Bracknell Forest Council

NOTICE OF MEETING

Health and Wellbeing Board
Thursday 2 March 2017, 2.00 pm
St. Gabriel's Meeting Room, Ascot Priory, Priory Road, Winkfield Row, Ascot, SL5 8RS.

To: The Health and Wellbeing Board

Councillor Dale Birch, Executive Member for Adult Services, Health & Housing (Chairman)
Dr Tong, Bracknell & Ascot Clinical Commissioning Group (Vice-Chairman)
Councillor Dr Gareth Barnard, Executive Member for Children & Young People
Philip Cook, Involve
Alex Gild, Berkshire Healthcare NHS Foundation Trust
Jane Hogg, Frimley Health NHS Foundation Trust
Lise Llewellyn, Director of Public Health
Rachel Pearce, South Central Sub Region NHS
Mary Purnell, Bracknell & Ascot Clinical Commissioning Group
Mark Sanders, Healthwatch
Fidelma Tinneny, Berkshire Care Association
Hilary Turner, NHS England South Central Region
Linda Wells, Bracknell Forest Homes
Nikki Edwards, Bracknell Forest Council
Gill Vickers, Bracknell Forest Council
Timothy Wheadon, Chief Executive, Bracknell Forest Council

ALISON SANDERS
Director of Corporate Services

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If you require further information, please contact: Priya Patel
Telephone: 01344 352233
Email: priya.patel@bracknell-forest.gov.uk
Published: 21 February 2017

Health and Wellbeing Board
Thursday 2 March 2017, 2.00 pm
St. Gabriel's Meeting Room, Ascot Priory, Priory Road, Winkfield Row, Ascot, SL5 8RS.

Sound recording, photographing, filming and use of social media at meetings which are held in public are permitted. Those wishing to record proceedings at a meeting are however advised to contact the Democratic Services Officer named as the contact for further information on the front of this agenda as early as possible before the start of the meeting so that any special arrangements can be made.

AGENDA

Page No

1. **Apologies**

   To receive apologies for absence and to note the attendance of any substitute members.

2. **Declarations of Interest**

   Any Member with a Disclosable Pecuniary Interest or an Affected Interest in a matter should withdraw from the meeting when the matter is under consideration and should notify the Democratic Services Officer in attendance that they are withdrawing as they have such an interest. If the Interest is not entered on the register of Members interests the Monitoring Officer must be notified of the interest within 28 days.

3. **Urgent Items of Business**

   Any other items which the chairman decides are urgent.

4. **Minutes from Previous Meeting**

   To approve as a correct record the minutes of the meeting of the Board held on 8 December 2016. 5 - 8

5. **Matters Arising**

6. **Public Participation**

   QUESTIONS: If you would like to ask a question you must arrive 15 minutes before the start of the meeting to provide the clerk with your name, address and the question you would like to ask. Alternatively, you can provide this information by email to the clerk Priya Patel: priya.patel@bracknell-forest.gov.uk at least two hours ahead of a meeting. The subject matter of questions must relate to an item on the Board's agenda for that particular meeting. The clerk can provide advice on this where requested.

   PETITIONS: A petition must be submitted a minimum of seven working days before a Board meeting and must be given to the clerk by this

deadline. There must be a minimum of ten signatures for a petition to be submitted to the Board. The subject matter of a petition must be about something that is within the Board's responsibilities. This includes matters of interest to the Board as a key stakeholder in improving the health and wellbeing of communities.

7. **Actions taken between meetings**

Board members are asked to report any action taken between meetings of interest to the Board.

8. **Better Care Fund 2017/18 Planning** 9 - 16

To note the timetable and agree that approval be sought from the Chair of the Health and Wellbeing Board to permit the Director Adult Social Care, Health and Housing to submit the BCF plan(s) to the Department of Health / NHS England by 31 March 2017.

9. **Bracknell & Ascot Clinical Commissioning Group: Operating Plans**

The Board is asked to endorse the collective commissioning ambitions of Bracknell & Ascot, Slough and Windsor, Ascot & Maidenhead Clinical Commissioning Groups for the period April 2017 to March 2019. The Plan has been informed by NHS England (NHSE) Planning Guidance, the Frimley Sustainability and Transformation Plan (STP) and key local transformation programmes such as New Vision of Care. 17 - 84

The Board Meeting to be followed by a work shop for Board Members on Emotional Wellbeing in Bracknell Forest.

VENUE AND CAR PARKING INFORMATION

The St. Gabriel's Room is located behind the Ascot Priory residential home. Once entering Ascot Priory from Priory Road, follow signs for the 'Retreat and Meeting Room' this will take you behind the residential home. There will then be a grassed area beyond the staff car park which can be used for parking. This will be signposted as 'meetings parking'.

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HEALTH AND WELLBEING BOARD
8 DECEMBER 2016
2.00 - 4.00 PM

Bracknell Forest Council

Present:

Councillor Dale Birch, Executive Member for Adult Services, Health & Housing (Chairman)
Dr Tong, Bracknell & Ascot Clinical Commissioning Group (Vice-Chairman)
Councillor Dr Gareth Barnard, Executive Member for Children & Young People
Philip Cook, Involve
Gill Barker, Berkshire Healthcare NHS Foundation Trust
Nikki Edwards, Director of Children, Young People & Learning
Jane Hogg, Frimley Health NHS Foundation Trust
Lise Llewellyn, Director of Public Health
Mary Purnell, Bracknell & Ascot Clinical Commissioning Group
Mark Sanders, Healthwatch
Linda Wells, Bracknell Forest Homes
Gill Vickers, Bracknell Forest Council
Timothy Wheadon, Chief Executive, Bracknell Forest Council

Also Present:

Lisa McNally, Public Health Consultant
Viki Wadd, Director of Integration and Transformation
Alex Walters, Chairman of the Local Safeguarding Children's Board

Apologies for Absence were received from:

Fidelma Tinneny, Berkshire Care Association

24. **Declarations of Interest**

There were no declarations of interest.

25. **Urgent Items of Business**

There were no urgent items of business.

26. **Minutes from Previous Meeting**

RESOLVED that the minutes of the meeting of the Board held on 15 September 2016 be approved as a correct record and signed by the Chairman, subject to minute 20 being amended as follows:

- It was clear that *some* GP practices were unlikely to remain on their current sites
- The *Director of Public Health* reported that Wokingham BC had progressed their work around primary care mapping as they considered it to be a priority as 30,000 new residents were expected over the next few years.

27. **Matters Arising**

- The Public Health Consultant reported that the Board's first workshop following the peer review would be held on 20 January 2017. A facilitator for the session had now been secured for this session from the Local Government Association – Andrew Cozens.
- The Chairman reported that he had met with the minister for Planning & Housing to discuss the lack of attention to health and care facilities within Planning policy. The Chairman had requested that more specific consultation around this area be undertaken. The Chairman hoped to see planning policies that were more geared towards health and care facilities in the future as a result. In addition, Planning officers would be looking through the Council's Local Plan to ensure that the progress of health & care facilities were not being impeded.
    - The Chairman reported that there was expected to be a 20% rise in births in the upcoming years whilst hospitals were already at capacity at current levels. This rise would need to be funded and resource would need to be identified. He reported that the Council's Executive would not encourage the use of the Community Infrastructure Levy to fund this, but that resource would need to be found from other sources and from working jointly to develop health and care facilities.
    - The Chairman stated that consideration be given to how developers worked with partners and whether developers should contribute to social care. In order to do this, there would need to be evidence of an impact from a development on health and social care.
    - The Public Health Consultant reported that she was currently developing spreadsheets to assess the impact of the level of housing on health and social care.

28. **Public Participation**

No submissions had been received under the terms of the Health & Wellbeing Board's public participation scheme.

29. **Actions taken between meetings**

- The Vice Chairman reported that the Chairman of the Transferring Children Board had submitted a transformation plan for children in October 2015. This plan needed to be resubmitted and would be sent to Board members over the next week for consideration. The Vice Chairman reported that he hoped to submit the Plan by 14 December.
    - In response to Members queries, the Vice Chairman reported that the Plan had been formatted in line with the requirements set out be NHS England. A more user friendly version would be provided once the Plan had been signed off.

30. **Bracknell & Ascot Clinical Commissioning Group - Commissioning Intentions and Operating Plan**

A presentation was delivered to the Board from Viki Wadd, Associate Director Strategy, Planning and Organisational Development. Ms Wadd reported that due to tight timescales it was not possible to put the final Operating Plan before the Board before it was signed off.

In response to Members queries, Ms Wadd made the following comments:

- In terms of links to the Sustainability and Transformation Plans (STP), the operational plan included all of the work streams in the STP and the two plans were interwoven. It was confirmed that the assumptions made in the STP had also been aligned. If there was a specific local problem, the STP was silent on this, the STP would only look at the benefit of things that could be done at scale across an area.
- The STP and commissioning intentions would be mapped against one another.

The Public Health Consultant reported that with regard to raising awareness amongst men accessing bowl screening, that in self care week officers would be working with Men United to target men and raise awareness, as well as using a number of other male orientated media.

Ms Wadd reported that in terms of next steps, the operating plan would now be submitted to NHS England for sign off and then used as a template for the next two years. The Plan would also then be shared publicly through a variety of ways. Some work would need to be undertaken to ensure that the plan was communicated in a user friendly way.

The Vice Chairman stated that it would be hugely effective to have all the major players talking from one page.

The Public Health Consultant reported that the Public Health team had created a lot of the data that had fed into this plan and that the basic acknowledgment of need was very well aligned.

The Board supported the Bracknell & Ascot Clinical Commissioning Groups, commissioning intentions and operating plan.

31. **Frimley Health & Care System Sustainability & Transformation Plan**

A presentation was jointly delivered by the Director of Adult Social Care, Health & Housing and the Director of Integration and Transformation, Frimley Health Foundation Trust.

The Board made the following points:

- The Director of Children, Young People & Learning expressed concern that the Sustainability & Transformation Plan (STP) contained nothing pertinent to children. Clearly the benefits of educating children and early intervention was well documented. The benefits of work with children could be very wide ranging and preventative. The language of the STP felt very adult orientated.
- The Director of Integration and Transformation reported that the STP was intended to cover the whole population and not specifically adults. She stated that there would be an opportunity for a greater focus on children when more detailed delivery plans were developed.
- The Chairman agreed that references to children could be better articulated in the STP.
- The Involve representative stated that it was important to include the voluntary sector in the STP as this sector had much to offer and this opportunity of joint working should not be missed.
- The Director of Integration & Transformation reported that the STP had been put before this Board in the interests of transparency and to demonstrate progress with this work. The Board was also asked to give a view as to whether alignment across different areas had been achieved. A lot of work

had gone into developing this STP and it had been developed from the ground up based on local priorities.

- The Chairman stated that he was pleased to see the joined up approach and terminology being used with this work. He asked that all partners be engaged in the process of communicating this message to the public.
- The Director of Integration & Transformation reported that the STP was now on all partner websites alongside a short summary and why the plans would benefit local residents. The Director encouraged all Board Members to visit these documents to see the messages being communicated. She confirmed that the same information appeared on all partner websites, demonstrating a joined up approach.

The Board supported and endorsed the Frimley Health & Care STP.

32. **Local Safeguarding Children Annual Report 2015-16**

The Chairman of the Local Safeguarding Children Board (LSCB) made the following points:

- Ms Walters stated that the core function of the LSCB Board was to scrutinise and hold partners to account. Section 2 of the annual report set out how the LSCB had delivered against this function. Section 4 of the annual report set out the progress made against the LSCB's priorities for 2015/16. The Challenge log at Appendix C demonstrated the work of the Board over the year and showed how partners were continually held to account.
- Ms Walters stated that as a statutory partnership the LSCB knew itself well and worked via constructive challenge and recognised the collective ownership and responsibility for safeguarding children amongst partners.

The Chairman stated that the Board had done some work around reducing waiting times in the Child & Adolescent Mental Health Service but that there still remained disappointing waiting times. Ms Walters reported that the LSCB had been keeping a watching brief of this work and would continue to do so. Further the LSCB could collectively with other partners encourage and support CAMHS to improve their waiting times.

The Vice Chairman reported that GPs hadn't got to grips fully with the issues surrounding young carers and it would be useful to share the work of the LSCB on this. Ms Walters stated that she would look into this further.

The Board noted the LSCB Annual Report 2015-16.

33. **Forward Plan**

There were no additions or amendments to the forward plan.

CHAIRMAN

TO: HEALTH AND WELLBEING BOARD
2 MARCH 2017

BETTER CARE FUND – 2017/18 PLANNING
Chief Officer: Commissioning and Resources

1 PURPOSE OF REPORT

1.1 The purpose of this report is to inform the HWB of the process for Better Care Fund planning for 2017/18 and to request that due to the timescales imposed by NHS England, delegated approval is sought from the Health and Wellbeing Board, for the Director Adult Social Care, Health and Housing to sign off the BCF submission for 2017/18.

2 RECOMMENDATION

2.1 That the Health and Wellbeing Board notes the timetable and agrees that approval be sought from the Chair of the Health and Wellbeing Board to permit the Director Adult Social Care, Health and Housing to submit the BCF plan(s) to the Department of Health / NHS England by 31 March 2017.

3 REASONS FOR RECOMMENDATION

3.1 As at 10th February 2017, the detailed guidance from the Department of Health / NHS England for the 2017/18 BCF Planning submission had not been published. It is likely that the guidance will be issued towards the end of February, with the written submission for the Bracknell Forest Better Care Fund being required to be received by NHS England on 31 March 2017. It is understood that this year's submission will be expected to address around 35 Key Lines of Enquiry and is likely to take much of March to complete. A national condition of the process is that appropriate approval for the formal submission is obtained from the relevant Local Authority Health and Wellbeing Board.

This precludes the Bracknell Forest submission being reviewed at the next meeting of the Health and Wellbeing Board as this is taking place on 2nd March which would not allow sufficient time for the final draft of the submission to have been prepared.

As a consequence of the short timescales, delegated authority from the Chair of the Health and Wellbeing Board is sought, to enable the Director Adult Social Care, Health and Housing to submit the plan(s) on behalf of the Health and Wellbeing Board. Approval is requested to implement this proposal, which was also adopted in 2016/17 for the same reasons.

4 ALTERNATIVE OPTIONS CONSIDERED

4.1 There is no alternative to following the BCF planning guidance.

5 SUPPORTING INFORMATION

5.1 In June 2013, the Government announced the Better Care Fund. It was designed to bring improvements to the way health and social care services work together through

the mechanism of a pooled budget. It was designed to bring an opportunity for change, so that people receive the right care and support at the right time, in the right place.

5.2 The 2016 Bracknell Forest BCF plan can be viewed at the following link: http://www.bracknell-forest.gov.uk/bettercarefund

5.3 The 2016 plan was preliminarily assessed as "assured" by the Department of Health / NHS England in April 2016 and formally assured in July 2016. See Appendix 1. It is understood that for 2017/18, the process may be streamlined although no detail is available yet. However, it is understood that this time, the plan will cover a 2 year period rather than just 1.

5.4 The BCF programme is governed by the BCF Steering Group, the BCF Programme Board and the Health and Wellbeing Board. Highlight reports and risk logs are reported monthly to the Steering Group and quarterly to the Programme Board. Minutes of the Programme Board are sent to members of the Health and Wellbeing Board following each meeting.

5.5 The BCF reports quarterly to the Department of Health / NHS England; the latest report, for quarter 2, can be found at Appendix 2 to this report. Quarter 3 is due for submission by the beginning of March.

5.6 Webinar guidance received from NHS England for the BCF 2017/18 (see Appendix 4) shows that when published, the guidance is likely to reduce the National Conditions from 8 to 3; these being for 2017/18

- Plans to be jointly agreed
- Maintain provision of social care services
- Agreement to invest in NHS commissioned out-of-hospital services

There will still be a requirement to submit quarterly reports on performance, against certain key national indicators; these being:

- Non elective admissions
- Admissions to residential home
- Effectiveness of reablement
- Delayed Transfers of Care

5.7 The guidance is also expected to require that the BCF submission clearly demonstrates and links to the overarching vision for Health and Social care integration and addresses how the local vision will move services towards being more community based and preventative approached; with a clear explanation of what role the BCF plays in this. For the Bracknell Forest BCF Plan, there will be a need to show a coherent linkage to the Frimley Health and Care System Sustainability and Transformation Plan, as well as the "New Vision of Care".

5.8 Funding allocations have not yet been published. The overall BCF is expected to be broadly in line with the 2016/17 allocation although this has not been formally confirmed.

6 ADVICE RECEIVED FROM STATUTORY AND OTHER OFFICERS

Borough Solicitor

6.1 This report reflects the current position in relation to the development of the Better Care Fund.

Borough Treasurer

6.2 Finance will input to the Better Care Fund plan to ensure it aligns to existing budgets where relevant. There are not expected to be any budgetary pressures arising from the plan.

Equalities Impact Assessment

6.3 Equalities are considered within each scheme funded by the Better Care Fund.

Contact for further information

Neil Haddock, ASCHH - 01344 351385
Neil.haddock@bracknell-forest.gov.uk

Lynne Lidster, ASCHH - 01344 351610
lynne.lidster@bracknell-forest.gov.uk

Appendix 1 – BCF Approval letters April 2016 and July 2016
Appendix 2 – BCF Quarterly Reporting Template – Quarter 2 2016/17
Appendix 3 – Infographic- Bracknell Forest BCF Performance Q1 / Q2 2016 and BCF 2016/17 review
Appendix 4 – Webinar Guidance on BCF Planning 2017-19 (15 December 2016)

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NHS England
Skipton House
80 London Road
London,
SE1 6LH
E-mail: Andrew.ridley1@nhs.net

To: *(by email)*

Councillor Dale Birch, Chair of Bracknell Forest Health & Wellbeing Board
Timothy Wheadon, Chief Executive, Bracknell Forest Council
John Lisle, Accountable Office, Bracknell and Ascot Clinical Commissioning Group

11 July 2016

Dear colleagues

BETTER CARE FUND 2016-17

Thank you for submitting your Better Care Fund (BCF) plan for regional assurance. We know that the BCF has again presented challenges in preparing plans at pace and we are grateful for your commitment in providing your agreed plan. As you will be aware the Spending Review in November 2015, reaffirmed the Government's commitment to the integration of health and social care and the continuation of the BCF itself.

I am delighted to let you know that, following the regional assurance process, your plan has been classified as '**Approved**'. Essentially, your plan meets all requirements and the focus should now be on delivery.

Your BCF funding can therefore now be released subject to the funding being used in accordance with your final approved plan, which has demonstrated compliance with the conditions set out in the BCF policy framework for 2016-17 and the BCF planning guidance for 2016-17, and which include the funding being transferred into pooled funds under a section 75 agreement.

These conditions have been imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These sections allow NHS England to make payment of the BCF funding subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG in your Health and Wellbeing Board area as to the use of the funding.

You should now progress with your plans for implementation. Ongoing support and oversight with your BCF plan will be led by your local Better Care Manager.

Once again, thank you for your work and best wishes with implementation and delivery.

