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LA v7

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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	West Berkshire Health & Wellbeing Board has membership of two Clinical Commissioning Groups – Newbury & District CCG and North West Reading CCG. North West Reading CCG has 3 GP practices within the boundaries of West Berkshire Council. Newbury & District CCG and North West Reading CCG are both represented at the HWB, have contributed to the pooled funding and are aligned on the West Berkshire schemes. A number of the schemes proposed for West Berkshire will also operate across neighbouring authorities, making best use of provider services which operate across local authority boundaries.

	Details of relevant schemes, and their cross authority impact and management, are found within the main body of this submission.
Date agreed at Health and Well-Being Board:	**27/03/2014**
Date submitted:	**Revised 09/07/2014**
Minimum required value of ITF pooled budget: 2014/15	**£417,000**
2015/16	**£9,533,000**
Total agreed value of pooled budget: 2014/15	**£417,000**
2015/16	**£9,533,000**

b) Authorisation and signoff

West Berkshire's initial Better Care Fund submission was approved by the West Berkshire Health & Wellbeing Board on 27th March 2014. Updated submissions were subsequently approved by the Health & Wellbeing Board on 9th July 2014. This latest revision has been approved by an extraordinary Health & Wellbeing Board of 18th September 2014. Minutes from this meeting are included in Section 1 (c) supporting documents.

Signed on behalf of the Clinical Commissioning Group	Newbury & District CCG
By	Dr A Irfan
Position	Chair & Clinical Lead
Date	3rd April 2014 (Revised 09/07/14)

Signed on behalf of the Clinical Commissioning Group	North West Reading CCG
By	Dr R Smith
Position	Chair & Clinical Lead
Date	3rd April 2014 (Revised 09/07/14)

Signed on behalf of the Council	West Berkshire District Council
By	Gordon Lundie
Position	Leader of the Council
Date	3rd April 2014 (Revised 09/07/14)

Signed on behalf of the Health and Wellbeing Board	West Berkshire District Council
By Chair of Health and Wellbeing Board	Marcus Franks
Date	3rd April 2014 (Revised 09/07/14)

c) 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
Berkshire West CCG's 5 Year Strategic Plan	This is the five year Strategic plan for the four Berkshire West CCGs (unit of planning) for 2014-2019. Document attached.
Better Care Project Plan for West Berkshire	The Plan sets out 7 projects that meet the requirements of the Better Care Fund
Risk Sharing Agreement	This document is a collaborative agreement developed to provide an appropriate vehicle for sharing risks between the associated partners. Document attached.
Communication and Engagement Plan	This document provides the principals that we will use for Communication and Engagement. Document attached.
Newbury & District CCG 2 Year Operational Plan	Local plan detailing proposals for local healthcare services to meet the needs of our local population, and to drive improvements in health services for 2014 – 2016. Document attached.
North & West Reading CCG 2 Year Operational Plan	Local plan detailing proposals for local healthcare services to meet the needs of our local population, and to drive improvements in health services for 2014 – 2016. Document attached.
West Berkshire Council Strategy 2014-18	Describes the local authorities overarching vision, purpose and priorities for the next 4 years
Joint Strategic Needs Assessment (JSNA)	Describes and profiles the demographic needs of the West Berkshire population, and informs NDCCG commissioning activity. http://www.westberks.gov.uk/index.aspx?articleid=25800
Berkshire West Pioneer Application	Berkshire West 10 application to become an integration pioneer
Health and Wellbeing Strategy	
Newbury & District CCG 'Call to Action' Report	Agreement on the consequential impact of changes in the acute sector
Home Care Survey	

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Our Vision – To Add Life to Years and Years to Life for all our residents

Our vision for better care is based on improving outcomes for individuals through the delivery of care which is responsive, enabling and available as close to home as possible. We are committed to doing things with (rather than to) service users/patients and therefore meaningful engagement is a key part of how we will implement change.

Introduction to West Berkshire

West Berkshire has a population of around 156,000 people. It makes up over half of the geographical area of the county of Berkshire - covering an area of 272 square miles. Largely rural, it has the most dispersed population in the South East with 253 people per hectare.

The overall level of health of the local population is good in comparison to the national average but we do experience the impact of socio-economic factors on the inequality in health with areas of greater deprivation having a lower life expectancy and higher mortality rate than the local authority average.

The biggest challenge to West Berkshire is the increasing ageing population. It is projected that the number of older people with complex physical and mental health problems (for example dementia) and increased social care requirements will increase, along with the number of ageing carers and the societal costs of supporting them. Therefore, primary prevention to help older people maintain positive social engagement, good physical health and mental wellbeing is crucial. Our current system is already under pressure with a number of challenges including:

- An increasing population, particularly in those over the age of 65
- Increasing growth in non-elective care
- Increasing A& E attendances, and pressure on urgent and emergency capacity
- Rising delayed transfers of care, and subsequent bed days lost
- Increasing pressures on adult social care for community packages and care homes at a time when the overall Council budget is significantly shrinking
- Increasing demand for planned (elective) care
- Inequality of access to services across the “whole system :the whole week”
- Care Workforce Availability
- Care Act 2014 – new national eligibility criteria for social care

We recognise that the challenges facing the local health and social care system are significant. Demand for services is forecast to increase and this is not sustainable in the current systems. Funding pressures are set to continue and it is clear that without wide scale transformation we will not be able to meet future needs.

We see the Better Care Fund as an opportunity to stimulate the integration of Health and Social Care Services both within West Berkshire and across West of Berkshire and have created a range of projects to help us deliver this.

By 2019 we expect to see:

- Person centred services that focus on outcomes rather than outputs
- Provision of good quality information and advice that empowers people to make good choices and self-manage
- Care closer to home as the first option
- Flexible services that operate across 7 days where appropriate.
- Services will be simpler to access, have less duplication and reach service users/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.
- A greater range of local services that promote independent living
- Reduction in avoidable hospital admissions.
- Lengths of stay in Hospitals will be kept to a minimum
- Increased numbers taking up Health and social care personal budgets

Delivery of our vision will achieve system sustainability and therefore deliver value for money. We will do this by commissioning new models of care based on integrated Health and Social care pathways that focus on outcomes for users/patients.

In achieving transformational change we will draw on our patient's and population's views, and use robust health needs assessment in identifying our ongoing priorities. The commissioning and redesign of services will be informed by recognised best practice, and performance data analysis, in a context of an absolute requirement for improving health and social care outcomes and achieving system sustainability.

As a partnership we will jointly commission services unless there is evidence that it will not deliver the following:

- Enable us to respond to the needs of our local populations by targeting services to give the greatest impact on health and social care outcomes
- Address the views expressed by our local populations of how they wish services to be provided through partnership and co-production
- Avoid duplication and ensure value for money & efficiency
- Promote further health and social care integration where a case for change is made
- Where appropriate we will combine resources, sharing best practice and expertise

The leaders of the 10 Health and Unitary Authority partners, known as the Berkshire West 10,have developed a direction setting vision around integration which formed the

basis for a Pioneer Bid in 2013. Despite being unsuccessful with this bid, the 10 partners are united in their ambition to undertake a methodical and systematic journey towards more integrated care for the people we serve. The integration programme presents an opportunity now underpinned by the Better Care Fund to test different models of integration across different settings and care groups.

Based on our earlier analysis (see Capita report and Berkshire West 10 Pioneer bid provided as "Related documentation) the first phase of our Integration Programme is focussed on the integration of services for older people, and the development of a frail elderly pathway will form the service user/patient centred backbone of system changes.

This pathway has been developed through a multi-agency project supported by the King's Fund and is supported by an economic modelling element was led by Finnamore. The outcome of this financial modelling has yet to be formally signed off however this is expected to be approved over the coming months.

The defined pathway aims to improve experience of patients and carers, make better use of existing resources and achieve significant cost savings across the system through reduction of duplication in provision and workforce changes.

It is envisaged that the pathway will be accessed through a single hub for both social care and health, simplifying access to robust information and guidance that enables service users/ patients to understand the range of options available to them. Our services will have an enablement focus to enable people to self-manage where ever possible. Where care is required it will be delivered by care workers skilled in health and social care tasks to enable consistency, it will be supported by identified care co-ordinators and multidisciplinary teams structured around localities: the overall aim being to improve the care of older people with long-term conditions and those who are at highest risk of deteriorating health. Crisis support will be streamlined with care being provided in the most appropriate setting according to service user/patient and carer need. When hospital admission is unavoidable, the stay will be of high quality with discharge supported by a personal recovery guide ensuring people don't get lost in the system and are able to be get back to a more settled environment promptly. Support will be enhanced to enable people living in residential and nursing homes to receive their care and treatment there, and end of life care improved so that people are not admitted to hospital unnecessarily. In bringing key elements of the frail elderly (older peoples) programme on line through our local projects we will be able to assess its impact and use this as a template to inform planning for other pathways for the outer years of this five year period.

We also recognise that people need to access health and social care services flexibly. Evidence shows that the limited availability of some services at weekends can have a detrimental impact on outcomes for patients, including raising the risk of mortality. Admission rates may also be affected by GP practices being closed over the weekend period. Where admissions occur there is a need to ensure that care and support is available so patients can be discharged from hospital when they are clinically fit. We are therefore looking to ensure that a range of health and social care services is available

seven days a week.

Primary Care will play a pivotal role in delivering our vision to meet people's needs in the community wherever possible and we will look to facilitate this through the development of primary care co-commissioning arrangements with NHS England which will enable us to improve quality in primary care.

Having successfully implemented practice-based risk stratification and multi-agency care planning for high risk patients, our GPs are well placed to take on the role of Accountable clinician for patients who may be at risk of admission; co-ordinating care provided by a range of professionals to enable patients to remain in the community and are starting to do so through the Admissions Avoidance DES and other arrangements being put in place to support the care of the over 75s and high risk patients As well as fulfilling this function within their practices, our GPs will increasingly play an active role alongside other professionals in multidisciplinary services locally.

b) What difference will this make to patient and service user outcomes?

Through our Better Care Fund schemes we aim to deliver the following improved outcomes;

- 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. This will include the use of personal health and social care budgets to allow greater flexibility in how needs are met. We are committed to reducing the need for out of area placements enabling people to maintain family connections. Sometimes a local option is not available, where this occurs we will look at how we can support them to maintain family connections.
- "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:

In practice this should mean service users being able to say the following;

- "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 provide me with 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"

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Over the next five years, the pattern and configuration of services will be changed in West Berkshire to better respond to the local health needs and put the patient at the centre of care to empower more people to live well at home. This will require a number of changes to the services that we provide. The Better Care Fund schemes will be critical to driving some of these changes.

Developing patient/service user centred care pathways across health and social Care

We will continue to create joint system wide integrated pathways across key areas such as frail elderly, mental health and children's services that transcend organisational boundaries to deliver high quality, efficient care for patients. In the longer term, we will also go beyond traditional health and social care services to include wider determinants of physical and emotional wellbeing, to include services such as housing, transport and leisure. We aim to give mental health parity of esteem with physical health, commissioning high quality evidence based services which reflect the national mental health strategy and other key guidance.

In response to the high cost of care for older adults, and the growing numbers of older adults in West Berkshire, the frail elderly pathway has been developed to improve the care of older people with long-term conditions and those who are at highest risk of deteriorating health and are likely to need intensive social care support. As part of this, care will be delivered by care workers, supported by identified care co-ordinators and This pathway has been developed through a multi-agency project supported by the King's Fund and is supported by an economic modelling element was led by Finnamore. The outcome of this financial modelling has yet to be formally signed off however this is expected to be approved over the coming months.multidisciplinary teams structured around groups of local GP practices. In bringing key elements of the frail elderly (older people's) programme on line through our local projects we will be able to assess its impact and use this as a template to inform planning for other pathways for the outer years of this five year period.

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 capacity of local people 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

- Our workforce development strategy will allow us to understand more clearly where the gaps are so that we can stimulate the market to respond and target training/support more effectively. The development of shared health and social care competencies will build capacity and improve the experience of health and social care for service users/patients as it will mean they will be supported by fewer people who get to know them better.

- A proactive approach to provide information, advice and guidance that enables people to understand what universal services are available and, where appropriate, navigate the health and social care system making choices that support them to maintain their independence for longer.

- We will strengthen our community based asset approach, building on our 'doing with' rather than 'to' approach. Assessments will be person centred, outcome focused and continue to develop re-ablement potential.

Modernising and Expanding the Model of Primary Care

New models and approaches to primary care are required to meet the workforce challenge and the new demands on the primary care sector in a transformed system. We will look to facilitate this through the development of primary care co-commissioning arrangements with NHS England which will enable us to improve quality in primary care. The role of primary care will be increased, with GPs working in larger units that will strengthen integration with community and health and social care, building on the success of joint triage between GPs and the ambulance service.

Having successfully implemented practice-based risk stratification and multi-agency care planning for high risk patients, our GPs are well placed to take on the role of Accountable Clinician for patients who may be at risk of admission; co-ordinating care provided by a

range of professionals to enable patients to remain in the community and are starting to do so through the Admissions Avoidance DES and other arrangements being put in place to support the care of the over 75s and high risk patients. As well as fulfilling this function within their practices, our GPs will increasingly play an active role alongside other professionals in multidisciplinary services locally.

Vision for Health & Social Care in West Berkshire	**BCF Supporting Scheme**
Person centred services that focus on outcomes rather than outputs	Joint Care Provider (BCF04) Patients Personal recovery guide/keyworker (BCF03) 7 Day week Service BCF05
Provision of good quality information and advice that empowers people to make good choices and self-manage	Patient's Personal Recovery guide/keyworker (BCF03) Access to Health and Social Care Services through a single hub (BCF02)
Flexible services that operate across 7 days where appropriate	7 Day Week Service (BCF05) Joint Care Provider (BCF03)
Services will be simpler to access, have less duplication and reach service users/patients earlier	Access to Health and Social Care Services through a single hub (BCF02) Joint Care Provider (BCF04) 7 Day Week Service (BCF05)
Delivery of health and social care services to be localised wherever possible including access to crisis	Joint Care Provider (BCF03)
A&E and other services that meet local resident's needs – with appropriate specialist or wider access to regional services that improves outcomes on a sustainable basis	7 Day Week Service (BCF05)
A greater range of local services that promote independent living	Patients Personal Recovery guide/keyworker (BCF03)
Reduction in avoidable hospital admissions	Enhanced Care & Nursing Home Support (BCF07) 7 Day Week Services (BCF05)
Lengths of stay in hospital will be kept to a minimum	Patients Personal Recovery guide/keyworker (BCF03) Joint Care Provider (BCF03)
Increased numbers taking up Health and Social care personal budgets	Access to Health and Social Care Services through a single hub (BCF02)

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

In West Berkshire we share with our Berkshire West 10 colleagues an understanding that integrated care delivers the best outcomes for our patients and service users. We believe(supported by evidence) that working in partnership, is the most effective way for us to ensure that we are providing person centred, personalised, co-ordinated care in the most appropriate setting. As a partnership of ten organisations, with a full range of services across the health and social care sector, we can deliver end to end integrated care for our population, radically reducing the number of assessments and transactions individuals are subjected to and improving their experience of care.

There is a significant financial challenge facing West Berkshire over the next two years as we cope with increasing demand for high quality services while contending with a constrained and challenging financial position in the local health and social care economy.

There are 9 key areas, which collectively, provide sufficient evidence of growing demand pressures in West Berkshire's Health and social care economy. These areas are:

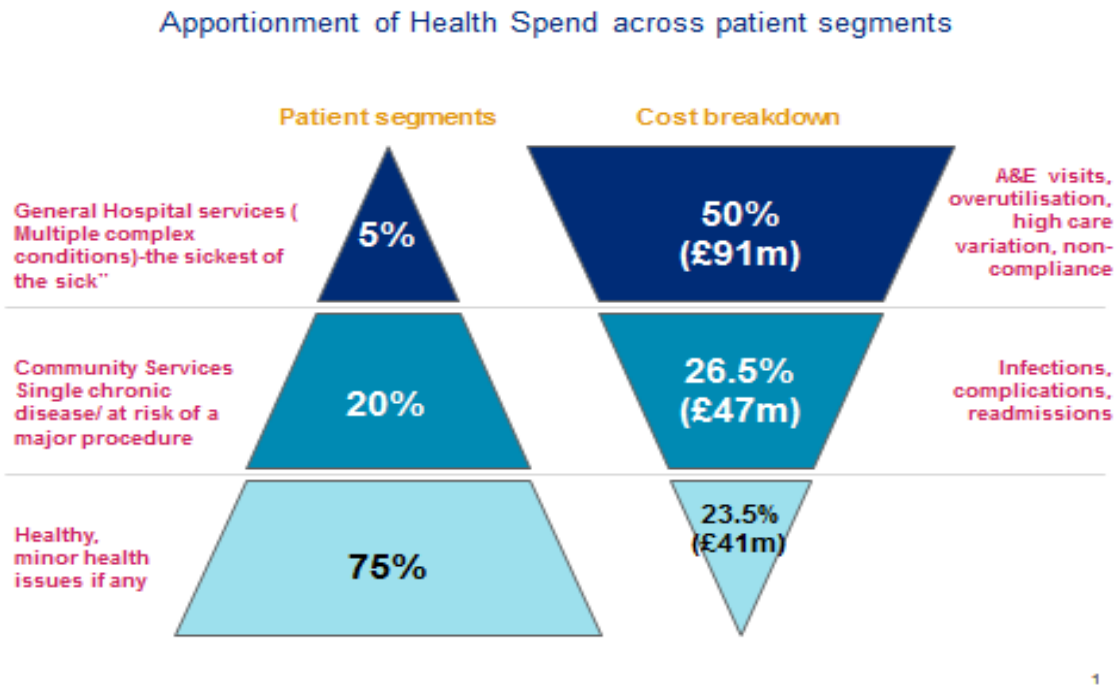
- An increasing population, particularly in those over the age of 65
- Increasing growth in non-elective care
- Increasing A& E attendances, and pressure on urgent and emergency capacity
- Rising delayed transfers of care, and subsequent bed days lost
- Increasing pressures on adult social care for community packages and care homes at a time when the overall Council budget is significantly shrinking
- Increasing demand for planned (elective) care
- Inequality of access to services across the "whole system :the whole week"
- Workforce Availability
- Care Act 2014 – new national eligibility criteria for social care

These pressures are likely to present the biggest challenges to affordability and sustainability over the next five years.

Our intention over the next five years is to transform the local health economy to support patients to manage their conditions at home, to keep well and remain out of hospital. As can be seen from the triangle of care needs below, small numbers of the population are associated with the highest cost and demand, whilst those lower down the triangle account for much lower cost impact per head of population.

We have a strong foundation in our shared vision and our track record, but we know that we need to increase momentum to tackle the system pressures and demographic challenges described above.

We simply do not have the resources to meet the expected increases in demand over the next few years if we continue to provide services in the same ways as we do now. Unless we find better ways of supporting people who are frail or living with long term health conditions, costs will increase exponentially. This will include the cost of care home placements, A&E attendances, emergency admissions to hospital, readmissions, and ambulance conveyance costs. Co-ordinated community based care is what people are asking for and what we know works. Indeed it is the only way to build a sustainable future.



Consequently our approach has been to identify the key challenges to the economy within the various segments of the diagram above. Combining best practice examples, a sound evidence base, alongside local knowledge, analytics and intelligence, we have been able to identify potential new models that will meet the needs of our population and address the key challenges we face over the coming years. Using a variety of risk stratification tools and methodologies, we have identified the cohorts of individuals that are most likely to benefit and the models of care most suited to meet the challenge in the most effective way. The key target populations are generally older adults and people with long term conditions.

Risk Stratification Methodology:

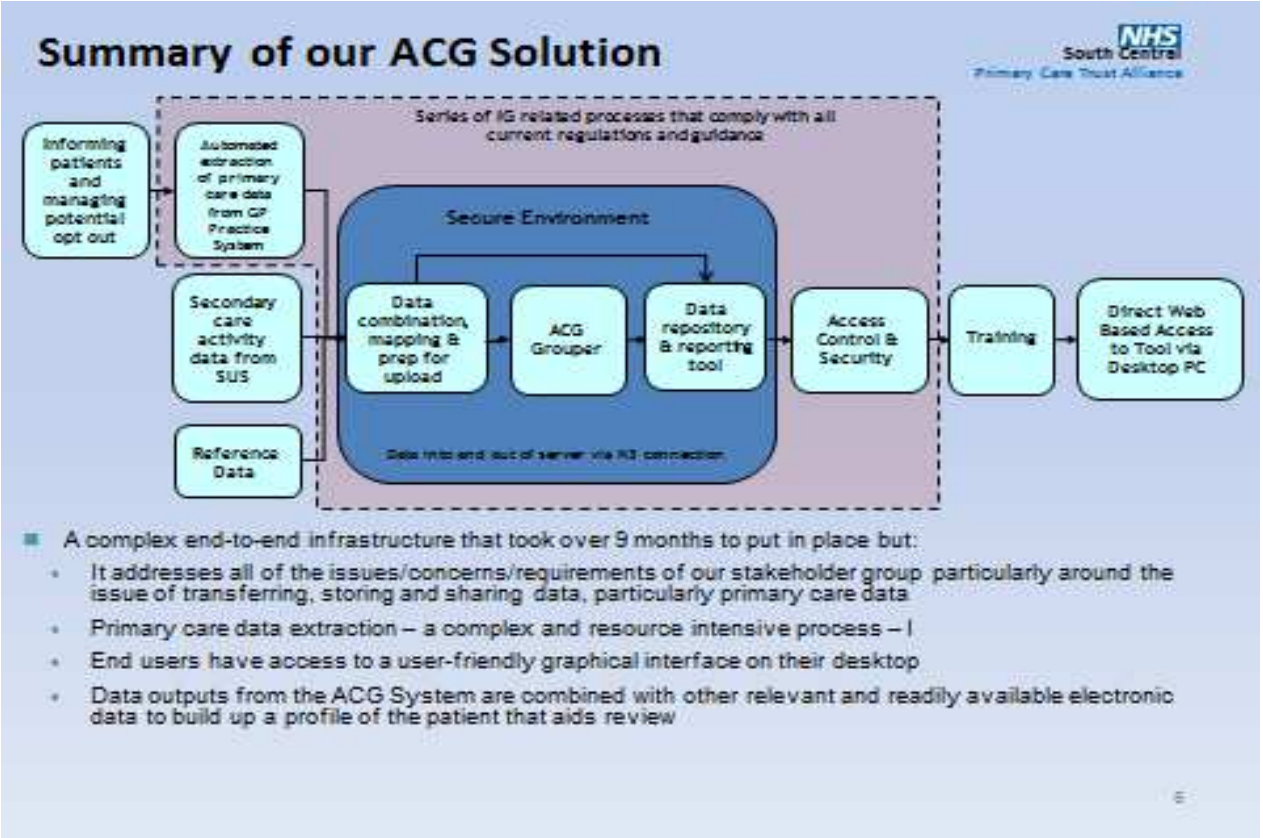
Dividing the population into groups of people with similar needs is an important first step to achieving better outcomes through integrated care. A one size fits all approach is inadequate and different sets of people have different needs. Grouping has helped us create models that are based on similar, holistic, individually-focused needs, and will also help us think about the health- and social-care system in a more holistic way.

