Our strategy
2014-19

Our Values
Service  Teamwork  Ambition  Respect
Executive summary

People are getting older and living longer with more complex health conditions. Our lifestyles are causing a rise in obesity and related health conditions such as diabetes. New drugs, technology and practice means more expensive treatment but also new opportunities for us to improve care.

People expect more from the NHS at a time when funding is not increasing. The challenges we face cannot be overcome simply by doing more of the same so we need to radically rethink how we do things. This is our five year strategy which looks at the challenges we face, where we are now and where we want to be in five years time and importantly how we will get there.

As a Trust, we have strong foundations with an outstanding workforce who are compassionate, caring and skilled, we have a good understanding of what our patients need and strong relationships with our partners – Clinical Commissioning Groups (CCGs), local authorities and the voluntary sector to enable us to deliver integrated care. Integrated care means - person centred, coordinated care. It means looking at the way we deliver care through the eyes of the patient not through the eyes of the professional.

We are a vital part of the local community, a resource people rely on in good times and in bad and we want to make sure we are in the best position to respond to their needs not only now but in the future.

Above all, we want to provide the best possible care for our patients and service users which is defined by our vision:

Our five year vision

‘Working together with our partners in health and social care we will deliver accessible, personalised and integrated, services for local people. We will provide high quality care whether at home, in the community or in hospital empowering people to lead independent and healthier lives’.

Our vision is deliberately ambitious and to deliver it, we will need to move further and faster to adopt new and innovative ways of delivering care.

We are a complex organisation and everything we aim to do over the coming years cannot be summarised into a small document like this. What this strategy does is set out our ambition and provides an overarching direction and context for all Trust strategies – for example, our People Strategy and Quality Strategy. It is part of a dynamic process and has been informed by our business and operational plans as well as discussions with key partners – staff, patients, their carers, GPs, members and our local community.
Our priorities

We will challenge ourselves to continue to provide high quality care for patients and service users in the right place and at the right time by making the most efficient use of resources. Our strategy is designed with the patient as the absolute focus, with quality and safety as the foundation of how we develop and deliver services in a sustainable way.

We have **six strategic objectives** which guide everything we do as a Trust, which are:

- To deliver consistently high quality, safe services which deliver desired patient outcomes and we will perform in the top 25% (upper quartile) of comparable Trusts in delivering HSMR, Patient Satisfaction and Staff Satisfaction.
- To improve the patient and carer experience of every aspect of the service and care that we deliver.
- To ensure that staff are proud to work for the Trust and would recommend the Trust as a place to work, and to receive treatment.
- To secure the long-term financial health of the Trust.
- To adopt new approaches and innovation to improve services as healthcare changes whilst continuing to become even more efficient.
- To work in partnership with others so that we provide seamless care for patients.

We have set ourselves **four strategic priorities** which are the broad outcomes we aim to achieve in the next five years. Five years is a long time and improvements will be delivered through progressive pieces of work with benefits being achieved at different times.

1. We will make our patients the centre of everything we do
2. We will work smarter not harder making the best use of limited resources
3. We will innovate and identify new ways of working
4. We will build capacity and capability by investing in our staff, infrastructure and partnerships.

These ambitions are underpinned by our **five key internal strategies** which describe how we will achieve our ambitions:

**Clinical Strategy**
Setting out the acute and community transformation agenda for the Trust and how this will support integration of our services in a sustainable and viable way.

**Quality Strategy**
Setting our clear ambitions for the standard of service and care we aspire to deliver and how we will provide services that are effective, safety and provide the best patient experience.

**People Strategy**
Addressing how we will meet the workforce challenges facing the Trust and the commitments we are making to staff.
Medium Term Viability strategy
Addressing key financial and performance challenges and opportunities over the next five years.

Infrastructure Strategy
Setting out our approach to making the best use of our IT, Estate and business intelligence infrastructure to empower our staff, reduce barriers to work giving them the tools and information to support them in their roles and to support the delivery of better patient care.

We know that there will always be significant change in the NHS and this makes a clear set of priorities and a clear sense of direction all the more important. As a Trust we do not want to see change just for the sake of change. Each new project initiative or development will be measured against these four ambitions so we are focused on those things that will help us achieve them.

Why do we need to change?
We have all seen the headlines about the pressures on the NHS. The challenges we are facing are unprecedented and if we do not plan how to overcome them now, the quality of care and service we provide will suffer.

The key challenges:

An ageing population
Many of the diseases that would have killed people 65 years ago when the NHS was created, are now able to be treated or cured, which is fantastic news for everyone. As our ageing population increases, more people are living with one or more long term complex conditions such as diabetes, heart and kidney disease which means they need ongoing treatment and specialist care. By 2020, we expect our Retirement Age Population to increase to 16.6% in Swindon and 22.9% in Wiltshire with the largest growth in people over 85 years old. This means that as Trust, we are caring for increasing numbers of frail and acutely unwell people who have complex health and social needs.

