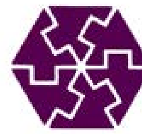
North and West Reading Clinical Commissioning Group
South Reading Clinical Commissioning Group



Reading
Borough Council
Working better with you

Our Vision:
A Healthier Reading

Better Care Fund Plan 2016/17

Our Local Vision

"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"

Contents

Introduction 3
Evidence base: The Challenges and the Case for Change 4
Challenge 1: An Increasing Population (Particularly in those over the age of 65) 4
Challenge 2: Growing Non Elective Admissions 4
Challenge 3: Increasing A&E attendances 7
Challenge 4: Delayed Transfers of Care 7
Challenge 5: Increasing Demand for Adult Social Care Community & Care Home Packages 11
Challenge 6: Increased Demand for Planned Care Services 11
Challenge 7: Inequity in Access to Service 7 Days a Week 11
2015/16 Better Care Fund Scheme Review 13
A) BCF Scheme 04: Discharge to Assess 14
B) BCF Scheme 05b Neighbourhood Clusters Initiatives 14
C) BCF Scheme 01 & 02: Hospital @ Home & Care Homes 16
D) BCF Scheme 03: Connected Care 17
E) BCF Scheme 5c: 7 Day Working 18
2016/17 Revised Better Care Fund Plan: What has changed? 21
Supporting Metrics and Targets for 2016/17 24
Programme Governance 28
2016/17 Integration & Beyond: Our plans for New Models of Care and Sustainability 30
Berkshire West Accountable Care System (ACS) 30
References 31
Annex 31

Introduction

In line with our local health and Wellbeing Strategy, by 2019 our vision is for Reading residents to be empowered to live well for longer at home. In order for this to become a reality, it will require health and social care to work together, with families and carers as experts partners. (See Better Care Fund Plan 2014 page 8 for further detail on patient outcomes.)

Since we wrote our Better Care Fund Plan in 2014, the population of Reading continues to grow. Census data from 2001 and 2011 indicate an increase of 11,300 people in the population of Reading borough in that time period and annual estimates indicated continued population growth. There has been an 11% increase in the past 10 years to the most recently available population figure of 160,825[1] in 2014. There has been an increase in the population across all age bands with the greatest increase seen in the 0-5 year old population (43% increases in 10 years). Recent population projections show that this increase in overall population is likely to continue to increase over the next 10 years though the increase is now no longer predicted to be greatest in the 0-5 year old population. However, it should be noted that these projections do not take into account planned housing developments in the area with these and other developments affecting the local area such as Crossrail being likely to attract new residents. We continue to see extremes of wealth and although poverty and deprivation have improved in some areas, there are areas of Reading that have seen further deterioration in their level of deprivation when compared to the England average. We have, however, also made some good progress in the last year:

- In North & West Reading , life expectancy for men has improved
- A reduction in the number of adults smoking
- A reduction in the number of under 16 year olds who are obese
- Reduced inactivity in adults
- Hip fractures have been reducing, in the main, over recent years
- Under 75 mortality from cancers considered preventable continues to reduce
- In South Reading, there has been a reduction in Alcohol binge drinking and alcohol related hospital admissions and the number of people under 75 years dying from liver disease continues to fall.
- Fewer pre-school children are estimated to have a mental health disorder
- Increasing numbers assessed and cared for in their own home. With declining numbers in residential care
- Increasing satisfaction with social care support , helping people to achieve positive outcomes
- A 32% reduction in delayed discharges from hospital

There is still a great deal of work to be done and with an increasing financial challenge within our economy coupled with an increasing demand for services, the drive towards integration and efficiencies are stronger than ever.

[1] This is the Reading borough population only. Reading CCGs and GPs cover a broader catchment area thus the higher population figure used elsewhere within this document and the BCF Narrative template.

Evidence base: The Challenges and the Case for Change

The seven key areas of challenge as outlined in our Better Care Fund submission in 2014 (page 16) remain the main drivers for change in our local economy:

- ✓ 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 (particularly in the under 5's)
- ✓ 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 (elective) care
- ✓ Improving but remaining inequality of access to services across the "whole system: the whole week"

In addition the pressure has heightened in recent months with all organisations within our economy, including acute & community providers, CCGs, ambulance trust and the local Authority experiencing significant financial challenge.

Challenge 1: An Increasing Population (Particularly in those over the age of 65)

A significant amount of successful work has taken place in relation to our frail elderly pathway during 2015/16. Life expectancy, at aged 65, for men in Reading is 18.2 years, for women it is 21.0 years (PHOF, 2012-14 data). We have mapped the spend in this population cohort, establishing that we spend £187m across health and social care in Berkshire West, which represents 28% of spend from our total resources on 2% of our population. Potential new models of care are now being considered but it is clear that our largest opportunity to ensure better value for money and reduce overall spend in this group of the population needs to include an increased focus on prevention and targeting frailty in the absence of any long term condition. By focusing on prevention and well-being, we will reduce the number of elderly people escalating to a higher level of need.

The frail elderly programme sits outside of the Reading BCF but is a major piece of work within our integration agenda. Our neighbourhood cluster schemes identified areas of success and have allowed us to review our models which will be adapted during 16/17 to maximise the benefit in supporting people to live well and remain in their own homes for as long as possible.

Challenge 2: Growing Non Elective Admissions

The two Reading CCGs remain in the lowest 5 CCGs in England for non-elective admission numbers. This makes further reduction to non-elective activity extremely challenging and growth in non-electives, with a growing and ageing population, is almost inevitable.

Significant programmes of work are already in place to help manage the non-elective demand and sit outside of the Better care Fund. However, during 2015/16 we have seen a 14.4% growth for South Reading and 11.4% for North & West Reading in non-elective admissions against a plan of 3.3% (based on raw SUS data i.e. before any data challenge).

	North & West Reading CCG	South Reading CCG
Base line total NEA activity 14/15	6409	7765
Actual 15/16	7142	8885
% growth in NEA	11.4%	14.4%

This has also resulted in subsequent pressure on adult social care provision. As is illustrated below under rising A & E attendances, we have seen a high conversion rate to admission alongside subsequently high referral to adult social care.

An in-depth analysis is currently underway to identify the causes of the rise in non-electives but headline findings show that a higher than initially anticipated proportion of activity and spend is within the 40-64 years age brackets, as demonstrated on the data extract below:

Age Group	BW Registered Population as at January 2016	% of BW Registered Population as at January 2016	NEL Spells	% NEL spells	NEL Spend	% NEL spend
0 - 18	119,893	23%	4,657	17%	£5,182,571	9%
19 - 39	156,468	30%	4,473	17%	£6,033,364	11%
40 - 64	171,767	33%	6,471	24%	£12,576,475	23%
65 - 74	43,822	8%	3,272	12%	£8,598,109	16%
75+	35,062	7%	8,177	30%	£22,472,636	41%

The outputs of this further analysis will help further inform service planning and provide an evidence base for further work required by system partners outside the BCF to support a reduction in these numbers. In order to meet our Better Care Fund objectives of reducing non-elective admissions and delayed transfers of care we need better understanding of:

- NELs and A&E attendances by age band <18, 19-64, >65, >75
- A breakdown of type sub-chapters by age band
- A breakdown of spend by age band
- Associated pressure of rising non electives on adult social care demands

The BCF template submitted on 03 May 2016, alongside this narrative, pulls through the non-elective activity plan from the CCG operating plan template (18TH April submission data) by apportioning the figures to the appropriate health and well-being board. This was populated by NHSE, using a baseline figure for non-elective actual activity for the CCGs. The CCG then applied a factor of growth to this plan based on a national tool called the Indicative Hospital Activity Model which gives the CCGs a guide of what growth levels should be expected. **This equated to 2.2% across the 4 CCGs in Berkshire West.** It is noted however that the rate may be further reviewed based on the outcome of contractual negotiations with the acute providers.

The CCG has not applied the transformational change projects (QIPPs) that are expected to deliver reductions in non-elective admissions. The reductions within the BCF to the NEL expected plan are made up of the following: i) Care Homes scheme (Reading Share of this across Berkshire West Service) and ii) NEL reductions from the local schemes , Discharge to Assess and the full intake model.

