APPENDIX A

Planned Care Programme

Our strategy for planned care is to reduce unwarranted variation in both outcomes and activity using the Right Care programme methodology to identify priority specialties and to deliver Constitutional standards. We are working with our providers to model the demand and capacity for all specialities including diagnostics to ensure we are commissioning the appropriate level of services and pathways are delivered efficiently. This work stream is aligned to the STP Reducing Clinical Variation work stream and shares the same priority areas*.

For 2017/18 We Said We Would ……	We Have …….	For 2018/19 We Will ……
Diabetes • Introduce a new specification for an Integrated Diabetes Service across community and acute services • Work with general practice and other healthcare professionals/clinicians to develop the necessary skills, competencies and confidence to improve the quality of routine diabetes management • Review the current dietetic service as part of the implementation of an integrated diabetes service • Commission new ambulance pathways for the management of hypoglycaemia Cardiology • Review all current locally commissioned	Diabetes • Drawn up an Integrated Diabetes Service specification that is being negotiated into contracts for 2018/19 • Implemented Diabetes care and support planning services, Diabetes foot care pathway, Diabetes inpatient nursing services, Digital access to structured education as well as commencement of referral hub • Put new ambulance pathways in place for the management of hypoglycaemia Cardiology • Commissioned GP outcomes framework to	• *Continue the service redesign for integrated community neurology service, MSK and gastrointestinal pathways • Advice & Guidance/Triage – building on the success of dermatology and ophthalmology prioritise the following pathways: MSK, Pain, GI, Urology, Pain • Complete an intermediate services review to include ENT and ophthalmology • *Continue our Cancer and Diabetes services improvement work • Maintain key area of focus on our demand management work including access to regular data at practice level, peer review and education, access to guidelines and evidence based information, and reducing consultant to consultant referrals and follow up

For 2017/18 We Said We Would ……	We Have …….	For 2018/19 We Will ……
services from primary care associated with cardiology • Improve management of patients with hypertension • Evaluate the provision of cardiac rehabilitation across the three CCGs • Develop an integrated community heart failure nursing team expanding the use of telehealth • Commission an IV diuretic lounge with all our providers <u>Reducing clinical variation/ demand management</u> • *Engage in the STP wide unwarranted variation programme, influencing service and pathway changes as these are developed • Commission a new model of dermatology services • *Develop a strategy for neurology service provision basing as much of the service within the community as possible • Commission an expanded community ophthalmology model • *Evaluate local demand management pilots, with a view to defining a future strategy for the commissioning of musculoskeletal (MSK) services	include increasing prevalence of Atrial Fibrillation and Hypertension to expected rates • Cardiac rehabilitation service specification agreed and is with providers to commence provision • Commissioned an integrated community heart failure service. Improved AF and hypertension prevalence within practices • Commissioned an IV diuretic lounge • Implemented new stroke pathway <u>Reducing clinical variation/ demand management</u> • Engaged with STP wide unwarranted variation work stream on MSK, Diabetes, Gastro-Intestinal, Respiratory and Neurology • Dermatology business case to be considered in November • *Progressed development of an integrated community neurology service across the STP • Commissioned Evolutio to help manage ophthalmology referrals with a view to commissioning an integrated approach in 2018/19 • Decommissioned the existing GRACE service • Commissioned a LCS for referral management to reimburse practices for management of	appointments) • Review anticoagulation LCS in line with renewed guidelines of the use of newer agents. • Work on a CKD pathway that incorporates Frimley Health and Royal Berkshire Hospital (resource allocation permitting) • Review ENT contracts and commission an integrated ENT service (resource allocation permitting)

