NHS
Slough
Clinical Commissioning Group

Title of meeting			
Date of Meeting	2nd June 2015	**Paper Number**	SCCG/02/06/15/4
Title		Chief Officer's Report	
Sponsoring Director (name and job title)		Matthew Tait, Interim Chief Officer	
Sponsoring Clinical / Lay Lead (name and job title)		N/A	
Author(s)		Matthew Tait, Interim Chief Officer	
Purpose		For information	

The xxx Committee is required to (please tick)

Approve		**Receive**	✓	**Discuss**	✓	**Note**	✓

Risk and Assurance (*outline the key risks / where to find mitigation plan in the attached paper and any assurances obtained)*	N/A
Legal implications/regulatory requirements	N/A
Public Sector Equality Duty	N/A
Links to the NHS Constitution (relevant patient/staff rights)	N/A
Strategic Fit	N/A
Commercial and Financial Implications *(Identify how the proposal impacts on existing contract arrangements and have these been incorporated?* *Include date Deputy CFO has signed off the affordability and has this been incorporated within the financial plan. Include details of funding source(s)*	N/A Date Deputy CFO sign off ……

Quality Focus *(Identify how this proposal impacts on the quality of services received by patients and/or the achievement of key performance targets* *Include date the Director of Nursing has signed off the quality implications)*	N/A Date Director of Nursing sign off…….
Clinical Engagement *Outline the clinical engagement that has been undertaken*	N/A
Consultation, public engagement & partnership working implications/impact	N/A
NHS Outcomes *Please indicate (highlight) which Domain this paper sits within by highlighting or ticking below:* *Please note there may be more than one Domain.*	Domain 1 Preventing people from dying prematurely; Domain 2 Enhancing quality of life for people with long-term conditions; Domain 3 Helping people to recover from episodes of ill health or following injury; Domain 4 Ensuring that people have a positive experience of care; and Domain 5 Treating and caring for people in a safe environment; and protecting them from avoidable harm.

Executive Summary
(summary of the paper and sign-posting the reader to the key sections within the report / paper)

This report is in two parts. The first section provides an update on topical and strategic issues from the Chief Officer. The second section provides an update from the CCG Head of Operations on progress in delivering the CCG plans including education and training events, commissioning plans and project work as well as key meetings and organisational development plans.

Recommendation(s)

N/A

Introduction

Welcome to the Chief Officer's report, covering March to May 2015. This report brings together an update from the Chief Officer, followed by a report from the Head of Operations for the CCG and the same for the other two east Berkshire CCGs.

Report from the Chief Officer

Organisational Development

Following the agreement to support the existing federated model the process to recruit a substantive Accountable Officer has commenced with interviews planned for mid-June. The cross CCG working group is now established and has held two workshops during May and a joint governing body session is planned for July. A review of the wider management structure is also taking place, in response to the work on collaboration, and will be available to discuss with the substantive Accountable Officer, upon appointment, before any formal consultation exercise takes place with staff.

Lead Provider Framework for Commissioning Support services

NHS England developed the Lead Provider Framework (LPF) for commissioning support services to ensure commissioners are able to source as quickly as possible a range of services from quality assured providers. The LPF is fully compliant with OJEU procurement rules, and as part of the accreditation process LPF suppliers have been tested on their ability to provide high quality commissioning support. There is a strong mix of NHS, commercial consortia and public-private partnerships. They have demonstrated a range of diverse supply chains with other specialist organisations, voluntary organisations and small and medium enterprises.

The main commissioning support service contract for the three CCGs is commissioned through South Central and West CSU (previously Central Southern CSU) with an annual value of just under £4m per annum covering services such as Finance, Provider Performance Management, General Practice IT support and Informatics. The present contract will expire in March 2016. The CCG will be undertaking a "Make, Share or Buy" review of services between June and July to confirm which services will go through a reprocurement process through the LPF and will also work closely with neighbouring CCGs to ensure alignment and economies of scale.

