NHS Slough Clinical Commissioning Group

Operational Plan 2014-2016

NHS Slough CCG

Feb 2014

Our Approach

NHS Slough Clinical Commissioning Group

- This Plan sets out how Slough CCG intends to commission for its local population for the next 2 years, to ensure that working together with its stakeholders we will continually improve the health of Slough
- The plan outlines outcome ambitions for the next 5 years which will feed into the unit of planning 5 year strategy as we work towards June submission
- We will set an ambition to deliver 5 system objectives and will be measured on outcomes
- We will commit to a joint plan with Slough UA through the Better Care fund deliver integrated health and social care services to the residents of Slough
- We will strengthen delivery of primary care services by working together to achieve excellent primary care
- We will strengthen our clinical collaboration with our stakeholders to deliver a plan which is integrated and inclusive. Innovation will be embraced where there is a strong indication that this will be successful.
- The CCG will work closely with neighbouring CCGs where this will give an optimum outcome and use of resources.
- The CCG will work with local providers through contractual and clinical relationships to drive quality and sustainability in services.

Slough_CCG System Plan on a Page

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Clinicians and patients working together within the NHS to continually improve the health of Slough and healthcare services. Delivering a comprehensive range of high quality services based on best practice

Slough will develop an integrated health and social care system My Health, My Care that provides consistent, high quality , personalised for residents at high risk of hospitalisation or care home admission

System Objectives Measured by Seven Outcome ambitions

Delivered through Interventions

1.To significantly reduce under 75 CVD mortality rates by 2% over 5 yrs

Cardiovascular deaths under 75 are significantly above England average. Program to deliver identification and primary prevention of CVD e.g. by increasing number of NHS Health checks for over 40 Optimise achievement of control of cholesterol by a series of life style and therapeutic interventions. In addition improve cancer screening,
Increase efforts on smoking cessation uptake and improve management of familial hypercholesteraemia especially in **women**

2.Increase people's confidence in managing their LTC to 80% (baseline 75%)

3.Increase number of older people living independently at home (as measured by **reduction of NELA admissions)**

Greater use of shared decision making coupled with a joint management plan. Increasing the use of Telehealth and Telecare. **Advance management of diabetes**. Increase primary prevention and self care programs through structured patient education, Behavioural change management programmes, vision assessment for falls prevention. Care co-ordination through Integrated care teams and case management. Discharge support fallowing patients back into the community and home from acute care. Rapid response with short term intermediate care and reablement. Improving management of end of life care.

4.Improve patient experience of access in Primary Care and Community services (as measured by Outcome Ambition 6)

During the winter months availability of 5% additional GP appointments, GP after hours paediatric clinic, and patient information regarding local services and 111. Local community gynaecology and dermatology services. Direct access to diagnostics e.g., echo, MRI. Services across primary and community available 7 days. Review of urgent care services to improve access and enable IT infrastructure for data sharing across all organisations

5. improve patient experience (Friends & Family Test) and improve experience of care in a hospital setting

Improvements in quality e.g., maternity by using experience led commissioning .. Training professionals and highlighting safeguarding issues. Identification of improvements through Practice leads . Raising clinical concerns via patient experience. Following through practice audits.

Overseen through the following governance arrangements

- Slough Wellbeing Board
- CCG Governing Body
- Unit of planning (Berkshire East) and its federated committees
- Partnership Boards
- Locality of Member Practice
- Urgent Care Programme Group

Delivery of the following transformational model

- Maintain financial sustainability
- Achieve a modern model on integrated care by achieving our vision and ambition asset out in Better Care fund
- High quality urgent and emergency care by delivering our Urgent care Strategy
- Delivering a model of primary care operating over 7 days and with strengthened IT systems
- Patient / Citizen involvement using the model of experience led commissioning

System values and principles

- Focussed on improving our patients' health and experience of health services
- GPs working together to deliver high quality services consistently in the community
- Reliable, trustworthy, respected, transparent and accountable
- Innovative – using best practice,
- evidence based
- Community focused on population needs

Meet local trajectories for Dementia, IAPT and C-Difficile. Meet the NHS Constitution requirements for Cancer, A&E, 18 wks, Cat A Red 1 ambulance calls.

Vision and Values

NHS Slough Clinical Commissioning Group

VISION : Clinicians and patients working together within the NHS to continually improve the health of Slough and healthcare services and making the best use of taxpayers' money.

Our Values

- Reliable, trustworthy and respected
- Transparent and accountable - Nolan Principles
- Innovative – using best practice/evidence based
- Community focused on population needs
- Efficient and effective

Principles

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Focussed on improving our patients' health and experience of health services through
Education; supporting our patients to make healthy choices and to understand and take control of their own illness
Listening: using patient experience and feedback to improve care locally
Communicating: giving clear and consistent message about our services

Clinicians working together to deliver high quality services consistently in the community through :
Education: supporting every practice to deliver consistently the best quality primary care
Listening: using real experiences of services to continuously improve services
Collaborating: working with hospital doctors to deliver the best range of services across the area

Delivering a comprehensive range of high quality services based on the best practices which:
Supports patients within the community, working to keep patients well and at home,
Delivers real integration between health and care services
Ensures a **viable and stable** local hospital
Ensuring **a financially stable health economy** through:
Improving services according to **best practice**
Commissioning service effectively with **our strategic partners** where this maximises the benefits for our patients

