Better Care Fund planningtemplate – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**West Berkshire Council**
Clinical Commissioning Groups	**Newbury and District CCG**
	North West Reading CCG
Boundary Differences	The main focus is partnership with Newbury and District and the principles drafted by this partnership will be negotiated with North West Reading CCG to ensure consistency; the BHFT serves both CCG's and partnership with BHFT ensures consistency across the 3 Unitary Authorities.
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£417,000**
2015/16	**£8,580,000**
Total agreed value of pooled budget: 2014/15	**£417,000**
2015/16	**£8,580,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Newbury & District CCG

By	Dr A Irfan
Position	Chair & Clinical Lead
Date	<date>

Signed on behalf of the Clinical Commissioning Group	North West Reading CCG
By	Dr R Smith
Position	Chair & Clinical Lead
Date	<date>

Signed on behalf of the Council	West Berkshire District Council
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

There is well established West Berkshire Integration Steering Group and has representatives from all relevant stakeholders across health and social care, including key providers. The proposals outlined in this draft have been worked together, including at a system-wide joint workshop held in December 2013 which included acute and community providers.

Service provider engagement will be further developed through integration work during 2014/15.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Consultation and engagement has been through a variety of methods, most noticeably through the NHS 'Call to Action' event. This event involved good high quality engagement with patients and the public about the future of both health and social care services in the district, which has in turn shaped our collective planning submissions.

Further and ongoing engagement is being planned, with follow-up 'Call to Action' events scheduled to continue an inclusive and open dialogue with the public.

Within the CCG, the Patient Voice Group has also been actively involved in feedback on plan developments.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Better Care Project Plan for West Berkshire	The Plan sets out 8 projects that meet the requirements of the Better Care Fund
Joint Strategic Needs Assessment (JSNA)	
Hospital at Home (including Newbury Urgent Care Unit) Business Case	
Care Homes Business Case	
Newbury & District CCG 'Call to Action' Report	Agreement on the consequential impact of changes in the acute sector
7 day working	As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Medical Intra-operability Gateway business case	Better data sharing between health and social care, based on the NHS number

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

A) Vision for West Berkshire 2018/19:

The Vision for West Berks has the following key features:

- An increased level of services that are formally integrated under a Pooled Budget.
- A 7 day service by expanding existing services to cover weekends.
- The services will be simpler to access, have less duplication and reach patients earlier. Delivery of health and social services to be localised wherever possible including access to crisis, A&E and other services that meet local residents' needs – with appropriate specialist or wider access to regional services that improve outcomes on a sustainable basis. This includes children and adults with a view to preventing out of area long term placements, and institutional settings in general
- Unnecessary admissions to Hospitals or Care Homes will be avoided.
- Lengths of stay in Hospitals will be kept to a minimum
- Include the Joint Health and wellbeing strategy vision with added objectives of integration, sustainability, and greater efficiency across all sectors.
- Promote care closer to home and promotion of family centred approach where appropriate

B) Changes to health and social care services over the next five years:

Build capacity in the community across primary, community health and social services to work collaboratively and through integrated services to better meet the needs of local residents that avoid their admissions to hospital or care homes.

Expand the reablement capacity linked closely to integration with appropriate primary and community healthcare on a localised basis (via Locality Hubs).
As community capacity is increased overall including targeted in-reach to acute, realign acute sector capacity to achieve improved patient outcomes, greater efficiency and sustainable acute provider capacity on a reduced basis.

Develop cross sector working that targets intervention and support to those most at risk of admissions, including enhancing clinical capacity in the community that also supports those admitted to acute hospitals to return home quickly.

Maximise the local people's and their communities' capacity to self care through implementation of the Care Act that enhances information advice, advocacy, carer support, with an overall preventative impact on intensive support and admissions.

C) Improved patient and service user and carer outcomes:

Improved outcomes will include:

Less duplication between sectors, faster and more efficient joint assessments with lead professionals for those with long term conditions.

Earlier diagnosis, treatment, and support that prevents crises or better enables responses to crises without admissions to hospitals or care homes.

Improved access to information, advice, advocacy and community capacity to manage health and social care needs at low or nil cost to the user or carers. This will include online and flexible locally developed access.

