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Slough Borough Council

Taking pride in our communities and town

Date of issue: 9th July 2014

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| **MEETING** | **SLOUGH WELLBEING BOARD**<br>Councillor Rob Anderson, Leader<br>Ruth Bagley, Chief Executive<br>Superintendent Simon Bowden, Thames Valley Police<br>Councillor Sabia Hussain, Health & Wellbeing Commissioner<br>Ramesh Kukar, Slough CVS<br>Lise Llewellyn, Strategic Director of Public Health<br>Dr Jim O'Donnell, Slough Clinical Commissioning Group<br>Colin Pill, Healthwatch Representative<br>Dave Phillips, Royal Berkshire Fire and Rescue Service<br>Matthew Tait, NHS Commissioning Board<br>Jane Wood, Strategic Director of Wellbeing |
| **DATE AND TIME:** | WEDNESDAY, 16TH JULY, 2014 AT 5.00 PM |
| **VENUE:** | SAPPHIRE SUITE 5, THE CENTRE, FARNHAM ROAD, SLOUGH, SL1 4UT |
| **DEMOCRATIC SERVICES OFFICER: (for all enquiries)** | GREG O'BRIEN<br>01753 875013 |

## SUPPLEMENTARY PAPERS

The following Papers have been added to the agenda for the above meeting:-

* Item 5 was not available for publication with the rest of the agenda.

## PART 1

| AGENDA ITEM | REPORT TITLE | PAGE | WARD |
|---|---|---|---|
| 5. | Slough CCG 5 Year Final Plan | 1 - 28 | |

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# SLOUGH BOROUGH COUNCIL

**REPORT TO:** Slough Wellbeing Board

**DATE:** 16th July 2014

**CONTACT OFFICER:** Carrol Crowe, Interim Director of Strategy and Development
**(For all Enquiries)** (01753) 636175

**WARD(S):** All

## PART I

## FOR INFORMATION/FOR COMMENT & CONSIDERATION

## Slough Clinical Commissioning Group 5 year strategic plan

1. **Purpose of Report**

To inform the meeting of the strategic direction for Slough Clinical Commissioning Group over the next 5 years, highlighting the major challenges and pressures in the current system and outlining the local vision for transformation of services to manage these.

2. **Recommendation(s)/Proposed Action**

The Committee is requested to note the report and make any comments.

3. **The Slough Wellbeing Strategy, the JSNA and the Corporate Plan**

The Slough Joint Wellbeing Strategy (SJWS) is the document that details the priorities agreed for Slough with partner organisations. The SWS has been developed using a comprehensive evidence base that includes the Joint Strategic Needs Assessment (JSNA). Both are clearly linked and must be used in conjunction when preparing your report. They have been combined in the Slough Wellbeing Board report template to enable you to provide supporting information highlighting the link between the SWS and JSNA priorities.

3a. **Slough Wellbeing Strategy Priorities –**

**Health** - By 2028, Slough will be healthier, with reduced inequalities, improved wellbeing and opportunities for our residents to live positive, active and independent lives.

*Cross-Cutting themes:*
The strategy is underpinned by what patients tell us matters and the things that they want to do to help themselves and so reflects their civic responsibilities.

Our population is going to grow by 6.45% over the next 5 years and there will be a 13.35% growth in the numbers of people aged over 65, who are more likely to have long term conditions. There will also be an 8.68% growth in the number of children under the age of 16 years.

The strategy will work to address key issues in the JSNA report that;

- Life expectancy for men is lower than the England average: 7.3 years lower for men and 6.6 years lower for women in the most deprived areas of Slough than in the least deprived areas.
- The early death rate from heart disease and stroke has fallen but is worse than the England average. A priority is cardiovascular disease in those aged under 75 especially those with diabetes
- Estimated levels of adult smoking and physical activity are worse than the England average.
- The rate of hip fractures is worse than the England average.

## 4. Other Implications

(a) Financial

Major transformational change is required in response to the challenges of demographic change and financial efficiencies.
Slough has a predicted £37m shortfall by 2020/21 as its part of the national £30bn challenge.

(b) Human Rights and other Legal Implications

There are no human rights or other legal implications arising from this report.

## 5. Supporting Information

none

## 6. Comments of Other Committees / Priority Delivery Groups (PDGs)

none

7. **Conclusion**

This presentation provides an overview of the more detailed 5 year strategic plan document.

8. **Appendix**

Appendix – 5 Year Strategic Plan (June 2014)

9. **Background Papers**

Everyone Counts, Thinking Locally, Working Together.
5 year strategic plan June 2014/15 – 2018/19

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NHS
Slough
Clinical Commissioning Group

# 5 Year Strategic Plan

June 2014

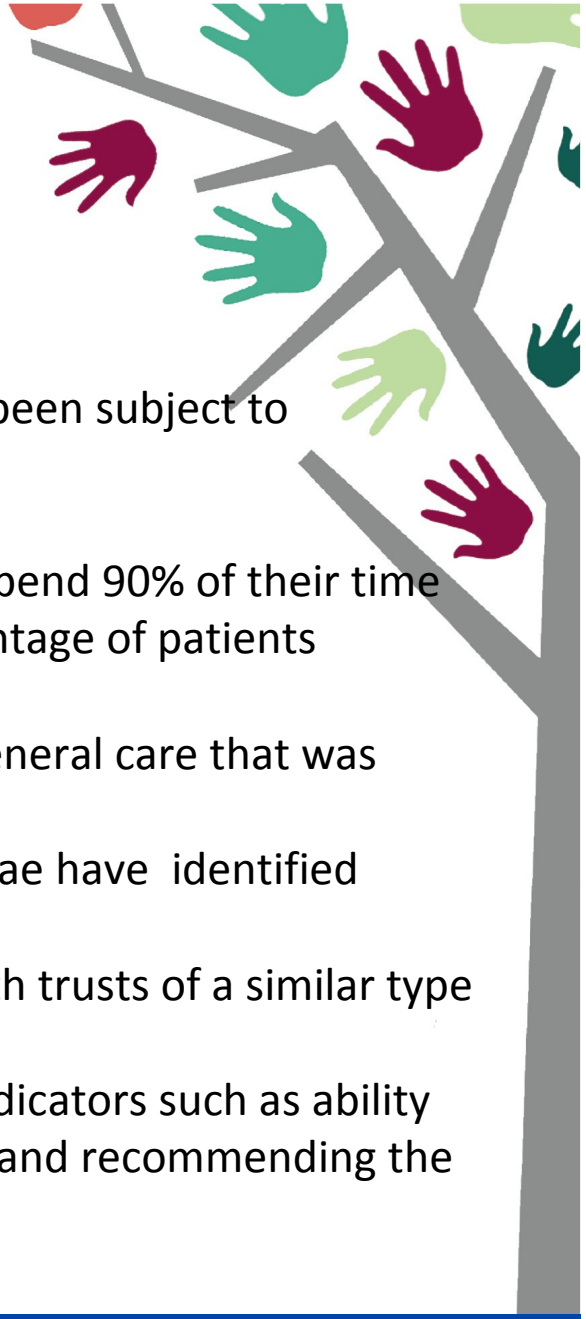
**“Preserving the values that underpin a universal health service, free at the point of use, will mean fundamental changes to how we deliver and use health and care services”**
**NHS Call to Action**

