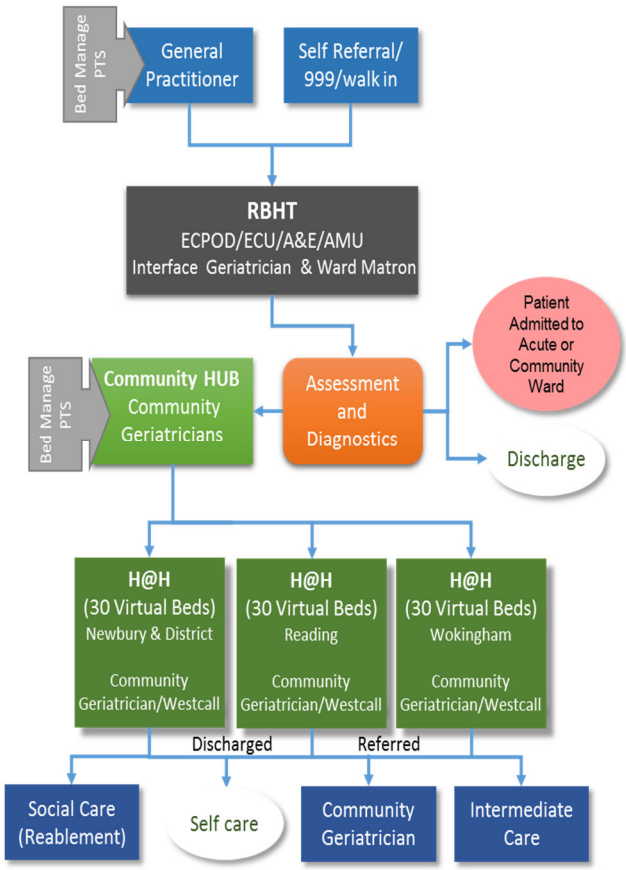
Scheme ref no.
BCF01
Scheme name
Hospital at Home
What is the strategic objective of this scheme?
The service aims to enable care to be delivered closer to home, reducing avoidable non-elective admissions into the Acute Trust, providing a positive patient experience and journey of care through intensive, integrated and seamless multi-disciplinary case management in the patient's own home. A large number of non-elective admissions are a result of acute episodes that could be treated at home, as the patients are clinically stable and do not require diagnostic assessment. The Hospital at Home scheme will facilitate this by providing a "virtual ward" by which patients can be cared for at home. The service will provide safe intensive health support at home for people who are high acuity.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The service is being provided by Berkshire Healthcare NHS Foundation Trust (BHFT), a Community Services Provider. Patients attending Royal Berkshire ED department, who meet the inclusion criteria and are considered suitable for H@H, will receive full diagnostics and treatment in RBFT and then will be transported home by South Central Ambulance Services, to be met at the home by the Matron from BHFT. Daily virtual ward rounds including Social Services, BHFT medical team, and the clinicians responsible for the well-being of the patient will take place. Visits to the patient home will occur as necessary, and it is expected that there will be multiple visits per day. Social Services will support the patient where applicable. The Hospital at Home Service will need to be coordinated, both proactively and reactively, providing clear and integrated pathways of care. This means that those patients that are already known to clinicians within the community and are already receiving continuous care would benefit from contacting a single point of access to the Hospital at Home Service when experiencing a crisis. The target population for this service is those patients with acute infections, or deteriorating long term conditions, or conditions like dehydration, where they are clinically stable, but require intensive support. Patients will be selected by the Community Geriatricians when they consider that an admission would be appropriate and the patient would normally have had a greater than zero length of stay in hospital. We will use the National Early Warning Score (NEWS) and suitable patients will have a NEWS score of 5 or less and be assessed as being stable. They will also be carefully selected according to the inclusion and exclusion criteria for the scheme, but could potentially be anyone over the age of 18 who is registered with a Reading GP and resides within the Reading Unitary

Authority area. The patient needs to consent to be treated in their usual place of residence (home). Patients who meet these criteria therefore are likely to cover a wide age span of suitable patients who may have a variety number of different medical conditions. I.e. the inclusion criteria are not disease specific but offer a more holistic and outcomes focused view of the patient.

Hospital at Home will deliver:

- Locality sensitive operational pathways that deliver sub-acute care in the individual's home, seven days a week
- Clinical assessment and intervention within 4 hours of attendance at the ED in the RBH and effective interface arrangements to ensure as many patients as possible are offered the opportunity to be treated in their own home wherever clinically appropriate, and therefore supported in early and proactive discharge from Emergency Department
- Multi-disciplinary assessment, intervention and review of patients referred into the service led by a Community Geriatrician
- Effective operational liaison between community health and social care services to ensure coordinated and seamless patient care, and timely and safe discharge from Hospital at Home

Overview of Hospital @ Home



The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Wokingham CCG is leading the commissioning of this service. RBFT is the secondary Trust provider that will be responsible for identifying, diagnosing and treating the patient initially, before transferring the patient into the ward at home. BHFT will be the main provider of all clinical and medical staff that will support the patient during their admission, through to discharge, where the community re-ablement team and other appropriate community services provided by BHFT and Adult Social Care may be engaged, where necessary.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The need for a solution in Reading

Non elective admissions to hospital are rising in Reading due to the increased age profile in Berkshire West, and there is also an expected increase in long term conditions that will have an impact on services. Older people stay one and a half times longer in hospital than the average for all age admissions and people with a diagnosis of dementia stay on average four times longer.

The people admitted who are elderly or have long term conditions are often acute but clinically stable. In these instances it is possible to care for patients in the community via a virtual ward.

Evidence base – hospital at home

With specific reference to the "Hospital at Home" scheme a recent report from the King's Fund ***"Avoiding hospital admissions – what does the research evidence say?"*** confirmed that a systematic review of trials comparing 'Hospital at Home' schemes with inpatient care found that, for selected patients, avoiding admission through provision of hospital care at home yielded similar outcomes to inpatient care at similar or lower cost. Elderly patients with a medical event such as stroke or COPD, who were clinically stable and did not require diagnostic or specialist input, had slightly more subsequent admissions in the hospital at home group, but had greater levels of satisfaction, and their care at home was less expensive. This report went on to recommend that commissioners should consider implementing hospital at home.

In addition, the *Nuffield Trust study (June 2013*) of 3 current Virtual Ward programmes, has shown an overall reduction in Electives, Outpatients, A&E and Emergency costs for the first 6 months post discharge to the ward of around 5% overall, compared to the costs of the patients pre referral. However:

- In Devon emergency admissions were reduced by 25.7%;
- In Wandsworth it was a 45% reduction in the first few months;

- In North East Essex they expect a 25% reduction over the first year.