Improved choice and control through better access to a wider range of care and support in the local health and social care market especially for those with long term conditions including the use of personal budgets and direct payments for those receiving continuing health care or social services. Local services should therefore prevent out of area placements separating users from their families and communities on a sustainable basis.

"Hard to reach" groups with health and social care needs that then require higher levels of intervention will have better access to tailored information, advice, care and support which is person centred and aligned to cultural, faith, or other requirements. During the Newbury Call to Action event, our plans for integrating care were discussed and some of comments on what Newbury's new integrated system will make to patients and service users are provided below:

- "There are no gaps in my care"
- "I am fully involved in the decisions and know what is in my care plan"
- "My Team always talk to each other to get the best care"
- "I will always know who is in charge of my care and who to contact"
- "I won't have to wait in all day for lots of different people to come at different times"
- "it is less time consuming if all services are together in one place"
- "My care is planned with people who work together to understand me and my carer, put me in control, coordinate and deliver services to achieve the best outcomes for me"

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

As above.

Measures will be :

1) The options outlined in the project plan will require more detailed analysis and costing to go into the metrics submission

2) Also it is assumed that whilst acute commissioning remains the duty of the Local CCG's outside of the BCF, the targets in the BCF will include investment and capacity to reduce acute activity, improve outcomes, and achieve sustainable financial investment across the whole health and social care system.

3) These aims will be measured by lower rates of admissions to acute hospitals for unscheduled care, shorter lengths of stay, lower rates of admissions to care homes, and significantly higher rates of early diagnosis, treatment and support for those most at risk of hospital or care home admissions, including dementia, end of life care, and those with long term conditions (children and adults).

4) Health gain measures will include: with public health) rates of diagnosis of key conditions linked to hospital and care home admissions including strokes, falls, complex older peoples conditions, dementia, pressure sores, lower instances of carer and care support crises for self funders or those not previously assessed. The increased targeting of health and social care resources on those most at risk will also help reduce health inequalities as well as through prevention/voluntary sector commissioning being joined up across the whole system. We will work with partners to implement the local measures.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Scheme 1. Community Nurses directly commissioning Care/ Reablement Services.

The point of contact for the majority of patients in the community who are either eligible for Council services, or who are at risk of admission to care homes or hospitals is the Community Nurse. Currently if a Community Nurse identifies the need for care they will have to refer the case for assessment by Council staff or other Health teams who may then refer for Crisis, Reablement, Carer's, Council commissioned or in house care provision services; in all cases the Community Nurse is able to initiate and commission in broad terms the care that is needed; if the initial care delivery for all services is through the in house care provision system Community Nurses could directly prescribe this service, leading to safe care being put in place and then worked up to the practical on going solution for that individual.

In addition, It is hoped that WBC's physical disability team will build upon joint working with Health's Long Term conditions teams to progress integration further.

Process developments

- Identification of range of Health Clinicians from Unscheduled Services to be licensed under scheme.
- Training of licensed Health Professionals.
- Health Professionals will commission services directly to provide a prompt response to patient needs; the change should not create extra work for Health Professionals and therefore there should not be any ongoing cost implications
- The service that provides the care will be supported by the coordinating service which will establish the eligibility and need keeping control over the Council's commissioning budgets.

Scheme 2. Access to Health and Social Care Services through the BHFT HUB:

For hospitals, GP's, and Access for All we need one entry point, preferably routed through the Health Hub for Reablement, Crisis Care, Hospital or Care Home admission avoidance, including Carer Breakdown. This will require setting new protocols with the HUB and with AFA.

Process development:

Hillcroft front door upgrading for access to Reablement, Crisis Care, Hospital or Care Home admission avoidance, including Carer Breakdown, Urgent Care, End of Life.

Negotiation with Hub to build on success of this new service

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Scheme 3. Patient's Personal Recovery Guide / Keyworker:

Each patient will be supported for the journey through the service. This may be a single role, or it could be a function depending on complexity of the role of a Personal Budget Support worker, a Social Worker, a qualified clinician or a trained Care Worker; there would be a strong attraction of building on the latter as a model detaching the function from other more defined roles.

i. Recovery Agreement: as a deliberate discipline to centralise the Customer/Patient. An agreement will frame the journey ensuring that the priorities are set by the patient, and creating flexibility as circumstances, speed of progress and conditions change along the way.

ii. Delivery of service elements: the Recovery Guide can engage the different service elements as would a Personal Shopper, ensuring that the right choices are made and the practical delivery arrangements are in place.

iii. Case Manager: when the active intervention is complete monitoring will be needed initially to ensure the transfer to normal life is successful, and in cases where long term support is indicated to ensure that this is successful and appropriate. Currently this is covered by a Council review system which cannot effectively deliver. For many stable low cost long term support plans it may be possible for Community Nurses, or other health staff who regularly visit patients to deliver other services to periodically 'sign off' an annual renewal of service.

