Operating Plan 2017-19
Progress update

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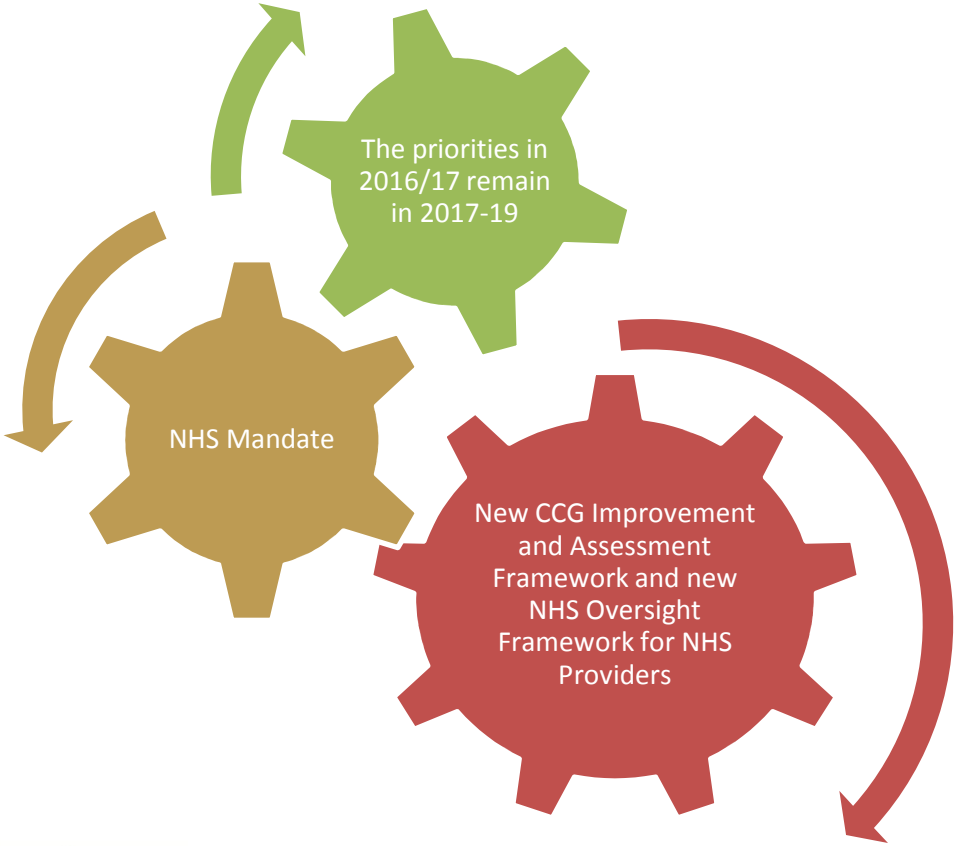
Slough CCG

Nine ‘must dos’ for 2017-19

NHS Slough Clinical Commissioning Group



- STPs
- Finance
- Primary Care
- Urgent & emergency care
- Referral to treatment times and elective
- Cancer
- Mental Health
- People with learning disabilities
- Improving quality in organisations

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Population

- The population profile differs from the national picture with a larger proportion of children aged 0 to14 and younger adults aged 25 to 44, but a smaller proportion of adults aged 45 and over. 28% of the CCG's total registered population is under 19
- 5 of the lower super output areas in the CCG boundary are in the 20%most deprived nationally
- Life expectancy at birth for men is 78.5 years, which is significantly worse than the national figure of 79.2 years. Life expectancy at birth for women is 82.7 years, which is similar to the national figure of 83.0 years
- The recorded prevalence of cardiovascular diseases, cancer, respiratory diseases, chronic kidney disease, depression and dementia is lower than the national prevalence rates and comparator CCG group. The recorded prevalence of diabetes is higher. Mental health disorders are marginally higher than England, but lower than the comparator CCG group
- The CCG had 8,144 potential years of life lost (PYLL) considered amenable to healthcare in 2012-14. This rate of 2,460 PYLL per 100,000 registered population is significantly higher than the national rate. Ischaemic heart disease was the main cause of PYLL in the CCG at 36.0%

Opportunities for improvement

Improved outcomes in cancers, maternity, gastro-intestinal, neurology, trauma and injury, diabetes, dementia and learning disability

