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Notice of Meeting

Health and Wellbeing Board

Thursday, 27th March 2014 at 9.00am

in Council Chamber Council Offices
Market Street Newbury

Date of despatch of Agenda: Wednesday, 19 March 2014

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Jessica Bailiss on (01635) 503124
e-mail: jbailiss@westberks.gov.uk

Further information and Minutes are also available on the Council's website at www.westberks.gov.uk

West Berkshire COUNCIL

To: Dr Bal Bahia (Newbury and District CCG), Adrian Barker (Healthwatch), Leila Ferguson (Empowering West Berkshire), Councillor Marcus Franks (Health and Well Being), Dr Lise Llewellyn (Public Health), Councillor Gordon Lundie (Leader of Council & Conservative Group Leader), Councillor Gwen Mason, Councillor Graham Pask, Rachael Wardell (WBC - Community Services), Councillor Quentin Webb and Dr Rupert Woolley (North and West Reading CCG)

Also to: John Ashworth (WBC - Environment), Jessica Bailiss (WBC - Executive Support), Nick Carter (WBC - Chief Executive), Andy Day (WBC - Strategic Support), Balwinder Kaur (WBC - Adult Social Care), Matthew Tait (NHS Commissioning Board), Cathy Winfield (Berkshire West CCGs) and Lesley Wyman (WBC - Public Health & Wellbeing)

Agenda

Part I

			Page No.
9.00 am	1	**Apologies for Absence** To receive apologies for inability to attend the meeting (if any).	
9.02 am	2	**Minutes** To approve as a correct record the Minutes of the meeting of the Board held on 23 January and 6 February 2014.	1 - 12
9.07 am	3	**Declarations of Interest** To remind Members of the need to record the existence and nature of any Personal, Disclosable Pecuniary or other interests in items on the agenda, in accordance with the Members' Code of Conduct.	
9.10 am	4	**Public Questions** Members of the Executive to answer questions submitted by members of the public in accordance with the Executive Procedure Rules contained in the Council's Constitution.	

a **Question submitted by Mrs Pearl Baker to the Health and Wellbeing Board**

"1. How do the HWBB propose to implement the DOH 'closing the Gap' priorities for essential change in mental health including physical and mental health, so that more people have a positive experience of their care and support?

2. How do the HWBB propose to implement Mental Health Independent Advocacy as described in The Care Bill, particularly for those subject to a COP Order? This is to inform the patient of their rights to NHS choices of care and support, including a personal Budget, and ongoing support.

3. What monitoring process will be put in place to ensure the above?

4. Will the Board address the discharging of patients subject to Section 117 while still receiving care and treatment? Refer to the Care Bill Subsection 5.

5. Will the HWBB re-instate those patients discharged from section 117 still receiving care and treatment? Ref: The Local Government Ombudsman Report on Section 117 Discharge.

6. Will the HWBB look into why section 117 patients placed in 'specific' accommodation by the LA for their mental health needs, with a care and support package are being charged for this accommodation?

7. Will the Board address the GPs role into an integrated system of care?

8. Will the HWBB set up an email alert system on a number of Priority Topics, which would include mental health. This could also be advertised via the Monitor in GP Surgeries? I am a recipient of NHS England's Bulletins and other Parliamentary Committees Enquires and Meetings, one would have to originally subscribe by a 'password."

5 **Petitions**

Councillors or Members of the public may present any petition which they have received. These will normally be referred to the appropriate Committee without discussion.

9.15 am	6	**Joint Strategic Needs Assessment Report (Lesley Wyman)** *Purpose: To approve the Joint Strategic Needs Assessment for West Berkshire.*	13 - 16
9.30 am	7	**Newbury and District and North West Reading Clinical Commissioning Groups' Two Year Operational Plans (Philip Mcnamara and Dr Rupert Woolley)** *Purpose: to receive the CCGs' 2 year operational plans and assure alignment with the Health and Wellbeing Strategy.*	17 - 146

9.40 am	8	**Health and Wellbeing Performance Framework (Lesley Wyman)** *Purpose: To present the framework in its entirety to the Board.*	Verbal Report
9.55 am	9	**Better Care Fund update and next submission (Rachael Wardell)** *Purpose: To seek agreement to the final plan as to how the Better Care Fund pooled budget will be used.*	147 - 174
10.10 am	10	**The Urgent Care System (Cathy Winfield)** *Purpose: To inform the Board about the Urgent Care System.*	Verbal Report
10.25 am	11	**Pharmaceutical Needs assessment (Lise Llewellyn)** *Purpose: To outline the Health and Wellbeing Board's responsibilities and the programme of work to deliver these responsibilities.*	175 - 180
10.40 am	12	**Review of Children's Public Health Commissioning Opportunities (Lise Llewellyn)** *Purpose: To update the board on responsibilities and progress to review services.*	181 - 186
10.55 am	13	**Management of Charters (Lesley Wyman)** *Purpose: To agree a protocol for vulnerable groups.*	187 - 188
11.00 am	14	**Members' Question(s)** Members of the Executive to answer questions submitted by Councillors in accordance with the Executive Procedure Rules contained in the Council's Constitution.	
	a	**Question to be answered by the Health and Wellbeing Board submitted by Councillor Gwen Mason** *"Health and Wellbeing Boards have been established amongst other things to smooth the integration of health and social care. This makes the health landscape very complex and potentially confusing for the public and local community groups.* *Would the Health and Wellbeing Board agree that there is a need and agree to undertake a task of producing a "map" of local organisations which are involved in health and social care (including public health) so that it is clear where local people and groups go to seek information, advice and guidance."*	

15 **Future meeting dates**

15th May 2014
24 July 2014
25 September 2014
27 November 2014
22 January 2015
28 May 2015

Andy Day
Head of Strategic Support

If you require this information in a different format or translation, please contact Moira Fraser on telephone (01635) 519045.

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Note: These Minutes will remain DRAFT until approved at the next meeting of the Committee

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON THURSDAY, 23 JANUARY 2014

Present: Dr Bal Bahia (Newbury and District CCG), Councillor Marcus Franks (Health and Well Being), Heather Hunter (Healthwatch), Councillor Gordon Lundie (Leader of Council & Conservative Group Leader), Rachael Wardell (WBC - Community Services), Dr Rupert Woolley (North and West Reading CCG) and Lesley Wyman (WBC - Public Health & Wellbeing)

Also Present: Jessica Bailiss (WBC - Executive Support), Councillor Adrian Edwards, Councillor Mollie Lock, Councillor Gwen Mason, Philip McNamara, Sarah Mussett (NHS England - Thames Valley Team), Fatima Ndanusa (Public Health), April Peberdy (Public Health), Jon Shatford (Caremark), Martha Vickers (Healthwatch), Councillor Quentin Webb and Cathy Winfield (Berkshire West CCGs)

Apologies for inability to attend the meeting: Adrian Barker, Leila Ferguson and Dr Lise Llewellyn

PART I

68. Minutes

The Minutes of the meeting held on 28 November 2014 were approved as a true and correct record and signed by the Leader.

69. Declarations of Interest

Councillor Gordon Lundie declared an interest in all matters pertaining to Health and Wellbeing, by virtue of the fact that he was a director of the pharmaceutical company UCB, but reported that, as his interest was not personal, prejudicial or a disclosable pecuniary interest, he determined to remain to take part in the debate and vote on the matters where appropriate.

70. Public Questions

There were no public questions submitted, relating to items on this agenda.

71. Petitions

There were no petitions presented to the Board.

72. Forward Plan (Councillor Marcus Franks)

Councillor Marcus Franks drew Members attention to the forward plan, which had been circulated with the agenda. The aim of the forward plan was to help the agenda setting process. It would be publicly available. Councillor Franks urged all to think ahead and submit forward plan items to Jessica Bailiss.

RESOLVED that Members of the Board would send items to be placed on the forward plan to Jessica Bailiss.

The Health and Wellbeing Board was a meeting of the Executive and therefore agenda items needed to be placed onto the forward plan at least 28 working days (about six weeks) prior to the meeting where it would be considered.

Councillor Gordon Lundie referred to the refresh of the Health and Wellbeing Strategy and queried the process for this. Lesley Wyman stated that essentially input was required from other services on the refresh. The original Strategy only spanned two years. There were not yet plans in place to refresh the Strategy. An option would be to have a focused group of representatives working on the refresh. If this approach was taken, it would be important that the right people were on the group including a representative from Healthwatch and each of the relevant Council directorates. Lesley Wyman stated that she would be happy to lead the work if this approach was chosen by the Board.

Councillor Lundie highlighted that the Council had a three to five year financial strategy and that would be an election in 15 months time, therefore it would be helpful for the process to be established sooner rather than later.

Sarah Mussett noted item ten on the agenda, which would inform the Board of the planning timetable for the Clinical Commissioning Groups (CCGs) five year strategy. Sarah Mussett reported that two year plans were being submitted on the 4th April 2013 and five year plans on 20th June 2014. Councillor Lundie noted that a piece of work focusing on the refresh could take place from July to September.

73. Social and Emotional Wellbeing for Children and Young People (Rachael Wardell)

Rachael Wardell introduced her report, which aimed to make the Health and Wellbeing Board aware of issues around young people's emotional wellbeing and to initiate a strand of work to support improved emotional wellbeing as part of the health and social care integration.

In essence the report acknowledged issues around children and young people's emotional wellbeing and proposed a way forward. A West of Berkshire Children's Joint Commissioning Group had been established with the aim of looking at opportunities for joint working and commissioning around children's emotional health and wellbeing. The report proposed that the West of Berkshire Children's Joint Commissioning Group took the work strand forward on a west of Berkshire basis.

In December 2013 the report 'Overlooked and Forgotten' by the Children and Young People's Mental Health Coalition identified weaknesses around Children's Emotional Health and Wellbeing as a result of resource pressures and proposed that these be tackled jointly.

Sarah Mussett noted that CAMHS Tier 1 and Tier 2 services were highlighted in the report however, stated that Tier 4 was also a problem. Rachael Wardell confirmed that it was unlikely that this would form part of the discussions however locations would be looked at more closely to view this issue in more detail.

Councillor Gordon Lundie asked what the next step for the work would be. Rachael Wardell confirmed that if the Board were happy with the proposed approach she would go back to the Children's Joint Commissioning Group who would begin to move the work forward. Issues would require unpicking and then work would need to be developed accordingly. Rachael Wardell confirmed that concerns had been raised about the pathway however, at this stage it did not look like focus would be given to fleshing this out. Rachael Wardell highlighted that issues were shared and would be tackled collectively.

Sarah Mussett reported that Oxfordshire had their pathway right and therefore suggested that West Berkshire look at what its neighbours were doing.

Heather Hunter reported that a number of issues had been raised through their consultation with users around children's emotional health, particularly users who had

children in transition. Rachael Wardell reported that she had received feedback from Adrian Barker, who besides Healthwatch also represented the organisation Time2talk, regarding new literature that had been developed.

RESOLVED that Rachael Wardell would have the piece of work placed on the next agenda of the Children's Joint Commissioning Group and then would bring a proposal back to the Board by May 2014.

74. The Better Care Fund (Formally known as the Integrated Transformation Fund) (Cathy Winfield)

Cathy Winfield introduced her report which aimed to inform Members of the Health and Wellbeing Board about the Better Care Fund (BCF). Cathy Winfield reported that the BCF was originally known as the Integration Transformation Funding (ITF).

BCF plans offered the opportunity to transform local health and social care services and provide better integration care and support. It provided an opportunity to improve the lives of the most vulnerable providing them with better services, support and improved quality of life.

Guidance for the BCF had been published before Christmas 2013. The BCF included money that was originally designated as the Social Care Fund.

Berkshire West would receive about £270k in total and this was in line with what had been expected. Berkshire West CCGs had experienced a better growth than expected and therefore were able to transfer some money into the BCF. The whole of this budget could be spent on new projects. The Health and Wellbeing Board would have to decide how this money was spent prior to the deadline of 14th February 2014. Proposals would have to meet certain criteria, which in essence aimed to protect social care services. An informal meeting was planned to talk about the proposals.

Some of the BCF money would be allocated under a 'rewards for meeting goals' criteria. Money would be retained if the goals were not met and a recovery plan would need to be submitted as an initial step to releasing it. The spending round established six national conditions for accessing the fund:

- Plans to be jointly agreed.
- Protection for social care services (not spending)
- As part of agreed local plans, 7 day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.
- Better data sharing between health and social care, based on the NHS number.
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional.
- Agreement on the consequential impact of changes in the acute sector.

Councillor Gordon Lundie asked what the next steps were and Cathy Winfield reported that planning was underway for a special meeting of the Health and Wellbeing Board to take place on 6th February 2014, where proposals could be agreed.

Councillor Lundie questioned if any of the conditions in particular presented a challenge. Rachael Wardell explained that this depended on the success of plans. She was confident that there was a strong common understanding of what needed to be achieved. It was anticipated that there would be challenges around seven day working.

Councillor Graham Pask asked for clarification around targets and how they would be monitored. Cathy Winfield confirmed that targets set out under each of the conditions were detailed on page 20 of the agenda. There would be a requirement for the Health and Wellbeing Board to sign off plans. Plans would also go through an assurance process involving NHS England and the Local Government Association (LGA) to assure ministers.

RESOLVED that Cathy Winfield would being a paper to the next meeting on the urgent care system.

Sarah Mussett questioned to what degree the BCF would deliver around the urgent care agenda. Cathy Winfield felt this would largely be addressed during conversations about seven day working. Letters had been received by accountable officers from NHS England to plan a recovery for the urgent care system. It was vital that patient flow around the system was maintained.

75. Commissioning Intentions (Phil McNamara)

Phil Mcnamara gave a presentation to the Health and Wellbeing Board, which gave an overview of the process and timescales for the CCGs Commissioning Plans.

The key points of the presentation were:

- key items that had derived from the Call to Action events.
- Demands on Newbury and District identified through Call to Action were an ageing population, long terms conditions, urgent care and patient expectations.
- The local financial forecast showed demand increasing rapidly.
- Challenges identified related to the growth, included a requirement for £10.5 million efficiency savings having to be found.
- The main focus over the next five years would be prevention and early detection.
- The five year vision also identified the need for better integration between health and social services.
- There would be a move towards hospital at home services in order to reduce the pressure on Accident and Emergency Services.
- There was pressure for primary care to move to a 24/7 model.
- The five year vision included a proposal for an Urgent Care Unit at West Berkshire Community Hospital. The service would be open to anyone over 18 years of age however, would be focused on the frail and elderly.
- Operation plans had to be submitted by CCGs by 24th January 2014 however, there was a further deadline in June 2014. The CCG Operation Plan needed tying together with relevant plans within the Council.

Councillor Graham Pask thanked Phil Mcnamara for his presentation and in particular was pleased to hear about the proposed urgent care unit for Newbury. He asked how this service would reduce pressures on services already in place. Phil Mcnamara reported that this option was being considered due to financial tensions. The cost of people going to Accident and Emergency was very high and in certain cases it was more suitable for people to receive their care in a more appropriate setting.

Rachael Wardell expressed her support for the proposals highlighted in Newbury and District CCGs Vision for the next five years.

Lesley Wyman reported that there was a strong link between the CCG and the Public Health Team and it was assuring to know that the CCGs plans were based on the Joint Strategic Needs Assessment. Lesley Wyman stressed that it was vital that the focus on self care was even greater and people's ability to look after their own health and wellbeing. This should not just start later in life but during early childhood years to prevent issues later on in life.

Sarah Mussett stated that she looked forward to seeing greater detail on quality.

Councillor Gordon Lundie reported that in January a capped Drugs Bill had come into force, resulting in anything above 2% having to be paid by the industry. There was uncertainty about where this money was going and concern that it would not find its way back to the NHS and CCGs. Cathy Winfield reported that she was unable to comment on Councillor Lundie's specific example however, confirmed that there was a very high level of growth. The figures included in the presentation were presumptions only. If more people were cared for in their own homes in the future, present costs could be expected to rise. Councillor Lundie commented that it was unhelpful to be handed a cost with no funding associated.

RESOLVED that CCG colleagues noted the comments made by Councillor Lundie.

76. The Clinical Commissioning Group's Five Year Strategy (Cathy Winfield)

Cathy Winfield drew the Boards attention the table on page 30, which informed the Board of the planning timetable for the CCGs five year strategy.

The main theme was that there were numerous conditions that needed to addressed when developing the strategy. The strategy would be patient experience and outcome based. Largely it needed to close the £10million Quality Improvement Productivity Prevention (QIPP) gap. Planning could no longer take place at a single organisational level. Increasingly they were moving towards a whole system planning scenario.

Berkshire West had decided to group key messages under the three headings;

- Outer hospital setting – these often operated seven days per week,
- The urgent care system – this included 111; 999 and Accident and Emergency. These services needed to be grouped together to ensure people were routed correctively.
- Thinking was required around the implications on hospitals as how they currently operated would have to change.

Cathy Winfield stated that some acute hospitals were merging into partnerships, e.g. Heatherwood and Wexham Park and Frimley, The Oxford Hospital Trusts, but the Royal Berkshire Hospital was not going down this route and remained a small stand alone provision. It was likely that each speciality within hospitals would need reviewing.

Councillor Gordon Lundie noted that there should be a level of understanding through hospital business plans for example the one produced by the Royal Berkshire NHS Foundation Trust (RBFT), which the Board had been consulted on.

Cathy Winfield confirmed that the RBFT were now refreshing their business plan to ensure it aligned with the commissioning and financial aims of the NHS.

77. Performance Management Framework - Update on Progress (Lesley Wyman)

Lesley Wyman presented to the Board an overview of progress with the Performance Management Framework. The key points were as follows:

- The priorities within the Health and Wellbeing Strategy were closely linked to the Public Health Outcomes Framework (PHOF).
- The main difference between the Health and Wellbeing Strategy priorities and outcomes and the Public Health outcomes was that the Public Health outcomes Framework included major incidents and infectious diseases, whereas the H&WB Strategy subsumed these into supporting a vibrant district.
- For each priority Lesley Wyman reported that she had pulled out the key measurable indicators from the PHOF that could be reported on.
- The aim was to focus on outcomes rather than process.
- Additional key performance indicators to demonstrate ongoing progress towards the higher level PH outcomes would need to be added and these would come from the PH and Wellbeing Action Plan and the Council Service Plan.

Cathy Winfield suggested that a high level dash board of indicators be developed and reported on to the Board. A fewer number of indicators would mean greater focus could be given to each one.

Councillor Lundie felt that the Health and Wellbeing Board needed to have an overview of the whole system element.

RESOLVED that Lesley Wyman and Councillor Marcus Franks would have a discussion outside the Board meeting regarding the Performance Management Framework.

78. Quarterly Update Report from Healthwatch (Heather Hunter)

Heather Hunter introduced her quarterly update report from Healthwatch. An excellent level of data was being collected from grass roots level. The aim was to find out the views of services users.

Out of the feedback collected to date 74% was positive and 26% negative. The main areas of concern were around primary care services, maternity services (shortage of rather than quality of care), disability support, access to information and mental health.

Access to services had largely been a concern raised by younger people. As a result Healthwatch would be sending out surveys to capture further information on these concerns. Concerns relating to metal health services were largely from parents with children in transition either between schools or going from children's to adult's services.

Heather Hunter reported that the information Healthwatch had gathered was both qualitative and quantitative. In quarter four Healthwatch would begin building on this data. In the fourth quarter Healthwatch would also be establishing Healtwatch Champions, who would feed into an Advisory Board.

Heather Hunter compared Healthwatch findings to the areas of work prioritised by other sectors and stated the main outstanding difference was that there was no concern raised about the frail and elderly. This featured largely in CCG forward planning. Heather Hunter however, placed a caveat on the Healthwatch data as it only represented what users currently missed.

Dr Bal Bahia asked how Healthwatch were seeking views from the frail and elderly and it was confirmed that a group had been worked with that represented people in care

homes. It was confirmed that Healthwatch would soon look to visit day centres and numerous luncheon clubs. Councillor Gordon Lundie suggested re-ablement services also be included in future consultation around elderly services.

Rachael Wardel explained that there was a large difference between problems identified by users to those identified through the economy. The aim of Healthwatch was to ensure services heard the views of users and did not become solely focused on the system. Rachael Wardell expressed her interest in findings for children and young people, maternity and mental health services.

Cathy Winfield concurred with Rachael Wardell and stressed that a stronger direct link was required between Healthwatch and the CCGs.

RESOLVED that Heather Hunter bring a report back to the future meeting of Board explaining how the information collected by Healthwatch could turned into accountable items for providers.

79. Members' Question(s)

There were no Member questions submitted, relating to items on this agenda.

80. Future meeting dates

It was confirmed that the next meeting of the Health and Wellbeing Board would take place on 27th March 2014.

(The meeting commenced at 9.00 am and closed at 10.45 am)

CHAIRMAN …….

Date of Signature …….

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Note: These Minutes will remain DRAFT until approved at the next meeting of the Committee

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON THURSDAY, 6 FEBRUARY 2014

Present: Dr Bal Bahia (Newbury and District CCG), Councillor Marcus Franks (Health and Well Being), Dr Lise Llewellyn (Public Health), Councillor Gordon Lundie (Leader of Council & Conservative Group Leader), Rachael Wardell (WBC - Community Services) and Dr Rupert Woolley (North and West Reading CCG)

Also Present: Jessica Bailiss (WBC - Executive Support), Steve Duffin (Head of Adult Social Care Change Programme), Balwinder Kaur (WBC - Adult Social Care), Councillor Gwen Mason, Philip McNamara (Newbury and District CCG), Councillor Joe Mooney, Councillor Graham Pask, Cathy Winfield (Berkshire West CCGs) and Lesley Wyman (WBC - Public Health & Wellbeing)

Apologies for inability to attend the meeting: Leila Ferguson

PART I

81. Declarations of Interest

Councillor Gordon Lundie declared an interest in all matters pertaining to Health and Wellbeing, by virtue of the fact that he was a director of the pharmaceutical company UCB, but reported that, as his interest was not personal, prejudicial or a disclosable pecuniary interest, he determined to remain to take part in the debate and vote on the matters where appropriate.

82. Better Care Fund

Rachael Wardell introduced the item to Members of the Health and Wellbeing Board. The purpose of the report circulated was to update the Board on the Better Care Fund (BCF) and seek agreement to the high level plan as to how the single pooled budget would be used.

The BCF was originally known at the Integrated Transformation Fund (ITF), which supported the integration of health and social care services. Included within the guidance when the BCF became the ITF was that some of the money would be required to meet the obligations of the Care Bill.

BCF plans had to deliver on the following national conditions:

- Protecting social care services:
- Seven day services to support discharge:
- Data sharing and the use of the NHS number:
- Joint assessment and accountable lead professional:

The proposed use of the BCF was outlined from paragraphs 4.2 to 4.9 of the report.

4.2: Direct Commissioning of Care by Community Nurses and other community clinicians: This created a single pathway and reduced the delay for patients accessing a package of care.

This built upon an expectation of professional trust. Steve Duffin reported that each proposal could be viewed in more detail under page 18 of the report. It was acknowledged that staff training would be required.

4.3: Access to Health and Social Care services through the HUB: This hub was already in existence in a sense however, there was a growing need for a single Health and Social Care Hub. The aim would be to reduce four points of access down to one. Rachael Wardell reported that there was reference to the Hillcroft front door within the report as there were already aspects of a hub in place there. Councillor Marcus Franks noted that the sum of £279k capital monies was a minimal amount. It was confirmed that £279k represented the total capital available from the BCF and not the total available within the system for development.

4.4: Creating the role of a Personal Recovery / Key worker: This was referring to individuals within the community who were often labelled as a key person/worker.

It was asked why this key person would not be a general practitioner (GP). GPs were an expensive part of the system and it was therefore unwise to maximise their capacity.

Councillor Gordon Lundie queried if additional people would need to be recruited for this role and it was confirmed that there would be an element of new staff but also current staff through redeployment.

Dr Bal Bahia queried if steps were be taken to map what was currently available and whether the third sector were being approached. Rachael Wardell confirmed that it drew upon the strength based approach of the family group conferencing model.

4.5: Joint Care Provider: This involved combining the care assessment and delivery units of the Council's Maximising Independence Team, Homecare Team and the Berkshire Healthcare Trust's Intermediate Care as all provided similar care.

4.6: Social Care seven day working: Councillor Lundie asked if this was different to seven day discharging. Rachael Wardell confirmed that it was very closely linked and was focused around seven day discharging.

Councillor Graham Pask questioned how much input would be required to deliver this proposal. It was reported that there was a lot of pressure due to the weekend mortality rate. The whole system was being requested to gear up towards delivering the same level of quality seven days per week. Councillor Pask referred to his own personal experience and stated that there was a long way to go before this was achieved. Rachael Wardell reported that there was a responsibility to ensure that this was achieved, her front door services saw a peak of patients on Friday afternoons. People were being pushed into the acute system prior to a weekend.

Cathy Winfield reported that she had suggested bringing a paper to the next Board meeting in March on the urgent care system, as it was an important issue for the Board to be aware of.

RESOLVED that Cathy Winfield would bring a report to the next Board meeting in March on the urgent care system.

Councillor Joe Mooney raised his concerns about seven day working. People were often discharged on a Friday from hospitals without any papers. It was vital that people were discharged with the necessary papers. Councillor Gordon Lundie noted Councillor Mooney's point however, stated this was a discussion for another time.

Cathy Winfield explained that £15 million of the BCF was from the four Clinical Commissioning Groups (CCGs). 8% of this was new money that could be spent on new projects. The saving had been made though the Quality Improvement Productivity

Prevention Plan (QIPP). Much of the saving had been generated through reduced hospital activity and therefore the impact needed to be managed collectively.

4.7: Hospital at Home: Philip McNamara explained that this had been touched on at the last meeting of the Health and Wellbeing Board. The aim was to make the system more efficient though directing people away from Accident and Emergency services, if they could receive their treatment in a more suitable setting. It was for those patients who needed sub acute but intensive support in a more suitable environment. A feasibility study was being carried out on the proposal of a Newbury urgent care facility. This was currently only being explored as an option.

Councillor Pask was concerned that GP involvement might be greater than envisaged. He referred to page 22 of the report and queried what a virtual ward bed was. Philip McNamara reported that this was a clinically led pathway where patients were treated where was most appropriate, possibly a sub acute unit. Dr Bal Bahia stated that patients wanted local care and this was a step in the right direction. Dr Bahia stated that the most able person should be providing the treatment and this was not necessarily GPs.

Lise Llewellyn reported that Croydon had been practicing the hospital at home method for several years and the patient satisfactory levels were very high.

Councillor Franks noted that the maximum stay on a Hospital at Home ward was seven days. Cathy Winfield reported that the aim was to have people moving through the system and therefore seven days was the absolute maximum length of time people should stay in one of the Hospital at Home wards. It was hoped that most patients would move on from the ward within three to five days.

4.8 Nursing / Care Home project: Rachael Wardell reported that this was about better management of what took place in care homes. Care within care homes would be improved if it was standardised. Currently patients could be admitted to hospital before being seen by a GP. The aim was to improve the education and support of staff looking after people in care homes.

Councillor Mooney reported that the level of admissions within the community concerned him. Often people were sent to hospital as a first resort where as it should be a last resort. Councillor Mooney stressed that re-ablement services needed strengthening, in order to reduce admissions to hospital. Dr Bahia reported that admissions to hospital were avoided wherever possible. Lise Llewellyn felt that communication and marketing was a fundamental part of changing peoples' expectation that hospitals were always the safest place to be. It was noted that great deal of workforce training would be required.

4.9: Meeting the requirements of the Care Bill: This included expanding eligibility for Council Services to meet the new lower eligibility criteria and providing far more support to carers. It would mean that individuals would receive care at an earlier stage which will have a positive impact on admission avoidance and on maintaining independence.

Rachael Wardell explained that this led the meeting into the second stage of the discussion required.

Current guidance on the BCF had become firmer although elements were still unclear. Guidance stated that the cost of implementing the Better Care Bill was included within the BCF. Guidance was not clear about whether there would be further funding to meet the demands of the Care Bill.

Steve Duffin reported that Officers had worked through what the Better Care Bill would cost and were of the view that the BCF would not sufficiently cover its demands. Three Local Authorities including West Berkshire, Wokingham and Northumberland had their eligibility criteria set at critical and would need to move to satisfactory, which brought with

it cost implications. The Better Care Bill was still going through the parliamentary process and therefore it was difficult to predict the overall cost implications.

Councillor Lundie questioned if the Better Care Bill would be retrospective. Steve Duffin reported that it was not about how much was paid but the cost of care packages and therefore was not retrospective. Caps would be introduced at certain points and there was a risk that people would resist entering the care system until these were in place. Lise Llewellyn queried if care at home contributed to an individuals care account and Steve Duffin confirmed that it did however, this type of care was not as expensive.

Rachael Wardell drew the Boards attention to Appendix C and D on page 35 and 37 of the report, which showed two ways of modelling the BCF. The balanced version was what the Area Team would expect West Berkshire Health and Wellbeing Board to approve. The model on page 37 showed what the Better Care Bill would cost West Berkshire if the BCF was expected to cover it.

Councillor Lundie noted that the balanced version (Appendix C) enabled the preparation of the Better Care Bill but not its implementation. Rachael Wardell highlighted that Appendix D showed the gap in funding if the BCF was expected to meet the cost of the implementation of the Better Care Fund in its entirety.

Cathy Winfield stated that the Area Team would expect West Berkshire to submit a balanced budget and not a deficit.

Rachael Wardell reported if West Berkshire submitted the balanced sheet (Appendix C) they would be indifferent to other local authorities. If West Berkshire were to also voice the financial risk shown in Appendix D they would not be alone in doing so.

RESOLVED that the Board were in favour of submitting Appendix C and for the financial risk in Appendix D to be highlighted in the submission.

(The meeting commenced at 9.00am and closed at 10.15am)

CHAIRMAN …….

Date of Signature …….

Title of Report:	West Berkshire Joint Strategic Needs Assessment
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	27 March 2014

Purpose of Report:

The Joint Strategic Needs Assessment (JSNA) allows local authorities to provide information and data on the current picture of health and well being in West Berkshire. The Health and Wellbeing Board can use the JSNA to agree priorities to inform the Health and Wellbeing Strategy.

Recommended Action:

Approval by Board

Health and Wellbeing Board Chairman details	
Name & Telephone No.:	Gordon Lundie (01488) 73350
E-mail Address:	glundie@westberks.gov.uk

Contact Officer Details		
Name:	Lesley Wyman	Rachel Johnson
Job Title:	Head of PH and Wellbeing	Senior PH Programme Officer
Tel. No.:	01635 503434	01635 519934
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Executive Report

Aims of the JSNA

- Provides an analysis of data to show the health status of different groups
- Identifies any health inequalities
- Highlights any unmet needs
- Indicates recommendations
- Acts as a useful tool for commissioning

JSNA Process

- Berkshire Shared Team review datasets that form the basis of JSNA chapters
- West Berkshire Public Health team obtain data from the Berkshire Shared Team
- West Berkshire Public Health team liaise with information team within the council
- West Berkshire Public Health team involve people from adult social care, children's services, road safety and other local authority departments in the writing of the relevant JSNA sections

Information included within the JSNA

- The structure of the JSNA is similar to the chapters identified within the Public Health Strategy for England, Healthy Lives, Healthy People; Starting Well, Developing Well, Living Well and Ageing well. The JSNA incorporates information on health and social issues and the broader determinants of health.

Starting well

- The Starting Well chapter is about giving children a healthy start in life and laying the groundwork for good health and wellbeing throughout life. The information within this chapter focuses on pregnancy and maternal health, smoking in pregnancy, antenatal and newborn screening, breastfeeding, infant mortality, birth weight, immunisations and vaccinations, foundation stage attainment and child development.

Developing well

- The developing well is a chapter about children and young people and what affects their health. Data includes information on road accidents, childhood obesity, oral health, immunisations and vaccinations, smoking, drug and alcohol use, teenage pregnancy, sexual health (including Chlamydia screening, Children that are Not in Education, Employment or Training (NEET), Looked After Children, child and adolescent mental health, children in need, school life and youth offending.

Living Well

- The Living Well chapter contains information about general health and wellbeing, and lifestyles. Many premature deaths and illness could be avoided by improving lifestyles. Data includes information on smoking, adult obesity, drug misuse, alcohol, sexual health, circulatory disease (including cardiovascular disease and coronary heart disease), diabetes, cancer, respiratory disease (includes asthma and COPD), communicable disease (tuberculosis, hepatitis B&C, sexual health), screening (including cervical, breast, bowel and diabetic retinal screening), NHS health checks, mental health, residential and nursing care home provision and access to social care/personalisation.

Ageing Well

- The Ageing Well chapter contains information about the health of people aged 65 and over. West Berkshire has an increasing older population and is important for this age group to stay active and well so they can remain independent in their homes for as long as

possible. Data includes information on independence in old age, excess winter deaths, seasonal flu, falls and mobility, mental health in old age (including information on dementia and depression), transport accessibility for older people, residential and nursing care home provision, access to social care/personalisation, preventable site loss (including information on age related macular degeneration, glaucoma, diabetic eye disease and sight loss certifications) and end of life care.

Wider determinants and vulnerable groups

- There are wider range of factors that shape the health and wellbeing of individuals, families and local communities such as education, employment and the environment. Data includes information on the wider determinants of health; deprivation, crime and disorder (including domestic abuse), environment, transport, housing and homeless and employment and income. Within this chapter is information about the following vulnerable groups; children in poverty, carers (including young carers), adults with a learning disability, adults with autism, physical disability and sensory impairment and offenders. This chapter contains information about delayed transfers of care and safeguarding.

Demography

- The demographic chapter provides a brief overview of West Berkshire, covering information about the population, births, deaths and life expectancy, ethnicity and, religion and belief.

Accessing the JSNA on the West Berkshire Council website

The JSNA link is www.westberks.gov.uk/JSNA

Currently all chapters are on the website in PDF format and there are links between various chapters that can be followed. A more interactive JSNA will be available as part of the new council website when it is launched later in the Spring.

Next steps

The redesigned JSNA will be a new style web based version for 2013/14 and beyond. It has been developed using a phased approach.

Phase 1: Develop a web based JSNA which tells the local story with updated data and newly created ward profiles.

Phase 2: Further develop the web based JSNA by identify gaps in the JSNA sections, reviewing the availability of new information, refreshing data sets as new data is released.

Phase Three: Build on other local information/data to provide details of health and wellbeing inequalities.

Phase Four: Review whole web based JSNA and refresh data and content.

The ability of the relevant council staff to update and review sections of the JSNA will mean that the whole entity will reflect the most up to date picture of the health and wellbeing needs of local residents at any one point in time.

The use of the local ward profiles will enable councillors, officers, health professionals, the third sector and residents to compare and contrast different wards within the district to help identify gaps and inequalities in health that can be addressed through redesign of health and social care services.

Appendices

There are no Appendices to this report.

NHS
NEWBURY & DISTRICT
CLINICAL COMMISSIONING GROUP

OPERATING PLAN 2014/16

Newbury & District Clinical Commissioning Group

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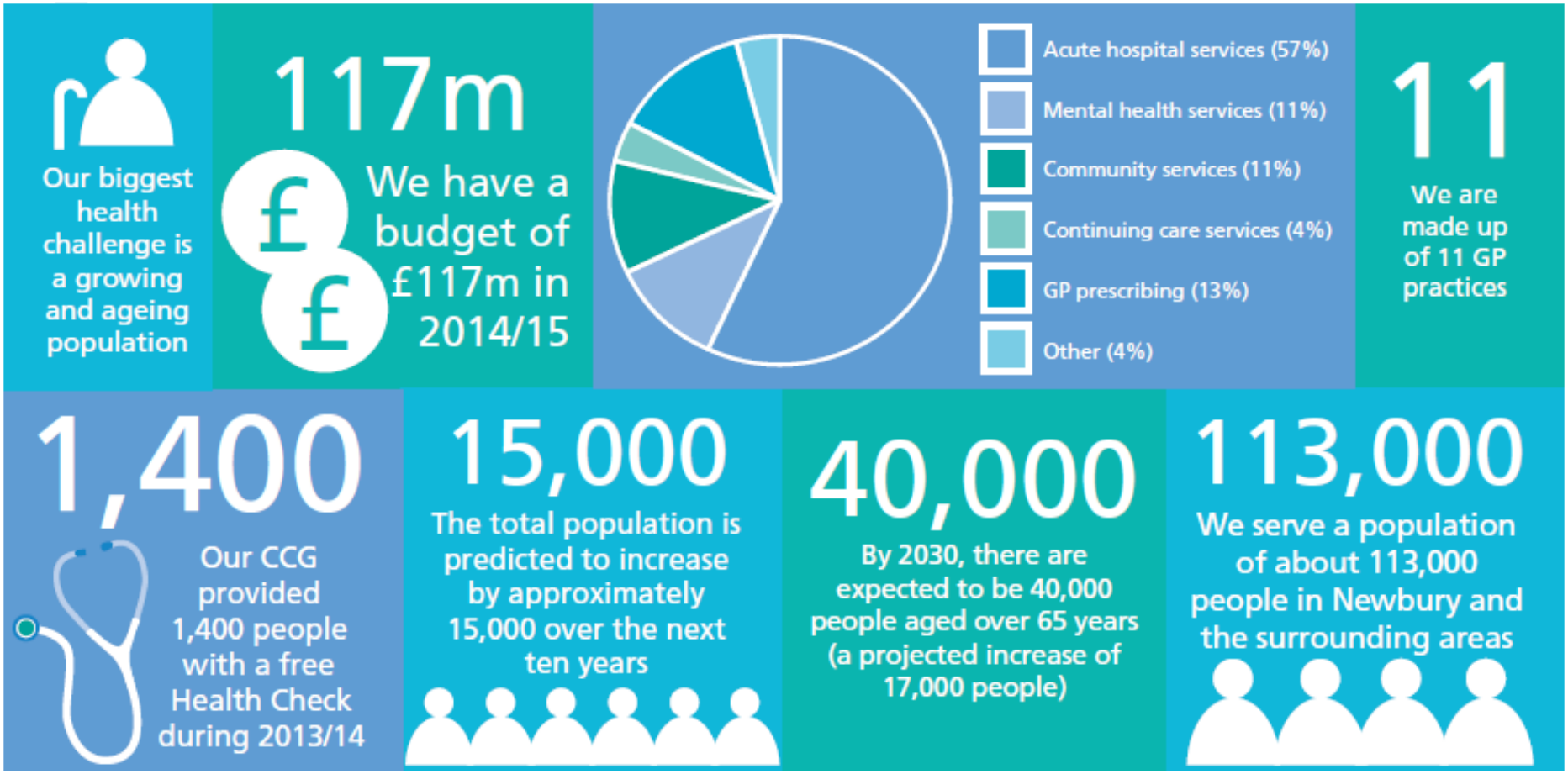
Contents

Our CCG at a Glance



Foreword

Reforms to health services during 2013 saw Clinical Commissioning Groups take on the local leadership of services for patients and the public. This newly redrawn NHS places patients and their interests at the heart of everything we do, and empowers clinicians to ensure that the services our patients need are being provided locally and to the highest quality. This model brings many advantages including reducing inefficiencies within a complex health system, while the challenge of ensuring that the NHS remains sustainable for future generations directly involves the public and clinical leaders alike.

