ITEM NO: 57.00

TITLE	**Better Care Fund**
FOR CONSIDERATION BY	Health and Wellbeing Board on 30 January 2014
WARD	None Specific
STRATEGIC DIRECTOR	Stuart Rowbotham, Director Health and Wellbeing

OUTCOME / BENEFITS TO THE COMMUNITY

The principle of the Better Care Fund Plan is for health and social care services to work more closely together. It supports a local commitment to moving towards better integrating services, working in partnership through a single pooled budget to achieve a better customer journey, better outcomes and better value for money. This will benefit all those living in the borough using health and social care services.

RECOMMENDATION

That

1) the Health and Wellbeing Board notes and supports the outline of the proposed Better Care Plan and progress made to date in relation to developing the plan for the submission of a draft to the Local Government Association (LGA) and NHS England by 14 February 2014.

This will later be followed by the final plan which is then due for submission by 4 April 2014.

2) the Board delegates authority to the Chairman and Vice Chairman of the Board to sign off any agreed amendments to the proposed Better Care Plan

SUMMARY OF REPORT

The attached reporting template details the Wokingham Better Care Fund draft Plan for integrating local health and social care services which the Health and Wellbeing Board are required to approve ahead of submission.

Background

The Better Care Fund (previously referred to as the Integration Transformation Fund) was announced in June as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change.

The Better Care Fund provides an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life.

The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work Clinical Commissioning Groups (CCGs) and councils are already doing, for example, as part of the integrated care "pioneers" initiative, through Community Budgets, through work with the Public Service Transformation Network, and on understanding the patient/service user experience.

The Fund provides for £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users and carers. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare for the Better Care Fund in 2015/16.

In summary:

- Announced at Spending Round 2013
- £200m for Local Authorities (LAs) in 2014/15 (Section 256 of the NHS Act 2006)
- £3.8bn pooled budget in 2015/16 (Section 75 of the NHS Act 2006) for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities
- £1bn of £3.8bn 'payment by performance' in 2015/16
- Signed off by Health and Wellbeing Boards (HWBs)

Better Care Fund plans must deliver on national conditions:

- Protecting social care services;
- 7-day services to support discharge;
- Data sharing and the use of the NHS number;
- Joint assessments and accountable lead professional

Pay for performance will be based on:

- Delayed transfers of care
- Emergency admissions
- Effectiveness of reablement
- Admissions to residential and nursing care
- Patient and service-user experience
- One agreed additional local indicator

- The Better Care Fund is integral to the NHS Strategic & Operational Planning process and local government planning.
- NHS England launched a 'Call to Action' in July this year, which outlines the key national challenges facing the NHS over the next 10 years.
- Clinical Commissioning Groups (CCGs) are required to submit 5-year strategic, operational & financial plans, with the first two years at an operational level of detail.
- Timing for the BCF is aligned with the CCG 2-year operational plans:
    - Draft Better Care Fund plan due by 14 February 2014
    - Final Better Care Fund plan due by 4 April 2014
- The BCF is required at Health and Wellbeing Board (HWB) level.

Analysis of Issues

Detailed analysis is contained within the planning guidance.

FINANCIAL IMPLICATIONS OF THE RECOMMENDATION

The Council faces severe financial challenges over the coming years as a result of the austerity measures implemented by the Government and subsequent reductions to public sector funding. It is estimated that Wokingham Borough Council will be required to make budget reductions in excess of £20m over the next three years and all Executive decisions should be made in this context.

	How much will it Cost/ (Save)	Is there sufficient funding – if not quantify the Shortfall	Revenue or Capital?
Current Financial Year (Year 1)	£2,691m		Both
Next Financial Year (Year 2)	£8,004m		Both
Following Financial Year (Year 3)	To be confirmed		

Other financial information relevant to the Recommendation/Decision
As part of government's drive to provide improved local efficiencies across services and a more co-ordinated experience of care for patients, a national £3.8 billion Better Care Fund allocation has been made available in 2015/16 to support the integration of health and social care services locally. The services outlined in this report are an integral part of the drive towards an increase in community based care which will result in cost reductions in acute and residential based services. In addition to this a number of reforms proposed by the Care Bill which will place further financial pressure on key social care services. The borough has received an allocation of £8,044m from the national total for 2015/16. The total includes £7,431m funding via Clinical Commissioning groups, together with £389k Disabled Facilities Grant and £224k Social Care Capital Grant. The proposed breakdown of cost allocation to the various parts of the plan is yet to be completed but will detailed within section 5 of the plan template (Finance) for draft submission.

Cross-Council Implications (how does this decision impact on other Council services and priorities?)
N/A

Reasons for considering the report in Part 2
N/A

List of Background Papers
Better Care Fund Planning Guide – Annex to the NHS England Planning Guidance; 'Developing Plans for the Better Care Fund'.

Contact Mike Wooldridge	**Service** Strategic Commissioning Division, Health and Wellbeing
Telephone No 0118 9746783	**Email** mike.wooldridge@wokingham.gov.uk
Date 21 January 2014	**Version No.** 1.0

Local Government Association

NHS England

Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Wokingham Unitary Authority**
Clinical Commissioning Groups	**NHS Wokingham CCG**
Boundary Differences	**<Identify any differences between LA and CCG boundaries and how these have been addressed in the plan>**
Date agreed at Health and Well-Being Board:	**30 January 2013**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£ to be confirmed**
2015/16	**£ to be confirmed**
Total agreed value of pooled budget: 2014/15	**£ to be confirmed**
2015/16	**£ to be confirmed**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Wokingham CCG
By	Steve Madgwick
Position	Clinical Chair
Date	<date>

<Insert extra rows for additional CCGs as required>

Signed on behalf of the Council	
By	Stuart Rowbotham
Position	Director – Health and Wellbeing
Date	<date>

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	David Lee
By Chair of Health and Wellbeing Board	Leader of Wokingham Borough Council
Date	<date>

<Insert extra rows for additional Health and Wellbeing Boards as required>

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it.

Engagement with health and social care providers has started at an early stage through representation at the sub group governance of the Health and Wellbeing Board (the Wokingham Integrated Strategic Partnership). The partnership has worked to scope and define the integrated pathway and develop remodelled service designs to feed into service re-specification. On the 6th December Wokingham UA and Wokingham CCG, shared that development plans through the Berkshire West Unit of planning, this meeting included acute and community provider organisations. Social care providers have been involved and engaged through series of forums and workshops to comment on the outline proposals and have joint workshops considering detail of operation, honing ideas and understanding implication and opportunities for their services. There have highlighted areas of current activity where practice could further be improved; identified where commissioning could be more effective and done jointly; possible issues for implementation and thinking about how their own services will contribute and compliment to the integrated service.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Consultation and engagement has been through various methods. These include an NHS 'Call to Action' day. Also through a Learning Disability Partnership Health and Social Care self-evaluation day which gave key messages that have shaped the service design model.

