NHS North and West Reading Clinical Commissioning Group

NHS Newbury and District Clinical Commissioning Group

NHS South Reading Clinical Commissioning Group

NHS Wokingham Clinical Commissioning Group

Operational Plan 2016/17 Executive Summary

Wokingham, Newbury and District, South Reading and North and West Reading Clinical Commissioning Groups

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1. Strategic Context and key challenges

This document reflects the Berkshire West CCGs unit of planning and sets out our high level Operational Plan for 2016/17. This plan is supported by a suite of documents including our Financial Strategy, 16/17 Activity plans, Dementia Action plan, Cancer recovery plan, and the Systems resilience plan. This Operational plan sets out our priorities for the coming year in the context of the NHS England planning guidance, forming year one of the emerging Sustainability and Transformation Plan (STP), and which builds on the Berkshire West CCGs strong track record of financial and non-financial performance.

The Berkshire West CCGs are collectively recognised as a high-performing and benchmark well nationally on a number of key performance measures, including non-elective admission rates and prescribing. We are also recognised across Thames Valley and nationally for leading the development of innovative approaches to improving clinical care and patient experience e.g. Diabetes Care, Stroke care, and Improving Access to Psychological Therapy services.

Nevertheless, like other health and care systems we recognise we are facing increasing operational and financial challenges. Within that context we acknowledge that although individual sectors largely perform well, the overall experience of services for our residents can sometimes be uncoordinated and fragmented, and that the current design of the system and services means that people are often driven into higher and more costly levels of care than their needs determine. This fragmentation of care can impact on both the citizen's experience and outcomes, and is a poor use of public money**.** Health and social care partners in Berkshire West are therefore committed to developing, testing and implementing innovative approaches to new ways of working and in delivering our shared vision for our system as a key foundation on which to build.

By 2020/21, our vision is that enhanced primary, community and social care services in Berkshire West will have a developed service model which prevents ill-health within our local populations and supports people with much more complex needs to receive the care they need in their community. People will be supported to take more responsibility for their health and wellbeing and to make decisions about their own care. Care providers will share information, and use this to co-ordinate care in a way that is person centred, and reduces duplication and hand-offs between agencies.

This vision is underpinned by the principle that people will only be admitted into hospital, nursing or residential homes when the services they require cannot be delivered elsewhere. All the services that respond to people with an urgent need for care will operate together as a single system, ensuring that people with urgent but not life-threatening conditions will receive responsive and effective care outside hospital.

2. New Models of Care and Sustainability

2.1 Berkshire West Accountable Care System (ACS)

The Berkshire West system has been working as the Berkshire West 10 (BW10) comprising of 4 CCGs, 3 local authorities, Royal Berkshire NHS Foundation Trust (RBFT), Berkshire Healthcare Foundation Trust (BHFT) and South Central Ambulance Trust (SCAS) for some time within a shared governance structure. The Berkshire West system first came together as an agreed footprint back in 2013 with the submission of our Integration Pioneer bid, and has continued to capitalise on this with the development of a Berkshire West Integration Programme. The Integration programme identified three priority areas of work following an initial review of demand and capacity across the health and social care system; these are Frail Elderly, Children and Young Peoples services, and Mental Health. We have subsequently further prioritised joint work on a Frail Elderly Pathway which will report back in March 2016, with the findings and actions to be used to inform further pathway redesign and the exploration of new approaches to funding in the current Better Care Fund planning and health provider contracting round.

To meet our challenges and overcome the barriers to change in the current system, Berkshire West is proposing to establish a New Model of Care and to operate as an ACS. The ACS is a collective enterprise that will unite its

members and bind them to the goals of the health system as a whole. In so doing we will hold ourselves collectively to account for delivering the necessary transformation of services and in getting the most out of each pound spent on the NHS within Berkshire West.

The key characteristics of our ACS will be:

- We will support our population to stay well through preventative care which considers the lives people lead, the services they use and the wider context in which they live
- We will improve patient experience and outcomes for our population through delivery of a Berkshire West Shared Strategy
- we will get optimal value from the 'Berks West £' by organising ourselves around the needs of our population across organisational boundaries, working collectively for the common good of the whole system
- clinical decision-making and service developments will drive proactive management of care and provision of care in the most effective settings, underpinned by a payment system that moves resources to the optimal part of the system
- finances will flow around the system in a controlled way that rewards providers appropriately and helps all organisations achieve long term financial balance by unlocking efficiencies in different parts of the system; incentives will be aligned and risks to individual organisations will be mitigated through the payment mechanism
- we will develop and use long term contracts to promote financial stability of the providers
- it will be governed by a unified leadership team comprising all commissioners and providers, with delegated powers from the constituent organisations.

The three Local authorities in Berkshire West have given their support to health colleagues fast tracking the development of a new model of care which will enable further integration with social care over the medium term. The objectives of the ACS programme are aligned with the wider BW10 integration programme and support the delivery of Health and Well Being Strategies. The implementation of the Five Year Forward View requires the production of Sustainability and Transformation Plan (STP), see below, and the development of an ACS for Berkshire West will be at the heart of the Thames Valley plan (see section 2.2) and will be the vehicle for delivering the service transformation locally that will lead to wider financial sustainability.

The key objectives of our ACS will be to:

1. Improve individual and population health, promoting primary and preventative care and reducing the requirement for more costly care. The ACS will require a strong public health and health promotion component to be effective in this area.
2. Improve people's experience of care by providing transformed, more integrated pathways of care with minimal hand offs between different parts of the system
3. Achieve financial balance at a system level through redesigned pathways and optimal models of delivery, supported by shared cost effective back office mechanisms, providing public confidence in the local NHS

In its first year the ACS will need to achieve two key deliverables: the production of a multiyear Berkshire West Shared Strategy and an underpinning system wide financial model which demonstrates how the transformation strategy will deliver financial sustainability.

The proposal is that social care could be included in the ACS in a subsequent phase of the programme and this has the support of all three Local authorities. This allows time for the three local authorities to pursue the development of a joint commissioning unit on the same Berkshire West footprint.

The ACS Programme will be managed against a clear documented project plan and a risk and issues log maintained. The programme management approach will be underpinned by partnership working and a communications and engagement plan to ensure all stakeholders are kept up to date.

2.2 Development of a Thames Valley Footprint STP

The CCGs with colleagues from Buckinghamshire and Oxfordshire (BOB) are working together as requested by NHS England to scope an umbrella Thames Valley Sustainability and Transformation Plan (STP). The proposed footprint presents a number of risks, issues and opportunities which the respective Chief Officers and Chairs will consider over the coming weeks. The key concern is to ensure that such an approach would not have an adverse impact on the local plans for an Accountable Care System.

Once agreement on the footprint has been reached, the organisations concerned will need to undertake considerable work to prepare for and deliver the STP. This will include agreeing governance arrangements as well as undertaking further analysis of current gaps across the domains of health and wellbeing, care and quality and finance and efficiency; identifying key priorities for addressing these before Easter. After Easter the focus will be on the detailed development of a plan which must cover the nine initial 'must-dos' described in the planning guidance as well as setting out a broader platform for transforming local health and care services in accordance with a number of key national parameters.

West Berkshire, Oxford and Buckinghamshire CCGs (BOB) remain committed to our main transformation programmes being at CCG or unit of planning levels, focussed on our key service providers of secondary, community, mental health and primary care as these cover the majority of demand from our local population's health needs. This has led to very different approaches across the wider STP footprint, including one devolution bid and one ACS model.

Whilst we clearly have very different approaches to our transformation programmes, we have identified key areas of our transformation that should be undertaken at BOB STP scale.

In summary, those are:

- Specialised commissioning (note that this is wider than the BOB footprint)
- Workforce
- PLCV and Priorities
- Primary Care provider development
- CSU support
- Urgent & Emergency Care
- Digital Innovation

These have been mapped to the three identified gaps, for clarity and range from transformational work at scale (e.g. digital innovation and interoperability) through to areas where it makes sense to share learning to hasten wider implementation, such as primary care provider development.

BOB Alliance - Forum for STP Development Oversight

The BOB AOs and Chairs meet monthly and it is this meeting that will oversee the development of a robust STP. This group will:

- Track progress of STP development, ensuring ongoing alignment with local strategies
- Oversee the aggregation of all local engagement with stakeholders & populations
- Identify further opportunities for BOB scale work to gain maximum efficiencies
- Ongoing monitoring of the work streams above and any further opportunities identified

Draft governance arrangements for this Alliance are in the process of being developed and are going through CCG governance sign-off. These arrangements will ensure effective system governance to oversee both the short and longer term objectives.

3. Financial sustainability

3.1 Local context

The Berkshire West CCGs remain as some of the lowest funded commissioners in England on an allocation per person measure (£1,047 compared to a national average of £1,221), and remain underfunded when compared to their target allocations by approximately £20 a person (i.e. £10m in total). The target allocation of the Berkshire West CCG (if it existed) would be £1,067 per person, the second lowest in the South of England area.

Allocations and growth for 2016/17 are as follows:

	Newbury	N&WR	SR	Wok	BW CCGs total
Baseline 16/17 - £m	131.0	125.4	135.3	172.1	563.8
Primary care 16/17 - £m	14.0	13.7	18.2	18.1	64.0
Growth in above baseline - £m	3.8	5.6	7.2	5.0	21.6
% growth	3.05%	4.78%	5.75%	3.05%	4.07%

The key financial targets for the BW CCGs in 2016/17 are:

- Achievement of I&E surplus of the greater of 2015/16 surplus less any agreed drawdown or 1%;
- Achievement of agreed QIPP plan;
- Commitment of only 99% of resource recurrently in 2015-2016, and for this budget to remain uncommitted at the planning stage.
- Contingency of 0.5% set aside.
- Commitment to an increase in funding for mental health in line with our percentage increase in allocation for 2016/17.
- Manage within our running cost allocation
- Payment to suppliers in line with the Better Payment Practice Code;
- Management within agreed cash limit; and
- Demonstrating value for money.

The four Berkshire West CCGs plan to comply with each of these requirements.

3.2 Alignment with activity and growth assumptions

All trust contracts will as a starting point use estimated 2015/16 outturn as the starting point for 2016/17 contract negotiations.

The CCG has used the same activity assumptions for the finance and activity components of the plan. In 2016-2017, activity growth will be agreed with each provider based on local circumstances. Initial discussions with the main acute provider (RBFT) and also upon review of the Indicative Hospital Activity Model (IHAM), suggest that overall activity growth will be approximately 2% overall with some areas of emergency activity growing by up to 4%.

The assumptions have been made on a Berkshire West basis rather than at CCG level to account for small number variations and to align to the way the CCG commissions services across Berkshire West. These assumptions still require further work and we still need to understand non-recurrent elements of growth for elective care to reduce waiting list backlogs, especially for cancer services. The CCGs have not modelled in the transformational QIPP changes into the activity models due to further detailed work being required, although this has been done for the

financial plan. Further testing of the growth assumptions is required, especially for non-elective care, compared to what happened in 2015/16 and the CCG has commissioned a specific piece of work to support this.

3.3 QIPP and Efficiency

It is recognised that the delivery of QIPP plans is a necessary lever to ensure real change to safeguard future financial stability and it is our intention to establish realistic and achievable levels of QIPP and efficiencies within the system. The QIPP gap has been identified for the CCGs for 2016/17, and amounts to £16m in total, which is 2.8% of allocation.

In order to drive the achievement of QIPPs in 2016/17, a new Planning and Transformation team has been recruited (previously outsourced to the South Central and West CSU) and over the last 3 months the focus has been on developing new processes and governance structures which are now embedded across the organisation. Each QIPP scheme is supported by a full suite of documentation, including PIDs and Quality & Equality Impact Assessments and delivery is overseen through both the new QIPP Operational Delivery Group and strategically through the CCGs QIPP & Finance Committee each month.

Schemes are being developed to meet the QIPP gap and these are shown in the table below. Other schemes are under development to close the financial gap, and currently the schemes yet to be identified amount to £6m.

Scheme name	Net saving £m
Frail Elderly	1.2
Care homes	1.2
Business rules	1.6
MSK	0.9
Placements	0.7
Meds management	0.7
Planned care	0.8
Better Care Fund	0.6
Ophthalmology provision	0.3
Referal variation	0.5
Urgent care	0.2
End of life	0.3
Respiratory	0.4
Other Long term conditions	0.6
Innovations in electives	0.2
Other schemes	0.6
	10.8

3.4 Parity of Esteem

Planning guidance set out the requirement for CCGs to invest further in mental health services to endure parity of esteem between mental and physical health services. Berkshire West CCGs have committed to investing in line with their increased allocation.

The increased investment of up to £2.4m will be utilised in a number of organisations within the health economy including Berkshire Healthcare NHS FT, Royal Berkshire Hospital NHS FT, CCGs and Primary Care.

3.5 Moderating demand

Despite a number of initiatives and schemes being put in place during 2015/16 to reduce non-elective activity the system has seen unprecedented activity growth in non-elective activity. Although some of this can be explained by the introduction of a short stay Observation Unit at the RBFT this by no means explains growth of in excess of 10%.

