NHS
Bracknell and Ascot
Clinical Commissioning Group

NHS Bracknell & Ascot CCG **Commissioning Plan 2014-2016**

April 2014 – FINAL

A summary for Bracknell Forest Health and Wellbeing Board

10 April 2014

1. Contents

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This two year Commissioning Plan incorporates the following details:

- ✓Our population and their CCG
- ✓Current Health Systems – opportunities and challenges
- ✓Strategic deliverables and innovation
- ✓Prioritisation
- ✓Partner Engagement
- ✓Enabling Plans
- ✓Delivery and Governance arrangements

NHS Bracknell and Ascot Clinical Commissioning Group: 'Plan on a Page' 2014/16

Vision

"To commission local outcome based, cost effective services, for the health benefit of our local population now and in the future"

Strategic Aims

Prevention and Self care

- Working in partnership, Deliver the Joint Health and Well-being Strategies
- Deliver a targeted programme of self care and prevention together with partners
- Deliver highly cost effective prescribing
- Deliver excellence in primary care services including integration with the Bracknell Urgent Care Centre centred around the patient
- Embed self-care and public engagement throughout our programmes

Deliver on the National domain:

- *Ensure that people have a positive experience of care*

Recovering from Ill health

- Deliver a new Musculoskeletal pathway
- Commitment by all member practices to refer appropriately (reduce clinical variation)
- Support clinicians through education to deliver evidence based clinical care and better outcomes for patients
- Ensure effective use of the clinical policies and thresholds for procedures of limited clinical value

Deliver on the National domain:

- *Helping people to recover from ill health or following injury*

In 2014/16 we will deliver improved patient experience of General Practice and prescribing efficiency savings

In 2014/16 we will make quality improvements in planned pathways and reduce follow up rates to national benchmarks

Trajectory 2015/16

Excellence in primary care through the development of the Strategy
Improve on the reported patient experience of their GP practices

Trajectory 2015/16

Implement the most efficient and effective planned pathways in line with the needs of our patients
Increase the % of the eligible population receiving IAPT services and improve the dementia diagnosis rates
Reduction in Fractured Neck of Femur

Long Term Conditions and Urgent Care

- Open the Bracknell Urgent Care Centre i working with general practice, 111 and other partners
- Further develop integrated care for people with complex needs through partnership working and building on the success in 2013/14 to further reduce unnecessary hospital admissions

Deliver on the National domains:

- *Preventing people from dying prematurely*
- *Enhancing quality of life for people with long term conditions*

In 2015/16 we will strive to reduce inappropriate unplanned hospital admissions and increase the number of patients feeling supported to manage their conditions

Trajectory 2015/16

Achieve national benchmarks in efficient use of unplanned care services
Deliver a Better Care Fund that achieves the vision shared with our partners
Increase the number of patients who feel supported in managing their condition

Quality and Safety

- Strong clinical leadership working proactively with all providers to ensure high quality, safe services incorporating recommendations from the Francis report, and CQC reports
- Implement robust safeguarding arrangements for both adults and children with particular attention to the post Winterbourne recommendations
- Monitor quality schedules from providers using incident reporting systems to triangulate quality information

Deliver on the National domain:

- *Treating and caring for people in a safe environment and protecting them from avoidable harm*

Patient Experience and Engagement

- Implement Public and Patient Engagement strategy to keep people at the heart of planning and service design
- Support the development of the local Healthwatch organisations
- Facilitate local Patient reference groups to work together through a forum arrangement bringing together our communities' views

Other Organisational Priorities

- ➢ Continue to work to our constitution following revision in 13/14
- ➢ Corporate Governance and assurance to members and public
- ➢ Ensure appropriate support is matched to priorities and strategic aims
- ➢ Working in partnership to deliver the local Health and Well-being Strategy and CCG Commissioning Plan across our complex health and social care environment
- ➢ Implement Organisational Development plan to ensure skills and capacity are in place to deliver agreed outcomes

Quality Premium

National Quality Indicators

- ✓ Improve Dementia Diagnosis
- ✓ Increase the % of the eligible population receiving IAPT services

Local Quality Indicators

- ✓ Satisfaction with GP Services
- ✓ People supported to manage their condition
- ✓ *Reduction in Fractured Neck of Femurs*

Health Priorities

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Joint Strategic Needs Assessment

- Reduction in Demand for Urgent care
- Self care
- Falls prevention
- Smoking cessation
- Well Being for CYP
- Improve Community MH
- Integration supporting LTCs

Local Health and Well Being Strategy

- **Children** need to have the best possible life chances, including good housing, good education and healthy lifestyles
- **Mental Health**, particularly Depression and Dementia
- **Long Term Conditions,** particularly respiratory illness, diabetes and cardiovascular disease,
- **Cancer**
- **Sexual Health**
- **Vulnerable groups** with particular attention to people who are more likely to become ill, or who may need particular services.

