North and West Reading Clinical Commissioning Group

2014/16

Draft Operational Plan

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Table of Contents

Foreword by Dr Rod Smith, Chair of North & West Reading CCG 3

Overview of 2013/2014 from the Chair of the Council of Practice, Dr George Boulos 6

North & West Reading CCG - Our Vision for 2019: A Shared Vision with the 3 other CCGs in the Berkshire West Federation 8

Berkshire West CCGs 5 Year Strategic Plan on a Page: 9

North & West Reading - Our Local CCG Vision for the next two years – 2014-2016 10

North & West Reading CCG's 2 Year Operational Plan on a Page: 11

How we developed our Plan 12

Work together with partners and the community to set common goals and priorities 16

Improvement Interventions 21

Developing the 6 characteristics of a high quality, sustainable health and care system 24

Assuring Quality 30

Equality and Diversity 36

Our Partners 37

NHS Constitution Pledge 39

Financial Overview 41

IM&T Strategy 43

Appendix 1 - Alignment of the CCG Operating Plan with the Reading and West Berkshire Local Authorities Health and Wellbeing Strategies 44

Appendix 2 - Berkshire West CCGs NHS Framework Outcome Ambitions aligned to the four Programme Boards 49

Appendix 3 - Improvement Interventions 63

Appendix 4 - Improving Health Outcomes through QIPP and the Four Programme Boards 78

Appendix 5 - Our GP Practices 81

Appendix 6 - Map of our area 82

DRAFT

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

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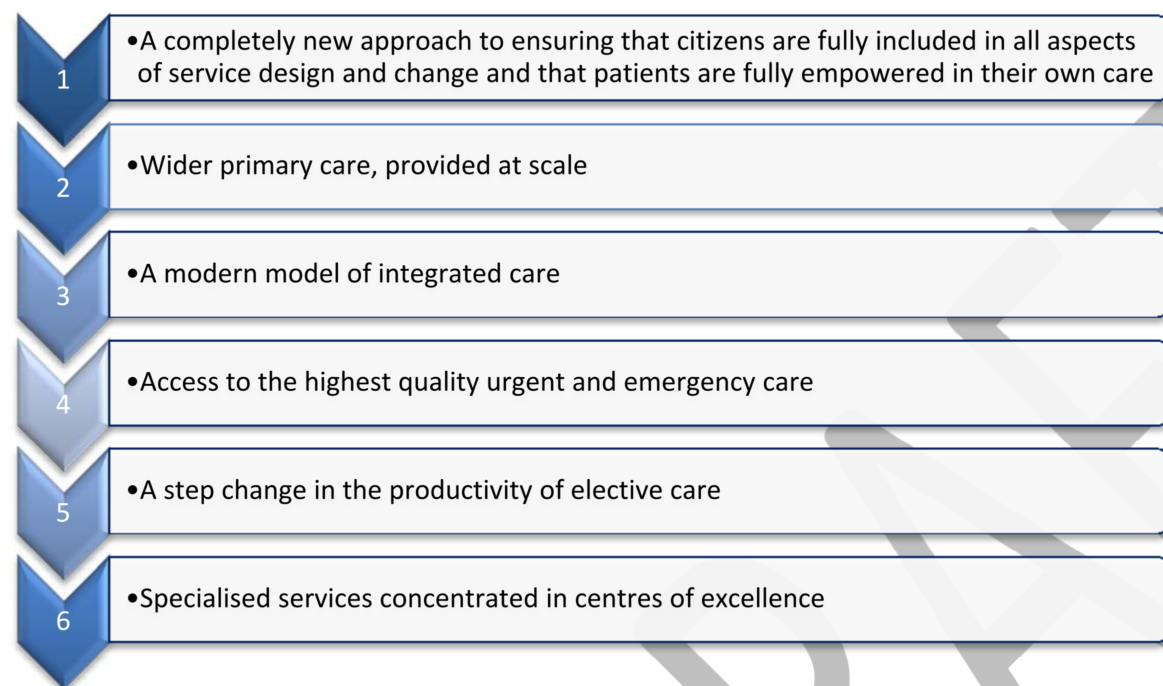
In addition, NHS England has identified that any high quality, sustainable health and care system will have the following six characteristics and our plan shows how we plan to develop these characteristics locally:



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.

