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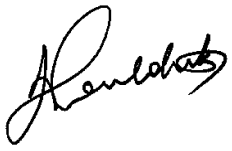
WOKINGHAM
BOROUGH COUNCIL

A Meeting of the **HEALTH AND WELLBEING BOARD** will be held in Council Chamber - Civic Offices, Shute End, Wokingham RG40 1BN on **THURSDAY 10 AUGUST 2017** AT **5.00 PM**



Andy Couldrick
Chief Executive
Published on 2 August 2017

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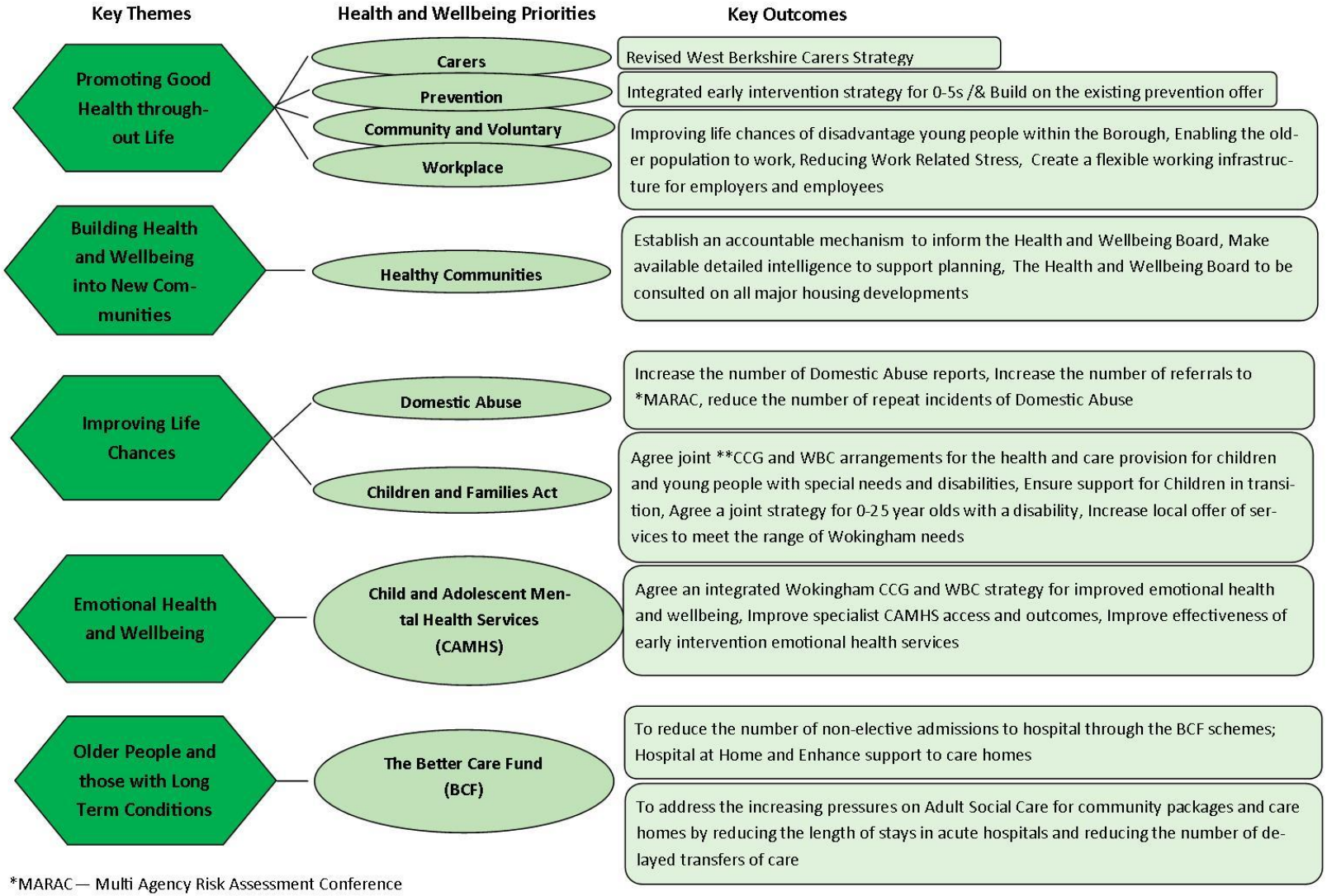
Wokingham's Health and Wellbeing Strategy 2014-2017