Our Commissioning Approach

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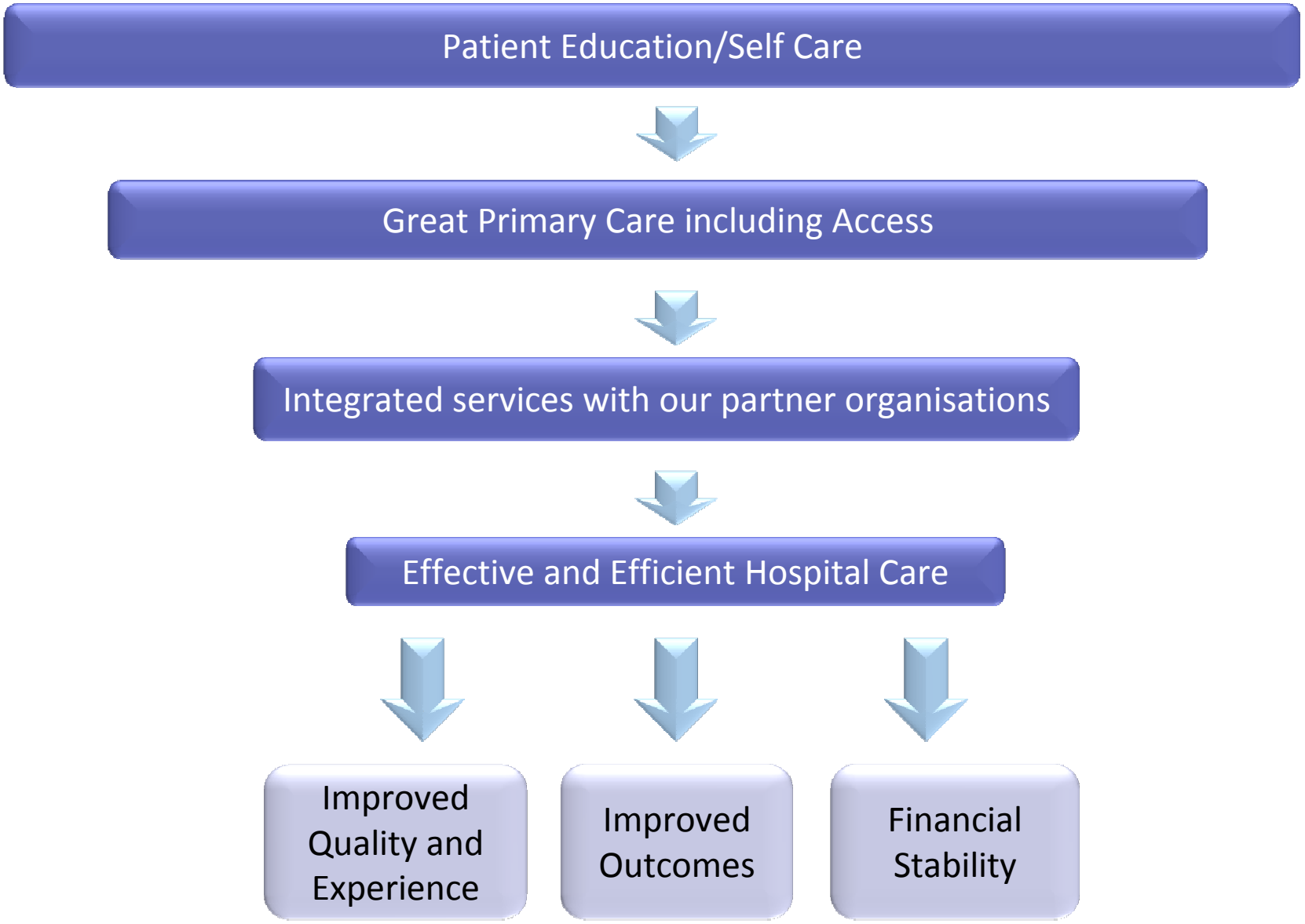