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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

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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:

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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/

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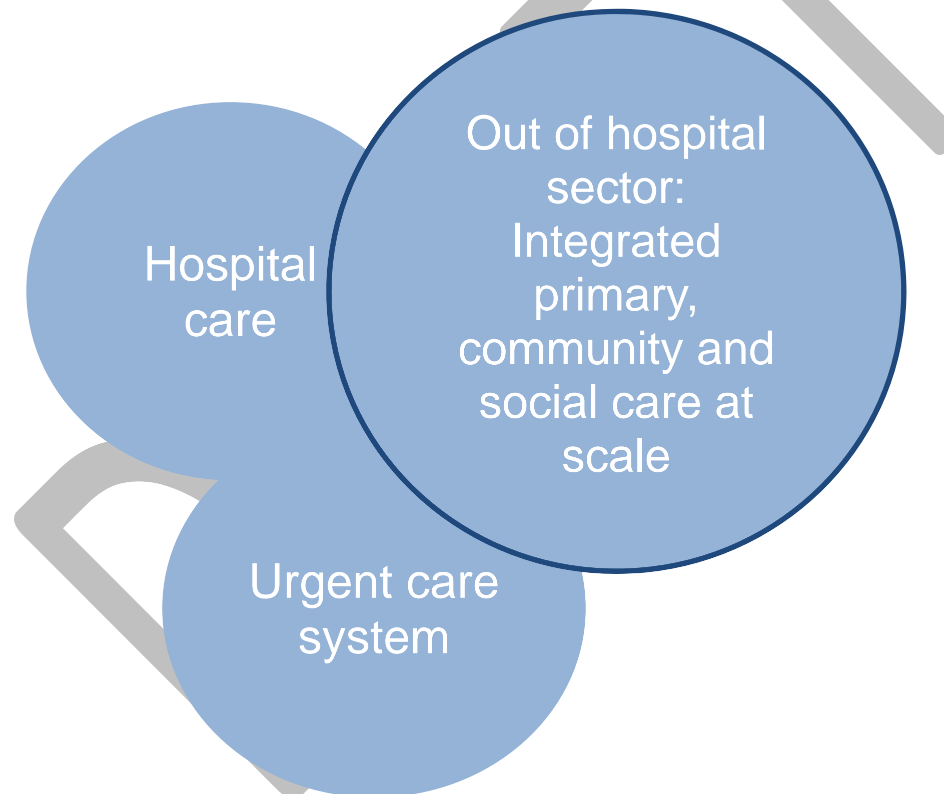
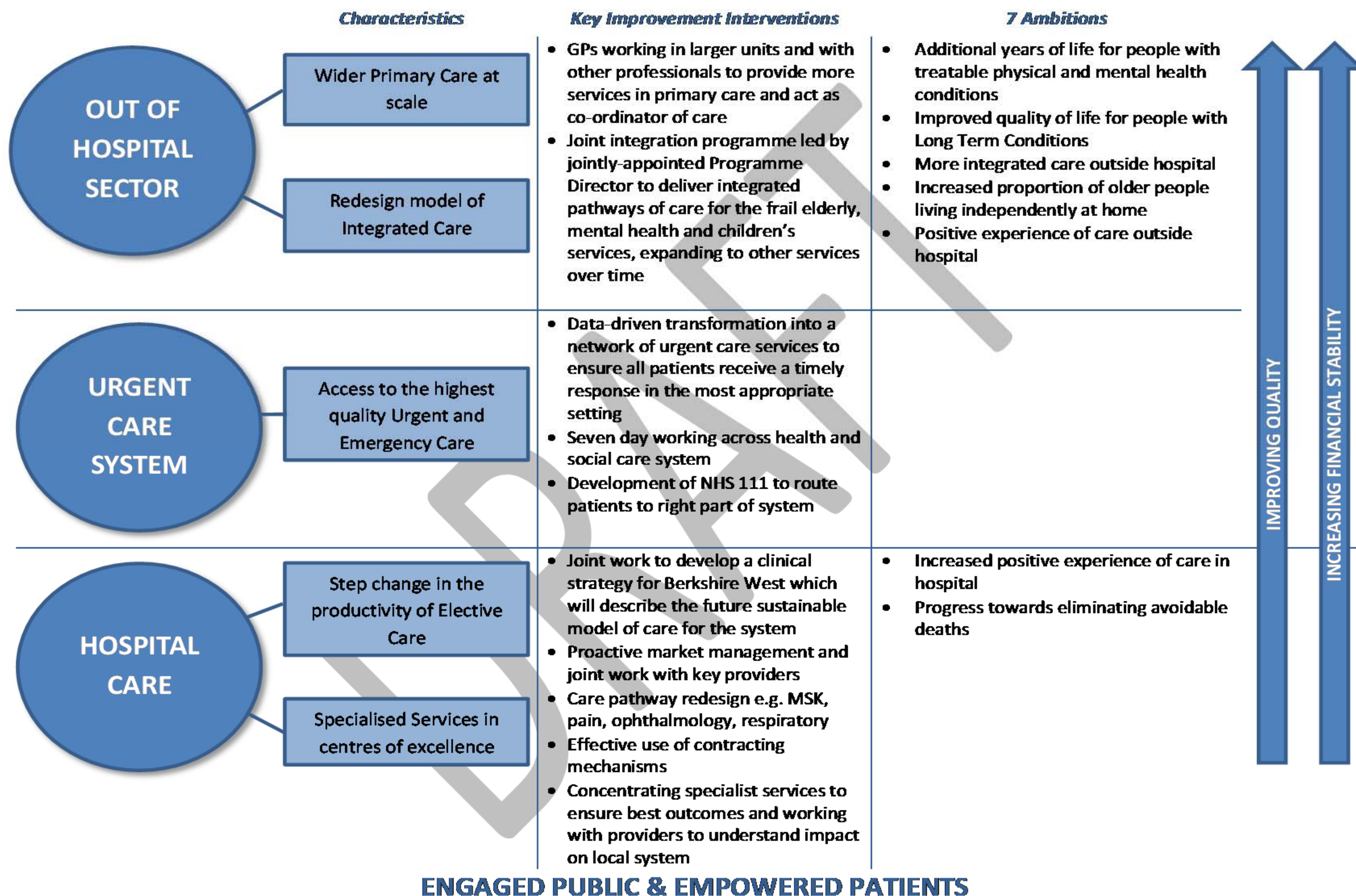
North & West Reading CCG - Our Vision for 2019: A Shared Vision with the 3 other CCGs in the Berkshire West Federation