Yours sincerely,

Andrew Ridley
Regional Director, South of England, and SRO for the Better Care Fund

NHS England

Copy (by email) to:
Anthony Kealy, Programme Director, Better Care Support Team

Steve Eker
Lynne Lidster

By Email

South (South Central)
Jubilee House
5510 John Smith Drive
Oxford Business Park South
Cowley
Oxford OX4 2LH
Telephone: 01865 963 891

Date: 31 March 2016

Dear Steve and Lynne,

BCF Submission 21 March 2016: NHS England South Central Feedback

Thank you for submitting the Health and Wellbeing Board's BCF Narrative Plan to the deadline of the 21 March 2016. We would like to acknowledge the work that has gone into producing the plan, taking into account the shortened timescales.

Your BCF plan was of excellent quality with detailed supporting evidence on how all the National Conditions will be delivered. Your plan met all of the minimum key lines of enquiry and is an exemplar BCF Plan.

The panel agreed that at this time, your submission is assured. However, the panel askes that you review the BCF Plan in the context of any revised activity growth assumptions in the final CCG Operating Plan submission on 11th April.

Thank you for your continued attention to this process. The final BCF plan submission is on 25 April 2016 and I welcome updates you are able to share in advance.

Yours sincerely

Hilary Turner
Better Care Manager
NHS England – South Central

Enclosures: BCF Assurance Matrix

NHS
Bracknell and Ascot
Clinical Commissioning Group

NHS
Slough
Clinical Commissioning Group

NHS
Windsor, Ascot and Maidenhead
Clinical Commissioning Group

Operational Plan
2017/18 – 2018/19

Contents

1. Executive Summary

This plan represents the collective commissioning ambitions of Bracknell & Ascot, Slough and Windsor, Ascot & Maidenhead Clinical Commissioning Groups (hereafter the 3 CCGs) for the period April 2017 to March 2019. It has been informed by NHS England (NHSE) Planning Guidance, the Frimley Sustainability and Transformation Plan (STP) and key local transformation programmes such as New Vision of Care.

This document reaffirms our collective commitment to improving outcomes and delivering sustainable, consistent standards of care within the resources available. It has been informed by local clinicians, patients, and key partners.

Our plan is focussed on improving care pathways and addressing the often fragmented system experienced by patients. This fragmentation of care can impact on the individual experience and outcomes, which often results in inefficiencies and poor value for money**.** Our aim is to commission person centred and integrated care, particularly for the most frail and vulnerable in our communities.

Together with social care partners we are committed to developing, testing and implementing innovative approaches to new ways of working and we are actively seeking to pool collective resources where this offers better value across our health and care system. In addition to our local plans we are working with our STP partners and local clinical networks to develop bids for Sustainability and Transformation Funds to address the three Five Year Forward View gaps.

The Frimley Sustainability and Transformation Plan (STP) provides an exciting opportunity to work with a range of partners to realise system level changes that ensure the long term sustainability of the health and care sector in both East Berkshire and across the Frimley STP footprint. Through the STP we are committed to achieving transformation and performance improvement at scale and at pace.

The 3 CCGs as individual statutory organisations are committed to working through joint a governance structure to effectively deliver a combined programme of work. This programme is sensitive to local health needs, and focuses on those areas where a targeted approach to improved outcomes is required. Our plans reflect strong clinical engagement with member practices, dedicated clinical leads and our strength of CCG clinical leadership.

During 2017/18 we will be taking on further commissioning responsibilities for general practice, with Windsor, Ascot and Maidenhead CCG (WAMCCG) and Bracknell and Ascot CCG (BACCG) planning to become fully delegated commissioners from 1 April 2017. At this stage Slough CCG will be continuing with the joint commissioning arrangements with NHS England.

Our approach during the period 2017-19 is to:

- Put a greater emphasis on prevention and putting patients in control of their own care planning
- Ensure our plans explicitly align with the CCG strategies and programmes such as the STP and New Vision of Care
- Use the Right Care programme as a basis for identifying opportunities for reducing unwarranted variation
- Exploit opportunities for expanding the use of technology enabled care
- Commission services which provide our populations with information and choice, ensuring care closest to home is offered wherever possible
- Expand and strengthen the role of primary and out of hospital care, whilst ensuring our acute providers are equipped to treat patients who require in-hospital care
- Only purchase interventions, treatments and drugs that are evidenced to be cost-effective, including through NICE TAG or evidence reviews that have been specifically accepted and adopted on the recommendation of the Thames Valley Priorities Committee

- Commission additional services from Primary Care where these support delivery of our strategic vision
- Actively consider decommissioning services where there is limited evidence of improved outcomes for patients and value for money for the taxpayer
- Evaluate the impact of the current Better Care Fund arrangements and consider greater pooling of resources with our three local authorities, ensuring alignment with the Sustainability and Transformation Plan for the Frimley Footprint
- Use quality incentives effectively and consistently across the health economy to focus on improving outcomes for patients

Our priorities have been developed using:

- strong clinical engagement (clinical leadership/ innovation forums, discussions with member practices and clinical leads for specific initiatives)
- an analysis of the Right Care data packs in identifying unwarranted variation
- engagement with and feedback from our patients, and stakeholders
- discussions with our STP partners and alignment to the priorities set out within the STP
- NHSE planning guidance and an analysis of our current performance against the national priorities

2. Our Vision

The 3 CCGs are committed to working together to deliver high quality, affordable healthcare which delivers excellent patient experience and improved health outcomes.

The 3 CCGs believe that individuals should take responsibility for their health and be supported by their family, social networks and communities to do so. We will engage with patients and the wider public in the design and implementation of any changes. Mental health is equally as important as physical health and our commissioning will recognise this. General practice is the foundation on which all other services are built and our aim is to ensure that it is able to deliver this, in tandem with excellent community and hospital based care as demonstrated by our "New Vision of Care" (Appendix 2).

In order to deliver our vision we will need:

- An activated population which is supported to take more responsibility for their health and wellbeing and to make decisions about their own care
- A service model which prevents ill-health within our local populations and supports people with much more complex needs to receive the care they need within their communities
- A sustainable workforce that is well trained and open to working differently
- Estate that is fit for purpose to deliver the services of the future
- Shared access to care plans so that patients only have to tell their story once
- Care providers who will share information, and use this to co-ordinate care in a way that is person centred, and reduces duplication.

Change of this nature can only be achieved through a sustained and shared commitment from leaders, clinicians and staff, patients and the public. We will work collaboratively with our STP partners. The ability to commission differently from general practice will be key to the delivery of ours.

3. Addressing local needs

Whilst the CCGs are working closely together to maximise the impact of programmes of work, we are committed to addressing local needs and priorities. The populations of three CCG are different and this is reflected in their Health and Wellbeing Strategies. This section highlights the key points about local populations, priorities from the Health and Wellbeing Strategies and how this Operational Plan supports these. The 3 CCGs achieved a good rating under the IAF during 2016/17 and we aspire to become outstanding. In order to do this we have been assessed against our delivery of the six national clinical priority areas and the ratings for each CCG are shown below.

3.1 Bracknell & Ascot CCG

Population

- The population profile differs from the national picture with a larger proportion of children and young people (aged 5 to 19) and adults aged 40 to 59. In contrast, there is a smaller proportion of adults aged 20 to 34. 25% of the CCG's total registered population is under 19.
- Life expectancy at birth for men is 80.7 years, which is significantly better than the national figure of 79.2 years. Life expectancy at birth for women is 83.9 years, which is significantly better than the national figure of 83.0 years.
- The recorded prevalence of cardiovascular diseases, cancer, respiratory diseases, diabetes, chronic kidney disease, mental health disorders and dementia is lower than the national prevalence rates and comparator CCG group. The prevalence of depression is higher.
- The CCG had 5,998 potential years of life lost (PYLL) considered amenable to healthcare in 2012-14. The rate of 1,516 potential years of life lost per 100,000 registered population is significantly lower than the national rate. Neoplasms were the main cause of PYLL in the CCG at 32.0% in 2012-14.

For further detail please see the CCG Public Health profiles at Appendix 8.

National Clinical Priority Areas

National Clinical Priority	IAF Rating
Diabetes	Requires
Maternity	Good
Mental Health	Good
Cancer	Requires Improvement
Dementia	Good
Learning Disability	Requires Improvement

NHS Right Care Headline opportunity areas

Spend and Outcomes	Outcomes	Spend
Cancer	Cancer	Neurological
Circulation	Circulation	Circulation
Mental Health	Mental Health	Cancer
		Gastro-intestinal
		Endocrine

Alignment to Local Plans/ Strategies

	Local Theme	CCG Plans
Bracknell Forest Health and Wellbeing Strategy	*Protecting vulnerable people*	Safeguarding of vulnerable people, care homes, carers
	Increasing life expectancy by focussing on inequalities	Cancer, cardiology, diabetes
	Improving mental health and wellbeing	Mental health and Prevention sections
Bracknell Forest Council Plan 2015-2019	*Supporting people to live healthy and active lifestyles*	Diabetes prevention programme, CAMHs, physical inactivity project, smoking cessation, weight reduction, cancer screening
	Increasing the number of young people participating in leisure an sport	Physical inactivity project
	Increased personal choices available to allow people to live at home	Personal health budgets, complex case management, assistive technology/ equipment/ telecare, social prescribing
	More preventative activities	Prevention section, falls prevention, diabetes prevention programme, care homes
	Increased integration of council and health service care pathways for long term conditions	Integrated care section
	Accessibility and availability of mental health services for young people and adults	Child and Adolescent Mental Health Services

3.2 Slough CCG

- The population profile differs from the national picture with a larger proportion of children aged 0 to 14 and younger adults aged 25 to 44, but a smaller proportion of adults aged 45 and over. 28% of the CCG's total registered population is under 19.
- 5 of the lower super output areas in the CCG boundary are in the 20% most deprived nationally.
- Life expectancy at birth for men is 78.5 years, which is significantly worse than the national figure of 79.2 years. Life expectancy at birth for women is 82.7 years, which is similar to the national figure of 83.0 years.
- The recorded prevalence of cardiovascular diseases, cancer, respiratory diseases, chronic kidney disease, depression and dementia is lower than the national prevalence rates and comparator CCG group. The recorded prevalence of diabetes is higher. Mental health disorders are marginally higher than England, but lower than the comparator CCG group.
- The CCG had 8,144 potential years of life lost (PYLL) considered amenable to healthcare in 2012-14. This rate of 2,460 PYLL per 100,000 registered population is significantly higher than the national rate. Ischaemic heart disease was the main cause of PYLL in the CCG at 36.0%.

National Clinical Priority Areas

National Clinical Priority	IAF Rating
Diabetes	Requires
Maternity	Poor
Mental Health	Good
Cancer	Requires Improvement
Dementia	Requires Improvement
Learning Disability	Requires Improvement

NHS Right Care Headline opportunity areas

Spend and Outcomes	Outcomes	Spend
Neurological	Maternity	Neurological
Gastro-intestinal	Cancer	Respiratory
Trauma and Injuries	Gastro-intestinal	Genito Urinary
	Neurological	Gastro-intestinal
	Trauma and Injuries	Trauma and Injuries

Alignment to Local Plans/ Strategies

	Local Theme	CCG Plans
Slough Health and Wellbeing Strategy	*Promoting active and healthy lifestyles*	Physical inactivity project, diabetes prevention programme, CAMHs, smoking cessation, weight reduction
	Mental health and services for children and young people	Child and Adolescent Mental Health
	Preventing people from becoming socially isolated and lonely	Personal health budgets, Carers, assistive technology, social prescribing
	Workforce	Workforce
Slough Borough Council 5 Year Plan 'Growing a place of opportunity and ambition'	*Enabling and preventing*	Diabetes prevention programme, CAMHs, physical inactivity project, smoking cessation, weight reduction, cancer screening, falls prevention, care homes
	Children and young people in Slough will be healthy, resilient and have positive life choices	Child and Adolescent Mental Health, physical inactivity
	More people will take responsibility and manage their own care and support needs	Personal Health Budgets, assistive technology, social prescribing

3.3 WAM CCG

- The population profile is similar to the national picture with a slightly lower proportion of adults aged 25 to 29 and a higher proportion of adults aged 35 to 49. 23% of the CCG's total registered population is under 19.
- Life expectancy at birth for men is 81.2 years, which is significantly better than the national figure of 79.2 years. Life expectancy at birth for women is 84.8 years, which is significantly better than the national figure of 83.0 years.
- The recorded prevalence of cardiovascular diseases, respiratory diseases, diabetes, chronic kidney disease and depression is lower than the national prevalence rates. Prevalence of cancer is marginally higher than England, but lower than the comparator CCG group. Prevalence of mental health disorders is marginally higher than the comparator CCG group, but lower than England. Prevalence of dementia is marginally higher than both England and the comparator CCG group.
- The CCG had 7,689 potential years of life lost (PYLL) considered amenable to healthcare in 2012-14. This is a rate of 1,730 PYLL per 100,000 registered population which is significantly lower than the national rate. Neoplasms were the main cause of PYLL in the CCG at 33.7% in 2012-14.

National Clinical Priority Areas

National Clinical Priority	IAF Rating
Diabetes	Requires
Maternity	Requires Improvement
Mental Health	Good
Cancer	Requires Improvement
Dementia	Good
Learning Disability	Requires Improvement

NHS Right Care Headline opportunity areas

Spend and Outcomes	Outcomes	Spend
Circulation	Circulation	Circulation
Genito Urinary	Trauma and Injuries	Genito Urinary
Trauma and Injuries	Cancer	Neurological
Respiratory	Maternity	Gastro-intestinal
Mental Health	Mental Health	Respiratory

Alignment to Local Plans/ Strategies

	Local Theme	CCG Plans
Royal Borough of Windsor and Maidenhead Health and Wellbeing Strategy	*Supporting a healthy population*	Diabetes prevention programme, CAMHs, physical inactivity project, smoking cessation, weight reduction
	Prevention and early intervention	Cancer screening, falls prevention, care homes, social prescribing
	Enabling residents to maximise their capabilities and life chances	Personal health budgets, social prescribing, carers, assistive technology
Royal Borough of Windsor and Maidenhead - Council Strategic Plan 2016 – 2020	*Encouraging healthy people and lifestyles*	Diabetes prevention programme, CAMHs, physical inactivity project, smoking cessation, weight reduction
	Reducing obesity	Physical inactivity and weight reduction programmes
	Increasing childhood immunisation levels	
	Reducing smoking especially in pregnancy	Smoking cessation
	Reducing the number of residents dependent on drugs and alcohol	
	Residents of all ages taking up health checks	Prevention section, particular focus on those with a learning disability and serious mental health

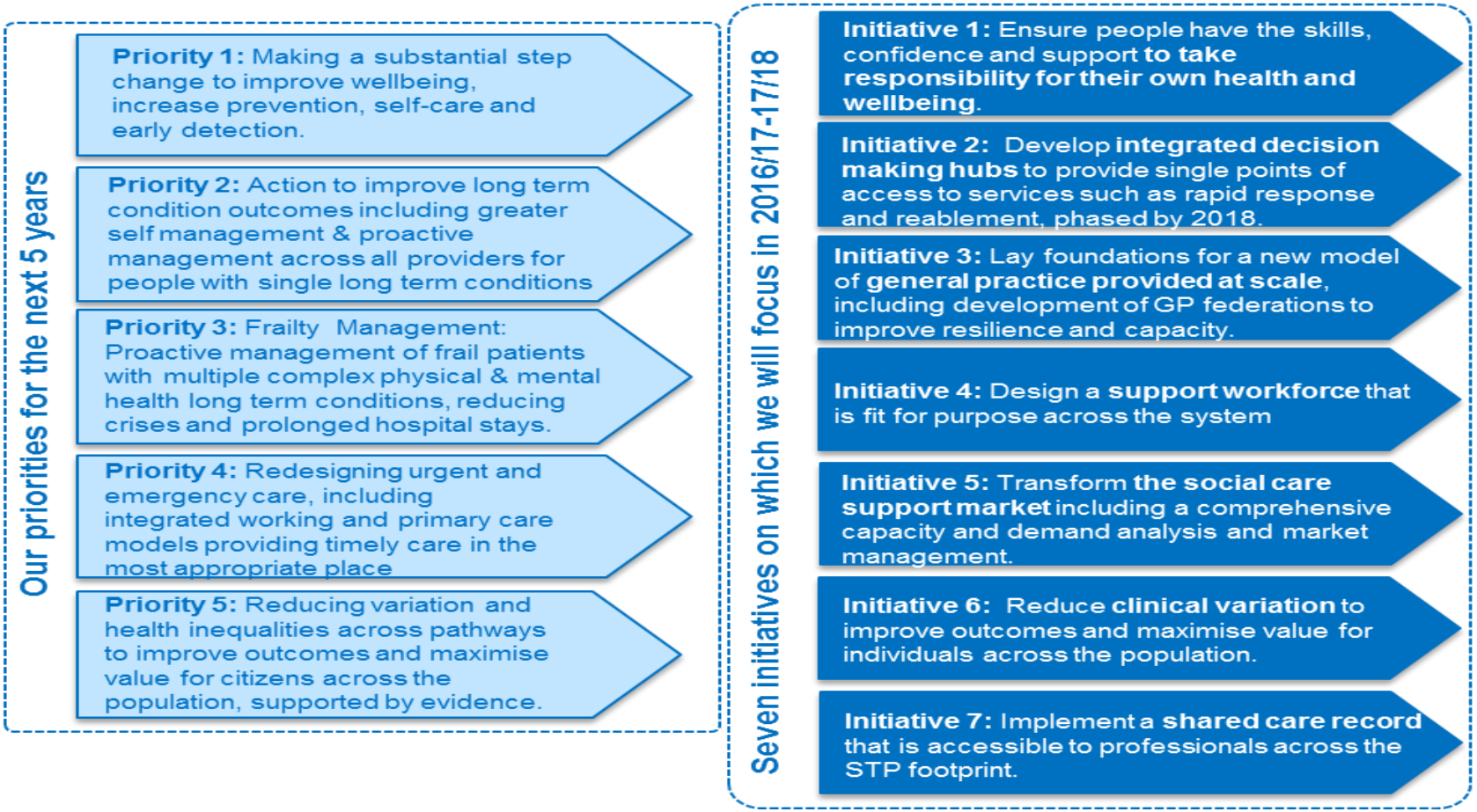
Additionally there are areas where we know our performance is either variable month on month or across the three CCGs. We will be paying particular attention to these:

- A and E performance at Frimley Health
- RTT 18 weeks Incomplete at Frimley Health
- 31 day cancer wait times standard
- 62 day cancer wait times standard
- Ambulance response times RED 1 RED 2 and CAT A

4. The Frimley Health and Care Sustainability and Transformation Plan

The CCGs are active partners in the Frimley health and social care system. Our aim is to achieve system change that is right for patients, communities and the taxpayer and not allow organisational boundaries to get in the way. The CCGs have engaged strongly in the development of the STP (Appendix 1) at a senior and clinical level and this includes our local authority partners. The STP is based on detailed analysis across the system of performance and potential for improvement in outcomes and increasing value to the system. This shared analysis has informed the choice of priorities and initiatives. The STP sets out how we will become sustainable in the future as a system of commissioners and providers and this operational plan focusses on developing initiatives that will provide system benefit rather than pure commissioner benefits e.g. by negotiating tariff changes. Our commissioning partners in the footprint are Surrey Heath and North East Hampshire and Farnham CCGs. With the exception of Slough, our populations are very similar and we face many of the same challenges. The STP will drive our collective efforts over the next five years and will act as our route map. Across the STP footprint, there are strong relationships with local authorities which will enable further integration of services during the lifespan of these plans. What we do locally will support the delivery of the STP priorities and contribute to the system control total. Our approach to communications across the STP footprint is set out in Appendix 5e.

