Operating Plan

2016-17

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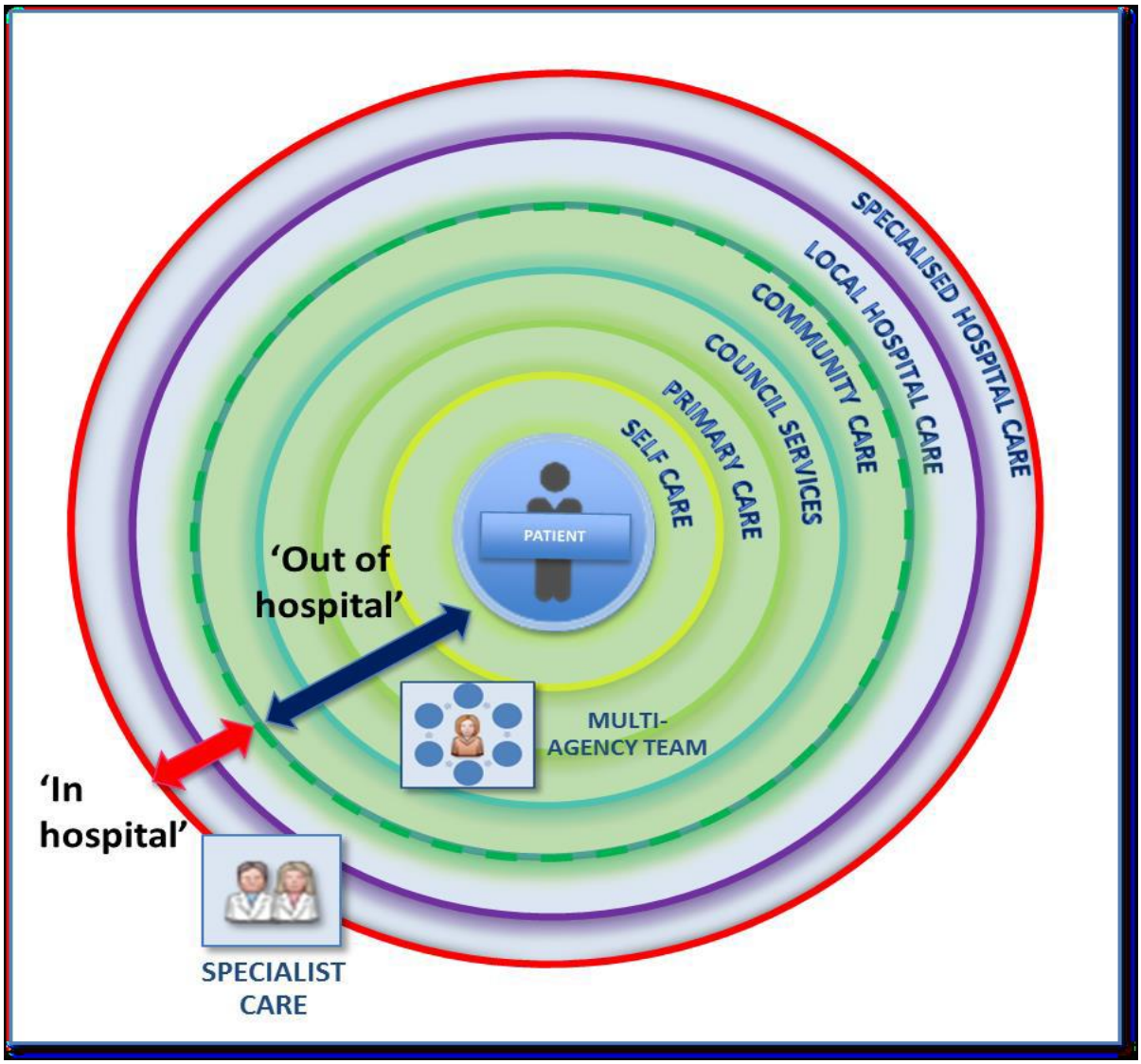
2. Vision & Strategic Objectives

CCGs Joint Vision

2.1 Bracknell & Ascot CCG, Slough CCG and Windsor, Ascot & Maidenhead are committed to working together to deliver high quality, affordable healthcare which delivers excellent patient experience and improved health outcomes.

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



2.3 In order to deliver our vision we will need:

- a sustainable workforce that is well trained and open to working differently
- need to review and develop our estate so that it is fit for purpose to deliver the services of the future
- ensure that a shared care record is available so that patients only have to tell their story once
- clinicians have access to the same information no matter where a patient is seen.

2.4 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 wide sustainability and transformational 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.

2.5 The key strategic themes to deliver our vision are set under the following programmes of work, these will continue to be developed and updated in line with our Sustainable Transformation Plan.

2.6 Self-management and prevention

- People will be encouraged to take action to improve their health now and for the future with a particular focus on obesity, smoking and alcohol consumption.
- People will understand 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 their condition have confidence in managing it. They will be provided with information on how to seek help when they need it.
- We will work with the third sector and other networks to provide people with support on an ongoing basis.
- We will tailor our approach to different communities.
- The CCGs aims to address variation in the provision of diabetes and specifically to improve uptake in patients aged 40 – 64 years.

2.7 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 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.

2.8 Person Centred co-ordinated care

- The 'New Vision of Care' for frail people will drive commissioning for our most vulnerable patients.
- Integrated care will be developed to complement the primary care clusters and federated groups. These services will include respiratory and diabetes with easy access to specialist nurses, consultants and upskilling of primary care in the management of these patients.
- 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.
- Integrated teams will provide support to avoid admission and support patients back into the community following acute care. These integrated teams will support short term intermediate care and re-ablement.
- The integrated teams will work closely with voluntary groups and carers to help people manage their health more effectively. The role of community pharmacists will also be developed to support self care.
- We will take steps to improve medicines optimisation for people with multiple conditions.

2.9 Urgent Care

- We will develop an urgent care system which removes duplication and maximises the use of resources.
- 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.
- Entry points to urgent care will be rationalised. We will work with NHS 111 to improve their services.
- 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.

2.10 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, and with a much reduced demand on consultant led hospital clinics. Primary care clinicians will require access to diagnostics to achieve this.
- Specialists will provide remote support when required for GPs, carers and patients based in practices.
- End to end pathways will be developed. We will take an integrated approach to commissioning these and a standardised approach to implementing them through system wide use of DXS.
- Post-operative care will be provided by senior decision makers and specialist nurses in the community, enabled by technology.
- There will be improved access to enabling services such as therapy and pain management.
- The aim is reduce length of stay in hospital by means of highly co-ordinated discharge.
- The principles of enhanced recovery will be embedded across all elective surgical pathways.

2.11 Mental Health

- Improve Mental Health Liaison service and CAMHS in line with Parity of esteem requirements
- Improve community services to reduce reliance on inpatient facilities by enhancing Crisis Resolution Home Treatment Team.
- Achieve and maintain the dementia standard in each of the three CCGs by using a targeted approach for practice populations.

3.0 CCG Demographics / Population health needs

3.1 There are three Clinical Commissioning Groups (CCGs) in the East Berkshire area:

- **Bracknell and Ascot** has a registered population of 136,863. 81% of the CCG's population reside in Bracknell Forest Council and the remainder in Ascot within the Royal Borough of Windsor and Maidenhead.
- **Slough** has a registered population of 143,343. This CCG shares the same boundaries as Slough Borough Council.
- **Windsor, Ascot and Maidenhead (WAM)** have a registered population of 150,364. This CCG covers the majority of the Royal Borough of Windsor and Maidenhead, together with one ward in North Surrey.