By making these groupings explicit, we are able to provide a more logical way of informing the new models of care that are likely to be needed, identifying the outcomes we plan to achieve and by which we will measure our success, as well as allowing us to create payment models to incentivise providers to achieve these outcomes.

Risk Stratifying our High Risk of an Emergency Admission Population

In 2009, nine of the then PCTs in South Central decided to collaboratively procure a risk stratification tool which would support case finding for community health staff as well as supporting other programmes for patients with long term conditions. The Adjusted Clinical Groups (ACG) tool was implemented into all 54 GP practices within the Berkshire West PCT, including the 30 GP practices in North and West and South Reading CCGs. This tool has allowed us, in collaboration with our Berkshire Community Health Service, to have a

richer source of information about the health needs of the local practice population and to be able to support a reduction in emergency admissions.



The Case for Change

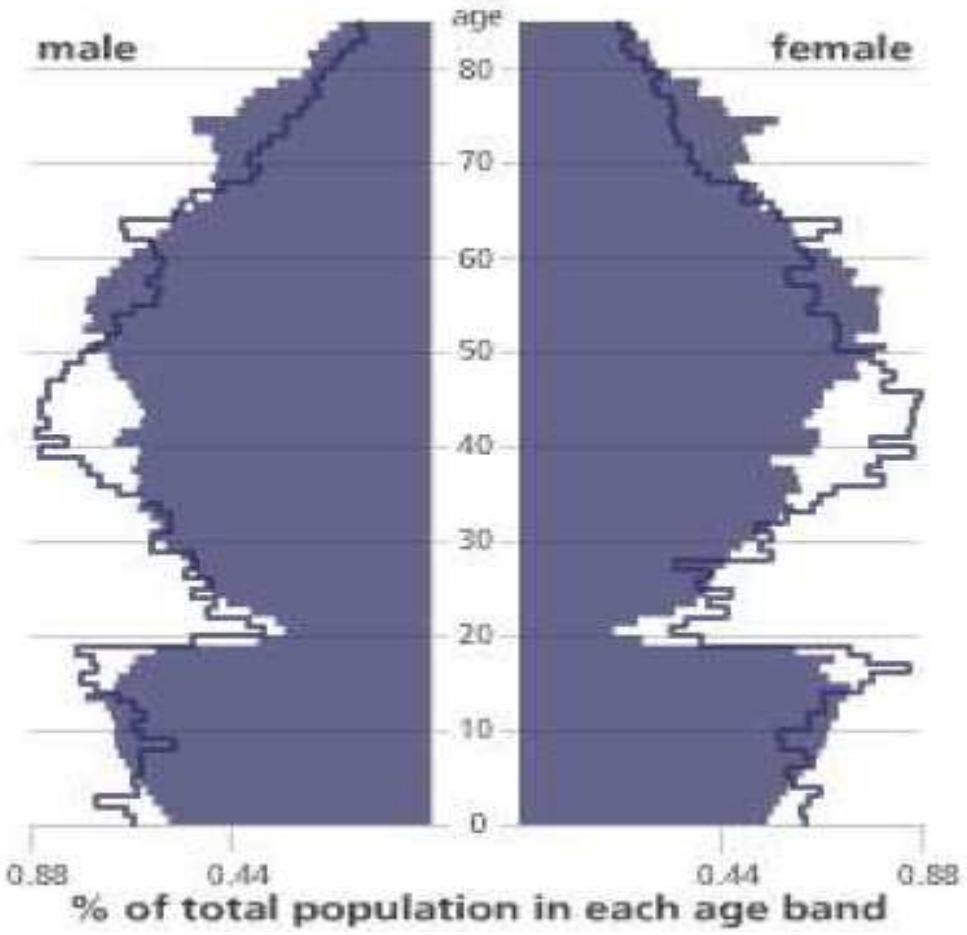
Challenge 1: Increasing Demand

A growing population particularly in those over the age of 65, with disproportionately high health and social care needs leading to a growth in health and social care requirements across the Berkshire West economy

The latest (2011) population *projections* by the Office for National Statistics, in predicting population growth across the country, estimate the population of West Berkshire to be 170,100 by 2021 – an increase of some 10%. This compares with an average increase in population across the South East of 9.3%.

Changes in population will not be universal across the age bands. Most graphically, the population pyramid below shows how the age profile of West Berkshire is expected to change over the next decade. The solid outline shows West Berkshire's population profile in 2011, whilst the shaded area represents the district's new population profile in 2021.

Projected population age profile for West Berkshire , 2011-2021.



Source: ONS, Interim 2011 sub-national population projections

Noticeable, is that, almost without exception, the reduction in the relative size of age groups under the age of 65. The district's 'waist band' remains reflecting a significant number of people leaving the district at around 20 years of age, but then returning over the proceeding two decades.

If the pyramid above shows how the relative size of age bands will change in relation to one another over the next decade, the table below describes this in absolute terms.

This estimates the number of 0-9 year olds living in West Berkshire to have grown by 3,300 by 2021 (or 17%). This compares to a similar expected growth across the South East of around 15%. The numbers of 10-19 year olds is anticipated to have increased by around 1,500 (or 8%), which is in line with the projected growth rate for the district as a whole.

At the other end of the age spectrum, the figures show an anticipated growth in the over 65 population of 34% (or 8,000 people) compared to 26% regionally. Breaking this down, the most significant growth is in the oldest age groups (75+).

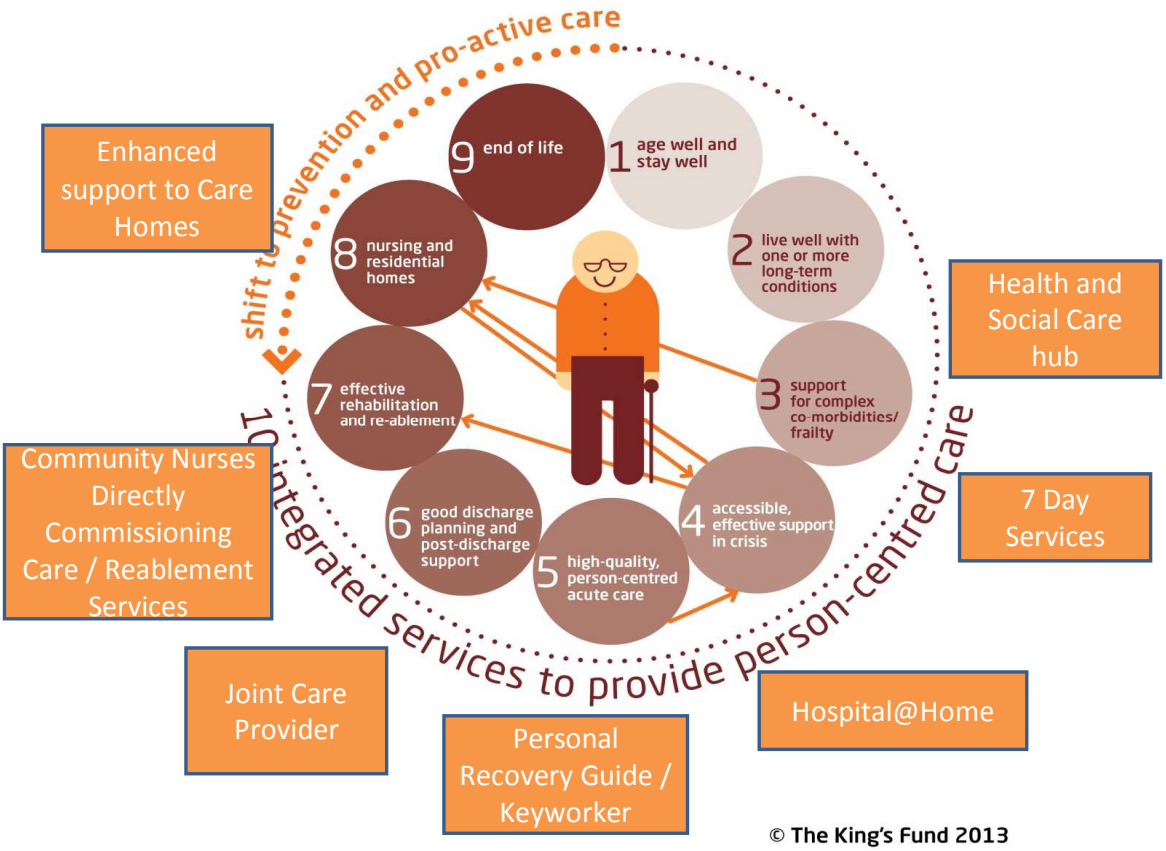
Projected change in population 2011-21 – by age						
	West Berkshire			Berkshire	South East	England
	Pop'n 2021	Change in pop'n (nos)	Change in pop'n (%)	Change in pop'n (%)	Change in pop'n (%)	Change in pop'n (%)
0-4	10,516	418	4%	5%	6%	9%
5-9	11,961	2,911	32%	27%	24%	23%
0-9	22,477	3,329	17%	15%	15%	16%
10-14	11,797	1,851	19%	19%	11%	9%
15-19	9,509	-304	-3%	1%	-6%	-8%
0-19	43,783	4,876	13%	13%	8%	8%
20-24	6,221	-1,060	-15%	0%	-4%	-4%
25-29	8,499	114	1%	6%	7%	9%
30-34	10,267	941	10%	7%	11%	16%
20-34	24,986	-6	0%	4%	5%	7%
35-39	11,314	342	3%	6%	5%	9%
40-44	11,613	-959	-8%	0%	-8%	-8%
45-49	11,688	-782	-6%	-2%	-9%	-10%
50-54	12,505	1,460	13%	15%	13%	11%
55-59	12,070	2,547	27%	29%	30%	26%
60-64	10,201	417	4%	8%	3%	2%
35-64	69,390	3,024	5%	8%	4%	4%
65-69	8,401	833	11%	12%	7%	7%
70-74	8,497	2,992	54%	41%	43%	37%
75-79	6,386	2,009	46%	29%	32%	26%
80-84	4,258	955	29%	24%	19%	18%
85-89	2,757	662	32%	36%	28%	26%
90+	1,664	629	61%	75%	63%	62%
65+	31,963	8,080	34%	29%	26%	24%
85+	4,421	1,291	41%	50%	40%	39%
All	**170,123**	**15,975**	**10%**	**11%**	**9%**	**9%**

Source: ONS, Interim 2011 sub-national population projections

As the graph and table above indicates, it is predicted that the number of over 65s will increase 24% by 2021 and those over 85 years of age by 39%. The impact of this demographic change on the health and social care systems will be vast – 30% of the population in West Berkshire will be living with a long term condition and we expect there to be a large rise in the numbers of older people living with more than one long term condition, e.g. Cardiovascular disease, Dementia, Respiratory Disease, Liver disorders and Diabetes. West Berkshire has a significant number of older people living alone and consequently at risk of social isolation with the negative impacts on physical and emotional wellbeing which this brings; integrating across the whole health and social care system becomes an imperative. These increases are likely to present the biggest challenge to affordability and sustainability over the next five years.

We know that the Health and Social care requirements of the elderly population over the age of 65 population are set to grow significantly over the next seven years and that will place huge financial pressure on the health and social care system within West Berkshire.

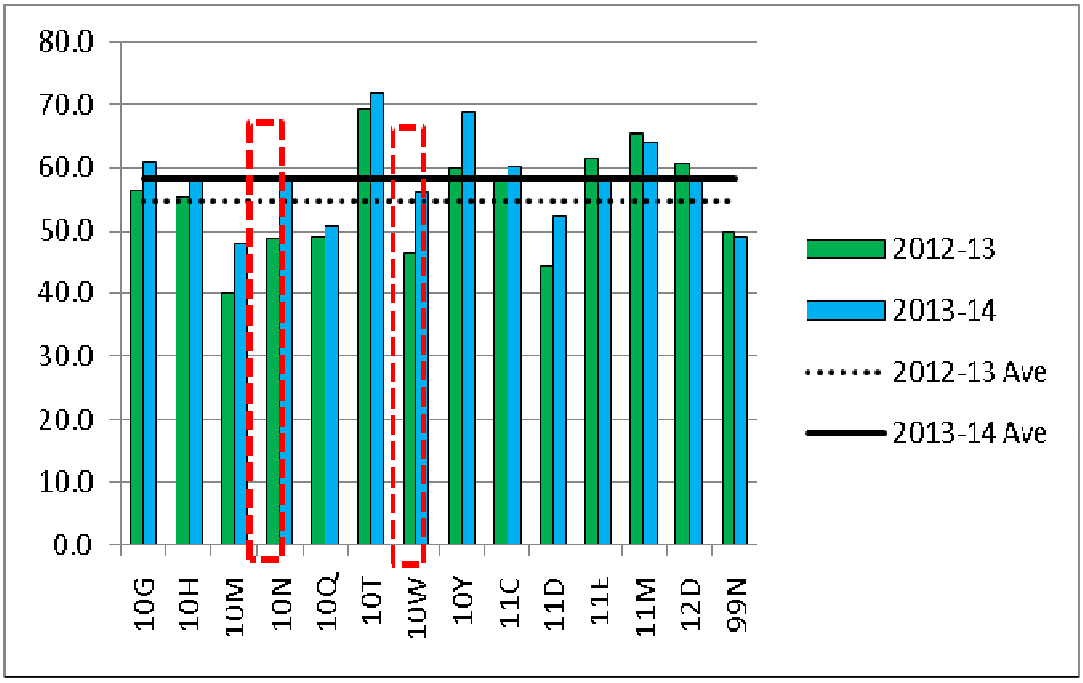
The solution: Extensive work is already underway in the frail elderly pathway, which was Identified as a key Integration work stream in our Pioneer bid last year. This Berkshire West wide work stream forms the backbone of system change and our local West Berkshire BCF schemes will be critical to delivering a number of elements of this as outlined in the orange boxes below:



Challenge 2: Growth in Non-Elective Admissions

Non-elective admissions are rising in West Berkshire, and future projections suggest that due to the increased age profile and expected double digit increase in certain long term conditions, this trend will continue unless there is system wide change. The graph below illustrates this trend across the whole of our South central CSU geography,

Graph: A & E attendance rates resulting a Non Elective Admission 2012/13 compared with 2013/14



Analysis of these figures reveals two specific problematic areas which have the potential to be amenable to change:

1. Non elective admissions with a medical event where patients are clinically stable and do not require diagnostic input such as acute infections, deteriorating long term conditions, unstable COPD, dehydration.

   Over 2012/13 there were 10,116* emergency admissions to hospital each year for Berkshire West residents with at least one long term condition, of which 4,590 were relevant to the patient type that with intensive support for a defined period of time, would
   be possible to manage in the community.

**Note that these figures are for total Berkshire West not just Newbury & District CCG*

2. Patients whose place of residence is a care home.

Within Berkshire West there were a total of 2770 people residing in care homes (residential and nursing care) who were associated with the following activity during 2013-14 and for the first quarter of 2014-15.

	Places	1 Calls		2 Conveyance		3 A&E		4 Admissions	
		2013-14	2014-15	2013-14	2014-15	2013-14	2014-15	2013-14	2014-15
Grand Total	2770	898	545	238	303	1326	354	961	260

In West Berkshire, during 2013/14 there were 201 Non elective admissions from Care Homes costing £640k. This therefore offers us a considerable level of opportunity to impact on this specific cohort of our population.

The Solution:

The outcomes for both of these cohorts can be dramatically improved by integrated care, and as such we have allocated two of our Better Care Fund schemes to address these issues.

The first scheme, Hospital at Home (BCF06) will provide an alternative to an Acute admission, for a sizeable patient cohort. This service will keep the patient in the community, and provide Acute-level treatment from a multidisciplinary team including nursing, social care and linking in with specialist nurses and therapists, to provide a patient-centric model of delivery, rather than the traditional disease specific organisation of care, to patients who are clinically stable. By identifying the right patient cohort, it is estimated that this service will reduce non elective admissions significantly (84% reduction for the patient cohort).

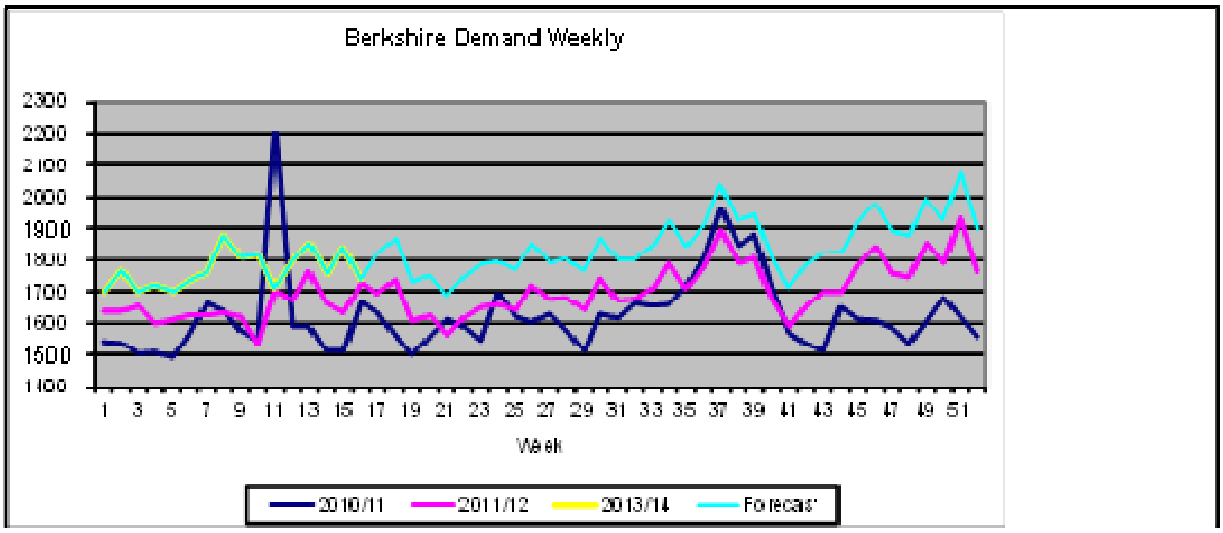
The second scheme is in response to the pressure on the acute sector coming from care homes. The enhanced support to care homes scheme (BCF07) provides a new model of high level health care support into care and nursing homes throughout the borough to improve consistency in the quality of care and outcomes for residents. We aim to reduce Care Home resident non elective admissions in West Berkshire by 40% in 2014/15.

As a result of these schemes, non-elective admissions will reduce by 1.1% in 2015/16vs. 2014/15. Although this is not at the 3.5% target, this is a very ambitious plan, given that Newbury and District CCG is already in the top performers for non- elective admissions in the South of England.

The Health & Wellbeing Board has forecast 4% growth in non-elective admissions for 2015/16 based on population growth and population change relating to an ageing population. After extensive modelling of the schemes, ensuring that there is no double counting, this results in an expected net reduction of 1.1% in non-elective admissions in 2015/16 compared with 2014/15 forecast outturn.

Challenge 3: Increasing A&E Attendances and Pressure on Urgent Care Capacity

A&E is under increasing pressure in West Berkshire , as the chart below shows, with attendances increasing for the last three years.



Between April–July 2013 and the same time period in 2014 West Berkshire has seen an increase in A&E attendance of 5.3%. This has been further analysed to identify the cohorts of patients this is attributed to. Within South Reading, the under-5 age group account for a large proportion of this increase. This is being addressed outside of the BCF with support from system resilience funding from November 14-April 15. However in North & West Reading A&E increases are associated with a much older age group in line with their demography. This pattern is also seen across the other CCGs within Berkshire West.

The Solution:

In addition to a review that was undertaken in January to assess the causes of A&E breaches, a number of Better Care Fund schemes will also seek to target key populations at high risk of A&E attendance to reduce the pressure on urgent care.

