NHS
Swindon
Clinical Commissioning Group

ANNUAL OPERATING PLAN 2015/16

Version 2 April 2015

1. Introduction

The Swindon CCG Five Year Strategic Plan 2014-2019 was finalised in June 2014. This Operating Plan for 2015/16 should be seen in the context of the Five Year Plan and the Swindon Health and Wellbeing Strategy 2013-2016.

2. Context and system working

The 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'

This Operating Plan for 2015/16 supports the CCG mission 'To optimise the health of the people of Swindon and Shrivenham'

NHS Swindon CCG and the Swindon Borough Council have aligned their 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 in the development of the Operating Plan.

The Operating Plan links closely to the Better Care Fund Plan which is a summary of jointly agreed areas of priority. Over the last eighteen months specific service redesign workshops were held on long term conditions, mental health, carers and community based support for older people. The findings from these workshops have been incorporated into this plan.

In Swindon 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' in 2013 to become and integration pioneer. Our vision for the Operating Plan and the Better Care Fund builds on our successful integration and the Five Year Strategic Plan for Swindon.

3. **Joint Strategic Needs Assessment (JSNA) 2014/15**: The JSNA provides the evidence for commissioners on what the needs of the local community are.

The JSNA has been refreshed and there are a number of key points taken from the strategy below which provide context for some of the decision making in relation to the 2015/16 deliverables for the CCG Operating plan.

3.1. **Population**: Figures from mid-2013 for Swindon Unitary Authority show that there were 50,544 under 18s (23.6%); 132,132 aged between 19 and 64 (61.7%) and 31,361 aged 65 or older (14.7%). Projections indicate that almost half (25,000 people) of the population growth between 2011 and 2031 will be in the 65 plus age group.

The structure and population vary greatly by electoral ward, which emphasises the need for planning targeted to local needs.

3.2. **Long term conditions**: the two key factors for developing a long term condition (LTC) are lifestyle and aging. 14% of those aged under 40 report having a LTC and 58% of those aged 60 and over report having a LTC, with 25% of those over 60 having two or more LTCs. 70% of those aged 80 or over have at least one LTC.

People with physical LTCs often have psychological distress in addition. In such cases NICE recommends psychological interventions to relieve distress and improve coping skills.

There are a range of LTCs that the JSNA highlights

- Cardiovascular Disease (CVD) which accounts for about a quarter of all deaths in Swindon each year.
- Diabetes which is associated with a life expectancy that is 10 years shorter than the average and is an area where Swindon has benchmarked poorly in terms of diagnosis and management in previous years.
- Cancer which is the leading cause of death in Swindon, mortality rates have been falling due to earlier detection and better treatment. This does mean there are more cancer survivors who need support.

3.3. **Mental health and Wellbeing**: one person in four will develop one or more mental disorders in their lifetime. In Swindon there are an estimated 22,600 – 29,000 individuals with depression or common mental health problems. Swindon also has a high rate of emergency admissions due to self-harm than when compared to England rates.

3.4. **Dementia**: one in six people over 65 will develop dementia at some stage during their lifetime. Estimates suggest that there are about 2035 people aged 65+ with dementia in Swindon, nearly half of whom are over 85. Ensuring timely diagnosis and ensuring support services are in place for people who need them post diagnosis is a key issue.

4. Health and Wellbeing Strategy

4.1. The Health and Wellbeing Board oversee the delivery of the three year strategy and the CCG are active members in the partnership. The CCG Clinical Chair is the Vice Chair of the Board and the Chief Operating Officer is a key member.

4.2. Appendix one contains the summary of the strategy listing the five key outcomes, the priorities to deliver these and the indicators for success.

4.3. Successful delivery of the strategy is key to improving current health inequalities for the population of Swindon.

4.4. The 2014/15 health and wellbeing strategy update report identifies 3 outcomes which are currently identified as red (performance is worse than national average). The CCG priorities for 2015/16 pick these up as key areas

4.4.1. Self-harm hospital admission rates for under 18s (see children)

4.4.2. New admissions of older people (over 65) into residential and nursing care (urgent care model, LTC management and Dementia will all support maintaining people at home)

4.4.3. Cervical cancer screening coverage

5. **Quality Premium 2015/16**

5.1. The Quality Premium is a national scheme which is intended to support improvements in health outcomes and reductions in inequalities in access and in health outcomes.

5.2. There are 2 nationally prescribed schemes

Reducing potential years of lives lost through causes considered amenable to healthcare

Improving prescribing in primary and secondary care

5.3. There are 2 areas where CCGs are asked to choose measures in conjunction with the H&WBB

Urgent and emergency care – one of the following 3 indicators

- A reduction in the number of avoidable hospital admission for ambulatory care conditions (asthma, diabetes, epilepsy, respiratory infections) in adults and children
- A reduction in the number of delayed transfers of care
- An increase in the number of patients admitted for non-elective care who are discharged at weekends or bank holidays

Mental health – one of the following 4 indicators

- A reduction in the number of patients attending an A & E Department for a mental health related need who waits more than four hours to be treated and discharged, or admitted.
- A reduction in the number of people with a severe mental illness who are current smokers
- An increase in the proportion of adults in contact with secondary mental health services who are in paid employment
- Improvement in the health related quality of life for people with a long term mental health condition

5.4. In addition the CCG are asked to pick 2 local measures based on local priorities such as those identified within the health and wellbeing strategy.

Based on the strategy progress report received by the H&WBB in February possible areas for consideration are

- A reduction in the number of under 18s admitted to hospital for alcohol specific causes (per 100,000)
- A reduction in the number of hospital admissions as a result of self-harm (10-24 years)
- An increase the number of Carers who had their needs assessed
- Improved cervical cancer screening coverage

The Quality premium will be discussed at the H&WBB meeting in May and an update will be included in the final version of the plan.

6. Performance

6.1. **NHS Constitution**: the constitution makes a set of commitments to patients and the public about the core standards they can expect from the NHS. The table below summarises areas where improvement is needed and a summary of planned improvement actions

Constitution standard	Planned improvements
95% of people will be seen and discharged from A&E within 4 hours	Reduction in numbers of medically fit patients delayed in hospital beds (acute and community). Increased social work capacity (including senior leadership). Development of the urgent care model including rapid assessment unit (managing demand at the front door) Bed capacity modelling to ensure sufficient capacity to manage demand levels.
RTT standards	Working with GWH to identify specialties at risk and redesigning pathways (see key priorities section: rheumatology, dermatology and ophthalmology are pressured specialties). GWH outpatient transformation programme – looking at how to reduce follow up appointments releasing capacity. GWH to implement best practice waiting list management systems in line with Intensive Support Team recommendations. Review bed capacity model to protect elective bed capacity to maintain patient flow.

7. Quality

In driving up quality in our services, we have readily adopted the key learning from national reviews that include: the *'Francis Report'* (February 2013), *'Winterbourne View'* (December 2012) and *'Berwick Report'* (August 2013) to ensure we have a compassionate heath system that puts 'People First and Foremost', ensuring open transparent services, where staff are supported to do the right thing and where they deliver the best possible care for our patients.

Moving forward, the Quality Team are refining the CCG Quality elements and objectives of the Assurance Framework to assure the local population that commissioned services are safe and effective, that patient's experience of these services is improving and that it demonstrates both medical and nursing leadership is working to continually improve the provision of high quality healthcare services today.

As set out in the CCG's Quality Matters 'Our Strategy' 2014-2017, throughout the commissioning cycle the challenges are a constant: for patients and public to be treated safely; to provide care that ensures the best possible outcomes and to deliver positive experiences of healthcare.

7.1. Safety

The CCG will continue to monitor all commissioned provider organisations to ensure services are delivered safely. This will include the review and monitoring of:

- associated action plans for any reported serious incidents requiring investigation (SIRI) and never events
- all other reported clinical incidents (via data submitted to the NRLS), including issues relating to medicines management
- safeguarding - ensuring both the CCG and providers have arrangements in place to safeguard and promoted the welfare of adults and children in line with national policy, guidance and locally identified areas of concern.
- infection prevention and control (IP&C) – patients are entitled to receive care delivered in a safe, clean environment
- sign up to safety
- Care Quality Commission – (CQC) inspections and outcomes of hospital intelligent

7.2. Effectiveness

The CCG will continue to utilise a range of quality improvement resources in order to measure and continually improve patient experience:

- Monitoring of patient and carer feedback within all commissioned services via reported complaints, concerns, comments and compliments

- Engagement with patient and carer groups
- Collaborative working with Swindon Healthwatch
- Review of patient surveys – both national and local
- Monitoring of outcomes from the national Friends and Family Test (F&FT) CQUIN, ensuring providers have sought to implement quality improvement initiatives as a result of patient feedback. Moving forward into 2015-16, F&FT will be monitored as part of the NHS Standard Contract requirements as it is anticipated it will be removed from the national CQUIN scheme

7.3. Experience

There are a number of methodologies utilised in order to measure the effectiveness of commissioned services. A continued focus for the CCG going forward into 2015/-16 will be:

- Oversight and monitoring of all provider quality improvement / audit plans
- Completion of action plans as identified via incident reporting processes
- Review of stroke pathway via the national post-acute SSNAP audit planned for 2015-16
- Monitoring of CQUIN schemes and be able to evidence improved outcomes for patients
- Achievements of the sign up to safety campaign
- Focus on patient centred care, ensuring full involvement of patients, carers and families during care planning and decision making process
- Inclusion of patient stories at every Governing Body

7.4 Working with providers to embed the practice of clear clinical accountability

All members of professional bodies are required to adhere to their relevant Code of Conduct, which includes the need to understand individual roles and responsibilities with regard clinical accountability.

The Francis Report also made a number of recommendations on the need for there to be a named clinician who is accountable for a patients care whilst in hospital. The CCG consequently requested all commissioned provider services to share their organisation's response to the Francis Report, ensuring a detailed action plan was provided, where necessary, to achieve and embed the practice of clear clinical accountability.

Further recommendations were made in 'Guidance for Taking Responsibility: Accountable Clinicians and Informed Patients' (Academy of Medical Royal Colleges, June 2014) which set out two key objectives that were felt to be of benefit to patients and improve the quality of care. These objectives focused on the need for coordinated, caring, effective and efficient care with an individual named clinician - the Responsible Consultant/Clinician - ensuring every patient knows who their responsible consultant/clinician is.

The CCG will continue to work closely with providers to ensure published guidance and best practice is adhered to and clear clinical accountability is embedded and evidenced within each commissioned organisation. This will include supporting and monitoring both secondary and community care services aimed at improving the quality of care provided. The collation of patient experience feedback; clinical risk/incident data; outcomes of clinical quality review meetings, quality impact assessments aligned to service redesign projects and dedicated quality visits are key measures that will provide assurance that the practice of clear clinical accountability is being embedded locally

7.5 Care Quality Commission (CQC)

NHS Swindon CCG will continue to maintain its collaborative working processes with the Care Quality Commission (CQC), in order to ensure effective measures are in place to review and monitor compliance with essential standards of quality and safety within commissioned provider services.

Information regarding published CQC quality inspection visits are provided directly from the CQC on a weekly basis. In collaboration with Swindon Borough Council (SBC), NHS Swindon CCG has developed an IT database aimed at monitoring compliance to essential standards within services commissioned by both organisations across the Swindon health and social care economy. This information is used to inform and support Swindon Borough Council and CCG quality visits to health care services, care homes and domiciliary care agencies.

Any enforcement notices issued by the CQC, or any areas of significant non-compliance with essential standards, are raised jointly between the Care Quality Commission, CCG and Swindon Borough Council in order to establish collaborative and focused monitoring arrangements. This includes full engagement at dedicated multi-agency service review meetings where appropriate.