Lifestyle factors
The way we live is seriously affecting our health with people smoking, drinking too heavily, eating too much of the wrong types of food and not doing enough exercise. This all impacts on our health and nationally we are seeing an increase in obesity - the King’s Fund predicts that in the UK by 2020 37% of men and 34% of women will be obese, resulting in more than 550,000 cases of diabetes, around 400,000 additional cases of heart disease and stroke and up to 130,000 additional cancer cases.

Changing patient expectations and rising costs
Originally tackling disease was the main job of the NHS, but we now all expect so much more. From advice on health management through to mental and social care and fast, efficient customer service whether at home, in the community or a hospital environment. This means that limited resources are more stretched to provide the responsiveness and quality of service that patients expect. As new technologies, are introduced, patients
expect care and treatment to be available seven days a week and provided in the most convenient manner to suit their busy lifestyles. As we all become used to seven day services like online shopping and call centres, so too patients expect us to offer similar access and service. This becomes more challenging at a time when money is getting much tighter.

Quality

The NHS has rightly experienced increased scrutiny in the light of the failings of care at Staffordshire Hospitals and in other parts of the NHS and the subsequent Francis report amongst many others. As a Trust we are committed to delivering safe, high quality care that meets patient’s expectations and we have developed, for the first time, a clear quality strategy setting out how we will improve the quality of care we provide.

Increasing demand

In general, we are experiencing an increase in demand for all our services but in particular more and more people are visiting our Emergency Department and Minor Injury Units as their first port of call. This is stretching the ability of these departments to respond as well as creating pressure on other services within the Trust. Many people attend these departments because they are open 24/7 and they may be unclear about the most suitable place to access appropriate advice. Every winter sees an increase in the numbers visiting these departments and we need to support people to choose the most appropriate setting of care and understand where to access information and advice. Increased pressure in other sectors such as social services also has a negative impact on the Trust and affects our ability to support patients to return home as soon as possible. We cannot continue as we are with the massive increases in demand we have seen in recent years.

Advances in medicines and technology

The positive news is that we have never been better placed to change the way we work with many new advances medicine and surgery alongside new drugs and treatments and innovations in IT and technology. This offers us opportunities to improve how we do things by embracing new ways of working such as telehealth, e-prescribing.

Workforce

We have an outstanding workforce who are compassionate, caring and skilled. As a Trust, our challenge is to keep recruiting the right people as demand grows and models of care change. We need to ensure we have the right people in the right location with the right skills to provide the right care first time. Nationally and locally, there are shortages of key groups of health professionals and as a Trust we will need to ensure we have a compelling offer to attract the best people to work with us. But it is not just skills that are important. The scandal of Mid Staffordshire showed just how important it is to get the right values and culture in place to provide the best possible care.

We recognise that the quality of our patient experience is absolutely in the hands of our staff. Investment in our workforce has been a priority for the last three years, and it is from this strong foundation that our strategic plans are based. A detailed People Strategy has been developed to support this work which you can read on the Trust website.
Where are we now

As a Trust, we provide services to a diverse population with different health needs across a large area which includes Swindon, Wiltshire and parts of Gloucestershire, West Berkshire, Oxfordshire and Bath and North East Somerset.

We are a high performing and progressive Foundation Trust which is committed to delivering the highest standards of care and patient experience to all our service users and patients. Historically our finances have been strong but each year, the opportunities to make savings are becoming more difficult.

We have over 5,000 staff delivering care in hospital, in the community and in people’s homes. Our acute teams at Great Western Hospital provide services to approximately 300,000 local people whilst our community teams serve approximately 1.3 million people across Wiltshire and Bath at community hospitals, GP surgeries and health centres. We know through feedback collected by the Friends and Family test and other routes that we consistently provide high quality care in a compassionate and professional manner. However, we know there is more we can do and we are committed to listening more effectively to our customers and acting on their feedback.

Our teams deliver a wide range of acute and community services from orthopaedics, dentistry, sexual health and maternity to community nursing, emergency care, cardiology and stroke services. Our community teams in Wiltshire are split into three localities mirroring Wiltshire CCGs structure which enables us to work more closely with Wiltshire CCG as well as partner organisations in social services and the voluntary sector to deliver integrated care to patients. The main community services in Swindon are provided by SEQOL – a social enterprise.

Over the past three years, we managed Maternity Services in Wiltshire, Bath and parts of North East Somerset but following a competitive tender process, this will be run by the Royal United Hospital in Bath from June 2014. We are proud of the service that we have delivered over the past few years and have made improvements in safety, quality and patient experience which has included an investment of almost £700,000 in additional midwives and a massive improvement to the patient environment at the Princess Anne Wing in Bath.

We have spent time creating a culture and environment throughout the Trust where our staff want to work. In 2013, we were again voted as one of the top three Trusts in the South West in the NHS Staff Survey. We are committed to investing in our staff and continuing our work to embed our values and develop a culture which promotes initiative, encourages innovation and promotes accountability.
Our patients

We want to create services and patient experiences that meet the needs of our local population so it is important to understand how demand and expectations will change over the next five years.