Quarter Three Assurance Process

The quarter three assurance process was held with NHS England on the 26 March 2015. The assurance process assesses the CCGs against the six domains (below) and the overall rating was **"Assured with Support"** for each WAM CCG, Slough CCG and Bracknell and Ascot CCG.

1. Are patients receiving clinically commissioned, high quality services?
2. Are patients and the public actively engaged and involved?
3. Are CCG plans delivering better outcomes for patients?
4. Does the CCG have robust governance arrangements?
5. Are CCGs working in partnership with others?
6. Does the CCG have strong and robust leadership?

It was recognised that the CCGs had made good progress in improving constitutional delivery, supporting the quality improvement plan of Frimley Health and improving collaborative working. However, in order to become fully assured, the CCGs will need to continue to demonstrate quality improvements at the Wexham site; consistently achieve the constitutional targets and appoint a substantive Accountable Officer.

CCG Assurance Framework 2015/16

NHS England has issued their approach to Clinical Commissioning Group assurance for 2015/16. The new CCG assurance framework for 2015/16 consists of the following components:

- Well-led organisation
- Performance: delivery of commitments and improved outcomes
- Financial Management
- Planning: short term and long term
- Delegated Functions

The process will be supported by a published scorecard in relation to five population groups : the generally well, people with long term conditions, people with mental health problems or learning disabilities, children and young people and the frail elderly.

CCGs will be assured as Outstanding / Good / Limited / Not assured with a further category of Special Measures designed to address persistent and chronic difficulties.

http://www.england.nhs.uk/commissioning/wpcontent/uploads/sites/12/2015/03/ccg-assurance-framework.pdf

Urgent and Emergency Care

The CCGs are working on refreshing local strategies to reflect the need for greater integration, the impact of future 7 day working models and the potential redevelopment of the Wexham site A&E department. As part of this strategy the CCGs are working through the re-procurement process for NHS111 services and GP Out of Hours services to ensure that they become more integrated and aligned to the needs of the local population. As part of a Thames Valley wide procurement process the CCGs have issued a Prior Interest Notice and, subject to final agreement on the approach to procurement and guidance from NHS England, are planning to have a more integrated service model in place by the 1 April 2016.

Non-Emergency Patient Transport Service (NEPTS)

There are currently three NEPTS contracts across Oxfordshire, Berkshire and Buckinghamshire all with the same NEPTS Contractor which expires 31 March 2016. The CCGs across the Thames Valley Region have signed up to a Collaborative Commissioning Agreement to undertake a robust procurement project to deliver NEPTS which will include providing a Centralised Call Handling/Booking, Coordination and Management Service for all eligible patients. A final specification and schedules have now been agreed and the Invitation to Tender was issued during the week commencing the 18 May 2015. The plan is to award the contract week commencing 12 October 2015 and for the contract to commence on 1 April 2016

Operational Plans for 2015/16

The final version of CCG plans were submitted on the 28 May to NHS England for approval. At this point we are awaiting formal feedback to confirm that the plans are assured. The key areas discussed with NHS England colleagues over the last few weeks have focussed on whether activity and contract levels are sufficient to ensure constitutional standard delivery and the risk to delivery and mitigating actions on local QIPP (Quality, Improvement Prevention and Productivity) programmes.

Collaborative Care for Older Citizens

Collaborative Care for Older Citizens (CCOC) is a system-wide transformation programme for the care and services for the people aged over 65 and living in Bracknell and Ascot, Windsor, Ascot and Maidenhead, Slough and the southern Chiltern and Wooburn localities of Chiltern CCG. 575,000 people live in this area and 89,000 of them are currently aged over 65. This programme of work is sponsored and supported by the Health and Social Care System Leaders Group, which is made up of the four NHS Clinical Commissioning Groups, four Local Authorities, both NHS Foundation Trusts and the ambulance service. A key part of

the CCOC programme is to design a new model of care for older people. A model of care is a description of how services are provided – who does what, where, how services work together, and importantly the relationship with the citizen (patient, service user, and carer).

