Integration and Better Care Fund

Narrative Plan for West Berkshire 2017/19

Area	West Berkshire
Constituent Health and Wellbeing Boards	West Berkshire
Constituent CCGs	Newbury & District CCG North West Reading CCG

Contents

Introduction

The Policy Framework for the Better Care Fund (BCF) sets out the Government's vision that by 2020 health and social care should be integrated across the country in order to reduce health inequalities, support sustainable systems and better co-ordinated care. The BCF supports this objective by providing a framework for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, the Disabled Facilities Grant (DFG) and funding paid directly to Local Government for Adult Social Care Services – the Improved Better Care Fund (iBCF).

The Integration and Better Care Fund planning requirements for 2017-19 document produced by NHS England in partnership with the Local Government Association requires BCF Plans to set out how Clinical Commissioning Groups (CCG's) and Local Authorities are working towards fuller integration and better co-ordinated care, both within the BCF and in wider services.

Local Authorities and Clinical Commissioning Groups are required to develop a joint plan that meets the national conditions and is agreed through Health and Wellbeing Boards.

West Berkshire's narrative plan sets out our joint vision and approach for integration, including details of how we plan to meet the national conditions, how the work in our plan complements the direction set in the Next Steps on the NHS Five Year Forward View, the development of Sustainability and Transformation Partnerships (STP's), the requirements of the Care Act 2014 and wider local government transformation.

West Berkshire's planning template confirms funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes, a scheme level spending plan demonstrating how the fund will be spent and quarterly plan figures for the National Metrics.

West Berkshire's vision for better care is based on improving outcomes for individuals through the joint 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

As part of delivery of the NHS's Five Year Forward View in Berkshire West the four CCG's are collaborating with the two local NHS Providers (Royal Berkshire Hospital Foundation Trust and Berkshire Healthcare Foundation Trust) to establish a new way of working together known as the Accountable Care System (ACS), one of only 8 systems nationally. . New Governance arrangements have been put in place led by an independent Chair and the system plans to operate on a system level financial control total as a sub division of the STP.

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

- Less duplication between sectors, faster and more efficient joint assessments with lead professionals for those with long-term conditions.
- Prevention, earlier diagnosis, treatment and support including support for carers to prevent crisis or better enable responses to crises without admissions to hospital 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.
- Locality based multi-disciplinary health and social care teams who will target support to people most at risk of hospital admission enabling them to remain living independently in the community. This will include a wide range of risk factors including falls.

- Improved choice and control through better access to a wider range of care and support in 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 require higher level of intervention will have better access to tailored information, advice, care and support which is person centred.(it is difficult to define hard to reach but could include: people with Mental Health issues, health inequalities or people living in rural areas etc)

By 2020 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 with timely discharges
- Increased numbers taking up Health and social care personal budgets
- Focus on prevention to enable people to remain as independent as possible. Including support for carers.

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 joint 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

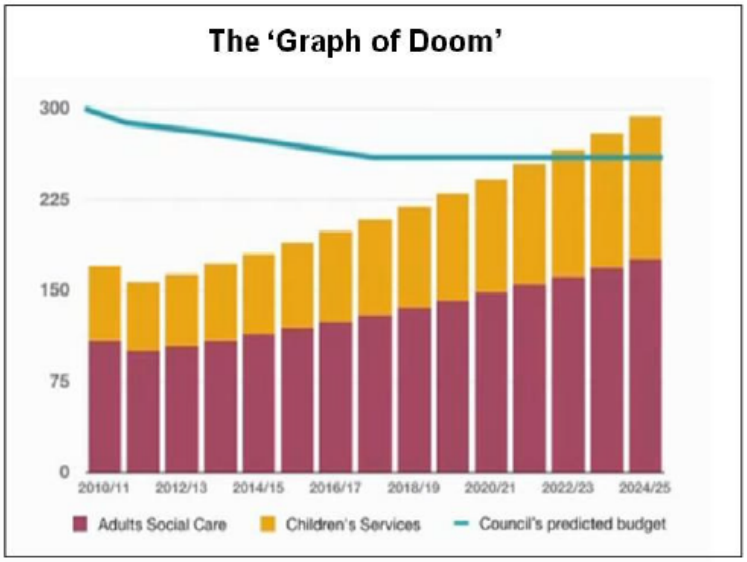
West Berkshire has a current population of 156,020 people. It makes up over half of the geographical area of the County of Berkshire – covering an area of 272 square miles. Largely rural, it has the most dispersed population in the South East with 253 people per hectare.

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 is 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:

1. An increasing population, particularly in those over the age of 65
2. Increasing growth in non-elective care
3. Increasing A& E attendances, and pressure on urgent and emergency capacity
4. Rising delayed transfers of care, and subsequent bed days lost
5. Increasing pressures on adult social care for community packages (particularly in rural areas) and care homes at a time when the overall Council budget is significantly shrinking
6. Care closer to home as the first option
7. Inequality of access to services across the whole system, the whole week
8. Workforce availability
9. Increasing pressure on Social care in relation to prevention and early intervention

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.



Without significant changes in the way care services are provided or councils' funded, the increasing numbers needing support would mean that **by 2022-23 council's would only be providing social services**.

There being no money left for anything else.

The CCG operational Plan embedded below sets of how the Berkshire West CCGs will deliver the NHS Five Year Forward View, working as part of the Buckinghamshire, Oxfordshire and Berkshire (BOB) Sustainable Transformation Plan (STP) driving the establishment of the Berkshire West Accountable Care System (ACS). The CCGs will continue to build on strong partnerships working with the three Local Authorities in Berkshire West to deliver the BW10 programme and maximise the impact of the Better Care Fund Investment.

Operating Plan 2017.pdf

The Berkshire West CCGs, Local Authorities and providers operating in Berkshire West are members of the BOB STP. This is a large STP with three distinct local health economies that are affectively driving place based commissioning to deliver the Five Year Forward. The local health economies provide the best mechanism to transform primary care, redesign the interface with local hospitals and drive integration with social care. Much of the delivery of the Five Year Forward View will take place at a local health economy level with the STP ensuring that rapid adoption of innovation across BOB. Nevertheless each of the member organisations recognises the opportunities of working together with partners at this larger scale and will be progressing initiatives to improve quality and realise financial benefits for the wider system.

The Operating Plan above outlines the BOB STP Wide programmes which have project charters, with clear leadership, milestones and descriptions of benefits and are reflected in each of the chapters in the plan above

Berkshire West will be one of eight Accountable Care Systems (ACS's) across the Country who will bring together local NHS organisations, often in partnership with Social Care Services and the Voluntary Sector to build on the learning from and early results of NHS England's new care model

"vanguards", which are slowing emergency hospitalisations growth by up to two thirds compared with other less integrated parts of the country.

The four CCG's which comprise "Berkshire West" are collaborating with the two local NHS providers (Royal Berkshire Hospital Foundation Trust and Berkshire Healthcare Foundation Trust) to establish a new way of working together known as the ACS. New governance arrangements have been put in place led by an independent Chair and the system has applied to operate a system level financial control total as a sub division of the STP. All parties are committed to developing new payment mechanisms to underpin the transformation change required.

The leaders of the 10 Health and Unitary Authority partners, known as the Berkshire West 10 (BW10), have been working together since 2013 within a shared governance structure. The BW10 integration programme is an ambitious transformation programme involving a number of projects across these 10 organisations. The projects operate both at locality level and Berkshire West wide to deliver the intended benefits. The collective objective is focused on improving outcomes for users and patients and achieving long term financial sustainability. Overseen by an Integration Board and with project implementation supported by a joint Delivery Group, the BW10 has focused on specific improvements for the frail elderly population, Mental Health Care and Children's Services.

The West Berkshire locality integration board informs the strategic direction for Health and Social Care Services both in the locality and across West of Berkshire and reports to the Health and Wellbeing Board. This board is responsible for the business and overall performance of projects within the BCF and Integration Programme and their focus is to steer and provide direction to deliver the agreed outcomes, benefits and efficiencies of each project contributing towards greater integration of health and social care.

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

By 2020 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
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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. We have recently submitted an application to the NHS Patient Leadership Programme for a patient leader/representative to sit on both the step down bed and integrated care team projects.

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 make commissioning decisions based on what works best for our communities. This may be across the West of Berkshire or on a more local level. All the work will need to 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, focus on strengths and ensures 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 across the system with the Accountable Care System, The BW10 Group and the BOB STP.

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

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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"

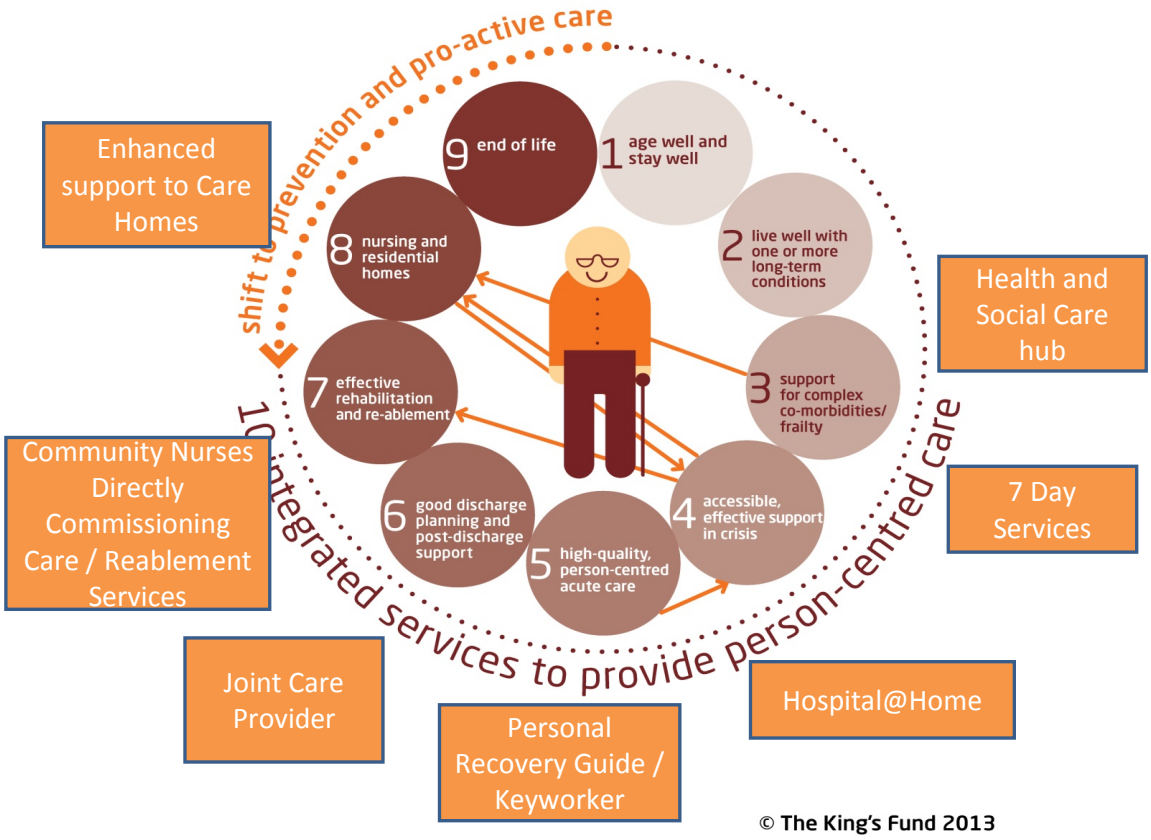
- "My care is planned with people who work together to understand me and my carer, put me in control, coordinate and deliver services to achieve the best outcomes for me"

Our Better Care Fund Programme will result in greater integration of services., 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 provider. 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. This pathway has been developed through a multi-agency project supported by the King's Fund and is supported by detailed economic modelling. 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

Below are the changes that will be required to meet the needs of health and social care over the next five years: -

1. Build capacity in the community across primary, community health, Mental 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.

2. Expand the Reablement capacity linked closely to integration with appropriate primary and community healthcare on a localised basis (via locality hubs)

3. As community capacity is increased it will reduce pressure on the acute sector.

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

5. Our system workforce availability 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

6. 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.

7. We will strengthen our community based asset approach, building on our “doing with” rather than to approach to enable people to self care through embedding the Care Act. . Assessments will be person centred, outcome focused and continue to develop Reablement potential.

8. We will continue to develop locality based working to ensure we know our patch really well and help people as close to their home as possible.

9. The NHS Digital Roadmap will enable all integrated working across the system ie. Connected Care.

Background and context to the plan

In West Berkshire we share with our Berkshire West 10 colleagues an understanding that integrated care delivers the best outcomes for our people. We believe (supported by evidence) that working in partnership, is the most effective way for us to ensure that we are providing person centre, 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 a number of key areas, which collectively, provide sufficient evidence of growing demand pressures in West Berkshire's health and social care economy. These areas are:

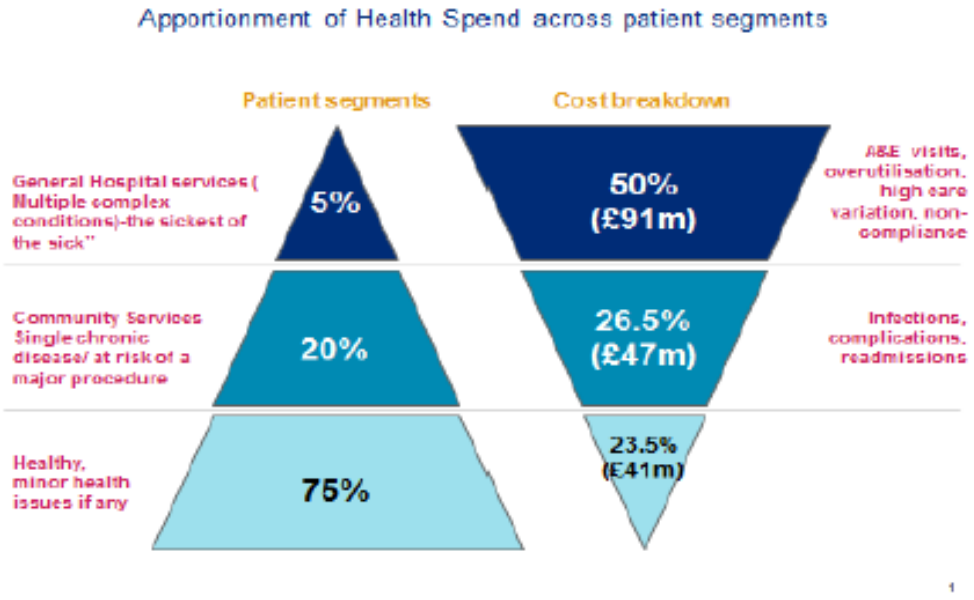
- An increasing population, particularly in those over the age of 65
- Increasing growth in non-elective care
- Increasing A& E attendances, and pressure on urgent and emergency capacity
- Rising delayed transfers of care, and subsequent bed days lost
- Increasing pressures on adult social care for community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

These pressures are likely to present the biggest challenge 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 people 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.

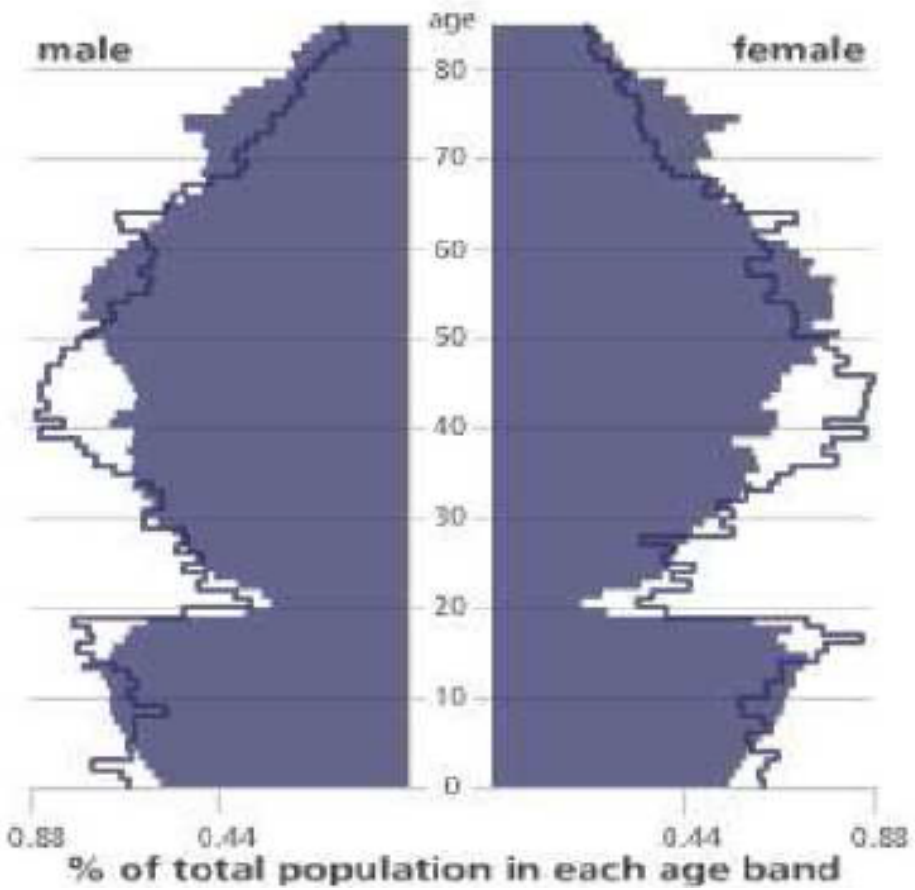
By making these groupings explicit, we are able to provide a more logical way of informing the new models of care that are likely to be needed, identifying the outcomes we plan to achieve and by which we will measure our success, as well as allowing us to create payment models to incentivise providers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

From 1st July 2017 GP practices will be required to use an appropriate tool to identify patients aged 65 or over who are living with moderate and severe frailty. Our amended Anticipatory Care CES will build on this by using risk stratification tools already deployed in practices to ensure resources are targeted most effectively and efficiently. Demand for services is predicted to continue to rise with a growing older population and people living with more complex long term conditions. Our ambition is to expand our focus beyond the top 2% of the population to the top 10% who may not necessarily be high users of services now but are at risk of becoming so without early intervention.

