Part 1:

NHS Wiltshire CCG
Five Year Strategic Plan
2014-2019

NHS
Wiltshire
Clinical Commissioning Group

Document Control Sheet

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FOREWORD

We are delighted to present our first Five Year Strategic Plan for Wiltshire Clinical Commissioning Group (CCG), which is being developed with partners and stakeholders across the County and covers the period 2014/15 to 2018/19.

The introduction of Clinical Commissioning gave us, in Wiltshire, an unprecedented opportunity to realise our simple but bold vision, to ensure the provision of a health service which is high quality, effective, clinically led and local. Perhaps the most significant achievement of the last year has been the progress made, in very close collaboration with Wiltshire Council, towards establishing joint arrangements to deliver far better integrated health and social care services in the future.

Building on the achievements of our first year, this plan projects the vision and describes a road map to the future delivery of sustainable, integrated services to help the people of Wiltshire establish and maintain their wellness, as well as supporting those experiencing ill health. The delivery of our vision and the achievement of better outcomes for the people of Wiltshire will require further progressive and strong integration between local NHS organisations, our close partners in Wiltshire Council, the voluntary sector and the wider community.

Key to the successful implementation of our vision is putting individuals in control whilst ensuring that every opportunity is provided to improve the health and wellbeing of the population. We aspire to create a model within which, when care is needed it can be delivered closer to home, creating a system built around individuals and local communities, with a focus on the most vulnerable people, supporting them appropriately to reduce or avert crises. Key to achieving this will be multi-disciplinary teams based in small community based clusters, working across community health, social care, mental health, the voluntary sector and friends and family networks to provide integrated and accessible care.

The dispersed and rural community of Wiltshire means that we need to understand and reflect local needs, in order to ensure the benefits of this localism are maximised Wiltshire Clinical Commissioning Group will continue to operate as three local groups. The geography of Wiltshire naturally divides into three areas of population separated by the sparsely populated Salisbury Plain.

The three groups cover the natural communities of South Wiltshire centred around Salisbury, (Sarum Group) with its population mostly choosing to use Salisbury Foundation Trust for its hospital based services, the community of North and East Wiltshire, mostly choosing to use the services provided by Great Western Hospital (NEW Group) and the area covering the market towns of West Wiltshire (WWYKD Group) where the population mostly choose Royal United Hospital in Bath for its services.

We are confident that this plan is patient focused and its implementation will be led by a range of very able and enthusiastic local clinicians supported by a creative, dynamic and experienced management team. We look forward to discussing and evolving our work via an-going programme of public and stakeholder engagement.

Deborah Fielding
Accountable Officer
NHS Wiltshire CCG

Dr Steve Rowlands
Chair
NHS Wiltshire CCG

Executive Summary

The purpose of this document is to:

- Set out the strategic direction for the development of health and care services across Wiltshire over the five year period 2014-2019
- Show in detail for the first two years how we will deliver our objectives between 2014 and 2016, and lay the foundations for transformational change
- Demonstrate how over the five year horizon of this plan, 2014 to 2019, we will deliver transformational change that provide high quality, effective, clinically led and local services for people in Wiltshire

This Five Year Plan builds upon the many successes of our first year, achieved in partnership with colleagues from across the local NHS organisations and Wiltshire Council, to develop and improve services across Wiltshire, and incorporates a range of national and local ambitions and their associated outcomes.

The table below sets out how the structure of the following sections:

Laying the foundations – 2014/15 to 2015/16	
Section	**Content**
Beginning the Journey	Sets out the current position in Wiltshire and why we and our partners need to undertake our transformational journey
System Vision	A summary of our strategic vision for health and care in Wiltshire, including some of our key priorities
Ensuring Safe and Effective Services	This section sets out our commitment to safe and effective services for our patients, and some of the key actions we are taking to ensure this
How Will We Do This?	A summary of the key system interventions needed to transform the health and care system in Wiltshire, including our plans for the period 2014-16
Governance	Sets out the main governance arrangements that underpin this five year strategy

This document is designed to be read in conjunction with "**Part 2: Finance Plan**", which sets out the financial assumptions and projections associated with realising our five year vision for Wiltshire.

NHS Wiltshire CCG – Five Year Strategic Plan 2014-2019: Our "Plan on a Page"

Clinical Commissioning Group

Our vision is that Health and Social Care services in Wiltshire should support and sustain independent healthy living

INTEGRATION

QUALITY, SAFETY and SAFEGUARDING

PUBLIC AND PARTNER INVOLVEMENT

Increased investment and support into developing and maintaining personal responsibility. Focus on education, prevention and support to develop and maintain healthy and independent living

Delivered through a range of interventions including:

- Understanding and tackling the wider determinants of health
- Health promotion and education programmes re lifestyle
- Increased use of technology, providing advice guidance and signposting
- Patient engagement and awareness of clinical pathways
- Increased and proactive use of personalised care and treatment plans
- Shared Decision Making
- Parenting skills and support

Enhanced and integrated community care with a broader range of services provided in a local setting

Delivered through a range of interventions including:

- Developing integrated community services, wrapped around the individual, accessed and co-ordinated through extended primary care teams
- Shared data and information
- Core and consistent Primary Care Provision
- Expanded Primary Care Services
- Extended skills in community teams to manage higher acuity patients
- Proactive identification and management of patients with chronic conditions in Primary Care, supported by care co-ordinators
- Increase use of technology for monitor & review and advice and

Improved productivity and effectiveness of care with a reduced reliance on bed-based solutions

Delivered through a range of interventions including:

- Investment in alternative community based solution – Enhanced 'out of hospital care' (beds and/or services) with Rapid Response, Simple Point of Access ad Care Co-ordination to support admission avoidance and earlier discharge
- Increased ambulatory care management or emergency admission – Ambulatory Care Sensitive Conditions, plus use of Rapid Assessment and Diagnostics services with emphasis on early discharge out of acute setting
- Systems in place to facilitate early supported discharge to reduce length of stay and tackle Delayed Transfer of Care
- Improved efficient and appropriate use of planed care beds – applying enhanced recovery programme principles, and moving care from inpatients to day case and day case to outpatients

The design of our future system is based on three key design principles:

1. **People encouraged and supported to take responsibility for, and to maintain / enhance their well-being**
2. **Equitable access to a high quality and affordable system, which delivers the best outcome for the greatest numbers**
3. **Care should be delivered in the most appropriate setting, wherever possible at, or as close to home**
   - **Where acute care is one-off or infrequent, there should be formal and rapid discharge**
   - **Where care is on-going (e.g. chronic**

Measuring Success:

1. **Increased personal responsibility**
2. **Improvements in quality**
3. **Increased patient/carer satisfaction**
4. **Increased efficiency and sustainability**
5. **More integrated services**
6. **Reduced health inequalities**
7. **Reduced avoidable unplanned/urgent care**

Overseen through the following governance arrangements

- **CCG Programme Management Office (PMO)**
- **Regular CCG Programme Governance Group (PGG)**
- **CCG Executive Management Team**
- **CCG Clinical Executive**
- **CCG Governing Body**
- **Wiltshire Health & Wellbeing Board**

Section 1: Beginning the Journey

The National Context

As described in NHS England's recent "Call To Action" campaign, across England there are a range of pressures which deliver unprecedented challenges to maintaining high quality and sustainable health and care services to all: an **ageing society, increasing expectations, the rise of long-term conditions, increasing costs of providing care, limited productivity gains and constrained public resources.**

Older people are forming a larger proportion of the population, with the greatest growth expected in the number of people aged 85 or older. This group are the most intensive users of health and social care. The health needs of the elderly are particularly apparent in non-elective care within the acute sector where:

- Nearly two-thirds of people admitted to hospital are over 65.
- Unplanned admissions for people over 65 account for nearly 70% of hospital emergency bed days.
- When they are admitted to hospital, older people generally stay longer and are more likely to be readmitted.

In addition to the ageing population, lifestyle choices amongst the rest of the community are impacting demand. Around 80% of deaths in England are from major diseases, such as cancer, many of which are attributable to lifestyle risk factors such as excess alcohol, smoking, lack of physical activity and poor diet. Forecasts indicate that 46% of men and 40% of women will be obese by 2035. This is projected to result in 550,000 additional cases of diabetes and 400,000 additional cases of stroke and heart disease nationally.

Over 15 million people in England have a Long Term Condition (LTC), around 25% of the population and this cohort currently utilise:

- 50% of all GP appointments
- 70% of all hospital bed days
- 70% of the total health and care spend in England.

People with one or more long-term conditions are the most important source of demand for NHS services:

- The 30% who have one or more of these conditions account for £7 out of every £ 10 spent on health and care in England.
- Patients with a single long-term condition cost about £3,000 per year whilst those with three or more conditions cost nearly £8,000 per year.

The number of patients with long term conditions is projected to grow by 50% in a decade.

This growth in demand is taking place at a time of austerity, which continues to put pressure on NHS funding. Even with NHS budgets protected in real terms, current forecasts point to a £30bn gap in funding by 2020/21.

The above diagram sets out the key drivers that affect the future sustainability of the NHS without transformational change, and reflects wider international trends in the developed world of:

- Healthcare spending taking up increasing proportions of GDP across developed countries
- Changes in demographics, particularly a growing proportion of older people, driving up the demand for, and overall cost of, healthcare
- Increasing life expectancy which, whilst very welcome, does not reduce the cost of healthcare, but instead postpones the high costs associated with healthcare at the end of a person's life

To address both the quality and sustainability challenge posed by this combination of trends, the NHS has set out several high level ambitions to ensure quality is improved and services designed around patients and their needs in the future:

Securing **additional years of life** for the people of England with treatable mental and physical health conditions
Improving the health related **quality of life** of the 15 million+ people with one or more long-term conditions, including mental health conditions
Increasing the proportion of **older people living independently at home** following discharge from hospital.
Increasing the number of people with mental and physical health conditions having a **positive experience of hospital care**
Making significant progress towards **eliminating avoidable deaths** in our hospitals caused by problems in care.
Increasing the number of people with mental and physical health conditions having a **positive experience of care outside hospital**, in general practice and in the community
Reducing the amount of **time people spend avoidably in hospital** through better and more integrated care in the community, outside of hospital

The Local Context in Wiltshire

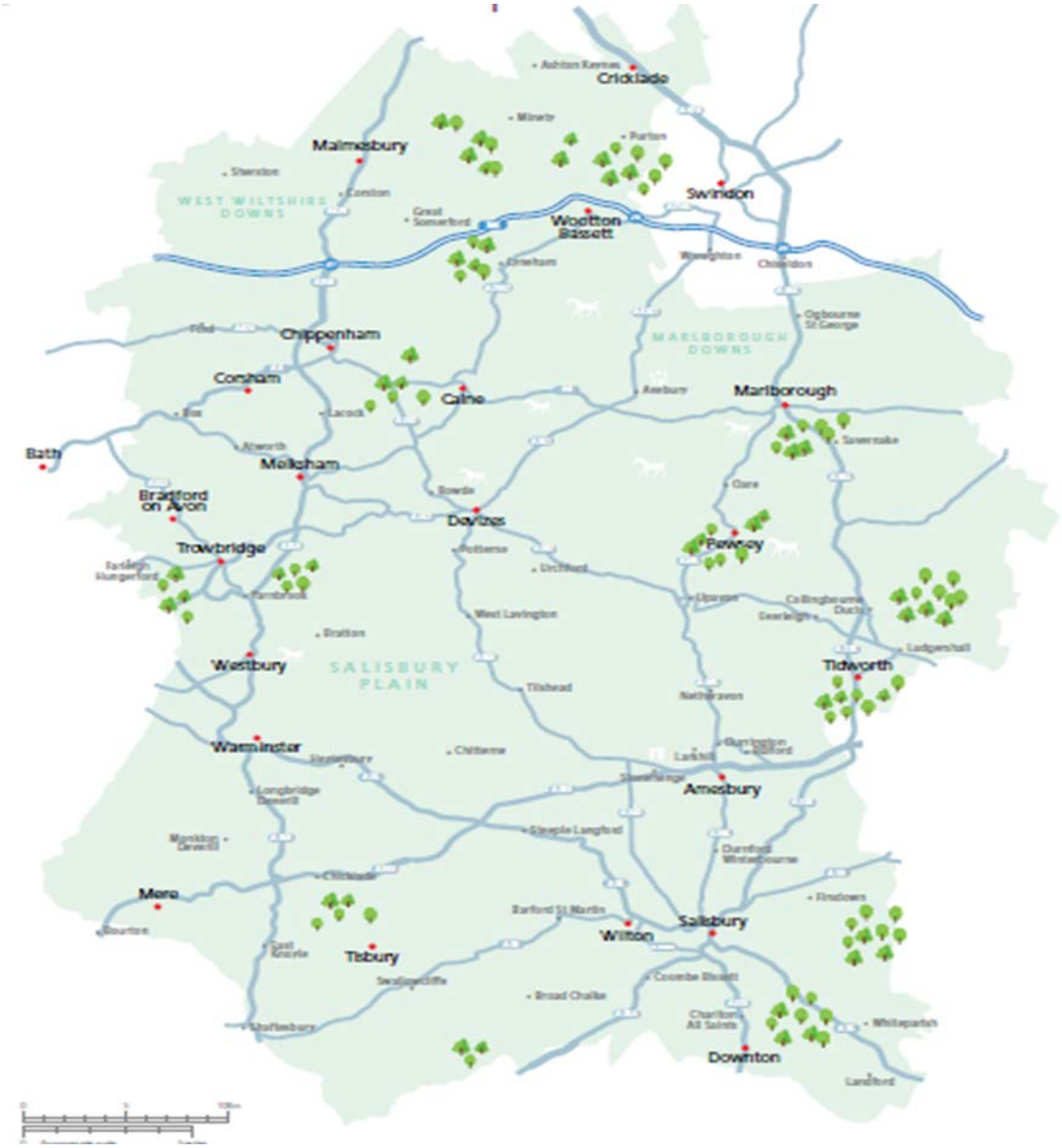
We have a deep understanding of the structure, nature and health position of our local population. This has been developed from a wide range of sources both within and outside the CCG including:

- Public Health analysis, through the JSA looking at the structure and health of the current population, as well as projected changes identified through ONS projections
- Joint work with Public Health through the Health and Wellbeing Board, drawing on a range of indicators such as those in the Public Health Outcomes Framework to understand the state and needs of different population groups
- Joint work with the Council through the Community Transformation Team to understand the health position and care needs of the elderly population
- Our own quantitative analysis such as the evaluation of health and outcome indicators, Atlas of Variation, CCG/Local authority “profiles” from NHS England, SPOT and our assessment of the impact of population projections, overall and within age bands, which helps us understand health needs and relative performance

What Do We Know About Our Population?

The Joint Strategic Assessment (JSA), developed by our partners at Wiltshire Council, provides us with detailed information about the population across the County. Wiltshire is a large,

predominantly rural and generally prosperous County with a population of 479,992. Almost half of the population resides in towns and villages with less than 5,000 people and a quarter live in villages of fewer than 1,000 people. Approximately 90% of the County is classified as rural and there are significant areas with a rich and diverse heritage of national and international interest, such as Avebury, the Kennet and Avon canal, Stonehenge and Salisbury Cathedral. The relationship between the city of Salisbury and the larger towns in Wiltshire and the rest of the County has a significant effect on transport, employment, travel to work issues, housing and economic needs. With 141 people per sq. km, Wiltshire has a lower population density than the South West or England overall. The rural nature of the County has implications for the planning and provision of health and social care services, particularly with a shift towards more provision of services in the community.



In order to design health services that provide the right care for people both now and in the future, it is important to understand some basic information about the make-up of the population, and how this is going to change in the future. Using this, and other information that we have about the prevalence of disease we can build up a picture of what services we need to develop or change in order to keep our population as healthy as possible.

The JSA shows four key messages:

Our population is relatively healthy:

Our analysis of Wiltshire's population shows that overall; people in Wiltshire are healthier than comparative groups in England, with lower than average rates of:

- Mortality from causes considered preventable
- Smoking related deaths
- Premature deaths from cancer

What our analysis also demonstrated is that there is a growing challenge in terms of the ill health effects from lifestyle conditions and needing to improve engagement with healthcare services to address preventable illness. Examples include areas such as:
Number of overweight and obese children – 20% 4 to 5 year old children classed as overweight or obese, increasing to 29.6% of 10 to 11 year olds

- Vaccination rates for under-3s which are falling whilst the England average is improving
- Over 40% of adults failing to achieve the guidelines for weekly exercise
- Falling rates of screening for cancer and low take up of NHS health check

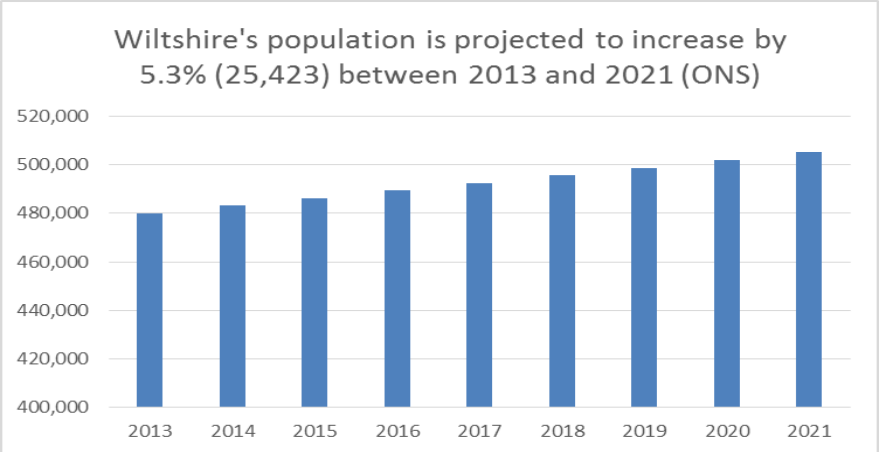
Therefore whilst our population is relatively healthy, we recognise our future approaches will need to incorporate measures around:

- Prevention
- Early intervention
- Developing the individual's personal responsibility for healthy lifestyle choices, health and well-being to keep them in health

These themes feed directly into our developing strategy and approaches for improving health and outcomes within Wiltshire.

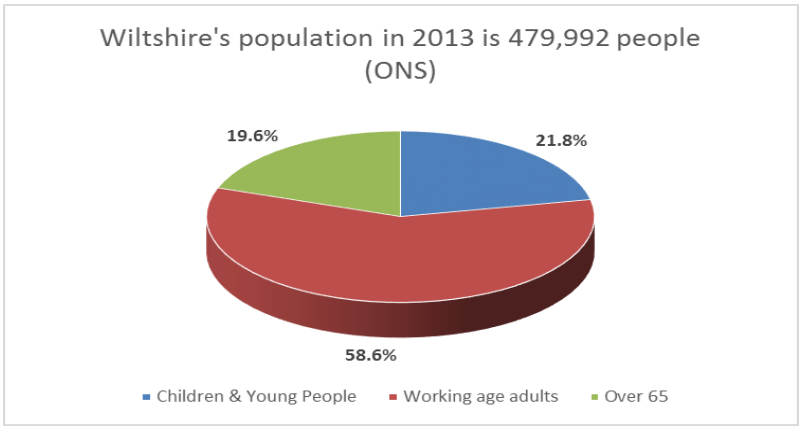
Our population is growing:

The CCG's current population is 479,992 (2013), and forecast to grow by an additional 3.3% (15,603) by 2018, and by 5.3% (25,423) to 505,416 by 2021. This excludes some additional 10,000 people because of military restructuring and developments in the County.

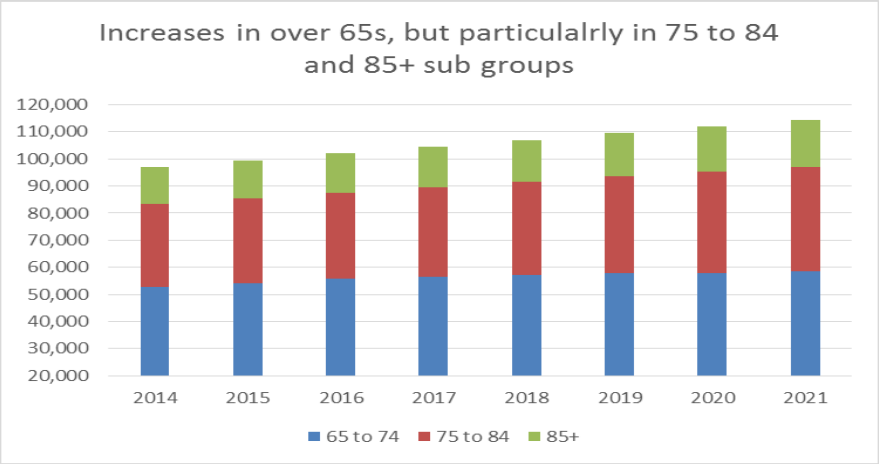


Our population is changing:

By 2021 there will be proportionately more children & young people (+5533) and less working age adults (-632). People over 65 make up 20% of the County's population and will make up 22.5% of the County's population within the next 7 years, and the number of older people is rising much faster than the overall population of the County (+20,253 by 2021).