The forthcoming years in the NHS present significant challenge in terms of delivering a step-change in the efficiency of services while promoting great joined up care for patients.

During 2014 we will be working to deliver a range of national and local improvements to health services:

- **Securing additional years of life** for people with treatable mental health and physical conditions
- **Improving the health related quality of life** for people living with one or more long-term conditions, including mental health
- **Reducing the amount of time people spend avoidably in hospital** through better and more integrated care in the community outside of hospital
- **Increasing the proportion of older people living independently** at home following discharge from hospital
- Increasing the number of people having a **positive experience of hospital care**
- Increasing the number of people with mental and physical health conditions having a **positive experience of care outside of hospital**, in general practice and in the community
- Making significant progress towards **eliminating avoidable deaths** in our hospitals caused by problems of care

Locally, our vision to 2016 includes the development of an **Urgent Care Unit** located at the West Berkshire Community Hospital site. This innovation will provide short –term 'sub-acute' care for those patients who need it, linking GP care and our valued community hospital resources and supporting our planned reduction in inappropriate A&E admissions. This project will feature engagement from partners and progress to a feasibility study during 2014.

Dr Abid Irfan
Chair & GP Clinical Lead
Newbury & District CCG

Review of our Clinical Aims

During 2013, Newbury & District CCG established itself and set out plans to improve health services for local patients; amongst our aims were three local priorities that reflected feedback from our patients and the public:

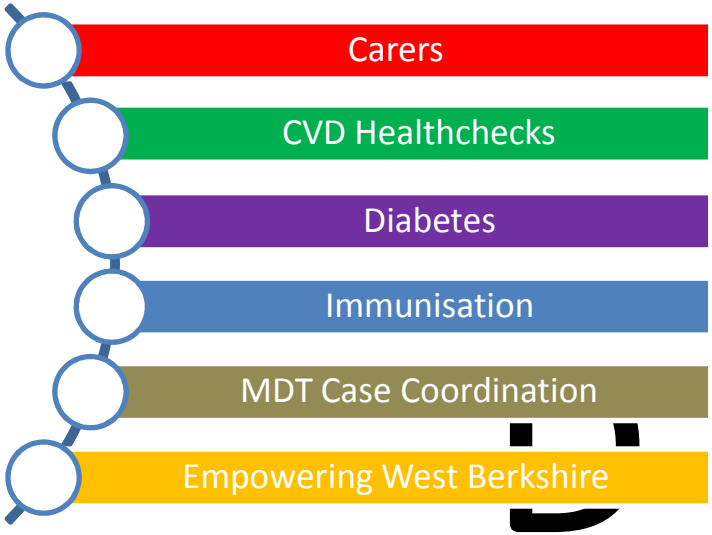
- **To better identify those who are Carers in our area, so that we can provide them with support**. It is was an aspiration of our GP's to have identified additional carers during 2013, meaning that we can now tailor support and services to those who provide care for family or friends on a regular basis. Our GP's have an ambition to work closely with our partners to identify carers and offer support incorporating an integrated approach
- **To offer Cardiovascular Health Checks to eligible patients, in order to proactively help people to remain well and healthy**. Working closely with West Berkshire Council, we publicised free health checks available through GP Practices. It is the ambition of the CCG to encourage take up of health checks amongst the target group to detect these illnesses early on so they can be given support and advice to help them reduce or manage that risk
- **To offer 9 care processes to people identified with diabetes, so that all patients diagnosed with diabetes have the same standard of care**. We implemented an innovative system to allow patients to proactively manage their diabetes alongside their GP's care, enabling them to proactively manage their condition with a self-management plan and support of a multidisciplinary team. Thus, empowering patients to be the primary decision makers in control of the daily self-management of their diabetes

Our Council of Members is now firmly established as the clinically-led Board responsible for the strategic direction of the. Council members are drawn from local GP Practices to ensure that we focus on matters that are important to our patients yet also continue to stay appraised to regional and national services and initiatives. Council also features GP Practice Manager and Locality Nurse input, and is supported operationally by the CCG Management Team.

We also actively sought a wide range of views and opinions around local and national NHS services. In September, we ran a 'Call To Action' consultation to which great numbers of patients and the general public attended, all keen to give their views and share their experiences so as to better shape the future of health and social care services for all. Our Governing Board meetings are also well attended by members of the public and press. Additionally, our Patient Voice group gives patients a more local opportunity to provide feedback through their GP Practice. We also implemented our CCG website (www.newburyanddistrictccg.nhs.uk) and Twitter feed (@NewburyCCG) which provides new and electronic means of communicating directly with your CCG.

Dr Angus Tallini
Chair, Council of Members & GP Lead
Newbury & District CCG

1.0 Our Achievements in 2013



Carers

The CCG is committed to increasing the number of carers identified and offering appropriate information and support. GP Surgeries have been proactive in the management of their systems and processes to identify and work with carers, offering priority appointments, information on available services as well as working in collaboration with Berkshire Carers on the 'Take 5' project which assists and supports carers in their role.

CVD Health Checks

We worked jointly with West Berkshire Public Health in offering preventive health checks to adults aged 40-74 who are at risk of developing vascular disease, followed by appropriate medical management and lifestyle interventions, in line with one of our local priorities. Performance reported at 6.4% in December 2013 (Target 5.5%). A total of 2,234 CVD Health checks were carried out between April 2013 and December 2013.

Diabetes

Newbury & District CCG is keen to improve the lives of people in the area. The aim of our work on diabetes has been to prevent people at greatest risk from developing diabetes. Running across all the GP surgeries in this area has worked to help identify people at highest risk of developing diabetes in the next ten years, people have been invited to a structured health and lifestyle program called Eat4Health. Sessions have been rolled out in GP surgeries and public places throughout 2013. The CCG has successfully hosted pre-screening days with drop in sessions offering point of care HbA1C blood tests. Screening has resulted in a rise in the number of patients being identified as having diabetes or being borderline, due to increased pick up rates. As at December 2013 44.3% of our Diabetics have received care through the 9 care processes- enabling patients to proactively manage their diabetes alongside their GP's care, manage their condition with a self-management plan and support of a multi-disciplinary team.

Immunisations

In 2012/13, 95.6% of children from GP Practices located within West Berkshire received the 5-in-1 vaccine. The data shows 92.6% of children received the second dose of the MMR vaccine and 94.3% received the preschool booster.

MDT / Case Coordination

Newbury & District Clinical Commissioning Group (CCG) has worked with Berkshire Healthcare Foundation Trust (BHFT), West Berkshire Borough Council and a range of other partner organisations, to develop an integrated model of care, with a key focus on Case Management based upon a Multi-Disciplinary Team (MDT) case review, for the identification and case management of patients identified as seriously ill or at risk of emergency hospital admission. The

CCG has invested in the community matron and assistant practitioner roles, to ensure case coordination is embedded within the overall team function. MDT's in Newbury and District meet on a monthly basis to ensure patients are discussed in a timely manner with care management plans.

Empowering West Berkshire

Newbury and District CCG has worked in collaboration with Empowering West Berkshire in line with the three local priorities identified for 2013/14. This collaborative working has had many successes over the year with the launch of the Wellbeing of West Berkshire Pop up Shop at the Kennett Centre Newbury, events to raise awareness of Carers Rights Day and the development of the Service Directory available on the Empowering West Berkshire website outlining a range of voluntary sector organisations in West Berkshire and the wide variety of services and activities they provide. There are currently around 800 services listed on the database, making it the definitive guide to the West Berkshire's voluntary and community sector.

Long Term Conditions

- Recruitment of specialist diabetic nurses and community diabetologist to run 'one stop shop' clinics and increased patient engagement through care planning and technology
- Introduction of an Exacerbation Assessment Service
- Implemented a COPD Discharge Care Bundle
- Tele-monitoring of patients using an automated telephone messaging service
- Increasing Pulmonary Rehabilitation provision

Urgent Care

- Successful implementation of NHS 111
- Introduction of new Urgent Care dashboard being used by all partners across the health and social care system to inform capacity and demand planning and interventions on a daily basis
- Redesign of the A&E unit at the Royal Berkshire Foundation Trust to improve patient experience and ensure rapid access to expert assessment and care
- Expanded Rapid Response and Reablement Service

Planned Care

- Initiated a comprehensive programme of multi-provider engagement spanning NHS and Independent providers
- Enhanced patient choice through a greater range of providers for Ophthalmology services
- Ensured that spend on Pathology is closely monitored, with modifications to Pathology requesting software in Primary Care to better manage the effectiveness of costs

Children, Maternity, Mental Health/Learning Disabilities, Carers and Voluntary Sector

- West Berkshire Integration Steering Group bringing together health and social care partners
- Identification of health and social care initiaitves against the Better Care Fund:
  - **24/7 Services** – across community and social care
  - **Joint Care Provider** – integrated care assessment and delivery units across West Berkshire Council and Berkshire Healthcare
  - **Health HUB** – a single entry point (SPE) for reablement, crisis care, hospital or care home admission avoidance
  - **Personal Recovery Guide** – tailored support throughout the patients journey, engaging the right elements of health and social care
  - **Nursing & Care Homes** – GP support to registered nursing and care home residents via MDT

2.0 Developing the two year Operational Plan

This document outlines the CCG's Operating Plan over the next two years. In preparing its plan the CCG has taken the following into account:

- The delivery of clinical outcomes set out within the NHS Outcomes Framework
- Current performance against the NHS Constitution and action to improve this where required
- The local health needs of the population
- The feedback we have received from patients
- The programmes of work undertaken by Strategic Clinical Networks (SCNs) and the Academic Health Science Network (AHSN)

2.1 The National Framework

Our CCG goals are set with regard to a number of key national policies. The ***NHS Outcomes Framework*** sets out the outcomes of Clinical Commissioning groups are charged with delivering.

The framework is grouped around five themes or domains, these set out the national outcomes the NHS should be aiming to improve:

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long term conditions
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Ensuring that people have a positive experience of care
Domain 5	Treating and caring for people in a safe environment, and protecting them from avoidable harm

NHS England has identified and set seven ambitions to improve health outcomes:

- **Reduce years of life lost** for treatable conditions, ensuring that mental health has parity of esteem with physical health
- **Improve quality of life** for people with long-term conditions, including both physical and mental health

- **Reduce avoidable admissions** and develop more integrated care outside hospital
- **Increase the percentage of elderly living independently** at home post discharge form hospital
- **Reduce the proportion of people reporting very poor experience** of in-patient care
- **Reduce the proportion of people reporting very poor experience** of community and primary care
- Significant progress towards **eliminating avoidable deaths** in hospital

In addition, NHS England has identified that any high quality, sustainable health and care system will have the following six characteristics. We aim to further develop these characteristics locally:

1. A completely new approach to ensuring that citizens are fully included in all aspects of service design and change, and that patients are fully empowered in their own care
2. Wider primary care, provided at scale
3. A modern model of integrated care
4. Access to the highest quality urgent and emergency care
5. A step change in the productivity of elective care
6. Specialised services concentrated in centres of excellence

2.2 The NHS Constitution

The CCG will continue for have regard to, and promote the ***NHS Constitution***.

The Constitution also sets out the rights and responsibilities of NHS patients: These rights cover how patients access health services, the quality of care they will receive, the treatments and programmes available, confidentiality, information and the right to complain if things go wrong. Over the next two years the CCG will need to improve on the delivery of the following commitments.

Measure	Our areas of focus
Referral to Treatment waiting times for non-urgent consultant-led treatment	(Debbie New is supplying direct to Ops Directors)
Diagnostic test waiting times	(Debbie New is supplying direct to OPs Directors)
A&E waiting times	Despite a continued focus at strategic and operational level across the health economy, the Berkshire West system has not met the A&E 95% standard for much of the year. The Berkshire West CCGs have made significant investment in the emergency and urgent care pathway in order to improve performance. These investments

Measure	Our areas of focus
	have been targeted to deliver additional capacity, extend availability of services (hours of operation and days of the week) and deliver improvements to the pathway (based on ECIST recommendations). Specific actions being taken to support achievement of the A&E 4 hour standard include; • Expansion of the Service Navigation Team to support improved discharge planning, use of EDDs and early day discharge • Implementation of the ECIST recommendations for RBFT including Single Point of Access for all acute admissions to allow for senior clinical triage and streaming of patients and an Ambulatory Care Unit • Enhanced Intermediate Care Services across the 3 Localities with services operating with extended hours via a genuine Single Point of Access • Use of winter monies to support increased 7 day working in RBFT and BHFT • Additional [illegible] Health liaison with the A&E [illegible] at RB • [illegible] working in liaison with SCAS to support the response to Amber and Green calls • Investment into social services to support mobilising care packages at the week-end • Integrated care with Community Nurses/Matrons in the community (including 24 hour District Nursing services) managing patients in their own homes • Use of a dashboard populated daily to understand cause and effect across the system and providing objective data on which to make decisions around escalation and investment • The system is also implementing the recommendations from the ECIST report to Berkshire West, December 2013. All actions are overseen by the Urgent Care Programme Board and a new Operational Group is being established to drive improvement and address issues along the pathway. Newbury & District CCG continues to monitor delivery of A&E wait times for those patients who access A&E through Great Western Hospitals NHS Foundation Trust and also North Hampshire Hospitals NHS Foundation Trust. Our **Quality Scorecard -** received at both our Quality Committee and Governing Board - details performance at all trusts who provide A&E services for our patients and is regularly monitored for assurance.
Cancer 2WW/31/62 Waiting Times	The Berkshire West CCGs support the delivery of the Cancer Standards in the following ways: • Close monitoring of targets and trends to ensure delivery will not be compromised • Regular liaison with secondary care thus ensuring they are aware of issues which might mean targets may not be met e.g. national or regional awareness campaigns and commissioning additional capacity if

Measure	Our areas of focus
	required • Use of contractual levers • Analysis of breach reports at Newbury & District CCG level - even when standards are being met at overall Provider level – to ensure our patients and population receive timely access to cancer care regardless of which cancer centre or unit they are treated at
Ambulance Handovers	South Central Ambulance Service (SCAS) work with RBFT and other acute providers to agree an annual handover plan which all parties sign up to. This plan covers the process and management of handovers between both parties in order to reduce any delays and ensure continuity of care for patients. In addition, SCAS have introduced a double verification process in 2013/14 which has vastly reduced the data challenges received on ambulance handovers and will continue to be the process in the coming years.
Category A Ambulance Calls	For Category A Ambulance calls SCAS are already achieving this as a contract level for 2013/14 and this will remain a requirement going forward. This is reported and monitored monthly by CCGs. SCAS continue to recruit and train first responders to support the achievement of these targets.

2.3 The Health Needs of our Population

2.4 Listening to our Patients and the Public

The CCG wants to take account of patient views and public opinion in developing its plan. During our first year we have established a number of ways of capturing feedback and plan to develop these going forward (see section 4.1). A key event was our first "Call to Action" meeting held in November at Shaw House, Newbury when over 60 members of the public attended to contribute their views. The purpose of the event was to discuss how local NHS will rise to the challenge of meeting increasing demand as the population gets older with reducing financial resources. The key views from the public were:

- they wished to see the NHS remain free at the point of need
- they greatly valued the NHS and its ability to provide care for those who require it
- they valued West Berkshire Community Hospital
- they wanted to see a more joined up health and social care service that uses the skills and expertise of the voluntary sector to full effect
- they want to see more of a focus on keeping people well and preventing ill health
- that mental health needs be given parity with physical health needs
- Importantly they want to see improved communication between all health and social care systems.

Key themes highlighted at the event included:

The CCG has used this feedback to plan for an expansion of community services, which ensures good use of West Berkshire Community Hospital, and provides much stronger links with social care.

2.5 Expert Clinical Advice

NHS England has recognised the value of Strategic Clinical Networks (SCNs) as 'engines for change' in the modern NHS. SCNs are therefore a further element in the wider system that will support CCG's to deliver quality improvements and outcomes benefits for patients.

There are four Strategic Clinical Networks covering the Thames Valley.

- Cancer
- Cardiovascular
- Maternity & Children
- Mental health, dementia and neurological conditions

Newbury & District CCG will endeavour to engage with SCNs to ensure that their work informs our commissioning plan. In the same way the CCG will be part of the Academic Health Science Network (AHSN) and be cognisant of their work programmes.

3.0 Our Five Year Strategic Vision

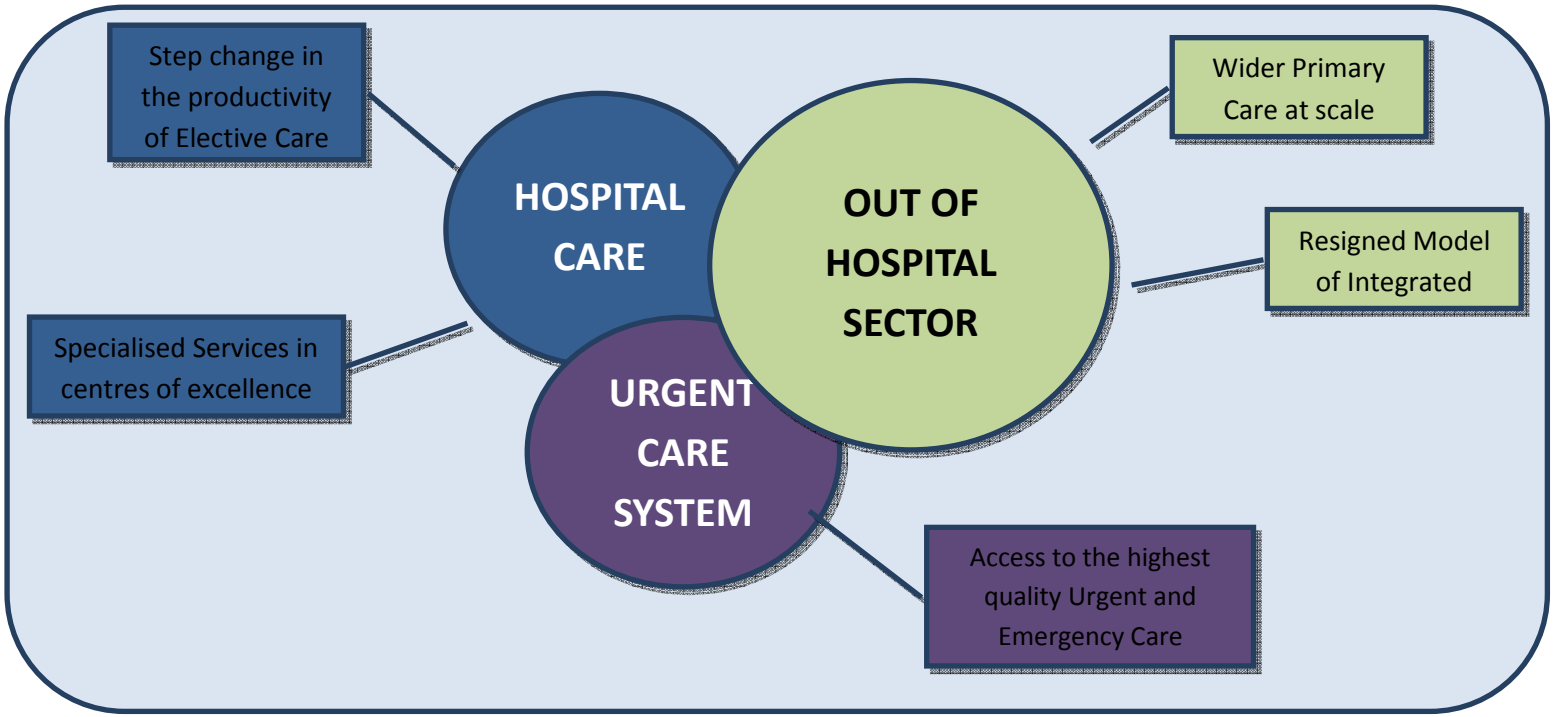
Newbury & District CCG has worked with three other CCGs in Berkshire West to develop a 5 year Strategy for the Berkshire West health and social care economy. This "unit of planning" was endorsed by the West Berkshire Health and Wellbeing Board.

By 2019, enhanced primary, community and social care services in Berkshire West will work together to prevent ill-health and support patients with much more complex needs at home and in the community. Service users will be supported to take more responsibility for their health and wellbeing and to make decisions about their own care. Patients will only be admitted into acute hospitals when they require services that cannot be delivered elsewhere and will be treated in centres with the right facilities and expertise.

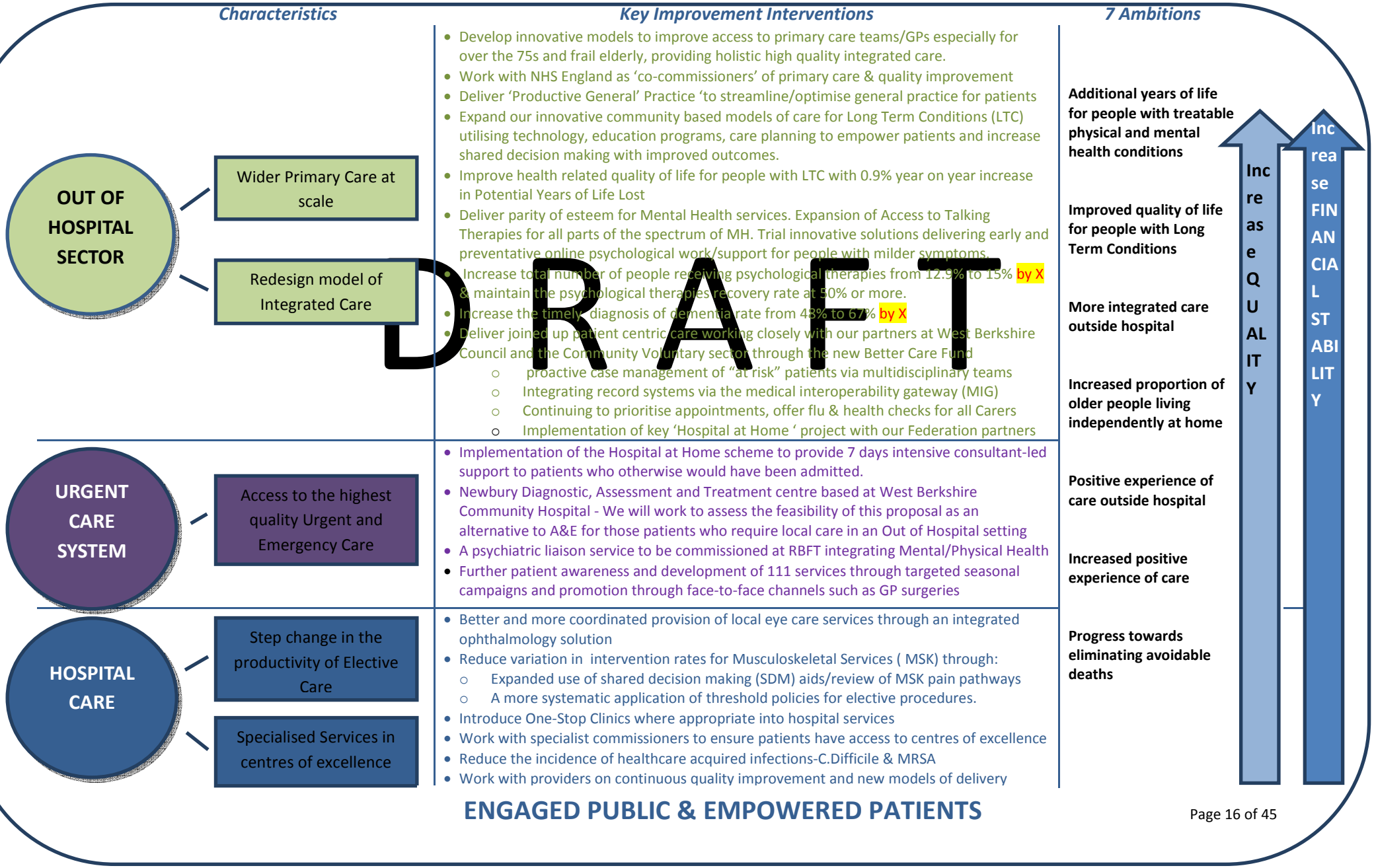
All the services that respond to people with an urgent need for care will operate together as a single system. This will ensure that the service people receive is commensurate with their clinical need. People with urgent but not life-threatening conditions will receive responsive and effective care outside hospital.

People with serious and life-threatening conditions will be treated in centres that maximise their chances of survival and a good recovery.

Our plan aligns to the characteristics of high quality and sustainable health systems that NHS England identified.



3.1 The CCG 'Plan on a Page' 2014/16



3.2 Our Local Priorities for 2014/16

By implementing our vision we look to secure the following improvements in outcomes for patients and service users by 2019:

- **A 3.2% reduction in the potential years of life lost from conditions which can be treated**
- **An increase in the proportion of patients who say they feel supported to manage their long-term condition from 78.5% to 81%.**
- **A XXX reduction in unplanned admissions to hospital.**
- **A 3.6% reduction in the number of patients reporting poor experience of inpatient care.**
- **An XXX increase in the number of people reporting a positive experience of care outside hospital**

We also intend to make further progress towards eliminating avoidable deaths in hospital and increase the proportion of older people living independently at home following discharge.

Delivery of our vision will mean moving to new models of care developed in partnership with our patients, and new approaches to contracting and paying for health services. Health and social care services will need to be organised so that they can work optimally together to deliver the best outcomes and experiences for patients and best value for the tax payer. It is envisaged that this may require reconfiguration of existing organisations within this five year timescale.

DRAFTING NOTE : THIS SECTION NEEDS TO BE REWRITTEN TO SHOW PROJECTS AS PER PLAN ON A PAGE

3.3 Operating Plan Initiatives 2014/16

	OUTCOMES			
Project	**Local**	**Patient**	**System**	**Clinical**
Outcome 1: Securing additional years of life for people of England with treatable mental health and physical conditions				
Diabetes	Diabetes has been and continues to be a local priority for NDCCG. We have pioneered and implemented an innovative process that can screen for high risk patients and provide the necessary lifestyle interventions to reduce their lifetime risk of developing diabetes. As a result of the new program and increased numbers of Healthchecks we have done this year the numbers of diabetic or pre-diabetic patients will continue to rise.	Improved quality of life for people living with diabetes. More health screening and education in Diabetes care. More consistent communication of health messages from GP surgeries Proactive self-management by patients, supported by their GP Improved psychological and mental health support for people living with diabetes and other long term conditions	We have introduced exciting new technologies (Eclipse system) which will allow proactive interventions and care management in conjunction with self-management by empowered patients with diabetes Integrated systems in the community allowing care to be provided by highly skilled professionals with immediate advice from hospital consultants via virtual clinics and other technologies	Risk stratified processes and multi-disciplinary team approach to patient care Highly empowered patients involved in shared decision making Significantly reduced complications (like Myocardial Infarction/Stroke/blindness/Kidney problems) and reduced drug burden Continuous improvement in the numbers of patients who receive the 9 diabetic care processes
Mental Health/Learning Disabilities Urgent care and crisis support (CMMV	We will work locally with our mental health provider to improve patient pathways for people with mental health and learning disability who are at risk of self-harm or		To work with Berkshire Healthcare NHS FT and other agencies, as appropriate, to continue the 13/14 development of the mental	To intervene early in order to minimise the likelihood of the patient lapsing into a subsequent crisis or risk of harm.

	OUTCOMES			
Project	**Local**	**Patient**	**System**	**Clinical**
Programme Board)	challenging behaviour		health and learning disability systems' response to patients identified with a specific risk of suicide or serious self-harm, or with a mental health or challenging behaviour crisis, whether in hospital, the community or identified through the criminal justice system, such as those requiring an approved place of safety	To develop care pathways, with clinical and patient outcomes, for the future commissioning of mental health and learning disability urgent and crisis services.
Outcome 2: Improving the Health related quality of life of the 15+million people with one or more long-term condition, including mental health				
Talking Health	In NDCCG self-reported estimates (Annual Population Survey 2010) 15% feelings low worthwhile; 22% feelings low happiness; 38% feelings of high anxiety. This does indicate better wellbeing than the National Average. IAPT service for those with LTC and psychological aspects affecting their self-management (either motivational or anxiety/depression related)	Psychological support for people with LTC and psychologist aspects. Interventions aimed at preventing progression to anxiety and depression.	Interventions aimed at preventing progression of Mental Health to anxiety and depression. Psychiatric Liaison service expansion to include all adults attending either the Emergency Department or the wards in the Royal Berkshire Hospital. The Psychological Medicine service is expanding from the Medically Unexplained Symptoms service.	Integrated service with early intervention The interface between physical and mental health is now being addressed comprehensively with the two new services building on a current Medically Unexplained Symptoms psychology service. The psychiatric liaison service will connect patients attending the Acute Physical Health Trust (e.g. Emergency Department attenders) or those attending physical health

	OUTCOMES			
Project	**Local**	**Patient**	**System**	**Clinical**
				specialty clinics (often with multiple clinic attendances) . These patients will be assessed from a mental health perspective and linked in as appropriate to the community mental health team, the community psychological medicine team or the Talking Therapies team. This will reduce unwarranted re-attendances at physical health services where this only serves to worsen the patients' physical and mental health, by addressing their unmet mental health need.
Increasing Access to Talking Therapies (CMMV programme Board)	Access to Talking Therapies locally is lower than the target 15% of population, at 11%. Although NDCCG area is still within national average for Antidepressant Prescribing, we can aim to reduce this as a measure of good quality primary mental health care, closer to the rates of some of our neighbouring CCGs who are at the lower edge of the prescribing rates along with higher referral rates to Talking Therapies. Also for more serious mental	An increasing number of patients with serious mental illness will be able to report that they have access to psychological interventions and treatment within waiting time standards and established patient and clinical outcomes Modern outcomes-based mental health treatment has long been proven to require a psychological component of treatment in order to be able to aspire to recovery from serious mental illness, rather	Expansion of Access Talking Therapies for patients with both mild to moderate mental illness and those with severe and enduring illness Access to Psychological interventions has been shown to have a good evidence base for improving outcomes for those with serious mental illness as well as those with milder forms. This is well received by patients who can build more resilience and can recover more fully than with medication alone.	The Talking Therapies service will in 2014/2015 implement the commissioning requirements for outcomes, numbers of patient entering treatment and adherence to maximum waiting times. Access to psychological therapy will need to be in a timely and effective fashion along the journey of patients with serious mental illness, and also those with mild or moderate mental illness. It will also deliver evidence based psychological treatments according to NICE and RCPysch guidance.

	OUTCOMES			
Project	**Local**	**Patient**	**System**	**Clinical**
	illness there is difficult and delayed access to psychological therapy currently. It is also important to recognise and strive to improve access by hard to reach groups including offenders. To work with local Talking Therapies service provider to continue to develop and performance manage the implementation of new funding made available in 2013/14, to ensure that the service meets the KPIs required	than just mitigation. For milder forms of mental illness, then early access to psychological interventions may help prevent deterioration, and build resilience.	For mild and moderate severity depression and anxiety, promotion of the self-referral (direct access) route to Talking Therapies may improve uptake of this service locally, by facilitating patients' route into the service and also validating this therapy to the population through the promotional work. Development with Public Health of an easily accessible on line resource for milder mental illness, particularly depression/anxiety, which is available to the local population. This is to promote prevention and build resilience strategies early on in the patient journey.	Development of the online resource in a supported virtual environment which is closely linked to the Talking Therapies service which would provide the next step up for any patients whose condition deteriorates
Services for people with a learning disability (CMMV programme Board)	To ensure that local people with learning disability have access to appropriate setting of care according to their needs, through working across health and social care	To ensure that people with learning disability are cared for in appropriate settings, within Berkshire Ensuring through annual screening we are meeting all	To work with unitary authorities and providers of learning disability services to develop local services to meet both the requirements of the Winterbourne Concordat Recommendations and the	Appropriate care that is monitored and is of a high quality standard which meet the needs of learning disability individuals

	OUTCOMES			
Project	**Local**	**Patient**	**System**	**Clinical**
	We will continue to offer and provide annual healthchecks for patients with learning disabilities.	needs of patients with learning disabilities.	outcomes of the 2013 Learning Disability Self-Assessment.	
Mental Health (CMMV Programme Board and specific local focus)	In Newbury & District during 2009-2011 rate of admissions was 125 for every 100, 000 for mental ill health. West Berkshire had around 270 contacts with mental health services for every 1000 people	Improved mental health and wellbeing of our population through early intervention and focus on a good start in life. Improved outcomes, physical health and quality of life for people with mental health problems and learning disabilities through high quality services and equality of access	Mental illness is the single largest cause of disability in the UK. At least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time. Approximately 1% of the UK population has a severe mental health problem. To ensure that more people have a positive experience of care and support	The NHS Outcomes Framework 2012/13 also contains three improvement areas relating specifically to mental health, which includes premature mortality in people with serious mental illness, employment of people with mental illness and patient experience of community mental health services.
Outcome 3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community outside of hospital				
Newbury local diagnostic, assessment and treatment centre	The West Berkshire Community Hospital is an excellent facility that serves our local population. All our public engagement events confirm that out our patients and public wish this to be used in the most efficient way possible. We will work with partners to	A local yet comprehensive and quality service, better able to respond to the sub-acute patient and provider services closer to home.	support the wider strategy for urgent care in Berkshire West which aims to ensure that different parts of the system including A&E, primary care, ambulance services and NHS 111 work together as one to ensure that patients with differing degrees of urgency and acuity are responded to in a timely way and by the	Better use of clinical skills across a range of providers Improved patient experience and clinical outcomes especially for the frail elderly Aid Delivery of our integration plans and will facilitate joint working between GPs, community geriatricians/matrons, social care,

	OUTCOMES			
Project	**Local**	**Patient**	**System**	**Clinical**
	develop this service as an alternative to Hospital and A&E for those suitable patients who require local care in an Out of Hospital setting		most appropriate service. The unit would also link in to all our Reduction in A&E attendance for non-emergency cases through appropriate local service provision	community services and existing admissions avoidance schemes such as Rapid Response and Reablement and Hospital at Home
Local Tariff for Urgent Care	We will agree a local tariff for Urgent Care that incentivises use of ambulatory care pathways	Patients managed safely and appropriately on the same day without admission to a hospital bed.	Maximising the benefits of local tariff	Better clinical management and outcomes for patients
Urgent Care Dashboard	The Urgent Care Dashboard will provide transparent objective information available to all, enabling tracking of real-time demand and capacity. Providing strategic information to support investment decision and prioritisation	Patient pathway informed by robust multi agency working with better outcomes for patients	System wide tracking of real time demand and capacity enabling organisations to plan their resources, work more effectively together and inform escalation plans	Better clinical management and outcomes for patients Clinical resources deployed in response to anticipated demand
Hospital at Home	We will work with neighbouring CCGs to implement this Key project locally. We will utilise the resources of our local community nursing and geriatrician teams currently covering the Berkshire West	Benefits for patients and their relatives who will avoid lengthy & frequent hospital visits and allow them to be more involved in their own care. Recovery in familiar surroundings. More consistent and seamless care	Increased level of intensive support to patients in the home setting to avoid the need for admission to hospital or support earlier discharge during a period of illness.	Reduced risk of healthcare acquired infection. Care closer to home with improved patient experience and outcomes

	OUTCOMES			
Project	**Local**	**Patient**	**System**	**Clinical**
	area and will work closely with our Unitary authority colleagues to adequately support step down of patients into the community.	as patients are stepped down into community and social care support according to their needs.	Reduced pressure on acute hospitals.	
Supporting Nursing & Care Homes	We will work to ensure that each care home in our area receives this enhanced service from a local GP practice.	Improve standards of care provided by care home staff and continuity of health care for residents	Introduction of a model of enhanced services to nursing and care homes which will provide training and support to homes to help with longer term care planning for the residents and support during times of crisis. To avoid unnecessary acute admissions from nursing and care homes.	Increase knowledge and continuity of health care for nursing and care home residents. Improved standards of care to residents. Long term care plans in place, allowing resident and family wishes to be respected and implemented.
Psychiatric Liaison and community psychological medicine Service (CMMV Programme Board)	We will work locally with our mental health provider to develop a new psychiatric community liaison service	To improve patients' health, skills and knowledge for self-management of their health issues	Reductions in usage of A/E and inpatient services	To improve health care for people presenting to acute and community physical health services with co-morbid physical and mental health needs, through a new psychiatric liaison and community psychological medicine service, which will work with patients and physical health providers.
CAMH Service changes (CMMV Programme Board)	We will work locally through our CMMV programme board to erasure our local children and families are better supported and family breakdown is minimised	Young people will be supported in the community, family breakdown will be minimised, local CAMHS pathways will be strengthened and out of area	Ensure that the Tier 3 CAMHs service meets the needs of today's service users in the context of safety and quality. There is particular work around having community	Improved support for children and their families with improved outcomes and strengthening/clarity of patient pathways

