Operational Plan 2017/18 – 2018/19

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

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1. Berkshire West Strategic Priorities

This document sets out the Berkshire West CCGs' ("Berkshire West") Operational Plan for 2017/18 and 2018/19. The plan forms part of the Berkshire (West), Oxfordshire and Buckinghamshire ("BOB") Sustainability and Transformation Plan (STP), and builds on the Berkshire West CCGs' strong track record of financial and non-financial performance. The year ahead, however, reflects an increased set of challenges which include delivering higher levels of efficiency savings than ever before whilst also implementing a new model of care through the Accountable Care System (ACS).

The Berkshire West CCGs are collectively recognised as high-performing and benchmark well nationally on a number of key performance measures, including non-elective admission rates and prescribing. For the last two full years, Berkshire West CCGs have been in the top 4% of CCGs for non-elective admission rates. We are also recognised across Thames Valley and nationally for leading the development of innovative approaches to improving clinical care and patient experience e.g. Diabetes Care, Stroke care, and Improving Access to Psychological Therapy services.

Nevertheless, in line with other health and care systems we are facing increasing operational and financial challenges. Both elective and non-elective activity has increased significantly in recent months with significant spikes in emergency admissions.

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

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

This plan has set out how the Berkshire West CCGs will deliver the NHS Five Year Forward View, working as part of the BOB STP and driving the establishment of the Berkshire West Accountable Care System. The CCGs will continue to build on strong partnership working with the three local authorities in Berkshire West to deliver the BW10 programme and maximise the impact of the Better Care Fund investment.

2. Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability & Transformation Plan (STP)

Clinical Commissioning Groups (CCGs) and providers operating in Berkshire West are members of the Berkshire (West), Oxfordshire and Buckinghamshire (BOB) Sustainability and Transformation Plan (STP). This is a large STP with three distinct local health economies that are effectively driving place based commissioning to deliver the Five Year Forward View. The local health economies provide the best mechanism to transform primary

care, redesign the interface with local hospitals and drive integration with social care. Much of the delivery of the Five Year Forward View will take place at local health economy level with the STP ensuring the rapid adoption of innovation across BOB. Nevertheless each of the member organisations recognises the opportunities of working together with partners at this larger scale and will be progressing initiatives to improve quality and realise financial benefits for the wider system.

Across our STP we have a proven track record of implementing innovation and excellence in clinical practice to deliver high quality patient care. This has led to us being a highly cost effective system, which we will build on as part of this plan.

2.1 BOB STP wide programmes

For each of the proposed programmes where working at the STP scale adds value, we have developed Project Charters, with clear leadership, milestones and descriptions of benefits. These are reflected in each of the chapters of this plan. Through its ACS improvement schemes and local initiatives Berkshire West CCGs will contribute fully to the delivery of these STP wide programmes. Our ambition is to co-design with patients and clinicians and implement a new model of care to address the challenges facing our health and social care system.

Our proposals focus on the following priority areas:

BOB programme	**Objectives**
Prevention	• To reduce levels of adult and childhood obesity • To increase levels of physical inactivity • To reduce sedentary lifestyles
Urgent Care	• Provide an accessible and consistently high quality urgent and emergency care telephone and online advice service that promotes self-care and direct access to community based services via a single call.
Acute Services – Clinical variation	• Reduction of unwarranted variation in access to clinical care and delivery of clinical outcomes.
Acute Services - Maternity	• To ensure capacity and capability of maternity services within the Thames Valley is sufficient to respond to demand over the next 10 years.
Acute Services - Paediatrics	• To reduce unwarranted paediatric admissions within the BOB region as identified by the AHSN report. • To achieve clinical and financial sustainability for all paediatric sub-specialities across the Oxford and Southampton Children's clinical network.
Acute Services - Procurement	• Trusts work collaboratively to share procurement data and resources to improve efficiency, value and deliver cost savings.
Specialised Commissioning	• Lead, facilitate and drive integration and cross health-system redesign for specialist commissioning across STPs.
Mental Health	• Create a system for mental healthcare designed to consistently secure the best outcomes for service users and carers, building on innovation across BOB.
Workforce	• Development of a recruitment strategy • Create an education framework for the personal and professional development of health and social care support workers.

	• For Trusts within the BOB geography to achieve quality and financial improvements through the more effective utilisation and deployment of the regions healthcare workforce.
Digital Interoperability	• Delivering integrated health and care records • Empowering patient well-being and self-care through the design of personal health records

3. Local Health Economy – Accountable Care system

3.1 Delivery of the Berkshire West New Model of Care - Accountable Care System

As part of delivery of the Five Year Forward View in Berkshire West, the four CCGs which comprise 'Berkshire West'[1] are collaborating with the two local NHS providers (Royal Berkshire Hospital Foundation Trust and Berkshire Healthcare Foundation Trust) to establish a new way of working together known as an 'Accountable Care System' (ACS). New governance arrangements have been put in place led by an independent Chair and the system has applied to operate a system level financial control total as a sub division of the STP. All parties are committed to developing new payment mechanisms to underpin the transformational change required.

The Berkshire West ACS is a complete transformation of how the NHS organisations within Berkshire West will work and transact with each other. By moving away from a system of contractual transactions and closer to an allocative distribution of monies coming into the local health economy, the ACS seeks to move to a system whereby resources are allocated to the efficient delivery of pathways at cost rather than price.

The ACS represents an opportunity to fundamentally change how these organisations formally contract with each other in order to maximise the value for money available from the financial resources which are allocated to the local health economy each year, as well as improve patient experience. We are looking to the system regulators to keep pace with our ambition and provide the necessary support for this transformational approach.

3.2 Case for Change

As a local health system we are facing a number of significant operational, clinical and financial challenges including: providers coming under increasing financial, performance and quality pressures, demand management programmes with variable levels of success, workforce issues in recruitment across health and social care, and commissioners facing significant affordability pressures given the current configuration of services.

There are a number of barriers in the current operating environment that inhibit our ability to address these challenges. These are primarily the contracting and payment mechanisms and the different regulatory regimes under which each organisation operates. Other barriers

[1] NHS Wokingham CCG, NHS South Reading CCG, NHS North & West Reading CCG, NHS Newbury & District CCG

include the lack of a coherent approach to technology, workforce and patient engagement and empowerment.

The range of payment regimes across different providers has resulted in misaligned incentives that are preventing rapid transformation and the incentives for commissioners and providers to work collectively towards system wide sustainability. This system is determined that our current high standards will not fall and changing the existing tariff-based approach is fundamental to our progress. Our finances need to flow around the system in a way that appropriately pays providers and helps all organisations achieve long term financial balance by unlocking efficiencies in different parts of the system.

4. Integration – Berkshire West 10

The Berkshire West system has been working together as the Berkshire West 10 (BW10) comprising 4 CCGs, 3 local authorities, Royal Berkshire NHS Foundation Trust (RBFT), Berkshire Healthcare Foundation Trust (BHFT) and South Central Ambulance Trust (SCAS) since 2013 within a shared governance structure.

The Berkshire West 10 Integration Programme is an ambitious transformation programme involving fourteen projects / programmes across these ten organisations. These operate both at locality level and Berkshire West wide to deliver the intended benefits. The collective objective is focused on improving outcomes for users and patients, and achieving long term financial sustainability.

Overseen by an Integration Board and with project implementation supported by a joint Delivery Group, the BW10 focuses specifically on improvements for:

- Frail Elderly population
- Mental Health care
- Children's services

Much of our Better Care Fund investment is managed through this integration structure and as per national guidance has a focus on:

- Avoiding unnecessary non-elective admissions (NEA)
- Reducing delayed transfers of care (DTOC)

A summary of the BW10 projects is included below, mapped to the anticipated benefits of the overall programme of work.

BENEFITS – PROJECT SPECIFIC - alignment to BCF measures or national conditions

#	Project		Reduction in DTOC	Avoiding unnecessary NEA	Effective enablement	Avoiding unnecessary admissions to care homes	Improved experience	Better use of Resources / Cost reduction	Other National Conditions
1.	Care homes	Berkshire West		X			X	X	Joint assessments
2.	Connected care	Berkshire West		||			||	||	Data sharing
3.	Frail elderly pathway	Berkshire West	X	X		X		X	
4.	Getting home (Home First)	Berkshire West							
5.	Integrated carers commissioning	Berkshire West	X	X	X		X	X	
6.	Integrated H&S hub	Berkshire West					X	X	Support for carers
7.	Workforce	Berkshire West	||	||			||	||	7 day working
8.	Community reablement team	Reading	X	X	X	X	X		Maintaining ASC
9.	Discharge to assess	Reading	X	X	X	X		X	Maintaining ASC
10.	Joint care provider	West Berkshire	X		X		X	X	7 day working
11.	CHAS	Wokingham	X	X		X		X	
12.	Integrated short term H&S team (WISH)	Wokingham		X			X	X	
13.	Night responder	Wokingham	X	X		X			
14.	Step up / Step down	Wokingham	X	X		X			

KEY: X = supporting Berkshire West targets X = supporting Locality targets only || = enabling benefit Berkshire West wide **Page 4 of 4**

5. Financial sustainability

The Berkshire West CCGs remain as some of the lowest funded commissioners in England on an allocation per person measure (£1,064 compared to a national average of £1,239), and remain underfunded when compared to their target allocations by approximately £20 a person (i.e. £10m in total). The equivalent allocation per head of a Berkshire West CCG (if it existed) would be £1,074 per person, one of the lowest in the South of England area.

Allocation growth in 2017/18 and 2018/19 averages at 2.2% and 2.1% respectively for the Berkshire West CCGs, with recurrent allocations totalling £641m and £655m in the two years. It is expected that the cost of providing the current pattern of services to our population will exceed this allocative growth during this period.

The key financial targets for the BW CCGs in 2017/19:

- Achievement of in year I&E breakeven in both years:
- Retention of 1% surplus brought forward from prior year;
- Achievement of agreed QIPP plan;
- Commitment of only 99% of resource recurrently in 2017-2018, and for half this budget to remain uncommitted at the planning stage.
- Contingency of 0.5% set aside.
- Commitment to an increase in funding for mental health in line with our percentage increase in allocation for the two years.
- Manage within our running cost allocation
- Payment to suppliers in line with the Better Payment Practice Code;

- Management within agreed cash limit; and
- Demonstrating value for money.

The four Berkshire West CCGs plan to comply with each of these requirements, recognising that this is a high risk plan and have begun an internal financial turnaround process. The size and scale of the financial challenge is greater than in previous years and may yet increase. Added to this, previous financial positions have been achieved with the aid of reserves. In 2017/18 this flexibility will no longer be available.