Within our over 65s age group, there will be a particular increase in the number of Wiltshire residents aged >75 (+13,086), and >85 by 2021.



There are specific areas we need to focus upon, including inequalities:

The implications of an ageing population are great in terms of people living longer into older age, with an increased demand for health services, a higher burden of chronic disease and susceptibility to the negative impacts of social isolation. In parallel to this there will be a reduction in working age people, a reduced contribution to the economy and lower incomes, and an increased need for care services (paid and unpaid carers).

Older people are more likely to need health and care services and we know that nearly half of Wiltshire's NHS financial resources (47.4%) are used by people aged over 65. Much of this resource is needed for frail and vulnerable older people. Dementia can affect people of any age, but is most common in older people. One in 14 people over 65 have a form of dementia and one in six people over 80 have a form of dementia. The prevalence of dementia in Wiltshire is predicted to rise due to our ageing population. Oxford Brookes University and the Institute of Public Care (2013) estimate that there are approximately 6,538 people with dementia in Wiltshire. It is predicted that this number will increase by 27.8% by 2020 – equating to an additional 1,800 people with dementia and will nearly double by 2030 to 11,878 people. It is also estimated that there will be an increase in those people with severe dementia from approximately 800 in 2012 to 1,600 in 2030.

Additionally, while overall health outcomes in Wiltshire are very good, this masks some specific local issues that we need to address. Some of our Lower Super-output Areas are among the most deprived in England, with significantly lower life expectancies in the poorest parts of Melksham, Salisbury, Trowbridge, Royal Wootton Bassett and Cricklade. The County also has the second-largest military population in the UK and some unique establishments that affect the way we must plan emergency health services, like Porton Down.

Our Financial Position

Wiltshire CCG has a strong financial position at the end of 2013/14 with a reported surplus of £5m and successful implementation of QIPP initiatives totalling £9.3m. Looking forward, the financial future is characterised by austerity, with current national forecasts pointing to a £30billion gap in

funding by 2020/21, despite NHS budgets being protected. The biggest factor that creates this pressure is from demographic change, especially increases in the elderly population.
Our population analysis has already shown that the number of people in Wiltshire in the over 65 population group is rising each year and we identified:

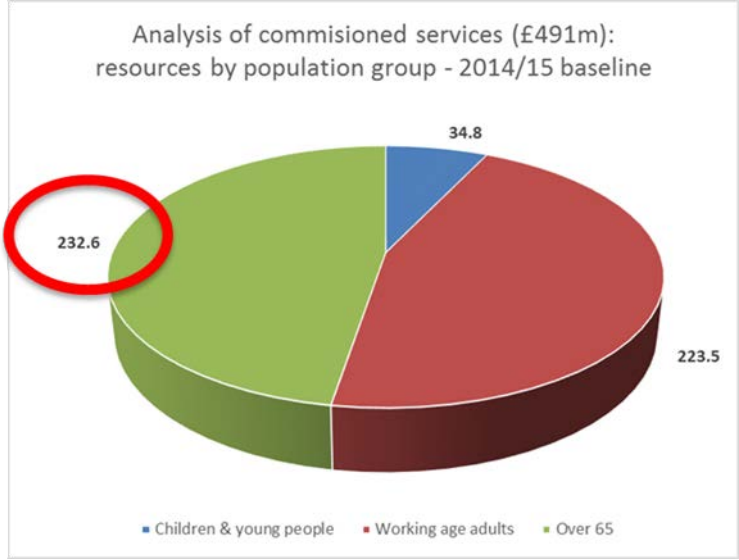
- The relative resource use by different population groups
- The impact that this would have on our resources
- The implications of this change for the services we provide

Relative resource use by population groups:

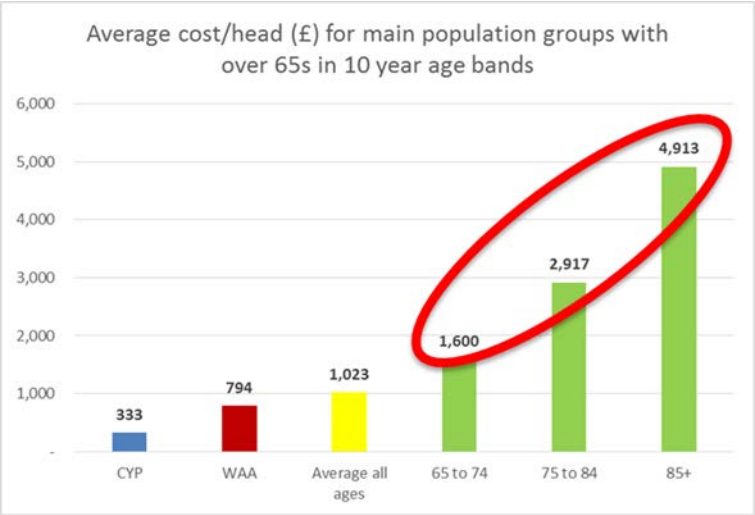
Our financial baseline for 2014/15 shows that £491m of resources were allocated for commissioned services, which included acute, community, mental health, local authority and jointly commissioned services.

The breakdown of resources by population group showed that:

- The smallest overall spend is on Children & Young People (£34.8m)
- The largest overall spend is on over 65s (£232.6m)
- Over 65s consume the largest proportion of CCGs resources (47.4%)



The average spend per head for Wiltshire CCG was £1,023. However, the pattern of spend by population group was significantly different, with a marked distinction between under and over 65s.



This analysis demonstrated that:

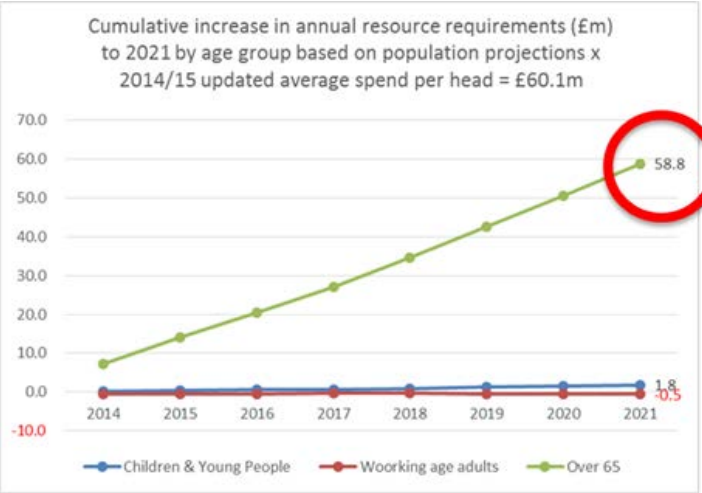
- Over 65s consume the largest volume of resources per head, as well as the largest overall proportion of the CCGs resources
- Once individuals have exceeded their Disability Free Years of life, average consumption of healthcare resources increases to between three and five time the CCGs average spend per head (from £2,917 to £4,913)

The conclusion is that the resource consumption of over-65 age group is significantly higher per head that that of other age groups and that the impact of population changes will therefore have a profound impact on the CCGs future resource needs, which is shown below.

Impact of population change on resources:

This demographic pressure is projected to result in a profound increase in health needs and costs within Wiltshire and by 2021:

- The estimate of the overall additional cumulative resource requirement resulting from population growth is £60.1m
- The impact of the changes in the over 65 population is a cumulative additional resource requirement of £58.8m – the vast majority of the projected overall requirement of £60.1m

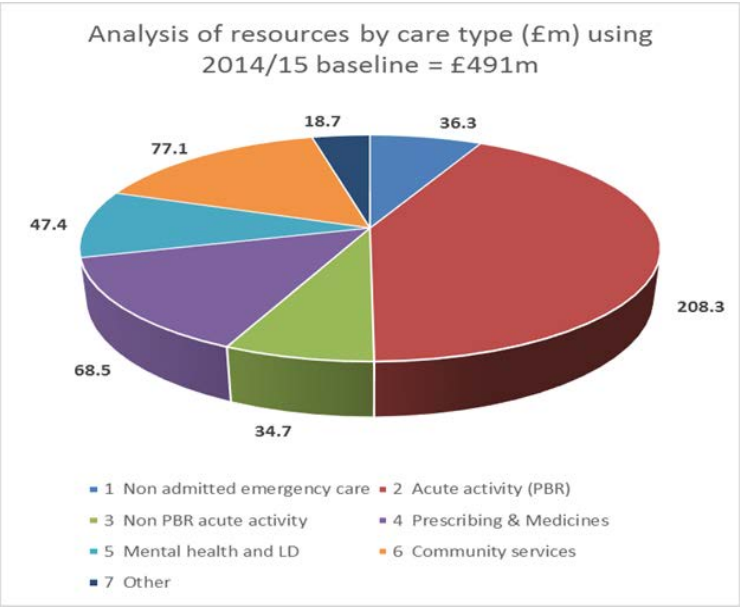


Implications of population change and resource use on services:

As a County we will not be able to absorb this projected increase in cost within our constrained resources, despite the current strength of our financial position, without implementing transformational change. To effectively address the healthcare needs of people in Wiltshire, we need to commission care that both meets the needs of an increasing number of elderly and frail people, but can also be delivered affordably.

Our current allocation of resources is skewed towards the acute sector, with

- 57% of resources concentrated on emergency and acute sector (£279.3m)
- Over 65s taking up high levels of resource per head in both PBR and non-admitted emergency care
- Community based services excluding MH/LD comprising only 16% (£77.1m) of spend

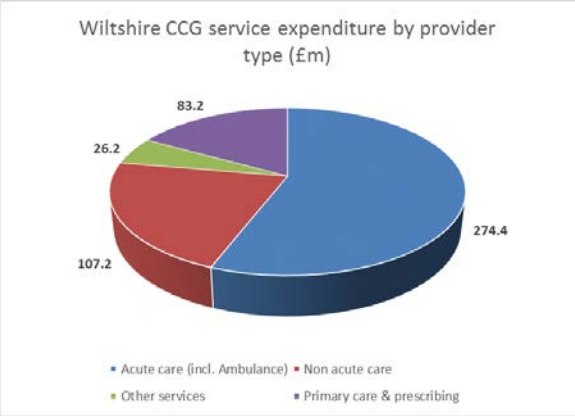


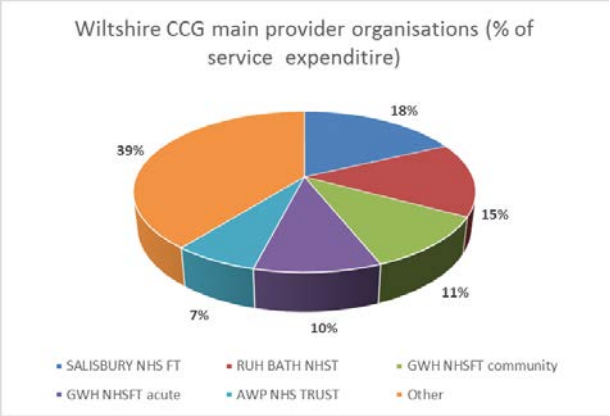
Our aim is to change the nature of the healthcare we commission, moving away from care that is largely reactive and focused on acute secondary care as the default care model. Our plans over the next five years will support this transformational change and by frontloading the proposed changes, we anticipate early benefits.

Our approach in this strategic plan builds upon our analysis, primarily focusing on the over 65 group - particularly over 75s - as this is likely to have the greatest impact. Over 75s are a relatively small proportion of the population that consumes per head the largest amount of resource.
Without this type of fundamental change through a shift in the balance of care, relying less on reactive acute services and more on proactive community care, the CCG's financial position will become unsustainable and we will not have the resources available to commission the healthcare needed by people in Wiltshire.

The Provider Landscape

In common with most health systems, our provider sector is dominated by acute providers who make up 56% (£274.4m) of service expenditure. Non acute care, which includes community and mental health services makes up the second largest element of expenditure, 22% (£107.2m) of overall service expenditure.





We do not "face" a single provider as some rural commissioners do. Our provider landscape is dominated by four main providers, which make up 61% (£298.2m) of service expenditure. In essence each of our Groups faces one acute provider, with community and mental health services provided across the CCG.

The following table sets out the current position:

Provider	Services
Salisbury NHS Foundation Trust (£88.3m)	Provides general and acute services to a local population of some 0.25m people, mainly delivered from Salisbury District Hospital The Trust also provides specialist regional services including burns, plastic surgery, cleft lip and palate, genetics and rehabilitation and cross regional spinal services across most of southern England
Royal United Hospitals Bath NHS Trust (£72.9m)	Provides acute healthcare services for a population of some 0.5m people mainly in Bath but also in North East Somerset and Western Wiltshire. The Trust provides a broad range of acute services including medicine and surgery, services for women and children, accident and emergency as well as diagnostic and clinical support services, mainly from the Bath Hospital site, plus other services at local community hospitals
Great Western Hospital NHS Foundation Trust (£54.3m acute; £49.6m community)	Provides acute hospital services from the Great Western Hospital site, as well as community services across Wiltshire, Bath and North East Somerset. A full range of acute services is delivered from the Great Western Hospital site with community service provided from community hospitals as well as primary care centres and community based teams
Avon & Wiltshire Partnership NHS Trust (£33.1m)	Provides mental health services across a wide geography from Wiltshire to Gloucestershire. Services include general mental health, needs relating to drugs and alcohol, mental health services for people with learning disabilities as well as secure services. An increasing range of services are provided in community settings or people's homes

Overall, the quality of services across providers is good with a range of patient feedback indicators including NHS Choices, Friends and Family test and the National Patient Survey showing scores that range from normal to best. Analysis of a range of other indicators shows that whilst some performance measures vary, there are no underlying structural issues around poor or unacceptable service quality across the CCGs providers.

We have identified scope for improving resource utilisation in a number aspects of acute provision, such as non-elective length of stay, higher than expected levels of non-elective activity and scope for redesigning care pathways to deliver elements of planned care that are more in line with best practice norms. These form part of our two year delivery plan and will be extended into more strategic changes arising from this five year strategy.

There are demand, capacity and resource pressures in areas such as A&E waiting times, although these are being managed by providers and specific plans are being implemented to address particular performance issues such as plans at Bath to improve A&E performance. The section on the NHS Constitution below provides a more in depth analysis of the CCGs performance against specific areas and gives additional details on provider performance.

Although this assessment of quality, performance and resource utilisation has not highlighted any fundamental underlying performance concerns, our analysis is that:

- Current services are too heavily focussed upon the acute sector and bed-based hospital services
- There is scope to develop further community and home based services as credible high quality alternatives to the current default of acute inpatient care
- We should build further on joint work with Wiltshire Council through Neighbourhood Teams to deliver home based services

Whilst current provider performance is reasonable and stable, the current state of acute inpatient care as the expected care setting is neither desirable nor sustainable over the next five years. Looking forward, there is an urgent need to change the provider landscape to deliver services designed around patients and carers, and ensure our specialist centres are used to treat the most sick.

Our approach will be to work positively and constructively with providers in the health and social care system to deliver new services. This will represent a fundamental shift in both the nature of care provided and the setting within which it is delivered, particularly as the initiatives underpinned by the Better Care Fund take effect. We aim to use the skills and expertise within our current provider base to best effect as we develop the future shape of services.

Our Current Performance

Wiltshire CCG and its partners begin their transformational journey from a strong starting position in terms of the overall performance of the health and care system. The table below summarises in particular our performance against the NHS Outcomes Framework for England, and in delivering against the pledges and rights our patients should expect as part of the NHS Constitution.

The NHS Outcomes Framework:

The NHS Outcomes Framework describes the health outcomes required from NHS organisations under 5 domains. These requirements are reflected in the CCG and JSA priorities for the plan period and various initiatives have been developed to help achieve these outcomes.

The CCG Outcome Indicators Set shows that, in most cases and against four of the five domains, our relative performance against the England median is either better than average or much better than average.
In one domain the measures adopted indicate that there is substantial scope for improvement as the current measures show performance worse than that planned. This is similar to the position for locally adopted indicators in 2013/14, where performance is also generally worse than plan.

The table below sets out our main performance headlines against each area of the framework:

NHS Outcome Domain	Key Priorities for 2014-16
Domain 1 Preventing people from dying prematurely	Our outcome in this domain, using a range of nationally measured outcomes, is much better than average with fewer potential years of life lost (PYLL) than the England average and a lower mortality rate from preventable causes for under 75s. This reflects the general public health analysis of the local population, which shows a better position against a range of health indicators than the England average for under-75s, which is reflected in the position in this domain.
Domain 2 Enhancing quality of life for people with long term conditions (including dementia)	Our outcome in this second domain is again much better than average, with higher health related quality of life for people with long term conditions than the England average and lower rates of unplanned hospitalisation than the England average for a range of long term conditions. This is reflected in the OIS data that shows a higher proportion of people feel supported to manage their condition and positively reinforces our ambitions around self-care and self-management.
Domain 3 Helping people to recover from episodes of ill health or following injury	OIS data shows we have a lower level of non-elective admissions and re-admissions than the England average; and better than average reported outcomes reported by patients for four common planned surgical procedures This is a positive position and our strategy will continue to build upon this.
Domain 4 Ensuring that people have a positive experience of care	Our position relative to the England average is much better or better than average for most OIS measures in primary and secondary care, which is positive. One acute provider scores as below average, which is the single instance of below average performance in this domain, and will be a focus for improvement over the next 12 months
Domain 5 Treating and caring for people in a safe environment and protecting them from avoidable harm	An area of focus for the CCG over the next 12-24 months will be to continue to work with our acute and community providers to eradicate any instances of avoidable healthcare-acquired infections (HCAIs)

The NHS Constitution

We recognise our obligations to patients in Wiltshire as set out in the NHS Constitution. Our patients have a right:

- To non-emergency treatment starting within a maximum of 18 weeks from referral
- To be seen by a specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected
- To a choice of a number of hospitals for elective care
- To view their personal health record
- To be treated with dignity and respect, including single sex accommodation
- To have complaints dealt with efficiently and investigated properly

Our plans include commissioning sufficient services to deliver the NHS Constitution rights and pledges for patients on access to treatment not just for 2014/15 and 2015/16, but over the whole five year plan period.

The below sets out our main performance headlines against each area of the Constitution:

Referral-to-Treatment Times (RTT)

The CCG has performed well in ensuring most of our patients receive treatment within 18 weeks of referral by their GP, with the exception of two patients waiting more than 52 weeks. QIPP plans that form part of this strategic plan will help maintain and improve performance in this area as further developments in triage and referral management reduce the volumes of referrals, making this commitment easier for providers to achieve. Improvements in community based treatments, such as through changes to the MSK pathway, will also have an impact on reducing referrals. The issue of over 52 week waiters is part of current contract discussions and providers will be required to provide explanations and commitments that processes are in place not only to identify long waiters, but to ensure remedial actions is taken far earlier than the 52 week target. Our expectation is that the actions taken will address the issue of over 52 week waiters and ensure that there are no further breaches of this standard.

Diagnostic Waiting Times

This aspect of performance shows whether patients have timely access to treatment, by highlighting delays resulting from not having the required diagnostic tests undertaken promptly. The CCG has consistently met its commitments in this area, and is working closely with providers to understand current trends and patterns in diagnostic activity now that tariff arrangements for diagnostics have been implemented. We will review this in detail in the current contracting round to ensure that these changes do not adversely impact upon waiting times. It is therefore expected that we will continue to achieve the current levels of performance and either meet or exceed expectations in this area.

A&E Waiting Times

This standard shows whether patients are promptly treated in an urgent care setting, whether in A&E or an MIU. In 2013/14 the CCG is close to achieving the target for all A&E departments, although some adverse performance during the year has impacted on overall year to date performance:

- Royal United Hospital Bath has experienced difficulties in several months, leading to a position at the end of November of 94.3% and a 2013/14 forecast of Amber.
- Great Western Hospital has experienced difficulties in several months, leading to a position at the end of November 93% although the 13/14 overall forecast is green.