	OUTCOMES			
Project	**Local**	**Patient**	**System**	**Clinical**
	.Local solutions to avoid out of area placements will be explored whenever possible	placements will be avoided	cover outside 9-5 Monday to Friday for YP who are in crisis or presenting with high levels of risk.	
Children and Young People -Palliative Care (CMMV Programme Board)	Ensure our local children and young people have access to a fair and transparent service for palliative care	Patients will have access to a fair and transparent service resulting in an improved patient experience: Care closer to home and improved patient experience	Ensure CCGs compliance to the Palliative Care Funding Review in 2015 where the per-patient tariff currently being developed will be implemented. All palliative care providers, including Children's Hospices, will be able to charge commissioners for care delivered to individual patients	Review of Palliative Care service for Children and young people ensuring there are clear: 1. Palliative Care pathways 2. Referral criteria 3. Assessment Process for integrated packages of palliative care Service Specification for Hospice / other provider delivery
Maternity – Introduce an Early Labour Assessment Service for low risk mother (CMMV Programme	Across Berkshire West our average Home birth rate is low at rate 3%. Early labour assessments can help to reduce the number of women arriving at labour suite too early and reduce demand in the maternity triage unit. Local evidence through the Home Birth Review (November 2013) has shown approx 50% of women are low risk at the start of labour. If early labour assessments were carried out on 25 % of these women, then up to 26 early labour assessments per	Operating an Early Labour Assessment Service will support mothers and partners, to consider alternative options to hospital delivery and support enhanced take up to the Home Delivery and Midwifery Led Units. The Berkshire West Home Birth Review (Nov 2013) reviewed maternity practices in part of Wales, where they have reached a target of10% home births.	Maternity systems in Wales includes early labour assessment; promotions of information about place of birth for women throughout pregnancy and the screening of women for suitability for home birth. The Wales system operates a team model to promote continuity in care. A team at Glan-y-mor have sustained home birth rate of 23-25% in the last 10 years.	Over 2014 a midwifery team approach will be developed to facilitate increasing the number of home births. This will involves developing 3 maternity teams of geographically based home birth specialist midwives, across Berkshire West, in addition to the traditional team of community midwives, to care for women ante- and post-natally The Early Labour assessment service will be piloted over 2014/16. The resources needed for this pilot would be: - 16.5 WTE to provide 3 midwives available at any time of day, so requiring an extra 5 WTE midwives

	OUTCOMES			
Project	**Local**	**Patient**	**System**	**Clinical**
	week could be made across Berks West.			in the community team - there would need to be 32.3 WTE in the traditional team, based on current caseload numbers.
Outcome 4: Increasing the proportion of older people living independently at home following discharge from hospital				
Carers (CMMV Programme Board)	Within our local Better Care Fund we have identified support for carers as a key scheme for further development	Increase identification of carers including young carers Personalised support for carers Support to remain mentally and physically well Improve the health and well-being of carers	To implement across the system the recommendations from the carers scoping report	Improved support for carers to ensure they remain mentally and physically well
Integration of Health and Social Care Services (CMMV Programme Board)	Locally with a high number of young people and pockets of deprivation , we will work through our CMMV board to help better support children and families through health and social care integration	Reduced family break up. Reduced offending behaviour. Reduced use of mental health, substance misuse, maternity and physical health services	Compliance with SEN changes to be mandated from April 2014 Financial savings over the life course.	Integration may benefit the following groups: 1. Children and Young People with special educational needs/ complex health conditions 2. Troubled Families - characterised by high incidence of mental health/substance misuse/offending/ worklessness/children in

	OUTCOMES			
Project	**Local**	**Patient**	**System**	**Clinical**
				care/domestic violence
Increased Rapid Response and Reablement Services	More flexible Rapid Response and Reablement Services across the CCG and the other 3 CCG localities based on predicted discharge numbers aimed at reducing the numbers of patients medically fit for discharge at F[illegible]	Patients supported to live independently at home. Better patient experience.	Reduction in admissions to hospital. Reduction in both the numbers of patients medically fit for discharge and the length of time spent waiting for discharge.	Most efficient use of clinical resources and skills
Outcome 5: Increasing the number of people having a positive experience of hospital care				
Patient Related Outcomes Measures	Participation in Friends & Family Test Participation in Patient Satisfaction Surveys including National Cancer Patient Satisfaction survey	Empowering patients and promoting patient voice relating to the quality of services	Empirical study of actual patient satisfaction, to better enable outcomes based commissioning	Empirical surveys to define services provided
Maternity – rate of C-sections **(CMMV Programme Board)**	Reduce elective C-section to less than 10%		For the system to monitor on a monthly basis the service provision and efficiency regarding numbers of elective C-section in relation to KPI	
Outcome 6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside of hospital , in general practice and in the community				
NHS 111	Raised patient awareness of 111 services through targeted seasonal campaigns and promotion through face-to-	Patient treated as close to their home as possible.	Decrease in self-referral to A&E after successful triage to another primary/urgent care service	Most efficient use of clinical resources and skills

	OUTCOMES			
Project	**Local**	**Patient**	**System**	**Clinical**
	face channels such as GP surgeries.			
Digital Care Plans	Availability of digital care plans/special notes to 111 provider to avoid cold-triage of patients with known conditions and plans	Better patient experience and patient treated as closely to home as possible	Reduction of ambulance call-outs by 33% from 111 for patients on EoL or with LTCs	Most efficient use of clinical resources and skills
Direct Referral of NHS 111 into primary and community services	Promotion and pilot of direct referral from 111 into primary and community services without the need for further clinical assessment/referral	Better patient experience and patient treated as closely to home as possible	Reduction in inappropriate transfers to GP/GPOOH for assessment and onward referral to community services	Most efficient use of clinical resources and skills
Electronic patient records in 999 service	Implementation of electronic patient records in 999 service allowing crews to access patient demographics, care plans. Supports timely transmission of data to A and E departments and improved reporting to Commissioners	Better patient experience and patient treated as closely to home as possible	Reduction in level of conveyance through appropriate management and continuity of any existing care plans in the community. Improved access to existing patient records and past medical history through the Summary Care Records allowing for quicker assessment and better patient outcomes.	Most efficient use of clinical resources and skills
Emergency Care Practitioners	Increased use of Emergency Care Practitioners to treat patients in their own homes with extended prescribing skills, minor injury skills and suturing skills	Better patient experience and patient treated as closely to home as possible	Increased numbers of patients who are seen and treated at home and reduced the level of conveyance to A and E	Most efficient use of clinical resources and skills
Protocols with	Development of protocols	Better patient experience	Supports appropriate use of	Most efficient use of clinical

	OUTCOMES			
Project	**Local**	**Patient**	**System**	**Clinical**
Minor Injury Units	with Minor Injury Units to accept appropriate 999 conveyance for minor injury patients to avoid an A and E attendance	and patient treated as closely to home as possible	Minor Injury Services for patients reducing the level of conveyance to A and E	resources and skills
Care Plans	Use of 999 data sets including Nursing Home activity and frequent caller activity to ensure care plans are in place to support management of patients more effectively in the community	Reduced level of conveyance from Nursing Homes and better patient experience	More efficient use of resources	Better clinical management and outcomes for patients
Integrated Nursing Teams	Local community integrated nursing teams centred around GP practices with a named clinical nursing lead for care of the patient within a locality cluster. This will be further supported by named GPs within each practice having responsibility for patients over 75 years of age	Patients encouraged to self-manage and obtain the highest quality of life possible.	Patients managed more seamlessly within the community, avoiding duplication of assessments and provision of more holistic support. This also supports the Hospital at Home implementation and current work on-going around redesign of the frail elderly pathway.	Enhanced patient experience and integrated access to care. Potential to improve quality and timeliness of care in the community.
Integrated Ophthalmology Service	Increase provision of local eye care services through an integrated ophthalmology solution	Affords greater choice of provider for patient benefit Fosters innovation and efficiencies	More efficient use of resources across the wider health system	Greater integration of clinical services
MSK	Integrated MSK (Musculo-Skeletal)service, bringing together appropriate and	Affords greater choice of provider for patient benefit Fosters innovation and	More efficient use of resources across the wider health system	Greater integration of clinical services

	OUTCOMES			
Project	**Local**	**Patient**	**System**	**Clinical**
	accredited providers	efficiencies		
Children-Provision for Children with complex needs (CMMV Programme Board)	We will work locally through the CMMV programme board with local providers to improve the quality of care for children and young people with complex needs.	Improved quality of care for the four groups of children and young people with complex needs that have been identified as requiring Community Nursing provision: 1. Children with acute and short-term conditions 2. Children with long-term conditions 3. Children with disabilities and complex conditions, including those requiring continuing care and neonates; and Children with life-limiting and life-threatening illness, including those requiring palliative and end-of-life care	We aim to improve accessibility to service provision and ensuring there is an equitable service available across the area. There will be a specific focus to ensure there are seamless transitional arrangements in place for children moving onto adult services.	Improve quality of care
Voluntary and Community Sector (CMMV Programme Board)	Through our CMMV we will strengthen our local links with the voluntary sector to provide maximal support to patients and carers	Improved links for patients and carers and engagement with the voluntary sector	Improved links for patients and carers and engagement with the voluntary sector	Improved quality of life and support from the voluntary sector may improve clinical outcomes and recovery
Maternity – Supporting anxious mother and partners (CMMV Programme	The rates of planned C-section rates have increased 5% over the past 4 years across Berkshire West. This is felt to be a result of Berkshire	Women and partners will be able to access psychological support through their GP, or women can self-refer to the service. Midwives /		

	OUTCOMES			
Project	**Local**	**Patient**	**System**	**Clinical**
Board)	West increase diverse culture, where some culture there is an expectation to have a C-section e.g. some eastern Europe countries and from increasing anxiety to natural delivery. From 2014, Women and partners who express anxiety to natural delivery will be offer psychological support through Talking Therapies	obstetricians can refer via the GP or signpost the women for self-referral.		
Maternity – Reduce the number of women being diverted to an alternative midwifery unit during labour (CMMV Programme Board)	Aim of a diversion policy to be implemented <1-3 times per months,	Increase women and partners experience of maternity care	A planned and timely service, that increases capacity and supports a better women experience	
Outcome 7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems of care				
Enhanced Recovery Programme (ERP)	Commissioning for outcomes in relation to ERP programmes within Elective Care	Defined clinical pathway from elective care through to appropriate and timely discharge	Provides for efficiencies within elective care enabling more activity to be completed with the same or less resources	Proactive management through to timely discharge, supported by MDT care

3.4 Financial Plan

Clinical Commissioning Groups (CCG's) are expected to manage expenditure with the resources allocated to them by NHS England and to deliver a 1% surplus. Newbury and District CCG's financial plan delivers this surplus in each year. The plan also sets aside 2.5% for non-recurrent expenditure in 2014/15 (with 1% of this 2.5% set aside within a 'Call to Action' fund), reducing to 1% from 2015/16 onwards, and a 0.7% contingency fund.

In 2015/16 the CCG contributes 4.7% of its allocation towards a pooled budget with its local authority partners, called the Better Care Fund (BCF). This fund will be managed in partnership with the Council, and has been created by a combination of NHS funding already committed and new investments by the CCG.

Investments set aside for 2014/15 includes funding for primary care to better identify and support elderly patients in the community (this investment has been set at £5 per head of registered population). Investment in community services to enable patients to stay at home with appropriate support (rather than be admitted to an acute hospital), additional community based numbers and increased capacity with intensive care services.

Running costs are planned to continue at current levels in 2014/15, with a reduction of 0.70% in 2015/16 in line with national guidance.

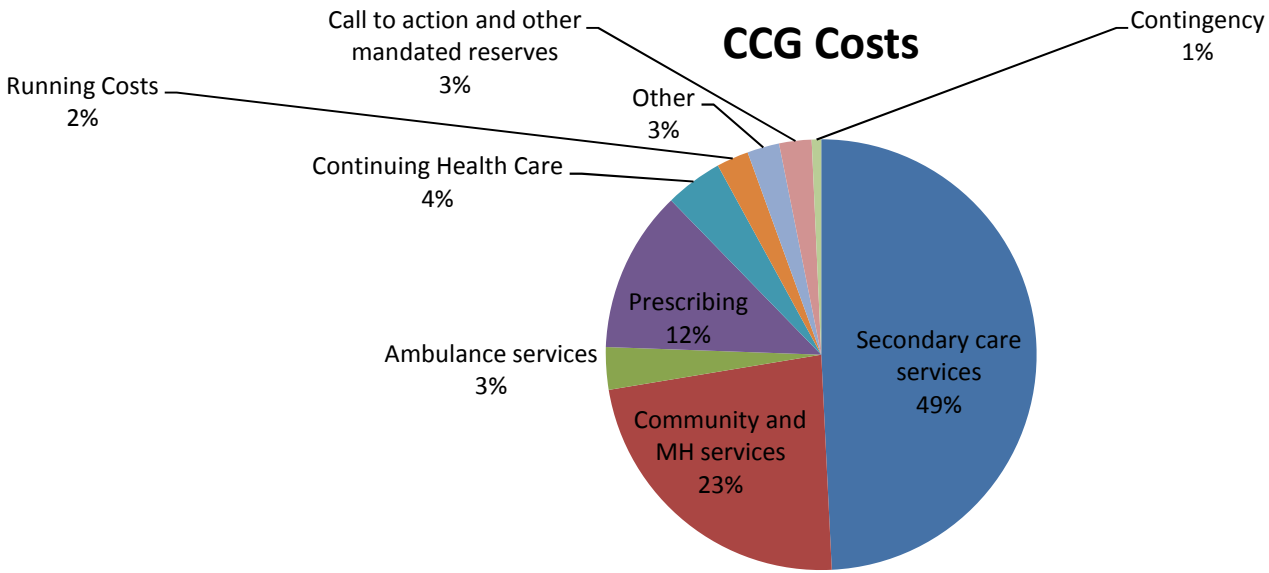
In addition to the holding of contingencies, as one of the four CCGs within the Berkshire West federation some risk will be managed through the pooling of budgets in areas such as Continuing Healthcare and high cost mental Health placements.

Financial Plan 2014/15	**£'000**
CCG Income	
Recurrent allocation baseline	111,347
Growth in year	4,034
	115,381
Non recurrent	
Return of prior year surplus & Misc	1,961
	117,342
CCG Expenditure	
Secondary care services	57,197
Community and MH services	26,916
Ambulance services	3,696
Prescribing	14,108

Major Investments in 2014/15	**£'000**
escalation bed capacity and service navigation	302
support for over 75's	588
Francis / Berwick report - implications	249
Intensive care	283
Care Home Support	158
Hospital at Home	274
Community Reablement and Rapid Response	153
Psychiatric Liaison Service	239
	2,244

DRAFTING NOTE: NEEDS TO ALIGN WITH HEADINGS IN OPERATIONAL PLAN

Continuing Health Care	5,025	
Running Costs	2,786	
Other	2,816	
Call to action and other mandated reserves	2,815	
Contingency	830	
	116,188	
Required Surplus	1,154	1.00%%



Detailed information pertaining to our financials has been submitted directly to NHS England in a separate document.

DRAFTING NOTE : NEED TO INCLUDE QIPP PLAN

4.0 Enabling the Delivery of the Plan

The CCG will undertake a number of activities that will enable the delivery of its Operating Plan these include:

- Developing the way we engage with patients and public so that we can be sure we capture the views of patients, they input to our plans and share our ambition for the local NHS.
- Considering the workforce that will be required to deliver the services we are planning and working with Health Education England to ensure that staff are trained and developed accordingly.
- Considering the informatics and information technology developments we will need to ensure that everyone involved in the care of a patient has access to the same information and using technology to support people with long term conditions to be monitored at home.

4.1 Public and Patient Engagement

Our programme of events within 'Call to Action' will continue during 2014, with further events being planned to allow us to continue to receive feedback and comments from the public around the future shape of NHS services in Newbury & District.

We are rolling out a sustained programme of engagement with the public under the banner of the NHS 'Call to Action' campaign, so that we continue to work with our patients and the public in order to develop our plans. We will focus on engaging the widest possible audience of patients, carers, staff and other stakeholders and asking for their views on the future of the NHS.

As part of this ongoing dialogue, we plan to spread the net of engagement much wider than traditional audience for such events. We have plans to use a wide range of innovative communications techniques including video, graphics and social media to encourage active participation in the debate from every possible demographic sector – children and young people, the working population and hard to reach groups.

Our aim will be to ensure that all our local engagement activity is coordinated, accessible and appealing across our entire demographic.

Wellbeing in West Berkshire

A particular innovation being driven forward through our Patient & Public Engagement team is a 'pop-up' shop featuring health and social care support and information within the Kennet Centre, Newbury. This joint venture between the CCG and Council builds on community initiatives to provide a retail unit that features a weekly footfall of 50,000 persons and will offer tailored information and service signposting on health and social care to members of the public.

The health 'pop up' shop will be staffed by volunteers, decorated by members of local restorative justice initiatives, and supported by both the CCG and West Berkshire Council.

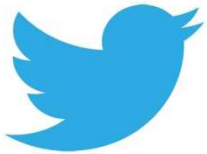
The public have been invited to take up free Health Checks through the shop, as well as to access tailored information from support groups including local mental health groups, carers groups, children and young adults wellbeing groups amongst many others.

The Kennet Centre, Newbury

The launch of the pop-up shop was supported by our various partners in health and social care, and attended by both the Rt. Hon. Richard Benyon MP and the Mayor of Newbury.

Digital engagement

Our public-facing website www.newburyandidstrictccg.nhs.uk contains information for our patients and their carers, general health information and details about the workings of the CCG and how we will engage with the public.



We have an active Twitter feed, which we continue to grow and develop. We used Twitter to great effect at the very first Call to Action event, Tweeting key facts and views live from the event, stimulating a range of discussions with interested members of the public who were unable to attend in person.

Working with partners

The CCG also works closely with our partners in the Patient Information Point (PIP) at West Berkshire Community Hospital. The PIP provides valuable support services to patients and their carers, including access to disease-specific information relating to certain conditions, as well as Shared Decision Making tools to support patients in their health and treatment choices. During 2013, both the CCG and the PIP attended the Newbury Show to promote health and wellbeing and to give information to the public on our engagement services.

Our Patient Voice Panel is growing in strength, and continues to be a key mechanism through which the CCG receives direct feedback from patients through their GP practice. The Patient Panel is regularly engaged by the CCG in relation to key themes and services, and feedback included within our planning.

We are also establishing an effective partnership with West Berkshire Healthwatch and look forward to working with them to improve our understanding of patient's experience of local services.

Working with the media

We are building relationships with the press and local radio in the Newbury area, working closely with key local journalists to ensure that news and information about the CCG's activities and health matters in the local area are covered fairly and accurately. We engage with the media using a proactive, targeted approach ensuring that information reaches the appropriate audience via the channel that suits them best.

4.2 Workforce Development

The CCG has been successful in bidding for a joint fund from Health Education England to look at developing the role of the care worker. This will be a joint project with the other CCGs and local authorities in West Berkshire

4.3 IT and Informatics

(section from KS)

5.0 The Quality of Our Services

Quality

Delivering compassionate, high quality, outcomes-focussed care in a timely manner is at the very heart of our values. We recognise that developing a shared understanding of quality and a commitment to place it at the centre of everything we do provides us with the opportunity to continually improve and safeguard the quality of local health and social services for everyone, now and for the future.

Quality is assured through a wide range of metrics, indicators, dashboards, information and intelligence gathered nationally, regionally and locally. In addition to the contractual and operating performance related standards, there will be an ongoing focus on ensuring that providers of services to Berkshire West communities are delivering quality services.

Our vision for quality is straightforward, patients and service users should:

- Receive clinically effective care and treatments that deliver the best outcomes for them
- Have a positive patient experience of their treatment and care
- Be safe, and the most vulnerable protected

Quality will be fully integrated with performance and finance in assessing the delivery of this plan and will continue to be at the centre of all of our discussions with providers.

The Francis Report, Berwick and Keogh reports

We fully understand the recommendations of the Francis, Berwick and Keogh reports and are fully committed to implementing these recommendations. The CCG will challenge healthcare providers to make on-going improvements in the quality of care provided to ensure that quality and patient safety is an integral feature of commissioned services.

This will be achieved through robust processes to seek assurance from providers to ensure that:

- fundamental standards and measures of compliance are always met
- they demonstrate openness and candour
- they promote and provide compassionate, caring and committed nursing
- they promote strong healthcare leadership
- they provide information and data that is transparent to service users and the public

Through this work we will ensure that the patient remains at the centre and that a culture of openness, transparency and candour is promoted throughout the system.

Response to Winterbourne View
We are working together across the system to move people out of Assessment and Treatment units (hospital-based care) by June 2014. A strategic plan to manage care of these patients in the community through pooled budget arrangements is under development. Consideration is also being given to the development of a new service model to support people with learning disabilities and severe challenging behaviour in the community, thereby avoiding crisis management and hospital admissions.

Patient Safety
It is of paramount importance that people know that they will be safe in our care. We will ensure systems are in place to track and manage performance including taking action when required standards are not met. To ensure patient and staff safety, it is important that we encourage learning from mistakes and make changes in practice to ensure that any incidents are not repeated.

The CCG will expect healthcare providers to continue to demonstrate a reduction in Healthcare Associated Infections (HCAI) in line with agreed trajectories, which will continue to include zero tolerance of MRSA. Additionally, there must be robust infection prevention and control plans, policies and capacity in place to demonstrate full compliance with the Health Act 2006 Hygiene Code.

Clinical Effectiveness
In order to provide cost and clinically effective care and treatment, the CCG will require providers to comply with national and local standards/guidance such as National Service Frameworks and NICE technology appraisals and guidance. The CCG will also expect to see evidence of compliance with guidance from other professional bodies. Through a quality scorecard and quality framework, the CCG will ensure that providers can evidence delivery of quality services, with benchmarking to assess performance.

Patient and service user experience
We will strive to promote compassion, dignity and respect by demonstrating positive patient and service user experience. This will be measured through a variety of means including reviewing the outcomes of national satisfaction surveys, feedback from patient participation groups, information provided by Healthwatch, complaints data, Patient Advice and Liaison Service (PALS) enquiry data and for health services the results of the Friends and Family Test. Providers will use feedback to improve and will be required to regularly inform, consult and involve patients, service users, their families and carers and the public in the planning and review of services.

Compassion in practice
We embrace the values and behaviours outlined within the vision and strategy for nurses, midwives and care staff – *Compassion in Practice*. We will ensure that all of our providers focus on the 'Six C's' (care, compassion, competence, communication, courage and commitment) putting the person being cared for at the heart of the care that is delivered to them.

Staff satisfaction
We recognise the importance of staff satisfaction to the delivery of high quality services. There is good evidence that happy, well-motivated staff deliver better care resulting in better outcomes. We recognise that health and social care staff work very hard, often under great pressure and we are committed to ensuring that we work with all our providers to make it possible for them to do the best job they can.

CQUINS
CQUIN is an incentivised monetary reward scheme (currently up to 2.5% of provider contracts) that CCGs use allocate payments to providers if they meet defined quality outcomes. The CCG will continue to work with providers to ensure that the CQUIN schemes both in the current and future contracts are stretching and deliver quality services for our population.

Seven day services
We recognise that people need health and social care services every day. Evidence shows that the limited availability of some hospital services at weekends can have a detrimental impact on outcomes for patients, including raising the risk of mortality. To support the implementation of seven day services, the CCG will be developing a CQUIN (2014/15) to support our providers in ensuring consultant cover seven days a week. We are also committed to utilising future CQUINs to support similar initiatives around 7 day working.

Access
Linked to the above is the need to ensure good access to all of the services we commission. The CCG will ensure that local providers adhere to all NHS constitution measures and access standards to provide patients with care in a timely manner. The added importance of this in relation to waiting times for a diagnosis and treatment of cancer is understood.

The Choose & Book access system for outpatient appointments will continue to be utilised to support patients to make a choice of where and when they would like their treatment.

Safeguarding
As public bodies we have a statutory duty to make arrangements to safeguard and promote the welfare of children and young people and to protect vulnerable adults from abuse or the risk of abuse. We are committed to fulfilling this function to a high quality standard.

We will ensure that systems and processes are in place to fulfil specific duties of co-operation and that best practice is embedded. The CCG is enhancing the safeguarding team to ensure sufficient support is available to providers and that we are able to fully engage with our partners on safeguarding concerns.

Relationship with external regulators
All service providers are subject to assessment and audit by a range of external regulators and assessors including the Care Quality Commission, Monitor, Royal Colleges, the Health and Safety Executive, the National Audit Office and Healthwatch.

We will build relationships with local representatives, for example from the CQC and Monitor, and commissioners will meet with these regularly to ensure any areas of concern are shared early so that support can be provided immediately to make necessary improvements.

DRAFTING NOTE: THIS APPENDIX TO BE REWRITTEN TO SHOW HOW OUTCOMES DELIVERED

Appendix 1

Newbury & District CCG has been working closely with the other CCGs in Berkshire West and our local partners, to develop a number of new initiatives and programmes to improve health outcomes and the quality of services, in line with national and local priorities already outlined in this Operating Plan.

These initiatives and programmes are set out in detail in Appendix A and summarised in the NHS England Ambition matrix below:

Initiatives 2014 to 2016	Linked to: • local Priorities (LP) • Better Care Fund (BCF) • Programme Board Oversight – Planned Care (P) Long Term Conditions (LTC) Urgent Care (U) Children, Mental Health (CMMV)	NHS England Ambitions						
		Securing additional years of life	Improving health-related quality of life for 1 or more LTC	Reducing the time spent avoidably in hospital	Increasing the proportion of older people living independently at home following discharge from hospital	Increasing the number of people having a positive experience of hospital care	Increasing the number of people having a positive experience of care outside of hospital	Making significant progress towards eliminating avoidable deaths in hospitals caused by problems in care
Care Home Support	BCF, LTC		✓	✓			✓	
Community Heart Failure	F, LTC		✓	✓			✓	
Hospital at Home	BCF, U		✓	✓		✓	✓	
Continence and Fall	F, LTC			✓			✓	
Increase in community reablement and rapid Response	F, U		✓	✓	✓		✓	

Initiatives 2014 to 2016	Linked to: • local Priorities (LP) • Better Care Fund (BCF) • Programme Board Oversight – Planned Care (P) Long Term Conditions (LTC) Urgent Care (U) Children, Mental Health (CMMV)	NHS England Ambitions						
		Securing additional years of life	Improving health-related quality of life for 1 or more LTC	Reducing the time spent avoidably in hospital	Increasing the proportion of older people living independently at home following discharge from hospital	Increasing the number of people having a positive experience of hospital care	Increasing the number of people having a positive experience of care outside of hospital	Making significant progress towards eliminating avoidable deaths in hospitals caused by problems in care
Psychiatric Liaison Service	F, CMMV			✓		✓	✓	
Integrated Eye Care Service	LP, P			✓		✓	✓	
Musculoskeletal service	LP, P			✓		✓	✓	
Cancer Care pathway	LP, P	✓	✓			✓	✓	
End of Life	LTC			✓	✓	✓	✓	
Pathology	P					✓		
Haematology	P		✓					
Frail Elderly Pathway	LTC		✓	✓	✓	✓	✓	
Improving access to Talking Therapies	CMMV		✓				✓	
CAMHS Changes	CMMV		✓				✓	
Young People (Palliative Care)	CMMV	✓	✓					

Initiatives 2014 to 2016	Linked to: • local Priorities (LP) • Better Care Fund (BCF) • Programme Board Oversight – Planned Care (P) Long Term Conditions (LTC) Urgent Care (U) Children, Mental Health (CMMV)	NHS England Ambitions						
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Maternity Early Labour Assessment Model	CMMV							
Improve Information sharing in Urgent care	U		✓	✓		✓	✓	
Carers Health Checks	LP		✓	✓				
Improvement in Dementia, Increase to memory clinic	LP, LTC	✓	✓	✓	✓	✓	✓	
Children with Complex needs	CMMV		✓					
Digital Care Plan	U		?	✓		✓		
Emergency Care Practitioners	U							
Referral s to General practices from NHS 111	U			✓				
Enhanced Recovery	P		✓				✓	✓

Initiatives 2014 to 2016	Linked to: • local Priorities (LP) • Better Care Fund (BCF) • Programme Board Oversight – Planned Care (P) Long Term Conditions (LTC) Urgent Care (U) Children, Mental Health (CMMV)	NHS England Ambitions						
		Securing additional years of life	Improving health-related quality of life for 1 or more LTC	Reducing the time spent avoidably in hospital	Increasing the proportion of older people living independently at home following discharge from hospital	Increasing the number of people having a positive experience of hospital care	Increasing the number of people having a positive experience of care outside of hospital	Making significant progress towards eliminating avoidable deaths in hospitals caused by problems in care
programme								
Neighbourhood Clusters	LP		✓	✓	✓	✓	✓	





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Title	N&W Reading CCG draft 2 Year Operational Plan
Sponsoring Director	Maureen McCartney, Operations Director
Author(s)	Maureen McCartney, Operations Director
Purpose	To inform the Health & Wellbeing Board of progress on the development of the CCG 2 Year operational plan
Previously considered by	North & West Reading Governing Body 18th March

Executive summary

NHS England issued planning guidance to Clinical Commissioning Groups (CCGs) "Everyone Counts: Planning for patients 2014/15 to 2018/19" on 20th December 2013. This guidance requires CCGs to produce a 5 year Strategic Plan and associated 2 year Operational plan.

The 5 year Strategic Plan and associated 2 year Operational plan are required to be formally approved by NHS England with involvement of the Health and Wellbeing Board in ensuring the plans triangulate with the Health and Wellbeing Strategy.

The CCG is continuing to develop both its five Year Strategic Vision and the 2 Year Operational Plan in line with guidance and advice issued by NHS England. The 2 year Operation Plan builds on patient and public feedback gathered through the November 2013 Call to Action event as well as input from Public Health and the four Programme Boards.

The first draft was submitted to the Local Area Team on 14th February 2014. The plan needs to be signed off by the Council of Practices (meeting being held 1st April) prior to final submission to the Local Area Team on 4th April 2014.

Attached is the current draft of the North & West Reading 2 Year Operational Plan.

Recommendation

The Health & Wellbeing Board is asked to **note** the current draft plan, in particular the 'Plan on a Page' (on page 11) and to **note** the ongoing work of the CCG in supporting the delivery of the West Berkshire Health and Wellbeing Strategy.

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NHS
North and West Reading
Clinical Commissioning Group

2014/16

Draft Operational Plan

Table of Contents

Foreword by Dr Rod Smith, Chair of North & West Reading CCG

This 2 Year Operational Plan describes what North & West Reading Clinical Commissioning Group (CCG) will be doing during the next 2 years to ensure that our patients have access to high quality health services that will help ensure better outcomes for them and generations to come.

The CCG has been in operation since the 1st April 2013, leading the commissioning of healthcare services for our local population. Over the last decade, the role of commissioning, as a key driver of quality, efficiency, and outcomes for patients, has become increasingly important to the health system in England. In its simplest form commissioning is the process of planning, agreeing and monitoring services. It is not one action but many ranging from the health needs assessment of a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.

The plan shows what we will be doing to help deliver better outcomes for our patients against the five domains and seven outcome measures of the national NHS Outcomes Framework, as well as improving health, reducing health inequalities and parity of esteem.

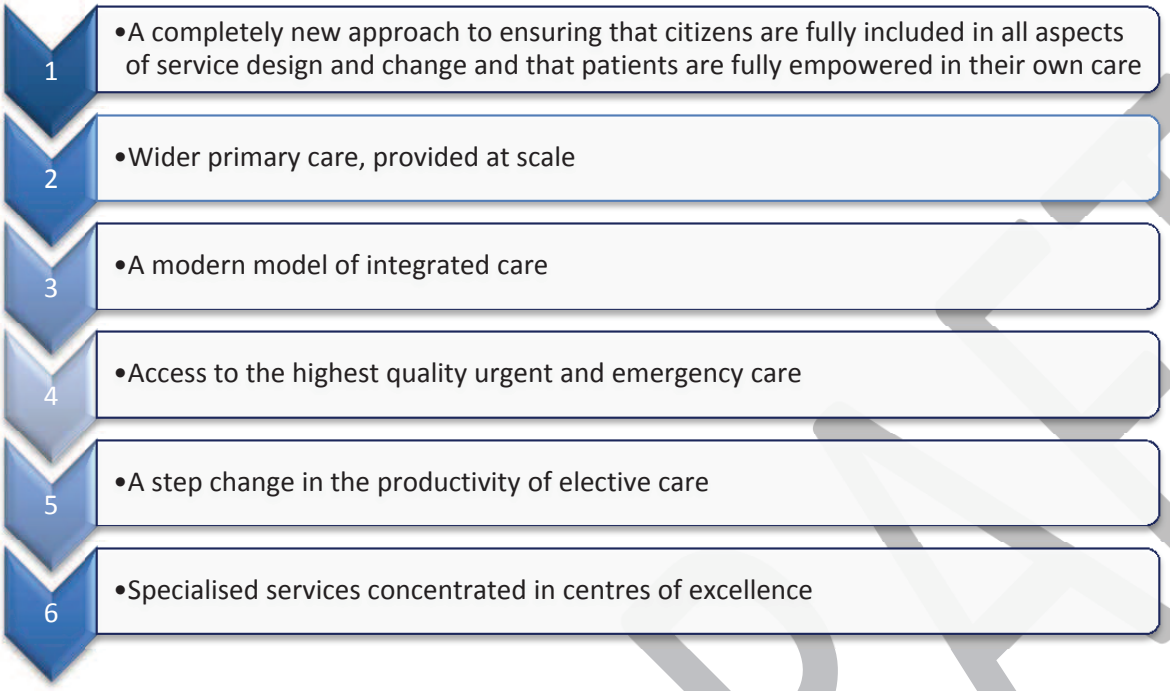
The Five Domains:

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long term conditions
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Ensuring that people have a positive experience of care
Domain 5	Treating and caring for people in a safe environment, and protecting them from avoidable harm

The Seven Improving Outcome Ambitions:

1.	Securing additional years of life for people of England with treatable mental health and physical conditions
2.	Improving the Health related quality of life of the 15+million people with one or more long-term condition, including mental health
3.	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community outside of hospital
4.	Increasing the proportion of older people living independently at home following discharge from hospital
5.	Increasing the number of people having a positive experience of hospital care
6.	Increasing the number of people with mental and physical health conditions having a positive experience of care outside of hospital, in general practice and in the community
7.	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

In addition, NHS England has identified that any high quality, sustainable health and care system will have the following six characteristics and our plan shows how we plan to develop these characteristics locally:



The plan will be delivered in partnership with our patients, our 3 CCGs partners in the Berkshire West Federation, the Royal Berkshire NHS Foundation Trust, Berkshire Healthcare Foundation Trust, South Central Ambulance Trust, Reading Local Authority and West Berkshire Local Authority. We hope this will assure our local community that all parts of the health and social care system are working together to provide the best possible high quality services for our patients.

We are committed to making sure that public, patient and carer voices are at the centre of our healthcare services from planning to delivery. As NHS Commissioners we have a duty to support better patient and public engagement. We will continue to ensure that patients and carers are able to participate in planning, managing and making decisions about their care and treatment through the services we commission. We will also ensure the effective participation of our public in the commissioning process itself so that services reflect the needs of our local population.

There are a number of pressures facing the CCG. We have a financial challenge and demand for services is predicted to rise, with a recent analysis suggesting that the "do nothing" scenario could result in a potential £10.2m cost pressure to the CCG by 2018/19. As national benchmarks show that our local health and social care economy is already a productive system it is clear that there will not be enough money to meet this additional demand unless services are provided in a different way.

In the autumn we carried out a very successful “Call to Action” engagement campaign to enable as many of our local population to understand the financial challenges ahead and to help shape our views on the future of our local health services. Some of the key messages from this were that local people want care to be more co-ordinated, and that organisations should work more effectively together to support people to remain in their own homes for as long as possible, with care plans empowering patients and carers to work alongside professionals to improve their health.

There is also a growing recognition of the influence of lifestyle factors on ill-health and the need to improve levels of prevention, self-care and education for our population. This will help to contain demand as services work to meet the needs of an increasingly elderly population. People also thought that we needed to value more the vital contribution that the Voluntary Sector can make.

This plan reflects these views and also describes a new relationship whereby patients and carers play an instrumental role in shaping the services available to them and as a partner in the services they receive.

This 2 year operational plan should be read in conjunction with the 5 year strategic plan for the 4 CCGs in Berkshire West. This is available at www…To be Inserted

Overview of 2013/2014 from the Chair of the Council of Practice, Dr George Boulos

The North and West Reading CCG is a clinically led organisation made up of the clinicians from our 10 member GP practices. This group of practices has come together to commission the majority of NHS Services for people who live in our local community. We work with other healthcare professionals and in partnership with local communities and Local Authorities to do this.

We have a strong and interactive Council of Member Practices with a voting representative from each practice. Council members elect our Board representatives. A list of our Council of Practices and a map of our CCG area can be found at Appendices 5-6.

The CCG has practices within two Local Authority boundaries, three in West Berkshire and seven in Reading. Good working relationships have been established with both Local Authorities. Patient flows for healthcare services are common and primarily focused around the Royal Berkshire NHS Foundation Trust for acute care and Berkshire Healthcare Foundation Trust for mental health and community services.

During 2013/14 our clinicians have embraced their new role as clinical commissioners with the support of their staff and have demonstrated their absolute commitment to deliver improvements to services, better outcomes for patients and to make cost effective use of health resources. The following are some examples of some of our key achievements in 13/14:

North & West Reading Key Achievements in 2013/14
Bowel Cancer Screening has increased from 55.5% to 61.9%. This means an additional 457 patients have been screened.
Improved the care of patients with diabetes in partnership with our patients. The numbers of patients receiving all 9 care processes has increased from 962 for 2012/13 to 1900 2013/14 (as of December 2013)
Achieved savings of £458K against an unscheduled care QIPP target of £397K at M8
Successfully engaged with our Practice Patient Group Representatives via our monthly Patient Voice Group meetings, a fundamental part of a patient centred NHS.
Held a very successful "Call to Action" event in November 2013, the outputs of which are informing this plan and our 5 year strategy.
CCG Board visits to all 10 practices to ensure that all clinicians and staff in the practice are engaged in the commissioning process and understand the key role they each have in supporting the CCG meet its commissioning objectives.
Further developed our relationships with our health and social care partners, Health watch and the Voluntary Sector.