This activity has been in part paid for from the Performance Fund identified in the BCF and if not effectively managed and contained will increase financial unsustainability.

3.6 Improving health

The CCGs recognise the importance of prevention and health promotion in reducing the ultimate demand for healthcare. Effective, evidence-based prevention, addressing the lives people live, the services they access and the wider context in which they live will require co-ordinated action and the CCGs are working closely with Local Authority colleagues to ensure these services are delivered effectively across Berkshire West. This collaborative approach is exemplified by the Prevention Working Group, part of the BW10 Integration Programme, which will enable identification and sharing to develop best practice across the region and will support the development of health promoting health organisations.

3.7 Accountable Care System

The current profile of service provision in Berkshire West is not sustainable and this position will worsen unless action is taken to address the challenges set out above, promoting primary and preventative care.
In 2015/16 and 2016/17, our system is forecasting an overall deficit:

	2015/16 (deficit)/ surplus forecast (£m)	2015/16 (deficit)/ surplus as a % of turnover	2016/17 (deficit) forecast (£m)
Royal Berkshire NHS FT	(9)	(2.40)	(11)
Berkshire Healthcare NHS FT	(2)	(0.85)	(8)
South Central Ambulance Service NHS FT	(4)	(2.10)	TBC
Berkshire West CCGs	5	0.90	(16) QIPP Gap
Total	**(10)**		**(36)**

NB This is prior to the control totals provided by NHSI to providers

The local health economy financial baseline shows that the size of the LHE financial challenge is set to grow significantly. Work undertaken across the health authority last year (currently being refreshed) shows the scale of the challenge by FY19.

	FY15	**FY16**	**FY17**	**FY18**	**FY19**
BHFT CIP cumulative total is **£41.5m**	£8.6m	£12.6m	£6.2m	£6.8m	£7.3m
BHFT CIP target as % of income	3.9	5.8	2.8	3.1	3.3
RBFT CIP cumulative total is **£77.9m**	£18.5m	£16.9m	£15.2m	£13.6m	£13.7m
RBFT CIP target as % of income	5.3	4.7	4.1	3.6	3.6
Commissioner cumulative net QIPP (RBFT)	£6.1m	£11.9m	£16.8m	£21.1m	**£24.8m**
Commissioner cumulative net QIPP (other)	£1.5m	£3.4m	£5.1m	£6.6m	**£8.0m**
Combined CIP and QIPP challenge (FY19)					**£152.2m**
Stranded costs at RBFT through alignment of plans					£4.3m
LHE challenge, assuming plans are aligned (FY19)					**£156.5m**

(Source: Berks West Clinical Strategy Programme LHE Financial Baseline, June 2014)

3.8 Primary Care

As CCGs we have already invested £5m in primary care over the last two years in CESs to enhance extended hours provision (see above) and maximise the impact of care planning and ensure we provide proactive support to care homes. We have also developed a plan for the reinvestment of PMS premium monies through a Quality CES which will be developed on an incremental basis over the next five years, reflecting the role that we need primary care to play in the delivery of our strategic objectives. We are exploring the affordability of commissioning such a CES in the CCGs which do not have PMS premium funding.

As we take on fully-delegated responsibility for commissioning primary medical services we will be working to ensure that the delegated budgets we receive are used to maximum effect to commission high quality care for our population. We will also be working with NHS England through the PCTF bidding process and other capital allocation mechanisms to ensure investment in the premises schemes and technological developments which we have identified are a priority for the delivery of our overall strategy for primary care.

3.9 Better Care Fund (BCF)

Over £25m has been invested from health monies into the pooled budgets creating the Better Care Funds of the 3 Local Authorities, £15m of which was new investment in 2015/16. Section 75 agreements have been put in place for the management of the overall pooled budgets of £27m.

The CCGs are currently working with local authority partners to evaluate the schemes funded through the BCF during 2015/16 and to agree their plans for the coming year. The requirements set out in the Better Care Fund Planning Requirements for 2016/17 received on 23rd February issued by NHS England will be considered in the development of local plans. Local areas are also expected to maintain the progress made around 2015-16 BCF metrics including admissions to residential and care homes, patient experience, effectiveness of reablement and delayed transfers of care. Details of the final plans will be included in our planning submission on 21st March and in the final plans which will be submitted on 25th April. Approval of the final BCF plans will be via the individual Health and Wellbeing Boards (March for West Berkshire and April for both Reading and Wokingham).

Examples of achievements in 15/16 include:

- Working through the BCF Wokingham has supported the recruitment and training of 12 volunteer navigators to support patients to access the right services and reduce demand on GP appointments, by delivering social prescriptions and guiding patients to voluntary organisations who can support their needs
- In Reading the CCG have funded a Full Intake Model which aims to increase community reablement team capacity offering admission avoidance, reablement and support to the "discharge to assess bed base". The "Discharge to Assess" service has been expanded to 12 beds including for older people with mental health conditions such as dementia
- In West Berkshire the Joint Care Provider Project (incorporating seven day working and direct commissioning by specified health staff) has led to a more cohesive service which will reduce duplication, improve access and increase capacity.

4. Primary Care

A strong and effective primary care sector is acknowledged to be a critical aspect of an effective and high performing health care system. The challenges of increasing demand from elderly and frail patients living with multiple and complex chronic diseases is placing an increasing strain on practices and how they respond over the next five years will be crucial to the delivery of our Operational Plan.

Over the last 18 months we have engaged the public, partners and member practices in the development of a detailed Primary Care Strategy. Our Primary Care Strategy clearly defines the following 'asks' of primary care:

- Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting.
- Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home.
- Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and appointments are available in the evenings and at weekends.
- Making effective referrals to other services when patients will most benefit.

The implementation of our Primary Care Strategy is overseen by our Primary Care Commissioning Committee which includes representatives of all four CCGs. A quarterly programme report incorporates progress on both Berkshire-West wide work streams and projects undertaken within individual CCGs. In this way, learning from local projects can be shared across the four CCGs and synergies and further opportunities for joint working can be identified.

Key work streams are described in the following sections.

4.1 Sustainability

Across the 4 CCGs we are supporting practices to explore opportunities to work together to create efficiencies and achieve sustainability and are using commissioning levers to align incentives with these models. Below are examples of the CCG specific areas of work we will be focusing on over the coming year.

In South Reading (where there are a large number of smaller practices) our vision for the future of primary care is that we will see a smaller number of providers, working in merged or federated arrangements likely to include hub and spoke models. We envisage that each of these will serve a population of 25,000 - 30,000 patients. Two such provider units are already emerging. We intend to use a proportion of our released PMS premium funding, together with NHSE's vulnerable practice funding to progress this work.

In Wokingham as a CCG we are supporting practices to explore opportunities to work together to create efficiencies and achieve sustainability and are using commissioning levers to align incentives with these models. Our neighbourhood cluster model has created three clusters of practices, each serving a population of 40-60,000 patients, and practices within these clusters are now considering shared posts, pooled back office functions and a joint approach to meeting on-the-day demand.

In North West Reading CCG it is our intention that current procurement exercises will stabilise two practices where there has been a turnover of providers; putting in place contracts that closely reflect our broader primary care strategy.

Newbury and District CCG practices are exploring opportunities to work together to address current pressures particularly around workforce, and are already training a new role called a GP administrative assistant intended to free up GP time and are also piloting clinical pharmacists in practice.

The JPCC will take an oversight role in assessing the impact of these differing approaches and the impact these have on delivery of the Berkshire West Primary Care Strategy.

The Quality Dashboard that we are currently developing for primary care will allow improved comparison with local peers and national figures, thereby enabling a more detailed assessment of variation and inequalities. This will build upon an earlier risk mapping exercise which considered the potential vulnerability of practices based on a range of metrics including CQC visit outcomes, staffing issues, the standard of practice premises and financial status. We are

using this information to support discussions with practices regarding options for future sustainability and in considering priorities for Primary Care Transformation Fund bids and other potential sources of investment.

In addition, where we have had practices rated 'inadequate' by the CQC we are working with NHS England to support these practices to make the necessary improvements and to put in place contingency plans where required.

4.2 Workforce

We are currently developing a detailed programme of work to respond to primary care workforce issues, led by a working group reporting to the Primary Care Commissioning Committee. This will consider workforce planning, recruitment and retention of GPs and other staff, innovative approaches to training and CPD and workforce diversification. We will ensure we consider links with the 10 point plan for GP recruitment and retention as part of this. We will also give further consideration to how we can maximise the impact of retainer placements.

We have worked with the University of Reading, BHFT and RBFT to establish a local training programme for Physician Associates. A number of our practices are hosting training placements and will be supporting their first student over the coming weeks. One of the working groups of the Joint Primary Care Co-commissioning committee will be leading on workforce development including workforce planning, recruitment and retention, training and CPD, workforce diversification including scoping the opportunities for expanding the range of professionals offering primary care services such as pharmacists, a specialist GP role for care home patients, and extending the roles of health care assistants and practice nurses supported by appropriate accredited training and development programmes. As part of this we are exploring the potential to collaborate with Health Education England Thames Valley to develop a primary care training hub in Berkshire West.

4.3 Managing Demand

We recognise the need to develop a more robust approach to managing demand in primary care and therefore the CCGs are proposing the creation of a joint sub group of the Joint Primary Care Co-commissioning Committee and the Innovation technology and Information systems Programme Board with the purpose of scoping and developing a work plan which aims to address this challenge in Berkshire West. This will include:

- Exploring how we utilise IT to maximum effect to give patients the opportunity to access primary care in new ways thereby enabling practices to better manage demand
- Exploring opportunities for greater self-management by patients, including automating elements of QOF as well as for joint working on urgent access.
- Maximising opportunities around self-care of self-limiting illness, including through the use of symptom-checker and GP triage apps.
- Developing a pilot in Wokingham CCG for NHS111 direct booking into in-hours Primary Care
- Exploring collaborative models which will ensure enhanced access to Primary Care across the week including Sundays and which build on the current CES, and take into account the workforce capacity challenges.

4.4 Premises

There will be further development of our Estates Strategy including detailed planning around areas of population growth and maximising CIL/S106 contributions. Our Primary Care Transformation Fund bids reflect additional facilities likely to be required as a result of population growth.

Our priorities for primary care premises investment reflect the need to respond to significant projected population growth, particularly in Wokingham CCG, and to ensure our 'up scaled' providers work from modern, fit-for-purpose premises which support the delivery of an extended range of services in primary care. Our Primary Care Transformation Fund (PCTF bids) will reflect these priorities, focussing on a small number of larger schemes we expect to be required over the next 2-3 years. We have also reviewed the findings of the six-facet premises survey

undertaken by NHS England and assess schemes proposed by practices against this as well as in the light of projected population growth.

As set out above we are currently considering how we can expand extended access provision beyond current commissioned levels and will review premises and technological implications as part of this. As set out in our submission, our Connected Care procurement includes a patient portal which will underpin delivery of self-management and triage approaches. As we pilot NHS 111 direct booking and collaborative working around 7-day routine provision and meeting urgent care demand we will be considering the role of technology within this, including ensuring we maximise the benefit of online access, self-management and remote triage.

5. Prevention

Strong public health and health promotion are core components to delivering an effective ACS. The CCGs will continue to work closely with Public Health to place greater emphasis on prevention and putting patients in control of their own health; we will use the individual CCG Public Health profiles (see supporting documents) to inform local priorities in addressing health inequalities. These profiles show that life expectancy for both men and women are significantly better than the national average within 3 of the 4 Berkshire West CCGs. In contrast, South Reading CCG's life expectancy is significantly worse than the national average (2 years less for men, 1.2 years less for women).

Potential Years of Life Lost (PYLL) is an indicator of premature mortality and shows the number of years not lived by an individual from birth to 75. A death is considered amenable if, in the light of medical knowledge and technology at the time of death, all or most deaths from that cause could be avoided through good quality healthcare. In 2012-14, the England PYLL rate was 2,032 per 100,000 population. Both Newbury & District CCG and Wokingham CCG's rates were significantly better than the national level and the two Reading CCGs had similar rates. All of the Berkshire West CCGs had similar or better rates of PYLL to their respective CCG comparator groups. The main cause of PYLL in England was ischaemic heart disease. The main cause across all of Berkshire West CCGs was neoplasms, with ischaemic heart disease as the second main cause.

Complimenting existing activity the cross-organisation BW10 Prevention Working Group will develop a comprehensive plan for prevention to support the sustainability of the Berkshire West Health and Social Care system. We will continue to promote healthy lifestyles and target the leading risk factors for ill-health in partnership with Public Health to decrease numbers of smokers and decrease levels of alcohol consumption, increase levels of physical activity, detect people with high blood pressure and cholesterol, and reduce obesity in children and adults by increasing the uptake of the NHS Health Check Programme and referring into local services e.g. Eat 4 Health. Local practices have been tasked with increasing referrals by 25% and are on track to deliver this target with 67 referrals in Q1, health walks, recording alcohol consumption and supporting a reducing alcohol intake through brief interventions and signposting.

