SLOUGH BOROUGH COUNCIL

REPORT TO: Slough Wellbeing Board **DATE:** 23rd March 2016

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WARD(S): All

PART I
FOR COMMENT & CONSIDERATION

NHS SLOUGH CCG: 5 YEAR PLAN REFRESH AND UPDATE ON 2 YEAR PLAN

1. Purpose of Report

To inform the Board of the CCGs updated 5 yr plan and to provide an update on our 2 yr operational plan

1.1 The CCG has refreshed its 5 yr strategy and paper below outlines a high level summary. In December 2015 NHS England published – Five year Forward View planning guidance 2016-2020. This sets out the requirement for local areas to set set out plans that are transformational across systems that enable system sustainability. The health and care system will be embarking on planning to respond to the guidance in the coming months.

1.2 The CCG reports annually on our progress and achievements on our operational plans. This report is detailed on page 5

2. Recommendation(s)/Proposed Action

The Wellbeing Board is asked to:

(a) Note the progress to date on the CCG 2yr operational plans.

(b) Note the recommendation for the CCG plans to work on a wider system transformational plans on a wider footprint.

(c) Note and Approve CCG refreshed 5 yr plan and 1yr 16-17 operational plans.

3a. Slough Joint Wellbeing Strategy Priorities –

3a.1 The Slough 5 yr plans and 2 yr operational plan builds on the JSNA and joint wellbeing strategy to put plans in place that enable us to achieve better health outcomes for our population.

Priorities:

- Health
- Regeneration and Environment
- Housing
- Safer Communities

3b. Five Year Plan Outcomes

The CCG refreshed 5yr plan and 2 yr operational plans will support delivery on the Slough Borough Councils five year outcomes listed below

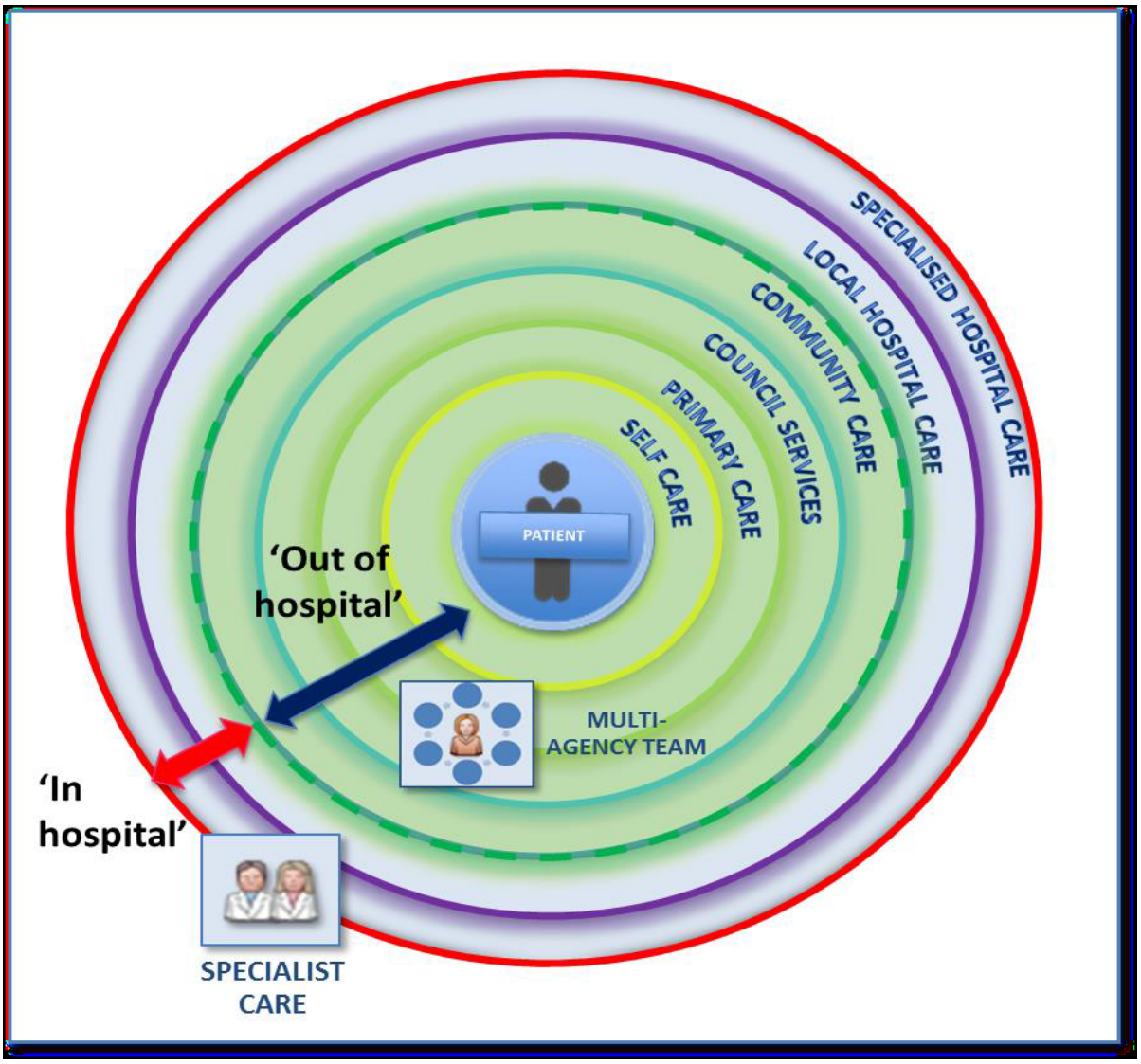
- More people will take responsibility and manage their own health, care and support needs
- Children and young people in Slough will be healthy, resilient and have positive life chances

