ITEM NO: 34.00

TITLE	**Berkshire West Operational Resilience and Capacity Plan 2014-15**
FOR CONSIDERATION BY	Health and Wellbeing Board on 9 October 2014
WARD	None Specific

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REPORT OF THE WOKINGHAM CCG GOVERNING BODY: 1 JULY 2014

Title	Berkshire West Operational Resilience and Capacity Plan 2014-15
Sponsoring Director	Dr Cathy Winfield
Author(s)	Carolyn Lawson, Urgent Care Programme Lead
Purpose	To fulfil the requirements of the national ORCP guidance
Previously considered by	Urgent Care Programme Board, Clinical Commissioning Committee
Risk and Assurance	
Legal implications/regulatory requirements	
Public Sector Equality Duty	
Links to the NHS Constitution (relevant patient/staff rights) *All NHS organisations are required by law to take account of the NHS Constitution in performing their NHS functions*	
Consultation, public engagement & partnership working implications/impact	

Executive Summary
This plan demonstrates how the Berkshire West CCG plan to address the requirements contained within the national Operational Resilience and Capacity Planning guidance published by NHS England.

Recommendation
To note the contents of the plan.

NHS
South Reading
Clinical Commissioning Group

NHS
Wokingham
Clinical Commissioning Group

NHS
Newbury and District
Clinical Commissioning Group

NHS
North and West Reading
Clinical Commissioning Group

Berkshire West Health and Social Care Operational Resilience and Capacity Plan 2014-15

July 2014 version 2.0

Introduction

This plan has been developed in response to the Operational Resilience and Capacity Planning guidance for 2014-15 published on 13 June 2014 and prepared by NHS England, the NHS Trust Development Authority, Monitor and the Association of Directors of Adult Social Services.

It addresses all recommendations within the guidance and describes the Berkshire West health and social care approach to operational resilience and capacity planning for 2014-15. The work described in this plan will set the ground work for longer term changes to strategic and operational delivery of urgent care that will be driven by the outputs from the Keogh Urgent and Emergency Care Review.

The plan will be subject to further development during August and posted on the websites of the Berkshire West Clinical Commissioning Groups (CCGs) in September 2014, having been signed off by all the partners through the Berkshire West Urgent Care Programme Board. The plan will be refreshed in October prior to winter 2014-15.

Context

The Berkshire West health and social care economy is comprised of the Berkshire West 10; North & West Reading CCG, South Reading CCG, Wokingham CCG, Newbury & District CCG, Royal Berkshire Hospital NHS Trust (RBFT), Berkshire Healthcare Foundation Trust (BHFT), Reading Borough Council (RBC), Wokingham Borough Council (WBC), West Berkshire District Council (WBDC) and the South Central Ambulance Service (SCAS) There are also strong links with the independent and voluntary sector.

The economy has a strong track record of partnership working together within an effective Urgent Care Programme Board (and supporting Urgent Care Operational Group) and Planned Care Programme Board. The economy has faced significant challenges in meeting the A&E 4 hour performance standard during 2013-14 leading to the development of a System Wide A&E Recovery Plan in January 2014 and a request to the Emergency Care Intensive Support Team (ECIST) for an independent diagnostic review and ongoing programme of support.

The ECIST diagnostic report published in March 2013 described the system as follows "the Berkshire West Health and Social Care community continues to face significant service pressures within its emergency care pathway, with potentially serious implications for clinical risk to patients. This is despite evidence of positive partnership relations and whole system innovation." As part of the January 2014 Recovery Plan process the system undertook an analysis of the root causes of underperformance and identified that the front door delays in the ED (Emergency Department) were a symptom of an impeded flow through the inpatient beds and the main contributing factors were related to discharge practices which resulted in avoidable delays, variable emergency takes with surges in demand, time of day of arrivals at RBFT and a rise in numbers attending both the ED and Non Elective admissions (NEL).

Following on from the initial Recovery Plan, Berkshire West has now developed an overarching action plan which brings together the actions within the Recovery Plan and the recommended actions arising from the ECIST diagnostic visits and subsequent Length of Stay reviews. ED 4 hour performance has subsequently improved steadily through quarter 1 2014-15 and the 95% was achieved for quarter 1 2014-15.

Elective care in Berkshire West is provided primarily through the Royal Berkshire NHS Foundation Trust, with some additional elective services provided locally through independent providers including Circle Hospital, Berkshire Independent Hospitals and Spire Dunedin, all located within Reading. Berkshire West benefits from a Planned Care Programme Board which works in partnership across the elective care system to develop clinically effective sustainable models of care for the system.

During 2013/14 the Planned Care Programme Board has progressed care pathway redesign in areas including Musculoskeletal, Pain and Ophthalmology. The aims of the Planned Care Programme Board are to ensure a

step change in the productivity of elective care, concentrating specialist services in order to ensure the best outcomes for patients while working with providers to understand the impact on the wider system.

During 2013/14 BW saw overall strong performance against the 18 Weeks Referral to treatment (RTT) standard but recognises that there are challenges to ongoing sustainability of RTT performance and seeks to address this through close working with referrers and providers to validate activity information and to develop local protocols which manage demand.

Role of System Resilience Groups

The Operational Resilience and capacity planning (ORCP) guidance was considered at the Berkshire West CCG Clinical Commissioning Committee on 24 June 2014. The Committee decided that Berkshire West will continue with the current configuration of Clinical Transformation Boards through which it will ensure wider system resilience. Berkshire West will therefore continue to have the following;

Urgent Care Programme Board
Planned Care Programme Board
Long Term Conditions Board
Children's, Maternity, Mental Health and Voluntary Sector Board
Primary Care Programme Board

The final ORCP plans will be signed off by both the Urgent Care Programme Board and the Planned Care Programme Board. Allocation of the resilience funding and Marginal Rate Emergency Tariff (MRET) monies will continue to be overseen by the Urgent Care Programme Board.

The following section refers to the role of the Urgent Care Programme Board (UCPB).

Roles and Remit

The UCPB revised its Terms of Reference in January 2014 and also reviewed its membership to ensure Director level representation from the appropriate organisations.

Urgent Care Programme Board (excerpt from the Terms of reference)

The Programme Board is responsible for delivering the following vision for Urgent Care Services in Berkshire West:

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

It will ensure the successful planning, commissioning and delivery of emergency and urgent services in Berkshire West. It will hold the system to account and ensure that each organisation delivers what is needed to provide efficient and effective care

It has a particular key responsibility for ensuring that all parts of the Health and Social Care System work together to ensure that the national 4 hour A&E target is met.

The Board is the forum of mutual accountability of all partners in the local urgent care system and will have strong and effective senior level input and leadership from all partner organisations.

It has an important role in supporting Health and Wellbeing Boards as they determine the overarching health and health care strategy and monitor progress against delivery.

It provides programme direction and takes decisions including approval of projects, products, budgets and plans within the overall Urgent Care Programme as agreed by the QIPP and Finance Committee.

Membership

The UCPB is chaired by Dr Andy Ciecierski, GP and Clinical Lead for Urgent Care. The following organisations are represented on the Board;

- CCG Chair
- CCG Director of Operations
- Secondary Care Consultant (Berkshire West Federation of CCGs)
- Chief Officer (Berkshire West Federation of CCGs)
- Urgent Care Network Clinical Director, Royal Berkshire NHS FT
- Director of Operations (Urgent Care), Royal Berkshire NHS FT
- Regional Director (Berkshire Healthcare Foundation Trust)
- South Central Ambulance Service (including 111)
- CCG Clinical representatives x 4
- Heads of Adult Social care Reps x 3
- Clinical Director Westcall (GP OOH)
- Patient Representative
- Thames Valley Area Team representative
- Healthwatch representative

Others may be required to provide further information on specific deliverables.