Challenge 1: Increasing Demand

West Berkshire has a current population of 156,020 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 estimated population of West Berkshire in 2021 is 170,100.

Our Joint Strategic Needs Assessment (JSNA) tells us that 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.



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 have grown by 3,300 by 2010 (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 project growth rate for the district as a whole.

At the other end of the spectrum, the figures show an anticipated growth in the over 65 population of 34% (or 8,000) 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	481	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**%

As the graph and table above indicates, it is predicted that the number of over 65's will increase 24% by 2021 and those over 85 years of age by 39%. This 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, eg Cardiovascular disease, dementia, respiratory disease, liver disorders and diabetes. West Berkshire has a significant number of older people living along 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 are set to grow significantly over the next five years and that will place huge financial pressure on the health and social care system within West Berkshire.

The Solution :

During 2016/17 we progressed our work around the frail elderly pathway (FEP) (outside of the BCF but within the integration portfolio at BW10 level). This has allowed us to identify those costing us the highest amount of resources in the system. We will continue to embed early projects developed as a

result of the FEP work eg. Rapid Response and Treatment (RRAT) and the Joint Care Pathway (JCP) In 2017/18 we have been working with PA Consulting to explore the potential impact of increasing use of telecare and assistive technology in Berkshire West and we anticipate implementing this in 2018/19. A copy of the care technology diagnostic from PA Consulting is embedded below:

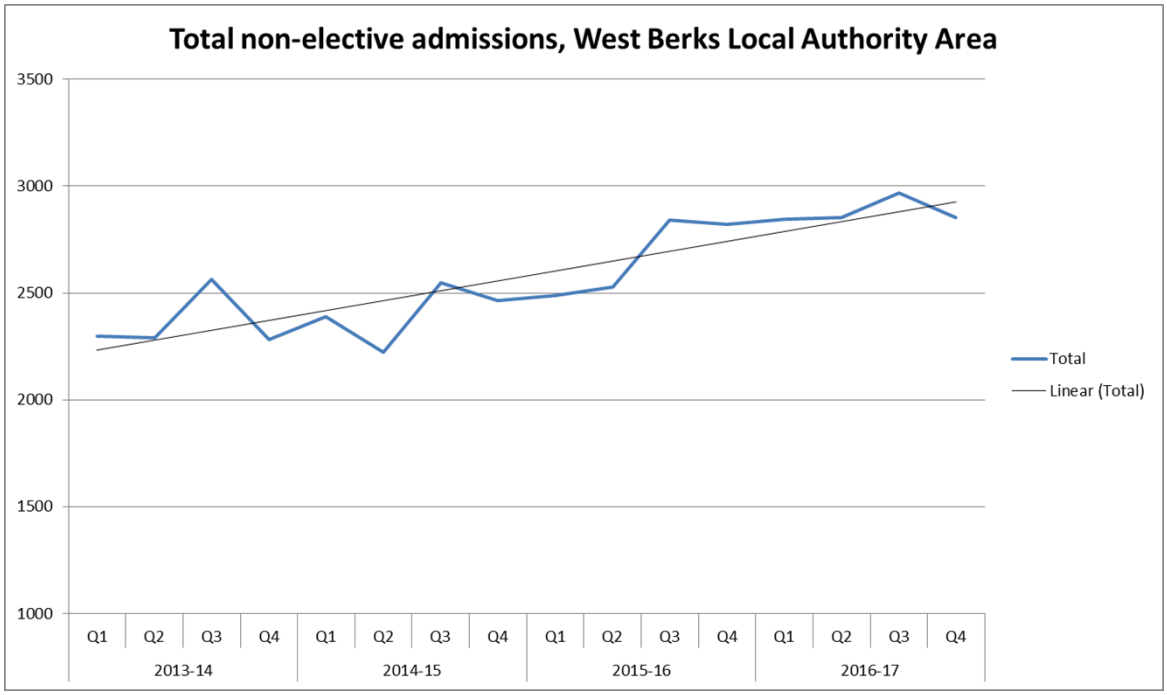
West Berkshire Care Technology Diagnosti

Challenge 2 : Growth in Non-Elective Admissions

The BerkshireWest CCG's are collectively recognised as high performing and benchmark well nationally on a number of key performance measures, including non-elective admission rates. For the last two full years, Berkshire West CCG's have been in the top 4% of CCGs for non-elective admission rates.

In 2016/17 Newbury & District CCG was the 6th best performer in the Country for non-elective admissions.

CCG	Admissions	Population	Rate	Rank
NHS Wandsworth CCG	24273	386602	62.79	1
NHS Gloucestershire CCG	40692	636034	63.98	2
NHS Wokingham CCG	11194	160468	69.76	3
NHS South Reading CCG	10061	140413	71.65	4
NHS West London CCG	17393	242428	71.75	5
NHS Newbury and District CCG	8519	117634	72.42	6
NHS Tower Hamlets CCG	22070	300382	73.47	7
NHS North & West Reading CCG	8097	109686	73.82	8
NHS Central London CCG	15857	212847	74.50	9
NHS Richmond CCG	15925	211353	75.35	10



However, future projections suggested that due to the increased age profile and double digit increase in certain long term conditions, this trend will continue unless there is a system wide change.

The Solution:

Our NEL analysis has progressed significantly in year and we identified a cohort of 104 high intensity users who had frequent multiple admissions and attendances at hospital A&E. We have begun a targeted approach led by our A&E Delivery Group and implemented through GP practices, to better manage people with frequent attendances to identify blocks and barriers that prevent these individuals from remaining well and stabilised in their home environment.

Also in partnership with our Public Health colleagues we carried out some detailed analysis of non-elective admissions in West Berkshire. A copy of the analysis is embedded below and a working group has been set up to look at how we can offer a more targeted approach to NEL's during 2017-18.

NELs in West Berkshire.ppt

From 1st July 2017 GP practices will be required to use an appropriate tool to identify patients aged 65 or over who are living with moderate and severe frailty. Our amended Anticipatory Care CES will build on this by using risk stratification tools already deployed in practices to ensure resources are targeted most effectively and efficiently. Demand for services is predicted to continue to rise with a growing older population and people living with more complex long term conditions. Our ambition is to expand our focus beyond the top 2% of the population to the top 10% who may not necessarily be high users of services now but are at risk of becoming so without early intervention.

In 2017-19 we will also use this intelligence to address and identify resources that can support individuals and communities in those wards with the highest attendances. This targeted approach will help us address and manage non-elective attendances further to improve health of those in our most deprived areas of West Berkshire.

Many of our schemes as well as the wider integration programme aim to specifically target the highest risk/cost segment of our population. Moving into 2017-18 and beyond our vision for supporting patents with long term conditions is underpinned strategically by development of our Accountable Care System and more operationally for 2017/18 and 2018/19 through the work of the CCG's Long Term conditions (LTC) Programme Board, aligned with to BCF and Frail Elderly Pathway.

Berkshire West will continue with the Care Home Project in 2017-19. Further detail on the progress of this project is in the next section.

Locally, a new project will start in 2017/18 Integrated Care teams. The vision of this project is around aligning teams, which provide a wrap around service for people to ensure continuity of care using a multi-disciplinary team (MDT) approach. The project will create and develop a joined up way of working for health and social care across West Berkshire to reduce hospital admissions. It is based upon the concept of providing joint management of complex patients and preventative care to people deemed to be at high risk of future admissions, thus reducing pressure on acute hospitals.

The CCG operating plan for NEAs was set following the NHS planning rules and includes IHAM (indicative hospital activity model) growth including demographic growth and a QIPP reduction with a net reduction against 2016/17 out turn. The proposed net reduction target will be a real challenge

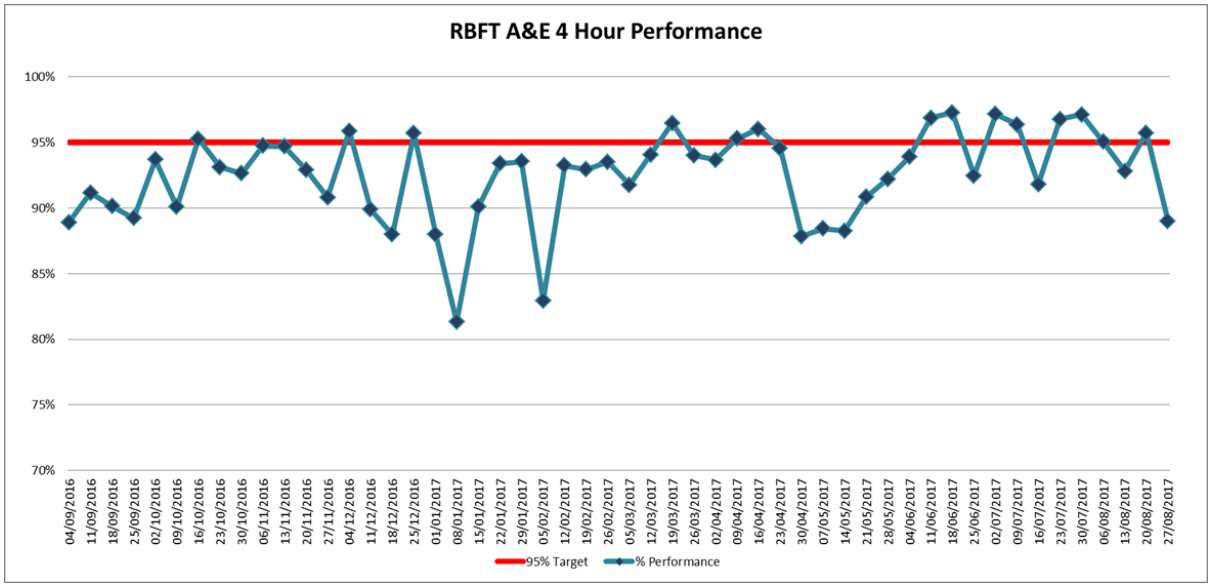
considering that we are already a high performing system, therefore reductions in NEAs for 2017/18 are challenging.

Based on analysis of year to date performance, and realistic impact of BCF schemes, we have no additional NEA reductions planned for our BCF plan and we are continuing to investigate the inconsistencies, which appear to be a national issue post submission and we expect to revise our submission accordingly

Challenge 3 : Increasing A&E Attendances and pressure on urgent care capacity

The high levels of A&E attendances experienced in 2015/16 continued into 2016/17 with no apparent let up during the traditionally quieter quarter 1. Hospitals are tasked with treating 95% of patients within 4 hours of presenting at A&E and the graph below shows that during 2016-17 this was only achieved for a few months of the year.

The geographical constraints within the A&E Department at the Royal Berkshire Hospital are such that when more than 50-60 patients are in the department at any one time then patient flow is compromised and the department struggles to function effectively. RBFT have made internal changes in 2016/17 to try and address the geographical constraints, including a new Senior Triage and Treat facility outside the old main doors and an expanded Observation Ward, but the challenge remains.



The Solution:

In September 2016, in line with national guidance the Berkshire West A&E Delivery Board was established. This forum focuses solely on Urgent & Emergency Care and membership comprises senior clinical and managerial decision makers from across Berkshire West. The new Board took immediate responsibility for recovery of the A&E 4 hour standard. In quarter 3 a local A&E Improvement Plan was developed comprising actions from the 5 mandated national improvement actions for A&E and other key actions agreed at 2 “Round Table” events held in July and September 2016.

Key features of the plan in relation to the integration agenda include: -

- Delivery of the NEL Action Plan (following the Deep Dive into NEL admissions)
- Health and social care support to A&E frequent attenders to reduce reliance on A&E

- Rapid Response services within 2 hours to prevent admission
- Discharge to assess embedded
- 7 day discharges
- Minimising Delayed Transfers of Care.

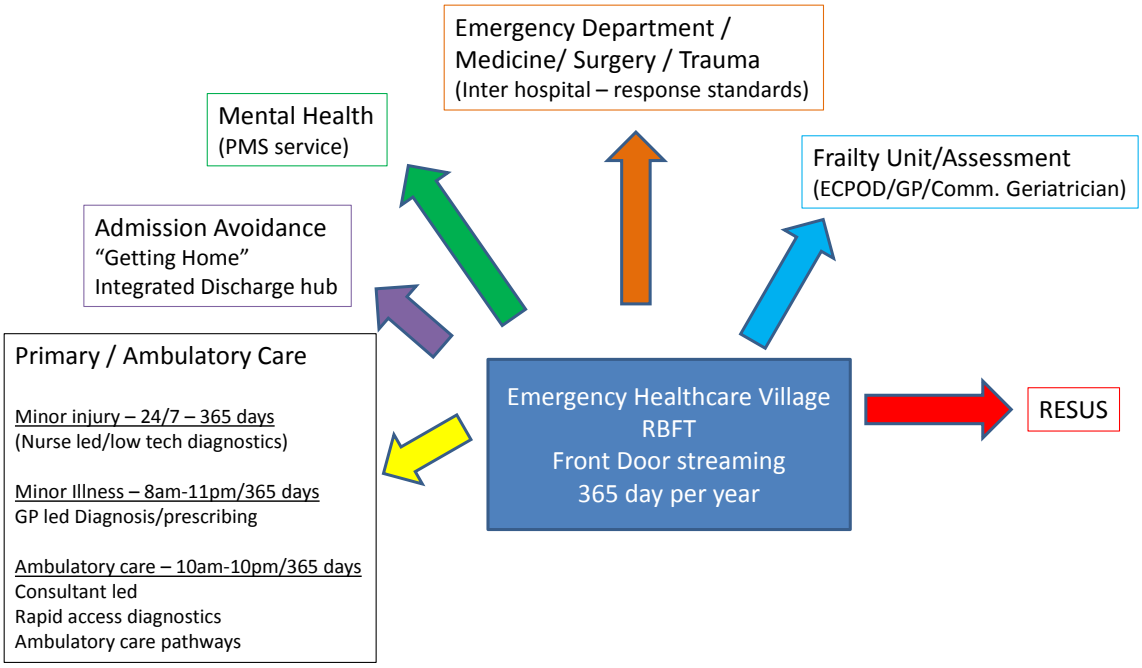
Good progress has been made on elements of the plan including improvements to ambulatory care, access to early senior opinion, Next Steps programme and CAMHs. Other areas require further focus and improvement in 17-18 including mental health crisis response, Getting Home project, DToC performance (noting that performance in community beds has improved). In June 2017 the A&E Delivery Board held a joint workshop with members of the Urgent Care Operational Group and other key stakeholders to agree the Board workplan for 2017-18. The revised plan includes the 7 nationally mandated pillars of Urgent and Emergency Care alongside local improvement priorities for pre-hospital, inter-hospital (acute, community and mental health) and discharge. KPIs are being developed so that the effectiveness of the key interventions can be measured and the A&E Delivery Board continues to take oversight of delivery of the plan.

BCF schemes targeting admission avoidance and a reduction in DToCs will support flow through the system and A&E 4 hour performance is one barometer of how well health and social care are working together to move patients through the urgent care system

Primary Care Streaming in A&E

From October 2017 a new approach to "streaming" patients will be introduced which will support improvements in waiting times at A&E and contribute to managing demand.

Berkshire West has been successful in bidding for £997k capital monies to deliver the physical changes required to support this new streaming approach.



Falls and Frailty

The aim of this service is to improve the experience of emergency care by providing an acute, blue light multi-disciplinary response to the older, frail patient who has fallen by providing on scene assessments and treatment at the time of the fall. The FFR response will make the patient safe, functional and independent in their own home through immediate clinical and therapy input.

This also reduces the risk of further falls through immediate treatment of minor illness and the supply of aids and equipment to assist in falls prevention with signposting to community services where necessary, This bespoke response will reduce the number of frail older fallers that are conveyed to hospital (when compared to a normal ambulance response).

It is planned to mobilise a three day a week service (Saturday, Sunday and Monday) from October 2017.

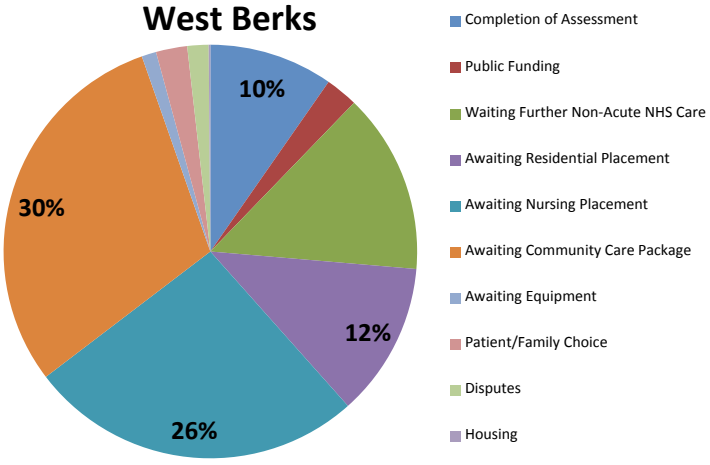
Challenge 4 : Rising Delayed Transfers of Care and subsequent bed day lost

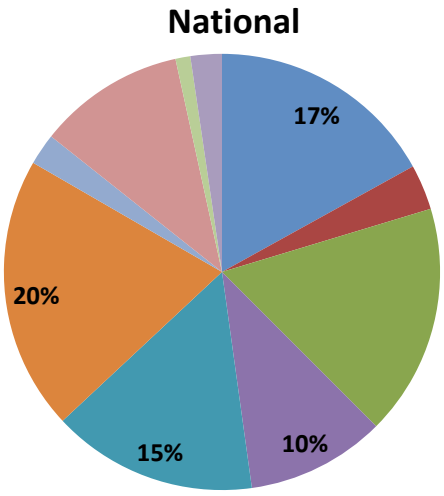
An increasing proportion of those attending A&E and who are subsequently admitted are frail elderly patients who have a higher level of acuity and longer lengths of stay vs the average patient.