5.1 Alignment with activity and growth assumptions

All trust contracts will as a starting point use estimated 2016/17 outturn as the basis for 2017/19 contract negotiations.

In 2017-18 and 18-19, activity growth will be agreed with each provider based on local circumstances. Any activity savings derived from implementation of QIPP schemes will be adjusted in contracts once the detail has been agreed with the providers concerned.

5.2 QIPP and Efficiency

It is recognised that the delivery of QIPP plans is a necessary lever to ensure real change to safeguard future financial stability and it is our intention to establish realistic and achievable levels of QIPP and efficiencies within the system. The QIPP gap has been identified for the CCGs for 2017/18, and amounts to £23m in total (with £15m currently estimated for 2018-19). This year additional ACS schemes, that will deliver system efficiencies, will also help contribute towards this gap. See Appendix 2 for ACS schemes PIDS.

5.3 Parity of Esteem

Planning guidance set out the requirement for CCGs to invest further in mental health services to ensure parity of esteem between mental and physical health services. Berkshire West CCGs have committed to investing in line with their increased allocation. Any increased investment may be utilised in a number of organisations within the health economy including Berkshire Healthcare FT, Royal Berkshire Hospital FT, CCGs, the voluntary sector and Primary Care.

5.4 Moderating demand

Despite a number of initiatives being put in place during 2016/17 to reduce non-elective activity the system continues to see growth in non-elective activity in excess of plan, although this is below the national average in a population with high and rising numbers of the elderly. A number of schemes are being developed to mitigate this pressure in the coming two years.

5.5 Improving health

The CCGs recognise the importance of prevention and health promotion in reducing the ultimate demand for healthcare. Effective, evidence-based prevention, addressing the lives

people live, the services they access and the wider context in which they live will require co-ordinated action and the CCGs are working closely with Local Authority colleagues to ensure these services are delivered effectively across Berkshire West.

This collaborative approach is exemplified by the Prevention Working Group, part of the Berkshire West 10 Integration Programme, which will enable identification and sharing to develop best practice across the region and will support the development of health promoting organisations.

5.6 Accountable Care System

The current profile of service provision in Berkshire West is not sustainable and this position will worsen unless action is taken to address the challenges set out above, promoting primary and preventative care. In 2017/18, our system is forecasting an overall financial gap to be bridged of approx. £52m:

	2017/18 savings required (£m)
Royal Berkshire NHS FT	(23)
Berkshire Healthcare NHS FT	(6)
Berkshire West CCGs	(23)
Total	**(52)**

5.7 Primary Care

Berkshire West CCGs recognise that primary care is a key part of the system and faces significant challenge in terms of demand and workforce pressures. Ahead of the GP Forward View the CCGs have already invested £5m in primary care in each of the last two years to enhance access and maximise the impact of care planning and ensure we provide proactive support to care homes. In 2016-17 the CCGs took on fully-delegated responsibility for commissioning primary medical services bringing a strategic capability to the commissioning of primary care and supporting its integration with the wider health and social care system.

5.8 Better Care Fund (BCF)

In 16/17 the Berkshire West CCGs Minimum Contribution to the BCF was £25.7m, representing just under 84% of the total BCF funding of £30.6m. Although we do not yet have the NHS England Allocations for 17/18 and 18/19, planning is proceeding on the basis of a broadly similar level of funding to that in the current year.

For 2017-19 the intention is to build on the foundations of the integration programmes which have been successful so far, while continuing to critically evaluate all schemes and where necessary redirect investment towards reconfigured or new projects. The plans will be subject to sign off by Health and Well Being Boards by March 2017

6. Supporting Self Care and prevention

The Berkshire West CCGs measure well against national life expectancy, Newbury and Wokingham areas are both in the top decile of affluence and exceed national life expectancy, though Reading with lower affluence has lower life expectancy with men being below the national average (78.5 years). Similarly the potential years of life lost (PYLL) due to amenable causes are lower in Wokingham and West Berkshire, though similar to the national average in Reading.

The STP prevention programme and the linked local prevention programme reflect priorities that tackle the causes of inequalities in our communities. The Buckinghamshire, Oxfordshire, and Berkshire populations benchmark well against the England average for public health outcomes. However within all our areas there are pockets of our residents where outcomes are not good, and so the direction of the programmes is to address the factors that drive these inequalities, with a slight modification to include diabetes (which is linked significantly to being overweight) and physical inactivity (due to the increasing recent evidence on the separate impact of physical inactivity on health).

Prevention programmes can be delivered in a variety of settings and at different population levels. At an STP level two key enablers have been identified to drive programmes to change lifestyle behaviours:

- engaging with health and care staff to maximise the "teaching moment " of care delivery to nudge lifestyle choices "Making Every Contact Count" and
- industrialising our use of digital approaches, linking with the Connected Care programme, to improve knowledge on lifestyles, signposting to services and supporting / coaching lifestyle changes

These benefit from a STP approach and will drive delivery in two key lifestyle areas: reducing levels of obesity in adults and children and improving levels of physical activity. In addition the staff programme "Making every Contact Count" will also drive stretch improvement in NHS employee health, building on the national CQUIN initiatives, improving staff indicators and will link with an Academic Health Science Network wide programme to engage with other major employers to maximise employee health.

Locally 'Beat the Street' is a well-established programme of increasing activity and will continue in to 2017/19. Between 15th April and 27th May 2016, 6,876 people from Reading registered online to take part. Many others, including school children, took part but did not register individually. At the end of Beat the Street, 3,216 people who provided an email address and agreed to be followed up were invited to provide feedback. In total, 570 people did so (18%). The proportion of adults reportedly meeting this target increased from 36% to 53% which is statistically significant. Positive trends were also apparent for children, though the numbers were too small to draw conclusions. Importantly the proportion of people who were active on only 0 or 1 day per week reduced from 15% to 5% by the end of Beat the Street ($p<0.05$) and people with long-term conditions were just as likely to report benefits as everyone else.

6.1 Long term conditions and self-care

Our work on long term conditions (LTC) will significantly contribute to the ambition of the Five Year Forward View and our local strategic vision for 2019 which sets out an ambition for enhanced primary, community and social care services in Berkshire West to have a service model which prevents ill-health within our local populations and supports patients with much more complex needs to receive the care they need in their community.

Our vision is underpinned by the principle that patients will only be admitted into hospital when the services they require cannot be delivered elsewhere, and that when acute care is needed they will be treated in centres equipped with the appropriate facilities and clinical expertise. People with serious and life-threatening conditions will continue to be treated in acute centres that maximise their chances of survival and a good recovery.

In transforming our approach, it is recognised that there is a fundamental shift from more traditional reactive and unplanned approaches to one which is truly patient centred, proactive and anticipatory, where possible enables patients and carers to access services at or as close to home as possible and aligns specialist, primary and community care in one coherent package, and where required along a continuum of care which meets palliative and end of life care needs. Service users will be supported to take more responsibility for their health and wellbeing and to make decisions about their own care.

The Berkshire West LTC Programme aims to identify effective and sustainable approaches to underpin the prevention of an avoidable increase in health need that may lead to a loss of independence and an increase in demand on services. Using profiling and risk stratification tools we will be able stratify populations to ensure resources are targeted most effectively and efficiently. Demand for services is predicted to continue to rise with a growing older population and people living with more complex long term conditions. We will expand our focus beyond the top 2% of the population to the top 10% who may not necessarily be high users of services now but are at risk of becoming so without early intervention.

We will move towards a model which reduces fragmentation, and is underpinned by care and support planning. This has been successfully embedded as an approach for diabetes, based on the Year of Care approach and has been partially adopted as an approach for COPD. This provides a strong foundation on which to build our new model of support to people with multiple Long Term Conditions to include respiratory disease, cardio-vascular disease, mental health and dementia. This would move from a system focused on a single condition towards a more patient centred, holistic approach improving health and wellbeing, streamlining and improving quality of care including earlier intervention and approaches which reduce the impact on specialist resource. There is real opportunity to progress this at scale.

Through our BCF initiatives, we will continue to work collaboratively across health and social care and the voluntary sector to provide quality care for patients; minimising the risk of an individual's health deteriorating and requiring increased service intervention, and maximising opportunities for patient self-management.

6.1.1 End of Life Care

Meeting the palliative and end of life (EOL) care needs of patients (and their carers) along a continuum of care is critical to our overall vision and approach to integrated long term conditions management. This enables us to drive forward patient centred, holistic end of life care regardless of specific conditions, with services wrapped round the patient and where possible provided at or closer to home. It also focuses on a planned and proactive approach, minimising reactive and crisis response which often leads to hospital admission as the only option.

Locally, benchmarking data indicates that we are deemed to have a higher percentage of deaths in hospital at end of life. However, we know that this is higher in Newbury where there are a number of hospice style beds within the community which contributes to the overall reporting. The average however across Berkshire West is better than the national.

There are a number of initiatives in place across the area which supports proactive approaches to the management of end of life care, with the aim of enabling patients/individuals to die in their preferred place of residence. This is highly reliant on our whole system approach to reduce the impact of urgent/crisis response and ensuring that palliative and end of life care needs are considered integral to all LTC work.

The EOL Steering Group meets quarterly, with representation from all key stakeholders and reports into Long Term Conditions (LTC) Programme Board. This ensures that all the LTC work programmes align with ambitions for EOL e.g. Heart Failure/COPD/Dementia as key examples and aligns to other programme areas e.g. urgent care and cancer. This was set up is in recognition that End of Life is a crosscutting theme across a wide range of disease areas.

The Steering Group has been a key driver in progressing commissioning of a new 24 hour, 7 days a week Palliative care co-ordination and support service called “PallCall.” The service, with a single point of contact for patients, families and healthcare professionals, is available to anyone in their last 12 months of life with a Berkshire West GP, or to anyone who is providing support to those people. The service is designed to support End of Life patients to die in their preferred place and to prevent avoidable, unwanted admissions for that patient group. PallCall launched in mid-October 2016 and has in its first six weeks, dealt with 100 calls from patients, families, GPs, care homes, district and community nurses, and the ambulance service. They have prevented 19 admissions and supported 6 patients to die in their preferred place. The service is still developing and we will build on these early successes to deliver in home assessment directly in 2017/18, and to ensure GPs caring for palliative patients have considered anticipatory medication.

In addition Berkshire West uses Adastra to deliver the Electronic Palliative Care and Co-ordination System (EPaCCS) thereby contributing to the co-ordination of patient care through access to patient relevant information, with all GPs having access alongside A&E (a terminal in A&E) and SCAS. Additionally A&E and SCAS have GP Bypass numbers to reduce the need for conveyance and/or admission as the only option and ensures the needs and wishes of patients are addressed. There is additionally access to the hospital based palliative care team and access to the 24/7 PallCall service.

