REPORT FROM SOUTH READING CLINICAL COMMISSIONING GROUP & NORTH & WEST READING CLINICAL COMMISSIONING GROUP

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**14TH Feb 2013**	**AGENDA ITEM:**	**4**
TITLE:	**BERKSHIRE WEST 5 YEAR STRATEGIC PLAN AND 2 YEAR OPERATIONAL PLANS FOR SOUTH READING CCG AND NORTH & WEST READING CCG**		
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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 NHS England issued planning guidance to Clinical Commissioning Groups (CCGs) "Everyone Counts: Planning for patients 2014/15 to 2018/19" on 20th December 2013. This guidance requires CCGs to produce a number of documents for submission to NHS England within a timeframe. These documents include a 5 year Strategic Plan and associated 2 year Operational plan(s), Financial plan and a Better Care Fund Plan.

1.2 The Better Care Fund requires formal assurance from Health & Wellbeing boards and NHS England and will be discussed as a separate document.

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

1.4 This report outlines a summary known as the "Plan on a Page" for the 5 year Strategic plan and the individual CCG 2 year operational plans, ahead of the submission deadline of 4th April 2014, to allow the Health and Wellbeing board early sight of the plans intentions and to allow a triangulation with the Reading Health and Wellbeing Strategy 2013-206 which was published in April 2013.

1.5 This report demonstrates how the 5 Year Strategy and 2 Year plans align with the four goals and sub objectives of the Reading Health and Wellbeing Strategy 2013-16 and the recent Reading JSNA and individual CCG public Health profiles.

1.6 Full 2 Year Operational Plans and a 5 year Strategic Plan will be presented at the March 2014 Health and Wellbeing Board.

2.1 2. RECOMMENDED ACTION: To note the priorities identified by the CCGs as outlined in the "2 Year Operational plan on a page" and to support the ongoing work of the CCGs in supporting the delivery of the Reading Health and Wellbeing Goals.

2.2 To note the vision for the direction of travel for the Berkshire West health and social care system as outlined in the "5 Year Strategic plan on a page" and to support the ongoing work of the Berkshire West CCGs in supporting the delivery of the Reading Health and Wellbeing Goals.

2.3 To note that full 2 year and 5 year strategic plan will be reported to the Health & Wellbeing Board in March 2014.

3. POLICY CONTEXT
The NHS Outcomes Framework and the Seven Outcome Ambitions

3.1 NSH England aspires to develop an NHS that delivers great outcomes for patients. These outcomes are described within the framework of the NHS Outcomes Framework Domains and the Seven Improving Outcome Ambitions.

NHS Outcomes Framework 2014/15

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

The Seven Improving Outcome Ambitions

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

4. THE READING HEALTH & WELLBEIGN STRATEGY 2013-2016

Our Vision – A Healthier Reading

Communities and agencies working together to make the most efficient use of available resources to improve life expectancy, reduce health inequalities and improve health and wellbeing across the life course

Goal One – The health of communities is promoted and protected

Goal Two – Focus is increased on early years and the whole family

Goal Three – The impact of long term conditions is reduced

Goal Four – Health-enabling behaviours and lifestyle are promoted

5. BERKSHIRE WEST FIVE YEAR STRATEGIC PLAN 2014-19

The Strategic Plan will set out a vision for what health and social care services in Berkshire West will look like by 2019. It will describe the key interventions and changes required to deliver improved outcomes for service users and patients and to ensure financial sustainability, based around six characteristics identified by NHS England as being common to high performing systems. It will also set out levels of ambition for improvement against the NHS Outcomes Framework, focussing on six key indicators selected by NHS England.

The Plan on a Page is one of a set of national templates to be completed as part of the planning process. As well as summarising the vision and key workstreams that will be set out in the plan itself, it incorporates the success criteria, governance arrangements and system values which have been agreed by the ten statutory organisations that form part of the Berkshire West 10 integration programme.

The slidepack attached at **Appendix A** gives more detail on current strategic thinking.