There is strong clinical leadership within the group with the Urgent Care Leads for each CCG and the Clinical Group Director for Urgent Care forming a key part of the Board.

For the meeting to be quorate the following need to be present:
Chair/Deputy Chair
At least 2 other CCG GP representatives
CCG Operations Director/Deputy
At least 1 representative from RBFT
At least 1 representative from BHFT
At least one representative from the LAs

There is no independent sector or voluntary sector representation on the Board but representatives can attend as appropriate to address agenda items. Berkshire West will consider whether additional independent or voluntary sector representation should be included on any of the Boards.

The Urgent Care Operational Group (UCOG) has a wider membership which includes all of the organisations above and extends to bring in specific expertise in areas such as NHS 111 and out of hours primary care.

Responsibilities

The Board is focused on understanding the drivers of system pressures and developing collaborative solutions. The system has worked closely with ECIST to understand the drivers of urgent and emergency care pressures and ECIST have undertaken diagnostic reviews within RBHT and across the health and social care system. ECIST have also supported Length of Stay reviews across all the acute and community wards and continue to facilitate theme based workshops on areas such as ambulatory care pathways and the Therapy Challenge.

In October 2013 the BW CCGs commissioned Alamac to provide an urgent care "kitbag", a comprehensive dashboard to provide robust transparent information about capacity and performance across the whole health and social care system. This data system is key to providing insight into where the blocks, delays and pressures are along the pathway and informed the system recovery plan which was developed in January 2014.

Information from this system is used on many levels, from day to day resilience to informing investment decisions.

As per the Terms of Reference the Board provides direction to the urgent care programme of work and takes decisions including approval of projects, products, budgets and plans. It advises on and signs off use of the marginal tariff and other non-recurrent funds. It is the forum whereby all partners are held to mutual account and is itself accountable to the QIPP and Finance Committee.

Planned Care Programme Board (excerpt from Terms of Reference)

Function
The aim of the Programme Board is, through efficient commissioning, to ensure the strategic programme is delivered to time, quality and cost requirements; ensuring good governance, robust decision making and appropriate engagement with stakeholders.

To hold the responsible CSU project lead to account for the delivery of their agreed actions.

Role
The role of the Planned Care Programme Board is to provide programme direction and take decisions including approval of projects, products, budgets and plans within the overall Planned Care Programme as agreed by the QIPP & Performance Committee.

The Programme Board is responsible for engaging with the population of West Berkshire and ensuring that clinical commissioners and commissioning support teams focus on commissioning equitable services that provide quality integrated care for patients, maximising the outcomes of planned care procedures and ensuing access to appropriate services in the most appropriate settings within the healthcare system.

Membership

The following are members of the Planned Care Programme Board;

- CCG Chair
- CCG Director of Operations
- Secondary Care Consultant (Berkshire West Federation of CCGs)
- Chief Officer (Berkshire West Federation of CCGs)
- Planned Care Director of Nursing, Royal Berkshire NHS FT
- Director of Operations (Planned Care), Royal Berkshire NHS FT
- Director of Planned Care, Royal Berkshire NHS FT
- Regional Director, Berkshire Healthcare FT
- CSU Project Managers
- CCG Clinical representatives x 4
- Others may be called to provide further information on specific deliverables

Responsibilities

To support the four CCG Boards, by taking accountability for the successful delivery of all the projects within the programme.

To set the strategic direction and priorities for the planned care programme which reflect the views of CCG member practices and the public, as delivered through CSU project groups, ensuring that the work is co-ordinated across all partner agencies. This will include taking into account the relevant Joint Strategic Needs Assessment and developing a work programme, which will be reviewed at each meeting.

To establish and monitor the portfolio of projects within the planned care programme including:

- Develop, review and monitor the programme plan, recommending any changes as appropriate to the QIPP & Performance Committee
- Receive highlight and exception reports from each of the projects
- Ensure risk is managed effectively by each project and collectively all programme risks are reviewed and recorded on appropriate risk registers, ensuring that mitigation plans are in place and escalation of risks follow organisation policies
- Ensure projects stay within the agreed programme and project brief, including but not limited to, changes to scope, plan, benefits and budget
- Review end of stage and project closedown reports before submission to QIPP & Performance Committee
- Ensure post evaluation of impact on activity, workforce and KPIs, including lessons learnt, within projects are disseminated across the programme
- Ensure the best use of available resources to meet the needs of Berkshire West population; ensuring high quality care is delivered in the most appropriate healthcare setting.
- Engage with stakeholders and the wider public in developing its strategy and work programme, including QIPP and redesign of clinical pathways.
- Promote high quality planned care and where appropriate transfer of care from hospital to community and primary care settings.
- Ensure, where appropriate, the integration of work streams including Long Term Conditions, QIPP and quality and ensure that all national requirements, targets and standards are met.
- Co-ordinate the commitment of resources where appropriate to deliver the action plan.
- Agree terms of reference for planned care and project groups and to ensure that sub-groups and project groups deliver on key tasks.

Scope of the Planned Care Programme Board

- Orthopaedics
- Pathology
- Ophthalmology
- Any Qualified Provider (AQP)
- Endoscopy
- Tier 2 Services
- Radiology
- End of Life
- Cancer
- Stroke/Cardiovascular
- National "Planned Care" Targets
- Urology

Operational Resilience and Capacity Plans

Non-Elective Care

- ***Enabling better and more accurate capacity modelling and scenario planning across the system***

Berkshire West has been using the Alamac "kitbag" since October 2013. The kitbag supports immediate capacity and demand forecasting for non-elective activity and discharge activity across health and social care organisational boundaries. The first of two workshops to further develop the use of the kitbag in supporting escalation was held in July 2014. Organisations from across health and social care came together to identify escalation actions they are able to undertake and to agree the order in which these should be initiated. The second workshop will be held in August and will be focused on agreeing triggers points within Alamac that will prompt organisations to take the relevant action. The alert functions within Alamac will also be activated ahead of winter 2014.

Through the use of the "kitbag" and regular system wide telemonitoring Berkshire West have improved their forecasting of surges in demand and the central resilience monies will be used to fund additional surge capacity where required based on historical trends.

Figures from the Alamac kitbag and analysis undertaken locally and nationally show that demand for unscheduled care continues to rise with an increase in both ED attendances and NEL admissions. RBFT have done some analysis on the age range of those being admitted and have seen a significant increase in those in the over 75s age band.

The UCPB and other Boards, most notably the Long Term Conditions Board, continue to focus on the commissioning, and development of admission avoidance schemes and work to prevent people reaching crisis. This spans all sectors of health and social care and includes schemes which have been commissioned for 20141/15 such as Hospital at Home, Enhanced Services for Care Homes and the Red Cross Prevention of Admission to Hospital scheme.

The Thames Valley Area Team is identifying potential capacity modelling tools to be adopted across Thames Valley, and Berkshire West are keen to participate fully in the use of any tools adopted.

- ***Working with NHS 111 providers to identify the service that is best able to meet patients' urgent care needs***

Based on Gateway letter ref: 01798 from the National Programme Director BW is keen to develop and enhance the existing NHS 111 service. BW will work with SCAS as its NHS 111 Provider to turn NHS 111 into a more personalised service which offers more access to clinicians and more appropriate appointment booking.

BW will link in with phase 2 of the national work around

- Learning and formally evaluating the various models
- Getting wider access to clinicians and specialist professionals (e.g. mental health, pharmacists, community nurses)
- Improvements for specific groups e.g. frail elderly, people with mental health needs, end of life.
- Developing a digital NHS 111 service
- Exploring the value of real-time biometric information
- Access to records.