3.2 The three CCGs work together as the East Berkshire Federation and also work closely with their unitary authorities: **Bracknell Forest Council, Slough Borough Council** and the **Royal Borough of Windsor and Maidenhead (RBWM).**

3.3 The three unitary authorities are different in terms of their population and demographics, their health needs and present challenges. Life expectancy in Bracknell Forest and the Royal Borough of Windsor & Maidenhead is higher than the England average. In contrast, life expectancy in Slough is lower than the England average.

3.4 These differences give rise to different priorities set out in full in the Joint Health and Wellbeing Strategies and are summarised below:

- **Bracknell Forest Council**
  - Falls prevention
  - Smoking
  - Immunisations
  - Mental health in the community
  - Self-Care
- **Slough Borough Council**
  - **Diabetes:** Increase early diagnosis of all types of diabetes
  - **Tuberculosis:** Increase access to TB screening for earlier diagnosis
  - **Obesity:** Increase the level of physical activity undertaken by residents of all ages and encourage healthier eating
  - **Children:** Improve emotional and physical health of children of all ages from 0 to 19 years. We will engage with partners to deliver our pledge to improve Special education needs for identified children and young people
  - **Sexual Health:** improve services in adults and young people as an integrated offer of services
  - **CVD:** Improve access to CVD screening programmes and develop care pathways that support prevention of CVDs
  - **Drug and alcohol misuse:** Reduce drug and alcohol misuse and their impact on domestic abuse and violent crime
  - **Self-care/mental health:** Increasing access to self-care programmes and to effective services for people with long-term conditions and mental health problems
- **Royal Borough of Windsor and Maidenhead**
  - **Supporting a Healthy Population:** Stopping smoking, health checks, vaccinations, exercise, health and wellbeing campaigns
  - **Prevention and Early Intervention:** telecare/telehealth services, long-term conditions, dementia, children, elderly falls, respiratory tract infections amongst children, early support, addressing domestic abuse
  - **Enable Residents to Maximise their Capabilities and Life Chances:** long-term conditions, commissioning home-based services, housing options, employment/volunteering opportunities, patient experience, supporting carers, drug/alcohol treatment.

4.0 Five Year Forward View Key Priorities for 16/17 Summary

In response to NHS England delivery requirements for the **'Forward View' our response to the nine 'must do'** for our system are outlined in the table below:-

	Delivering Priorities	Provide an summary of high level plans to deliver this priority	Outcomes
1	Development of a high quality and agreed **STP**	The CCGs in East Berkshire are proposing to develop our footprint at three interlinked levels: • In line with our New Vision of Care to work with the three Unitary Authorities, Berkshire Healthcare Trust and Frimley Health to develop integrated social care, primary care and community care for populations of approximately 50,000 people. • To continue with the successful arrangements for mental health, learning disabilities and specialised community services on a Berkshire footprint with the West Berkshire CCGs and Berkshire Healthcare Trust. • To work collaboratively with Chiltern CCG, North East Hants and Farnham and Surrey Heath CCGs to commission high quality acute care from Frimley health for those people who cannot be supported safely in the community. These footprints will deliver the benefits of working at scale whilst responding to local needs and delivering a patient centred approach. Once the footprint has been agreed by NHS England the CCG will work with stakeholders to put in place formal governance arrangements.	Achieve the triple aim as set out in the **Forward View**
2	Return the system to **aggregate financial balance**	See section -7 – Sustainable Finances	
3	Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.	**Infrastructure: -** Practices are working at scale within each CCG to deliver extended opening hours by centralising and sharing access points across practices and by working smarter through use of technology On line and email consultations are planned to use interactive digital Applications. The Primary Care Transformation fund will be used to support premises to meet the needs of modern general practice. **Focus on care and quality: -** Development of a local Quality dashboard with a portal linking externally available sources of information to identify and support vulnerable practices. Introduce a local support team to lead training and development for CQC standards and beyond including local specialists to provide support and mentorship. The 3 CCGS will review how the Quality and Outcomes Framework for General Practice could be re-engineered to provide most relevant local patient quality outcomes. **Workforce analysis & development**: - Each CCG will have clear data to show GP workforce in primary care and highlight areas of risk by June 2016 as a starting point for our development plan. Individual CCGs have plans in place	20% of the population will have enhanced access to primary care at evenings and weekends leading to improved access to services All practices to be the best they can and deliver high quality services and be rated Good or above by the CQC. 6WTE Clinical pharmacists will be recruited by July 2016 in Slough.

	Delivering Priorities	Provide an summary of high level plans to deliver this priority	Outcomes
		to deliver the following programmes:- ➢ Windsor Ascot & Maidenhead CCG is establishing a training hub to develop new primary care and community roles with support from HETV. It will link with voluntary sector and local authority. This will retrain and retain a workforce. ➢ Slough CCG is implementing Clinical Pharmacist role in Slough practices to include: • Long-term condition clinics • Post-discharge medication review and support • Polypharmacy medication review • Domiciliary medication reviews • Minor ailments clinics • Resolving prescription problems • Reducing waste by monitoring repeat ordering processes • Ensuring monitoring of medications is correct and identify people on combinations increasing risk of admission • Implementation of national & local clinical guidance and Drug Safety Alerts ➢ Bracknell and Ascot CCG is extending the role of Health makers in 2016 to optimise self-management and support to others. The aim is to recruit 420 health makers by March 2017 and 800 by March 2018.	
4	Urgent and Emergency care Transformation	**As part of the Thames Valley Urgent & Emergency Care Networ**k the CCGs will take part in the implementation of the network plan including the re-procurement of an integrated NHS111 service which will result in a comprehensive "clinical hub"(includes social care) and achieve a single point of contact for all patients- by April 2017 **Undertake robust marketing study to fully understand patient behaviours** and why they choose to attend A&E rather than go via NHS 111 or alternative services. **Review Slough Walk in Centre** and commission effective primary care provision on site. **Extend Out of Hours Contract** and commence integration with NHS 111 services including warm transfer of care plan patients and directly bookable appointments into OOH primary care centres **Review and Transform the NHS 111 Directory** of Services to reduce number of ED dispositions and make better use of alternative services in the system **Improve discharge flows from hospital**, a key project is to develop and agree and approve a single common transfer of care protocol that clearly defines the processes that will transfer a patient to their home or other care provider. **Commence investigating Discharge to Assess**" model where patients are discharged once they are medically fit and have their support needs assessed on arrival at home by members of the community intermediate care and social care teams.	Achieve 95% A & E Achieve 75% Category A calls within eight minutes Reduce the number of DTOCs

	Delivering Priorities	Provide an summary of high level plans to deliver this priority	Outcomes
		Mobilisation of PTS. This service represents a key part of the patient flow within the system and will need to work in conjunction with all stakeholder organisations including the emergency transport service provision. **Use of ambulatory care pathways** and delivery of these in community to avoid unnecessary admissions hence to reduce A&E episodes. Implement and improve the end of life pathways which will result in more people dying in their place of choice and avoid distressing emergency admissions. **Increased use of 'hear & treat' and 'see & treat'**. This project will need to undertake a full review of current activity and understand the interdependencies with other incentives to appropriately contract levels of see/Treat and Hear/Treat with the focus being on the ambulance trust providing a high level mobile urgent care service and not purely a transport service. Review and continue to develop the real-time data systems used to monitor daily resilience and system health. Robust surge and escalation process in place to monitor daily demand and capacity response including management of bank holidays and seasonal pressures.	
5	Improvement against and maintenance of the NHS Constitution standards of 92% non-emergency pathways	The three CCG is committed to achieve the 92 % Incomplete RTT standard and has consistently achieved it from April – November 2015/16. Our main Provider Frimley Health is achieving the 92% standard but with pressure in Dermatology and T&O. However our alternative Provider RBFT has not been achieving the RTT standards for some time in Ophthalmology **Planned action** • Frimley North Dermatology backlog reduction is underway with additional resource and weekend clinics being held in to reduce waiting times to within 18 weeks by mid-February 2016. Longer term plans to review the Dermatology pathway are in development by all 3 CCGs • Frimley North and South T&O backlog exists in orthopaedics and is being addressed by utilising capacity in the local independent sector plus the use of locums taking additional lists at Heatherwood Hospital site. The Trust is also developing a longer term plan to focus on hips, knees to be undertaken by Extended Scope Practitioners (ESP's) thus enabling them to take more patients. This will be further developed in 2016/17. • Ophthalmology backlog at RBFT has a remedial action plan in place which includes actions on data quality where patients waiting >18 weeks were not visible. This is being monitored on a monthly basis and will be achieved by 31 March 2016.	Achieve the 92% of Non-emergency pathways for RTT
6	Improve Cancer survival rate via early diagnosis and treatment	The three CCGs support East Berkshire wide strategic cancer steering group which has the following aims: • Improve quality of 2ww referrals (Slough CCG with support from Macmillan Charity) • Use of benchmarking to review the patients	Deliver the **62 day cancer waiting standard**,; continue to deliver