The CCG works in a federated arrangement with the 3 other CCGs in the Berkshire West area, South Reading CCG, Wokingham CCG and Newbury & District CCG to support each other with key pieces of work and to help improve health outcomes across a wider health economy. A key feature of this is the work of our Programme Boards listed below. Each CCG has a lead for the work of a Programme Board. Examples of some achievements that the Programme Boards delivered in 13/14 are as follows:

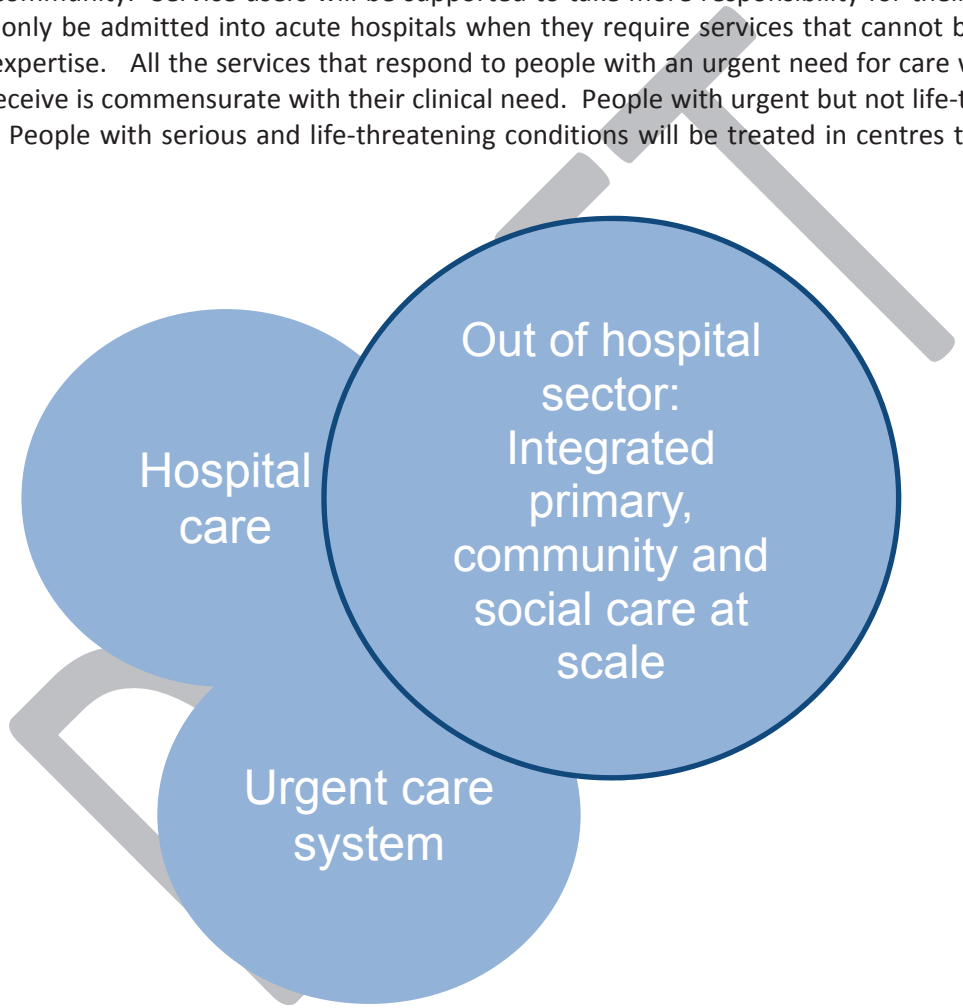
Berkshire West Wide Achievements 2013/2014	
LONG TERM CONDITIONS – Led By South Reading CCG – **Dr Elizabeth Johnston** • Recruitment of specialist diabetic nurses and community diabetologist to run 'one stop shop' clinics and increased patient engagement through care planning and technology. • Enhancements to COPD service including the introduction of a COPD Exacerbation Assessment Service, helping to avoid admissions and implemented a COPD Discharge Care Bundle • Telemonitoring of patients with heart failure using an automated telephone messaging service • Introduction of risk profiling and multidisciplinary meetings to help support patients at high risk of an admission.	**URGENT CARE** – Led by North & West Reading CCG – Dr Andy Ciecierski • Successful implementation of NHS 111. • Introduction of new Urgent Care dashboard being used by all partners across the health and social care system to inform capacity and demand planning and interventions on a daily basis. • Redesign of the clinical decision unit at the Royal Berkshire Foundation Trust to improve patient experience and ensure rapid access to expert assessment and care • Expanded Rapid Response and Reablement Service
PLANNED CARE - Led by Newbury & District CCG – **Dr Abid Irfan,** • Initiated a comprehensive programme of multi-provider engagement spanning NHS and Independent providers • Enhanced patient choice through a greater range of providers for Ophthalmology services • Ensured that spend on Pathology is closely monitored, with modifications to Pathology requesting software in Primary Care to better manage the effectiveness of costs • Delivered redesign of MSK pathways across a range of providers for patient benefit	**JOINT COMMISSIONING** - Led by Wokingham - Dr Stephen Madgwick • Decreased waiting times for IAPT to 95% access within 28 days • Improved and extended access to Personality Disorder , ADHD ASD services • Improved urgent care/crisis response service for people with Mental Health and social problems.

We are looking forward to building on these successes and hope that this plan for the next 2 years once again demonstrates how placing clinicians at the heart of NHS commissioning means we can work with our partners and communities to lead, shape and make real improvements in local health care and wellbeing.

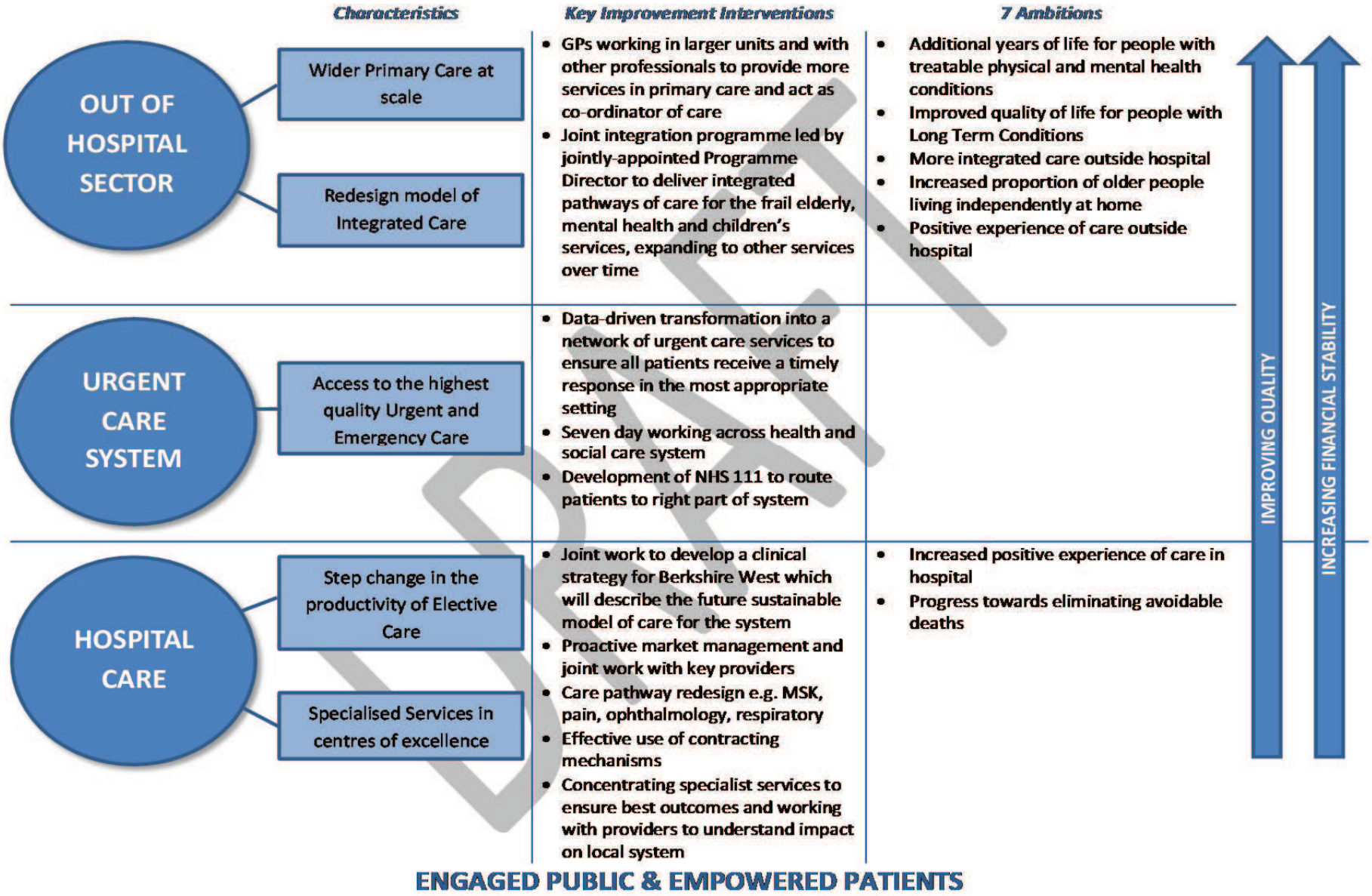
Further information on the CCG is available on our website at: www. http://www.nwreadingccg.nhs.uk/

North & West Reading CCG - Our Vision for 2019: A Shared Vision with the 3 other CCGs in the Berkshire West Federation

By 2019, enhanced primary, community and social care services in Berkshire West will work together to prevent ill-health and support patients with much more complex needs at home and in the community. Service users will be supported to take more responsibility for their health and wellbeing and to make decisions about their own care. Patients will only be admitted into acute hospitals when they require services that cannot be delivered elsewhere and will be treated in centres with the right facilities and expertise. All the services that respond to people with an urgent need for care will operate together as a single system. This will ensure that the service people receive is commensurate with their clinical need. People with urgent but not life-threatening conditions will receive responsive and effective care outside hospital. People with serious and life-threatening conditions will be treated in centres that maximise their chances of survival and a good recovery.



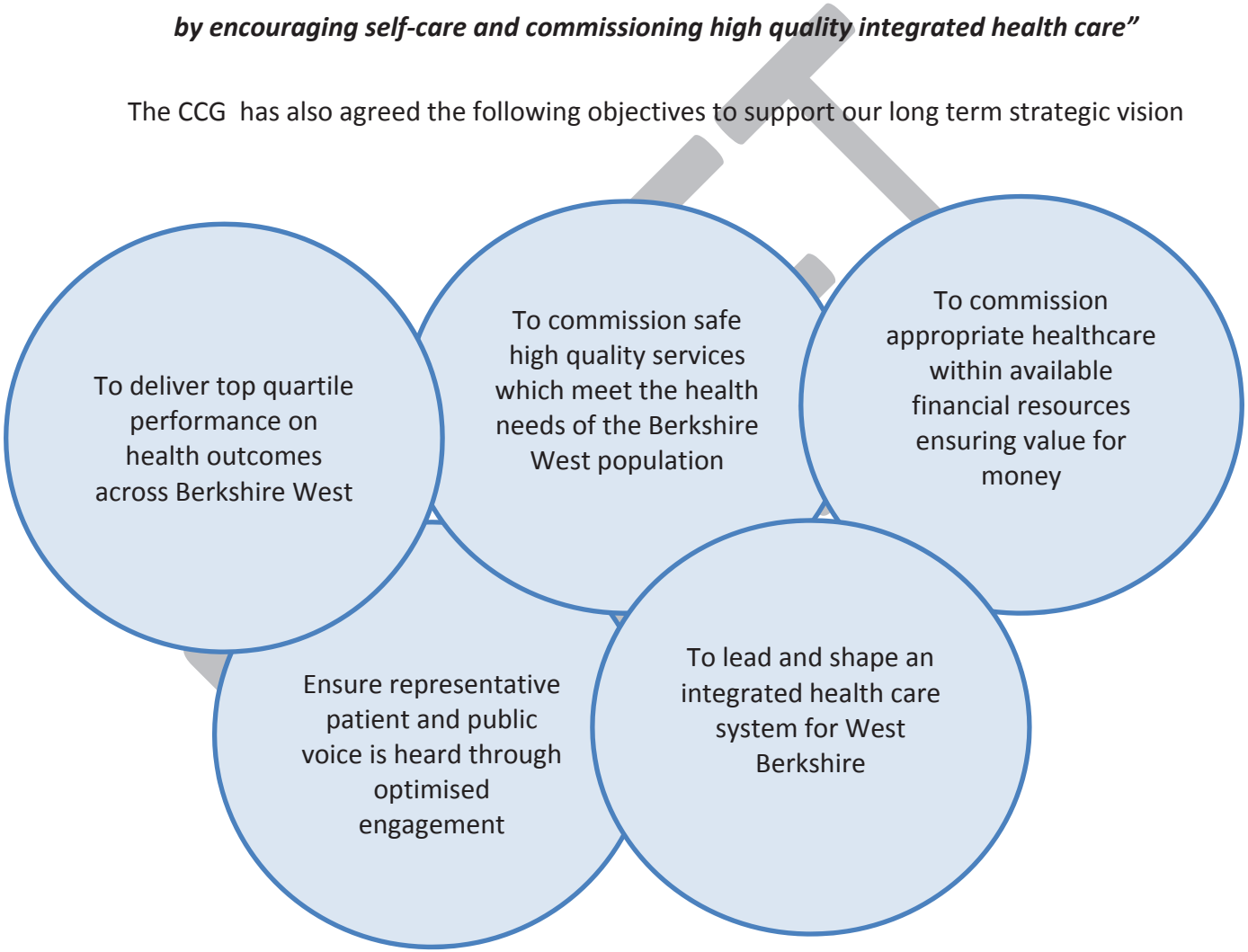
Berkshire West CCGs 5 Year Strategic Plan on a Page:



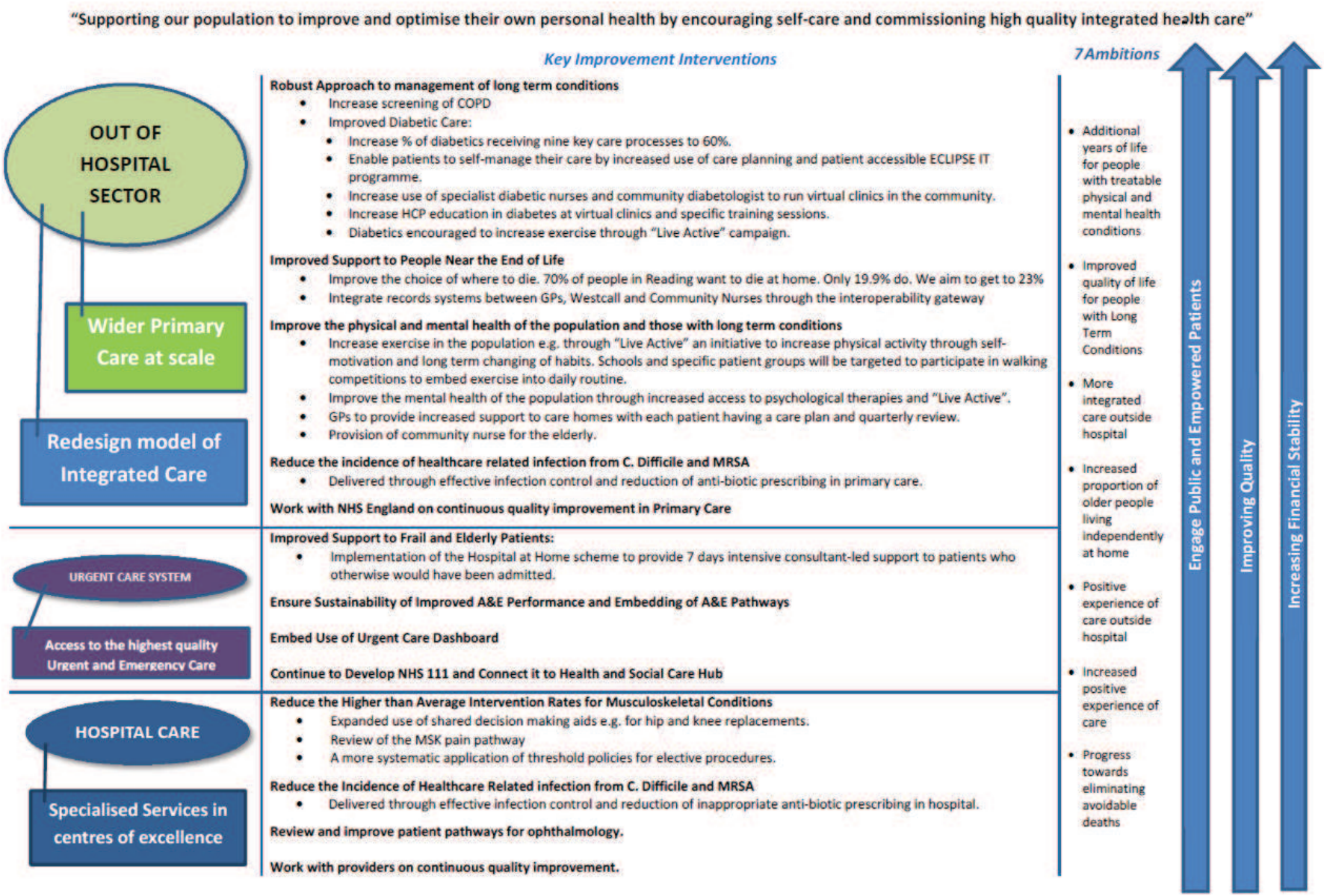
North & West Reading - Our Local CCG Vision for the next two years – 2014-2016

"Supporting our population to improve and optimise their own personal health by encouraging self-care and commissioning high quality integrated health care"

The CCG has also agreed the following objectives to support our long term strategic vision



North & West Reading CCG's 2 Year Operational Plan on a Page:



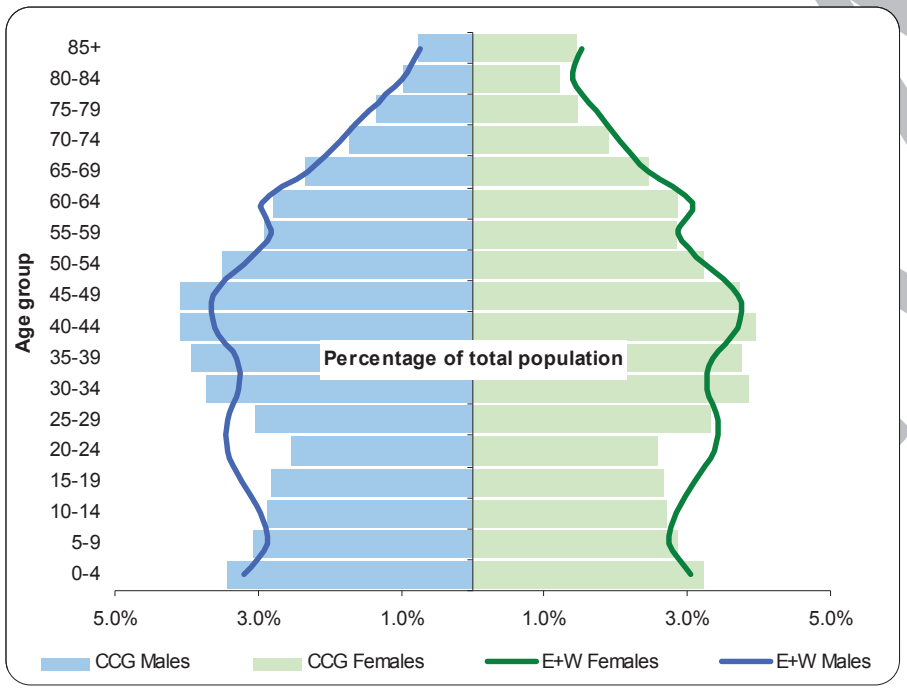
How we developed our Plan

In developing this 2 Year Operational Plan the CCG has taken the following steps:

1. **We have analyse the most important health problems at population level**
2. **Working together with partners and the community we have set common goals and priorities**
3. **Identified improvement interventions which link to the NHS Outcome ambitions**

1. Our Population – An analysis of Health Needs in North & West Reading

The CCG's resident population is estimated to be 99,350 and the registered population is 107,093. The figures below show the registered population profile of North and West Reading CCG compared with the national profile (2012).



Age Group	Male	Female	People
0-4	3682	3443	7125
5-9	3290	3077	6367
10-14	3063	2895	5958
15-19	3029	2849	5878
20-24	2722	2786	5508
25-29	3275	3560	6835
30-34	3983	4123	8106
35-39	4224	4031	8255
40-44	4363	4227	8590
45-49	4363	3983	8346
50-54	3741	3444	7185
55-59	3126	3034	6160
60-64	2988	3067	6055
65-69	2507	2630	5137
70-74	1845	2033	3878
75-79	1441	1578	3019
80-84	1037	1302	2339
85+	816	1536	2352
Total	**53,495**	**53,598**	**107,093**

The CCG spans two Local Authority areas, Reading and West Berkshire and the specific characteristics and health needs for our population are outlined in the "Public Health Locality Profile" (2013), produced as part of the Joint Strategic Needs Assessments for West Berkshire Council and Reading Borough Council. This shows the following:

Population

- The CCG's resident population is estimated to be 99,350 (Census 2011) and the registered population is 107,093, this will result in a rise in older people in future, at a greater rate than the national average.
- 9.7% of the CCG's resident population have identified themselves as carers which is slightly higher than the Berkshire CCG percentage.
- There is also a variation in the CCG population with regards to health and social needs due to wider determinants of health such as educational attainment, employment status, types of housing, income, and the local environment.
- The population profile differs from the national picture with a smaller proportion of younger people (aged 10 to29) and a larger proportion of people aged 30-54
- The most deprived areas within the CCG boundary are in parts of Caversham, Southcote and Kentwood wards (Reading Borough Council). These are all in the 20% most deprived neighbourhoods in the country

Health Behaviour

- When asked to comment on their level of health in the Census 2011 and whether this affected their day-to-day activities, more people in the CCG boundary felt that they had a good or very good level of health compared with the national response.
- Obesity levels are higher than the Berkshire CCG area of 8.9% and is a specific area of focus for the CCG. Obesity increases the risk of heart disease, diabetes, stroke, depression, bone disease and joint problems and decreases life expectancy by up to nine year
- Obesity: 8,067 people aged 16 and over are on the CCG's Obesity Register (9.3% of the population). The highest prevalence for obesity is in an area of the Calcot ward (West Berkshire Council).
- Obesity: 8.1% of children aged 4-5 and 15.3% of children aged 10-11 are obese.
- Binge drinking: 23% of people who live in an area of the Theale Ward (West Berkshire Council) are defined as binge drinkers
- Healthy eating: neighbourhoods in the Southcote ward (Reading Borough Council) has the lowest proportion of healthy eaters in the CCG at 24.5%

Health

- There were 21,092 emergency admissions into hospital over the three year period (2006-2008).
- The prevalence of cardiovascular diseases, cancer and respiratory diseases is higher in the CCG than it is in the Berkshire CCG region. However prevalence of Diabetes is lower.

Health Protection To be updated

- The CCG met the national screening targets for breast cancer, cervical cancer and bowel cancer
- The CCG met the 95% coverage target for childhood immunisations for 1 and 2 year olds in 2012/2013. The CCG just missed the target for 5-year olds MMR immunisations, but was the highest performing CCG in Berkshire for this vaccine.
- The CCG met the 75% coverage target for seasonal flu immunisations for people aged over 65 and over.

Patient Satisfaction

- The CCG performed well in the last GP Survey, compared with Berkshire and the national scores. The CCG's patients rated the overall experience of their out-of-hours services highly and also stated that it was easy to contact them. A comparatively large proportion also said that they would recommend their GP Surgery who moved into the area.

THE CHALLENGES WE FACE (to be completed)

Our CCG is performing highly in many clinical outcome indicators. However the CCG Outcome Tools and Atlases listed above highlight the following key challenges facing the CCG where performance could be improved compared to national or similar CCG data. There are operational and strategic plans in place to address and further investigate the majority of these issues, as outlined below.

Challenge	Intervention
Asthma prevalence - 6.79% compared to national average of 5.94% [Commissioning for Value Tool]	
Percentage of people with diabetes using 9 care processes	
Depression (ages 18+) prevalence - 14.54% compared to national average of 11.68% [Commissioning for Value Tool]	
Hypertension prevalence - 13.25% compared to national average of 13.63% [Commissioning for Value Tool]	
Hyperthyroidism prevalence - 3.20% compared to national average of 3.12% [Commissioning for Value Tool]	
Musculoskeletal – spend on all secondary care admissions – 45509 compared to national average of 39092 [Commissioning for Value Tool] Musculoskeletal – spend on elective and day-case admissions – 41809 compared to national average of 35484 [Commissioning for Value Tool]	
Cancer prevalence - 1.93% compared to national average of 1.77% [Commissioning for Value Tool]	
Chronic kidney disease (ages 18+) prevalence - 4.28% compared to national average of 4.27% [Commissioning for Value Tool]	
Reported prevalence of COPD on GP registers as % of estimated prevalence - 41.1% compared to national average of 57.8% [Commissioning for Value Tool]	Increased Screening of COPD
Reported prevalence of CHD on GP registers as % of estimated prevalence - 64.0% compared to a national average of 73.4% [Commissioning for Value Tool]	

Gastro – intestinal – mortality from liver disease under 75 years - 20.9 compared to national average of 16.0 [Commissioning for Value Tool]	
Spend on FHS prescribing – 1982 compared to national average of 1672 [Commissioning for Value Tool]	
Potential Years of Life Lost amenable to healthcare – male – 2786 compared to national average of 2267 - [CCG Outcome Tool and Levels of Ambition Atlas]	
Incidence of healthcare-associated infection – C.Difficile - 42.02 compared to national average of 27.88 [CCG Outcome Tool and Operational Planning Atlas]	
Incidence of healthcare related infection – MRSA - 2.80 compared to national average of 1.77 [CCG Outcome Tool and Operational Planning Atlas] – in 5th quintile nationally at 24.9% [Atlas of Variation]	
Ratio of reported to expected prevalence of epilepsy (Berkshire West PCT) - in 5th quintile nationally at 0.75 [Atlas of Variation]in highest quintile nationally at 9230 [Atlas of Variation]Rate of cemented primary hip replacements expenditure (Berkshire West PCT) - in highest quintile nationally at 5476 [Atlas of Variation]	

Work together with partners and the community to set common goals and priorities

Working together with Reading and West Berkshire Local Authorities

The CCG has worked with our two Partner Local Authorities to set common goals and priorities aligned to their individual Health & Wellbeing strategies.

The Reading Health and Wellbeing strategy vision is: *A healthier Reading – Communities and agencies working together to make the most efficient use of available resources to improve life expectancy, reduce health inequalities and improve health and wellbeing across the life course.* Underpinning this vision are the following four goals:

- Goal 1 – Promote and protect the health of all communities particularly those disadvantaged
- Goal 2 – Increase the focus on early years and the whole family to help reduce health inequalities
- Goal 3 – Reduce the impact of long term conditions with approaches focused on specific groups
- Goal 4 – Promote health-enabling behaviours & lifestyle tailored to the differing needs of communities

The West Berkshire Health and Wellbeing Strategy outline the following five priorities to deliver its vision *"To Add Life to Years and Years to Life":*

- Addressing childhood obesity in primary school children
- Giving every child and young person the best start in life
- Supporting those over 40 years old to address lifestyle choices detrimental to health
- Supporting a vibrant district
- Promoting independence and supporting older people to manage their long term conditions

Appendix one shows the alignment of our plans with the two Health and Well Being strategies referred to above.

Working together with our Patients

The CCG is committed to ensuring that public, patient and carer voices are at the centre of our healthcare services from planning to delivery. As commissioners, we need to be informed by insightful methods of listening to those who use and care about our services.

In his foreword to this plan the Chair of the CCG talked about the pressures that face the NHS going forward. Preserving the values that underpin a universal NHS, free at the point of use, will mean fundamental changes in the way we deliver and use health and care services. This is not necessarily about structural change; it's about finding ways of doing things differently harnessing technology to fundamentally improve productivity, putting people in charge of their own health and care, integrating more health and care services and much more besides.

This new approach cannot be delivered by any organisation standing alone. That is why we want to work together, alongside patients, the public and other stakeholders to improve standards, outcomes and value.

We will explore the range of options that we can use to ensure that patients can be active in their own healthcare and to ensure that the services we commission meets the wants and needs of the local population. We will develop our Communications and Engagement Strategy during the year ahead and use the guidance in "*Transforming Participation in Health and Care*" to support us with this.

To build on, enable and support the public mandate for change within the NHS, we are rolling out a sustained programme of engagement with the public under the banner of the NHS 'Call to Action' campaign. A series of events began in late 2013 and will continue during 2014, with a focus on engaging the widest possible audience of patients, carers, staff and other stakeholders and asking for their views on the future of the NHS. We began this process by holding a very successful "Call to Action" event in November 2013, (summarised over the next few pages). This enabled us to engage with as wide an audience as possible to support and understand the financial challenges ahead at a local level and to share views on the future of local health services. This in turn has helped shape this two year Operational Plan and our five year Strategic Plan.

As we go forward with the 'Call to Action' campaign, we plan to spread the net of engagement much wider than traditional audience for such events. We have plans to use a wide range of innovative communications techniques including video, graphics and social media to encourage active participation in the debate from every possible demographic sector – children and young people, the working population and hard to reach groups. Our aim will be to ensure that all our local engagement activity is coordinated, accessible and appealing across our entire population.

We are holding follow up "Call to Action" events in April and September 2014. We will also use our monthly Patient Engagement Steering Group and Patient Voice meetings to ensure that that the voice of our local population is heard in all aspects of the CCG's business and that opportunities are created and protected for patient and public empowerment in the work of the CCG.

What our Patients Told Us at the "Call to Action" Event held 13th November 2013

Care to be more co-co-ordinated

Need to promote self-care through education and responsibilities for own health

Better communication and improve information sharing "Tell the story once"

Supporting people to remain in their own homes

Organisations working more effectively together

Need to maximise the contribution from the voluntary sector

Empowering Patients and Carers

What our Patients Told Us at the "Call to Action" Event held 13th November 2013

What people want from their NHS

- People want and value an NHS that is free at the point of use, trustworthy, reliable and providing a consistent level of care with equal treatment for all
- A desire to limit the amount of private sector involvement in delivery of healthcare
- Recognition of the vital contribution the voluntary sector makes to health care and planning
- Healthcare professionals should all have the same access to the same information (preferably using the same IT system)
- Complex care to be better coordinated.
- Greater levels of integration across health and social care providers
- Better integration of health and social care to reduce unnecessary admissions e.g. to care homes, and appropriate involvement of carers and patients in care planning meetings
- High quality and reliable services
- Patients to be in control of their care
- Right care, right place, right time with the most appropriate healthcare professional
- More focus on community services, particularly for those with long term conditions and for the elderly.
- The idea of 'hospital at home' was welcomed, if with caution
- Some areas of Reading are very diverse so there should not be a "one size fits all" model
- Better management of public expectation of services and better education of patients about what their care costs

How Should the NHS Spend its Money?

- Greater focus on keeping people well and preventing ill health
- More advice on the benefits of physical exercise and more health promotion and education.
- One person asked 'How are the local commissioners going to move their budgets from 'late treatments' to 'early intervention'?'
- Improved levels of preventative care, incorporating more self-care and education for patients
- Complete transparency over the extent of the financial challenge ahead and a requirement for the public to be educated as to the real cost of the service being provided
- Effective links between health and education with messages in schools including the importance of mental wellbeing as well as healthy eating and physical activity

Areas of Concern:

- Lack of a seven-day service
- Adequate checks and balances in relation to private sector involvement in the NHS
- Access to GPs and continuity of care
- The NHS needs to learn from its mistakes
- Liked the idea of outreach by Consultants but wanted to know that this would not be too expensive in practice. The need for earlier diagnosis of dementia, especially in younger people, was identified
- Concern about the drop in children's physical activity levels. People wanted to see GPs offering access to exercise and information on the benefits of exercise as a routine alternative. It was felt that people should be encouraged to help themselves more with GPs used as a funnel for public health information and as a route for improving people's level of physical exercise

Patients were also asked whether they felt our draft plans captured the key challenges for the next two years and their responses were as follows:

Plans for Frail/Elderly People:

- Services need to focus on supportive neighborhoods, Consultant services delivered in the community, better information sharing and integrated working
- More focus and investment in community services and more community nurses
- More care at home
- Idea of " Hospital at Home" welcomed with caution
- Better integration of health and social care to reduce unnecessary hospital admissions from Care Homes
- Involvement t of patients and carers in care planning meetings
- Elderly people need access to alternatives to A&E, to be able to access GPs over the phone and to be able to access services in a timely way before the issue becomes an emergency.

Plans for Children:

- Need early intervention with families and a focus on early care
- Families of children not having immunisations should be targeted.
- A view that children's mental health problems and self-harm seemed to be increasing
- More support for (particularly young) parents to help their children, more use of health visitors, perhaps for longer periods (as in New Zealand)
- Opportunities for health promotion and promotion of healthy eating for families in more deprived localities
- More education about the dangers of too much fat and sugar with this education starting in the kinder garden
- Voluntary sector support for families

Plans for Mental Health:

- Greater involvement of the whole family so that families understand the condition and do not exacerbate it further
- The interface between the NHS and voluntary sector needs to be reviewed as this sector could help break down the stigma of mental illness in certain community groups
- Particular focus is needed on transition issues through Child and Adolescent Mental Health Services to adult services and on the provision of inpatient mental health services for the under 18s.
- Opportunities to address the mental health problems of those committing crime while they were in prison
- Mental Health and Alzheimer's to have a more explicit focus in future plans

Plans for Respiratory Health:

- Could Reading do something to aim to be a "low smoking town"
- Recognition of the fact that people in lower social-economic groups may find it more difficult to give up smoking and drinking
- What impact does very hard water and traffic have on respiratory health in the area
- Patients with respiratory problems could be helped more to help themselves
- GPs needed to have more time than they do currently in order to have a sufficiently good quality interaction with the patient

Plans for End of Life Care:

- The concept of a good death is very important.
- A " good death" means good care contact is most important
- Face to face
- 70% of people in Reading want to die at home but only 19.9% do
- Need to remove the social taboos around discussing death
- Plans should reflect that home is a better place to die but that appropriate support is necessary to enable this to happen
- The importance of services like 'night sitting and day sitting'

Plans for Diabetes:

- Need to see more evidence of health screening, preventative healthcare and education in future plans
- Better, more consistent communication of health messages from GP surgeries with the same communication methods being used by all.

Plans for GP Services

- More efficient GP services with more flexible appointment systems, less use of locums and more access to own named GP
- Improved access to GP services would reduce attendance at A&E
- More access to minor injuries units
- Increased use of technology with integrated health records, online ordering of prescriptions and reviewing of test results, extension of electronic prescribing and repeat dispensing
- More sign posting of services
- GPs needed to have more time than they do currently in order to have a sufficiently good quality interaction with the patient

Improvement Interventions

Appendix 3 sets out our plans to ensure the ongoing sustainability of the local health and social care system translated into specific interventions to provide care in different ways thereby improving outcomes for patients and delivering financial savings

Our key priorities and initiatives are assessed against an established prioritisation process. A Prioritisation Framework Tool is applied to each new initiative and scored against the following criteria:

- Strategic Fit/ Statutory Requirement
- Financial Impact
- Quality & Health Outcomes
- Achievability Assessed Needs
- Evidence based
- Effect on health inequalities

The relevant Programme Board will review each proposal in depth and will take into account potential disinvestment opportunities identifying provision that will be affected locally. Recommendations from Programme Boards are taken to the federated QIPP & Finance Committee for a final decision.

Our highest priority federated programmes/initiatives in 2014-16 based on the prioritisation scores and the level of potential efficiency gain in the health economy are:

Hospital at Home (Potential net saving 14/15 of £1,438,000) - .

This model within the LTC programme board of work includes providing more intensive support for short periods of time to patients in the community under the care of a consultant led team. Patients will be identified as requiring a higher level of support than is currently provided and will receive a level of care as if they were in a hospital setting. This intervention will support the CCGs achievement of their Outcome Ambition 3 and will help to reduce emergency admissions. This scheme is also featured within the **Better Care Fund** plans for the three local authority areas across Berkshire West. **(see Better Care Fund page ?)** as the integration of services across health and social care are seen as an essential success criteria.

Care Home Initiative (Potential Net saving in 14/15 £520,000) –

To introduce a model of enhanced services to nursing and care homes which will provide training and support to homes to help with longer term care planning for their residents and support during times of crisis. This intervention will support the CCGs achievement of Outcome Ambition 3 and will help to reduce emergency admissions. This scheme is also featured within the **Better Care Fund** plans for the three local authority areas across Berkshire West. **(see Better Care Fund page ?)** as the integration of services across health and social care are seen as an essential success criteria.

Integrated Eye Service (Potential Net Saving in 14/15 £500,00) –

The overall aim of this intervention is to deliver more effective commissioning of an integrated ophthalmology service, ensuring consistency and reducing clinical variation. The intervention will result in overall cost savings through a reduced tariff. Patients will benefit from pathway improvements and this initiative will support the CCGs in achievement of **Outcome 6 -** Increasing the Number of People with Mental and Physical Health Conditions Having a Positive Experience of Care Outside of Hospital, in General Practice and in the Community.

MSK Service Redesign (Potential Net Savings in 14/15 £427,000) –

This intervention expands the focus on pathway improvement for MSK services. It will include an expansion of the current shared decision-making scheme (SDM) in primary care ensuring that SDM applies to all the selected pathways and with all relevant providers. This will incorporate the ongoing review and implementation of the MSK pain pathway to develop an integrated pathway and improvement in the pain management service. Part of this work will involve the de-commissioning of the MSK CAS service. The MSK integrated pathway will address waiting time issues that are currently present, and ensure there is equity between NHS and Independent pathways. Reduction in the number of surgical interventions for hip and knee replacements can be achieved by a combination of the use of Shared Decision Making (SDM) Tools and Threshold policies. There will be associated savings for CCGs related to the reduced activity. this initiative will support the CCGs in achievement of **Outcome 6 -** Increasing the Number of People with Mental and Physical Health Conditions Having a Positive Experience of Care Outside of Hospital, in General Practice and in the Community

In addition the four programmes boards have identified the following work streams for 2014-2016

Berkshire West Programme Board Strategies2014/2016	
Long Term Conditions Programme Board • Risk stratification –Identification and monitoring of patients at risk of health deterioration; preventing crisis. • Integrated care-Care planning and care delivery provided seamlessly between health and Social Care • Empowerment of patients to self-management, using technology, psychological support and increased rehabilitation after a period of ill health.	**Children, Maternity, Mental Health/Learning Disabilities, Carers and Voluntary Sector (CMMV) Programme Board** • Improving the mental health and wellbeing of our population • To improve outcomes and quality of life for people with mental health problems and learning disabilities through high quality services and equality of access • To improve the physical health of people with mental health and learning disabilities • Co-ordinate the commissioning of children's health and social care across the whole spectrum of children's needs • To ensure accessible, safe, high quality supportive maternity services meeting the needs of our population and making the most effective use of NHS resources • Ensure that carers and families have the right support
Planned Care Programme Board • Using more community-based health services rather than hospitals wherever possible • Harnessing new technology to afford a greater range of means of interaction between patients and their care teams • Incentivising providers through contractual and pricing mechanisms to build in greater integration and efficiencies in pathways • Fewer inappropriate hospital admissions and shorter lengths of stay in hospital • Ensuring care pathways plan for their scheduled discharge • Efficient and appropriate number of outpatient visits Improved patient reported outcomes for planned procedures	**Urgent Care Board Programme Board** • Resilient system able to meet the national 4 hour A&E target • Demand and capacity is balanced across the urgent pathway underpinned by a system wide urgent care dashboard and metrics • Patients are directed to the most appropriate service for their needs • There are robust community based alternatives to support admission avoidance • Patients requiring admission receive early senior assessment and streaming to the appropriate specialty, with pro-active discharge planning • All parts of the system work together to ensure that patients awaiting discharge from the acute to another care setting are moved in a timely manner • Continued development of NHS 111 with connection to Health & Social care Hub

Developing the 6 characteristics of a high quality, sustainable health and care system

In his foreword, the Chair of the CCG, Dr Rod Smith, referred to the six characteristics of a high quality, sustainable health and social care system. This section describes our plans to develop these characteristics locally.

