Berkshire West
Clinical Commissioning Group

Berkshire West CCG – Operational plan 2020-2021

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1. Executive Summary

Berkshire West CCG is a high performing organisation which commissions health care services to a population of approximately 550,000 residents. The CCG plays a key role in working across Buckinghamshire and Oxfordshire as part of the Integrated Care System (ICS) as well as more locally through the Berkshire West Integrated Care Partnership (ICP). The CCG has an excellent history of collaboration and integration and we are seeking to build on this in order to realise a stretching set of aspirations for our population.

The purpose of the Berkshire West Operating plan is to respond specifically to the ask of the CCGs and other NHS organisations as set out in the operational guidance released by NHSE/I in January 2020 and therefore does not seek to replicate the Buckinghamshire, Oxfordshire and Berkshire West Long Term Plan (LTP) submission.

Financial sustainability is one of the key aims of the Berkshire West CCG. In 2020/1 the CCG has a forecast gap of £20m between what it has been allocated and what it is projected to spend. To mitigate this, we have identified £6m of efficiency improvements which will not reduce the range or quality of services which our patients are able to access. This leaves a gap of £14m for which further schemes are being currently developed through the Berkshire West Integrated Care Partnership (ICP) and Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (ICS). Due to the current COVID-19 pandemic the financial regime for this year may be subject to change and at the time of writing the CCG are awaiting further guidance nationally on this.

Delivery of more joined up care for the population served by Berkshire West is golden thread of the plan. Our approach to Population Health Management (PHM) will ensure we are better placed to understand the needs of the local population as a whole with specific improvement actions identified through which we can improve both clinical and financial outcomes.

Delivery in 2020/1 will focus on seven key clinical areas of transformation, underpinned by PHM and delivery of financial sustainability; these packages of work were defined during the financial year 2019/20 and have been developed for implementation during this financial year and beyond, including:

- A new Urgent & Emergency Care delivery model
- Development of our Primary Care Networks
- Transforming how and where we deliver outpatient services
- Implementing an Integrated MSK service
- Improved detection of Respiratory and Cardio vascular conditions
- A Mental Health crisis pathway and a new model of support in primary care.
- Embedding a preventative approach to all our work

This plan is supplemented by the Activity, Finance and Performance submissions made to NHSE/I in March 2020 which outline our commitment to deliver the constitutional (RTT, cancer, diagnostics), access, and other standards within the system (acute, primary care and community) alongside the finance and activity trajectories.

It should be noted that at the time of writing this plan the NHS is experiencing its biggest peacetime challenge as it responds to the global spread of COVID 19 and therefore as more

unfolds during the first quarter of this year some of the plans articulated here may be subject to change.

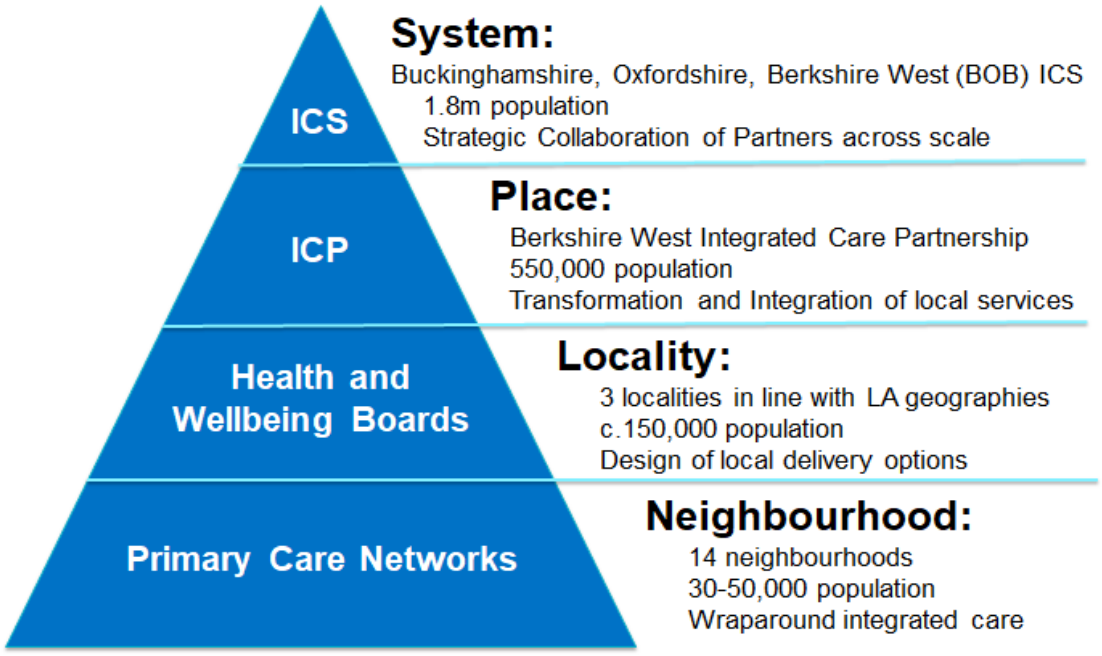
2. Introduction

This operational plan sets out our transformation plans for 2020/21 to meet the needs of our local population and drive improvements in health and wellbeing, quality and care and the efficiency of local NHS services to ensure sustainable services for the people of Berkshire West. Our plan sets out how we intend to deliver our statutory responsibilities and our vision for healthcare services in Berkshire West over the next year. It outlines our strategy for local services, within the framework of the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System and our Berkshire West Integrated Care Partnership (ICP).

It is a public document which aims to provide assurance to our Governing Body, and to inform our local stakeholders of our current position, our plans and next steps in the commissioning and delivery of health care in Berkshire West. This plan sits alongside the BOB strategic delivery plan (not yet published) for implementing the requirements of the NHS Long term plan as well as a Berkshire West ICP plan which sets out the health and social care priorities to deliver locally (under development).

Delivering high quality health and social care within the resources available has never been a greater challenge for the NHS and its local authority colleagues and this financial pressure is significant in 2020/1.

Figure 1: How our system fits together



3. About us

Berkshire west CCG serves a population of approximately 550,000 residents working alongside six other public sector organisations including**:**

- Three local authorities – Reading, Wokingham and West Berkshire
- Berkshire Healthcare Foundation Trust
- Royal Berkshire Foundation Trust
- South Central Ambulance Foundation Trust

There are also 47 GP practices and 14 Primary Care Networks (PCNs) that operate across the geography that are a core part of the healthcare landscape.

