over all, a reduction in the gap between the least and most advantaged in our communities, the development of ambulatory care, emergency admissions for children with the most common diseases, and healthcare associated infections.

The areas where improvement is needed are:

Potential years if life lost for women fallen from being in the best to the worst quartile over the last eighteen months

Respiratory diseases and **cancers** both of which have seen the mortality rate for the under 75 population rise

The unplanned admission rates for **asthma** and for **diabetes** are also high, and thus both **diabetes** and **respiratory diseases** are amongst our top clinical priorities.

The local experience of GP out-of-hours services is rated as poor amongst patients which drags the overall score for patient experience of GP services down to just below the English average whereas otherwise it would be above English average

The areas of poor performance that need to be addressed are as follows:

Waiting standards within A&E. This is a direct result of the volumes of admissions presenting though our local district general hospital with emergency medical admissions and readmissions increasing overall and this stacking back into the emergency department, causing delay. Thus our strategy is to continue the reduction in unplanned admissions

Healthcare infection. We are amongst the best CCGs in the country in terms of the low levels of incidence of both MRSA and C Difficile. However, as a consequence in 2013-2014 we were set some of the toughest measures in England and therefore continue to tightly monitor and manage infection.

Access to radiotherapy at our specialist centres. Although we do not commission these services, we closely monitor the position from the perspective of Swindon residents and part of this strategy is investment in bringing additional local radiotherapy capacity into Swindon.

Finally, this section summarises the outputs from our service redesign programme which identified the following as priorities for new ways of working:

- Urgent care
- Diabetes
- Dementia
- Children
- Joint Pain and Musculoskeletal Care
- COPD
- Cancer
- Heart failure and Cardiology
- Long Term Conditions
- End of Life Care
- Mental Health

Outcomes

We have set improvement targets over the next five years for every outcome in all five domains against which the CCG will be monitored by NHS England. Delivery of improvement in outcomes in these five domains triggers additional investment in local healthcare (known as our Quality Premium) and so this is important not just for the health and wellbeing of the local population but also for investing in the delivery of new services.

The chart overleaf shows the position of Swindon CCG against the outcome measures within the five domains as a blue dot and then compares us with the national position and the outcomes of the best (the green zone) and worst (the red zone) performing CCGs.

The arrows show where we have improved or deteriorated and we are showing a decline in outcome in three areas:

- Under 75 mortality from cancer
- Emergency admissions for children with respiratory tract infection
- Patient experience of GP Out of Hours services

The red diamond shows what is seen as a reasonable target for improvement over the next five years based on the outcome of other CCGs with similar populations to Swindon.

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

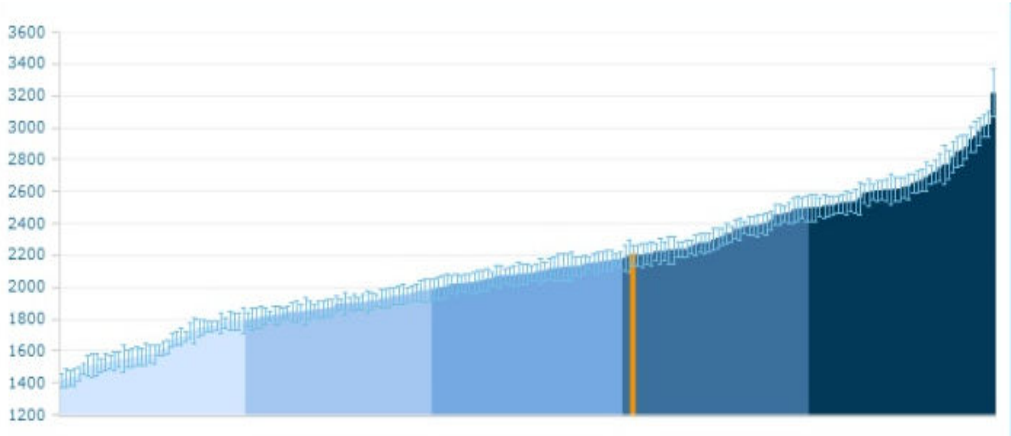
Indicator	Value		England	Region	England Min	Spine chart
▼ Outcomes - domain 3						
Emergency admissions for acute conditions that should not usually r...	1,227.7	↑	1,217.9	979.7	289.3	
Emergency readmissions within 30 days of discharge from hospital	11.8		11.8	11.3	8.1	
Hip replacement casemix adjusted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

Potential years of life lost (PYLL) and saved

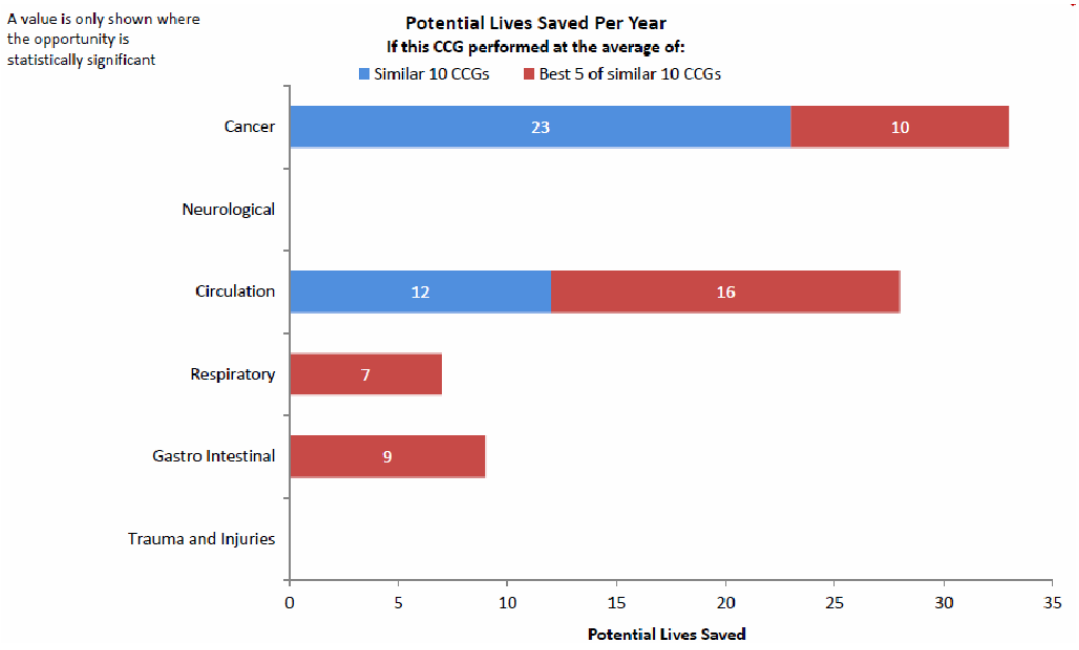
Swindon's PYLL has apparently moved from being best tertile to worst tertile in the single year of 2012 and our ambition is to return to the best tertile position at 1819 or where the local community was in 2010. (See chart overleaf with the Swindon CCG current position being shown in yellow in the histogram)

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

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



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

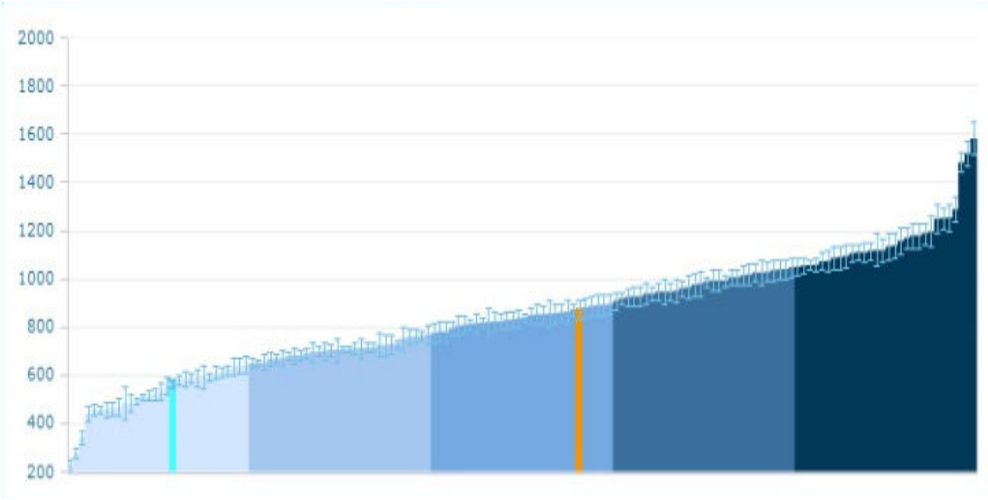


Avoidable emergency admissions

Although the Swindon comparative and actual admission rate for emergencies has improved over the last nine months and in the period 2007 to 2011 our admission rate deteriorated in 2012 (note: this is due to the inclusion of Ambulatory Care activity in the figures) 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).