There are a number of additional schemes which support and enable patients to remain in their preferred place of residence (including care homes) and where possible reduce the need for admission to hospital and/or A&E attendance. These include the provision of inpatient beds and the West Berks Community Hospital Rainbow Rooms. Patients also have access through our community and acute services in the form of:

- The Rapid Response Team for patients in own homes (and care homes)
- Hospital based palliative care team

The Anticipatory Care Enhanced Service (CES) in addition supports both the implementation of care planning and Do Not Attempt Cardiac Pulmonary resuscitation (DNACPR) discussions for patients approaching end of life.

We will also further build upon the EOL CQUIN put into place in 16/17, with the community providers which has improved the recognition of those patients who are entering their last year of life and are on the caseload of a community service (e.g. District Nurses, Community Nurses, Community Matrons, & Inpatients). The CQUIN supports organisational development and delivery of an action plan to improve the ability of appropriate staff to identify patients who might be entering the last year of live, flag those patients on appropriate clinical systems and work effectively with GPs and the palliative care hub to support co-ordinated working for that patient.

Increasing access to healthcare education and shared learning has led to the development of a rolling programme of education across all CCGs. Practices can benefit from the local Palliative Care Consultant for case based discussion teaching. This has included managing difficult conversations and/advanced care planning, ultimately supporting the overall approach to improving patient care and outcomes.

There is also a Palliative Care Community Enhanced Service (CES) which supports one GP per Practice per year to attend a relevant EOL learning event and to subsequently evidence that this learning has been disseminated through the Practice team.

6.2 Diabetes

Across Berkshire West CCGs, we recognise Diabetes as a significant issue with the prevalence and number of people at risk of developing Diabetes being very high in some areas (such as the south of Reading).

The House of Care and Care & Support Planning have been central to the Diabetes service re-design over recent years. Within Berkshire West we have strong clinical leadership and an integrated approach to the management of diabetes, which has been widely recognised and acclaimed nationally.

Our vision is to identify people at risk of developing Diabetes early and refer them to risk-reduction services. We will also support people with diabetes in Berkshire West, to live healthier lives by improving outcomes and reducing complications, and to do that efficiently. We aim to do this through informed, engaged patients, informed motivated Health Care

Professionals, collaboration between stakeholders and supported by the use of informatics and technology.

Across Berkshire West, we have commissioned a community enhanced service (CES) for pre-Diabetes since 2013, and have committed future funding for a three year period through to 2019. This CES has successfully identified Diabetics and Pre Diabetics as well as promoting lifestyle interventions for Diabetes prevention. This has provided us with a sound base as early adopters within the national Diabetes prevention programme, successfully participating in the first-wave as a pilot site across the whole of Berkshire (all 7 CCGs and 6 LAs). This programme is locally led by Public Health working closely with the CCGs and complements the local CES scheme. More than 30 GP Practices across Berkshire have invited 576 patients with pre-diabetes to the NHS NDPP programme. With 147 patients (26% uptake) so far being enrolled, the number of invitations and referrals each month continues to rise by the rate of additional GP surgeries being enrolled onto the programme. Across Berkshire we envisage that we will refer at least 2,300 people with pre-diabetes in first year for risk reduction, building on the early successes in the CES.

In South Reading CCG where there are higher levels of diabetes the GP practices are participating in a Prescribing Quality Scheme, which includes specific diabetes related prescribing targets aimed at optimising prescribing of medications to improve outcomes for diabetic patients. The development of prescribing formularies by the Medicines Optimisation Team supports prescribers in ensuring that the most cost effective treatments are used in line with NICE.

We will continue to commission an innovative interactive database technology "**Eclipse"**, to which all our practices have access. ECLIPSE is a software tool originally procured by Berkshire West CCG's to help support improvement in diabetes care. Use of the software has had a significant impact in improved diabetes care and now increasingly supports identification of risk in a range of other Long Term Conditions. Berkshire West have subscribed to the advanced "LIVE" version which includes true Risk Stratification, Safety Alerts, Centralised Project Management, Integrated Care and Automated Patient Care Plans. Weekly extracts allow practices to identify at-risk patients and automatically generate safety reports. In addition Berkshire West has developed an extremely effective Community Diabetes Service, led by a Community Diabetes Consultant and support network of Diabetes Specialist Nurses. This team uses Eclipses' virtual capability to identify practices needing support in the delivery of high quality diabetes care to its patients in a highly effective and cost efficient way. Eclipse has the capability of being utilised for the management of other long term conditions. We have put into place a system of remote monitoring of blood glucose in diabetic pregnancy.

South Reading CCG was one of eight CCGs in England participating in a CQC Diabetes thematic review which demonstrates and shares best practice examples across the country. South Reading has been cited in this report as demonstrating a number of areas of good practice. One such area is our comprehensive range of health care professional and patient education programmes for type 1 and Type 2 Diabetes. This is a key element of the House of Care model. Our commissioned XPERT course (type 2 Diabetes education) delivered by Berkshire Health Care Trust, recently received two national awards. Type 1 Diabetics have access to our local course "CHOICE", commissioned in 2016, which now offers greater capacity, more sustainability, greater cost-effectiveness, and for patients much more

convenience. In addition, type 1 diabetics have access to a short three-hour carbohydrate awareness course, combined with instruction on basal dose optimisation and bolus/correction dose instruction. 700 of our type 1 diabetics have been able to access this course. However we know from Eclipse, that as of October 2016, we have 2144 type 1 diabetics and 18,403 type 2, an increase on last year of 17% and 9.8% respectively. To meet this rising demand during 17/19 we will be addressing this challenge of reaching even more diabetics, and we are undertaking a review of a range of education offers and in particular options to include using online education with better use of technology. By early 2017, we will have identified and costed a range of options to better meet the future demand.

Other local initiatives to directly support and reduce the numbers of patients with very badly controlled diabetes include the insulin optimisation programme. This was set up in 2015, to provide a more focussed opportunity to work with individuals with Type 2 Diabetes who are not optimally controlled. The overall objective is to reduce individuals HbA1c levels and therefore improving their longer term health outcomes. This service has been reviewed in 2016 and we have been able to demonstrate 53% of those who attended had achieved a 10mmol/mm reduction in their HbA1c levels and of these 55% achieved changes of 20mmol/mm or more. A 10mmol/mol reduction in HbA1c levels tallies to a 17% reduction in events of non-fatal myocardial infarction and a 15% reduction in events of coronary heart disease. Throughout 17/18 and beyond we will continue to build on this success and implement further actions identified which will see improved uptake of support within the programme as well as improved data capture around insulin type associated with the courses.

Using a variety of data sources and analysis combined with our self-assessment against NICE criteria of service delivery, we have identified other inequalities and variation in Diabetes care, resulting in committed funding for 17/18 to offer a new service for the care of highly complex diabetic patients. This cohort of patients is known to have frequent associated emergency admissions. This builds on the success seen in the “virtual diabetes” clinics and will see the implementation of a community based service for this often dis-engaged patient cohort, aiming to reduce non-elective admissions and readmissions through improved Diabetic control.

These initiatives, combined with good quality education for our health care professionals, helps support and address the findings from the National Diabetic audit (100% participation rate), the recent 2016/17 CCG Improvement and Assessment Framework also tells us that more work is needed to improve coding of those attending education and to improve outcomes for diabetics locally, preventing them from developing complications and progressing to renal replacement therapy.

6.3 Obesity and Diabetes

The provision of comprehensive weight management services to our population is an important priority to help address and prevent people developing other illnesses, including Diabetes, which in turn further increases the health burden in our local area.

Weight management services are categorised into 4 tiers as outlined below. Tiers 1 and 2 are commissioned for people in Berkshire West by our three local authorities. Tier 4 (pre

surgical assessment and Bariatric surgery) is commissioned through specialised commissioning but will move to CCG responsibility on 1st April 2017.

Currently there is no provision of Tier 3 weight management service for the Berkshire West CCGs and prior to the transfer in April 2017; we plan to establish a Tier 3 services offer as the missing part of the weight management pathway. This will provide a more specialist intervention delivered by a multidisciplinary team with an aim to support and reduce the numbers of patients moving to Tier 4 (bariatric surgery) and reducing the development of other illnesses.

We have already begun discussions with our partner CCGs within the STP, BOB footprint with the aim of commissioning a service that can be provided across the geography that is consistent and supports the needs of our local populations. The aim is to provide a Tier 3 weight management intervention service as recommended by NICE guidance (CG 189). Work has taken place in 2016/17 to estimate demand for a new service and also anticipated investment costs. This business case will form a sound basis to move forward into 2017 and beyond with a comprehensive offer to our populations.

The provision of Tier 3 in Berkshire West of a Weight Management intervention service will lead to a step change within the NHS in preventing ill health and supporting people to live healthier lives, specifically addressing obesity and reducing the risk of diabetes.

7. Primary care

An effective and sustainable primary care sector will be a key element of our Accountable Care System. As fully-delegated primary care commissioners we are working with our member practices to deliver a strategic programme for primary care which will meet the following key objectives for primary care set out in the *Berkshire West Primary Care Strategy:*

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

Delivery of these objectives is predicated on ensuring the sustainability of the primary care sector. As CCGs we have already invested £5m in primary care over the last three years and have established work streams relating to new workforce models, estates, access and IM&T. We have procured three new APMS contracts aligned to local need and have supported practice mergers and joint working, resulting in the emergence of a new GP provider organisation in South Reading CCG and shared approaches to workforce in the other CCG areas. We are currently piloting clinical pharmacist roles in two of the CCGs and have commissioned training for administrative staff to enable them to assist GPs in co-

ordinating care as well as working with the University of Reading to launch a training programme for Physicians' Associates for which many of our practices now provide placements. We have also established robust processes for undertaking the functions delegated to us by NHSE, including a quality improvement programme based around a Quality Dashboard which combines local and national data to give a 'rich picture' of local primary care provision, enabling us to work to improve the quality of care provided and address any areas of poor performance.

Under the ACS model we will look to primary care providers to offer proactive care to their registered population; supporting patients with long-term conditions in the community, working to prevent ill-health and co-ordinating robust care plans for patients most at-risk of admission. We have already invested significantly in care planning in primary care and are working to further refine our model, including enhancing links with care homes. However in order to ensure there is sufficient capacity for primary care to undertake this role, we believe that same-day demand needs to be managed differently and we are working with our practices to explore the potential for collaborative working to stream demand through Primary Care Access Hubs and other joint arrangements. These collaborative approaches will also offer opportunities to commission extended hours differently. We intend to build upon the Enhanced Access CES we have already commissioned to move towards delivering our trajectory to meet the requirement for all patients to have access to routine and booked appointments each early morning and evening and on both Saturdays and Sundays. Hubs would also align with the broader urgent care system including the re-procured NHS 111 service and it is also our intention to review the role of the Reading Walk-in Centre within this model of provision.

