Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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

1) PLAN DETAILS

a) Summary of Plan

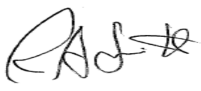
Local Authority	**Reading Borough Council**
Clinical Commissioning Groups	**South Reading Clinical Commissioning Group**
	North & West Reading Clinical Commissioning Group
Boundary Differences	The South Reading CCG is made up of 20 practices within the Reading Borough Council boundary. The North and West Reading CCG includes seven practices within the Reading Borough Council boundary and three in a neighbouring authority (West Berkshire). (It should be noted that any data related to the registered population for North & West Reading CCG is assumed at 50%, with the remaining 50% attributed to the West Berkshire BCF Submission). 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. Details of said schemes, and their cross

	authority impact and management, can be found within the main body of the submission.
Date agreed at Health and Well-Being Board:	**21.03.14**
Date submitted:	**29.08.14**
Minimum required value of BCF pooled budget: 2014/15	**£0.00**
2015/16	**£9,825k**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£10,196k**

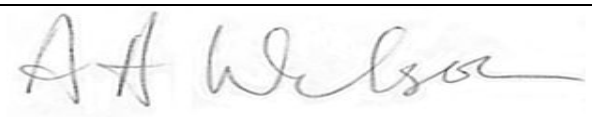
b) Authorisation and signoff

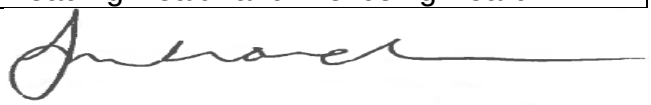
Reading's initial Better Care Fund submission was approved by the Reading Health & Wellbeing Board on 14.02.2014. Updated submissions were approved by the Health and Wellbeing Board on 04.04.2014 and 09.07.14. This latest revision has been informed by a meeting of Health and Wellbeing board members plus invited stakeholders on 27.08.2014. Minutes from this meeting can be found in section 1c) related documents. Formal approval will be sought retrospectively at the Health and Wellbeing Board's next scheduled meeting on 10.10.2014.

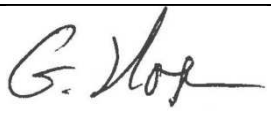
Signed on behalf of the Clinical Commissioning Group	South Reading Clinical Commissioning Group
By	 Dr Elizabeth Johnston
Position	Chair of NHS South Reading CCG
Date	14.02.2014 – revised 04.04.2014 and 09.07.2014, plus attended HWBB stakeholder event on 27.08.14

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 – revised 04.04.2014 and 09.07.2014, plus attended HWBB stakeholder event on 27.08.14

Signed on behalf of the Council	Reading Borough Council

By	 Avril Wilson
Position	Director of Education, Adults & Children's Services
Date	14.02.2014 – revised 04.04.2014 and 09.07.2014 , plus attended HWBB stakeholder event on 27.08.14

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, Reading Borough Council
Date	04.04.2014 (Chair to 10.6.14)

Signed on behalf of the Health and Wellbeing Board	 Councillor Graeme Hoskin, Leader, Reading Borough Council
Date	09.07.2014 , plus attended HWBB stakeholder event on 27.08.14

c) Related documentation

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

Please note the table has been organised alphabetically.

Document or information title	**Synopsis and links**
Berkshire West CCGs 5 year Strategic Plan	This is the five year Strategic plan for the four Berkshire West CCGs (unit of planning) for 2014-2019. Document attached.
Better Care Fund project plan	This GANTT chart provides detail of all the Better Care Fund projects delivery plans. Document attached.
Care Act and Integrated Governance structure	The governance structure illustrates the different boards and working group in which the integration agenda including the BCF is accountable, including hierarchy. Due to the synergies with the Care Act, the document also covers this. Document attached.
Communication and	This document provides the principles that we will use for Communication and Engagement. Due to the cross over

engagement plan	between the integration and the Care Act implementation this document relates to both. Document attached.
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
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/
North and West Reading CCG 2 year operational plan	Local plan detailing proposals for local healthcare services to meet the needs of our local population, and to drive improvement in health services for 2014-2016. Document attached.
Prevention Framework	A commissioning strategy for preventative and support services: www.reading.gov.uk/meetings/details/3344/ (appendix 12)
Health & Wellbeing Strategy	Integrated Health and Wellbeing strategy for Reading: www.reading.gov.uk/residents/public-health/public-health-health-being-strategy/
Hospital at Home Memorandum of Understanding	This document provides formal partnership arrangements in advance of the final patient pathway being incorporated into contracts between the CCG and provider partners. It sets out expectations for each partner. The principles of which will form the basis for other projects. Document attached.
Joint Strategic Needs Assessment	Used to inform the commissioning of services by Reading Borough Council and Reading CCGs: jsna.reading.gov.uk
Minutes of Health and Wellbeing stakeholder workshop 27.8.14	Minutes of the Health and Wellbeing stakeholder workshop to discuss the latest iteration of the Better Care Fund submission, held on 27.08.14. Document attached.
Pioneer Bid	The submission by the 'Berkshire 10' to receive support to integrate health and social care across Berkshire West. http://www.newburyanddistrictccg.nhs.uk/images/publications/BoardPapers/11-July-2013/Item_13.pdf
Risk Sharing Agreement	This document is a collaborative agreement developed to provide an appropriate vehicle for sharing risks between the associated partners. Document attached.
Reading	This describes the key priorities for the Local Authority for the

Borough Council Corporate Plan 2014-2017	next three years 2014–2017. http://www.reading.gov.uk/council/strategies-plans-and-policies/corporate-plan-2009-2012/
South Reading CCG 2 year operational plan	Local plan detailing proposals for local healthcare services to meet the needs of our local population, and to drive improvement in health services for 2014-2016. Document attached

2) VISION FOR HEALTH AND CARE SERVICES

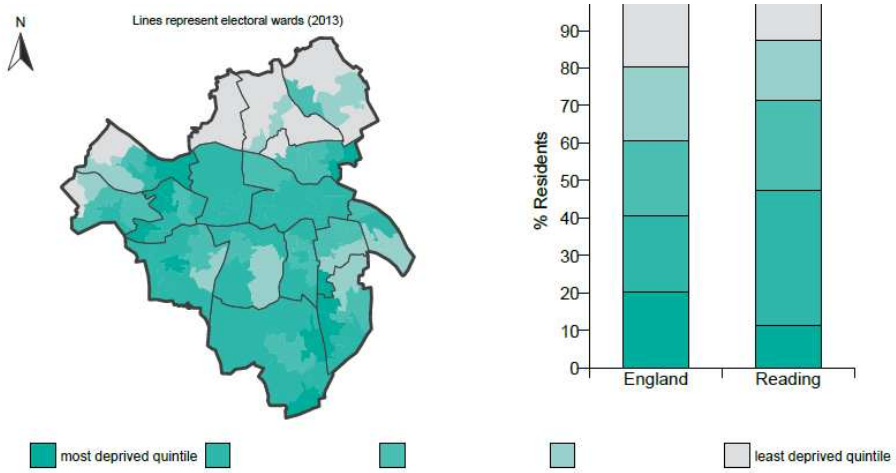
a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Our Vision - A Healthier Reading

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

Introduction to Reading

Reading has a population of circa 187,000 people. The overall health of the people in Reading is varied compared to the national average, as it is characterised by extremes of wealth and poverty in a small geographical area. Patterns of inequality are complex with poor outcomes for communities in some of our most deprived neighbourhoods.



The JSNA reveals that the population structure of Reading is generally younger compared to the average for England. There are a smaller proportion of older adults living in the area, although this is less marked for over 75s. The population of Reading is projected to increase by 9% between 2011 and 2026. Although Reading expects to see a relatively small increase of older adults in comparison to the average in England, the biggest increase will be seen in the very elderly who are at most risk of developing long term conditions.

Currently 30% of people in Reading are living with a long term condition such as diabetes, COPD and dementia. There are a growing number of people with both physical and mental health needs – national forecast trends show that by 2035 46% of men and 40% of women are likely to be obese, resulting in additional cases of diabetes, stroke and heart disease.

It is recognised by all partners that the financial challenge facing the local health and social care system is significant. The council continues to see significant decrease in the annual budget, and demand for services is predicted to continue to rise with a growing older population. It is clear that without wide scale transformation there will not be enough money to fund health and social care services locally to meet this predicted

additional demand.

There are seven key areas which collectively provide sufficient evidence of growing demand pressures in the economy in Reading:

- An increasing population, particularly in those over the age of 65
- Increase in non-elective care
- Increasing A&E attendances, and pressure on urgent and emergency capacity
- Rising delayed transfers of care, and subsequent bed days lost
- Increasing pressures on adult social care for community packages and care homes
- Increasing demand for planned care services
- Inequality of access to services across the "whole system: the whole week"

In addition to the challenges facing the health economy, our vision for the future of care in Reading has been informed by patients, service users and members of the public, who have shared with us their experiences of local health and social care, and their aspirations for the future. The evidence is exceptionally strong, and feedback from the public is unequivocal for the need for us to work better together across health and social care. In addition, Reading residents have given a strong message that maintaining independence and having choice and control over how they receive care is very important.

We have collected this feedback in a number of forums – including a joint Patient Led Dementia Conference held in May 2013, and a Call to Action event in April 2014, and a public presentation during Carer's Week the feedback was clear:

"Better communication between organisations. Preparedness to work together other than jealously guarding their independence when others could help more effectively".

"It is too disjointed as each organisation does its own thing and the patients/clients/service users fall through the gaps. Each organisation needs to know what all the others are doing so they don't" all reinvent the wheel".

This feedback has given us a firm mandate to develop integrated services with the individual at the centre.

Local Healthwatch Reading, who form an integral part of our Health and Wellbeing Board and Integration Board, has recently carried out research into the patient experience of hospital discharge and case co-ordination. These findings have clarified the issues to be addressed from a patient/service user, carer and family perspective.

Our Five Year Vision

In line with our Joint Health and Wellbeing strategy, our vision is for:

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

By 2019 our vision is for Reading residents to be empowered and supported to live well for longer at home. In order for this to happen, it will require health and social care professionals to work alongside one another, and with family carers as expert partners in care to:

1. **Provide the right care by the right people at the right time and in the right place:**
   - To meet patients' needs and empower people to manage their health at home wherever possible.
   - Services that respond to patients with an urgent need for care will operate together as a single system, ensuring that people with urgent but not life-threatening conditions will receive responsive and effective care outside hospital.
   - To develop enhanced primary, community social care services and voluntary and community services which prevent ill-health within our local population and support patients with more complex needs to receive the care they need in their community.

2. **Deliver easily accessible care seamlessly, across health and social care**
   - Care providers will work together, breaking down organisational barriers to deliver patient centric care to deliver the best outcomes.
   - Care providers will share information, and use this to co-ordinate care and support in a way that is person centred using health and social care personalised budgets, reducing duplication and hand-offs between agencies.

3. **Provide a positive patient/service user journey and experience of care that is consistent and efficient, through the whole system throughout the whole week.**
   - Patients will have access to the services that they require every day of the week to ensure the best outcomes.

4. **Make the experience of care a more positive one**
   - Improve communication between the individual, their family and health and social care professionals to improve the experience of the care that is given.
   - Service users will be supported to take more responsibility for their health and wellbeing and to make decisions about their own care.

5. **Promote health and wellbeing to improve health outcomes**
   - We will actively promote health and well-being through the effective development of universal services drawing on community and neighbourhood based resources to help service users with lower support need.
   - As part of this we will 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.

Our vision for the future is one which puts the patient at the centre of care, focussing on keeping people well and empowering more people to be cared for as close to home as possible. By 2019, health and social care will have further converged and will be organised locally so that local areas can work optimally together in designing integrated pathways which deliver the best outcomes and experiences for patients and offer the best value for the tax payer. As a system, we will jointly commission services where appropriate and where there is strong evidence from users and carers on the quality and sustainability of the service.

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

We need to provide the right care by the right people at the right time and in the right place and keep the individual at the centre of a co-ordinated health and care system.

Through the Integration of health and social care, our Better Care Fund schemes and programme aims to deliver the following patient outcomes:

- Ensure that Reading Residents feel empowered and supported to live well for longer in their own home
- Improve Communication between the individual , their family, carers and health and social care professionals
- Provide a positive patient/service user journey and experience of care which is consistent and efficient, through the whole system throughout the whole week.
- Provide easily accessible care, seamlessly across health and social care
- Reduce avoidable unplanned admissions to hospital

In practice, what this this means for patients and service users:

Ensure that Reading Residents feel empowered and supported to live well for longer in their own home

- **I am cared for in my own home instead of going into hospital or into a care home.** The Hospital@Home service (Scheme 1) will be developed to support patients that require initial intensive 24-hour support and treatment but can then continue to be managed at home by being discharged after a few days into traditional community care provision.
- **I am able to live as independently as possible in my own home for longer.** I was able to return home with a support package instead of being admitted to a Care Home. (Scheme 4 :Time to decide- Discharge to Assess)
- **While at home, my quality of life is much improved –** People who use care services will experience better quality care which addresses their needs holistically. They will be supported to live the fullest lives they can and, as far as possible, to plan for when they may need additional care. (Scheme 1 , H@H ; Scheme 4 Discharge to Assess and Scheme 5 Whole System Whole Week)

Improve Communication between the individual, their family, carers and health and social care professionals

- **I feel better informed.** I have been given the opportunity to make a better informed decision about my future care options (Scheme 4: Discharge to Assess)
- **My medical, medication and social care records are available to those who need them** - The Berkshire West Connecting Care (Scheme 3) system will ensure that information held in health and social care systems can be made available to all who need to access them as a real time data view. This will improve clinical safety and efficiency. One benefit of this will be to speed up the transfer of patients/service users into the right part of the care system.

Provide a positive patient/service user journey and experience, consistently and efficiently through the whole system throughout the whole week.

- **I do not have to stay in hospital longer than needed.** Scheme 4 Discharge to assess is designed to address a specific problem of delays in discharge from hospital whilst individuals wait for a residential home bed to be available. Once individuals are assessed as being fit for discharge to a residential care home, they will be given the opportunity to have an assessment in a more appropriate environment, giving them the opportunity to reassess their options with the full support from health and social care professional. Scheme 5 Whole system whole week will also allow individuals to be discharged in a more timely manner with appropriate support from the whole system across the whole week. Avoiding delays in discharge will help avoid hospital acquired infections and individuals losing their independence.

- **I was dealt with by one team throughout my care** - Referrals will be managed at one point of entry (Scheme 5 Whole System Whole Week) whereby the responsibility and accountability for finding, accessing and transfer of patients sits within one integrated team with the patient/service user and their carer(s) actively involved in designing their own care plan. It will prevent those circumstances when a patient 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.