Unit of Planning

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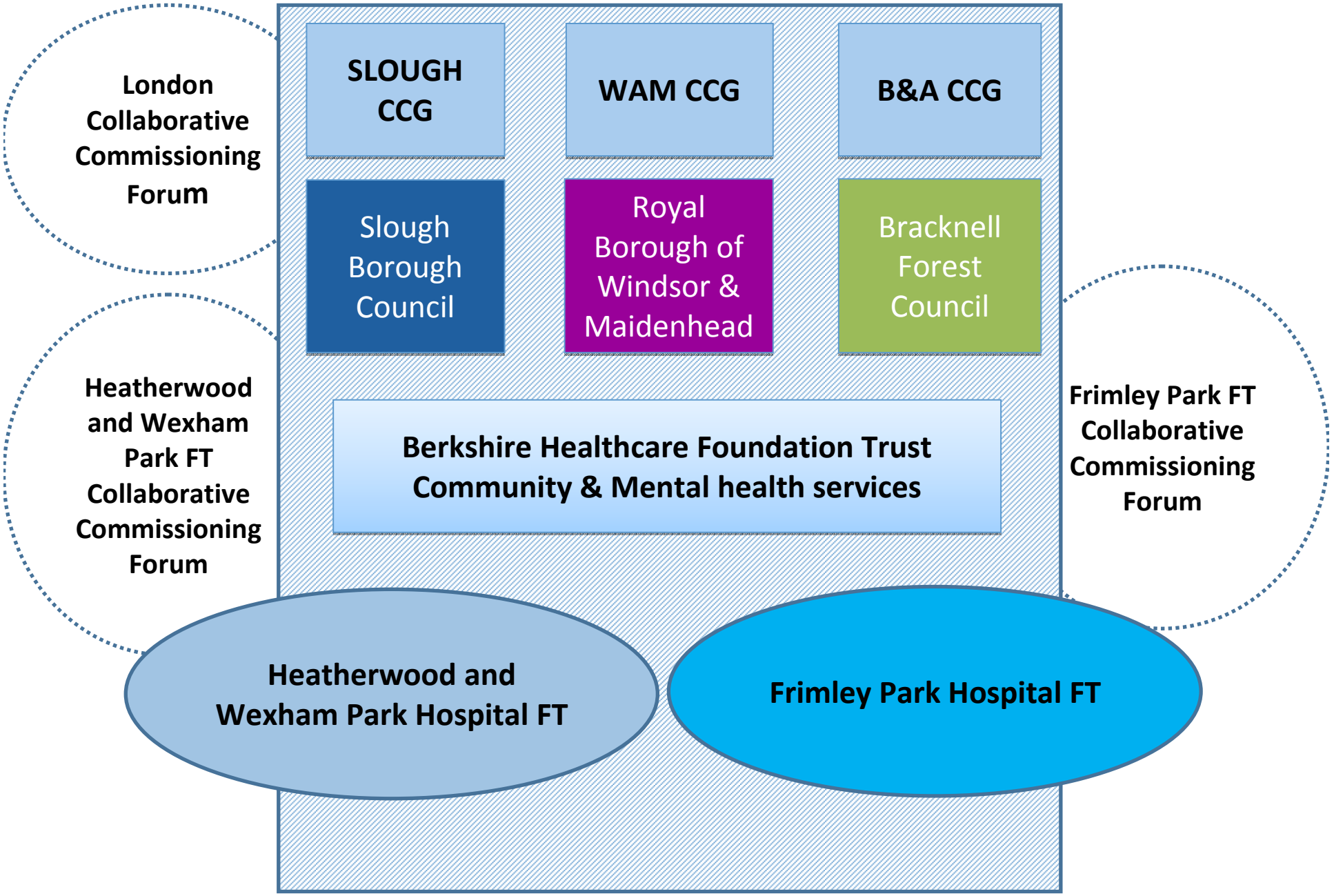

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Joint Strategic Needs Assessment and NHS Outcomes

Joint Strategic Health Analysis

NHS Outcomes framework – Slough Baseline

Slough Identified Health Priorities

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Link NHS Outcomes Framework to JSNA Priorities

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	Health Priority	COF	Link to CCG Outcomes Indicator Set 2013/14
1.	Diabetes	**2.1** **2.3.1**	People with diabetes who have received nine care processes People feeling supported to manage their health condition Reducing unplanned hospitalisation for diabetes in under 19s
2	Coronary Heart Disease	1.1 1.4 3.4 2.1	Reducing under 75 mortality rate from cardiovascular disease Increase 1 & 5 year survival rate from lung cancer Improving recovery from stoke (are admitted to a stroke unit within four hours of arrival to hospital People feeling supported to manage their condition
3	Sexual health and family planning (HIV,TOP,birth rate, Cervical Smears)	1.4 1.13-1.15	Increase 1 &5 year survival rate from all cancers Reducing deaths in babies and young children (antenatal assessments <13 weeks, maternal smoking at delivery, breast feeding prevalence at 6-8 weeks)
4	Mental Health include CAMHS, depression inc. (dementia)	1..1.2 2.6(i) 2.6 2.10 2.11 2.12	People with severe mental illness who have received a list of physical checks Estimated diagnosis rate for people with dementia People with dementia prescribed antipsychotic medication Access to psychological therapy services be people fro BME groups Recovery following talking therapies for people of all ages Recovery following talking therapies for people older than 65
5	Early interventions to reduce child poverty, child obesity and improve child safety,	2.3(ii) 3.2 1.13-1.15	Reduce unplanned hospitalisation for asthma & epilepsy in under 19s Preventing LRTI in children from becoming serious(emergency admissions for child with LRTI Reducing deaths in babies and young children (antenatal assessments <13 weeks, maternal smoking at delivery, breast feeding prevalence at 6-8 weeks)
6	Reduce violent crime, domestic abuse and sexual abuse	LA OF 4A	No CCG outcomes indicator available. LA indicator proportion of people who use the services who feel safe.
7	Reduce inequalities in health (TB, support for new entrants, oral health, immunisation	2.1 4.1	People feeling supported to manage their condition Patient experience of GP services

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Slough - Stakeholder Assessment

Readiness of the Local System to Deliver the Change Agenda

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- **Our Unit of Planning is complex as**
  - 3 CCGs in Berkshire east are working in a federation 3 broadly co-terminous Local Authorities
  - 1 Community/Mental Health Provider
  - 2 Main Acute Providers – one about to be the subject of an acquisition by the other to form a merged Trust
  - Other important providers
- **Collaborative Commissioning Forums created with fellow CCG** Commissioners (outside UoP) for 2 main acute providers and London Providers
- **Local context has made some relationships difficult** – challenging public consultation leading to unsuccessful Judicial Review and request for Independent Review panel- Acute provider the subject of ongoing risk summit.

Local Stakeholder development

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Our first order of priority has been to create the environment for shared system leadership, while forging ahead with local integration strategies. The three CCGs have undertaken the following process to support development of our local stakeholders and overcome previous relationship difficulties.

