NHS
North and West Reading
Clinical Commissioning Group

Operational Plan 2014/16

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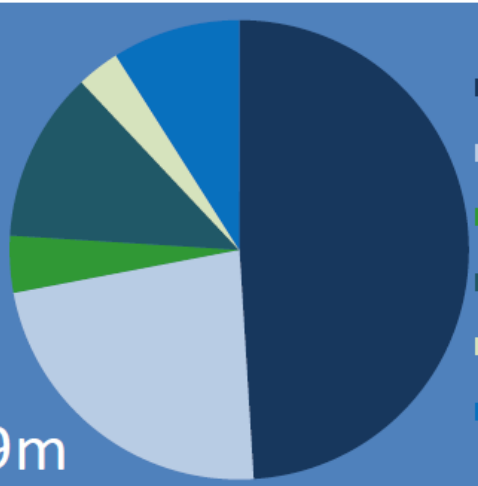
Our CCG at a glance:

10

We are made up of 10 GP practices

£109m

We have a budget of 109m in 2014/15



10 – 29

Our population has below average numbers of people aged 10 – 29…

30 – 54

… but above average numbers of people aged 30-54

Our population has relatively little deprivation

49%

Spent on acute hospital services

Our population has more in common with Newbury and the West of Berkshire than Reading as a whole

107,000

We serve a population of about 107,000 people in North & West Reading

Foreword from the Chair, Dr Rod Smith

This 2 Year Operational Plan describes what the CCG will be doing during the next 2 years to ensure that our patients have access to high quality health services that will help ensure better outcomes for them and generations to come.

The CCG has been in operation since the 1st April 2013, leading the commissioning of healthcare services for our local population. Over the last decade, the role of commissioning, as a key driver of quality, efficiency, and outcomes for patients, has become increasingly important to the health system in England. In its simplest form commissioning is the process of planning, agreeing and monitoring services. It is not one action but many ranging from the health needs assessment of a population, through the clinically based design of patient pathways, to service specification and contract negotiation or procurement, with continuous quality assessment.

The plan will be delivered in partnership with our patients, our 3 CCGs partners in the Berkshire West Federation, the Royal Berkshire NHS Foundation Trust, Berkshire Healthcare Foundation Trust, South Central Ambulance Trust, Reading Local Authority and West Berkshire Local Authority. We hope this will assure our local community that all parts of the health and social care system are working together to provide the best possible high quality services for our patients.

There are a number of pressures facing the CCG. We have a financial challenge and demand for services is predicted to rise, with a recent analysis suggesting that the "do nothing" scenario could result in a potential £10.7m cost pressure to the CCG by 2018/19. As national benchmarks show that our local health and social care economy is already a productive system it is clear that there will not be enough money to meet this additional demand unless services are provided in a different way.

We are committed to making sure that public, patient and carer voices are at the centre of our healthcare services from planning to delivery. As NHS Commissioners we have a duty to support better patient and public engagement. We will continue to ensure that patients and carers are able to participate in planning, managing and making decisions about their care and treatment through the services we commission. We will also ensure the effective participation of our public in the commissioning process itself so that services reflect the needs of our local population.

In the autumn we carried out a very successful "Call to Action" engagement campaign to enable as many of our local population to understand the financial challenges ahead and to help shape our views on the future of our local health services. Some of the key messages from this were that local people want care to be more co-ordinated, and that organisations should work more effectively together to support people to remain in their own homes for as long as possible, with care plans empowering patients and carers to work alongside professionals to improve their health.

There is also a growing recognition of the influence of lifestyle factors on ill-health and the need to improve levels of prevention, self-care and education for our population. This will help to contain demand as services work to meet the needs of an increasingly elderly population. People also thought that we needed to value more the vital contribution that the Voluntary Sector the can make.

This plan reflects these views and also describes a new relationship whereby patients and carers play an instrumental role in shaping the services available to them and as a partner in the services they receive. This 2 year operational plan should be read in conjunction with the 5 year strategic plan for the 4 CCGs in Berkshire West. This is available at www.nwreadingccg.nhs.uk

Overview of 2013/2014 and key achievements from the Chair of the Council of Practices, Dr George Boulos

The CCG is a clinically led organisation made up of the clinicians from our 10 member GP practices. This group of practices has come together to commission the majority of NHS Services for people who live in our local community. We work with other healthcare professionals and in partnership with local communities and Local Authorities to do this.

We have a strong and interactive Council of Member Practices with a voting representative from each practice. Council members elect our Board representatives. A list of our Council of Practices and a map of our CCG area can be found at Appendices 3-4.

The CCG has practices within two Local Authority boundaries, three in West Berkshire and seven in Reading. Good working relationships have been established with both Local Authorities. Patient flows for healthcare services are common and primarily focused around the Royal Berkshire NHS Foundation Trust for acute care and Berkshire Healthcare Foundation Trust for mental health and community services.

During 2013/14 our clinicians have embraced their new role as clinical commissioners with the support of their staff and have demonstrated their absolute commitment to deliver improvements to services, better outcomes for patients and to make cost effective use of health resources. The following are some examples of some of our key achievements in 13/14:

North & West Reading CCG Key Achievements in 2013/14

Bowel Cancer Screening has increased from 55.5% to 61.9%. This means an additional 457 patients have been screened.
Improved the care of patients with diabetes in partnership with our patients. The numbers of patients receiving all 9 care processes has increased from 962 in 2012/13 to 1900 as of December 2013. These important markers ensure diabetes is well controlled and are designed to prevent long term complications. The nine key tests are: weight, blood pressure, smoking status, HbA1c, urinary albumin, serum creatinine, cholesterol, eye examinations and foot examinations.
CCG Board visits to all 10 practices to help all clinicians and staff in the 10 Practices feel properly engaged in the commissioning process and understand the key role they each have in supporting the CCG meet its commissioning objectives.
Successfully engaged with our Practice Patient Group Representatives via our monthly Patient Voice Group meetings, a fundamental part of a patient centred NHS.
Held a very successful “Call to Action” event in November 2013, the outputs of which are informing this plan and our 5 year strategy.
Achieved savings of £458K against an unscheduled care QIPP target of £397K at M8
Further developed our relationships with our Health and Social Care partners, Health watch and the Voluntary Sector.

The CCG works in a federated arrangement with the 3 other CCGs in the Berkshire West area, South Reading CCG, Wokingham CCG and Newbury & District CCG to support each other with key pieces of work and to help improve health outcomes across a wider health economy. Berkshire West wide achievements in 13/14 are as follows:

Hospital Care

- Initiated a comprehensive programme of multi-provider engagement spanning NHS and Independent providers
- Enhanced patient choice through a greater range of providers for Ophthalmology services
- Ensured that spend on Pathology is closely monitored, with modifications to Pathology requesting software in Primary Care to better manage the effectiveness of costs

Urgent Care System

- Successful implementation of NHS 111.
- Introduction of new Urgent Care dashboard being used by all partners across the health and social care system to inform capacity and demand planning and interventions on a daily basis.
- Redesign of the clinical decision unit at the Royal Berkshire Foundation Trust to improve patient experience and ensure rapid access to expert assessment and care
- Expanded Rapid Response and Reablement Service

Out of Hospital Care

- Recruitment of specialist diabetic nurses and community diabetologist to run 'one stop shop' clinics and increased patient engagement through care planning and technology.
- Introduction of a COPD Exacerbation Assessment Service
- Implemented a COPD Discharge Care Bundle
- Tele-monitoring of patients with heart failure using an automated telephone messaging service
- Introduction of risk profiling and multidisciplinary meetings to help support patients at high risk of an admission
- Increased pulmonary rehabilitation provision
- Reading Integration Steering Group bringing together Health and Social Care Partners
- Identification of the following joint health and social care initiatives for use of the "Better Care Fund".
    - Hospital at home Service
    - GP support to Nursing and Care Homes
    - Health and Social Care Systems Interoperability
    - Time to Think Beds
    - 7 day integrated Health and Social Care Neighbourhood Teams
- Decreased waiting times for IAPT to 95% access within 28 days
- Improved and extended access to Personality Disorder , ADHD ASD services
- Improved urgent care/crisis response service for people with Mental Health and social problems

We are looking forward to building on these successes and hope that this plan for the next 2 years once again demonstrates how placing clinicians at the heart of NHS commissioning means we can work with our partners and communities to lead, shape and make real improvements in local health care and wellbeing.

Further information on the CCG is available on our website at: NHS North and West Reading Clinical Commissioning Group Website

1. How we developed our 2 year Operating Plan

In developing the Plan the CCG has taken into account the following:

- The delivery of clinical outcomes set out within the NHS Outcomes Framework
- Current performance against the NHS Constitution and action to improve this where required
- The local health needs of the population
- The feedback we have received from patients
- The programmes of work undertaken by Strategic Clinical Networks (SCNs) and the Academic Health Science Network (AHSN)

2.1 The National Framework

The plan shows what we will be doing to help deliver better outcomes for our patients against the five domains and seven outcome measures of the national NHS Outcomes Framework, as well as improving health, reducing health inequalities and parity of esteem.

The five domains or themes which set out the national outcomes the NHS should be aiming to achieve are as follows:

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

The seven outcome ambitions are:

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

Appendix 1 shows how the initiatives and programmes described in this plan link to the NHS England outcome ambitions listed above.

2.2 NHS Constitution Pledge

The CCG will continue to promote the NHS Constitution and ensure that local providers adhere to all NHS constitution measures and access standards to provide patients with care in a timely manner in the most appropriate setting.

There are some areas where performance has been below expected and mandated levels during 2013/14 and improvement trajectories have been set for each of these areas to ensure performance is recovered and sustained. (Further details available through the following link: **(NHS Rights and Pledges).**

The main areas where improvement trajectories have been required are as follows:

Diagnostic Waits: Diagnostic wait times have not always been achieved within the 6 week timescale during 2013/14 at RBFT. This has been mainly due to Radiology capacity. The Trust is undergoing the building work required to replace existing scanning equipment which has resulted in reduced capacity within the department. Temporary mobile units are on site to increase the capacity within the department and to ensure improvement during Quarter Two of 2014/15.

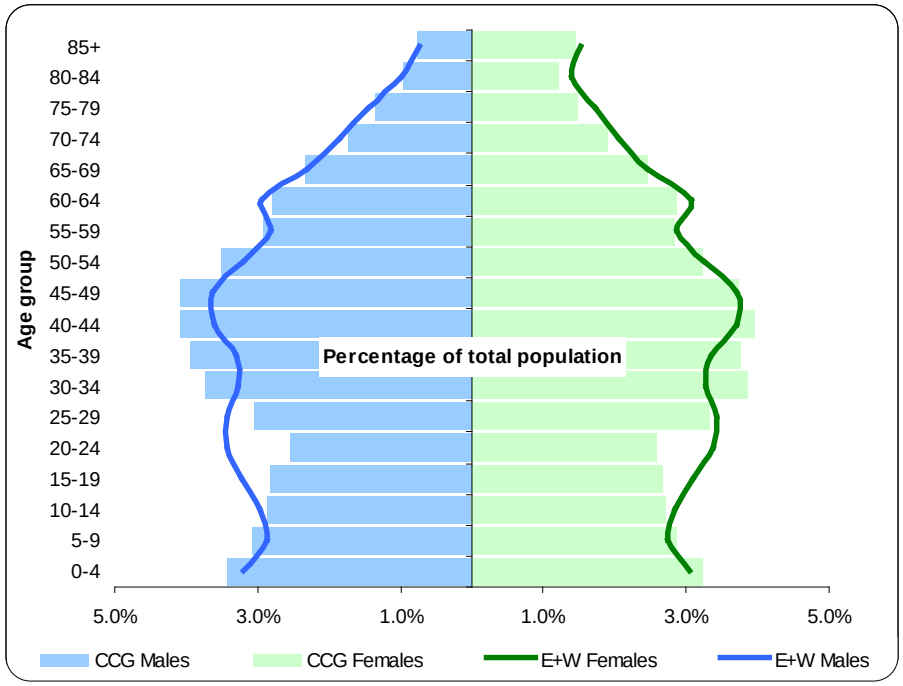
A&E Waits: Despite a continued focus at strategic and operational level across the health economy, the Berkshire West system has not met the A&E 95% standard for much of the year. The Berkshire West CCGs have made significant investment in the emergency and urgent care pathway in order to improve performance. These investments have been targeted to deliver additional capacity, extend availability of services (hours of operation and days of the week) and deliver improvements to the pathway. All actions are overseen by the Urgent Care Programme Board and a new Operational Group has been established to drive improvement and address issues along the pathway. A trajectory is in place to ensure performance improves during 2014/15. Our Quality Scorecard, received at both our Quality Committee and Governing Body, details performance at all Trusts who provide A&E services for our patients and is regularly monitored for assurance.

Referral to Treatment Time (RTT): Ophthalmology Referral to Treatment waiting times have been longer than the 18 week requirement as set out in the NHS Constitution. An action plan is in place to clear the backlog of patients waiting and recover performance during April 2014.

Ambulance Handovers: South Central Ambulance Service (SCAS) work with RBFT and other acute providers to agree an annual handover plan which all parties sign up to. There have been a number of ambulance handover delays during 2013/2014 at RBFT. This plan covers the process and management of handovers between both parties in order to reduce any delays and ensure continuity of care for patients. In addition, SCAS have introduced a double verification process in 2013/14 which has vastly reduced the data challenges received on ambulance handovers and will continue to be the process in the coming years.

2.3 Our Population – An analysis of Health Needs in North & West Reading

The CCG's resident population is estimated to be 99,350 and the registered population is 107,093. The figures below show the registered population profile of North and West Reading CCG compared with the national profile (2012).



Age Group	Male	Female	People
0-4	3682	3443	7125
5-9	3290	3077	6367
10-14	3063	2895	5958
15-19	3029	2849	5878
20-24	2722	2786	5508
25-29	3275	3560	6835
30-34	3983	4123	8106
35-39	4224	4031	8255
40-44	4363	4227	8590
45-49	4363	3983	8346
50-54	3741	3444	7185
55-59	3126	3034	6160
60-64	2988	3067	6055
65-69	2507	2630	5137
70-74	1845	2033	3878
75-79	1441	1578	3019
80-84	1037	1302	2339
85+	816	1536	2352
Total	**53,495**	**53,598**	**107,093**

The CCG spans two Local Authority areas, Reading and West Berkshire and the specific characteristics and health needs for our population are outlined in the "Public Health Locality Profile" (2013), produced as part of the Joint Strategic Needs Assessments for West Berkshire Council and Reading Borough Council. This shows the following:

Population

- The CCG's resident population is estimated to be 99,350 (Census 2011) and the registered population is 107,093, this will result in a rise in older people in future, at a greater rate than the national average.
- 9.7% of the CCG's resident population have identified themselves as carers which is slightly higher than the Berkshire CCG percentage.

- There is also a variation in the CCG population with regards to health and social needs due to wider determinants of health such as educational attainment, employment status, types of housing, income, and the local environment.
- The population profile differs from the national picture with a smaller proportion of younger people (aged 10 to29) and a larger proportion of people aged 30-54
- The most deprived areas within the CCG boundary are in parts of Caversham, Southcote and Kentwood wards (Reading Borough Council). These are all in the 20% most deprived neighbourhoods in the country

Health Behaviour

- When asked to comment on their level of health in the Census 2011 and whether this affected their day-to-day activities, more people in the CCG boundary felt that they had a good or very good level of health compared with the national response.
- Obesity levels are higher than the Berkshire CCG area of 8.9% and is a specific area of focus for the CCG. Obesity increases the risk of heart disease, diabetes, stroke, depression, bone disease and joint problems and decreases life expectancy by up to nine year
- Obesity: 8,067 people aged 16 and over are listed on the GP Practice Registers (9.3% of the population). The highest prevalence for obesity is in an area of the Calcot ward (West Berkshire Council).
- Obesity: 8.1% of children aged 4-5 and 15.3% of children aged 10-11 are obese.
- Binge drinking: 23% of people who live in an area of the Theale Ward (West Berkshire Council) are defined as binge drinkers
- Healthy eating: Neighbourhoods in the Southcote ward (Reading Borough Council) has the lowest proportion of healthy eaters in the CCG at 24.5%

Health

- There were 21,092 emergency admissions into hospital over the three year period (2006-2008).
- The prevalence of cardiovascular diseases, cancer and respiratory diseases is higher in the CCG than it is in the Berkshire CCG region. However prevalence of Diabetes is lower.