In Berkshire West, the Central Southern Commissioning Support Unit (CSCSU) is directly commissioned to maintain, expand and update the Directory of Services (DoS) supporting NHS 111. The NHS 111 team performs multiple functions, including forward-planning and operational management of the DoS. Functions include;

- Reviewing access criteria for walk-in services (Walk-in-Clinics, Minor Illness/Injury Units, Urgent Care Centres etc.), to steer traffic away from Emergency Departments and into local community services that provide efficiencies for the health economy as well as a better pathway for the caller

- In-depth analysis of call-data from the NHS 111 provider leading to improvements to NHS 111 referrals
- Plans to expand DoS capabilities,
- Having mobile device access for community health professionals to be able to look up services anywhere at any time
- DoS rollout to healthcare colleagues in practice settings for information on 3rd sector, charity and other support networks where they overlap health and social care. In a single package, the system can support NHS 111 Pathways in the call centre and also health colleagues across the economy.

Clinical leads are always consulted by DoS management upon a change to an entry, be it the introduction of a new service or pathway, or due to an upgrade to the Pathways triage tool meaning DoS must be edited. This process has proven to be robust and has been in-place since go-live.

The CSCSU team combine the maintenance and continued-improvement processes to provide a Directory of Services that works for the community it is used by, and is continually improving.

- ***Additional capacity for primary care***

It is anticipated that primary care will play a pivotal role in delivering our vision to meet people's needs in the community wherever possible and the BW CCGs are looking to facilitate this through the development and implementation of a Primary Care Strategy. This will include well developed primary care co-commissioning arrangements with NHS England enabling quality improvements in primary care and the use of new contracting mechanisms as appropriate.

Having successfully implemented practice-based risk stratification and multi-agency care planning for high risk patients, BW 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. They are starting to do this through the Admissions Avoidance Directly Enhanced Service 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 multi-disciplinary services locally, such as the development of an assessment and diagnostic clinic which is proposed at West Berkshire Community Hospital. The interface between general practice, community services and social care is likely to change, as new integrated models emerge, for example the Neighbourhood Cluster Teams being developed in Reading and Wokingham.

Our GP practices are also interfacing in new ways with specialisms which were historically provided in secondary care, examples of which include the work of our community Diabetologists and community Geriatricians. We anticipate these models becoming the norm as more specialisms are facilitated to move out of hospital and into a community setting. This approach will further enable practices to better support the increasing numbers of patients in their local populations who suffer from one or more long-term conditions.

Practices in BW face high levels of demand, particularly for urgent care, and many have chosen to explore different ways of responding to this, for example by implementing full GP triage or working to identify efficiencies through the Productive General Practice programme. The CCGs recognise that primary care needs to take a systematic approach to responding to requests for urgent appointments, functioning as 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 through the resilience funding we are looking to expand the availability of primary care beyond current core hours particularly for same day access, mirroring the overall shift towards seven-day services across the NHS and linking in with the broader seven-day working work stream which forms part of the Berkshire West 10 Integration Programme.

The Berkshire West CCGs will also be investing in Primary Care initiatives to support improvements in patient access and services for the elderly. Bids are being invited and will be evaluated against a set of criteria including;

Strategic fit	Supports delivery of one of more of the following: • Integration – co-ordinating care with others to prevent admission for patients with long-term conditions or other complex problems • Managing increasingly complex chronic disease in a primary care setting • Improving access to urgent care in general practice and overall responsiveness of primary care services • Seven-day working
Compatibility	Supports care of the Over 75s (for £5 per head funding) or seven-day/cluster working (for CTA/BCF funding)
Equitable	Supports delivery of an equitable level of service to all patients
Scale	Involves collaboration between practices and/or providers
Sustainability	Supports the sustainability of the health and social care system
VFM	Will deliver savings Will improve productivity in primary care Will have a positive impact on demand for services
Quality	Offers an enhanced experience for patients Improves outcomes for patients Reflects parity of esteem between physical and mental health needs
Innovation	Demonstrates real innovation / a new way of doing things
Deliverability	No blockages to delivery e.g. workforce, capacity, IM&T, governance
Evaluation	Clear processes in place for evaluating impact, sharing learning and revising models accordingly

Berkshire West have nominally allocated £0.5m of the central resilience funding to creating additional urgent and on the day access capacity in Primary Care. The bids for the use of this funding were considered at the UCPB meeting on 24 July 2014 and details can be found in the attached template.

Improve services to provide more responsive and patient-centred delivery seven days a week

As part of the development of a Urgent and Emergency Care Strategy for Berkshire West the UCPB will formally re-visit and undertake an assessment against the relevant commissioner plans for "more responsive and patient-centred delivery seven days per week" arising from "Everyone Counts: planning for patients 2014/15 – 2018/19 and as per the best practice from the 7 Days a Week forum which is listed below;

- Patients to be actively involved in shared decision making and supported by clear information
- All NEL admissions clinically assessed by Consultant within 14 hours of arrival
- All emergency inpatients must have assessment by MDT Team to identify complex or ongoing needs within 14 hours
- Shift handovers led by competent senior decision maker and standardised across 7 days per week
- Scheduled access to x-ray, ultrasound, CT, MRI, echocardiography, endoscopy, bronchoscopy and pathology
- 7 day access to Consultant directed interventions such as critical care, interventional radiology and endoscopy and emergency general surgery
- Mental Health - where required patients are assessed by psychiatric liaison 7 days per week
- High dependency patients reviewed by Consultant twice daily, on general ward every 24 hours, 7 days per week
- Transfer to community, primary and social care - available 7 days per week
- All staff involved in delivery of acute care to participate in reviews of patient outcomes.

Most notably, Berkshire West Commissioners have already identified the need for investment in Psychiatric Liaison services and hospital services to support 7 day access.

In 2013-14 and 2014-15 MRET monies were invested in RBFT to fund implementation of the key ECIST recommendations and to progress the 7 day working agenda. The following initiatives were funded as part of developing 7 day working;

- Additional ED Consultants
- Extended hours in radiology
- Out of hours phlebotomy and cannulation service
- Additional Trauma Co-ordinators
- Additional junior doctor support
- Additional Paediatric Consultant
- Clinical Site Management out of hours

The Recovery Plan process also highlighted that discharge from the acute hospital only operated effectively 4 days a week (Monday to Thursday) and as a result this significantly impedes flow through the system. Many of the Recovery Plan measures (now monitored through the Alamac kitbag) are related to access to appropriate care across 7 day including social care.

A new Psychiatric Liaison service has been commissioned for 2014-15. The service will employ 6 WTE Mental Health nurses and 1.6 WTE Psychiatrists and will support prevention of admission 24 hours a day, seven days a week. The team will be linked into Community and Primary Care services via the Hub (also encompassing access to clinical psychologists). The service is already running a skeleton service across the week with additional staff over peak times at evenings and weekends Thursday to Monday and is due to commence in full from September 14.

Berkshire West is planning to further develop 7 day access through investing central resilience monies into schemes which will provide more responsive patient-centred delivery 7 days per week.

The resilience monies will also be used to support schemes specifically aimed at 7 day working within the Local Authorities.

Link Better Care Fund principles in with the wider planning agenda

Further details on BCF plans can be found later in this document. The UCPB members have had a key role in informing the developing BCF projects for all 3 local areas in support of achieving better integrated community care and outcomes for local people. The Board is being kept appraised on two key schemes which are commencing this financial year, and will play a critical role in the reduction of unnecessary admissions and attendances, the Hospital at Home scheme and implementation of the Care Homes Community Enhanced Service.