We understand we have an issue with capacity in the market and we will continue to work with providers to explore this issue and look at other areas of similar demographics and rurality to learn from what they are doing

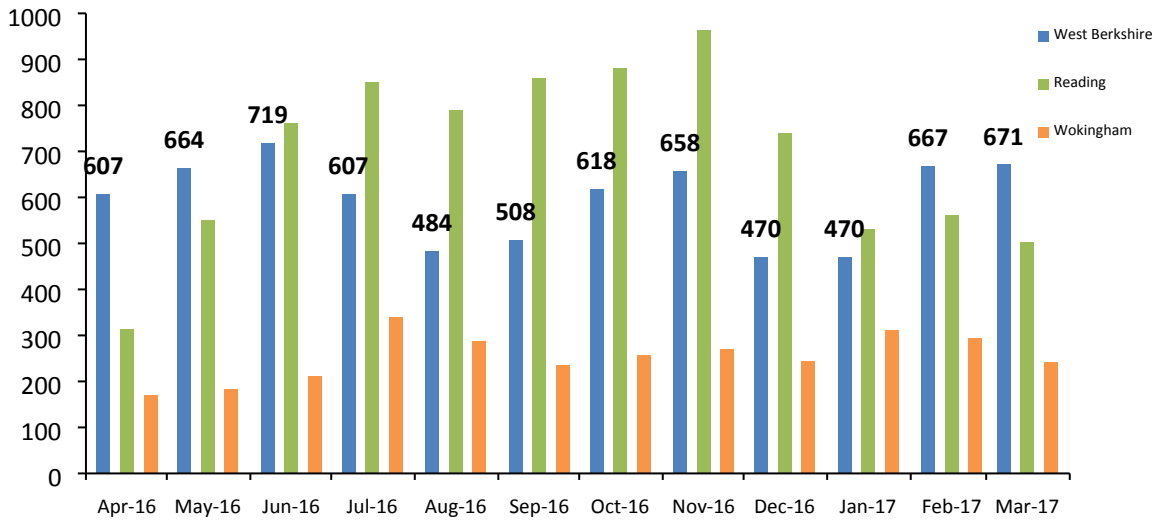
West Berkshire did not meet its target of reducing DTOC in 2016/17 and our performance identified the main reasons for delay were: -

- Awaiting nursing care placement - identifying homes and awaiting assessment by the provider
- Awaiting residential care placement – identifying homes and awaiting assessment by provider
- Awaiting care package in own home – sourcing package of care





Total Bed Days Delayed by LA per 100,000 population by Month



The Solution:

Delayed Transfers of Care High Impact Model

The BCF Planning requirements for 2017/19 require the Local Authority and CCG to consider their respective performance in relation to DToCs and to put in place a proportionate plan to improve the baseline position in 2017/19 leading to no more than 3.5% bed days lost.

To do this the local system is following the national best practice guidance High impact change model – "Managing transfers of care between hospital and home" (https://www.local.gov.uk/sites/default/files/documents/25.1%20High%20Impact%20Change%20model%20CHIP_05_Web_0.pdf).

West Berkshire has completed a self-assessment against the High Impact Change Model a copy of which is embedded below. .

High Impact Change Self Assessmentwestl

Following this self-assessment we have developed a DTOC Action plan against the 8 high impact change areas and this action plan is presented in the Delayed Transfer of Care section in this document. .

West Berkshire holds 2 weekly scrutiny DTOC meetings, one at team level and one at senior management level to review all hospital delays including Mental Health. All delays are monitored through the fit to go list, discussions with the Acute Trust and Community Trust takes place on a weekly basis to agree DTOC data before it is submitted, and we have introduced a heat map which shows people with delays of 5 days or more.

West Berkshire's Locality Integration board took the decision in November/December 2016 to invest money into improving our DTOC performance. It was agreed at that time to commission an external domiciliary care provider to provide 120 hours of additional capacity in the community and invest in 5 step down beds to facilitate hospital discharge to help improve our DTOC position.

Following the announcement of the iBCF West Berkshire agreed to increase the 5 step down beds to 10, employ a link worker in Prospect Park Hospital (Mental Health) to work across all the wards, working with clinicians to ensure information is being shared and to identify opportunities to discharge patients, employ a 2nd social worker to work at Royal Berkshire Hospital to support the hospital in discharging patients on the fit to go list, incentivise providers to get into hospital promptly and allow us to discharge a patient from hospital on a weekend, provide more OT Reablement support within Hospital settings to support the hospital as we often find they are risk adverse and will only discharge if a large package of care is available and employ a BCF analyst to support the BCF projects, in particular DTOC.

The BCF analyst will take forward a huge piece of work we have started around validating the data on DTOC to ensure we are confident with what is being submitted by the Hospitals. We recently completed a piece of work with Berkshire Healthcare Foundation Trust to review their data submissions, this piece of work highlighted a number of issues: -

- Ordinary residence – patients placed in a care home in West Berkshire but their ordinary residence was with another Local Authority but they were being reported as a West Berkshire delay.
- Over reporting days – in some cases patients were being reported when they hadn't met midnight and
- Codes and responsibility – in some case these were being mis-coded.

We now have a system in place with Berkshire Healthcare Foundation Trust and are receiving the data weekly for checking before it is submitted. This now needs to be replicated across all of the trust we work with and is part of what the BCF analyst will do. In June 2017 we saw a slight improvement in our performance.

We have only allocated a small amount of iBCF funding to the Care Market to offer an incentive to providers to get into hospital promptly and allow us to discharge patients from hospital on a weekend. West Berkshire's commissioning budgets are circa £37 million, the iBCF is £704K for 2017/18 therefore we could not make a commitment to increasing funding rates as it is unsustainable going forward, particularly in light of the fact we have to make savings of £895K from Adult Social Care in 2017/18.

We understand we have capacity issues in the market and we will continue to work with providers to explore this issue and look at other areas of similar demographics and rurality to learn from what they are dong. In August 2017 we held a DTOC workshop which was attended by the 3 Local Authorities in Berkshire West, the CCG's BHFT and RBH to look at DTOC data and to ascertain what we could all learn from each other regarding operational processes in order to make improvements to our performance. For West Berkshire the workshop reinforced our key issue of market capacity, particularly home care in rural areas. We also identified that our Joint Care Pathway received more referrals each month by comparison with the other two localities, by up to 30. Therefore we are looking at what else we can do to support admission avoidance this will include the work we are undertaking with Primary care to target individuals most at risk of hospital admission, improvements, introduction of step up beds and maximising the existing admission avoidance services.

Challenge 5 : Increasing pressure 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 reduced funding Through its corporate plan, the Local Authority has affirmed its commitment to caring for and protecting the most vulnerable in its community. There is also an

explicit acknowledgement of the need to work differently to avoid the consequences of a widening gap over the next few years and a greater focus on building community resilience.

The key areas of demand for adult social care in West Berkshire are amongst adults with learning disabilities, those over 75 and those with dementia, both the latter have a longer than average length of stay due to waiting for community based services this is primarily because they have complex needs requiring more care. Attendances at the main acute Trusts continue to rise and consequently the number of patients on the “fit to go” list. This has significantly increased demand for care in all settings e.g. nursing, residential and homecare. 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 long term solution is a resilient care market that offers people high quality, consistent and flexible care whatever the setting. The Better Care Fund makes a significant contribution to adult social care commissioning budgets, helping the Council protect social care services and the additional iBCF monies have supported us to do more. Plans for the next two years are focused on creating capacity in the care market, including the introduction of 10 step down beds that focus on re-abling people to reducing the amount of care they need. We have a West of Berkshire workforce project focused on improving recruitment and retention for carers. We are also employing a range of strategies with homecare providers including supporting the development of micro providers, developing new block contract arrangements and use of gain share to encourage care homes to respond more promptly to hospital discharge.

Dementia Care

By 2020 we expect to have 1614 living with Dementia in Berkshire West. This is expected to rise to 2165 by 2030 (50% more than in 2015). Identifying those living with Dementia and the provision of high quality diagnosis care is a priority for all four Berkshire West CCG’s.

A new refreshed Berkshire West Dementia stakeholders group has been established with the specific aim of sharing good practice and identifying solution to current gaps in order to deliver against the Prime Ministers challenge on Dementia 2020. The West Berkshire Dementia Alliance is working with other Alliances in Reading and Wokingham as part of this group to shape and inform a new integrated approach to joint assessment, care planning and ongoing management of people with Dementia. Younger people, as well as older people with Dementia have integrated commissioning of services already in place and Dementia Care Advisors in addition to an admiral nurse resource to ensure support is provided in a patient centred approach.

Over 2017/18 and beyond we will be working to update and deliver our Local Berkshire West implementation plan, which will include improving timely diagnosis and delivery quality ongoing management and support for people with Dementia and their carer/s. A separate Dementia action plan and plan on page with key milestones is available alongside the Berkshire West CCG’s Operating Plan submission for 2016/17.

Dementia Action Plan June.pdf

Challenge 6 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.

The Solution:

There is an expectation that all patients will have access to a GP 7 days a week 8am-8pm by April 2019.

As part of the development of collaborative/hub arrangements for extended hours, we also want to work with providers to further explore the potential benefits of streaming in-hours same-day appointment requests into Primary Care Access Hubs as described in the *GP Forward View.* We intend to build upon the Enhanced Access CES we have already commissioned to move towards delivering our trajectory to meet the requirement for all patients to have access to routine and booked appointments each early morning and evening and on both Saturdays and Sundays. Hubs would also align with the broader urgent care system including the re-procured NHS 111 service.

These hubs, which we anticipate will be run through our GP Alliance will work as part of our urgent care system to respond to on-the-day demand in the most efficient way, including by receiving direct bookings from the NHS 111 service and undertaking early home visiting. This will enable GP practices themselves to focus on providing high intensity input to the most complex patients. We are still working to further define possible models which could vary from alliances between practices to cope with excess demand to fully-integrated arrangements for dealing with all on-the day demand.

The redesign of same day access to primary care is a complex workstream with a number of co-dependencies. These include links to our Urgent Care Strategy including the designation of Urgent Care Treatment Centres, recent developments around primary care streaming in ED and the current re-procurement of the NHS 111 programme. As such we are taking this work forward as part of our ACS programme and will also be reflected in the STP Urgent and Emergency Care Strategy

The Royal Berkshire Foundation Trust is compliant with the 4 priority clinical standards for 7 day access;

1. Less than 14 hours from admission to first Consultant review
2. Access to Consultant directed diagnostics
3. Access to Consultant directed interventions
4. Consultant led ward round at least once every 24 hours

In addition in 2016-17 the CCGs agreed a new Discharge CQUIN with RBFT to ensure that internal causes of delay were closely monitored and addressed across 7 days. The CQUIN incentivised the Trust to rollout their Next Steps programme across all wards. The Next Steps programme requires the next step in the patient's care to be documented on the Electronic Patient record system thus supporting visibility of internal waits. The CCGs then worked with the Trust to understand the most significant reasons for delay and agree plans to address these. The Trust also put in place electronic internal referrals again promoting visibility of waits across 7 days.

In response to issues created by a lack of provision over the weekend, our 7 Day services project enhances the existing 7 day provision across both health and social care in a coordinated and affordable way. The Joint Care Pathway project and the Community Nurses Directly Commissioning Care / Reablement Services 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 7 : 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.

The 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.

Progress to date

Health and Wellbeing Board

West Berkshire's Health & Wellbeing strategy 2017/2020 below was approved by the Health and Wellbeing Board on 24th November 2016 and adopted by the Council on 2nd March 2017. The Strategy sets out five strategic aims that the board is working towards. Under each aim, three or five objectives specify what the Board wants to do to achieve its aims.

Appendix A - West Berkshire Joint Health

There are four themes that underpin all of the priorities outlined in the strategy above: -

1. Integrated care – working in partnership to ensure that health and social care is personalised and delivered in the right place at the right time, in community settings and close to home wherever possible.
2. Prevention – improving health and wellbeing by encouraging and supporting people to take responsibility for improving and maintaining their own health
3. Building communities together – enabling communities to be stronger and resilient, solving problems for themselves, working together with partner agencies and the voluntary sector to meet their health and wellbeing needs.
4. Tackling inequalities in health – addressing the wider determinants of health such as housing, unemployment, homelessness, education, social isolation, transport and community safety. Ensuring those who have the most need in our district are as healthy as everyone.

Berkshire West 10 Projects

The leaders of the 10 Health and Unitary Authority partners, known as the Berkshire West 10 (BW10), have been working together since 2013 within a shared governance structure. The BW10 integration programme is an ambitious transformation programme involving a number of projects across these 10 organisations. The projects operate both at locality level and Berkshire West wide to deliver the intended benefits. The collective objective is focused on improving outcomes for users and patients and achieving long term financial sustainability. Overseen by an Integration Board and with project implementation supported by a joint Delivery Group, the BW10 has focused on specific improvements for the frail elderly population, Mental Health Care and Children's Services.

During 2016/17 we have completed work around the frail elderly pathway (outside of the BCF but within the integration portfolio at BW10 level). This has allowed us to identify those costing us the highest amount of resources in the system.

Many of our schemes as well as the wider integration programme aim to specifically target the highest risk/cost segment of our population

A copy of the latest Berkshire West 10's dashboard is embedded here and includes the BW10 projects as well as projects at a local level. A progress update on each of the projects which ran in 2016/17 is detailed below. .

BW10dashboard.ppt

Care Home Project – This project was established in Berkshire West in April 2015 with the aim to provide a common and consistent approach to improving outcomes for those people living in Nursing and Residential Homes in Berkshire West. This was through the training and education of care home staff, medication reviews of all residents and since October 2015 enhanced care through the introduction of a Care Home Rapid Response and Treatment Service (RRAT) that provides 7 days a week, 9am – 7pm treatment via a multidisciplinary team linking in with specialist nurses and therapists. The services offers the residents a co-ordinated and joined up health and social care service, reducing unnecessary admissions to hospital, improving the flow of patient from community to acute and back to community and avoiding unnecessary delays in discharges back to the care homes.

There are 54 care homes (both nursing and residential) in Berkshire West that have engaged with the Care Home services to ensure that their staff have the skills and knowledge to deliver optimum care to their residents and that their residents receive quality care within their own home.

The aspiration is to have a service that is 'wrapped around a resident's needs', and provides the proactive management of long term conditions. This should prevent deterioration of the resident condition/s, enable early intervention of 'ill health' and promote the health and wellbeing of residents in care homes. By also, engaging early with resident and their families and carers, they are enabled to make informed decisions about their future care, whilst providing a rapid response treatment service to those residents with acute need within their home.

The project is showing encouraging signs of success and proposes to build on the work already undertaken to reduce NEL admissions from care homes and the supporting pathway to ensure residents of care homes in Berkshire West are able to remain in their place of residence as far as is reasonably practicable and appropriate.

The data set out below (Table 1) reflects 12 months of activity, however as the programme was not fully mobilised until September 2016 the data has also been split to give a more accurate picture of the impact of the programme (Table 2)

Table 1 – 2016/17 performances

	2015/2016	2016/17	No. Difference	% percentage
SCAS				
- Calls	1,927	2,144	+217	+11%
- Hear & Treat				
- See & Treat	56	66	+10	+18%
- See, treat & Convey	619	638	+19	+3%
	1215	1440	+225	+19%
A&E	1,133	1,315	+182	+16%
NELs	1,117	1,196	+79	+7%

Whilst M1 to M12 data is demonstrating an increase in SCAS, A&E and NELs activity in 16/17 compared to 15/16, Table 2 below demonstrates a considerable difference in activity in M6-M12 16/17 compared to M1 to M5 16/17; this highlights the positive impact of the Care home Rapid Response and Treatment (RRaT) service once all 54 care homes went live in September 2017. It is also worth noting that compared to 2015/16 there were 2 additional homes opened in Berkshire West.

Table 2 – 2016/17 performance aligned to full roll out of the RRAT team

	M1 to M5 Actual		No. Difference	% difference	M6 to M12		No. Difference	% difference
	15/16	16/17			15/16	16/17		
SCAS	694	858	+164	+24%	1233	1286	+53	+4%
A&E	419	555	+136	+32%	714	760	+46	+6%
NELs	396	513	+117	+30%	721	683	-38	-5%

This work project will continue to be delivered through a project group that will oversee the delivery of the project's objectives, focussing on collaborative working directly with key stakeholders, in particular the care home staff and Local Authorities. In 17/18 it will continue to support:

1. The Rapid Response team and on-going evaluation of the impact of the service on the delivery of 30% reduction of NEL admissions. The 30% reduction is in line with the outcome from best practice examples of schemes undertaken by similar health economies to Berkshire West A Protocols and Standards process that is supported by all providers focusing on the delivery of quality social and health care and reducing the impact of any necessary interventions outside the care home, in particular length of stay in secondary care. To work with partners in the development and roll out of these protocols, standards and ESD that supports the care of patients in the care home.

2. A Health and Social care process for the monitoring of Care Home performance through collaborative working with all providers. The group will work to establish processes that bring all elements of health and social care together in the monitoring and review of care homes. Linking the Care Quality Commission (CQC) work with that of safeguarding processes and how this quality assurance moves across into the contracting process. Working in partnership to develop a central reporting function that provides comprehensive data on each Care Home, it's facilities, specialist competence, staffing skill mix and case reports that share the learning across Berkshire West

3. The Care home Medicines management team to ensure medication reviews continue in a timely manner and explore how the team can work more closely/in partnership with the new GP provision to care homes to, increase efficiency.

4. The piloting of a new model of GP support to care homes that moves away from the traditional 'reactive' model of care towards a 'proactive 'care model that is centred on the needs of the resident, their families and care home staff. This model ensures that all residences have a 'holistic' assessment to establish care needs, care plans and consider appropriate intervention to maintain health and well-being and reduce risk. It ensures the pro-active management of Palliative /End of Life Care and reduces the fear of dying and

enhances the experiences of dying for residents and their families. This model will also improve the residence's experience through high quality essential care – reducing distress from depression, disorientation, agitation, pressure sores, contractures, constipation, pain and sleeplessness, whilst minimising predictable acute events. This model will also improve the residence's experience through high quality essential care – reducing distress from depression, disorientation, agitation, pressure sores, contractures, constipation, pain and sleeplessness, whilst minimising predictable acute events.