The CCGs ambition is to restrict growth in demand in emergency care below our age adjusted annual growth in demand. Our interventions would also see a further switch from unplanned care to planned and ambulatory care 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 reduction in unplanned care over the 5 years of this strategy in line with our overall ambitions. The graph below shows where the CCG is comparatively when looking at the opportunity to reduce avoidable admissions. Note: the data has not been updated since March 2013 and so does not take into account the movement towards ambulatory care in the last 12 months.



Redesigning local health services

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

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

Web and social media are not seen as being used well whilst expert patient programmes appear to have disappeared or gone into retreat. Many patients would welcome knowing far more about their condition and also about where to go for advice in addition to or as an alternative to their local GP surgery and hospital. Many also feel that when they have developed more than one condition, the way in which the health service treats each condition separately is neither helpful nor efficient.

Summary from Swindon's 2013/14 Service Redesign Programme

Dementia

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

Diabetes

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

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

Joint pain

The current pathway and complex offering is not understood by local residents and many services are by-passed or not referred to e.g. MATS. The RMS further complicates the process and can lead to incomplete information being sent to surgeons for review. Discrepancies in diagnosis in primary care have led to misdiagnosis of knee and hip pain.

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

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

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

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

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

Urgent Care

Four workshops resulted in a six point plan:

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

Cancer

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

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

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

Paediatrics

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

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

COPD

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

End Of Life

The recommendations were:

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

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

Cardiology and Heart Failure

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

Long Term Conditions

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

Being navigated to the best advice, but also being helped to put together the life-long health plan that will enable each of us to cope with our conditions is essential and this is why Swindon CCG has placed considerable stock in the development of our SUCCESS programme (releasing primary care team time to review patients with long term conditions) and the Community Navigator role within every

primary care team, based on the models that have been successful in the US, France, Italy and Germany, and more recently piloted in NE London.

Addressing immediate areas of poor performance

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

- access to radiotherapy
- control of infection
- A&E 4 hour performance

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

Sub domain	Reference	Short Description	Target	Performance: In period		Direction	Year to date		Year end forecast	Trend	Direction to improve
Treating and caring for people in a safe environment	CB_A15	Healthcare acquired infection (HCAI) measure (MRSA)	0	0	G	⇔ Dec	3	R	4		⇩
	CB_A16	Healthcare acquired infection (HCAI) measure (c. difficile)	0	3	R	⇔ Dec	44	R	59		⇩
Waiting times	CB_S5i	Mental Health Measure- Improved access to psychological services - The proportion of people who have depression and/or anxiety	0%	0%		Apr	3%		14%		⇧
	CB_S5ii	The proportion of people who complete treatment who are moving to recovery	0%	0%		Apr	48%	R	48%		⇧
	CB_B1	i. The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period on an	90%	96%	G	⇧ Dec	96%	G	96%		⇧
	CB_B2	ii. The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period	95%	97%	G	⇧ Dec	97%	G	97%		⇧
	CB_B3	iii. The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period	92%	95%	G	⇩ Dec	95%	G	95%		⇧
	CB_S8iii	Number of 52 week RTT incomplete pathways greater than 52 weeks for patients on incomplete pathways at the end of the	0	0	G	⇩ Dec	23	R	31		⇩
	CB_B4	Diagnostic test waiting times - over 6 week waits	1.00%	0.40%	G	⇩ Dec	0.57%	G	0.57%		⇩
	CB_B5iii GWH	A&E Department - % of A&E attendances under 4 hours (GWH)		92%	A	⇩ Dec	95%	G	95%		⇧
	CB_B6	All Cancer 2 week waits	93%	96%	G	⇩ Nov	96%	G	96%		⇧
	CB_B7	Two week wait for breasts symptoms (where cancer was not initially suspected)	93%	94%	G	⇩ Nov	94%	G	94%		⇧
	CB_B8	Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of	96%	96%	G	⇧ Nov	96%	G	96%		⇧
	CB_B9	31-day standard for subsequent cancer treatments-surgery	94%	95%	G	⇩ Nov	96%	G	95%		⇧
	CB_B10	31-day standard for subsequent cancer treatments-anti cancer drug regimens	98%	100%	G	⇔ Nov	100%	G	100%		⇧
	CB_B11	31-day standard for subsequent cancer treatments-radiotherapy	94%	80%	R	⇩ Nov	80%	R	80%		⇧
	CB_B12	All cancer two month urgent referral to first	85%	85%	A	⇩	85%	A	85%		⇧

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OUR AMBITIONS

In this section we look at our ambitions: the ten measurable improvements in outcomes that we will deliver by 2019.

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

- reducing the potential years of life lost in Swindon to 1,819 years (17.5% improvement) thus increasing female life expectancy to above the English average
- reducing the gap in life expectancy between the most and least advantaged of our male population to below 8 years
- meet the specific health needs of our growing population from minority groups and also reducing the health inequalities experienced by those who provide informal care for others
- shift an average of 1.5% of emergency admissions each year into planned or ambulatory care
- reducing our emergency hospitalisation or admission rates by 1.5% per annum
- provide greater support to those with long term conditions such that at least 80% of those for whom we care feel supported
- reducing the norm for medical length of stay by 10% by 2019
- reducing the percentage of patients who are ready to leave hospital but yet to go by 60%
- increasing the number of patients who when surveyed say their experience of local healthcare was neutral to positive to 90%
- ensuring through the commissioning of specialist services that at least 95% of patients are offered the choice of a specialist centre for their care if they require a specialist service

Improving local health outcomes

The key opportunities for improvement locally are:

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

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

  i. **Reducing** our standardised admission rate for emergencies. In 2007-2011 we had one of the lowest rates of growth in England (indeed we saw an annual reduction in unplanned care of just under 1% per annum in that period and have seen the same level of reduction during the winter peak period of 2013-2014 as well)

ii. **Increasing** our access to ambulatory care and thus shifting the balance of unplanned care towards planned care. Our uptake on ambulatory care has been one of the fastest in England bit there is still a significant opportunity to do more (because we are charged the short stay admission tariff for ambulatory care this has resulted in planned ambulatory care being classified as emergency admissions rather than as avoided admissions or planned care)
iii. **reducing** readmissions, which are particularly high in general medicine

- Increasing the percentage of those with **long term conditions who feel supported**. We are currently above the English average but have set ourselves the target of getting to 80% by 2019. Our vision and programme for long term conditions includes considerably more support at every level from self care to public information and expert patient groups to more time in primary care to rapid access to outpatient consultation so we are considering that a shift from 75% to 80% in a population of 32,000 is achievable over five years

Reducing health inequalities

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

- The gap between the least and most disadvantaged men in terms of their life expectancy is currently 8.9 years and we aspire to reduce this by at least 0.9 years to below 8 years through targeting households and the work place and expanding on successful exercise, leisure, no smoking and healthy weight programmes

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

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

- Those households with lowest incomes and/or with people living in isolation or over-crowded conditions are significantly more likely to access hospital care than the rest of the population and also have lower life expectancy and self-assess themselves to be in poorer health (based on Census 2001, 2011 and Mosaic household analysis)

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

Key supporting strategies include: our Health and Wellbeing strategy 2013; Self Care strategy 2014 (*Well Fit),* Healthy Weight Strategy 2014, and our public and patient involvement strategy *One Swindon: One Voice, 2013*

OUR PROGRAMME OF CHANGE

This section looks at our key Interventions. There are in total fourteen interventions and these divide between:

those which will be led by the CCG using our main enablers (contract management, technology, market stimulation, partner engagement, strategic leadership, public and patient engagement, service redesign)
those where we are working through partners to deliver population or community change (healthy weight, exercise, smoking cessation, reduction in alcohol abuse and stress) and
those where other parties commission services on which we rely and have assumed change (the development of primary care and specialist services, Better Care Fund, carer support, early start initiatives, voluntary sector development)

This section looks at the economic and service benefits of our intervention programme and includes a high level road map of the developments. (Appendix 1 sets out each Intervention in more detail, including investment, timescales for delivery, benefits and governance).

