Appendix 1

Great Western Hospitals NHS
NHS Foundation Trust

Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

South Western Ambulance Service NHS
NHS Foundation Trust

Swindon Clinical Commissioning Group

Integrated Health and Social Care Operational Resilience & Capacity Plan 2014/15

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Integrated Health and Social Care Operational resilience and capacity plan 2014/15

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1 Introduction

1.1 The Operational Resilience and Capacity Planning (ORCP) guidance published in June 2014 clearly sets out the expectations required of health and social care commissioners and providers to continue to plan for all year round planning and resilience. They need to ensure the plan is delivered while maintaining financial balance with no-trade-off between finance and performance. The guidance also calls for plans to be developed around both urgent and planned care. This brings together a single planning process and underlines the importance of whole system resilience to ensure the system operates as effectively as possible.

1.2 Recognising the success of Urgent Care Working Groups (UCWGs) the guidance calls on the groups to build on their success and expand their remit- they are to evolve into System Resilience Groups (SRG).

1.3 The System Resilience Group is a whole system network designed to bring together multiple stakeholders to undertake the regular planning of service delivery. The group should plan for the capacity required to ensure service delivery, and oversee the coordination and integration of services to support the delivery of effective, high quality accessible services. It will enable all parts of the local health and social care system to co-develop strategies and collaboratively plan safe, efficient services for patients.

1.4 The work being undertaken by local systems and the outputs from the Urgent and Emergency Care Review (Keogh, 2013) is setting the groundwork for the longer term changes to strategic and operational delivery. The CCG and other local stakeholders have attended regional roadshows this summer, and these have enabled commissioners and providers to contribute to the future design and plans for Urgent Care networks. With the second phase of the review due to be published in Autumn 2014, greater clarity of the future of urgent and emergency care will emerge.

1.5 Swindon CCG through the Urgent Care Working Group and now evolving SRG has worked with it's partners to meet all expected requirements and subsequent actions from the ORCP guidance. This plan will continue to be developed over the next few weeks as we further review our demand and capacity analysis; develop our agreed QIPP interventions and revise our Better Care Fund plan.

1.6 Both a local and NHS England Area Team wide 'Winter lessons learnt event' was held in May 2014 with all key partners to critically assess and share with each other what went well, key challenges and recommendations for improvement. The learning from this has led to agreement and sign up to a number of changes in both process and systems that should release capacity in the system and provide alternative services where appropriate in the community and primary care setting, plus bring consistency in practice. The changes have also been informed by a review from the Emergency Care Intensive Support Team (ECIST) within Great Western Hospital (GWH) which took place in the spring.

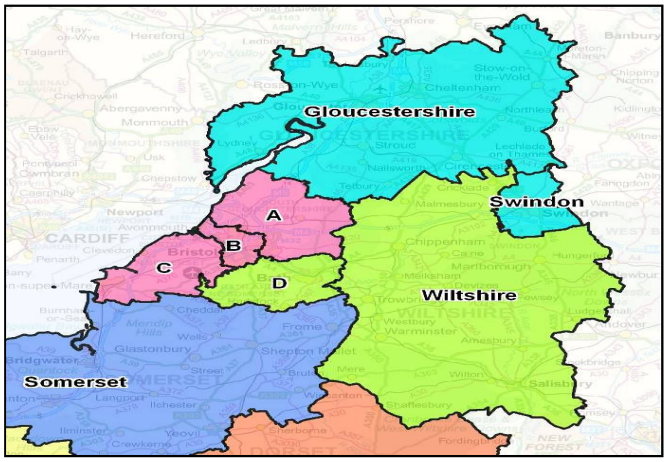
1.7 As part of 2013/14 Winter review NHS England committed to lead a piece of work looking at workforce planning across wider health economies and Swindon are keen to be partners in taking this forward. A key challenge relates to recruitment and the need to ensure staff are trained and confident to work in a range of care settings particularly as the development of new care pathways in settings closer to people's homes are commissioned and implemented.

2. Context

2.1 Population and Geographical context

2.1.1 Swindon CCG covers a population of 226,000 people registered with 26 practices in and around Swindon including those served by the Elm Tree Surgery in Shrivenham in the county of Oxfordshire.

2.1.2 The CCG is coterminous with the unitary local authority, (Swindon Borough Council) supported by a single acute trust (Great Western Hospital NHS Foundation Trust), an integrated community health and social care provider (SEQOL), one urgent care ambulance provider (South Western Ambulance Service); one mental health provider (Avon and Wiltshire Mental Health Partnership NHS Trust) and a network of voluntary organisations.



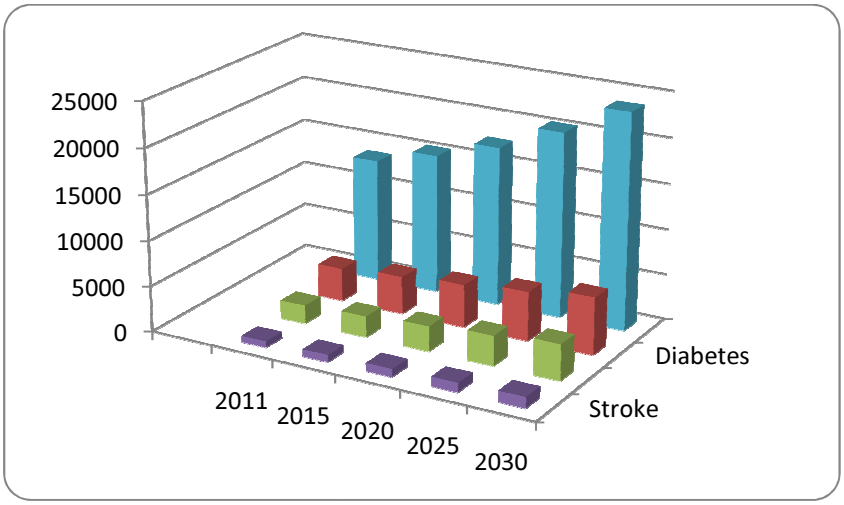
2.1.3 The catchment area for GWHFT has seen an increase in flow of patients from the Gloucestershire and Oxfordshire area. The hospital sits strategically next to two major road system the A419 and M4. Thus making attendance and conveyance easier to and from the hospital.

2.1.4 The 2011 Census saw Swindon buck the national trend (which saw population estimates revisited downwards in many parts of England). Population growth continued at the same pace overall in Swindon with an average of 1.3-1.4%

per annum. At the local plan enquiry in December 2013, the estimates for future population in Swindon were considered by the Inspector to be potentially understated by as much as 7,000 people (a further 1.83% growth by 2019).

2.2 Projected demand Growth

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



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

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

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

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

- Managing long term conditions differently in primary care through investment in urgent care centres and home visiting that will release primary care time
- Investment in greater community support for individuals and households to help the development of self-care and coping strategies
- Investment in health promotion and prevention
- Greater coordination of and better navigation to the voluntary, primary care and community support that exists

- Placing the patient in control of their condition through access to better information about conditions using web and social media and also investing in expert patient programmes and peer support networks

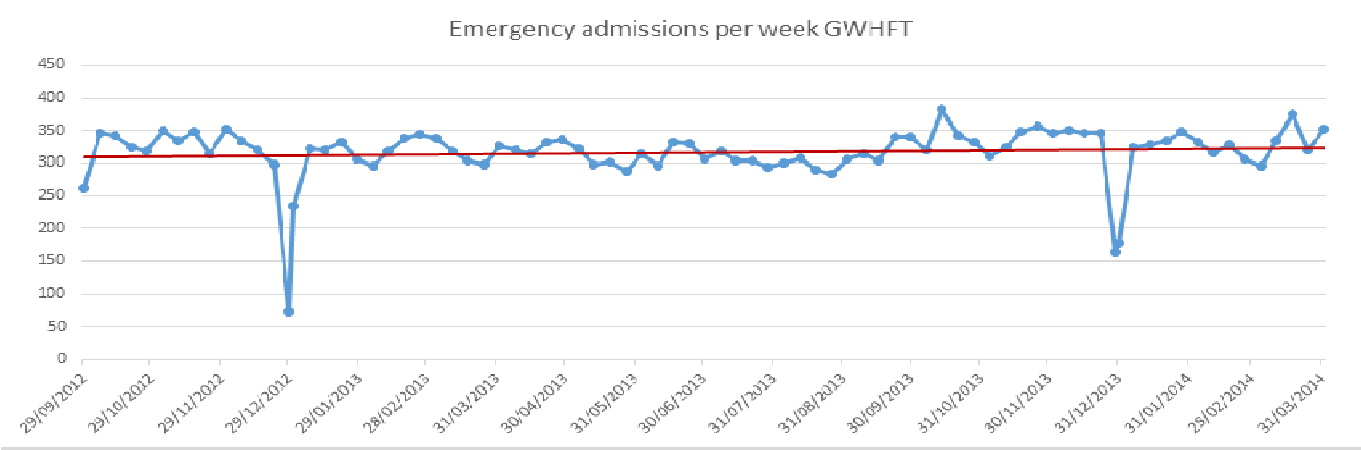
Long term conditions are being managed in primary care by GPs and their teams, including practice and district nurses. However, not all patients receive the same level of care nor are achieving the same level of outcomes and the volume of urgent care is saturating all of our member practices, reducing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