For 2017/18 We Said We Would ……	We Have …….	For 2018/19 We Will ……
• De-commission the existing GRACE service. Develop a new specification to re-commission a service which will provide triage and update all referral forms and pathways on DXS. • Work with general practice to reduce unwarranted clinical variation in primary care • Improve utilisation of e-Referral. Providers to ensure that the DXS system is notified of changes to pathways and referral forms. Providers will ensure that sufficient bookable slots are available on e-referrals • Commission new contracts for MSK physiotherapy, audiology, podiatry, and other small contracts including ENT, and ophthalmology <u>Cancer</u> • Review cancer services Improve management of patients with Chronic Kidney Disease (CKD)	referrals and to utilise DXS as well as e referral systems. Support practices to undertake clinical peer review of referrals • Improved the utilisation of e-referrals • MSK Physiotherapy, Audiology and Podiatry contracts are being negotiated with Berkshire Healthcare Foundation Trust and are near completion • Ophthalmology contracts are being reviewed with a contract issued for 1 year to October 2018 <u>Cancer</u> • Reviewed and improved Cancer services – cancer champions in place; 99.9% sign up to the LCS; 64% of practices engaging with CRUK Berkshire facilitators - 60% of Bracknell & Ascot practices, 50% of Slough Practices and 82% of WAM practices, and improved rehabilitation service offer to patients post treatment in place	

** STP footprint projects*

Integrated Care Programme

In line with our local priorities set out in the plan and in the context of the vision of the Frimley Health and Care STP, we are working in partnership with Bracknell Forest Council, Slough Borough Council and the Royal Borough of Windsor and Maidenhead and to deliver plans to integrate health and social care services which improve the lives of the local people.

In 2017/18 We Said We Would ……	We Have …….	In 2018/19 We Will ……
• Increase the number of personal health budgets in line with national policy • Expect all providers to adopt and work to the New Vision of Care principles and its approach to frailty identification and management. This includes adopting a locally agreed frailty tool within their services and applying the principles of "Making every contact count" • Review key service lines and agree revised service specifications including the Mobility Service, Community Hospital in-patients, and Community Nursing through the remainder of 2016/17 with a view to having a new service specification in place by April 2017 • Review community services currently provided by Virgin Care for our registered population living in Surrey with a view to re-procurement during 2017/18 • Explore with our local authority commissioners opportunities for joint	**In conjunction with our partners:** • Piloted process for extending personal health budgets in partnership with the 3 Unitary Authorities. Pilot to complete in November 2017 • Extended the reach of our New Vison of Care Programme across the STP by agreeing a common clinical definition of frailty and a common population stratification tool across the STP population • Completed phase 1 of our Community Nursing Review and agreed an interim service specification for 2017/18 and an extended service for our Surrey population following the end of the Virgin Care contract • Developed a proposal for integrating Section 117 and CHC budgets across the 3 CCGs and UAs • Implemented an End Of Life Locally Commissioned Primary Care Service (LCS) to	**Work collaboratively with our partners to:** • Integrate Decision Making in the community, bringing together multi-disciplinary teams, led by Primary Care, to develop anticipatory and advanced care plans for our most vulnerable patients (Severely Frail, and multiple co-morbidities) • Inclusion of social prescribing as a core component to Primary Care and Integrated Decision Making in the community • Commission a Frailty Pathway through prevention to acute care, including outreach of frailty specialists from the acute to support community teams and GPs to keep people out of hospital • Implement the Enhanced Care Homes framework to enable a step-change in the quality, consistency and resilience of our care home workforce • Develop a Market Management strategy for

In 2017/18 We Said We Would ……	We Have …….	In 2018/19 We Will ……
commissioning for individuals who are eligible for funding from Continuing Healthcare, voluntary sector provision and learning disability and mental health placements	improve the integrated approach to care for people approaching the end of their lives • Commissioned a 24/7 Rapid Response team from Thames Valley Hospice to provide advice and home based support 24/7/365 • Appointed a care home delivery manager to enhance the support to care homes and work with Registered Managers to improve education and training • Appointed two Wellbeing Prescribers to work in Primary Care on a Social Prescribing Pilot • Supported the developed of a community asset map for GPs to search and refer to social prescribing offers • Piloted a Complex Case Management Locally Commissioned Primary Care Service to proactively manage conditions in the community and avoid crisis and hospital admission *(see also under Primary Care)*	the home care workforce across the STP to build capacity, confidence and resilience • Extend the Complex Case Management LCS across the east Berkshire footprint and incorporate new services as they come on-line (e.g. Social Prescribing) • Extend the Wellbeing Prescribers across the east Berkshire footprint • Complete phase 2 of our Community Nursing Review with a revised specification of service expectations of a modern, integrated district nursing service

