Appendix 1

Local Government Association

NHS England

Updated July 2014 v0.6 HWB

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Swindon**
Clinical Commissioning Groups	**Swindon**
Boundary Differences	**CCG area covers Shrivenham, the community health services for Shrivenham are included in this plan**
Date agreed at Health and Well-Being Board:	**September 2014**
Date submitted:	**19th September 2014**
Minimum required value of BCF pooled budget: 2014/15	**£3,525,754 Section 256**
2015/16	**£12,679,000 (plus 175k for community health services Shrivenham)**
Total agreed value of pooled budget:	**£3,525,754 Section 256**

2014/15	
2015/16	**£12,679,00** **£1,587,500 voluntary sector LA**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Swindon CCG
By	Dr Peter Crouch
Position	Clinical Chair
Date	September 2014

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	Swindon Borough Council
By	Brian Mattock
Position	Deputy Leader of the Council
Date	September 2014

<Insert extra rows for additional Councils as required>

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

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

Document or information title	**Synopsis and links**
Health and Wellbeing Strategy	Statutory Plan to improve the health and well-being of the people in Swindon http://www.swindon.gov.uk/sc/sc-healthmedicaladvice/Pages/sc-healthmedicaladvice-Health-and-Wellbeing-Strategy.aspx
JSNA 2013-2022	Needs assessment for Swindon http://www.swindon.gov.uk/sc/sc-healthmedicaladvice/jsna/Pages/sc-jsna.aspx
One Swindon	The Community Strategy and Vision for Swindon http://www.oneswindon.org.uk/cs/Pages/default.aspx
Adult Care Strategy	Our strategy for managing demand for adult services http://ww5.swindon.gov.uk/moderngov/mgConvert2PDF.aspx?ID=46045
Strategy for care	The vision how care and support needs to change to improve the

(CCG)	health of people in Swindon http://www.swindonccg.nhs.uk/media/file-browser/Swindon%20CCG%20Strategy%20for%20care.pdf
The Five Year Strategic Plan 2014-2019	NHS required vision under a call to action
Pioneer Bid 'Shoulder to Shoulder'	Vision for integrated commissioning and integrated working for Swindon
Commissioning Intentions 2013/14 and Joint Commissioning Plan 2013/14	Joint commissioning priorities http://www.swindon.nhs.uk/Library/Publications/About_us/Business/Organisational_Development_Plan_2008-13.pdf

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

1. Vision

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

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

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

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

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

We have been involved in discussions with public, patients, GP practices, providers, voluntary sector, other stakeholders, providers, children and young people, and the Youth Forum in the development of the documents referred to above. The Better Care Fund Plan is a summary of jointly agreed areas of priority. Specific service redesign workshops were held on mental health, carers and community based support for older people. The findings have been incorporated into this plan.

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

***2.* What will be different in 2019 for services and people?**

Swindon will have grown substantially by 2019 with a population of close to 250,000 including Shrivenham. We will be delivering more services in the community.

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

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

Outcomes for service users and patients will improve

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

2.1 Prevention and self help

We understand the population of Swindon at a locality/ward area and at GP practice level. Preventative and self-help integrated services are in place locally to engage and support individuals. This will mean for individuals that:

- 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 your own or family home, **kept as your home**, with us using new practice and technology that maintains the home environment.
- Supporting you to live at home when mobility, functionality or health is impaired does not mean leaving you to be bed bound or placing your home with a clinical environment.
- Our vision is to support you **to live to the full** within your community despite the long term conditions you may have THUS avoiding institutionalised care in a community setting

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

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

You will have access to a range of programmes designed **to improve your health**, ranging from healthy eating and healthy exercise (ranging from cycling to sports activities and recreational swimming to walking and gardening schemes); to smoking cessation programmes; to cultural activities, all of which have been shown to benefit health and wellbeing and extend quality of life.

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

Self-care can be supported in the home or the local community through informal routes such as family, friends and carers, or by more formal routes for advice from pharmacists, Swindon Borough Council Localities, the voluntary and third sector, self-help groups, and

the local integrated community health and primary care teams.

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

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

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

Case study

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

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

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

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

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

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

If you need to **access emergency services**, then you will often be seen by a 'GP at the scene' who will assess whether you can be safely treated at home. If you need to go to the local hospital you can expect to be seen and your treatment commence or to have been admitted within a maximum of four hours within either a GP/Nurse Led urgent care clinic or the Emergency Department at GWH. Patients will be directed to the right department depending on whether you need to see a GP urgently, have a minor injury, require an urgent diagnosis and outpatient appointment, require a medical assessment, require urgent treatment, need to be admitted, need resuscitation or immediate surgery or need to be kept under observation and review. We are calling this new model of care our 'Fix Me Hub'.

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

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

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

Case study

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

Urgent care 2019
All GP's in Swindon know of community navigators and the referral process. Patrick is identified at high risk of hospital admission. The community navigator meets him and discusses his health, drinking regularly and looking after himself. 'Using My care My Support', Patrick is allocated a volunteer to befriend him. A plan is made so that if he has another infection he can be given anti- biotics intravenously. This means that when Patrick suffers from an infection, he is cared for at home and not admitted to hospital.

2.3 Long Term conditions

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

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

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

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

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

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

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

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

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

2.4 Mental health & Learning Disability

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

If you have a learning disability or mental illness you are enjoying leisure and culture and have opportunities for employment. More of you say that you feel safe.

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

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

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

.

Case study

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

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

2.5 Being a carer

As a carer, you will have been made aware by your GP, your health visitor or social worker about the support offered by the Carers Centre. You will have been offered an assessment to discuss with you what help you may need. You have been offered short terms breaks to help you caring and you feel valued and supported. Your GP has discussed your health with you and you know that you can receive a health check in the community. You have registered for the Emergency Card so that plans can be put in place quickly. As a parent carer you know that advice and information is available and you are supported by a multi-agency team. In your local area there are groups that support you. Support is flexible and based on what you need

The Census 2011 estimated that there are 16,000 carers in Swindon. We currently commission support for carers from the Swindon Carers Centre and there is an increasing number of short term breaks. From April 2015, the Care Act means that all carers can request an assessment of their needs. Carers will be able to do this online or through skills support from the voluntary sector as well as SEQOL our social enterprise for community health and social care and the mental health provider. Carers will have support that is flexible, outside of Monday to Friday. A personal budget enabling carers to have choice and control will be offered. Informal support is available in local areas.

b) What outcomes are we striving to achieve?

- **Enhancing quality of life for people with long term conditions** (such as diabetes and dementia) by commissioning services that appropriately support patients' and carers' needs and help them manage their own conditions and maintain them to live in their own homes for as long as possible and avoid unnecessary hospital admissions.
- **Helping people to recover following illness** through better patient flow to ensure that people are given the care and support required in the most efficient and appropriate care settings at the right time, across health and social care. This will also mean commissioning direct access to planned care seven days a week.
- **Improving patient experience and safety** improving access, quality and safety of

services.

- **Reducing health inequalities** in Swindon working with other partners e.g. One Swindon, Health and Wellbeing Board, Swindon Borough Council and NHS England to ensure voluntary, private and public sectors are working together to support the most disadvantaged communities and households.
- **Preventing people from dying early** including preventing disease in the first place. Early diagnosis and appropriate treatment of disease can also reduce premature death.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

We already have an integrated provider of community health and adult social care in place. The provider is jointly funded and its services in relation to reablement, community health, community navigator will continue to be funded from the better Care Fund. SEQOL provides integrated learning disability and older people social work teams. Community health services are part of social work teams. Care is co-ordinated around the individual. A Single Point of Access is already in place as well as integrated hospital discharge services, a rapid assessment service (DART) as well as the Virtual Ward and 'Fix Me Hub'. A joint contract is in place across Swindon CCG and Swindon Borough Council supporting carers as well as jointly funded carer's breaks.

Our ambition for our integrated care model is first and foremost driven by our daily appreciation of the delays and confusion in healthcare delivery caused by the current disintegrated model of care delivery, despite our best efforts to ensure the patient experience is right first time for everyone. The most common complaint from both patients and clinicians is that every pathway of care has too many points where care must be handed over to another organisation, that these handover stages cause confusion and delay, that delay results in poor healthcare and also discontinuity of provision, that the resulting communication between healthcare professionals and health and social care could be better and needs new systems to improve it.

The commissioning of the voluntary and third sector is led by the joint commissioning arrangements. This funding will also be part of the Better Care Fund as well as support to carers.

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

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

A range of public health initiatives are already in place and will be strengthened through our joint community capacity work targeting healthy lifestyles and a reduction in risk

taking behaviour such as alcohol and drug misuse.

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

All services are delivered within the community and in community based locations.

