HEALTHY PEOPLE
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in healthy communities

Eastern Devon

NHS
Northern, Eastern and Western Devon
Clinical Commissioning Group

Transforming Community Services:

Proposed Commissioning Intentions for the Eastern Locality

Pathways for the future

'Photo by Lewis Clarke'

Foreword

To commission new models of care that promote early intervention, self-care and high quality care at home (our ambition)

Community health services are services that take place in people's homes or other local healthcare settings. As clinical commissioning leads we understand the need for services outside of hospital and we know these services are highly valued by patients, their carers and the health and social care professionals working in them. However, it is widely acknowledged that the demographic changes expected in the Eastern Locality over the next five years will result in increased demands on community services. We need to prepare for this so that these important services remain strong, safe, equitable and sustainable in the long term.

The Eastern Locality is part of the Northern, Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG). The locality has a population of c380,800 and is represented by four sub-localities: Exeter, Mid Devon, WEB (Woodbury, Exmouth and Budleigh) and Wakley (Axminster, Seaton, Sidmouth, Honiton and Ottery St Mary). Sub localities are smaller populations within the Eastern Locality where care is tailored to ensure it meets their different needs. The NEW Devon CCG is a membership organisation of general practices of Devon. In the Eastern Locality we have 52 member practices, each of which has a clinical commissioning lead with responsibility for commissioning. We have engaged these clinical commissioning leads in the development of these proposals and maintain a regular dialogue with them.

We have also spent a lot of time engaging with our local populations to understand what is important to them in their community. We have also worked with public health to understand the local needs of the community. We now need to make some plans for the future based on agreed principles set out in our CCG strategy. We are aware that resources are currently spent on our community services in a way that leads to inequity of service across the locality. We intend to commission services for the future in a way that will reduce these inequalities for our patients and that will achieve equity of outcomes for patients across all of our sub-localities.

Within the pathways that we have described we have addressed the CCGs six priorities – Helping people to stay well; integrate care; personalise support; co-ordinate pathways; think carer, think family and home as the first choice. (Appendix1)

We already have some excellent examples of innovative practice in local community services that are making a difference now. The commissioning proposals we set out in this document are based on examples of the learning and successes available in some areas across the locality. We would welcome your views on these proposals.

Thank you

Dr David Jenner	Eastern Locality GP Chair / Mid Devon Sub-Locality Chair
Dr Alex Degan	Mid Devon Sub-Locality Vice Chair
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Dr Tom Debenham	Woodbury, Exmouth and Budleigh (WEB) Chair
Dr Rick Mejzner	WEB Sub-Locality Vice Chair
Mrs Gillian Champion	Exeter Sub-Locality Co-Chair
Dr Rob Turner	Exeter Sub-Locality Co-Chair
Dr Simon Kerr	Eastern Locality GP Vice Chair / Wakley sub locality Chair
Dr Mike Slot	Wakley Sub-Locality Vice Chair

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Aim of the document

The aim of this document is to share our proposals for delivering care in the future. We have worked with public health information to incorporate knowledge about the population's specific needs, how the population may change over the forthcoming years. We have also listened to community views and taken into account evidence and national policy to inform how we plan for tomorrow, not just today.

We aim to describe a model where community healthcare is more closely integrated with social care. We must have a greater focus on health promotion and ill health prevention, where more resources are shifted from traditionally acute services into modern, efficient community services.

We are also sharing some of the work undertaken with the NHS providers of healthcare in the county with the CCG on the financial position. We are identified as one of the most financially challenged communities in the country and what is clear is that the cost of the current service we provide is not affordable now and the gap will become greater over time. This is not a good position to be in and creates a risk of short term solutions and rapid changes to healthcare which are not tested or planned fully.

We set out our commissioning proposals in line with our CCG strategic framework in four main areas of care and welcome your views.

The over-arching NEW Devon CCG "Integrated, personal and sustainable: Community services for the 21st Century" document is split into four categories shown in the table below. Each of the areas details a tailored approach to best meet the health needs of the population and deliver quality, effective and efficient care. The Eastern Locality commissioning intentions address these as follows:

Category	Service
Pathways for people with complex health needs	Range of community hospital and community services to support people with complex health needs such as multiple long term conditions, frailty or disability with a new co-ordinated pathway design from pro-active care through crisis responses and to ongoing care. **This is covered in Section 1 of the document.**
Preventive and personalised support	Community services designed to help people who are older, frail or otherwise have complex health needs to remain well, support them to recover and enable them to have choice and control of their own care through a new model and design of services. **This is covered in Section 3 of the document.**
Urgent care in the community	Urgent minor injury and illness services to a new design that will achieve consistent, quality, resilient and networked urgent care in line with the requirements of the recent Keogh report. This new system design aims to listen to, see or treat people in the right setting. **This is covered in Section 4 of the document.**
Community specialty services	Subject to a separate review