Expand, adapt and improve established pathways for highest intensity users within emergency departments

The development of a Berkshire West frail elderly (older peoples) pathway will form the patient centred backbone of system changes. The pathway was developed through a multi-agency project supported by the King's Fund and economic modelling led by Finnamore, and the final outputs (due shortly) will be used to inform medium to long term commissioning and service transformation decisions and financial planning of partner organisations. The defined pathway aims to improve experience of patients and carers, make better use of existing resources and achieve significant cost savings across the system through reduction of duplication and workforce changes.

It is envisaged that the pathway will be accessed through a single hub for both social care and health, and care will be delivered by generic care workers, supported by identified care co-ordinators and multidisciplinary teams structured around groups of local GP practices: the overall aim being to improve the care of older people with long-term conditions and those who are at highest risk of deteriorating health. Crisis support will be streamlined with care being provided in the most appropriate setting according to patient and carer need. When hospital admission is unavoidable, the stay will be of high quality with discharge immediately when acute care is no longer required. Support will be enhanced to enable people living in residential and nursing

homes to receive their care and treatment there, and end of life care improved so that people are not admitted to hospital unnecessarily. Key elements of the frail elderly (older peoples) programme will commence within the early to middle part of 2014-15. The pathway is integral to the BCF work locally and assessment of the early impact will inform planning for other pathways for the future years across the Berkshire West Health and social care system.

All relevant organisations are signed up to local Mental Health Crisis Care Concordat, and the Children, Maternity, Mental Health and Voluntary sector Programme Board is taking the lead on this. The Strategy planning workshop will include partner organisations who provide support for people with Mental health conditions, and will ensure that future plans support improved outcomes for people presenting with a MH crisis, and developing services which prevent crisis escalation.

Berkshire West plans to invest resilience monies in the following schemes aimed specifically at those who have been identified as high intensity users of the ED including those with a mental health co-morbidity.

SCAS already have CQUINs in their contract linked to increased awareness of the needs of people with a mental health condition and 'frequent fliers' to incentivise improvements in these areas.

Have Consultant-led rapid assessment and treatment systems (or similar models) within emergency departments and acute medical units during hours of peak demand

RBFT operate Consultant led Senior Triage and Treat (STATing) from 0800 to midnight seven days a week and telephone triage of GP referrals from 0900 to 1800 by Acute Physicians. Some central resilience monies will be spent on Advanced Nurse Practitioners who can support this process and ensure it operates robustly at times of peak pressure.

All parts of the system should work towards ensuring patients' medicines are optimised prior to discharge

It is planned to allocate central resilience funding to week-end and evening pharmacy support. This will increase the dispensary hours to support the extended hours of senior review.

RBFT have satellite pharmacies doing ward dispensing.

Processes to minimise delayed discharge and good practice on discharge

Berkshire West recognises the important of robust discharge planning and an active pull from both acute and community wards. In spring 2014 ECIST supported Berkshire West in undertaking several length of stay reviews on both acute and community wards to provide a diagnostic on what factors are contributing to delays. The findings and recommendations from those reviews have been incorporated into an overarching action plan which is being delivered via the UCOG and overseen by the UCPB.

Impeded flow leading to delayed transfers of care and increased numbers of patients on the "fit to go" list was highlighted as a significant contributing factor in the breach analysis undertaken during the Recovery Plan process and through the ongoing performance monitoring by the system. Numbers and times of discharges from the Emergency Care Unit and Acute Medical Unit along with numbers passing through the discharge lounge are therefore tracked in the kitbag as we know these influence flow.

Some examples of local discharge related recent initiatives are described below. The UCPB will seek to build on this existing good practice through the allocation of the resilience funding as part of our resilience plan for 14-15.

BHFT is proposing to further develop a new Integrated Discharge Team based on the Post-Acute Enablement (PACE) model which will create a 'pull' out to community services which is proving extremely effective in other health and social care economies. They are working with the clinicians in the hospital and community teams to re-organise post-acute care and re-ablement to match resources to the needs of the patients, avoiding unnecessary admissions and promoting timely discharge for this cohort of patients preventing de-compensation and loss of independence.

This multi-disciplinary team comprises BHFT Community Physiotherapy/Occupational therapy and RBFT Service Navigation Team member and the aims of the team are as follows;

- to proactively and collaboratively identify ('pull') inpatients whose clinical needs do not require the intensity of care provided by an acute hospital and who, with appropriate support in their homes, can be discharged in a more timely fashion
- to enable and support RBFT and BHFT to manage the timely discharge of patients where appropriate, thus decreasing the length of patient stay and increasing bed capacity in the acute hospital
- to mitigate the risks associated with an acute hospital admission i.e. loss of independence and confidence
- to provide a high-quality patient experience by delivering seamless, well-coordinated health and social care.

Service Navigation Team

The Service Navigation Team supports internal discharge planning within RBFT and is the liaison point for all other partner health and social organisations into whose services a patient may be transferred. The CCGs made an additional investment into this team in 2013-14 so that this team would be present at Board rounds, ensure Estimated Dates of Discharge are being completed and provide support to complex discharges.

Social Workers in ED and on the wards

All Unitary Authorities now have social worker presence on the wards and in the ED at the Royal Berkshire Hospital. Berkshire West already has an early notification model in place whereby RBFT provides community services, including social care, with information on admissions by locality in advance of patients becoming fit for discharge and this is now complimented by an increasing presence of Social Workers present in RBH on both the wards and in ED, and the development of the Trusted assessor roles referred to previously.

All three Local Authorities have identified the need to expand the numbers and availability of Social workers and Trusted Assessors and some resilience funding will be used to support development of this role.

Plans should aim to deliver a considerable reduction in permanent admissions of older people to residential and nursing care homes

The development of the capacity and scope of community based services through the resilience funding aims to enable patients to return to their normal place of residence post attendance at or discharge from hospital. The UCPB will be monitoring the achievement of a reduction in permanent admissions for care homes through its performance reporting mechanisms.

Reading Borough Council is developing several specific initiatives for this winter period including;

- The development of Time to Assess (Discharge to assess) Beds for patients on the fit to go list who will benefit from a further period of assessment to determine new consideration for alternative living arrangement in extra care sheltered, residential or nursing care. Access criteria will include adults with chaotic life-styles and onward care not funded by Reading Borough Council.
- Full Intake Model: enabling the flow of patients (both those known to services and new) with timely discharge from acute and non-acute hospitals to access the Community Reablement Service. Allowing a further period for assessment to maximise independence and organise on-going with external care agencies. . This will operate on a 7/7 basis to help the flow through the system.

Discussions are also being held to consider how therapy services across hospital and community services can be re-modelled and integrated as per the ECIST "Therapy Challenge" session. Major change will take careful planning but there is a plan to pilot some new ways of working for winter 2014-15. Professor David Oliver is running a follow up session in September to drive this work forward. Details of this plan will emerge over the coming months and will be overseen by the UC Operational Group.

Enhanced Recovery Programme at RBFT

The enhanced recovery programme is about improving patient outcomes and speeding up a patient's recovery after surgery which results in benefits to both patients and staff. The programme focuses on making sure that patients are active participants in their own recovery process and aims to ensure that patients always receive evidence based care at the right time.

Outcomes of the enhanced recovery programme are;

- Better outcomes and reduced length of stay
- Increased numbers of patients being treated (if there is demand) or reduced level of resources necessary
- Better staffing environment.

There are four elements to the enhanced recovery programme;

1. Pre-operative assessment, planning and preparation before admission.
2. Reducing the physical stress of the operation.
3. A structured approach to immediate post-operative and during (peri-operative) management, including pain relief.
4. Early mobilisation.