Future plans for consultation on the integrated care pathway include a series of coproduction events through January and February

Engagement with local Patient and Public involvement groups

e) Related documentation

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

Document or information title	Synopsis and links
Pioneer Application	
Health and Wellbeing Strategy	
Joint Strategic Needs assessment	
Hospital at Home business case	
7 day working	As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Medical Intra-operability Gateway business case	Better data sharing between health and social care, based on the NHS number
Wokingham case coordination Operation plan Wokingham Health Hub	Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
Wokingham Call to Action report	Agreement on the consequential impact of changes in the acute sector
Integration of health and social care short term reablement services Project Plan	

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

"Better Care Together" (or whatever agreed strapline is to be used)

Wokingham's vision for health and social care services

Our aim is to provide health and social care services to people within the borough that deliver:

- **Better customer journey** – people get the right care and support when they need it, have a smooth transition across and between different services; between hospital and home; between involvement of different professionals. This is experienced as seamless, well co-ordinated and happens without undue delay.

- **Better customer outcomes** – services are coordinated around the individual, where people are well informed about their conditions and options available to them, are able to maximise their independence, exercise choice and supported to manage long term care arrangements.

- **Better value for money to commissioners** – through better co-ordination, closer working and timely interventions which lead to better outcomes; the need for more costly interventions are avoided or delayed; and the health and social economy in Wokingham delivers more efficient, cost effective services.

Working towards these outcomes requires focus and planning to achieve the following:

- A greater emphasis on prevention and self-care;
- Patients being in control of their own care planning,
- Making better use of technology;
- Establishing a single integrated short team health and social care team
- Establishing 'hospital at home' services
- 7 day access to essential services that enable community based response to alleviate pressure on acute services
- Removing organisational boundaries, bringing together hospital and community services into a more integrated health and social care system.

The difference this will make for patients and service users is that for many individuals who are at risk of losing their independence as a result of delays or lack of the right support at the right time will be supported to continue to live safe and well in their own homes and communities for longer and helped to manage their physical or mental health conditions.

During the Wokingham Call to Action event, our plans for integrating care were discussed and some of comments on what Wokingham's new integrated system will make to patients and service users are provided below:
What we want people to say about their experience of health and social care services in Wokingham (Sam's Story: a typical patient/customer)

- "There are no gaps in my care"
- "I am fully involved in the decisions and know what is in my care plan"
- "My Team always talk to each other to get the best care"
- "I will always know who is in charge of my care and who to contact"
- "I won't have to wait in all day for lots of different people to come at different times"
- "it is less time consuming if all services are together in one place"
- "My care is planned with people who work together to understand me and my carer, put me in control, coordinate and deliver services to achieve the best outcomes for me"

Other local stories demonstrate where working across different services and organisations currently fails:

1. An elderly couple, Mr and Mrs E who live in the borough; husband diagnosed with Alzheimers and his wife who is receiving cancer treatment. Mrs E goes to hospital in Oxford for her appointment leaving husband at home.

   Mr E goes out but becomes disorientated and has a fall, cutting his head and bruising his face. He is taken to A&E by ambulance. The hospital contacts Mrs E who comes to visit her husband and is upset about what's happened but feeling unwell after her own treatment.

   OT phoned Rapid Response but they say they cannot take the case as its open to a social worker in Optalis (Local Authority Traded Company). OT then rang Optalis who explained that they have an independent broker involved but only in relation to assisting the family's daughter in considering future care options. They therefore advised that the OT ring the assessment duty team. Assessment duty team is then contacted who advise that the case is not open to them (not currently receiving services) and that it should be referred to Rapid Response.

   There were an estimated 8 phone calls made by the OT to access a service.

2. A patient was admitted to Clinical Decision Unit. A referral was made to Health Hub for Rapid Response team to support discharge home. Hub received and recorded referral but not able to confirm RR as only RR can decide on receipt of the referral.

   The referrer undertook to contact Rapid Response directly to ask for confirmation. This led to confusion and concern in the Single Point of Access as Hub had not yet processed referral to SPA. Referrer dissatisfied when informed by SPA that patient did not meet criteria for Rapid Response or Intermediate Care.

   SPA contacted adult social care, to whom the patient was known, to see if they could provide support to enable the patient to be safely discharged from hospital.

b) Aims and objectives
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

The outline plan

More people are living longer, with more long term conditions. As a result, demand for services is increasing and is forecast to continue to increase. This is set against the context of reduced budgets in real terms on both health and social care commissioners and Wokingham's expected 12% increase in population size by 2018. Integrated care has been identified as a key route to more effectively address the demands and challenges posed.

Integrated care makes sense for Wokingham patients and service users. It means a better customer experience, better patient outcomes, less confusion and complexity for patients (and carers) and because our model is mostly focused on providing care closer to home, presents a real cost saving opportunity.

The single model of health and social care for Wokingham offers an opportunity to test different ways of working to achieve shared goals of reducing unplanned care admissions and reducing the cost for people with LTC to the system

It was agreed that local objectives need to encompass the aims set out in National Voices:

Objectives:

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

[To include how will make a positive difference to social care services compared to service plans in the absence of the funding transfer.]

c) Description of planned changes
Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The local partners have recognised the need to develop a shared narrative to explain why integrated care matters. That is to identify causes of common difficulties and problems and to work together to overcome fragmentation between services and develop more integrated models of care. The proposed integration plan for Wokingham making use of the opportunity under the Better Care Fund is as follows:

1. **A Single Point of Access for local health and social care services in Wokingham.**

This is important to manage referrals into one point of entry whereby the responsibility and accountability for finding, accessing and transfer of cases sis within one integrated team. It will prevent those circumstances when a case is batted between services due to differing referral criteria or lack of capacity. It will make it much easier for the public and professionals to access health and social care services. Accessing the range of currently disjointed services both frustrates referrers in taking undue time to access the right service and has the effect of slowing down the process of discharge or mobilising short term community based services to avoid an unnecessary admission.

Referrals are made to the already established Health Hub (which operates across the West of Berkshire) through which all referrals from professionals for healthcare services are now channelled. For example, all local authorities in west of Berkshire now receive their referrals from the Royal Berkshire Hospital through the Health Hub. This is proving effective and time saving as the referral arrives already screened leading to quicker allocation and assessment times. This hub will be developed further to extend to all local health and social care services and become a true single point of access for all local services.

Access to short term services in the Borough received and managed at the local Wokingham SPA for all health and social care short term services. This will have a single telephone number which will do take on case co-ordination and management of all the referrals into it.

2. **Integrated Short term health and Social care team**

To provide effective and efficient intermediate care and reablement services in order to promote self-sufficiency and to reduce dependence.

This project brings together the existing START (short term assessment and reablement team) with Intermediate Care into a single short term intervention team under a single manager and with a shared resource and budget.

Currently short term services within the borough are fragmented although good joint working does exist at an operational level. People referred to services through the Health Hub indicate lack of clarity about respective services and their criteria, responsibilities and remit, often being passed between services with no service taking responsibility for making arrangements.

The aim of the integrated team is to improve customer experience as well as the outcomes and efficiency of care.