Our joint ambition is to work closely on all areas that impact our joint strategies and thus we have actively engaged in the Slough one public estate strategy and the Slough digital transformation plans.

4. **A summary of our refreshed strategy is set out below:**

In East Berkshire the three CCGs are committed to working together to deliver high quality, affordable healthcare which delivers excellent patient experience and improved health outcomes.

We 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" below. Slough Borough Council has been heavily engaged in the development of the 'New Vision of care'



In order to deliver our vision we will need a sustainable workforce that is well trained and open to working differently. We will need to review and develop our estate so that it is fit for purpose to deliver the services of the future. We will ensure that a shared care record is available so that patients only have to tell their story once and clinicians have access to the same information no matter where a patient is seen. Our digital roadmap will set out how we can maximise the use of technology assisted care and improve efficiency through digital technologies.

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 the other commissioners of our major providers to develop and deliver a system sustainability plan. The ability to commission differently from primary care will be key to the delivery of our vision and we aim to have full delegation of primary care commissioning by April 2017. We will also take on a greater role in the commissioning of specialist services.

The key strategic themes to deliver our vision are:

Self management and prevention

- People will be encouraged to take action to improve their health now and for the future. Understanding how their lifestyles impact on their health and how they can make positive changes.
- Those living with long term and chronic conditions will be supported to understand and have confidence in managing their health needs, and we will improve medicines optimisation for people with multiple conditions.
- We will work better with community pharmacists, carers and the voluntary sector to provide people with support on an ongoing basis, tailoring our approach to different communities.

Primary Care

- Primary care will come together in clusters or federated groups. This will allow pooling of limited resources and expertise which will create efficiencies to sustain primary care.
- Primary care clinicians will develop further areas of specialist expertise and refer patients to each other.
- We will develop a model of primary care for 7 day working from 8am to 8pm which complements the existing high quality services
- New arrangements will be introduced to manage demand, including initial telephone consultations to assess whether an appointment is necessary and non face-to- face appointments.

Person Centred co-ordinated care

- Integrated care will be developed to complement the primary care clusters and federated groups. General practices will contact patients who are most at risk of developing complex care needs and develop a shared care plan.
- The shared care plan will draw on all appropriate services, including other primary care clinicians, social care, community health services, mental health services and acute specialists. They will work in integrated teams to avoid admission and support patients back into the community following acute care.

Elective Care

- Decision support aids will be used to support conversations between clinicians and patients about the best course of action for the individual.
- The traditional outpatient model will change. The aim is that primary care clinicians can increasingly draw upon specialist expertise through networks, enabled by technology, with a much reduced demand on consultant led hospital clinics.

- End to end pathways will be developed. We will take an integrated approach to commissioning these and a standardised approach to implementing them.
- The aim is reduce length of stay in hospital by embedding enhanced recovery across all elective surgical pathways and improving discharge co-ordination.