- **Urgent care:** locally enhanced service models are being put in place to ensure the roll out of risk stratification. All GP practices are participating in risk stratification. Improving access to primary care through the SUCCESS model with urgent primary care centres in place as well as increased home visiting and joint work between community and acute services (Fix Me Hub); supporting the implementation of a lead GP for each patient over the age of 75 years. Those people who have had a stay in hospital have access to community based and residential reablement services.
- **Long term conditions:** Diabetes, Dementia, cancer, heart failure, stroke, COPD review of care pathways through on-going redesign process so that services appropriately meet the demand created through better diagnosis and increased awareness for dementia, better treatment for cancer, diabetes and COPD.
- **Self-care and prevention**. Community navigator on a pilot basis has been put in place in four GP practices in Swindon. Further roll out to other practices planned in 2014/15. Community navigators have a case load based on risk stratification for those with long term conditions including older people. Reshaping of provision in the voluntary and third sector to improve health and well-being is being undertaken. Advice and information service as well as web site offering information is in place. Voluntary sector organisations supporting those with a learning disability, mental illness, carers and support services are co-located in the centre of Swindon. Further improved advice and information so that people can make plan and make choices for themselves
- **Reducing a growing burden of lifestyle related ill health and cancer** particularly due to physical inactivity, obesity and smoking that we want to address through increasing community capacity to tackle the wider determinants in relation to housing and employment. Swindon has higher rates of smoking, alcohol consumption, physical inactivity and obesity in areas of disadvantage, which in turn leads to higher incidents of heart disease and diabetes in those communities. We continue to invest in initiatives that tackle heath inequalities throughout the life course. We will be commissioning services to reduce social isolation so older people remain linked to their communities for as long as possible.
- **Improving the health of children** by reducing child obesity to prevent long term ill health, reducing paediatric admissions and ensure targeted support for children and families
- **Improving mental health** through wellbeing co-ordination and improved work between voluntary and third sector mental health services and secondary mental health services
- **Improving health, social and emotional development of people with a learning disability** so that health outcomes improve, people live and are supported locally and find suitable employment and training.
- **Supporting Carers:** Developing an extended assessment and information sharing supporting carers including young carers. Reviewing all services to ensure they adequately provide for the needs and rights of carers and ensuring carers are

aware of support and short term breaks available to them

Swindon Clinical Commissioning Group and Swindon Borough Council already have a National Health Services Act 2006 Section 75 Agreement in place. As the Better Care Fund is largely funds from existing budgets, many of the services are already funded. If the Better Care Fund was not in place than the following community based services could be at risk:

- Community health services
- 7 day working in adult social care
- Reablement support and accelerated discharge form hospital through access to care packages 7 days a week

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

The Better Care Fund Plan is based on a thorough analysis of need of the population in Swindon. It addresses the key challenges, which are evidenced below of:

- Reducing emergency admissions to hospital by strengthening our urgent care plans
- Reducing emergency admissions and improving health of those with long term conditions through community based support, advice & information, community based support, community navigators
- Strengthening reablement services for those discharged from hospital including 7 day working in social care and health
- Improving locally based support for people with a learning disability
- Improving advice, information, assessment and support for carers
- Addressing the needs of an aging population and improving health inequalities

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

Swindon is strongly placed to build on its existing delivery of integrated care with an existing Section 75 agreement in place for health and social care comprising a total aligned fund of £16m CCG and £55m SBC (total £72m). We already have an established community provider providing integrated health and social care services, SEQOL. We are a single unitary local authority (Swindon Borough Council), one CCG (Swindon CCG, representing 26 member practices in Swindon and Shrivenham), a single acute Trust in the Town (Great Western Hospitals NHS Foundation Trust), one mental health provider (Avon and Wiltshire Mental Health Partnership NHS Trust, who have established a clinical directorate that just serves Swindon), one emergency patient transport provider r (South Western Ambulance Service NHS Foundation Trust) and one network of voluntary sector organisations (Voluntary Action Swindon or VAS).

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

The data below outlines the challenges in detail which we will continue to address in an integrated way through the schemes outlined in Section 4 of this plan.

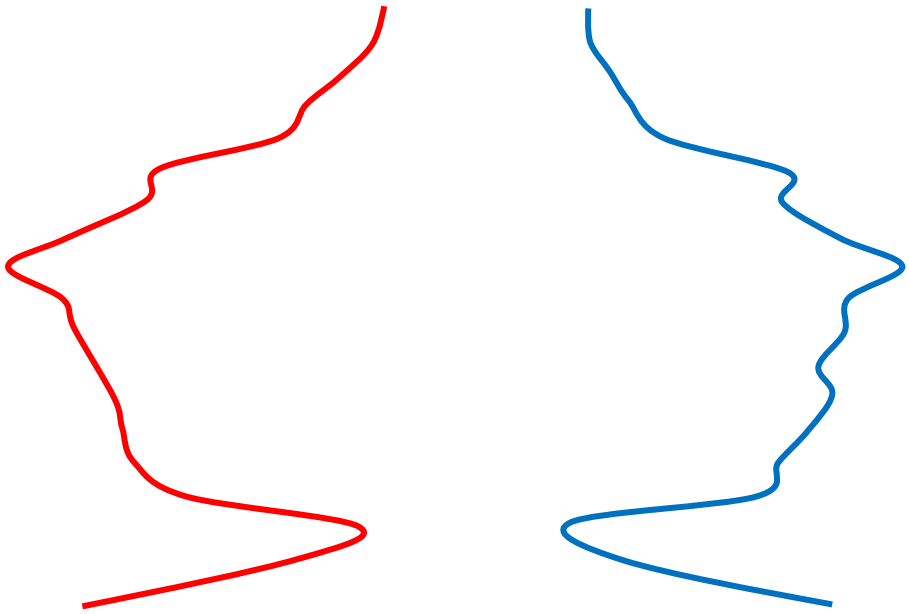
Swindon faces significant population growth over the next 10 years as the data below shows. We will see a larger rise than nationally amongst children under five and older people with long term conditions, both of whom are high users of primary and secondary health services. Looking at our demographics, we can see the unique consequences of the growth in our industries in the 1980s and 1990s with a materially larger proportion of

our people being in the 30-64 age groups. Forecasts between 2001 and 2011 also show that we would see the over 85 populations grow at a much faster rate than the rest of the population due to increased life expectancy.

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

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

Population Pyramid 2011 with 2019 projection shown as lines



Population Forecast

Age Group	2010	2015 Projection	2022 Projection
People aged 0 to 4 years	14,805	14,926 +0.8% from 2010	15,437 + 4.3% from 2010
People aged 65+ years	28,857	32,944 +14.2%	38,721 +34.2%
People aged 75+ years	13,892	15,556 +12%	19,391 +40%
People aged 85+ years	3,865	4,681 +21.1%	6,161 +59.4%
Total Population	201,053	211,102 +5%	231,867 +15.3%

Future Projections for Population 65 +

Number of over 65s in Swindon projected to have:-	2011	2015	2020	2025	2030	% Increase 2011 to 2030
• Dementia	2,014	2,289	2,734	3,265	3,941	95.7%
• A long-standing health condition caused by a stroke	673	767	877	1,023	1,191	77.0%
• A limiting long-term illness	13,599	15,412	17,526	20,397	23,762	74.7%
• A fall leading to the need for support	7,716	8,777	10,119	11,698	13,786	78.7%
• A BMI of 30 or more	7,582	8,670	9,717	11,057	12,835	69.3%
• Diabetes	3,617	4,133	4,686	5,379	6,279	73.6%

The 2011 Census also identified a significant increase in non-White British population to 15% and 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.

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

2012 for the first time in a decade, indicating there is far more that we can do locally to further increase female life expectancy.

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

Based on the 2011 Census and 2013 hospitalisation rates, this is no longer the case. Hospitalisation rates are now on the English average with key health determinants such as female life expectancy coming much closer to the English average (82.7 years compared with 82.9 years). Life expectancy for both men and women in Swindon has improved at a much faster rate than the English average.

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

The growth in people from Black and Minority Ethnic and Diverse Communities to 16% places even greater emphasis on the development of approaches to healthcare design and delivery that reach out to and are guided by our new communities. The greatest growth has been in communities who are also vulnerable to diabetes and cardiovascular disease in the Asian community (both for which are priorities for new interventions in 2014-2019 therefore).

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

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

Meanwhile, in 2001, 27,476 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 32,302. 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. Modelling by Swindon Borough Council on increases in demand estimates an additional 60 older people for 52 weeks of the year each year until 2016. Thereafter, it is likely that this number increases due to the demographic changes outlined above. The net financial pressure of this is modelled at an additional £420k per annum. The number of people with a learning disability is expected to rise by 30 people each year as life expectations rise and a larger number of young people become the responsibility of adult social care each year. This adds a net budget pressure of £1.3m each year.

