

Berkshire West CCG

27 Background to the CCG and an introduction to the Berkshire West Integrated Care Partnership (ICP)

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Background to the CCG

28

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- Established by the Health & Social Care Act (2012) we are a clinically led, statutory body within the NHS which is a membership organisation comprised of all GP practices within our boundary
- Single organisation which covers the whole of “Berkshire West” – coterminous with West Berkshire, Reading and Wokingham Borough Councils. Annual budget of £678m.
- Responsible for commissioning (buying-in) and managing ambulance, hospital and community and mental health services
- Delegated authority from NHS England to commission Primary Care Services
- c. 215 separate statutory duties including:
 - acting as funder
 - setting local priorities and incentives
 - arranging the provision of care by determining needs
 - contracting with providers for provision of that care
 - oversight of contracts, ensuring best value for the taxpayer
 - ensuring the provision of a comprehensive local NHS within the available resources.

- As a membership organisation, we are committed to working in a democratic and transparent manner, underpinned by our CCG Constitution
- We are guided by our 'Triple Aim' of:
 - Improving outcomes for patients
 - Providing a better experience of our services for patients and their families
 - Creating a more financially sustainable environment
- Since our establishment, we have been in the vanguard of promoting collaboration and joint working with other NHS organisations, Local Authorities and the Third Sector as the best means to achieving better care for patients
- Since 2016 we have been working with our partners to create the Berkshire West Integrated Care System (now Partnership), proving the concept for the delivery of transformation through joint working. In 2017 we were designated as a National Exemplar ('Wave 1') ICS
- In 2019, the Buckinghamshire, Oxfordshire and Berkshire West STP was designated as a Wave 3 ICS and Berkshire West is a constituent part of this arrangement

Working with our partner organisations, including Local Authorities, we have achieved:

- Establishment of a **multi-disciplinary integrated discharge service** co-located at the RBH which includes social workers and focuses on 'Home First' for patients.
- Year on year **reduction in the numbers of patients delayed (DToCs)** in all hospital settings including weekly director system meeting oversight to identify and address themes through locally agreed coding
- ³¹ Specialist response established as **collaboration between RBH and SCAS for frail fallers** with assessment, treatment and installation of equipment if necessary at home so as to reduce ED attendances. Non-conveyance rate maintained of 75-80%
- **Rapid Response and Treatment service established for Care Homes** which is a medically led multidisciplinary team to assist patients in care homes to remain there and avoid hospital admissions. An 11% decrease in Non-Elective Admissions from care homes was seen in Berkshire West
- High numbers of discharge delays seen due to self funders so **brokerage service** procured and included within integrated discharge service to aid patients and their families. Also made available to patients in other settings within the system
- Consistent in maintaining **mental health parity of esteem** across Berkshire West.

- Committed to the strengthening of the Berkshire West Integrated Care Partnership (see next section)
- NHS Long Term Plan was published in February 2019 and the BOB ICS has been asked to provide a formal response during the Autumn
- This response is likely to include consideration of the future arrangements for CCGs in this larger geography, an issue which is likely to be the subject of consultation with partners later in the year

Primary Care Networks & Designing Our Neighbourhoods

33

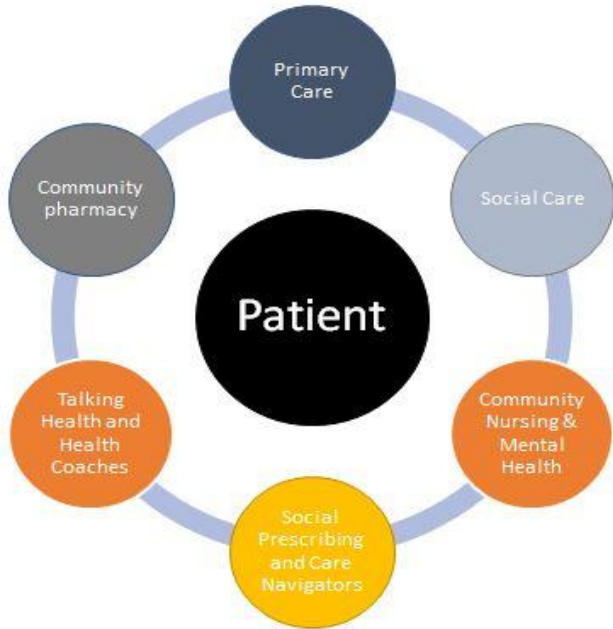
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Wokingham Borough Council

Our vision for integration in Wokingham



34

Core team



35

Collectively managing demand
Health and care support
Prevention and early intervention

Extended team



Wrap services around patient
Strengthen integration
Redesign pathways (LTC and OPD)

We have been running neighbourhood events in localities....