1) Pathways for Adults with Complex Needs

What you said: "Access to care closer to home"

1.1 Introduction:

Increasing numbers of older people and some younger people have one or more conditions that are affecting their health and ability to live independently. In some cases the conditions that people present with are interconnected, but many are not, and this can be complicated further by an increasing general frailty and cognitive impairment from dementia. Patients and their carers have told us that services too often focus on an individual condition rather than the individual person. Continuing to commission services that focus on individual conditions rather than individuals themselves can lead to fragmented, poorly coordinated care, which is inefficient, ineffective and delivers a poorer patient experience. The importance of joined up care is one of the most consistent messages we have received from patients, carers and communities.

In order to address these issues we have therefore designed a pathway for adults with complex needs. The pathway runs from prevention to rehabilitation, recognising the need for integration and co-ordination of relevant services. It will consist of three key parts; proactive care including comprehensive assessment, crisis management and rehabilitation following crisis which are set out below:

Prevention: These services will be based in and integrated within the community. They will include promotion of health and wellbeing, maintenance of independence and prevention of ill-health or further deterioration of health where possible. The services will identify those at high risk of crisis and ensure that the appropriate services and interventions are put in place for them. Examples of these interventions include care planning and timely assessment by appropriate professionals. The services will also include the management of long term conditions and promotion of awareness and self-management.

Crisis: Where an individual has been identified as being at risk of admission due to functional decline, services will be put in place to allow the patient to stay at home if it is safe to do so.

Rehabilitation: These services will enable return to maximum health and function as well as support to carers. This will include services to make rapid discharge from the crisis episode.

1.2 What are the benefits to the patients, carers, local community and health economy?

Local outcomes

- A high quality, sustainable service that will integrate with the community and other services that will support patients and all members of the community with their health needs.
- Consistent use of frailty assessments will be used to identify patients at risk and in need of intervention.
- More patients will be cared for in their own homes, or normal place of residence, with community support.
- A 7 day service for those that need it.
- There will be fewer delays.
- Patients nearing the end of their life will be given the opportunity to choose their preferred place of death.
- The service will empower carers to support their family members.

Our ambition for patients is that they will:

- Have the right resources and information to look after their own health in the community.
- Have a personalised health plan with achievable and measurable goals.
- Be well managed in the community and experience a seamless pathway of care between community services.

- Receive their care closer to home and have the opportunity, where appropriate, to be cared for within their own homes.
- Be supported in the community to manage their health and wellbeing to prevent a crisis, during a crisis and following any crisis that may arise.
- Receive care as and when required and not experience a duplication of assessment or care from multiple organisations or healthcare professionals.
- Be cared for by competent and informed staff that understand their needs and will offer continuity of care throughout a period of illness.

Our ambition for the community is that they will:

- Have assurance their families and friends are cared for close to their local community.
- Receive support for carers and families and the provision of respite in a familiar and accessible place.

1.3 Current Services:

These services are currently provided differently across the locality and there are differences in waiting times and access to professionals.

1.4 What do we propose to commission?

An integrated pathway for adults that has the right professionals available at the right time to provide care for people (predominantly elderly) who have a set of identified needs. The service will be a clinically led multi-disciplinary team which will plan and deliver care. GPs will have the ability to shape and influence each aspect of the service and the team will include GPs, mental health, palliative care and specialist geriatrician input where appropriate. The service will run 7 days a week working to meet demand within available resources.

The service would include responsibility for educating the wider health and social care community, staff training and will provide support to manage risk and prioritise work. It will include care homes, residential homes and domiciliary providers. It will be able to facilitate learning needs across the system and contribute to the delivery of this education.

2) Inpatient Care

What you said: "Bring more care out of large hospitals and into community settings"

2.1 Introduction:

Presently in the Eastern Locality we have 12 community hospitals. There are 174 beds across 10 inpatient units. In two communities, Budleigh Salterton and Moretonhampstead, we have been working actively with the support of local communities and plans are now in place for both of these units to be developed into health and wellbeing hubs, without inpatient beds. These hubs will bring health (including mental health) and social care with the voluntary and commercial sector to provide services for the community in a much more joined up way than has previously been possible.