7 Ambitions

- Additional years of life
- Improving health of patients with LTC
- Reducing amount if time in hospital through out of hospital care
- Increase the number of older patient living independently at home following discharge from hospital
- Positive experience of hospital care
- Positive experience of out of hospital care
- Eliminating avoidable deaths

Population Health Needs - JSNA

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Non-Elective Hospital Admissions

The rate per 100,000 pop in our area increased by 8% from 2011/12 to 2012/13 (the second highest increase in Berkshire). This rise is projected to continue in 2013/14. Work to support self care and appropriate use of hospital emergency services is therefore a priority.
Source: Secondary Uses Services.

Falls Prevention

Emergency admission rates for falls injuries in persons aged 80+ are significantly higher in our area than the national average and the second highest in Thames Valley region. Emergency admissions for hip fractures have increased, with the rate moving from being better than the England average to worse than average over the last few years.
Source: Hospital Episodes Statistics.

Smoking

Around 90% of cases of lung cancer are caused by smoking. Our area has a lung cancer death rate that is significantly worse then the national average and our rate of lung cancer registrations is the highest in the Thames Valley region. The local Stop Smoking Service has a quit success significantly higher than the national average – referral of smokers to this service is therefore a high priority.
Source: Local Tobacco Control Profiles and NHS Stop Smoking Service Statistics.

Population Health Needs - JSNA

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Mental Health in the Community

Among older people, the ratio of recorded to expected prevalence of dementia in our area is significantly poorer than the national average, suggesting a need for improved awareness and diagnosis. For younger people, Child and Adolescent mental health services (CAMHS) referrals were up 31% on last year along with case loads rising by 21%. This suggests a need for more preventative mental health work with children.

Source: Community Mental Health Profiles 2013, Local CAMHS Report 2013).

Immunisation and Screening

In our area, several vaccination rates among children are significantly poorer than the national average, including in relation to Measles, Mumps and Rubella (MMR). Screening rates in our area are also low, including diabetic eye screening for which uptake is significantly poorer than the national average.

Source: Source: Cover of Vaccination Evaluated Rapidly (COVER), Integrated Performance Measures Return

Self-Care

Recent data suggests that the proportion of people feeling supported to manage their condition in our area is relatively low compared to other areas. Improving support for self-care will have a positive impact on health and reduce burden on healthcare resources.

Source: GP Patient Survey / NHS England Benchmarking 2013

Health and Well Being Strategy – Bracknell Forest

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Priorities from Bracknell Forest HWB Strategy:

- **Children** need to have the best possible life chances, including good housing, good education and healthy lifestyles
- **Mental Health** particularly Depression and Dementia
- **Long Term Conditions** particularly respiratory illness, diabetes and cardiovascular disease,
- **Cancer –** raise the importance for cancer to be diagnosed early, to improve outcomes for patients
- **Sexual Health -** including sexual health promotion, family planning (contraception) as well as the prevention and treatment of sexually transmitted infections
- **Vulnerable groups** – paying particular attention to people who are more likely to become ill, or who may need particular services.

Challenges in Local Health System

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SYSTEM

Delivery of QIPP programme

Complex provider market

Development of the integration agenda with all partners and stakeholders

Risks around HWPH merger

PROVIDERS

Over performance in secondary care hindering integration agenda

Implementation of the newly commissioned services

Quality concerns and patient experience in some areas

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PRIMARY CARE

Engagement in the Primary Care Strategy

Meeting the challenge of integration and extending hours of work

STAKEHOLDERS

Assurance on safeguarding arrangements

Cross border UA issues

Inclusive stakeholders engagement

Response to our Challenges

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SYSTEM

Rigorous monitoring of QIPP and excellent member engagement

Complex provider market being addressed through partnership with neighbouring CCGs

Acquisition creates opportunity for clinical change

PROVIDERS

Over performance addressed through robust contract management by CSU

Working jointly on implementation of new services with providers new and existing

Quality systems embedded at CCG and Federated level

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PRIMARY CARE

Develop and implement the primary care strategy to meet the challenges set out in the framework: *Everyone Counts*

Facilitate the changes required for general practice to deliver high quality services to our population by reducing variation

STAKEHOLDERS

Engagement in integration agenda

Winterbourne plan in place

Full engagement in both HWBBs

Inclusive stakeholders engagement

Clear governance around the Better care Fund

Ambition 1: Securing additional years of life from conditions considered amenable to health care

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E.A.1	PYLL (Rate per 100,000 population)
Baseline	1512.0
2014/15	1502.0
2015/16	1492.0
2016/17	1482.0
2017/18	1472.5
2018/19	1460.0

Initial analysis suggested that the female population have good life expectancy in the CCG, with some opportunity to improve the life expectancy for the male population. Further investigation has shown the cancers, CVD and other long term condition in males have a significant impact on these statistics which is in line with the JSNA priorities in the programme around long term conditions.