OUR POPULATION AND PERFORMANCE

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

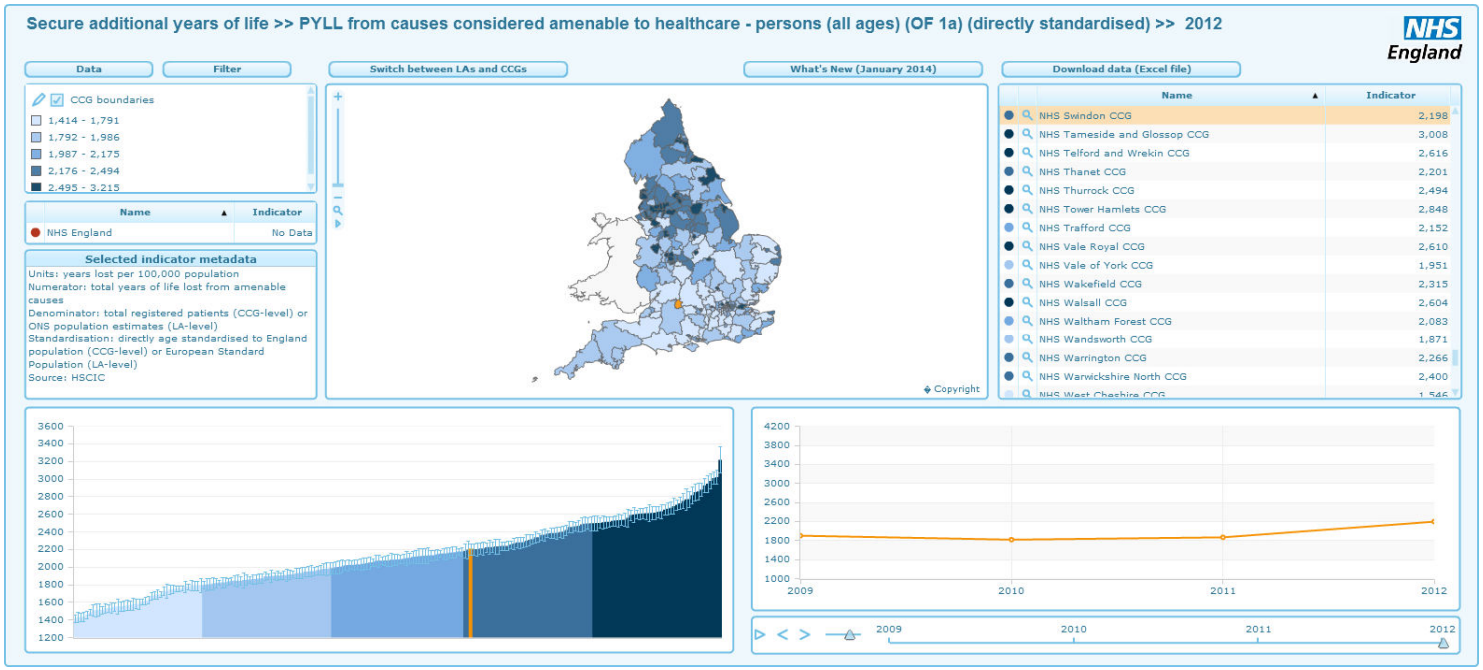
Indicator	Value		England	Region	England Min	Spine chart	England Max
▼ Outcomes - domain 1							
Potential Years of Life Lost amenable to healthcare - female	2,222	↑	1,911	1,712	1,098		3,071
Potential Years of Life Lost amenable to healthcare - male	2,182	↑	2,267	1,911	1,568		4,039
Under 75 Mortality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

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

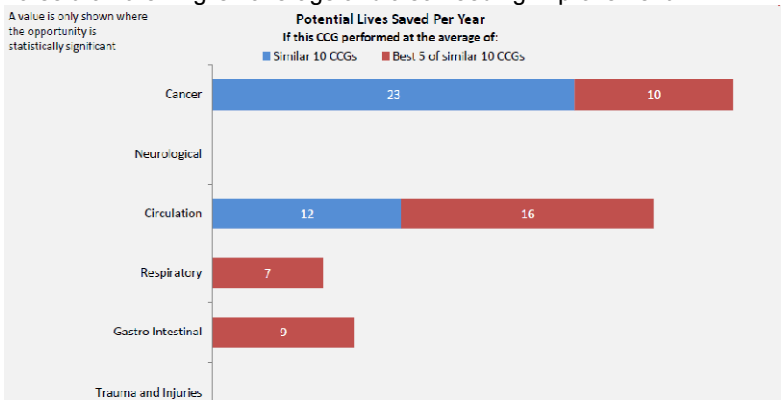
AREAS FOR IMPROVEMENT

Potential years of life lost (PYLL) and saved

Swindon's PYLL has moved from being best tertile to worst tertile in the single year of 2012 and our ambition is to return to the best tertile position at 1800 or where the local community was in 2010. With the exception of diabetes (female deaths working age) and respiratory disease (under 75 for both genders), mortality through avoidable deaths are fewer in Swindon than the English average. In 2009 (the latest year for which we have national statistics with which to compare), less than one per cent of the Swindon population died with the main causes of death being: RTA amongst children followed by congenital abnormalities; suicide was the main cause of death in the 15 to 34 age group; then coronary heart disease for men from 35 onwards and for women over the age of 65. For women aged between 35 and 64, breast cancer was the leading cause of death.

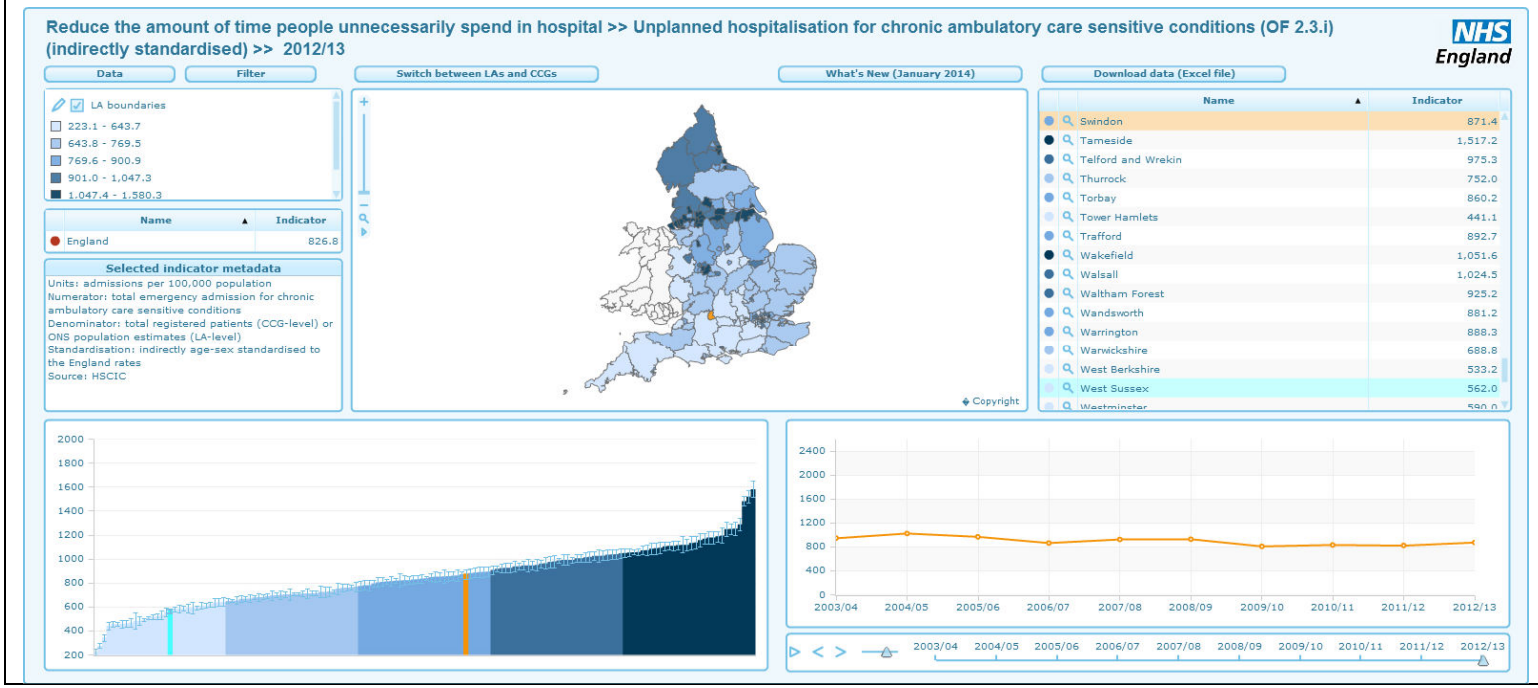


The main opportunities for intervention are in cancer and circulatory disease (see below) with under 75 mortality from respiratory disease being worse than the English average and also needing improvement:



Avoidable emergency admissions

Although the Swindon comparative and actual admission rate has improved over the last nine months and in the period 2009 to 2011, it deteriorated slightly in 2012 and so there remains a significant opportunity when comparing the CCG with its peer group and with all CGGs (with potentially just over £1.5m savings in circulatory and respiratory diseases alone). The CCGs ambition is to restrict growth in demand in emergency care at a maximum of 1.3% which is 1.5% per annum below age adjusted annual growth (2% below the three year rolling average growth over the last ten years). However, the interventions proposed in this plan would also see a further switch from unplanned care to planned and ambulatory care of 1.5% to 2% per annum as part of the change in management of urgent care and long term conditions. The overall gross change (when combining the admissions avoided altogether and those shifting to ambulatory care) would therefore be a 15.5% reduction in unplanned care over the 5 years of this strategy.