Alignment of the plan with the Reading Health and Wellbeing Strategy is demonstrated below:

HEALTH & WELLBEING GOAL	HOW REFLECTED IN STRATEGIC PLAN
Goal 1 The health of communities is promoted and protected	• Objectives include a reduction in years of life lost from treatable conditions. • Quality section sets out how patient safety will be ensured.
Goal 2 Focus is increased on early years and the whole family	• Integration programme includes implementation of integrated pathways of care for children's services as well as frail elderly.

	• Work to improve health and reduce health inequalities will include specific initiatives for improving child health. • Plan focuses on better meeting needs of older and vulnerable people.
Goal 3 The impact of long term conditions is reduced	• Objectives include an ambition to improve quality of life for patients with long-term conditions. • Vision statement reflects need to support those with long-term conditions to make decisions about their care. • Building role of primary care will include enhancing support for those with long-term conditions. • Improvement interventions described in main section of plan include implementing telehealth and joint monitoring for patients with long-term conditions.
Goal 4 Health-enabling behaviours and lifestyle are promoted	• Plan will include section on reducing health inequalities and promoting good health. This is reflected in vision statement which states that services will work together to prevent ill-health.

6. SOUTH READING CCG 2 YEAR OPERATIONAL PLAN 2014-2016

There are 9 main Objectives of South Reading CCG Plan on a Page which have been identified using a number of information sources. Various sources of Outcomes data are available to the CCG to help inform our planning priorities for 14/15 and beyond.

These include:

- The South Reading CCG Outcome Atlas, which compares performance against the Outcomes Framework against England averages
- Levels of Ambition Atlas
- Operational Planning Atlas
- South Region Commissioning for value pack for South Reading CCG

In addition we have reviewed our Joint Strategic Needs Assessment (JSNA) which was refreshed in 2013/14. The JSNA helps inform our local commissioning and decision making by providing us with valuable information to allow us to commissioning quality health services now and in the future. Through a series of workshops with our GP members, practices visits, public meetings (Call to Action) and consultation we have been able to develop specific areas of focus that underpin and support the Reading Health and Wellbeing strategy and vision.

6.1 Alignment of the South Reading Objectives with the Reading Health & Wellbeing Strategy is demonstrated below

HEALTH & WELLBEING GOAL ALIGNMENT	OBJECTIVE
Goal 1 The health of communities is promoted and protected	• To reduce the incidence of healthcare related infection from C. Difficile and MRSA • We will continue to promote health screening for cardiovascular disease and cancer.
Goal 2 Focus is increased on early years and the whole family	• To continue the joint work underway within the children's subgroup , particular to resolve issues with under 5 year old unnecessarily attending A & E.
Goal 3 The impact of long term conditions is reduced	• To improve health related quality of life for people with Diabetes • To improve the quality of life for people with Mental health conditions (psychosis and depression) • To reduce unplanned admissions due to amenable health conditions for COPD • To increase access to Reablement following discharge improving independent living and maximising quality of life • Introduce a Hospital at Home service to provide care to patients who would have usually been admitted, allowing them to safely remain at home. All care home residents will have a dedicated GP and supportive care plan to prevent u unplanned hospital care ,within 6 weeks of admission
Goal 4 Health-enabling behaviours and lifestyle are promoted	• To reduce the impact of Obesity in under 11year olds over the next 3-5 years and improve the level of inactivity in the population as a whole. • To reduce unplanned admissions related to alcoholic liver disease. • Build upon current levels of public engagement to help shape and influence our local commissioning decisions so that services reflect the needs of local people

7. NORTH & WEST READING CCG 2 YEAR OPERATIONAL PLAN 2014-2016

There are 9 main Objectives of North & West Reading CCG Plan on a Page which have been identified using a number of information sources. Various sources of Outcomes data are available to the CCG to help inform our planning priorities for 14/15 and beyond.