5. The roll out of the 'red bag' initiative across Berkshire West Care homes

6. Assessment of the current IT provision in care homes and future requirement to allow joint working with health and social care

7. Pilot 'Patient alert system' for care home residences attending RBH A&E and/or admitted to RBH

8. Pilot the 'Trusted Assessor' to reduce delayed discharges back to Care home

Getting Home Project – In 2016/17 Local Authorities and CCGs in Berkshire West agreed a local action plan to reduce DTOC, which included 8 high impact actions. This project focuses on implementation of three of the high impact changes for DToC's – Multi-agency discharge team, discharge to assess and trusted assessment.

Multi-agency discharge team a new Integrated Discharge Service with a jointly funded(between RBH and BHFT) service manager will form part of the work under the Getting Home Project. The discharge to assess and trusted assessor/assessments model and pathways will be integrated into this service. The existing Service Navigation Team and Integrated Discharge team will form the basis of this new team with progression opportunities and a number of new posts created from vacancies.

The new Integrated Discharge Service (IDS) will adopt a case management approach to manage complex discharges throughout the Trust using the principles of the "Getting Home" project. The concept of 4 levels of discharge will enable those cases which require input from the service to be identified. Level 0 discharges are straightforward and require no or minimal input (eg district nurse for sutures) from other services, these should be managed by the ward teams. Level 1 and 2 discharges require input from services such as CRT or transfer to a community hospital and will in the main be managed by the ward teams with light touch from the integrated discharge service. Levels 3 discharges are complex and may require social care input or self-funding status. These will require active case management by the integrated discharge service.

Colleagues in social care are a key component of the service and close working is expected. This will be enabled through the "Integrated Discharge Hub"; a new working area for all staff involved in discharge planning and also housing the discharge lounge. This area will be central to the service and enable "discharge huddles" and close working.

Partial implementation is scheduled for 23rd October 2017.

Discharge to Assess - A pilot started in Hurley Ward RBH in June using the 'discharge to assess' model and the trusted assessor approach. A process was agreed with each locality. The RBH occupational therapists from Hurley ward being the trusted assessors taking patients home and assessing them in their home with the view to reducing the package of care and freeing up a hospital bed. This pilot will be reviewed at the end of September.

Trusted Assessment: - A successful trusted assessor workshop was held in May with stakeholders across Berkshire West. The focus was to understanding what is meant by a trusted assessor? The operational challenges faced? How to overcome them and what a good trusted assessor approach looks like? This led to a decision to focus on the reablement pathway. A smaller task and finish group has developed a standard operating procedure, agreed the use of a single referral form and a shared care plan. A scoping exercise is underway and to be completed in September. This will include agreeing a set of targets, who and what is being assessed, agree who can be the trusted assessor, a robust feedback loop and the review mechanism. The group will also explore the option of including the care home element. A pilot will run for 3 months will a provisional start date of October 2017.

Connected Care – This programme has been established since 2014 and currently consists of 17 organisations all using one technical solution, the Graphnet portal, which has been designed to

- safely share health and social care information from multiple health and social care IT systems
- via a portal which displays information
- provides a person centric view of care across organisaitons to appropriately authorised professionals.

This solution also supports the delivery of the 10 universal capabilities as defined in the Berkshire Local Digital Roadmap and enables service transformation as specified in Buckinghamshire, Oxfordshire and Berkshire Sustainable Transformation Plan (STP).

The Connected Care programme began to roll out in March 2016 and has already proved to be an active vehicle to support collaboration between health and social care organisations. Within the first 3 weeks, 535 professionals had accessed 2400 records across Berkshire West, with clear benefit identified.

West Berkshire will go live in October/November 2017 and has already put in place measures to ensure that all West Berkshire Residents use the NHS identifier.

The Vision in the Better Care Fund is that, Connected Care on its own can't delivery change but it can enable our collective workforce to work in new innovative ways. Technology joined with the desire to transform care around the individual will support us on the path to integrated care. Therefore an assessment of Connected Care for each of the Better Care Fund schemes has been undertaken to assess the opportunities from embracing this technology – this can be viewed in the embedded document above.

Workforce – This project was derived as a key enabler from the work to develop the Frail Elderly Pathway to support the BW10 ambitions to transform the workforce to meet current and future challenges faced by health and social care providers. This will be aligned with the BOB STP priority work-stream to improve workforce value and focus on development of a cross-organisational staff bank and a recommended next step for the work-stream was to achieve greater alignment with the ADASS work. This is being followed by the BW10 delivery group.

Care Planning and Case Management

Patient centred care has been adopted within health since 2012 using the "House of care" model. To date this has been successfully rolled out to people in Reading with Diabetes through the delivery of care and support planning. During 2017 we have begun to embark on a journey across the system to transform the delivery of care to people with multiple long term conditions. The approach includes further roll out of care and support planning and case management, in a multidisciplinary manner, to other long term conditions. This will transformation the way people access follow up care. With greater use of technology, we will be able to deliver care closer to home, which is aligned with people's individual goals and aspirations. Our Connected Care project will allow all parts of the system to share care plans and better integrate care according to need. We are working alongside our colleagues in psychological therapies to ensure we offer parity of esteem and support to people with mental health issues associated with their long term health and social care needs.

West Berkshire Projects

Locally in 2016/17 West Berkshire ran the following projects: Patient Recovery Guide, Joint Care Pathway, and 7 day services.

Patient Recovery Guide Project – This project ran from July 2015 – June 2016. The origin of the project was to develop a dedicated personal support service to assist patients through the care pathway and to ensure that patients do not remain in hospital for longer than was necessary nor do they become the subject of avoidable admissions to hospitals. However, a decision was taken by the local integration board to cease funding this project in June 2016 as the evidence suggested the project did not meet all of its expected outcomes and that the money could be used better elsewhere. A copy of the evaluation report is embedded below:

Patient Recovery Guide Pilot Project ev

The under spend from the Patient Recovery Guide project was allocated to create additional capacity in the Market in providing 120 hours of community care to assist hospital discharge and improve our DTOC performance. Due to a delay in recruiting carers the community care did not start until 20th February 2017.

The Joint Care Pathway and 7 day Services Project - – This project was set up in June 2015, building on the then existing informal joint working arrangements between West Berkshire Council(WBC)and Berkshire Healthcare Foundation Trust (BHFT) teams at an operational level to create a combined service. The three teams that were combined to create The Joint Care Pathway were Intermediate Care Service (BHFT), Maximising Independence Team (WBC) and In-house Reablement Team (WBC). The project had 4 key objectives: -

1. All hospital discharges needing a service from Health or Social Care Services to be routed through one Joint Care Pathway.
2. A 7 day response service that can ensure that preparation for discharge can continue over weekends and where appropriate discharges can take place on a 7 day per week basis.
3. The 7 day service to be available to patients in the full range of hospital including acute and the Community Hospital sector.
4. Joint Care Provider service to develop a co-ordinated workflow to ensure that there is not confusion in accessing services between the Joint Care provider and the Council's Locality Teams.

This project will become business as usual in 2017/18 (a copy of the closure report is embedded below). and following an evaluation using the tool developed through the BCF in 2015/16 the 7 day services element will be re-configured with a smaller budget but mirror what the Royal Berkshire Healthcare Trust are delivering and support hospital discharges over 7 days. The evaluation can be found in the next section.

jcpclosurereport.docx

In addition a review of the Joint Care Pathway was conducted to look at the systems and processes being used, identify enablers and barriers for integration and identify what should happen next to solve the barriers. A copy of the report is embedded below but a number of key priorities for the next

2 years include: trusted assessment, single management and linking in with the STP with simplifying the Section 2 and Section 5 paperwork for all hospital discharges. .

reviewreportfinal.docx

West Berkshire Locality also held a self-assessment workshop "stepping up to the place" in December 2016. The results of which are embedded below. We are planning re revisit this evaluation at our Locality Integration Board in November 2017 to make plans to graduate in March 2018.

steppinguptotheplaceevaluation.docx

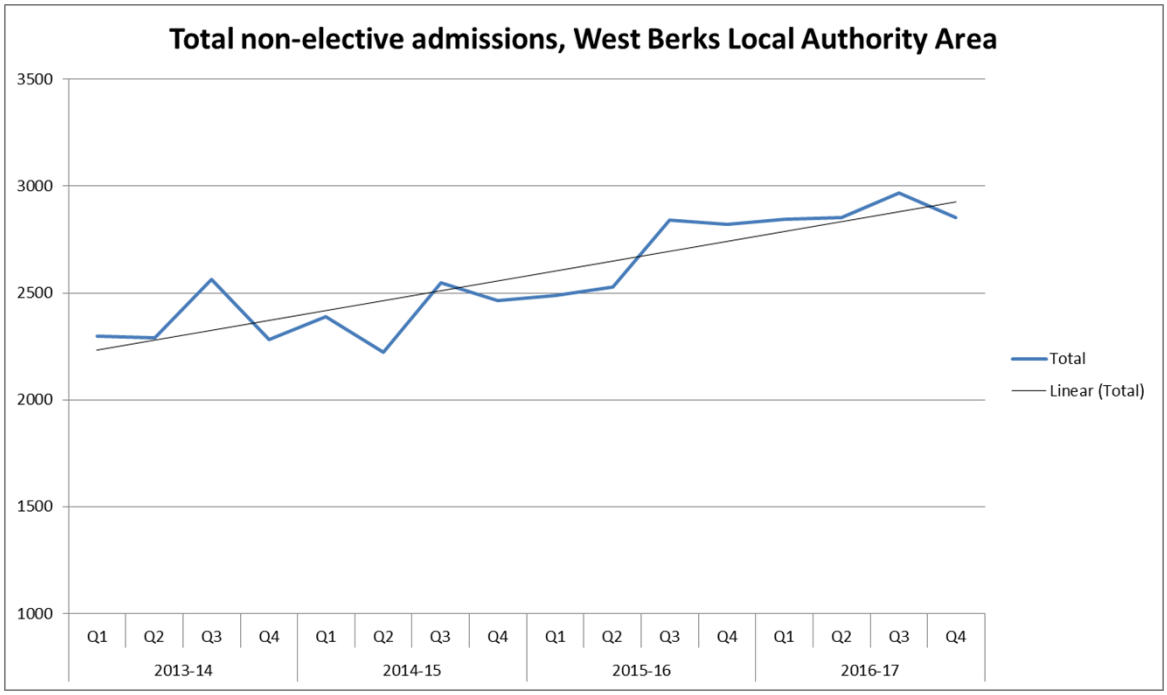
Current Performance on Metrics

Non Elective Admissions

The Berkshire west CCG's are collectively recognised as high performing and benchmark well nationally on a number of key performance measures, including non-elective admission rates. For the last two full years, Berkshire West CCG's have been in the top 4% of CCGs for non-elective admission rates.

In 2016/17 Newbury & District CCG was the 6th best performer in the Country for non-elective admissions as demonstrated in the table below: -

CCG	Admissions	Population	Rate	Rank
NHS Wandsworth CCG	24273	386602	62.79	1
NHS Gloucestershire CCG	40692	636034	63.98	2
NHS Wokingham CCG	11194	160468	69.76	3
NHS South Reading CCG	10061	140413	71.65	4
NHS West London CCG	17393	242428	71.75	5
NHS Newbury and District CCG	8519	117634	72.42	6
NHS Tower Hamlets CCG	22070	300382	73.47	7
NHS North & West Reading CCG	8097	109686	73.82	8
NHS Central London CCG	15857	212847	74.50	9
NHS Richmond CCG	15925	211353	75.35	10



Delayed Transfers of Care

In 2016-17 the CCG's worked with Local Authorities in Berkshire West to develop a system wide "Delayed Transfers of Care Action Plan" which was signed off by all partner organisations across the health and social care system. The Urgent Care Programme Board, now A&E Delivery Group and Health and Wellbeing Boards took oversight of delivery of the plan. The key deliverables within the plan were: -

- Coding review – a new local coding set for DToC's which align to the national codes is now in use and LA's meet with BHFT on a weekly basis to agree and sign off the DToC reporting.
- Improvements to the Continuing Health Care (CHC processes)
- Choice Policy: Berkshire West adopted the new national framework and the new Choice Policy was signed off by the Urgent Care Programme Board in September 2016.
- Getting Home Project – this project focuses on implementation of three of the high impact changes for DToC's – Multi-agency discharge team, discharge to assess and trusted assessment. Some improvements have been achieved in 2016-17 but this proj3ect will carry forward into 2017-18.

A decision was taken in-year to support RBFT in letting a short term contract to CHS, a company providing specialist support to self funders and complex discharges. This contract commenced on 8th January 2017 and the impact and learning will be closely monitored by the Integration board. West Berkshire has introduced weekly scrutiny meetings to review all patients regardless of length of stay in hospital – early indications are that delays are improving as a result of this.

Despite this progress BCF targets in 2016/17 were missed and further improvement is required. It should, however, be noted that an issue with reporting of delays in mental health beds that was corrected in-year meant that the targets were set artificially low as these delays were not in the baseline.

In 2017/18 we will work with our Health Partners to fully understand the reasons for delay, look at how these delays are reported and coded and work with them to reduce what can sometimes be lengthy

delays. In August 2017 we held a DTOC workshop which was attended by the 3 Local Authorities in Berkshire West, the CCG's BHFT and RBH to look at DTOC data and to ascertain what we could all learn from each other regarding operational processes in order to make improvements to our performance.

Our key focus in the 2017/19 BCF will be to improve our DTOC performance.

Residential Admissions

Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency and the inclusion of this measure in the Adult Social Care Outcomes Framework (ASCOF 2A, part 2.Long-term support needs met by admission to residential and nursing care homes, per 100,000 population**)** supports local health and social care services to work together to reduce avoidable admissions.

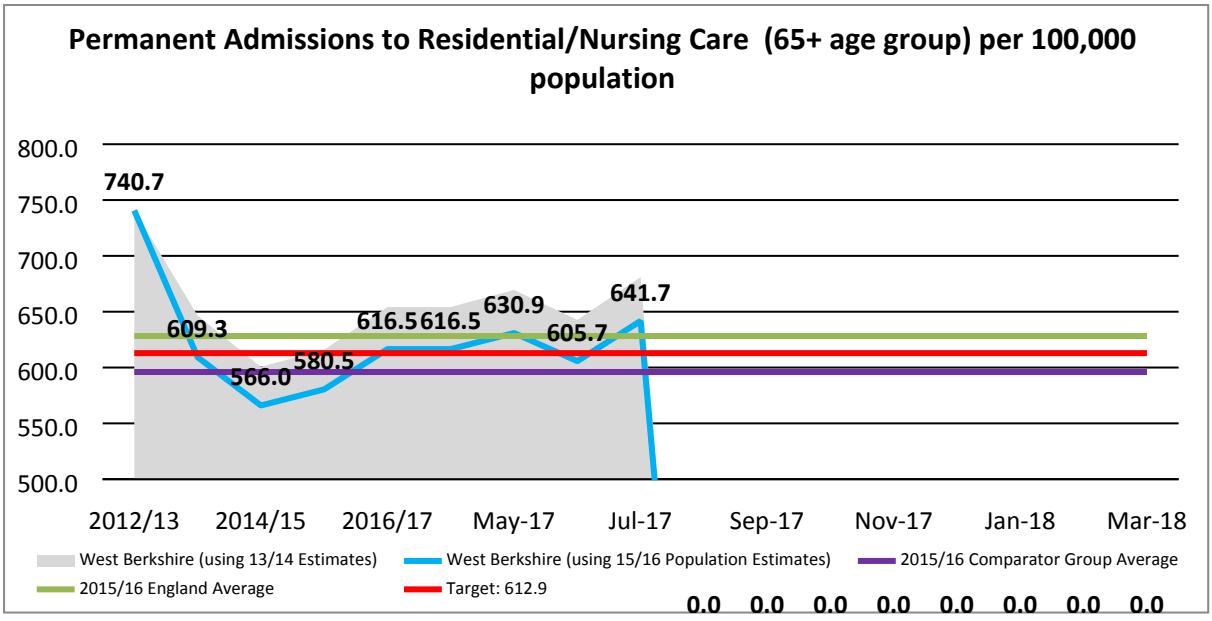
Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation.

This measure reflects the sum of the number of Local Authority supported older people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) per 100,000 population.

Our performance in 2015/16 at was 581 (161 admissions) which, positively, was below the England average for 2015/16 (last published data) at 628.1.

The published data for 2016/17 is not due until October 2017. Our actual for 2016/17 was 171 new admissions and once the published data is issued we will be able to compare our performance to the England average for 2016/17.

Overall placements increased last year indicating increased demand as a result of challenges in relation to commissioning care in the community and significant pressures on DToC and how we get people out of hospital quickly and safely. It is unlikely these pressures will decrease so we can predict that the number of new placements will continue to increase. Our target has been set at 5% for 2018/19 as outlined in our planning template submission.



Reablement

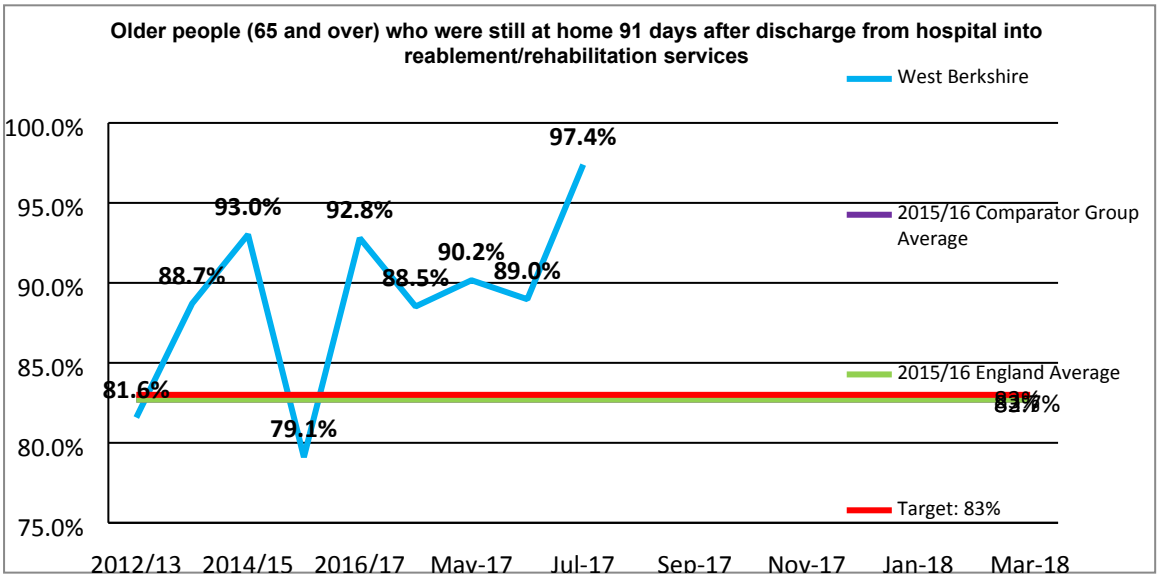
(ASCOF 2B part 1 – Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into Reablement/rehabilitation services.

