Strategic Plan

2014-19

Version Control

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3.3	09/06/14	F Slevin-Brown	Draft	Various amendment
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3.5	19/06/14	Fiona Slevin-Brown	Final draft	Final submission 20/06/14

Contents

Introduction

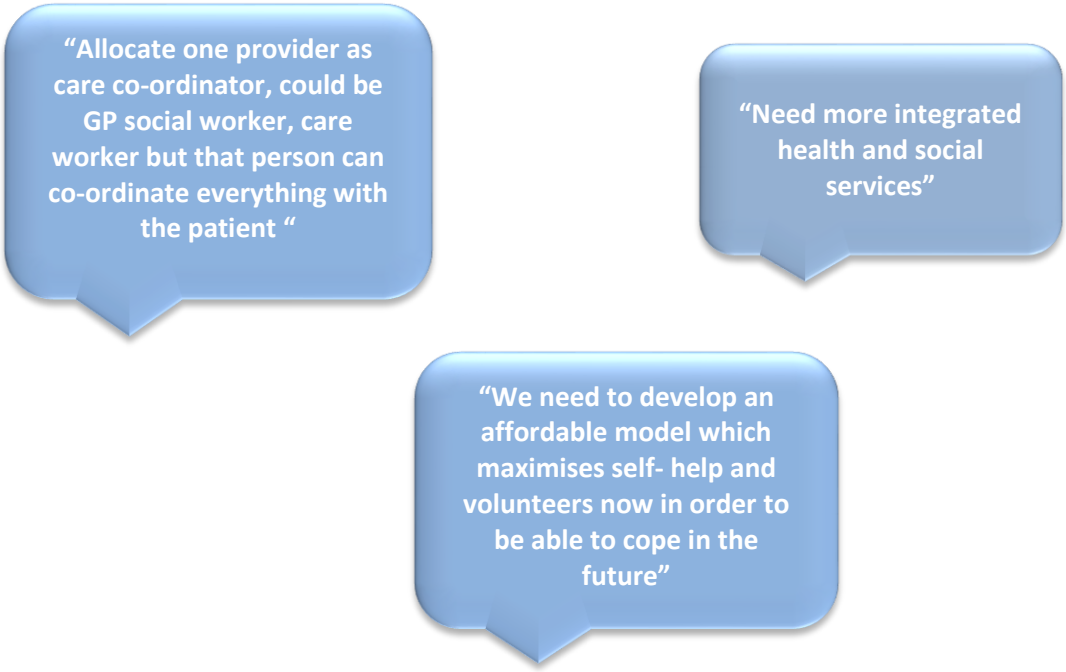
The Berkshire West health and social care economy is committed to developing, testing and implementing innovative approaches to service redesign co-produced through engagement with our local populations and strong collaborative leadership. Our collective objectives are focused on improving outcomes for users and patients, and achieving long term financial sustainability.

This five year plan has been developed at a Berkshire West level, and has been informed by each of the local JSNAs and the respective Joint Health and Wellbeing Strategies. The unit of planning was agreed by the local Health and Wellbeing Boards on the basis that it covers a population recognised by the CCGs, patients, providers and local authorities, takes into account patient flows, is of a size that makes delivery of transformational change viable and encompasses a community of commissioners and providers that have an appetite to work together. This community, known as the 'Berkshire West 10', encompasses the four Clinical Commissioning Groups (Newbury and Community, North and West Reading, South Reading and Wokingham CCGs), three local authorities (Reading Borough Council, West Berkshire Council and Wokingham Borough Council) and three provider trusts (Royal Berkshire NHS Foundation Trust (RBFT), Berkshire Healthcare NHS Foundation Trust (BHFT) and South Central Ambulance Services NHS Foundation Trust (SCAS)). As a health and social care community we are committed to aligning our organisational plans to deliver the vision described in this Strategic Plan.

It is recognised by all partners that the financial challenge facing the Berkshire West health and social care system is significant. Demand for services is predicted to rise with a growing older population, and it is clear that without further wide scale transformation there will not be enough money to meet this predicted additional demand. Having undertaken a provider impact analysis this strategy sets out our plan for the service changes required over the next 5 years which aim to address the major financial and demand challenges we face as a system. Our 5 year strategy is underpinned by the individual CCG operational plans, as the first phase of delivery of the strategy in years 1-2, and a series of system wide transformation programmes, and strategies, some of which are under development. These include:

- 5 year financial plan (annex B)
- Berkshire West 10 Integration programme
- Clinical Strategy programme
- Primary Care Strategy – under development
- IM&T strategy
- Patient engagement strategy - under development
- Mental Health strategy – under development
- Children and Young Peoples Commissioning programme – under development

A key priority in our planning processes has been to seek the views of our local populations. They have told us that they believe that organisations should work more effectively together to support people to remain in their own homes for as long as possible, with care plans which empower patients and carers to work alongside professionals in improving their own health.



In the delivery of our strategy we will continue to listen to patients' feedback (examples of which are presented above) and we will build on the firm mandate we already gained through our "Call to Action" events to develop integrated services around patients and their lives. We have a wide range of mechanisms across all the partner organisations for listening to the patient voice on both a geographical and care pathway perspective. We are embarking on developing our patient and user engagement strategy to underpin the work of all our strategic programmes.

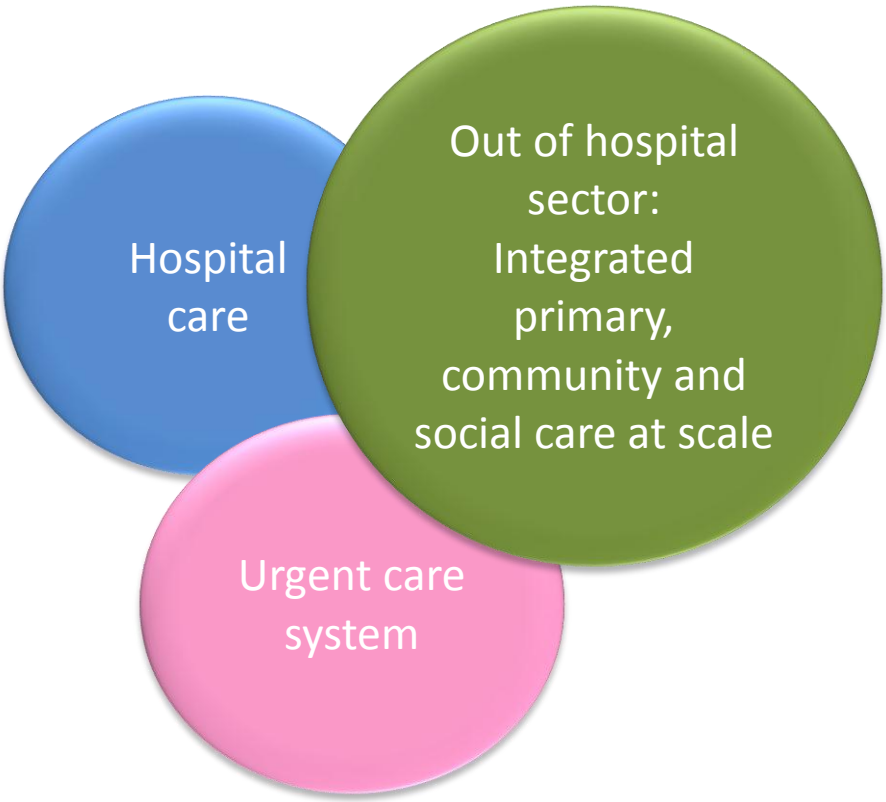
The key elements of this will be:

- Keeping the individual's experience and perspective as the organising principle of service design
- Keeping the needs and perspective of individuals at the heart of the discussion
- Patient representation throughout the governance structure; locality integration groups and Partnership Board
- Involvement must be simple and easily accessible
- The twin activities of co-production and consultation - there needs to be continual feedback to ensure the process is working
- We will develop a broad range of communication and engagement materials that facilitate the participation of all parts of our community, regardless of language spoken, mental capacity or learning disability
- We will develop and embed a patient and public involvement programme that uses a range of mechanisms to engage people in the commissioning, operation and design of health services for people across Berkshire West ,including traditionally harder to reach groups
- We will develop new measures of patient experience to assess the benefits of integration.

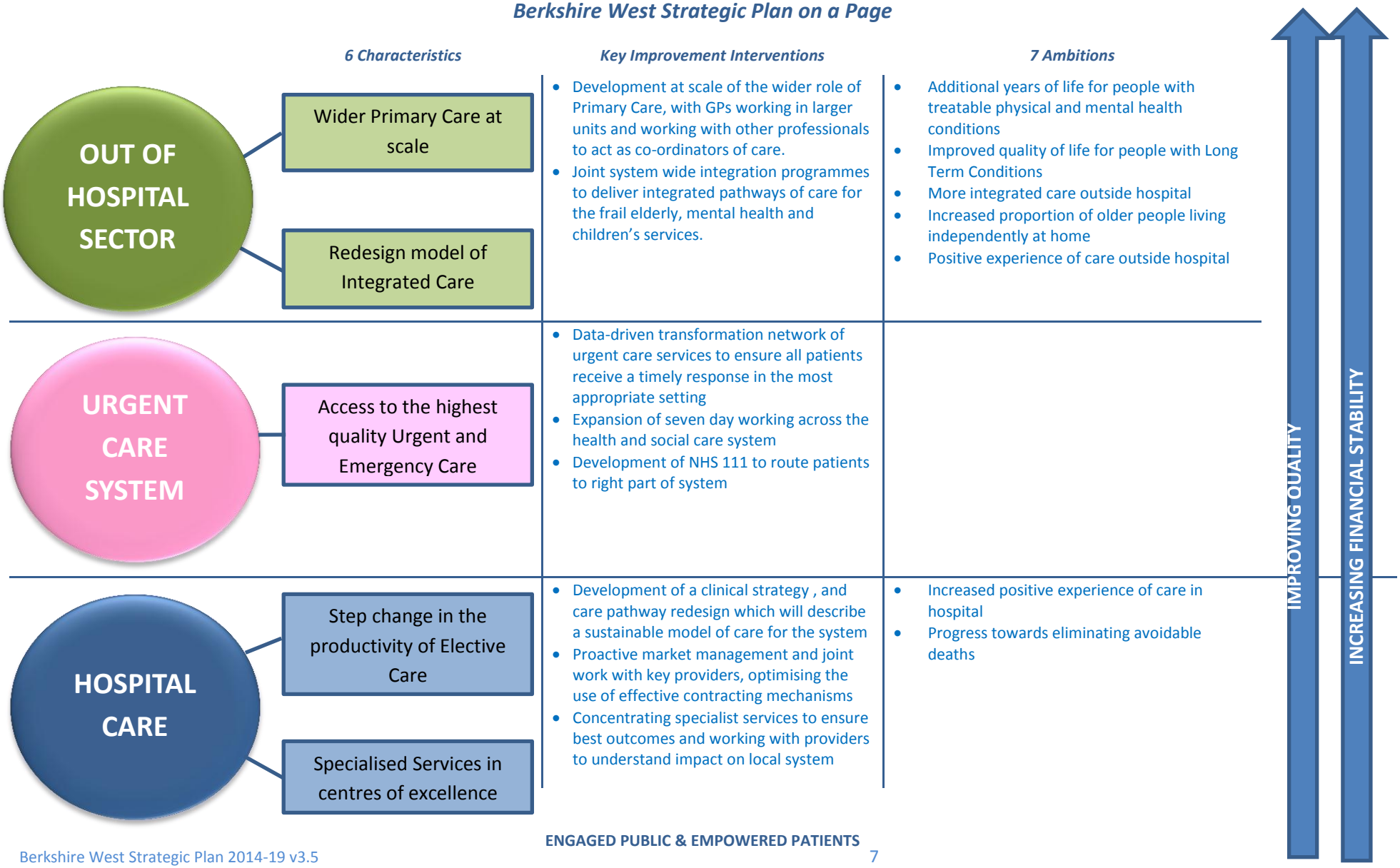
Our Vision for 2019

1. Our Vision

By 2019, 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 patients with much more complex needs to receive the care they need in their community. Service users 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 patients will only be admitted into hospital when the services they require cannot be delivered elsewhere, and that when acute care is needed they will be treated in centres equipped with the appropriate facilities and clinical expertise. 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. People with serious and life-threatening conditions will continue to be treated in acute centres that maximise their chances of survival and a good recovery.



Berkshire West Strategic Plan on a Page



NHS England has identified that any high quality, sustainable health and care system will have the following six characteristics. We aim to deliver our vision by further developing these characteristics locally:

- A completely new approach to ensuring that citizens are fully included in all aspects of service design and change, and that patients are fully empowered in their own care.
- A wider primary care offer, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step change in the productivity of elective care
- Specialised services concentrated in centres of excellence

2. Improving quality and outcomes

In achieving our vision we look to secure the following improvements in outcomes for patients and service users by 2019:

% change by end of 5 year timescale for each ambition measure

	Newbury &District	North and West Reading	South Reading	Wokingham
EA1 PYLL	8.8%	10.2%	16.2%	3.2%
EA2 LTC support	3.1%	2.2%	3.8%	2.4%
EA4 NEL composite measure (this one hasn't changed)	3.2% reduction in unplanned admissions to hospital in the first year of this plan.			
EA5 Inpatient Experience	1.6%	0.7%	0.7%	0.7%
EA6 Primary Care and OOH experience	13.0%	0%	26.8%	7.1%

We also intend to make further progress towards eliminating avoidable deaths in hospital and increase the proportion of older people living independently at home following discharge.

The 'Improving Quality and outcomes' section (below) sets out how we will ensure the quality and safety of the services we commission.

3. Population profile

The Berkshire West CCGs' Operational Plans set out in detail the health needs of their local populations, informed by the appropriate Joint Strategic Needs Assessment, and the local Health and Wellbeing Strategies and include the actions being taken to address these locally.

Overall as a health and social care system we are experiencing increasing demand for services, and a significant increase in the numbers of over 65s averaging 10% across the 4 CCGs. We also expect there to be a large rise in the numbers of older people living with more than one long term condition, e.g. cardiovascular disease, Dementia and Diabetes. These increases are likely to present the biggest challenges to affordability and sustainability over this strategic planning period.

As a system we will work together to tackle health inequalities, illustrated most strongly by the differences in life expectancy of people living in the three unitary authorities in Berkshire West.

	Life expectancy at birth for LA 2009-2011
Reading	**M 78.4** **F 82.9**
West Berkshire	**M 80.7** **F 84.5**
Wokingham	**M 81.5** **F 84.4**

The causes of death that contribute most to the gap in life expectancy at birth between the least and most deprived areas vary for males and females as well as varying between the 3 localities. However cardiovascular disease (including stroke and CHD), cancer, respiratory disease and digestive disease (including liver disease) account for between 48% and 78% of the gap in life expectancy. We will work alongside the Public Health teams in local authorities to develop the most cost effective and appropriate interventions to prevent premature mortality and decrease the gap in life expectancy. Key areas of activity are outlined in the 'Improvement Interventions' section (below).

Responsibility for the direct commissioning of Section 7A services under the Health and Social Care Act 2012 now sits within NHS England's Public Health Area Team. This includes screening programmes for adults and children (cancer and non-cancer), immunisations, Health Visiting Services, Family Nurse Partnerships Schemes and Child Health Information. As many of these services are currently delivered within primary care and are of great importance in helping to address health inequalities in our local CCG areas, it is important we have an effective working relationship with NHS England and Public Health England and that plans are co-ordinated to achieve optimal impact for our local populations.

We also recognise that there is evidence to suggest that life expectancy and health outcomes may be adversely affected by serious mental illness, substance misuse and depressive episodes and similarly that those with physical health conditions have a much greater risk of also developing mental health problems. We aim to give mental health parity of esteem with physical health through commissioning high quality evidence-based services which reflect the national mental health strategy and other key guidance.

4. Delivering transformational change

Delivery of our vision and system sustainability will mean commissioning new models of care, developed in partnership with our populations, and partner organisations, and will also include the need to explore new approaches to payment mechanisms and contracting for services. Health and social care services will need to be organised locally so that they can work optimally together in designing integrated pathways which deliver the best outcomes and experiences for patients and offer best value for the tax payer. It is recognised that to achieve a sustainable health and social care system locally that we will need to deliver transformational change at scale, and that this will require a major reconfiguration of pathways and care models which may ultimately lead to structural changes to existing provider organisations within this five year period.

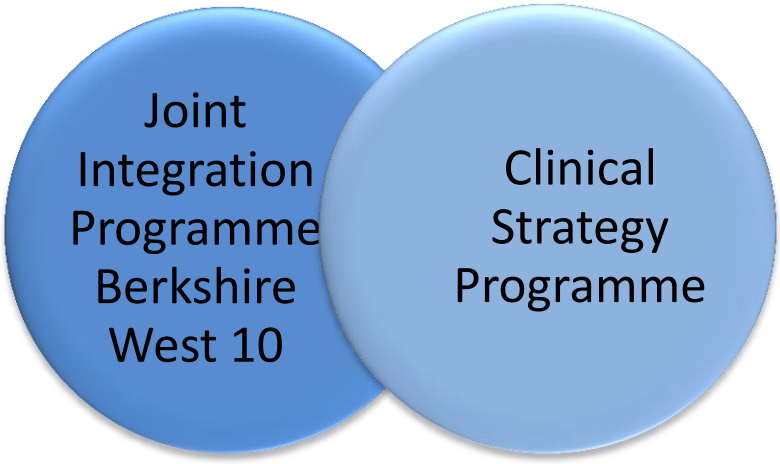
In achieving transformational change we will continue to draw on our patient's views, and use robust needs assessment in identifying our priorities. The commissioning and redesign of services will be informed by effective clinical engagement, recognised best practice, and performance data analysis, in a context of an absolute requirement for improving the health and social care outcomes and system sustainability.

We will continue to work with partners to jointly commission services where appropriate and where there is evidence that this will:

- Enable us to target services to give the greatest impact on outcomes
- Avoid duplication
- Ensure value for money & efficiency
- Develop integrated services
- Combine resources; sharing best practice and expertise

The Berkshire West CCGs have 5 topic specific transformational Programme Boards, which are clinically led, and which have cross organisational representation. These Boards cover our key planning themes, Long Term Conditions, Planned Care, Urgent Care and Children, Maternity, Mental Health and the Voluntary sector. Their key purpose is to ensure the delivery of our strategic vision through shaping local commissioning intentions and overseeing high quality service provision through the generation of innovative approaches to improving the health outcomes. They also have a key role in informing, and monitoring the achievement of our QIPP projects.

We accept that in order to successfully achieve our strategic objectives there needs to be large scale change at pace and that local provider organisational resilience and adaptability will be essential to delivering long term system sustainability. To achieve this we are engaged in two major system wide transformation programmes as shown below.



1. The **Berkshire West 10 Integration programme** will build on and strengthen current initiatives which target those people who currently find themselves in the wrong part of the system, those who can be assisted to avoid unnecessary admission to hospital and those who can return to the community more swiftly following admission. The programme will further develop partnerships with the independent care sector, the voluntary sector and importantly patients, their carers and their communities. Further detail is provided in the next section of this strategy.

2. The **Clinical Strategy Programme** for Berkshire West is focusing on three specific areas:

- Establishing the financial baseline
- Undertaking service line reviews of three clinical services to develop an optimal patient pathway spanning all settings of care
- Determining the system attributes that will required to deliver care according to our vision

The objectives of the programme are to:

- Articulate a clear case for change, setting out the impact of proposed changes on viability and sustainability of individual providers.
- Determine the preferred configuration of services for safe and effective care
- Articulate the roadmap for "Berkshire West PLC" in securing the long term viability (clinical and financial) of healthcare services for the local population
- Agree the key attributes of the health system - including financial incentives and governance, and design the operating model

System sustainability

1. Patients at the centre of service planning and care delivery

To build on, enable and support the public mandate for change within the NHS, we need a seismic shift in how we engage with individuals and communities. Our strategy for communications will ensure that engagement activity is co-ordinated, accessible and appealing across our entire demographic, and that information flows both ways between services and the public. Building on the recent Call to Action events, we will employ a range of techniques including public meetings, social media, polls, surveys, engagement with community groups and membership structures to build a continuous 24/7 dialogue with the public, targeting particular audiences where appropriate. Patients and service users can expect to:

- Communicate with us through an approach/channel which suits them; reflecting their individual interests and lifestyle
- Be kept up to date and feel able to 'dip in and out' when it suits them
- Have access to a variety of options to make their views heard
- Be kept informed about what others think through online analysis of the input we have received
- Receive feedback about what has been done as a result of their input and involvement
- Respond anonymously if they prefer

In direct response to our public's views we have developed interactive videos about urgent care services and our planned Hospital at Home scheme. These have been shared through a series of 'Call-to-Action' meetings and online. They encourage people to consider what course of action they would take in the scenarios portrayed and, to feed in their views on our proposals.

