Ian Wardle
MANAGING DIRECTOR

Civic Centre, Reading, RG1 7AE
☎ 0118 937 3737

To: All members of the Health & Wellbeing Board

(Agenda Sheet to all Councillors)

Our Ref:
Your Ref:

Direct: ☎ 0118 937 2112
e-mail: nicky.simpson@reading.gov.uk

6 February 2014

Your contact is: Nicky Simpson – Committee Services

NOTICE OF MEETING – HEALTH & WELLBEING BOARD – 14 FEBRUARY 2014

A meeting of the Health & Wellbeing Board will be held on **Friday 14 February 2014 at 2.00pm in the Kennet Room, Civic Offices, Reading.** The Agenda for the meeting is set out below.

AGENDA

Cont/..

CIVIC CENTRE EMERGENCY EVACUATION: Please familiarise yourself with the emergency evacuation procedures, which are displayed inside the Council's meeting rooms. If an alarm sounds, leave by the nearest fire exit quickly and calmly and assemble at the Hexagon sign, at the start of Queen's Walk. You will be advised when it is safe to re-enter the building.

../Cont

4. BERKSHIRE WEST 5 YEAR STRATEGIC PLAN AND 2 YEAR OPERATIONAL PLANS FOR SOUTH READING CCG AND NORTH & WEST READING CCG 35

A report giving a summary known as the "Plan on a Page" for the 5 year Berkshire West Clinical Commissioning Groups (CCGs) Strategic Plan and the individual CCGs' 2 year operational plans, ahead of the submission deadline to NHS England of 4 April 2014, to allow the Health and Wellbeing Board early sight of the intentions in the plans and to allow a triangulation with the Reading Health and Wellbeing Strategy 2013-2016. The report demonstrates how the plans align with the four goals and sub-objectives of the Reading Health and Wellbeing Strategy 2013-16 and the recent Reading JSNA and individual CCG Public Health profiles.

5. DATE OF NEXT MEETING – Friday 21 March 2014 at 2pm -

READING BOROUGH COUNCIL

REPORT BY DIRECTOR OF EDUCATION, ADULT & CHILDREN'S SERVICES

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**14th FEBRUARY 2014**	**AGENDA ITEM:**	**3**
TITLE:	**BETTER CARE FUND SUBMISSION**		
LEAD COUNCILLOR:	**COUNCILLOR HOSKINS / COUNCILLOR EDEN**	**PORTFOLIO:**	**HEALTH / ADULT SOCIAL CARE**
SERVICE:	**HEALTH / ADULT SOCIAL CARE**	**WARDS:**	**BOROUGH WIDE**
LEAD OFFICER:		**TEL:**	**0118 937 4164**
JOB TITLE:	**DIRECTOR OF JOINT COMMMISSIONING, BERKSHIRE WEST CCGs / HEAD OF ADULT SOCIAL CARE, READING BOROUGH COUNCIL**	**E-MAIL:**	**Gabrielle.Alford@nhs.net / Suzanne.Westhead@reading.gov.uk**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The Better Care Fund (BCF), previously called the Integration Transformation Fund, provides for local funding for health and care services in ways which take forward the integration agenda. Funding will be made available from NHS England in 2014-15 and then as local pooled budgets in 2015-16.

1.2 The BCF provides an opportunity to improve the lives of some of the most vulnerable people in Reading who use health and social care services. The Fund is intended to be used to help those people by providing them with better services and better quality of life. Through the BCF, services will be redesigned and developed so that more people receive the right care in the right place at the right time.

1.3 In order to draw down the funding available through the BCF allocation, Local Authorities and Clinical Commissioning Groups (CCGs) must submit agreed two-year plans for use of the BCF, which plans have also been approved by the appropriate Health and Wellbeing Board. A duly approved 'first cut' must be submitted by 14 February 2014 to NHS England and the Local Government Association (LGA). A revised version must then be submitted by 4 April 2014.

1.4 Reading's first BCF submission is attached to this report in two parts. See:

Better Care Fund planning template – Reading – February 14 - Part 1
Better Care Fund planning template – Reading – February 14 - Part 2

2. RECOMMENDED ACTION

2.1 The Health and Wellbeing Board:
(a) notes progress to date in developing an agreed BCF submission for Reading; and
(b) approves the annexed planning templates for submission to NHS England and the LGA.

3. BACKGROUND

3.1 The Better Care Fund is intended to be used locally so as to manage pressures, and to improve the long term sustainability of an integrated health and social care service. It has been established on the premise that there will be a significant expansion of care in community settings, taking forward both the integration and the prevention agendas. The BCF plan is for health and social care services to work more closely together, working in partnership through a single pooled budget to achieve a better customer journey, better outcomes and better value for money.

3.2 Nationally, the BCF provides for £3.8 billion worth of funding in 2015/16 to be spent on integrated improved services in health and social care. Through the BCF, minimum sums will be specified to be included in pooled budgets for each locality. CCGs and local authorities may choose to pool more of their resources.

3.3 The 2013 Spending Round established six national conditions for access to the BCF.

1. Plans must be jointly agreed – signed off by the Health and Wellbeing Board and its constituent Councils and CCGs and following engagement with providers likely to be affected by the use of the BCF.
2. Protection for social care services is defined and agreed within the plan.
3. Plans will provide for 7 day services to support discharge and prevent unnecessary admission at weekends.
4. Plans provide for safe and secure data sharing to support seamless care, moving towards use of people's NHS number as the primary identifier across health and social care services.
5. Plans ensure a joint approach to assessments and care planning with an accountable professional co-ordinating care.
6. There is local agreement on how BCF plans will impact on the acute sector.

3.4.1 There is a payment-for-performance element to the Fund. Funding in April 2015 is dependent on making progress against the following performance measures:

- Decrease in Delayed Transfers of Care
- Decrease in Avoidable Emergency Admissions

Funding in October 2015 is dependent on making continued progress against these performance measures plus a further four measures, so in total:

- Decrease in Delayed Transfers of Care
- Decrease in Avoidable Emergency Admissions
- Reduction in Permanent Admissions to Residential and Nursing Care
- Increase in the Effectiveness of Re-ablement (measured as the proportion of older people still at home 91 days after discharge from hospital into re-ablement)
- Improved patient and service user experience (against a national metric which is still in development)
- One agreed local indicator. In Reading's submission, the proposed local measure is a decrease in the number of people who remain in hospital after being assessed 'Fit to Go'

3.5 If a local area achieves 70% or more of the levels of ambition set out in each of the indicators in its plan, it will be allowed to use a held-back portion of the performance pool to fund its agreed contingency plan, as necessary. If an area fails to deliver 70% of the levels of ambition set out in its plan, it may be required to produce a recovery plan.

4. READING'S BETTER CARE FUND VISION

4.1 Partners across health and social care have worked collaboratively to develop a local vision for the BCF.

Our vision is of Reading residents being empowered and supported to live well for longer at home.

Health and social care professionals will work alongside one another and with family carers as expert partners in care, to:

- **Provide the right care by the right people at the right time and in the right place** with more people supported within their homes and community, and the development of 7-day working across health and social care
- **Keep the individual at the centre of a co-ordinated health and care system** with a single point of contact
- **Develop and earn trust**, from patients/service users and across organisational boundaries
- **Keep improving health and care systems with the people who use them** increasingly involved in the design, delivery and evaluation of services

- **Protect community (including family) connections** for those with care and support needs, in recognition of the positive impacts these have on emotional and physical wellbeing;
- **Proactively address the risk of hospital or care home admission**, putting in place preventative services to mitigate those risks; and
- **Make the experience of care a more positive one**, in which the individual retains as much choice and control as possible.

5. BCF SCHEMES FOR DELIVERY IN READING

5.1 Five schemes have been identified in Reading's draft BCF submission

A Hospital at Home Service - targeted at those patients that require initial intensive 24-hour support and treatment but can be managed at home and then discharged after a few days into traditional community care provision.

Supporting residential and nursing care homes - through introducing a GP enhanced community service, providing additional training to care home staff and additional community pharmacist resource.

Health and Adult Social Care Services systems interoperability – to address delayed transfers and discharges as well as supporting better informed decisions at all stages and improving the patient/service user experience.

Time to Think Beds – focusing on patients with complex care needs who, at the point of discharge from hospital, are likely to have a need for nursing care.

7-day Integrated Health & Social Care Neighbourhood Teams – linked to an integrated health and social care hub, with strong connexions across a range of neighbourhood services including preventive support provided by voluntary and community groups, and supported by GP extended working.

6. CONTRIBUTION TO STRATEGIC AIMS

6.1 Reading health and social care providers and commissioners have already set out an intention to streamline and integrate services for the benefit of patients and the public. This BCF submission is an extension of the plans articulated in the 'Berkshire West 10' application to become an integration pioneer. The BCF submission also draws on and develops the strategic priorities set out in Reading's Health and Wellbeing Strategy (2013) and RBC's Prevention Framework (2011). It supports the vision outlined in the Berkshire West Strategic plan 2014-2019 and in the Reading CCGs Operating Plans 2014-2016 to 'keep people well and out of hospital in partnership'.

4

7. COMMUNITY INVOLVEMENT

7.1 The BCF submission has drawn on Reading patient, service user and public feedback gathered recently across a range of health and social care involvement channels, particularly the RBC-led 'Let's Talk Health' programme, the Home Carer User Interview Project (a joint RBC and Healthwatch initiative), the NHS Call to Action event and the 2013 Dementia and Elderly Care Conference. This feedback indicates a strong appetite for better integrated health and social care and also illustrates that maintaining independence and having choice and control over how they receive care is very important to the people of Reading.

7.2 The submission sets out a shared commitment to ensure future service development involves and is centred on the individuals receiving care. The details of how this will operate will be part of the implementation plans for the various schemes identified.

8. LEGAL IMPLICATIONS

8.1 In 2015-16 the BCF will be put into pooled budgets under Section 75[1] joint governance arrangements between Clinical Commissioning Groups and Councils. A condition of accessing the money in the BCF is that CCGs and Councils must jointly agree plans for how the money will be spent and these plans must meet certain requirements as described above.

9. EQUALITY IMPACTS

9.1 All public sector bodies are under a legal duty to comply with the public sector equality duties set out in the Equality Act 2010. In order to comply with these duties, the relevant organisations must seek to prevent discrimination and protect and promote the interests of 'protected' groups.

9.2 As the proposed BCF schemes are developed, equality analyses will be carried out to inform that development and will be presented so that decision makers can give conscious and open minded consideration to the impact of the equality duty when reaching any future decisions in relation to the integration of health and social care locally.

[1] NHS Act 2006

10. FINANCIAL IMPLICATIONS

Revenue Implications

10.1 Nationally, the BCF comprises £1.1bn in 2014-15 and will increase to £3.8 bn in 2015-16. For Reading the overall pool available to fund the various service options will be £9.024m in 2015-16.