NHS Swindon CCG also meet regularly with CQC and other key commissioning organisations as part of the regional quality surveillance group meetings (QSG).

NHS Swindon CCG will continue to engage directly with the Care Quality Commission in order to align quality assurance processes and provide a robust approach to supporting and monitoring the quality of services provided by all commissioned health and social care organisations in Swindon.

7.6 CQUINs (outputs from 14/15 and moving forward into 15/16)

Commissioning for Quality and Innovation (CQUIN's) are utilised to incentivise providers to deliver quality and innovation improvements over and above the baseline requirements set out in the NHS Standard Contract. In 2014/15, the national CQUIN schemes, as set out by NHS England included:

- The Friends and Family Test (FFT)
- Patient Safety Thermometer

- Dementia and Delirium
- Improving physical healthcare to reduce premature mortality in people with severe mental illness (mental health trusts only)

In addition to the national CQUIN's, the CCG develops CQUIN schemes in collaboration with our providers, focusing on key areas based on the needs of the Swindon population. During 2014/15 our providers worked on a number of CQUIN's which included the following topic areas and summarised outcomes:

- End of Life Care
    - Staff training across GWHNHSFT and SEQOL on the conversation project to enable them to engage in difficult conversations with patients/families/carers as end of life approaches.
- Cancer
    - Improved communication of disease stage from GWHNHSFT to primary care
    - Increased numbers of patients having a holistic needs assessment and care plan
- Dementia
    - Introduction of a SEQOL lead dementia café in Pinehurst
- 7/7 working
    - Increased number of emergency admissions at GWHNHSFT being reviewed by a Consultant within 14 hours of admission.
- Diabetes
    - Two project work-streams have been formally established: foot pathway and assessment of diabetic foot for inpatients, with workbooks in development and good progress with both projects is being made.
- Functional movement for elderly patients
    - Increase number of patients with a fractured neck of femur having a robust mobility care plan
    - A reduced length of stay for fractured neck of femur patients
- Effective hospital communication with Primary Care
    - An increase in number of outpatient department letters delivered to GP's within two working days

To progress the excellent work achieved by providers with CQUINs throughout 2014/15, key outcomes will now be embedded in to the relevant local quality schedules to facilitate continual reporting and monitoring to ensure the changes are embedded. Swindon CCG is working with providers to develop 2015/16 which will include a focus on:

- Urgent Care
- Cancer
- Diabetes
- Children in Transition
- Reducing Inpatient Length of Stay (Avon and Wiltshire Mental Health Partnership)

7.7 Patient and Public Involvement and Communications

During 2014-15, Swindon CCG delivered a number of key pieces of work to ensure the meaningful and continuous engagement of its public and patients. These included:

- Attendance at over 50 engagement events in 2014-15, these included Swindon Carer's Centre AGM, Community Coffee Mornings and Practice Participation Forums, all of which the CCG has been an active member of.
- Achieving engagement in a range of formats, including Patient reference groups meeting directly with provider services, Patient based evaluation of our pilot scheme and Patient telephone and video interviews
- Development and regular review of the of the PPI forum and associated work programme, this forum assures the Governing Body that patients and public are meaningfully engaged in the work of the CCG and identifies opportunities for improvement
- Establishing strong working relationships with key stakeholders including Healthwatch, Carer's Centre, VAS, public health and localities team at Swindon Borough Council.

As a result of this work, the CCG's plans have been strengthened. Examples of this include changes to commissioning plans, increased support to new schemes such as Swindon Advice And Support Centre, and increased public engagement in partner and community events.

In 2015-16, we will seek to achieve the following objectives:

- To enable all stakeholders to have a voice and encourage them to use it in terms of influencing the decisions of the CCG
- To ensure the PPI Forum operates effectively to achieve its three key functions
- To build continuous and meaningful engagement with the public, patients and carers to influence the shaping of services and improve the health of people in Swindon and Shrivenham through each stage of the commissioning cycle (listed below):
- Utilise patient experience and opinion and close working with our provider organisations to improve quality and responsiveness of local services. This patient experience data can be used at any point in the three stages of the commissioning cycle:

a. Planning and designing pathways
b. Procuring services
c. Monitoring and evaluating services.

7.8 Equality and Diversity

In order to review compliance with the Public Sector Equality Duty (PSED), the CCG has in the last year undertaken an in-depth review of the systems, processes and documentary evidence available to demonstrate due regard to the aims set out in the general equality duty.

7.8.1 Benefits of Compliance with the PSED

The benefits include:

- Understanding of the local population and service users' needs
- Informed decision making and population targeted policy development
- Effective use of resources
- Transparency of activity and the learning to improve patient experience
- Reduction in instances of discrimination and claims
- Enforcement action avoidance by the Equality and Human Rights Commission

7.8.2 CCG Actions taken:

External Audit

In October 2014, an external audit was commissioned from the Central Southern Commissioning Support Unit, by the CCG with the objective of ascertaining the CCG's compliance with its legal obligations under the equality 'umbrella'.

The results demonstrated adequate governance arrangements and a CCG commitment:

'To ensuring that equality, diversity, inclusion and human rights principles are central to the way it commissions and delivers healthcare services and supports its staff'.

Recommendations have been taken forward, predominantly in regards to documentation and this has been reflected within the refreshed equality objectives.

NHS Equality Delivery System 2

The CCG has also embedded the use of the NHS Equality Delivery System 2 (EDS 2) which is currently optional, but to be mandated for all NHS organisations from April 2015 within the NHS Standard Contract.

When using EDS 2, NHS organisations complete a grading exercise (for the five goals and outcomes of equality compliance). The grades are underdeveloped, developing, achieving and excelling.

Following the initial grading exercise (for Swindon CCG) an action plan was developed and progressed, in alignment with the external audit action plan. All

apart from two were graded as achieving. The two remaining 'goals' (actions) graded as 'developing' and being progressed to 'achieving' are:

1. To strengthen 'inclusive leadership' at Board level by formal appointment and additional training for Equality Champions

2. To obtain staff feedback in terms of middle management support within an environment free from discrimination

Workforce Race Equality Standard (WRES)

This is to be mandated for all NHS organisations (within the NHS Standard Contract) from April 2015. The WRES will require NHS organisations to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of Black and Minority Ethnic representation at senior and Board levels. The CCG has instigated future monitoring actions required both by the CCG Contract Team and also by ConsultHR.

7.8.3 Improved Understanding of our population

Population profiling has an important role in helping the CCG to understand the needs, wants, expectations and behaviours of the local population. By working closely with GWH and SBC, the CCG has renewed insight into the behaviours and traits of the local population through 'Mosaic Public Sector', a consumer insights tool designed by Experian, to profile residents. It provides location, demographic, lifestyle and behavioural data on the individuals living within the Swindon area.

7.8.4 Improved Communication with the Hard to Reach Groups

The PPI Forum has tasked the CCG with ensuring that it successfully interacts with hard to reach groups. The CCG knows the groups of people traditionally harder to reach or communicate with include:

- Gypsy and traveller communities
- Homeless people, especially in and around Swindon town centre
- Carers, including young carers
- Eastern European populations
- Older people and disabled people who are isolated at home
- Adults with learning difficulties.

The CCG has made progress with these communities by strengthening work with different partner organisations who have direct links with many of these communities including, SEQOL community leads, the Public Health team, Healthwatch Swindon, different localities, and community and voluntary sector providers
The CCG will therefore meet the specific health needs of our growing population from minority groups and also reducing the health inequalities

experienced by those who provide informal care for others, as per the Five Year Strategic Plan (2014-2019) ambition.

Equality Objectives
In alignment with the Board Assurance Framework the following equality objectives have been agreed. As NHS Swindon CCG is still a fairly new NHS organisation, the objectives are set to ensure solid equality foundations are embedded.

During 2014 the CCG reviewed all processes relating to Equality and subsequently published the following four objectives

Equality Objective 1: To enhance the current mandatory training programme for Swindon CCG staff and Governing Body members; to provide practical role based knowledge to ensure that staff have a full understanding of how to assess the equality risks to patients in regards to any decisions made
Equality Objective 2: To implement an internal system of reporting (by exception) in regards to EIA identified risks and subsequent identified actions, to ensure that these are shared, managed & monitored
Equality Objective 3: We will ensure that all commissioned health service providers fulfil their duties under the Equality Act 2010 (as per NHS Standard Contract 2015/16)
Equality Objective 4: Any new health services or future health service changes will be assessed for equality impact as a part of the proposal. The summaries will be published on the CCG website

7.8.5 Documentation

The CCG has formally introduced Quality Impact Assessments (QIA's) and also refreshed the Equality Impact Assessment (EIA's), to capture equality as an integral part of quality monitoring within general business activity wherever appropriate. Both documents will formally record inclusion, consideration and summarise risks and actions required.

The new QIA (and inclusive EIA process) has been tested as a part of the Community Navigator Pilot evaluation, and the EIA future summaries are to be published on the website.

7.8.6 NHS Swindon CCG Annual Equality Report

As a statutory duty, a report is required to be published annually. NHS Swindon CCG acknowledges the benefits of reporting:

- Confirmation of the variety of equality data and information available (as per required 'duties')
- Identification of how this information is being used to make decisions
- Identifying how this information is being used to address the health needs of our community and any health inequality within it.
- Identify the gaps in information and enable mitigation; in order to be better informed in our decision making and future compliance with our Equality Duty
- Organisation equality transparency by enhanced monitoring and reporting
- The monitoring of progress against the organisational Equality Objectives
- Raising the Equality Duty profile within the organisation

The report is available on the CCG website, as of the end of January 2014.

8 Five year forward

The NHS England document five year forward into action: planning for 2015/16 asks commissioners to consider the design and implementation of new models of care. In outlining the foundations for early adoption the document recommends that 'rather than proceed with a stand-alone re-procurement of community services, one option CCGs may want to consider is how to integrate these within a new MCP model'. There are a range of delivery models proposed in the NHS 5 year Forward View which bring together acute and community, social care and health services under one model (Primary and Acute Care Systems) whilst another model integrates primary care with community care or acute care (multi-speciality Community Provider).

In Primary and Acute Care Systems a single organisation could provide NHS hospital services together with mental health, social care and community care services based on a list of registered patients (linked to GP lists). This is similar to the model of Accountable care organisations in the United States. This could involve capitated budgets linked back to the registered population.

Multi-Speciality Community Providers take on a wider set of services which could include ambulatory care, outpatients, community based services such as pharmacy and dentistry. The model could include community and social care services with a pooled budget delegated to the Multi-Speciality Community Provider.

These models would mean fundamental changes to the way we currently contract for community, social care and acute health services. Very few of these models have also been tested in the UK. This means that further work with providers needs to take place to test what might be the best model for Swindon. The NHS Forward View recognises that models take time to develop and will need to be tested.

The CCG has identified a number of principles which it will want to see within any future provider models that are developed in Swindon. The draft set of principles are contained within Appendix 2.

New models are being considered for the urgent care system and frail elderly and mental health provision, looking at system integration, population based delivery and capitated budgets. The development of the models and the procurement methodology will be developed during 2015/16.

9 Key Priorities 2015/16

A review of progress against the 5 year plan, activity levels, outputs from JSNA and Health and Wellbeing Strategy has led us to identify a range of priorities for 2015/16 which will support the delivery of our strategic plan.

9.1 Planned Care

During 2014 there have been a number of specialties where there have been pressures related to capacity versus demand with the main acute provider Great Western Hospitals NHS Foundation Trust. These specialties will form the priorities for review in 2015/16, although the CCG will continue to work with providers to identify any other areas where pressures may be developing.