SRG plans should utilise patient risk stratification tools with an aim of gaining a better understanding of the needs of the 2-5% percent of highest risk patients

As referred to earlier, the Thames Valley Area Team is implementing the Avoiding Unplanned Admissions DES – Proactive Case Finding and Care Review for Vulnerable People within Primary care which requires Practices to;

- Establish a case management register
- [The register should be 2% of population aged 18 and over and at risk of unplanned admission to hospital and CCGs are required to provide a risk stratification tool to identify at risk patients.]
- Inform patients they are on the register and of their named accountable GP and care co-ordinator (if appropriate)
- Put care plans in place for patients on the register
- Offer bypass telephone access to healthcare staff and providers to discuss patients requiring a potential hospital admission
- Offer same day telephone access/consultation to patients included on the case management register for urgent (not routine) enquiries and provide follow-up as appropriate
- Contact patients on the case management register following discharge from hospital
- Regularly review emergency admissions and A&E attendances of patients from care and nursing homes to understand why the admissions/attendances occurred and where they could have been avoided
- Monthly reviews of unplanned admissions and readmissions and A&E attendances of patients on the case management register.

The Enhanced Service will be monitored through a national reporting template for submission to the Area Team.
The Berkshire West CCGs has also agreed to support an enhanced service which compliments the National DES, and will require practices to develop care plans for all over 75s who have had one or more unplanned admissions.

Measurement

As mentioned previously Berkshire West has developed the Alamac urgent care "kitbag", a comprehensive dashboard to provide robust transparent information on capacity and performance across the whole health and social care system. This data system was key to providing insight into where the blocks, delays and pressures are along the pathway and helped informed the system recovery plan which was developed in January 2014. Information from this system is being used on many levels, from day to day resilience to informing commissioning decisions. The potential of the kitbag to support the health and social care economy

is always being developed and a workshop was held in July to look at the potential for the alerts functions within the kitbag to be used to inform early and appropriate escalation.

Investments from ORCP monies

What the diagnostic work told us	What we measure in Alamac to track progress	What initiatives are we investing in for winter 14-15
Need to 'know our numbers' and understand and react to the impact of changes and investments across the system	Review and add measures to Alamac as necessary to track impact of investments and developments on both health and social care	- Alamac dashboard - ORCP Co-ordinator
Need to maintain flow through the ED and have rapid access to senior triage	ED 4 hour performance Daily ED attendances	- ANPs to support STATing - Additional ambulatory care capacity - Privacy and Dignity nurses in ED at peak times
Need to maintain flow 7 days per week	Daily discharge numbers from ECU and AMU Daily numbers through the Discharge Lounge	- Additional medical staff to discharge 7 days - Week-end opening of Discharge Lounge - RBC 7 day capacity - WBC SW and OP capacity - Pharmacy opening evenings and week-ends
Need to have timely effective discharge from acute and community beds	Average LOS on Ready to Go list	- Discharge and Placement Leads in the Community - Integrated Discharge Team at the RBH - Additional Reablement capacity (Reading) - Supported Discharge (RBC) - Willows supported discharge expansion (RBC) - Trusted Assessor training (WBC) - Extra Care housing (RBC) - Scheme to support reduction in DToCs (WBDC)
Predict and manage surges	Triggers being defined in August	- Additional doctors to manage surges in demand - Additional surge capacity in OOH Primary Care - Early Bird GP with SCAS (to smooth flow)
Ensure good quality access arrangements in Primary Care		- Additional capacity across all CCGs
Find alternative pathways for mental health patients		- Mental Health street triage (BHFT/SCAS)

Elective care pathways

Review and revise patient access policy, and supporting operating procedures

The RBFT Access Policy has been recently reviewed and is currently under final review. The policy is due for submission to the RBFT Executive Team in July 2014 and then will be presented at the Planned Care Programme Board in August 2014. The policy will be made available to the public on the Trust website by 30 September 2014.

Develop and implement a Referral to Treatment (RTT) training programme for all appropriate staff

Focused training is being provided to relevant post-holders within the RBH to ensure they have both a broad understanding of the 18 week RTT and specific training to support them in their job role. A full training programme will be carried out from August through to October with super users identified within each location and specialty to champion the 18 week RTT. The super users will be responsible for cascade training for all new joiners.

Carry out an annual analysis of capacity and demand for elective services at sub specialty level, keeping under regular review and updating when necessary

Regular reviews of capacity at sub specialty level are undertaken to support effective management of waiting lists and waiting times. A rigorous, in-depth review of all waiting lists is being undertaken as part of the systems resilience work and a gap analysis will be undertaken to identify the initial and ongoing capacity required to reduce waiting times to 16 weeks and sustain waiting times at this level. This is already completed for the majority of planned care specialties. Medical specialties will be the next phase. A report highlighting any gaps will be brought to the October meeting of the Planned Care Programme Board.

Build upon any capacity mapping that is currently underway and use the outputs from mapping exercises as an annex to operational resilience and capacity plans

This will be an outcome of the capacity and demand work being undertaken as described above and will be brought to the October meeting of the Planned Care Programme Board.

Ensure that all specialties understand the elective pathways for common referral reason/treatment plans, and have an expected RTT 'timeline' for each

Trauma & Orthopaedics have already completed the review of their pathways. Agreement has been reached to focus initial work on pathways and timelines for the top 10 "common" pathways per specialty. Once these have been approved at specialty level, they will be rolled out to waiting list officers and booking officers in order to support their training and understanding of the 18 week pathway for these cohorts of patients. Once the top 10 "common" pathways have been embedded, each specialty will systematically work through their remaining pathways in order to develop a full suite of elective pathways.

In July 2014 the theatre system will be used to identify the top 10 "common" procedures per specialty. Pathways are due to be complete by August 2014 with sign off during September 2014 at the relevant clinical governance or business meetings, followed by implementation.

'Right size' outpatient, diagnostic and admitted waiting lists, in line with demand profile and pathway timelines

The system intends to use IMAS capacity and demand tools to complete the capacity and demand analysis. To tools will be used to identify any gaps along the pathway for outpatients, diagnostics, bed capacity, staffing, theatre capacity and any supporting services required to manage the activity. The review will also identify any gaps to deal with the increase in throughput required in order to manage the initial reduction in waiting times and to sustain waiting times at this level. An action plan will be developed setting out how any gaps can be affordably managed. This will be completed by the end of September.

With immediate effect, review local application of RTT rules against the national guidance, paying particular attention to new clock starts and patient pauses

Validation is business as usual at pathway and speciality level. Cross checking of different data sources is required to ensure all reports reflect the same position.

Pay attention to RTT data quality. Carry out an urgent 'one off' validation if necessary and instigate a programme of regular audits

RBFT validate pathways using various systems as a standard embedded process. However, as a one off exercise, a full and robust validation will be undertaken of all current pathways. A systematic review of the use of RTT rules within the pathways will be undertaken and this will support production of an accurate RTT PTL. Work will commence in July and be complete by the end of August.

Put in place clear and robust performance management arrangements, founded on use of an accurate RTT patient tracker list (PTL) and use this is discussion across the local system

A PTL Group is being established. The group will be Trust-wide and Terms of Reference have already been completed. The Planned Care Group also holds a weekly meeting to monitor theatre activity.

Ensure that supporting KPIs are well established (size of waiting list, clearance time, weekly activity to meet demand, RTT rate etc.) and are actively monitored

RBFT have been asked to suggest a potential set of indicators which are to be agreed by 31 July 2104.

Demonstrate how good practice in referral management is being followed

Timely access to elective service is measured and monitored, and the Programme Board is engaging with GPs and providers to ensure that patients are suitably prepared to have elective surgery carried out within 16 weeks of referral. Work has already commenced in relation to referral refinement for MSK and Ophthalmology services, with practice level referral information having been generated and shared with CCGs and practices to enable outliers in referrals to be discussed. Clinical commissioners within the Planned Care Programme Board will oversee expansion of this early work into all elective areas undergoing service redesign and transformation, working through the appropriate sub-groups.