10.2 In 2014-15 the transfer of funding to adult social care 'to benefit health' will continue be distributed using the social care relative needs formula (RNF). The formula for distribution of the full BCF in 2015-16 will be based on the CCG formula and then mapped to local authorities. Some elements (the current social care transfer, adult social care capital funding, and Disabled Facilities Grants) will be allocated in the same way as in 2014-15.

10.3 It is for local areas to decide how to spend their allocations on health and social care services through their joint plan. However, half of the 2015-16 BCF 'pot' will come from NHS funding and the other half will be made up from Carers Break Funding, CCG re-ablement funding, capital funding to include Disabled Facilities Grant allocations, and previously announced transfers of funding from health to adult social care. Local plans for the BCF should therefore set out the level of resource which will applied to maintaining services funded through these channels previously, particularly the amounts dedicated to carer-specific support and intended to ensure a continued focus on re-ablement. A key element of the funding is that it will need to be realised from existing commitments across the health and social care economy

Capital Implications

10.4 The majority of the funding will be revenue, but the fund does include the Social Care Capital Grant and the Disabled Facilities Grant. It is expected that health partners will also contribute some capital to fund specific programmes such as ICT integration and other appropriate schemes.

Value for Money

10.5 The options that are being identified within the Better Care Fund are being reviewed to ensure they deliver both improved patient/client outcomes but also doing this efficiently within the resources available.

6

Risks

10.6 The Better Care Fund is a catalyst to help local health and Government to make substantial changes to the way health and care is delivered. However, with any change of this complexity there are significant risks that all the new schemes will be delivered successfully. This is a major issue for the partners as part of the funding is reliant on the improved performance being delivered. Failure to deliver this change will result in the funding not being provided which could then lead to significant financial issues for all partners. Part of the further work that is required before the April submission will be to consider how this risk is managed and what contingency plans will be required.

10.7 Although not ring-fenced, identified proportions of the BCF are intended to be used to help Councils to prepare for new obligations under the Care Bill, e.g. new entitlements for carers, stronger provision of information, advice and advocacy and moving towards the capped cost system. At this stage it is difficult to estimate exactly what the financial implications of the Care Bill will be for Reading. Within the National guidance for the BCF there was an assumption that £135m Nationally could be allocated to cover some of these costs. For the purpose of the first BCF submission, Reading has used this guidance and has applied the relevant portion to the local BCF financial plan. However, Officers anticipate that this will not cover the true cost of the change and there is a risk for the Council that it will not receive the necessary funding to cover the costs of this change.

10.8 The governance and resourcing implications of the changes being proposed are significant. Further work is required to determine which organisation will in 2015/16 hold the pooled budgets and what the governance arrangements (including risk share arrangements) will be. In addition, this work will require a large amount of resource from staff across the various organisations at a time when all of the organisations' staff are under significant work load pressures. It will be important for the successful delivery of the BCF that these issues are examined and solutions identified as the work to deliver the BCF is implemented during 2014/15.

Better Care Fund planning template – Reading – February 14 - Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Reading Borough Council**
Clinical Commissioning Groups	**South Reading Clinical Commissioning Group**
	North & West Reading Clinical Commissioning Group
Boundary Differences	The South Reading CCG is made up of 20 practices within the Reading Borough Council boundary. The North and West Reading CCG includes 7 practices within the Reading Borough Council boundary and 3 in a neighbouring authority (West Berkshire). Some of the schemes proposed for Reading will also operate across neighbouring authorities, making best use of provider services which operate across local authority boundaries.
Date agreed at Health and Well-Being Board:	**14 February 2014**
Date submitted:	**14 February 2014**
Minimum required value of ITF pooled budget: 2014/15	**£2,500,000**
2015/16	**£9,024,000**
Total agreed value of pooled budget: 2014/15	**£2, 814,280**

2015/16	**£10,619,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	South Reading Clinical Commissioning Group
By	Dr Elizabeth Johnston
Position	Chair of NHS South Reading CCG
Date	14.02.2014

Signed on behalf of the Clinical Commissioning Group	North and West Reading Clinical Commissioning Group
By	Dr Rod Smith
Position	Chair of NHS North and West Reading CCG
Date	14.02.2014

Signed on behalf of the Council	Reading Borough Council
By	Avril Wilson
Position	Director of Education Adults & Children's Services
Date	14.02.2014

Signed on behalf of the Health and Wellbeing Board	Reading Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Jo Lovelock, Leader of Reading Borough Council
Date	14.02.2014

c) Service provider engagement

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

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

This submission has been developed over a series of meetings involving community health providers, social care and primary care and also discussed at the Reading Integration Programme Board. These meetings have acted as a local catalyst to co-

develop new programmes, drawing on provider views about local pressures and opportunities to work differently to achieve better outcomes.

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

The Berkshire Healthcare Foundation Trust, the Royal Berkshire Hospital, local GPs, WestCall (out of Hours GP Service) and the Adult Social Care Service are all expected to form part of the implementation teams as we go forward with our plans. Other providers, such as the South Central Ambulance Service, residential and nursing care homes, sheltered, extra care and other housing providers, and local voluntary and community sector providers will be consulted and invited to join transitional planning groups. We have a range of local provider forums at which we intend to present this plan and secure wider provider involvement in its evolution.

d) Patient, service user and public engagement

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

Patients, service users and members of the public have shared with us their experiences of local health and social care, and their aspirations for the future. This has given us a firm mandate to develop integrated services with the individual at the centre. The distinction between health and social care makes no sense to the people who need support. They perceive the hand-offs between health and social care as unnecessary bureaucracy standing in the way of them receiving the services they need. Reading residents have also given commissioners a strong message that they are looking to statutory services to support them to support themselves and their families. Maintaining independence and having choice and control over how they receive care is clearly very important to the people of Reading.

We have a wide range of mechanisms across health, social care and voluntary and community sector partners to give patients and service users the opportunity to influence service development. These include groups based on geographical location, condition-specific forums, and service based feedback mechanisms.

Our engagement strategy is evolving based on our shared commitments to:

- Keep the individual's experience and perspective as the organising principle of service design, building on the experience of Reading Borough Council in using this approach to reframe their home care commissioning
- Ensure there is strong patient and service user representation throughout the governance of our integration programme, with involvement mechanisms kept simple and accessible
- Developing opportunities for co-production and co-commissioning alongside involving the public through formal consultation as appropriate
- Placing patient and service user feedback at the heart of our evaluation processes, and developing continual feedback such as the Friends and Family

Test to ensure services keep improving

- Using a broad range of communication and engagement materials that facilitate the participation of all parts of our community, regardless of language spoken, mental capacity or disability
- Develop new measures of patient experience to assess the benefits of integration.

Much of the expertise through experience drawn on to inform our integration planning so far was articulated through Reading's 'Let's Talk Health' community involvement programme, but is also a reflection on conversations which are continuing within patient and service user forums across the town such as the NHS Call to Action events and the Dementia and Elderly Care Conference organised by the CCGs.

e) Related documentation

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

Document or information title	Synopsis and links
Prevention Framework	A commissioning strategy for preventative and support services: www.reading.gov.uk/meetings/details/3344/ (appendix 12)
Home Care Users Feedback Report	Results of a six month survey of people using home care services: www.reading.gov.uk/council/consultations/this-year-s-closed-consultations/home-care-users-research-project/
Dementia & Elderly Care Conference Report	Outcomes from a joint conference with Reading CCGs in collaboration with South Reading Patient Voice and Healthwatch to identify gaps and share best practice in dementia provision across Reading: www.southreadingccg.nhs.uk/images/publications/Events/Dementia-and-Elderly-Care-conference-Final-report.pdf
Call to Action Report	The views of patients and the public in response to current issues facing the NHS and future identified challenges
Joint Strategic Needs Assessment	Used to inform the commissioning of services by Reading Borough Council and Reading CCGs: www.reading.gov.uk/residents/public-health/public-health-health-being-strategy/
Health & Wellbeing Strategy	Integrated health and wellbeing strategy for Reading: www.reading.gov.uk/residents/public-health/public-health-health-being-strategy/
Pioneer Bid	A submission by the 'Berkshire 10' to receive support to integrate health and social care across Berkshire West.

Commissioning Intentions	A description of how the Berkshire West CCGs will use their commissioning budgets to deliver the CCGs' strategic vision for healthcare services.

2) VISION AND SCHEMES

a) Vision for health and care services

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

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

Our vision is of Reading residents being empowered and supported to live well for longer at home.

Health and social care professionals will work alongside one another, and with family carers as expert partners in care, to:

- **Provide the right care by the right people at the right time and in the right place** with more people supported within their community, and the development of 7-day working across health and social care
- **Keep the individual at the centre of a co-ordinated health and care system** with a single point of contact via a 'hub'
- **Develop and earn trust**, from patients/service users and across organisational boundaries
- **Keep improving health and care systems with the people who use them** increasingly involved in the design, delivery and evaluation of services
- **Protect community (including family) connections** for those with care and support needs, in recognition of the positive impacts these have on emotional and physical wellbeing;
- **Proactively address the risk of hospital or care home admission**, putting in place preventative services to mitigate those risks; and
- **Make the experience of care a more positive one**, in which the individual retains as much choice and control as possible.

NHS England has identified that any high quality, sustainable health and care system will need to take a completely new approach to ensuring that citizens are fully included in all aspects of service design and change, and that patients are fully empowered in their own care. The future expectation is one of wider primary care, provided at scale; a modern model of integrated care; access to the highest quality urgent and emergency care; a step change in the productivity of elective care; and specialised services concentrated in centres of excellence. We are committed to working with individuals, families and communities to understand what works for them, with a real focus on early support, care and treatment for patients with physical and mental health needs.

We intend to deliver care across a range of initiatives centred around the individual

patient/service user managed through a 'hub' which will provide one point of entry to an integrated team. We are committed to delivering end to end integrated care and to radically reducing the number of assessments and transactions people currently have to undergo to receive care.

The case for change

We have a strong foundation in our shared vision and our track record, but we know that we need to adopt a revolutionary rather than an evolutionary approach if we are going to succeed in tackling the system pressures and demographic challenges facing us. More people are living with mental health issues and long term conditions and the numbers are expected to keep rising. 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.

Whilst Reading expects to see a relatively small increase in the total number of older people compared to most other areas, the biggest increase will be in the very elderly, who are at greater risk of experiencing long term health conditions. Reading has a significant number of older people living alone and consequently at risk of social isolation with the negative impacts on physical and emotional wellbeing which this brings. There are also significant numbers of older people living in relative deprivation, making them especially vulnerable. Levels of unpaid care are expected to rise, and we know that those providing high levels of care are twice as likely to experience ill health as members of the general population.