Process of local stakeholder development	Timetable
CCGs engage the Kings Fund to support system wide relationship development. Telephone interviews of all system leaders, individual organisation feedback followed by facilitation of strategic workshops	November 2013 to January 2014
Area Team facilitate a series of Transaction meetings to enable co-ordination of commissioner response to the Acquisition	November 2014
CCG/Local Authority Partnerships consolidated, Joint Strategies developed and signed off by HWBs, BCF Governance agreed and in place.	January 2014
Commissioner/Provider Joint clinical strategic events – Frimley Park Hospital FT, Heatherwood and Wexham Park Hospital FT, Berkshire Healthcare FT. Workshop national strategies – 15% reduction emergency, 20% increase elective efficiency, 7 Day working	February 2014
Clinical Vision for merged acute trust created.	February and March 2014
Health and Social Care Leaders Forum created across the Unit of Planning.	2014

Our Joint Approach – Build Vision, Turn it into Action

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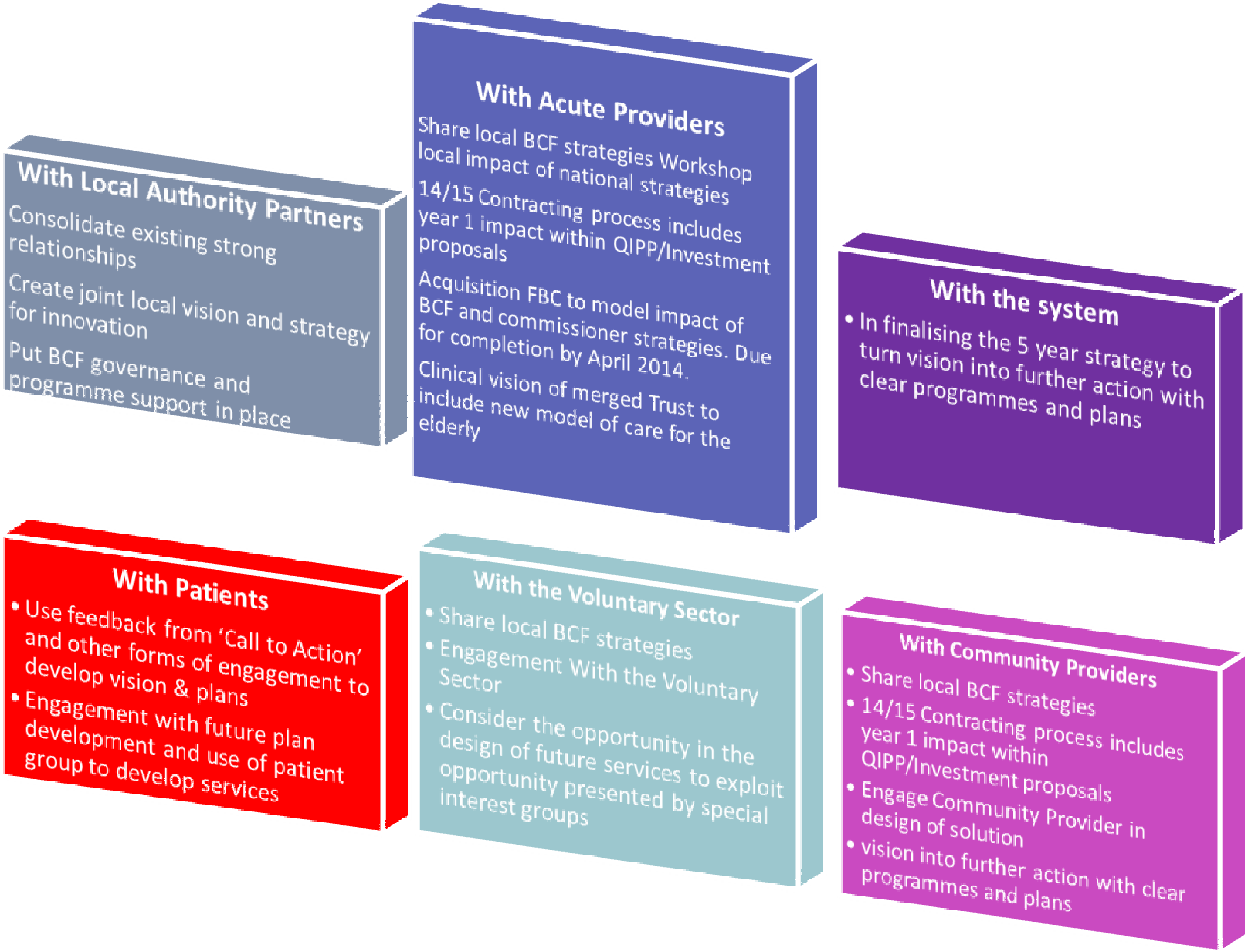

Call to Action Events

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Slough CCG has continuously engaged with its patients and carers in a series of engagement events

Objectives

•To build continuous and meaningful engagement with the public, patients and carers to influence the shaping of services and improve the health of people in Slough.

•To deliver improvements in patient experience of health care services.

•To increase knowledge and awareness of the range of local services, increasing the appropriate use of these services.

Public and patients

General Public

Saturday morning road shows at Tesco Superstore held 25th January 2014

System wide workshop with providers, patients and local councillors to develop our vision for Better integrated services

Specific Patient Groups

Older People event including PPG representatives held 12th Feb 2014.