*MARAC— Multi Agency Risk Assessment Conference

**CCG and WBC—Clinical Commissioning Groups and Wokingham Borough Council

MEMBERSHIP OF THE HEALTH AND WELLBEING BOARD

Julian McGhee-Sumner	WBC
Dr Johan Zylstra	NHS Wokingham CCG
Mark Ashwell	WBC
Nick Campbell-White	Healthwatch
Shaun Virtue	Community Safety Partnership
Beverley Graves	Business Skills and Enterprise Partnership
Charlotte Haitham Taylor	WBC
Ian Pittock	WBC
Dr Lise Llewellyn	Director of Public Health
Nikki Luffingham	NHS England
Judith Ramsden	Director of People Services
Clare Rebbeck	Voluntary Sector representative
Katie Summers	Director of Operations, Wokingham CCG
Kevin Ward	Place and Community Partnership Representative
Dr Cathy Winfield	NHS Wokingham CCG

18. **APOLOGIES**
To receive any apologies for absence

19. **MINUTES OF PREVIOUS MEETING** **7 - 12**
To confirm the Minutes of the Meeting held on 15 June 2017.

20. **DECLARATION OF INTEREST**
To receive any declarations of interest

21. **PUBLIC QUESTION TIME**
To answer any public questions

A period of 30 minutes will be allowed for members of the public to ask questions submitted under notice.

The Council welcomes questions from members of the public about the work of this Board.

Subject to meeting certain timescales, questions can relate to general issues concerned with the work of the Board or an item which is on the Agenda for this meeting. For full details of the procedure for submitting questions please contact the Democratic Services Section on the numbers given below or go to www.wokingham.gov.uk/publicquestions

22. **MEMBER QUESTION TIME**
To answer any member questions

23. None Specific **COMMUNITY HEALTH & SOCIAL CARE** **13 - 84**
To receive an update on Community Health & Social Care. *(15 mins)*

24.	None Specific	**BERKSHIRE WEST ACCOUNTABLE CARE SYSTEM** To receive an update on the Berkshire West Accountable Care System. *(15 mins)*	**85 - 96**
25.	None Specific	**URGENT AND EMERGENCY CARE DELIVERY PLAN: SUMMARY BRIEFING** To receive the Urgent and Emergency Care Delivery Plan: Summary Briefing. *(15 mins)*	**97 - 102**
26.	None Specific	**LETTER FROM THE PLACE AND COMMUNITY PARTNERSHIP** To consider a letter from the Place and Community Partnership. *(10 mins)*	**To Follow**
27.	None Specific	**UPDATES FROM BOARD MEMBERS** To receive updates on the work of: • Business, Skills and Enterprise Partnership; • Community Safety Partnership; • Place and Community Partnership; • Healthwatch Wokingham Borough; • Voluntary Sector *(20 mins)*	**Verbal Report**
28.	None Specific	**WOKINGHAM BOROUGH HEALTH AND WELLBEING STRATEGY 2017-2020 - ACTION PLAN UPDATE** To receive the Wokingham Borough Health and Wellbeing Strategy 2017-2020 - Action Plan Update. *(15 mins)*	**103 - 104**
29.	None Specific	**PUBLIC HEALTH OUTCOMES FRAMEWORK - EXCEPTIONS** To receive the Public Health Outcomes Framework (exceptions from the quarter). *(15 mins)*	**105 - 108**
30.	None Specific	**FORWARD PROGRAMME 2017-18** To receive the Forward Programme for the remainder of the municipal year. *(5 mins)*	**109 - 122**