There has been no significant analysis of H@H schemes and even those that exist in the USA (e.g. VA Centres, Presbyterian Healthcare Services, Mercy health and Cigna Medical Group) are based on different models with different outcomes, but all show a reduction in costs of at least 19%.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£827,000

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The key outcomes anticipated are:

- A reduction in non-elective admissions from the defined cohort of patients by 84% over 2 years, which translates to 69.6% in 2015/16, based on 88% bed occupancy and 45 beds open at any one time. This is higher than the evidence base reported above as it is modelled on a more targeted population than was done in Cornwall, with a very clearly defined patient cohort. In addition, the proof of concept that we undertook in July has given us a high level of confidence that this level of reduction is achievable.
- An increase in patient satisfaction levels based on the Adult Social Care User Experience Survey: Q3b "Do care and support services help you in having control over your daily life?"
- Successful discharge from the service to integrated community teams; and
- No avoidable readmissions back to hospital from the H@H service.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The benefits realisation reporting mechanism is still being designed, and we expect to have absolute measurables for reporting actual benefits for both patients and the health and social care system.

There is a project board in place which will monitor the implementation of the scheme, and which has representatives from all partners including Healthwatch and patient representatives.

What are the key success factors for implementation of this scheme?

Key success factors for the Hospital at Home scheme:

- Awareness of the service to ensure that there is enough uptake of the service
- Adherence to a length of stay of seven days to avoid bed blocking

- Sustaining the workforce – although a lot of the staff for this will be redeployed from elsewhere, this will be critical to the success of the scheme
- The model is dependent on a quick turnaround of diagnostic/pathology results
- The volume of calls may impact on the ability for the HUB to manage the coordination process
- Availability of patient transport to convey patients home
- A robust risk assessment of the patient environment will be critical

Scheme ref no.
BCF02
Scheme name
Supporting Residential and Nursing Care Homes
What is the strategic objective of this scheme?
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. Residents and their families will experience improved communication with those responsible for their care across the whole of the health and social care system. Their care will be more patient centric, making their experience of care a more positive one. When a crisis occurs, the needs and wishes of the individual will be fully documented in their pre prepared care plan, allowing the right care to be provided at the right time in the right place, This will include avoiding any unnecessary visits to A & E or an unplanned admission to hospital, thus reducing the pressures on the urgent and emergency care system. Care home residents will have equity of access to the care that meets their need over the whole week that is independent of their place of residence, including avoiding any delayed discharges or transfers of care. This scheme will support our aspiration to reduce delayed transfers of care as well as our local metrics of reducing the “Fit to Go” list and the length of time individuals remain on this list. With more people being supported to live at home for longer, those who need 24 hour support in a care home are likely to have complex or multiple long term health conditions. This has growing cost implications for the health and social care economy. These costs can include Accident & Emergency attendances, emergency admissions to hospital, and readmissions. Some admissions are potentially avoidable, such as those for fractures or urinary tract infections. The aim is to reduce non-elective hospital admissions from care homes through introducing a GP enhanced community service, providing additional training to care home staff, and additional community pharmacist resource. The scheme overall will strengthen partnership working between care home providers, community geriatricians, and health and care staff to improve the quality of life for residents. This will include reducing the number of falls, and the prescribing of multiple medications to elderly people. This will in turn improve the overall health and wellbeing of care home residents.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Reading has chosen to target Better Care Fund resources on care home residents because their medical needs are complex and rapidly changeable. 80% will have mental health needs such as dementia, depression or a long term mental health diagnosis. They have higher needs than other patients for essential medical cover because they are not able to attend their local GP practice. This means that regular GP visits to the care home are required as well as frequent and multiple prescribing interventions. Currently,

however, the range, type, quality and consistency of overall care can vary widely between the individual care homes.

The project is expected to deliver an improved quality of life for patients in care homes through a reduction in emergency admissions, the number of falls, and poly-pharmacy. It will also deliver improved end of life experience through advanced care planning, which will in turn improve the overall health and wellbeing of the patients in homes. The work streams within this project are detailed below.

(a) GP Enhanced Community Service

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

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

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

(b) Enhanced training to care home staff

This scheme will also include additional nurse trainer resource going into care homes. Currently, the Royal Berkshire Healthcare Trust and the South Central Ambulance Service receive a high number of referrals from care homes which turn out to be either inappropriate or avoidable if there was better knowledge within the care home setting of how to manage long term conditions. There are 970 members of staff employed in a care or nursing capacity (i.e. excluding catering, maintenance etc.) based in care homes in Reading. Developing capability within this workforce has the potential to make a significant impact on hospital admission rates.

(c) Introduction of an additional Community Pharmacist Resource

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

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and

providers involved

Berkshire West CCGs will commission this enhanced service from local GP practices. Berkshire Healthcare Foundation Trust's Care Home In-reach team, supported by CCG medicines management pharmacists, will deliver a programme of training to all care home staff across the nursing and residential homes within Berkshire West .

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The case for change

As the UK population ages, GPs and NHS providers face an increasingly difficult task managing the complex needs of care home residents whilst there is increasing pressure through the system. The case for change is unequivocal. In 2011 more than 400,000 people were living in care homes across England, equivalent to the population of Bristol. Over the next 40 years, this is expected to rise to 825,000.

In 2008 Sheffield PCT reported[1] that 'medical cover to care homes is haphazard, evident in a rising and variable rate of emergency admissions that is unacceptable'. In 2005, for example, Sheffield admissions rose by 30 per cent and after a 2006 drop, peaked at 2,270 in 2007. A 2004 local bed usage survey showed 40 per cent of these were for long term condition exacerbations and 25 per cent of admissions from care homes were 'avoidable'. Analysis of non-elective admissions data showed a nearly ten-fold difference in admission rates between homes, indicating inconsistency of care between care homes.

Evidence base for impact

The Cornwall and Isles of Scilly PCT project[2] to train nursing home staff resulted in:

- Reduction in falls and injuries;
- Reduction of hospital admissions by 50%; and
- Prescription savings of £100 per patient per year.

Similarly in Sheffield, savings were evidenced, and if extrapolated to apply to the Berkshire West population the overall cost of secondary care admissions from care homes could be reduced by approximately £941,500.

The introduction of an additional Community Pharmacist and eradicating issues from poly-pharmacy along with a further 5% reduction due to improved training could realise gross savings of £1,258,500.