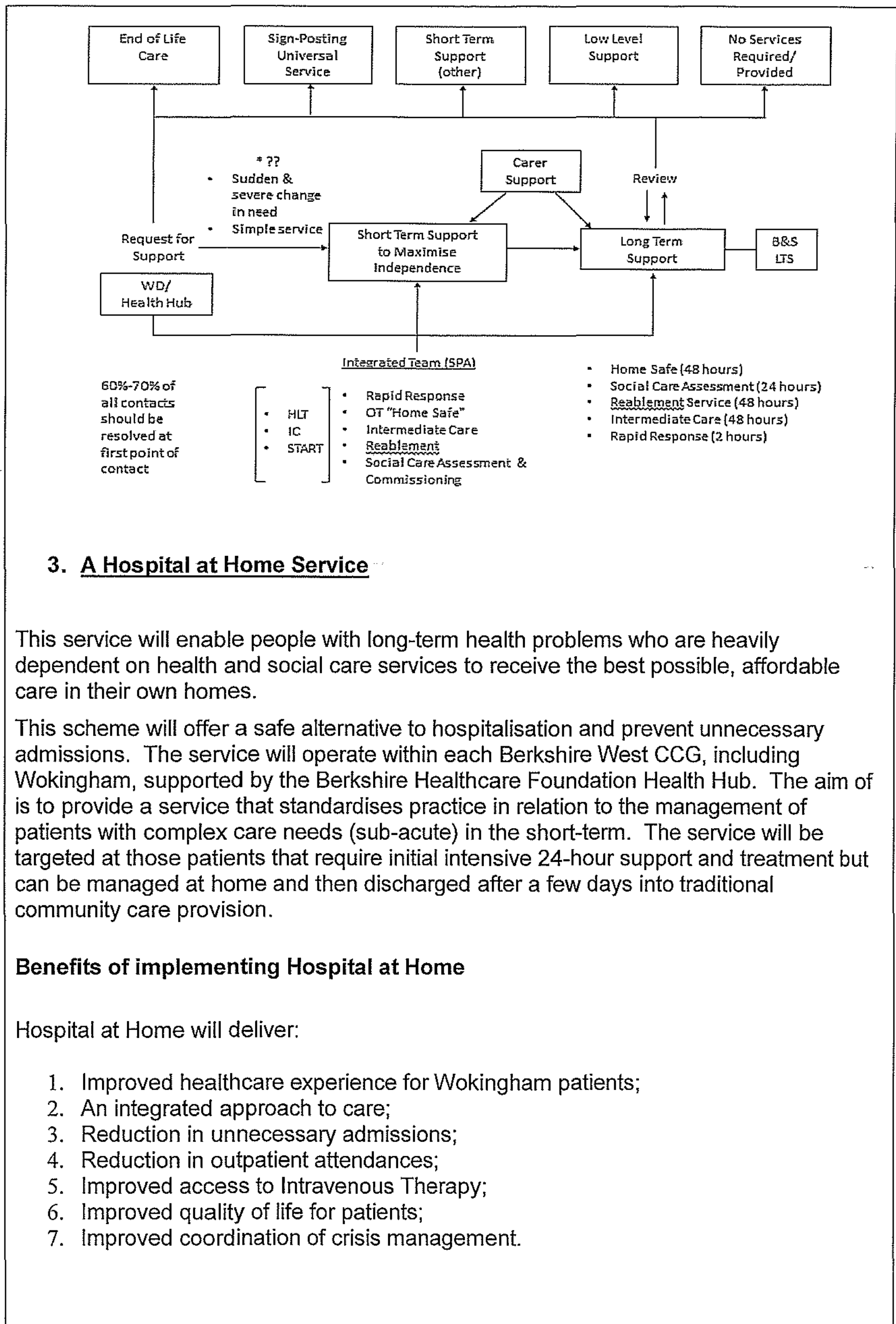
Integrated care is further reinforced by the development of whole system working to address the demands arising from an ageing population and increases in the number of people with multiple long term conditions.

Project objectives:

1. To change the model of service delivery to better meet people's demands for a modern care service which is customer focused and offers choice, personalisation and maximises independence.
2. To increase the effectiveness of intermediate care and reablement services using detailed modeling drawn from the lessons learnt. This new integrated reablement service will be able to assess the potential financial impact and possible savings in the following areas:
   - Reduction in nursing and residential care placements.
   - Achieve and maintain up to 50-60% of patients and customers receiving no further intervention after reablement, Wokingham Intermediate Care achieved 78% this year.
   - Prevent admissions through a number of changes to how care is delivered in the short-term through the use of step up, step down facilities, resulting in lower attendances at secondary care as well as enhancing the discharge pathway for people returning home, preventing inappropriate long term care placements.

     Wokingham is lacking a short-term residential therapeutic or assessment facility. Such short term service facilities would give greater choice to people either to prevent them going into hospital/care home in the first place as well as ensuring that reablement and independence is professionally assessed post hospital discharge.

The service specification brings together NHS domiciliary rehabilitation, specialist rehabilitation and adult social care linked services under one single person-centred, outcome based pathway.
[Update version of diagram here]



3. A Hospital at Home Service

This service will enable people with long-term health problems who are heavily dependent on health and social care services to receive the best possible, affordable care in their own homes.

This scheme will offer a safe alternative to hospitalisation and prevent unnecessary admissions. The service will operate within each Berkshire West CCG, including Wokingham, supported by the Berkshire Healthcare Foundation Health Hub. The aim of is to provide a service that standardises practice in relation to the management of patients with complex care needs (sub-acute) in the short-term. The service will be targeted at those patients that require initial intensive 24-hour support and treatment but can be managed at home and then discharged after a few days into traditional community care provision.

Benefits of implementing Hospital at Home

Hospital at Home will deliver:

1. Improved healthcare experience for Wokingham patients;
2. An integrated approach to care;
3. Reduction in unnecessary admissions;
4. Reduction in outpatient attendances;
5. Improved access to Intravenous Therapy;
6. Improved quality of life for patients;
7. Improved coordination of crisis management.

4. Enhanced Care and Nursing Home Support

This scheme will provide 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 non-elective hospital admissions from care homes through Introducing a GP enhanced community service. It will do this through strengthening partnership working between care home providers, community geriatricians, health and care staff to improve the quality of life for residents by 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.

Scope of the scheme

The local authority and Wokingham CCG are partners to this project which is intended to be rolled out across the West of Berkshire, and is led by the Berkshire West Care Home Working Group.

The aim of the model is to enhance the quality of medical cover for all residents of registered care homes in Berkshire West (excluding care homes for adults with a learning disability) over 18 years of age.

Each care home will have a named GP 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 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 between 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

Benefits of the scheme

Wokingham 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 not be 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.

With more people being supported to live at home for longer, those who need 24 hour support in a care home likely to 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 fractures or urinary tract infections.

Enhanced training to care home staff

This scheme will also include additional nurse trainers into care homes. Currently, the Royal Berkshire Healthcare Trust receives 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.