4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Swindon already has integrated joint commissioning and delivery in place. This is supported by Section 75 Agreements for adult social care, community health and mental health services. These agreements will be revised in 2014 so that a new Section 75 in in place with a schedule for the Better Care Fund.

2014/15

Quarter 1 and 2

- Implementation of personal health budgets
- Evaluation of community navigator pilot
- Development and initiation of SUCCESS centres
- Develop business case for 'Fix me hub' development
- Develop ambulatory pathways for the frail elderly
- Develop out of hospital strategy
- Tendering of community based mental health services
- Learning disability work stream established
- Re-design workshops: mental health, carers, diabetes, COPD, and dementia
- Urgent care workshop
- Co-location of voluntary and community sector and launch of 'My Care My Support'
- Advice and Information services for adult social care and community health services in place, meeting requirements of Care Act 2012

Quarter 3 and 4

- Roll out of community navigators to further GP practices
- Full operation of the SUCCESS Centre
- Community based mental health services through voluntary and third sector I n place
- Evaluation of befriending services for older people
- Development of common assessment process for carers
- Learning disability community based support in place and savings achieved
- Implementation of ECIST findings with improved hospital discharge service
- Business case for 7 day working in social care agreed and implemented
- Dementia strategy action plan in place
- Data analysis of demand by older people for acute and residential care services and responding action plan
- Development and implementation of Care Act requirements in relation to carers and assessments
- Workforce development workshops on personalisation and Care Act

2015/16

Quarter 1 and 2

- Older people work stream commences to explore community based support and reduce admissions to residential care
- Continued operation of SUCCESS model
- Tendering of befriending services for older people
- Implementation of carers assessment on-line
- Implementation of social care self-assessment on-line
- Implementation of improved transition process from children to adult services for those with a disability
- Development of financial assessment systems in relation to Care Act
- Continued improvements to patient flow across the health system
- Review and revise admission and discharge management processes and invest in systems to reinforce clinical decision making at point of admission
- Expert patient programme

Quarter 3 and 4

- Delivery of community based support for older people with long term health conditions including rapid access clinics and live telephone consultations
- Implementation of financial systems in relation to Care Act
- Continued work force development in relation to the Care Act
- Implementation of schemes to mitigate demand for 2016/17 based on data analysis under taken in 2014/15
- Improve e- communication between secondary, primary and community care (crisis support, carer support, hospital discharge schemes, reablement, social care support 24/7)
- Extend lifelong health planning to planning for retirement
- Re-commission community based support and supported accommodation for people with learning disabilities

b) Please articulate the overarching governance arrangements for integrated care locally

Swindon has two national Health Services Act 2006 section 75 Agreements for the commissioning of adult health and social care services including mental health and commissioning of health, education and social care services for children. A joint commissioning plan bringing together all our joint priorities as well as a delivery plan is in place. These are reviewed six monthly and renewed annually by the Join t Commissioning Board referred to below

Governance arrangements to monitor the section 75 Agreements are already in place through the Joint Commissioning Board Children & Adults. The CCG and Swindon Borough Council are members of the JCB. Meetings of the Board take place quarterly and are open to the public. The Board is a subcommittee of Cabinet and the Clinical Commissioning Group's Governing Body. The new Better Care Fund will sit as a pooled

fund within the Section 75 Agreement and will be monitored by the JCB. The existing Section 75 Agreements will be refreshed to take account of the new arrangements.

The Joint Commissioning Board Terms of References will be amended to provide a link to the Health & Well-Being Board who will agree the Better Care Fund. There will also be links between the Better Care Fund and the Operational Resilience and Capacity Plan and the Swindon Strategic Systems Resilience Group which is the new whole system network designed to bring together multiple stakeholders from across Swindon and Wiltshire and replaces the Strategic Change Forum. **Diagram to be inserted**

c) Please provide details of the management and oversight of the delivery of the Better Care Fund plan, including management of any remedial actions should plans go off track

Operationally, the delivery of the Better Care Fund Plan will be through the CCG Executive Management Team and the Adult Demand Programme Board. Joint membership of both groups is in place. Joint reports will go to the Joint Commissioning Board as well as progress reports against the Joint Commissioning Plan.

Each of the Better Care Fund schemes is part of either the CCG Interventions or the Adult Demand Programme. Project managers and work stream leads are in place for each scheme.

The delivery of joint community health and social care services is monitored through a monthly contract meeting. There are contractual arrangements in place for escalating performance issues.

The CCG is seeking real time information from SEQOL that will inform practices on the activity of the community health service that has been involved in for their patients.

Delivery of work stream targets is reported to the Adult Programme Board and CCG executive team. Delivery issues and risks are reported to the relevant Board where remedial actions will be agreed.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme	Governance
1	**Integrated Crisis and rapid response** Crisis support to prevent admission to hospital and enable those who leave hospital with access to assessment facility for people discharged from hospital linked to reablement so that length of stay in hospital reduces and people are able to regain their skills as quickly as possible.	SEQOL contract management and reports to the Joint Commissioning Board.
2	**Enhanced Reablement** People will regain skills and quickly as possible without the need for on-going support. This will be provided from an integrated service including OT and therapists with direct referrals from the Hospital Discharge team to enable speedy discharge from hospital.	As above.
3	**Community navigators and enhanced voluntary sector capacity** The role of the community navigator will be to coordinate a holistic pan for patients at high risk of hospital admission. A plan is put in place with the support from various sectors and agencies to deliver this package of assistance. Patients with long term conditions are identified through risk stratification which is in place in all GP surgeries. Community navigators are now being piloted in 4 GP practices from January 2014. Roll out to further practices by April 2015. **Wider community capacity** In addition to community navigators, mental health well-being co-ordinators are introduced through the commissioning of mental health third and voluntary sector contracts. Process re-designs and training is in place and piloted from November 2013. To support the above, the second strand of the project is the development of a	Joint work stream CCG Interventions Programme/Adult Programme Board. Reports to the Joint Commissioning Board.

	single database **My Support, My Care** that can be accessed by the patient and the link worker in assembling the package of support. Alongside the link workers, we need to ensure that investment in the voluntary and third sector is aligned to support those in most need of self-care. In particular we will commission voluntary and community based support linked to localities and GP practices. Supporting volunteers reduces the need for some targeted and specialist services. Community and voluntary sector groups provide important flexible services either informally or as part of local contracts.	
4	**Community Rehabilitation Scheme** (**Fessey**) We will be funding nursing assessment beds with enhanced health care so that patients can be discharged from hospital more quickly. Process has been designed and additional staffing introduced. Discharge from hospital into Fessey was implemented in December 2013.	Adult Programme Board
5	**Enhanced hospital discharge** We will continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible. We will ensure access to brokerage and verification services so that there is speedy access to social care packages seven day a week. Integrated discharge team comprising of health and social care is in place. Since September 2013 a Discharge Assessment and Referral Team (DART) has also been in place to avoid admission and discharge as early as possible. Both services operate 7 days a week and work closely with hospital clinicians. We will be reviewing home from hospital support so that any delay is avoided and a community support package is in place. The Virtual ward will be working closely with the hospital discharge services and the Single Point of access to both avoid admissions and enable speedy discharge.	CCG Interventions Programme/Adult Demand Programme
6	**Learning disability** We will re-commission services by shifting	Adult Demand Programme

	towards supportive living model by stimulating local market and expanding both occupational and educational opportunities. A project team is in place from January 2014. There are currently 234 people living in residential care at a cost of £14m per annum. 32 young people aged 18 – 30 are living in residential care as of March 2014. In 2014/15 we will be reviewing all 32 young people and identify those to be supported in community based living in Swindon and develop transition plan for them to be implemented in 2015/16.	
7	**Carers Support** A joint carer's contract is already in place which was tendered in 2012/13. The Carers centre provides advice and information for carers, welfare benefits advice as well as support groups. Young carers support is provided by the same voluntary organisation and was part of the same tender. Outcomes for carers continue to improve. Additional investment was made available in April 2012 for short term breaks for carers and the investment has been maintained. Development of improved assessment process for carers and improved access to health checks	Adult Programme Board
8	**Capital allocations** Capital allocations fund the joint Integrated Community equipment Store for children and adult services as well as investment in telehealth and telecare. We will continue investment in technology to support self-care and prevention and enable for this a disability to live as independently as possible.	Adult Programme Board
9	**Implementation of new responsibilities under the Care Act 2014** We will be implementing the required systems under the health & Social Care Bill and prepare systems for an increase in financial assessments and self-assessments. Wherever possible we will be investing in new technology to automate processes as quickly as	Adult Programme Board

	possible.	
10	**Supporting independence and reducing length of stay in hospital** Virtual Ward, Intermediate Treatment beds (SWICC), Hospital discharge services and 7 day working for clinicians	SEQOL contract management
11	**Alternative community based health services preventing hospital admissions** Continued development and enhancement of a range of community based support such as the Single Point of Access, SUCCESS, nurse home visiting	CCG Interventions Programme and SEQOL contract management
12	**Adult social care support for older people and those with a learning disability** Increase in care packages due to demographic pressure leading to reduced length of stay in hospital. Work with residential and nursing providers to increase access to health care within homes so that admissions to hospital reduce	Adult Programme Board

