South Reading
Clinical Commissioning Group

Commissioning Plan

South Reading Clinical Commissioning Group

2014-2016

Contents

	Page
What is South Reading CCG?	4
Introduction from the Chair	5
Our Key Achievements 2013-14	6
Developing the Two Year Operational Plan 2014-16	8
Patients' Rights – The NHS Constitution	10
The Health Needs of the Population	11
Our Five Clinical Areas of Focus	17
Listening to our Patients and the Public	20
Strategic Long Term Vision 2019	22
Our Local Areas of Focus 2014-2016	24
South Reading CCG – Plan on a Page 2014-2016	26
Delivering High Quality, Sustainable Health Care	27
1. Engagement with our Patients, the Public and Other Stakeholders	28
2. Wider Primary Care, Provided at Scale	31
3. Modern Model of Integration (Better Care Fund)	33
4. Access to Highest Quality Urgent and Emergency Care	33
5. A Step Change in Productivity of Elective Care (Planned Hospital Care)	35

Section	Page
6. Specialised Services Concentrated in Centres of Excellence	35
Other Enablers	36
1. Expert Clinical Advice	36
2. Workforce Development	36
3. Information Management &Technology	39
Quality & Patient Safety	40
Equality & Diversity	46
Financial Plans	47
Appendix 1 – Our GP Practices	50
Appendix 2 – Berkshire West Outcomes/Improvement Interventions	51

What is South Reading Clinical Commissioning Group?

South Reading Clinical Commissioning Group (CCG), with a growing population of approximately 128,000, is made up of 20 GP practices (see appendix 1 for full list of our member practices) with an excellent track record of working together since 2006. The local population is younger than the national average, made up of a higher proportion of young children and also adults under 44 years whilst the proportion of over 60 years old is much lower. The most deprived areas within Reading are amongst the 20% most deprived areas of the country.

To date we have been actively involved in developing alternative pathways and service redesign projects locally as well as taking a lead role on Quality, Innovation, Productivity and Prevention (QIPP) projects across the local health economy (see appendix 3).

The majority (87%) of patients registered within South Reading are predominately seen in local hospitals, including, Royal Berkshire NHS Foundation Trust for acute services and Berkshire Healthcare Foundation Trust for mental health and community services. It is therefore important for South reading CCG to ensure and promote sustainability of the local health economy so that we can commission high quality services for our local population close to home.

The CCG has a Board as its Governing Body, consisting of five GP members, a nurse director, chief finance officer, chief officer, two lay members and a hospital consultant. The Board is supported by and accountable to its member practices in the form of a Council of Practices, with representatives from all 20 practices in South Reading; as well as a management team made up of elected representatives and supported by commissioning management staff. South Reading CCG is one of four CCGs in Berkshire West and works in close collaboration (Federation) with the other three CCGs in Berkshire West. A similar "Federation" also exists covering the three CCGs in Berkshire East.

We also actively engage and work alongside with our public health colleagues, within the local authority and other health care professionals, such as speech and language therapists, physiotherapists, pharmacists etc., as well as social care professionals and the voluntary sector in our programmes. This collaborative working will supplement our local CCG team resources in implementing local initiatives. Further support will be provided by a comprehensive Commissioning Support Unit who provides further capacity in supporting the implementation of QIPP **(Quality, Innovation, Productivity and Prevention) at a federation level.**

You can find us at www.southreadingccg.nhs.uk

Introduction from the Chair

This document details the Operational Plan for NHS South Reading Clinical Commissioning Group (CCG) for the next two years (2014-2016).

Since full authorisation as a CCG from 1st April 2013, South Reading CCG has made significant progress in shaping the commissioning of services to our relatively young and ethnically diverse patient population, living and working in Reading. With increasing demands on health services we have faced many challenges and learnt a great deal in the last year. We worked well collaboratively with our GP practices and health visitors to successfully target our hard to reach children , ensuring that as many as possible have received their year 1 immunisations This innovative model has recently been adopted by our colleagues in NHS England for a National MMR catch up campaign in our 10 to 16 year olds.

We are confident we can build upon all our learning from our first year and will be focusing our efforts on both the need for prevention and treatment, as well as placing improved outcomes for our patients at the heart of everything we do. In particular we would like to improve patient outcomes for Respiratory Disease (COPD), Diabetes; alcohol related liver disease and mental health. We are also joining with North & West Reading CCG to target Obesity in our younger population in an initiative called "Live Active".

We will continue to strive for the highest quality services, working together with our patients and partners in foundation trusts and the local authority to maximise the efficient use of resources and to share and support best practice. The coming years in particular will see more integrated and seamless care for patients across health and social care. We have also committed through Reading's Health and Well-being board to work alongside Reading Children's Centres to promote early years support to children and families.

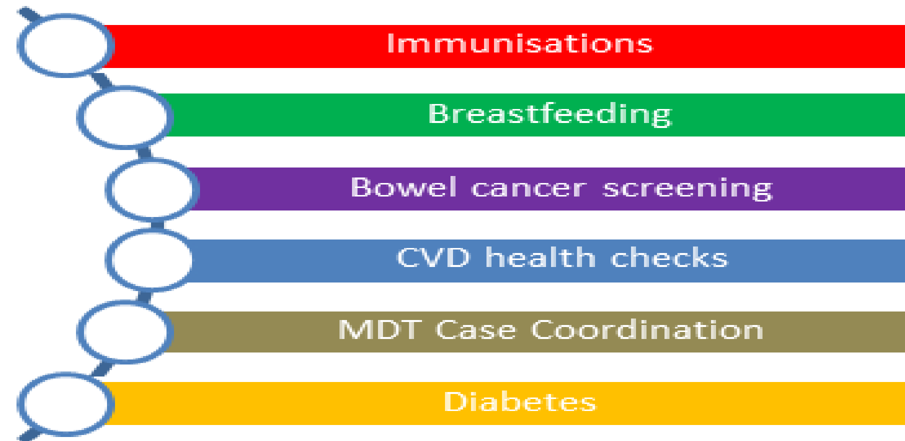
The input from our patient participation groups, South Reading Patient Voice, HealthWatch and patients though our various conferences and events , continues to be invaluable, and has helped shape and direct our decision making at local level. I would like to reflect on some of the key messages from our recent "Call to Action Event"

> ***"We would like to see more preventative, self-care and education for patients"***
> ***"We would welcome more valuable and vital contributions to be made with the Voluntary Sector"***
> ***"We would support earlier and better understanding of physical and mental health issues"***
> ***and a resounding message "To keep our care as local as possible".***

We shall endeavour to keep listening to our patients, working together with our partner organisations, including the voluntary sector to deliver services that patients want and we can all be proud to be a part of.

Dr Elizabeth Johnson
Chair South Reading Clinical Commissioning Group

Our Key Local Achievements - 2013-2014



Immunisations - We have immunised 1264 children with year 1 immunisations, including specific targeting of children who have been particularly hard to reach. Through collaborative working between our GP practices and health visitors, we have successfully targeted our hard to reach children , ensuring that as many as possible have received their year 1 immunisations This innovative model has recently been adopted by our colleagues in NHS England for a National MMR catch up campaign in our 10 to 16 year olds.

Breast Feeding - We have increased breastfeeding uptake meeting our target of 54%

Bowel Cancer Screening - We have initiated a programme to increase uptake of bowel cancer screening by personally writing to eligible patients

CVD Health Checks - We worked jointly with Reading Public Health in offering preventive health checks to adults aged 40-74 who are at risk of developing vascular disease, followed by appropriate medical management and lifestyle interventions, in line with one of our local priorities. We have carried out 1741 CVD Health checks between April 2013 and December 2013.

MDT / Case Coordination - We have worked with Berkshire Healthcare Foundation Trust (BHFT) and a range of other partner organisations, to develop an integrated model of care, with a key focus on Case Management based upon a Multi-Disciplinary Team (MDT) case review, for the identification and case management of patients identified as seriously ill or at risk of emergency hospital admission.

Diabetes - The aim of our work on diabetes has been to prevent people at greatest risk from developing diabetes. As of March 2014 47.14% of our Diabetics have received care through the 9 care processes- enabling patients to proactively manage their diabetes alongside their GP's care, manage their condition with a self-management plan and support of a multi-disciplinary team.

Our Key Berkshire Wide Achievements – 2013-2014

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 A&E 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 an Exacerbation Assessment Service
- Implemented a COPD Discharge Care Bundle
- Tele-monitoring of patients using an automated telephone messaging service
- Increasing Pulmonary Rehabilitation provision
- Identification of health and social care initiaitves against the Better Care Fund:
    - **24/7 Services** – across community and social care
    - **Time to Decide Beds –** supporting patients leaving acute care
    - **Health HUB** – a single entry point (SPE) for reablement, crisis care, hospital or care home admission avoidance
    - **Clinical system interoperability –** joing up health and social care clinical systems
    - **Nursing & Care Homes** – GP support to registered nursing and care home residents via MDT
    - **Hospital at Home service-** providing more intensive support for short periods of time to patients in the community under the care of a consultant led team.

Developing the Two Year Operational Plan – 2014-2016

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

The Seven Improving Outcome Ambitions

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

All our programmes, both at local CCG level and through collaborative programmes across Berkshire West help support the achievement of the desired health outcomes.

Various sources of Outcomes data are available to the CCG to help inform our planning priorities for 14/15 and beyond. These include:

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

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

Patients' Rights – The NHS Constitution

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)**

Key Areas of Particular Focus:

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 is being established to drive improvement and address issues along the pathway. A trajectory is in place to ensure performance improves during 2014/15.

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.

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.