Introduction of an additional Community Pharmacist Resource

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

5. **Streamlined or integrated Assessment**

Investment will be made to develop a model of assessment and care planning which is based around people's needs which does not duplicate assessments; respects the knowledge and wishes of those being assessed and enables people to have control over their care plan. This would include the sharing of demographic information using the NHS number as the unique identifier and greater detail that would aid screening and understanding of need more holistically (so including environmental and housing needs).

This will be developed at a Berkshire West level or wider to achieve consistency and process for assessment of frail elderly people and ability to share assessment information electronically.

6. **Joint Information**

This will be to improve production, analysis and sharing of information across health and social care services. This will focus on three areas of information activity to ensure:

- signposting and advice is shared resource and consistent,

  Where people are directed to other available services or given information and advice this information this should be from a shared resource and be both consistent and of a high quality

- performance management shared intelligence

  At both a strategic and operational level information and intelligence should be shared and discussed across services and partner agencies, including providers, public health, CCG and local authority. This should form the annual needs assessment process and commissioning activity. Service improvements and

outcome monitoring will be based upon shared information and intelligence derived from existing health and social care information systems.

- operational sharing to facilitate seamless service (includes systems interoperability)

Health and Adult Social Care Services systems interoperability

The ability to share patient data electronically across healthcare and social care settings will enable clinicians and care staff to make better informed judgements about the care they provide or arrange. It also means that people don't have to tell their story or give information more than once. Information sharing is often an important factor in ensuring that people can be moved as quickly as possible to the most appropriate setting for the care they need, so systems interoperability will help to address delayed transfers and discharges.

Scope of the proposal

There is a number of technology solutions which facilitate wide-scale information sharing between the clinical systems used in different settings. The Berkshire West Federation of Clinical Commissioning Groups (which includes the Wokingham CCG) has engaged with an ICT development organisation to ascertain the functionality of its Medical Interoperability Gateway (MIG), and to confirm interoperability across the local health economy.

Only a small proportion of the population will request and be deemed eligible for social care services so as to acquire a social care record. However, most people will be registered with a GP. The GP record is therefore the natural "hub" in terms of a patient's full health and social care record.

Currently, the GP record is built and maintained as a result of interaction with the patient within the GP Practice, but also includes reports such as pathology and radiology results, out-of-hours primary care reports, and discharge summaries from acute, community and mental health providers. Most of these reports are transmitted electronically. Outbound information sharing is used to enable GP practices to complete referral forms into other provider services automatically, or to submit core data to the Summary Care Records (SCR), i.e. medication, adverse reactions and allergies. More data could be submitted into the SCR with the existing technology but only manually, and there have been some technical difficulties with authorised agencies viewing the SCR

Benefits of systems interoperability

The MIG is a secure gateway for exchanging real time data between GP Practices and wider healthcare settings. It presents information in existing clinical systems while meeting interoperability technical and security standards.

Subject to information sharing agreements and patient consent being established, data can be presented within a Detailed Care Record. The benefits include the following.

1. Real time display of the detailed GP patient record

2. GPs fully control access through local sharing agreements
3. Common view of the record in end user systems
4. Fully integrated and embedded into the end user system i.e. no separate login
5. Provides clinicians with access to more clinically-rich patient data at the point of care
6. Fewer investigations ordered creating less duplication
7. Robust audit functionality to support Information Governance

The Medical Interoperability Gateway is being developed to offer the following:

1. **Community Record Service** – views of community information held in the Community systems and made available to GPs as real time view of data.
2. **Medication Reconciliation Service** – access to real time GP patient medication e.g. into a hospital pharmacy system to improve clinical safety and efficiency and reciprocally, discharge medications electronically issued to the GP system.

As an "off-the-shelf" product, the MIG is able to interact with the majority of clinical systems used locally. Where systems do not currently interact we will seek to establish relationships with respective clinical system suppliers in order to build interoperability with their systems.

Careful consideration around information governance is required to preserve information security and to build and maintain the confidence of patients and clinicians. Experience from information sharing initiatives indicates that careful stakeholder management is required and that extensive work is required to establish acceptable and effective information sharing agreements.

7. Supporting People to Self Care

The majority of people are themselves best placed to make decisions about their own health and care needs provided they have capacity and are supported with good information and advice.

The focus on supporting people to have greater choice and control and ability to manage both their health and social care. This will form part of the development of long term conditions management and integrated personal budgets for health and social care for people to manage and co-ordinate their care and support arrangements.

Self-care can benefit people from making basic daily lifestyle choices through to people with long term chronic and complex conditions. Supporting people to self-care requires a focus on better information, support to help with care co-ordination and planning, making best use of new technologies and assistive technology.

8. Development of functions and services at Wokingham Hospital

Currently the Wokingham Hospital provides rehabilitation, intensive nursing or end of life. This is in the main to support frail elderly people but there are no diagnostic services. This means that patients have to travel to and from the Royal Berkshire Acute hospital in order to access these services. The services at Wokingham Hospital are to be expanded to include x-ray, blood analysis, ultrasound and pathology for outpatients as well as inpatients.

9. **Integrating acute and social care working at the Royal Berkshire Hospital**

To have greater Social Work presence in the acute hospital.

This includes have earlier contact by Social Worker when required at A&E to support the access to short term services and assist in pre-discharge discussions working with service navigation team at the 'front door'. This is a new enhanced service outside the support to the normal discharge process. It will work within and alongside the ECU (emergency care unit) and AMU (acute monitoring unit) within A&E.

This is in addition the existing SW presence This would include a named social worker working within the units and to support ward rounds working together with the service navigation team.

10. **Step up and down facilities**

Development of potential sites within Wokingham – links into short term reablement /intermediate care, increasing capacity and broaden options/range of services to give enhanced reablement function.

11. **Night Sitting Carers Service**

Part of longer team support to people at home and avoiding care home placement (currently available upto 3-4 nights as part of Intermediate Care to avoid admission but short term)

12. **7 day services**

Part of longer team support to people at home and avoiding care home placement (currently available upto 3-4 nights as part of Intermediate Care to avoid admission but short term)

13. **Primary Care Enhanced hours**

This element is supporting the proposals already being put forward to the Prime Minister's Challenge Fund which focus around extending access to local GP services from 8am-8pm Monday to Friday and 8am-1pm at weekends. (This will link with integrated short term team in 2.)