To date, within the Better care Fund, specific work carried out, particularly focusing on care homes (BCF Scheme 02) during 2015/16 has delivered training and education, has seen a reduction of 72 (20%) non elective admissions (from the targeted care homes) when compared to baseline at 2014/15, but which is lower than the original plan for a 50% reduction for this scheme. There has however been a reduction in 999 calls with a 48% conversion rate to non-elective admission, but with 70% of the short stay admissions identified as could potentially have been avoidable. There has been a review of full medication carried out on 815 (34%) of patients in 25 (48%) of our care homes with a saving of £106,997.

A full review of the scheme has been carried out and our learning has allowed us to refocus this scheme during 2015/16 and into 2016/17 by linking it with the Hospital at Home programme (BCF Scheme 01) to establish a new service providing rapid response and assessment in care homes through a dedicated geriatrician led team. Our intention would be to look to expand this to support all residents in the community to further support admission avoidance. This has started to produce early positive results and outcomes to date have included a 23% (14) reduction in non-elective admissions in its first phase of operation covering 15 care homes. Anecdotally all calls to the new service were appropriate and would have resulted in a call to 999 and an A &E attendance. We therefore plan to build on our successes and further enhance and expand during 16/17 within the refreshed BCF. We plan to further focus on improving skills and knowledge within care homes helping them to better support individuals in times of crisis and in developing synergy with the Local Authority Quality Assurance and Safeguarding systems. We will recruit a second care home pharmacist to expand the medication reviews across all care homes and to all residents. We plan to focus on avoidable admissions due to respiratory disorders, urinary tract infections and trauma. Combined these disorders account for 45% of hospital admissions year on year within our care homes across Berkshire West.

The main aims of the refreshed scheme for 16/17 will be to:

- Reduce avoidable admissions or readmissions or A &E attendances from care homes.
- Reduce non-emergency ambulance dispositions and conveyances from care homes.
- Reduce 999 calls from care homes.
- Reduce the number of on the day unplanned visits by GPs to care homes.
- Increase the number of patients going back to care homes on the same day after attendance at A&E.
- Increase use of the single point of access hub (BCF 05a) to access timely community services for admission avoidance for those in care homes and in supported living accommodation.
- Increased use of near patient testing and telehealth to support delivery of care within the home care setting.
- Improve access to a dedicated 24/7 support for end of life care.
- Establish MDT in reach teams within care homes according to need, providing training, urgent clinical care and regular medication and care panning reviews.
- Proactive support to ensure they are able to work within the Care Quality Commission (CQC) and safeguarding requirements outlined within their contract with Local Authorities (LA)
- Achieve greater resilience and consistency to care home performance monitoring and review across the care quality system, through improved health and social care collaboration

- Proactive targeting by joint health and social care MDT teams, to homes where quality, safeguarding, elevated non elective and A & E /NHS 111 activity or calls to primary care are higher than anticipated.

As part of the 2016/17 project a programme of work will be established for 2017/18 - 2020/21 continuing on the themes already established that ensure Health and Social Care together meet the objectives set out in the supporting documents for those people in our society that are reliant on care and extra support to help them lead better more comfortable lives. This will include looking outside the care home setting at care options delivered within an individual's home, supported living and where required use of step up and down facilities.

Challenge 3: Increasing A&E attendances

High levels of A & E attendances have remained a challenge within 15/16. More people are been recorded has having injuries due to falls (this will predominantly be older people) however hip fractures have been reducing, in the main, over recent years (though rates have increased for men and reduced for women). In addition we are seeing higher conversion rates, with nearly 1/3 of attendees requiring a non-elective admission. Many of these are short stay but many are also more complex presentations, which in turn impacts on lengths of stay and increased difficulties for timely discharge.

The Berkshire West system has a strong track record of effective partnership working with all organisations across health and social care understanding their contribution to the A&E standard and the Urgent Care Programme Board takes an oversight and scrutiny role in relation to achievement of the target. Admission avoidance services are robust with Rapid Response teams mobilising with a 2 hour response, additional investment in night sitting services in 15-16 and of note our Ambulance service (SCAS) having one of the highest non conveyance rates in the country. However, we will continue to review capacity within the service on a monthly basis, to ensure it addresses any increased demand. Whilst recognising that there is further work to do on improving delayed transfers of care performance, against a background of increasing non elective activity, the Berkshire Healthcare Foundation Trust (BHFT) Integrated Discharge Team has been successful in delivering the 'pull' model of discharge into community services (as per ECIST recommendations). Health have also been working in partnership with Local Authorities to deliver new integrated models of care to support patients requiring onward care post-acute discharge. The approach varies in each locality but all approaches are built on the principles of referral to an integrated health and social care team via a Single Point of Access, discharge to assess and a full intake model. All these initiatives are specifically aimed at improving flow through the hospital, supporting achievement of the A&E target, which acts as a barometer of patient flow. Other models of delivery will also be considered by the CCG during 16/17 to further support reduced admissions.

Despite the rise in A&E activity levels performance against the 4 hour standard has been strong through the majority of 15-16 with the target achieved in quarters 1, 2 and 3. Performance has been challenged in quarter 4 but the system remains one of the best performing in the South Central region.

Challenge 4: Delayed Transfers of Care

We welcome the Better Care planning requirement to agree a local action plan to reduce delayed transfers of care (DToCs) and improve flow and took this opportunity to work with our partner CCGs and LAs in Berkshire West to agree a system wide approach to the development of our local action plans.

The Berkshire West urgent care system has a history of strong effective partnership working. Managing the "Fit List" and DTOC is an integral part of its work so partners agreed that the Berkshire West Urgent Care Programme Board should have an oversight role in the development of the action plan and the monitoring of its impact.

Delayed Transfers of Care (DToCs) are effectively people stranded in the wrong place and behind each number is a personal story. By working in partnership to reduce DToCs we will help avoid the situation whereby people remain in an acute hospital setting when they no longer need acute care.

10 days in hospital is equivalent to 10 years ageing if you are over 80 years old

AND

A patient is defined as 'safe to discharge' when:

- A clinical decision has been made that the patient no longer needs acute care AND
- An MDT decision has been made that the patients is ready for transfer AND
- The patient is safe to discharge.

Situation Analysis

The first part of this work involved an analysis of current DTOC performance across the three localities as reported for BCF purposes and also an analysis of current "health performance" in relation to the national ambition to have no more than 3.5% bed days lost as proportion of total occupied bed days at acute trust provider level each month. This highlighted the need to ensure that all partners understood these differences when considering what a proportionate plan to improve DTOC performance should be.

Royal Berkshire NHS FT *(Oct 2014 to Sep 2015)*

Reason for Delay	NHS Patients	NHS DTOC Days	Social Care Patients	Social Care DTOC Days
A Completion Assessment	2	26	13	304
B Public Funding	0	0	0	26
C Further Non Acute Nhs	99	3,667	0	0
Di Residential Home	8	272	21	741
Dii Nursing Home	33	1,232	34	1,248
E Care Package In Home	0	11	56	1,908
F Community Equip Adapt	1	30	1	44
G Patient Family Choice	19	711	1	8
H Disputes	75	2,570	1	19
I Housing	4	131	0	0
Grand Total	**241**	**8,650**	**127**	**4,298**

Highest reasons for delay are further NHS care, nursing homes and disputes.

Berkshire Healthcare NHS FT ***(Oct 2014 to Sep 2015)***

Reason for Delay	NHS Patients	NHS DTOC Days	Social Care Patients	Social Care DTOC Days
A Completion Assessment	2	47	6	142
B Public Funding	2	9	8	83
C Further Non Acute Nhs	28	1,004	0	0
Di Residential Home	5	204	34	1,044
Dii Nursing Home	16	537	31	957
E Care Package In Home	13	395	33	1,057
F Community Equip Adapt	2	44	1	62
G Patient Family Choice	7	181	9	250
H Disputes	0	0	0	9
I Housing	2	75	0	0
Grand Total	**77**	**2,496**	**122**	**3,604**

The highest reasons for delay are further NHS care, residential homes and care packages in the community.