The experience from the Call to Action meetings and elsewhere shows us that the audience reached by traditional communications and engagement tools such as newspaper advertising and meetings – is important, but limited in size and scope.

In a move to try and engage with groups of the population who haven't attended our Call to Action meetings in any number, including people of working age and minority groups, we are trialling an approach which we call 'Call to Action in a box' – where we identify events and settings where we know we can find a particular audience, then run a short survey via an iPad. This will help us reach audiences we could not reach by other means. Early examples of events we have been invited to include two workshops for adults with learning disabilities, an information day for carers and a coffee morning for care home residents.

Another example of this approach is the development of our Polish-language app, which was chosen as a method of engaging with Polish speakers following research conducted by HealthWatch Reading. This pointed out a number of salient facts:

- Polish people often settle here for short periods of time, while doing short-term contracts. This makes printed communications such as leaflet drops an expensive waste of time – as no sooner have the leaflets reached their target audience (if they do – many direct mail outs transit straight to recycling) than those people have moved out and been replaced by others.
- They are often young, of working age, likely to be users of mobile technologies.

Both of these factors make an instantly-downloadable app the ideal vehicle for communicating with young Polish workers about their health.

We have also collaborated with Reading Healthwatch, and the Public Health team in Reading Borough Council to identify the health needs of the local Nepalese population and as a direct result of this; we have supported three Nepalese Health weeks in partnership with the Reading Community Learning Centre. The focus of these events was to to enable ex Gurkhas and their families understand the healthcare system in this country and identify and access the support available to them.
The content of these weeks included:

- 2 days specifically for men's health, 2 days for women and one interactive health day
- Health workshops, pampering, information and advice
- Translators and NHS professionals will deliver the workshops

With limited resources we must broaden our engagement by reaching out first to those groups where information is most needed.

Patients and service users will also be supported to become active participants in their care, developing an understanding of how they can stay as healthy as possible and making joint decisions with professionals about how their needs can best be met. Taking our successful programme for monitoring diabetes jointly with patients as a starting point, we will use shared care planning, personal budgets, telehealth and social media to empower service users to make informed choices about the options available to them.

2. Wider primary care, provided at scale

It is anticipated that primary care will play a pivotal role in delivering our vision to meet people's needs in the community wherever possible and the CCGs will look to facilitate this through the development and implementation of a Primary Care Strategy, including well developed primary care co-commissioning arrangements with NHS England which will enable us to improve quality in primary care and to employ new contracting mechanisms as appropriate.

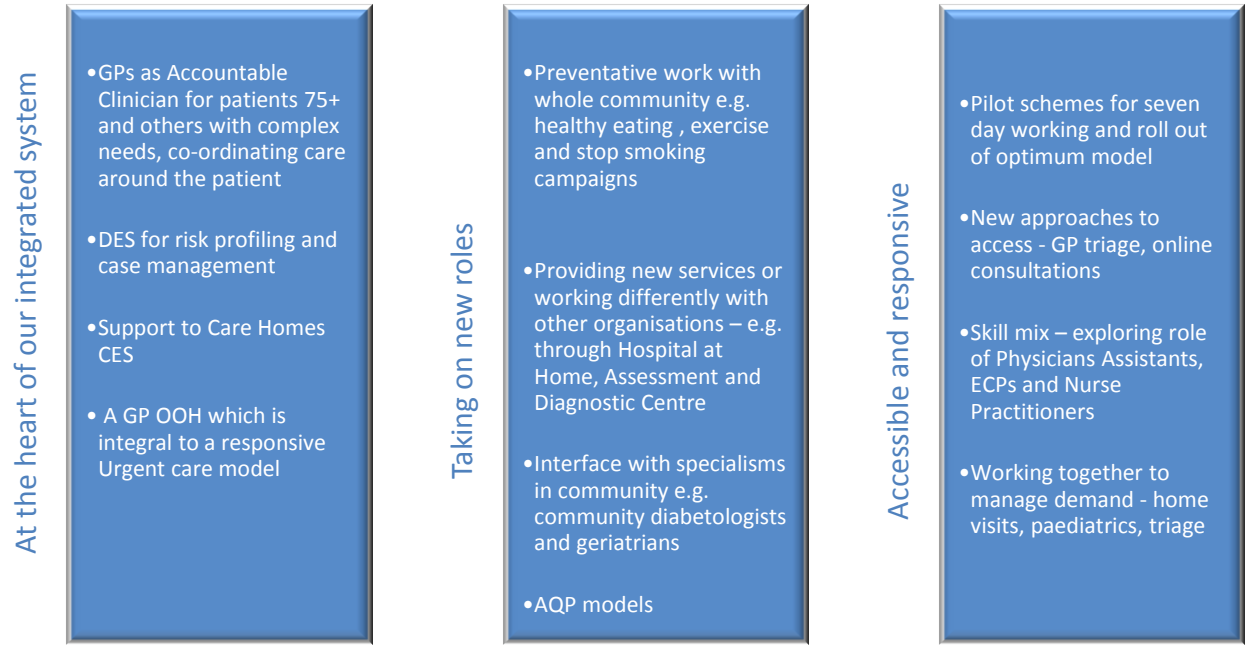
Having successfully implemented practice-based risk stratification and multi-agency care planning for high risk patients, our GPs are well placed to take on the role of Accountable clinician for patients who may be at risk of admission; co-ordinating care provided by a range of professionals to enable patients to remain in the community and are starting to do so through the Admissions Avoidance DES and other arrangements being put in place to support the care of the over 75s and high risk patients As well as fulfilling this function within their practices, our GPs will increasingly play an active role

alongside other professionals in multidisciplinary services locally such as in the development of an assessment and diagnostic clinic which is proposed at West Berkshire Community Hospital. The interface between general practice, community services and social care is likely to change, as new integrated models emerge, for example the Neighbourhood Cluster Teams being developed in Reading and Wokingham.

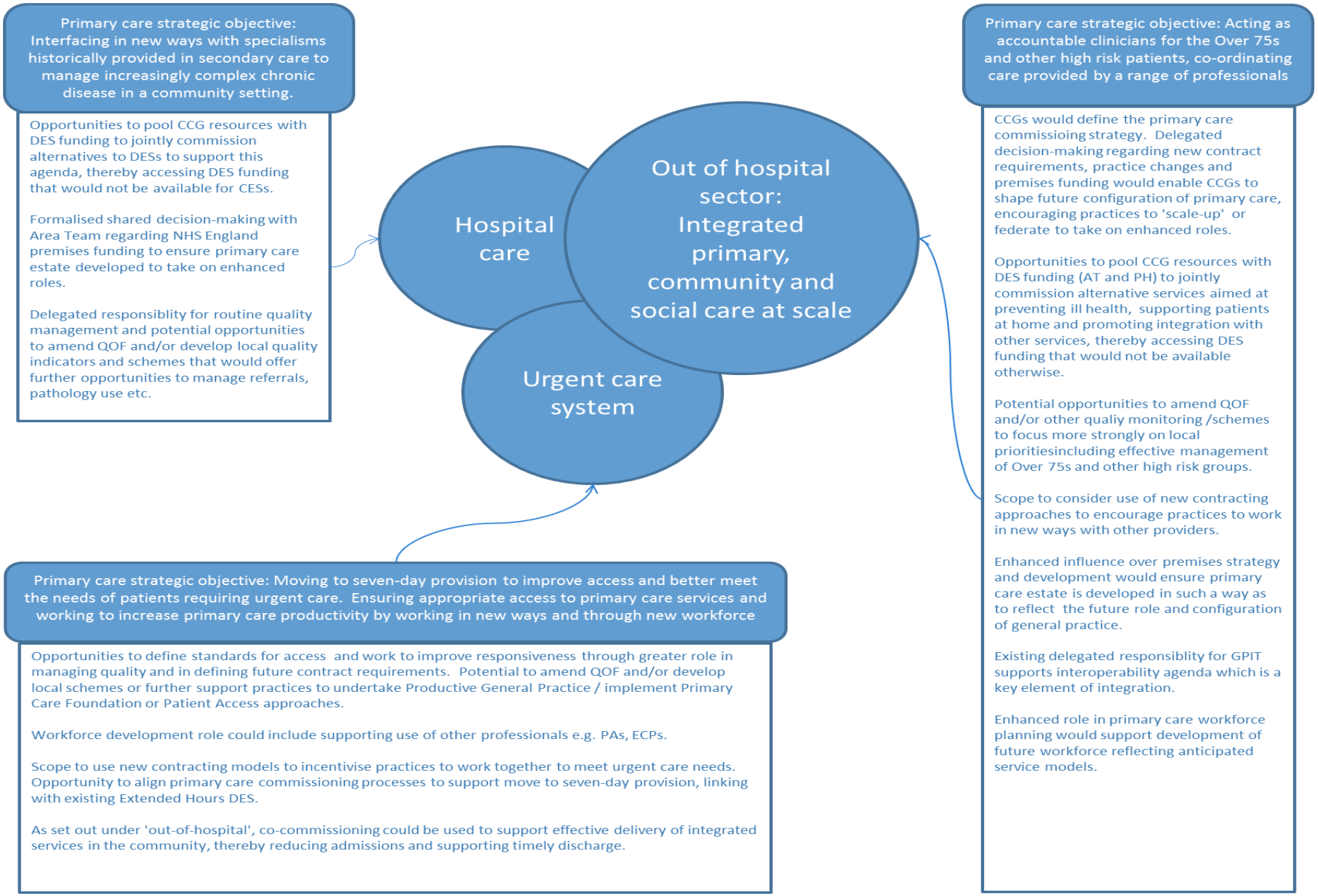
Our GP practices are also already interfacing in new ways with specialisms which were historically provided in secondary care, examples of which include the work of our community Diabetologists and community geriatricians. We anticipate these models becoming the norm as more specialisms are facilitated to move out of hospital and into a community setting. This approach will further enable practices to better support the increasing numbers of patients in their local populations who suffer from one or more long-term conditions.

Practices in Berkshire West face high levels of demand, particularly for urgent care, and many have chosen to explore different ways of responding to this, for example by implementing full GP triage or working to identify efficiencies through the Productive General Practice programme. We recognise that primary care needs to take a systematic approach to responding to requests for urgent appointments, functioning as a key component of a multi-tiered urgent care system which then ensures that patients have timely access to the right service provided in the most appropriate setting. Patients have also told us that they would welcome access to routine care in the evenings and at weekends. As such we are looking to expand the availability of primary care beyond current core hours, mirroring the overall shift towards seven-day services across the NHS and linking in with the broader seven-day working enabling work stream which forms part of the Berkshire West Integration Programme we are also considering defining standards for access and using co-commissioning arrangements to ensure that future capacity is sufficient to ensure these can be delivered going forward.

Primary care in Berkshire West



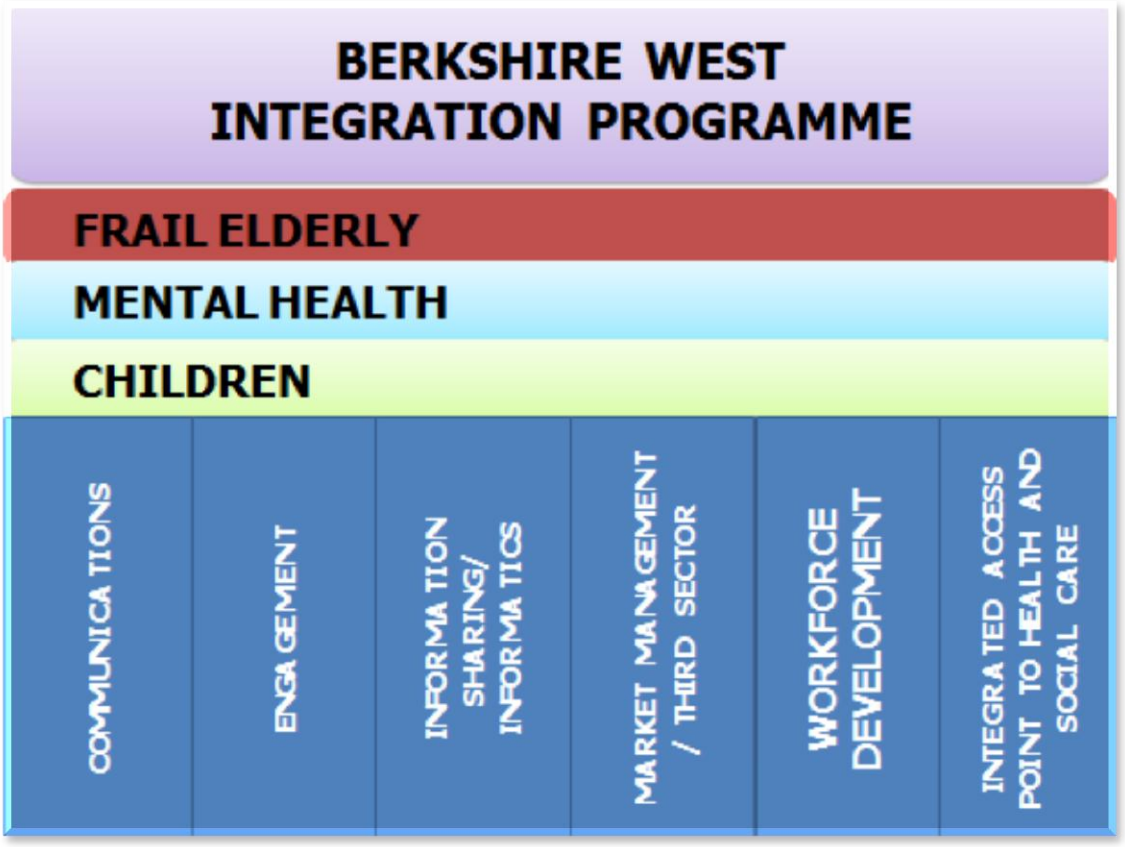
The diagrams above sets out the key change programmes currently associated with primary care in Berkshire West. The diagram below summarises our strategic vision for primary care and how we would look to use co-commissioning to deliver this. In order to take on these new roles and ways of working, particularly in a context of increasing demand and workforce constraints, we anticipate that general practice will start be organised differently and that larger or federated practices will emerge. Building on this, as practices work as part of an integrated system they are likely to start to co-operate in new ways with other provider organisations. This reflects the direction of travel emerging from our clinical strategy work (see below) and the CCGs will look to use innovative methods of contracting and lead provider frameworks to support the development of these new service models.


Primary care strategic objective: Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting.
Opportunities to pool CCG resources with DES funding to jointly commission alternatives to DESs to support this agenda, thereby accessing DES funding that would not be available for CESs.
Formalised shared decision-making with Area Team regarding NHS England premises funding to ensure primary care estate developed to take on enhanced roles.
Delegated responsiblity for routine quality management and potential opportunities to amend QOF and/or develop local quality indicators and schemes that would offer further opportunities to manage referrals, pathology use etc.
Hospital care
Out of hospital sector: Integrated primary, community and social care at scale
Urgent care system
Primary care strategic objective: Acting as accountable clinicians for the Over 75s and other high risk patients, co-ordinating care provided by a range of professionals
CCGs would define the primary care commissioing strategy. Delegated decision-making regarding new contract requirements, practice changes and premises funding would enable CCGs to shape future configuration of primary care, encouraging practices to 'scale-up' or federate to take on enhanced roles.
Opportunities to pool CCG resources with DES funding (AT and PH) to jointly commission alternative services aimed at preventing ill health, supporting patients at home and promoting integration with other services, thereby accessing DES funding that would not be available otherwise.
Potential opportunities to amend QOF and/or other qualiy monitoring /schemes to focus more strongly on local prioritiesincluding effective management of Over 75s and other high risk groups.
Scope to consider use of new contracting approaches to encourage practices to work in new ways with other providers.
Enhanced influence over premises strategy and development would ensure primary care estate is developed in such a way as to reflect the future role and configuration of general practice.
Existing delegated responsiblity for GPIT supports interoperability agenda which is a key element of integration.
Enhanced role in primary care workforce planning would support development of future workforce reflecting anticipated service models.
Primary care strategic objective: Moving to seven-day provision to improve access and better meet the needs of patients requiring urgent care. Ensuring appropriate access to primary care services and working to increase primary care productivity by working in new ways and through new workforce
Opportunities to define standards for access and work to improve responsiveness through greater role in managing quality and in defining future contract requirements. Potential to amend QOF and/or develop local schemes or further support practices to undertake Productive General Practice / implement Primary Care Foundation or Patient Access approaches.
Workforce development role could include supporting use of other professionals e.g. PAs, ECPs.
Scope to use new contracting models to incentivise practices to work together to meet urgent care needs. Opportunity to align primary care commissioning processes to support move to seven-day provision, linking with existing Extended Hours DES.
As set out under 'out-of-hospital', co-commissioning could be used to support effective delivery of integrated services in the community, thereby reducing admissions and supporting timely discharge.

3. Integrated care

As part of the commitment to service integration by the Berkshire West 10 a west wide integration programme has recently commenced led by a jointly appointed Programme Director. Locality and organisational plans have been aligned to the overarching programme of work, which aims to balance locally determined initiatives with cross boundary work where there is added value in terms of scope and scale.

The Integration programme as a whole is underpinned by enabling work streams and will be delivered through a joint Programme board responsible not only for Frail Elderly but also for an integrated approach to Children's services, and Mental health.



The first phase of the Berkshire West 10 Integration Programme is focussed on the integration of services for older people, and the development of a frail elderly (older peoples) pathway will form the patient centred backbone of system changes. This pathway has been developed through a multi-agency project supported by the King's Fund and the economic modelling element was led by Finnamore, and the final output from both will be used to inform medium to long term financial planning of partner organisations. The defined pathway aims to improve experience of patients and carers, make better use of existing resources and achieve significant cost savings across the system through reduction of duplication in provision and workforce changes.

It is envisaged that the pathway will be accessed through a single hub for both social care and health, and care will be delivered by generic care workers, supported by identified care co-ordinators and multidisciplinary teams structured around groups of local GP practices: the overall aim being to improve the care of older people with long-term conditions and those who are at highest risk of deteriorating health. Crisis support will be streamlined with care being provided in the most appropriate setting according to patient and carer need. When hospital admission is unavoidable, the stay will be of high quality with discharge immediately when acute care is no longer required. Support will be enhanced to enable people living in residential and nursing homes to receive their care and treatment there, and end of life care improved so that people are not admitted to hospital unnecessarily. In bringing key elements of the frail elderly (older peoples) programme on line within the early to middle part of 2014-15 we will be able to assess its impact and use this as a template to inform planning for other pathways for the outer years of this five year period.

The Better Care Fund (BCF) budget has added further momentum to the integration programme, and offers a vehicle to lever the transformation of health and social care services in the provision of integrated care and support. Integrated commissioning and provision through the use of the BCF also offers an opportunity to improve the lives of the most vulnerable, providing them with better services, support and improved quality of life. As members of the Berkshire 10 it enables us to take forward the integration agenda at pace and provides a catalyst for change

The BCF has required the formulation of joint plans for integrated health and social care and these plans have been developed through Berkshire West's three local Integration Steering Groups, which include representation from the CCGs, local authorities, health and social care providers and the voluntary sector, and the on-going development of these plans will ensure that there is a system-wide shared view of the shape of future integrated services both at a local and Berkshire wide level.

The on-going development of these plans will ensure that there is a system-wide shared view of the shape of future integrated services.

All of the plans demonstrate how the system will meet the national conditions around this funding. These are:

- Protecting social care services
- 7 day services to support discharge
- Data sharing
- Joint assessments and care planning and establishing an accountable lead professional
- Planning for the impact of changes in the acute sector

Proposals for the use of the BCF are summarised below. Further financial detail is included at Annex C.

Reading	West Berkshire	Wokingham
Hospital @ Home	Hospital @ Home	Hospital @ Home
Intermediate care Integration	Integration of Intermediate Care/Reablement Services	Integration of Reablement/Intermediate Care including two hour response for social care assessment
Care Bill implications	Care Bill implications	Care Bill implications
Frail Elderly Pathway	Frail Elderly Pathway	Frail Elderly Pathway
Joint access to the Health and Social care Hub	Joint access to the Health and Social care Hub	Joint access to the Health and Social care Hub
7 day working – enhanced primary care	7 day working – enhanced primary care	7 day working – enhanced primary care
GP cluster models	Development of neighbourhood cluster teams	Supporting primary care developments/neighbourhood cluster teams
Support to carers	Support to carers	Support to carers
Enhanced Care and Nursing Home support	Enhanced Care and Nursing Home support	Enhanced Care and Nursing Home support
Time to Think Beds-Assessment beds/24hour support (Willows)		Step up/step down beds
Health and social care system IT interoperability	Health and social care system IT interoperability	Health and social care system IT interoperability

The Integration programme also includes a set of enabling projects which underpin the transformational nature if the changes required, including the development of the workforce across health and social care, a health and social care access hub, market management, and personal health and social care budgets.