Our main focus over the next 12-24 months will be to work with these two providers, particularly RUH Bath, whose performance in 2013/14 followed unsatisfactory performance in 2012/13 (when the Trust only achieved 91.9% on this target). RUH Bath have been taking positive measures to address performance with a successful bid for winter pressures funding. The planned improvements in processes are designed to effectively address rather than just acknowledge pressures and form part of a whole system solution that positively involves commissioners too.

Cancer Waiting Times

This standard shows the speed with which patients are treated across the cancer pathway and includes both referrals and definitive treatment for patients with cancer or suspected cancer. The CCG has consistently achieved the required level of performance in this basket of targets, whether at two weeks, 31 days or 62 days. We are confident that over the course of 2014-16 we will continue achieve or exceed expectations in this area.

Ambulance Calls

The Ambulance calls standards are designed to show the speed of different types of emergency response as well as the time taken to hand over patients from the ambulance service to an acute hospital's A&E. Performance around Ambulance calls and response times to date in 2013/14 shows that the CCG has not achieved the required standard of performance we expect for our patients. Our main area of focus to resolve this over 2014-16 will be around Category A Red 1 incidents, which were adversely impacted in April by the transition to the new NHS 111 system. There are still a significant number of breaches at Great Western Hospital; however performance has improved with minimal breaches at Salisbury FT and RUH Bath.

Mixed Sex Accommodation

This standard measures whether patients are in mixed sex accommodation during a hospital stay as part of the privacy and dignity agenda. Performance around this standard in 2012/13 was poor, with

only Great Western Hospital achieving the target. There has been some improvement with a much smaller number of breaches, through 2013, mainly in July and September. Our determination to address this issue and the plans put in place should result in performance being either Green for all providers or a mix of Green or Amber.

Cancelled Operations

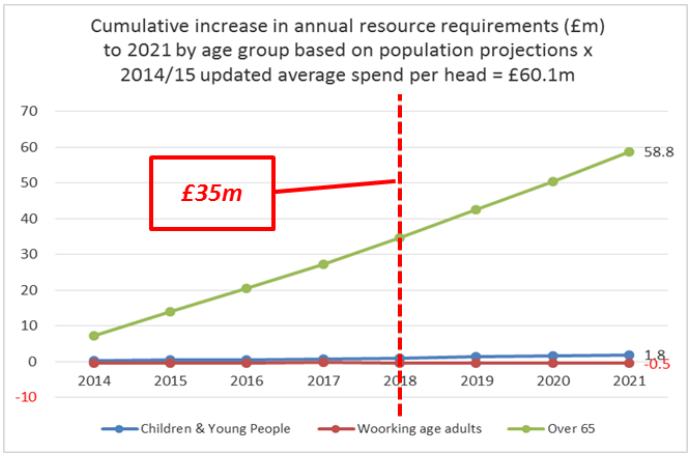
This standard measures the number of operations cancelled for non-clinical reasons upon or after admission to hospital. Overall our providers have performed very well in this area, with minimal cancellations for our patients. Currently only RUH Bath has had difficulty due to short- term operational problems that have since been addressed. We will be reviewing this with all providers as part of the contracting round to ensure that patient flows are proactively managed to avoid the need for cancellations.

Mental Health

This standard measures the proportion of people who were promptly followed up after discharge that were treated using a Care Programme Approach. The NHS Constitution requirements for this indicator have been met consistently in 2012/13, to date in 2013/14 and we expect this standard to be met or exceeded in 2014/15 and 2015/16.

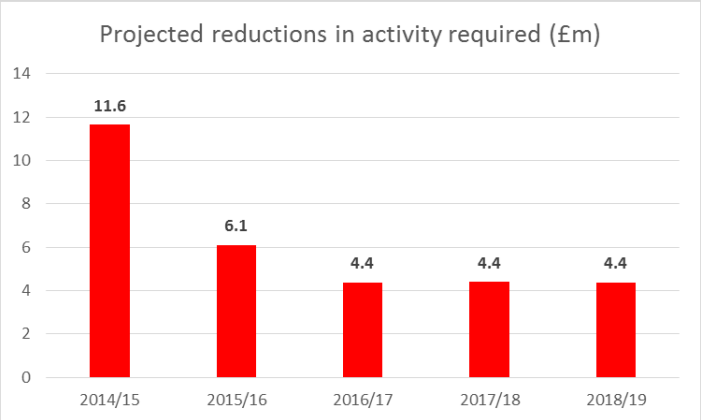
The Imperative for Change

Our analysis of the "do nothing" position in the financial position section of this strategy has identified significant requirement for additional resources, which reflects the pressures faced by the broader NHS. By the end of the period of this five year plan, the anticipated requirement for additional resources is some £35m, based on the growth in population and the cost per head within each population group.

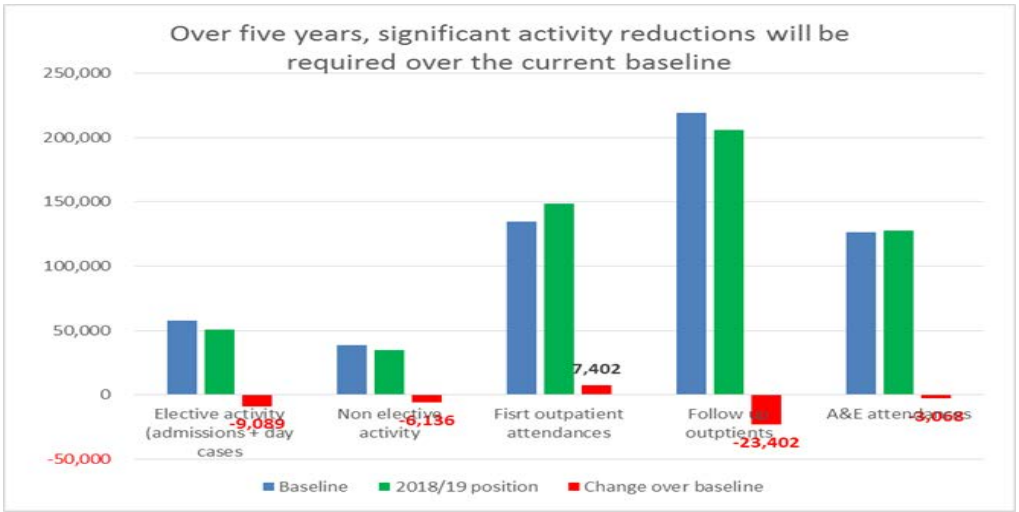


Although we will receive a measure of growth over the coming five years, our projections show a gap of £31m between demand and available resources.

We have already undertaken detailed modelling to plan how we will manage this change and have formulated a plan that anticipates significant reductions in acute activity through transformational change over the coming five years. The approach is to "front load" the changes taking advantage of the Delivery Plan initiatives that are already in train, linking these with the development of a series of new transformational initiatives. These changes will result in a shift on the balance of care previously discussed in this strategy to deliver high quality care for our patients, whilst staying with our available resources.

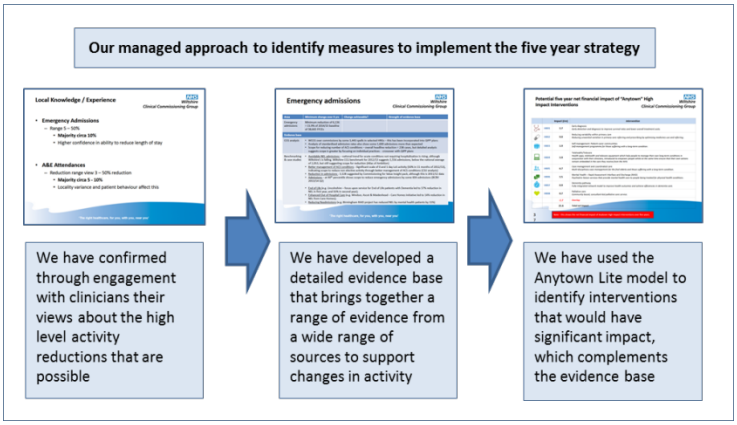


Our activity projections show that at the end of five years, in most acute care settings, activity will be lower or similar to baseline activity at the beginning of the five year plan period. Therefore, even though we anticipate growth in demand, this will be offset by activity reductions to make acute activity in absolute terms lower or similar to what it is now.



The table above indicates the scale of change required against existing NHS activity patterns across Wiltshire, with a move over five years to over 6,000 fewer emergency admissions, over 23,000 fewer follow-up outpatient appointments, and over 9,000 fewer elective admissions/day cases.

This scale of reduction requires significant transformational change, which is reflected in the ambition of this strategic plan. To make sure our plans are robust, we have used a structured approach to develop a rich knowledge base of potential interventions that will help develop and successfully achieve these transformational changes. The approach is illustrated below:



Highlights of the ideas, interventions and approaches that we will use to develop the transformational schemes to fulfil our strategic objectives include:

- **Local clinical knowledge and experience** – which demonstrates confidence in the ability of local clinicians to influence and reduce the rates of emergency admissions and A&E attendances through a series of initiatives and interventions targeted in these areas
- **Our existing analysis and benchmarking** –have identified scope to change settings of care within planned care as well as reducing the scale of planned care in line with best practice norms, particularly within MSK services. There is also scope to address the level of demand for unplanned care based on analysis that shows areas of significant over commissioning
- **Assessment of best practice case studies** – which has identified a range of best practice initiatives targeted at both specific patient groups and broader care settings that improve the quality of patient care as well as reducing levels of demand for and activity within acute care settings
- **Anytown Lite**, which shows significant scope for improvement through High Impact Interventions such as Case Management/Co-ordinated care and reductions in variability within primary care. These suggested interventions are congruent with CCG plans to develop primary care at scale and work within the Better Care Fund framework to improve the scale and intensity of home based services. This would be particularly focused on the over 65s, which is the age group that drives significantly the requirement for additional resources. The detailed outputs from the Anytown Lite model are shown in Appendix 2

As we bring together our detailed plans for the five year period we will ensure that there is a clear understanding of how plans within Health and Social Care work together, particularly making sure that initiatives through the Better Care Fund are not double counted elsewhere.

We already have clinical buy in to and understanding of the scale and type of change in acute care that will be required over the coming years. We have involved CCG staff, local clinicians as well as the provider sector in workshops to develop the strategy and to articulate the nature and scale of change required. The result of the workshops was agreement to:

- The need for fundamental change within the local health and social care system, as the current system is not sustainable
- The scale of change needed within the acute sector, which represents significant reductions in activity over the coming five years
- The direction of travel in this strategy as the way in which services would develop in future

We will continue working with the clinician body and providers to develop and agree the specific strategic measures that deliver the changes in acute activity and the new model of care within this strategy. These changes will be aligned to our financial plans, to ensure our use of resources remains within the available envelope.

Whilst increased life expectancy is a cause for celebration, the high rate of growth in the number of elderly people and people with dementia in Wiltshire is placing a burden on care budgets, creating financial pressures and capacity issues for health and social care. For NHS services, we have estimated that without transformational change, we would need an additional £60.1m by 2021 – of that 97.85% (£58.8m) would be required for people aged 65 and over. The scale of this challenge is beyond traditional QIPP and similar interventions. It requires fundamental system redesign. There must be a major shift in focus and resources into prevention and care at, or close, to home. As part of the new model it is essential to increase people's sense of personal responsibility for their wellbeing and to engage with friends and families and local communities to change lifestyles and deal with root causes (such as loneliness) which, if unaddressed, lead to demands on the social and health care system. Such fundamental change will not be easy. It requires a different mind-set, deep engagement with the public, communities and partners and a collective resolve to bring the new system to life. However, a failure to achieve such transformational change will result in a reversal of many of the societal gains that the health and social care system has delivered over the years, particularly to the quality of life.

As a result of this imperative for change, it is crucial that we work with our partners across Wiltshire over the next 2 years to lay the foundations for the transformational change that is required.

Key Challenges

The main challenges we and our partners face in Wiltshire in bridging this gap and delivering transformational change are:

- Developing a robust and sustainable integrated system - Care and support is often fragmented, so people experience gaps in care and patients are treated as a series of problems rather than as a person. Care and support plans do not link together, which is inefficient and frustrating for people on the receiving end of our services. People have to repeat their stories to different agencies and are not always kept informed.

- Too many people make a decision about their long-term care and support whilst they are in hospital often resulting in frail elderly people being rushed into decisions and possibly an unnecessary admission to a residential or nursing home.
- Developing and implementing a robust model of primary and community based care - Acute hospitals, specialist hospitals and emergency departments are under pressure, with unacceptably high levels of delayed transfers of care and extended lengths of stay in hospital.
- Increasing personal responsibility for health and well-being - The health and care system gives a higher priority to treatment and repair rather than prevention or early intervention. Often, people are not eligible to receive services until they reach a point of crisis, when a little support earlier may have avoided the crisis from developing.

Section 2: System Vision

Our vision is that ***Health and Social Care services in Wiltshire should support and sustain independent healthy living*** and the design of our future system is based on three key principles:

- People encouraged and supported to take responsibility for, and to maintain / enhance their well-being
- Equitable access to a high quality and affordable system, which delivers the best outcome for the greatest numbers
- Care should be delivered in the most appropriate setting, wherever possible at, or as close to home
    - Where acute care is one-off or infrequent, there should be formal and rapid discharge
    - Where care is on-going (e.g. chronic conditions) the default setting of care should be primary care

It is paramount that we maintain our focus on improving quality and ensure the future sustainability of our system. We are wholly committed to developing a truly integrated system, and accordingly our plans have been jointly developed with our partners in Wiltshire Council and across the County.

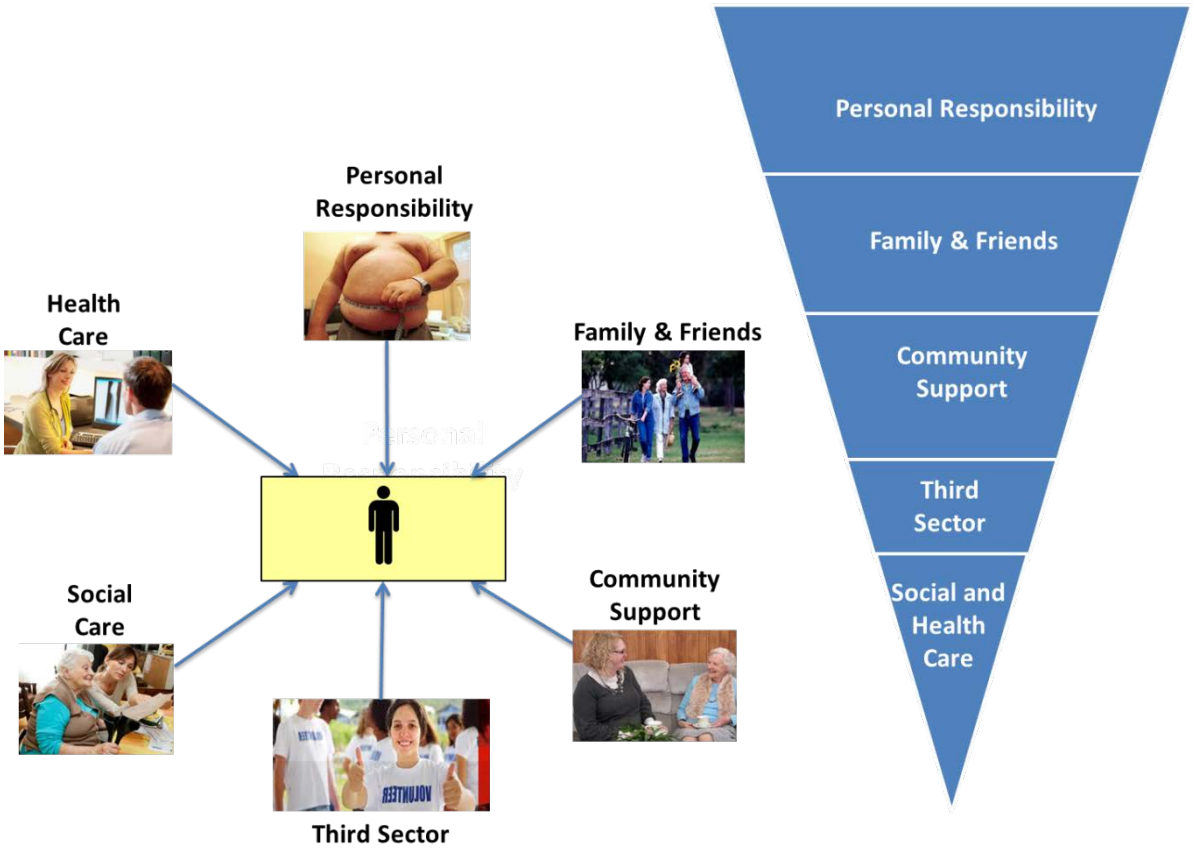
The financial and quality drivers mean that more of the same is not an option for us in Wiltshire. We have been transparent with our partners about the challenge that lies ahead and have a common understanding of the need for radical transformation and a shared responsibility to deliver the system change and manage the associated risks. This includes the need to use the next two years to lay the foundations for the required changes.

Building on the existing work and relationships we intend to make the most of this rare opportunity and design a system that reflects what our population requires and changes the nature of the contract with people around responsibility for their own health and well-being.

We know from our public and stakeholder work that the people in Wiltshire want more joined up services available in their communities and, at the same time, we know we cannot sustain the current proportion of our expenditure that is spent on hospital services. We therefore want to support people to be well and independent, and to take control of their own care. When intervention is needed we want this to be provided in people's homes, in primary care or in the community. Only when there is a good reason why this should not be the case should care be provided in our local acute hospitals. All services in Wiltshire will be delivered in an integrated way, led by primary care working with our social care partners, and to the highest standards of safety, quality and safeguarding.

Future Care Model

As we move towards 2018/19 we will see increased investment and support to develop and maintain healthy and independent living. The starting point for our future model of care is personal responsibility with people supported to be more in control of their lives and increasingly confident to draw on their personal resources and those of their families and communities.



Establishing and sustaining wellness and independence

In developing this model, we are aware that we need to look at the traditional health and care system differently, refocussing our investment, giving greater priority to prevention, early intervention, shared decision making and self-care.

We recognise that the wider determinants of health, including isolation, housing, and lifestyle choices can be equally, if not more, important that the health and care services in terms of keeping people well and healthy.

To ensure we can provide the population of Wiltshire with access to the high quality, responsive and sustainable health and care services they need to manage ill-health or address a care need within our available resources, we will shift the focus of our investment towards tackling the root causes of demand and support people to establish and sustain wellness and independence.
Alongside our commissioned services we will seek to develop healthy community networks and promote well-being by moving away from a medical model of care, promoting a sense of community, as well as signposting support and activities in the community which are available and may be more appropriate for themselves and those they care for.

Health and Care Service Design

Where interventions from Health and Social Care are required, our integrated Primary, Community and Social Care services will be wrapped around the individual, accessed and co-ordinated through Extended Primary Care Teams, delivering a proactive and preventative approach to healthcare. There will be a resilient Acute sector, dealing primarily with those patients that cannot be cared for in a community setting and services in the Acute sector will provide both in reach and outreach services. Highly specialised services will be focused at centres of excellence, reducing variety, improving quality and safety and ensuring the future of Health and Social Care services.

Services will be provided as close to home as possible from good, well-resourced facilities, robustly monitored and able to demonstrate excellence in all standards. The system will be high quality, lean and sustainable for future generations, delivering appropriate services to our population.

Commissioning for Outcomes

We will approach the implementation planning of our vision using an outcomes based approach in order to deliver the desired end state while allowing for tolerable variation within the bounds of our guiding principles to accommodate the specific needs of our localities. In this way we aspire to deliver the best possible outcomes in a manner tailored to the distinct and diverse needs of our populations with services specifically designed by their local clinical leaders, and so deliberately tailored to take account of local issues and need.

