Royal Berkshire NHS Foundation Trust

Berkshire West Clinical Commissoning Group

Berkshire Healthcare NHS Foundation Trust

BERKSHIRE WEST INTEGRATED CARE SYSTEM

OPERATING PLAN: 2018/19

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1 EXECUTIVE SUMMARY

The Berkshire West Integrated Care System (ICS) is a high performing set of health and care delivery organisations which provide outstanding services to a population of 528,000 residents. The constituent organisations have an excellent history of collaboration and integration which are seeking to build on this in order to realise a stretching set of aspirations. The ICS strives to deliver the NHS Constitution by uniting patients and staff in a shared ambition for high quality care by putting these values at the heart of everything we do:

- Working together for patients.
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts

As a nationally recognised exemplar ICS we have been developing our system wide approach to progressing shared transformation opportunities which will also ensure our organisations are financially sustainable for the future. Recognising that we are stronger together, this theme of collaboration underpins our system operating plan for 2018/19.

At the heart of the ICS is the delivery of consistent high quality and safe care, ensuring the best possible outcome for patients. The commitments outlined in the ICS Memorandum of Understanding (MoU) provide the focus for our work with our local ICS Clinical Strategy acting as the cornerstone that underpins how we will transform and improve our services. This is supported by key enabling programmes such as digital transformation and a focus on our collective estates and back office functions to ensure these are fit for purpose and support our objectives.

The organisations which form the ICS are united in their commitment to:

- Deliver the *Five Year Forward View* further, faster and beyond the priorities set out in the *Delivery Plan: Next Steps* document published in 2017
- Manage our resources together, which includes our finance, workforce and physical assets as a collective with a commitment to operating a Financial System Control Total made by each of our statutory Boards
- Develop a new approach to service improvement based on the principles of Population Health Management, analytics and data which will inform improved planning and transformation
- Work as a single system, with a combined leadership which values the principle of collaboration

Financial sustainability is one of the key aims of the ICS and a significant amount of shared resource has been and will continue to be required to support this. The ICS has a forecast gap of £16.9m between what it has been allocated and what it is projected to spend in 2018/19. To mitigate this, our system has identified £11m of efficiency improvements which will not reduce the range or quality of services which our patients are able to access. This leaves a gap of £6m for which further schemes are being currently being developed through the ICS as a whole.

Our approach to Population Health Management (PHM) will ensure we are better placed to understand the needs of the local population as a whole with specific improvement actions identified through which we can improve both clinical and financial outcomes. This work is supporting our long term conditions (LTC) transformation which will align specialist, primary and community care in one coherent package. This will also take into consideration, along a

continuum of care, any palliative and end of life care needs. We plan to move towards a model which reduces fragmentation, and underpins care and support planning (C&SP).

Delivery in 2017/18 has focussed on six key clinical areas of transformation; these packages of work were defined during the financial year 2016/17 and have been developed for implementation during 2018/19 and 2019/20 including:

- Outpatient transformation
- Development of an integrated Respiratory Service
- High Intensity Users programme
- Design and development of an Integrated MSK service
- Maternity transformation
- Diabetes transformation

These, along with other programmes of work, are supported by key enablers including a review of back office functions and estates, understanding and modelling our collective bed base, exploring opportunities for a streamlined approach to medicines management, digital transformation as well as workforce development.

The ICS Quality Framework sets out how the ICS will use a strength based approach to 'System Wide Quality Improvement.' Berkshire West is leading the way nationally to demonstrate what can be achieved when Quality is placed at the heart of a collaborative model for service improvement. As a successful ICS we are working together with a shared vision to achieve agreed quality goals and an openness and willingness to challenge and scrutinise each other; to ensure examples of best practice, as well as learning from when things go wrong is shared across the system to achieve best outcomes.

This System Operating Plan provides the detail which underpins all of the above, demonstrating the strength of our collective system and the confidence our leadership has that we can achieve our vision and objectives.

2 BACKGROUND

2.1 About us

The ICS is collaboration between health organisations to improve services for our local population, delivering consistent high quality and safe care, ensuring the best possible outcome and experience for patients, whilst delivering financial stability across the system.

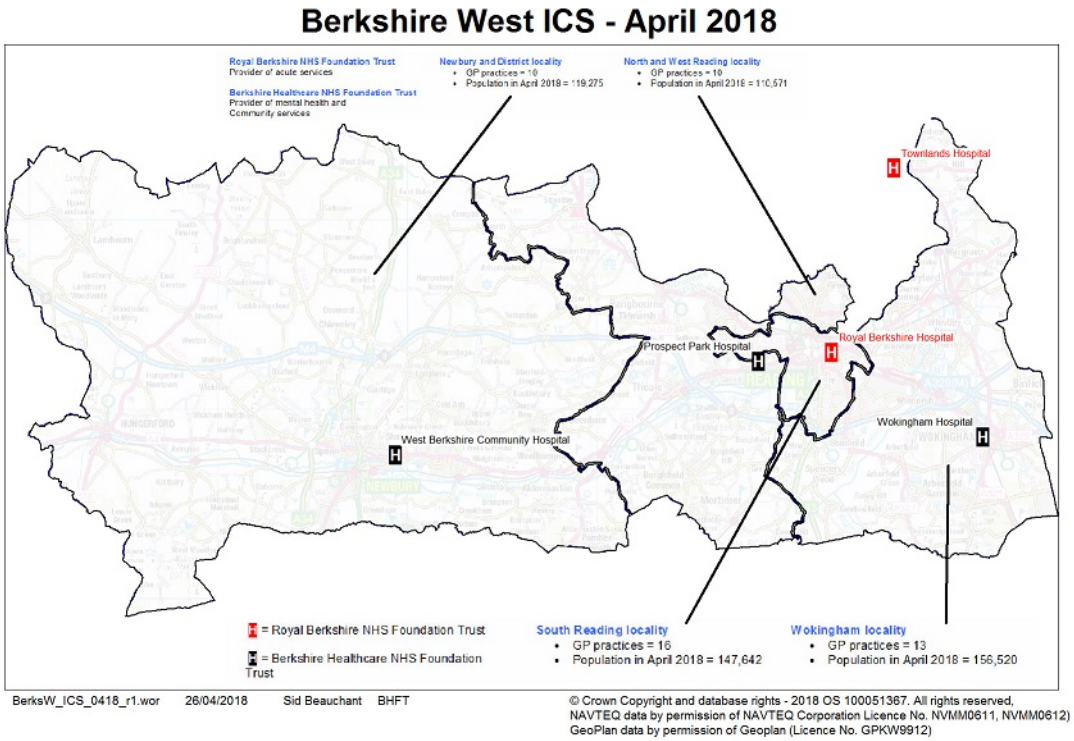
The ICS is comprised of the following constituent members:

- **Acute Hospital Provider** – Royal Berkshire NHS Foundation Trust (RBFT)
- **Community/Mental Health services Provider** – Berkshire Healthcare Foundation Trust (BHFT)
- **Primary Care Provider Alliances** – covering four distinct localities – South Reading, Wokingham, Newbury and North and West Reading Alliances
- **Clinical Commissioning Group** – Berkshire West CCG

Together with our Local Authority partners we are responsible for the health and wellbeing of 528,000 residents living across three Local Authority Areas:

- West Berkshire;
- Reading; and
- Wokingham.

Map 1: Berkshire West Geographical Footprint



The ICS footprint, with a population size similar to Frimley Health & Care STP, is a self-contained health economy with 80% of patient movement, and the majority of funding, being between the constituent organisations. There are three main urban areas – Reading, Newbury and Wokingham alongside vast areas of rurality, particularly in the far west of the area. The areas themselves are also quite distinct in terms of their demographic and health profiles.

The ICS is also a member of the Berkshire West, Oxfordshire and Buckinghamshire ("BOB") Sustainability and Transformation Partnership (STP) recognising the opportunities of working together with partners at this larger scale and progressing initiatives to improve quality and realise financial benefits for the wider system. Through its ICS improvement schemes and local initiatives Berkshire West contribute fully to the delivery of STP wide programmes, for example Maternity services, Urgent Care, Workforce and Prevention.

Generally, the health of residents of Berkshire West is good; however, there are some clear differences between the populations in each of the local authority areas and this is reflected in the differing health needs (full locality profiles can be found in Appendix 1 – separate attachment)

For most of Berkshire West the smoking rates are lower than the national rate in England, however in Reading the rates are higher and therefore a health priority. The number of people drinking alcohol above the recommended levels is fairly high, particularly in South Reading, and along with smoking is an area of focus for the ICS.

Obesity levels across the area are similar to the national figure as are rates of physical inactivity. The ICS works closely with public health colleagues to monitor and improve these levels with targeted interventions in place to support healthy eating and promoting healthy lifestyles.

Overall the health priorities for Berkshire West include:

- Reducing childhood obesity
- Reducing alcohol consumption to safe levels and alcohol related harm
- Promoting positive mental health and well-being
- Preventing and reducing early deaths from cardiovascular disease, diabetes, COPD, chronic kidney and cancer
- Reducing levels of infectious diseases e.g. Tuberculosis
- Promoting self-care and empowerment

2.2 Our aims and objectives

The commitments outlined in the MoU provide the focus for our work with our local ICS Clinical Strategy acting as the foundation that underpins how we will transform and improve our services. This is supported by key enabling programmes such as digital transformation and a focus on our collective estates and back office functions to ensure these are fit for purpose and support our objectives, as well as strong leadership from across ICS parties.

Focussed on the health and wellbeing of our local population, we are working together to develop a preventative model of working, improve outcomes and experience for patients and deliver financial stability across our system.

Our collective aspiration is aligned with our separate organisational strategic objectives, values, and vision statements, and is supported by the objectives within our MoU.

Our overarching objectives as an ICS are to deliver:

- **An improvement in the health and wellbeing of our population**
- **Enhancements to the experience of using health care services**
- **Value for money to local taxpayers and financial sustainability of services**

This will require us to:

- Make fast and tangible progress in urgent and emergency care reform, strengthening general practice and improving mental health and cancer services.
- Manage these and other improvements within a shared financial control total and to maximise the system-wide efficiencies.
- Integrate services and funding, operating as an integrated health system, and progressively to build the capabilities to manage the health of the ICS' defined population, keeping people healthier for longer and reducing avoidable demand for healthcare services.
- Demonstrate to other parts of the health and care system what can be achieved with strong local leadership and increased freedoms and flexibilities.

We will know that we have been successful if:

- People take more responsibility for their own health and well-being
- Care is being provided closer to home, wherever appropriate
- Clinical pathways are better integrated across providers to improve patient experience
- The capability and capacity of primary, community and social care is increased to provide multidisciplinary "wrap around" co-ordinated care that efficiently meets the patient's needs
- We have a better understanding of the clinical needs of our population and maximise the opportunity to prevent, and to intervene early to reduce the need for more intensive on-going care
- We have a high quality, fit for purpose acute and specialist hospital service
- We have a shared quality strategy with system wide approach to the delivery and monitoring of quality
- We operate to single budget for the whole health care system, making the most effective use of the Berkshire West pound and delivering financial sustainability
- People tell us that they are having good experiences of care and, importantly, people tell us when they have not had good experiences of care so that trends can be identified and quality improvement solutions co-designed to improve patient experiences.
- Staff and workplace wellbeing is improved, and we build a sustainable and highly skilled health and care workforce in Berkshire West
- We ensure that duplication and waste is reduced across front and back office services
- 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 on the most appropriate setting and where possible outside hospital.

These commitments have been set out in a Memorandum of understanding between the members of the ICS and the NHS national bodies (NHS England and NHS Improvement).

2.3 Our constituent organisations

Most of the programme will be delivered through our constituent organisations each of which has refreshed its strategy and aligned to our collective vision.

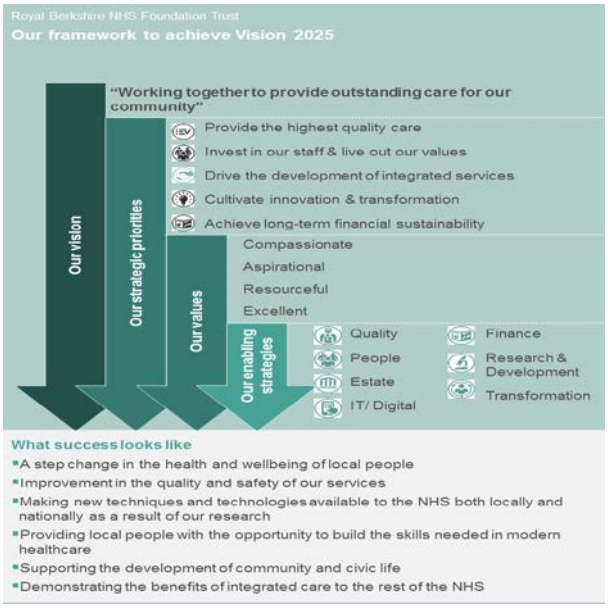
Royal Berkshire Foundation Trust

Royal Berkshire NHS Foundation Trust (RBFT) is one of the largest general hospital foundation trusts in the country. It provides acute medical and surgical services to the local population as well as specialist services such as cancer, dialysis and eye surgery to a wider population.

Across September – October 2017 the RBFT was inspected by the CQC and the **hospital site was rated as 'outstanding'** (overall the **Trust was rated 'good'** as the CQC did not inspect other locations at this time.) This was a remarkable achievement from the previous rating of 'requires improvement' in 2014. To date, RBFT is one of only two hospitals in the country who have achieved this; and one of only 18 acute hospitals who have been awarded an 'outstanding' rating nationally.

In light of our collective journey toward being a fully functioning ICS, RBFT's strategy and its clinical service strategy have been reviewed and updated and aligns with the ICS clinical vision. More broadly in refreshing the strategy it is recognised that the shared nature of the causes of the challenges that the health economy faces means it will be difficult for RBFT to remain a successful independent organisation unless it works in proper partnership with patients and colleagues from across the ICS. This is reflected in RBFT's new vision statement which is ***"Working together to provide outstanding care for our community"***

Figure 1 – Royal Berkshire Hospital Trust Strategy



RBFT is well placed to deliver on its strategy through:

- The hyper-acute stroke service is in the **top 10% nationally** and the heart attack centre consistently achieves the **fastest treatment times in the country.**
- RBFT achieved the best improvement nationally in the proportion of **cancer patients** receiving treatment within 62 days.
- Whilst the Trust has an excellent record in delivering our A&E Waiting Times significant challenges were experienced in the 2017/18 winter – however, we continue to work collaboratively with our regulators to return to full compliance for **A&E waiting time performance.**
- RBFT is **valued by patients** with consistently high levels of satisfaction The Friends and Family test, a national inpatient survey, places us in the top 10% of the country
- **RBFT is one of the most research-active District General Hospitals in the country.** The Trust had the second highest number of patients recruited to trials and are 21st out of 161 NHS trusts recruiting to clinical trials nationally. In 2016/17, the Trust has more than 5,500 participants in around 100 studies.

However, to meet future challenges there is a need to continually seek to change and innovate in order to provide health care in ways that deliver the vision and outcomes expressed above. RBFT has a strong record in participating in research and delivering transformative change and is continuing to build upon its capability to deliver improvement in an ever more challenging economy. To this end an approach of listening and learning in order to develop momentum and the required engagement with staff at all levels through the development of a success model will enable further development and continuous improvement. This will occur as part of an overall transformation programme for the ICS.

Examples at RBFT are: good track record in LoS (Length of Stay) reductions through pathway redesign; 5 year OTIS theatre project which has been highly successful in increasing efficiency in theatre, collaborative work with Local Authorities and Community colleagues to reduce long lengths of stay in hospital and increasingly we will be using benchmarked and digital data to support further developments. The Trust is proud of its achievements and continues to be committed to being an organisation of continual learning and improvement in order to deliver outstanding care to the community and across the ICS.

A major platform for transformation at the Trust is its position as a fast follower **Digital Exemplar site** linked to Oxford University Hospitals, with a 5 year programme of development to implement full clinical digital documentation, voice enabled EP, and the development of advanced analytics and actionable intelligence to support audit, research and clinical/operational service provision and the progression through to proactive population and personal health management positioning the acute services at the heart of the prevention and wellbeing agenda across the ICS.

Berkshire Healthcare Foundation Trust

Berkshire Healthcare Foundation Trust's (BHFT) vision is '***to be recognised as the leading community and mental health service provider by our staff, patients and partners***'. It provides a wide range of hospital and community

based services to people of all ages living in Berkshire. The Trust employs around 4,500 staff operating from many hospital and clinic sites across the county, as well as in people's homes and various community settings.

BHFT delivers integrated physical and mental health services, helping people to remain independent at home for as long as possible and providing the care and support that best meets the needs of patients, from early years to end of life, in the most suitable location. In addition to inpatient mental health and community physical health hospital services, the Trust provides a range of specialist clinics and services aimed at young people, adults and older people to support and treat mental health, physical health and sexual health conditions. The Trust works in close partnership with Berkshire's two acute hospital trusts, Royal Berkshire Hospital NHS Foundation Trust and Frimley Health NHS Foundation Trust, Berkshire's six local authorities and a diverse range of community and charitable organisations.

Berkshire Healthcare's overall **CQC rating is Good**, with the Trust's **older people's community mental health services rated as Outstanding**. Berkshire Healthcare is only one of two similar trusts in the country to be awarded a Good rating, and its ambition is to achieve an overall rating of Outstanding in 2018. The Trust is in **NHS Improvement segment one**, defined as "maximum autonomy and lowest level of oversight appropriate", reflecting a strong track record of effective financial management and its digital maturity and innovation has been recognised with the award of **Global Digital Exemplar** status.

As a community and mental health service provider, BHFT also recognises the key contribution they make in providing more care closer to patient's homes, working alongside our partner acute, primary care, community and voluntary sector providers. BHFT is committed to partnership working over the long term – delivering many integrated services with partner providers – and their strategic plans reflect their understanding that long term sustainability of services requires a system wide approach. The Trust is a committed partner in the two integrated care systems, making a major contribution to leadership and governance, as well as specific work streams. The Trust has developed appropriate structures and systems to enable it to work efficiently and flexibly with both integrated care systems. Its key objectives incorporate achievement of targets within national and local priorities as well as development of the capability required to fully exploit the opportunities presented by the ICS.

2.4 Our achievements

The Berkshire West local health economy is collectively recognised as high-performing and benchmarks well nationally on a number of key performance measures, including non-elective admission rates and prescribing. We are recognised across Thames Valley and nationally for leading the development of innovative approaches to improving clinical care and patient experience, for example Diabetes Care, Heart Service Stroke care, and Improving Access to Psychological Therapy services.

Together we have a long and successful history of working together to deliver common programmes, projects and goals. 2018/19 is the second year of a two year plan and examples of success in year one include:

Launch of Thames Valley Integrated Urgent Care Service (111)

The new Thames Valley IUC 111 service was launched in September 2017 and ensures that people can access a wide range of clinical care through a single call, including dental, pharmacy and mental health services. This new service is provided by South Central Ambulance Service in collaboration with BHFT, Oxford Health NHS Foundation Trust and Buckinghamshire Healthcare NHS Trust. The procurement and mobilisation of this pioneering service was led by Berkshire West CCG with expert opinion provided by senior clinicians in the ICS organisations.

Achievement of the Cancer 62 Day Waiting Time Target

In 2017, Berkshire West was recognised for outstanding improvements in the provision of timely access to cancer services. This improvement was delivered collaboratively between the CCGs and RBFT, with a significant programme of improvement within RBFT to deliver both capacity and process improvements, building on the excellent joint working arrangements in place between the organisations. This improvement was recognised in the form of a letter from the Secretary of State to acknowledge the progress which has been made for cancer patients in our system.