Our Joint Strategic Needs Assessment tells us:

- The population of Reading increased by 9% between 2001 and 2011.
- Reading's older population is expected to increase at the greatest rate over the next few years compared to other age groups.
- Almost 8% of Reading residents provide informal or unpaid care to friends, family or neighbours.
- Life expectancy is 8.5 years lower for men and 7.0 years lower for women in the most deprived areas of Reading compared to the most affluent areas.

Research from Dying Matters found that 70% of people want to die at home, however in Reading fewer than 20% of all deaths happen at home (lower than national average rates) with around 50% of all people dying in hospital.

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.

Developing patient / service user centred care pathways

We will examine new models of service delivery across different settings, going beyond traditional health and social care services to include wider determinants of physical and

emotional wellbeing. Including services from across the local authority such as housing, transport and leisure as well as those delivered by voluntary and community sector organisations, we will design along pathways that support people to stay well, recover from illness and optimise independence and wellbeing. We will start by looking at the best ways to support frail elderly people, both from a physical and mental health perspective, and will move on to children's services including health, social care, education and mental health.

Encouraging independent living

We will work across health and social care organisations as well as voluntary sector and community based organisations to support people's independence.

Promoting self care – We have already deployed a web based tool to promote joint care planning between individuals and doctors and will build on this to deliver further self care initiatives. This will include partnerships with social enterprises to design new non clinical coaching modalities to support people with long term conditions. We will also work with Reading's various condition specific support groups within the voluntary and community sector to enhance opportunities for peer support and learning from others' experiences.
.
Supporting care homes – Consolidated effort across Reading will provide proactive support to care and nursing homes. Strategic partnerships will be established with Supported Housing providers and social enterprises to support timely hospital discharge through direct provision for people with complex needs.

Developing Supported Housing - Strategic partnerships will be established with Supported Housing providers and social enterprises to support timely hospital discharge through direct provision for people with complex needs. We realise that not all dwellings in the borough are 'care ready' to provide a base for care at home as people become more frail. We are therefore committed to increasing the supply of Extra Care Housing to 240 units across the town, and the local authority has foregone capital receipts in order to be able to offer land for development in this way. Oaktree House is already available and can accommodate up to 60 people, and a further development at Cedar Court will accommodate up to 40 people. Feasibility studies were commissioned in 2013 on the development of up to 80 additional units on land identified in Caversham and in Southcote.

Changing the way we work

Modernising the current model of primary care – New models and approaches to primary care are required to meet the workforce challenge and the new demands on the primary care sector in a transformed system. The emerging trend is for more part time salaried doctors which challenges the current partnership model. Small and single handed practices are less able to respond to increased demand. Therefore we will explore new organisational models for the provision of primary care that will strengthen integration with community health and social care, building on the current success of joint triage between GPs and the ambulance service.

Revolutionising our workforce – We will bring together the qualified and non qualified home care workforce to improve the quality of care and provide seamless services which

prevent patients bouncing around our system. We will work with service users on a programme of continuous improvement with the service user voice central at all stages of commissioning.

Targeting resources to achieve greatest impact

We have implemented risk stratification across Reading GP practices and are keen to maximise the benefits of this investment, both at a strategic and individual level. By sharing information across health services and the local authority we can work as a whole system to target key groups of residents further down the risk triangle to prevent ill health and identify people who need additional support to promote independent living and prevent deterioration. This will include developing awareness within statutory services of third sector provision and the health benefits which come from strengthening individuals' community connections. There will be increasing 'social prescribing' to support people to stay well, particularly combating social isolation. We will work to overcome the technical and information governance issues that have so far excluded information on Continuing Health Care and Social Care packages from our Adjusted Clinical Groups (ACG) risk stratification model.

Changing the way we commission care and delivering efficiency savings for reinvestment

We recognise the drive for greater integration may present a challenge for individual organisations. We already have integrated health and social care teams within mental heath, learning disability and re-ablement services. We will apply what we know delivers better outcomes for individuals through this way of working and use it to identify further options for structural integration and the development of social enterprises. We will be driven by the goals of improving both quality and continuity of care in ways which are financially sustainable.

Testing new models of funding options – We intend to work to overcome the challenges posed by the current Payment by Results payment system. We will explore moving away from this model of payment within the acute sector and look at alternatives such as a 'year of care' approach that is pathway based, with outcome based contracts, capacity model funding and increasing the flexibility and blurring between health and social care.

Application of personal health budgets. - Building on the learning from the successful implementation of personal budgets in social care, we will seek to enable a more personalised, flexible approach and greater control for individuals. Initially, we would offer personal health budgets to people currently in receipt of both health and social care services. A pilot would be taken forward with social care as the lead agency, focusing on identifying groups of people where aligning or pooling budgets, e.g, for continuing health care, could lead to improved outcomes. This approach would also enable inclusion and development of input from the non statutory sector eg. voluntary sector bodies and private providers.

b) Aims and objectives

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

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

Through our plans for integration, we aim to:

- Deliver excellent care;
- Enhance the options for care at home across a range of long term health conditions; and
- Enable people who are frail or unwell to maintain maximum choice, control and independence

In future, people with long term conditions will have a care plan, contained in one set of records shared between organisations. Care at home will be offered by multidisciplinary teams, with more specialist support for those with more complex needs. We aim to see fewer people admitted to hospital, with hospital stays becoming shorter, and fewer permanent admissions to residential or nursing care. Transitions between care providers, where necessary, will become much smoother.

In all, our objective is to reduce long term dependency leading to better wellbeing and quality of life as well as a more sustainable system for the future. Physical and emotional wellbeing will have parity in how we identify care needs and stratify risk in future.

Whilst our scheme to improve system interoperability has the potential to benefit all residents, most of the schemes in this plan are focusing on improving service integration for people with long-term conditions. Such conditions can greatly impair the quality of people's lives and potentially place immense pressure on health and social care budgets. The Department of Health estimates that treatment and care of people with long-term conditions accounts for almost £7 in every £10 spent across the health and social care system. Although they can affect anyone, long-term conditions become more common as people advance in age. People living in relative deprivation are also more likely to be affected. As the Reading population ages, we therefore expect to see a growth in the number of people living with long-term conditions, and also a growth in the number caring on an unpaid/informal basis for a friend or family member with health consequences for those carers.

Part 2 of this submission describes how we expect to measure the impact of these changes.

c) Description of planned changes

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

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

The local partners have agreed that the following schemes demonstrate a shared vision for improving local services for patients. These schemes aim to eliminate fragmentation in our service caused by operational and organisational boundaries. We intend to deliver the following five schemes:

1. A Hospital at Home Service

This scheme will offer a safe alternative to hospitalisation and prevent unnecessary admissions. The service will operate within each Berkshire West CCG, including the North and West Reading CCG and the South Reading CCG, supported by the Berkshire Healthcare Foundation Trust Health Hub. The aim is to provide a service that standardises practice in relation to the management of patients with complex care needs (sub-acute) in the short-term. The service will be targeted at those patients that require initial intensive 24-hour support and treatment but can be managed at home and then discharged after a few days into traditional community care provision.

Hospital at Home will deliver:

1. Improved healthcare experience for Reading patients;
2. An integrated approach to care;
3. Reduction in unnecessary admissions;
   Reduction in outpatient attendances;
5. Improved access to Intravenous Therapy;
6. Improved quality of life for patients;
7. Improved coordination of crisis management.

2. Supporting residential and nursing care homes

This scheme provides a new model of high level health care support into care and nursing homes throughout the borough to improve consistency in the quality of care and outcomes for residents.

The aim is to reduce non-elective hospital admissions from care homes through introducing a GP enhanced community service, providing additional training to care home staff, and additional community pharmacist resource. The scheme overall will strengthen partnership working between care home providers, community geriatricians, and health and care staff to improve the quality of life for residents. This will include reducing the number of falls, and the prescribing of multiple medications to elderly people. This will in turn improve the overall health and wellbeing of care home residents.

Scope of the scheme

The local authority and both Reading CCGs are partners to this project which is intended to be rolled out across the West of Berkshire, and is led by the Berkshire West Care Home Working Group.

The aim of the model is to enhance the quality of medical cover for all residents of registered care homes in Berkshire West (excluding care homes for adults with a learning disability) over 18 years of age.

Benefits of the scheme

Reading CCGs have chosen to target Better Care Fund resources on care home residents because their medical needs are complex and rapidly changeable. 80% will have mental health needs such as dementia, depression or a long term mental health diagnosis. They have higher needs than other patients for essential medical cover because they are not able to attend their local GP practice. This means that regular GP visits to the care home are required as well as frequent and multiple prescribing interventions. Currently, however, the range, type, quality and consistency of overall care can vary widely between the individual care homes.

With more people being supported to live at home for longer, those who need 24 hour support in a care home likely to have complex or multiple long term health conditions. This has growing cost implications for the health and social care economy. These costs can include Accident & Emergency attendances, emergency admissions to hospital, and readmissions. Some admissions are potentially avoidable, such as fractures or urinary tract infections.

(a) GP Enhanced Community Service

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

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

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

(b) Enhanced training to care home staff

This scheme will also include additional nurse trainers into care homes. Currently, the Royal Berkshire Healthcare Trust and the South Central Ambulance Service receives a high number of referrals from care homes which turn out to be either inappropriate or

avoidable if there was better knowledge within the care home setting of how to manage long term conditions.

(c) Introduction of an additional Community Pharmacist Resource

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

3. Health and Adult Social Care Services systems interoperability

The ability to share patient data electronically across healthcare and social care settings will enable clinicians and care staff to make better informed judgements about the care they provide or arrange. It also means that people don't have to tell their story or give information more than once. Information sharing is often an important factor in ensuring that people can be moved as quickly as possible to the most appropriate setting for the care they need, so systems interoperability will help to address delayed transfers and discharges.

Scope of the proposal

There are a number of technology solutions which facilitate wide-scale information sharing between the clinical systems used in different settings. The Berkshire West Federation of Clinical Commissioning Groups (which includes the Reading CCGs) has engaged with an ICT development organisation to ascertain the functionality of its Medical Interoperability Gateway (MIG), and to confirm interoperability across the local health economy.

Only a small proportion of the population will request and be deemed eligible for social care services so as to acquire a social care record. However, most people will be registered with a GP. The GP record is therefore the natural 'hub' in terms of a patient's full health and social care record.

Currently, the GP record is built and maintained as a result of interaction with the patient within the GP Practice, but also includes reports such as pathology and radiology results, out-of-hours primary care reports, and discharge summaries from acute, community and mental health providers. Most of these reports are transmitted electronically. Outbound information sharing is used to enable GP practices to complete referral forms into other provider services automatically, or to submit core data to the Summary Care Records (SCR), i.e. medication, adverse reactions and allergies. More data could be submitted into the SCR with the existing technology but only manually, and there have been some technical difficulties with authorised agencies viewing the SCR.