Sheffield - Integrated care and supporting care homes, BGS March 2012

[1] Sheffield - Integrated care and supporting care homes, BGS March 2012

[2] Improving the Quality of Dementia Care, HSJ October 2012

Improving the Quality of Dementia Care, HSJ October 2012
Nursing Homes in Walsall, Improving care for elderly people, December 2011

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£175,000

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The Care Homes scheme should:

- Reduce unnecessary NEL admissions of Care Home patients by 35% over 2 years (this has been calculated based on the evidence base and also a retrospective review at the reasons for non-elective admissions);
- Reduce prescription costs as a result of regular review by the GP and community pharmacist, in line with the evidence base (to be further modelled and quantified);
- Increase the skills of care home staff (numbers trained will be monitored and competency levels assessed as part of the training programme);
- Improve end of life experience through advanced care planning (numbers of care plans in place will be monitored, which will include those with end of life planning templates in place, and in addition the number of residents being admitted and dying within 0 days will be captured);
- Avoid unnecessary A&E/Clinical Decision Unit (CDU) attendances (to be monitored through acute activity data by the project board as it is has not been possible to retrospectively differentiate by patient address from current data, only by postcodes which includes neighbouring properties to the care home);
- Support the reduction of the incidence of falls by appropriate prescribing of medication and referral to Therapy Services(monitored through the Falls Prevention QIPP project);
- Reduce the number of care home residents appearing on the “fit to go list” (Local Metric HWB Supporting metric tab, monitored through “Alamac Kit Bag”); and reduce length of time on the “fit to go list” for care home residents (Local Metric HWB Supporting metric tab, monitored through “Alamac Kit bag”) - the specifics of both of these are currently being modelled.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The benefits realisation reporting mechanism is still being designed, and we expect to have absolute measurables for reporting actual benefits for both patients and the health and social care system.

Indicator/Outcome	Baseline (Current Value)	Target Value	How Measured?	Frequency of Measurement
Number of patients assessed by GP by CH within 4 weeks of admission to CH	10%	< 80%	Adastra System	Monthly
Number of patients assessed by GP by CH within 8 weeks of admission to CH	50%	100%	Adastra System	Monthly
Number of staff trained by Nurses by CH within 6 months	10%	< 50%	BHFT Training Records	Monthly
Number of staff trained by Nurses by CH within 12 months	10%	< 95%	BHFT Training Records	Monthly
Number of dysphagia training sessions provided by CH in 12 months	0	48	BHFT Training Records	Monthly
Number of CH staff trained by Pharmacist by CH in 12 months	50%	< 95%	Pharma Training Records	Monthly
Number of patients reviewed by pharmacist by CH	50%	100%	Service Record	Monthly
Number of patients reviewed by GP by CH within 6 months of commencement	10%	< 50%	Adastra System	Monthly
Number of patients reviewed by GP by CH within 9 months of commencement	10%	100%	Adastra System	Monthly

There is a project board in place which will monitor the implementation of the scheme, and which has representatives from all partners including Healthwatch and patient representatives.

In addition the project board will closely monitor the participation in the scheme by GPs as this will be critical to the success of the scheme.

What are the key success factors for implementation of this scheme?

The critical success factors for this scheme are:

- GP engagement and participation as the scheme relies on GPs as the accountable lead professional
- Care home staff to be released to attend training
- Availability of training to care home staff
- Defining the care and support delivered by GPs to patients & care homes.
- Supporting the establishment of standards for care planning, medicines reviews, information & communication
- Improved end of life experience through advanced care planning which in turn will improve the overall health and wellbeing of patients in homes

Scheme ref no.
BCF03
Scheme name
Berkshire West Connecting Care
What is the strategic objective of this scheme?
The strategic objective of this project is to improve communication by connecting all the organisations across Berkshire West. We will aim to remove information silos in health and social care, allowing health and social care professionals to make more informed decisions by having access to accurate and timely information regarding their patients/service users. By facilitating the sharing of information, across the whole system over the week, patients will only have to tell their story once and will experience improved communication between themselves, their family, carers and those responsible for their care. The scheme will also enable patients/service users to have a more positive experience of care which is consistent, efficient and seamless across health and social care. This scheme will directly improve efficiency of working, and will also indirectly support - through improved communication - avoidable unplanned admissions, and avoidance of delays by facilitating more timely discharges. Good communication between health and social care will support our aim of providing the right care by the right people at the tight time and in the right place.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This initiative is being split into multiple phases to ensure the expected benefits are being realised and appropriate controls are in place at all stages of the project. Phase 1: The Medical Interoperability Gateway (MIG) will be purchased and information sharing agreements put in place to enable GP practices to share their data with Westcall (OOH), Reading Walk in Centre and Newbury Minor Injuries Unit. Currently these healthcare settings do not have access to any medical information from primary care and use systems that are compatible with the MIG, meaning a quick implementation is feasible. No cohort of patient is being targeted during this phase as this will potentially benefit any West Berkshire resident who attends these care settings and gives consent for their record to be viewed. Phase 2: This will be the implementation of a “quick-start” portal solution provided by Orion. This portal solution will be purchased for one year and will form the basis of a full

business case for the next phase. The portal will be implemented with feeds from at least GP Practices via the MIG, Royal Berkshire Foundation Trust, Berkshire Healthcare Foundation Trust and Out of Hours. There will also be the opportunity for other organisations to feed data into the portal, but is dependent on the use of the NHS number within the system and it being compatible with Orion.

This limited rollout will be the first time that multiple healthcare systems have been linked up in Berkshire West and will provide a single point of access for health and social care workers. The viewing organisations will cover both health and social care, and the project will be looking for a wide range of clinicians and social care workers to view the data and to compare expected benefits against those realised.

The teams that will make up the pilot will be focussed on the frail and elderly cohort of patients to ensure there is a maximum impact of this limited rollout.

Phase 3:

Presuming that the expected benefits were realised, the third phase would be initiated which would be to procure a full portal with feeds from all participating organisations in health and social care in Berkshire West. Access will being given to all health and social care staff that would benefit and are involved in the direct care of patients. During this phase, the scope of the project, or future projects, would also be revisited, with patient access portals and mobile working potential explored.