Health promoting schemes that we have funded in 15/16 and will continue to fund during 16/17 include the Eat4Health and 'Beat the Streets' programmes. This year 23,992 people took part in Beat the Streets (including 12% of patients with LTCs) and walked 306,599 miles. This is a 63% increase in participants from when the project was first piloted in 2014. At the beginning of the project 40% of people reported meeting the Department of Health's guidelines for levels of activity (30 minutes of physical activity for five or more days per week). By the end of the project, this had increased to 48%. 78% of participants said they would try to continue the changes they had made. In 2015/16 North & West Reading CCG commissioned Age UK to deliver a 'Living Well' pilot which provides upstream interventions for older people not requiring medical or nursing care to support improvements in wellbeing and reduce avoidable GP appointments, A&E attendances and 999 contacts. Results from the first 2 quarters of the pilot show that wellbeing has improved by 28% and that there has been a 30% reduction in GP appointments, 50% reduction in A&E attendances and 50% less 999 contacts.

5.1 Obesity and being overweight

Berkshire West CCGs have a recorded obesity prevalence rate of 7.0% in the registered population aged 16 and over, which is approximately 29,472 people. This prevalence rate varies between the CCGs, from 6.6% in Wokingham CCG to 7.4% in North & West Reading CCG. However, these are all lower than their respective comparator groups and the national prevalence rare of 9.0%.

Adults with a Body Mass Index over 25 are defined as being overweight. Figures collected through the Active People Survey (2012-2014) estimate that 64.6% of adults living in England are overweight or obese. All of the Berkshire West LAs have a lower level of adults with excess weight and Reading's is significantly lower at 61%.

Key objectives across Reading's Healthy Weight Strategy will be to ensure that people in Berkshire know how to achieve and maintain a healthy weight, are able to choose a healthy diet and can become more physically active in everyday life. In children, there is a significant link between being an overweight or obese child and becoming an obese adult. Establishing a healthy weight and healthy lifestyle habits in early years will help to create the blueprint for life. A focus will be given within the strategy to evidence based interventions and recommendations for the prevention and management of childhood obesity across the CCG area, including schemes to improve facilities for cycling and walking; encouraging active play, minimising sedentary behaviour and the provision of healthy catering in early year's settings and appropriate referral to and endorsement of weight management, physical activity and healthy eating programmes.

We will commission during 2016/17 a Tier 3 weight management intervention service in line with the NICE guidance (CG 189, 2014). Tier 3 services form an important part of the weight management pathway and provide a more specialist intervention delivered by a multidisciplinary team with the aim of reducing mortality rates and levels of co-morbidity associated with clinical obesity. The social and psychological benefits are well known. The objective is to commission an effective and accessible weight management intervention service for patients (with or without co-morbidities) who have already been through an appropriate Tier 1 and Tier 2 weight loss service including nutrition and physical activity advice and psychological approaches to behaviour change.

In addition to obesity services those at risk of developing diabetes will be referred and managed under the National Diabetes Prevention Programme and working with Public Health we will be promoting a cross Berkshire digital campaign which builds on the successful Change for Life programme.

The prevalence of obesity in children as measured though the National Child Measurement Programme (2014/15) show that the prevalence of obesity in Reading is similar to the national average for both ages four to five and ten to eleven, while Wokingham and West Berkshire's are significantly better. The Reading CCGs have committed to working in partnership with the Public Health team to deliver the Beat the Street competition for the third year running, and to explore wider opportunities to collaborate with Primary Care, Maternity services, Health Visiting, School Nurses and Schools to address this issue. We have re-procured programmes to support children who are overweight (Let's Get Going) and within West Berkshire we are piloting an active schools programme from 0-19 years to increase levels of activity. In addition working with Public Health we will review the awaited children strategy and develop an action plan based upon this.

5.2 Alcohol

In 2013/14, there were over 333,000 alcohol-related hospital admissions in England, which equates to 645 admissions per 100,000 population. Three of Berkshire West's CCGs had significantly better rates of admission than the national figure, ranging from 366 in Wokingham CCG to 493 in Newbury & District CCG. South Reading CCG's admission rate was similar to England's at 597 per 100,000 population.

Public Health England has estimated the increase on average life expectancy for men and women at a local level if all alcohol-related deaths were prevented. This ranges from 7 to 16 months for men and 3 to 5.5 months for women in the Berkshire West CCGs.

In 2016/17, we will be commissioning a new Alcohol Specialist Nursing Service for people who present and/or are admitted to hospital for alcohol related harm. This will support better management of patients presenting at the ED department at the RBFT with alcohol related problems by ensuring that there are clear pathways into both primary care and specialist drug and alcohol services, and provide a rapid response assessment and triage to avoid delayed discharges and avoidable hospital admission. The service will link with the appropriate community services for on-going community treatment and support to reduce re-attendances at ED. The service will also provide education and training to acute and Primary Care clinicians to enable better manage patients with chronic and acute alcohol problems.

In addition, we will be taking part in the Public Health England led improvement programme reviewing the current pattern of services against best practice. This will support the development of our 5 year action plan to address the impact of alcohol across West Berkshire.

5.3 Cholesterol and Blood Pressure

QOF data and Right Care data demonstrate that once detected primary care intervention for high cholesterol and/or blood pressure is effective; however there remains a low level of ascertainment of patients that would benefit from intervention. The national NHS Health Check Programme aims to prevent vascular disease, by inviting eligible people to an assessment of risk of developing a vascular condition. They are then given advice and support to help them manage or reduce any risks identified. GP Practices are the main providers of Health Checks nationally and all of the West of Berkshire LAs have Primary Care Contracts in place with their CCGs to provide this service.

Berkshire West CCG GP Practices completed 22,736 Health Checks from 1st April 2013 to 31st Dec 2015, which equated to 15% of the eligible registered population. The uptake in England over this time was 25%. The local uptake is lower than the national figure and also lower than the apportioned target for this time period (27.5%) and PHE ambition (37%). Working with Public Health we will continue to focus on health checks, including determining alternative ways and venues to find people with high blood pressure in the community.

5.4 Tobacco

In 2014 the national smoking prevalence rate for adults was 18.0%. Reading's rate was similar at 17%, while Wokingham and West Berkshire's were significantly better at 9.8% and 15.5% respectively. If we compare this to local smoking prevalence rates from 2010, this would suggest that there are now over 14,000 less smokers in Berkshire West than there were 5 years ago.

Stop Smoking Services operate to offer support to those people finding it difficult to quit. The service in Berkshire 'Smoke Free life Berkshire' is provided by Solutions 4 Health Ltd and jointly commissioned by all 6 Berkshire local authorities. The Stop Smoking Service and Public Health teams have worked closely with Berkshire Healthcare Foundation Trust to address smoking in certain priority groups. This includes people with mental health conditions among whom smoking rates are very high and quit smoking success rates are traditionally poor. The stop smoking service offer quit support on site at mental healthcare settings as well as work with BHFT to promote the service to people with mental health conditions resident in the community. In addition to smoking cessation support, the service has also worked with BHFT to make all community and in-patient mental healthcare settings smoke free. This work was completed in October, meaning that Berkshire is one of the few areas in the country to have totally smoke free mental healthcare facilities, including both indoor areas and grounds.

5.5 Screening and Immunisation

Currently screening and immunisation are reviewed and overseen by the health protection community and NHS England area team working across Berkshire. This group has public health and CCG representation ensuring the vital link between primary care development and NHS England in the delivering of screening and immunisation programmes. In a concentrated effort to address the inequalities in immunisation uptake in the 0-5 year cohorts in Berkshire, two Childhood Health Inequalities Nurses have been recruited to work within BHFT on a pilot project (Feb

2016 to April 2017). They will be working with child health records department, primary care, health visitors, local authorities, children's centres and other stakeholder agencies to improve timely childhood immunisation uptake in areas with historically low coverage, follow-up children with delayed or missing immunisation and facilitate access to immunisation services and target hard-to reach families.

Concerted effort is being made to maximise uptake of bowel cancer screening and reduce local variations in uptake. This includes Cancer Research UK's media campaign and screening enhancement kits and North and West Reading CCG quality premium initiative.

6. Improving quality of care through better outcomes and experience

Ensuring the quality of patient care provided by our commissioned services continues to be a primary focus in 2016/17. The CCGs have supported our providers to make significant progress in addressing key quality priorities to date, including reducing patient harm, such as a significant reduction in grade three and four pressure ulcers (average of 24 per year reduced to 5 to date in 2015/16), reducing incidents of infection (number of Clostridium Difficile has reduced from 40 in 2013/14 to 29 in 2014/15 and 23 year to date) and reducing falls causing serious harm (22 falls in 2013/14 and in 2014/15 to just 4 in 2015/16 to date). The monitoring of quality performance is underpinned by robust governance processes, which include benchmarking our providers performance with other Trusts across Thames Valley and holding them to account using tools such as Quality visits, clinical audits, and improvement plans to ensure improvements are made when standards fall below what is expected.

The CCGs are in the process of developing the contractual quality schedules which set out clearly our expectations for quality in 2016/17. These are based upon ytd performance in 2015/16, triangulated with feedback from our patients/ users and GPs gathered and reviewed through our Quality Committee, findings from the regulator and local intelligence.

The CCGs will continue to work with RBFT to monitor 104 day waits on the 62 day pathway with the expectation to move towards zero waits in this area in 2016/17. RBFT are developing a process for ensuring all of these patients have a clinical harm review and the CCGs will monitor the outcome of these in 2016/17. In addition, the CCGs will continue to monitor serious incidents that are a result of a failure to meet cancer targets and ensure learning is effectively captured and embedded.

In 2016/17 the CCGs will continue to monitor progress being made by our providers following recent CQC inspections, ensuring any areas requiring improvement are made, with real evidence of change being embedded. The CCGs will continue with its programme of Quality Observational visits to our providers across 2016/17, gaining direct feedback from staff and patients and their families on the care they are receiving.

6.1 Primary Care

In 2016/17 the CCGs will continue to improve the quality of primary care provided across all of our practices. The CCGs have developed a quality dashboard for primary care to monitor performance and support continuous improvement in quality against key quality indicators, which will be monitored through the Quality Committee and at CCG Council Meetings to support improvement. In addition, the CCGs will continue to work with NHS England in supporting those practices in our area as rated by the CQC as requiring improvement, ensuring any decisions made are in line with our Primary Care Strategy and produce the best outcome for delivering the highest quality of care for our patients.

6.2 7 day services

The Berkshire West CCGs have made significant progress on achieving 7 day services access across a range of primary, community and acute services in line with the 10 clinical standards. This is underpinned and driven through several different work programmes including the delivery of the Systems Resilience High Impact Actions, the development of an integrated community care model supported through the BCF and in line with the BCF national

conditions, and the development of relevant CQUINs and Service Development Improvement plans (SDIP) in both Provider contracts for 15/16 (a core part of the 15/16 planning guidance).

In addition to investments made via the BCF, through systems resilience and into MH services all of which directly support 7 day access we have invested in an Enhanced Access CES for Primary Care. This has resulted in over 80% of the CCGs' population now being able to access routine appointments outside of core hours; the vast majority of which are provided by patients' normal practices across the geography of the four CCGs. However, due to workforce constraints in primary care as described previously, as we work to improve coverage and expand availability to all day Saturday and Sundays, we envisage that practices will increasingly need to work together through 'hub' arrangement and/or that we may need to consider alternative provider models. We envisage that this would include provision within each of the four CCG localities; there is no intention for the routine offer to be centred on the walk in centre.

Patients with urgent needs can already access primary care in the evenings and weekends through the Westcall Out of Hours (OOH) service. The Reading walk in centre is also open from 8am-8pm, seven days a week. In addition, the CCGs have worked with NHSE to jointly commission an Enhanced Access CES as an alternative to the Extended Hours DES. This has resulted in 1321 additional routine bookable appointments per week on Saturday mornings and outside of core hours on weekdays (i.e. late evenings or early mornings), covering over 80% of the CCG's population. Some practices are working together to provide these sessions and we intend to increase coverage by promoting this further. A small number of practices continue to offer further extended hours sessions under the DES. We are currently reviewing the potential to expand provision under the CES, recognising however that many practices are affected by workforce constraints. To significantly expand capacity towards full 7 day access we will need to consider alternative provider models such as more systemic collaboration between providers.

Access to our community services is facilitated 24/7 via a Health Hub which is used by all discharging Acute Trusts as the single phone number for any health or social care referral.

In 15/16 we agreed a service development improvement plan (SDIP) with the RBFT which covered standards 2, 5, 6, 7 and 9. RBFT is reporting compliance with standard 2 (Time to first consultant review), standards 5/6 partially compliant and the Trust have completed and agreed with commissioners a Quality impact assessment associated with this position in year. The Trust has met their agreed actions on standards 7 and 9.

We are in the process of finalising the requirements for Q4 15/16 and have already commenced as part of the contract build the development of the 16/17 SDIP to include standard 8 as well as 2, 5 and 6 which are the national priorities for the coming year. The Trust will be completing the self-assessment tool on 7 days as required by the end of April and we will use the results of this to support continued dialogue with the Trust on full achievement of all 10 standards.