It is recognised that in order to work together in an integrated way, services need to be able to share appropriate data at patient or service user level. A key enabling element of our integration programme therefore is also the agreement of a shared strategy to deliver interoperability of IT systems, enabling us to share key information across settings.

4. Children's and Young People

As CCGs we will work with providers and commissioners from across health and social care, including the voluntary sector, and in partnership with parents and children and young people to:

- Improve the health and wellbeing of children and young people
- Ensure active engagement with children and young people and their families

- Work with public health to progress work on early intervention and prevention with a focus on the evidence base for the life course approach
- Monitor progress against the children and young people s outcomes indicators
- Coordinate the commissioning of children's health and social care across the spectrum of children's needs across the life course. This will include working with NHS England and other commissioning partners on the commissioning arrangements for school nursing/health visiting programmes/ family nurse partnership, SEND reforms and the development of personal health budgets.
- Review access to services across the system including primary care, community ,social care, acute, specialist and voluntary sector services

The Berkshire West CCGs have convened a joint Health and Local Authority Children's Commissioning Strategy group which will coordinate this work, including:

- Informing the plans for co-commissioning of primary care to include a focus on training for GP's in child health and paediatrics.
- Development of a local health deal for children and young people to ensure engagement and expectation of their health care including those from disadvantaged groups.
- The enhancement of services for children and young people in care, those in need of safeguarding including /learning disabilities those with complex need and those in transition to adult services.
- Service improvements which will include implementation of an integrated CAMHS services in the context of the NHS England strategic review of specialist CAMHS services.
- New models of delivery, talking therapies, urgent care and crisis support, effective palliative care, improving the quality of care for community nursing services for children with complex needs.
- Addressing the needs of young carers and parent carers
- Working with the Thames Valley Strategic Clinical network to include palliative care, transition, asthma management and reducing emergency admissions.

5. Mental Health Services

In recognition of the poorer health outcomes and life expectancy experienced by people with a mental health diagnosis, and that similarly that those with physical health conditions have a much greater risk of also developing mental health problems, we will aim to give mental health parity of esteem with physical health through the commissioning high quality evidence-based mental health services which reflect the national mental health strategy and other key guidance. We will also work with our providers to ensure that there is a holistic approach to care planning, and care co-ordination which take into account individuals mental health as well as physical health needs. We will also explore at every opportunity a preventative which focuses on people's emotional health and wellbeing.
In working towards mental health outcomes we will:

- Work jointly to promote good mental health, tackling inequalities with a focus on the promotion of emotional health and wellbeing.
- Promote the mental health and wellbeing of children and young people and improve timely access to services when needed.
- Work across the whole system to develop an integrated model of physical and mental health care provision.

- Gather intelligence on and monitoring progress on the mental health outcomes.
- Improve access to services and monitor waiting times performance for mental health services, in the same way as is already in place for physical health services.
- Maximise the impact of psychological therapies in helping people to recover from and cope with both their mental and/or physical health problems.
- Extend the offer choice in mental health and provide opportunities for the individual to choose their provider and mental health professional.
- Improve the overall health and wellbeing of those who are living with or recovering from mental health problems.
- Ensure crisis and urgent care services are available at all times including expanding access to liaison services in the hospital and community, working in conjunction with primary care.
- Ensure better co-ordination between Urgent care services and local mental health services.
- Use the friends and family test to allow patients to comment on their experience of mental health services including children's mental health services.
- Ensure there is support for carers to meet their own health needs and to be involved in discussion about service provision.

Developing the Berkshire West Urgent Care System

Our vision for urgent care reflects the findings of the national Emergency Care Review and centres on different parts of the urgent care system including A&E, tertiary centres, primary care, SCAS and NHS 111 working together as one to ensure that patients with differing degrees of urgency and acuity are responded to in a timely way and by the most appropriate service.

We have a well-established Urgent Care Board which involves all partners and includes a Strategic Group as well as a sub-group responsible for operational system resilience. The Board aims to ensure that:

- Demand and capacity is balanced across the urgent pathway underpinned by a robust proactive performance management system and Patients are directed to the most appropriate service for their needs
- There are robust community based alternatives to support admission avoidance
- Patients requiring admission receive early senior assessment and streaming to the appropriate specialty, with pro-active discharge planning
- All parts of the system work together to ensure that patients awaiting discharge from the acute to another care setting are moved in a timely manner
- The system is resilient and able to meet all national targets in relation to emergency care
- There is a co-ordinated system wide response to national guidance and policy changes which impact on operational resilience and emergency planning

System performance is continually monitored through a multi-agency Dashboard which enables us to take a data-driven approach to performance improvement and service transformation. By providing us with an understanding of the capacity of different parts of the system and of how patients flow through each service, the dashboard will ensure that we can balance capacity and demand across the urgent care pathway, directing patients to the most appropriate service for their needs.

We are using CQUINS and other mechanisms to build in incentives for providers to work with us on schemes to reduce admissions such as Hospital at Home and crisis prevention through robust care planning and information sharing. Where patients do require an admission, a system of early senior clinical assessment and streaming to the appropriate specialty has been implemented. Proactive discharge planning will start on day one with all parts of the system working together to ensure that once patients are ready to leave hospital they can be moved in a timely manner. We will also develop a local tariff for urgent care that incentivises the use of ambulatory care pathways so that a greater proportion of patients can be managed safely and appropriately on the same day without the need for admission to a hospital bed.

The urgent care dashboard has demonstrated that there have been disruptions to patient flow during and immediately after weekends due to issues with discharge planning and variability in the availability of community services over the weekend. This has then impacted upon delivery of the four hour A&E target. A key strategic priority for us is for all providers to move to increased levels of seven-day provision and responsiveness so that we can maintain an even flow of patients through the system at all times of the week. The Better Care Fund will be applied in support of this.

Over the coming months the Urgent Care Board will work towards a networked model of urgent care provision, defining the role of Royal Berkshire FT's A&E department and other services as part of this process, linking with other organisations outside of Berkshire West as appropriate. The Urgent Care Board will also continue to lead on system resilience and winter planning, working to ensure that the system is able to cope with seasonal pressures and that national targets are met.

NHS 111 which was safely launched in 2013 will continue to play a major role in ensuring patients are directed to the most appropriate service for their needs. We will increase the integration between the local GP OOHs, NHS 111 services and 999 services, promoting the re-direction of patients to community services where appropriate. This will aim to further reduce the pressure on A&E and within the emergency care system.

Hospital Services

Our strategy for planned care will enable patients to access routine healthcare services in the most appropriate location and to use robust contractual arrangements to assure the quality of these services and secure maximum value-for-money. New technologies will be used to enable our patients to interact with health services in new ways, reducing lengths of stay in hospital and the number of outpatient appointments required, also enabling services to be provided closer to home wherever possible.

Benchmarking against NHS England's Commissioning for Value data packs and other sources has identified areas where the CCGs could make savings on elective care. Most significant is the potential to reduce the higher than average intervention rate for musculoskeletal conditions, ensuring that surgical procedures are only undertaken at the most appropriate time and where shared decision making has ensured that both the patient and GP are clear that the benefits clearly outweigh the risks. There is also scope to improve performance on the first to follow-up outpatient ratio.

Over the coming years, the CCGs intend to make use of tariff flexibilities and financial levers to generate efficiencies and incentivise providers to deliver improved productivity and services which reflect our strategic vision. Key schemes include applying pathway prices, and lead provider models to encourage efficient provision, for example through 'one-stop shop' outpatient clinics, paying tariff minus to providers with less complex caseloads and the use of locally developed best practice tariffs to commission pathways of care, thereby incentivising providers to work together with other service providers.

As part of our Clinical Strategy programme we have completed an externally supported clinical services review with Royal Berkshire Foundation Trust and Berkshire Health Care Foundation Trust to determine the best care pathway models which improve patient outcomes and support financial sustainability. This review process considered 3 Initial pathways, respiratory care, chronic pain and liver disease.

It is our intention that the clinical pathway review will deliver redesigned care from a patient perspective, eliminating variation in outcomes. We are confident that the size and scale of the initial pathways identified will have a transformational impact on activity levels as well as clinical outcomes, and we expect to see full implementation of the benefits including the associated efficiencies of this programme realised as part of our QIPP plans for 2015/16 onwards.

The Clinical Strategy programme will also provide us with a framework for future elective pathway reviews which in collaboration with our providers will deliver safe and effective care, and support the long term clinical and financial viability of the healthcare system in Berkshire West.

Specialised Commissioning

Effective, high quality specialised services have been identified as one of the 6 characteristics of a high quality and sustainable health and care system. NHS England has commenced work on the development of a strategy for specialised services but the results of this will not be available until later in 2014. What is known is that NHS England will aim to commission high quality, cost effective specialised services providing excellent outcomes for patients through greater concentration of specialised services across a smaller number of providers.

As the commissioner of specialised services, NHS England will look for national consistency in quality of service and price and will look over the 5 year period to drive for improvements in both of these areas. It will also look to improve outcomes for the population and where there is good clinical evidence that outcomes are improved if services are provided in fewer centres, this is a likely direction of travel, whether services are commissioned by CCGs or NHS England.

There are some specific specialised services for which service transformation work is continuing. This is either where service reconfiguration was already underway before the commissioning system changes of 2013 or where there are particular local issues which are required to be addressed. In addition there are a number of national priority pieces of work which are taking place which could impact upon the provision of specialised services in a geographic area. These include:

- Reconfiguration of vascular services, in order to establish arterial centres and networks of vascular providers in order to improve national outcomes to rates comparable with the rest of Europe.

- A national procurement exercise linked to the reconfiguration of Genetic Laboratory services nationally will commence in 2014.

- A review of CAMHS provision has recently been completed and an implementation plan is expected shortly.

The CCGs will continue to work closely with NHS England and the four Thames Valley Strategic Clinical Networks to ensure that patients requiring specialist care can be referred to centres whose caseloads mean they are best placed to deliver optimum outcomes for patients, working beyond Berkshire West boundaries as appropriate. Members of the CCG Executive team are actively involved at a national and regional level in NHS England workstreams on Finance and Commissioning. It is recognised that this is likely to have an impact on the RBFT which currently continues to provide services that are acknowledged as specialist by definition but not by volume. Further work will be undertaken with RBFT to better understand and plan for the potential implications for the Trust.

Provider sector impact

The Berkshire West health economy is largely self-contained in that it has 3 main NHS service providers, and a vibrant expanding independent sector

1. Royal Berkshire Hospital NHS Foundation Trust (Acute services) (RBFT)
2. Berkshire Healthcare NHS Foundation Trust (Mental health and community services) (BHFT)
3. South Central Ambulance Services NHS Foundation Trust (Ambulance, PTS and 111 Services) (SCAS)
4. A range of independent sector providers including Circle, Berkshire Independent Hospital, and the Dunedin

As Foundation Trusts, all the NHS organisations need to deliver a Continuity of Service Rating (COSR) of 3 to demonstrate financial sustainability. Both BHFT and RBFT are challenged in this respect into 14/15, 15/16 and all health organisations in Berkshire West agree that they need to work together on a system wide strategic planning approach to ensure continuity of high quality services are provided within the financial envelope available for the population of the Berkshire West health economy.

Royal Berkshire NHS Foundation Trust (RBFT)

RBFT is a major district general hospital also providing a range of well-regarded specialist services. However financial sustainability over the last couple of years has only been achieved through non recurrent commissioner support. The Trust and CCGs recognise that the Trust in its current form with the existing payment regime faces significant financial challenges. It reported an unplanned deficit for 2013-2014 of circa £6.5m and has an underlying deficit in excess of £8m. Maintaining a COSR of 3 is difficult for 2013-2014 and beyond. This position is as a result of a number of issues including historic capital investments with large associated revenue consequences of those investments, increasing pay costs associated with the impact of the Keogh and Berwick reports, failure to deliver CIPs of 4%annually and an estate that is old, inefficient and consumes a large proportion of the annual capital programme due to extensive backlog maintenance.

As commissioners the CCGs have worked closely with the Trust supporting business cases associated with emergency care in particular, reinvesting the full amount of the Marginal Rate Emergency Tariff (MRET) and the penalties associated with readmissions. The Trust has had considerable issues with the quality of its data, part of which relates to on-going challenges associated with the implementation of its new EPR system in June 2012 and this has inevitably resulted in a significant number of activity and financial challenges from the CCGs during 2013-2014. The 2014/15 contract was signed in April 2014.

The Trust has a number of assumptions in their financial plan which could have an impact on the CCGs:

- The Trust has assumed growth and repatriation of elective activity over the 5yr period of £48m. If this is truly repatriation, it should have little financial impact on the CCGs, as the activity will not need paying for elsewhere. In fact if the repatriation is from areas with higher market forces factor there may be a marginal benefit to the CCGs. However, an overall increase in capacity specifically at RBFT could adversely impact on CCGs and consequently the whole health and social care system.
- The Trust have assumed that CCG QIPP savings schemes which will impact on secondary care activity will not deliver , and the 5 year impact of this is in the region of £77m. If this is correct it will have significant impact on the CCGs financial plan.
- As with BHT, RBFT do not consider that it will be possible to achieve 4% efficiencies year on year, and this will also affect the financial plans over this 5 year period.

Berkshire Healthcare NHS Foundation Trust (BHFT)

BHFT is the main provider of mental health and community services (split approx. 50:50) for the whole of Berkshire (West and East). The Trust's income is primarily obtained through block contract with its 7 main CCGs (4 West and 3 East) which although provides certainty of income, inevitably exposes the Trust to financial risk as activity increases. The Trust currently has a healthy cash and balance sheet position and although it reported a £1m surplus for 2013-2014 it has an underlying deficit of up to £2.5m going into 2014-2015, with its financial position becoming more challenged in years 3-5. It is not "estate heavy" although it does have 2 PFI schemes –one at its main mental health facility in Reading and the other at its community hospital in Thatcham.

The Trust is currently developing its 5 year strategy and has engaged CCGs fully in this process. Their assessment of the financial position is that a "do nothing" scenario will result in a financial gap in excess of £20m by 2015-2016. Although the Trust has a history of achieving 4% CIPs, even if this were sustainable it would be insufficient on its own to close this financial gap.

The CCGs have worked closely with the Trust over the last year and have invested to support developments in services provided by the Trust and to enable the Trust to provide system wide community services which prevent admissions into and facilitate discharge out of the RBH and neighbouring acute trusts. This investment is proposed to continue into 2014-2015 to also support the delivery of the CCGS QIPP plans.

In the 5 year period there were no significant differences between the income assumed by BHT and that assumed by the CCGs. However we have had high level discussions with the Trust on the need for non-recurrent bridging support by the CCGs until we move to a more sustainable system wide model as BHFT do not expect to be able to achieve the national efficiency assumed in tariff over the period which will give them a cumulative financial challenge by the end of year 5. This will only be possible if the 13/14 additional CCGs surplus can be drawn down in 15/16.

As part of our Clinical Strategy programme and the diverging financial alignment between the local NHS providers and the CCGs over the 5 year period of this strategy, Ernst and Young recently

facilitated two workshops on behalf of the West Berkshire CCGs, supporting leaders from across the Unit of Planning (West Berkshire CCGs, RBFT, BHFT) and latterly Local Authorities to achieve an in-depth and shared understanding of the quality and financial case for change.

As a system there was consistent agreement that the system should embody the following attributes:

- Make use of technology to deliver new modalities of care
- Encourage patient activation
- Facilitate Information sharing in real time between different entities
- Incentivise working together
- Allow for forward capacity planning

There was also consensus that the following criteria would be used in considering future options.

- Improve patient outcomes and reducing health inequalities
- Minimise costs
- Promote health and social care integration
- Improve staff satisfaction and morale
- Offers appropriate patient choice through transparent procurement processes
- Be achievable, including within the local and national political climate

As a next step the senior leadership from across the Berkshire West Health and Local Authority organisations have agreed to the initiation of a system transformation programme starting with the development of a senior governance group, and a series of "thought leadership "workshops with input from national experts, and specialists on large scale system redesign.

Improvement interventions

1. Summary of approach

Annex F sets out how our high-level plans translate into specific interventions to provide care in different ways, thereby improving outcomes and delivering financial savings to ensure the on-going sustainability of the local health and social care system. These schemes are described in more detail in the two-year operational plans developed by each of the CCGs. These plans include details of local schemes which will complement these system-wide initiatives and other work streams led by our four of our Programme Boards (Long-Term Conditions, Planned Care, Urgent Care and Children's, Mental Health, Maternity and the Voluntary Sector (CMMV)).

The Berkshire West CCGs follow an established prioritisation process for assessing key priorities and initiatives. A Prioritisation Framework Tool is used to score each potential scheme against the following criteria:

- Strategic Fit/ Statutory Requirement
- Financial Impact
- Quality & Health Outcomes
- Achievability
- Assessed Needs
- Evidence based
- Effect on health inequalities

The relevant Programme Board reviews each proposal in depth, taking into account potential disinvestment opportunities and identifying provision that will be affected locally. Recommendations from the programme boards are taken to the Berkshire West CCGs QIPP & Finance Committee for a final decision.

Current improvement interventions can be summarised as follows:

2. Out-of-Hospital services

- Commissioning GP practices to provide an enhanced service for Care Home support. This will support care planning for patients and offer training and support to care homes thereby reducing unplanned admissions and improving end-of-life care.

- Further development of community-based services for patients with heart failure, including additional specialist nursing roles, a further roll-out of telehealth, provision of IV furosemide in the community and improving end-of-life care. It is anticipated that the number of home visits and outpatient attendances required will be reduced for patients using telehealth.

- Redesign and further integration of continence and falls teams. These developments also link to the new frail elderly pathway and aim to create better integration between these teams and other services. A redesigned falls pathway will support more proactive care of patients who are at risk of falling, reducing the risk re-admission for further falls. It will also ensure that all patients with hip fracture receive falls and bone health assessment and are offered preventative therapy as appropriate, in line with best practice guidelines. Improvements to the continence service will reduce the risk of urinary tract infection in older patients which can often lead to poorer health outcomes.

- Increased investment into the Rapid Response and Reablement service will enable capacity to be flexed across the three localities based on predicted discharge numbers, thereby working proactively to reduce the numbers of patients remaining in hospital beyond the point at which when they are medically fit for discharge, improving patient experience.

- Development of a community-based psychological medicine service which will support patients with the impact of long-term conditions on their mental wellbeing, in turn reducing the impact that this has on their physical health. This service will build upon the local Medically Unexplained Symptoms project to offer support to patients with mental health issues which do not meet the threshold for accessing clinical mental health support.

- Improved identification of patients who may be in the last year of life in order to support advanced care planning processes and sharing of information between services. The aim is to reduce acute admissions in the last days of life and to support patients who prefer to die at home to do so. To improve palliative care pathways for terminally ill children.

- Reducing variation in GP practices' use of pathology services by auditing outlying practices and offering further training and guidance for GPs.

- Implementation of DAWN model for remote monitoring of haematology patients in order to reduce follow-up appointments and improve outcomes. The DAWN system will reduce routine appointments but will enable the early detection of patients who have an exacerbation in their condition, allowing them quick access to a specialist review.

- Improved access to talking therapies for people with mild to moderate mental illness as well as severe and enduring mental illness. The aim is to establish access to a range of talking therapies as an integral part of the treatment of all forms of mental illness and to expand the range of psychological interventions available to patients with enduring mental health problems.

- To review access to and service provision for children with complex needs in the community, including those with long-term conditions, disabilities and complex care needs.

3. Urgent care

- Establishment of a 24/7 psychiatric liaison service in the RBH to better meet the needs of patients presenting to acute services with mental and physical co-morbidities.

- Review of urgent care and crisis support for patients with mental health needs, developing in particular an improved response to patients identified as being at risk of suicide or serious self-harm, or with a mental health or challenging behaviour crisis. This response should span patients identified in hospital, in the community or through the criminal justice system, including those requiring an approved place of safety. Work will also be undertaken with stakeholders to improve care pathways so as to as minimise the risk of the patient lapsing into a subsequent crisis.

- To complete the review of Child and Adolescent Mental Health Services provision, ensuring that services meet the needs of today's patients in the context of safety and quality. This will include ensuring community cover outside of core working hours for young people in crisis or presenting with high levels of risk. The focus will be on supporting children and young people within their own community and avoiding out-of-area placements.

4. Hospital services

- Work to reduce relatively high intervention rates for musculoskeletal conditions through the expanded use of shared decision making aids, review of the MSK pain pathway and more systematic application of threshold policies.