Urgent & Emergency Care

We are committed to designing a simplified system with fewer access points, greater coordination across pathways and providers, supported by more effective information sharing. From a public perspective there will only be 4 points of access to urgent and emergency care services: 111, GP, 999 and A&E. Regardless of the point of access there will be a consistent approach dependent on the level of need.

In 2017/18 We Said We Would ……	We Have …….	In 2018/19 We Will ……
• Mobilise the new Integrated NHS111/ Urgent Care contracted service model • Review the Bracknell and Maidenhead Urgent Care Centres, the Slough Walk-in centre and East Berkshire Out of Hours Services and commission new service models • Review the impact of all of our resilience and out of hospital investments from 2015/16 and 2016/17 • Review of the impact of the recently commissioned AIRS service in Bracknell, Ascot, Windsor and Maidenhead populations with a view to extending the service to Slough from April 2017 • Work with our local Acute Providers to expand the use of ambulatory care pathways, and agree a local price for this activity • Revise our approach to the management and use of the directory of service (DOS) • Work with South Central Ambulance Service	• New 111 service launched in September 2017 with the implementation of the new integrated clinical hub – this will be further developed during the course of the contract. Direct booking into OOHs in EB went live during October 2017 and plans are in place to extend this to urgent care centres and walk in centres during 2017/18 • Developed the Out of Hospital strategy with wider partners and bringing together the urgent and emergency care, integrated care and the primary care strategy to enable alignment and better outcomes for patients from greater integration of services • AIRs extension to Slough from September 2017 • Emergency ambulatory care services were expanded to 7 days a week from October 2017 and financial arrangements have been agreed across the STP	• Through the Frimley System Joint A&E Delivery Board, work together with all partners to deliver the transformation of urgent and emergency care across the 7 pillars of transformation: 111 on line, 111 calls, ambulance, Urgent Treatment Centres (UTC), GP access, hospital and hospital to home. These plans will be monitored monthly and outcomes reported through a bespoke Alamac dashboard. • As current contracts come to an end, continue the review of the Bracknell and Maidenhead Urgent Care Centres, the Slough Walk-in centre, East Berkshire Out of Hours Services, and GP extended access to agree a model of services that supports our Out of Hospital Strategy and under market testing (subject to procurement advice) and commence the commissioning process for new service models

In 2017/18 We Said We Would ……	We Have …….	In 2018/19 We Will ……
(SCAS) to implement the recommendations from the national review of Ambulance Services • Work with providers to ensure that national quality indicators, best practice and standards are embedded within the contracts for 17/19	• A review of the DOS has taken place to ensure that all services are represented on the DOS and that dispositions into pharmacy, OOHs, UTCs and other local services are utilised fully rather than directing patients to A&E • SCAS mobilisation of Ambulance Response Programme (ARP) will go live October 2017 • All urgent and emergency care services are contracted for using NHS Standard Contract which includes comprehensive quality sections. Contracts are monitored on a monthly basis	• Deliver the national integrated urgent care specification through the extension of the clinical hub, DOS development and direct booking in and out of hours to meet national trajectories

Primary Care

Our Primary Care Strategy is to develop a transformed and sustainable model of general practice for east Berkshire, improve overall access to general practice appointments and realise the opportunities and benefits set out in the general practice forward view through delegated commissioning. We are working with our member practices as providers to develop how they will work together across GP Federations and clusters. This programme of work is aligned to the STP General Practice Transformation work.