These include:

- The North & West Reading CCG Outcome Atlas, which compares performance against the Outcomes Framework against England averages
- Levels of Ambition Atlas
- Operational Planning Atlas
- South Region Commissioning for value pack for North & West Reading CCG

In addition we have reviewed our Joint Strategic Needs Assessment (JSNA) which was refreshed in 2013/14. The JSNA helps inform our local commissioning and decision making by providing us with valuable information to allow us to commissioning quality health services now and in the future.

7.1 Alignment of the North & West Reading Objectives with the Reading Health & Wellbeing Strategy is demonstrated below :

HEALTH & WELLBEING GOAL ALIGNMENT	**OBJECTIVE**
Goal 1 The health of communities is promoted and protected	• To promote increased screening of COPD to improve the rate of reported prevalence as a percentage of the estimated prevalence from 41% to the England average of 58% • To reduce the higher than average intervention rates for musculoskeletal conditions ensuring that surgical proceedings are only undertaken at the most appropriate time and where it is clear that the benefits outweigh the risks • To reduce the incidence of healthcare related infection from C. Difficile and MRSA • Continue to promote opportunities for health screening and immunisations. •
Goal 2 Focus is increased on early years and the whole family	• To continue the joint work underway within the children's subgroup.
Goal 3 The impact of long term conditions is reduced	• Increase percentage of people with diabetes receiving the nine key care processes to 60%

	• To reduce unplanned hospitalisation of frail and elderly patients by implementing the hospital at home scheme, enhanced GP service to care homes and community nurse for the elderly. • To improve the mental health of the population and reduce prevalence of adult depression from 15% to England average of 12%
Goal 4 Health-enabling behaviours and lifestyle are promoted	• To reduce physical inactivity as a percentage of the population from 42% to 40% and reduce childhood obesity in year 6 children from 35% to the England average of 33% • Improve the choice of where to die for patients near the end of life. 70% of people in Reading want to die at home. Only 19.9% do. We aim to get to 23% • Effective participation of the public in the commissioning process so that services reflect the needs of local people

8. NEXT STEPS

8.1 Following feedback from NHS England regarding our submission of early plans on 24th January, we will revise the plans accordingly and present updated full 2 year Operational plans for each CCG and a 5 year strategic plan to the Reading Health & Wellbeing Board in March 2014.

8.2 The final 2 year plans will be approved fixed and approved by NHS England by 4th April 2014 and the 5 Year Strategic Plan by 20th June 2014.

9. COMMUNITY ENGAGEMENT AND INFORMATION

9.1 Both the 2 year and 5 Year Strategic Plans will be shared with key stakeholders including Providers, HWBB , Local Authority, Healthwatch, Patients and carers and with NHS England between January and end of March 2014. This will help inform any alterations that need to be made to plans before final submission. A "Call To Action" event was held jointly between the two CCGs in November 2013 where early plans , strategy and objectives were shared with the public and their views sought and used to influence future development of the plans seen here in their latest version.

10. BACKGROUND PAPERS

10.1 NHS England "Everyone Counts: Planning For Patients 2014/15 to 2018/19"

10.2 Reading's Health and Wellbeing Strategy 2013-16

10.3 NHS Outcomes framework 2014-15

BERKSHIRE WEST STRATEGIC PLAN ON A PAGE 2014-2019

1

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

2

System Objective One
A 3.2% reduction in years of life lost from treatable conditions

System Objective Two
An increase in the proportion of people who feel supported to manage their long-term condition from 78.5% to 81%.

System Objective Three
To reduce unplanned admissions to hospital by Figure TBC

System Objective Four
A 3.6% reduction in people rating their experience of hospital care as poor. Similar measure tbc for primary care.

System Objective Five
Increase in number of older people supported to live at home following discharge

System Objective Six
To work to eliminate avoidable deaths in hospital

3

Engagement - New and varied approaches to talking to patients and service users, supporting them to understand their needs and working jointly with them to manage their condition

Primary care at the heart of an integrated system - GPs working together in larger units to offer improved accessibility and co-ordinate other services around the needs of the patient.