5) RISKS AND CONTINGENCY

a) Risk log

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

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Risk 1: Demand at a higher rate than population growth assumption of 2.8 - 3.2%	4	5	20	Focus on self-care and prevention through My care, My Support and Voluntary sector commissioning – Head of Commissioning

				Children and Adults by April 2015
Risk 2: Community based self-care pilots too small to impact on demand	5	4	20	Link of community navigator and mental health well-being coordination schemes to maximise impact. Tender in 2014 with implementation April 2015 Head of Commissioning Children and Adults
Risk 3 demand outstrips capacity in reablement services	4	3	12	Spot purchasing of reablement packages through Better Care Fund allocation – Head of Commissioning Children & Adults (during 14/16)
Risk 4 patients continue to go to A&E rather than community alternatives leading to increased hospital admissions	5	4	20	Communication strategy, close work between GP practices and community health services. Distribution of information materials, promotion of online advice and information – Associate Director of Commissioning (Out of Hospital)
Risk 5 Political resistance to change	2	5	10	Cross Party Lead Member Advisory Group in place monitoring adult change programme. Good political ownership and multi-agency ownership of vision and strategy through health & Well-Being Board and JCB- Board Director Commissioning (DASS) and Clinical Chair

Risk 6 Cultural change required from staff across public sector	4	4	16	Multi agency work force development programme across Swindon on managing expectation and managing change through redesign workshops and workforce development. Actions throughout 2014/15 and 2015/16 Executive Director Commissioning/Head of Commissioning Children & Adults
Risk 7 Capacity to drive pace of change under developed	4	4	16	Additional programme management in place for Adult Programme from August 2014 until April 2016 and Head of Change Management in the CCG
Risk 8 NHS Provider viability - Potential risk to small and medium size providers during tendering of services and the potential of service disruption	3	3	9	Publication of commissioning intentions and potential tendering with significant lead in time for tendering of services – Chief Operating Officer, CCG

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

There is a formal risk sharing process in place between the CCG and Great Western Hospital.

Swindon Borough Council agrees to undertake work with those care homes in Swindon that have been identifies with the highest hospital admissions based on data to be supplied by Swindon CCG. **Risk share from GWH contract to be included**

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

This plan links closely to the strategies and plans referenced in Section 1 of this document.

In addition the Urgent Care Programme and CCG Interventions include community navigators, the SUCCESS scheme and the 'Fix me hub'. These interventions will have a substantial impact on reducing emergency admissions. A whole systems review of patient flow as undertaken by ECIST in early 2014 culminating in a system wide workshop. The actions have been taken forward by the Urgent Care Working Group and are monitored by the System Resilience Group.

As explained elsewhere the Better Care Fund brings together schemes which are part of the SEQOL contract, CCG Interventions and the Adult demand programme. It develops the schemes further to address our joint priorities. These schemes are also aligned with the Swindon Operational Resilience and Capacity Plan.

Personal budgets in social care have been implemented with over 63% of the population in receipt of a personal budget. A personal health budget has been piloted by the Continuing Health care team and 3 people have gone through this process. With all existing CHC eligible patients are made aware of the Personal Health Budgets option and all new eligible patients being offered a Personal Health Budget at the point that eligibility is agreed. This has enabled individuals who currently have a Direct Payment through Social Care to continue to receive services from a Personal Assistant.

This plan is supported by the current development of the Housing Strategy to meet the needs of those with a learning disability and older people. Already a new housing development for people with a learning disability has been agreed as well as life time housing for older people in Wichelstowe, a new housing development in Swindon

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

This plan builds on the agreed priorities of:

- Health & Well-Being Strategy
- The 5 year Strategic Plan 2014- 2019 for CCG
- Swindon Borough Council
- The Commissioning Intentions 2014/15, which have been discussed with

providers and have been developed jointly with Swindon Borough Council;

- The Joint Commissioning Plan which brings together the priorities for both the CCG and Swindon Borough Council. The priorities of this plan have also been shared and discussed with the voluntary and community sector.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The CCG submitted an expression of interest in co-commissioning primary care. The main impact that co-commissioning would have on the BCF schemes is in respect of the alternative community based services to a hospital admission. This includes the community navigator scheme and the SUCCESS project.

Work on the management of patients at risk of an emergency admission; the role of the accountable GP and the development of care plans can also be considered as part of the co-commissioning work.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Swindon Borough Council uses its core budget allocation and the additional funding of the Better Care Fund to promote integrated working across health and social care. We are joint partners in the National health Services Act 2006 section 75 Agreements with Swindon Clinical Commissioning Group. We have an annual joint commissioning plan which sets out our joint priorities and funding of services included in the Section 75 Agreements. The Joint Commissioning plan's priorities are refreshed in light of the JSNA and the heath & Well-Being Strategy annually. The Joint Commissioning plan is reviewed twice a year and demonstrates the outcomes that have been achieved across health and social care for the benefit of the people of Swindon. We are defining the protection of adult social care as maintaining eligibility at substantial and critical. We are awaiting the final statutory guidance on eligibility criteria and these will then be incorporated into this definition. Funding from the Better care Fund for increase in demand is used to protect adult social care as well as investment in existing schemes. Eligibility criteria are described in detail on My CareMy Support website accessible for carers, patients and service users.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Swindon Borough Council is proposing a net investment of £550k in care packages for people with a learning disability and £500k in care packages for older people in its core budget for 2014/15. Savings have been identified against supported housing schemes, limiting the rise of inflation and remodelling short term residential breaks for people with a learning disability and to review local learning disability provision to reduce out of area placements. This will include working with the market with the Market Position Statement to further identify what additional services or changes to existing services are required to meet the needs of local adults with a learning disability. Swindon already has a joint health and social care integrated social enterprise. Additional funding from the Better Care Fund will be used to increase care packages to meet demographic growth in 2015/16. Specific schemes to protect adult social care are support for carers, learning disabilities, crisis support and integrated care, community capacity building and increase in care packages to support hospital discharge. Schemes protecting adult social care account for £4.4m revenue funding in addition to the allocation for the implementation of the Care Act

An advice and information service has been commissioned as well as a service directory on line to give the public and patients access to up to date information. This is aimed at promoting independence and choice. The voluntary and third sector is commissioned to improve self-help and prevention for carers, those at risk of mental ill health and older people. Further services in relation to breaking isolation are currently piloted with a view to a full tender in 2015.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

£4.4m has been allocated for schemes which protect spending in adult social care but also supports hospital discharge and emergency admissions through community navigators. .

£460k has been allocated within the BCF for the implementation of the Care Act and a further £170k capital will need to be funded from outside the batter Care Fund as the capital allocation is insufficient to meet demand for equipment and the Care Act. A change programme is in place with programme management. Advice and Information has been delivered ahead of the care Act implementation. A self-assessment process for service users and carers will be developed and a project team is in place. The implementation of the Care Act is managed through the Adult Programme Board.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Investment by the Local Authority in advice and information web based information and an advice and Information service at Sanford House commissioned from Swindon CAB.

On online self-assessment for self funders is being developed. Increases in demography in social care have been modelled through the Adult demand programme and the analysis was published in papers to the Health Overview and Scrutiny Committee in September 2013 and December 2013 www.swindon.gov.uk.
Work streams have been established for the implementation of the Care Act for carers, self-assessment, work force development and financial planning.

v) Please specify the level of resource that will be dedicated to carer-specific support

£806k has been identified within the BCF to support carers. A contract is already in place to provide community based support. This was based on best practice and developed with carers. A budget for the provision of short term breaks, emergency access to support and emergency card details are in place. A workshop has been held with carers to develop the menu of support and ensure the assessment process is developed in partnership. A work stream in relation to carers will be in place as part of the Care Act implementation and report into the Adult programme and CCG Interventions.
The Carers Centre has GP liaison workers and will be based in the Swindon Advice and Support centre raising awareness amongst the voluntary and third sector of carers needs. Additional scheme to support carers in hospital discharge process and carer support are being developed as part of the carers work stream

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

The areas of spend have been maintained in this revised BCF. This means there is no change to the budget planning for 2015/16 within the local authority social care budgets. If funding is not allocated to the schemes agreed then there is likely to be an impact on reablement services, delayed discharge, 7 day working in social care and support to carers and eligibility criteria for social care.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

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

Seven day working is identified as a CQUIN with our health providers and is recognised as a key piece of work identified by the ECIST review of GWH and is included in the ORCP.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

We will be using the NHS number as primary identifier for correspondence across health and care services. SEQOL is a joint health and social care provider and the NHS number is used and recorded on the Social care Information system (SWIFT) and Capita One. SWIFT and Capita One are owned by Swindon Borough Council so that commissioners and providers have access to the NHS number for both children and adults. A project manager will be employed by Swindon borough Council in September 2014 to lead on system development in relation to social care and supporting information governance work so that the NHS number is used consistently.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We will be adopting Open API and Open Standards as part of the SUCCESS project we have commissioned an interoperability platform that allows communication between different primary care systems, secondary care and social care systems. This is not Open API but is secure provider interface technology which is being developed locally through bespoke software. This should be operational in September 2014.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practice and in particular requirements set out in Caldecott 2.