- Development of an integrated ophthalmology service incorporating all aspects of the service from community eye services through to emergency care, thereby ensuring consistency and reducing variation.

- Review of cancer care pathways to reduce follow-up appointments in accordance with best clinical practice. The intention is to use a risk-stratified approach to scheduling follow-ups and to make more use of telephone appointments. To include implementing new pathways for breast and prostate cancer patients.

- To work to improve maternity care by reviewing the induction pathway and reducing C-section rates. To provide support for anxious mothers following traumatic births and to review the reasons for maternity unit diversions and work to reduce these.

5. Preventing ill-health

The local authority-based public health teams are working with CCGs and others on a programme of initiatives aimed at preventing ill-health and identifying disease at an early stage. Priorities are developed and approaches tested in accordance with the five steps outlined in the Commissioning for Prevention element of the national Call to Action programme. Key areas of focus are set out below. As well as preventing ill-health, these measures are intended to support early diagnosis and

treatment, reflecting the National Audit Office's recommendations regarding interventions which can have the greatest impact on reducing gaps in life expectancy. Our communications and engagement work will take every opportunity to support this work and promote positive messages about the steps individuals can take to lead healthier lives.

- Smoking cessation services and targeted campaigns to deter under 18s from smoking and promote smoke-free homes and cars. Supporting the work of the Berkshire Tobacco Control Alliance to encourage smoke-free environments.

- Healthy eating campaigns such as Change 4 Life, including displaying resources within GP practices and in other health and social care venues. Referring people who are overweight and obese to weight management programmes such as Eat 4 Health, or to specialist weight management services such as Barometer.

- Campaigns to raise awareness of the dangers of alcohol and the silent nature of liver disease. Primary care practitioners to opportunistically screen patients for levels of alcohol consumption, carrying out brief interventions and referring to community-based alcohol services as appropriate. The CCGs are considering piloting early screening for liver disease using the Southampton Traffic Light test.

- Extending screening programmes to include flexible sigmoidoscopy for every 55 year old, new screening pathway for patients with a family history of breast cancer and improvements to laboratory services for cervical screening.

- Promoting physical activity through initiatives which aim to get people moving and exercise referrals.

- Campaigns to raise aware of high blood pressure and how to control it, including reducing salt intake and consumption of processed food.

- Full implementation of the NHS Health Check programme to identify and offer treatment and advice to patients with high blood pressure and high cholesterol, as well as those with unhealthy lifestyles.

- Ensuring availability of testing for Hepatitis B and C for those in high risk groups. Campaigns to raise awareness of how these diseases are transmitted and how the risk of infection can be reduced. Consideration will also be given to universal vaccination against Hepatitis B for those in at-risk groups.

- Implementing the recommendations of the recent Carers' Scoping Report including provision of carers' support and breaks. To progress joint commissioning of services for carers' and build voluntary sector engagement.

- Using the opportunity provided by Carers' Week to run a mini-survey aimed at identifying young carers and finding out more about their health needs.

6. Ongoing development

The development of service redesign and cost saving initiatives is a continuous and iterative process and as such there will always be a number of potential schemes in the pipeline. In particular it is anticipated that a number of further schemes will follow during 2014-15 as part of the implementation of the new frail elderly pathway and the subsequent pathways to be developed for mental health and children's services. Work is also underway to firm up proposals to make better use of financial levers and contractual flexibilities to incentivise different types of providers to deliver services in such a way as to maximise their contribution to the realisation of the strategic vision described in this plan. In addition there is scope locally to develop additional medicines optimisation schemes.

7. Seven day services

We recognise that people need health and social care services every day. Evidence shows that the limited availability of some hospital services at weekends can have a detrimental impact on outcomes for patients, including raising the risk of mortality. Admission rates may also be affected by GP practices being closed over the weekend period. Where admissions occur there is a need to ensure that care packages can be instigated and patients discharged from hospital on whatever day of the week they are clinically fit to leave. We are therefore looking to ensure that a full range of health and social care services is available seven days a week. The expansion of capacity where required across 7 days week is a key enabler of our Berkshire West integration plan.

8. Access

Linked to the above is the need to ensure good access to all of the services we commission. The CCGs in particular will ensure that local providers adhere to all NHS Constitution measures and access standards to provide patients with care in a timely manner, as summarised at Annex D. The added importance of this in relation to waiting times for diagnosis and treatment of cancer is understood.

The Choose & Book access system for outpatient appointments will continue to be utilised to support patients to make a choice of where and when they would like their treatment. This will support continued achievement of the 18 week referral to treatment standards. Waiting times in A&E and ambulance response times are expected to improve and ambulance handover delays expected to be maintained as low as possible.

9. Innovation

We will work to promote innovation, putting in place mechanisms which support relevant research and linking with national and local bodies including Strategic Clinical Networks and Academic Health Science Networks to learn from best practice examples and disseminate these locally.

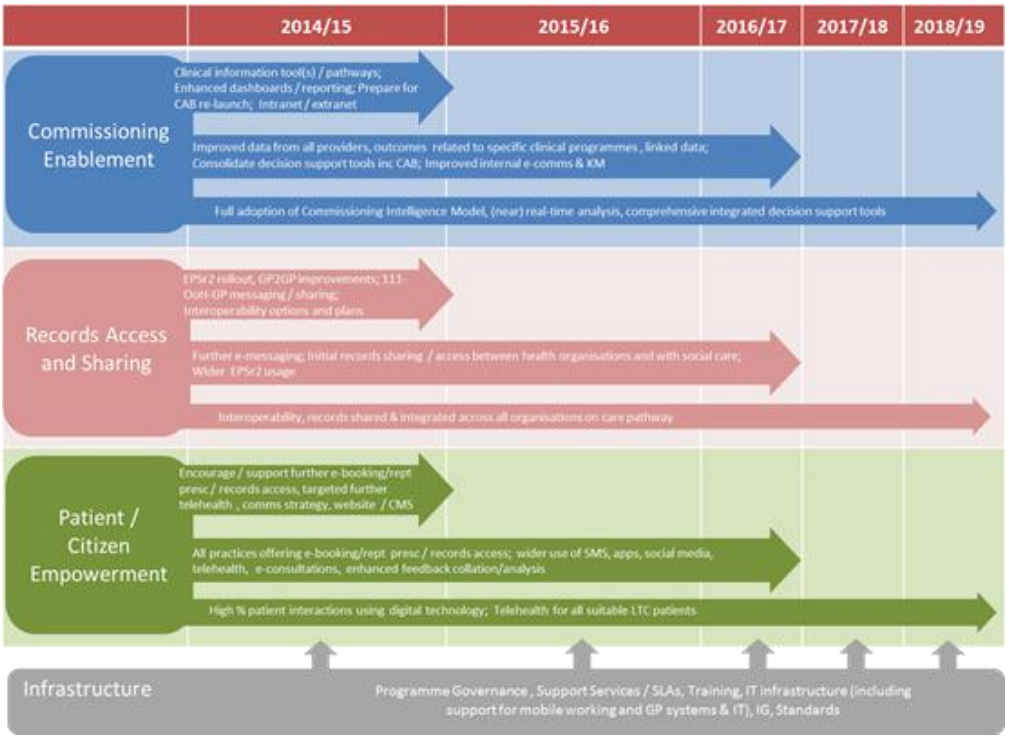
We have actively sought out opportunities to pilot new approaches, for example by applying to become an Integration Pioneer and more recently supporting two bids against the Prime Minister's Challenge Fund for primary care. We will continue to pursue further such opportunities at both a local and national level. Whilst our integration pioneer bid was unsuccessful at the final stage, we are now working with the Integrated Care and Support Exchange (ICASE) to share our progress through our Integration Programme and to learn how others have addressed key challenges. We have also expressed an interest in the NHS England Accelerated Learning programme.

We will link with the national Innovation, Health and Wealth programme to ensure that we keep up-to-date on emerging innovations and consider how these can best be implemented locally. As described above we have put in place arrangements to ensure implementation of NICE Technology Appraisals and through our contract management processes ensure that providers have innovation plans in place.

10. Technology

For Berkshire West, we have recognised the role of innovation, information and technology to support transformation of the Health and social care system over the next 5 years. Over the past year the CCGs have been developed their strategy for IM&T (Annex E), through a Berkshire West CCG IM&T Steering Group to drive our ambitions which are outlined in (annex E), the timetable for our programme of Digital care improvement is outlined below: The CCG also recognises the need for accurate, timely and relevant information to enable it to both commission and deliver the highest quality health care and to operate effectively as a modern and efficient public sector organisation responsible for health and social care of individuals requiring support.

Berkshire West CCGs wishes to increase the use of digital technology in the delivery of healthcare services to patients in order to bring about improvements in the quality, safety and the efficiency of the NHS services it commissions on behalf of the population we serve building on local successes such as the use of telehealth in the management of people with heart failure, and Eclipse in the management of people with Diabetes.


2014/15
2015/16
2016/17
2017/18
2018/19
Commissioning Enablement
Clinical information tool(s) / pathways; Enhanced dashboards / reporting; Prepare for CAB re-launch; Intranet / extranet
Improved data from all providers, outcomes related to specific clinical programmes , linked data; Consolidate decision support tools inc CAB; Improved internal e-comms & KM
Full adoption of Commissioning Intelligence Model, (near) real-time analysis, comprehensive integrated decision support tools
Records Access and Sharing
EPSc2 rollout; GP2GP improvements; 111-Out-GP messaging / sharing; Interoperability options and plans
Further e-messaging; Initial records sharing / access between health organisations and with social care; Wider EPSc2 usage
Interoperability, records shared & integrated across all organisations on care pathway
Patient / Citizen Empowerment
Encourage / support further e-booking/rept presc / records access, targeted further telehealth , comms strategy, website / CMS
All practices offering e-booking/rept presc / records access; wider use of SMS, apps, social media, telehealth, e-consultations, enhanced feedback collation/analysis
High % patient interactions using digital technology; Telehealth for all suitable LTC patients
Infrastructure
Programme Governance , Support Services / SLAs, Training, IT infrastructure (including support for mobile working and GP systems & IT), IG, Standards

11. Workforce

Workforce considerations are taken into account at all stages of developing our plans and we recognise that the skill mix required to deliver a largely community-based model of care will look very different to our existing provider staffing models. The Berkshire West 10 have successfully bid for £500,000 from Health Education Thames Valley to fund the development and implementation of a Workforce Integration Strategy. This will deliver co-ordinated workforce planning across organisations and will set the direction for transforming the health and social care workforce to deliver integrated models of provision. It will be underpinned by a joint training programme across health and social care.

The CCGS are engaging with Health Education Thames Valley, the Thames Valley and Wessex NHS Leadership Academy and the Oxford Deanery to mould the shape of the future wider healthcare workforce and ensure that new staffing requirements can be met. We are exploring opportunities to use staff in different ways, for example through the GP and Nurse Fellowship programmes. A joint project between RBFT, the CCGS and the University of Reading aims to establish the role of Physicians' Assistants working in both acute and primary care settings.

The transformational changes described in this plan will be underpinned by a programme of organisational development activities which support the delivery of change both within individual organisations and in a way that facilitates improved organisational level interaction at a pathway level. The CCGs have undertaken a range of organisational development activities in their first year, including identifying potential successors for the GP Chair roles, undertaking governing body training and effectiveness reviews and completing a management team development programme. NHS England South's CCG Organisational Development Needs Diagnosis Tool will now be used alongside the findings of the 360 degree stakeholder survey to refresh each CCG's Organisational Development Plan and to agree priorities going forward.

Assuring quality

1. Overview

Delivering compassionate, high quality, outcomes-focussed care in a timely manner is at the very heart of our values. We recognise that developing a shared understanding of quality and a commitment to place it at the centre of everything we do provides us with the opportunity to continually improve and safeguard the quality of local health and social services for everyone, now and for the future.

Quality is assured through a wide range of metrics, indicators, dashboards, information and intelligence gathered nationally, regionally and locally. In addition to the contractual and operating performance related standards, there will be an on-going focus on ensuring that providers of services to Berkshire West communities are delivering quality services.

Our vision for quality is straightforward; patients and service users should:

- Receive clinically effective care and treatments that deliver the best outcomes for them
- Have a positive patient experience of their treatment and care
- Be safe, and the most vulnerable patients protected

Quality will underpin the development and delivery of every service and pathway and be at the heart of every commissioning decision we make. Quality will also be prioritised alongside performance and finance in assessing the successful delivery of this plan and will continue to be at the centre of all of our discussions with our population and with local commissioned providers. Should provider performance not meet expected quality and safety standards, contractual redress will be sought.

2. The Francis Report, Berwick and Keogh reports

We fully understand the recommendations of the Francis, Berwick and Keogh reports and are committed to implementing these recommendations. The CCGs will challenge healthcare providers to make on-going improvements in the quality of care provided to ensure that assurance about patient safety is an integral feature of commissioned services. This will be achieved through robust governance processes with providers to ensure that:

- fundamental standards and measures of compliance are always met
- they are able to demonstrate openness and candour
- they promote and provide compassionate, caring and committed care across their professional, and trained workforce
- they promote strong healthcare leadership
- they provide information and data on quality that is transparent to service users and the public

Through this work we will ensure that the patient remains at the centre and that a culture of openness, transparency and candour is promoted throughout the system.

3. Response to Winterbourne View

We are working together across the system to move people out of Assessment and Treatment units (hospital-based care) by June 2014. A strategic plan to manage care of these patients in the community through pooled budget arrangements is under development. Consideration is also being given to the development of a new service model to support people with learning disabilities and severe challenging behaviour in the community, thereby avoiding crisis management and hospital admissions.

4. Patient Safety

It is of paramount importance that people know that they will be safe in our care. We will ensure systems are in place to track and manage performance including taking action when required standards are not met. To ensure patient and staff safety, it is important that we encourage learning from mistakes and make changes in practice to ensure that any incidents are not repeated. This includes continuing to develop systems to ensure the widespread reporting of incidents and concerns relating to primary care, ensuring timely resolution as necessary and sharing learning where appropriate across providers. Where serious incidents occur in any setting, commissioners will be informed within an agreed timeframe and will monitor the investigation and any subsequent learning from the incident.

The CCGs will expect healthcare providers to continue to demonstrate a reduction in Healthcare Associated Infections (HCAI) in line with agreed trajectories, which will continue to include zero tolerance of MRSA. Additionally, there must be robust infection prevention and control plans, and demonstration of full compliance with the Health Act 2006 Hygiene Code.

Providers will also be required to ensure the following safety indicators are in place:

- Implementation of National Patient Safety Agency guidance
- Identification of safeguarding issues relevant to their areas of provision
- Arrangements to ensure that policies and procedures related to safety are implemented and monitored
- Safe recruitment procedures including meeting the vetting and barring requirements of the Independent Safeguarding Authority
- Robust incident reporting and monitoring systems that include escalation procedures for serious incidents
- Compliance with Care Quality Commission (CQC) regulations and standards
- Arrangements to meet National Safety Thermometer requirements

We will fully engage in the Area Team Quality Surveillance groups and ensure that we are proactive members of our local Patient Safety Collaboration, sharing intelligence and contributing to a collaborative improvement system that underpins a culture of continual learning and patient safety across the local health system.

5. Clinical Effectiveness

In order to provide cost and clinically effective care and treatment, the CCGs will require providers to comply with national and local standards/guidance such as National Service Frameworks and NICE technology appraisals and guidance. The CCGs will also expect to see evidence of compliance with guidance from other professional bodies.

Clinical and practice audit is one of the key mechanisms that monitors the performance and quality of services and demonstrates continuous quality improvement at service level. All healthcare providers will be expected to demonstrate an active approach to audit by having in place jointly agreed prioritised clinical and practice audit programmes, including participation in national audits.

Providers will be required to share outcomes of clinical and practice audits. Additionally, the CCGs will undertake independent audits where necessary. Through a quality scorecard and quality framework, the CCGs will ensure that providers can evidence delivery of quality services, with benchmarking to assess performance. The CCGs' Quality Committee will undertake this monitoring on behalf of the CCGs and provide assurance to the CCG Governing Bodies, highlighting any risks as they occur.

6. Patient and service user experience

We will strive to promote compassion, dignity and respect by demonstrating positive patient and service user experience. This will be measured through a variety of means including reviewing the outcomes of national satisfaction surveys, feedback from patient participation groups, information provided by Healthwatch, complaints data, Patient Advice and Liaison Service (PALS) enquiry data and for health services the results of the Friends and Family Test. Feedback from professionals, such as GPs reporting on their patients' experience and any clinical concerns, will also be used to monitor what services feel like from the perspective of those who use them. We will inform people of how their involvement in these surveys has improved services and facilitated the development of on-going engagement mechanisms.

Providers will use feedback to improve service delivery and will be required to regularly inform, consult and involve patients, service users, their families and carers and the wider public in the planning and review of services. We will contribute to this by engaging with specific groups of patients and service users via the 'Call to Action in a box' method, and take account of their feedback in planning services with providers.

One aim of this engagement is to ensure compassion by engaging staff and promoting an environment of empathy in which service users are listened to. We will promote dignity and respect, for example by monitoring how providers are meeting single sex accommodation requirements.

7. CQUINS

CQUIN is an incentivised monetary reward scheme (currently up to 2.5% of provider contracts) that CCGs use to allocate payments to providers if they meet defined quality outcomes. The CCGs will continue to work with providers to ensure that the CQUIN schemes both in the current and future contracts are stretching and deliver improved quality services for our population. The aim in future

will be to have fewer CQUINs to allow greater incentive payment for change on each. Where national CQUINs are already being achieved, stretch quality indicators will be introduced. We will be following national and regional guidance in the development of our local CQUIN arrangements, but would only expect to pay the full 2.5% to providers who have demonstrated truly exceptional quality, part of which will mean ensuring that all national standard quality requirements have been met.

To support the implementation of seven day services, the CCGs will be developing a CQUIN (2014/15) to support our providers in ensuring there are appropriate levels of consultant cover seven days a week. Providers have been required to submit an action plan to deliver the Seven Day Clinical Standards developed by the NHS Services Seven Days a Week Forum in preparation for full implementation through the NHS Standard Contract in 2016/17. We are also committed to utilising future CQUINs to support further initiatives around 7 day working.

8. Compassion in practice

We embrace the values and behaviours outlined within the vision and strategy for nurses, midwives and care staff – *Compassion in Practice*. We will ensure that all of our providers focus on the 'Six C's' (care, compassion, competence, communication, courage and commitment) putting the person being cared for at the heart of the care that is delivered to them.

9. Staff satisfaction

We recognise the importance of staff satisfaction to the delivery of high quality services. There is good evidence that happy, well-motivated staff deliver better care resulting in better outcomes. We recognise that health and social care staff work very hard, often under great pressure and we are committed to ensuring that we work with all our providers to make it possible for them to do the best job they can.

The CCGs and providers will use the results of the staff survey and the staff Friends and Family Test (as it comes into effect) to monitor NHS staff satisfaction and these results will be considered alongside all other quality metrics as a measure of the quality of services being provided.

10. Safeguarding

As public bodies we have a statutory duty to make arrangements to safeguard and promote the welfare of children and young people and to protect vulnerable adults from abuse or the risk of abuse. The Berkshire West CCGs are committed to fulfilling this function.

Commissioning organisations also have a responsibility to ensure that all providers from whom we commission services (both public and independent sector) have comprehensive single and multi-agency policies and procedures to meet these requirements.

We will ensure that systems and processes are in place to fulfil specific duties of co-operation and that best practice is embedded. All contracts and SLAs will require providers to adhere to Berkshire-wide safeguarding policies which promote the welfare of adults and children. Contracts will also require all providers to complete an annual section 11 audit (adapted to include safeguarding adults) and to provide assurance of compliance with required staff training levels and continuing professional

development which ensure that staff have an understanding of 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 will inform commissioners of all incidents involving children and adults, including death or harm whilst in their care.

The CCGs' Nurse Director will provide senior clinical leadership in the oversight of safeguarding arrangements at Board level for both Adults and Children and will continue to represent the CCGs on the Local Safeguarding Children and Adult Boards. The CCGs are enhancing their safeguarding team to ensure sufficient support is available to providers and that we are able to fully engage with our partners on safeguarding concerns. We are also committed to using this enhanced resource to support the improvement in safeguarding practice across primary care providers in Berkshire West and have appointed a Named Nurse Safeguarding Children Primary Care to support the Named GP function.

In our statutory role we are also committed to supporting the Prevent strategy which is part of a national strategy led by the Home Office focusing on working with individuals and communities who may be vulnerable to the threat of violent extremism and terrorism. The CCGs recognise that supporting vulnerable individuals and reducing the threat from violent extremism in local communities is a priority for the health service and its partners.

The CCG will ensure that there are robust Prevent arrangements in place across the health environment economy. This will be monitored through safeguarding assurance processes and form part of quality contracting monitoring in regard to all providers.