Figure 2: Berkshire West geography

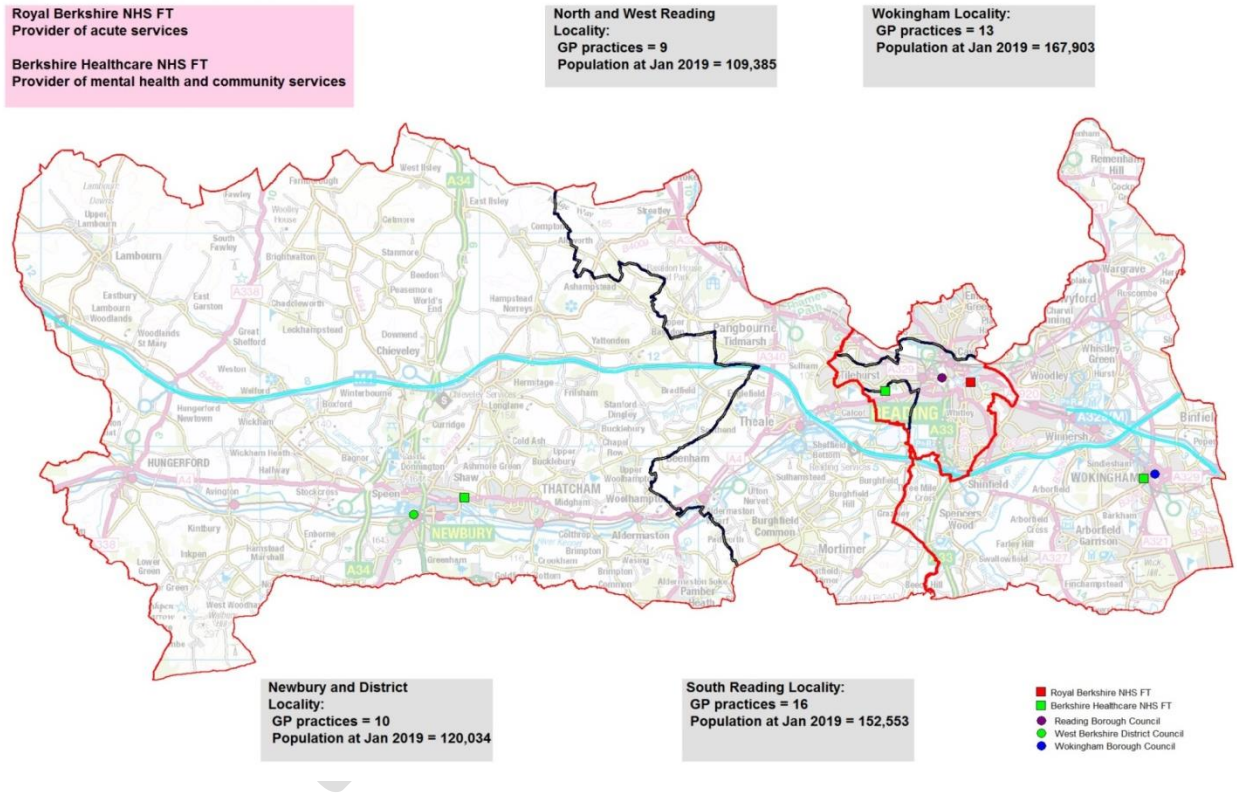
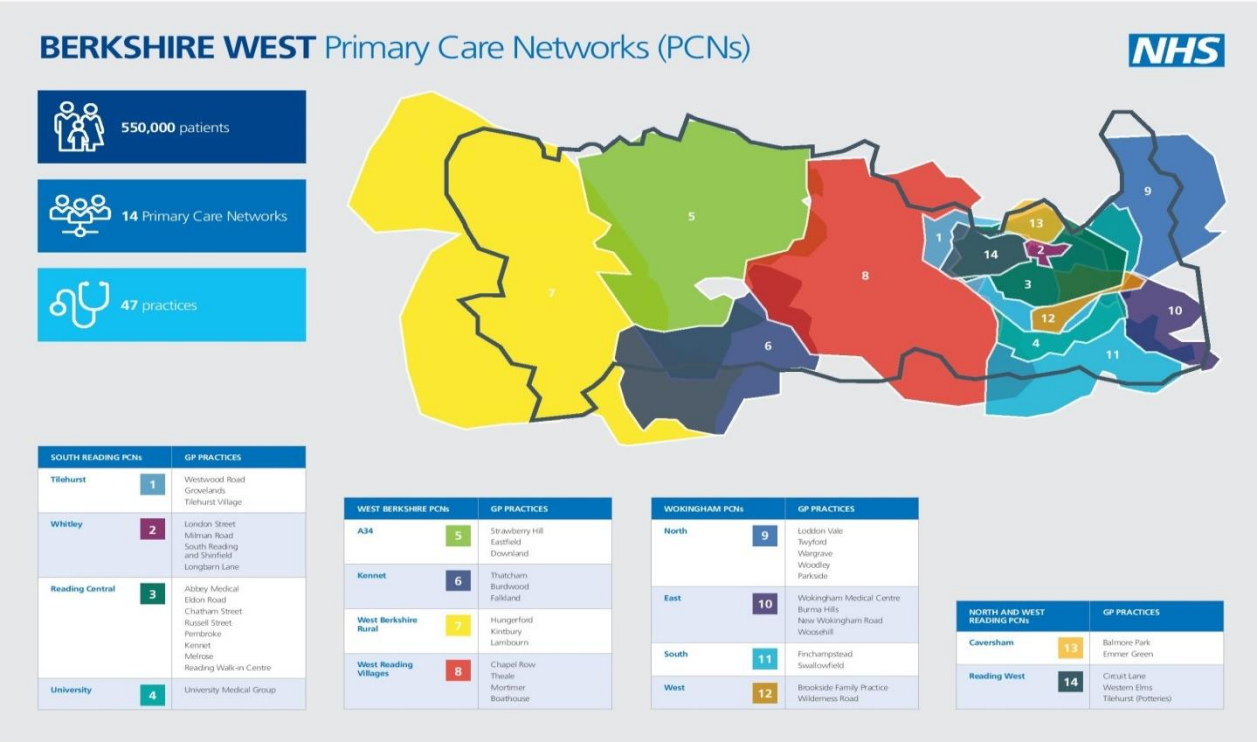


Figure 3 Berkshire West Primary Care Networks



The three local authority areas have some notable differences in terms of their demographic and health profiles. Reading has a much younger population with typical characteristics of an inner city diverse population, Wokingham is suburban with rapid housing expansion under way, whilst West Berkshire has an older population and significant rurality.

Generally, the health of residents of Berkshire West is good; however, there are some clear differences between the populations in each of the local authority areas and this is reflected in the differing health needs. This corresponds with recent analysis of population segmentation for Berkshire West residents (figure 4).

Figure 4 Berkshire West Population Segmentation insights

Segment	Percentage of Population	Percentage of Total Cost
Frailty Risk	3%	19%
Organ Failure	3%	11%
Cancer	3%	8%
Disability	4%	6%
Multi-Morbidity	14%	21%
Single LTC	20%	15%
Maternity	1%	3%
Children	17%	6%
Mostly Healthy	35%	12%

4. NHS long term plan commitments – 2020/1

In response to the NHS Long Term Plan (LTP) BOB ICS has been developing its five year plan. The five year, one system plan aims to describe how partners within the ICS will work together and with people in their communities, to deliver the ambitions of the NHS LTP and address the specific priorities, opportunities and challenges within the BOB ICS area. The plan sets out how we will work together to deliver joined up health and care, support people to live longer, healthier lives, make best use of public investment to secure the best outcomes, focus locally unless there are benefits to working across the ICS and/or with our partners across the Thames Valley.

The aims of BOB ICS include:

- To work together to deliver joined up health and care services based on the needs of individuals and shaped by the circumstances and priorities of local communities
- To support people to live longer, healthier lives and treat avoidable illness early on
- To make the best use of available public funds and resources so that, together, we can secure the best outcomes
- To make our focus local unless it is more efficient and effective for us to pool our expertise and resources to work together as an integrated health and care system across Buckinghamshire, Oxfordshire and Berkshire West (BOB).
- To reach out, where appropriate, beyond our borders and work in partnership with others – for example, across the wider Thames Valley region on specialist cancer services.

The challenge for BOB as an ICS is translate and deliver the ambitions of the NHS Long Term Plan into an ICS strategy that provides 21st century care supported by a data-driven model of care planning. The challenge in addressing the NHS LTP 5 year plan priorities will be to:

- Integrate and prioritise the strategic initiatives to build the plan and deliver our vision;
- Ensure the strategic initiatives are coordinated and effective;
- Plan and manage the management and resource capacity effectively.

Services will need to be provided in an increasingly integrative manner, using population health information to inform priorities, improving digital capability and ensuring we have the workforce to support the needs of our population.

The BOB ICS has agreed a set of principles for how it will operate that prioritises delivering care as close to the patient as possible but where there are outcome or efficiency benefits to operating at scale, we will do so. BOB ICS has a place-based focus, recognising that system working at a county level is a key driver of much of the transformation across the BOB footprint. Figure 3 below sets put the BOB ICS strategic priorities and their relationship with place based delivery

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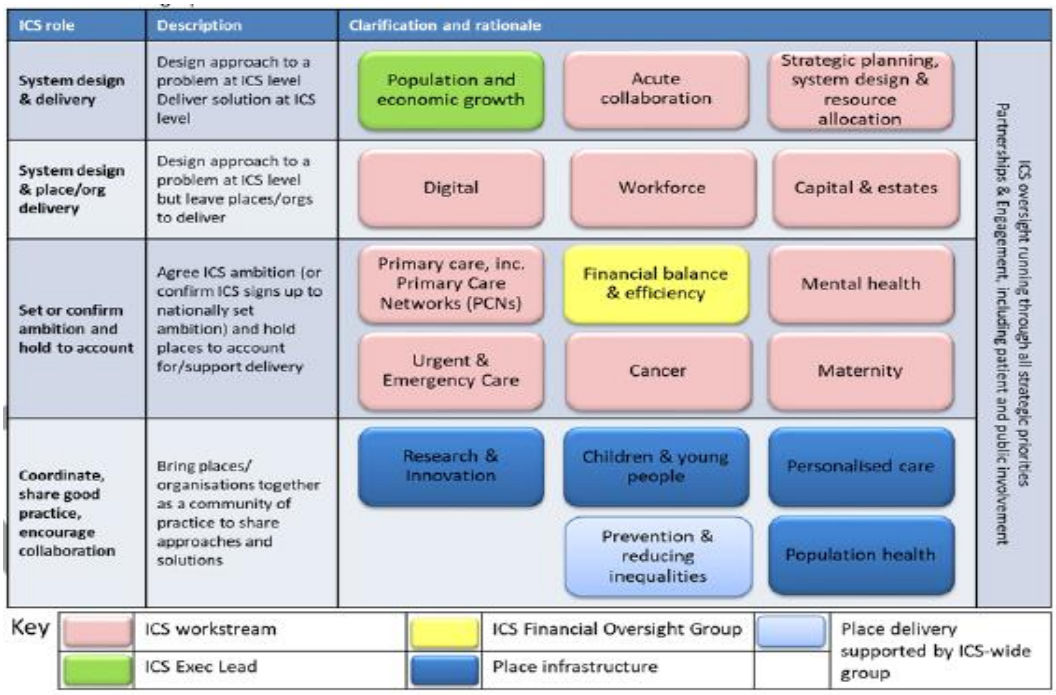
Figure 3: BOB ICS Strategic priorities