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

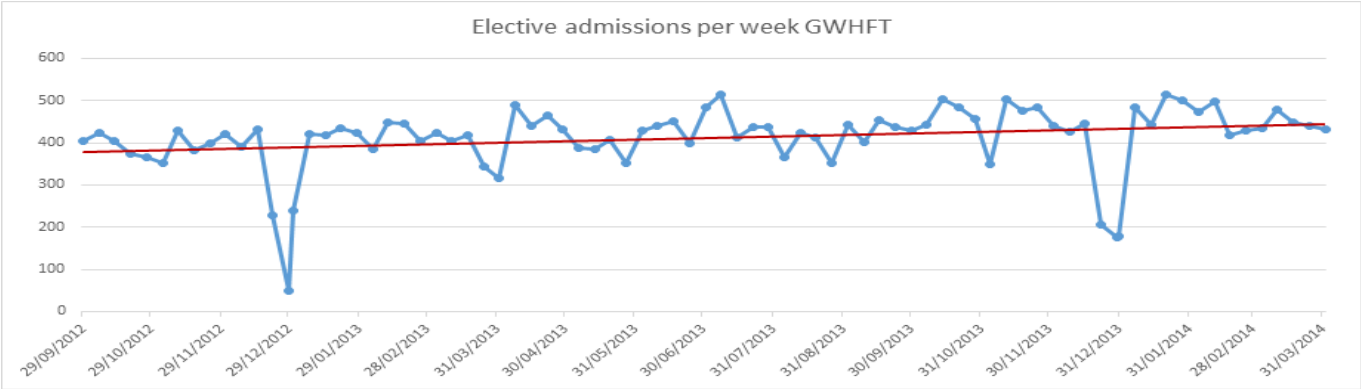
People who have long term conditions can also have reduced mobility and thus become housebound or isolated. This can lead in turn to depression, anxiety and frailty. We will therefore develop a dedicated home visiting service as part of our SUCCESS programme, work with local communities and the voluntary sector to avoid isolation within our communities, and with primary care and community teams to support people's physical and mental health needs. The SUCCESS programme will also release GP time to spend more with patients who have a LTC or requires more intense assessment of need that would enhance self-care management or support patients at the end of life.

2.3 Trends in hospital admissions

The Joint Strategic Needs Assessment (JSNA) in 2012 identified growth in the number of admissions in Swindon. It did not differentiate between **unplanned** admissions and **planned** admissions. More importantly, it forecast a growth in emergency admission rate based on the last ten years. Since then, the CCG has had the opportunity to incorporate and quantify that analysis. Furthermore, the CCG also has trend analysis for 2013-2014 as the most recent trend gauge which has been effected by the acute care pathway interventions. The resulting message is very different from that within the 2012 JSNA and has changed the focus of our strategy towards the levels of urgent care within primary care, our GP referral rate, and our planned admission rate as a consequence.



Historically, in the period 2007-2011, Swindon did see a reduction in emergency admissions, however more recently admissions trends are increasing. Our GP referral rate has averaged at around 5% in the period 2007-2014 and this has seen a growth in planned admissions at the same rate of approximately 5% per annum. Whilst the above figures are both still **below** the average for England, the overall impact is an annual growth in admissions at a slightly higher rate than our population growth, which is unsustainable in the long term.



Our *Five Year Strategic Plan* therefore sets out an ambitious programme of change for both acute referral management and also for the way we will commission elective secondary care consultation with much greater use of technology to allow specialist consultations and skill base to migrate to primary care and community settings, rather than within a secondary care setting.

2.4 Local context

2.4.1 This plan augments the Swindon CCG integrated winter plan for 13/14 which had been developed against a demand and capacity model for the Swindon and Shrivenham footprint. The plan also detailed the benefits of a number of schemes that would impact positively and support reduction in admission rates, reduce length of stay and Emergency Department (ED) attendance, with the overall result in freeing-up bed capacity. A number of these schemes carry over into 2014/15 with continued expectation they will deliver against planned benefits.

2.4.2 In March 2014 Great Western Hospital Foundation Trust (GWHFT) invited the Emergency Care Intensive Support Team (ECIST) to review the acute pathway and parallel elective capacity planning. ECIST collaboratively completed a twelve week programme scoping exercise and reviewed, not only the internal acute urgent care system, but a whole system walk through including community and primary care across Swindon and Wiltshire. Their recommendations are well evidenced good practice principles. In summary the Emergency Care Intensive Support review clearly demonstrated that the acute Trust provides a high quality service when there is flow in the system however it is vulnerable at times of increased activity, complexity and has a challenged discharge process complicated by different commissioned models potentially causing confusion and delays and is postcode dependant and not patient centred.

2.4.3 Delivering the 4 hour standard requires a whole system approach and a new way of working which needs to involve risk sharing and joint governance. This is being addressed through the System Resilience Group and Urgent Care Working Group, whilst recognising a number of the recommendations from the review are for GWHFT internal action and implementation.

2.4 4 The internal work focuses on the SAFER bundle and move towards 7 day working to reduce length of stay (LOS) and shift the discharge profile. It is recognised that early daily consultant review impacts on mortality by significantly improving flow, preventing crowding of the Emergency department and putting the right patients in the right beds by removing outliers and appropriate in reach to assessment areas.

2.4.5 The weekend discharge rate needs to be aligned to the weekdays to create enough capacity in the system for the full 7 days. The discharge peak needs to be brought forward from 5-7pm to 12-2pm to facilitate the admission peaks which are a critical success factor in maintaining flow. It was identified that there is a real opportunity to provide a fully integrated service with a wealth of skill set for all minor injury and illness. The current process was identified as being fragmented with duplication and many non-value adding steps such as dual streaming. ECIST strongly recommend that this service is reviewed to stream patients with minor problems away from the sick patients requiring emergency care. A good service aims to provide a see & treat model for all minor illness and injury utilising all the skill sets currently available in the urgent care centre and ED minors. This has been taken forward and is now the second phase of the fix me hub QIPP scheme as described in Interventions schemes.

2.4.6 The elderly care pathway requires a shared vision across the whole health economy supporting a “discharge to assess model of care”, ambulatory services and comprehensive plans that are communicated and agreed with the patient by the providers. Integrated health & social care is vital to support this model and joint decision making between GP’s and care of the elderly physicians/acute physicians requires robust communication networks and access to the patient notes.

2.4.7 The largest area where the ECIST felt the trust could free capacity is through ambulatory care by re-directing approximately one third of admissions through this

route. The Trust are currently engaged with the ambulatory care network to realise this capacity and the use of the resilience funding is supporting this shift.

2.4.8 In addition the ECIST review and subsequent feedback to all stakeholders identified a number of key areas that would benefit are being addressed. They include:

- Review each of the urgent care work streams to have representation of stake-holders.
- Strengthen the sharing between CCGs of commissioning intentions for urgent care to reduce variation of pathway development and postcode differences in service response.
- Review the governance arrangements to support pathway implementation when more than one organization is commissioned to provide elements of care within the pathway or service.

2.4.9 The ECIST team have continued to work with commissioners and providers to take this forward and continues to support and advice as the system implements their recommendations.

3. Governance

3.1 Swindon CCG Urgent Care Working Group and the Strategic Change Forum has considered the guidance and agreed to work together to achieve whole system resilience . It has therefore been agreed for the Strategic Change Forum to become the new System Resilience Group and take on the key roles and responsibilities of the UCWG but for the UCWG to continue and to become a more operational delivery group to drive and implement the ECIST change programs and interventions. This also applies to the well-established elective care group.

SRG Terms of Reference can be found in **Annex 1.**

3.2 There was an established project scheme framework in place and following the ECIST review partners have refined this to incorporate the ECIST work streams, elective interventions and merge some of the urgent care change programmes.

3.3 In **Annex 2** the project management and intervention structure can be found showing the key work streams across urgent and elective care with its governance reporting. Both operational groups have clinical membership including GPs.

3.4 All members of the SRG and UCWG have been involved and engaged in all planning requirements resulting in extra meetings being held to review capacity and resilience plans.