11. Relationship with external regulators

All service providers are subject to assessment and audit by a range of external regulators and assessors including the Care Quality Commission, Monitor, the Royal Colleges, the Health and Safety Executive, the National Audit Office and Healthwatch. It is important that commissioners are aware of the findings of all external regulator reports and use these to inform commissioning decisions and monitor any required developments. We will ensure that mechanisms are in place to share relevant information in timely manner.

We will build relationships with local representatives, for example from the CQC, Monitor, and Healthwatch, and as commissioners will meet with these regularly to ensure any areas of concern are shared early so that support can be provided immediately to make necessary improvements. Where necessary, as commissioners we will work in partnership with external regulators, supporting providers and monitoring actions plans to ensure that changes are made and full compliance is achieved as quickly as possible.

12. Primary Care Quality

Through primary care co-commissioning arrangements we intend to build upon our statutory duty to improve the quality of primary care services by combining national datasets with local intelligence in order to build up a rich picture of the quality of primary care provision and identify areas for improvement. The CCGs will then act as a source of support and information for practices looking to

improve the services that they provide, escalating serious or unresolved concerns to the Area Team as appropriate.

Governance

In addition to our own internal governance structures (Annex G), and in order to maximise our chances of success as a partnership, the Berkshire West 10 have developed robust governance arrangements to underpin our joint working. These are depicted below. They are designed to draw in all partners and incorporate the work of a number of bodies which have proven their resilience over a period of time, including the Berkshire West Partnership Board and the network of Locality Integration Groups. The work of these bodies is given further momentum by the direct engagement of each organisation at the most senior level through the Chief Officers Group which now meets regularly to review progress.
Progress against the Integration project is driven through a dedicated Programme Management Office, headed up by a jointly appointed Programme Director who works to ensure that progress is monitored, managed and delivered swiftly.

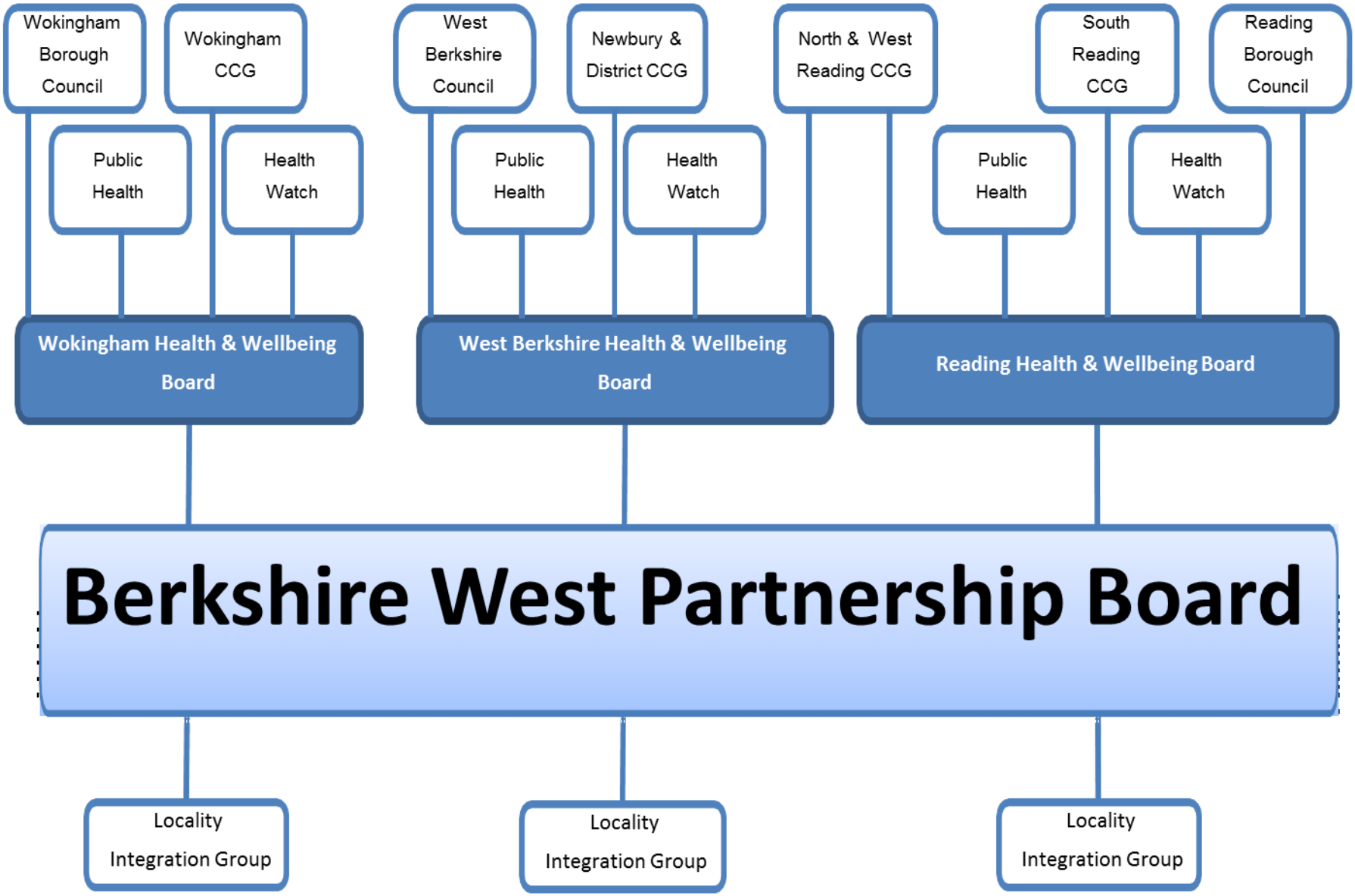
In addition, our Better Care Fund plans include further specific governance arrangements to ensure that we operate pooled budgets effectively to deliver change, maximising the impact of these and working together to minimise the risk of any de-stabilisation of the system as a whole.

To support us in judging our effectiveness in integration, we have defined the following desired patient outcomes and performance metrics which we will use to measure our progress:

Patient outcomes:

- Patients will co-produce their care plans, setting their own goals and outcomes
- Patients will have a single point of contact to co-ordinate all their care needs
- Patients will have sufficient information to support their decision-making and choices
- Patients will have a personal budget where they choose to do so

Berkshire West's three local Health and Wellbeing Boards will play a central role in our planning governance structures and will hold partners to account for the delivery of the strategic vision set out in this plan. This plan has been shared with each of the Health and Wellbeing Boards and this shared vision clearly defines what success will look like for our partnership.


Wokingham Borough Council
Wokingham CCG
West Berkshire Council
Newbury & District CCG
North & West Reading CCG
South Reading CCG
Reading Borough Council
Public Health
Health Watch
Public Health
Health Watch
Public Health
Health Watch
Wokingham Health & Wellbeing Board
West Berkshire Health & Wellbeing Board
Reading Health & Wellbeing Board
Berkshire West Partnership Board
Locality Integration Group
Locality Integration Group
Locality Integration Group

Key values and principles

1. Equality and Diversity

Equality and Diversity is central to our work to ensure there is equality of access and treatment within the services that are commissioned and provided. The promotion of equality, diversity and human rights is also central to the NHS Constitution We have used the NHS Equality Delivery System (EDS) to develop the following Equality Objectives.

Goals	Objective
Better health outcomes for all	Make effective use of equality data within the commissioning cycle to prioritise commissioning of services and embed equality within provider contracts. Increasing awareness of the Equality agenda
Improved patient access and experience	Improve equality data collection across all protected characteristic groups and use to inform service planning.
Empowered engaged and included staff	Improve training and development opportunities for staff at all levels for equality, diversity and human rights.
Inclusive leadership at all levels	Ensure Board members and senior and middle managers have an understanding of equality, diversity and human rights so that equality is advanced within our organisations.

2. Shared principles for whole system working

We have also developed the following shared principles for how we will work as a system:

- Develop a shared compelling vision of the health and social care economy, supported by evidence-based business cases
- Develop a high level set of outcomes and performance metrics and monitor the system's performance against these
- Align individual organisational plans across the whole system
- Operate within our agreed governance framework (see above)
- Share resources to establish a joint Programme Management Office, hosted by Wokingham Borough Council
- Deploy our own staff into programme activities where they have particular expertise
- Openly share data for the cost of service provision to support informed decision-making on service reconfiguration
- Support service changes that improve (or at least maintain) health outcomes for our population and reduce the cost of provision for the system as a whole
- Provide transitional relief for a fixed period, subject to available resources, where the impact of a service redesign reduces an organisation's financial viability
- Ensure recommendations for use of the Better Care Fund support the delivery of the Integration Programme

- Take collective responsibility and champion the programme, creating the culture for change to take place
- Identify and overcome the obstacles to integration

The following further principles apply specifically to service redesign:

- Service redesign will keep users/patients at its heart and be co-produced
- Design will be evidence-based wherever possible
- The model will prioritise the prevention of illness or crisis and develop proactive services
- Move care closer to home or to 'better value' care settings as the norm
- Reduce fixed costs in the system as far as possible and optimise the use of taxpayers money
- Provide single points of access for patients and integrate service provision
- Reduce the requirement for hospital beds, nursing and residential home placements

Annexes

Annex A: Strategic Plan Key Lines of Enquiry (KLOE)

Segment	Key Line of Enquiry	Organisation response	Supported by:
Submission details	Which organisation(s) are completing this submission?	NHS Newbury and District CCG NHS North and West Reading CCG NHS South Reading CCG NHS Wokingham CCG The plan describes the shared vision of the ten statutory health and social care organisations operating in Berkshire West.	
	In case of enquiry, please provide a contact name and contact details	Cathy Winfield Chief Officer (4 Berkshire West CCGs) 57-59 Bath Road Reading RG30 2BA 0118 9822932 Cathywinfield@nhs.net	
a) System vision	What is the vision for the system in five years' time?	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 hospital 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	The plan on a page

Segment	Key Line of Enquiry	Organisation response	Supported by:
		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.	
	How does the vision include the six characteristics of a high quality and sustainable system and transformational service models highlighted in the guidance? Specifically: 1. Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care 2. Wider primary care, provided at scale 3. A modern model of integrated care 4. Access to the highest quality urgent and emergency care 5. A step-change in the productivity of elective care 6. Specialised services concentrated in centres of excellence (as relevant to the locality)	1. Through our Communications Strategy we will implement a totally revised approach to engaging patients in designing services. Our new integrated care pathways will be built around empowering patients and service users to work with professionals to maximise health outcomes. Our commissioning intentions continue to reflect the influence of patient choice in determining activity flows and a number of our QIPP schemes, e.g. heart failure and haematology DAWN are focussed on rolling out other successful local approaches to support patients to be more involved in managing their long-term conditions. 2. We aim to build the role of GPs as the accountable clinician co-ordinating integrated care around the needs of the patient. The continuing shift to community-based provision will require GPs to continue to work in new ways with other professionals including specialties previously provided in a hospital setting. We are developing the role of practices as a key component of the urgent care system and as such are considering investing in seven-day primary care services. We anticipate that these changes will result in new primary care provider organisations and larger scale practice configurations emerging and will work with NHS England	Details provided within the activity and financial templates which will be triangulated.

Segment	Key Line of Enquiry	Organisation response	Supported by:
		on ways of contracting which will support such larger scale provision. 3. We are working to deliver fully integrated services which will support a shift in activity away from the hospital sector and with increasingly complex care provided in the community, through the Berkshire West 10 Integration Programme 4. Our Urgent Care Board is using real-time data to drive the transformation of our urgent care system in order to ensure that patients with differing levels of need all receive care in a timely manner and in an appropriate setting. We are setting up alternatives to admission such as Hospital at Home, investing further in Rapid Response and Reablement and working to improve our ability to discharge patients and instigate care packages 7 days per week. 5. Our activity plans reflect the fact that our patients are increasingly choosing to have care in the private sector, employing tariff flexibilities to ensure that providers are paid fairly for the work they deliver. We plan to align financial incentives with the models of care which we wish to commission and to work with NHS providers to develop a shared direction of travel for their services. 6. We will work with NHS England to ensure patients requiring specialist care are treated by the most appropriate provider. We recognise that this could have an impact on activity at RBFT and are working with the trust to understand the implications of this.	

Segment	Key Line of Enquiry	Organisation response	Supported by:
	How does the five year vision address the following aims: a) Delivering a sustainable NHS for future generations? b) Improving health outcomes in alignment with the seven ambitions c) Reducing health inequalities?	Our Financial Strategy and financial plan submissions include the QIPP schemes we have identified to meet savings targets in the early years. There are a number of further schemes in the pipeline; however the future sustainability of the system depends on the delivery of transformation change as described in this Strategic Plan. This Strategic Plan will improve outcomes across the seven outcomes highlighted in the planning guidance and our Operational Plans set out how our key interventions link directly to these. Our level of ambition for each of these outcomes is set out below. The Plan also includes details of interventions which will work to reduce health inequalities, most notably the gap in life expectancy seen between residents of each local authority. More detail of specific schemes linked to priorities identified in the Joint Health and Wellbeing Strategies is included in the CCGs' Operational Plans.	Financial Strategy – Annex B Unify financial planning template Two year CCG Operational Plans and Plan on a Page.
	Who has signed up to the strategic vision? How have the health and wellbeing boards been involved in developing and signing off the plan?	This document describes the shared strategic vision of the Berkshire West 10 partnership which includes the four CCGs, three local authorities, RBFT, BHFT and SCAS. Health and Wellbeing Boards received a paper on the planning process in December and agreed that the strategic unit of planning should be Berkshire West. Members have been briefed regularly since then and will be working on the further development and sign-off of this plan between now	

Segment	Key Line of Enquiry	Organisation response	Supported by:
		and June. In addition Health and Wellbeing Boards have signed-off plans for the use of the Better Care Fund and play a key role in the governance structure that supports delivery of the Berkshire West 10's integration programme.	
	How does your plan for the Better Care Fund align/fit with your 5 year strategic vision?	The Better Care Fund will act as a key vehicle for the delivery of the new ways of working described in this strategic plan.	
	What key themes arose from the Call to Action engagement programme that have been used to shape the vision?	Key themes were the need to sustain the NHS as a provider of high quality and reliable services and to keep it free at the point of delivery. People also said they wanted to see a more joined up health and social system, using the voluntary sector to full effect and using community-based services to keep people well and prevent ill-health. All of these themes are strongly reflected in the strategic vision described in this plan. Concerns were expressed by some about the use of the private sector and specifically about ensuring that the NHS retains control over services. At an individual level we are seeing more patients choose to receive care in the private sector. We will need to do more to assure the public about the control we have in place with regard to quality and cost.	
	Is there a clear 'you said we did' framework in place to show those that engaged how their perspective and feedback has been included?	This is in development and will be fed back to members of the public through follow-up Call to Action events to be held in the Spring and captured in the final version of the Strategic Plan.	

<table>
<tr><th>Segment</th><th>Key Line of Enquiry</th><th>Organisation response</th><th>Supported by:</th></tr>
<tr><td rowspan="3">a) Current position</td><td>Has an assessment of the current state been undertaken? Have opportunities and challenges been identified and agreed? Does this correlate to the Commissioning for Value packs and other benchmarking materials?</td><td>This plan reflects the population needs identified in the JSNA and a demand and capacity analysis previously undertaken across the system which identified a range of short and long-term redesign opportunities. In addition each CCG has reviewed the Commissioning for Value packs and plans are in place to further review and reduce areas of variation. As Berkshire West is already a high performing system few opportunities were identified, but a key area for exploration is the level of musculo-skeletal activity where there are significantly higher levels of activity than would be expected for our population.</td><td></td></tr>
<tr><td>Do the objectives and interventions identified below take into consideration the current state?</td><td>Our programme of interventions is based upon this analysis of our current position and potential opportunities. They include a number of pilot schemes and pump primed initiatives which reflect our starting position but should put us in a position to realise further savings in future years.</td><td></td></tr>
<tr><td>Does the two year detailed operational plan submitted provide the necessary foundations to deliver the strategic vision described here?</td><td>The two year Operational Plans describe key interventions to be undertaken over the next two years which deliver a balanced financial position at March 2016 but will also move us towards our strategic vision and inform planning for the outer years.</td><td></td></tr>
<tr><td>b) Improving quality and outcomes</td><td>At the Unit of Planning level, what are the five year local outcome ambitions i.e. the aggregation of individual organisations contribution to the outcome ambitions?</td><td><table><tr><th>Ambition area</th><th>Metric</th><th>Proposed attainment in 18/19</th></tr><tr><td>1 Years of life lost to treatable</td><td>As per guidance</td><td>3.2% reduction compared to</td></tr></table></td><td></td></tr>
</table>

Segment	Key Line of Enquiry	Organisation response			Supported by:
		conditions		2013/14	
		2 Improving quality of life for people with long-term conditions	Patients reporting that they feel supported to manage their long-term condition in GP Patient Survey	To increase from 78.5% to 81%.	
		3 Supporting older people to live at home	Metrics tbc as per guidance		
		4 Reducing avoidable admissions	As per guidance	3.2% reduction in first year of plan.	
		5 Increasing number of people having positive experience of care in hospital	Friends and Family Test	3.6% reduction in rate of people reporting poor care	
		6 Increasing number of people having positive experience of care outside	GP Patient Survey – measures for practice and OOH	13.9% reduction in rate of people reporting poor experience of primary care in S.Reading, 3.6%	

Segment	Key Line of Enquiry	Organisation response			Supported by:
		hospital		reduction in Wokingham and maintenance of current top quintile position in North and West Reading and Newbury.	
		7 Reducing avoidable deaths	Metrics tbc as per guidance		
	How have the community and clinician views been considered when developing plans for improving outcomes and quantifiable ambitions?	The public have been involved in the development of our ambitions through discussion at our three Call to Action events and through the associated online survey. There are patient representatives on all our key care programmes. We are shortly holding a summit with all 3 Healthwatchs, the third sector leaders and the CCG PPI lay members to review our patient engagement. Clinicians have been consulted through our on-going work with partner organisations and discussions at GP Councils, including a strategic planning workshop attended by 60 GP Council members. We are undertaking a joint clinical service review with our two key providers to further inform our 5 year strategy			
	What data, intelligence and local analysis was explored to support the development of plans for improving outcomes and	The development of local outcomes ambitions as set out in the CCGs' two year operational plans has been informed by the JSNA and Joint Health and Wellbeing Strategies. We			

Segment	Key Line of Enquiry	Organisation response	Supported by:
	quantifiable ambitions?	have developed our trajectories against the national outcomes indicators with reference to the 'How to Guide' which includes a review of our current performance against that of CCGs serving similar populations.	
	How are the plans for improving outcomes and quantifiable ambitions aligned to local JSNAs?	The local outcomes ambitions set by each CCG reflect the priorities highlighted in the JSNA for their area.	
	How have the Health and well-being boards been involved in setting the plans for improving outcomes?	Health and Wellbeing Boards have been involved as part of the on-going dialogue around the planning process. The local outcomes ambitions of each CCG reflect Joint Health and Wellbeing Strategy priorities.	
c) Sustainability	Are the outcome ambitions included within the sustainability calculations? I.e. the cost of implementation has been evaluated and included in the resource plans moving forwards?	Confirmed.	
	Are assumptions made by the health economy consistent with the challenges identified in a Call to Action?	Yes – analysis of local demand and capacity, together with future funding projections has shown that the challenges identified in the national Call to Action programme such demographic pressures, increasing numbers of patients with long-term conditions, changing patient expectations will have an impact locally and we have built our Strategic Plan in such a way as to set out how we as a system can withstand these challenges.	

Segment	Key Line of Enquiry	Organisation response	Supported by:
	Can the plan on a page elements be identified through examining the activity and financial projections covered in operational and financial templates?	Yes – the operational and financial plans reflect the key elements of this Strategic Plan as set out in the Plan on a Page.	
d) Improvement interventions	Please list the material transformational interventions required to move from the current state and deliver the five year vision. For each transformational intervention, please describe the : • Overall aims of the intervention and who is likely to be impacted by the intervention • Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have • Investment costs (time, money, workforce) • Implementation timeline • Enablers required for example medicines optimisation • Barriers to success • Confidence levels of implementation	See Annex E	

Segment	Key Line of Enquiry	Organisation response	Supported by:
	The planning teams may find it helpful to consider the reports recently published or to be published imminently including commissioning for prevention, Any town health system and the report following the NHS Futures Summit.		
e) Governance overview	What governance processes are in place to ensure future plans are developed in collaboration with key stakeholders including the local community?	The Berkshire West 10 has a robust governance structure in place as described above. This includes linking the work of established bodies with overall assurance provided by the Health and Wellbeing Boards.	
f) Values and principles	Please outline how the values and principles are embedded in the planned implementation of the interventions	The system reform initiatives described in this document reflect the shared principles around system reform which members of the Berkshire West 10 partnership have agreed. The overall programme of transformation described is in line with the shared principles for whole-system working also developed by the partnership.	