Information sharing protocols will be in place. Consent will be asked for by SEQOL for all patients and social care service users so that information can be shared. SEQOL, SBC and CCG will all meet relevant information governance requirements

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

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

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

All patients with long term conditions and identifies as high risk through risk stratification tool will be on the Community matron caseload. GP LES in place supporting risk stratification.
As part of the GP contract for 2014, the GP practices are identifying the accountable GP for the over 75s and those patients identified with complex needs. The risk stratification tool is being used by practices to identify those patients that need a care plan.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

Risk stratification will identify patients in need of case management supported by community matrons, practice attached community navigators who are supported by a database of available community, voluntary sector and neighbourhood support.

Data is not yet readily available to identify the proportion of individuals at high risk who already have a joint care plan in place.

Care Line provides holistic information for care and refers all requests for service to SEQOL. Detailed advice and information for service users is in place through My care, My Support. SEQOL provide joint community health and social care teams and there is a single assessment process already in place with a single SEQOL professional allocated to meet health and care needs.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Our service users, patients, carers and public have been involved in the run up to, and the complete development of the better care fund plan. We have involved each group in different stages of the above commissioning cycle by:

1. Seeking feedback on new and current plans (such as the health and well-being strategy, the CCG five year strategic plan 2014-19, two year operational plan 2014-16, and the joint commissioning plan. Each consultation reports how plans have been adapted and improved through meaningful local engagement with all stakeholders. All consultation materials is published on the CCG website and advertised through a range of meetings and electronic channels to return feedback from a range of groups and public.
2. Planning and designing our clinical service redesign workshops (carers support / ambulatory and urgent care / mental health) with our local patients and representatives. The agenda for each workshop is set by patient groups and representatives and the action plans from each workshop have informed the development of the Better Care Fund plan. In July 2013, in response to A Call to Action, we accelerated this redesign programme and developed it further to include the six emerging themes: prevention, mental and physical health and wellbeing, learning from the best, putting the patient in control, developing and testing future scenarios, and enhancing the quality of life for people with long term conditions.
3. Seeking wide representation of local groups and patients to take part in the CCG's PPI sub-committee, this group provides continual positive challenge and improvement to the way we operate, and engage with our local population. It seeks to assure the Governing Body that the CCG is effectively engaging with a wide range of groups and individuals.
4. Working closely with our local GP Patient Participation Groups (PPG), to seek feedback on healthcare in Swindon for primary care users, and their experience of hospital, community and mental health services in Swindon.
5. Driving awareness and education by supporting both national and locally defined health awareness campaigns based on the SBC and CCG clinical priorities. This includes a health education program which the CCG is seeking to deliver to help its service users and carers adapt to the new challenges of health conditions, and to improve their ability and confidence to self-care.
6. Listening to our providers and third sector groups, as a result of this we are seeking to increase the access to services, examples include working closely with the carer's centre in Swindon regarding the rollout of the better care fund and the development of a CQUIN with SEQOL to target the hard to reach populations of Swindon i.e. the Goan population. Feedback from service users and the voluntary and community sector for adult social care has led to priorities for:

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

In response, My Care My Support was developed with service users as well as the development of the advice and information service. Personalisation training has been held with staff. Support to carers was increased through a new contract and additional funding. The carers' assessment was simplified and supported with access to short term breaks.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

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

- Health & Well-Being Strategy
- The 5 year Strategic Plan 2014 – 2019 for the CCG
- The Commissioning Intentions 2014/15, which have been discussed with providers and have been developed jointly with Swindon Borough Council;
- The Joint Commissioning Plan which brings together the priorities for both the CCG and Swindon Borough Council. The priorities of this plan have also been shared and discussed with the voluntary and community sector.

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

This Plan covers 95% of the amounts transferring in 2014 and 2015 in detail, which funds will transfer to Swindon Borough Council to be part of a new pooled budget under a S75 agreement. Discussions are on-going with other LAs regarding their plans and the amounts to transfer. The £12.675m in the attached Better Care Plan is the ***total*** transferring into the Better Care Plans of all of the LAs who provide social care for Swindon CCG's registered population and also includes amounts that will transfer from sources other than CCGs e.g. the disability grant. It does not include any amounts that will transfer from other CCGs to Swindon Borough Council as these amounts have yet to

be notified to the CCG.

ii) Primary care providers

The 26 GP practices have been engaged in the development of the CCG Strategic plan and in the development of the SUCCESS programme and have sought their participation in the community navigator project and how the additional resource made available to support the management of over 75s.

iii) Social care and providers from the voluntary and community sector

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

A workshop with carers, the carers centre was held to develop a future action plan for carers. A workshop was also held with mental health providers in the voluntary and third sector and older people's organisations to shape the tender for mental health services and befriending services for older people.

Workshops with a large group of voluntary and third sector providers were held to shape the 2 year and 5 year CCG Plan and suggestions incorporated into the 2 year plan and BCF, particularly on reducing isolation amongst older people and support for carers

Providers of residential and nursing care regularly meet with commissioners to improve the quality of services. As a result two nursing homes are piloting IV fluids to prevent hospital admissions. Dementia training has taken place in care homes and providers across Swindon. Further work will be undertaken during 2014/15 with community based support and residential and nursing services to develop services further, with a more outcomes focussed care plan, reducing the incidences of challenging behaviour and additional 1:1 support being used to improve outcomes for users of the services

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The main acute provider for the CCG is Great Western Hospitals NHS Foundation Trust. The programme of work which includes the schemes identified as being funded by the Better Care Fund and the programme of interventions to transform services in Swindon will have an impact on the activity that will be delivered in Great Western Hospital. The contract negotiations for 2014/15 with GWH are identifying approximately £4m of activity being withdrawn from GWH, £2m is attributable to Urgent Care and £1m to Self Care interventions. The remainder is linked to Planned Care interventions. The urgent care schemes include the SUCCESS programme; GP and nurse led urgent care centre; GP at scene and 'hot tots'. The main project associated with self-care is the project implementing community navigators across Swindon working with individuals identified from the risk stratification tool held in General Practice. A pilot has been operational in 2013/14 which has already been identified as delivering savings.

Although activity is expected to reduce in the acute sector in terms of emergency admissions; re-admissions and A&E attendances there will be an impact on the voluntary sector; primary care; and community services in that these will be commissioned to provide additional services or the delivery of services using a different approach to current provision. In the event that the proposed schemes do not deliver they will be decommissioned to fund the over-performance in the acute sector.

We seek to reduce emergency admissions to hospital by increasing provision in the community. Swindon faces significant population growth over the next 10 years as the data below shows.