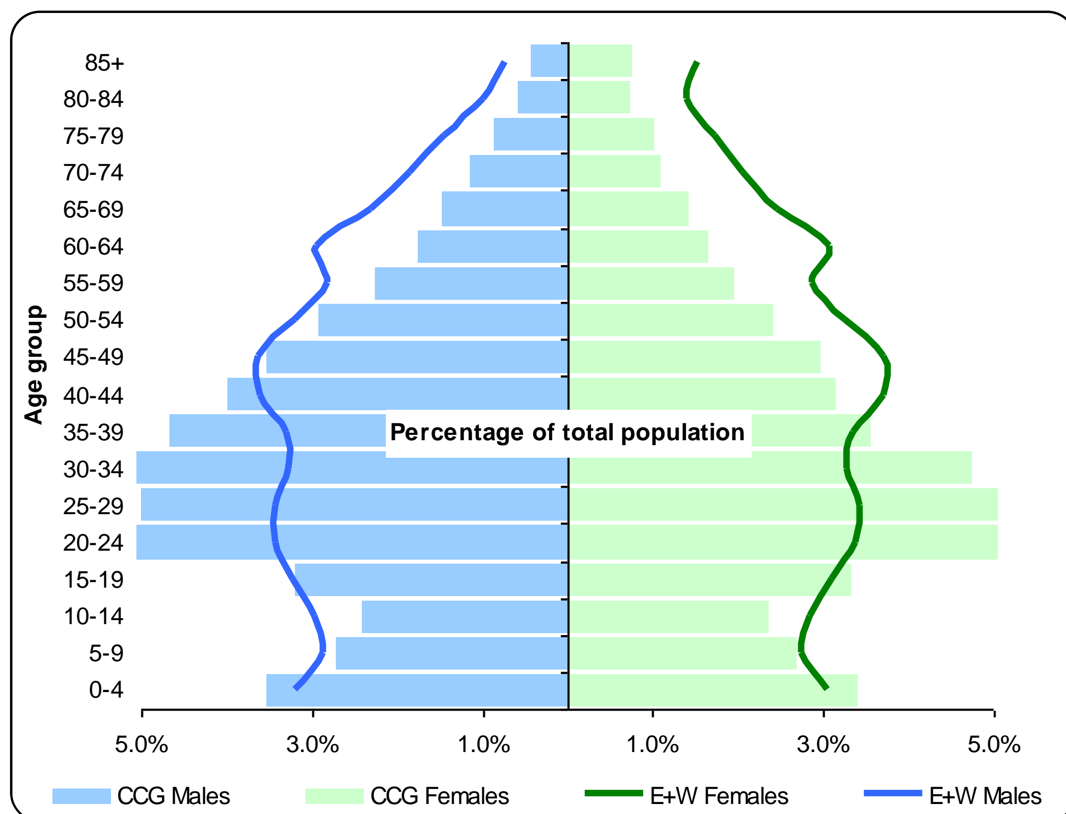
Ambulance Handovers:
South Central Ambulance Service (SCAS) work with RBFT and other acute providers to agree an annual handover plan which all parties sign up to. This plan covers the process and management of handovers between both parties in order to reduce any delays and ensure continuity of care 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.

The Health Needs of our Population

The Population:

The 2011 ONS Census reported that the resident population for the South Reading CCG locality is 105,782. The population profile is younger than the national and regional average. There are a higher proportion of young children and adults under 44, while the proportion of adults over 60 is much lower. The registered population is higher at 128,033. This discrepancy will be made up of people who live outside of the CCG boundary.

The figure below shows the registered population profile of South Reading CCG compared with the national profile:



Age Group	Male	Female	People
0-4	4509	4356	8865
5-9	3484	3459	6943
10-14	3086	3038	6124
15-19	4088	4271	8359
20-24	7159	7561	14720
25-29	6406	6870	13276
30-34	6963	6083	13046
35-39	5966	4556	10522
40-44	5099	4020	9119
45-49	4504	3810	8314
50-54	3731	3087	6818
55-59	2894	2487	5381
60-64	2257	2100	4357
65-69	1894	1836	3730
70-74	1452	1412	2864
75-79	1109	1292	2401
80-84	739	934	1673
85+	548	973	1521
Total	**65,888**	**62,145**	**128,033**

Focus on Children

Reading has a higher-than-England-average proportion of young people not in employment, education or training and also looked after children. There were nearly 60/10,000 of our children subject to a child protection plan in 2011, a rate that is far higher than the rest of England or the South East region;

Reading has relatively high rate of teenage pregnancy;
Low child immunisation numbers in Reading mean children are at higher risk of avoidable, fatal, childhood diseases;
Reading stood at 5.7 per 1000 live births while child mortality rate was 0.81 per 100,000 - rates which exceed the regional averages.

There is already much joint working between health agencies and Reading Borough Council's early help services. Health Visitors (currently commissioned by NHS England) are a virtual 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.

During the summer of 2013, the Chairs and Managers of both CCGs and the Director of Public Health have toured a number of children's centres and met with children's centre and Reading Borough Council managers to identify opportunities for increased joint working and further integration to improve health outcomes for children and families. From these visits a number of opportunities were identified. A Children's working group, with dedicated health and local authority project support, is currently working towards implementing 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

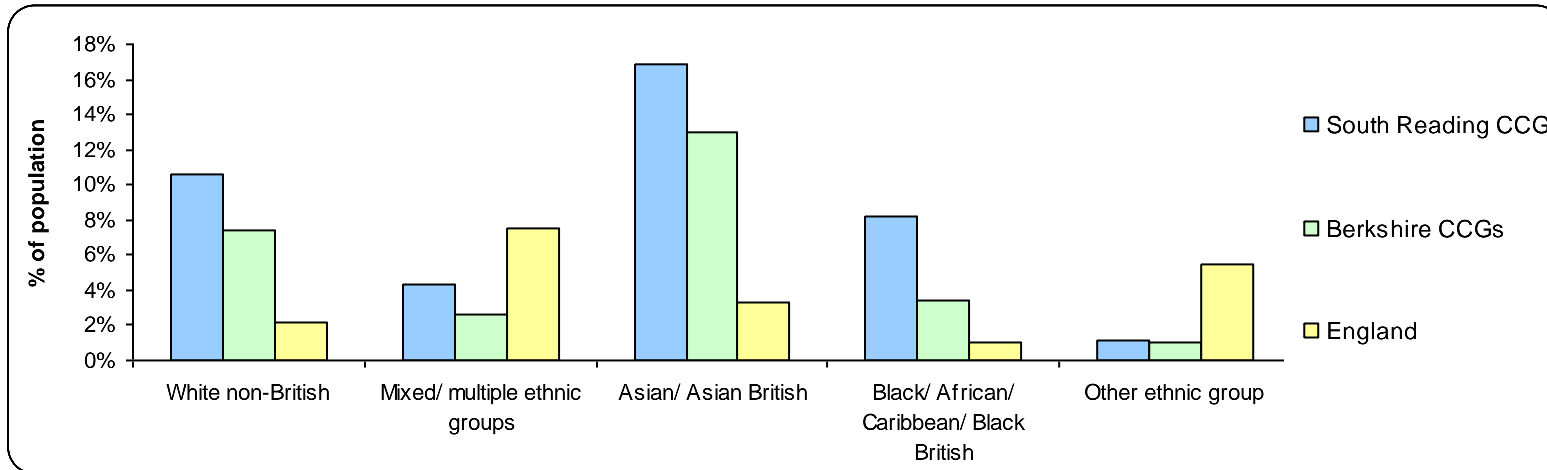
South Reading has the highest A&E attendances in the Berkshire West locality. Although this is a problem faced by CCGs nationally, we have identified a particular problem with high numbers of paediatric attendances. A review of the data suggests that it is after school and early evening that sees the highest attendances. We have begun work with Reading Borough Council and Berkshire Healthcare Foundation Trust to better utilise the locality's Children's Centres. The work aims to raise the profile of the Children's Centres within GP practices through better communication and is exploring the co-location of clinical staff to provide 'one stop shops' for families by offering minor illness advice and guidance. We intend to use the newly purchased television screens to promote this work.

We have created strong relationships with our A&E department. Consultant colleagues have provided a clinical training day for our GPs and nurses in new paediatric pathways. We have also part funded a Reading Borough Council owned health bus (First Stop Bus) to provide first aid and minor injury treatments in Reading town centre at the evenings on weekends and promotional public health messages during the week. The bus launched in December 2013 and we will continue to work with the Local Authority and providers to identify innovative ways to utilise the bus during the week and assess its impact on the A&E department at weekends.
We will continue to work collaboratively via the Urgent Care Programme Board.

Ethnicity

The 2011 census shows that 30.5% of the resident population of South Reading CCG is from a Black and Minority Ethnic (BME) group. An additional 10.6% are from a White non-British background, such as White Irish, Gypsy, Irish Traveller or European.

Ethnicity breakdown for the non White-British resident population of South Reading CCG (ONS Census 2011)



- 31,203 (29.5%) of the resident population were born outside of the UK and 5,984 (6.7%) have been resident in the UK for less than 2 years.

Deprivation

The Index of Multiple Deprivation (IMD) combines a number of indicators to measure the level of deprivation in an area. These cover seven different domains, including crime, health deprivation and disability, employment, education, skills and training, barriers to housing and services and living environment. The IMD enables neighbourhoods, or Super Output Areas (LSOAs), to be ranked against each other according to their level of deprivation. Each LSOA covers a population of 1000-3000 people and an area with a higher IMD score will be more deprived than another.

- The most deprived areas within the CCG boundary are specific neighbourhoods in Whitley, Church, Norcot and Redlands wards. These are amongst the 20% most deprived areas of the country.