BHFT also had an SDIP which covered the respective elements of standard 7(MH on acute admission, PMS) and 9 (transfer to Community, Primary and Social Care). BHFT have provided performance data for Q3 and our intention is also to use this to inform our 16/17 BCF planning.

6.3. Avoidable deaths

The CCGs have a robust Serious Incident process with monthly meetings to scrutinise investigation reports into any incident which has resulted in serious harm or death of a patient. The CCGs will continue to ensure that any lessons learnt from these investigations are fully embedded and will challenge robustly if there are any recurring themes, taking action as necessary if care falls below the quality standards we expect.

The CCGs will continue to encourage an open culture of reporting, which has seen a significant increase in reporting across all our providers in the past two years.

6.4 Sepsis

The CCGs acknowledge the risks associated with failure to diagnose and treat sepsis early to reduce mortality. In 2015/16 the CCGs supported a 'Sepsis Improvement Project' delivered by the Berkshire West GP Out of Hours provider WestCall. This project has involved the introduction of a screening and treatment toolkit in the form of a lactate monitor, to support GPs to diagnose potential sepsis and initiate treatment with appropriate antibiotic immediately. Since implementation of the pilot, WestCall have increased their Sepsis diagnosis rates from 5 cases is April 2015 to 32 cases in January 2016. The CCGs plan to roll work with providers to expand this project into primary care and the ambulance service in 2016/17 and are exploring how best to do this, in collaboration with the Academic Health Science Network (AHSN). The CCGs plan to either continue the Sepsis CQUIN for a second year with our acute trust (depending on national CQUIN guidance), or transfer the requirements for screening and treatment within 1 hour to the Trusts quality schedule to ensure practice is embedded as business as usual.

6.5 Maternity

The CCGs Maternity Steering Group includes membership from all key partners including the MSLC. In 2016/17, we will continue to focus on supporting maternal choice through increasing the percentage of midwifery led deliveries, increasing the number of home births supported and reducing the need for RBFT to divert women in labour. The CCGs have several key performance indicators for maternity in the RBFT quality schedule and in addition monitor a comprehensive Trust maternity dashboard at quarterly Maternity Steering Group meetings, escalating any concerns through to the Berkshire West Quality Committee to agree any action required.

Following the recent publication of the National Maternity Review, a review will be undertaken, led by our CCG Maternity lead and the Maternity Steering Group to ensure its recommendations are fully implemented and progress reported through the Children, Maternity, Mental Health & Voluntary Sector (CMMV) Programme Board and subsequently through the Governing Bodies.

6.6 Medicines Management

The CCGs recognise that medicines form a significant part in addressing quality of care in terms of better patient experience, improving health outcomes and reducing patient harm. Optimising the use of medicines aims to ensure that the right drug is received in the right dose in the right place; that the most cost effective choices are made in line with national and local guidance; and that only those medicines that continue to benefit a patient are continued.

Work streams carried out by the CCG Medicines Optimisation Team to support these overarching aims include:

- A GP prescribing Quality scheme which has prescribing targets for practices to achieve.
- A prescribing support dietitian who reviews patients on gluten free foods, oral nutritional supplements and baby milks.

Both schemes above are delivering successfully with over £880k of efficiency savings delivered up to January 2016.

In addition to this, our Medicines Management team were presented with a CCG Prescriber award In November 2015 for cost effective delivery of diabetes care, which took a whole system approach to prescribing.

6.7 Antimicrobial stewardship

As part of the Primary Care Prescribing Quality Scheme (PQS) 2015-16, practices were asked to achieve three targets. Two of the targets were based on the national quality premium targets for CCGs which are to have an overall reduction in items (to date 37 of the 52 practices are now meeting this target) and also a reduction of specific broad spectrum antibacterials (to date 50 of the practices are now meeting this target). The last target requires practices to undertake an audit of all patients being prescribed an antibacterial for sore throat. Early results suggest there has been a reduction; however the data is in the process of being reviewed. It is expected that for 16/17, all of these targets will be in the PQS.

We are working with the local health economy to set up an Antimicrobial stewardship (AMS) group which will be looking all aspects of AMS, including having a joint strategy than spans primary, secondary and community care.

In addition, ambitions for reducing prescribing rates in secondary care will be added into the Provider contract in line with the expected Quality Premium.

6.8 Learning from cases of violence and abuse

There is an expectation that all providers will deliver domestic abuse awareness training as part of their statutory and mandatory training requirement for staff, ensuring staff know how to identify potential abuse and what support services are available to victims. Compliance with this requirement is monitored through provider quality schedules. Domestic abuse awareness training has been provided to primary care through the IRIS programme and through Berkshire Women's Aid.

The CCGs have a safeguarding children and a safeguarding adult lead to support staff, particularly primary care in understanding their responsibility for safeguarding children and vulnerable adults and this includes victims of abuse. The CCG Designated Nurse Safeguarding chairs the Berkshire West case review group where all cases of abuse are reviewed and lessons learnt are shared across the health economy and formally discussed, ensuring closure of all actions, through the Berkshire West CCG Safeguarding committee, which has a membership of safeguarding leads from all main providers.

6.9 CQUINS

Good progress is being made during 15/16, for example the BHFT Transition CQUIN. This CQUIN was designed to ease the journey of the child with mental health need to adult services. This CQUIN has been thoroughly embraced by CAMHS, as was discussed during a quality assurance visit. In order to achieve this CQUIN the Trust has implemented training for staff, questionnaires for the patients, a robust database to ensure all patients are highlighted.

We expect to reflect national guidance on CQUINs in our contract for 2016/17 and as we have done in previous years, secure a mutually acceptable but challenging agreement around CQUIN that reflects national and local clinical commissioning priorities. Our plan is to identify a list of CQUINs via our Transformation Boards and to use contracting levers to accelerate the adoption of best practice and to drive innovation and improvement where this supports better clinical outcomes. In reviewing CQUIN proposals we will need to jointly identify those CQUIN targets that should appropriately move from being incentivised through CQUIN to core standards as part of the 2016/17 contract, as well as new priorities for CQUIN development for 2016/17. We have actively sought provider input into the development of our proposals for 2016/17, noting that the number of local CQUINs will be relatively limited.

The CCGs have worked with our providers to agree a smaller number of local CQUINs schemes for 2016/17, providing a greater incentive and more intelligently focused on local health needs. The proposed CQUIN schemes are likely to include areas such as End of Life Care, 7 day working focused on weekend discharges, reducing contacts from high care homes users, and suicide prevention

6.10 Safeguarding

The CCGs will continue to be active members of the three Local Safeguarding Children Boards (LSCB) and the Berkshire West Safeguarding Adult Partnership Board (SAPB) and will ensure our providers are fully engaged in delivering the safeguarding priorities of these boards. These include early help, child sexual exploitation, domestic violence and vulnerable groups, the child's voice and the continued development of the safeguarding board in its effectiveness. We will commit to improving safeguarding quality, by sustaining the improvement in compliance of delivering LAC Health Assessments within 20 days and continuing to improve GP report submission to child protection case conferences.

All contracts and SLAs require providers to adhere to the Berkshire-wide safeguarding policies. Contracts also require all providers to complete an annual section 11 audit (adapted to include safeguarding adults), and to provide

assurance of compliance staff training levels, and continuing professional development covering topics such as their roles and responsibilities in regards to safeguarding children, adults at risk, Children Looked After, the Mental Capacity Act and Deprivation of Liberty Safeguards. Providers are required to inform commissioners of all incidents involving children and adults, including death or harm whilst in their care.

Our quality assurance reporting framework will monitor progress and contract compliance on the DH and Home Office Prevent strategy against NHS standard contract for all our providers. We will ensure quarterly reporting on training compliance and prevent referrals is submitted to our prevent lead. This training is in accordance with the NHS England prevent and training competencies Framework and as a CCG we have encouraged the use of both Home Office e-learning training and health wrap supported by the regional prevent co-ordinators forum. This is in accordance with the CCGs current status as a non-priority area.

6.11 Carers

The CCGs lead a Joint Health and Social Care Carers Commissioning forum which has been instrumental in the procurement of an Advice and Information service which is due to start on 1st April 2016. This forum is leading the development of a Joint Berkshire West Health and Social Care Commissioning Strategy.

We recognise the importance of Carers and the pressures that are often associated with those in a caring role. We have therefore continued our focus on identifying and supporting carers by ensuring that at least 90% of those registered with participating GP practices identified as carers are pro-actively contacted by way of phone or mail and given key information to help them including advice on NHS health checks, benefits, information on respite care and voluntary organisations providing specialist advice and services. We are also encouraging the role out of the use of 'carer champions' in some practices. In addition to expanding the role of Primary Care, the CCGs are also in the process of commissioning Carers Health and Wellbeing reviews with collaborative funding from Public Health West Berkshire. This will involve commissioning Carers Health and Wellbeing reviews being offered through Community Pharmacies, and active signposting by the voluntary sector and other health care professionals. The proposal is to pilot this service from April 2016 with evaluation by Reading University.

We have also engaged our main providers BHFT and the RBFT to ensure that their services are carer friendly.

7. Clinical Priorities

The following principles will support our Clinical Priorities for 16/17:

- To put a greater emphasis on prevention and putting patients in control of their own care planning including through the expanded use of technology enabled care, multi-disciplinary care planning led by GPs here (under Anticipatory Care CES), and proactive support for carers and families. This will underpinned through CCG Programme Board led pathway redesign, service line reviews and the development of the CCG QIPP programme for 16/17.
- We will work with providers to explore opportunities to move away from disease specific pathways to care delivery which is person centred and place based, using national and local benchmarking data, best practice, NICE guidance etc to inform priorities (for example, JSNA, SCN, Commissioning for Value, RightCare Programme)
- We will work with providers to implement new models of care which better support better integration which expand and strengthen the role of primary and out of hospital care, whilst ensuring our acute providers are equipped to treat patients who require in-hospital care.
- We will work with our providers to ensure that appropriate levels of care and diagnostics are available across the week which enable achievement of improved health outcomes for our populations.
- We would want to work with providers to ensure that contracts are delivered within the agreed financial and activity envelope.
- We would want to explore new payment mechanisms which incentivise the delivery of outcome focused care at the right time in the right place, and which support the future sustainability of our local health and care system.

- We will only purchase treatments and drugs that are evidenced to be cost-effective, either through NICE TAG or evidence reviews that have been specifically accepted and adopted by Commissioners on the recommendation of the Thames Valley Priorities Committee.
- We will seek demonstrable improvements in quality across all services and will expect providers to implement a range of best practice pathways for specific treatments and conditions within the agreed contract value.

8. Urgent and Emergency Care

8.1 Performance

The CCGs Urgent Care Programme Board will work to deliver a programme of improvements based upon the best practice as set out within the recently published NHSE 'Safer, Faster, Better' document and will take an oversight and scrutiny role in relation to performance; holding individual organisations to account for the role they have to play in an effective Urgent and Emergency Care system.

The Berkshire West health economy will build on its performance during 2015-16 to maintain achievement of the A&E 4 hour standard for each quarter and the full year in 2016-17. The Urgent Care Programme Board takes an oversight and scrutiny role in relation to the A&E 4 hour target and has responsibility for ensuring that the health and social care system provides resilient urgent and emergency care services which consistently meet the A&E target.

Reports generated from the Alamac kitbag will support the Urgent Care Board to understand the drivers and constraints affecting A&E 4 hour performance. The CCGs have recently refreshed the measures collected in the kitbag and are working with Alamac to set what 'good looks like' so that from these standards automated alerts can be sent out to partners to prompt timely escalation.

In 2015/16 SCAS has been challenged in delivering the ambulance response time standards for the Thames Valley contract. All three of the national standards are at risk of being achieved on an annual basis for the year. During 2015/16, the CCGs served a contract performance notice for this performance and following this a remedial action plan was agreed. This action plan included a trajectory for recovering the standards, all of which should be achieved for the month of March and onwards during 2016/17. This remedial action plan is on track and performance is expected to achieve the March recovery date as agreed. Performance will be challenged during 2016/17 due to the ongoing financial and resource pressures for the ambulance Trust. The contract negotiations are therefore key to ensuring sustainability of performance and achievement in 2016/17.