For the last 3 years improvement and robust delivery has been seen for routine patients accessing care via the RTT 18 week waiting time standard. This is involved collaborative working between the CCGs and RBFT and wrapped around a strong improvement programme within RBFT. This included a technological solution to support clinicians navigate the complex system of reporting RTT stages of treatment along the pathway, and thereby releasing time for both clinical and administrative staff

A&E 4 Hour Standard and Urgent and Emergency Care Delivery incl DTOC reduction

Berkshire West has a strong track record in delivering improvements in urgent and emergency care and increasingly via the A&E Delivery Board partnership working in this area has further developed. Evidence of this over recent years is a strong system of primary and community care services providing the right care, right place and right time to avoid attendance at hospital. In tandem, there have been steady improvements in opening up the 'back door' supported by Local Authorities, across all hospital sites – both acute and community. RBFT is a strong performer locally in Thames Valley, usually sitting in the top slot for performance for the 4 hour quality standard. However, a drop in performance in Q3/Q4 of 2017/18 has prompted a further review of all aspects of end to end emergency care directed at returning delivery of the 4 hour waiting time requirement to 95% by the end of 2018/19. This includes further collaborative work following a Local Authority review to take to the next stage improvements on long stay pathways, building on improvements in 2017/18.

Implementation of the Connected Care IT platform

Working in collaboration with Berkshire East CCGs and the Frimley Health and Social Care ICS, the Berkshire West system has led the way in the provision of integrated digital platforms which enable the sharing of information across health and social care organisational boundaries. As well as combining information held in different IT systems across the county, the shared record allows care professionals to create and update care plans, creating co-ordinated multi-agency care for individual patients and enables new ways of delivering services.

We are working in partnership with FHFT to deliver the goal of developing and deploying a Cancer Health Information Exchange (HIE) to enable both improvements to the flow of information between provider sites and increase the visibility of relevant information to the patient themselves.

In addition our organisations are regularly nominated for national awards which recognise the scale of our ambition, particularly with regard to our digital innovations (Connected Care), values (Mental Health) and research (Stroke, Nursing and Patient Involvement).

3 DELIVERING AN INTEGRATED CARE SYSTEM

Set out in the section below are the five domains against which the ICS will deliver. This are:

- Domain 1 - Deliver the 5 Year Forward View
- Domain 2 – Deliver local transformation priorities
- Domain 3 – Deliver financial sustainability
- Domain 4 – Embed a population health approach
- Domain 5 – ICS Governance and Leadership

These domains and how they interact with each are presented below:

Figure 2: Berkshire West ICS transformation programme

3.1 Domain 1 - Five year forward view

As one of the pillars of the ICS, delivery of the Five Year Forward View is central to improving the health of our local population. Each of the sections below sets out achievements to date as well as how the Forward View will be delivered by the ICS in 2018/19 aligned to the expectations of the MoU. Each of these areas of work has a developed project plan with clear milestones and is overseen by the ICS governance framework to ensure successful delivery.

3.1.1 Cancer

The approach to providing cancer services in Berkshire West in 2018/2019 continues to be delivered through the jointly agreed Berkshire West Cancer Framework. We continue to work closely with the Thames Valley Cancer Alliance and are fully engaged in all the emerging work streams. We have reviewed our progress against our objectives and agreed our local and Cancer Alliance priorities for 2018/2019 to continue the momentum of implementing the six priorities in the national Cancer strategy, the Five Year Forward View and the Thames Valley Cancer Alliance key ambitions by 2021. Please see **Annex 1** for more information.

3.1.2 Mental Health

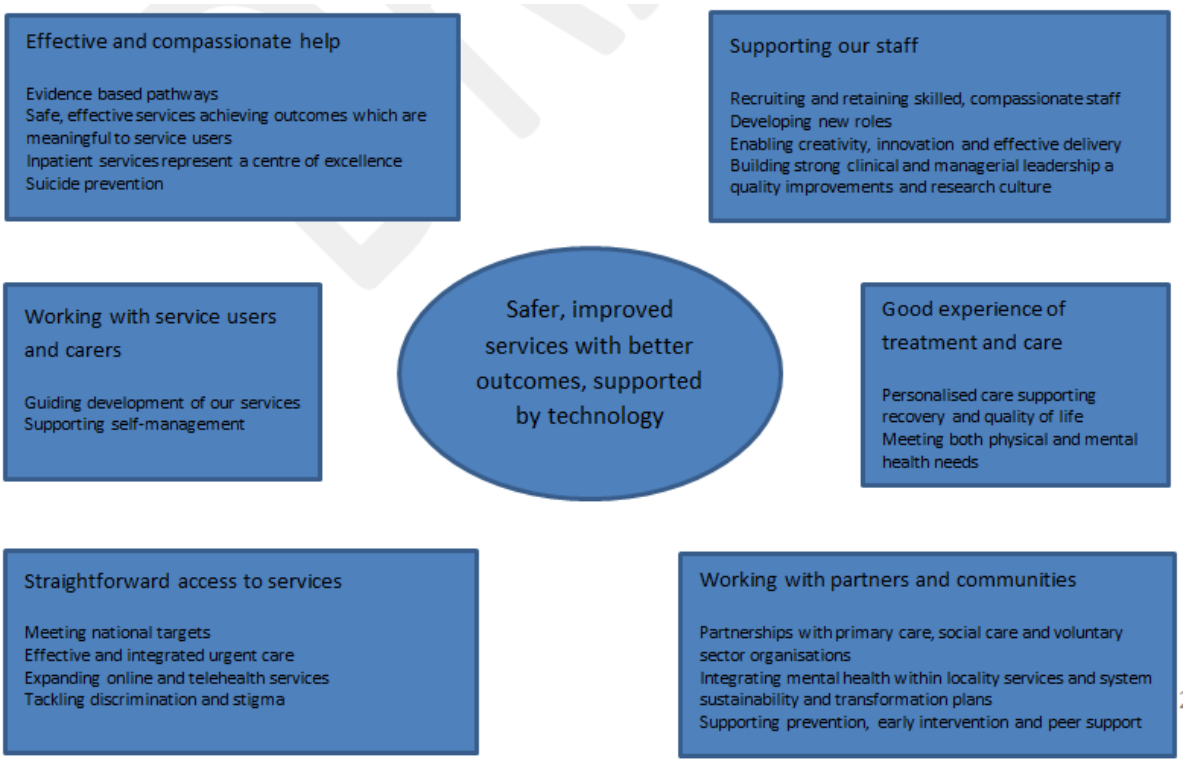
Improving mental health is a fundamental part of our ICS operating plan. The Five Year Forward View for Mental Health (2016) sets out a clear direction for the NHS to improve mental health and wellbeing, highlighting why change is required and what good will look like. Some of what is needed can be brought about by the NHS itself. Other actions require partnerships with local organisations including local government, housing, education, employment and the voluntary sector.

Berkshire West has a strong foundation of partnership working in mental health, with well-established collaborative approaches to strategic and financial planning. We plan to build on this through the establishment of a joint mental health strategy function within our ICS to drive the delivery of the Five Year Forward View ambitions.

The evidence is clear that improving outcomes for people with mental health problems supports them to achieve greater wellbeing, build resilience and independence and optimise life chances, as well as reducing premature mortality. We recognise that putting more focus on early intervention, investing in effective evidence-based care and integrating the care of people's mental and physical health will have significant gains for local people and support the achievement of ICS objectives.

Developed in partnership with commissioners, local authority partners and public health, the Berkshire Healthcare Mental Health Strategy outlines the key areas of focus for 2016 – 2021 which are summarised below.

Figure 3: Berkshire Healthcare Mental Health Strategy



Our Connected Care Programme for our shared electronic patient record, along with the work we are doing as Global Digital Exemplar for mental health are key enablers for us in the delivery of Five Year Forward View Targets. Use of technology is supporting the delivery of increased access through online delivery models, and effective use of staffing resources. Our Mental Health Workforce Plan, which will be completed in March 2018, will outline our key risks and mitigation of these – and progress will be monitored by the ICS Workforce Group as well as by the Berkshire Healthcare Workforce Strategy Steering Group.

Our multi-agency Mental Health Delivery Partnership Steering Group is responsible for ensuring delivery of the Five Year Forward View for Mental Health, and is accountable to the Unified Executive of our ICS. Full information on the following projects can be found in **Annex 2:**

- Increasing Access to Psychological Therapies (IAPT)
- Physical Health Check and Care co-ordination
- Early Intervention in Psychosis (EIP)
- Psychiatric Liaison service
- Individual Placement and Support services (IPS)
- Reducing suicide rates
- Perinatal Mental Health
- Eliminating out of area placements for non-specialist acute care
- Dementia
- Children and Young People
- Mental Health Investment Standard (MHIS)

3.1.3 Primary Care

The Berkshire West General Practice Forward View (GPFV) Local Implementation Plan sets out a vision for a sustainable primary care sector working at-scale and as an integral component of the ICS to offer an extended range of integrated and proactive services in the community. To achieve this vision, our practices have come together into Primary Care Provider Alliances, with all practices within them working in geographically-contiguous clusters which will interface with other services to meet the health needs of groups of 30-50,000 patients (Primary Care Networks). At a system-level, the alliances are working together in an 'Alliance of Alliances' which will look to maximise their impact within the ICS.

The ICS's GPFV programme for 2018-19 will include the following key components:

- Primary Care Networks – the network/alliance structure is to support delivery of primary care at-scale. Integrated health and social care teams within networks will use population health analytics to plan targeted care and will deliver a joined-up community response to acute presentations. The range of services provided in primary care setting are to be expanded through new ways of working with other ICS partners, e.g. through outpatients transformation and care and support planning for patients with long-term conditions.

- Access – delivery of Enhanced Access (100% of patients to have access to primary care in the evenings, at weekends and on bank holidays) and new ways of responding to same day demand through primary care access hubs.

- Workforce – systematic workforce modelling/planning, further development of skill-mix in primary care including clinical pharmacists, paramedics and physicians' associates, actions to improve GP recruitment and retention, continued professional development across the primary care workforce and development of clinical and managerial leadership capability.

- Workload – delivery of Time for Care programme with focus on active signposting, group consultations and quality improvement. Completing implementation of workflow optimisation and online consultation and supporting alliances to further explore sharing of back office functions. Wearable technology project as part of work to maximise impact of self-care.

- Estates and infrastructure – delivery of ETTF (NHSE Estates and Technology Transformation Fund) and non-ETTF premises schemes and further development of primary care estates strategy (see Enablers, below). Roll out of access to Connected Care Health Information Exchange (see Enablers, below) to primary care.

- Sustainability and resilience funding – further funding to be allocated in accordance with guidance to support future sustainability of primary care sector.

- Delegated commissioning – fully delegated commissioning processes to underpin delivery of GPFV which will be overseen by Primary Care Commissioning Committee. The approach to improving quality is to be reviewed in 2018/19 as part of development of ICS Quality Framework (see below).

Please see **Annex 3** for more information.

3.1.4 Urgent Care

The A&E 4 hour standard remains one of the key indicators of success for the urgent and emergency care system. Whilst the winter of 2017/18 has been very challenging we have a strong track record of delivery across the urgent care pathway and learning from 2017/18 has, and continues to be used to, inform plans for 2018/19 Whilst our system is proud to be achieving over 90% performance, which is a reflection of the whole system focus on patient safety-experience and maintaining flow through the acute site and recipient organisations, this is not sufficient. The drive to return to compliance at 95% is strong and is being supported by the Accident and Emergency Delivery Board who have developed a suite of improvement initiatives aimed at driving improvement against this constitutional standard. We will do this by delivering improved service provision in support of the principles of valuing patients' time by providing a combination of care at home wherever possible, the avoidance of overnight stays by increasing ambulatory options and reducing time in hospital where hospital admission is needed.

. Priorities include:

- Increased usage of ambulatory care pathways utilising the new protected Ambulatory Care area
- Increased use of hot clinics and telephone access to Consultants
- Maximising the potential of the Primary Care streaming service with the inclusion of paediatrics
- Continued drive on efficiency through the bed base across the system with red/green actions for all patients and a reduction in stranded patients
- A partnership model for managing bedded care across the system as a whole, ensuring right care, right place, right time including a system wide bed management system to create visibility and smoother access
- Integrated Discharge service working with medically fit patients on a case management approach to improve discharge flow
- Increased focus on discharge to assess and further development of the Trusted Assessor approach with roll out of the Standard Operating Procedure and single referral form
- Robust use of the Choice Policy with interim placements being seen as a part of the pathway

The Thames Valley Integrated Urgent Care (TVIUC) service successfully launched in September 2017. The service is provided by an Alliance led by South Central Ambulance Service NHS Foundation Trust, working in partnership with Berkshire Healthcare NHS Foundation Trust, Oxford Health NHS Foundation Trust and Buckinghamshire Healthcare NHS Trust. The service is based on a specification designed in 2016 and refined during a period of co-production between the Alliance and commissioners during Q1 of 2017-18. The new service incorporates a Clinical Assessment Service (CAS) with a range of specialist clinicians including GPs, mental health practitioners, nurses, prescribing pharmacists, dental professionals and currently 30% of calls receive advice from a clinician within the CAS. Call streaming also ensures that vulnerable groups such as the under 5s, over 85s and those receiving palliative care can benefit from immediate clinical advice.

Please see **Annex 4** for more information

3.1.5 Maternity

In February 2016 Better Births was published and it set out the Five Year Forward View for NHS maternity services in England. It set out a compelling view of what maternity services should look like in the future. The vision is clear: we should work together across organisational boundaries in larger place-based systems to provide a service that is kind, professional and safe, offering women informed choice and a better experience by personalising their care.

A national Maternity Transformation Programme has been established to take forward implementation of the vision. However, *Better Births* recognised that delivering such a vision would rely primarily on local leadership and action. Consequently, it recommended commissioners, providers and service users coming together as Local Maternity Systems to deliver local transformation.

A Local Maternity System (LMS) was established across the BOB STP in March 2017 as recommended by the Better Births Report: National Maternity Review published in June 2016. As a result of the capacity issues across Thames Valley maternity services is one of the main priorities for the BOB STP. The Senior Responsible Officer for Maternity is the Chief Executive of Buckinghamshire Healthcare NHS Trust who nominated the Chair responsibility to the Director of Nursing for Berkshire West CCG. The membership of the LMS Board includes representatives as recommended in the NHS E LMS Resource pack. The LMS Board meets quarterly with working groups set up to address the 5 main priorities:

1. Improving the safety of maternity care by 2020/21
2. Increasing Choice and Personalisation
3. Transforming the workforce
4. Improve access to Perinatal Mental Health Services
5. Improving Prevention

Please see **Annex 5** for more information.

3.1.6 Learning Disabilities

The Transforming Care Partnership (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.

Please see **Annex 6** for more information

3.2 Domain 2 - Local transformation priorities

The work of the ICS can be categorised within two distinct areas – New Care Models and New Business Models (Enablers). These packages of work were defined during the financial year 2016/17 and have been developed for implementation during this phase of the programme. A second phase of workstreams will quickly follow, building on the work achieved to date to enable greater clinical transformation.

The objective of the New Care Models workstreams is to give the freedom and support to our clinical leaders for the design of service improvements for our patients. These clinical improvements will deliver the main programme objectives such as ensuring the requirements of the Five Year Forward View, improving the financial position and enhancing patient experience and outcomes.

The objective of the New Business Models workstreams are to find new ways of working collaboratively which support the infrastructure of the ICS for example contractual form and payment mechanisms to deliver better efficiencies in the way we work.

In defining the priorities of the ICS it is recognised that there are areas of clinical variation and high demand where transformation of existing ways of working and service delivery is required in order to fulfil our ambitions for excellent patient care as well as support financial sustainability. These cover the clinical areas set out below:

- Outpatient transformation
- Development of an integrated Respiratory Service
- High Intensity Users programme
- Design and development of an Integrated MSK service
- Maternity
- Diabetes transformation

These, along with other programmes of work are supported by key enablers including review of back office functions and estates, understanding and modelling our collective bed base, exploring opportunities for a streamlined approach to medicines management, digital transformation as well as workforce development.

3.2.1 Outpatients

Nationally and locally there are increasing demands on outpatient services with growth in referrals year on year putting demands on outpatient facilities, waiting times and clinicians. Across England there was an increase of 9% in referrals between 2016 and 2017, and locally the increasing volume of referrals to RBFT in some specialties has reinforced the understanding that there is a need to review our approach to outpatients and ensure that future models are safe and cost effective.

The vision for the outpatients transformation programme is to redesign outpatient services by:

1. Developing alternative options to complement current practice

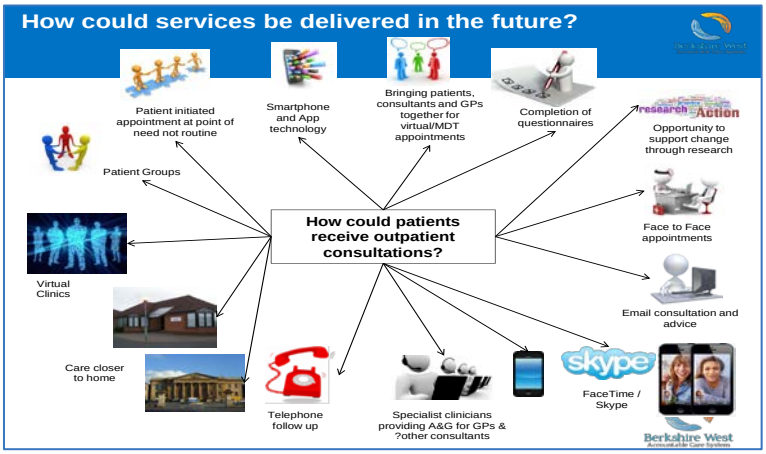
2. Optimising the use of technology advances
3. Truly integrating working across pathways
4. Developing care closer to home to improve patient experience and reduce the reliance on the acute RBFT site

The overall aim is to provide the optimum patient experience and best value for money for the Berkshire West pound.

This transformation programme is a strategic change programme delivered as a collaborative approach through the ICS with RBFT, BHFT, Berkshire West CCG and the emerging GP Alliances working together to achieve the changes. It builds upon an internal RBFT three year outpatients modernisation programme that started early in April 2017 and takes advantage of the ICS development to give the programme a wider perspective and gain greater benefits.

Following extensive pathway mapping, engagement of patients and clinicians, a menu of options for implementation have been developed which will be used in all clinical specialties at RBFT. The changes have been designed to achieve a combination of a significant shift of outpatient appointments on the main RBFT site to locality sites across the network so they are closer to patient's homes. Options include the introduction of patient initiated clinics to support a reduction in unnecessary follow ups, the further development of virtual clinics and one stop clinics and new offers such as skype consultations and easier access to Consultant opinions by GPs will reduce the need for patients to be referred in. For more information please see **Annex 7**.

Figure 4: How outpatient services could be delivered in the future



3.2.2 Integrated Respiratory Service

Work is under way to develop an integrated approach to managing patients with respiratory conditions. This builds on a previous case for change to increase access to specialist consultant skills across community and secondary care implementing an appropriate outcome based approach to meet local population needs.