We will work together to tackle health inequalities, which is illustrated most strongly by the differences in life expectancy of people seen within Reading. Life Expectancy at birth for reading males is 78.4 years and 82.9 years for Females. This is lower than seen in the rest of Berkshire West. The causes of death that contribute most to the gap in life expectancy at birth between the least and most deprived areas vary for males and females as well as varying between the 3 local authority areas. However cardiovascular disease (including stroke and CHD), cancer, respiratory disease and digestive disease (including liver disease) account for

between 48% and 78% of the gap in life expectancy. We also recognise that life expectancy may also be adversely affected by serious mental illness, substance misuse and depressive episodes and similarly that those with physical health conditions have a much greater risk of also developing mental health problems.

We will work with Public Health teams in local authorities to develop the most cost effective and appropriate interventions to prevent premature mortality and decrease the gap in life expectancy. Key areas of activity are outlined in the 'Improvement Health Outcomes –Local Areas of Focus (below page 22).

Health Behaviours & Lifestyle:

Smoking:

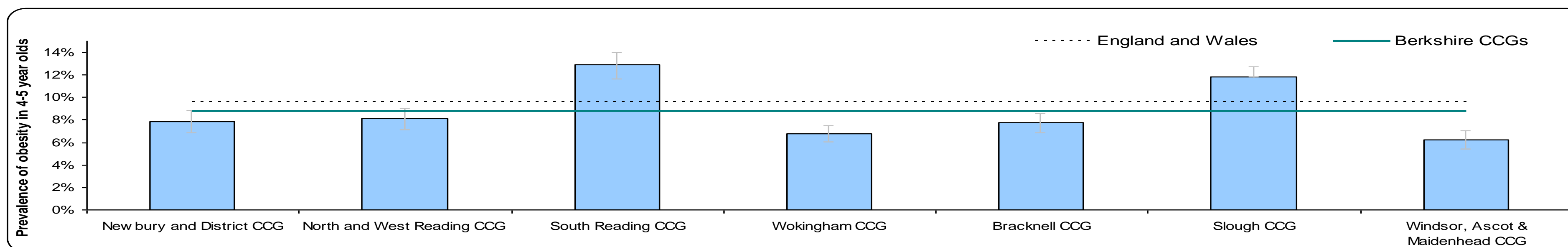
Smoking is the single most important cause of preventable morbidity and premature death in England, as well as the primary reason for the gap in healthy life expectancy between rich and poor (NICE 2008). A wide range of diseases and conditions and caused by smoking, such as cancers, respiratory diseases and cardiovascular diseases.

In the latest GP Survey (2012/13), people were asked to comment on their smoking habits. This survey was completed by 2,237 patients from South Reading CCG and 12,755 across the whole of Berkshire. 59% of people who responded to the survey said that they never smoked, while 20% were either occasional or regular smokers.

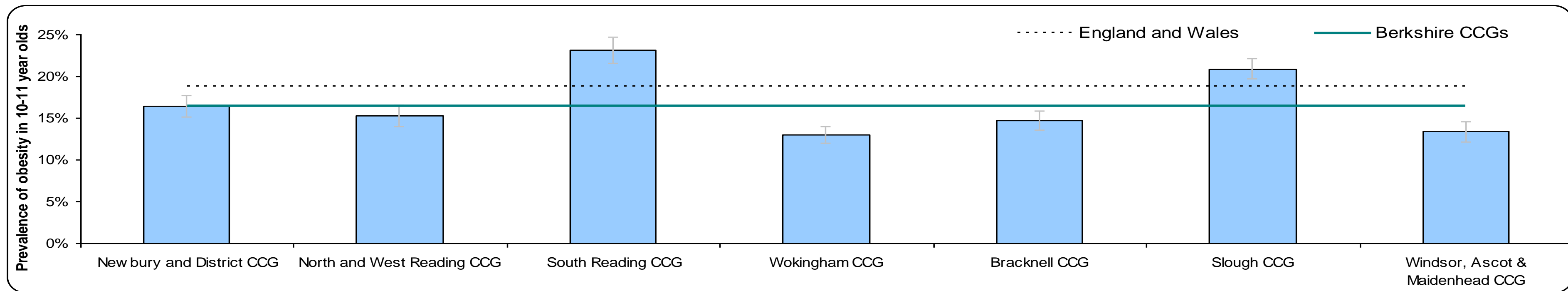
Obesity:

12.9% of children aged 4-5 and 23.2% of children aged 10-11 are obese.

Obesity prevalence for children aged 4 to 5 years old, 2008/09 to 2010/11 (NCMP, NHS Information Centre)



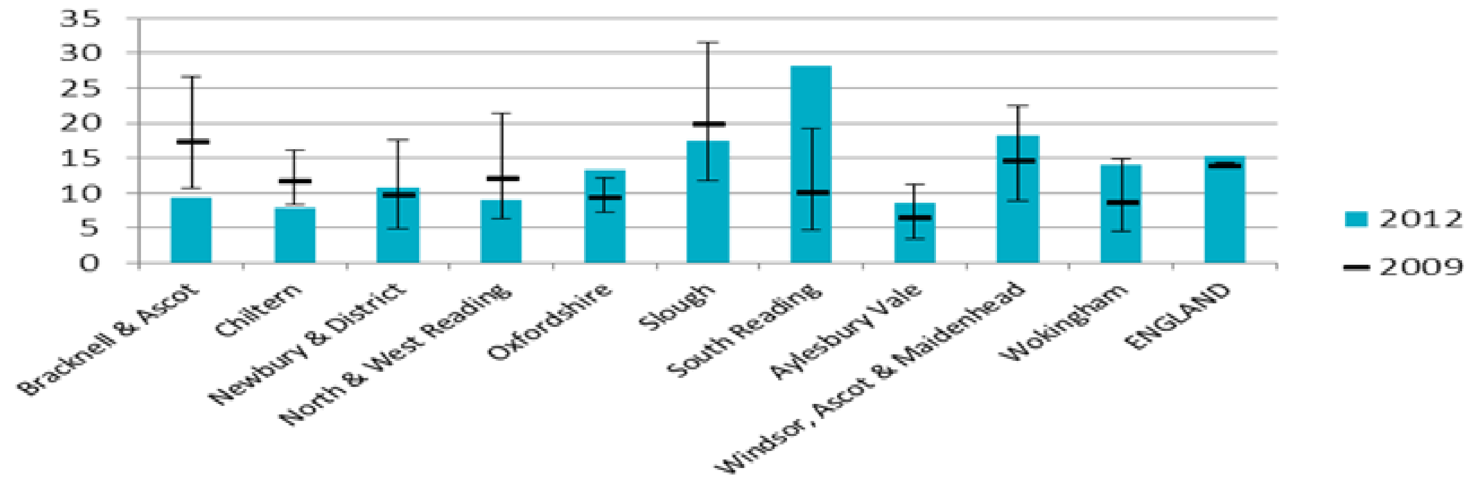
Obesity prevalence for children aged 10 to 11 years old, 2008/09 to 2010/11 (NCMP, NHS Information Centre)

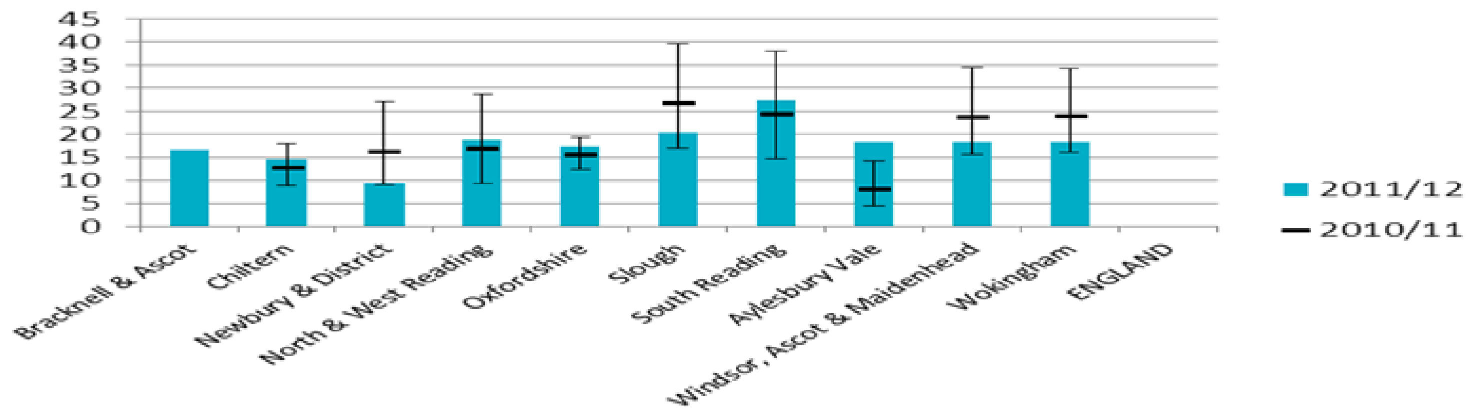


- Obesity: 9,317 people aged 16 and over are on the CCG's Obesity Register (9% of population).
- Health eating: Neighbourhoods in the Church and Whitley wards have the lowest proportion of healthy eaters in the CCG area (20% and 20.4% respectively).

Alcohol:

Binge drinking: 29.3% of people who live in an area of the Redlands ward are defined as binge drinkers.