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.

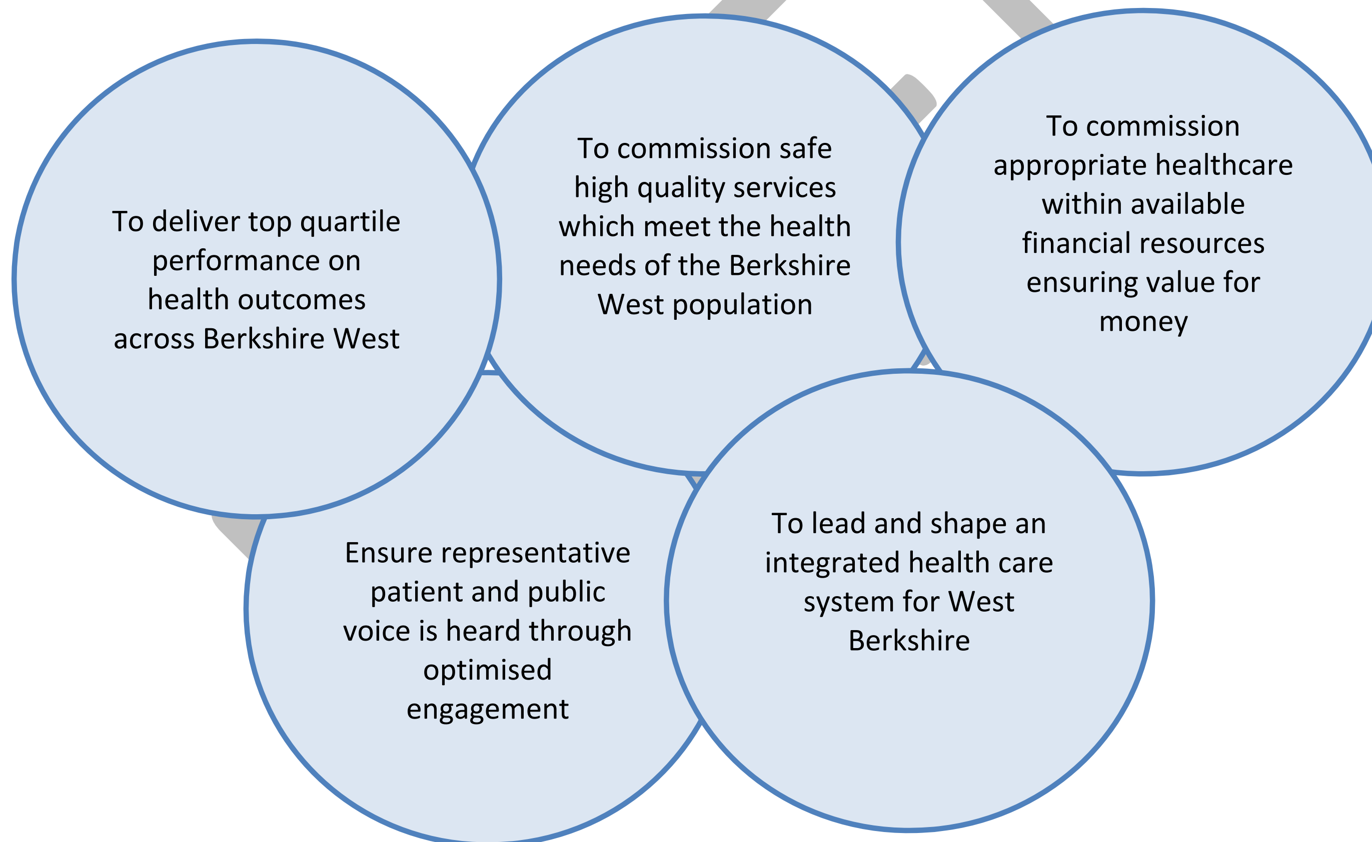


Berkshire West CCGs 5 Year Strategic Plan on a Page:

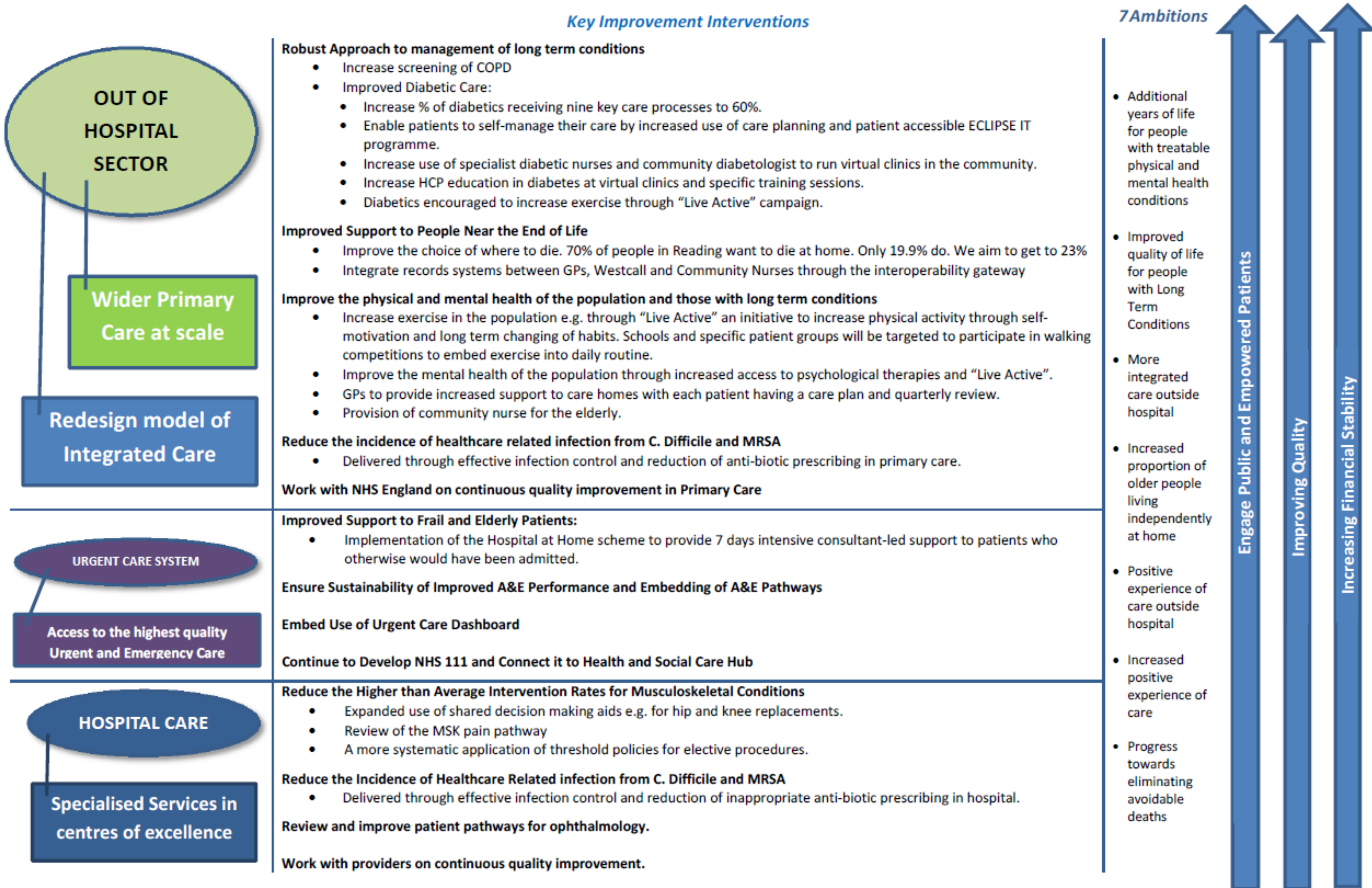


"Supporting our population to improve and optimise their own personal health by encouraging self-care and commissioning high quality integrated health care"