Process Developments:

- Link with Elderly Care Pathway Project for definition, resposibilities, duties and powers of keyworker role.
- Defining role and host organisation, including option of Voluntary Organisation.
- Development of Business Case to include redefining of some roles within existing services to release funding.
- Drafting and sign off of protocols for role across whole range of Health and Social Care operation.

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Scheme 4. Joint care provider as a 'pooled' service with the potential to be funded through a Pooled Budget:

The Council's Maximising Independence Team and Homecare Team, and the Berkshire Health Foundation Trust's Intermediate Care as part of the Integrated Community Health services have separate care assessment and delivery units providing similar care in response to patients currently triaged through a joint system. Developing these three staffing units into a combined service would simplify the deployment to support individuals, would cut out artificial service transfers, increase continuity of service, and create efficiencies by avoiding duplication; initially this could be created as a 'Pooled' service, developing into a Pooled Budget.

The service is available for people in the community as well as hospital discharge.

The current annual budgets for these services are

Maximising Independence	1,020,760
Home Care	1,780,000
Intermediate care	1,700,000

Whilst efficiencies would be expected from this project, the initial reconstruction of services would require additional project management of £75-100k.

Process Developments:

There are a range of staff working within the two current care services who would need to be merged into a single service.

In Health reablement is provided by a mix of Team Leader Occupational Therapy, Nurses, Physiotherapy and 3 grades of multi therapy assistant staff:

- Band 2 assistants deliver care to fixed care plan, or 2nd on a double up
- Band 3 assistants support patient in working on their goals
- Advanced assistants can progress individuals through goals
- These staff are supported by a multi therapy and care assistant coordinator and a group of Therapists.

In the Council's service there are;

- Team Managers,
- Senior Carers,
- Care Assistants
- Occupational Therapists
- Social Workers

- Personal Budget Support Workers.

The pooled service would be supplemented by the purchase of agency care to deal with fluctuating demand. However the flexibility of this proposed single service may make it possible for both Health and Social Care to reduce their commissioning of external care.

Scheme 5. 7 Day Week service

Between the Health Trust and the Council there is already a combination of services that are available 7 days per week; a small amount of adjustment could be made to provide an adequate 7 day response service.

An initial structure can be developed that would match the wider Health and Social Care economy which currently has only limited services available on 7 days per week, However, with a structure in place it will be a simple step to build more comprehensive 7 day per week services if the wider 'economy' starts to spread it's services over 7 days. This scheme links with scheme 4 above.

Process Development:

- Review the current out of hours services:
  - WBC Extended hours, WBC Homecare inc Nightwardens and the Emergency Duty Team run by Bracknell Forest Council.
  - 24 Community Nursing Cover, managed centrally for Reading, Wokingham and WBC area
  - Rapid Response 9am -10pm x 7 days (at weekend covered across 3 areas)
  - Rapid Discharge Service for patients admitted for less than 48 hours.
- Proposal to Integrated Steering Group re realistic 7 Day week service that is currently required in context of whole health economy. This needs to include access for to Carer Breakdown service, e.g. Ambulance Service, or relatives may need access, etc.

Scheme 6 Hospital at Home:

This project reduces the pressure on hospital beds by 10,920 bed days per local authority area. Additional health services are costed at £2.4m for Berkshire West; to support this the Council will be required to manage additional care during treatment episodes and a discharge service to support patients after the treatment episode. The additional funding would be built into the Pooled Budget at 4 above.

The Hospital at Home initiative aims to support patients through the introduction of a clinician-led sub-acute service that interfaces with the wider health system to appropriately stream protocol-driven cases to an out of hospital care setting. In common with the proposed Newbury Urgent Care unit, the clinical treatments considered include:

- Short-term IV therapy/fluids;
- High level of pathology;
- High intensity monitoring; and
- Functional assessment / management.