There is significant variation between towns in the need for, and provision of, inpatient care. The current configuration of both hospitals and beds is uneconomical, unsustainable and does not optimise patient safety and quality. In addition, it does not enable the development of inpatient services in the community that will help to avoid more admissions to acute hospitals. The current configuration also causes issues with staffing resilience, especially in very rural units. These issues make the inpatient services comparatively expensive, inefficient and contribute to extended stays in community hospitals.

We commission 15 community stroke beds (across Crediton and Exmouth) – over the past 2 years extensive work has been carried out with stroke patients, communities and our local provider organisations to agree the best pathway for stroke patients. As a result of this work we will consolidate stroke beds in Exeter and introduce early supported discharge for all stroke patients.

Patients are admitted to community hospitals either directly by their GP or by transfer from the acute hospitals (for example the Royal Devon and Exeter). As clinicians, our patients frequently tell us of their wish to be cared for at home during periods of illness. National evidence also demonstrates that people are more likely to achieve their rehabilitation potential if cared for appropriately at home. If we are to look after more people at home we need to increase the numbers of nurses, therapists and carers working in the community. To increase the capacity of our community teams in this way will require a fundamental change to the way in which we spend NHS monies in the Eastern Locality – we will need to spend less on inpatient beds and more on enhanced community services.

We believe our adults with complex needs pathway will reduce the number of people who will need admission or transfer to a community hospital. The pathway will also reduce the length of time people spend in a community or acute hospital. When we are confident that the number of people requiring a community hospital bed has reduced we will reduce the total number of community beds we commission.

However, as a first step to release some money and ensure the hospitals we commission offer optimum safety and efficiency we will not make any significant bed reductions but we will concentrate inpatient beds on to fewer hospital sites.

Our recent audits of people in our inpatient beds indicate that approximately 20% of patients in community inpatient beds could be cared for differently in the community with the appropriate therapy, health and social care support. These audits, which have been carried out by local GPs, also indicate that up to 50% of people in community inpatient beds do not require medical oversight. We know from this that there is potential to look after people differently in the locality. Looking after people at home will demand more from our community teams. Our commissioning intentions: to first consolidate our inpatient beds and develop our community teams before reducing our bedded capacity more significantly will allow us to move to the new model of care we describe only when we are assured that we have reduced our dependency on beds.

2.2 What are the benefits to the patients, carers, local community and health economy?

Pilot projects in community rehabilitation and recuperation for vulnerable elderly patients have demonstrated significant improvements in recovery time and patient and carer satisfaction compared to traditional care models. Currently there are several units in the Eastern Locality that have mean bed occupancy rates of less than 90%. Clinical studies have shown that bed occupancies above 90% adversely affect safe, effective hospital function and may be associated with increased risk of hospital acquired

infection. Our goal is to utilise the benefits of multidisciplinary team working to allow us to achieve safe, sustainable bed occupancy rates while optimizing patient pathways.

Our aim is to provide community inpatient beds in units that focus on helping individual patients regain maximum health and independence. Having larger teams working in inpatient units in close cooperation with community teams will allow efficient team working with a greater emphasis on early assessment and management of individual care needs and personalised rehabilitation programs. The combination of safe and sustainable bed occupancy rates in units with well-resourced rehabilitation teams will ensure that patients spend only as much time as they need to in hospital, and return to their communities as soon as they feel able.

Making more efficient use of multidisciplinary teams in this way will also allow closer integration with primary care and community nursing teams.

2.3 Current Services:

Presently in the Eastern Locality we have 12 community hospitals. There are 174 beds across 10 inpatient units including stroke beds. In two communities, Budleigh Salterton and Moretonhampstead, we have been working actively with the support of local communities and plans are now in place for both of these units to be developed into health and wellbeing hubs, without inpatient beds. There are currently inpatient beds in the following hospitals

- Exeter Community Hospital
- Exmouth
- Tiverton
- Crediton
- Okehampton
- Axminster
- Seaton
- Sidmouth
- Ottery St Mary
- Honiton

2.4 What do we propose to commission?

- The same number of hospital buildings. All community hospitals have an important role although their roles may be different from now.

- No significant bed reductions until we are confident that our community services can look after people at home or as close to home as possible.

- Sufficient community inpatient beds to provide capacity to manage the same number of patients being admitted to hospital as in the previous financial year.

- Concentrate the community inpatient services we commission on fewer hospital sites to optimise quality, safety and efficiency. This will mean there will be no material reduction in bed numbers at the present time.