Ambition 2 : Improving the health related quality of life of people with one or more LTC

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E.A.2 Target	Average EQ-5D score for people reporting having one or more long-term condition
Baseline	76.50
2014/15	76.70
2015/16	76.90
2016/17	77.10
2017/18	77.30
2018/19	77.50

Long Term condition and self management are priorities in the CCG plans. The impact the programmes around prevention and self care, and long term conditions and urgent care provides a focus on supporting patients with support on diagnosis and a framework to manage their own condition. The impact on patients will result in improve quality of life showing a 1% improvement over 5 years retaining a good position for the CCGs population under this indicator.

Ambition 3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital

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E.A.4 Target	Emergency admissions composite indicator
Baseline	1583.0
2014/15	1583.0
2015/16	1535.0
2016/17	1488.0
2017/18	1433.0
2018/19	1390.0

The managed of long term conditions and self management should reduce the overall number of patients admitted to hospital in an unplanned way. Additional support in the community through integrated care teams, case management and mental health support through Talking Health will provide patients with ability to stay out of hospital with less exacerbations. This CCG commits to a reduction of 3% annually for the next 5 years for this ambition

Ambition 5: Increase the number of people who have positive experience of hospital care

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E.A.5 Target	The proportion of people reporting poor patient experience of inpatient care
Baseline	143.0
2014/15	143.0
2015/16	143.0
2016/17	143.0
2017/18	143.0
2018/19	143.0

The CCG will work with all providers around their user feedback through Friends and Family Tests, patient surveys and other feedback tools. The position for this trajectory is within other local CCGs.

Our ambition to maintain our current good position on this indicator, is significant taking into account the local acquisition with our two main acute providers.

Ambition 6: Increase the number of people who have positive experience of care outside of hospital, primary care and community

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E.A.7 Target	The proportion of people reporting poor experience of General Practice and Out-of-Ours Services
Baseline	8.03
2014/15	7.73
2015/16	7.43
2016/17	7.13
2017/18	6.83
2018/19	6.53

The CCG is committed to improving patient experience in primary care and other community services. The CCG will work with all providers around their user feedback through Friends and Family, patient surveys and other feedback tools to achieve the current national average which means a reduction in negative responses of 1.52% which is also in line with our quality indicators previously

Improvements in Mental Health - IAPT

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iii) What level of IAPT recovery are you aiming for in 2014/15 and 2015/16?

E.A.S.2 Target	The number of people who have completed treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness" and at final session did not)	(The number of people who have completed treatment within the reporting quarter, having attended at least two treatment contacts) minus (The number of people who have completed treatment not at clinical caseness at initial assessment)	% recovery rate
2014/15	795	1590	**50.00%**
2015/16	911	1822	**50.00%**

iii) For IAPT, what proportion of people that enter treatment against the level of need in the general population are planned in 2014/15 and 2015/16?

E.A.3	The number of people who receive psychological therapies	The number of people who have depression and/or anxiety disorders (local estimate based on National Adult Psychiatric Morbidity Survey 2000)	Proportion
Q1 2014/15	**483**	**15160**	3.19%
Q2 2014/15	**511**	**15160**	3.37%
Q3 2014/15	**540**	**15160**	3.56%
Q4 2014/15	**568**	**15160**	3.75%
2015/16	**2274**	**15160**	15.00%

Improvements in Mental Health- Dementia

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ii) What dementia diagnosis rate are you aiming for in 2014/15 and 2015/16:

E.A.S.1 Target	Number of people diagnosed	Prevalence of dementia	% diagnosis rate
2014/15	969	1445	67.06%
2015/16	989	1475	67.05%

- Improving early diagnosis for people with dementia
- Redesign of services to enhanced community teams to provide psychiatric liaison, dementia advisors, crisis response functions, and improve access to memory services.
- Redesign pathways to facilitate reduction of admissions and reduce length of stay
- Improving access to psychological therapies for long tern conditions
- Improving employment opportunities for adults of working age