We know that over the next seven years our local population is expected to increase by 4.8% in Wiltshire and 10.6% in Swindon. The largest growth will be in the Retirement Age Population (RAP - people over 65 years old), who are more likely to require health services and this is forecast to be significant both in Swindon and Wiltshire which will result in increased demand for our services.

Older people are more likely to suffer from complex and long term conditions (for example COPD and dementia) and this will put increased demand on the Trust to provide services. Our ageing population and the increased prevalence of chronic diseases such as hypertension, diabetes, coronary heart disease, COPD and respiratory conditions requires a reorientation away from an emphasis on acute care towards prevention, self-care and care that is integrated. This will involve providing better coordination of care to prevent avoidable ill health and hospital admissions resulting in better value for money.

Military personnel account for 3.3% of Wiltshire’s population and every year 60% of people leaving the armed forces who are based in the South West settle here. Military personnel and ex service people often have specific health needs and we will work with our partners in mental health Trusts and social care to ensure we support the health needs of these individuals.

The health indicators for people in Swindon are generally better than the English average but there are significant inequalities between the health of people living in the most affluent and most deprived areas. Swindon has higher than average obesity and obese patients have a greater number of associated health issues such as diabetes, cardiac and vascular problems as well as more complex needs for services such as maternity and surgery.

The health of people in Wiltshire is generally better than the English average. The rural nature of Wiltshire and poor public transport provision has implications for us in providing health services and moving more services into the community.

Swindon increase of 25,000
(population in 2011, 209,300 rising to 234,221 in 2020)

and

Wiltshire increase of 25,000
(population of 470,900 in 2011 rising to 494,719 in 2020)
How will our strategy benefit our patients, staff and partners?

Our five year plan and the ambitions we have set ourselves have been informed by feedback from staff, patients and other stakeholders. The aim of our five year plan is to make a positive difference to the people that walk through our doors or whose homes we visit every day. We have used real experiences to illustrate the difference our five year strategy will help us deliver.

1. Services that are designed with and around patients

What will this look like?

We will effectively engage with patients to gather their feedback and develop services designed around their needs with care wrapped around the patient. The right care will be provided in the right place at the right time, with more services enabling self-care at home and care in the community to empower greater independence.

We will adopt technology to enable virtual clinics and professional to professional consultations and we will only cancel appointments where it cannot be avoided to accommodate the busy lives of our patients.

We will work with our colleagues in primary and social care to identify joint initiatives where we can bring together our expertise to keep people well and out of hospital for longer. For example, in Wiltshire, we have worked with GPs to introduce Care Coordinators to support frail elderly patients and people with complex conditions to live well at home for longer and help reduce medically unnecessary admissions to hospital.
CASE STUDY
integrated care

What can happen now

Ethel is a frail 90 year old lady who still lives in her own home. She is admitted to the Emergency Department by ambulance after she falls in her home and a concerned neighbour finds her. She is admitted to a ward, and has an operation within 24-48 hours to repair her hip. Unfortunately there aren’t any rehabilitation beds available in the community and Ethel has to stay in hospital and develops a chest infection and doesn’t recover as quickly as expected. As Ethel has no family living nearby who can support her, she can’t return to her own home when she is medically fit for discharge so she ends up staying in hospital longer than she needs to as there are issues agreeing how a place for her at a local care home should be funded. Funding is agreed but Ethel decides she doesn’t want to go because she has heard bad reports about the care home. Eventually after several weeks, a place is found in a care home in Ethel’s home town and she is discharged from hospital.

What could happen

Ethel will still be admitted to hospital as an emergency admission and operated on within 24-48 hours as she has fractured her hip. Prior to her operation she will be tracked by the Enhanced Trauma Coordinator and placed on the Fractured Neck of Femur Pathway - and then be referred to the Discharge Assessment Referral Team (DART single referral process) who will triage Ethel and depending on where Ethel lives ensure that the correct services are alerted and working in partnership with the ward staff and therapist, ensure the most suitable route for discharge is ready for Ethel. With the use of Twilight Therapy Provision, Ethel is likely to be assessed by a therapist more quickly. If Ethel was medically stable for discharge and has inpatient rehabilitation goals she could be transferred to a rehabilitation bed 48 hours after her operation, which would reduce the risk of developing a chest infection.

Following a comprehensive assessment from a therapist and social services, it will be agreed that when Ethel is ready to progress to independent living, the necessary support services will be identified which could include: support from a voluntary services organisation, which will provide volunteers to make sure her home is ready for her return, making sure she has a supply of basics such as bread and milk and will visit her regularly to check how she is doing, take her to any future appointments and get her shopping. With this support, Ethel will be able to return home from a community bed as quickly as soon as she is medically fit. Ethel will also be provided with a reablement package of care and ongoing therapy support and she will be able to access Telecare and if appropriate a Community Matron/District Nursing. If necessary (as Ethel has no family) a night sitting service will be arranged which will enable Ethel to return home more quickly as a carer will spend the night at Ethel’s house providing care and support.