This programme of change has been developed through the following:

Benchmarking our outcomes and performance including running the Anywhere Town model
Reviewing trends in performance
Engagement with members to identify their priorities for change
Site visits - to those CCGs whose outcomes are better than ours eg Kingston
Engagement with the national Transformation Network, Technology Network and NHS England Innovation Hub
Piloting changes in 2013 to prove the concepts and benefits for 2014 onwards
Review of published literature and research building on our links with the National Institute of Health Research, Scottish Intercollegiate Guidance Network, National Institute of Clinical Excellence and three Applied Health Science Networks.
Capturing the experience of local clinicians and managers

The opportunity is in excess of £20M of savings over five years but more importantly there is a real opportunity to reduce demand on healthcare (as shown by the success of our Community Navigator scheme and the surveys done in preparing our Success programme in primary care), as well as improving the quality of what we offer in support of 32,000 residents with long term conditions.

Commissioning for Value

Swindon CCG is ranked in the best tertile in terms of value already realised through commissioning.

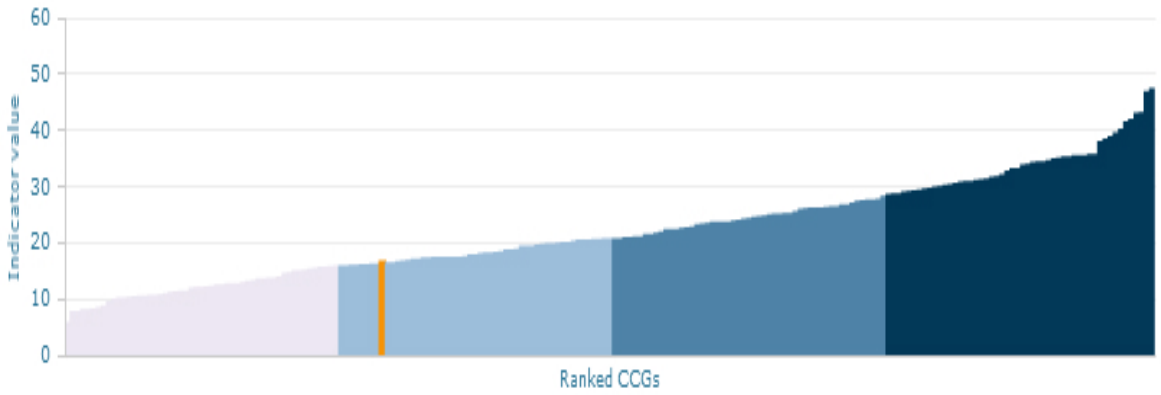
The summary data pack provided by NHS England identifies some £8m of opportunity split approximately 50% in planned care, 25% in medicines optimisation and 25% in avoidable emergency admissions.

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

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

Savings carried forward from 2013-2014

In addition, we have the full year effect of schemes implemented within 2013-2014, particularly opening the GP Urgent Care Centre (£0.47m), GP at the Scene (£0.28m), Community Navigator (£1.08m), changes to the local spinal threshold (£0.10m), SAU (£0.04m), ISTC use (£0.80m) and COPD (£0.16m), totalling **£2.93m** carried forward. The chart below shows that as a CCG we have already successfully pursued a large proportion of the savings identified through benchmarking and are already in the best tertile in terms of savings delivered.



Our Priority Interventions

Our change programme has been developed around the delivery of fourteen key interventions, each of which has its own business plan and many are clinical priorities as identified by our membership:

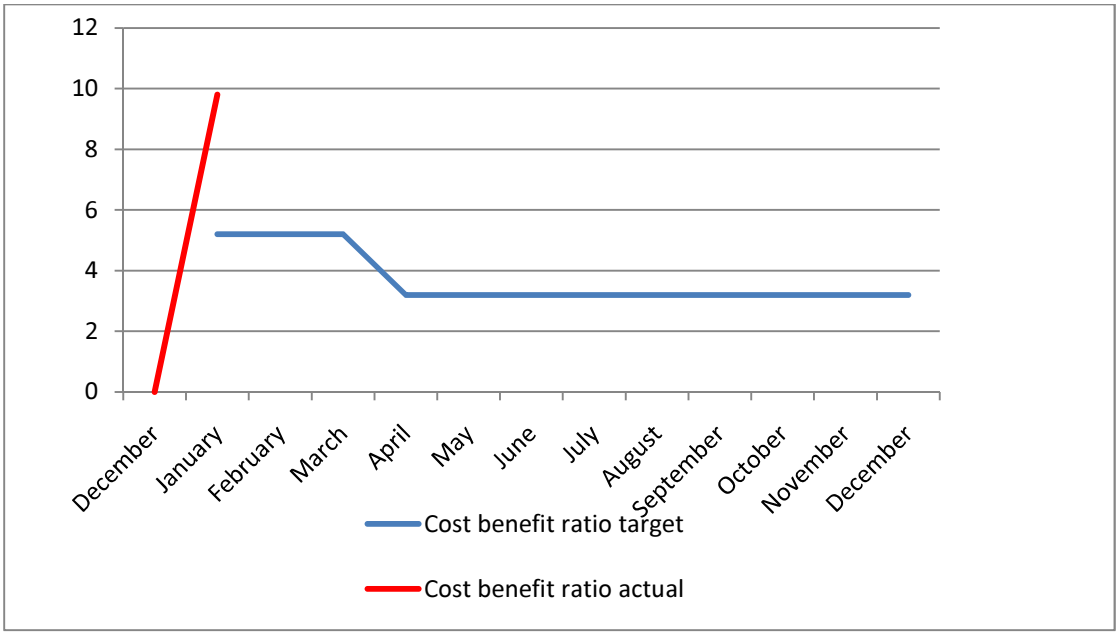
- Self-care and self-management
    - Community Navigators
    - Healthy Weight, exercise, no smoking programme
    - Troubled families (Early Start) disability
- Urgent Care
    - Cancer
    - At the scene
    - Fix me Hub
    - Patient Flow
    - SUCCESS programme Transformation
- Medicines optimisation
- Early diagnosis and assistive technology
- Lifelong planning and end of life
- Early Start programme
- Long term conditions
- Mental health and learning
- Planned care
- Carer Support
- Control of Infection
- One Swindon
- Better Care Fund

Self-Care and Self-Management

One of the two major interventions in the early years of our strategy is the roll out of the self-management programme underpinned by the Community Navigator scheme, early start initiative and mental health and wellbeing coordinators. Each of these interventions has proven itself as a pilot.

Community Navigator Programme

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



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

Urgent Care Programme

The Urgent Care programme has been highlighted by our membership as the top priority for 2014-2016 and comprises a number of big impact changes.

The SUCCESS Programme

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

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

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

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

The SUCCESS programme should achieve a reduction in both emergency attendances and admissions and is an enabler for our self-care, end of life and long term condition programmes (see below). The first centre will open in May 2014, with the remaining two centres opening by the end of July.

Fix Me Hub

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

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

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

Optimised Patient Flow

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

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

International research, the experience of Kaiser Permanente, and a review by the East of England Public Health Network published in the Bandolier shows that the conventional wisdom that changes to flow can be delivered through cultural change and business rules

alone has little or no evidence base. Any change to business rules, unless it also leads to the immediate change of the systems used daily by clinicians, will not last longer than the first occasion they log on. System investment needs to go hand in hand with training, development, protocol and process redesign.