Funding Allocations 2014-15 and 2015-16

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	Bracknell & Ascot 2014/15 £m	Bracknell & Ascot 2015/16 £m
Programme	135.0	139.9
Running Costs	3.4	3.1
Better Care Fund		1.9
	138.4	**144.9**
Transfers not yet actioned	-0.3	-0.3
	138.1	**144.6**
Growth on previous year	**0.0**	**4.9**
Percentage growth	3.92%	3.61%

NHS England has adopted a revised funding formula for CCGS recommended by the Advisory Committee on Resource Allocation. This formula allocates the overall national funding for CCGs based on the needs of the local population, and calculates a "target" allocation. Over time actual funding levels will be moved closer and closer to the "target" (this is sometimes referred to as the "Pace of Change").

- Bracknell & Ascot CCG is currently funded below its "target" allocation, and therefore is in receipt of an above average increase in funding.
- For 2014-15 the CCG is still 6.4% below target (which equates to £9.2m)
- As the CCG will still be more than 5% below target at the end of 2015-16, the CCG is anticipating further movement towards target in future years, but this has not built into our financial modelling as this is not yet confirmed.
- The growth figures relate to "programme" funding (which is spent on services for patients), our funding for CCG running costs will fall by about 10% in 2015/16

Funding 2014/16

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2013/14 Budget & Spend

	£m
Funding Allocation	**132.8**
Forecast Spend	**129.0**
Surplus	**3.8**

2014/15 Funding

	£m	
	132.8	
Growth	5.1	
Other	(0.7)	
Funding Allocation	**137.2**	**8.2**
Previous Yr Surplus	3.8	
	141.0	

2015/16 Funding

	£m	
	137.2	
Growth	4.9	
Better Care Fund	1.9	
Running Cost Reduction	(0.3)	
Funding Allocation	**143.7**	**7.8**
Previous Yr Surplus	1.3	
	145.0	

- The tables on this page show how funding for the CCG is expected to change between 2013/14 and 2015/16, and the key changes between years.
- The tables on the next page show the key areas of expenditure within our budget, and also the planned reserves and contingencies. It is expected that reserves will be fully used for purchasing services for patients in year, but they have not been fully allocated or committed at this point

	£m
Growth	2.4
Inflation/Efficiency	(1.1)
NR Headroom	2.1
Support for Primary Care	0.7
Better Care Fund	
- Investment	0.3
- Offsetting Budgets	
QIPP	
- Investments	2.2
- Savings	(3.5)
Other	3.8
1% Surplus	1.3
	8.2

	£m
Growth	2.3
Inflation/Efficiency	(0.6)
NR Headroom (2.5% to 1%)	(1.9)
Better Care Fund	
- Investment	6.9
- Offsetting Budgets	(2.5)
QIPP	
- Investments	0.5
- Savings	(1.1)
Other	2.8
1% Surplus	1.4
	7.8

Budget 2014/16

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Budget Summary

	13/14 £m	14/15 £m	15/16 £m
Secondary Acute			
- Heatherwood & Wexham	17.7	18.3	19.1
- Royal Berkshire	11.0	11.0	11.1
- Frimley Park	29.6	30.2	30.6
- Other	12.8	12.8	12.8
Mental Health	12.4	12.6	12.8
Community Health	11.8	12.0	12.0
Other Programme	2.0	1.9	2.0
Primary Care	-	-	-
- Prescribing	14.8	15.3	16.0
- Other	2.7	3.5	3.6
Out of Hospital	9.0	9.5	10.2
Corporate	3.2	3.3	3.0
Reserves	2.1	7.3	11.0
Contingency	0.7	1.9	1.5
	129.9	**139.6**	**145.5**
Surplus	3.8	2.3	1.4
	133.7	**141.9**	**146.9**

Reserves

		14/15 £m	15/16 £m
Gen Reserves	- Better Care Fund	-	4.4
	- Commissioning Reserve	1.3	1.3
	- Other Committed Reserves	3.7	4.4
	- Uncommitted	-	1.0
		5.0	**11.0**
NR Headroom	- Better Care Fund	1.2	-
	- Transformation Investment		
	- CHC Reserve	0.5	0.5
	- QIPP Reserves	0.7	0.1
	- Committed Reserves	0.7	0.6
	- Uncommitted	0.3	0.2
		3.4	**1.4**
QIPP	- Investments	2.1	2.2
	- Savings	(3.1)	(3.6)
		(1.0)	**(1.4)**
		7.3	**11.0**