There is strong evidence that suggests reablement services lead to improved outcomes and value for money across the health and social care sectors. Reablement seeks to support people and maximise their level of independence, in order to minimise their need for ongoing support and dependence on public services.

This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services. It captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement.

Our Actual performance for 2016/17 was 93%, the England average for 2015/16 (last published data) was 82.7%.

As a result of the Joint Care Pathway and emphasis on reablement we have seen numbers receiving reablement increasing, however there is a market capacity limitation to this and as this indicator only measures the last 3 months in the year it remains volatile and therefore we propose that the target in 2017/18 is cautious but will increase to outperform the England average. Our targets for 2018/19 are outlined in the planning template submission. (Once the published date for 2016/17 has been issued we can compare our performance and readjust if needed). .



Evidence base and local priorities to support plan for integration

West Berkshire's Integration Board is responsible for the business and overall performance of projects within the BCF and integration programme and we have a strong foundation in our shared vision and our track record.

As described in the background and context section of our plan there is a significant financial challenge facing West Berkshire over the next 5 years as we cope with increasing demand for high quality services while contending with a constrained and challenging financial position as well as a very challenging care market.

There are number of key areas, which collectively, provide sufficient evidence of growing demand and care market pressures in West Berkshire's Health and Social Care economy these are: -

- An increasing population, particularly in those over the age of 65
- Increasing growth in non-elective care
- Increasing 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 (particularly in rural areas) and care homes at a time when the overall Council budget is significantly shrinking
- Inequality to access to
- workforce availability
- Increasing pressure on Social Care in relation to prevention and early intervention

It is predicted that the number of over 65's in West Berkshire will increase 24% year by 2021 and those over 85 years of age by 39%. The impact of this demographic change on the health and social care system will be vast. It is also predicted that 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 1 long term condition.

During 2016/17 we progressed our work around the Frail Elderly Pathway (FEP) and this has allowed us to identify those costing us the highest amount of resource in the system. We will continue to embed the early projects developed as a result of this work eg. Rapid Response Treatment Team embedded in the Care Home Project and the Joint Care Pathway and take forward the work that PA consulting have done with us to explore the potential impact of increasing use of telecare and assistive technology.

In 2016/17 Newbury & District CCG was the 6th best performer in the country for non-elective admissions. In 2017/18 we will continue with the Care Home Project which is focused on reducing Non-elective Admissions and following our amended Anticipatory Care CES we will be introducing a new project on integrated care teams, this is based on the concept of providing joint management of complex patients and preventative care to people deemed to be high risk of future admissions, thus reducing pressure on acute hospitals.

The CCG operating plan for NEAs was set following the NHS planning rules and includes IHAM (indicative hospital activity model) growth including demographic growth and a QIPP reduction with a net reduction against 2016/17 out turn. The proposed net reduction target will be a real challenge considering that we are already a high performing system, therefore reductions in NEAs for 2017/18 are challenging.

Based on analysis of year to date performance, and realistic impact of BCF schemes, we have no additional NEA reductions planned for our BCF plan and we are continuing to investigate the

inconsistencies, which appear to be a national issue post submission and we expect to revise our submission accordingly

The high levels of A&E attendances in 2015/16 continued in 2016/17 and in September 2016, in line with national guidance the Berkshire West A&E Delivery Board was established. This forum focuses solely on urgent and emergency care and membership comprises of senior clinical and managerial decision makers from across Berkshire West. The new board developed a Local A&E Improvement Plan and this work will continue into 2017/18.

West Berkshire's DTOC position worsened in 2016/17 with four consecutive quarters of increases compared to the previous financial year and 70% of delays were as a result of capacity issues in the care market in all settings.

Within the mandate to NHS England for 2017/18 there is a very specific target which has been imposed nationally "target reduction in total delayed transfers of care to 3.5% by September 2017" It should be noted that the market is getting more challenging alongside the demographic demand increase year on year so this is a very demanding target.

Whilst we are committed to achieving the national target of 3.5%, based on our performance in 2016/17, capacity issues and increasing demand further investment will be required to fully address market concerns and for us to meet the target of 3.5%. We have however focused our investment on schemes that will bridge the gap to allow us to help people out of hospital more quickly and believe a 5% target is more realistic. If further permanent funding was available it would allow us to pass this directly to providers and create a more sustainable care market.

Details of how we plan to improve our DTOC performance and the projects we will take forward in 2017-19 are detailed in the DTOC metric section along with a copy of how we plan to meet the 8 high impact changes.

Like every other Local Authority in the Country, West Berkshire faces challenges in delivering its priorities against reduced funding. Through its Corporate Plan the Authority has affirmed its commitment to caring for and protecting the most vulnerable in its community. The Better Care fund makes a significant contribution to adult social care commissioning budgets, helping the Council protect social care services and the additional iBCF monies have supported us to do more.

In 2017-19 we are focussed on creating capacity in the care market and reducing our Delayed Transfers of Care. The introduction of our 10 step down beds will focus on reabling people to reduce the amount of care they need and help improve of DTOC Performance. We also have a West of Berkshire recruitment project focused on improving recruitment and retention for carers. We will also be looking at a range of strategies with homecare providers including supporting the development of micro providers, developing new block contract arrangements and the use of an incentive to encourage care homes to respond more promptly to hospital discharges.

It is widely accept that people need health and social care services every day and 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.

There is an expectation that by April 2019 all patients will have access to a GP 7 days a week 8am – 8pm and as part of the development of collaborative/hub arrangements for extended hours we also want to work with providers to further explore the potential benefits of streaming in hours, same day appointment requests into Primary Care Access hubs as described in the GP forward view.

West Berkshire Locality held a self-assessment workshop “stepping up to the place” in December 2016. The results of which are embedded below. We are planning re revisit this evaluation at our Locality Integration Board in November 2017 to make plans to graduate in March 2018.

steppinguptotheplaceevaluation.docx

Better Care Fund plan

Berkshire West

West of Berkshire Projects for 2017/18 and 2018/19 include: Connected Care, Care Homes, Getting Home, Street Triage for Mental Health Patients, SCAS falls and RBH Delayed Discharges Project (CHS). The workforce project which ran in 2016/17 will now be aligned with the STP workforce aspirations.

Connected Care – In 2017/18 Connected Care will seek to build on the rich data source to establish secondary uses for the data to inform commissioners and providers of the Better Care Fund on population health analytics. This information could help us inform planning and service redesign.

The Locality Authority in West Berkshire will be going live in October/November 2017.

Care Homes -. I In 17/18 it will continue to support:

1. The Rapid Response team and on-going evaluation of the impact of the service on the delivery of 30% reduction of NEL admissions. The 30% reduction is in line with the outcome from best practice examples of schemes undertaken by similar health economies to Berkshire West A Protocols and Standards process that is supported by all providers focusing on the delivery of quality social and health care and reducing the impact of any necessary interventions outside the care home, in particular length of stay in secondary care. To work with partners in the development and roll out of these protocols, standards and ESD that supports the care of patients in the care home.

2. A Health and Social care process for the monitoring of Care Home performance through collaborative working with all providers. The group will work to establish processes that bring all elements of health and social care together in the monitoring and review of care homes. Linking the Care Quality Commission (CQC) work with that of safeguarding processes and how this quality assurance moves across into the contracting process. Working in partnership to develop a central reporting function that provides comprehensive data on each Care Home, it's facilities, specialist competence, staffing skill mix and case reports that share the learning across Berkshire West

3. The Care home Medicines management team to ensure medication reviews continue in a timely manner and explore how the team can work more closely/in partnership with the new GP provision to care homes to, increase efficiency.

4. The piloting of a new model of GP support to care homes that moves away from the traditional 'reactive' model of care towards a 'proactive 'care model that is centred on the needs of the resident, their families and care home staff. This model ensures that all residences have a 'holistic' assessment to establish care needs, care plans and consider appropriate intervention to maintain health and well-being and reduce risk. It ensures the pro-active management of Palliative /End of Life Care and reduces the fear of dying and enhances the experiences of dying for residents and their families. This model will also improve the residence's experience through high quality essential care – reducing distress from depression, disorientation, agitation, pressure sores, contractures, constipation, pain and sleeplessness, whilst minimising predictable acute events. This model will also improve the residence's experience through high quality essential care – reducing distress from depression, disorientation, agitation, pressure sores, contractures, constipation, pain and sleeplessness, whilst minimising predictable acute events.

5. The roll out of the 'red bag' initiative across Berkshire West Care homes

6. Assessment of the current IT provision in care homes and future requirement to allow joint working with health and social care

7. Pilot 'Patient alert system' for care home residences attending RBH A&E and/or admitted to RBH

8. Pilot the 'Trusted Assessor' to reduce delayed discharges back to Care home

Getting Home - This project will continue to focus on implementation of three of the high impact changes for DToC's – Multi-agency discharge team, discharge to assess and trusted assessment.

Multi-agency discharge team A new Integrated Discharge Service with a jointly funded(between RBH and BHFT) service manager will form part of the work under the Getting Home Project. The discharge to assess and trusted assessor/assessments model and pathways will be integrated into this service. The existing Service Navigation Team and Integrated Discharge team will form the basis of this new team with progression opportunities and a number of new posts created from vacancies.

The new Integrated Discharge Service (IDS) will adopt a case management approach to manage complex discharges throughout the Trust using the principles of the "Getting Home" project. The concept of 4 levels of discharge will enable those cases which require input from the service to be identified. Level 0 discharges are straightforward and require no or minimal input (eg district nurse for sutures) from other services, these should be managed by the ward teams. Level 1 and 2 discharges require input from services such as CRT or transfer to a community hospital and will in the main be managed by the ward teams with light touch from the integrated discharge service. Levels 3 discharges are complex and may require social care input or self-funding status. These will require active case management by the integrated discharge service.

Colleagues in social care are a key component of the service and close working is expected. This will be enabled through the "Integrated Discharge Hub"; a new working area for all staff involved in discharge planning and also housing the discharge lounge. This area will be central to the service and enable "discharge huddles" and close working.

Partial implementation is scheduled for 23rd October 2017.

Discharge to Assess - A pilot started in Hurley Ward RBH in June using the 'discharge to assess' model and the trusted assessor approach. A process was agreed with each locality. The RBH occupational therapists from Hurley ward being the trusted assessors taking patients home and assessing them in their home with the view to reducing the package of care and freeing up a hospital bed. This pilot will be reviewed at the end of September.

Street Triage for Mental Health Patients –. This service will ensure that a mental health professional is available to provide on the spot advice/support to police officers dealing with people with possible mental health problems 7 days per week 5pm – 1pm. This service will reduce the avoidable use of Section 136, contribute to a reduction of avoidable Mental Health admissions, provide rapid access to a mental health practitioner for those in Mental Health crisis in a public place, provide support and sign post people in need to appropriate services, reduce the risk of self harm or harm to others for those experiencing mental health crisis in the community out of hours and weekends, raise awareness of mental health with the Police and Care Professionals through effective partnership working and manage the impact of the new Police and Crime Bill Policy guide to be introduced by 1st April 2017.

SCAS Falls and Frailty Service – This project aims to improve the patient's experience of emergency care by providing an acute, blue light multi-disciplinary response to the frail elderly who have fallen in their own homes.

With falls in patients over the age of 65 making up 8.5% of the emergency workload locally for South Central Ambulance, SCAS have found themselves in a prime position to assess, treat and discharge this cohort of patients pre-hospital. This delivers the Keogh vision that care and treatment should be delivered closer to home without the need for hospital.

With increasing demands on SCAS frontline resources, responses to fallers are not as timely as would be desired and the literature tells us that those who have fallen are likely to fall again within 24 hours if immediate intervention is not provided.

The New Trauma Audit Research Network (TARN) data shows us that the majority of major trauma has shifted demographic to our older patients who fall less than 2 metres sustaining significant injury. With this in mind, early falls prevention assessments become imperative to prevent serious injury and/or admission. On admission the frail older patient can become disorientated, deconditioned and at risk of further falls.

This project is based on a successful pilot which took place during 2015-16 (every Saturday for 50 weeks).

A multi-disciplinary team of specialist paramedic and advanced occupational therapist was created with the ability to provide on scene; Clinical assessment; Wound closure; Administration of PGD medicines and Mobility, functionality and care input.

The response vehicle was stocked allowing for immediate provision of walking aids, commodes, chair and toilet raisers, grab rails to be fitted within hours and pendant alarms to be activated for more isolated patients.

The pilot operated one day a week for a year.

Patient experience via the Friends and Family test was overwhelmingly positive with comments including : “I was very impressed by the professional service and understanding…”, “…response was brilliant as were all services involved immediately and afterwards. Thank-you to all involved…”, “….thankful such help available. The Falls and Frailty response staff were superb, very kind and professional…, “…great service – hope you will extend it to everyday..” This project aims to increase non conveyance, reduce A&E attendances and reduce non elective admissions.

Hospital Discharge – This project supports a 1 year contract for an external company to support the timely discharge of self-funding patients from Royal Berkshire Foundation Trust and other Berkshire West Community Hospitals. The contract will be let by RBFT to a company that have worked in other parts of the country with good results..

West Berkshire

Locally in 2017/18 and 2018/19 the Joint Care Pathway will become business as usual. The 7 day services project will continue to run but will be reconfigured with a smaller budget as the evidence from this project over the last 12 months suggested that it was not offering value for money in its current format. However, Social Care will still provide on call management and a Social Worker presence at acute hospitals on Saturdays (and Sundays as required) to support hospital discharges over the weekends .

West Berkshire’s new locality projects for 2017/19 include: -

Additional Capacity Project - Towards the later part of 2016/17 we introduced the Additional Capacity project, offering 80 extra hours of community care to assist with our DTOCs. The aim of this project is for a commissioned Domiciliary Care Provider to work alongside the Joint Care Pathway and Social Work Teams to identify people that are fit for discharge and enable the individuals relocation; to manage/coordinate/deliver care for a period of up to 6 weeks and then to identify any longer term care requirements. The expected outcomes of this project are to improve our DTOC performance and bed days delayed

Step Down Beds – this project intends to create 10 step down beds in a Local Authority Home. The step-down beds will only be used for patients (18+) being discharged from hospital and will provide reablement, residential or nursing services for up to 6 weeks whilst permanent alternative arrangements are put into place. This service will be available for all acute hospitals we work with. The primary aim of this project is to reduce the number of 'delayed transfers of care' and the total delayed days within West Berkshire. This project was up an running from the beginning of August.

Integrated Care Teams – The vision of the project is around aligning teams, which provide a wrap around service for patients to ensure continuity of care using a Multi-disciplinary Team (MDT) approach. This builds on the approach Mid-Nottinghamshire (Vanguard site) used to improve a number of Urgent Care National outcomes.

This project will create and develop a joined up way of working for health and social care across West Berkshire to reduce hospital admissions. It is based upon the concept of providing joint management of complex patients and preventative care to patients deemed to be at high risk of future admissions. These patients will be identified through a risk stratification tool via primary care. .

In the short-term, the teams will work together to provide a holistic approach to care but not necessarily be co-located – this will be our long-term vision in Phase 3 of the project. The teams will work closely with other existing community teams, like falls and specialist intermediate care teams, to enable a whole system integrated approach to working within the proactive model.

The purpose of these teams is to work with the patients, their families and carers to provide physical, mental and social care solutions to enable people to be cared for at home wherever possible.

The Integrated Care teams will deliver proactive, low and enhanced levels of intermediate care to help people at home wherever possible to avoid hospital admissions, thus reducing pressure on acute hospitals.

Improved Better Care Funding

This funding was agreed at our Locality Integration Board in July 2017 and is detailed below: -

Improved Better Care Fund		**2017/18**
Increase to 10 step down beds at Birchwood	DTOC	315,000
Link worker in Mental health hospital	MH DTOC	64,000
7 day week second social worker in RBH	DTOC	64,000
Gain share with Providers to incentive them to take more clients / more complex cases	DTOC	15,600
Temporary staff in ASC teams	Integrated Care Teams(NEL's)	96,000
OT Reablement Support	DTOC	64,000
SCIP	Enabler for Connected Care	10,000
ICS Hospital Discharge / Avoidance Service	DTOC	6,000

BCF Data Analyst	All BCF projects	38,200
More capacity into reablement	DTOC	31,200
		704,000

Disabled Facilities Grant (DFG)

This funding for 2017/18 has been agreed as follows: -

	£K
Major adaptions to homes enabling people to stay at home	1,112
Equipment to help people live at home	390
Care technology in the home diagnostic – phase 1	16
Care technology in the home business care – phase 2	25
	1,543

The Disabled Facilities Grant is managed through the Local Authorities Housing team and has seen the introduction of Occupational Therapists working within the team, specifically for the purposes of completing Disabled Facilities Grant funded adaptation(s) assessments. This has allowed for, a far more efficient service and ability to process DFG applications and therefore installation of grant funded works quicker.

In 2016/17 the grant was used to provide much needed adaptations to West Berkshire residents' homes and has truly been used for the intrinsic purpose of the DFG: to allow individuals to remain independent and in their own homes for longer. The range of adaptations provided over this period includes (but not limited to): installation of level access showers (or wet rooms), stair lifts, through floor lifts, hoists, ramps, step lifts, specialist kitchens and extensions. Whilst a majority of this funding was received by our elderly clients, this funding was used to help children and adults of ranging tenure across West Berkshire to remain living independently at home.

Risk

Risk Register

All BW10 projects and locality projects are required to submit a monthly highlight report, which includes the projects top 3 risks from the risk log.

