NHS
NEWBURY & DISTRICT
CLINICAL COMMISSIONING GROUP

OPERATING PLAN 2014/16

Newbury & District Clinical Commissioning Group

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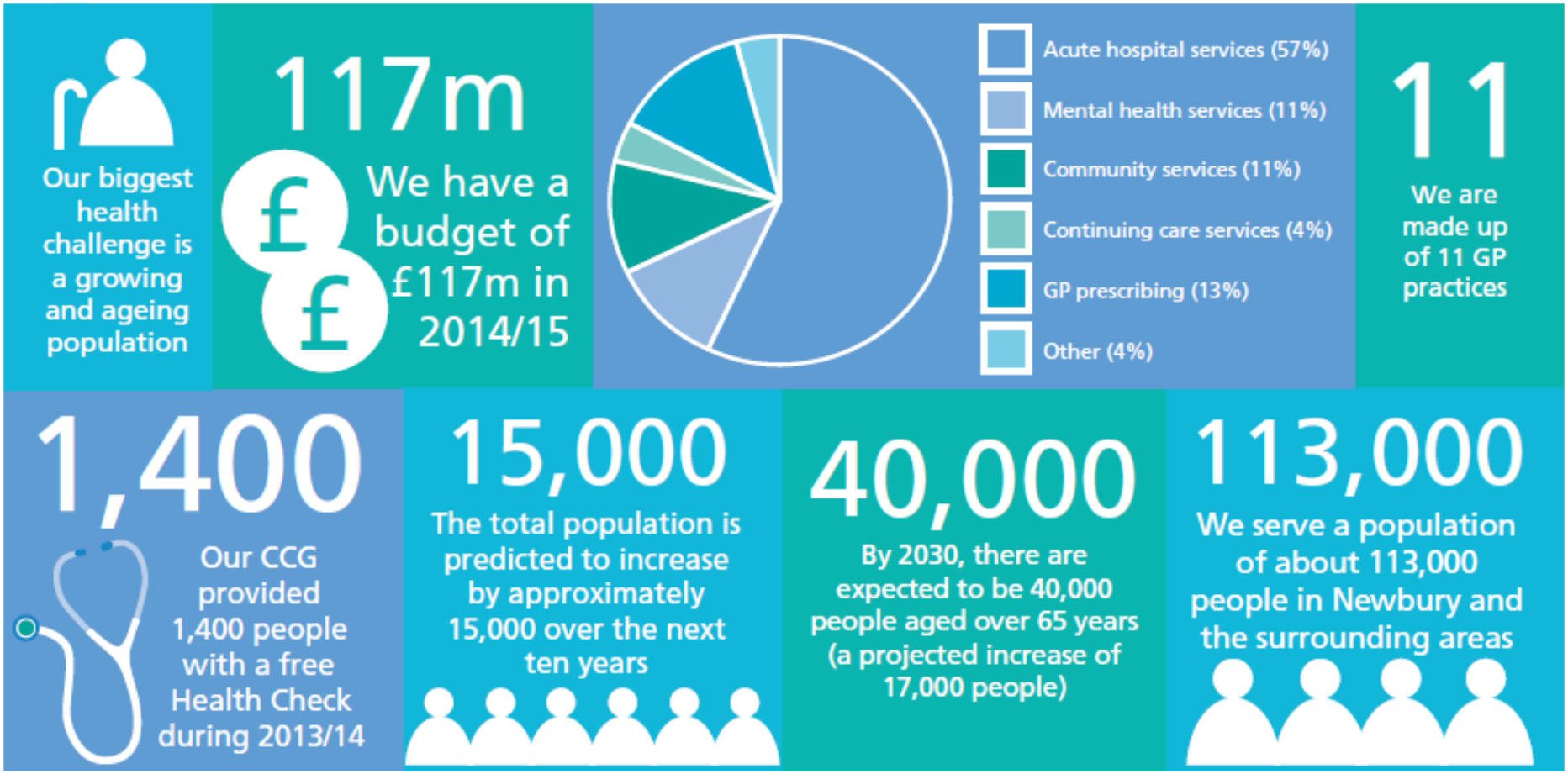
Contents

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:

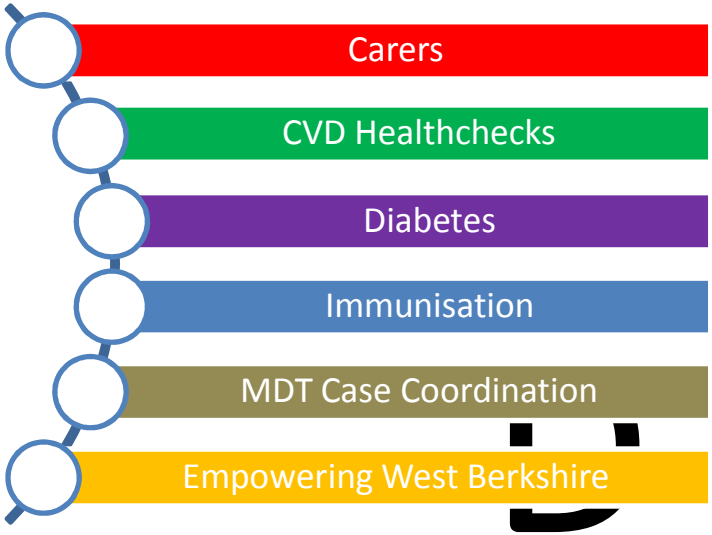
- **To better identify those who are Carers in our area, so that we can provide them with support**. It is was an aspiration of our GP's to have identified additional carers during 2013, meaning that we can now tailor support and services to those who provide care for family or friends on a regular basis. 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 peop identi ed with abe s, so that a pa ients diagn sed with diabet s have the same standard of care**. We implemented an innovative system to allow patients to pr actively ma age their diabe s alongside thei GP's care, enabling them to proactively manage their condition with a se manag ement pla and upport a multidisciplin y team. Thus, mpowering 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

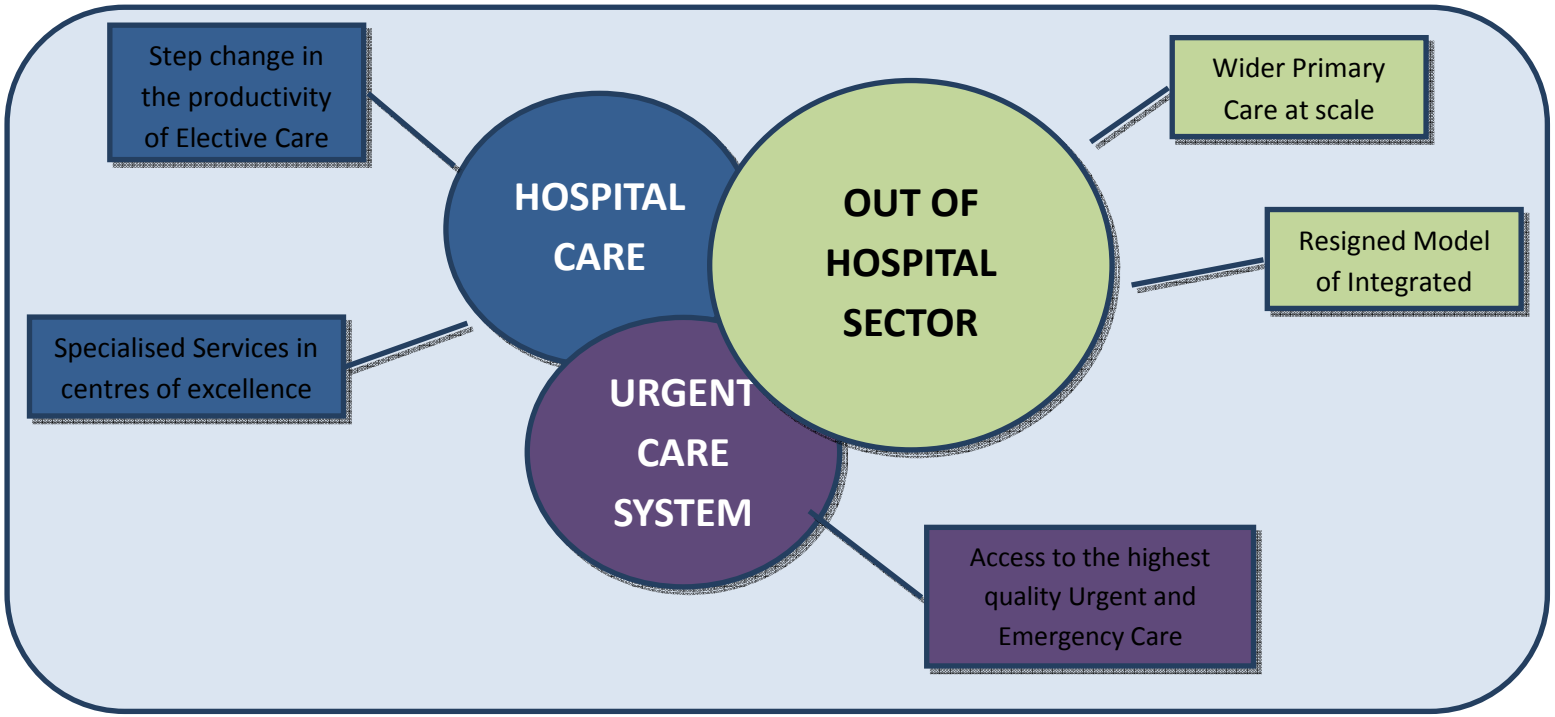
Newbury & District CCG has worked with three other CCGs in Berkshire West to develop a 5 year Strategy for the Berkshire West health and social care economy. This "unit of planning" was endorsed by the West Berkshire Health and Wellbeing Board.