BACCG QIPP Triangle

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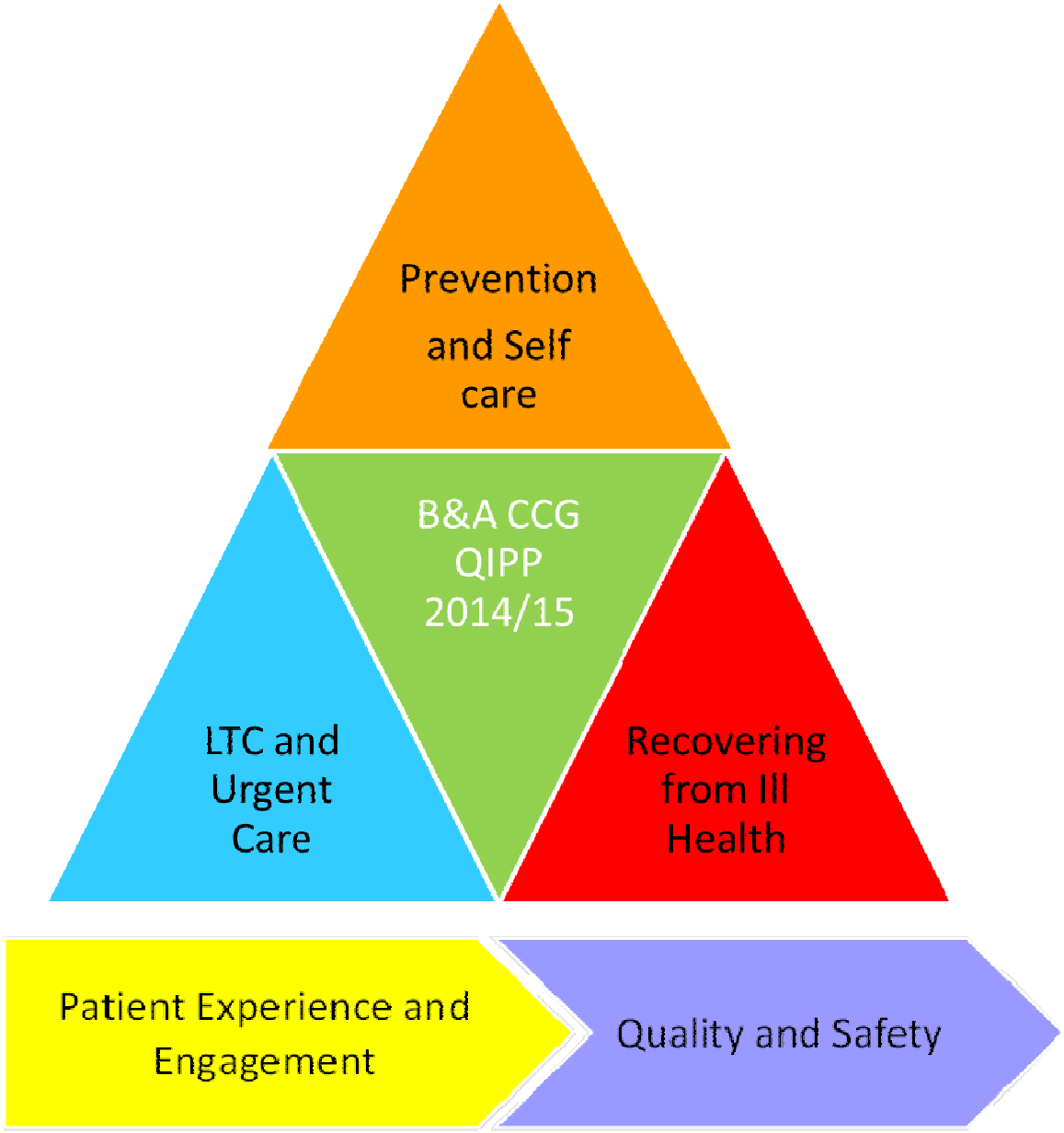

QIPP 14/15- to support delivery of CCG objectives as measured by Seven Ambitions

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Preventing people from dying prematurely - The focus will be on prevention in line with the priorities in the JSNA and Supported Self-management for people with long terms conditions such as COPD, asthma, diabetes and dementia following diagnosis and throughout the course of their condition. Targeted and evidence based programme with an emphasis on reducing NELs and A&E attendances

Enhancing quality of Life for people with long term conditions- This will focus on providing support for patients in the community to manage their conditions, that patients can access the right planned care in the right place based on need and best practice. The aim of this programme is to prevent crisis and provide support to those in crisis in the most appropriate setting. This will be through excellence in crisis management, planning care closer to home, urgent care and enhanced intermediate care delivery. A focus on prevention and transfer of services from hospital to community settings to avoid admission and reduce lengths of stay will be key elements of the programme. From a patients perspective this will mean choice and personalisation of their care and a more integrated approach to the delivery of their care. This will support the QIPP for unplanned admissions and to manage the increasing demand on accident and emergency services.