Benefits of systems interoperability

The MIG is a secure gateway for exchanging real time data between GP Practices and wider healthcare settings. It presents information in existing clinical systems while meeting interoperability technical and security standards.

Subject to information sharing agreements and patient consent being established, data

can be presented within a Detailed Care Record. The benefits include the following:

1. Real time display of the detailed GP patient record;
2. GPs being able to fully control access through local sharing agreements;
3. A common view of the record in end user systems;
4. Full integration and embedding into the end user system i.e. no separate login;
5. Providing clinicians and care providers with access to richer data about the individual at the point of care;
6. Fewer investigations ordered creating less duplication;
7. Robust audit functionality to support Information Governance.

The Medical Interoperability Gateway is being developed to offer the following:

(a) Community Record Service – views of community information held in Community systems and made available to GPs as real time view of data.

(b) Medication Reconciliation Service – access to real time GP patient medication e.g. into a hospital pharmacy system to improve clinical safety and efficiency and reciprocally, discharge medications electronically issued to the GP system.

As an 'off-the-shelf' product, the MIG is able to interact with the majority of clinical systems used locally. Where systems do not currently interact we will seek to establish relationships with respective clinical system suppliers in order to build interoperability with their systems.

Careful consideration around information governance is required to preserve information security and to build and maintain the confidence of patients and clinicians. Experience from information sharing initiatives indicates that careful stakeholder management is required and that extensive work is required to establish acceptable and effective information sharing agreements.

4. Time to Think Beds

The Time To Think (TTT) bed scheme is designed to enable patients to move on from acute care as soon as they are medically stable so they can then receive rehabilitation or re-ablement support in a community setting prior to an assessment of their long term support needs.

Setting up this service will improve the rate of discharge from hospital by offering a suitable community setting for typically longer stay patients. Reading's Intermediate Care / Re-ablement service will support the TTT provider to establish goals for the individual and monitor progress towards these.

5. 7-day Integrated Health & Social Care Neighbourhood Teams

We will build on the successful working of our joint re-ablement team, which works to maximise the independence which can be regained after an illness or injury. This model will be developed to incorporate:

(a) a health and social care hub
(b) Multi disciplinary teams of health and social care staff at a neighbourhood level organised around groups of GP practices
(c) Extended GP hours

(a) health and social care hub

It is important to manage referrals into one point of entry whereby the responsibility and accountability for finding, accessing and transfer of cases sits within one integrated team. It will prevent those circumstances when a case is batted between services due to differing referral criteria or lack of capacity. It will make it much easier for the public and professionals to access health and social care services. Accessing the range of currently disjointed services both frustrates referrers in taking undue time to access the right service and has the effect of slowing down the process of discharge or mobilising short term community based services to avoid an unnecessary admission.

Referrals are made to the already established Health Hub (which operates across the West of Berkshire) through which all referrals from professionals for healthcare services are now channelled. For example, all local authorities in west of Berkshire now receive their referrals from the Royal Berkshire Hospital through the Health Hub. This is proving effective and time saving as the referral arrives already screened leading to quicker allocation and assessment times. This hub will be developed further to extend to all local health and social care services and become a true single point of access for all local services.

(b) Multi disciplinary teams of health and social care staff at a neighbourhood level organised around groups of GP practices

The multidisciplinary teams will link with a wider base of community services, such as timebanks, peer support groups and befriending services, to ensure seamless pathways of care for patients and service users. Services will operate within a clearly defined geographical location that is common to all partners and that reflects local communities. In this way, the neighbourhood clusters will enable patients and service users to access community services as close to home as possible.

Establishing the neighbourhood teams will facilitate the development of resource targeting based on the ACG risk stratification tool described above, and combining this with local intelligence. The integrated team will identify and target patients most likely to benefit from a coordinated approach to their care as determined by practice profile and needs analysis. This community-based and pro-active approach will identify individuals at high risk of hospital admission, assess their needs, produce a personal care plan, agree a lead professional and ensure co-ordination of that plan, whilst caring for the patient at home.

(C) Extended GP hours

We aim to deliver improvements to access general practice services for patients in Reading that is sustainable in the longer-term. We are exploring the development of GP hubs, which will allow closer working by practices, and will encourage development of more formal structures or federations to support the delivery of services.

Alongside extending practice hours, there are a number of technological initiatives we wish to deliver, for example, e-consults and/or Skype consultations, alongside an expansion of the range of services on offer at the weekend to include, for example, ultrasound or health screening programmes.

Carers

Carers are more likely to have poor health compared to those without caring responsibilities. Health problems such as stress, anxiety and depression and poor physical health can occur due to their caring role. Their health can also suffer as they consider their own health needs unimportant compared to the needs of the person they look after and their caring role means they can find it difficult to attend clinical appointments.

We are mindful of the need to plan to use the Better Care Fund to address the requirements of the Care/Children's and Families Bill which aims to strengthen carers/young carers rights from April 2015 onwards including developing co-designed plans for use of proposed additional Government funding which is expected to be made available on a phased basis over a 5 year period. We intend that this should focus on early intervention and prevention.

We have already pooled budgets across health and social care to commission an information, advice and support service across the West of Berkshire (covering three local authority areas, including Reading) and to deliver a range of services which support carers to take breaks from caring. Our aim is to move towards single pot funding for all carer support across the West of Berkshire and offer a consistent range of services, particularly to improve the experience of carers supporting others across local boundaries. We will dedicate a proportion of the Better Care Fund allocation for Reading to carer-specific support in Reading, including breaks. Details are set out in Part 2 of this submission.

Adult Social Care funding to meet new Care Bill obligations

The Care Bill will result in a number of additional responsibilities for Adult Social Care to deliver. Preparing for the transition to the capped cost system will incur capital costs. Preparing to respond to new entitlements for carers, transition to a new national eligibility threshold, and ensure stronger provision of information, advice, advocacy and safeguarding protection will all incur ongoing revenue costs.

We will set aside a specific proportion of the Better Care Fund allocation for Reading to meet both capital and revenue costs associated with meeting new Care Bill obligations.

Details are set out in Part 2 of this submission.

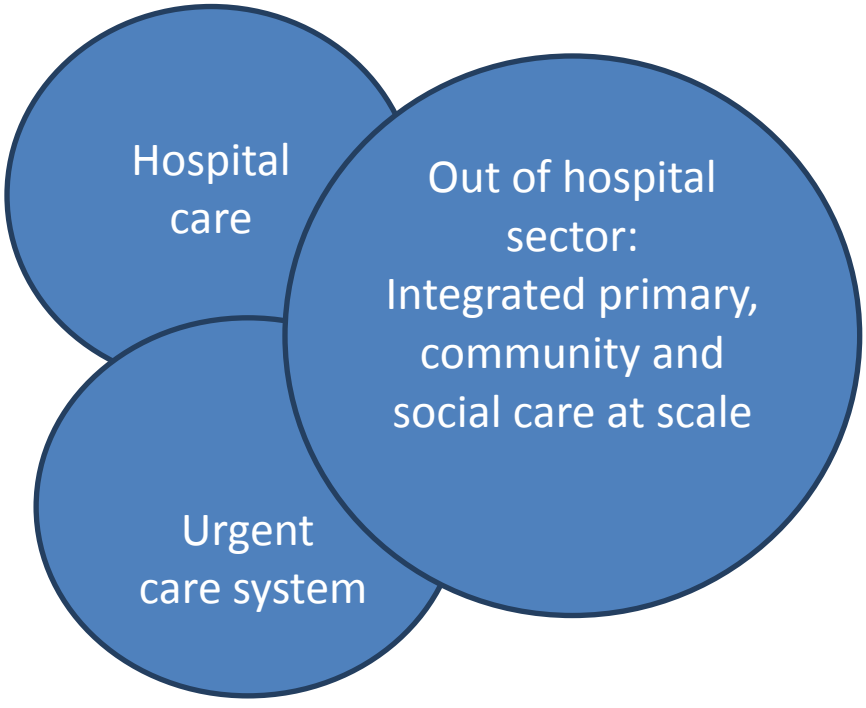
Disabled Facilities Grant

The provision of physical adaptations to property is an important element of delivering integrated support for individuals living with long term conditions, and remains a statutory duty on local authorities. We will set aside a specific proportion of the Better Care Fund allocation for Reading to provide Disabled Facilities Grants. Details are set out in Part 2 of this submission.

d) Implications for the acute sector

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

Increasingly, enhanced primary, community and social care services in Reading will work together to prevent ill-health and support patients with much more complex needs at home and in the community. Service users will be supported to take more responsibility for their health and wellbeing and to make decisions about their own care. Patients will only be admitted into acute hospitals when they require services that cannot be delivered elsewhere and will be treated in centres with the right facilities and expertise. All the services that respond to people with an urgent need for care will operate together as a single system. This will ensure that the service people receive is commensurate with their clinical and social care needs. People with urgent but not life-threatening conditions will receive responsive and effective care outside hospital. People with serious and life-threatening conditions will be treated in centres that maximise their chances of survival and a good recovery

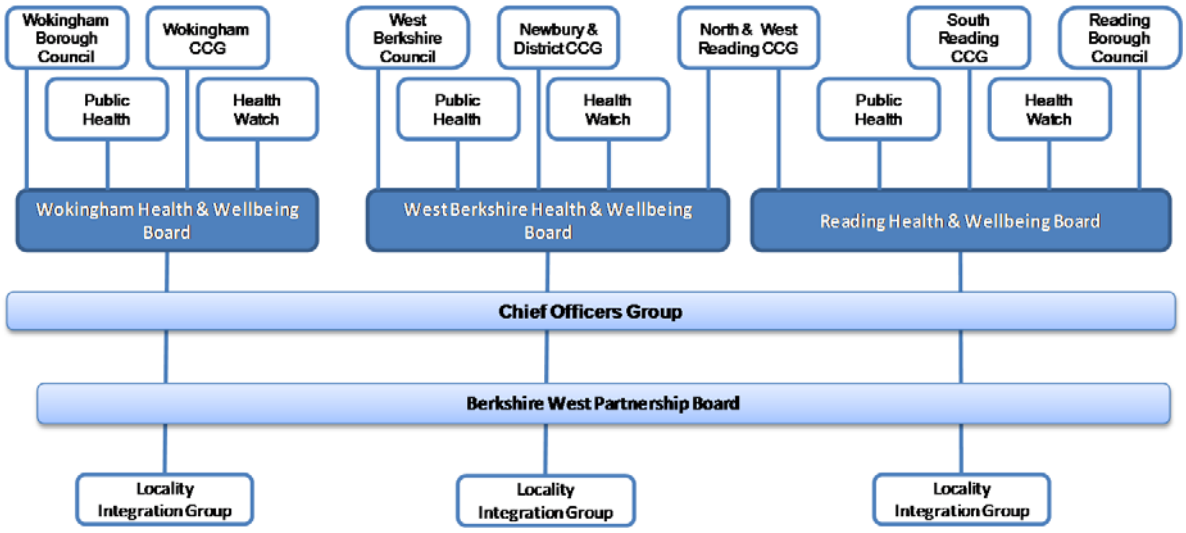


e) Governance

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

In Reading, we have a history of pooling health and social care budgets to deliver improved outcomes, and we have consequently established robust governance structures for working in this way. The schemes described in this plan have been developed so far within existing partnership forums accountable to our Health and Wellbeing Board which is central to these arrangements.