It is recommended that for planned care a Programme Group is convened for each of these specialties, chaired by a primary care clinician. All interested providers will be members of the Programme Group along with patient representatives. These groups will be provided with data to show current activity and spend across all providers and data projections for future demand. This information will be used to support discussions on the development of future pathways. Reports from these groups will be discussed at the CCG Clinical Leadership Group and will be used to develop service specifications for the delivery of pathways into the future and to ensure sufficient capacity is commissioned across the range of required services.

9.1.1 Rheumatology: service pressures resulting from workforce issues across a number of acute providers. Work needs to take place to remodel services, with particular consideration to the chronic nature of the condition and the range of support patients may need.

9.1.2 Ophthalmology – The backlog in patients waiting for the follow up appointments has reduced significantly, but commissioners recognise this is a specialty with increasing chronic caseload numbers, linked to other conditions (such as diabetes which is projected to increase in incidence). Service redesign work has commenced, working with community optometrists.

9.1.3 Dermatology – flagged as a service coming under increasing pressure from demand, particularly related to patient awareness of the impact of skin cancers. A full review of current activity and of access thresholds to the range of available services to meet demand will be completed.

9.1.4 Cardiology – flagging potential pressures in capacity as demand continues to increase.

9.1.5 Gastroenterology, capacity pressures linked to expected increased demand in endoscopies as cancer screening programmes and improved public awareness continues.

9.2 **Urgent Care / New model**. The Urgent and Emergency Care National Review proposes a fundamental shift. The CCG has worked with membership practices to design the model of care it intends to commission going forward (see Appendix 3). This model is intended to improve the integration of services and ensure that there is a defined and controlled access to the acute bedded part of the system, through a new urgent care centre which would be the access point to the hospital. A new urgent response service would also be developed which would be a single point of telephony access for public and professionals alike for health and social care services.

Work has commenced on specifying the detail of the model and a number of work streams have been identified as a part of this (estate, IM&T and Workforce).

A new Rapid Assessment Unit which is part of the Urgent Care Centre is being reviewed, this will be an assessment centre staffed by clinicians with a primary care skill set, they will have access to rapid diagnostics and will be able to refer into step up or virtual ward services. The intention is to trial this element March to May 2015.

The CCG OIS (appendix 4) demonstrates a small reduction in the numbers of patients who had an acute condition that should not usually result in a hospital admission. This is an area the CCG will continue to concentrate on during 2015/16, with a particular emphasis on heart failure patients, respiratory (COPD), and dehydration/UTI conditions.

9.2.1 System Resilience
National funding has been identified to support system resilience for the urgent care system. The Swindon Strategic Resilience Group has agreed the following schemes

Scheme description	Area of Impact	Key Benefit
Great Western Therapist at Front Door	Impact will be for assessment areas (ED, Ambulatory Care, LAMU, SAU, Short Stay) Supporting patients to avoid admission and increasing safety	Number of patients with therapy support where admission avoided. Number of patients discharged home Number of patients transferred to another non –acute setting directly.
SEQOL Therapist at Front Door	Supporting patients to avoid admission and increasing patient safety	Number of patients with therapy support where admission avoided. Number of patients discharged home Number of patients transferred

		to another non –acute setting directly.
Prospect Therapist	Access to 7 day rapid response to access to equipment at weekends and during bank holiday .Compliments above schemes	Increase in therapy support enabling improved response and provision of equipment out of hours.
GWH 7 day/SAFER	Dedicated 7 day additional junior doctor on each – in-patient medical wards with an additional registrar and consultant circulating for review and input	7.5 dedicated doctor over weekend All medical patients being physically reviewed by junior doctor and capacity to escalate to Reg/Consultant Reduce ward patients having long delay in waiting for reviews, increasing discharges over weekends
SWICC Staffing	Increase staffing ratio to manage safety increased profile of patients with dementia/LTC complexity	Reduce Los for Dementia patients Access to 2 ambulatory care beds Safer staffing levels to support those patients with increased complex needs.
Dedicated palliative care team admin support	Dedicated admin support to the palliative care team at GWH to release CNS time to respond more rapidly to those patients who are being discharged or to ensure end of life care needs are assessment and met., whom are increasingly becoming more complex.	Increase response time of palliative care team to support early/ timely discharge for those patients wishing to die at home. Reduce time to assess the completion for needs assessment for fast track as time released for CNS to complete

9.2.2 Seven day services-The CCG along with Swindon Borough Council currently commission a number of health and social care services that cover 7 day a week access. In 2015/16 the CCG will continue to pursue the opportunities to further commission and implement 7 day services ensuring they are equitable and of high quality and available on the basis of need. In 2014/15 a CQUIN has been in place with the acute trust as an incentive to implement standard 2 of the 10 clinical 7 day service standards. The CCG are currently working with

the trust to agree a phasing of the full implementation of all the 10 clinical standards during 2015/16.

9.2.3 Better Care Fund – section 10.7 provides an overview of the investment and schemes which are funded through the better care fund. The original intention was that these schemes should reduce demand on the acute hospital by 3.5%. In reality we have seen an increase in admissions during 2014/15, which has led to pressures within the system and impacted on the constitution target of 95% patients seen within 4 hours.

A review of urgent care admissions in 2014/15 has identified that the BCF target to reduce admissions by 3.5% from the previous years volume is a challenging one. The assumption for 2015/16 is that through a combination of the BCF schemes and the front door/urgent care model Swindon will manage to reduce admission levels by 1.5% (from 2014/15 levels) and manage out the expected demographic growth of 3%, in essence giving a 4.5% target against which commissioners need to remodel services.

Carers: this is a key deliverable for the H&WBB and some of the investment the CCG has put into the BCF will support this. The Carers support centre in Swindon has been commissioned to help identify people and support assessments in the next year. Healthwatch are also promoting this.

9.3 **Long term conditions**: The increasing prevalence of LTCs is highlighted within the JSNA. The financial pressures facing health and social care into the future indicates a radically new approach is required to tackle this trend. The CCG and SBC applied for national transformation funding to look at the role of a Community Navigator in supporting individuals with a LTC.

Working with providers and service users, service redesign workshops were run during 2014/15 on diabetes, COPD and CVD. As a result of this work a programme of work streams have been set up and through 2015/16 and will be implemented during this next year.

9.3.1 Respiratory/COPD:

The Commissioning for Value pack identifies high non elective spend and over 75 mortality rates for COPD for Swindon's population. This makes it a priority area for 2015/16.

Progress to further strengthen an integrated model of out of hospital care model, including improved use of a virtual ward and a stop smoking programme

Improve patient access to the most appropriate service and the development of a local awareness initiative will help deliver this.

Collaborate with the British Lung Foundation, Respiratory Health Care Professional and Volunteers who are affected by respiratory illness to establish a local Breath Easy Group in Swindon.

9.3.2 Diabetes:

A joint pathway for foot ulcers and strengthening care delivery and decision making through a Multi-Disciplinary Team which will help to reduce amputations, this

Delivery of a structured primary care education programme which will help to support management of blood pressure and cholesterol levels, and may reduce hospital admissions

A revised Swindon Diabetes website will be taken forward provide up to date information about service, symptoms and support for patients and clinicians.

9.3.3 CVD

Commissioning for value pack identifies that non-elective spend on heart disease pathways is worse than England average, this has supported the decision to prioritise a review of pathways particularly related to heart failure.

Immediate telephone access to consultant advice (Consultant Link)

Expert GPs in cardiology at locality or CCG level

Introduction of a new protocol for admission through implementation of a rapid access chest pain pathway

Swindon CCG are currently discussing the development of community heart failure pathways with cardiologists at Great Western Hospital.

9.3.4 Community Navigator

Pilot a new Community Navigator model, with navigators working in each GP Practice. The aim is to help people understand and access opportunities and support from community, voluntary and statutory resources. They will help people identify appropriate support and tools to self-manage their condition. The navigators will work with people on a one to one basis, focussing on goal setting and supporting behaviour change. The target group will be people with a long term condition, but the specific cohort defined in collaboration with each practice. The patient cohort will be adapted as the project expands to ensure that maximum effect is delivered and patient are more confident and supported in the management of their conditions. The project will monitor impact on health and social care cost and activity.

9.4 Cancer

9.4.1 Radiotherapy – work will commence on the new radiotherapy service which will be based at the Great Western Hospital, this is a development which has been prioritised by the population of Swindon.

9.4.2 During 2013/14 the CCG led a programme of service redesign specifically looking at cancer the impact of cancer growth and demand. The CCG and partners have now consolidated all the actions into a cancer working plan for 20115/16. The key areas to progress are:

- Continued achievement of the national cancer standards
- Improvements in early diagnosis and reduction in emergency presentations
- A pathway to support planned and pre-booked diagnostic appointments, including increasing more direct access testing for GPs
- Holistic needs assessments (HNA) at time of diagnosis as well as at end of treatment pathway (currently only undertaken at end of active treatment) for breast cancer patients
- Renewed focus on older people who are diagnosed and survive cancer

9.5 Paediatrics

9.5.1 Children's emotional wellbeing and mental health, there are a number of key challenges to be considered within this next year and they include:

- review of TaMHS and On Trak (emotional support and counselling) to meet increasing demand and reduce waiting lists;
- improving transition arrangements for young people turning 18;
- support for young people who self-harm (high numbers in Swindon);
- support for young people with complex social and mental health needs and the use of out of area placements (increasing demand);
- CAMHS contract expires in 2017 so the needs assessment and strategy will also inform procurement of specialist services. The CCG will work closely with NHS England to develop the future models of care across the tier 3 and 4 services.

9.5.2 Review of urgent care services for children to reduce unnecessary admissions to hospital

The CCG are developing an urgent care project in collaboration with the new GWH consultant with a special interest in paediatric urgent care, the project will include:

- Looking at the impact of the Children's Clinic and information booklets distributed to parents;
- review of the Community Outreach Nursing Service to work with families to prevent unplanned admissions and optimise discharge;
- review of the acute pathway and the potential for paediatricians to work more in the community.
- CCG outcomes indicators set - admissions of children with respiratory infections (Appendix 4) demonstrates potential for further improvement in levels of children being admitted. This is

supported by the Commissioning for value pack which identifies high non elective spend and emergency admissions rates for children with asthma (under 18s).

9.5.3 Reviewing support for children with complex and life-limiting medical conditions

9.5.4 Working with GWH to improve transitions for young people moving between paediatrics to adult services

9.6 **Mental Health**

Choice in mental health services has been in place in Swindon and allows individuals to choose where they would go for their assessment of need. Our main provider AWP has been instructed to make a choice of initial assessment clear on referral and the assessment post completion, from provider of choice are then conveyed clearly back to AWP to initiate if there are identified needs beyond local services this is escalated to the CCG for consideration.

9.6.1 A new mental health pathway is being implemented with our main provider and will result in the following outcomes

- Local whole pathway contracts focused on outcomes and sustained recovery with high level scrutiny measures
- An emergency response better than outlined within Parity of Esteem and Crisis Concordat
- A model which is empathetic to pressure in Primary care and does not add to it by increasing availability of specialism locally
- A non linear pathway which reduces demand on primary care and empowers self management and uses pull to support genuine recovery
- Far better whole systems understanding
- System integration to focus on Mental Health and Physical Health care simultaneously fulfilling national ambition, delivering better outcomes, more synergies, using less or same resources

9.6.2 Psychiatric liaison services: there is a service in place at the Great Western Hospitals NHS Foundation Trust. A review of this will take place during this year, with a particular emphasis on the requirements of patients to dementia to identify what further development is required. This also links into the urgent care model and an intention to site the Crisis Response Service and the psychiatric liaison service within the urgent care centre.