**Meeting the challenges over the next five years in Slough**

# The Health and Wellbeing Strategy sets a clear direction

By 2028, Slough will be healthier, with reduced inequalities, improved wellbeing and opportunities for our residents to live positive, active and independent lives

# There are significant pressures in the current system

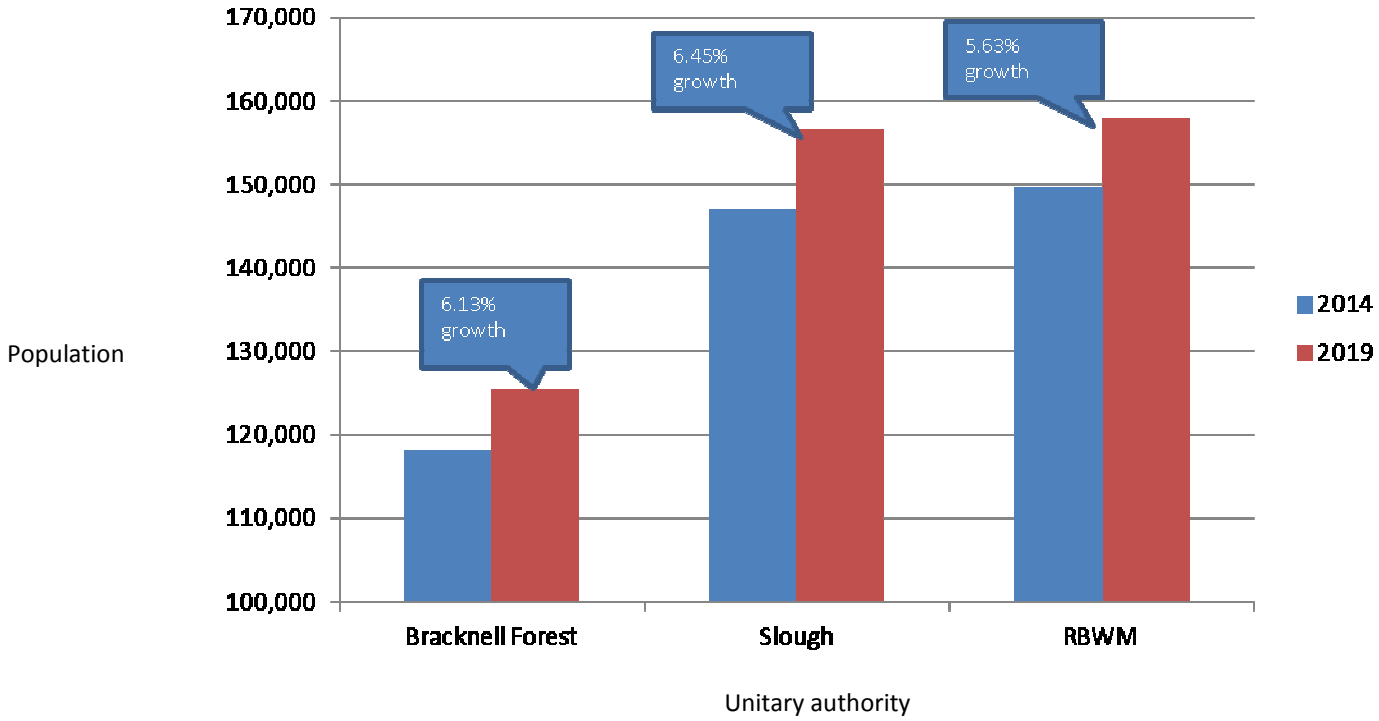


- Heatherwood and Wexham Park Foundation Trust has:
- failed to meet the required essential CQC standards and has been subject to enforcement actions
- consistently failed to meet A&E waiting targets
- failed also to meet the national percentage of patients who spend 90% of their time of stroke unit. It has not met the national target of the percentage of patients admitted to a stroke unit within 4 hours
- poor patient survey results on key indicators, including the general care that was provided and cleanliness of the wards
- Clusters of incidents during Summer 2013 within obs and gynae have identified problems with the culture of the department.
- Staff satisfaction scores in the worst 20% when compared with trusts of a similar type

- Slough CCG, is significantly below England averages on key indicators such as ability to get an appointment, overall experience of the GP surgery and recommending the GP surgery to someone who has moved to the local area

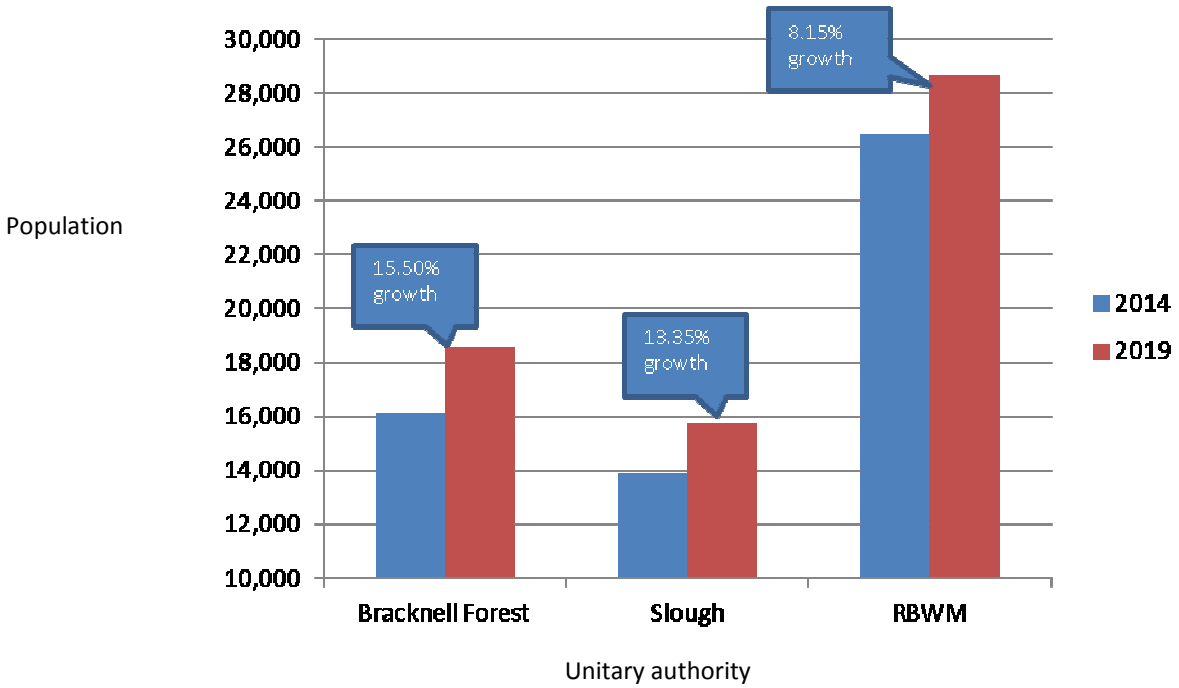
# Looking forward, the population in the area will grow significantly over the next five years

**Figure 1:** Population growth in the 3 East Berkshire unitary authorities, 2014- 2019
**Source:** ONS Population projections 2011



# There will be a significant rise in the number of people aged over 65, who are more likely to have long term conditions