Many of the schemes described are Berkshire West wide federated projects and the governance arrangements across all four CCGs into their Health and Wellbeing Boards is as follows:



Our Health and Wellbeing Board has strategic oversight of our plans to develop more integrated services within the borough. The Board expects to improve outcomes for residents, carers and the population through promoting closer integration between health services and the Council as a whole, going beyond social care to include housing, transport and cultural services in recognition of the wider determinants of health.

The Health and Wellbeing Board has already overseen the production of the latest Joint JSNA for Reading, and led the development of a Health and Wellbeing Strategy and Delivery Plan. The Board is therefore well placed to ensure Reading's integration plans draw on local evidence of need and health inequalities, and are developed to realise the vision of:

Communities and agencies working together to make the most efficient use of available resources, to improve life expectancy, reduce health inequalities, and improve heath and wellbeing across the life course.

3) NATIONAL CONDITIONS

a) Protecting social care services

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

In Reading, Better Care Fund resources will be used to maintain and sustain social care services at a time of growing demand and budgetary pressures. This will include ensuring resources are available in readiness to meet the new obligations on adult social care which will come under the Care Bill, i.e. providing statutory support to older or vulnerable adults who meet the new national eligibility threshold for adult social care, offering assessments to all carers, and developing additional advice and support services for those who fund their own care but wish to set up care accounts with the local authority.

Through an increasingly integrated approach to care, we will develop services across sectors to ensure timely support is available to reduce, prevent or delay demand pressures on the health sector, i.e. community support which is effective in keeping people well and out of hospital. Support for voluntary and community sector services will be a key element of this in recognition of the health benefits they deliver, including supporting emotional wellbeing.

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

Social care services have had to manage significant cuts in recent times. Resources have been committed to retaining successful services which deliver real benefits, including cost avoidance, across the health and social care economy. What remains in Reading is a lean system with minimal capacity to absorb new pressures.

The Care Bill will bring significant additional responsibilities for social care to deliver. The service will need to capacity build in preparation for these, including recruiting and training new staff. There is also a need to develop new systems, both in-house and commissioned externally, to deliver significantly more care and carer assessments, and to manage care accounts for people who have hitherto had little or no contact with statutory care services.

The Better Care Fund will be used to support investment in adult social care so as to maintain timely assessment, care management and support reviews whilst also developing integrated services, including our joint Intermediate Care service, support for carers and delivery of Disabled Facilities Grants.

b) 7 day services to support discharge

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

Building on previous shared aspirations, and through its approval of this submission, our

Health and Wellbeing Board has affirmed its commitment to overseeing the development of 7-day health and social care services in Reading. We will strengthen provision and the availability of decision makers at evenings and weekends so that people can receive care in the most appropriate setting whenever they need that care.

Reading already has a number of out of hospital services, including mental health services, which operate on a 24/7 basis:

- Westcall Out of Hours GP service
- Night wardens linking in with Westcall
- Rapid Response health and social care team
- Health hub
- Night sitting service
- Out of hours crisis services
  NHS 111
- Community nursing

Our local development will build on these successful initiatives to expand 7 day working across a wider number of providers, and to draw on the skills which have been developed within multidisciplinary teams both to facilitate discharge from hospital and to avoid unnecessary admissions. We have worked across sectors and with users and carers to map out of hours pathways. This is driving the schemes described to harmonise services more effectively around individual need, whenever that need arises.

We intend to increase the number of people who benefit from an integrated intermediate care and reablement service. This will offer a system of care that can respond to escalating need as and when that is needed. A collaborative approach will shift capacity into community based provision, the purpose being to ensure that more people are moved on in a timely fashion into rehabilitation support prior to decisions being made about long term care.

c) Data sharing

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

Health partners use the NHS number as the primary identifier for correspondence. Social Care is in the process of implementing this approach, started as a result of establishing joint working across health and social care in our Intermediate Care & Mental Health teams.

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

The NHS Number will be the primary identifier across health and social care systems by April 2015.

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

The Berkshire West Federation of Clinical Commissioning Groups (which includes the South Reading CCG and the North and West Reading CCG) has engaged with Healthware Gateway to ascertain the functionality of its Medical Interoperability Gateway (MIG) and to confirm interoperability across the local health economy. This solution will deliver a 'Detailed Care Record' of the patient by pulling live data from the systems used across Health & Social Care.

GCSX (secure email) is used to communicate with health and social care partners. The requirements of the GCSX Code of Connection are of a similar standard to the NHS IG Toolkit.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

The local authority and CCGs for Reading have made this in principle commitment.

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

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

There is a commitment to creating a joint framework across the organisations by September 2014. This will build on the Berkshire NHS "Overarching Policy for sharing personal information Between Organisations 2010."

d) Joint assessment and accountable lead professional

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

Multi- disciplinary team (MDT) meetings are already in existence across Reading GP practices and are the centre of providing local integration with health and social care.

The integrated teams now have a process in place to agree a lead professional as part of the joint review and joint planning of identified patients to support the reduction in unnecessary admissions to hospital by improving preventative clinical care and managing complex conditions.

The MDT discuss the 2%-3% of patients at the top of the 'risk triangle' (those with complex long term conditions and at high risk of being admitted to hospital) identified via the ACG (Adjusted Clinical Groups) risk stratification tool and local intelligence. The meetings agree a personal care plan, the lead professional and also ensure the co-ordination of that plan, whilst caring for the patient at home. The Care Programme Approach is well established for mental health services which we will build on in our approach to the management of long term conditions.

A process will be adopted to agree a named accountable clinician for over 75s, although the lead will vary. In complex cases there will be a lead professional across health and social care with a coordinator managing the long term conditions cases.

4) RISKS

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

Risk	Risk rating	Mitigating Actions
1. The increased capacity in the Out of Hospital sector is not realised across the system	High	Reading Borough Council and the three Local Authorities will work closely with our local partners across the system to monitor demand and match capacity
2. Potential for double running costs across the system across the health and social care system	Medium	Further detailed planning will take place to ensure that activity and finances are counted once within each identified scheme
3. Cost of delivering on Care Bill obligations will exceed estimates and impact on the funding available for other schemes within the Better care Fund plans for integrated working	High	Further modelling of the potential impact is required in conjunction with the Local Government Association and the Department of Health
4. Financial risks around the Local Authorities across Berkshire West failing to risk share	High	The Local Authorities across Berkshire West to sign up to risk sharing agreements.
5. . Failure of residential and nursing care providers to adapt to changes	Medium	Early engagement with the sector to involve them in implementation plans.

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Reading BC	TBC	2,814,280	749,000	1,595,000
North and West Reading CCG				
South Reading CCG				
Above CCG's	TBC		9,024,000	9,024,000
BCF Total		**2,814,280**	9,773,000	10,619,000

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

These plans are currently in development.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Better Care Fund planning template - Reading - February 14 - Part 2

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

Scheme No*	BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits		Notes
			Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	
i	Bed Based Intermediate Care Scheme	RBC	*378,812*				*378,812*				1
ii	Social Care - Intermediate Care Team	RBC	*373,826*				*373,826*				1
iii	Community re-ablment Team	RBC	*1,066,125*				*1,066,125*				1
iv	Mental Health Re-ablement and recovery Team	RBC	*150,000*				*150,000*				1
v	Specialist Nursing Placements (to support hospital discharges)	RBC	*138,830*				*138,830*				1
vi	Additional Intermedi te Care and Re-ablement resources to support H@H, delayed discharges	RBC	*367,687*				*367,687*				1
vii	Community Equipment and Minor Adaptations	RBC	*35,000*				*35,000*				1
1	Hospital at Home (Cost based on Business case with costs shared across the West of Berkshire)	Berkshire West CCG's	*0*				*776,000*		*1,852,380*		2
2	Support to Residential and Nursing Homes (Cost based on Business case with costs shared across the West of Berkshire)	Berkshire West CCG's	*0*	*172,711*			*175,000*		*900,000*		3
3	Health and Social Care ICT interoperability	All partners									4
5	Seven Day Integrated Health and Social Care Neighborhood Teams	RBC and CCG	*0*	*TBC*			*1,883,000*		*1,980,000*		5
4	Time to think Beds	RBC					*1,154,720*				6
viii	Protection of Social Care service	RBC					*1,039,000*				7
ix	Care Bill Costs						*662,000*				8
x	Contingency						*182,000*				9
xi	Carers Funding	CCG	*337,000*				*337,000*				10
xii	Carers Funding - Grants	RBC	*214,000*				*214,000*				11
xiii	Carers Funding - respite/ DPs	RBC	*90,000*				*90,000*				12
xiv	Reablemnet funding	CCG	*779,000*				*779,000*				13
xv	DFG	RBC					*432,000*				14
xvi	DFG (extra investment)	RBC					*68,000*				15
xvii	Social care Capital Grant	RBC					*317,000*				16
xviii	Increase in Extra Care Housing	RBC									17
	Total		*3,930,280*	*172,711*	*0*	*0*	*10,619,000*	*0*	*4,732,380*	*0*	

* Schemes 1-5 inc are described in full with this numbering in section 2 (c.) of the Part 1 template

Note 1 (schemes i-vii)	These costs are the resources agreed by the Reading HWB for the use of the S256 in 13/14, with an increase for particular schemes that are subject to formal agreement
Note 2 (scheme 1)	Based on CCG business case
Note 3 (scheme 2)	Based on CCG business case
Note 4 (scheme 3)	There are no specific costs identified as the hope is the cost of this would be part funded (if appropriate) via the 14/15 social care capital grant
Note 5 (scheme 5)	The exact details of this are being worked on and this is a n estimate of likely costs

Note 6 (Scheme 4)	This would support clients that are on the fit to discharge list to be transferred for a short period to non acute beds with a multi dispalinary team to support the move to more appropriate accommodation/home
Note 7 (scheme viii)	This is an estimate of key service that could be impacted by "efficiency measures" in 15/16 that would impact the deliver of these changes. The Council is committed to maintaining adult services but will need some support to prevent further reductions in capacity
Note 8 (scheme ix)	Care Bill costs are calculated based on the national guidance that £135m of the £1.1bn would need to be identified to cover this liability
Note 9 (scheme x)	As per national guidance
Note 10	Identified by CCG as current funding
Note 11	Funding provide by RBC mainly to Vol sector to provide carer support service
Note 12	Funding used to support individual carers
Note 13	As per CCG Schedule
Note 14	As by national allocation guidance
Note 15	Expected additional funding from RBC
Note 16	As by national allocation guidance
Note 17	The Council over the next two Years is seeking to bring on line 80 additional extra care units. 40 should be available mid 2014, with a further 44 subject to a procurement exercise and would hope to be available in early 2016. Cost of care in these would be funded from exiting Council funding and built on existing Council land.
Benefits	These are a pro rota of the CCG QUIPP savings. This has been allocated on the basis of the "allocation of the pool to each Council Area". Whilst this has been allocated to certain lines the £1.98 million attached to the frail elderly pathway work is likely to require other schemes to deliver this.