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:



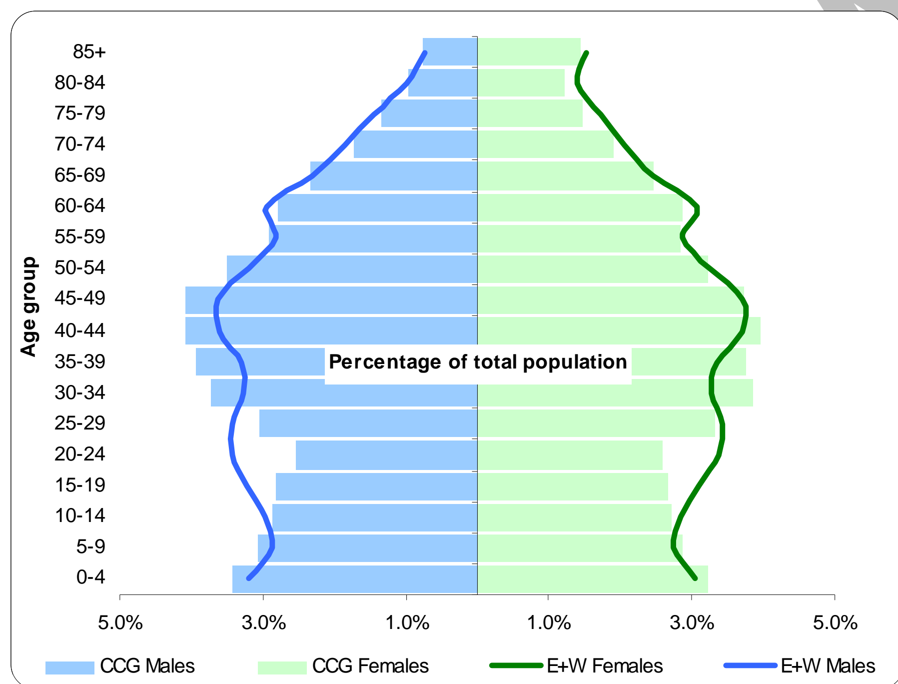
How we developed our Plan

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**

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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.

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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]	

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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.

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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.