Urgent Care

- We will develop an urgent care system which removes duplication and maximises the use of resources. Entry points to urgent care will be rationalised, and we will work with NHS 111 to improve their services.
- Access to primary care will be improved through the development of seven day working. Emergency appointments will be available out of hours with a certain number held for children.
- The role of the Ambulance Service will be transformed. There will be a retraining of ambulance staff, enhancing their skills and increasing the number of paramedics who can see people in their own homes.
- People will only go to A and E when they need it. A and E will be designed to ensure that patients have the right level of intervention and support.

4.1 CCG System Sustainability and Transformation plans (STP)

In addition the CCGs are required to work across a wider system 'footprint' to develop a Sustainability and Transformation Plan (STP), which will become an umbrella plan for many of our existing strategies. The STP will have to ensure that all of these strategies are aligned to deliver our collective vision for the transformation of services and the Five Year Forward View. Our system will not have access to any transformation funding from 2017/18 onwards without an agreed STP. STPs are intended to be place/ population based plans, encompassing all partner organisations.

Following discussion with stakeholders, we are working collaboratively as part of the 'Frimley Footprint'. This brings together the populations covered by the three East Berkshire CCGs, Surrey Heath CCG and North East Hants and Farnham. Chiltern CCG will also be involved although not a formal partner. Our footprint brings together a group of high performing and ambitious providers, commissioners and wider systems serving a population of c900,000 people. Together, these organisations have a reputation for delivering excellent care that meet and exceed national targets and benchmarks and innovating to further improve services to patients. Our ambition now is to use our strength and track record to develop an excellent, sustainable health and care system.

We recognise the importance of the layers of plans that sit above and below our STP and the importance of our horizontal links to other STP's. Within our footprint there will be plans that are best taken forward at local, CCG or County level and these will continue the string working relationships we have with our partners. For some services, for example some specialist services, the appropriate planning footprint will be larger than our footprint.

The existing East Berkshire System Leaders Group will play a strong role in the STP and has membership from Slough Borough Council and an Executive Group responsible for pulling the plan together will also have representation from Slough Borough Council. The final plan has to be submitted by the end of June 2016.

5. Slough CCG 2 year operational plans- progress to date:

5.1 Summary

Our 2 year operational plans were refreshed in line with NHS England guidance published in December 2014.
In December 2015 NHS England have published renewed set of planning guidance which will require us to set out transformational plans which address system sustainability over a 5 yr period. We will additionally be required to publish a one year operational plan which must align with our system plans.

This report sets out our journey to date and our plans to further build our system plans

5.2 What is our progress to date on our current 2 year operational plans (Italics states the plan as was submitted to NHS England)

1) *We will continue to ensure that patient is at the centre of all that we do and continue to involve the public and patients in commissioning services.*
   Patient engagement in planning and improving our services has been at the heart of our commissioning plans.
   We have a regular forum of engagement ranging from the community partnership forum to discuss strategic priorities to a well-established patient forum group that has fed into various pieces of improvements e.g. primary care access work streams, engagement in primary specific projects e.g. simple words programme or group consultations work. Actively reporting to Overview scrutiny committees e.g. GP access issues paper, mental health concordant report. We have been working closely with Healthwatch to ensure we improve services in line where Helathwatch have carried out reviews e.g. primary care access.

2) *To deliver all the NHS Constitutional standards sustainably in year and to have in place recovery/improvement plans for those that are currently not achieving the standard.*

   2.1 We have had significant improvement and achievement of our constitutional standards as the year has progressed. To note are A&E waiting times and 18 week RTT targets and cancer waiting time and recently maternity
   2.2. We are actively working to change the pathways on Stroke and thus improve our performance. The model and change of service will be presented to March Slough Health and Overview Scrutiny with an implementation start date in September 2016.

3) *To continue to build on the improvement in outcomes achieved 2014/15 as demonstrated in the 7 outcome measures*.
   3.1 – see areas detailed below in table
4) *To improve integrated working and emergency care through the delivery of our Better Care Fund plans.*
   a. 4.1 The committee to note the previous report that have detailed performance on Better Care fund plans and significant delivery to date of our plans and impact these have had of our metrics.