Under 75 mortality from liver disease
35
30
25
20
15
10
5
0
Bracknell & Ascot
Chiltern
Newbury & District
North & West Reading
Oxfordshire
Slough
South Reading
Aylesbury Vale
Windsor, Ascot & Maidenhead
Wokingham
ENGLAND
2012
2009


Emergency admissions for alcohol related liver disease
45
40
35
30
25
20
15
10
5
0
Bracknell & Ascot
Chiltern
Newbury & District
North & West Reading
Oxfordshire
Slough
South Reading
Aylesbury Vale
Windsor, Ascot & Maidenhead
Wokingham
ENGLAND
2011/12
2010/11

Based on our findings we have identified Five Clinical Areas of Focus specific to South Reading for 2014-2016

1. **Diabetes**

The Quality and Outcomes Framework for 2011/12 shows

Number of people on Diabetes Register (17+)	4,451
Prevalence in CCG area	4.4%

Figures from the Diabetes Prevalence Model (2012) suggest that there are an additional 6,643 adults with undiagnosed diabetes living in the South Reading CCG area.

Diabetes is one of the key local priorities across all four Berkshire West CCGs and is driven by a Diabetes network who reports through the Long Term Conditions Programme Board. People with diabetes are more likely to have a myocardial infection, stroke or a heart admission related to heart failure than the general population. The number of Reading residents living with diabetes is expected to rise year-on-year and although deaths from diabetes are not as common as from other long-term conditions its complications and effect on quality of life, if not properly managed, can be catastrophic. It is also estimated that nearly 1 in 5 cases still remain undiagnosed.

Improving the quality of care for patients with Endocrine disease has been highlighted as an area of focus from the Commissioning For Value Insight pack for South Reading CCG. Our JSNA also highlights specifically that the Diabetes 9 care processes as an area still requiring further work. We have made significant investment in 13/14 into diabetes care and will continue to increase our effort to improve care for people with Diabetes, keeping them out of hospital. We also want to expand our focus on care planning in Diabetes in 2014/15 and have chosen this as our local quality premium.
During 2009-2011, there were 237 emergency admissions for Diabetes in South Reading CCG. 54% of these admissions were for women and 46% were for men. South Reading CCG’s admission rate was higher than the Berkshire average.

2. **Respiratory Disease (COPD)**

South Reading CCG (2012 data) is in the poorest performing quartile for mortality in the under 75 year olds due to Respiratory Disease. Further analysis identities our higher than average rate of admission for Chronic Obstructive Pulmonary Disease (COPD) and a higher rate of modelled prevalence of this condition in the Reading Area.

Number of people on COPD Register	1,127
Prevalence in CCG area	0.87%

During 2009-2011 there were 3,194 emergency admissions for respiratory disease in South Reading, accounting for 14% of all emergency admissions over that time.

In 2013/14 we introduced an Exacerbation Assessment service, enabling rapid outpatient assessment of a patient, avoiding admission. Telemonitoring continues to be expanded using an automated telephone messaging service. In addition we have invested in increased Pulmonary Rehabilitation provision. We are currently looking to find new ways in which we can improve the diagnosis of this condition to help better support patients. This has included a redesign of patient pathways to provide quicker access to necessary medication when needed. We also plan to improve the training and guidelines locally available to health professionals ensuring every patient has access to spiromtery testing. We will continue to encourage and support our population to stop smoking and hence reduce the likelihood of them developing COPD.

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. 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 new Mental Health Outcomes Framework was published in 2011, which aims to provide better mental health for all and to increase the numbers of people recovering from mental illness. The NHS Outcomes Framework 2012/13 also contains three improvement areas relating specifically to mental health, which includes premature mortality in people with serious mental illness, employment of people with mental illness and patient experience of community mental health services.

Number of People on Mental Health Register	
(Schizophrenia, bipolar or psychosis):	984
Prevalence in CCG area:	0.8%
Number of people on Depression Register (aged 18+):	8,641
Prevalence in CCG area:	8.8%

During 2009-2011 there were 743 admissions for mental or behavioural disorders of which 268 were for people with Psychoses, a rate higher than the Berkshire average.

Within our (Children, mental health, maternity and voluntary sector) CMMV Programme Board we have identified the following aspirations:

- To improve the mental health and wellbeing of our population through early intervention and focus on a good start in life
- To improve outcomes and quality of life for people with mental health problems and learning disabilities through high quality

services and equality of access

- To improve the physical health of people with mental health problems and learning disabilities
- To ensure that more people have a positive experience of care and support
- To review the relevant outcome measures for mental health across the three outcomes frameworks

4. Alcoholic Liver Disease

We have identified above that South Reading CCG has a higher than national average level of deaths in our under 75 year olds attributable to alcoholic liver disease, as well as a higher than average rate of emergency admissions. Both of these indicators are higher than all other CCGs within Berkshire. An estimated 21% of the population aged over 18 years in Reading are increasing-risk alcohol drinkers, and there has been an higher than average level of alcohol related crime

We have identified a local GP who will help drive improvements in this area and plan to explore a variety of methods to increase referrals to our local drug and alcohol teams to support patients requiring help with alcohol problems. We will alongside our partners including public health and the voluntary sector to promote and support patients in making lifestyle changes. We have recently started work with our local hospital liver consultant to improve the current alcoholic liver disease pathway across community and secondary care.

5. Obesity

As we have seen above South Reading has a high number of obese children under the age of 11, with 405 between the ages of 4 and 5 rising to 613 between 10 and 11 years of age. Only 1 in 10 Reading residents achieve the recommended 5 sessions per week of 30-minutes sport/active recreation; more primary school children in Reading walk to school than do so nationally, but secondary school age children often have to travel further to school and have fewer opportunities to get regular exercise by walking there.

Obesity increases the risk of heart disease, diabetes, stroke, depression, bone disease and joint problems and decreases life expectancy by up to nine years. South Reading CCG area has an obesity prevalence rate of 9.0% in the aged 16+ registered population. This is approximately 9,317 people. This prevalence rate is slightly higher than both the Berkshire CCG area of 8.9%, but lower than the national prevalence rate of 10.7%.

We will jointly with North & West Reading CCG and Reading Unitary Authority promote targeted multigenerational exercise throughout the community in a scheme known locally as the “Beat the Street” campaign. 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 by referring to dieticians and referring to the eat4Health Programme. We will aim to learn from others in England who have had successful programmes introduced and improve awareness of the services that are available locally. Healthy eating messages will be incorporated alongside immunisation programmes and during other early year’s contacts. An obesity strategy is currently under development locally led by Public Health.

Listening to our Patients and the Public

We will continue to talk and listen to our local community and work with patients and the public so we can ensure we are doing the best we can to improve the health and wellbeing of the people we serve. We want to continue to involve our local community in commissioning care and work with them to improve the health and wellbeing of Reading residents. We have established a number of ways of capturing feedback and plan to develop these going forward. The recently published "*Transforming Participation in Health and Care, Guidance for Commissioners"* will enable us to identify a range of ways by which we can fulfil our statutory duties and seize the opportunity to deliver personalised and responsive care to all.

Call to Action

We are rolling out a sustained programme of engagement with the public under the banner of the NHS 'Call to Action' campaign. A series of events began in late 2013 and will continue during 2014, with a focus on engaging the widest possible audience of patients, carers, staff and other stakeholders and asking for their views on the future of the NHS. As we go forward with the 'Call to Action' programme, we plan to spread the net of engagement much wider than traditional audience for such events. We have plans to use a wide range of innovative communications techniques including video, graphics and social media to encourage active participation in the debate from every possible demographic sector – children and young people, the working population and hard to reach groups. Our aim will be to ensure that all our local engagement activity is coordinated, accessible and appealing across our entire demographic.

Our first Call to Action event had two goals: to help determine the direction of the NHS with a rising elderly population and to provide input into our local priorities. Seventy members attended. Their responses showed a desire to see a more joined-up health and social care service, using the skills and expertise of the voluntary sector to full effect. They also want to see more of a focus on keeping people well and preventing ill health. Importantly they want to see all of this in the context of keeping the NHS free, for the most part, at the point of use and not ceding state control of the health service to the commercial sector. The session also demonstrated that the attendees are not averse to innovation and new ways of thinking about the future NHS.

As part of the session, the public were asked specifically for their views on our priorities for 2014/16. Here is a summary of the key points, which will be fed into future commissioning discussions:

Physical Exercise	GPs need to offer access to exercise and information on the benefits of exercise as a routine alternative. 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.
Children	Early intervention is most important and families of children not having immunisations should be targeted. Increased levels of autism and self-harm should be addressed in future plans. More help for mothers to help their children, more help for young fathers and more use of health visitors, perhaps for longer periods (as in New Zealand). Health promotion and promotion of healthy eating is needed by families in deprived localities. Improve the use of the voluntary sector for helping to intervene with families.
Frail & Elderly	More integration of health and social care, more self-care, and more funding put into preventative care. The patient should be in control and healthcare professionals should have access to the same information (preferably using the same IT system) and for complex care to be better co-ordinated.
Mental Health	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. It is important to maintain effective links between health and education with messages in schools including the importance of the maintenance of mental wellbeing as well as focusing on the importance of healthy eating and physical activity. Talking Therapies needs to be more available to the elderly and Black, Minority, Ethnic (BME) patients. Young people also needed more help and earlier.
Respiratory	There should be more dietician input for BME groups, more advice on the benefits of physical exercise and more health promotion and education.
Diabetes	More evidence of health screening, preventative healthcare and education in future plans. Better, more consistent communication of health messages from GP surgeries and the same communication methods should be used by all.

Our Strategic Long Term Vision to 2019

South 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.