**Figure 2**: Growth in the number of people aged over 65 in the 3 East Berkshire unitary authorities, 2014- 2019
**Source:** ONS Population projections 2011

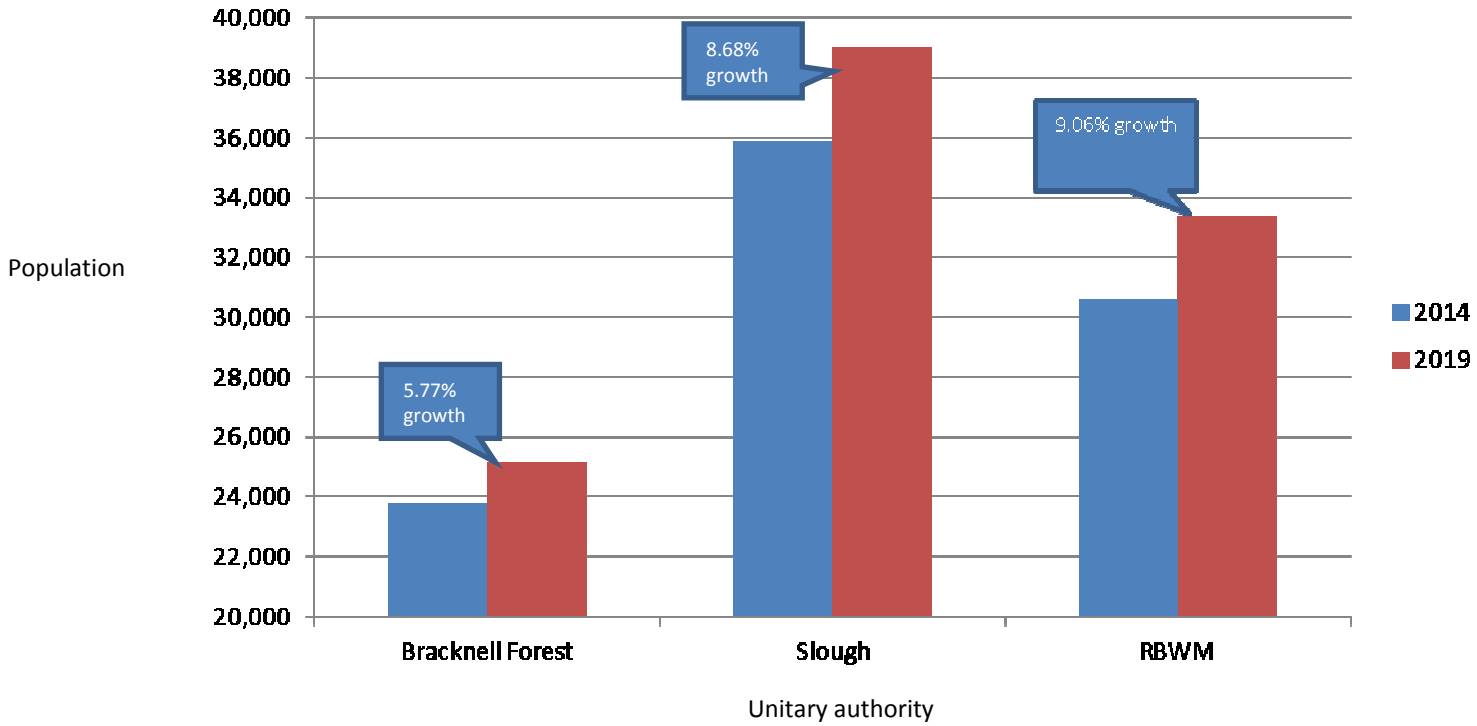



NHS England data suggests that around £7 in £10 of health and social care spending in England is attributed to caring for people with long-term conditions.

Moreover, the number of people with multiple long-term conditions is projected to grow from 1.9 million in 2008 to 2.9 million in 2018. The additional cost to the NHS and social care for the increase in co-morbidities is likely to be £5 billion in 2018 compared to 2011.

# There will also be a significant increase in the number of children

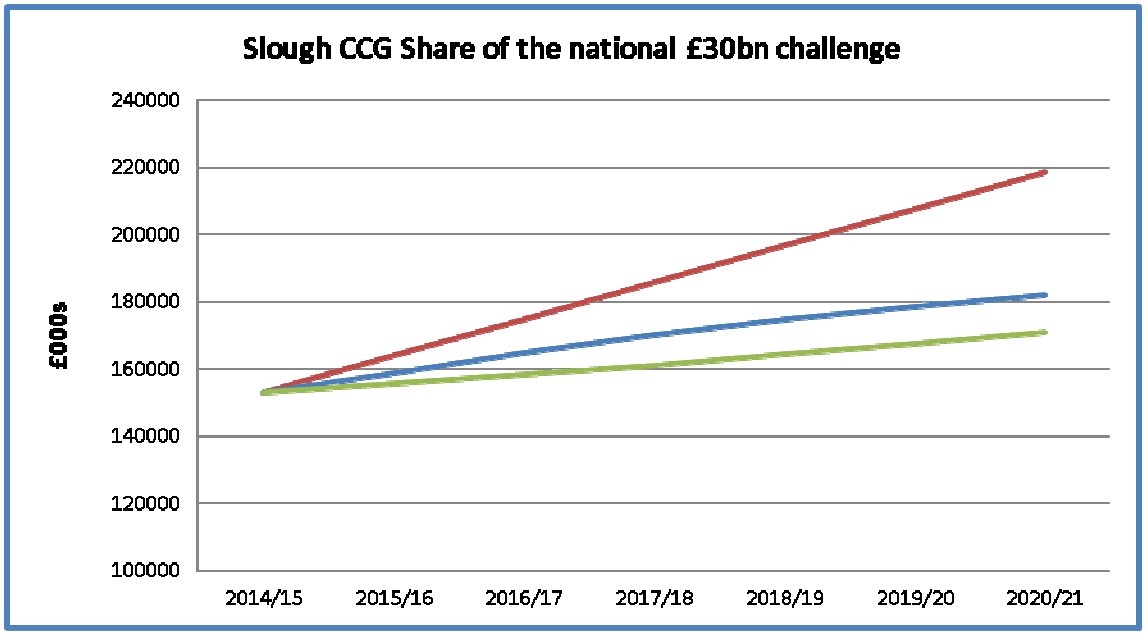
**Figure 3**: Growth in the number of peoples aged under 16 in the 3 East Berkshire unitary authorities, 2014-2019
**Source:** ONS Population projections 2011



# Financial projections suggest an accumulated shortfall of £37m for Slough by 2020/21

- The estimated QIPP shortfall is **£37m,** broken down between:
- **£27.6m** of provider efficiency targets, based on the assumption that providers will meet ongoing 4% efficiency targets, at a time when demand will increase significantly
- with a further **£9m** to be found from additional QIPP