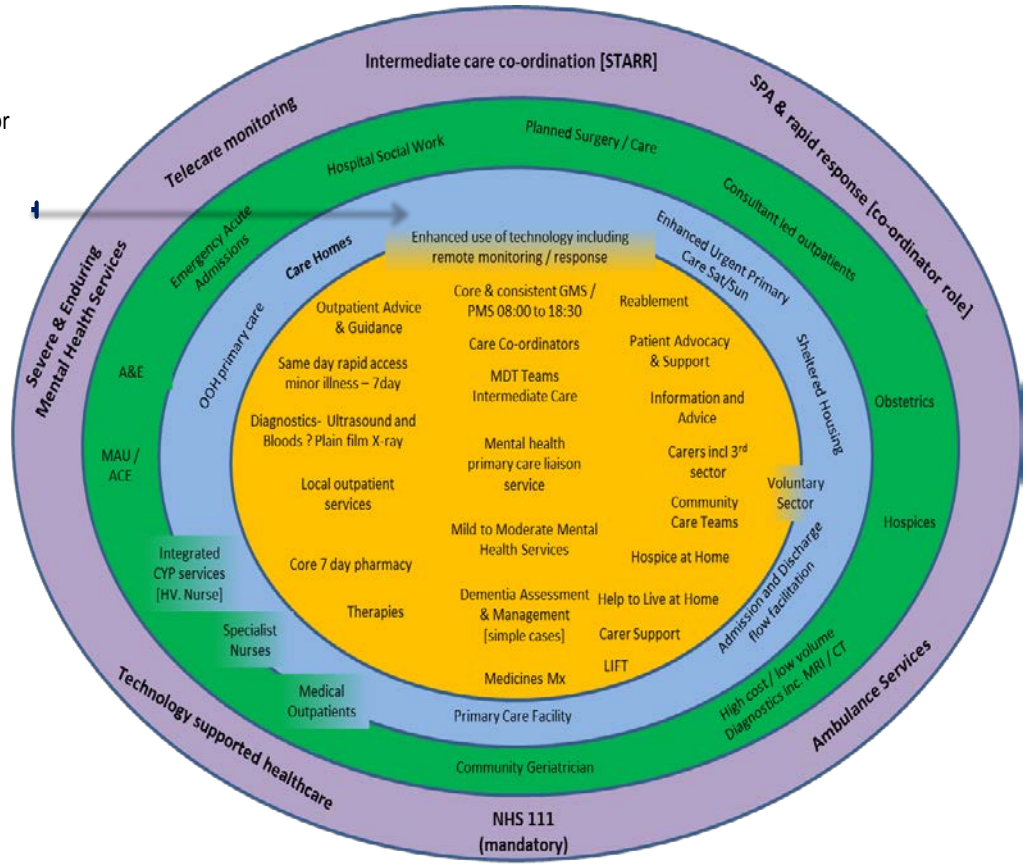
Our Model:

The diagram below sets out, at-a-glance, the key features of our future vision for wellbeing, care and health across Wiltshire. Due to the large, rural nature of our County, we have focussed upon using building blocks of 20,000 people as the core of our model (a very broad average list size for a GP Practice). The outer layers of the model then progressively move up towards a market town level (40,000 population), a Group level (consistent with our being divided into three natural geographical areas in NEW, WWYKD and Sarum), and a County-wide level. In this way we have brought together health and care services to work with stakeholders in mapping out the most sustainable way to deliver the outcomes we aspire to over the next five years:

Future Health and Care Service Vision

Potential locations for "Market Town" 40,000-level population:

- Chippenham
- Malmesbury
- Bradford on Avon
- Tisbury
- Warminster
- Trowbridge
- Melksham
- Marlborough
- Tidworth
- Salisbury
- Devizes



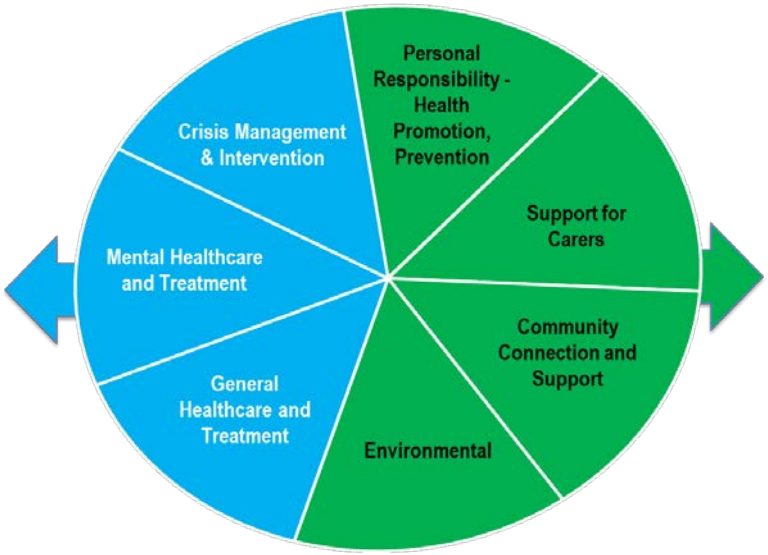
In addition to the above model, we have also worked extensively with our partners to produce the additional model below which builds upon this, but adds a range of ambitions and interventions (the right-hand side in green) which are targeted at the broader determinants of wellbeing and health, such as support for carers and developing community assets.

NHS Wiltshire Clinical Commissioning Group

Health and Care services in Wiltshire supporting and sustaining independent healthy living

Strategic Priorities

Establishing and sustaining wellness, health and care service redesign, and delivering against statutory priorities are all key features of the new model of care



Commissioned Services

Community day centres for older people
Other older people services - e.g. Age concern, Community First, Good Neighbour Scheme, Alzheimer's and Stroke Association
User led networks
Carer support
Learning Disabilities – including day centres, social centre, training / employment support, community support and outreach, housing and travel support
Mental health – supported housing, information and advice, day services and supported employment
Disabilities – day and social activities, communication centre, supported employment, living with HIV support
Drug and Alcohol – support for families and carers, dry houses and rehabilitation
Housing related support and community alarm service
Homelessness – hostels, refuges, temporary accommodation, teenage parents and the homeless
Children's Centres
Youth Development Schemes
Parenting and Family Support
School Nursing
Activities for the under 5s
Health promotion and prevention schemes

Community Based Assets

Healthy Communities Network
Developing independent communities

Statutory Responsibilities e.g. Safeguarding

In delivering our vision the key components of the new integrated system are:

1. **Increased investment and support into developing and maintaining personal responsibility. With a focus on education, prevention and support to develop and maintain healthy and independent living**
2. **Enhanced and integrated community care with a broader range of services provided in a local setting**
3. **Increased productivity and effectiveness of care with a reduced reliance on bed based solutions**

Further detail on the interventions and system changes required to deliver our vision can be found in the 'How will we do this?' section of this document. Appendix 1 also contains a further example of the application of the new care model with respect to Mental Health.

Characteristics of a high quality, sustainable health and care system

Our Five Year Plan builds on, and takes lessons from, our existing work to develop and improve integrated services provided as close to home as possible across Wiltshire. We are confident that we are developing plans and an implementation methodology that will demonstrate the six characteristics of a high quality, sustainable health and care system

Ensuring patients and citizens will be fully included in all aspects of service design and change and that patients are fully empowered in their own care

We have ambitious plans to redesign and integrate services and we know that patients and members of the public across Wiltshire want to be fully engaged in making choices about their health and lifestyles, participate in the shaping and development of health and care services and influence the planning and design of local healthcare services at each stage of the process. We have a strong track record of engagement in development of strategies and programmes, however we recognise this is an area where improvement can always be made and we are keen to ensure that patients and the public are at the centre of our healthcare service commissioning from planning to delivery. This is outline further in the section on "Engagement" on page 44.

Wider Primary Care, Provided at Scale

In order to realise our vision we are aware of the need to extend and enhance our primary care services. Primary Care will play a key role in the leadership, co-ordination and provision of services across Wiltshire. This will require investment in workforce development, investment in technology to support innovative care delivery, improved utilisation and development of our community estate infrastructure and education and refocus patients' behaviour. This will require a step change in the way in which services are designed, commissioned and provided.

Our Five Year plan places Primary Care, alongside patients, at the centre of the health and social care economy. The aim being that not only will Primary Care continue to lead the design of the

healthcare system via clinical commissioning, but also provide a greater range and improve the quality and safety of services delivered to patients and to support our plans for integration, moving care out of hospital and our reconfiguration of community services.

The development of primary care is required due to a wide range of national and local drivers which include demographic pressures, rising prevalence of chronic disease, rising demand for primary care services, constrained funding growth and rising patient expectations.

As a CCG we will work in collaboration with NHS England and the Local Area team to implement the recommendations in the strategic framework for commissioning of general practice services, due to be published in the autumn, stimulating new models of care and developing innovative forms of commissioning and contracting to support these new models.

A Modern Model of Integrated Care

A coordinated, care system with services wrapped around the patient using integrated care services and support accessed and co-ordinated by Primary Care teams is the foundation stone for our strategic vision, and across Wiltshire the CCG and the Council are already engaged in a programme of Community Transformation aimed at developing integrated community health and care services. As a system we have used the Better Care Fund as an opportunity to further strengthen this work and deliver at greater pace and scale.
More detailed information can be found in within our Better Care Fund documentation. We are, however, confident that the investment and joint working in place builds on our success to date and will make a significant impact in addressing what we see as the key challenges / barriers to delivering modern integrated care in Wiltshire (see page 28).

Access to the highest quality urgent and emergency care

Wiltshire CCG are committed to ensuring the delivery of high quality effective urgent and emergency care services for our population and are keen to develop a proactive, robust systems for patients that redirects significant levels of urgent care into planned or managed care.

Unscheduled care can broadly be segmented into three categories of users:

1. Those with **urgent care** such as minor trauma and illnesses needing an experienced primary care response for the initial assessment and treatment
2. Those with **chronic illness** such as mental health, elderly care, end of life care and long term conditions
3. Those who require **emergency care** e.g. trauma, needing immediate access to fully staffed hospitals with senior clinical capability

We are currently undertaking a review of the **Urgent Care** system across Wiltshire – A&E, Walk in Clinics, Minor Injury Units and the opportunity to manage more Urgent Care patients within an enhanced primary care setting, in order to define an optimum service pathway for patients. The aim

is that patients see the most appropriate clinician in the most appropriate setting, taking into account national examples and evaluation of the local pilots that are taking place in and around Wiltshire.

The solution is likely to be a combination of patient education and self-care, enhanced primary care and community services to increase the range of patients that can be managed safely in an out of hospital setting and a pragmatic solution, possibly involving a more multi-disciplinary primary and secondary care team approach in A&E. Building on our early success with regards admission avoidance using Risk Stratification, Simple Point of Access / Rapid Response and the new team of Care Co-ordinators, our model for Primary, Community and Social Care services wrapped around the individual, accessed and co-ordinated through the Extended Primary Care Teams, will support proactive management of patients with a **Chronic Illness**, identifying those patients who are at risk of a hospital admission and providing necessary care and support to maintain the patient care in the community.

Where patients require **Emergency Care** our aim is to increase the levels of ambulatory care management, rapid diagnostics and treatment so that patients do not require admission to a hospital bed. For those patients who do require admission, our aim is to develop our community based services to be able to manage an increased level of acuity in the community to reduce the pressure on acute hospital beds and ensure that patients are discharged as soon as possible.

Key enablers to successful delivery of our vision in this area are our plans for enhanced / extended Primary Care and Community services and seven day working across Health and Social Care.

A step-change in the productivity of elective care

Wiltshire CCG spend over £86M a year on planned care (elective inpatients, day cases and outpatient care) and we committed to the commissioning of timely and effective elective care services for our patients, working with our providers to deliver a significant step change in elective care.

We are adopting a systematic approach to developing and commissioning new pathways for elective care to support the development of evidence based, high value care pathways that:

- Promote self-management, supported by care management plans which ensure the patient knows where and when to access support, rather than routinely see all patients as follow-ups
- Reduce unnecessary secondary care use and maximise what can be managed in primary care through the commissioning of 'tiered' services, moving away from the only opportunity to access consultant support being via the traditional face to face consultant contact to commissioning different service levels e.g. Results only clinics, telephone advice and guidance to increase ability to manage patients within primary care.
- Improve access to diagnostics services and agree pre-clinic work ups that ensure when a patient see a specialist for the first time they are able to get maximum benefit from that appointment.

- Reduce unwarranted variation in intervention rates (Dr Foster indicates a higher than expected elective admission rate for MSK conditions within Wiltshire, and the last Programme Budgeting report (2011/12) confirmed that Wiltshire spent more per head on MSK than their peers.
- Support patients to review the treatment options available to them and make an informed decision which best suits their needs and expectations (Shared Decision Making)
- Apply Enhanced Recovery Programme principles to elective procedures to reduce length of stay
- Move interventions to the most effective care setting i.e. Inpatient Procedures to Day Case and Day Case to Outpatient Procedures.

Specialised services concentrated in centres of excellence (as relevant to the locality)

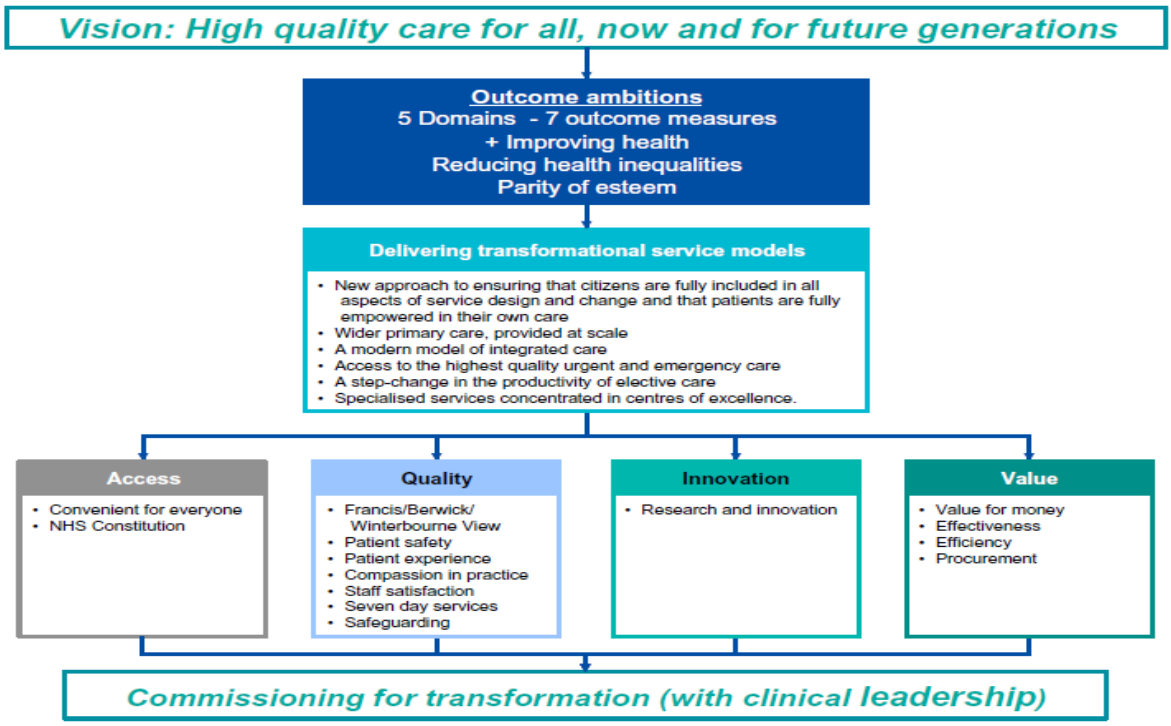
Although the responsibility for commissioning of specialised services sits outside of the CCG, the majority of specialised services form part of a patient pathway. In Wiltshire, we are keen to work in collaboration with NHS England to ensure that patients can access specialised care promptly and also, once clinically ready for discharge, can move out to intermediate step down or more community based care settings.

NHS England has developed a set of principles to support their approach to specialised commissioning, which focus on ensuring patients receive the most appropriate care in the optimum care setting with the most effective use of specialised resources. These principles are aligned to our wider approach to commissioning and reinforce and build upon patients' rights under the NHS Constitution.

- Right patient - In order for patients to receive optimum care, they need to be assessed and referred appropriately.
- Right provider - Ensuring patients are referred to the most appropriate provider will support achievement of 18 weeks as well as the most effective use of resources.
- Right treatment - The national service specification compliance process, together with the implementation of national clinical policies, will ensure that only the most effective treatments are commissioned from compliant providers, supported by outcome based evidence.
- Right place - Patients should receive their treatment in the optimum care setting. This means that patients should receive care within designated centres that meet national clinical standards, and that delayed admission and discharge into and out of specialised care should be considered a priority for action.
- Right time- This recognises the importance of early referral and prompt treatment, with a particular emphasis on compliance with national waiting times and delayed discharges.
- Right price - The development of local and national tariffs that represent best value for money whilst ensuring appropriate levels of reimbursement is fundamentally important.

Improving Quality and Outcomes

The national quality and sustainability agenda for the NHS is captured in the schematic below:



Wiltshire CCG is committed to ensuring sustainable health and care services for our population both now and in the future, and are confident of working with our partners to achieve this agenda.
The table below sets out our local outcome ambitions (in addition to those contained in our Quality Premium, other local objectives such as Improving Access to Psychological Therapies, and working with our partners at Wiltshire Council to meet the ambitions set out in the Wiltshire Health & Wellbeing Strategy):

Wiltshire CCG Ambition	NHS England Ambition	Outcomes
Increased investment and support into developing and maintaining personal responsibility. Focus on education, prevention and support to develop and maintain healthy and independent living	Securing **additional years of life** for the people of England with treatable mental and physical health conditions	**Potential years of life lost (PYLL)** are an estimate of the average years a person would have lived if he or she had not died prematurely. It is therefore a measure of premature mortality. The **lower the score, the fewer years our patients have lost through ill health.** Our **current PYLL** per 100,000 population in Wiltshire is **1902**. Over the **next five years** we will improve this to **1827.7.**
	Improving the health related **quality of life** of the 15 million+ people with one or more long-term conditions, including mental health conditions	**EQ-5D** is a survey tool for use as a **measure of health status or health-related quality of life** developed by the EuroQol Group. The **higher the score, the more positive the individual's assessment of their own quality of life**. Our **current average EQ-5D** score in Wiltshire is **75.8**. Over the **next five years** we will improve this to **76.4.**
Enhanced and integrated community care with a broader range of services provided in a local setting	Increasing the proportion of **older people living independently at home** following discharge from hospital.	We will work with our Health & Wellbeing Board to set an ambition in this area, which is at the heart of our Five Year Strategic and Better Care Fund Plans
	Increasing the number of people with mental and physical health conditions having a **positive experience of care outside hospital**, in general practice and in the community	Patients who use **GP or Out-of-Hours (OOH) services** are asked to provide feedback on their experiences via structured surveys. This is reported as the proportion of patients reporting that they have received a "poor" experience of care. Therefore, the **lower the score, the less dissatisfied patients.** Our **current average feedback** score

		in Wiltshire is **5**. Over the **next five years** we will improve this to **4.9.**
Increased productivity and effectiveness of acute care with a reduced reliance on Bed Based Solutions	Increasing the number of people with mental and physical health conditions having a **positive experience of hospital care**	Patients who use **hospital services** are asked to provide feedback on their experiences via structured surveys. This is reported as the proportion of patients reporting that they have received a "poor" experience of care. Therefore, the **lower the score, the less dissatisfied patients.** Our **current average feedback** score in Wiltshire is **128.5**. Over the **next five years** we will improve this to **113.5.**
	Making significant progress towards **eliminating avoidable deaths** in our hospitals caused by problems in care.	Section 3 sets out in more detail the range of initiatives we are adopting to ensure safe and effective services for Wiltshire patients

In addition to these overarching ambitions, the CCG also has several further local ambitions that flow from this, our local JSA and policies in other care areas, including Parity of esteem, personal health budgets, reducing health inequalities and seven day working.

Parity of Esteem

As we look to improve the health services for Wiltshire we recognise the importance of ensuring parity of Esteem for Mental Health, not only in the services that are commissioned specifically for the treatment of mental health but also by ensuring parity of accessibility to physical health services for those with mental health conditions.

In order to ensure parity of esteem for mental health we aim to address the 25 areas identified in 'Closing the Gap: priorities for essential change in mental health', DoH, January 2014. This information, together with the Wiltshire specific information that will be contained within the Wiltshire Mental Health Strategy, (draft due to be published early February 2014), will allow commissioners to ensure that commissioning decisions are informed by local context and the drive to ensure parity of esteem for Mental Health.