3.5 The plan is to sign off the resilience plans and funding was signed off on 7th August 2014. Currently all proposed schemes have been received, joint meetings have taken place to prioritise schemes and clearly identify where schemes have single or whole system benefit.

4. Performance Arrangements

4.1 The SRG will receive monthly verbal and written reports through a performance dashboard of agreed KPIs clearly showing the impact of not only those schemes supported with the non-recurrent funding, but the performance of whole system KPI metrics. These metrics will go to the Swindon SRG on 2nd October 2014 for sign off.

4.2 The acute hospital and community performance is managed through the monthly contract meetings. Monthly quality and patient safety meetings take place one week prior to the main contract meeting and a report is presented at each of the contract meetings detailing any quality concerns, including all serious untoward incidents.

4.3 Quality Assurance is overseen by the Commissioning for Quality Group who will also report to the Urgent Care Working Group, particularly monitoring Hospital Standardised Mortality Rate (HSMR), Falls, Readmission rates, MRSA, C Diff, Norovirus, other Complications, Pressure sore incidence, Complaints, Wound care and Serious Untoward Incidents (SUI). This group reviews all quality related and patient safety information and a means by which we cross check and triangulate quality date and information. Any increases in particular in SUIs, complaints, infection targets or Hospital Standardised Mortality Rate will be reviewed to understand if they are the result of increased pressures on the systems.

4.4 In specific reference to the implementation of the urgent care centre and virtual hub, these are designed to improve access to urgent care by simplifying the system for both patients and staff. The implementation of the community wards is designed to support people with long term conditions to be 'the best they can be'. Performance management of the system will therefore include:

- Review of population based (whole and condition based) admission and attendance rates
- Consistency of assessment
- Consistency of clinical outcomes
- Shared information systems
- Implementation of a shared workforce development programme
- Improved quality of service delivery
- Improved patient experience

4.5 Daily sitrep reports on key performance metrics will continue to be monitored. This information can be used by the commissioners and performance managers to monitor pressure on capacity and fluctuations in demand. This allows potential difficulties to be identified in time to implement escalation across the health and social care community.

4.6 The following additional planning tools are used to inform staffing requirements and bed requirements (virtual or inpatient) across the system:

- GWH Emergency Admissions Prediction Report (daily). This provides detailed information about the number of patients expected to come in each day and has been praised by the site managers as extremely accurate. It is used in calculating the upcoming bed state and general site management, as well being able to determine the need to adjust staffing levels in the emergency and assessment wards.
- GWH Referral to Treatment (RTT) Demand Forecaster (updated every 3 weeks, looks 9 months ahead), predicting elective demand.
- Met Office Website Reports, which are used in conjunction with the above reports to calculate the effects of the weather on increased demand, for example, potential impact for respiratory services during a period of cold and wet weather.
- HPA Primary Care (weekly) Reports.
- Reports daily and weekly on infectious disease outbreaks and ward closures
- Weekly commissioner pressure reports
- Daily A&E and admission reports.

4.7 During August and September further work will be developed to use real time system wide data. The CCG have developed this for NHS 111, and both the CCG and GWHFT are in agreement to move towards the implementation of a real time bed flow system for the acute hospital and information on community activity should also be available from SEQOL.

5 Good practice- Non elective care pathways

5.1 Planning

5.1.1 Capacity Planning

The CCG commissioned the Central Southern Commissioning Support Unit to carry out a capacity and demand analysis of non-elective activity (NEL) over the past 3 years and forecast demand for the next 5 years.

This took account of growth based on ONS data (averaging approx. 1-1.3% per annum) and also QIPP/Interventions as per the CCG's Strategic Plan.

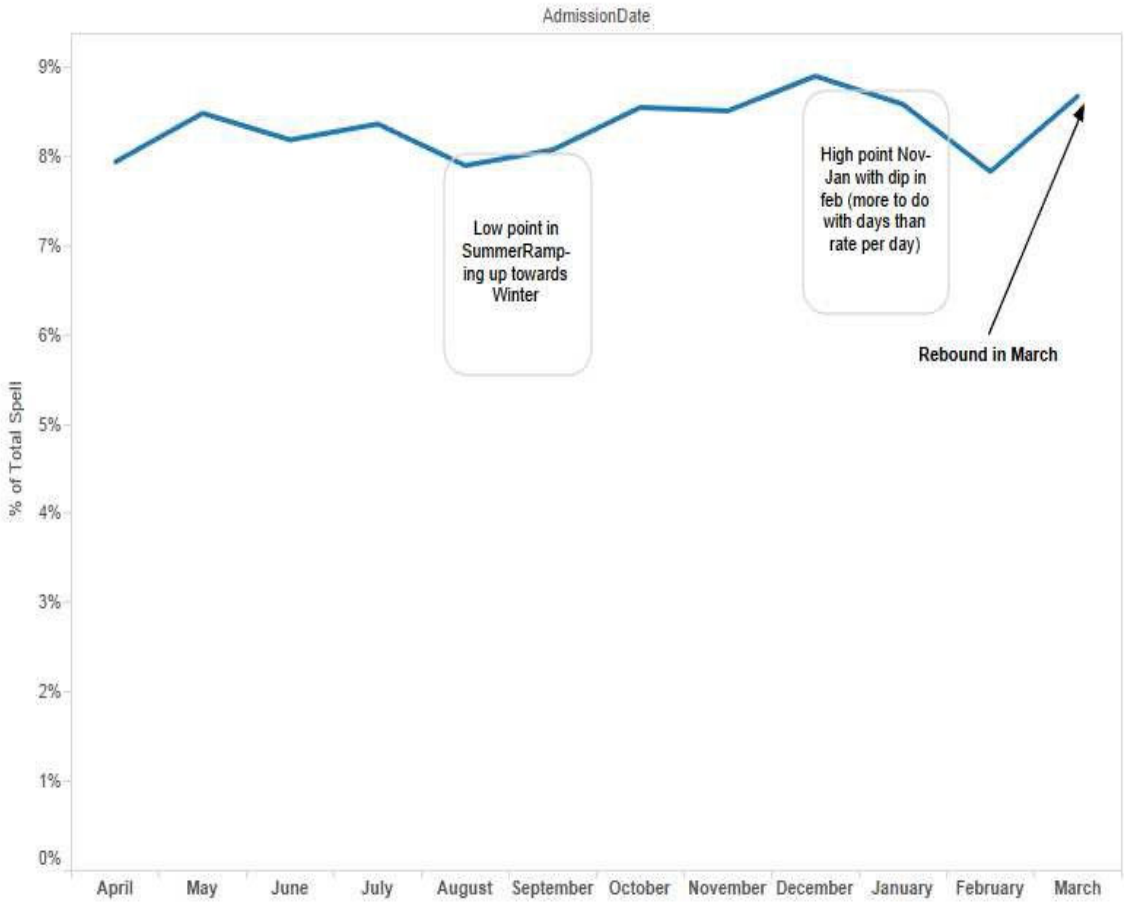
The results of this work indicated:

1. Swindon has a reasonably "normal" seasonality, with one slight exception, March figures sit as an anomaly and are close to December levels. (It could be expected to be a busier month than February purely due to days in the month. However, we would not expect March to exceed January as it does for Swindon).

2. The Dec-Jan 'hump' is due to more elderly patients being admitted in general medicine than expected

3. The March rebound is closely linked to an increase in paediatric admissions, on further investigation this is mainly in 2 HRGs:
   3.1 PA19A – Viral infections less than 1 day spell length
   3.2 PA11Z – Acute Upper respiratory infection and common cold.

4. Although the majority of specialities are within their capacity, General Medicine and Paediatrics cannot cover admissions within current bed capacity and given the demographic profile Swindon's population, this is highly likely to exasperate in future years.



5. Historically Swindon has seen a decrease in activity and impact of QIPP/Interventions should (if successful) equate to a saving of circa 50 beds in 5 years' time.

6. The capacity planning work focused on stroke services, because the Swindon health economy had identified the need to review this clinical pathway. The GWH has been receiving more stroke patients from outside of Swindon and more patients are surviving strokes resulting in additional demand for these services. It concluded that there is over utilisation of beds by stroke patients at SWICC: occupying 9 beds per day, compared to the 5 commissioned. Levels of demand indicated this could rise to 12 beds required in future years, based on number of patients expecting to need the service multiplied by demographic growth for Older People in Swindon.

   Further work will need to be undertaken to review the current pathway to improve the outcomes for these patients.