Annex B: Financial Strategy

Draft Financial Strategy 2014-2015 to 2018-2019

Contents

Introduction

1. This financial strategy for the Berkshire West CCGs incorporates and takes into account the following guidance and policies that are currently in place:

    - Everyone Counts: Planning for Patients 2014-2015 to 2018-2019
    - Clinical Commissioning Group allocations 2014/15 and 2015/16
    - 2014-15 NHS Berkshire West CCGs Commissioning Intentions FINAL
    - Joint Strategic Needs Assessment
    - The Mandate: A mandate from the Government to NHS England: April 2014 to March 2015
    - The NHS belongs to the people: A Call to Action
    - CCG Outcomes Atlas
    - Level of Ambitions Atlas
    - Operational Atlas
    - Commissioning for Value Packs

1.1 In line with Everyone Counts, this financial strategy takes a longer term view of the planning of the CCGs' finances.

1.2 This financial strategy is based on the Unit of Planning which the CCGs have chosen to use which covers Newbury and District CCG, North and West Reading CCG, South Reading CCG and Wokingham CCG (the CCGs). Individual CCG financial plans and strategies will also be available.

1.3 The Better Care Fund plan is developed using the same Unit of Planning from a health perspective. However, this will be made up of 3 plans – one for each local authority in Berkshire West, which will be signed off by the respective Health and Wellbeing Boards.

1.4 The financial strategy includes further elaboration of the key financial metrics to support the assurance of and measure performance against strategic plans.

1.5 The objectives of the financial strategy are to ensure that collectively and individually the CCGs are in a strong financial position to:

- Implement efficient and effective clinical commissioning, including collaborative working where appropriate to ensure that high quality services are available to the CCG populations;
- Maintain strong financial grip whilst delivering the required non-financial performance and quality standards;
- Achieve the required agreed financial surplus;
- Identify, managed and mitigate financial risks which may include financial risk sharing across the CCGs;
- Be in a strong position to take advantage of any opportunities to innovate and develop;
- Support the development of provider healthcare services across Berkshire West (and beyond where appropriate);
- Support longer term financial sustainability and improved outcomes; and

- Demonstrate robust financial management control and best value for taxpayers.

National Context

2. The NHS in the last 10 years has benefitted from significant growth in funding and investment. This has now changed as a result of the current economic climate and this continues to have both direct and indirect impact on the NHS and presents financial challenges and opportunities including:

    - The affordability gap of £30 billion by 2020-2021 as forecast in A Call to Action (based on continuing with the current model of care) and the more immediate affordability challenges of the final two years of the current QIPP programme which is designed to find £20 billion of efficiency savings across the NHS by 2015.
    - Minimal growth in funding in the medium term (see section 3)
    - Reduction in social care funding of up to 25%

2.1 In addition there are a number of future pressures on demand for NHS services including the ageing population, a significant increase in the number of people with long term conditions and rising expectations.

2.2 On the supply side we are faced with increased costs of providing healthcare, limited productivity gains and constrained public resources. In Berkshire West we also have issues relating to increasing provider capacity and ambition.

2.3 The development of the "Better Care Fund" pooled budget with Local Authorities in 2015-2016 provides us with an opportunity to secure more sustainable, efficient and integrated health and social care services that provide better value for money

Local Context

2.4 The Berkshire West health economy is still one of the lowest funded in the UK despite the welcome increase in allocations for the 2 years 2014-2015 and 2015-2016 for the CCGs as follows:

CCG	2014-2015	2015-2016
Newbury and District	3.7%	3.4%
North and West Reading	3.5%	3.1%
South Reading	3.3%	2.8%
Wokingham	4.4%	4.0%

2.5 This provides us with a greater opportunity to invest in transformational schemes to support seamless care for our population.

2.6 However, our current financial plans show that the CCGs will need to save in excess of £37m over the next five years to achieve the required levels of surpluses. Transformational change underpinned by robust financial control is therefore required.

Commissioning Intentions

2.7 In line with national expectations, the CCGs will be working to ensure that their commissioning activities over the coming years deliver improved outcomes on the following seven key areas:

- Reducing years of life lost for treatable conditions;
- Improving the health related quality of life for people with long-term conditions;
- Reducing avoidable admissions and develop more integrated care in the community outside hospital;
- Increasing the proportion of elderly living independently at home following post discharge from hospital;
- Reducing the proportion of people reporting very poor experience of inpatient care;
- Reducing the proportion of people reporting very poor experience of primary care; and
- Making significant progress towards eliminating avoidable deaths in hospital.

2.8 The CCGs will also be required to ensure that providers continue to meet essential levels of quality and safety and to deliver the key rights and pledges to patients as set out in the NHS Constitution and the NHS Mandate.

2.9 Our commissioning intentions are set out in our document *2014-15 NHS Berkshire West CCGs Commissioning Intentions FINAL,* which is available on the CCG websites.

2.10 Commissioning intentions have been shared with our providers.

Financial Plan Summary

3. The key financial targets are:

- Achievement of I&E surplus;
- Achievement of agreed QIPP plan;
- Commitment of only 97.5% of resource recurrently in 2014-2015, including the funding for Call to Action. In 2015-2016 onwards, the target is 99%;
- Commitment to the establishment of the Better Care Fund pooled budget with Local Authorities;
- Payment to suppliers in line with the Better Payment Practice Code;
- Management within agreed cash limit; and
- Demonstrating value for money.

4. Programme

The table below sets out how our programme allocations are planned to be deployed over the next 5 years. Secondary care expenditure in the acute sector is largely remaining static as although we are planning to reduce admissions into hospital and deliver more integrated care in the community this is somewhat offset by the increase in demographic population growth and the associated impact on acute hospital (particularly urgent care) demand. Expenditure in community services in particular increases over the 5 year period reflecting our commissioning intentions as set out in Section 4 above.

Allocations	2014/15' £m	2015/16' £m	2016/17' £m	2017/18' £m	2018/19' £m
Recurrent	503.87	526.07	543.79	559.01	573.79
Non recurrent	11.01	12.54	5.21	5.44	5.59
Total Allocations	514.88	538.61	549.00	564.45	579.38
Planned Expenditure					
Secondary care services	251.69	254.28	258.15	261.27	263.96
Community and MH services	114.02	115.25	119.65	125.27	130.74
Ambulance services	16.29	16.41	17.24	17.71	18.17
Prescribing	62.17	64.66	67.25	69.94	72.73
Continuing Health Care	22.84	23.42	24.16	24.91	25.67
Better Care fund	0.00	25.04	25.54	26.05	26.57
Other Programme costs	13.50	13.38	15.42	17.39	19.31
Investment fund (non recurrent)	12.31	10.15	5.33	5.48	5.63
Running costs	12.02	10.82	10.84	10.85	10.86
Total expenditure	504.84	528.41	543.58	558.87	573.65
Surplus	10.04	5.21	5.42	5.58	5.73

5. Running Costs

Everyone counts: Planning for patients 2014-15 to 2018/19 set out that the running costs envelope will remain flat in cash terms in 2014-2015 and then reduce 10% in 2015-2016, with flat in cash terms for 2016-2017 to 2018-2019. It was also set out that Running Costs Allocations will be adjusted for population change and based on the latest available ONS population projections.

Running Cost Allocations have now been set on the basis of 'unweighted' population and unlike programme spend allocations; there is no "pace-of-change" so any changes in the population of a CCG are immediately reflected.

The CCGs' Running Costs Allocations have been confirmed and are included in paragraph 6.2. CCGs have received some additional funding for population changes and this amounts to £24,000 in 2014-2015. In 2015-2016, the CCGs will see a £1,182k (9.83%) reduction in running costs funding. This is the 10% reduction net of some population growth.
Approximately £1.35m of our running cost budget was unallocated in 2013-2014 and the budget is expected to underspend by just under £1m in 2013-2014. Where possible, we will continue to hold this budget for non-recurrent purposes, but in 2015-2016 the amount available will be reduced to contribute to the £1.2m savings target. In addition, we will look at the following areas for efficiencies:

- CSU: almost 50% of our running cost budget is currently used to purchase services from CSU, so we will be working with them to secure efficiencies on all services lines that they provide for the CCGs. We have been offered 1.9% efficiency for 2014-2015 and CSU has

made a commitment to deliver 7%, we will be asking them to go further on this to deliver the full 10% required. The CCGs have committed to receiving some services from CSU until the 31st March 2016. The capability and capacity of the CSU to provide services is critical to the delivery of the financial strategy.

- We are developing a pipeline of procurement projects with our CSU procurement team, which will deliver savings in 2014-2015 onwards on our key areas of non-healthcare expenditure.

6. 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 following QIPP gap has been identified for the CCGs over the next 5 years, amounting to just over £37m in total:

CCG	2014-2015 £000	2015-2016 £000	2016-2017 £000	2017-2018 £000	2018-2019 £000
Newbury and District	-1,744	-2,236	-1,737	-1,382	-1,382
North & West Reading	-1,688	-2,174	-1,689	-1,344	-1,344
South Reading	-1,947	-2,495	-1,939	-1,543	-1,543
Wokingham	-2,184	-2,800	-2,175	-1,731	-1,731
Total	-7,563	-9,705	-7,540	-6,000	-6,000

- Schemes have been developed to meet the QIPP gap in 2014-2015 which are listed overleaf. Some of these schemes e.g. Hospital at Home will start in 2014-2015 and therefore will contribute only a part year effect in 2014-2015, the full year effect will impact in 2015-2016 and beyond. All schemes have been risk assessed and are monitored through the 4 Programme Boards and the CCGs QIPP and Finance Committee. Other schemes are under development to close the greater financial gap in 2015-2016, particularly in relation to the redesign of the frail elderly pathway and currently these schemes amount to just over £9.5m :

QIPP Project	14/15 FYE Net Savings £000
Hospital at Home	1,438
Care Home Support	521
MSK (clinical variation)	950
Contracts and pricing	2,000
Medicines Management	750
Integrated Eye Care Services	500
Reablement	690
Other	714
Total	**7,563**

Sources of Funding

7. Overview

For CCGs, NHS England has adopted a revised funding formula recommended by the Advisory Committee on Resource Allocation. The implication of the distribution of resources is a differing level of efficiency challenge in 2014-2015 and 2015-2016 by commissioner. In 2014-2015 specialised commissioning remains the area with the most challenging efficiency requirement. In 2015-2016 with the introduction of the Better Care Fund, CCGs face a more significant efficiency challenge. Over the two years the efficiency challenge for both CCHs and specialised commissioning is similar at approximately 9 per cent, including the provider efficiency deflator.

To support commissioners to manage this challenge over the two year period NHS England has proposed to prioritise access the drawdown of surpluses from prior years for specialist commissioning in the first year and CCGs in the second year. This means that the Berkshire West CCGs will not be receiving the additional surplus generated in 2012/13 of £2.5m originally committed by the SHA to be drawn down in 2014/5. For planning purposes we have assumed repayment of this surplus in 2016/17 to "smooth" the increased levels of QIPP required in that year.

For 2016-2017 and 2018-2019 onwards we have been advised to assume a continuity of the current allocations policy. For subsequent years it is assumed that income growth increases in line with the GDP deflator.

7.1 Allocations

Allocation	2014-2015 £m	2015-2016 £m	2016-2017 £m	2017-2018 £m	2018-2019 £m
Programme	491.82	508.48	526.20	541.40	556.17
Running Costs	12.02	10.82	10.84	10.85	10.86

Total Notified Allocation	503.84	519.30	537.04	552.25	567.03
Better Care Fund	-	6.75	6.75	6.75	6.75
Non-recurrent (including return of surplus)	11.01	12.54	5.21	5.44	5.59
Total Revenue	**514.88**	**538.61**	**549.00**	**564.45**	**579.38**
Capital (requested)	1.50	1.50			

7.2 Surplus Draw Down

The following assumptions have been made about the drawdown of surplus:

- The £2.5m surplus carried forward from 2012-2013 will be returned in 2015-16
- The original planned surplus of £5.1m from 13-14 will be drawn down in 2014-2015
- The additional planned surplus of £5m from 2014-15 will be drawn down in 2015-16, together with the original planned surplus.

7.3 Capital Resource Limit

The CCGs have applied for £1.5m of capital funding in each of the years 2014-2015 and 2015-2016. It is the intention that this funding be used to support the capital investment requirements relating to the development of the Better Care Fund and the Primary Care Strategy including 7 day working. The capital investment will be undertaken by Local Authorities and GP practices and will be funded via a capital grant. Business cases are currently being developed.

Key Planning Assumptions

8. Our financial planning assumptions are in line with (or more prudent than) current National Guidance and are set out below. In the first year of the financial plan (14/15) the CCG's have agreed to plan to achieve a surplus equivalent to 2% of allocation (rather than the 1% defined in national guidance), this additional surplus will be returned to the CCGs in 2015/16.

Assumption	Source	2014-15	2015-16	2016-17	2017-18	2018-19
Allocation for Growth	National	3.78%	3.38%	3.48%	2.89%	2.72%
PbR deflator	National	-1.10%	-1.60%	+0.40%	-0.60%	-0.70%
Prescribing Inflation	Local	4.00%	4.00%	4.00%	4.00%	4.00%
CHC Inflation	Local	2.00%	2.00%	2.00%	2.00%	2.00%
Acute activity growth	Local	2.50%	2.50%	2.50%	2.50%	2.50%

Better Care Fund	National	0.26%	3.26%	3.26%	3.26%	3.26%
Surplus	National	2%	1%	1%	1%	1%
Non-Recurrent Spend	National	2.50%	1%	1%	1%	1%
Contingency	Local	0.7%	0.7%	0.7%	0.7%	0.7%

Risks and Opportunities

9. Significant financial risks have been identified as follows:

- CHC provision not being returned in 2014-2015. Use non-recurrent funding to contribute to national risk share pool and rebuild the provision up to £12m;
- Transfer of funding to the Better Care Fund £25m;
- QIPP non-delivery;
- Sustainability of providers mitigated by integrated working;
- Acute contract over performance;
- Ambulance contract over performance;
- Private Provider over performance; and
- Response to ageing population – failure to resource and redesign.

9.1 These risks are reflected in our Risk Register and where a threat to achieving the CCGs strategic objectives will be reflected in the Governing Bodies Assurance Framework.

9.2 Opportunities

- Better Care Fund pooled budget;
- Path system integration; and
- Pathway redesign

10. Risk Sharing

The CCGs' constitution allows for an annual review of risk sharing arrangements. The areas that have been agreed for 2014-2015 are:

10.1.1 The Berkshire Healthcare NHS FT Community Services Contract. This is currently a block arrangement so there is no risk to the CCGs as a whole. Individual CCGs are allocated levels of activity against this contract through fair shares but this does not necessarily effectively equate to the levels of services individual CCGs are accessing/receiving e.g. South Reading look like they are spending more than they actually are but they are not receiving the same levels of services as other CCGs. Movement away from a block contract will create risk so CCGs will risk share this. We will be in a better position at the end of 2014-2015 to quantify the risks as a project is underway to disaggregate the contract at both CCG and service line level as part of the development of the Better Care Fund.

10.1.2 The Berkshire Healthcare NHS Mental Health Contract as above is currently a block contract with similar issues but the Mental Health need in Reading is greater than say Newbury so fair shares is probably not representative – CCGs will risk share and the work on disaggregation will also apply here.

10.1.3 Unregistered patients in secondary care.

10.1.4 CHC and FNC – whilst it will be possible to identify these patients on an individual CCG level the costs are high and volatile and could create cost pressures in individual CCGs that collectively may wish to mitigate, recognising that there is little control over where these patients are ultimately taken care of. CCGs agree that an individual CCG should not be penalised for having a greater number of nursing homes in its patch and therefore agreed to risk share.

10.1.5 High cost Out of Hospital Placements – similar to above – tend to be small numbers and high cost. Examples include placements under section 117 and placements for neuro-rehabilitation.

10.1.6 Critical care costs.

10.1.7 High cost drugs and appliances.

10.1.8 SCAS 999 contract which is now capable of sharing data on actual usage.

10.1.9 SCAS PTS contract which is now capable of sharing data on actual usage.

Investment

In addition to the contribution to the Better Care Fund and Primary Care Strategy Development, there is an investment reserve to fund the following:

- Escalation beds in the community
- Expanded service navigation team to help reduce admissions into the acute hospital
- Support for the over 75s, particularly in primary care as GPs take on the role of accountable clinician and in line with national guidance
- IVF extension to reflect the change in policy removing the lower age limit in line with age discrimination legislation
- The implications of the Francis and Berwick reports in line with national guidance
- QIPP investments to enable the savings to be delivered

The CCGs may also need in year to fund a number of other contract related pressures and will hold a small commissioning reserve to support this.

Better Care Fund

The four CCGs in Berkshire West have been working closely with the 3 Local Authorities (Reading, West Berkshire and Wokingham) to establish a pooled Better Care Fund for 2015-2016, the financial detail of which can be seen at Annex C. The amount going into the fund is in excess of £27m spread across the 3 Local Authorities with over £15m of this being new commitment from the CCGs. Local NHS Providers were involved in the development of these plans, and continue to play a key role in their local implementation.

As with our health providers, relationships with the 3 Local Authorities are good and have developed significantly over the last 12 months.

Statement of Financial Position

Our draft opening and closing Statement of Financial Position is included below for 2014-2015 and the draft closing position for future years is currently expected to be similar in future years.

Assets		**31 March 2014 £000**	**31 March 2015 £000**
	Non-Current	0	0
	Current		
	- Trade and Other Receivables	1,412	1,412
	- Cash and Cash Equivalents	1,401	2,115
	Total Assets	2,813	3,527
Liabilities			
	Non-current	0	0
	Current		
	- Trade and other payables	36,988	37,702
	- Provisions		
	Total Liabilities	36,988	36,274
Total Assets Employed		**(34,175)**	**(34,175)**
Tax Payers Equity			
	General Fund	(34,175)	(34,175)

Cash

Our draft statement of cash flows for 2014-2015 is included below and is expected to be similar in future years:

Statement of Cash Flows for the Year Ended	**£000**
Cash Flows from Operating Activities	
- Net Operating Costs for the financial year	(511,340)
- (Increase)/decrease in trade and other receivables	0
- Increase/(decrease) in trade and other payables	714
Net Cash Inflow/(Outflow) from Operating Activities	**(510,626)**
Cash flows from Financing Activities	
- Net parliamentary funding received	509,840
- Capital grants	1,500
Net Cash Inflow/(Outflow) from Financing Activities	**511,340**
Net Increase (Decrease) in Cash and Cash Equivalents	714
Cash and Cash Equivalents at the Beginning of the Financial Year	1,401
Cash and Cash Equivalents	2,115

Contract Values

Contract negotiations with all our providers for 2014-2015 are well underway but have not yet been concluded for all contracts. The levels of financial risk are understood by all main parties and we are

working collaboratively to close the financial gaps that currently exist. Heads of Terms have been signed with our two main providers, Royal Berkshire NHS FT and Berkshire Healthcare NHS FT (with values detailed below). We are aiming to achieve signed contracts by 30th April 2014.

It is our intention as commissioners as part of our contract negotiations and QIPP plans to make effective use of tariff flexibilities and financial levers to generate efficiencies and incentivise our providers to deliver services that reflect our strategic vision and commissioning plans. We will be looking to apply locally agreed pathway prices where appropriate and to negotiate tariff minus payments to providers that do not provide a full range of services and hence have a less complex case mix of patients. We will also be incentivising collaborative working across the system by the use of best practice tariffs for pathways of care across organisational boundaries.

Trust	contract Value (£M) excluding CQUINs	CQUINs Value (£M)	Total (£M)
Royal Berkshire NHSFT	196.14	4.49	200.63
Berkshire Healthcare NHSFT	91.58	2.18	93.76

Conclusion

This financial strategy underpins our 5 year strategic plan. The financial environment and future across the whole system in Berkshire West is challenging and there is an absolute recognition that the individual organisations need to work collaboratively together to deliver financial sustainability to allow and ensure operational and clinical excellence for the population of Berkshire West.