Health Protection

- The CCG met the national screening targets for breast cancer, cervical cancer and bowel cancer
- The CCG met the 95% coverage target for childhood immunisations for 1 and 2 year olds in 2012/2013. The CCG just missed the target for 5-year olds MMR immunisations, but was the highest performing CCG in Berkshire for this vaccine.
- The CCG met the 75% coverage target for seasonal flu immunisations for people aged over 65 and over.

Patient Satisfaction

- The CCG performed well in the last GP Survey, compared with Berkshire and the national scores. The CCG's patients rated the overall experience of their out-of-hours services highly and also stated that it was easy to contact them. A comparatively large proportion also said that they would recommend their GP Surgery who moved into the area.

2.4 Key messages for the CCG from the Public Health Locality Profile and other National Benchmarking data

Our CCG is performing highly in many clinical outcome indicators. However the Public Health Locality profile 2013, the CCG Outcomes Tool, Atlases and JSNA highlight the following key areas facing the CCG where performance could be improved compared to national or similar CCG data.

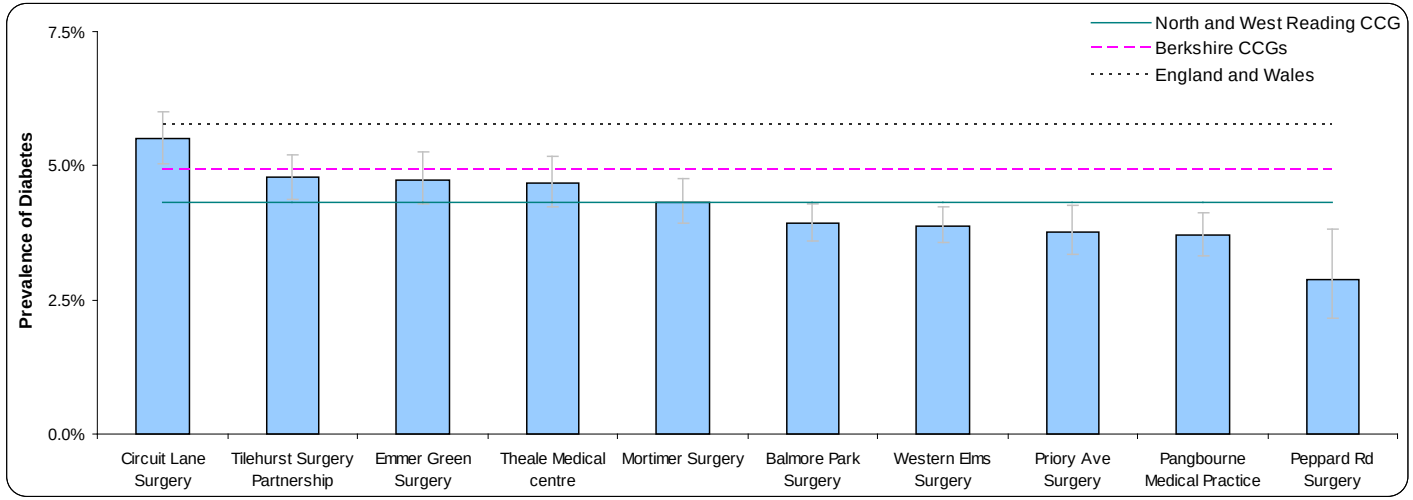
1. Diabetes

Diabetes is a key priority for the CCG. It is a long term disease with significant morbidity and mortality. People with diabetes are more likely to have a myocardial infection, stroke or a heart admission related to heart failure than the general population. It is also estimated that nearly 1 in 5 cases still remain undiagnosed. The table below taken from the Quality and Outcomes Framework for 2011/12 shows the prevalence of Diabetes in the CCG area.

Number of people on Diabetes Register (17+):	3,682
Prevalence in CCG area:	4.3%
Comparison of prevalence:	⇩ than the Berkshire CCG rate of 4.9%
	⇩ than the national rate of 5.8%

Figures from the Diabetes Community Health Profile suggest that there are an additional 5,888 adults with undiagnosed diabetes living in the North & West Reading CCG area.

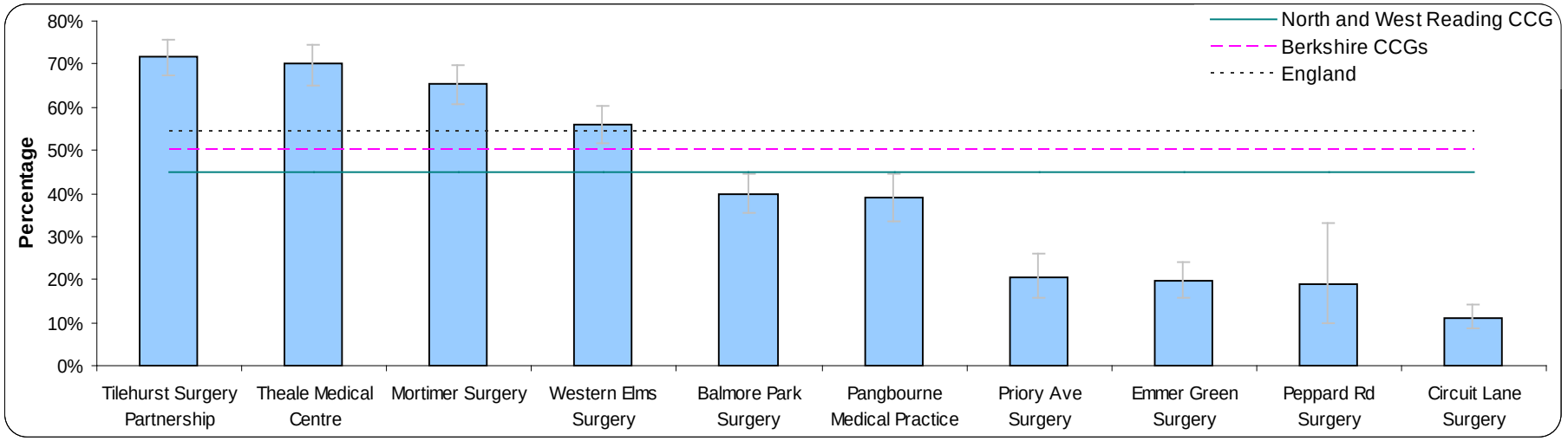
The Prevalence of Diabetes at a GP Practice level (Health & Social Care Information Centre, Quality Outcomes Framework 2011/12) can be seen below:



During 2009/11 there were 211 emergency admissions for diabetes in the CCG area. This admission rate was higher than the Berkshire average.

The National Diabetes Audit (NDA) is a national clinical audit, which measures the effectiveness of diabetes healthcare against the National Health and Clinical Excellence (NICE) Clinical Guidelines and Quality Standards. The Audit identifies whether people with diabetes are receiving the nine key processes identified by NICE. These include five risk factors (BMI, blood pressure, smoking, glucose levels and cholesterol) and four tests for early complications (digital eye photography, urine micro albumin: creatinine ratio, serum creatinine and foot examination). The graph below shows:

The Percentage of people registered with diabetes who received the 9 key processes of diabetes care (National Diabetes Audit 2010/11)



CCG Response

We have made significant investment in diabetes care and have increased the numbers of patients receiving all 9 key care processes from 25.4% in 12/13 to 48% at Dec 13. We expect that the March 2014 figure will show an increase to 55 %. We have appointed a community diabetologist who, with specialist diabetic nurses will run virtual and “one stop shop” clinics within the community to educate patients on how self-manage their care. The virtual clinics enable the community diabetologist to discuss up to 25 patients with our Primary Care teams, providing a valuable education resource for GPs and practice diabetic nurses which will increase the quality of care in primary care where most diabetics are actually treated. A specialist diabetes website with information for patients with be further developed and effective care planning, ECLIPSE and HCP education will be used to improve health related quality of life for patients with diabetes. Diabetics and those at high risk will also be encouraged to increase their exercise thorough the Live Active programme.

There is a national NHS Health Checks Screening Programme to assess the risk of CVD in people over the age of 40, this includes screening for diabetes. The Local Authorities are responsible for managing this programme and have commissioned local GP practices to provide this screening for our local population.

There is emerging evidence from the 2012/13 NDA that diabetes care is improving in the CCG but we need to improve further and continue to identify diabetics not yet diagnosed. We plan to increase the percentage of patients receiving all 9 care processes to 60% during the next 2 years.

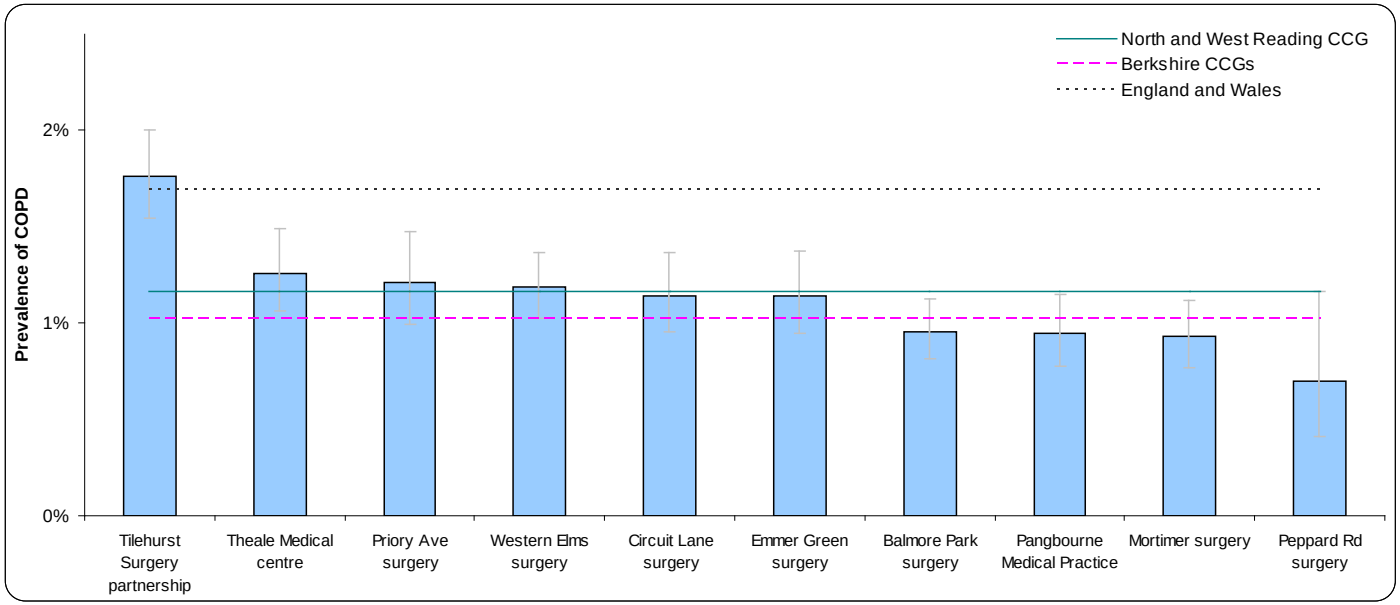
2. Respiratory Disease (COPD)

Chronic Obstructive Pulmonary Disease (COPD) is one of the most common respiratory diseases in the UK and is the second most common cause of emergency admissions to hospital. During 2009-2011, there were 2,799 emergency admissions for respiratory disease in the CCG area, accounting for 14% of all emergency admissions over that time.

The Quality and Outcomes Framework for 2011/12 shows the following for the CCG:

Number of people on COPD Register:	1,244	
Prevalence in CCG area:	1.16%	
Comparison of prevalence:		⇧ than the Berkshire CCG rate of 1.03%
		⇩ than the national rate of 1.69%

Prevalence of COPD at a GP Practice level (Health & Social Care Information Centre, Quality Outcomes Framework 2011/12)



CCG Response

A COPD Exacerbation Assessment service was introduced in 1012/13 which enables rapid outpatient assessment of a patient, avoiding admission.

Telemonitoring continues to be expanded using an automated telephone messaging service. In addition the CCG has invested in increased Pulmonary Rehabilitation provision. This has included a redesign of patient pathways to provide quicker access to necessary medication when needed. Our patients with COPD are given medication to take immediately if they get an exacerbation of the condition. We also plan to continue to improve the training and guidelines locally available to health professionals ensuring every patient has access to spiromtery testing.

We will continue to work with our practices to screen patients at risk of COPD particularly smokers and are also looking to find new ways in which we can improve the diagnosis of this condition to help better support patients. As part of the prescribing incentive scheme our practices are required to review all COPD patients to ensure that they have a severity score for their condition recorded in the last 18 months. The GP clinical management software, ECLIPSE will be expanded to

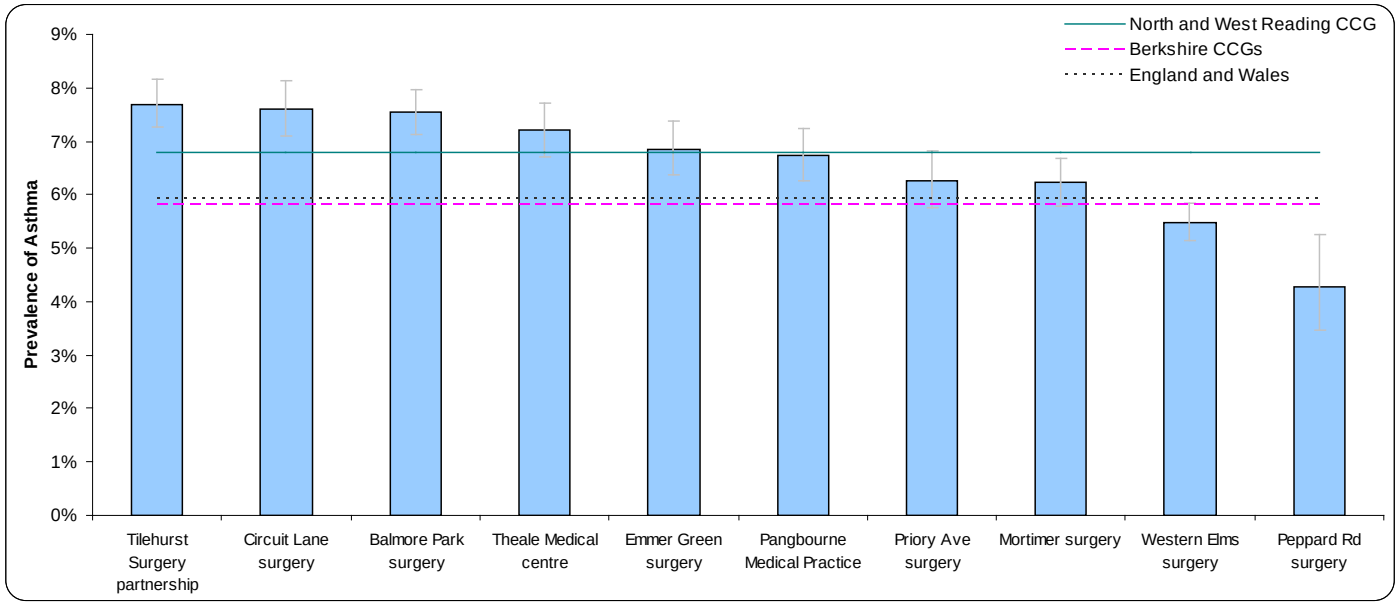
include COPD to promote greater patient involvement in their care. A new social media platform, Puffell will be launched. This will allow self-management of health and wellbeing as well as the opportunity for patients to talk to others with similar health conditions informally and create communities to support self-management of care.