Provide easily accessible care, seamlessly across health and social care

- **I have been given my independence back** – Health and social care support will be organised around a re-abling approach to maximise the skills each individual can retain or regain. The integrated re-ablement service for people coming out of hospital will be offered to a wider group of patients than before. (Scheme 5 – Hospital at Home, Scheme 5 – neighbourhood cluster teams).

- **I have the support of a wider range of professionals** – Regular contact and patient visits will be made by GPs with care home staff and community

geriatricians to monitor the health status of care home residents, reducing the need for emergency call outs and thereby non-elective admissions to hospital. (Scheme 2: Support to Care Homes).

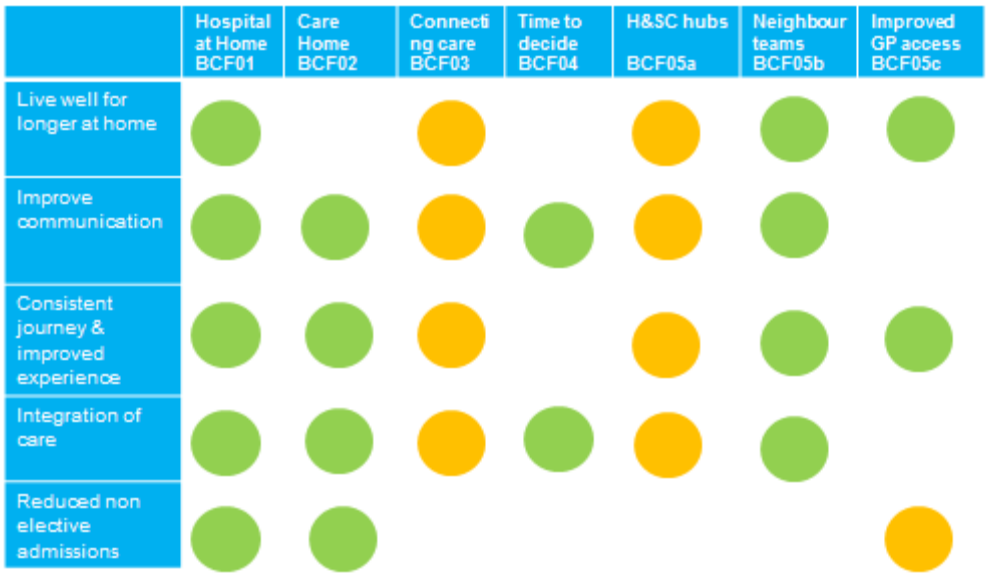
- **I have consistent access to services across the whole week –** Scheme 5 aims to aims to deliver improved access to general practice, community and social care services in Reading that is sustainable in the longer-term. We developing neighbourhood clusters that are focused around a group of GP practices, supported by complementary clustering of social care teams, and services commissioned from the third sector.

Reduce avoidable unplanned admissions to hospital

- **I have my own individual care plan** – People who use health and social care services will have a plan setting out the support they need, tailored to their personal situation. Each care home resident will have a named GP as their principal point of contact along with a comprehensive assessment and Supportive Care Plan . By planning care in advance unplanned admission should be avoided or minimised. (Scheme 2 Support to Care Homes).

- **The care home staff are much better trained -** A new level of support into care and nursing homes throughout the Borough will develop staff awareness and knowledge, particularly in relation to medicine management, falls prevention and end of life care. Social care focused training will benefit from additional input from health professionals. This will improve consistency in the quality of care given and the outcomes for residents, including a reduction in unplanned admisisons for Care Home residents. (Scheme 2 Support to Care Homes)

As can be seen in the table below each of our BCF schemes will contribute to a number of different patient/ service user outcomes .



Through our engagement plans, Reading HealthWatch as well as patient experience feedback, we will keep improving health and social care systems with the people who use them. We will involve them in the design, delivery and evaluation of our services.

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

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

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

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

In response to the high cost of care for older adults, and the growing numbers of older adults in Reading, the frail elderly pathway has been developed to improve the care of older people with long-term conditions and those who are at highest risk of deteriorating health and are likely to need intensive social care support. As part of this, care will be delivered by care workers, supported by identified care co-ordinators and multidisciplinary teams structured around groups of local GP practices. In bringing key elements of the frail elderly (older people's) programme on line through our local projects we will be able to assess its impact and use this as a template to inform planning for other pathways for the outer years of this five year period.

The Better Care Fund schemes will be crucial to establishment of integrated pathways, with the development of multidisciplinary neighbourhood cluster teams (BCF05b) that put the patient/service user at the centre of care, increasing efficiency and reducing hand offs. In addition, the Connecting Care scheme (BCF03) that allows different organisations to all have access to the same patient record, and the health and social care hub (BCF05a) that will be an integrated entry point for professionals, and eventually patients as well, will be critical enablers of integrated pathways.

Expanding the Role of Services in the Community

In order to keep the patient closer to home, the number of services delivered in the community will increase. This will include services to both prevent admission in the first place and facilitate discharge as quickly as possible to ensure that care can be delivered

closer to home. In addition to healthcare provision, we will also develop more supported housing. Strategic partnerships will be established with providers to support timely hospital discharge through direct provision for people with complex needs. We are committed to increasing the supply of extra care housing to 240 units across the town.

The Better Care Fund schemes will allow more care to be delivered closer to home. The Hospital at Home scheme (BCF01) will ensure that when hospital admission is unavoidable, the stay will be of high quality with discharge immediately when acute care is no longer required. The Time to Decide scheme (BCF04), we will create ten step down beds for patients who require a residential placement, to get them out of hospital as soon as possible and promote independence.

We will also provide more proactive support to care and nursing homes, with the provision of training to care home staff, and also an enhanced GP community service (BCF02), with each care home being designated a named GP who is their principal point of contact, providing consistent care to reduce unplanned admissions and improve end of life care.

Modernising and Expanding the Model of Primary Care

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

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

A number of Better Care Fund schemes will support the enhanced role for primary care. The Neighbourhood cluster teams (BCF05b) will bring general practice, community services and social care together to streamline the approach to case managing care for patients and respond to patient/service user need providing early interventions and facilitating discharge. In addition, the improved access to GP scheme (BCF05c), that will provide 7 day care in primary care, will ensure that GPs are available 7 days a week to provide better access to primary care and as a result improve patient outcomes.

Access to Care 7 days a Week

We recognise that people need health and social care services every day. As a result we are looking to adopt a whole system, whole week approach to ensure that a full range of health and social care services is available seven days a week. Evidence shows that the limited availability of some services at weekends can have a detrimental impact on

outcomes for patients, including raising the risk of mortality. In addition, the lack of services at the weekend affects admission rates and delaying discharge.

We recognise that primary care is a key component of a multi-tiered urgent care system which then ensures that patients have timely access to the right service provided in the most appropriate setting. Patients have also told us that they would welcome access to routine care in the evenings and at weekends. As such we are looking to expand the availability of primary care beyond current core hours through our 7 day working project, mirroring the overall shift towards seven-day services across the NHS and Social care.

The Better Care Fund 7 day working schemes will boost the development of 7 day services, increasing access to GPs, providing a single point of access to health and social care, and ensuring that the community neighbourhood cluster teams are available seven days a week, to respond to patient/service user need as and when it arises.

Promoting Self-Care

We will promote self-care and support people to take more responsibility for their health and wellbeing and make decisions about their own 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.

Changing the Way We Commission Care

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 value based contracts focused on the achievement of improved outcomes for service users, capacity model funding and increasing the flexibility and blurring between health and social care.

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 e.g. voluntary sector bodies and private providers.

As described above, the Better Care Fund schemes are critical to some of the key changes that will be delivered to the pattern of services over the next five years. The table below summarises how the Better Care Fund schemes will contribute to the changes that will take place in Reading over the next five years:

Vision for health & social care in Reading	BCF scheme supporting
Increased patient centred, integrated pathways	- Neighbourhood cluster teams (BCF05b) - Enablers: Connecting Care (BCF03); Health and social care hubs (BCF05a)
Expanding the role of services in the community	- Hospital at Home (BCF01) - Time to Decide (BCF04) - Neighbourhood cluster teams (BCF05b) - Care Home support (BCF02)
Modernising and expanding the model of primary care	- Increased access to GP services (BCF05c) - Care Home support (BCF02) - Neighbourhood cluster teams (BCF05)
7 day access to care	- Health & social care hub (BCF05a) - Neighbourhood cluster teams (BCF05) - Increased access to GP services (BCF05c)

Without the Better Care Fund the Time to decide beds, Neighbourhood cluster teams and Hospital at home schemes would not be in place. In addition the other projects would be progressing at a much slower rate.

3) CASE FOR CHANGE

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

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

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

There are 7 key areas, which collectively, provide sufficient evidence of growing demand pressures in Reading's Health and social care economy.

These areas are:

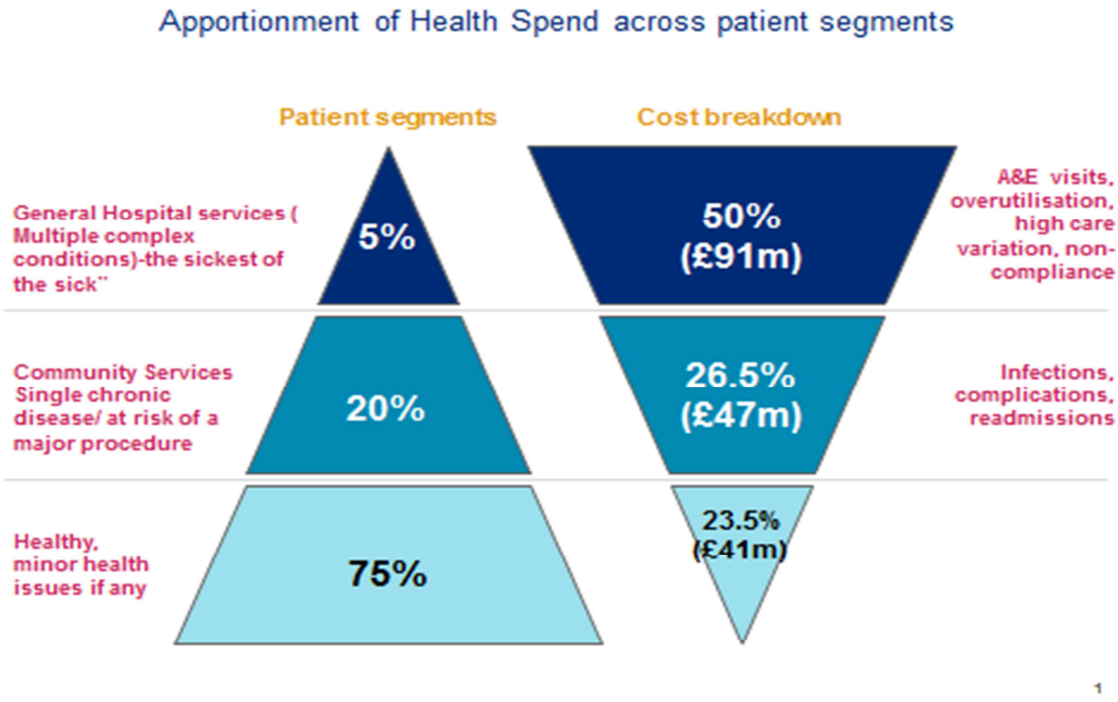
- An increasing population, particularly in those over the age of 65
- Increasing growth in non-elective care
- Increasing A& E attendances, and pressure on urgent and emergency capacity
- Rising delayed transfers of care, and subsequent bed days lost
- Increasing pressures on adult social care for community packages and care homes at a time when the overall Council budget is shrinking by £40m
- Increasing demand for planned (elective) care
- Inequality of access to services across the "whole system :the whole week"

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

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

We have a strong foundation in our shared vision and our track record, but we know that we need to adopt a revolutionary rather than an evolutionary approach if we are going to succeed in tackling the system pressures and demographic challenges described above.

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



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

Risk Stratification Methodology:

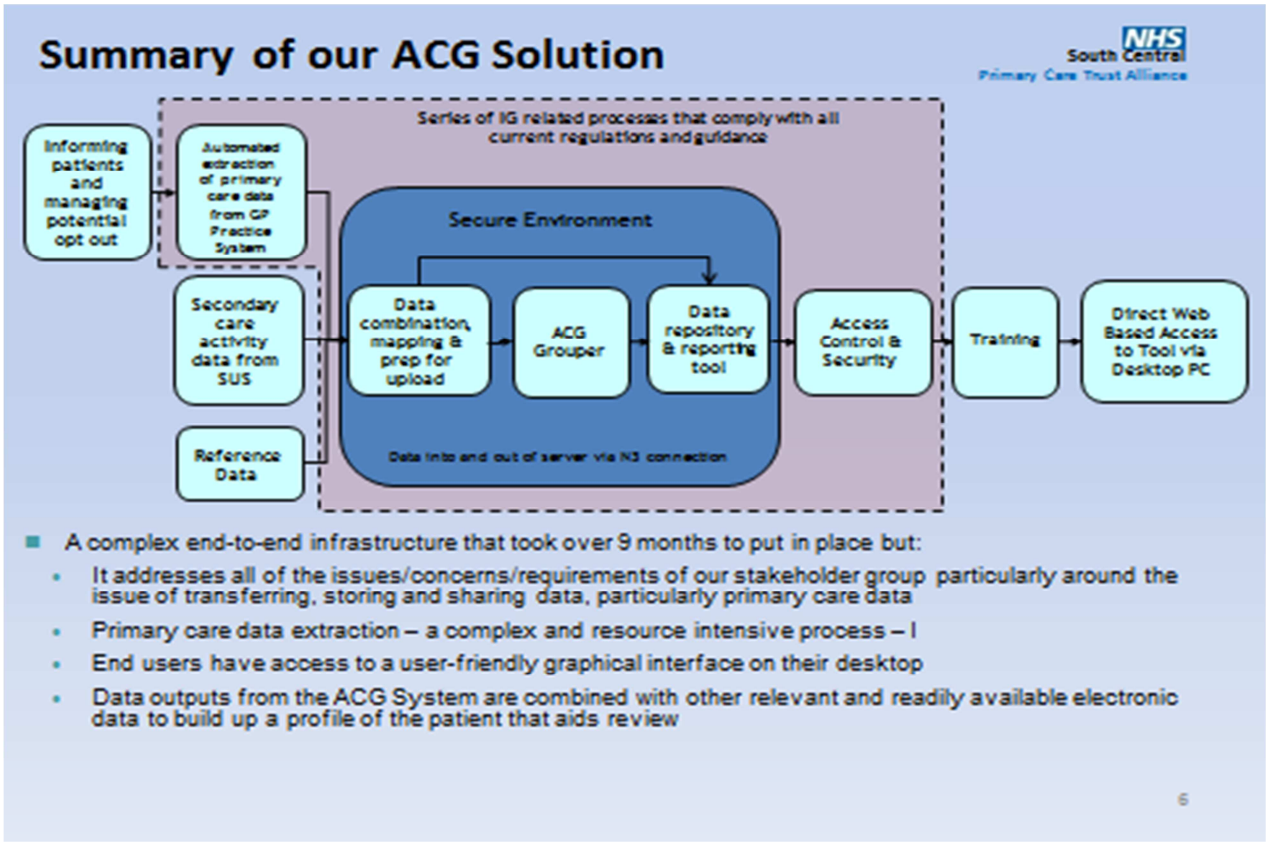
Dividing the population into groups of people with similar needs is an important first step to achieving better outcomes through integrated care. A one size fits all approach is inadequate and different sets of people have different needs. Grouping has helped us create models that are based on similar,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

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

create payment models to incentivise providers to achieve these outcomes.