The approach taken by CCOC to design this new model of care has been to form a multidisciplinary design group. This group is made up of around 30 people from across the geography and covering a good cross section of roles – including 7 patient and public group members, community and hospital nurses and therapists, 6 GPs, Hospital Consultants, Public Health, Senior Paramedic and Pharmacy and the Council for Voluntary Services. The design process is based around three facilitated workshops for the design group and two public meetings in between to provide a sense check. Two of these design workshops have now been held and the third is on 28 May.

The first workshop developed a set of design principles for the new model and agreed a series of big questions that they would want to seek debate and feedback after the workshop. The design principles are:

1. The health, wellbeing and quality of life of older citizens are promoted, and their choices and capabilities respected, so that people stay independent for as long as possible.
2. The goals and ambitions of older citizens, their carers and families will drive the way we provide care and support.
3. The system will be easy to navigate for all parties so that older citizens, their carers and families will get the right care at any time of day or night - the right thing to do will be the easy thing to do.
4. The care experienced by the older citizen, their carers and family will be integrated and make good use of all the strengths in the local system, including the voluntary sector
5. People will receive high quality and holistic support and care.
6. Older citizens, their carers and family will tell their story once and all necessary information will be securely shared and accessible to all those who need to know to deliver support and care at the right time.
7. Care provided will be adaptive and flexible, sustainable and affordable.
8. Older citizens safeguarding and high quality of care is assured through effective and efficient system wide governance.
9. Older citizens, their carers and family and staff providing care are able to influence changes within the health and care system.

The steering group has also Started a “big conversation” in which the health and care system and members of the public have the opportunity to comment and add to the design is another important part of the process. On-line comments and discussion are happening through Health Connect and Ideascale and public

workshops are being held to sense check and add to the work of the design group.

At the second design group workshop there was detailed design of the new model. Professor John Young, a Consultant Geriatrician in Bradford and the national lead for Integration and Frail Elderly, joined the second workshop and gave a presentation that described the national work underway to recognise frailty as a long term condition, the ways that this can be identified in practice and the way that services can respond early and support older people to maintain independence. A lot of ideas and material was generated at this second workshop, leading to a number of potential core system components being debated and refined through the Public Workshop of 14 May and a Steering Group workshop on 20 May.

A lot of thoughtful and thorough work has gone into designing the new model of care for older citizens to date. The design group have reviewed the evidence base, started a "big conversation", spent time with the national lead, and drawn on each other's knowledge and expertise. At the third workshop on 28 May they will aim to describe in more detail the draft system components of the new model, to a level of detail that it can be shared widely, tested, discussed and debated through the summer.

Report from the CCG Head Of Operations

Slough CCG update:

Primary Care Development

Our 'Steps to the Future Vision' for the development of primary care began with the award of the Prime Minister Challenge Fund (PMCF) back in June 2014.

We have made significant progress in that time by having delivered our target of 44,000 appointments up to the end of May 2015, during weekends and evening hours. Three surveys of over 870 patients have told us that people are highly satisfied with the convenience and experience of service they have received via the 4 GP practice hub sites at Langley Health Centre, Crosby House Surgery, Farnham Road Surgery and Bharani Medical Centre on Bath Road. Over 97% satisfaction ratings gave us this positive indication.

We remain committed as a CCG in listening to our patients in the pursuit of continuous improvement. Our second Slough wide Open Day was held on 14th May where 15 of our 16 practices invited people to complete a simple questionnaire about the changes over the past 12 months. Hundreds of people took part and we are currently analysing responses. The day was led by our very active CCG Patient Reference Group that has been instrumental in our achievements for over a year now. Partners from Healthwatch, Slough Council for Voluntary services and Slough

Borough Council joined CCG staff in spending the day on the front line.