7. The following can be predicted to occur with some certainty based on previous winter peak periods:

(1) The standardised admission rate for secondary care will increase over the winter period driven by a combination of diseases and conditions such as COPD, heart failure, flu, pneumonia, dehydration, renal and gastric problems which are exacerbated by cold weather or known to be seasonal

(2) The above will be further aggravated by any growth in population particularly in children and the over 75 age group that is most vulnerable to complications arising from the above diseases

(3) Whilst the average position may change within reasonable tolerance limits, the size of any peaks will grow and their frequency will increase

(4) The Christmas and New Year bank holidays will see a build-up of demand in primary care and at the point of discharge, leading to a peak in demand coinciding with a time when patient flow is likely to be at its least effective given other pressures in the system

(5) Loss of beds due to an outbreak e.g. norovirus

(6) One or more neighbouring providers will encounter difficulties which could result in changes in the catchment population being supported by the local general hospital or diversions to our local Emergency Department

(7) Length of stay will increase in general medicine and trauma and orthopaedics mainly driven by a combination of:

   a. An increase in the dependency and co-morbidities of those presenting at hospital
   b. Deteriorations in patient flow (caused in turn by an increase in outliers and the use of escalation beds but also by an increase in readmissions and delays in discharge)

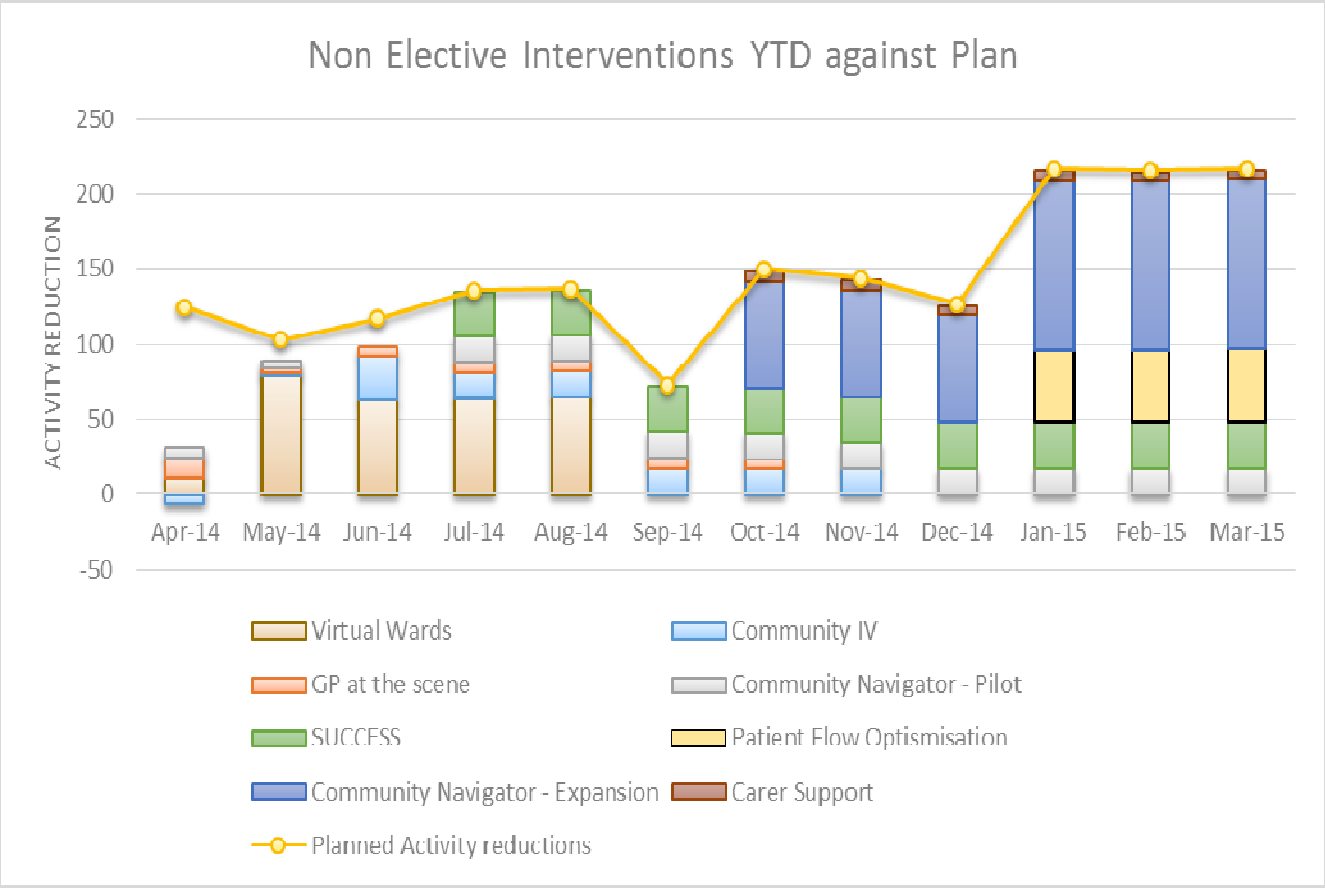
c. Bed occupancy increasing to the point where it takes longer than 6 days to recover to normality and each peak therefore combines with the previous peak

5.1.2 The net effect of the above is to increase the demand for medical beds, in particular, whilst reducing the effective use of each bed. The lack of availability of beds (or the alternatives), then sees patients needing to remain for longer periods in the Medical Assessment Unit and Emergency Department after a decision has been taken to admit. Once delays are experienced in discharges at the back door, then it this impacts on delays at the front door and onward flow through the hospital.

5.1.3 There are currently **487** beds at Great Western Hospital and in 2014/15 we have experienced the use of escalation beds continuing into spring. These have now been reduced during the second quarter of the year as GWH are focusing on reducing backlog of patients requiring elective treatment who are not meeting the 'RTT' targets. This has resulted in the removal of any escalation beds previously used within surgical care wards.

5.1.4 In 13/14 a number of QIPP schemes and new services were planned to reduce admissions, increase local capacity and improve patient flow, in order to deliver a range of 85 to 117 beds or their equivalent at GWH. In 14/15 the system has implemented a further range of QIPP schemes and Interventions again aimed at reducing demand particularly in NEL. These include the roll-out and refocusing of initiatives implemented during 13/14 such as Virtual Ward, GP at the scene, Community Navigator and Community IV and new proposals such as SUCCESS and optimising Patient Flow.

5.1.5 The graph below profiles the impact of the NEL Interventions in terms of activity reductions in GWH monthly during 2014/15. These will ramp up over the traditional winter period and it is expected that the latter 3 months of 2014/15 they will be reducing NEL activity by over 200 per month.



5.1.6 Swindon health system has been able to take advantage of additional national funding which has been earmarked to ensure services are being delivered in line with best practice as described in the 'Operational resilience and capacity planning' guidance issued for 2014/15.

5.1.7 It has therefore invested in a range of schemes across acute, community, social services, hospice and primary care and will be monitoring their performance closely to ensure intended benefits are realised and key performance targets achieved.

Description of scheme	Value	Key Benefits
Trauma Co-ordinators	£ 32,000	4 Hour Waits
SAFER & 7/7 DW in unscheduled care	£ 244,000	4 Hour Waits
ECIST Therapies at the front door	£ 189,000	Reducing Emergency Bed Numbers
7 day physio at front door	£ 129,000	4 Hour Waits
Frail Elderly Unit	£ 177,000	Reducing Emergency Bed Numbers
ECIST Ambulatory Care	£ 157,000	4 Hour Waits
Hospice at Home	£ 90,000	Reducing Emergency Bed Numbers
Continuation of Fix-Me Hub	£ 83,000	4 Hour Waits
SPA additional support to GPs	£ 50,000	Reducing Emergency Bed Numbers
	£ 1,151,000	

These schemes are aimed at ensuring the system successfully negotiates and manages winter. Swindon is aware of the characteristics of those systems that deliver and those tactics which exacerbate or aggravate the winter peak and that we will avoid in the next six months.

The ORCP takes all the below into consideration.