Helping people to recover from episodes of ill health or following injury -The objective of this programme is to ensure that patients can access the right planned care in the right place based on need and best practice. The programme will improve patient choice, access and ensure patients are seen by appropriate clinicians using agreed planned care pathways. The focus of the programme is centred ensuring best practice and follow nice guidelines and reduce clinical variations in practice.

Ensuring People have a positive experience of care - The objective of this programme is to ensure that the care that patients receive when they use commissioned services is a positive one. Information about patient experience will be used to shape commissioning decisions and employ contractual levers. There will be real time information about patient experience, patients will feel empowered to provide feedback and feel that the CCGs has considered this feedback and acted appropriately. Work in partnership with **Healthwatch** to ensure broad engagement across the CCG population and aim to deliver on “Call to Action”.

Treating and caring for people in a safe environment and protecting them from avoidable harm- To work with our partner agencies and provider organisations to ensure that those receiving commissioned services are safe and protected from avoidable harm, irrespective of where they receive their care. People should be enabled to live full lives as independently as possible. To co-ordinate joint services between health and social care system and where appropriate commission services jointly together within individual CCG’s and through Health and Well Being Boards. We will be exploring greater

QIPP Priorities Mapping

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CCG Commissioning Priorities

- Prevention and Self care
- Long Term Conditions and Urgent Care
- Recovering from Ill health
- Patient Experience and Engagement
- Quality and Safety

NHS Outcome Framework

- Preventing people from dying prematurely;
- Enhancing quality of life for people with long-term conditions;
- Helping people to recover from episodes of ill health or following injury;
- Ensuring that people have a positive experience of care;
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

7 Ambitions

- Additional years of life
- Improving health of patients with LTC
- Reducing amount if time in hospital through out of hospital care
- Increase the number of older patient living independently at home following discharge from hospital
- Positive experience of hospital care
- Positive experience of out of hospital care
- Eliminating avoidable deaths

Programme One: Prevention and Self Care

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The focus will be on prevention in line with the priorities in the Joint Health and Well bring Strategies and supported self-management for people with long terms conditions such as COPD, diabetes and dementia following diagnosis and throughout the course of their condition. Targeted and evidence based programme with an emphasis on reducing NELs and A&E attendances, particularly for children and younger people.

The JSNA analysis and HWB Strategy has prioritised the local prevention agenda to identify the high impact programmes and encourage innovation and joint working in line with *Commission for Prevention*

Intended projects 2014/16:

- **Smoking cessation** prior to elective surgery
- **Targeted education** sessions for parents with 0-5 year olds
- **Healthy Lifestyle** education clinics in primary care as part of whole system programme
- **Talking Health programme** to support the mental health of patients with LTCs
- **Engaging young people** working with Bracknell and Wokingham College students
- Campaign to promote **immunisations and vaccinations** to prevent ill health
- **Falls prevention** with a focus on the over 65s

Programme One: Prevention and self care

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Theme	2014/15	2015/16 commitment	Outcomes
Promote self-care	Awareness campaigns: •Keep Calm •Self care week •Targeted joint campaign to deliver JHWS priorities •Education on the use of UCC, including young people	• Continue to develop the patient self care APP • Implement a plan from a neighbourhood Experience Led Commissioning programme to identify residents use of health and care services	• Local people have knowledge to self-care and use services appropriately • Reduction in minor attendances at A&E and 0 length of stays, as patients are informed
Supported self-management	Review existing services: •Expert patient programme •Extended coverage and integration of self management •Falls prevention	• People diagnosed with a long term conditions are enabled to self-manage	• Increase in patients reporting that they are confident in managing their LTC
Prevention and health improvement	• Flu immunisation campaigns and vaccinations • Increase capacity at falls clinic • Smoking cessation for surgical patients	• Risks that local people face are identified and mitigated	• Reduction in year of life lost

Programme Two: Long Term Conditions

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This programme will achieve the local quality indicator to support patients to feel they can manage their own condition, through integrate care planning and a focus on a limited number of LTCs to get the best impact for our population.

Investment in 2013/14 enabled opportunities to improve COPD and diabetic management in the community.

A revised Dementia Strategy is developed with the Unitary Authority.

Additional investment in COPD and Diabetic clinical leads has been established to engage with members and partners.