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

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

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

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

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

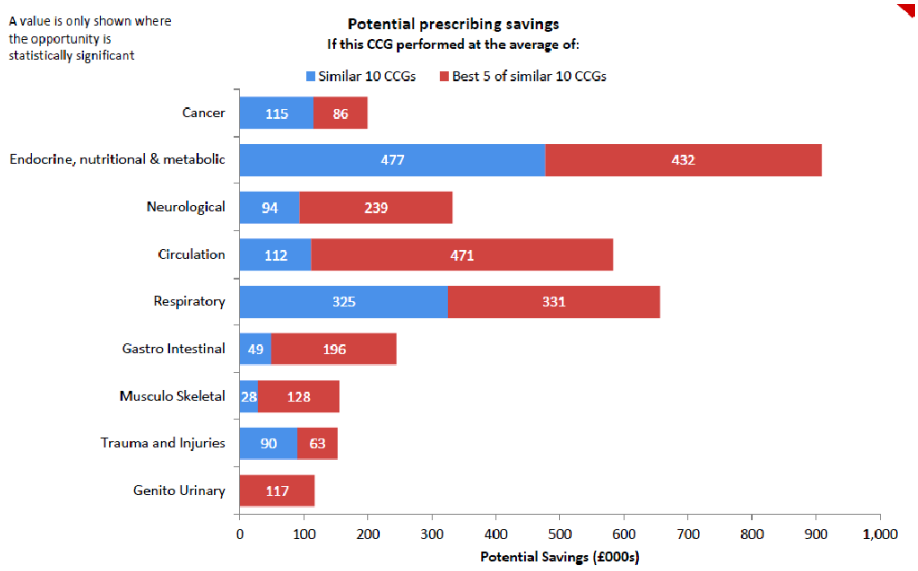
Medicines Optimisation

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

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

approximately 15% of the CCG's allocation per head of population or an average of just over £150 per head per annum.

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



Planned Care

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

In the period 2007-2011, we saw annual growth in the range of 4-5% in planned care. 2011-2013 saw this position reverse. It also saw a reduction in GP referral rates over the same period. However, in 2013-2014 we have seen a return to steady **reductions** in unplanned admissions and 5% - 12% **increases** in elective admissions.

Our SUCCESS programme aims to address what appears to be the consequence of primary care becoming saturated with immediate demand for one off consultations with low levels of underlying pathology dissipating our ability to manage long term conditions and planned care. We have already achieved a shift from unplanned to planned care in our first year as a CCG we aim to further shift activity by releasing the time in primary care to sustain that shift.

Schemes such as Consultant Link and Virtual Follow Up have transformational and economic potential. One pilot study in Bristol looking at outpatient consultations in cardiology avoided 60% of outpatient appointments.

Our vision for the future is for a predominantly *immediate* or instant consultation with secondary care to be made available in the GP surgery with the patient present, largely avoiding the need for an outpatient appointment with c.15% of current follow up appointments having to being face to face.

So whilst the volumes of surgical intervention and referral for specialist advice may increase (in some cases faster than average population growth given the ageing nature of our population), the models of delivery we propose to introduce may significantly reduce the wait for a consultation.

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

There is some evidence of possible price movement in planned care: *intermediate* knee procedures comes up for example as having increased significantly above our population requirement with minor knee operations reducing by a commensurate amount. Similarly we have seen the number of procedures classified as “with complications” increase since 2012. During each year of our five year plan we will undertake external coding and activity reviews to ensure there is no “price drift”. The first of these reviews reported during 2013 led to significant savings in our contract with one of our providers.

In 2014, we aim to switch more activity towards our local ISTC, who have spare capacity for Swindon residents and whose contract is currently under-utilised by us.

Mental Health and Learning Disability Services

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

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

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

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

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

One contributor to this change in the sense of priority was highlighted by a number of members, namely that Swindon benefits from having one of the best IAPT service in the country with its model of open access to psychology being supported by all practices.

The next two years will see a number of key developments:

First the CCG wishes to support and grow the current model of IAPT and the current service provision. We will support the current service provider however if there is any detrimental change to the current model of delivery and service we will reconsider alternative providers.

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

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

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

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

Learning disability

In 2013, a Joint Needs Assessment of the 546 residents of Swindon who are registered with a learning disability and live or have lived within the borough showed that a high proportion live in residential care (32) at least twice the expected proportion compared to the reference sites we used and many of these do not have a personalised care assessment. This is now a local performance indicator in line with The Better Care Fund initiative.

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

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

Cancer

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

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

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

Carer Support

This sees a joint investment of £1m per annum over the life of the plan for the delivery of £0.3m savings per annum, principally in reducing re-admissions although there will also be some emergency and planned care admission avoidance opportunity based on national studies and as a result of the introduction of Health Checks for carers. The savings will be re-evaluated once we have the results of a complete 12 months of implementation of the programme.

Better Care Fund

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

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

Control of Infection programme

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

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

Life-long planning

This programme aims see the CCG deliver the following during 2014-2015 with benefits running over the following four years. For the c.2000 Swindon and Shrivenham residents who will die each year, nearly 3,500 who will be in the last stages of life and need support, and over 24,000 residents who will be touched in some way or another by the death of a loved one

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

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

Long term conditions programme

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

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

Our programme looks at:

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

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

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

There are then specific issues relating to diabetes care which is one of our top priorities. Generally, there is concern in Swindon over footcare, foot assessments, retinopathy screening and the slow uptake of new technology and practice. There are active peer support groups that feel frustrated at how little engagement there is between the support they can offer and primary and secondary care. The vast majority of feedback about any care or treatment received is positive, but there remains a general feeling that support other than face to face contact with a GP, consultant or specialist nurse, is lacking. The vast majority of those with diabetes want to get on with their lives and not be over-medicalised. Most also remain concerned at the stigma associated with diabetes and its constant link in the public mind with obesity when less than one third of those with type 2 diabetes are obese.

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

One Swindon

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

12 Transformation Projects

12 business cases have been approved by the One Swindon Board and supported by both HM Treasury and the national Transformation Network of nine organisations pioneering integrated working nationally. These range from a single procurement hub to new and integrated workforce initiatives to investment in reducing alcohol and domestic violence related crime, abuse and hospitalisation to support for troubled families, those with mental health problems and the Community Navigator scheme.

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

Social and charitable investment including bonds

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

One Swindon Transformation Hub

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

Healthy weight Strategy

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

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

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

Smoking Cessation Programme

The CCG will look to increase its support for this programme as part of its plan to reduce potential years of life lost.

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

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

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

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

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

Nonetheless, given a key part of the programme is looking at the health and wellbeing of this cohort of Swindon residents and that they represent some of our largest users of healthcare, we anticipate some benefit in reducing admissions and have assumed for this submission of our strategy that 1 in 20 households will see one admission avoided over the life of the strategy.

Mobilisation timeline

Intervention	;Lead organisation	2014				2015	2016	2017	2018
		Q1	Q2	Q3	Q4				
Self management	CCG								
Urgent care	CCG								
SUCCESS	CCG								
At the scene	CCG								
Fix me Hub	GWH								
Better flow	CCG								
Medicine optimisation	CCG								
Life long planning	CCG								
Long term conditions	CCG								
Mental health and LD	SBC								
Mental health	SBC								
Learning disability	SBC								
Cancer	CCG								
Carer support	SBC								
Planned care	CCG								
Consultant link	CCG				Pilots	Roll out of specialities phased over four years			
Virtual follow up	CCG			Pilots	Pilots	Roll out of specialities phased over four years			
One stop clinics	CCG								
Referral management	CCG								
Revised thresholds	CCG					Rolling programme of threshold reviews			
Coding reviews	CCG								
New pathways	CCG								
ISTC	CCG								
One Swindon									
Procurement	INSIGHT								
Early start	SBC								
Domestic violence	Wilts PCC								
Alcohol abuse reduction	Wilts PCC								
One workforce	SBC								
Healthy weight	SBC								
Healthy exercise	SBC								
Smoking cessation	SEQOL								
Stress management	IAPT								

Key
Planning
Mobilise
Go live
Benefits

Our Two Year Operational Plan 2014-2016

The following table describes our interventions and what will be achieved during 2014-2016 in more detail.