Risk Stratifying our High Risk of an Emergency Admission Population

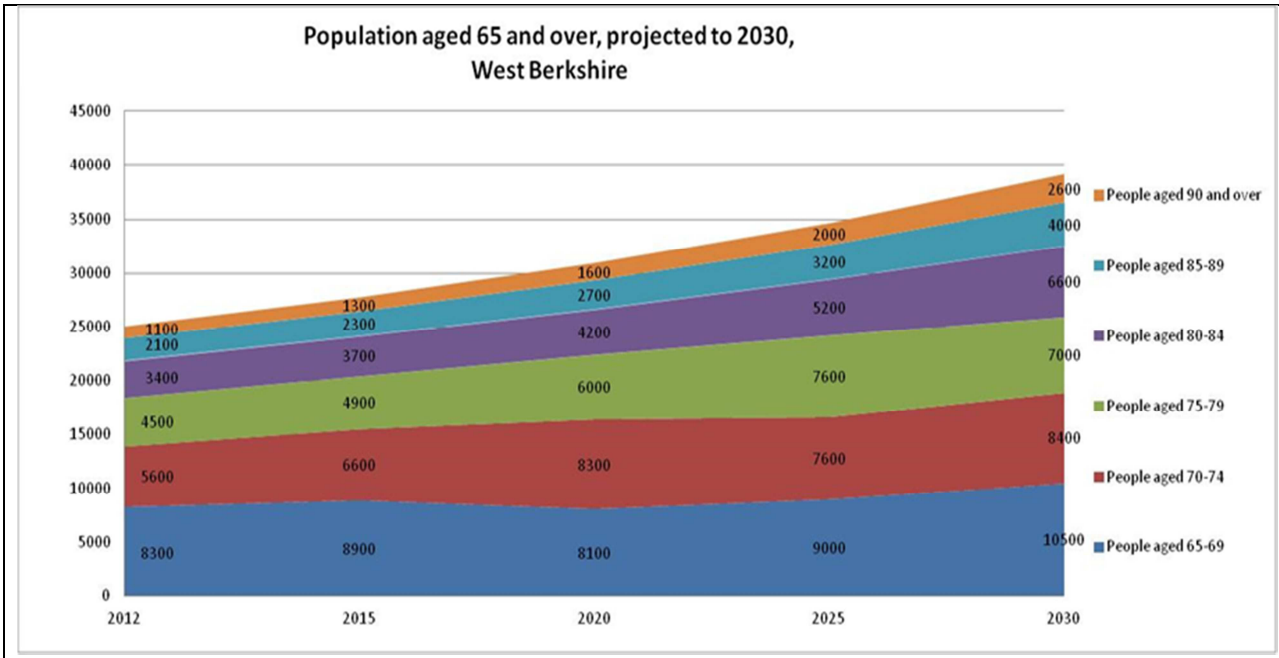
In 2009, nine of the then PCTs in South Central decided to collaboratively procure a risk stratification tool which would support case finding for community health staff as well as supporting other programmes for patients with long term conditions. The Adjusted Clinical Groups (ACG) tool was implemented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



The Case for Change

The health economy in Reading is facing a number of key challenges. We have identified these key challenges and used an impact modelling approach to understand the detail sitting below the statistics.

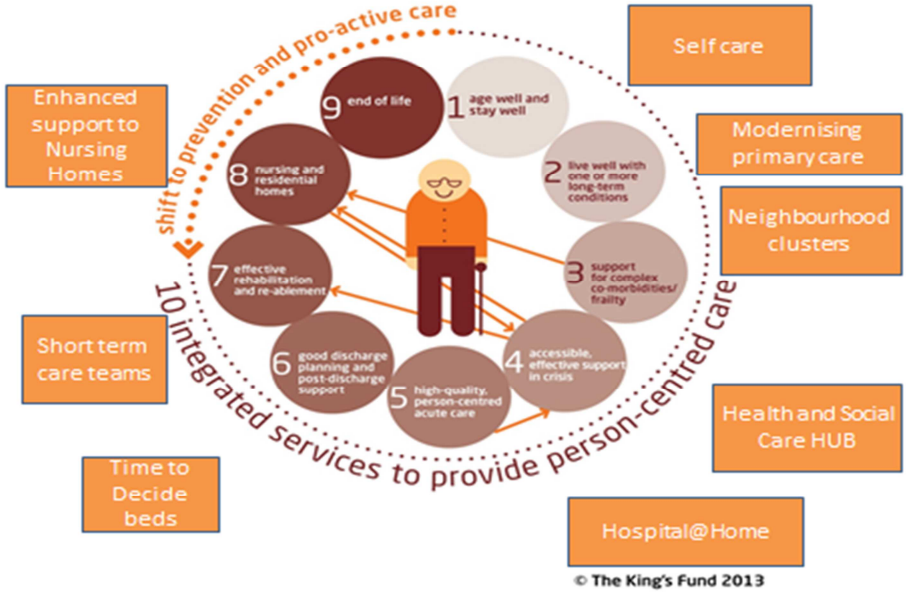
Challenge 1: A growing population particularly in those over the age of 65, with disproportionately high health and social care needs leading to a growth in health and social care requirements of +19% equating to £77m across the Berkshire West economy



As the graph above indicates, we it is predicted that the number of over 65s will 10% by 2021. The older population is expected to increase at the greatest rate. The impact of this demographic change on the health and social care systems will be vast – 30% of the population in Reading will be living with a long term condition and we expect there to be a large rise in the numbers of older people living with more than one long term condition, e.g. Cardiovascular disease, Dementia, Respiratory Disease, Liver disorders and Diabetes. 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; integrating across the whole health and social care system becomes an imperative. These increases are likely to present the biggest challenges to affordability and sustainability over the next five years.

We know that the Health and Social care requirements of the **elderly population** over the age of 65 population are set to **grow by 19%** over the next five years, and that this equates to a **£77 million pound increase in spend across the health and social care** system within Berkshire West , which is a 26% increase on 2012/13. Within a 'do nothing' scenario this increase in spend would be different across acute (23%), community (31%), social care (35%) and primary care (19%).

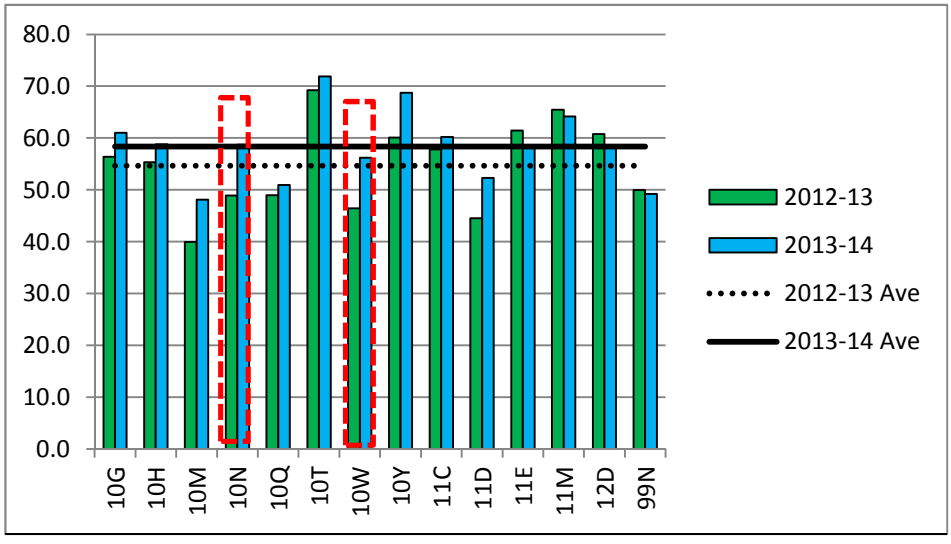
The solution: Extensive work is already underway in the frail elderly pathway, which was identified as a key Integration work stream in our Pioneer bid last year. This Berkshire West wide work stream forms the backbone of system change and our local Reading BCF schemes will be critical to delivering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



Challenge 2: Growth in Non-Elective Admissions

Non-elective admissions are rising in Reading, and future projections suggest that due to the increased age profile and expected double digit increase in certain long term conditions, this trend will continue unless there is system wide change. The graph below illustrates this trend across the whole of our South central CSU geography, but of particular concern in South Reading (10W) and North and West Reading (10N) where growth is higher year on year than in other areas.

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



10W - South Reading CCG
10N - North & West Reading CCG

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

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

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

**Note that these figures are for total Berkshire West not just Reading*

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

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

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

In Reading, during 2013/14 there were 285 Non elective admissions costing just under £1m. This therefore offers us a considerable level of opportunity to impact on this specific cohort of our population.

The Solution:

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

The first scheme, Hospital@Home (BCF01) will provide an alternative to an Acute admission, for a sizeable patient cohort. This service will keep the patient in the community, and provide Acute-level treatment from a multidisciplinary team including nursing, social care and linking in with specialist nurses and therapists, to provide a patient-centric model of delivery, rather than the traditonal disease specific organsisation of care, to patients who are clinically stable. By identifying the right patient cohort, it is estimated that this service will reduce non elective admissions significantly (84% reductoin for the patient cohort).

Our second scheme is in response to the pressure on the acute sector coming from care homes. The enhanced support to care homes scheme (BCF02) provides a new model of high level health care support into care and nursing homes throughout the borough to improve consistency in the quality of care and outcomes for residents. We aim to reduce Care Home resident non elective admissions in Reading by 40% in 2014/15.

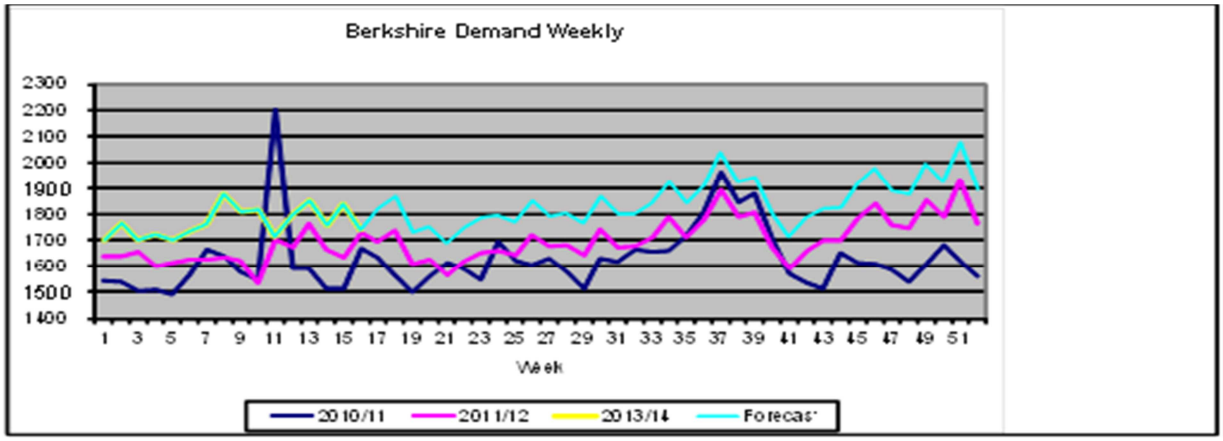
As a result of these schemes, non-elective admissions will reduce by 2.8% in 2015/16 vs. 2014/15. Although this is not at the 3.5% target, this is a very ambitious plan, given that Reading CCGs are already in the top performers for non- elective admissions in the

South of England.

The Health & Wellbeing Board has forecast 4% growth in non-elective admissions for 2015/16 based on population growth and population change relating to an ageing population. After extensive modelling of the schemes, ensuring that there is no double counting, this results in an expected net reduction of 2.8% in non-elective admissions in 2015/16 compared with 2014/15 forecast outturn.

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

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



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

The Solution:

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

The first cohorts of patients are those with long term conditions and frail elderly patients. Both of these cohorts will benefit from the increased provision of care in the community, via the Hospital@Home scheme and Neighbourhood cluster team scheme, and the extended availability throughout the week for this care via the 7 day working schemes.

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

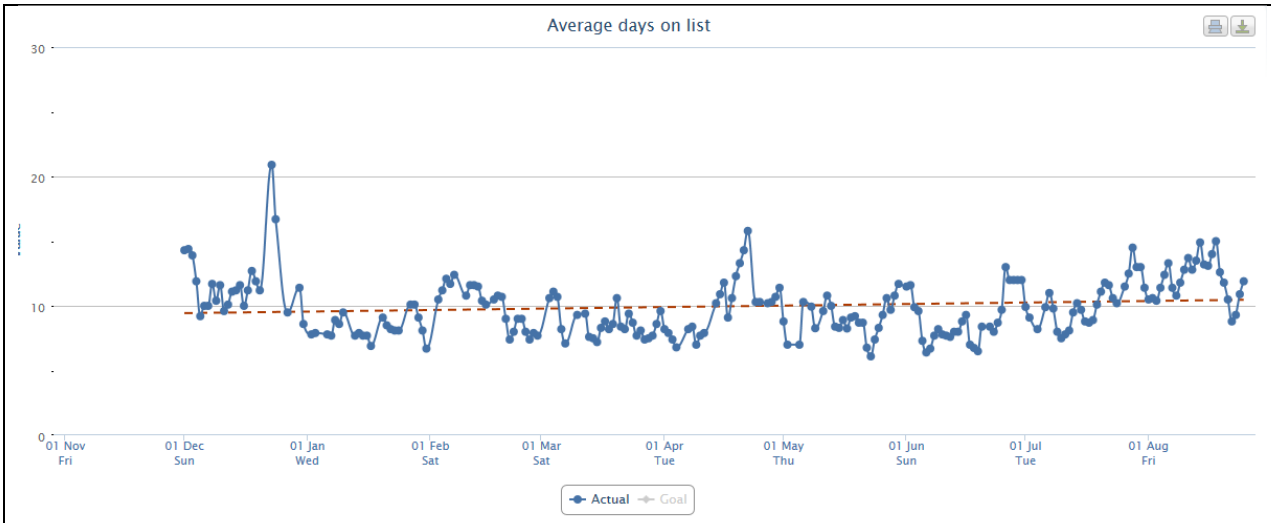
Patient cohort at high risk of A&E attendance	BCF fund to support
Patients with LTCs and frail elderly patients susceptible to dehydration etc.	Hospital at Home 7 day access to GP care Neighbourhood cluster teams
Patients residing in Care Homes	Enhanced service for Care Homes

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

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

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

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



Solution:

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

1. The number of patient discharges on an average weekend day is less than half the number of patients who are discharged on an average weekday. A key reason for this is access to health and social care in the community over the weekend. In response to this we have developed a number of 7 day services, including neighbourhood cluster teams (BCF05b), and our health and social care hub (BCF05a) that will be available to take referrals and provide services seven days of the week, facilitating discharge over the weekend.