With the support of the Public Health Teams in the Local Authorities we will continue to encourage and support our population to stop smoking and hence reduce the likelihood of them developing COPD.

Asthma

Number of people on Asthma Register:	7,262	
Prevalence in CCG area:	6.8%	
Comparison of prevalence:		⇧ than the Berkshire CCG rate of 5.8% ⇧ than the national rate of 5.9%

Prevalence of Asthma at a GP Practice level (Health & Social Care Information Centre, Quality Outcomes Framework 2011/12)



CCG Response

Our medicines management team has supported improvements in GP prescribing and this is now a key part of the prescribing incentive scheme. We will continue to work with our practices to improve the management of patients with asthma. The practices will also review all asthmatic patients on combination inhalers to identify patients who require a review of the current treatment.

3. Mental Health

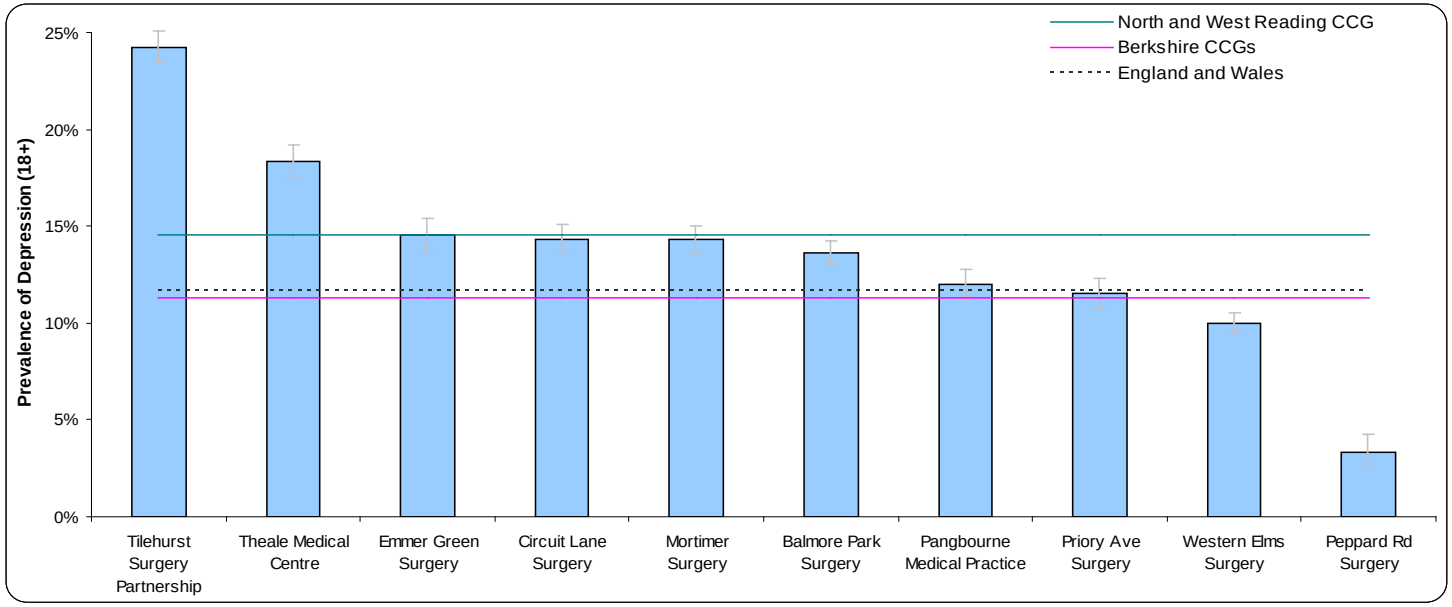
Mental illness is the single largest cause of disability in the UK. At least one in four people will experience a mental health problem at some point in their life and one in six adults have a mental health problem at any one time. Approximately 1% of the UK population has a severe mental health problem and many will have begun to suffer from this in their teens or early twenties.

Depression

The Quality and Outcomes Framework for 2011/12 shows the following:

Number of people on Depression Register (aged 18+):	12,243	
Prevalence in CCG area:	14.5%	
Comparison of prevalence:		⇧ than the Berkshire CCG rate of 11.3%
		⇧ than the national rate of 11.7%

Prevalence of Depression in population aged 18 and over at a GP Practice level (Health & Social Care Information Centre, Quality Outcomes Framework 2011/12)



CCG Response

We aim to give mental health parity of esteem with physical health, commissioning high quality evidence-based services which reflect the national mental health strategy and other key guidance. A 24/7 psychiatric liaison service will be established at Royal Berkshire Hospital and a community based psychological medicine service. These initiatives will ensure that services are able to respond appropriately to both physical and mental health needs, recognising the inter-relationships between these. Through use of the voluntary sector, we will introduce social prescribing where patients, specifically with minor mental health conditions are signposted to services in their community to improve quality of life.

We will also improve appropriate access to and the quality of, Child and Adolescent Mental Health Services, through the review of the access criteria and improve access to our Talking Therapies service. Exercise is an evidence based treatment for depression and other Mental Health conditions and Mental Health patients will be encouraged to join Live Active. We will provide training for our GPs to support a consistent message about exercise to particular groups of patients as well

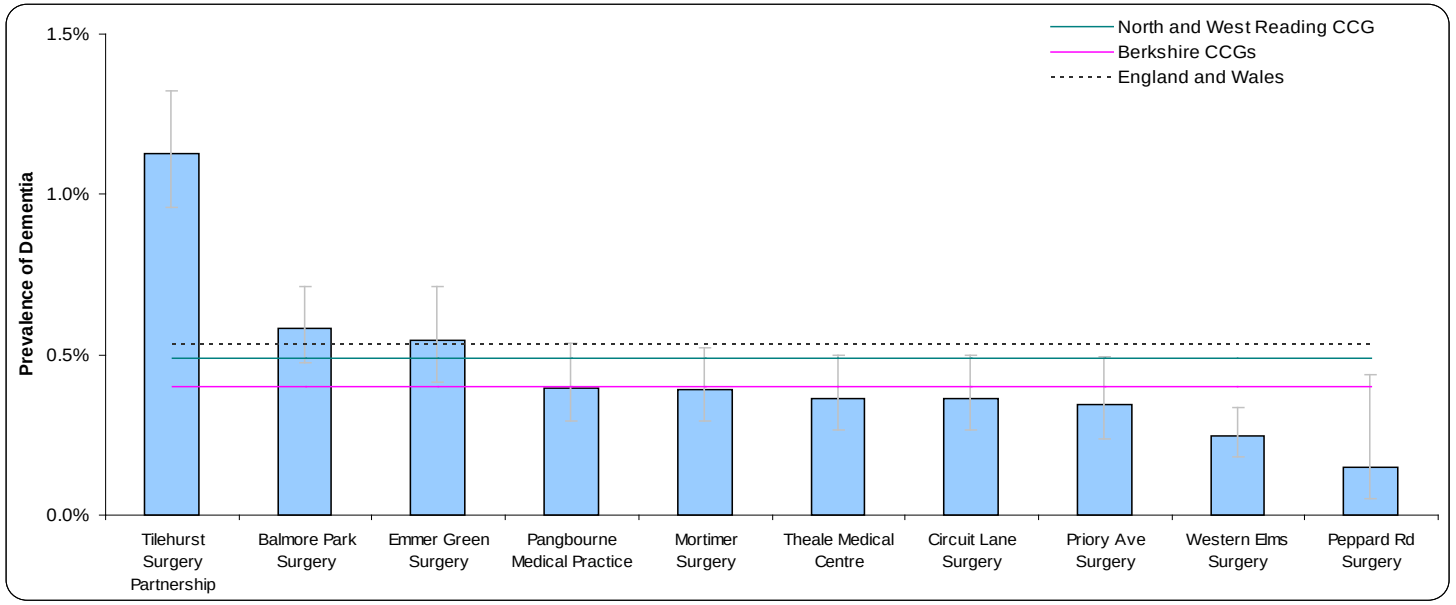
as the population as a whole. Our GPs will encourage physical activity in all sectors of the population but particularly those with depression or anxiety whose condition would benefit from this intervention. E.g. ½ hour walk 5 days a week.

Dementia

According to the Alzheimer's Society, there are around 800,000 people in the UK with dementia. One in three people over 65 will develop dementia and two-thirds of people with dementia are women. The number of people with dementia is increasing because people are living longer. It is estimated that by 2021, the number of people with dementia in the UK will have increased to around 1 million.

Number of people on Dementia Register:	522
Prevalence in CCG area:	0.49%
Comparison of prevalence:	⇧ than the Berkshire CCG rate of 0.40%
	⇩ than the national rate of 0.53%

Prevalence of Dementia at a GP practice level (Health & Social Care Information Centre, Quality Outcomes Framework 2011/12)



CCG Response

National figures indicate that the expected number of people with dementia in our population is 1100 and we that 550 have been diagnosed. We aim to increase the number diagnosed to 737 by March 2016. We note the variation in numbers diagnosed per practice (which partly reflects the age profile of the Practices) and we are encouraging our practices to screen high risk sectors of the population including those over 75, those with diabetes, heart conditions etc., for dementia and refer to the memory clinics where appropriate.

4. Cardiovascular Disease (CVD)

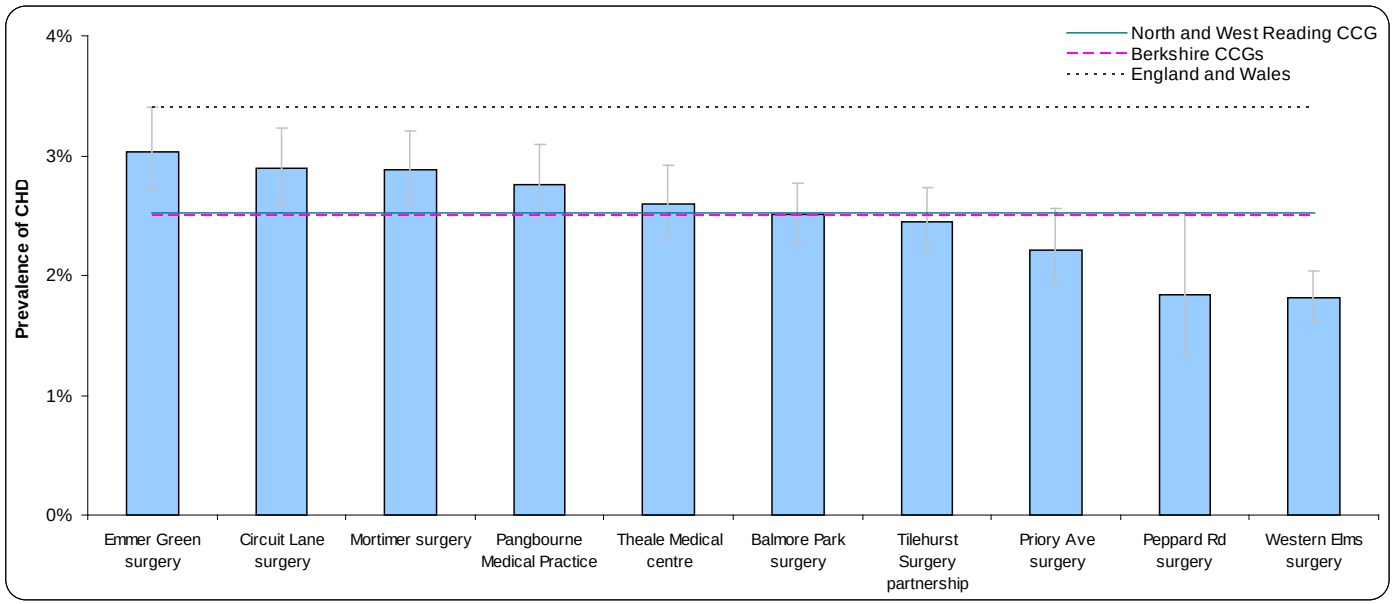
Cardiovascular disease (CVD) is the second largest cause of death in England, accounting for 29% of all deaths in 2011. Around 46% of all deaths from CVD are from coronary heart disease (CHD) and almost a fifth from stroke (18%). Most deaths caused by cardiovascular disease are premature and could easily be prevented by making lifestyle changes, such as eating a healthy diet and stopping smoking. With an ageing population and the current levels of obesity and diabetes in the population, preventative work is essential in reducing mortality and morbidity and narrowing inequalities.

The Quality and Outcomes Framework for 2011/12 shows the following.

Number of people on Coronary Heart Disease Register:	2,698
Prevalence in CCG area:	2.5%
Comparison of prevalence:	⇔ than the Berkshire CCG rate of 2.5% ⇩ than the national rate of 3.4%

Coronary Heart Disease Prevalence

Prevalence of CHD at a GP Practice level (Health & Social Care Information Centre, Quality Outcomes Framework 2011/12)



CCG Response

There is a national NHS Health Checks Screening Programme to assess the risk of CVD in people over the age of 40. The Local Authorities are responsible for managing this programme and have commissioned local GP practices to provide this screening for our local population. Patients with mental health problems are at high risk of developing heart disease and we encourage our practices to screen these patients and other high risk groups in particular

Further areas where performance could be improved and the CCG response to these

Area	Response
Obesity levels are higher than the Berkshire CCG area of 8.9% and are a specific area of focus for the CCG.	Our 2 year plan identifies what we will be doing to increase the exercise levels of our population.
Incidence of healthcare-associated infection – C.Difficile - 42.02 compared to national average of 27.88	Our 2 year plan identifies this as a priority area where we will aim to reduce the incidence of healthcare related infections from C.difficile in both Hospital and the Community
Incidence of healthcare related infection – MRSA - 2.80 compared to national average of 1.– in 5th quintile nationally at 24.9% [Atlas of Variation]	Our 2 year plan identifies this as a priority area where we will aim to reduce the incidence of healthcare related infections from MRSA in both Hospital and the Community
Cancer – Receiving first definitive treatment within the national 62 day standard from GP referral, 85.2% compared with national of 87.1%	We will work to ensure that the Royal Berkshire Hospital meets national target standard
Cancer - Successful smoking quitters at 4-weeks, 3.6 % compared with national of 4.6%	We will continue to support the Local Authority who commission smoking cessation services for our population.
Continue to achieve national targets on screening and immunisation programmes e.g. bowel cancer, cervical cancer, breast cancer screening and flu and influenza immunisations	Our 2 year plan confirms that we will continue to work with NHS England on key primary care quality targets
Musculoskeletal - Spend on all secondary care admissions 45.5 compared to national of39.0 Musculoskeletal - Spend on elective and day care admissions 41.8 compared to national of 35.4	Our 2 year plan confirms what we will be doing to reduce the higher than average intervention rates for Musculoskeletal conditions. The details of this can be found 3.5 Key Improvement Interventions: 2014/2016
Only 19.9 % of people in Reading die at home, 70% would like to	Our 2 year plan confirms the improved support we will be giving to people near the end of their life

2.5 Working together with Reading & West Berkshire Local authorities and our Patients and the Public to set common goals and priorities

Working together with Reading and West Berkshire Local Authorities

The CCG has worked with our two Partner Local Authorities to set common goals and priorities aligned to their individual Health & Wellbeing strategies.