There is significant evidence to support data sharing amongst organisations with NHS England supporting initiatives through the integrated digital technology fund. The Kings Fund highlight integrated care teams as a key priority and one of the enablers for this is sharing data. A case study was also completed in Cumbria for data sharing through the MIG.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

- Procurement of the MIG (Berkshire West CCGs)
- Information sharing via MIG between GP Practices and Westcall and MIU (Berkshire Healthcare Foundation Trust and Berkshire West CCGs)
- Information sharing via MIG between GP Practices and Reading Walk in Centre. (Virgin Health Care and Berkshire West CCGs)
- Information sharing between GP Practices to facilitate extended hours. (South Reading CCG).
- Information sharing via Orion between GP practices, identified services within RBFT, BHFT and SCAS. (Berkshire West CCGs, Royal Berkshire Foundation Trust, Berkshire Healthcare Foundation Trust and South Central Ambulance Service).
- As above but to include at least one Unitary Authority (Reading Borough Council, Wokingham Borough Council and/or West Berkshire Borough Council).
- Full procurement of a vendor neutral portal solution with rollout to all

participating organisations.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There is a significant evidence base for the benefits that can be realised by having an IT system that can be accessed by all, removing health and social care silos.

The benefits that have been seen elsewhere include

- Contribution to a reduction in elective inpatient activity
- Reduction in A&E attendances
- Reduction in diagnostic testing

Sources for the benefits estimates are:

- Health & Social Care NI Electronic Care Record Deployment
- NHS Greater Glasgow & Clyde EPR
- NHS Lanarkshire Clinical Portal deployment
- Walsall ERDIP programme - the "Fusion" project
- Connecting Care programme in South West of England
- Wrightington, Wigan & Leigh NHS trust EPR deployment
- Canterbury District Health Board in New Zealand

  Province of Alberta in Canada

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£256, 000

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

As this scheme is an enabler, there are no direct measurable impacts on the HWB metrics.

However, it is envisaged that interoperability will be key to ensuring the success of other integrated schemes, and as such will indirectly deliver a number of benefits. In particular, a key interdependency exists with BCF01. For the Hospital@ home scheme to be efficient and safe, health and social care staff need to have real time and timely access to patient care records. Connecting Care will provide the vehicle for staff to communicate with each other and to be able to update care plans,

avoiding unnecessary delays in care provision and minimising the risks of errors in the delivery of care. Without Connecting Care, the Hospital@Home scheme would become less efficient and could incur delays at numerous stages in the patient's journey. Connecting Care will help reduce hand –offs and duplication across agencies.

Information sharing between practices and out of hours and urgent care providers will facilitate robust communication and may support admission avoidance and unnecessary A & E attendances.

Improved communication in general across health and social care integrated teams will being efficiencies in work patterns as well as streamline the patient journey by avoiding unnecessary delays which currently exist due to the lack of real time communication routes.

Patient experience will be measured through feedback questionnaires and it is anticipated that a positive experience will influence the patient experience metric as outlined in the HWB supporting metric tab in Part 2.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Each phase is broken into individual work streams where expected benefits will be measured before moving onto the next work stream. There is a significant change to clinical working so it is important to ensure the change management is sufficient to ensure the clinical transformation is safe and benefits are maximised.

Success will be measured using questionnaires that have been developed from other pilots, usage statistics and assessing secondary care data to check that the expected cost savings are achieved over the period of the pilot.

What are the key success factors for implementation of this scheme?

The key success factors for this scheme include:

- Agreement and sign up by all organisations to information governance and data sharing protocols that are robust and clear
- Regular use and input by health and social care professionals form all organisations in the system, such that this way of working becomes the norm
- Sufficient numbers of patients, when asked, that consent to the wider spread access to their care records

Scheme ref no.

BCF04

Scheme name

Time To Decide / Discharge to Assess

What is the strategic objective of this scheme?

The strategic objective of this scheme is to support the reduction in admissions to residential and nursing care homes, reducing the increasing pressures on adult social care for care home packages.

Patients who have been assessed in hospital as requiring a residential placement will not remain in hospital for longer than is necessary. The length of time these individuals remain on the "Fit To Go List "as described in our local measure will be reduced as will the overall number of people on the list.

We know that a hospital environment, particularly for those with dementia, can be a frightening one, where behaviours associated with dementia are difficult to manage. This has an impact on the assessment process and assessment outcomes, with the likelihood of selecting more intensive onward care solutions being higher than if the individual was in a calmer environment, which is dementia friendly. Patients entering this service will be assessed in a more suitable environment, allowing them, whenever possible, to be empowered and supported to manage their health at home for as long as possible.

Patients will therefore be given better opportunities to have care provided by the right people at the right time and in the right place.

It is hoped that this will provide for a more positive patient/service user journey and experience of care

Our Reading vision, outside of the BCF, is also to increase the number of people in Extra Care Housing, and utilising Extra Care Housing as a viable alternative to residential care. Together, these two initiatives will contribute to the overall aim of reducing demand for residential care packages.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The proposed scheme will provide a "step down from hospital" approach for people whose likely onward care needs on leaving hospital would be for residential care or residential care with dementia support.

This service will be available to all patients/service users over the age of eighteen years, who pay Council Tax to Reading Borough Council. It will be free for up to six weeks. Patients will be selected after having been assessed whilst in hospital as

requiring onward residential care. It is anticipated that approximately 150 individuals will be eligible to be placed in a "Discharge To Assess" bed over a 12 month period (based on 10 beds and an average length of stay of 3 weeks).

The service will build upon an already tried and tested integrated intermediate care model that is provided within one of the Council's care homes. The current service provides support with the aim of working on goals which will enable people to practise the skills of daily living in a supported setting The primary aim will be to maximise independence, so that the person can return to their home environment.

The service will provide support to a variety of people, utilising capacity in the residential dementia unit as well as through the ten self- contained flats within the facility. Procurement of extra care living assessment flats is also underway so that people whose needs could best be met by a service somewhere between Extra Care Housing and residential care can receive a comprehensive and supportive assessment with a view to moving into supported housing.

Service input will be provided by a dedicated social worker, who will develop a more comprehensive assessment in alliance with nurses, physiotherapists, occupational therapists, intermediate care assistants, community psychiatric nurse and general practitioner support.

The service with take on a phased approach, which will be developed on the success of this project and constant scrutiny of the "fit list" to see what other support, could assist a reduction in this number.

Phase one: the service is focused on service users whose long-term care needs could be met in an extra care / sheltered housing environment or residential home. This includes people with dementia (cognitive impairment).

Phase two: following service review, data from the fit list will be scrutinised to ascertain whether there would be benefits in extending the service to people waiting for nursing care.

The scheme will enable patients to be discharged from hospital environments as soon as they are medically stable, seven days a week.

The scheme can support up to one hundred and fifty people annually based on an average length of stay of three weeks. Currently, this type of assessment is provided at two Independent Living Assessment Flats, one in sheltered and the other in an extra care housing scheme. These additional resources will increase the annual assessment capacity from eight to one hundred and fifty.