Alongside the specific operating guidance requirements set out for the NHS in 2020/21 Berkshire CCG will also continue to work with colleagues across the BOB ICS to deliver the ongoing requirements of the NHS Long Term Plan (LTP). These include the following key areas of focus:

- Integrated Care, with particular work streams on primary care, urgent and emergency care and population health
- Prevention and Health Inequalities
- Care Quality & Outcomes, with particular work streams on Maternity, Mental Health, Cancer and Acute Care Collaboration
- Workforce
- Digital transformation – a shared priority including our Local Health and Care Record Exemplar programme but with work undertaken and coordinated at place-level within our ICS
- Efficiency and Productivity, including capital requirements
- Engagement and Partnerships

The governance structure at BOB to support the delivery of the above priorities can be found in Appendix 1. The draft BOB LTP submission can be found below – this outlines in more detail how each of the areas highlighted in the bullet points above will be delivered.
https://www.bobstp.org.uk/media/1752/ics-ltp-1st-draft-submission-v10-2.pdf

The purpose of the Berkshire West Operating plan is to respond specifically to the ask of the CCGs and other NHS organisations as set out in the guidance released by NHSE/I in January 2020 and therefore does not seek to replicate the BOB LTP submission.

5. Berkshire West Strategic Priorities and transformation programme

In light of the NHS LTP and the challenges faced by the local health and care system Berkshire West ICS has identified 9 strategic priorities for the year ahead (2020/1). Services will need to be provided in an increasingly integrative manner, using population health information to inform priorities, improving digital capability and ensuring we have the workforce to support the needs of our population.

Our priorities for 2020/21 are set out below and build on the work undertaken in previous years:

- Development and implementation of a new Urgent & Emergency Care delivery model
- Development of our Primary Care Networks (or Neighbourhoods), with a wraparound model of care.
- Transforming how and where we deliver outpatient services
- Development and implementation of an Integrated MSK service
- Improved detection and management of people with respiratory and cardio vascular conditions in primary care.
- Development and implementation of a Mental Health crisis pathway as well as a new model of support in primary care.
- To work with public health colleagues to embed a preventative approach to all our work
- Implement and embed our approach to Population Health Management and Digital transformation
- Implement the ICP financial recovery plan

As part of the COVID recovery process there may also be areas of learning that we can capitalise on, for example our use of digital technology, which will enable us to identify further transformation priorities for the CCG and our ICP.

6. Berkshire West Integrated Care Partnership

At a local level, ICPs will design strong systems (using a set of common strategic objectives) to plan and commission care for their local populations. This will take place under joint system leadership bringing together NHS providers, commissioners and local authorities to work together in partnership to improve health and care in their areas.

In July 2018 the Berkshire West ICP was established. We have developed our ICP as a place based alliance of NHS providers (including PCNs), commissioners, local authorities and stakeholders that will work by collaboration not competition responsible for:

- A joint approach to Population Health Management (PHM);
- Development of joint plans to meet the needs of residents
- Management of commissioning budgets;
- An open book approach through a cost based, system I&E approach to managing the cost of care;
- Joint working with Local Authorities and having a shared responsibility for statutory duties (e.g. safeguarding);
- Ensuring a coordinated, multidisciplinary clinical input into local decision making;
- Ensuring a coordinated, multi -focussed approach to public engagement;

- ICP performance & assurance

The ICP is where we work together using a population health management approach to ensure resources are targeted to the most appropriate need and we are working towards being aligned by a single Health & Wellbeing Strategy.

The work programme is driven by the strategic objectives of the ICP which ensures projects are aligned to the overall vision and are focussed on what are known as local issues for all partners.

The ICP strategic objectives are as follows:

Berkshire West ICP has identified four priorities or 'flagship' programmes of work in 2020/1 and beyond (to be reviewed post-COVID), these include:

- Delivery of the Berkshire West Urgent and Emergency care strategy
- Prevention
- Joint commissioning
- Neighbourhoods (including multi-disciplinary team working and social prescribing)

Work to define these programmes of work and their constituent projects is under way with outline project briefs that clearly identify the objectives, deliverables benefits and impact for the individual projects of each key priority area.

7. Our approach – Population health

Delivery of more joined up care for the population served by Berkshire West is golden thread of the plan. PHM will be integral to create a single source of truth, identify the priority opportunities to proactively target the right care for specific populations and shape the culture of Berkshire West. Population Segmentation and risk stratification are two concepts used to help understand the needs of the population so that services can be better planned and delivered. Segmentation is grouping the local population by what kind of care they need as well as how often they might need it. The CCG is currently using Bridge to Health concept of

segmentation, but are looking beyond this to seek to use predictive analysis and actuarial science to support future service planning.

8. Financial sustainability and performance

Berkshire West CCG has reported an in year financial deficit in 2019-20 of £9m, against a planned breakeven position. When set against the CCG's carried forward cumulative surplus of £9.48m, this has left the CCG with a surplus balance of £0.48m to carry forward into 2020-21. The financial planning process for 2020-21 which the CCG and its partner organisations were completing during March 2020, was frozen before completion of either the contracting cycle or its associating setting of financial budgets for the period.

The draft operating plan for 2020-21 which the CCG submitted before the freezing of the process had the CCG forecasting a deficit in the year of £5.1m. This was after assumed efficiency savings of £20.3m had been achieved. The make-up of these assumed savings includes £5.8m to be delivered at a BOB ICS system level, which the CCG considered to be undeveloped at the point the plan was drafted, these together with the achievement risk already included in the other savings, lead to the CCG including a figure within the plan of £15m as an estimate of unmitigated risk.

These plans were not however developed further, due to the Coronavirus pandemic. In order to enable the NHS to focus fully on the pandemic, a simplified financial regime was introduced in mid-March, and will last until at least the end of October 2020. This regime ensures sufficient cash is held by NHS providers, for it not to be a barrier to fighting the pandemic, and non NHS providers have been directly contracted by NHSE to refocus their capacity in coordination with local NHS providers. Additional funds directly related to the additional costs of the pandemic are claimed by NHS organisations on a monthly basis. Details of how the regime will work in the remainder of the year are still being worked through centrally by NHSE.

This plan is also supplemented by Finance, Activity and Performance submissions made to NHSE/I in March 2020. The overarching aim of the 20-21 operating plan is to support delivery of the 20-21 long term plan commitments made by the CCG. This includes a commitment to deliver the constitutional (RTT, cancer, diagnostics), access, and other performance standards within the system (acute, primary care and community) whilst delivering the finance and activity trajectories. It should be noted that whilst this commitment remains, it is likely that the COVID-19 pandemic may impact on these trajectories. Berkshire West is actively working through a recovery planning process to ensure any issues are identified and managed appropriately.

9. Sustainable Development

The CCG continues to develop plans to assess risks, enhance our performance and reduce our impact, including against carbon reduction, waste management and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning. The CCG is developing a sustainability strategy.

The CCG has increased its use of teleconferences and has promoted the use of public transport, cycling and/or walking to work to reduce the negative impact of transport on the environment and promote a healthy lifestyle. The CCG has also been rolling out laptops to

primary care colleagues to enable remote working and in response to the COVID19 incident has used technology to enable staff to work from home. 56,615 business miles were claimed during the year compared with 52,281 in 2019/20. This is a reflection of the growth in the CCG's workforce following the in-housing of support functions from the Commissioning Support Unit.

The CCG operates an effective recycling system as part of its approach to waste management and has increased the use of mobile technology to reduce its use of paper, ink and electricity.