5) *We will continue to progress our major programmes of service improvement – see table 1*
6) *We will work with Frimley Health to improve the quality of local services following the acquisition and system wide transformation through the Collaborative Care for Older Citizen.*

6.1 This programme has now been reinvigorated since the summer and is now renamed New Vision of Care as a recognition that frailty is not always associated with older age but more aligned to complexity of the health and social care issues an individual and family endures.
6.2 the programme is a key enabler in the CCG transformational plans as detailed in our 5 yr plans refreshed

7) *We will work with Public Health colleagues to develop prevention programmes at an industrial scale to prevent ill health and empower individuals to manage their own health.*

7.1 We have been actively promoting and scaling up programmes of work eg diabetes prevention, physical activity and smoking cessation. **The CCG is the highest in the country** in achieving number of diabetics having all eight care processes in diabetes measured
7.2 We have engaged in a local initiative to case find within our population people/ families at risk of Familial Hypercholesterolemia and where found a service that supports these families intensively to prevent premature death. The CCG is first in East Berkshire to offer this initiative.
7.3 We have been successfully awarded monies to promote / screen population for latent TB and we have actively engaged with Frimley health and the TB control board to ensure the service is targeted to our hard to reach populations.
7.4 We have a funded programme of improving cancer screening and early identification specifically in the BME communities supported by Macmillan UK. This programme has delivered a number of outreach promotion activities in our communities as well as meeting with GP practices to support the promotion of and uptake of national screening programmes.

8) *We will drive quality and incentivise service improvements through robust and enforceable contractual levers.*

8.1 We have seen significant improvement in Frimley health quality markers and recently the CQC revisited the trust. The trust was rated overall good with outstanding rating in Accident and emergency department and critical care.

9) *We will work together with member practices to deliver sustainable improvement to primary care and support the development of co-commissioning*.
9.1 The CCG is commissioning primary care jointly with NHS England and will be working towards full delegated responsibility from April 2017 onwards.

Table 1 – Report on progress on workstreams as identified

Delivery Priorities	**Outcomes**
Cardio Vascular Disease	- Deliver the optimum pathways for Chest Pain, Heart Failure, Arrhythmia, rehabilitation with our partners- *Plans have been scoped with a view to implement in 2016* - Increase the number of people getting an early diagnosis of hypertension in line with the commissioning for value pack indicators- *We will review our progress as QOF data is published* - Work with Public health and primary care around prevention of disease in partnership with our patients –*Working with public health to promote NHS health checks and target diabetes prevention programmes.*

	- commission the optimum Stroke pathway - *Plans underway and will be implemented in Sept 2016.*
Mental health services & Learning Disabilities and see (Maternity , Children & Young people)	- Deliver the Mental Health concordat- Is incorporate din overall plans - Increase dementia diagnosis to national recommendations as a minimum- Slough currently as 62% against a target of 67%. Working actively with GP practices and support from Alzheimers Association to promote early identification and referral for assessment as well as support for patients and carers - From April 2015 we will meet 15% referral rate for IAPT as a minimum and continue to target those with a long term condition by reaching out to our population groups which are hard to reach. We are currently achieving this target - Be assured of parity of esteem for people with mental illness- Is incorporated in all our plans and commissioned services - An east Berkshire LD steering group with representation from all partner agencies has been initiated and meets monthly. The terms of reference include development and improvement of LD specific services, development of a strategy to improve all health and social services interface with LD clients, ensure multiagency governance and ensure full implementation of the Transforming Care agenda. Work underway and is being led jointly with the Unitary authority
Diabetes	- Reduce the number of hospital admissions where diabetes is a secondary condition – *Slow progress on reduction but we have seen significant improvement in diabetes outcomes measures* - Improve the knowledge of and support to diabetics to enable them to self-care more effectively- *Ongoing* - Expression of interest to pilot the national diabetes prevention programme.- *We have submitted our case for piloting the NDPP service and will be starting the service from April 2016.*
Cancer	- Improve early diagnosis by improving the uptake of screening especially in our BME populations- *Successful in securing Macmillan funding and have in place a programme manager leading this work piece with impressive engagement achieved* - Improve clinical pathways for early assessment and treatment- *Piloting a CRUK programme to improve pathways and have appointed a clinical lead who is reviewing breast cancer pathways*
Better Care Fund	- Commission enhanced paediatric asthma service- *Asthma nurses in post and we have seen a reduction in non elective admissions in children* - Reduce the number of emergency admissions through the development of single point of access-