The Programme Board is leading the introduction of a clinical decision support system (DXS) that enables recommended content such as care pathways, medicines, referrals, patient education and support groups to be filtered and presented to Primary Care during a consultation and which will inform appropriate referral patterns appropriate to the patient's condition.

Demonstrate that patients receiving NHS funded elective care are made aware of and are supported to exercise choice of provider

The Planned Care Programme Board has the responsibility for ensuring that choice of provider for consultant-led services is available for the local population, and to date 80% of all practices are signed up to using Choose and Book.

Wider planning considerations

Avoid inappropriate delays in the Emergency department

Following the ECIST report RBFT have a programme of redesign within the ED including the recruitment of additional ED staff to improve the timeliness of assessment, appropriate clinical streaming. Streaming of minors with Advanced Nurse Practitioners has been real success story with minors rarely breaching the 4 hour standard.

Working with ambulance services

SCAS have sight of the live ED system and are able to see at a glance the current position in the department (how many patients in the department and wait times). Ambulance handover times are one of the trigger

points for RBFT internal escalation should delays start to occur. A robust handover policy is now in place which has been jointly agreed by RBFT and SCAS.

Berkshire West have a well-established GP Triage scheme whereby ambulance crews attending an incident which could be better managed on a primary care or other out of hospital pathway can be passed to the care of the patient's GP. SCAS also have direct access to the BHFT Hub in order to access other community care pathways.

The UCPB and CCGs recognise that there is further work to increase SCAS "see and treat" and "hear and treat" rates and will continue to work on initiatives through this plan to support this. Central resilience monies have been allocated to a scheme whereby SCAS will work with our Primary Care Out of Hours provider to provide an enhanced service to care home patients requiring a GP early in the day and also to fund the 'SOS' bus that operates in Reading City Centre.

Flu Planning

CCGs will ensure compliance with the NHS Pandemic Flu plan. Local plans will focus on raising awareness of the impact of seasonal influenza amongst both staff and the public and promoting take up of the national vaccination schemes. Uptakes rates for flu vaccinations have historically been high in Berkshire West. RBFT and BHFT both have Flu plans in place with supporting Infection prevention control policies. CCGs will support NHS England Public Health in engaging with all national health and wellbeing campaigns.

Maintaining or improving financial performance

The financial stability of the Berkshire West health and social care system is reliant upon the development of person centred community based care which supports a reduction in dependency on statutory agencies amongst the local population, reduces unplanned or unnecessary activity, delays admission to long term care placements, and promotes integration where it improves outcomes for local people, and provides efficiencies for commissioners.

All Programme Boards have a responsibility for the delivery of relevant QIPP schemes and report into the CCG Federation QIPP & Finance Committee.

QIPP schemes schedule 2014/15

Scheme	Programme Board
Psychiatric Liaison service	CMMV
Care Home support	LTC
Community Heart Failure	LTC
Hospital at Home	LTC
Falls (Fracture Liaison Nurse Service)	LTC
Continence	LTC
End of Life	LTC
Integrated Eye Care services	PCPB
De-commission MSK CAS service	PCPB
MSK – clinical variation	PCPB
Cancer care pathways	PCPB
Pathology	PCPB
Haematology/DAWN	PCPB
Medicines optimisation (Prescribing Support Dietician)	PCPB
Increase in community Re-ablement and Rapid Response	UCPB

The QIPP & Finance Committee receives regular Provider Performance reports detailing activity throughput at both NHS and independent providers commissioned. Demand for services including MSK and Ophthalmology

has risen, with the Planned Care Programme Board continuing to focus on service redesign and transformation projects aimed at efficient use of elective care resources.

The Berkshire West CCGs are also using CQUINS and other mechanisms to build in incentives for providers to work with us on schemes to reduce admissions such as Hospital at Home and crisis prevention through robust care planning and information sharing. Where patients do require an admission, a system of early senior clinical assessment and streaming to the appropriate specialty has been implemented. Proactive discharge planning will start on day one with all parts of the system working together to ensure that once patients are ready to leave hospital they can be moved in a timely manner. We will also develop a local tariff for urgent care that incentivises the use of ambulatory care pathways so that a greater proportion of patients can be managed safely and appropriately on the same day without the need for admission to a hospital bed.

Patient Experience

Right care, right time, right place

NHS 111 is one of the key gateways to urgent care and as per the NHS 111 section under principles of good practice; BW will continue to work with SCAS, as its NHS 111 Provider to ensure the Directory of Services is subject to continual improvement. BW will work with CSCSU to intelligently use the outputs from the DoS to inform commissioning decisions.

BW has a number of services/initiatives in place to support directing the patient to the most appropriate service for their needs. This includes the very successful BHFT 'Hub' which accepts referrals to community and mental health services and ensures the patient is directed to the most appropriate service or team.

The Service Navigation Team at RBFT work across the Trust and intensively at the front door of the hospital. They keep their knowledge of non-acute services up-to-date so that they are able to advise clinical teams of any suitable alternative to acute admission and help them make necessary arrangements. This is complemented by the Integrated Discharge Team who bring the 'pull' element into the community.

BW also works closely with SCAS to ensure they have pathways in place to take patients to the most appropriate service. BW operates a successful GP Triage scheme for those needing primary care services and SCAS also have direct access to the Hub in order to access community schemes.

Patients accessing ED as an alternative to primary care during the Out of Hours period can be diverted to the Westcall Primary Care Centre, located in the Maternity Block, under a robust transfer policy.

Children's services

As CCGs we will work with providers and commissioners from across health and social care, including the voluntary sector, and in partnership with parents and children and young people. The Berkshire West CCGs have convened a joint Health and Local Authority Children's Commissioning Strategy group which will coordinate this work, including:

- Informing the plans for co-commissioning of primary care to include a focus on training for GP's in child health and paediatrics.
- Development of a local health deal for children and young people to ensure engagement and expectation of their health care including those from disadvantaged groups.
- The enhancement of services for children and young people in care, those in need of safeguarding including /learning disabilities those with complex need and those in transition to adult services.
- Service improvements which will include implementation of an integrated CAMHS services in the context of the NHS England strategic review of specialist CAMHS services.
- New models of delivery, talking therapies, urgent care and crisis support, effective palliative care, improving the quality of care for community nursing services for children with complex needs.
- Addressing the needs of young carers and parent carers

- Working with the Thames Valley Strategic Clinical network to include palliative care, transition, asthma management and reducing emergency admissions.

Berkshire West CCGs also have a comprehensive Paediatric Handbook which contains GP pathways and parental advice on management of the top 5 common childhood illnesses of;

- Bronchiolitis
- Fever
- Gastroenteritis
- Head injury
- Hip pain/limping

South Reading CCG is developing a proposal to run specific children's clinics in a local venue through the winter funded from central resilience monies.

Mental Health services

In recognition of the poorer health outcomes and life expectancy experienced by people with a mental health diagnosis, and that similarly that those with physical health conditions have a much greater risk of also developing mental health problems, we will aim to give mental health parity of esteem with physical health through the commissioning high quality evidence-based mental health services which reflect the national mental health strategy and other key guidance. We will also work with our providers to ensure that there is a holistic approach to care planning, and care co-ordination which take into account individuals mental health as well as physical health needs. We will also explore at every opportunity a preventative which focuses on people's emotional health and wellbeing.