In addition, together with Wiltshire Council, we have signed up to taking forward Mental Health Commissioning jointly. The exact mechanisms for joint commissioning will be explored and agreed during 2014/15. Both organisations are clear that by working together services commissioned can be better planned and delivered resulting in better outcomes for the people of Wiltshire.
Wiltshire CCG and Wiltshire Council have a joint commissioning arrangement in place for children's health services, including improving children and young people's emotional well-being and mental health. The Emotional Wellbeing and Mental Health Strategy (2011 – 2014), overseen by the Children's Trust Partnership, has focussed on a small number of priorities to ensure that children and young people with emerging mental health difficulties and diagnosable mental health conditions are identified and have access to effective support. Since the Strategy was approved, a number of changes have been made to mental health support.

The Emotional and Wellbeing Strategy will shortly be updated and, based on feedback from GPs, schools and other professionals, future areas for development in the next 2 years are:

- Further development of the Primary Mental Health Service, building on the experience of Oxford Health running an IAPT pilot project;
- Creating a single point of access for the Primary Mental Health Service and Wiltshire Council early intervention services to address the cross-over between an emerging mental health difficulty and behavioural issues;
- Looking at the role of School Nurses in delivering a short term intervention to respond to emotional difficulties;
- A pilot project with CAMHS for the Outreach Service (OSCA) to continue intervention with young people they are supporting beyond the age of 18. This will ensure that some vulnerable young adults, including looked after young people, will still receive a mental health service beyond the age of 18 even if they do not meet the criteria for the adult mental health service.
- During 14/15 the CAMHS service provider will work with the adult MH service provider to look to improve the transition for young people into adult mental health services. This is an area of concern nationally and NHS England is currently developing a service specification which should aid in the work that is already being taken forward locally. The first step in our piece of work locally is an audit of some of the cases that have transitioned recently and the learning from this work will inform the next steps.

Within the 14/15 secondary mental health contract there will be a CQUIN about physical health checks. This should help with the early identification of physical health problems and subsequent treatment.

In 2013/14 Wiltshire CCG invested heavily into Acute Liaison Services, resulting in acute liaison services being in place at the Royal United Hospital Bath, The Great Western Hospital Swindon and Salisbury District Hospital, 7 days a week 9-5. These services are having a positive impact on services in ED, including the services for individuals who have self-harmed, but also services on the wards for patients with dementia and other mental health conditions. In the next few months the services will be evaluated to best understand how to further improve services in the future.

As part of the Transforming Community Services work in 14/15 the community services will be tendered. Within the specifications of the services it will be explicit that physical health services must be equally as assessable to individuals with mental health needs as those without.

Appendix 1 sets out our vision of the new health and care model as it applies to Mental Health.

Safe, appropriate, and high quality care for those with Learning Disabilities

As part of improving health services for Wiltshire we also recognise the importance of ensuring parity of esteem for those with Learning Disabilities, not only in the services that are commissioned specifically for the care and treatment of those with learning disabilities but also by ensuring parity of accessibility to physical health services.

The Government's Mandate to the NHS Commissioning Board sets out that "The NHS Commissioning Board's objective is to ensure that Clinical Commissioning Groups work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care. The presumption should always be that services are local and that people remain in their communities; we expect to see a substantial reduction in reliance on inpatient care for these groups of people."

We aim to transform health and care services and improve the quality of the care offered to people of all ages with learning disabilities or autism and address the areas identified in the Winterbourne view national reports. During 2014/15 we will also develop joint commissioning arrangements to ensure we are commissioning safe and appropriate care. Further details about how we will ensure we deliver safe services are in Section 3 below.

Personal Health Budgets

The Government pledged to roll out Personal Health Budgets to patients in receipt of Continuing Healthcare funding who ask for one, from April 2014 and to all those in receipt of CHC from October 2014. Our aim in Wiltshire is to refine the Personal Health Budget process so that it becomes an integral part of the CHC assessment process and therefore an 'opt out' rather than an 'opt in' for patients at the point of eligibility as a default position.

We are committed to the national development programme and have identified a small cohort of individuals who we believe would benefit from a PHB. We have started working with these individuals and their families and the outcomes will be monitored locally and via the national Personal Outcomes Evaluation Tool (POET) and the CCG's progress against implementation is being monitored against the National Markers of Progress.

Reducing Health Inequalities

Wiltshire is a largely rural area and people in minority groups are often not present in sufficient numbers to form coherent groups. This can result in an unknown demand for services and hence unmet need which the CCG is aware of in planning services. Analysis to identify the groups of people and areas of our County where health inequalities exist is facilitated by the Health and Wellbeing element of the Joint Strategic Assessment (JSA) for Wiltshire. In Wiltshire the programme provides a hierarchy of needs assessments, the most strategic being the JSA for Wiltshire, which is underpinned by a range of detailed needs assessments including the JSA for Health and Wellbeing and JSAs for each of our twenty local communities. Naturally the CCG is strongly represented in the entire process.

The JSA for Health and Wellbeing provides an opportunity to look ahead three to five years so that:

- inequalities within our population are reduced
- services are shaped by local communities
- social inclusion is increased
- the above outcomes are maximised at minimum cost

There is a range of wider determinants of health that impact on inequalities including rurality, transport deprivation, service deprivation and housing deprivation. The increased needs of particular groups such as families, young people, the elderly, disabled persons and carers[14], the military, prisons, black and minority ethnic groups and Gypsies and Travellers and the way these are met can also affect the inequality gap. Tackling health inequalities (including infant and child mortality) requires local service providers to work in partnership to address the wider determinants of health such as poverty, employment, poor housing and poor educational attainment.

Wiltshire shows high levels of relative deprivation with regards to barriers to housing and services, reflecting the rural nature of the County. The indicators comprising the barriers to the housing and services deprivation domain are structured into two groups, representing 'geographical barriers' and 'wider barriers'. Geographical barriers are generally the greater issue in Wiltshire. 78 of Wiltshire's 281 Lower Super Output Areas (28%) are within the 10% most deprived in England for geographical barriers and 12 of Wiltshire's LSOAs (4%) are within the 1% most deprived in England for this theme.

Seven Day Services

We are committed to implementing the 10 Seven Day Clinical Standards and are embedding them in our contracts with providers in the 2014/15 contracting round. These standards are critical to ensuring services are safe and effective regardless of when our patients need to access them. We expect our providers' Service Development & Improvement Plans (SDIPs) to be robust and compliant with these key standards, and have been working closely with them to ensure this will be achieved – e.g. our work with the Royal United Hospital Bath to implement the initiatives recommended by the national Emergency Care Intensive Support Team (ECIST) review of their emergency department, as

well as our continued work with Avon & Wiltshire Partnership Mental Health Trust to implement standards 7 (psychiatric liaison) and 9 (support services).

This work will be complemented by our own work on Urgent Care review and redesign, Rapid Response and Early Supported Discharge - focussing on the primary, community and social care response aligned to Seven Day Working. Our plans around utilising the Better Care Fund and Community Transformation have fully integrated, 24/7 services at their heart, with a focus upon enhanced primary care across Wiltshire with improved services wrapped around general practice (social, community and mental health services). This will particularly focus upon care for the frail and vulnerable elderly at high risk of unplanned hospital admission.

System Sustainability

Our vision provides a clear direction and focuses us all jointly on the delivery of a sustainable system. We have a significant financial challenge and have to put plans in place to identify significant savings by the financial year 18/19, we are clear that this will only be delivered through radical change and working together.

Current services will need to be redesigned so that investment can be freed up to develop the necessary infrastructure and services out of hospital to deliver this vision, and create the necessary savings to remain within our budgets. The CCG will need to ensure that there is a managed process of transition for all organisations impacted by the redesign of services to maintain the clinical safety, quality, safeguarding and financial viability of their remaining services to ensure long term sustainability is achieved.

Engagement

Engaging Our Wellbeing, Health and Care Partners:

We have a structured approach to engagement with partners across the Wiltshire health and social care system, including both commissioners and providers. Whilst we have not developed a formal framework of principles and values of joint working, we do use the following values in all our engagement and joint working:

- Delivering change that genuinely improves people's health and lives
- Using clinical judgement and expertise as a primary driver for shaping our change
- A commitment to sustainability, so change delivers quality and excellence within available resources across the whole system
- Openness and transparency through honest engagement in initiating, developing and implementing change

As a CCG we are committed to collaboration with all of our partners and stakeholders, building consensus around the need for change and working together to deliver this. Our vision and ambitions have been created in conjunction with clinicians across the system, we are clear that both will only be achieved if we take a clinically-led approach. As part of this we have worked closely at every stage with the Wiltshire Clinical Executive, a body comprised of GPs from across our three Groups. Clinicians have also been at the heart of a series of workshops and Group-based engagement sessions throughout the development of our five year strategy.

Our strategy for the future of health and care in Wiltshire has also been produced with extensive engagement and working with our partners at Wiltshire Council, our local Healthwatch and other key stakeholders across the County. This follows a robust stakeholder analysis and engagement plan produced to ensure plans are inclusive and reflective of wider views and needs. We have worked hard to ensure coherence of approach with close neighbours in Bath &North East Somerset and Swindon CCGs, via their involvement in the derivation of our plans and a series of Board to Board discussions between the CCGs and Acute providers. It is vital that all of our plans, while reflecting local Health & Wellbeing Board priorities, are complementary.

We have closely engaged our local Health and Wellbeing board in the development of our vision and ambitions, ensuring close co-ordination between strategic plans and those for the Better Care Fund. We have clear outcomes we jointly wish to achieve for the population of Wiltshire, as set out in our joint Health & Wellbeing Strategy.

We are aware that this level of transformational change to service delivery and system design will have significant implications for our provider market. Throughout the development programme we have been working with our key providers including Acute, Mental health, Primary Care, Out of Hours and the Ambulance Trust to ensure that they are aware of, able to influence and respond to our strategic intent.

This engagement has been through direct involvement in our programme of workshops and we have held executive level discussions to discuss the alignment of strategic intent on a one to one basis. We are delighted that our provider partners are fully supportive of our direction of travel and are ready to take on the challenge that new service models of delivery will bring. As many of our providers serve more than one commissioner, we have adopted a similar model of one to one discussions and invitations to our development workshops and as a result are confident that our priorities align.

Engaging Our Communities:

We have Patient Participation Groups (PPGs) linked to GP practices across Wiltshire, Local Area Boards and a Service Users' Network. Using Area Boards developed across Wiltshire also builds upon our commitment to involve every community, and to work in partnership with our Local Authority

colleagues. We also work in partnership with community groups and voluntary organisations to reach and understand the communities we are seeking to work with. The CCG is continually seeking to improve mechanisms to capture patient and public insight so that it can underpin and inform CCG decision-making processes. Complaints and patient feedback are used as an important indicator of the quality and safety of services and we have direct user involvement in service redesign projects. All of the information received through our engagement with patients informs our Patient and Public engagement strategy and we constantly strive to improve the ways in which we engage our population, avoiding a one size fits all approach.

The following table provides some examples of public and patient engagement that has been, or will be, undertaken as part of our current delivery programmes:

Programme	Patient / Public Engagement Description
Community Transformation	Workshops including patients and the public were held across Wiltshire to look at the 'As Is' and 'To Be' models of care. The resulting care model has been developed using the data gathered from these workshops.
Dementia	The dementia strategy was developed with input from members of the Wiltshire Dementia Delivery board, which includes Alzheimer's Society and Alzheimer's Support, Carer Support organisations and Advocacy organisations. Additionally as part of this work the CCG visited and collected views and feedback from people with dementia and carers at various local groups in Wiltshire.
End of Life	The strategy for End of Life which the CCG developed in partnership with providers included patient representatives as key members of the group. The strategy was also discussed at our November stakeholder event, which included both patients and the public
Planned Care **MSK and Ophthalmology**	**Rheumatology** – an event held across Wiltshire and BaNES CCG, facilitated by the British Society of Rheumatology, including patients and patient group representatives identified service and quality issues as well as best practice which will inform our commissioning intentions this year. **MSK and Ophthalmology** - Patients will be involved in the planning and subsequent development of the new service pathways in 2014/15 We are also keen to work with patients to get a better understanding of the ways in which we can improve communication and information to support active involvement in decisions about treatment and care – particularly Shared Decision Making, where clinicians and patients discuss together which treatment, tests or management options for a particular condition is best for the patient

Programme	Patient / Public Engagement Description
Long Term Conditions - Diabetes	The newly formed Diabetes Steering Group has Diabetes UK, acting as the patient representative in the first instance and will then be seeking to widen patient and public engagement to better understand the support people need in terms of prevention and self-management and in the planning and development of new service pathways
Urgent Care	The review of Urgent Care services will collect patient views on their use and awareness of Urgent Care services and also gauge the level of comfort with an increased personal responsibility model. Redesigning the urgent and emergency care system is likely to be highly challenging and as part of this process the CCG will be developing a structured patient and public engagement and communication programme to support the planning and development of a new model

To further develop our Public and Patient Involvement processes we will be working closely with Healthwatch, who will provide advice and guidance as to the most effective engagement methods. Having reached the stage of being able to clearly articulate our vision for the future we will shortly embark on a broad and deep public engagement programme, which will not just consult on our Five Year Plan, but as part of an enduring commitment to consult and engage on how services are delivered across Wiltshire. The guiding principle for internal and external stakeholder participation in the our Five Year Plan can be put simply thus:

"We must put citizen and patient voice absolutely at the heart of every decision we take in purchasing, commissioning and providing services."

Tim Kelsey
National Director of Patients and Information, NHS England

By following this ethos throughout the evolution of our Five Year Plan, the result should be wellbeing and health services which are understood, supported and embraced by the majority of our staff, public and patients. Taking them on the journey with us, step by step, making it their new model of healthcare for Wiltshire as much as it is that of the CCG.

Every part of our health and care system is shaped and improved by involving those who use and care about our services. Everyone contributes their distinctive perspective, especially those who face the greatest health disadvantage and the poorest health outcomes. Progressing from listening and understanding to collaboration and responsiveness, we all benefit from a rich understanding of what is needed and how to co-design and deliver services that meet these needs. People have a voice at different levels throughout our structures, from board level to frontline services, and we are committed to ensuring that all voices are heard.

Building on the significant engagement work to-date, the CCG is now able to move into the next phase of the engagement process. The aim is to enable as wide an audience as possible to understand the financial challenges which lie ahead at both a national and local level and to share their views on the future of health services in Wiltshire. We want to reach as wide an audience as possible, going beyond the regular voluntary sector input that regularly contribute to these discussions. Working in partnership with Wiltshire Council and Wiltshire Healthwatch, the CCG will develop and implement a meaningful and sustainable programme of stakeholder participation.

The engagement events will be designed to capture all feedback, and whilst local commissioners may not necessarily be in a position to put some of these ideas into practice, they will be included to fulfil the need for a complete response. Inclusion may also indicate that an appetite for innovation and new ways of thinking about the future NHS amongst those consulted should not be underestimated.

The programme of engagement on our Five Year Plan will be divided into three phases.

Phase 1

To be held during April 2014

The aim of this phase will be to improve awareness and understanding among internal and external stakeholders of the basic principles of the Five Year Plan.

Phase 2

To be held during May 2014

The aim of this phase will be to further develop awareness and understanding of our Five Year Plan with specific focus on the proposals for the future models of care

Phase 3

To be held between September 2014 until January 2015

This is yet to be developed but will focus on a more formal consultation process on the Five Year Plan, and the key strands which emerged from the previous phases of intensive participation and information sessions

To achieve these aims we intend to further develop and our engagement activity (including online) which supports Wiltshire CCG to:

- Build a community of interest through membership
- Engages with people on their chosen topic of interest
- Tracks relationships and member activity
- Records and analyses feedback from online, social media and other engagement activity
- Let's people know the outcomes
- Creates a continuous dialogue that is available 24/7.

As a result this will:

- Build community interest and involvement
- Improve accessibility and increases participation by broadening our reach and the variety of channels in which the public can engage through
- Ensure we're talking about what really matters to the public
- Share outcomes; enabling continuous and flowing dialogue
- Capability to track, connect, record and analyses activity, behaviours, demographic etc. which will feed into reporting.

The benefits to the CCG mean that we will:

- Access quick and cost effective community dialogue and feedback
- Ability to target different groups and individuals for specific topics, e.g. Long term conditions
- Reach new audiences through multiple platforms and new media
- Gather a body of evidence on patient and public activity and participation
- Use tools to analyse and report on online AND traditional engagement, e.g. focus groups, meetings, correspondence - to save time and money
- Promote and easily publish outcomes - what is heard and what is done as a result.

We will continue to fully involve our health and care community, and our patients/carers, as we move forward on our transformational journey over the next five years together.

Section 3: Ensuring Safe and Effective Services

NHS Wiltshire CCG sees the improvement of quality and patient safety to be at the heart of what we do. We will ensure that the services we commission provide high quality safe care to patients and their families and carers. We will do this by focusing our monitoring of quality on patient experience and patient outcomes, as well as an overview of the CQC's current essential standards and its emerging new methodologies in 2014/15.

We use the three fold approach within the international definition of quality, namely:

- Safety
- Effectiveness
- Patient experience

Within this definition we continue to review quality metrics and strengthen the links with performance and contracting so that we can be sure the impact on and experience of patients is heard and that improvements are made as a result. In the last year a number of seminal reports and recommendations have influenced the quality and safety agenda in England, most notably the Winterbourne View Concordat, the report of Robert Francis QC, the Government's response

"Patients first and foremost" and the Berwick Review of patient safety: "A promise to learn – a commitment to act: Improving the safety of Patients in England".

We have embraced the recommendations of the Francis Report, from its development of a complaints management process, the identification and monitoring of trends and early warning signs of changes. We will strengthen the quality and safety reporting to include further trend information and benchmarking data. Although the implementation of the recommendations from these reports is still "work in progress" we are committed to commissioning safe, high quality services whether in acute or community settings. We hold providers to account for the quality and safety of services with structured reports across providers using a range of indicators and metrics from a number of sources, which are regularly reported to our Governing Body.
As the nature and focus of services changes, particularly through the developments arising from this Strategic Plan, quality and safety will continue to be at the heart of services and service developments.

Patient safety

We will continue to drive improvements in patient safety through projects such as Harm Free Care and the National safety thermometer with a particular focus on local priorities and clinical risks. We will strengthen the reporting of harm across Wiltshire, and encourage a greater reporting of clinical incidents and investigating incidents. We will participate in the National Patient Safety Learning "Collaborative". We note here our intention to implement the recommendations of the over-arching report by the National Advisory Group on the Safety of Patients in England, A Promise to Learn – a Commitment to Act, Improving the Safety of Patients in England. This approach supports that Patients and their carers should be involved at all levels of healthcare organisations

We will also continue to use all available tools and systems available to us to ensure patient safety is as robustly and proactively monitored as possible, including the **National Reporting and Learning System (NRLS)** and the **National Patient Safety Alerting System (NPSAS)**. We will ensure that mechanisms are in place for all alerts issued by the NPSAS to be received by Central Southern Commissioning Support Unit and brought to our attention as necessary. NHS England publishes monthly data on their website showing Provider's compliance with the alerts and we will use this information as part of the Clinical Quality Review Meetings with contracted Providers.

We are currently strengthening the reporting of harm across Wiltshire and supporting providers to comply with NPSA guidance with regard to reporting and investigating incidents. In 2014-15 Incidents which occur during NHS funded care in primary care organisations that do not have access to STEIS (e.g. individual care homes) will be supported to complete a RCA, and we will report on to STEIS on the provider's behalf. RCA training will be offered to support this process. By linking with the care home forum, learning can be shared collaboratively. (Everyone Counts http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf)

Management of Serious Incidents

Serious incidents requiring investigation in healthcare are rare, but when they do occur we have systematic measures in place to respond to them. These measures are designed to protect our patients and ensure that robust investigations are carried out, which result in organisational learning from serious incidents to minimise the risk of the incident happening again.
Our policy has been written with reference to the national guidance framework issued by NHS England in April 2013 and the revised Never Events Policy Framework.
Providers are required to notify us of a Serious Incident Requiring Investigation ("SIRI") within two working days. The provider consults with us as the commissioner to decide on an initial grading of the incident in terms of seriousness and severity, and the incident is reported on the STEIS and National Reporting and Learning Systems. We can decide whether or not to be represented on the provider's investigation panel and it can also require the provider to implement an external review. We oversee and hold providers accountable for their reporting and investigations processes, including adhering to timescales, deadlines and the implementation of actions and learning, holding monthly Serious Incident Committee meetings to review the root cause analysis reports (RCA's) submitted by the providers. The Committee review the reports received from the providers and ensure during the review of the reports that the root cause of the incident has been identified and that lessons have been learned and actions are in place to mitigate the risk of the incident occurring again. We give feedback to the provider requesting further information if necessary and support closure when assurance received and continue to monitor closed incidents to ensure that the actions are completed.