	Delivering Priorities	Provide an summary of high level plans to deliver this priority	Outcomes
		presenting at a late stage of cancer development through the emergency admission • Implementation of NICE guidance • Reviewing cancer pathway across the two sites of Frimley Health NHS Foundation Trust. • Improvement to early cancer diagnosis and achieve the Cancer NHS constitutional standards. All the cancer targets are being achieved by the three CCGs with exception of WAM CCG which is not achieving the 31 day cancer target in Q2. There is an improvement plan in place with RBFT to achieve the appropriate performance. The CCGs plans to improve uptake by early diagnosis for breast and GI and screening uptake. The CCG has prioritised screening of colorectal cancer by increasing uptake of bowel screening especially for the BME populations, where uptake is low and outcomes worse than national averages. **Diagnostic capacity-**The CCG plans the following actions: • **Develop agreement with Provider Trust** which 2 week wait referrals should go straight to test rather than to an outpatient appointment. • **Develop agreement with Provider Trust** of mechanisms for direct access tests for GPs including x-ray, ultrasound, brain MRI, CT and oesophago-gastroscopy. Including clinical responsibility, the process of managing patients who need further review and who communicates results to patients. • **Undertake a review of current waiting times** for direct access tests and agreement of when tests will be available within 2 weeks as recommended by NICE. • **Review current Provider Trust diagnostic capacity** as per Strategic Clinical Networks Diagnostic Demand & Capacity Planning Project outcomes and agree required investment/redirection of current funding (from OPA to direct access). • **Implement a phased implementation plan** for all cancer services to deliver the recovery package as described in the National Cancer Survivor Initiatives. • **Holistic Needs Assessment** and care planning at key points in the care pathway. • **Treatment summary** completed at the end of each acute treatment phase (sent to patient and GP) • **Cancer Care Review** completed by GP or practice nurse to discuss patient's needs • **Patient education** and support event such as a Health and Wellbeing Clinic to prepare the patient for the transition to supported self-management which includes advice on healthy lifestyle and physical activity The three CCGs has education plans in place for ensuring implementation of NICE guidelines including adhering to clinical guidelines and utilising audit tools and dashboards to enable a sharing of expertise within primary and secondary care.	the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

	Delivering Priorities	Provide an summary of high level plans to deliver this priority	Outcomes
7	Improve Mental Health service	The Mental Health programme will support the continued delivery of parity of esteem and delivery of the national priorities for mental health as outlined in Delivering the Forward View: NHS Planning Guidance 2016/17. These will include: 1. Enhanced perinatal mental health services 2. Review of antipsychotic prescribing in primary care for Learning Disabilities and/ or autism 3. Dementia – maintain enhanced younger people with dementia service 4. Crisis Care Concordat delivery – including maintained 24/7 MH Liaison, Street Triage, review of Place of Safety, and scoping the commissioning of crisis beds 5. Continuation of the wellbeing and recovery community programme for the elderly, those with LTC and socially isolated 6. Review of MH & LD placements 7. Achievement and sustainability of national requirements in the following areas:- **IAPT** - This access target is already achieved; this will be maintained thorough 2016/17 and monitored via the quality schedule. **Early Intervention in Psychosis -** A NICE concordant service will be in place to achieve the access standard in 2016/17. **Dementia Diagnosis** – Bracknell & Ascot CCG have been achieving since summer 2015 and Windsor Ascot and Maidenhead CCG have recently achieved in December 2015. This achievement will be maintained throughout 16/17. Slough CCG is currently achieving 61.3% and has plans in place to achieve the target by the end of quarter 2. These included work with the local memory clinic to ensure data harmonisation between GP practices and the memory clinic. Supporting the GP practices with lower diagnosis rates and target specific groups at their place of worship/community centres. Dementia adviser (DA)are is in place for all three CCGs and plans are in place to provide creatively support by using assistive technology strategies and objectives through widening the DA service in a more flexible and dynamic way.	Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.
8	Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment	A three year plan across Berkshire is in place to improve services for people with learning disabilities and/or autism, who display behaviour that challenges, including those with a mental health condition. This will drive system-wide change and enable more people to live in the community, with the right support, and close to home. The Transforming Care programme will focus on addressing long-standing issues to ensure sustainable change that will see: 1. more choice for people and their families, and more say in their care; 2. providing more care in the community, with personalised support provided by multi-disciplinary health and care teams ; 3. more innovative services to give people a range of care	Delivery of improved choice in LD

	Delivering Priorities	Provide an summary of high level plans to deliver this priority	Outcomes
	reviews in line with published policy.	options, with personal budgets, so that care meets individuals' needs; 4. providing early more intensive support for those who need it, so that people can stay in the community, close to home; 5. but for those that do need in-patient care, ensuring it is only for as long as they need it. This will take the form of: • a reduction in the number of inpatients to between 10-15 inpatients/million • implementation of an intensive intervention service • implementation of the positive behaviour support model • community teams for people with a learning disability/ autism that have the right skills and capacity • wider and more local range of providers to support individuals which will support reduced out of area placements • increased use of personal health budgets • redesigned assessment and treatment unit	
9	Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality**	We agree with our Providers a range of Quality Indicators both nationally mandated and locally developed to track quality performance and patient safety based on concerns, national initiatives or poor performance. Regular monitoring of such indicators occurs at Provider Clinical Quality Review Meetings (CQRM's) and CCG Federated Quality Committee.	

5. Transformation Programme and QIPP Delivery

5.1 **Development of a high quality and agreed Sustainability Transformation Plan**

The CCGs in East Berkshire are proposing to develop our footprint at three interlinked levels:

- In line with our New Vision of Care to work with the three Unitary Authorities, Berkshire Healthcare Trust and Frimley Health to develop integrated social care, primary care and community care for populations of approximately 50,000 people.
- To continue with the successful arrangements for mental health, learning disabilities and specialised community services on a Berkshire footprint with the West Berkshire CCGs and Berkshire Healthcare Trust.
- To work collaboratively with Chiltern CCG, North East Hants and Farnham and Surrey Heath CCGs to commission high quality acute care from Frimley health for those people who cannot be supported safely in the community.

5.1.1 These footprints will deliver the benefits of working at scale whilst responding to local needs and delivering a patient centred approach. Once the footprint has been agreed by NHS England the CCG will work with stakeholders to put in place formal governance arrangements.

5.2 **Right Care**:

The CCG has adopted the NHS Right Care approach to enable effective prioritisation of our plans to deliver population wide health benefits. Where do we target our efforts best to deliver effective outcomes by creating a culture of clinical change led by effective systems and processes underpinning the change in a sustained manner.