The aim of the service is to reduce unplanned hospital admissions and demand for specialist outpatient services by achieving the following objectives:

- To provide a fully integrated service for primary, secondary and community care through virtual clinics and an MDT approach to respiratory provision in a community setting
- To promote early identification of COPD and Asthma self-management and intervention to improve the well-being of patients with respiratory disease
- To reduce reliance on specialist skills where alternative approaches can be adopted.
- To upskill primary and community to ensure the potential to support the patient population is maximised.

There are a number of current work-streams which form part of the Outpatient Transformation Programme and are focussing on revised pathways for managing both Sleep Apnoea and chronic cough. In addition work is in progress to review existing patients with COPD/Asthma, mainly in relation to current medication. This will continue to support discussions regarding most effective ways to meet the needs of the local population. For more information please see **Annex 8**

3.2.3 High Intensity Users

A substantial proportion of the healthcare budget is accounted for by relatively few patients. This indicates significant potential for reducing workload on urgent care services and the wider health economy via a targeted and proactive intervention. Learning from Blackpool has demonstrated that an approach of empathy and coaching rather than enforcement has the potential to reduce the volume of urgent care activity for this cohort and indeed improve outcomes for patients.

This model of support has been replicated locally through the implementation of a High Intensity User (HIU) service working across RBFT, BHFT, SCAS and primary care. The approach offers a robust way of working across the ICS to reduce activity to 999, NHS 111, A&E, GP contacts and hospital admissions, freeing up front line resources to focus on more clients and reduce costs. It uses a health coaching approach, targeting high users of services and supports the most vulnerable clients within the community to flourish, whilst making the best use of available resources.

The service will measure the impact directly on 999 call outs, A&E attendances and associated admissions as well as qualitative outcomes for clients. However, through the Connected Care technology the project will also have the visibility of how the work of the coaches impacts on the wider health system, for example primary care and mental health services. For more information please see **Annex 9**.

3.2.4 Integrated MSK

Musculoskeletal conditions (MSK) are one of the areas of greatest spend for Berkshire West with care currently split across primary care, intermediate services and acute provision. With an ageing population there are increasing levels of demand and variation in referrals and management of MSK conditions which supports an overall case for change. Further work is required to improve the service to patients through developing and implementing a more integrated and coordinated programme.

People with MSK conditions need to be able to access high quality support and a wide range of treatments. These range from simple behavioural or exercise advice to highly technical, specialised medical and surgical treatments. Multidisciplinary, integrated services are essential and need to incorporate rapid assessment and diagnosis.

The new integrated service aims to deliver the following outcomes:

1. An end to end pathway that encompasses de-medicalising MSK and promoting self-care and healthy living such as exercise and healthy eating as enablers to have a positive impact on MSK issues;
2. A community provision where primary and community care providers work closely with physiotherapists to provide direct access for patients with MSK conditions to physiotherapists. By ensuring all aspects of self-management are explored to manage the condition this will result in appropriate referrals to secondary care in line with clinical need;
3. Patients to participate in a shared decision making process before referral for a procedure to secondary care;
4. Reducing clinical variation and duplication through pathway coherence;
5. Ensuring that every MSK practitioner is consistent in their approach;
6. Addressing the issues and concerns identified by patients and improving the quality of patient experience;
7. Patients are given choices for treatments in line with the NHS Constitution
8. Providers will identify and eliminate waste from within the MSK pathway and supply chain (as outlined in the Getting it Right The First Time report) therefore delivering commercial efficiency for the Berkshire West system moving toward a whole-system approach;
9. Utilisation of IT solutions to provide integrated care

For more information please see **Annex 10.**

3.2.5 Diabetes

The overarching BOB STP plan for Diabetes Transformation focuses on improving the efficiency of the BOB area while bringing care closer to home and improving access to more appropriate and timely healthcare for their population. This plan shows the commitment of all the constituent CCGs to move towards a common goal of reducing variation in care across the whole STP area.

The projected rapid increase in numbers of people with diabetes and those at risk, combined with a transient population places considerable challenges on the health and care systems.

Table 1: Predicted Diabetes Populations in the next 5, 10 and 15 years.

Berkshire West	27,124	7.1%	2020

Buckinghamshire	37,134	6.9%	
Oxfordshire	34,302	8.0%	
Berkshire West	29,492	7.5%	
Buckinghamshire	40,597	7.2%	
Oxfordshire	37,524	8.5%	2025
Berkshire West	32,220	8.0%	
Buckinghamshire	44,493	7.7%	
Oxfordshire	41,052	9.1%	2030

The ICS within the STP footprint is committed to enabling people with diabetes to have access to appropriate, sustainable healthcare and support. Therefore the Diabetes Transformation fund provides us with the opportunity to create more flexible options to improve health outcomes for people with diabetes. Additional funds will accelerate the ability of the system to reduce variation in care delivered, increase the amount of care provided in the community and closer to home and improve access to secondary care services when needed for people with diabetes.

Across the ICS the recorded prevalence of Diabetes for adults is lower than the expected prevalence. This discrepancy varies across the geography with primary care management in Newbury & District, Wokingham and South Reading sitting within the lower quartile. The whole system approach being adopted by the ICS is aimed at reducing this variance, which we acknowledge cannot be attributed to population structures and deprivation alone. In 2012 the reports from the National Diabetes Audit of 2009-2010 identified the need for change with the 8 key processes for diabetes care being amongst the worst in matched communities in England.

Across Berkshire West significant improvements have been made in the last 5 years to improve the outcomes and experience, reduce variation and improve sustainability of resources. However there are still some unacceptable gaps in provision. Plans are in place to improve this through patient engagement, collaboration with other stakeholders, supporting Health Care Professionals (HCP) and investing in the use of technology and informatics. This includes the recognition within our Long term Conditions transformation programme that Diabetes is rarely a single condition and therefore holistic assessment and support is crucial. It is recognised that for many people with diabetes this is only one of many conditions they live with. Therefore our aim is to embed a truly patient centred, holistic approach, and we plan to continue to extend the focus of the current care and support planning to include review of other related conditions and aim to develop a single all-encompassing care plan for people with multiple needs. This will concentrate on what is important for the patient, enable joint decision making, to increase patient participation and self-management. For more information please see **Annex 11.**

3.3 Domain 3 - Financial Sustainability

Financial sustainability is one of the key aims of the ICS and a significant amount of shared resource has been and will continue to be required to support this. The allocations for 18/19 provide welcome additional funding for both providers and commissioners, but from a CCG allocation perspective Berkshire West now has the second lowest per head funding in the country.

Table 2: CCG allocation

Per Capita Funding*	
Berkshire West CCG	£1,059
SE England average	£1,196
England average	£1,254

*raw population

Compared with other CCGs, Berkshire West CCG is the 7th furthest away from target funding with a distance from target of c£25m.

The ICS has a Chief Finance Officers' Group which has developed a number of work streams to support our sustainability in 2018/19:

- **New payment mechanisms** (linked into national work streams) – The ICS has a shared ambition to move away from PbR, the final arrangements for this continue to be developed alongside the work on the system control total.
- **System control total** (linked into national work streams) – This is currently subject to discussion with NHSE/I and will be finalised post submission subject to individual Governing Body/Board approval.
- **Contractual form** – The ICS will be using the Standard NHS Contract which will be supplemented with an Alliance Agreement setting out the risk share arrangements for 2018/19.
- **New ways of working** – enabling finance, Business Intelligence and contracting staff to have different conversations focussed on identifying issues and solutions rather than focussing on reconciling different datasets.
- **Group Accounts** – the development of a consolidation model for group accounts giving full visibility of system income and costs and enabling the identification of inconsistent assumptions each month, which is assisting with contract alignment work.

The ICS system gap is calculated to be £16.9m for 2018/19. Against this gap the CCG has identified £5.6m of savings which do not impact on the wider system and where there is high degree of confidence on delivery - this includes prescribing initiatives, merger and contractual savings. The ICS has also identified £1.8m of savings which are the full year effect of schemes identified in 2017/18 and other schemes that have sufficient work up to allow confidence regarding delivery. A further £9.5m of new schemes including the opportunities identified by Right Care and linked to the 10 Point Efficiency Plan are currently being developed by the ICS. There are a number of mitigations available to the CCGs should it not be possible to fully close the gap with new transformation schemes in year.

Providers have the following CIPs:

- RBFT - £16m (4.6%) requirement against which there is a risk adjusted plan of £12.5m
- BHFT - £4.8m (1.9%) requirement against which there is a risk adjusted plan of £3.9m (Berkshire West's share being 60%)

The work on system transformation is focussed on addressing both demand and cost.

The ICS management teams are working together to develop a plan for long term financial sustainability. Using our ICS Group Accounts tool we are working with colleagues and our regulators to understand our unmitigated financial gap for the future period and identify the issues which are causing this.

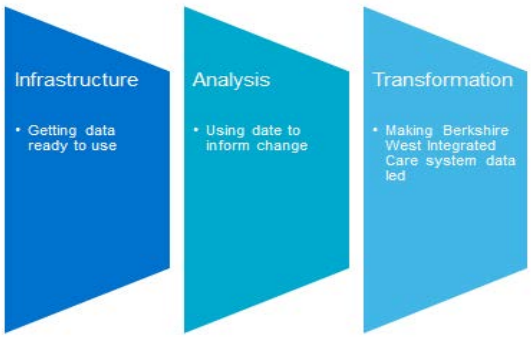
In order to generate additional transformation focus areas, the ICS will seek to work within the current *Five Year Forward View* performance framework to identify areas for improvement. These services will be benchmarked against comparators and examined in the context of our overarching Population Health Management approach to understand where opportunities may exist to improve services and reduce their cost. However, available benchmarking data does indicate that the system will need to be very creative and that real transformation will be required in order to close the underlying gap while funding is below target. Furthermore, the ICS has a focus on reducing cost and maximising value rather than shifting the gap between commissioner and provider with traditional QIPP schemes focussing on PBR.

The ICS Clinical Delivery Group which brings together our lead clinicians from across the ICS that will own this work and drive the delivery of transformation projects through well-established system programme boards to ensure that opportunities are realised. The ICS participants will continue to use available data and national programmes to inform the system wide efficiency programme which focusses on both new care models and new business models.

3.4 Domain 4 - Population health management and prevention

Population Health Management (PHM) is an approach to better understand the needs of the local population as a whole with specific improvement actions identified through which the local NHS can improve both clinical and financial outcomes. PHM is the aggregation of patient data across multiple health information technology resources, the analysis of that data into a single, actionable patient record, and the actions through which care providers can improve both clinical and financial outcomes. The overarching objective of population health management is to identify, predict, intervene and support patients to manage conditions cost-effectively, but also move the system from performance monitoring to outcome monitoring, through:

Figure 5: Population health management approach:



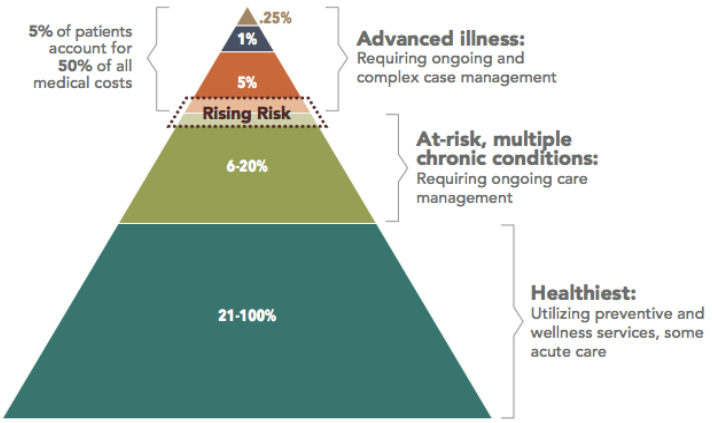
This approach will promote integrated care, centred on the patient, in order to provide better health outcomes and value for money. The ICS has already begun to work on PHM, with the use of Theograph to plan and monitoring High Intensity user patients, this approach will be adopted for New Models of Care across the system in 2018/19, through the uses of wider data sources.

Our developing approach to Population Health Management is to:

- Build and expand on the information within the Connected Care Health Information Exchange to support Direct Care, including effective shared care planning and to identify individuals within the population at greater risk to and provide early invention services
- Design both an Operational Dashboard and a Planning Dashboard that focuses the ICSs clinicians, operational and executive teams on meeting the Triple Aims moving from Performance to Outcome based Models of Care
- Use our population health management approach to accurately segment the local population to enable better service planning and delivery

During 2018/19, the ICS is working with NHS England as a National Population Health Dashboard Exemplar, linking with Cerner, North East London CSU and Imperial University College. During April 2018 the Berkshire West Integrated System will be completing NHS England Population Health Readiness Assessment and undertaking a deep dive on Data, Information Governance and Analytics in order to understand our system strengths, what we need to adapt and what we will need to procure to support a data led system.

Figure 6: Our population health management approach



People with Multiple Long Term Conditions: Demand for services is predicted to continue to rise with a growing older population and people living with more complex long term conditions. The utilisation of Population Health analytics has formed the basis of our work within the ICS which has commenced during 2017/18, aiming to transform care for people with multiple Long Term Conditions. Analysis of data within the Adjusted Clinical Groups (ACG) system ACG Tool (University (Johns Hopkins Adjusted Clinical Groups® (ACG®) System) has been utilised to support benchmarking and subsequent identification of resource requirements. Using profiling and risk stratification resources we are able to stratify populations to ensure resources are targeted more effectively and efficiently. It is recognised that there needs to be a fundamental shift from more traditional reactive, compartmental and unplanned approaches to one which is truly patient centred, proactive and anticipatory, enabling patients and carers to access services at or

as close to home as possible and which aligns specialist, primary and community care in one coherent package. This will also take into consideration, along a continuum of care, any palliative and end of life care needs. We plan to move towards a model which reduces fragmentation, and underpins care and support planning (C &SP). The Long Term Conditions Programme approach 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.

Prevention and self-management: Prevention and self-management sits at the core of our methodology to improving the health and wellbeing of the population in Berkshire West, consistent with a population health management approach. The increased prevalence of chronic diseases occurring in all Western economies requires a strong reorientation away from the reliance on acute and episodic based care, towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated, integrated and anticipates and avoids/minimises deteriorations and complications.

Seeing systematic population level change in the health and wellbeing of the Berkshire West population will require a preventative approach, delivered from the community, which will address modifiable risk factors to ensure better health.

In embedding a focus on prevention and self-management, the ICS will:

- Ensure technology such as information provision and decision support is rolled out to assist patients to manage their own conditions
- Improve patient knowledge and education, particularly in relation to long term conditions, to empower patients to take control of their conditions and understand how to manage them effectively
- Focus on lifestyle factors such as a reduction in smoking and obesity and an increase in exercise to prevent the onset of disease
- Ensure that every contact with a health or social care professional counts, taking the opportunity to deliver health promotion messages at each opportunity where the setting of care enables this interaction to occur.

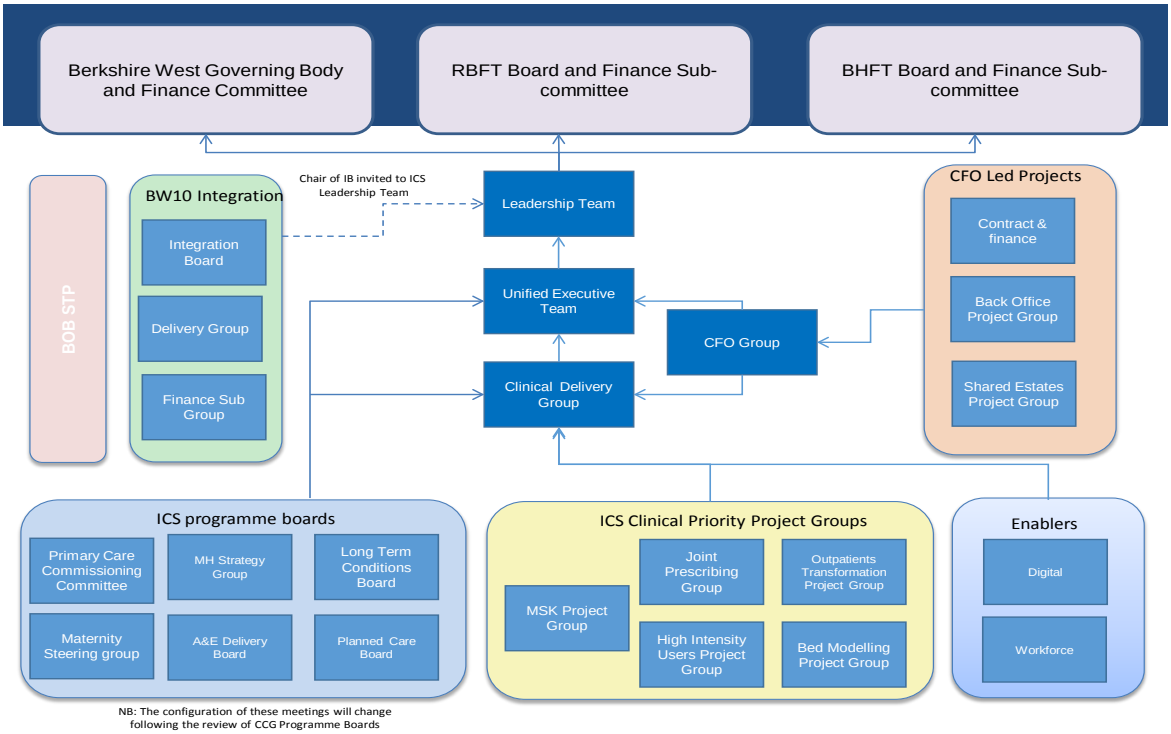
3.5 Domain 5 - Governance and leadership

The ICS has been in place since 2015 with a ‘programme governance’ structure that has been refreshed in 2017 to reflect both leadership and delivery within the ICS. The structure that has been set up enables us to monitor progress against delivery of the MoU objectives which drives the measures of success for Berkshire West. This is governed by a monthly programme dashboard which tracks this progress.

This approach has been founded on a number of principles, most importantly that of reaching joint consensus prior to any further decision which may be required at an organisation level. Other principles include:

- Maintaining strong clinical leadership through a clinically led process to ensure that decision makers can be confident that changes are being made in the best interests of patients
- Clear points of accountability for projects and deliverables
- Using business as usual / standard governance procedures as widely as possible to take decisions
- A commitment to wider integration with Local Government and other strategic partnerships which add value for the taxpayer
- Remaining transparent and open to scrutiny from patients and the public
- Providing assurance in a coherent manners to our regulators
- Ensuring Healthwatch are involved at ICS Programme Board level ICS and patient champions are involved with individual projects wherever possible.

Figure 7: Berkshire West ICS Governance structure



Escalation and scrutiny is provided by the ICS Unified Executive with clinical oversight, support and guidance is provided by the ICS Clinical Delivery Group. The latter also performs a critical function in ensuring that opportunities for cross-programme board working and the elimination of duplication are realised.

3.5.1 Integration of the ICS into the wider health and social care system

The Berkshire West ICS and partners have been working together as the Berkshire West 10 (BW10). This comprises of the CCG, three local authorities, RBFT, BHFT and SCAS since 2013 within a shared governance structure. The chair of the BW10 Integration Board is also a key member of the ICS leadership group, as well as a number of key clinical and managerial leads, which ensures there is strong collaboration between BW10 and the ICS. Social Care is recognised as an important part of our overall health and social care delivery system and working effectively together with further strengthen our ability to improve outcomes for residents.

The BW10 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
- Prevention

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

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

These feature as a key part of delivering the five year forward view around urgent and emergency care. The work of the BW10 on this links closely with the A&E delivery board to ensure a consistent and joined up approach across the system.