The Reading Health and Wellbeing strategy vision is: ***A healthier Reading – Communities and agencies working together to make the most efficient use of available resources to improve life expectancy, reduce health inequalities and improve health and wellbeing across the life course.*** **Underpinning this vision are the following four goals:**

- Goal 1 – Promote and protect the health of all communities particularly those disadvantaged
- Goal 2 – Increase the focus on early years and the whole family to help reduce health inequalities
- Goal 3 – Reduce the impact of long term conditions with approaches focused on specific groups
- Goal 4 – Promote health-enabling behaviours & lifestyle tailored to the differing needs of communities

The West Berkshire Health and Wellbeing Strategy outline the following five priorities to deliver its vision ***"To Add Life to Years and Years to Life":***

- Addressing childhood obesity in primary school children
- Giving every child and young person the best start in life
- Supporting those over 40 years old to address lifestyle choices detrimental to health
- Supporting a vibrant district
- Promoting independence and supporting older people to manage their long term conditions

Appendix 2 shows the alignment of our plans with the two Health and Well Being strategies referred to above.

Working together with our Patients and the Public

The CCG is committed to ensuring that public, patient and carer voices are at the center of our healthcare services from planning to delivery. As commissioners, we need to be proactive and innovative in listening to those who use and care about our services.

During our first year we have developed a number of ways of engaging with our patients and the public and plan to improve and develop this as we move forward. Please see section 4, on enabling delivery of our plan. We have a very active and engaged "Patient Voice Group" which meets with CCG representatives monthly. This is made up of Chairs of the CCG Practice's Patient Voice Groups and Healthwatch.

The focus of the meetings alternates between "business" and "presentations" on key areas of the CCG work. The latter provide a valuable opportunity for patient engagement with and input to key aspects of local health care provision. For example we have had presentations from the Chair of one of our Patient Groups on "Making a Change" from her perspective, the introduction of NHS 111, the Francis Report, Management of COPD in the CCG, the "Beat the Street" initiative which

is a key priority for the CCG this year, a Youth Counselling Service, an advocacy service and the Berkshire Carers Service. We also had a clinically led session on our first 6 months achievements as a CCG. .

One of the things that our "Patient Voice" Group told us was that they felt the local community in Caversham missed not having a local Health Visitor for the Elderly, a service that had been available in the past. In response to this we are piloting a Community Nurse for the Elderly in North & West Reading to act as a dedicated support for older people identified as vulnerable who do not require social care packages, medical or nursing interventions.

In late 2013 we started to roll out a sustained programme of engagement with the public under the banner of the NHS 'Call to Action' campaign which will continue during 2014. This has a focus on engaging with the widest possible audience of patients, carers, staff and other stakeholders and asking for their views on the future of the NHS. We held the first very successful "Call to Action" event in November 2013 which enabled us to engage with as wide an audience as possible to support and understand the financial challenges ahead at a local level and to share views on the future of local health services. This in turn has helped shape this two year Operational Plan and our five year Strategic Plan.

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

What people want from their NHS

- People want and value an NHS that is free at the point of use, trustworthy, reliable and providing a consistent level of care with equal treatment for all
- A desire to limit the amount of private sector involvement in delivery of healthcare
- Recognition of the vital contribution the voluntary sector makes to health care and planning
- Healthcare professionals should all have the same access to the same information (preferably using the same IT system)
- Complex care to be better coordinated.
- Greater levels of integration across health and social care providers
- Better integration of health and social care to reduce unnecessary admissions e.g. to care homes, and appropriate involvement of carers and patients in care planning meetings
- High quality and reliable services
- Patients to be in control of their care
- Right care, right place, right time with the most appropriate healthcare professional
- More focus on community services, particularly for those with long term conditions and for the elderly.
- Some areas of Reading are very diverse so there should not be a "one size fits all" model
- Better management of public expectation of services and better education of patients about what their care costs

How Should the NHS Spend its Money?

- Greater focus on keeping people well and preventing ill health
- More advice on the benefits of physical exercise and more health promotion and education. People wanted to see GPs offering access to exercise and information on the benefits of exercise as a routine alternative. It was felt that people should be encouraged to help themselves more with GPs used as a funnel for public health information and as a route for improving people's level of physical exercise
- One person asked 'How are the local commissioners going to move their budgets from 'late treatments' to 'early intervention'?'
- Improved levels of preventative care, incorporating more self-care and education for patients
- Complete transparency over the extent of the financial challenge ahead and a requirement for the public to be educated as to the real cost of the service being provided
- Effective links between health and education with messages in schools including the importance of mental wellbeing as well as healthy eating and physical activity

Areas of Concern:

- Lack of a seven-day service
- Adequate checks and balances in relation to private sector involvement in the NHS
- Access to GPs and continuity of care
- The NHS needs to learn from its mistakes
- Liked the idea of outreach by Consultants but wanted to know that this would not be too expensive in practice. The need for earlier diagnosis of dementia, especially in younger people, was identified
- Concern about the drop in children's physical activity levels.

Patients were asked whether they felt our draft plans captured the key challenges for the next two years and their responses were as follows:

<table>
<tr>
<td>Plans for Frail/Elderly People:

• Services need to focus on supportive neighborhoods, Consultant services delivered in the community, better information sharing and integrated working
• More focus and investment in community services and more community nurses
• More care at home
• Idea of " Hospital at Home" welcomed with caution
• Better integration of health and social care to reduce unnecessary hospital admissions from Care Homes
• Involvement of patients and carers in care planning meetings
• Elderly people need access to alternatives to A&E, to be able to access GPs over the phone and to be able to access services in a timely way before the issue becomes an emergency.</td>
<td>Plans for Children:

• Need early intervention with families and a focus on early care
• Need to target families of children not having immunisations
• A view that children's mental health problems and self-harm seemed to be increasing
• More support for (particularly young) parents to help their children, more use of health visitors, perhaps for longer periods (as in New Zealand)
• Opportunities for health promotion and promotion of healthy eating for families in more deprived localities
• More education about the dangers of too much fat and sugar with this education starting in the kinder garden
• Voluntary sector support for families</td>
<td>Plans for Mental Health:

• Greater involvement of the whole family so that families understand the condition and do not exacerbate it further
• The interface between the NHS and voluntary sector needs to be reviewed as this sector could help break down the stigma of mental illness in certain community groups
• Particular focus is needed on transition issues through Child and Adolescent Mental Health Services to adult services and on the provision of inpatient mental health services for the under 18s.
• Opportunities to address the mental health problems of those committing crime while they were in prison
• Mental Health and Alzheimer's to have a more explicit focus in future plans</td>
</tr>
<tr>
<td>Plans for Respiratory Health:

• Could Reading do something to aim to be a "low smoking town"
• Recognition of the fact that people in lower social-economic groups may find it more difficult to give up smoking and drinking
• What impact does very hard water and traffic have on respiratory health in the area
• Patients with respiratory problems could be helped more to help themselves
• GPs needed to have more time than they do currently in order to have a sufficiently good quality interaction with the patient</td>
<td>Plans for End of Life Care:

• The concept of a good death is very important.
• A " good death" means good care contact is most important
• Face to face
• 70% of people in Reading want to die at home but only 19.9% do
• Need to remove the social taboos around discussing death
• Plans should reflect that home is a better place to die but that appropriate support is necessary to enable this to happen
• The importance of services like 'night sitting and day sitting'</td>
<td>Plans for Diabetes:

• Need to see more evidence of health screening, preventative healthcare and education in future plans
• Better, more consistent communication of health messages from GP surgeries with the same communication methods being used by all.

Plans for GP Services

• More efficient GP services with more flexible appointment systems, less use of locums and more access to own named GP
• Improved access to GP services would reduce attendance at A&E
• More access to minor injuries units
• Increased use of technology with integrated health records, online ordering of prescriptions and reviewing of test results, extension of electronic prescribing and repeat dispensing
• More sign posting of services
• GPs needed to have more time than they do currently in order to have a sufficiently good quality interaction with the patient</td>
</tr>
</table>

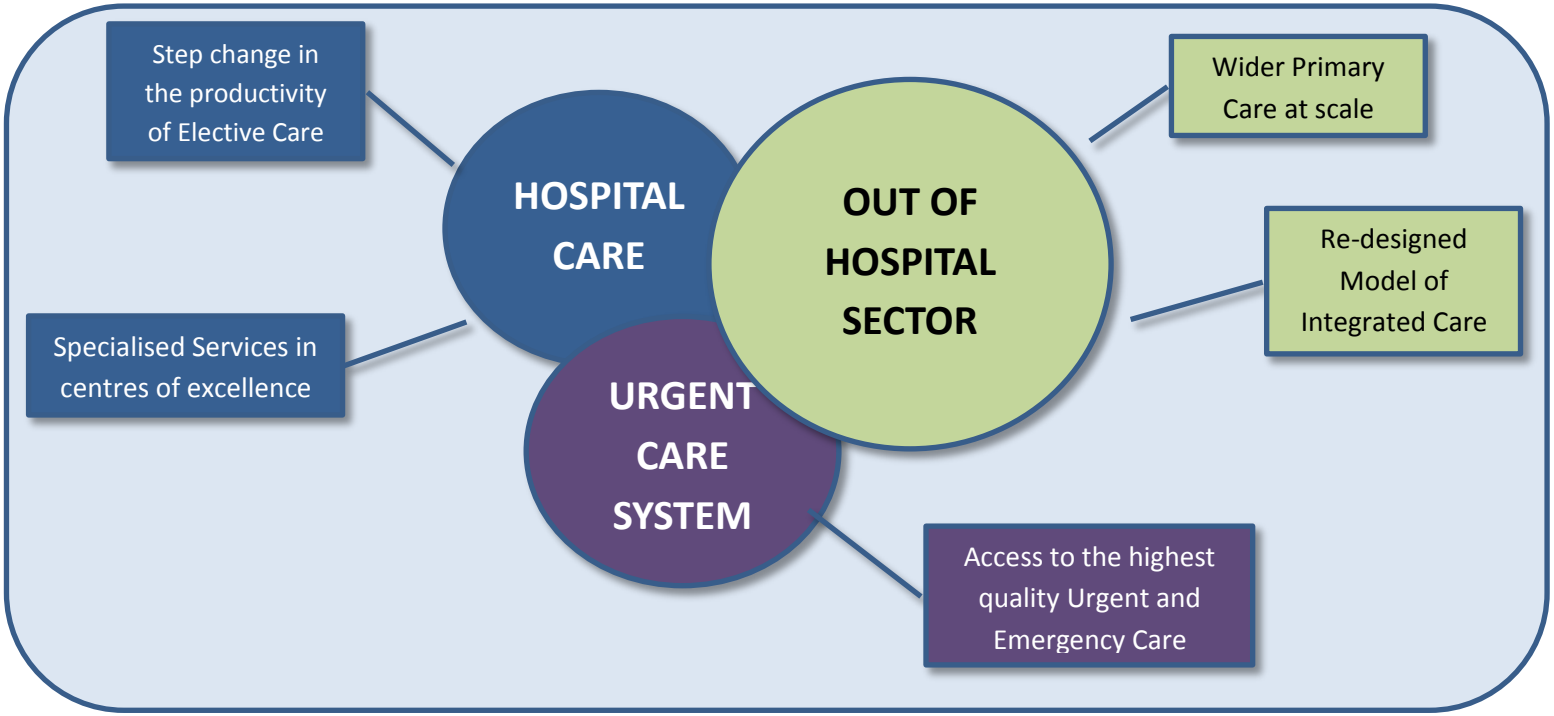
2. Our Five Year Strategic Vision

North & West Reading CCG has worked with three other CCGs in Berkshire West to develop a 5 year Strategy for the Berkshire West Health and Social Care economy.

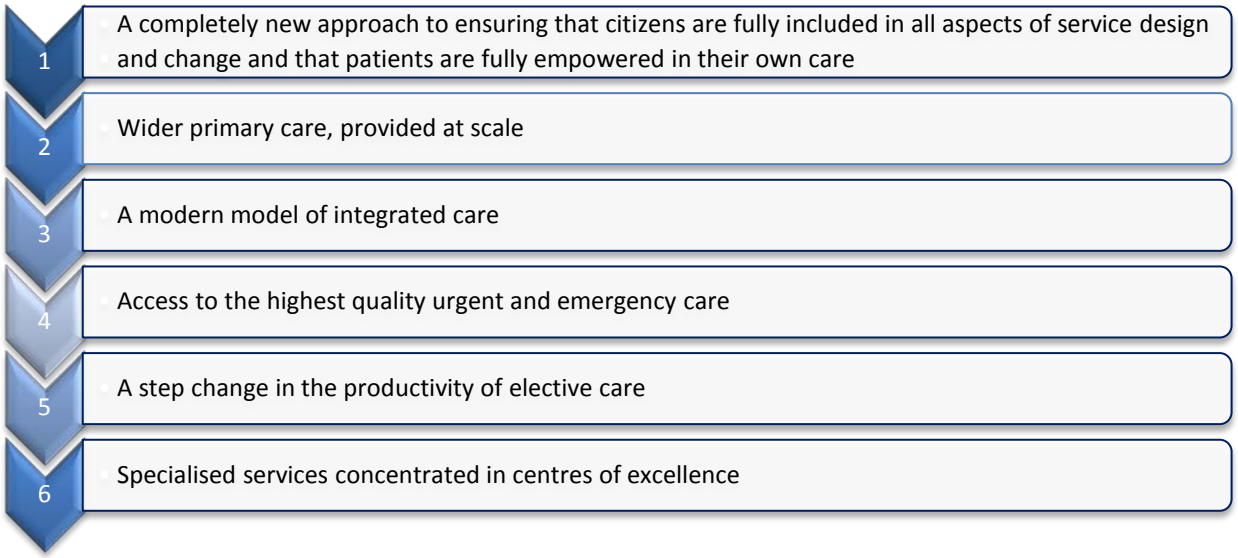
By 2019, enhanced primary, community and social care services in Berkshire West will work together to prevent ill-health and support patients with much more complex needs at home and in the community. Service users will be supported to take more responsibility for their health and wellbeing and to make decisions about their own care. Patients will only be admitted into acute hospitals when they require services that cannot be delivered elsewhere and will be treated in centres with the right facilities and expertise.

All the services that respond to people with an urgent need for care will operate together as a single system. This will ensure that the service people receive is commensurate with their clinical need. People with urgent but not life-threatening conditions will receive responsive and effective care outside hospital. People with serious and life-threatening conditions will be treated in centres that maximise their chances of survival and a good recovery.

This is best illustrated by thinking about our strategy in relation to Hospital Care, the Out of Hospital Sector and the Urgent Care System and our 5 and 2 years plans are aligned to these 3 key areas.



NHS England has identified that any high quality, sustainable health and care system will have the following six characteristics.



Our plans for a completely new approach to public and patient engagement are described on page 47.

Our plans to develop the other 5 characteristics locally in relation the three sectors, Out of Hospital, Hospital & Urgent Care are as follows:

3.1 Out of Hospital

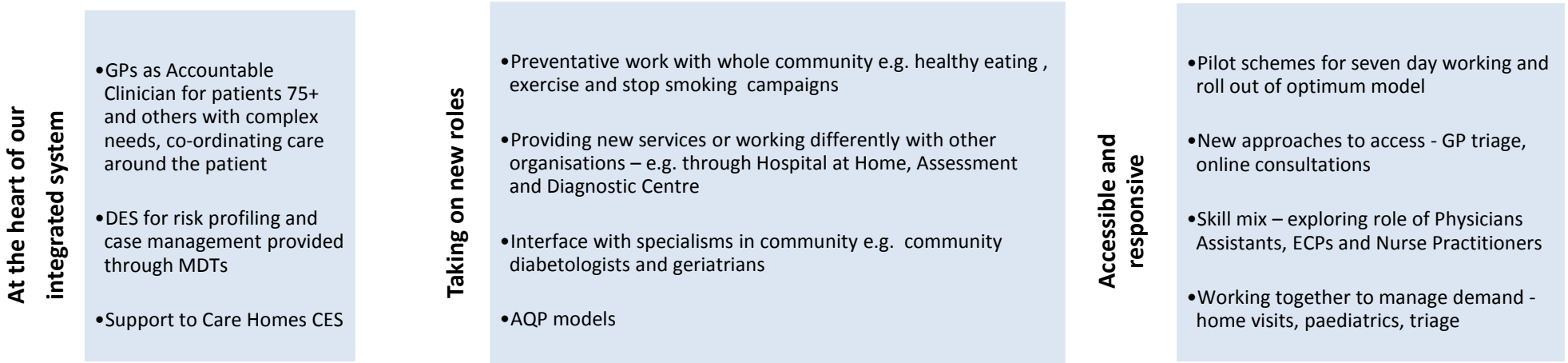
Wider Primary Care Provided at Scale: We believe that primary care will play a key role in delivering the CCG vision and the CCG will look to facilitate this through co-commissioning arrangements with NHS England. Having successfully implemented practice-based risk stratification and multi-agency care planning for high risk patients, our GPs are well placed to take on the role of accountable clinician for patients who may be at risk of admission, co-ordinating care provided by a range of professionals and ensuring this enables patients to remain at home.