Characteristics of success in winter	
What works	**What does not work**
Implement additional capacity in advance of known peaks	Delay implementation in order to respond to peaks
	Open escalation beds in wards, day units or through temporary use of facilities such as endoscopy and theatre recovery
Accelerating discharge in the run up to the Christmas break	Having no plan for the purchase of additional nursing, residential and home care packages in November and December
Reducing outliers to a maximum of 3% of beds and bed occupancy to 93% or less	Having no plan for reducing outliers and bed occupancy
Developing a plan that is a mixture of improved patient flow admission rate reduction	Relying entirely on community based alternatives and additional bed capacity AND community alternatives
Additional investment early to avoid the costs of a system in escalation	Not committing to additional investment until the crisis unplanned escalation later
Investment in patient flow technology and better timely communication across the whole system e.g. Scotland, Australia, US in preparation for this winter	Assuming such technology makes no or little despite evidence to contrary
Planning for minimal elective activity around the known 30 redictable days of peak emergency admissions	Planning to resume elective activity when there is a peak in emergency demand or it is likely that the system will still be in recovery from a peak in emergency demand
Phasing the introduction of additional capacity around the four known peak periods: **- November to December build up** **- Christmas and New Year bank holidays** **- January to mid February peak** **- February to April recovery**	Bringing all additional capacity on line at once could result in it being used appropriately and prevent its use when needed

5.2 Working with NHS 111

- The procurement of NHS 111 and OOHs has allowed the CCG an opportunity to ensure improved integration with other service providers, in particular between NHS 111 and OOHs. This will ensure that patients accessing urgent healthcare in Swindon and Shrivenham will have a much more streamlined process. .

- Demonstrating access to and sharing of important and key clinical information regarding patients is being evaluated. Direct booking into OOHs Treatment centres from NHS 111 is mandated. The key outcome for patients being sought is a simpler entry and integrated pathway for patients through the urgent care system.

- SCCG has secured a real time data feed indicating Information about NHS 111's performance is important. Where demand upon the 111 service peaks resulting in significant delays to callers, abandoned calls or complaints NHS 111 follow their own escalation process and informs all providers of the incident or peak in demand, thus alerting local urgent care providers of potential demand locally.

- The Directory of Services (DoS) remains a commissioner owned product with robust governance arrangements in place to ensure that a full and comprehensive DoS has been populated and clinically assured by services leads and commissioners. Key system wide impact disposition data is reviewed as part of the clinical led Urgent and Emergency Care Working Group. Disposition data at a more granular level at the clinically led NHS 111 performance meetings has brought about actions to ensure improvements to the DoS and improved signposting for patients

5.3 Primary Care

5.3.1 Swindon Urgent Care Collaborative Expedited Surgeries Services (SUCCESS)

- The SUCCESS scheme pilot is to develop a modern Urgent Care Centre of excellence throughout the Swindon community, accessed via patients' respective primary care surgery. The project is focused on coping with "on the day" demand in primary care in order to allow General Practitioners to focus on the most vulnerable of their patients who need their input to remain in good health and stable. This is hoped to cope with demand and have an effect on the acute pathway.

- The SUCCESS project will underpin and deliver an extensive range of key outputs for patients who are registered with practices who are members of Swindon Clinical Commissioning Group and who reside in the Swindon and Shrivenham area.

  These are outlined below;

- Extending access to on the day assessments within general practice by improving access for patients to on the day assessments of their urgent medical needs.

- Greater flexibility for patients choosing a time that is convenient from the urgent care centre.

- Facilitated real-time access to pertinent patient information for treating clinicians where the patient receiving clearly documented treatments delivered elsewhere other than their practice

- Greater integration of urgent and out of hours care by introducing the facility for the OOH service to offer appointments in the early part of the next day (where clinically appropriate) and an expedited home visiting service during the daytime for when "I'll pop out after surgery" isn't soon enough.

- Working closely with NHS England to test and pilot innovative new approaches to commissioning primary care services

- Better management of Long Term Conditions by releasing more time back to practices to focus on those issues which benefit from continuity and longer more reliably uninterrupted appointment times.

- Integrated approach to providing general practice and wider out-of-hospital services, such as community nursing and pharmacy, diagnostic services and voluntary sector provision

- Expanded diagnostic ability in community setting (near patient testing)

- Facilitation of the provision of expanded care options in the community e.g. Paediatric "Hot Tots" observation facility

5.4 Care at the Scene

- Following a successful pilot, a Care at the Scene service has been set up by SEQOL the community provider. Whereby a GP is available to support paramedic crews should they believe the patient could be treated away for ED. The GP is based at the SWASFT Clinical hub with the aim of being able to:

  - Enable provision of high quality care closer to the patient's home
  - Divert the patient to more appropriate care pathways
  - Enhance patient experience

- The service to date has resulted in reduced assessment, admissions and ambulance conveyances. From historical usage of the Urgent Care Centre it is estimated that there will be an additional 4,500 patients per year seen at the centre instead of at ED, in addition to those currently attending via a divert from Emergency Department.

- The intended continuation of Care at the scene is to ensure that this service is used in synergy with the OOH's service and also over the weekends with the provision of Home visiting within the SUCCESS model.

5.5 Risk stratification

- The CCG procured a risk stratification tool to support practices to identify patients who are at high risk of an emergency admission. The tool makes use of both primary and secondary care activity data to produce a risk score for a patient being admitted into hospital. The data is regularly updated and practices are able to regularly review their patients at multidisciplinary meetings. This provides the opportunity to identify those would benefit from having a care plan or being referred to an appropriate service e.g. virtual ward; community navigator etc.

- All Swindon practices are now able to see their top 2% of patients who are at risk and would benefit in having a care plan. The intention is for practices over the next 2 months to support the development of the care plan, they will then be recorded and flagged on clinical system. This can be seen at the SUCCESS centres, as systems are developed and rolled out the ED department will be able to see care plan. This will support those high risk patients.

- A daily data feed is in place to provide each GP practice with information on those patients who are registered with their practice using the emergency department. The data provides information detailing the presenting condition, time of attendance, and where they were streamed to for the right care. This information allows practices to see the activity and journey of their patients. Practices are reviewing and auditing cases. This in turn feeds the risk stratification tool, giving each practice an updated risk score for likelihood of emergency attendance or admission. This score will be used as part of the early warning system within Swindon.

5.6 Seven Day Working

- To improve seven day working, there are a number of interventions to support the achievement of this across the Swindon Health economy:

  - The SUCCESS model extended hours in primary care
  - Care at the Scene
  - Augmentations to Long Term Condition pathways
  - Additional Capacity for the Virtual ward model
  - Extended hours for Mental Health Liaison this year as a contractual change and increase in resource

- A key national condition of the Better Care Fund call for a 7 –day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekend – additional social care resources have been commissioned to ensure that patients are discharged from hospital at weekends.

- SCCG and Wiltshire CCG have invested in a Discharge Assessment Rapid Team (DART) covering 7 days a week working. This includes access to a therapist to support discharge planning.

- Annex 1 provides a range of improvements to take forward 7 day working including SAFER bundle across unscheduled care.

6. Patient Experience

6.1 Mental Health Crisis Care Concordat

- Swindon CCG is working on a multi-agency declaration, signed by the CCG and partner organisations, setting out the principles that will be applied in dealing with people experiencing a mental health crisis and making a commitment to work together to improve patient experience. The aim is to achieve parity of esteem with people experiencing a physical health crisis. At the moment in many cases the reaction of people to a mental health patient in crisis is to call the police. This needs to change so that people are given the right care and treatment, in a timely way, to the right standards of quality.

  The themes covered in the concordat are:

- Urgent and emergency access to crisis care
  - We have outlined a model which provides much more rapid response to Mental Health Crisis Presentation and has been given the secondary care provider (Avon and Wiltshire Partnership NHS Trust to work up with support from Swindon Borough Council and also that of the Section 136 group).

- The right quality of treatment and care when in crisis
  - The new model will provide much more high quality care and cross organisational care planning within Swindon to support a change in working practices

- Recovery and staying well, and preventing future crises
  - The model also ensures support from specialist services when needed post discharge and looks at key engagement points within the service

  The requirements for the Swindon local declaration are:

- A jointly agreed local declaration across the key agencies that mirrors the key principles of the national Concordat – establishing a commitment for local agencies to work together to continuously improve the experience of people in mental health crisis in their locality
  - We have developed strategic direction of services locally to provide better quality of service and parity which we have led from commissioning.

- Development of a shared action plan and a commitment to review, monitor and track improvements
    - An action for responsiveness from providers is being developed starting with commissioning and developing different ways of working with providers.

- A commitment to reduce the use of police stations as places of safety (under Section 136 of the Mental Health Act 1983)
    - This will be monitored from Wiltshire Police Service and Swindon Borough Council

- Improving outcomes for people experiencing mental health crisis by setting an ambition for a fast-track assessment process for individuals whenever a police cell is used
    - This will form an aspect of the integral new model

- Evidence of sound local governance arrangements
    - To be developed by providers across new working arrangements jointly.

6.2 How to access appropriate emergency care for children

6.2.1 In Swindon, children and their families can access urgent care in a number of ways through same-day GP appointments, an Urgent Children's Clinic, the Urgent GP/Nurse Centre or through the Paediatric Emergency Department. Parents will seek help through either their GP or by going directly to the Great Western Hospital site. If a GP needs to see a child the same day, they will either book an appointment at the practice where they are registered or will be referred to the Urgent Children's Clinic. If a child is seen on the GWH site they will be triaged for either care at the Urgent/GP Nurse Centre or at Paediatric ED.

