Theme	Six Priority Projects Four supporting strategies	Planned Service Developments	Outcomes/Benefits
Healthy independent lives	**Project: Health Coaching** Roll out of training in health coaching techniques to front line community clinicians.	Support the establishment of more clubs and group sessions Agree priority prevention themes and use of advice and guidance information	• All community staff using health coaching • Promotion of healthy lifestyle = increased self care • Group support reduces isolation
A service for primary care	**Project: Musculo-skeletal Physiotherapy** Increased availability of physiotherapy assessment and treatment in the community	Integrated working between community and practice nursing Named contacts for specialist advice Strengthen delivery links with voluntary sector	• Reduction in MSK secondary care referrals • Closer working between community and practice nursing
Higher intensity care	**Project: Higher Intensity Care** Increasing the capacity and capability of blended teams of community geriatricians, other medical resource specialists and general nursing to offer a higher intensity of care	Roll out of Rockwood Frailty scoring across core community teams (linked to CQUIN)	• Reduced hospital admissions • More people managed intensively in own home • Consistent use of Rockwood frailty scoring • Comprehensive Geriatric Assessments
Community based urgent care	**Project: Design and development of Urgent Care Centres** Developing and agreeing a design for local urgent care centres		• Closer alignment with urgent primary care • Strong links designed between Urgent Care Centres and 'link' EDs
Leading the way	**Project: Mobile Working** Making full use of hardware, software and redesigning administrative process to support our mobile workforce **IT Strategy** To be developed during 2016/17, setting the direction for use of technology	Option appraisal for new telephone systems to support service delivery Scheduling of Core Community team workload moved onto SystmOne.	• Shared clinical records in real time • Reduced duplication of assessment • Reduced clinical risk relating to handover between teams • Increased efficiency in core community teams
Best practice: normal practice	**Project: Stroke Early Supported Discharge** Development of an ESD service for Wiltshire, run from two hubs (North and South) **Quality strategy** Setting out priorities for Wiltshire Health and Care's quality focus	Care coordination for people with LD and long term conditions (linked to CQUIN)	• Increased stroke rehabilitation and recovery in own home • Decreased inpatient length of stay • Improved individual outcomes • Supported access to health care for those with Learning Disability
Broadening Skills	**Workforce Strategy** A skills plan, linked to training and development plans.	Diabetes services: • review of pathways in South with SFT; • Working with CCG to address no provision in East Strengthen geographic link between specialist advice and local populations Boost knowledge and expertise of mental health issues, incl. dementia	Broadened general skills help control demand for specialist resource
More for your money	**Estates Strategy** Use of estates, shrinking the footprint	Development of productivity metrics Use of new compression therapy across Wiltshire Re-tendering of orthotics contract	Improved ability to track productivity improvements Efficiency opportunities related to estates identified.