Performance between 2014/15 and 2015/16

	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Berkshire West delayed days					3,239	3,821	3,725	2,878	3,425	2,829	3,026
Annual moving average					3,239	3,530	3,595	3,416	3,462	3,214	3,040
								15/16 Change:	**-9.4%**		

	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Reading delayed days	865	806	1,040	1,202	901	1,444	1,879	1,035	1,217	959	1,005
Annual moving average				978	987	1,147	1,357	1,315	1,394	1,273	1,054
				14/15 Change:	**34.4%**			***15/16 Change:***	**-19.4%**		

	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
West Berkshire delayed days					1,099	1,061	1,028	951	1,163	923	1,052
Annual moving average					1,099	1,080	1,063	1,035	1,051	1,016	1,022
								15/16 Change:	**1.1%**		

	Q1 13/14	Q2 13/14	Q3 13/14	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
okingham Berkshire delayed days					1,239	1,316	818	892	1,045	947	969
Annual moving average					1,239	1,278	1,124	1,066	1,018	926	963
								15/16 Change:	**-7.4%**		

Across the 3 localities there has been significant improvement for Reading (19.4% improvement) and Wokingham (7.4% improvement) with West Berkshire remaining almost the same. These significant improvements in 2015-16 will mean that further improvement in 2016-17 will require even more effort and significant transformation.

Royal Berkshire NHS Foundation Trust Delays 2015

Delay Transfer of Care		*Beds:*	627			
Month	**Reading**	**West Berks**	**Wokingham**	**Oxford**	**Other**	**Total**
Jan-15	202	93	105	196	174	**770**
Feb-15	185	154	169	153	84	**745**
Mar-15	250	113	160	189	135	**847**
Apr-15	181	148	111	249	87	**776**
May-15	320	99	190	227	75	**911**
Jun-15	315	247	304	127	78	**1,071**
Jul-15	219	136	166	173	59	**753**
Aug-15	189	31	119	214	132	**685**
Sep-15	217	75	173	158	204	**827**
Oct-15	195	117	154	147	184	**797**
Nov-15	216	250	142	229	91	**928**
Dec-15	166	173	205	339	50	**933**
Annual Total	**2655**	**1636**	**1998**	**2401**	**1353**	**10043**
Share Proportion	26.4%	16.3%	19.9%	23.9%	13.5%	

Oxfordshire and Reading are the largest contributors to delayed days at the Royal Berkshire Hospital. West Berkshire, Wokingham and other localities make up about half of the remaining delayed days. The overall delayed day percentage is 4.4% which is above the 3.5% national target.

Berkshire Healthcare NHS FT Delayed Transfers of Care 2015

Delay Transfer of Care		*Total Beds:*	140	
Beds per Locality/Site	35	*59*	46	
Month	**Reading**	**West Berks**	**Wokingham**	**Total**
Jan-15	174	39	178	**391**
Feb-15	115	5	73	**193**
Mar-15	96	35	113	**244**
Apr-15	99	20	70	**189**
May-15	109	62	108	**279**
Jun-15	188	65	208	**461**
Jul-15				
Aug-15	122	9	186	**317**
Sep-15	142	16	193	**351**
Oct-15	87	19	91	**197**
Nov-15	72	32	123	**227**
Dec-15	149	29	62	**240**
Annual Total*	**1353**	**331**	**1405**	**3089**
Share Proportion	43.8%	10.7%	45.5%	
**Annual total only includes 11 months - original data missing July 2015 data*				

Data only includes beds commissioned by Berkshire West CCGs (Oakwood Unit Reading, West Berkshire Community Hospital and Wokingham Hospital).

Reading and Wokingham together contribute approximately 90% of the delays at Berkshire Healthcare sites. In terms of number of delayed days, BHFT has almost 30% of delayed days as RBFT indicating that 2016-17 schemes will also need to target discharge planning in community sites.

Overall BHFT is operating at 6.6%, with Reading and Wokingham operating at over that average.

Annually the percentage by site is as follows;

- Reading – 11.5%
- Wokingham – 9.1%
- West Berkshire – 1.7%

Challenge 5: Increasing Demand for Adult Social Care Community & Care Home Packages

Adult social care costs during 2015/16 have increased, resulting in significant cost pressures within Reading Borough Council. Reading also has a high level of placements into residential care and has seen escalating demand for therapy services. Additional home care packages have also placed further unsustainable demand on the local authority. However, our Better Care Fund Scheme 04 "Discharge to Assess" has played a part in helping address this demand, but has in turn consumed more local authority resources than originally planned, at a rate which is unsustainable. We plan during 2016/17 to further invest and expand this service building to the successes seen to date.

During 2015/16 we have seen the number of permanent admissions to care from April to December 2015 decreased by 57 admissions from 2014. However, Reading Borough Council remains outliers with higher rates of residential placements.

Challenge 6: Increased Demand for Planned Care Services

Year on year we have only seen a small increase in demand for planned care services, 0.4% growth across Berkshire West providers. Although elective care is outside the scope of the BCF it is important to ensure the balance between elective and non- elective work is managed across the system. High levels of non-elective demand, combined with Delayed transfers of care have the potential to reduce capacity to carry out planned procedures. Clearly a balance is important and improvements in DTOC and reduction in NEL through the better care fund schemes and other initiatives will help free important capacity to carry out planned work, which in turn can reduce /address the burden of long term morbidity.

Challenge 7: Inequity in Access to Service 7 Days a Week

During 2015/16, (BCF 05c) we increased service provision within our GP practices to provide routine care in the evenings and on Saturday mornings. In addition pre-bookable resilience appointments are available at peak times over the winter period to support the reduction in A & E attendees. 97% (28) of our eligible GP practices in the two Reading CCGs have offered these extend services since Sept 2015. Further consideration now needs to be given to provide enhanced access cover for the remaining 3% and to consider extending to Sundays.

Within social care and across our providers, we have worked to identify and realign those services seen as essential to provide a robust whole system: whole week approach. This has included a Reading Borough Council Social Worker presence in the hospital at weekends, funded from resilience monies and increased Occupational Therapy time to ensure assessments can be carried out in a timely way over 7 days. We continue to focus on discharge planning and offering access to social work support for relatives considering care home placements, including individuals who will be funding their own care. We continue to monitor progress and identify gaps in service provision that impact on delayed transfers of care or increase pressures during Monday to Friday. Our connected care and integrated hub schemes (BCF05a & BCF03) continue to be important enablers in allowing care to be provided seamlessly and consistently throughout the whole week.

The Local Authority has a duty to provide an Approved Mental Health Practitioner (AMHP) service to its population. Over a 24 hour period this is covered across the Community Mental Health Team (Monday – Friday, 9-5) and by the Emergency Duty Service run by Bracknell Forest Council who run their service from 5pm – 9 am weekdays and throughout the weekend. This does create some challenges in terms of work not being started and delayed until the next ‘shift’ which lends to a delay in the assessment process for individuals.

We are in the process of reviewing the AMHP service to ensure that we can provide a seamless and timely offer to people with mental health needs who required an AMHP assessment.

This work commenced in March 2016 and is expected to be concluded by June 2016.

SDIPs are in place within the acute and community/mental health provider contract around 7 day working for 16/17.

See page 15 of this narrative for further detail on our plans to develop 7 day working for 16/17.

2015/16 Better Care Fund Scheme Review

A workshop to reflect on the Better Care Fund (BCF) progress over 2015/16 and to evaluate the local Reading BCF schemes was held in Dec 2015. We utilised the national self-assessment toolkit as an opportunity to critique existing schemes and to help inform our plans for 16/.17. This review workshop had representation from key stakeholders across health, social care, Healthwatch Reading, Berkshire Healthcare Foundation trust, Royal Berkshire Hospital and Reading Voluntary Action.