[To add]

1. the level of resource that will be dedicated to carer-specific support, including carers' breaks, and how this will help to meet key outcomes
2. how the funding will be used to help local authorities to meet capital costs associated with transition to the capped cost system
3. how the revenue funding will be used to help local authorities prepare to

meet new Care Bill obligations, inc. new entitlements for carers, moving to a national eligibility threshold, better information, advice, advocacy, new safeguarding responsibilities

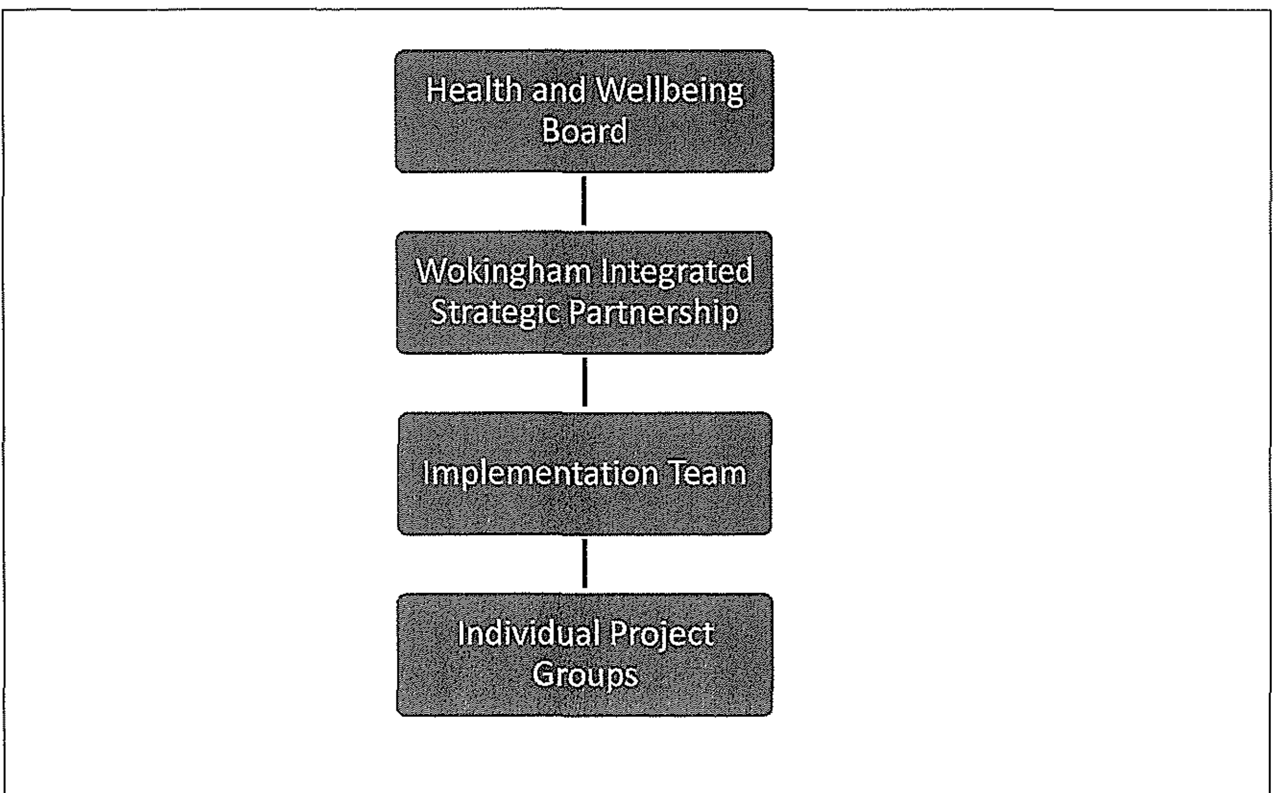
4. Protection of existing social care services

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes



3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

[To be confirmed]

Please explain how local social care services will be protected within your plans

[detail to add]

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy).

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

Our commitment is to care for the most vulnerable people in our community 24 hours a day, 7 days a week throughout the year. This includes support through social work, GPs and in A&E to support avoiding admissions and enabling safe discharge throughout the week.

We currently have community nursing provided 24 hours a day, 7 days a week from the Berkshire Healthcare Foundation Trust.

Similarly Intermediate Care, Rapid Response and START services also run a 7-day service (but not 24/7)

Additional funding has been identified to facilitate discharge and avoid un-necessary admissions from hospital over the weekend which includes support into A&E, GP cover, Social Work and ancillary services such as transport.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

Yes, all health and social care systems will use the NHS number as the primary identifier across health and social care services.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

The multi- disciplinary team meeting (MDT) are the centre of providing local integration with health and social care teams, and have enabled joint patients review and joint planning to support the reduction in unnecessary admissions to hospital by improving preventative clinical care.

Patients with LTC and those who are a high risk of being admitted to hospital have been identified via the ACG risk satisfaction tool and discussed at the a MDT meeting by key professional including community health staff, primary care, social care, medicine manager and voluntary sector and a health improvement plan is put in place.

A lead professional is names for each patient to ensure the effective delivery of actions form health improvement plan and co-ordinate integrated services when there are a number of professionals/service involved

4) RISKS

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

Risk	Risk rating	Mitigating Actions
<Risk 1>		
<Risk 2>		
<Risk 3>		
<Risk 4>		

Association

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Wokingham Borough Council				
Wokingham Clinical Commissioning Group				
BCF Total				

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
BCF01 - Single Point of Access									
BCF02 - Integrated short term health and social care									
BCF03 - Hospital at Home Service									
BCF04 - Enhanced care and nursing home support									
BCF05 - Streamlined or integrated assessment									
BCF06 - Joint Information									
BCF07- Supporting People to self care									
BCF08 - Development of functions and services at Wokingham Hospital									
BCF09 - Integrated acute and social care working at Royal Berks Hospital									
BCF10 - Step-up/down facilities									
BCF11- Night Sitting Carer Service									
BCF12 - 7 day services									
BCF13 - Primary Care Enhanced Hours									
Total									

Association

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Rapid response within two hours.
Home from Hospital
Reablement services in place within 24 hours
Single Point of Access for Health and Social Care teams
Reduced delays and fewer emergency admissions

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	102.7	N/A	
	Numerator	135		
	Denominator	131500		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	63.80%	N/A	
	Numerator	44		
	Denominator	69		
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	5.78		
	Numerator	7.6		
	Denominator	131500		
		2012-13	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*			
	Numerator			
	Denominator			
		(TBC)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]		*(insert time period)*	N/A	*(insert time period)*
[local measure - please give full description]	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	*(insert time period)*	*(insert time period)*

Annex to the NHS England Planning Guidance

Developing Plans for the Better Care Fund

(formerly the Integration Transformation Fund)

What is the Better Care Fund?

1. The Better Care Fund (previously referred to as the Integration Transformation Fund) was announced in June as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change.

2. The Better Care Fund provides an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life.

3. The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work Clinical Commissioning Groups (CCGs) and councils are already doing, for example, as part of the integrated care "pioneers" initiative, through Community Budgets, through work with the Public Service Transformation Network, and on understanding the patient/service user experience.

What is included in the Better Care Fund and what does it cover?

4. The Fund provides for £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users and carers. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare for the Better Care Fund in 2015/16.

5. The tables below summarise the elements of the Spending Round announcement on the Fund:

The June 2013 Spending Round set out the following:	
2014/15	**2015/16**
A further £200m transfer from the NHS to adult social care, in addition to the £900m transfer already planned	£3.8bn to be deployed locally on health and social care through pooled budget arrangements

In 2015/16 the Fund will be created from:
£1.9bn of NHS funding
£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. This will comprise: • £130m Carers' Break funding • £300m CCG reablement funding • £354m capital funding (including £220m Disabled Facilities Grant) • £1.1bn existing transfer from health to adult social care.