Intended projects 2014/16:

- Investment in community **Mental Health**: including clinical psychology and Dementia
- Implementation of the **Better Care Fund** vision with supporting programme of work
- **Sustainable and effective Integrated Care Teams** building on evidence and experience to grow care planning for our patients, particularly the patients over 75 and with complex health needs
- **COPD** management in primary care review and further integration with specialist COPD services
- Continue to improve skills in general practice to manage **diabetics** and develop a clear model of care with specialist services
- Promote and link to the clinical network to obtain the best outcomes and early diagnosis of **Cancers**

Programme Two: Long Term Conditions

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Theme	2014/15 projects	2015/16 commitment	Outcomes
Mental Health	• Review existing gaps in services • Implement Talking Health in the prioritised LTCs	• Talking Health considering broader scope and outcomes • Dementia Strategy	• Effective community based services available to all delivering parity of esteem
Diabetes	• Implement the education programme • Review foot health provision • Review and propose new extended diabetic services in primary care	• Review of pathway for hypoglycaemic episodes to support patients in prevention	• Best practice pathways for all diabetic patients • Elimination of unnecessary diabetes related admissions
COPD	• Review existing pathways and identify gaps • Ensure all COPD patients have comprehensive reviews and care plans in general practice	• Expand the pulmonary care service in the community with outcome based specification	• Reduction of unplanned respiratory related admissions

Programme Two: Urgent Care

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This programme will support the QIPP for unplanned admissions (66 per 1,000 patient benchmark for unplanned admissions and reducing by to 64 per 1,000 patients in 15/16.)

The projects in this programme included the Urgent Care Centre commissioned to manage the increasing demand on accident and emergency services and inappropriate unplanned admissions.

In 2013/14 a significant project for the CCG has been the awarding of a contract for the provision of the Urgent Care Centre in Bracknell.

Intended projects 2014/16:

- Deliver the **Bracknell urgent primary care centre** and business case
- **Integrated frail elderly pathway**, with 'real time' information, support through patient journey around FPH system
- **Falls Clinic** redesign local pathway to incorporate prevention and reduce fractured neck of femurs
- Expand **Integrated Care Teams** and work with clinicians to determine more effective patient identification
- **Nursing and residential homes** quality improvement project delivered jointly with Unitary Authorities and medicines optimised team
- Develop and implement the **discharge management tool** (Vision 10) in general practice for admission avoidance.
- **Support for general practices** (and neighbourhoods) experiencing high levels of unplanned admissions and A&E attendances

Programme Two: Urgent Care

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Theme	2014/15 projects	2015/16 commitments	Outcomes
Bracknell Urgent Care Centre	• Successful contract implementation • Robust communications and engagement plan implemented	• Realisation of full UCC benefits	• Reduction in minor attendances at A&E and 0 length of stays
Integrated Care and Frail Elderly Pathway	• Integrated pathway as part of BCF, including falls prevention • Pathway and best practice review and gap analysis	• Fully integrated services incorporating 'new Bridgewell'	• Utilise the opportunities through Better Care fund , to integrate further the older peoples pathways
Integrated care teams	• Support to practices for case identification • Sustainable cluster teams that meet identified needs • Develop further integration with specialist services in the ICT model	• All people with complex needs anticipated and supported by ICTs	• Reduce unplanned admissions, system failure when inappropriate admissions occur

Programme Three: Recovering from Ill Health

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This programme includes projects in planned care pathways/services which will maintain the 115 referral per 1,000 patient target, and benchmarked levels of elective care whilst commissioning services closer to home.

The main focus has been the procurement of a new Bracknell and Ascot community Musculoskeletal service and the direct access physiotherapy service across east Berkshire CCGs

In 2014/15 review of existing community ENT and ophthalmology pathways and opportunities to reduce the variation around the activity in gastroenterology. Specialist services with as much of the patient pathway delivered closer to the patient in the community.