The presenting patient may have:

- Acute infections e.g.
  - Cellulitis
  - ENT
  - Pyelonephritis/UTI
  - Pneumonia/influenza
- Chronic Obstructive Pulmonary disease/asthma;
- Dehydration and gastroenteritis;
- Decompensation of LTC; and
- Falls and/or mobility issues that cannot be managed within the existing services

Principles of the model that will underpin the service

- To reduce non-elective admissions from ambulatory sensitive conditions by 50%;
- The service is open to anyone over the age of 18 years;
- The service will operate 7/7 365 days;
- Clinical responsibility for patients within the Hospital at Home service will be overseen by the Community Geriatrician;
- In-hours responsibility will held by Community Geriatrician, Out of hours responsibility will be held by WestCall (with support from medics at RBFT);
- All patients presenting to A&E (Self referrers, 999, or GP referral) will be reviewed as Hospital at Home patients as default;
- Virtual ward rounds for patients within the H@H will be undertaken daily;
- All patients will have a dedicated Ward Matron assigned to their care, supported by Case Coordinators;
- Each UA will be assigned with 30 virtual ward beds; and
- Max length of stay in the H@H ward will be 7 days.

Specifically within Newbury, the CCG will evaluate the development of a local Diagnostic and Assessment Unit within West Berkshire Community Hospital (or other suitable location) that standardises practice across the Newbury registrant population in relation to the management of patients with complex +care needs (sub-acute) in the short-term. The service will be targeted at those patients that require initial intensive diagnostics and assessment, then 24-hour support and treatment but can be managed at home and then discharged after a few days into traditional community care provision.

Scheme 7. Nursing and Care Homes

As the UK population ages, GPs and NHS providers face an increasing difficult task managing the complex needs of care home residents whilst there is increasing pressure through the system. A case for change is unequivocal; In 2011 more than 400,000 people were living in care homes across England, equivalent to the population of Bristol. Over the next 40 years, this is expected to rise to 825,000.

Within Berkshire West there are 22 registered Nursing Homes with a total of 1248 beds. The average nursing home has 67 beds with a range of 22-137 beds. There are 2 dual registered care homes which provide residential and nursing care but the admission data does not differentiate which part of the care home the patient was admitted from. In addition there were 26 Residential homes (48 in total), with a total of 922 beds, average number of beds is 33 and the range is 8-192 beds.

This lead to the establishment of the Care home working group in January 2013 by Berkshire Healthcare Trust.The group includes membership from BHFT, CCG, LA, RBFT, SCAS, Marie Currie, and Berkshire Care Home Association.

The aim of the group is to improve the quality of care and provision of service to and within care homes within West Berkshire. To support this aim the group identified 8 work strands

1. Analysis of activity data
2. Improving access to services
3. Developing clinical pathways/standards/protocols
4. Skills development for staff
5. Leadership development and management in care homes
6. Medication Optimisation
7. Communication and engagement
8. Resident and relative views

Since August the Care Home working group has been chaired by the CCG. Operational support for the group, currently will continue to be provided by BHFT.

In addition to Care Home working group, Dr Charles Gallagher had been developing a "Good Model of GP care for Care homes" for Wokingham. The proposed model would include the following:

- Each care home should have a named GP who is their principle point of contact with the general practice looking after their residents. Practices that have such an arrangement will be eligible for payment under a proposed New Patient Assessment (NPA) LES.
- All residents will have an initial multidisciplinary assessment about a month after admission to the home using the CCG NPA protocol.
- GPs will actively encourage advanced care planning.
- Joint medication reviews will be performed annually between the GP and the Care Home Pharmacist from the Medicines Management Team using the CCG protocol.

Prescribers to adhere to the CCG antipsychotic prescribing protocol.

The project provides support to care Homes; before confirming this project health and social care partners need to work through this jointly to decide the actual scale of the project, because a major part of what is being highlighted is actually the normal delivery of good quality care and as a service purchasing such care we would expect contract compliance to cover at least some of the items for focus in the project.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The ASCOF data will be used to monitor performance together with data from the

Alamac System adopted by the Royal Berkshire Hospital. The Hospital at Home Project will reduce the demand on the Acute Hospitals.