4.1 STP Priorities and Initiatives



The STP is governed by a strong System Leaders Reference Group which is the mechanism by which system working is agreed and progress with delivering the STP is monitored.

We are working with our member practices to realise our new model of general practice. This programme of work is entwined with the development of integrated care hubs. Both of these are at the core of our transformational model. We firmly believe that until we have greater clarity about the whole care landscape we should not identify what organisational model (new care model) we are likely to move towards in the future. Form must follow function but we will be engaging with our member practices and major providers, along with our STP partners to come to a conclusion about this by May 2017.

5. Financial Sustainability

5.1 The Financial picture

5.1.1 Financial context

NHS England has advised CCGs that the following key business rules will apply for 2017/18 and 2018/19:

- A minimum 1% surplus. Where CCGs have accumulated more than a 1% surplus this can be 'drawn down' over a four year period through to 2020/21
- In order to provide funds to insulate the health economy from financial risks, a further 1% of allocations should be set aside for non-recurrent expenditure, and of this 0.5% must be uncommitted at the start of the year (and will only be available for investment later in the year to the extent that it is not required to secure the overall national financial position).
- A minimum requirement to show 0.5% contingency

Our plans comply with these key national planning requirements, and we have agreed contracts with our main local providers, Frimley Health Foundation Trust and Berkshire Healthcare Foundation Trust, for the next two years.

5.1.2 Funding allocations

The table below shows the core funding allocation for our three CCGs in 2017/18 and the growth compared to 2016/17. Adjustments have been made to our funding for the impact of changes in responsibility commissioning specialist healthcare (the Identification Rules ("IR")) and for changes to how acute care is paid for (the HRG4+ adjustment)

	NHS Bracknell and Ascot CCG £000s	NHS Slough CCG £000s	NHS Windsor, Ascot and Maidenhead CCG £000s	Total £000s
2016-17 Revised CCG Programme Allocation	**153,169**	**171,379**	**164,570**	**489,118**
IR Rule Changes	289	510	269	**1,068**
HRG4+ Adjustment	(266)	(123)	(275)	**(664)**
Opening 2017-18 Allocation before growth	**153,192**	**171,766**	**164,564**	**489,522**
Growth	3,877	4,065	3,584	11,526
2017/18 Programme Allocation	**157,069**	**175,831**	**168,148**	**501,048**
Growth %	2.53%	2.37%	2.18%	**2.35%**
Programme Allocation	157,069	175,831	168,148	**501,048**
Running Cost Allocation	3,003	3,180	3,191	**9,374**
Return of Surplus	426	46	230	**702**
Total	**160,498**	**179,057**	**171,569**	**511,124**

Although in total the three CCGs have received 'growth' of £11.5m, this is significantly less than last year (£20.8m), and has to cover:

- an underlying inflation assumption of 1.8% (the GDP Deflator) – an estimated cost of £8.8m
- population growth – an estimated cost of £4.9m
- any impact of changes to how acute care is paid for (the HRG4+ adjustment) over and above the allocation adjustment – an estimated cost of £2.1m

Therefore, rather than growth of £11.5m we have a real terms ***reduction*** in core funding for the local health system of £4.3m. A large proportion of the inflationary is born by our local healthcare providers, as the national tariff which is used to pay for most care is only increasing by 0.1% (i.e. it assumes 1.7% of efficiencies can be made by providers).

5.2 Forecast position 2016/17 and impact on 2017/18

During 2016/17 increases in demand and patient acuity have put the CCGs under significant financial pressure. In addition the CCGs have had to absorb other cost pressures such as a 40% rise in the cost of Funded Nursing Care. At the start of the year CCGs were asked not to spend 1% of their funding (in addition to the normal surplus requirements) to offset financial pressures elsewhere in the national health economy, but it was hoped that some of this could be used to meet local pressures. Unfortunately we have not been allowed to do this, and therefore all the contingencies the CCGs set aside at the start of the year have been used, and they have had to use other non-recurrent measures to balance the in-year position. The financial impact in 2017/18 of rebuilding a modest level of contingencies in line with national business rules, and replacing the non-recurrent funding measures, is about £9.5m

5.3 QIPP Programme

To address our funding shortfalls, the pressures we have experienced in the current year, the expected growth in demand during 2017/18 and our plans for service improvements, it has been necessary to develop a substantial QIPP programme. The identified savings gap for 2017/18 amounts to £12.3m in total, which is 2.4% of our combined allocations.

It is our intention to establish realistic and achievable levels of QIPP and efficiencies within the system. We have approached this through using the NHS Right Care approach to identify opportunities where Commissioning for Value packs indicate unwarranted variation in outcomes and/ or financial value. We have used this approach to drive a robust plan of clinical and wider stakeholder engagement in the generation and development of new ideas for QIPP projects. The decision tree in Appendix 4 has been used to inform our QIPP pipeline.

The new ways of working developed in 2016 have allowed us to focus the staff of the 3 CCGs on our major programmes of work. These teams are aligned to Programme Boards which have a clear focus on engagement, development of business cases and implementation plans. We have reviewed our project management system (Verto) and associated documentation to focus on the development of strong business cases, implementation plans and monitoring. The QIPP programme will be managed by a new Programme Management Office (PMO). Business Cases are signed off by the Business Planning and Clinical Commissioning Committee, which includes clinical members, and delivery is monitored strategically through the CCGs QIPP & Finance Committee each month.

The main QIPP schemes (value over £0.2m individually) included within the QIPP plan, are shown in the summary table below.

Summary of QIPP for 2017/18	NHS Bracknell and Ascot CCG £000	NHS Slough CCG £000	NHS Windsor, Ascot and Maidenhead CCG £000	Total £000
Ambulatory Care Pathways	559	890	792	2,241
Respiratory Services		358		358
Cardiology Services	141	160	154	455
Referral Management	431	175	776	1,382
Diabetes	492	158	202	852
Musculoskeletal	502			502
Neurology	449	780	652	1,881
Medicines Management	484	495	406	1,385
End of Life Care	588	592	572	1,752
Complex Case Management		346	330	676
Mental Health Placements		150	350	500
Improved Value through Contracting	1,876	1,451	1,583	4,910
Connected Care Interoperability	379	411	423	1,213
Other	290	381	353	1,024
Total Gross	**6,191**	**6,347**	**6,593**	**19,131**
Less Investments to support QIPP	(1,001)	(1,404)	(1,173)	(3,578)
Less risk of delivery	(1,668)	(1,576)		(3,244)
Net QIPP Target	**3,522**	**3,367**	**5,420**	**12,309**
QIPP as % of Resource	2.2%	1.9%	3.2%	2.4%

We will continue to develop a pipeline of QIPP schemes and get work streams under way for delivery in 2018/19. These schemes have been generated and prioritised through engagement of clinicians and patients at workshops, Clinical Innovation Fora and discussions with member practices.

5.4 Financial Summary 2017/18

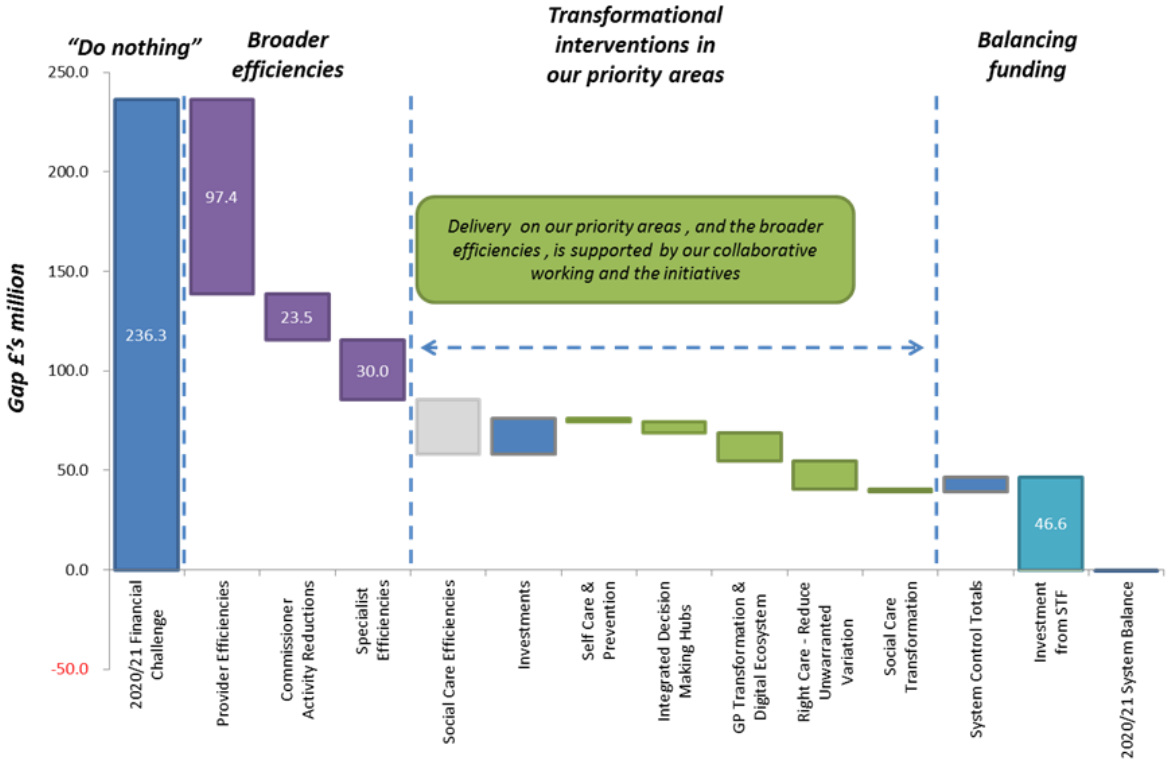
After taking account of the impact of our QIPP schemes, our expenditure plans are summarised below.

Summary of Allocations, Expenditure, Contingency and Surplus for 2017/18	NHS Bracknell and Ascot CCG £000s	NHS Slough CCG £000s	NHS Windsor, Ascot and Maidenhead CCG £000s	Total £000s
Programme Allocation	157,069	175,831	168,148	501,048
Running Cost Allocation	3,003	3,180	3,191	9,374
Return of Surplus	426	46	230	702
Total Allocation & Return of Surplus	**160,498**	**179,057**	**171,569**	**511,124**
Acute	85,810	103,834	91,318	280,962
Mental Health	15,405	17,175	16,122	48,702
Community	10,946	10,993	11,273	33,212
Continuing Healthcare	18,563	16,303	20,799	55,665
Primary Care	19,567	21,387	22,114	63,068
Other Programmes	6,394	5,268	5,887	17,549
Sub Total	**156,685**	**174,960**	**167,513**	**499,158**
Running Costs	3,003	3,180	3,191	9,374
Contingency (Minimum 0.5%)	803	896	859	2,558
Surplus in-year Movement	7	21	6	34
Total	**160,498**	**179,057**	**171,569**	**511,124**

5.5 Medium term financial context across the STP 'footprint'

The Frimley Health and Care Sustainability and Transformation Plan (STP) was published in November 2016. It describes how currently £1.4bn is being spent on health and social care across the 'footprint' but that although there are modest increases in funding over the period to 2020/21, demand will far outstrip these increases if we 'do nothing', leading to a theoretical funding gap of £236m by 2020/21 (£187m relating to healthcare, and £49m to social care). In addition to being unaffordable, the implied demand would require an increase in acute bed capacity of about 10%.

Assuming the system continues to make broader efficiencies by reducing demand by 1% and delivering 3% health provider savings each year, plus social care efficiencies, the gap reduces to £85m, which will need to be met by a combination of transformational savings and an additional £47m allocation from the national Sustainability and Transformation Fund (STF).



As part of the Plan, the STP requested additional funding of £20m in 2017/18 which would help support funding of the transformational solutions described in the STP (£12m) and delivering overall financial balance (£8m). It was originally anticipated in the Five Year Forward View that the STPs would be the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. It is now clear that this funding can only be secured through application to a variety of bespoke funding streams. To date, only about £4m of the £20m required for 2017/18 has been secured, and clearly this impacts on the ability of our CCGs to deliver the aspirations outlined in the STP.

6. Our transformation programmes and initiatives

We will operationalise our plan through the following programmes of work:

- Primary care
- Planned care
- Prevention
- Urgent and emergency care
- Mental health
- Learning disability and autism
- Integrated care
- Children's and maternity services
- Specialised services

The sections below set out these programmes and demonstrate how the major initiatives relate to the national 9 must dos, clinical priority areas and also how they support the STP delivery.

Continued monitoring of progress and alignment between the STP and operational plan will be maintained through the East Berkshire System Leadership Reference Group.

6.1 PRIMARY CARE

Our strategy is to:

- Develop a transformed and sustainable model of general practice for east Berkshire
- Improve overall access to general practice appointments
- Realise the opportunities and benefits set out in the general practice forward view through delegated commissioning

Our focus will be to:

- Develop an agreed strategy for general practice across the CCGs
- Develop a general practice outcomes framework
- Improve prevention and screening uptakes
- Improve engagement and communication with patients
- Develop the seven day service infrastructure

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The development of the general practice vision in each CCG in east Berkshire started back in 2014, with all three CCGs embarking on an application to the Prime Minister Challenge Fund either through wave one in 2013 or wave two in 2014. Since then a significant investment from NHS England or in Bracknell and Ascot CCG's case, through directing local innovation funds, to implement an extended hours general practice model. The evaluation of these pilots will be utilised in the service design for

integrated general practice services. The resulting vision is illustrated in Appendix 3a. This programme of work is aligned to the STP General Practice Transformation work stream and is underpinned by digital developments such as electronic transmission of prescriptions, e-referrals and patients using online services in general practice. Our vision has been shaped with input from local people about what it is they want from primary care.

6.1.1 Sustainability and Quality

The CCG has developed a strong approach to supporting practices with challenges to deliver the highest standards. We have also identified those practices that may require some additional support. We will continue to proactively identify and support vulnerable practices. We will focus on patient experience through the Quality Premium indicator, improving experience through clear communication approaches and sharing best practice about access through practices and PPGs.

Further investment into general practice will ensure greater resilience as a result of our programme of provider assessment, support in practices and sustaining change with skills workforce, which has been developed by the providers with the CCG with themes around capacity and demand tools, future workforce profiling, communications and workforce development. We will be submitting an expression of interest to the Time of Care programme to ensure we have the ability to respond to the needs of our providers to continue to deliver high quality services for our populations.

6.1.2 GP Transformation

Our transformation programme will develop new roles within primary care teams at scale across and within practices. We will move to needs and evidence based service rather than historical commissioning by developing a better framework for providers to respond to and enable GP federations to become providers of services in a more sustainable way and ensuring equity of access for all our patients to locally commissioned extended services. Our approach will be to focus on quality improvement and the role of general practice in the wider commissioning agenda through the new General Practice Outcomes Framework. We will develop the integrated model for general practice, taking the vision forward through GP Access Fund programmes. We intend to secure the mid-term future of the GP Access Fund/Better Futures for All services through a robust roadmap for sustainable general practice extended hours in April 2018. We will seek continual feedback and evaluation of the pilot services and ensure benchmarking continues on outcomes and value for money. In delivering the transition to primary care we will increase capacity for patients to access general practice services improving patient experience and work closely with our STP partners on a consistent service from general practice. We will deliver a communication and engagement programme around the core offer from general practices and develop consistent messages to patients and the public. As CCGs we will ensure that the processes and systems in place are the most efficient and ensure that they support change management processes.

Where opportunities align with our plans we will encourage integration with community, acute and social care services, including the development of wellbeing focused and family centric models of extended general practice. This will extend the range of services which can be provided close to our populations such as dressings, diagnostics and better access to specialist professionals.

Through the development of the GP federations in east Berkshire we envisage sustainability for practice units to work at scale for functions which would have benefits across practices and populations creating efficiencies which could be directed as investment to patient facing services.

The General Practice Forward View (GPFV) sets the direction to strengthen the general practice model to sustain the wider model of the NHS, with this framework laid out in April 2016, the CCGs have worked to develop an outline plan to support the operational planning and investments over the next two years. The document describes some of the investments and priorities in securing sustainable general practice models across East Berkshire under the GPFV framework; improved access to general practice; workforce development; Infrastructure, workload and care re-design.

6.1.3 Workforce

This programme is part of a wider initiative to develop our workforce across health and social care is outlined in the STP. In order to deliver sustainable services through the development of primary care and associated workforce, we will analyse workforce data available to identify areas of opportunity and risk, establish the link between Community Education Provider Network, Local Workforce Advisory Board and Health Education Thames Valley, work with providers on plans to sustain services where workforce challenges have been identified, consider the widest opportunities to extend and integrate our workforce across the STP footprint, develop a programme of placements, apprenticeships and career paths across the primary care workforce within the CEPN and sustain primary care services through closer working arrangements with other services, workforce approaches with federations and practices coming together to deliver services more efficiently creating capacity improving access.

We will be a proactive fast follower for nurse associates in primary care, continue with the benefits of being a Clinical Pharmacists pilot, through social prescribing introduce the wellbeing co-ordinator and implement with our community and mental health provider the implementation of the IAPT professionals in primary care supporting patient with long term conditions. A programme of development for non-registered primary care work force will be implemented between January 2017 and December 2017, supported through the GP Forward View investment for front line non clinical staff. To strengthen the senior management in general practice individuals will be encouraged to commit to leadership and wider management skills training through our liaison with the Leadership Academy. We also wish to develop greater staff leadership with patients in supporting and promoting self care and prevention through Making Every Contact Count (MECC) and motivational interviewing approaches.

6.1.4 General Practice Infrastructure

We will agree the estates strategy including the One Public Estate programme and secure new premises or new ways of working for areas with significant growth – working with other local partners in Bracknell and Maidenhead. This will allow us to decide on the most appropriate use of public estates including the location of integrated services. We will also seek to establish more proactive relationships with the planning departments in relation to health services needs. A priority will be to ensure that the ETTF investment (estates and technology) achieves an affordable outcome and sufficient capacity for the providers and commissioners.

6.1.5 Technology and Digital Self Management

Work is underway to explore solutions to improve access to general practice for our population including online consultations and to support the transformation required over the next five years in general practice. We are also liaising closely with partners within the STP to ensure we are learning lessons from their implementations. Within 17/18, we will support practices with utilising video consultation software to enable them to treat patients remotely.

In addition to this, we are also exploring using technology with additional features to just online consultations which support triage, linking to self-care and ones that support federated working where appropriate. Providers that are being looked at include eConsult, Digital Life Science and Ask My GP. There will also be a pilot run with a practice in 16/17 to look at the Hurley group methodology which will help inform a requirements specification for a broader rollout of a preferred solution.

Finally we will be taking lessons learnt from Buckinghamshire that is going live with an Airedale model in 16/17 with online consultations as part of the solution. This will also help ensure alignment across the STP footprint and ensure best practice and lessons learnt are used in our implementation in 17/18.