**THIS DOES NOT INCLUDE SOCIAL CARE COSTS**

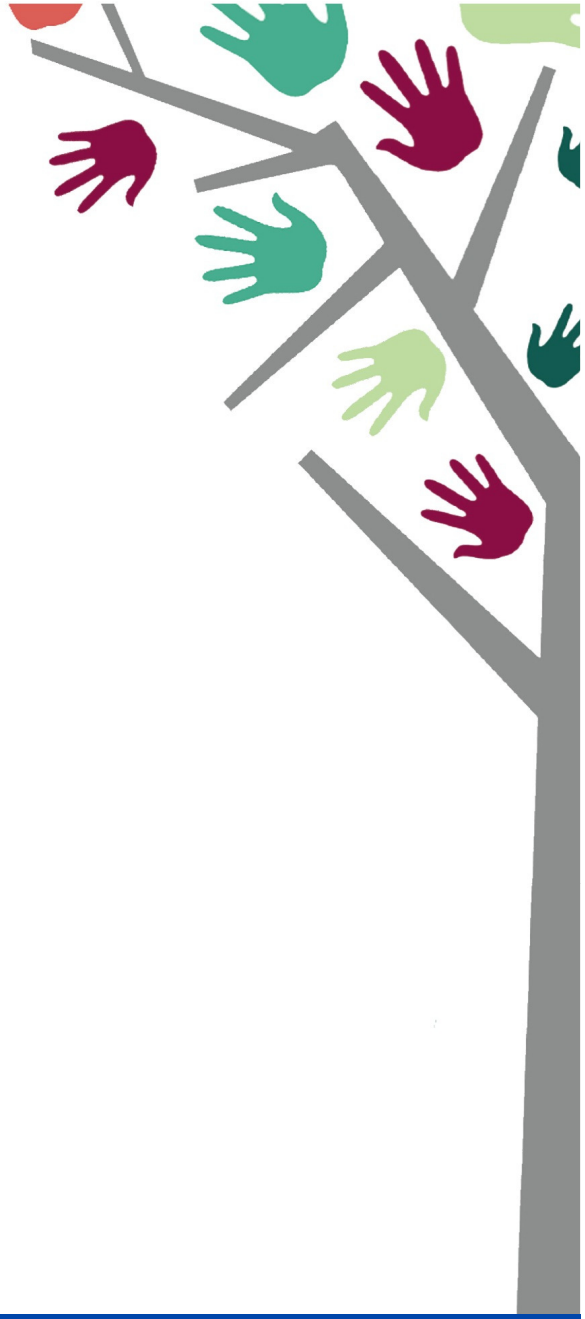


# We believe transformational change is required

The case for major, transformational change is compelling. Our current initiatives do not provide a sufficient response to the challenges of demographic change and financial efficiencies.

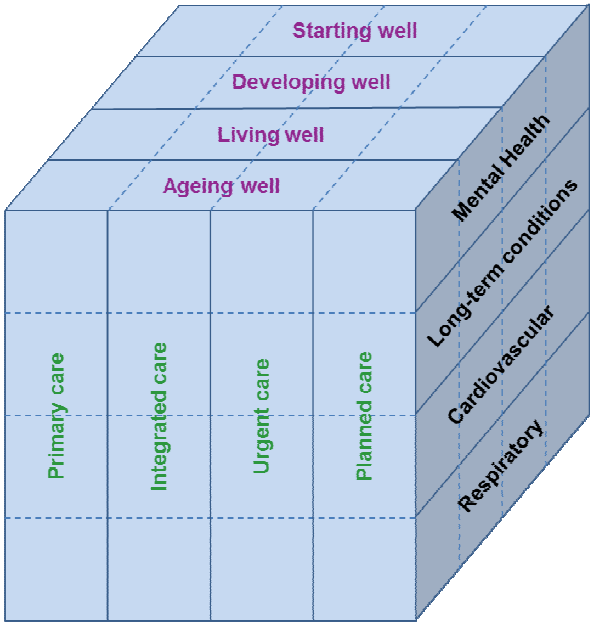
Decisive action needs to be taken in the next two years to re-design the health and care system. A failure to do so would lead to a significant deterioration of performance against the following strategic objectives:

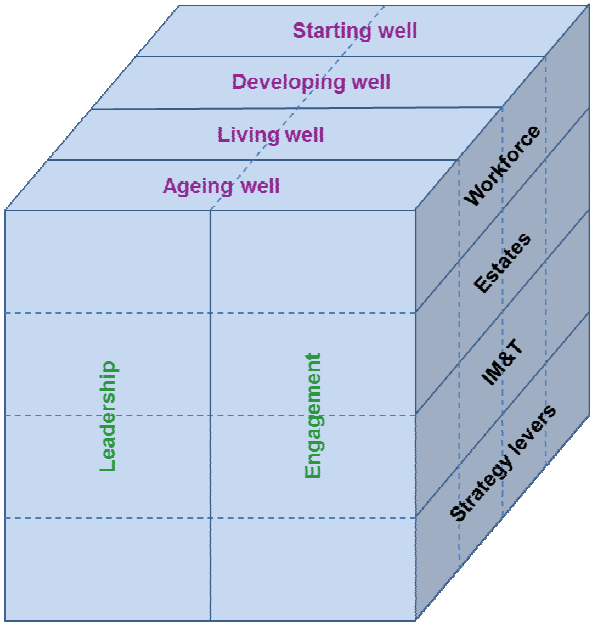
- Improved Quality of Care
- Improved Outcomes
- Improved Access
- Financial Sustainability



# Our local vision

# Driving transformational change



# Starting Well, Developing Well, Living Well, Ageing Well

**Starting Well**

•Increase immunisation and screening rate particularly for MMR
•Promote asthma plans through an asthma and viral wheeze app
•Ensure safe transition of the health visiting services to local authorities

**Developing Well**

•Reviewing school nursing service, with a particular focus on the importance of children and young people's mental wellbeing
•Review CAMHS and review pathways to prevent unnecessary entry to CAMHS tier 3 services