In working towards mental health outcomes we will:

- Ensure crisis and urgent care services are available at all times including expanding access to liaison services in the hospital and community, working in conjunction with primary care.
- Ensure better co-ordination between Urgent care services and local mental health services.

Berkshire West CCGs have made significant investment in 2014 to improve liaison psychiatry service at RBH and in the Community to support mental health service users who access A&E and UCC. Working in collaboration with ED, UCC & the Wards it is expected that mental health service users will receive rapid access for timely assessment of their needs by qualified mental health practitioners; this will reduce unnecessary hospital admission and avoid delayed discharge from inpatient care settings.

SCAS have a CQUIN in their contract to incentivise improved management of patients with a mental health need. BHFT are working with SCAS to look at using some central resilience funding to develop a mobile mental health team which could work alongside SCAS.

Engagement with the independent and voluntary sectors

Principles

The CCG has formed strong links with Voluntary Sector leads in West Berkshire, Reading and Wokingham to facilitate a robust process for commissioning future services from the sector. This will involve early aligning services to the CCGs commissioning priorities. A seminar is planned to take place in autumn to share the criteria for applying for voluntary sector funds and future contracts will have agreed performance indicators to ensure that the CCGs and Local Authorities as partners achieve health outcomes and value for money.

Capacity Planning

Currently the CCGs fund 61 voluntary sector organisations to deliver various services to support the local needs. The CCG also developed a process with local authority colleagues to map services that are funded by both organisations and this will be further looked at for the 2015/16 grant process.

Key Independent and Voluntary Sector providers

Voluntary sector				
Organisation name	**Elective/Non Elective**	**Type of service**	**Current capacity commissioned**	**Additional potential capacity to support surge in demand**
Red Cross	Non elective	Prevention of admission to hospital scheme operating from ED	Service accepted 826 referrals in 2013 and is funded at the same level this year	Discussions have been held with Red Cross to look at the potential to extend the hours of service
Arthritis Care UK	Elective – Hip & Knee TFRs	Shared Decision making	260 places on ACUK programme	Can commission additional capacity from ACUK if required
Independent sector				
Circle, Reading	Elective	IP/Daycase/OP	Via Choose and Book	Could be commissioned to provide surge capacity
Spire Dunedin	Elective	IP/Daycase/OP	Via Choose and Book	Could be commissioned to provide surge capacity
BIH Ramsay	Elective	IP/Daycase/OP	Via Choose and Book	Could be commissioned to provide surge capacity

Social Action Fund

Berkshire Age UK submitted a bid against the fund and the outcome is awaited. Berkshire West met with the Red Cross to discuss a bid to expand the Prevention of Admission to Hospital scheme which runs successfully at RBFT but this was superseded by a national bid.

The Care Act 2014

The Care Act 2014 introduces a number of changes for local authorities including a new national eligibility criteria, new duties in relation to provision of information, guidance and advice, market oversight, prevention, assessments, implementation of care accounts for self-funders and strengthening of carers' rights. The changes will be implemented over two years from April 2015 onwards. Although the responsibility for managing this change resulting from this legislation rests primarily with the Local Authorities they will be working in partnership with the Berkshire West CCGs to develop co-designed plans on key areas some of which

are already detailed in proposals in the Better Care Fund e.g. Health and Social Care Hub. .Overall there will be a strong focus on early intervention and prevention whilst ensuring that the statutory duties and responsibilities of relevant partners are discharged. The partnership already jointly commission services for carers, this work will continue to try and ensure consistency whilst still reflecting needs specific to each locality.

The Better Care Fund

The following sections are excerpts from the Better Care Fund plans and further detail can be obtained from reading the plans in full.

Reading Borough Council in partnership with South Reading CCG/ North & West Reading CCG

The Reading BCF integration agenda aims to;

- Deliver excellent care
- Enhance the options for care at home across a range of long term health conditions
- Enable people who are frail or unwell to maintain maximum choice, control and independence
- Improve the sustainability of the local care system, with measureable improved health outcomes for the population.

Under a reconfigured system, funding will flow where it is needed in order to realise these aims. New commissioning and contracting arrangements will be made which incentivise co-operation and deliver payments against outcomes achieved for individuals.

The following are the planned schemes;

- Hospital at Home service: designed to treat acute-illness patients that would have been admitted into hospital in their own home or usual place of residence. The aim is to reduce non-elective admissions into hospital, as well as improve overall patient experience.
- Supporting residential and nursing homes: this scheme provides a new model of high level health care support into care and nursing homes throughout the Borough to improve consistency in the quality of care and outcomes for residents. The aim is to reduce admissions from care homes through introducing a GP enhanced community service, providing additional training to care home staff, and additional community pharmacy resource. The scheme overall will strengthen partnership working between care home providers, community geriatricians and health and care staff to improve the quality of life for residents. This will include reducing the number of falls and the prescribing of multiple medications to elderly people.
- Health and Adult Social Care services systems interoperability: a key requirement for better collaborative working is the sharing of information. The implementation of a portal solution which will have feeds from multiple health and social care organisations will facilitate a holistic patient record, with live data which is accessible to health and social care workers securely 24/7.
- Time to Decide beds: the TDD scheme is designed to enable patients to move on from acute care as soon as they are medically stable so they can receive rehabilitation or re-ablement support in a community setting prior to an assessment of their long term care needs. This service is focused on those whose likely long term care needs could be met in Extra Care or Sheltered Care home environment, a residential care home or a nursing home.
- 7 day Integrated Health and Social Care neighbourhood teams: Reading intend to build upon the successful joint working in the Re-ablement Team which works to maximise independence which can be regained after an illness or injury.

Over 2014/15 the model will be developed to incorporate;

a) A health and social care hub
b) Multi-disciplinary teams of health and social care staff at a neighbourhood level
c) Extended GP hours.

West Berkshire Council in partnership with Newbury & District CCG/North & West Reading CCG

The aims of the West Berkshire BCF schemes are;

- Less duplication between sectors, faster and more efficient joint assessments for patients and service users
- Earlier diagnosis, treatment and support to prevent crises, facilitate rapid response by integrated services and prevent unnecessary admissions to hospitals or care homes
- Improved access to information, advice, advocacy and community capacity to manage health and social care needs
- Improved choice and control through better access to a wider range of care and support in the local health and social care market.

The following are the planned schemes;

- Community nurses directly commissioning care/reablement services: the point of contact for the majority of patients in the community who are either eligible for Council services or at risk of admissions to a care home or hospital, is the Community Nurse. Currently if the Community Nurse identifies a care need they have to refer the case for assessment by council staff or other health team who may then refer for crisis, re-ablement, carers support, council commissioned or in-house care provision. In all cases the Community Nurse will be able to initiate and commission in broad terms the care that is needed. If the initial delivery for all services is through in-house care provision, Community Nurses could directly prescribe this service.
- Access to health and social care services through the BHFT Hub: one single entry point is required for access to hospitals, GPs and Access for All, preferably routed through the Health Hub for reablement, crisis care, hospital or care home admission avoidance, including carer breakdown. This will require setting new protocols with the Hub and AFA.
- Patient's Personal Recovery Guide/Key Worker: Each patient will be supported for the journey through the service. This may be a single role, or it could be a function depending on the complexity of the role of a Personal Budget Support worker, a Social Worker, a qualified clinician or a trained care worker.
- Joint care provider as an integrated service: The Council's Maximising Independence Team and Homecare Team, and the BHFT Intermediate Care, as part of the Integrated Community Health services have separate care assessment and delivery units providing similar care in response to patients currently triaged through a joint system. Developing these three staffing units into a combined service would simplify the deployment to support individuals, cut out artificial service transfers, increase the continuity of service and create efficiencies.
- 7 day week service: across health and social care there are already combinations of services available 7 days per week. Provision of an adequate 7 day response service will be scoped and developed as part of the local projects.
- Hospital at Home: (as previously described)

Wokingham Unitary Authority in partnership with Wokingham CCG

The aims of the Wokingham BCF schemes are;

- Achieve the best outcomes for Wokingham residents through early and prevention, case management and maintenance and end of life care
- Reduce unnecessary hospital admissions through a co-ordinated, focused response
- Provide management and maintenance of people with long term conditions, including dementia, moving towards self-care
- Provide services which promote faster recovery and maximise independent living.