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.

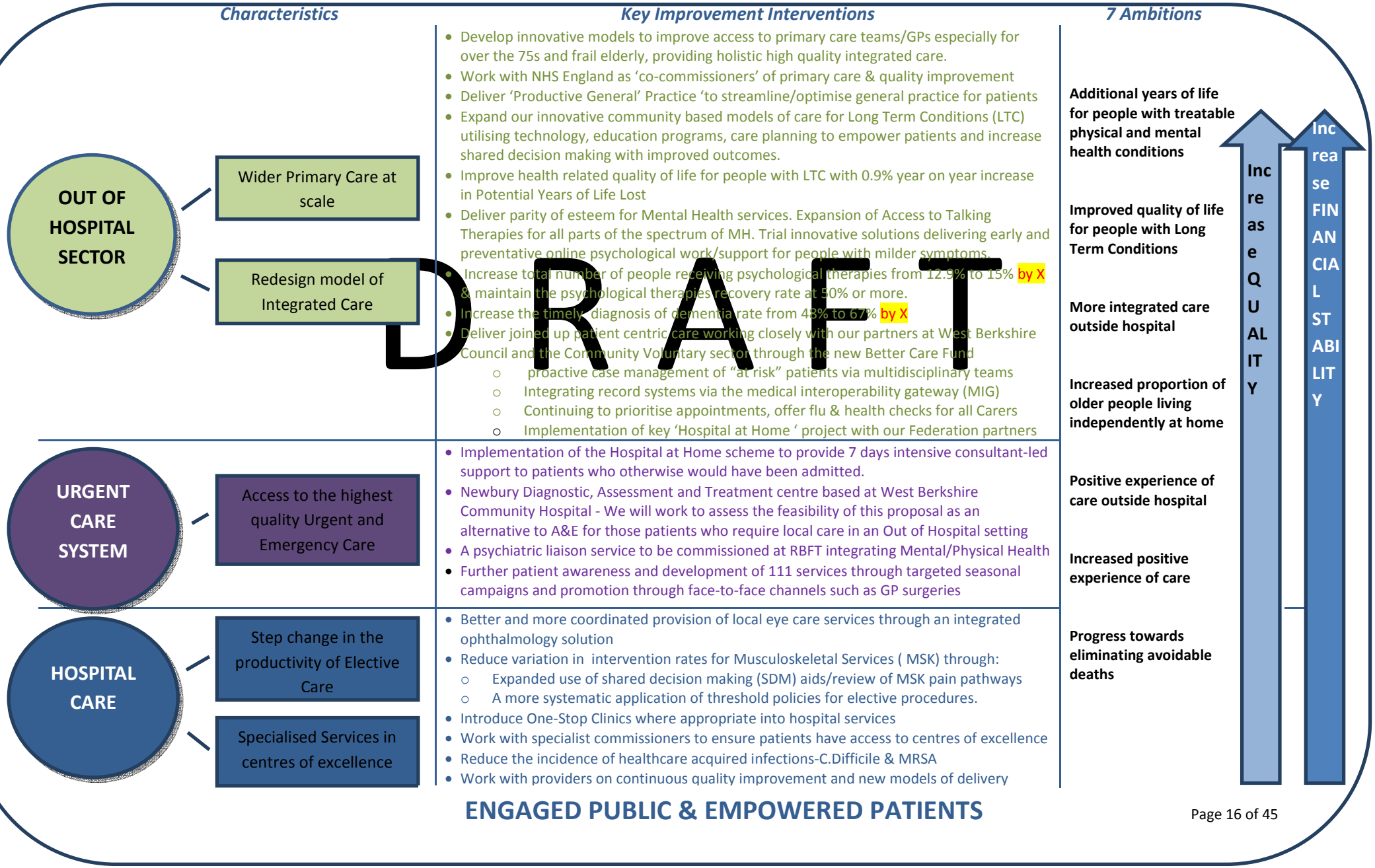
All the services that respond to people with an urgent need for care will operate together as a single system. This will ensure that the service people receive is commensurate with their clinical need. People with urgent but not life-threatening conditions will receive responsive and effective care outside 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 recognised 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 10% in 2015/16 in line with national guidance.