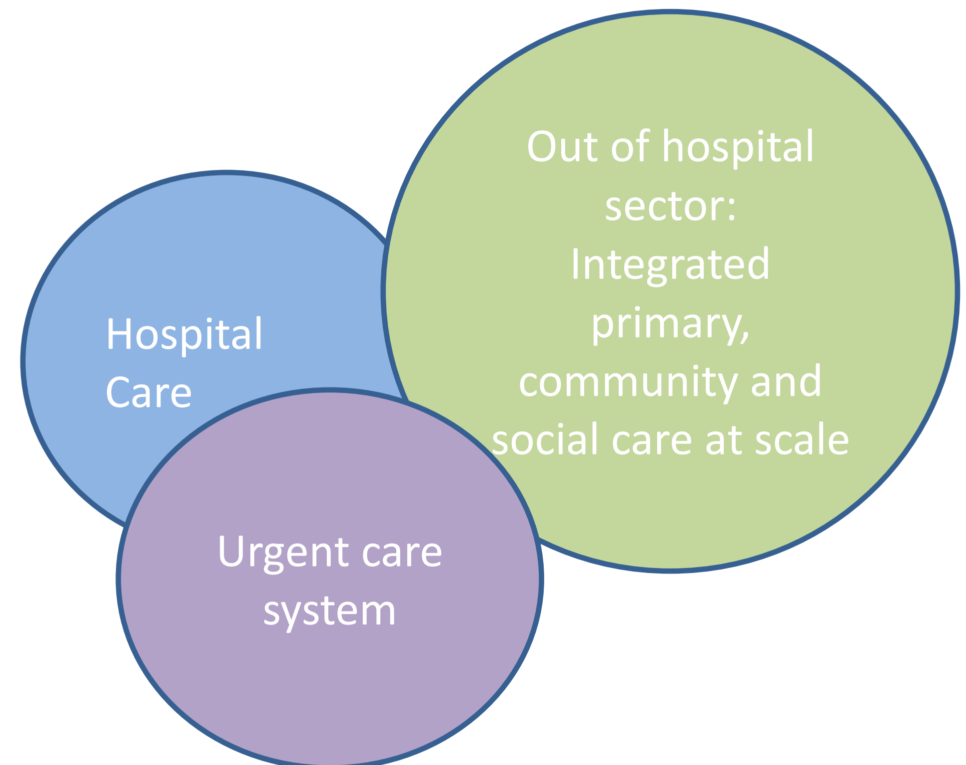
This "unit of planning "was endorsed by the Reading Health and Wellbeing Board.

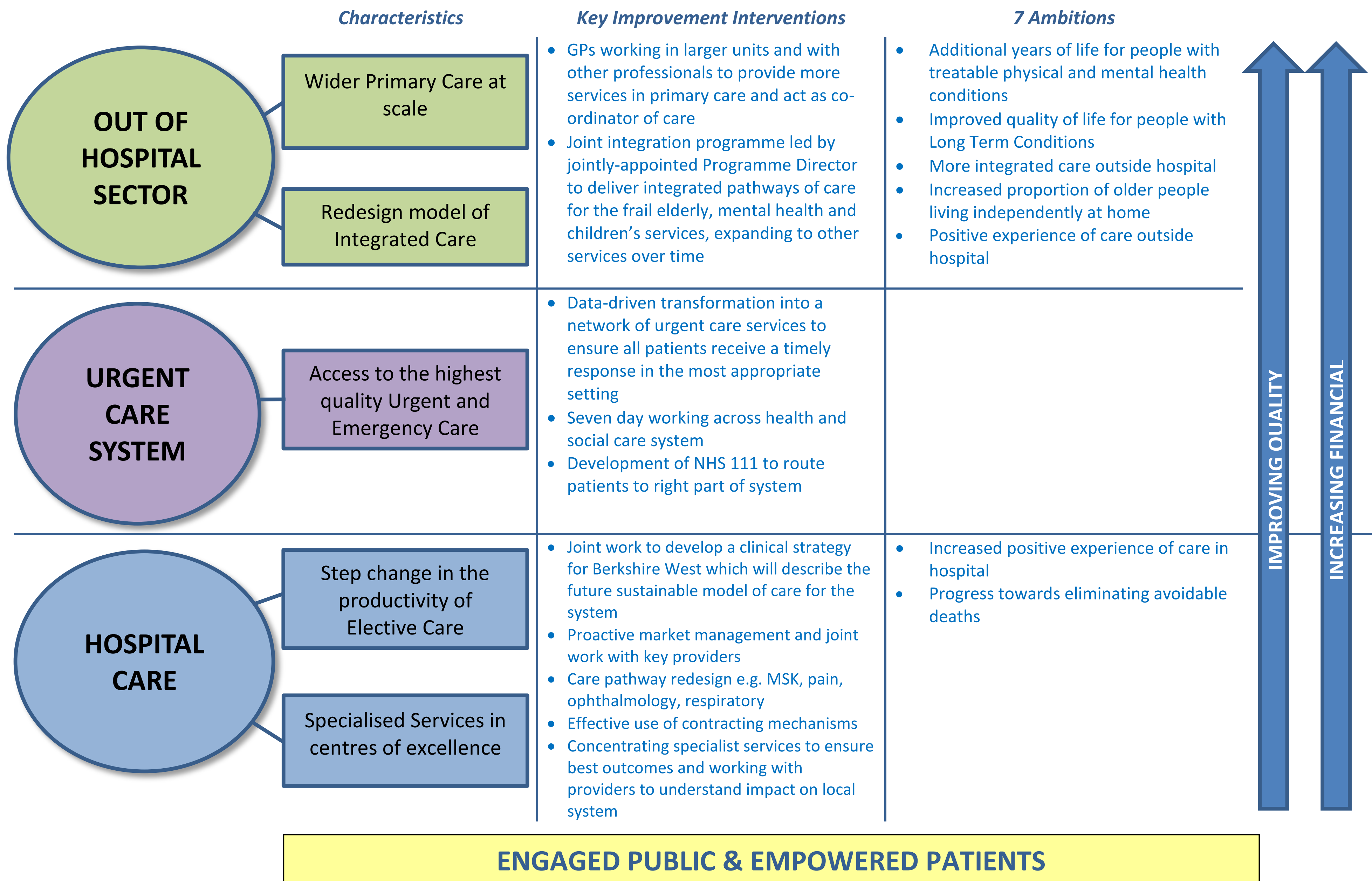
By 2019, enhanced primary, community and social care services in Berkshire West will work together to prevent ill-health and support patients with much more complex needs at home and in the community. Service users will be supported to take more responsibility for their health and wellbeing and to make 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.

Our plan aligns to the characteristics of high quality and sustainable health system that NHS England has identified (Known as the Six Characteristics).





Characteristics
Key Improvement Interventions
7 Ambitions
OUT OF HOSPITAL SECTOR
Wider Primary Care at scale
Redesign model of Integrated Care
• GPs working in larger units and with other professionals to provide more services in primary care and act as co-ordinator of care
• Joint integration programme led by jointly-appointed Programme Director to deliver integrated pathways of care for the frail elderly, mental health and children's services, expanding to other services over time
• Additional years of life for people with treatable physical and mental health conditions
• Improved quality of life for people with Long Term Conditions
• More integrated care outside hospital
• Increased proportion of older people living independently at home
• Positive experience of care outside hospital
URGENT CARE SYSTEM
Access to the highest quality Urgent and Emergency Care
• Data-driven transformation into a network of urgent care services to ensure all patients receive a timely response in the most appropriate setting
• Seven day working across health and social care system
• Development of NHS 111 to route patients to right part of system
HOSPITAL CARE
Step change in the productivity of Elective Care
Specialised Services in centres of excellence
• Joint work to develop a clinical strategy for Berkshire West which will describe the future sustainable model of care for the system
• Proactive market management and joint work with key providers
• Care pathway redesign e.g. MSK, pain, ophthalmology, respiratory
• Effective use of contracting mechanisms
• Concentrating specialist services to ensure best outcomes and working with providers to understand impact on local system
• Increased positive experience of care in hospital
• Progress towards eliminating avoidable deaths
IMPROVING QUALITY
INCREASING FINANCIAL
ENGAGED PUBLIC & EMPOWERED PATIENTS

Our Local Areas of Focus 2014-2016

Delivery of our vision 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.

The table below provides a summary of the **key areas of focus throughout** 2014-2016 and how these align to the Seven Outcomes Ambitions. Further detail is found in Appendix 2.

Ambition	Supporting Health Outcome Ambitions
Hospital at Home	**Outcome 3** - Reducing the Amount of Time People Spend Avoidably in Hospital Through Better and More Integrated Care in the Community Outside of Hospital
Care Home Initiative	**Outcome 3** - Reducing the Amount of Time People Spend Avoidably in Hospital Through Better and More Integrated Care in the Community Outside of Hospital
Integrated Eye Service	**Outcome 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
Musculoskeletal Services	**Outcome 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

Hospital at Home (Potential net saving 14/15 of £1,438,000)

This model within the LTC programme board of work 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 and will help to reduce emergency admissions. This scheme is also featured within the **Better Care Fund** plans for the three local authority areas across Berkshire West **(see Better Care Fund page 33)** as the integration of services across health and social care are seen as an essential success criteria.

Care Home Initiative (Potential Net saving in 14/15 £520,000)

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 and will help to reduce

emergency admissions. This scheme is also featured within the **Better Care Fund** plans for the three local authority areas across Berkshire West **(see Better Care Fund page 33)** as the integration of services across health and social care are seen as an essential success criteria.

Integrated Eye Service (Potential Net Saving in 14/15 £500,000)

The overall aim of this intervention is to deliver more effective commissioning of an integrated ophthalmology service, ensuring consistency and reducing clinical variation. The intervention will result in overall cost savings through a reduced tariff. Patients will benefit from pathway improvements.