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	❑ 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 ➢ Carer support ➢ hospital discharge schemes ➢ reablement ➢ social care support 24/7 ❑ SUCCESS programme ➢ New primary care urgent centres
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 ❑ Great Western Hospital has established excellent links with the top cancer centres in Oxford and London and thus can offer many services locally ❑ Cancer services in Great Western are not in one place	❑ Bringing radiotherapy to Swindon ❑ Survivorship programme ❑ National standard is travel time to radiotherapy is 45 minutes maximum ❑ Centralise cancer services underpinned by single Cancer Strategy and Plan with radiotherapy as the catalyst

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 weight, healthy exercise, volunteering and no smoking programmes (the latter saved more lives in 2013 than any other programme in UK) ❑ 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 ❑ Community navigator initiative rolled out ❑ 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 wellbeing is not supported then this materially affects the health and wellbeing 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 Community Navigators and existing support network for carers ❑ Rolling out the benefits of the carer support pilots in 2012 and 2013
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 ○ Highest hospitalisation rate ○ Amongst the highest spend ❑ The care we provide being the second highest cause of child death	❑ Supporting key households and families through One Swindon ❑ Providing dedicated services for children ❑ Looking at adolescent services where there are shown to improve outcomes e.g. Cancer ❑ Providing a dedicated service for children with high temperature but where the most likely outcome is that this will settle ❑ Taking on responsibility for commissioning special educational

	needs ❑ 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 ,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 weight, 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	❑ 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

conditions ❑ 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 ❑ Implement Parity of Esteem Initiative
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.	❑ 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 c.f. cancer 14 day pathway ❑ Lifelong care plans including last 3 years of life and 18 months post death support for family and friends

❑ Supporting people to live at home when 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	

Benefits realisation (financial)

We have identified sufficient financial benefits from the first four years of the plan to address the size of the financial challenge facing Swindon. Further work is required particularly in terms of phasing benefits to be derived in 2017/18 to ensure it addresses the remaining financial gap of £101k in 2018/19.

Intervention	Workstreams	SRO	Net Savings/(Investment) £'000				
			14/15	15/16	16/17	17/18	18/19
Carry forward fron 2013-2014	Virtual Wards expansion	Gill May	152				
	Ambulatory Care Phase 1	Gill May					
	Ambulatory Care Phase 2	Gill May		21			
	Community IV	Gill May	241				
	Surgical Assessment Unit	Gill May	27				
Cancer		Anna Field		(250)	(250)		
Planned Care	ISTC	Anna Field	135	535	0	0	0
	Outpatients (virtual clinic, consultant link, RMC)**	Anna Field	175	425	500	500	500
	Reduction in referrals (5-3.15%)	Anna Field			333	334	
	Inpatient to day surgery switch	Anna Field				502	502
One Swindon	Early Start Programme	Tony Ranzetta		80	150		
	Transformation Hub	Tony Ranzetta			300		
	Mental Health and Wellbeing Coordinators	Thomas Kearney	13	156	274		
Self Management Patient Care	Community Navigator	Tony Ranzetta	940	1,200	1,280	0	0
	CN Extension to schools and ED	Tony Ranzetta		120	480	0	0
Urgent Care	SUCCESS	Gill May	(249)	140	260	260	260
	At the scene	Gill May	340				
	GP and Nurse led urgent care centre	Gill May	628				
	Better patient flow	Gill May	180	540			
	New emergency department (Fix me Hub)	Gill May		(250)	(250)		
Medicine Optimisation		Paul Clarke	1,580	1,590	1,590	1,590	1,590
Long term conditions*	Diabetes	Gill May	Schemes being worked up for yrs 3-5				
	COPD	Gill May					
	Cardiology	Gill May					
Carer Support Programme		Sue Wald	300	0	0	0	0
Life Long Health Planning*	End of Life	Thomas Kearney	(140)	800	910		
Mental Health & LD	Mental health	Thomas Kearney	230	230	230	230	230
	Learning disabilty	Thomas Kearney		80	80	80	80
Control of Infection		Gill May	0	0	0	0	0
Assistive technology and early diagnosis	Teleconferencing	Paul Bearman	Schemes being worked up for yrs 3-5				
	Self assessment	Paul Bearman					
	Primary care based technology	Paul Bearman					
Technical Adjustments		Caroline Gregory	1,256	1,756	1,256	1,256	1,256
Total			**5,808**	**7,173**	**7,143**	**4,752**	**4,418**
Financial Challenge			***(5,801)***	***(5,105)***	***(6,490)***	***(2,699)***	***(4,519)***
Over/(Under) Achieved			**7**	**2,068**	**653**	**2,053**	**(101)**

* Time released to support this scheme derived from SUCCESS

** See attached control sheet for outpatient modernisation for last 3 years

Summary of activity changes (2014-2019)

The table below provides a high level summary of the activity changes when we take the impact of all of the Interventions together. The key changes in the first two years are as follows:

- A further reduction in A&E attendances as we roll out the full year impact of the Urgent GP and Nurse led centre at Great Western Hospital and the GP on the ambulance scheme, both of which went live during 2013-2014
- The impact of our review and re-launch of the Referral Management Centre and the ongoing roll out of Optimise Referral Management Software with new surgical thresholds, building on the achievements made in spinal surgery in 2013-2014
- The piloting of Consultant Link and the roll out of the Virtual Follow Up Clinic Scheme
- The roll out of the Community Navigator Scheme
- The removal of those ambulatory care episodes that are not admissions – to be counted as ambulatory care (see table below)
- The removal of the planned ambulatory care admissions currently defined as short stay emergency admissions
- The first pilot of multiple condition one stop clinics in 2015-2016.

	Activity (Inpatient, Daycase, A&E, Non Elective & Outpatient)				
Intervention	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**
Carry forward fron 2013-2014	(1,157)	(330)	0	0	0
Cancer	0	0	0	0	0
Planned Care	(982)	(1,740)	(2,098)	(2,098)	(1,416)
One Swindon	(24)	(384)	(673)	0	0
Self Management Patient Care	(604)	(893)	(1,246)	0	0
Urgent Care	(1,168)	(2,839)	0	0	0
Medicine Optimisation	0	0	0	0	0
Long term conditions*					
Carer Support Programme	(67)	0	0	0	0
Life Long Health Planning*	(127)	(588)	(519)	0	0
Mental Health & LD	(205)	(6)	(7)	(6)	(6)
Control of Infection	0	0	0	0	0
Assistive technology and early diagnosis					
Technical Adjustments	0	0	0	0	0
Total	**(4,334)**	**(6,779)**	**(4,543)**	**(2,104)**	**(1,422)**

* Time released to support this scheme derived from SUCCESS

Years	*Points of Delivery*									
	Day Case	Electiv IP	1st OP	OP Follow Ups	Emerg IP	A&E	Comm urgent care	Ambul	Other eg MH	Total
2014/15	*(836)*	*(223)*	*59*	*(527)*	*(2,360)*	*(7,971)*	*6,289*	*1,261*	*(25)*	*(4,334)*
2015/16	*(873)*	*(123)*	*11*	*(1,052)*	*(2,531)*	*(2,367)*	*0*	*210*	*(54)*	*(6,779)*

Workforce

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

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

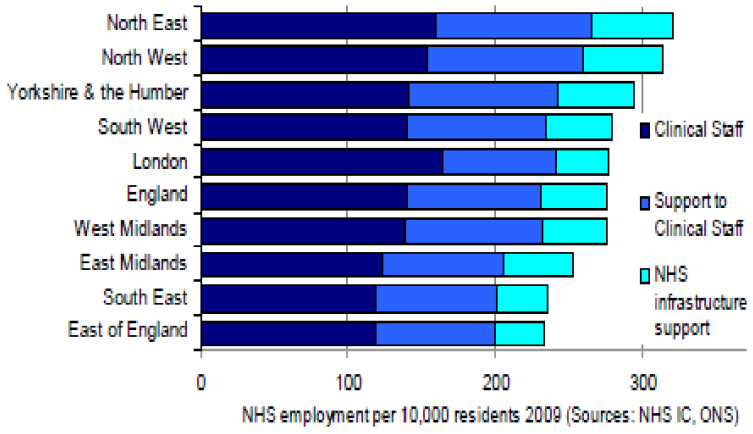
Our strategy assumes a 1.5% shift per annum from hospital care to out of hospital care as part of our overall vision to hold demand for secondary care at 1.39% rather than the 3.2% growth in demand we are forecasting.