The first cohorts of patients are those with long term conditions and frail elderly patients. Both of these cohorts will benefit from the increased provision of care in the community, via the Hospital at Home scheme, the extended availability throughout the week for this care via the 7 day working schemes and the changing eligibility threshold for social care in West Berkshire.

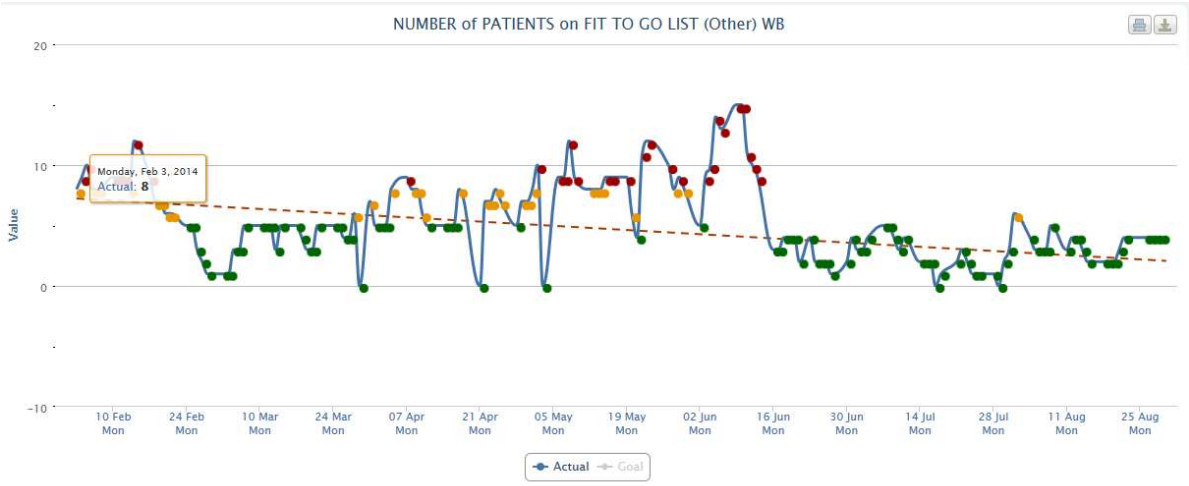
The third group is care home residents, of which 48% across Berkshire West had an attendance at A&E in the last year. The Care Home project will address the training of care home staff, and the maintenance of relevant, up to date care plans and reviews to keep care home patients out of A&E.

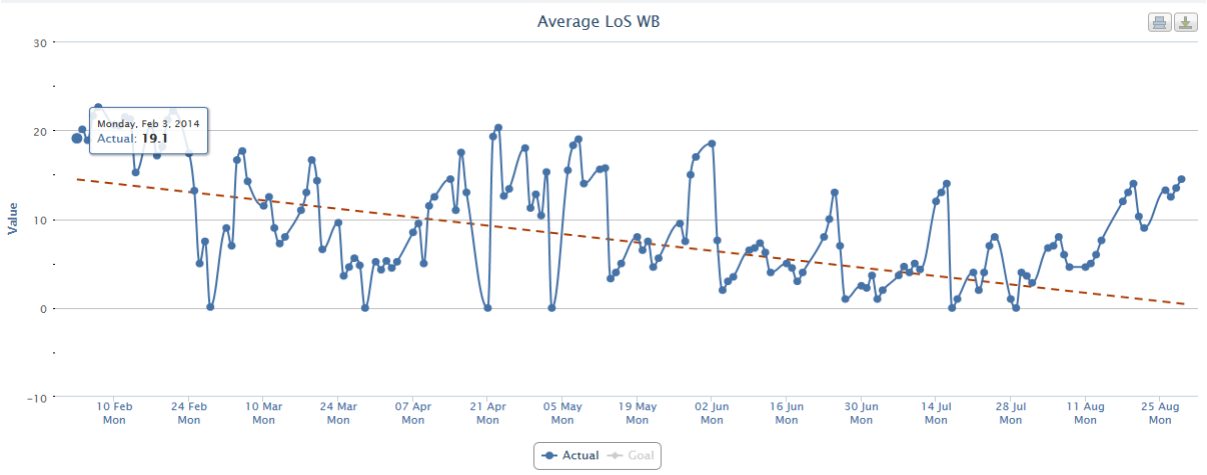
Patient cohort at high risk of A&E attendance	**BCF scheme to support**
Patients with LTCs and frail elderly patients susceptible to dehydration etc.	Hospital at Home 7 day access to GP care Joint Provider Service
Patients residing in Care Homes	Enhanced service for Care Homes

Challenge Statement 4: Rising Delayed Transfers of Care and Subsequent Bed Days Lost

An increasing proportion of those attending A&E and who are subsequently admitted are frail elderly patients who have a higher level of acuity and longer lengths of stay vs. the average patient.

The following graphs show the number of patients and duration of time on the “Fit To Go” List (Feb to Aug 2014). Despite a significant amount of resource being focussed on this area we still experience widely fluctuating figures. Whilst we have had some success in bringing down the number of patients, the average length of time that patients remain on the “Fit to Go” List has remained above the system wide target of five days agreed as part of the A&E Recovery Plan and is currently above 9 days. This in turn contributes to the impeded flow through the inpatient beds.





Solution:
There are a number of factors that we have identified where integrated care can help reduce delayed transfers of care, and as result we have developed our BCF schemes accordingly.

1. The number of patient discharges on an average weekend day is less than half the number of patients who are discharged on an average weekday. A key reason for this is access to health and social care in the community over the weekend. In response we will use our 7 Day Services Scheme (BCF05) to enhance the existing 7 day arrangements across both health and social care. Our Health and Social Care Hub Scheme (BCF 02) will enable us to take referrals and direct services seven days of the week, facilitating discharge over the weekend.

2. Another key reason for delayed transfers of care is the cohort of patients who are waiting for social care packages, who often have to wait for their care, despite being fit to be discharged. Our Joint Care Provider Scheme (BCF04) will reduce these delays by the using the benefits of a single service, operating with a pooled budget, to provide an appropriate onward destination for this cohort of patients, with a focus on maximising their independence.

Challenge Statement 5: Increasing pressures on adult social care for community packages and care homes at a time when the overall Council budget is significantly shrinking.

Like every other local authority in the country, West Berkshire faces challenges in delivering its priorities against national government settlements. Through its Corporate Plan, the local authority has affirmed its commitment to caring for and protecting the vulnerable in its community However, there is an explicit acknowledgement of the need to work differently to avoid the consequences of a widening funding gap over the next 3 years.

The key areas of demand for adult social care in West Berkshire are amongst those over 75 and those with dementia, both of whom have a longer than average length of stay due to waiting for community based services.

As described above, the number of patients on the “fit to go” list continues to increase due to the increasing demand for nursing care, residential care and community reablement, and the lack of supply. This lack of supply is felt most acutely in the rural areas of West Berkshire where the distances involved in getting to and from client’s in the very sparsely populated communities is prohibitive for providers.

The Solution:

The Better Care Fund spending plans for 2015/16 include a significant sum to protect social care services, particularly the universal preventative services that have been established. The Personal Recovery Guide / Keyworker scheme (BCF03) will initially focus on helping move patients through the care pathway with one of the aims being to facilitate their prompt discharge from hospital. We understand that most people will not have had the need to access care services prior to a hospital admission and will be faced with the need to make life changing decisions. This scheme will prevent them from getting lost in the system and connect them to good quality information about what services are available and what the impact of their choices will be. As the scheme develops we will seek to expand the focus to support people to access community based services, both universal and commissioned, and link into some of the Public Health funded initiatives including the ‘Village Agent’ scheme. Most people want to stay in their communities and this scheme will

be developed to support them to do that.

Challenge Statement 6 Increased Demand for Planned Care Services

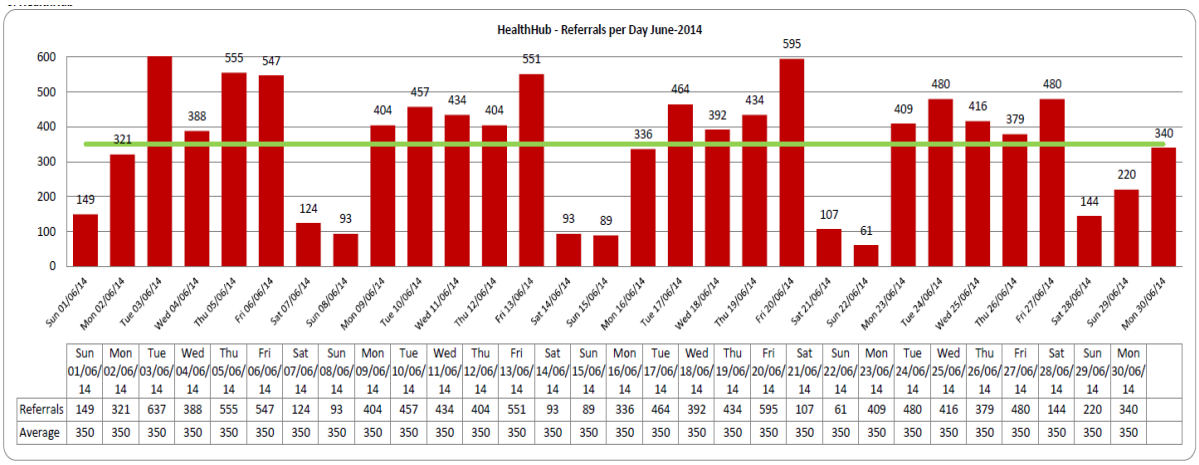
Work is currently underway across our health economy to address these issues and this is outside the scope of the BCF.

Challenge Statement 7: Inequity in Access to Services 7 Days a Week

It is widely accepted that people need health and social care services every day. Evidence shows that the limited availability of some hospital services at weekends can have a detrimental impact on outcomes for patients in hospital, including raising the risk of mortality.

Local acute data from Royal Berkshire Foundation Trust shows that there are far fewer discharges at the weekend vs. during the week with less than half the weekday average number of discharges. This is due to system that does not operate flexibly across the seven days, our 7Day Week service will address deficits in cover from the acute services, primary care and community based social.

Since all requests for discharge support (health and social care) from our main acute provider (Royal Berkshire Foundation Trust) as well as requests for community support are processed through the current Health hub, the graphs below clearly demonstrate a marked reduction in referrals into the hub for these services at weekends which is likely to affect discharge rages and admission rates.



	Sun 01/06/14	Mon 02/06/14	Tue 03/06/14	Wed 04/06/14	Thu 05/06/14	Fri 06/06/14	Sat 07/06/14	Sun 08/06/14	Mon 09/06/14	Tue 10/06/14	Wed 11/06/14	Thu 12/06/14	Fri 13/06/14	Sat 14/06/14	Sun 15/06/14	Mon 16/06/14	Tue 17/06/14	Wed 18/06/14	Thu 19/06/14	Fri 20/06/14	Sat 21/06/14	Sun 22/06/14	Mon 23/06/14	Tue 24/06/14	Wed 25/06/14	Thu 26/06/14	Fri 27/06/14	Sat 28/06/14	Sun 29/06/14	Mon 30/06/14
Referrals	149	321	637	388	555	547	124	93	404	457	434	404	551	93	89	336	464	392	434	595	107	61	409	480	416	379	480	144	220	340
Average	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350	350

Solution:

In response to issues created by a lack of provision over the weekend, our 7 Day Scheme (BCF05) will seek to enhance the existing 7 day provision across both health and social care in a coordinated and affordable way. The Joint Care Provider Scheme (BCF04 and the Community Nurses Directly Commissioning Care / Reablement Services (BCF01) will also play a key role in improving and simplifying the 7 day arrangements. These plans will support all patient cohorts but the provision is expected to be particularly effective for patients with complex needs, those identified as part of the national service to avoid unplanned admissions including the over 75 year olds.

In addition the single point of access health and social care hub will operate seven days a week to act as a point of contact for patients, signposting them throughout the week to the most appropriate service.

Challenge Statement 8: Workforce Availability

A major challenge already facing West Berkshire is the lack of carers both those directly employed by the local authority and those employed by private sector providers. The shrinking working age population (see census data above) and high employment rates in the area have resulted in a lack of people willing to enter into what are relative low paid carer jobs. This impacts on our ability to commission domiciliary care in particular where providers regularly turn down work due to their lack of staff.

Solution:

As one of the Better Care Fund Plan 'enablers', the Workforce Development project aims to help us understand more clearly where the gaps are so that we can stimulate the market to respond and target training/support more effectively. The development of shared health and social care competencies will build capacity and improve the experience of health and social care for service users/patients as it will mean they will be supported by fewer people who get to know them better.

Challenge Statement 9: Care Act 2014 – new national eligibility criteria for social care

West Berkshire District Council is one of just 3 local authorities in England currently operating an eligibility criteria for social care of 'critical only'. As a result it faces significant challenges in complying with the new national eligibility criteria that comes into force on the 1st April 2015. The change will result in more residents being eligible for social care support and an increased level of support for a large number of existing clients. The challenges will be finding sufficient workers to enable delivery of the additional care and meeting the cost of the change at a time when budgets are reducing.

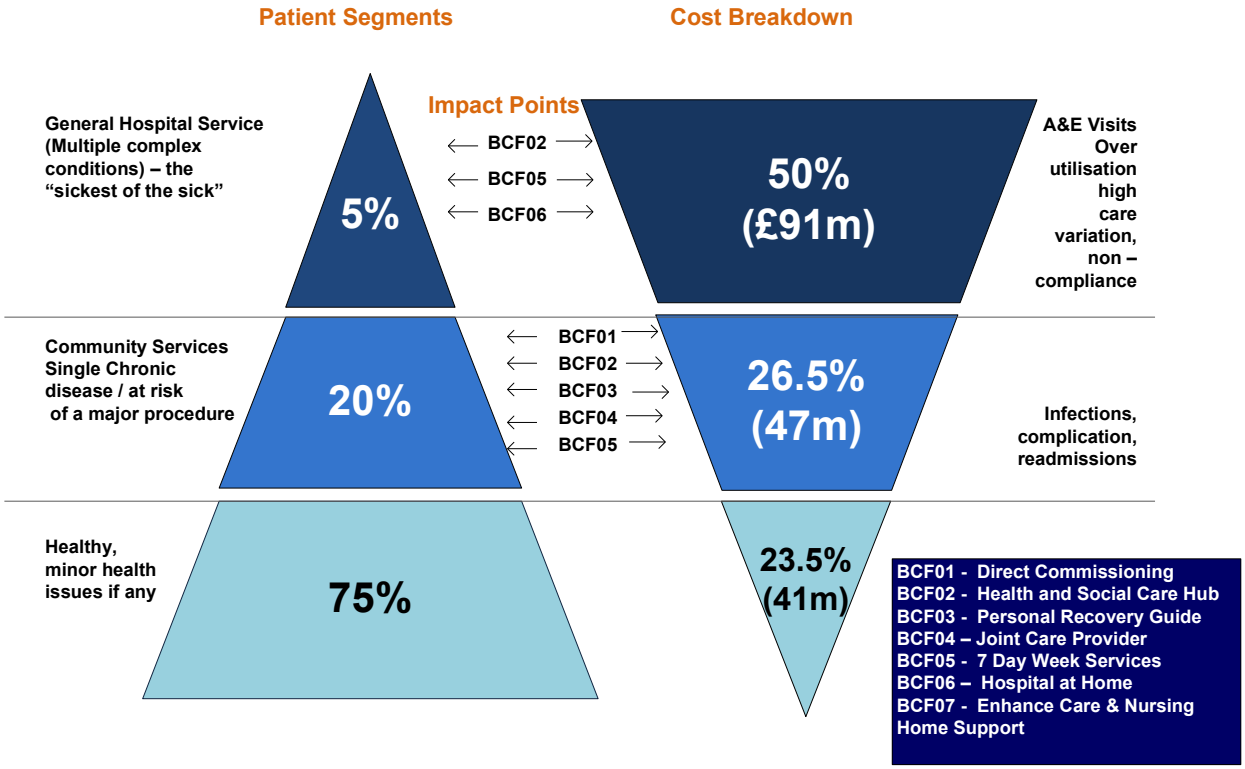
Solution:

Within the constraints of the money available, the BCF spending plans include a significant contribution toward the Care Act costs, recognising that no specific allocation was made into the fund by the Department of Health to recognise the 'critical only' issue. As already mentioned it is hoped that the Workforce Development enabler will contribute towards addressing the workforce issues in West Berkshire.

Delivering Change via the BCF

We have built our Better Care Fund submission around the key challenges in West Berkshire with a focus on those areas where we feel care can most be improved by integration, based on our experiences in West Berkshire and the evidence base. The diagram below shows on a high level how our BCF schemes will cater to the population across Reading, with a strong focus on the most costly patients.

Apportionment of Health Spend Across Patient Segments



The table below summarises at a high level how the schemes will address a number of the key challenges in the Reading health and social care economy. More detail on these schemes can be found in Annex 1.

Pressures vs Schemes table

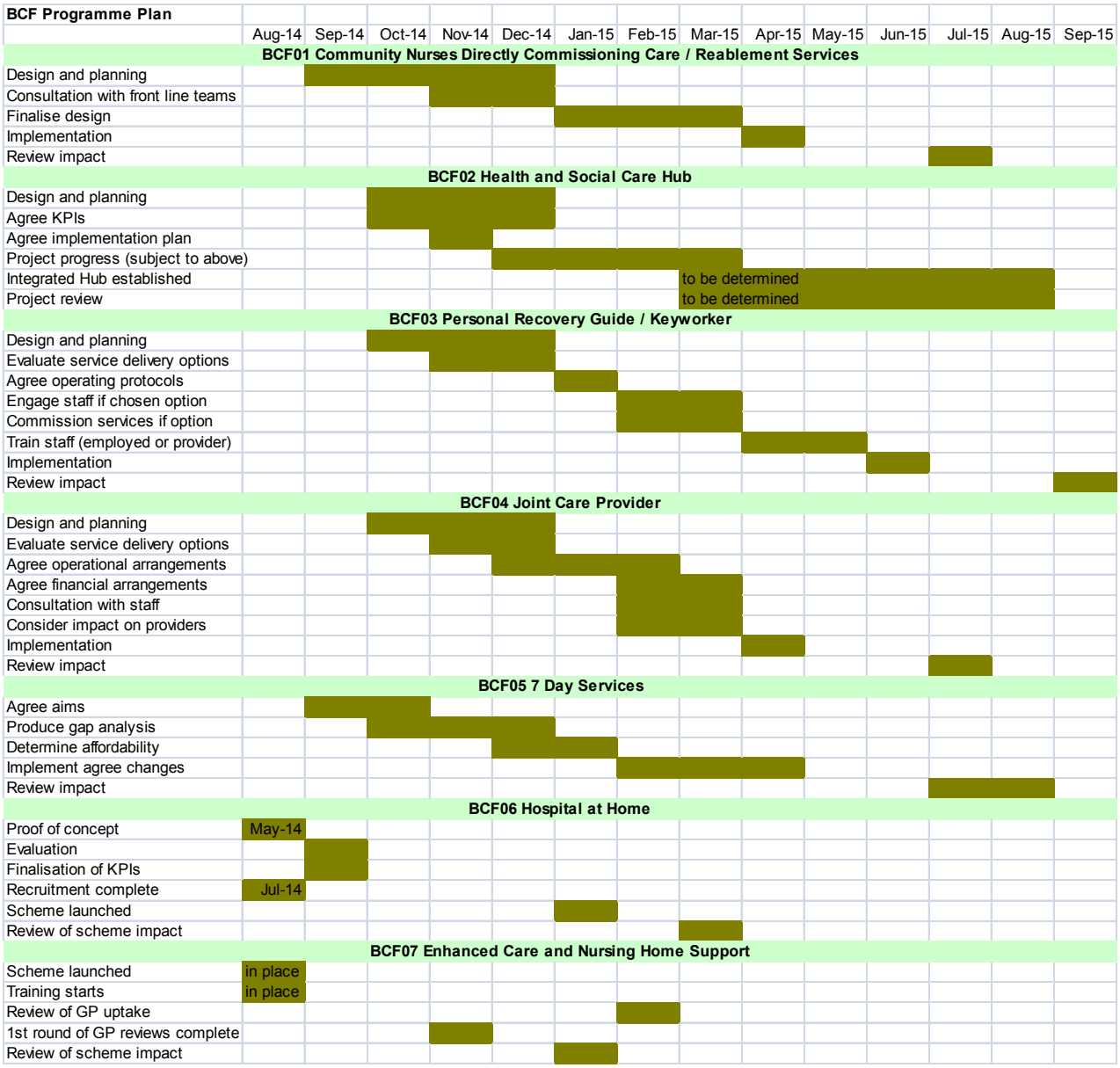
Key: Direct Impact / Indirect Impact	BCF01 - Direct Commissioning	BCF02 Health and Social Care Hub	BCF03 - Personal Recovery Guide	BCF04 – Joint Care Provider	BCF05 - 7 Day Week Services	BCF06 – Hospital at Home	BCF07 - Enhance Care & Nursing Home Support
Growing Population	Direct	Direct	Indirect	Direct	Indirect	Direct	Direct
Rise in non elective care	Direct	Direct					
Increasing A&E attendance		Direct				Direct	Direct
Delayed transfers of care				Direct		Direct	Direct
Increasing pressure on social care			Indirect	Direct	Indirect		
Inequity of access throughout the week	Direct	Direct				Direct	Direct

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Milestones

The programme plan below illustrates the high level key milestones by scheme for the delivery of the Better Care Fund plan. The key milestones for each scheme are laid out in the relevant project briefs and project initiation documents. Under the governance arrangements (see section 4c) these milestones are approved and progress monitored by the Integrated Care Steering Group, West Berkshire Partnership Board and the Health and Wellbeing Board.