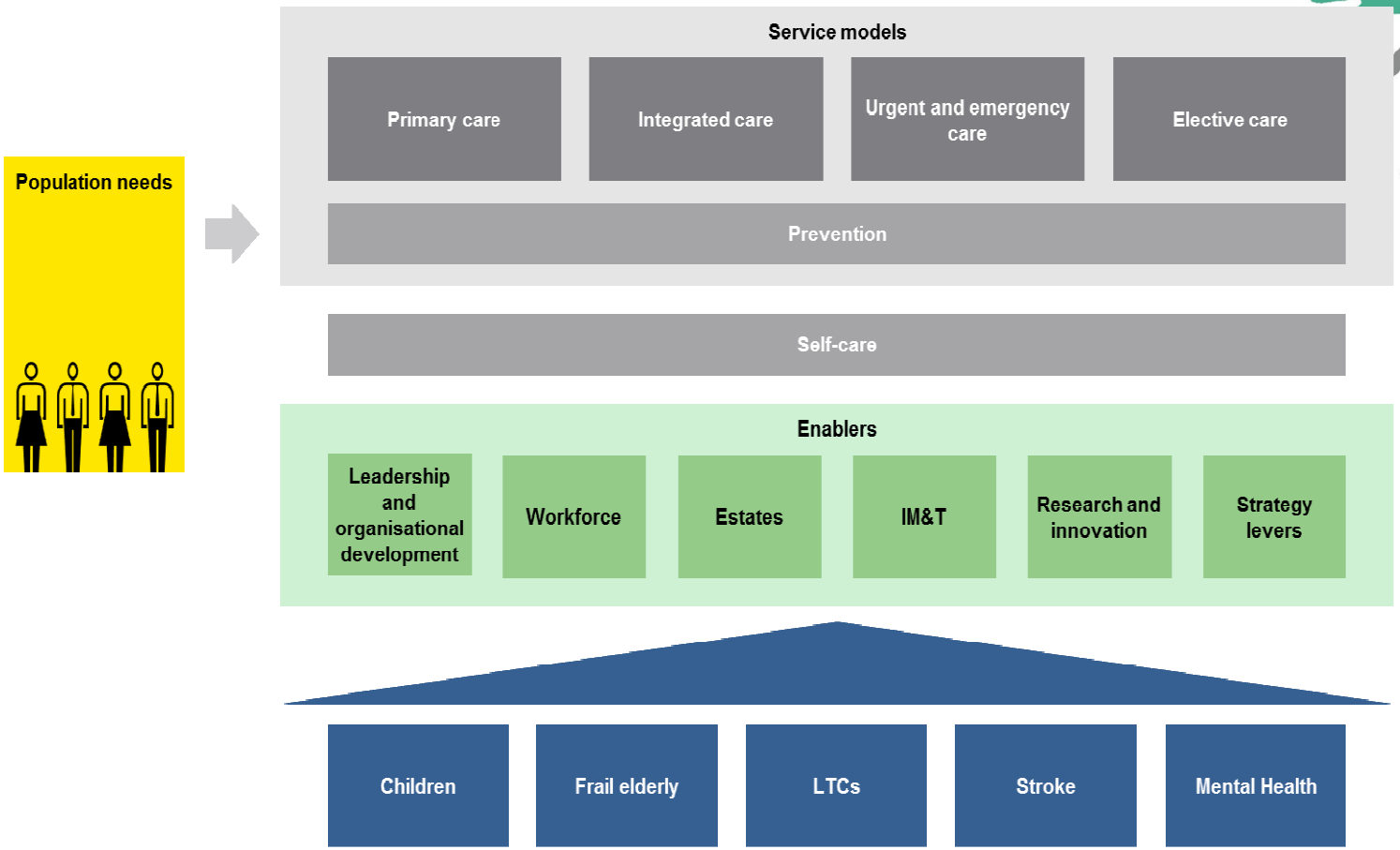
**Living Well**

•New information resources to support self-care and expand access to primary prevention services; smoking cessation, weight management and alcohol harm reduction
•Expand NHS Health Check programmes focusing efforts towards specific at risk groups
•Help GPs deliver best practice support for people with diabetes **(Is this there already?)**
•Increase immunisation and screening rates, including NHS cancer screening

**Ageing Well**

•Expand Falls Prevention work
•Develop programmes for positive physical and mental wellbeing, looking at social isolation
•Work together to integrate health and social care to reduce the number of emergency admissions

# Whole system reform



# Transforming Primary Care

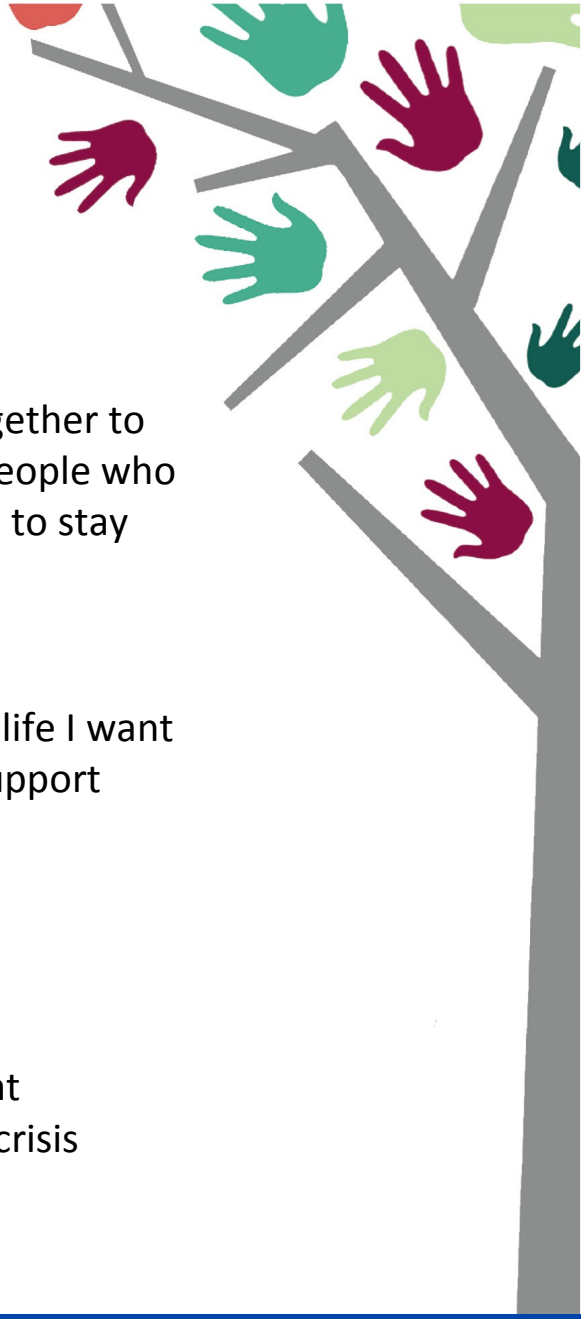

Slough Vision of Primary Care as designed with our patient group representatives from each practice using the methodology of Experience led commissioning

# Improve primary care access

Slough will operate as four clusters of primary care, with an initial focus on offering an extended hours service. Extended primary care services will be available at evenings and weekends until 8pm. The extended hours services will offer routine and much needed review of long-term conditions as well as access for urgent need. The clusters will integrate with a view to testing innovative schemes that would truly transform primary care services - including access to specialist consultant-led services, diagnostics and outreach (services offered out-of-hospital), where possible.

In order to improve access to primary care, we will offer online booking of appointments, text reminders of appointments and the facility to cancel by text. Mobile phone contacts will be offered for a very few patients with complex and unstable conditions, to ensure a direct line of contact to the health professional who knows them best. Email and Skype consultations will be available for 5-20 minute slots.