9.6.3 Dementia: Recognising increased demand and priority of dementia care, the CCG are planning a Locally Enhanced Service with General Practitioners to manage more routine diagnosis and management of those with dementia. Performance against the national 28 day diagnosis target has been challenging in recent years, however we have now secured a new model of care which will deliver this requirement by the end of March 2015. Within the

dementia strategy there is a model for specialised treatment and management of more chronic and specialist requirements. The business case to support this model is being discussed as part of the planning prioritisation process.

9.6.4 IAPT: There is a national requirement to continue to develop IAPT services and this is a further consideration by the CCG as part of the planning process, including looking at how this model could provide more support to individuals with long term conditions.

9.7 Primary Care:

Pressures on primary care continue to grow with increasing demand at a time when it is growing more challenging to secure the required workforce. The CCG will be working with NHS England to develop our strategy to support primary care, there are a number of key strands which will be progressed during 2015/16.

9.7.1 **Co commissioning**:

Swindon CCG Governing Body agreed at its meeting on 22 January 2015 to apply to NHS England to jointly commission primary care services. Swindon CCG believe that joint commissioning of primary care services with NHS England will help the CCG and the broader Swindon Health and Wellbeing partnership better integrate care outside hospitals to support our whole healthcare system, making it easier for patients, engaging the community and local clinicians, to design the most appropriate high quality services and minimising local health inequalities. The CCG anticipate that co-commissioning will increase the pace of transformation change required to improve the quality and outcomes that will benefit the local people.

Joint commissioning also links with the CCG's vision, expressed in our 5 year plan. Commissioning primary care at scale, to a mechanism of commissioning which will be transparent, with robust governance arrangements and which has the appropriate safeguards against conflicts of interest.

Joint commissioning gives the CCG the opportunity to influence the key priorities within the NHSE strategy related to Swindon, ensuring that local priorities such as diabetes and cervical screening are taken forward.

9.7.2 Neighbourhoods

Two engagement events have been held with our member practices and they are beginning to identify how they would want to work together to develop primary care services and resilience as well how they may want to see community based services develop in the future. The table below shows the clusters which are being discussed with practices to determine an agreed

footprint which could be used to deliver services to support groups of practices.

Proposed neighbourhoods and associated practices

North Swindon neighbourhood
Abbey Meads Medical Practice; Hawthorn Medical Practice; Moredon Medical Centre; North Swindon Practice and Taw Hill Medical Practice
West Swindon neighbourhood
Ashington House Surgery; Phoenix Surgery; Sparcells Surgery and Ridge Green Medical Centre
Central Swindon neighbourhood
Carfax NHS Medical Centre; Great Western Surgery; Park Lane Practice; Victoria Cross Surgery and Whalebridge Practice
South Swindon neighbourhood
Eldene Health Centre; Eldene Surgery; Old Town Surgery; Hermitage Surgery; Kingswood Surgery; Lawn Medical Centre and Priory Road Medical Centre
Rural Outer Ring neighbourhood
Cornerstone Practice; Elm Tree Surgery; Merchiston Surgery; Ridgeway View Family Practice and Westrop Surgery

9.7.3 SUCCESS/primary care capacity

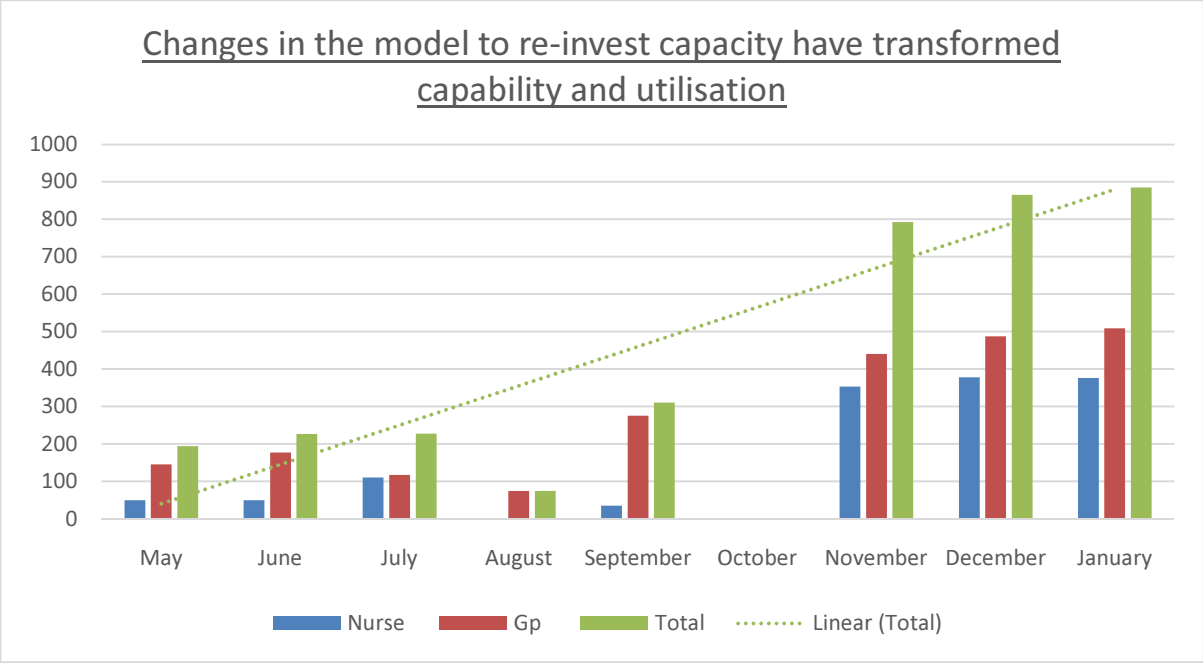
During 2014/15 the CCG and NHS England pump primed the implementation of a new project. The aim of this pilot was to create an environment in which recalibration of primary urgent and routine care could occur in line with national drives for primary care innovation to meet elevated patient expectation whilst preserving the role of host GP surgeries.

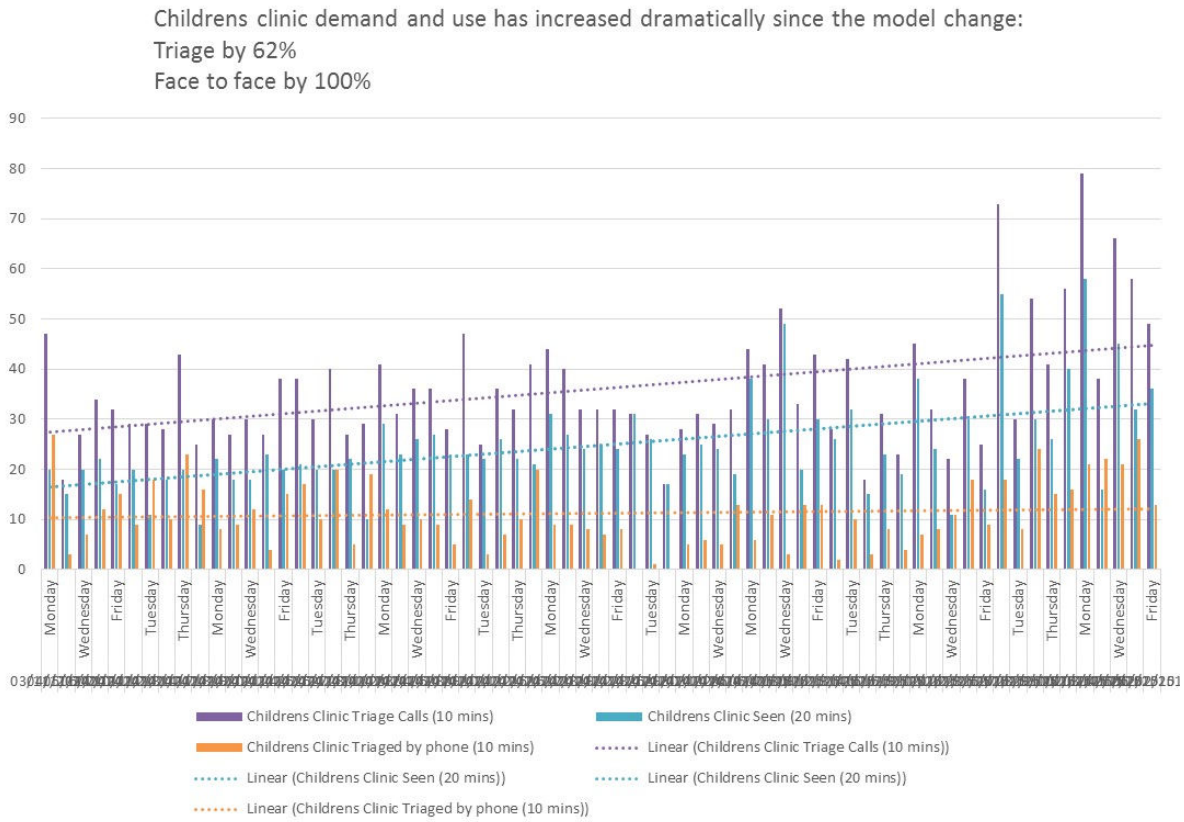
This would be obtained by managing and evenly distributing unplanned on the day demand and allowing primary care surgeries to treat and assess those patients who most benefit from continuity of care. The service would in turn reduce waiting times for routine appointments throughout the primary care and increase the available consultation time for those patients who will most benefit from the expertise and experience of their GP coordinating multidisciplinary assessments and interventions.

The model was based around three core services:

- An appointment only clinic based urgent care centre
- An appointment only urgent children's clinic
- An appointment based home visiting service

The project was overseen by a Committee comprising representatives from both the CCG and NHSE and performance was monitored by the Governing Body each month. Utilisation of the model was impacted by a variety of factors, the graphs below shows how re-profiling the service improved utilisation of the urgent care centre slots and the children's clinic.





There has been an opportunity to bid for national funding via the ***Prime Ministers Challenge Fund wave 2: Improving Access to General Practice*** which the CCG has responded to with an enhanced model. The CCG submitted this proposal on behalf on behalf of the majority of local practices in January 2015 and were informed in April that £3.9m funding had been awarded.

The bid set out a range of services that could be put in place to support the increasing burden of delivering urgent demand within primary care. The proposal particularly focused on feedback from membership practices that continuity of care for patients was critical, as well as for both patients and practices to retain the choice of services available to them and when to access them. The range of services includes the three core services tested in 2014/15 (urgent care clinic, children's and young person clinic, and daytime home visiting service) and adds additional capacity to these to respond to service demand, but also includes;

- Improved access to routine general practice appointments at the weekends available at 5 locations.
- Additional multi-disciplinary service provision at local GP practices
- Expansion of a range of options for consultations using modern technology to improve efficiency and test new ways of working.

This project represents an opportunity to further test new models of services to support the delivery of high quality clinical care at scale, and will also test delivery of care in more locations aligned to 'neighbourhoods' of membership practices. The infrastructure supporting this project will also allow for online booking for services and the rapid transfer of a clinical précis of the patients clinical records to and from the referring practice to support the delivery of urgent care. There will be ongoing evaluation of this scheme to review the activity and quality of care each service is delivering.

The project supports the implementation of a new urgent care model for Swindon and Shrivenham and will dovetail with other primary, community and acute services, including a single point of telephone contact for health and social care queries, and existing clinical advice services.

10 Supporting workstreams

10.1 Infrastructure

To be able to deliver the *Five year Forward View* the CCG is going to need to commission the right infrastructure for this to happen. The right infrastructure will be the right estate and the correct supporting information management strategy.