Interdependencies:

Within our Better Care Fund plan, there are a number of schemes that are enablers of some of the key improvements in non-elective admission, reducing delayed transfers of care and improving patient experience.

Connecting Care is the name of the enabler project which will deliver the interoperability between various health and social care providers. The project is being run on a West of Berkshire basis with all 3 local authorities committed to delivering the agreed outcomes. This enabling project will be critical to the efficiency and smooth running of the Hospital at Home (BCF06) and Health and Social Care Hub (BCF02) Schemes. Service delivery will run more efficiently, and decisions will be able to be made quicker as a result of a more complete set of information in real time .In the Hospital at Home pilot, we found that the lack of data sharing, (which is not yet in place), led to delays as health and social care professionals had to spend time getting updates on the progress of the patient from other professionals directly. IT interoperability will be critical to the smooth running of this service, allowing professionals to access the data they require instantly and therefore increasing productivity. In addition it will facilitate a more robust assessment of the patient's fitness for the scheme in the acute setting as the community geriatrician will have access to a more comprehensive information set. Similarly the Health and Social Care hub, which will form a single point of access for health and social care professionals, and eventually patients, will be critical to the success of the schemes. The Health and Social Care hub will signpost patients and professionals to the most appropriate services, and ensure that there is adequate awareness of new services to ensure optimal uptake.

The schemes connected to seven day working are all interconnected. In order to be as effective as possible, 7 day requires a full complement of services – i.e. hub to be a port of call to direct patients and professionals to the most appropriate service, and the GP and community teams so that they can interact with each other to ensure that patients receive the right service at the right time.

The underlying feature of integration is working in ways that eradicate silo working. The aim of which is to benefit the individual who is in need of care and support. Integration, in relation to the Better Care Fund, will require a change to the way that we work, as well as a change within the relationships with have created with our partner organisations.

The complexity of such interdependencies requires new ways of working. The Hospital at Home Project is the first project to work in such a joined up way, and as such a Memorandum of Understanding has been developed. This ensures that all partners are clear about the role they play in project delivery. A copy of the Memorandum of Understanding has been provided a one of the supporting documents.

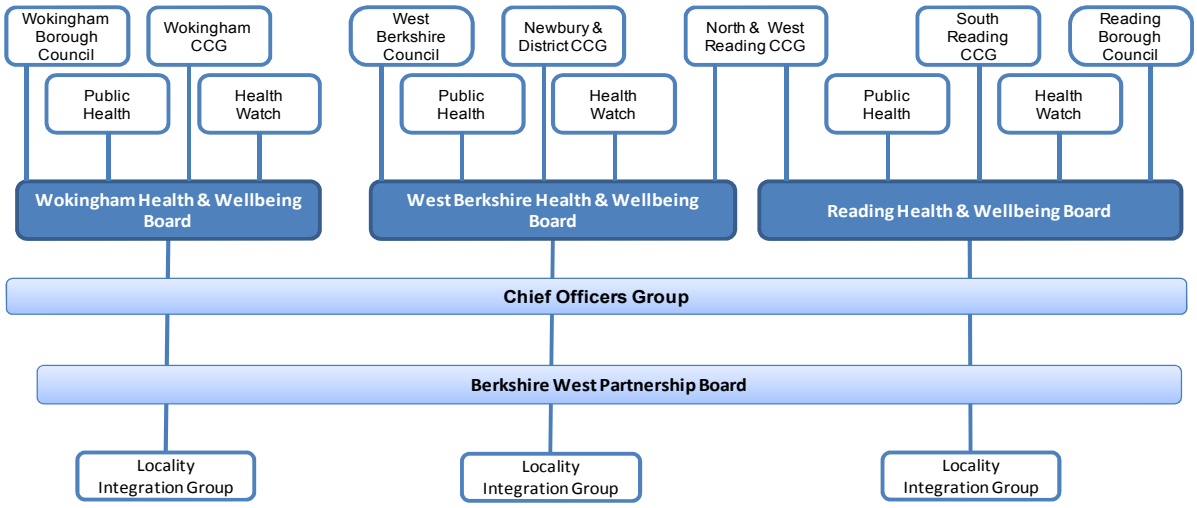
Our health economy in West Berkshire also reflects our patient flows to other acute providers, namely Hampshire Hospitals NHS Foundation Trust (Basingstoke) and Great Western Hospitals Foundation Trust (Swindon). Our CCG maintains close links with both North Hampshire CCG and Swindon CCG. Within our BCF governance structure, it should be noted that Hampshire Hospitals are already members of our Berkshire West Integration Steering Group and within that the groups role in overseeing and assuring partnership to deliver our BCF programme. Additionally, Newbury & District CCG are members of the North Hampshire CCG Systems Resilience Group, further demonstrating the cross-boundary nature of our local partnerships.

Whilst the Hospital at Home Project is exclusively for patients who attend the Royal Berkshire Hospital for treatment; the Council will take forward the learning from this project in the planning for improved discharge arrangements for patients at the two other key acute hospitals at Basingstoke and Swindon, as well as the West Berkshire Community Hospital

b) Please articulate the overarching governance arrangements for integrated care locally

The West Berkshire Health and Wellbeing Board will have strategic oversight and governance for the West Berkshire Better Care Fund and related arrangements. Membership of this Board includes two voluntary sector representatives, as well as West Berkshire Healthwatch, together with Newbury & District CCG, North West Reading CCG and West Berkshire Council. This Board meets regularly and will receive 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.

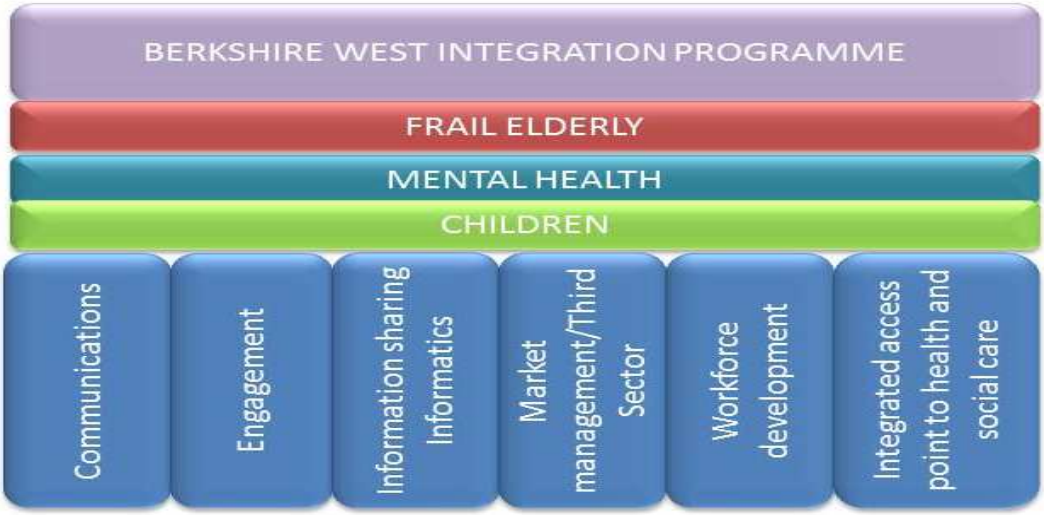
Because the local health and social care economy works across our Berkshire West boundaries many of the schemes within the plan are part of a wider Integration Programme, as outlined below:



There are monthly Berkshire West Partnership Board meetings with representatives from each of the partner organisations are in attendance. For projects that span all three unitary authorities in Berkshire West (Reading Borough Council and Wokingham Borough Council as well as West Berkshire Council), accountability is held with the Berkshire West Partnership Board.

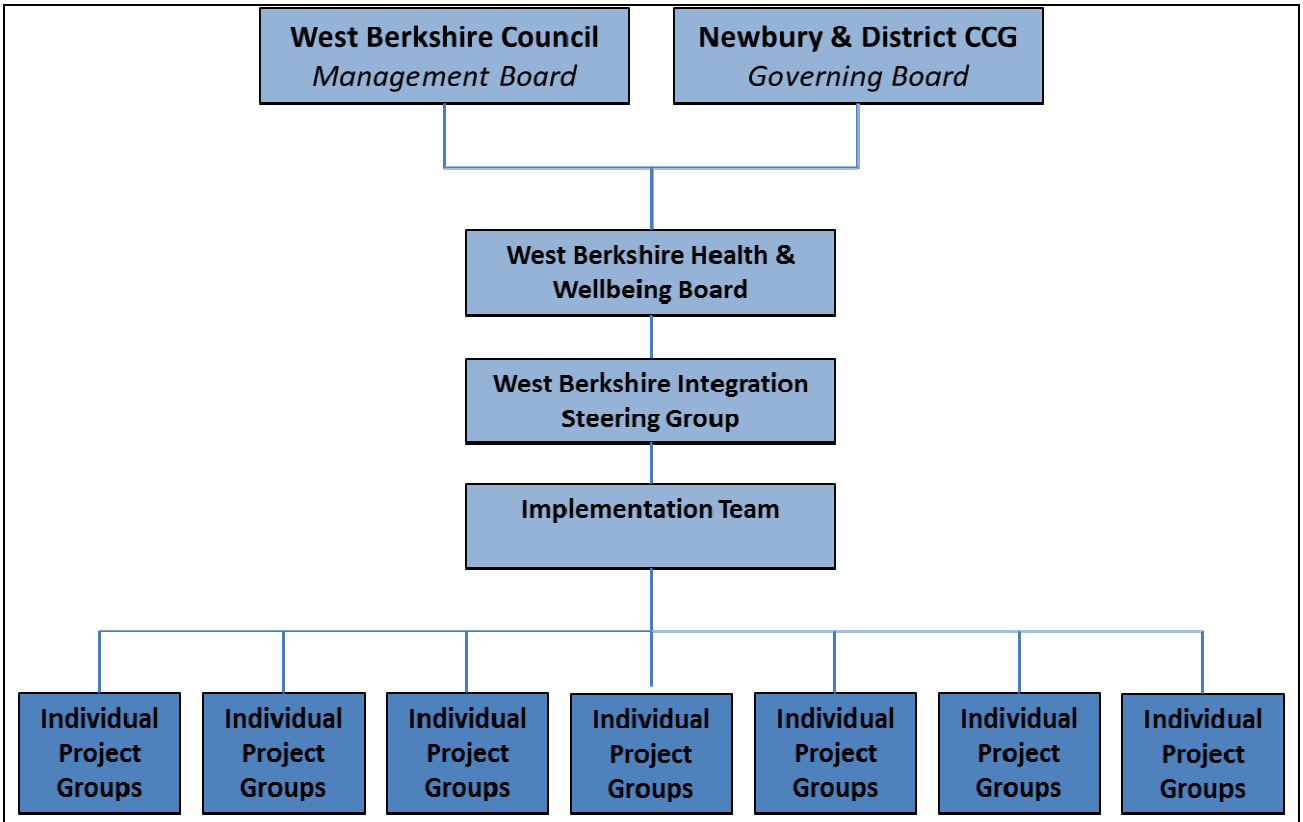
This Board will oversee the delivery of the Workforce Development strategy and other overarching system wide schemes which are included within the BCF programme. The partnership has appointed an Integration Programme Manager who is responsible and accountable for ensuring the system wide objectives of the wider integration programme are delivered We recognise that both provider and voluntary sector representation is essential to ensure engagement and improvement of the workforce across the system.

The structure and the relationship to the work streams within the Berkshire West integration programme is represented thus:



West Berkshire's Health and Wellbeing Board has strategic oversight of our plans to develop more integrated services within the district. The Health and Wellbeing Board has already overseen the production of the latest Joint Strategic Needs Assessment for West Berkshire, and led the development of a Health and Wellbeing Strategy and Delivery Plan. The Board is therefore well placed to ensure West Berkshire's integration plans draw on local evidence of need and health inequalities.

We now have a Programme Office across Berkshire West in order to ensure there is sufficient project management capacity to deliver both the local and wider enabling schemes identified within this submission. The next section describes the management and oversight which monitors project delivery to ensure our identified schemes remain on track.



Within the Programme Management Methodology being used to implement the BCF the Health and Wellbeing Board act as the Programme Board and the West Berkshire Integrated Care Steering Group acts as a Projects Board

Every project is sponsored by one or more senior manager and clinician from across the health and social care economy.

There are implementation teams for each of the named projects with assigned Project Managers.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

We are utilising the Office of Government Commerce (OGC) best practice framework "Managing Successful Programmes" to manage the overarching programme and the Prince 2 Project Management Methodology for management of the individual projects within it.

The Partnership Board will be the governance group for the overarching integration programme and it will report progress at regular intervals to the sponsoring group. The BCF projects will be monitored and controlled through a Projects Board known as the Integrated Care Steering Group who will report directly to the Partnership (Programme) Board. Project Managers will report to the Projects Board at regular intervals. Terms of reference exist for all groups and specific responsibilities have been documented for named roles, e.g. Programme Manager

Governance Strategies for the Programme have been formulated and documented to ensure consistency across the projects and encompass the following:

- Benefits management
- Information management;
- Risk management;
- Issue resolution;
- Monitoring and control
- Quality management;
- Programme resource management;
- Stakeholder engagement/consultation/communication

For example project issues or risks which have been identified and logged at the project level but cannot be resolved/managed there, will be escalated to the Projects Board (Integration Steering Group) through regular Highlight Reports and if they cannot be resolved/managed there, they will be escalated to the Partnership Board and so on. Programme risks will be regularly reviewed by the Steering Group and an action plan put in place for any risks that remain red following mitigation.

This programme will have the support of an experienced Programme Office

d) **List of planned BCF schemes -**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
BCF01	Community Nurses Directly Commissioning Care/ Reablement Services
BCF02	Access to Health and Social Care Services through a single Hub
BCF03	Patient's Personal Recovery Guide / Keyworker
BCF04	Joint Care Provider
BCF05	7 Day Week Service
BCF06	Hospital at Home
BCF07	Enhanced Care & Nursing Home Support

5) RISKS AND CONTINGENCY

a) Risk log

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 and any financial risks for both the NHS and local government.

The following risk register is simply an extract of the key risks from a more detailed Programme Risk Register. Beneath this sits a risk register for each project which project managers are required to review on a regular basis and escalate unmanageable risks up through the governance structure.

		Gross Rating				Net Rating		
No	**Risk description**	**Likeli-hood**	**Impact**	**Score**	**Controls (existing and expected)**	**Likeli-hood**	**Impact**	**Score**
1	Lack of certainty regarding the existence of the Better Care Fund after 2015/16	3	4	**12**	Maintain links with external bodies to understand current thinking. Close monitoring of government policy developments. Possible appointment of new staff on fixed term contracts Commissioned services contracted for 1 year with options to extend.	3	3	**9**
2	Planned reduction in acute care does not materialise	3	3	**9**	Robust monitoring of community services to ensure impact and identify any remedial action required. Close monitoring of acute activity.	3	2	**6**
3	Double running costs during changes in the health and social care system	4	3	**12**	Call to Action reserve to pump prime some schemes. Careful timing of other schemes to minimise double running costs	3	2	**6**
4	The delivery of the programme may adversely affect day-to-day operation	3	3	**9**	Incremental approach to change. Additional resources to backfill staff where possible. Role of Project Sponsors (Heads of Service) and Programme Sponsor (Director) in balancing project and operational pressures. Project planning to minimise impact.	2	3	**6**
5	Insufficient funding for responsibilities arising from the Care Act.This would result in significant negative impact on social care services.	3	4	**12**	Detailed modelling of likely cost impact. Lobbying of DH via LGA amd ADASS Maximising the contribution from the BCF towards linked Care Act duties, within the constriants of the overall fund.	2	3	**6**
6	Providers may not respond with the speed, quality and range of services needed.	4	3	**12**	Early identification of requirements Use of existing provider engagement networks Possible pump priming of service developments	2	3	**6**
7	Schemes may not deliver the level of expected savings	3	3	**9**	Realistic savings targets set with clear understanding how they would be delivered from each project. Clear overall financial framework and support at Programme level Project management disciplines for each project. Accountability and monitoring via Prog	2	3	**6**
8	Changes in government policy forcing a strategic change of direction	4	3	**12**	Maintain links with external bodies to understand current thinking. Close monitoring of government policy developments. Application of change management procedures.	4	2	**8**

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The Clinical Strategy Programme for Berkshire West federation of CCGs is focusing on three specific areas:

Establishing the financial baseline
Undertaking service line reviews of three clinical services (respiratory care, chronic pain and liver disease) to develop an optimal patient pathway spanning all settings of care
Determining the system attributes that will required to deliver care according to our vision

The objectives of the programme are to:
Articulate a clear case for change, setting out the impact of proposed changes on viability and sustainability of individual providers.
Determine the preferred configuration of services for safe and effective care
Articulate the roadmap for "Berkshire West PLC" in securing the long term viability (clinical and financial) of healthcare services for the local population
Agree the key attributes of the health system - including financial incentives and governance, and design the operating model.

As part of our Clinical Strategy programme we have completed an externally supported clinical services review with Royal Berkshire Foundation Trust and Berkshire Healthcare Foundation Trust to determine the best care pathway models which improve patient outcomes and support financial sustainability. This review process considered 3 Initial pathways, respiratory care, chronic pain and liver disease.

It is our intention that the clinical pathway review will deliver redesigned care from a patient perspective, eliminating variation in outcomes. We are confident that the size and scale of the initial pathways identified will have a transformational impact on activity levels as well as clinical outcomes, and we expect to see full implementation of the benefits including the associated efficiencies of this programme realised as part of our QIPP plans for 2015/16 onwards.

The Clinical Strategy programme will also provide us with a framework for future elective pathway reviews which in collaboration with our providers will deliver safe and effective care, and support the long term clinical and financial viability of the healthcare system in Berkshire West.

As identified above, we are conducting a review of three clinical pathways. It is anticipated that this work will generate savings which could be used to meet growth in activity. If this is insufficient to meet the financial shortfall, we would use the contingency monies set aside and identified in the Health and Wellbeing Board financial submission and which supports this narrative. If after both of these measures are implemented a financial gap still remains, we would investigate further savings through existing or new QIPP projects.

Draft Risk Share Agreement

West Berkshire Council (The Local Authority), Newbury and District CCG and North West Reading CCG (The CCGs)

Better Care Fund Pooled Budget - Risk Sharing Agreement

1. Introduction

1.1 By its nature a pooled budget provides an appropriate vehicle for sharing risk between the associated parties. The general principles for risk-sharing are:

(a) The financial impact of unpredictable incidences on system wide deliverables should be shared proportionality, dependent on the scheme and service, amongst the parties to the agreement. This supports a general principle that all parties equally contribute effort to the effectively delivery of the schemes

(b) Where the impact is so financially significant that individual bodies could be at financial risk, the parties need to work together to ensure that their service delivery arrangements mitigate the impact as far as is possible.

2. Scope of Agreement

2.1 Only the financial elements of services covered by the Better Care Fund (BCF) are eligible for risk sharing (although there will be flexibility to add to the arrangement subject to agreement by all parties and by approval of the Health and Well Being Board).

2.2 Responsibility for the management of the Better Care Fund that is the Pooled budget is split between the CCGs and The Local Authority by mutual agreement. The assigned responsibility for the different elements of the Pooled budget is shown in pooled budget responsibility table below.

2.3 All parties recognise that risks associated with the Better Care Fund need to be funded by it and not be a pressure on individual organisational budgets outside the Better Care Fund.

2.4 The principle risks to the CCGs are those associated with failure to achieve the savings associated with the delivery of the QIPP schemes incorporated into the BCF and in particular the failure to reduce non elective activity in the acute sector which means that the CCG is also likely to incur additional costs in terms of financial over performance.

2.5 As most of the Better Care Fund has been provided from CCG budgets the principle financial risk to The Local Authority is the failure to earn the performance elements of the fund. In order to fully mitigate this risk for the Local Authority the performance element of the fund is held by the CCGs and is not factored into the BCF schemes expenditure plans. This also avoids the opportunity costs and effort

in trying to earn this additional payment that may be disproportionate to the influence and benefit that the LA can gain from the achievement of the 1.1% reduction in non-elective activity.

3. Risk Categories

3.1 Financial Risk

- Financial overspends on each element of the BCF scheme are the responsibility of the authorising organisation (as set out in the table below) and will not be funded through the BCF, unless agreed by all parties.
- Financial underspends on each element of the BCF scheme will be retained by the Pooled budget for use within the pool in year, and returned to the partners in proportion to their contribution, at year end.
- Under achievement of planned savings and KPIs will be met from contingency and retained performance fund.

3.2 Delivery Risk

The Local Authority and the CCGs are responsible for ensuring that they deliver their inputs required to deliver the BCF KPIs.

3.3 Performance Risk

- Failure to achieve the non-elective admissions reduction will mean that the performance element of the fund is not payable for use on the BCF schemes.
- Achievement will be on a proportionate basis:-

  - 100% achievement — 100% performance fund payable
  - 75-99% achievement — 75% performance fund payable
  - 50-74% achievement — 50% performance fund payable
  - 25-49% achievement — 25% performance fund payable
  - < 25% achievement — No performance fund payable

- The performance fund remaining for non/reduced performance will be used by CCGs to fund associated over performance associated with failure to deliver the non-elective activity reductions in the acute sector, subject to agreement of Health and Wellbeing Board.