6.2.2 The above information is shared with parents via their GP, online and in the 'Managing your child's health' booklet, which has been developed to give guidance on self-care and local services. The recently piloted Urgent Children's Clinic was publicised through a range of local services including: GPs, the Carfax Walk-in Centre, children's centres, health visiting teams and the emergency departments at GWH as well as the local media, ensuring that parents can access the clinic wherever they make contact.

This information will also be available on the new 'Local Offer' website which provides a directory of all children's services, this is due to be launched in August 2014.

6.2.3 Engaging parents in service redesign, Swindon CCG targets families and carers as part of a comprehensive annual programme of engagement. We regularly attend the Swindon young carers' forum and the Children's Health Commissioner has developed close links with the Swindon Parent Carers Forum. Representatives from these forums have attended a number of paediatric service redesign workshops and contributed to the design of the Urgent Children's Clinic. Groups of parents are further engaged on specific

topics, for example, a review of the Diagnostic Pathway for ASC, through the Parent Carers Forum.

6.3 Ambulatory care and Assessment units

- All patients needing a hospital medical assessment are discussed by the referring GP via telephone with a senior nurse from the assessment team. This conversation will agree an appropriate time for that patient to attend along with the best place to send them too. Patients will then be directed to the Linnet Medical Assessment Unit (LAMU) or the Ambulatory Care Unit.

- In addition to this the acute trust implemented a new Rapid Access Triage service.

- Working towards the national 49 ambulatory care conditions, patients attend ambulatory care between 10:00 – 22:00 Monday to Friday where every effort is made to discharge the patients that day, this unit is staffed by senior consultants with on hand diagnostics to ensure rapid assessment/management and discharge.
-
  If following an initial referral phone call it is felt the patients are going to need an overnight stay or admission, they are directed to LAMU where they will also undergo a full assessment and will be given a consultant management plan.

- Out of hours patients are managed through LAMU with the same emphases of preventing admission.

- Patients attending through the Emergency Department are referred onto either LAMU or ACU dependant on need.

- The Great Western Hospital is working collaboratively with community partners to ensure that the pathway for patients who require ongoing community care is robust and is linked with the service changes outlined above.

- A key workstream following the ECIST is to implement an elderly ambulatory care model. This pathway will be integrated with SEQOL and GWH Community services to maximise the user of the urgent care GPs and step up bed facility if further assessment and support is needed once diagnostics has been undertaken and or consultation with geriatrician.

- Access to reablement and rehabilitation services will be supported through the investment of therapy at the front door. Patients can then if needed access a range of community rehabilitation and reablement services, to support them to return home. The Discharge Assessment and Referral Team (DART) includes social workers, therefore automatic referral is ensured.

6.4 Surgical Ambulatory Care

In May 2013 a new 18 bedded surgical assessment ambulatory model was implemented Patients are accepted via telephone like the medical model but by a junior doctor, they are then directed straight to the Surgical Assessment Unit for on-going

assessment and management. This model has been very successful and contributing positively to improve patient flow and reduction in Length of stay.

6.5 Measurement

GWH updated their Medway PAS system in May 2014, this will provide real time data on the management of patient flow and bed capacity across the system to help predict availably capacity over a longer period of time to give better visibility and targeting for community team and acute staff. This will be completed by 1st November 2014. This functionality will include:

- Measurements against EDD
- Aspects of outstanding care
- Those patients requiring care packages
- Tracking of HCAI through inpatient care to avoid spread
- Better visibly of flow at ward level

7. Good Practice Elective care pathways

7.1 Planning

7.1.1 The Patient Access Policy has been reviewed and signed off by the GWHFT Executive Committee in June 2014

7.1.2 Standard Operating Procedures are currently under development to support the implementation and compliance of the national patient access policy. This will be followed by a training programme to support implementation.

7.2 Building on existing work

7.2.1 Great Western Hospital are undertaking detailed modelling with plans to reconfigure the bed base, to support non elective capacity over winter.

7.2.2 Focus on non-elective schemes is vital in terms of delivery, and resilience planning needs to be viewed in its entirety, so as not to further compromise the surgical programme if medical outliers are placed in the reduced bed base. GWH have identified 35 beds that are ring-fenced for elective care during the Winter and this has been supported by the CCG.

7.2.3 A key area for the SRG to ensure any capacity modelling is contractually understood regarding any potential increase in activity and costs to the CCG.

7.3 Pathway design

7.3.1 A number of common referrals have expected treatment timelines already, but as part of the GWH demand and capacity work and training this will be achieved by the end of September 2014.

7.3.2 'Patient Choice' and patient rights under the NHS Constitution are well communicated across elective care. NHS Foundations Trusts and CCGs will have information and web links about NHS Constitution on their websites.

7.3.3 Work will be undertaken as part of the demand and capacity work to review "Right Size" outpatient, diagnostic and admitted waiting lists. This is to be completed by the end of July 2014 and will form part of our revised plan.

7.4 Measurement

7.4.1 GWHFT have provided SCCG with detailed and comprehensive action plans and trajectory of achievement to meet RTT waiting times.

7.5 Governance

7.5.1 Weekly reports to SCCG are in place through the performance management route.

7.5.2 Assurance of achievement, risk and mitigations and consequences discussed at monthly contract review meeting.

8 Wider Planning considerations for System Resilience Groups

8.1 Discharge planning

8.1.1 Discharge Planning has been reviewed extensively this year. Reducing length of stay, excess bed days and delayed transfer of care are performance targets for GWHFT, SWICC, Adult Social Care and Care and Support for both elective and non elective patients.

8.1.2 The numbers of patients being cared for who are ready to leave hospital but still being assessed for ongoing either health or social care needs have reduced following an intense focus on discharge planning, and daily reports of green to go patient status is shared.

8.1.3 Daily reviews take place involving health and social care partners and patient flow coordinators to discuss and agree action plans for patients who are on the green and amber to go list.

8.1.4 Criteria led discharge has been implemented for a range of conditions within the acute hospital setting and this is delivering an increased rate of discharge both during the week and at weekends. Hospital and Community services are linked together to ensure proactive discharge planning for all patients.

8.1.5 There are weekly multi-agency and professional meeting and telephone conference allows for improved constructive challenge to delays in discharge planning and alternative options to the patients on going care.

8.2 Discharge to Assess

8.2.1 Providing Discharge to assess capacity is a priority to the CCG and SBC. Currently there are six beds all year round, with flexibility to support additional reablement care at home.

8.2.2 In 13/14 between December and March 15 discharge to assess beds were commissioned. These beds support patients predominately from Swindon and Wiltshire but also out of area.

8.2.3 GWHFT have provided a ORPC plan on a page. **See figure 1**. This predicts the need for an additional 55 beds during the peak months across the whole system. The CCG and SBC have agreed the requirement to commission additional discharge to assess beds to support this short fall. Potential providers are being explored. These beds will need to be part of patient flow model in GWH.

8.3 South Western Ambulance Service NHS Foundation Trust (SWAST)

8.3.1 Swindon CCG meets via the associate commissioner meetings, which throughout this year has set out its intentions with SWAST to meet the QIPP outcomes and delivery of the urgent care pathway. SWAST are members of the urgent care working group.

8.3.2 SWAST has monitored activity over previous years and is using this information to predict activity levels and resources accordingly. The capacity plan for both Winter and the Christmas and New Year period clearly identifies escalation triggers and actions, known as the Resource Escalation Plan (REAP). REAP has 6 levels with associated measures that can be introduced locally and trust-wide to deal with increased activity or adverse weather conditions.

8.3.3 The SWAST clinical support desks continue to triage green calls. This has resulted in a SWAST crew being able to directly refer to the Single Point of Access (SPA) based in the hub of the urgent care primary care centre. This provides crews with access to a range of alternative pathways, thus reducing the conveyance of avoidable attendance in ED.

8.3.4 SWAST are working locally with other providers (SEQOL and Carfax Health Enterprise) to ensure that all appropriate “GREEN 1-6” or Historic Cat C calls are understood for treatment at appropriate other providers to avoid unnecessary conveyance to A & E – conveyancy in Swindon remains low. This is line with ***Right Care, Right Time, Right Place***

8.3.5 Locally, the SWAST escalation processes are being linked to the country-wide triggers as part of the escalation plans. SWAST will participate in all routine performance management arrangements.