Right Estate

The new model of care being proposed for the Swindon and Shrivenham population will require services being delivered from different localities to those previously used by traditional healthcare services. The table below summarises what type of different premises will be required for the new model:

Service	Location	Comments
Community navigators	Admin – SBC offices Team – located in neighbourhoods in most suitable accommodation ie village centres; community centres; GP practices Service – at clients home	
Primary care sub-specialty clinics including: • LTC management • MDT support- nurse, social work, therapy and mental health in-reaching to GP practices	GP practices	Using freed up consulting rooms with the shift of some GP appointments to the weekend
Diagnostics	Urgent care centre?	Opportunity for more provision of diagnostics in primary care?
Virtual ward & reablement	Admin – provider Team – located in neighbourhood premises see above Service – at patients home	
Urgent response service	Single point of access	• One telephone point of contact for Primary, Health & Social Care (24/7) • Walk in Service (7 days) • GP OOHs service (Paeds) • GP urgent bookable service (7 days) • Access to specialist telephone advice (frail elderly)

The CCG will need to consider working with primary care to identify opportunities to develop the appropriate estate for the new models of care. The CCG did consider whether to submit a bid to be part of the Primary Care Infrastructure Fund with primary care, however, at this stage there were no sufficiently worked up proposals to take forward. During 2015/16 work will need to be completed with practices to be in a position to bid for investment in future years.

10.2 Infrastructure/IM&T

The key component of the IM&T infrastructure required in the new model of care will be having effective interoperability between organisations information systems. During 2015/16 the work initiated with the Black Pear system as part of the SUCCESS pilot will be further developed. This approach could be readily adapted for GP referrals to urgent care centre; urgent response service and other primary care centres. The aim of this IT system would be to secure the seamless booking of appointments from any GP practice or location into one or more urgent care centres or home visiting services. The system allows patient records to be sent at the time of booking and consultation outcomes returned to the referring GP/Practice immediately post appointment.

10.3 Workforce

The workforce required to deliver the new models of care will need to be different to the existing workforce. During 2015/16 further work will need to be undertaken to determine the skill-mix of medical and nursing and allied health professionals to perform the services required. There will be greater opportunities for the development of generic workers; multi-disciplinary teams; care co-ordinators. There will also be the expectation that more resource will need to be identified in localities and neighbourhoods.

A key part of the new model of care will see consultants working with primary, community and social care colleagues to improve the diagnosis and treatment of patients outside of hospital. A central part of the consultant's new role is education and training which will include advising and supporting primary and community staff. The new services will need to be able to offer placements and training posts to prepare the future workforce to work in a more integrated system.

During 2015/16 there will be a need to explore the opportunities for the development of Physician Assistants in the new model of care.

The CCG are working with the HEE/LETB, Oxford Brookes and the University of the West of England looking at the nursing workforce requirements into the future and different models/skill mix. The CCG are also working with the Deanery looking at primary care workforce – GP and there is a workshop planned May 13th to commence this work stream.

10.4 Research and Innovation

The CCG has a statutory duty to promote research and the translation of research evidence into practice. The introduction of the new models of care should support this duty by ensuring that there are mechanisms for collating information on the clinical interventions and the improvement in outcomes, so that it is possible to determine which new models achieve the greatest improvement in outcomes. During 2015/16 the CCG will be continuing to work

with the West of England Academic Health Science Network on the interoperability project and the employment of a GP Clinical Fellow.

10.5 **Personal health budgets**

The *Five year Forward View* emphasises the point that when people do need health services, patients will gain far greater control of their own care. The CCG is part of the South West Integrated Personal Commissioning Network which has been established to support the design and implementation of personal health budgets and integrated budgets to improve outcomes for people and reduce cost pressures. The implementation of integrated personal commissioning should mean that people who need support from different organisations will have their: assessment of needs better co-ordinated; needs captured in one personalised care plan; support tailored to meet the outcomes they want for their life; choice of how that support is delivered; and if they wish it, their own budget to control themselves.

11 Finance

11.1 Financial overview

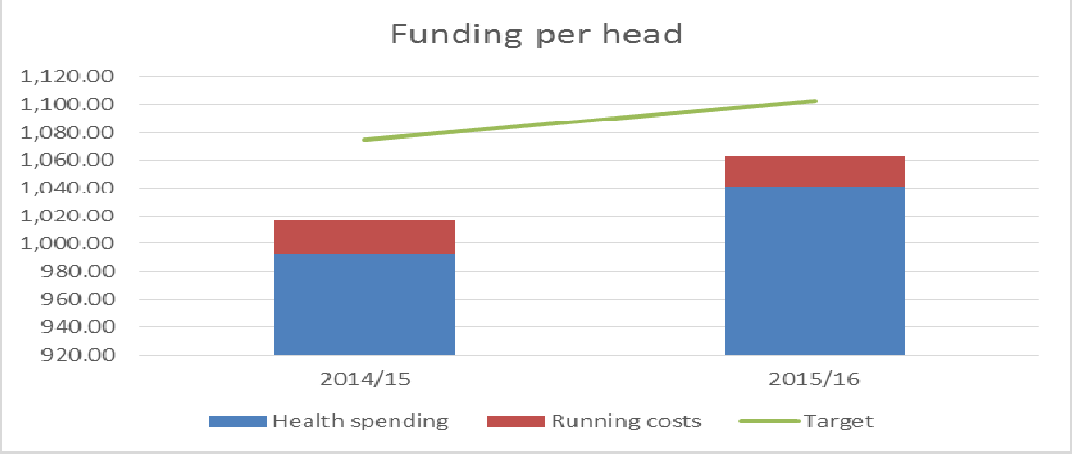
The CCG funding is determined through the Department of Health's annual spending review. In December 2013, NHS England approved allocations for 2014/15 and an indicative allocation for CCGs for 2015/16. The Autumn Statement in December 2014, announced additional funding for NHS front line services and transformation amounting to £1.98bn; to assist with implementing the agenda set out in the NHS Five Year Forward View.

It was proposed that:

- £1.5bn of the extra funding be used to support front line services which should be allocated to CCGs, moving those *furthest* from their 'fair share' at a faster pace to their target allocation. 'Furthest' being defined as those with a distance from target at over 5%.
- £480m be used to support transformation in primary care, mental health and local health economies

Health systems have been given the opportunity to bid for transformation funding by registering their interest to become a vanguard site for new models of care against a pot of £200m. An extra £250m can be applied for over each of the next four years where health economies can demonstrate a step change in primary and community care infrastructure.

As Swindon's distance from our fair shares target in 2014/15 was 5.58%, we benefitted from this funding and circa £14m has been made available (£7m more than previously announced in the indicative allocations for 2015/16) which brings Swindon 3.68% from our fair shares target of £252m.



The health funding gap has therefore reduced from £59 per head to £40 per head which equates to a total of £9.3m.

CCG's annual allocation has been supplemented in previous years by additional non-recurrent funding which generally has been made available in year to support system wide pressures emerging in year. In 2014/15, Swindon received £5.3m of non-recurrent funding to support:

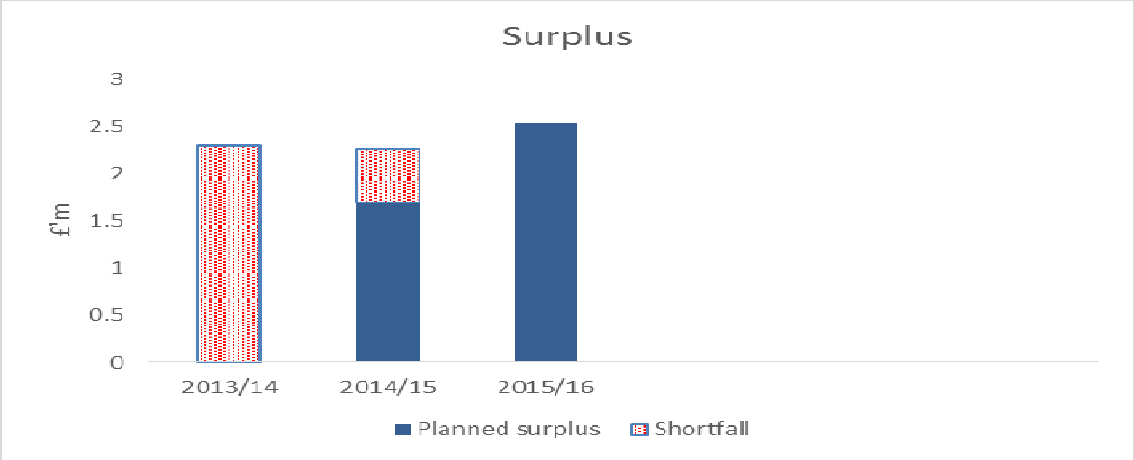
- costs of system resilience schemes
- clearing backlog in RTT and,
- capital grants to invest in equipment and IT infrastructure.

The CCG has been notified that its system resilience funding will be £1.23m which compares to the two tranches of non-recurrent monies received for system resilience in 2014/15 which totalled £2.5m. Section 9.2 contains the detail of schemes being funded in 2015/16.

Swindon received £0.6m for capital grants in 2014/15 which was used mainly to invest in additional community equipment and wheelchairs; services managed by Swindon Borough Council. The decision has been taken nationally (due to disparity across the north and south of the country on the application of these grants) to phase these out. It is now likely that the CCG will receive some funding in 2015/16; nationally they are debating whether to apply a pace of change.

The CCG is expected to generate a surplus equivalent to 1% of its overall resource allocation. Graph 1 below demonstrates the CCG surplus position across a three year period. In 2013/14 the CCG reduced its surplus in year to break even; this was caused by transfers of funding for specialist commissioning services to NHS England which did not prove to be cost neutral for the CCG. In 2014/15 the CCG originally planned to achieve a surplus of 0.5%; this has been revised to 0.75% as NHS England have given CCG's a rebate from the national Continuing Health Care (CHC) risk pool based on current and anticipated under-utilisation in year. For 2015/16 the CCG has targeted to achieve a 1% surplus.

Graph 1 CCG Surplus



11.2 Planning Assumptions

NHSE planning guidance released in December 2014 proposed that the CCG apply the following assumptions to its financial plan for 2015/16:

- 6% of the CCG's growth be set aside to fund investment in Mental Health
- Further growth to be applied to cover increases in costs due to inflation on CHC (3.5%), Prescribing (4.0%) and Payroll (1.0%).

This was supplemented by the 'national tariff' paper produced by Monitor, which recommended:

- Inflationary uplift to PbR prices of 1.93% to take account of costs of drugs, payroll, capital and CNST
- Continuation of the cash releasing efficiency saving be applied across all providers at a slightly lower rate of 3.8%
- Emergency Marginal Rate Tariff share changed from 70:30 CCG: Provider to 50:50

However, a further announcement from NHSE in January 2015, stated that given the number of challenges received from NHS organisations, Monitor's Board have concluded that the proposed 2015/16 tariff (including changes to marginal rate) could not be adopted in its current form.

New guidance issued on 18th February 2015, has allowed providers the choice of an enhanced alternative (the Enhanced Tariff Option- ETO). This will entail the adoption of the 2015/16 prices (PbR at 1.93% with opportunity to increase this to 3% for CNST premium increases), reduction in application of CRES from 3.8% to 3.5% and a rise in the marginal cost reimbursement for emergency hospital admissions from 50% to 70%. This latter adjustment should be used to support ongoing system resilience schemes.