One: A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that [atients are fully empowered in their own care

To build on, enable and support the public mandate for change within the NHS, we need a seismic shift in how we engage with individuals and communities. Our strategy for communications will ensure that engagement activity is co-ordinated, accessible and appealing across our entire demographic, and that information flows both ways between services and the public. Building on the recent Call to Action events, we will employ a range of techniques including public meetings, social media, polls, surveys, engagement with community groups and membership structures to build a continuous 24/7 dialogue with the public, targeting particular audiences where appropriate. Patients and service users can expect to:

- Communicate with us through an approach/channel which suits them; reflecting their individual interests and lifestyle
- Be kept up to date and feel able to 'dip in and out' when it suits them
- Have access to a variety of options to make their views heard
- Be kept informed about what others think through online analysis of the input we have received
- Receive feedback about what has been done as a result of their input and involvement
- Respond anonymously if they prefer

We will are looking to develop an interactive resource which will explain what the vision set out in this plan will mean for patients and service users. This is likely to take the form of a series of short video clips and/or slides with prompts to encourage people to give the feedback we need to develop this plan further and prepare for its implementation. It will be used to support a series of follow-up 'Call to Action' meetings and also shared online.

Patients and service users will also be supported to become active participants in their care, developing an understanding of how they can stay as healthy as possible and making joint decisions with professionals about how their needs can best be met. Taking our successful programme for monitoring diabetes jointly with patients as a starting point, we will use shared care planning, personal budgets, telehealth and social media to empower service users to make informed choices about the options available to them.

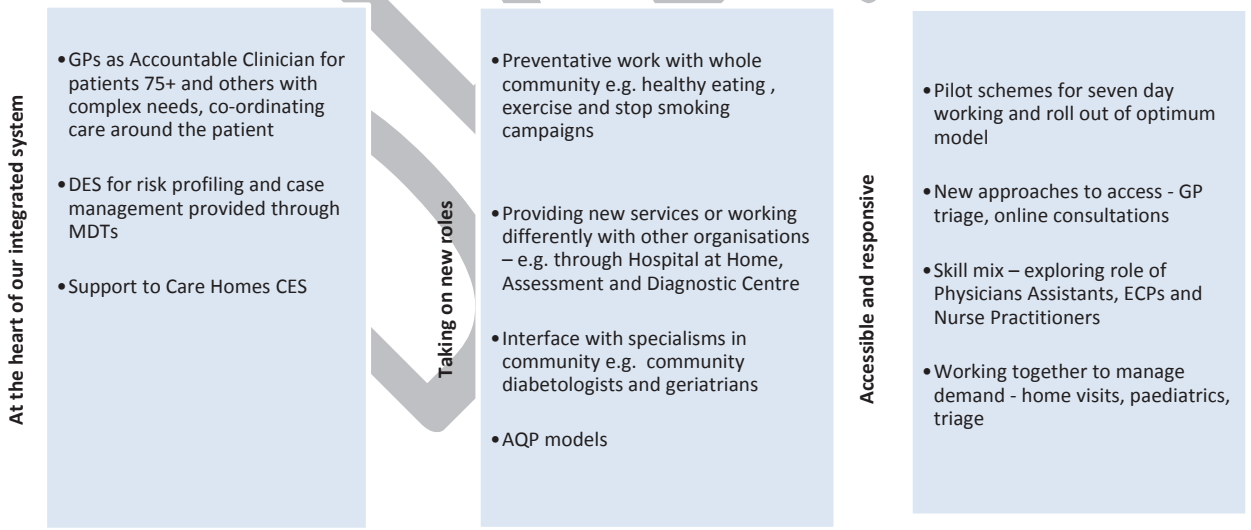
Two: Wider Primary Care Provided at Scale

It is anticipated that primary care will play a key role in delivering our vision to meet people's needs in the community wherever possible and the CCGs will look to facilitate this through co-commissioning arrangements with NHS England. Having successfully implemented practice-based risk stratification and multi-agency care planning for high risk patients, our GPs are well placed to take on the role of accountable clinician for patients who may be at risk of admission, co-ordinating care provided by a range of professionals and ensuring this enables patients to remain at home. As well as fulfilling this function within their practices, GPs will increasingly work alongside other professionals in multidisciplinary services such as the assessment and diagnostic clinics which it is proposed to establish at West Berkshire Community Hospital.

Our GP practices are already interfacing in new ways with specialisms historically provided in secondary care through the work of our community diabetologists and community geriatricians. We anticipate these models becoming the norm as more specialisms move out of hospital and into a community setting.

Practices in Berkshire West face high levels of demand, particularly for urgent care, and many have chosen to explore different ways of responding to this, for example by implementing full GP triage or working to identify efficiencies through the Productive General Practice programme. We now recognise that primary care needs to take a systematic approach to responding requests for urgent appointments, functioning as a key component of a multi-tiered urgent care system which ensures that patients have timely access to the right service provided in the most appropriate setting. As such we are exploring the potential to expand the availability of primary care beyond current core hours, mirroring the overall shift towards seven-day services across the NHS. We are also looking to support practices to test out new ways of working and potential changes to skill-mix which may better equip them to cope with demand and take on new roles within the integrated system that we are looking to develop.

The diagram below sets out the key change programmes currently associated with primary care in Berkshire West. In order to provide new models of care, it is anticipated that general practice will need to be organised differently, and it is likely that larger organisations or federations of practices will emerge as a result. Practices may also start to co-operate in new ways with other provider organisations and the CCGs will look to use innovative methods of contracting to support the development of these new service models.



Three: Modern Model of Integration across Health & Social Care (Better Care Fund)

Meetings with our patients and the public confirm support for our view that integrated care delivers the best outcomes for our patients and service users. We believe that working in partnership is the most effective way for us to ensure that we are providing person-centred, personalised and co-ordinated care in the most appropriate setting. By working together we can ensure that funding is used flexibly across organisational boundaries to radically reduce the number of assessments and transactions and improve service user experience. The requirement to establish a pooled Better Care Fund budget has given us the opportunity to progress this work further at pace. Our Health and Wellbeing Boards have agreed a plan for the use of this fund which reflects what needs to be done to deliver integrated services focusing on early prevention, detection, assessment and support in the community.

Services that we plan to integrate between 2014-2016 are:

Reading	West Berkshire
Hospital @ Home	Hospital @ Home
Intermediate care Integration	Integration of Intermediate Care/Reablement Services
Frail Elderly Pathway – Time to Think beds – Assessment beds/ 24 hour support (Willows)	Frail Elderly Pathway
Joint access to the Health and Social care Hub	Joint access to the Health and Social care Hub
7 day Services	7 day Services
Support to carers	Support to carers
Enhanced Care and Nursing Home support	Case Coordination model

Four: The Urgent Care System

The recently published Sir Bruce Keogh Report on "Transforming Urgent and Emergency Care Services in England" sets out the following vision for the NHS:

- We must provide highly responsive, effective and personalised services outside of hospital for those people with urgent but non-life threatening services outside of hospital. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families
- We should ensure that people with more serious or life threatening emergency needs are treated in centres with the very best expertise and facilities in order to reduce risk and maximise their chances of survival and a good recovery

If we can get the first part right then we will relieve pressure on our hospital based emergency services, which will allow us to focus on delivering the second part of the vision.

The Report sets out proposals for the future of urgent and emergency care services in England. This has the following 5 key elements, all of which must be taken forward to ensure success:

1. Better Support for People with self-care
2. Help for people with urgent care needs to get the right advice in the right place, first time
3. Highly responsive urgent care services outside of hospital so people do not choose to queue in A&E
4. Ensuring that people with more 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. Connecting all urgent and emergency care services together so that the overall system becomes more than the sum of its parts

The CCG welcomes the vision and proposals set out in the report and will continue through the work of the Urgent Care Programme Board, to build on work to date to ensure the local emergency and urgent care systems meets these.

The Urgent Care Programme Board will provide clear strategic oversight and drive to tackle the key challenges to the local emergency care system. The commissioners intend to focus on outcomes, setting clear objectives and bringing the system together. The CCGs will take more of an oversight, scrutiny and challenge role supported by a vision for the system. Together with providers we will strive to ensure a much better understanding of capacity of different parts of the system and how patients flow through each component. The board aims to ensure that:

- Demand and capacity is balanced across the urgent pathway underpinned by a robust proactive performance management system and dashboard (Alamac Kitbag)
- Patients are directed to the most appropriate service for their needs
- There are robust community based alternatives to support admission avoidance
- Patients requiring admission receive early senior assessment and streaming to the appropriate specialty, with pro-active discharge planning
- All parts of the system work together to ensure that patients awaiting discharge from the acute to another care setting are moved in a timely manner
- The system is resilient and able to meet all national targets in relation to emergency care

Providers will be expected to take a stronger leadership and accountability for delivering outcomes and taking responsibility for determining the best methods for doing this. We will work with Providers to construct a local tariff for urgent care that incentivises use of the ambulatory care pathways i.e. a greater proportion of patients managed safely and appropriately on the same day without admission to a hospital bed.

NHS 111 successfully launched in 2013 will continue to play a major role in ensuring patients are directed to the most appropriate service for their needs. We will increase the integration between NHS 11 services and 999 services, promoting the re-direction of patients to community services where appropriate. This will help to reduce pressure on A&E and within the emergency care system.

Specific Investments in Services to Support Urgent Care

We are investing more in our Community Rapid Response and Reabalement Services to provide more support for patients in times of crisis and to help reduce delays in discharge from hospital.

We are also investing in the "Service Navigation" Team within the Royal Berkshire Hospital to support better discharge planning and to agree the individual management plans for patients within 24 hours of them being admitted as an emergency. This will improve patient experience and also further help reduce delayed discharges.

The CCGs have also allocated additional funding to develop further work on reducing inappropriate hospital admission and improve the patient journey through the hospital.

We will fully implement the findings of an independent review by the national Emergency Care Intensive Support Team into a whole system review of the emergency and urgent care system across the Berkshire West Health and Social Care economy.

All of this will help support achievement of the 4 hour A&E target in 2014/16.

Five: Improving elective care productivity

Our strategy for planned care will enable patients to access routine healthcare services in the most appropriate location and to use robust contractual arrangements to assure the quality of these services and secure maximum value-for-money. New technologies will be used to enable our patients to interact with health services in new ways, reducing lengths of stay in hospital and the number of outpatient appointments required and providing services closer to home wherever possible.

Benchmarking against NHS England's Commissioning for Value datapacks and other sources has identified areas where the CCGs could make savings on elective care. Most significant is the potential to reduce the higher than average intervention rate for musculoskeletal conditions, ensuring that surgical procedures are only undertaken at the most appropriate time and where shared decision making has ensured that the patient and GP are clear that the benefits clearly outweigh the risks. There is also scope to improve performance on the first to follow-up outpatient ratio.

Over the coming years, the CCGs intend to make use of tariff flexibilities and financial levers to generate efficiencies and incentivise providers to deliver services which reflect our strategic vision. Key schemes include applying pathway prices to encourage efficient provision, for example through 'one-stop shop' outpatient clinics, paying tariff minus to providers with less complex caseloads and the use of locally developed best practice tariffs to commission pathways of care, thereby incentivising providers to work with other services.

The CCGs are planning to undertake an externally supported clinical services review with Royal Berkshire Foundation Trust and Berkshire Health Care Foundation Trust to determine the best service models to improve patient outcomes and achieve financial sustainability. This in turn will inform the optimal organisational configuration for the health and social care economy.

Six: Specialised services concentrated in centres of excellence

The CCGs will work closely with NHS England to ensure that patients requiring specialist care can be referred to centres whose caseloads mean they are best placed to deliver optimum outcomes for patients. It is recognised that this is likely to have an impact on the RBFT which currently continues to provide services that are acknowledged as specialist by definition but not by volume. Further work will be undertaken with RBFT to better understand and plan for the potential implications for the Trust.

Assuring Quality

Overview

Delivering compassionate, high quality, outcomes-focussed care in a timely manner is at the very heart of our values. We recognise that developing a shared understanding of quality and a commitment to place it at the centre of everything we do provides us with the opportunity to continually improve and safeguard the quality of local health and social services for everyone, now and for the future.

Quality is assured through a wide range of metrics, indicators, dashboards, information and intelligence gathered nationally, regionally and locally. In addition to the contractual and operating performance related standards, there will be an ongoing focus on ensuring that providers of services to Berkshire West communities are delivering quality services.

Our vision for quality is straightforward, patients and service users should:

- Receive clinically effective care and treatments that deliver the best outcomes for them
- Have a positive patient experience of their treatment and care
- Be safe, and the most vulnerable protected

Quality will underpin the development and delivery of every service and pathway and be at the heart of every commissioning decision. Quality will be fully integrated with performance and finance in assessing the delivery of this plan and will continue to be at the centre of all of our discussions with providers. Should provider performance not meet expected quality and safety standards, contractual redress will be sought.

The Francis Report, Berwick and Keogh reports

We fully understand the recommendations of the Francis, Berwick and Keogh reports and are fully committed to implementing these recommendations. The CCGs will challenge healthcare providers to make on-going improvements in the quality of care provided to ensure that quality and patient safety is an integral feature of commissioned services. This will be achieved through robust processes to seek assurance from providers to ensure that:

- fundamental standards and measures of compliance are always met
- they demonstrate openness and candour
- they promote and provide compassionate, caring and committed nursing
- they promote strong healthcare leadership
- they provide information and data that is transparent to service users and the public

Through this work we will ensure that the patient remains at the centre and that a culture of openness, transparency and candour is promoted throughout the system.

Response to Winterbourne View

We are working together across the system to move people out of Assessment and Treatment units (hospital-based care) by June 2014. A strategic plan to manage care of these patients in the community through pooled budget arrangements is under development. Consideration is also being given to the development of a new service model to support people with learning disabilities and severe challenging behaviour in the community, thereby avoiding crisis management and hospital admissions.

Patient Safety

It is of paramount importance that people know that they will be safe in our care. We will ensure systems are in place to track and manage performance including taking action when required standards are not met. To ensure patient and staff safety, it is important that we encourage learning from mistakes and make changes in practice to ensure that any incidents are not repeated. Where serious incidents occur, commissioners will be informed within an agreed timeframe and will monitor the investigation and learning from the incident.

The CCGs will expect healthcare providers to continue to demonstrate a reduction in Healthcare Associated Infections (HCAI) in line with agreed trajectories, which will continue to include zero tolerance of MRSA. Additionally, there must be robust infection prevention and control plans, policies and capacity in place to demonstrate full compliance with the Health Act 2006 Hygiene Code.

Providers will also be required to ensure the following safety indicators are in place:

- Implementation of National Patient Safety Agency guidance
- Identification of safeguarding issues relevant to their areas of provision
- Arrangements to ensure that policies and procedures related to safety are implemented and monitored
- Safe recruitment procedures including meeting the vetting and barring requirements of the Independent Safeguarding Authority
- Robust incident reporting and monitoring systems that include escalation procedures for serious incidents
- Compliance with Care Quality Commission (CQC) regulations and standards
- Arrangements to meet National Safety Thermometer requirements

We will fully engage in the Area Team Quality Surveillance groups and ensure that we are proactive members of our local Patient Safety Collaboration, sharing intelligence and contributing to a collaborative improvement system that underpins a culture of continual learning and patient safety across the local health system.

Clinical Effectiveness

In order to provide cost and clinically effective care and treatment, the CCGs will require providers to comply with national and local standards/guidance such as National Service Frameworks and NICE technology appraisals and guidance. The CCGs will also expect to see evidence of compliance with guidance from other professional bodies.

Clinical and practice audit is one of the key mechanisms that monitors the performance and quality of services and demonstrates continuous quality improvement at service level. All healthcare providers will be expected to demonstrate an active approach to audit by having in place jointly agreed prioritised clinical and practice audit programmes, including participation in national audits.

Providers will be required to share outcomes of clinical and practice audits. Additionally, the CCGs will undertake independent audits where necessary. Through a quality scorecard and quality framework, the CCGs will ensure that providers can evidence delivery of quality services, with benchmarking to assess performance. The CCGs' Quality Committee will undertake this monitoring on behalf of the CCGs and provide assurance to the CCG Governing Bodies, highlighting any risks as they occur.

Patient and service user experience

We will strive to promote compassion, dignity and respect by demonstrating positive patient and service user experience. This will be measured through a variety of means including reviewing the outcomes of national satisfaction surveys, feedback from patient participation groups, information provided by Healthwatch, complaints data, Patient Advice and Liaison Service (PALS) enquiry data and for health services the results of the Friends and Family Test. Feedback from professionals, such as GPs reporting on their patients' experience and any clinical concerns, will also be used to monitor what services feel like from the perspective of those who use them. We will inform people of how their involvement in these surveys has improved services and facilitated the development of ongoing engagement mechanisms.

Providers will use feedback to improve and will be required to regularly inform, consult and involve patients, service users, their families and carers and the public in the planning and review of services. One aim of this engagement is to ensure compassion by engaging staff and promoting an environment of empathy in which service users are listened to. We will promote dignity and respect, for example by monitoring how providers are meeting single sex accommodation requirements.

CQUINS

CQUIN is an incentivised monetary reward scheme (currently up to 2.5% of provider contracts) that CCGs use allocate payments to providers if they meet defined quality outcomes. The CCGs will continue to work with providers to ensure that the CQUIN schemes both in the current and future contracts are stretching and deliver quality services for our population. The aim will be to have fewer CQUINs to allow greater incentive for change on each. Where national CQUINs are already being achieved, stretch quality indicators will be introduced. We will be following national and regional guidance in the development of our local CQUIN arrangements, but would only expect to pay the full 2.5% to providers who have demonstrated truly exceptional quality, part of which will mean ensuring that all national standard quality requirements have been met.

Compassion in practice

We embrace the values and behaviours outlined within the vision and strategy for nurses, midwives and care staff – *Compassion in Practice*. We will ensure that all of our providers focus on the 'Six C's' (care, compassion, competence, communication, courage and commitment) putting the person being cared for at the heart of the care that is delivered to them.

Staff satisfaction

We recognise the importance of staff satisfaction to the delivery of high quality services. There is good evidence that happy, well-motivated staff deliver better care resulting in better outcomes. We recognise that health and social care staff work very hard, often under great pressure and we are committed to ensuring that we work with all our providers to make it possible for them to do the best job they can.

The CCGs and providers will use the results of the staff survey and the staff Friends and Family Test (as it comes into effect) to monitor NHS staff satisfaction and these results will be considered alongside all other quality metrics as a measure of the quality of services being provided.

Seven day services

We recognise that people need health and social care services every day. Evidence shows that the limited availability of some hospital services at weekends can have a detrimental impact on outcomes for patients, including raising the risk of mortality. Admission rates may also be affected by GP practices being closed over the weekend period. Where admissions occur there is a need to ensure that care packages can be instigated and patients discharged from hospital on whatever day of the week they are clinically fit to leave. We are therefore looking to ensure that the full range of health and social care services is available seven days a week.

To support the implementation of seven day services, the CCGs will be developing a CQUIN (2014/15) to support our providers in ensuring consultant cover seven days a week. We are also committed to utilising future CQUINs to support similar initiatives around 7 day working.

Access

Linked to the above is the need to ensure good access to all of the services we commission. The CCGs in particular will ensure that local providers adhere to all NHS Constitution measures and access standards to provide patients with care in a timely manner, as summarised at Annex D. The

added importance of this in relation to waiting times for a diagnosis and treatment of cancer is understood.

The Choose & Book access system for outpatient appointments will continue to be utilised to support patients to make a choice of where and when they would like their treatment. This will support continued achievement of the 18 week referral to treatment standards. Waiting times in A&E and ambulance response times are expected to improve and ambulance handover delays expected to be maintained as low as possible.

Safeguarding

As public bodies we have a statutory duty to make arrangements to safeguard and promote the welfare of children and young people and to protect vulnerable adults from abuse or the risk of abuse. We are committed to fulfilling this function to a high quality standard.

Commissioning organisations also have a responsibility to ensure that all providers from whom we commission service (both public and independent sector) have comprehensive single and multi-agency policies and procedures to meet these requirements.

We will ensure that systems and processes are in place to fulfil specific duties of co-operation and that best practice is embedded. All contracts and SLAs will require providers to adhere to Berkshire-wide safeguarding policies which promote the welfare of adults and children. Providers will inform commissioners of all incidents involving children and adults, including death or harm whilst in their care.

The CCGs' Nurse Director will provide senior clinical leadership in the oversight of safeguarding arrangements at Board level for both Adults and Children and will continue to represent the CCGs on the Local Safeguarding Children and Adult Boards. The CCGs are enhancing their safeguarding team to ensure sufficient support is available to providers and that we are able to fully engage with our partners on safeguarding concerns. We are also committed to using this enhanced resource to support the improvement in safeguarding practice across primary care providers in Berkshire West.

Relationship with external regulators

All service providers are subject to assessment and audit by a range of external regulators and assessors including the Care Quality Commission, Monitor, Royal Colleges, the Health and Safety Executive, the National Audit Office and Healthwatch. It is important that commissioners are aware of the findings of all external regulator reports and use these to inform commissioning decisions and monitor any required developments. We will ensure that mechanisms are in place to share relevant information in timely manner.

We will build relationships with local representatives, for example from the CQC and Monitor, and commissioners will meet with these regularly to ensure any areas of concern are shared early so that support can be provided immediately to make necessary improvements. Where necessary, commissioner will work in partnership with external regulators, supporting providers and monitoring actions plans to ensure that changes are made and full compliance is achieved as quickly as possible.

Innovation

We will work to promote innovation, putting in place mechanisms to support research as appropriate and linking with national and local bodies including Strategic Clinical Networks to learn from best practice examples and disseminate these locally.

We have actively sought out opportunities to pilot new approaches, for example by applying to become an Integration Pioneer and more recently supporting two bids against the Prime Minister's Challenge Fund for primary care. We will continue to pursue further such opportunities. Whilst our integration pioneer bid was unsuccessful at the final stage, we are now working the Integrated Care and Support Exchange (ICASE) to share our progress and learn how others have addressed key challenges.

We will link with the Innovation, Health and Wealth programme to ensure that we keep up-to-date on emerging innovations and consider how these can best be implemented locally. As described above we have put in place arrangements to ensure implementation of NICE Technology Appraisals and our contract management processes ensure that providers have innovation plans in place. Going forward we will look to work with the Oxford Academic Health Science Network to consider how we can further build innovation in Berkshire West.

Workforce

Workforce considerations are taken into account at all stages of developing our plans and we recognise that the skill mix required to deliver a largely community-based model of care will look very different to our existing staffing models. As such we are engaging with Health Education Thames Valley, the Thames Valley and Wessex NHS Leadership Academy and the Oxford Deanery to mould the shape of our future workforce and ensure that new staffing requirements can be met. We are also exploring opportunities to use staff in different ways, for example through the GP and Nurse fellowship programmes and other workforce development schemes.

The transformational change described in this plan will be underpinned by a programme of organisational development activities supporting the delivery of change both within individual organisations and in the way that organisations interact with one another.

Equality and Diversity

Equality and Diversity is central to our work to ensure there is equality of access and treatment within the services that are commissioned and provided. The promotion of equality, diversity and human rights is also central to the NHS Constitution We have used the NHS Equality Delivery System (EDS) to develop the following Equality Objectives.

Goals	Objective
Better health outcomes for all	Make effective use of equality data within the commissioning cycle to prioritise commissioning of services and embed equality within provider contracts. Increasing awareness of the Equality agenda
Improved patient access and experience	Improve equality data collection across all protected characteristic groups and use to inform service planning.
Empowered engaged and included staff	Improve training and development opportunities for staff at all levels for equality, diversity and human rights.
Inclusive leadership at all levels	Ensure Board members and senior and middle managers have an understanding of equality, diversity and human rights so that equality is advanced within our organisations.

Our Partners

Providers (to be developed further)

Each of the CCGs within Berkshire West , supported by the commissioning support unit, contracts, quality and finance divisions, has an identified clinical lead for one of the main providers (hospital, community and other services we buy).

With each provider we will:

- Develop contracting strategies which deliver according to need, but also create long term sustainability via innovation, pathway restructuring, advanced cost management, risk management/business continuity.
- Ensure Provider Performance is evaluated encompassing:
- Structured process, with agreed goals and quality initiatives
- Specific, transparent measures and process understood by the providers
- Patients/Users actively involved in shaping care
- Regular formal feedback sessions on current performance and further improvement
- “Voice of the provider” solicited for a balanced, two-way view of performance
- Identify and manage joint improvements efforts with the providers

Work is also under way to inform a longer term view of sustainability in our health economy and we, collaboratively with the Unitary Authority and our main providers, commissioned work which will inform demand and capacity planning across health and social care for the next five years.

Reading and West Berkshire Councils

As a key member of both Health & Wellbeing boards, we will share responsibility for providing leadership to the local health and social care services. We will continue to develop our relationships with the local authorities, in particular promoting the Integrated Care agenda. Work is already underway to identify options for integrated care.

Voluntary Sector

We have invested in partnership development , with the voluntary sector, who will support and help introduce initiatives which will support our overall aim of providing care at the right place, at the right time and appropriate to the patient’s needs, whilst promoting self-care and independence.

Local Area Team

We will work in close collaboration with the local Area Team to support the development of primary care services as well as providing direct support within practice to enable programmes of work to be successfully implemented.

Clinical Networks & Senates

The NHS Commissioning Board has recognised the value of Strategic Clinical Networks (SCNs) as "engines for change" in the modern NHS. SCNs are therefore a further element in the wider system that will support CCG"s to deliver quality improvements and outcomes benefits for patients. The NHSCB has mandated four SCN groupings across England, as follows:

- Cancer
- Cardiovascular
- Maternity & Children
- Mental health, dementia and neurological conditions

Strategic Clinical Networks may also be bolstered on key work-programmes and disease groups identified by the Local Area Team, through Operational Delivery Network (ODNs). Given the natural links between the CCG"s priorities (including national priorities), South Reading CCG will endeavour to engage with SCNs to ensure a consistent and robust emphasis on quality improvements and patient outcomes at all times.

Health Watch Reading [Needs further development with Healthwatch]

We look forward to continuing our relationship with Healthwatch Reading, the local consumer champion for both health and social care. It aims to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided in Reading.

Healthwatch Reading monitors the quality of the Social Care, Health Care and Public Health Care, being commissioned and provided in Reading; it also monitors how all the people in Reading experience the quality of all aspects of the Care, which they receive.

The Healthwatch Reading functions are as follows:

- It has the power to enter and view services
- Influence how services are set up and commissioned by having a seat on the local health and wellbeing board
- Produce reports which influence the way services are designed and delivered by commissioners
- Pass information and recommendations to Healthwatch England and the Care Quality Commission
- Provide information, advice and support about local services, by providing advice and signposting to individuals regarding the services available in the local area

Healthwatch Reading is a Charitable Incorporated Organisation supported by Reading Voluntary Action. It has an elected Board, made up of local people, patient's and representatives from local organisations. The 'Board is responsible for ensuring that the contract, which it holds with the Local Authority to implement the Authority's statutory duty, is being managed to a high level of professional competence, with excellent outcomes for local people. Healthwatch Reading ensures that patients and service-users contribute to the commissioning decisions of both the NHS and of the Local Authority, with regard to Social Care, Health Care and Public Health Care. It seeks to inform and to educate different groups within local communities, so as to enable them to participate in, and to contribute appropriately to, shared decision-making.

NHS Constitution Pledge

The CCG will continue to have regard to, and promote the ***NHS Constitution***. The Constitution sets out the rights and responsibilities of NHS patients: These rights cover how patients access health services, the quality of care they will receive, the treatments and programmes available, confidentiality, information and the right to complain if things go wrong. Over the next two years the CCG will need to improve on the delivery of the following commitments.

Measure	Our areas of focus
Referral to Treatment waiting times for non-urgent consultant-led treatment	18 weeks referral to treatment targets will continue to be achieved at provider and CCG level. Waiting lists will be monitored closely and when there are any potential long wait issues on the horizon, the CCG will take proactive action to ensure patients are treated in a timely manner as per the standards. The Choose & Book access system for outpatient appointments will continue to be utilised across the CCG to support patients to make a choice of where and when they would like their treatment. This will support continued achievement of the 18 week referral to treatment standards.
Diagnostic test waiting times	Diagnostic wait times have not always been achieved within the 6 week timescale during 2012/13 at RBFT. This has been mainly due to MRI capacity. The Trust is undergoing the building work required to install a new MRI scanner and in the meantime have a mobile unit on site while the work is underway.
A&E waiting times	Despite a continued focus at strategic and operational level across the health economy, the Berkshire West system has not met the A&E 95% standard for much of the year. The Berkshire West CCGs have made significant investment in the emergency and urgent care pathway in order to improve performance. These investments have been targeted to deliver additional capacity, extend availability of services (hours of operation and days of the week) and deliver improvements to the pathway (based on ECIST recommendations). Specific actions being taken to support achievement of the A&E 4 hour standard include; • Expansion of the Service Navigation Team to support improved discharge planning, use of EDDs and early day discharge • Implementation of the ECIST recommendations for RBFT including Single Point of Access for all acute admissions to allow for senior clinical triage and streaming of patients and an Ambulatory Care Unit • Enhanced Intermediate Care Services across the 3 Localities with services operating with extended hours via a genuine Single Point of Access • Use of winter monies to support increased 7 day working in RBFT and BHFT • Additional Mental Health liaison with the A&E department at RBFT • GP working in liaison with SCAS to support the response to Amber and Green calls • Investment into social services to support mobilising care packages at the week-end • Integrated Care with Community Nurses/Matrons in the community (including 24 hour District Nursing services) managing patients in their own homes • Use of a dashboard populated daily to understand cause and effect across the system and providing objective data on which to make decisions around escalation and investment

Measure	Our areas of focus
	• The system is also implementing the recommendations from the ECIST report to Berkshire West, December 2013. All actions are overseen by the Urgent Care Programme Board and a new Operational Group is being established to drive improvement and address issues along the pathway. Newbury & District CCG continues to monitor delivery of A&E wait times for those patients who access A&E through Great Western Hospitals NHS Foundation Trust and also North Hampshire Hospitals NHS Foundation Trust. Our **Quality Scorecard** - received at both our Quality Committee and Governing Board - details performance at all trusts who provide A&E services for our patients and is regularly monitored for assurance.
Cancer 2WW/31/62 Waiting Times	The Berkshire West CCGs support the delivery of the Cancer Standards in the following ways: • Close monitoring of targets and trends to ensure delivery will not be compromised • Regular liaison with secondary care thus ensuring they are aware of issues which might mean targets may not be met e.g. national or regional awareness campaigns and commissioning additional capacity if required • Use of contractual levers • Analysis of breach reports at Newbury & District CCG level - even when standards are being met at overall Provider level – to ensure our patients and population receive timely access to cancer care regardless of which cancer centre or unit they are treated at
Ambulance Handovers	South Central Ambulance Service (SCAS) work with RBFT and other acute providers to agree an annual handover plan which all parties sign up to. This plan covers the process and management of handovers between both parties in order to reduce any delays and ensure continuity of care for patients. In addition, SCAS have introduced a double verification process in 2013/14 which has vastly reduced the data challenges received on ambulance handovers and will continue to be the process in the coming years.
Category A Ambulance Calls	For Category A Ambulance calls SCAS are already achieving this as a contract level for 2013/14 and this will remain a requirement going forward. This is reported and monitored monthly by CCGs. SCAS continue to recruit and train first responders to support the achievement of these targets.
Cancelled Operations	The proportion of patients who are cancelled on the day of an operation for a non-clinical reason will be maintained below 0.5% of all operations at RBFT and if a patient is cancelled on the day, they will be rebooked within 28 days or offered an alternative provider for their treatment. No urgent operation will be cancelled for a 2nd time for a non-clinical reason. RBFT have revised their existing policy for cancelled operations and ensured all staff understand this policy to support achievement of these standards

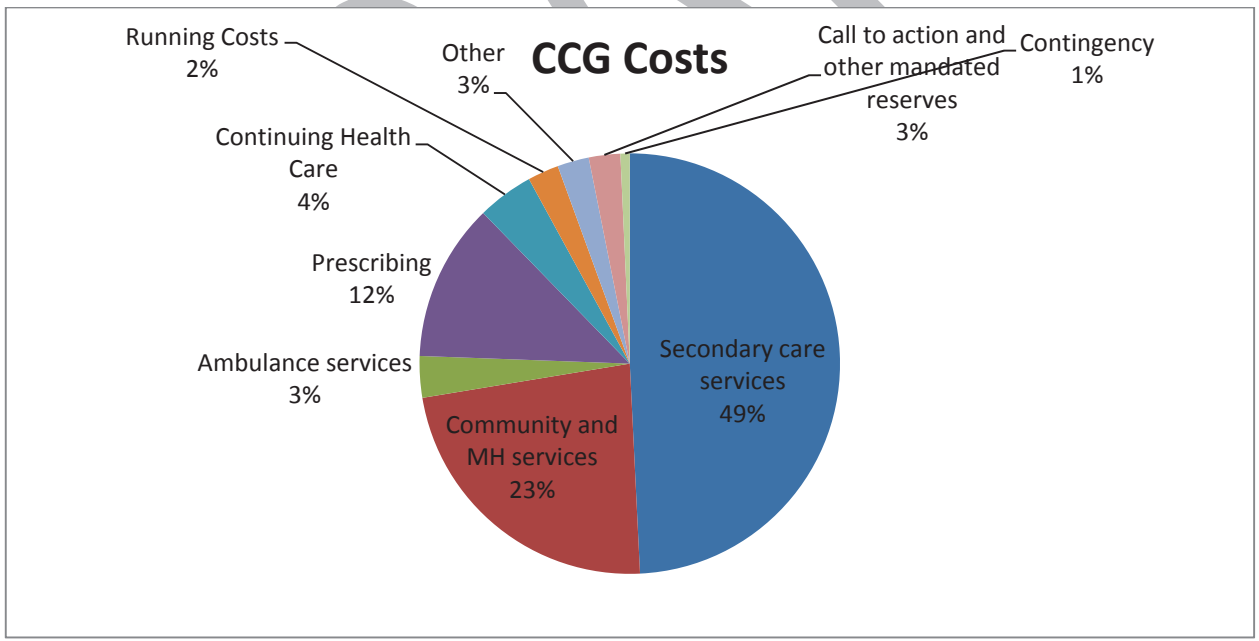
Financial Overview

The CCG is expected to manage expenditure with the resources allocated to it by NHS England and to deliver a 1% surplus. North and West Reading CCG's financial plan delivers this surplus in each year. The plan also sets aside 2.5% for non-recurrent expenditure in 2014/15 (with 1% of this 2.5% set aside within a 'Call to Action' fund), reducing to 1% from 2015/16 onwards, and a 0.7% contingency fund.

In 2015/16 the CCG will contribute 4.8% of it allocation towards a pooled budget with its local authority partners, called the Better Care Fund (BCF). This fund will be managed in partnership with the Council, and has been created by a combination of NHS funding already committed and new investments by the CCG.

Investments set aside for 2014/15 includes funding for primary care to better identify and support elderly patients in the community (this investment has been set at £5 per head of registered population), Investment in community services to enable patients to stay at home with appropriate support (rather than be admitted to an acute hospital), additional community bed numbers and increased capacity with intensive care services.

Running costs are planned to continue at current levels in 2014/15, with a reduction of 10% in 2015/16 in line with national guidance. In addition to the holding of contingencies, as one of the four CCGs within the Berkshire West federation some risk will be managed through the pooling of budgets in areas such as Continuing Healthcare and high cost mental Health placements.



Financial Plan 2014/15		
	£'000	
CCG Income		
Recurrent allocation baseline	109,346	
Growth in year	3,721	
	113,067	
Non recurrent		
Return of prior year surplus & Misc	1,898	
	114,965	
CCG Expenditure		
Secondary care services	56,886	
Community and MH services	26,780	
Ambulance services	3,592	
Prescribing	13,755	
Continuing Health Care	4,886	
Running Costs	2,477	
Other	1,905	
Call to action and other mandated reserves	2,765	
Contingency	789	
	113,834	
Required Surplus	1,131	1.00%
Major Investments in 2014/15	**£'000**	
escalation bed capacity and service navigation	293	
support for over 75's	571	
Francis / berwick report - implications	242	
Intensive care	276	
Care Home Support	153	
Hospital at Home	266	
Community Reablement and Rapid Response	149	
Psychiatric Liaison Service	232	
	2,182	

Financial Plans 2015/16 onwards

	2014/15'	2015/16'	2016/17'	2017/18'	2018/19'
CCG Income					
Recurrent allocation baseline	109,346	113,067	117,875	120,671	123,359
Better care fund tarnsfer	0	1,618	0	0	0
Growth in year	3,721	3,190	2,796	2,688	2,733
	113,067	117,875	120,671	123,359	126,091
Non recurrent					
Return of prior year surplus & Misc	1,898	1,688	1,736	1,207	1,234
	114,965	119,563	122,407	124,565	127,325
CCG expenditure					
Clinical Services	107,803	108,497	111,290	113,399	116,110
Better care fund	0	5,716	5,716	5,716	5,716
Running Costs	2,477	2,226	2,221	2,216	2,210
Mandated reserves and Contingency	3,554	1,945	1,973	2,000	2,028
	113,834	118,385	121,200	123,332	126,064
Required Surplus	1,131	1,179	1,207	1,234	1,261

IM&T Strategy

The strategy sets out the direction of travel for information management and technology (IM&T) to support the four clinical commissioning groups within Berkshire West Federation (Newbury & District, North & West Reading, South Reading, Wokingham). It represents a first step towards defining a strategy and implementation plans for the next 3-5 years.