6. For 2014/15 there are no additional conditions attached to the £900m transfer already announced, but NHS England will only pay out the additional £200m to councils that have jointly agreed and signed off two-year plans for the Better Care Fund.

7. In 2014/15 there are no new requirements for pooling of budgets. The requirements for the use of the funds transferred from the NHS to local authorities in 2014/15 remain consistent with the guidance[1] from the Department of Health (DH) to NHS England on 19 December 2012 on the funding transfer from NHS to social care in 2013/14. In line with this:

8. *"The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition we want to provide flexibility for local areas to determine how this investment in social care services is best used.*

9. *A condition of the transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and wellbeing boards will be the natural place for discussions between NHS England, clinical commissioning groups and councils on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.*

10. *In line with our responsibilities under the Health and Social Care Act, an additional condition of the transfer is that councils and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.*

11. *A further condition of the transfer is that local authorities councils and clinical commissioning groups demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer"*

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

12. Councils should use the additional £200m to prepare for the implementation of pooled budgets in April 2015 and to make early progress against the national conditions and the performance measures set out in the locally agreed plan. This is important, since some of the performance-related money is linked to performance in 2014/15.

13. The £3.8bn Fund includes £130m of NHS funding for carers' breaks. Local plans should set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes (e.g. reducing delayed transfers of care). The Fund also includes £300m of NHS funding for reablement services. Local plans will therefore need to demonstrate a continued focus on reablement

14. It was announced as part of the Spending Round that the Better Care Fund would include funding for costs to councils resulting from care and support reform. This money is not ring-fenced, but local plans should show how the new duties are being met.

    i. £50m of the capital funding has been earmarked for the capital costs (including IT) associated with transition to the capped cost system, which will be implemented in April 2016.

    ii. £135m of revenue funding is linked to a range of new duties that come in from April 2015 as a result of the Care Bill. Most of the cost results from new entitlements for carers and the introduction of a national minimum eligibility threshold, but there is also funding for better information and advice, advocacy, safeguarding and other measures in the Care Bill.

What will be the statutory framework for the Fund?

15. In 2015/16 the Fund will be allocated to local areas, where it will be put into pooled budgets under Section 75[2] joint governance arrangements between CCGs and councils. A condition of accessing the money in the Fund is that CCGs and councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

16. Funding will be routed through NHS England to protect the overall level of health spending and ensure a process that works coherently with wider NHS funding arrangements.

17. DH will use the Mandate for 2015/16 to instruct NHS England to ring-fence its contribution to the Fund and to ensure this is deployed in specified amounts at local level for use in pooled budgets by CCGs and local authorities.

18. Legislation is needed to ring-fence NHS contributions to the Fund at national and local levels, to give NHS England powers to assure local plans and performance, and to ensure that local authorities not party to the pooled budget can be paid from it, through additional conditions in Section 31 of the Local

[2] Sec 75 of the NHS Act, 2006, provides for CCGs and local authorities to pool budgets.

Government Act 2003. This will ensure that the Disabled Facilities Grant (DFG) can be included in the Fund

19. The DFG has been included in the Fund so that the provision of adaptations can be incorporated in the strategic consideration and planning of investment to improve outcomes for service users. DFG will be paid to upper-tier authorities in 2015/16. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate this funding to their respective housing authorities (district councils in two-tier areas) from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.

20. Special conditions will be added to the DFG Conditions of Grant Usage (under Section 31 of the Local Government Act 2003) which stipulate that, where relevant, upper-tier local authorities or CCGs must ensure they cascade the DFG allocation to district council level in a timely manner such that it can be spent within year. Further indicative minimum allocations for DFG have been provided for all upper-tier authorities, with further breakdowns for allocations at district council level as the holders of the Fund may decide that additional funding is appropriate to top up the minimum DFG funding levels.

21. DH and the Department for Communities and Local Government (DCLG) will also use Section 31 of the Local Government Act 2003 to ensure that DH Adult Social Care capital grants (£134m) will reach local areas as part of the Fund. Relevant conditions will be attached to these grants so that they are used in pooled budgets for the purposes of the Fund. DH, DCLG and the Treasury will work together in early 2014 to develop the terms and conditions of these grants.

How will local Fund allocations be determined?

22. Councils will receive their detailed funding allocations in the normal way. NHS allocations will be two-year allocations for 2014/15 and 2015/16 to enable more effective planning.

23. In 2014/15 the existing £900m s.256 transfer to councils for adult social care to benefit health, and the additional £200m, will continue to be distributed using the social care relative needs formula (RNF).

24. The formula for distribution of the full £3.8bn fund in 2015/16 will be based on a financial framework agreed by ministers. The current social care transfer of £1.1bn and the £134m of adult social care capital funding included in the Fund in 2015/16 will be allocated in the same way as in 2014/15. DFG will be allocated based on the same formula as 2014/15. The remainder of the Fund will be allocated on the basis of the CCG allocations formula. It will be for local areas to decide how to spend their allocations on health and social care services through their joint plan.

25. The announcement of the two-year CCG allocations, communicated to CCGs and councils alongside this planning guidance, includes the Fund allocations in 2015/16. In 2014/15, the additional £200m will be transferred directly from NHS

England to councils along with the rest of the adult social care transfer. The local authority and CCGs in each Health and Wellbeing Board area will receive a notification of their share of the pooled fund for 2014/15 and 2015/16 based on the aggregate of the allocation mechanisms. The allocation letter also specifies the amount that is included in the payment-for-performance element, and is therefore contingent in part on planning and performance in 2014/15 and in part on achieving specified goals in 2015/16.

26. Allocation letters will specify only the minimum amount of funds to be included in pooled budgets. CCGs and councils are free to extend the scope of their pooled budget to support better integration in line with their Joint Health and Wellbeing Strategy.

27. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected by the new Better Care Fund requirements, and will be helpful in taking this work forward.

How should councils and CCGs develop and agree a joint plan for the Fund?

28. Each statutory Health and Wellbeing Board will sign off the plan for its constituent councils and CCGs. The Fund plan must be developed as a fully integral part of a CCG's wider strategic and operational plan, but the Better Care Fund elements must be capable of being extracted to be seen as a stand-alone plan.

29. Where the unit of planning chosen by a CCG for its strategic and operational plan is not consistent with the boundaries of the Health and Wellbeing Board, or Boards, with which it works, it will be necessary for the CCG to reconcile the Better Care Fund element of its plan to the Health and Wellbeing Board level. NHS England will support CCGs in this position to ensure that plans are properly aligned.

30. The specific priorities and performance goals in the plan are clearly a matter for each locality but it will be valuable to be able to:

- aggregate the ambitions set for the Fund across all Health and Wellbeing Boards;
- assure that the national conditions have been achieved; and
- understand the performance goals and payment regimes that have been agreed in each area.