As this 'ask' of primary care becomes further defined, we will continue to work closely with provider leads to consider the models of care which will best deliver it for our population, recognising that the provider landscape is likely to vary somewhat across the four CCGs. We have started to discuss the potential opportunities offered by the new MCP contract with providers and will step this up once more details of the contract are released. We anticipate that a combination of federations, networks and practice mergers will move us towards the future state described in our Primary Care Strategy where at-scale providers cover at least 10,000 patients and usually 30,000 or more with increased skill-mix work in an integrated way with other ACS partners to care for patients in the community wherever possible.

Our local GP Forward View implementation will set out in more detail how we intend to realise this vision for primary care (see Appendix 4). We have already identified three key enablers; capacity for practices to consider how their future business model will make them sustainable, workforce diversification and infrastructure.

With regard to practice sustainability, we are already using Vulnerable Practice and Practice Resilience funding to support practices to plan for the future, utilising the ten High Impact Changes where appropriate. We will now support practices to access the Time to Care and General Practice Improvement Leaders' programmes, working closely with those that choose to use these processes and considering how we can make funding available as set out in the planning guidance to continue to support those for which a different approach is required.

As set out above we have already established a workforce programme for primary care and will now be linking this with the various initiatives and funding streams announced in the GPFV, for instance to roll out our clinical pharmacist programme and establish the role of mental health therapists in primary care. In addition we have submitted an application to HETV to develop a Community Provider Education Network in our area which we will act as a vehicle for supporting recruitment and retention through enhanced continued professional development and for the broader diversification of the primary care workforce.

Infrastructure development is a further key enabler and our ETTF bids reflect the CCGs' local strategic priorities for premises and IM&T investment. The proposed premises developments are required to support at-scale working and respond to significant population growth in Newbury and Wokingham in particular. Similarly, investment in IM&T will provide the early interoperability that will underpin practice collaboration and will sit alongside our broader strategy to maximise the potential of technology in meeting demand and co-ordinating care. Section 14 of this document describes our Digital Roadmap and initiatives underway to open up new ways for patients to access primary care and to ensure we make best use of existing tools such as online access, e-referrals and EPS.

8. Planned Care

Our strategy for Planned Care will deliver a step change in the productivity of elective care by redesigning planned care services to improve health outcomes for patients, reducing lengths of stay in hospital and fundamentally reviewing the delivery of outpatient services. Our vision includes the use of new technologies to enable our patients to interact with services in new ways; we will explore virtual clinics and other modalities to deliver some of the functions currently provided by outpatient departments.

To date we have been working to enable patients to make informed decisions about their care and where secondary clinical interventions are necessary to have access to specialist assessment and treatment and in line with national performance standards.

We are part of phase 2 of the national Right Care Programme and we already adhere to the principles outlined in this programme and utilise the tools to scope opportunities across all CCGs in Berkshire West to highlight unwarranted variation and develop solutions working with all stakeholders to redesign services. Our Integrated Pain Assessment and Spinal Service (IPASS) is an outstanding example of applying these principles and this service won an award for Emerging Best Practice from the British Society for Rheumatology. The Right Care Approach will support and underpin all delivery programmes by focussing on reducing unwarranted variation to improve people's health and outcomes, and ensure that the right person has the right care, in the right place, at the right time offering better value to patients, the population and the taxpayer.

As part of the Accountable Care System (ACS) model we are already working closely with our acute trust provider to review end to end pathways and redesign services to implement the required step change in productivity.

Our Planned Care Programme of work for 2017/2019 includes continuing work to redesign and streamline pathways and reduce clinical variation focusing on Orthopaedics and MSK

(including patient self-referral for physiotherapy), Ophthalmology, Diagnostics, efficiencies in outpatients including exploring other modalities for follow ups (e.g. virtual clinics, telephone follow ups), access to consultant advice and guidance for GPs, patient initiated clinics and Pre-op assessments.

This programme of work will become part of our ACS clinical improvement programme. Working closely with our acute trust providers we plan to take a systematic approach to the commissioning and redesign of following services:

1. MSK
2. Ophthalmology
3. New model for delivery of Outpatient appointments:
    a. ENT
    b. Audiology
    c. Pre op assessments
    d. Other modalities for follow up

Through this work we aim to apply national best practice to reduce clinical variation and ensure appropriate referrals are made to secondary care, and redesign outpatients.

8.1 Cancer

Significant improvements in cancer wait time standards have been seen during 2016/2017 at RBFT, the main acute provider for the CCGs in Berkshire West. The Trust is forecasting to achieve the 62 days target from Q3 onwards. The CCGs are expecting that this performance will be sustained during 2017/18 and beyond and is one of the best performers in RTT in the region. The CCGs will continue to focus on working with RBFT to reduce the size of the backlog of patients waiting beyond 18 weeks yet to be treated, especially those with the longest waits beyond 40 weeks. In aligning our demand and capacity modelling we have factored in the capacity required to achieve the national performance standard, including diagnostic capacity.

The Berkshire West CCGs have jointly developed a cancer framework (see Appendix 5) with stakeholders from RBFT, Public Health, Thames Valley Strategic Cancer Network, Macmillan and Cancer Research UK to improve the outcomes for people affected by cancer in Berkshire West. Through this framework we will deliver the strategic priorities outlined in “Achieving World-Class Cancer Outcomes: A Strategy for England” over the next five years.

The framework includes a series of initiatives across the patient pathway emphasising the importance of earlier diagnosis and of living with and beyond cancer in delivering outcomes that matter to patients. We plan to reduce the mortality rate and increase survival rates through early diagnosis, appropriate interventions, delivering high quality care to improve patient experience, promote national and local awareness and provide care closer to home.

The Berkshire West Cancer Steering Group has been formed with all of the relevant stakeholders to lead the delivery of the prioritised strategic objectives and will work through the local Cancer Alliance.

Our overall ambition is to prevent people from dying prematurely by decreasing the potential years of life lost (PYLL) from cancer related causes and decreasing the under 75 mortality rate from associated cancers.

We also continue working with RBFT colleagues to understand and forward plan for the demand and capacity required over the coming years taking into account the impact of changes in demographics, increasing demands for diagnosis from cancer pathways, compliance with NICE Guidance on suspected cancers, GP direct access and diagnosis expected earlier in the pathway (as per the upcoming 28 day standard).

9. Urgent and emergency care

During 2017-18 and 2018-19 we will continue to work with the Berkshire West A&E Delivery Board which brings together system leaders from partner organisations to ensure delivery of:

- The NHS Constitutional Standard that 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival at A&E
- The 5 national mandated actions to improve A&E Performance
- Further locally agreed priorities for the Berkshire West System arising from two "Roundtable" events held in July and September 2016

The Board will also work closely with the Thames Valley Urgent & Emergency Care Network (UECN) to further deliver the vision of the national Urgent and Emergency Care review. The TV U&ECN is focused on delivery of the 3 national strategic asks of the network:

1. Development of a roadmap for delivery of the following for 100% of the population by 2020-21:
    - All patients admitted via the urgent and emergency care pathway to have access to acute hospital services that comply with the four priority clinical standards on every day of the week
    - Access to Integrated Urgent Care, to include at a minimum Summary Care Record, clinical hub and 'bookability' for GP content; mental health crisis response in hospital; Ambulance Response Programme
    - Improved access to primary care in and out of hours
2. Carrying out further enabling activities for delivery of Keogh Review in 2017-18
3. Designate 'local' UEC services and standardise delivery e.g. Urgent Care Centres to be open 16 hours daily with x-ray and blood testing available throughout.

The Delivery Board have an agreed work plan which addresses both the 5 nationally mandated improvement actions and locally agreed priorities for the urgent & emergency care system. Berkshire West has held two Urgent Care Roundtable events in July and September 2016 which have helped to shape the strategic and operational priorities for the AEDB.

Key themes from the plan include (see Appendix 6 for full plan):

- ED streaming
- Increase in NHS 111 calls being handled by clinicians
- Delivery of the Ambulance Response programme (ARP)
- Measures to improve flow

- Improving Discharge processes/DToC performance by implementing the national Choice policy, strengthening CHC processes and the “Getting Home” project

9.1 Thames Valley Integrated Urgent Care service

Key local priorities as part of this overarching programme are the mobilisation of the Thames Valley 111 Integrated Urgent Care service from 2017/18 and a review of the contribution of Reading Walk In Centre.

The UECN is leading the Urgent Care work stream of the STP and Berkshire West CCGs are actively working to achieve the agreed deliverables, in particular Berkshire West is leading the procurement of a new Integrated Urgent Care service across Thames Valley.

Key deliverables for the workstream are:

- Regional 111 Integrated Urgent Care service, including enhanced clinical hub and enhanced Directory of Services
- Standardisation of UEC clinical pathways and designation, mapping and signposting of UEC services across the Thames Valley UEC network area
- Interoperability of UEC systems that allow the patient record to travel with the patient and be accessible to healthcare professionals across the patient pathway
- U&EC competency framework and workforce ‘passport’ arrangements across Providers
- Establishment of interface clinician roles offering portfolio employment across UEC services
- Best practice framework for 7 day access to standardised care across primary, community and secondary settings.

The Integrated Urgent Care (IUC) service, which launches in 2017/18, will offer a step change in meeting the urgent and emergency physical, mental and social care needs of patients across Thames Valley. NHS 111 will have the potential to be the single entry point to all urgent care services for the public.

The IUC service will offer improved management of patients with an increased clinical work force who can provide clinical review and early intervention for patients including vulnerable groups such as under 5s, patients at the end of life, support for self-care where clinically appropriate, and greater integration with downstream services such as community health and social care hubs. The service will provide improved transfer of patient information and access to care records.

Patients will be confident that, with one call to 111, the care that they are directed to will meet their physical, mental and social care needs in a timely and clinically safe manner. Health and Social Care professionals will be confident that the 111 Integrated Urgent Care Service has assessed and managed patients appropriately, placing them with the service that can most effectively meet their needs.

The Clinical Advice Hub is a new feature that will serve two purposes: providing enhanced clinical advice and management to patients contacting the service including generalist and specialist advice such as mental health, dentistry and pharmacy; and providing support to

clinicians (particularly ambulance staff such as paramedics and emergency technicians) via dedicated Health Care Professional (HCP) lines to ensure that no decision is made in isolation without proper clinical advice. The Hub will, in time, become the one location where a patient's physical, mental and social care needs can be co-ordinated and become, through patient's experiential learning, the choice for access to care.