FIG 1

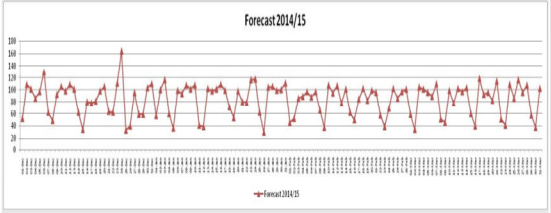
Operational Resilience Plan Adults General & Acute

Objective: To build system reliability to meet the needs of people accessing urgent, emergency and elective care efficiently.

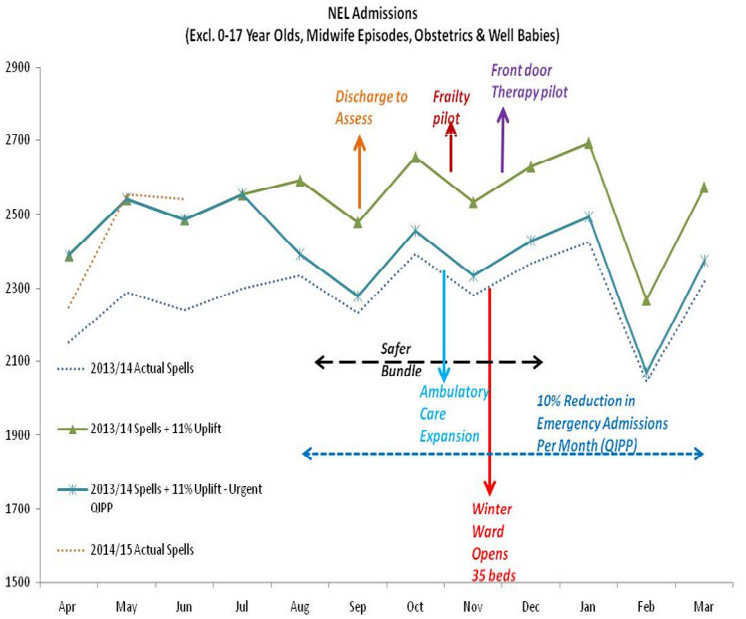
Outcome measures:

- Reduce emergency admissions to the acute hospital by 10% per month from August 2014
- Reduction of green to go (maximum 15) and over 14 day length of stay (maximum 60 GWH)
- 30% of acute take through ambulatory care
- Increased under 72 hour length of stay for frail patients
- Meet NHS Constitution Standards and rights

Daily Admissions Forecast – Range 40 to 120



Forecast Emergency Admissions Graph



Adult general & acute beds	August	September	October	November	December	January	February	March
Beds required	454	434	460	492	477	496	502	491
Bed available	440	399	399	434	434	434	434	434
Variance	-14	-35	-61	-58	-43	-62	-68	-57

Planning assumptions:

- Worst case scenario, rise of 11% emergency admissions continues
- Introduction of Frailty model, expansion to ambulatory model, RATs in ED, SAU continues, Therapy at the front door
- Implementation of Safer Bundle and Real time reporting
- Bed occupancy 93% emergency, 98% elective
- Winter ward from November 2014

Risk:

- Continued rising emergency admissions
- Failure to commission winter ward
- Capacity constrained services outside acute sector unable to flex to meet daily variation of demand

Critical Success Factors:

- 30 plus discharge to assess beds/ home discharge to assess placements
- 10% reduction of emergency admissions from August 2014
- Real Time Reporting & Proactive escalation
- Safer bundle, frailty & ambulatory model, SAU, front door therapy, RATs
- Ring fence 10% of inpatient beds and DSU for elective flow
- Responsive community services to turnaround patient at front door and ambulatory/frailty unit

8.4 Non-Emergency Patient Transport (NEPTS)

8.4.1 *"Arriva Transport Solutions Limited"* (ATSL) provide Non-Emergency Patient Transport Services in Gloucestershire, BaNES, Swindon and Wiltshire. The service is available 24/7, 365 days a year.

8.4.2 Initial capacity was based on the activity figures provided by the CCGs during the procurement process however, early into the provider taking on this contract in December 2013 demand was high. The CCG is currently working with other commissioners to review the contracted level of activity to support demand and pressures.

8.4.3 ATSL are contracted to provide a flexible and responsive 24hr service and should have the ability to react to changing circumstances/demands. They use local and central control and service delivery teams (with personnel on-site at key points of care) who co-ordinate the service and respond to emerging situations. They will use a transport planning system and real-time GPS vehicle tracking to plan the best scheduling and allocation of vehicles and re-plan routes and reschedule crew work patterns when required (e.g. severe weather) to minimise disruption to patients.

8.4.4 As they are operating multiple contracts in the same area they will have the ability to pool contingency vehicles and move resources if required.

8.5 Prevention and Management of Norovirus and Influenza

8.5.1 For surveillance of the local health economy, Public Health England will continue to produce local epidemiological data regarding Norovirus and influenza on a daily or weekly basis (dependant on number of cases), for dissemination to identified IP&C leads within NHS Swindon CCG, Great Western Hospitals NHS Foundation Trust and SEQOL. The Local Public Health team will cascade letters to SEQOL, Care Homes, GP practices and schools during October 2014, setting out the prevention and management of Norovirus and necessary infection prevention and control practices in the wider community, in line with national guidance.

8.5.2 Management of Norovirus and influenza within Provider Services:

- NHS Swindon CCG monitor adherence to infection prevention and control policies within provider services via contract monitoring arrangements and ensure close working relationships are maintained between community and acute IP&C teams, Public Health England (PHE) and Swindon Borough Council.

- Both the Great Western Hospital and SEQOL have reviewed and updated policies and procedures in relation to Outbreak Management and Ward Closures; Management of Diarrhoea and Vomiting Including Norovirus; Pandemic Flu; IP&C Standard Precautions; Hand Hygiene, Isolation and

Reporting of Notifiable Diseases. A clear escalation plan is in place for both organisations, based on national guidance.

- Suspected outbreaks of infection within Swindon Intermediate Care Centre (SwICC) are managed by the SEQOL IP&C team. An on call Microbiologist from Great Western Hospital is available for advice if an outbreak is suspected or occurs out of hours within the Swindon Intermediate Care Centre. SEQOL have an agreed norovirus escalation plan, to include management of patients with norovirus in their own home.

- Outbreak reports and updates will continue to be provided by the Great Western Hospital and SEQOL Infection Prevention and Control Teams on a daily basis to all relevant service leads, Directors, Commissioners and the Health Protection Agency.

- NHS Swindon CCG is represented at the Great Western Hospital NHS Trust's IP&C Committee where detailed aspects of outbreak management, risk assessments and audit are shared.

8.6 Care Homes

8.6.1 Care homes will use the virtual hub as first point of call if concerned that a resident may have Norovirus or be at risk of Norovirus. Community teams, led by the community matrons, will provide care and advice to people in residential and nursing homes, including clinical interventions if required to rehydrate.

8.6.2 The urgent care centre assessment team will direct people away from the hospital if Norovirus is suspected and arrange support at home if required. The virtual hub will co-ordinate escalation plans.

8.6.3 Outbreak management within care homes is also supported by the Health Protection Agency and reported to public health teams, CCG leads and provider organisations on a regular basis. Throughout the winter period these reports are generated daily where applicable. Routine monitoring of IP&C practices within the care home setting is carried out locally via Swindon Borough Council Contracts Team. NHS Swindon CCG will continue to work closely with the Contracts Team in order to support and provide advice with regard to required IP&C practices.

8.7 Education and Training

8.7.1 Education and monitoring of infection prevention and control practices amongst the healthcare workforce is routinely audited and cascaded within provider services and monitored via CCG clinical quality review meetings.

8.7.2 Infection prevention and control link networks (ICLN) are operational in both the Great Western Hospital and SEQOL and provide specialist education and training for staff. Key updates are provided for all staff with regard to manage-

ment of norovirus and influenza, which includes appropriate risk assessments and timely isolation procedures.

8.7.3 SEQOL's ICLN is available for all care homes and independent providers in Swindon and is able to demonstrate regular attendance.

8.8 Public Health Communication

8.8.1 In readiness for the winter season, plans are in place to cascade public health information letters to SEQOL; Care Homes; GP practices, schools and colleges during October 2013, setting out the prevention and management of norovirus and necessary infection prevention and control practices in the wider community.

8.9 Prevention and Management of Seasonal and Pandemic Flu

8.9.1 Seasonal flu vaccination is available to over 65 year olds, carers, health workers, the under 65's in vulnerable at risk groups including those with chronic conditions such as asthma or COPD and pregnant women.