2. Another key reason for delayed transfers of care is the cohort of patients who are waiting for social care packages, who often have to wait for their care, despite being fit to be discharged. Our Time to Decide scheme (BCF04) will reduce these delays by providing an onward destination for this cohort of patients, providing step down beds with a focus on maximising independence.

Challenge Statement 5: Increasing Pressures on Adult Social Care for Community Packages and Care Homes

Like every other local authority in the country, Reading faces challenges in deliver its priorities against national government settlements. Through its Corporate Plan, the local authority has affirmed its commitment to keep on delivering high-quality, good-value services that protect people who are most at risk, and provide the best public services it can. However, there is an explicit acknowledgement of the need to work differently to avoid the consequences of a widening funding gap is projected to be £40m between 2014 and 2017.

The key areas of demand are for adult social care in Reading, in particular amongst over 75 population and those with dementia, both of whom have a longer than average length of stay due to waiting for nursing placements.

As described above, the number of patients on the “fit to go” list continues to increase due to the increasing demand for nursing care, residential care and community

reablement, and the lack of supply.

The Solution:

Addressing the needs of these cohorts of service users will reduce length of stay in acute hospitals, reduce the number of patients on the fit to go list, in turn reducing delayed transfers of care. In addition, if their needs are addressed, this will ultimately reduce the number of service users admitted to residential care.

The provision of integrated health and social care will greatly improve outcomes for patients who are medically fit to be discharged, but are awaiting further care. The Time to Decide scheme (BCF04) will ensure that patients/service users receive a full assessment and have the opportunity to reach their optimum level of independence which will ensure that their discharge destination is the right one for them.

This service will be primarily for patients/service users who are highlighted as potentially requiring residential (DE) care as a discharge destination. This will reduce the amount of patients/service users waiting for onward care along with the length of stay for patients that are fit for discharge within the Acute Trust. As individuals will have a longer period to recuperate and reach their optimum level of independence, the number of people discharged to residential (DE) care will reduce.

Challenge Statement 6: Increased Demand for Planned Care Services

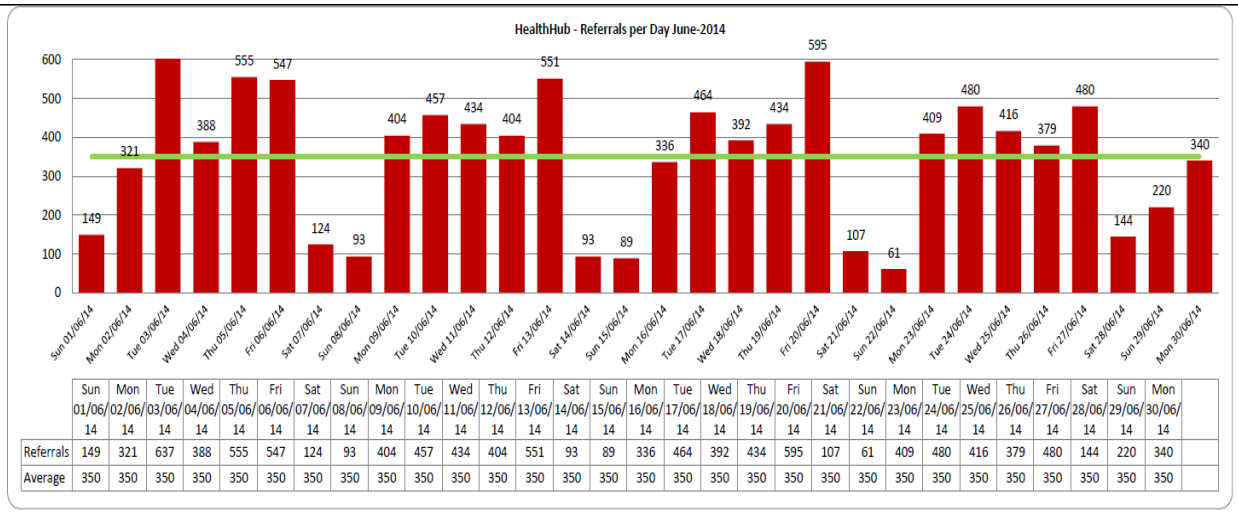
Work is currently underway across our health economy to address these issues and is outside the scope of the BCF.

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

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

Local acute data from Royal Berkshire Foundation Trust shows that there are far fewer discharges at the weekend vs. during the week with less than half the weekday average number of discharges. This is in part due to the lack of provision in the community to hand over care and instigate care packages at the weekend.

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



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

Solution:

In response to issues created by a lack of provision over the weekend, we have developed a number of interconnected work schemes within our BCF to address this. These plans will support all patient cohorts but the provision is expected to be particularly effective for patients with complex needs, those identified as part of the national service to avoid unplanned admissions including the over 75 year olds.

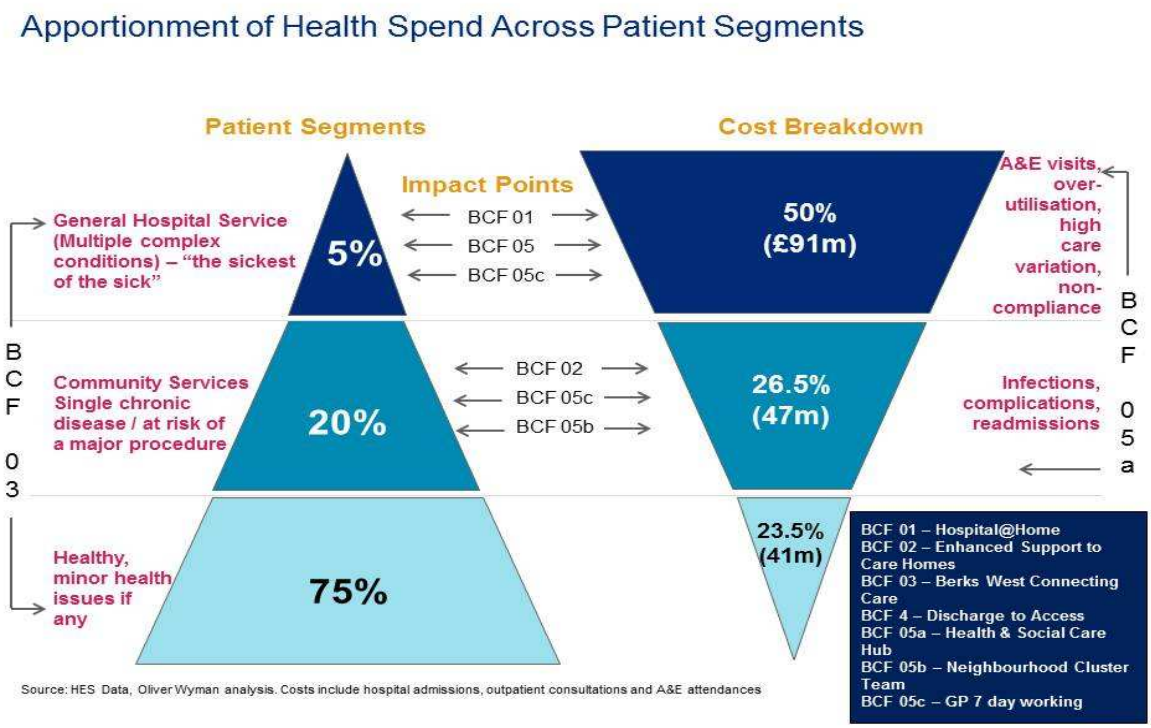
Expansion of GP service provision (BCF05c) beyond core hours will broaden access and ensure that people can access the GP when they need to. Practices will offer both routine and urgent appointments during these periods. The increased aviailability of GPs will to support admissions avoidance, and reduce A&E attendance with GPs signposting patients to the most appropriate service.

Neighbourhood Cluster Teams (NCTs) (BCF05b) are multidisciplinary teams of health and social care professionals who will be allied to GP clusters or hubs across Reading. The Neighbourhood Cluster Teams NCTs) will integrate health and social care teams across the week to respond to local patient/service user need providing early interventions through care planning to reduce the need for admission to hospital and facilitate discharge.

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

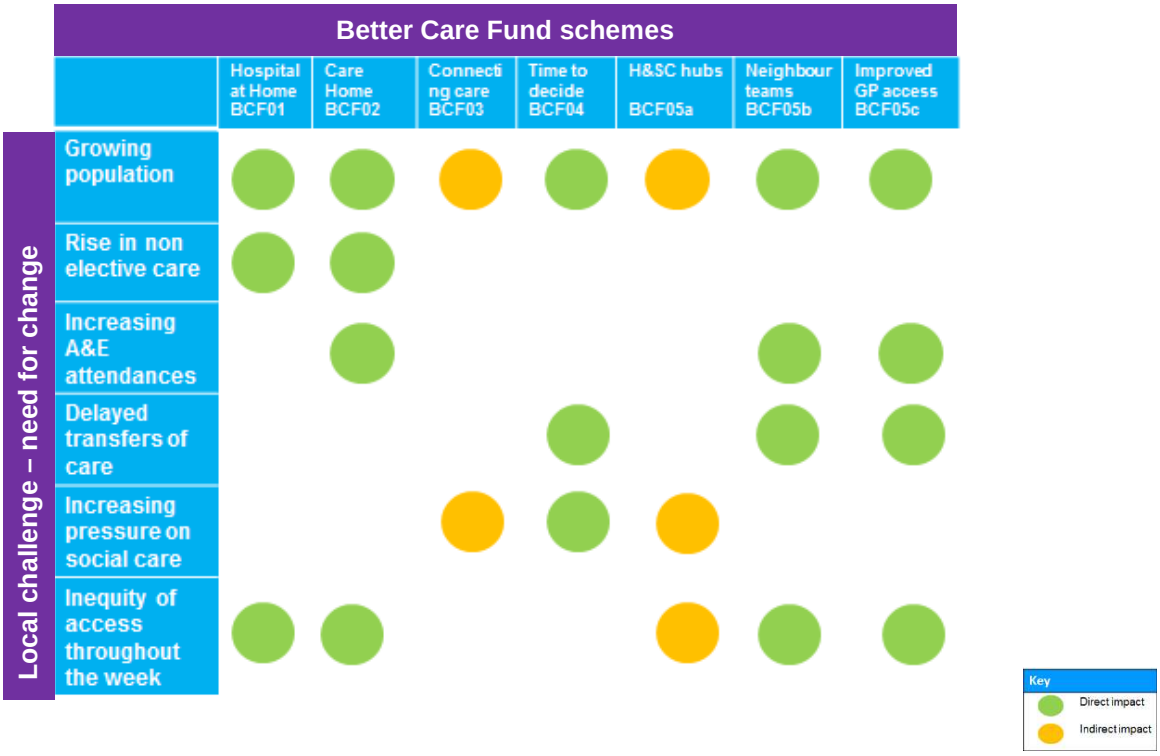
Delivering Change via the BCF

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



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

Overview of How the BCF Will Address Reading's Key Challenges:



4) PLAN OF ACTION

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

Milestones

The programme plan below illustrates the high level key milestones by scheme for the delivery of the Better Care Fund plan. The full project plan for the schemes can be found in section 1c).

BCF Programme Plan:

	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept
Hospital at home														
Proof of concept	May													
Evaluation														
Finalisation of KPIs														
Recruitment complete	Jun/Jul													
Scheme launched														
Review of scheme														
Care Homes support														
Scheme launched	in place													
Training starts	in place													
Review of GP uptake														
1st round of GP reviews complete														
Review of scheme impact														
Connecting care														
Data protection protocol signed off														
Information sharing with acutes														
Information sharing with social care														
Decision to procure portal solution														
Full roll out														
Time to decide														
Design and planning														
Agree KPI's														
Sign off of initiative														
Recruitment of staff														
step down beds														
Official launch														
Health and Social Care Hub														
Design and planning														
Agree KPI's														
Agreement of implementation plan														
Project progress- to be detemined once plan agreed														
Integrated health and care hub established								to be determined						
Project review								to be determined						
Neighbourhod Clusters														
Design and planning														
Sign off of initiative	To be determined													
Agree KPI's														
Recruitment	To be determined													
Establish new neighbourhood teams in shadow form	To be determined													
Neighbourhood teams go live	To be determined													
GP 7d working														
1st Pilot approved														
Pilot commences														
KPI's agreed														
Review														

Progress on these milestones and more generally are detailed in the Integration Dashboard for August 2014, which can be found as one of the related documents in section 1c. This is monitored via the Berkshire West Partnership Board, where not only are the projects held to account but there is also opportunity to identify any synergies or interdependencies between different projects, and where there can be shared learning and understanding.

Interdependencies:

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

Connecting care (BCF03) which will deliver the interoperability between various health and social care providers will be critical to the efficiency and smooth running of the Hospital at home scheme, neighbourhood clusters, health and social care hubs and Time to Decide beds. These programmes will run more efficiently, and decisions will be able to be made quicker as a result of a more complete set of information in real time.

In the Hospital@Home pilot, we found that the lack of data sharing, (which is not yet in place), led to delays as health and social care professionals had to spend time getting updates on the progress of the patient from other professionals directly. IT interoperability will be critical to the smooth running of this service, allowing professionals to access the data they require instantly and therefore increasing productivity. In addition it will facilitate a more robust assessment of the patient's fitness for the scheme in the acute setting as the community geriatrician will have access to a more comprehensive information set.