In 2016/17 the Board work programme will be based on the best practice contained within 'Safer, Faster, Better' with agreed priorities including;

Acute:

Achievement of the required clinical standards for 7 day services which will deliver:

- consultant led daily review with consistent "board" rounds leading to early discharge 7 days a week
- Increase in % of patients discharged "same day" and by midday and at weekends
- Focus on expediting straight forward discharges
- Agreement and monitoring of interdepartmental response standards
- 7 day working for therapies and pharmacy
- Focus on ambulatory care and LOS <48 hours

Community services:

- Consistent and timely management of frailty in the community

- Integrated health and care teams which are able to respond rapidly 7 days a week, with extended hours access to equipment and social care packages

Primary Care:

- A range of options for same day urgent care
- Protected slots for on the day appointments for children
- Development of Urgent Care Metrics for Primary Care
- Explore the opportunities of collaborative approaches for 7 day working in Primary Care
- Continued focus on accountable clinicians, robust care planning and sharing records
- Piloting direct booking into Primary Care for on the day GP appointments via NHS 111

Ambulance service:

- Direct access by the ambulance service to a wide range of alternatives to conveyance (physical and mental health)
- Access to a wide range of clinicians via Clinical Hubs, linking into resources already available 'on the ground' (e.g. specialist nurses working in the community)
- A continued focus on increasing 'hear and treat' and 'see and treat' rates
- Increased access to patient transport for discharge 24/7

In addition the Board will continue to focus on a number of general themes along the patient pathway including:

- Increased use of community alternatives pre-admission supporting higher non-conveyance rates for the ambulance service and more rapid response (admission avoidance) in the community
- Ambulatory care as the default pathway in the acute and a greater proportion of patients staying for 2 midnights or less through a relentless focus on straightforward discharges
- Discharge planning for patients in likely need of onward care starting at the point of admission with a fully integrated pathway for discharge reducing duplication/hand offs and delays
- A pull model operating at the back door at the hospital drawing patients out into the community, operating on the principles of Discharge to Assess and Trusted Assessment, moving patients out swiftly, maximising their rehab potential and reducing their long term dependence on care
- Smoothing of patient flow across the days of the week and hours of the day, minimising surges in demand.

Improvements will be incentivised though the investment of resilience monies targeted at delivering desired outcomes, aligned with the CCGs QIPP, and BCF, and their impact on urgent and emergency care performance will be rigorously monitored by the Urgent Care Programme Board.

8.2 Integrated NHS 111/Urgent Care Service

In line with "Safer Faster Better" and the recently published Commissioning standards for Integrated Urgent and Emergency Care, the Thames Valley CCGs are working jointly to commission an Integrated NHS 111/Urgent Care service to replace the current NHS111 service which will go live in April 2017. The service will via NHS111 offer a functionally integrated Urgent Care Service with immediate access for assessment and advice to a wide range of clinicians including mental health, pharmacy and dental. The model will also offer advice to health professionals so that no decision needs to be taken in isolation. The new integrated service will have access to a range of dispositions including, but not limited to, red and green ambulances dispositions, 24/7 primary care and direct booking into a wider range of urgent on the day services such as Walk In Centres and Minor injuries units. Clinicians in the Hub will have access to all relevant care records supporting robust clinical decision making.

During 2016-17 the Berkshire West CCGs will work with the incumbent NHS111 and Out of Hours Primary Care Provider to deliver improvements ahead of the establishment of the fully Integrated Service. Improvements will be aimed at delivered aspects of the new Commissioning Standards for Integrated Urgent Care including;

- Providing additional clinical expertise to the current NHS 111 service
- Direct booking from NHS 111 in the OOH service
- Special Patient notes, End of Life and Crisis Care plans to be available at the ideal point in the patient pathway
- Joint management of patient pathways and capacity across NHS 111 and OOH
- Early identification of callers who would benefit from speaking directly to a clinician
- Integrated governance arrangements.

8.3 System resilience

System resilience for the urgent & emergency care system operates year round, balancing demand and capacity, planning for expected surges, smoothing patient flow, and early and timely escalation and de-escalation. The Berkshire West system adheres to the Thames Valley Escalation Policy and uses this as a guide and reference point.

Resilience monitoring operates at a number of levels on daily, weekly and monthly basis and is underpinned by robust data and intelligence from the performance dashboard which is the Alamac urgent care kitbag.

In planning for winter 2016/17 the CCGs will build up on the successes of 15/16 and seek to address those opportunities identified for improvement as part of the review of winter 15/16.

Worked well	Opportunity for improvement
• Patient flow was good during the two week holiday period • Conversion rates were high (40-50%) so system working effectively in terms of admission avoidance • Positive response from nursing and care homes • Good liaison between SCAS and RBFT with SCAS activity levels not as high as predicted • Primary Care with extended opening hours offering more capacity and focusing on early visiting • Fit List well maintained with a good flow out to adult social care services	• Capacity in Domiciliary care became constrained by mid-January as the market was saturated (Councils responding by focusing on use of reablement services) • Pressure on the system built through January with RBFT tipping onto internal black by mid-month – different profile of demand compared to 14-15 • Difficulties arranging patient transport evenings and week-ends • Westcall extremely busy and challenges getting full shift cover • Lack of pharmacy cover as Oxford Road was the only pharmacy commissioned to open on the Bank Holidays

Plans for the critical Christmas and New Year period will be scrutinised by the Urgent Care Programme Board. Alamac will be used proactively to predict emerging pressures so that organisations can respond accordingly.

In 2015-16 the CCGs invested recurrent resilience monies into BHFT to support introduction of a 'pull' model from the RBFT acute wards into community services. BHFT established an Integrated Discharge Team with a view to expediting discharges and maintaining flow into community services seven days per week. The team have been hugely successful with a significant reduction in-year for the number of patients on the Medically Fit for Discharge list awaiting community services and patient being pulled out of the acute before they reach the list. The impact of

the scheme is quantified by the number of bed days saved by the team (by comparing the actual and estimated discharge dates) and in the first three quarters of 2015-16 over 2,000 bed days have been saved.

The CCGs also invested in the SCAS) SOS Bus which operates out of Reading Town Centre on week-end evenings. The resilience funding pays for two paramedics to be based on the bus treating patients on scene who would otherwise require conveyance to A&E. In the first three quarters of 2015-16 253 patients have presented at the bus of which 74% have been successfully treated on scene. The patient cohort that can be managed through this service are often under the influence of alcohol and often A&E is the wrong environment for them so it is of significant benefit to both the user and the health economy that they can be treated in this way.

The CCGs are committed to investing resilience monies into the urgent care system where there is a defined case for change and measurable benefits which will contribute to improved system resilience and maintenance of the relevant performance standards throughout the year.

9. Hospital Care (Elective care)

Our strategy for Planned Care is to enable patients to make informed decisions about their care and where secondary clinical interventions are necessary to have access specialist assessment and treatment where necessary in a timely way and in line with national performance standards. The CCGs will support local providers to improve their referral to treatment time performance, ensuring they can adhere to all NHS Constitution measures and access standards to provide patients with care in a timely manner.

Our vision includes the use of new technologies to enable our patients to interact with services in new ways; reducing attendances at hospital, lengths of stay and the number of follow up outpatient appointments required.

We plan to work with our providers to model the demand and capacity for all specialities including Diagnostics to ensure we are commissioning the appropriate level of services and pathways are delivered efficiently. We will also explore other modalities to deliver follow ups in the hospital and work with primary care to reduce clinical variation in referrals through regular review of data and targeting practices with higher than average level of activity.

The work programme for planned care for 2015/2016 delivered a number of successful outcomes:

- The development of an Integrated Pain Assessment and Spinal Service (IPASS) service for patients with chronic pain enabling them to access the most appropriate level of care to improve their condition and to reduce the outcomes for patients with chronic pain who had previously been accessing multiple services and undergoing multiple procedures without satisfactory resolution of the condition. This service was launched in September 2015 and has recently won an award for Emerging Best Practice by the British Society for Rheumatology.

- Arthritis Care - offers support for patients with hip and knee conditions as an alternative to surgery. The initiative, provided by the voluntary sector organisation Arthritis Care offers four options to patients which includes face to face sessions, online and telephone support. Integrating the Arthritis Care programme and a shared decision making approach into the hip and knee arthritis care pathway has enabled a more patient centred approach to care. The service was launched in June 2014 and feedback from patients and referring GPs has been positive and the programme was extended in 2015/2016.

- We have worked with the RBFT as our main provider to look at efficient methods of delivering elective follow up appointments and the Trust has successfully implemented telephone follow ups for T&O, urology and dermatology where clinically appropriate. The CCGs have also commissioned the Trust to set up a virtual fracture clinic, and see and treat clinics for Dermatology. We are in process of implementing a one stop shop for Urology.

- Best practice pathways are continuing to be developed across several specialities including MSK, and Dermatology for utilisation in Primary Care and accessible via the DXS system with the aim of reducing unwarranted clinical variation.

Our Planned Care Programme work plan for 2016/2017 includes continuing work to redesign services and reduce clinical variation focusing on Orthopaedics and MSK, Ophthalmology, Dermatology, Diagnostics, Gynaecology, Gastroenterology, Urology and Pre-op assessments in primary care.

9.1 18 weeks RTT

The RBFT and each of the 4 CCGs are achieving the national incomplete standard for RTT. During 2014/15, there were a number of challenges with RTT reporting at RBFT and as a result the Trust was on a data reporting holiday from July 2014 to January 2015 while the full waiting list was validated. During 2015/16 the Trust has been reporting fully each month, although discussions are continuing with regards to data quality. The CCGs focus during 2015/16 has predominantly been on working with RBFT to reduce the size of the backlog of patients waiting beyond 18 weeks yet to be treated, especially those with the longest waits beyond 40 weeks. The CCGs will have a continued focus on RTT performance and the size of the backlog of patients waiting beyond 18 weeks into 2016/17. In aligning our demand and capacity modelling with local Acute Trust we will be factoring in the capacity required to achieve the national performance standard, this will include as referenced previously the capacity for Diagnostics as a critical step in the clinical pathway. The CCG is expecting to agree a Service Development Improvement Plan or quality schedule indicators to build on the improvements in 2015/16.

9.2 Cancer

We will continue to focus on delivering the cancer standards especially in Dermatology and Upper and Lower GI pathways. The RBFT's performance against three of the standards require improvement and these are the 2ww from GP referral, the 2ww for symptomatic breast and the 62 day from GP referral standards. The CCGs agreed remedial action plans for all of these standards with RBFT in August 2015. The 2ww standard for symptomatic breast has since recovered performance in line with the agreed trajectory and is expected to continue to achieve in 2016/17. The 2ww from GP referral and the 62 day from GP referral standards are not on plan with the agreed trajectories and the CCGs have been working very closely with RBFT to agree revised remedial action plans and recovery trajectories. The revised remedial action plans are currently being tested with RBFT to ensure that they are robust and achievable. The 2ww from GP referral standard is expected to recover for quarter one of 2016/17. The 62 day from GP referral standard is expected to recover in Q2, although this is subject to the Trust being able to secure additional capacity and this is therefore not finalised at the point of submission.

Revised trajectories and action plans will be included in more detail in the April version of the Operational plan and within the contract for 2016/17. Once agreed the plans will be monitored closely with the provider via a number of meetings already in place, including the RBFT Cancer Taskforce meeting where tumour site clinicians attend to review the factors limiting achievement of the cancer wait time standards.

The CCGs are working with an external organisation and the Trust to understand the demand and capacity required for diagnostics for year 1 and the 5 years forward planning considering the impact of

1. Changes in demographics;
2. Increasing demands for diagnosis from cancer pathways (including current backlogs)from:
    a. Compliance with NICE Guidance on suspected cancers
    b. Diagnosis expected earlier in the pathway (as per the upcoming 28 day standard)
    c. Exploring GP direct access

The CCGs are also engaged in the SCN Diagnostics Demand and Capacity Project which we anticipate to utilise to inform year 1 demand.

The CCGs have set up a Cancer Steering Group which includes all local stakeholders from the provider, Public Health and Voluntary Sector with the aim of developing a joint local Cancer Framework/Strategy to deliver the priorities as set out in the national Cancer Strategy. The main focus is on prevention, earlier and faster diagnosis, improved survivorship and better aftercare. We are working with stakeholders to deliver the following objectives:

- To promote health lifestyle changes to reduce cases of preventable cancer
- To increase uptake of early screening
- Enable direct access tests for GPs including x-ray, ultrasound, brain MRI, CT and gastroscopy including clinical responsibility, the process of managing patients who need further review and who communicates results to patients.
- Increase referrals for suspected cancer ensuring adherence to the NICE Guidance utilising the DXS system,
- Develop a pathway to support and enable GPs to make urgent or 2WW referrals for patients with vague, atypical symptoms and no red flags
- Provide GP/health professional education
- Review and agree local pathways for the four main tumour sties to deliver an efficient flow through the pathway including a review of current waiting times for direct access tests and agreement of when tests will be available within 2 weeks and review which 2 week wait referrals should go straight to test rather than to an outpatient appointment.
- Improve patient experience
- Further develop cancer rehabilitation including risk stratified pathways and the provision of end of treatment summaries
- Ensure the Trust are staging all cancers

Examples of work streams we have in place or are planned which will support delivery of our local Cancer Framework include:

- Working with our Public Health teams and Cancer Research UK to improve prevention and reduce the number of cancer diagnosed following emergency presentation. This service will aim to deliver an educational health promotion intervention to those found to be cancer-free having been referred via the 2ww pathway, using this teachable moment to lead to more sustained health behaviour change.
- Working with Public Health, RBFT and Cancer Research UK we will be piloting a cancer prevention service as part of supporting the development of RBH as a health promoting healthy organisation. This service will aim to deliver an educational health promotion intervention to those found to be cancer-free having been referred via the 2ww pathway, using this teachable moment to lead to more sustained health behaviour change.
- Working with the Macmillan team to improve the aftercare of patients and implementing cancer rehabilitation and to increase the attendance of patients in South Reading CCG for 2 weeks appointments for suspected cancer.