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

Practices in North and West Reading face high levels of demand, particularly for urgent care, and many have chosen to explore different ways of responding to this, for example by implementing full GP triage or working to identify efficiencies through the Productive General Practice programme. We now recognise that primary care needs to take a systematic approach to responding requests for urgent appointments, functioning as a key component of a multi-tiered urgent care system which ensures that patients have timely access to the right service provided in the most appropriate setting. As such we are exploring the potential to expand the availability of primary care beyond current core hours, mirroring the overall shift towards seven-day services across the NHS. We are also looking to

support practices to test out new ways of working and potential changes to skill-mix which may better equip them to cope with demand and take on new roles within the integrated system that we are looking to develop.

The diagram below sets out the key change programmes currently associated with primary care in Berkshire West. In order to provide new models of care, it is anticipated that general practice will need to be organised differently, and it is likely that larger organisations or federations of practices will emerge as a result. Practices may also start to co-operate in new ways with other provider organisations and the CCGs will look to use innovative methods of contracting to support the development of these new service models.



Modern Model of Integration across Health and Social Care (Better Care Fund): Meetings with our patients and the public has confirmed our view that integrated care delivers the best outcomes for our patients and service users. We believe that working in partnership is the most effective way for us to ensure that we are providing person–centred, personalised and coordinated care in the most appropriate setting. By working together we can ensure that funding is used flexibly across organisational boundaries to radically reduce the number of assessments and transactions and improve service user experience. The requirement to establish a pooled Better Care Fund budget has given us the opportunity to progress this work further at pace. Our Health and Wellbeing Boards have agreed a plan for the use of this fund which reflects what needs to be done to deliver integrated services focusing on early prevention, detection, assessment and support in the community. Services that we plan to integrate between 2014 - 2016 are:

Reading	West Berkshire
Hospital @ Home	Hospital @ Home
Intermediate care Integration	Integration of Intermediate Care/Reablement Services
Frail Elderly Pathway – Time to Think beds – Assessment beds/ 24 hour support (Willows)	Frail Elderly Pathway
Joint access to the Health and Social care Hub	Joint access to the Health and Social care Hub
7 day Services	7 day Services
Support to carers	Support to carers
Enhanced Care and Nursing Home support	Case Coordination model

We will also co-ordinate the commissioning of children's health and social care across the whole spectrum of children's needs and work with Berkshire Healthcare Foundation Trust and our 2 Local Authorities to improve outcomes and quality of life for people with mental health problems and learning disabilities.

3.2 Urgent Care

The recently published Sir Bruce Keogh Report on "Transforming Urgent and Emergency Care Services in England" sets out the following vision for the NHS:

- We must provide highly responsive, effective and personalised services outside of hospital for those people with urgent but non-life threatening services outside of hospital. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families

- We should ensure that people with more serious or life threatening emergency needs are treated in centres with the very best expertise and facilities in order to reduce risk and maximise their chances of survival and a good recovery

It also confirms that if we can get the first part right then we will relieve pressure on our hospital based emergency services, which will allow us to focus on delivering the second part of the vision.

The Report sets out a proposal for the future of urgent and emergency care services in England which has the following 5 key elements, all of which must be taken forward to ensure success:

1. Better Support for People with self-care
2. Help for people with urgent care needs to get the right advice in the right place, first time
3. Highly responsive urgent care services outside of hospital so people do not choose to queue in A&E
4. Ensuring that people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery
5. Connecting all urgent and emergency care services together so that the overall system becomes more than the sum of its parts

The CCG welcomes the vision and proposals set out in this report. The Urgent Care Programme Board will continue to provide clear strategic oversight and drive to tackle the key challenges to the local emergency care system and to ensure that we have a resilient system able to meet the national 4 hour A&E target. It will ensure that:

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

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

3.3 Hospital Care

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

Benchmarking against NHS England's Commissioning for Value 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 the patient and GP are clear that the benefits clearly outweigh the risks. There is also scope to improve performance on the first to follow-up outpatient ratio.

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

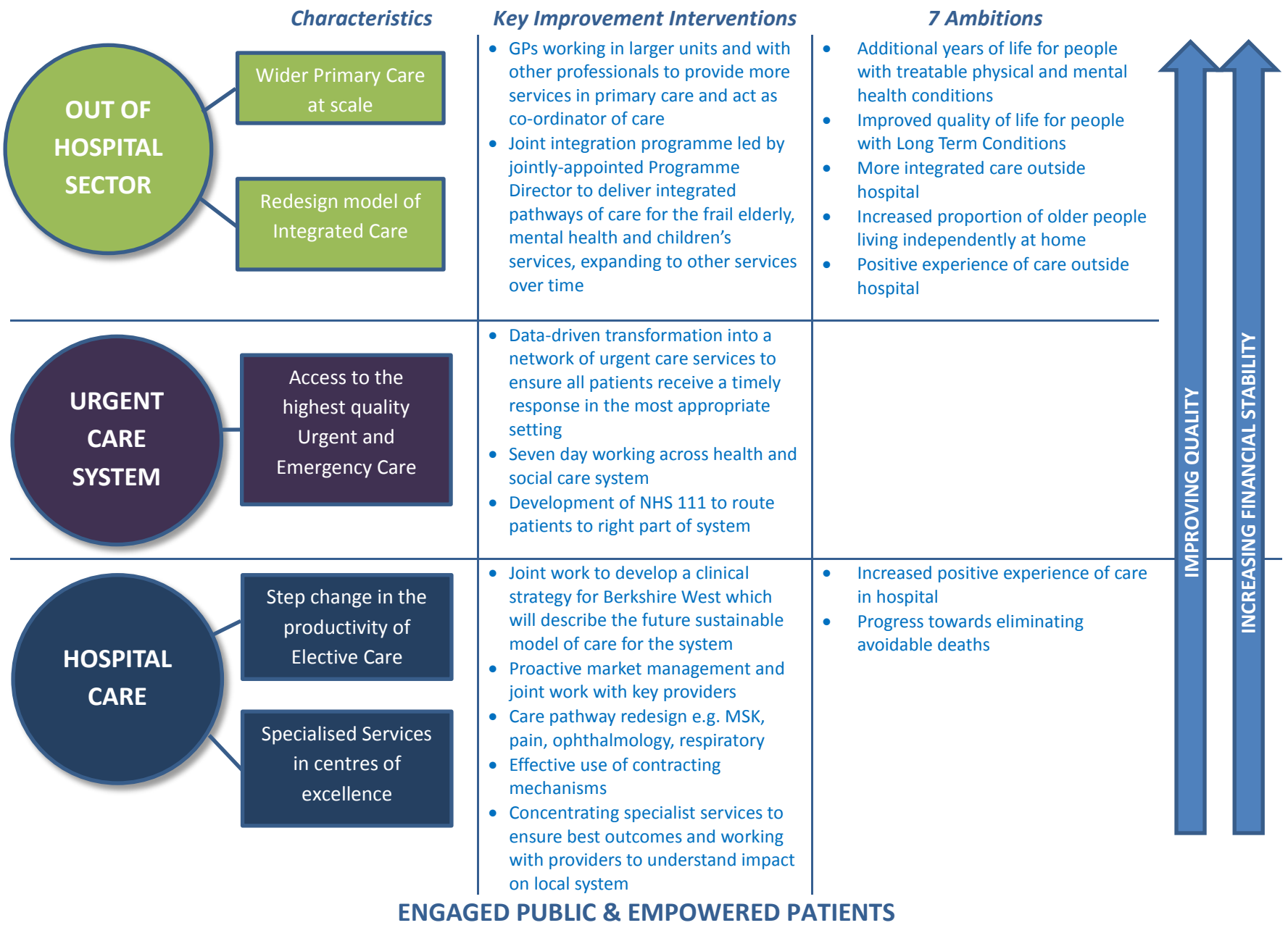
The CCGs are planning to undertake an externally supported clinical services review with Royal Berkshire Foundation Trust (RBFT) and Berkshire Health Care Foundation Trust to determine the best service models to improve patient outcomes and achieve financial sustainability. This in turn will inform the optimal organisational configuration for the health and social care economy.

Specialised services concentrated in centres of excellence:

The CCGs will work closely with NHS England to ensure that patients requiring specialist care can be referred to centres whose caseloads mean they are best placed to deliver optimum outcomes for patients. It is recognised that this is likely to have an impact on the RBFT which currently continues to provide services that are acknowledged as specialist by definition but not by volume. Further work will be undertaken with RBFT to better understand and plan for the potential implications for the Trust.

Delivery of our plan will mean moving to new models of care, developed in partnership with our patients, and new approaches to contracting and paying for health services. Health and social care services will need to be organised so that they can work optimally together to deliver the best outcomes and experiences for patients and best value for the tax payer. It is recognised that this may require reconfiguration of existing organisations within this five year timescale.

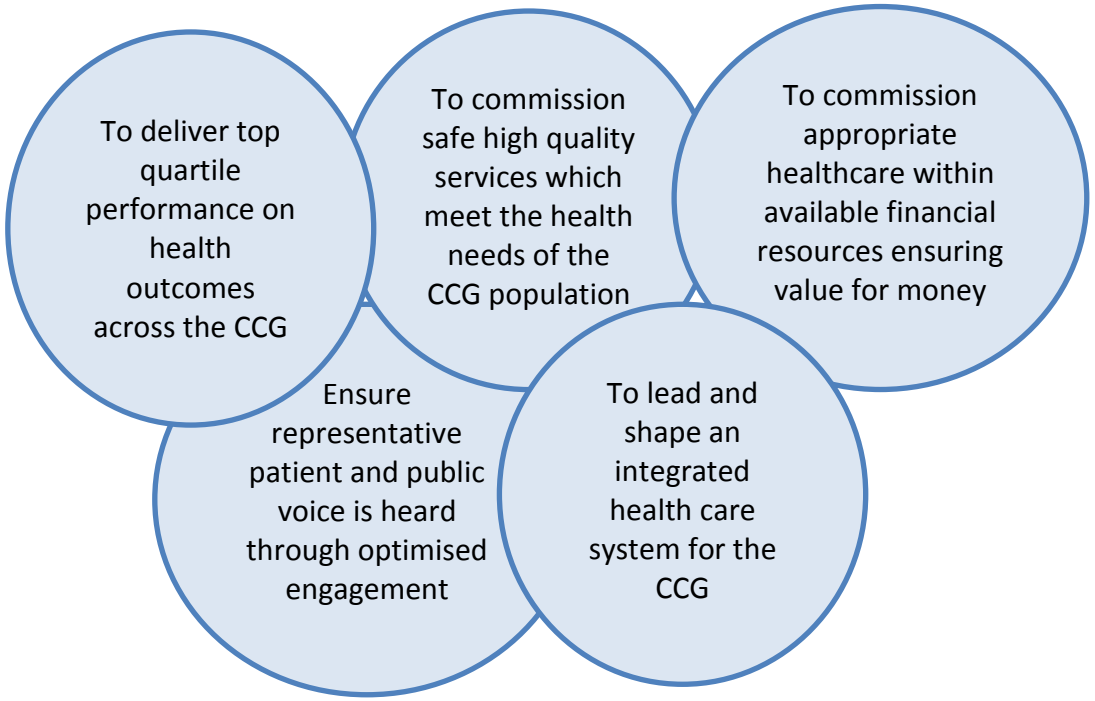
3.4 The CCG 5 Year Strategic Plan on a Page



3.5 The CCG 2 Year Vision and Objectives

The CCG vision 2014/2016: ***"Supporting our population to improve and optimise their own personal health by encouraging self-care and commissioning high quality integrated health care"***

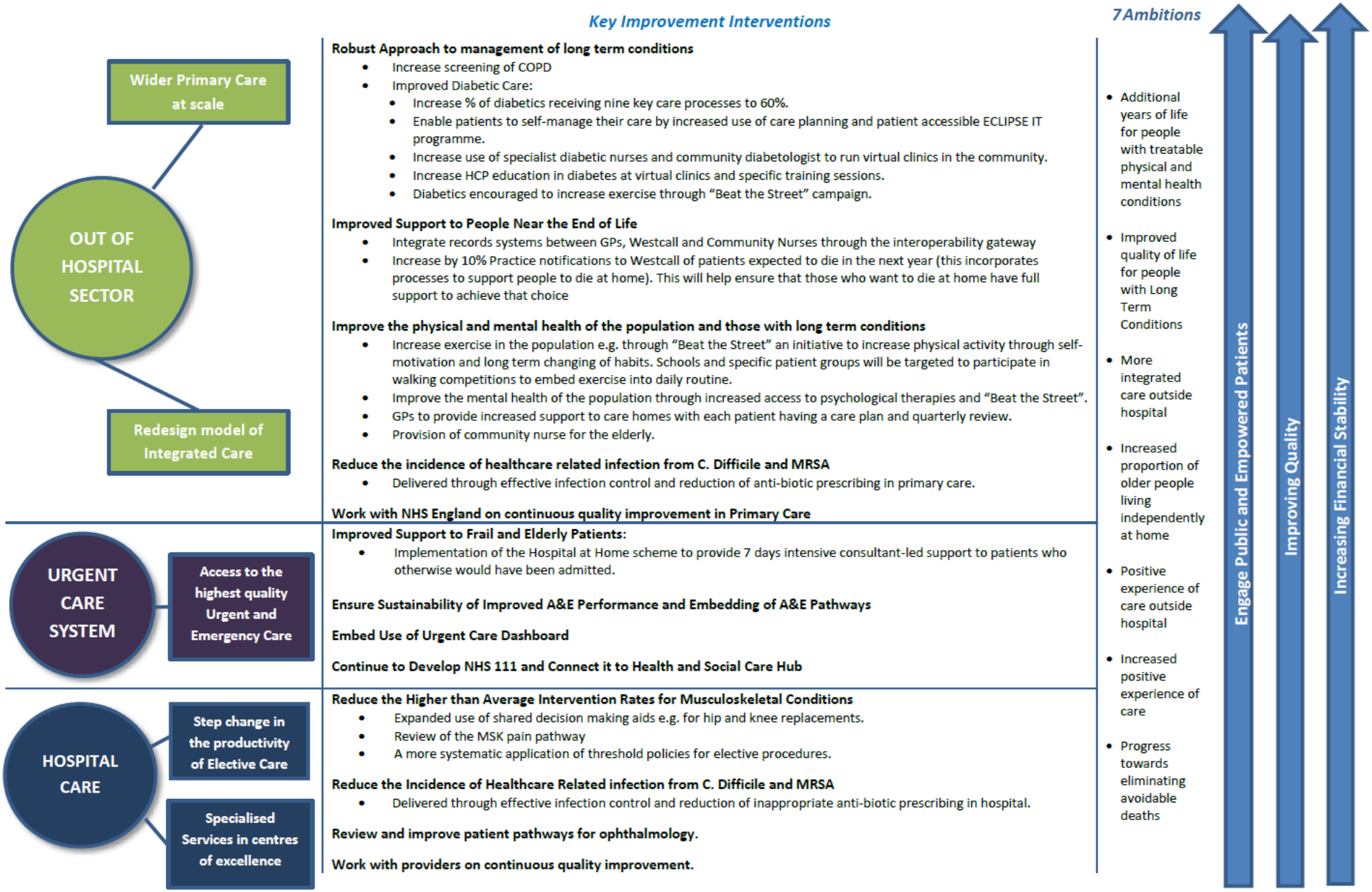
To support this vision the CCG has agreed the following objectives:



The "Plan on a Page" overleaf describes what we have committed to do over the next 2 years to help achieve the vision described above. The next section then lists the key improvement interventions that we have prioritised for the next 2 years.