If providers choose not to adopt the ETO, they can continue with current 2014/15 prices (Default Tariff Rollover- DTR) until such time as Monitor publish a new

tariff. However providers opting for DTR will not be eligible to CQUIN for the entirety of 2015/16 in recognition of the lower efficiency applied (net -1.4%).

In recognition of the additional financial pressures which CCGs could face, if providers choose ETO, NHSE has set aside £150m nationally. Discussions will be had with CCGs locally before any decision is made regarding release of this funding and the CCG has been informed by NHSE that the increase in costs due to CRES are likely to be funded but not MRET, which should already be in the local health system (used to fund QIPP schemes aimed at reducing demand for acute services).

GWH and SEQOL have formally notified the CCG that they will be choosing the ETO option. Neither organisation has been adversely affected by a significant rise in their CNST premium costs, so this financial risk has been mitigated.

11.3 Demographic Growth

In its Strategic Plan which was published last year, the CCG identified the level of demographic growth it expected to occur across its main areas of programme spend (as defined by national Programme Budget data).

Table 1 programme budgeting & demographic growth assumptions

Programme	2011-2012 (%)	2012-2013 (%)	Annual growth estimate	Projected spend before inflation, developments and efficiencies					
				2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019
				%	%	%	%	%	%
Mental health	14.69%	14.05%	3.83	13.31%	0.00%	3.75%	3.88%	3.73%	3.84%
Circulation	10.52%	11.56%	4.05	11.34%	4.09%	3.93%	4.07%	4.19%	4.02%
Genito urinary	7.08%	7.05%	4.04	6.96%	3.59%	4.46%	3.79%	4.11%	3.95%
Gastrointestinal	6.46%	6.68%	1.39	6.39%	1.68%	1.10%	1.63%	1.60%	1.05%
Cancer	6.46%	6.33%	4.11	6.24%	4.00%	4.40%	3.68%	4.06%	4.39%
Neurological	6.46%	5.20%	3.62	5.10%	3.50%	4.05%	3.25%	3.77%	3.64%
Musculoskeletal	6.35%	7.70%	4.04	7.56%	4.25%	4.07%	3.91%	4.18%	4.02%
Respiratory	5.83%	6.19%	3.44	6.06%	2.94%	4.00%	3.30%	3.19%	3.61%
Learning disability	5.73%	2.35%	0	5.17%	0.00%	0.00%	0.00%	0.00%	0.00%
Maternity	5.21%	5.37%	1.39	5.35%	1.33%	1.32%	1.30%	1.92%	1.89%
Endocrine and metabolic	4.38%	4.43%	3.87	4.35%	3.28%	3.97%	3.82%	3.68%	4.26%
Dental	3.96%	4.34%	1.39	4.17%	0.85%	1.69%	1.67%	0.82%	1.63%
Trauma and injuries	3.96%	4.80%	2.01	4.64%	1.54%	2.27%	2.22%	1.45%	2.14%
Vision	3.44%	3.62%	4.04	3.57%	4.00%	3.85%	3.70%	4.46%	4.27%
Skin	2.92%	3.74%	1.01	3.57%	1.00%	0.99%	0.98%	0.97%	0.96%
Infectious diseases	1.77%	1.99%	1.39	1.93%	0.00%	1.85%	1.82%	1.79%	1.75%
Poisoning	1.56%	1.26%	1.11	1.18%	3.03%	0.00%	0.00%	2.94%	0.00%
Neonatal	1.46%	1.36%	0	1.28%	0.00%	0.00%	0.00%	0.00%	0.00%
Hearing	1.04%	0.99%	2.01	0.96%	0.00%	3.70%	0.00%	3.57%	0.00%
Blood disorders	0.73%	0.99%	1.11	0.93%	3.85%	0.00%	0.00%	0.00%	3.70%
	100.00%	100.00%							
Totals (incl specialist services)				280.3	287.1	295.6	304.4	313.5	323
Overall growth in demand (%)					2.43%	2.96%	2.98%	2.99%	3.03%

Local analysis indicates that demographic demand is likely to rise across various sectors by on average 3% which based on a profile of current spend would cost

the CCG £3.5m. The CCG has decided to use this as a basis for determining use of its additional 2015/16 allocation to ensure the costs associated with this demand are recognised across its main Swindon providers. Currently it is considering whether to recognise growth at an average of 3.8%; this reflects previous year's historic performance and pressures particularly on non-elective and accident & emergency services.

11.4 Risks and Reserves

The NHS England planning guidance specifies that CCG's should set aside 1% of their allocation to cover non recurrent commitments and ensure that initiatives which drive system wide financial benefits are recognised and pump primed. It has also set aside a further 1.0% as a local contingency to cover off any in year ad-hoc risks and financial pressures. Given the historic performance of the CCG, we are likely to see these a rise in the areas highlighted in the table below:

Risk	Nature of risk
QIPP	Currently the CCG is planning for £4.8m of QIPP, schemes will need to be robust and provide real cash releasing savings for the local health economy. This has increased by £3.9m to £8.7m.
CHC retrospective claims	The risk share contribution for 15/16 to NHS England has reduced to £350k. There are currently delays in the timeliness of reviewing and concluding retrospective claims (period pre 2012/13) which was hoped to have concluded by 31/03/2015. The CCG could be required to contribute further to this national reserve if costs exceed 'risk reserve'.
Capital monies	It is highly likely that CCGs will no longer be able to receive funding from NHS England for capital grants to Borough Councils.
Contracts with Providers	All contracts are yet to be agreed with providers for 2015/16, the uncertainty of tariff adds to this complication.
Property costs	NHS Property Services costs are still a risk particularly with CCGs having to pick up void costs and subsidising tenants.
Pace of change	Despite further funding to move the CCG closer to its fair share target, it is still underfunded by circa £9m.

In total, the CCG has £4.8m set aside to cover this range of risks in year; however an element of the 1% non-recurrent investment has been committed, leaving the CCG with uncommitted reserves of £3.6m. This is much lower than previous years; in 2014/15 the CCG held £6.8m as an uncommitted reserve. The expectation is that the highest area of risk, relating to over performance on acute contracts, will be reduced by funding the providers at outturn which should recognise the recurrent nature of the demand for services.

Growth has also been allocated to our main providers in Swindon to acknowledge the above average pressures on local health services due to the demographic profile of the local population. If this risk is not minimised through the terms negotiated in the contracting round, the CCG will need to reconsider increasing the level of reserves it sets aside to manage risks in year.

11.5 2014/15 Financial Performance

The February/month 11 finance report shared with the CCG Governing Body assumes the CCG will achieve its target surplus of £1.1m (0.5% of its overall allocation). CCGs were notified early December 2014 of a rebate due to under-utilisation of the national provision which had been set aside to cover costs of Continuing Health Care (CHC) claims prior to 2012/13. They were requested to use this to increase their surplus; as a consequence the CCG is now reporting a forecast outturn of £1.7m (0.75%).

The risk based outturn position assumes there is sufficient flexibility to cover any further ad hoc pressures during the last few months of the financial year and that the most significant areas of financial risk associated with over performance across acute providers can be contained within predicted levels. At month 11, the CCG was able to share with the Governing Body, that the largest area of financial risk associated with the over performance on the GWH contract, had been settled. The CCG agreed to pay the GWH £5m for 2014/15; this was in excess of its affordability level of £4m and reflected the fact that the CCG had benefitted from additional income in the latter part of the financial year which it was able to transfer across to GWH to recognise the deterioration in their financial position and increase in over performance during the latter months of 2014/15.

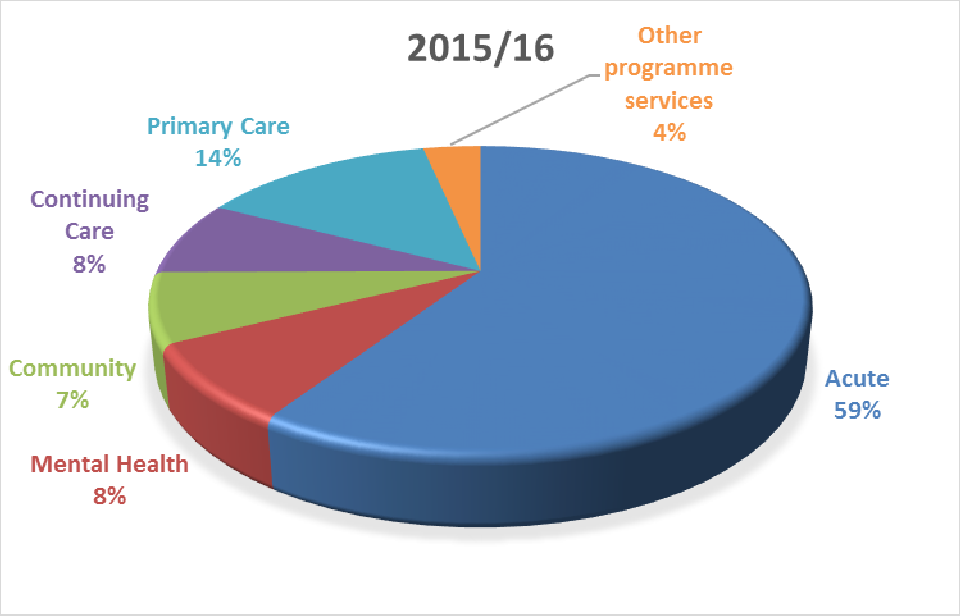
11.6 Overview of 2015/16 Financial Position

High level overview of ‘Income and Expenditure’ over the past two years and planned for 2015/16 is reflected in the table below. This clearly shows the significant increase in growth of £14m for 2015/16 when compared to previous years to take the CCG’s overall allocation to £246m.

	2013/14 £'m	2014/15 £'m	2015/16 £'m
Opening Baseline	(217.98)	(219.33)	(229.16)
Growth	(5.01)	(8.57)	(14.18)
Bettercare fund			(3.63)
Specialist Commissioning	3.66		
Winter pressures funding	(1.21)	(2.53)	
Capital grants	(2.17)	(1.01)	
Other NR adjustments	(0.07)	(1.76)	
	(222.78)	(233.20)	(246.97)
Running cost allocation	(5.46)	(5.49)	(4.97)
Return of prior year surplus	(2.23)	0.00	(1.70)
Closing Baseline	(230.47)	(238.69)	(253.63)
Analysed as:			
Recurrent	(224.83)	(233.38)	(251.19)
Non-recurrent	(5.62)	(5.71)	(1.70)
	(230.45)	**(239.09)**	**(252.89)**
Opening Commitments	210.17	219.92	227.56
Demographic and other growth	4.51	5.84	7.56
Bettercare fund (costs transferred)			3.63
Provider inflation	6.47	4.23	4.31
CRES in tariff	(8.12)	(6.66)	(5.33)
Investments/Over activity	11.98	8.57	6.31
	225.01	231.90	244.04
Non recurrent investment			2.42
Contingency			2.49
Resilience reserve			1.24
	225.01	**231.90**	**250.19**
Interventions			(4.80)
Running costs	5.46	5.49	4.97
(Surplus)/Deficit	0.01	(1.70)	(2.53)

This is supplemented by a 'Running Costs' allowance to cover the costs of managing the CCG. As with all other CCG's this has reduced by circa 10% to £5.0m in 2015/16.

As the CCG recognises the historic levels of over performance as reflected in the outturn position across its main providers including acute trusts, the recurrent costs to the CCG have risen from £233m to £251m. The relative proportions of this recurring baseline across different health sectors are shown in the pie chart below of which the largest commitment at 59% is funding costs of acute services.