Other integrated initiatives this scheme will support include:
- Seven Day Access to Health & Social Care
- Health and social care hub
- Development of a Single Point of Access Through a Health & Social Care Hub
- Frail Elderly Care Pathway
- Reading Borough Council policy of 'Value for Money

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

- Service delivery is integrated and provided by Berkshire Health Foundation Trust and Reading Borough Council. Primary care input will also be evident as part of the scheme.
- Five additional intermediate care assistants (full time equivalent) and one member of the clinical support team (full time equivalent) will be recruited to meet the increased demand to provide services for people with more complex needs including double-up support.
- This service will be commissioned by Reading Borough Council

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The case for change

Evidence shows that admissions to the Royal Berkshire Hospital are increasing significantly and particularly for those over 75 years of age. It is also evident that the length of stay for this age group and for those with dementia is much greater than for any other cohort of patients. Equally, it is evident locally that those with the longest length of stay in hospital are those who require discharge to a care home rather than returning to their own home.

Once a placement is identified the current pattern of discharge is only between Mondays and Thursdays as care homes are reluctant to receive a resident directly from hospital over the weekend. It is anticipated this scheme operating seven days a week will help address this issue.

Data collected from the hospital 'Fit List' one day per week for the first quarter of 2014 show patients waits as follows:

	Packages of care		Residential care	
	Incidents	Waiting	Incidents	Waiting
April	10 incidents	53 days	2 incidents	36 days
May	13 incidents	67 days	4 incidents	47 days
June	15 incidents	65 days	5 incidents	40 days

If we forecast this for a year the likely number of people that would be able to receive this service would be 196, with a potential reduction of bed days lost 308.

Evidence for the impact

These types of assessments already take place at two Independent Living Assessment Flats in sheltered and extra care sheltered housing schemes. Evidence

demonstrates that where hospital assessments have been inconclusive in determining a discharge pathway, the majority of people have returned home or moved to sheltered housing schemes following a period of assessment. In designing this pathway, the Kings Fund research into good integration following 'Sam's Story' is being used to ensure best practice in service design and delivery. Currently, rehabilitation is provided with the goal of people returning people to their homes. The admissions criteria are restrictive and only provide services for people with lower level needs. It is mainly older frail adults accessing the service.

The new scheme will provide an appropriate assessment to determine the right accommodation pathway for adults with complex needs, particularly for those whose onward journey would have been a residential setting. Historically, Reading has had a service deficit with assessment facilities for younger adults who often have complex needs. This deficit is reflected across the country resulting in people having to move a long distance from home creating isolation from next of kin and family members. The other outcome has been people moving directly into expensive long-term placements without being given the opportunity to identify the most suitable accommodation. The ethos of this scheme will change to be inclusive of younger adults.

There are similar models operating across the country.

External service is that providers of residential or nursing care report insufficient confidence in the hospital assessment to facilitate hospital discharge on Fridays and at weekends. In many cases, this limits the number of discharge days per week to four. The outcome is that medically stable patients are kept waiting in the hospital setting for community services, and risk being exposed to further infection and deterioration which can have serious consequences.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£456,000

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Supported by our planned commitment to increase extra care housing provision, we plan to reduce our residential admissions by 19 in 2014/15 and a further 20 in 2015/16 (this has not been included in the financial benefits as it has not yet been signed off by the local authority).
- Will support reducing the number of patients on the Royal Berkshire Hospital 'Fit To Go List' due to better patient flow –overall for all patients from Reading we have set ourselves a target of five patients to be on the list for 2015/16 (this has not been included in the financial benefits as it has not yet been signed off by the local authority).
- Support reducing the number of days patients appear on the Royal Berkshire

Hospital 'Fit To Go List' – overall for all patients from Reading we have set ourselves a target of achieving no more than five days duration on the on the Fit to Go list for 2015/16.

- Reduction in delayed discharges from acute and non-acute hospitals over the whole week (seven days).
- Increase in effectiveness of enablement (to be monitored by project board following implementation to assess level of impact).

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Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

- Use of data from the Alamac Kitbag on the fit list which will include numbers and length of stay. This data is inputted by each partner in the health and social care system and produced by the Royal Berkshire Hospital and circulated to local authorities on a daily basis
- User satisfaction feedback from the intermediate care questionnaire given to everyone using the scheme. The data will be processed and analysed by Reading Borough Council.
- Complaints and commendations from those using the service.
- The metrics will be monitored via a dashboard at the Reading Integration Board that is currently in development.

What are the key success factors for implementation of this scheme?

- Patient / family "buy in"
- Competent, well trained staff who are able to deliver reablement
- Shared vision and buy in from staff across the health and social care system including the acute sector, primary care, social care and community health
- Dedicated social worker support will provide advice and guidance to enable timely planning and discharge to appropriate accommodation.
- Implementation of a trusted assessment process to enable timely decisions and discharges from the scheme to be made.

Scheme ref no.
BCF 05a
Scheme name
Whole System - Whole Week (Health & Social Care Hub)
What is the strategic objective of this scheme?

This scheme is one element of a suite of three schemes within the "Whole System: Whole Week" programme (BCF05a-c). They are grouped together as they all share the same strategic aims and all are interdependent upon each other to ensure these aims are met.

The project will be composed of 3 interconnected work streams:

A. **Berkshire West Health & Social Care Hub** –

B. **7 day Integrated Neighbourhood Teams** - Multi-disciplinary teams of health and social care staff at a neighbourhood level organised around groups of GP practices.

C. **Increased Access to GP Practices**

The strategic aim of this suite of schemes is to ensure equity of access to services across the whole system for the whole week. This will provide a more positive patient/service user journey and experience of care which is both consistent and efficient. Integrated care provided by neighbourhood teams, centred on GP practices, accessed by all through a single point of access, will ensure seamless accessible care is delivered. Reading residents will feel empowered and supported to live well for longer in their own home. There will be improved communication between the individual, their family, carers, and health and social care professionals responsible for their care.

Care providers within acute care, primary care, the community and in social services will work together, breaking down organisational barriers to deliver patient centric care offering the best patient outcomes. The right care will be provided by the right people at the right time and in the right place.

We will, through our neighbourhood teams, have more opportunity to promote health and wellbeing for people with lower support needs.

These schemes are aimed at contributing to a reduction in delayed transfers of care and increasing the effectiveness of reablement.