All NHS organisations including CCGs are being asked to remove single-use catering plastics from their offices which could help reduce NHS waste by over 100 million plastic items by 2021. The CCG has signed up to the pledge to support NHSE&I in eliminating avoidable single-use plastics so by April 2021:

- the CCG no longer purchased single-use plastic stirrers and straws
- the CCG no longer purchased single-use plastic cutlery, plates or single-use cups made of expanded polystyrene or oxo-degradable plastics

The CCG hopes to go beyond these commitments in reducing single-use plastic cups for beverages. The CCG does not use covers and lids for cups.

Matters on environmental issues are raised and discussed at the CCG's Staff Partnership Forum meetings, where initiatives such as these can be taken forward.

We will ensure the clinical commissioning group complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012.

Prescribing

The CCG has also looked at its prescribing practices to understand the impact of items such as Metered Dose Inhalers (MDI). The CCG are committed to reducing this impact by:

- Reviewing ways the use of dry powder devices can be safely promoted and where appropriate. Dry Powder Inhalers (DPI) are now being considered as the first line choice for new patients. DPIs have been included in our recent guidance for Asthma and COPD to ensure the patient has the option to choose the best device for them in terms of compliance and environment. The latest COPD guidance makes reference to DPIs having less of a carbon footprint.
- Ensuring patients are on the correct therapy so as to reduce the number of doses/inhalers a patient is requiring to keep them controlled. Pharmacists will review patients who appear uncontrolled and thus reduce the number of inhalers dispensed.
- Exploration of the Glaxo recycling scheme and promoting the return of empty inhalers to pharmacies for green disposal.

10. Operational requirements – 2020/1

The table below sets out the response to the Operating plan guidance released in January 2020, with a focus on how the CCG will deliver against these throughout 2020/1 both a system level (ICS) and as an organisation working with our partners in Berkshire West. It should be note that the content of these plans may be subject to change due to the current COVID-19 pandemic and resulting impact on NHS services.

9.1 Primary care and community health	
Operating plan requirements	**System – BOB Delivery**
The three main priorities for PCN development support in 2020/21 are: (i) supporting workforce redesign and team development, (ii) improve patient access and practice waiting times, and (iii) building operational relationships with community providers (including pharmacies) to support integrated care. **Deliverables:** • Work with PCNs to maximise recruitment under the Additional Roles Reimbursement Scheme, developing a plan to spend available funding. • Support the recruitment and retention of extra doctors working in general practice practices with long waits for routine appointments. CCGs must provide monthly data to each PCN showing the number and cost of A&E	The BOB primary care strategy – now part of the Long Term Plan - sets out the actions that will be taken across the three Integrated Care Partnerships to invest the new resource identified to deliver a transformed model of primary care. Much of this work is already in train, with Primary Care Networks already set up, with 100% coverage across the BOB ICS area. Clinical Directors have now all been appointed and are in the early stages of forming the development plans necessary to provide structure to the ambitions set out at a local level. As a system, a wide range of support mechanisms are in place to ensure these plans and structures are robust, sustainable, and in line with the Long Term Plan vision and principles. **Workforce** GP Mentorship Scheme – The GP Mentoring scheme gives all GPs working in the BOB area the opportunity to access mentoring support free of charge. We have developed an online web platform which enables mentees to define their issue of concern, choose a mentor who they believe can help them resolve it, communicate directly with them and facilitate their one to one meetings. BW so far has 5 mentors and 5 mentees, less than the other places, and we would like to expand this. GP Locum Chambers Scheme – BOB Locum Chambers has been developed to offer local GP locums the opportunity to work together as small independent groups under a shared administrative and clinical governance structure, to better support NHS GP practices across our area. In BW, one of the South Reading PCN Practice Managers has agreed to support the project delivery to practices.

attendances by that PCN's patient population. Ensure full delivery of online consultation systems to general practices where these are not already in place; learn from the work of the digital first primary care accelerator project; and ensure full delivery of direct booking from 111 to in hours appointments (as per the 2019/20 GP contract). • Lead the transition to the new GPIT Futures Digital Care Services Framework arrangements. CCGs should work collaboratively with their constituent GP Practices and PCNs to develop plans to re-procure the GP systems. • Work with PCNs to deliver national service requirements from 2020/21, details of which will be set out in the final version of the forthcoming GP contract and Network Contract Direct Enhanced Service (DES). Funding invested by CCGs during 2019/20 in local service provision which will be duplicated through delivery of the new service requirements in the Primary Care Network Contract DES in 2020/21 should be reinvested within primary medical care. • Provide CCG support to implement the NHS's comprehensive model of personalised care and meet 2020/21 system trajectories for personalised care and support planning, Personal Health Budgets and social prescribing.	GP Careers Support – The GP Careers Support Scheme will improve access to comprehensive GP career development information. The scheme will provide curated training and development opportunities as well as individually tailored careers advice for GPs working in the BOB area. The development of this scheme is at an early stage, but it is scheduled to accelerate, with a clinical lead recently recruited. International GP Recruitment – The IGPR project is a national scheme that has been rolled out across the country based on greatest need. The scheme aims to identify International GPs who are able to integrate into the existing NHS workforce. Berkshire West has been relatively successful in this scheme, with one GP already placed, one GP waiting to start an agreed placement and another GP looking for a practice in the Wokingham area. New to practice fellowship scheme – This new scheme was announced as part of the GP contract update. The scheme is a 2 year programme of support for newly qualified GPs and nurses recruited into General Practice. The opportunity is open to anyone about to take up a post or already working in a practice. **Place – Berkshire West Delivery** **Primary Care Network (PCN) Development** Within Berkshire West, we will continue to work to support our fourteen Primary Care Networks to develop and mature in order to ensure the sustainability of the sector and promote integrated working within neighbourhoods. We will support PCNs to work with community teams and others to build the capacity and capability of Multi-Disciplinary Teams to undertake care planning and support delivery of the national PCN service specification for Enhanced Support to Care Homes. We will also work with PCNs to further embed social prescribing as a key component of care and to support them to use PHM methodologies to better target proactive care which meets the specific health needs of the population they serve. **Access** During 2020/21 access to appointments outside of core general practice hours will be commissioned through PCNs, thereby offering increased flexibility for patients looking to utilise appointments at these times. We will continue to work to identify and share best practice access models and to support practices to proactively manage capacity and demand and to utilise new technologies and other means of providing care e.g. through group consultations and digital triage. We will also look to improve

integration with community pharmacy, ensuring that new arrangements to direct patients to pharmacies are used to best effect to improve overall access to care.

Workforce

The Berkshire West CCG primary care team will work with PCNs on further workforce development through the ARRS funding allocation in 2020/1, as set out in the Network DES Guidance.

The new GP Contract update included a strong focus on workforce, and the expansion of the Additional Roles Reimbursement Scheme (ARRS). The contract also provided guidance for the role that the ICS/CCGs would be expected to support. Some of the work that is already underway includes:

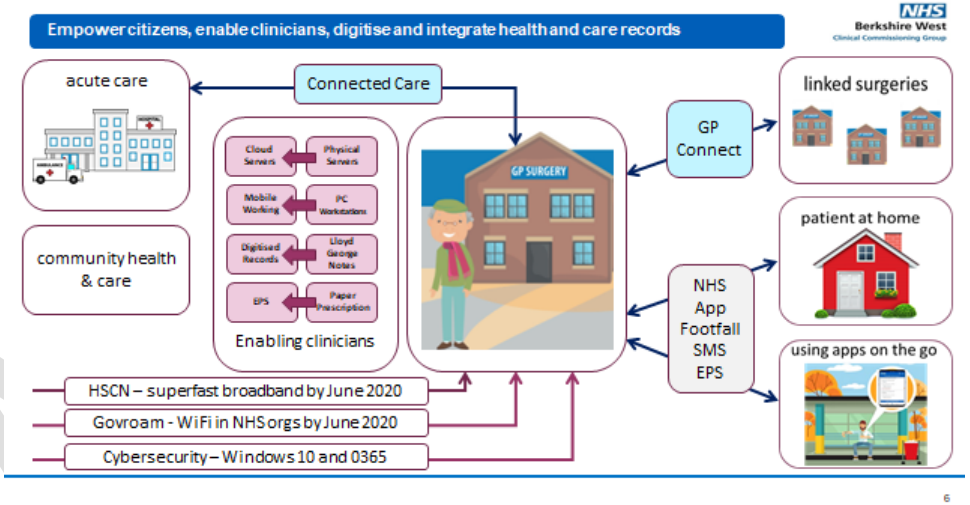
- CCGs to work with PCNs to understand PCNs' future recruitment intentions – To support this, the BOB PC Workforce Group have developed a workforce planning tool that can help PCNs understand how they can configure their workforce within the funding envelope available to them through the ARRS. The data can be complied to help shape the training pipeline for the new workforce types. This is complemented by the latest iteration of the Wessex Workforce Audit Tool, which Practices and PCNs can use to help them understand how the new workforce can support the workload of their existing staff. This work will be supported by a payment of £500 per practice to complete the data collection exercise.