5.2.1 Using the Right care methodology and commissioning for value packs the CCG has identified the following areas for improvement and which will be addressed during 16/17:

- **Cardiovascular**
- **Neurology**
- **Respiratory**
- **Integrated care**

5.2.2 A task and finish group has been set up to enable the CCGs is East Berkshire to embed the NHS right care methodology including its business processes into the way we deliver QIPP.. The three CCGs in East Berkshire are in the Wave 1 cohort of CCGs that will be working with the National NHS Right care team to lead on embedding the process and thus support population benefit. Slough CCG has been showcasing its successful implementation of Diabetes and Complex case management which is being rolled out to all CCGs in East Berkshire.

5.3 New Vision of Care

During 2015/16 The East Berkshire CCGs together with Chiltern CCG have been working with Frimley Health FT, Berkshire Healthcare FT, LA, voluntary sector and the public to develop a new and transformed model of care to commission health and social care services for people with complex needs.

Through this project the partners are developing a new and transformational vision of care to help avoid unnecessary admissions to hospitals and care homes and the loss of independence. This will be for all adults but the vast majority of intensive users will be people with more complex conditions.

The pathways of care have now been worked through and the key project areas for delivery during 2016/17 will be:-

- Workforce development

- Communication & engagement
- Collaborative leadership
- Aligning incentives
- Connected Care
- System governance

5.4 Continuation of 2015/16 Transformation Programme and QIPP Delivery

5.4.1 The CCG's 2015/16 plan outlined eight transformation programme of work which will continue to remain in place during 2016/17 and will be responsible for the delivery of the identified QIPP programme. We used a structured process to develop the schemes, engaging with clinicians, groups and localities-

a. We used right care and the commissioning for value packs to identify areas for review. A task and finish group has been set up to enable the CCGs to embed the right care methodology including its business processes into the way we deliver QIPP.

b. We used a hackathon to develop a longlist of possible opportunities for unscheduled and planned care

c. We refined the 'longlist' into a 'shortlist' and the analytics and finance team sized the scheme to confirm financial impact by provider and POD.

d. Supporting projects have been identified in each project area and these are now in the scoping stage with savings being assessed as transformational or transactional.

e. All schemes are profiled into contracts through the negotiation round together with appropriate quality and efficiency measures. Negotiations are particularly challenging this year given the requirements on Trust to reduce deficits and increase surpluses. As far as possible in all cases the CCGs have looked to reduce demand in areas which will allow the Providers to reduce costs at the same time.

5.4.2 These programmes are listed below and supported by detailed project plans and link to our vision and strategic objectives

- **Starting Well, developing Well, living Well, ageing**
- **Primary care**
- **Integrated care including Better Care fund**
- **Urgent care & Emergency Care**
- **Elective care**
- **Mental Health and Learning Disabilities**
- **Maternity & Children & young People**:
- **Medicine Optimisation**

6.0 Improving Quality

6.1 The CCG has a Quality Strategy which covers the time period from 2014-2017 which sets out how the CCG will work collaboratively to endeavour to ensure high quality, safe care is provided and that patients and their carers experience is a good one from the services they receive. The Quality Strategy in 2016 is to be refreshed to reflect the changes and priorities within the CCG. The model below illustrates the three components of quality and when quality is discussed throughout the document each of the 3 areas are considered.

6.2 **Sign up to Safety**

The CCG is committed in 2016/7 to publish its five Sign up to Safety pledges from a Commissioners perspective. By making a commitment to bringing them to life, and by helping others to understand their role in this, we are working together to create the right conditions for safer care and actively encouraging our providers to sign up.

6.2.1 **Putting safety first**. Committing to reduce avoidable harm in the NHS by half.

6.2.2 **Continually learn by reviewing incident reporting and investigation processes** to make sure that providers are truly learning from them and using these lessons to make their organisation more resilient to risks. Listen, learn and act on the feedback from patients and staff and by constantly measuring and monitoring how safe the Provider services are

6.2.3 **Being honest. Being open and transparent with people** about our progress to tackle patient safety issues and working with them.

6.2.4 **Collaborate.** Stepping up and actively collaborating with other organisations and teams; sharing work, ideas and learning to create a truly national approach to safety. Work together with others, join forces and create partnerships that ensure a sustained approach to sharing and learning across the system

6.2.5 **Being supportive.** Be kind to our staff; help them bring joy and pride to their work. Be thoughtful when things go wrong; help staff cope and create a positive just culture that asks why things go wrong in order to put them right. Give staff the time, resources and support to work safely and to work on improvements. Thank our staff, reward and recognise their efforts and celebrate your progress towards safer care.

6.3 Developments and improvements in quality for Primary Care

6.3.1 The CCG has been working with NHSE on the quality of Primary Care through Co-commissioning. The first Quality Improvement Meeting for Primary care met in February 2016. This meeting will focus on Quality issues and ways for improvement using local intelligence and relationships. There will be representation from Primary Care, Healthwatch, NHSE and the CCG. The Quality Team are in the process of developing a data base which will be populated with intelligence from Primary Care this includes Patient experience (FFT, complaints and NHS Choices), incidents, safeguarding and CQC compliance.

6.3.2 The CCG aims to measurably reduce examples of poor patient experience, both within and outside of the hospital settings, utilising tools such as the Friends and Family Test, complaints safeguarding alerts and other patient and carer feedback. To work with Providers to ensure that they have a robust complaints system in place using the NHSE Assurance of good complaints handling toolkits. A Commissioner themed complaints observational visit will be used for Frimley Health and BHFT using the toolkit as a framework. The CCG will continue to monitor implementation of Providers Duty of Candour with moderate and serious harm incidents.

6.4 Antimicrobial Prescribing and resistance rates

6.4.1 The IPCN will be working closely with the medicine optimisation and public health team on the antimicrobial prescribing and resistance rates. There is a local Antimicrobial plan to improve antibiotic prescribing within primary and secondary care. This plan for 2016/17 is to have a reduction in the number of antibiotics prescribed. Frimley Health have an antimicrobial stewardship action plan, which includes ward rounds, evidence based prescribing, audit programme and education and training. The IPCN will work with all Providers and the antimicrobial prescribing and resistance rates are included in all 2016/17 Quality Schedules.

6.4.2 Within Primary Care individual practice reduction is to be agreed by the CCG. Indicators are monitored quarterly, and a local Antimicrobial Stewardship Group has been set up to start in 2016. The ambition for prescribing is to ensure best practice, through education and local incentive schemes.

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

6.5 Post Infection reviews

6.5.1 There is support and attendance at Provider Root Cause Analysis & Post Infection Review meetings including Primary Care to investigate local Healthcare acquired infections. Local Root Cause Analysis & Post Infection Review meetings are organised for *Clostridium difficile* & MRSA which are allocated to primary care. The review ensures working together with colleagues to identify any area for learning about *C. diff* & MRSA cases and taking forward recommendations across the health economy e.g. awareness and compliance with antibiotic prescribing guidelines.

6.6 Sepsis

6.6.1 The local Sepsis plans will be broadened to include the NICE guidelines that are to be published in March 2016. Primary care will be supported in ensuring compliance with these guidelines, raising awareness of Sepsis, encouraging routine and seasonal immunisation programmes, and highlighting the importance of hand hygiene in preventing infections**.** A national CQUIN focusing on sepsis screening and antibiotic administration has been in place for acute Trusts in 2015/16; results from Frimley Health have shown significant improvement throughout the year on the screening metrics, with further improvement targeted by year-end. Baseline antibiotic administration scores are good, and an improvement trajectory to the end of the year has been set; latest figures against the baseline are due at the end of January 2016 and these were achieved. These improvements have followed the introduction of a standardised screening and treatment protocol, incorporating the 'Sepsis Six' red flag clinical action framework. This has been supported by a staff awareness campaign. These measures

will continue to be monitored into 2016/17 as part of the Quality Schedule requirements. The ambulance service has had a local CQUIN on Sepsis. The Urgent Care centre will be having a local CQUIN on Sepsis for 2016/17 on sepsis screening.