Similarly the Health and Social Care hub, which will form a single point of access for health and social care professionals, and eventually patients, will be critical to the success of the schemes. The Health and Social Care hub will signpost patients and professionals to the most appropriate services, and ensure that there is adequate awareness of new services to ensure optimal uptake.

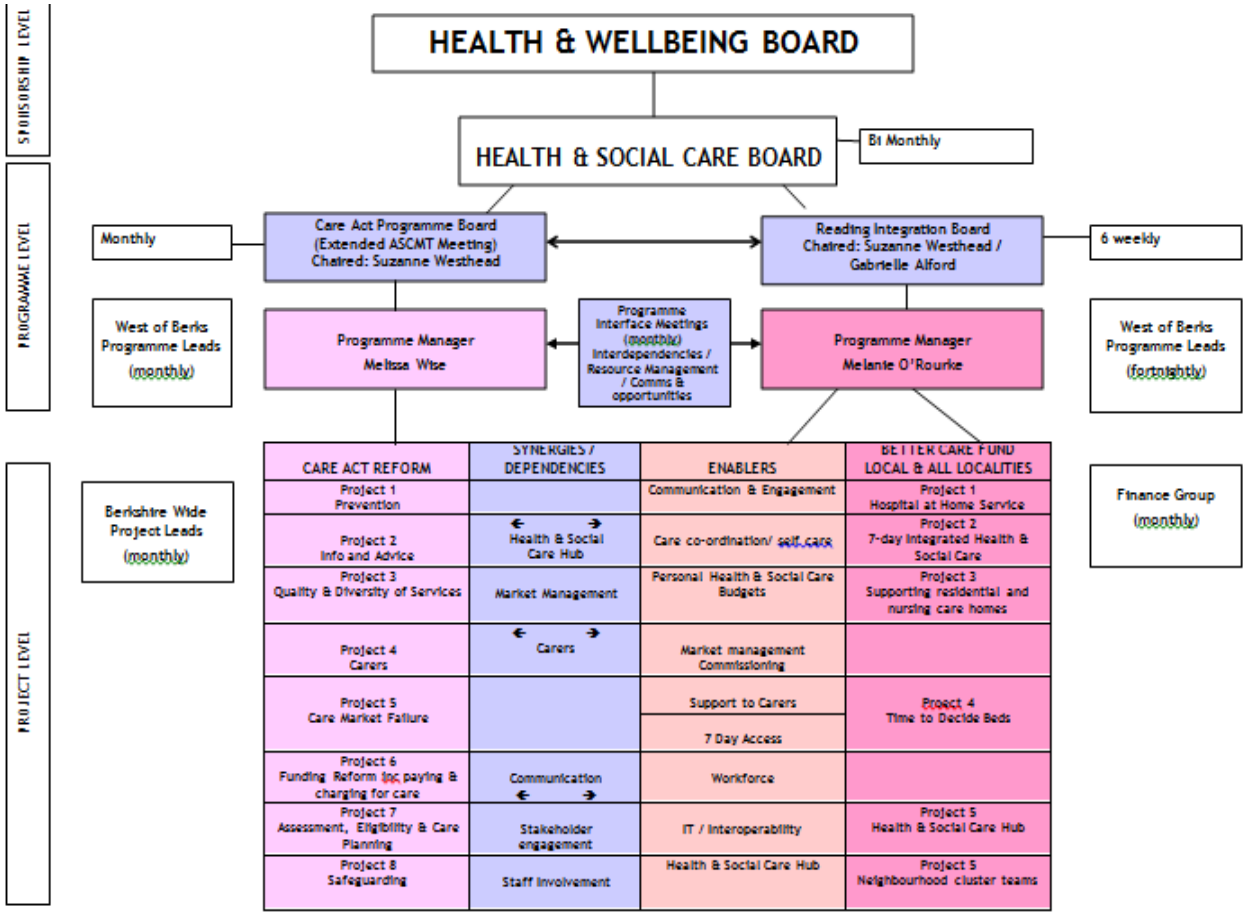
The three schemes connected to seven day working are all interconnected. In order to be as effective as possible, 7 day requires a full complement of services – i.e. hub to be a port of call to direct patients and professionals to the most appropriate service, and the GP and community teams so that they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

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

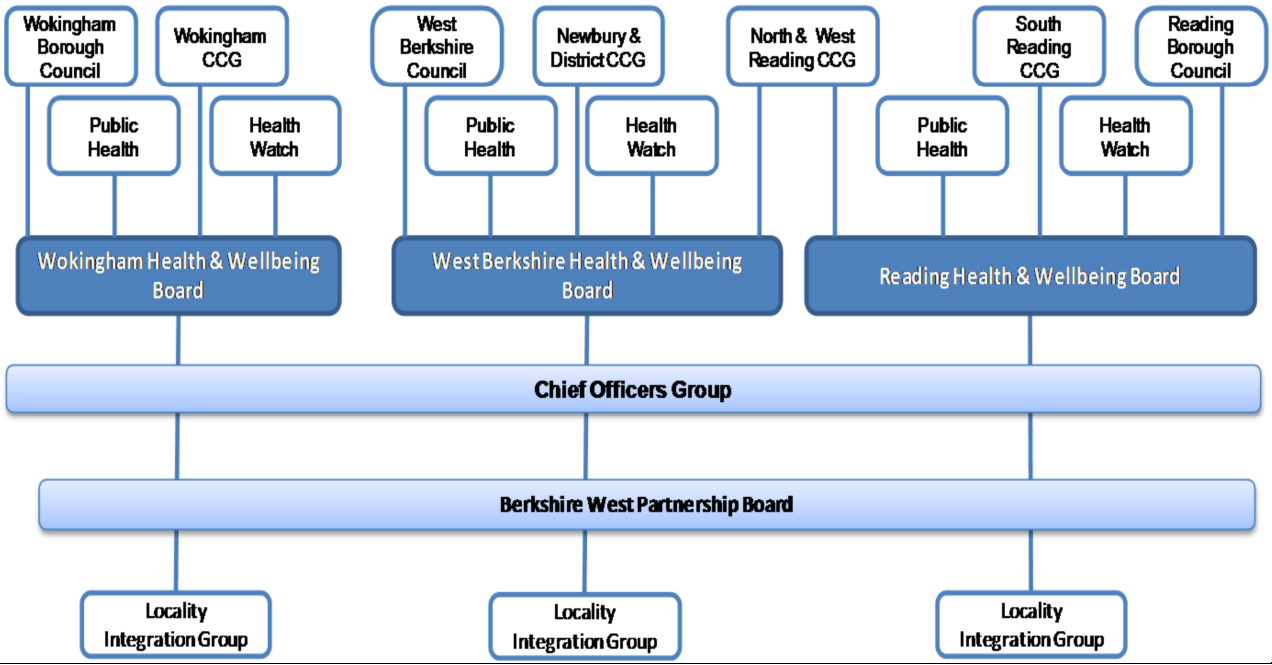
In Reading, we have a history of pooling health and social care budgets to deliver improved outcomes, and have therefore developed governance arrangements appropriate for integrated care. These have, however, been refreshed recently to establish joint governance arrangements covering both our Better Care Fund and Care Act implementation programmes. This enables us to map synergies and interdependencies between the two, which directly involve many parts of our operational services, and set the context in which the whole of Adult Social Care is being taken forward.

The Governance structure is set out on the next page.

Governance Structure:



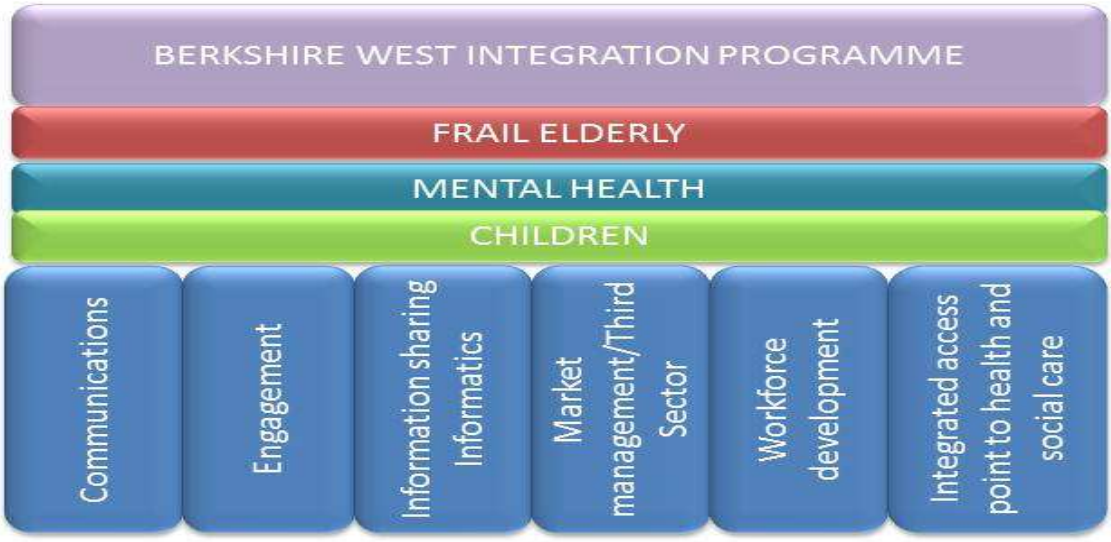
As many of our Better Care Fund schemes will span all three unitary authorities and all four CCGs across Berkshire West, as well as local projects specific to particular unitary authority areas, we have established robust governance structures for working across the sub-region.



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

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

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



Reading's Health and Wellbeing Board has strategic oversight of our plans to develop more integrated services within the Borough. The Health and Wellbeing Board has already overseen the production of the latest Joint Strategic Needs Assessment 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.

Reading's Health and Wellbeing Board is now supported by a Health and Social Care Board bringing together senior officers from partner agencies to focus on the development of our integration plans. This is chaired by the Managing Director of the local authority and includes representation from provider organisations as well as Healthwatch. This forum has a strategic overview across all integration projects as well as the Care Act implementation challenges and issues facing all partners.

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

track.

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

Reading Integration Board

The primary accountable board for the Better Care Fund schemes across Reading is the Reading Integration Board. This is chaired jointly by the Head of Adult Social Care at Reading Borough Council and the Director of Joint Commissioning for the Berkshire West Clinical Commissioning Groups.

At this board, a programme synopsis of the activities undertaken is regularly presented evidencing progress, risks and issues, and any remedial action to be taken or any decisions required by the board. This board will also deal with issues that may impact on the risk sharing agreement.

Individual project reporting will be in the form of highlight reports with a RAG rating, and any project which appears to be going off track will be given close scrutiny by the Board.

Snapshot Highlight Report:

Monthly Highlight Report

Project:	**Hospital at Home**	**Planned Outcomes:** – Prepare for Proof of Concept – Patient inclusion and exclusion criteria agreed – Comms strategy agreed – IM&T approach agreed – Staffing Model to be approved – Service Contract being drafted – Financial impact due to service delays		**Project Status**
Report for month:	June 2014			**Finance Status**
Period Covered:	June 2014			**Activity Status**
Senior Responsible Officer / Project Lead:	Katie Summers SRO Dr Johan Zylstra – Clinical Lead David Lighterness – Project Manger			**Milestone Status**

Key achievements last month:

- Project Board agreed in principal for Proof of Concept to commence on 21 July'14
  Decision to be made at extraordinary board meeting on 15 July '14
  - 2 patients from each UA
  - Objective is to stress-test the system and ensure all parties understand the impact of go-live when it is scheduled
- IT System – Adastra will be the system used in RBH and OoH
  - Rio will continue to be used by BHFT and the UA's
- Subgroup meetings continue to run fortnightly
- Latest re-revised resource proposal under review – Contract meetings with CSCSU, BHFT and WCCG scheduled
- Memorandum of Understanding drafting commenced
- Datasets defined for local/SUS submission - agreement to be obtained from BHFT
- Job description for H@H consultant currently with the Deanery
- Agreement with RBH A&E on staffing and processes achieved

Key steps for next month:

- KPIs construction to be agreed
- Dataset collections to be agreed
- Benefits realisation to be agreed
- Contract Management to be agreed
- Revised Staffing model agreed
- Medicines process and responsibility agreed

- Prepare for Proof of Concept
- Deliver pre-PoC workshop
- Circulate H@H Operating Manual

Actions planned but NOT progressed from last month

Action	Reason not achieved	Next steps
Resourcing still an issue	Constantly under review and recalculation	Meetings are on-going.

Any significant risks or issues which require a system wide debate will be will be escalated to the Berkshire West Partnership Board or to the Reading Health and Social Care Board depending upon whether it is a local Reading Project or a system wide enabling scheme.

Additionally a weekly update will be provided to the Chair of the Reading Health and Social Care Integration Board. This report will be submitted each Friday with weekly progress, planned progress for the week ahead and any immediate risks to the programme. The current programme risks are detailed in Section 5.

Risks relating to the financial or performance of any scheme will initially be raised at the Reading Integration Board at the earliest opportunity to allow for transparent conversations and shared problem solving. In the event of the board either not being in a position to remedy this action, the issue will be escalated to the Reading Health and Social Care Board, where key chief executives are in attendance inclusive of provider

services. If the issue has wider connotations, impacting on the whole of Berkshire West, the issue will be addressed at the Berkshire West Partnership Board.

The financial performance against the elements of the pooled budget held by the CCGs (which will generally be the elements related to the CCG QIPP schemes and are set out in Annex 1 to the Risk Sharing Agreement) will be monitored through the CCG QIPP and Finance Committee which is a Committee of the CCG Governing bodies. Recommendations and decisions arising from that Committee will be made to the Berkshire West Partnership Board.