Our key findings were:

- Although 2015/16 has seen significant progress towards improving integration , much more is still required to be done to fully ensure we are working as efficiently as possible across the whole system , involving all key stakeholders
- Many schemes highlight the potential to become more fully integrated and we have been able to demonstrate varying degrees of integration within our existing projects along with some important next steps to build on learning this year.
- We identified across all schemes the need to improve and better define outcomes allowing more meaningful data collection
- It was identified that there was a need to urgently review the resources available from a workforce perspective to ensure adequate support is available to drive projects forward more efficiently in 16/17.
- We identified the importance of co-production of schemes with clearly defined shared aims and outcomes
- It was evident that we need to improve collection of patient experience feedback which is both consistent and informs future project/service developments.
- We recognised the complexity of the governance arrangements at both local and Berkshire West level, with some projects appearing to be outside of local control.
- Scheme accountability requires further definition and clarification if we are to be more successful in 16/17
- Further clarification is sought to define existing core resources and how these fit with and local scheme requirements
- Duplication in commissioning arrangements could be further refined.
- We reaffirmation the ultimate aims of the BCF to reduce non elective admissions and reduced delayed transfers of care.
- We need to increase prevention, maximise independence and self-management within our population, as a means of helping contain future costs.

A) BCF Scheme 04: Discharge to Assess

All members present supported the carry forward, with modifications and improvements, into the BCF for 16/17 of the most successful of our two local work streams, the "Discharge To Assess" scheme.

This Scheme consists of **two elements:**

1. The Full Intake Model element aims to increase community reablement team capacity offering admission avoidance, reablement and support to the "discharge to assess bed base".

2. The "Discharge to Asses" service consisted initially of 10 beds in the Willows residential home. A further 2 beds were funded in year , following identification of a gap in service provision and increasing demand, specifically for older people with mental health including dementia at a cost to RBC outside of the scope of the original BCF)

The total cost of these services provided jointly by RBC and BFHT is currently £854k p.a. (£456k for Discharge to Assess and £398k for Full Intake).

The Full intake model element achieved the highest score of all the schemes reviewed, closely followed by the Discharge to Assess bed based element.

The lowest individual scores within the scoring matrix for both reflected the need for improved patient/user satisfaction assessments. It is planned to introduce the Friends and family test to this service for 16/17. Both elements of this scheme, on reflection, had delivered and exceeded against the intended outcomes, reducing delayed transfers of care and length of stay in an acute hospital. This however, now needs to be refreshed to address changes seen in the patient cohort and model of care, since the original BCF was produced and to address capacity issues where activity has been far higher and of higher acuity than originally planned. Both elements of the scheme need improved data collection to provide solid evidence of value for money in the longer term e.g. costing of the impact on reduction in requirements for residential care. Further opportunities exist for improved integrated working e.g. single service manager across health and social care as well as further pathway improvements.

Next Steps:

It was agreed to urgently set up a task and finish working group during 16/17 with all key stakeholders early in Jan 2016 to refresh and refocus the scheme and prepare a Project initiation document (PID) which addresses the issues highlighted during the review process. The 16/17 BCF plan should be strengthened to better describe the Full intake model and to further analysis the impact of these two elements on DTOC and NEL. The staff mix of the services will also be reviewed with a possible reduction in Health staff (Nurse, Pysio etc.) replaced with additional care staff/assistances in line with patient/users needs. The budget split between the Council and BHFT (local community health provider) will be adjusted accordingly.

B) BCF Scheme 05b Neighbourhood Clusters Initiatives

This scheme during 2015/16 has consisted of four phased pilots which have been running independently of each other using existing resources (outside of the BCF). Each pilot was scored separately during the evaluation process but a number of themes emerged which

allowed us to make recommendations for a more integrated approach going forward into 16/17.

Pilot 1: Social Prescribing

This pilot commenced in June 2015 and is funded currently through CCG Partnership development funds (£29k) and is provided by Reading Voluntary Action. This pilot has received 22 referrals in the first 9 months. Although the service is valued by users and has seen improvements in wellbeing outcomes and offers a valuable function in signposting and supporting individuals within the community, the greatest challenge has been to receive large enough numbers of referrals from GP practices into the service. This project is not currently integrated with the other pilots nor into social services and may duplicate some of the work currently already commissioned elsewhere, e.g. the citizen's advice bureau. Plans to roll the pilot out across the whole of Reading are currently being reviewed within the PDF process and were therefore felt to be outside of the BCF.

The Reading Integration Board in principle felt this scheme would be worth strengthening, particularly around the source of referrals and could link into the other pilots in a fully integrated manner but would be better placed outside of the BCF, due to the different funding stream and recognition that, although important integration work streams, they do not **all** impact directly on DTOC nor Non Elective admissions.

Pilot 2: Living Well

This pilot also commenced in June 2015 and is operating across the 10 practices in North & West Reading, funded from Quality premium money £79k. The pilot has seen 91 people in the first 8 months and some good early outcomes and clear deliverables in reduced GP appointments, 99 calls, A & E attendances as well as a 50% reduction in unplanned admissions in the patient cohort. Patient wellbeing scores had also seen improvements and although patient satisfaction data had been collected it has yet to be analysed. The greatest challenge, as with the social prescribing pilot has been the low numbers of referrals seen from within GP practices.

The Reading Integration Board in principle felt this scheme would be worth strengthening, particularly around the source of referrals and as with the social prescribing pilot, could link into the other 4 pilots in a fully integrated manner, but outside of the main BCF.

Pilot 3: Case Co-Ordinators

This pilot commenced in July 2015 and utilises existing BFHT resource funded by the CCGs of 1 w.t.e Case Coordinators at a cost of approximately £44k p.a. The pilot, through the use of the ACG tool and local knowledge had identified large numbers easily identifiable clients suitable for early intervention and community support. In the first 4 months, 70 people were reviewed. Results from quarter 1 show a 30% reduction in GP contacts, 64% less calls to NHS 111, a reduction of 69% in A & E attendance and a 85% reduced unplanned admissions for this cohort of patient before and after the interventions. The lessons learnt from this pilot where it is possible to identify a specific cohort of frequent flyer clients could be further developed and integrated with the other neighbourhood pilots to maximise future value for money. Introduction of the Friends and family test would help strengthen and inform this pilot going into 16/17.

The Reading Integration Board in principle felt this scheme would be worth linking, particularly around its ability to identify suitable clients, with other 3 pilots in a more fully integrated manner, again outside of the BCF.

Pilot 4: Right 4 U

This pilot commenced in Nov 2015 and is provided by Reading Borough council through a different way of working using existing staff. It currently only offers support to approximately 300 RG2 postcode residents and first contacts, but there are plans to extend across reading going forward. It should be noted that this pilot was only commenced in Nov 2015 and it has not yet been possible to evaluate it fully. The early indications are that the pilot has identified large numbers of clients suitable for early prevention and community support. There has been a low conversion rate to requiring with over 60% of contacts being offered timely personalised help , without the need for long term social care or short term social care services. This project is not currently integrated with the other pilots nor into health.

The Reading Integration Board in principle felt this scheme would be worth strengthening, particularly by linking into the other pilots in a fully integrated manner, in a separate work stream outside of the BCF.

Next Steps:

We have identified strengths and weaknesses in all four schemes. By bringing those successful elements of the schemes together we could significantly improve the offer to the Reading population in relation to prevention and early community support. We now need to re-establish a neighbourhood cluster working group as a task and finish working group with all key stakeholders to refresh and refocus the scheme and prepare a Project initiation document (PID) which addresses the issues highlighted during the review process. This particular work stream will due to difference in funding streams remain run outside of the main BCF, but remain a key work stream for Integration in Reading.

C) BCF Scheme 01 & 02: Hospital @ Home & Care Homes

In 2015/16 a CCG investment of £387,000 in a Care Homes project moved to the Better Care Fund (BCF) and a total of £2,981,000 (FYE) investment was provided to also support the Hospital at Home (H@H) project. Following monitoring and learning early during the implementation phase, The H@H project was rebranded in September 2015 and was replaced by the Rapid Response and Treatment Service (RRAT) for Care Homes. RRAT is a new service provided by the locality community teams which will respond within 2 hours of receipt of a referral or within 2 hours of a patient returning home from A&E. The RRAT provides increased and targeted Community Geriatrician input, including active treatment interventions including crisis support and the use of telehealth to support those at risk of admission. The enhanced rapid response pathway provides crisis response and treatment for patients in care homes. The service is available 8am – 8pm, 7 days a week with a proposed length of stay of up to 5 days on the pathway.