Opportunities to spend money more wisely in: neurology, respiratory, genito-urinary, gastro-intestinal and endocrine

Our high level priorities for the next two years are

- Ensure patient rights under the NHS Constitution are upheld
- Develop a transformed model of general practice
- Reduce unwarranted variation in outcomes and the use of money
- Prevent crisis and escalation of health issues, through early identification and treatment
- Improve urgent on the day responsiveness of services and response to those in crisis
- Ensure that mental health receives as much attention as physical health
- Develop integrated services across the NHS and social care
- Give people support to live healthy lives and look after their conditions

Our priority areas of work

- Improve access to general practice and integrate other services and develop capacity and skills
- Improve the use of technology for online consultations and sharing records
- Provide information about early diagnosis and screening for cancers
- Support people at risk of developing diabetes and offer all diabetics the 8 care processes, structured education and group consultations
- Commission integrated community based MSK, Eye, Neurology, Cardiology, Respiratory and Dermatology services
- Implement an integrated care record
- Increase clinical input to NHS 111 calls. Stream patients to the most appropriate service in A & E
- Improve arrangements for discharging people from hospital
- Mental health - develop services for children and young people, people in a crisis and those with long term conditions, depression and anxiety and eating disorders. Focus on physical health
- Focus on the physical health of people with a learning disability and support them in the community
- Improve support to people who have been diagnosed with dementia
- Improve maternity services
- Commission integrated teams for people with complex conditions
- Deliver personal health budgets, self help and self care programmes
- Provide 24/7 support and share care records for people at the end of their lives
- Encourage people to stop smoking, increase physical activity, reduce alcohol consumption, and reduce their weight

What will the impact be?

- I will be given the information I need to stop myself getting ill and will have more control if I do
- I will be helped to give up smoking or drinking too much alcohol, I will be helped to lose weight and get active
- I will be more likely to go to the correct service first time and avoid a health crisis
- I will only have to tell my story once and all the relevant services will have up to date information about me
- If I am a parent or carer I will have information to help anyone I am caring for if they are sick or hurt
- I will be less likely to stay in hospital longer than I need to
- I will be more likely to have earlier diagnosis and treatment for circulatory disease, dementia, diabetes, cancer (particularly bowel and breast) and hypertension
- If I have a learning disability or mental ill health, I will also be checked for physical health problems and will be more likely to be cared for doser to home
- I will be more likely to live longer despite any health problems (particularly cancer)
- If I am a mother, I will be more likely to have a better experience of maternity services

Our supporting strategies

- Engagement of communities and patients to give people the skills and confidence to look after themselves and stay healthy
- Development of our workforce to deliver new models of care
- Development of the public estate to make the best use of public resources and deliver our new models
- Use of technology to support patients and clinicians in becoming more efficient, ensuring patients have to tell their story only once and can look after themselves
- Becoming a system with a collective focus on the population
- Robust quality and safeguarding procedures

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The Operating Plan linking to local priorities

Health and Wellbeing Strategy

- Mental health and wellbeing
- Increasing life expectancy
- Protecting vulnerable people

Improving Outcomes

- Cancer
- Learning disability
- Diabetes
- Circulatory disease
- Mental health

Potential unwarranted variation in spend

- Neurological
- Cancer

Circulatory disease

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Examples of future developments

- Continued improvements in access to mental health services for children and young people
- Improved health outcomes for people with a learning disability through early identification of mental and physical health needs
- Increased emphasis on prevention, and improved cancer diagnosis treatment times
- Enhanced support for people at the end of their lives
- Integrated care planning for people with diabetes and cardiac problems such as heart failure
- Increased access to Personal health budget
- Expanding opportunities for further integration with social care e.g. complex case management

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Working Collaboratively with partner CCGs

- Slough clinicians driving commissioning through local GP member practices and the Clinical Leadership Group
- One leadership team supporting local delivery across Slough, Bracknell and Ascot, and WAM CCGs.
- Close working with Slough Borough Council to deliver integration
- Partners in the STP footprint will work on priorities that are:
  - common to the 5 CCG populations
    and/ or
  - where working collaboratively will deliver added benefit
- CCG team will continue to deliver local priorities in conjunction with our local partners