MSK Service Redesign (Potential Net Savings in 14/15 £427,000)

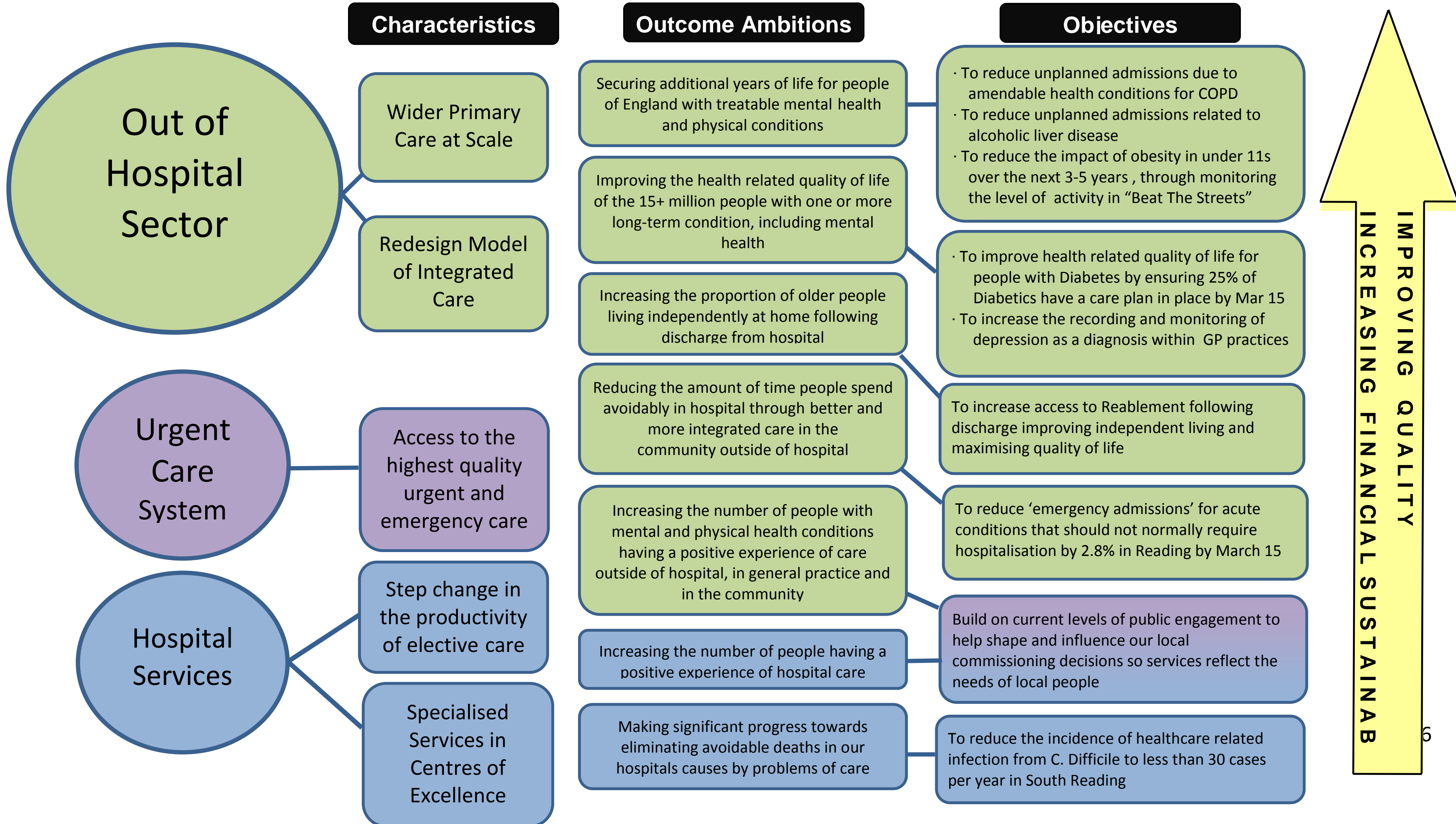
This intervention expands the focus on pathway improvement for MSK services. It will include an expansion of the current shared decision-making scheme (SDM) in primary care ensuring that SDM applies to all the selected pathways and with all relevant providers. This will incorporate the ongoing review 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. 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.

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

- A 16**.2%** reduction in the potential years of life lost from conditions which can be treated over the next 5 years
- An increase in the proportion of patients who say they feel supported to manage their long-term condition from **77.2%** to **78.3%** in 2 years
- A **2.8%** reduction in unplanned admissions to hospital in 2014/15
- A **0.7%** reduction in the number of patients reporting poor experience of inpatient care in 5 years to maintain our position as one of the best in the country
- A **28.6%** reduction in the number of patients reporting poor experience of primary care in 5 years
- **15%** of people with anxiety and/or depression will receive psychological therapies in 2015/16
- **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.

South Reading CCG – Plan on a Page 2014-2016



Delivering High Quality Sustainable Health Care

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

1. 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
2. Wider primary care, provided at scale
3. A modern model of integrated care
4. Access to the highest quality urgent and emergency care
5. A step change in the productivity of elective care
6. Specialised services concentrated in centres of excellence

1. Engagement with Out Patients, the Public and Other Stakeholders

Working with GP Practices

Improving services and patient quality is the prime motivation for our GPs getting involved in commissioning to enable a change in how we operate and work with our partner organisations. The Council of Practices, represented by a GP and Practice Manager from each of our twenty practices within the CCG, is a strong and interactive body, which ensures the commissioning group reflects all GP practices in the locality.

The aim of the Council of Practices is to ensure that there is a mechanism to reflect all GP practice views, review decisions of the governing body and to help set the CCG priorities from the bottom-up.

In 2013 we 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 intend to work with the Central Southern Commissioning Support Unit to develop a communications strategy to enable full use of our redesigned website and Twitter feed to highlight our key objectives over the next two years, so that we provide consistent and targeted messages to our patients.

Working with our Partner Organisations

Providers of Hospital and Community Services

Each of the CCGs within Berkshire West, supported by the commissioning support unit, has an identified a clinical lead for one of the main providers (hospital, community and other services). South Reading CCG has the lead responsibility for the Berkshire Healthcare Foundation Trust contract (community & mental health services).

With each provider we will:

- Develop contracting strategies which deliver according to need, but also create long term sustainability via innovation, pathway restructuring, advanced cost management, risk management/business continuity
- Ensure Provider Performance is evaluated encompassing:
- Structured process, with agreed goals and quality initiatives
- Specific, transparent measures and process understood by the providers

- Patients/Users actively involved in shaping care
- Regular formal feedback sessions on current performance and further improvement
- “Voice of the provider” solicited for a balanced, two-way view of performance
- Identify and manage joint improvements efforts with the providers
- Offers Patient Choice - We promote the use of the Choose and Book system and have ensured that as many providers, including the independent sector and primary care services are published on the Directory of Services. This supports the offer of choice at the point of referral

Reading Borough Council and the Health & Well Being Board

As a key member of the Reading Health & Wellbeing board, we will share responsibility for providing leadership to the local health and social care services. We will continue to develop our relationships with Reading Borough Council, in particular promoting the Integrated Care agenda. Work is already underway to identify options for integrated care.

Voluntary Sector

We have invested in partnership development , with the voluntary sector, who will support and help introduce initiatives which will support our overall aim of providing care at the right place, at the right time and appropriate to the patient’s needs, whilst promoting self-care and independence.

Local Area Team

We will work in close collaboration with the local area team to support the development of primary care services as well as providing direct support within practice to enable programmes of work to be successfully implemented. Examples include the provision of care co-ordinators to work alongside district nurses and practices, a variety of software tools, dementia advisers, diabetic specialist nurses and community geriatricians to offer advice and support when necessary.

Direct Commissioning (NHS England) Public Health

Responsibility for the direct commissioning of Section 7A services sits within NHS England Public Health Area Team local area team. This includes screening programmes for adults and children (cancer and non-cancer), immunisations, Health Visiting Services, Family Nurse Partnerships Schemes and child health information. As many of these services are currently delivered within primary care and carry a high importance in helping to address health inequalities in our local CCG area, it is important we have clear communications routes and jointly plan to have maximal impact for our local populations. We recognise the need to jointly develop and implement different and innovative models of care that utilises a wider range of health professionals and recognise the importance of reliable data sharing across all sectors. Optimising the benefits for 7 day working and extended primary care opening hours will be of high importance in delivering local

solutions. The CGG will continue to work closely with public health NHS England to ensure our local providers are committed to delivering the public health initiatives.

Listening to the Public

We will continue to talk and listen to our local community and work with patients and the public so we can ensure we are doing the best we can to improve the health and wellbeing of the people we serve. We want to continue to involve our local community in commissioning care and work with them to improve the health and wellbeing of Reading residents.

We are developing a 'Plan on a Page' for Patient Engagement which includes Participation Groups (PPGs) based within GP practices, to help us engage with patients at practice level. We encourage PPGs to have an input into the commissioning cycle and to contribute to engagement events. Each GP practice within the CCG has or is developing **Patient Participation Groups** which are essential for enabling members of the community to have an active voice in shaping local health and social care services.

We also work closely with the **South Reading Patient Voice,** which enables patients to input into commissioning decisions.

Our engagement with PPGs and Patient Voice happens through face to face meetings and electronically. These engagement channels have enabled us to close the 'feedback loop' by producing a 'You Said We Did' section for our website, which we will continue to develop in the next two years.

We will continue to build on the strong links we have already made with **Healthwatch Reading**, the local consumer champion for health and social care. It gives 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 Reading people experience the quality of all aspects of the care they receive.