West Berkshire project highlight reports are presented to the Locality Integration Board on a monthly basis and also shared at BW10 Delivery Group. Copies of the West Berkshire's highlight reports for June are embedded below. Also below is the latest copy of the BW10 dashboard which shows all projects across Berkshire West and their Red, Amber, Green Status.


highlight report June2017.doc


highlight report June2017.doc


highlight reportjune2017.doc


BW10dashboard.ppt

Risk Share Agreement

By its nature a pooled budget provides an appropriate vehicle for sharing risk between the associated parties. The arrangements for risk share, overspends and underspends in the BCF are set out in Schedule 3 of the Locality S75 Agreement.

S75 Agreement

2.1 The risk share fund in the BCF comprises the value of the aggregate reduction in non-elective admissions expected to be achieved in the year from the successful implementation of the specified schemes.

2.2 At the commencement of the agreement the value of the risk share fund is withheld by the CCG from its BCF allocation.

2.3 Where admission avoidance schemes are successful and the planned levels of activity are achieved and, as such, value is delivered to the NHS in that way, then the risk share funding may be released to be spent as agreed by the partners. Any payments made from the risk share fund will be on a quarterly basis, in arrears, which are equivalent to the value of the savings made, up to the maximum risk share fund.

2.4 Any amount released from the risk share fund cannot exceed the amount set aside for the schemes listed in the Locality S75 Agreement.

2.5 Where the anticipated savings benefits are not achieved, any unreleased funds are retained by the CCG to cover the cost of additional non-elective activity.

3. Pooled Fund Manager

3.1 The Pooled Fund Manager will at all times be responsible for managing schemes within the budget available, including any amounts which may have been released from the risk share.

3.2 The Pooled Fund Manager will be responsible for setting out a phased budget for both costs and benefits for schemes at the commencement of the financial year and for reporting actual costs and benefits year-to-date with a forecast for the full year on a monthly basis.

3.3 Overspends which cannot be otherwise mitigated, shall be met in the first instance from the respective scheme's Pooled Fund Contingency. Should this be insufficient, then any residual overspend shall be met by the Pooled Fund holder for the respective scheme.

3.4 In the event that expenditure from any Pooled Fund in any financial year is less than the aggregate value of the financial contributions made for that financial year, the surplus monies will be returned to the Partner contributing to the Pool unless alternative arrangements are agreed by the Partners.

3.5 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

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(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 recognise its share of the pooled budget in it individual accounts and memorandum accounts will be maintained.

National Conditions

National condition 1: jointly agreed plan

The narrative plan was presented to the Health Wellbeing Board on the 4th May 2017 where it was signed off by all parties.

The Local Authority authorising officer is:
James Fredrickson
Chair of the Health and Wellbeing Board
West Berkshire Council

The CCGs authorising officer is:
Cathy Winfield
Chief Officer
Berkshire West Clinical Commissioning Groups
cathywinfield@nhs.net

CCG Minimum Contributions – The allocation of funding within the CCG minimum contribution is detailed in the planning template.

DFG – This is ring fenced funding and used for capital equipment in people's homes as per the attached West Berkshire Council's Housing Grants and Loans Policy.

Housing Grants policy July 2016 7 9 1

This policy explains the mandatory and discretionary Housing Grants and Loans available to West Berkshire residents to assist with the cost of adaptations, essential repairs and home improvements. The only mandatory grant covered by this policy is the Mandatory Disabled Facilities Grant.

In 2016/17 the grant was used to provide much needed adaptations to West Berkshire residents' homes and has truly been used for the intrinsic purpose of the DFG: to allow individuals to remain independent and in their own homes for longer. The range of adaptations provided over this period includes (but not limited to): installation of level access showers (or wet rooms), stair lifts, through floor lifts, hoists, ramps, step lifts, specialist kitchens and extensions. Whilst a majority of this funding was received by our elderly clients, this funding was used to help children and adults of ranging tenure across West Berkshire to remain living independently at home.

This plan includes use of the improved Better Care Fund to support Delayed Transfers of Care including Mental Health Delays and Non Elective Admissions. In the 2017 Spring budget Central Government announced an additional £2 billion to support social care in England. West Berkshire is allocated £704,449 in 2017/18 and £583,666 in 2018/19. Partners have agreed the allocation of this grant which is detailed as follows:-:

Improved Better Care Fund		**2017/18**
Increase to 10 step down beds at Birchwood	DTOC	315,000
Link worker in Mental health hospital	MH DTOC	64,000
7 day week second social worker in RBH	DTOC	64,000

Gain share with Providers to incentive them to take more clients / more complex cases	DTOC	15,600
Temporary staff in ASC teams	Integrated Care Teams	96,000
OT Reablement Support	DTOC	64,000
SCIP	Enabler for Connected Care	10,000
ICS Hospital Discharge / Avoidance Service	DTOC	6,000
BCF Data Analyst	All BCF projects	38,200
More capacity into reablement	DTOC	31,200
		704,000

National condition 2: Social Care Maintenance

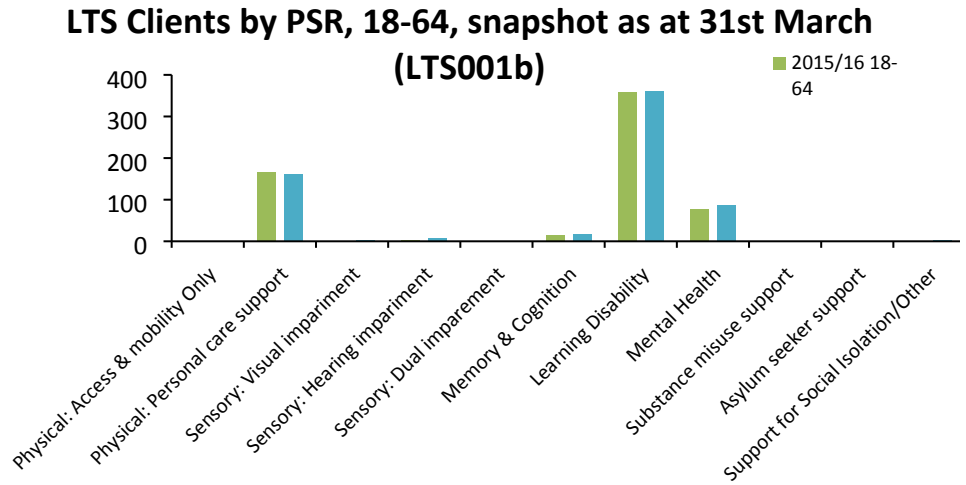
Adult Social Care has been uplifted by 2.3% in 2017/18 and 2% in 2018/19. This is in line with estimates of inflation in March 2017. For 2017/18 this represents a real terms increase on the previous financial year and therefore meets the requirement of this national condition. This increase should help ensure some stability for ASC, however it should be noted that the overall gross commissioning budget for social care is £47m. The spreadsheets embedded below demonstrate how the funding was allocated in 2016/17 and how it will be allocated in both 2017/18 and 2018/19.

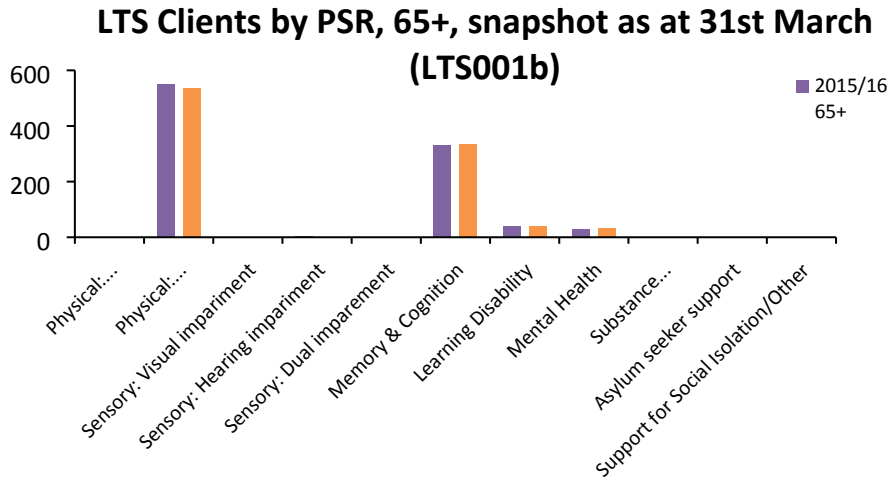
BCF Budget August 2017 V3 (2).xls

West Berkshire 2017-19 BCF budget

The table above confirms the total amount of social care maintenance for 2017/18 is £4,464m and £4,554m in 2018/19. The funding is invested into three key areas:

1. To commission care for vulnerable adults who meet Care Act (2014) eligibility: although predominantly people aged 65+ a third of the Council's long term service clients are adults with a learning disability. A wide range of services are commissioned to meet needs including residential, nursing, homecare and supported living.

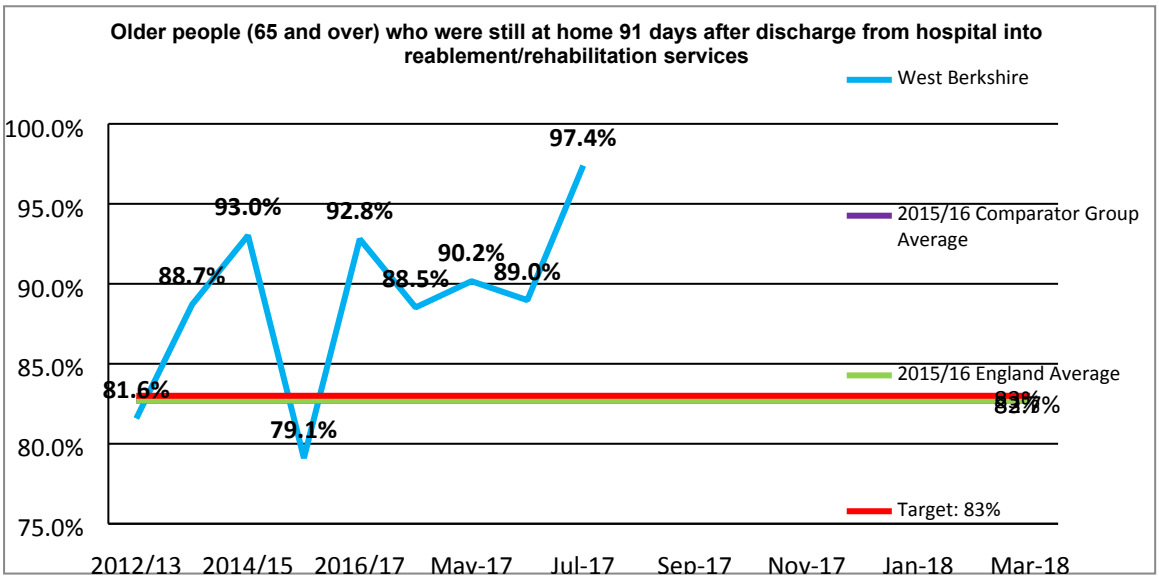


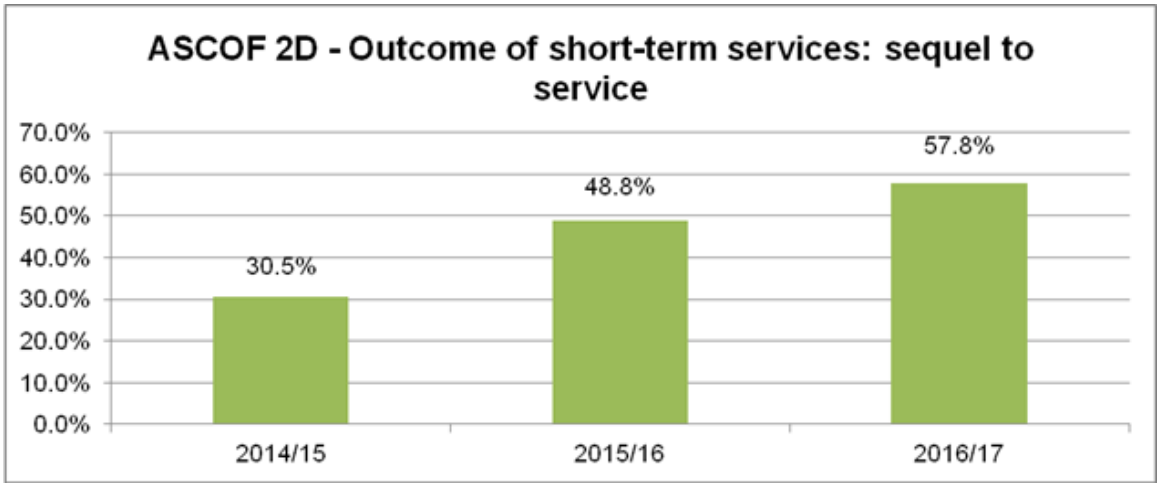


2. Support for carers: recognising the key contribution carers make we use some of the money to fund services for carers. This includes joint commissioning of a Berkshire wide information, advice and guidance service as well as support that enable carers to maintain their caring role.

3. Promoting independence: reducing the need for care, enabling people to remain living in their own home for as long as possible is a critical. We use some of the funding to enable us to continue to build on this work; this includes enabling us to maintain our provision of Reablement. Following a positive evaluation of the implementation of the Joint Care Pathway this funding also allows us to maintain the arrangement alongside BHFT.

In 2016/17 we performed strongly on the percentage of people who were still at home 91 days after discharge from hospital (ASCOF 2B). We also saw an improved performance on ASCOF 2D, the percentage of people who had little or no care needs after a period of Reablement, although we accept that more work has to be done.





For 2017-19 we aim to maintain the performance on ASCOF 2B and build on the improvements in ASCOF 2D.

National condition 3: NHS commissioned out-of-hospital services

NHS commissioned out of Hospital Services were uplifted by 3.3% in 2017/18 and by 2.26% in 2018/19.

As outlined in the 2016 Better Care Fund submission for all three Local Authorities within Berkshire West, we have identified five key NHS Commissioned Out of Hospital service investments which sit within the scope of the Better Care Fund and it is our intention that these will be carried forward into the 2017-19 plans. These out of hospital services were chosen due to their potential contribution either directly or indirectly to reducing delayed transfers of care, non elective admissions and supporting effective Reablement across the system.

For 2017-19 we plan to revise our KPI's where possible for these service lines so as to improve the monitoring against key performance indicators. We will also continue to review the service lines on a quarterly basis, through the Berkshire West 10 Delivery Group and to review levels of investment versus impact and make any necessary substitutions or additions with other out of hospital services as part of our integration journey.

The specific service lines constitute a small proportion of a much wider range of services provided within a block contract held by the Berkshire West CCGs with Berkshire Healthcare Foundation Trust, our main community and mental health provider. The specific services are listed below:-

Out of Hospital Service Description	**BCF Measure Condition**
Adult Speech & Language Therapies	NELS/Reablement
Care Home in-reach support	NELS/Reablement
Care of the Elderly (Community Geriatrician Service)	NELS/DTOC/Reablement
Intermediate Care (includes rapid response, night sitting, equipment, integrated discharge team, intermediate care services and Reablement)	NELS/DTOC
Health Hub single point of access	NELS/DTOC/Reablement

During 2016/17 we have reviewed the services above and have identified the importance of each service function in stemming the flow of rising non elective admissions and in particular avoiding care home admission an A&E Attendances. Intermediate care, night sitting and Reablement have also been significant contributors to help managed delayed transfers of care. The health hub and intermediate care services operate as 24 hours, 7 day a week services.

The key objectives of the services are to:-

1. Promote independence and improved quality of life for the population of Berkshire West through the delivery of community services to residents in their own homes and in places of residential care.

2. Provide support to carers and other health and social care colleagues to facilitate effective care for people with acute and long term health care needs across Berkshire West.

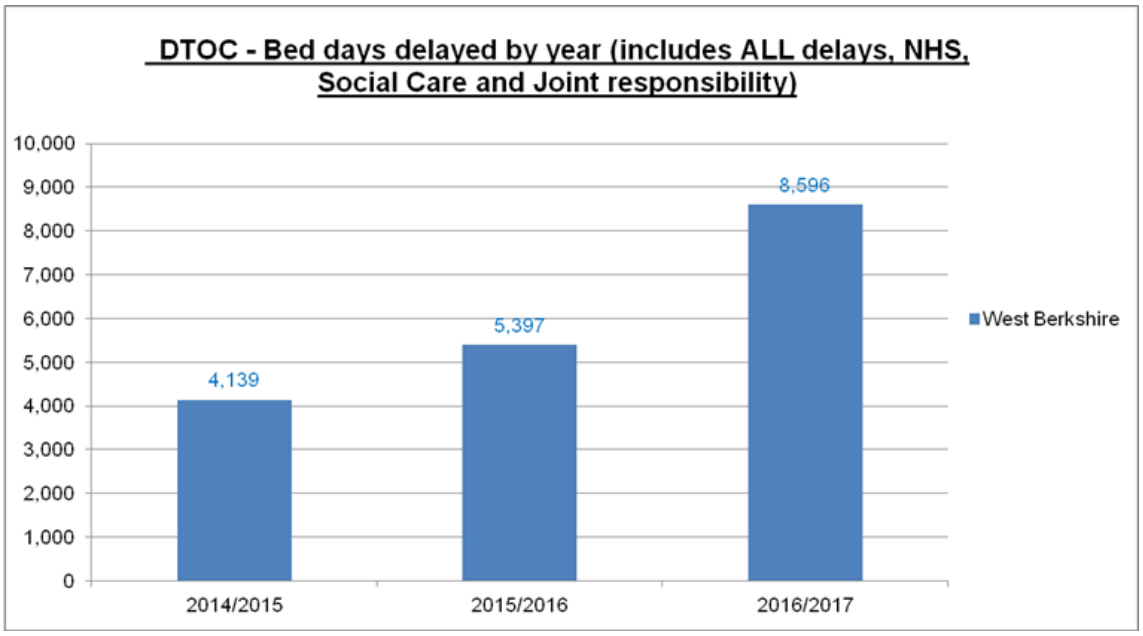
3. To contribute to baseline in non-elective admissions, admissions to residential care, DTOC's and Reablement across Berkshire West.