Harm Free Care

Harm free care is a national programme that helps NHS teams in their aim to eliminate harm in patients from four common conditions:

- Pressure ulcers
- Falls
- Urinary tract infections in patients with a catheter
- New venous thromboembolism (VTE).

These conditions affect over 200,000 people each year in England alone, leading to avoidable suffering and additional treatment for patients and a cost to the NHS of more than £400M. The programme supports the NHS to eliminate these four harms through one plan within and across organisations. It helps us in Wiltshire to consider complications from the patient's perspective, with the aim of every patient being 'harm free' as they move through the system. This moves away from the more usual approach of addressing these patient safety issues in silos.

Through using the **NHS Safety Thermometer** during their working day teams can measure harm and the proportion of patients that are 'harm free', for example at shift handover or during ward rounds.

The Safety Thermometer provides a 'temperature check' at any particular point in time and can be used alongside other measures of harm to measure progress.

Both SFT and GWHFT were below both the national and regional average in December 2013 for Harm Free Care. SFT were below the national and regional averages for four months, however, since November 2013 there has been improvement.

Compassion in Practice

The values and behaviours of Compassion in Practice are: Care, Compassion, Competence, Communication, Courage and Commitment; the 6Cs. As well as the clear focus on the 6Cs, Compassion in Practice sets out six areas of action to concentrate our effort and create impact for our patients and the people we support. These six areas of action will be delivered together as one programme to achieve the values and behaviours of the 6Cs.

As a CCG we will ensure that local provider plans are delivering against the six action areas of the Compassion in Practice implementation plans by monitoring action plan and specifically:

- Increase % of Care makers at providers and commissioner
- Identify metrics and indicators reflecting compassion and effective care
- Develop the Safety Thermometer in mental health, learning disabilities, children and young people

We have obtained national funding to support the Help to Live at Home Providers in Wiltshire to deliver compassionate care to those individuals in receipt of care at home. These individuals in receipt of care will range from frail elderly to those people requiring complex care packages and palliative care. This particular front line work force are often excluded from specialist training and support and we would wish to offer the four main providers an opportunity to share case scenarios, experience in practice through a structured set of training events. We would also aim to use nationally available training material which could be used and modified if necessary to meet the specific cohort needs.

Safeguarding

We have governance arrangements in lace to ensure that the organisations from which we commission services provide a safe system that safeguards children and adults at risk of abuse or neglect. This includes:

- Safeguarding children and safeguarding adults schedule in all provider contracts
- Oversight of safeguarding children and adult arrangements in commissioned services
- Robust systems to follow up concerns about care and protection of children and adults
- Plans to train their staff in recognising and reporting safeguarding issues
- A clear line of accountability for safeguarding, properly reflected in the CCG governance arrangements

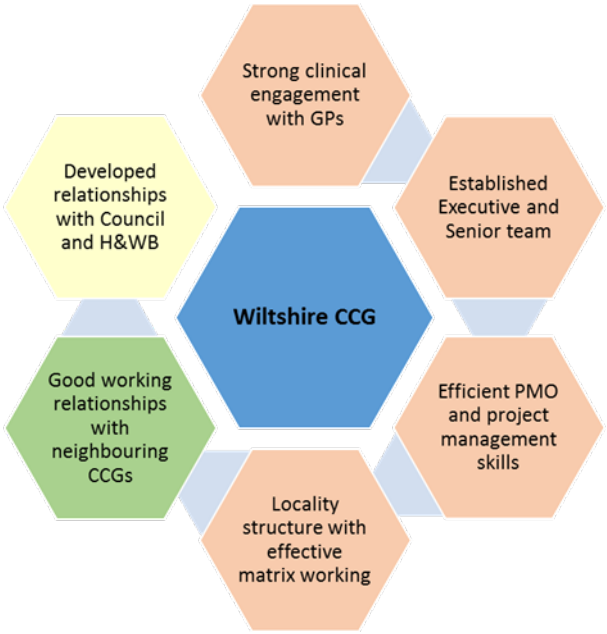
- Effective arrangements in place for information sharing
- Commissioning the services of a designated doctor and employing nurses for safeguarding children, a named GP and a safeguarding adults lead, and a lead for the Mental Capacity Act (supported by the relevant policies and training)
- Arrangements for supporting the Child Death Overview process, including sudden unexpected death in childhood
- Work underway between the CCG and Wiltshire Council to ensure that the we can fulfil our specific responsibilities for looked after children

We are represented at a senior level and by designated safeguarding children professionals on the Local Safeguarding Children Board (LSCB) and are fully engaged and represented at a senior level on local Safeguarding Adults Board (SAB), working in partnership with local authorities to fulfil their safeguarding responsibilities. We also have robust processes in place to learn lessons from cases where children or adults die or are seriously harmed and abuse or neglect is suspected. This includes contributing fully to Serious Case Reviews (SCRs) which are commissioned by LSCBs/SABs and also, where appropriate, conducting individual management reviews.
We have designated clinical experts, embedded in the clinical decision making of the organisation, with the authority to influence local thinking and practice. They provide clinical advice, to other health professionals, in complex cases or where there is dispute between practitioners.
We employ a Mental Capacity Act (MCA) lead with responsibility for supporting commissioners and providers by ensuring clarity about MCA requirements in safeguarding adults' schedules within all provider contracts**.**

Section 4: How Will We Do This?

Our plans require us to implement significant changes to the way care is delivered to the people in Wiltshire, including an increased focus upon prevention and personal responsibility. We have established structures and positive relationships that support the delivery of these ambitions:

- Internally we have a strong team, clinically led and supported by an effective management structure centrally and at locality level through matrix working
- There are good relationships with co-commissioners to help develop impactful plans with neighbouring CCGs together acting in concert to be an effective agent when dealing with strong providers
- We have a strong track record of co-operation and partnership working with non NHS bodies, particularly Wiltshire Council, with whom the CCG has worked collaboratively with for some time



We are also able to call upon the resources of the Central Southern Commissioning Support Unit to complement our own expertise with service, analytical or other support as may be required. We will augment this capability with additional planning and delivery capacity and capability, as required. Overall this provides a well-rounded and complete package of relationships, skills and capabilities

We have set ourselves an ambitious vision, which we are committed to delivering over the next five years, including laying the foundations for change during 2014-16.

Health and Social Care services in Wiltshire should support and sustain independent healthy living

Our future care model places a new emphasis on personal responsibility, with people supported to be more in control of their lives and increasingly confident to draw on their personal resources and those of their families and communities (as seen in our Plan on a Page at the beginning of this document). This, together with a health and care system wrapped around the individual, accessed and co-ordinated through Extended Primary Care Teams, will require true transformational change, with significant impact on our providers. It will also require a managed shift in the balance of resources, from acute-based treatment to community-based prevention.

The key components of the new care model are:

1. Increased investment and support into developing and maintaining personal responsibility. With a focus on education, prevention and support to develop and maintain healthy and independent living
2. Enhanced and integrated community care with a broader range of services provided in a local setting
3. Increased productivity and effectiveness of acute care with a reduced reliance on bed based solutions

We are confident that our priorities for the first two years will both address the financial challenge within the system and lay the foundations for the delivery of our strategic vision for five years' time. Our development of operational priorities for the next two years is primarily focused around the six workstreams set out below. These workstreams were identified using a structured and robust prioritisation process that involved:

- Identifying scope for improvements through a range of benchmarking and analysis to ascertain clinical areas where the scope for improvement was judged to be the greatest
- Assessment of evidence to confirm that there was supporting clinical evidence and best practice experience that supported the deliverability of these improvement areas
- Clinical engagement with GPs to review, assess and sift priorities to establish a workable shortlist using an open and objective scoring process
- Review of the final shortlist of workstreams to confirm their "fit" against local and national priorities

In addition to these, we will work with our partners across the Wiltshire health and care system to develop and implement a more detailed programme of work designed to pilot, test, evaluate and roll-out our ambitious agenda to increase the focus upon wellbeing as well as traditional healthcare. This will build upon and be integrated with the our 6 key operating plan workstreams articulated below, with the aim of using the next two years as an opportunity to test and evaluate our new care model, which will put Wiltshire in a position to develop a detailed sequencing plan for years 3, 4 and 5.

The prioritised workstreams are discussed below, showing the rationale for the proposed change and the outcomes expected.

1. Urgent Care – including Rapid Response & Early Supported Discharge
2. Community Teams
3. Primary Care
4. End of Life
5. Planned Care
6. Long Term Condition Management

We also intend to use these first two years to develop and begin the implementation of the new care model.

The CCG priorities are aligned with those within the Better Care Fund which are based on four priority outcomes which are set in our Joint Health and Wellbeing Strategy:

- I will be supported to live healthily
- I will be listened to and involved
- I will be supported to live independently
- I will be kept safe from avoidable harm

Our plans around utilising the Better Care Fund and Community Transformation have fully integrated, 24/7 services at their heart and are consistent with our CCG priorities focusing on enhanced primary care across Wiltshire with improved services wrapped around general practice (social, community and mental health services), with a particular focus upon care for the frail and vulnerable elderly at high risk of unplanned hospital admission.

(Full details of the Better Care Fund can be found in our BCF submission).

The key components required to deliver our system vision are set out in the table below with interventions aligned to the Operating Plan workstreams.

Key Component	Intervention / System Change	Operating Plan Workstream
Increased investment and support into developing and maintaining personal responsibility. Focus on education, prevention and support to develop and maintain healthy and independent living	Health promotion and education programmes re lifestyle choices	Public Health
	Understand and tackle the wider determinants of health	Public Health
	Increased use of technology - virtual support chat rooms, advice & guidance and signposting / awareness raising and well as assistive technology	Planned Care, Urgent Care and LTC
	Patient engagement and education in clinical pathways - knowing where and when to access help and supporting early discharge from care with self-management guidance / advice reducing the need for follow-up appointments	Planned Care, Urgent Care and LTC
	Increased / proactive use of Individualised Care Plans, including 'Ceiling of Treatment' and 'what to do if I get worse' LTC plans	EoL and LTC
	Shared Decision Making to ensure that patients are informed, empowered and have clearly managed expectations	Urgent Care, Planned Care and LTCs
	Parenting skills and support	Children's
	Build local assets to encourage healthier active lifestyles	New Care Model

Key Component	Intervention / System Change	Operating Plan Workstream
Enhanced and integrated community care with a broader range of services provided in a local setting	Core and consistent Primary Care provision - including reduced unwarranted variability re. referrals and prescribing	Planned Care, Primary Care
	Expanded Primary Care Services (7 day working)	Urgent Care, Primary Care
	Extended skills in community teams to manage increased acuity of patients e.g. IV antibiotics	Primary Care, Community Teams
	Proactive identification and management in Primary Care to ensure condition remains stable and can be managed without need for admission	LTC, Primary Care
	Increased use of technology - for monitor and review (Telecare and Telehealth)	LTC
	Increased use of technology - for advice and guidance to support clinician to clinician and clinician to patient interaction, reducing the reliance on face to face care	Planned Care
	Moving secondary care services into community setting including outpatients and diagnostics	Planned Care
Increased productivity and effectiveness of acute care with a reduced reliance on Bed Based Solutions	Invest in alternative community based solutions - Enhanced 'out of hospital' care (beds and/or services) with Rapid Response, SPA and Care Co-ordination to support admission avoidance and earlier discharge	Community Services, Rapid Response and Early Discharge
	Improved efficiency and appropriate use of planned care beds - enhanced recovery programme, move care from inpatients to day case and day case to outpatient procedure	Planned Care
	Improved efficiency and appropriate use of beds - increased ambulatory management of emergency conditions - ACS conditions, plus use of Rapid Assessment and Diagnostic services with emphasis on early discharge out of acute setting	Urgent Care
	Reducing variability in care - Intervention Rates and Length of Stay	Planned Care

Operating Plan Workstream Summaries

Urgent Care (Including Rapid Response and Early Supported Discharge)

Pressures on Urgent Care have increased substantially across the NHS and this has become an area of national interest. During January to March 2013, waiting times were the highest since 2004, with 90 Trusts (40%) reported breaching the waiting times target, an increase in 50% over the previous quarter and the proportion of patients waiting longer than four hours before being admitted from A&E to hospital rose to almost 7 per cent, also the highest level since 2004.

Wiltshire CCG's Emergency admissions and A&E attendances have remained fairly stable over the past 16 months, yet the attendances at the WICs, MIUs and in Primary Care are reported to have increased. This would appear to represent an overall growth in the demand for urgent care in Wiltshire. SFT sees more Wiltshire patients arrive at A&E; however RUH sees the most Emergency admissions for Wiltshire patients. RUH also admits the most patients via A&E, has the highest number of zero day Length of Stay Emergency admissions and as a result, has the highest conversion rate from A&E attendance to admission of the three providers.

The pressures on Urgent Care have increased substantially across the NHS and there is a strong national focus with funding identified to support NHS A&E departments through this winter. This is essentially a short-term fix in terms of funding and the system needs to address the rising urgent care attendances and associated emergency admissions.

Year one of this workstream seeks to review the Urgent Care system across Wiltshire – A&E, Walk in Clinics and Minor Injury Units in order to define an optimum service pathway for patients. The aim being to ensure patients see the most appropriate clinician in the most appropriate setting, taking into account national examples and evaluation of the local pilots that are taking place in and around Wiltshire.

The structured approach will:

- Review urgent care demand and supply of existing service provision including MIU, WIC and A&E
- Evaluate all existing urgent care pilots and evidence from examples from across the country around improving urgent care system
- Identify preferred options and consult
- Commission redesigned services and streamline components of provision (Primary Care, A&E, Walk in Clinics, Minor Injury Units, 111 and Out of Hours)

Rapid Response

We will build on the 24/7 service that acts as the principle contact point for a range of care providers that is currently being run as a pilot. It co-ordinates the care for a patient in crisis

arranging packages of care and support to prevent avoidable admission to the acute hospital, and/or support a timely discharge.

Our Simple Point of Access (SPA) works in partnership with all key stakeholders, enhancing existing pathways and developing new ways of learning through the expansion of the service. The frequency and intensity of support is determined through need and their support plan. At present the service provides support for up to 72 Hours with a one hour response time from referral. The 6 month pilot launched on the 4th of November was designed to support winter pressure by preventing inappropriate admissions to hospitals, and supporting early discharges. In the early stages of the pilot the service averaged circa 8 cases per week, now just three months later the average is now double that and rising, with referrals coming from all areas of health, emergency and social care

Although the pilot was a soft launch during its first three months it has received 152 referrals, and of those in just over 85% of cases the patient was either discharged early due to the support provided by the SPA or avoided and unnecessary trip to hospital and possible admission.
The first three months has seen the service provide a rapid intervention with average response times of less than an hour from the point of referral, in addition we have introduced community nursing as an important element of the rapid response, established three bases across Wilshire from which the RR teams can operate, though logistics made available both simple support aids and Telecare response technology which can be provided immediately, and seen the service evolve to fill the gap between EDD and a package of care starting.

We expect to see the SPA continue to grow and develop during the remainder of the pilot, working closer with key stakeholders such as AWP etc. to ensure that the service does become a fully supportive service

Linked to this workstream is the investment made through the **Better Care Fund** to support the development of Simple Point of Access and Telecare support to improve access to services whilst retaining the delivery of care within primary care as far as possible.

Early Supported Discharge

There is evidence across the system of problems with patients not being discharged in a timely manner (Appropriate Place of Care Audit) - the study showed that the main problem was not patients being admitted inappropriately, rather the main issue was patients staying too long.
In support of this study work carried our prior to the Transfer of Care Pilots (in Reach) being established show in one sample of ten patients the average difference between the

Estimated Discharge date and the Actual Date was 56 days i.e. 5.6 days per patient longer in hospital.

The rationale for the project is therefore to work within the acute hospitals supporting the timely discharge of patients and reducing the bed days.
The benefits expected to be delivered through this project are that real focus will be brought to bear to deliver the philosophy of Right Team, Right Time.

The project consists principally of three dedicated teams, one per acute hospital with the teams working across each hospital, liaising with the various departments including A&E to facilitate the discharge of patients either on or before their Expected Discharge Date (EDD). Each team will become the single point of discharge whose principle objective will be to:

- Improved Patient experience
- Increase focus on EDD resulting in reduced bed days
- Work to reduce system delays
- Reduce readmission risk by ensuring that appropriate community support is in place

Linked to this workstream is the investment made through the Better Care Fund to support weekend capacity across the whole health system as well as actions through social care to speed up appropriate discharge from acute care.

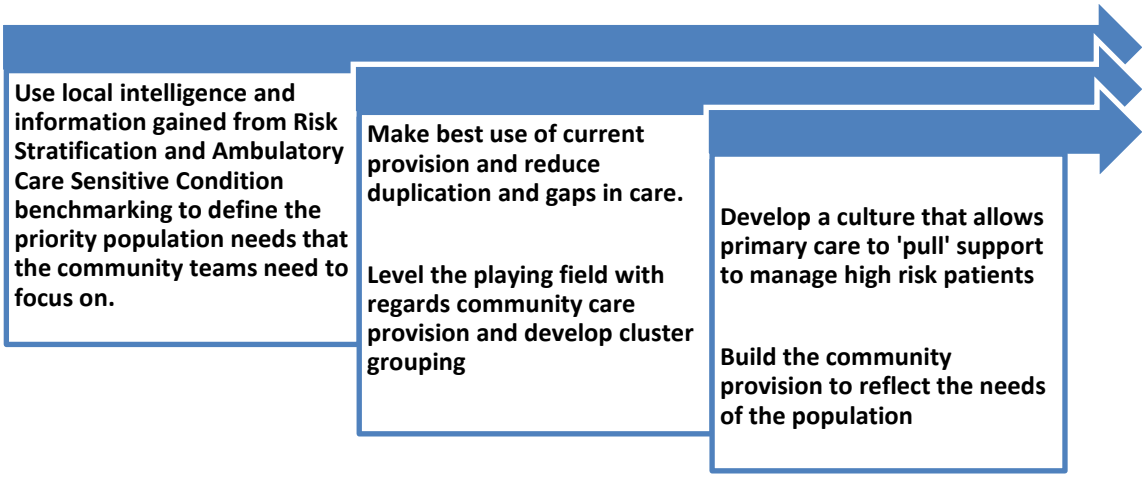
Community Teams

Our goal is to ensure that people are better supported in the community so they can age more healthily and put less demand on hospital services. To support the delivery of this vision locally based services which ensure that healthcare meets the needs of the population with integrated services will be commissioned around the three Groups. In addition to reviewing and addressing capacity constraints within the community teams the Wiltshire Better Care Fund plan identified that there are challenges in the system, including disconnection between the referrers and the community teams and the potential in the current system for duplication and gaps for some care groups.

The Community Transformation team are working on the development of new service specifications; however these new services will not be in place and delivering benefits for 2014/15. The first year of this workstream will build on the existing Risk Stratification work and the deployment of the Care Co-ordinators, making best use of the existing teams and services to provide a co-ordinated and integrated service that supports primary care to manage their priority patients and bridge the gap between the current situation and the implementation of the new community service model.
Care Coordinators are attached to a cluster of practices and work closely with Primary, Community, Social Secondary Care and voluntary agencies to help manage patients, including those that go outside the Primary Care setting, and help facilitate their return to it. Over the next two years the service will develop to include a mental health worker and aligned social care worker to create a dynamic multidisciplinary team that links with the Community Care Teams. The Care Coordinators

support those patients that are identified as at risk using practice based data and the Devon risk tool.

The Community Care Teams (CCTs) are being rolled out across Wiltshire to deliver services to patients in or very near their homes. They will replace existing Neighbourhood teams and serve clusters of populations linked to the Care Coordinators. Each CCT will comprise a Clinical Lead, team leader, Nurses, HCA, OTs, Physiotherapists, Social Worker, Voluntary Sector representative and an administrator. They will receive additional training and support to enable staff to deal with an increased level of acuity and complexity in the community. This should enable patients to be treated in their home as opposed to an acute setting to reduce hospital admissions and lengths of stay.



Linked to this workstream is the investment that the CCG has made through the **Better Care Fund** to support the development of step up and step down care plus increased reablement capacity, designed to shift the balance of care and reduce demand in the acute sector.