9.2 Four priority standards for seven-day hospital services

As the main provider of acute services of in this area, Royal Berkshire NHS Foundation Trust are making strong progress with the implementation of the four priority standards for 7 Day Services (7DS).

As a result of this focused and targeted approach, the current position is as follows:

N	Standard	RBH Position
2	Time to first consultant review	Fully compliant
5	Access to diagnostics	Partially compliant
6	Access to Consultant-directed interventions	Fully compliant
8	On-going Review	Fully compliant

Berkshire West CCGs will continue to ensure that the provider is best placed to achieve as many of the standards (and maintain this position) as quickly as possible.

9.3 Ambulance response times

During 2015/16 and 2016/17 SCAS has been challenged in delivering the ambulance response time standards for the Thames Valley contract. All three of the national standards will not be met for the year. The CCGs have had a remedial action plan in place during 2016/17 that is forecasting recovery in the month of February 2017. This plan assumes activity levels are in line with agreed contractual levels; however it is worth noting that up to the end of August 2016, activity was 7.8% above plan which puts delivery against the plan at risk. A trajectory for 2017/18 is yet to be agreed with the provider.

When compared to other providers nationally, SCAS is one of the best performers against the national standards and was also the first ambulance service to receive a Good CQC inspection result. There is a national programme underway piloting various different response time options and the outcomes of these pilots are expected in early 2017 and this is likely to result in a change in targets within the 2017/19 contract.

9.4 Avoidable transportation to an A&E department

The IUC service will provide safe, effective and responsive integration with emergency ambulance services ensuring that ambulances can be dispatched without delay as clinically appropriate, for life-threatening 'Red' cases.

Patients that do not require an emergency response will be warm transferred to the IUC hub for review by a clinician and management in a more clinically appropriate community setting. 'Green' ambulance dispositions reached through NHS Pathways by 111 will be automatically transferred to a clinician for review and, where appropriate, patients will be supported to

access alternative services in the community that are appropriate to manage their level of need.

An improved, up-to-date Directory of Services (DoS) will also be central to the IUC service, including a comprehensive range of local health, community, third sector, mental health and social care service information that can provide support where appropriate. The DoS will also be made available to health professionals to search for local services to support their patients and make better decision making to manage a patient, where appropriate, in the community without recourse to attendance at an Emergency Department or admission due to lack of knowledge of local care.

SCAS are proactively seeking local opportunities to increase see and treat rates where clinically appropriate. See and treat hubs are being established to increase see and treat support through Specialist Paramedics. Five sites have been identified across the SCAS geography with a pilot currently running in Reading. The CCGs will work with SCAS in 2017-18 on delivery of the CQUIN "A reduction in the proportion of ambulance 999 calls that result in transportation to a type 1 or type 2 A&E departments". The CQUIN will act as a driver in the development of ambulance services as they become community-based providers of mobile urgent and emergency healthcare, fully integrated within Urgent and Emergency Care Networks. The CQUIN will incentivise SCAS to manage a greater proportion of care closer to home and reduce the rate of ambulance 999 calls that result in conveyance to A&E.

10. Mental health

The core objectives of the Five Year Forward View for Mental Health are to improve access to high quality care, provide early intervention and integrated services with the aim of reducing spend in acute settings and inpatient services. In Berkshire West across 2017/19 we will commission mental health services which will enable savings to be realised across the health and social care system by providing people with the most appropriate care in the right setting, this will align to the BOB STP mental health workstream objectives.

Working with our main provider, Berkshire Healthcare Foundation Trust (BHFT), we will lead service transformation to bring services in line with National Standards to meet the Parity of Esteem "Call to Action Framework" and we will be working with them to deliver the two new national mental health standards.

The CCGs are leading a local Mental Health Taskforce for Berkshire West and this will be the first time there has been a strategic approach to improving mental health outcomes for people of all ages in the health and social care system.

In 2016/17 we have made significant investment in mental health services to support the delivery of 'Parity of Esteem' and we will continue to drive change throughout the next two years to ensure all our mental health users and carers receive a high quality, outcome focussed service comparable with physical health care. As part of the primary care five year forward view Berkshire West have invested in primary care to provide physical health checks for those patients with a severe and enduring mental health illness in the community. In

addition BHFT are committed to increasing physical health checks for patients within the community.

10.1 Crisis Care

In relation to crisis care, we have invested in expanding our Crisis Response and Home Treatment Teams (CRHTT) that will make a critical contribution to managing the pressures on acute in-patient beds that lead to increased bed occupancy and, ultimately, to people being sent out of area. The acute care pathway that we are developing during 2017/18 will incorporate demand and capacity management and will use learning from other areas where the acute care pathway has been redesigned so as to completely eliminate Out of Area placements (OAP). By redesigning our crisis care pathway into CRHTT we will see the benefit from reduced mental health in-patient admission at Prospect Park Hospital and reduce delayed transfers of care.

The Berkshire Crisis Care Concordat describes what people experiencing a mental health crisis should be able to expect of the public services that respond to their needs and how different services can best work together. The Berkshire Concordat Action Plan has been informed by engagement with people who have needed to use crisis services and establishes key principles of good practice that local services and partnerships should use to raise standards and strengthen working arrangements.

Our local concordat focuses on the need for agencies to work together to deliver a high quality response when people with mental health problems need help; to establish joint intent and common purpose as to the roles and responsibilities of each service.
Berkshire Crisis Care Concordat is arranged around four key areas;

- Access to support before crisis point
- Urgent and emergency access to crisis care
- Quality of treatment and care when in crisis
- Recovery and staying well/preventing future crises

We are working with partners to provide better access to support people before crisis point by:

- Providing a rapid response service 24/7 to all urgent and emergency mental health crisis
- Delivering an early intervention and prevention service
- Ensuring people in crisis will be kept safe, have their needs met and be helped to achieve recovery
- All staff having the right skills and training to respond to mental health crisis appropriately
- Ensuring access to our local 24 hour helpline staffed by mental health professionals for people in crisis, their carers and GPs
- Delivery of the Crisis Resolution and Home Treatment Team, available 24/7
- Delivery of a street triage service and places of safety

Both the Crisis Response Team and the Home Treatment Team will be fully operational on a 24/7 basis from 2017/18.

The effective planning and management of mental health service pathways, including the involvement of patients and their carers in the development of Berkshire West Crisis Services, will support more people to have good mental health and those people with mental health problems will recover quickly.

10.2 Improving Access to Psychological Therapy (IAPT)

The Berkshire West IAPT service has been achieving the target of 75% of people with relevant conditions accessing talking therapies in six weeks and 95% within 18 weeks. The Berkshire West IAPT service has been recognised nationally as a high quality service with excellent wait times and access rates. This service has received national recognition for its achievements:

- A recovery rate of more than 50%
- Wait time of 4 weeks (against a national target of 18 weeks)
- 95% patients reporting a positive experience

Our priorities for 2017/18 & 2018/19 are to ensure that current performance is maintained and that recovery rates are above 50%. This service will continue to evolve and we have secured National IAPT Expansion Site Funding from NHSE as wave 1 site to roll-out the IAPT service in managing long term conditions i.e. COPD/Diabetes.

Berkshire West is part of the University of Reading Children and Young People's IAPT collaborative and has been for a number of years. Many BHFT CAMHs Tier 3 staff and some local authority Tier 2 staff are undertaking CYP IAPT training. Learning from CYP IAPT has helped to shape care pathways and the development of an outcome framework in Berkshire West.

KPIs	2017/18	2018/19
Achieve a recovery rate of more than 50%	50%	53%
Waiting time of 4 weeks	75%	78%
95% patients reporting a positive experience	95%	98%

10.3 Early Intervention Psychosis (EIP)

Berkshire West Early Intervention in Psychosis service promotes early detection and engagement to reduce the duration of untreated psychosis to less than three months. BHFT employ specialist staff to provide a range of interventions, including psychosocial interventions and anti-psychotic medications, tailored to the needs of young people with a view to facilitating recovery. This service seeks to normalise experiences at a crucial developmental stage and offer therapeutic optimism, expertise and confidence in a recovery based approach. The service focuses on being person-centred, family focused, responsive and engaging.
In 2016/17 we have put in place a Service Development Plan with BHFT to implement a NICE compliant EIP service that is able to deliver the following recommended treatments to more than 50% of people within 14 days of referral:

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

This is being monitored monthly at our service and performance meeting with BHFT and we are working closely with the South Region EIP Support Team to develop an EIP service that will meet the national accreditation criteria in Berkshire.

In Berkshire we have set out some local outcome measures for the EIP service to deliver in 2017/18;

- Patient Reported Outcome Measures (PROMs)
- Patient Reported Experience Measures (PREMs)
- Carers Reported Outcome Measures (CROMs)
- Reduce Hospital Admission
- Improve Outcomes for BME Groups

10.4 Out of Area placements (OAP)

Berkshire patients should be treated in a location which helps them to retain the contact they want to maintain with family, carers and friends, and to feel as familiar as possible with the local environment. BHFT have experienced staff as part of their placement review team to regularly review all out of area placements and provide reports to a Berkshire West funding panel, plans are in place to repatriate patients into local services. The review officers have an important role in terms of care quality, service user experience and financial management. Commissioners will monitor the progress made in reducing OAPs and report to NHSE Quarterly based on BHFT submissions.

Berkshire West CCGs are also working with our local authority partners to develop the local provider market to manage complex needs mental health patients in the area ensuring they can remain connected to their communities.

10.5 Perinatal Mental Health

Berkshire West Perinatal Mental Health Service provides a comprehensive range of community services for women requiring pre-conceptual counselling Talking Therapy or who experience mental health problems or illness during pregnancy or in the first year after birth. The service provides assessment and management of women at risk of, or suffering from mental illness that requires pre-conception advice, is pregnant or in the post-natal period. The service supports mother and infant relationship in the context of maternal mental illness and offers a service that is fully integrated in existing mental health services in Berkshire.

The following will be delivered across 2017-2019:

- Central Point of Entry (CPE) will have an identified perinatal clinical lead who will undertake the majority of the clinical work relating to new referrals into the Trust and act as a resource for referrers and the CPE team in matters relating to perinatal assessment.

- CPE perinatal lead and Manager of Trust Perinatal Mental Health Services will provide guidance to professionals within the Trust providing perinatal care including joint visit where required.

- Care Pathway/CMHT teams will have an named perinatal lead who has sufficient identified and ring fenced time to fulfil the role in order to provide care to the majority of new referrals into their team from CPE and to ensure/enable quality liaison between relevant services. They will act as resource for information and support to colleagues who have a client already open within the team and who subsequently come within the perinatal remit.