# The Better Care Fund sets out a vision for integrated services

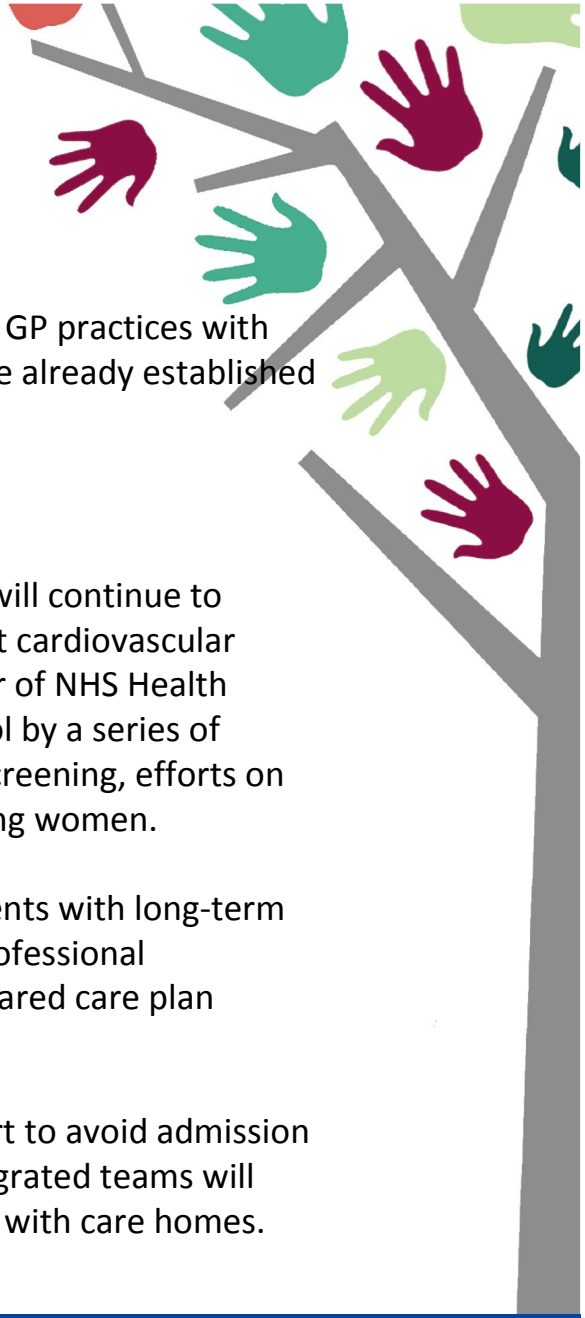


**My Health, My Care** - Slough health and social care service will join together to provide consistent, high quality, personalised support for me and the people who support me when I'm ill, keeping me well and acting early to enable me to stay happy and healthy at home.

By April 2018 patients in these groups will be able to say:

- I have access to a range of support that helps me to choose to live the life I want
- I am supported to achieve my goals and take control of my care and support needs
- If I have questions about my care I know who to contact
- I have information and support to remain as independent as possible
- I take responsibility for my health and my care
- I have support for any carer(s) involved in my care
- I am involved in discussions and decisions about my care and treatment
- I have someone I trust so that I can get help at an early stage to avoid crisis

# Our vision for integrated care



"We will deliver services through integrated care teams in 'clusters' based around GP practices with access to specialist and generic services to support patients' needs. Pilot teams are already established and case studies demonstrate good outcomes for Slough people."

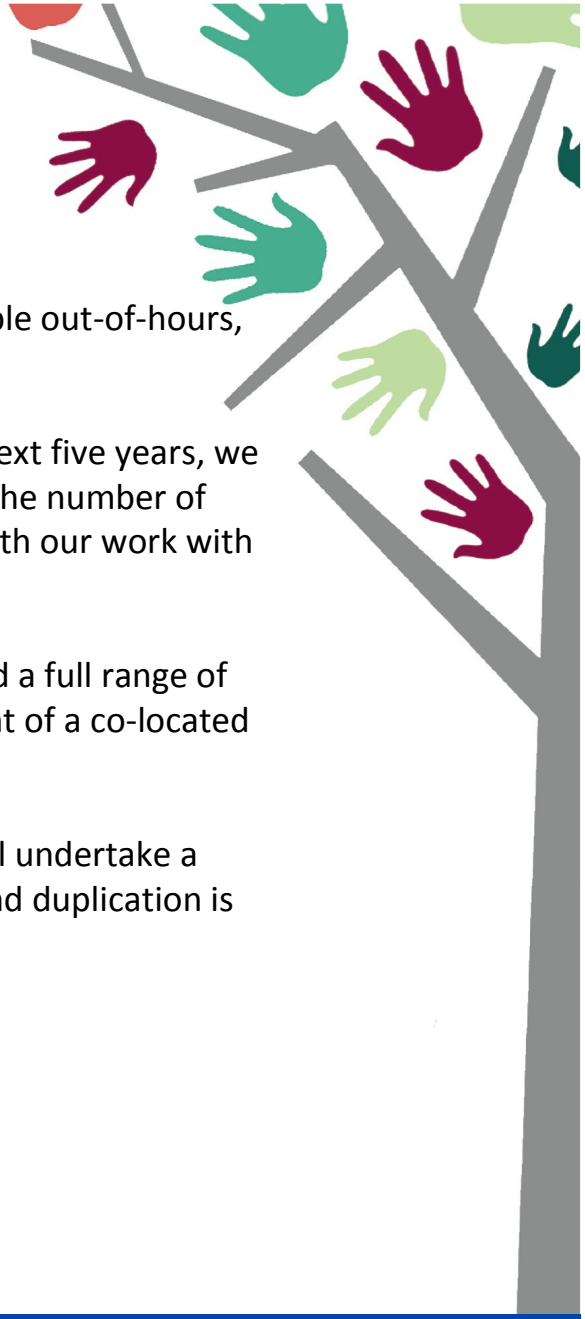
The integrated care teams will focus on the following interventions:-

•**Identification of patients who need support the most:** Slough general practices will continue to proactively identify patients who require more intensive support. Recognising that cardiovascular deaths under 75 are above the England average, the CCG will increase the number of NHS Health checks for people aged over 40 and optimise achievement of control of cholesterol by a series of lifestyle and therapeutic interventions. In addition, the CCG will improve cancer screening, efforts on smoking cessation uptake and management of familial hypercholesteraemia among women.

•**Care coordination:** Named GPs will be established for complex patients and patients with long-term complex needs. Integrated care teams will be established, with an accountable professional coordinating a shared care plan. All appropriate services will be drawn into this shared care plan approach, with acute specialist input drawn in as required.

•**Maintaining and promoting independence:** Integrated teams will provide support to avoid admission and to support patients back into the community following acute care. These integrated teams will support short-term intermediate care and reablement. They will have strong links with care homes.

# We will transform urgent care



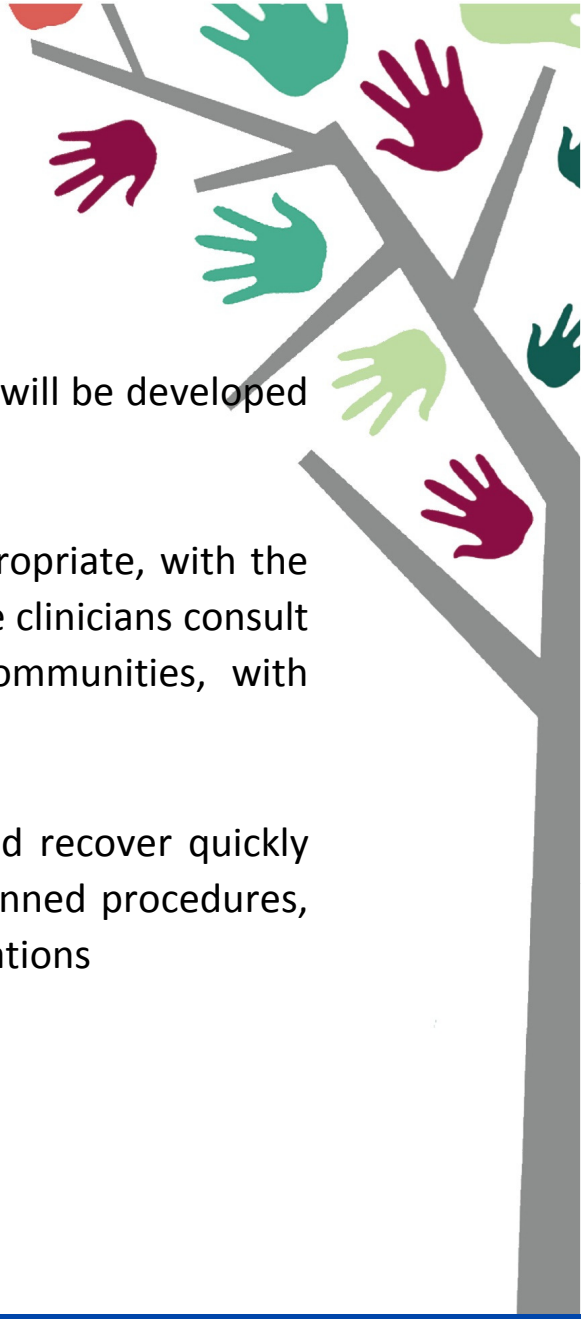
- Primary care access will be increased. Emergency appointments will be available out-of-hours, with a certain number held for children