Scheme 5a aims to create an effective integrated single point of access for health and social care across West Berkshire, Reading and Wokingham by:

- providing one centralised point of contact for patients, service users and health/social care professionals, available 24/7; and,
- Developing a model that provides a simplified process, a consistent approach,

less bureaucracy and less duplication.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

There are currently around 56 different points of access to care across Berkshire West, all with different arrangements and resources, using different referral criteria for eligibility into specific services. Few of the existing points of access are available 24/7. This creates inconsistency, fragmentation and duplication.

The aim is to create a model of referral and assessment that moves from a fragmented set of health and social care services to a co-ordinated service that is easily accessible through a single point. It will build on and integrate with the newly established Berkshire-wide Health Hub and on the "Berkshire 10" system wide approach to integration.

A Berkshire West Health Hub, hosted by Berkshire Healthcare Trust, our community and mental health provider, has been operating for some time and is demonstrating. efficiency benefits for the staff as well as improving delays in discharge, evidenced by a reducing "Fit To Go list" within the acute sector. The aim will be to replicate some of these gains into the new single point of access health and social care hub.

Detailed works is underway via consultation and engagement with all key stakeholders to scope out, plan and develop an integrated single point of access Health and Social Care Hub across Berkshire West. This will include mapping of existing patient flows with the aim of improving efficiency and productivity. The service will operate throughout the week providing a 7-day service, 24 hours a day.

As part of the detailed scoping work, the Project Board will explore options relating to who will deliver the Integrated Health and Social Care Hub and from where – e.g.: it could be incorporated into the existing health hub run by BHFT or into one of the existing points of access run by one of the local authorities.

It is important to recognise that the development of an integrated single point of access Health and Social Care Hub will require a significant culture shift to achieve better collaboration, partnership working and integration, not only across local government and the local NHS at all levels but also across and between the three localities in Berkshire West. There will be a need for staff to embrace change and to focus on doing things differently and not just delivering more of the same.

This initiative will align with the frail elderly pathway work, and will be closely interrelated with a number of other BCF schemes.

- The Berkshire West Connecting Care IT solution - true interoperability will significantly enhance the efficiency and effectiveness of the Hub.

- A 24/7 single point of access for health and social care will support the implementation of neighbourhood working and increased GP access over the week by providing an effective and timely resource for triage, provision of advice, information, support and signposting and so potentially reducing delay in the management of referrals.

It is proposed to target patients and services users most likely to benefit: i.e. those in high risk groups with complex health and social care needs and with multiple long term conditions, with the intention of reducing the occurrence of additional health problems in this group and supporting them to achieve greater control and ability to manage their health and social care.

The volume of patients that will benefit from this scheme is yet to be determined, as the detailed design of the hub has not yet been agreed. However it is anticipated that the 2% with high risk of unplanned admissions will be included. The baseline will be determined from the current activity through the Health Hub, Reading Borough Council and all other main points of entry into the system.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The delivery of this scheme will be designed, managed and controlled by a dedicated Integrated Health & Social Care Hub project board, reporting to the Berkshire West Partnership Board and the West of Berkshire Integration Programme Board.

The aim is to establish the Hub by June 2015; details regarding the "Hub" timelines are indicated on the GANTT chart in section 1 c)

A key part of the detailed planning will involve the key stakeholders, the Berkshire West Partnership Board and the West of Berkshire Integration Programme Board agreeing the commissioner(s), budget, performance metrics and management structure for the Hub.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

A lack of joined-up care has been described by National Voices as a huge frustration for patients, service users and carers. (National Voices 2011). Emerging evidence suggests that developing an integrated single point of access health and social care hub where services are co-located (either virtually or in reality) is more convenient for users, and has the potential to help enable more integrated and timely care (Imison *et al* 2008).

Reviews by The King's Fund and the Nuffield Trust of the research evidence conclude that significant benefits can arise from the integration of services where these are targeted at those client groups for whom care is currently poorly co-ordinated (Curry and Ham 2010; Goodwin and Smith 2011; Ham *et al* 2011b; Rosen *et al* 2011).

The literature confirms that focusing on patients at highest risk leads to better outcomes (Hofmarcher, Oxley and Rusticelli, 2007) and that focusing on improving patient care helps to overcome professional boundaries for staff working in an integrated and collaborative structure (Heenan and Birrell, 2006).

The provision of information and support for patients / carers / members of the public through a single point of contact will create better informed service users. Being informed is a prerequisite to being involved and engaged, and there is a growing consensus that more engaged patients experience better outcomes (Health Education England, 2014).

The establishment of a single point of access for health and social care in conjunction with other transformational improvement schemes is identified as being best practice, as demonstrated by initiatives across the country, e.g.: NHS North West London, Torbay & Southern Devon Care Trust, Bridgewater Community Health NHS FT. However, many of these initiatives have yet to publish robust, evidence based evaluations of their impact. In addition, as most of the initiatives include a number of different improvement schemes, it is not yet possible to identify with certainty the unique impact of developing a single point of access health and social care hub.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Part of 7 day scheme – total £1.37m

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Improved communication, transmission of information and data sharing within and between health and social care teams across all 3 localities
- Faster response times which should reduce delays in referrals and should expedite discharge by facilitating the co-ordination of timely support and care
- Contributing to enhancing patient and service user satisfaction as the difficulties and frustrations they experience in navigating a complex and un-coordinated health and social care system will be reduced if not removed entirely
- Assist the acute unit in achieving greater efficiencies through improved patient flows

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

During development of this scheme, the Single Point of Access Health & Social Care Hub project board will undertake ongoing monitoring of progress. As part of implementation, the project board will determine the process for regular assessment, review and evaluation of the Hub.

It is likely to be agreed that providers working within the Integrated Health & Social Care Hub will be required to collect data around service utilisation and service user

satisfaction; in particular from the perspective of whether the new model of service provision makes a difference to those on the receiving end and whether patients and service users report a better, more seamless, experience of care.

Project evaluation will involve both qualitative and quantitative evaluation to ensure that the Hub is operating effectively and is achieving its objectives. Key performance indicators will be agreed during development and will include delivering better outcomes and customer experience for patients and service users and the Hub's contribution to the achievement of any of the targets within the Better Care Fund metrics. Evaluation will be undertaken through analysis of data and satisfaction surveys and recorded on the project dashboard.

The findings from the reviews will be reported to The Health and Well Being Boards in all localities via the Berkshire West Partnership Board and also to the Berkshire West Integration Programme Board (meetings for the remainder of 2014 are scheduled for 18 Sept, 16 Oct, 20 Nov, and 18 Dec).

What are the key success factors for implementation of this scheme?

The scoping, planning and development of an integrated single point of access Health and Social Care Hub will take place during 14/15 with the aim of having an agreed model of an integrated Health and Social Care Hub in place and operational by June 2015, although this might be in the form of a pilot across a smaller area initially, to ensure the success of the initiative prior to full roll-out.