The two schemes funded from the Better Care Fund which will have the greatest impact on Great Western Hospital are the community navigators and the SUCCESS programme. These should both support the reduction in A&E attendances and in emergency admissions.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no. 1
Scheme name Crisis, rapid response and integrated care
What is the strategic objective of this scheme?
• Reduction in emergency admissions by having 24/7 access support to social care at a time of crisis • Reduction in admissions to residential and nursing care through access to social work services and packages at a time of crisis and 24/7
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
• Single point of access to crisis support provided by SEQOL and based at Great Western Hospital. The team is staffed by qualified nurses and social workers as well as health and social care assistants. A telephone triage services directs referred to the correct professional. Immediate access to assessment, crisis beds, care packages and overnight crisis support. • This service is part of the integrated health and social care services provide by SEQOL
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioner: Swindon Borough Council, Provider: SEQOL with links to Great Western Hospital (GWH)
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Crisis support as part of the Single Point of access is regarded as good practice nationally so that social care service users can be supported as quickly as possible avoiding admission to permanent residential care and hospital.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan **£737,100**
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Reduction in hospital admission Reduction in admission to residential care
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Monthly joint contract performance meeting with SEQOL and CCG, escalation of issues to Strategic Resilience Forum Quarterly report to Joint Commissioning Board
What are the key success factors for implementation of this scheme?
Existing scheme funded from NHS Transfer to LA

Scheme ref no. 2
Scheme name: Enhanced reablement service and telecare
What is the strategic objective of this scheme?
• Reduction in admissions to residential and nursing care through access to reablement services • Reduction in delayed discharge and thereby improving patient flow and reducing re-admission rates
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
• Our reablement service has two elements, a domiciliary service and a residential placement service, both are commissioned and provided through Seqol, who provide a reablement domiciliary care service in peoples own homes to help people regain skills lost through injury or illness. • Single integrated reablement service staffed by OT, health and domiciliary care workers. The service is located at GWH close to SWICC (Intermediate care Centre – step up, step down). Additional funding means that the service now operates 7 days a week and has additional staffing for winter pressure. • The service is targeted at patients discharged from hospital to home where a package of support is likely to reduce the need for long term care and residential care
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioner: Swindon Borough Council, Provider: SEQOL with links to Great Western Hospital (GWH)

The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Reablement services have been successful in reducing the need for long term care packages by enabling individuals to regain their skills. Our reablement domiciliary service supported a total of 278 adults during the year, compared to 225 in 2012/13. The majority of people supported with reablement are aged 75 or over, with only 5% of people aged between 18-64. This prevention service is mainly targeting people who do not already have services in place, aiming to reduce the need for mainstream care for longer. Of those that had no services to start with (221), 84% needed no long term package following their reablement episode. This shows this prevention service is achieving the right outcomes in helping them maintain their own independence for as long as possible.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan **£799,800**
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Reduction in hospital re-admission Reduction in admission to residential care Reduction in delayed discharge
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Monthly joint contract performance meeting with SEQOL and CCG, escalation of issues to Strategic Resilience Forum Quarterly report to Joint Commissioning Board
What are the key success factors for implementation of this scheme?
Existing scheme funded from £524k NHS Transfer to LA, £175k CCG

Scheme ref no. 3
Scheme name: community capacity
What is the strategic objective of this scheme?
• Reduction in admissions to residential and nursing care through access to community based support • Reduction in emergency hospital admission

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

- All voluntary sector contracts across the CCG and Swindon Borough Council are joint for mental health and vulnerable adults.
- The model of care is community based support through the third and voluntary sector promoting health and well-being, mental health, support for people with a learning disability, befriending and reducing social isolation. In particular we will commission voluntary and community based support linked to localities and GP practices. Supporting volunteers reduces the need for some targeted and specialist services. Community and voluntary sector groups provide important flexible services either informally or as part of local strategy. Voluntary sector organisation providing advice and support, promoting mental well-being, advocacy, support for carers and support planning for those with a direct payment are co-located in the centre of Swindon. This also gives the opportunity for health checks in addition to advice and information
- All services are aligned to the CCG Strategic Plan and the adult demand Strategy.
- The role of the community navigator will be to coordinate a holistic pan for patients at high risk of hospital admission. A plan is put in place with the support from various sectors and agencies to deliver this package of assistance. Patients with long term conditions are identified through risk stratification which is in place in all GP surgeries. Community navigators are now being piloted in 4 GP practices from January 2014. Roll out to further practices by April 2015.
- To support the above, the second strand of the project and meeting the Care Act requirements, is the development of a single database **My Support, My Care** that can be accessed by the patient and the link worker in assembling the package of support.
- Targeted support is commissioned form the council's Locality team to pilot Circles of support for older people and carers in order to reduce social isolation. A dedicated befriending service will be commissioned in 2015

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioner: Swindon Borough Council, CCG
Provider: voluntary and third sector

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There is extensive evidence from Think Personal Act Locally that investing in community capacity and self-help increases the resilience of individuals to improve their health. Swindon is building on evidence from NE London on community navigators and has included this in the development of well-being co-ordinators in the recent tender of community mental health services provided by the third sector. Circles of support is funded by NESTA to develop community resilience and capacity through supporting older people on low care packages

Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan £ 1.1m BCF with an additional £1.5m from Swindon Borough Council core budget added to the BCF
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Reduction in hospital re-admission Reduction in admission to residential care
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Monthly joint contract performance meeting with voluntary and third sector, escalation of issues to Strategic Resilience Forum Quarterly report to Joint Commissioning Board
What are the key success factors for implementation of this scheme?
Existing scheme funded from £ 100k NHS Transfer to LA and existing commitments. Good networks of voluntary sector provision will be key to success as well as co-location of the sector

Scheme ref no. 4
Scheme name: residential reablement and discharge to assess
What is the strategic objective of this scheme?
• Reduction in admissions to residential and nursing care through access to reablement services • Reduction in delayed discharge and thereby improving patient flow and reducing re-admission rates
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
• This is the residential and discharge to assess part of our reablement service, provided through Seqol, who provide a reablement domiciliary care service in peoples own homes to help people regain skills lost through injury or illness. • The service is targeted at patients discharged from hospital to assessment beds. It offers temporary placements to support those in need of a slower more intensive episode of support. This element of reablement has only been in place since the

beginning of the 2014 and now has 19 beds. Additional beds are accessed in the private nursing sector during winter pressures

- The service is targeted where a package of support is likely to reduce the need for long term care and residential care

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioner: Swindon Borough Council,
Provider: SEQOL

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Reablement services have been successful in reducing the need for long term care packages by enabling individuals to regain their skills.
The residential reablement service is new this year & supported 37 people in total to regain their independence. 89% of people were aged 75 or over, & again the majority (26 people) had no mainstream services prior to their episode of reablement, and of them 22 or 59.5% needed no mainstream service following.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
£387,000

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Reduction in hospital re-admission
Reduction in admission to residential care
Reduction in delayed discharge

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Monthly joint contract performance meeting with SEQOL and CCG, escalation of issues to Strategic Resilience Forum
Quarterly report to Joint Commissioning Board

What are the key success factors for implementation of this scheme?

Existing scheme funded from £387k NHS Transfer to LA,

Scheme ref no. 5
Scheme name: Enhanced Hospital discharge
What is the strategic objective of this scheme?
• Reduction in admissions to residential and nursing care through access to reablement services • Reduction in delayed discharge and thereby improving patient flow and reducing re-admission rates
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
• We will continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible. We will ensure access to brokerage and verification services so that there is speedy access to social care packages seven day a week. Integrated discharge team comprising of health and social care is in place. Since September 2013 a Discharge Assessment and Referral Team (DART) has also been in place to avoid admission and discharge as early as possible. Both services operate 7 days a week and work closely with hospital clinicians. We will be reviewing home from hospital support so that any delay is avoided and a community support package is in place. The Virtual ward will be working closely with the hospital discharge services and the Single Point of access to both avoid admissions and enable speedy discharge. Additional funding for care packages will be available to enable speedier discharge. Adult social care will be working 7 days a week as part of the Integrated Hospital discharge team and DART.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioner: Swindon Borough Council, Provider: SEQOL
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Integrated hospital discharge is regarded as good practice. The team is located within GWH and is implementing the relevant findings from the recent ESIS review. Adult social care commissioning works closely with the teams to ensure that there is no delay in accessing adult social care packages
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£1.226m
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Reduction in hospital re-admission Reduction in admission to residential care Reduction in delayed discharge
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Monthly joint contract performance meeting with SEQOL and CCG, escalation of issues to Strategic Resilience Forum Quarterly report to Joint Commissioning Board
What are the key success factors for implementation of this scheme?
New scheme funded from NHS Transfer to LA, recruitment of staff and 7 day working to facilitate speedier hospital discharge. GWH to start discharge planning as part of admission to hospital

Scheme ref no. 6
Scheme name: Learning disability
What is the strategic objective of this scheme?
• Reduction in admissions to residential and nursing care through access to community based support •
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
We will re-commission services by shifting towards supportive living model by stimulating local market and expanding both occupational and educational opportunities. A project team is in place from January 2014. There are currently 234 people living in residential care at a cost of £14m per annum. 32 young people aged 18 – 30 are living in residential care as of March 2014. In 2014/15 we will be reviewing all 32 young people and identify those to be supported in community based living in Swindon and develop transition plan for them to be implemented in 2015/16. A good practice shared lives scheme and supported housing for people with a learning disability is already in place. Additional social work capacity has been recruited to undertake reviews. Commissioning has identifies additional programme management resource to support the implementation of this work

The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioner: Swindon Borough Council, CCG Provider: SEQOL
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Comparator data shows that Swindon is a high spent area for learning disability spending on average an additional 23% per head of population on learning disability packages. This is due to high numbers in residential care. New admissions of people under 65 to residential care have reduced to below the national average. Supporting people locally means links with communities and families are maintained. We will therefore be investing in locally based support
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan **£1.083m**
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Reduction in hospital re-admission Reduction in admission to residential care Reduction in delayed discharge
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Monthly joint contract performance meeting with SEQOL and CCG, escalation of issues to Strategic Resilience Forum Quarterly report to Joint Commissioning Board
What are the key success factors for implementation of this scheme?
New scheme funded from NHS Transfer to LA and CCG baseline, recruitment of social workers has taken place. Capacity planning important to ensure actions from reviews are implemented

Scheme ref no. 7
Scheme name: Carer Support
What is the strategic objective of this scheme?