IM&T has a broad definition, covering data, information, intelligence, knowledge, systems, IT/digital technologies, supporting skills and services. The strategy aims to convey the breadth of issues and to provide pointers to the way forward. The focus is on support for commissioning, and the interdependency between provider IM&T, GP (provider) IT & Systems issues. The findings and preliminary conclusions are based on reviews of local and national documentation, interviews with individuals from the CCG's/primary care, and discussions at the Berkshire West IM&T Advisory Group.

Appendix 1 - Alignment of the CCG Operating Plan with the Reading and West Berkshire Local Authorities Health and Wellbeing Strategies

Promote and protect the health of all communities particularly those disadvantaged (Reading).	Objective 1 – Implement plans to protect health and reduce the burden of communicable diseases
	Objective 2 - Ensure effective support is available to vulnerable and disadvantaged communities to protect their own health
	Objective 3 – Increase awareness and uptake up of Immunisation and screening programmes

Focus of North & West Reading CCG

- Increase the uptake of all screening programmes, specifically COPD as this has been recognised as an area where reported prevalence on GP registers is significantly lower than the estimated prevalence in in the population.
- The GP clinical management software, ECLIPSE will be expanded to include COPD and diabetes to promote greater patient involvement in their care.
- A new social media platform, Puffell will be launched. This will allow self-management of health and wellbeing as well as the opportunity for patients to talk to others with similar health conditions informally and create communities to support self-management of care.
- North & West Reading CCG met the national screening targets for breast cancer, cervical cancer and bowel cancer and cancer screening will continue to be promoted at every opportunity through GP practices.
- The CCG met the 95% coverage target for childhood immunisations for 1 and 2 year olds in 2012/13 and just missed the target for 5-year old MMR immunisations, but was the highest performing CCG in Berkshire for this vaccine. Increased uptake will be further promoted with GPs at Council meetings and practice visits.
- We met the 75% coverage target for seasonal flu immunisations for people aged 65 and over and will continue to work collaboratively with NHS England to increase uptake of seasonal flu vaccine in high risk patients.

Increase the focus on early years and the whole family to help reduce health inequalities (Reading).	Objective 1 – Ensure high quality maternity services, parenting programmes, childcare and early years education is accessible to all
	Objective 2 – Reduce inequalities in early development of physical and emotional health, as well as language and social skills
	Objective 3 - Reduce the prevalence and social and health impact of obesity in children
Giving every child and young person the best start in life (West Berkshire).	Ensuring there is a focus on giving every child the best start in life is crucial to reducing health inequalities. One of the most effective ways to address long term public health is to provide high quality support and services to parents, beginning with preconception care and continuing through pregnancy, birth and the early years.
Addressing childhood obesity in primary school children (West Berkshire).	Children who are obese are more likely to become obese adults, and this likelihood increases the heavier they are as a child and if their parents are also obese.
	More health problems will be seen in the next generation of adults if more of our children are overweight or obese today.
	Childhood obesity is a powerful predicator of increased risk of Coronary Heart Disease (CHD) and type 2 diabetes mellitus in early adulthood.

<u>Focus of North & West Reading CCG</u>

Guides for parents and carers of young children on how to deal with Common Childhood illnesses will be commissioned. These have been successful in other areas of the country and will be made available to all parents in various formats and in a range of languages.

Health Visitors (currently commissioned by NHS England) are a vital part of Reading's multi-professional, locality-based Children's Action Teams. Health Visitors also work close with children's centres; each centre has a lead Health Visitor and they will routinely discuss emerging concerns with children's centre staff and make referrals as required. Maternity services currently run ante-natal and post-natal support from four children's centres, which have had a positive impact in strengthening joint working between these services.

Our CCG is a member of the Reading Health and Wellbeing Board Children and Families Joint Working Subgroup and we working jointly with colleagues across the health and social care system including South Reading CCG to implement 4 key themes of work:

1. Improved Awareness of Children's Services for GPs and Health Care Professionals
2. Education and Resources for Families
3. Opportunities for awareness raising and making contact with families
4. Promotion of Immunisations

Live Active, a project to increase physical activity in the population will specifically target school children with an aim to reduce childhood obesity and change habits at a young age. We will commission, jointly with South Reading CCG and Public Health, cards and readers that will track the number of miles children have walked or cycled. This will be used to initiate promotion of exercise and active living through inter-school competitions and effective media coverage throughout Reading.

Reduce the impact of long term conditions with approaches focused on specific groups (Reading).	Objective 1 - Assist and support ability to self-care across all groups, communities and people with existing long term conditions
	Objective 2 - Target long term conditions such as dementia, mental ill-health and obesity based on health inequality
	Objective 3 - Build on and strengthen the quality and amount of support available to carers

Focus of North & West Reading CCG

Diabetes is a key focus for North and West Reading CCG. We have an above average prevalence of diabetics with an HbA1c of 59mmol/mol or less and the percentage of people receiving the diabetes nine care processes is below national average. Initiatives are currently underway to address these issues. We have appointed a community diabetologist who, with specialist diabetic nurses will run virtual and "one stop shop" clinics within the community to educate patients on how self-manage their care. The virtual clinics enable the community diabetologist to discuss up to 25 patients with our Primary Care teams, providing a valuable education resource for GPs and practice diabetic nurses which will increase the quality of care in primary care where most diabetics are actually treated. A specialist diabetes website with information for patients with be further developed and effective care planning, ECLIPSE and HCP education will be used to improve health related quality of life for patients with diabetes. Diabetics and those at high risk will also be encouraged to increase their exercise thorough the Live Active programme.

Our CCG has higher than average intervention rates for musculoskeletal conditions. Through the effective use of decision aids and by working with patients, these will be reduced to ensure that surgical proceedings are only undertaken at the most appropriate time and where it is clear that the benefits outweigh the risks.

There is also a higher than average prevalence of adult depression in the population of our CCG. This will be addressed through various initiatives. A 24/7 psychiatric liaison service will be established at Royal Berkshire Hospital and a community based psychological medicine service. These initiatives will ensure that services are able to respond appropriately to both physical and mental health needs, recognising the inter-relationships between these. Through use of the voluntary sector, we will introduce social prescribing where patients, specifically with minor mental health conditions are signposted to services in their community to improve quality of life. We will also improve appropriate access to and the quality of, Child and Adolescent Mental Health Services, through the review of the access criteria and improve access to our Talking Therapies service. Exercise is an evidence based treatment for depression and other Mental Health conditions and Mental Health patients will be encouraged to join Live Active. We will provide training for our GPs to support a consistent message about exercise to particular groups of patients as well as the population as a whole.

Promote health-enabling behaviours & lifestyle tailored to the differing needs of communities (Reading).	Objective 1 – Improve tobacco control and reduce the harm due to alcohol
	Objective 2 – Introduce and support initiatives to increase physical activity in Reading, particularly in hard to reach groups
	Objective 3 – Introduce and support initiatives that promote healthier eating for all ages and communities
Supporting those over 40 years old to address lifestyle choices detrimental to health (West Berkshire).	Addressing lifestyle behaviours detrimental to health and wellbeing in working age adults will optimise good health, decrease ill health and the need to use health and social care services, not only today, but also in years to come. This will help to prevent the development of many long term conditions, benefitting individuals, their families and society in general.
Supporting a vibrant district (West Berkshire).	Social capital describes the links that bind and connect individuals and communities. This is important as it provides a source of resilience, a buffer against the risks of poor health.
	The extent of people's participation in their communities, how safe they feel and the added control this brings has the potential to positively contribute to their psycho-social wellbeing.
Focus of North & West Reading CCG We will work with our children centres who provide healthy eating and cookery classes and continue to promote sensible weight loss in overweight secondary school children through referral to dieticians and to the eat4Health Programme. We will aim to improve awareness of the services that are available locally and work collaboratively with Public Health on developing the obesity strategy and other healthy living initiatives. The use of the media with the Live Active project will help to target hard to reach groups and after the initial project with cards and sensors to monitor distances walked by the public, this will be extended to include various other projects to allow the population to remain active – green gyms, city farms and use of the voluntary sector in promotion of community sporting activities. We will aim to connect with individuals and families by effectively engaging with patients through various channels including important community venues such as children's centres, libraries, our general practices and places of worship to improve health education and to encourage positive lifestyle choices. The voluntary sector will be increasingly used to signpost and support patients in using locally located resources and activities which would be beneficial for their health and wellbeing.	
Promoting independence and supporting older people to manage their long term conditions.	People aged over 75 stay one and a half times longer in hospital than the average for all age admissions and people with a diagnosis of dementia stay on average four times longer.

	Groups in particular need to include older people living alone and those who are carers. In addition, there is predicted to be an increase in age-associated long term conditions. This includes a rise in the number of people with dementia and poor mental health in older people as well as in the number of older people with learning disabilities.

Focus of North & West Reading CCG

Improvement of the frail and elderly pathway will be a specific focus for North and West Reading CCG. We will increase GP access to patient records across sites and provide a named GP for elderly patients. We will also commission a community nurse for the elderly. We will work alongside our neighbouring CCG's and the Long Term Conditions programme Board to implement the Hospital at Home project to provide traditional hospital care in patient homes, where appropriate, and prevent unnecessary hospital admissions.

Research from Dying Matters found that 70% of people want to die at home, however in Reading fewer than 20% of all deaths happen at home with around 50 % of all people dying in hospital. This was also raised by patients at our Call to Action event. We will enable a direct communication channel to Westcall Out Of Hours for end of life patients to offer a choice of where their final care is delivered and ensure that our current rate of deaths at home increase in line with their wishes. We will retain our attached district nursing teams within our practices and develop shared recording keeping as with Westcall between GP medical records and nursing records to ensure that patients receive consistent integrated care whether they are seen by a District Nurse, their own GP or an OOH GP.

Appendix 2 - Berkshire West CCGs NHS Framework Outcome Ambitions aligned to the four Programme Boards

(To be referenced in main body of plan)

Transformational Project	Local	Patient	System	Clinical
Outcome 1 - Securing Additional Years of Life for People of England with Treatable Mental Health and Physical Conditions				
COPD (Long Term Conditions Programme Board) and specific local focus	Further analysis identities our low rate of reported prevalence of Chronic Obstructive Pulmonary Disease (COPD) as a percentage of estimated prevalence. We are currently looking to find new ways in which we can improve the diagnosis of this condition to help better support patients. We will continue to encourage and sport our population to stop smoking and hence reduce the likelihood of them developing COPD.	Improved diagnosis and management within the community COPD teams, avoiding unnecessary admissions and improving care.	In 2013/14 we introduced an Exacerbation Assessment service, enabling rapid outpatient assessment of a patient, avoiding admission. We implemented evidence based COPD Discharge Care Bundle, including follow-up phone calls and consultant input to the Early Supported Discharge scheme. Telemonitoring continues to be expanded using an automated telephone messaging service. In addition we have invested in increased Pulmonary Rehabilitation provision. We have committed through our programme board to increase investment in our specialist community respiratory team and a redesign of patient pathways to provide quicker access to necessary medication when	Reduced admissions and mortality from undiagnosed or poor levels of care.

			needed.	
Mental Health/Learning Disabilities Urgent care and crisis support (CMMV Programme Board)	We will work locally with our mental health provider to improve patient pathways for people with mental health and learning disability who are at risk of self-harm or challenging behaviour	Patients will have a prompt response to the patient in need, their family and/or carers and other agencies.	To work with Berkshire Healthcare NHS FT and other agencies, as appropriate, to continue the 13/14 development of the mental health and learning disability systems' response to patients identified with a specific risk of suicide or serious self-harm, or with a mental health or challenging behaviour crisis, whether in hospital, the community or identified through the criminal justice system, such as those requiring an approved place of safety.	To intervene early in order to minimise the likelihood of the patient lapsing into a subsequent crisis or risk of harm. To develop care pathways, with clinical and patient outcomes, for the future commissioning of mental health and learning disability urgent and crisis services.

Transformational Project	Local	Patient	System	Clinical
Outcome 2 - Improving the Health Related Quality of Life of the 15+million People with One or More Long-Term Condition, Including Mental Health				
Increasing Access to Talking Therapies (CMMV programme Board)	To work with local Talking Therapies service providers to continue to develop and performance manager the implementation of new funding made available in 2013/14, to ensure that the service meets the KPIs required	An increasing number of patients with serious mental illness will be able to report that they have access to psychological interventions and treatment within waiting time standards and established patient and clinical outcomes	Expansion of Access Talking Therapies for patients with both mild to moderate mental illness and those with severe and enduring illness	The Talking Therapies service will in 2014/2015 implement the commissioning requirements for outcomes, numbers of patient entering treatment and adherence to maximum waiting times.
Services for people with a learning disability (CMMV programme Board)	To ensure that local people with learning disability have access to appropriate setting of care according to their needs, through working across health and social care	To ensure that people with learning disability are cared for in appropriate settings, within Berkshire	To work with unitary authorities and providers of learning disability services to develop local services to meet both the requirements of the Winterbourne Concordat Recommendations and the outcomes of the 2013 Learning Disability Self-Assessment.	Appropriate care that is monitored and is of a high quality standard which meet the needs of learning disability individuals
Diabetes (Long Term Conditions Programme Board) and specific local focus	Diabetes is a key focus for the CCG we have an above average prevalence of HbA1c of 59mmol/mol or less and the percentage of people receiving the 9 diabetes care processes is below the national average.	Improved quality of life for people living with diabetes. More health screening and education in Diabetes care. More consistent communication of health messages from GP surgeries	The number of residents living with diabetes is expected to rise year-on-year and although deaths from diabetes are not as common as from other long-term conditions its complications and effect on quality of life, if not properly managed, can be catastrophic. It is also estimated that nearly 1 in 5 cases remain	People with diabetes are more likely to have a myocardial infection, stroke or a heart admission related to heart failure than the general population

			undiagnosed. Diabetes care priorities are driven by a Diabetes network who reports through the Long Term Conditions Programme Board.	
Mental Health (CMMV Programme Board and specific local focus)	In South Reading during 2009-2011 there were 743 admissions for mental or behavioural disorders of which 268 were for people with Psychoses, a rate higher than the Berkshire average.	Improved mental health and wellbeing of our population through early intervention and focus on a good start in life. Improved outcomes, physical health and quality of life for people with mental health problems and learning disabilities through high quality services and equality of access	Mental illness is the single largest cause of disability in the UK. At least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time. Approximately 1% of the UK population has a severe mental health problem. To ensure that more people have a positive experience of care and support	The NHS Outcomes Framework 2012/13 also contains three improvement areas relating specifically to mental health, which includes premature mortality in people with serious mental illness, employment of people with mental illness and patient experience of community mental health services.

Outcome 3 - Reducing the Amount of Time People Spend Avoidably in Hospital Through Better and More Integrated Care in the Community Outside of Hospital				
Psychiatric Liaison and community psychological medicine Service (CMMV Programme Board)	We will work locally with our mental health provider to develop a new psychiatric community liaison service	To improve patients' health, skills and knowledge for self-management of their health issues	Reductions in usage of A/E and inpatient services	To improve health care for people presenting to acute and community physical health services with co-morbid physical and mental health needs, through a new psychiatric liaison and community psychological medicine service, which will work with patients and physical health providers.
Hospital at Home (Long Term Conditions Programme Board)	We will work alongside our neighbouring CCGs to implement this key project locally. We will utilise resources of our local community nursing and geriatrician teams and will work closely with our Unitary Authority colleagues to adequately support step down of patients into the community.	Benefits for patients and their relatives who will avoid lengthy & frequent hospital visits and allow them to be more involved in their own care. Recovery in familiar surroundings and more consistent and seamless care as patients are stepped down into community and social care support according to their needs.	Increased level of intensive support to patients in the home setting to avoid the need for admission to hospital or support earlier discharge during a period of illness. Reduced pressure on acute hospitals.	Reduced risk of healthcare acquired infection.
Supporting Nursing & Care Homes (Long Term Conditions Programme Board)	We will work with our practices to ensure each care home in our area is covered by one GP practice as a minimum under the scheme.	To improve standards of care provided by care home staff and continuity of health care for residents.	To introduce a model of enhanced services to nursing and care homes which will provide training and support to homes to help with longer term care planning for their residents and support during times of crisis. To avoid unnecessary acute admissions from nursing and care homes.	To increase knowledge and continuity of health care for nursing and care home residents. Improved standards of care to residents and long term care plans in place, allowing resident and family wishes to be respected and implemented.

Heart Failure (Long Term Conditions Programme Board)	We will work alongside our neighbouring CCGs to implement this key project locally. We will utilise resources of our local community nursing and specialist IV therapy teams, heart failure nurses and geriatrician teams.	Reduced emergency admissions Improved quality of life for patients Reduced the need for face-to-face consultations To continue to reduce the number of home visits and outpatient attendances for those patients receiving telehealth	To further enhance the heart failure team with additional nursing roles. Development and implementation of enhanced care pathways including palliative care and IV furosemide To provide more preventative support within the community setting, helping to avoid hospital admissions and reducing some of the burden on secondary care providers whilst providing a cost-effective model of care for the management of the condition Improvement in discharge rates from the service	Increased medication compliance Optimisation of clinical care Increased stabilisation of patients in the community
CAMH Service changes (CMMV Programme Board)	We will work locally through our CMMV programme board to ensure our local children and families are better supported and family breakdown is minimised. Local solutions to avoid out of area placements will be explored whenever possible.	Young people will be supported in the community, family breakdown will be minimised, local CAMHS pathways will be strengthened and out of area placements will be avoided	Ensure that the Tier 3 CAMHs service meets the needs of today's service users in the context of safety and quality. There is particular work around having community cover outside 9-5 Monday to Friday for YP who are in crisis or presenting with high levels of risk.	Improved support for children and their families with improved outcomes and strengthening/clarity of patient pathways
Children and Young People - Palliative Care (CMMV Programme Board)	Ensure our local children and young people have access to a fair and transparent service for palliative care.	Patients will have access to a fair and transparent service resulting in an improved patient experience: Care closer to home and improved patient experience	Ensure CCGs compliance to the Palliative Care Funding Review in 2015 where the per-patient tariff currently being developed will be implemented. All palliative care providers, including Children's	Review of Palliative Care service for Children and young people ensuring there are clear: 1. Palliative Care pathways 2. Referral criteria 3. Assessment Process for integrated

			Hospices, will be able to charge commissioners for care delivered to individual patients	packages of palliative care 4. Service Specification for Hospice / other provider delivery
Maternity – Introduce an Early Labour Assessment Service for low risk mother (CMMV Programme Board)	Across Berkshire West our average Home birth rate is low at rate 3%. Early labour assessments can help to reduce the number of women arriving at labour suite too early and reduce demand in the maternity triage unit. Local evidence through the Home Birth Review (November 2013) has shown approx 50% of women are low risk at the start of labour. If early labour assessments were carried out on 25 % of these women, then up to 26 early labour assessments per week could be made across Berks West.	Operating an Early Labour Assessment Service will support mothers and partners, to consider alternative options to hospital delivery and support enhanced take up to the Home Delivery and Midwifery Led Units. The Berkshire West Home Birth Review (Nov 2013) reviewed maternity practices in part of Wales, where they have reached a target of10% home births.	Maternity systems in Wales includes early labour assessment; promotions of information about place of birth for women throughout pregnancy and the screening of women for suitability for home birth. The Wales system operate a team model to promote continuity in care. A team at Glan-y-mor have sustained home birth rate of 23-25% in the last 10 years. For the Berkshire West System an Early labour Assessment will begin from April 2014. With a target to increase Home Birth rates to 5% by 2015.	Over 2014 a midwifery team approach will be developed to facilitate increasing the number of home births. This will involves developing 3 maternity teams of geographically based home birth specialist midwives, across Berkshire West, in addition to the traditional team of community midwives, to care for women ante- and post-natally The Early Labour assessment service will be piloted over 2014/16. The resources needed for this pilot would be: - 16.5 WTE to provide 3 midwives available at any time of day, so requiring an extra 5 WTE midwives in the community team - there would need to be 32.3 WTE in the traditional team, based on current caseload numbers.
Local Tariff for Urgent Care (Urgent Care Programme Board)	We will agree a local tariff for Urgent Care that incentivises use of ambulatory care pathways	Patients managed safely and appropriately on the same day without admission to a hospital bed.	Maximising the benefits of a local tariff	Better clinical management and outcomes for patients

Urgent Care Dashboard (Urgent Care Programme Board)	The Alamac Kit Bag will provide transparent objective information available to all, enabling tracking of real-time demand and capacity. Providing strategic information to support investment decision and prioritization	Patient pathway informed by robust muiti agency working with better outcomes for patients	System wide tracking of real time demand and capacity enabling organisations to plan their resources, work more effectively together and inform escalation plans	Better clinical management and outcomes for patients Clinical resources deployed in response to anticipated demand
Outcome 4 - Increasing the Proportion of Older People Living Independently at Home Following Discharge from Hospital				
Carers (CMMV Programme Board)	Within our local Better Care Fund we have identified support for carers as a key scheme for further development	Increase identification of carers including young carers Personalised support for carers Support to remain mentally and physically well Improve the health and well-being of carers	To implement across the system the recommendations from the carers scoping report	Improved support for carers to ensure they remain mentally and physically well
Integration of Health and Social Care Services (CMMV Programme Board)	Locally with a high number of young people and pockets of deprivation , we will work through our CMMV board to help better support children and families through health and social care integration	Reduced family break up. Reduced offending behaviour. Reduced use of mental health, substance misuse, maternity and physical health services	Compliance with SEN changes to be mandated from April 2014 Financial savings over the life course.	Integration may benefit the following groups: 1. Children and Young People with special educational needs/ complex health conditions 2. Troubled Families - characterised by high incidence of mental health/substance misuse/offending/ worklessness/children in care/domestic violence
Increased	More flexible Rapid Response and	Patients supported to live	Reduction in admissions to	Most efficient use of clinical resources

Rapid Response and Reablement Services (Urgent Care Programme Board)	Reablement Services across the CCG and the other 3 CCG localities based on predicted discharge numbers aimed at reducing the numbers of patients medically fit for discharge at RBFT	independently at home. Better patient experience.	hospital. Reduction in both the numbers of patients medically fit for discharge and the length of time spent waiting for discharge.	and skills
Outcome 5 - Increasing the Number of People Having a Positive Experience of Hospital Care				
Maternity – rate of C-sections (CMMV Programme Board)	Reduce elective C-section to less than 10%		For the system to monitor on a monthly basis the service provision and efficiency regarding numbers of elective C-section in relation to KPI	
Patient Related Outcomes Measures (Planned Care Programme Board)	Participation in Friends & Family Test Participation in Patient Satisfaction Surveys including National Cancer Patient Satisfaction survey	Empowering patients and promoting patient voice relating to the quality of services	Empirical study of actual patient satisfaction, to better enable outcomes based commissioning	Empirical surveys to define services provided

Outcome 6 - Increasing the Number of People with Mental and Physical Health Conditions Having a Positive Experience of Care Outside of Hospital, in General Practice and in the Community				
Children- Provision for Children with complex needs (CMMV Programme Board)	We will work locally through the CMMV programme board with local providers to improve the quality of care for children and young people with complex needs.	Improved quality of care for the four groups of children and young people with complex needs that have been identified as requiring Community Nursing provision: 1. Children with acute and short-term conditions 2. Children with long-term conditions 3. Children with disabilities and complex conditions, including those requiring continuing care and neonates; and 4. Children with life-limiting and life-threatening illness, including those requiring palliative and end-of-life care	We aim to improve accessibility to service provision and ensuring there is an equitable service available across the area. There will be a specific focus to ensure there are seamless transitional arrangements in place for children moving onto adult services.	Improve quality of care
Voluntary and Community Sector (CMMV Programme Board)	Through our CMMV we will strengthen our local links with the voluntary sector to provide maximal support to patients and carers	Improved links for patients and carers and engagement with the voluntary sector	Involvement of the voluntary sector in pathway development and provision of services Increase the role of the voluntary sector in providing commissioning support	Improved quality of life and support from the voluntary sector may improve clinical outcomes and recovery

Maternity – Supporting anxious mother and partners (CMMV Programme Board)	The rates of planned C-section rates have increased 5% over the past 4 years across Berkshire West. This is felt to be a result of Berkshire West increase diverse culture, where some culture there is an expectation to have a C-section e.g. some eastern Europe countries and from increasing anxiety to natural delivery. From 2014, Women and partners who express anxiety to natural delivery will be offer psychological support through Talking Therapies	Women and partners will be able to access psychological support through their GP, or women can self-refer to the service. Midwives / obstetricians can refer via the GP or signpost the women for self-referral.		
Integrated Care for the Frail Elderly (Long Term Conditions Programme Board)	Local community integrated nursing teams centred around GP practices will be established with a named clinical nursing lead for care of the patient within a locality cluster. This will be further supported by named GPs within each practice having responsibility for patients over 75 years of age	Patients will be encouraged to self- manage and obtain the highest quality of life possible.	Patients will be managed more seamlessly within the community, avoiding duplication of assessments and provision of more holistic support. This would also support the Hospital at Home implementation and current work on-going around redesign of the frail elderly pathway.	Enhanced patient experience and integrated access to care. Potential to improve quality and timeliness of care in the community.
Chronic Fatigue Syndrome Service (Long Term Conditions Programme Board)	We will work alongside our neighbouring CCGs to implement this key project locally. We will utilise resources of our local community psychology, physiotherapy and other theory led services	Improved access to a therapy led integrated service to help manage their condition	Commissioning of an integrated therapy led community CFS/ ME Service covering Berkshire with specialist support for diagnosis and complex case management as appropriate.	Improved ability to self-manage and improved quality of life. Provide a service which is fully integrated offering physiotherapy, graded exercise and psychological

			Improved patient pathway and access to integrated care when needed closer to home.	support
Maternity – Reduce the number of women being diverted to an alternative midwifery unit during labour (CMMV Programme Board)	Aim of a diversion policy to be implemented <1-3 times per months,	Increase women and partners experience of maternity care	A planned and timely service, that increases capacity and supports a better women experience	
MSK (Planned Care Programme Board)	Integrated MSK service, bringing together appropriate and accredited providers	Affords greater choice of provider for patient benefit Fosters innovation and efficiencies	More efficient use of resources across the wider health system	Greater integration of clinical services
Integrated Ophthalmology Service (Planned Care Programme Board)	Increase provision of local eye care services through an integrated ophthalmology solution	Affords greater choice of provider for patient benefit Fosters innovation and efficiencies	More efficient use of resources across the wider health system	Greater integration of clinical services
NHS 111 (Urgent Care Programme	Raised patient awareness of 111 services through targeted seasonal campaigns and promotion through face-to-face	Patient treated as close to their home as possible.	Decrease in self-referral to A&E after successful triage to another primary/urgent care service	Most efficient use of clinical resources and skills

Board)	channels such as GP surgeries.			
Digital care Plans (Urgent Care Programme Board)	Availability of digital care plans/special notes to 111 provider to avoid cold-triage of patients with known conditions and plans.	Better patient experience and patient treated as closely to home as possible	Reduction of ambulance call-outs by 33% from 111 for patients on EoL or with LTCs	Most efficient use of clinical resources and skills
Direct Referral of NHS 111 into primary and community services (Urgent Care Programme Board)	Promotion and pilot of direct referral from 111 into primary and community services without the need for further clinical assessment/referral	Better patient experience and patient treated as closely to home as possible	Reduction in inappropriate transfers to GP/GPOOH for assessment and onward referral to community services	Most efficient use of clinical resources and skills
Electronic patient records in 999 service (Urgent Care Programme Board)	Implementation of electronic patient records in 999 service allowing crews to access patient demographics, care plans. Supports timely transmission of data to A and E departments and improved reporting to Commissioners	Better patient experience and patient treated as closely to home as possible	Reduction in level of conveyance through appropriate management and continuity of any existing care plans in the community. Improved access to existing patient records and past medical history through the Summary Care Records allowing for quicker assessment and better patient outcomes.	Most efficient use of clinical resources and skills
Emergency Care Practitioners (Urgent Care Programme Board)	Increased use of Emergency Care Practitioners to treat patients in their own homes with extended prescribing skills, minor injury skills and suturing skills	Better patient experience and patient treated as closely to home as possible	Increased numbers of patients who are seen and treated at home and reduced the level of conveyance to A and E	Most efficient use of clinical resources and skills

Protocols with Minor Injury Units (Urgent Care Programme Board)	Development of protocols with Minor Injury Units to accept appropriate 999 conveyance for minor injury patients to avoid an A and E attendance	Better patient experience and patient treated as closely to home as possible	Supports appropriate use of Minor Injury Services for patients reducing the level of conveyance to A and E	Most efficient use of clinical resources and skills
Care Plans (Urgent Care Programme Board)	Use of 999 data sets including Nursing Home activity and frequent caller activity to ensure care plans are in place to support management of patients more effectively in the community	Reduced level of conveyance from Nursing Homes and better patient experience	More efficient use of resources	Better clinical management and outcomes for patients
Outcome 7 - Making Significant Progress Towards Eliminating Avoidable Deaths in our Hospitals Caused by Problems in Care				
Enhanced Recovery Programme (Planned Care Programme Board)	Commissioning for outcomes in relation to ERP programmes within Elective Care	Defined clinical pathway from elective care through to appropriate and timely discharge	Provides for efficiencies within elective care enabling more activity to be completed with the same or less resources	Proactive management through to timely discharge, supported by MDT care

Appendix 3 - Improvement Interventions

NHS Outcomes Met	Intervention	Description	Expected Outcomes (Activity/Quality)	Changes derived from recognised good practice	Investment Costs Financial	Investment Costs Non - Financial	Anticipated Savings (Net) *Indicative in 2015/16	Implementation timeline	Enablers	Barriers to success	Confidence levels of implementation
2014-15 Improvement Interventions. * Interventions relate also to 2015/16											
3	***Care Home Support**	To introduce a model of enhanced services to nursing and care homes which will provide training and support to homes to help with longer term care planning for their residents and support during times of crisis. This intervention will support the CCGs achievement of their Outcome Ambition 3 - reducing emergency admissions.	The expected outcomes of this intervention are to avoid unnecessary acute admissions from nursing and care homes; to increase knowledge and continuity of health care for nursing and care home residents; reduced unnecessary non-elective admissions; reduced number of prescriptions; improved co-ordination of crisis management and improved end of life experience for patients through advanced care planning. There will be a reduction in acute hospital activity and associated costs.	Use of a similar model to that developed in Sheffield (Sheffield - Integrated care and supporting care homes, BGS March 2012), supplemented by a model on Cornwall (Improving the Quality of Dementia Care, HSJ October 2012) and Walsall (Nursing Homes in Walsall, Improving care for elderly people, December 2011), as well as some of the initial locally developed work undertaken in Wokingham by Dr Charles Gallagher. Savings are based on the Sheffield model with additional prescribing savings factored in with the additional Community Pharmacist post.	£685,321 (2014/15) £500,538 (2015/16)	Enhanced primary care training and additional pharmacy support. Care homes to release staff to undertake training required. Increased nursing and pharmacist posts in local workforce.	£520,870	It is anticipated that the service agreements will be agreed with Providers by the end of March 2014.	Use of an enhanced service specification for the provision of Care Home outlines the more specialised services to be provided by primary care that practices will be monitored against.	GP Practices may come under too much pressure with their own lists to effectively manage the additional requirements. Furthermore, Berkshire West has 48 care homes (of which 24 have nursing care). This level of provision causes a net influx into the region of dependant elderly residents which has growing resource implications for health and social care. Care homes may not have the capacity or resources to engage with intervention.	This intervention has dedicated project management support and thus there is a high level of confidence of implementation.

3	**Community Heart Failure**	To further enhance the heart failure team with additional nursing roles. The intervention will develop and implement enhanced care pathways including palliative care and IV furosemide care in the community. To provide more preventative support within the community setting, helping to avoid hospital admissions and reducing some of the burden on secondary care Providers whilst providing a cost-effective model of care for the management of the condition. To continue to reduce the number of home visits and outpatient attendances for those patients receiving telehealth. This intervention will also support the CCGs achievement of	Expected outcomes will result in improved quality of life for patients with heart failure, providing intensive support at home and in the community. There will be a reduced need for face-to-face consultations with an improvement in discharge rates from the service. Improved patient outcomes (chiefly improved quality of care, optimised prescribing and titration of heart failure medications and maximised independence). To reduce emergency admissions and support increase medication compliance. Clinical safety and effectiveness of treatment will be ensured because the right people are caring for patients and are able to give each case the appropriate attention.	Expansion of this service is based on and in line with guidance from the British Heart Foundation. Inclusion of a community based IV Furosemide servce is based on positive outcomes found in the recent national British Heart Failure pilot that reduced the need for patients to be treated as an acute inpatient. Feedback from patients was unanimously positive as they were able to be treated at home.	£185,926	This intervention increases the workforce of the community heart failure team by appointing two full time additional specialist nurses.	-£77,160	Recruitment to the posts will commence to enable service commencement from April 2014. A new service specification will be agreed with the existing provider and included in the 2014/15 contract to meet national timescale.	This is an expansion of an existing and well-established service with strong links with primary care and secondary services. Strategic enablers such as the NHS Standard Contract will be employed to manage provider performance. Deployment of the telehealth units to manage patients requiring more intensive input.	There is always the potential difficulty/delay in recruiting to specialist nursing posts within the agreed timescales.	Local Provider is confident that they will attract the right candidates for the roles and have not experienced issues relating to recruitment to heart failure specialist nursing roles. This is an expansion of an existing and well-established service with strong links with primary care and secondary services. Confidence levels of implementation are thus moderately high.

		their Outcome Ambition 3 - reducing emergency admissions and Outcome Ambition 2 - improvement in the health-related QoL for people with long term conditions.									
3	**Hospital at Home (H@H)**	This model within the LTC programme board of work includes providing more intensive support for short periods of time to patients in the community under the care of a consultant led team. Patients will be identified as requiring a higher level of support than is currently provided and will receive a level of care as if they were in a hospital setting. This intervention will support the CCGs achievement of their Outcome Ambition 3 - reducing emergency admissions.	Increased level of intensive support to patients in the home setting to avoid the need for admission to hospital or support earlier discharge during a period of illness. There will be benefits for patients and their relatives who will avoid lengthy and frequent hospital visits and allow them to be more involved in their own care. Patients will be able to recover in familiar surroundings with more consistent and seamless care as patients are stepped down into community and social care support according to their needs. There will be a reduced risk of healthcare acquired infection as a result with reduced pressure	There is not a lot of detailed evaluation around Hospital at Home schemes. Over the past 5 years there have been various models of Hospital at Home Services/Virtual wards introduced, including Community Nurse Led, GP Led and GP Practice Led. A recent study from the Nuffield Trust (June 2013) analysed Hospital at Home Services (Virtual Wards) based on three areas; Croydon, Devon and Wandsworth, but they had significant length of stays. There has been no significant analysis of H@H schemes and even those that exist in the USA (e.g. VA Centres, Presbyterian Healthcare Services, Mercy health and Cigna Medical Group) are based on different models with different	£1,189,568(2014/15) £2,152,091 (2015/16)	The intervention will establish a dedicated core H@H team. In order that we ensure medical leadership for each patient within the H@H service, a high level of medical input and supervision is required to ensure good governance and patient safety. The role could be undertaken by the following staff: General Practitioner, GPwSI, Consultant Geriatrician, Associate Geriatrician and possibly a Specialist Nurse	£1,438,195	Due to significant staffing challenges commencement of the new service is expected in July 2014. The recruitment process is about to start to ensure that we mitigate this risk as much as possible.	There is a commitment across all partner organisations in Berkshire West to a shared vision of integration that will support the implementation of H@H. H@H may act as catalyst in supporting integrated pathway development currently in progress.	The main barrier to success will be the ability to recruit the appropriate clinical and nursing staff with the associated competencies.	The full effect of the savings will be realised in 2015/16, with part realisation in 2014/15 (depending on service commencement). Service commencement is likely in July 2014 with half the beds planned. After six months the full stock of beds (60) will be brought on line so that the full benefit will be realised from April 2015.

			on acute hospitals.	outcomes, but all show a reduction in costs of at least 19%. See: Exploring Best Practices in Home Health Care: A Review of Available Evidence on Select Innovations Home Health Care Management Practice, October 2013, and Improving outcomes and lowering costs by applying advanced models of in-home care, Cleveland Clinic Journal of Medicine, January 2013.		Consultant. This will include a full time role within each H@H locality.					
3	*** Continence & Falls**	This intervention aims to redesign and integrate health teams for falls, continence services, specialist nursing and therapies within the community setting. The intervention will enhance the current falls services and establish a falls and bone health pathway, reducing the likelihood of repeat admissions for falls This would also	Patients will be managed more seamlessly within the community, avoiding duplication of assessments and provision of more holistic support. Patients will be encouraged to self- manage and obtain the highest quality of life possible. It will reduce the likelihood of admission for a Urinary tract infection which often leads to poor outcomes for patients. The falls pathway will be modified to ensure that any patient with a fall is registered within the	This is based on a similar redesign undertaken in Rotherham. In the four years since the redesign was introduced, nationally continence prescribing costs increased by 21.56% whereas in Rotherham the costs decreased by 8.99%. Rotherham's expenditure on continence appliances in 2012/13 was £561,200 however if their costs had increased in line with national growth expenditure it would have been £800,791. The recruitment of the Fracture Liaison Nurse will enhance proposals being developed in	£305,374	There will be an increase in the number of community staff to deliver the service with some changes to existing roles.	£134,706	Recruitment to the posts will commence to enable service commencement for the continence service from April 2014. A new service specification will be agreed with the existing provider and included in the 2014/15 contract to meet national timescale. Care pathway work will be carried out for the falls element of the intervention with an anticipated service start date from September	Strategic enablers such as the NHS Standard Contract will be employed to manage provider performance. NICE guidelines, Quality Standards and PBR Best Practice Tariff, all stipulate that people with hip fracture should receive falls and bone health assessment and appropriate preventative therapy. Medicine's Optimisation. There are	The falls care pathway review may take longer than anticipated.	There is excellent stakeholder engagement and confidence levels of implementation are moderately high. There is an assigned clinical lead for the project who has met with secondary care representatives. A workshop for stakeholders is to be arranged imminently from which a project implementation plan will be developed.

		support the Hospital at Home implementation and current work on-going around redesign of the frail elderly pathway. This intervention will support the CCGs achievement of their Outcome Ambition 3 - reducing emergency admissions and Outcome Ambition 2 - improvement in the health-related QoL for people with long term conditions.	surgery and followed up by the GP to minimise the risk of subsequent falls. A pathway to develop an integrated fracture liaison service will be developed.	primary care to monitor patients at risk of falls and to improve integration of care across primary, community and secondary care.				2014. .	established community services with good relationships across all stakeholder groups which will ensure the additional community investment and pathway redesign is integrated.		
4	**Increase in community Reablement and Rapid Response**	The project will increase investment into the community Reablement and Rapid Response service. Capacity will be rapidly flexed across the three localities based on predicting discharge numbers and will have an impact on reducing the numbers of patients medically fit for discharge at the main local	The main expected outcomes of this intervention is a reduction in both the numbers of patients medically fit for discharge and the length of time spent waiting. Target is no more than 20 patients with a maximum length of 5 days.	The report from the Emergency Care Intensive Support Team (Dec-13) references the continued 'bottlenecks' at the back-end of the acute pathway delaying discharge for a significant group of patients at RBH. The report also finds that although there have been positive developments in the scope and capacity of these services that the responsiveness of services remains variable across Berkshire West.	£665,508		£24,597	There is additional capacity and extended working hours already in place so implementation is well underway.	There is a central hub for all referrals into the service.	There is always the potential difficulty/delay in recruiting to the posts within the agreed timescales.	There is a high level of confidence of implementation.

		acute hospital.		ECIST found that the Wokingham and West Berkshire Localities particularly had "insufficient community rehabilitation capacity". This QIPP is aimed at addressing these insufficiencies.							
3	*** Psychiatric Liaison Service**	The overall aims of this intervention is to improve health care for people presenting to acute and community physical health services with co-morbid physical and mental health needs. The service will work with patients and physical health providers.	Expected outcomes are improvements in patients' health, skills and knowledge for self-management of their health issues, with reductions in the usage of A&E and inpatient services. Two aspects to the service: [a] 24/7 liaison psychiatry within the Royal Berkshire Hospital and [b] community-based Community Psychological Medicine service to receive referrals of patients identified both through attendance in acute care and from direct GP referrals. This community service mainstreams the experience and developments from the Dept of Health Medically	These outcome/impact opportunities are supported by evidence from national evaluations of Liaison services and other hospitals where the service has been substantially funded to optimise impact. For example: • Matt Fossey; (Economic Analyst for the RAID study showing £4 savings for every £1 invested in Psychiatric Liaison in QE2 Birmingham, who is now working at the Kings fund) reports that a paper is near publication showing that Birmingham has extended the RAID model to all the city hospitals and similar savings have been made. • Plymouth has demonstrated decreased admissions since Liaison Psychiatry was attached to it's A&E department • The Faculty of	£1,038,159		£143,723	Berkshire Healthcare NHS Foundation Trust to develop Implementation plan in January 2014 for agreement by Berkshire West CCGs. Subject to agreement of the implementation plan, recruitment to psychiatry, mental health nurses and health psychology posts to start as soon as possible. Development of Project Board to develop and monitor implementation and development of metrics and informatics requirements.	The key enabler is the participation of mental health trusts, acute hospital trust and CCGs. Agreement on improved informatics and data set to identify patients with co-morbid conditions	The main barriers to success are possible complications of informatics developments and delays in recruitment of key posts, such as liaison psychiatrists.	The confidence level of implementation is high as there is multi-agency agreement on the importance of improving expertise and capacity to address co-morbid presentations.