The costs of local demographic demand locally and other growth funding for CHC and prescribing are expected to cost the CCG £7.5m. This is in addition to the need to recognise increases to PbR tariff (£4.1m) and a further cash releasing productivity gain for providers to achieve (£5.3m). The impact of the changes to MRET have also been reflected in this line.

11.7 Better Care Fund

With the inception of the Better Care Fund (BCF) in 2015/16, the CCG will contribute £14.4m into a pooled budget with Swindon Borough Council on a range of services which will support the health, wellbeing, mental health, education, care for children, families and adults in the community. The CCG has allocated some of its additional growth allocation to support these initiatives, including:

- Care Act to support the introduction of the new act: £460k
- Adults Social Care growth in demand for services: £800k
- Reablement services: £350k

It will also be identifying a further £175k to ensure Oxfordshire CCG and Borough Council provide equivalent level of support to residents of Shrivenham.

Services funded by the Better Care Fund are shown below:

Service	£000s
Integrated Crisis and Rapid Response	737
Reablement	800
Enhanced Community Sector Capacity	2,250
Community Rehabilitation	387
Enhanced Hospital Discharge and 7 day working	1,035
Learning Disability	183
Carers Support	807

Capital Allocations	926
Care Act	630
Managing demand in ASC	800
Community services provided by SEQOL	5,889
TOTAL	**14,444**

Nationally, CCGs now have the discretion to transfer funds directly to Borough Councils; last year this process was administered by NHS England and so £3.6m of current monies earmarked for the Better Care Fund is being passed to Swindon. These arrangements will be formalised through a Section 75 agreement.

11.8 QIPP

The CCG has restated its QIPP challenge at £4.8m to achieve through schemes aimed at delivering efficiencies by focusing on quality, innovation, productivity and prevention (QIPP). There was an expectation that this would rise significantly to over £8m due to the changes from modelling impact of ETO; this has now reduced because the CCG has clarity that national funding will be made available to fund a proportion of this and it has been able to release circa £2m from the funds it was holding for SUCCESS pending the decision on whether the bid for Wave II scheme would be supported.

The QIPP target of £4.8m is in line with national expectations which have benchmarked delivery at 2% of a CCG's overall allocation.

To meet the third year of the QIPP agenda will require renewed focus on pace and challenge. Providers recognise the range of schemes which have been implemented over the past couple of years and there is consensus that these are right for the system and more needs to be done to ensure they are embedded and delivering as planned.

A range of QIPP interventions have been identified to support the delivery of the CCGs finance targets during 2015/16. These schemes are also consistent with our priority areas identified in Section 5. The CCG is working up the financial and associated benefits of these schemes and has recognised a risk of circa £1m which it is working to address.

QIPP Intervention	**Overview** **Modelling of the impact of these changes is currently taking place.**
Medicines Optimisation	There will be a renewed focus on ensuring GP prescribing is cost effective and additional investment in Dietetic Support to Primary care to review and reduce spend on ONS, gluten free and baby milk prescribing.
Rapid Assessment Unit	As part of the ambulatory primary care model, to trial the Rapid Assessment Unit model at GWH. This service would see based on the current model circa 1300

	patients within the first year.
Heart Failure Service and COPD management	Alternative services to manage patients with these long term conditions.
Hospice at Home	A recent audit showed a number of patients who were within an acute setting who would rather be in their home, this service would manage palliative patients at home.
Dementia	The new dementia service would help support patients and prevent admissions, and would also reduce los for those who had needed an episode of acute care.
Urgent care system	A new clinical pathway for primary, community and acute elements of care across Swindon has been developed from the NHSE Five Year Forward View and it is expected that this will deliver financial savings along with a host of other clinical, infrastructure, workforce and IM&T benefits. Focus will be on implementing this over the next eighteen months and so 2015/16 is seen as a transitional year which will be pivotal to build a new system and ensure a secure and viable baseline for the future.

11.9 Activity Assumptions

The CCG establishes the activity levels (numbers of patient treatments) it intends to commission for its population from its annual strategic plans; taking account of previous performance, national and local requirements. It embeds these into the contracts it negotiates and agrees each year with it the relevant providers of these treatments.

Swindon CCG activity plan for 2015/16 is based on assessment of 2014/15 recurrent out-turn as a start point. Due to the geographical spread of the population served by the CCG, we have assumed that most of the impact of population and demographic growth will be felt with its main provider GWH at an average of 3.8%. Across service lines this is variable, with a higher level of growth assumed within non-elective services (circa 6.3%) which is reflective of the higher level of demand seen during 2014/15 (circa 4.8%).

11.10 Contract Management

For the main provider contract (GWH) a number of key performance indicators have been agreed in order to track baseline activity planning assumptions in relation to demand and efficiency in the system (for example the ratio of new to follow up outpatients at a specialty level). These will be monitored on a monthly basis and when an indicator tracks above the baseline then this will be noted and

discussed at the joint Finance and Information Group (FIG) with GWH as an early indication that there may be an issue in the system. A rise above the baseline (using standard deviations as a measure) will result in a review of the underlying reason for the variance. The outcome of this will feed into contract board for agreement on next steps including any remedial actions required, or financial impacts for the provider.

A new approach to monthly contract data challenges including the monitoring of a restricted procedure policy will be taken in 2015/16 in order to minimise the resource intense burden this placed on both the CCG and provider teams during 2014/15. Again, expected benchmarked baseline activity/volumes will be set for 2015/16 and will be tracked and monitored on a monthly basis.

11.11 Mental Health Investment

The CCG has set aside 6.0% of its growth allocation recurrently to support the requirements of mental health services. Section 8.6 provides the details on mental health developments for 2015/16.

11.12 Primary Care Funding

Support to primary care in 2015/16 will be from the Community Navigator Pilot, continuing elements of the SUCCESS scheme, increasing Out of Hours capacity and from the Prime Ministers Challenge Fund (PMCF).

During 2015/16 as part of the co-commissioning work with NHS England the CCG will be reviewing the current GP PMS contracts and expenditure on enhanced services to determine where investment should be focused in future years

11.13 Running Costs

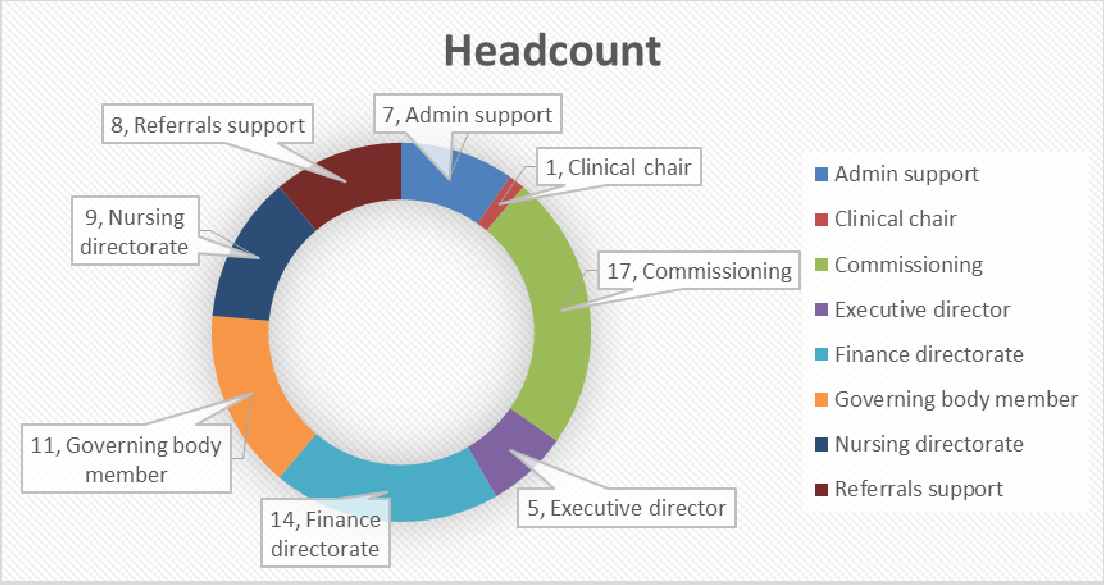
CCG's receive a separate allocation to cover their running costs. In 2015/16 this has reduced from £5.5m to £5.0m (a decrease of circa 10%). The CCG has renegotiated its service level agreement with Central Southern Commissioning Support Unit (CSCSU), transferred a significant number of services in house and reduced the use of consultants and temporary staff; resulting in a saving of £467k. Further economies have been identified through:

- the CCG refocusing its Service Redesign Programme
- one off IT costs which CCG incurred moving to Pierre Simonet

	14/15 £000s	**15/16 £000s**
Funding allocation	(5,494)	(4,970)
CSU contract and payroll	4,539	4,072
Premises	338	345
Office overheads	62	78

IT Overheads	134	95
Professional fees	140	170
Training and development	156	85
Communication	5	5
Depreciation/Amortisation	120	120
Surplus/Deficit	**0**	**0**

The pie chart below describes the current headcount across CCG directorates.



The CCG are using the lead provider framework to procure commissioning support services during 2014/15 for implementation from April 2016. During 2014/15 the CCG's organisational development has concentrated on: the ways of working in the new headquarters; the integration of former commissioning support services in the CCG; and strengthening the governance arrangements. The organisational development plan for 2015/16 is currently being drafted and this will be focused on the results of the Ipsos Mori 360 stakeholder survey and the CCG staff survey. Consideration will be given to whether this needs to be expanded to the development of the wider health community.

12 Governance

12.1 The Operating Plan will be developed into a delivery document once finalised and agreed by the Governing Body. Appendix 5 provides the outline for the document, this will be used to refresh the Board Assurance Framework for 2015/16 and will be formally reported to the Governing body on a quarterly basis. Risks will be included in the organisations risk register, and any high risks will be brought to the Governing Body's attention on a monthly basis.

12.2 Individual projects will be reviewed by the Executive Management team to ensure that delivery timetables are being met, and to identify slippage against schemes and ensure that mitigating plans are developed and implemented in a timely way. This is supported by a monthly Project Management and QIPP group which consists of Executive Directors and Project Senior Responsible Officers, in the meeting progress will be reviewed, with SROs providing both peer support and challenge into the process, alongside the Head of PMO and finance and information colleagues.

12.3 The Operating Plan has been shared with the Health and Wellbeing Board in draft and the final iteration will be shared with them at the May meeting to ensure that the CCGs annual plan continues to support the agreed strategies for Swindon.