6.1.6 Digital Infrastructure

A significant amount of work has been conducted already as part of the Berkshire East LDR (see Appendix 23a) programme and will continue with the Frimley LDR as it forms. There are three key strands which include an information sharing strategy, whole system intelligence and patient facing technology. All three of these areas will become significant enablers for GP transformation activities. We will work with general practice IT providers for a solution to align and share full medical records across various systems and implement an extraction tool with analysis support direct from primary care providers. We will ensure that innovative initiatives such as social prescribing and group consultations leading to self management are supported with the technology to realise the benefits for patient envisaged as patient empowerment and ownership of their conditions.
The information sharing strategy is underpinned by the Connected Care programme which has delivered a clinical portal in 16/17. This portal creates a holistic patient record with feeds from primary care, acute, community, mental health and social care. This ensures that the clinician has access to required information at the point of care and will support any products that support triage and referral to self-care. This interoperability strategy will also enable further developments around system wide care plans and provide common standards for future initiatives through open API's. Connected Care will also enable a patient facing portal which will be a key enabler to patients accessing NHS services and support for self care. It will act as a single point of entry for patients to access primary, secondary or social care services, but be flexible enough to allow access through native apps, websites and wearable technology. It will be able to sign post residents to voluntary sector support and also lifestyle services.

Finally, there is an infrastructure work stream within the LDR governance which will look at utilising the HSCN standards and ensuring the replacement for N3 takes into consideration the local needs of GP Practices, as well as emphasising links to other dependent organisations such as care homes, secondary care and social care. The LDR process has ensured there is a vehicle for aligning all 8 organisations in Berkshire East, with an aligned system-wide digital strategy. This ensures that any digital investments made in primary care will benefit the wider system and vice versa.

6.1.7 Delegation

We will plot a trajectory to move to delegation status for Slough by 2018/19 and have a transition plan for Bracknell and Ascot and Windsor, Ascot and Maidenhead CCGs to transition to delegation.

Delegation will allow the CCGs to more independently commission patient centred pathways from prevention to specialist care for our local populations/ It should also provide greater flexibility in the financial sustainability of general practice services. Quality outcomes will be flexible to local needs through localised commissioning.

Trajectories

	Forecast 16/17 outturn/ baseline	**March 2018**	**March 2019**
Commission weekday provision of access to pre-bookable and same day appointments in evenings to provide an additional 1.5 hours a day	100%	100%	100%
Commission weekend access to pre-bookable and same day appointments on both Saturdays and Sundays	70% (Slough & WAM)	100%	100%
Commission a minimum additional 30 minutes consultation capacity per 1000 population rising to an additional 45 mins (not clear on when)	35% (WAM)	100%	100%

Milestones

2017/18				2018/19			
Q1 Transition to delegation for WAM and Bracknell and Ascot CCGs IT solution for GP Access Funds hub/ cluster sites Implementation of the General Practice Outcomes Framework Due diligence on supported ETTF delivery programme Providers are supported with a sustainability plan improving quality, performance and providing a future service model Deliver the GPAF requirements within the two local programmes and local other related transformation programme	Q2 Vision for community hospital estates developed Road map for extended practice integrated services including extended hours Introduction of new workforce roles including MH working , wellbeing co-ordinators and associate nurses	Q3 Development of specification for procurement of new general practice integrated services Evaluation of Social prescribing, group consultations, recruitment and capacity and demandplans Commissioning intentions for extended scope services with integration of intermediate and community care services	Q4 Contract award for extended general practice integrated services	Q1 Launch of new general practice integrated services	Q2 Evaluation of new workforce roles including MH working , wellbeing co-ordinators, clinical pharmacists and associate nurses	Q3 Commissioning intentions for extended scope services with further integration	Q4 Implementation of the outcomes of ETTF

6.2 Planned Care

Our strategy for planned care is to reduce unwarranted variation in both outcomes and activity using the Right Care programme methodology to identify priority specialties and to deliver Constitutional standards. We are also focussing our attention on those pathways where we do not perform well against clinical standards. We are working with our providers to model the demand and capacity for all specialities including diagnostics to ensure we are commissioning the appropriate level of services and pathways are delivered efficiently. The CCGs already make extensive use of the independent sector, primarily driven by patient choice. We are not intending to commission further additional activity from the independent sector. This workstream is aligned to the STP Managing Variation workstream and shares the same priority areas. Shared decision making will be a key consideration in any pathway re-design that we undertake.

6.2.1 Identifying priority areas for planned care

The CCGs have made substantial improvements in RTT incomplete performance but there are some challenges in trauma and orthopaedics, plastics and neurology. Dermatology is a key area of review and development due to challenges with the 2 week cancer wait and long waits for non-cancer related conditions. Our focus will be on those specialties where there are difficulties in achieving Constitutional standards and where service redesign opportunities can add value in the context of our Right Care priorities – these include neurology, musculoskeletal, cardiology and respiratory.

Demand management remains a key area of focus for the three CCGs and is reflected in several of our programmes including general practice transformation, planned care (pathway re-design and the implementation of DXS) and urgent and emergency care. The Performance Reference Groups in each of the CCGs have responsibility for reviewing and agreeing action to be taken using practice level variation data to drive discussions. This approach will be paramount to reducing demand where possible or containing it in the context of predicted future changes in our populations. We intend to incorporate lifestyle measures into any new pathways and tackle variation in giving lifestyle advice.

6.2.2 Cancer

The three CCGs have agreed a cancer local action plan and an implementation project (see supporting documents appendix 11) to ensure the three CCGs meet the 2020 targets, “must dos” relating to cancer and improve clinical outcomes and patient experience (as highlighted through NHS Right Care). Performance against the cancer constitutional standards has been strong and the 3 CCGs will continue to work with providers to maintain this.

In year 1 of this plan the following will have been implemented, an Early Diagnosis workstream which will include, a screening uptake improvement project focussing on bowel and breast screening through increased primary care engagement, delivering a GP education programme including 2WW pathways, support prevention programmes e.g. to achieve the tobacco prevalence target), vague symptoms and safety netting, redesign pathways for breast and lower GI including improving access to diagnostics and where applicable apply for bid monies to support modelling and implementing diagnostic capacity requirements to achieve 28 day target, staging work to increase the number of diagnosis at stage 1 and 2. A recovery workstream will ensure a new rehab service is commissioned from April 2018.

In year 2, the project will continue to embed the service changes that ensure earlier diagnosis is achieved and implement the new rehabilitation service as part of the recovery workstream. We will continue to review progress against targets and take action where progress is not being achieved. Further pathway redesign may occur across the STP.

6.2.3 Diagnostics

We will work with our acute providers to deliver the 7 day diagnostic standard which will increase and improve access to diagnostics across the system.

6.2.4 Diabetes

The diabetes programme seeks to define and shape consistent, high quality, personalised support for people with or at risk of diabetes including their carers and families.

The recently published integrated assessment framework (IAF) clearly indicates all three CCGs is East Berkshire perform within the top decile in treatment targets achievement but have some work to do to support our patients with access to a comprehensive package of structured educations support. The IAF looks to integrate primary and specialist care services and ensure everyone with diabetes is offered the NICE care processes. This will be achieved through the commissioning of the Integrated Diabetes Service which will provide specialist diabetes care across community and primary care settings, providing specialist advice, support and education to general practice and health care professionals. Care and support planning will be included in the general practice outcomes framework (see appendix 16 for business case). The care and support planning training will inform the development of care and support planning for other conditions. A multidisciplinary foot care team will provide specialist footcare. A business case for structured education sessions will be implemented (see Appendix 16). A key element of this programme will be to increase the numbers of our patients with a diagnosis of diabetes take part in structured education, and also those at risk of diabetes are referred and take part in the national diabetes prevention programme so reducing the rate of increase in diabetes. The formulary for diabetes will be developed.

The three CCGs are already part of the National Diabetes Prevention Programme and will seek to apply for further funding streams relating early identification of diabetes in the future.

6.2.5 Improving value and managing variation

6.2.5.1 Cardiology

Our cardiology projects are to review the current atrial fibrillation pathway and implement changes, support GPs in the identification of atrial fibrillation patients and the use of anti-coagulants. Commission a rapid access heart failure clinic, expansion of the heart failure nursing service, a heart failure IV lounge and cardiac rehabilitation services. End of life care will be included as part of the pathway re-design. Hypertension and atrial fibrillation are part of our prevention programme. The CCGs will also support Frimley Health in the development of the chest pain pathway.

6.2.5.2 Neurology

Right Care shows that there are opportunities for increasing value in neurology services. The CCG will develop and commission an integrated community neurology service model, develop pathways for parkinsons, multiple sclerosis, headaches and epilepsy and repatriate neurology activity closer to home (respecting patient choice). These will cover the whole pathway including end of life care.

6.2.5.3 Musculoskeletal

MSK will be reviewed to determine opportunities for service redesign in 2017/18. Whilst not identified by RightCare as a priority, the high volume offers an opportunity for savings if operating at scale across East Berkshire and in alignment with STP plans. Current mapping work identifies the following: challenges in delivering the 18 week RTT standard, inequitable access to services across East Berkshire, increasing demand, high volume specialty (consistently in top 3 for GP practice referral counts), increasing acute spend both NHS and independent providers. A focus on lifestyle and self care at the start of the pathway will be incorporated into this stream of work.

6.2.5.4 Dermatology

Dermatology has been selected due to challenges in delivering the 2 week cancer wait and long waits for non-cancer related activity. In order to address this the CCGs will implement see and treat clinics, upskill GPs in dermatology through targeted educational events and shadowing consultants, implement teledermatology and move from day cases to outpatient procedures.

6.2.5.5 E referral and DXS

We have now access to a comprehensive set of data about referrals made by GPs to secondary care from e- referrals. As a result of this we have built a comparator CCG and practice level view of all referrals generated by the e referral system. We are utilising this data and building a number of interventions to support the management of the increase in referral activity over and above these benchmarks. Slough is not particularly high on referral rates against these benchmarks, but of course there has been an increase in referrals from previous years as there has been with the two CCGs. We are committed to addressing this increase in referrals.

Each CCG is reviewing their practice level data and planning peer review visits to practices which have higher than average rates of referrals. Member meetings are being used to share data and discuss actions to change practice processes. For 2017/18 we have developed a whole system referral management support scheme to encourage practices to utilise DXS and manage internal peer review and triage. We expect demand management to be a key platform of practice work plan for 2017/18 across the three CCGS. This will require a systematic review of pathways to sit within the DXS system (see Appendix 22).

E-referrals - We have set up a joint working group with Frimley Health to escalate the implementation of e-referral utilisation. The group are already working on areas that require improvement and will be working jointly to enable 100% utilisation. This includes working with individual clinical departments and GP practices to adopt the 100% utilisation by 2019. This will enable referrals to be created and transferred electronically, patients to be supported in the choice of their provider and every initial outpatient appointment booked for a date and time of the patient's choosing.

Milestones – Planned Care

2017/18				2018/19			
Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
New heart failure service to go live Commence integrated neurology service Begin commissioning cycle for MSK service New Care Planning Locally commissioned service (April) Recovery Package - new service - start of commissioning cycle New integrated diabetes service launched. Capacity modelling and redesign to meet 28 day standard. Diabetes locally commissioned service in place Locally commissioned service for referral management in place Business case developed for hypertension identification and management.	Start of new process for referrals to and package of structured education in place for diabetes New diabetic footcare pathway implemented Neurology primary care quality indicators operational	GP Education on early cancer diagnosis complete (Dec) Bowel screening non responders project ends (Dec 17)	Lower GI and Breast Pathway redesign and service development complete (March 18) Implement new MSK service Hypertension business case operational.	Recovery package – new service implemented	12 month service review of new referral and triage service Early diagnosis transformation work complete		12 month service review of MSK service (Dec)

Trajectories - Planned Care

Priority	Forecast 16/17 outturn	March 2018	March 2019
More than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment	B&A 92% Slough 93% WAM 93%	B&A 92% Slough 92% WAM 92%	B&A 92% Slough 92% WAM 92%
100% use of e- referrals and choice of first outpatient appointment offered by April 2018	B&A 80% Slough 76% WAM 76%	B&A 80% by end Q2 2017/18 Slough 80% by end Q2 2017/18 WAM 80% by end Q2 2017/18	B&A 100% by end Q2 2018/19 Slough 100% by end Q2 2018/19 WAM 100% by end Q2 2018/19
Deliver the 62 day cancer standard (85%)	B&A 85% Slough 87% WAM 87%	B&A 86% Slough 87% WAM 87%	B&A 87% Slough 87% WAM 87%
Increasing the proportion of cancers diagnosed at stage one and two	50%	55%	Towards 62% by 2020

6.3 Urgent and emergency care

Our strategy for urgent and emergency care is to:

- Prevent crisis through improved access to General practice to avoid the escalation of health issues
- Improve urgent on the day service responsiveness through helping people easily navigate services, offering direct access to clinical advice, and which enables people to have their care needs met outside of a hospital setting where clinically appropriate
- Patients only to stay in hospital as long as they need to, supported by an integrated model of community health and social care services

Our focus will be on the following 5 national priority areas:

- Streaming at the front door – to ambulatory and general practice
- NHS 111 – Increasing the number of calls transferred for clinical advice
- Ambulances – Directory of Services and code review pilots; Health Education England increasing workforce
- Improved flow – 'must do's that each Trust should implement to enhance patient flow – SAFER Bundle
- Discharge – mandating 'Discharge to Assess' and 'Trusted Assessor' models

Constant achievement of the A and E target is challenging despite Frimley Health being one of the best performers in the Region. We intend to continue to use the A and E Delivery Board to maintain levels of performance and govern our complex programme of admission and A and E attendance avoidance and the complex discharge issues which impact on flow through the Trust.

We are committed to designing a simplified system with fewer access points, greater coordination across pathways and providers, supported by more effective information sharing. This means a move towards a clear single point of access for urgent and emergency care, with a consistent triage to ensure people with physical and mental health needs are supported into the best part of the system to meet their needs.

To achieve this, we will greatly enhance the NHS 111 services so that it becomes the trusted call to make, creating a 24 hour, personalised single point of access service. This enhanced service will have knowledge about people's medical problems, and allow them to speak directly to a nurse, doctor or other healthcare professional if that is the most appropriate way to provide the help and advice they need. It will also be able to directly book a call back from or an appointment with, a GP or at whichever urgent or emergency care facility can best deal with the problem. Central to this will be the development of a 'Clinical Hub' offering patients who require it access to a wide range of clinicians, both experienced generalists and specialists. The development of the Directory of Services linked to dispositions is a crucial activity to support this.

This programme will be supported through digital developments including A&E, ambulance, 111, community and acute pharmacies being able to access information from patients records where this information may inform clinical decisions. Access to detailed coded GP records will also be actively offered to patients who would benefit and where it supports their active management of a long term or complex condition. All discharge summaries will be sent electronically from all acute providers to the GP within 24 hours and All Care Act 2014 compliant Assessment, Discharge and associated Withdrawal Notices will be sent electronically from the acute provider to local authority social care within the timescales specified in the Act

6.3.1 Reduced ambulance conveyance and improved response times

Our ambulance provider SCAS has continued to increase the number of patients that are responded to by 'hear and treat' and 'see and treat' rather than conveying them to another service compared to previous years. This data is reviewed monthly as part of the contract monitoring arrangement with SCAS. We will continue to work with the Trust to increase these numbers and develop the workforce to meet the needs of this service model.

A number of improvements are planned by SCAS that improve response times these include implementation of auto dispatch for red 1 nature of call, reduce time on scene , reduce handover/clear up delays, improve recruitment and retention of paramedic staff, develop a new long term framework with private provides in line with the new national agency framework rates to increase capacity and incentivise nights and weekend work.

6.3.2 A&E Improvement & Emergency Care Review delivery

Our urgent and emergency care plans address the delivery of the following clinical standards – 4 hour A and E and ambulance standards, four priority standards for 7 day hospital services, clinical hub for NHS 111, 999 and out of hours, reduction in the number of 999 calls resulting in transportation, waiting standards for those in a mental health crisis (to be defined). Delivery of these standards will be supported by system wide improvements in the following areas that are shown in more detail in our Frimley North system resilience plan (see Appendix 12).

- Streaming at the front door – to ambulatory and general practice
- NHS 111 – Increasing the number of calls transferred for clinical advice
- Ambulances – Directory of Services and code review pilots; Health Education England increasing workforce
- Improved flow – 'must do's that each Trust should implement to enhance patient flow – SAFER Bundle
- Discharge – mandating 'Discharge to Assess' and 'trusted assessor' type models.

In addition as part of the Thames Valley Urgent and Emergency Care network we will deliver:

- Regional 111 integrated urgent care service including enhanced clinical hub and enhance directory of service
- Standardisation of urgent and emergency clinical pathways
- Designation of urgent care centres
- Connected care systems so that the patients care record is accessible across the system
- Competency framework for multidisciplinary staff
- Best practice framework for 7 day access to standardised care across primary, community and acute services

The development of ambulatory care pathways (ACU), the frailty unit access to the paediatric unit are key developments in streaming at the front door.

In addition a number of community schemes are in existence which aim to address a reduction in A and E attendances. These include the development of paediatric pathways, paediatric advice line, support and infrastructure building in nursing homes, complex case management, plans to support people at the end of life (see business case attached at Appendix 18), AIRS respiratory service (see business case attached at Appendix 19), heart failure service (see Business case attached at Appendix 20), diabetes integrated service (see business case at Appendix 21), stroke pathway and IAPT extension.

In order to deliver our STP ambitions we will be:-

- Confirming provider of the new integrated 111 service and commencing the mobilisation phase in order to deliver the single point of access for clinical advice, clinical hub, direct booking and data sharing including access to care plans.
- Mobilising the stroke pathway in EB and continue working with our urgent care network to delivery pathways at scale
- Continuing discussions with the ambulance trust to support the delivery of hear and treat and see and treat

6.3.3 Delivery of 7 day services

Delivery of 7 day services

We will continue to support the development and delivery of 7 day services in primary, community and acute services and by 2020 we will achieve:

1) Pre-bookable appointments to GP services in the evenings and at weekends
2) Arrange to see or speak to a GP or other health professional for clinical advice assessment or treatment through one call (NHS 111)
3) Receive the same high quality of assessment, diagnosis and treatment, any day of the week when admitted to hospital in an emergency

During the next 2 years the development of our primary care strategy and the mobilisation of a new integrated 111 service during 2017 will enable to support the delivery of 1 & 2 above.

We will continue to work with our providers to improve compliance against the 10 clinical standards by 2020. Frimley Health have submitted self-assessments against progress to NHSE of the 4 standards set out below:-

- Standard 2: Time to consultant review
- Standard 5: Diagnostics
- Standard 6: Consultant directed interventions
- Standard 8: On-going review in high dependency areas

We are working with the Trust following their recent case note review to agree a delivery plan for full compliance as they are not in the first wave of Trusts to roll out the seven day service initiatives. Compliance against standard 9 – transfer to community, primary or social care is being taken forward by our discharge programme of work which is detailed in the urgent care milestones. The other 5 standards will be subject to ongoing review with Frimley Health as our main acute provider and Berkshire Health Care Trust as our mental health provider in respect of standard 7, we will continue to work with our Trusts to implement all the standards by 2020.