3.6 The CCG 2 Year Operational Plan on a Page

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



3.7 Key Improvement Interventions for 2014/2016

Our plan aims to secure the following improvements in outcomes for patients and service users:

1	A 3.2% reduction in the potential years of life lost from conditions which can be treated over the next 5 years
2	An increase in the proportion of patients who say they feel supported to manage their long-term condition from 78.3% to 79.4% in next 2 years, by 2016.
3	An 3.9% reduction in potentially avoidable unplanned admissions to hospital in 2014/15
4	A 3.6% reduction in the number of patients reporting poor experience of inpatient care in 5 years
5	To maintain our position in the top quartile in respect of the number of patients reporting poor experience of primary care in the next 5 years
6	15% of people with anxiety and/or depression will receive psychological therapies in 2015/16.
7	67% of people thought to have dementia will be diagnosed with dementia in 2015/16

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 following sections detail all of the Improvement Interventions that the CCG plans for the next 2 years against the 3 key sectors, Out of Hospital Care, Hospital Care and Urgent Care.

Out of Hospital Sector	
Description	**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.**
Expected Outcomes (Activity/Quality)	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.
Changes derived from recognised good practice	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.
Investment Costs Financial	£685,321 (2014/15) £500,538 (2015/16)
Investment Costs Non - Financial	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.
Net savings	£520,870 (2014/15), £810,272 (2015/16)
Implementation timeline	It is anticipated that the service agreements will be agreed with Providers by the end of March 2014.
Enablers	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.
Barriers to success	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.
Confidence levels of implementation	This intervention has dedicated project management support and thus there is a high level of confidence of implementation.

Description	**Community Heart Failure: To further enhance the heart failure team with additional nursing roles. The intervention will develop and implement enhanced care pathways including palliative care and IV furosemide care in the community.** **To provide more preventative support within the community setting, helping to avoid hospital admissions and reducing some of the burden on secondary care Providers whilst providing a cost-effective model of care for the management of the condition.** **To continue to reduce the number of home visits and outpatient attendances for those patients receiving telehealth. This intervention will also support the CCGs achievement of their Outcome Ambition 3 - reducing emergency admissions and Outcome Ambition 2 - improvement in the health-related QoL for people with long term conditions.**
Expected Outcomes (Activity/Quality)	Expected outcomes will result in improved quality of life for patients with heart failure, providing intensive support at home and in the community. There will be a reduced need for face-to-face consultations with an improvement in discharge rates from the service. Improved patient outcomes (chiefly improved quality of care, optimised prescribing and titration of heart failure medications and maximised independence). To reduce emergency admissions and support increase medication compliance. Clinical safety and effectiveness of treatment will be ensured because the right people are caring for patients and are able to give each case the appropriate attention.
Changes derived from recognised good practice	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 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.
Investment Costs Financial	185926
Investment Costs Non - Financial	This intervention increases the workforce of the community heart failure team by appointing two full time additional specialist nurses.
Implementation timeline	Recruitment to the posts will commence to enable service commencement from April 2014. A new service specification will be agreed with the existing provider and included in the 2014/15 contract to meet national timescale.
Enablers	This is an expansion of an existing and well-established service with strong links with primary care and secondary services. Strategic enablers such as the NHS Standard Contract will be employed to manage provider performance. Deployment of the telehealth units to manage patients requiring more intensive input.
Barriers to success	There is always the potential difficulty/delay in recruiting to specialist nursing posts within the agreed timescales.
Confidence levels of implementation	Local Provider is confident that they will attract the right candidates for the roles and have not experienced issues relating to recruitment to heart failure specialist nursing roles. This is an expansion of an existing and well-established service with strong links with primary care and secondary services. Confidence levels of implementation are thus moderately high.

Description	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 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.
Expected Outcomes (Activity/Quality)	Increased level of intensive support to patients in the home setting to avoid the need for admission to hospital or support earlier discharge during a period of illness. There will be benefits for patients and their relatives who will avoid lengthy and frequent hospital visits and allow them to be more involved in their own care. Patients will be able to recover in familiar surroundings with more consistent and seamless care as patients are stepped down into community and social care support according to their needs. There will be a reduced risk of healthcare acquired infection as a result with reduced pressure on acute hospitals.
Changes derived from recognised good practice	There is not a lot of detailed evaluation around Hospital at Home schemes. Over the past 5 years there have been various models of Hospital at Home Services/Virtual wards introduced, including Community Nurse Led, GP Led and GP Practice Led. A recent study from the Nuffield Trust (June 2013) analysed Hospital at Home Services (Virtual Wards) based on three areas; Croydon, Devon and Wandsworth, but they had significant length of stays. There has been no significant analysis of H@H schemes and even those that exist in the USA (e.g. VA Centres, Presbyterian Healthcare Services, Mercy health and Cigna Medical Group) are based on different models with different 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.
Investment Costs Financial	£1,189,568(2014/15) £2,152,091 (2015/16)
Investment Costs Non - Financial	The intervention will establish a dedicated core H@H team. In order that we ensure medical leadership for each patient within the H@H service, a high level of medical input and supervision is required to ensure good governance and patient safety. The role could be undertaken by the following staff: General Practitioner, GPwSI, Consultant Geriatrician, Associate Geriatrician and possibly a Specialist Nurse Consultant. This will include a full time role within each H@H locality.
Net savings	£1,438,195 (2014/15), £3,854,226 (2015/16)
Implementation timeline	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.
Enablers	There is a commitment across all partner organisations in Berkshire West to a shared vision of integration that will support the implementation of H@H. H@H may act as catalyst in supporting integrated pathway development currently in progress.
Barriers to success	The main barrier to success will be the ability to recruit the appropriate clinical and nursing staff with the associated competencies.
Confidence levels of implementation	The full effect of the savings will be realised in 2015/16, with part realisation in 2014/15 (depending on service commencement). Service commencement is likely in July 2014 with half the beds planned. After six months the full stock of beds (60) will be brought on line so that the full benefit will be realised from April 2015.

Description	**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.**
Expected Outcomes (Activity/Quality)	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.
Changes derived from recognised good practice	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.
Investment Costs Financial	£305,374
Investment Costs Non - Financial	There will be an increase in the number of community staff to deliver the service with some changes to existing roles.
Net savings	£134,706 (2014/15), £308,772 (2015/16)
Implementation timeline	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. .
Enablers	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.
Barriers to success	The falls care pathway review may take longer than anticipated.
Confidence levels of implementation	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	**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.**
Expected Outcomes (Activity/Quality)	The main expected outcome of this intervention is a reduction in both the numbers of patients medically fit for discharge and the length of time spent waiting. Target is no more than 20 patients with a maximum length of 5 days.
Changes derived from recognised good practice	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.
Investment Costs Financial	£665,508
Net savings	£24,597 (2014/15)
Implementation timeline	There is additional capacity and extended working hours already in place so implementation is well underway.
Enablers	There is a central hub for all referrals into the service.
Barriers to success	There is always the potential difficulty/delay in recruiting to the posts within the agreed timescales.
Confidence levels of implementation	There is a high level of confidence of implementation.

Description	**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.**
Expected Outcomes (Activity/Quality)	The main outcome will be a reduction in inappropriate referrals for pathology services thereby reducing cost to CCGs.
Changes derived from recognised good practice	The 2014-15 QIPP focuses on increasing the uptake of the ICE 2 ordering system is 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.
Investment Costs Non - Financial	None
Net savings	£60,000 (2014/15)
Implementation timeline	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.
Enablers	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.
Barriers to success	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.
Confidence levels of implementation	The success of this initiative is dependent on changing GP ordering behaviour. Last year's 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	**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.**
Expected Outcomes (Activity/Quality)	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.
Changes derived from recognised good practice	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.
Investment Costs Financial	£89,232
Investment Costs Non - Financial	This initiative increases the workforce within haematology by the provision of a specialist nurse to monitor the results and liaise with GP and patients.
Net savings	£35,000 (2014/15)
Implementation timeline	The intervention go live date is the end March 2014.
Enablers	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.
Barriers to success	Previous delays have been due to IT issues which are being resolved.
Confidence levels of implementation	Rheumatology DAWN had been successful at reducing follow ups. This imitative uses similar technology and there is a good confidence level of implementation of this current intervention.

Description	**Medicines Optimisation - Prescribing (under development): This intervention aims to realise efficiency savings from optimising the use of medicines**
Expected Outcomes (Activity/Quality)	Efficient and optimal prescribing of medicines.
Changes derived from recognised good practice	Will be based on the relevant prescribing and NICE guidelines and recommendations.
Investment Costs Financial	No additional investment.
Net savings	£675,000 (2014/15), £650,000 (2015/16)

Description	**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.**
Expected Outcomes (Activity/Quality)	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.
Changes derived from recognised good practice	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 locality and for one of the indicators more than national.
Investment Costs Financial	£50,000
Investment Costs Non - Financial	Increase in the workforce of the Medicines Optimisation team.
Net savings	£69,113 (2014/15)
Enablers	Existing intervention structure is already in place. ScriptSwitch is also used to inform prescribers of the latest ONS prescribing guidelines
Barriers to success	The intervention relies on engagement of GPs with many actions resting with them.
Confidence levels of implementation	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	**Increased access to Talking Therapies**
Expected Outcomes (Activity/Quality)	Reduction in prevalence of serious mental health conditions.
Changes derived from recognised good practice	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) and for those with milder forms of mental illness. Treatment will be delivered according to NICE and Royal College of Psychology Guidance.
	To be developed further

Description	**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.**
Expected Outcomes (Activity/Quality)	The main outcomes will be a reduction in acute admissions and will support patient choice and preferences to die at home.
Changes derived from recognised good practice	This is based on the national End of Life strategy and has been recognised and communicated across all providers.
Net savings	£50,000 (2014/15)
Implementation timeline	The EoL beds admission criteria have been agreed and the intervention will be implemented on April 2014.
Enablers	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	Barriers to success include potential engagement issues with Primary Care and the uptake of training is possible but not anticipated.
Confidence levels of implementation	The confidence levels of implementation are good as the redefining of admission criteria has already been agreed and has good support from all parties.

Description	**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.**
Expected Outcomes (Activity/Quality)	Increased uptake of home delivery and midwifery-led units.
Changes derived from recognised good practice	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.
Investment Costs Non - Financial	Pilot will involve development of three geographically based home birth specialist teams. Will require an additional 5 WTE midwives in the community team.
Implementation timeline	Target to increase home births to 5% by 2015.
Enablers	The Home Birth Review showed that 50% of women are low risk at the start of labour.
Barriers to success	Recruitment of midwives. Changing perceptions around home births.
Confidence levels of implementation	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.

Description	**Community Psychological Medicines Service:**
Expected Outcomes (Activity/Quality)	See Psychiatric Liaison Service under Urgent Care (below)
Description	Carers Support (under development)
Expected Outcomes (Activity/Quality)	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.

Description	**Urgent care and crisis support for patients with mental health needs or learning disability: (under development)**
Expected Outcomes (Activity/Quality)	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.

Description	**Frail Elderly Pathway: Building on the Hospital at Home, Care Homes, Reablement, and Continence & Falls projects underway in 2014/15, a programme of projects to improve care for Frail Elderly patients will be extended from 2015/16 onwards. This will be based on the integrated Frail Elderly pathway currently under development across the Berkshire 10 Partnership.**
Expected Outcomes (Activity/Quality)	2015/16 programme under development. Anticipated savings from this and frail elderly at-home support scheme: £3.5m.

Urgent Care System	
Description	**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 (Activity/Quality)	Expected outcomes are improvements in patients' health, skills and knowledge for self- management of their health issues, with reductions in the usage of A&E and inpatient services. Two aspects to the service: [a] 24/7 liaison psychiatry within the Royal Berkshire Hospital and [b] community-based Community Psychological Medicine service to receive referrals of patients identified both through attendance in acute care and from direct GP referrals. This community service mainstreams the experience and developments from the Dept of Health Medically 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.
Changes derived from recognised good practice	• 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 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.
Investment Costs Financial	1038159.16
Net savings	£143,723 (2014/15 and 2015/16)
Implementation timeline	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.
Enablers	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
Barriers to success	The main barriers to success are possible complications of informatics developments and delays in recruitment of key posts, such as liaison psychiatrists.
Confidence levels of implementation	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.
Description	**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.**
Expected Outcomes (Activity/Quality)	Under development. Estimated savings on A&E attendances in 2015/16: £250K.

Hospital Care	
Description	**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.**
Expected Outcomes (Activity/Quality)	The intervention will result in overall cost savings through a reduced tariff. Patients will benefit from pathway improvements.
Changes derived from recognised good practice	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.
Investment Costs Financial	None
Net savings	£500,000 (2014/15)
Implementation timeline	There have been delays to the original implementation timeline. The expectation is that he provider will commence implementation in April 2014.
Enablers	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.
Barriers to success	The acute trust has been delayed in implementing because the specialty has had recruitment difficulties in particular temporary sub-consultant grades of medical staff.
Confidence levels of implementation	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.

Description	**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.**
Expected Outcomes (Activity/Quality)	To reduce elective c-section rates.
Changes derived from recognised good practice	Berkshire West is an outlier in terms of the rate of elective c-sections.
Enablers	Comparative data shows that there is potential to reduce the elective c-section rate.
Barriers to success	Cultural factors e.g. high rates of c-sections in Eastern European countries and growing evidence of increased anxiety towards natural delivery.
Confidence levels of implementation	Confidence is high as the provision of talking therapies offers a new approach to addressing this issue.

Description	**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 ongoing review and implementation of the MSK pain pathway to develop an integrated pathway and improvement in the pain management service. Part of this work will involve the de-commissioning of the MSK CAS service.**
Expected Outcomes (Activity/Quality)	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.
Changes derived from recognised good practice	Review of the evidence base of the impact on patients of the use of patient decision aids.
Investment Costs Financial	£50,000
Investment Costs Non - Financial	Support to practice staff on using the SDM tool. Robust audit and contract monitoring of all providers carrying out hip and knee procedures.
Net savings	£1,427,274 (2014/15)
Implementation timeline	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.
Enablers	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.
Barriers to success	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.
Confidence levels of implementation	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.