- Our hospitals will work for patients from a wider geographical area than previously, i.e. they would serve patients across a sub-locality rather than just from their immediate vicinity.

- Robust discharge planning from the point of admission in larger well-resourced multidisciplinary teams. These teams will be led by experienced clinical managers with expertise in reablement and will result in all units achieving or exceeding the current best performance in length of stay.

- Increased capacity in community teams to enable patients to be cared for at home where appropriate.

- Inpatient units with the flexibility to expand provision to cope with the seasonal pressures would be in Exeter, Exmouth, Tiverton, Okehampton, Seaton, Sidmouth and Honiton. This is in addition to other hospital based services.

- We propose the remaining units would have alternative services to inpatient beds and could include outpatient clinics, health and wellbeing hubs or other services subject to local need and discussion with communities. The hospitals without inpatient beds would be Crediton, Axminster and Ottery St Mary. Already in Budleigh Salterton and Moretonhampstead we are actively working with the communities in the development of new health and wellbeing hubs as an alternative.

Through a series of stakeholder events over the next 12 weeks, we will work with local clinicians, voluntary sector organisations and communities to explore options for services that could run from community hospitals that would no longer have inpatient beds. Some of these discussions have already started and we are exploring options, for example health and social care hubs, dementia day case assessment centres etc.

3) Prevention and well-being services

What you said: "High quality healthcare for the frail elderly pathway and a community focal point in the form of well-being centres"

3.1 Introduction:

Although our responsibility and commitment is to ensure quality healthcare for people of all ages, we also recognise we must take steps now to design services to meet the needs of the growing elderly population and their carers. Clinical evidence tells us that there should be greater focus on prevention and a pro-active approach to enhancing and sustaining health and wellbeing for older people. We also know from our engagement with communities so far that this is what older people themselves would like. The King's Fund have produced considerable research into health and social care for older people and this work tells us that there is a need to find innovative ways to deliver high quality care. The research suggests there is a pressing need for more specialist skills within the community. It also recommends a focus on integration between health and social care services with multi- skilled staff that can work across boundaries between these sectors.

It is important that we help our patients to take responsibility for their own health by providing the right resources in the community to do this. In order to do this we must:

1) Recognise the importance of well-being and social engagement as crucial factors in health
2) Bring together primary care, social care, mental health services, the voluntary sector and community services more readily
3) Empower communities to evolve services aligned to local needs
4) Ensure that all patients (including those in very rural areas) have the ability to access high quality inpatient and urgent care services not too far from where they live
5) Commission services around the needs of the individual/s.

3.2 Use of Community assets

We want to use this opportunity to encourage a different way of using our community assets (hospitals) by allowing the voluntary sector, social care providers and commercial organisations (where they add value) to use these assets alongside our core health services.

Examples of such additional uses include;

- Access to information and advice
- Cafes/bistros which could also be the venue for people to meet, including dementia cafes
- Internet cafe/shop/hairdresser/cinema
- Mother and toddler groups
- Private rooms - for confidential matters
- Voluntary Sector Services such as hospice care, services for the elderly etc.
- Fitness (gym) / meeting rooms (bookable for local community groups)
- Adult education groups
- Peer support groups/learning cafes
- Health promotion events with local agencies such as fire service and home safety assessments
- Signposting to other services
- Dementia support services
- Day activities (more formal day care may feature where there is a demand which could be in partnership with the voluntary sector)

We will explore the concept of health and wellbeing to promote prevention and wellbeing and we will promote networks to support integration and empower communities to lead these and use existing assets.

3.3 What are the benefits to the patients, carers, local community and health economy?

We expect the following benefits to the local communities and the health and social care system;

- Services will integrate with the community and other services that will support people and all members of the community with their health needs
- People that are identified as at risk will be supported to remain at home
- Greater range of opportunities for patients to be cared for in the community
- All people will be given the opportunity to be cared for at home by competent, reliable, stable staff
- Service users will be offered care 7 days a week when needed
- No delays in people's care as they move from one service to another
- We will be better able to take into account people's wishes regarding their place of death
- People will experience a seamless pathway of care between services
- Have assurance their families and friends are cared for, as appropriate, close to their local community enabling carers, family and friends to care and support patients at any time and within easy access
- Receive support for carers and families and the provision of respite in a familiar and accessible place

We will test the concept in the areas of early development and base the learning from these to develop further. It is our ambition that communities will lead the development of these and they will become self-sustaining.

3.4 Current Services:

There are currently no integrated health and wellbeing hubs in any of the community hospitals. Hubs are in development in Budleigh Salterton and Moretonhampstead and there are early discussions about Crediton.