6.7 Avoidable deaths

6.7.1 The Frimley Health will continue to give commissioners an analysis of Mortality data (SHMI) and CRAB surgical complications / medical practice triggers data via the monthly Quality and Performance Reports. The February 2016 CQC inspection report highlighted this as an area of good practice at Frimley Health. These will be supplemented by quarterly Mortality and Morbidity reports submitted in line with the Quality Schedule, and scrutinised by the Clinical Quality Review Groups. Additionally, there will be a requirement in 2016/17 for the Provider to report on numbers of avoidable deaths, giving a quarterly number which will be compared against a 2015/16 baseline.

6.7.2 Latest data shows that SHMI scores remain satisfactory with a marked improvement in elective SHMI

	14/15	Nov-14	Dec	Jan-15	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov-15	YTD	Target	Threshold
Mortality (one month's data)																	
Number of deaths	2470	208	228	272	222	230	201	204	179	185	171	209	189	212	1550		
Number of discharges	199183	16546	16839	15927	15923	18307	16008	16264	17109	17732	15771	17440	17703	16983	135010		
% deaths	1.2%	1.3%	1.4%	1.7%	1.4%	1.3%	1.3%	1.3%	1.0%	1.0%	1.1%	1.2%	1.1%	1.2%	1.1%		
SHMI (Summary hospital-level mortality indicator) (12 months' rolling data)																	
Overall observed number of deaths		3129	3164	3242	3292	3352	3396	3420	3427	3419	3433	in arrears	in arrears	in arrears		TBC	
Overall expected number of deaths		3341	3406	3491	3522	3603	3638	3666	3687	3708	3737	in arrears	in arrears	in arrears		TBC	
Overall SHMI rate		94	93	93	93	93	93	93	93	92	92	in arrears	in arrears	in arrears		<=100	>125
Non-elective SHMI rate		93	93	93	93	93	93	93	93	92	92	in arrears	in arrears	in arrears		<=100	>125
Elective SHMI rate		114	107	109	109	103	100	94	90	90	86	in arrears	in arrears	in arrears		<=100	>125

KEY: Higher than expected | Within expected range | Lower than expected

6.7.3 Other relevant areas of focus are the National Hip Fracture Database, which periodically publishes national audit results; the Provider performance on these has improved in 2015/16 and commissioners will look to see that this is sustained. In Stroke care, there is a planned move to a new model that will see the Frimley Park site, which scored a grade 'A' in the recent national SSNAP results, continue to operate as a Highly Acute Stroke Unit (HASU) while Wexham Park, currently an Acute Stroke Unit, converts to Stroke Rehabilitation. This is aimed at focusing timely and excellent care in HASUs with better patient outcomes in terms of both mortality and rehabilitation.

6.7.4 Commissioners also hold monthly Serious Incident Panels at which all serious incident investigation reports are scrutinised and signed-off. This involves the agreement and monitoring of action plans for each case, along with thematic reviews and overarching action plans where required. Recent examples include the development of a thematic review of patient falls to feed into the organisational falls action plan, and an upcoming thematic review of Never Events. Examples of key actions taken in relation to Serious Incidents include:

- Alarms added to exit doors on wards to minimise risk of dementia patients leaving unsupervised.
- Improved links between Radiology and cancer multi-disciplinary teams to ensure that there is effective follow-up post-imaging where indicated.

6.7.5 For BHFT all unexpected deaths are reported as Serious Incidents, for people that have come in contact with their services as per National guidance. As per National guidance for reporting of serious incidents the provider discusses the serious incident with the Commissioner. These discussions are minuted at the serious incident panel meeting. If the coroner confirms natural causes, the incident is then downgraded. BHFT will be reviewing the 'Independent review of deaths of people with a Learning Disability or Mental Health problems in contact with Southern Health NHS Foundation Trust April 2011 to March 2015' report to assess whether there is any learning for the organisation. This will also be discussed with other providers to ensure lessons are learnt.

6.8 Maternity Assessment of performance

6.8.1 For Frimley Health we receive monthly submissions of maternity clinical quality dashboards covering both maternity units. For 2016/17 the content of these dashboards is to be revised to refresh the performance thresholds and for standardisation across sites. These indicators will be monitored against agreed performance thresholds, with improvement trajectories and action plans set out where required. These will be benchmarked against other providers.

6.9 Routine identification of carers and signposting to support

6.9.1 There has been a CQUIN in place Heatherwood and Wexham Park Hospital during 2015/16 focusing on the improvement of support to carers of patients with Parkinson's disease and Multiple Sclerosis. Work to date has included setting up a carers' steering group which has overseen the carrying out of discovery / survey work to map out areas for improvement in the carers' journeys. From this, carers' pack and website are in development, along with the appointment of link nurses on each ward and a staff awareness campaign. The aim is to build on this work in 2016/17 with a local CQUIN being considered which would broaden the work to patient / carer groups in other settings for example outpatients.

6.10 Quality in Action

6.10.1 **Quality Schedule Monitoring** – We agree with our Providers a range of Quality Indicators both nationally mandated and locally developed to track quality performance and patient safety based on concerns, national initiatives or poor performance. Regular monitoring of such indicators occurs at Provider Clinical Quality Review Meetings (CQRM's) and CCG Federated Quality Committee. Clinical Quality penalty notices can be raised where performance is deemed unsatisfactory

6.10.2 **Patient Safety Incidents** - The CCG aims to encourage Providers to increase reporting of patient safety incidents. This will be tracked and monitored via the CQRM's. The CCG chairs monthly SI Panels with Providers to review serious incidents resulting in harm and Never events, review and approve action plans, share learning and agree to changes in clinical practice.

6.10.3 The CCG is working collaboratively with the NHS England to improve reporting of patient safety incidents in Primary Care.

6.10.4 **Clinical Concerns** - The CCG actively encourages GP's reporting of clinical concerns regarding Providers. These concerns are collated on a database and themes identified. The concerns are then raised with Providers and where appropriate actions identified.

6.10.5 **Patient Experience** – CCG monitors patient experience from our Providers by review at CQRM of a quarterly patient experience report that includes, complaints with themes by Specialty and actions arising, FFT outcomes, compliments, PALS, NHS Choices summary, you said we did. Robust scrutiny by CCG is given to Providers to ensure learning and improvement in experience of patients. A collated summary report of Provider patient experience including CCG PALS and complaints is presented at CCG Federated Quality Committee in order to review Provider performance across east Berkshire. Each Provider presents a patient story quarterly to the CQRM and what lessons were learnt.

6.10.6 **Friends & Family Test** – CCG monitors FFT on a monthly basis via Quality Schedule submission and review of nationally published data, this is reported quarterly to the CCG Quality Committee.

6.11 Safeguarding of Vulnerable People

6.11.1 The Clinical Commissioning Groups (CCGs) recognises and works to the NHS Commissioning Board revised *Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework* July 2015**.** This framework details CCG statutory responsibilities for safeguarding vulnerable people which includes ensuring that the organisations from which they commission services provide a safe system that safeguards children and adults at risk of abuse or neglect. The framework was primarily revised to recognise new responsibilities of all

statutory organisations under the Care Act 2014. Additionally, primary care co-commissioning arrangements between CCGs and NHS England will have implications for safeguarding responsibilities; progress against the framework is identified within the action plan detailed below:-

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

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

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

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

6.12.1 The CCGs are responding to improved identification of violence and improved support to victims. To by introducing new quality schedules for our Frimley Park Hospital and for Berkshire Healthcare Foundation Trust. Quality schedules will include submission of a Domestic violence strategy for FPH and BHFT including training, support for staff who are victims of violence and how concerns are raised. Midwives will be requested to submit level of interventions following domestic abuse inquiry to all pregnant women. Routine information will continue to understand identification of violence which includes allegations of abuse against professionals and number of assaults perpetrated against staff members.