The Thames Valley Urgent Care network is providing support to implement the priority clinical standards in vascular, stroke, major trauma, heart attack, and children's critical care across the network by Autumn 2017. For East Berkshire the stroke pathway has been redesigned with the support of the network and the London model of care will commence implementation from January 2017 and be fully in place by 1st May 2017.

Urgent and Emergency Care Milestones

2017/18			
Q1	**Q2**	**Q3**	**Q4**
NHS 111 Service launched GP Out of Hours Integration with NHS 111 in place Directly Bookable appointments available to GP OOH 7 day reporting, from acute and all short term services, into Alamac, numbers available in the system by 9am Monday Whole system flow, (includes all short term service e.g. reablement), measures identified and reported on Complete baseline which includes MADE audit across short term services re: activity at the weekend. Implementation of the Choice Policy Contract agreement for 18/19 Develop a whole system ambulatory emergency care (AEC) process and support pathway redesign Identify AEC conditions for implementation Engage with general practice and Community care providers to develop system wide standard referral methods New Stroke Service Q1 review	DOS Transformation Resource in Place General practice Model commissioning decisions Review systems contracts in light of NHS 111 activity. Review and simplification of current access criteria to short term services which embraces D2A and simplifies the system from the patients' perspective Multi agency Trusted Assessor / shared assessment across agencies – resulting in reduced OT assessments required to facilitate discharge; reduced 72hrs intervention logs completed in Wexham Support ACU Pathways and Processes across the unscheduled care system Support interdependent work streams e.g. integrated teams and community services Education and Training for Primary care and Community Care providers	OOH notice period commences OOH Procurement Decision DoS Change review point Sustainable increase in disciplines providing 7 day services within the hospital and short term services which results in completion of onward assessment and facilitates discharge	Directly Bookable appointments available to in Hours General practice DoS Change review point Complete follow up MADE audit to complement baseline which includes MADE audit across short term services re: activity at the weekend. Evaluation and business continuity plan

2018/19			
Q1	**Q2**	**Q3**	**Q4**
GP OOH Service Re-commissioning DoS Change review point NHS 111 Service Review	DoS Change review point	DoS Change review point	DoS Change review point

Urgent and Emergency Care Trajectories

Priority	**Forecast 16/17 outturn**	**March 2018**	**March 2019**
4 hour A and E standard (95%)	FHFT 95%	FHFT 95%	FHFT 95%
Reduction in the number of incidents Managed Without Need for Transport to A&E Departments"	SCAS 41.2%	SCAS 41.1%	SCAS 41%

6.4 Mental Health

Our strategy for mental health is to:

- Improve the physical health outcomes of people with mental health
- Provide opportunities for people with mental health to live and be treated in a safe environment as close to home as possible
- Ensure those in crisis receive the rapid support they need
- Support people with long term conditions and dementia
- Support people to maintain or secure employment
- Develop our joint commissioning capacity with local authorities
- Provide people with opportunities to be supported by their peers
- We will use an analytical framework for mental health services to inform future commissioning

Our focus will be on

- Improving response rates for those in a crisis
- Commissioning enhanced psychological support for people with long term conditions
- Reducing the number of care and treatment beds for people with a learning disability and out of area placements through the commissioning of care for people closer to home

The CCG is committed to transforming locally commissioned services, co-produced with people with lived experience of services, their families and carers, in order to ensure sustainability as well as delivering the key priorities outlined in the Five Year Forward View for Mental Health. Our work programme includes:

6.4.1 Evidence based mental health services for children and young people including community eating disorder teams

Our aim is to commission high quality evidence based mental and physical health services which are fully integrated, inclusive, accessible, timely, and responsive and informed by the needs expressed by children and young people. This aim is fully inclusive of services from routine, to urgent and specialist. A CAMHS Transformation Working Group meets monthly to ensure delivery of clearly defined objectives. The Group includes representation from all local area partners including patient/users, CCG, Local Authorities and providers and is accountable to a multi-agency Children's and Young Peoples' Transformation Board. The Plans developed by the Working Group are updated and published annually. The latest CAMHS Plan shortly to be published sets out a refreshed local vision, together with nine strategic performance indicators which run consistently across major work streams which include Early Prevention and Early Intervention, Targeted Support for Vulnerable Children including children with SEND and those in the Youth Justice System, Crisis Care, Specialist Care and NICE compliant Eating Disorder services, IAPT, workforce capacity and skill mix. Using a structured approach, the Working Group's review of population needs and service user feedback together with detailed CAMHS provider performance outcomes enables the Group to collaboratively identify any gaps in service and plan future commissioning in a timely way. The CCG has as part of its Children's and Young People's Transformation Plan is piloting a range of services across NHS, Local Authority and the voluntary sector that have been identified from the strategic priorities. This is with a view to delivering increased and earlier access to services for children and young people and their families. Over 2017/18 these will be evaluated and where successful will formally commission these. Our final plan is being revised to reflect feedback from stakeholders.

The CCGs have recurrently invested in a NICE compliant eating disorders service (see service specification at Appendix 26) to deliver the access standards of 1 week for urgent and 4 weeks for routine referrals. We will continue to review delivery of the service on a quarterly basis through our Quality & Performance schedule of the contract.

6.4.2 Child and Adolescent Mental Health Services

We are recurrently investing in CAMHS services in line with Parity of Esteem to increase capacity which has resulted in reduced waiting times. Our intention is to reduce waiting times further over the period of this plan.

6.4.3 Perinatal Mental Health

We have already commissioned community perinatal mental health service that will deliver a NICE compliant service from 1 April 2017. We were successful in securing funding for this from the Community Services Development Fund - the application setting out our plans is attached at Appendix 14. We will ensure that as part of this programme adequate training and development is in place.

6.4.4 Increasing access to psychological therapies

We are committed to increasing access to psychological therapies in line with the national ambition of 25% and integrating these with physical healthcare to support people with physical and mental health problems. We have been successful in attracting funding across the 3 CCGs from the Enhanced Access IAPT Early Implementer Programme which will set us in good stead for addressing the access and integration requirements for IAPT. The application for the Early Implementer Programme is attached at Appendix 15 and sets out the delivery programme which includes integration into primary care hubs, support to those with physical health issues and work with frequent attenders.

6.4.5 Early Intervention Service

The CCGs have invested recurrently under parity of esteem to commission a NICE compliant all age EIP service in order to meet the national access and waiting times standards, which launched in 2016. This is a multidisciplinary community mental health service that provides treatment and support to people experiencing or at high risk of developing psychosis and provides:

- Psychological therapy
- Support for families and carers
- Physical health
- Medicines management
- Education employment and training
- Crisis care

This service is currently delivering in the region of 80% of people experiencing a first episode of psychosis starting treatment within two weeks, so we are already achieving the access target and the extended target from 17/18. We will continue to monitor this service to ensure that it continues to deliver this level of response times and undertake the CCQI self-assessment to demonstrate a 'good' rating. The service specification for this service is at Appendix 25.

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6.4.6 Suicide prevention

The 3 CCGs collaborate with Berkshire Healthcare Foundation Trust, Unitary Authorities and other CCGs across the Berkshire footprint as part of the Suicide Prevention and Intervention Network. This is led by Public Health colleagues. A draft strategy is in place and will be agreed in early 2017 and is informed by the latest Public Health England guidance.

6.4.7 Crisis Care – Crisis Resolution, Home Treatment and Mental Health Liaison

The CCG already commissions a 24/7 Crisis Response Home Treatment Team (CRHTT) as an alternative to acute admissions. That team is currently piloting a number of alternative models for delivery including separating the home treatment and crisis functions of the service. These pilots will be evaluated alongside best practice in early 2017 with a view to re-designing the service to manage the volume of activity more effectively. The CCGs are also redesigning the urgent and emergency care pathways across CRHTT, community mental health teams and acute mental health inpatient services based on national best practice in order to ensure crisis support is appropriate and effective. We are committed to monitoring feedback and outcomes from these services. These services are currently supported by the Street Triage scheme which will be evaluated and recommissioned if the results are positive by July 2017.

The CCGs currently commission a core 24/7 service which works to the one hour response time. The current model is under review and we intend to bid for additional mental health liaison funding to ensure that this service is both robust and sustainable going forward.

6.4.8 Out of area placements (OAPs)

We will agree CCG/ Berkshire Healthcare Foundation Trust plan for reducing OAPs for non-specialist inpatient care ensuring people do not escalate into crisis and therefore requiring inpatient facilities. We will do this through reviewing our urgent and emergency care pathways to moderate the number of people from escalating to a point where they require an inpatient bed. This will include reviewing the model of existing inpatient care as well as CRHTT and CMHT provision. We will also look at alternative to admission provision based on national best practice.

6.4.9 Physical Health

We currently have the national CQuIN in place with Berkshire Healthcare Foundation Trust to deliver physical health checks for individuals with a serious mental illness (SMI) accessing early intervention in psychosis, inpatient and community mental health services. We will look to commission NICE-recommended screening and physical health interventions for those with a serious mental illness and reflect this in our general practice outcomes framework. Extended IAPT will link into our programme for integrated teams to provide those with long term conditions and more complex needs with access to psychological support. The CCG will also review mortality for those with a serious mental illness to identify areas of improvement across primary, secondary & mental health care.

6.4.10 Individual placement service (IPS)

We will use the national IPS baseline audit to develop plans for improving access to individual placement support for people with serious mental illness.

6.4.11 Dementia

The 3 CCGs have variable performance against the 67% dementia diagnosis target with Slough being the most challenged. Our strategy for increasing these rates and attaining the 67% diagnosis rate is to agree trajectories for diagnosis with action plan to support delivery (the action plans for Slough and Bracknell and Ascot CCGs are attached at Appendix 17), monthly monitoring and reporting of CCG diagnosis rates, inclusion of dementia in the General practice Outcomes Framework and annual monitoring of care plan reviews. In developing our programme on high BP detection , coupled with the NHS health checks programme the long term aim is to reduce the prevalence of vascular dementia in our communities.

The CCGs are committed to increasing the number of people being diagnosed with dementia and starting treatment within six weeks of referral. We intend to do this by identifying the current post diagnostic support across the three Unitary Authorities and jointly commission post diagnostic support to meet the existing gaps in services. We also aim to include referral to voluntary groups and lifestyle services to improve the course of the illness. End of life care for people with dementia is included as part of the end of life care business case.

6.4.12 Data Quality and Transparency and Digital Maturity

Our data quality improvement plan (DQIP) within the contract requires providers to submit information to the Mental Health Services Data Set (MHSDS) and will be regularly monitored through contract review. This will ensure our providers are submitting complete and accurate data for all mental health services but in particular:

- Increased Access to Psychological Therapies (IAPT)
- Child and Adolescent Mental Health Services (CAMHS)
- Community Eating Disorders
- Crisis Resolution and Home Treatment (CRHTT)
- Early Intervention in Psychosis (EiP)

Our Digital Roadmap (Appendix 23a) is underpinned by the Connected Care programme which has delivered a clinical portal in 16/17. This portal creates a holistic patient record with feeds from primary care, acute, community, mental health and social care.

Mental Health - Milestones

2017/18				2018/19			
Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
NICE concordat CYP community eating disorder service operational NICE concordat Perinatal mental health service 50% people experiencing first episode psychosis start treatment within 2 weeks with NICE recommended package of care Street triage evaluated and commissioning plans agreed Suicide prevention strategy agreed Dementia diagnosis rate of 67% achieved or exceeded			7% increase access to CYP services 19% IAPT access 53% people experiencing first episode psychosis start treatment within 2 weeks with NICE recommended package of care Reduced out of area placements for non-specialist acute care (10%) 30% of population on GP register with SMI accessing NICE recommended screening and physical interventions Delivery of access and waiting times for liaison services (1 hour)				32% of local CYP need met 22.5% IAPT access Suicides reduced by 10% Plan for improving access to IPS employment support for people with SMI across STP

Mental Health – Trajectories

Mental Health

Priority	Forecast 16/17 outturn	March 2018	March 2019
At least 19% of people with anxiety and depression can access psychological therapies and to be integrated with primary care	15.5%	16.8%	19%
32% of children with a diagnosable condition able to access services by April 2019	B&A 12.8% Slough 7.5% WAM 13.9%	B&A 30% Slough 30% WAM 30%	B&A 32% Slough 32% WAM 32%
More than 53% of people with the first experience of psychosis begin treatment within two weeks of referral	B&A 75% Slough 75% WAM 85%	B&A 75% Slough 75% WAM 60%	B&A 75% Slough 80% WAM 80%
95% of children and young people receive treatment within four weeks of referral to a community eating disorder team for routine cases	Data collection commenced with very small numbers	B&A 50% Slough 50% WAM 67%	B&A 80% Slough 80% WAM 75%
95% of children and young people receive treatment within one week of referral to a community eating disorder team for urgent cases	Data collection commenced with very small numbers	B&A 50% Slough 33% WAM 33%	B&A 67% Slough 50% WAM 50%
Reduce suicide rates by 10% against the 16/17 baseline	B&A 8.1 Slough 8.8 WAM 7.1 Taken from 2013-15 figures (16/17 not available)	We will work with our partners to agree trajectory	
24/7 access to community crisis resolution teams	Yes	Yes	Yes
24/7 access to home treatment teams	Yes	Yes	Yes
24/7 access to mental health liaison services in acute hospitals	Yes	Yes	Yes
Eliminate out of area placements for non-specialist acute care by 2020/21	Baseline and trajectories to be agreed		
Screening and physical health interventions to cover 30% of the population on a GP register with SMI and 60% by 18/19	Data not available until Q4 2016/17	30%	60%
Dementia	B&A 67% Slough 66.7% WAM 68%	B&A 68.8% Slough 68.1% WAM 70.1%	B&A 67.6% Slough 68.5% WAM 69.2%

6.5 Learning disability and autism

Our strategy for learning disability is in line with the national Transforming Care agenda and is to:

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

Our focus will be on

- Implementing our Transforming Care Plan.
- Reducing the number of care and treatment beds for people with a learning disability and out of area placements through the commissioning of care for people closer to home
- Reviewing and appraising the future model to deliver an attention deficit hyperactivity disorder (ADHD) service that meets the needs of the local population
- Improve access to healthcare for people with a learning disability and access to annual health checks
- Improve access to health services, education and training of staff and making necessary reasonable adjustments for people with a learning disability.

This programme of work is overseen by the Berkshire wide Transforming Care Partnership Board with representation from the Unitary Authorities and neighbouring CCGs. The complete programme of work can be seen in the Transforming Care Plan which can be found at Appendix 13.

6.5.1 We will regularly review local and out of area placements commissioned by the CCGs and NHS England specialist commissioning teams to ensure that individuals receive the right support as locally as possible

We will also identify future needs to ensure sustainable local provision for all ages.

6.5.2 Preventing hospital admissions and reducing the reliance on bed-based care, by commissioning an Intensive Support Team. The CCGs are developing risk registers in conjunction with the Unitary Authorities to monitor the risk of admission for people and to put in place measures to prevent admission. This process is supported by commissioner led Care and Treatment reviews which recommend placements or onward support, review the need for admission to an inpatient facility, timescales and arrangements for discharge and whether community services would be better placed to support the individual in the community. The Team will use the Positive Living Model to provide personalised, intensive intervention in the community. To complement this work, opportunities will be developed and improvements made to the forensic service pathways to minimise in-patient admissions and building additional capacity in short break/crisis intervention support and facilities. We will develop our coding and analysis of usage of secondary care by residents with a learning disability we aim to further understand the pattern of secondary care in this group, and its impact on health.

6.5.3 Strengthening the role of Primary Care to support health and wellbeing there will be an additional focus on working with GP colleagues to improve early identification of physical and mental health needs and will feature in the General Practice Outcomes Framework.

6.5.4 Improving care standards by enabling people and their families to have greater access to local care provision and support, the CCGs will shape the private provider workforce market by adopting the Commissioning Positive Behaviour Foundation standards and Quality of Life Standards to assess workforce provision. Identify

opportunities for providers to create support networks to maintain the health and wellbeing of their staff, assessments will include co-assessments led by experts by experience using the new Berkshire wide TCP Workforce Competency Framework.

6.5.5 Transition -There is a transition work stream of the Partnership Board which is working towards ensuring a smooth transition between child and adult services.

A multiagency mortality review is underway.

Learning Disability - Milestones

2017/18			
Q1	**Q2**	**Q3**	**Q4**
Reduced LD assessment and treatment beds (by 6) Joint commissioning arrangements in place and pooled budget opportunities expanded Agree joint commissioning standards for autism CCG commissioned out of area repatriation programme commences Intensive support team roll out General practice Outcomes Framework	Review of Children and young people in transition plans Reduce OOA placements to 25 Fully functioning intensive support team Campaign to promote STOMPwLD best practice guidelines	Reduce the number of separate funding streams that users have to access Training and support for health visitors, GPs, paeds, perinatal mental health and CPE on autism Finalise agreements for joint commissioning Reduce OOA placements to 20 Campaign to reduce inequalities in access to oral care	Increased health checks for those on LD Register Capacity and demand stocktake Increased access to pre-assessment specialist support for autism Reduce OOA placements to 18 Campaign to reduce inequalities in access to diabetes services

2018/19			
Q1	**Q2**	**Q3**	**Q4**
Identify opportunities for pooling commissioning resources across health and social care Introduce autism support navigators in health and education Campaign to reduce inequalities in access to nutrition, education and sport activities	Reduce out of area placements to 16 Campaign to promote access to cancer services	Increased access to ADS services for youth offending services Reduce OOA placements to 14	Reduce OOA placements to 12

Learning disability – Trajectories

Priority	Forecast 16/17 outturn	March 2018	March 2019
Reduce inpatient bed capacity to 10-15 in CCG commissioned beds per million patients by March 19	28	18	12
75% or people with a learning disability on a GP register receive an annual health check by 2020	45%	60%	75%

6.6 Integrated care

Our Strategy for integrated care is to:

- Reflect our New Vision of Care Programme through all of our commissioning activities
- Work with the public and a range of partners from all sectors including primary care, social care, and the third sector to create a fully integrated system delivering new care models
- Use shared care records and the recently commissioned interoperability solution
- Develop joint commissioning arrangements, pooled budgets and common care principles across the STP footprint to accelerate the opportunities for integrated care delivery
- Work closely with our partners to proactively identify and support people with complex needs and those who are frail to live independently for as long as possible
- Work to realise the vision for general practice as central to the development of local integrated clusters/hubs
- Work with partners and the public to improve the way that we commission wellbeing and preventative services

Our focus will be on:

- Extending the CCGs personal health budgets offer, focussing initially on people with a learning disability
- Improving care for people approaching the end of their lives
- People who are at risk of or in an early stage of frailty and giving them access to proactive help, with one person known to them co-ordinating their support
- Community capacity and sustainability, in particular, support to care homes and carers, with local authority colleagues
- Expanding the use of social prescribing, care navigators and Healthmakers
- Further support residents in the community using assistive technology, digital technology and equipment, building on existing schemes

6.6.1 Integrated Care Development

As a system the STP provides an overall framework for local integration plans with a focus primarily on function over form. We acknowledge that integration should always be population oriented and person centred and judged based on the outcomes it achieves. Our New Vision of Care Programme continues as the ideological framework within which we will work together to improve outcomes for our residents and this has informed the development of the integrated care decision making hubs workstream of the STP which will in turn inform local delivery.