- CCGs to help PCNs recruit staff – There are a number of initiatives underway to explore how recruitment to the new roles can be made easier and quicker for PCNs. BWPCNs are in talks with RBFT about a rotational workplace scheme for Physicians Associates. The Training Hub is involved in discussions with SCAS about rotational recruitment for Community Paramedics. Finally, the CCG (through the Medicines Optimisation Team) are working with the RBFT pharmacy to examine the potential for rotational posts for Clinical Pharmacists and Pharmacy Technicians.

Digital First

The CCG ambition is to provide and commission digital services and solutions that ultimately result in more effective and efficient healthcare for our population, improving health outcomes and driving down costs. To do this, the CCG Primary Care IT strategy will be employed to: empower citizens, enable clinicians, digitise and integrate health and care records, and make intelligent use of information. Our approach will be 'digital first' so that digital opportunities are always considered, and digital services and

solutions are good enough, that people prefer to use them. In addition we will continually work to source new and innovative solutions to serve this agenda.



During 2020/21, the CCG GPIT Committee, will overseeing the programme of digital first and agreed a digital first approach to ensuring practices and PCNs are fully supported. Some of the work to be includes

- By June 2020, all GP Practice will be upgrade on the broadband connectivity, with superfast broadband to support HSCN.
- Adoption of mobile working workforces, replacing desktops with laptops for all PCN and GP staff to allow flexibility
- Promotion of Online Consultation, currently 98% of practices offer online consultation, but by Q2 all practices will provide this service. The CCG will also work with local Healthwatch to promote this facility and hold promotion event for online consultation in each of the localities.
- Roll out GP Connect, across all practice site to all sharing of practice booking systems and also share clinical systems. The CCG will support practices with this new way of working with support from the Primary Care Team and Locality Teams.

9.2 Mental health	
Operating plan requirements	**System – BOB Delivery**
Delivery of Mental Health Implementation Plan: • IAPT roll out • Number of inappropriate OAP bed days for adults by quarter four of each year that are either 'internal' or 'external' to the sending provider • Number of inappropriate OAP bed days for adults by quarter four of each year that are 'external' to the sending provider. • People with severe mental illness receiving a full annual physical health check and follow up interventions • Perinatal Mental Health: Number of women accessing specialist perinatal mental health service • Mental Health Liaison services within general hospitals meeting the "core 24" service standard • Number of people accessing Individual Placement and Support (IPS) • EIP Services achieving Level 3 NICE concordance • Number of people receiving care from new models of integrated primary and community care for adults and older adults with severe mental illness • Coverage of 24/7 crisis provision for children and young people (CYP) that combine crisis	<u>Children and Young People</u> We will work to increase the number of children and young people accessing services, employ additional staff to achieve this and also make greater use of online service delivery, partnerships with schools and community and third sector organisations to address workforce shortages. We will fully use transformation funding to develop MH Support Teams in schools across the BOB area, seeking recurrent funding to support increased activity required in CAMHS while reducing waiting times <u>Crisis response and interventions</u> We will develop crisis home treatment services to ensure coverage across the BOB area. We will develop alternative to admission services , (such as Safe Havens and services for high intensity users of services) and strengthen our community MH services and workforce, to reduce bed occupancy, average length of stay and delayed transfers of care from inpatient services to reduce inappropriate out of area placements. Our Urgent Care services will include effective responses to people with MH needs delivered in partnership between 111, Urgent Treatment Centres, Emergency Departments, Inpatient services and Thames Valley Police, (including street triage). We will improve the access to a range of community based MH and wellbeing support and services through a single point of access. Third sector workers and outreach from secondary care community MH teams will be closely integrated with general practice and PCNs. <u>Understanding need</u> We will use our developing Population Health Management capability to better understand the mental health needs of our population, how people are using our services and how best to use our collective resources to achieve good outcomes for people with MH problems. Greater service user involvement in our planning processes will ensure that services are increasingly co-produced. <u>Prevention & Intervention</u> The improvement of CAMHS and perinatal services is focused on preventing long term mental health issues. We will work in partnership with developing Primary Care Networks to provide prompt support for people with common mental health disorders We will continue to expand IAPT Services subject to recurrent funding, providing prompt access to evidence based psychological therapies and employment based support for adults and older adults. We will increase the number accessing services, train/employ

assessment, brief response and intensive home treatment functions. • Improve access to Children and Young People's Mental Health Services (CYPMH) • We will provide physical health checks for people with severe mental illness, learning disability and autism • IAPT (Talking Therapies) services for people with long term physical health problems will be expanded with availability of recurrent funding • Develop crisis home treatment services to ensure coverage across the BOB area. • Urgent Care services will include effective responses to people with MH needs delivered in partnership between 111,Urgent Treatment Centres, Emergency Departments, Inpatient services and Thames Valley Police, (including street triage) • Care closer to home: Crisis, home treatment and alternatives to hospital admission will be improved, and community mental health teams strengthened to enable more people to be treated at or near home, reducing the need for out of area placements • Prevention: strengthened prevention of mental ill health, mental health promotion and reduced stigma linked to mental ill health • Holistic treatment and care: improved physical health for people with severe mental health problems, improved health and wellbeing of people with a learning disability and autism	additional staff and make greater use of digital treatments. Our Suicide Prevention Intervention Network will continue to work in inpatient and community settings to reduce suicide and self-harm, and support those bereaved by suicide. <u>Holistic treatment and care</u> We will provide physical health checks for people with severe mental illness, learning disability and autism aiming to reduce health inequalities, and continue our focus on smoking cessation. We will expand IAPT (Talking Therapies) services for people with long term physical health problems reaching more people with a wider range of LTCs, subject to recurrent funding. We will increase the number of older people accessing IAPT and work to improve the mental wellbeing of people with a learning disability and those with autism. <u>Finance</u> Five key elements of revenue funding are supporting delivery of our plan, recognising the required scale of increased access, delivery of new service models and effective response to growth: • Funding in response to agreed demand growth assumptions in mental health is a key priority and is subject to decision-making between commissioners and providers at "place" level in Buckinghamshire, Oxfordshire and Berkshire West. • Five Year Forward View and LTP Funding which has previously been committed to nationally has been assumed as ongoing. • Uplift to CCG budgets to support delivery of mental health aspects of the LTP has been included in our planning in line with national assumptions. • Specified time-limited Transformation Funding is also linked to the delivery of LTP targets. Our ability to achieve these on an ongoing basis is contingent on availability of recurrent CCG funding. • Efficiency savings will continue to be required at organisational level – recognising that a significant effort is required to minimise waiting times as we increase access to services. Our NHS Provider Trusts already benchmark well for efficiency, adding to the challenge of finding additional efficiency opportunities. Analysis of the above sources of investment across the 5 years of the plan is currently being undertaken in Bucks, Oxon and Berkshire West, to ensure delivery of locally agreed priorities. This may mean LTP targets are phased over a longer period than national trajectories.

	Place – Berkshire West Delivery
	2020/1 priorities Continue to meet the Mental Health Investment Standard – a clear plan of investment(s) in place. <u>Children and Young people</u> Continued investment and all provider reporting to meet the access target of 34% Comprehensive offer for CYP aged 0-25 started with a clear needs assessment and analysis Continue with mental health support team roll out to meet the 33% coverage target Eating Disorder Services continued investment to meet 95% access standard. Implement the crisis review recommendations for CYP: - Development of a new Crisis Line available 24/7 for all ages (BHFT Crisis Team) *note – already in place in response to Covid-19* - Development of specialist access for CYP : An improved CYP Crisis model offering crisis assessment in the community within 24-48hour of a referral Adults <u>Perinatal Mental Health</u> Continue to develop services to meet the access target of 7.7% this year. Developing & strengthening the offer by extending treatment offer to 2 years; broadening the psychology offer, a birth trauma offer; extending maternity outreach clinics; digital offer (skype and Dad pad) <u>IAPT</u> Increase the Talking Therapies offer to meet the access target of 25%, whilst maintaining recovery rate above 50%. Continue to expand the workforce with 9 new trainees. <u>Crisis care</u> – implement the 14 recommendation's agreed in the MH Crisis review, in particular: Ongoing investment to meet the Core 24 offer at RBFT Develop single point of access for adults and children and 24/7 response to support through 111. Development of a pilot Crisis Café <u>Adult and Older Community MH services</u> Community Mental Health in Primary care through PCN development. Continue work in relation to developing and agreeing PCMH model - agree pilot site/s with PC colleagues.