One of main achievements in 2017/18 has been the significant reduction in the number of bed days lost due to patients waiting in hospital longer than they needed to be there. Much of this success can be attributed to the focused work we have undertaken through the BW10 Integration Programme and we will seek to build on this in 2018/19 so that each of localities has a realistic aspiration to meet the national target in this area.

Building on the success of recent years, 2018/19 will be an important year for us to move our collective aspiration on to greater integration achievements.

4 ENABLERS

4.1 Back office

There is a potential opportunity to integrate and implement a new delivery model for back office services across the ICS which enables the continuation of high quality delivery but at a reduced cost. The providers and CCG have been working together over the past year to review the options available, the phasing of the development of any shared capability and the potential savings. Phase 1 of the programme focusses on transactional services with a target saving of 15%. There is also a significant linked piece of work around re-procurement of core financial systems and the opportunity to move to a single system for providers.

During this 2017/18 the CCG have brought services in-house from CSU in a preparatory phase with further in-housing to occur in 2018/19 at a saving of approximately 20% in year 1 and a further 20% in year 2.

4.2 Estates

A high quality, modern, accessible and welcoming estate is critical to our ability to serve our patients. Our estate presents us with a number of challenges. Like many health and care systems our estate is a patchwork of bespoke buildings built in a range of different eras across multiple sites.

Within the RBFT portfolio, the Royal Berkshire Hospital (RBH) site comprises buildings that range from relatively new, supporting the effective delivery of services, through buildings built in the 1960s and 70s that require investment or replacement, to listed buildings that are expensive to maintain and run services from and no longer support the delivery of care in the 21st Century. . Equally a number of these facilities (including the emergency department) were commissioned prior to the increase in local population. With population set to expand again we face the prospect that these facilities will struggle to deal with the demands placed on them. There are significant infrastructure challenges which impacts upon the experience of patients, visitors and staff. Likewise progress should be made on reducing the impact of heating and powering the building on the environment and reducing the carbon footprint of our services and our buildings. RBFT are seeking to utilise estate away from RBH site, alongside evolving digital and technological solutions, reducing the requirement for patients to attend the acute hospital site.– delivering care at or closer to people's homes. RBFT is developing the estate masterplan to reduce the running costs, reduce backlog maintenance and ongoing maintenance costs and ensure that, where services need to be delivered from an acute hospital site, they can be delivered from premises that are fit for the delivery of 21st century hospital care We also have a range of opportunities notably the facilities BHFT already operates from across the county. Many of these buildings have the potential to provide more care – and are closer to people's homes.

Within the BHFT estate portfolio, a number of actions have already been taken to rationalise the number of smaller service locations within the Reading area, dispose of older buildings no longer fit for purpose and integrate services into a smaller number of modern well places locations that better serve the community.

There are a number of factors which have prompted the ICS to commit to further development of the Primary Care Estates Strategy in 2018/19. These include demographic change and growth as a result of significant housing development; new ways of working including the use of different workforce models and IT solutions; and the requirement to future proof new developments to enable potential new care models that shift work from hospital settings to primary care.

Together, the ICS participants also have an opportunity to review administrative estate linked to the Shared Back Office programme.

The aim of this work is to maximise effective utilisation (clinical and non-clinical) of our NHS estate portfolio and identify opportunities to deliver cash receipts through disposals and reduced annual revenue costs across the system. This will support and be shaped by the emerging estates requirements of the new care model and system changes identified via the ICS change programmes and ensure the estate portfolio is fit for the delivery of modern healthcare services that meets the expectations of patients/service users. For more information please see **Annex 12.**

4.3 Shared Bed Modelling

This project was established to ensure our 'bed base' across the ICS health economy is fit to meet our current and anticipated demographic and that it supports the new care model and system changes as they are identified via the ICS programmes. The context for this work is that whilst maximising opportunities for patients to have care outside hospital and reduce time in hospital overall we want to ensure that bedded care is optimised across the system for patients whose clinical needs require it. By this we mean that bedded care is provided in the correct volume at the Acute Trust, and in other settings, with the underlying principle that time in hospital should be minimised to avoid the well evidenced risk of decompensation for patients as a result of prolonged hospital stays.

The project is mapping capacity and patient flow across provider organisations, sites and bed types. A key output will be a move to manage all bedded care across the system 'as one' supported by a system wide bed management system based on real time data. In addition, a work stream to improve the functional processes 'on the day' whereby available beds are identified, patients matched to those beds and transfers take place earlier in the day to settle patients into their onward care in a more timely manner.

At its heart is a redesign across the system of bedded care to deliver provision that can care for the right patient in the right setting as part of care pathways that provide alternatives to bedded care where appropriate. Current state for acute and community bedded care is complete, the next stages will pull in mapping of domiciliary, nursing and residential home care and include in the future state design alternatives to bedded care.

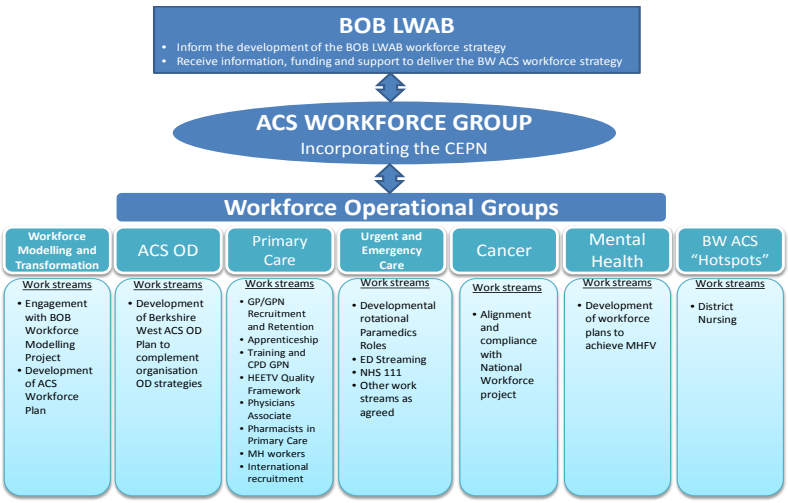
For more information please see **Annex 13.**

4.4 Workforce planning

A major part of our ICS ambition focuses on making improvements for staff across the area. As well as specific aims to improve workplace wellbeing there are ambitions to enhance leadership capability, up skill the workforce and create a shared workforce plan to increase opportunities for rotation across organisations – giving staff greater experience and enabling them to deliver better care.

Our aim is to develop a network which will facilitate partnerships between service providers and the education and training providers within the ICS footprint that will accelerate the development of a sustainable and highly skilled health and care workforce in Berkshire West. By working together we will develop the infrastructure and stakeholder relationships necessary to effectively identify workforce needs and secure the investment and innovative approaches required to address these. Please see **Annex 14** for more information.

Figure 8: ICS Workforce Group Structure and current work streams



4.5 Digital Transformation

The role of digital and technology will be a key enabler to support the vision, objective and transformational change required to truly deliver improved patient outcomes, organisational financial health and maintain high quality services for the ICS.

Our Digital transformation is overseen by the Digital transformation Programme Board which has representation from health and social care organisations from Berkshire West. The Board coordinate the Local Digital Roadmap and digital aspirations to harnessing technology for the Integrated Care System.

Berkshire West is well on track toward joining up and digitalising our health systems. We can provide clinicians with more timely access to accurate information, support service change to help improve health for all and provide patients with better access to their records and support service change which will improve health for all.

With BHFT and SCAS recognised as NHSE Global Digital Example[1], and RBFT part of the Fast Follower programme, our ICS is in a strong position to further improve patient care and strategic planning through innovative digital solutions.

Berkshire West collectively submitted a Local Digital Roadmap (LDR) in 2016 and the detail on the implementation continues to develop, encompassing 7 key themes –

Records sharing for cross-organisational care - Enable health and care professionals to have immediate and appropriate access to all relevant information about a person's care, treatment, diagnostics and previous history. This includes care plans and all necessary transfers of care information.

Citizen facing technology - Support and enable people to be actively involved in managing and making decisions about their care. This provides a strong basis for well-being and prevention.

Whole system intelligence - Health and care professionals across communities, geographic and clinical, have the data, analytics, decision support, information and insights they require to run an efficient and effective service. This includes risk stratification, care delivery, planning, targeting, monitoring, auditing, and research.

Infrastructure and network connectivity - A fast, reliable infrastructure, with shared connectivity, at a lower cost. Common ways of working support access to 'home' systems across localities and the ICS/STP regions.

Information Governance - A common set of processes to appropriately and effectively use information, in line with the expectations of patients and citizens. Information Governance becomes an enabler, not a barrier, to care planning, targeting and research.

Digital training and education - Delivering education and training to public, patients and staff as efficiently and effectively as possible to drive improvements in the effectiveness and quality of services.

Quality improvement and quality assurance – Regular analysis and feedback to individual clinicians, teams and services on their performance and quality to measure the effect of service changes and education and training.

[1] an internationally recognised NHS provider delivering exceptional care, efficiently, through the use of world-class digital technology and information

5 PATIENT AND PUBLIC ENGAGMENT

The ICS exists to serve the health needs of its population. The ICS will deliver the NHS Constitution by uniting patients and staff in a shared ambition for high quality care by putting these values at the heart of everything we do:

- Working together for patients.
- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Everyone counts.

The ICS consider working in partnership with patients and the public to be central to the way that we work. We are committed to ensuring that public and patient voices are involved as we develop and design services and monitor provider performance. We are also committed to effective communication with patients and the public, including a '*you said, we did'* approach.

Our Objectives

- To develop a compelling and coherent narrative that illustrates the ICS's overarching vision and how it is working to improve health and care for Berkshire West localities.
- To build a network of ICS patient representatives/champions who will be key partners in the ICS to create and deliver the core narrative to engage and build commitment with internal audiences whilst communicating benefits and change implications to staff, patients and the wider public.
- To disseminate, promote and publicise the vision and objectives of the BW ICS and its benefits for patients and healthcare across the localities to external influential organisations and stakeholder groups
- To build trust and commitment amongst patients and the public in general for the aims and vision of the ICS in their localities.

We are adopting a phased approach to communications and engagement which clearly defines the aim and objectives for each stakeholder group, both internal and external. (N.B. A phased approach does not necessarily mean that one phase will follow another and phases are interdependent on timescale for mobilisation) Phases for the ICS communications and engagement strategy for 2018/19 are:

Phase One – Producing a compelling narrative. To develop a compelling and coherent narrative that illustrates the ICS's overarching vision and how it is working to improve health and care for Berkshire West localities

Phase Two – Building commitment – internally. To build a network of ICS champions who can deliver the core ICS narrative with enthusiasm across all partners and internal audiences and build commitment throughout staffing groups.

Phase Three – Building commitment with external stakeholder groups such as patient forums.

To build commitment by delivering consistent key messages and compelling narrative to all our stakeholder groups. The communication of such messages and narrative should be accompanied by external engagement in a variety of formats including but not limited to:

- Speaker opportunities
- Event collaboration
- Media engagement

- Events/meetings

Phase Four – Building commitment with public and patients

To build commitment from patients and the public, we will involve them in our work and develop a programme of communication, engagement and involvement that will reassure them and build confidence in our partnership. We have three local authority HealthWatch officers who each have a crucial role to play in the development of the ICS and the reshaping of services. To enable local HealthWatch officers to be effective partners we have developed a new and innovative approach which is embedding HealthWatch within the ICS governance framework

What we have done so far

The approach outlined above has been adopted in the IMSK work stream. During the initial scoping of the project, patient workshops were held to understand what worked well and what didn't work well for our population. This feedback was then presented to clinical and management leads in further scoping workshops to prove the need for change.

Before the programme started, 4 patient leads were recruited by advertising through our local networks, patient groups and BW10 partners. These 4 patients became a central part of the redesign process, and attended a number of workshops throughout 2017. These workshops were attended by clinical and management leads from across the ICS and wider health system and designed the new IMSK service. The patients were fundamental partners during this redesign and their views and questions often led to innovation and new ways of thinking during the workshops. As the IMSK programme developed, the collaborative had to submit gateways to enable the programme to continue. The patient leads reviewed these gateways independently of the service providers, and their feedback was central to the board papers which the CCG used to decide if the project should continue.

Finally, one of the patient leads volunteered to sit on the IMSK oversight group (which is the central management and leadership group of the service) and during the first meeting it was proposed and agreed that he should be the chair of the oversight group going forward. This ensures patient voice is central to this new service going forward.

6 DELIVERING AND IMPROVING QUALITY

This ICS Quality Framework sets out how the ICS will use a strength base approach to 'System Wide Quality Improvement' adapting the 'signs of success' framework developed in Ontario, to deliver the quality objectives. We will move away from a traditional quality assurance approach, to a more collaborative system wide approach to quality, with shared responsibility and accountability across the system. We will ensure patient feedback is at the heart of our quality assurance approach.

As a successful ICS we are working together with a shared vision to achieve agreed quality goals and an openness and willingness to challenge and scrutinise each other; to ensure examples of best practice, as well as learning from when things go wrong is shared across the system to achieve best outcomes.

There are nationally set improvement targets that are mandated for all Integrated Care Systems to deliver from the respective five year forward view e.g. achievement of key cancer standards and clearly mandated mental health standards. An ICS Quality Dashboard is therefore under development and will allow for close monitoring by all partners across all of the required standards and most importantly, shared understanding of the issues when improvements are required and a system wide approach to making these improvements. In addition, locally agreed priorities will be included and monitored to ensure focus on agreed priority areas and subsequent delivery, so that the focus is on delivering and improving care.

The ICS will follow the *signs of success approach* which develops profile areas instead of collecting vast amounts of abstract data which is often inter-related but rarely connected. The profile development allows for the interconnectedness of abstract information to build a story that can make a difference. For example, taking a particular disease pathway and gathering information on what it's like from the patient's perspective, the family or carer, the staff delivering the service and the clinical outcomes for that disease. A full profile will then be built and used to make improvements where they are needed across the system to improve the patient experience and achieve best clinical outcome.

Our indicators of success will be that:

- The four dimensions of quality (and their congruence and balance) are discussed and recorded before major decisions.
- The whole ICS improves together (not one organisation failing and another succeeding)
- Voices from the grassroots are systematically heard across the system
- All organisations within the ICS demonstrate a culture that incorporates reflection, appreciation and shared learning
- The ICS will be delivering high quality services that best meet the needs of our population by engaging and listening to our local populations health needs.
- The ICS will move towards a joint ICS Quality Committee which will replace the individual Clinical Quality Review Meetings currently held with each provider. The ICS Quality committee will review the ICS Quality Dashboard to monitor progress against the key agreed indicators for quality and performance, but will focus on how as a system we can make improvements required, rather than using contractual levers, utilising signs of success approaches.
- Partners will contribute to the agenda setting, with opportunity to share examples of innovation and improvements made, to share learning across the whole system.

- A combined monthly 'Serious Incident Panel' will be established, to scrutinise root cause analysis and best benefit from a system wide approach to learning. The ICS Quality Committee will delegate safeguarding children and adult assurance to the already established ICS Safeguarding Committee, which will report to the ICS Quality Committee through a chairs report . A clear objective of the committee will be to reduce reporting and not duplicate.
- To further develop the established system wide infection prevention committee to encompass plans to reduce gram negative infections.
- To develop systems to ensure system wide learning from deaths.

The ICS Quality Committee will form an alliance of providers that collaborate to meet the needs of a defined population. The Committee will monitor, discuss and collectively take action to drive quality improvement as specified within the NHS Standard Contract between Berkshire West CCG, RBFT, and BHFT.

6.1 BHFT Quality Improvement programme

Berkshire Healthcare's Quality improvement Programme was introduced in 2017 to create a culture focused on continuous improvement and sustainability. It empowers and enables staff to make improvements, equipping them with the tools and techniques they need while aligning all teams on achieving the Trust's strategic objectives ("True North"). These are:

1. To provide safe services, prevent self-harm and harm to others
2. To strengthen our highly skilled and engaged workforce, and provide a safe working environment
3. To provide good outcomes from treatment and care
4. To deliver services which are efficient and financially sustainable

The Trust is being supported for an initial 18 months, by external partners with worldwide experience of implementing Quality Improvement programmes in healthcare organisations. At the end of this period, staff across the organisation will be fully trained and able to maintain and continue the work, with QI methodology being fully embedded.

Berkshire Healthcare has a robust internal process for identifying, investigating and learning from deaths of patients who are under the care of the Trust's learning disability, mental health and community services.

The Trust contributes to a system-wide approach to learning from deaths by:

- Engaging with the local Learning Disability Mortality Review (LeDeR) process (referring cases, nominating staff to support the LeDeR review process)
- Actively participating with the system- wide mortality review and assurance process, led by the Berkshire West CCG
- In cases where the Trust's mortality review process identifies multi-agency concerns, case are referred to the local adult safeguarding board and learning brought back to the Trust
- In cases where the Trust mortality review process identifies potential concern about the care provided to the patient by another healthcare provider, it is raised directly with the provider (acute hospital or primary care), to include in their own internal mortality review.

6.2 RBFT Quality Improvement programme

Ensuring safety and quality of care for every patient is RBFT's top priority. The Trust wants all its services to be outstanding every day of the week and to maintain its position as a top performer in delivering NHS access standards. RBFT also strives to be the one of the safest and most caring NHS organisations in the country. In 2018 the Trust refreshed its Quality Strategy (2018-2023) which provides the framework for the quality improvement work taking place across the Trust, based around the 5 CQC domains of safe, effective, caring, responsive, and well-led.

The Trust develops an annual Clinical Audit & Quality Improvement programme every year which consists of all mandatory national audit projects as well as locally agreed priority quality improvement projects, including those for the annual Quality Accounts. These priorities are developed through:

- Review of progress against last year's priorities, carrying forward any work streams which have scope for on-going improvement;
- Analysis of themes arising from internal quality indicators (complaints, incidents, clinical audits, mortality reviews, outcomes data);
- Patient engagement;
- Staff engagement;

- Key stakeholder engagement – seeking the views of our governors, regulators, Healthwatch and other community partners.

As a result, the Trust is confident that the priorities we have selected are those which are meaningful and important to our community.

In 2018-19 the Trust will be participating in all applicable National Clinical Audit Patient Outcomes Programme and Quality Account reportable national audits and all applicable national CQUIN projects. The Quality Account priorities have been agreed as:

- Reduction of avoidable falls with harm
- Reduction of avoidable pressure ulcers
- Reduction of mortality due to sepsis
- Improving recognition of the deteriorating patient
- Improving patient experience of car parking
- Improved effectiveness of transition from admission to treatment and discharge for complex patients
- Improving involvement of patients and carers in managing their own care

The Trust has a robust process of mortality surveillance and learning form deaths, and this is shared system wide

A RBFT consultation has taken place to identify any additional local priorities for clinical audit and quality improvement which have also been included on the 2018-19 Clinical Audit & Quality Improvement Programme. Progress against all of these projects will be monitored through the Clinical Outcomes & Effectiveness Committee chaired by the Medical Director.

This reports to the Quality Assurance & Learning Committee and up to the Quality Committee, chaired by a Non-Executive Director. There are additional monitoring mechanisms for the CQUINS and the Quality Account priorities. This allows appropriate scrutiny against the progress being made with these quality improvement initiatives, and also provides an opportunity for escalation of issues. This will ensure that improvement against each priority remains a focus for the year and will give the Trust the best chance of achievement.