In line with our local priorities set out earlier in the plan and in the context of the vision of the Frimley Health and Care STP, Windsor, Ascot and Maidenhead, Bracknell and Ascot and Slough CCGs are working in partnership with Slough Borough Council, the Royal Borough of Windsor and Maidenhead and Bracknell Forest Borough Council to deliver plans to integrate health and social care services which improve the lives of the local people. These plans will build on the progress we have made through the Better Care Fund, will cover at least the five following areas: Assessment, Commissioning, Provision, Support services and Governance.

We have already agreed on 6 joint roles/shared functions across health and social care, and are in the process of recruiting to a joint Integrated Care post that will work lead this work on behalf of the system.

Areas already agreed	Context	Opportunity
Integrated Health and Social Care – leadership	Requirement to develop local integrated care plans March 17 Lack of a cohesive vision for integration across health and social care Fragmented approach which is inefficient and suboptimal impact	Shared plans which articulate the core characteristics of an integrated health and social care system. Embedding NVoC as the overarching vision for East Berkshire Improved outcomes and better use of resources
Direct Payments / Personal Health Budgets	Challenges to health to deliver Experience and infrastructure in Local Authorities Joint complex care packages Improving choices and outcomes	Shared system for administering and supporting individuals Reduced costs Consistency
Care Homes (quality/fees & pricing)	Consistency in care quality Gaps in market Variation in fees	Joint commissioning/ contracting Market management Collective management of increasing pressure in the marketplace
Mental Health	Shared provider Demand and capacity pressures	Holistic personal approach for physical and mental health Integrated assessment of needs Integrated approach to supporting those with chaotic lives
Placement procurement	Multiple interfaces with providers Inconsistency of oversight of placements and reviews Variation in fees High numbers of people placed out of area	A co-ordinated person centred approach to the procurement of placements Opportunity to include gain share arrangements.
Section 117	Fragmented organisational level commissioning of section 117 placements	A shared understanding of the funding needs of individuals health and care needs

We are committed to including our patients, residents, provider partners and the third sector to develop and embed a contemporary and effective integration plan founded on an asset based approach to communities. Our plan will aim to secure the greatest opportunity for local residents to be in control of their own lives and the future of their local care services.

6.6.2 Complex Case management

Our programme of work to support those who are the most frail and suffering from complex conditions is a priority. It is being delivered through close working with our unitary authority colleagues and partners across the STP footprint the vision created by partners and local people under the New Vision of Care. This work is aligned to the STP Integrated Decision Making Hub workstream.

Key elements of this programme of work are to develop a population based frailty tool to identify people at risk of frailty, advanced care plans to support pro-active care, jointly commissioned integrated care hubs to coordinate delivery of care, commissioning of preventative services to maintain independence eg social prescribing and telehealth and telecare available to support care at home. We will underpin this by a population based approach to identifying future need and providing alternatives to hospital care, delivering infrastructure through the digital roadmap, workforce planning to ensure capacity and capability, pooling of budgets above and beyond Better Care Funds and a market analysis of capacity to support increasingly frail population. Our analysis will be supported working with our Connected Care partners. Access to detailed coded GP records will be actively offered to patients who would benefit and where it supports their active management of a long term or complex condition.

6.6.3 Personal Health budgets

We have a working party across the three CCGs and UAs to develop a co-ordinated approach to the delivery of personal health budgets. In the coming months we will set up our model in partnership with the UAs and move towards a phased implementation towards the goal of 0.2% of population coverage.

6.6.4 End of Life Care

Supporting people approaching the end of their lives is an important aspect of our integrated care programme. The main elements of this workstream are: commissioning an integrated team with 24/7 support line and response service, inclusion of end of life care in our general practice outcomes framework, migrating the end of life care register to the digital road map solution and increased hospice capacity and integrated community response. End of life care will be taken into account in our priority pathway re-designs (CVD, dementia, respiratory and neurology) as outlined in the business case. Further detail can be found in the end of life care business case at Appendix 18. All patients at end of life will able to express their preferences to their GP and know that this will be available to those involved in their care through the electronic sharing of this information.

6.6.5 Carers

An east of Berkshire working group is now established between CCG leads and local authority leads to take forward an opportunity to work collaboratively on shared activities to identify, recognise and support carers. Following publication of *'integrated approach to identifying and assessing carer health and wellbeing'* each area is taking forward the proposed memorandum of understanding to be jointly agreed between all partners within East Berks wellbeing boards in support and understanding of shared duties towards carers. The working group has Terms of Reference established and provisionally three key priority areas identified (acute, GP and primary care, young carers) but also looking to include community and MH in scope.

There is engagement and discussion with members of the Patient Panel on a proposal to co-design and deliver a project to support identification and support in GP practices and primary care. This will be through benchmarking current support provided by GPs, seek out good practice examples, find out how GPs can be better supported (e.g through interest and commitment to social prescription) and raising awareness of carer contribution.

6.6.6 Better Care Funds

All three CCGs are committed to continue the progress already made through the Better Care Funds supported by the existing governance arrangements. We will also work together to share good practice and progress areas jointly where we can have greater impact by working together. Key areas of focus for each of the Better Care Funds are: care homes, intermediate care, carers, equipment/ assistive technology/ telecare, falls prevention and social prescribing.

Milestones

2017/18				**2018/19**			
Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Frailty model agreed Framework for social prescribing established General practice Outcomes Framework in place Integrated team with 24/7 line in place CCG offer of personal health budgets published for first cohort	First integrated hub in place		% of people dying in their place of choice is on track to reach national average	Social prescribing adopted by all practices with full offer All integrated hubs established			All frail people with care plan and support in place 100% of people identified as being in last year of life, have a care plan which reflects their needs and wants and is shared with those who need to know 0.2% population offered PHBs

6.7 Services for children and women

Our strategy for children's and women's services is aligned to the delivery of the Children's and Young Peoples and Better Births Plans.

Our focus will be commissioning NICE compliant services, providing children and young people with faster access to mental health services, ensuring the CCGs meeting their obligations for children with special educational needs and disabilities and developing our Better Births Plan.

Our Health and Wellbeing Boards focus on whole populations which include children. Through our integrated care programme we will be progressing areas such as end of life care, support to young carers and reducing avoidable admissions of 0-5 year olds.

A commissioner and provider working group has been convened to commence in January 2017 when the new head of midwifery takes up post. This forum will enable an overview of progress and sharing of best practice ensuring the 3 CCGs meet the requirements set out in Better Births within the stipulated timescales. A service user forum has already been established and will feed into the Working Group. The CCG has reviewed the requirements set out in Better Births and will be working collaboratively with all Local Area partners to fulfil its responsibilities. Frimley Health has also reviewed its current service in line with Better Births and identified required actions. The January 2017 meeting agenda will establish a terms of reference and include data and outcome measures, protocols and shared care pathways for smooth transition between midwifery, obstetrics and neonatal from GPs and HVs as well as transition to and from specialist services and the saving babies lives care bundle using the latest available data.

Slough and WAM CCGs are significantly higher than Bracknell for the rate of stillbirths and deaths within 28 days of birth. Further audit and review is planned to establish whether there are any characteristics that could steer public health or other interventions aimed at reducing the rate. In Slough we will be working to improve reported patient experience of maternity services.

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6.8 Prevention

6.8.1 Evidence base for prevention

Whilst the general health status of the population across BACCG and WAMCCG is good, Slough CCG and wards within the aforementioned CCGs show poorer outcomes and that progress can be made. One of the key duties of the CCGs is to tackle this inequality. Therefore in the prevention work stream we are focussing on the lifestyle factors identified through the National Audit Office report that contribute to both general improvement in health and also inequalities:

Tobacco Alcohol High BP Obesity Physical Activity

We have also included physical activity as there is increased evidence to show the independent positive impact increasing physical activity can have on the community and individual risk , and physical inactivity is more common in deprived communities (Slough has significantly low levels of physical activity).

In identifying projects for this plan we have focussed on those areas that build on established programmes (e.g our tobacco cessation services that show the highest quit rates in the South East) but target work to release savings in the short and medium term for the system. The work is based on the Public Health England evidence base produced for the STPs. This Operational plan sits alongside the UA public health initiatives working with communities.

6.8.2 Key priorities

This workstream is aligned to the STP prevention programme and the local operational plans reflect priorities that tackle the causes of inequalities in our communities. The Frimley Health populations benchmark well against England average for public health outcomes.

The priority for prevention is articulated as making a substantial step change to improve wellbeing, increase prevention, self-care and early detection. The overall objectives identify two key enablers to drive programmes that maximise lifestyle behaviour change:

- engaging with health and care staff, improving employee health but maximising the 'teaching moment' of care delivery to nudge lifestyle choices 'Making Every Contact Count'
- Industrialising our use of digital approaches, linking with the Connected Care programme , to improve knowledge on lifestyles, signposting to services and supporting / coaching lifestyle changes as part of received care

These benefit from a STP approach and will drive delivery in our lifestyle areas. The staff programme will also drive stretch improvement in NHS employee health, building on the national CQUIN initiatives, improving staff indicators and will link with Academic Health Science Network and Health Education England programmes to engage with other major employers to maximise employee health.

6.8.3 Physical inactivity

The aim of the STP plan is to reduce levels of physical inactivity across the footprint to 20%

LA	Percentage inactive[1]	Total adult pop (over 18)	Number inactive	To reduce to 20%	% reduction
Bracknell Forest	20.3%	90,824	18,437	272	0.3%
Slough	31.1%	105,173	32,709	11,674	11.1%
RBWM	22.3%	113,962	25,414	2,621	2.3%
Berkshire East Total	**%**	**367,300**	**76,560**	**18,631**	**4.7%**

Across the STP geography the plan is to develop digital approaches to encourage physical activity in the community. The programme will develop sign posting and coaching approaches to residents, linking with the wide range of opportunities to be active in each community and maximising use of Public Health England programmes such as One You.

[1] Public Health Outcomes Framework - August 2016

In the workplace we will support staff through a number of initiatives working with our community sports partnership organisations to increase their physical activity levels, working as part of AHSN workplace network.

As part of clinical care we will initially focus on cancer and CVD pathways to increase awareness and patient activation in physical activity since these are significant causes of early mortality and hospital usage. The evidence that physical activity can improve outcomes in secondary prevention is strong.

Public Health also supports Sport in Mind with Berkshire Healthcare Foundation Trust to run activity programmes for patients with mental illness. This offers a wide range of activities to encourage physical activity and also then to introduce patients to ongoing local sports clubs. This programme will continue to be supported to address the significant difference in life expectancy in our residents with Sever and enduring mental illness (SEMI). We will monitor the percentage of patients accessing and participating in increased activity by condition and practice.

6.8.4 Tobacco

Across the STP footprint work is planned to maximise the stop smoking opportunities when patients have elective surgery and a focus on maternity services in support of the drive to improve neonatal outcomes in year 2. This investment would see a new enhanced programme run in conjunction with surgical departments within hospitals and general practice to contact and support all surgical elective admissions to stop smoking. Whilst not a mandatory approach this will very actively encourage people to give up smoking even if only for the month before their procedure. Within each UA area within East Berkshire work continues to reduce smoking prevalence, (Slough 18.3 %, Bracknell 16.7 % Windsor 13%), however with reducing available resources in some areas there is more targeting of the service to deprived communities.

Work will increase with NHS providers to support the implementation of the smoking CQUIN and also to ensure all settings are smoke free

We will continue to support BHFT to be a smoke free Trust to address the smoking prevalence in those with a serious mental illness. Improving the rates of physical checks to patients with SEMI will also offer more opportunities for smoking cessation advice to be given.

We will monitor referrals to smoking cessation services and quit rates by practice and CCG and the average length of stay for smokers undergoing elective surgery.

6.8.5 Hypertension and Atrial Fibrillation

The evidence is clear that early detection of high blood pressure and management according to guidelines will improve outcomes and reduce costs: the national cost of hypertension is £2 billion. Within East Berkshire treatment of high BP is good and matches best practice. The recorded prevalence of hypertension in East Berkshire CCG's for 2014/15 are all significantly lower than the England average of 13.8%, below the levels in comparator CCGs and significantly below the modeled prevalence that should be seen. The recorded prevalence for hypertension across Frimley Health STP was 12.0% in the 2014/15 QOF, with 91,046 people recorded as having hypertension. The estimated prevalence for hypertension in the area was 22.0%, which means that there were 76,091 people "missing" from the GP registers in 2014/15.

The plan over the next two years is to pilot and then implement approaches to improve detection of unknown hypertension in the community whilst balancing the workload in general practice. This plan would work in conjunction with the UA based NHS health checks programmes to ensure that there is alignment between these plans. Investment in this programme costs will be mainly prescribing however we will supplement drug therapy with initial lifestyle programmes linking into digital approach to improve exercise and weight. The next stage of this work will be to improve the detection of atrial fibrillation in the community.

6.8.6 Alcohol

In 2012-14, 153 people died from alcohol-specific conditions in the Frimley Heath STP footprint. 75% of these were men. The rate of deaths per 100,000 population varied in the area from 6.4 per 100,000 population in Bracknell & Ascot CCG to 10.1 per 100,000 in NE Hampshire & Farnham CCG.

The impact of alcohol is seen across a range of diseases, health and social settings. Using PHE and NICE modelling two approaches show significant impact in the short and medium term on hospital impact and levels of drinking in the community.

Alcohol care teams: In the coming year the aim is to roll out the model of care in Frimley South implemented in 15/16, targeting those whose alcohol use impacts most heavily on services. The approach involves: improving staff awareness of alcohol-related ill health in hospitals and providing specialist care to alcohol misusing patients, through case identification and brief advice, comprehensive alcohol use assessments, care planning, delivering medically assisted alcohol withdrawal management and psychotherapeutic interventions and plan safe, accelerated discharge and continued alcohol treatment in community services.

We will also improve the scope and impact of brief intervention in the community. The approach seeks to achieve this by tackling the poor understanding of alcohol-related health risks amongst patients and professionals through training of healthcare staff in e.g. General Practice, increasing screening of patients (using Audit-C scratch cards), providing simple brief advice on alcohol consumption to cover potential harm and strategies to reduce alcohol intake and where relevant referral for specialist treatment. We are seeking to reduce the number and length of stay for alcohol related admissions.

6.8.7 Obesity and over weight

The Global Burden of Disease (2013) shows that 9.0% of all deaths in South East England were attributable to a high body-mass index. This was the 3rd highest attributable risk, behind smoking and high blood pressure. NICE (2014) guidelines state that obesity prevalence increases with greater levels of deprivation for women, regardless of the measure used

The National Obesity model shows the medium and longer terms savings achieved through reduction in community obesity levels (which is the aim of the existing obesity management services commissioned by the UAs). The aim of this additional initiative is to expand the existing tier 2 services to focus on patients who are obese and have an existing known long term condition, to maximise the impact of this approach in the short to medium term. The approach would identify NHS patients with BMI of over 30 / 35 and support weight reduction. The service would target patients from GP lists with chronic respiratory conditions, serious mental illness and cardiac disease. The STP will also focus on developing the provision of digital information and support and coaching. Our aim is to reduce weight in participant, increase the numbers referred and participating in weight management programme from key long term conditions by practice and reduce prescribing costs in patients achieving weight loss.

6.8.8 Diabetes

The 3 CCGs have started the implementation of the national diabetes prevention programme. The programme is utilising text messages to recruit patients. We have identified and invited 1059 eligible patients to the ‘Healthier You’ programme. Out of the 1059 eligible patients, 286 have contacted Reed Momenta across East Berkshire to date. In Slough, all practices have consented on the I-Plato portal this approach is set up to continue across the remainder of East Berkshire.

6.8.9 Ongoing programmes

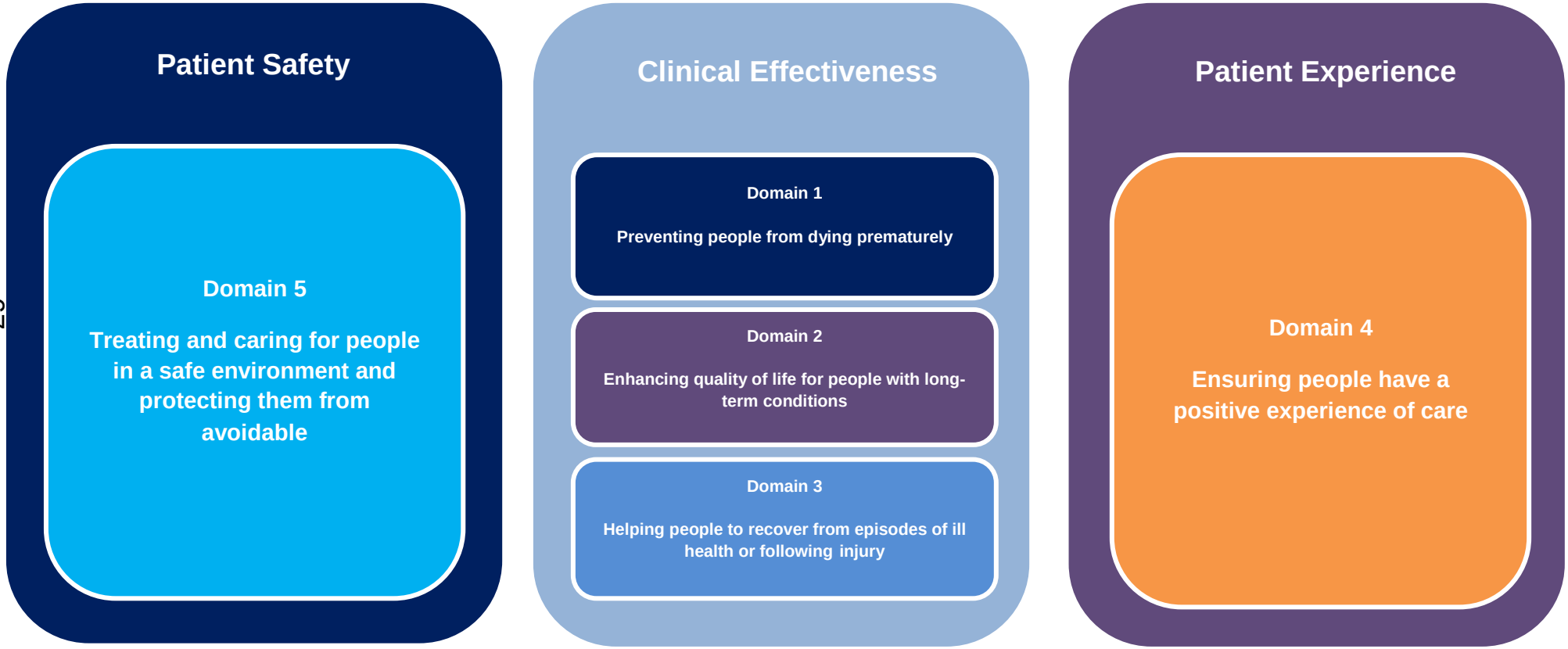
There is on an ongoing robust work plan to increase immunisation in both adults and children. The CCGs are members of the immunisation working group, flu resilience group and health protection committee to work in partnership with the main commissioner (NHSE) to increase immunisation rates. New posts that support communities with historic low uptake of childhood immunisations have developed new approaches and during the coming year we will work with NHSE to ensure that the transfer of CHIS occurs smoothly with minimum disruption to immunisations performance. In the adult programme we continue to support NHS organisations to hit their staff targets and develop new approaches to at risk groups to ensure high and consistent uptake.