			Unexplained Symptoms Project in Berkshire. The service will address co-morbid conditions of patients with severe and enduring mental illness as well as the larger number of patients with less severe clinical mental illness, or who have mental health issues that do not meet the threshold for definition of a clinical mental illness.	Liaison Psychiatry at the Royal College of Psychiatrists has, in 2013, identified five key patient groups who stand to benefit from effective liaison psychiatry in ED, 4 of which are relevant to this Project in Berkshire West [the fifth relates to older people]: - People who self-harm and need medical or surgical treatment as a consequence. - People with the physical and psychological consequences of alcohol and drug misuse. - People with known severe mental illness. - People admitted with primarily physical symptoms which, on assessment, have mainly psychological or social causation.						
6	**Integrated Eye Care Services**	The overall aim of this intervention is to deliver more effective commissioning of an integrated ophthalmology service, ensuring consistency and reducing clinical variation.	The intervention will result in overall cost savings through a reduced tariff. Patients will benefit from pathway improvements.	Increased choice of providers through plurality in the market place. Definition of an integrated ophthalmology service incorporating all aspects of the service from community eye services through to emergency care. (supplied by PMN - pending business case from United	None		£500,000	There have been delays to the original implementation timeline. The expectation is that he provider will commence implementation in April 2014.	An intermediate outpatient service to consist of experienced practitioners (middle grades; optometrists; orthoptists; nurses) to undertake pre-operative and other assessments; treatment of non-complex	The acute trust has been delayed in implementing because the specialty has had recruitment difficulties in particular temporary sub-consultant grades of medical staff.	Due to the difficulties experienced by the provider, there is currently a moderate confidence level of implementation. However, the trust has committed to a number of mitigating actions which include: The appointment of

				Health).					conditions; monitoring chronic conditions; and, follow-ups.		locum consultants to work at the Prince Charles Eye Unit and at the RBH; additional Saturday morning lists at the RBH and the West Berkshire Community Hospital and additional pre-operative assessments on Saturdays and Sundays.
6	**Musculo Skeletal (MSK) services**	This intervention expands the focus on pathway improvement for MSK services. It will include an expansion of the current shared decision-making scheme (SDM) in primary care ensuring that SDM applies to all the selected pathways and with all relevant providers. This will incorporate the ongoing review and implementation of the MSK pain pathway to develop an integrated pathway and improvement in the pain	The MSK integrated pathway will address waiting time issues that are currently present, and ensure there is equity between NHS and Independent pathways. Reduction in the number of surgical interventions for hip and knee replacements can be achieved by a combination of the use of Shared Decision Making (SDM) Tools and Threshold policies. There will be associated savings for CCGs related to the reduced activity. Reduced waiting times and a one-stop appointment for	Review of the evidence base of the impact on patients of the use of patient decision aids.	£50,000	Support to pratice staff on using the SDM tool. Robust audit and contract monitoring of all providers carrying out hip and knee procedures.	£427,274	Shared Decision Making (SDM) is already available to primary care practice staff but needs to be re-launched and embedded. This intervention plans to relaunch to practices during February and March 2014 and ensure that it is consistently applied for all NHS and independent sector provider pathways.	Require robust referral management process across primary care together with the use of contractual levers in secondary care (independent and NHS). I.e provider contracts to ensure that payment will be related to compliance with threshold policies.	A likely barrier to success is the potential resistance from primary care. However, this will be overcome by implementing robust audit processes for both NHS and Independent providers.	The confidence level of implementation is good since this will be a two-pronged approach engaging both primary and secondary care, in particular by using contractual levers.

		management service. Part of this work will involve the de-commissioning of the MSK CAS service.	back pain.								
5	**Cancer Care Pathways**	This intervention aims to enhance the existing service. The focus is on reducing the number of follow up appointments for newly diagnosed patients.	To provide high quality, efficient, accessible, effective and safe follow up care for cancer patients. This will lead to reduction in hospital based follow up appointments.	The model is based on the NHS Improvement Risk stratified breast cancer pathway.			£50,000	The work involves scoping the possibility of a risk-stratified prostate cancer pathway and embedding this amended pathway. The lead in time could be 6 months, therefore implementation will be September 2014.	The intervention is dependent upon clinical engagement with the Consultant Urologist (Lead for Prostate), Clinical Nurse Specialist and the Oncology team involved in the pathway.	Barriers to successful implementation may include the failure to engage and agree on the pathway by the clinical team. Patient confidence may be a barrier if clinicians are uncomfortable with new pathway (involves discharge from secondary care).	There is currently a telephone follow up existing for some of the pathway. The number of patients eligible may be fewer than expected - this needs further scoping and investigation. Given this the confidence levels are moderate.

3	**End of Life (EoL)**	This intervention aims to enhance the existing service. Better identification of patients at EoL and ensuring they have an Advanced Care Plan in place and sharing of information.	The main outcomes will be a reduction in acute admissions and will support patient choice and preferences to die at home.	This is based on the national End of Life strategy and has been recognised and communicated across all providers.			£50,000	The EoL beds admission criteria have been agreed and the intervention will be implemented on April 2014.	A key enable has been the change in referral criteria to the hospice. Also, further education and uptake of advanced care planning training being is implemented as funding obtained from Health Education England to progress this.	Barriers to success include potential engagement issues with Primary Care and the uptake of training are possible but not anticipated.	The confidence levels of implementation are good as the redefining of admission criteria has already been agreed and has good support from all parties.
6	**Pathology**	The overall aim of this intervention is referral management. It will identify and audit outlying GP practices, educate and promote existing guidelines to GPs.	The main outcome will be a reduction in inappropriate referrals for pathology services thereby reducing cost to CCGs.	The 2014-15 QIPP focuses on increasing the uptake of the ICE 2 ordering system s a tool to drive clinical effectiveness. The use of IT to influence GP ordering by embedding good practice guidelines/pathways and blocks has been highlighted by the Royal College of Pathologists. There are a small number of identified tests that if ordered in line with guidance can deliver financial savings and be in line with clinical effectiveness. The guidance used to inform the QIPP has been generated by NIC, PHE e.g (Diagnosis of UTI in promary care (HPA, 2011). Additionally, cliical audit and advice from subject matter experts and		None	£60,000	The implementation timeline relates to deploying the ICE 2 IT software that will help with demand management. The timeline for this to be fully installed is the end March 2014.	CCGs are sent regular Pathology updates delivered by the pathology team at the local acute trust and the project lead. This supports the practices to make changes in their referrals. Clinical leads have time to attend steering meetings.	The success of this intervention is dependent upon adoption of demand management initiatives within primary care. Some national initiatives such as the health check programme have resulted in increased requesting of some tests.	The success of this initiative is dependent on changing GP ordering behaviour. Last years pathology QIPP did not achieve projected savings. Project manager working closely with CCG clinical leads to reinforce good practice guidance and to embed the use of ICE 2. There is a Moderate level of confidence in successful implementation of this intervention.

				secondary care consultants have informed this QIPP.							
2	**Haematology / DAWN**	2	The expected outcomes will be an improvement in clinical outcomes, reduction in follow-up appointments, and provision of a more cost effective service. It will enable the early detection of patients who have an exacerbation of their condition, allowing patients quick access for specialist review.	This intervention ties in with the commissioning intentions of keeping people well and out of hospital. The Rheumatology DAWN project has been operating successfully for some time and has delivered the target reduction in new to follow-up ratio and the Haematology DAWN is based this methodology.	£89,232	This initiative increases the workforce within haematology by the provision of a specialist nurse to monitor the results and liaise with GP and patients.	£35,000	The intervention go live date is the end March 2014.	Detailed service specification and liaison between acute trust and project lead. This is a similar initiative to rheumatology DAWN so lessons learned from this project are being applied.	Previous delays have been due to IT issues which are being resolved.	Rheumatology DAWN had been successful at reducing follow ups. This initative uses similar technology and there is a good confidence level of implementation of this current intervention.
2015/16 Improvement Interventions											
3	**Integrated care / Frail Elderly programme:** **Changes required for which initiatives have not yet been identifed**	Building on the Hospital at Home, Care Homes, Reablement, and Continence & Falls projects underway in 2014/15, a programme of projects to improve care for Frail Elderly patients will be extended from 2015/16 onwards. This									

		will be based on the integrated Frail Elderly pathway currently under development across the Berkshire 10 Partnership.									
	Market Management and Contractual levers:	The CCGs will pursue a market management approach that strengthens the delivery of care outside of hospital, optimises the provision of care from multiple sectors, and delivers technical contract efficiencies with our providers. This approach will include (see below):									
	Contractual & Pricing mechanisms	The CCGs will implement relevant technical contracting & pricing levers for contracts in 2014/15. These reflect the strategic intentions of the CCGs around market management, and will be applied and extended where possible in 2015/16.			No additional investment. Potential savings have been identified.		£2,000,000*				
	Review & rationalisation of contracts	A review has been carried out of Berkshire West CCG's overall contract portfolio identifying opportunities to generate financial savings through a combination of: • Rationalisation of the existing portfolio into	Realisation of efficiencies over the next two years.		No additional investment. Potential savings have been identified.		£250,000*		Contractual levers and review.		

		fewer consolidated contracts. • Re-procurement where this is felt to potentially generate savings. • Non-renewal of contracts where duplication or lack of coherence is identified.									
	PLCV and threshold-dependent procedures	CCGs will strengthen compliance at local Trusts with resultant savings with the appropriate application of protocols over Procedures of Low Clinical Value (PLCV) and Threshold Dependent Conditions (TDC).			No additional investment						
	Reducing length of stay & excess bed days (EBD) supported by clinical utilisation audit tool	This intervention aims to improve timely discharges for patient supported by advanced Clinical case-review tools such as MCAP and MEDWORXX. These provide evidence-based indications on the clinically appropriate level of care	Improved compliance of local Trusts		Investment costs of deploying tools are being explored.						

		that a patient requires, and more accurate pathway management to out-of hospital care.									
Medicines Optimisation:											
	Medicines Optimisation - Prescribing	This intervention aims to realise efficiency savings from optimising the use of medicines	Efficient and optimal prescribing of medicines	Will be based on the relevant prescribing and NICE guidelines and recommendations	No additional investment. Potential savings have been identified.		£675,000*				
	Medicines Optimisation - Prescribing Support Dietician	Project aims to reduce inappropriate prescribing of Oral Nutritional Supplements (ONS), gluten free and specialist infant formulas through a precsribing support dietician post auditing and supporting genral practices.	All 55 surgeries audited yearly with a view to reducing inappropriate prescribing of ONS. All 55 surgeries audited yearly with a view to reducing inappropriate prescribing of gluten free products. A policy on prescribing of specialist infant formulas will be written and published. An education/launch event is conducted for GP's and Health Visitors for the above guidelines. Support all practices with their service for diabetic individuals Reduction in	This intervention is In alignment with the NICE Guidelines: • NICE suggests that vast improvements to the treatment of malnutrition will result in high cost savings for the NHS In alignment with BAPEN Guidelines: • British Association for Parenteral and Enteral Nutrition (BAPEN) estimate savings of £130 million a year if 1% of public expenditure on malnutrition was saved In alignment with National Prescribing Cost Comparators for quarter one of 2013-14, figures for the Berkshire West CCG's show that the average weighted spend per patient is more than the Thames Valley	£50,000	Increase in the workforce of the Medicine's Optimisation team.	£69,113*		Existing intervention structure is already in place. ScriptSwitch is also used to inform prescribers of the latest ONS prescribing guidelines	The intervention relies on engagement of GPs with many actions resting with them.	A pilot has been previously conducted with the practices and this began with ONS prescribing. This intervention will extend to gluten free products and specialist infant formulas. As the infrastructure is already in place, confidence levels of implementation are moderately high.

			spend for ONS.	locality and for one of the indicators more than national.							

Appendix 4 - Improving Health Outcomes through QIPP and the Four Programme Boards

(Need to reference in main body of plan)

Working through the "How to Change" approach North & West Reading CCG has been working with the other CCGs in Berkshire West and our local partners, to develop a number of new initiatives and programmes to improve health outcomes and the quality of services, in line with national and local priorities already outlined in this Operating Plan. These initiatives and programmes are set out below and summarised in the NHS England Ambition matrix below:

Initiatives 2014 to 2016	Linked to: • local Priorities (LP) • Better Care Fund (BCF) • Programme Board Oversight – Planned Care (P) Long Term Conditions (LTC) Urgent Care (U) Children, Mental Health (CMMV)	NHS England Ambitions						
		Securing additional years of life	Improving health-related quality of life for 1 or more LTC	Reducing the time spent avoidably in hospital	Increasing the proportion of older people living independently at home following discharge from hospital	Increasing the number of people having a positive experience of hospital care	Increasing the number of people having a positive experience of care outside of hospital	Making significant progress towards eliminating avoidable deaths in hospitals caused by problems in care
Care Home Support	BCF, LTC		✓	✓			✓	
Community Heart Failure	F, LTC		✓	✓			✓	
Hospital at Home	BCF, U		✓	✓		✓	✓	
Continence and Fall	F, LTC			✓			✓	
Increase in community reablement and rapid Response	F, U		✓	✓	✓		✓	
Psychiatric Liaison Service	F, CMMV			✓		✓	✓	
Integrated Eye Care	LP, P			✓		✓	✓	

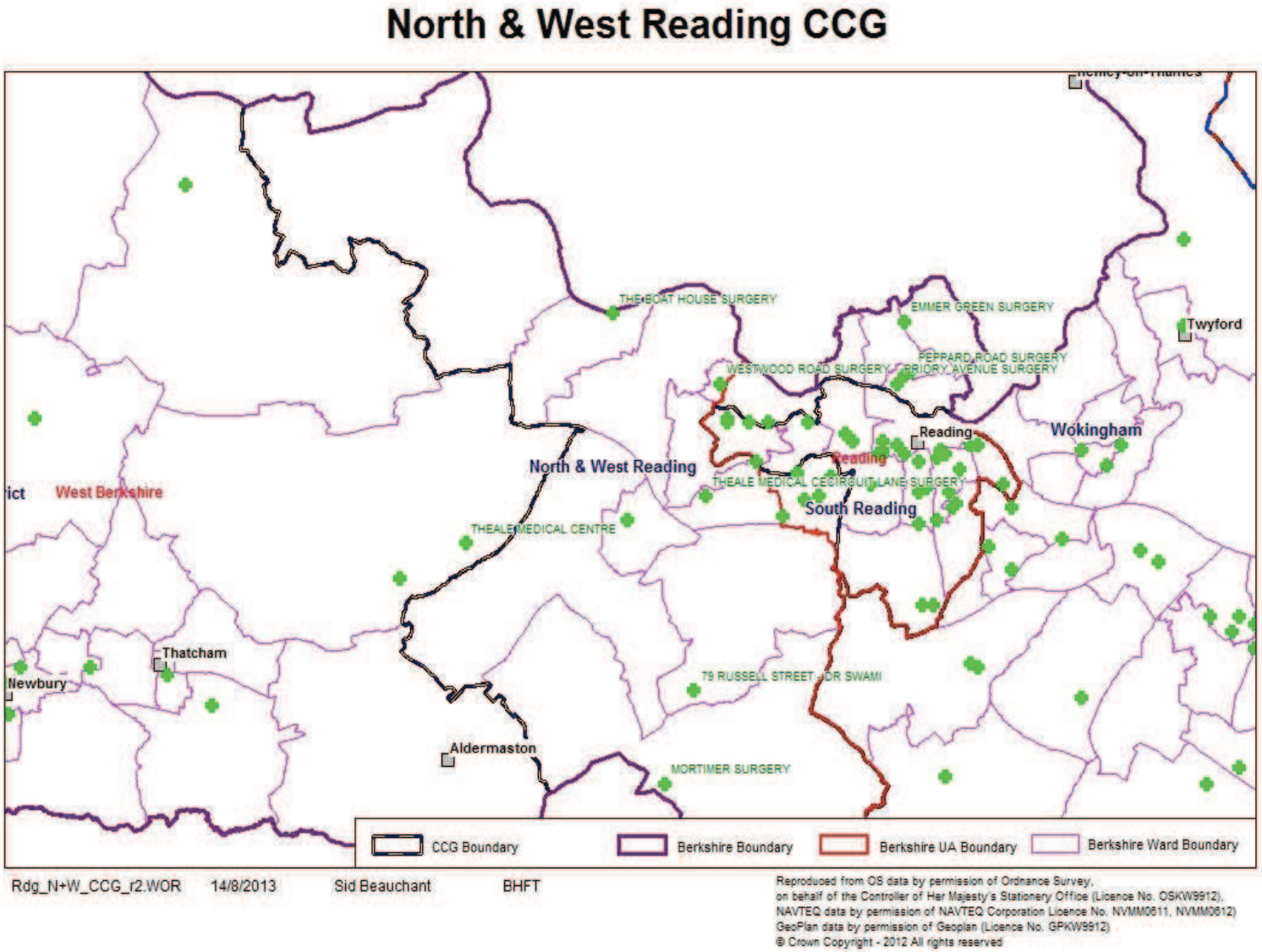
Initiatives 2014 to 2016	Linked to: • local Priorities (LP) • Better Care Fund (BCF) • Programme Board Oversight – Planned Care (P) Long Term Conditions (LTC) Urgent Care (U) Children, Mental Health (CMMV)	NHS England Ambitions						
		Securing additional years of life	Improving health-related quality of life for 1 or more LTC	Reducing the time spent avoidably in hospital	Increasing the proportion of older people living independently at home following discharge from hospital	Increasing the number of people having a positive experience of hospital care	Increasing the number of people having a positive experience of care outside of hospital	Making significant progress towards eliminating avoidable deaths in hospitals caused by problems in care
Service								
Musculoskeletal service	LP, P			✓		✓	✓	
Cancer Care pathway	LP, P	✓	✓			✓	✓	
End of Life	LTC			✓	✓	✓	✓	
Pathology	P					✓		
Haematology	P		✓					
Frail Elderly Pathway	LTC		✓	✓	✓	✓	✓	
Improving access to Talking Therapies	CMMV		✓				✓	
CAMHS Changes	CMMV		✓				✓	
Young People (Palliative Care)	CMMV	✓	✓					
Maternity Early Labour Assessment Model	CMMV			✓				

Initiatives 2014 to 2016	Linked to: • local Priorities (LP) • Better Care Fund (BCF) • Programme Board Oversight – Planned Care (P) Long Term Conditions (LTC) Urgent Care (U) Children, Mental Health (CMMV)	NHS England Ambitions						
		Securing additional years of life	Improving health-related quality of life for 1 or more LTC	Reducing the time spent avoidably in hospital	Increasing the proportion of older people living independently at home following discharge from hospital	Increasing the number of people having a positive experience of hospital care	Increasing the number of people having a positive experience of care outside of hospital	Making significant progress towards eliminating avoidable deaths in hospitals caused by problems in care
Improve Information sharing in Urgent care	U		✓	✓		✓	✓	
Carers Health Checks	LP		✓	✓				
Improvement in Dementia, Increase to memory clinic	LP, LTC	✓	✓	✓	✓	✓	✓	
Children with Complex needs	CMMV		✓					
Digital Care Plan	U		?	✓		✓		
Emergency Care Practitioners	U							
Referral s to General practices from NHS 111	U			✓				
Enhanced Recovery programme	P		✓				✓	✓
Neighbourhood Clusters	LP		✓	✓	✓	✓	✓	

Appendix 5 - Our GP Practices

Practice Name	Address	No of Patients	Practice Manager	Chair of PPG *[To be added]*
Balmore Park Surgery	59a Hemdean Road Caversham, Reading, RG4 7SS	15,800	Eileen Flood	
The Boat House Surgery	Whitchurch Road Pangbourne, Reading, RG8 7DP	10,500	Steve Wells	
Circuit Lane Surgery	The Surgery 53 Circuit Lane Reading, Berkshire, RG303AN	10392	Jenny Marnock	
Emmer Green Surgery	4 St Barnabas Road Emmer Green, Reading, RG4 8RA	9400	Helena Stacey	
Mortimer Surgery	72 Victoria Road Mortimer Common Reading, RG7 3SQ	11810	Debbie Cowley	
Peppard Road Surgery	45 Peppard Road Caversham, Reading, RG4 8NR	2079	Dr Janet Chadwick	
Priory Avenue Surgery	2 Priory Avenue Caversham, Reading, RG4 7SE	8500	To be included	
Theale Medical Centre	Englefield Road Theale, Reading, RG7 5AS	10431	Sally Gifford	*To be included*
Tilehurst Surgery Practice	Tylers Place Pottery Road Tilehurst Reading, RG306BW	13200	Desiree Warren	Kirsten Willis
Western Elms Surgery	317 Oxford Road Reading, Berkshire, RG301AT	16600	Lisa Trimble	Alan Porton

Appendix 6 - Map of our area



Title of Report:	**Better Care Fund – Final Plan**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	27th March 2014

Purpose of Report: To seek agreement to the final plan as to how the Better Care Fund pooled budget will be used.

Recommended Action: The Health and Wellbeing Board to approve the joint plans agreed between the CCGs and the Council for use of the Better Care Fund.

Health and Wellbeing Board Chairman details	
Name & Telephone No.:	Gordon Lundie (01488) 73350
E-mail Address:	glundie@westberks.gov.uk

Contact Officer Details	
Name:	Steve Duffin
Job Title:	Head of Service
Tel. No.:	01635 519594
E-mail Address:	sduffin@westberks.gov.uk

Executive Report

1. Introduction

1.1 A detailed report on the planned use of the Better Care Fund (BCF) was considered by HWB at its meeting on the 6th February 2014 and approval given for the draft plans to be submitted to the Department of Health (DH).

1.2 This report provides an update of developments since that meeting and seeks approval for the submissions of the final plans to the DH by the 4th April 2014 deadline.

1.3 The final plans are provided as Appendix A and Appendix B.

2. Developments

2.1 Feedback from DH on the draft plans was received very late on the day prior to this report having to be submitted therefore it has not been possible to make the necessary changes to the original BCF plan. However the feedback makes it clear that the schemes identified are appropriate and the changes required are predominately about adding some further detail around implementation and risks. The feedback from DH has been provided as Appendix C, a column has been added showing the action to be taken against each point.

2.2 Once these fairly minor changes have been made to the plan an amended version will be circulated to all members of HWB.

2.3 A number of discussions have taken place between the Council, the Clinical Commissioning Groups (CCGs) and the NHS Trusts regarding the plans and, whilst there will be significant details to be agreed during implementation, all parties remain committed to the schemes outlined in the draft plans.

2.4 On the 10th March 2014 the DH notified the CCGs that there was a correction to the allocations, this resulted in the West Berkshire BCF being reduced by £52k. Rather than unravel the schemes to find this saving it has agreed to reduce the original contingency sum from £172k down to £120k.

3. Implementation Plans

3.1 The schemes outlined in the plan present a significant programme of work for all of the organisations involved. It also needs to be recognised that implementation will be taking place alongside other major developments including the Care Bill.

3.2 A meeting has been held to discuss how this work should be organised, the resources required and the governance arrangements that would need to be established.

3.3 The outline proposals can be summarised as follows;

- A BCF programme consisting of 5 separate projects (some schemes are best merged into a single project)

- The bi-monthly Integration Steering Group will oversee the programme of work, reporting to HWB

- HWB will act as the Programme Sponsor

3.4 Further work is underway to document the work programme and quantify the resources that will be required and identify how they will be funded. This will then need to be considered and agreed by all parties.

4. Summary

4.1 All parties remain committed to the schemes outlined in the draft plan submitted to the DH in February 2014. The feedback from the DH has confirmed that the schemes are in line with what is expected and align to the key system pressure.

4.2 Implementation of the schemes will require a huge amount of work from a wide variety of people and therefore a very structured approach and significant additional resources will be required.

Appendices

Appendix A – BCF Planning Template
Appendix B – BCF Financial Summary and Metrics Template
Appendix C – Feedback from DH

West Berkshire BCF Checklist Summary – 14th February Submissions

Question		
General	West Berkshire	Response
1. Is there a single plan covering all relevant organisations in the HWB area?	Yes	None
2. Has the plan been signed off by an appropriate person from each organisation?	No signatures attached to document	Final submission will be signed by all parties
3. Does the plan clarify how any boundary differences have been handled?	No	This will be added before the final submission
4. Does the plan provide adequate evidence of provider engagement?	Yes - Use of existing mechanisms, including system wide workshop in December	None
5. Does the plan provide adequate evidence of patient and public engagement?	Yes - Engagement has been undertaken via Call to Action and use of other mechanisms e.g. Patient Voice Group. Further engagement is planned.	None
6. Are the governance arrangements clear?	No - Oversight and reporting provided via HWBB but no detail of governance processes	The governance arrangements are outlined in the HWB report and these will be added to the final submission
Vision & Schemes		
7. Is the vision consistent with that of wider CCG strategic plans?	Yes – the schemes identified are consistent with the CCG plans and align to the key system pressure.	None
8. Are the schemes and service changes well described?	Schemes are clear but some lack in detail in terms of delivery strategy and outcome metrics. Quite high level ambitions, without clear timescales or process	The implementation plan is being developed and will cover all of the issues raised here regarding timescales, processes and impacts. This will be made clear

	steps for delivery, requires further work up, including assessment of impact upon existing services.	in the final submission.
9. Are the implications for the acute sector and other existing services adequately addressed? They should include an assessment of future capacity and workforce requirements across the system.	This level of detail is not currently in the plan	This will be added before the final submission.
10. Is it clear that the plan will not have a negative impact on the level and quality of mental health services?	This is not specifically referenced	There are no negative impacts on mental health services and this will be made clear in the final submission.
National Conditions (you may want to review this alongside the table below)		
11. Does the plan provide evidence of: • How the changes will protect the level of social care services? • How the changes will support the development of seven-day health and social care services? • How they will use the NHS number as the basis of information sharing? • How the changes will ensure joint assessment arrangements and provide for accountable lead professionals? • Agreement on the consequential impact of changes in the acute sector?	• The plans reference the inclusion of re-ablement and in-reach hospital social work services, together with continued working with housing as the way of protecting social service outcomes. • The plan states that there is commitment to joint planning with health partners around 7 day services to support discharge and states that they will further explore development of services at weekends. However there is no detail or evidence that this is more than an aspiration. • West Berkshire is not currently using the NHS number as the primary identifier but has clear plans to introduce it as standard to new clients from 1st April 2014 and	None 7 day working is one of the schemes in the BCF Plan and therefore delivery will be ensured through the implementation plan and governance arrangements. None

	install for all existing clients from 1st April 2015. • No reference to accountable lead professionals • No reference to the impact of changes on acute sector, with the exception of a recognition a stable acute provider is necessary within the system	Will be included in the final submission Will be included in the final submission
Risk		
12. Does the plan include a clear risk mitigation plan, covering the impact on existing NHS and social care delivery and the steps that will be taken if activity volumes do not change as planned	Risks identified are not comprehensive for the detail of the plan. No risk rating is included. No detail or specific reference to impact upon existing NHS or social care delivery, signal lack of adequate engagement with providers around risk. Risk mitigation insufficiently specific and robust	The original submission stated that further detailed work would be required around the identification and mitigation of risks. The implementation plan will require risk registers at both programme and individual project level. This will be explained in the final submission.
Finance		
13. Does the plan include at least the minimum required amount to be pooled?	Yes	None
14. Is there a contingency plan for the possibility of targets not being met?	No	Further work to be done if this is to be included in the final submission.

Better Care Fund planningtemplate – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**West Berkshire Council**
Clinical Commissioning Groups	**Newbury and District CCG**
	North West Reading CCG
Boundary Differences	The main focus is partnership with Newbury and District and the principles drafted by this partnership will be negotiated with North West Reading CCG to ensure consistency; the BHFT serves both CCG's and partnership with BHFT ensures consistency across the 3 Unitary Authorities.
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£417,000**
2015/16	**£8,528,000**
Total agreed value of pooled budget: 2014/15	**£417,000**
2015/16	**£8,528,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Newbury & District CCG

By	Dr A Irfan
Position	Chair & Clinical Lead
Date	<date>

Signed on behalf of the Clinical Commissioning Group	North West Reading CCG
By	Dr R Smith
Position	Chair & Clinical Lead
Date	<date>

Signed on behalf of the Council	West Berkshire District Council
By	Gordon Lundie
Position	Leader of the Council
Date	<date>

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Gordon Lundie
Date	<date>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

There is well established West Berkshire Integration Steering Group and has representatives from all relevant stakeholders across health and social care, including key providers. The proposals outlined in this draft have been worked together, including at a system-wide joint workshop held in December 2013 which included acute and community providers.

Service provider engagement will be further developed through integration work during 2014/15.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Consultation and engagement has been through a variety of methods, most noticeably through the NHS 'Call to Action' event. This event involved good high quality engagement with patients and the public about the future of both health and social care services in the district, which has in turn shaped our collective planning submissions.

Further and ongoing engagement is being planned, with follow-up 'Call to Action' events scheduled to continue an inclusive and open dialogue with the public.

Within the CCG, the Patient Voice Group has also been actively involved in feedback on plan developments.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Better Care Project Plan for West Berkshire	The Plan sets out 8 projects that meet the requirements of the Better Care Fund
Joint Strategic Needs Assessment (JSNA)	
Hospital at Home (including Newbury Urgent Care Unit) Business Case	
Care Homes Business Case	
Newbury & District CCG 'Call to Action' Report	Agreement on the consequential impact of changes in the acute sector
7 day working	As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Medical Intra-operability Gateway business case	Better data sharing between health and social care, based on the NHS number

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

A) Vision for West Berkshire 2018/19:

The Vision for West Berks has the following key features:

- An increased level of services that are formally integrated under a Pooled Budget.
- A 7 day service by expanding existing services to cover weekends.
- The services will be simpler to access, have less duplication and reach patients earlier. Delivery of health and social services to be localised wherever possible including access to crisis, A&E and other services that meet local residents' needs – with appropriate specialist or wider access to regional services that improve outcomes on a sustainable basis. This includes children and adults with a view to preventing out of area long term placements, and institutional settings in general
- Unnecessary admissions to Hospitals or Care Homes will be avoided.
- Lengths of stay in Hospitals will be kept to a minimum
- Include the Joint Health and wellbeing strategy vision with added objectives of integration, sustainability, and greater efficiency across all sectors.
- Promote care closer to home and promotion of family centred approach where appropriate

B) Changes to health and social care services over the next five years:

Build capacity in the community across primary, community health and social services to work collaboratively and through integrated services to better meet the needs of local residents that avoid their admissions to hospital or care homes.

Expand the reablement capacity linked closely to integration with appropriate primary and community healthcare on a localised basis (via Locality Hubs).
As community capacity is increased overall including targeted in-reach to acute, realign acute sector capacity to achieve improved patient outcomes, greater efficiency and sustainable acute provider capacity on a reduced basis.

Develop cross sector working that targets intervention and support to those most at risk of admissions, including enhancing clinical capacity in the community that also supports those admitted to acute hospitals to return home quickly.

Maximise the local people's and their communities' capacity to self care through implementation of the Care Act that enhances information advice, advocacy, carer support, with an overall preventative impact on intensive support and admissions.

C) Improved patient and service user and carer outcomes:

Improved outcomes will include:

Less duplication between sectors, faster and more efficient joint assessments with lead professionals for those with long term conditions.

Earlier diagnosis, treatment, and support that prevents crises or better enables responses to crises without admissions to hospitals or care homes.

Improved access to information, advice, advocacy and community capacity to manage health and social care needs at low or nil cost to the user or carers. This will include online and flexible locally developed access.

Improved choice and control through better access to a wider range of care and support in the local health and social care market especially for those with long term conditions including the use of personal budgets and direct payments for those receiving continuing health care or social services. Local services should therefore prevent out of area placements separating users from their families and communities on a sustainable basis.

“Hard to reach” groups with health and social care needs that then require higher levels of intervention will have better access to tailored information, advice, care and support which is person centred and aligned to cultural, faith, or other requirements. During the Newbury Call to Action event, our plans for integrating care were discussed and some of comments on what Newbury’s new integrated system will make to patients and service users are provided below:

- "There are no gaps in my care"
- "I am fully involved in the decisions and know what is in my care plan"
- "My Team always talk to each other to get the best care"
- "I will always know who is in charge of my care and who to contact"
- "I won’t have to wait in all day for lots of different people to come at different times"
- "it is less time consuming if all services are together in one place"
- "My care is planned with people who work together to understand me and my carer, put me in control, coordinate and deliver services to achieve the best outcomes for me"

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

As above.

Measures will be :

1) The options outlined in the project plan will require more detailed analysis and costing to go into the metrics submission

2) Also it is assumed that whilst acute commissioning remains the duty of the Local CCG's outside of the BCF, the targets in the BCF will include investment and capacity to reduce acute activity, improve outcomes, and achieve sustainable financial investment across the whole health and social care system.

3) These aims will be measured by lower rates of admissions to acute hospitals for unscheduled care, shorter lengths of stay, lower rates of admissions to care homes, and significantly higher rates of early diagnosis, treatment and support for those most at risk of hospital or care home admissions, including dementia, end of life care, and those with long term conditions (children and adults).

4) Health gain measures will include: with public health) rates of diagnosis of key conditions linked to hospital and care home admissions including strokes, falls, complex older peoples conditions, dementia, pressure sores, lower instances of carer and care support crises for self funders or those not previously assessed. The increased targeting of health and social care resources on those most at risk will also help reduce health inequalities as well as through prevention/voluntary sector commissioning being joined up across the whole system. We will work with partners to implement the local measures.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Scheme 1. Community Nurses directly commissioning Care/ Reablement Services.

The point of contact for the majority of patients in the community who are either eligible for Council services, or who are at risk of admission to care homes or hospitals is the Community Nurse. Currently if a Community Nurse identifies the need for care they will have to refer the case for assessment by Council staff or other Health teams who may then refer for Crisis, Reablement, Carer's, Council commissioned or in house care provision services; in all cases the Community Nurse is able to initiate and commission in broad terms the care that is needed; if the initial care delivery for all services is through the in house care provision system Community Nurses could directly prescribe this service, leading to safe care being put in place and then worked up to the practical on going solution for that individual.

In addition, It is hoped that WBC's physical disability team will build upon joint working with Health's Long Term conditions teams to progress integration further.

Process developments

- Identification of range of Health Clinicians from Unscheduled Services to be licensed under scheme.
- Training of licensed Health Professionals.
- Health Professionals will commission services directly to provide a prompt response to patient needs; the change should not create extra work for Health Professionals and therefore there should not be any ongoing cost implications
- The service that provides the care will be supported by the coordinating service which will establish the eligibility and need keeping control over the Council's commissioning budgets.

Scheme 2. Access to Health and Social Care Services through the BHFT HUB:

For hospitals, GP's, and Access for All we need one entry point, preferably routed through the Health Hub for Reablement, Crisis Care, Hospital or Care Home admission avoidance, including Carer Breakdown. This will require setting new protocols with the HUB and with AFA.

Process development:

Hillcroft front door upgrading for access to Reablement, Crisis Care, Hospital or Care Home admission avoidance, including Carer Breakdown, Urgent Care, End of Life.