- Females who are aged 16-18 at the time of pregnancy/referral/delivery will be assessed jointly between perinatal lead at CPE adult services and CAMHS and signposted to the most appropriate service.

- Women who may require need admission to MBU will be referred to CRHTT for intensive interventions at home but where care cannot be safely managed in the community with crisis team CRHTT and with regard to risk - admission to MBU is sought from 24 weeks of pregnancy and up to one year post-partum and will be directed to MBU where at all clinically possible.

- Admission to CRHTT will also be sought to facilitate discharge from MBU.

- The named professional for the service user will attend the reviews held at MBU prior to discharge to facilitate a support plan to enable discharge.

- Advice regarding medication during pregnancy or whilst breastfeeding to be provided by pharmacy or psychiatrist as required as part of a whole assessment.

- Referrals within four weeks of birth from any source to any team within BHFT are treated as 'urgent' to commence the assessment process on the same day regardless of the information provided in order to eliminate risk of psychosis (this is the point of highest risk of psychosis).

- Women who are pregnant and come into contact with BHFT services will have a maternity planning document completed to be shared between the woman and all professionals involved with the care of the woman during pregnancy and in the early post-natal period. This document will detail information about risk in respect of medication and risk of relapse together with a plan in the event of relapse.

10.6 Suicide Prevention

The Berkshire suicide prevention strategy is being developed and is out for stakeholder's consultation, it is expected that this will be agreed by key partners by 31st January 2017. The Berkshire suicide prevention strategy commits every organisation to reduce suicide rates by 25% by 2020/21. There is a clear action plan as part of the suicide prevention strategy supported by BHFT to reduce suicide rate amongst mental health service users. The plan will:

- Implement the NICE guidelines on self-harm, specifically ensuring that people who present to Emergency Departments following self-harm receive a psychosocial assessment.

- Evaluate the Berkshire CALMzone and recommission targeted suicide prevention work for younger men and middle aged men.

- Work to provide and commission interventions which improve the public's mental health. These may include: awareness of mental health and peer support in young people; anti-bullying campaigns in schools; addressing stigma and social isolation in older people; workplace health promotion and support with local business; working with police on mental health literacy; and addressing issues relevant to the local population.

- Ensure that local authority public health teams take the leadership for liaison with any Escalation Process in their area, and report on progress to the Steering Group.

- A named Highways England officer is identified to act as a liaison link and group member, and to share real-time intelligence of highways network incidents.

- Ensure that local authority public health teams work with other council departments such as parking and open space services to identify local actions to prevent suicide including staff awareness training.

10.7 Dementia

Identifying those living with Dementia and the provision of high-quality post diagnosis care is a high priority for the four Berkshire West CCGs.

We have an established nationally accredited Memory Clinic service provided locally by Berkshire Healthcare Trust. In addition we have commissioned an award winning service for young people with Dementia which plays a significant role in supporting younger clients and their carers. Following the refresh of our Berkshire West Dementia Stakeholders Steering Group in late 2016, we will, in conjunction with our partners and utilising the forthcoming NHS implementation guidance, conduct a gap analysis which will allow us to update our Prime Ministers Dementia Challenge for 2020 action plan.

Currently the average Dementia diagnosis rate across all Berkshire West CCG practices at Sept 2016 is 66.9%. However, two of our CCGs currently remain below the 67% target and with support from NHSE and the SCN they are implementing CCG specific action plans to improve diagnosis rates to 67% by March 2017 (Wokingham) & April 2017 (Newbury). However, it is recognised that with changes to the denominator in April 2017, our positon may deteriorate in some CCGs further against target but with a potential for improvement in Wokingham. (Worst case scenario is for the CCG average to fall to 64.1% with all four CCGs below the 67% target). Three of our four CCGs we anticipate will therefore be in a positon to reach the 67% target by 1st April 2017 and will continue to maintain this over 2017/18 and beyond. We will continue to work closely with Newbury & District CCG to improve their positon as quickly as possible through implementation of their comprehensive action plan. For all CCGs we will continue to commission regularly updated "Dementia lists" direct to all four CCG practices from our memory clinic provider, allowing data harmonisation and registers to be kept up to date. Across all four CCGs other initiatives will include further raising awareness, on the importance of recording Dementia diagnosis, mapping and improving referral routes into the Memory Clinic and focusing on ensuring accurate and timely coding of newly identified Dementia patients from several of our newly built local Care Homes.

Building on work underway in comparable and neighbouring CCGs, we will implement a new pathway in 2017 for Mild Cognitive Impairment, led by Newbury & District CCG. This will offer us the opportunity to monitor and appropriately identify deterioration which may lead to a further improvement in Dementia diagnosis recording. A mapping exercise to identify "Dementia Friendly Practices" during late 2016 will allow us to target and promote support and training to practices, with the aim of achieving 100% Dementia Friendly practice access to our population by March 2019. To become dementia friendly, GP surgeries will sign up to the local dementia action alliance and commit to carrying actions that aim to help people living with dementia and their carers. We are adopting the iSPACE model which consists of 6 key steps to becoming a Dementia Friendly Practice:

1. **Identify** one or two Dementia Champions in the practice
2. **Staff** who are skilled and have time to care
3. **Partnership** working with carers, family and friends
4. **Assessment** and early identification of dementia
5. **Care plans** which are person centred
6. **Environments** that are dementia friendly

In line with the aspirations of the Prime Ministers Dementia Challenge 2020 to have diagnosis and treatment of Dementia within 6 weeks of referral, we will continue the work already underway with our Memory Clinic to refine patient pathways. A key deliverable within our action plan will be the achievement of a dementia initial assessment within 6

weeks of GP referrals. This will require identification of variation in referral and diagnosis rates within primary care. We will provide dedicated support to those practices identified as outliers but also to allow us to share good practice between practices.

The integration of our Dementia Care Advisors within GP practices will further help support the identification of and provide improved ongoing support to dementia patients and their carers.

As well as building on the Prime Ministers challenge on Dementia in the 5 key areas of care, we will refocus on improving the quality of post-diagnosis treatment and support in line with the 2020 vision using benchmarking and best practice wherever possible.

Our current established dementia stakeholders group will meet monthly and will take responsibility for the implementation of the Dementia action plan for 2017/18 and beyond. This will include ensuring robust processes are in place to provide regular reviews of Dementia Care Plans, and this will align with our plans to extend care and support planning to other Long Term Conditions, including Dementia as well as our local enhanced service for anticipatory care planning. Recent data provided by the Department of Health's Dementia Atlas will be utilised to allow us to learn and share best practice wherever possible. By refining our models of Dementia care delivery, we will be looking at the option to further integrate older people's mental health specialists within our GP practice.

Outcome measures of importance to us will include admission avoidance, reduction in requirements for respite /social care intervention as well as reductions in the need for medical intervention (e.g. measure reduction in mental Health practitioner and community support worker contacts). This information is invaluable to assessing the value for money Dementia Services offer but also to release funds to allow further investment in Dementia services. By the end of 2017 we will have a clearer identification of the cost of current services and the size of any need for additional investment to meet the future needs of the population.

10.8 Emotional health and wellbeing in children and young people

We published our Local Transformation Plan for child and adolescent mental health and wellbeing in 2015 in response to Future In Mind and refreshed these plans in October 2016. Our Local Transformation Plans focus on integrating and building resources within the local community, so that emotional health and wellbeing support is offered at the earliest opportunity. This will reduce the number of children, young people and mothers requiring specialist intervention, a crisis response, an in-patient admission or out of area placement. Help will be offered as soon as issues become apparent.

As well as increasing the capacity of specialist CAMHs (Tier 3), Berkshire West CCGs have commissioned partners from the voluntary sector, third sector and Local Authorities to provide emotional and mental health services in the community before needs escalate to specialist level. We anticipate that access rates will be met through a combination of specialist (Tier 3) services and services from partners.

Additional specialist CAMHs staff have been recruited and trained and waiting times for specialist CAMHs have reduced. More children and young people are having treatment. In

17/18 waiting times will reduce further and expect there to be an increase in the number of children accessing help.

We are working to reduce CAMHs crisis mental health presentations through swifter risk assessment of new referrals and better risk mitigation of new and existing cases. Referrals are being triaged faster and urgent cases access help on the same day.

The CAMHs Urgent Care Pilot operates over extended hours Monday to Friday, over bank holidays and weekends providing timely mental health assessments and care. The service is integrated with RBFT to maximise joined up working and training opportunities. Short term intensive interventions in the community are provided to young people who have experienced a mental health crisis with the aim of reducing the number of children and young people who have a second crisis. The service also provides wrap around support when there are delays in sourcing a Tier 4 in CAMHS patient bed. In 16/17 the service will be evaluated and a sustainable model will be agreed and commissioned for implementation in 17/18. We are working with neighbouring CCGs and NHSE Specialised Commissioning to ensure best use of resources and implement a care pathway that reduces the need for out of area placements. The number of in-patient beds at Berkshire Adolescent Unit has been increased. The unit is now open 7 days a week.

Our CAMHS Community Eating Disorders service has been jointly commissioned with Berkshire East CCGs. The service became operational in 2016 and is on track to meet the access targets.

School based early identification and intervention projects have been commissioned. PPEPCare emotional health and wellbeing training is being delivered across the children's workforce including school nurses, GP's, school staff, Local Authority staff. An online Young SHaRON workforce support hub has been launched to support professionals who have concerns about children. School exclusion data has been analysed with partners to identify which young people are most likely to be excluded from school and where more help in schools might make a difference. This work will be carried forward into 17/18.

In 2016 we under took an Appreciative Inquiry into services for children and young people with autism, including those who are waiting for an assessment. We are using the learning from this inquiry to work with partners to develop improved care for these children across the system and across settings. Two voluntary sector organisations have been commissioned to provide support to families whose children are waiting for autism or ADHD assessment. We have also commissioned post diagnostic support to families whose children have a diagnosis of autism and other neurodevelopmental issues. The neurodevelopmental care pathway (ADHD and ASD) is being reviewed within BHFT.

11. Learning disability

11.1 Transforming Care

The Transforming Care Projecting Adult Needs and Service Information (PANSI) projections in 2015 identified 7313 people aged 18-64 with challenging behaviours in Berkshire West with projections showing a growth of 5% year on year until 2030. Predictions suggest nearly a third have an autistic spectrum disorder.

This Berkshire Transforming Care Partnership (TCP) builds upon the lessons' learnt from learning disability and autism schemes across Berkshire West and established partner forums focused on improving people's health outcomes, to ensure parity of access and equal opportunities for people with LD and/or Autism who have health and social care needs.