Primary Care

Our vision for primary care centres around building an effective and sustainable model of care, wrapped around general practice in localities of about 20,000. To deliver this model, we will work alongside NHS England in implementing the Primary Care Strategy, and in particular in developing general practice at the heart of wider systems of more integrated out-of-hospital care to facilitate:

- improved care for vulnerable older people;
- seven day working;
- reduced avoidable admissions;
- continuity of care and
- improved overall quality and productivity of services.

Plans are in place within the CCG for developing this model and delivering services at locality level, building up primary, community and social care services. GP Practices have also participated in a

number of schemes under the winter pressures funding in providing additional primary care capacity, such as weekend working focussed on providing continuity of care for the vulnerable and frail elderly, and other local initiatives testing new models of care in each of the Groups of NEW,WWYKD and Sarum.

The CCG will support practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by commissioning additional services which practices, individually or collectively (i.e. as a town/cluster/in federation with others) have identified will further support the accountable GP in improving the quality of care for older people. We will also work to ensure individual practices have as much influence as they need over the commissioning of associated community services – e.g. community nursing, district nursing and end of life care.

Linked to this workstream is the investment made through the **Better Care Fund** to support the "accountable GP" model and the development of integrated "wrap-around" services in the community.

End of Life Care Pathway

Research shows that the majority of people would prefer to die at home but in reality this is not the case. With an aging population End of Life is one of the key priorities for commissioners. Wiltshire CCG is in the process of developing an End of Life Strategy to meet the needs of people requiring End of Life Care in Wiltshire.

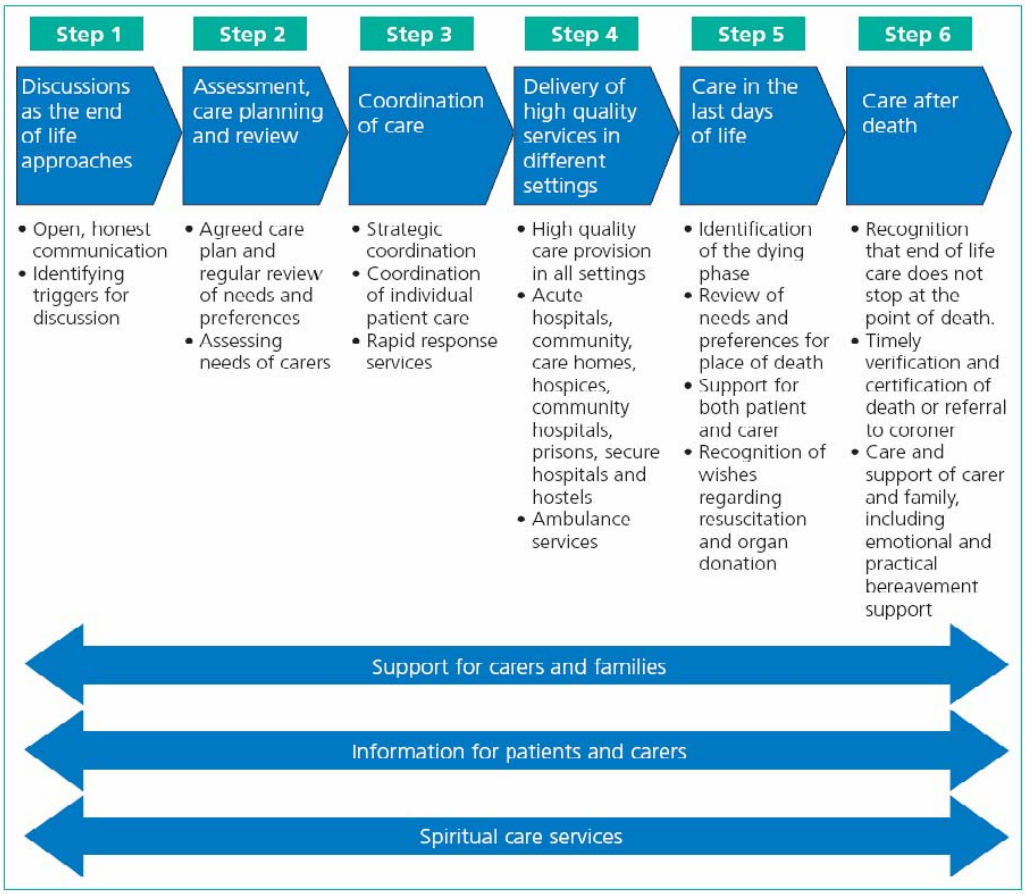
The Wiltshire Joint Strategic Needs Assessment identified that, on average over the last three years, 4145 Wiltshire residents have died each year (1936 men and 2209 women). The majority of deaths occur in adults over the age of 65, following a period of chronic illness. These figures contrast with national data on people's expressed preferences about place of death, with 64% of people preferring to die at home, 21% in a hospice and only 4% in hospital.

The vision for end of life care is that the patient and their family/carer receive the care and support that meets their identified needs and preferences through the delivery of high quality, timely, effective individualised services. Ensuring respect and dignity is preserved both during and after the patient's life.

Our strategy aims to:

- Support people to be cared for and die in their preferred place of care.
- Improve patient and family experience.
- Ensure all providers are skilled and competent in delivering high quality EOL care.
- Encourage and support people to start thinking and planning for end of life at the earliest opportunity and whilst they are well able to contribute to decisions affecting their future care.
- Reduce inappropriate transfers of care from all settings.

Once agreed, implement of our strategy will be implemented over the next two years and will be consistent with the key elements contained in the National **End of Life Care Strategy**, as shown below. Further detail can be found in the latest version of our End of Life strategy:



Planned Care

This project proposes the systematic development of a new approach to planned care using Muscular Skeletal conditions (including T&O, Rheumatology & Pain specialities) and Ophthalmology to develop prototype pathways in year one.
Supporting the development of evidence based, high value care pathways that:

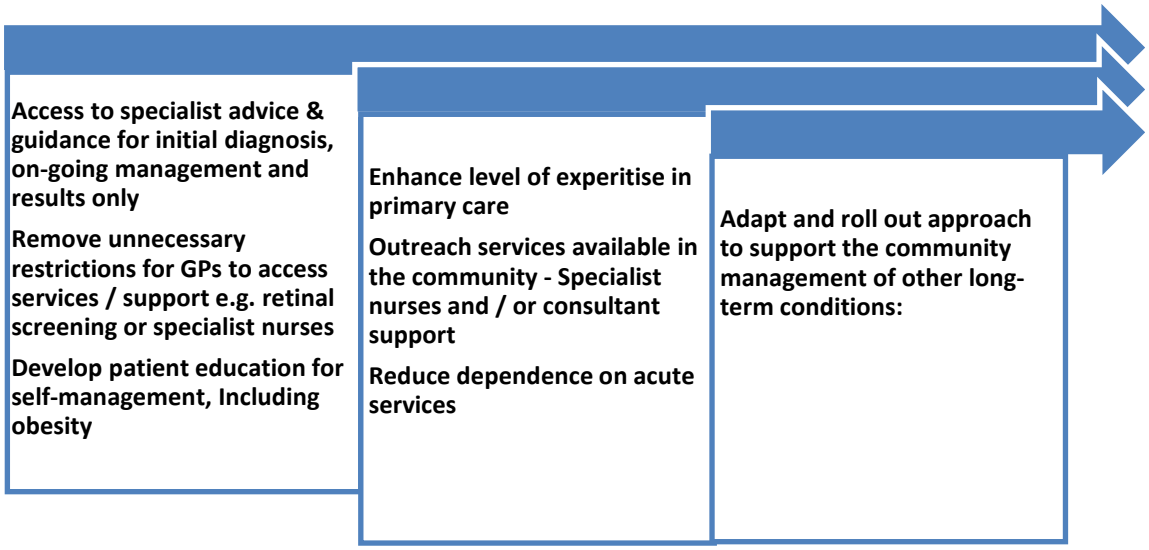
- Promote self-management
- Reduce unnecessary secondary care use
- Maximises what can be managed in primary care through the commissioning of 'tiered' services, moving away from the only opportunity to access consultant support being via the traditional face to face consultant contact to commissioning different service levels e.g. results only clinics, telephone advice and guidance to increase ability to manage patients within primary care.

- Remove restrictions to GPs being able to access some diagnostics services directly and agree pre-clinic work ups that ensure when a patient sees a specialist for the first time they are able to get maximum benefit from that appointment.
- Reduce unwarranted variation in intervention rates (Dr Foster indicates a higher than expected elective admission rate for Musculoskeletal conditions within Wiltshire, and the last Programme Budgeting report (2011/12) confirmed that Wiltshire spent more per head on MSK than their peers).
- Support patients to review the treatment options available to them and make an informed decision which best suits their needs and expectations (Shared Decision Making)
- Provide community based alternatives where better value and better care can be demonstrated

Additionally this workstream will address productivity in planned care, particularly around New: Follow-Up ratios in Outpatients and apply effective contract management to ensure best value commissioning and the application of coding rules and national case mix benchmarks

Long Term Conditions

The development of improved care pathways for long term conditions is a key priority within the CCG's Strategic Plan. The programme focuses on the systematic development of a primary care led approach to managing long term conditions, with diabetes as the prototype in year one, followed by Congested Heart Failure, Cardiovascular Disease and / or COPD in year two. The new approach will place primary care in partnership with the patient at the centre then define and develop the required access to supporting services. There will also be an initial focus upon pathway redesign to improve the quality and choice of service available for adult obesity.



Children and Young People

Our prioritised work streams are cross cutting, delivering benefits to the Children, Working Age Adults and Elderly population groups for both physical and mental health conditions. Additionally we have a joint programme of work with Wiltshire Council, which is clearly aligned to the delivery of our strategic vision but specific to Children and Young People, aiming to improve outcomes; ensuring good safeguarding practice; reduce, prevent and mitigate the effects of child poverty; and enable resilient individuals, families and communities.
Based on our needs assessment and what children and young people tell us, it is suggested that improvement in the life chances and outcomes for children and young people can be achieved by multi-agency working across these three schemes:

1. Prevention and early intervention
2. Raising aspirations and narrowing the gaps
3. Promoting healthy lifestyles

Within the prevention and early intervention scheme we will:

- Maximise the potential of our Children's Centres and Health Visiting Service to provide support to vulnerable families, including antenatal support, to ensure all children in Wiltshire receive the best possible start in life
- Introduce a developmental checks for all children at 2 ½ years
- Intervene and at earlier stage to support parents (and young people) and enable families to manage their problems before they become too big and complex and require social care intervention
- Continue to focus on domestic abuse and 'hidden harm' as two if the key issues that need to be addressed in order to keep children safe within their families, and ensuring there are effective links between children's and adult's services
- Ensure that everyone who works with children and young people has access to information about available family and parenting support services
- Continue to develop and embed the Common Assessment Framework as the process for early identification of need amongst children and families

Within the raising aspirations and narrowing the gap scheme we will:

- Continue with the improvement in Early Years to ensure that achievement for all increases and that children vulnerable to underachievement continue to make good progress
- Accelerate the improvements at Key Stage 2 and Key Stage 4 to meet the goal of attaining in the top quartile of national figures
- Continue the work on narrowing the gap between those vulnerable to underachievement and the rest. This is especially so for pupils with free school meals; looked after children; some black, Asian and minority ethnic groups; some service children; those with Special Educational Needs; pregnant teenagers and teenage parents

- Support young people to move into employment and training. This includes developing mentors through the flexible support fund for young people who are aged 18 – 24, who meet relevant criteria
- Raise aspirations by enabling and increasing young people's participation. We are currently developing a Participation and Involvement Strategy for Wiltshire
- Address the key elements of the Green Paper on Special Educational Needs and Disability on integrating assessments and care plans across education, health and social care in line with feedback from Wiltshire Parents Carers Council
- Provide early support to vulnerable young people, including young people with disabilities, to support a successful transition to adult life

Within the promoting healthy lifestyles scheme we will:

- Ensure there is greater multi-agency working at a strategic level on child accident prevention, focussing on accidents in the home and at school
- Continue to promote healthier lifestyles through schools, young people, support services and Children's Centres. This includes the roll-out of multi-agency Health and Wellbeing drop-ins in every secondary school in Wiltshire
- Support anti-bullying initiatives and counselling services to ensure children and young people have appropriate adults to talk to if they are experiencing difficulties
- Provide clearer information on both local and national support available for children and young people with emotional and mental health difficulties
- Invest in early support for vulnerable young people including those engaging in risky behaviours, particularly through alcohol consumption, and those at risk of teenage pregnancy
- Promote the Wiltshire Healthy Schools programme as a key local driver for improving the health of young people and implementing evidence based practice as part of a joined up approach in the school setting

Further detail, including how we will monitor our progress can be found in the Wiltshire Children and Young People's Trust plan

Developing and beginning the implementation of the new care model

Building Community Capacity

This involves making best use of the resources & skills within the voluntary sector and local communities to make a positive, co-ordinated contribution to the care of people in their own homes. The projects will be based around Local Area Teams. This will contribute to self-management and people taking more responsibility for themselves, their families and their communities.

Appropriate Place of Care

In 2013 Wilshire CCG commissioned a Patient Flow Audit. The project was focussed on the appropriateness of the level of care for the patient in the acute hospital, community hospital or STARR (reablement) facility. The reviews revealed that at each facility, a proportion of patients were not at the appropriate place of care i.e. their needs could have been met in an alternative level of care, or in a few cases the patient could have been discharged home with follow up from their GP. Building on these findings the Appropriate Place of Care workstream will look across the health and social care system to:

- undertake an analysis of bed demand, capacity, quality and price;
- review of published bed management best practice;
- undertake consultation & engagement with customers, carers & care home providers;
- identify opportunities for financial savings through joint procurement & rationalisation of contracts & contract management; look at the impact of transferring investment to non-bed based services; review and revision of bed related processes;
- seek an outcome based payment by results approach;
- identify and quantify whole system impact;
- look at utilisation of suitable ICT systems for procurement & paying for services;
- develop contract management and brokerage;
- create a joint commissioning strategy for beds only;
- develop a service specification & choice policy review & revision.

Linked to the development and implementation of our new care model is investment made through the Better Care Fund into three schemes:

1. Support communities to be more resilient – funding for carers and home support with the council and voluntary sector to develop community level support capacity
2. Data sharing and joint assessments – developing shared records to improve patient experience, quality and service efficiency
3. Service user feedback and involvement – support to Healthwatch to develop an effective 'patient voice' and develop effective public involvement in services and decision making

Recognising the scale of change required in the system we plan to phase the work over next five years. As much of this work requires innovative change it is therefore, as yet, untested to manage this risk our implementation plan will be subject to regular review and refinement both internally and with our wider stakeholders.

We have shared our expected impact of the new care model with our key providers, which are summarised below with the activity and finance information captured in the Finance plan for 14/15 and 15/16.

Expected Impact of the Model – Urgent Care:

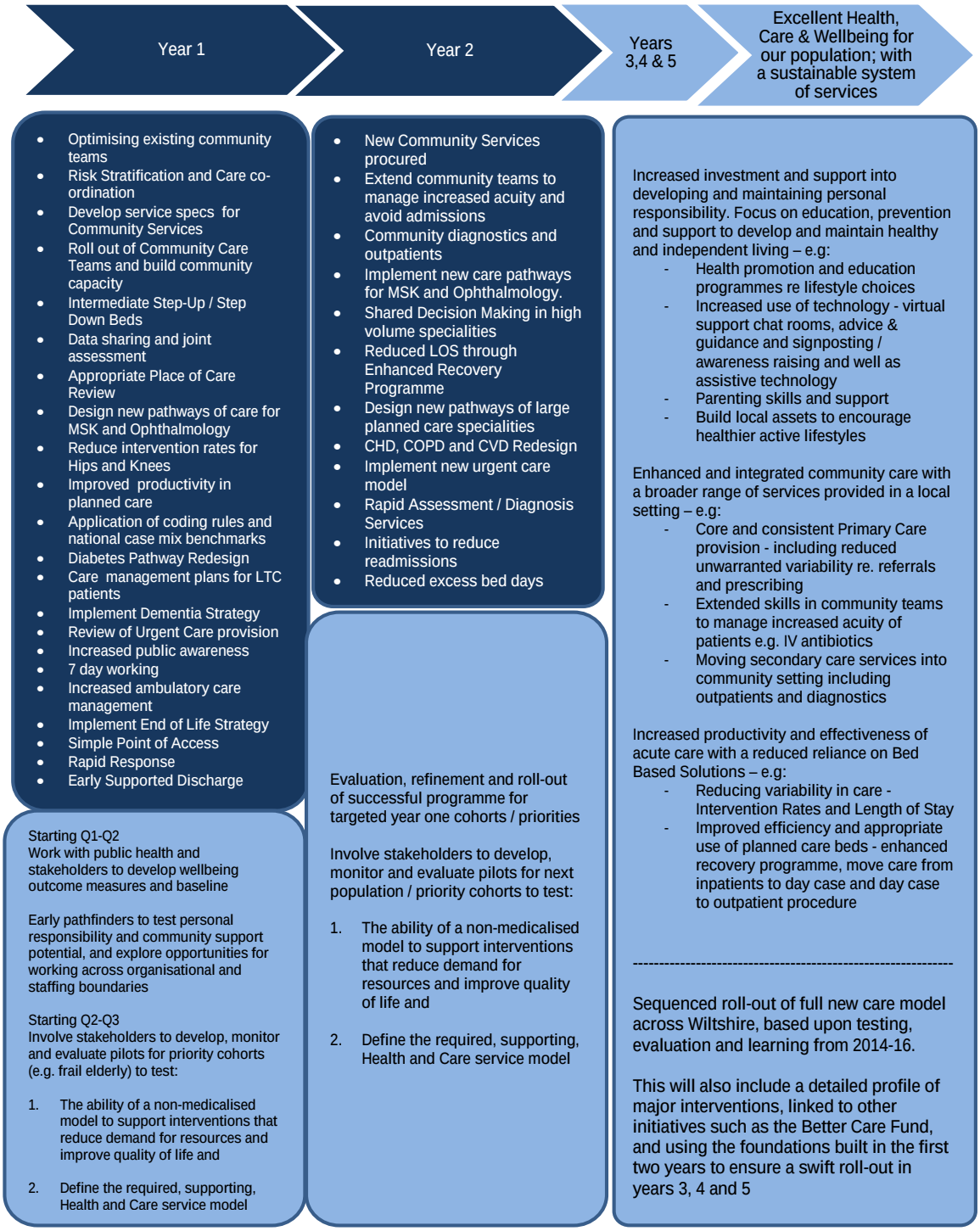
Reduction
• Hospital emergency admissions • Length of bed based stays • Hospital A&E attendances
Increase
• Personal support networks – public health, voluntary , third sector and social care • Enhanced / extended hours Primary Care • 7 day working – health and social care • Community Nursing / Rehab Teams • Ambulatory Care – Rapid diagnostics, assessment and treatment • Community 'step up' and 'step down' beds • Technology supported advice and guidance (public and professional applications) • Community and direct access Mental health services

Expected Impact of the Model – Elective Care:

Reduction
• Surgical intervention rates • New and Follow-Up outpatient attendances • Length of bed based stay for elective procedures
Increase
• Use of technology to support Medical outpatients being undertaken in a community setting • Personal support networks – public health, voluntary , third sector and social care • Enhanced Primary Care • 7 day working – health and social care • Community Nursing / Rehab Teams • Ambulatory Care – Rapid diagnostics, assessment and treatment • Community 'step up' and 'step down' beds

High Level Phasing Plan

In order to realise our vision for the future of health and care across Wiltshire in five years' time, it is vital that the building blocks are laid through our work over the next 24 months. The high-level plan below sets out how the next two years will be used to lay the groundwork for the required transformational changes, including engagement, pilots, evaluation and the working up of further detailed plans:



Strategic Enablers

There are a series of strategic enablers that will be pivotal in ensuring the strategic vision for Wiltshire is realised by 2019, and much of the preceding period will be about laying the foundations and ensuring these enablers are fit for purpose. These include:

- **Market innovation**– conducting a rigorous analysis of our local provider markets, particularly for non-acute and smaller providers, to inform areas that need extra support and stimulus to build capacity and capability.
- **Capacity and demand modelling** – including robust assessment of provider investments/disinvestments
- **Contract change and innovation** - new contractual forms such as alliance contracting, prime contracting, and commissioning for outcomes present important potential levers for change
- **Key provider workforce design implications** – ensuring the right workforce for the future is critical to developing more community-based health and care services, and this will involve close working with our co-commissioners and our Local Education and Training Board.
- **IT and estates** – a sufficiently strategic assessment will need to be made of the required infrastructure for supporting the delivery of models that use shared records, the ability of more tele-health and other innovations for patients
- **Clinical Workforce Development** – working with our partners to ensure the clinical workforce is able to deliver the future vision, with appropriate training, education and recruitment programmes

Developing our Workforce and Organisation

Our people, with their combination of talent, skills and commitment are our greatest asset. Our Governing Body recognise that a happy, motivated, well supported and appropriately skilled workforce is key to the achievement of our objectives.