Community groups such as Somali and Pakistani held 13th Dec 2013

Patients at risk or suffering from long-term conditions such as diabetes, CVD planned for March

Maternity programme- Series of engagement events and co-design work specifically to improve outcomes in pregnancy and childbirth

Patients at GP Practices

Engagement with PPG members to support the build up of primary care strategy held 31st January 2014

Member practices and other clinicians

•Developing effective engagement and communications with member practices and practice representatives.

•Effective use of the CCG website

•Survey practice managers on best approach for newsletter

•Support role of practice representatives

Challenges in Local Health System

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SYSTEM

Delivery of QIPP programme

Challenged provider

Development of the integration agenda with all partners and stakeholders

Risks around HWPH merger with Frimley

PROVIDERS

Over performance in secondary care hindering integration agenda

Implementation of the newly commissioned services

Quality concerns and patient experience in some areas

Slough CCG

PRIMARY CARE

Engagement in the Primary Care Strategy

Meeting the challenge of integration and extending hours of work

Access to primary care service in a deprived and high demand population

STAKEHOLDERS

Partnership working on safeguarding

Inclusive stakeholders engagement

Patients/ Citizen engagement to shape commissioned services

Response to our Challenges

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SYSTEM

Rigorous monitoring of QIPP and excellent member engagement

Partnership with neighbouring CCGs to manage provider performance

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

Slough CCG

PRIMARY CARE

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

Continue to develop engagement with member practices and enable collaborative working and improve access to primary care services

STAKEHOLDERS

Co- designing commissioning plan with citizens and clinicians

Robust governance to deliver the Better care Fund

Enable provider engagement

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Setting our Ambition

Setting our ambition and planning transformation

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- The CCG and its member practices met to agree our objectives and areas of priority to deliver sustainable improvement in health in our population.
- The areas we developed broadly map into the 7 outcome ambitions as set out in the planning guidance NHS England 'Everyone Counts' 14-15
- The CCG therefore has taken the step to map our plan to the 7 outcome ambitions with an agreed trajectory of improvement over 5 years.
- We are engaging our citizens in this approach by using innovative methods e.g. experience led commissioning to co- design the plan and therefore truly enable our plan to be patient / citizen centred.
- The following slides set out our current baseline and sets out our challenges and informs system objectives.

Slough Outcome Ambitions – 5 year framework

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The 7 ambitions	Do I have to submit a 5-year 'quantifiable' ambition figure?	What is the baseline measure to set the quantifiable ambition against?
1. Securing additional years of life for your local population with treatable conditions.	✓	Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (Adults, children and young people)
2. Improving the health related quality of life of people with one or more long-term conditions	✓	Health-related quality of life for people with long-term conditions
3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	✓	Quality Premium Composite Indicator
4. Increasing the proportion of older people living independently at home following discharge from hospital	*No indicator available at CCG level to set quantifiable level of ambition against. However CCG plans on this ambition should be making explicit links to the related ambition as part the Better Care Fund, set for 2 years at Health & Wellbeing Board level.*	
5. Increasing the number of people having a positive experience of hospital care	✓	Patient experience of hospital care
6. Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community	✓	Patient experience of GP services and GP Out of Hours services
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	*Baseline data not yet available at CCG level to set quantifiable level of ambition against. However 'case note review' data will be available to measure progress on local plans in the next few years.*	

E.A.1	Potential Years Life Lost (PYLL) from causes considered amenable to healthcare (DSR per 100k population)
E.A.2	Average EQ-5D score for people reporting having one or more long-term conditions (Q34 GP survey, weighted)(out of 100)
E.A.4	Composite measure of avoidable emergency admissions (per 100k pop, indirectly standardised)

Better Care fund metric includes: Number of Permanent admissions of older people (aged 65 and over) to residential and nursing care homes,Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services,Delayed transfers of care from hospital

E.A.5	Poor patient experience of inpatient care (2012 CQC inpatient survey; standardised by age, gender and NEL/EL; average number of 'poor' responses per 100 patients, 15 selected questions)
E.A.7	Proportion of 'poor' responses to GP survey overall experience questions for GP and out of hours.

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QIPP PLAN 2014-2016

Preventing people from dying prematurely

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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 CHD, 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

Project Name	Proposed Action	Intended impact
Smoking cessation prior to	This initiative will aim to increase the number of smokers quitting prior to elective surgery and reduce surgical complications	Reduction in OP follow ups Increase referrals to quit smoking services
Diabetes screening	Reduce the number of undiagnosed patients with diabetes through targeted screening of high risk groups and via collaboration between the CCG, public health, and other groups (e.g. industry, faith groups, charities).	Screen 20% appropriate Slough population by end 2014/15
Puffell	To adopt a free online platform (www.puffell.com) to local needs. The platform is designed to encourage individuals, families and communities to self manage their health and wellbeing. Primary focus is prevention and early intervention; helping to self-care and do more for themselves and for others, reducing burden on the system now and in the future.	2000 people to be signed up by month three from launch Nos of local courses held to promote the resource to those who do not own a computer or smart phone -3 per quarter in library settings following launch

Enhancing quality of Life for people with long term conditions-

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This programme will focus on providing support for patients in the community to manage their conditions. 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.