The TCP Board comprises 14 Health and Social Care partners across the county who hold a shared vision and commitment to support the implementation of the national service model for children, young people and adults with learning disabilities and/or autism, who have behaviour that challenges and may or may not have mental health issues and have come into contact with the criminal justice system. The model requires integration and collaboration by commissioners, providers and other sectors to enable this cohort of people to lead meaningful lives through tailored care plans that meet individual needs.

Berkshire Transforming Care Plan has 4 key aims:

1. Making sure less people are in hospitals by having better services in the community.
2. Making sure people do not stay in hospitals longer than they need to
3. Making sure people get good quality care and the right support in hospital and in the community
4. To avoid admissions to and support discharge from hospital, people will receive and be involved in a Care and Treatment Review (CTR)

To achieve those aims the TCP Board has established a programme and governance structure built around a number of work streams, with children and young people and those in transition being a core component of each.

11.1.1 Priority actions for 2017 – 2019:

We know that providing suitable accommodation and appropriate and flexible support in a home environment is key to helping people with LD and/or Autism come out of hospital and stay out of hospital; whether that be in an acute or secondary care setting. This will inform the development of a programme of work for 2017/18 and 2018/19 that enables the partners to have a coherent picture of demand and supply to underpin a strategic approach to market management to ensure that people with learning disabilities are able to access services in their community.

The new Berkshire TCP service model for people with learning disabilities and autism includes an Intensive Support Team (IST) who will provide high quality functional

assessment in the person's own home, aiming to improve safety for the person and reduce reliance on hospital admission. The service will use non-aversive strategies (Positive Behaviour Support) to improve people's lives and build resilience in a constructive way by focusing on improving quality of life and the reduction of behaviours that pose a risk to self and others.

The IST will be: safe, responsive, caring, effective and well-led with health and social care staff working closely together to improve people's lives, building resilience for the individual in their own environment and their community.

The TCP Board has set a plan to reduce Berkshire East and West CCGs commissioned in-patient beds to 10-15 beds per million population by the end of 2018/19. Working with the provider, Berkshire Heath Care NHS Foundation and NHS England Specialist Commissioning Team the plan is on track to reduce CCG and NHS England commissioned bed capacity from 44 to 28 within the time line. Working with the best of local experience, skills and knowledge a new service model has been created that incorporates Positive Behavioural Support and increased level of community based provision resulting in a reduction in beds. The Berkshire West CCGs and 3 local authorities are planning to deliver intensive care support in the community as a viable alternative to hospital assessment and treatment beds. This will be achieved through specialist skills and knowledge to be transferred to community support settings and for the remaining beds to be redesigned as part of a challenging behaviour pathway. Cost savings will be released for investment into community intensive support.

To ensure plans and changes maintain safe and high quality services, responsibility for the auditing of patient outcomes during the programme will sit with the TCP Star Chamber, a group of expert clinicians and service users.

The Primary Care work stream aims to produce a collaborative health action plan in 2016/17 that over the next 2 years will support people in health, education and community settings to identify their needs, their goals, outcomes and what they want to achieve for their own health and wellbeing.

National benchmarks of physical activity rates for children and young people with learning disabilities, and adults in residential care in relation to participation in sport are poor. The health action plans will aim to foster confidence in individuals and identify where support is needed to access a range of opportunities to improve physical health and reduce obesity rates.

The CCGs will work with BHFT to review the levels of mortality in Berkshire in line with the recommendations of the Mazars report. The CCGs will ensure that there is good quality healthcare to avoid unnecessary admissions, based on an understanding of the current rate and reasons for mortality amongst people with learning disabilities. In parallel the TCP board will identify how services will need to be commissioned and provided in the future to ensure that people with learning disabilities and/or autism with behaviours which challenge services are supported within their local community and only require in-patient services for clearly defined purposes.

A significant proportion of mortality rates are due to preventable illnesses or conditions (i.e. heart disease and diabetes). The action plans will improve information on good nutrition and improve access via advocates, to primary and secondary healthcare services e.g. Dental, GP, ophthalmic, occupational therapies and diagnostic services. In addition the action plans will address inequalities in the uptake of cancer screening by people with a learning disability across Berkshire West by targeting people most in need.

11.2 Special Educational Needs (SEND)

Berkshire West CCGs continue to work with local authorities, health providers, the voluntary sector, families and service users to improve collaborative working across education, health and care for children and young people with SEND aged 0 – 25 years and to give parents more control. This work is in accordance with Part 3 of the Children and Families Act 2014. A Designated Clinical Officer is in post to support to CCGs in meeting their statutory responsibilities for children and young people with SEND. “Local Offers” have been published in each area. The Local Offers provide accessible information on local services and resources for children with SEND and their families. The “Ready Steady Go” programme has been introduced in many clinical areas to improve transition into adult services and to better prepare young people and their families for adulthood. Education partners are considering how the Ready Steady Go principles can be aligned to Education Health and Care Plans to improve integrated working.

Community health services for children, young people and families (e.g. therapies, CAMHs) have integrated into a single team. The needs of children and young people referred to services are considered in a more holistic and collaborative manner with a greater emphasis on agreeing a joint care plan with meaningful outcomes with families.

12. Maternity

The CCGs Maternity Steering Group includes membership from all key partners including the MSLC and Thames Valley Maternity Network. The broad objectives of this forum are to:

1) Review the quality of maternity services provision for women across Berkshire West in line with the agreed service specification
2) To ensure that women’s feedback is heard and contributes to strategic planning
3) To agree key initiatives to improve the quality of maternity services for women across Berkshire West, in line with national guidance and recommendations and supported by all Berkshire West CCGs
4) To monitor the implementation and achievement of key initiatives and targeted service improvements in maternity care provision

It is collectively agreed by the forum, that the above overarching objectives will enhance the patient experience and support the choice agenda, in addition to the identification of any gaps in provision to ensure that any improvements in service provision are completed with the above as a priority.

When focussing on the various deliverables in order to achieve the objectives of the forum, in collaboration with the CCGs, RBFT have chosen to;

a) Prioritise the improvement of maternal choice through increasing the percentage of midwifery led deliveries (25% in 2017/18) and continue drive to recruit to midwifery vacancies until full establishment is achieved
b) Increasing the number of home births through commissioning of a dedicated home birth service commencing 1st April 2017, aiming to achieve 3% by Q4 2017/18
c) Reducing the need for RBFT to divert women in labour
d) Improved postnatal care through the introduction of smaller community teams (4-6 midwives) and a linked consultant obstetrician, it is thought that this will be fully implemented by March 2017.

It has been identified that in order to provide benchmarking with providers and visibility of performance trends, a Thames Valley Maternity Dashboard is currently under development. This is led by the network allowing for CCGs to monitor the providers against an agreed set of key indicators, it is hoped that this will be implemented by June 2017. The CCGs will utilise these indicators during the contract period 2017/19 to monitor performance and, where required, set improvement trajectories through the provider quality schedule within the NHS contract. Challenge, scrutiny and assurance of actions regarding these indicators will continue through the maternity steering group, reporting to the CMMV Programme Board.

The CCGs are also working with the Thames valley SCN to model the future demand for maternity services in the light of an anticipated rising birth rate as a result of significant housing growth within the locality.

In addition to the specific objectives highlighted above, within 2017/19, the CCGs will ensure progress is achieved to deliver the recommendations of the National Maternity Review, Better Births (Appendix 8).

13. Improving quality of care through better outcomes and experience

Ensuring the quality of patient care provided by our commissioned services continues to be a primary focus in 2017/19. Significant progress has already been made in addressing key quality priorities to date, including reducing patient harm, such as a significant reduction in grade three and four pressure damage, reducing incidents of infection and reducing falls causing serious harm. The monitoring of quality performance is underpinned by robust governance processes, which include benchmarking our providers' performance with other Trusts across Thames Valley and holding them to account using tools such as Quality visits, clinical audits, and improvement plans to ensure improvements are made when standards fail to meet contractually obligated expectations.

The contractual individual provider quality schedules set out the expectations for quality in 2017/19. The schedules are based upon year to date performance in 2016/17, triangulated with feedback from our patients/ users and GPs gathered and reviewed through our Quality Committee, findings from the regulator and local intelligence. The schedules are then amended to reflect local priorities with removal of indicators where consistent achievement has been noted or, the addition of new indicators based upon the collective guidance and feedback relating to services or processes.

The CCGs will continue to work with RBFT to monitor 104 day waits on the 62 day pathway with the expectation to move towards zero waits in this area in 2017/19. There is a clinical harm review process for all patients with a confirmed cancer diagnosis who have waited

longer than 104 days. The CCGs will continue monitor the outcome of these in 2017/19. In addition, the CCGs will continue to monitor cancer and RTT performance at the Royal Berkshire Hospital, ensuring progress to full compliance is sustained. All serious incidents (SI) will be monitored through our robust SI processes; ensuring learning from any lapses in care is effectively captured and embedded.

In 2017/19 the CCGs will continue to monitor progress being made by our providers following recent CQC inspections. A number of inspections were carried out during 16/17; this is inclusive of SCAS (all areas), Spire Dunedin, Circle Reading, Ramsay BIH and Maternity and Gynae at RBFT. The new CCG in-housed Quality Team will ensure action plans are established and monitored to address and note progress regarding any areas requiring improvement.

The CCGs will continue with its programme of Quality Observational visits to our providers across 2017/19, which are now inclusive of patient pathways, gaining direct feedback from staff, patients and their families on the care they are receiving. Recommendations from the visit are then shared with the Trust and followed up within the Clinical Quality Review group.

In 2017/19 the CCGs will continue to improve the quality of primary care provided across all of our practices and will take over the full quality improvement monitoring and supportive function in 2017/18. The CCGs have developed a quality scorecard for primary care to monitor performance and support continuous improvement in quality against key quality indicators, which will be monitored through the Quality Committee and at CCG Council Meetings to support improvement. The scorecard will form part of a broader Primary Care Quality Report which will also incorporate information on complaints, significant events, safeguarding incidents and other information relating to managing the quality of services provided. The CCGs will be developing a quality framework for primary care to set out clearly support and intervention to be taken when individual practices are not meeting the required standards expected by the CCG. The CCG primary care team, in partnership with the quality team will continue to support those practices in our area as rated by the CQC as requiring improvement, ensuring any decisions made are in line with our Primary Care Strategy and produce the best outcome for delivering the highest quality of care for our patients.

Part of this process will ensure there is a robust system in place for recording and monitoring any incidents which arise within the primary care setting. This process will also ensure that any learning that has arisen will be cascaded and embedded within the CCG constituent practices.