We are supporting Healthwatch Reading in their project to further develop PPG groups in GP surgeries across South Reading. The project intends to network the groups more closely to South Reading Patient Voice and Healthwatch Reading by:

- Supporting the enablement of a PPG or patient feedback mechanism in every GP surgery in Reading
- Developing a mechanism to share information and ideas across PPGs, Healthwatch and Patient Voices
- Identifying, collecting and sharing best practice in PPGs
- Developing a toolkit with support information for PPGs

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.

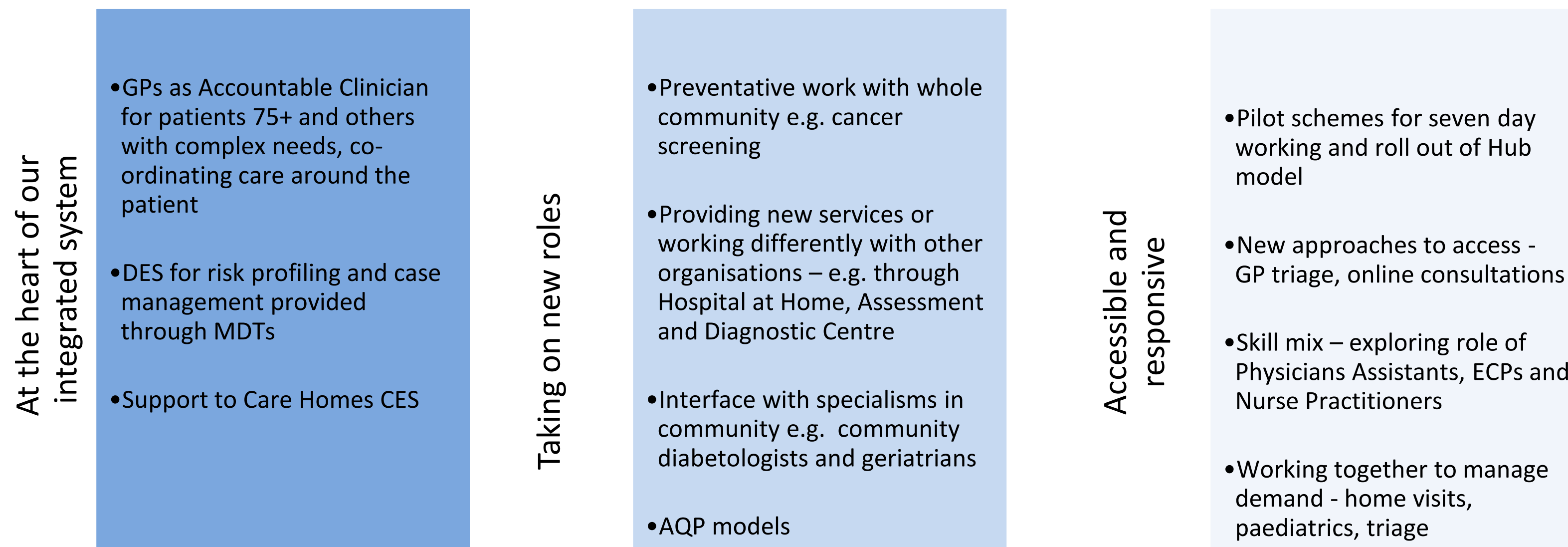
2. Wider Primary Care , Provided At Scale

It is anticipated that primary care will play a key role in delivering our vision to meet people's needs in the community wherever possible and the CCG will look to facilitate this through co-commissioning arrangements with NHS England. With 20 GP practices within South Reading, spread over 28 sites, we have has the largest number of GP practices per CCG within the whole of Berkshire. Practices vary considerably from a number of single handed GPs to large practices with several GP partners and also a general increasing trend to employ salaried GPs. 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. This will enable practices to better support the increasing numbers of patients who suffer from one or more long-term conditions.

Practices in South 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 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. Within South reading we are exploring a proposal to establish Five Hub practices across the geography, with NHS 111 being identified as a possible triage route into the hub system of appointments. It is proposed to consider at weekends splitting urgent and routine pre-bookable appointments on a 50:50 basis. The most important factor in designing and monitoring the expansion of GP services would be positive and measurable patient outcomes. The possibility of using technology such as Skype for appointments will also be considered.

Primary Care in Berkshire West



The diagram above sets out the key change programmes currently associated with primary care in Berkshire West. Practices may also start to co-operate in new ways with other provider organisations and other sectors of primary care e.g. community pharmacy, and to use innovative methods of contracting to support the development of these new service models.

3. Modern Model of Integration across Health and Social Care (Better Care Fund):

A meeting 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 in Reading between 2014-2016 are:

- **24/7 Services** – across community and social care
- **Time to Decide Beds –** supporting patients leaving acute care
- **Health HUB** – a single entry point (SPE) for reablement, crisis care, hospital or care home admission avoidance
- **Clinical system interoperability –** joing up health and social care clinical systems
- **Nursing & Care Homes** – GP support to registered nursing and care home residents via MDT
- **Hospital at Home service-** providing more intensive support for short periods of time to patients in the community under the care of a consultant led team.

4. Access to the Highest Quality Urgent & Emergency 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:

- Better Support for People with self-care
- Help for people with urgent care needs to get the right advice in the right place, first time
- Highly responsive urgent care services outside of hospital so people do not choose to queue in A&E4. 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
- 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 11 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.

5. A Step Change in Productivity of Elective Care (Planned 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 datapacks 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 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. Our strategy for the delivery of clinically effective affordable elective care will be directly informed by the outputs of these clinical pathway work streams of our Clinical Strategy programme. The focus of this programme to date has been on the Pain, Liver and Respiratory pathways, with the first phase having recently been completed. It is our intention that this work will deliver redesigned care from a patient perspective, eliminate variation in outcomes, and identify ways to increase cost effectiveness through reduction in duplication and waste. We are confident that the size and scale of the initial pathways identified will have a transformational impact on activity and outcomes, and we expect to see full implementation of the benefits including the associated efficiencies of this programme realised in the second year of this plan.

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

6. 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. As a member of the Oxford Academic Health Science network (OAHSN), our clinicians are linked into the clinical academic groups as a source of sharing

of expertise and best practice which is then used to directly inform our local commissioning decisions, and planning processes. Specific examples of this are the Diabetes and Dementia networks, and the Mental health/physical health co-morbidity network, all of which have had clinical engagement from local clinicians, and from which we have used intelligence which has informed local CCG operating and Federation level QIPP plans.

We will continue to engage with the Strategic clinical network and OAHSN to optimise the benefits in closer integration between the clinical and academic communities in enabling us to achieve improved outcomes for our local populations.

Other Enablers:

1. Expert Clinical Advice

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. There are four Strategic Clinical Networks covering the Thames Valley:

- Cancer
- Cardiovascular
- Maternity and Children
- Mental Health, Dementia and Neurological conditions

South Reading CCG will endeavour to engage with SCNs to ensure that their work informs our commissioning plan. In the same way the CCG will be part of the Academic Health Science Network (AHSN) and be cognisant of their work programme.

2. Workforce Development/Changing the way we work

Modernising the current model of primary care – New models and approaches to primary care are required to meet the workforce challenge and the new demands on the primary care sector in a transformed system. The emerging trend is for more part time salaried doctors which challenges the current partnership model. Small and single handed practices are less able to respond to increased demand. Therefore we will explore new organisational models for the provision of primary care that will strengthen integration with community health and social care, building on the current success of joint triage between GPs and the ambulance service.

***Revolutionising our workforce* –** The ten organisations in the Berkshire West health economy, of which Reading organisations are a part of, are committed to developing, testing and implementing innovative approaches to integration through strong collaborative leadership and through a workforce which is fit or 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, and we have been successful in securing funding from Health Education Thames Valley to support the implementation of this programme

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 among our staff by helping them understand why change is needed and clarifying the benefits that will deliver at all levels.

Our Better Care Fund plans offer the opportunity to transform local services and provide better integrated care and support and enable the integration agenda to be taken forward at scale and pace and provide a catalyst for change. The transformation and engagement of the workforce is key to this change.

We will bring together the qualified and non-qualified home care workforce to improve the quality of care and provide seamless services which prevent patients bouncing around our system. We will work with service users on a programme of continuous improvement with the service user voice central at all stages of commissioning.

The benefits include:

- Enhanced productivity and cost savings
- Improved quality of care
- Competency based education; and workforce commissioning across health and social care
- Flexible transferable workforce
- The right skills in the right place and more efficient staff
- Consistent expectations and standards as a whole system approach

Targeting resources to achieve greatest impact

We have implemented risk stratification across our GP practices and are keen to maximise the benefits of this investment, both at a strategic and individual level. By sharing information across health services and the local authority we can work as a whole system to target key groups of residents further down the risk triangle to prevent ill health and identify people who need additional support to promote independent living and prevent deterioration. This will include developing awareness within statutory services of third sector provision and the health benefits which come from strengthening individuals' community connections. There will be increasing 'social prescribing' to support people to stay well, particularly combating social isolation. We will work to overcome the technical and information governance issues that have so far excluded information on Continuing Health Care and Social Care packages from our Adjusted Clinical Groups (ACG) risk stratification model.

Changing the way we commission care and delivering efficiency savings for reinvestment

We recognise the drive for greater integration may present a challenge for individual organisations. We already have integrated health and social care teams within mental health, learning disability and re-ablement services. We will apply what we know delivers better outcomes for individuals through this way of working and use it to identify further options for structural integration and the development of social enterprises. We will be driven by the goals of improving both quality and continuity of care in ways which are financially sustainable.