Physical health for people with serious mental health in primary care
Continue to develop the IPS offer to meet target of 150 patients

Early intervention in Psychosis
Invest to Maintain 60% EIP Access Standard and 70% Level 3 NICE concordance. Prepare for expansion of service in following 3 years.

Dementia and Frailty
Exploring models to support people with dementia in their own home to prevent crisis.
Improving the management of patients with dementia in the community and in their home
Maintaining dementia diagnosis to meet the target rate of 66%
Improving integrating physical and dementia care interventions in the community to prevent admission to acute hospital

Suicide prevention
Establish standardised psychosocial assessments in general hospitals across the ICS
Enhanced Bereavement Support

OAP placements

The following numbers are the trajectory target for Berkshire West for the year 2020-2021. There is expected to be a surge in demand for Mental Health services which may have a knock on effect for inpatient beds.

Trajectory targets for each quarter in the year 2020-2021

	Target
Q1 2020/21	116
Q2 2020/21	76
Q3 2020/21	36
Q4 2020/21	0

9.3 Learning disabilities and Autism

Operating plan requirements	System – BOB Delivery
• A reduction in reliance on inpatient care for people with a learning disability, autism or both to meet the NHS Long Term Plan commitments so that by 2023/24 there will be no more than 30 adults with a learning disability, autism or both per million adults in an inpatient setting and no more than 12-15 children and young people per million children in an inpatient setting. • Local areas will align their plans for children and young people across special educational needs and disability, mental health, health and justice and learning disability and autism to ensure that children and young people have a better start. • Engagement with emerging provider collaboratives (from April 2020) which will develop discharge pathways and community alternatives to inpatient provision. • Development of community services that can provide robust and person centred alternatives to hospital admission. • Making full use of Care (Education) and Treatment Reviews (CTRS and CETRS) and independently chaired C(E)TRs to ensure that all those involved in a person's care and treatment are acting to ensure that the person can be discharged from hospital (using the 12 Point Discharge Plan) as soon as they are well enough to leave.	LD & Autism has been incorporated into the governance arrangements of the Mental Health workstream. Feeding into this are place based Transforming Care Boards and Autism Partnership Boards. Programme infrastructure, and a BOB-wide dashboard (to manage and monitor reductions variations and work towards reducing inconsistency of outcomes for both formal collaborations and informal sharing of good practice) will be developed over the early years of the ICS plan. Establishment of these will mitigate risks such as coordinated use of resources. **Place – Berkshire West Delivery** <u>2020/21</u> Berkshire –wide Programme Board to continue and to be reviewed after 6 months. Additional investment in key posts to ensure continued delivery of 6 and 8 week visits to out of area placements; robust and consistent approach to CTR's and CETRs and consistent discharge planning Embed Host Commissioner arrangements Bids will be submitted to NHSE to support proposals detailed below: 1) Development of community placements through capital investments 2) Purpose-designed supported housing established with skilled support staff. 3) Intensive support & adapted therapies for people with autism, specialist autism expertise available across all ages. 4) Pilot a project to reduce admissions for 18 to 24 year olds. 5) Children & Young People Transition pilot. 6) PBS and therapy-based, holistic, family-centred multi-disciplinary support for children with autism or LD & challenging behaviours 7) Robust Child and Adolescent Mental Health Services (CAMHS) pathway for mental health support for children with Learning Disability (LD) or Autism 8) System-wide Positive Behavioural Support (PBS) training and consistent approach embedded 9) Setting up dynamic risk register to manage escalation

• 8 week visits for all adults and 6 week visits for all children and young people in inpatient settings out of area. • Establishing arrangements for 'host commissioner' oversight of local inpatient facilities. • At least 75% of people aged 14 and over with a learning disability on GP learning disability register should have had an annual health check within the last twelve months, and CCGs should also work with PCNs to increase flu vaccinations rates for people with a learning disability. A robust CCG plan in place to ensure that Learning Disability Mortality Reviews (LeDeR) are allocated within 3 months and completed within 6 months of the notification of death to the local area. CCGs are expected to be a member of a 'Learning from LeDeR' steering group and have a named person with lead responsibility. An annual report will be submitted to the appropriate board/ committee for all statutory partners demonstrating action taken and outcomes from LeDeR reviews.	In addition, ICP focus on: • Work with partners to promote reasonable adjustments for people with learning disabilities to improve access to healthcare services and peoples reported experience of these services • Work with primary care to support upskilling and confidence in the promotion of health and well-being and early identification of deterioration of physical health of people with a learning disability • Continue emphasis on annual health checks in Primary Care • Continued engagement and support to LeDeR steering group in BWCCG
9.4 Urgent and Emergency Care (UEC)	
Operating plan requirements	**System – BOB Delivery**
• Deliver material improvement against A&E performance benchmark • Reduce general and acute bed occupancy levels to a maximum of 92%	At ICS level the three places coordinate through the ICS UEC Committee and regional expertise such as the Clinical Senate, to ensure that patients across BOB can access timely and specialist care no matter where they experience an event. The following priorities have been identified as work at ICS level over the next 5 years for UEC: • Review of primary care streaming at Emergency Departments and development of an enhanced model of care

• Increase the proportion of patients seen and treated in the same day (or within 12 hours if this spans midnight) to a level agreed regionally • Ensure the SDEC activity is recorded on the Emergency Care Data Set or Admitted Patient Care to allow activity to be counted • Ambulance services should ensure they meet the ambulance response time constitutional standards	• Modelling of acute and community bedded care capacity and assessment of future need. • Management of stranded patients and improvements to Delayed Transfers of Care • Implementation of the new Urgent & Emergency Care standards, when published • Completion of Urgent Treatment Centre designation and the coordination of same day illness and injury provision Supported by development of a workforce strategy that includes a coordinated response to the domiciliary care market and coordination of staffing. **Priorities for delivery at supra-ICS level** The development of ambulance services and Integrated Urgent Care (IUC) is undertaken jointly with partners across Frimley. Across BOB & Frimley, the following services will be developed during the life of this plan: ***IUC*** • Increasing clinical capacity within Integrated Urgent Care. • Providing access to rapid community response and reablement. • Implementing MiDOS (an enhanced Directory of Services). • Increasing direct booking into GP practices from 111. ***Ambulance*** • Implement a single Clinical Assessment Service across 999 and 111. • Developing paramedic rotational posts within Primary and Community Care. • Improving Technology and Digital enablement for 999 crews. • Developing a Total Health and Social Care Transport solution. • Enhancing the ability of crews on scene to manage patients in the community and avoid a clinically unnecessary conveyance to ED.

	Place – Berkshire West Delivery
	Deliver material improvement against A&E performance benchmark A&E performance is a barometer of flow through the UEC pathway and the following are key developments to support improved flow; • NHS 111 increasingly becoming the single point of access to urgent care services ensuring only those needing ED are directed to the service • Rapid assessment and management in frailty and ambulatory care settings to support safe and effective return home the same day where clinically appropriate • Maintain multi-disciplinary management of delayed patients and those with a long length of stay, including regular Executive focus and support to help patients home safely • Further develop 7 day working, improving discharge levels at weekends to reduce the potential for patients to remain in hospital with a long length of stay • Improved co-ordination with the third sector to provide additional non-medical support to patients and their families in hospital and at home. The system is also preparing to deliver the new urgent & emergency clinical standards for care, including stroke, trauma, sepsis and heart attack. We will ensure that patients requiring critical care receive assessment within 15 minutes and treatment in an hour, providing responsive, safe care across all pathways. **Reduce general and acute bed occupancy levels to a maximum of 92%** We will work with our community services and ambulance provider to ensure that only patients who really need hospital based care come into hospital. New pathways of care will ensure that more patients will be treated without an overnight stay and for those that need admission length of stay will be minimised. Capacity and responsiveness in community health urgent response services will be increased to provide support to those that need it most with flexible teams working across primary and community care providing recovery, reablement and rehabilitation support.