There needs to be an economically viable local acute hospital within the network of other regional hospitals, to provide the access and treatment the West Berkshire population require.

The improvements in outcomes for patients of the BCF plan would be: shorter lengths of stay more personalised tailored treatment and reablement plans that ensure successful returns to their homes, and clinicians that support those with complex and long term conditions in both acute and community settings.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The West Berkshire Health and Wellbeing Board (HWB) will have strategic oversight and governance for the West Berkshire BCF and related arrangements. Membership of this Board includes two voluntary sector representatives, as well as West Berkshire Healthwatch, together with West Berkshire CCG, West Berkshire Council. This Board meets regularly and will receive summary reports on progress, outcomes and exceptions on performance and risks. This board will ensure appropriate monitoring of progress against national and local performance in the BCF, and regular updating of the risk register associated with such performance.

NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Adult Social Services have to provide a range of statutory services to all residents who are eligible under the Fair Access To Care criteria; for West Berkshire this represents and increased number of eligible residents as the level of eligibility changes from ‘Critical’ to ‘Substantial’ under the Care Bill.

The local definition of protecting adult social services is to focus upon prevention, early intervention and for health and social services delivery aimed at avoiding admissions to institutional care (especially care homes and hospitals) together with maximising people and their communities’ capacity to self care. It is based upon the social asset based model of helping people with health and social care needs to meet them by retaining their dignity and independence in their own homes through access to family, neighbour and community support together with specialist or essential health and social care and support.

The social services lead on multi agency safeguarding adults will be developed under the

Care Act, with local priorities secured within the BCF for Mental Capacity Act assessments, Deprivation of Liberty assessments, and general multi disciplinary safeguarding adults activity.

Please explain how local social care services will be protected within your plans.

The inclusion of reablement (Council funded as well as transfer funded), and in reach to hospital social work services in the BCF will help protect the social services outcomes for those at risk of admission or admitted to hospital.

The capital funding associated with Disabled Facilities Grants (DFG) within the BCF will also build upon the successful record West Berkshire has in working with housing partners in securing wider investment in homes that promote independence, as well adapting existing housing stock

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

The Council is committed to planning jointly with health partners the increasing availability of services at weekends. The Council provides and funds a large range of services on a 7 day basis but it will further explore the development of processes to allow increased movement between services at weekends. A key element is to secure the cooperation of the range of domiciliary and care home providers to provide flexibility to assess and set up services at short notice outside normal working hours.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

This primary identifier is not currently used across the whole health and social care system in West Berkshire.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

The NHS number is being introduced as standard to all new clients from 1st April 2014. A separate project will be required to install the NHS number for all existing clients by 1st April 2015**.**

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

It is a qualified yes. We try to adopt systems that are open but sometimes the 'best systems' in terms of our business needs adopt their own proprietary standards. We seldom reject anything where this is the case

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott2.

The Council would need to fully understand the relevant IG controls before it would be in a position to commit to them.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

All Surgeries are engaged with the Case Coordination process for identifying high risk patients and agreeing joint tasks to minimise the risk of hospital admission. The CCG Tool, together with local; intelligence is used to identify high and medium risk patients.

3) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Risk 1 Not realising the benefit of increased community capacity by ongoing increases in demand upon on acute		Integrated and joint commissioning capacity Close monitoring of demand in community and acute to align resources working with external providers to ensure that they understand the current and future demands and recruit workforce accordingly
Risk 2 Double running costs during changes in the health and social care system		Detailed planning to follow BCF submission to ensure and providers meet cost

		targets
Risk 3 Insufficient funding for responsibilities arising from Care and support Bill		Detailed modelling of available funds and ongoing discussions with DH and LGA
Risk 4 Provider failure to deliver better ways to meet needs in the community that trigger risk 1		Ensure preparation in 14/15 on integration and joint assessments in community builds capacity by 2015
Risk 5 Failure to protect social services as set out in BCF		Detailed planning after BCF submission to ensure long term resource planning matches efficiencies from integration.
Risk 6 Failure by acute sector to realign to meet BCF aims and targets		Linked to whole system implementation of BCF and CCG plans.
Risk 7 – the funding for the Care Bill contained within the BCF is insufficient to meet costs of new responsibilities.		