In April 2015 the GP CES was incorporated into and moved to the Anticipatory Care CES and funding adjusted.

The aim of the project to date has been to provide a common and consistent approach to improving outcomes for those people living in Nursing and Care Homes in Berkshire West through training and education of care home staff, medication review of all residents and anticipatory care planning and since October 2015 enhanced through the introduction of RRAT.

Full review of each of these elements has been carried out and the learning has concluded:

- Training & Education: The KPIs need to be more reliably measurable. It is proposed that going forward, further training options are considered especially to ensure we are able to better target the key four diagnoses that have the greatest impact on NEL admissions: UTI, Pneumonia, Falls and Dementia. In addition a focus on reducing

calls to 999 through empowering staff in their decision making and ensuring all homes are aware of the alternative care options

- Reduction in Non- Electives: The planned gross savings £292k across Berkshire West anticipated in the 2015/16 project will not be realised, however we have seen a reduction in non-elective activity in this cohort of patients of 72 unplanned admissions (20%) against a target of 50% reduction and an associated saving of £215k. 999 calls have not shown a decrease and with a 48% conversion to admission, there is still further work to be done to fully address this problem. There appears to be potential to further reduce the 0-1 length of stay admissions, of which 70% are considered potentially avoidable.
- Medication review: further investment is required to maximise the savings on investment and to increase from 1 to 2 w.t.e pharmacists (1 w.t.e. in 2015/16 has released £107k of savings.)
- Whilst the RRAT service data is only very recent, and therefore limited, it does demonstrate an effective impact on the numbers of NEL admissions from the first phase of 15 Care Homes and this is demonstrated in both the QIPP and Care Home report. For phase 1, 15 NEL admissions have been avoided in the first 2 months of the scheme: a 23% reduction in NEL admissions for this cohort of care homes. Anecdotally all calls attended by the clinical staff were felt to be appropriate and all would have resulted in calls to SCAS and attendances at A&E in their opinion had the RRAT service not been in place. For 2016/17 the project will recommend continued investment in this service and roll out as planned across all 4 phases to cover all nursing and residential homes in Berkshire West.

The Reading Integration board has agreed to carry forward the revised care Home Scheme into the 16/17 Better care fund, in line with our findings and learning to date. It is felt locally that this scheme has the greatest potential to impact on the care home Non Elective Admissions.

In addition for 2016/17 a review of the reporting mechanisms and savings options across the pathway will be undertaken. Following review of the data the following savings for 2016/17 is recommended:

- South Central Ambulance Service (SCAS) – Hear and Treat is reduced by 90%
- SCAS Calls - See and Treat is reduced 50% reduction.
- SCAS - See, Treat and Convey is reduced by 50%
- Secondary care 0-1 day Length of stay (LOS) is reduced by 75%
- Secondary Care 2+ days LOS is reduced by 30% in line with national evidence of similar project outcomes.

The Reading board also supported the continuation of the Rapid Treatment for care homes project within an overarching Care Home Project for 16/17 which bridges Health and Social Care.

D) BCF Scheme 03: Connected Care

Currently across Berkshire there are 17 different organisations that hold data in one or more systems relating to an individual's health, social care and wellbeing. This high number of organisations, and the different culture, systems & technology, processes and legislation which drive them, makes it difficult to get a single view of a person at a point in time.

What our Connected Care solution is offering is the ability to have a single point of access to a person's health and social care records giving accurate and up to date information at the point in time of accessing the data.

This supports the different integrated services in the following ways:

- The NHS number is used as the consistent patient/user identifier
- No need for multiple laptops to access health and social care data separately
- Access to real time data reducing the need for phone calls to various organisations to collate pieces of information
- Reduce the amount of time required to contact the relevant organisations in relation to a person.
- More accurate data
- The ability to streamline the integrated services better by creating true single assessments
- The ability to streamline the transfer of a person from one service to another by developing health and social care pathways

Please See Narrative Template for further information.

E) BCF Scheme 5c: 7 Day Working

We have made good progress on achieving 7 day services access across a range of primary, local authority, community and acute services in line with the 10 clinical standards. This is underpinned and driven through several different work programmes including the delivery of the Systems Resilience High Impact Actions, the development of an integrated community care model supported through the BCF and in line with the BCF national conditions, and the development of relevant CQUINs and Service Development Improvement plans (SDIP) in both Provider contracts for 2015/16 (a core part of the 2015/16 planning guidance). Further detail is provided in our Berkshire West CCGs Operating Plan 2016/17. *(Ref Berkshire West CCGs Operating Plan 2016/17 section 6.2 7 day services).*

Primary care: In addition to investments made via the BCF, through systems resilience and into MH services all of which directly support 7 day access we have invested in an Enhanced Access CES for Primary Care. Access to our community services is facilitated 24/7 via a Health Hub which is used by all discharging Acute Trusts as the single phone number.

Acute Care: In 15/16 we agreed a service development improvement plan (SDIP) with the RBFT which covered standards 2, 5, 6, 7 and 9. RBFT is reporting compliance with standard 2 (Time to first consultant review), standards 5/6 partially compliant and the Trust have completed and agreed with commissioners a Quality impact assessment associated with this position in year. The Trust has met their agreed actions on standards 7 and 9.

Across Berkshire West , We are in the process of finalising the requirements with RBFT (acute provider) for Q4 15/16 and have already commenced as part of the contract build the development of the 16/17 SDIP to include standard 8 as well as 2, 5 and 6 which are the national priorities for the coming year. The Trust will be completing the self-assessment tool on 7 days as required by the end of April 2016 and we will use the results of this to support continued dialogue with the Trust on full achievement of all 10 standards.

The key milestones and timelines proposed will require by the end of quarter 1 (end of June 2016) for baseline positons and trajectories to be agreed for implementation in 16/17 against four priority clinical standards as well as for several new agreed priority clinical standard areas to ensure full coverage of the 10 clinical standards by the end of March 2017. Following agreement of the baseline and trajectory values at the end of quarter 1 , implementation and delivery will then be monitored at the end of quarters 3 (End of Dec 2016) and quarters 4 (end of March 2017) for each clinical standard area.

Community Care: Berkshire Healthcare Foundation Trust (BHFT), our community provider, also had an SDIP in 2015/16 which covered the respective elements of standard 7(MH on

acute admission, Psychological medicines services (PMS) and 9 (transfer to Community, Primary and Social Care). BHFT have provided performance data for Q3 and our intention is also to use this to inform our 16/17 BCF planning.

Key health services in the community, such as rapid response and reablement, home care and reablement as well as the mental health crisis teams already operate on a 7 day a week basis but uptake of these services is lower at week-ends. Using the results of our stocktake during 15/16, of which community services operate at the week-ends and how workload is profiled across the week we will use the outcomes to develop our work further for 2016/17 with our community provider. The Integrated Discharge Team does operate 7 days a week 'pulling' patients out into the community.

Mirroring our acute provider, our community and mental health provider (BFHT) will be required to build and develop a 16/17 SDIP to cover standards relating any consultant led care e.g. mental health and community inpatients and geriatrician services. The trust will be required to complete a self–assessment tool and quarter by quarter through 2016/17 have specific milestones to deliver the appropriate standards. The key milestones and timelines proposed will require by the end of quarter 1 (end of June 2016) for baseline positons and trajectories to be agreed for implementation in 16/17 in priority clinical standards to ensure full coverage of the applicable clinical standards by the end of March 2017. Following agreement of the baseline and trajectory values at the end of quarter 1, implementation and delivery will then be monitored at the end of quarters 3 (end of Dec 2016) and quarters 4 (end of March 2017) for each clinical standard area.

Social Care: Reading Discharge to Assess services operate on a 7 day basis but again uptake is lower at the week-ends and joint work is needed with the hospital to smooth this flow.

Reading Council have new contracts and rotas in place to achieve a social worker presence at the Royal Berkshire Hospitals 7 days a week in 2016/17 to ensure that assessments and placement can take place consistently across the week. Further work will be undertaken with Independent Care Providers so that care packages can be started over 7 days. A robust feedback loop to the RBFT will be required so that any issues with week-end discharges can be immediately addressed.