6.13 **Acute kidney injury (AKI)** -The CCG is working with the main provider, Frimley Health who has been undertaking the National AKI CQUIN and is on track for achieving their milestones in Quarter 4, 2015/16.

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

6.15 **Commissioning for Quality and Innovations (CQUINS)**

6.15.1 **National CQUINS** - The Providers that we commission from will be undertaking the National CQUINS for 2016/17. In addition our main acute provider Frimley Health Foundation Trust and community provider, Berkshire Healthcare Foundation Trust have requested a variation on the Health and wellbeing CQUIN concerning flu vaccination for front line staff.

6.15.2 **The local CQUINS**. The CCGs are working with all the CCGs in the Frimley Health footprint to ensure a coordinated approach on the local CQUINS. We have agreed on five areas which are: AKI, Right Care, 62 day cancer target, unscheduled care for children and delayed discharge which incorporate end of life care.

6.15.3 The CCGs have agreed the following CQUIN Berkshire Health Care Foundation Trust, our main community & mental health provider.

- Failure to return from agreed leave
- CMHTs to adopt an Outcomes Profile tool for CPA patients with Dual Diagnosis (cluster 16)
- End of Life Care

6.16 **Seven Day Services** Frimley Health completed a self-assessment against compliance on 4 of the 10 standards that were identified by NHS England. The areas targeted for improvement in 2016/17 are:-

- Access to diagnostics within 12 hours for urgent patients at the Wexham Park site (1 hour and 24 hour performance is good
- Twice-daily consultant review for patients on Acute Medical and Acute Surgical Units (both sites)
- Metrics around inpatient specialist referrals (both sites).

Each CCG is currently providing primary care bookable appointments across 6 and 7 days a week through hub and spoke models and these will be reviewed in year to agree a new model of primary care and integration of 111 and OOH services.

6.16.1 **Quality Premium using the atlas of variation and right care approach the following areas have been agreed.**

	Measures	Indicator	CCGs
National	Cancer	Demonstrate a 4 percentage point improvement in the proportion of cancers (invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas and invasive melanomas of the skin) diagnosed at stages 1 and 2 in the 2016 calendar year compared to the 2015 calendar year.	All three CCGs
	Increase in the proportion of GP referrals made by e-referrals	Meet a level of 80% by March 2017 and demonstrate a year on year increase in the percentage of referrals made by e-referrals (or achieve 100%)	B & A CCG
		March 2017 performance to exceed March 2016 performance by 20 percentage points	Slough CCG & WAM CCG
	Overall experience of making a GP appointment	A 3% point increase from the July 2016 publication on the percentage of respondents who said they had a good experience of making an appointment	All three CCGs
	Improving antibiotic prescribing in primary care	reduction in the number of antibiotics prescribed in primary care	All three CCGs
	Improving antibiotic prescribing in primary care	reduction in the proportion of broad spectrum antibiotics prescribed in primary care	All three CCGs
Local Indicators	Circulation	Circulation – reported prevalence of hypertension of GP registers as % of estimated prevalence. Medium (data variation) and high (variability). Again data packs indicate that this requires local interpretation.	All three CCGs

	Measures	Indicator	CCGs
	Genito-urinary	Reported to estimated prevalence of CKD. This was based on GU being high for Use in terms of elective and non-elective savings, and the only indicator recommended for GU as being medium timeliness and variation. All the data packs suggest that this is an area that requires local interpretation.	All three CCGs
	Respiratory	Emergency COPD admissions relative to patients on the disease register. Links into respiratory as one of our key areas and all three CCGs are red against comparators on NEL spend for COPD admissions and work is ongoing	All three CCGs

7.0 Sustainable Finances

7.1 The table below shows the 'programme' funding allocation for our three CCGs for 2016/17 of £490m and the growth compared to 2015/16. For 2016/17 NHS England has made some fundamental changes to how the 'target' allocations are calculated for CCGs (the amount a CCG should theoretically receive based on a 'fair share' of the national funding available) and this means the actual funding for each of our CCGs is now much closer to this theoretical target. Slough CCG is funded marginally above the target, with Bracknell and Ascot CCG 1.5% below target and Windsor Ascot & Maidenhead CCG 3.3% below target.

	2016-17 Final allocation after place based pace-of-change £k	2016-17 Final growth £k	2016-17 Final growth %	2016-17 Final per capita allocation £
NHS Bracknell and Ascot CCG	153,421	6,601	4.50%	1,085
NHS Slough CCG	171,799	5,083	3.05%	1,117
NHS Windsor, Ascot and Maidenhead CCG	165,111	9,160	5.87%	1,077

Table 1

7.2 In total the three CCGs have received 'growth' of £20.8m, this is significantly consumed by:

- an underlying inflation assumption of 1.7% (the GDP Deflator);
- population growth;
- three funding streams which we previously received via non-recurrent allocations in 2015/16 for GP IT, additional funding for CAMHS, and for additional national tariff costs.

7.3 Therefore the remaining growth, after taking account of these items is only £4.3m and the additional requirements outlined in the NHS Mandate need to be funded from within this growth number. In addition to our 'programme' funding we receive an allocation for CCG running costs and are allowed a 'carry-forward' of the surplus from 2015/16. Therefore in total the available resources for 2016/17 are £507.6m, as shown in the table 3. This table also outlines our forecast expenditure for 2016/17.

In preparing our plans we have taken account of key national planning requirements, including:

- delivery of a surplus in 2016/17 of £7.9m, which is at the same level as 2015/16. For all three CCGs this is more than the minimum 1% required. A 1% surplus would equate to £5.1m, and the CCGs would like to be allowed to spend the additional £3.8m on local services;
- holding contingencies of at least 0.5%;
- holding a further 1% for non-recurrent expenditure (in line with the planning guidance, there are currently no commitments against this). This will operate as a risk pool across the Frimley STP Footprint;
- increases in national tariff prices of on average 1.7% for acute services and 1.1% for other services;
- increasing expenditure on mental health services by 3.6%
- growth in acute activity in line with national planning projections after taking account of QIPP savings, table 2 below

	NHS Bracknell and Ascot CCG	NHS Slough CCG	NHS Windsor, Ascot and Maidenhead CCG
Elective Activity (Episodes)	13,001	12,550	13,324
Elective Activity (Percentage growth on 2015/16)	2.9%	4.3%	4.0%
Non-elective Activity (Episodes)	10,796	16,617	14,427
Non-elective Activity (Percentage growth on 2015/16)	1.8%	2.0%	2.3%

Table 2

Summary of Allocations, Expenditure, Contingency and Surplus for 2016/17	**NHS Bracknell and Ascot CCG £000s**	**NHS Slough CCG £000s**	**NHS Windsor, Ascot and Maidenhead CCG £000s**	**Total £000s**
Programme Allocation	153,421	171,799	165,111	490,331
Programme Allocation -Adjustments	-14	9	4	-1
Running Cost Allocation	2,996	3,164	3,188	9,348
Return of Surplus	3,304	1,954	2,634	7,892
Total Allocation & Return of Surplus	**159,707**	**176,926**	**170,937**	**507,570**
Acute	83,760	99,727	92,541	276,028
Mental Health	14,586	16,369	15,828	46,783
Community	10,557	11,236	11,196	32,989
Continuing Healthcare	18,679	14,871	17,441	50,991
Primary Care	18,372	20,756	20,919	60,047
Other Programmes	5,030	5,616	4,596	15,242
Sub Total	**150,984**	**168,575**	**162,521**	**482,080**
Running Costs	2,996	3,164	3,188	9,348
Contingency (Minimum 0.5%)	889	1,515	942	3,346
Non Recurrent Reserve (Minimum 1%)	1,534	1,718	1,651	4,903
Surplus (Minimum 1%)	3,304	1,954	2,635	7,893
Total	**159,707**	**176,926**	**170,937**	**507,570**

Table 3

7.4 In order to meet these planning assumptions significant savings will be required in 2016/17, amounting to just under £13.5m which is equivalent to 2.7% of our recurring funding. The second table below shows the key areas where we are looking to achieve these savings.