Negotiation with Hub to build on success of this new service

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Scheme 3. Patient's Personal Recovery Guide / Keyworker:

Each patient will be supported for the journey through the service. This may be a single role, or it could be a function depending on complexity of the role of a Personal Budget Support worker, a Social Worker, a qualified clinician or a trained Care Worker; there would be a strong attraction of building on the latter as a model detaching the function from other more defined roles.

i. Recovery Agreement: as a deliberate discipline to centralise the Customer/Patient. An agreement will frame the journey ensuring that the priorities are set by the patient, and creating flexibility as circumstances, speed of progress and conditions change along the way.

ii. Delivery of service elements: the Recovery Guide can engage the different service elements as would a Personal Shopper, ensuring that the right choices are made and the practical delivery arrangements are in place.

iii. Case Manager: when the active intervention is complete monitoring will be needed initially to ensure the transfer to normal life is successful, and in cases where long term support is indicated to ensure that this is successful and appropriate. Currently this is covered by a Council review system which cannot effectively deliver. For many stable low cost long term support plans it may be possible for Community Nurses, or other health staff who regularly visit patients to deliver other services to periodically 'sign off' an annual renewal of service.

Process Developments:

- Link with Elderly Care Pathway Project for definition, resposibilities, duties and powers of keyworker role.
- Defining role and host organisation, including option of Voluntary Organisation.
- Development of Business Case to include redefining of some roles within existing services to release funding.
- Drafting and sign off of protocols for role across whole range of Health and Social Care operation.

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Scheme 4. Joint care provider as a 'pooled' service with the potential to be funded through a Pooled Budget:

The Council's Maximising Independence Team and Homecare Team, and the Berkshire Health Foundation Trust's Intermediate Care as part of the Integrated Community Health services have separate care assessment and delivery units providing similar care in response to patients currently triaged through a joint system. Developing these three staffing units into a combined service would simplify the deployment to support individuals, would cut out artificial service transfers, increase continuity of service, and create efficiencies by avoiding duplication; initially this could be created as a 'Pooled' service, developing into a Pooled Budget.

The service is available for people in the community as well as hospital discharge.

The current annual budgets for these services are

Maximising Independence	1,020,760
Home Care	1,780,000
Intermediate care	1,700,000

Whilst efficiencies would be expected from this project, the initial reconstruction of services would require additional project management of £75-100k.

Process Developments:

There are a range of staff working within the two current care services who would need to be merged into a single service.

In Health reablement is provided by a mix of Team Leader Occupational Therapy, Nurses, Physiotherapy and 3 grades of multi therapy assistant staff:

- Band 2 assistants deliver care to fixed care plan, or 2nd on a double up
- Band 3 assistants support patient in working on their goals
- Advanced assistants can progress individuals through goals
- These staff are supported by a multi therapy and care assistant coordinator and a group of Therapists.

In the Council's service there are;

- Team Managers,
- Senior Carers,
- Care Assistants
- Occupational Therapists
- Social Workers

- Personal Budget Support Workers.

The pooled service would be supplemented by the purchase of agency care to deal with fluctuating demand. However the flexibility of this proposed single service may make it possible for both Health and Social Care to reduce their commissioning of external care.

Scheme 5. 7 Day Week service

Between the Health Trust and the Council there is already a combination of services that are available 7 days per week; a small amount of adjustment could be made to provide an adequate 7 day response service.

An initial structure can be developed that would match the wider Health and Social Care economy which currently has only limited services available on 7 days per week, However, with a structure in place it will be a simple step to build more comprehensive 7 day per week services if the wider 'economy' starts to spread it's services over 7 days. This scheme links with scheme 4 above.

Process Development:

- Review the current out of hours services:
  WBC Extended hours, WBC Homecare inc Nightwardens and the Emergency Duty Team run by Bracknell Forest Council.
  24 Community Nursing Cover, managed centrally for Reading, Wokingham and WBC area
  Rapid Response 9am -10pm x 7 days (at weekend covered across 3 areas)
  Rapid Discharge Service for patients admitted for less than 48 hours.
- Proposal to Integrated Steering Group re realistic 7 Day week service that is currently required in context of whole health economy. This needs to include access for to Carer Breakdown service, e.g. Ambulance Service, or relatives may need access, etc.

Scheme 6 Hospital at Home:

This project reduces the pressure on hospital beds by 10,920 bed days per local authority area. Additional health services are costed at £2.4m for Berkshire West; to support this the Council will be required to manage additional care during treatment episodes and a discharge service to support patients after the treatment episode. The additional funding would be built into the Pooled Budget at 4 above.

The Hospital at Home initiative aims to support patients through the introduction of a clinician-led sub-acute service that interfaces with the wider health system to appropriately stream protocol-driven cases to an out of hospital care setting. In common with the proposed Newbury Urgent Care unit, the clinical treatments considered include:

- Short-term IV therapy/fluids;
- High level of pathology;
- High intensity monitoring; and
- Functional assessment / management.

The presenting patient may have:

- Acute infections e.g.
  - Cellulitis
  - ENT
  - Pyelonephritis/UTI
  - Pneumonia/influenza
- Chronic Obstructive Pulmonary disease/asthma;
- Dehydration and gastroenteritis;
- Decompensation of LTC; and
- Falls and/or mobility issues that cannot be managed within the existing services

Principles of the model that will underpin the service

- To reduce non-elective admissions from ambulatory sensitive conditions by 50%;
- The service is open to anyone over the age of 18 years;
- The service will operate 7/7 365 days;
- Clinical responsibility for patients within the Hospital at Home service will be overseen by the Community Geriatrician;
- In-hours responsibility will held by Community Geriatrician, Out of hours responsibility will be held by WestCall (with support from medics at RBFT);
- All patients presenting to A&E (Self referrers, 999, or GP referral) will be reviewed as Hospital at Home patients as default;
- Virtual ward rounds for patients within the H@H will be undertaken daily;
- All patients will have a dedicated Ward Matron assigned to their care, supported by Case Coordinators;
- Each UA will be assigned with 30 virtual ward beds; and
- Max length of stay in the H@H ward will be 7 days.

Specifically within Newbury, the CCG will evaluate the development of a local Diagnostic and Assessment Unit within West Berkshire Community Hospital (or other suitable location) that standardises practice across the Newbury registrant population in relation to the management of patients with complex +care needs (sub-acute) in the short-term. The service will be targeted at those patients that require initial intensive diagnostics and assessment, then 24-hour support and treatment but can be managed at home and then discharged after a few days into traditional community care provision.

Scheme 7. Nursing and Care Homes

As the UK population ages, GPs and NHS providers face an increasing difficult task managing the complex needs of care home residents whilst there is increasing pressure through the system. A case for change is unequivocal; In 2011 more than 400,000 people were living in care homes across England, equivalent to the population of Bristol. Over the next 40 years, this is expect to rise to 825,000.

Within Berkshire West there are 22 registered Nursing Homes with a total of 1248 beds. The average nursing home has 67 beds with a range of 22-137 beds. There are 2 dual registered care homes which provide residential and nursing care but the admission data does not differentiate which part of the care home the patient was admitted from. In addition there were 26 Residential homes (48 in total), with a total of 922 beds, average number of beds is 33 and the range is 8-192 beds.

This lead to the establishment of the Care home working group in January 2013 by Berkshire Healthcare Trust.The group includes membership from BHFT, CCG, LA, RBFT, SCAS, Marie Currie, and Berkshire Care Home Association.

The aim of the group is to improve the quality of care and provision of service to and within care homes within West Berkshire. To support this aim the group identified 8 work strands

1. Analysis of activity data
2. Improving access to services
3. Developing clinical pathways/standards/protocols
4. Skills development for staff
5. Leadership development and management in care homes
6. Medication Optimisation
7. Communication and engagement
8. Resident and relative views

Since August the Care Home working group has been chaired by the CCG. Operational support for the group, currently will continue to be provided by BHFT.

In addition to Care Home working group, Dr Charles Gallagher had been developing a "Good Model of GP care for Care homes" for Wokingham. The proposed model would include the following:

- Each care home should have a named GP who is their principle point of contact with the general practice looking after their residents. Practices that have such an arrangement will be eligible for payment under a proposed New Patient Assessment (NPA) LES.
- All residents will have an initial multidisciplinary assessment about a month after admission to the home using the CCG NPA protocol.
- GPs will actively encourage advanced care planning.
- Joint medication reviews will be performed annually between the GP and the Care Home Pharmacist from the Medicines Management Team using the CCG protocol.

Prescribers to adhere to the CCG antipsychotic prescribing protocol.

The project provides support to care Homes; before confirming this project health and social care partners need to work through this jointly to decide the actual scale of the project, because a major part of what is being highlighted is actually the normal delivery of good quality care and as a service purchasing such care we would expect contract compliance to cover at least some of the items for focus in the project.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The ASCOF data will be used to monitor performance together with data from the

Alamac System adopted by the Royal Berkshire Hospital. The Hospital at Home Project will reduce the demand on the Acute Hospitals.

There needs to be an economically viable local acute hospital within the network of other regional hospitals, to provide the access and treatment the West Berkshire population require.

The improvements in outcomes for patients of the BCF plan would be: shorter lengths of stay more personalised tailored treatment and reablement plans that ensure successful returns to their homes, and clinicians that support those with complex and long term conditions in both acute and community settings.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The West Berkshire Health and Wellbeing Board (HWB) will have strategic oversight and governance for the West Berkshire BCF and related arrangements. Membership of this Board includes two voluntary sector representatives, as well as West Berkshire Healthwatch, together with West Berkshire CCG, West Berkshire Council. This Board meets regularly and will receive summary reports on progress, outcomes and exceptions on performance and risks. This board will ensure appropriate monitoring of progress against national and local performance in the BCF, and regular updating of the risk register associated with such performance.

NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Adult Social Services have to provide a range of statutory services to all residents who are eligible under the Fair Access To Care criteria; for West Berkshire this represents and increased number of eligible residents as the level of eligibility changes from ‘Critical’ to ‘Substantial’ under the Care Bill.

The local definition of protecting adult social services is to focus upon prevention, early intervention and for health and social services delivery aimed at avoiding admissions to institutional care (especially care homes and hospitals) together with maximising people and their communities’ capacity to self care. It is based upon the social asset based model of helping people with health and social care needs to meet them by retaining their dignity and independence in their own homes through access to family, neighbour and community support together with specialist or essential health and social care and support.

The social services lead on multi agency safeguarding adults will be developed under the

Care Act, with local priorities secured within the BCF for Mental Capacity Act assessments, Deprivation of Liberty assessments, and general multi disciplinary safeguarding adults activity.

Please explain how local social care services will be protected within your plans.

The inclusion of reablement (Council funded as well as transfer funded), and in reach to hospital social work services in the BCF will help protect the social services outcomes for those at risk of admission or admitted to hospital.

The capital funding associated with Disabled Facilities Grants (DFG) within the BCF will also build upon the successful record West Berkshire has in working with housing partners in securing wider investment in homes that promote independence, as well adapting existing housing stock

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

The Council is committed to planning jointly with health partners the increasing availability of services at weekends. The Council provides and funds a large range of services on a 7 day basis but it will further explore the development of processes to allow increased movement between services at weekends. A key element is to secure the cooperation of the range of domiciliary and care home providers to provide flexibility to assess and set up services at short notice outside normal working hours.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

This primary identifier is not currently used across the whole health and social care system in West Berkshire.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

The NHS number is being introduced as standard to all new clients from 1st April 2014. A separate project will be required to install the NHS number for all existing clients by 1st April 2015**.**

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

It is a qualified yes. We try to adopt systems that are open but sometimes the 'best systems' in terms of our business needs adopt their own proprietary standards. We seldom reject anything where this is the case

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott2.

The Council would need to fully understand the relevant IG controls before it would be in a position to commit to them.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

All Surgeries are engaged with the Case Coordination process for identifying high risk patients and agreeing joint tasks to minimise the risk of hospital admission. The CCG Tool, together with local; intelligence is used to identify high and medium risk patients.

3) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Risk 1 Not realising the benefit of increased community capacity by ongoing increases in demand upon on acute		Integrated and joint commissioning capacity Close monitoring of demand in community and acute to align resources working with external providers to ensure that they understand the current and future demands and recruit workforce accordingly
Risk 2 Double running costs during changes in the health and social care system		Detailed planning to follow BCF submission to ensure and providers meet cost

		targets
Risk 3 Insufficient funding for responsibilities arising from Care and support Bill		Detailed modelling of available funds and ongoing discussions with DH and LGA
Risk 4 Provider failure to deliver better ways to meet needs in the community that trigger risk 1		Ensure preparation in 14/15 on integration and joint assessments in community builds capacity by 2015
Risk 5 Failure to protect social services as set out in BCF		Detailed planning after BCF submission to ensure long term resource planning matches efficiencies from integration.
Risk 6 Failure by acute sector to realign to meet BCF aims and targets		Linked to whole system implementation of BCF and CCG plans.
Risk 7 – the funding for the Care Bill contained within the BCF is insufficient to meet costs of new responsibilities.		

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Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
West Berkshire District Council			*0*	*0*
Newbury and District CCG			*5,722,000*	*5,722,000*
North West Reading CCG			*2,806,000*	*2,806,000*
BCF Total			*8,528,000*	*8,528,000*

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

These plans are currently under development

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Scheme 1 - District Nurses direct commissioning of social care/reablement services		0	0	0	0	0	0	0	0
Scheme 2 - Access to Health and Social Care services via single Hub		0	0	0	0	0	0	0	0
Scheme 3 - Hospital patient's Personal Recovert Guide		0	0	0	0	310,000	0	0	0
Scheme 4 - Joint Health & Social Care Intermediate Care Assessor and Care Provider service		0	0	0	0	556,000	0	426,000	
Scheme 5 - 7 day week service		0	0	0	0	1,886,000	0	1,444,000	
Scheme 6 - Hospital at Home		0	0	0	0	1,128,000	0	2,580,000	0
Scheme 7 - Nursing & Care Homes		0	0	0	0	167,000	0	850,000	
Care Bill costs		0	0	0	0	1,507,000	0	0	0
Existing S256 spend		0	0	0	0	2,114,000	0	0	0
Existing CCG reablement spend		0	0	0	0	740,000	0		0
Contigency		0	0	0	0	120,000	0		0
Total						8,528,000	0	5,300,000	0

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Metric - Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population
The combined impact of the package of proposed new schemes will be to help people maintain their independence longer, avoid the institutionalisation that often follows a sustained hospital stay and therefore reduce the number of nursing and care home placements.
Metric - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
Scheme 1. District Nurses directly commissioning Care/ Reablement Services : resulting in speedier commencement of service, and maintenance of independence at higher levels. Measured by shorter waiting times for service, and admission avoidance.
Scheme 4. Joint Health and Social Care Intermediate Care Assessor and Care provider as a single 'pooled' service with the potential to be funded through a Pooled Budget: will reduce duplication, reduce numbers of overlapping professionals being involved with individual patients; measured by patient satisfaction, and marginal increase in capacity of overall service to meet increased demand.
Metric - Delayed transfers of care from hospital per 100,000 population (average per month)
Scheme 3. Patient's Personal Recovery Guide : each complex patient will be supported for the journey through the services. Measured by reduction in Delayed Transfers of Care (DTOC).
Scheme 4. Joint Health and Social Care Intermediate Care Assessor and Care provider as a single 'pooled' service with the potential to be funded through a Pooled Budget: will reduce duplication, reduce numbers of overlapping professionals being involved with individual patients; measured by patient satisfaction, and marginal increase in capacity of overall service to meet increased demand.
Scheme 5. 7 Day Week service: outcome will be reduced DTOC
Scheme 6. Hospital at Home: the project reduces the pressure on hospital beds by 10,920 bed days per local authority area.
Metric - Avoidable emergency admissions (composite measure)
Scheme 1. District Nurses directly commissioning Care/ Reablement Services : resulting in speedier commencement of service, and maintenance of independence at higher levels. Measured by shorter waiting times for service, and admission avoidance.
Scheme 5. 7 Day Week service: outcome will be reduced DTOC
Scheme 6. Hospital at Home: the project reduces the pressure on hospital beds by 10,920 bed days per local authority area.
Scheme 7. Newbury Urgent Care Unit - The Newbury Project is to explore the potential of introducing a Diagnostic and Assessment Unit within West Berkshire Community Hospital (or other suitable location) that standardises practice across the Newbury registrant population in relation to the management of patients with complex +care needs (sub-acute) in the short-term. The service will be targeted at those patients that require initial intensive diagnostics and assessment, then 24-hour support and treatment but can be managed at home and then discharged after a few days into traditional community care provision.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

The assurance process for all of the metrics would be as follows;

The performance measures are all existing national measures and are routinely reported.
All performance targets will be included in annual service planning.
A Performance Group will monitor outcomes on a regular basis
Performance reporting is an embedded procedure throughout the Council
Performance will be routinely reported into the Health and Wellbeing Board
Performance is reported quarterly to elected members
Key performance data is published externally and available to the public

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Metrics		Current Baseline (as at...)	NOTES	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment	
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	741	(x/y)*100000	N/A	667	10% DECREASE
	Numerator	186	ASCOFSummary_2011213		167	
	Denominator	25110	Population of 65 + in area -- ASCOFSummary_2011213 (from the mid-year ONS data)		25110	Population is static - will increase at next ONS update
		(April 2012 - March 2013)			(April 2014 - March 2015)	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	81.6%	x/y	N/A	86.5%	6% INCREASE
	Numerator	31	ASCOFSummary_2011213		33	
	Denominator	38	ASCOFSummary_2011213		38	
		(April 2012 - March 2013)			(April 2014 - March 2015)	
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	102.8	(Rate from x/y)/number of months *100000	99	95	4% DECREASE
	Numerator	1468	DTOC Summary, total DTOCs for 12 months	1409	1353	

	Denominator	118994	Population of 18+ in area -- ONS Website --> Population Estimates for England and Wales, Mid 2012 (ZIP 812Kb) --> Mid-2012-unformatted-data-file	118994	118994	Population is static - will increase at next ONS update
		(April 2012 - March 2013)		(April - December 2014)	(January - June 2015)	
Avoidable emergency admissions (composite measure)	*Metric Value*					
	Numerator	For Health to provide				
	Denominator	118994	Population of 18+ in area -- ONS Website --> Population Estimates for England and Wales, Mid 2012 (ZIP 812Kb) --> Mid-2012-unformatted-data-file			Population is static - will increase at next ONS update
		(TBC)		(April - September 2014	(October 2014 - March 2015)	
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]				N/A		
Offer 90% of eligible carers identified during 2013/14 baseline a Cardiovascular Disease Healthcheck	*Metric Value*	To be confirmed in March 2014 - actual numbers of carers identified in 13/14 baseline exercise	Baseline assessment year is 2013/14, thus 90% standard (of identified carers) to be offered a CVD healthcheck during 14/15	% of carers offered a CVD healthcheck	% of carers offered a CVD healthcheck	
	Numerator	TBC	TBC	TBC	TBC	
	Denominator	TBC	TBC	TBC	TBC	
		April 2014 to March 2015		*April 2014 to March 2015*	*April 2014 to March 2015*	

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Title of Report:	Pharmacetucial Needs Assessment
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	27 March 2014

Purpose of Report: To set out the scope of the Pharmaceutical Needs Assessment (PNA) and to inform the Board on what is required within a PNA, the approach to be used and the timeline for delivery of the project.

Recommended Action: The Health and Wellbeing Board is asked to note the requirement of the Health and Wellbeing Board to undertake a PNA and to agree with the process outlined

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Executive Report

1. Purpose of report

1.1 This report sets out the scope of the Pharmaceutical Needs Assessment (PNA). It states what is required within a PNA, the approach to be used and the timeline for delivery of the project.

2. Pharmaceutical Provision

2.1 If a person (a pharmacist, a dispenser of appliances or in some circumstances and normally in rural areas, GPs) wants to provide NHS pharmaceutical services, they are required to apply to the NHS to be included on a pharmaceutical list. Pharmaceutical lists are compiled and held by the NHS England. This is commonly known as the NHS "market entry" system.

2.2 Under the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations ("the 2013 Regulations"), a person who wishes to provide NHS pharmaceutical services must generally apply to NHS England to be included on a relevant list by proving they are able to meet a pharmaceutical need as set out in the relevant PNA. (There are exceptions to this, such as applications for needs not foreseen in the PNA or to provide pharmaceutical services on a distance-selling (internet or mail order only) basis.) The first PNAs were published by NHS primary care trusts (PCTs) and were required to be published by 1 February 2011.

3. Legislative background

3.1 The Health and Social Care Act 2012 transferred responsibility to develop and update PNAs from PCTs to Health and Well Being boards. Simultaneously NHS England became responsible for using PNAs as the basis for determining market entry to a pharmaceutical list.

3.2 Each Health and Well-being Board must in accordance with Department of Health regulations—

(a) assess needs for pharmaceutical services in its area, and

(b) publish a statement of its first assessment and of any revised assessment

3.3 The preparation and consultation on the PNA should take account of the JSNA and other relevant strategies, such as children and young people's plan, the local housing plan and the crime and disorder strategy.

3.4 The development of PNAs is a separate duty to that of developing JSNAs as PNAs will inform commissioning decisions by local authorities (public health services from community pharmacies) and by NHS England and clinical commissioning groups (CCGs).

3.5 The PNA will provide information on the current pharmaceutical services in West Berkshire and Berkshire, and identify gaps in the current service provision, taking into account any known future needs.

4. Pharmaceutical Services

4.1 The types of pharmaceutical services commissioned are :

- *"essential services"* which every community pharmacy providing NHS pharmaceutical services must provide and is set out in their terms of service[1] – the dispensing of medicines, promotion of healthy lifestyles and support for self-care;

- *"advanced services"* - services community pharmacy contractors and dispensing appliance contractors can provide subject to accreditation as necessary – these are Medicines Use Reviews and the New Medicines Service for community pharmacists and Appliance Use Reviews and the Stoma Customisation Service for dispensing appliance contractors; and
- *locally commissioned services* (known as enhanced services) commissioned by NHS England.
- 4.2 The following are types of pharmacy contractors included in a pharmaceutical list. They are:
- *pharmacy contractors* (healthcare professionals working for themselves or as employees who practice in pharmacy, the field of health sciences focusing on safe and effective medicines use); and
- *dispensing appliance contractors* (appliance suppliers are a specific sub-set of NHS pharmaceutical contractors who supply, on prescription, appliances such as stoma and incontinence aids, dressings, bandages etc). They cannot supply medicines.

In addition, there are two other types of pharmaceutical contractor:

d*ispensing doctors,* who are medical practitioners authorised to provide drugs and appliances in designated rural areas known as "controlled localities" (see Appendix 1).

local pharmaceutical services (LPS) contractors who provide a level of pharmaceutical services in some HWB areas. A Local Pharmaceutical Service (LPS) contract allows NHS England to commission community pharmaceutical services tailored to specific local requirements. It provides flexibility to include within a single locally negotiated contract a broader or narrower range of services (including services not traditionally associated with pharmacy) than is possible under national pharmacy arrangements set out in the 2013 Regulations. All LPS contracts must, however, include an element of dispensing.

These types of contractor (or provision) must be included in the PNA.

5. The Pharmaceutical Needs assessment Document

5.1 The PNA will be used by the NHS to commission pharmaceutical services in Berkshire. It will also be used by the public health team in West Berkshire Borough Council to commission locally enhanced services.

5.2 The PNA must comply with legislative requirements:

Statutory requirements of a Pharmaceutical needs assessment
1. Schedule 1, paragraph 1 Necessary services – current provision Pharmaceutical services which are identified as services that are provided: (a) in Berkshire and which are necessary to meet its need for pharmaceutical services (b) outside Berkshire but which nevertheless contribute towards meeting its need for pharmaceutical services

2. Schedule 1, paragraph 2 Necessary services – gaps in provision

Pharmaceutical services that have been identified as services that are not provided in Berkshire but which will -

(a) need to be provided (whether or not they are located in the area of the HWB) in order to meet a current need for pharmaceutical services, or pharmaceutical services of a specified type, in its area;

(b) will, in specified future circumstances, need to be provided (whether or not they are located in the area of the HWB) in order to meet a future need for pharmaceutical services, or pharmaceutical services of a specified type, in its area.

3. Schedule 1, paragraph 3 – Other relevant services – current provision

Pharmaceutical services that are identified as services that are provided-

(a) in Berkshire or in neighbouring counties, and which, although they are not necessary to meet the need for pharmaceutical services in Berkshire, nevertheless resulted in improvements, or better access to pharmaceutical services

(b) in or outside Berkshire and, which do not fall under "necessary" category, help the pharmaceutical service provision in Berkshire

4. Schedule 1, paragraph 4 – improvements and better access: gaps in provision

Pharmaceutical services which are identified as services that are not provided in Berkshire but which -

(a) will, if they were provided, secure improvements, or better access to pharmaceutical services, or pharmaceutical services of a specific type

(b) will, if in specified future circumstances they were provided, secure future improvements, or better access, to pharmaceutical services, or pharmaceutical services or a specified type

5. Schedule 1, paragraph 5 – other services

Any NHS services provided or arranged by HWBs, NHS Commissioning Board, a Clinical Commissioning Board (CCG), an NHS trust or an NHS foundation trust, which affect-

(a) the need for pharmaceutical services, or pharmaceutical services of a specified type, in Berkshire

(b) whether further provision of pharmaceutical services in Berkshire would secure improvements, or better access to pharmaceutical services, or pharmaceutical services of a specific type in its area.

6. Schedule 1, paragraph 6 – how the assessment was carried out

An explanation of how the assessment has been carried out, in particular –

how it has determined what are the localities in its area;

how it has taken into account (where applicable)-

the different needs of different localities in its area, and the different needs of people in its area who share a protected characteristic; and

(c) a report on the consultation that it has undertaken.

West Berkshire HWB will need to publish its PNA by 1st April 2015. This will require board-level sign-off and a period of public consultation beforehand. Failure to produce a robust PNA could lead to legal challenges because of the PNA's relevance to decisions about commissioning services and new pharmacy openings.

HWB will also need to ensure that the NHS Commissioning Board and its Area Teams have access to the PNA.

5.3 Methodology:

A steering group will be established to ensure stakeholder involvement and compliance with the statutory requirements for the report. This group will oversee the 6 PNA reports - one for each Health and well being board.

Report design: There will be one common PNA format for the for each Health and well being board, however each will be designed to align with the corporate requirements of each UA. A common approach and timescale will be undertaken for pharmacy providers, user feedback and consultation.

5.4 The key elements of the process are in summary:

- Service mapping : Existing pharmaceutical services in Berkshire will be mapped against population density and against rate of long term diseases. Joint Strategic Needs Assessment (JSNA) and other relevant existing documents will be used to identify health needs of the population and gap analysis
- Review of services : detailed questionnaire to service providers
- Users' views will be obtained through a questionnaire for the public using pharmacy services and another questionnaire for the pharmacists
- Draft report for consultation presented to each HWB board and then out to consultation for 3 months
- Final report will be sent to the six Health and Wellbeing Boards in Berkshire for approval before publishing it.

5.5 Consultation will include:

- Public
- Local Pharmaceutical Committee for Berkshire
- Berkshire Local Medical Committee
- Berkshire CCGs
- Any persons on the pharmaceutical lists and any dispensing doctors list for Berkshire population
- Any LPS chemist with whom the NHS England has made arrangements for the provision of any local pharmaceutical services for Berkshire population
- Local Health Watch organisations, and any other patient, consumer or community group in Berkshire, which has an interest in the provision of pharmaceutical services in Berkshire
- NHS Trusts
- Thames Valley NHS England Area Team
- Neighbouring Health and Wellbeing Boards

5.6 Milestones

	Deadline
Meeting commissioners (NHS Thames valley Area Team and CCGs), public health consultants, LPC and Pharmacy Network lead for Berkshire	November – December 2013
User and pharmacist surveys	March – April 14
Writing first draft	March - April 2014
Incorporation of survey results into draft report	May
Consultation period	May – June 2014
Analysis of consultation results	July 2014
Final report	September 2014

6. Conclusion

The Health and Wellbeingboard is asked to note the requirement of the Health and Wellbeing Board to undertake a PNA and to agree with the process outlined.

Title of Report:	Review of Children's Public Health Commissioning Opportunities
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	27 March 2014

Purpose of Report:

The West Berkshire Health and Welling Being Strategy as part of its key principles indentifies the need to focus on our children. This paper summaries a practical programme that will allow us to explore and identify these opportunities.

To inform the Board of the outline of the national changes that will be occurring in children's' commissioning for public health services and the proposal of a local approach to support this change.

To outline a local approach to support the change. In consultation with a range of stakeholders to scope out current services, identify levels of need and establish a way forward for commissioning and service delivery.

Recommended Action:

To note this approach to children's planning to drive the provision of public health services to children.

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Children are indentified as a key priority group in the Health and Wellbeing Strategy. The review of Children's Public Health Commissioning Opportunities is relevant in terms of encouraging and supporting the integration of services based on the needs of our children. One of the aims is to give every child and young person the best possible start in life; in particular to promote the health of children aged 0 to 19 years.

Two of the principles that underpin the Health and Well-Being strategy are:

- Working collaboratively with neighbouring authorities and partners to ensure effective use of resource and sharing best practice.

- To ensure that we effectively safeguard he most vulnerable children in our district. Enhancing service provision, focusing child protection resources on those children most at risk and providing high quality, evidence based preventative support.

This paper therefore outlines the work to address the priorities indentified in the Health and Wellbeing Strategy.

1 Introduction - National Context

1.1 The Health and Social Care Act changed the pattern of commissioners for a range of Health Services including those that serve children.

1.2 The Local Authority already has established and extensive responsibilities with regards children's' care: education, safeguarding and social care services as well as early intervention and prevention services - often delivered through children's' centres.

1.3 From 2013/2014, Clinical Commissioning Groups (CCGs) have been charged with commissioning the majority of health services (supported by the national NHS England) and are responsible for allocating resources and providing commissioning guidance. This includes children's accident & emergency services, paediatrics in district general hospitals and children & adolescent mental health services (excluding level 4 provision).

1.4 The NHS England Local Area Team is responsible for Level 4 Children & Adolescent Mental Health Services (CAMHs). In addition the area team commissions children's' immunisation services, newborn screening and routine primary care and health visiting until 1ST Oct 2015.

1.5 As part of the movement of public health responsibility to the Local Authority, public health services for children and young people aged 5-19 have been transferred though in a staged approach. West Berkshire Council currently has an overview role on immunisation and directly commissions school nursing.

1.6 The next stage is the transfer of Health Visiting and Family Nurse Partnership Programme in 2015 following the expansion of the Health Visitor Programme. This expansion is part of a national government commitment to expand the number of Health Visitors by 4200 and ensure sustainability of service. The investment in Health Visiting Services provides a further opportunity to strengthen the support to families through the delivery of the Health Child Programme.

2 Public Health Outcomes

2.1 The new role of Local Government is to improve the health of their local population but also to reduce inequalities in health.

2.2 Nationally whilst life expectancy is increasing the reduction in health inequalities is not being seen. In the original Marmot report in 2008 the review of the evidence of what works in reducing inequalities and identified that there were six core actions that would lead to reduction in inequalities. However central to a long term solution was a focus on the child - giving every child the best start in life and maximizing their opportunities. School Nursing and Health Visiting are key public health services.

2.3 Public Health Outcomes that will be influenced by the School Nursing and Health Visiting programmes include:

- Under 18 conceptions
- Infant mortality
- Low birth weight of term babies
- Smoking status at time of delivery
- Breastfeeding (initiation and at 6-8 weeks)
- Vaccination coverage
- Healthy weight 4-5 years
- Tooth decay in children age 5

2.4 The opportunity of the change in the commissioning of Children's' Universal Public Health services allows each Unitary Authority to examine how best to align the current pattern of care to achieve the best outcomes in this time of financial constraints maximising the impact of the Health Visitor and School Nursing roles and transfer.

3 Proposal for Children's Services Review

3.1 Nationally there is work underway to ensure the smooth and sustainable transfer of Health Visiting services to Local Government and ensure the leadership role of Health Visitors is continued within the new commissioning arrangements.

3.2 However we also wish to review the 0-19 year old offer across our services to ensure that they are focused on the existing and emerging needs of our children, since School Nursing is now already commissioned through Public Health in West Berkshire Council.

3.3 The approach therefore begin with a through review of existing services for our children, reflecting these against needs and best practice to develop a 5 year plan to support our health and well being strategic goals. The work will be managed to ensure that the needs of the various age groups are addressed and allow us to re- specify and commission the School Nursing and Health Visiting roles.

3.4 The work will describe in detail the current pattern of services for our children within each Unitary Authority area, to review whether these services best serve the needs of our local children now and going forward and then to re design the services, to allow the services to be re-commissioned to achieve the best outcomes and alignment. A more detailed description of these stages of work is in Appendix A.

3.5 This work will involve all key stakeholders including Local Government staff in Children's' Social Care, Education representatives from schools, voluntary sector representatives / users, Healthcare provider services, Public Health, Local Political Leaders, local area NHS England team and Clinical Commissioning Groups.

3.6 Nationally, part of the Health Visitor Transition work has made available a small amount transition funding - approximately £20k for Berkshire to support this process. The fund was announced on 6th November 2013 with applications submitted by November 13.

The approach we submitted was built on work which is summarised above and previously discussed with the Director of Children's Services and leaders. In summary the focus of this bid for funding was to review the approach to 0-5 year's service delivery and develop a new strategy for this area for West Berkshire Council. This bid was successful and an allocation of £6k has been identified to support the stage one detailed in Appendix A.

This approach will be repeated for older school age children to maximize the integration and impact of services.

Appendices

Appendix A

Health Visitor Transformation Proposal

Stage one *- What is currently available to our children and families?*

Recent powerful experience has shown that there is not a full understanding of the range of services provided by others within the local economy. Therefore the first stage of this work will be a workshop whereby each area presents the full range of services they provide; this allows each stakeholder to understand the full range of services in their area. This will allow immediately a greater understanding and potentially an immediate impact on care.

In addition with the funding available we will undertake parent and user experience surveys , asking for ways in which services could be improved Professionals working in the children's services will also be invited to give feedback on how they think services cold be improved. This will feed into services redesign

Opportunity to share and understand review the services / patterns in the neighbouring authorities so we can share experience / best practice / outside of the UA boundary

Stage 2

Review of needs assessment for children 0-5 in each LA, which will allow working in local groups to identify goals and outcomes to be delivered in the new environment. This will focus on universal and hard to reach groups to ensure both an improvement in health and a reduction in equalities.

The services will then be challenged to review how going forward, using the new evidence of effective service provision, and addressing the issues raised by users and providers their services can deliver these outcomes effectively maximizing the increase in health visitor capacity.

Stage 3

Service re design and implementation, which may involve:

I. additional support for existing professionals with in services to embed new ways of working - support may be sought from the Thames Valley Local Education and Training Boards (LETBs)
II. workforce development of new roles and skills
III. new contract formats supporting an outcomes based approach/delivering pooled/integrated budgets

Provider support

The bid also includes immediate support to the provider to implement some key evidence based tools that maximise the outcomes for our children.

Ages and Stages tool kit

The provider has been with others developing a HV Service improvement plan. Part of this is the introduction of the Ages and Stages Child Health Review Tools for the 9 month and 2 year universal reviews from January 2014.

The expectation is that this tool will allow earlier detection of children requiring support. The strategy development phase of this work will establish how these connections can be improved linking the child and family to the full range of services.

Solihull Approach

The Berkshire Health Foundation Trust (BHFT) Health Visiting Service will introduce the 'Solihull Approach to understanding children's behaviour'. This is an evidence based integrated theoretical model, that can be used in practice, to provide a way of thinking about relationships. It supports professionals in their work with families and it has been proven to improve children's and parents' emotional relationship and wellbeing.

The approach is known to support the parent-child relationship. Service within children's centres and more widely also have this underpinning principle.

The review of services will allow us to explore this tool and its application within the boarder framework of children's services in each LA to ensure consistency of approach for families irrespective of provider.

The national resources available will be used to deliver the workshops, venues, facilitation and write up of events (cartoonists will be used to capture the details and develop new models - an effective and engaging method to ensure clarity of outputs). In addition the resources will support professional and user experience capture through a variety of routes.

Governance

Engagement
The work will be coordinated across Berkshire with Directors of children's services as key leaders and designers of this work - the events will be co chaired Public and Health and Children's services.

The major provider for health visitor provision has been a part of the early discussions on this work as part of regular Public health and commissioner service development meetings

Programme oversight

In the West of Berkshire there is a strategic Children's Commissioning group this group will act as the overarching group for this work.

A Health Visitor Transition Board (with children's services and public health involvement) working with providers will be established across Berkshire and link into both the strategic children's commissioning group and with regular reports to the Health and Well-being board.

Title of Report:	Management of Charters
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	

Purpose of Report: To propose a process for managing charters coming to the Health and Wellbeing Board.

Recommended Action: Adoption of the process set out in paragraph two of the report.

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Executive Report

1.0 Introduction

1.1 The Health and Wellbeing Board at one of its early meetings was asked to support a Charter from the Disabled Children's Trust. At that time the Board felt that there could be many other similar requests forthcoming and whilst the Board might be sympathetic to the aims and objectives of each Charter they did not feel that it would be appropriate to formally sign up to any one of them.

1.2 The Board's concern was that in signing up to a Charter it did not want to be seen to support any one organisation which could then lead to requests for resources for that area of work which might not accord with the aims and objectives of the Health and Wellbeing Strategy. The Board agreed that its work should be led by the Joint Strategic Needs Assessment (JSNA) and therefore asked for a process to be developed which could manage such requests.

2.0 Proposed Management of Charters

2.1 It is suggested that, in future, requests to support "Charters" applicable to the Health and Wellbeing Board be managed by the Head of Public Health and Wellbeing in the following way:

(i) The Head of Public Health and Wellbeing should acknowledge receipt of the Charter.
(ii) The Head of Public Health and Wellbeing should cross reference any Charter with the Health and Wellbeing Strategy and assess whether the Strategy supports the aims and objectives of the Charter.
(iii) If the Strategy supports the aims and objectives of the Charter, the Head of Public Health and Wellbeing should respond by advising that the Board's Strategy already has actions related to the Charter's area of activity and, as a consequence, the Board did not need to formally sign up to the Charter.
(iv) If the Strategy did not support the aims and objectives of the Charter then the Head of Health and Wellbeing should respond advising that the Boards "direction of travel" is shaped by the JSNA which does not raise the area covered by the Charter as a priority and, as such, the Board would not sign up to the Charter.

3.0 Conclusion

3.1 In order to support the Board in managing "Charters" it is suggested that the process set out in paragraph 2 be adopted.