In addition, clinical audit & quality improvement is promoted across the Trust through bi-monthly training sessions available to all staff; participation in promotional events through “Clinical Audit Awareness Week” held in November; and an annual Clinical Audit & Quality Improvement competition open to all staff to promote and celebrate best practice.

7 SUPPORTING APPENDICES

7.1 Annex 1 – Cancer

Responsible ICS partner: Berkshire West CCG and Royal Berkshire Foundation Trust

Overall Goals for 2017-2019

The approach to commissioning and delivering cancer services in Berkshire West in 2018/2019 continues to be delivered through the jointly agreed Berkshire West Cancer Framework developed by the Berkshire West Cancer Steering Group. This group is comprised of clinical and non-clinical representatives from Berkshire West CCG (including GP lead), Royal Berkshire Foundation Trust, Thames Valley Cancer Alliance, Cancer Research UK, and Macmillan. We have reviewed our progress against our objectives and agreed our local and Cancer Alliance priorities for 2018/2019 to continue the momentum of implementing the six priorities in the National Cancer Strategy, the Five Year Forward View and the Thames Valley Cancer Alliance key ambitions by 2021.

Progress in 2017/2018

- Our STP prevention work stream focuses on joint working across the footprint and launched the 'making every contact count' work stream and are working with our local Public Health teams to improve targets for smoking cessation, alcohol and obesity.
- Our teachable moment pilot went live in two GP practices in September 2017 and we will continue to review the uptake and impact of this pilot in 2018/2019.
- Focusing on South Reading to reduce the proportion of cancers which present as an emergency and improve cancer screening uptake we have worked with Macmillan to commission Rushmoor healthy living (a Hampshire based charity) to raise awareness of signs and symptoms of cancer particularly in hard to reach populations. To date 40 cancer champions have been recruited and they have engaged with over 1000 people.
- The majority of our 2 week referral proformas have been aligned to NICE guidance and jointly agreed with primary and secondary care clinicians.
- As per NICE Guidance we have ensured there is Direct Access for non-obstetrics ultrasound and chest x-rays.
- A focus on increasing the recording of staging data has meant that this has significantly improved (our overall baseline of 30% has increased to 70% - beyond the national target).
- For patients living with and beyond cancer we continue to assess the Macmillan funded Cancer rehabilitation service to ensure it is aligned with the requirements of the recovery package and we have also increased the number of electronic holistic needs assessments (HNAs) as 6/11 tumour sites are completing HNAs.
- We are working in partnership with FHFT to deliver the goal of developing and deploying a Cancer Health Information Exchange (HIE) to enable both improvements to the flow of information between provider sites and increase the visibility of relevant information to the patient themselves.

Deliverables for 2018/2019

- We will continue progress with the work streams outlined in 2017/2018 on prevention, teachable moments, South Reading project, staging data and living with and beyond cancer. We also plan to deliver the following objectives:
- Our Integrated Care System is currently meeting all eight waiting time standards for cancer; however we do have outliers in the far West of the area where patients are accessing other acute providers. We are seeing an improvement in this performance and will continue to work with all our providers to maintain and improve standards. We will also start to explore how we can work towards the 2020 target of a definitive diagnosis within 28 days.
- Working with the cancer alliance we plan to review the four main cancer pathways to ensure timely access for patients and we are exploring the pilot of multi-disciplinary diagnostics for vague or unclear symptoms.
- We are further developing our engagement with patients and working to utilise different modalities for follow ups.
- We will continue to work with PHE through our STP prevention work stream to increase the uptake of all screening programmes, including the roll out of FIT bowel cancer screening and considering the benefits of lung cancer screening.
- We plan to deliver risk stratified pathways as business cases for breast and urology have been developed and are currently in the sign off process.
- Through the Thames Valley Cancer Alliance we are working with partners to support the implementation of new radiotherapy services and upgrading machines.

Risks and issues associated with the delivery of this plan:	How does the ICS intends to work together to mitigate these risks and issues?
• Engagement with local partners for improvement of targets of screening, smoking cessation, obesity and alcohol. • Workforce capacity and/or provision of diagnostics may put at risk the provision of services, meeting national standards and delivery of transformational work streams. • Engagement with clinicians e.g. delivery of the living with and beyond cancer recovery package and risk stratified pathways.	• We work very closely with our public health partners through our Health and Wellbeing Boards and through the BOB STP prevention group to ensure delivery of these targets. • We work jointly within our ICS to ensure we will maintain the cancer national standards. Working with through our local steering group and the alliance groups we would ensure our workforce is maintained or increased to support delivery of all elements. We would also work with our partners to ensure we plan ahead for the diagnostic provision. • Working with our ICS partners and the cancer alliance we would understand the barriers to clinical delivery (primary or secondary care) and work jointly to overcome the issues.

What are the projects programmes we expect to contribute?

- The Berkshire West Cancer Steering Group priorities for 2018/2019 have been defined into local and Cancer Alliance work streams. As the emerging Cancer Alliance work stream objectives are confirmed we plan to obtain a local resource to implement the deliverables. Our local work streams have been identified as:
- Prevention – continue working locally with Public Health teams and through the STP prevention work stream to promote healthy lifestyle changes and improve the uptake of screening
- South Reading prevention – continue with our community engagement and education with a harder to reach demographic
- Living With and Beyond Cancer – aligning cancer rehabilitation with the requirements of the recovery package and delivery of risk stratified pathways
- Patient Experience – focusing on service user engagement and exploring different modalities of follow ups
- Cancer Staging – continue to improve the recording of staging information
- 2 week proformas – complete updating all our 2 week proformas
- Direct Access – tracking progress and exploring further options for Direct Access
- End of Life - Ensure that CCG commission appropriate integrated services for palliative and end of life care, in line with the NICE Quality Standard.

7.2 Annex 2 – Mental Health

Responsible ICS partner: Berkshire Healthcare Foundation Trust

Overall Goals for 2017-2019

Improving mental health is a fundamental part of our ICS operating plan. The Five Year Forward View for Mental Health (2016) sets out a clear direction for the NHS to improve mental health and wellbeing, highlighting why change is required and what good will look like. Some of what is needed can be brought about by the NHS itself. Other actions require partnerships with local organisations including local government, housing, education, employment and the voluntary sector.

Progress in 2017/18	Deliverables for 2018/19
Increasing Access to Psychological Therapies (IAPT) • Our performance against the national IAPT access, recovery and waiting time standards has been consistently strong, and includes innovative approaches to the use of online service delivery. Our service is an “early implementer” of enhanced access and services	• The focus for 2018-19 will be to have a fully integrated service that is cost effective while continuing to meet national access and waiting times and recovery standards with better access by BME communities. • We will also be using the results of our Long Term Conditions

for people with long term physical health conditions (LTC), which is showing very encouraging results in terms of reduced GP and A&E attendances by people receiving the service. • In 2017-18 there has been a focus on recruiting additional trained staff and trainees to be PWPs (psychological well-being practitioners) and high intensity therapists.	pilot to inform financial and activity modelling to support medium to longer term planning for use of resources across the system
Physical Health Check and Care co-ordination • We have made good progress in meeting Physical Health Checks target for people with severe mental illness in secondary care, and are achieving screening rates of 83% and 94% of those who required interventions as a result of screening.	• We will continue to develop partnership work across Primary Care and Secondary Care, maximising the opportunity presented by our GP Cluster teams, to enhance physical health screening and interventions
Early Intervention in Psychosis (EIP) • Our EIP service is NICE compliant and is meeting the national standards for access and treatment. We have been meeting the new waiting time standards which require 50% of patients experiencing a first episode of psychosis to commence treatment within two weeks of referral.	• Work is in progress to project future need and associated staffing requirements in order to maintain high levels of performance. This work will be overseen by our Mental Health Delivery Group and a review of progress will be undertaken at the end of the second quarter of the year.
Psychiatric Liaison service • We have a well-established service based in the local acute hospital (Royal Berkshire Foundation Trust), which has had a positive impact on the quality and responsiveness to people who attend the Emergency Department. Good levels of performance have been achieved in identifying people with previously un-diagnosed dementia, and enabling them to access appropriate help and reduce risk of delayed transfer of care. • The service model mirrors the 'RAID' (Rapid Assessment Intervention Discharge) model, and is supported by the Community Crisis Response teams and the Community Psychological Medicine Service working with high intensity service users and those with medically unexplained symptoms.	• We plan to develop the service to enable a timely response to people of all ages, and continue to support understanding and awareness of mental health within the acute hospital setting. A detailed plan for this work will be in place by the end of the first quarter of the year.
Individual Placement and Support services (IPS) • We have established a local service which is achieving good results in supporting people into employment – however, expansion and recurrent funding is needed to ensure that Five Year Forward View targets are met. A bid for NHSE funds is being submitted to expand the current model, which has "fidelity" status in terms of national guidance.	• The Berkshire West element of the BOB STP bid has been successful in achieving funding in wave 1, and we will continue to support partners in work to secure wave 2 funding. A plan will be developed by the end of quarter one to guide this work, building on the outline provided in the NHSE bid.
Reducing suicide rates • A partnership Berkshire Wide Suicide prevention strategy has been developed and approved by all six Berkshire Health and	• Over the next 2 years we will continue to work closely with Public Health and GPs to help more GPs recognise and manage those patients in high risk groups.

Wellbeing boards. In addition, Berkshire Healthcare has established a Zero Suicide initiative, which embraces the belief that suicide is preventable, and has achieved significant progress in provision of training, development of risk assessment and safety planning.	
Perinatal Mental Health • Our local service has secured "wave one" funding to develop access to evidence based services for local women. Over the next three years this funding will be utilised to ensure all elements of the perinatal targets are met and our aim is to ensure women are offered the full range of NICE compliant interventions. • We have developed an online service which provides a secure, anonymous and moderated Facebook type site for women during the perinatal period across the range of emotional disorders and distress. There are more than 260 activated users of this service and five peer moderators recruited from the users to support the clinical moderating team. A birth trauma pilot has been live for nine months and offers both individual and group work - referral numbers have exceeded those anticipated. Work is in progress to train perinatal clinicians in therapeutic techniques and integrate this with current provision to achieve a sustainable pathway. • We are on target to meet the increased access target trajectory of 450 patients for 2017/18, and plan to continue to develop training and recruitment of peer supporters during the next year to support sustainability.	• Our service will continue to meet access targets, prioritising the implementation of a sustainable approach to online and face to face provision. The plan for this work will be reviewed in quarter one, enabling any significant risks to delivery to be highlighted and mitigated.

Eliminating out of area placements for non-specialist acute care
• We are committed to ensuring that by 2020/21 no service users requiring non-specialist acute care receive their treatment in an out of area placement (OAP) setting . We recognise the challenges inherent in achieving this goal, as our inpatient service benchmarks as lower than average bed numbers for the local population. We have established a trajectory to enable us to plan improvements required each year. Our baseline has been established at 476 bed days for 2017/18 and we aim to reduce this by 33.3% in 2018-19.
	• We are committed to achieving the FYFV target to eliminate acute out of area inpatient placements by 2021, and to achieve a 33% reduction in baseline activity in 18/19. This is a key priority for the ICS in 2018/19.
	• A bed optimisation programme is in place to reduce avoidable admissions, reduce length of stay and out of area placements for non-specialist acute care:
	• **Bed flow and bed management**
	  ◦ dedicated resource, enhanced gatekeeping
	  ◦ Spring to Green aims to reduce occupancy of acute beds from 112% to 85%
	• **Reducing delayed discharge:**
	  ◦ System escalation calls routinely available
	  ◦ Swift agreement to social care packages with delegated authority to joint heads of community MH teams
	  ◦ Swift resolution of s117 aftercare funding with commissioners
	• **Reducing inappropriate admissions to hospitals**
	  ◦ Effective Psychiatric Liaison team at Royal Berkshire Hospital
	  ◦ End to end Personality Disorder clinical pathway

	reviewed and agreed, rolling out in 2018/19 • Exploring options for bed and non bed based alternatives for both admission avoidance and on-going recovery and rehabilitation • We have commissioned an independent review of bed numbers required for the population of Berkshire, for completion at the end of Q1
Dementia • Delivery of our dementia action plan across Berkshire West to ensure we continue to meet the National Dementia Diagnosis Standard is a priority for us: our current performance is 63% against a target of 66.7%. A number of initiatives are being put in place to ensure this target is reached by March 2018 and work will continue with GP practices to provide dedicated support to those practices that are underperforming, and also share good practice between practices. • Our local memory services are nationally accredited and achieving the national standard of six week waits. Through the Academic Health Science Network (AHSN) this best practice model of delivery has been shared and adopted across the Thames Valley. We have an award winning local service for young people with Dementia which is highly valued by local service users and staff. Although our memory clinic service delivery is very strong, we are aware that we need to plan for increased need, while maintaining high levels of performance.	• Review of 18/19 plan to meet diagnosis standard to take place in quarter one, with progress of targeted approach assessed and reported through both mental health delivery and primary care transformation groups to ensure engagement and ownership of continued progress. • Demand and capacity review to take place in quarter two to enable medium – long term planning of response to growth in demand.
Children and Young People • Our Local Transformation Plan has been developed collaboratively and co-produced with local stakeholders including children and young people and outlining the need to transform care and support on a whole system basis. It was refreshed in 2017, and includes 3 inter-related programmes of work: • Building the infrastructure, enabling the workforce to respond to young people's mental health and promoting anti-stigma • Promoting prevention, early intervention, resilience and promoting mental health and wellbeing • Targeting resources to those most at risk - those in crisis, Looked After Children and those known to youth offending services. • Local Child and Adolescent Mental Health services continue to experience high numbers of referrals which mean that meeting access and waiting time targets presents a significant challenge.	• We will need to work together with Local Authority commissioners to align commissioning and provision of services across the whole pathway in order to meet the national target of at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019. • In 2018/19 we will make further progress towards delivering the 2020/21 waiting time standards for children and young people's eating disorder services of 95% of patient receiving first definitive treatment within four weeks for routine cases and within one week for urgent cases.

Mental Health Investment Standard (MHIS) • In 2017-18 the Berkshire West projected expenditure on mental health related care is £67,863,000.	• The CCG plans to increase this expenditure in 2018-19 by at least 2% in order to meet our obligations under the Mental Health Investment Standard. The mental health related expenditure in 2018-19 is planned to be at least £69,342,000 • The ICS will support the use of these resources to enable delivery of Five Year Forward View targets – we have a strong foundation to build on, as well as the opportunity to shift resources to support further progress – which will be facilitated by our plans for integrated strategic planning for mental health as part of our ICS.

Risks and issues associated with the delivery of this plan:
• Demand growth is significant in some service areas and capacity has been constrained as a result of reduced funding available to Local Authorities
• Workforce supply is a key risk – this is a national issue but compounded locally by high housing costs and high employment
• IAPT LTC is showing evidence of reduced activity in A&E and Primary Care – but shifting recurrent resource to support continued development is challenging given demand pressures **in** those areas
	How does the ICS intends to work together to mitigate these risks and issues?
	• Specific Initiatives are supporting the collaborative management of demand pressures (see below)
	• Governance and joint planning structures are in place to enable risks and mitigation to be understood and agreed between partners:
	  • Mental Health Delivery Group
	  • IAPT Steering Group
	  • ICS Unified Executive
	  • Development of joint strategic planning/transformation team across commissioner and provider functions is currently in progress– this will be done on a Berkshire-wide basis, incorporating commissioners and partner providers in the Frimley ICS to develop a collaborative approach to strategic planning and effective use of resources.

<u>What are the projects programmes we expect to contribute?</u> • Out of Area Placements • Common Point of Entry • IAPT Increased Access/LTC • High Intensity Users • Child and Adolescent Mental Health Future in Mind • Mental Health Workforce Planning	

7.3 Annex 3 - Primary Care

Responsible ICS partner: Berkshire West CCG
Overall Goals for 2017-2019 The Berkshire West General Practice Forward View (GPFV) Local Implementation Plan sets out a vision for a sustainable primary care sector working at-scale and as an integral component of the Berkshire West ICS. To achieve this vision, our practices have come together into Primary Care Provider Alliances, with all practices within them working in geographically-contiguous clusters which will interface with other services to meet the health needs of groups of 30-50,000 patients (Primary Care Networks). At a system-level, the alliances are working together in an 'Alliance of Alliances' which will look to maximise their impact within the Berkshire West ICS. The GPFV programme describes how the CCG will support the Primary Care Provider Alliances to work to address sustainability challenges and build an expanded and integrated primary care sector which meets same day demand in the most appropriate way and works proactively to support patients in the community.

Progress in 2017/18	Deliverables for 2018/19
Primary Care Networks • Primary Care Provider Alliances made up of clusters (networks) of practices serving 30-50,000 cover all but two of our practices (which are engaged in discussions). • The four locality alliances are working together in an 'Alliance of Alliances' which will look to maximise their impact within the Berkshire West ICS. • Process and criteria in place for making the remainder of the £3 per head primary care transformation monies (£2 per head in 2018-19 as we invested £1 per head in 2017-18) available to alliances to support delivery of business plans which are aligned with key system priorities (e.g. delivery of extended access to primary care, engagement with pathway redesign and further development of integrated teams at a cluster level) and demonstrate how alliances will move towards being self-sustaining from 2019-20. • Integrated cluster working implemented in the Wokingham locality where the Community Health and Social Care (CHASC) teams have been working with GP practices and others to support proactive care planning and multi-disciplinary team (MDT) review for complex patients linked to our Anticipatory Care CES.	• Further development of alliance business plans to underpin allocation of £2/head. Funding allocation and progress to be overseen by Primary Care Commissioning Committee. Appointment of management lead for Alliance of Alliances and further OD input at all levels. • Development of cluster/network 'visions' for primary care aligned with GPFV programme/estates strategy. • Roll-out of Insights Population Analytics (IPA) to be used this year to support delivery of Anticipatory Care CES. Further development of ongoing approach to use of population health management in primary care through Connected Care. • Further development of CHASC model in Wokingham and roll-out of integrated health and social care team approach to other clusters/networks with Anticipatory Care CES as an initial focus. • Further develop role of integrated care teams in meeting acute care needs, building on GP Consultant and ECP pilots and exploring opportunities to integrate these more closely with existing rapid response teams • Going forward the alliances and associated clusters will serve as a vehicle for delivery of an extended range of services in primary care and new ways of interfacing with other services (e.g. through the MSK and Outpatients transformation and care and support planning work described elsewhere in this document).
Access • Across Berkshire West 89.2% of patients currently have access to evening appointments on some weekdays, 92.53% to weekend (Saturday) appointments and 84.52% to both. Practices are currently delivering 36.6 minutes of extended hours' capacity per 1000 population. • Practices in South Reading are considering how best they can work together to meet same day access demands building on a baseline mapping of demand, capacity and staffing.	**Enhanced Access** • In accordance with the planning guidance we intend that 100% of patients will have full access to evening and weekend appointments by 1st October 2018. Our planning trajectories show a phased implementation process over the next six months which should achieve full compliance with the seven core requirements by October 2018. Arrangements will include some same day appointments as well as slots bookable in advance (in this way primary care will form part of our broader urgent care offer and we will look to ensure NHS 111 can book into these slots at the earliest opportunity) and will ensure that appointments are available on days when practices are usually closed e.g. bank holidays. • As individual practices will not be able to deliver the level of capacity required, each of the alliances is working with their member practices to develop a plan for delivery of the additional capacity within clusters with potential wider collaboration through hubs at weekends. Our existing Enhanced Access CES allows for collaborative provision to expand hours of availability and sub-contracting where practices do not want to provide capacity themselves and in the first instance we will look to vary this CES to incorporate the requirements above. • The Enhanced Access CES was previously deemed to only be capable of provision by existing primary care contractors; we will review this position during 2018-19 and agree a procurement approach as appropriate. • The CCG will work with providers to put in place appropriate operational arrangements e.g. for access to patient records. The CCG will also ensure that services are appropriately advertised and that an equalities impact assessment is undertaken and any findings acted upon. We will test out