3.4 Reputational Risk

- Reputational risk will be managed through an aligned communications and engagement plan.

4. Risk Management Framework& Governance Arrangements

4.1 A comprehensive risk register will be in place to manage or mitigate known and emerging risks associated with the development and implementation of the Better Care Fund Plan.

4.2 Resources to support the development and maintenance of the risk register will be identified by the parties .

4.3 The Risk Log will be reviewed by groups that are responsible for the individual identified risks – e.g. the finance risks will be reviewed on a monthly basis by the finance group who will update the Risk log for the Programme and provide these updates to the Programme manager for inclusion into the Master Risk Log. The Programme Manager has overall responsibility for ensuring the Risk Log is updated regularly and reported to the Integration Board. Significant risks will be escalated to the Partnership Board and the Health and Well Being Board and up to the key decision making bodies in both organisations as appropriate

4.4 The Risk Log will also be reviewed in both health and social care individual governance frameworks.

5. Accounting Arrangements

5.1 In determining the pooled budget arrangements the following factors have been considered

(a) Whether the funds are being transferred or not from health to social care
(b) Who is commissioning the service associated with the budget
(c) Which organisation is providing the resources to run/manage the service
(d) Who are parties to any associated contracts
(e) Which organisation bears the risk of any overspend
(f) Where any cost savings benefit arise
(g) Which staff are involved

5.2 The appropriate accounting standards of each organisation will apply in relation to any joint arrangements that are put in place.

5.3 Each of the CCGs and the Local Authority will recognises its share of the pooled budget in it individual accounts and memorandum accounts will be maintained.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

All parties in West Berkshire are committed to promoting integrated care, and as a result we already have in place a number of integrated teams. The BCF schemes align well and bolster these existing initiatives.

Personal Budgets are embedded into the social care pathway and are utilised extensively across all client groups to enable people to meet their eligible needs in a person centred way. The Care Act reinforces the importance of personal budgets and places them in law for the first time. Personal Budgets can improve outcomes for people, enable them to exercise choice and control and places the person at the centre of their care. The BCF schemes aim to deliver a personalised approach and improved outcomes for people. This natural synergy with the established Personal Budget offer will support people to maintain control over their care and support as far as possible and in turn improve their wellbeing.

The Council has recognised that not all dwellings in the district are 'care ready' to provide a base for care at home as people become frailer, which is part of our Better Care Fund vision. The Council is committed to increasing the supply of Extra Care Housing, over the last 2 years two developments have been completed increasing the number of units by 97. We have a commitment to continue to identify land in the East of our district to increase provision by a further 50 units. Strategic partnerships are being established with supported housing providers and social enterprises to support timely hospital discharge through direct provision for people with complex needs.

Our Better Care Fund proposals are also clearly aligned with the vision that we have for urgent care services going forward. In his report on " Transforming Urgent and Emergency Care Services in England " Sir Bruce Keogh sets out a vision for the NHS to " *provide highly responsive , effective and personalised services outside of hospital for those people with urgent but non-life threatening conditions. These services should deliver care in or as close to people's homes as possible, minimising disruption and inconvenience for patients and their families…."* Both CCGs' Two Year Operational Plans and Five Year Strategic Plans articulate a commitment to working to achieve this vision in partnership with health and social care partners. Strategic oversight for this work is provided by the Urgent Care Programme Board which has representation from health and social care partner organisations. Both CCGs' Two Year Operational Plans and Five Year Strategic Plans articulate a commitment to working to achieve this vision in partnership with health and social care partners. Strategic oversight for this work is provided by the Urgent Care Programme Board which has representation from health and social care partner organisations.

All Urgent Care Programme Board (UCPB) partners have recently contributed to the development of a Berkshire West Operational Resilience and Capacity Plan 2014-15 (ORC) which confirms how the system will work together to manage operational resilience throughout 2014/15. The UCPB and its members have a key role in supporting improved integration between health and social care and improving outcomes for local

people. The ORC Plan demonstrates the clear link between the BCF principles and the wider urgent care agenda and plans for 14-15. Many of the initiatives being funded from national resilience monies will act as a precursor to the BCF schemes.

Other Local Authority plans

Care Act 2014
The Care Act 2014 is the single largest programme of work being currently being undertaken by social care. The focus of this work relates to the first phase of the Care Act changes that come into force on the 1st April 2015. A similar programme of work will be required next year for the 1st April 2016 changes.

The key changes for 1st April 2015 are as follows;;

- New national eligibility criteria (West Berkshire Council currently one of just 3 councils currently operating at 'critical only'.
- New duty to support carers
- New statutory duty to provide preventative services
- Universal deferred payment schemes
- New duties in respect of information and advice
- New duties in respect of market management and dealing with provider failure

Beneath these headline items sits a huge level of detailed new 'must do' duties for councils.

Whilst uncertainty remains around the final guidance the greater concern for West Berkshire Council is the level of funding that will be provided to cover the costs of the changing eligibility criteria.

Plan to refocus Communities Directorate toward Restorative Practice
We recognise that funds will continue to be limited and that the Council will need to move away from a paternalistic approach to a more enabling role, helping people to self manage. Our focus will be on developing community capacity, working collaboratively with the voluntary sector and supporting people to access universal services. We will be seeking to actively promote self-management rather than creating dependency by focusing on traditional approaches.

Voluntary Sector Prospectus
We recognise that the voluntary sector is a valuable resource and have sought to build on this by developing an outcomes based prospectus that allows services to be co-produced and results in longer term agreements providing more confidence about funding.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Integration plays a central part in the **CCG's two year operational plans and five year strategic plans.** We believe that working in partnership is the most effective way for us to ensure that we are providing person–centred, personalised and coordinated care in the most appropriate setting. All the schemes identified in this submission are included within our CCG Operational plan along with other local priorities and projects.

Our unit of planning, for the purposes of our five year Strategic Plans has been agreed with NHS England to be as a "Berkshire West" Economy, The **Five Year Berkshire West Strategic Plan** is our overarching strategy which aligns the Berkshire 10 organisations and our five year plan, this document clearly articulates that the Better Care Fund will act as a key vehicle to lever the transformation of health and social care services in the provision of integrated care and support.

Consequently, a number of our West Berkshire schemes also feature in the Integration programmes described in the BCF submissions for Reading and Wokingham Unitary Authorities. Schemes such as Hospital at Home, Care Home support, Connecting Care, , seven day working in primary care and the Health and Social care Hub appear in all three BCF submissions. This clearly offers us the ability to take forward the integration agenda at pace and scale and provides a catalyst for change. It also allows us the unique opportunity to have the flexibility to design schemes which are specific to our local areas

The BCF has required the formulation of joint plans for integrated health and social care and these plans have been developed through Berkshire West's three local Integration Steering Groups, which include representation from the CCGs, local authorities, health and social care providers and the voluntary sector, and the on-going development of these plans will ensure that there is a system-wide shared view of the shape of future integrated services both at a local and Berkshire wide level.

The West Berkshire Council Strategy 2014-18

The purpose of the Council as stated in the above publication includes the following;

1.Helping you to help yourself – this means enabling people to get access to the information and support they need to help them getting on with living their lives without relying on the direct provision of council services.

Whilst there are clear links with many of the BCF schemes and other BCF spending plans, the alignment is strongest with the following schemes;

BCF01 Community Nurses Directly Commissioning Care / Reablement Services. This scheme will enable both care and reablement services to be in place sooner than at present and will contribute to returning service users maintaining their independence for longer.

BCF02 Health and Social Care Shared Hub – this scheme will improve the 'front door' service provided to residents of West Berkshire. The early provision of good advice and signposting to services will again help residents maintain their independence.

BCF03 Personal Recovery Guides / Keyworker – the aims of this scheme includes helping people to move through the care pathway in a timely manner thus improving their ability to maintain their independence.

BCF05 7 Day Services – enhancing the availability of services across 7 days will play a key role in helping residents of West Berkshire to help themselves.

2. Helping you when you cannot help yourself – this means supporting and protecting the vulnerable in our communities, be they children or adults.

Again there are clear links with many of the BCF schemes and other BCF spending plans, the alignment is strongest with the following schemes;

BCF03 Personal Recovery Guide / Keyworker – this scheme is very much aimed at providing personalised support to patients and service users to help them move smoothly through the care pathway.

BCF05 7 Day Services – enhancing the availability of services across 7 days will play a key role in supporting residents.

BCF07 Enhanced Care and Nursing Home Support – enhanced training of Care and Nursing Home staff will improve the quality of care provided to some of the most vulnerable service users.

3. Helping you to help one another–this means working with and supporting people and communities to achieve their own ambitions

Whilst not scheme specific, the use of the BCF includes protecting existing funding levels for support to carers provided by both the LA and the CCG.

All of the BCF schemes and spending plans align very clearly with the priority of 'Caring for and protecting the vulnerable' set out in the Council Plan.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Newbury & District CCG has submitted an Expression of Interest to NHS England's Area Team to undertake co-commissioning of primary care services from 1st April 2015 with possible shadow arrangements in place in the interim. This was developed through the Primary Care Programme Board which includes GP representatives of each CCG who communicate with other GPs through GP Council structures. The Better Care Fund schemes have also been discussed in both of these forums - at the Primary Care Programme Board and with the GP Councils to ensure the alignment of primary care.

It is envisaged that co-commissioning will underpin integration, encouraging the development of new models of service provision outlined in the BCF. In addition a

number of BCF schemes link closely to the enhanced GP service that is to be delivered through “Transforming Primary Care”. For example, the care home project (BCF07) will also facilitate the Proactive Care programme for over 75s living in residential care.

A further area of the BCF plan that will support the enhanced GP service is the scheme to deliver a much wider and integrated range of seven day services (BCF05). Co-commissioning will support the implementation of this scheme, enabling the CCGs to influence the working hours incorporated into any new GP contracts tendered, there are opportunities to further pool funding with NHS England, for instance that used for the current Extended Hours DES, to better incentivise practices to increase their availability, thereby also mitigating any potential risks associated with practice engagement.

There are a number of risks relating to the involvement of primary care with the BCF schemes, which are captured in the risk log. The main risk is around GP engagement in relation to the schemes – in particular the Care Home scheme and 7 day working scheme. These schemes rely heavily on GP engagement, for example if GPs do not engage with the Care Home scheme, the non-elective admission reductions will not be realised as the service is contingent upon GP participation. To mitigate this risk, we are reviewing GP uptake of these schemes on an ongoing basis, and where this is falling short; we will proactively engage GPs to ensure that they participate with the schemes. To help ensure participation, the BCF is an ongoing agenda item at the Primary Care Programme Board.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

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.

West Berkshire Council is committed to delivering the good quality affordable services to residents who have care or support needs. The Council is committed to working with its partners (particularly the voluntary sector, local providers of care and the NHS) to develop services for residents that help people live as independently as possible with minimal interference.

We will deliver a fair system of Social Care where the resources that are offered relate to the level of assessed needs a person might have and where their contribution towards the costs of that care clearly relates to their ability to pay. On the 1st April 2015 West Berkshire will make a significant move from its current eligibility threshold (set at supporting those who face a 'critical risk to their wellbeing or independence) to the new national eligibility criteria. This move will result in both more residents being supported and the level of such support being greater.

We will promote health and well-being through the effective development of universal services. We will draw on community and neighbourhood based resources to help people with lower support needs (and their carers) to remain living safely at home. We will give priority in our future service delivery to helping people recover, recuperate, and rehabilitate so that they are able to live as independently as possible. We will ensure that all staff (Health and Social Care) and providers understand how to work with service users in ways that promote their independence, ensure their safety and support their recovery.

We will promote a 'whole family' approach that seeks to promote great outcomes for children by supporting their parents. We will develop staff awareness and expertise in

dealing with issues like domestic violence, mental ill health and substance misuse that can prevent adults from nurturing children. We will also plan good transitions from Children's Services to Adult Services for both service users and young carers.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Adult Social Care has to provide a range of statutory services to all residents who are eligible under the existing Fair Access To Care criteria; for West Berkshire these services are currently only provided to residents meeting the 'Critical' criteria (West Berkshire is one of just 3 Local Authorities in England operating at this level). From April 2015 the Care Act 2014 will introduce a new national minimum eligibility criteria that is expected to be something akin to the existing 'Substantial' level. This will impact on social care in West Berkshire very significantly and result in a far greater number of residents being entitled to receive support from the Council and the level of those support packages to be far greater. In accordance with the guidance, a significant element of the BCF will be used to support the Council in meeting the key new duties (eligibility & support for carers) of the Care Act 2014.

BCF03 – The Personal Recovery Guide / Key Worker scheme will contribute to the protection of social care but minimising the period a person stays in hospital. Independent evidence shows that the longer a person remains in hospital the quicker their condition deteriorates and the more dependent they become on long term social care. Ensuring unnecessary delays are avoided should place downward pressure on social care costs. If successful in the hospitals, the intention would be to expand the scheme into community based services with the aim of moving residents through what can be a complicated pathway as efficiently as possible. Again this should help residents maintain their independence and become less reliant on social care services.

BCF04 – The Joint Provider scheme, bringing together the separate care assessment and delivery units operated by the local authority and the Berkshire Health Foundation Trust, will provide a more efficient service therefore maximising the use of the pooled resources. It will offer increased opportunities to manage the external provider market more effectively and therefore allow the diminishing social care budgets to be utilised to provide the maximum benefits. The BCF will also protect social care by enabling the planned budget reduction for its reablement function to be cancelled thereby protecting this valued service.

BCF05 – 7 Day Services, whilst social care already provides a range of 7 Day Services, anything that enables their further development and integration with the Health offering would protect social care. Avoiding hospital admissions and the early discharge of patients to social care would place downward pressure on the level of ongoing social care required.

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. The DFG also allows significant adaptation of existing housing stock to meet the needs of individual social care clients.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The total sum allocated from the BCF to protect adult social care services is £3.7m. This includes protecting existing S256 funding for preventative services and supporting carers, funding to maintain reablement services at present levels and also a contribution towards those significant new duties under the Care Act 2014 defined in the BCF guidance. As one of the 3 local authorities in England currently operating an eligibility level of 'critical only' the proportion of the £135m national sum is woefully inadequate to meet the new demands faced by adult social care in West Berkshire.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met.

At present, with the final version of the Care Act guidance not expected until October / November 2014 and significant uncertainty over the level of funding to be provided it is very difficult how the new Care Act 2014 duties will be met. As already highlighted the financial implications of the change to the eligibly criteria are a particular concern due to the uncertainty around the level of funding to be provided.

From an operational viewpoint, a Care Act work programme has been established and significant numbers of staff are engaged in theme based projects to ensure new duties will be met. A formal programme management methodology has been adopted including a governance structure that includes both senior officers and senior elected Members.
At the senior levels staff working on the preparation for the implementation of the Care Act are linked into the BCF programme through regular meetings at project, finance and programme levels. Progress, issues and risks are reported regularly to the Programme Board.

In addition to the local implementation arrangements, a Berkshire wide Care Act leads group has been established to share ideas / issues and also to jointly commission services where appropriate.

As a locality within Berkshire West we are part of an area wide integration programme which aims to promote integrated commissioning and delivery across the whole health and social care system. The Better Care Fund is a source of funding within this wider integration programme. The priorities of the programme are to deliver better outcomes for individuals within a sustainable health and social care economy.

The full integration programme is underpinned by the need to address the duties of the Care Act. It also addresses ongoing work which has taken place within the whole system on an agreed frail elderly care pathway. This process seeks to prevent, delay and, reduce needs and to reduce delayed discharge from care through a whole system response to care closer to home. It is thus closely interlinked with the Care Act duties.

In addition to the specific projects within the Better Care Fund, the wider integration

programme has been designed to take account of the new duties set out within the Care Act. There are work streams within the programme that support a whole system approach to market management, carers and workforce development which in turn contribute to delivering against Care Act duties.

v) Please specify the level of resource that will be dedicated to carer-specific support –

We recognise the significance of supporting carers within an integrated care system, particularly through ensuring they are able to take breaks from caring. This is a key preventative service which helps keep carers themselves and those they support, well and out of hospital.

Carers have comparatively poor health, which is recognised as a critical public health issue. They are a high risk population as they tend to neglect their own health; sometimes for practical reasons (like not being able to leave the home to attend appointments or hospital treatment) and sometimes simply because their sole focus is caring for the person they are looking after. They often do not even notice their own health is deteriorating. Carers may also forget to make or miss routine health appointments like 'flu vaccinations or check-ups with doctors or dentists. Caring can also limit carers' ability to take time out to exercise. Reduced income and lack of cooking skills may contribute to excess weight gain or loss. As many as 20% of adult carers increase their alcohol consumption as a coping strategy. Emotional impacts such as worry, depression and self-harm have been identified in both adult and young carers.

A total of £738k from the Better Care Fund will be dedicated to carer specific support

Existing s256 agreement has £417k that is dedicated to support Carers	This used to fund a range of support services to carers delivered by the voluntary sector, these are accessible whether they meet the Council's eligibility criteria or not.
CCG passport a further £321k, via a s256 agreement, to the Council	Used to fund a range of services to prevent carer breakdown including respite services.

The Carer specific support will entail the following:

Carers Assessments

The Care Act introduces a new obligation on the local authority to offer all carers an assessment on the appearance of need, including additional entitlements for young carers and parent carers of disabled children to receive carer assessments. The carer assessment is an opportunity for the carer to consider how caring impacts on them, how they can be supported to care and to enjoy a life outside caring. It is an important element in ensuring that many people with care needs can be supported informally and so stay safe and well at home for longer.

We have used the 'Lincolnshire model' to estimate the cost of delivering additional carer assessments to meet the local authority's extended duties in this respect from April 2015. The additional assessment costs are expected to be £117k p.a.

Support Packages for Carers Eligible for Adult Social Care

The Care Act also introduces a new entitlement for carers to receive services in their own right, provided they meet new national eligibility criteria. This is currently a discretionary provision, and adult carers in West Berkshire are able to apply for grants to be spent on alleviating the stain of caring. Both health and social care funding are applied to this service, with a Section 256 agreement in place relating to the relevant CCG funding transfers to the local authority.

Again using the Lincolnshire modelling tool, we estimate that the additional cost of meeting this statutory obligation in West Berkshire will be £585k p.a. from 2015.

Information & Advice for Carers

The CCG and local authority collectively contribute £136k p.a. towards a carer information advice and support service which is jointly commissioned across Berkshire West (i.e. with neighbouring local authorities and CCGs as additional commissioning partners). This provides an initial information and contact point for any carer, whether or not eligible for statutory services, and supports carers to connect with further guidance and services relevant to their particular situation or current priorities. The service is designed to prevent carers' own support needs from escalating, and hence to reduce or delay the level of formal care required by those supported by family/unpaid carers.

Carers Community-Based Services

We fund a wide range of carers support services to prevent carer breakdown including sitting services and crisis response.

Other Community Support for Carers

NHS Berkshire West Clinical Commissioning Groups (CCGs) currently commissions Carers services through Section 256 agreements of the National Service Act 2006 to fund a range of services described as 'carers respite' through the 3 local authorities and jointly funds information, advice and support through Berkshire Carers. The CCG also has a contract with Berkshire Healthcare Foundation Trust to support Carers activities as well as commissioning a range of services through the Partnership development fund.

Future Aspirations

A Berkshire West Carer Commissioning Forum has been established to oversee the future commissioning and development of carer support across Berkshire West. This is identified as one of the enabling work streams within our integration programme, and is being led by the CCG Director of Joint Commissioning. This Forum will ensure that carer specific resource identified within the Better Care Fund allocations is used effectively to improve outcomes for carers. The Forum will lead on the development of strategic plans

and commissioning arrangements for supporting carers across Berkshire West, and also inform the development of other plans and arrangements which have the potential to improve outcomes for carers. The Berkshire West CCGs investment of £120k in twilight nursing, for example, whilst retained within a block contracting arrangement covering wider provision, comes within the remit of the Berkshire West Carer Commissioning Forum to scrutinise.

We are committed to promoting choice for carers as well as service users, the Care Act allows joint health and social care personal budgets and we will aim to use this flexibly. We also recognise that there is still a need for some joint services and we continue to jointly commission services where it makes sense to offer a consistent range of services, particularly to improve the experience of carers supporting others across local authority boundaries.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

Since the original BCF plan was submitted the modelling of the costs of the Care Act has continually been developed using information and guidance coming from both the DH and the numerous models being promoted by DH, LGA and ADASS.

The funding level required to protect adult social cares services and to fund the Care Act costs remains significantly (£4m) above any identified sources of funding at the present time. The need for West Berkshire Council to change its social care eligibility criteria is the key issue and until there is certainty around the level of government funding this remains a significant financial risk for social care.

The Council is aware of the level of the risk arising from the Care Act and also the Government's stated commitment to fund the implications in full.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

We are committed to planning jointly across the health system to increase availability of services at weekends. West Berkshire Council and the CCG already provides and funds a large range of services on a 7 day basis but through the Better Care Fund 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.

Currently within Newbury & District CCG a number of services are working extended hours. Berkshire Healthcare Foundation Trust provides community nursing 24 hours a day, 7 days a week. Other services such as Intermediate Care, Rapid Response run a 7-

day service (but not 24hrs)

West Berkshire Council has an Extended Hours Service provided by the In House Domiciliary Care Service 6am to 11pm 7 days per week; this initially provides care in urgent circumstances, for example for avoidance of admissions into Care Homes or Hospitals; it could provide support where a carer becomes unwell; it may also deal with urgent referrals being passed over from health services. The service will also expedite discharges from hospitals either through the Council's direct service or through a care provider which is already supporting an individual. Planned admissions to care homes or to domiciliary care agencies following a hospital assessment can be effected at weekends on a limited basis.