Milestones

Year	17/18 Q1 – 2	Q3 - 4	18/19 q1 – 2	Q3-4
Physical activity	Digital –design application with staff to test impact, usability and link to care record Workplace - support GBA workplace challenge across Berkshire to increase physical activity	Implement pilot Implement new web based tools to support SME employers with GBA	Test patient care record link	Rollout patient record link for lifestyle advice
Tobacco	Implement tobacco cessation enhanced programme in elective surgery	Address staff knowledge and likelihood to address patient smoking behaviours Making Every Contact Count (MECC)	Continue work to ensure NHS sites smoke free : increase support in maternity departments	Ongoing work with UAs to minimise illegal product and underage
Hypertension	Design and pilot programmes to detect hypertension in the practices and community	Implement approach across practices and communities with lowest detection	Implement approach across all practices and communities	Review and adjust approaches
Obesity	Design and pilot a targeted obesity service addressing LTC patients from practice registers	Roll out the programme in key wards and practices with highest prevalence of obese and overweight patients	Coverage of programme across CCGs	Coverage of programme across CCGs
Alcohol	Increase staff knowledge and skills in Alcohol impact Design and implement alcohol care teams in Wexham site building on Frimley South pilot	Design brief intervention approach in NHS settings : pilot in acute and primary care	Roll out BIA programme across setting	Roll out BIA programme across setting
Diabetes	Slough CCG upload to be complete at end of 16/17. A further 20/33 practices in WAMCCG and BACCG to upload through the IPLATO system for the NDPP	Remaining 13/33 to upload to NDPP in WAMCGG and BACCG. Pending successful NHSE funding bid to start the upload to invite patients diagnosed with diabetes to an integrated structured education programme	Evaluation of year 1 NDPP (led by Newcastle, Durham and Cambridge Universities). Culturally appropriate structured diabetes education in place and uptake exceeds national rates for T2DM and T1DM	Evaluation of structured education programme if funded by NHSE.

7. Improving quality in organisations

The CCG has a Quality Strategy which covers the time period from 2014-2017 this is to be refreshed to reflect the changes across health and social care. This sets out how the CCG will work collaboratively to endeavour to ensure high quality, safe care is provided across all commissioned services and that patients and their carers experience is good from the services they receive. The model below illustrates the three components of quality and when quality is discussed throughout the document each of the 3 areas are considered.



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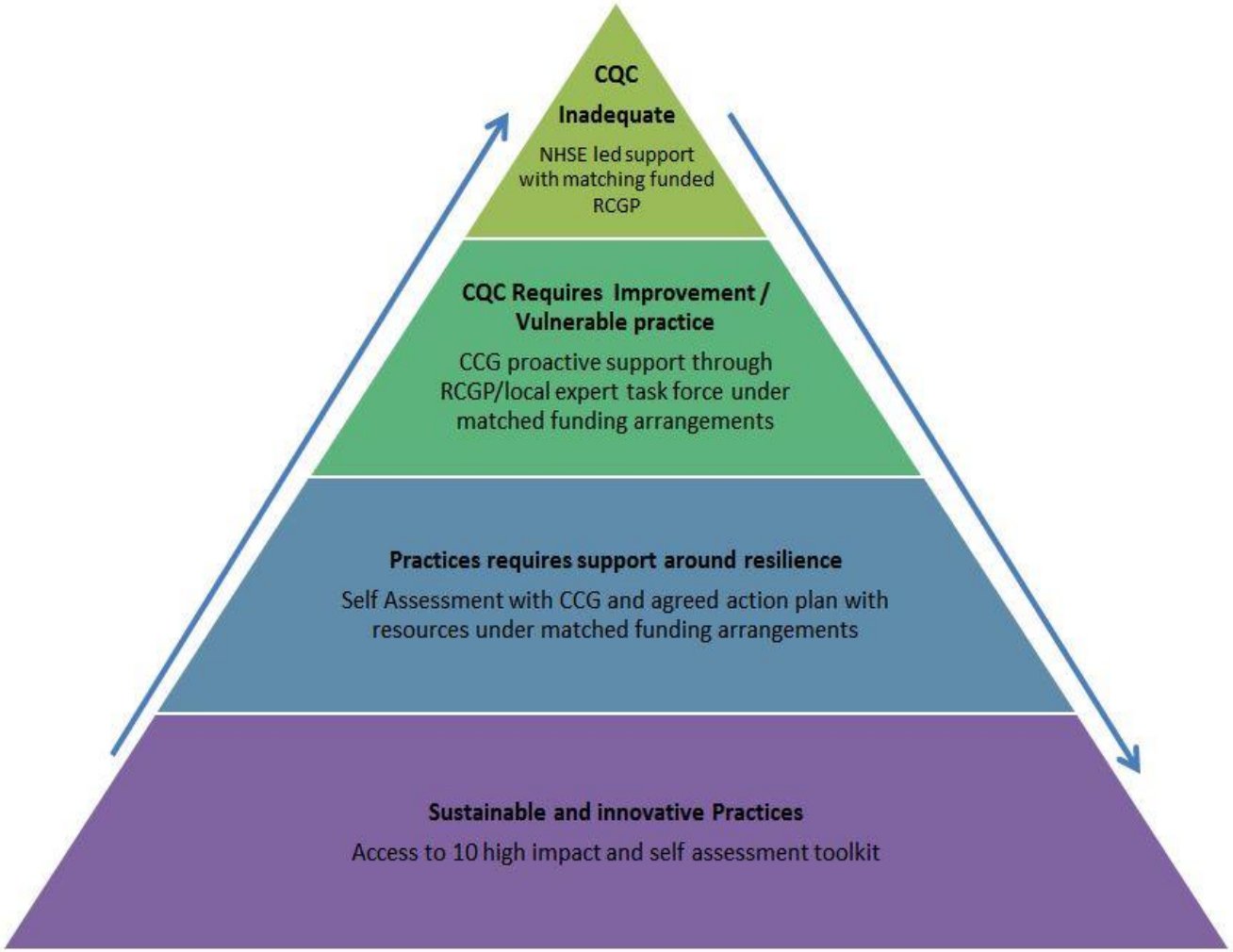
7.1 Sign up to Safety

The CCGs are committed to action the five Sign up to Safety pledges that it has agree from a Commissioners perspective. The CCG is making a commitment to bringing them to life. The commitments can be found on the CCG website.

7.2 Developments and improvements in quality for general practice

The CCGs have been working with NHSE on the quality of general practice through Co-commissioning and the move to delegation. From April 2017 there will be a Quality Memorandum of understanding for Quality with NHSE. There is a monthly Quality Improvement Meeting for general practice. This meeting focuses on Quality issues and ways for improvement using local intelligence and relationships. The Quality Team will use the Quality data base that includes Patient experience (FFT, complaints and NHS Choices), incidents, safeguarding and CQC compliance to be able to identify vulnerable practices. A dashboard will also be available. This is part of the vulnerable GP practices and resilience scheme. The practices will be offered an observational visit using a diagnostic framework which has been developed. The majority of the Practices have been rated as good by the Care Quality Commission but those rated as inadequate or require improvement will be supported by the CCG to ensure that they are then rated as good following their follow up 6 month inspection by Care Quality Commission. The Infection Prevention Control Nurse works with practices where their patient has had a MRSA bacteraemia or Clostridium Difficile infection. They also have quarterly meetings with the practice leads and the nurse also works with practices to ensure good infection prevention and control following practice visits. Practices are gives a compliance rating. The CCG has developed an incident reporting system for practices. Patient safety incidents will be uploaded to the National Reporting and Learning System. Training will be rolled out in 2017 with the ambition that practices will report more incidents through this system than they currently do through the NHSE e-form.



7.3 Infection prevention and control

7.3.1 Antimicrobial prescribing and resistance rates

The Infection Prevention Control Nurse (IPCN) medicine optimisation and public health team are working collaboratively on the antimicrobial prescribing and resistance rates. This is included in the CQUINS and Quality Premium for 2017-19.

All NHS Standard Quality schedules have an ambition for effective antibiotic use this will be monitored through CQRM and individual improvement plans as necessary.

Sepsis is also included in the 2017-19 CQUINS to carry on the work from 2016 and implementation of the July 2016 NICE guidelines.

7.3.2 Post infection reviews

There is engagement and support at Provider Root Cause Analysis & Post Infection Review meetings including General practice to investigate local Healthcare acquired infections. Local Root Cause Analysis & Post Infection Review meetings are organised for *Clostridium difficile* & MRSA which are allocated to general practice. The review ensures working together with colleagues to identify any area for learning about *C. diff* & MRSA cases and taking forward recommendations across the health economy e.g. awareness and compliance with antibiotic prescribing guidelines. In 2017 we will explore having the post reviews across the health economy for wider learning.

7.3.3 Other infection prevention and control work

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During the flu season the CCGs work with NHSE, PH and local providers to have a level of assurance that there is a good uptake of the flu vaccine with the at risk groups. Planning for the campaign starts with a workshop in July to evaluate the previous year's campaign and plan for that year, a monthly assurance meeting is held throughout the season to identify any local areas of concern.

Slough CCG has a high level of Tuberculosis (TB) and has been awarded some money from PHE and NHSE to increase the screening of people for Latent TB infection. This work supports the national Collaborative Tuberculosis Strategy for England 2015-2020. The initiative involves General Practice identifying people who have come to Slough from a high risk country. The screening is then carried out by the Frimley Health TB service. At present we do not know whether funding will continue for 2017/18.

7.4 Avoidable deaths

The CCG has set up a multi-provider mortality review group Chaired by the CCG Medical Director. The first priority will be to review the identified cohort of 11patients with Learning Disabilities that were identified by BHFT in response to the Mazars review of Southern Health. Once this is complete there will be a regular Mortality review for all providers to bring cases that they believe extend across other providers, this will not replace existing internal provider mortality review arrangements. This will ensure that there is learning shared across providers.

Malnutrition and dehydration has substantial effects on health across the community and acute setting, with better nutritional care this can reduce complications and length of stay in hospital and mortality rates. NHSE has published its guidance on Commissioning Excellent Nutrition and hydration 201-2018 with key outcomes. The Quality and Nursing Directorate will work together to identify how these key outcomes can be delivered.

The CCG is involved in the review the root cause/harm analysis of 62 and 104 day Cancer ensuring that improvement plans for any failing tumour groups reflect the findings.

Commissioners also hold monthly Serious Incident Panels at which all serious incident investigation reports are scrutinised and signed-off. This involves the agreement and monitoring of action plans for each case, along with thematic reviews and overarching action plans where required. The CCG process was audited by internal audit in 2016 the audit did not identify any gaps or risks. Where there are themes being identified a comprehensive improvement plan is developed and monitored by the provider at the panel or the CQRM, for example pressure ulcers and falls. Learning is shared with other providers if appropriate and agreed by the provider. In 2017 the CCG Quality team will explore with providers whether they would support a serious incident summit to share learning. An example of where learning from a serious incident is improving practice is where a patient with learning disabilities did not have their needs met and areas where care could have been improved will feed in to the learning disability work. The CCG has also been supporting NHSE with a multiagency serious incident and presented this at the NHSE Serious incident event in November as a model of good practice.

For BHFT unexpected deaths are reported as Serious Incidents, for people that have come in contact with their services as per National guidance and are discussed with the commissioner. These discussions are documented at the serious incident panel meeting. If the coroner confirms natural causes, the incident is then downgraded. BHFT are already hitting the targets for early intervention in psychosis which will be mandatory from 2017 and are taking part in a stretch programme in this area. The CCG had commissioned a review around life expectancy data for people with SMI; the CCG is working with BHFT and public health on the next steps. BHFT have are implementing a plan to help reduce the suicide rates of people known to their mental health services, this involves working on risk assessments and reviewing, monitoring action and improvement plans following serious incidents.

7.5 Maternity assessment of performance

For Frimley Health we receive monthly submissions of maternity clinical quality dashboards covering both maternity units. The content of these dashboards is now standardised across the maternity network. These indicators will be monitored against agreed performance thresholds, with improvement trajectories and action plans set out where required. Frimley Health have a Maternity Action plan for the National maternity review 'Better Births' Improving outcomes of maternity services in England A Five Year Forward View for maternity care. From a quality perspective this action plan will be regularly reviewed at the CQRM to ensure that the improvements are being met.

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7.6 Quality in action

7.6.1 Quality schedule monitoring –The CCGs works collaboratively with its Providers to agree a range of Quality Indicators both nationally mandated and locally developed to track quality performance and patient safety based on concerns, national initiatives or poor performance to build comprehensive Quality Schedules. Regular monitoring of such indicators occurs at Provider Clinical Quality Review Meetings (CQRM's) and CCG Quality and Constitutional Standards Committee. Contract Performance Notice can be raised where performance is deemed unsatisfactory. These are published if raised against one of the Constitutional Standards.

7.6.2 Care pathway/service redesign - The Quality team are involved in the development of care pathway/service redesign and sign off of the business cases to ensure that all elements of quality have been considered for example, end of life, general practice transformation, diabetes.

7.6.3 Patient safety incidents - The CCG encourages Providers to increase reporting of patient safety incidents. This is tracked and monitored via the CQRM's. The CCG chairs monthly Serious Incident Panels with Providers to review serious incidents resulting in harm and Never events, review and approve action plans, share learning and agree to changes in clinical practice.

The CCG is working collaboratively with the NHS England to improve reporting of patient safety incidents in General practice and the development by the CCG of the local General practice risk management system.

7.6.4 Clinical concerns

The CCG actively encourages GP's reporting of clinical concerns regarding Providers, this supports early identification of themes and trends. The concerns are then raised with Providers and where appropriate actions identified. These concerns are collated on a database and themes identified and supporting other quality intelligence. These themes can then be raised through the CQRM for a deeper analysis of the issue. Examples of this are concerns about discharges and this was a CQUIN for 2016/17 and will continue as a national CQUIN for 2017/19 and E-Referrals which again is a national CQUIN. The CCG is looking at ways that providers could also raise a concern.

7.6.5 Patient experience

The CCG aims to measurably reduce examples of poor patient experience, both within and outside of the hospital settings, utilising tools such as the Friends and Family Test, complaints safeguarding alerts and other patient and carer feedback. The CCG works with Providers including general practice to ensure that they have a robust complaints system in place using the NHSE Assurance of good complaints handling toolkits. Complaints are monitored as part of the Quality monitoring of the CCG. In 2017-19 the Quality team and lay members will undertake themed assurance visits across clinical pathways and organisations for example End of life care. The CCG will continue to monitor implementation of Providers Duty of Candour with moderate and serious harm incidents.

The CCG also monitors provider patient experience through the CQRM by having a quarterly patient experience report that includes, complaints with themes by Specialty and actions arising, FFT outcomes, PALS, NHS Choices summary and 'you said we did'. This is robustly scrutinised by the CCG to ensure learning and improvement in experience of patients. **Friends & Family Test** – CCG monitors FFT on a quarterly basis via review of nationally published data. A collated summary report of Provider patient experience including CCG PALS and complaints is presented at CCG Quality and Constitutional Standards Committee in order to review Provider performance. Each Provider presents a patient story quarterly to the CQRM and what lessons were learnt. Patient stories are an agenda item for the CCG Quality and Constitutional Standards Committee. There is a balance at both the CQRMs and the CCG Quality Committee between positive and negative patient stories.

7.6.6 Risks

Risks are identified through Quality monitoring, patient experience and clinical effectiveness. The risks are recorded on the Quality and Constitutional standards and Quality Primary Care Improvement Group risk registers. The risks are reviewed regularly at the Quality and Constitutional Standards Committee. For risks identified as high risk to the organisation will be escalated to the corporate risk register.

7.7 Equality and diversity

The CCG is committed to equality of opportunity for all people and to eliminating unlawful discrimination. We recognise and value the diversity of the local communities and believe that equality is central to the commissioning of modern, high quality health services, particularly in relation to the protected characteristics as set out by the Equality Act 2010. We will set our objectives through patient and staff consultation. This means that:

- We will take account of the diversity of the population we serve, and the potential barriers some people face when accessing health services and how we can work to reduce these
- We will tackle health inequalities and ensure there are no barriers to health and wellbeing. We will ensure our health providers also meet the legal requirements around equality and human rights
- We will strive to ensure that patient's rights are upheld so that they can expect the care and treatment they receive to be provided in an environment that is free from unlawful discrimination
- We will use the Equality Delivery System (EDS) as a framework for assessing our Equality and Human Rights performance
- We will seek to engage with the public, stakeholders and employees to enable them to base their policies/commissioning on evidence rather than assumptions

7.8 Nursing vision

The Nursing Vision will need to link in with the STP and New Vision of Care. The vision work stream brings nurses together from across the health economy; acute BHFT and FH as well as Care homes, primary care and the independent providers. Following the Nursing Conference in September 2016 a number of key areas of work will be identified during a meeting in November 2016. A quarterly newsletter is produced to share best practice and innovative ideas across the Health economy. It is also a forum for sharing skills and knowledge.

7.9 Safeguarding of vulnerable people

The CCG recognises and works to the NHS Commissioning Board revised Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework July 2015. This framework details CCG statutory responsibilities for safeguarding vulnerable people which includes ensuring that the organisations from which they commission services provide a safe system that safeguards children and adults at risk of abuse or neglect. The framework was primarily revised to recognise new responsibilities of all statutory organisations under the Care Act 2014. Additionally, general practice co-commissioning arrangements between CCGs and NHS England will have implications for safeguarding responsibilities; progress against the framework is identified within the action plan detailed below:-

The framework includes specific responsibilities for looked after children and for supporting the Child Death Overview process. CCGs have a statutory duty to be members of Local Safeguarding Children Boards (LSCBs) and, from April 2015 (Care Act 2014), local Safeguarding Adults Boards (SABs), working in partnership with local authorities to fulfil their safeguarding responsibilities.

The CCG ensures that robust processes are in place to learn lessons from cases where children or adults die or are seriously harmed and abuse or neglect is suspected. This includes contributing fully to Serious Case Reviews (SCRs) which are commissioned by LSCBs/SABs and also, where appropriate, conducting individual management reviews.

The CCGs' designated clinical experts (children and adults) are embedded in the clinical decision making of the organisation, with the authority to work within local health economies to influence local thinking and practice. They are able to give clinical advice, for example in complex cases or where there is dispute between practitioners.

The CCG safeguarding team will facilitate and monitor the implementation of CP-IS across Local Authorities and health organisations which provide unscheduled health care for children and families.

The CCG safeguarding team will develop a multiagency steering group to respond to the needs of unaccompanied children who are seeking refuge and Syrian refugee families.

The CCG safeguarding team will continue to focus on victims of exploitation as part of their annual work plan which includes victims of forced marriage, female genital mutilation, domestic abuse, modern slavery and victims of human trafficking.