Scheme No	Reconciliation		
	New BCF funding		
8	Hospital at Home	776,000	
9	Care Home support	175,000	
10	n/a		
11	Seven day working	1,883,000	
12	Time to think beds	680,000	(£680k from BCF and £474k from existing RBC funding)
13	Protection of Social care service	1,039,000	
14	Care Bill Costs	662,000	
15	Contingency	180,000	
	Total	**5,395,000**	
	CCG vr2 template	5,395,000	
	Variance	0	

Scheme No	**Total BCF**	
	From CCG vr 2 schedule	9,773,000
	from above	10,619,000
	Variance	**-846,000**
	Reason for variance - RBC funding	
12	Time to think beds	474,000
17	Carers Funding - Grants	214,000
18	Carers Funding - respite	90,000
21	DFG (extra investment)	68,000
	Total	**846,000**

Better Care Fund planning template - Reading - February 14 - Part 2

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Metric - Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

The partnerships' intention is to support greater numbers of clients in their own homes. By strengthing multi-agency support out of hospital, we will reduce the numbers of people needing to turn to nursing and care home placements, older people being the group most affected. Permanent care home placements often follow lengthy periods of hospitalisation, and so reducing dependency on institutionalised care following acute episodes will be key to our success. An integrated health and social care intermediate care team is already in place, and will be expanded to support the range of emerging schemes identified to reduce hospital admission further and facilitate early discharge. The development of extra care housing units within Reading will enhance our ability to support older people at home, with the opening of a further 40 units in 2014 and additional sites under consideration. Of the units opened in 2014, 33% will be for clients with high needs (specifically diverted away from residential care) and 33% for clients with medium needs (likely in the medium term to need residential care in the absence of alternative supported accommodation).

Metric - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

The partnership has been working effectively over the last few years to develop pathways and support that enable clients to be discharged appropriately and then supported to regain maximum capacity and independence at home. Integrated teams delivering intermediate care (bed based and social care based), community re-ablement, and mental health re-ablement & recovery are already in place. Intermediate care resource will be increased, including to support the hospital at home service. Specialist nursing placements have been commmissioned which support hospital discharge, as does the community equipment and minor adpatations service. Re-ablement support is enhanced through Council services to offer appropriate housing for older people from minor adaptations and 'handyman' support through to DFGs, sheltered and extra care schemes. Additional out-of-hospital support for those coming through re-ablement will be delivered through the integrated 7 day clusters across health and social care.

Metric - Delayed transfers of care from hospital per 100,000 population (average per month)

The partnership is working to improve the pathways to support faster discharges. Improved data sharing, the appointment of accountable lead professionals and improving access to health and social care staff on a 7 day basis will all improve the ability to take appropriate care decisions as early as possible so people can then progress to the next phase of their care. The introduction of the Time to Think beds will allow a sub acute step down into 15 new bed spaces, and facilitate earlier discharge for more complex patients.

Metric - Avoidable emergency admissions (composite measure)

The schemes described in this plan will together reduce the number of admissions into the acute hospital. Achieving this objective is dependent on our successfully supporting people to manage their emotional and physical condition, and offering accessible alternatives to hospital admission at key stages. Support to residential and nursing care homes will be a key part of this, but all of the schemes will contribute to strengthening care pathways so as to offer multiple routes back to home as the preferred setting for care to be given.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

Reading will use the national metric (under development)

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

The performance measures are all routinely reported. A Performance Group will monitor outcomes on a regular basis, and performance reporting is an embedded procedure throughout the Council and the CCGs. The Partnership will jointly monitor the progress of the Better Carer Fund schemes specifically through the Reading Health and Social Care Board, with exceptions reported to the Health and Wellbeing Board.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	960.89	N/A	700
	Numerator	172		
	Denominator	17900		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	84.51%	N/A	90%
	Numerator	60		
	Denominator	71		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	6.01		
	Numerator	7		
	Denominator	17900		
		(April 2012 - March 2013)	*(April-December 2014)*	*(January-June 2015*
Avoidable emergency admissions (composite measure): This data is currently available at CCG rather than LA level. Reading baseline and targets remain under discussion. Admissions for 2012/13 for South Reading CCG (all within Reading UA) were 1,546 and for North & West Reading CCG (covers both Reading and West Berkshire UAs) were 1,506	*Metric Value*			
	Numerator			
	Denominator			
		(TBC)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience - Reading will use the national metric (under development)			N/A	
		(insert time period)		*(insert time period)*
A 'Fit To Go' list is compiled and circulated daily by the acute hospital, from which patients can be identified by local authority area. Patients on the list are those who have been assessed as medically fit for discharge but remain in hospital the day after such assessment. Enhancing integrated health and social care support out of hospital will facilitate earlier discharge for those with a need for ongoing support. We will therefore use reductions in the Fit to Go list as our local measure of success.	*Metric Value*	18	7	5
	Numerator			
	Denominator			
		2013 average	*Jan-Mar 2015 average*	*Jun-Aug 2015 average*

REPORT FROM SOUTH READING CLINICAL COMMISSIONING GROUP & NORTH & WEST READING CLINICAL COMMISSIONING GROUP

TO:	**HEALTH AND WELLBEING BOARD**		
DATE:	**14TH Feb 2013**	**AGENDA ITEM:**	**4**
TITLE:	**BERKSHIRE WEST 5 YEAR STRATEGIC PLAN AND 2 YEAR OPERATIONAL PLANS FOR SOUTH READING CCG AND NORTH & WEST READING CCG**		
LEADS:	**DR ELIZABETH JOHNSTON**	**TEL:**	**0118 921 3827**
	DR ROD SMITH		**0118 982 2917**
	DR CATHY WINFIELD		**0118 982 2732**
JOB TITLE:	**CHAIR, SOUTH READING CCG**	**E-MAIL:**	**ejohnston@nhs.net**
	CHAIR, NORTH & WEST CCG		**rodsmith1@nhs.net**
	CHIEF OFFICER BERKSHIRE WEST CCGs		**cathywinfield@nhs.net**

1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 NHS England issued planning guidance to Clinical Commissioning Groups (CCGs) "Everyone Counts: Planning for patients 2014/15 to 2018/19" on 20th December 2013. This guidance requires CCGs to produce a number of documents for submission to NHS England within a timeframe. These documents include a 5 year Strategic Plan and associated 2 year Operational plan(s), Financial plan and a Better Care Fund Plan.

1.2 The Better Care Fund requires formal assurance from Health & Wellbeing boards and NHS England and will be discussed as a separate document.

1.3 The 5 year Strategic Plan and associated 2 year Operational plan(s) and Financial plan are required to be formally approved by NHS England with involvement of the Health and Wellbeing board in ensuring the plans triangulate with the Health and Wellbeing Strategy.

1.4 This report outlines a summary known as the "Plan on a Page" for the 5 year Strategic plan and the individual CCG 2 year operational plans, ahead of the submission deadline of 4th April 2014, to allow the Health and Wellbeing board early sight of the plans intentions and to allow a triangulation with the Reading Health and Wellbeing Strategy 2013-206 which was published in April 2013.

1.5 This report demonstrates how the 5 Year Strategy and 2 Year plans align with the four goals and sub objectives of the Reading Health and Wellbeing Strategy 2013-16 and the recent Reading JSNA and individual CCG public Health profiles.

1.6 Full 2 Year Operational Plans and a 5 year Strategic Plan will be presented at the March 2014 Health and Wellbeing Board.

2.1 2. RECOMMENDED ACTION: To note the priorities identified by the CCGs as outlined in the "2 Year Operational plan on a page" and to support the ongoing work of the CCGs in supporting the delivery of the Reading Health and Wellbeing Goals.

2.2 To note the vision for the direction of travel for the Berkshire West health and social care system as outlined in the "5 Year Strategic plan on a page" and to support the ongoing work of the Berkshire West CCGs in supporting the delivery of the Reading Health and Wellbeing Goals.

2.3 To note that full 2 year and 5 year strategic plan will be reported to the Health & Wellbeing Board in March 2014.

3. POLICY CONTEXT
The NHS Outcomes Framework and the Seven Outcome Ambitions

3.1 NSH England aspires to develop an NHS that delivers great outcomes for patients. These outcomes are described within the framework of the NHS Outcomes Framework Domains and the Seven Improving Outcome Ambitions.

NHS Outcomes Framework 2014/15

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Ensuring that people have a positive experience of care
Domain 5 –	Treating and caring for people in a safe environment; and protecting them from avoidable harm

The Seven Improving Outcome Ambitions

1.	Securing additional years of life for people of England with treatable mental health and physical conditions
2.	Improving the Health related quality of life of the 15+million people with one or more long-term condition, including mental health
3.	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community outside of hospital
4.	Increasing the proportion of older people living independently at home following discharge from hospital
5.	Increasing the number of people having a positive experience of hospital care
6.	Increasing the number of people with mental and physical health conditions having a positive experience of care outside of hospital, in general practice and in the community
7.	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

4. THE READING HEALTH & WELLBEIGN STRATEGY 2013-2016

Our Vision – A Healthier Reading

Communities and agencies working together to make the most efficient use of available resources to improve life expectancy, reduce health inequalities and improve health and wellbeing across the life course

Goal One – The health of communities is promoted and protected

Goal Two – Focus is increased on early years and the whole family

Goal Three – The impact of long term conditions is reduced

Goal Four – Health-enabling behaviours and lifestyle are promoted

5. BERKSHIRE WEST FIVE YEAR STRATEGIC PLAN 2014-19

The Strategic Plan will set out a vision for what health and social care services in Berkshire West will look like by 2019. It will describe the key interventions and changes required to deliver improved outcomes for service users and patients and to ensure financial sustainability, based around six characteristics identified by NHS England as being common to high performing systems. It will also set out levels of ambition for improvement against the NHS Outcomes Framework, focussing on six key indicators selected by NHS England.