Communicating with our people is clearly vital, and we use a system of weekly team meetings in each Directorate to cascade information and brief on developments. Naturally we also utilise an internal staff brief and our web-site, and we hold regular whole CCG staff briefs hosted by our Chair and Chief Officer at least 3 times a year.

Throughout our first year of operation, we have worked hard to establish an output based performance management regime in order to allow the effective management and development of our business. This comprises three elements:

- A monthly integrated Performance Report
- A robust system for the identification and management of key risks
- A staff appraisal system built upon cascaded objectives, so that every employee can identify the contribution their work makes to the achievement of our strategic goals.

As well as providing the mechanism for annual performance appraisals to highlight areas of strong performance and identify development needs, our system includes six monthly mid-period appraisal face to face discussions. The system also includes the requirements for each employee (in conjunction with their line manager) to identify annual objectives, which must be linked to those of their line manager. Hence, by ensuring that the strategic objectives of the CCG are clearly articulated within the annual objectives of our senior management, we can ensure that our efforts are targeted at achieving them at every level. The suite of appraisal documentation also provides a Personal Development Plan, which support employees and their managers in identifying training and development needs arising from both their post and those which support future career development.

Throughout the last year we have successfully taken up leadership training opportunities presented by the NHS Leadership Academy as part of our talent management regime. We have also provided some bespoke professional training to our Commissioners, in order to better equip them for their roles, and we host regular lunchtime learning events to deliver specific updates on an opportunity basis. We have developed a comprehensive Induction Training process, which includes both briefings and a written guide, as well as completing a full Training Needs Analysis, which has supported the delivery to all staff of a full suite of statutory and mandatory training.
Our aim, of course, is to ensure our workforce are fully able to deliver better patient outcomes. To support this, we are developing a radically refreshed Organisational Development plan in order to better formalise our approach, and which will most likely focus upon:

- Clinical Leadership
- Internal & External Communications and Engagement
- Workforce & Team Development
- Performance Management
- Talent Management & Succession Planning
- Programme & Project Management
- Values and Behaviours

The CCG senior management team has regular quarterly meetings with the NHS England Area Team in order to provide Assurance against the CCG Assurance framework. Accordingly, we have developed our own Integrated Performance Report to be fully coherent with the areas which we are assessed against. We achieve transparency on our performance in this regard since the Integrated Performance Report is produced monthly, and is always discussed at our Governing Body meeting, which are held in public, as well as being posted on our web-site.

Research and Innovation

Wiltshire CCG is committed to using innovation and research as much as possible in order to drive the system wide transformation we aspire to. In this way we believe we will be able to be at the cutting edge of the most transformational and innovative ideas, and be able to use evidence to drive best practice into the outcomes for our people, delivered by an effective and efficient system approach. Our Community Transformation programme, with a clear focus on the delivery of

community services integrated across health and social care, drawing upon best practice from pathfinder areas such as Torbay is a clear example of this. Our intended procurement strategy for this service is designed to maximise innovation and creative solutions. Furthermore, our aspiration to introduce a single health and social care record aims to exploit technology to the full across a large ruralised community.

By virtue of our geography, the CCG is fortunate to be represented on two Academic Health Science Networks (West of England and Wessex). This enables us to share information across a very wide network of NHS, higher education institutions and industry partners to focus on improving the identification, adoption and spread of innovative health care across our County. Accordingly we are able to draw on the collective experience in linking clinical service and research networks to improve clinical outcomes and utilise the network to translate discoveries into clinical care rapidly. The priorities set by both West of England and Wessex are broadly coherent with our own aspirations, and include improving the health and wellbeing of the entire population; implementing radical new ways to face the challenge of an ageing population (and the consequent rise in Dementia); and managing long term conditions.

The Governing Body of the CCG already manage performance in an empirical manner by virtue of a data rich monthly integrated performance report. This along with our robust business risk management regime and a system of cascaded objectives within our appraisal system linked to our organisational priorities forms our integrated performance management system. This enables the Governing Body to monitor our progress against our plans, and forecast future issues, so facilitating decisions and corrective action in a timely manner.

Our Commissioning Support Unit provides regular benchmarking and Horizon Scanning support to identify areas where we may be an outlier in terms of activity, finance and quality. Accordingly we are able to compare ourselves with others nationally depending on the measure and data source. This information comes from a variety of sources including Dr Foster and a host of other benchmarking tools and takes various forms, either through specific requests from individual CCG members or as part of the regular Horizon Scanning work.

We are also investing in continuous education and training for our staff; by professionally up skilling our workforce we seek to create an environment where new ideas and concepts can flourish. We have also made a strong commitment to leadership training and development of our people to give them the vision and confidence to be leaders of change.

Section 5: Governance

Our strategic vision and plans have been developed in close collaboration with partners and stakeholders across Wiltshire, including working proactively with our co-commissioning colleagues in neighbouring CCGs. We have also worked collaboratively with our local Area Team and Providers to ensure we develop a shared vision of the future in Wiltshire, and agree on a set of tangible system interventions to realise this vision.
We have used a wide range of analytical and data tools to inform them. This includes:

- CCG Outcomes Tool
- Levels of Ambition Atlas
- Commissioning for Value Atlas & Packs
- Local Authority Outcome Information Packs
- Right Care website and case studies
- Any Town CCG guidance (particularly the guidance for "rural CCGs")

The CCG has a well-established and functioning programme and project management methodology in place to ensure the delivery of its objectives via our dedicated Programme Management Office (PMO) team. This extends to the publication of protocols and standard operating procedures within a blueprint for programme management, which guides our people, as well as a rigorous step by step guide for the compilation of business cases. Naturally, our project approach encompasses all the performance metric, risk management and benefit realisation structure in common use. We will track progress against clearly defined deliverables in each workstream area, enabling us to bring together all elements of the required transformational change in one place, thus facilitating an intelligent understanding of what is actually happening across Wiltshire. The PMO will also provide support to develop the skills and knowledge in the local Groups so that the right data is being collected and the team are able to convert it into meaningful information to manage current contracts and inform future commissioning. Reporting on outcomes will continue through to the governing body of the CCG and from there through to the Local Area Team of NHS England. Part of our well established governance structure for the oversight of projects is a regular Programme Governance Group (PGG), which meets monthly. This group comprises the entire Executive of the CCG, and drives the delivery agenda for the range of projects being implemented, as well as providing process control. The main purpose of the PGG is:

- Monitoring delivery of existing projects
- Unblocking barriers to project delivery with commitment of resources as required.
- Making recommendations about cessation of projects in order that resources can be diverted and reprioritised.
- Signing off of new projects with approval of Milestones, Quality Impact including Equality, Deliverables including Financial
- Process control of new projects so that resources are allocated appropriately to enable delivery of objectives.
- Sharing learning and good practice from across the organisation.

In addition, the Executive Management Team (which meets weekly) always has a status report and review of the progress against our current projects. Governance extends through the organisation, with regular reports on progress being provided at each Locality Executive meeting across our three Groups, and the CCG's own Clinical Executive is regularly apprised on both progress against project objectives and new initiatives under consideration. Naturally, the CCG Governing Body is fully engaged in oversight of delivery, which is achieved via our Monthly Integrated Performance Report. This enables the Governing Body to keep fully abreast of the organisation's progress in delivery of the strategy. Our Integrated Performance Report is published monthly on the CCG web-site.
In the critical area of integrated working, then naturally the Wiltshire Health and Wellbeing Board has the lead.

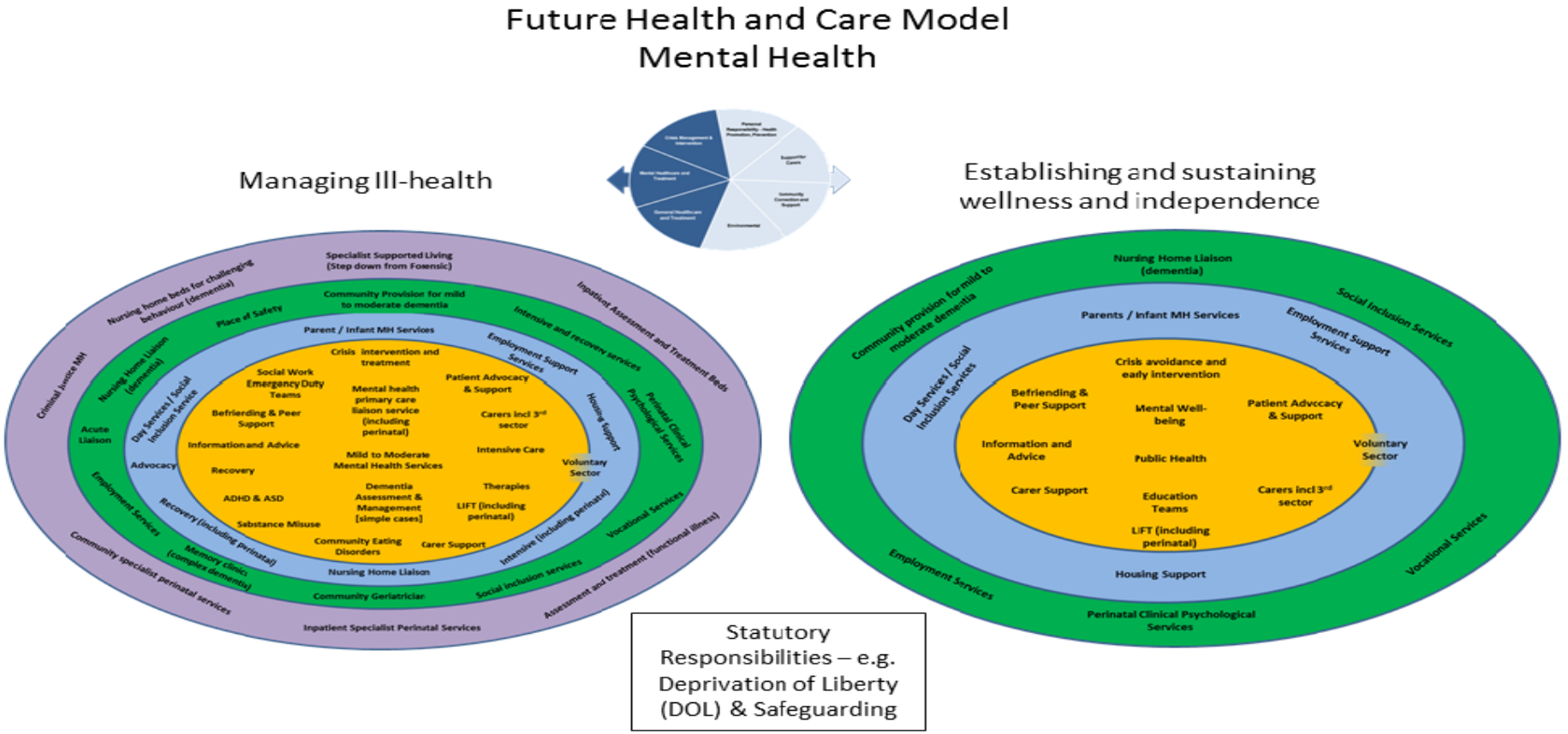
The **Health and Wellbeing Board** will oversee the delivery of the Wiltshire Better Care Plan and has endorsed this plan, since delivery will be a key element in the implementation of the Wiltshire Health and Wellbeing Strategy, and ultimately our aspiration is for a better integrated health and social care system. Health providers all sit on our Health and Wellbeing Board as well as other partners such as Wiltshire Council, Wiltshire Police, NHS England and HealthWatch. Supporting the Health and Wellbeing Board we have a well-established **Joint Commissioning Board** for Adults' Services and many of the currently emerging service changes have been developed and overseen by this Board, which comprises key Executives from the CCG and the Lead Councillor & Officers of Wiltshire Council.

Indeed for delivery of the Better Care Plan, which is naturally coherent with this plan, we have agreed new joint arrangements for project management and oversight, including the establishment of a bespoke Better Care Fund Programme Governance Group as a subcommittee of the JCB. This group will have an entirely similar remit to the CCG's established PGG, and bring the same level of scrutiny and control to all those projects within the Better Care Fund. Many of these are coherent and inter-dependent on projects arising from this plan, and accordingly we are committed to working with our Council Partners to work smartly and collaboratively to deliver the best possible effect without duplication of staff effort. Each project will require a team of people working together to deliver on objectives. Each of these teams will be joint between health and social care. Teams will be led by either commissioners from the Council or the CCG (work streams have been allocated on the basis of which organisation is likely to have the most professional/clinical expertise in the area in question) and will engage with existing service providers (e.g. acute hospital trusts, social care, Help to Live at Home providers, out-of-hours services etc) to ensure that new arrangements can be co-produced to get the best results.

Since both the CCG and the Council have well-established programme and project management methodologies in place, programme office support arrangements will come from whichever organisation has been allocated the lead role. Naturally, our arrangements in this area include robust performance management processes, and the Health and Wellbeing Board will be kept fully apprised of progress against our joint objectives, via a report from the Joint Commissioning Board.

The future model for the delivery of integrated health and social care described earlier in Section 2 presents a potential opportunity in the future for the development of new governance arrangements which might be considered in due course as the system design within this plan matures.

Appendix 1: Future Health & Care Model – Mental Health

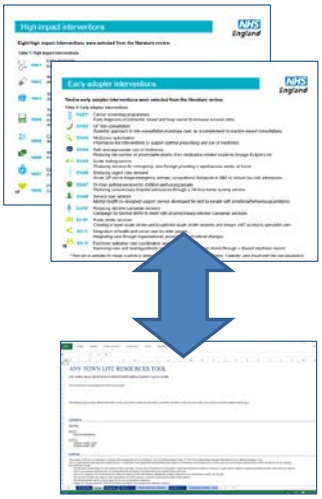


Appendix 2: Application of "Anytown" CCG Modelling Tool

Potential five year financial impact of "Anytown" Interventions

NHS Wiltshire Clinical Commissioning Group

- NHS England has made the Anytown tool available to CCGs to understand the impact of suggested interventions on individual CCGs
- The results of the analysis are indicative and based on a range of assumptions, to provide an indication of the scale and relative impact of individual interventions and a mix of different types of interventions
- The model does not provide a definitive projection of the financial impact of interventions
- The financial impacts shown are based on:
  a) A five year horizon – this is the cumulative impact over five years, with different start points for the different interventions
  b) The net financial impact – the impact after costs
  c) Impacts including overlap – there is overlap between interventions, which is deducted on a "bottom line" basis
- The following slides show the impact of:
  a) High Impact Interventions (HII) only
  b) A mix of HII and Early Adopter Interventions
- The analysis does not include the potential impact of additional military personnel being relocated into the area. This is consistent with the CCGs planning approach which does not include the impact of this demographic change



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Potential five year net financial impact of "Anytown" High Impact Interventions

NHS Wiltshire Clinical Commissioning Group

	Impact (£m)	*Intervention*
HII01	1.7	Early diagnosis *Early detection and diagnosis to improve survival rates and lower overall treatment costs.*
HII02	9.0	Reducing variability within primary care *Reducing unwanted variation in primary care referring and prescribing by optimising medicines use and referring.*
HII03	1.9	Self-management: Patient-carer communities *Self-management programme for those suffering with a long-term condition.*
HII04	1.9	Telehealth/Telecare *Health apps, telehealth and telecare equipment which help people to manage their own long-term conditions in conjunction with their clinicians, introduced to empower people whilst at the same time ensure that their own actions remain embedded in the care they receive from the NHS.*
HII05	6.7	Case management and coordinated care *Multi-disciplinary case management for the frail elderly and those suffering with a long-term condition.*
HII06	1.5	Mental Health – Rapid Assessment Interface and Discharge (RAID) *Psychiatric liaison services that provide mental health care to people being treated for physical health conditions.*
HII07	0.9	Dementia pathway *Fully integrated network model to improve health outcomes and achieve efficiencies in dementia care.*
HII08	0.7	Palliative care *Community based, consultant-led palliative care service.*
	-2.7	*Overlap*
	21.6	*Total net impact*

Note – this shows the net financial impact of Anytown High Impact Interventions over five years.

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Potential five year net financial impact of a mix of "Anytown" High Impact Interventions and Early Adopter Interventions

NHS Wiltshire Clinical Commissioning Group

		Impact (£m)	*Intervention*
	HII02	9.0	Reducing variability within primary care *Reducing unwanted variation in primary care referring and prescribing by optimising medicines use and referring.*
	HII05	6.7	Case management and coordinated care *Multi-disciplinary case management for the frail elderly and those suffering with a long-term condition.*
	EAI05	4.2	Acute visiting service *Reducing demand for emergency care through providing a rapid-access doctor at home.*
	EAI02	2.6	GP tele-consultation *Systemic approach to tele-consultation in primary care, as a complement to practice-based consultations.*
	HII04	1.9	Telehealth/Telecare *Health apps, telehealth and telecare equipment which help people to manage their own long-term conditions in conjunction with their clinicians, introduced to empower people whilst at the same time ensure that their own actions remain embedded in the care they receive from the NHS.*
	EAI06	1.2	Reducing urgent care demand *Acute GP unit to triage emergency arrivals; occupational therapists in A&E to reduce low-risk admissions.*
	EAI08	0.8	Service user network *Mental health co-designed support service developed for and by people with emotional/behavioural problems.*
	EA11	0.6	Integration of health and social care for older people *Integrating care through organisational, procedural and cultural changes.*
		-0.5	*Overlap*
		26.5	*Total net impact*

Note – this shows the net financial impact of a mix of Anytown High Impact Interventions (HII) and Early Adopter Interventions (EII) over five years.

References

Document	Content
Joint Strategic Assessment (JSA) http://www.intelligencenetwork.org.uk/joint-strategic-assessment/	A joint assessment of population needs, produced for different audiences, including local community area information
Joint Health and Wellbeing Strategy (JHWS) http://www.wiltshire.gov.uk/healthandsocialcare/jointhealthandwellbeingstrategy.htm	Setting out the priority outcomes and actions for the year ahead
Wiltshire Council Business Plan http://www.wiltshire.gov.uk/council/howthecouncilworks/plansstrategiespolicies.htm	The Plan sets out priorities for the next four years, as follows: • Protect those who are most vulnerable • Boost the local economy • Bring communities together to enable and support them to do more for themselves
Joint submission for Local Vision: Systems Leadership programme	This document elaborates on our intention to improve urgent care, through the story of Gwen Wiltshire, a persona developed to illustrate the current and future system to reduce inappropriate hospital admissions
Community Campuses in Wiltshire http://www.wiltshire.gov.uk/communityandliving/communitycampuses.htm	A series of documents describing the Council's proposals for innovative community campuses across the County. Campuses will help deliver services which are value for money, tailored to local need and influenced by local people and partners. They are a key opportunity for health and social care integration at a community-level.
Help to Live at Home Service: an outcomes approach to social care http://ipc.brookes.ac.uk/publications/index.php?absid=691	This paper by Professor John Bolton of the Institute of Public Care, describes Wiltshire Council's approach to developing its Help to Live at Home Service for older people. The approach has focussed on the outcomes older people wish to gain from social care and involved an overhaul of care management and contracting within the Council.

Document	Content
Wiltshire Dementia Strategy 2014-2021 http://cms.wiltshire.gov.uk/ieListDocuments.aspx?CId=141&MId=7216&Ver=4	This is a joint strategy, currently out to consultation. The aim of the strategy is that all people with dementia in Wiltshire are treated as individuals and are able to access the right care and support, at the right time so that they can live well with dementia and can remain independent and living at home for as long as possible within supportive communities
NHS Wiltshire CCG/Wiltshire Council "Better Care Fund" proposal 2014-16	Proposal setting out schemes to improve integrated system working that Wiltshire CCG and Wiltshire Council would implement
Wiltshire End of Life Care Strategy 2014-17	This strategy, developed by NHS CCG and Wiltshire Council, in collaboration with statutory and voluntary partners and local stakeholders, sets out a vision for high quality care across Wiltshire for all adults approaching the end of life