	on going and is reported via BCF programme update. - Identify vulnerable adults and children and manage their care through integrated teams- This has been reviewed in the BCF delivery groups and JCC . *Implemented a complex case management programme that is delivering significant impact* - Increase the involvement of voluntary services to provide care to our identified at risk populations.- *Ongoing and picked up in BCF programme report* - Reduce the number of falls by adopting falls prevention programme- *Successful programme and has delivered a reduction in falls over the previous 3 months*
Referral management	- Adopt referral guidelines and education to ensure we manage as many patients appropriately in the community – - *We have commissioned a system called DXS that will improve access to best practice pathways for GPs and will significantly improve availability of these pathways at the time of consultations with additional patient information immediately available at the time of the patient consultation* -
Self-care and prevention programme	- Increase in people feeling supported to manage their own condition - Increase in recorded prevalence of hypertension - Increase in numbers of women taking up breast screening and cervical smear tests - Prevention is a part of our major programmes of work around cardio vascular disease, diabetes, frail older people and mental health - Self-care and management for people with long term conditions and their Carers will be supported through Integrated Care Teams - Continue to support various programmes started under PMCF on self-care e.g. peer support groups and wellbeing programme Prevention strategies are being worked with jointly with patients , local authority and public health. We have actively worked with Slough Borough council to promote self care via digital platforms e.g participating in the Smart City initiative and Adult social care reform programmes
Urgent & Emergency Care	As indicated in our 5 year plan we require system plan to develop and implement new urgent care working arrangements across the system. During 2014/15 this will be developed through the follow areas of work:- - Confirmation of strategy and agreement of year 1 implementation plan, which will include proposal to change A&E access, urgent care ambulatory care pathways, discharge arrangements and 7 day working. - Collaborate with Frimley Health on the clinical vision to underpin the major rebuild of Wexham Park

	Emergency Department - Re-procurement of 111 - Re-procurement of walk In/Urgent Care Centre - Re-procurement of OOH *All of the above are underway and have made significant progress in year. Reported via various committees including System Resilience Group and System Leaders groups.*
Primary Care	- We will continue our successful pilot of Prime Ministers Challenge Fund as extended access- *Successfully implemented this pilot and have been nationally commended on the success.* - We have expressed an interest to develop a multispecialty practice group as a test pilot for new models of care – *we were not successful but we will continue to work up new models of working* - We have applied to jointly commission primary care with NHS England with a view to apply for delegated responsibility in year- *we are jointly commissioning with NHS England*
Pathway redesign • Parkinson's • Community IV & DVT • Urology • Spinal • End of Life Care	- Pathways are being redesigned and developed collaboratively with our secondary care, community & primary care. We are also collaborating with Frimley Health on the clinical vision to underpin the building of a state of the art cold elective centre on the Heatherwood site. - These have been established as service improvement plans in our contracts for 15/16. These will support the following outcomes: o better prevention, o earlier diagnosis o better treatment o Improve access. *This work is underway- Ref Slough Operating plans 2016-17 appendix 1*
Maternity , Children & Young people	- CCG plans to develop women's and children and young people's strategy with their partners. - Take part in NHS England review for maternity services and develop action plan on the recommendation to provide appropriate choice for mothers without compromising on safety. - Collaborate with Frimley Health on the capital refresh of Wexham Park Maternity and Gynaecology facilities to improve patient flow and experience. - The CCG will work with Local Authorities, Public Health, midwives, schools and primary care to identify and treat emerging mental health issues earlier, before difficulties escalate. This includes Early Intervention in Psychosis. - Additional capacity will be provided to tier 3 CAMHs to meet the growth in demand and complexity of cases.

	- The CCG will continue to work with NHSE and BHFT to improve access to local Tier 4 CAMHs provision. *A national maternity strategy has been published and we will be reviewing our services in line with the strategy. Regular updates are reported to the Governing Body on our performance measures on maternity services and all measure have seen a substantial improvement.* *Our Transforming Children's Services plan was signed off last November and we continue to work with our partners and providers to improve delivery of CAMHS services to our population*
Collaborative Care for the Older Citizen	Through this project, the four CCGs and Frimley Health and Berkshire Healthcare Foundation Trusts and Local Authorities will work in partnership to develop a new and transformed model of Care for older people. The new model will cover the population of people aged over 65 who are registered with one of the Four CCGs. *As detailed in 5 yr strategy- the programme has been refreshed to New Vision of Care -*

Financial Performance
The CCG aims to report a balanced budget in 2015/16 but there are significant pressures on the budget with reserves now all committed and will leave the CG with significant gaps into the next financial year.

CCG Assurance;
The CCG has been assured overall with support. The significant improvements seen on performance and quality within Frimley have improved our overall rating.
We are moving into next year with an improved position especially as we have been successful in appointing a substantive Accountable officer.

Appendices

Appendix 1 - Draft Slough CCG operating Plan 2016-17