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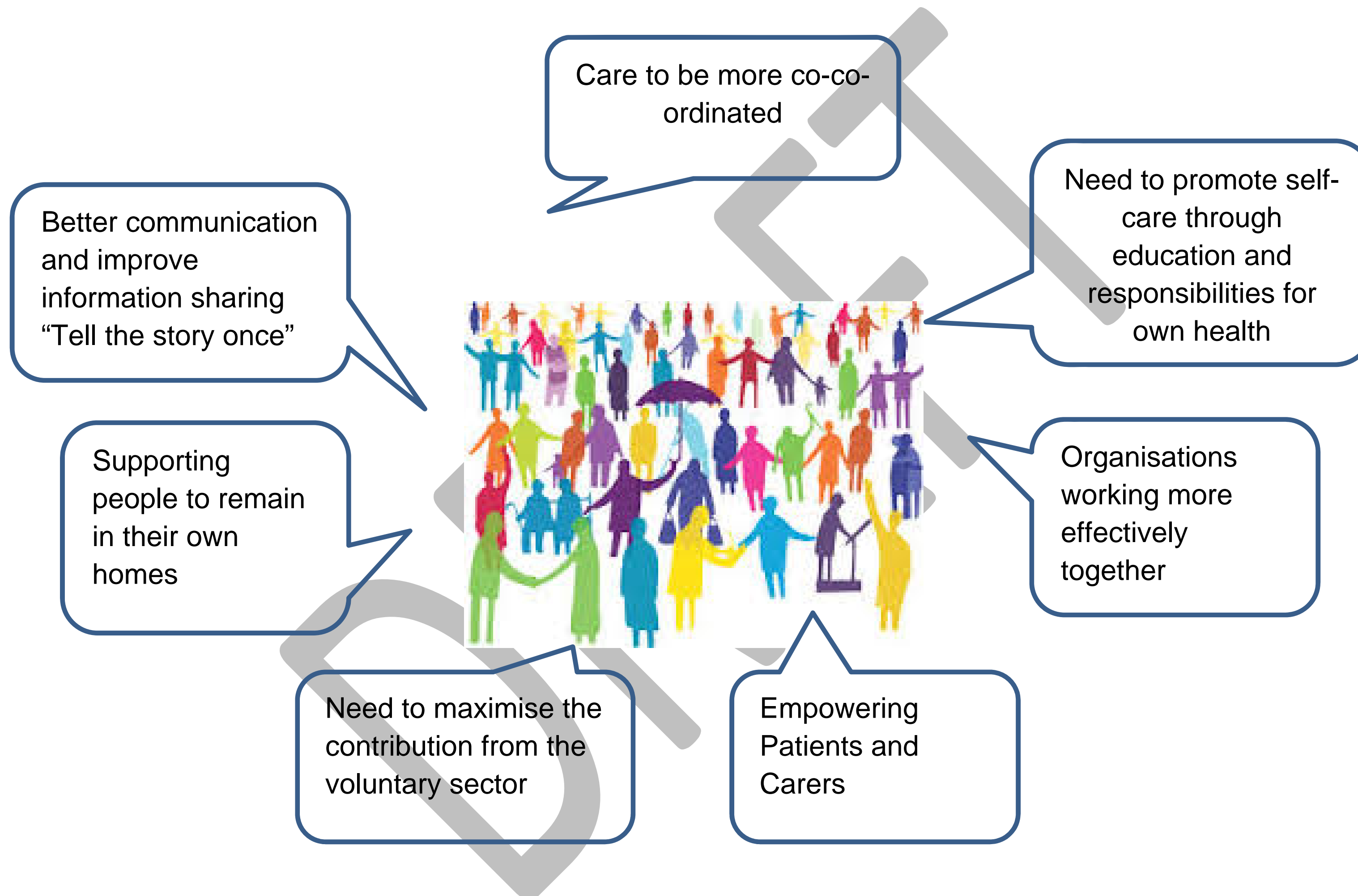
What our Patients Told Us at the "Call to Action" Event held 13th November 2013



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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

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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

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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.

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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

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

<table>
<tr><th colspan="2">Berkshire West Programme Board Strategies2014/2016</th></tr>
<tr><td>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.</td><td>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</td></tr>
<tr><td>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</td><td>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</td></tr>
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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.

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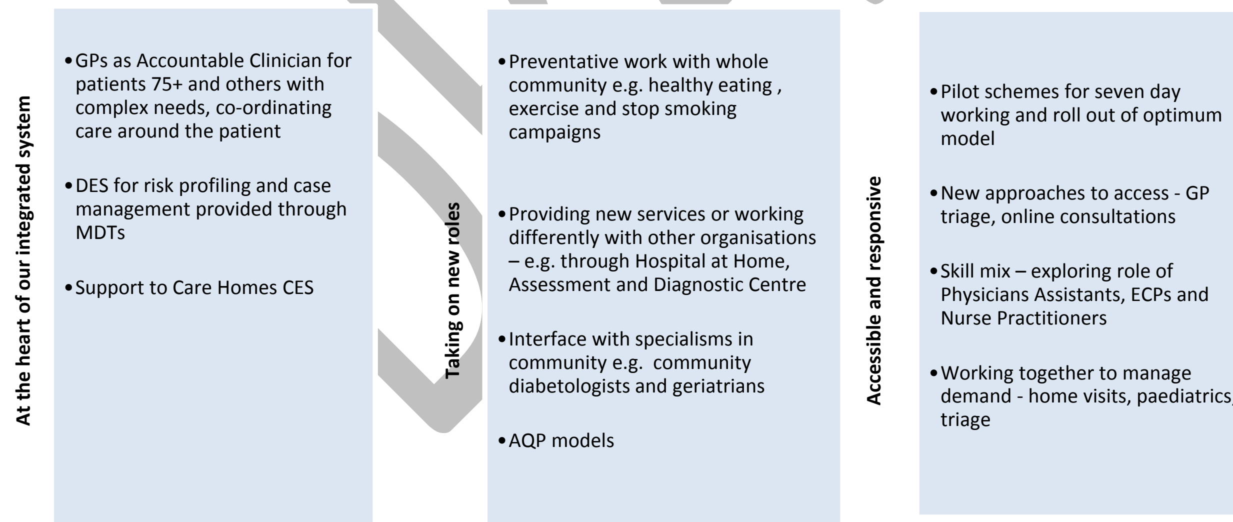
Our GP practices are already interfacing in new ways with specialisms historically provided in secondary care through the work of our community diabetologists and community geriatricians. We anticipate these models becoming the norm as more specialisms move out of hospital and into a community setting.