Summary of QIPP for 2016/17	NHS Bracknell and Ascot CCG £000s	NHS Slough CCG £000s	NHS Windsor, Ascot and Maidenhead CCG £000s	Total £000s
Urgent and Emergency Care Programme	1,522	2,416	2,464	6,402
Elective care	1,021	1,809	1,780	4,610
Medicine Management	450	619	494	1,563
Other	230	241	304	775
Total	**3,223**	**5,085**	**5,042**	**13,350**
QIPP as % of Resource	2.1%	2.9%	3.0%	2.7%

Table 4

7.5 Alignment of our plans with our providers

7.5.1 The CCGs are working collaboratively to agree contracts with our main providers, Frimley Health NHS Foundation Trust, Royal Berkshire NHS Foundation Trust, South Central Ambulance NHS Foundation Trust and Berkshire Healthcare NHS Foundation Trust.

7.5.2 We are seeking to agree the following key planning assumptions with our providers:

- a common start-point of the Month 9 2015-16 forecast outturn;
- broad consistency in activity planning assumptions;
- a shared understanding of the implications of pathway redesigns which move activity into new settings or the application of business rules for example for procedures of limited clinical value. Some of these are already included within contract activity plans, and others will generate savings under the normal application of business rules;
- a gradual repatriation of activity to Frimley Health Foundation Trust from other acute providers, partly from patient choice (due to of the improved quality of care at Wexham Park hospital), and partly from the proactive repatriation of more specialist activity from London and other tertiary providers.

7.6 Contracting

7.6.1 The three CCGs in East Berkshire intend to act reasonably and responsibly as commissioners of healthcare. To this end the following principles will apply. We will:

- aim to commission sufficient activity to meet the demand and constitutional standards required for our populations;
- apply standard NHS Contracting principles of engagement as well as guidance and regulations;
- not seek to unfairly shift risk across other parts of our healthcare system;
- use all tools and leverage available to ensure receipt of provider services to the prescribed standards and quality;
- use all relevant contractual clauses and schedules in support of developing and implementing service change.

7.6.2 We will use the NHS Standard contract to drive quality, innovation, productivity and efficiency to ensure the delivery of the highest quality services at best value.

7.6.3 We will benchmark productivity measures with the aim of achieving or further moving towards upper decile performance in line with affordability. We expect to work with our providers and

with primary care to reduce unnecessary activity within the principles of providing the lowest level of intervention required to manage the patient's condition effectively.

7.6.4 Through jointly agreed Service Development & Improvement Plans we are intending to reflect work programmes throughout the year with our Acute, Community and Mental Health service providers to improve patient pathways, inter-organisational delivery, provider performance and to develop services. We expect all organizations to strive to achieve the agreed milestones and report to the Contract Management Meetings if any have not been delivered. Day to day monitoring of these plans will be undertaken at monthly intervals unless there is failure to progress, in which case, in the absence of reasonable impediments, contractual levers will be used to maintain pressure for delivery.

8.0 Enabling Strategies

Engagement and Co-production

8.1.1 The CCGs believes strongly that engagement is a continuous process of discussion and listening. Wherever possible this will be done in conjunction with our local authorities and provider stakeholders.

8.1.2 Our Communications and Engagement Strategy was completely revised at the end of 2015 and views are currently being sought from patients, the public and other stakeholders. The strategy is now shared across the three CCGs and sets out the principles for communications and engagement and three key objectives:

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

8.1.3 Two key Forums are in place to facilitate and plan communications and engagement:

- **Each CCG has a Forum/Network** bringing together representatives from their practice Patient Participation/Reference Groups. Each meets bi-monthly and their agendas include a section for bringing an update from the CCG about key projects and initiatives which might be of interest to their groups and opportunities to get involved. Hosting and chairing arrangements vary but the lay member for Patient and Public Involvement is a member and Healthwatch also attend. The groups offer support to each other and share good practice as well as develop work plans for the year.

- **The Community Partnership Forum** brings together representatives from the communities across east Berkshire to allow for wider discussion about issues that are shared. Membership includes representatives from local councils, voluntary sector, Healthwatch, PPGs, Patient groups and the public. The Clinical Chairs and other members of the CCGs attend and the topics are agreed with the wider membership. All meetings are open to the public with information published on the CCG websites, including papers and presentations. This Forum is chaired by voluntary sector representative.

8.1.4 The CCGs recognise that their ambition in relation to engagement will only be realised by exploiting technology. This will allow a much greater reach, more projects to engage effectively and will increase efficiency. This is being achieved through a number of initiatives:

- **Twitter:** The CCGs are actively engaging via their Twitter accounts and incorporate twitter into all project communications and engagement plans.
- **Health Connect:** This on-line engagement tool was launched in February 2015 and has more than 650 members to date. Patients, public and community organisations are encouraged to register. The tool is currently used to broadcast messages, send invitations to events, such as workshops and public meetings and to run surveys to enhance the engagement in various projects. The format of the site is consistent with the other Thames Valley CCGs so that collaborative engagement can also be facilitated. For example, NHS111 is being re-procured on a Thames Valley-wide basis and the public engagement needs to be coordinated across all 10 CCGs. Having the same online systems for running surveys allowed the format to be cloned onto the engagement sites for each CCG. Results were analysed on a CCG basis as well as drawing themes across CCGs for the project.
- **CCG Website**: The website is a key tool for engaging and communicating with the public. Its use is monitored and reviewed regularly. Plans are in place for a refresh of

sites with Slough's new site planned to go live in the spring with full engagement of patients to ensure it holds information and is structured to support effective engagement.

8.1.5 **Engaging diverse communities:** The diverse communities across East Berkshire are engaged in the work of the CCG in a variety of ways. The communities are very different and the CCGs employ different methods depending on the community to be reached. For Bracknell and Ascot CCG, this includes the Nepali community around Sandhurst, for Slough CCG, this includes recognising the changing demographics with new migrant communities as well as the existing diverse communities, for Windsor, Ascot and Maidenhead CCG this includes recognising the growing number of older people and the relatively large number of people living in care homes. Methods for engaging these diverse communities varies and includes making sure information are accessible and available in different languages. A local translation service responds to requests in a timely way. The CCG attends community events and meetings including one-off events such as an information day for the Somali Community in Slough, the Retirement Fair in Ascot, Self-Care Week events in Bracknell Forest and Older People Forums in all areas.

8.2 System leadership

8.2.1 The CCGS recognise the importance of system leadership in the development and delivery of our Sustainability and Transformation Plan and Operating Plan. We are clear about the governance arrangements required to lead the Frimley system and also that all partners in this also need to work across other systems. We are comfortable with this complexity as we have been working across different footprints for a number of years.