Other key developments are the introduction of the iPlato texting service across every practice in Slough. This is just embedding and means that patients can receive appointment reminders and other messages as well as being able to cancel appointments and save valuable Dr and Nurse clinical time.

Group consultations, a new way of seeing your GP together with other like-minded patients was launched at 240 Wexham Road Surgery along with Peer Group sessions, for patients to be educated about their condition as well as supporting each other. Other practices are starting their sessions now too.

A new Patient Navigator service has been launched in 3 of the hub sites, (Langley Health Centre, Farnham Road Surgery and Bharani Medical Centre on Bath Road). It is designed to help people access local information and activities to help them keep well. This pilot is being led by voluntary sector organisations working as part of the practice team. A new Wellbeing website has also been created and will be advertised across all Slough practices.

These are just some examples of the new and innovative approaches that aim to support and educate patients to have a better experience and use health services wee. They will be spreading across primary care services in Slough over the next 12 months. There are many more projects and all of these were shared at the Open Day, as well as at a 'One Year On' celebration event held at the Slough Centre on 31st March 2015. Over 40 partners and members of the public attended.

Co-Commissioning

Slough CCG has entered into primary care joint co-commissioning arrangements with NHS England. Sharing this responsibility will mean that services can be better integrated around the patient and that the CCG will have more control over the wider NHS budget.

Co-commissioning is seen as an enabler to improving access to primary care and wider out of hospital services, delivering a better patient experience. It is another next step towards ensuring patients, communities and clinicians have more involvement in determining their local health care services.

In order to deliver joint co-commissioning, Slough CCG will be forming a quarterly joint commissioning committee with NHS England; this committee will be the forum where decisions about local primary care are made. These meetings will take place in public so everyone is welcome to attend and observe the proceedings and the first is planned for July 2015.

Better Care Fund (BCF)

Telehealth

The pilot project has been launched which supports people with complex conditions through the remote monitoring of vital signs such as blood sugar and blood pressure via smart technologies. This aims to reduce the need for frequent home visits and maintains recovery. The pilot is supporting up to 15 patients at a time and is receiving positive feedback from patients and community health practitioners. The pilot will be evaluated after six months to review benefits and options to extend.

Care Homes

This pilot project is working jointly with the Council to improve quality of care through a training strategy working with local Care Home providers to reduce the admissions from care homes to hospital. The strategy has been developed with Bucks New University which provides a core framework of training and education to care home staff which will improve confidence and capability to identify and respond to symptoms at an early stage. The training is scheduled to take place through June and July after which it will be evaluated.

Community Respiratory Service - Children

The CCG will implement a Community Paediatric Respiratory service with a focus on asthma aimed at reducing unnecessary hospital attendances for the newly diagnosed, admission avoidance, supported discharge and to prevent readmission. A recruitment process is currently underway for 1.5 whole time equivalent (WTE) paediatric respiratory nurses who will be based within the Paediatric Team at Wexham Hospital. The team will establish community clinics taking referrals from GPs for new and difficult asthma, from a variety of sources including children centres. The service will improve the support and management of children and young people both within the hospital following an admission and with follow up support once they have returned home. The one year pilot will be evaluated as to its impact on reducing admissions and A&E attendances of children.

Single Point of Access

Work is progressing on the design of a Single Point of Access for professional referral via a single phone number in order to quickly access a range of health and social care services in Slough. A multi-agency steering group has been established which has been focused on research and analysis of current activity and an options appraisal of similar models which have been established in other areas. The group is soon to share a proposal of how this could operate for Slough and then consult to seek views of a wider group of stakeholders and practitioners.

Community Capacity

Within the Better Care plan was a proposal to build and strengthen the role of the voluntary and community capacity in support of improving health outcomes through residents and communities taking greater control and working with health and social care professions to better plan and manage health and care needs. A joint voluntary sector strategy is being developed which will mark a renewed engagement with a large part of the voluntary sector which offers information and advice, community based support and prevention. Following the strategy there will be a re-commissioning programme of voluntary and community sector services to support delivery of health and social care outcomes in Slough from next year.