Quality Framework/Assurance :

Our vision for quality is straightforward. Patients and service users should:

- Receive clinically effective care and treatments that deliver the best outcomes for them
- Have a positive patient experience of their treatment and care; and
- Be safe, and the most vulnerable protected

We will ensure systems are in place to track and manage performance including taking action when required quality standards are not met. Quality will be fully integrated with performance and finance in assessing the delivery of this plan and will continue to be at the centre of all of our discussions with providers. Quality monitoring across the schemes will be reported into the locality integration groups and onwards to the Berkshire West Partnership Board. Specific quality issues will be escalated if necessary through to the quality teams and the Berkshire West Quality Committee in order to address issues and put in place any remedial action plans.

d) List of Planned BCF Schemes

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

Ref no.	Scheme
BCF01	A Hospital at Home Service
BCF02	Supporting Residential and Nursing care homes
BCF03	Berkshire West Connecting Care
BCF04	Discharge to Asses (Time to Decide Beds)
BCF05 (a-c)	Whole System - Whole Week (7 day Working) a. Health & Social Care Hub b. 7 day Integrated Neighbourhood Teams c. Improved Access to GP Services

5) RISKS AND CONTINGENCY

a) Risk log

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

Area of work	Risk Description	Impact	Likelihood	Risk Rating	Mitigation
Planning	The timescale of the requirements to deliver the BCF are challenging and as a result not all options will be fully developed and therefore some uncertainty may exist in terms of project and efficiency delivery	4	2	Medium	The project teams are working through each scheme in detail and where fully developed business cases do not exist, plans of action are in place indicating where further work is required, with named leads and defined timescales for completion. These will be monitored in the Reading Integration Board for progress.
Finance	Pooled Budget arrangements - Organisations do not reach agreement of who holds the budgets and the impact of any under or overspends	5	2	Medium	The parties have developed a risk sharing agreement that sets out how the interdependencies and pooled budget arrangements will work across health and social care. Although this clearly has yet to be tested in practice both parties are in agreement that it will be implemented and reviewed during the course of 2015/16 .
Finance	The potential for increase in volume of use (Unplanned activity) may lead to overspends.	4 (£720k)	2	Medium	The BCF performance and contingency funds will be used to fund any overspends in RBH due to non-delivery of NEL admission reductions; The CCGs have a robust process for monitoring activity monthly through QIPP and Finance against contracted levels and actions taken to mitigate growth are also reviewed there.
Finance	The overall BCF funding (£10.9m) is dependent on the CCG delivering on its overall QIPP programme	4 (£3.6m)	4	High	The CCGs have a programme of QIPP schemes which are monitored monthly via QIPP and Finance and where if a scheme is going off then remedial action is taken. Planning for QIPP schemes outside of the BCF which underpin the achievement of the performance around NELs for 2015/16 is already in train.
Finance	A risk that funding identified in the BCF will not	3	3	Medium	Local agreement has so far identified £1.5m to

	be sufficient to cover the cost of the Care Act (on top of the money from DCLG to cover the impact)	(£102k)			support this area. Local authority are working to understand the impact of the Care Act .At the time of submission, the funding is viewed to be sufficient, but the requirements of the Care Act will be continuously reviewed and fed into the BCF program via the Reading Integration Board.
Performance	Schemes identified do not deliver expected reduction in activity	5	3	High	A clear performance framework with KPIs is in development to be monitored regularly and to track if there are issues proactively. The CCGs have a programme of QIPP schemes which are monitored monthly via QIPP and Finance and where if a scheme is going off then remedial action is taken. Planning for QIPP schemes outside of the BCF which underpin the achievement of the performance around NELs for 2015/16 is already in train.
Governance	The governance of the BCF is too complicated to cover all issues	4	2	Medium	Separate operational &delivery and financial governance mechanisms are in place to ensure total management of the program and to ensure that there is adequate control
Delivery	Plans do not go live on time and as such the savings arising from the schemes are diminished	4	2	Medium	Programme management of the schemes overseen by a locality Integration lead, supported by scheme project managers. Reporting via strong governance
Performance	Hospital at home patients are recorded as an admission and despite the fact that they will be on a lower tariff, so the projected financials will be correct, the NEL activity will not be reduced to the same level, risking the performance against activity and the P4P	2	4	Medium	Discussions are underway with RBH to find an alternative and legitimate way of recording the hospital at home cases, taking into account clinical governance requirements.
General	Primary care contracts not in place for GP for "7 day working" by the 1 April 2015. Contracts in place for timescales that don't fit with wider implementation of whole system whole week working	3	3	Medium	Initial dialogue underway with primary care commissioners and GP colleagues to solidify deliver planning from April 2015.
GP Engagement	GPs do not engage with the Enhanced care home service or neighbourhood clusters reducing their impact	4	3	Medium	GP engagement plan at GP councils and Primary Care Board to ensure GPs are on board. Regular reviews of uptake by practices of Care Homes and Neighbourhood clusters
Workforce	The schemes are delayed by delays in recruiting	4	2	Medium	All plans factor in a 3 month recruitment window.

	staff and so benefits are not realised. Additionally risks of GP and health and social care professionals to allow full seven day working.				Review of skill mix to ensure the most appropriate grade of staff provides care and advice. Pursue options of using Physicians assistants trained by Reading University.
Reputational risk	There is a risk to our reputation with patients and our providers if the BCF schemes do not work	4	2	Medium	Ensure that all key stakeholders are engaged on the BCF on an ongoing basis, and monitor performance of schemes closely and escalate when necessary to avoid slippage
Public engagement	Patients and the public are not adequately engage with the BCF schemes and as a result there is dissatisfaction around the changes to services	4	2	Medium	Continue to engage patients and the public, and local health watch on the Better Care Fund via existing forums

b) Contingency Plan and Risk Sharing

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

In Reading, we have taken a pragmatic approach to risk sharing and have considered the risk to the BCF program in three elements:

1. Funding availability
2. Delivery costs
3. Underachievement of benefit realisation

All plans for expenditure, scheme allocations and pooled budget amounts and hosting arrangements have been developed jointly and with full transparency with the HWBB and our local economy stakeholders.

To address the risk of BCF funding availability, the CCG has undertaken a robust QIPP planning process which has developed a plan for 14/15 and 15/16 which will deliver sufficient resources to support the BCF and other CCG improvement plans. We also recognise that planning is just the beginning and have implemented a programme delivery approach tour work and will be monitoring delivery of the schemes monthly through our CCG programme boards as well as through the Reading Programme Board which is co-chaired by the Local Authority and the CCG Federation. Additionally, for year one of the BCF, the CCG may be able to draw upon non-recurrent funding to support delivery in order to address scheme slippage.

In order to address the risk under/over spend in relation to the operational delivery of the program and the underachievement in benefit realisation (NEL admission reduction), the detail has been included in the risk share agreement and can be seen in section **3** below.

We would like to note that we are looking towards alternative contracting methods with our providers in the future which will assist in increasing wider ownership of the BCF plans and distribution of risk to the system, but these are in early stages and will take time to develop. We feel this is the future of the program and contracting process and want to ensure that we enable the Berkshire West 10 to reach the end point collectively and in a positive manner.

The following draft risk share draws upon our experience and existing risk share arrangement that we have in place in the Reading economy. This can be evidenced through the Hospital@Home MoU, which includes our providers. A copy of this can be found in section 1 c).

Draft Risk Share Agreement
Reading Local Authority, North and West Reading CCG & South Reading CCG

Better Care Fund Pooled Budget - Risk Sharing Agreement

1. Introduction

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

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

(ii) Where the impact is so financially significant that individual bodies could be at financial risk, the parties need to work together to mitigate the impact.

2. Scope of Agreement

2.1 Only the financial elements of services covered by the Better Care Fund (BCF) are eligible for risk sharing (although there will be flexibility to add to the arrangement subject to agreement by all parties and by approval of the Health and Well Being Board). E.g. where budgets are held locally for services outside the BCF but are for the same services as in the Better care Fund e.g. Carers).

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

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

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

2.5 As most of the Better Care Fund has been provided from CCG budgets the principle financial risks to the Local Authorities include the failure to earn the performance elements of the fund. In order to fully mitigate this risk for the Local Authority the performance element of the fund is held by the CCGs and is not factored into the Local Authority expenditure plans. This also avoids the opportunity costs and effort in trying to earn this additional payment that may be disproportionate to the influence and benefit that the LA can gain from the achievement of the 2.82% reduction in non-elective activity.

3. Risk Categories

(i) Financial Risk

- Financial overspends on each element of the BCF scheme are the responsibility of the authorising organisation (as set out in the table below)

and will not be funded through the BCF, unless agreed by all parties.

- Financial underspends on each element of the BCF scheme will be retained by the Pooled budget for use within the pool in year, and returned to the partners in proportion to their contribution, at year end.
- Under achievement of planned savings and KPIs will be met from contingency and retained performance fund.

(ii) Delivery Risk

Failure to deliver the inputs required to deliver KPIs should be borne by the organisation failing to deliver.

(iii) Performance Risk

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

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

- The performance fund remaining for non/reduced performance will be used by CCGs to fund associated over performance associated with failure to deliver the non-elective activity reductions in the acute sector.

(iv) Reputational Risk

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

4. Risk Management Framework & Governance Arrangements

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

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

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

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

5. Accounting Arrangements

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

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

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

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

Pooled Budget Responsibility

			Reading £'000
Baseline spend - from minimum BCF			
	LA's Services funded from historic S256	LA	2,511
	DFG	LA	432
	Social care capital grant	LA	317
	Carers funding	NHS	337
	Contingency	NHS	98
	Reablement	NHS	779
Baseline			**4,474**
New Spend - from minimum BCF			
	Protection of Social Care Services	LA	1,100
	Social Care Bill	LA	361
	7 Day working - other	LA	404
	Time to Decide beds	LA	456
	Personal recovery guide	LA	0
	Intermediate care assessor & service	LA	0
	SPA	LA	0
	Integrated health and social care	LA	0
	Prevention and support	LA	0
	Night sitting	LA	0
	H at H	LA	51
			2,372
	Hospital at Home (fye) - NHS spend	NHS	776
	Nursing / care home projects (fye)	NHS	175
	7 Day working - Primary Care	NHS	896
	Connected care (interoperability)	NHS	256
	Health Hub	NHS	72
	Performance fund	NHS	719
			2,894
	Contingency	NHS	84
New			**5,350**
Total			9,824
BCF funding from LA budgets			
	Carers - grants	LA	214
	Carers - respite/DPs	LA	90
	DFG - extra invest	LA	68
	Time to Decide beds	LA	699
			1,071
TOTAL BCF			**10,895**

The above table figures are replicated in the Part 2 template. At this point we would like to note that while tab 4 contains the detailed savings projection against the above spend for the NHS provider metrics, the savings projections for the Local Authority metrics are not fully contained in the submission. They are currently being reworked, as a result of the change in the NEL target, using robust methodology and impact modelling and will be signed off by the Local Authority members. They will be available for review and provided in full during the assurance process interview.

6) ALIGNMENT

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

All parties in Reading are committed to promoting integrated care, and as a result there a number of integrated care projects already underway in Reading. The BCF schemes align well and bolster these existing initiatives.

In November 2013, the Council's Adult Social Care Children's Services and Education Committee received a report on the impact of the Care Bill, and endorsed the principle of closer integrated working with health partners based on a vision of person centred care and support delivered at neighbourhood level, and utilising the skills and capacity within local communities, in line with some of the key Better Care Fund plans.

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

The local authority has recognised that not all dwellings in the borough are 'care ready' to provide a base for care at home as people become frailer, which is part of our Better Care Fund vision. The Council has therefore committed to increasing the supply of Extra Care Housing to 240 units across the town, and 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.

The local authority is committed to developing additional extra care housing as an alternative to residential care, which will contribute to reducing the number of permanent admissions into residential or nursing care homes. Strategic partnerships are being established with supported housing providers and social enterprises to support timely hospital discharge through direct provision for people with complex needs. Increasing the supply of Extra Care Housing will also complement the Discharge to Assess (Time to Decide) scheme within our Better Care Fund proposals.

As outlined previously, an integrated frail elderly pathway has been developed and it is the backbone of system change. All our BCF schemes support this pathway at various points in the elderly patient's journey. (See Case for Change Challenge Statement 1.) The overall aim which the pathway is designed to achieve is an improvement in the care of older people with long-term conditions and those who are at highest risk of deteriorating health and needing intensive social care support. In bringing key elements of the frail elderly (older people's) pathway on line through our local projects we will be able to assess the impact of various approaches, and use this as a template to inform

planning for other pathways.

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

All Urgent Care Programme Board (UCPB) partners have recently contributed to the development of a Berkshire West Operational Resilience and Capacity Plan 2014-15 (ORC) which confirms how the system will work together to manage operational resilience throughout 2014/15. The UCPB and its members have a key role in supporting improved integration between health and social care and improving outcomes for local people. The ORC Plan demonstrates the clear link between the BCF principles and the wider urgent care agenda and plans for 14-15. Many of the initiatives being funded from national resilience monies will act as a precursor to the BCF schemes.

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

Reading's Joint Health and Wellbeing Strategy 2013-2016, has a "shared vision" with the BCF plans, demonstrating that the BCF schemes underpin and support the delivery of the overall joint strategy. Our vision is for "A Healthier Reading" and our BCF programme supports the delivery of Goal Three: To reduce the impact of long term conditions with approaches focused on specific groups.

Integration plays a central part in both of the **CCGs' two year operational plans and five year strategic plans.** We believe that working in partnership is the most effective way for us to ensure that we are providing person–centred, personalised and coordinated care in the most appropriate setting. All the schemes identified in this submission are included within our respective CCG Operational plans (pages 40-42 (South Reading) and 52-54 (North & West) along with other local priorities and projects.

Integration is also a key part of Reading Borough Council's Corporate Plan 2014-17, which articulates the local authority's commitment to promoting integrated care under Priority 2 (People are supported and protected when they need to be; People are healthy and can thrive in their community). Specifically within this theme, the Corporate Plan identifies the following measures which link directly to projects developed within our Better Care Fund submission:

- Support people to stay in their own home

- Commission high quality services for home care, supported living, residential and nursing homes
- Commission Extra Care Housing units
- Meet our obligations under the Care Bill – redesigning systems to support the new 'wellbeing' duties

In November 2013, the Council's Adult Social Care Children's Services and Education Committee received a report on the impact of the Care Bill, and endorsed the principle of closer integrated working with health partners based on a vision of person centred care and support delivered at neighbourhood level, and utilising the skills and capacity within local communities.

The Corporate Plan also sets out the local authority's increasing emphasis on neighbourhood working, which will contribute directly to the development of the '7 day integrated health & social care' scheme. Teams will operate in dedicated areas centred around GP practices, co-ordinating services being delivered between them. The intention is that this will enable local authority teams, partners and residents to identify and propose areas where outcomes could be improved through greater integration of activities between those involved. More local authority resources and coordination is being shifted into frontline services to support this approach.

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

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

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

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

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

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

It is envisaged that co-commissioning will underpin integration, encouraging the development of new models of service provision outlined in the BCF. In addition a number of BCF schemes link closely to the enhanced GP service that is to be delivered through "Transforming Primary Care". For example, the Neighbourhood cluster BCF scheme (BCF05b), supports the changing role of the GP as the Accountable Clinician co-ordinating care and links to the Proactive Care programme as outlined in "Transforming primary care". In addition, the care home project (BCF02) will also facilitate the Proactive Care programme for over 75s living in residential care.