Whilst we have a distinct BCF scheme for 7 Day Services (BCF05) all of other BCF schemes will contribute to the enhancement of our existing 7 day arrangements. The planned enhancement of these arrangements will be underpinned by our 7 day health and social care hub (BCF02), a single point of access to health and social care that will signpost professionals and patients throughout the whole week.

Delivery of the 7 day working arrangements will be ensured through the implementation plan (scheme BCF05) and governance arrangements overseen by the Health and Wellbeing Board. All changes will need to be developed in partnership to ensure that services are coordinated and therefore provide a clear care pathway for the local community and also deliver best value for the investment being made from the BCF.

We have a 7 day working CQUIN with our main acute provider to deliver the following;

> 75% of patients admitted as an emergency by A&E or directly from the community must have been assessed face to face by a consultant and documented within 14 hours of admission to the hospital.

This CQUIN will support a move towards an equitable service on weekends and weekdays in terms of consultant cover and assessment for patients.

We are also in the process of agreeing a Service Development & Improvement Plan (SDIP) with the main acute provider to ensure a clear and robust plan is in place to determine what level of services each department will be required to deliver 7 days a week by when with clear milestones and deliverables included.

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c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

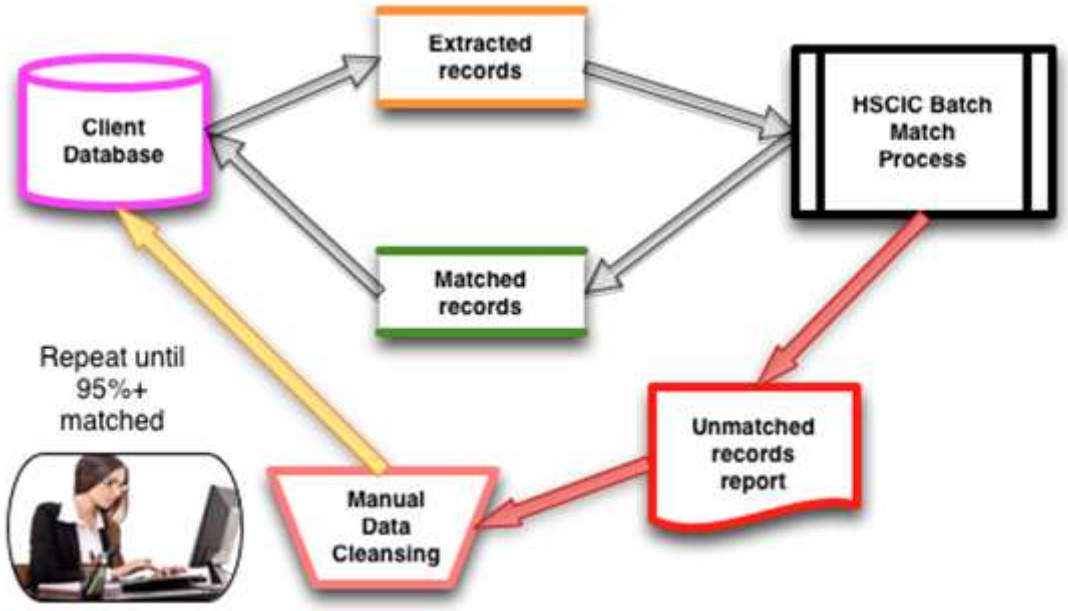
The NHS number as the primary identifier for correspondence will be implemented by April 2015. This will be critical to the success of our system wide Interoperability initiative (Berkshire West – Connected Care)

A project group has been established to oversee the implementation of NHS Number throughout the Berkshire West system, led by Reading Borough Council, reporting to the

Berkshire West Interoperability Programme Board. This group will oversee the delivery of the plan and milestones. The key actions in place for primary identifier:

1. Royal Berkshire Foundation Trust, Berkshire healthcare Foundation Trust to ensure all patient communication to include NHS Number by April 2015

2. Reading, Wokingham and West Berkshire Local Authority Board adopt the process of Batch Matching through Demographic Batching System, commencing in October 2014, as demonstrated below



A West of Berkshire project manager has been identified to help not only with the NHS numbers but also the broader issues relating to interoperability and data sharing.

Ensuring health and social care professionals have access to accurate and timely information regarding patients /clients by facilitating the sharing of information will be an important enabler to the success of our BCF schemes. IT interoperability is critical to improving the quality and experience of care that service users receive, removing silos to ensure that all professionals have access to comprehensive records and that patients /clients only have to tell their story once.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Through the Berkshire West Interoperability Programme Board an Application Programming Interface (API) is being pursued, as part of the Connecting Care project, a key enabler to the delivery of the Better Care Fund schemes. This project aims to remove the IT silos that exist in health and social care and has the ultimate aim of ensuring that

patient information and social care records will be accessible to all who need them.

The Interoperability programme Board has engaged with IT development partners (Central Southern Commissioning Support Unit) to undertake work on the feasibility of a 'medical interoperability gateway' which will provide a greatly enhanced information sharing of records providing access to live data on various systems in use across the local health and social care sector.

A proposed IT solution has been identified and phases for connectivity determined, starting with GPs and out of hours services in October, followed by key NHS Trusts in December, and then in phase 3 . Connections with the individual social care systems have been agreed for consideration.

Appropriate information sharing agreements are being developed through this project. The CCGs across Berkshire West have moved to a system of secure email for all communications within and across partner organisations in addition to the use of GCSX.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott2.

There is a firm commitment to ensuring appropriate IG controls.

We acknowledge and support the findings of the Caldicott 2 review and the inclusion of the new 7th Principle. In terms of the 26 Recommendations arising from the report the Berkshire West System partners (Acute, Community, CCG, LA) already comply or we are working actively to address these areas together between and across health and social care. The key areas which require new protocols and information systems to support them are common to all UK Health services and Local Authorities and we are forward thinking in our approach to resolving them.

To ensure adherence to these controls each organisation operates its own Information Security Policy underpinned by legislation which details principles used for data sharing. This includes:

- Protection against unauthorised access
- Availability of information to authorised users when needed e.g. for the benefit of the service user or patient
- Maintaining confidentiality of information
- Integrity of information through protection from unauthorised modification.
- Ensuring regulatory and legislative requirements will be met as a result of robust policies and procedures and training for staff

There is a commitment to creating a joint framework across the organisations by October 2014 through the establishment of joint Informatics governance group. This will build on the Berkshire NHS "Overarching Policy for sharing personal information Between Organisations 2010."

West Berkshire Council has adopted an Access to Information policy the purpose of which is to ensure that it complies with the requirements of the existing access to information legislation, including the Data Protection Act 1998, the Freedom of Information Act 2000, the Environmental Information Regulations 2004, and the Local Government Act 1972 Schedule 12A, and with any subsequent legislation. This policy is supported by an ongoing programme of mandatory staff training.

In order to share information with Health West Berkshire Council needs to undertake two key steps;

- A need to adopt NHS IG standards. This will involve a major project to identify how the council's existing policy differs from the NHS IG requirements and implement a programme of work to deliver any changes that are required. There will also be a need to identify if the NHS IG standard falls short of the Council's requirements in any area. This work will be undertaken as part of the Berkshire West Interoperability Project

- The Care Management system used by West Berkshire Council is coming towards the end of its life. The BCF requirements around data sharing have hastened the need for the Council to make a major investment in new software. This work is being progressed through the usual Council approval process.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

West Berkshire patients have been identified as being at high risk of hospital admission in 2014/15. The criteria defined within the national Directed Enhanced Service for Unplanned Admissions, the top 2% of registered patients aged over 18 and at the highest risk of an unplanned admission, has been used to identify these patients.

The risk stratification approach used to identify the 2% of patients at the highest risk of an unplanned admission was done through the use of the ACG tool which identifies characteristics such as condition and utilisation of healthcare resources (excluding community and social care data) to stratify those at risk. The ACG model is underpinned by clinical algorithms and is driven by each patient's diagnostic and prescribing records. The ACG tool also clusters co-morbidity and compounded impact on resource needs.

The success of using this tool is evidence through work conducted in 2012/13. At this time patients lower down the risk pyramid were identified by recent presentations at A&E alongside local intelligence from health and social care services. This was known locally as our care coordination project which was designed to minimise the risk of increased resource use by these patients and to reduce hospital unplanned admissions. Developing this multidisciplinary approach enabled us to proactively identify management strategies to avoid increased use of resources and was a valuable first step to providing more integrated care co-ordination across health and social care.

Multi- disciplinary team meetings (MDTs) are the centre of providing local integration with health and social care teams, and have enabled joint patients review and joint planning to support the reduction in unnecessary admissions to hospital by improving preventative clinical care.

Patients with LTC and those who are a high risk of being admitted to hospital have been identified via the ACG risk satisfaction tool and discussed at the a MDT meeting by key professional including community health staff, primary care, social care, medicine manager and voluntary sector and a health improvement plan is put in place.

A lead professional is named for each patient to ensure the effective delivery of actions form health improvement plan and co-ordinate integrated services when there are a number of professionals/service involved

We are committed to ensuring that there is joint assessment and accountable lead professionals and our further plans will detail how we will achieve this. In the Newbury & District CCG area joint care lead training will take place over the next year.

Monthly multi-disciplinary team (MDT) meetings in GP surgeries are used to identify people at high risk of hospital admission or of needing long term care, and to develop a preventative plan, with the appropriate organisation taking the lead for the plan. MDTs are attended by GPs, Community Health staff and social care staff.

We recognise the role of GP practices in taking the lead professional role, but also the importance of social care and health professionals in supporting coordinated care and support plans. We are working on plans to deliver a model of accountable lead professional, focused on those most in need. The Hospital at Home team and Integrated Short Term Health and Social care team developments will support those most at risk by providing a coordinated, timely care plan.

Through the governance arrangements being put in place, the implementation of the schemes outlined in this paper will be overseen by senior professional from across both health and social care. The integration changes envisaged will strengthen the joint assessment arrangements, simplify procedures and allow for clearer identification of the appropriate lead professional.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

The Case Coordination Model as described in i) above has been operating for 12 months in the Newbury and District CCG surgeries and jointly identifies risk for a small number of key patients constructing joint support solutions to minimise the risk of Care Home or Hospital admissions.

Locally, outside of the BCF programme, we have invested our £5/head funding for GP's as the Accountable Health Professional for the over 75 year olds within practices to further drive and support this work. This will ensure all care plans are uploaded onto a central repository, for access by multiple organisations, provide further support in the form of administrators and health professionals for the delivery of the admissions avoidance DES and a commitment to develop 50% of care plans following a face to face

consultation for over 75 year olds who are also in the top 2% risk category.

The named accountable GP is responsible for ensuring the creation of the personalised care plan and the appointment of a care co-ordinator (if different to the named accountable GP). The named GP will also maintain overall accountability for ensuring that the personalised care plan is being delivered and patient care, including the personalised care plan, is being reviewed as necessary. A number of patients within this cohort will have dementia or mental health problems and the lead professional will be responsible for ensuring that these patients have a personalised care plan and that they and their carers are closely involved in the development and implementation of the plan, as described above. This will be particularly beneficial for these groups, ensuring that proactive care is given, rather than responding to crisis.

The lead professional will be supported in their role by a practice team made up of a mixture of clinical and administrative roles. They will act as the main point of contact for the patients and their families. They will support clinicians in following up referrals/results/investigations/letters and liaising with other health and social professionals and they will make regular telephone contact with patients, carers and families to update them on progress of their care plan (this might be general health status or after a particular acute event such a bereavement). This may be as agreed in healthcare plans or simply courtesy calls. Many frail elderly do not have family who live locally and this would improve the quality of care delivered and provide comfort to relatives that their loved ones are in safe hands.

This dedicated resource should provide focus and continuity of care for patients and their carers/families and provide them with assurance that their concerns and issues can easily be resolved with minimal fuss. They will facilitate navigation from the Practice reception service to the right person who can take immediate action when required, and support the GP in prioritising responses, to ensure that any problems are dealt with appropriately. They will also ensure that care for the patient is coordinated across all health and social agencies involved in the care of the patient.

Practices are required to assess the impact that the scheme has on the care of these vulnerable patients. It is expected that this will be discussed at regular practice meetings and there will be a specific practice review meeting, involving all clinicians in the practice at year end to assess the impact on patient care and outcomes. As part of this, the practice will consider the results of the annual patient/carer satisfaction survey which will be developed in consultation with the practice patient group.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

Data required

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

The views of patients, service users and the public have been critical to shaping this plan. Members of the public have shared their experiences of local health and social care, and their aspirations for the future. This has given us a firm mandate to develop integrated services with the individual at the centre. The distinction between health and social care makes no sense to the people who need support. They perceive the hand-offs between health and social care as unnecessary bureaucracy standing in the way of them receiving the services they need.

Consultation and engagement has been through a variety of methods, most noticeably through NHS 'Call to Action' events which have featured both CCG and West Berkshire Council collaboration. 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.

Call to Action 20 March 2014, Visual Minutes

Working in partnership, health and social care came together in March 2014 to set up and run a 'pop up shop' called Wellbeing in West Berkshire in the Kennet Centre, Newbury. This unique and innovative engagement with the public afforded us an opportunity to listen to patient and public views on integrated services, and also allowed health and social care partners to provide high quality and tailored information on local services to those who visited the pop-up shop.

We also attended both the Newbury Culture Festival (July 2014) and Newbury Youth Festival (August 2014), engaging with a more diverse and younger audience around their

health and social care expectations.

Going forward, we will proactively engage with a wider range of community forums to reach those who may identify more readily with neighbourhood, cultural or other interest groups. Both the local authority and the CCGs have in the past taken part in local festivals to raise awareness of services or proposed changes to these. This has been highly successful in reaching large numbers of people. Our communications and engagement strategy therefore identifies opportunities for interactions in places the public is naturally drawn to; for example, shopping centres, supermarkets, town centres and a vast range of summer and winter festivals and carnivals. Average attendance by number and demographic profile is being mapped so that our integration programme makes best use of the various opportunities for public engagement as are most appropriate for different aspects of the programme.
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 Panel Group has also been consulted on plan developments.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

We recognise the need to work across health and social care boundaries in order to move towards our vision of fully integrated health and social care for the residents of Newbury & District. GP Commissioners and providers have come together to develop the vision and schemes described in this plan, including developing our understanding of the behavioural and attitudinal shifts needed to achieve real and lasting change. Lead Members for Health and for Adult Social Care within the local authority have been closely involved in the preparation of this submission. Through them, commitments have been secured from across the Council to enable us to draw on a range of services which can support and promote wellbeing for local residents.

This submission has been developed over a series of meetings involving community health providers, Social Care and Primary Care and also discussed at the West Berkshire Integration Steering Group. These meetings have acted as a local catalyst to co-develop new programmes, drawing on provider views about local pressures and opportunities to work differently to achieve better outcomes.

Early development plans have been shared with Royal Berkshire Hospital through a Berkshire West planning meeting, which included acute and provider sector organisations and their input has been taken into account. We will continue to involve them in our plans going forwards.

The main local NHS Providers Berkshire Healthcare Foundation Trust and Royal Berkshire Hospital Foundation Trust have been engaged in the development of all the schemes. Both clinicians and managers from the Trusts have played into the

development of business cases and models of care delivery. Hampshire Hospitals NHS Foundation Trust are now members of the Berkshire West Integration Steering Group, reflecting patient flows from Newbury & District towards Basingstoke. Plans are also in place to involve the Great Western Hospital.

Developing and refining our Better Care Fund projects will continue to be undertaken via whole system workshops including key stakeholders.

The main local acute provider Royal Berkshire Hospital Foundation Trust is aligned to the figures, as outlined in Annex 2. This will be reflected in the 2015/16 operational plan that is currently in development.

ii) primary care providers

Primary care providers have been engaged in the development of the BCF plan through discussion at the Newbury & District CCG Council of Practices. These discussions were informed by feedback from the GP lead who attends both the West Berkshire Health & Wellbeing Board and the West Berkshire Integration Steering Group.

Likewise the CCG's Council of Practices has a representative on the Primary Care Programme Board (which meets every four weeks), through which the primary care aspects of the BCF plan, such as 7 day working (BCF05), and the Care Homes project (BCF07) have been developed.

These engagement mechanisms will continue as the plan moves into the implementation stage, and the various BCF schemes are discussed on an ongoing basis.

iii) social care and providers from the voluntary and community sector

Representatives from the independent and voluntary sector were involved in the Call to action events and have commented on the locality's proposals. We have established provider forums and these will be used to inform integration work ongoing.

c) Implications for acute providers

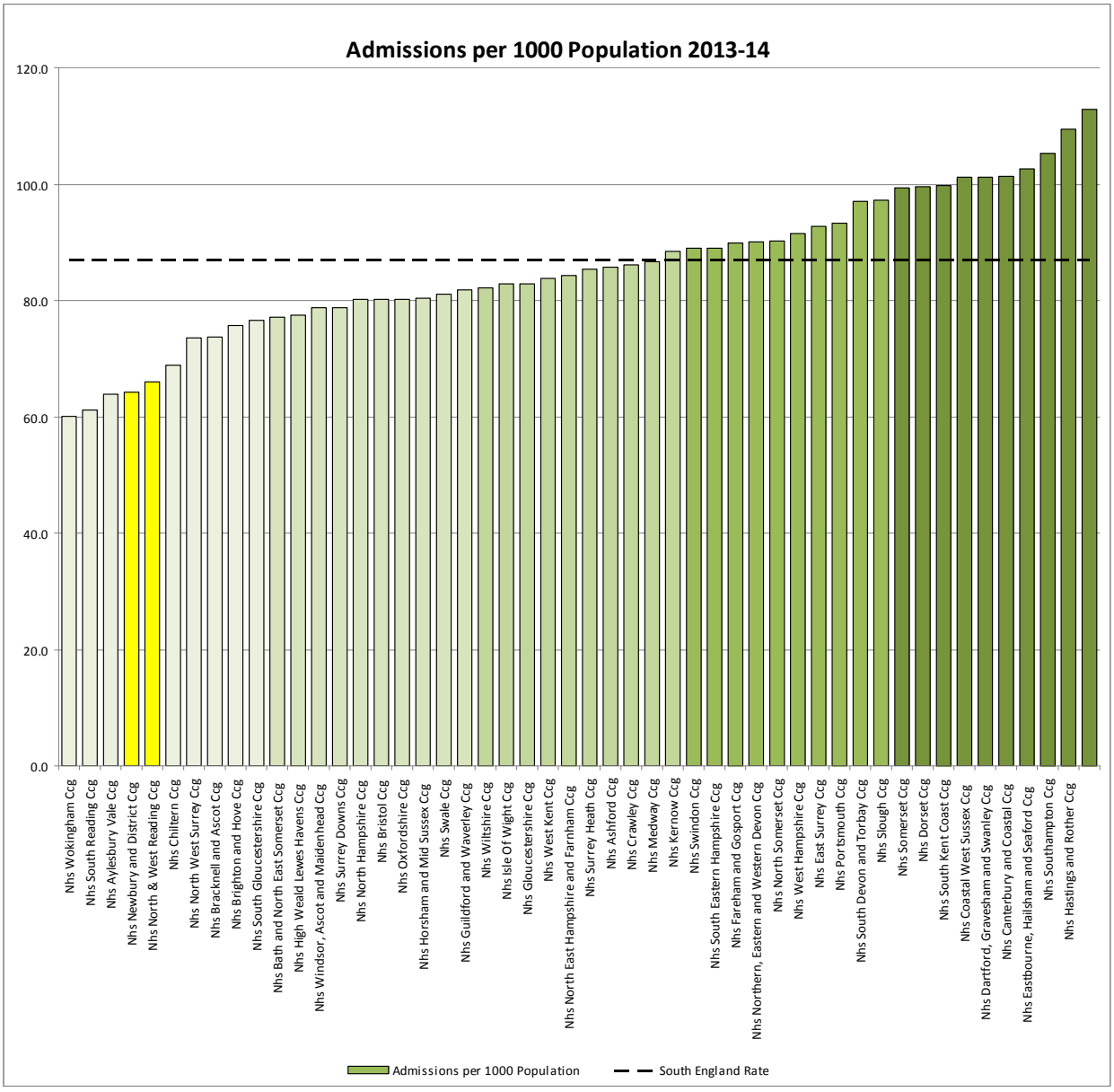
Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The BCF schemes are intended to transform the pattern of activity in West Berkshire reducing non elective admissions, delayed transfers of care and admissions into care placements.

Extensive work has been done to model the impact of the schemes on non-elective admissions. As a result of the plans in place, non-elective admissions will reduce by <1.1%> in 2015/16 vs. 2014/15.

Although this is not at the 3.5% target, this is a very ambitious plan, given that Newbury & District CCG is already in the top performers for non-elective admissions in the South of England:



The graph shows non-elective admissions per 100,000 population for the South of England. The two West Berkshire CCGs are highlighted in yellow and as can be seen are in the upper quintile of the South of England. The rates of non-elective admissions have been increasing year on year for the last 3 years which would again suggest a large reduction in rates would not be possible.

The H&WB has forecast 4% growth in non-elective admissions for 2015/16 based on population growth and population change relating to an ageing population. After extensive modelling of the schemes, ensuring that there is no double counting, these result in an expected net reduction of 1.1% in non-elective admissions in 2015/16

compared with 2014/15 forecast outturn.