Annex C: Summary of BCF Plan

BETTER CARE FUND - financial detail (draft) - revised 11 march

			Councils			
Breakdown of total fund						
			West Berkshire £'000	Reading £'000	Wokingham £'000	Total £'000
Baseline S256 funding - 2013/14			1,793	2,038	*1,437*	5,268
Additions to grant in 2014/15			417	475	*335*	1,227
Baseline S256 funding - 2014/15			2,210	2,513	1,772	6,495
Funding added to the BCF, already committed						
	Carers funding		321	337	*278*	936
	Reablement		740	779	*641*	2,160
Committed funds			3,271	3,629	2,691	9,591
New 15/16 commitment			**5,257**	**5,447**	**4,740**	**15,444**
Total BCF funding via CCGs			8,528	9,076	7,431	25,035
BCF funding from DFG			726	432	*389*	1,547
BCF funding from Social care capital grant			279	317	*224*	820
Total BCF funding - 2015/16			9,533	9,825	8,044	27,402
New 15/16 commitment - breakdown						
			West Berkshire £'000	Reading £'000	Wokingham £'000	Total £'000
New commitments - schemes due to commence in 14/15						
	Hospital at Home (fye)		1,128	776	940	2,844
	Nursing / care home projects (fye)		166	176	*145*	486
			1,294	952	1,085	3,330
Draft commitments - 15/16						
	Joint schemes between Health and Social care		2,456	2,794	2,712	7,962
	Social Care Bill		1,507	1,701	944	4,152
New 15/16 commitment			**5,257**	**5,447**	**4,741**	**15,444**
			0	0	-1	
How will councils be paid						
			West Berkshire £'000	Reading £'000	Wokingham £'000	Total £'000
	Direct by DH		1,005	749	613	2,367
	standard terms (tbc) - from CCGs		6,019	6,490	5,314	17,824
	linked to outcomes - from CCGs		2,509	2,586	2,117	7,211
			9,533	9,825	8,044	27,402
	Linked to outcomes	payment				
	Progress to 4 National conditions	april '15	627	646	529	1,803
	progress against local metrics and 2 national metrics	april '15	627	646	529	1,803
	Further progress against local and national metrics	oct '15	1,254	1,293	1,058	3,606
			2,509	2,586	2,117	7,211

* see para 52-57 of guidance for detail on consequences of non acheivement of outcomes.

Annex D: NHS Constitution access measures

Referral to treatment waiting times for non-urgent consultant led treatment	Patients to start treatment within a maximum of 18 weeks from referral by the GP (90% Admitted; 95% non-admitted & 92% incomplete)
Diagnostic test waiting times	99% Patients waiting for diagnostic tests (x-rays, scans etc) should have been waiting less than 6 weeks from referral by the GP
A&E Waits	95% Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E Department
Cancer Waits – 2 week wait	93% -A maximum two week wait for the first outpatient appointment for patients referred urgently with suspected cancer 93%- A maximum two week wait for the first outpatient appointment for patients referred urgently with breast symptoms (where cancer is suspected)
Cancer Waits – 31 days	96%-A maximum of one month (31 days) wait from diagnosis to first definitive treatment for all cancers 94%-Maximum 31-day wait for subsequent treatment where that treatment is surgery 98% -Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen 94% -Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy
Cancer Waits – 62 days	83%-A maximum two month (62 days) wait from urgent GP referral to first definitive treatment for cancer 90%-Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set
Category A ambulance calls	75%- Category A calls resulting in an emergency response arriving within 8 minutes 95%-Category A calls resulting in an ambulance arriving at the scene within 19 minutes [Category A calls are '999' calls that are immediately life threatening. Where onward transport is required, an ambulance vehicle will transport the patient within 19 mins of the request being made].
NHS Constitution Support Measures	
Mixed Sex Accommodation Breaches	Minimal number of mixed sex accommodation breaches in hospitals
Cancelled Operations	All patients who have operations cancelled, on or after the day of admission (including the day of surgery) for non-clinical reasons will be offered another dated within 28 days, or the patients treatment funded at the time and hospital of the patients choice
Mental Health	Care Programme Approach (CPA). The proportion of people under adult mental illness specialties on CPA who are followed up within 7 days of discharge from psychiatric inpatient care

Referral To Treatment waiting times for non-urgent consultant-led treatment	Zero tolerance of over 52 week waiters
A&E waits	No waits from decision to admit to admission (trolley waits) over 12 hours
Cancelled Operations	No urgent operation to be cancelled for a 2nd time
Ambulance Handovers	All handovers between ambulance and A & E must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. Financial penalties, in both cases, for delays over 30 minutes and over an hour.

Annex E

Information Management & Technology Strategy for Berkshire West: Plan on a Page

Our IM&T Vision

Widespread exploitation of information and IT is essential to achieve the CCGs' goals, through:

- *Enabling transformation of care pathways and services;*
- *Improving whole-system care service efficiency, effectiveness and safety ;*
- *Supporting commissioning decision-making;*
- *Empowering patients and the public to take greater responsibility for their own health and healthcare;*
- *Ensuring confidential information is held securely and shared on a need to know basis.*

Our IM&T Programme

To turn the vision into reality we need:

- ***Records Access & Sharing*** - providing secure access to / sharing of patient records between partner organisations, through integration of systems and improved electronic communications.
- ***Commissioning Enablement*** - improving the tools and information available to support commissioning; Exploiting health intelligence, knowledge management and decision support tools; Enhanced corporate communications.
- ***Patients / Citizen Empowerment*** – improving information for, and feedback mechanisms from, patients and the public; Tools to better support patients and their carers such as access to online services, "apps", social media and telehealth.
- ***Enabling Infrastructure*** – ensuring IM&T is underpinned by robust information governance and security arrangements; Technical infrastructure, IT and Informatics support services which are resilient and fit for purpose.

Our Strategy in Context

Some examples of *why* IM&T is crucial to our success, *what* it will deliver and *how* this will be achieved

Why? - Drivers for Change / Our Aims	*What? - Required IM&T Outcomes*	*How? – Existing and Proposed Initiatives*
Integrated care, e.g. Providing person-centred and co-ordinated care in the most appropriate setting; Joined up care pathways, integrated care planning & delivery between health and social care; Hospital at Home through integrated multidisciplinary teams; Reduced avoidable admissions;. Improved End of Life care planning and delivery; 'Tell your story once'.	• Right information, right place, right time • Improved information sharing, with healthcare professionals having access to the same information • Integrated care planning and record keeping between health and social care teams.	• Shared strategy / plans for integrating patient records / systems across all local health and social care organisations • Digital records available to 111 provider to avoid "cold-triage" • Increased GP access to patient records across sites • End of Life care – integrated records.
Patient / citizen engagement, e.g. Ensuring that public, patient and carer voices are at the centre of our healthcare services from planning to delivery, and that information flows both ways between services and the public.	• Improving information provision to patients and the public • Empowering service users to make informed choices by improving communications through technology • Using technology to help measure patient experience.	• Systematic Communications & Engagement Strategy • Re-designed websites and Twitter feeds, use of social media • Wider use of text alerts / reminders • Video screens for GPs' waiting rooms to improve communication.
Patient empowerment, e.g. Increasing the proportion of people who feel supported to manage their long-term condition; Improving interaction between patients and their care teams; Patients, families and carers actively involved in shared decision making to make fully informed choices.	• Using technology to facilitate new ways of interacting with health care professionals e.g. Skype appointments • Patients accessing electronic records/systems to improve management of their own conditions • Exploiting technology to improve monitoring of patients with chronic conditions.	• Patient online access to (GP systems) records, booking, prescriptions • Telemonitoring of LTC patients, e.g. those with heart failure, COPD • Use of Choose & Book and e-referrals system • Diabetes care – enable greater self-management by increased use of care planning, patient access and input to records.
Commissioning decision-making, e.g. Maintain strong financial grip whilst delivering the required non-financial performance and quality standards; Commission high quality evidence-based services; Clinicians understand and are supported in delivering commissioning priorities.	• Commissioning decision-making intelligence-based - underpinned by accurate, accessible and appropriate data, information and knowledge • Information used routinely to engage and support practices in commissioning process • Clinical decision-making tools which support agreed pathways and protocols.	• Improvements to quality and comprehensiveness of routine data • Improved access to local , regional and national information, indicators and intelligence • Robust analysis and flexible information usage – performance and quality reporting, score cards, dashboards, benchmarking • Use of risk stratification tool to identify and monitor at risk patients.

Annex F

Description	Expected Outcomes (Activity/Quality)	Changes derived from recognised good practice	Investment Costs Financial	Investment Costs Non - Financial	Net savings	Implementation timeline	Enablers	Barriers to success	Confidence levels of implementation
Out of Hospital Sector									
Care Home Support: To introduce a model of enhanced services to nursing and care homes which will provide training and support to homes to help with longer term care planning for their residents and support during times of crisis. This intervention will support the CCGs achievement of their Outcome Ambition 3 - reducing emergency admissions.	The expected outcomes of this intervention are to avoid unnecessary acute admissions from nursing and care homes; to increase knowledge and continuity of health care for nursing and care home residents; reduced unnecessary non-elective admissions; reduced number of prescriptions; improved co-ordination of crisis management and improved end of life experience for patients through advanced care planning. There will be a reduction in acute hospital activity and associated costs.	Use of a similar model to that developed in Sheffield (Sheffield - Integrated care and supporting care homes, BGS March 2012), supplemented by a model on Cornwall (Improving the Quality of Dementia Care, HSJ October 2012) and Walsall (Nursing Homes in Walsall, Improving care for elderly people, December 2011), as well as some of the initial locally developed work undertaken in Wokingham by Dr Charles Gallagher. Savings are based on the Sheffield model with additional prescribing savings factored in with the additional Community Pharmacist post.	£685,321 (2014/15) £500,538 (2015/16)	Enhanced primary care training and additional pharmacy support. Care homes to release staff to undertake training required. Increased nursing and pharmacist posts in local workforce.	£520,870 (2014/15), £810,272 (2015/16)	It is anticipated that the service agreements will be agreed with Providers by the end of March 2014.	Use of an enhanced service specification for the provision of Care Home outlines the more specialised services to be provided by primary care that practices will be monitored against.	GP Practices may come under too much pressure with their own lists to effectively manage the additional requirements. Furthermore, Berkshire West has 48 care homes (of which 24 have nursing care). This level of provision causes a net influx into the region of dependant elderly residents which has growing resource implications for health and social care. Care homes may not have the capacity or resources to engage with intervention.	This intervention has dedicated project management support and thus there is a high level of confidence of implementation.
Community Heart Failure: To further enhance the heart failure team with additional nursing roles. The intervention will develop and implement enhanced care pathways including palliative	Expected outcomes will result in improved quality of life for patients with heart failure, providing intensive support at home and in the community. There will be a reduced need for	Expansion of this service is based on and in line with guidance from the British Heart Foundation. Inclusion of a community based IV Furosemide service is based on positive outcomes	£185,926	This intervention increases the workforce of the community heart failure team by appointing two full time additional specialist nurses.		Recruitment to the posts will commence to enable service commencement from April 2014. A new service specification will be agreed with the existing provider and included in the 2014/15 contract to meet	This is an expansion of an existing and well-established service with strong links with primary care and secondary services. Strategic	There is always the potential difficulty/delay in recruiting to specialist nursing posts within the agreed timescales.	Local Provider is confident that they will attract the right candidates for the roles and have not experienced issues relating to recruitment to

Description	Expected Outcomes (Activity/Quality)	Changes derived from recognised good practice	Investment Costs Financial	Investment Costs Non - Financial	Net savings	Implementation timeline	Enablers	Barriers to success	Confidence levels of implementation
care and IV furosemide care in the community. To provide more preventative support within the community setting, helping to avoid hospital admissions and reducing some of the burden on secondary care Providers whilst providing a cost-effective model of care for the management of the condition. To continue to reduce the number of home visits and outpatient attendances for those patients receiving telehealth. This intervention will also support the CCGs achievement of their Outcome Ambition 3 - reducing emergency admissions and Outcome Ambition 2 - improvement in the health-related QoL for people with long term conditions.	face-to-face consultations with an improvement in discharge rates from the service. Improved patient outcomes (chiefly improved quality of care, optimised prescribing and titration of heart failure medications and maximised independence). To reduce emergency admissions and support increase medication compliance. Clinical safety and effectiveness of treatment will be ensured because the right people are caring for patients and are able to give each case the appropriate attention.	found in the recent national British Heart Failure pilot that reduced the need for patients to be treated as an acute inpatient. Feedback from patients was unanimously positive as they were able to be treated at home.				national timescale.	enablers such as the NHS Standard Contract will be employed to manage provider performance. Deployment of the telehealth units to manage patients requiring more intensive input.		heart failure specialist nursing roles. This is an expansion of an existing and well-established service with strong links with primary care and secondary services. Confidence levels of implementation are thus moderately high.
Hospital at Home: This model includes providing more intensive support for short periods of time to patients in the community under the care of a consultant led team. Patients will be identified as requiring a higher level of support than	Increased level of intensive support to patients in the home setting to avoid the need for admission to hospital or support earlier discharge during a period of illness. There will be benefits for patients and their relatives who will avoid lengthy and frequent hospital visits and	There is not a lot of detailed evaluation around Hospital at Home schemes. Over the past 5 years there have been various models of Hospital at Home Services/Virtual wards introduced, including Community Nurse Led, GP Led and GP Practice Led. A recent study from	£1,189,568 (2014/15) £2,152,091 (2015/16)	The intervention will establish a dedicated core H@H team. In order that we ensure medical leadership for each patient within the H@H service, a high level of medical input and supervision is required to ensure good governance and patient safety.	£1,438,195 (2014/15), £3,854,226 (2015/16)	Due to significant staffing challenges commencement of the new service is expected in July 2014. The recruitment process is about to start to ensure that we mitigate this risk as much as possible.	There is a commitment across all partner organisations in Berkshire West to a shared vision of integration that will support the implementation of H@H. H@H may act as catalyst in supporting	The main barrier to success will be the ability to recruit the appropriate clinical and nursing staff with the associated competencies.	The full effect of the savings will be realised in 2015/16, with part realisation in 2014/15 (depending on service commencement). Service commencement is likely in July 2014 with half the beds

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is currently provided and will receive a level of care as if they were in a hospital setting. This intervention will support the CCGs achievement of their Outcome Ambition 3 - reducing emergency admissions.	allow them to be more involved in their own care. Patients will be able to recover in familiar surroundings with more consistent and seamless care as patients are stepped down into community and social care support according to their needs. There will be a reduced risk of healthcare acquired infection as a result with reduced pressure on acute hospitals.	the Nuffield Trust (June 2013) analysed Hospital at Home Services (Virtual Wards) based on three areas; Croydon, Devon and Wandsworth, but they had significant length of stays. There has been no significant analysis of H@H schemes and even those that exist in the USA (e.g. VA Centres, Presbyterian Healthcare Services, Mercy health and Cigna Medical Group) are based on different models with different outcomes, but all show a reduction in costs of at least 19%. See: Exploring Best Practices in Home Health Care: A Review of Available Evidence on Select Innovations Home Health Care Management Practice, October 2013, and Improving outcomes and lowering costs by applying advanced models of in-home care, Cleveland Clinic Journal of Medicine, January 2013.		The role could be undertaken by the following staff: General Practitioner, GPwSI, Consultant Geriatrician, Associate Geriatrician and possibly a Specialist Nurse Consultant. This will include a full time role within each H@H locality.			integrated pathway development currently in progress.		planned. After six months the full stock of beds (60) will be brought on line so that the full benefit will be realised from April 2015.

Description	Expected Outcomes (Activity/Quality)	Changes derived from recognised good practice	Investment Costs Financial	Investment Costs Non - Financial	Net savings	Implementation timeline	Enablers	Barriers to success	Confidence levels of implementation
Continence and Falls: This intervention aims to redesign and integrate health teams for falls, continence services, specialist nursing and therapies within the community setting. The intervention will enhance the current falls services and establish a falls and bone health pathway, reducing the likelihood of repeat admissions for falls This would also support the Hospital at Home implementation and current work on-going around redesign of the frail elderly pathway. This intervention will support the CCGs achievement of their Outcome Ambition 3 - reducing emergency admissions and Outcome Ambition 2 - improvement in the health-related QoL for people with long term conditions.	Patients will be managed more seamlessly within the community, avoiding duplication of assessments and provision of more holistic support. Patients will be encouraged to self-manage and obtain the highest quality of life possible. It will reduce the likelihood of admission for a Urinary tract infection which often leads to poor outcomes for patients. The falls pathway will be modified to ensure that any patient with a fall is registered within the surgery and followed up by the GP to minimise the risk of subsequent falls. A pathway to develop an integrated fracture liaison service will be developed.	This is based on a similar redesign undertaken in Rotherham. In the four years since the redesign was introduced, nationally continence prescribing costs increased by 21.56% whereas in Rotherham the costs decreased by 8.99%. Rotherham's expenditure on continence appliances in 2012/13 was £561,200 however if their costs had increased in line with national growth expenditure it would have been £800,791. The recruitment of the Fracture Liaison Nurse will enhance proposals being developed in primary care to monitor patients at risk of falls and to improve integration of care across primary, community and secondary care.	£305,374	There will be an increase in the number of community staff to deliver the service with some changes to existing roles.	£134,706 (2014/15), £308,772 (2015/16)	Recruitment to the posts will commence to enable service commencement for the continence service from April 2014. A new service specification will be agreed with the existing provider and included in the 2014/15 contract to meet national timescale. Care pathway work will be carried out for the falls element of the intervention with an anticipated service start date from September 2014. .	Strategic enablers such as the NHS Standard Contract will be employed to manage provider performance. NICE guidelines, Quality Standards and PBR Best Practice Tariff, all stipulate that people with hip fracture should receive falls and bone health assessment and appropriate preventative therapy. Medicine's Optimisation. There are established community services with good relationships across all stakeholder groups which will ensure the additional community investment and pathway redesign is integrated.	The falls care pathway review may take longer than anticipated.	There is excellent stakeholder engagement and confidence levels of implementation are moderately high. There is an assigned clinical lead for the project who has met with secondary care representatives. A workshop for stakeholders is to be arranged imminently from which a project implementation plan will be developed.

Description	Expected Outcomes (Activity/Quality)	Changes derived from recognised good practice	Investment Costs Financial	Investment Costs Non - Financial	Net savings	Implementation timeline	Enablers	Barriers to success	Confidence levels of implementation
Increase in community reablement and rapid response: The project will increase investment into the community Reablement and Rapid Response service. Capacity will be rapidly flexed across the three localities based on predicting discharge numbers and will have an impact on reducing the numbers of patients medically fit for discharge at the main local acute hospital.	The main expected outcomes of this intervention are a reduction in both the numbers of patients medically fit for discharge and the length of time spent waiting. Target is no more than 20 patients with a maximum length of 5 days.	The report from the Emergency Care Intensive Support Team (Dec-13) references the continued 'bottlenecks' at the back-end of the acute pathway delaying discharge for a significant group of patients at RBH. The report also finds that although there have been positive developments in the scope and capacity of these services that the responsiveness of services remains variable across Berkshire West. ECIST found that the Wokingham and West Berkshire Localities particularly had "insufficient community rehabilitation capacity". This QIPP is aimed at addressing these insufficiencies.	£665,508		£24,597 (2014/15)	There is additional capacity and extended working hours already in place so implementation is well underway.	There is a central hub for all referrals into the service.	There is always the potential difficulty/delay in recruiting to the posts within the agreed timescales.	There is a high level of confidence of implementation.

Description	Expected Outcomes (Activity/Quality)	Changes derived from recognised good practice	Investment Costs Financial	Investment Costs Non - Financial	Net savings	Implementation timeline	Enablers	Barriers to success	Confidence levels of implementation
Pathology: The overall aim of this intervention is referral management. It will identify and audit outlying GP practices, educate and promote existing guidelines to GPs.	The main outcome will be a reduction in inappropriate referrals for pathology services thereby reducing cost to CCGs.	The 2014-15 QIPP focuses on increasing the uptake of the ICE 2 ordering systems a tool to drive clinical effectiveness. The use of IT to influence GP ordering by embedding good practice guidelines/pathways and blocks has been highlighted by the Royal College of Pathologists. There are a small number of identified tests that if ordered in line with guidance can deliver financial savings and be in line with clinical effectiveness. The guidance used to inform the QIPP has been generated by NIC, PHE e.g (Diagnosis of UTI in primary care (HPA, 2011). Additionally, clinical audit and advice from subject matter experts and secondary care consultants have informed this QIPP.		None	£60,000 (2014/15)	The implementation timeline relates to deploying the ICE 2 IT software that will help with demand management. The timeline for this to be fully installed is the end March 2014.	CCGs are sent regular Pathology updates delivered by the pathology team at the local acute trust and the project lead. This supports the practices to make changes in their referrals. Clinical leads have time to attend steering meetings.	The success of this intervention is dependent upon adoption of demand management initiatives within primary care. Some national initiatives such as the health check programme have resulted in increased requesting of some tests.	The success of this initiative is dependent on changing GP ordering behaviour. Last years pathology QIPP did not achieve projected savings. Project manager working closely with CCG clinical leads to reinforce good practice guidance and to embed the use of ICE 2. There is a Moderate level of confidence in successful implementation of this intervention.