In 2017/18 We Said We Would ……	We Have …….	In 2018/19 We Will ……
• Transition of delegated authority for the Primary Medical Services contracts to the CCG from NHS England • Invest in General Practice transformation enabling practice to work differently together to develop services such as proactive care for housebound patients using appropriate skill mix and integration with other teams • Commission extended hours general practice services for all patients in East Berkshire for evenings and weekends as population needs require. • Commission a single quality scheme to replace the current locally commissioned services to include atrial fibrillation, complex case management, and near patient testing • Support the use of technology in primary care to support self-care, patient communication, reduction in DNAs and public health	• Maintained our Delegation transition on plan with NHS England for completion in March 2018 • Invested in General Practice transformation enabling practice to work differently together to develop services such as proactive care for housebound patients using appropriate skill mix and integration with other teams • Commissioned extended hours general practice services for all patients in East Berkshire for evenings and weekends as population needs require • Commissioned a single quality scheme to replace the current locally commissioned services to include atrial fibrillation and near patient testing *(Commission the complex case management service from General Practice by December 2017*) • Developed an approved Primary Care Strategy	• Support the use of technology in primary care to support self-care, patient communication, reduction in DNAs and public health screening/prevention improvement • Develop social prescribing across general practice to widen the support for patients and carers • Commission a practice resilience programme to support all practices • Commission complex case management that will also include and support social prescribing • Commission a visiting service to ensure proactive care for housebound and care home patients using appropriate skill mix on a population basis • Develop infrastructure plans to support the Primary Care Strategy for the sustainability of general practice services, including estates assessments, workforce development with

In 2017/18 We Said We Would ……	We Have …….	In 2018/19 We Will ……
screening/prevention improvement • Develop social prescribing across general practice to widen the support for patients and carers • Commission a practice resilience task force to support practices in crisis • Commission specimen collection to support 7 day services, support interoperable primary care/general practice records and identify professional resources to support the realisation of the estates and other infrastructure proposals	across the CCGs • Launched the Practice Resilience Programme supporting practices in identifying areas requiring greater resilience within their practice and providing through GPFV investment funding for improvement and developing resilience for the future • Developed and implemented the Time for Care Programme that will support practices in developing greater efficiency, taking forward innovation and provide skills and resources into practices • Piloted various models of Social prescribing working in partnership with social care, public health and the voluntary/community service • Commissioned specimen collection to support 7 day services, support interoperable primary care/general practice records and identify professional resources to support the realisation of the estates and other infrastructure proposals being considered by NHSE to create capacity in general practice	the STP and technology aligned with the Connected Care programme • Invest further in General Practice sustainability through the local delivery of the General Practice Forward View aligned to the Primary Care Strategy

Mental Health & Learning Disabilities

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

In 2017/18 We Said We Would ……	We Have …….	In 2018/19 We Will ……
• Reduce the numbers of learning disability assessment and treatment unit beds • Implement the Learning Disability Community Intensive Support service • Re-scope the role and function of the Learning Disability Community Teams • Develop the market for local placements and support for people with mental ill health, LD and/or autism thereby reducing the number of out of area placements. We will de-commission the Out of Area Placement Brokerage Service provided by BHFT with effect from 1 April 2017 and intend to provide this service in house • Expect a learning disability liaison nurse function to be provided at Wexham Park in line with other providers • Expect the prescribing of antipsychotics to be reduced in all care settings • Develop a locally commissioned service to improve the quality of learning disability	• Reduced the numbers of learning disability assessment and treatment beds and commissioned a community intensive support service • Supported some people with learning disabilities to move into their own homes using the HOLD scheme and Transforming Care Partnerships • Commissioned a placement review team in house to review the quality and appropriateness of people who are in placements funded through section 117 aftercare. This will include looking at the prescribing of antipsychotic medications for people in these placements • Commissioned an improved service for psychiatric liaison and crisis at Wexham Park Hospital and reviewed the Crisis Response and Home Treatment Teams locally. We have also increased the provision in Street Triage service • Successfully obtained funding to support	• Continue to work with the transforming care partnership to support people with learning disabilities to live better lives locally. This will include working with the community teams • Work together with the local authority and voluntary sector locally to develop the market for local placements and support for people with mental ill health, LD and/or autism • Continue to develop plans to ensure people with Learning Disabilities and mental health issues receive good quality physical health care and the checks they require and enhance the learning disability liaison service at Wexham Park • Further explore new models of care for people who are experiencing a mental health crisis to continue to improve the quality of care and choice available • Redesign the 'front door' to mental health services (common point of entry – CPE) and monitor the impact on Community Mental Health Teams and other parts of the system