A Primary Care Network is a grouping of GP practices working with community services, social care and the voluntary sector to plan and co-ordinate care within a neighbourhood of 30-50,000 patients with a strong focus on understanding population need and responding proactively to maintain health and wellbeing.



36

From 1st July 2019 all patients should be covered by a Primary Care Network

What PCNs will deliver:

- Resilient primary care
- Proactive care of at risk patients
- Develop new pathways that reduce reliance on hospital care
- Diversified workforce within the PCN – social prescribers, clinical pharmacists, physician’s associates and paramedics
- Neighbourhood teams – district nurses, community geriatricians, dementia workers, social care – the “required norm”



To do this, the PCN Clinical Director will:

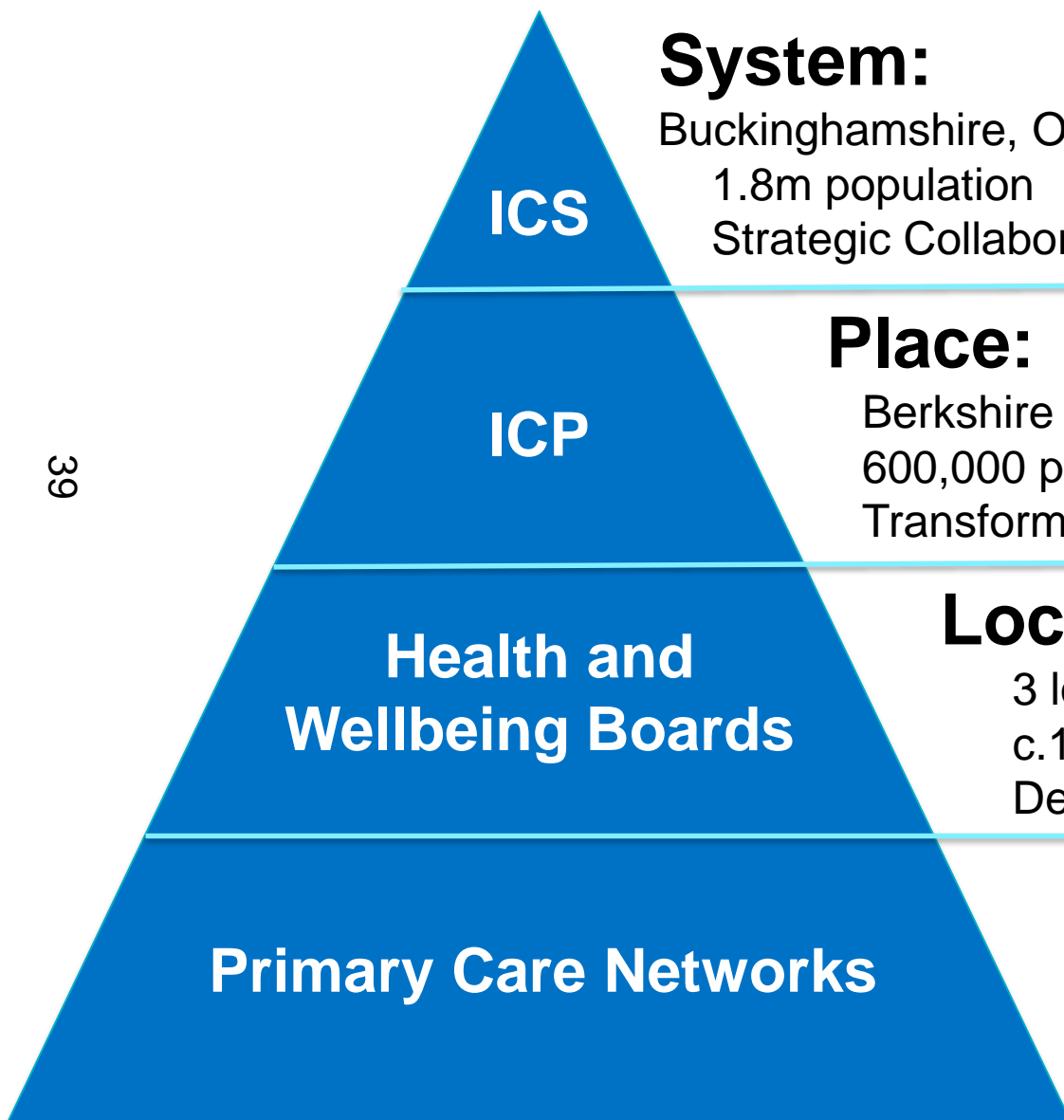
- Work with the commissioner to develop, support and deliver local improvement programmes aligned to national/local priorities – future expansion of the DES.
- Represent the network at CCG and ICS meetings, contributing to the strategy and wider work of the ICS
- Work closely with clinical leaders from other providers
- Develop relationships and work closely with the LMC