Description	Expected Outcomes (Activity/Quality)	Changes derived from recognised good practice	Investment Costs Financial	Investment Costs Non - Financial	Net savings	Implementation timeline	Enablers	Barriers to success	Confidence levels of implementation
Haematology / DAWN: This intervention will implement a service that will ensure a safe and effective method of monitoring patients with chronic long-term haematological conditions.	The expected outcomes will be an improvement in clinical outcomes, reduction in follow-up appointments, and provision of a more cost effective service. It will enable the early detection of patients who have an exacerbation of their condition, allowing patients quick access for specialist review.	This intervention ties in with the commissioning intentions of keeping people well and out of hospital. The Rheumatology DAWN project has been operating successfully for some time and has delivered the target reduction in new to follow-up ratio and the Haematology DAWN is based this methodology.	£89,232	This initiative increases the workforce within haematology by the provision of a specialist nurse to monitor the results and liaise with GP and patients.	£35,000 (2014/15)	The intervention go live date is the end March 2014.	Detailed service specification and liaison between acute trust and project lead. This is a similar initiative to rheumatology DAWN so lessons learned from this project are being applied.	Previous delays have been due to IT issues which are being resolved.	Rheumatology DAWN had been successful at reducing follow ups. This initiative uses similar technology and there is a good confidence level of implementation of this current intervention.
Prescribing Support Dietician: Project aims to reduce inappropriate prescribing of Oral Nutritional Supplements (ONS), gluten free and specialist infant formulas through a prescribing support dietician post auditing and supporting general practices.	All 55 surgeries audited yearly with a view to reducing inappropriate prescribing of ONS. All 55 surgeries audited yearly with a view to reducing inappropriate prescribing of gluten free products. A policy on prescribing of specialist infant formulas will be written and published. An education/launch event is conducted for GP's and Health Visitors for the above guidelines. Support all practices with their service for diabetic individuals Reduction in spend for ONS.	This intervention is In alignment with the NICE Guidelines: • NICE suggests that vast improvements to the treatment of malnutrition will result in high cost savings for the NHS. In alignment with BAPEN Guidelines: • British Association for Parenteral and Enteral Nutrition (BAPEN) estimate savings of £130 million a year if 1% of public expenditure on malnutrition was saved. In alignment with National Prescribing Cost Comparators for quarter one of 2013-14, figures for the Berkshire West CCG's show that the average weighted spend per patient is more than the Thames Valley	£50,000	Increase in the workforce of the Medicines Optimisation team.	£69,113 (2014/15)		Existing intervention structure is already in place. ScriptSwitch is also used to inform prescribers of the latest ONS prescribing guidelines	The intervention relies on engagement of GPs with many actions resting with them.	A pilot has been previously conducted with the practices and this began with ONS prescribing. This intervention will extend to gluten free products and specialist infant formulas. As the infrastructure is already in place, confidence levels of implementation are moderately high.

Description	Expected Outcomes (Activity/Quality)	Changes derived from recognised good practice	Investment Costs Financial	Investment Costs Non - Financial	Net savings	Implementation timeline	Enablers	Barriers to success	Confidence levels of implementation
		locality and for one of the indicators more than national.							
Medicines Optimisation - Prescribing (under development): This intervention aims to realise efficiency savings from optimising the use of medicines	Efficient and optimal prescribing of medicines.	Will be based on the relevant prescribing and NICE guidelines and recommendations.	No additional investment.		£675,000 (2014/15), £650,000 (2015/16)				
End of Life: This intervention aims to enhance the existing service. Better identification of patients at EoL and ensuring they have an Advanced Care Plan in place and sharing of information. An associate programme of work is in place to improve palliative care pathways for terminally ill children.	The main outcomes will be a reduction in acute admissions and will support patient choice and preferences to die at home.	This is based on the national End of Life strategy and has been recognised and communicated across all providers.			£50,000 (2014/15)	The EoL beds admission criteria have been agreed and the intervention will be implemented on April 2014.	A key enabler has been the change in referral criteria to the hospice. Also, further education and uptake of advanced care planning training being is implemented as funding obtained from Health Education England to progress this.	Barriers to success include potential engagement issues with Primary Care and the uptake of training is possible but not anticipated.	The confidence levels of implementation are good as the redefining of admission criteria has already been agreed and has good support from all parties.
Increased access to Talking Therapies	Reduction in prevalence of serious mental health conditions.	Access to Talking Therapies locally is currently is lower than the target 15% of the population. Talking therapies have been shown to be effective both for those with serious mental illness (who recover better than on medication alone)	To be developed						

Description	Expected Outcomes (Activity/Quality)	Changes derived from recognised good practice	Investment Costs Financial	Investment Costs Non - Financial	Net savings	Implementation timeline	Enablers	Barriers to success	Confidence levels of implementation
		and for those with milder forms of mental illness. Treatment will be delivered according to NICE and Royal College of Psychology Guidance.							
Early Labour Assessment Service: The aim of this intervention is to offer an early labour assessment service for low risk mothers to support them to consider alternative options to hospital delivery. It is intended to pilot the service from 2014-16.	Increased uptake of home delivery and midwifery-led units.	Based on comparison with Wales where the home birth rate is 10%. A rate of 23-25% has been sustained over the last year 10 years in Glan-y-Mor.		Pilot will involve development of three geographically based home birth specialist teams. Will require an additional 5 WTE midwives in the community team.		Target to increase home births to 5% by 2015.	The Home Birth Review showed that 50% of women are low risk at the start of labour.	Recruitment of midwives. Changing perceptions around home births.	The confidence levels are high as comparative data from other areas shows there is potential to significantly increase the home birth rate in Berkshire West from 3% currently.
Community Psychological Medicines Service					See Psychiatric Liaison Service under Urgent Care (below)				
Carers Support (under development)					As part of BCF it is intended to further develop support to Carers. This will involve implementation of the recommendations from the recent Carers' Scoping report.				
Urgent care and crisis support for patients with mental health needs or learning disability (under development)					Workstream under development. Current services will be reviewed with a view to developing an improved response to patients identified as being at risk of suicide or self-harm, or with a mental health or challenging behaviour crisis. To include those identified in hospital, the community or through the criminal justice system and to include those requiring an improved place of safety. Links to broader workstream to improve services for patients with a learning disability and to complete review of CAMHS provision, focussing on supporting patients within the community and avoiding out-of-area placements.				
Frail Elderly pathway redesign	The main outcomes will be a reduction in acute admissions, and outpatient activity, and an increase in community activity. It is also anticipated that this will support the achievement of indicators within the BCF as it aligns to the local BCF projects	This will be based on the integrated Frail Elderly pathway currently under development across the Berkshire 10 Partnership. led by the Kings Fund, and Finnamore, in partnership with patients and local commissioner and provider stakeholders	tbc	Pathway will require the development of the local workforce, particularly the role of lead professional, generic workers, and semi-skilled staff. Funding has been secured via HEETV, to undertake a skills analysis, and develop a workforce development plan, and associated training programmes	2015/16 programme under developme nt. Anticipated savings from this and frail elderly at-home support scheme: £3.5m.	To be developed	The development of the workforce, a single health and social care hub, IT interoperability, 7 day working, support for carers, and promoting self-care. The development of Primary Care services and the role of accountable clinicians will also be pivotal	Barriers to success include the engagement of all agencies in the implementation of required changes, and the realisation of associated changes. Changes to current contracts, and organisation sustainability may also be a fact.	The final financial modelling and the pathway model have yet to be formally published and shared with all parties and therefore it is too early to define a level of confidence on achievability, however building on the Hospital at Home, Care Homes, Reablement, and

Description	Expected Outcomes (Activity/Quality)	Changes derived from recognised good practice	Investment Costs Financial	Investment Costs Non - Financial	Net savings	Implementation timeline	Enablers	Barriers to success	Confidence levels of implementation
									Continence & Falls projects underway in 2014/15, a programme of projects to improve care for Frail Elderly patients will be extended from 2015/16 onwards.

Urgent Care System									
Psychiatric Liaison Service: The overall aims of this intervention is to improve health care for people presenting to acute and community physical health services with co-morbid physical and mental health needs. The service will work with patients and physical health providers.	Expected outcomes are improvements in patients' health, skills and knowledge for self- management of their health issues, with reductions in the usage of A&E and inpatient services. Two aspects to the service: [a] 24/7 liaison psychiatry within the Royal Berkshire Hospital and [b] community-based Community Psychological Medicine service to receive referrals of patients identified both through attendance in acute care and from direct GP referrals. This	• Matt Fossey; (Economic Analyst for the RAID study showing £4 savings for every £1 invested in Psychiatric Liaison in QE2 Birmingham, who is now working at the Kings fund) reports that a paper is near publication showing that Birmingham has extended the RAID model to all the city hospitals and similar savings have been made. • Plymouth has demonstrated decreased admissions since Liaison Psychiatry was attached to its	£1,038,159		£143,723 (2014/15 and 2015/16)	Berkshire Healthcare NHS Foundation Trust to develop Implementation plan in January 2014 for agreement by Berkshire West CCGs. Subject to agreement of the implementation plan, recruitment to psychiatry, mental health nurses and health psychology posts to start as soon as possible. Development of Project Board to develop and monitor implementation and development of metrics and informatics requirements.	The key enabler is the participation of mental health trusts, acute hospital trust and CCGs. Agreement on improved informatics and data set to identify patients with co-morbid conditions	The main barriers to success are possible complications of informatics developments and delays in recruitment of key posts, such as liaison psychiatrists.	The confidence level of implementation is high as there is multi-agency agreement on the importance of improving expertise and capacity to address co-morbid presentations.

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	community service mainstreams the experience and developments from the Dept. of Health Medically Unexplained Symptoms Project in Berkshire. The service will address co-morbid conditions of patients with severe and enduring mental illness as well as the larger number of patients with less severe clinical mental illness, or who have mental health issues that do not meet the threshold for definition of a clinical mental illness.	A&E department • The Faculty of Liaison Psychiatry at the Royal College of Psychiatrists has, in 2013, identified five key patient groups who stand to benefit from effective liaison psychiatry in ED, 4 of which are relevant to this Project in Berkshire West [the fifth relates to older people]: - People who self-harm and need medical or surgical treatment as a consequence. - People with the physical and psychological consequences of alcohol and drug misuse. - People with known severe mental illness. - People admitted with primarily physical symptoms which, on assessment, have mainly psychological or social causation.							
Extended primary care provision (under development): The aim of this intervention is to enhance the role of primary care in responding to urgent care needs and supporting integrated service provision outside of core surgery hours. Consideration will be given as to how the model developed as part of the Prime Minister's Challenge Fund bidding process can best be implemented.					Under development. Estimated savings on A&E attendances in 2015/16: £250K.				

Description	Expected Outcomes (Activity/Quality)	Changes derived from recognised good practice	Investment Costs Financial	Investment Costs Non - Financial	Net savings	Implementation timeline	Enablers	Barriers to success	Confidence levels of implementation
Hospital Care									
Integrated Eye Care Services: The overall aim of this intervention is to deliver more effective commissioning of an integrated ophthalmology service, ensuring consistency and reducing clinical variation.	The intervention will result in overall cost savings through a reduced tariff. Patients will benefit from pathway improvements.	Increased choice of providers through plurality in the market place. Definition of an integrated ophthalmology service incorporating all aspects of the service from community eye services through to emergency care.	None		£500,000 (2014/15)	There have been delays to the original implementation timeline. The expectation is that he provider will commence implementation in April 2014.	An intermediate outpatient service to consist of experienced practitioners (middle grades; optometrists; orthoptists; nurses) to undertake pre-operative and other assessments; treatment of non-complex conditions; monitoring chronic conditions; and, follow-ups.	The acute trust has been delayed in implementing because the specialty has had recruitment difficulties in particular temporary sub-consultant grades of medical staff.	Due to the difficulties experienced by the provider, there is currently a moderate confidence level of implementation. However, the trust has committed to a number of mitigating actions which include: The appointment of locum consultants to work at the Prince Charles Eye Unit and at the RBH; additional Saturday morning lists at the RBH and the West Berkshire Community Hospital and additional pre-operative assessments on Saturdays and Sundays.

Musculoskeletal (MSK) services: This intervention expands the focus on pathway improvement for MSK services. It will include an expansion of the current shared decision-making scheme (SDM) in primary care ensuring that SDM applies to all the selected pathways and with all relevant providers. This will incorporate the on-going review and implementation of the MSK pain pathway to develop an integrated pathway and improvement in the pain management service. Part of this work will involve the de-commissioning of the MSK CAS service.	The MSK integrated pathway will address waiting time issues that are currently present, and ensure there is equity between NHS and Independent pathways. Reduction in the number of surgical interventions for hip and knee replacements can be achieved by a combination of the use of Shared Decision Making (SDM) Tools and Threshold policies. There will be associated savings for CCGs related to the reduced activity. Reduced waiting times and a one-stop appointment for back pain.	Review of the evidence base of the impact on patients of the use of patient decision aids.	£50,000	Support to practice staff on using the SDM tool. Robust audit and contract monitoring of all providers carrying out hip and knee procedures.	£1,427,274 (2014/15)	Shared Decision Making (SDM) is already available to primary care practice staff but needs to be re-launched and embedded. This intervention plans to relaunch to practices during February and March 2014 and ensure that it is consistently applied for all NHS and independent sector provider pathways.	Require robust referral management process across primary care together with the use of contractual levers in secondary care (independent and NHS). I.e provider contracts to ensure that payment will be related to compliance with threshold policies.	A likely barrier to success is the potential resistance from primary care. However, this will be overcome by implementing robust audit processes for both NHS and Independent providers.	The confidence level of implementation is good since this will be a two-pronged approach engaging both primary and secondary care, in particular by using contractual levers.
Cancer Care Pathways: This intervention aims to enhance the existing service. The focus is on reducing the number of follow up appointments for newly diagnosed patients.	To provide high quality, efficient, accessible, effective and safe follow up care for cancer patients. This will lead to reduction in hospital based follow up appointments.	The model is based on the NHS Improvement Risk stratified breast cancer pathway.			£50,000 (2014/15)	The work involves scoping the possibility of a risk-stratified prostate cancer pathway and embedding this amended pathway. The lead in time could be 6 months; therefore implementation will be September 2014.	The intervention is dependent upon clinical engagement with the Consultant Urologist (Lead for Prostate), Clinical Nurse Specialist and the Oncology team involved in the pathway.	Barriers to successful implementation may include the failure to engage and agree on the pathway by the clinical team. Patient confidence may be a barrier if clinicians are uncomfortable with new pathway (involves discharge from secondary care).	There is currently a telephone follow up existing for some of the pathway. The number of patients eligible may be fewer than expected - this needs further scoping and investigation. Given this the confidence levels are moderate.

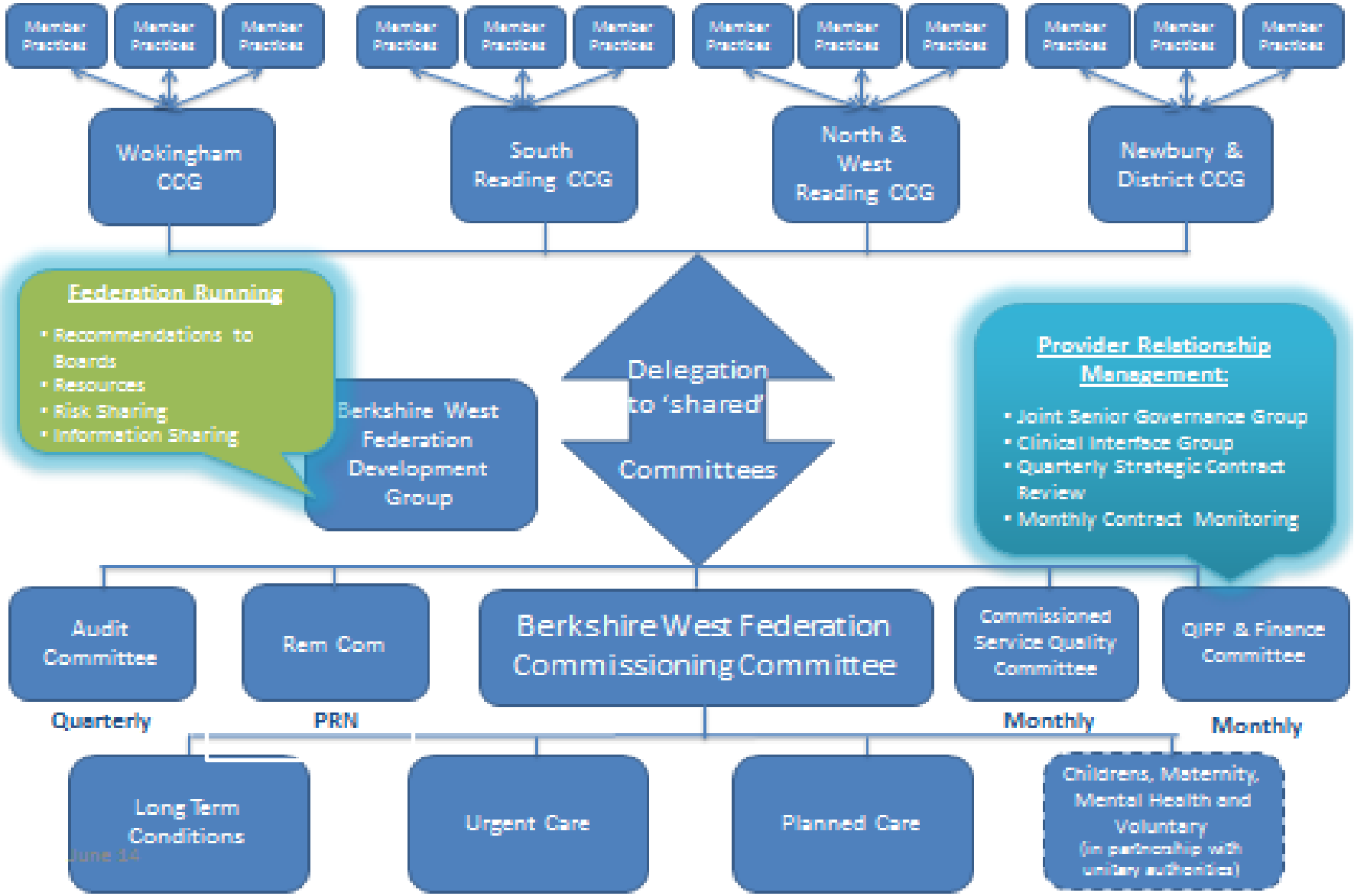
Maternity - Supporting Anxious Mothers and Partners: The aim of this intervention is to better support anxious mothers and their partners by offering support and talking therapies to address concerns around natural deliveries, thereby reducing elective C-section rates.	To reduce elective C-section rates.	Berkshire West is an outlier in terms of the rate of elective C-sections.					Comparative data shows that there is potential to reduce the elective C-section rate.	Cultural factors e.g. high rates of C-sections in Eastern European countries and growing evidence of increased anxiety towards natural delivery.	Confidence is high as the provision of talking therapies offers a new approach to addressing this issue.
Contractual and Pricing Mechanisms (under development): The CCGs will implement relevant technical contracting & pricing levers for contracts in 2014/15. These reflect the strategic intentions of the CCGs around market management, and will be applied and extended where possible in 2015/16.			No additional investment.		£2,000,000 (2014/15), £1,160,000 (2015/16)				

Review and rationalisation of contracts (under development): A review has been carried out of Berkshire West CCG's overall contract portfolio identifying opportunities to generate financial savings through a combination of: • Rationalisation of the existing portfolio into fewer consolidated contracts. • Re-procurement where this is felt to potentially generate savings. • Non-renewal of contracts where duplication or lack of coherence is identified.	Realisation of efficiencies over the next two years.		No additional investment. Potential savings have been identified.		£250,000 (2014/15), £250,000 (2015/16)		Contractual levers and review.		
Procedures of Low Clinical Value and Threshold Dependent Conditions (under development): CCGs will strengthen compliance at local Trusts with resultant savings with the appropriate application of protocols over Procedures of Low Clinical Value (PLCV) and Threshold Dependent Conditions (TDC).			No additional investment		£100,000 (2015/16) - Estimate				

Reducing length of stay and excess bed days (under development): This intervention aims to improve timely discharges for patient supported by advanced Clinical case-review tools such as MCAP and MEDWORXX. These provide evidence-based indications on the clinically appropriate level of care that a patient requires, and more accurate pathway management to out-of hospital care.	Improved compliance of local Trusts		Investment costs of deploying tools are being explored.		£350,000 (2015/16) - Estimate				
Extension of shared decision-making into other (non-MSK) conditions (under development)	2015/16 programme under development. Anticipated savings £250K.								

Annex G

Berkshire West CCGs Governance Structure (1)



June 14