- The role of the Ambulance Service will be completely transformed. Over the next five years, we will see a re-training of ambulance staff, enhancing their skills and increasing the number of paramedics available who can treat patients in their own homes. In parallel with our work with the Ambulance Service, we will work with NHS 111 to improve their services

- Urgent Care Centres will be at the heart of primary care with 24/7 services and a full range of diagnostics.  A feasibility study will be carried out into the further development of a co-located urgent care service at Wexham Park Hospital and Frimley Park Hospital

- As we develop and implement new urgent care working arrangements, we will undertake a whole system service review. This will ensure that resources are maximised and duplication is removed throughout the process.

# We will drive through elective productivity



- Primary care will manage patients in communities. New pathways will be developed which support patients to lead active and healthy lives

- Primary care clinicians will draw on acute sector expertise as appropriate, with the traditional outpatient model replaced with one where primary care clinicians consult acute counterparts. Diagnostic services will be available in communities, with reports provided to GPs

- An Enhanced Recovery Programme will help patients prepare and recover quickly from surgery. Heatherwood will be developed as a centre for planned procedures, driving up productivity and reducing the number of cancelled operations

# We will develop new pathways

We will work together with patients, provider organisations and other stakeholders to develop new pathways which exploit the new service model.

•Frail elderly

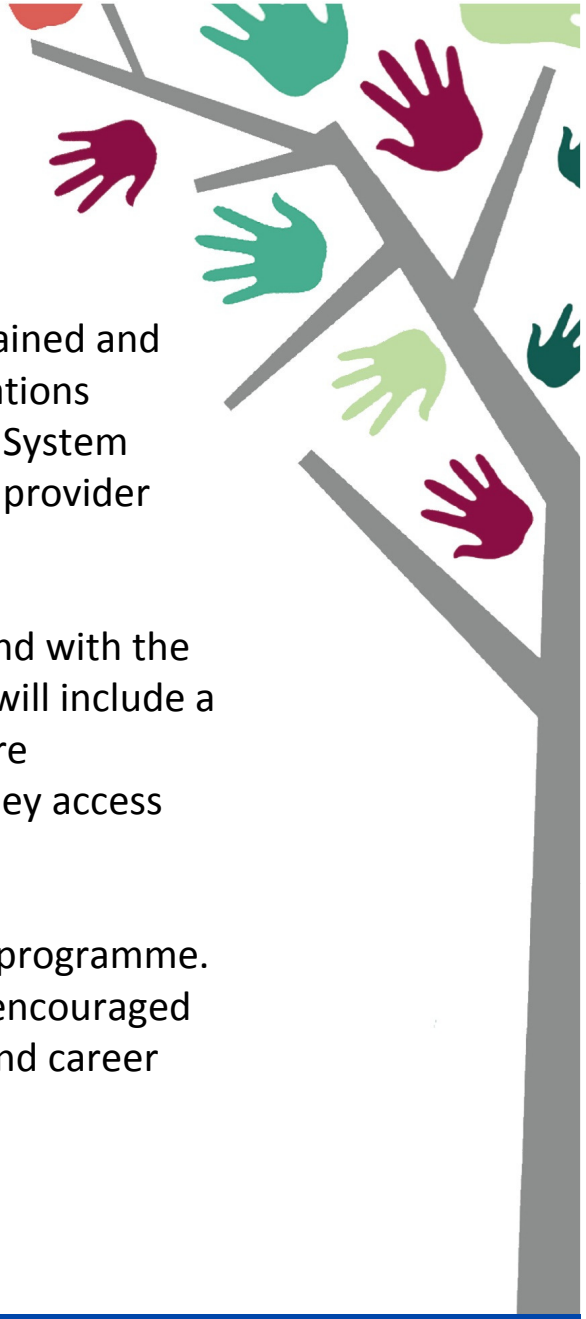
•Main long-term conditions, plus considering how pathways are coordinated to ensure a person's whole needs are addressed

•Stroke

•Mental health pathways

•Children and young people. We will set up a new children's group in East Berkshire headed by the Public Health Director Lise Llewellyn

# Building leadership and engagement

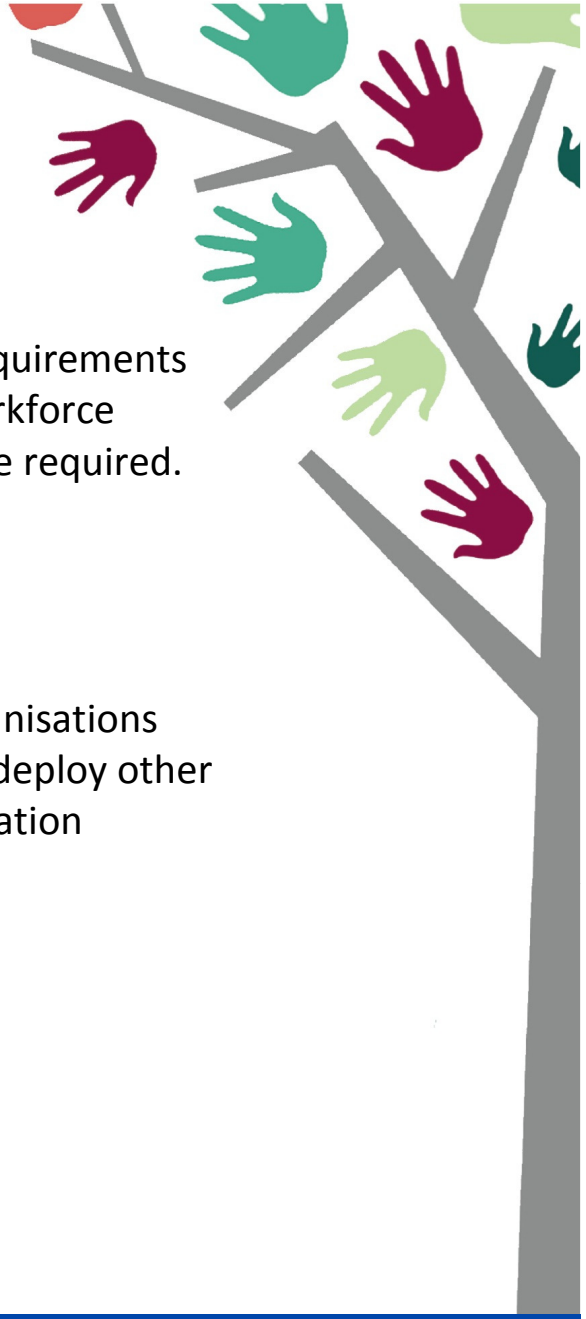


- Effective change of this nature can only be achieved through a sustained and shared commitment from leaders, clinicians and staff of all organisations involved, as well as patients and the public. The CCGs have set up a System Leaders Group with leaders of the CCGs, unitary authorities, health provider organisations and the Area Team.