Intended projects 2014/16:

- **Dermatology** commissioning including low risk BCCs in the community
- **Implementation of MSK** service and the new **community physiotherapy** service
- Addressing **clinical variation through support and education** via Performance Review Group for referral management, medicines management and pathology.
- Realising the opportunities identified for planned pathways, **ophthalmology, ENT, dermatology, gastroenterology and cardiology**
- Specialist Acute Neurological and general **rehabilitation service** review to scope gaps in these services to address and establish commissioning intentions to provide services for affected patients.
- Proactively commission **Locally Commissioned Services** to deliver the CCG plans
- Encourage **innovation and new models** of work i.e. leg ulcers

Programme Three: Recovering from Ill Health

NHS
Bracknell and Ascot
Clinical Commissioning Group

Theme	14/15 QIPP projects	15/16 vision	Outcomes
MSk	• Procurement of new service and contract implementation	• Achievement of top decile performance in MSk elective	• Reduce clinical variation for MSk pathways
Direct Access Physiotherapy	• Establish the new service with provider • Ensure a smooth transition for existing patients into new service	• Continue to monitor the impact of the new service on the patient pathway	• Improved outcomes for patients • Appropriate waiting times for patient requiring therapy
Clinical variation in referrals and benchmarked variation in elective procedures	• Additional support to practices to reduce variation • Review local strategy on C&B and peer review	• Reduce the clinical variation across highest volume outpatient specialties • Understand the opportunities of new eReferrals	• Reduce inappropriate outpatient referrals with a shift to community provision closer to the patient

Programme Four: Patient Experience &Engagement

NHS
Bracknell and Ascot
Clinical Commissioning Group

This programme is a cross-cutting theme to the strategic plan emphasising the importance of patient and public engagement in all that we do.

In 2013/14 the CCG has looked to support the new Healthwatch providers to develop the engagement framework.

The consultation on the CCG Communications and Engagement strategy will commence with key stakeholders and patient representative forums. These actions combined with other opportunities such as Self Care week has supported the conversations for Call to Action.

Intended projects 2014/16:

- Review areas for improvement for **patient experience** feedback including Friends and Family tests, PALS themes, general practice patient surveys and clinical concerns from professionals and patients
- Gain understanding of the impact of the **Personalised Health Budgets**
- **Effective public and patient** involvement in service redesign
- Invest and develop an innovative model for **patient advocates** for engagement in health, training ***Healthmakers*** to work alongside the CCG and help facilitate the delivery of the new Communications and Engagement Strategy.
- Establish a proactive and effective working arrangement with **Healthwatch** and shared purpose
- Broaden engagement through student participation through joint working with Bracknell College and working proactively with the practices PPGs

Programme Four: Patient Experience &Engagement

NHS
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Theme	2014/15 projects	2015/16 commitment	Outcomes
Patient Experience	• Establish robust links with experience feedback to improving quality	• Reflect on all user surveys including new Friends and Family tests	• Improved patient experience with commissioned services
Communication and Engagement Strategy (C&E)	• Complete the consultation and implementation of C&E strategy • Call to Action – continue the consultation • Implementation of C&E strategy	• Review impact of strategy with partners	• Establish robust engagement structure with population with better diverse representation
Public and patient engagement in service redesign	• Continuation throughout all areas of redesign and commissioning • Programme of engagement working with Healthwatch/s	• Implement the Health Makers model of engagement and patient empowerment • Fully integrated network of engagement with Healthwatch at hub	• Ensure patients are at the centre of service changes, learning from previous models

Programme Five: Quality and Safety

NHS
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This programme includes quality improvement areas and commissioning intentions for existing provider contracts. All projects have a relationship with quality and safety and with that in mind this programme spans all the three QIPP programmes for the CCG.

2013/14 intentions for contracts:

•Review of the Community Service specifications to reflect commissioning intentions and integration

•Ensure robust quality schedules and monitoring for all new and revised services

•Working collaboratively across the Unit of Planning and Frimley System

•Support joined up provision of safeguarding across our population in line with Winterbourne

Intended Project 2014/16:

•Continual review all provider contracts and service specifications including **unit of planning** and Frimley System

•Develop further the collaborative and integrated approach to commissioning with all our partners

•Continue to support our providers to deliver the best high quality services, including CQC, Monitor and assurance around Francis report and Keogh principles

•Maintaining the high quality in general practice and enter into a programme of transformation for local primary care

Programme Five: Quality and Safety

NHS
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Theme	2014/15 projects	2015/16 commitments	Outcomes
CQUIN	• Appropriate management of unplanned care	• Working across all provider on the shared CQUIN • 7 day working implementation	• Extension on 13/14 unplanned care CQUIN (three year programme)
Joint (Health) Commissioning	• Ensure robust quality schedules and monitoring for all new and revised services	• Establish robust unit of planning with clear strategic objectives	• Ensure through best practice of commissioning, procurement and contracting we obtain value for money
Ensuring high quality standards	• Continue to reflect on CQC • Respond to Clinical Concerns, patient and user feedback to improve quality and outcomes	• Service specification review with best practice from Networks • Deliver quality outcomes indicators i.e. C-diff and MRSA	• Continue the focus on patient safety throughout all services in line with the Berwick review and the Francis report