Integrated Care

Better Care, funds a number of services providing intermediate care and re-ablement or rehabilitation services. Slough CCG and local authority are together taking part in the National Audit of Intermediate Care services in 2015. This will evaluate our Intermediate Care service provision with a view to improving our current range of intermediate care services to achieve improved outcomes and better value for money. The audit takes place from May through to July with the analysis and drafting of reports through September and October.

Cancer

Macmillan has awarded the CCG £61,800 across 3 years, to fund a Macmillan GP Facilitator specifically for Slough (2 sessions [4 hours] per week). The aim of the post is to develop continuity and quality of cancer services including End of Life across Primary Care. Were pleased to report the recruitment process is underway with the aim to fill the post by June 2015.

Macmillan have also awarded the CCG £281,622 across 2 years to fund a full time Project Lead and a full time Macmillan Screening Co-coordinator (administrator role) to manage the delivery of a Health Screening promotional strategy. The programme has decided to target bowel screening first as public health data suggests this screening area requires the most attention across Slough, particularly targeting black and minority ethnic groups (BME) and men where uptake rates are lower. The recruitment process is underway with the aim to have the roles filled by July 2015.

Accelerated, Coordinated, Enhanced (ACE) Project

The CCG has been successful in achieving £30k from NHS England in partnership with Macmillan and Cancer Research UK to fund a research project aimed at improving earlier diagnosis for patients with vague symptoms or non- alarm cancers.

The pathways that will be audited include gynaecology, urology, unknown origins suspected tumours and general surgery (upper and lower gastrointestinal tract). The overall aim of the audit is to identify areas for service improvement. The audit is a collaborative effort involving clinicians based in Primary Care and Consultants from Frimley Health (Heatherwood & Wexham Park Hospital). To date, a clinical consultation on the overall audit approach has taken place and the data collection tool is being built.

End of Life Services Transformation

The End of Life (EoL) Steering group met in March and agreed to work together to integrate EoL services and committing to the following key aims to be achieved across the next five years:

- To support the development of a 5 year service integration vision - 'So defining '*what does good look like?'*
- To identify all patients 1 year before their EoL (for earlier identification)
- To achieve End of Life (EoL) care planning for every patient.
- To achieve advanced care planning for every patient
- To support the development and delivery of an action plan to achieve the 5 year vision, with key milestone targets set for benefit realisation (e.g. when to achieve 95% of patients have an Advanced care plan in place.

It has now been agreed that a Federated approach would be taken to this work across all 3 East Berkshire CCG's. The clinical senate has also agreed to support this EoL transformation strategy work.

Diabetes

Diabetes is a prioritised Quality, Innovation, Productivity and Prevention (QIPP) programme for Slough and the CCG is working with Public Health England and the Thames Valley Diabetes clinical network (CVD) Network to deliver the integrated diabetic care services in primary and community care. The scope of the programme includes a total transformation and re-design to create an integrated service encompassing primary, intermediate and secondary care.

The aim is to enhance the uptake of 9 care processes, improve detection of diabetes and prevention of diabetes development by implementing pre-diabetes screening program.

The transformational service redesign also includes a community outreach Diabetologist -GP virtual clinics, in order to reduce non-elective admissions to hospital and long periods of stay bringing patient activity and flow back into the primary and community care.

To achieve the above objective, there will be development of the complex case management approach, virtual and/or tele-health clinic, and monitoring performance.

Cardiovascular Disease (CVD)

Slough CCG recognised that the existing CVD QIPP project had an area of improvement to deliver better outcome for Slough patients. The work stream is divided into heart failure, arrhythmia, and chest pain and community rehabilitation.