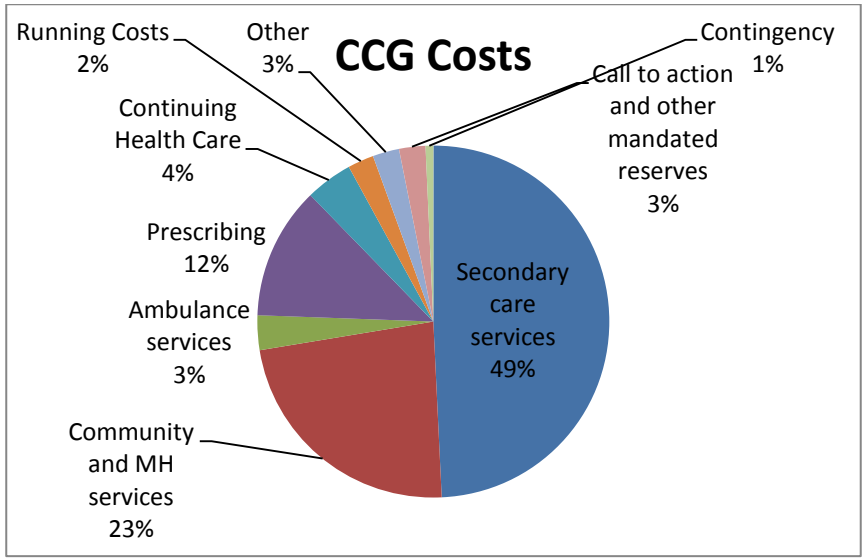
Description	**Cancer Care Pathways: This intervention aims to enhance the existing service. The focus is on reducing the number of follow up appointments for newly diagnosed patients.**
Expected Outcomes (Activity/Quality)	To provide high quality, efficient, accessible, effective and safe follow up care for cancer patients. This will lead to reduction in hospital based follow up appointments.
Changes derived from recognised good practice	The model is based on the NHS Improvement Risk stratified breast cancer pathway.
Net savings	£50,000 (2014/15)

Implementation timeline	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.
Enablers	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 success	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).
Confidence levels of implementation	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.
Description	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.
Investment Costs Financial	No additional investment.
Net savings	£2,000,000 (2014/15), £1,160,000 (2015/16)
Description	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.
Expected Outcomes (Activity/Quality)	Realisation of efficiencies over the next two years.
Investment Costs Financial	No additional investment. Potential savings have been identified.
Net savings	£250,000 (2014/15), £250,000 (2015/16)
Enablers	Contractual levers and review.
Description	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).
Investment Costs Financial	No additional investment
Net savings	£100,000 (2015/16) - Estimate
Description	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.
Expected Outcomes (Activity/Quality)	Improved compliance of local Trusts
Investment Costs Financial	Investment costs of deploying tools are being explored.
Net savings	£350,000 (2015/16) - Estimate
Description	Extension of shared decision-making into other (non-MSK) conditions (under development)

3.8 Financial Overview

Clinical Commissioning Groups (CCG's) are expected to manage expenditure with the resources allocated to them by NHS England and to deliver at least a 1% surplus. North and West Reading CCG's financial plan delivers this surplus target in each year. The plan also sets aside 2.5% for non recurrent expenditure in 2014/15 (with 1% of this 2.5% set aside within a 'Call to Action' fund), reducing to 1% from 2015/16 onwards, these funds are set aside to pump prime initiatives, particularly in 14/15 as these initiatives relate to the Better Care fund. A 0.7% contingency fund is also held, to manage in year volatility..

In 2015/16 the CCG contributes 4.8% of it allocation towards a pooled budget with its local authority partners, called the Better Care Fund (BCF). This fund will be managed in partnership with the Council, and has been created by a combination of NHS funding already committed and new investments by the CCG.



Investments have been set aside in 14/15 to support the delivery of the CCG's Operational and Strategic plans this includes funding for primary care to better identify and support elderly patients in the community (this investment has been set at £5 per head of registered population),

Investment in community services to enable patients to stay at home with appropriate support (rather than be admitted to an acute hospital), additional community bed numbers and increased capacity with intensive care services.

Running costs are planned to continue at current levels in 2014/15, with a reduction of 10% in 2015/16 in line with national guidance.

Financial Plan 2014/15		
	£'000	
CCG Income		
Recurrent allocation baseline	109,323	
Growth in year	3,721	
	113,044	
Non recurrent		
Return of prior year surplus & Misc	2,236	
	115,280	
CCG Expenditure		
Secondary care services	58,551	
Community and MH services	25,641	
Ambulance services	3,647	
Prescribing	14,077	
Continuing Health Care	5,015	
Running Costs	2,477	
Other	1,187	
Call to action and other mandated reserves	2,765	
Contingency	789	
	114,149	
Required Surplus	1,131	1.00%

In addition to the holding of contingencies, as one of the four CCGs within the Berkshire West federation some risk will be managed through the pooling of budgets in areas such as Continuing Healthcare and high cost mental Health placements.

Major Investments in 2014/15	£'000	£'000
Out of Hospital		1,432
escalation bed capacity and service navigation	293	
support for over 75's	571	
Care Home Support	153	
Hospital at Home	266	
Community Reablement and Rapid Response	149	
Urgent Care		232
Psychiatric Liaison Service	232	
Hospital services		276
Intensive care	276	
Quality		242
Francis / berwick report - implications	242	
	2,182	2,182

Main QIPP Schemes in 2014/15 - gross savings	£'000	£'000
Out of Hospital		1,342
Medicines management	179	
Care Home Support	259	
Hospital at Home	745	
Community Reablement and Rapid Response	159	
Urgent Care		241
Psychiatric Liaison Service	241	
Hospital services		963
Business rules / improving efficiency	517	
MSK service review	334	
Eye care service review	112	
	2,546	2,546

Financial Plans 2015/16 onwards	2014/15'	2015/16'	2016/17'	2017/18'	2018/19'
CCG Income					
Recurrent allocation baseline	109,323	113,044	117,852	121,502	124,036
Better care fund tarnsfer	0	1,618	0	0	0
Growth in year	3,721	3,190	3,650	2,534	2,564
	113,044	117,852	121,502	124,036	126,600
Non recurrent Return of prior year surplus & Misc	2,236	1,688	1,179	1,215	1,240
	115,280	119,540	122,681	125,251	127,840
CCG expenditure					
Clinical Services	108,118	108,474	111,555	114,079	116,620
Better care fund	0	5,716	5,716	5,716	5,716
Running Costs	2,477	2,226	2,221	2,216	2,210
Mandated reserves and Contingency	3,554	1,945	1,973	2,000	2,028
	114,149	118,362	121,466	124,011	126,574
Required Surplus	1,131	1,179	1,215	1,240	1,266

3. Enabling delivery of our plan

3.1 Public and Patient Engagement

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

In his foreword to this plan the Chair of the CCG talked about the pressures that face the NHS going forward. Preserving the values that underpin a universal NHS, free at the point of use is important both to the CCG and our population but will mean fundamental changes in the way we deliver and use health and care services. This is not necessarily about structural change; it's about finding ways of doing things differently harnessing technology to fundamentally improve productivity, putting people in charge of their own health and care, integrating more health and care services and much more besides.

This new approach cannot be delivered by any organisation standing alone. That is why we want to work together, alongside patients, the public and other stakeholders to improve standards, outcomes and value.

We will explore the range of options that we can use to ensure that patients can be active in their own healthcare and to ensure that the services we commission meets the needs of the local population. We will develop our Communications and Engagement Strategy during the year ahead and use the guidance in "*Transforming Participation in Health and Care*" to support us with this.

To build on, enable and support the public mandate for change within the NHS, we 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 our first successful " Call to Action" event, 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

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.

We will look to develop an interactive resource which will explain what the vision set out in this plan will mean for patients and service users. This is likely to take the form of a series of short video clips and/or slides with prompts to encourage people to give the feedback we need to develop this plan further and prepare for its implementation. It will be used to support a series of follow-up 'Call to Action' meetings and also shared online.

We are holding follow up "Call to Action" events in April and September 2014. We will also use our monthly Patient Engagement Steering Group and Patient Voice meetings to ensure that the voice of our local population is heard in all aspects of the CCG's business and that opportunities are created and protected for patient and public empowerment in the work of the CCG.

We have recently invested in video screens for GPs' waiting rooms. This is an excellent opportunity to improve communication with patients, enabling us to give them information at a time when they are available and receptive. The screens provide an important channel to keep our patients up to date with key health promotion messages as well as raising awareness of seasonal campaigns – for example, encouraging flu jabs and MMR vaccinations. We are working with the Central Southern Commissioning Support Unit to develop a communications strategy to enable us to ensure that public and patient communication is consistent and targeted.

3.2 Key Relationships

Healthwatch Reading: We look forward to continuing our relationship with Healthwatch Reading, the local consumer champion for both health and social care. It aims to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided in Reading. Healthwatch Reading monitors the quality of the Social Care, Health Care and Public Health Care, being commissioned and provided in Reading. It also monitors how all the people in Reading experience the quality of all aspects of the Care, which they receive. The Healthwatch Reading functions are as follows:

- It has the power to enter and view services
- Influence how services are set up and commissioned by having a seat on the local health and wellbeing board
- Produce reports which influence the way services are designed and delivered by commissioners
- Pass information and recommendations to Healthwatch England and the Care Quality Commission
- Provide information, advice and support about local services, by providing advice and signposting to individuals regarding the services available in the local area
- Provide an advocacy service for those who wish to complain about an NHS service they have received

Healthwatch Reading is a Charitable Incorporated Organisation supported by Reading Voluntary Action. It has an elected Board, made up of local people, patients and representatives from local organisations. The 'Board is responsible for ensuring that the contract, which it holds with the Local Authority to implement the Authority's statutory duty, is being managed to a high level of professional competence, with excellent outcomes for local people. Healthwatch Reading ensures that patients and service-users contribute to the commissioning decisions of both the NHS and of the Local Authority, with regard to Social Care, Health Care and Public Health Care. It seeks to inform and to educate different groups within local communities, so as to enable them to participate in, and to contribute appropriately to, shared decision-making.

Health and Wellbeing Boards: The CCG is a partner in both Reading and West Berkshire Health and Wellbeing Boards which were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the health and care system could work together to improve the health and wellbeing of their local population and to promote integrated services.

We have had a successful first year and have produced joint strategic needs assessments (JSNAs) and Health and Wellbeing Strategies which have helped inform this Operational Plan. The Boards have also signed off plans for the Better Care Fund and we are looking forward to developing this partnership further to lead the integration and transformation of local services in the CCG area.

Voluntary Sector: We plan to improve our links and level of engagement with the voluntary sector to enable proactive involvement at relevant stages in our commissioning processes. We recognise the strength of voluntary and community groups in identifying the needs of specific communities and delivering community based services and activities to address them. We wish to build on this strength by seeking to provide opportunities for the voluntary sector to be involved in patient care pathway development and to provide services linked to the CCG commissioning priorities. We will also look to develop opportunities to jointly commission the voluntary sector with our Local Authority Partners.

NHS England Local Area Team: NHS England is the statutory commissioner of core primary medical services, the services provided by the GPs in the CCG area. The CCG has a duty to improve the quality of primary care and we work with the NHS England Team Thames Valley Area Team on this and other matters relating to the provision of GP services. The CCG clinical leadership and relationships with member practices is key in further developing this joint work.

NHS England has recently set out its ambition for greater collaboration with CCGs in the commissioning of general practice in a document called "Improving General Practice: Phase one Report" dated March 2014. We look forward to moving towards joint arrangements for commissioning general practice services with NHS England. This will:

- allow us to pool resources, where appropriate, and make more optimal decisions about how resources are allocated between primary care, community health services and hospital services
- strengthen local clinical leadership and ownership of plans to transform general practice services and ensure that they are aligned with our wider strategic plans
- strengthen the links between in hours GP Services and wider out of hours services
- support development of more integrated arrangements for providing GP services and community health services
- allow a more cohesive approach to incentives for general practice
- support joint working with Local Authorities to commission more integrated health and social care
- provide greater confidence that, where local plans require additional investment in GP services, this investment is made in ways that do not give rise to perceived conflicts of interest for GPs involved in clinical commissioning

We also look forward to working with NHS England to identify where premises developments are needed to support our strategic plans .

Clinical Networks & Senates: NHS England has recognised the value of Strategic Clinical Networks (SCNs) as "engines for change" in the modern NHS. SCNs are therefore a further element in the wider system that will support CCG"s to deliver quality improvements and outcomes benefits for patients. NHS England has mandated four SCN groupings across England, as follows:

- Cancer
- Cardiovascular
- Maternity & Children
- Mental health, dementia and neurological conditions

Strategic Clinical Networks may also be bolstered on key work-programmes and disease groups identified by the Local Area Team, through Operational Delivery Network (ODNs). Given the natural links between the CCG"s priorities (including national priorities), North & West Reading CCG will endeavour to engage with SCNs to ensure a consistent and robust emphasis on quality improvements and patient outcomes at all times.

3.3 Workforce Development

Organisations in the Berkshire West Health and Social Care Economy are committed to developing, testing and implementing innovative approaches to integration through strong collaborative leadership and through a workforce which is fit for purpose. This will include the development of an Integrated Workforce Development Strategy to meet our ambitions to transform our workforce to meet the future challenges of health and social care provision. A system wide transformational programme is being put in place to deliver large scale integrated change and a shared approach across organisations. This will present real opportunities as well as challenges in collaborative leadership to undertake workforce transformation and remodelling alongside service redesign.

We recognise the need to implement cultural change programmes that will result in a different workforce for the future. We will have a clear focus on the skills/competencies required to deliver integrated care and not be constrained by professional boundaries.

As system leaders we need to instil ownership amongst our staff by helping them to understand why change is needed and clarifying the benefits that it will deliver at all levels.

The proposal is to develop a Whole System Integrated Workforce Development Strategy including:

Inter-Organisational Workforce planning across health and social care will include:

- To review the ratio of qualified and unqualified staff
- Targeted skills
- Development of HCA's/Support workers /Key worker roles
- Establish career pathways for health and social care staff

- Ensure that the voluntary/.independent workforce is an integral part of the whole system workforce redesign

The proposal will improve the recruitment process by ensuring the following are delivered:

- Values based recruitment
- Joint recruitment rounds
- Recruitment and retention programmes
- Pre- employment programmes
- Drivers to becoming employers of choice
- Labour market intelligence

Finally the strategy will include an integrated training plan with core values to improve leadership, identifying talent within the organisations creation of personal recovery guides, redesigning roles, skills and competencies and a joint training programmes

3.4 IM&T Strategy

The strategy sets out the direction of travel for information management and technology (IM&T) to support the four clinical commissioning groups within Berkshire West Federation (Newbury & District, North & West Reading, South Reading, Wokingham). It represents a first step towards defining a strategy and implementation plans for the next 3-5 years.

IM&T has a broad definition, covering data, information, intelligence, knowledge, systems, IT/digital technologies, supporting skills and services. The strategy aims to convey the breadth of issues and to provide pointers to the way forward. The focus is on support for commissioning, and the interdependency between provider IM&T, GP (provider) IT & Systems issues. The findings and preliminary conclusions are based on reviews of local and national documentation, interviews with individuals from the CCG's/primary care, and discussions at the Berkshire West IM&T Advisory Group.

4. Assuring Quality

4.1 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 ongoing focus on ensuring that providers of services to Berkshire West communities are delivering quality services. Our vision for quality is straightforward, patients and service users should:

Receive clinically effective care and treatments that deliver the best outcomes for them

Have a positive patient experience of their treatment and care

Be safe, and the most vulnerable protected

Quality will underpin the development and delivery of every service and pathway and be at the heart of every commissioning decision. Quality will be fully integrated with performance and finance in assessing the delivery of this plan and will continue to be at the centre of all of our discussions with providers. Should provider performance not meet expected quality and safety standards, contractual redress will be sought.

The Francis Report, Berwick and Keogh reports

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

- fundamental standards and measures of compliance are always met
- they demonstrate openness and candour
- they promote and provide compassionate, caring and committed nursing
- they promote strong healthcare leadership
- they provide information and data that is transparent to service users and the public

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

Response to Winterbourne View

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

Patient Safety

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

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

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

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

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

Clinical Effectiveness

In order to provide cost and clinically effective care and treatment, the CCG will require providers to comply with national and local standards/guidance such as National Service Frameworks and NICE technology appraisals and guidance. The CCG 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 CCG 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 CCG and provide assurance to the CCG Governing Bodies, highlighting any risks as they occur.

Patient and service user experience

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

Providers will use feedback to improve and will be required to regularly inform, consult and involve patients, service users, their families and carers and the public in the planning and review of services. One aim of this engagement is to ensure compassion by engaging staff and promoting an environment of empathy in which service users are listened to. We will promote dignity and respect, for example by monitoring how providers are meeting single sex accommodation requirements.