31. To assist Health and Wellbeing Boards we have developed a template which we expect everyone to use in developing, agreeing and publishing their Better Care Plan. This is attached as a separate Word document and Excel spread sheet. The template sets out the key information and metrics that all Health and Wellbeing Boards will need to assure themselves that the plan addresses the conditions of the Fund.

32. As part of this template, local areas should provide an agreed shared risk register. This should include an agreed approach to risk sharing and mitigation covering, as a minimum, the impact on existing NHS and social care delivery and

the steps that will be taken if activity volumes do not change as planned (for example, if emergency admissions or nursing home admissions increase).

33. CCGs and councils must engage from the outset with all providers, both NHS and social care (and also providers of housing and other related services), likely to be affected by the use of the fund in order to achieve the best outcomes for local people. The plans must clearly set out how this engagement has taken place. Providers, CCGs and councils must develop a shared view of the future shape of services, the impact of the Fund on existing models of service delivery, and how the transition from these models to the future shape of services will be made. This should include an assessment of future capacity and workforce requirements across the system. It will be important to work closely with Local Education and Training Boards and the market shaping functions of councils, as well as with providers themselves, on the workforce implications to ensure that there is a consistent approach to workforce planning for both providers and commissioners.

34. CCGs and councils should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services. It is also essential that the implications for all local providers are set out clearly for Health and Wellbeing Boards and that their agreement for the deployment of the Fund includes agreement to all the service change consequences.

What are the National Conditions?

35. The Spending Round established six national conditions for access to the Fund:

National Condition	Definition
Plans to be jointly agreed	The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

National Condition	Definition
Protection for social care services (not spending)	Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with the 2012 Department of Health guidance referred to in paragraphs 8 to 11, above.
As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends	Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.
Better data sharing between health and social care, based on the NHS number	The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas should: • confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to; • confirm that they are pursuing open APIs (ie. systems that speak to each other); and • ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place. NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

National Condition	Definition
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.
Agreement on the consequential impact of changes in the acute sector	Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

How will Councils and CCGs be rewarded for meeting goals?

36. The Spending Round indicated that £1bn of the £3.8bn would be linked to achieving outcomes. Ministers have agreed the basis on which this payment-for-performance element of the Fund will operate.

37. Half of the £1bn will be released in April 2015. £250m of this will depend on progress against four of the six national conditions and the other £250m will relate to performance against a number of national and locally determined metrics during 2014/15. The remainder (£500m) will be released in October 2015 and will relate to further progress against the national and locally determined metrics.

38. The performance payment arrangements are summarised in the table below:

When:	Payment for performance amount	Paid for:
April 2015	£250m	Progress against four of the national conditions: • protection for adult social care services • providing 7-day services to support patients being discharged and prevent unnecessary admissions at weekends • agreement on the consequential impact of changes in the acute sector; • ensuring that where funding is used for integrated packages of care there will be an accountable lead professional
	£250m	Progress against the local metric and two of the national metrics: • delayed transfers of care; • avoidable emergency admissions; and
October 2015	£500m	Further progress against all of the national and local metrics.

National and Local Metrics

39. Only a limited number of national measures can be used to demonstrate progress towards better integrated health and social care services in 2015/16, because of the need to establish a baseline of performance in 2014/15. National metrics for the Fund have therefore been based on a number of criteria, in particular the need for data to be available with sufficient regularity and rigour.

40. The national metrics underpinning the Fund will be:

- admissions to residential and care homes;
- effectiveness of reablement;
- delayed transfers of care;
- avoidable emergency admissions; and
- patient / service user experience.

41. The measures are the best available but do have shortcomings. Local plans will need to ensure that they are applied sensitively and do not adversely affect decisions on the care of individual patients and service users.

42. Further technical guidance will be provided on the national metrics, including the detailed definition, the source of the data underpinning the metric, the reporting schedule and advice on the statistical significance of ambitions for improvement.

43. Due to the varying time lags for the metrics, different time periods will underpin the two payments for the Fund as set out in the table below. Data for the first two

of these metrics, on admissions to residential and care homes and the effectiveness of reablement, are currently only available annually and so will not be available to be included in the first payment in April 2015.

Metric	April 2015 payment based on performance in	October 2015 payment based on performance in
Admissions to residential and care homes	N/A	Apr 2014 - Mar 2015
Effectiveness of reablement	N/A	Apr 2014 - Mar 2015
Delayed transfers of care	Apr – Dec 2014	Jan - Jun 2015
Avoidable emergency admissions	Apr – Sept 2014	Oct 2014 – Mar 2015
Patient / service user experience	N/A	Details TBC

44. For the metric on patient / service user experience, no single measure of the experience of integrated care is currently available, as opposed to quality of health care or social care alone. A new national measure is being developed, but will not be in place in time to measure improvements in 2015/16. In the meantime, further details will be provided shortly on how patient / service user experience should be measured specifically for the purpose of the Fund.

45. In addition to the five national metrics, local areas should choose one additional indicator that will contribute to the payment-for-performance element of the Fund. In choosing this indicator, it must be possible to establish a baseline of performance in 2014/15.

46. A menu of possible local metrics selected from the NHS, Adult Social Care and Public Health Outcomes Frameworks is set out in the table below:

NHS Outcomes Framework	
2.1	Proportion of people feeling supported to manage their (long term) condition
2.6i	Estimated diagnosis rate for people with dementia
3.5	Proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 / 120 days
Adult Social Care Outcomes Framework	
1A	Social care-related quality of life
1H	Proportion of adults in contact with secondary mental health services living independently with or without support
1D	Carer-reported quality of life

Public Health Outcomes Framework	
1.18i	Proportion of adult social care users who have as much social contact as they would like
2.13ii	Proportion of adults classified as "inactive"
2.24i	Injuries due to falls in people aged 65 and over

47. Local areas must either select one of the metrics from this menu, or agree a local alternative. Any alternative chosen must meet the following criteria:

- it has a clear, demonstrable link with the Joint Health and Wellbeing Strategy;
- data is robust and reliable with no major data quality issues (e.g. not subject to small numbers);
- it comes from an established, reliable (ideally published) source;
- timely data is available, in line with requirements for pay for performance;
- the achievement of the locally set level of ambition is suitably challenging; and
- it creates the right incentives.

48. Each metric will be of equal value for the payment for performance element of the Fund.

49. Local areas should set an appropriate level of ambition for improvement against each of the national indicators, and the locally determined indicator. In signing off local plans, Health and Wellbeing Boards should be mindful of the link to the levels of ambition on outcomes that CCGs have been asked to set as part of their wider strategic and operational plans. Both the effectiveness of reablement and avoidable emergency admissions outcomes metrics are consistent with national metrics for the Fund, and so Health and Wellbeing Boards will need to ensure consistency between the CCG levels of ambitions and the Fund plans.

50. In agreeing specific levels of ambition for the metrics, Health and Wellbeing Boards should be mindful of a number of factors, such as:

- having a clear baseline against which to compare future performance;
- understanding the long-run trend to ensure that the target does not purely reward improved performance consistent with trend increase;
- ensuring that any seasonality in the performance is taken in to account; and
- ensuring that the target is achievable, yet challenging enough to incentivise an improvement in integration and improved outcomes for users.