Project Name	Proposed Action	Intended impact
Urgent care & LTC admission	To implement agreed urgent care and LTC models in Berkshire East .	Reduction in NEL admissions Reduction in length of stay -To improve performance to upper decile or 9th best in England for each CCG
Community integrated care teams for people with Long Term Conditions	To continue to provide community services in an integrated capacity so that the patients with LTC are managed in the community in timely manner.	Reduce NEL admissions Reduction in length of stay Increase the number of people with LTC are managed in the community
Medicine Optimisation in Asthma	To use clinical pharmacists to review patients with asthma and COPD in practices to see if therapy is optimised.	Appropriate and effective use of inhalers
Review of Congestive obstructive Pulmonary disease	To ensure that all patients receive the most cost effective care for COPD leading to an overall improvement in their quality of life and disease status.	A reduction in inappropriate A&E attendances and admissions. Facilitate early discharge Patients Patients will be diagnosed at an earlier stage Reduction in Non elective attendances. Increase in community contact
Community nursing services (All CCGs)	Review of community nursing services so that they are fully intergrrated to provide seamless care for the patients in the community in particular for specialist nursing, mental health and district nursing including Leg Ulcers clinics	Increase in community contacts
Data sharing of GP Clinical records	To enable a solution to the sharing of patient information. from GP Clinical records to allow two-way communication between GP Practices and secondary care and other primary care services.	Patients will receive coordinated and integrated responses to their care needs reducing margin for error, saving time and making sure patients are given the appropriate treatment from the start.

Helping people to recover from episodes of ill health or following injury

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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

Project Name	Proposed Action	Intended impact
Community Physiotherapy services	Procurement of a high quality, dedicated and professional physiotherapy MSK service which provides comprehensive assessment and treatment which is high in quality.	Improve access to Physiotherapy services Reduction in waiting times Improve in patient experience
GP Referral management	Reduce clinical variation in referrals to Acute providers for identified specialities	CCG to achieve the top decile performance
Benchmarked variation in elective procedures	Reduce Clinical variation in identified areas for elective procedures	Reduction in waiting times Improve in patient experience CCG to achieve the top decile performance for identified procedures
Ophthalmology	Review of current service with a view to commission more effective ophthalmology services, ensuring consistency and reducing clinical variation. Promotion of a model of co-ordinated care across secondary and primary care.	Provide timely access to specialist assessment, diagnosis and initiation of treatment. Improve in quality Improve patient experience Reduction in first OP and follow ups
Dermatology	The CCGs will commission dermatology services that can be provided in a community setting.	Provide local service Reduce waiting times Reduction in First Out patients and Follow up appointments
Cardiology	Service Redesign of cardiology services in Berkshire East. To ensure patients with a suspected non urgent cardiac condition can be receive consistent management in a community setting promote early diagnosis therefore increasing life expectancy in this group of patients	Provide timely access for cardiology services, appropriate diagnostics services . Early diagnosis Reduction in waiting times

Ensuring People have a positive experience of care

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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

Project Name	Proposed Action	Intended impact
Pathology	Review of pathology referrals and use benchmarking data to highlight outlying GP practices to reduce clinical variation across Berkshire East.	Reduction in duplication of pathology referrals
Community Gynaecology service	The CCG will commission gynaecology services that can be provided in a community . To ensure that clinicians are using evidence based clinical protocols resulting in quicker and more appropriate care in an intermediate care setting	Improve access to services. Provide local services Reduction in inappropriate referrals from practices
Procedures of Limited Clinical Value	The CCGs will continue their schedule of low priority policies, ensuring adherence to these via the contracts. Have clear and transparent procedure for the treatment of patients on the PLCV pathways.	Reduction in secondary care surgical activity in line with best clinical practice
Reducing waste through inhaler exchange	The project will run as an “inhaler exchange”. People collecting repeat prescriptions will be asked to return their used inhalers prior to issue of their next inhaler.	To reduce waste by identifying patients who order inhalers and don’t use them. Identification of patients who’s therapy needs optimising
Management of gastroenterology digestive systems in primary care.	Setting up a triage system of initial assessment and management whereby all upper GI related referrals will be reviewed by the Clinical Lead GI. Patient group will be classified according to the seriousness of their injuries or illnesses so that treatment priorities can be allocated between them.	Referrals in to secondary care are both timely and appropriate Better Patient Outcomes Reduction in inappropriate referrals from practices
Management of Urological Conditions	The new model of care will require collaborative partnership working across primary care, community and secondary care.	Reduce waiting times Out patient & Elective admissions
Audiology (micro suction) (All CCG)	The aim is to improve patients’ experience of adult hearing rehabilitation by the provision of a service for the removal of earwax as part of an integrated adult hearing pathway by the provision of a ‘one-stop’ shop	Reducing the number of health care attendances required in the management of their condition Reduction in related Outpatient referrals
Wound Care Prescribing	Review of dressings and prescribing budgets	Effective use of resources of wound care products leading to improvement in wound treatment.

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

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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 integration of teams where possible to reduce avoidable harm.