- Reduction in admissions to residential and nursing care through access to support carers
- Reduction in delayed discharge and thereby improving patient flow and reducing re-admission rates

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

- A joint carer's contract is already in place which was tendered in 2012/13. The Carers centre provides advice and information for carers, welfare benefits advice as well as support groups. Young carers support is provided by the same voluntary organisation and was part of the same tender. Outcomes for carers continue to improve. Additional investment was made available in April 2012 for short term breaks for carers and the investment has been maintained. Development of improved assessment process for carers and improved access to health checks. The carers centre has a number of full time, part time and volunteer staff. There is now a GP liaison service and carers champions in GP surgeries. As part of the BCF we want to improve the number of carer assessments, short term breaks and hospital discharge through a dedicated resource.
- All carers are targeted through this service which will be co-located with other voluntary sector service sin the centre of Swindon

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioner: Swindon Borough Council, CCG
Provider: carers centre and private sector

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

.
Extensive national research is available to support the evidence base for carer support. Carers' assessments support personalisation, helping to maintain the independence & resilience of service users and their carers being supported within the community.
As well as the two main providers, the Swindon Carers Centre complete assessments, which are then validated by an SBC care manager.

The target for the year was 30% Although we achieved just below at 29.2% which equates to 1374 carer's assessments being completed. In addition to these, 3.8% of carers were offered but declined an assessment during the year.
Therefore we will be providing on line and face to face support to increase the number of carers assessments which are completed each year and thereby increasing appropriate support

Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan **£806k**
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Reduction in hospital re-admission Reduction in admission to residential care Reduction in delayed discharge
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Quarterly performance meeting with carers centre, escalation of issues to Strategic Resilience Forum Quarterly report to Joint Commissioning Board
What are the key success factors for implementation of this scheme?
Existing scheme funded from NHS Transfer to LA and CCG allocation

Scheme ref no. 8
Scheme name: Capital grant adult social care
What is the strategic objective of this scheme?
• Reduction in admissions to residential and nursing care through access to support • Reduction in delayed discharge and thereby improving patient flow and reducing re-admission rates
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Capital allocations fund the joint Integrated Community equipment Store for children and adult services as well as investment in telehealth and telecare. We will continue investment in technology to support self-care and prevention and enable for this a disability to live as independently as possible.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioner: Swindon Borough Council

Provider: SEQOL
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
. Capital required to ensure equipment to support hospital discharge and maintain people living at home is in place
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan **£926k**
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Reduction in admission to residential care Reduction in delayed discharge
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Monthly contract performance meetings with SEQOL, escalation of issues to Strategic Resilience Forum Quarterly report to Joint Commissioning Board
What are the key success factors for implementation of this scheme?
Existing scheme funded from capital allocation

Scheme ref no. 9
Scheme name: Care act implementation
What is the strategic objective of this scheme?
• Reduction in admissions to residential and nursing care through access to support
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
. We will be implementing the required systems under the health & Social Care Bill and prepare systems for an increase in financial assessments and self-assessments.

Wherever possible we will be investing in new technology to automate processes as quickly as possible. We will focus on • On line assessment • Carers assessment • Increased advocacy for older people • Advice and information and promotion of well-being • Deferred payment scheme • Preparation for changes to financial support
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioner: Swindon Borough Council, Provider: SEQOL, voluntary and third sector
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
. Statutory requirements of care Act 2014
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan **£460k**
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Reduction in admission to residential care
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Monthly contract performance meetings with SEQOL, escalation of issues to Strategic Resilience Forum Quarterly report to Joint Commissioning Board
What are the key success factors for implementation of this scheme?
New scheme, project management support for implementation of new guidance, ICT infra-structure, work force development

Scheme ref no. 10
Scheme name: Virtual ward and intermediate Treatment

What is the strategic objective of this scheme?
• Reduction in hospital admissions • Reduction in delayed discharge
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
. Virtual Ward, Intermediate Treatment beds (SWICC), Hospital discharge services and 7 day working for clinicians, single point of access •
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioner: CCG Provider: SEQOL,
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan **£**
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Reduction in emergency admission to hospital and improved delayed discharge
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Monthly contract performance meetings with SEQOL, escalation of issues to Strategic Resilience Forum Quarterly report to Joint Commissioning Board
What are the key success factors for implementation of this scheme?

Scheme ref no. 11
Scheme name: community health aimed at reducing emergency admissions
What is the strategic objective of this scheme?
• Reduction in admissions to residential and nursing care through access to support
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
. •
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioner: CCG Provider: SEQOL
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan **£800k**
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Reduction in admission to residential care
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Monthly contract performance meetings with SEQOL, escalation of issues to Strategic Resilience Forum Quarterly report to Joint Commissioning Board
What are the key success factors for implementation of this scheme?
New scheme, project management support for implementation of savings schemes, work force development so that community based resources are used to maximum capacity

Scheme ref no. 12
Scheme name: Managing increase in demand for adult social care
What is the strategic objective of this scheme?
• Reduction in admissions to residential and nursing care through access to support
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
. • Increase in care packages due to demographic pressure leading to reduced length of stay in hospital. Work with residential and nursing providers to increase access to health care within homes so that admissions to hospital reduce • Modelling showing due to population changes explained din section 3, an additional 60 older people per year in need of adult social care services and 30 people with a learning disability. The local authority is targeting work in learning disabilities to reduce demand and ensure efficient and effective delivery. This is planned to mitigate against demand by £3.2m for 2015/16. This additional funding of £800k from BCF is to ensure eligibility criteria can be maintained.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioner: Swindon Borough Council, Provider: SEQOL, voluntary and third sector
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
. Section 3 outlines the increase in population of older people and those with long term conditions which will increase demand for adult social care
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan **£800k**
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Reduction in admission to residential care
Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Monthly contract performance meetings with SEQOL, escalation of issues to Strategic Resilience Forum Quarterly report to Joint Commissioning Board
What are the key success factors for implementation of this scheme?
New scheme, project management support for implementation of savings schemes, work force development so that community based resources are used to maximum capacity

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Swindon
Name of Provider organisation	Great Western Hospitals NHS Foundation Trust
Name of Provider CEO	Nerissa Vaughan
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	19971
	2014/15 Plan	19610
	2015/16 Plan	18919
	14/15 Change compared to 13/14 outturn	691
	15/16 Change compared to planned 14/15 outturn	361
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	686 Q4 2014/15 – Q 4 2015/16

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	

Payment by result targets based on data supplied by NHS England with pre populated baseline activity

Non - Elective admissions (general and acute)

Metric		Baseline (14-15 figures are CCG plans)			
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	**2,384**	**2,078**	**2,116**	**2,457**
	Numerator	5,175	4,510	4,592	5,333
	Denominator	217,059	217,059	217,059	217,059

Pay for performance period				
Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
2,273	**1,981**	**2,017**	**2,342**	**2,167**
4,993	4,351.00	4,430.00	5,145.00	4,817.00
219,656	219,656	219,656	219,656	222,299

P4P annual change in admissions	*-691*	
P4P annual change in admissions (%)	*-3.5%*	
P4P annual saving	*£1,029,590*	**£1,490**

Residential admissions

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	**744.7**	**742.6**	**736.8**
	Numerator	225	240	245
	Denominator	30,345	32,319	33,253
		Annual change	*15*	*5*
		Annual change (%)	*6.7%*	*2.1%*

Reablement

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	**94.0**	**96.9**	**96.9**
	Numerator	65	63	63
	Denominator	65	65	65
		Annual change	*-2*	*0*
		Annual change (%)	*-3.1%*	*0.0%*

Delayed transfers of care

Metric		13-14 Baseline			
		Q1 (Apr 13 - Jun 13)	Q2 (Jul 13 - Sep 13)	Q3 (Oct 13 - Dec 13)	Q4 (Jan 14 - Mar 14)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	**844.9**	**867.7**	**911.1**	**872.7**
	Numerator	1,403	1,441	1,513	1,472
	Denominator	166,064	166,064	166,064	168,678

14/15 plans			
Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)
843.0	**867.3**	**910.6**	**872.5**
1,422	1,463	1,536	1,490
168,678	168,678	168,678	170,776
		Annual change	*82*
		Annual change (%)	*1.4%*

Appendix 1

15-16 plans			
Q1 (Apr 15 - Jun 15)	**Q2 (Jul 15 - Sep 15)**	**Q3 (Oct 15 - Dec 15)**	**Q4 (Jan 16 - Mar 16)**
842.6	**867.2**	**910.0**	**872.2**
1,439	1,481	1,554	1,507
170,776	170,776	170,776	172,776
		Annual change	*70*
		Annual change (%)	*1.2%*