8.9.2 NHS England has responsibility for commissioning the seasonal flu programme with GPs, midwives, other health care professionals and immunisation system leaders, managers and coordinators playing vital role in delivery. NHS England must ensure that robust plans are in place to locally identify all eligible patients, to ensure that sufficient vaccine has been ordered by practices to meet their needs, and that high vaccination uptake levels are reached in all the eligible groups.

8.9.3 Public Health England is responsible for planning and implementation of the national approach at a local level through the Area Teams, working closely with the local public health teams in local authority, monitoring and reporting on the key indicators related to flu, including flu activity and vaccine uptake.

8.9.4 GP practices and other providers are responsible for ordering the correct amount and type of vaccine and ensuring that all those eligible for the flu vaccine are invited personally to receive their vaccine.

8.9.5 All employers of individuals working in the NHS are responsible for management and oversight of the flu vaccine campaign for their frontline staff and providing support to providers to ensure access to flu vaccination and to improve the uptake by our eligible populations. Managers will be responsible for encouraging staff to consent to flu vaccination and monitor staff uptake by directorate.

8.9.6 Swindon Borough Council, through the Director of Public Health will provide local leadership, advocacy and challenge to local arrangements to ensure access to flu vaccination and to improve the local uptake by our eligible populations. Primary Care will work closely with community services to cover the

nursing homes. SEQOL have agreed to support primary care in the delivery of the flu vaccine for house bound patients and the residential homes.

8.9.7 Local data will be collected via the web based ImmForm system that collates weekly data extracted automatically from our local GP practices.

8.9.8 This year sees the extension of the flu vaccination programme to all two and three years olds through general practice and NHS England has secured vaccine for use in 2013/14 to allow the roll out of the programme

8.9.9 A joint local communication campaign has been agreed to promote and encourage uptake locally through various channels including GP practices and other health and social care staff encouraging uptake and local media and awareness raising activity.

9. Communication Strategy

9.1 For a number of years Swindon CCG have supported the national 'Choose Well' winter publicity campaign. Support has included distribution of 'Choose Well' campaign leaflets, posters and information cards throughout the local health and social care community. Targeted campaign messages are supported with proactive news releases and active participation in broadcast media interviews.

9.2 There will be communications support to the organisation by working closely with our partners and providers to ensure that we achieve three key milestones:

- The provision of communications advice to support the escalation process in the case of increased demand and/or emergency
- Provision of advice and information to support increased access to alternative, more appropriate sources of healthcare
- Supporting wider health messages including: get your flu jab, protect against norovirus, wrap up warm.

9.3 Partners and providers will meet monthly to agree the most appropriate channels and forms of communication advice, which will target the public, our patients, staff and other stakeholders. Each supporting organisation will lead on individual pieces of work, reducing duplication, and maximising the use of shared resources. More detail on this plan can be found in **Annex 3.**

10. Escalation

10.1 This year, the pressure on the system has once again been unrelenting and we have seen significant escalation within the hospital well in to the spring. During Christmas and New Year the whole escalation processes was tested and challenged resulting in the need to redefine our escalation response and actions. This provided the opportunity to review our escalation process, use escalation capacity across the community setting in a more robust and targeted way, and tighten up escalation reporting data. A key response to escalation is the use of whole system conference calls.

10.2 To enhance local escalation conference calls SCCG developed a web based reporting template to be used by health and social care providers to be completed 20 minutes before any escalation call. The need to have this template was based on the experience of both providers and commissioners spending too much time trying to agree actual pressure and patient flow, including discharge information status. The chair for the call can work through each section with those on the call, agree actions and provide a written summary of the call with clear actions and then email out to all providers and commissioners.

10.3 During winter 13/14 GWHFT and SEQOL submitted real time data to the Bath and North East Somerset (BaNES) hub. Measurable metrics were used and this enabled both commissioners and providers to see the current position, growing pressures in the system across Wiltshire, BaNES and Swindon and then enabled commissioners to facilitate calls to ensure all actions were being taken in accordance with escalation plans and provider reliance plans. It addition it enabled to seek peripheral support if needed and each provider to prepare for demand if another provider was in escalation.

10.4 The whole system escalation plan will be reviewed in October in the form of a simulation event. Not only will the escalation plan be tested but the CCG and each provider will refer to their business continuity plans to ensure a robust response following any internal or external event that may impact service and operational delivery.

11. Links to National and Strategic funds intended to develop synergy and integrated working – Better Care Fund (2013), Social Action Fund (2014) and the Care Act (2014)

11.1 Swindon CCG and Swindon Borough Council have well-established integrated partnership arrangements in place for many years and is in a strong place to **deliver integrated care, with an existing Section 75 agreement for Children and** Adults in place for health and social care comprising an aligned fund of £16m CCG and £55m SBC (total £72m).

11.2 Our joint vision for people in Swindon is enshrined in the Health and WellbeingStrategy:

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

11.4 Joint resources have been aligned to support the health, wellbeing, mental health, education and care of children, families and adults in the community to achieve the mission of both Swindon CCG and SBC.

11.5 Integrated services for children will have brought together community health, education and social care services. These have been co-located and managed as a single service.

11.6 Swindon is therefore strongly placed to implement integrated care in that the organisations currently providing local health and social care services are dealing with the same patients and communities.

11.7 In preparation for the Better Care Fund Plan an extensive literature review on the opportunities presented through integration (particularly in the delivery of out of hospital care) was undertaken. This identified that the delivery of integrated care appears to require the integration of sources of funding, planning and commissioning, otherwise the inherent differences/competitiveness built into procurement and the different payment regimes drive integrated pathways apart. We are implementing models for the integration of sources of funding, resource allocation and provision across adults and children with a particular focus on enhancing the role of community based health and social care support. This includes community navigators and community based support through the voluntary and third sector.

11.8 We see integration as essential to the improvement of the patient's and service user experience and we will be setting out examples (as patient stories) of how genuine and ambitious care integration will achieve improvements in quality and the cost of health care delivery.

11.9 A number of the BCF national conditions have already been taken forward that support ORCP :

- **Protection for social care services – local areas must include an explanation of how adult social care services will be protected within their plans.** For Swindon this is made easier as the integrated community provider, SEQOL provides both health and social care service

- **Better data sharing between health and social care, based on the NHS number (*the safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care*).** In Swindon plans to use of the NHS number as a primary identifier are being progressed.

- **Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional** – Swindon's approach has been developed from the joint adult demand strategy.

This includes:

- Identification of those needing case management and those needing self-management through risk stratification supported by practice attached
- community navigators
- Access to dedicated case managers provided by SEQOL;
- Access to a range of self-help support including a Healthy Life Plan coordinated by practice attached link worker supported by a database of available community, voluntary sector and neighbourhood support.

- **Agreement on the consequential impact of changes in the acute sector** – this is considered in our *Strategic Plan 2014-2019* and in particular our assumptions regarding the reduction in unplanned care against the overall context of growth in planned care as required by population growth. The net assumption is an increase of 1 – 1.2% per annum in activity compared to growth in population based demand of 2.8 – 3.2%.

12. Social Action Fund

12.1 A joint bid has been submitted between Swindon and Wiltshire council and CCGs aiming to increase the use of the British Red Cross and Age Concern UK to extend discharge support.

13. The Care Act 2014

13.1 Work is in hand to ensure that local adult social care services are delivered in accordance with the new Care Act 2014. The cap on care costs comes into force in April 2015. SBC have held a workshop on the new act engaging with key stakeholders and more work is being done on the importance of carers and carer assessments.

14. Capacity Planning – Engagement with the independent and voluntary sector. Annex c provides details.

15. Assessment of risk to delivery and mitigations in place

15.1 The SRG will review risks and mitigating action at each meeting, escalating risks to the relevant corporate risk registers as well as authorising remedial action on behalf of all partners to this plan.

Key Risks for 2014/15

Risks have also been identified separately within each organisation's individual plans.

The key risks identified for 2014 -15 are:

- Impact on the quality of care to patients with potential numbers of incidents increasing at times of escalation and pressure.
- Delivering and sustaining performance on key targets- **4 hour target**
- Risk to business continuity from increased demand for acute services and community care as a result of influenza and Norovirus
- Dealing with the continued levels and rates of growth over and above those planned for
- Loss of elective capacity
- Delivery of vaccination programmes may not achieve the planned levels
- NHS 111 provider not able to provide a sustainable level of performance over weekends.
- Impact of interventions being implemented in Q3/4
- Not having a real time solution in place in time for Winter

16. Timetable

All funding of schemes from the non-recurrent monies a roadmap of delivery of plan has now been agreed. Submission of the tracker has been submitted to the Area Team detailing KPIS and timelines. The CCG has a comprehensive performance dashboard for all non-elective and elective schemes and this is for agreement and sign off at the October SRG.