In addition to this there are a number of other metrics that the schemes will affect, which will impact on the income and activity of the acute providers, around key areas including delayed transfers of care, reablement, and A&E attendances.

In line with the in depth analysis that we have done to reach our non-elective reduction, we are now modelling the other impacts of all schemes, in granular detail in order to accurately model the impact on the acute sector. This is currently a work in progress, but we anticipate we will have this finalised with the acute sector in line with the business cycle.

The 2014/15 impact has already been modelled into this year's contract, and we would expect through our contracting conversations for 2015/16. We would expect that where there is an indicated reduction in non-elective activity, we will be building these reductions into the RBH contract for next year, and we would expect that these would be reflected in their 2015/16 operating plan.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
BCF01
Scheme name
Community Nurses Directly Commissioning Care / Reablement Services
What is the strategic objective of this scheme?
The scheme aims to significantly reduce the time taken from a District Nurse identifying a social care need to that care being in place. The early provision of care will minimise the risk of loss of independence and the resulting need for higher levels of care. The local authority agreeing to health staff directly commissioning services on its behalf will allow the removal of a number of layers of the existing process thus reducing the bureaucratic burden on front line staff.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
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 District Nurse. Currently if a District 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 District 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 District 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, WBC's physical disability team will aim to build upon joint working with Health's Long Term conditions teams to progress integration further. Process development: • Identification of range of Health Clinicians from Unscheduled Services under the scheme • Training of Health Professionals • Health Professionals will commission services directly to provide a prompt response to patient needs, and therefore there should not be any ongoing cost implications • In the first few days of the service Council staff will assess the suitability of the service as an ongoing commitment, consider any equipment needs, confirm eligibility, and confirm the individual's personal budget as the ongoing funding source for care; this will establish the standard controls that are used for the Council's commissioning budgets

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This service will be jointly commissioned by West Berkshire Council and Berkshire Healthcare Foundation Trust. West Berkshire Council will be the main provider for the service

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

A review of the existing process from a District Nurse identifying a social care need to the care being put in place identifies layers of the process that are only in place to avoid a situation whereby the health professional would be committing social care to expenditure.

Social care accepting the professional judgement of the District Nurse and allowing them to determine the initial social care needs of there patient it would enable a far simpler and speedy process that would benefit all.

The expected outcomes would be;
- The District Nurse would only need to make a single call
- Social care 'control' stages could be removed
- The patient / service user would benefit from the social care package being in place far sooner.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The impact of this scheme will not be able to be measured by any metric nor is expected to deliver cashable savings. It will however deliver a better outcome for the service user and will reduce the administrative burden placed on District Nurses freeing up time to do what is important.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- The key measure of the scheme will be feedback from the District Nurses regarding the effectiveness of the new process for requesting social care for their patients. A mechanism for gathering this feedback will be agreed with the Berkshire Health Foundation Trust.
- The local authority will monitor the consistency of District Nurse initiated services with the social care eligibility regulations.

It is recognised that, as with most new arrangements, the processes are likely to require adjustment once they have been live for a period of time.

What are the key success factors for implementation of this scheme?
• Shared vision from staff from all organisations involved in the current process • Agreement on new processes • Training of District Nurses to ensure consistent understanding of the new national social care eligibility criteria.

Scheme ref no.
BCF02
Scheme name
Berkshire West Health & Social Care Hub
What is the strategic objective of this scheme?
To improve the communication between the individual, their family, carers and health and social care professionals. The aim is to create an effective integrated single point of access for health and social care across West Berkshire, Reading and Wokingham by: • providing one centralised point of contact for patients, service users and health/social care professionals, available 24/7; and, • developing a model that provides a simplified processes, a consistent approach, less bureaucracy and less duplication.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
There are currently around 56 different points of access to care across Berkshire West, all with different arrangements and resources, using different referral criteria for eligibility into specific services. Few of the existing points of access are available 24/7. This creates inconsistency, fragmentation and duplication. The aim is to create a model of referral and assessment that moves from a fragmented set of health and social care services to a co-ordinated service that is easily accessible through a single point. It will build on and integrate with the newly established Berkshire-wide Health Hub and on the “Berkshire 10” system wide approach to integration. A Berkshire West Health Hub, hosted by Berkshire Healthcare Trust, our community and mental health provider, has been operating for some time and is demonstrating efficiency benefits for the staff as well as improving delays in discharge, evidenced by a reducing “Fit To Go list” within the acute sector. The aim will be to replicate some of these gains into the new single point of access health and social care hub. Detailed work is underway through consultation and engagement with all key stakeholders to scope out, plan and develop an integrated single point of access Health and Social Care Hub across Berkshire West. This will include mapping of existing patient flows with the aim of improving efficiency and productivity. The service will operate throughout the week providing a 7-day service, 24 hours a day. As part of the detailed scoping work, the Project Board will explore options relating to who will deliver the Integrated Health and Social Care Hub and from where – e.g.: it could be incorporated into the existing health hub run by BHFT or into one of the existing points of access run by one of the local authorities.

It is important to recognise that the development of an integrated single point of access Health and Social Care Hub will require a significant culture shift to achieve better collaboration, partnership working and integration, not only across local government and the local NHS at all levels but also across and between the three localities in Berkshire West. There will be a need for staff to embrace change and to focus on doing things differently and not just delivering more of the same.

This initiative will align with the frail elderly pathway work, and will be closely interrelated with a number of other BCF schemes.

- The Berkshire West Connecting Care IT solution - true interoperability will significantly enhance the efficiency and effectiveness of the Hub.
- A 24/7 single point of access for health and social care will support the implementation of neighbourhood working and increased GP access over the week by providing an effective and timely resource for triage, provision of advice, information, support and signposting and so potentially reducing delay in the management of referrals.

It is proposed to target patients and services users most likely to benefit: i.e. those in high risk groups with complex health and social care needs and with multiple long term conditions, with the intention of reducing the occurrence of additional health problems in this group and supporting them to achieve greater control and ability to manage their health and social care.

The volume of patients that will benefit from this scheme is yet to be determined, as the detailed design of hub has not yet been agreed. However it is anticipated that the 2% with high risk of unplanned admissions will be included. The baseline will be determined from the current activity through the Health Hub, West Berkshire Council and all other main points of entry into the system.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The delivery of this scheme will be designed, managed and controlled by a dedicated Integrated Health & Social Care Hub project board, reporting to the Berkshire West Partnership Board and the West of Berkshire Integration Programme Board.

The aim is to establish the Hub by June 2015.

A key part of the detailed planning will involve the key stakeholders, the Berkshire West Partnership Board and the West of Berkshire Integration Programme Board agreeing the commissioner(s), budget, performance metrics and management structure for the Hub.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

A lack of joined-up care has been described by National Voices as a huge frustration for patients, service users and carers. (National Voices 2011). Emerging evidence suggests that developing an integrated single point of access health and social care hub where services are co-located (either virtually or in reality) is more convenient for users, and has

the potential to help enable more integrated and timely care (Imison *et al* 2008).

Reviews by The King's Fund and the Nuffield Trust of the research evidence conclude that significant benefits can arise from the integration of services where these are targeted at those client groups for whom care is currently poorly co-ordinated (Curry and Ham 2010; Goodwin and Smith 2011; Ham *et al* 2011b; Rosen *et al* 2011).

The literature confirms that focusing on patients at highest risk leads to better outcomes (Hofmarcher, Oxley and Rusticelli, 2007) and that focusing on improving patient care helps to overcome professional boundaries for staff working in an integrated and collaborative structure (Heenan and Birrell, 2006).

The provision of information and support for patients / carers / members of the public through a single point of contact will create better informed service users. Being informed is a prerequisite to being involved and engaged, and there is a growing consensus that more engaged patients experience better outcomes (Health Education England, 2014).

The establishment of a single point of access for health and social care in conjunction with other transformational improvement schemes is identified as being best practice, as demonstrated by initiatives across the country, eg: NHS North West London, Torbay & Southern Devon Care Trust, Bridgewater Community Health NHS FT. However, many of these initiatives have yet to publish robust, evidence based evaluations of their impact. In addition, as most of the initiatives include a number of different improvement schemes, it is not yet possible to identify with certainty the unique impact of developing a single point of access health and social care hub.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Improved communication, transmission of information and data sharing within and between health and social care teams across all 3 localities
- Faster response times which should reduce delays in referrals and should expedite discharge by facilitating the co-ordination of timely support and care
- Contributing to enhancing patient and service user satisfaction as the difficulties and frustrations they experience in navigating a complex and un-coordinated health and social care system will be reduced if not removed entirely
- Assist the acute unit in achieving greater efficiencies through improved patient flows

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

During development of this scheme, the Single Point of Access Health & Social Care Hub project board will undertake ongoing monitoring of progress. As part of implementation, the project board will determine the process for regular assessment, review and evaluation of the Hub.

It is likely to be agreed that providers working within the Integrated Health & Social Care

Hub will be required to collect data around service utilisation and service user satisfaction; in particular from the perspective of whether the new model of service provision makes a difference to those on the receiving end and whether patients and service users report a better, more seamless, experience of care.

Project evaluation will involve both qualitative and quantitative evaluation to ensure that the Hub is operating effectively and is achieving its objectives. Key performance indicators will be agreed during development and will include delivering better outcomes and customer experience for patients and service users and the Hub's contribution to the achievement of any of the targets within the Better Care Fund metrics. Evaluation will be undertaken through analysis of data and satisfaction surveys and recorded on the project dashboard.

The findings from the reviews will be reported to The Health and Well Being Boards in all localities via the Berkshire West Partnership Board and also to the Berkshire West Integration Programme Board (meetings for the remainder of 2014 are scheduled for 18 Sept, 16 Oct, 20 Nov, 18 Dec).

What are the key success factors for implementation of this scheme?

The scoping, planning and development of an integrated single point of access Health and Social Care Hub will take place during 14/15 with the aim of having an agreed model of an integrated Health and Social Care Hub in place and operational by June 2015, although this might be in the form of a pilot across a smaller area initially, to ensure the success of the initiative prior to full roll-out.

Whatever the final design of the hub, there will be a need to:

- Achieve agreement, support and commitment for the scheme from all key stakeholders, including agreement of a project plan. This will include identifying any conflicting organisational priorities / different ways of working between the various organisations, any potential impact on the services required by other providers and any perceptions of professional boundaries that may hinder the project and agreed action to address these
- Agree where/how the Hub is to be established, be that in a virtual or actual location
- Ensure that effective IT systems are in place to support delivery of care via the Hub
- Identify and address any real and perceived barriers to data sharing across the constituent parts of the local health and social care system that might impinge on the development of the Hub
- Ensure appropriate governance processes are in place relevant to the integrated health & social care hub
- Ensure availability of staff in sufficient numbers with the right skills to provide adequate staffing for the hub in response to anticipated no of contacts
- Provide the required education and training to equip the existing and future workforce for this new models of care

-

Scheme ref no.
BCF03
Scheme name
Patient's Personal Recovery Guide / Keyworker
What is the strategic objective of this scheme?
The strategic objective of this scheme is to ensure that patients who have been assessed as requiring social care do not remain in hospital for longer than is necessary. We know that a hospital environment is not conducive to supporting a person to maintain their independence and any avoidable delays in their discharge has a negative impact on the outcome of their social care assessment and can result in more intensive long term social care support being required. The aim will be that the length of time individuals remain on the "Fit to Go List" will be reduced. The second phase of the scheme will be see the concept of dedicated personal support through the care pathway rolled out to community based services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The first phase of the scheme will be available to all vulnerable or frail hospital patients. If the model is successful it will then be rolled out to provide similar support through the care pathway for vulnerable patients/service users in the community. The patient will be supported for the journey through the care pathway. This support may be provided by either a Social Worker a qualified clinician, a trained Care Worker or volunteers or staff working for a voluntary organisation; there would be a strong attraction of building on the latter as a model detaching the function from other more defined roles. The complexity of each case will determine the level of professional support required. The key elements of the service would include; • Recovery Agreement: as a deliberate discipline, 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. • 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. • Case Management: 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.

Other integrated initiatives that will support this scheme include, 7 Day Services, Health and Social Care Hub and Joint Care Provider.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The delivery role of each organisation will be determined as the project goes through the design stage. There are a number of options available that need full evaluation before any final decisions are taken.

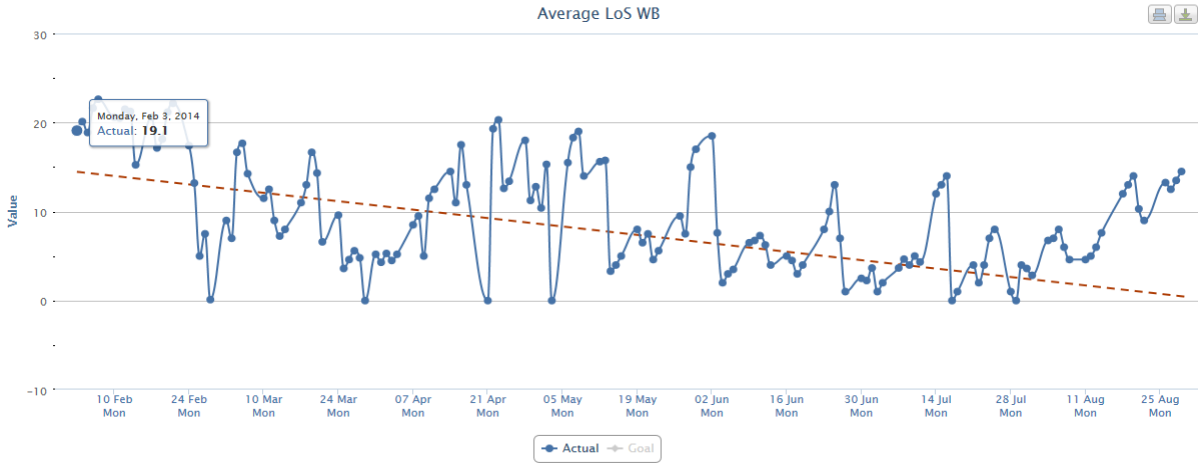
At this stage it is anticipated that the service will be commissioned by West Berkshire Council.

The options for service delivery include the direct employment of staff by West Berkshire Council, contracting with the voluntary sector for the service or organising through the Joint Care Provider service (BCF04), a joint arrangement between West Berkshire Council and the Berkshire Health Foundation Trust.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

An increasing proportion of those attending A&E and who are subsequently admitted are frail elderly patients who have a higher level of acuity and longer lengths of stay vs. the average patient. The following graph shows that the numbers of patients who are medically fit to be discharged, but are still in hospital have steadily increased over the last six months with the recent norm being between 50 and 60. This is against a system wide target, agreed as part of the A&E Recovery Plan, of no more than 20 patients on this list at any one time.

The following graph shows the duration of time on the "Fit To Go" List (Feb to Aug 2014), both of which are increasing.



The average length of time that patients remain on the “Fit to Go” List has remained significantly above the system wide target of five days agreed as part of the A&E Recovery Plan and is currently above 10 days. This in turn contributes to the impeded flow through the inpatient beds.

For social care the impact of these delays often manifest themselves in the service users having an increased dependency resulting in greater long terms social care needs than would have otherwise been the case.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

With the demographic changes facing all health and social services over the coming years it is very difficult to set achievable targets. In the first 5 months of 2014/15 West Berkshire social care has seen a 7% increase in it’s client numbers with the resulting increase in care and nursing home placement numbers.

This scheme will place downward pressure on the delayed transfer or care figures and should also contribute in a small way to social care’s challenge of managing increasing demand at a time of reducing budgets.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Use of data from the Alamac Kitbag on the ‘fit list’ which will include numbers and length of stay. This data is input by each partner in the health and social care system, produced by the Royal Berkshire Hospital and circulated to local authorities on a daily basis.
Detailed analysis of the length of stay in hospital for patients using the scheme and

comparing to average lengths of stay.
Measure of patient satisfaction for those using the scheme;

What are the key success factors for implementation of this scheme?

- Drafting and sign off of protocols for role across whole range of Health and Social Care operation.
- Link with Elderly Care Pathway Project for definition, responsibilities, duties and powers of keyworker role.
- Defining role and host organisation
- Determining delivery vehicle, including option of Voluntary Organisation.
- Redefining of some roles within existing services to release funding
- Patient/service user “buy in”

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Scheme ref no.
BCF04
Scheme name
Joint Care Provider
What is the strategic objective of this scheme?
The strategic aim of this scheme is to improve the service user experience by removing duplication caused by having separate health and social care teams delivering similar services. This will enable the referral process to be reacted to more quickly thereby achieving a more accurate first time match between the individual and the service. The intention is to build on existing informal joint working at an operational level to create a combined service that breaks down organisational barriers to ensure that care is provided at the right time and in a way that is seamless for the service user. By working together the organisations involved will be able to make better use of their diminishing resources.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
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 shared 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. There a number of forms this shared service could take and this will be evaluated during the scheme design stage. Operating as if a single service would improve the service user experience by removing the duplication that often exists. There would also be an opportunity to better manage the external provider market where at present both organisations can find themselves competing for the same services at peak times. The flexibility of this proposed shared service may make it possible for both Health and Social Care to reduce their commissioning of external care. The services provided by the teams are available for people in the community as well as those discharged from hospital. The Better Care Fund will also provide a key role in protecting the capacity of the social care reablement service that would otherwise have to be reduced in 2015/16 in response to falling council budgets.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The two organisations providing the assessment and care delivery services are Berkshire Health Foundation Trust and West Berkshire Council. The key categories of staff involved are as follows;

Berkshire Health Foundation Trust

- Occupational Therapists
- Nurses,
- Physiotherapists
- Therapists
- Multi therapy assistant staff
- Care Delivery Assistants (various levels)

West Berkshire Council

- Senior Carers,
- Care Assistants
- Occupational Therapists
- Social Workers
- Personal Budget Support Workers

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The selection and design of this scheme has very much been driven by service managers and front line staff across both Berkshire Health Foundation Trust and West Berkshire Council. These staff have very clearly articulated the duplication that exists and the regular actions they take on an informal basis to try to improve the overall system.

By developing these informal arrangements into a shared service arrangement we expect to build on the existing joint working and design arrangements that make best use of the resources available to each organisation.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Whilst this scheme has been driven by a desire to make best use of resources across the two organisations involved, it will provide other benefits. The sharing of resources should

result in a far more flexible service allowing the required care to be put in place much quicker. This flexibility will be particular important as we move to a model of 7 Day services.

This scheme should help reduce the number of people readmitted to hospital within 91 days as a direct result of the right care being delivered at the right time.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The success of this scheme will be measured by the following;

- Monitoring the number of those service users readmitted to hospital within 91 days
- Monitoring the number of contacts at the Council's Access for All (front door) Team.
- The level of service user satisfaction, this will be measured via the annual statutory customer survey.
- The views of front line staff managers will be gathered as part of a formal review of the scheme post go-live

What are the key success factors for implementation of this scheme?

- Agreement to be reached between Berkshire Health foundation Trust and West Berkshire Council on the design of the new scheme
- Buy in from staff of both organisations for the new working arrangements

Scheme ref no.
BCF05
Scheme name
7 Day Week Service
What is the strategic objective of this scheme?
The strategic aim of this scheme is to enhance the range of health and social care service that are currently available on a 7 Day basis. The new offering will need to be both seamless across the services and on a scale that is affordable to each of the organisations involved in the delivery.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Across health and social care in West Berkshire there is already a combination of services that are available 7 days per week. Currently within Newbury & District CCG a number of services are working extended hours. Berkshire Healthcare Foundation Trust provides community nursing 24 hours a day, 7 days a week. Other services such as Intermediate Care, Rapid Response run a 7-day service (but not 24hrs) West Berkshire Council has an Extended Hours Service provided by the In House Domiciliary Care Service 6am to 11pm 7 days per week; this initially provides care in urgent circumstances, for example for avoidance of admissions into Care Homes or Hospitals; it could provide support where a carer becomes unwell; it may also deal with urgent referrals being passed over from health services. The service will also expedite discharges from hospitals either through the Council's direct service or through a care provider which is already supporting an individual. Planned admissions to care homes or to domiciliary care agencies following a hospital assessment can be effected at weekends on a limited basis. Whilst we have this distinct BCF scheme for 7 Day Services all of other BCF schemes will contribute to the enhancement of our existing 7 day arrangements. The planned enhancement of these arrangements will be underpinned by our 7 day health and social care hub (BCF02), a single point of access to health and social care that will signpost professionals and patients throughout the whole week. Building upon what is already in place, the initial emphasis will be on ensuring we can deliver safe planned discharges from acute hospitals on a 7 day basis. As the acute hospital deliver increased levels of 7 day discharge services then social care will develop services to match this change of demand. A key element will be to ensure that external providers of both residential care and domiciliary care are able to meet any new requirements, as much a capacity issue as a cost issue in West Berkshire. The model will involve an expansion of GP service provision beyond core hours (8am -

6.30 pm, Monday – Friday) to offer access into early mornings, evenings and at weekends, particularly Saturday mornings. This builds upon and enhances existing extended hour arrangements that have been commissioned by NHS England.

Practices will offer both routine and urgent appointments during these extended periods, interfacing with other services to support admissions avoidance, reduce type 3 A&E attendances and maximise opportunities for discharge back to GPs. During these hours there will be requirements to ring fence some appointments for patients who have been discharged to access their GP practice (particularly on a Saturday morning) and a requirement to give a priority to patients identified by practices as being at high risk of admission. These will include patients included on the 2% care management registered developed by GPs as part of the national Avoiding Unplanned Admissions Directed Enhanced Service (DES) (see section 7d)

The scheme will provide more opportunity for patients to access GP services to help manage their long term conditions in the community, thereby avoiding unnecessary admissions and/or attendances to A&E.