The Plan on a Page is one of a set of national templates to be completed as part of the planning process. As well as summarising the vision and key workstreams that will be set out in the plan itself, it incorporates the success criteria, governance arrangements and system values which have been agreed by the ten statutory organisations that form part of the Berkshire West 10 integration programme.

The slidepack attached at **Appendix A** gives more detail on current strategic thinking.

Alignment of the plan with the Reading Health and Wellbeing Strategy is demonstrated below:

HEALTH & WELLBEING GOAL	HOW REFLECTED IN STRATEGIC PLAN
Goal 1 The health of communities is promoted and protected	• Objectives include a reduction in years of life lost from treatable conditions. • Quality section sets out how patient safety will be ensured.
Goal 2 Focus is increased on early years and the whole family	• Integration programme includes implementation of integrated pathways of care for children's services as well as frail elderly.

	• Work to improve health and reduce health inequalities will include specific initiatives for improving child health. • Plan focuses on better meeting needs of older and vulnerable people.
Goal 3 The impact of long term conditions is reduced	• Objectives include an ambition to improve quality of life for patients with long-term conditions. • Vision statement reflects need to support those with long-term conditions to make decisions about their care. • Building role of primary care will include enhancing support for those with long-term conditions. • Improvement interventions described in main section of plan include implementing telehealth and joint monitoring for patients with long-term conditions.
Goal 4 Health-enabling behaviours and lifestyle are promoted	• Plan will include section on reducing health inequalities and promoting good health. This is reflected in vision statement which states that services will work together to prevent ill-health.

6. SOUTH READING CCG 2 YEAR OPERATIONAL PLAN 2014-2016

There are 9 main Objectives of South Reading CCG Plan on a Page which have been identified using a number of information sources. Various sources of Outcomes data are available to the CCG to help inform our planning priorities for 14/15 and beyond.

These include:

- The South Reading CCG Outcome Atlas, which compares performance against the Outcomes Framework against England averages
- Levels of Ambition Atlas
- Operational Planning Atlas
- South Region Commissioning for value pack for South Reading CCG

In addition we have reviewed our Joint Strategic Needs Assessment (JSNA) which was refreshed in 2013/14. The JSNA helps inform our local commissioning and decision making by providing us with valuable information to allow us to commissioning quality health services now and in the future. Through a series of workshops with our GP members, practices visits, public meetings (Call to Action) and consultation we have been able to develop specific areas of focus that underpin and support the Reading Health and Wellbeing strategy and vision.

6.1 Alignment of the South Reading Objectives with the Reading Health & Wellbeing Strategy is demonstrated below

HEALTH & WELLBEING GOAL ALIGNMENT	OBJECTIVE
Goal 1 The health of communities is promoted and protected	• To reduce the incidence of healthcare related infection from C. Difficile and MRSA • We will continue to promote health screening for cardiovascular disease and cancer.
Goal 2 Focus is increased on early years and the whole family	• To continue the joint work underway within the children's subgroup , particular to resolve issues with under 5 year old unnecessarily attending A & E.
Goal 3 The impact of long term conditions is reduced	• To improve health related quality of life for people with Diabetes • To improve the quality of life for people with Mental health conditions (psychosis and depression) • To reduce unplanned admissions due to amenable health conditions for COPD • To increase access to Reablement following discharge improving independent living and maximising quality of life • Introduce a Hospital at Home service to provide care to patients who would have usually been admitted, allowing them to safely remain at home. All care home residents will have a dedicated GP and supportive care plan to prevent u unplanned hospital care ,within 6 weeks of admission
Goal 4 Health-enabling behaviours and lifestyle are promoted	• To reduce the impact of Obesity in under 11year olds over the next 3-5 years and improve the level of inactivity in the population as a whole. • To reduce unplanned admissions related to alcoholic liver disease. • Build upon current levels of public engagement to help shape and influence our local commissioning decisions so that services reflect the needs of local people

7. NORTH & WEST READING CCG 2 YEAR OPERATIONAL PLAN 2014-2016

There are 9 main Objectives of North & West Reading CCG Plan on a Page which have been identified using a number of information sources. Various sources of Outcomes data are available to the CCG to help inform our planning priorities for 14/15 and beyond.

These include:

- The North & West Reading CCG Outcome Atlas, which compares performance against the Outcomes Framework against England averages
- Levels of Ambition Atlas
- Operational Planning Atlas
- South Region Commissioning for value pack for North & West Reading CCG

In addition we have reviewed our Joint Strategic Needs Assessment (JSNA) which was refreshed in 2013/14. The JSNA helps inform our local commissioning and decision making by providing us with valuable information to allow us to commissioning quality health services now and in the future.

7.1 Alignment of the North & West Reading Objectives with the Reading Health & Wellbeing Strategy is demonstrated below :

HEALTH & WELLBEING GOAL ALIGNMENT	OBJECTIVE
Goal 1 The health of communities is promoted and protected	• To promote increased screening of COPD to improve the rate of reported prevalence as a percentage of the estimated prevalence from 41% to the England average of 58% • To reduce the higher than average intervention rates for musculoskeletal conditions ensuring that surgical proceedings are only undertaken at the most appropriate time and where it is clear that the benefits outweigh the risks • To reduce the incidence of healthcare related infection from C. Difficile and MRSA • Continue to promote opportunities for health screening and immunisations. •
Goal 2 Focus is increased on early years and the whole family	• To continue the joint work underway within the children's subgroup.
Goal 3 The impact of long term conditions is reduced	• Increase percentage of people with diabetes receiving the nine key care processes to 60%

	• To reduce unplanned hospitalisation of frail and elderly patients by implementing the hospital at home scheme, enhanced GP service to care homes and community nurse for the elderly. • To improve the mental health of the population and reduce prevalence of adult depression from 15% to England average of 12%
Goal 4 Health-enabling behaviours and lifestyle are promoted	• To reduce physical inactivity as a percentage of the population from 42% to 40% and reduce childhood obesity in year 6 children from 35% to the England average of 33% • Improve the choice of where to die for patients near the end of life. 70% of people in Reading want to die at home. Only 19.9% do. We aim to get to 23% • Effective participation of the public in the commissioning process so that services reflect the needs of local people

8. NEXT STEPS

8.1 Following feedback from NHS England regarding our submission of early plans on 24th January, we will revise the plans accordingly and present updated full 2 year Operational plans for each CCG and a 5 year strategic plan to the Reading Health & Wellbeing Board in March 2014.

8.2 The final 2 year plans will be approved fixed and approved by NHS England by 4th April 2014 and the 5 Year Strategic Plan by 20th June 2014.

9. COMMUNITY ENGAGEMENT AND INFORMATION

9.1 Both the 2 year and 5 Year Strategic Plans will be shared with key stakeholders including Providers, HWBB , Local Authority, Healthwatch, Patients and carers and with NHS England between January and end of March 2014. This will help inform any alterations that need to be made to plans before final submission. A "Call To Action" event was held jointly between the two CCGs in November 2013 where early plans , strategy and objectives were shared with the public and their views sought and used to influence future development of the plans seen here in their latest version.

10. BACKGROUND PAPERS

10.1 NHS England "Everyone Counts: Planning For Patients 2014/15 to 2018/19"

10.2 Reading's Health and Wellbeing Strategy 2013-16

10.3 NHS Outcomes framework 2014-15

BERKSHIRE WEST STRATEGIC PLAN ON A PAGE 2014-2019

1

By 2019, enhanced primary, community and social care services in Berkshire West will work together to prevent ill-health and support patients with much more complex needs at home and in the community. Service users will be supported to take more responsibility for their health and wellbeing and to make decisions about their own care. Patients will only be admitted into acute hospitals when they require services that cannot be delivered elsewhere and will be treated in centres with the right facilities and expertise. All the services that respond to people with an urgent need for care will operate together as a single system. This will ensure that the service people receive is commensurate with their clinical need. People with urgent but not life-threatening conditions will receive responsive and effective care outside hospital. People with serious and life-threatening conditions will be treated in centres that maximise their chances of survival and a good recovery.

2

System Objective One
A 3.2% reduction in years of life lost from treatable conditions

System Objective Two
An increase in the proportion of people who feel supported to manage their long-term condition from 78.5% to 81%.

System Objective Three
To reduce unplanned admissions to hospital by Figure TBC

System Objective Four
A 3.6% reduction in people rating their experience of hospital care as poor. Similar measure tbc for primary care.

System Objective Five
Increase in number of older people supported to live at home following discharge

System Objective Six
To work to eliminate avoidable deaths in hospital

3

Engagement - New and varied approaches to talking to patients and service users, supporting them to understand their needs and working jointly with them to manage their condition

Primary care at the heart of an integrated system - GPs working together in larger units to offer improved accessibility and co-ordinate other services around the needs of the patient.

Integration - Implementation of joined up pathways of care for the frail elderly, mental health and children's services and development of further integrated pathways of care

Urgent care - Data-driven transformation of urgent care into a network of services to ensure all patients receive a timely response in the most appropriate setting.

Productive elective care - Reducing level s of musculo-skeletal activity and using contracting mechanisms to commission most efficient care. Proactive market management through joint work with key providers.

Concentrating specialist care – securing best outcomes for patients and working with providers to understand impact on local health system.

4

Overseen by the following governance arrangements

- Shared governance structure incorporating Health and Wellbeing Board oversight
- Senior leadership through the Berkshire West Partnership Board with support from the Chief Officers' group
- Delivery assured through shared programme with jointly-appointed Programme Director

5

Measured using the following success criteria

- Set of specified patient outcomes – co-production of care plans, single point of contact, supporting patients to make decisions and offering personal budgets
- Underpinned by set of programme performance metrics

6

System values and principles

- Develop a compelling vision for integrated care and monitor progress against this
- Align individual organisational plans across the whole system
- Identify and overcome the obstacles to integration

SOUTH READING CCG PLAN ON A PAGE

South Reading health economy is a system comprised of partners from Reading Health & Well-Being Board, Royal Berkshire Hospital, Berkshire Healthcare Trust and South Central Ambulance Service.
The CCG vision is "Working innovatively with patients and partners to improve the health of our local community"

Securing additional years of life for people of England with treatable mental health and physical conditions

Improving the Health related quality of life of the 15+million people with one or more long-term condition, including mental health

Increasing the proportion of older people living independently at home following discharge from hospital

Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community outside of hospital

Increasing the number of people with mental and physical health conditions having a positive experience of care outside of hospital , in general practice and in the community

Increasing the number of people having a positive experience of hospital care

Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems of care

To reduce unplanned admissions due to amenable health conditions for COPD

To reduce unplanned admissions related to alcoholic liver disease.