Slough CCG is actively working in partnership with the secondary care providers, CVD Network and Public Health England to develop effective clinical pathways, tackle issues and the improve management of long term conditions (i.e., heart failure) to reduce non-elective admissions

As part of this, an integrated multi-disciplinary heart failure network has been developed to achieve a streamlined patient journey to enable early specialist access, enhance community heart failure nursing care and manage exacerbations effectively.

STEPS Education Events

The CCG's recent STEPS events have focussed on Mental Health and Stroke care. The mental health event outlined additional ways in which primary care clinicians could identify patients who needed assistance with mental health conditions and the appropriate services that they could be referred to, and was very well received.

The Stroke care event focussed on best practice for treating patients with suspected stroke and featured speakers from other CCGs as well as hospital consultants, and clinicians found this event very informative in hearing from others.

The forthcoming STEPS event in June 2015 will focus on ENT and prevention of Non-Elective admissions. This event will feature a specialist ENT consultant who will give tips on referral pathways and identification of ENT conditions. The Non-elective prevention element of the event will outline ways in which primary care clinicians can manage patients within the community to keep them well and prevent them getting to the stage where they might have to go into hospital.

Care Homes

The Multi Agency Care Homes Project is led by Slough Borough Council with close partnership working with the CCG Clinical Lead and the Community Health Service. The group is working closely with the 8 Care Homes in Slough addressing training needs, safeguarding, recording and medication management which will in turn improve quality of care and reduce emergency admissions. A rolling programme of

training has been implemented and an action plan to improve quality of care is currently being devised in consultation with the Care Homes.

Dementia

The CCG has been focussing on ensuring that patients with dementia are identified so that they can receive the appropriate treatment and support from the health service. This work has included raising awareness through Alzheimer's Society with a dementia bus that has been stationed at Langley Health Centre, with plans to have the bus stationed at other Slough locations in the summer and in October 2015. We have also been working with GP practices, carrying out visits with a Consultant Old Age Psychiatrist to support them with ways to enhance identification of patients with dementia. The recent STEPS event on Mental Health also featured an item on dementia awareness and identification. We will continue this work through raising awareness and ensuring that information is more readily available in different languages to reach out to all areas of our diverse community in Slough.

Bracknell and Ascot CCG update:

Primary Care Transformation

Plans for primary care transformation are now well underway. Our bid for PMCF was unsuccessful but alternative funding has been secured to invest £2.8m in improvements to primary care. We have called our programme "Better Futures for All".

A major event was held on 28th April for member practices, stakeholder and most importantly patients to co-design what extended hours in primary care would look like. Patients can expect to start seeing changes in the Summer 2015.

Other workstreams are looking at workforce issues, on-line access for patients, 'HealthMakers' and more efficient working between practices. As part of this, a new members' website was launched last month, improving communications between practices and consistency of information available to practices keeping them up to date with alerts and information. GP practices are also benefitting from Emis Enterprise which is a means for practice information systems to share and use anonymised data to improve quality, and carry out audits. Patients will also have the opportunity to benefit from alternatives to traditional appointments such as group consultations which are also being trialled.

HealthMakers

HealthMakers deserves a special mention. The HealthMakers project now has a total of 38 recruits. We have been training patients and clinicians as facilitators, training patients with long term conditions in self-management and other patients in leadership skills (ongoing).

We have had positive feedback on all aspects of the programme and 100% positive feedback from attendees on the self-management course in relation to knowledge, understanding and overall assessment of the workshop and improving ones self-management style (information extracted from actual questionnaires completed by volunteers).

Not only is this beneficial for the individual patient but we anticipate there will be benefits for local services. As patients are empowered and are confident in managing their long-term condition as part of their life, this will lead to more constructive consultations with clinicians, less strain on A&E and fewer GP attendances (whilst being cost-effective at the same time). The project has also been shortlisted for a national patient leadership award.