A further area of the BCF plan that will support the enhanced GP service is the scheme to deliver seven-day GP services (BCF05c). Co-commissioning will support the implementation of this scheme, enabling the CCGs to influence the working hours incorporated into any new GP contracts tendered, there are opportunities to further pool funding with NHS England, for instance that used for the current Extended Hours DES, to better incentivise practices to increase their availability, thereby also mitigating any potential risks associated with practice engagement.

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

7) NATIONAL CONDITIONS

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

a) Protecting social care services

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

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

We will develop a fair system of Social Care where the resources that are offered relate to the level of assessed needs a person might have and where their contribution towards the costs of that care clearly relates to their ability to pay. Fairness and independence will be at the heart of Social Care in Reading. Reading expects to maintain its currently eligibility threshold (set at supporting those who face a 'critical' or 'substantial' risk to their wellbeing or independence under current local policy, but translated into the new national eligibility criteria from April 2015).

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

We will promote a 'whole family' approach that seeks to promote great outcomes for children by supporting their parents. We will develop staff awareness and expertise in dealing with issues like domestic violence, mental ill health and substance misuse that can prevent adults from nurturing children. We will also plan good transitions from Children's Services to Adult Services for both service users and young carers.

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

Demographic changes and the increasing complexity of the clients being supported are placing an increased demand on Adult Care services. At the same time national reductions in funding to local government reduces the resources available across the Council. Nationally, ADASS has estimated social care demand growth of around 3%, which for Reading in 15/16 equates to around £1m in growth pressures.

Considering how to deliver on our Care Act obligations to promote preventative

approaches to care has resulted in the Council committing to maintaining current levels of investment in preventative services offered by the voluntary and community sector to support people to stay well at home. These prevention services span a range of primary and secondary provision in the form of condition specific information & advice and exercise classes to handyman services and Telecare. This commitment needs to be funded but provision will be bolstered by the 7 day working BCF schemes and by adopting a proactive approach to prevention and ensuring it is a focus for the 'whole system'.

We are pursuing a Full Intake Model which will form part of an enabling adult social care pathway and support the new Care Act obligations by ensuring those that come into the system are supported to remain as independent as possible for as long as possible e.g. requiring less intervention and social care support. This in turn could mean a service user would have no eligible needs or lower level needs for longer and/or would be required to purchase less support that would count towards their funding cap.

Reading's Integration programme and its Better Care Fund proposals in particular, are designed to transform the local approach to care so that our adult social care service becomes more robust and sustainable notwithstanding the challenges faced.

The Enhanced Care Home (BCF02) scheme will enhance the capacity of care home staff to support people with multiple health conditions and complex needs. Taken together, the various elements of the scheme will promote a shift towards more planned and less reactive care, the latter being notoriously more resource intensive.

The Time to Decide (BCF04) scheme will afford patients coming out of hospital a better opportunity to evaluate long term care options. This is expected to reduce the number of permanent admissions to residential care, which are more costly care options than discharge back to a home setting.

In addition to the Better Care Fund investment, the Council is investing substantial amounts (land value alone over £1.5m) outside of the BCF in new extra Care Housing with the first new scheme opening in August/September 2014 and a further scheme now out at OJEU for procurement to ensure that there is adequate provision for the people of Reading.

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

£1.1m has been allocated for the protection of adult social care services

£361k has been allocated in the BCF for the implementation of the Care Act – (in line with our local proportion of the £135m)

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

The implementation of the Care Act in Reading is governed through the Care Act

Programme Board which brings together seven projects to ensure that the new duties arising from the Care Act will be met. Each project is listed below along with a brief description of the main focus for each project.

1) Funding reform
    - Existing policies are being reviewed to ensure they meet Care Act requirements and the systems and processes will change to adapt to new funding cap obligations

2) Assessment, eligibility & care planning
    - The local authority's approach to assessment and support planning for clients and carers is being updated to meet Care Act requirements in terms of a greater emphasis on prevention, whole family approaches and arranging independent advocacy to support assessments, reviews and support planning.

3) Information, advice & advocacy and prevention
    - Existing provision will need to be aligned to meet Care Act obligations and gaps in provision will need to be procured and funded. Key focus areas are the provision of independent advocacy and financial information and advice which are new in the Act.

4) Safeguarding
    - Safeguarding Adults Boards and existing partnership working are formalised in the Care Act and reviews need to be undertaken to ensure existing arrangements are fit for purpose and ensure that Safeguarding is perceived as 'everyone's business'

6) Quality and diversity of services
    - A market position statement is being co-produced with partners to provide the market with a clear steer of commissioning intentions for future years that will meet the requirements of our population

7) Care market failure
    - A protocol is being written to define how we react as a result of a provider failure, how our processes fit with the role of CQC and how we can proactively identify provider issues.

Each project is owned by a Senior Manager and progress is monitored monthly at the Board and highlights are reported to our Health and Social Care Board attended by CEO's from the Local Authority, CCG's and Health partners.

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

A total of £712k from the Better Care Fund will be dedicated to carer specific support:

Delivering carer assessments	£119k p.a.
Providing support packages to eligible carers	£174k p.a.
Universal carer information advice and support service	£136k p.a.
Carers community based breaks services	£88k p.a.
Funding other voluntary and community services providing carer-specific support	£195k p.a.
TOTAL	**£712k p.a.**

This carer specific support will entail the following:

Carers Assessments

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

We have used the 'Lincolnshire model' to estimate the cost of delivering additional carer assessments to meet the local authority's extended duties in this respect from April 2015. The additional assessment costs are expected to be £119k p.a. Any shortfall between 'new burdens' funding and the actual additional cost will be met from the Better Care Fund and the Council's own resources.

Support Packages for Carers Eligible for Adult Social Care

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

Again using the Lincolnshire modelling tool, we estimate that the additional cost of meeting this statutory obligation in Reading will be £174k p.a. from 2015. Any shortfall between 'new burdens' funding and the actual additional cost will be met from the Better Care Fund and the Council's own resources.

Information & Advice for Carers

The Reading CCGs and local authority collectively contribute £136k p.a. towards a carer information advice and support service which is jointly commissioned across Berkshire West (i.e. with neighbouring local authorities and CCGs as additional commissioning

partners). This provides an initial information and contact point for any carer, whether or not eligible for statutory services, and supports carers to connect with further guidance and services relevant to their particular situation or current priorities. The service is designed to prevent carers' own support needs from escalating, and hence to reduce or delay the level of formal care required by those supported by family/unpaid carers.

Carers Community-Based Break Services

Via the mechanism of Section 256 agreements, we have pooled budgets across health and social care in Reading to commission a range of services which support carers to take breaks from caring. Through this arrangement, £46k p.a. is committed to providing clubs where young carers can take a break from caring and connect with other sources of support such as school nurses, counsellors and social workers. A further £20k p.a. is the Reading contribution to another joint health & social care commissioned service across Berkshire West to provide respite for carers of younger people with dementia. An additional £22k p.a. represents the Reading funding into a jointly commissioned community support service for families affected by stroke.

Other Community Support for Carers

The local authority has committed a further £111k p.a. into grant funding carer-specific support delivered by voluntary and community sector partners for 2014-15. This includes a 'Back Me Up' contingency planning service with the issue of a carer's emergency card, an out-of-hours carers emergency contact line, peer support groups for carers who are particularly isolated or who face barriers to accessing other support, and a range of social opportunities which include an element of respite care to enable carers to take a break. The Reading CCGs have similarly committed grant funding of £84k.

Future Aspirations

A Berkshire West Carer Commissioning Forum has been established to oversee the future commissioning and development of carer support across Berkshire West. This is identified as one of the enabling work streams within our integration programme, and is being led by the CCG Director of Joint Commissioning. This Forum will ensure that carer-specific resource identified within the Better Care Fund allocations is used effectively to improve outcomes for carers. The Forum will lead on the development of strategic plans and commissioning arrangements for supporting carers across Berkshire West, and also inform the development of other plans and arrangements which have the potential to improve outcomes for carers. The Berkshire West CCG investment of £120k in twilight nursing, for example, whilst retained within a block contracting arrangement covering wider provision, comes within the remit of the Berkshire West Carer Commissioning Forum to scrutinise.

Our aim is to move towards single pot funding for all carer support across the West of Berkshire and to offer a consistent range of services, particularly to improve the experience of carers supporting others across local authority boundaries.

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

Since the original BCF plan was submitted, a more detailed review has been undertaken in relation to the costs of the Care Act, the need to protection Social Care services and the need use BCF funds on schemes that are focused on promoting independence.

This has resulted in the funding identified to protect adult social cares services and to fund the Care Act costs being reduced by over £200k.

This impact has been considered within the Council's budget planning assumptions. The Council is aware of the level of risks in the economy around both the BCF and the Care Act and is therefore working with partners to ensure that a strong performance management system is in place to manage the financial implications.

b) 7 day services to support discharge

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

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 the provision and 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 including out of ours GP service, night wardens, rapid response and out of ours 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.

A number of our BCF schemes will deliver seven day working, such the scheme to improving access to GP services (BCF05c) which will expand the availability of GP services in the evenings and at weekends. Pilots will commence from October, focussing initially on Saturday mornings, and this service will have both routine and urgent appointments. It is expected that the urgent appointments will alleviate the pressure on urgent care and prevent avoidable admissions. In addition, the availability of GPs at weekends should also facilitate more timely patient discharge. We will be monitoring the patient uptake of these services to understand the impact on patient flow.

Our neighbourhood cluster teams (BCF05b) are multidisciplinary teams of health and social care professionals that will run seven days of the week to ensure that there is the opportunity to provide the right care as and when it is needed to reduce the need for admission into hospital, and facilitate discharge. This will offer a system of care that can respond to escalating need as and when that is needed.

These 7 day schemes will be underpinned by our 7 day health and social care hub (BCF05a), a single point of access to health and social care that will signpost professionals and eventually patients, throughout the whole week.

Practices in South Reading are also using system resilience funding to pilot an evening paediatric clinic over the Winter period. The service to be commissioned from April 2015 will be shaped by the findings of the pilots, national best practice including emerging results from the Prime Minister's Challenge Fund pilots, and a baseline audit of in-hours capacity and utilisation currently being undertaken. The Primary Care Programme Board has a workshop on this issue scheduled in September, supported by PCC which will look to further define our approach.

As such we are making strong progress to deliver clinical standards for seven day services. There are some risks associated with this, captured in the risk log – primarily being that 7 day working is contingent on the participation of GPs and recruitment into these seven day services. We are engaging with GPs to ensure they participate, and we will be closely monitoring GP uptake. In addition we envisage that our plans to co-commission of primary care this will facilitate the move to 7 day services.

c) Data sharing

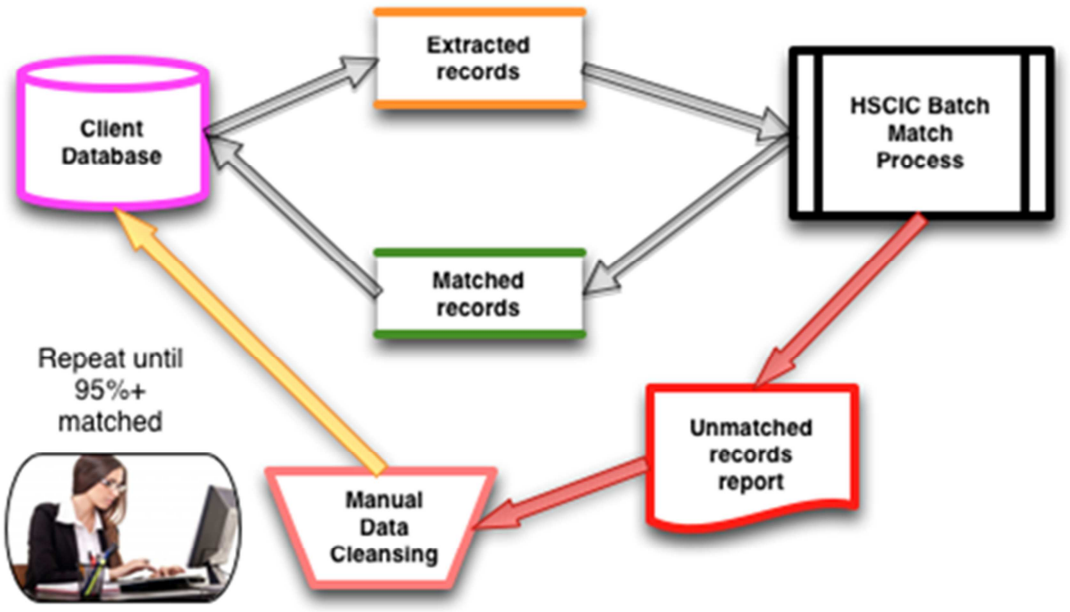
i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

The NHS number as the primary identifier for correspondence will be implemented by April 2015.

A project group has been established to oversee the implementation of NHS Number throughout the Berkshire West system, led by Reading Borough Council, reporting to the Berkshire West Interoperability Programme Board. This group will oversee the delivery of the plan and milestones. The key actions in place for primary identifier:

1. Royal Berkshire Foundation Trust, Berkshire healthcare Foundation Trust to ensure all patient communication to include NHS Number by April 2015
2. Reading, Wokingham and West Berkshire Local Authority Board adopt the process of Batch Matching through Demographic Batching System, commencing in October 2014, as demonstrated below

This will be critical to the success of our system wide Connecting Care BCF scheme (BCF03), which seeks to ensure health and social care professionals have access to accurate and timely information regarding patients by facilitating the sharing of information. IT interoperability is critical to improving the quality and experience of care that patients receive, removing silos to ensure that health professionals have access to comprehensive records, and that patients only have to tell their story once.



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

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

Through the Berkshire West Interoperability Programme Board an Application Programming Interface (API) is being pursued, as part of the Better Care Fund Connecting Care scheme (BCF03) (for more information see Annex 1). This scheme is designed to remove the IT silos that exist in health and social care and has the ultimate aim of ensuring that patient information and data will be accessible to all who need them.

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

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

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

iii) Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit

requirements and professional clinical practice and in particular requirements set out in Caldicott 2.

There is a firm commitment to ensuring appropriate IG controls are in place.

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

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

1. Protection against unauthorised access
2. Availability of information to authorised users when needed e.g. for the benefit of the service user or patient
3. Maintaining confidentiality of information
4. Integrity of information through protection from unauthorised modification.
5. 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 Information Governance framework across the organisations by October 2014 through the establishment of joint Informatics governance group. This will build on the Berkshire NHS "Overarching Policy for sharing personal information Between Organisations 2010."