If Ethel is a patient with dementia, she could be admitted to a dedicated dementia ward, which would help reduce confusion and distress for Ethel. She would be cared for by staff specialising in caring for patients with dementia which would help her to recover as quickly as possible.
2. Joined up patient pathways creating excellent patient experience

What will this look like?

We will work together with partner organisations (commissioners, GPs, social services and charities) to ensure that each patient experiences the best possible care and outcomes whether in hospital, in the community or at home. Quality and safety will be the responsibility and priority of every member of staff – both clinical and non-clinical - and we will have a clear set of measures for ensuring that we deliver high quality care across every service. Services will be provided seven days a week where there is demand from patients and the accessibility and quality of the care we provide will be consistent during the week and at weekends.

We will be recognised as a leading provider of care and patients and service users will choose us and recommend us to their families and friends.

CASE STUDY
Urogynaecology

What happens now:
Shirley is a 60 year old woman with continence issues. She puts off going to her GP for a number of months but finally plucks up the courage to see her GP. Her GP suggests that she should have an appointment at the hospital. Shirley receives an appointment from Great Western Hospital and attends the hospital for tests. She then receives another appointment letter, inviting her to return to the hospital to see a Consultant. At the appointment, the Consultant says she needs to see a physio/ have an operation. This is very inconvenient for Shirley as she lives 40 minutes away from the hospital and she only has a limited income so prefers not to have to drive too far because of fuel costs.

What could happen:
Shirley attends a one stop clinic at Great Western Hospital where she has all the tests she needs at the same appointment, sees a specialist nurse and consultant, receives a diagnosis and is booked for surgery on the same day. She receives all the information she needs about her condition and following the appointment is sent a login to a secure area of the Trust’s website where she can access information about the procedure – what to expect, recovery times and how to access help if she needs it. Shirley is really happy about the service she receives and she tells her friends that she would recommend Great Western Hospital if they have a similar problem.
3. A culture of excellent ‘customer service’

What will this look like?

Together with providing the best quality of care, we will embed a culture of ‘excellent customer service’ (a GWH Trust way) across the organisation supported with relevant training and development for staff. This will create welcoming and lasting first impressions – online, by phone and in person across all our locations. We will support patients through self help initiatives and targeted use of social media to lead independent, healthier lives. We will use new and innovative ways to communicate and share information with our customers helping them to make more informed decisions about their care. All of our staff will understand what excellent customer service is and the role they have in providing it to everyone we see.

Patients will be in control of their care and the information they need. We will provide a secure online portal which patients can access through personalised logins - this portal will provide a personalised record of all their booking and patient information as well as a range of relevant information, resources and video tours.

CASE STUDY
Customer experience

What can happen now:

Following a referral from her GP, Carolyn receives a letter for an outpatient appointment two weeks later. The appointment is a few weeks away and due to a last minute commitment she forgets to attend the appointment meaning it can’t be used by someone else.

Another appointment is arranged for the following month which she attends. Carolyn walks into the atrium of the Great Western Hospital but is unsure of where to go. She arrives at the clinic and is asked to take a seat but the receptionist does not check any personal information as the clinic is busy and running late. When she is called for her appointment, she is told she will need an operation. Carolyn is nervous about having the operation and has a number of questions about what she can expect and how long her recovery will take but doesn’t know where to find this information. She searches the internet and finds a number of different and conflicting pieces of information.

Six weeks later Carolyn returns for her planned operation and goes straight to the ward. Later that day she has the operation and requires follow up appointments to check on her recovery which means returning to the hospital.

What could happen:

Following a referral from her GP Carolyn is referred to the Great Western Hospital which is linked to her online patient care record. She leaves the GP surgery with a reference number which allows her to track the progress of her referral. Carolyn logs into her online care record and sees that her referral has been reviewed by the doctor at the hospital who has marked it routine.

Carolyn receives an automated telephone call the next day to agree a time and date for her appointment. She then receives an email to confirm the appointment with a link to the relevant area of the Trust website which contains information about
the clinic she is attending, FAQs, information about support groups and a virtual tour of the department. A few days before the appointment, Carolyn receives a text reminder giving her the option to confirm or rearrange the appointment if it is not convenient.

When she arrives at the hospital for her appointment, Carolyn is greeted by a member of staff with a mobile device. Carolyn asks for directions and the member of staff says they will check whether the clinic is on time. The clinic is running late as the doctor has been called to theatre so Carolyn is given a bleeper and takes a seat. The member of staff lets her know she can access free wifi and where to get a coffee. Carolyn’s bleeper goes off and she passes it back to the member of staff who guides her to the clinic and helps her check in using the self service check and complete a smoking cessation survey. Carolyn takes a seat and sees that she is third in the queue on the flat screen on the wall. Carolyn is told she’ll need an operation and the consultant gives her a link to a personalised area of the website where she can find all the information she needs about the procedure, recovery etc.