In 2017/18 We Said We Would ……	We Have …….	In 2018/19 We Will ……
health checks in primary care • Commission consolidated acute based mental health liaison services • Review Community Mental Health Teams and work with partners to jointly commission a transformed model of community mental health provision • Review the current Crisis Response Home Treatment Teams and commission a new model of urgent and emergency care for mental health users • Expand the Increasing Access to Psychological Therapies (IAPT) service. Expand the psychology intervention community nursing pilot (PINC) across the 3 CCGs in line with the IAPT expansion programme • Continue to increase dementia diagnosis rates and review post diagnostic support for people with dementia. Developing dementia friendly practices and expanding the service for younger people with dementia from 2 to 5 days • Review the existing Friends in Need service with a view to expand this to Slough and Bracknell and Ascot CCGs • Review the Street Triage pilot and explore the potential for continuation in conjunction with	IAPT's services work with people who have long term conditions and have operationalised this service, including working closely with the community nurses to support people more psychologically • Commissioned Healthmakers a group of volunteers who have long term conditions offering support to others • Commissioned a Young People with Dementia service improving the support available to people when initially diagnosed • Improved the Dementia diagnosis rates locally • Expanded Friends in Need services across all three boroughs to support people who are socially isolated	• Continue to work with our partners to reduce the numbers of people who need acute inpatient care or long term placements many of which are out of area. Develop a pathway of care and support for people with dementia that is equitable across the CCG's • Develop our current limited Individual Placement Service (IPS) with support from our colleagues in our STP footprint. This will facilitate an increase in the numbers of people accessing the IPS and the numbers of people gaining meaningful employment

In 2017/18 We Said We Would ……	We Have …….	In 2018/19 We Will ……
Local Authorities		

Children's and Maternity Services

Our aim is to commission high quality evidence based mental and physical health services which are fully integrated, inclusive, accessible, timely, and responsive and informed by the needs expressed by children and young people.

In 2017/18 We Said We Would ……	We Have …….	In 2018/19 We Will ……
• Commission a fully NICE compliant community eating disorder and perinatal services • Work with our providers to implement the recommendations from Better Births • Review the Children's and Young Persons Transformation pilots and make recommendations on future commissioning • Continue to reduce CAMHS waiting times across all pathways • Work with partners to ensure that our collective responsibilities for children with special educational needs and disabilities are met • Commission upstream support to children and young people and their parents before they develop a mental health disorder	• Received funding and commissioned NICE compliant eating disorders service for children locally and a perinatal service • Commissioned a number of CAMHs transformation projects e.g. Kooth online, counselling services to support children wellbeing • Developed and published 'The Little Book of Sunshine' CAMHs resource • Reduced waiting times and improved access for CAMHs • Reduced the number of young people we are sending out of area for specialist hospital treatment for their mental health needs • Worked with our local partners to support the SEND agenda • Developed with partners across STP a local maternity transformation plan	• Review the CAMHS Transformation Projects to assess their impact • Work closely with local authorities to commission children's services more collaboratively • Assess the need for an ageless Autism and ADHD service and the impact this could have for local people • Work more collaboratively to further the impact we have for young people with special educational needs and disabilities • Continue to work with providers in implementing recommendations from Better Births as detailed in the local maternity transformation action plan