Developments through our Connected Care programme will allow for child protection information to be checked for every child or pregnant mother presenting in an unscheduled care setting with a potential indicator of the child being at risk and Indication of child protection plan, looked after child or unborn child protection plan and the social worker of a child on a child protection plan, looked after or on an unborn child protection plan to receive a notification when that child presents at an unscheduled care setting.

7.10 Identification of violence and abuse and improved support to victims.

The CCG is responding to improved identification of violence and improved support to victims. Quality schedules will include submission of a Domestic violence strategy for FPH and BHFT including training, support for staff who are victims of violence and how concerns are raised. Midwives will be requested to submit level of interventions following domestic abuse inquiry to all pregnant women. Routine information will support the increasing understanding and identification of violence which includes allegations of abuse against professionals and number of assaults perpetrated against staff members.

7.11 Patient confidentiality

The CCG has a "Caldicott Guardian" who holds responsibility for ensuring that the CCG is compliant with the Health and Social Care Act 2012. The CCG has processes and procedures in place to ensure that it adheres to this Act. Any documents which are received which contain personal identifiable information is treated as an information governance breach and managed in line with the HSCIC Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incident Requiring Investigation. All clinical concerns have to have the patients consent before the Provider is able to share personal identifiable information.

The Quality Premium scheme will become a two-year scheme. The 2017/18 to 2018/19 scheme has evolved from the 2016/17 scheme, in that NHS England has streamlined the indicator set and:

- Retained indicators on Cancer Stage of Diagnosis and Patient Experience of Accessing their GP;
- Evolved the existing Anti-Microbial Resistance measure into a measure on Bloodstream Infections;
- Retained a locally selected indicator towards delivering the aims of the RightCare programme;
- Introduced two new indicators, one to be selected from a Mental Health menu, and one focused on delivery of Continuing Healthcare.

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8. Enabling programmes/ strategies

8.1 Digital Roadmap

Our digital roadmap (see Appendix 23a) underpins all of the CCG priorities and has particular significance for urgent and emergency care, general practice transformation and integrated care. This includes the deployment of digital enablers that will facilitate paper-free at the point of care (supporting efficiency within the system), digitally enabled self-care (to support our prevention and self-care agenda), real-time data analytics (to support the urgent and emergency care agenda) and whole systems intelligence (supporting our work in urgent and emergency care and with frailty and complex case management). The Connected Care programme will significantly further enhance and normalise the digitisation of workflow within, and between, organisations and support the shared care record which is key to our strategy. This will bring significant benefits to patients in our system. The October updated LDR is attached at Appendix 23b along with the Universal Capabilities Plan which sets out the milestones for delivery. The Universal capabilities are reflected in the relevant section of this Plan.

8.2 STP Workstreams

The STP workstreams have been developed with strong input from the 3 CCGs. Our local programmes of work are also being informed by the STP direction of travel and we have clinical and management leads engaged with all of these workstreams. It is an ongoing two way process.

The workstreams are as follows:

- Ensure people have the skills, confidence and support to take responsibility for their own health and wellbeing - this workstream is linked into our prevention agenda, development of social prescribing and the experience of Healthmakers.
- Develop integrated decision making hubs to provide single points of access to services such as rapid response and re-ablement, phased by 2018 – this has been informed by our experience in developing support to complex patients through integrated teams and our New Vision of Care.
- Lay foundations for a new model of general practice provided at scale, including development of GP federations to improve resilience and capacity. A significant amount of work has been undertaken to develop our vision for general practice and this is being included in the development of this workstream.
- Design a support workforce that is fit for purpose across the system . We have a number of initiatives including the CEPN which are contributing to this work and we are represented at the Local Workforce Advisory Board. This is co-chaired by the Managing Director of the Royal Borough of Windsor and Maidenhead.
- Transform the social care support market including a comprehensive capacity and demand analysis and market management.
- Reduce clinical variation to improve outcomes and maximise value for individuals across the population – The 3 CCGs have been working with the Right Care methodology for at least two years and are playing an active part in this workstream, including sharing the learning from NHS Right Care. The clinical areas of focus in the STP are well aligned to the programmes of work that we already have underway.
- Implement a shared care record that is accessible to professionals across the STP footprint. The CCGs are at the forefront of embedding an interoperability solution through the Connected Care programme and have had a workstream on shared care records as part of the New Vision of Care. These are integrated into the STP workstream.

8.3 Workforce

Workforce is a critical enabling strategy. New roles, ways of working and a shift of culture will be required to deliver our transformation programmes. We know that we have significant challenges with an ageing workforce and high levels of vacancies in some areas of our commissioned services e.g. paramedics. We are engaged in the Local Workforce Advisory Board and are setting up a Community Education Provider Network to develop a primary care and community workforce to support our transformation plans. East Berkshire is leading the STP workstream on the support workforce which covers a range of roles in health and social care including rehabilitation, re-ablement, domiciliary and support workers, care and healthcare assistants and residential care staff. We are also working with partners in the STP footprint to develop a programme of collaborative leadership development to ensure that leaders at all levels are able to respond to the challenges. We will develop the approach taken in Slough on group consultations which delivers good outcomes for patients and supports our workforce strategy. Social prescribing is another element of our underpinning strategies and we will build on the excellent programme of Healthmakers to support our self-care programme. We are also developing innovative approaches to securing our future workforce

including the carers to nurses project. Training will be put in place to develop the skills of clinicians in general practice to deliver care and support planning. This will initially be focussed on diabetes but will extend to other long term conditions. We will work with NHS Improvement and Leadership Academy frameworks to support quality improvement skills amongst the wider workforce.

8.4 Estates

The 3 CCGs have been successful in gaining significant support to the development of the local estate to underpin our strategy through the ETTF. This will constitute a large programme of work to support our new model for general practice. We will undertake this in conjunction with our local partners, ensuring we maximise the use of the public estate and plan for areas of significant growth, notably Bracknell and Maidenhead. We will also work closely with planning departments to maximise the impact of new developments. We will seek to get best value from the ETTF investments to support this overall programme.

9. Communications and Engagement

The CCGs believe strongly that engagement is a continuous process of discussion and listening, in conjunction with our local authorities, provider stakeholders, communities and voluntary sector (a list of our major stakeholders is set out in Appendix 5d). Our Communications and Engagement Strategy was completely revised after engagement with member practices, as well as patients and voluntary sector partners, in 2016. The strategy is now shared across the three CCGs and sets out the principles for communications and engagement and three key objectives:

- To proactively engage with stakeholders and enable people in east Berkshire to contribute to shaping future health services commissioned by the CCGs
- To develop a culture that promotes open communication and engagement with patients and the public
- To ensure member practices and staff are informed, engaged and involved in the work of their CCG and participate in commissioning activities for the benefit of patients.

The strategy, which centres on patient experience, has been approved by the three CCG Governing Bodies. While the strategy is shared across the three CCGs, specific action plans are being developed, with detailed alignment to the STP and New Vision of Care. This will be approved by Governing Body members and will ensure we are delivering more than just the statutory duty for patient and public involvement. Increasingly, the three CCGs in the east of Berkshire are working together; we envisage a collective and localised vision to develop PPI further. Currently, communication and engagement updates are presented at all Governing Body meetings, in line with the three objectives above. Each project is required to identify its communication and engagement plans from the initial idea stage through to business plan stage, whether this be engagement of clinicians and local people/ patients throughout the development of the project or the requirement for wider communications campaigns as part of the delivery phase.

9.1 Evaluation

When project specific communication and engagement plans are developed, they include indicators for evaluation. For example, the New Vision of Care strategy included evaluation of the number of people engaged at various stages of the project, face to face and online, and how these contributions influenced the design of the final model. Patient panel groups help evaluate the programmes they are involved in. Social media and other digital metrics are evaluated regularly. For the future, particularly in relation to STP developments, the intention is to establish regular testing of messages and benchmarking of channels and their best use. In addition, we intend to set up evidence-based, data-driven communications practice throughout the three CCGs from 2017 onwards, with particular reference to changing and influencing public perception and behaviours, taking a social marketing approach to the projects that we run.

9.2 Digital Communications

The CCGs recognise that their engagement ambitions will be strengthened by better use of digital technology. This will allow a much greater reach, plus better and more efficient engagement. This is being achieved through a number of initiatives:

- Twitter: the CCGs are actively engaging via their Twitter accounts and incorporate Twitter into all project communications and engagement plans
- Facebook: the CCGs have a joint Facebook site which is in its development phase and which will be used to extend the reach of projects and campaigns
- Health Connect: This online engagement tool was launched in February 2015 and has more than 650 members to date; patients, public and community organisations are encouraged to register; the tool is used to broadcast messages, send invitations to events, such as workshops and public meetings, and to run surveys to enhance engagement in various projects; the format of the site is consistent with other Thames Valley CCGs, so that collaborative engagement can be facilitated; for example, NHS111 is being reprocured in Thames Valley, with public engagement coordinated across all 10 CCGs; having the same online systems for running surveys allowed the format to be cloned onto the engagement sites for each CCG;. results were analysed on a CCG basis, as well as drawing themes across CCGs for the project
- CCG Website: the website is a key tool for engaging and communicating with the public and its use is monitored and reviewed regularly.

9.3 Engaging diverse communities

The diverse communities across east Berkshire are engaged in the work of the CCG in a variety of ways. The communities are very different and the CCGs employ different methods, depending on the community to be reached. For Bracknell and Ascot CCG, this includes the Nepali community around Sandhurst. For Slough CCG, this includes recognising the changing demographics with new migrant communities, as well as existing diverse communities. For Windsor, Ascot and Maidenhead CCG, this includes recognising the growing number of older people and the relatively large number of people living in care homes.

Methods for engaging these diverse communities vary and include making sure information is accessible and available in different languages and formats. A local translation service is available on request. The CCG attends community events and meetings, including one-off events such as an information day for the Somali community in Slough, the Retirement Fair in Ascot, Self-Care Week events in Bracknell Forest, and Older People Forums in all areas. The CCGs in the east of Berkshire have an Equality and Diversity Steering Group, as well as a Patient Panel Group to support this agenda.

9.4 Highlights from engagement to date

Engagement is vital for the CCGs, and it is important that we get it right. For example, in working up the New Vision of Care model, a design group of professionals and clinicians and a patient engagement group linked in very closely. The patient group was consulted, using outcomes from the clinical design group, and feedback was reported back to ensure comments were incorporated into the final model. Once the draft model was designed, it went to a public workshop for signup and to ensure comments from members of the public were reflected in the final model. Suggestions included better use of technology in care, including the opportunity to book appointments via the internet and using self-testing kits , as well as allowing patients to see and talk to their GP or hospital doctor from home.

In all the engagement to date, there has been strong support for integration of care from various workshops and surveys. The suggestion that computer systems are more integrated is also well supported and a patient panel group are working in detail on this. There has also been much engagement around the transformation of general practice, which includes testing of concepts such as social prescribing. This work is continuing. More examples of engagement, of the type that we intend to continue to support the operating plan and STP, are available in Appendix 5e.

10. Risks and mitigations

Risks	Mitigation
Lack of engagement with public and general practice for the general practice transformation plans	Robust engagement plan under development including all stakeholders and reiterating the population benefits to providers and commissioners
General Practice workforce not fit for purpose to achieve change	New skill mix in general practice is planned, thorough evaluation and work force planning with other primary care providers through the CEPN
Practices unable to continue to provide high quality services	Targeted vulnerable practice support and practice resilience scheme to ensure practices are sustainable through working at scale with the appropriate infrastructure
Clinical engagement to manage demand of elective referrals	Utilising clinical leadership and engage with planned care leads for all three CCGs to implement a peer review and best practice guidelines approach
Technical and change management issues preventing the successful implementation of DXS thus utilisation is compromised	Utilise clinical leadership roles as well as engage with DXS project support to ensure successful resolution of both technical and content management issues.
Engagement of clinicians and supporting workforce in primary care to proactively manage long term conditions	Align plans with primary care new models of care, implementing locally commissioned services to support consistent approach in primary care thus preventing crisis and preventing avoidable significant events eg stroke and MI
The mobilisation of the new integrated NHS 111 service is delayed will not be in place in 2017/18	The preferred provider is approved by GB by 1/4/17 and mobilisation commences in Q1/2 of 2017/18
Staff recruitment and retention in key clinical and care service areas is not sufficient to have enough staff in place to deliver a sufficient level of service.	STP and Urgent Care Network have supporting workstreams in place, SCAS have a overseas recruitment and workforce plans in place to support the paramedic shortfall.

Demand increases above planned levels and there is insufficient capacity within the system to cope with pressures resulting in unsafe care and failure of national standard	Daily review of activity levels and system pressures to ensure that early intervention is carried out to delivery safe care and achievement of recovery of standards.
No funding available for Increased Access to Psychological Therapies - 25% of people with anxiety and depression access treatment & integrated with physical healthcare by 2020/21	CCGs are one of the expansion pilot sites with additional funding in place until 2017/18. Plan for expansion in place and recruitment already underway. Evaluation to support impact and continued funding planned for Autumn 2017/18
Increase in access not achieved for Children & Young Peoples Mental Health - 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of Children and Young People Improving Access to Psychological Therapies (CYP IAPT) by 2018;	The multi-agency Children and Young People's Transformation working group to set out roadmap for delivery to 2020/21 Current pilots funded to increase access to be evaluated with a view to formally commissioning to support the access target
Early Intervention in Psychosis - Service does not achieve the access target of 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral by 2017/18	The existing commissioned service is NICE compliant and currently delivering in the region of 80% beginning treatment within 2 weeks. This will be continually monitored to ensure the service maintains delivery
No funding available to increase Individual Placement Support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline;	CCG will bid for national funding in 17/18 to support delivery of target
Eating Disorders Service does not achieve the access target 95% of children and young people receive treatment within four weeks of referral for routine cases; and one week for urgent cases;	The existing commissioned service is NICE compliant and is currently delivering the access standards. This will be continually monitored to ensure the service maintains delivery.
24/7 access to community crisis resolution teams is not achieved and home treatment teams and mental health liaison services in acute hospitals.	CRHTT – 24/7 access currently provided but service being reviewed to ensure maximum efficacy of service. MH Liaison – redesign of existing service started to ensure robust service provision that delivers 24/7 service. CCGs will bid for funding to support delivery.
Diagnosis rate of 67% not achieved or maintained	Regular review of diagnosis rates at CCG performance review groups. Action plans in place for Slough & Bracknell and Ascot CCGs

OAPs not reduced and ultimately eliminated	Work commenced with Provider on baselining OAPS SDIP in contract to reduce OAPs in 17/18 -18/19 Plan to review Urgent and emergency care pathway for mental health to be developed. This will include improving inpatient flow so that OAPs not required.
Budget pressures and individual organisational priorities present a barrier to integrated working and slow progress	Risk acknowledged and openly managed at system leaders and other key for a. System control total provides a framework for managing organisational risk
Financial risks of double running for personal health budgets Risk of not meeting trajectories due to adequate resource and inadequate communications plans	Robust project planning and delivery. Clear articulation of risk for individual cohorts and plan to manage transition
External forces influence care home market and can be difficult to foresee Workforce issues affect whole sector	Build close relationships with providers and work collaboratively STP workforce programme will support
Failure to attract Sustainability Transformation Funding will result in the failure to invest and deliver the prevention projects above. This would be magnified if all SFF funds are focussed solely through specific or clinical workstreams e.g. cancer/ mental health	Project plans have been written to show the financial savings that can be delivered and could be translated into QIPP plans if local funding could be sourced.
Failure to engage staff in starting consultations with lifestyle advice would undermine a number of initiatives.	Robust staff communication plans will be put in place.
There is a risk that not all patients currently in Assessment and Treatment Units and Out of Area placements will be moved into appropriate community settings and/or repatriated back to Berkshire by March 2019	The Berkshire wide Transforming Care Plan (TCP) endorsed by all partners has established sub-groups to deliver the plan, supported by progress briefings to all 14 TCP Partners, inpatient bed suspensions by BHFT are monitored, service spec for Berkshire ATU is being developed, BHFT Intensive Support Team (IST) Services being developed

11. Governance

Our governance structures were reviewed in early 2016 to reflect the closer working together of the 3 CCGs whilst maintaining a local focus. The three CCGs share two committees that that have a key role in the development and monitoring of the Plan. These are QIPP and Finance (monitoring of the overall financial position and QIPP delivery) and Business Planning and Development (responsible for signing off business cases).

Each CCG has a Clinical Leadership/ Innovation Forum where discussions are held about local approaches to our common programmes.

Programme Boards are in place for each of our major programmes and these are responsible for developing and prioritising initiatives before business cases are presented for approval at the Business Planning and Development meeting.

Member engagement in our plans takes place at the three GP Council meetings.

The GP Councils' primary roles are:

a) To provide a forum for Member practices to give direction, inform and approve the commissioning plans for the population of Bracknell and Ascot;

b) To hear and represent the views of practices;

c) To own and deliver GP commissioning, as outlined in the Strategic Commissioning Plan produced on an annual basis;

d) To provide an integral role in the development of the JSNA jointly with the Unitary Authority(s) and Public Health;

e) To hold Member practices to account over practice performance in use of Health and Social Care resources;

f) To hold each other to account through peer review;

g) To enable and support the Governing Body to manage the CCG.

There is an organisational milestone tracker in place which is reviewed by the Executive Management Team on a monthly basis.

We have a robust performance management system which monitors progress against all Constitutional standards and other performance metrics. Performance reports are discussed at the Quality and Performance Sub-Committee and reported to the Joint Governing Body. Performance issues are discussed with providers at the relevant Contract Review Meeting and appropriate action taken.

Benefits at a programme and STP level will be monitored via Programme Boards and the STP Executive Delivery Group. This process will be supported by the CCG or STP programme management office as appropriate.

Appendices

1	**Sustainability and Transformation plan**
2	**New Vision of Care**
3a	**Vision for General Practice**
3b	**GP Five Year Forward View response template**
4	**Decision Tree**
5a	**Communication and engagement strategy**
5b	**Engagement to date**
5c	**Communication and engagement opportunities**
5d	**CCG stakeholders**
5e	**STP Communications**
6	**CQUINs and Quality premia**
7	**2016/17 performance**
8a	**Bracknell and Ascot CCG public health profile**
8b	**Slough CCG public health profile**
8c	**Windsor, Ascot and Maidenhead CCG public health profile**
9	**Commissioning Intentions**
10a	**Bracknell and Ascot CCG Plan on a Page**

10b	**Slough CCG Plan on a Page**
10c	**Windsor, Ascot and Maidenhead Plan on a Page**
11	**Cancer Plan**
12	**Frimley North System Resilience Plan**
13	**Transforming Care Plan**
14	**Perinatal mental health – application to the Community Services Development Fund**
15	**Application to the IAPT early implementer programmes**
16	**Diabetes – locally commissioned service and structured education business case**
17	**Dementia action plans for Slough and Bracknell and Ascot CCGs**
18	**End of life care business case**
19	**AIRS business case**
20	**Heart failure business case**
21	**Integrated diabetes team business case**
22	**Referral management business case**
23a	**Local digital roadmap**
23b	**LDR Challenge response**
23c	**Universal capability development plan**
24	**Frimley Health RTT Plan**
25	**EIP service specification**
26	**Eating disorders service specification**


Each other
Patients' rights
We respect
'Thinking locally, working together'
Our partners
Taxpayers' money
Local people

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