Appendix one Health and Wellbeing Strategy summary

Vision	Everyone in Swindon lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities

Outcomes	Our Priorities	Indicators for success
1. Every child and young person in Swindon has a healthy start in life	1. Improve the mental wellbeing of children and young people 2. Reduce risky behaviours amongst our children and young people such as smoking, drinking and self harm 3. Keep all children and young people safe 4. Improve educational attainment of children and young people 5. Reduce the number of young people not in education, employment or training	Prevalence of breastfeeding at 6-8 weeks from birth; Percentage of children gaining five good GCSE's including maths and English; Alcohol specific hospital admission rates for under 18's; Self-harm hospital admission rates for under 18's; Percentage of mothers smoking at time of delivery; Levels of overweight or obese 10-11 year olds; 16-18 year olds not in education, employment or training; Infant mortality; Childhood vaccination coverage; Children with second or subsequent child protection plans; The number of children in care; Emotional wellbeing of looked after children; First time entrants to the youth justice system
2. Adults and older people in Swindon are living healthier and more independent lives	1. Strengthen integrated working between health and social care 2. Reduce the number of people suffering from long term conditions through the promotion of healthy lifestyle choices 3. Promote independence and reduce the need for hospital services and long term care 4. Ensure that carers needs are met	New admissions of older people (over 65) into residential and nursing care; Take up of the NHS Health Check programme by the eligible population; Smoking prevalence rate for adults; Hospital admissions for alcohol related harm; Rates of early death (under 75's) from; cardio vascular disease (including heart disease and stroke); cancer; respiratory disease; Carers who have their needs assessed; Proportion of physically active adults; Seasonal flu vaccination rates

3. Improved health outcomes for disadvantaged and vulnerable communities	1. Ensure access to information and advice that supports choice and control 2. Ensure people from disadvantaged groups receive good quality care for their physical health 3. Local economic and social policies are developed to strive to narrow social inequalities rather than widen them 4. Prevent early death and disease through healthier lifestyle choices, early detection and screening	New admissions for people with learning disability into residential care; Gap in the employment rate between those with a learning disability and the overall employment rate; People receiving social care who say they have advice and information; Proportion of people feeling supported to manage their condition; The proportion of people who use services who feel safe; Cancer screening coverage; Life expectancy rates
4. Improved mental health, wellbeing and resilience for all	1. Develop effective pathways for people with mental health problems 2. Increase the opportunities for people with mental health problems to access support services and community facilities aimed at promoting recovery (including education, debt management, housing, leisure services, health promotion) 3. Promote positive mental health and recognise that mental health is everyone's business 4. Reduce the stigma and discrimination associated with mental ill health	First time entrants to the youth justice system; Successful completion of drug treatment; Suicide rate; Self reported wellbeing; Repeat incidences of domestic violence
5. Creation of sustainable environments in which communities can flourish	1. Build on the strengths of local communities, including the local voluntary sector, to enhance social cohesion and promote social inclusion of marginalised groups and individuals. 2. Work with our local communities to develop creative solutions for local issues. 3. Ensure that housing and development strategies for new and existing communities identify the health and wellbeing impacts for residents in the short and long term 4. Promote the use of green, open spaces and activities such as walking and cycling 5. Promote effective public transport and transport networks which ensure access to services and activities and encourage permeability within communities	Utilisation of green spaces: Self reported wellbeing; Adult social care service users feel they have the amount of social contact they want; Volunteering levels; Offending and anti-social behaviour rates

Key supporting local strategies and plans include: The Swindon Sustainable Community Strategy. One Swindon. The Local Plan (formerly The Swindon Core Strategy). Community Safety Partnership Business Plan. Healthy Weight Strategy. Active Swindon Strategy. The Swindon Tobacco Control Plan. Children and Young People's Early Support Strategy. Local transport Plan 3. Alcohol Strategy. Mental Health Promotion Strategy. End of Life Strategy. Swindon Clinical Commissioning Group Commissioning Intentions. Domestic Violence Strategy. Swindon Borough Council Corporate Strategy. Wiltshire and Swindon Police and Crime Plan.

Appendix Two

Draft Provider models of care – principles

The Five Year Forward document provides an outline of how provider design could change into the future. Swindon CCG has considered the principles of the design model and has identified the following characteristics as key to the future design of the provider models within Swindon.

These principles are part of the CCG commissioning intentions and will form a key element of how service delivery will be reviewed to enable an introduction of new models as we move into 2016/17. Organisations will:

- Have clear and robust governance, capability and leadership - whatever the organisational form, e.g. formal agreement such as a joint venture. Without clear leadership, with rights to make decisions about reshaping care, it is unlikely to succeed and be able to manage risk;

- Positive engagement, behaviours and partnership working between the NHS Trust or Foundation Trust, other community providers, and participating GP practices

- Incorporate the list of registered patients for the population it intends to cover, as well as wider community and hospital services for those patients.

- Have a joined-up electronic health record for its registered population;

- Excel at both empowering patients and involving local communities, with strong voluntary sector input. It will guarantee NHS constitution rights and support the development of personal budgets;

- Lead the way in reducing avoidable mortality, for example through better early diagnosis of diseases such as cancer as well as better treatment and support;

- Provide redesigned emergency care, and well as urgent care services in the community, in line with the urgent and emergency care review and the CCG and Borough Council model of urgent care;

- Provide in-reach services to other settings of care: for example into care homes

- Demonstrate a consistent cultural and strategic focus on developing preventative, primary care and community-based services. This focus is likely to be at least as strong as its focus on improving acute and tertiary medicine.

- Integrate mental health services for relevant population segments

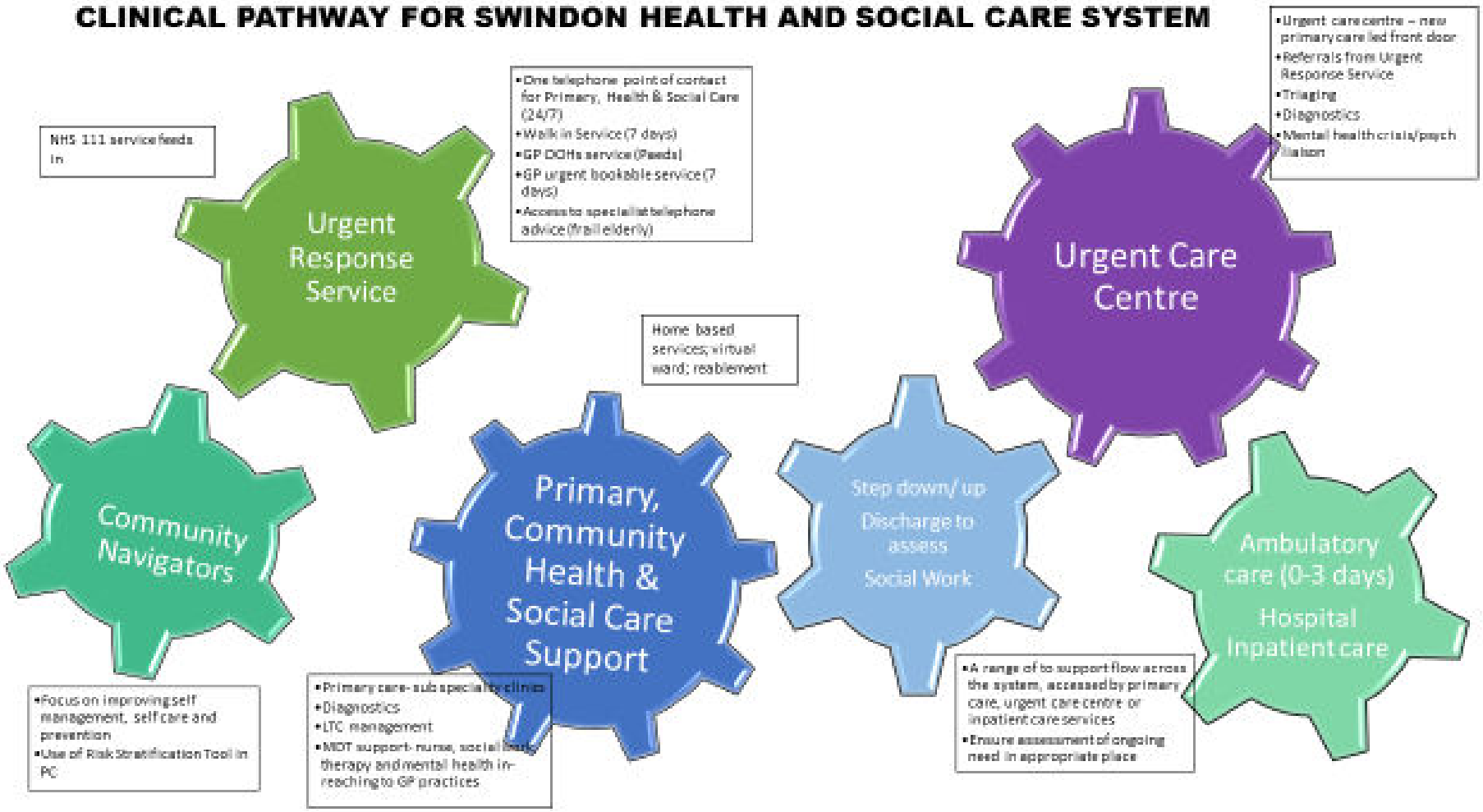
- Use risk stratification and patient population segmentation to identify patients who will benefit most from intensive support. Design dedicated services for different groups of patients, using remote and digital technology;

- Redesign and manage complete patient pathways, running multidisciplinary teams with redefined workforce roles.

- It will make optimal use of assets across the combined estate of providers and commissioners;

- Take on from commissioners (CCGs and local government acting together) a single full capitated budget for its registered population, on a long-term basis.

Appendix 3 Swindon Urgent Care Model



Appendix 4 CCG OIS (data source HSCIC)

Emergency admissions for acute conditions that should not usually require hospital admission

July 2013 to June 2014 (Provisional)	1,164.7
April 2013 to March 2014 (Provisional)	1,160.9
January 2013 to December 2013 (Provisional)	1,205.6
October 2012 to September 2013 (Provisional)	1,238.6
July 2012 to June 2013 (Provisional)	1,234.3
2012/13	1,220.4
2011/12	1,067.0
2010/11	975.6

Emergency admissions for children with lower respiratory tract infections

July 2013 to June 2014 (Provisional)	272.6
April 2013 to March 2014 (Provisional)	268.6
January 2013 to December 2013 (Provisional)	268.2
October 2012 to September 2013 (Provisional)	272.6
July 2012 to June 2013 (Provisional)	289.7
2012/13	282.2
2011/12	292.0
2010/11	304.7

People feeling supported to manage their condition

July 2013 to March 2014	66.6
July 2012 to March 2013	63.4
July 2011 to March 2012	65.7

Health-related quality of life for people with long-term conditions

2013/14	0.759
2012/13	0.764
2011/12	0.760
2013/14	0.759
2012/13	0.764
2011/12	0.760

Potential years of life lost (PYLL) from causes considered amenable to healthcare

2013	1,997.1
2012	2,138.5
2011	1,869.9
2010	1,781.7
2009	2,039.4

Patient experience of GP out-of-hours services	
July 2013 to March 2014	64.0
July 2012 to March 2013	70.6
July 2011 to March 2012	63.6

Patient experience of hospital care	
2013/14	75.4

Appendix 5 – Example of Implementation Plan

Key Priorities						
Specialty/ Scheme	**Objective**	**Compliance with specific CCG priority**	**Key Deliverables**	**Milestones**	**SRO**	**Key Performance Indicators**
Long Term Conditions						
Respiratory/COPD	Strengthen an integrated out of hospital care model, whilst encouraging self-management amongst patients and carers and increasing their confidence in the management of their own condition.	Five Year Forward View NHS Constitution Standards Quality Safety Equality and Diversity Better Care Fund	1. Development of a fully costed and scoped model of care. 2. Improve utilisation of the Virtual Ward. 3. Improve patient access to the most appropriate service through development of a local awareness initiative. 4. Establish a local Breath Easy Group in Swindon (with the British Lung Foundation).			Reduce number of emergency admissions to an acute hospital. Improve capacity of delivery of respiratory care in a non-acute setting. Increase utilisation of Pulmonary Rehabilitation programmes. Increase number of people attending smoking cessation programme
Diabetes	To improve management of diabetes for Swindon patients	NHS Constitution Standards Quality Safety Equality and Diversity Better Care Fund	Enhance the delivery of management of Diabetes in Primary Care through the Evidence in Practice Programme across all 26 practices	1. Initial baseline audit of 26 practices to be completed by 30.4.15. 2. Re-run clinical audit at 6 months - 31.10.15. 3. Re-run clinical audit at 12 months - March 2016. 4. Final Evaluation Report to be submitted to CCG - April 2016.		Reduce number of admissions to an acute setting. Improve provision of care in non-acute settings.