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.



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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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

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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

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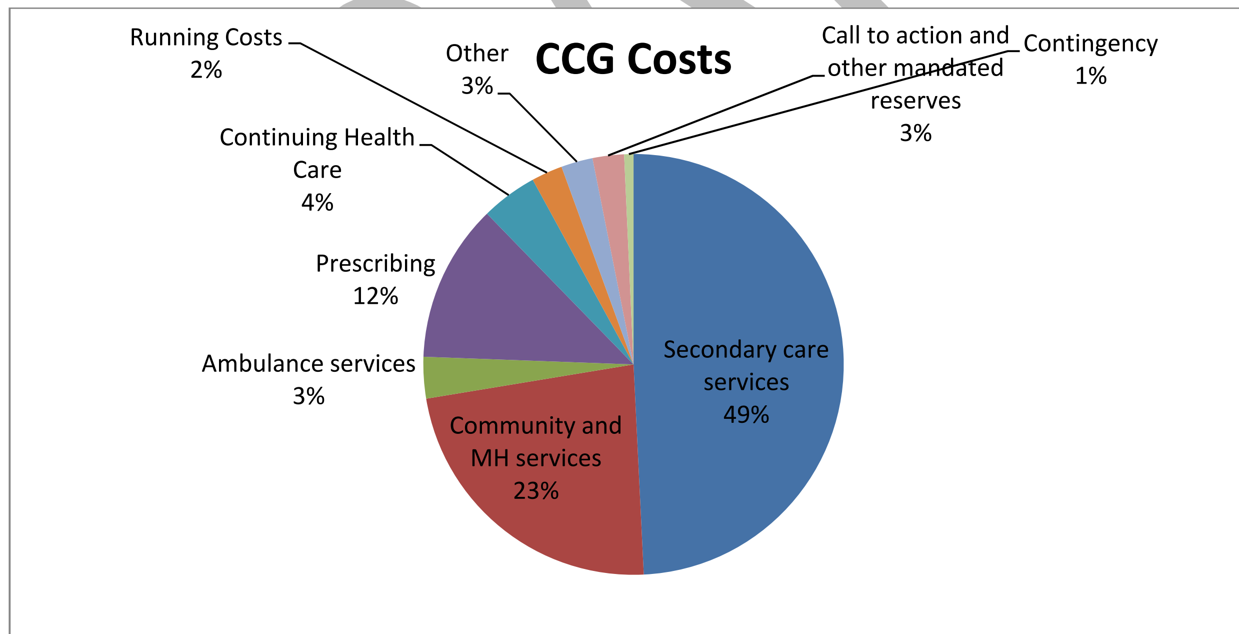
Financial Overview

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

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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.

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

<table>
<tr><td rowspan="3">Promote and protect the health of all communities particularly those disadvantaged (Reading).</td><td>Objective 1 – Implement plans to protect health and reduce the burden of communicable diseases</td></tr>
<tr><td>Objective 2 - Ensure effective support is available to vulnerable and disadvantaged communities to protect their own health</td></tr>
<tr><td>Objective 3 – Increase awareness and uptake up of Immunisation and screening programmes</td></tr>
<tr><td colspan="2"><u>Focus of North & West Reading CCG</u>

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.
</td></tr>
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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.

Focus of North & West Reading CCG

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.

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

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.

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<table>
<tr><td rowspan="3">Promote health-enabling behaviours & lifestyle tailored to the differing needs of communities (Reading).</td><td>Objective 1 – Improve tobacco control and reduce the harm due to alcohol</td></tr>
<tr><td>Objective 2 – Introduce and support initiatives to increase physical activity in Reading, particularly in hard to reach groups</td></tr>
<tr><td>Objective 3 – Introduce and support initiatives that promote healthier eating for all ages and communities</td></tr>
<tr><td>Supporting those over 40 years old to address lifestyle choices detrimental to health (West Berkshire).</td><td>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.</td></tr>
<tr><td rowspan="2">Supporting a vibrant district (West Berkshire).</td><td>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.</td></tr>
<tr><td>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.</td></tr>
<tr><td colspan="2"><u>Focus of North & West Reading CCG</u>

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.</td></tr>
<tr><td>Promoting independence and supporting older people to manage their long term conditions.</td><td>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.</td></tr>
</table>

	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.