Her operation requires a few days of recovery in hospital. On admission to an inpatient ward, she is visited by the ward manager so she knows who is responsible for care on the ward. Carolyn is also provided with a bedside booklet providing information on visiting times, meal times, cleaning schedule and other useful information during her stay.

Carolyn is discharged a few days later, on time and is asked to give feedback on the care she has provided through the Friends and Family Test. She is provided with information on what she should do to help her recovery and also the medication she should take. She is also provided with a contact name and number of who to call if she has any concerns.

Carolyn requires a follow-up appointment to check on her progress. Rather than bring her back into hospital, the Consultant reviews her through a virtual appointment through video link with two community specialists. Carolyn’s recovery is progressing well and therefore she doesn’t require any further follow up and is formally discharged from our care.

Whilst she’s recovering Carolyn misplaces some of the information she’s been given but still needs it. She is able to log onto the Trust website where her information is stored in a secure portal which only she has access to detailing her treatment record and providing links to other information relevant to her care.

Carolyn receives a text message asking her to rate her experience which is used by the Trust to monitor patient experience.
4. Strong valued relationships and partnerships with mutual benefit

What will this look like?

We will get value from every interaction with key stakeholders and ensure that our resources are targeted to where they will have the greatest impact to support excellent patient care. This will mean we develop strong relationships with key stakeholders such as commissioners and local authorities to share knowledge and will be best placed to find solutions to the challenges that face us as a Trust and benefit patients, staff and our local communities.

This will involve routinely identifying opportunities to work differently, adopt technology and work in innovative ways alongside partner organisations to deliver the quality of care and service that patients need and expect.

We are already working closely with primary care to provide Consultant led clinics in GP surgeries in dermatology and geriatrics. These clinics have brought specialist care closer to patients and also, importantly, allowed closer and more fruitful dialogue between specialists and GPs and improved care and medical education in both directions. We will be looking at further opportunities to offer clinics in convenient locations for patients at the same time as shifting specialist expertise from the acute environment to the community. We will actively engage with Health & Wellbeing Boards and groups such as One Swindon to bring together our resources.
5. A caring service and a caring work environment

What will this look like?

Our staff are our greatest asset and this strategy can only be achieved with them. We will continue to deliver health services that we are proud of and we will ensure we have a culture where staff are proud to work for the Trust and feel engaged and supported to suggest improvements and make changes.

The best benchmark for whether we have got it right, is whether our staff would be happy for their family to receive care here and we will use this as a guiding principle. We will ensure that staff are engaged, supported and valued and we will provide meaningful career and personal development opportunities, resulting in people aspiring to work with and for our Trust. We will provide our teams with exemplary leadership.

We will take responsibility for nurturing a learning culture that emphasises quality, safety, compassion, engagement and transparency in practice. We will design and implement a People Strategy and supporting plan to guide our work and we are setting out clear commitments to staff and key to this will be their health and wellbeing.

CASE STUDY
Nurturing talent

What happens now

We have many highly skilled and talented people eager to develop themselves and their service but at the moment talent is identified by individual managers and executives on an ad hoc basis. Although the Trust is keen to identify and nurture talent there is not a structured system in place to support talent management.

What could happen

The Trust will introduce an online talent management system which staff will be able to access through the Trust intranet. This will enable individual members of staff to register on the system and indicate their interest in taking part in secondment opportunities, task groups and cross directorate teams. The system would enable line managers and colleagues to provide endorsements and references for members of staff. This would help accelerate internal recruitment processes and help us to use the best skills on offer to ensure success of projects and service changes. The talent management system would also enable the Trust to develop an internal talent pool and demonstrate commitment to supporting staff to develop and use their skills and enhance their careers.

This system will help the Trust to retain talented staff who would otherwise have moved to another organisation. The scheme will increase staff motivation, share knowledge and skills from different departments and support staff achieve their personal and professional objectives.
6. Early adoption of proven health care

What will this look like?

With new technology and organisations such as Academic Health Science Networks, we will be much better at supporting innovation and adopting new advances in technology more quickly ensuring that any learning is channelled back into front line training and development. We have an active research and development department where we punch above our weight for a Trust of our size which enables us to offer greater choice of treatment and innovations in practice. We will see increased adoption of virtual healthcare and telemedicine and the move toward a digital health care environment.

Adopting advances in medicine and technology will help us deliver more care out of hospital, in the community and at home. It will help us become more efficient in the way we provide care and make the working lives of our staff easier.
CASE STUDY
Digital pens

We will be looking to be an early adopter of proven advances in technology and healthcare. For example, in 2012/13, the Trust introduced a new maternity information system with integrated digital pen technology. Using this technology enables all the information relating to each woman’s maternity care to be stored in a single, up-to-date electronic record which can be accessed and updated by any midwife or clinician involved in her care.