13.1 Avoidable deaths

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

The CCGs will continue to encourage an open culture of reporting, which has seen a significant increase in reporting across all our providers in the past two years. Further scrutiny and assurance will also be sought in light of 'Mazars' recommendations, through the development of a Berkshire Wide mortality review of all deaths of patients with a learning disability, ensuring any learning is shared across all providers across the system, in partnership with Berkshire East CCGs.

13.2 Medicines Management

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

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

- A GP prescribing Quality scheme which has prescribing targets for practices to achieve.
- A prescribing support dietitian who reviews patients on gluten free foods, oral nutritional supplements and baby milks.
- A joint post with the Royal Berkshire foundation trust to ensure the most cost effective drugs are used across the interface

The schemes above are delivering successfully with over £770k of efficiency savings delivered up to September 2016

The CCG MOT is strengthening the relationship with secondary care by a number of initiatives.

- Developing a cellulitis pathway in order to manage more patients in primary care and reduce the number of won-elective admissions.
- Work with the secondary care dietetics department to stop Oral Nutritional Supplements being added to Electronic Discharge Letters for low risk patients, which then lead to these products being inappropriately continued into primary care

In 2017/18, the CCGs will continue to utilise the local health economy Antimicrobial stewardship (AMS) Network which will look at all aspects of AMS, including having a joint strategy that spans primary, secondary and community care.

13.3 Safeguarding

The CCGs will continue to be active members of three Local Safeguarding Children Boards (LSCB) and the Berkshire West Safeguarding Adult Partnership Board (SAPB) and will ensure our providers are fully engaged in delivering the safeguarding priorities of these boards. We will commit to improving safeguarding quality, by sustaining the improvement in compliance of delivering LAC Initial Health Assessments within 20 days and continuing to improve GP report submission to child protection case conferences.

All contracts and SLAs require providers to adhere to the Berkshire-wide safeguarding policies and procedures and to work within the framework of national guidance and legislation. Contracts also require all providers to complete an annual section 11 audit (adapted to include safeguarding adults), and to provide assurance of compliance of staff training levels, and continuing professional development covering topics such as their roles and responsibilities in regards to safeguarding children, adults at risk, Children Looked After, the Mental Capacity Act and Deprivation of Liberty Safeguards. Providers are required to inform commissioners of all incidents involving children and adults, including death or harm whilst in their care.

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

13.5 Continuing Healthcare (CHC)

The Berkshire West CCGs are committed to ensuring their Continuing Healthcare processes are compliant with national guidance and delivered in a person centred way with the involvement of all key stakeholders.

To meet those aims Berkshire West have engaged with its local authority partners in a review of CHC processes, facilitated by the CHC Lead for NHS England South and the Lead for the CHC National Performance Advisory group. There are a number of agreed actions and these will be taken forward in 2016/2017 in an Action Plan with agreed timescales for implementation. This will improve the CCGs' processes for receiving referrals for CHC, undertaking multi-disciplinary assessments and supporting people who disagree with their assessment to appeal.

In addition the CCGs have signed up to the NHS England "CHAT" tool which enables CHC Services to evidence their compliance with the Quality Assurance Framework for CHC. We have completed the first upload of data in line with the timescales set by NHS England and plans are in place for the next phase.

14. Digital Transformation

14.1 The case for change

The Berkshire West Local Digital Roadmap forms part of the BOB STP digital work stream. The priorities described in the BOB STP are reliant on the development and utilisation of a number of technological innovations to enable improvement in outcomes, support of self-care and provision of a greater proportion of care in a community setting. The Berkshire West Local Digital Roadmap is aligned to the BOB Sustainability and Transformation Plan and includes a roadmap to achieve:

- Paper-free at the point of care.
- Digitally enabled self-care.

- Real-time data analytics at the point of care.
- Whole systems intelligence to support population health management and effective commissioning, clinical surveillance and research.

14.2 Digital technology as change enabler

It is recognised locally and nationally that the kinds of transformative change set out in the STP cannot be achieved without realising many of the opportunities afforded through extensive deployment of digital technology.

More recently the General Practice Forward View emphasises the importance of greater use of technology to connect primary care with others, for the sharing of best practice, for greater online access for patients and to deliver new modalities for provision of advice and support for patients and the public.

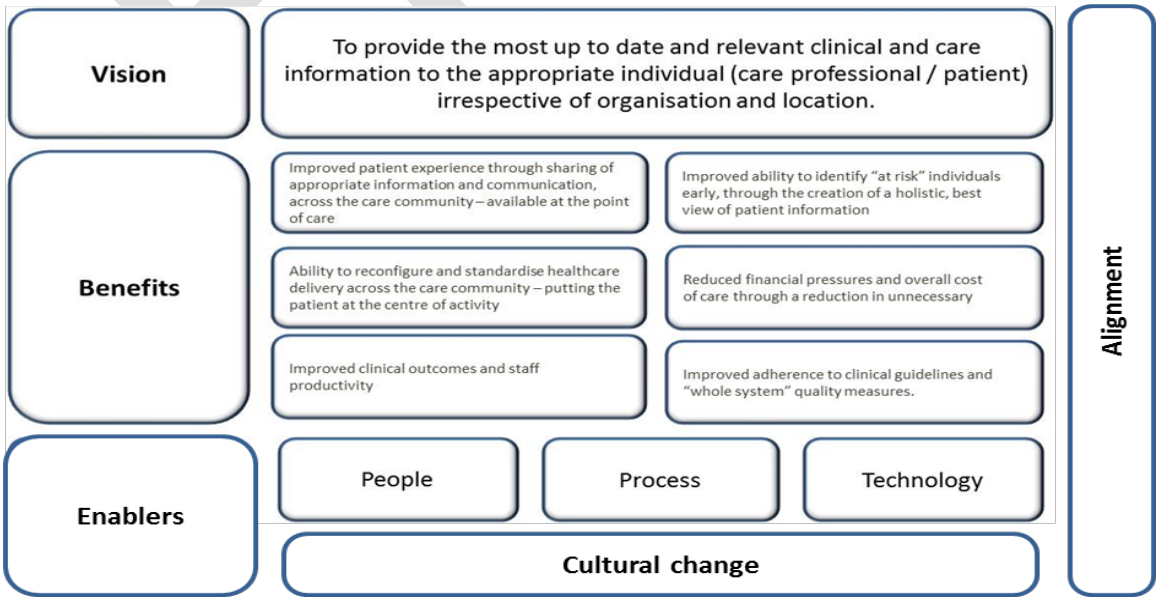
Initial benefits will relate to improvements in patient experience and patient outcomes, but with moves to more integrated care, further efficiencies will be realised by ensuring that patients can access the right care services to meet their needs, while clinicians can make better informed decisions and reduce duplication of tests and imaging.

14.3 Vision for digitally enabled transformation

Digitally enabled transformation is an essential component for addressing the challenges faced by the local health system. Berkshire West have been very clear that "digitally enabled transformation" should not focus on the technology alone but must be driven by the end-users, i.e. those at the front line of delivering care. Often the level of transformation of business processes is significantly under estimated.

Our vision is summarised in Figure 1 with investment in technology to support self-care through digital tools and enablers, data and information sharing across organisations and the development of a predictive urgent care model across the footprint.

Figure 1 - Berkshire West vision



The alignment of the local LDR into an integrated BOB STP LDR provides an aligned approach that has the commitment of provider, commissioner and local authority partners to realise the vision for health delivery for those we serve, and the ability to ensure that developments in digital maturity reflect the priorities of our future care models and services

The technology enablers of our digital vision need to meet a broad set of requirements across a number of care settings, however collectively, they need address three high level objectives:

- Improve the overall digital maturity of our providers
- Interoperability and information exchange between health and social care organisations
- Having a person / patient held record (PHR) for health and social care for the citizens
- Whole systems intelligence.

Engagement with both clinical staff and patients has been a cornerstone of our delivery approach to ensure that quality of care and patient experience are enhanced by our digital priorities.

Year one (June 2016 to June 2017) of Connected Care focusses on wide-spread deployment of the integrated digital care record platform (IDCR), making this accessible from Berkshire's main strategic health and social care systems. This will cover three phases, moving from 500 users in phase 1 to 3000 users by phase 3.

Based on the 10 universal capabilities and the work to improve digital maturity in providers, the Berkshire West Digital Transformation Board has agreed a set of work streams, which will be mirrored by work streams in the other economies of the STP. Work streams may cover a set of systems rather than a single deliverable – for example the record sharing work stream will not only deliver Connected Care, but will also deliver the federated architecture to support Primary Care at Scale, and e-Prescribing will look at delivering these systems in the acute sector, but also look at ePS incentives for dispensing practices. The work streams are supported by an STP wide professional reference group, information governance group and patient panel.

The focus on collaboration across the STP allows shared learning across the 3 health economies. Berkshire West intends to learn from work currently underway in Buckinghamshire on digital consultation, particularly in relation to urgent on the day Primary Care and remote services to Care Home residents. The Digital Centre of Excellence in Oxford University Hospitals will support improved digital maturity in our acute provider, and the pan Berkshire Work on personal health records and our healthy workforce pilot provide innovative approaches that can be shared.

We will monitor improvement in outcomes delivered through the clinical change programmes that Connected Care and our broader digital agenda enable. We intend to work with partners to develop a benefits model for enabling technology, which will help us to identify process benefits directly attributable to deploying technology but also quantify the extent of outcome improvement that could not have been achieved without our digital transformation programme.

14.4 E-referrals

The CCG is forecasting to meet the national targets in relation to e-referral utilisation and is working with providers and GP practices to support delivery of these trajectories. There are some risks associated with achievement of this indicator though, especially at 100%. There is an issue specifically for 2 week wait referrals for RBFT where we have a very good clinical triage process that is initiated on e-referrals by GPs. However these 2 week wait clinics do not count towards utilisation for the national definition even though the referrals are taking place on the e-referrals system. The CCGs are working to try and overcome this issue locally without altering the excellent clinical pathway.

There are also some technical issues with the metric which will mean 100% is very difficult to achieve, even if GPs make all referrals on the e-referrals system. This is mainly because the numerator and denominator come from different data sources nationally and therefore the numerator is not necessarily a subset of the denominator.

15. Appendix

1. Delivery of the Nine Must Dos
2. Accountable Care System - PIDS
3. Berkshire West CCGs – Operating Plans on a page
4. Berkshire West CCGs – Primary Care GPFV plan
5. Berkshire West CCGs – Cancer Framework
6. Berkshire West CCGs – A&E delivery plan
7. Berkshire West CCGs – Dementia plan on a page
8. Berkshire West CCGs – Better births implementation plan
9. Berkshire West CCGs – Local Digital Roadmap
10. Berkshire West CCGs – Communication and Engagement strategy