For 16/17 our focus on 7/7 services will continue, however with the move to full delegation from April 2016 for primary care services, the GP element of the 7 day funding will transfer from the BCF to the Primary care budgets held by the Berkshire West CCGs. This will then be managed through the primary care commissioning committee which has representation form NHSE, CGGs as well as local authority representation.

For 16/17 our focus on 7/7 services will continue, however with the move to full delegation (where CCG will see the transfer of responsibility and funds move from NHSE to the CCGs, who will have fully delegated authority to manage the budget and commission primary health care from GP practices)from 1st April 2016. The decision was taken to avoid splitting the budget resource for access to primary care that the GP element of the 7 day funding will transfer from the BCF to the Primary care budgets held by the Berkshire West CCGs. This will then be managed through the primary care commissioning committee which has representation form NHSE, CGGs as well as local authority representation.

F) BCF Scheme 5a Health & Social Care Hub

A review report was considered by the Berkshire West 10 delivery group in Jan 2016. This outlined the progress to date with the Wokingham Hub. The main of this scheme is to provide a single point of access that ensures patients/users only tell their 'story' once; that has an overview of all local suitable/available support resources and has the authority to commission said resources directly.

West Berkshire local authority area are currently committed to their access model as the first step towards an integrated hub, but recognised that there must be learning from both systems and that it the models are not directly comparable and therefore once both models have been sufficiently evaluated that the learning be brought back to enable optimisation of the benefits of both models to the system as a whole.

Reading had recently launched through their partners for change program "Right 4 U" model which is showing early sings of success. (see review above B) BCF scheme 5b). Although this will sit outside of the BCF in 16/17, it is important that the findings coming from the Frail Elderly Pathway programme highlights the aspirations for a streamlined access for users to both health and social care which reduces handoffs and promotes integration. Reading will continue to work with partners on future options and expansion of their model to ensure it is fully integrated across health and social care.

2016/17 Revised Better Care Fund Plan: What has changed?

A summary of the funding for 2016/17 is detailed below with the comparative 2015/16 figures and accompanying narrative highlighting key changes.

The planning template provides a full overview of the funding contributions for 2016/17 and has been jointly agreed by the CCG and Local Authority via the Reading integration Board and Reading Health & Wellbeing Board.

Scheme Name/Expenditure Line	**16-17 Expenditure (£)**	**15-16 Expenditure (£)**
s256/Protection of Social Care		
1. Bed based intermediate care Willows	523,000	379,000
2. Bed based intermediate care Assessment Flats	46,000	0
3. Social care intermediate care team	863,000	374,000
4. Additional intermediate care and re-ablement resources to support H@H, delayed discharges	0	368,000
5. Community reablement team	1,529,000	1,066,000
6. Mental Health reablement and recovery team	200,000	150,000
7. Specialised nursing placements (to support hospital discharges)	400,000	139,000
8. Community equipment & minor adaptations	50,000	35,000
9. Protection of Social Care	0	1,100,000
10. Care Act Monies	361,000	361,000
11. Carers Support Funding	641,000	641,000
12. Time to Decide/Discharge to Assess	556,000	456,000
13. Full Intake	398,000	0
14. Reablement	779,000	779,000
NHS Out Of Hospital Commissioned Services		
15. Speech and Language Therapy	44,000	0
16. Community Geriatrician	87,000	0
17. Intermediate Care	92,000	0
18. Health Hub	742,000	0
19. Intermediate Care night sitting, rapid response, reablement and falls	341,000	0
20. Care Homes in reach	244,000	0
21. Support to residential and nursing care homes (Enhanced Care in Care Homes)	158,000	175,000
22. Rapid Response and Treatment to Care Homes – RRAT	280,000	0
23. Hospital at Home	0	827,000
24. Health and Social Care ICT (Interoperability)	300,000	256,000
25. Seven day Integrated Health and Social Care Teams (Inc. GP 7 Day Access and Full Intake)	0	1,372,000
26. Programme Management	209,000	0
27. Disabled Facilities Grant	815,000	500,000

28. Social Care Capital Grant	0	317,000
29. Contingency	217,000	182,000
30. Risk Share Agreement	542,000	719,000
	10,417,000	**10,196,000**

Summary of changes

S256/Protection of Social Care (lines 1 – 9)

Lines updated to reflect actual expenditure and to enable consistent financial reporting. Please see 'Maintaining the provision of social care' in the narrative document for more detail.

Time to Decide/Discharge to Assess (line 12)

Following our programme evaluation we are continuing with the Discharge to Assess 'step down/step up' beds at the Willows residential home and expanding the service with two additional units/beds at a cost of £100k pa. The budget split between health and social staffing is being reviewed inline with patient/user needs and is subject to change from the figures reported in the Planning Template. Please see page 11 above for further details. This also applies to the Full Intake Model funding and staff mix.

Seven day Integrated Health and Social Care Teams (Inc. GP 7 Day Access and Full Intake) (lines 13 & 25)

Improving access to General Practice element of 7 day services removed and now funded outside of the BCF to allow alignment with other primary care budgets under full delegation responsibilities.

The Full Intake model continues to be funded with the remaining balance invested into NHS Commissioned out of Hospital Services.

Hospital at Home/ Rapid Response and Treatment to Care Homes (lines 22-23)

Hospital at Home project redesigned in September 2015 and replaced by the Rapid Response and Treatment Service (RRAT) for Care Homes.

Programme Management (line 26)

Dedicated resource has been included for both local and pan Berkshire BCF/Integration programme management.

Disabled Facilities Grant/Social Care Capital (lines 27-28)

In lieu of final determination correspondence it is assumed the DFG allocation includes the Social Care Capital thus figures have been combined for 16/17.

NHS Commissioned Out of Hospital Services (lines 15-20)

New to the BCF in 16/17 will be a range of Out of Hospital Services commissioned by the CCG through our community provider. These schemes , alongside other initiatives outside of the BCF, supports the overall delivery of the NEL and DTOC BCF Objectives as well as managing demand for urgent care including A & E attendances as well helping our resident remain as healthy and well as possible in the community.

The new service lines within the BCFs are as follows:

- **Adult Speech & Language:** This service supports indirectly avoidance of NELs through timely swallowing assessment in at risk individuals, hence avoiding future episodes of aspiration pneumonia and chest infections.
- **Care Home Support Services**: This is in addition to the new investment included in BCF within 16/17.
- **Community Geriatricians:** The community geriatricians will support the primary care teams, intermediate care teams, care homes and community hospitals within their area and provide easily accessible and speedy advice with the intention of reducing admissions to secondary care.
- **Intermediate Care** (including but not restricted to: rapid response, reablement, falls and night sitting): The aim of the Intermediate Care Services is to provide individuals who are referred to the service, with a structured gaol based action plan. This is provided by a multidisciplinary team, which is responsive to an individual's physical, psychological and social needs. This includes those who have early onset dementia, or whose needs are of a palliative nature and who wish to remain at the end of their life in their own home. In the Reading Locality the Intermediate Care Service is an integrated service provided by Berkshire Healthcare NHS Foundation Trust (BHCNHSFT) and Reading Borough Council.
- **Health hub:** The Health Hub is the single point of access for referrals from healthcare professionals to scheduled and unscheduled community services. Clinical advisors are based within the Hub providing clinical screening of referrals supporting effective prioritisation of resources to meet clinical need. This service helps facilitate patient flow (thus avoiding DTOCs) from RBFT to the community Beds or alternative community services based upon clinical need. Out Of hours referrals are also processed and administrated through the Health Hub. Referrals are prioritised and actioned appropriately in respect of risk and urgency and forwarded to the most appropriate service in a timely manner as indicated on referral or after triage. Access is available 24/7, 365 days a year and the Hub works with other services and teams within the Trust to ensure a smooth and seamless transition or transfer between services.

Supporting Metrics and Targets for 2016/17

Non-elective admissions

Please see Page 5 of this document for detail regards how our NEA target for 16/17 has been set. Further details are also enclosed on our BCF Planning Template.