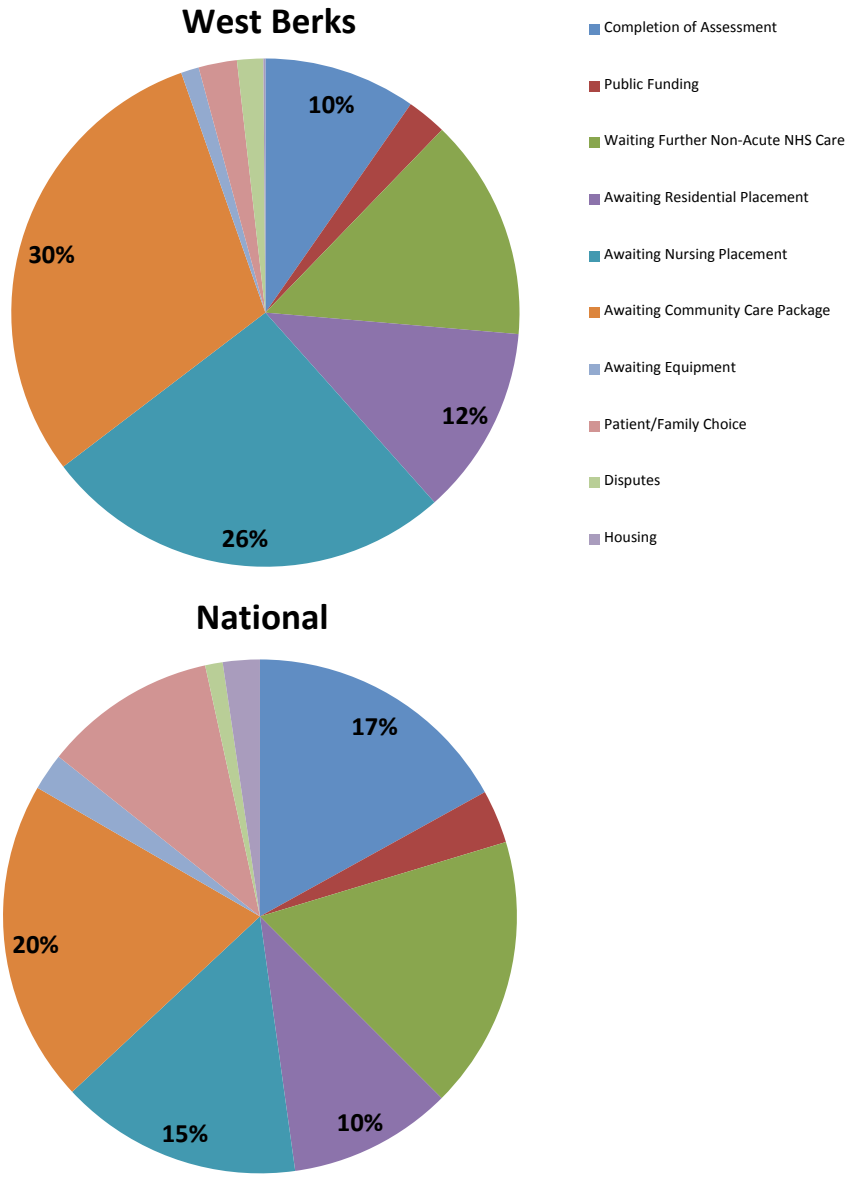
4. Support baseline demand management for urgent care by contributing to the avoidance of A&E visits across Berkshire West.

National Condition 4: Managing Transfers of Care

Within the mandate to NHS England for 2017/18 there is a very specific target which has been imposed nationally "target reduction in total delayed transfers of care to 3.5% by September 2017" It should be noted that the market is getting more challenging alongside the demographic demand increase year on year so this is a very demanding target.

West Berkshire's DTOC position worsened in 2016/17 and 70% of delays were as a result of capacity issues in the care market in all settings.





Whilst we are committed to achieving the national target of 3.5%, based on our performance in 2016/17, capacity issues and increasing demand further investment will be required to fully address market concerns and for us to meet the target of 3.5%. We have however focused our investment on schemes that will bridge the gap to allow us to help people out of hospital more quickly and believe a 5% target is more realistic. If further permanent funding was available it would allow us to pass this directly to providers and create a more sustainable care market.

Our DTOC targets for 2017/18 by CCG are below: -

westberkshireHWB
DTOC Metric Plan coll

Our DTOC targets for 2017/18 by trust are set out below for both the national target of 3.5% and a more realistic target of 5%: -

West Berkshire DTOC Targets for 2017/18 based on 3.5%: -

Trust	Responsibility	Q1	Q2	Q3	Q4	Total
RBH	NHS	326	263	200	200	2078
	Joint	150	121	92	92	
	Social Care	208	168	128	128	
NHH	NHS	152	108	64	64	1328
	Joint	207	147	87	87	
	Social Care	162	115	68	68	
BHFT	NHS	166	106	46	46	1505
	Joint	50	32	14	14	
	Social Care	468	300	131	131	
GWH	NHS	69	55	42	42	520
	Joint	10	8	6	6	
	Social Care	94	75	57	57	
Total		**2061**	**1499**	**935**	**935**	**5430**

West Berkshire DTOC Targets for 2017/18 based on 5%: -

Trust	Responsibility	Q1	Q2	Q3	Q4	Total
RBH	NHS	326	306	286	286	2528
	Joint	150	141	132	132	
	Social Care	208	195	183	183	
NHH	NHS	152	121	91	91	1562
	Joint	207	166	124	124	
	Social Care	162	129	97	97	
BHFT	NHS	166	116	66	66	1710
	Joint	50	35	20	20	
	Social Care	468	328	188	188	
GWH	NHS	69	64	42	42	632
	Joint	10	9	6	6	
	Social Care	94	88	57	57	
Total		**2061**	**1699**	**1336**	**1336**	**6432**

These targets are based on: -

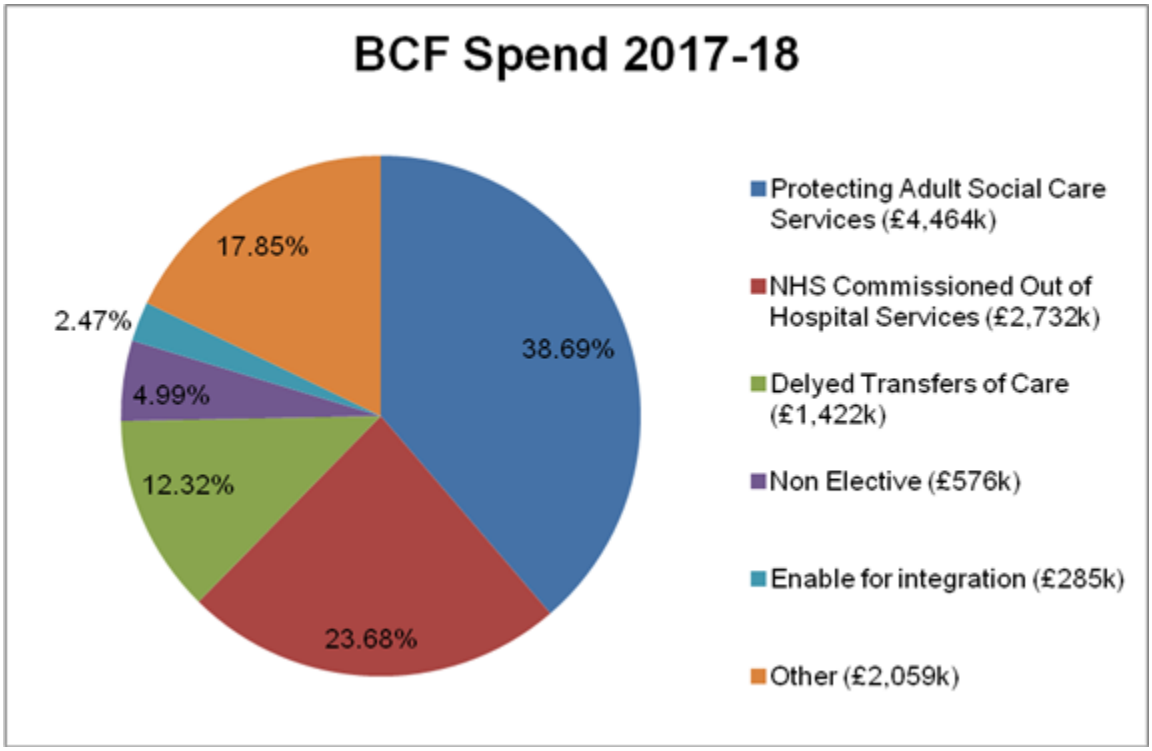
Bed stock – Each trust provided the bed stock for the trust, the available bed days for the year/month were then worked out and the national target of 3.5% and 5% applied.

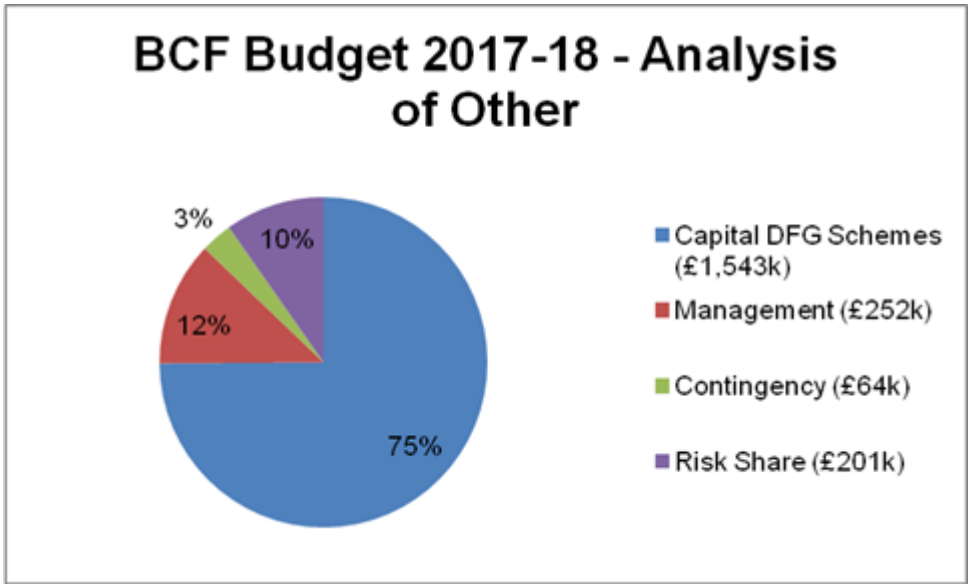
Baseline performance – West Berkshire's proportion of total bed days delayed by trust were based on previous DTOC performance from January 2016 – March 2017 (15 months)

Details of how we plan to improve our DTOC performance are detailed in the DTOC metric section along with a copy of how we are progressing against the high impact change model.

Overview of funding contributions

The minimum contribution from the CCG is £8,965,075 for 2017/18 and £9,135,411 for 2018/19 this includes funding to support the implementation of the Care Act 2014**.**

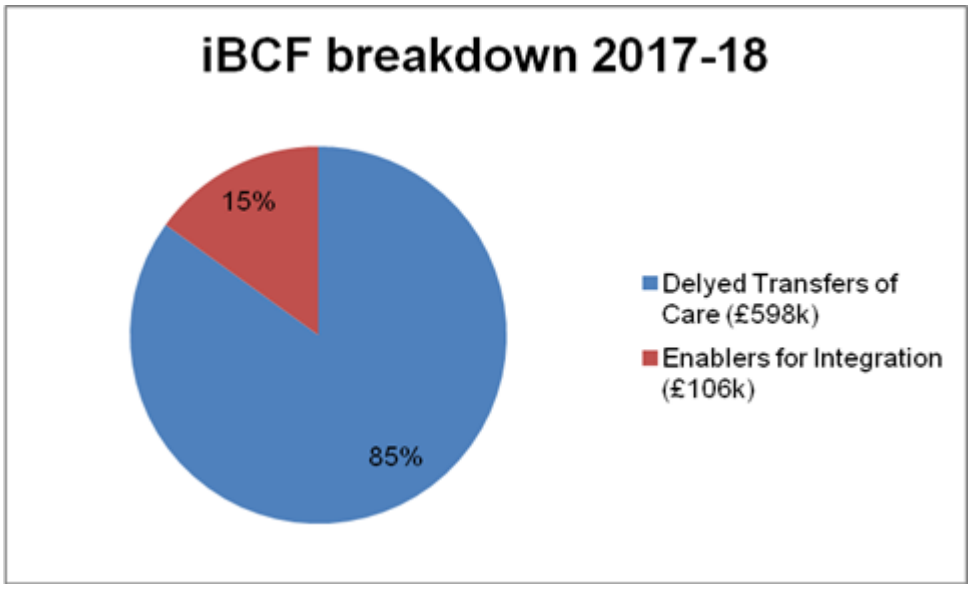




The spreadsheet embedded below shows all projects including Reablement, Carer's breaks and protecting Social Care budgets in 2017/18 and 2018/19.

BCF Budget August 2017 V3 (2).xls

The iBCF funding is included in the spreadsheet above but is broken down into more detail below:-



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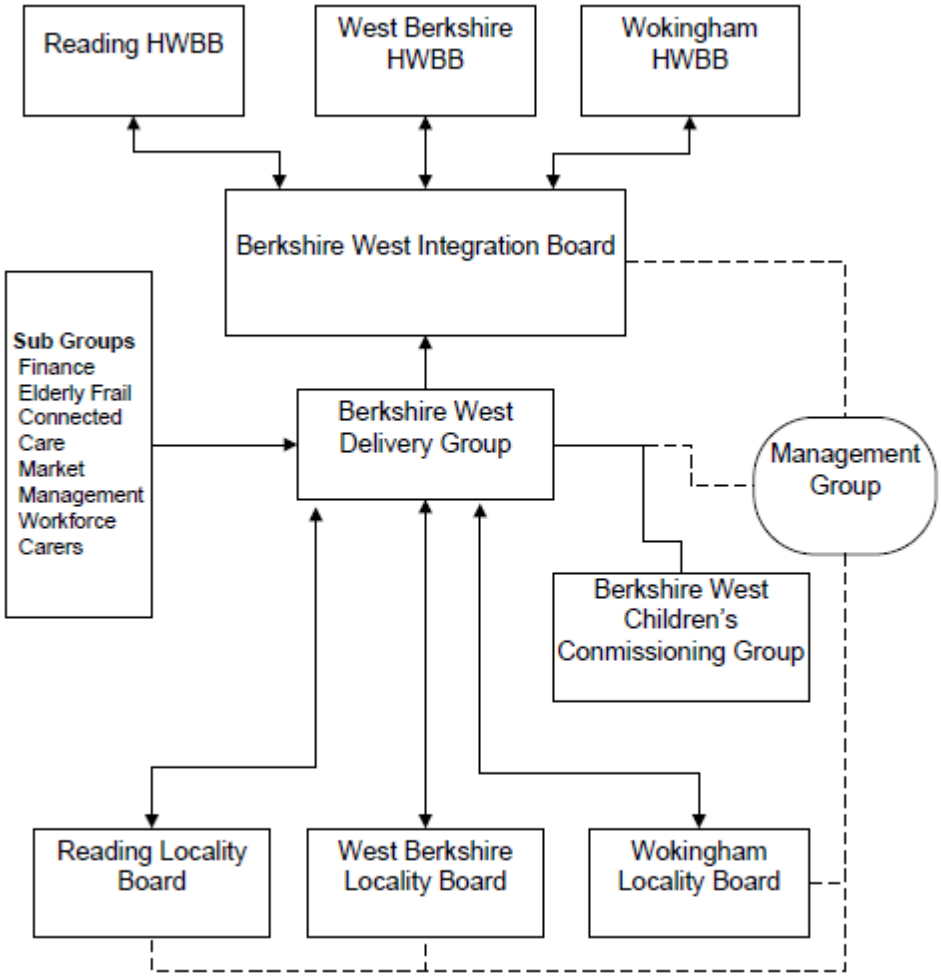
Programme Governance

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 Delivery Group meetings with representatives from each of the partner organisations 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 Integration Board. All projects that span the three localities are required to submit a monthly highlight report, which includes milestone and financial status, key achievements, next steps, issues and risks.

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.

The Programme Office across Berkshire West ensures 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.

The Health and Wellbeing Board act as the Programme Board and the West Berkshire Integration Board as a project board for the Better Care Fund. Embedded below is a copy of the Locality Integration Board's terms of reference.

TOR WB locality Board Final vs 21041

Every project is sponsored by one or more senior managers and a clinician from across the health and social care economy. There are implementation teams for each of the named projects with assigned Project Managers

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.

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 Health and Wellbeing Steering Group through regular Highlight Reports and if they cannot be resolved/managed there, they will be

escalated to the Delivery Group 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.

From 2017-19 , within West Berkshire's locality any exisitng projects or projects that are deemed business as usual have a PID on a page, which summaries the objectives, benefits etc. A full project PID is required to be submitted to the locality integration board for any new projects. These full PIDs are also presented to the Finance sub-group who under the new Chair are currently developing a value for money model, which will be used for any future projects.

Assessment of Risk and Risk Management

Risk Share Agreement

By its nature a pooled budget provides an appropriate vehicle for sharing risk between the associated parties. The arrangements for risk share, overspends and underspends in the BCF are set out in Schedule 3 of the Locality S75 Agreement.