3.5 What do we propose to commission?

- Integrated services to support prevention and promotion of health and wellbeing based within communities.
- A range of community services to be based within the community including the adults with complex needs pathway consisting of proactive care including comprehensive assessment, crisis management and rehabilitation following crisis.

4) Urgent Care Services

What you said: "Travel a bit further to access an extended range of services that will be completed in one visit"

4.1 Introduction:

There are considerable differences between the Minor Injury Units (MIUs) and the two Walk in Centres (WiCs) within the Eastern Locality. The larger units see a greater range of clinical problems and are staffed by a larger pool of nurse practitioners. In smaller units there is variable access to diagnostics such as x-rays and challenging issues around maintaining clinical skills when very few patients are seen. Additionally, there has been variability in the opening hours of some of the MIUs/WiCs which has caused problems for patients who are unsure whether a unit is open. The present configuration of MIUs also creates difficulties in providing clinical cover for the units in cases of staff sickness. These issues, along with national guidance from the Keogh Review, have led the Eastern Locality to re-specify the way in which urgent care is delivered to our patients.

Our commissioning proposals hope to ensure that these services are aligned with other out of hours services such as ambulance services, out of hours GP services and rapid response services. Our proposals are in line with the Keogh report and aim

1. To provide better support for self-care.
2. To help people with urgent care needs get the right advice in the right place, first time.
3. To provide highly responsive urgent care services outside of hospital, so people no longer choose to queue in A&E.
4. To ensure that those people with serious or life-threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery.
5. To connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.

4.2 What are the benefits to the patients, carers, local community and health economy?

- Patients will receive a clinical assessment within 30 minutes for adults, 15 minutes for children.
- Patients requiring transfer to the accident and emergency (A&E) department will be seen within 60 minutes of arriving at the emergency department.
- A summary of care provided will be communicated to a patient's GP by 08:00 the next working day.

4.3 Current Service:

- Minor Injury Units in: Honiton, Ottery St Mary, Sidmouth, Exmouth, Okehampton, Tiverton
- Urgent Care Centre in Tiverton
- Walk in Centres in Exeter (Sidwell Street and RD&E Hospital site)

4.4 What do we propose to commission?

- Urgent Care Centres in Exmouth, Tiverton, Honiton and Exeter that are able to offer a wider range of care – reducing the need for onward referral to the RD&E
- A Minor Injury service will continue to be commissioned for Okehampton in view of its excessive distance from either an emergency department or planned urgent care centre
- Consistent opening hours. Our centres will open 8am–10pm, 7 days a week.
- Minor injury services in GP surgeries to a consistent specification where it makes sense to do so to ensure appropriate access.

5) Summary

5.1: Adults with complex needs services:

All communities would have access to a high quality, sustainable adults with complex needs service that will integrate with the community and other services and will support patients and all members of the community with their health needs. These services will run 24 hours a day, 7 days a week. Patients will have access to a named senior clinician and have personal care plans. Patients will be supported to remain independent and at home if they choose.

5.2: Inpatient Care:

We will commission inpatient units at a scale that guarantees clinical safety, efficiency and the flexibility to provide resilience and additional capacity during periods of increased demand. In the first instance we plan to consolidate the existing number of beds, without significant or material change in bed numbers, into bigger units in the following towns.

Mid Devon Sub-Locality:
- Tiverton
- Okehampton

Exeter Sub-Locality:
- Whipton (Exeter)

WEB Sub-Locality:
- Exmouth:

Wakley Sub-Locality:
- Honiton
- Seaton
- Sidmouth

We intend to use the flexibilities of the Better Care Fund to develop the capacity and capability of our community nursing, therapy and care teams over the next 12 months. This will allow patients who currently require community bed based care to be looked after at home or in other care settings. When we are confident that these services are in place we will reduce the number of beds and/or inpatient units accordingly.

5.3: Prevention and well-being services:

We will explore the concept of health and wellbeing to promote prevention and develop networks to support integration and empower communities to lead this and utilise existing assets.

Initially there will be needs based integrated health and wellbeing hubs in Budleigh Salterton, Moretonhampstead and Crediton, with a view to developing these in other areas.

5.4: Urgent care services:

- Nurse-led urgent care centres in Exeter, Exmouth, Tiverton and Honiton
- Minor Injury Service in Okehampton
- Primary care minor injury services

5.5: Stroke Services:

- We intend to commission stroke beds amalgamated on a single, central site in Exeter.
- There will be early support discharge services for the whole population of the Eastern Locality.
- Based on the pilot we have run we know the early supported discharge service will result in fewer stroke patients requiring hospital stays.