This increased access will also enable private home care and residential and care home providers to be confident about taking patients on at the weekend as they will be able to speak to a GP if necessary.

Practices are being commissioned to increase extended hour arrangements during 2014-15 under pilot arrangements which will make more early morning, evening and Saturday morning services available. The service to be commissioned from April 2015 will be shaped by the findings of these pilots, and national best practice including emerging results from the Prime Minister's Challenge Fund pilots, together with the audit of in-hours capacity and utilisation currently being undertaken. It will link with neighbourhood cluster working.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The detailed design for enhanced 7 day services needs to involve all of the health and social care organisations in West Berkshire. No one organisation should make changes without the full engagement of the other partners otherwise we risk ineffective and disjointed services**.**

The delivery chain would therefore involve the following;

- Royal Berkshire Hospital
- Berkshire Health Foundation Trust
- West Berkshire District Council
- Newbury and District CCG
- South Central Ambulance Service

It is anticipated that extended GP hours will be delivered by existing GP providers, working as collaboratively as appropriate, with an interoperable IT solution in place as soon as possible and if appropriate. The service is likely to be commissioned by the

CCGs as a Community Enhanced Service, potentially linking with NHS England around the existing Extended Hours DES.

GP Providers will commence extended hours working once appropriate plans are in place that ensure there is a sustainable workforce, services are being delivered from an appropriate site, and that the model of delivery is an improvement on existing access arrangements and better meets the needs of patients. It is anticipated that this will be from April 2015.

The GP element of this scheme will be overseen by the Primary Care Programme Board, with the Primary Care Team within the Berkshire West CCG Federation taking responsibility for setting service specifications and monitoring delivery. The Primary Care Programme Board will in turn feed into the West Berkshire Integration Group. It will be for individual GP providers to implement local practice arrangements.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Experience tells us that inflexibility in current service arrangements in the community results in delayed transfers of care. Proposals will enable people to be able to access services across 7 days whether this is returning home with a package of care or admission in to a residential/nursing home**.**

The evidence base around extending GP hours is still emerging and the arrangements will be commissioned as pilots initially with a requirement to collect capacity and utilisation data which will then be triangulated with A&E and Westcall attendance rates and admissions data.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Providing an enhanced offering across the week should be a key contributor to delivering a wide range of improvements across both health and social care. Being able to provide the right support at the right time should prevent situations escalating and reduce the prospect of individuals make inappropriate decisions regarding the carer pathway to follow. It is expected that this will play a role in delivering a reduction in unnecessary A&E attendances and a reduction in delayed hospital discharges.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Crediting performance improvements against any one scheme would be impossible but enhanced 7 days services should contribute to a number of the key performance

indicators that are already monitored across the health and social care systems. The key ones being;

- A&E attendances
- Delayed Transfer of Care
- 91 day post discharge data
- Social care long term care client numbers
- Social care annual service user experience results

What are the key success factors for implementation of this scheme?

- Effective engagement of all partners across health and social care
- Joint planning with all partners then delivering the agreed changes
- Engagement with external service providers to ensure they are able to meet requirements
- Increasing community resources to deliver enhanced models of 7 day working in order to reduce pressures in the acute sector.

Scheme ref no.
BCF06
Scheme name
Hospital at Home
What is the strategic objective of this scheme?
The service aims to enable care to be delivered closer to home, reducing avoidable non-elective admissions into the Acute Trust, providing a positive patient experience and journey of care through intensive, integrated and seamless multi-disciplinary case management in the patient's own home. A large number of non-elective admissions are a result of acute episodes that could be treated at home, as the patients are clinically stable and do not require diagnostic assessment. The Hospital at Home scheme will facilitate this by providing a "virtual ward" by which patients can be cared for at home. The service will provide safe intensive health support at home for people who are high acuity.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The service is being provided by Berkshire Healthcare NHS Foundation Trust(BHFT), a Community Services Provider. Patients attending Royal Berkshire ED department, that meet the inclusion criteria and are considered suitable for H@H, will receive full diagnostics and treatment in RBFT and then will be transported home by South Central Ambulance Services, to be met at the home by the Matron from BHFT. Daily virtual ward rounds including Social Services, BHFT medical team, and the clinicians responsible for the well-being of the patient will take place. Visits to the patient home will occur as necessary, and it is expected that there will be multiple visits per day. Social Services will support the patient where applicable. The Hospital at Home Service will need to be coordinated, both proactively and reactively, providing clear and integrated pathways of care. This means that those patients that are already known to clinicians within the community and are already receiving continuous care would benefit from contacting a single point of access to the Hospital at Home Service when experiencing a crisis. The target population for this service is those patients with acute infections, or deteriorating long term conditions, or conditions like dehydration, where they are clinically stable, but require intensive support. Patients will be selected by the Community Geriatricians when they consider that an admission would be appropriate and the patient would normally have had a greater than zero length of stay in hospital. We will use the National Early Warning Score (NEWS) and suitable patients will have a NEWS score of 5 or less and be assessed as being stable. They will also be carefully selected according to the inclusion and exclusion criteria for the scheme, but could potentially be anyone over the age of 18 who is registered with a West Berkshire GP and resides within the West Berkshire Council area. The patient needs to consent to be treated in their usual place of residence (home). Patients who meet these criteria therefore are likely to cover a wide

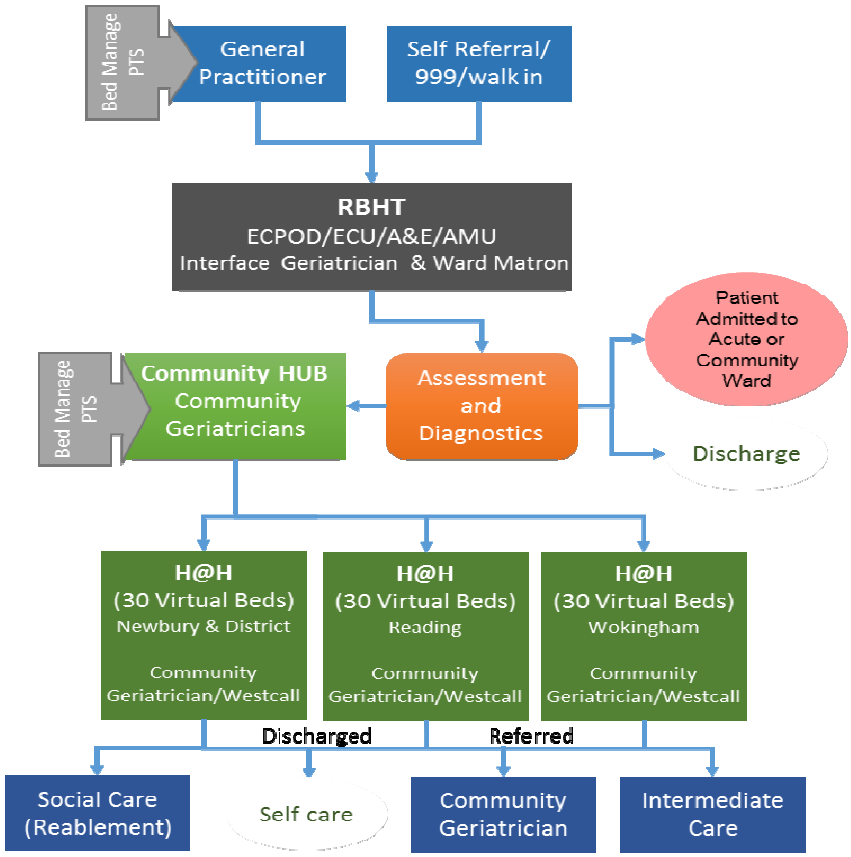
age span of suitable patients who may have a variety number of different medical conditions .i.e. the inclusion criteria are not disease specific but offer a more holistic and outcomes focused view of the patient.

Hospital at Home will deliver:

- Locality sensitive operational pathways that deliver sub-acute care in the individual's home, seven days a week
- Clinical assessment and intervention within 4 hours of attendance at the ED in the RBH and effective interface arrangements to ensure as many patients as possible are offered the opportunity to be treated in their own home wherever clinically appropriate, and therefore supported in early and proactive discharge from Emergency Department
- Multi-disciplinary assessment, intervention and review of patients referred into the service led by a Community Geriatrician
- Effective operational liaison between community health and social care services to ensure coordinated and seamless patient care, and timely and safe discharge from Hospital at Home

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Wokingham CCG is leading the commissioning of this service. RBFT is the secondary Trust provider that will be responsible for identifying, diagnosing and treating the patient initially, before transferring the patient into the ward at home. BHFT will be the main provider of all clinical and medical staff that will support the patient during their admission, through to discharge, where the community re-ablement team and other appropriate community services provided by BHFT and Adult Social Care may be engaged, where necessary.



The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Non elective admissions to hospital are rising due to the increased age profile in Berkshire West, and there is also an expected increase in long term conditions that will have an impact on services. Older people stay one and a half times longer in hospital than the average for all age admissions and people with a diagnosis of dementia stay on average four times longer.

The people admitted who are elderly or have long term conditions are often acute but clinically stable. In these instances it is possible to care for patients in the community via a virtual ward.

Evidence base – hospital at home

With specific reference to the "Hospital at Home" Scheme a recent report from the King's Fund ***" Avoiding hospital admissions – what does the research evidence say?"*** confirmed that a systematic review of trials comparing 'Hospital at Home' schemes with inpatient care found that, for selected patients, avoiding admission through provision of hospital care at home yielded similar outcomes to inpatient care at similar or lower cost. Elderly patients with a medical event such as stroke or COPD, who were clinically stable and did not require diagnostic or specialist input, had slightly more subsequent admissions in the hospital at home group, but had greater levels of satisfaction, and their care at home was less expensive. This report went on to recommend that commissioners should consider implementing hospital at home.

In addition, the *Nuffield Trust study (June 2013*) of 3 current Virtual Ward programmes,

has shown an overall reduction in Electives, Outpatients, A&E and Emergency costs for the first 6 months post discharge to the ward of around 5% overall, compared to the costs of the patients pre referral. However:

- In Devon emergency admissions were reduced by 25.7%;
- In Wandsworth it was a 45% reduction in the first few months;
- In North East Essex they expect a 25% reduction over the first year.

There has been no significant analysis of H@H schemes and even those that exist in the USA (e.g. VA Centres, Presbyterian Healthcare Services, Mercy health and Cigna Medical Group) are based on different models with different outcomes, but all show a reduction in costs of at least 19%.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The key outcomes anticipated are:

- A reduction in non-elective admissions from the defined cohort of patients by approx 84%;
- High patient satisfaction levels;
- Successful discharge from the service to integrated community teams; and
- No avoidable readmissions back to hospital from the H@H service.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The benefits realisation reporting mechanism is still being designed, and we expect to have absolute measurables for reporting actual benefits for both patients and the health and social care system.

There is a project board in place which will monitor the implementation of the scheme, and which has representatives from all partners including Healthwatch and patient representatives.

What are the key success factors for implementation of this scheme?

Key success factors for the Hospital at Home scheme:

- Awareness of the service to ensure that there is enough uptake of the service
- Adherence to a length of stay of seven days to avoid bed blocking
- Sustaining the workforce – although a lot of the staff for this will be redeployed from elsewhere, this will be critical to the success of the scheme
- The model is dependent on a quick turnaround of diagnostic/pathology results
- The volume of calls may impact on the ability for the HUB to manage the

coordination process

- Availability of patient transport to convey patients home
- A robust risk assessment of the patient environment will be critical

Scheme ref no.
BCF07
Scheme name
Enhanced Care and Nursing Home Support
What is the strategic objective of this scheme?
This scheme provides a new model of high level health care support into care and nursing homes throughout the borough to improve consistency in the quality of care and outcomes for residents. Residents and their families will experience improved communication with those responsible for their care across the whole of the health and social care system. Their care will be more patient centric, making their experience of care a more positive one. When a crisis occurs, the needs and wishes of the individual will be fully documented in their pre prepared care plan, allowing the right care to be provided at the right time in the right place, This will include avoiding any unnecessary visits to A & E or an unplanned admission to hospital, thus reducing the pressures on the urgent and emergency care system. Care home residents will have equity of access to the care that meets their need over the whole week that is independent of their place of residence, including avoiding any delayed discharges or transfers of care. This scheme will support our aspiration to reduce delayed transfers of care as well as our local metrics of reducing the "Fit to Go" list and the length of time individuals remain on this list. With more people being supported to live at home for longer, those who need 24 hour support in a care home are likely to have complex or multiple long term health conditions. This has growing cost implications for the health and social care economy. These costs can include Accident & Emergency attendances, emergency admissions to hospital, and readmissions. Some admissions are potentially avoidable, such as those for fractures or urinary tract infections. The aim is to reduce non-elective hospital admissions from care homes through introducing a GP enhanced community service, providing additional training to care home staff, and additional community pharmacist resource. The scheme overall will strengthen partnership working between care home providers, community geriatricians, and health and care staff to improve the quality of life for residents. This will include reducing the number of falls, and the prescribing of multiple medications to elderly people. This will in turn improve the overall health and wellbeing of care home residents. .
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
West Berkshire has chosen to target Better Care Fund resources on care home residents because their medical needs are complex and rapidly changeable. 80% will have mental health needs such as dementia, depression or a long term mental health diagnosis. They have higher needs than other patients for essential medical cover because they are not able to attend their local GP practice. This means that regular GP visits to the care home are required as well as frequent and multiple prescribing interventions. Currently, however, the range, type, quality and consistency of overall care can vary widely between the individual care homes. The project is expected to deliver an improved quality of life for patients in care homes through a reduction in emergency admissions, the number of falls, and poly-pharmacy. It will also deliver improved end of life experience through advanced care planning, which will in turn improve the overall health and wellbeing of the patients in homes. The work streams within this project are detailed below. **(a) GP Enhanced Community Service**

Each care home will have a named GP for each resident who is their principal point of contact with the general practice looking after their residents. There will be a comprehensive and formalised assessment and formation of an individual Supportive Care Plan (SCP) for each resident. This will be completed by the GP with input from a social worker.

There will be regular contacts and visits by GPs with care home staff and community geriatricians to monitor the health status of care home residents. This will pre-empt crises and emergency calls wherever possible through planned care interventions. It will enable a consistent, efficient approach to the use of medical cover, reducing the need for emergency call outs to individual patients and thereby non-elective admissions to hospital.

Joint medication reviews will be performed annually by the GP and the care home pharmacist from the Medicines Management Team using the CCG protocol. Prescribing interventions should maximise clinical benefit and minimise the potential for medicines related problems, e.g. incidence and impact of falls. Prescribers will adhere to the CCG antipsychotic prescribing protocol.

(b) Enhanced training to care home staff

This scheme will also include additional nurse trainer resource going into care homes. Currently, the Royal Berkshire Healthcare Trust and the South Central Ambulance Service receive a high number of referrals from care homes which turn out to be either inappropriate or avoidable if there was better knowledge within the care home setting of how to manage long term conditions. There are very significant numbers staff employed in a care or nursing capacity across care homes in West Berkshire. Developing capability within this workforce has the potential to make a significant impact on hospital admission rates.

(c) Introduction of an additional Community Pharmacist Resource

Increasing the community pharmacist resource will ensure the community pharmacist is able to visit each care home twice a year to undertake medication reviews and provide training on medicines.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Berkshire West CCGs will commission this enhanced service from local GP practices.
Berkshire Healthcare Foundation Trust's Care Home In-reach team, supported by CCG medicines management pharmacists, will deliver a programme of training to all care home staff across the nursing and residential homes within Berkshire West .

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The case for change

As the UK population ages, GPs and NHS providers face an increasingly difficult task managing the complex needs of care home residents whilst there is increasing pressure through the system. The 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 expect to rise to 825,000.

In 2008 Sheffield PCT reported[1] that 'medical cover to care homes is haphazard, evident in a rising and variable rate of emergency admissions that is unacceptable'. In 2005, for example, Sheffield admissions rose by 30 per cent and after a 2006 drop, peaked at 2,270 in 2007. A 2004 local bed usage survey showed 40 per cent of these were for long term condition exacerbations and 25 per cent of admissions from care homes were 'avoidable'. Analysis of non-elective admissions data showed a nearly ten-fold difference in admission rates between homes, indicating inconsistency of care between care homes.

Evidence base for impact

The Cornwall and Isles of Scilly PCT project[2] to train nursing home staff resulted in:

- Reduction in falls and injuries;
- Reduction of hospital admissions by 50%; and
- Prescription savings of £100 per patient per year.

Similarly in Sheffield, savings were evidenced, and if extrapolated to apply to the Berkshire West population the overall cost of secondary care admissions from care homes could be reduced by approximately £941,500.

The introduction of an additional Community Pharmacist and eradicating issues from poly-pharmacy along with a further 5% reduction due to improved training, could realise gross savings of £1,258,500.

Sheffield - Integrated care and supporting care homes, BGS March 2012
Improving the Quality of Dementia Care, HSJ October 2012
Nursing Homes in Walsall, Improving care for elderly people, December 2011

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The Care Homes scheme should:

- Reduce unnecessary NEL admissions ;
- Reduce prescription costs (to be further modelled and quantified);
- Increase the skills of care home staff(numbers trained will be monitored and competency levels assessed as part of the training programme);
- Improve end of life experience through advanced care planning (numbers of care plans in place will be monitored, which will include those with end of life planning templates in place, and in addition the number of residents being admitted and dying within 0 days will be captured);
- Avoid unnecessary A&E/Clinical Decision Unit (CDU) attendances(to be monitored through acute activity data by the project board as it is has not been possible to retrospectively differentiate by patient address from current data, only by postcodes which includes neighbouring properties to the care home);
- Support the reduction of the incidence of falls by appropriate prescribing of medication and referral to Therapy Services(monitored through the Falls Prevention QIPP project);

[1] Sheffield - Integrated care and supporting care homes, BGS March 2012
[2] Improving the Quality of Dementia Care, HSJ October 2012

- Reduce the number of care home residents appearing on the “fit to go list” (Local Metric HWB Supporting metric tab, monitored through “Alamac Kit Bag”); and
- Reduce length of time on the “fit to go list” for care home residents (Local Metric HWB Supporting metric tab, monitored through “Alamac Kit bag”).

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The benefits realisation reporting mechanism is still being designed, and we expect to have absolute measurables for reporting actual benefits for both patients and the health and social care system.

Indicator/Outcome	Baseline (Current Value)	Target Value	How Measured?	Frequency of Measurement
Number of patients assessed by GP by CH within 4 weeks of admission to CH	10%	< 80%	Adastra System	Monthly
Number of patients assessed by GP by CH within 8 weeks of admission to CH	50%	100%	Adastra System	Monthly
Number of staff trained by Nurses by CH within 6 months	10%	< 50%	BHFT Training Records	Monthly
Number of staff trained by Nurses by CH within 12 months	10%	< 95%	BHFT Training Records	Monthly
Number of dysphagia training sessions provided by CH in 12 months	0	48	BHFT Training Records	Monthly
Number of CH staff trained by Pharmacist by CH in 12 months	50%	< 95%	Pharma Training Records	Monthly
Number of patients reviewed by pharmacist by CH	50%	100%	Service Record	Monthly
Number of patients reviewed by GP by CH within 6 months of commencement	10%	< 50%	Adastra System	Monthly
Number of patients reviewed by GP by CH within 9 months of commencement	10%	100%	Adastra System	Monthly

There is a project board in place which will monitor the implementation of the scheme, and which has representatives from all partners including Healthwatch and patient representatives.

In addition the project board will closely monitor the participation in the scheme by GPs as this will be critical to the success of the scheme.

What are the key success factors for implementation of this scheme?

The critical success factors for this scheme are:

- GP engagement and participation as the scheme relies on GPs as the accountable lead professional
- Care home staff to be released to attend training
- Availability of training to care home staff
- Defining the care and support delivered by GPs to patients & care homes.
- Supporting the establishment of standards for care planning, medicines reviews, information &

communication

- Improved end of life experience through advanced care planning which in turn will improve the overall health and wellbeing of patients in homes

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	West Berkshire
Name of Provider organisation	RBFT
Name of Provider CEO	Jean O'Callaghan
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	10132
	2014/15 Plan	10301
	2015/16 Plan	10196
	14/15 Change compared to 13/14 outturn	1.67% Growth
	15/16 Change compared to planned 14/15 outturn	1.03% Reduction
	How many non-elective admissions is the BCF planned to prevent in 14-15?	176 for pump priming BCF although BCF not actually in place in 14/15
	How many non-elective admissions is the BCF planned to prevent in 15-16?	506

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes – the numbers are based on the HWB catchment rather than RBFT as a provider and therefore this does not match our provider plan exactly (West Berkshire HWB is around 1/3rd of our total activity). However, we understand and have been involved the calculations arriving at the numbers above and as such recognise the impact of the BCF on the Trust.
2.	**If you answered 'no' to Q.1 above, please explain why you do not agree with the projected impact?**	*N/A*
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes – the main impact on the Trust is the reduction in non-elective admissions as a result of the Hospital at Home project within the BCF (487 of the 506 above) The Trust is fully engaged with this project and sits on the Project Board. The Trust is actively working with the health and social care system to ensure that there are mechanisms in place to support discharge from the provider into community and home settings with associated investment in schemes such as reablement, carers, 7 day working in primary and social care