	Health and social care working in a more integrated way to ensure that following a hospital stay patients can return to their own home with any support that they require with 2 hour support for discharge and 2 day access to reablement. The Rapid Community Discharge principles adopted during the Covid-19 response will be embedded within normal working arrangements. **Ensure the SDEC activity is recorded on the Emergency Care Data Set or Admitted Patient Care to allow activity to be counted** Ensuing compliance with national reporting requirements. **Ambulance services should ensure they meet the ambulance response time constitutional standards** Key initiatives for SCAS, our local ambulance provider include; • Implementation of MiDOS, a tool which supports crews to manage by providing information about local services and pathways • Using technology to provide more proactive care and support welfare calls to those at risk of deterioration • Providing proactive and rapid response of patients at risk of falling or who have fallen • Improve support to palliative care patients to avoid unnecessary conveyance at end of life • Enhancing the ability of crews on scene to manage patients in the community and avoid a clinically unnecessary conveyance to ED. **Priorities for delivery - BW ICP** As part of delivery of the BOB Strategic Delivery Plan the BW ICP UEC Programme Board will oversee delivery of the following at place; • Developing a coordinated Out of Hours specification and alignment of services within IUC • Implementation of the Emergency Care dataset across relevant services • Implementation of the SAFER bundle and multi-disciplinary review of patients daily • Increasing joint working across health and social care including therapy and social work teams at the beginning of the acute hospital pathway • Development of support to High Intensity Users, frail patients and those at risk of falls

	The Board will also oversee delivery of the Berkshire West Urgent & Emergency Care strategy developed during 2019-20 that describes a suite of 14 improvement opportunities that we wish to deliver over the next five years. The improvement opportunities cover the following areas; • Wellbeing, prevention and self-care • Voluntary sector services • Integrated Urgent Care (NHS 111) • Person centred coordinated care • Same day urgent Primary Care • Same day urgent community services • Clinician access to same day specialist opinion • Mobile treatment services delivered by ambulance services, • Same Day Emergency Care (SDEC) • Optimising the Emergency Department • Optimising Mental Health crisis response • Optimising patient flow through RBH beds • Optimum use of community beds and home first as first choice. Each improvement opportunity has an associated set of key actions which will be delivered over the forthcoming months and years and work is underway to map the baseline position so we can measure improvement and benefits.
9.5 Referral to Treatment Time (RTT)	
Operating plan requirements	**System – BOB Delivery**
The waiting lists for elective care should reduce in 2020/1. Waits of 52 weeks or more for treatment should be eradicated. Systems should plan to use	The BOB ICS has formed a working group called the Acute Collaboration Workstream to provide an integrated approach on system pressures in planned care. The ACW is one of 9 work streams identified within the BOB ICS Strategy to focus on driving efficiency, increasing productivity, reducing waiting times, reducing pressure of demand and releasing capacity across the whole system for planned care. • Streamlining outpatients services through adoption of digital tools that support activities such as virtual consultations to increase access and a reduction in face to face consultations, over a five year period.

capacity flexibly across their systems to reduce long waits Introduction of supplementary choice at 26 weeks with reference to the 26 week Choice Rules and Guidance	This is based on the patient being seen in the right place first time and seeing the right healthcare professional. • Implement targeted improvement programmes in challenged services such as Ophthalmology, ENT and Musculoskeletal (MSK) and gynaecology to deliver an increase in planned surgical productivity that reduces waiting times of over 52 weeks by end of Mar 2020. • Implement the national 'Choice' programme, on a specialty by specialty basis and based on an assessment of affordability delivered via a placed based approach. • By 2023/24 provide access to First Contact Practitioners (FCP) plus online digital support for all patients with MSK conditions across ICS via ICPs. • In line with the reduction in waits reducing the size of the overall waiting list to within the March 2018 out turn levels over a five year period.
	Place – Berkshire West Delivery
	The CCG RTT performance has deteriorated in 2019-20 as compared to 2018-19. This is due to a number of factors; national shortage of dermatology consultant which has impacted RBFT capacity in the year as mentioned above. In addition to this ENT and ophthalmology performance has remained challenging in both our acute and out of area providers leading to a drop in performance. It is to be noted that RBFT has achieved the national standard throughout 2019-20. There were twenty patients waiting over 52 weeks at the end of March at RBFT. As part of a deep dive review of the current ENT and Plastics booking processes a few referrals were identified as waiting over 52 weeks. Urgent clinical review is currently taking place for these patients. In addition to this in March due to COVID-19, routine appointments have been deferred until the crisis is resolved. These patients however will continue to be monitored on the PTL and dealt with on a priority basis when routine appointments at RBFT will be resumed. As the NHS moves through the COVID-19 pandemic in the first quarter of 2020/1 it is likely that RTT will be impacted on fairly significantly during this period. Recovery plans are now under development to review how services can be re-established safely with a view to capitalising on rapid transformation work that has taken place as a response to COVID.

9.6 Outpatient transformation	
Operating plan requirements	**System – BOB Delivery**
• Systems should ensure that advice and guidance arrangements/agreements are in place between secondary and primary care providers and in line with the 2020/21 national specification • For 2020/21, systems should begin the implementation of video consultation in major outpatient specialties so that all patients can access outpatient care without travelling to hospital. • Accelerate patient-initiated follow up in outpatient specialties and to be able to demonstrate progress against their 2018/19 position. • Engage with the development and mobilisation of elective High Impact Interventions which will be developed during 2020/21. • Continue to embed First Contact Practitioner (FCP) services, participate in the national evaluation process, and roll out FCP services more widely. By March 2023, FCP services will be available to the whole adult England	In June 2019 the BOB ICS (wave 3) had support approved for input from the NHSEI Elective Care Delivery Team for a pan system approach to improvement of its outpatient services which includes using digitisation as an enabler to improve access and efficiency. The key ambitions for the programme have been developed in line with delivery of the Long Term Plan (LTP) principles and includes: • Development of a clinically led and locally owned plan for a system wide reduction in a third of all face to face outpatient consultations with alternative models of delivery or a reduction in demand • Development of a work force plan that harnesses alternative delivery methods incorporating first line therapist interventions such as direct referral for GP's to specialist physiotherapists in gynaecology, increased utilisation of the nurse consultant and specialist nurse model as first contact practitioner and undertaking diagnostics • Establishment of a system wide best practice model for outpatient services that utilises digitisation and other technologies to maximum effect including Advice and Guidance and Patient Initiated Follow ups. • A review of clinical pathways in specific high demand services such as ophthalmology to streamline delivery, reduce unwarranted variation, improve access and improve the service user experience • Utilisation of the estate to maximum effect relocating outpatient activity outside of the acute sector and into localities • Develop and implement, through collaboration with our population, a system wide education and support programme that introduces new technologies and prepares users for its implementation. These aims will be achieved over a five year period, with an agreed implementation plan with support and coordination provided through the ICS structure. They will be implemented as part of place based improvement programmes.

population. In 2020/21 coverage will increase to 50%, with planned rises to 75% in 2021/22 and 100% in 2022/23. • Ensure that all hospital eye services can report compliance with the Portfolio of Indicators for Eye Health and Care follow-up performance standard.	**Place – Berkshire West Delivery** **Berkshire West transformation programme priorities include:** • Developing standardised process for running telephone and video clinics including process maps and SOPs, consistent recording of activity, payment. • Clear process to moving clinics off site including use development of online booking tool and clinic utilisation data to highlight opportunities for change. • Greater central input into room allocation and staffing decisions in OP estate. • Phased roll-out of best practice menu of evidence based new models for outpatient delivery; • Collection and monitoring of implementation plans by specialty; • Start piloting of interventions in BHFT – beginning with Patient Initiated Follow-ups. • Focused review of pathways in Ophthalmology, Dermatology, Cardiology, ENT, MSK and Dementia to consider what activity can be moved into the community as part of service redesign; • Programme of education and process improvement to reduce unnecessary referrals and improve the quality of remaining referrals. Development of options and business cases for three areas – Berkshire Cancer Centre, Adult ENT and Audiology and Therapies – to move the large proportion of outpatient activity to another RBH site. RBFT eye services are reporting compliance with the identified indicators, these are monitored regularly within the service and annual audits are also carried out.

9.7 Cancer

Operating plan requirements	System – BOB Delivery
Improvement against the 62 standard and delivery of 28 day faster diagnosis standard (FDS) – meeting the DS at the initial threshold of at least 70%. All trusts within the alliance to have in place processes and capacity for supporting patients to navigate cancer pathways and robust PTL management	Our approach forms part of the Thames Valley Cancer Alliance's (TVCA) 5-year strategy for cancer developed in response to the long term plan for cancer with a focus on our achievements to date, our challenges now and for the future and how we plan to address them. **Thames Valley Cancer Alliance** In response to "Achieving World Class Cancer Outcomes: Taking the Strategy Forward" and the NHS Long Term Plan, TVCA have published a 5-year Cancer Strategy (September 2019). This will continue to implement the key recommendations of the national strategy and those of the Long Term Plan in Thames Valley by 2024.