We are currently evaluating the programme and making plans for how to take it forward so that more patients can benefit. Several patients have put their names onto a waiting list for future courses and we will be running a further self-management course over the summer and will be training more facilitators in September. Those patients that complete the leadership course will be choosing which projects they would like to be more closely involved so that we can build engagement into the work of the CCG at all levels.

Primary Care Co-commissioning

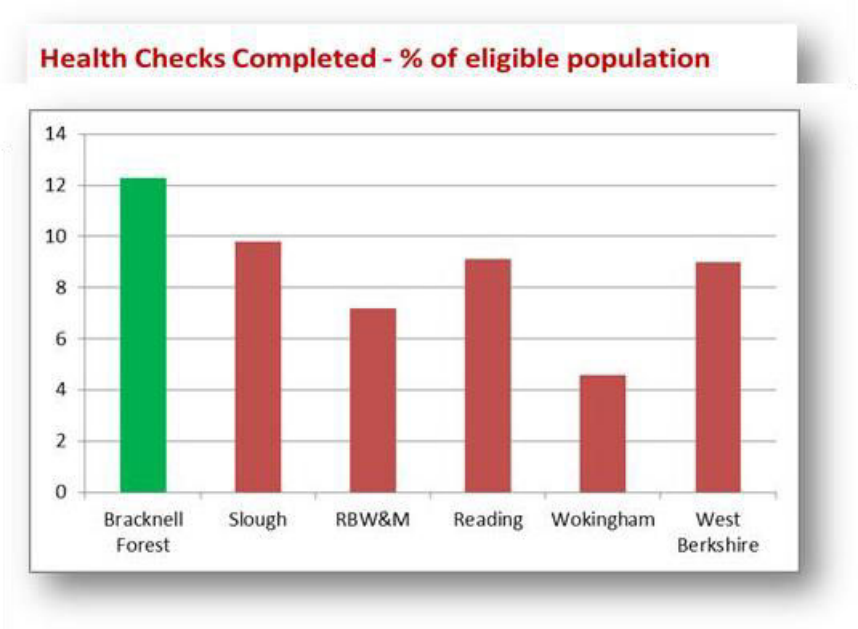
Primary care co-commissioning has also been the focus of much activity as the CCG prepares for the first public meeting scheduled for July, when the CCG will take joint responsibility with NHS England for commissioning primary care. This is a new way of working which brings accountability for primary care closer to home.

Growing population

Over the next few years there will be significant housing growth and other demographic change in Bracknell Forest as well as the regeneration of the town centre which is now well underway. These changes will have an impact on demands for health services, and in response to this the Bracknell Health and Wellbeing Board (HWBB) has commissioned a ‘task and finish’ group chaired by the CCG Head of Operations, to assess this impact and make recommendations for the future. The first report will go to HWBB in June.

Prevention

Preventing ill health is a top priority for the CCG. Amongst our current schemes, a new pre-diabetes service has been launched to offer people with early signs of diabetes, a full lifestyle overhaul with diet and exercise advice tailored to their needs, which is being delivered jointly with our partners in public health via Solutions for Health. Healthchecks are up too, and latest figures show Bracknell and Ascot topping the local charts, with 12% of the population receiving a health check against a target of 10%



Knee Pilot

We are really pleased to announce the success of a pilot scheme which was supported by the CCG's innovation fund. The pilot tested whether patients who are indicated for a total knee replacement could avoid surgery by going through a structured course of specialist physiotherapy.

There was an 83% success rate for those completing the 12 week course. Success is defined by improvement in pain, movement and stiffness as measured by the 'Oxford Knee Score'. The improvements are the same as those people experience having had a knee replacement. This improvement has been generally sustained for 6 months and we are continuing to follow up participants.

We are now looking to continue funding the knee programme and piloting a similar scheme for patients with hip pain.

Governing Body Appointments

We are pleased to announce that two of our GB members have been re-appointed for a further term. Jennie Ford will continue as practice manager representative and Jan Glaze as local nurse on the Governing body.