6) Continuing to involve you

We have been consistently impressed and pleased at the commitment of our communities to this work and the generosity of members of the public in giving their time and expertise to support and sometimes challenge us as we have developed our thinking. This has been seen both within the overall Transforming Community Services Programme with regard to individual locality and community schemes. We have a great deal of information from this prior engagement that we will continue to use in this phase of the programme. We are now involving and consulting with you over a twelve week period until 12th December 2014 to hear your views on our proposals.

7) How to contact us

Find us on the internet: NEW Devon CCG Website, Eastern Locality page:
http://www.newdevonccg.nhs.uk/eastern
Speak to us: 01392 356 082
Email us: D-CCG.EasternLocality@nhs.net
Write to us: Eastern Locality, Newcourt House, Old Rydon Lane, Exeter, EX2 7JU

We hope you will continue to support this work and engage with us as we work on the next steps and develop our proposals and implementation plans for the years ahead.

For more details on the CCG's processes for Transforming Community Services please see the following webpage: http://www.newdevonccg.nhs.uk/get-involved/get-involved/community-services/101039

8) Supporting Information available on request

1	Six Strategic Priorities (Attached)	NEW Devon CCG
2	Review of current bed configuration in the Eastern Locality – Bed Modelling	Dr. Rob Daniels (GP, Wakley)
3	Scope for moving acute care of frail elderly from the RD&E into the community	Dr. Jennie Bee
4	Urgent Care Centre Specification	Dr. Justin Geddes / Susan Cutting
5	Clinical Commissioning Group TCS Strategic Framework and engagement summary report	Clinical Commissioning Group
6	Eastern Locality Engagement Report	Eastern Locality
7	Joint Strategic Needs Assessment	Public Health
8	Wakley acuity audit July 2014	Northern Devon Healthcare Trust / CCG
9	Transforming Urgent and Emergency Care Services in England: http://www.nhs.uk/NHSEngland/keogh-review/Documents/uecreviewupdate.FV.pdf	NHS England Urgent and Emergency Care Review Team
10	The King's Fund - Ideas that change health care http://www.kingsfund.org.uk	The King's Fund
11	Devon Health and Wellbeing Scrutiny Committee Community Hospitals Task Group Report	Devon Overview and Scrutiny
12	NEW Devon CCG Case for Change Document	NEW Devon CCG

Appendix 1: Six Strategic Priorities:
The six strategic priorities based on discussion with stakeholders reflect the need for strategic shifts in the way we commission services, deploy resources, and design care to deliver the vision, principles, quality and outcomes described above.

Help people to stay well
From a primary focus on caring we would expect the emphasis to move towards prevention, self-management and early help recognising the importance of information and positive approaches, in particular helping older people remain well where possible.

Our pathway design for adults with complex needs addresses, this including the important role of community services in promoting wellbeing.

Integrate care
Services that are co-ordinated and integrated and that remove and minimise organisational boundaries should be a central feature for future services. The importance of services being wrapped around individuals and their families has been stressed time and again.

Our work with local authorities to strengthen integration is progressing rapidly. In addition this strategic framework emphasises the importance of integration with other services.

Personalise support
Personalisation, choice and control over areas such as personal health budgets, information, education and self-management support are all important. Personalisation is much more than personal health budgets and we need to develop a model of care that is designed for individuals.

We have tested views in a number of discussions and as a result this strategic framework increases the emphasis on flexible approaches to supporting individuals.

Co-ordinate pathways
The importance of pathway based approaches to care with co-ordination through prevention to crisis and ongoing care has been identified time and again, with a particular emphasis based on the natural flows of patients.

In addition to addressing the role of prevention, the work on pathways includes responses to crisis and ongoing care and evaluation.

Think carer think family
The key role of carers and the need to support carers' health and wellbeing in addition to that of patients and the population, to achieve mainstream services that are carer aware are especially important as more services are focused in people's homes and in the community.

The important learning from carers is central to implementation of the strategic framework and the Carers Strategy work and continued links will guide community services.

Home as the first choice
The growing understanding of the need to shift the emphasis to fewer beds but with a greater number of more personalised and responsive care packages at home is now indicating a clear impetus to achieve this at the earliest opportunity.

Getting the right balance of care is central to this strategic framework and will be the subject of ongoing engagement in both the planning and evaluation of services.