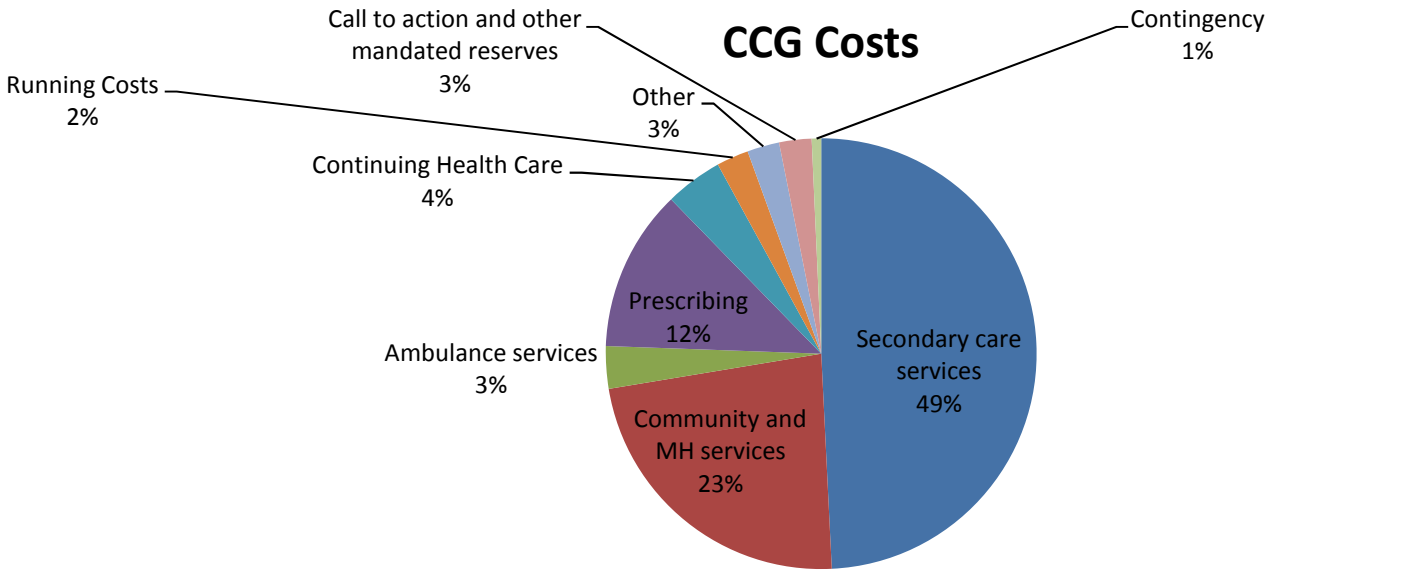
In addition to the holding of contingencies, as one of the four CCGs within the Berkshire West federation some risk will be managed through the pooling of budgets in areas such as Continuing Healthcare and high cost mental Health placements.

Financial Plan 2014/15	**£'000**
CCG Income	
Recurrent allocation baseline	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 Kennet Centre, Newbury

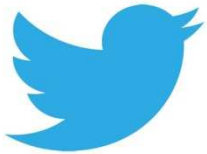
The health 'pop up' shop will be staffed by volunteers, decorated by members of local restorative justice initiatives, and supported by both the CCG and West Berkshire Council.

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 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						
		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
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		✓	✓	✓	✓	✓