Windsor, Ascot and Maidenhead CCG update:

Prime Ministers Challenge Fund

Implementation of plans for the Prime Ministers Challenge Fund are moving at a fast pace. We have a dedicated Programme Manager supported by others in the team. The topic has been covered at the last two GP Assembly meetings with good engagement from practice attendees. A launch event for all GPs and practice staff was held with good attendance. The Governing Body agreed a single tender waiver for Berkshire East Primary Care Out Of Hours to provide the majority of the extended services in conjunction with local practices. A wide ranging communications programme will be launched in June targetting patients, the wider public and people working in local services. The launch of extended hours services at St Marks Hospital and King Edward VII Hospital will be at the beginning of July.

Better Care Fund (BCF)

Although non elective admissions continues to rise overall, all falls related non-elective admissions are meeting the BCF target of 9% reduction against the BCF baseline. This is being achieved through a range of initiatives including:

- Increased promotion of, and referrals to, the Keep Safe Stay Well service by Berkshire Healthcare NHS Foundation Trust (BHFT), GPs and the Royal Borough of Windsor and Maidenhead (RBWM) sources
- Identification of high risk individuals through a polypharmacy pilot
- Continuing education and support of care home staff
- Closer working with South Central Ambulance Service leading to a significant reduction in conveyancing of care home residents following ambulance callouts.

Additional plans to target carers, particularly those caring for dementia patients are being developed to maintain current momentum.

Analysis of non elective of 0-5 year old children has identified a number of children/families and hard to reach population groups in each ward and practice who have been non-elective admission on several occassions. Opportunities to cross correlate this information with social care awareness of families needing

early help are being explored to enable a joint and supportive approach to key families within the area by RBWM and WAM CCG.

The Care Act

Launch of the Care Act has been supported by presentations at the WAM CCG EPIC and the WAM CCG carers' website which offers national and local information and advice to carers on a host of support services. Tailored support for GP practices and their patients is being provided through a newly appointed adviser at Berkshire Carers, with presentations to practice managers and invitations to attend local Patient Participation Group (PPG) meetings to promote carer identification and support.

End of Life

An end of life care workshop was held in May, attended by carers, staff from Royal Borough as well as WAM CCG clinicians. The workshop identified key issues that will contribute to an East Berkshire wide review of services, as well as a number of key gaps in current provision that can be addressed locally. This will include more active engagement and training for carers of those with dementia and their carers to support advanced care planning and access to timely support and advice during crisis to avoid non-elective admission to acute services.

Learning Platform

The CCG is finalising the plans for the launch of its learning platform 'GotoWAM'. This will provide everyone working within practices with access to learning portfolios, pathways, guidance and CCG information in an easily accessible format from their desktop or mobile devices. The pre-launch version has been seen by clinical leads who have provided positive feedback and content for the site.

Quality Premium

The CCG has had to choose two local targets in addition to those mandated by NHS England which if achieved will attract a 'quality premium' payments. The two local targets chosen are: number of carers identified and improved achievement of the 8 care processes for diabetes.

Dementia

The work with care homes and dementia has been nominated for a Patient Safety Award. Congratulations to Caroline Yeoman and Dr Chris Allen for the work they have put into this. Work is ongoing with practices to increase the identification and referral to appropriate services for people with dementia.

Operational Leadership Team

The Operational Leadership Team has discussed the following topics: referrals, out of hours, patient transport and 111 re-procurement, Quality Premium, locally commissioned services, prescribing incentive scheme, medicines review pilot, Collaborative Care for Older People, stroke services, the learning platform and CCG contributions to safeguarding boards. OLT regularly reviews QIPP progress and the contract and financial position.

New appointments

Dr Carolyn Robertshaw will be joining the Governing Body as the fourth GP member on 1 June 2015 and Hayley Edwards will be joining as CCG Manager.