Project Name	Proposed Action	Intended impact
Reduction in non elective admissions in care homes and improving quality of care delivered in our care homes	The aim would is to set up a project review group within Slough BC and Slough CCG to develop the following: Consistent set of care home provision dataset including contact details of GP, pharmacist, care home managers to inform the group Develop a consistent framework of quality markers e.g. non elective admission rates, DNR records, SUIs .pressure sores and develop a dashboard Review current adherence to each marker of quality and address gaps by development of a training module with partners e.g BHFT	Earlier identification of need – eg hearing and eye care, diabetes assessment, memory loss Identification of nutrition needs and then support individuals to achieve optimal health Activities to reduce social isolation and depression Attendance at regular healthchecks and medication reviews Fall prevention strategies Access to and use of equipment and assistive living technologies Tissue viability – prevention and early identification of pressure sores and leg ulcers Reduction in NEL attendances

Children and Young people- emerging strategy

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Children and Young People Aims:

- Ensure active engagement with children, young people and families
- Coordinate the commissioning of children's health and social care across the whole spectrum of children's and young people's needs across the life course
- Improve the health and wellbeing of children and young people with a focus on early intervention and prevention
- Development of integrated care pathways including primary care, community children's services, public health and secondary care services
- Ensure that Child and Adolescent Mental Health Services meet the needs of the population

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Mental Health

Project Name	Proposed Action	Expected Outcomes	Intended impact
Talking Health	To offer a service for patients that are outside IAPT service specification and for whom there is not a psychological support service to improve their physical health outcomes.	To improve self-care by teaching self-management CBT skills e.g.. Behavioural activation, motivational techniques, goal setting, anxiety management, adjustment to living to a LTC. Will focus on patients with COPD, Diabetes and Heart Disease in Year 1	Improve quality of life. Increase in self-management of diabetes and COPD . Reduction in isolation, patients are supported and consult less 250 patients seen
Medically Unexplained Symptoms Project (MUS)	The MUS project is designed to focus on a small number of complex and hard to define patients who make disproportionate use of primary care and acute hospital services. The Project will enable primary care to identify and address the complex agenda of MUS through: patient identification and management techniques, developing supporting services for psychological approaches, to optimize patient self-management	Reduction in Primary Care consultations; Skill GPs to manage MUS patients, supported by positive risk management and collaborative working with secondary care and liaison psychiatry to reduce unnecessary investigations, referrals and treatments; Develop specific multi–disciplinary pathways and management strategies. Develop clinical coding systems in primary care to flag at-risk patients and develop GP data processes to monitor the health of MUS patients. Establish the evidence base for improved management of MUS to deliver cost efficiencies through reduction in health care utilisation.	Reduction in symptoms of psychological distress and improvement in patient's quality of life , wellbeing and management of their own health Reduce frequent attenders in primary care and secondary care, reduce unnecessary referrals, investigations, treatment and the potential for iatrogenic complications Develop advanced consultation skills in primary care through GP training
Older people's Mental Health Liaison team	The proposal is to develop and provide a specialist Older People's Mental Health Liaison Team based in Heatherwood and Wexham Park hospitals (HWPH) that will work with inpatients from all three CCGs in east Berkshire. The main aim of the service is to reduce excess bed days in non-elective admissions in patients over 65 year whilst providing advice, diagnosis and signposting for effective treatment and management of mental health conditions including dementia.	The proposed service will support increasing the diagnosis rate of people with dementia in the area. Hospitalisation can give an opportunity to ensure proper diagnostic assessment and also to ensure that while in hospital and on discharge, reasonable adjustments are made to the person's care to take account of their dementia. These could have a positive impact on the length of stay and excess bed days Provide information and guidance for patients and carers in a range of appropriate formats. Support the delivery of junior doctor induction sessions, through contribution of specialist expertise	Provide rapid access to mental health professionals within agreed response times. Provide rapid, early and accurate detection and use of diagnostic tools and provisional diagnosis for dementia and exclusion of non-dementing illnesses in older people admitted to the hospital. Advise on inappropriate use of antipsychotics for behavioural symptoms in dementia. Reduce delayed discharges by liaising with relevant mental health and social care services. Outcomes of assessments and discharge or care plans will be communicated with relevant services

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Financial Overview

Financial Overview

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- CCGs are expected to manage expenditure within the resources allocated by NHS England, and deliver a 1% surplus (which can be carried forward to future years). The Slough CCG financial plan delivers the required 1% surplus in each year and a minimum contingency of 0.5% is retained, in addition to a specific commissioning reserve of £1m. The plan also sets aside 2.5% for non-recurrent expenditure in 2014/15, including 1% for system transformation. The primary vehicle for decision making around use of this transformation money will be in partnership with Slough BC via the Better Care Fund. For 2015/16 the plan assumes that approximately 50% of the CCG monies contributing to the Better Care Fund will be uncommitted, with the balance covering existing services (primarily ones already managed by our local authorities via s75 agreements). This is however dependent on delivering savings in 2014/15.
- The Plan also allows for £5/head for the development of primary care services enabling the better identification and support of elderly patients in the community. In addition a reserve has been established for monies received from the "70% non-elective threshold calculation" (part of our contractual arrangements with local acute Trusts). Reinvestment is likely to be decided either through the Better Care Fund arrangements or the local Urgent Care Board. During recent months the system has benefited from additional Winter Pressures monies. Although the CCG is aware that monies have been retained centrally for winter 2014/15, we are not placing reliance on this and the continuation of some schemes may be agreed via the Better Care Fund.
- Running Costs are planned to continue at current levels during 2014/15, with a reduction of 10% in 2015/16 in line with the national guidance. This reduction has been applied equally across all areas of our Running Costs.
- Our Plan assumes that the reported surpluses for 2013/14 (as at the end of December) will be available in full in 2014/15
- In addition to the holding of contingencies, as one of three CCGs in the Berkshire East Federation, some risk will be managed through the pooling of budgets in areas such as Continuing Healthcare and high-cost out of area mental health placements.
- Medium terms plans are to achieve a 3% reduction in emergency activity year on year, to fund new services supporting care closer to home.