Delayed Transfers of Care

At a meeting on 21 April 2016 the Reading Integration Board considered the DTOC situation analysis (summary at page 7 above and at annex 3) and the following three scenarios for what the overall DToC target should be (acute and community beds):

Scenario 1: Ambitious

Historical | Projection

	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16-17
Reading BCF DTOC measure (per 100,000)	728	1,166	1,516	832	978	771	808	697	670	649	615	567
Annual moving average	799	927	1,095	1,060	1,123	1,024	847	813	736	706	658	625
Reading population	123,881	123,881	123,881	124,415	124,415	124,415	124,415	124,971	124,971	124,971	124,971	125,483
Reading delayed days	901	1,444	1,879	1,035	1,217	959	1,005	871	837	811	769	711

Scenario 2: Moderate

Historical | Projection

	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16-17
Reading BCF DTOC measure (per 100,000)	728	1,166	1,516	832	978	771	808	767	740	720	687	636
Annual moving average	799	927	1,095	1,060	1,123	1,024	847	831	772	759	729	696
Reading population	123,881	123,881	123,881	124,415	124,415	124,415	124,415	124,971	124,971	124,971	124,971	125,483
Reading delayed days	901	1,444	1,879	1,035	1,217	959	1,005	959	925	900	858	798

Scenario 3: Conservative

Historical | Projection

	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16-17
Reading BCF DTOC measure (per 100,000)	728	1,166	1,516	832	978	771	808	792	784	765	731	680
Annual moving average	799	927	1,095	1,060	1,123	1,024	847	837	789	787	768	740
Reading population	123,881	123,881	123,881	124,415	124,415	124,415	124,415	124,971	124,971	124,971	124,971	125,483
Reading delayed days	901	1,444	1,879	1,035	1,217	959	1,005	990	980	956	914	853

It was agreed that the Reading target should be based on the ***Conservative scenario 3*** and these figures/targets have been entered onto the attached BCF Planning Template. The Board also agreed an action plan (annex 3) which contains a set of clear actions to deliver improvement and that builds on both the success of local initiatives and on nationally agreed best practice interventions.

Reduction in the numbers of people over the age of 65 in residential care

Reading Borough council have made significant progress on this in 15/16 but still benchmarks higher than neighbouring Local authorities. Continued focus is therefore to ensure only those who need intensive support, live in residential care settings. This focus is required in relation to patient flow/pathways and the front line culture of practice to ensure our strategies to support people in their own home are fully embedded.

At present health and social care teams are supported through improved decision making processes, e.g. R4U, integrated working and work-streams such as positive risk taking the RRAT and care home programme will continue within 2016/17. The proposed target within 2015/6 was to reduce admissions by 58%. The forecast target is a reduction of 31%. This

achievement will see a plateau within 2016/17 and further work with regards to length of stay will need to be addressed within the KPI metrics.

The planned target for 2016/17 is a further reduction of 8%. This is based on financial resources, national targets and statistical neighbour analysis.

Increase in the number of people at home 91 days post discharge

Focus and prioritisation continue in this area to ensure we have robust preventative and crisis management services in the community, in particular effective reablement services that support people post-discharge and help them to achieve their full potential recovery. In order to support patient flow the reablement service is currently prioritising hospital discharges – this will need to be regularly monitored to ensure the service can effectively support people in the community to prevent admission in the first place.

Performance improved during the year, but due to the unforeseen increase in demand, the target will not be achieved, based on the current upward trend early indication is that Reading should achieve the next year's target. This is due to the fact that within 2015/16 the stretch target of 95.5% still at home 91 days after discharge from hospital (community or acute) was too great and within 2016/17 although a stretch target has been implemented this is significantly less. The reduction within 2015/16 could be associated with the increase of NELs and the pressures placed within the system to discharge clients from the acute trust, as well as the higher acuity of the older people leaving the acute sector.

The planned target for 2016/17 is 82.7% and the stretch target will be 86.7%. This is based on a change in care services within the Willows Residential Care Home (DTA beds).

Local Metric - draft proposal

Within Reading, following a recent analysis of NEA activity the largest numbers of individuals (44%), by age group, contributing to the NEAs at the Royal Berkshire Hospital is 19-64 years. This group also represented 37% of the total NEA spend.

The BCF local metric is to plan and devise an analytical system that enables a greater integrated approach to gain a better understanding of this system pattern and identify any contributing factors. Working with Public Health/Housing and Drugs and Alcohol teams we plan to further align preventative work and tackle issues identified that are amenable to change.

Metric 5: Total non-elective admissions in to hospital (general & acute), age 19-64, per 100,000 population /month?	Effective joint working of hospital services (acute, mental health and non-acute) and community-based prevention services to analyse non-elective activity for residents aged between 19-64 years.
Rationale	With a particularly young population within Reading, it is important we focus our integration efforts not only towards the elderly population but also in a preventative manner at our younger age groups, to help support them remain well for longer and able to self-manage. There is a need for a series of comprehensive systematic reviews

	that will identify interventions to address the organisation of care and access for the purpose of reducing non-elective admissions (NEA in this patient cohort).This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the integration between health and social care services. Minimising non-elective admissions enabling people to be treated in the community or at home is one of the desired outcomes of the Better Care programme.
Definition	Total number of non-elective admissions for 19-64 year olds per 100,000 population. A non-elective admission occurs when an Admission that has not been arranged in advance. It may be an emergency admission, a maternity admission or a transfer from a Hospital Bed in another Health Care Provider. **Numerator:** The total number of non-elective admissions for patients (aged 19-64) for all months of baseline period by local authority of residence **Denominator:** ONS mid-year population estimate (mid-year projection for population) A literature review on the effectiveness of system programmes that have been implemented in Reading will consider emerging best practice in reducing NEAs. The evidence based support for BCF programmes has been considered in this review. The review highlights the effectiveness of emerging models of integrated care compared to usual care.
Source	This systematic review will be carried out across a wide range of electronic databases (ALAMAC, Mosaic and Rio) to identify NEA activity and a review of interventions used to reduce unplanned hospital admissions in 19-64 year olds.
Reporting schedule for data source	• Milestone plan production • NEA analysis 19-64 years

	• Quarterly highlight reporting • Programme analysis • Monthly at Reading Integration Board
Historic	April 2016

Patient experience

As a sector, we need to understand more about how services are affecting people's lives, rather than simply what outputs services are providing. If users are to be at the heart of care planning and provision within Reading, then user experience information will be critical for understanding the impact and outcomes achieved - enabling choice and informing service development.

The development of the BCF local User Metric based on user experience will be used:

- To provide assured, consistent and benchmarked local data on care outcomes. It is the most significant pool of personal outcome information for people receiving adult social care.
- To support transparency and accountability, enabling people to make better choices about their care.
- To help local services identify areas where outcomes can be improved in a very challenging financial climate, and support their own initiatives with an assured vehicle for obtaining outcome information.
- To populate outcome measures in the Adult Social Care Outcomes Framework

When care is not joined up it affects both patients and carers adversely, but currently there are few robust and tested instruments for assessing how well users of health and social care services feel their care is being coordinated.

The proposal is for feedback from patients/service users to be gathered through semi-structured interviews carried out in a number of settings spanning the services funded by the Better Care Fund and those that form part of the work plan of the Integration Programme Board. The same survey will be used in all settings and highlight results will be reported on monthly with a fuller quarterly report.

The survey will be carried out face-to-face, via an internal team or by a third sector provider, to ensure both statistical and qualitative feedback can be gathered. Research into how people answer questions about integrated care and health and social care services working together, shows there is sometimes a danger of people 'averaging out' their responses e.g. giving an average score to balance a good experience with a health professional with a bad experience with a social worker or vice versa. This stresses the importance of giving examples and explanations, this is one of the reasons a face-to-face interview is favoured, in terms of understanding and recording the person's own context and descriptions, to add greatest value to local intelligence on integration.

To date a patient service experience measure has been established across care providers and will be reported on within the first quarter. This quarter will also see the proposed service user experience plans built and signed off by Reading Integration Board. The full implementation date for this metric will be 1st July 2016.