How our joint working fits within the broader geography

38

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39



System:

Buckinghamshire, Oxfordshire, Berkshire West (BOB) ICS
1.8m population
Strategic Collaboration of Partners across scale

Place:

Berkshire West Integrated Care Partnership
600,000 population
Transformation and Integration of local services

Locality:

3 localities in line with LA geographies
c.150,000 population
Design of local delivery options

Neighbourhood:

14 neighbourhoods
30-50,000 population
Wraparound integrated care

1. Activities and decisions will occur as **locally** as they can, keeping close to patients and services;
2. Focus effort at the level where it will be most **efficient and effective** at achieving optimum outcomes;
3. **Reduce unwarranted variation** in outcomes and value;
4. Avoid wasted effort by **reducing duplication** within the system;
5. **Drive consistency** of intent, approach and outcome;
6. Align decisions with our long term **population health outcome goals** and our **long term plans and strategy**;
7. Deliver services in a way that is **well understood by our populations and those who deliver care.**

- **Seven** public sector organisations covering the **West of Berkshire:**
 - West Berkshire Council
 - Reading Borough Council
 - Wokingham Borough Council
 - Berkshire West CCG
 - Berkshire Healthcare Foundation Trust
 - Royal Berkshire Foundation Trust
 - South Central Ambulance Foundation Trust
- 44 **GP Practices** and 14 **Primary Care Networks**
- **600,000 residents** living in rural and urban localities
- Combined **budget of c.£1bn** with in excess of **10,000 staff**
- Residents use our services throughout their lives and expect them to operate in a seamless manner

- ✓ People are supported to take care of their own health and well-being
- ✓ Care is provided closer to home, wherever appropriate
- ✓ Services are better integrated across providers to improve experience
- ✓ Organisation of primary, community and social care is increased to provide 'co-ordinated care that efficiently meets residents' needs
- ✓ ⁴²The system has a better understanding of the needs of our population allowing us to design services more effectively
- ✓ A shared understanding of the quality of our services a system-wide approach to the delivery and monitoring of quality;
- ✓ Make the most effective use of the Berkshire West pound and delivering financial sustainability;
- ✓ Staff and workplace wellbeing is improved, and a sustainable and highly skilled health and care workforce is built in Berkshire West.

- For our residents that have been through the MDTs we have seen a **reduction in emergency admissions of 30%**, a **reduction in attendances at A&E of 25%** and a reduction in calls to our out of hour GP service of 27%.
- Community Navigators (Social Prescribing) - In 2018/19 the service received 242 referrals with **87% of users reporting that they felt more self-reliant**.
- The Care Homes Project reported that at the end of Q3 of 2018/19 the project is reporting a **4% decrease in See, Treat & Convey**, a **7.5% decrease** in A&E contacts and an **11% decrease** in Non elective Admissions from care homes in Berkshire West.
- Our Street Triage team reported in 2018/19 Q1 and Q2 **avoided 69 section 136's** which resulted in a **saving** of £117,990.
- Delayed Transfers of Care days for 2018/19 were 3,001 days v Plan of 3,360 (**10.7% better than plan**). This compares to 3,689 days for the same period in the prior year (**18.6% reduction year-on year**).

Any questions?