Midwives and clinicians use digital pen and paper technology to write handwritten notes and the information is collected by the digital pen and then transmitted to the woman’s electronic patient record. This removes any duplication of information and ensures that any clinician accessing that woman’s notes has the most up to date information about her care.

What could happen

We will support the adoption of technology that will enable us to provide the best level of care to our patients. For example, this could be a digital patient bedside record which integrates with our Patient Administration System and provides a single set of digital notes about that patient and can follow the patient.

We will look for opportunities to provide care in the most convenient and cost-effective manner for patients and this will involve the adoption of virtual health monitoring where appropriate and the introduction of interactive whiteboards on wards, e-prescribing, self check-in kiosks and tablets to streamline processes and provide better patient experience for example:

Electronic pre-operative assessment and patient self service

Instead of a paper-based questionnaire, the new electronic system will enable patients to register on arrival at a self check-in kiosk, update their demographics as well as complete a pre-operative assessment questionnaire which will be used to assess their health and fitness for surgery. Technology will also be adopted to show waiting times, automate the calling of patients to clinic rooms which will release nursing staff and help to improve overall patient experience through reduced waiting times. Patients will be able to complete customer satisfaction surveys at the kiosks and patients can choose their preferred language in which to complete the information at the kiosks.

Interactive whiteboards

We will replace static whiteboards with interactive whiteboards which will provide access to the right information at the right time for clinicians as well as reducing the time staff spend locating patient notes and information. This will help improve patient flow and community teams will be able to view patient case load, and the status of specific patient groups e.g. end of life care, Help to Live at Home, Virtual Ward along with supporting multidisciplinary meetings and case conferences.
7. A stronger focus on prevention and support

What will this look like?

We will use technology and information to understand our population and patients to help us plan health services. We work in partnership with partners such as public health in local authorities to help promote healthier lifestyles and bridge current health inequalities. We will support older people to live more independent lives integrated within their communities.

CASE STUDY
Rapid response night nursing in the community

Two pilot rapid response night nursing services have been established in the community in Wiltshire to care for patients between 10pm and 7am. This is part of the move to be able to provide a 24/7 service for patients and as a Trust we will be looking to provide more services that meet patients needs at any time of day or night. The pilot has received extremely positive feedback from patients who would have waited until the morning to receive care. The teams receive referrals from out of hours and aim to respond within an hour. The care they provide has improved patient's quality of life and avoided the need for hospital admissions on many occasions as well as making best use of limited resources, for example:

- the team were able to provide a lady with a syringe driver in a care home so she was comfortable at the end of her life rather than being in distress or dying in the Emergency Department if the care home had not been able to manage her distress
- the team dressed a wound of an elderly man who had fallen - he would have need to visit the Emergency Department without this care
- the team unblock/change or insert catheters for patients who would have been in distress and discomfort all night without their support which helps patients maintain their dignity.
8. Making the best use of our buildings and technology

What will this look like?

As part of our strategy, we will plan how to make the best use of the buildings - supporting a shift of appropriate services from the acute to community setting as well as making the best use of the Great Western Hospital site. We will use business intelligence and feedback from patients and service users to inform our planning. This offers us opportunities to use spare capacity in the community whilst reconfiguring services in the acute hospital to deliver the best patient experience.

We will work with our partners to identify opportunities to co-locate services to make it more convenient for users and to break down organisational barriers.

CASE STUDY

long term conditions

We will support initiatives that enable more care to be delivered in the community whilst releasing capacity in the acute hospital. Over time, this will see an increasing number of more acutely unwell patients with long term conditions cared for in the community instead of an acute setting. Experts in the community and in Great Western Hospital's Emergency Department will support admission avoidance to the acute setting and will have detailed knowledge of available community services. They will work in partnership with GPs to find the most suitable care setting for people with long term conditions.

A sustainable and viable future

The reason we are here is to provide patients with the best care possible and we know that to do this effectively, we need a strong and sustainable business. We know we cannot stand still, with increasing competition and pressures on funding we need to think differently about how we approach our business.

However, we want to grow our business in a sustainable way so we will not pursue growth for sake of it. Instead we will actively explore new business opportunities that help build stronger links with partners or those that make a material difference to our finances which will help provide new funding to invest in patient services. We will ensure our community service is in the strongest position possible through a period of consolidation and embedding the change already underway. New business opportunities will be identified incrementally so opportunities are well considered.

Through careful analysis of our business model and our services, we now understand the key risks to our sustainability as we were keen to answer the question about when we would become unviable as an organisation as more care is provided in different settings by more competitors. We commissioned this advice from external experts so that we can develop a clear plan to ensure we are sustainable, protecting where possible vulnerable specialities. We are now using this advice to shape future plans and inform decision making about new opportunities to support our focus on sustainability.

We will explore joint ventures with our partners to benefit from their skills and experience to deliver care. For example this could take the form of working with the Oxford University Hospitals Trust to provide a local Radiotherapy service in Swindon or working with the voluntary sector to use their skills to support patients outside of hospital to avoid readmissions.