8.2.2 We have set up a Frimley System Leaders Group, comprising CCGs, providers and local authorities. This will be the 'umbrella' group which will work closely with our other system leadership arrangements, to ensure coherence of plans and leadership within the Frimley footprint. In East Berkshire, we will build on our successful System Leaders Group which has championed a number of system programmes including Share Your Care and New Vision of Care. Several of our partners have been working with the Kings Fund on developing our system leadership and we are looking for them to support us in developing our new arrangements.

8.2.2 The Frimley footprint has a number of work streams underway to identify the three gaps in the Five Year Forward View (Health and Wellbeing, Care and Quality and Finance and Sustainability) which will inform our focus as a system. We also have set up an Executive Group which will drive the development and then operationalisation of our plans. As the Operational Plan is in effect year 1 of our STP we will ensure that those areas that require system leadership will be incorporated into these arrangements.

8.3 The digital roadmap/ interoperability

8.3.1 Digital technologies are fundamentally changing the way clinicians are working, information is shared and care is provided. They are also enabling patients to access information about, and participate in their care, in new and innovative ways. Our plans through to 2020 are being summarised in a document known as the Digital Roadmap. The 'footprint' for our Digital Roadmap covers the three CCGs in East Berkshire, the three Local Authorities and our main providers. The Roadmap will be completed by June 2016 and is overseen by our Digital Roadmap Board.

8.3.2 Central to our strategy is our 'Share Your Care' project which involves a £5m investment over 7 years to allow:

- Interoperability and information exchange between health and social care organisations with the flow of real time data between organisations to improve service provision, care and data analysis;
- Having a person held health and social care record with accurate real time data from GPs, providers, and citizens, enabling people to hold and manage their care data and give consent to providers/carers to view their record.

8.3.3 In February 2016 we selected Graphnet as our strategic partner for this project. In addition to being a fundamental prerequisite for delivering our 'New Vision of Care' for frailty it assists in delivering the national policy objectives that:

- by 2018 all clinicians in primary, urgent and emergency care operate without paper records;
- from March 2018 all patients able to record their own comments and preferences on their care record;
- by 2020 all care records will be digital, real time and interoperable.

8.3.4 Other key technology themes in our plans through to 2020 include:

- Increasing the use of clinical decision making tools which provide clinicians with computer-generated knowledge to aid with diagnostic and treatment decisions. During 2016 the DSX Clinical Pathway and Triage Solution will be implemented in the three CCGs;
- The remote monitoring of patients and improving self-care through use of apps, wearables and other devices, for example for diabetes and heart conditions;
- Enabling our GPs to expand the range of services they offer for example through point of care testing where GPs undertake tests on site which historically would have required a hospital laboratory;
- Supporting professional-to-professional telehealth in the form or real time phone, video or web consultations;
- Delivery of care and care advice electronically, for example psychological interventions through online modules such as computerised cognitive behavioural therapy;
- Using the data generated through shared electronic health records and monitoring devices to move to a model of more proactive care to identify those at risk and enabling early intervention;
- Using technology to support efficiencies in the clinical and managerial workforce through mobile working and better workforce planning.

8.4 Workforce development

8.4.1 The development of our workforce is a key enabler to our longer term plans and will require some attention in year. In order to deliver the transformed care we are aspiring to by 2021, we will need to re-design roles, address recruitment issues and develop a culture amongst our collective workforce that delivers our ambitions. We have a number of opportunities to do this at scale across the Frimley system and will be working closely with the local offices of Health Education England to develop our collective approach.

8.4.2 We will also be working across the Thames Valley Urgent and Emergency network to develop workforce plans and implement changes to roles within the 111 service.

8.4.3 During 2016/17 WAM CCG will be piloting a community education provider network which will provide an opportunity to develop a new approach to workforce development in primary care.

8.4.4 The New Vision of Care programme as part of the implementation of the new model of care has set up a system wide workforce work stream. The aim of this work stream is to identify the workforce changes and developments that will be required to successfully implement the new model and to capture this as a work stream action plan that has been developed and owned by the health, social and voluntary sector.

8.6 Estates Plan

8.6.1 The CCGs are developing an Estates Strategy which draws together plans across the primary, community and acute sectors to ensure we have the right premises available for new models of NHS care, at an appropriate cost. Key elements of the Strategy include:

8.6.2 Working with Frimley Health Foundation Trust on their ambitious plans to reconfigure the emergency care and assessment facilities on the Wexham Park hospital site, and a complete rationalisation of the outdated Heatherwood Hospital facilities. This will entail a complete rebuild to provide a state of the art elective care centre with 6 theatres and 62 beds.

8.6.3 A review of the services using community hospital facilities at Upton Hospital, King Edward VII Hospital and St Marks Hospital, with an immediate priority to reducing the amount of empty and derelict space which is an unnecessary financial burden on the local health economy.

8.6.4 Ensuring we have sufficient and appropriately located primary care (GP) facilities to meet the growing population in East Berkshire and the increasing focus on providing non urgent care in settings away from hospital and closer to people's homes. During 2015/16 some 17 schemes were given full or outline approval for funding through the Primary Care Transformation Fund, and a further bids will be submitted in April 2016. Key proposed practices developments / extensions include:

- Langley Health Centre (Slough) – major extensions;
- Farnham Road Practice (Slough) – fundamental review of practice location and capacity;
- Binfield Practice (Bracknell) – fundamental review of practice location and capacity;
- Ascot Practices - opportunity to consolidate onto two sites as part of the wider Heatherwood Hospital redevelopment;
- Reprovision of the Skimped Hill site which is part of the Bracknell town centre redevelopment zone.

8.6.5 Working with our local authorities to get a common view of 'One Public Estate' to support integrated care across health and social care, and maximising the opportunities from planning and Community Infrastructure Levy arrangements.

8.8.6 Underpinning our plans by thorough patient, public and partner participation via three Local Estates Forum.

9.0 Risk & Governance of Plan

9.1 CCG Assurance Framework

9.1.1 The CCGs are currently assessed as 'medium risk' and based on Q2 report we have been assessed as good on finance, planning and delegated functions and have limited assurance on well led organisation and performance. Following progressed made in Q3 and the confirmation of appointment of a permanent AO together with the work being carried out on our OD strategy we are planning to receive a good assessment on all areas by Q4.

9.1.2 With the development and implementation of the new CCG assessment framework we would anticipated that this good performance assessment will continue in relation to the four key facets outlined in the new arrangements. Our ambition during 2016/17 is for the CCGs to achieve an outstanding rating in at least one facet area.

9.2 Risk to delivery of the Operational Plan

9.2.1 The CCG has a risk management strategy and framework which is followed to identify and manage risks. All high and extreme risks are reported on a quarterly basis in public to the CCG Governing Body is using the Assurance Framework. The top risks are:-

- Negotiation of contracts with providers to ensure delivery of our financial, quality and activity plans
- Delivery of the transformation of services and at scale and pace during 2016/17 in order to deliver the requirements for our local system
- Resilience and sustainability of our local system during periods of high service demand
- Ability to recruit and retain workforce across the local system.

9.3 Governance & Local Assurance Process

9.3.1 As part of our organisational development programme we have been reviewing governance processes and will have two key subcommittees of the Governing Bodies that will play a role in the delivery and assurance of the Operational plan. These are Strategy and Planning which will ensure strategic alignment and the sign off of business cases across the three CCGs and Finance and QIPP Committee which will review QIPP delivery.

9.3.2 Our organisational structure is being aligned to the delivery of the major programmes of work in the Operating Plan. Clinical engagement at practice level will remain through member meetings and our clinical leadership is being aligned to programme delivery.

9.3.3 Programme Management Office

9.3.1 The CCGs has a Programme Management Office (PMO) to monitor the delivery of all projects across the three CCGs and identify areas of risks and non-delivery of benefits.