Whatever the final design of the hub, there will be a need to:

- Achieve agreement, support and commitment for the scheme from all key stakeholders, including agreement of a project plan. This will include identifying any conflicting organisational priorities / different ways of working between the various organisations, any potential impact on the services required by other providers and any perceptions of professional boundaries that may hinder the project and agreed action to address these
- Agree where/how the Hub is to be established, be that in a virtual or actual location
- Ensure that effective IT systems are in place to support delivery of care via the Hub
- Identify and address any real and perceived barriers to data sharing across the constituent parts of the local health and social care system that might impinge on the development of the Hub
- Ensure appropriate governance processes are in place relevant to the integrated health & social care hub
- Ensure availability of staff in sufficient numbers with the right skills to provide adequate staffing for the hub in response to anticipated no of contacts
- Provide the required education and training to equip the existing and future workforce for this new models of care

Scheme ref no.

BCF05b

Scheme name

Whole System - Whole Week (7 Day Integrated Neighbourhood Teams)

What is the strategic objective of this scheme?

This scheme is one element of a suite of three schemes within the "Whole System: Whole Week" programme (BCF05a-c). They are grouped together as they all share the same strategic aims and all are interdependent upon each other to ensure these aims are met.

The strategic aim of this suite of schemes is to ensure equity of access to services across the whole system for the whole week. This will provide a more positive patient/service user journey and experience of care which is both consistent and efficient. Integrated care provided by neighbourhood teams, centred on GP practices, accessed by all through a single point of access will ensure seamless accessible care is delivered. Reading residents will feel empowered and supported to live well for longer in their own home. There will be improved communication between the individual, their family, carers, and health and social care professionals responsible for their care.

Care providers within acute care, primary care, the community and in social services will work together, breaking down organisational barriers to deliver patient centric care offering the best patient outcomes. The right care will be provided by the right people at the right time and in the right place.

These schemes are aimed at contributing to the reduction in delayed transfers of care and increasing the effectiveness of reablement.

Scheme 5b will, through our integrated neighbourhood teams, have more opportunity to promote health and wellbeing to people with lower support need. Creating smaller, geographical areas as operational units, recognising the variances between populations within a district, and creating one team to work together for that community, would enhance the patient experience achieving a more effective and efficient service provision.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Neighbourhood Cluster Teams (NCTs) are multidisciplinary teams of health and social care professionals who will be allied to GP clusters or hubs across Reading.

The focus of NCTs is to streamline the approach to case managing care for patients utilising community based multi professional teams to provide joint care planning and co-ordinated assessment of need.

The NCTs will ensure that there is the opportunity to seek input from a range of health and social care specialists in the borough so that any specific care required can be provided early.

The Neighbourhood Cluster Teams NCTs) will integrate health and social care teams across the week to respond to local patient/service user need providing early interventions through care planning. This will reduce the need for repeated assessments by reducing duplication, improving that patient/service user experience by integrating care and reducing fragmentation of health and social services across the economy.

The target population will be those high risk groups with complex health and social care needs and multiple long term conditions, the majority of whom will be those in the top 2% at high risk of unplanned admissions as identified by the GP practices through the National Directed Enhanced Service.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The service will be commissioned jointly by CCGs/local authority and provided through integrated teams within Berkshire Healthcare Foundation Trust and Reading Borough Council.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Early in 2013, the Berkshire West health and social Care economy commissioned Capita to undertake a piece of work focusing on demand and capacity modelling. It identified 5 early specific areas of pressure the economy was experiencing:

1) Increased A&E attendances
2) Increase use of Out of Hours provision
3) Increased demand for Ambulances
4) Pressure on A&E capacity
5) Increase demand for non-elective procedures.

17 options to address these pressures were identified. Two of these relate directly to the Neighbourhood working project, namely, “enhanced use of risk stratification to support Multidisciplinary working” and “the creation of the Health and Social Care Coordinators”.

Thus a scheme of case coordination was established in July 2013 across health and social care, working specifically with those of a risk stratification score (RUB) of 3 – 4, i.e. a future likelihood of requiring an unplanned admission.

The case co-ordination project has brought health and social care together and has

acted as a catalyst to better support service users. The neighbourhood teams scheme will be natural extension of the success we have seen to date.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Part of 7 day scheme – total £1.37m

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

It is envisaged that an increase in impact of neighbourhood cluster teams will be an enabler to support:

- A reduction in delayed transfers of care (impact is currently being modelled)
- A reduction in demand for residential care placements (impact is currently being modelled)
- A reduction in unnecessary A&E attendances (impact is currently being modelled)
- An increase in patient satisfaction levels based on the Adult Social Care User Experience Survey: Q3b "Do care and support services help you in having control over your daily life?" (monitored through patient satisfaction surveys carried out by providers)

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

This scheme will be monitored through provider patient satisfaction surveys.

Contractual reporting between the providers and commissioners will be collated through the dashboard and monitored by the Reading Integration Board.

Key performance indicators will include caseload activity, utilisation of health and social care resource (activity and finance) and monitoring of any impact on admission avoidance, reduction in subsequent caseload, permanent residential admissions and any impact on increasing the effectiveness of reablement through correlation with the 91 day post discharge data with the NHS numbers of those on the neighbourhood cluster casemix.

What are the key success factors for implementation of this scheme?

- Good robust engagement and coproduction with health, social care, housing and voluntary sector
- Workforce development to include generic worker role
- Primary care involvement in designing the definition of the neighbourhoods

- Scoping of suitable accommodation within each neighbourhood area to provide a team base
- Robust information sharing agreements
- Strong leadership to deliver transformational change
- Increasing community resources to deliver new models of working over a 7 day period