9.3 Reducing unwarranted variation in elective care

The CCG is seeking to reduce unwarranted variation in referrals and use of secondary care services by providing practices with their current activity, which can be peer reviewed against the CCG and Federation averages. The aim is for practices to review and utilise this data to learn from and manage clinical variation. By comparing performance, the CCGs will seek to reduce unwarranted variation, underpinned by the use of evidence based clinical pathways.

In signing up to the national RightCare Programme, we will continue to look at the scope across all the CCGs in Berkshire West to provide professional development solutions and data comparisons across the CCGs and help promote services and demonstrate where there are potential opportunities for further cost savings, new services and service re-design.

10. Out of Hospital Care

Our Out of Hospital vision is underpinned strategically by the development of our ACS, and more operationally for 16/17 through the work of the CCGs Long Term Conditions (LTC) Programme Board, the BCF and the Frail Elderly Pathway Programme.

Our aim is to work collaboratively across health and social care and the voluntary sector to provide quality care for patients; minimising the risk of an individual's health deteriorating and requiring increased service intervention, and maximising the opportunities for patient self-management. Within this programme of work are a number of key work streams, supported in many cases by the Strategic Clinical Network and AHSN to help drive transitional change.

We have begun to make good progress in integrating local services – for example, our exemplary community-based multidisciplinary Diabetes service and we are in the process of applying the same principles to designing a community-based respiratory care pathway.

The CCGs will be implementing a project in 2016/17 for patients who have been diagnosed as at End of Life. The objective of the project is to increase the numbers of patients offered and able to achieve their choice of place to be cared for and subsequently die. We will be implementing a 24/7 advice and support service provided by specialist palliative care health professionals which will be available via a single number at the Hub for patients, families, carers, health and social care professionals.

The hub links directly with the appropriate support agency removing the requirement for patients to make multiple phone calls and using the expertise of the specialist palliative care clinical staff will avoid unnecessary admission to and end of life deaths in hospital.

10.1 Dementia

The CCGs have commissioned a Memory Clinic service which is now nationally accredited and is already achieving the contractual standard of 6 week waits. Through the AHSN this best practice model of delivery has been shared and is being adopted across Thames Valley. In addition we commission an award winning service for young people with Dementia , which has demonstrated in its first year encouraging outcomes measures for the clients is has served. Although our current models are considered exemplary and "fit for purpose", we are acutely aware that as our population continues to age and numbers of Dementia patients grows, our current model of delivery within the memory clinic services will need to be reviewed in order for us to have sufficient capacity to meet the needs of our population in the future.

During 16/17 our Dementia steering group will work with the AHSN to examine other possible models of delivery and assessment. This may include carrying out more assessments in a community setting e.g. through care home in reach teams , upskilling of the workforce to facilitate simple assessment where it is not appropriate to send the patient to a memory clinic service just for a diagnosis and a screening and triage process for appropriate access to memory clinic services. Using demand and capacity modelling, we will identify and project patient numbers requiring memory clinic service relative to those cohorts of patients who can receive service through different models of service provision. This will include the identification of key performance indicators which will include waiting times and patient numbers by CCG and practice (weighted according to age of population) and numbers of patients engaged with the Dementia care advisors and Admiral Nurse Services.

Outcome measures will include admission avoidance, reduction in requirements for respite /social care intervention as well as reductions in the need for medical intervention (e.g. measure reduction in mental Health practitioner and community support worker contacts). This information is invaluable to assessing the value for money these services offer but also to release funds to allow further investment in Dementia services. By the end of 2017 we will have identified and costed through a robust business case, as to how the current service may need to adapt to meet the future needs of the population.

We plan to continue delivery of our dementia action plan across Berkshire West to ensure maintenance of the 67% diagnosis of Dementia target in each CCG within Berkshire West. Currently the average across the 4 Berkshire West CCGs at December 2015 is 67.65% however we acknowledge that this varies across the four CCGs ranging from 63.5% to 71.3%. In January 2016 we also saw continued low attainment in Wokingham CCG and a downward trend in diagnosis rates in Newbury & District CCG. Newbury & District CCG have prepared and are implementing a specific 10 point action plan to address these issues. This includes a coding review, further work with individual practices where there is highest variance from predicted prevalence through the practice nurse facilitator as well as raising awareness within practices through a variety of routes at the CCG disposal. Wokingham CCG with the highest proportion of elderly of the four CCGs also has a CCG specific action plan which has been in place since Dec 2015. A number of the elements of this action plan are similar to Newbury but Wokingham are currently piloting the use of the Dementia Care Advisors in Wokingham practices which will help support GP practices identify and provide ongoing support to Dementia patients/carers on the GP registers. This initiative may also help GP practices identify new patients. If successful , this can be rolled out across the other Berkshire West CCGs. Wokingham have also introduced a referral form specifically to facilitate "remote" confirmation of diagnosis of Dementia in existing care home patients who would not be deemed suitable or able to attend a memory clinic, simply to confirm diagnosis. This will it is hoped increase the % diagnosis rates in many of the Wokingham practices in the next few months and could be a technique adopted, if successful , within Newbury CCG also. We aim to have achieved the 67% target in Newbury and Wokingham CCGs by September 2016.

During 2012, the Prime Minister launched the 'Dementia Challenge' which set out an ambitious programme of work to push further and faster in delivering major improvements in dementia care and research by 2015, building on the achievements of the National Dementia Strategy (2009). The local health and social care economy worked in partnership to develop and submit 7 proposals, 5 of which were successful in gaining full funding.

This plan will now be refreshed to allow us to meet the challenges and will be included with the April Operational Plan submission. We will work as a system to develop, own and deliver an agreed affordable implementation plan across Berkshire West. A key deliverable within our action plan will be the achievement of a dementia initial assessment within 6 weeks of GP referrals. This will require identification of variation in referral and diagnosis rates within primary care. We will provide dedicated support to those practices identified as outliers but also to allow us to share good practice between practices. Our current variation in primary care project and intelligent health dashboard will be key tools in measuring and addressing unwanted variation in the system. As well as building on the Prime Ministers challenge on Dementia in the 5 key areas of care, we will refocus on improving the quality of post-diagnosis treatment and support in line with the 2020 vision. An essential component for our plan will be to utilise performance benchmarking data to address variation in quality and outcomes for people with Dementia within our population as well as learning from the experiences and models of care elsewhere in the country as shared in the Dementia challenge 2020 publication.

Our current established dementia stakeholders group will meet monthly and by June 2016 will have agreed the Dementia action plan for 2016/17 and beyond. We recognise that as we have come some considerable way so far as a system, much of our anticipated investment in Dementia services planned is likely to be within our baseline expenditure. As part of the 2013-14 QIPP programme the Berkshire West CCGs prioritised increased investment into their Older People's Mental Health services delivered by Berkshire Healthcare Foundation Trust. This investment was in recognition of the costs associated with both the increase in the volume of patients with dementia and the prescribing issues relating to anti-dementia drugs. Capacity in memory clinics was increased in line with demand. Prescribing of anti-dementia drugs has been extended to those with mild dementia in line with NICE guidance. Shared care has been introduced between specialists and GPs, enabling suitable patients to transfer to GP care once stabilised on their medication and agreed by the clinicians involved.

We recognise that increasing demand will mean more people will be cared for by their GP practice and other models of delivery may include looking at the option to further integrate older people's mental health specialists within our practice GP clusters. We have already seen with our young people with dementia service is indicating that savings

can be generated through reduced impact on health and social care spend when patients and their carers are supported and managed appropriately within the community, However, through implementation of the action plan during 2016/17 , should further investment be required in order to deliver the plan, this will need to be clearly articulated and considered by all stakeholders within the resources currently available.

10.2 Diabetes

Prevention

Across Berkshire West CCGs, we recognise Diabetes as a significant issue with the prevalence and number of people at risk of developing Diabetes being very high in some areas (such as the south of Reading). It is already a strategic priority with a dedicated Federated Clinical lead and CCG locality clinical leads. QOF data indicates a gap between expected prevalence and recorded prevalence and we recognise that more can be done to build on the successful services in many GP practices, especially in identifying people at risk and referring them to risk-reduction services. We currently commission a community enhanced service for pre-Diabetes, which was commissioned in 2013 and further expanded in July 2014 across Berkshire West. Further investment of £51,000 has since been set aside for 2016/17 with agreement to fund the service for a further two years as a minimum. This builds on the pioneering Pre Diabetes Project which has been running within Newbury and District CCG through 2013-14, which has successfully identified Diabetics and Pre Diabetes as well as promoting lifestyle intervention for Diabetics prevention. The GP CES addresses the needs of those already identified with PreDM (coded with IGT, IFG, Resolved DM, h/o Gestational DM, at risk of Diabetes and those with previous HbA1c 42-47), with annual testing for progression, and lifestyle advice etc. As of October 2015, 2509 people had been invited for a review and 910 had taken up the offer.

Berkshire has been selected as a first-wave pilot site and will therefore receive funding for the National Diabetes Prevention programme (all 7 CCGs and 6 LAs). This programme will be locally led by Public Health working closely with the CCGs and will complement the local CES scheme. The lead partners will aim to deliver 3,800 referrals to providers of the Diabetes Prevention Programme across the two year timeframe. If a Diabetes prevention service was available to Berkshire from April 2016 we consider that we could refer at least 1,500 people with pre-diabetes and a further 1,500 with currently undiagnosed diabetes in the first year for risk reduction. Our reasoning is described in our expression of interest but builds upon the early success seen in our local community enhanced service which has been running across Berkshire West since July 2014. This provides us with a sound base to be early adopters within the national programme.

Diabetes Management

Within Berkshire West we have strong clinical leadership and an integrated approach to the management of diabetes, which has been widely recognised and acclaimed nationally. A Diabetes steering group has been in place since 2012 and has developed a vision supported by 4 key objectives. Our vision is to enable people with diabetes in Berkshire West to live healthier lives by improving outcomes and reducing complications, and to do that efficiently. We aim to do this through informed , engaged patients , informed motivated Health Care Professionals, collaboration between stakeholders , supported by the of informatics and technology. An action plan is currently in place and we have made major progress since 2012 in achieving our objectives. This has included the commissioning of an innovative interactive database technology “Eclipse”, to which all our practices have access. The Diabetes steering group reports directly to the Long term conditions programme board, a subcommittee of QIPP and finance which has delegated authority from the four Berkshire West CCG Governing Bodies to oversee and implement change.

In order to build on the current action plan, a comprehensive assessment of our performance against NICE Clinical Guideline guidance in type I and type II diabetes. This has enabled us to identify any further gaps in current service provision and forms our refreshed action plan for 2016-2017. A recent Business case presented in Jan 2016 gives an overview of current service provision and any gas that now require to be addressed. Eclipse tells us that we have 1829 type I diabetics and 16,763 type II diabetics currently registered in Berkshire West. With a 100% submission

rate to National Diabetes Audit, we have access to rich data sources on which to base any further actions that may be required locally to improve our Diabetes care.

We have recently invested in a new service for the care of highly complex diabetic patients post discharge, which builds on the success seen in the virtual clinics and will see the implementation of new community based service for this patient cohort, aiming to reduce non-elective admissions and readmissions. The national Diabetic audit also tells us that more work is needed to avoid diabetics locally developing complications and progressing to renal replacement therapy.

Other local initiatives to reduce the numbers of patients with very badly controlled diabetes include the insulin intensification program for patients very badly controlled diabetes on insulin therapy. There is also a focus on managing patients with early diabetic nephropathy. There has been local focus on care of people with diabetes foot problems. This has involved reconfiguration of the diabetic foot clinic with increased vascular and orthopaedic surgical input. HES data and atlas of variation information also indicates we perform well against national benchmarking. Throughout 16/17 we will continue to build on our success and implement further actions where gaps have been identified through data sources and a self-assessment against NICE criteria of service delivery.

South Reading CCG are also one of eight CCGs in England participating in a CQC Diabetes thematic review which aims to identify to challenges in delivery of diabetes services in the community and to share best practice examples across the country To will take this as a golden opportunity to learn from this experience.

10.3 Frail Elderly Pathway

Work on the development of a Frail Elderly Pathway first began in recognition of the need to improve the experience of older people in understanding the complex arrangement of services across our system, and the aspiration of being able to use resources more efficiently in the face of growing demand. Our aim is to develop a pathway that is centred on the needs of an individual person and their family, rather than the services themselves, professional boundaries or governance and structural requirements of individual organisations.

In 2014 the Kings Fund worked with the Berkshire West organisations to develop a new pathway for the provision of Frail Elderly Services. This was developed around the needs of a single service user 'Sam'. Work is now underway to assess the progress that has been made since 2014 in implementing the pathway and to model the activity changes and financial impact of its adoption.