Against being aware that the health and social care system has to move to a 7 day economy in order for services to be reactive and immediate when they are needed as well as being closer to home. This includes the vital services that support people with their emotional health and wellbeing at times of crisis.

Wokingham also recognise the need to more closely plan and integrate the acute and community health services together with the many care providers in the private, voluntary and independent sectors that contribute to the system.

The following are the planned schemes;

- Development of an integrated single point of access health and social care hub (as referred to in the other submissions)
- To develop an integrated health and social care Hub which brings together existing points of access
- Provide resources within the single point of access to enable 24 hour telecare and telemonitoring monitoring
- Provide a single point of contact for providing information and support to health and social care professionals and patients/carers/public
- Integrated Short Term Team providing efficient and effective intermediate care and reablement services in order to promote self-sufficiency and to reduce dependence.
- Hospital at Home: (as previously described)
- Supporting residential and nursing care homes: providing 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.
- Health and social care services systems interoperability: (as previous)
- Neighbourhood Clusters/Self-care
- Primary prevention and supporting people to self-care
- Night care service

Berkshire West, through its Better Care Fund work is procuring an IT solution which will enable information sharing across health and ultimately across social care. This solution, the medical interoperability gateway will ensure better collaborative working and improved patient experience and outcomes through the sharing of information. The implementation of this portal solution which will require patient consent will have feeds from multiple health organisations in the first instance and will facilitate a holistic patient record, with live data which is accessible to health and social care workers securely 24/7.

Governance process

Overview

The UCPB has responsibility for the successful planning, commissioning and delivery of emergency and urgent services in Berkshire West. It holds the system to account and ensures that each organisation delivers what is needed to provide efficient and effective care. It has a particular key responsibility for ensuring that all parts of the Health and Social Care System work together to ensure that the national 4 hour A&E target is met. The Board has clear, recently reviewed Terms of Reference, membership reflecting all parts of the urgent and emergency care pathway including Healthwatch and patient representation. There is strong clinical representation on the Board.

The PCPB has a similar role in regard to planned care and in relation to achievement of the 18 week RTT.

Reporting arrangements

The UCPB has oversight of use of the 70% marginal tariff funding within its Terms of Reference. The Board receives regular updates on use of the monies and progress on outcomes of investments.

At the June meeting of the UCPB, the Board agreed the high levels allocations for use of the central resilience monies. The UCPB will sign off the final schemes to be funded by the August meeting. This will include agreement of the KPIs for each scheme. BW will complete a monthly tracker on use and impact of the funding and this will be a standing agenda item on the Board agenda.

BW notes that the Chair will be held to account for use of resilience funding whilst individual members retain accountability for signing up to, and delivery of plans.

Role of Chair

As per the UCPB Terms of Reference the Board is the 'forum of mutual accountability of all partners in the local urgent care system and will have strong and effective senior level input and leadership from all partner organisations'. The chair of the Board is Dr Andy Ciercierski, G and Urgent Care Lead for the BW CCG Federation. In his role as Chair, Dr Ciecierski holds responsibility for the effective running of the Board and in supporting members in holding each other to account for improving system delivery. The Recovery Plan process and work on the Alamac kitbag has supported the Board by providing a clear set of actions and metrics that can be monitored by the Board.

BW recognises that a regional tri-partite group will hold the system to account through the Chair of the group as well as through the provider CEOs.

Independent Analytical Review of 2013/14

In January 2014 BW, supported by Alamac, produced a system wide ED Recovery Plan. This included;

- context for undertaking the work
- analysis of root causes of underperformance
- actions taken to date.

Implementation of the plan has seen a consistent sustained improvement on ED 4 hour performance and the achievement of 95% for quarter 1 2014-15.

BW has also been supported by ECIST who have been working with the health and social care economy since October 2013. Through October and November 2013 ECIST undertook a whole system review of the emergency and urgent care system. In December 2013 ECIST produced an independent report with their findings and a set of recommendations for areas of potential improvement. ECIST continued to work with BW and in the spring of 2014 supported Length of Stay reviews in both acute and community wards. The findings from the whole system review and the length of stay reviews have been combined into an overarching action plan. Delivery of the plan is under the remit of the Urgent Care Operational Group with the Urgent Care Programme Board providing oversight.

Identifying Local Needs

As part of the work with Alamac, the BW health and social care economy have held workshops and run diagnostics in order to understand what is working well, what can be improved and where delays are occurring. The measures within the kitbag were agreed as part of the Recovery Plan process and are tracked daily to give a live view of where the blocks are in the system and what are the weak spots. At a workshop in July 2014 the measures will be reviewed in line with the ORCP guidance and escalation framework to identify if any changes or additions are required.

The workshop will also consider what information should be made routinely available to the Urgent Care Programme Board to support them in their strategic oversight and delivery role and to the Urgent Care Operational Group is their role in identifying and addressing operational blocks and issues.

Risks

The following risks have been identified in relation to delivery of this plan.

	Risk to Delivery	Mitigation
1.0	This is a whole system plan and relies on the relationships between partner organisations for delivery. There is a risk that organisational priorities will compete with priorities in delivering this plan.	The UCPB will play a key role in holding organisations to account for delivery of the plan and supporting mutual accountability between organisations.
2.0	Key to success of the plan is clinical leadership and senior clinical staff will need to be actively involved in both delivery and monitoring. There is a risk that they will not be fully engaged.	Clinical Leaders are key members of the Urgent Care Programme Board (and Operational Sub-Group) and Planned Care Programme Board.
3.0	This plan requires the system to become "smarter" in predicting and responding to surges in activity. This has been a previous area of weakness.	The work with Alamac has strengthened performance in this area and workshops are being held to further develop the role of Alamac as a predictor.
4.0	There is a risk that the actions in the plan will not have the desired impact.	Robust performance arrangements linked to KPIs are being put in place. The Co-ordinators role will include rapid identification of schemes which are failing to deliver so alternatives can be planned.
5.0	Seasonal impact of influenza and/or norovirus could affect delivery of the plan.	Investment into schemes to support robust surge management and response and provide additional medical resource to deal with seasonal spikes in demand.
6.0	RBFT single front door model is based on good practice and supported by Commissioners. It does however, pose risk to achievement of the 4 hour standard.	Additional capacity to ensure front door flow is optimised being funded from resilience monies.
7.0	Activity from health economies other than Berkshire West is beyond the control of the BW health and social care economy.	Representation on the appropriate groups and workstreams.

Assurance Process, Sign Off and Publication

This first cut plan will be submitted to the NHS England Thames Valley by 30 July 2014 in accordance with requirements. Feedback received as part of the assurance process will be addressed during August with the final plan being signed off by CCG Governing Bodies and the relevant Programme Boards. The signed off plan will be published on CCG websites during September. The plan will be refreshed in October ahead of the traditional winter period. In line with the principles of transparency and openness, publishing the plan will allow patients and the public to see how the Berkshire West system is preparing for episodes of increased pressure.

Systems are to be risk assessed in relation to the likelihood of the acute provider at the centre of the system being able to maintain high quality services for patients and delivering key performance standards and the level of scrutiny and monitoring will reflect the assessment of our plans.