To reduce the impact of Obesity in under 11year olds over the next 3-5 years and improve the level of inactivity in the population as a whole.

To improve health related quality of life for people with Diabetes

To increase quality of life for people with severe and enduring Mental illness

To increase access to reablement following discharge improving independent living and maximising quality of life

To reduce "emergency admissions for acute conditions that should not normally require hospital admissions

Build upon current levels of public engagement to help shape and influence our local commissioning decisions so that services reflect the needs of local people

To reduce the incidence of healthcare related infection from C. Difficile and MRSA

Delivered through collaborative working between GPs and the community respiratory team. . We aim to **improve diagnosis using spirometry** and ensure **rapid access to appropriate medication** within the community

Delivered through developing methods of **increasing referrals to Drug and alcohol services.** Work in collaboration with public health and the voluntary sector to, led by a local GP **to improve the alcoholic liver disease pathway** across community and secondary

Delivered through launch of Live Active programme to increase physical activity through self-motivation and changing of lifestyle behaviours

Delivered through **intervention in primary care.** Promoting the Diabetic 9 care processes and self-care using care planning and technology such as **Eclipse**

Delivered through **increased access to IAPT in secondary care** and introduction **of recovery measures within the patient pathway**

Delivered through poling of budget through the better care fund and improved integrated working across health and social care, offering reablemetn assessment to all prior to discharge.

Introduce a **Hospital at Home service** to provide **c**are to patients who would have usually been admitted, allowing them to safely remain at home. All **care home residents will have a** dedicated GP and supportive care plan to prevent u unplanned hospital care ,within 6 weeks of admission

Delivered through **a range of engagement events, increased PPG inv**olvement, monitoring of Friends and family test results and responding to audits and patient views expressed through HealthWatch and PALS

Delivered through regular monitoring of Antibiotic prescribing in general practice. We will aim to learn from route cause analysis working in partnership with our infection control nurse. We will monitor progress monthly through our Quality dashboard.

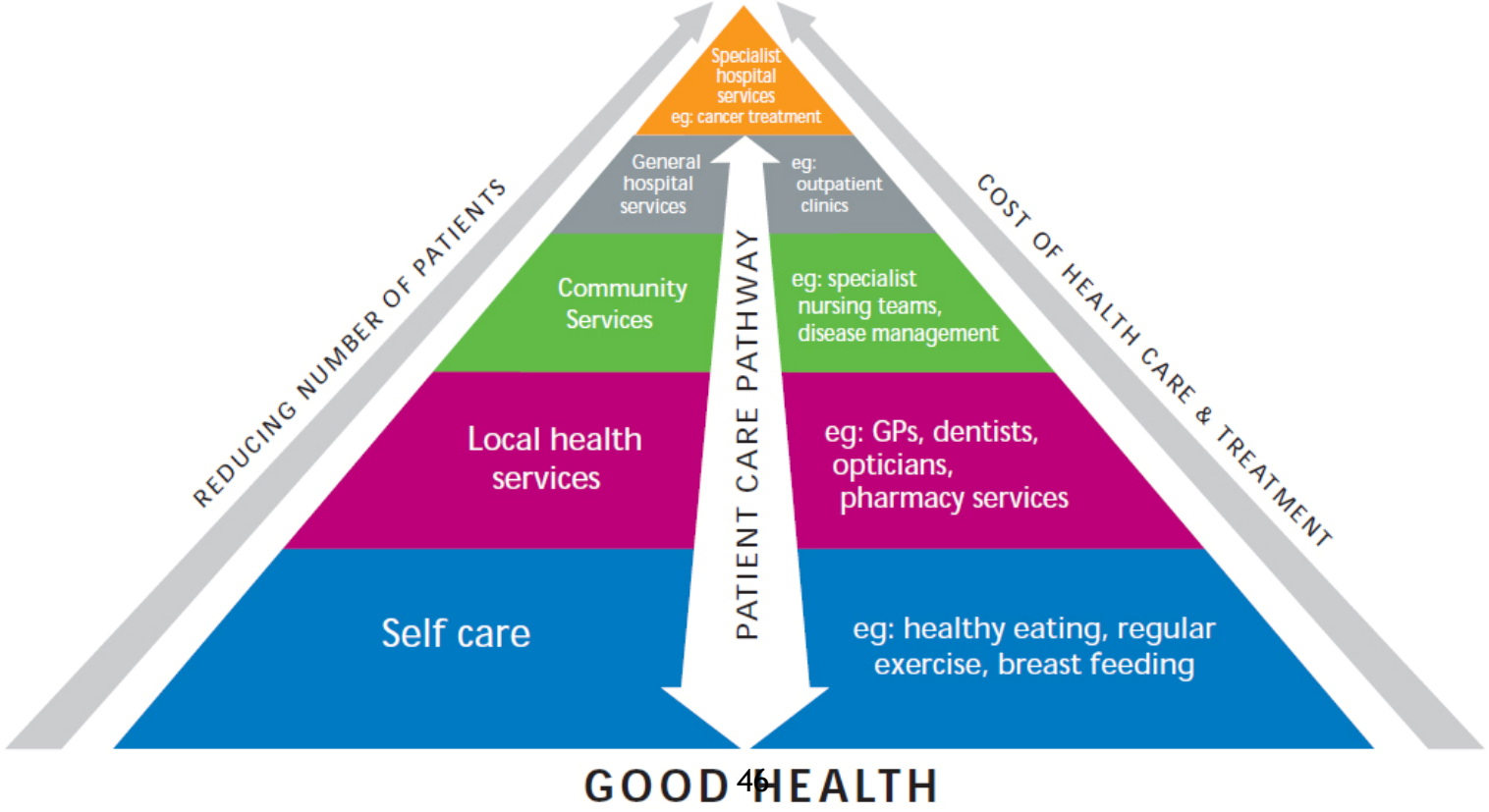
North & West Reading Operational Plan on a Page - 2014/16

Berkshire West 5 Year Strategy

- Improve patient outcomes and experience
- Close the £44m QIPP gap

"Keeping people well and out of hospital, in partnership"

The triangle of care



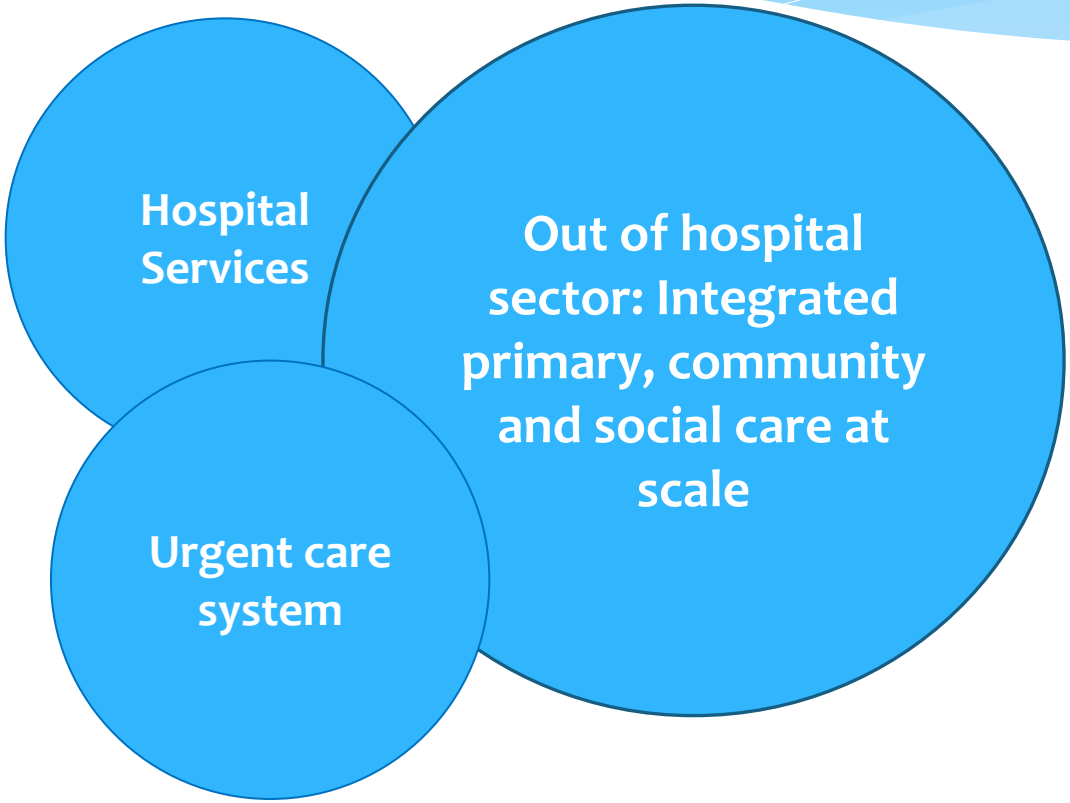
6 characteristics of high quality sustainable systems

* Citizen Participation and Empowerment
* Wider Primary Care provided at Scale
* Integrated Care
* Access to high quality Urgent and Emergency Care
* A step change in the productivity of elective care
* Specialised Services concentrated in centres of excellence

The change required

* Capability of primary, community and social care is increased to provide “wrap around” co-ordinated care
* Hospitals deliver more of their services directly in the community – physicians working beyond the hospital walls with primary and social care e.g. diabetes
* Providers work together to deliver a continuum of care to patients who are also supported to manage their own conditions
* Better focus on the health and well being of people, rather than simply dealing with sick patients arriving at hospital

The whole System



Urgent

•Accessible and Responsive Service for people with Urgent Care Needs
•Services that support people with non life threatening conditions to remain at home
•Operating as part of the wide care systems

Out of hospital sector

Primary, Community Social and Voluntary Care

- *New models of working*
- *New workforce*
- *Well integrated*
- *Better Care Fund*

Planned

•Supporting the population to keep healthy
•Pro active identification of people at risk and prompt intervention
•Supporting patients to manage their own condition
•Robust and systematic management of LTC and Frail Elderly

Urgent Care

Vision:

* People with urgent but non life threatening needs must get a highly responsive, effective and personalised service **outside of hospital**
* People with serious or life threatening emergencies should be treated in centres with the best expertise and facilities to maximise the chances of survival and a good recovery

New models of hospital care

* Patients only admitted to hospital if their clinical needs require it – more services out of hospital e.g. HAH
* Patients empowered through effective communication, shared decision making and self management
* Specialist medical care is not confined to the hospital walls e.g. diabetes
* Focus should be on recovery and enabling patients to leave hospital as soon as possible – 7 day discharges
* 7 day care – including diagnostics, support services and Consultant presence on wards over 7 days
* Specialities wrap around the patient e.g. geriatricians work with surgeons and palliative care consultants work with oncologists