CCG Governing Body and Member Workforce

As part of CCG authorisation in 2013, South Reading CCG developed a detailed Organisational Development plans which have continued to be delivered during 2013/14. We have delivered training for our Governing Board members, engaged in a programme of management team development, and also focused on succession planning to ensure we have the right leadership to deliver clinical commissioning within our CCG.

Our organisational development plan for the next two years is under development and will be delivered in a number of steps. We plan to work with single Organisational development specialist. We have already conducted one observation at CCG Board level. A second observational session is planned with our member practices. These assessments will be used to assess the elements of task, team and individual for the Board and will identify the gaps and priorities.

The Development Programme

The gap analysis and priorities will drive the programme. Initially we will focus on the elements of Governing Body development, followed up by a series of development workshops focusing on gaining clarity, understanding and priority actions for key areas.
The second session type would be leadership development training. For example, leadership skills, time management, conflict resolution. This would allow us to start of a "Board Charter".

3. Information Management and Technology (IM&T)

Our Information Management Technology (IM&T) strategy document sets out the direction of travel for information management and technology to support the four Berkshire West CCGs. 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.

Berkshire West's vision for IM&T is that *widespread exploitation of information and IT is essential to achieve the CCGs' goals*, through:

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

Quality and Patient Safety

Quality

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 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.

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.

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 CCGs in particular will ensure that local providers adhere to all NHS Constitution measures and access standards to provide patients with care in a timely manner, as summarised at Annex D. The added importance of this in relation to waiting times for a 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 a public body 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 CCG on the Local Safeguarding Children and Adult Boards. The CCG will enhance the 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.

Prevent

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

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

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.

Equality & Diversity

Equality and Diversity is central to the work of NHS South Reading CCG to ensure there is equality of access and treatment within the services that are commissioned. The promotion of equality, diversity and human rights is central to the NHS Constitution and your life, your health and other national drives to reduce health inequalities and increase the health and well-being of the population. NHS South Reading CCG is committed to embedding equality and diversity values into its policies, procedures, employment and commissioning processes that secure health and social care for people.

We have used the NHS Equality Delivery System (EDS) to develop and prepare our equality objectives which are:

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 for CCGs and their Membership practices
Improved patient access and experience	Improve equality data collection across all protected characteristic groups and usage
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 the organisation.

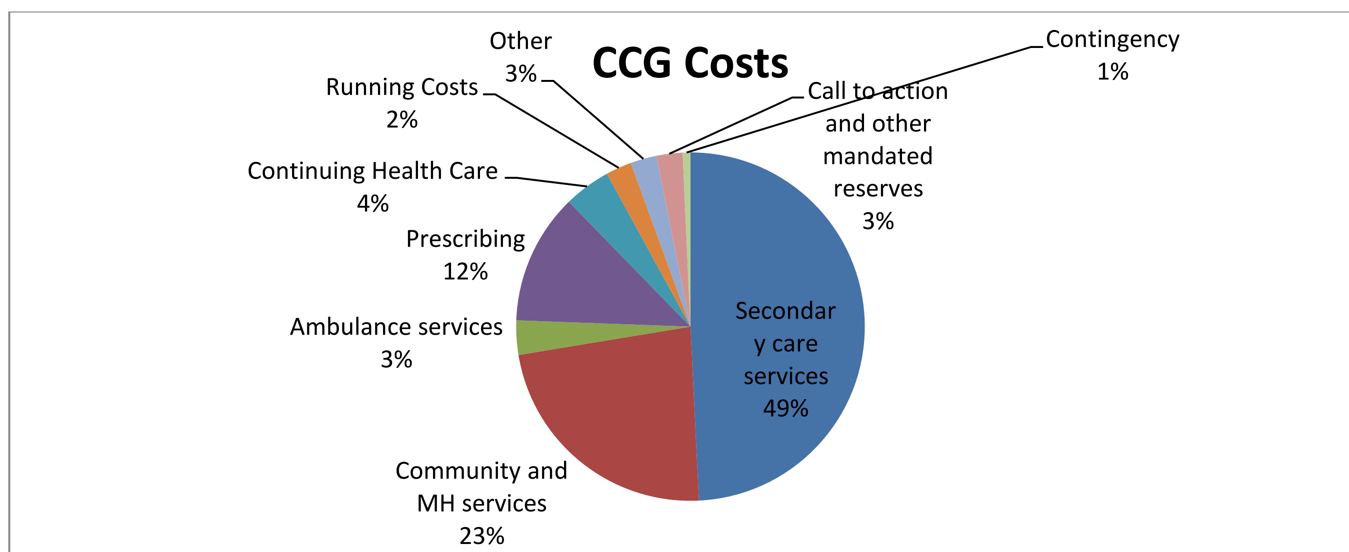
Further information on the CCG Equality and Diversity Guidance

Financial Plan

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. South 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 1% contingency fund is also held, to manage in year volatility. In 2015/16 the CCG contributes 4.8% of its 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. 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. The diagram illustrates how CCG costs are attributed:



Financial Plan 2014/15

Financial Plan 2014/15	£'000	
CCG Income		
Recurrent allocation baseline	118,476	
Growth in year	3,826	
	122,302	
Non recurrent		
Return of prior year surplus & Misc	2,526	
	124,828	
CCG Expenditure		
Secondary care services	61,529	
Community and MH services	28,908	
Ambulance services	4,188	
Prescribing	14,227	
Continuing Health Care	5,755	
Running Costs	2,961	
Other	1,882	
Call to action and other mandated reserves	2,989	
Contingency	1,164	
	123,603	
Required Surplus	1,225	1.00%

Major Investments in 2014/15	£'000	£'000
Out of Hospital		1,644
escalation bed capacity and service navigation	336	
support for over 75's	656	
Care Home Support	176	
Hospital at Home	305	
Community Reablement and Rapid Response	171	
Urgent Care		266
Psychiatric Liaison Service	266	
Hospital services		316
Intensive care	316	
Quality		278
Francis / berwick report - implications	278	
	2,504	2,504

Main QIPP Schemes in 2014/15 - gross savings	£'000	£'000
Out of Hospital		1,249
Medicines management	204	
Care Home Support	212	
Hospital at Home	703	
Community Reablement and Rapid Response	130	
Urgent Care		309
Psychiatric Liaison Service	309	
Hospital services		1,007
Business rules / improving efficiency	593	
MSK service review	285	
Eye care service review	129	
	2,565	2,565

Financial Plan 2015/16

Financial Plans 2015/16 onwards					
	2014/15'	**2015/16'**	**2016/17'**	**2017/18'**	**2018/19'**
CCG Income					
Recurrent allocation baseline	118,476	122,302	127,138	130,671	134,230
Better care fund transfer	0	1,749	0	0	0
Growth in year	3,826	3,087	3,533	3,559	2,984
	122,302	127,138	130,671	134,230	137,214
Non recurrent					
Return of prior year surplus & Misc	2,526	1,868	1,272	1,308	1,343
	124,828	129,006	131,943	135,538	138,557
CCG expenditure					
Clinical Services	116,489	116,497	119,372	122,903	125,872
Better care fund	0	6,166	6,166	6,166	6,166
Running Costs	2,961	2,660	2,652	2,645	2,636
Mandated reserves and Contingency	4,153	2,410	2,445	2,481	2,510
	123,603	127,733	130,635	134,195	137,184
Required Surplus	1,225	1,272	1,308	1,343	1,373

Appendix 1

Practice Name	Address
Abbey Medical Centre	41 Russell Street, Reading, Berkshire, RG1 7XD
Chatham Street Surgery	121 Chatham Street, Reading, Berkshire, RG1 7JE
Eldon Road Surgery	10 Eldon Road, Reading, Berkshire RG1 4DH
Grovelands Medical Centre	701 Oxford Road, Reading, Berkshire, RG30 1HG
Kennet Surgery	30 Cholmeley Road, Reading, Berkshire,l RG1 3NQ
London Street Surgery	72 London Sgtreet, Reading, Berkshire, RG1 4SJ
Longbarn Lane Surgery	22 Longbarn Lane, Reading, Berkshire, RG2 7SZX
Melrose Surgery – Dean	73 London Road, Reading, Berkshire, RG1 5BS
Melrose Surgery – Williams	73 London Road, Reading, Berkshire, RG1 5BS
Milman Road Health Centre - Lister	First Floor Milman Road, Reading, Berkshire, RG2 0AR
Milman Road Health Centre – Kumar	Ground Floor, Milman Road, Reading, Berkshrie, RG2 0AR
Pembroke Surgery	31 Alexandra Road, Reading, Berkshire, RG1 5PG
Reading Walk In Centre	First Floor, 103 Broad Street Mall, Reading, Berkshire, RG1 7QA
South Reading & Shinfield Medical Centre	257 Whitley Wood Road, Reading, Berkshire, RG2 8LE
The New Surgery / London Road	171 London Road, Reading, Berkshire, RG1 3PA
Tilehurst Village Surgery	92 Westwood Road, Tilehurst, Reading, Berkshire, RG31 5PP
University Medical Practice	9 Northcourt Avenue, Reading, Berkshire, RG2 7HE
Westwood Road Surgery	66 Westwood Road, Tilehurst, Reading, Berkshire, RG31 5PR
Whitley Village Surgery	1 Christchurch Road, Reading, Berkshire, RG2 7AB

Appendix 2 - Berkshire West Outcomes /Improvement Interventions

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 tele-health 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 Quality Of Life 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	305374
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 outcomes 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	665508
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	89232
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 initiative uses similar technology and there is a good confidence level of implementation of this current intervention.

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	50000
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	**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	**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	**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.
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	**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	50000
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	**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	**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)**

A Prioritisation Framework Took was used to score each potential scheme against the following criteria:

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