Funding Allocations 2014-15 and 2015-16

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	Slough 2014/15 £m	Slough 2015/16 £m
Programme	153.0	158.8
Running Costs	3.5	3.2
Better Care Fund		2.4
	156.5	**164.4**
Transfers not yet actioned	-0.1	-0.1
	156.4	**164.3**
Growth on previous year	**6.0**	**5.8**
Percentage growth	4.12%	3.76%

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").

- Slough 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 7.2% below target (which equates to £11.8m)
- 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.

Better Care Fund

NHS Slough Clinical Commissioning Group

	2014/15	2015/16
Health Budgets	**£m**	**£m**
Carers	0.210	0.210
Community Equipment (s.75)	0.583	0.583
Intermediate Care (s.75)	0.857	0.857
CCG match funding s256	0.430	0.430
Ward 8 & Early Suppotive Discharge Service	0.724	0.724
Oaks EMI		0.076
Henley Suite		0.247
Foot care		0.014
CCG additional BCF contribution		2.647
Sub Total	2.804	5.788
Local Authority Budgets		
s256 money continued from 2013/14	1.850	1.850
Additional s256 transfer	0.430	0.430
Disabilities Facilities Grant		0.407
Social Care Capital Grant		0.287
Intermediate Care	1.000	1.000
Sub Total	3.280	3.974
Overall Total	**6.084**	**9.762**

- The Better Care Fund comprises a range of existing health and social care budgets, plus additional monies for new community based services, predominantly focused on enabling older people to stay well and at home for longer.
- In 2014/15 the Better Care Fund will be operating in a shadow form, prior to being established as a “pooled budget” in April 2015.
- The table shows the anticipated budgets for the Better Care Fund overseen by Slough Health and Wellbeing Board.
- Slough Borough Council are planning to include their Intermediate Care budgets within the scope of the Fund, and it is probable that the overall value of activity managed through the Better Care Fund will continue to grow over time.
- The amount of money available for investment in new services will depend on the ability to achieve offsetting savings in acute services.

Slough CCG

NHS Slough Clinical Commissioning Group

2013/14 Budget & Spend

	£m
Funding Allocation	**151.2**
Forecast Spend	**149.2**
Surplus	**2.0**

2014/15 Funding

	£m	
	151.2	
Growth	6.0	
Other	(0.8)	
Funding Allocation	**156.4**	**7.2**
Previous Yr Surplus	2.0	
	158.4	

2015/16 Funding

	£m	
	156.4	
Growth	5.8	
Better Care Fund	2.4	
Running Cost Reduction	(0.3)	
Funding Allocation	**164.3**	**9.4**
Previous Yr Surplus	1.5	
	165.8	

- 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	2.8
Inflation/Efficiency	(1.2)
NR Headroom	2.9
Support for Primary Care	0.7
Better Care Fund	
- Investment	0.3
- Offsetting Budgets	
QIPP	
- Investments	1.5
- Savings	(3.9)
Other	2.6
1% Surplus	1.5
	7.2

	£m
Growth	2.6
Inflation/Efficiency	(0.7)
NR Headroom (2.5% to 1%)	(2.3)
Better Care Fund	
- Investment	8.1
- Offsetting Budgets	(2.6)
QIPP	
- Investments	
- Savings	(1.8)
Other	4.5
1% Surplus	1.6
	9.4

Slough CCG

NHS Slough Clinical Commissioning Group

Budget Summary

	13/14	14/15	15/16
	£m	£m	£m
Secondary Acute			
- Heatherwood & Wexham	68.5	69.7	69.5
- Royal Berkshire	4.0	4.0	4.0
- Frimley Park	0.1	0.1	0.1
- Other	13.0	13.0	13.0
Mental Health	14.6	14.8	14.9
Community Health	12.8	13.1	12.5
Other Programme	2.3	2.4	2.5
Primary Care	-	-	-
- Prescribing	15.7	16.3	17.0
- Other	2.6	3.5	3.6
Out of Hospital	10.5	11.0	11.8
Corporate	3.4	3.5	3.1
Reserves	1.7	5.0	6.5
Contingency	-	0.5	5.6
	149.2	**156.9**	**164.2**
Surplus	2.0	1.5	1.6
	151.2	**158.4**	**165.8**

Reserves

		14/15	15/16
		£m	**£m**
Gen Reserves	- Better Care Fund	-	5.4
	- CHC Reserve	0.7	0.7
	- Commissioning Reserve	1.0	1.0
	- Other Committed Reserves	0.8	0.8
	- Uncommitted	1.0	1.0
		3.4	**8.9**
NR Headroom	- Better Care Fund	0.4	-
	- Transformation Investment	1.1	-
	- QIPP Reserves	1.6	0.7
	- Committed Reserves	0.6	0.7
	- Uncommitted	0.2	0.2
		3.9	**1.6**
QIPP	- Investments	1.5	1.4
	- Savings	(3.9)	(5.3)
		(2.3)	**(3.9)**
		5.0	**6.5**

5 year system plan – Emerging strategy

NHS Slough Clinical Commissioning Group

- Better care fund
- Primary care strategy
- IMT strategy

Slough Primary Care Strategy

NHS Slough Clinical Commissioning Group

Emerging strands include:

- 7 day working
- Integrated care model – with community teams and in alignment with the Better care fund model
- Specialist clinics e.g. diabetes, COPD, Falls prevention
- Urgent care model to include diagnostics
- Self care and support groups in practices to enable patients to manage their own health.