In addition in 2015/2016 an evidence base on early prevention activities in older people was produced by Public Health that was shared with each local integration board, this highlighted local strengths and weaknesses and will be used to develop priorities in each locality in 2016/2017. This evidence will inform changes in the way services are commissioned to ensure resources are allocated to those services which make the greatest contribution in supporting the Frail Elderly in Berkshire West.

The governance of the programme is into the Berkshire West 10 Integration Board and Delivery Group and the expected outputs of this programme including identified opportunities for "quick wins" will be used where possible to inform commissioning and contracting decision for 16/17. The final reports including an implementation plan will be produced by the end of March 2016.

11. Mental Health - Parity of Esteem

The Mental Health Taskforce has recently published their 'Mental Health Strategy Five Year Forward View'. The CCG's CMMV Programme Board is reviewing this document against our Commissioning ambitions for 16/17. Any changes to these will be reflected in our April submission.

The CCGs are leading a local Mental Health Taskforce for Berkshire West and this will be the first time there has been a strategic approach to improving mental health outcomes for people of all ages in the health and care system, in partnership with the health arms-length bodies. Berkshire West CCGs is committed to work across the health and social care system in developing a joint mental health strategy to improve the experience of mental health service users and carers.

In Berkshire West we have already made significant investment in mental health services year on year to support the delivery of Parity of Esteem and we will continue to drive change to ensure all our mental health users and carers receive a high quality, outcome focus service to the same level as physical health care. The CCGs have invested in Primary Care education through our Training in Practice event, the latest event in January was specifically focused on Mental health and was adapted for not only to GPs but to practice nursing and reception staff.

We already have a well-established Crisis Care Concordat Steering Group in Berkshire (which will feed into the taskforce) that is hosted and co-ordinated by Berkshire West CCGs Director of Joint Commissioning, involving multi-agencies as part of the CCC Declaration Statement Signatories. A high level plan has been developed and is overseen by this group. As a result this has strengthened partnership working across multi-agencies i.e. Thames Valley Police, Ambulance Service, Local Authorities, CCGs, Mental Health & Acute Provider Trusts, Voluntary Sector Providers, Drug & Alcohol Services, Users/Carers and Public Health.

Berkshire CCGs jointly commission 3 places of safety (POS) with BHFT; these are based at Prospect Park Hospital. One of these is dedicated for Children and Young Person with facilities for parents to stay with their child during assessment period. The POS is managed by BHFT inpatient staff and has support system in place to effectively manage mental health patient with high risk presentation. The POS have significantly reduced mental health patients placed under Section 136 being detained in custody suite.

The Crisis Care Concordat plan includes steps to agree and implement a plan to improve crisis care for all ages, including investing in places of safety. For children and young people under the age of 18 years a CORE 24 compliant service is being piloted for 12 months. This builds on the existing CORE 24 compliant service for YP aged 16+. The pilot has been developed jointly by BHFT, RBFT and CCG commissioners.

In addition work with Public Health on a population wide approach to promoting good mental health and preventing mental illness and has included promoting Five Ways to Wellbeing messages across schools, businesses and local communities, and supporting local groups that work with people experiencing mental illness and social isolation e.g. Friends in Need, Pulling Together and Eight Bells.

11.1 Mental Health Standards

Working with our main provider, Berkshire Healthcare Foundation Trust (BHFT), we will lead service transformation to bring all its services in line with National Standards to meet the Parity of Esteem "Call to Action Framework" and we will be working with them to deliver on the Two New National Mental Health Standards as set out in the Planning Guidance.

IAPT – BHFT have been delivering on the IAPT trajectories (of 75% of people with relevant conditions accessing talking therapies in six weeks and 95% within 18 weeks).This is being reported quarterly and monitored in our contract monitoring meeting with the provider. The BHFT service has been recognised nationally as a high quality

service with excellent wait times and access rates. This service has received national recognition for its achievements:

- Achieved a **r**ecovery rate of more than 50%
- Wait time of 4 weeks (against a national target of 18 weeks)
- 95% patients reporting a positive experience

Our priority for 16/17 is to ensure that current performance is maintained and that recovery rates are above 50% going the next contractual year. This service will continue to evolve and we are working with BHFT to roll-out the IAPT service in managing long term conditions i.e. COPD/Diabetes.

Berkshire West is part of the University of Reading CYP IAPT collaborative and has been for a number of years. (Wokingham CCG is the lead CCG for Berkshire). Many BHFT CAMHs Tier 3 staff and some local authority Tier 2 staff are undertaking CYP IAPT training. Learning from CYP IAPT has helped to shape care pathways and the development of outcomes framework in Berkshire West

CAMHS –In 15/16 the CCGs invested over £1 million in BHFT to reduce the lengthy waiting list for CAMHS services with a focus on prioritising those children assessed as being high risk, as well as reducing the overall waiting times to provide assessment and offer an appropriate treatment package if required. We will continue to work with the Trust to ensure that we have defined metrics for improvement in 16/17 and that performance is monitored closely through the contract with the Trust (see section on CAMHS transformation and supporting document).

Early Intervention Psychosis (EIP) – In 2015/16 we have an agreed Service Development Plan with our Mental Health Provider BHFT to implement 'A NICE compliant EIP' service that is able to offer and deliver the following NICE recommended treatments to more than 50% of people within 14 days of referral:

- CBT for Psychosis (CBTp)
- Individual Placement Support (IPS) for education and employment
- Family Interventions
- Medicines management
- Comprehensive physical assessments
- Support with diet, physical activities and smoking cessation
- Carer-focused education and support programmes

We are working closely with the South Region EIP Support Team to develop an EIP service that will meet the national accreditation criteria. We are working through our baseline figure with BHFT for 2016/17 and this will be agreed by the EIP Regional Team in the coming month, for reporting to start from April 2016.

BHFT have already started to develop the RTT Pathway for EIP Service for people aged between 14 and 35 and the completion of this pathway is expected by Q1 in 2016. The Referral to Treatment pathways on RiO (the BHFT IT Management System for Health Care Record) will support the reporting of EIP Activity Data from April 2016 using the new NHSE EIP reporting template.

Crisis Resolution Home Treatment Team (CRHTT) – We have increased our investment in this service line to improve workforce capacity to cover week-ends and night shifts to support those experiencing mental health crises out of hours, provide short term interventions and face to face contact. We have also invested in 'Street Triage' one year pilot in Berkshire West to work alongside Police Officers in responding to emergency mental health calls and/or assess individuals picked up by Police on the street to reduce the application of Section 136 under the Mental Health Act 1983. The CRHTT service now operates from Prospect Park Hospital and provides 24hr/7 days a week service in Berkshire West providing rapid response to manage mental health crisis in the community.

Liaison Psychiatry Service (Psychological Medicine Service) – Operating from Royal Berkshire Hospital the Psychological Medicine Service mirrors the 'RAID' (Rapid Assessment Intervention Discharge) model, providing rapid

access to individuals presenting at Emergency Department with mental health problems and working with those admitted into an acute inpatient bed with co-morbid mental health conditions to reduce length of stay. This service is also supported by the Community Crisis Response teams and the Community Psychological Medicine Service working with frequent flyers and those with medically unexplained symptoms.

Male Mental Health - In Berkshire West there were 97 suicide/undetermined/open verdict deaths in 2012-2014 and males have a higher suicide rate compared to women in line with national figures (73% male; 26% female).As part of the Thames Valley network we are supporting the CALM project targeting information and support to men with mental illness to recognise signs of mental illness and access information and services.

Perinatal Mental Health – The Berkshire West Perinatal Service will be launched on the 1st April 2016. The service specification has been agreed including KPIs, Outcome Measures, Information Requirements and expected activity levels. The aim of the service is to provide a comprehensive range of community services for women requiring pre-conceptual counselling or who experience mental health problems or illness during pregnancy or in the first year after birth**.**

In 2016/17 we will continue to prioritise mental health investment, and will be considering recurrent investment in services such as the following:

- **Street Triage Service** – Improve the experience and outcomes for service users in crisis. There will be a professional mental health assessment undertaken by an experience healthcare worker (rather than for example a S136 applied by a police officer) and the person being taken to a Place of Safety, where a full MHA assessment is required. The number of Section 136's in Berkshire West will be reduced as a consequence.
- **Alcohol Specialist Nurse Service** – We have developed a business case to request funding for investment in the Alcohol Specialist Nurse Service to operate from RBH ED and Wards; this service will provide rapid assessment and treatment to all those presenting at ED with alcohol related problems and avoid hospital admission.
- **Recovery College** – We have set up a local project group to develop a recovery college service model to support mental health service users in their recovery journey from mental health problems and access education, training, vocational and paid employment. We also expect this service to support carers in accessing education and training.

Mental Health and Physical Activity – In 2015/2016 we supported Sport in Mind a local charity providing supported sports activity to users of mental health services to obtain a lottery grant for 3 years. Working with BHFT the project will widen participation in 2016/2017 using sport as part of recovery and ongoing health promotion for people experiencing mental health problems. Sport in Mind plan to deliver 1,750 sessions and expect to support 1,500 people in 2016/2017. In addition, working with Public Health, we have promoted the Activity for Health Scheme and Moving Forward; both schemes are designed for people experiencing both physical and mental health problems.

11.2 Transforming Care

The Berkshire West Transforming Care plan (see supporting documents) for people with Learning Disabilities is aligned to a regional 'Positive Living Model'. This plan provides the opportunity to develop integrated working, clear lines of accountability and clinical engagement with adult social care to deliver high quality provision in a cost effective way through reducing the need for inappropriate admissions whilst releasing savings into the health and social are system.

Working with the best of local experience, skills and knowledge a new service model has been created that incorporates Positive Behavioural Support and increased level of community based provision through a reduction in beds. The CCG and 3 local authorities are planning to deliver intensive care support in the community as a viable alternative to hospital assessment and treatment beds. This will be achieved through specialist skills and knowledge to be transferred to community support settings and for the remaining beds to be redesigned as part of a challenging behaviour pathway. Cost savings will be released for investment into community intensive support.

BHFT has signed up to Berkshire West CCGs commissioning intentions to reduce the contracted bed based provision for people with a LD by 2017. The CCG is in the process of completing joint plans aimed at transforming services for people of all ages with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition, in line with *Building the Right Support – a national plan to develop community services and close inpatient facilities* (NHS England, LGA, ADASS, 2015). These plans will cover 2016/17, 2017/18 and 2018/19.

The CCG will work with BHFT to review the levels mortality in Berkshire in line with the recommendations of the Mazars report. The CCG will aim to develop a process for ensuring that there is good quality healthcare to achieve outcomes such as admissions avoidance. This process will be developed through understanding the current rate and reasons for mortality amongst people with learning disabilities. In parallel the Transforming Care Programme board will aim to identify how services will need to be commissioned and provided in the future to ensure that people with learning disabilities and/or autism with behaviours which challenge services are supported within their local community and only require in-patient services for clearly defined purposes.

The Berkshire West plan will aim to demonstrate how the national service model will be implemented by March 2019 that requires CCGs and local authorities to work together to reduce the reliance on in-patient beds through intensive intervention services in the community. The Director for Joint Commissioning will be leading this process for Berkshire as the Senior Responsible Officer for transforming care. The aim of this plan is to show where people are placed and how they are funded to provide opportunities for collaborating health and social care to resources to discharge people into community placements. A Pan Berkshire Business plan is also in the process of being finalised, that will show a phased reduction of in-patient beds and mobilisations plans for the intensive intervention service in the community.

Berkshire Healthcare staff, the 3 local authorities, Carers and Commissioners developed new patient care pathways to support phased closure on in-patient beds and utilise the resources to implement a 'Positive Living Model in the community. Time lines for the phased closure will be agreed by a pan Berkshire Transforming Care Board on 3rd February 2016 and further detail will be included in our April submission.

11.3 CAMHS Transformation

The CCG has established a multiagency 'Future in Mind' group which includes all key stakeholders (e.g. Schools, Health Visitors, Local Acute and Community Providers and the three local authorities). This group will oversee the joint CAMHs transformation plan for Berkshire West. The focus of which is to improve early intervention and prevention services with the aim of improving outcomes for children and young people and reducing the demand on specialist CAMHS services.

We are putting additional training and support in place across the wider children's workforce (including schools and primary care) so that children and families can access help before problems reach the point where a specialist mental health service is required. We are working with the University of Reading to develop bespoke training for families who have a child with severe conduct disorder where Webster Stratten has been unsuccessful.

We are working with the voluntary sector, our community provider and Local Authorities to ensure appropriate support is provided to families who are awaiting Autism assessment. We are also developing a CAMHs outcomes framework which will be implemented by voluntary and statutory providers in all contracts from 16/17.

Following significant investment by the CCGs additional staff has been appointed into specialist CAMHs services in order to reduce waiting times, mitigate clinical risk and ultimately = minimise the number of children whose needs escalate into crisis. The CCGs are funding a 12 month pilot to improve access to urgent care CAMHs services for children aged less than 18 years, 7 days a week. By having more CAMHs staff available in the Royal Berkshire NHS FT

(RBFT) it is hoped that length of stay will reduce, there will be fewer "frequent fliers" and that children and young people who are in crisis are able to access help more quickly, particularly over weekends.