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

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

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

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



uth West region has a proportion of NHS staff ita than London and glish average. Only has a higher tion of clinical to non staff than our region

ures exclude GPs and y care teams however ONS for GPs shows a ratively similar position region

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

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

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

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

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

OUR PARTNERS

In this section we set out the opportunity for the voluntary, statutory sectors and business community to work together to provide support to our local communities

We have a strong history of working together across the above sectors in Swindon and now are starting to capitalise on this through national initiatives such as Building Healthy Partnerships and the national Transformation Network.

This section summarises *Shoulder to Shoulder*, our bid to be a pioneer for the local integration of care and support for our communities, which still represents the agreed direction of travel for the partners at the One Swindon table.

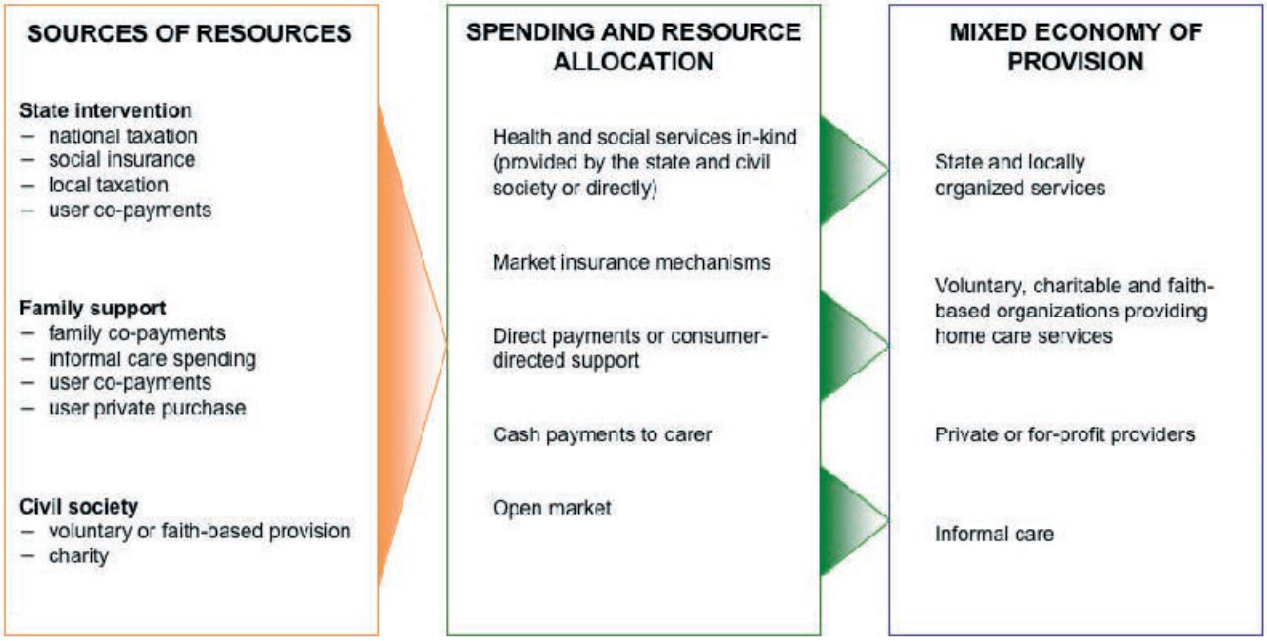
One Swindon is a partnership of Swindon Borough Council, Fire, Police, Probation, Health services, Voluntary sector and the business community whose leadership have aligned their expertise and resources to deliver a shared vision and strategy that seeks

- to grow our local economy
- to enhance the image, reputation and culture of our town
- to improve the health and wellbeing of our residents.

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

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

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

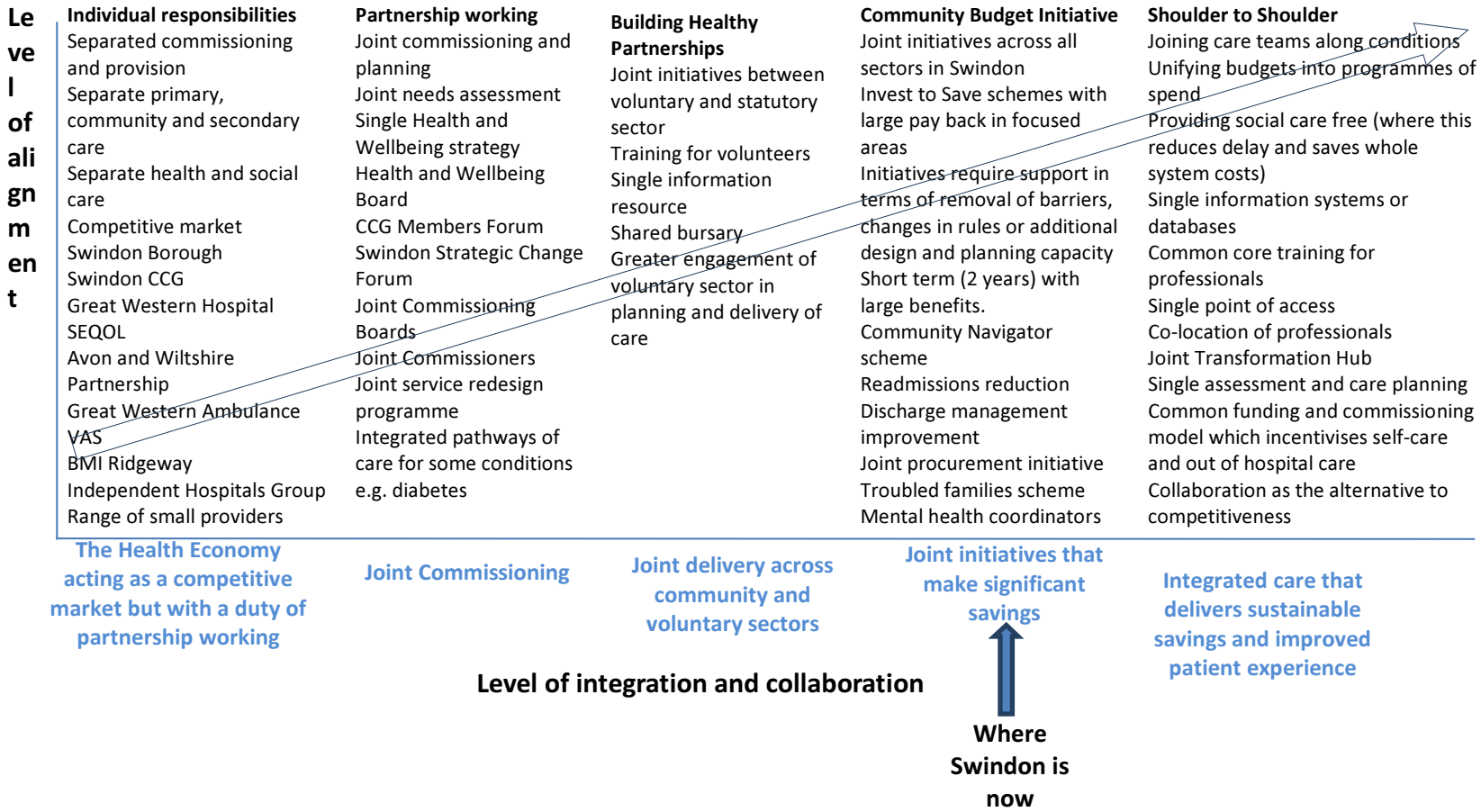


As part of our vision for the next five years, we will implement models for the integration of **sources of funding**, **resource allocation** (our Better Care Plan and Fund) as well as **provision**. It is our belief, based on the evidence from other community health and social care systems around the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

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

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

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



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

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

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

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

In five years' time the difference will be that there will be:

- less services involved in the delivery of care
- greater communication and faster patient flow between care professionals
- greater consistency and clarity regarding the best care
- patients and carers will be better informed about the care they can expect and will receive
- patients and carers will be supported to be more self-reliant
- less people will be delayed in going into or being discharged from hospital
- less people will then be re-admitted unnecessarily when this could be avoided.