We will also review our private service offering to ensure it meets private patients needs and increase private income to support NHS services.
Delivering our strategic ambitions – the process

To deliver our five year strategy objectives and ambitions, we will work collaboratively with partners, make best use of limited resources and support innovative solutions.

Our business planning process supports us to plan and deliver our services and achieve our ambitions. Over the next five years, we will be working differently to deliver the pace of change we need. This includes a strong emphasis on working closely with partner organisations such as local councils, social enterprises, voluntary sector and other NHS providers.

Achieving our vision

The Five Key Strategies
We want to be as clear as possible about the type of organisation we want to be. Each strategy sets out where we want to be in 2019. Each strategy is dependent on each other so key is their success is a clear line of sight between what each are doing. To do this each strategy has a clear work plan detailing specific actions from years 1-5. Each plan will be monitored by the appropriate sub-committee of the Trust Board.

How we will know if we’re on track?
There will be routine scrutiny at sub-committees. Development of an integrated performance dashboard showing performance against agreed KPIs linked to key strategies.

How will Directorates be supported in key programmes of work?
Clear links to the Service Improvement Team providing flexible project support to key strategic projects operating as our own internal service improvement resource.

How will teams and individuals know what part they can play in this journey
Everyone will be able to see how the work they do contributes to achieving our vision and four ambitions through clear objectives and regular 1 to 1s with their team manager.

Our Values
Service Teamwork Ambition Respect
Our commitments to our staff

As an organisation, we are fortunate to have a highly skilled and motivated workforce, who will be at the heart of delivering our strategy and vision. We have worked with staff to develop a People Strategy setting out how greatest asset - our staff – will help us meet future challenges to deliver this plan and the support staff can expect in return.

Our commitments are:

- To have the right people
- To listen to our people
- To empower our people
- To look after our people
- To develop our people
- To lead our people
Working in partnership to achieve our ambitions

As the world changes more quickly around us, we will need to adopt new innovative ways of delivering care and work with our partners in primary and social care and academic and voluntary sectors. By combining our strengths and expertise, we will be best placed to tackle the challenges of the future. The challenges we face cannot be solved alone.

We are making good progress in being an active partner bringing together new ideas and solutions for how we can work together. For example, we have productive relationships with our partners across Wiltshire with close working relationships with Clinical Commissioning Groups and Local Authorities. However, we recognise there is still more we can do and we will be focusing on strengthening how we work with our partners locally.

We are reshaping our own services to match the priorities and the structure of the new commissioners and are investing heavily in transforming our Neighbourhood Teams to provide more consistent and joined up care for patients.

Appointing Care Coordinators in the community provides us with the capacity and skill to bring care closer to the patient and contribute towards redesigning how the various sectors work together in the interest of patients.

Our vision states an important ambition – to empower people to lead independent and healthier lives. This means shifting from managing illness to supporting health and wellbeing. Not only will this require us to work closely with our Local Authorities as the bodies responsible for public health, it also means people themselves will need to take more responsibility and we aim to give them the tools to support them in doing that.

We believe we have firm foundations which will enable us to be an early adopter of innovation and new ways of working supporting us to deliver our strategic ambitions and achieve our vision.

Our five year plan provides us with a clear roadmap for how we will continue to deliver the highest standards of care for all our patients and provide excellent patient experience.
Strategic alignment

Our five year plan is designed to deliver what we know we need to do to improve services for patients and support our commissioners and key partners objectives.

<table>
<thead>
<tr>
<th>Swindon CCG ambitions</th>
<th>Wiltshire CCG design principles</th>
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</thead>
<tbody>
<tr>
<td>Saving lives and securing additional years of life</td>
<td>Support and sustain independent healthy living</td>
</tr>
<tr>
<td>Improving the health and equality of life for those with long term conditions</td>
<td>Care should be delivered in the most appropriate setting – wherever possible at or close to home – where care is ongoing (eg chronic condition, the default setting of care should be primary care)</td>
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<tr>
<td></td>
<td>Where acute care is one-off or infrequent, there should be formal and rapid discharge</td>
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<tr>
<td>Out of hospital care avoiding hospital care and reducing time spent in hospital</td>
<td>People encouraged and supported to take responsibility for, and to maintain/ enhance their wellbeing</td>
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<tr>
<td>Increasing those living independently following discharge from hospital</td>
<td>Equitable access to a high quality and affordable system, which delivers the best outcomes for the greatest number</td>
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<tr>
<td>Increasing number with mental and physical conditions having a positive experience of hospital care</td>
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<tr>
<td>Increasing number with mental and physical conditions having a positive experience of out of hospital and primary care</td>
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<tr>
<td>Reducing avoidable deaths</td>
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<td>Reducing health inequalities</td>
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<td>Improving health</td>
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The Trust has identified key work streams that will enable us to achieve our vision and strategic ambitions which include:

- Seven day working
- Work to improve patient flow which includes programmes to help achieve the four hour Emergency Department target; support early discharge; review the number of beds and their location and improve Electronic Discharge Summaries.
- Work to support frail elderly people which includes programmes for dementia, falls, end of life and community mental health
- Work to review and improve pathways including heart failure, stroke, musculoskeletal, diabetes, COPD and surgery.
<table>
<thead>
<tr>
<th>Priorities</th>
<th>Swindon CCG</th>
<th>Wiltshire CCG</th>
<th>Priority 1</th>
<th>Priority 2</th>
<th>Priority 3</th>
<th>Priority 4</th>
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<tbody>
<tr>
<td></td>
<td>Priorities</td>
<td></td>
<td>We will make our patients the focus of everything we do</td>
<td>We will work smarter not harder</td>
<td>We will innovate and identify new ways of working</td>
<td>We will build capacity and capability by investing in our staff, infrastructure and partnerships</td>
</tr>
<tr>
<td>Cancer and End of Life care</td>
<td>End of life</td>
<td>Cancer services redesign – seven day working on day therapy to increase capacity, five day mobile chemotherapy, expansion of breast screening, chemotherapy manufacturing in pharmacy and homecare, radiotherapy</td>
<td>End of Life and Palliative care review</td>
<td>Palliative care consultant sessions</td>
<td>Cancer care in the community</td>
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<td>Carer support</td>
<td></td>
<td>Meet and greet service to support dementia patients and their carers</td>
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<tr>
<td>Children</td>
<td>Children and Young People</td>
<td>Review of acute Children’s service – inpatient beds, children’s day area and Special Care Baby Unit (SCBU) to rationalise space and create a high dependency unit.</td>
<td>Extend working day and consultant cover</td>
<td>Integrate community and hospital services where possible</td>
<td>New IT system for children’s services in the community</td>
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<tr>
<td>Dementia, mental health and learning disability services</td>
<td>Elderly</td>
<td>Dementia – refurbishing areas to ensure they are equipped to support patients with dementia, introducing a meet and greet service in outpatients for dementia patients and their carers, ensuring patients are not moved unless necessary and providing activities if they are an inpatient, creating dementia friendly wards that have specially trained staff and equipment for caring for dementia patients</td>
<td>Falls services</td>
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<tr>
<td>Diabetes</td>
<td>Long term conditions – diabetes</td>
<td>Expand community diabetes, offer care closer to home, reduce admissions to hospital, provide specialist nursing care to reduce length of stay and diabetic complications</td>
<td>Early identification of diabetes with appropriate access to intervention, education and specialist, secondary care services.</td>
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<tr>
<td>Long term conditions – heart failure and diabetes</td>
<td>Optimising the existing community teams</td>
<td>Outpatient antibiotic therapy</td>
<td>Seven day Critical Care Outreach</td>
<td>Develop nurse/therapist teams and specialist teams and services in each Wiltshire locality</td>
<td>Specialist clinics in the community for long term conditions</td>
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<tr>
<td>Life long health planning</td>
<td></td>
<td>Telehealth and virtual health clinics</td>
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<td>Online support</td>
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<td>Self care and prevention</td>
<td>Working age adults</td>
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<td>E-prescribing, e-requesting</td>
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<td>Self help support for people with long term conditions</td>
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<td></td>
<td>Introduce self administration of drugs following successful trials</td>
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<tr>
<th>Urgent care</th>
<th>Urgent care – review pathway design and alignment of system</th>
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<tr>
<td></td>
<td>Seven day working with consultant presence per specialty</td>
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<td></td>
<td>Allied Health Professional seven day intervention and discharge</td>
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<td>Expansion of surgical discharge lounge at Great Western Hospital</td>
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<th>Rapid response</th>
<th>Expand Surgical Assessment Unit</th>
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<tr>
<td></td>
<td>Creation of a wound unit</td>
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<td>Review of Day Surgery Unit and 23 hour length of stay</td>
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<th>Early supported discharge</th>
<th>Discharge as soon as medically fit</th>
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<td>Night sitting service</td>
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<td>Seven day discharge – admission and discharge a combined process</td>
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<td></td>
<td>Nurse/therapist discharge</td>
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<td>Develop in-reach mode for frail/elderly</td>
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<tr>
<th>Planned care pathways – musculoskeletal</th>
<th>Therapies integrated care – based in community with inreach to acute for example new MSK model</th>
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<td>Continue to develop enhanced recovery, advice lines, supported discharge and reviews from hub</td>
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<tr>
<th>Develop and implement new model of care</th>
<th>Seven day working in physiotherapy, phlebotomy and pharmacy to support discharge</th>
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<tr>
<td></td>
<td>Seven day Trauma Coordinator</td>
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<td>Teledermatology for primary care – electronic images sent by GPs for virtual advice and guidance from Consultants</td>
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<td></td>
<td>Develop gynaecology hub – centre of excellence for women</td>
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