	staffing models to ensure that these are robust and that any risks to other services have been mitigated; we anticipate a more skill-mixed model will be used than for existing extended hours provision. Practices across Berkshire West are also implementing Footfall and we envisage that this will be one of means of accessing services outside of core hours as well as a source of advice on self-care. **Same day access** • New models of delivering same day care in-hours to be developed further in South Reading with the Walk-in Centre acting as a first hub. This work will inform future commissioning intentions around the current Walk-in Centre as well as the development of same-day access models across Berkshire West.
Workforce • Working proactively to address current and future workforce constraints in a key tenet of our GPFV programme. We have established a Primary Care Workforce Group involving the CCG, NHSE and HETV colleague and working as part of our overall ICS workforce workstream. • We are working in partnership with the University of Reading to deliver a Physicians' Associate (PA) programme with a significant level of primary care training placements. Eight students from the university programme were placed in primary care settings as part of the course in 2017/18 and two practices employ a PA. • Clinical pharmacists working a number of practices. • We have a number of practices using Emergency Care Practitioners (ECPs) for home visiting and have funded a pilot service in Wokingham. • Berkshire West has bid for 18 international GPs as part of the national programme. • Two of our GPs have already attended General Practice Improvement Leaders' Programme and a further ten GPs and others have expressed an interest in future cohorts. Each of our alliances has also engaged organisational development support to develop a stronger understanding of roles and opportunities within these new provider organisations and ensure clinical leaders work together effectively to maximise their impact.	• **Primary care workforce modelling** – gathering intelligence around current and future pressures and interfacing with emerging primary care demand and capacity tools to model modelling the impact of potential solutions. The information we have received to date from NHSE does not clearly indicate what proportion of the additional staffing resource set out in the GPFV we would expect to employ within Berkshire West, however we would look to progress these discussions as a matter of urgency in order to inform our future workforce planning. • **Supporting skill-mix** - We are actively promoting Physicians' Associates via the CCG and students will once again be placed within practices this year as part of the programme. For 2018-19 we will look to increase the number of qualifying PAs who choose to remain in primary care in Berkshire West and are working with a local PA Ambassador to achieve this. We hope that the Berkshire West joint alliance bid for national clinical pharmacist funding will significantly increase the impact that pharmacists can have in primary care. We are also now exploring the recently-announced national scheme for clinical pharmacist in care homes and would look to submit an ICS-level bid. During 2018-19 the CCG and alliances will continue to work with SCAS and others to consider the ongoing role of ECPs in primary care and how best to resource this. We will also be looking to further develop the role of mental health therapists in primary care, interfacing with the IAPT service as further clarity emerges around the GPFV investment in this area. • **GP recruitment and retention** – Over the coming months we will be working with NHSE leads to progress our international GP recruitment bid. We also continue to encourage GPs and practices to utilise the returner and retainer schemes. We currently have an over-supply of training practices but over the coming year intend to work with the Deanery to explore more diversified training models whereby registrars would spend time in practices that have not traditionally provided training opportunities. We also intend to develop an 'offer' aimed at retaining more GPs from the local programme than is currently the case based on a combination of additional support and development opportunities. Finally we are keen to explore the potential of rotational and portfolio posts across the ICS to attract and retain GPs. • **Continued Professional Development** – we are committed to providing excellent development opportunities for all primary care staff both in terms of formal learning, practical experience and portfolio posts and intend to use Community Provider Education Network funding to better align education and training

	provision with new models of primary care delivery. • **Development of clinical leadership in primary care** – we will work with NAPC and others to build the 'primary care voice' within our ICS. We will continue to take up national offers around leadership development in primary care. • **Practice Manager Development** - we are using GPFV funding to develop a locally-bespoke development offer for practice managers working as part of alliances and clusters. We are also encouraging practice managers to take up national development offers around primary care at scale. • **Staffing approaches –** we will support our alliances to further explore joint approaches to recruitment, shared posts and locum banks.
Workload • Practices have been working through alliances to undertake training on and implement workflow optimisation processes using GPFV funding. Newbury practices have taken a slightly different route and are further establishing a GP administrative assistant role to be funded through national apprenticeship monies. • Following a successful Time for Care showcase event in November 2017, alliances are also working with national facilitators to implement active signposting. Some will also be implementing group consultations • We have adopted a three-stage approach to implementing online consultation, starting with practice engagement to identify a preferred solution and moving onto procurement and adding functionality. We are in the process of procuring Footfall for all practices with CSU support for implementation thereby ensuring opportunities to maximise impact and interface with extended hours and other integrated services are fully utilised.	• Time for Care / Workflow Optimisation / Online Consultation work to be completed during 2018-19. • It is intended to commission the *Time for Care* team to run a quality improvement programme for practice staff in 2018-19 in addition to sessions on active signposting and group consultations. Whilst the exact mix of initiatives will vary, we can be confident that all practices will be implementing at least two of the Time for Care High Impact Actions by the end of 2018-19. • During 2018-19 we will look to build upon Footfall through add-on functionality and by exploring an alternative app-based solution such as Sensley. We will also be working to consider how we link online access to practices with the implementation of NHS 111 online and direct booking. • During 2018-19 we will work to maximise the impact of social prescribing, building on existing arrangements and ensuring these are a potential disposition from active signposting and Footfall. • We will also undertake a number of projects aimed at supporting self-care e.g. our wearable technologies project, roll-out of health pods in surgeries and selection and promotion of appropriate apps.
Estates • Four of our Estates and Technology Transformation Fund (ETTF) premises development schemes have been completed. • The first tranche of development of our primary care estates strategy focussed on assessing additional capacity required to meet the future considerable housing growth forecast in Berkshire West; this is being continually updated as new proposals for development come forward.	• A further eight ETTF schemes are on-track and scheduled to complete in 2018-19 and we have one remaining scheme for which we are working to agree a start date. Revenue implications have been assessed and accepted by the CCG. We have also provided in principle support for a further premises development in South Reading which will replace outdated premises and provide capacity for population growth. • During 2018-19 we intend to commission an updated six-facet survey and actual/potential capacity review of existing primary care premises and to undertake further opportunity location around sites which may lend themselves to joint development with ICS and other local partners. In so doing we intend to better align our approach to primary care estates with our broader ICS estates strategy therefore ensuring that we have the estates infrastructure required to underpin delivery of new models of care. • Our Connected Care programme is described in more detail

	below. Priorities for primary care in 2018-19 will include the roll-out of the Health Information Exchange to GP practices and further development of the role of population health management in delivering proactive care.
Sustainability and resilience funding • All GPFV sustainability and resilience funding received to date has been invested in supporting vulnerable practices in Berkshire West.	• Further funding to be allocated in accordance with guidance to support future sustainability of primary care sector.
Delegated commissioning • The CCG will continue to discharge delegated commissioning functions relating to primary care services in accordance with the Delegation Agreement in place with NHSE. All activities will continue to be overseen by the Primary Care Commissioning Committee to which NHSE is invited.	• Terms of Reference have been updated for 2018-19 to reflect the CCG merger. The committee and its associated functions were the subject of internal audits during 2016-17 and 2017-18. Completion of resulting actions is overseen by the CCG's Audit Committee. • During 2018-19 we will review and develop our approach to quality improvement in primary care, aligning this to the key principles of the ICS Quality Framework.
Risks and issues associated with the delivery of this plan: • Recruitment and retention of primary care clinical workforce • Lack of GP engagement in delivery of the plan • Implementation of the primary care estates strategy – availability of sites and funding and need to align plans to new clinical models. • Delivery of technical solutions e.g. online consultations • Lack of patient engagement/awareness of new models of care	**How does the ICS intends to work together to mitigate these risks and issues?** • Workforce planning and development strategy being developed across BW. • Engagement with the local Alliances and where appropriate with the Alliance of Alliances. • Engagement with the One Public Estate initiative locally and with local councils around population growth and estates opportunities. • IM&T infrastructure development being delivered as part of broader ICS Digital Strategy. • New ways of working in primary care to form part of ICS narrative and engagement plan.

What are the projects programmes we expect to contribute?

- Further development of Alliances/Networks/Alliance of Alliances to ensure sustainability and expand range of service provision in primary care through ICS workstreams
- Delivery of Anticipatory Care CES using IPA and through integrated health and social care teams
- Review of ECP pilot and opportunities for integration to meet acute care needs
- Enhanced Access – to be delivered by October 2018
- Same day access hubs (in hours) – piloting approaches
- Primary care workforce modelling
- Skill-mix in primary care – ECPs, clinical pharmacists, physicians' associates.
- Recruitment and retention in primary care (GPs and others)
- Continued professional development for primary care workforce and clinical leadership development
- Time for Care – active signposting, group consultations and quality improvement
- Workflow optimisation implementation
- Supporting self-care
- Online consultation
- Further development of primary care estates strategy
- Delivery of ETTF premises schemes and further work-up of non-ETTF schemes
- Roll-out of access to Connected Care HIE and development of population health management approach in primary care

7.4 Annex 4 – Urgent Care

Responsible ICS partner: Berkshire West CCG and Royal Berkshire Foundation Trust

Overall Goals for 2017-2019

The ICS and A&E Delivery Board are committed to delivering the next steps in the 5YFV for urgent & emergency care to support a return to achievement of the 95% standard. The system will continue to build on existing improvements to patient flow through the system with a focus on increasing the number of patients treated on ambulatory care pathways, a partnership model for bedded care across the system and front door streaming on arrival at ED. The ICS will continue to work closely with ASC colleagues to minimise delays for medically fit patients moving to onward care with a firm focus on the "home first" principle supported by trusted assessment processes reducing duplication. Integrated Urgent Care will move closer to a "consult and complete" model with 50% of calls being transferred to a clinician and direct booking into a greater number of services. NHS 111 online will be implemented by Jul-18. The MIU at West Berkshire Community Hospital provided by BHFT, will become a fully designated UTC with interoperability to support direct booking in place by Q2. The system will continue to support SCAS on implementing the recommendations of the Ambulance Response programme putting an end to long waits.

Progress in 2017/18	**Deliverables for 2018/19**
Integrated Urgent Care • The Berkshire West urgent care system achieved over 90% performance for 2017-18 • Data from Nov-17 shows that the percentage of calls closed within the service increased by 4.4% (compared to Nov-16), ambulance dispatches reduced by 1.4% and ED attendances reduced by 1.5%. Direct booking is in place for GP out of hours and there are plans to pilot direct booking in two Practices in Berkshire West. • Commissioners and the Alliance have agreed a robust Service Development Plan to enhance and monitor delivery of this service. This will allow the service to respond to local and national needs and priorities.	• The ICS will continue to work with SCAS in 2018/19 to reduce the number of people conveyed to hospital • As lead Provider for IUC SCAS will enhance their clinical co-ordination and IUC approach by; • Increasing the range of specialist providers in the CAS to include midwives, AHPs and the third sector (including palliative care and social care) • Developing closer integration with Single Points of Access for out of hospital services • Rolling out direct booking to Urgent Treatment Centres (UTCs) • Piloting direct booking into GP Practices in-hours • Supporting Health Information advice with text messaging • Increasing capability and number of care home using Skype technology building on an existing 999 pilot. • Work actively with NHS England to look at opportunities to pilot software for new online symptom checkers and shape the future design of on-line services. • Pilot direct booking into 'in hours' GP Practices once the new EMIS/Adastra links are established. A scoping exercise has identified that a maximum of 5 appointments would need to be booked per day and 2 Berkshire West practices will participate in the pilot.
Primary Care streaming • Primary Care streaming at the RBFT emergency department (ED) was launched in October 2017 in response to the requirements in the Urgent and Emergency Care Delivery Plan (NHS England, 2017). The service is provided by BHFT and operates daily between 0800 and 2300. • The service, which is being run as a six month pilot, is based on the GP streaming model at Luton & Dunstable Hospital and is co-located with ED. A senior nurse assesses all ambulatory care patients arriving at ED and identifies those appropriate for further triage or treatment by a Primary Care physician or nurse	• The Primary Care streaming service operating at the front door of the RBFT ED has recently been evaluated against the key deliverables set out in the Business Case. The A&E Delivery Board considered the outcomes of the review at its Mar-18 meeting. A briefing paper was presented to the ICS Unified Executive on 12th April and it was agreed that a Task and Finish group will be convened to rapidly review the operating model for the service and redesign the service to ensure greater patient throughput at lower cost whilst retaining patient satisfaction with the service.

whilst those requiring clinically greater assessment of care are directly booked into ED. • The service is currently being evaluated and a recommendation will be made to the A&E Delivery Board in March 2018. Initial indications are that the current model is not financially sustainable and that the numbers being streamed to the service are lower than planned.	
Integrated Discharge service (Getting Home) • In 2017 the RBFT Service Navigation Team and the BHFT Integrated Discharge Team were combined to form a new Integrated Discharge service (Getting Home) under a single manager. The new team provides a single point of contact for all complex discharges operating with a new e-referral system. The team are working closely with Adult Social Care colleagues to support a seamless discharge flow to out of hospital services. • Also under the Getting Home programme a Trusted Assessment pilot has been operating with positive results and excellent feedback from Adult Social Care on the standard of assessments and care plans provided by RBFT Occupational Therapists (OTs).	• In 18-19 the Integrated Discharge Service will move to "business as usual" within the Trust although this does not mean that the service will not continue to develop and evolve. The team will fully roll out the new e-referral system across the Trust and hold an official launch on 17th April which will showcase best practice in discharge and have Liz Sergeant as a guest speaker. The team will continue to work on the discharge pathways with the aim of simplifying the pathways and having increased consistency across Berkshire West. The team will also work with ASC colleagues on the best model for integrating social workers into the team. This is aimed at supporting achievement of the 3.5% target for DToC and reducing the number of stranded patients in the Trust through a focus on simplifying pathways, hone as the default discharge destination and community services pulling patients out of bedded care. • The Trusted Assessment pilot continues and in 18-19 with the aim of reducing the current duplication is assessment for patients. In 18-19 the focus will shift to Care Homes and how the use of the Trusted Assessment approach could reduce the delays experienced waiting for Care Home assessment. • The next stage of the Discharge to Assess pilot is the use of a single "home visit" assessment form" with a duplicate being left in the patient's home.
Minor Injuries Unit (MIU) • Current service provision at the Minor Injuries Unit (MIU) at the West Berkshire Community Hospital has been reviewed in light of the guidance on designation of Urgent Care Treatment Centres (UTC). The existing service already meets many of the conditions of a UTC but developments required include; upskilling the workforce in minor illness, establishing additional premises requirements, interoperability and introducing an appointment booking system. Additionally the extent of GP presence at the UTC is yet to be determined but opportunities presented by the more integrated approach to on the day management of urgent need are being explored.	• The unit will be in a position to achieve full UTC designation by December 2019. • Full interoperability will be in place by q2 to support direct booking • Agreed set of PGD (Patient Group Directives) in place

Delayed Transfers of Care
• In 17-18 Commissioners, Providers and Local Authority partners focused closely on delivery and robust monitoring of BCF schemes with DToC numbers remaining at some of their lowest levels during Dec-17 and Jan-18.
• The new Integrated Discharge Service launched their new operating model, working with medically fit patients on a case management approach and liaising closely with
	• In 2018-19 the ICS will work with Adult Social Care colleagues to implement the recommendations from the Local Government Association (LGA) review completed in February 2018 including:
	  • Focus on home first and discharge to assess
	  • Joint H&SC commissioning, demand and capacity planning and workforce strategy across all authorities

ASC on complex discharges.

- The Trusted Assessment pilot went live on Hurley ward with a new Berkshire West Standard Operating Procedure, single referral form and OTs acting as Trusted Assessors for care needs post discharge.
- The Specialist Support to Discharge team (CHS) provided individualised support to self funding patients and their families to facilitate timely discharge and materially decreased the number of days delayed for this cohort of patients.
- There was continued focus on discharge to assess and full use of D2A capacity and on flow through Community Hospitals with ongoing work on the time taken to transfer patients from acute to community beds.

- Providing social work service and community support seven days a week
- Simplifying and clarifying access to care pathways
- Successful implementation of the High Impact Changes.

Continuing Healthcare (CHC) service

- The Continuing Healthcare (CHC) service has continued to try to increase the number of patients who are interim funded pending a full CHC assessment, a process which began in September 2017. However the complex needs of some patients have meant we have not always been able to do this in a timely way. In Q4 N&W Reading met the percentage projected in the Improvements Plans (9%). North and West Reading achieved 20%, 5% over the Improvement Plan target. Newbury and District CCG's percentage increased to 33% from 14% in Q3. Wokingham's percentage remained at 25%. due to an inability to place patients identified for interim funding and assessment then needing to take place in hospital

Risks and issues associated with the delivery of this plan:

- Actions are not sufficient to deliver the submitted A&E trajectories
- Anticipated impact of bed modelling project not realised
- IUC service does not deliver the expected channel shift impact on downstream services
- DToC rates will remain above the 3.5% threshold target across acute and community beds

How does the ICS intends to work together to mitigate these risks and issues?

- The A&E Delivery Board will continue to take oversight of the transformational programme of work for UEC. The Board has a clear remit in holding partners to account for delivery and addressing risks and issues to support achievement of the A&E 4 hour target.
- External support is being commissioned to support the bed modelling work and ensure achievement of key deliverables
- The CCG will work closely with the IUC Alliance of Providers to support achievement of the Business Case deliverables
- The BW 10 Partnership Board will also continue to have an important role on oversight of delivery of key BCF schemes recognising that not all Local Authority partners are currently part of the ICS.

What are the projects programmes we expect to contribute?

- High Intensity Users
- Bed modelling and flow
- Streaming at the front door of ED
- Ambulatory Care
- Specialist support to discharge
- Suite of BCF schemes including Discharge to Assess, Falls and Frailty, Mental Health Street Triage

- Implementation of the LGA Peer Challenge on Delayed Transfers of Care

7.5 Annex 5 – Maternity

Responsible ICS partner: Berkshire West CCG

Overall Goals for 2017-2019

A Local Maternity System (LMS) was established across the BOB STP in March 2017 as recommended by the Better Births Report: National Maternity Review published in June 2016. As a result of the capacity issues across Thames Valley maternity services is one of the main priorities for the BOB STP. The Senior Responsible Officer for Maternity is Chief Executive of Buckinghamshire Healthcare NHS Trust who nominated the Chair responsibility to Director of Nursing for Berkshire West CCG. The membership of the LMS Board includes representatives as recommended in the NHS E LMS Resource pack. The LMS Board meets quarterly with working groups set up to address the 5 main priorities.

There are 3 acute Trusts in the BOB LMS, all providing maternity services. There are 4 main types of care settings for women giving birth: home, freestanding midwifery units (FMU), alongside midwifery units (AMU) and Consultant led Obstetric units. Within BOB LMS every Trust provides a home birth service, there are five FMUs, three AMUs and three Obstetric Units.