- The CCGs will continue to engage extensively with patient groups and with the public, listening and adapting to concerns and points. Engagement will include a focus on changing patient and carer behaviours, thereby taking more responsibility for their own health and wellbeing and for the way they access care.

- All organisations will engage with staff through the transformation programme. Staff will be motivated by the opportunities to transform care and encouraged to take advantage of the opportunities for personal development and career progression. All staff will be supported through this process.

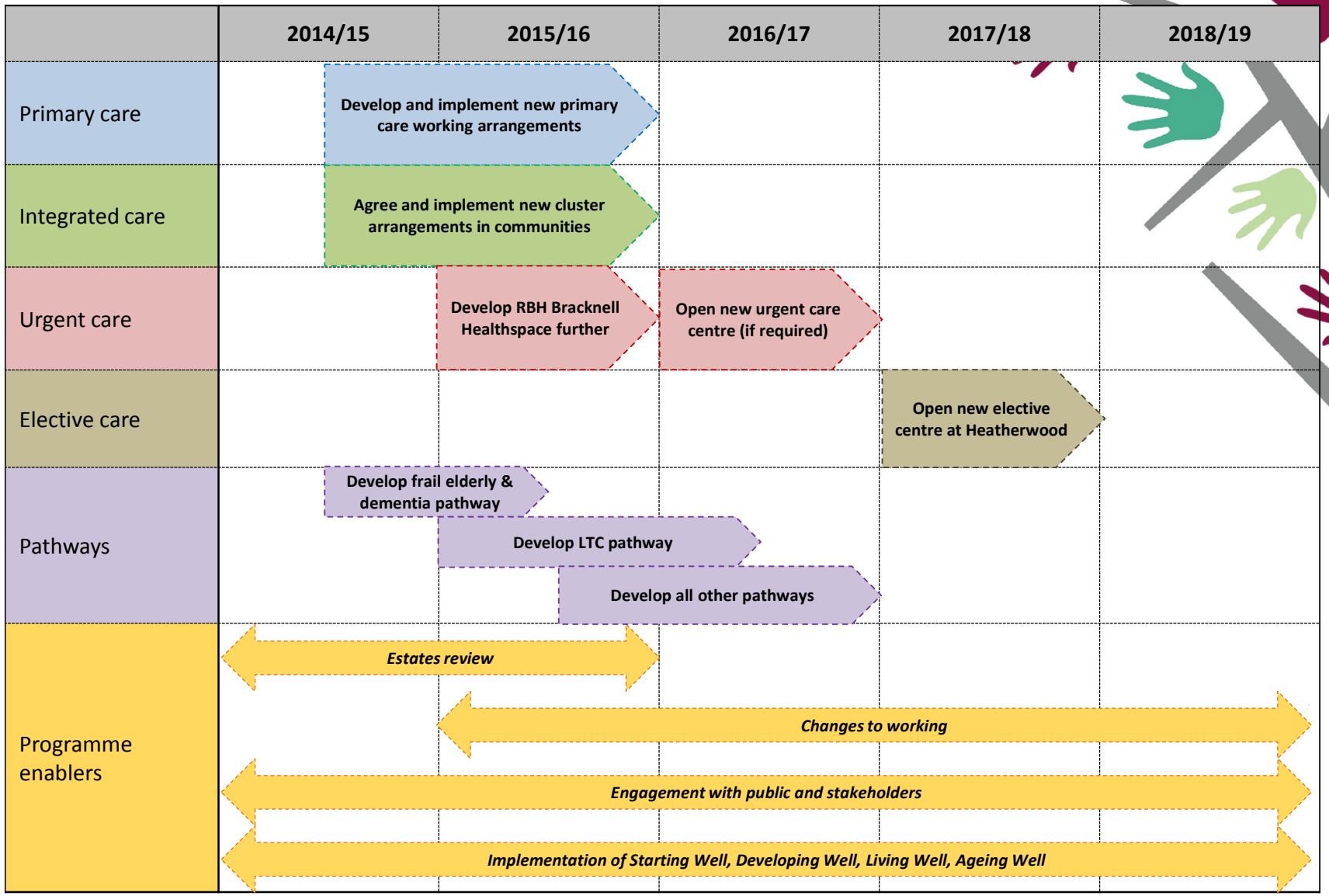
# Working through barriers and constraints



The CCGs will carry out an assessment of the workforce and estates requirements which result from the service transformation programme, with the workforce assessment covering the changes in organisational culture which will be required.

An IM&T strategy will be developed to underpin delivery of the service transformation programme, such as the shared care plan.

The three CCGs are all registering interest to be co-commissioning organisations with the Area Team on primary care. In addition, they will continue to deploy other strategic levers to ensure full implementation of this service transformation programme.


2014/15
2015/16
2016/17
2017/18
2018/19
Primary care
Develop and implement new primary care working arrangements
Integrated care
Agree and implement new cluster arrangements in communities
Urgent care
Develop RBH Bracknell Healthspace further
Open new urgent care centre (if required)
Elective care
Open new elective centre at Heatherwood
Pathways
Develop frail elderly & dementia pathway
Develop LTC pathway
Develop all other pathways
Programme enablers
Estates review
Changes to working
Engagement with public and stakeholders
Implementation of Starting Well, Developing Well, Living Well, Ageing Well

**In 2014:**

•I do not understand what I should do to manage my health

•I can't get hold of my GP

•When I see my GP, we talk about why I am ill today but not how to make me well

•My GP refers me to a hospital and the waiting lists are very long for an appointment

•My physical and mental health needs are dealt with separately

•Health and social services do not talk to each other

•I have more drugs in my cupboard than Boots

•I fell suddenly ill so called an ambulance and went straight to A&E

•A&E is the only place to go in a crisis

•I have waited for five months for my operation

•I see my elderly mum get frailer and frailer, and I am very worried

•My child has severe learning difficulties and is in residential care a long way away from home

**In 2019:**

•I have all the information I need and am exercising and eating well

•I took my child to see the GP on Friday night

•My GP understands me and helps me manage my health through a shared care plan

•My GP referred me to one of the other GPs who I saw the next day

•The NHS recognises my complex needs and organises a coherent response

•Social services have agreed to help me as part of my care plan

•My drugs have been reviewed as they were concerned I was taking too many

•The ambulance came and the paramedic treated me there and then

•It is great not to have to go to A&E and wait for hours

•I didn't have to wait long for my operation and was out in a day

•As a carer, I know the warning signs and am aware how I can help

•My child is now much closer to home