Integration - Implementation of joined up pathways of care for the frail elderly, mental health and children's services and development of further integrated pathways of care

Urgent care - Data-driven transformation of urgent care into a network of services to ensure all patients receive a timely response in the most appropriate setting.

Productive elective care - Reducing level s of musculo-skeletal activity and using contracting mechanisms to commission most efficient care. Proactive market management through joint work with key providers.

Concentrating specialist care – securing best outcomes for patients and working with providers to understand impact on local health system.

4

Overseen by the following governance arrangements

- Shared governance structure incorporating Health and Wellbeing Board oversight
- Senior leadership through the Berkshire West Partnership Board with support from the Chief Officers' group
- Delivery assured through shared programme with jointly-appointed Programme Director

5

Measured using the following success criteria

- Set of specified patient outcomes – co-production of care plans, single point of contact, supporting patients to make decisions and offering personal budgets
- Underpinned by set of programme performance metrics

6

System values and principles

- Develop a compelling vision for integrated care and monitor progress against this
- Align individual organisational plans across the whole system
- Identify and overcome the obstacles to integration

SOUTH READING CCG PLAN ON A PAGE

South Reading health economy is a system comprised of partners from Reading Health & Well-Being Board, Royal Berkshire Hospital, Berkshire Healthcare Trust and South Central Ambulance Service.
The CCG vision is "Working innovatively with patients and partners to improve the health of our local community"

Securing additional years of life for people of England with treatable mental health and physical conditions

Improving the Health related quality of life of the 15+million people with one or more long-term condition, including mental health

Increasing the proportion of older people living independently at home following discharge from hospital

Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community outside of hospital

Increasing the number of people with mental and physical health conditions having a positive experience of care outside of hospital , in general practice and in the community

Increasing the number of people having a positive experience of hospital care

Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems of care

To reduce unplanned admissions due to amenable health conditions for COPD

To reduce unplanned admissions related to alcoholic liver disease.

To reduce the impact of Obesity in under 11year olds over the next 3-5 years and improve the level of inactivity in the population as a whole.

To improve health related quality of life for people with Diabetes

To increase quality of life for people with severe and enduring Mental illness

To increase access to reablement following discharge improving independent living and maximising quality of life

To reduce "emergency admissions for acute conditions that should not normally require hospital admissions

Build upon current levels of public engagement to help shape and influence our local commissioning decisions so that services reflect the needs of local people

To reduce the incidence of healthcare related infection from C. Difficile and MRSA

Delivered through collaborative working between GPs and the community respiratory team. . We aim to **improve diagnosis using spirometry** and ensure **rapid access to appropriate medication** within the community

Delivered through developing methods of **increasing referrals to Drug and alcohol services.** Work in collaboration with public health and the voluntary sector to, led by a local GP **to improve the alcoholic liver disease pathway** across community and secondary

Delivered through launch of Live Active programme to increase physical activity through self-motivation and changing of lifestyle behaviours

Delivered through **intervention in primary care.** Promoting the Diabetic 9 care processes and self-care using care planning and technology such as **Eclipse**

Delivered through **increased access to IAPT in secondary care** and introduction **of recovery measures within the patient pathway**

Delivered through poling of budget through the better care fund and improved integrated working across health and social care, offering reablemetn assessment to all prior to discharge.

Introduce a **Hospital at Home service** to provide **c**are to patients who would have usually been admitted, allowing them to safely remain at home. All **care home residents will have a** dedicated GP and supportive care plan to prevent u unplanned hospital care ,within 6 weeks of admission

Delivered through **a range of engagement events, increased PPG inv**olvement, monitoring of Friends and family test results and responding to audits and patient views expressed through HealthWatch and PALS

Delivered through regular monitoring of Antibiotic prescribing in general practice. We will aim to learn from route cause analysis working in partnership with our infection control nurse. We will monitor progress monthly through our Quality dashboard.

North & West Reading Operational Plan on a Page – 2014/16