Progress in 2017/18

- The Implementation plan for the BOB LMS provides the detail to date of the 3 year maternity transformation programme. The BOB LMS has agreed the 5 main priorities; this requires each Locality to have a Local Maternity steering group and a Maternity Voices Partnership that will be represented on the LMS board in order to understand how each local maternity steering group is implementing all aspects of Better Births.
- The BOB LMS plan concentrates on workforce, capacity and safer care. The need to develop the digital agenda is highlighted as this is pivotal to accurately record outcomes using robust data.
- LMS Board 5 main priorities are:
- Improving the safety of maternity care by 2020/21
- Increasing Choice and Personalisation
- Transforming the workforce
- Improve access to Perinatal Mental Health Services
- Improving Prevention

Deliverables for 2018/19

- Achieve 20% of all deliveries within the Alongside Midwifery Unit
- Increase Home Births to 3% by end of 2017/18 and 4% by Q4 2018/19
- Continue progress towards 20% reduction in stillbirths, neonatal death and maternal death and brain injury during birth by 2020
- Ensure Diversion policy is activated less than 1-3 time per month and for as short a time as possible
- High HMU to be open and caring for postnatal mothers requiring additional support, unblocking delivery rooms and freeing up midwives.
- Every woman being cared for by small midwifery teams of 4-6 midwives, with a named lead obstetrician per team

Risks and issues associated with the delivery of this plan:

- Inability to recruit to midwife vacancies

How does the ICS intends to work together to mitigate these risks and issues?

- Participate in BOB LMS workforce day to develop plan for 2018/19 and beyond and monitored at LMS
- Local Berkshire West action plan in place and monitored at local Maternity Steering group

What are the projects programmes we expect to contribute?

- BOB LMS
- STP Governing Body

7.6 Annex 6 – Learning Disabilities

Responsible ICS partner: Berkshire West CCG and Berkshire Healthcare NHS Foundation Trust

Overall Goals for 2017-2019

The Transforming Care Partnership (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.

This reflects the national Transforming Care Partnerships (TCPs) that CCGs and STPs are expected to deliver. We have achieved the following in line with the national programme.

Progress in 2017/18	**Deliverables for 2018/19**
Berkshire Transforming Care Plan • The Berkshire Transforming Care Plan has 4 key aims: • More care in the community, with personalised support provided by multi-disciplinary health and care teams • More innovative services to give people a range of care options, with personal budgets, so that care meets individuals needs • Early, more intensive support for those who need it, so that people can stay in the community, close to home • Inpatient care, but only as long as is needed and is necessary • 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.	• There are seven work streams in place that support these aims and form our priority actions for 2018/19: 1. **Joint commissioning and integration** – aligning financial processes, explore joint commissioning, jointly managing the market 2. **Communication and engagement** – stakeholder identification, creation of communications plan, effective communication and engagement 3. **Workforce development and culture** – cultural audit, workforce development programmes for staff, creating a cultural change programme 4. **Children and young people** – engaging services, developing new joint ways of working and person led plans 5. **Autism** – engaging with service users, including people in developments, enhancing support 6. **Service reconfiguration** – deliver intensive support team service, reducing reliance on bed based care, growing housing and support services, developing meaningful day accommodation and employment opportunities, enhance services to meet needs of children and young people in transition, further support for people with autism 7. **Risk management** – shared financial, quality, relational risk plan, mitigate risks through a programme management approach.
Reduce inappropriate hospitalisation • We have continued to reduce inappropriate hospitalisation of people with a learning disability, autism or both, so that the number in hospital reduces at a national aggregate level by 35% to 50% from March 2015 by March 2019. • There are continuous efforts to move people out of long stay hospitals into appropriate community settings. Berkshire CCG and	• The TCP Board has set a plan to reduce Berkshire East CCG and Berkshire West CCG commissioned in-patient beds to 10-15 beds per million population by the end of 2018/19.

BHFT, working with the NHS England Specialist Commissioning Team, are 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.	
Improve access to healthcare • We have continued to improve access to healthcare for people with a learning disability, so that the number of people receiving an annual health check from their GP is 64% which is higher than in 2016/17. The TCP Board is working in partnership with GP practices to ensure that reasonable adjustments are made to enhance access for annual health checks. GP practices are encouraged to ensure that the right coding is used to ensure that people have timely access to annual health checks. We are presently on track to meet this target.	
Avoiding hospitalisation • We have made further investment in community teams to avoid hospitalisation. Berkshire West has developed an intensive support team, the remit of this team has been developed to ensure that people are supported in the community to manage risks and avoid hospital admissions. Berkshire West CCG and BHFT are working closely together to continue the development of this team. • We have ensured more children with a learning disability, autism or both get a Community care, Education and Treatment Review (CETR) to consider other options before they are admitted to hospital. We are continuing to work with our partners on this to ensure that the earliest intervention point is realised to gain better outcomes for our children. We are also working with NHS England on developing joint CETR for cohorts that are currently in tier 4 provision.	• To continue funding the intensive support team for the financial year 2018/19 • To develop a protocol working with NHSE for Tier 4 cohort clinical treatment reviews
Premature mortality • We continue to develop the work on tackling premature mortality by supporting the review of deaths of patients with learning disabilities, as outlined in the National Quality Board 2017 guidance. Berkshire West CCG has implemented the LeDeR programme that oversees the review of all deaths and have appointed reviewers.	• To continue to routinely review deaths of patients with learning disabilities, linking in with BHFT Quality Improvement Programme
Risks and issues associated with the delivery of this plan: • The risks and issues associated with this plan are mitigated through our risk register, board	**How does the ICS intends to work together to mitigate these risks and issues?** • This is a national programme of work dedicated to people with learning disabilities. We are proud of the work undertaken so

meetings and operational group meetings. By working together as a system we can identify and minimise the risks	far and for the support of partners. We look forward to a continued positive relationship with our partners through our ICS.

What are the projects programmes we expect to contribute?

- Transforming care board
- Berkshire West CCG Governing Body
- East Berkshire CCG Governing Body
- West Berkshire, Reading and Wokingham Local Authorities

7.7 Annex 7 – Outpatients

Responsible ICS partner: Berkshire West CCG, Royal Berkshire Foundation Trust, Berkshire Healthcare Foundation Trust,

Overall Goals for 2017-2019

The vision for the outpatients transformation programme is to redesign outpatient services provided to Berkshire West patients in ways that every contact for patients counts by:

1. Developing alternative options to complement current practice
2. Optimising technology advances
3. Truly integrating working across pathways
4. Developing care closer to home to reduce inconvenience for patients who may need to travel significant distances

The overall aim is to provide the optimum patient experience and best value for money for the Berkshire West pound.

This transformation programme is a strategic change programme delivered as a collaborative approach through the ICS with RBFT, BHFT, Berkshire West CCG and the emerging GP Alliances working together to achieve the changes. It builds upon an internal RBFT three year outpatients modernisation programme that started early in April 2017 and takes advantage of the ICS development to give the programme a wider perspective and gain greater benefits.

Progress for 2017/18	**Deliverables for 2018/19**
Programme Overview • Develop a vision and direction to scope all outpatient services. • Good engagement between the three organisations and the GP alliances to identify early specialties for inclusion in Phase 1 specialties. • Engaged meds management across the organisations to support the areas of change where meds management has a key role. • Identified the need for advanced advice and guidance to support secondary expertise in primary care. • Explored the role of digital technology and support management • Developed business cases to implement a new way of working with an advice and guidance solution. • Developed a business case to implement DAWN for multi-specialties to support the	• During Q1/2 2018/19 implement the pilot for a new Advice and Guidance (A&G) solution between primary, secondary care and mental health teams. • Go live with the implementation of consultant-led telephony triage of Rapid Access Chest Pain Clinic (RACPC) referrals in Q3 2018/19 following the implementation of the A&G solution • During Q2 2018/19 will see the introduction of a streamlined ambulatory care pathway for RACP patients • A chronic cough pathway using an integrated approach to the management of patients with a cough lasting ≥8 weeks will be implemented in Q1 2018/19. • In Q3 2018/19 a primary care led sleep apnoea service to manage patients within primary care and streamline referrals to secondary care where further intervention is required. • Introduction of virtual management of renal patients and their long term care planning. • Following technical enablement during Q2 2018/19 the use of electronic monitoring of patients results and telephone consultations for patients requiring long term disease

remote monitoring of patients bloods in response to management of their long term care. • Identified three areas of mental health to improve communication and streamline patient care. • In all areas where there will be changes to patient pathways workgroups have been developed with representation from operational teams, clinical teams from secondary care (RBFT or BHFT), GP and CCG. • Q4 2017/18 commence a pilot for virtual discharge planning between GP and Mental Health Team MDT for mental health inpatients to ensure primary care are part of discharge plans for patients and minimising the risk of patients going back into crisis management, readmission or re-referral. • Q4 2017/18 workshop and planning commences to explore the potential of a primary care based service to care for patients who have mental health and physical health problems.	modifying drugs in Gastroenterology, Respiratory, Dermatology and Neurology. • End of Q1 2018/19 an improved and streamlined dementia pathway and memory clinic working towards the delivery of the 6 week of diagnosing dementia. • Q1 2018/19 phase 2 of acute specialty reviews will commence and a rolling programme of specialty and outpatient services reviews continuing throughout 2018/19 and implementation of approved changes. • Q1&2 relocate the first cohort of outpatient services from the main RBH site to satellite clinics.
Project development • During 2017/18 a significant benchmarking exercise was undertaken across all RBFT outpatient departments, reviewing the detailed workings of the hospital outpatient departments within the main acute site and its satellite sites. A key priority is to reduce the variation ensuring patients receive a standard and equitable service for their outpatient care. The standardisation will support the elimination of any processes that are unnecessary and do not add value to the patients. Through working as an ICS primary care and secondary care clinicians will develop pathways, protocols and guidelines for referrals which will support this reduction in variation**.**	• This transformation is currently being developed across all RBFT specialties with planning already underway with Phase 1 specialties including: Cardiology, Respiratory, Renal, ENT, Gastroenterology, Rheumatology and Neurology. The careful phasing of changes and clinic moves starts on a small scale to ensure that patients are not compromised and learning from changes and innovation can be embedded before further rollout. During the course of the transformation programme, it is expected that every specialty and outpatient service will undergo a review with clinicians and management alike across primary and secondary care and patients co-designing the changes.
Optimising Clinic Space • In tandem with reviewing clinical pathways RBFT have developed on line room booking provision across all sites to ensure clinic space is maximised and used flexibly to support patient access. In line with the seven day working focus from NHSI/E providing clinics out of hours will be scoped and the general outpatient's management structure and skill mix reviewed. With workforce skills, needs and training underpinning any changes to service provision.	• Finalise outpatient data by patient postcode to determine the level of clinic appointments required per hospital location. • Commence a phased approach to moving specialties across the hospital outpatient sites. outpatient sites . • Develop the clinic utilisation tool to accurately record clinic booking. • Complete a skills review required to manage outpatients and new ways of working.
Using Technology to enable new ways of working • Focus has been placed on moving away from traditional models of outpatient services being held by consultants within a hospital outpatient setting and exploring the role of digital technology and new ways of working to provide more cost effective and timely ways of	• In parallel the clinical and operational teams of BHFT have been scoping changes for mental health services with an ICS focus starting with the Dementia/Memory service, virtual consultation between GPs and Psychiatrists as well as exploring a different model to support mental health patients

delivering outpatient care for example using remote monitoring, telephone and video conference appointments. The changes and New Models of Care have taken into account the release in clinician's timetables which could be used in more effective ways to modernise and adapt services to meet the emerging patient needs and expectations.	with physical health needs, with further RBFT and BHFT/Primary Care services following in 2018/19.
Putting patients at the centre • A key driver for the outpatients transformation programme is putting patients at the centre of the change. The different ways patients will communicate with the clinical teams managing their care and treatment will vary and put the patient as an active and informed participant of the management of their outpatient journey. This will require robust and continued focused communications with the community, voluntary sectors and targeted communication strategies to patients and carers. They will be kept informed of the changes being explored as well as having a voice in the shape of the future of outpatient services. It is a vital element of the change programme that patients are empowered to make informed choices as well as supporting them to embrace change and not be fearful of the New Models of Care as the health economy move forward with the change in delivery. Engagement has commenced with one of the local Patient Engagement Group as well as planned patient representatives being included in the project workstreams.	• Introduce new ways of communicating with patients: • When exploring changes at specialty level, we will be engaging patients to ensure they understand the change, have the opportunity to influence the process, be involved in patient comms. • Undertake before and after patients surveys before changes are made and 6 months post implementation of change in all specialties offering new ways of engaging with patients. • Engage with the ICS comms teams to engage with and influence the communications matrix to ensure patients are aware of the changes and have an opportunity to be involved. • Use existing patient groups as a forum to inform, engage, gain feedback and involve patients.
Risks and issues associated with the delivery of this plan: • Capacity to incorporate new ways of working within clinical areas. • No reduction in activity realised despite various intervention.	**How does the ICS intends to work together to mitigate these risks and issues?** • Ensure workstreams have representation from each area to ensure the workload changes are managed accordingly. • Ensure pace of change is manageable through phasing of rollout and close monitoring to minimise risk of failure of the project workstreams. • Close monitoring of all KPIs – activity PODs, staffing and quality benefits will be monitored to readily identify issues and analyse accordingly.
<u>What are the projects programmes we expect to contribute?</u> • Long Term Conditions Programme Board • Planned Care Programme Board • Outpatient transformation steering group • DTB Clinical Delivery Group • Medicines Optimisation Group • GP Alliances working group • Royal Berkshire Foundation Trust outpatient group • Mental Health Programme Board • Dementia work stream • Virtual Mental Health work stream • Mental Health/Physical Health work stream	

7.8 Annex 8 - Integrated Respiratory Service

Responsible ICS partner: Berkshire West CCG, Royal Berkshire Foundation Trust, Berkshire Healthcare Foundation Trust

Overall Goals for 2017-2019

Work is under way to develop an integrated approach to managing patients with respiratory conditions. This builds on a previous case for change to increase access to specialist consultant skills across community and secondary care implementing an appropriate outcome based approach to meet local population needs.

The aim being to reduce unplanned hospital admissions and demand for specialist outpatient services, with the following aims:

- To provide a fully integrated service for primary, secondary and community care through virtual clinics and an MDT approach to respiratory provision in a community setting
- To promote early identification of COPD and Asthma self-management and intervention to improve the well-being of patients with respiratory disease
- To reduce reliance on specialist skills where alternative approaches can be adopted.
- To upskill primary and community to ensure the potential to support the patient population is maximised.

Progress in 2017/18

- There are a number of current work-streams which form part of the Outpatient Transformation Programme and are focussing on revised pathways for managing both Sleep Apnoea and chronic cough. In addition work is in progress to review existing patients with COPD/Asthma, mainly in relation to current medication. This will continue to support discussions regarding most effective ways to meet the needs of the local population.

Deliverables for 2018/19

- Reduction in non-elective admissions for defined respiratory conditions
- Refresh of RightCare approach, and validation of opportunities, with agreed priorities and outcomes to reduce variation.
- Increased numbers of patients reviewed annually and assessment of breathlessness undertaken using validated approach
- Increased number of patients prescribed cost effective inhalers
- Implementation of sleep apnoea pathway
- Implementation of chronic cough pathway
- Development of community hub, to support diagnostic assessment and optimises prescribing costs

Risks and issues associated with the delivery of this plan:

- There is a need to identify a sustainable approach to reducing reliance on specialist skills and developing integrated pathways. A number of approaches have been identified over an extended period of time, which have not come to fruition, and therefore a re-fresh of outcomes, opportunities and skills and functions required to meet these is required.
- There are a number of inter-dependent approaches which are highly reliant on co-ordination to avoid duplication and overlap.

How does the ICS intends to work together to mitigate these risks and issues?

- The Long Term Conditions Programme Board has membership from ICS partners and has responsibility for delivery
- The respiratory work-streams are overseen by the Long Term Conditions Programme Board (LTCPB) which has membership from all ICS partners (both clinical and managerial), as is the case for the Respiratory Steering Group, which is a sub group of the LTCPB. This enables risks to delivery of the transformation plans to be identified, and mitigations developed through the Steering Group, with clear escalation plans to LTCPB**.** The LTCBP formally reports to the Clinical Commissioning Committee, and has reporting to the ICS Clinical Strategy Group (CSG) , with escalation to the ICS Unified Executive
- Equally the respiratory Outpatient Transformation work-streams are overseen by the LTCPB and also reports its overarching programme into the ICS Clinical Delivery Group. This ensures there is mitigation of the risk of duplication or overlap with other projects.
- There are identified clinical leads from each ICS partner organisation which significantly contributes to co-production of integrated pathways.

What are the projects programmes we expect to contribute?

- The Long Term Conditions Programme has a number of inter-dependent work-streams which will contribute to the transformation and integrated management of respiratory conditions. This includes consideration of other conditions which impact on both physical and mental health, and are often reviewed in isolation of the respiratory condition/s.
- Outpatients Transformation Programme – including Chronic cough and Sleep Apnoea pathways
- Care and Support Planning (this is being extended to focus on patients with respiratory and other long term conditions) to support increased confidence and self-management, and reduction in duplication of approach.
- Improving Access to Psychological Therapies for patients with Long Term Conditions (IAPT-LTC) work stream focusing on improving confidence and self-management for people living with long term conditions, ensuring that both physical and mental health needs are addressed.

7.9 Annex 9 – High Intensity Users

Responsible ICS partner: Berkshire West CCG

Overall Goals for 2017-2019

A substantial proportion of the healthcare budget is accounted for by relatively few patients. This indicates significant potential for reducing workload on urgent care services and the wider health economy via a targeted and proactive intervention. Learning from Blackpool has demonstrated that an approach of empathy and coaching rather than enforcement has the potential to reduce the volume of urgent care activity for this cohort and indeed improve outcomes for patients.

This model of support has been replicated locally through the implementation of a High Intensity User (HIU) service working across RBFT, BHFT, SCAS and primary care. The approach offers a robust way of working across the ICS to reduce activity to 999, NHS 111, A&E, GP contacts and hospital admissions, freeing up front line resources to focus on more clients and reduce costs. It uses a health coaching approach, targeting high users of services and supports the most vulnerable clients within the community to flourish, whilst making the best use of available resources.

The service will measure the impact directly on 999 call outs, A&E attendances and associated admissions as well as qualitative outcomes for clients. However, through the Connected Care technology the project will also have the visibility of how the work of the coaches impacts on the wider health system, for example primary care and mental health services.

Progress in 2017/18

- The ICS service started in October 2017 initially for a period of 8 months to establish if the same results can be replicated locally. Two coaches are working with up to 40 people in this timeframe after which an initial evaluation will take place to establish if there is a business case for a full roll out. Achievements to date include:
- Marked reduction in ED attendances for those patients on the HIU caseload (47%).
- Reduction in the volume of 999 calls
- Detox completed for a number of patients who remain free from the use of drugs and alcohol.
- Excellent links made with the local community, particular charitable and voluntary sector organisations who are providing vital support to patients
- The service is working directly with key stakeholders in the acute hospital, ambulance service and the police to ensure there is a

Deliverables for 2018/19

- In 2018/19 the focus will continue to be building the caseload of patients who are most likely to benefit from this different approach to support, undertaking a robust evaluation of the impact of the work to date including how the approach might be utilised in other areas of healthcare.

joined up approach to delivery of this support to patients. In addition it is likely that the initial phase will draw out gaps in our current service provision, not only within statutory health and social care services but also the voluntary sector services. It may also indicate where existing services need extra capacity to provide the relevant support. The latter will also be included as a key part of the evaluation.

