NHS Newbury and District Clinical Commissioning Group

NHS North and West Reading Clinical Commissioning Group

NHS South Reading Clinical Commissioning Group

NHS Wokingham Clinical Commissioning Group

2017/19 Plan on a Page

Ensuring high quality patient care is delivered by our commissioned services through the delivery of our Quality Improvement Strategy 2017-20, including:

- Implement 'Better Births' action plan
- Develop a quality framework for primary care
- Develop a strategy for antimicrobial stewardship that spans primary, secondary and community care

Work with partners in Berkshire West, Oxfordshire & Buckinghamshire to achieve a high quality sustainable NHS by preventing ill health, improving access to urgent care, hospital services, mental health and working with NHS England to improve specialist commissioning.

Transform mental health services in line with the Five Year Forward View and national standards, ensuring "parity of esteem" by improving access, providing early intervention and integrating services.

- Maintain performance of psychological therapies and expand into managing LTCs
- Review Out of Area Placements
- 50% of adults with 1st psychosis episode start treatment in 2 weeks
- 10% reduction in suicide rates
- Further reduction in CAMHs waiting times
- Commission new urgent care service for CAMHs following evaluation of pilot
- Improve collaborative working for people with Special Education Needs and Disabilities
- Achieve/maintain 67% dementia diagnosis

Achieve financial targets which are dependent on delivery of the QIPP programme.
Create efficiencies by working with our providers in new ways as an Accountable Care System.

Deliver the GP Forward View through our Primary Care Strategy, to ensure effective and sustainable general practice through new workforce models, estates, access and technology
Deliver a patient centred, integrated approach in primary and community settings for people with multiple long-term conditions through to end of life care.
Specific focus on Diabetes, through better use of technology and enhanced access to education and improved care for Diabetics with the most complex needs.

Implement Berkshire Transforming Care Plan which includes:

- Improving quality of care and ensuring community services for people with learning disabilities, including children, are available
- 75% of people with learning disabilities have access to NHS Health Check by 2020

The local cancer framework will deliver the strategic priorities outlined in "Achieving World-Class Cancer Outcomes: A Strategy for England" and work streams have been developed to:

- improve early diagnosis, increase screening rates and prevention, improve 1 year survival rate and access to recovery packages and enhanced end of life care
- Achieving and maintaining constitution waiting time standards of 62 days for cancer

Redesign pathways, and reduce clinical variation working with our providers in orthopaedics, musculoskeletal, ophthalmology and develop a new model of delivering out patients.

- Meet national targets by ensuring that no fewer than 92% of patients are seen within 18 weeks from referral
- 100% use of e-referral system by March 2018

Work with other health and social care organisations to:

- Deliver an agreed A&E improvement plan and achieve the 4 hour constitutional target
- Provide new integrated 24 hour urgent clinical assessment and treatment service bringing together NHS 111, GP out of hours and other clinical advice, such as dental, medicines and mental health
- Reduce Delayed Transfers of Care
- Reduce Non Elective Admissions for our most vulnerable patients of all ages
- Meet 7 day hospital service standards

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Local Plans

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Newbury & District CCG

- Promote healthy lifestyles in partnership with Public Health colleagues with a particular focus on:
  - Referring individuals into the National Diabetes Prevention Programme
  - Tackling childhood obesity
  - Falls prevention
  - Alcohol misuse
  - Targeting specific wards that have high levels of Non-elective admissions to hospital
  - Working together to do joint communication and engagement events.
- Establish integrated community teams which wrap around a GP practice population. Work with our providers and social care teams to streamline services so that patients get timely and co-ordinated care.
- Implement the Delayed Transfers of Care local action plan and work with the Local Authority through the Better Care Fund to increase capacity in the community by commissioning additional 'step down' beds.
- Continue to be system leaders working through the Health & Wellbeing Board and to deliver the two objectives identified for 2017-2018 which are alcohol harm reduction and building community resilience.
- Facilitate collaborative working between our GP member practices to create capacity in Primary Care. Integrate and build on the schemes piloted in 2016-2017 such as utilising Pharmacists in General Practice, providing enhanced medical administration training and expanding the comprehensive digital 'front door' to practices which aims to boost productivity by encouraging patients to do more online.
- Improve the uptake of diabetic patients who have received structured education. Increase the number of patients to 15%.

North & West Reading CCG

- Promote healthy lifestyles/services, particularly decreasing inactivity and smoking rates.
- Improve prevention of diabetes & care of pts. with diabetes by practices participating in NHS Diabetes Prevention Programme and reducing no. of diabetes pts. with HbA1c>75.
- Improve care of pts. with hypertension by continuing to increase no. of known hypertensives & increase % of patients with BP <150/90.
- 75% of high risk Atrial Fibrillation pts. to be on anticoagulation, reducing stroke emergency admissions .
- Increase breast screening rates to over 80%, maintain bowel cancer screening rates & non-attendance/completion flagged on clinical systems supporting opportunistic screening conversations.
- Support practices to become 'dementia friendly.'
- Increase CKD pts. treated with ACE-I or ARB
- Provide referral support by improved GP & Consultant engagement at point of referral.
- Support emotional resilience in children & young people through promotion of MindEd, School Link & Emotional Health Academy.
- Implement 'wellbeing' service for Reading people, supporting them to stay well by linking patients to sources of support in the community.
- Facilitate collaborative working between our GP member practices to create capacity in Primary Care.

South Reading CCG

- Work with Reading Borough Council to promote healthy lifestyles/services particularly decreasing inactivity and smoking rates.
- Continue to support the collaboration of GP practices through the South Reading Alliance and University practices cluster, to redesign the workforce, ensure sustainability and improve access.
- Participate in diabetes related prescribing targets to optimise medications to improve outcomes for diabetic patients.
- Improve outcomes for cancer patients by working in partnership with Macmillan and Rushmoor Healthy Living to raise awareness of the symptoms of cancer in the seldom heard population and introduce a 'Teachable Moment' programme to encourage lifestyle changes in people with negative cancer diagnoses.
- Increase number of known hypertensives to 14,288 by March 2018.
- Reduce rates of active Tuberculosis by promoting the New Entrant Screening Service and raising awareness of Tuberculosis with target populations.
- Implement 'wellbeing' service for Reading people, supporting them to stay well by linking patients to sources of support in the community.
- Review the alcohol pathway locally to increase screening opportunities and reduce acute presentations for alcohol related conditions.

Wokingham CCG

- Work with Wokingham Borough Council to promote healthy lifestyles/services.
- Implement Community Health and Social Care (CHASC) integrated model of care by September 2017.
- Support the development of collaborative working between Wokingham CCG practices with the development of an "alliance" by June 2017, to support workforce redesign improve access, and ensure sustainability.
- Increase the number of patients with diabetes (diagnosed for less than a year) who attended a structured education course (from 5.86% to 15%).
- Through CHASC, reduce non-elective admissions amongst the top 10% at risk patients by 7.5%.
- Increase referrals to Community Navigators by 25%. supporting people to stay well by linking them to sources of support in the community.
- Work with general practice and Wokingham Borough Council to ensure there is sufficient built capacity of primary care for the borough's growing population.