Scheme ref no.
BCF05c
Scheme name
Whole System - Whole Week (Increased Access to GP Practices)
What is the strategic objective of this scheme?
This scheme is one element of a suite of three schemes within the "Whole System: Whole Week" programme (BCF05a-c). They are grouped together as they all share the same strategic aims and all are interdependent upon each other to ensure these aims are met. The strategic aim of this suite of schemes is to ensure equity of access to services across the whole system for the whole week. This will provide a more positive patient/service user journey and experience of care which is both consistent and efficient. Integrated care provided by neighbourhood teams, centred on GP practices, accessed by all through a single point of access, will ensure seamless accessible care is delivered. Reading residents will feel empowered and supported to live well for longer in their own home. There will be improved communication between the individual, their family, carers, and health and social care professionals responsible for their care. Care providers within acute care, primary care, the community and in social services will work together, breaking down organisational barriers to deliver patient centric care offering the best patient outcomes. The right care will be provided by the right people at the right time and in the right place. We will, through our neighbourhood teams, have more opportunity to promote health and wellbeing to people with lower support need. These schemes are aimed at contributing to the reduction in delayed transfers of care and increasing the effectiveness of reablement. **Scheme 5c** specifically is anticipated to further support admission avoidance, reduce delayed transfers of care and provide enhanced care and access in the community so contributing to a reduction in demand for residential care placements.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
- **What is the model of care and support?** The model is an expansion of GP service provision beyond core hours (8am - 6.30 pm, Monday – Friday) to offer access into early mornings, evenings and at weekends, particularly Saturday mornings. This builds upon and enhances existing extended hour arrangements that have been commissioned by NHS England. Practices will offer both routine and urgent appointments during these extended periods, interfacing with other services to support admissions avoidance, reduce type

3 A&E attendances and maximise opportunities for discharge back to GPs. During these hours there will be requirements to ring fence some appointments for patients who have been discharged to access their GP practice (particularly on a Saturday morning) and a requirement to give a priority to patients identified by practices as being at high risk of admission. These will include patients included on the 2% care management registered developed by GPs as part of the national Avoiding Unplanned Admissions Directed Enhanced Service (DES) (see section 7d)

The scheme will provide more opportunity for patients to access GP services to help manage their long term conditions in the community, thereby avoiding unnecessary admissions and/or attendances to A&E.

This increased access will also enable private home care and residential and care home providers to be confident about taking patients on at the weekend as they will be able to speak to a GP if necessary.

Practices are being commissioned to increase extended hour arrangements during 2014-15 under pilot arrangements which will make more early morning, evening and Saturday morning services available. The service to be commissioned from April 2015 will be shaped by the findings of these pilots, and national best practice including emerging results from the Prime Minister's Challenge Fund pilots, together with the audit of in-hours capacity and utilisation currently being undertaken. It will link with neighbourhood cluster working.

- **Which patient cohorts are being targeted?**

All patient cohorts are likely to benefit from increased access, but the scheme is expected to be particularly effective for patients with complex needs, those identified as being at high risk of admission, those who would otherwise attend A&E for type 3 conditions and those discharged from hospital, including A&E.

Practices will be asked to conduct demand and capacity audits – Practices will be expected to continually review their demand and capacity. Slot availability should be flexible to respond to their patient populations needs. As part of the service specification practices will be required to report on the following:

- number of appointment slots offered over the course of the pilot broken down by each week
- Slot utilisation for each week with a total % slot utilisation over the course of the pilot
- DNA rate
- Targeted questionnaire to those attending during extended hours to establish whether patient would likely have presented at Westcall/A&E as an alternative

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

It is anticipated that extended GP hours will be delivered by existing GP providers,

working as collaboratively as appropriate, with an interoperable IT solution in place as soon as possible and if appropriate. The service is likely to be commissioned by the CCGs as a Community Enhanced Service, potentially linking with NHS England around the existing Extended Hours DES.

GP Providers will commence extended hours working once appropriate plans are in place that ensure there is a sustainable workforce, services are being delivered from an appropriate site, and that the model of delivery is an improvement on existing access arrangements and better meets the needs of patients. It is anticipated that this will be from April 2015.

The scheme will be overseen by the Primary Care Programme Board, with the Primary Care Team within the Berkshire West CCG Federation taking responsibility for setting service specifications and monitoring delivery. The Primary Care Programme Board will in turn feed into the Reading Integration Group. It will be for individual GP providers to implement local practice arrangements.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The evidence base around extending GP hours is still emerging and the arrangements will be commissioned as pilots initially with a requirement to collect capacity and utilisation data which will then be triangulated with A&E and Westcall attendance rates and admissions data. What is currently understood is the patient satisfaction rate with opening hours from the National Patient Survey. For Reading CCGs this indicates that the greatest desire is for practices to be open on Saturday and in the evenings.

	% requesting GP access before 8am	% requesting GP access after 6.30pm	% requesting GP access on Saturdays	% requesting GP access on Sundays
North & West Reading CCG	34	74	84	37
South Reading CCG	34	67	76	37

Ring fenced appointments will help patients who have been discharged from a hospital setting to have easier access to their GP practice. The scheme will also ensure that GP practices are available outside of core hours to support patients with the management of their long term conditions in the community, thereby avoiding unplanned admissions.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Part of 7 day scheme – total £1.37m

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

It is envisaged that an increase in access to GP practices will lead to:

- **Reduced (Out Of Hours) West call activity** – We would anticipate a drop in activity picked up by West call. We can track the activity over the length of the pilot and report back the amount of drop. OOH is able to provide us with a baseline.
- **Reducing delayed transfers of care** (impact to be monitored during pilot period over winter months and reviewed in March 2015 as there is no evidence base)
- **A reduction in demand for residential care placements** (impact to be monitored during pilot period over winter months and reviewed in March 2015 as there is no evidence base)
- **A reduction in unnecessary A&E** attendances (impact to be monitored during pilot period over winter months and reviewed in March 2015). Anticipated drop in attendances for patients who are redirected into the urgent slots available as part of the Saturday morning and evening provision
- **Better access for patients who are unable to attend GP surgery during normal working hours** – Baseline data is included within the business case. Follow up local surveys (required in the specification) and the national Ipsos MORI survey should reflect increased satisfaction with opening hours. Targeted advertising within practices to reach patients who could not otherwise attend during normal core hours

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The scheme will be overseen by the Primary Care Programme Board who will report to the Reading Integration Group.

As part of the providing the service, providers will be required to collect data around capacity, utilisation and patient satisfaction. A&E and Westcall attendances and admission rates will be reviewed, with a particular focus on what happens at times close to when the surgery is offering additional access. In addition to practice monitoring of patient satisfaction, GP Patient Survey data (questions relating to satisfaction with opening times) and Friends and Family data will be reviewed.

What are the key success factors for implementation of this scheme?

- Practice engagement will be critical to the success of this scheme. 27 out of 30 practices in Reading have already expressed interest in and have indicated a willingness to offer additional hours under proposed CCG proposed pilot schemes.
- Key Interdependencies: IT connectivity – the project will link with the Connecting Care workstream to ensure that GPs working through a hub model have access to the necessary clinical information. The Neighbourhood Cluster model will ensure that practices are able to link with other services in the out-of-hours period to meet patient needs.
- The scheme will require robust patient communication.
- Effective co-commissioning arrangements with NHS England to be formalised.