Risks and issues associated with the delivery of this plan:	**How does the ICS intends to work together to mitigate these risks and issues?**
• Continuing requirement to ensure that our interoperability systems (e.g. Connected Care) enable our health coaches to access patient data in different care settings • IG requirements make it challenging for the CCG / ICS to have visibility on a specific cohort of patients thus raising a difficulty in creating a baseline of activity and measuring changes against this to evaluate the success of the intervention	• In 18/19 we will experiment with embedding our health coaches directly into provider services (e.g. A&E) so that information systems can be accessed directly and health coaches can build networks with other care practitioners who also regularly treat these patients • Working with ICS partners to ensure robust data and information is being collected which is both useful and compliant with statutory IG requirements

What are the projects programmes we expect to contribute?

- High Intensity users is a project in its own right but has dependencies with Connected Care and the A&E Delivery Board

7.10 Annex 10 – Integrated MSK

Responsible ICS partner: Berkshire West CCG, Royal Berkshire Foundation Trust, Berkshire Healthcare Foundation Trust

Overall Goals for 2017-2019

Musculoskeletal conditions (MSK) are one of the areas of greatest spend for Berkshire West with care currently split across primary care, intermediate services and acute provision. With an ageing population there are increasing levels of demand and variation in referrals and management of MSK conditions which supports an overall case for change. Further work is required to improve the service to patients through developing and implementing a more integrated and coordinated programme.

People with MSK conditions need to be able to access high quality support and a wide range of treatments. Needs range from simple behavioural or exercise advice to highly technical, specialised medical and surgical treatments. Multidisciplinary, integrated services are essential and need to incorporate rapid assessment and diagnosis

Progress in 2017/18	**Deliverables for 2018/19**
• Through a fundamental re-design of the MSK pathway (completed in 2017/18) patients will be able to have greater control over their treatment and pathway. The CCG will be able to accurately predict annual spend on MSK and providers will be incentivised to improve quality of clinical care, identify and eliminate waste from within the MSK supply chain and deliver a seamless integrated experience of care to the patient. • To support a change in direction for MSK, it requires moving away from the traditional view of a single disease under the medical model, moving towards a holistic approach, seeing the	• The overall vision is to provide an integrated system of MSK care taking a holistic approach that will deliver high value care using hospital facilities only when necessary, empowering primary care, improving patient experience and enabling better self-management. • The new MSK integrated service model (due in October 2018) will be based on a contract with a single point of responsibility (Prime Provider), for the identified cohort of patients, with the associated budget and responsibility for clinical quality, patient safety and the efficient management of the patient pathway of care for MSK services for any patients registered with a GP in Berkshire West. • The new integrated service aims to deliver the following

patient as a whole rather than the condition they seek help for. With the right changes, right partnerships, and right investments Berkshire West will be able to achieve the holistic approach as set out in the Five Year Forward View. Through embedding shared decision making and adopting evidence based practice looks to break down professional boundaries ensuring the patient is on the right pathway receiving right care at the right place and at the right time.	outcomes: 1. An end to end pathway that encompasses de-medicalising MSK, promote self-care and healthy living such as exercise and healthy eating as enablers to have a positive impact on MSK issues; 2. A community provision where primary and community care providers work closely with physiotherapists to provide direct access for patients with MSK conditions to physiotherapists and ensuring all aspects of self-management are explored to manage the condition and there in guaranteeing appropriate referrals to secondary care in line with clinical need; 3. Patients to participate in a shared decision making process before referral for a procedure to secondary care; 4. Reducing clinical variation and duplication through pathway coherence; 5. Ensuring that every MSK practitioner is consistent in their approach; 6. Addressing the issues and concerns identified by patients and improving the quality of patient experience; 7. Patients should be given choices for treatments and the providers must have regard to the NHS Constitution Patient Choice; 8. Providers will identify and eliminate waste from within the MSK pathway and supply chain (as outlined in the Getting it Right The First Time report) therefore delivering commercial efficiency for the Berkshire West system moving toward a whole-system approach; 9. Utilisation of IT solutions to provide integrated care
Risks and issues associated with the delivery of this plan: • Agreeing the cost envelope for the service that is within CCG budget and provider cost • Getting to contract sign • Mobilisation of new service	**How does the ICS intends to work together to mitigate these risks and issues?** • Work together to design the optimum MSK service for patients • Ensure the ICS Exec working Group to kept up to date on the project progress and risks are escalated to this group
<u>What are the programmes we expect to contribute?</u> • Planned Care Programme Board • ICS Management, Finance and Clinical committees	

7.11 Annex 11 – Diabetes

Responsible ICS partner: Berkshire West CCG, Royal Berkshire Foundation Trust, Berkshire Healthcare Foundation Trust
Overall Goals for 2017-2019 The overarching BOB STP plan for Diabetes Transformation focuses on improving the efficiency of the BOB area while bringing care closer to home and improving access to more appropriate and timely healthcare for their population. This plan shows the commitment of all the constituent CCGs to move towards a common goal of reducing

variation in care across the whole STP area.

Our vision for better management of Diabetes is based around the NHS Year of Care process enabling genuine person centred care for people with long term conditions (LTCs) including diabetes. Our three areas of focus are centred on improved structured Education, 7 day access to specialist diabetes nurses within secondary care and reduced variation in the achievement of the three national treatment targets. Services are provided by both RBFT and BHFT working collaboratively with the CCG.

Progress in 2017/18	**Deliverables for 2018/19**
Diabetes Education • The uptake of structured education by patients varies across Berkshire West. A wide range of issues are known to influence the uptake and reasons for low attendance. There is a need to get people involved in their care in a way that is relevant to them, be that level 1, 2 or 3 of education. This can be both at and post diagnosis when there are other 'teachable moments' such as a change in medication or onset of a complication. • We have recognised locally that the current capacity within the Diabetes Specialist Nurse team was insufficient to effectively meet the needs of in-patients with diabetes. The enhanced service introduced during 2017/18 enables more targeted approaches to identify patients "at risk" earlier, and aims to reduce complications; improve patient reported outcomes and experience, reduce the level of medication errors and ensure people only stay in hospital when they need to. The team also provide on-going ward based training for staff aimed at improving knowledge. In the Maternity Unit, the team aim to identify and identify and reduce the risk of complications associated with diabetes. Additionally, the nurses manage those women attending clinic with diabetes providing specialist care including screening for gestational diabetes.	• The ICS is therefore committed to improving referrals and uptake to increase attendance over the next 3 years. Year one funding has allowed the CCG to commission a new "Carbaware" course for our population alongside additional training course for people with type I Diabetes. During this second year we will continue to develop a programme of work, which includes a "suite of education modules" that provides a variety of options for education based on individual learning needs. Each option is designed to move people towards structured education at the pace that is most appropriate for them. Each option will also be evaluated as an integral part of the process to ensure value for money and long term return on investment. • In addition to improved use of existing technology, for example Eclipse software, we have also recently commenced a programme of care support, specifically targeted at those with "complex diabetes" involving the use of specialist staff to support a multi-disciplinary approach to targeting and managing these complex patients in order to achieve better control and avoid repeat admissions and attendances at A&E for Hypoglycaemia or other manifestations of poor control. This will be further expanded and assessed during 2018/19 to better understand the impact on patient outcomes.
Risks and issues associated with the delivery of this plan:	**How does the ICS intends to work together to mitigate these risks and issues?**
• The national transformation funding is time limited, and has only recently been confirmed for 2018/19. This has impacted on the pace of delivery of the planned outcomes. • A sustainable approach to funding of each work-stream beyond this is required. This poses risks where longer time scales are required to demonstrate behaviour change and clinical outcomes to support return on investment. • Developing a sustainable approach to meeting the needs for specialist skills and ensuring optimal use of scarce resources e.g. dietician, consultant, diabetes specialist nurses.	• The Diabetes work-streams are overseen by the Long Term Conditions Programme Board (LTCPB) which has membership from all ICS partners (both clinical and managerial), as is the case for the Diabetes Steering Group, which is a sub group of the LTCPB. This enables risks to delivery of the transformation plans to be identified, and mitigations developed through the Steering Group, with clear escalation plans to LTCPB**.** The LTCBP formally reports to the CCG Governing Body and also reporting to the ICS Clinical Delivery Group (CDG) , with escalation to the ICS Unified Executive • A task and finish approach is in place to progress the work streams, which is driven by ICS membership. • The diabetes transformation proposals were co-produced by ICS partners with agreement at executive level from each respective organisation, a clear process is in place for review of progress on a quarterly basis, this is equally reported to NHSE.

What are the projects programmes we expect to contribute?

- The Long Term Conditions Programme has a number of inter-dependent work-streams which will contribute to the transformation of the management of diabetes; this includes
- Community clinics for people with complex needs as a result of their diabetes
- Care and support planning approach (this is being extended to focus on patients with diabetes and other long term conditions) to support increased confidence and self-management, and reduction in duplication of approach.
- Development of the Diabetes specialist nurse roles, and integrated pathways to optimise skills across primary, community and secondary care.
- Development of a suite of options to support increased knowledge and confidence self manage diabetes, this includes exploration of digital approaches and technology.
- IAPT-LTC work stream focusing on improving confidence and self-management for people living with long term conditions, ensuring that both physical and mental health needs are addressed.
- National Diabetes Prevention Programme (NDPP)
- National Diabetes Eye Screening Programme

7.12 Annex 12 – Estates

Responsible ICS partner: Berkshire Healthcare Foundation Trust and Royal Berkshire Foundation Trust

Overall Goals for 2017-2019

An efficient, effective, high quality, modern, accessible and welcoming estate is critical to our ability to serve our patients and contribute to the recovery and healing process. Our estate presents us with a number of challenges. Like many health and care systems our estate is a patchwork of bespoke buildings built in a range of different eras across multiple sites and with challenges associated with aging and expensive infrastructure, both in terms of replacement and on-going running costs

The aim of this work is to maximise effective utilisation (clinical and Non-Clinical) of NHS Estate portfolio and identify opportunities to deliver cash receipts through disposals and reduced annual revenue costs across the system. This will support and be shaped by the emerging estates requirements of the new care model and system changes identified via the ICS change programmes and ensure the estate portfolio is fit for the delivery of modern healthcare services that meets the expectations of patients/service users

Progress in 2017/18	**Deliverables for 2018/19**
• Initial scoping and planning of the project	• Taking the next step along the outpatient transformation journey RBFT are leading on the further development of Bracknell Healthspace atBrants Bridge as an Integrated Ambulatory and Community Health care centre with services provided by RBFT, BHFT and 3rd sector providers for patients in Bracknell and the surrounding area in 2018/19 and beyond. Alongside this RBFT will be increasing the amount of ambulatory care provided away from the acute hospital site for patients in other parts of the county from locations in Henley and Thatcham, making better use of and developing the premises in those locations with system partners as appropriate. • BHFT is leading on the development of a clinical services hub at the University of Reading Whiteknights campus for BHFT and RBFT Children, Young Peoples and Families Services and Adult Mental Health services from February 2018 with a 2 year roll out. • BHFT are nearing completion of a new 2- storey building at their Community Hospital which will house a Renal Dialysis Unit on the ground floor for occupation by RBFT and a Cancer Care Unit on the first floor will be occupied by Sue Ryder, RBFT, BHFT and the Cancer Care Trust. Opening in May 2018 to services will support patients in Newbury who

	previously had to travel to Reading for treatment. The unit has been fully funded by charitable donations through the support of the Newbury & Thatcham Hospital Building Trust and the Cancer Care Trust. • RBFT will be developing the masterplan for the acute hospital site, supporting new models of care and potentially the shared back office agenda, during 2018/19
Risks and issues associated with the delivery of this plan: • Alignment with other ICS schemes – consider using space differently before disposing. Programmes such as shared bed modelling must help inform what to do with the estate. • Access to redevelopment funding • Alignment with STP and OPE agendas/stakeholders	**How does the ICS intend to work together to mitigate these risks and issues?** • Established working groups for key programme deliverables with appropriate estates management and clinical representation from across the ICS. • A formal programme management structure that identifies and manages risk and dependencies with regular highlight reporting to CFO Group. Monthly scrutiny and oversight by ICS unified executive. • ICS finance directors and estates colleagues working with NHSPS to complete the STP (BOB) estates strategy workbook. Draft ICS estates strategy document to be ready for May for inclusion at STP level to align for STP level capital bid prioritisation.
What are the projects programmes we expect to contribute? • Other ICS clinical programmes - in particular outpatients, integrated MSK and bed modelling – as they explore options for care delivery in community / non acute settings. • Other ICS 'new business' work programmes - in particular back office and any estates requirements in relation to shared / co-located functions. • Primary Care estates / ETTF • BOB STP estates strategy	

7.13 Annex 13 – Shared Bed Modelling

Responsible ICS partner: Royal Berkshire Hospital Foundation Trust	
Overall Goals for 2017-2019 This project was established to ensure our 'bed base' across the ICS health economy is fit to meet our current and anticipated demographic and that it supports the new care model and system changes as they are identified via the ICS programmes. The project is mapping capacity and patient flow across provider organisations, sites and bed types. A key output will be a move to manage all bedded care across the system 'as one' supported by a system wide bed management system based on real time data. At its heart is a redesign across the system of bedded care to deliver provision that can care for the right patient in the right setting as part of care pathways that provide alternatives to bedded care where appropriate.	
Progress in 2017/18 • Current state for acute and community bedded care is complete, the next stages will pull in mapping of domiciliary, nursing and residential home care and include in the future state design alternatives to bedded care. • This will help inform the feasibility of different models of care delivery and identify opportunities and areas for improvement for the long term care requirements of the population. In addition, the project will look to deliver shared 'live' bed capacity visibility to support patient flow and bed management. The work	**Deliverables for 2018/19** • **Phase 4** - the final phase of the programme will deliver 3 key outputs: • A synthesis of the outputs of the work completed to date • Benchmarking of these outputs with international comparators to create an assessment of Berkshire West's bed base, including the ratios of beds between different settings of care • A fully designed set of costed interventions which are likely to mitigate the financial effects of any projected growth in beds.

has been divided into a number of phases, with the final element due by the summer of 2018. Work completed to date includes:

- **Phase 1** – An assessment of the current acute & community physical health beds in the Berkshire West system
- **Phase 2** – An indicative model of likely growth in demand for these beds and therefore future requirements
- **Phase 3** – An assessment of local mental health inpatient bed requirements for the next 10 - 20 years

Risks and issues associated with the delivery of this plan:	**How does the ICS intend to work together to mitigate these risks and issues?**
• Capacity of existing MI systems to support 'real time' bed management & patient flow reporting • Availability of community alternatives to bedded care – particularly domiciliary	• Established dedicated project group with appropriate representation from across the ICS. • Formal programme management structure, including risk identification / mitigation and escalation, with regular highlight reporting to A&E Programme Board. Monthly oversight by dedicated ICS clinical and senior executive groups. • The Berkshire West Digital Transformation board, that brings together senior ICT representation from across the ICS, will support the development of MI systems.

What are the projects programmes we expect to contribute?

- A&E Delivery Board and the Berkshire West 10 Integration Programme- oversee the delivery of a range of initiatives focused on reducing avoidable hospital admission and promoting more timely discharge. These initiatives will impact on future capacity and patient flow requirements.
- Other ICS clinical programmes that identify alterative care models and different delivery methods / locations.
- Estates programme - mutual dependency to consider using space differently before disposing. Shared bed modelling programme must help inform what to do with the estate and vice versa.
- ICS Workforce strategy – mutual dependency as alternative care models and bed provision may require a different roles.

7.14 Annex 14 – Workforce planning

Responsible ICS partner: Facilitated by Berkshire West CCG working in collaboration with all ICS partners

Overall Goals for 2017-2019

A major part of our ICS ambition focuses on making improvements for staff across the area. As well as specific aims to improve workplace wellbeing there are ambitions to enhance leadership capability, up skill the workforce and create a shared workforce plan to increase opportunities for rotation across organisations – giving staff greater experience and enabling them to deliver better care and ensuring that we have the workforce we need to deliver the New Models of Care while maintaining the current service in the transformation period.

Our aim is to develop a network which will facilitate partnerships between service providers and the education and training providers within the ICS footprint that will accelerate the development of a sustainable and highly skilled health and care workforce in Berkshire West. By working together we will develop the infrastructure and stakeholder relationships necessary to effectively identify workforce needs and secure the investment and innovative approaches required to address these.

Progress in 2017/18	**Deliverables to date 2017/18 include:**
• To deliver on our aims we have established an ICS Workforce Group to support workforce development and transformation across the Five Year Forward View priorities areas. This	• Formation of the ICS Workforce structure as detailed below. • Engagement with NHSE/HEETV HEE Leadership Academy for funding and professional guidance. Scoping of all workforce initiatives and teams within the ICS footprint.

group's function is to enable the Berkshire West workforce agenda to be delivered within the ICS model of collaborative partnership between organisations in Berkshire West, ensuring our services meet the health and care needs of the local population. To enable the group function and support the workforce aims and function of the providers within the ICS, the group membership includes Health Education Thames Valley (HEETV) NHS England (NHSE) The Health Education England Leadership Academy (HEELA) and the Health Education Regional Workforce Team.

- The group will inform the STP Workforce programme, which is delivered by HEETV via the Berkshire Local Workforce Action Boards (LWAB). The ICS group will also facilitate the delivery of the Local Workforce Advisory Board and national objectives.

Aims and Objectives of the ICS Workforce Group:

- Identify the workforce requirement across the ICS
- Develop an ICS Workforce Plan
- In line with NHSE policy, secure the Berkshire West capitated share of all national funding to support delivery of the workforce plan
- Provide assurance to funding parties e.g. HEE/NHS England (NHSE) that funding is appropriately deployed
- Set strategic direction and oversee the work of the workforce sub groups
- Develop innovative and transformational approaches to role design
- Ensure mobility of the workforce around the ACS system to retain staff within Berkshire West and optimise the deployment of key skill sets
- Commission appropriate levels of pre-registration and CPD training
- Establish or access the HETV workforce intelligence function to provide accurate workforce data and workforce modelling capability.
- The ICS Workforce Group has within its structure underpinning operational groups whose function is to bring together the key stakeholders for the various work streams. In its current incarnation the work streams are based on the key priorities areas as laid out in the NHS England (NHSE) and HEETV plans.

- Development and engagement with a draft BOB STP workforce plan.
- In 2018/19 it is expected that a whole system analysis of our short, medium and longer term workforce requirements will be mapped out in order to form the basis of our action plan for Berkshire West.

Risks and issues associated with the delivery of this plan:

- Without the collaborative partnerships between service providers facilitated by the ICS model allowing collective workforce planning and development, we would be instead be in a competitive workforce market driving providers to compete against each other for dwindling workforce resource.

How does the ICS intends to work together to mitigate these risks and issues?

- Via the ICs Workforce model there will be full ICs partner and stakeholder engagement in the plans and strategic level sign off for all workforce planning and development moving forward.
- The ICS workforce model enables transformation and innovative workforce planning to be piloted and modelled system wide within the ICS health and social care arena.

• There must be strategic level sign up from all partner organisations to the ICS Workforce model to enable a system wide approach to workforce planning and development	

What are the projects programmes we expect to contribute?

- A/E Board. Newly set up UEC Task and Finish operational group which will report into A/E board
- Long Term Condition Programme Board and Long Term Condition Steering Group
- ICS Provider Stakeholder Workforce Function. BHFT, RBHFT, BW10 providers
- ICS Outpatient Transformation Group Meeting
- ICS Workforce Operational Groups. Cancer/MH/Primary Care/UEC