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(f) Where any cost savings benefit arise

(g) Which staff are involved

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

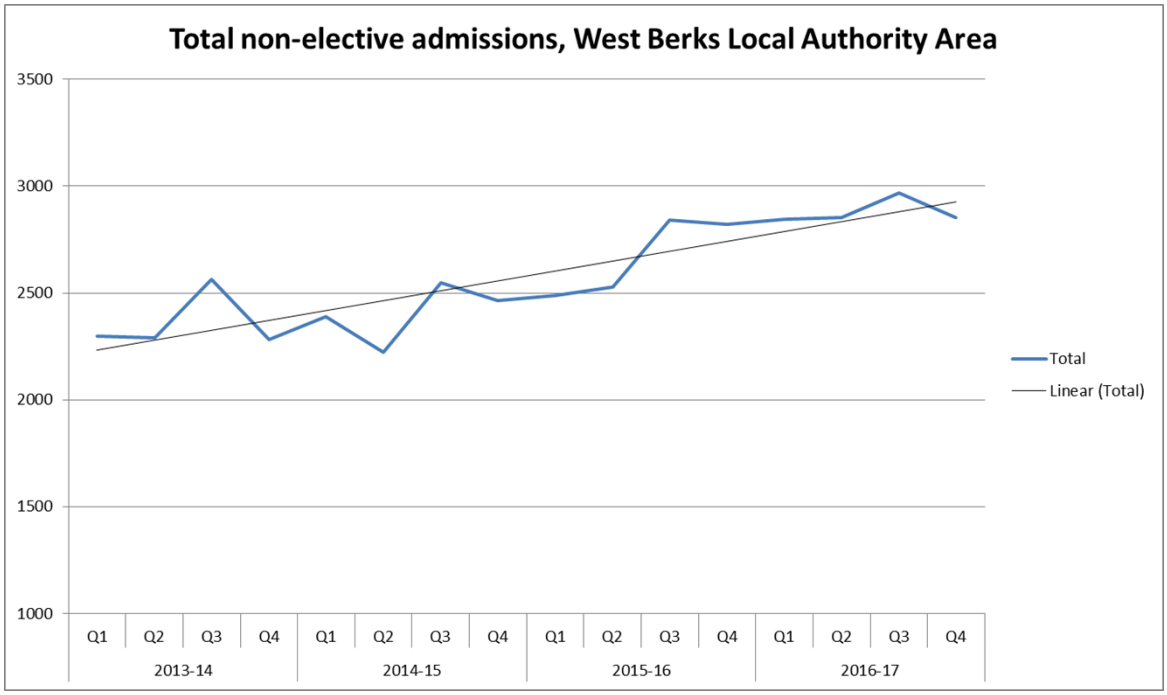
National Metrics

Non elective Admissions

The Berkshire West CCG's are collectively recognised as high performing and benchmark well nationally on a number of key performance measures, including non-elective admission rates. For the last two full years, Berkshire West CCG's have been in the top 4% of CCGs for non-elective admission rates.

In 2016/17 Newbury & District CCG was the 6th best performer in the Country for non-elective admissions.

CCG	Admissions	Population	Rate	Rank
NHS Wandsworth CCG	24273	386602	62.79	1
NHS Gloucestershire CCG	40692	636034	63.98	2
NHS Wokingham CCG	11194	160468	69.76	3
NHS South Reading CCG	10061	140413	71.65	4
NHS West London CCG	17393	242428	71.75	5
NHS Newbury and District CCG	8519	117634	72.42	6
NHS Tower Hamlets CCG	22070	300382	73.47	7
NHS North & West Reading CCG	8097	109686	73.82	8
NHS Central London CCG	15857	212847	74.50	9
NHS Richmond CCG	15925	211353	75.35	10



However, future projections suggested that due to the increased age profile and double digit increase in certain long term conditions, this trend will continue unless there is a system wide change.

The Solution:

Our NEL analysis has progressed significantly in year and we identified a cohort of 104 high intensity users who had frequent multiple admissions and attendances at hospital A&E. We have begun a targeted approach led by our A&E Delivery Group and implemented through GP practices, to better manage people with frequent attendances to identify blocks and barriers that prevent these individuals from remaining well and stabilised in their home environment.

Also in partnership with our Public Health colleagues we carried out some detailed analysis of non-elective admissions in West Berkshire. A copy of the analysis is embedded below and a working group has been set up to look at how we can offer a more targeted approach to NEL's during 2017-18.

NELs in West Berkshire.ppt

From 1st July 2017 GP practices will be required to use an appropriate tool to identify patients aged 65 or over who are living with moderate and severe frailty. Our amended Anticipatory Care CES will build on this by using risk stratification tools already deployed in practices to ensure resources are targeted most effectively and efficiently. Demand for services is predicted to continue to rise with a growing older population and people living with more complex long term conditions. Our ambition is to expand our focus beyond the top 2% of the population to the top 10% who may not necessarily be high users of services now but are at risk of becoming so without early intervention.

In 2017-19 we will also use this intelligence to address and identify resources that can support individuals and communities in those wards with the highest attendances. This targeted approach will help us address and manage non-elective attendances further to improve health of those in our most deprived areas of West Berkshire.

Many of our schemes as well as the wider integration programme aim to specifically target the highest risk/cost segment of our population. Moving into 2017-18 and beyond our vision for supporting patents with long term conditions is underpinned strategically by development of our Accountable Care System and more operationally for 2017/18 and 2018/19 through the work of the CCG's Long Term conditions (LTC) Programme Board, aligned with to BCF and Frail Elderly Pathway.

The BW10 Care Home project will continue to target non-elective admissions across the whole of Berkshire West. The introduction of the Street Triage for Mental Health and SCAS falls and frailty project will also target non electives across Berkshire West.

Locally in 2017/18 the Integrated Care team project will target non elective admissions across West Berkshire. . The vision of the project is around aligning teams, which provide a wrap around service for patients to ensure continuity of care using a Multi-disciplinary Team (MDT) approach. This builds on the approach Mid-Nottinghamshire (Vanguard site) used to improve a number of Urgent Care National outcomes.

This project will create and develop a joined up way of working for health and social care across West Berkshire to reduce hospital admissions. It is based upon the concept of providing joint management of complex patients and preventative care to patients deemed to be at high risk of future admissions. These patients will be identified through a risk stratification tool via primary care. .

In the short-term, the teams will work together to provide a holistic approach to care but not necessarily be co-located – this will be our long-term vision in Phase 3 of the project. The teams will work closely with other existing community teams, like falls and specialist intermediate care teams, to enable a whole system integrated approach to working within the proactive model.

The purpose of these teams is to work with the patients, their families and carers to provide physical, mental and social care solutions to enable people to be cared for at home wherever possible.

The Integrated Care teams will deliver proactive, low and enhanced levels of intermediate care to help people at home wherever possible to avoid hospital admissions, thus reducing pressure on acute hospitals.

The CCG operating plan for NEAs was set following the NHS planning rules and includes IHAM (indicative hospital activity model) growth including demographic growth and a QIPP reduction with a net reduction against 2016/17 out turn. The proposed net reduction target will be a real challenge considering that we are already a high performing system, therefore reductions in NEAs for 2017/18 are challenging.

Based on analysis of year to date performance, and realistic impact of BCF schemes, we have no additional NEA reductions planned for our BCF plan and we are continuing to investigate the inconsistencies, which appear to be a national issue post submission and we expect to revise our submission accordingly

Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency and the inclusion of this measure in the Adult Social Care Outcomes Framework (ASCOF 2A, part 2.Long-term support needs met by admission to residential and nursing care homes, per 100,000 population**)** supports local health and social care services to work together to reduce avoidable admissions.

Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation.

This measure reflects the sum of the number of Local Authority supported older people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) per 100,000 population.

Our performance in 2015/16 at was 581 (161 admissions) which, positively, was below the England average for 2015/16 (last published data) at 628.1.

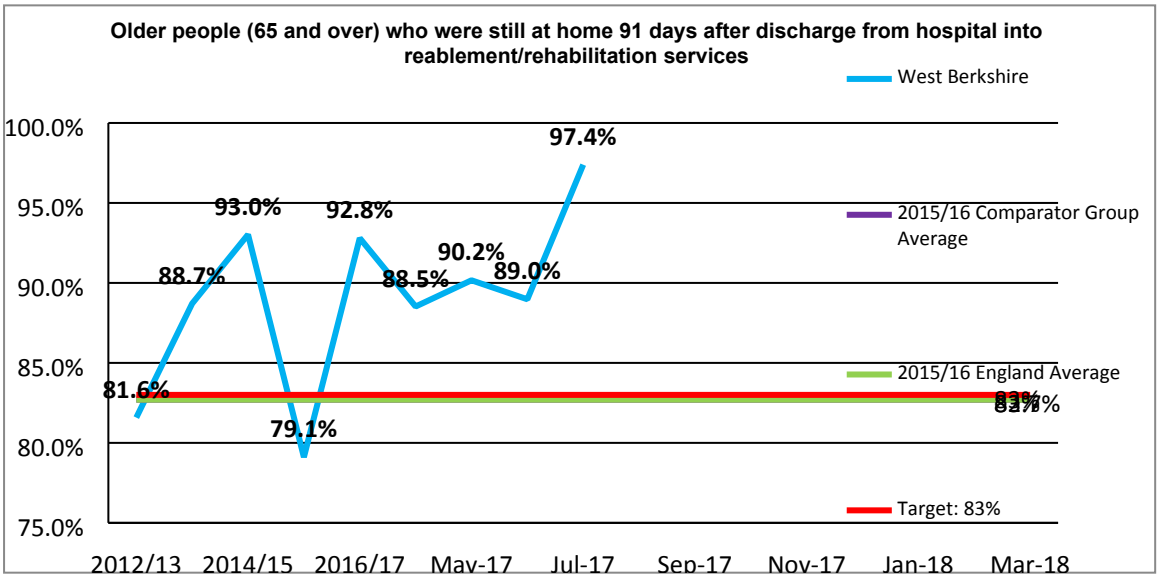
The published data for 2016/17 is not due until October 2017. Our actual for 2016/17 was 171 new admissions and once the published data is issued we will be able to compare our performance to the England average for 2016/17.

Overall placements increased last year indicating increased demand as a result of challenges in relation to commissioning care in the community and significant pressures on DToC and how we get people out of hospital quickly and safely. It is unlikely these pressures will decrease so we can predict that the number of new placements will continue to increase. Our target has been set at 5% for 2018/19 as outlined in our planning template submission.There is strong evidence that suggests reablement services lead to improved outcomes and value for money across the health and social care sectors. Reablement seeks to support people and maximise their level of independence, in order to minimise their need for ongoing support and dependence on public services.

This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services. It captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement.

Our Actual performance for 2016/17 was 93%, the England average for 2015/16 (last published data) was 82.7%.

As a result of the Joint Care Pathway and emphasis on reablement we have seen numbers receiving reablement increasing, however there is a market capacity limitation to this and as this indicator only measures the last 3 months in the year it remains volatile and therefore we propose that the target in 2017/18 is cautious but will increase to outperform the England average. Our targets for 2018/19 are outlined in the planning template submission. (Once the published date for 2016/17 has been issued we can compare our performance and readjust if needed). .



Our services will continue to have a reablement 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 through the Joint Care Pathway 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 addition

Delayed transfers of care

West Berkshire is committed to achieving the national target of 3.5% but based on our 2016/17 performance, market capacity issues and increasing demand further investment will be required to fully address market concerns and for us to meet the target of 3.5%.

We have however focused our investment on schemes that will bridge the gap to allow us to help people out of hospital more quickly and believe a 5% target is more realistic. If further permanent funding was available it would allow us to pass this directly to providers and create a more sustainable care market and meet the national target of 3.5%.

West Berkshire's DTOC metric plan based on the National 3.5% target by CCG is below:-

westberkshireHWB
DTOC Metric Plan coll

West Berkshire DTOC Targets by trust for 2017/18 based on 3.5%: -

Trust	Responsibility	Q1	Q2	Q3	Q4	Total
RBH	NHS	326	263	200	200	2078
	Joint	150	121	92	92	
	Social Care	208	168	128	128	
NHH	NHS	152	108	64	64	1328
	Joint	207	147	87	87	
	Social Care	162	115	68	68	
BHFT	NHS	166	106	46	46	1505
	Joint	50	32	14	14	
	Social Care	468	300	131	131	
GWH	NHS	69	55	42	42	520
	Joint	10	8	6	6	
	Social Care	94	75	57	57	
Total		**2061**	**1499**	**935**	**935**	**5430**

West Berkshire's DTOC metric plan based on a revised 5% by CCG is below:-

westberkshireHWB
DTOC Metric Plan coll

West Berkshire DTOC Targets by trust for 2017/18 based on 5%: -

Trust	Responsibility	Q1	Q2	Q3	Q4	Total
RBH	NHS	326	306	286	286	2528
	Joint	150	141	132	132	
	Social Care	208	195	183	183	
NHH	NHS	152	121	91	91	1562

	Joint	207	166	124	124	
	Social Care	162	129	97	97	
BHFT	NHS	166	116	66	66	1710
	Joint	50	35	20	20	
	Social Care	468	328	188	188	
GWH	NHS	69	64	42	42	632
	Joint	10	9	6	6	
	Social Care	94	88	57	57	
Total		**2061**	**1699**	**1336**	**1336**	**6432**

These targets are based on: -

- Bed stock – Each trust provided the bed stock for the trust, the available bed days for the year/month were then worked out and the national target of 3.5% and 5% applied.
- Baseline performance – West Berkshire's proportion of total bed days delayed by trust were based on previous DTOC performance from January 2016 – March 2017 (15 months)

West Berkshire's 2017-19 plan to reduce DTOC has been agreed by the Locality Integration Board and the BW10 Delivery Group. The accountability for the delivery of this plan will sit with the BW10 Delivery Group. Local Assurance, troubleshooting and escalation will be via the Locality Integration Board.

Plan to reduce Delayed Transfers of Care: -

Berkshire West 10 projects: -

Getting Home- -Berkshire West is committed to moving towards a position whereby a complete, integrated and trusted assessment is undertaken at the front door of the hospital. Common Documentation will be developed to support completion of a clinical and functional assessment which is trusted, shared and not repeated.

The aspiration would be for fully integrated discharge to assess arrangements to be in place for all complex discharges with full assessment of long term needs being carried out outside of hospital. This will support the majority of patients being able to be discharged from the hospital on their estimated date of discharge with flow maintained for 7 days.

The project is specifically focusing on the delivery of 3 of the 8 high impact changes: Development of a multi agency hospital discharge team, Implementation of home first discharge to assess model and trusted assessment.

Care Homes – The aspiration is to have a service that is "wrapped around a resident's needs" and provides the proactive management of long term conditions. This should prevent deterioration of the resident condition/s, enable early intervention of "ill health" and promote the health and wellbeing of residents in car homes. By also, engaging early with resident and their families and carers, they are enabled to make informed decisions about their future care, whilst providing a rapid response treatment service to those residents with acute need within their home.

Choice Policy – The Berkshire West system has adopted a robust Choice Policy based on the national template "supporting patients choice to avoid delayed discharge". The Royal Berkshire Foundation Trust now issue communications to all patients on admission outlining expectations regarding discharge and the role patients and their families and carers have to play in supporting effective discharge.

CHC – There is a new requirement in the Urgent and Emergency Care Delivery Plan (April 2017) to reduce the number of full CHC assessments occurring in acute settings to less than 15%. An action plan and impact analysis on this from the CHC team has been requested by the CCG's

Hospital Discharge Project – This scheme seeks to mitigate the risk presented due to the lack of progress in reducing medically fit patients waiting to leave hospital and in particular self-funders who are frequently categorised as delayed transfers of care. An external company provides an enhanced service spending with individual families addressing their own particular care needs and preferences and developing a detailed knowledge of and relationship with the local market through the development of personal relationships with the providers. The assumption is that 35+ DTOC's are prevented enabling the beds to be released back into the system.

Out of Hospital Services – A number of out of hospital services were chose due to their potential contribution either directly or indirectly to reduce delayed transfers of care, non elective admissions and supporting effective Reablement across the system. The specific service lines constitute a small proportion of a much wider range of services provided within a block contract held by the Berkshire West CCG's with Berkshire Healthcare Foundation trust, the main community and mental health provider. The specific services are:

- Adult Speech and Language Therapies
- Care Home in-reach support
- Care of the Elderly (Community Geriatrician Service)
- Intermediate Care (includes rapid response, night sitting, equipment, integrated discharge team, intermediate care services and Reablement)
- Health hub single point of access

West Berkshire locality projects: -

Joint Care Pathway – This project will continue as business as usual in 2017/18 and all hospital discharges will come through this pathway. Following the review conducted at the end of last year we will focus on a number of priorities over the next 2 years : trusted assessment, single management and linking in with the STP project looking at simplifying section 2 and section 3 paperwork for all hospital discharges.

Additional Capacity in the Community –A domiciliary care provider has been commissioned to deliver 120 hours of additional capacity in Q1 of 2017/18, increasing to 210 hours by Q4 2017/18. They will work alongside the Joint Care Pathway and social work teams to identify patients that are fit for discharge and reduce delayed transfers of care and bed days delayed in acute and community hospital settings.

Step Down Beds –10 step down beds will be created and up and running by August 2017. These beds will only be used for patients 18+ being discharged from hospital and will provide Reablement,

residential and nursing services for a short period of time whilst permanent alternative arrangements are put into place. This project is specifically aimed at reducing our delayed transfers of care.

Link Worker in Prospect Park (Mental Health Hospital) – A Social Worker will work across all the wards at Prospect Park, working with clinicians to ensure information is being shared and to identify opportunities do discharge patients preventing them for becoming a delayed transfer of care.

7 day services(/ 2nd Social Worker at RBH)–During our initial planning phase for our BCF 2017-19 and prior to the announcement of the IBCF West Berkshire had planned to reduce investment in this area. However, with the announcement of the additional funding we are now able to increase from 1 to 2 social workers working across a 7 day week to support RBH in discharging patients on the fit to go list.

Incentivise providers – We are working with our commissioning team in order to offer providers an incentive of £100 per week for 2 weeks in order to get providers into Hospital promptly to assess and patient and allow us to discharge a patient from hospital on a weekend.

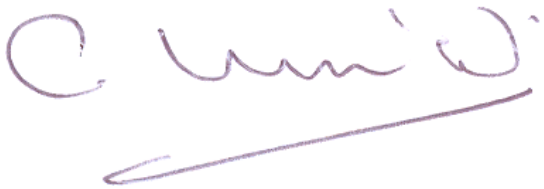
OT Reablement Support/more Capacity into Reablement – The aspiration is to work more closely with hospital staff as it is often found they can be risk adverse and will only discharge a patient if a large package of care is available.

BCF Data Analyst – We are planning to employ a data analyst to support all the BCF projects but in particular DTOC working with all hospitals to check data before it is submitted ensuring it is accurate, that we are in agreement with it and to ensure all patients are recorded against the correct Local Authority.

Embedded below is our progress against the high impact change model: -

Table showing how the BW10 projects ar

Please accept this document as the 2017/19 Better Care Fund Plan for West Berkshire.



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