Implementing optimal timed pathways and identifying challenged pathways and prioritising these for improvement. Support the implementation of Faecal Immunochemical Test (FIT) in bowel screening with a demonstrable reduction in colonoscopies Implementation of personalised stratified follow up pathways for colorectal and prostate cancer by April 2021 and ensure at least two thirds of breast cancer patients benefit from stratified follow up. Improve the recruitment and retention of Clinical Nurse Specialists and cancer support workers and implement local plans to recruit additional clinical and diagnostics staff by 2021. Support improved uptake and performance in other cancer screening programmes, including cervical and breast.	**Place – Berkshire West Delivery** **Berkshire West** At a local level our Berkshire West ICP cancer ambitions reflect the national and Thames Valley priorities. It also takes into account the local needs of our Berkshire West patients. The strategic objectives include: 1. Promote healthy lifestyle choices to reduce cases of preventable cancers 2. Deliver all nine Cancer Waiting Time Standards 3. Increase number of cancers diagnosed at stages 1 & 2 and improve 1 year survival rates by improving access to diagnostics 4. Increase uptake of Bowel, Breast and Cervical Screening, especially targeting screening inequalities 5. Implement Vague Symptoms Pathway and RDC at RBFT 6. Ensure all newly diagnosed cancer patients have access to appropriate Personalised Support as part of the Recovery Package 7. Ensure RBFT have protocols in place for open access (risk stratified) follow up of Breast, Prostate and Colorectal patients 8. Increase number of patients supported to die in their place of choice (led by BWCCG Long Term Conditions Programme Board) The Berkshire West ICP Cancer Framework 2019-2024 will continue to drive the work locally to respond to operating requirements as well as locally defined challenges.
9.8 Maternity	
Maternity Services E.Q.1 – Reduction in stillbirth rate E.Q.2 – Reduction in neonatal mortality rate E.Q.3 – Increase in proportion of women placed on a continuity of care pathway E.Q.4 – Reduction in brain injury rate	The local maternity system was established across BOB in March 2017 in line with the Better Births Report: National Maternity Review published in June 2016. However, this development builds on a history of co-production working across the Thames Valley. The BOB Local Maternity System Delivery Plan for 2017-2021 was published in February 2019 and all organisations continue to work together to deliver the activities specified in that plan. Key activities for the year ahead will be a continuing focus on the delivery of the specified priorities namely: • Workforce; particularly the focus on midwifery requirements at each Provider Trust • Digital; including the aspiration to ensure that women have a maternity digital handheld record • Better Births / Long Term Plan; working collectively to achieve the KLOEs required • Personalisation; over the year ahead a continued focus on ensuring all women have a PCP

	• Continuity of Carer (as above) • Saving Babies Lives; ensuring that each provider is working towards compliance with v2 • Perinatal mental health; continuing the development of work in this area • Infant feeding; continuing to improve provision in provider and community settings • Preventing smoking in pregnancy; working collaboratively to improve assessment and actions • Access to postnatal physiotherapy; reducing variation between our providers in this area In the year ahead, there is specific risk associated with the delivery of E.Q.3, the number of women placed on a continuity of care (CoC) pathway. The BOB LMS has made slow progress on delivering the national targets to increase the proportion of women placed on a continuity of carer pathway. Progress was impacted by a low starting point of only 8% across BOB, due to midwifery teams not set up to deliver services in this way and proposals to deliver the COC ask in Bucks (who were on 0%), requiring large scale staff consultation. Good progress is now being made, with BOB LMS achieving 20% of women on a continuity of carer pathway by April 2020 and robust plans reviewed and approved by the BOB LMS to deliver 35% by April 2021. Continuity of carer teams have been established or are due to go live imminently in the most deprived wards, with high BAME populations to ensure mothers that have been identified nationally as having the poorest outcomes are being targeted to receive continuity of carer as a priority. All 3 Trusts delivering midwifery services across BOB are now working hard to develop their plans to deliver the 51% target by April 2021, but this is a risk area for BOB, that has been highlighted to NHSE. Bucks have been partnered with Dorset as part of the NHSE 'Buddy programme' and NHSE are currently looking for potential buddies for Berkshire West and Oxford to try and support our progress in delivering this challenging target.

9.9 NHS public health functions and prevention	
Operating plan requirements	**System – BOB Delivery**
Support an additional 25,000 people lose weight and reduce their risk of diabetes through the Diabetes prevention programme and pilot low calorie diets at scale to support people with existing Type 2 diabetes achieve remission. NHS population cancer screening, non-cancer screening and national immunisation programmes are delivered optimally to the population. Expand alcohol care teams and roll out smoking cessation support for inpatients and maternity services.	Each of the Integrated Care Partnerships (ICPs) within the BOB ICS has developed plans for tackling the incidence and impact of Long Term Conditions (LTCs) in place. Plans to date and specifically those that have focussed on Cardiovascular Disease, Stroke, Diabetes, Respiratory Disease and Obesity include prevention, identification of those patients at high risk of developing LTCs and optimal management, all underpinned by empowerment of patients through supported self-care. The National Programmes in disease categories such as Diabetes are long established and are realising benefits. We will review and streamline pathways to remove some of the artificial barriers between primary, secondary, mental health and community care so that services and support is wrapped around the patient. We will provide a programme of education and training across all LTCs that supports professionals and patients involvement in development of new models of care that will include: • Prevention – A key pillar of the ICS LTCs programme including primary interventions (preventing the illness) secondary (reducing the impact) or tertiary (delaying the impact). • Personalised care – We will personalise care for the individual and their families to provide care closer to their homes and support them with digital tools and education to empower patients to better manage their conditions. We have a strong foundation on which to build rolling out work undertaken in Diabetes • Integrated Care – linking care and access to care records across primary care, primary care networks , secondary and tertiary care and the broader ICS where care for patients with LTCs crosses boundaries particularly where there are multiple comorbidities to be managed • Digitisation of pathway elements • Improved awareness of health and wellbeing - people with LTCs are more at risk of depression and anxiety • Streamlining of the whole disease pathway that enables timely care and shortens waiting times for planned aspects of care.
	Place – Berkshire West Delivery
	Berkshire West has a multifaceted approach to support individuals to manage their health effectively and prevent diabetes. The CCG is working to develop a Diabetes Dashboard using real time data to enable primary care to work more productively with those with diabetes and at risk of developing the condition. As

	the dashboard is integrated into practice as part of everyday working, there will be support given to encourage practices to use the dashboard to identify those at risk of diabetes through a locally developed diabetes toolkit. Practices will be supported to complete a self-assessment against specific quality markers aiming to increase referrals to the NDPP programme for those identified at risk of developing diabetes. This work will be further supported by visits from the Diabetes Clinical leads to all the Berkshire West Practices. The current pre-diabetes CES ensures that the most appropriate patients are referred to NDPP depending on their HBA1c levels and the NDPP referral criteria. Berkshire West is working with Thames Valley Cancer Alliance (TVCA) to improve local cancer screening rates in Primary Care. This is to ensure that we deliver against the key cancer ambitions of the NHS Long Term Plan – namely, to improve five year cancer survival and increase early stage cancer diagnosis. Using transformational funding from TVCA, Berkshire West CCG are rolling out two initiatives in Primary Care – the Quality Improvement Scheme (for all GP surgeries) and the Cancer Quality Award Scheme (for one PCN pilot site). Both projects require the local practices to look at their current screening rates & then to carry out QI activities in order to encourage further screening uptake. Within both schemes there is a strong element of looking at ways to increase screening in traditionally low uptake screening groups, which is another key theme across the NHS Long Term Plan. In addition, Berkshire West CCG work with Rushmoor Healthy Living and Macmillan to support the local Cancer Champions in South Reading. These Champions raise cancer awareness in the local population, including the BAME and LGBTQ+ communities. This gives these communities, which are often low uptake screening groups, a better understanding of cancer and the importance of screening. The Cancer Champions also work with local PPGs to raise screening awareness amongst patients and the community. The Cancer Champions were recruited as part of the Macmillan South Reading Project (in 2017), looking to increase screening in low uptake groups and therefore improve cancer survival. This project will now be extended across the Berkshire West CCG patch for 2020/21, with the CCG working closely with Macmillan, the Royal Berkshire NHS FT and Rushmoor Health Living. For 2020/21, the CCG will also support any national cancer awareness campaigns, e.g. Stoptober, by disseminating promotional information to GP Practices and members of the public. One of the key aims of these campaigns is to increase screening in the local population.

Appendix 1 – BOB ICS Governance