51. In agreeing levels of ambition, Health and Wellbeing Boards should also consider the level required for a statistically significant improvement. It would not be appropriate for the level of ambition to be set such that it rewards a small improvement that is purely an artefact of variation in the underlying dataset.

How will plans be assured?

52. Ministers, stakeholder organisations and people in local areas will wish to be assured that the Fund is being used for the intended purpose, and that the local plans credibly set out how improved outcomes and wellbeing for people will be

achieved, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

53. To maximise our collective capacity to achieve these outcomes and deliver sustainable services the NHS and local government will have a shared approach to supporting local areas and assuring plans.

54. The most important element of assurance for plans will be the requirement for them to be signed-off by the Health and Wellbeing Board. The Health and Wellbeing Board is best placed to decide whether the plans are the best for the locality, engaging with local people and bringing a sector-led approach to the process.

55. The plans will also go through an assurance process involving NHS England and the LGA to assure Ministers. The key elements of the overall assurance process are as follows:

- Plans are presented to the Health and Wellbeing Board, which considers whether the plans are sufficiently challenging and will deliver tangible benefits for the local population (linked to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy).

- If the Health and Wellbeing Board is not satisfied, and the plan is still lacking after a process of progressive iteration, an element of local government and NHS peer challenge will be facilitated by NHS England and the LGA.

- NHS England's process for assuring CCG strategic and operational plans will include a specific focus on the element of the plan developed for the Fund. This will allow us to summarise, aggregate and rate all plans, against criteria agreed with government departments and the LGA, to provide an overview of Fund plans at national, regional and local level.

- This overview will be reviewed by a Departmental-led senior group comprised of DH, DCLG, HMT, NHS England and LGA officials, supported by external expertise from the NHS and local government. Where issues of serious concern are highlighted the group will consider how issues may be resolved, either through provision of additional support or escalation to Ministers.

- Where necessary, Ministers (supported by the senior group) will meet representatives from the relevant LAs and CCGs to account for why they have not been able to produce an acceptable plan and agree next steps to formulate such a plan.

- Ministers will give the final sign-off to plans and the release of performance related funds.

What will be the consequences of failure to achieve improvement?

56. Ministers have considered whether local areas which fail to achieve the levels of ambition set out in their plan should have their performance-related funding

withdrawn, to be reallocated elsewhere. However, given the scale and complexity of the challenge of developing plans for the first time, they have agreed that such a sanction will not be applied in 2015/16. Further consideration will be given to whether it should be introduced in subsequent years.

57. If a local area achieves 70% or more of the levels of ambition set out in each of the indicators in its plan, it will be allowed to use the held-back portion of the performance pool to fund its agreed contingency plan, as necessary.

58. If an area fails to deliver 70% of the levels of ambition set out in its plan, it may be required to produce a recovery plan. This will be developed with the support of a peer review process involving colleagues from NHS and local government organisations in neighbouring areas. The peer review process will be co-ordinated by NHS England, with the support of the LGA.

59. If the recovery plan is agreed by the Health and Wellbeing Board, NHS England and the local government peer reviewer, the held-back portion of the performance payment from the Fund will be made available to fund the recovery plan.

60. If a recovery plan cannot be agreed locally, and signed-off by the peer reviewers, NHS England will direct how the held-back performance related portion of the Fund should be used by the local organisations, subject to the money being used for the benefit of the health and care system in line with the aims and conditions of the Fund.

61. Ministers will have the opportunity to give the final sign-off to peer-reviewed recovery plans and to any directions given by NHS England on the use of funds in cases where it has not been possible to agree a recovery plan.

Support for BCF Planning

62. CCGs and councils can access additional support for Better Care Fund planning from the same routes as for NHS operational and strategic plans: local support via CSUs or external providers, workshops and webinars, and specific tools and resources. Links to these, and contact details can be found on NHS England and the LGA's websites.

When should plans be submitted?

63. Health and Wellbeing Boards should provide the first cut of their completed Better Care Plan template, as an integral part of the constituent CCGs' Strategic and Operational Plans by **14 February 2014**, so that we can aggregate them to provide a composite report, and identify any areas where it has proved challenging to agree plans for the Fund.

64. The revised version of the Better Care Plan should be submitted to NHS England, as an integral part of the constituent CCGs' Strategic and Operational Plans by **4 April 2014**.

Better Care Fund

What is it?

The Better Care Fund, announced as part of the 2013 Spending Round, was discussed at the Health and Wellbeing Board meeting on 12 December. The aim of the fund is to ensure better outcomes for patients and social care customers by funding integrated health and social services through pooled budgets. Some of this funding is linked to new duties which will arise from changes anticipated in the Care Bill.

The aim of the fund is to ensure better outcomes for patients and social care customers by funding integrated health and social services through pooled budgets. Some of this funding is linked to new duties which will arise from changes anticipated in the Care Bill.

How much is involved?

In 2014/15, an additional £200m will be transferred to councils (on top of the previously announced 900 million transferred from health to social care) to prepare for the Better Care Fund. Wokingham's share of this additional £200m will be £335,000 and is subject to submission of a two year spending plan for the Better Care Fund.

In 2015/16 3.8 billion nationally will be available to be spent locally on integrated and improved health and care services. Wokingham's share of this will be £8.04 million. £1 billion of the national fund released in 2015 will however be performance related.

This is not new money but is money already allocated to Health and Social Care which will be transferred into pooled budgets. The Fund is subject to certain conditions and its use will be measured against a range of specified local outcomes.

How do we access the Fund?

Local authorities and Clinical Commissioning Groups must submit a jointly developed plan which is agreed and signed off by the Health and Wellbeing Board. The plan outlines how we will spend the fund to meet the national conditions and how this will impact on local services against a number of performance measures.

The first version of the Plan should be completed by **14 February 2014** and the final version of the plan should be submitted to NHS England by **4 April 2014**.

What are we proposing to use it for?

Proposals put forward for the fund include:

- Single Point of Access for Health and Social Care
- Integrated Short Term Health and Social Care Team
- A Hospital at Home service
- Enhance Care and Nursing Home Support
- Streamlined integrated assessment
- Joint Information
- Supporting People to self-care
- Development of functions and services at Wokingham Hospital
- Integrated acute and social care working at Royal Berkshire Hospital
- Step up and down facilities
- Night sitting carers service
- 7 day services
- Primary Care enhanced hours

What are the key issues?

- Costing the proposals
- Ensuring that existing social care services are protected
- Ensuring that we have the right systems, procedures, pathways and governance in place to deliver services that are truly integrated and achieve the desired outcomes
- Lining up with responsibilities arising from the Care Bill, including:
  - new entitlements for carers
  - new safeguarding responsibilities
  - universal offer of deferred payments
  - moving to a new national eligibility threshold
  - capital costs associated with transition to capped care cost system
  - better use of community support and networks
  - better information and advice