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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.

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			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.

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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

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			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.

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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.

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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

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			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

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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

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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

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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

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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

DRAFT

			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

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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

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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

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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.

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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.

DRAFT

		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.

DRAFT

			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.

DRAFT

		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.

DRAFT

		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.

DRAFT

			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

DRAFT

				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.

DRAFT

		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.

DRAFT

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.

DRAFT

				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									

DRAFT

		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.		

DRAFT

		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.						

DRAFT

		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.

DRAFT

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

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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

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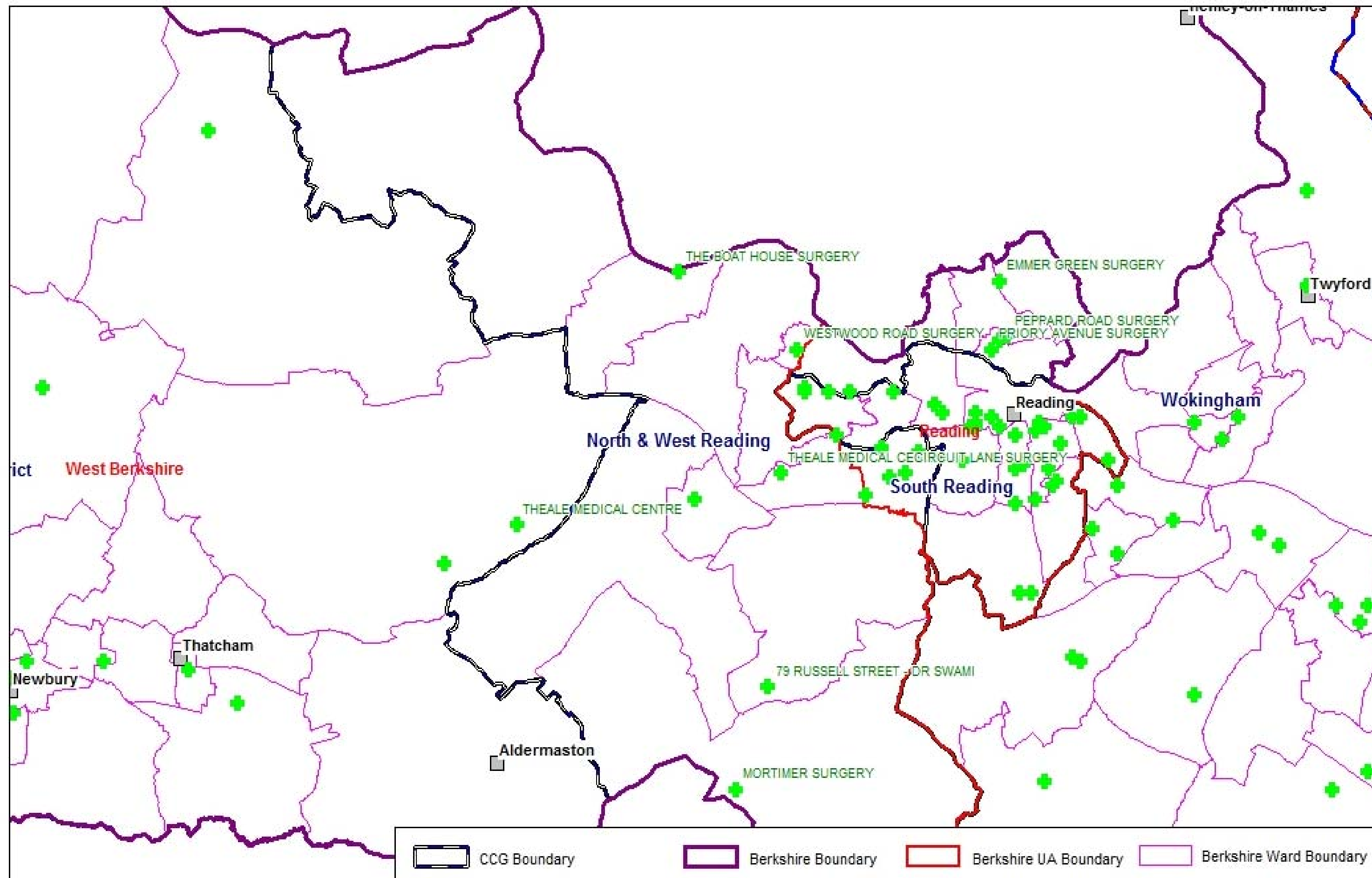
Appendix 6 - Map of our area

North & West Reading CCG



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