CQUINS

CQUIN is an incentivised monetary reward scheme (currently up to 2.5% of provider contracts) that CCGs use allocate payments to providers if they meet defined quality outcomes. The CCG will continue to work with providers to ensure that the CQUIN schemes both in the current and future contracts are stretching and deliver quality services for our population. The aim will be to have fewer CQUINs to allow greater incentive for change on each. Where national CQUINs are already being achieved, stretch quality indicators will be introduced. We will be following national and regional guidance in the development of our local CQUIN arrangements, but would only expect to pay the full 2.5% to providers who have demonstrated truly exceptional quality, part of which will mean ensuring that all national standard quality requirements have been met.

Compassion in practice

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

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

Seven day services

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

To support the implementation of seven day services, the CCG will be developing a CQUIN (2014/15) to support our providers in ensuring consultant cover seven days a week. We are also committed to utilising future CQUINs to support similar initiatives around 7 day working.

Access

Linked to the above is the need to ensure good access to all of the services we commission. The CCG 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.

Safeguarding

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

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

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 and continuing professional development so 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.

Relationship with external regulators

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

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

Innovation

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

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

We will link with the Innovation, Health and Wealth programme to ensure that we keep up-to-date on emerging innovations and consider how these can best be implemented locally. As described above we have put in place arrangements to ensure implementation of NICE Technology Appraisals and our contract management processes ensure that providers have innovation plans in place. Going forward we will look to work with the Oxford Academic Health Science Network to consider how we can further build innovation in Berkshire West.

Workforce

Workforce considerations are taken into account at all stages of developing our plans and we recognise that the skill mix required to deliver a largely community-based model of care will look very different to our existing staffing models. 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 set the direction for transforming the health and social care workforce to deliver integrated models of provision. It will be underpinned by a two-year training programme to support staff to gain the new skills required, thereby creating cultural change.

The CCG is engaging with Health Education Thames Valley, the Thames Valley and Wessex NHS Leadership Academy and the Oxford Deanery to mould the shape of our the future healthcare workforce and ensure that new staffing requirements can be met. We are also exploring opportunities to use staff in different ways, for example through the GP and Nurse Fellowship programmes. 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 change described in this plan will be underpinned by a programme of organisational development activities supporting the delivery of change both within individual organisations and in the way that organisations interact with one another. 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.

4.2 Equality and Diversity – NHS Equality Delivery System (EDS)

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.

Further information can be found on the CCGs website: Equality and Diversity

Appendix 1 – How our Plan links to the NHS England Outcome Ambitions

Working through the "How to Change" approach, North & West Reading CCG has been working with the other CCGs in Berkshire West and our local partners, to develop a number of new initiatives and programmes to improve health outcomes and the quality of services, in line with national and local priorities already outlined in this Operating Plan. These initiatives and programmes are set out below and summarised in the NHS England Ambition matrix below:

Initiatives 2014 to 2016	Linked to: • local Priorities (LP) • Better Care Fund (BCF) • Programme Board Oversight – Planned Care (P) Long Term Conditions (LTC) Urgent Care (U) Children, Mental Health (CMMV)	NHS England Ambitions						
		Securing additional years of life	Improving health-related quality of life for 1 or more LTC	Reducing the time spent avoidably in hospital	Increasing the proportion of older people living independently at home following discharge from hospital	Increasing the number of people having a positive experience of hospital care	Increasing the number of people having a positive experience of care outside of hospital	Making significant progress towards eliminating avoidable deaths in hospitals caused by problems in care
Care Home Support	BCF, LTC		✓	✓			✓	
Community Heart Failure	F, LTC		✓	✓			✓	
Hospital at Home	BCF, U		✓	✓		✓	✓	
Continence and Fall	F, LTC			✓			✓	
Increase in community reablement and rapid Response	F, U		✓	✓	✓		✓	
Psychiatric Liaison Service	F, CMMV			✓		✓	✓	
Integrated Eye Care Service	LP, P			✓		✓	✓	
Musculoskeletal service	LP, P			✓		✓	✓	
Cancer Care pathway	LP, P	✓	✓			✓	✓	
End of Life	LTC			✓	✓	✓	✓	
Pathology	P					✓		
Haematology	P		✓					
Frail Elderly Pathway	LTC		✓	✓	✓	✓	✓	

Initiatives 2014 to 2016	Linked to: • local Priorities (LP) • Better Care Fund (BCF) • Programme Board Oversight – Planned Care (P) Long Term Conditions (LTC) Urgent Care (U) Children, Mental Health (CMMV)	NHS England Ambitions						
		Securing additional years of life	Improving health-related quality of life for 1 or more LTC	Reducing the time spent avoidably in hospital	Increasing the proportion of older people living independently at home following discharge from hospital	Increasing the number of people having a positive experience of hospital care	Increasing the number of people having a positive experience of care outside of hospital	Making significant progress towards eliminating avoidable deaths in hospitals caused by problems in care
Improving access to Talking Therapies	CMMV		✓				✓	
CAMHS Changes	CMMV		✓				✓	
Young People (Palliative Care)	CMMV	✓	✓					
Maternity Early Labour Assessment Model	CMMV			✓				
Improve Information sharing in Urgent care	U		✓	✓		✓	✓	
Carers Health Checks	LP		✓	✓				
Improvement in Dementia, Increase to memory clinic	LP, LTC	✓	✓	✓	✓	✓	✓	
Children with Complex needs	CMMV		✓					
Digital Care Plan	U		☐	✓		✓		
Emergency Care Practitioners	U							
Referral s to General practices from NHS 111	U			✓				
Enhanced Recovery programme	P		✓				✓	✓
Neighbourhood Clusters	LP		✓	✓	✓	✓	✓	

Appendix 2 - Alignment of the CCG Operating Plan with the Reading and West Berkshire Local Authorities Health and Wellbeing Strategies

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

• Increase the uptake of all screening programmes, specifically COPD as this has been recognised as an area where reported prevalence on GP registers is significantly lower than the estimated prevalence in in the population.
• The GP clinical management software, ECLIPSE will be expanded to include COPD and diabetes to promote greater patient involvement in their care.
• A new social media platform, Puffell will be launched. This will allow self-management of health and wellbeing as well as the opportunity for patients to talk to others with similar health conditions informally and create communities to support self-management of care.
• North & West Reading CCG met the national screening targets for breast cancer, cervical cancer and bowel cancer and cancer screening will continue to be promoted at every opportunity through GP practices.
• The CCG met the 95% coverage target for childhood immunisations for 1 and 2 year olds in 2012/13 and just missed the target for 5-year old MMR immunisations, but was the highest performing CCG in Berkshire for this vaccine. Increased uptake will be further promoted with GPs at Council meetings and practice visits.
• We met the 75% coverage target for seasonal flu immunisations for people aged 65 and over and will continue to work collaboratively with NHS England to increase uptake of seasonal flu vaccine in high risk patients.</td></tr>
<tr><td rowspan="3">Increase the focus on early years and the whole family to help reduce health inequalities (Reading).</td><td>Objective 1 – Ensure high quality maternity services, parenting programmes, childcare and early years education is accessible to all</td></tr>
<tr><td>Objective 2 – Reduce inequalities in early development of physical and emotional health, as well as language and social skills</td></tr>
<tr><td>Objective 3 - Reduce the prevalence and social and health impact of obesity in children</td></tr>
<tr><td>Giving every child and young person the best start in life (West Berkshire).</td><td>Ensuring there is a focus on giving every child the best start in life is crucial to reducing health inequalities. One of the most effective ways to address long term public health is to provide high quality support and services to parents, beginning with preconception care and continuing through pregnancy, birth and the early years.</td></tr>
</table>

Addressing childhood obesity in primary school children (West Berkshire).	Children who are obese are more likely to become obese adults, and this likelihood increases the heavier they are as a child and if their parents are also obese.
	More health problems will be seen in the next generation of adults if more of our children are overweight or obese today.
	Childhood obesity is a powerful predicator of increased risk of Coronary Heart Disease (CHD) and type 2 diabetes mellitus in early adulthood.

Focus of North & West Reading CCG

Guides for parents and carers of young children on how to deal with Common Childhood illnesses will be commissioned. These have been successful in other areas of the country and will be made available to all parents in various formats and in a range of languages.

Health Visitors (currently commissioned by NHS England) are a vital part of Reading's multi-professional, locality-based Children's Action Teams. Health Visitors also work close with children's centres; each centre has a lead Health Visitor and they will routinely discuss emerging concerns with children's centre staff and make referrals as required. Maternity services currently run ante-natal and post-natal support from four children's centres, which have had a positive impact in strengthening joint working between these services.
Our CCG is a member of the Reading Health and Wellbeing Board Children and Families Joint Working Subgroup and we working jointly with colleagues across the health and social care system including South Reading CCG to implement 4 key themes of work:

1. Improved Awareness of Children's Services for GPs and Health Care Professionals
2. Education and Resources for Families
3. Opportunities for awareness raising and making contact with families
4. Promotion of Immunisations

Live Active, a project to increase physical activity in the population will specifically target school children with an aim to reduce childhood obesity and change habits at a young age. We will commission, jointly with South Reading CCG and Public Health, cards and readers that will track the number of miles children have walked or cycled. This will be used to initiate promotion of exercise and active living through inter-school competitions and effective media coverage throughout Reading.

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

Focus of North & West Reading CCG

Diabetes is a key focus for North and West Reading CCG. We have an above average prevalence of diabetics with an HbA1c of 59mmol/mol or less and the percentage of people receiving the diabetes nine care processes is below national average. Initiatives are currently underway to address these issues. We have appointed a community diabetologist who, with specialist diabetic nurses will run virtual and "one stop shop" clinics within the community to educate patients on how self-manage their care. The virtual clinics enable the community diabetologist to discuss up to 25 patients with our Primary Care teams, providing a valuable education resource for GPs and practice diabetic nurses which will increase the quality of care in primary care where most diabetics are actually treated. A specialist diabetes website with information for patients with be further developed and effective care planning, ECLIPSE and HCP education will be used to improve health related quality of life for patients with diabetes. Diabetics and those at high risk will also be encouraged to increase their exercise thorough the Live Active programme.

Our CCG has higher than average intervention rates for musculoskeletal conditions. Through the effective use of decision aids and by working with patients, these will be reduced to ensure that surgical proceedings are only undertaken at the most appropriate time and where it is clear that the benefits outweigh the risks.

There is also a higher than average prevalence of adult depression in the population of our CCG. This will be addressed through various initiatives. A 24/7 psychiatric liaison service will be established at Royal Berkshire Hospital and a community based psychological medicine service. These initiatives will ensure that services are able to respond appropriately to both physical and mental health needs, recognising the inter-relationships between these. Through use of the voluntary sector, we will introduce social prescribing where patients, specifically with minor mental health conditions are signposted to services in their community to improve quality of life. We will also improve appropriate access to and the quality of, Child and Adolescent Mental Health Services, through the review of the access criteria and improve access to our Talking Therapies service. Exercise is an evidence based treatment for depression and other Mental Health conditions and Mental Health patients will be encouraged to join Live Active. We will provide training for our GPs to support a consistent message about exercise to particular groups of patients as well as the population as a whole.

Promote health-enabling behaviours & lifestyle tailored to the differing needs of communities (Reading).	Objective 1 – Improve tobacco control and reduce the harm due to alcohol
	Objective 2 – Introduce and support initiatives to increase physical activity in Reading, particularly in hard to reach groups
	Objective 3 – Introduce and support initiatives that promote healthier eating for all ages and communities

Supporting those over 40 years old to address lifestyle choices detrimental to health (West Berkshire).	Addressing lifestyle behaviours detrimental to health and wellbeing in working age adults will optimise good health, decrease ill health and the need to use health and social care services, not only today, but also in years to come. This will help to prevent the development of many long term conditions, benefitting individuals, their families and society in general.

Supporting a vibrant district (West Berkshire).	Social capital describes the links that bind and connect individuals and communities. This is important as it provides a source of resilience, a buffer against the risks of poor health.
	The extent of people's participation in their communities, how safe they feel and the added control this brings has the potential to positively contribute to their psycho-social wellbeing.

<u>Focus of North & West Reading CCG</u>

We will work with our children centres who provide healthy eating and cookery classes and continue to promote sensible weight loss in overweight secondary school children through referral to dieticians and to the eat4Health Programme. We will aim to improve awareness of the services that are available locally and work collaboratively with Public Health on developing the obesity strategy and other healthy living initiatives.

The use of the media with the Live Active project will help to target hard to reach groups and after the initial project with cards and sensors to monitor distances walked by the public, this will be extended to include various other projects to allow the population to remain active – green gyms, city farms and use of the voluntary sector in promotion of community sporting activities.

We will aim to connect with individuals and families by effectively engaging with patients through various channels including important community venues such as children's centres, libraries, our general practices and places of worship to improve health education and to encourage positive lifestyle choices. The voluntary sector will be increasingly used to signpost and support patients in using locally located resources and activities which would be beneficial for their health and wellbeing.

Promoting independence and supporting older people to manage their long term conditions.	People aged over 75 stay one and a half times longer in hospital than the average for all age admissions and people with a diagnosis of dementia stay on average four times longer.
	Groups in particular need to include older people living alone and those who are carers. In addition, there is predicted to be an increase in age-associated long term conditions. This includes a rise in the number of people with dementia and poor mental health in older people as well as in the number of older people with learning disabilities.

<u>Focus of North & West Reading CCG</u>

Improvement of the frail and elderly pathway will be a specific focus for North and West Reading CCG. We will increase GP access to patient records across sites and provide a named GP for elderly patients. We will also commission a community nurse for the elderly. We will work alongside our neighbouring CCG's and the Long Term Conditions programme Board to implement the Hospital at Home project to provide traditional hospital care in patient homes, where appropriate, and prevent unnecessary hospital admissions.

Research from Dying Matters found that 70% of people want to die at home, however in Reading fewer than 20% of all deaths happen at home with around 50 % of all people dying in hospital. This was also raised by patients at our Call to Action event. We will enable a direct communication channel to Westcall Out Of Hours for end of life patients to offer a choice of where their final care is delivered and ensure that our current rate of deaths at home increase in line with their wishes. We will retain our attached district nursing teams within our practices and develop shared recording keeping as with Westcall between GP medical records and nursing records to ensure that patients receive consistent integrated care whether they are seen by a District Nurse, their own GP or an OOH GP.

Appendix 3 - Our GP Practices

Practice Name	Address	No of Patients	Practice Manager	Chair of PPG
Balmore Park Surgery	59a Hemdean Road Caversham, Reading, RG4 7SS	15,737	Eileen Flood	John Atwell
The Boat House Surgery	Whitchurch Road Pangbourne, Reading, RG8 7DP	10,876	Steve Wells	Diana Smith
Circuit Lane Surgery	53 Circuit Lane Reading, Berkshire, RG303AN	10,347	Jenny Marnock	TBA
Emmer Green Surgery	4 St Barnabas Road Emmer Green, Reading, RG4 8RA	9,270	Helena Stacey	Ruth Thomas
Mortimer Surgery	72 Victoria Road Mortimer Common Reading, RG7 3SQ	11,764	Debbie Cowley	Steve Lansley
Peppard Road Surgery	45 Peppard Road Caversham, Reading, RG4 8NR	2,203	Dr Harold Chadwick	TBA
Priory Avenue Surgery	2 Priory Avenue Caversham, Reading, RG4 7SBrown	*8,052*	Julie Pammenter	Francis Brown
Theale Medical Centre	Englefield Road Theale, Reading, RG7 5AS	10,581	Sally Gifford	Rosemary Balsdon
Tilehurst Surgery Practice	Tylers Place Pottery Road Tilehurst Reading, RG306BW	13,256	Desiree Warren	Kirsten Willis
Western Elms Surgery	317 Oxford Road Reading, Berkshire, RG301AT	17,004	Lisa Trimble	Alan Porton

Appendix 4 - Map of our area