Programme Governance

In Reading, we have a history of pooling health and social care budgets to deliver improved outcomes, and have developed governance arrangements appropriate for integrated care. These have been refreshed to establish joint governance arrangements covering both our Better Care Fund and Care Act implementation programmes.

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 Operations Directors for the Berkshire West Clinical Commissioning Groups.

Reading's Health and Wellbeing Board has strategic oversight of our plans to develop more integrated services within the Borough.

As many of our Better Care Fund schemes 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.

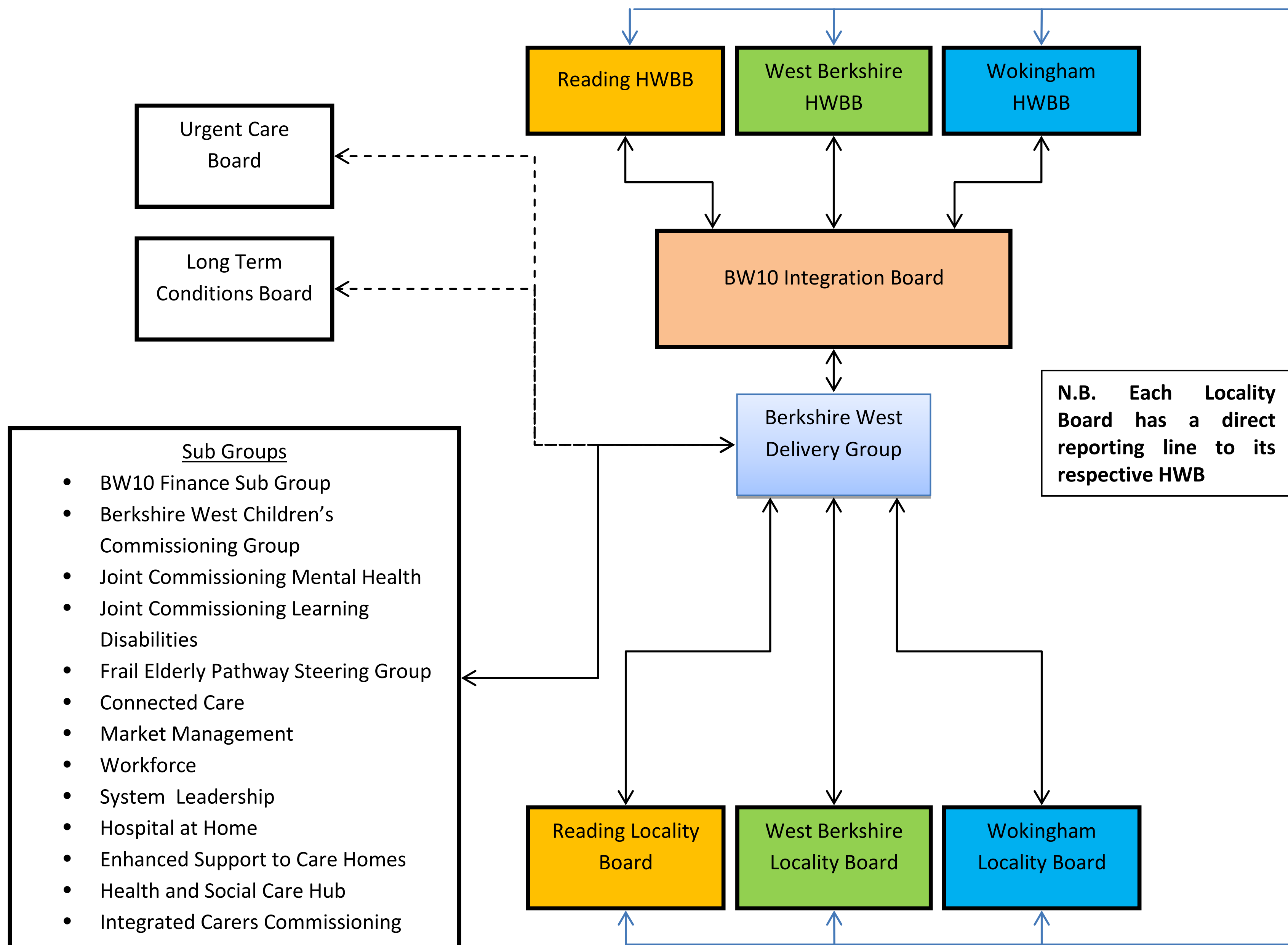
The diagram below shows the key structures across Berkshire West. The Reading Locality Board is the Reading Integration Board.

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 Integration Board, with the Berkshire West 10 Delivery Group acting as the programme board on their behalf.

An additional group, the Berkshire West 10 Finance Sub Group, provides financial support and analysis to the 3 local and the pan Berkshire Integration Boards

Terms of References for the Reading Integration Board are attached at Annex 5.

Berkshire West 10 Integration Programme Governance Map



2016/17 Integration & Beyond: Our plans for New Models of Care and Sustainability

Berkshire West Accountable Care System (ACS)

As outlined previously, the Berkshire West “Health and Social Care Economy” has been working as the Berkshire West 10 (BW10) comprising of 4 CCGs, 3 local authorities, Royal Berkshire NHS Foundation Trust (RBFT), Berkshire Healthcare Foundation Trust (BHFT) and South Central Ambulance Trust (SCAS) for some time within a shared governance structure. The Berkshire West system first came together as an agreed footprint back in 2013 with the submission of our Integration Pioneer bid, and has continued to capitalise on this with the development of a Berkshire West Integration Programme. The Integration programme identified three priority areas of work following an initial review of demand and capacity across the health and social care system; these are Frail Elderly, Children and Young Peoples services, and Mental Health. We have subsequently further prioritised joint work on a Frail Elderly Pathway which reported back in March 2016, with the findings and actions to be used to inform further pathway redesign.

To meet our challenges and overcome the barriers to change in the current system, Berkshire West is proposing to establish a New Model of Care and to operate as an ACS. The ACS is a collective enterprise that will unite its members and bind them to the goals of the health and Care system as a whole. In so doing we will hold ourselves collectively to account for delivering the necessary transformation of services and in getting the most out of each pound spent on the NHS within Berkshire West.

The key characteristics of our ACS will be:

- We will support our population to stay well through preventative care which considers the lives people lead, the services they use and the wider context in which they live.
- We will improve patient experience and outcomes for our population through delivery of a Berkshire West Shared Strategy
- We will get optimal value from the ‘Berks West £’ by organising ourselves around the needs of our population across organisational boundaries, working collectively for the common good of the whole system
- Clinical decision-making and service developments will drive proactive management of care and provision of care in the most effective settings, underpinned by a payment system that moves resources to the optimal part of the system.
- Finances will flow around the system in a controlled way that rewards providers appropriately and helps all organisations achieve long term financial balance by unlocking efficiencies in different parts of the system; incentives will be aligned and risks to individual organisations will be mitigated through the payment mechanism.
- We will develop and use long term contracts to promote financial stability of the providers
- It will be governed by a unified leadership team comprising all commissioners and providers, with delegated powers from the constituent organisations.

References

- **Reading Better Care Fund Plan 2014** - https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/fast-track/
- **Berkshire West CCGs Operating Plan 2016/17 (attached at Annex 10)**
- **Reading Market Position Statement** - http://old.reading.gov.uk/marketpositionstatement

Annex

Annex 1 – BCF Programme Plan

Annex 2 – BCF Programme Risk Log

Annex 3 – DTOC Reduction/Management Plan

Annex 4 – Risk Share Mechanism

Annex 5 – Reading Integration Board Terms of Reference

Annex 6 – Joint Assessment/Referral From

Annex 7a – Connected Care - Full Business Case

Annex 7b – Connected Care – Project Communications Plan

Annex 7c – Connected Care – IG Principles and Data Sharing

Annex 7d – Connected Care – Consent to Share Data

Annex 7e – Connected Care – IG Improvement Group – Terms of Reference

Annex 7f – Connected Care – IG Improvement plan/checklist

Annex 8 – 2015/16 BCF Scheme Review

Annex 9 – HWBB minutes delegating joint authority for plan approval to the CCG Chief Officer and Reading Borough Council Director of Adult Social Care and Health

Annex 10 – Berkshire West CCG Operational Plan