More people will be supported to return to their own home when discharged from hospital, achieving the levels of home care of the best systems in the world such as the Dutch and German care systems.

More people will be in control of the funding of their own care through personalised budgets and be expert in their own conditions, such that they can make informed choices over both improving their own health and health and social care interventions or treatments.

OUR PROVIDERS

In this section we set out how the changes in this strategy will broadly affect our main providers of health services (Great Western Hospitals NHS Foundation Trust, SEQOL and Avon and Wiltshire Partnership NHS Foundation Trust).

The income and expenditure assumptions set out below are indicative as in all three cases patient choice and public procurement means that none of the three providers can assume all of this income. Our market strategic analysis (see our Market Strategy) indicates that over **planned care** there is an active market that will see switches between providers based on choice BUT ALSO that Great Western Hospital and SEQOL will do well out of this in competition with neighbouring NHS providers.

Our strategic intent is to maintain the current configuration and over time to provide more stability and certainty in terms of income for our providers, in part achieved through a switch from unplanned care to planned care but also through seeking greater collaboration between providers as we move towards commissioning whole programmes of care and longer term contracts.

Our strategy will see year on year growth in income going into all three providers, linked to the development and implementation of new models of care, growth in demand driven by the age and size of our local population, but offset by the consequences of our Interventions. In addition, there are some specific priorities such as radiotherapy coming into Swindon and a new build for the local emergency department where we have set aside new investment.

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

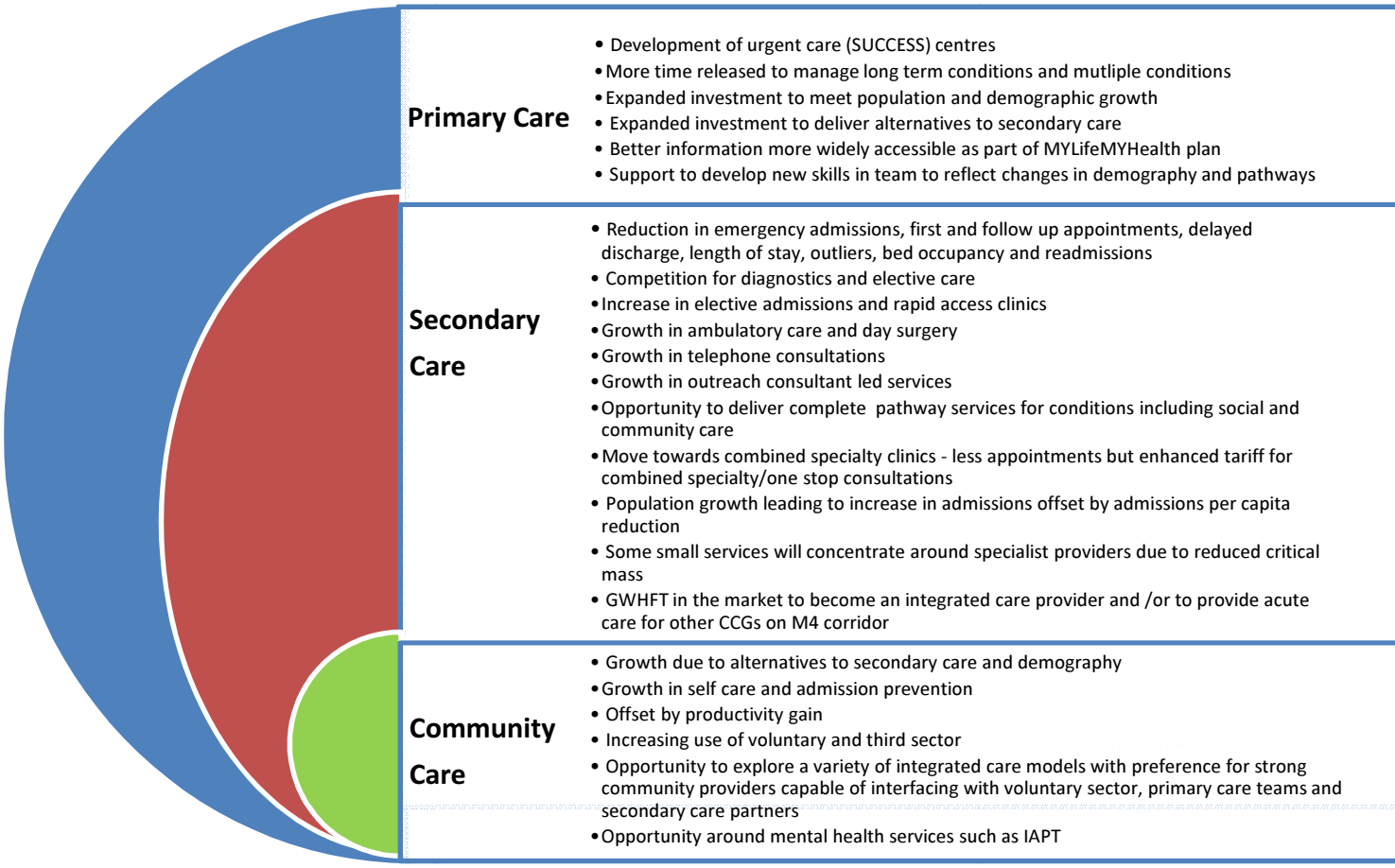
There may be some small specialties whose level of activity could drop below the critical mass to remain viable, given the changes in our demography, but none that we have identified as yet. There will be other services, such as vascular services, where we are already seeing the advantages of being part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

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

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

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

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



Primary Care

- *will see demand for immediate one off consultations streamed to GP led Urgent care centres (SUCCESS centres) allowing greater time for consultation and the management of long term conditions and planned care referrals*
- *will be supported by practice attached mental health liaison and social care "navigators" liaising with the voluntary sector, informal carers and schemes such as Troubled Families to help patients and households develop life-long health strategies that promote health, prevent the need for care and support self-reliance*
- *will grow in line with population growth with further local investment to enable primary care to develop alternatives to secondary care and to take on additional prevention roles*
- *the greater emphasis on self-care and continuity of care coupled with increased role in coordination of immediate community response possibly leading to integration of some community and primary care roles within primary care teams*
- *outreach and specialist community services develop on a collaborative basis at locality level particularly in support of long term conditions (see Circles of Support)*

Voluntary Sector

- *Investment linked to outcomes, specifically reduction in demand for health care due to greater community support and self-care*
- *greater engagement in design of health care pathways with emphasis on role in developing coping strategies for self-care, prevention and alternatives to health care*
- *greater integration and coordination to ensure services are targeted at those of greatest need in a way that does not confuse or conflict with other services*
- *greater focus on where there is evidence of proven health benefit*
- *longer term investment where benefits are proven to ensure stability of voluntary sector offering*
- *investment in Voluntary Action Swindon (VAS) to support voluntary sector in bidding for funding, understanding local health and clinical priorities and developing approach to self-care and prevention as part of programmes to support those with long term conditions, mental health and wellbeing and end of life, funded from Transformation reserve*