We will be working with the Police and Crime Commissioner, voluntary sector and Health and Justice commissioning to ensure that the emotional and mental health needs of children who are victims of crime or are involved in the criminal justice system are being met.

We are also working with Berkshire East CCGs and our community provider to develop a community Eating Disorders service that meets the new standards. An enhanced perinatal mental health service has been commissioned. The SHaRON online platform is being expanded to include perinatal, carer and CAMHs support.

11.4 Voluntary Sector

The CCG commissions' projects and services from the voluntary sector aligned to the CCG's commissioning priorities and use the Partnership Development fund (PDF) as one of the routes for doing this. This is an annual commissioning cycle and the CCG looks for innovation to support people in the community with Mental Health problems, Children and Young People, Older People and People with Learning Disabilities. Voluntary and community providers play a significant role and these organisations contribute to the wellbeing of people living in Berkshire West; connecting communities, stimulating innovation and flexibility to make a difference to people's lives.

The CCG is in the process of awarding funding to voluntary organisations that submitted PDF applications to support the CCG's strategic priorities. These range from Youth Counselling to support early intervention thus reducing crisis, support for organisations reaching families and children of people with learning disabilities and autism and support for early years. The CCG will also be funding organisations that aim to reach out to support for older people, people with long term conditions, hospital to home services, and community outreach support for people with mental health problems. The CCG will develop generic and specific KPI's to monitor the effectiveness of these services linked to the CCG's commissioning priorities. Successful organisations will be required to submit half yearly written reports to clearly demonstrate achievements against the KPIs.

12. Patient Experience and Engagement

12.1 Patient Choice

The Berkshire West CCGs support Patient Choice by commissioning a range of accessible physical and mental health services from both the NHS and independent sector. Choice is facilitated by maintaining an extensive and up to date Directory of Services in collaboration with all the local service providers and accessed by the E-referral system.

Clinical pathways around Maternity services, End of Life and Ophthalmology are being investigated to assess feasibility of choice and will be added to the E-referral system where appropriate.

Providers continue to offer access to named consultants on e-referrals system.

12.2 Personal Health budgets

Berkshire West CCGs are committed to further rolling out Personal Health Budgets (PHBs) across our area for all patients who would benefit from them and have a programme of work for taking this forward.

Our next step is to take what we have learned from already offering PHBs to those with Continuing Health Care needs (CHC) and apply this in a new offer to people with learning disabilities. In doing so we confidently expect to further develop our processes and practice to facilitate the further roll out of PHBs to other patient groups.

We will develop this work jointly with appropriate local partners in particular the relevant Local Authorities (LAs). The three LAs that cover Berkshire West have already taken part in a public engagement exercise to launch this work and are signed up to being involved in joint delivery and sharing of resources where appropriate and practical.

12.3 Patient Engagement

Berkshire West CCGs Patient and Public engagement plans recognise that there are many different ways which people might participate in health depending upon their personal circumstances and interest. In addition to awareness raising, preventative health and system resilience messages throughout the year, topics that were explored in-depth with patients during 2015/16 included;

- Frail elderly pathway redesign
- Alternative Provider Medical Services (APMS) contract procurements
- Primary care strategy
- End of life care planning
- Digital behaviours
- NHS111

We have developed robust methods of listening, engaging and involving patients and the public which have ensured that their insight and experiences have been acted upon at all stages of the commissioning cycle and have influenced our commissioning decisions. We will now make this more systematic and consolidate our engagement and involvement to better empower patients to shape services and the care that they receive.

The engagement strategy for Berkshire West recognises that there are many different ways which people might participate in health depending upon their personal circumstances and interest. Hence CCG engagement ranges from simple awareness building activities for the general public, through to working with patient and community groups to ensure that their concerns and aspirations are understood and considered by commissioners:

- ***Awareness raising*** - Throughout the year a range of messages are shared via CCG and partner communication channels, online, offline and face to face.
- ***Surveys*** - The Berkshire Health Network (BHN) is used to target engagement activities to interested organisations and individuals, and to publish and invite feedback from surveys and discussion documents.
- ***Governing body meetings*** - Members of the public are invited to observe and attend CCG governing body and JPCCC meetings in public.
- ***Public meetings*** - CCG's host regular public meetings themed around a specific area, such as the primary care strategy or the frail elderly pathway. Such meetings create opportunity for group discussion and meeting outputs are documented for commissioners. Public meetings are also used to ensure the widest possible engagement in service change, such as new contract procurement for a GP surgery.
- ***Patient representatives*** - Patient representatives can be found on each programme board. CCG governing bodies are also supported by a lay member with an interest in patient and public participation.
- ***Patient groups*** - The CCGs are currently broadening work in this area to establish dedicated patient groups that engage with and support specific streams of work.

Patient engagement work during 2016/17 will focus on:

- Socialisation of 16/17 CCG plans
- Areas of service change resulting from the implementation of the primary care strategy and QIPP plans
- The move towards the ACS and the introduction of the new Frail Elderly Pathway.
- Development of a digital roadmap by Berkshire West CCGs and support for patients to engage with existing digital services.
- Work with seldom heard and hard to reach groups, encouraging them to become more involved in their local NHS.
- Work to map and engage PPGs directly in communications and engagement work.

- Build on an early trial in West Berkshire to set up and co-ordinate a communications and engagement network; bringing together providers and the unitary authorities, to share intelligence and look at ways in which partners can better engage with the public together.

12.4 Patient Activation and self-care

There are a number of measures in place across Berkshire West to support patient activation and self-care, including:

- Development of a self-care strategy to support reduction in urgent care demand
- Development of a self-management protocol enabling patients to enter their own data and remind them to attend appointments
- A social prescribing pilot in South Reading with Reading Voluntary Action group focusing on patients social needs
- Use of a diabetes online tool (ECLIPSE) – including a secure patient portal. In 2015/16 Berkshire West CCGs won first place for the most effective prescribing as a result of using Eclipse widely
- The use of risk stratification and care planning for patients aged 75 and over with input from patients

13. Technology

The CCG has been working with partners since 2013 on the innovative and exciting programme called Connected Care to develop a joint vision and strategy for information sharing, and the development of an integrated care record across the 10 Health and Social Care organisations in the Berkshire West community. This will enable delivery of a comprehensive electronic record at the point of care by 2018, including social care partners. Procurement processes for the information integration solution and single electronic care record will be complete by the end of the 2015/16 financial year, allowing the focus to shift to delivery in quarter 3 2016/17.

Delivery of the Local Digital Roadmap will be governed by the Berkshire West CCGs Innovation, Technology and Information Systems Programme Board; this forms part of the overall governance of the Berkshire West 10 Health and Care Integration Programme (BW10). The Connected Care Programme governance feeds in through the BW10 Integration Board and the Delivery Group. This ensures that digital priorities are identified collectively on a system level, and are used as an integral enabler of clinical transformation and organisational priorities across the health economy.

Our system vision for Frail Elderly as described earlier has been used to inform the system requirements based on a local version of the “Sam’s Story” narrative initially created by the Kings Fund. This has enabled us to model our requirements using a patient centred approach to pathway redesign. This work has highlighted how much more efficient and effective care would be by avoiding information silos and having a single integrated record.

Programme benefits are projected at approximately £2.5 million per annum on a Berkshire footprint against a Berkshire system wide investment of circa £10 million over the period of the contract (this includes all health and social care organisations). These benefits are focused on the following:

- Reductions in length of stay
- Reductions in admission
- Reductions in duplicate and unnecessary testing

The benefit values are conservative to avoid double counting against other service transformation programmes which are co-dependent on the delivery of the Connected Care Programme and the broader digital agenda across the Berkshire West 10 organisations.

Key activities outside the Connected Care Programme which will form part of the Digital Roadmap delivery for 2016/17 include:

- working with providers to support their use of electronic prescribing solutions and vital signs monitoring,
- maximising the use of existing clinical systems at the point of care.

In Primary Care, Wokingham CCG will be leading the development of a pilot with their practices and NHS 111 in relation to on the day bookings to commence early in 2016/17. We also envisage expanded access to planned extended hours appointments during 2016/17. A number of practices are already piloting Skype consultations and the use of emails and telephone consultation/triage is widespread amongst our practices. We are still working to further define work streams to expand and build upon these new modes of access and to increase self-care and the use of symptom checker and/or triage apps. Our initial priority will be to maximise the use of existing systems such as EPS2, e-referrals and existing patient online tools accessed through the GP record. Further detail will be set out in our Digital Roadmap.

There are a number of additional clinical systems which support decision support and care planning, and we will work to evaluate and rationalise these, ensuring that any duplicate functionality from any new systems allows the decommissioning of existing systems where appropriate.

As part of the integrated record the CCGs have procured a patient portal which will support projects increasing self-management and prevention. This will allow comprehensive patient access to their records across health and care in future, along with the ability to integrate information from wearable devices and self-monitoring tools. In the interim the CCGs will continue to work with practices to improve the digital services offered to patients through the existing patient online tools accessed through the GP record.

The Digital Roadmap will form an integral part of the STP submission as a key enabler of service transformation.

14. Research and Innovation

This statutory responsibility is incorporated into the terms of reference and business cycle of the CCG's Joint Quality committee. The CCGs are committed to and are engaged with the Oxford Academic Health science network, through attendance at the Clinical Innovation Adoption Oversight group and the Strategic Clinical Network (SCN). The AHSN are routinely invited to attend the CCGs Clinical Commissioning committee and the relevant Programme Boards. Innovations are assessed on a case by case basis.

14.1 Genomics, precision medicine and diagnostics

As a result of increased molecular knowledge, disease classification will significantly improve over the next five years and will be more precise which will enable us to refine our diagnostic capability and apply a range of different therapeutic interventions. In turn, this will allow the identification of patient populations most likely to benefit from specific interventions and has the potential to improve the effectiveness and efficiency of the entire healthcare system.

In Thames Valley we are fortunate to have a very strong biomedical research centre and university and as well one of the strongest technology 'clusters' in Europe. Through our subscription to the AHSN we will be informed of developments in this field and will engage in opportunities to test new service models.

In the shorter term, we are aware that the capacity and demand gap for diagnostics is growing with the changing NICE guidelines. We are using the SCN support tools to help us quantify the gap and are participating in their programme of work that aims to jointly consider how this gap will be plugged. There are considerable work force issues that will need to be addressed and some consideration will need to be given to ensuring that going forward the work is done by a workforce fit for the future. This will be done in partnership with other health economies in Thames Valley.

15. Governance and Assurance

In line with the CCGs constitutions the Operating Plans are required to be signed off by the Council of Member Practices. All 4 plans will be presented at the March meetings which will enable member practices to ratify individual CCG plans in advance of the final April 11th submission date.

Progress against plans will be reported quarterly to Council of Practices and 6 monthly to CCG Governing Bodies. This process is underpinned by monthly reporting on delivery of quality and finance performance standards to the Berkshire West Federation of CCGs standing committees, and quarterly assurance meetings with NHSE area representatives.

The Berkshire West 10 system also has in place a formal governance structure which brings together the senior leadership from all partner organisations at both a strategic (Integration Board chaired by the CCG Federation CO) and operational level (Delivery Group, chaired by the Director of Adult Social Care for Reading Borough Council, and Vice Chair Director of Strategy for the BW CCGs) in support of the achievement of our overarching vision for Berkshire West. There is a direct link from these meetings through the membership to the three Health and Wellbeing Boards, and individual organisational Boards, Committees and Governing Bodies.

Supporting documents

1. Berkshire West CCGs – Public Health Profiles 16/17(to be submitted with 11th April plan)
2. Berkshire West CCGs Commissioning Intentions 2016/17(to be submitted with 11th April plan)
3. Berkshire West CCGs Finance Strategy 2016/17(to be submitted with 11th April plan)
4. Berkshire West CCGs Operating Plans on a Page(to be submitted with 11th April plan)
5. RTT and Cancer Treatment standard recovery plans(to be submitted with 11th April plan)
6. Berkshire West Operational Resilience Capacity Plan(to be submitted with 11th April plan)
7. Berkshire West Primary Care Strategy 2016/17 (attached)
8. Berkshire West CAMHs Transformation Plan (plans produced for each LA – copy of Wokingham plan attached)
9. Crisis Care Concordat Action plan (attached)
10. The Berkshire West Transforming Care plan (attached)
11. Connected Care Programme – Briefing document (to be submitted with 11th April plan)
12. Berkshire West Frail Elderly Pathway final report and implementation plan (to be submitted with 11th April submission)
13. Berkshire West CCG Dementia Action Plan(to be submitted with 11th April plan)
14. Berkshire West CCGs Communications and Engagement Plan (attached)
15. Berkshire West Diabetes Action plan (to be submitted with 11th April plan)
16. Berkshire West ACS PID(to be submitted with 11th April plan)

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