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

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

2,977* Reading patients have been identified as being at high risk of hospital admission in 2014/15. The criteria defined within the national Directed Enhanced Service for Unplanned Admissions, the top 2% of registered patients aged over 18 and at the highest risk of an unplanned admission, has been used to identify these patients.

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

The success of using this tool is evidence through work conducted in 2012/13. At this time patients lower down the risk pyramid were identified by recent presentations at A&E

alongside local intelligence from health and social care services. This was known locally as our care coordination project which was designed to minimise the risk of increased resource use by these patients and to reduce hospital unplanned admissions. Developing this multidisciplinary approach enabled us to proactively identify management strategies to avoid increased use of resources and was a valuable first step to providing more integrated care co-ordination across health and social care. Evaluation of a small cohort of patients (26) in Reading has shown promising early results, but will require further analysis as more data becomes available. To date this group of patients, with care plans in place have a reduced likelihood (risk score) of an unplanned admission, compared to the normal public, but this needs to be more fully assessed to measure the impact this translates into for non- elective admissions, A&E attendances and outpatient visits. This exercise will be completed in early 2015.

**Includes 50% of N & W Reading high risk population. The remaining 50% will be included in West Berkshire BCF due to cross boundary issues.*

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

Locally, outside of the BCF programme, we have invested our £5/head funding for GP's as the Accountable Health Professional for the over 75 year olds within practices to further drive and support this work. This will ensure all care plans are uploaded onto a central repository, for access by multiple organisations, provide further support in the form of administrators and health professionals for the delivery of the admissions avoidance DES and a commitment to develop 50% of care plans following a face to face consultation for over 75 year olds who are also in the top 2% risk category.

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

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

This dedicated resource should provide focus and continuity of care for patients and their carers/families and provide them with assurance that their concerns and issues can easily be resolved with minimal fuss. They will facilitate navigation from the Practice reception service to the right person who can take immediate action when required, and

support the GP in prioritising responses, to ensure that any problems are dealt with appropriately. They will also ensure that care for the patient is coordinated across all health and social agencies involved in the care of the patient.

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

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

We currently have 632* individuals at high risk with joint care plans in place. This is the case load associated with the "specialist community nursing teams" i.e Community Matrons, Heart Failure, and Respiratory teams. This therefore represents 16.5% of the total high risk stratified population at risk of an unplanned admission (The 2% on the risk registers).

In addition we also have a further 348* patients, lower down on the risk triangle with joint care plans in place as a result of work carried out in 2013/14 through our case co-ordination project and the National enhanced service for risk stratification.

In addition care plans will also be in place for those patients on the community nursing case load who are not in the high risk category.

**Includes 50% of N & W Reading high risk population. The remaining 50% will be included in West Berkshire BCF due to cross boundary issues.*

8) ENGAGEMENT

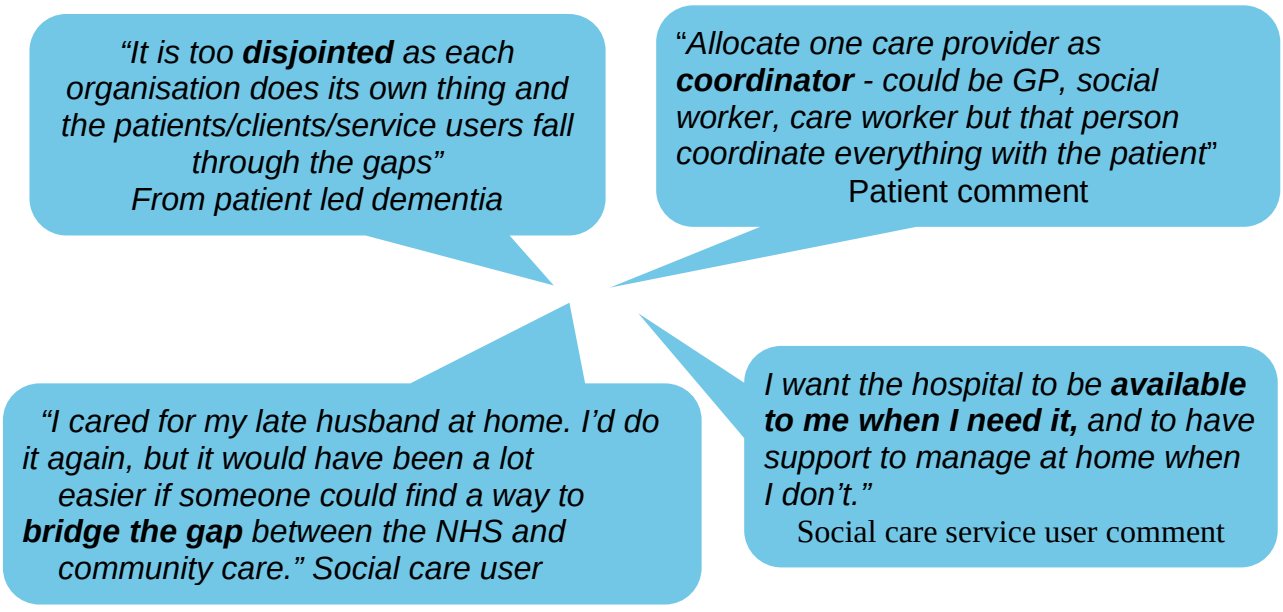
a) Patient, service user and public engagement

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

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

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. The borough-wide 'Let's Talk Health' engagement programme, led by the local authority and taken through a range of community and social care user forums, demonstrated that maintaining independence and having choice and control over how they receive care is clearly very important to the people of Reading.

Patient/service user views from various forums call for patient centred, joined up care:



The communication and engagement strategy we have developed to support our Better Care Fund proposals recognises patients, service users and members of the public as key partners in transforming the local care system. Over the past year, different elements of the integration proposals described in this submission have been discussed at a range of community forums across Reading. This includes patient or user led groups (the Physical Disability and Sensory Needs Network, the Learning Disability Carers Forum and the South Reading Patient Voice), GP-practice based Patient Participation

Groups, and also the Older People's Working Group, the Access and Disabilities Working Group, the Learning Disability Partnership, the Disability Strategy Group and the Carers Steering Group. Feedback from these groups has directly informed the development of our plans to date; and links will be maintained between these standing forums and the various integration projects.

In addition Healthwatch Reading is a member of Reading's Integration Board and thus brings a patient/ service user perspective to our oversight of health and social care integration. Our local Healthwatch has recently carried out research into the patient experience of hospital discharge and case co-ordination. These findings have particularly clarified the issues to be addressed from a patient and family perspective through our BCF schemes.

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

The Reading CCGs are commissioning a community roadshow to run for seven days in the autumn at a busy town centre shopping mall. Key messages will include support from health, local authority and voluntary sector providers to maintain healthy lifestyles (e.g. exercise); services to prevent ill-health (e.g. flu jabs); where to get advice to prevent health deterioration (e.g. NHS 111, pharmacies) and local plans for health and social care integration. CCG representatives will be sharing display space with up to four other public sector bodies over the course of the week, most probably police, local authority and housing. In addition to raising awareness, the public will be engaged through surveys or questionnaires. It is anticipated that there will be around 1,000 contacts with members of the public over the course of the campaign.

Adopting this approach represents a commissioner/provider response to what patients and service users have told us about how they would like to see public engagement developed. Patient engagement groups are in favour of taking messages to the public, rather than expecting the public to come to us. However, alongside this, there will continue to be a need for focus group style events (e.g. Call to Action) which gathers more in-depth information and feedback around service redesign projects or strategy.

We have launched a patient and service user panel to recruit people who will bring a user perspective into specific service re-design discussions across our integration programme. This began with the development of the Frail Elderly Pathway where a family carer was a member of the planning group. As particular projects evolve, patients, service users and family carers will be involved in bespoke ways which fit the requirements of the projects at different phases and also the capacity of individuals. We are keen to ensure the patient and service user panel is accessible to anyone who is willing to share their expertise by experience, and not just those able to commit to regular or lengthy

meetings. Members of the panel will also have the opportunity to be involved in virtual forums, reader panels, and mystery shopping via email or telephone. The panel will co-develop its work plan with health and social care representatives. This will be taken forward following a care and support conference on 8th September, which will bring patient/user panel members together with care providers from all sectors, and has health and social care integration as a key theme throughout the sessions.

b) Service provider engagement

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

i) NHS Foundation Trusts and NHS Trusts

We recognise the need to work across health and social care boundaries in order to move towards our vision of fully integrated health and social care for the residents of 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 main local NHS Providers Berkshire Healthcare Foundation Trust and Royal Berkshire Hospital Foundation Trust have been engaged in the development of all the schemes, and have representation at both the Reading Integration Steering group, and are also members of the Berkshire West Partnership Board. Both clinicians and managers from the Trusts have played into the development of business cases and models of care delivery.

Developing and refining our Better Care Fund projects will continue to be undertaken via whole system workshops including key stakeholders. This has been successful in terms of developing the scope of the Time To Decide service and the extension to intermediate care.

Additionally, representation of the two main NHS providers on the Reading Integration Board and the Berkshire West Partnership Board ensures that both managers and

clinicians from the trusts have played into the development of the business cases and models of care delivery.

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

ii) Primary care providers

Primary care providers have been engaged in the development of the BCF plan through discussion in GP Councils. These discussions were informed by feedback from the GP lead who attends the Locality Integration Steering Group which takes place every six weeks, at which the BCF plan is discussed.

Likewise each GP Council has a representative on the Primary Care Programme Board (which meets every four weeks), through which the primary care aspects of the BCF plan, such as 7 day working (BCF05c), and the Care Homes project (BCF02) have been developed.

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

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

The Adult Social Care Service along with 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, have been engaged at various stages in discussing the detail underpinning this submission.

Invitations have been issued to social care and third sector providers to join a reference group to influence the development of integrated care in Reading.

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.

We have a range of local provider forums at which we have started to present this plan and secure wider provider involvement in its evolution. A meeting of Healthwatch's Voices Forum for third sector care partners in June was particularly helpful in developing understanding of the role voluntary and community groups could play within neighbourhood based seven day integrated care teams.

We will be hosting a conference on 8th September which brings these various provider forums together for the first time to take a whole systems view of moving forward in a way which promotes integrated care. This conference will be an opportunity to develop provider understanding across the various projects which make up Reading's Integration Programme, and engage various providers within the workstreams they can contribute to most effectively.

c) Implications for acute providers

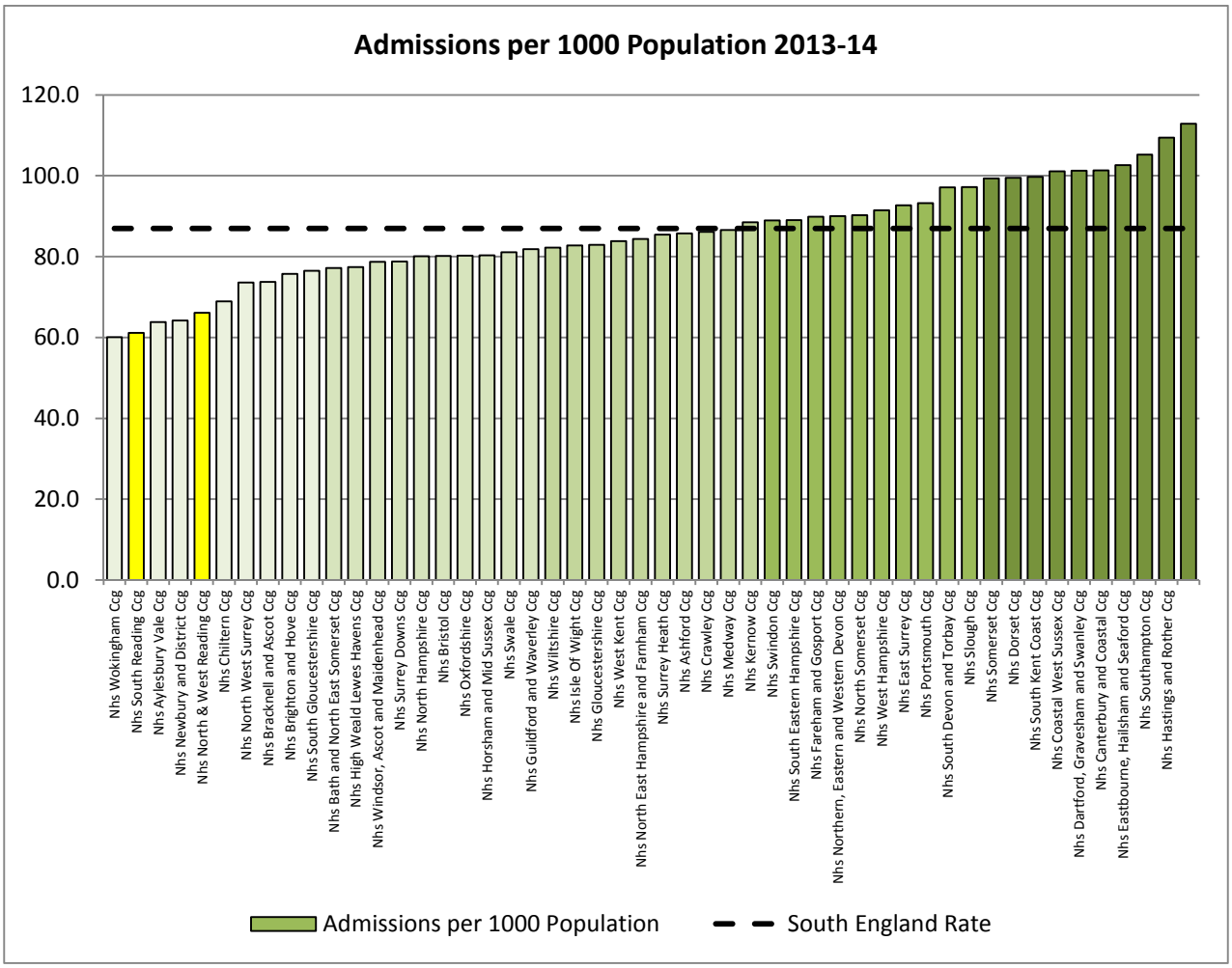
Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

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

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

Extensive work has been done to model the impact of the schemes on non-elective admissions. As a result of the plans in place, non-elective admissions will reduce by 2.8% in 2015/16 vs. 2014/15.

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



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

The H&WB has forecast 4% growth in non-elective admissions for 2015/16 based on population growth and population change relating to an ageing population. After extensive modelling of the schemes, ensuring that there is no double counting, these results in an expected net reduction of 2.8% in non-elective admissions in 2015/16 compared with 2014/15 forecast outturn.

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

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

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