Secondary Care

- *overall increase in income in line with annual population growth of 1.39% but reduction in urgent care and outpatient attendances (although less consultations the new model will see reinvestment in combined specialty clinics and outreach services) and increase un rapid access clinics*
- *net productivity gain of 6% per annum in planned care and a reduction of 15.5% in emergency care in line with national assumptions including reductions in emergency admissions due to ambulatory care alternatives*
- *radiotherapy coming locally to Swindon and acting as the spur for further investment in the co-location of cancer services close to or alongside the new radiotherapy centre*
- *Greater use of the acute hospital estate for other healthcare provision as the Great Western moves to become a Health Campus and One Stop Shop for both health improvement and healthcare*
- *Ongoing reductions in length of stay due to accelerated discharge and patient centred bed planning*
- *Reductions in new follow up outpatient activity and move towards Consultant Link, virtual clinics and telephone follow up*

- *Net increase in day surgical procedures with some moving into primary care but compensated for by all procedures moving to top quartile performance*
- *Increase in admissions due to population growth but offset in part by decreases in admission rate due to prevention and alternatives to secondary care. Some conditions and services will increase at a faster rate than 1.39% including cancer, orthopaedics and maternity*
- *Increase in admissions due to ageing population, also seeing an increase in length of stay due to greater co-morbidity offset by diversion of social care admissions and preventative management for long term conditions*
- *Increase in services that outreach into primary and community settings in order to aid self-care and prevention strategies*
- *Opportunity to develop whole pathway services for long term conditions e.g. diabetes in partnership with SEQOL*

Community care

- *increase in alternatives to secondary care resulting in greater community activity but offset in part by greater productivity*
- *development of comprehensive out of hospital care model in partnership with voluntary sector and primary care teams to avoid admissions for emergency care buy providing rapid community access e.g. GP at the scene, extension of virtual ward and telehealth and other models within the Out of Hospital Care strategy*
- *Coordination of voluntary and community sector response providing important continuity, development and regulation of voluntary sector provision as part of out of hospital care model and in partnership with VAS*
- *Some integration of community models within primary care teams*
- *Integration of urgent care models with secondary care teams at front end of A&E, back door of A&E and in SAU, MTAU and MAU*
- *Integration of accelerated discharge models with secondary care teams*
- *Development of new models for end of life care in partnership with Prospect Hospice*
- *Opportunity to lead on behalf of the local health system access to new funds (such as Cabinet office, charitable and social bonds and European grants)*
- *Opportunity to be a partner in the delivery of services that promote the health outcomes funded by above grants e.g. extending successful employment schemes and health improvement programmes such as smoking cessation, the delivery of prescribed exercise and leisure schemes, further development of reablement, the implementation of combined voluntary and statutory sector schemes such as leg clubs etc.*

GOVERNANCE ARRANGEMENTS

This final section sets out the responsibility for delivering this strategy. In Appendix 1 "Our Interventions" we identify the senior responsible officer (SRO) for each, a director level post whose responsibility is to ensure the Governing Body are aware of their achievements, benefits, concerns and risks associated with a programme of change and to bring these to the Governing Body's attention the remedial or mitigating action that will be taken to ensure an Intervention continues to deliver its original benefits.

This section also sets out the change management resource that the Clinical Commissioning Group will deploy and can access from other organisations, and the assurance that will be provided by the CCG's Committee structure.

Finally, this section sets out the process that each Intervention **led by the CCG** goes through from idea or concept to benefits realisation. Those interventions led by other organisations have their own governance arrangements and the implications of this form part of our risk assessment of an Intervention.

These governance arrangements have been reviewed by the NHS England Intensive Support Team and if there is a concern it is that the gateway process (particularly the risk assessment) is too detailed and led to delay in mobilising some schemes. The balance between ensuring a scheme has been fully risk assessed and getting on with delivering the benefits is often difficult to judge. Our local response has been to test or prototype some of the more radical changes on a small scale when we are unsure of the level of risk (the Community Navigator and At the Scene pilots being examples of this as would be the Better Flow initiative)

The Gateway Process

All Interventions go through the following process:

Identification of the opportunity

- Benchmarking and simulation
- Research and publications
- Service redesign programme
- Audit
- Quality and/or productivity review
- Guidance e.g. NICE SIGN
- Contract monitoring

Prioritisation by the Clinical Leadership Group (at this stage ensuring the CCG is not pursuing too many initiatives simultaneously)

Site visits to determine nature and scope of change required

Risk assessment and triangulation of evidence (including external view from subject matter expert)

Business case (including options for change) OR small scale prototype to prove concept

Review by Clinical Leadership Group (at this stage looking at the options around the model of care and the economic, qualitative and clinical consequences of a change)

Initiation including signing off programme/project plan and benefits realisation

Mobilisation including updating performance reporting to include new Intervention

GO LIVE

Benefits tracking
(*Time to Reflect*, February 2013)

Consistent programme management

The CCG has adopted the Managing Successful Programmes (MSP) approach to programme management with staff who are trained in and practitioners of MSP providing both coaching and informal programme management support to other staff in the CCG. The toolkits, guidance notes, case studies, learning materials and business case models in the Office of Government and Commerce website form the templates for the CCG but have been modified for smaller initiatives.

The CCG is then an Associate of the Wellington Institute of Project and Programme Management and as such has access to their support and guidance on change management technique as well as to the University of Aberdeen for their ongoing studies in the effectiveness of project management.

This is underpinned by an in house development programme on MSP complimented by an on line provider of formal Foundation and practitioner level MSP qualifications for those team members seeking to develop their project management skills further.

Change management support

The CCG has established a Transformation Hub into which we have seconded those staff with change management skills such as experience in LEAN thinking or qualifications in project management, to be a shared resource for all of the Interventions on which the CCG leads. This team is headed up by a new post our Head of Change Management and has access to additional change agent resources from the Transformation Hub set up by One Swindon.

Overseeing the delivery of this Strategy

The responsibility for overseeing the delivery of this strategy sits with the Governing Body, who will be held to account by both NHS England and our membership for demonstrating improvements in the health of the people of Swindon and Shrivenham.
The Accountable Officer is responsible to the Governing Body for providing a monthly report on the progress of the CCG's Transformation Programme (formerly our QIPP programme) as part of the monthly performance report.

Delivering the Ambitions

The CCG has ten ambitions and each has been allocated to a Board member on our Governing Body to provide leadership and assurance on progress and delivery. The interventions we have launched have been mapped to their relevant Ambition and this is shown on our plan on a page.

The documentation supporting this strategy was presented at the Governing Body on 27th March 2014. The outcome measures will be monitored quarterly and form part of our quarterly assurance meetings with NHS England. Our performance report will be updated to include these from April 2014.

Some of the indicators however are measured annually so the CCG will look to develop local measures to provide sensible proxies for monitoring progress.

Overseeing the delivery of the Interventions that support this strategy

Progress on the delivery of the Interventions will be monitored by the Governing Body as part of our monthly performance reporting cycle and performance report. Before coming to the Governing Body, each Intervention is reviewed fortnightly by the CCG's Transformation Board which reports to our Clinical Leadership Group and Executive Management Team

The Transformation Board is in turn supported by our Transformation Hub, our corporate learning programme, service redesign programme, and research education innovation and development programme.

Assurance regarding decision-making, quality, progress reporting and benefits realisation

This is provided by the CCG's Integrated Governance and Quality Assurance Committee supported by our Commissioning for Quality Forum, both of which are formal assurance committees of the Governing Body.

Governance structure

Assurance

Below we summarise the arrangements for providing the Governing Body with assurances that this strategy is being delivered.

Monthly performance report (Transformation chapter to replace QIPP section and cover all fourteen Interventions) reporting to the Governing Body in public session

Assurance on the above provided by:
Regular review of the ABCD report for each Intervention (Achievements Benefits Concerns and Do Next) by the Transformation Board
Monthly review by Executive Management Team (including formal review of risks to programme on risk register)
Monthly review by the Commissioning for Quality forum
Bi monthly review by Integrated Governance and Quality Assurance Committee

Programme management

Programme management is provided by the Transformation Hub using a hybrid PMO model, reporting through the Head of Change Management to the Accountable Officer. This includes programme reports to the Transformation Board on a fortnightly basis.

Escalation and reporting lines

If mitigating action is required to ensure an Intervention stays on target then this can be escalated by the Transformation Board to either the Clinical Leadership Group or to the Executive Management Team for nonclinical issues (both of which meet at least twice per month).