Any other items which the Chairman decides are urgent
A Supplementary Agenda will be issued by the Chief Executive if there are any other items to consider under this heading

CONTACT OFFICER

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MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD ON 15 JUNE 2017 FROM 5.00 PM TO 7.05 PM

Present

Charlotte Haitham Taylor	WBC
Julian McGhee-Sumner	WBC
Beverley Graves	Business Skills and Enterprise Partnership
Judith Ramsden	Director of People Services
Katie Summers	Director of Operations, Wokingham CCG
Darrell Gale (substituting Dr Lise Llewellyn)	Consultant in Public Health
Jim Stockley (substituting Nick Campbell-White)	Healthwatch Wokingham Borough

Also Present:

Madeleine Shopland	Democratic & Electoral Services Specialist
Nicola Strudley	Healthwatch Wokingham Borough

1. ELECTION OF CHAIRMAN

RESOLVED: That Councillor Julian McGhee Sumner be elected Chairman of the Health and Wellbeing Board for the 2017/18 municipal year.

2. APPOINTMENT OF VICE CHAIRMAN

RESOLVED: That Dr Zylstra be appointed Vice Chairman of the Health and Wellbeing Board for the 2017/18 municipal year.

3. APOLOGIES

Apologies for absence were submitted from Councillor Mark Ashwell, Nick Campbell-White, Superintendent Rob France, Kevin Johnson, Dr Lise Llewellyn, Nikki Luffingham, Clare Rebbeck, Kevin Ward, Dr Cathy Winfield, Judith Wright and Dr Johan Zylstra.

4. MINUTES OF PREVIOUS MEETING

The Minutes of the meeting of the Board held on 6 April 2017 were confirmed as a correct record and signed by the Chairman.

Judith Ramsden proposed that a paper be presented at a future meeting regarding energising and focusing the Health and Wellbeing Board.

5. DECLARATION OF INTEREST

Councillor Haitham Taylor declared a personal interest in Item 11 Healthwatch Wokingham Borough – Extra Care as her husband worked for a telecommunications business.

6. PUBLIC QUESTION TIME

There were no public questions.

7. MEMBER QUESTION TIME

There were no Member questions.

8. HEALTH AND WELLBEING STRATEGY STRATEGIC DELIVERY PLAN

The Board received the Health and Wellbeing Strategy Strategic Delivery Plan.

During the discussion of this item, the following points were made:

- Board members were reminded that there were four main priorities that underpinned the Health and Wellbeing Strategy.
- Darrell Gale took the Board through actions under each priority including 'Promoting 'Making Every Contact Count' approach across all services, beginning with most deprived LSOAS and new SDLs.' Katie Summers commented that this needed to be implemented across all of the Berkshire West, Oxfordshire and Buckinghamshire authorities. Judith Ramsden stated that points of commonality needed to be ascertained.
- A proposed action was 'Testing in one or more Neighbourhood Policing Teams a Police Officer taking role of Community Navigator.' Board members felt that this was an innovative proposal.
- With regards to the proposed action, 'Reduce percentage of those who are deemed inactive from 20.9% to 18% by 2018 in the specific areas', Katie Summers commented that a key workstream of the Buckinghamshire, Oxfordshire and Berkshire West Sustainability Transformation Plan was physical activity in the digital sphere. Nicola Strudley asked whether the Patient Portal could use data from Fitbits. Board members were informed of a pilot scheme involving fitness trackers that was under consideration. Beverley Graves informed the Board of an event that the Central Berkshire Education Business Partnership would be hosting on 20 July for Bulmershe School to encourage young people to pursue careers in Science, Technology, Engineering and Maths. It was suggested that the young people could also be another audience for the pilot.
- It was important to agree what was needed for Borough residents. The Board agreed that specific messages could be better communicated. Judith Ramsden suggested that community engagement events be planned.
- The Board considered how the action plan would be monitored. Many of the action plan actions were process oriented, reflecting the new 21st Century Council structure. A short progress report on the action plan would be presented to the Board every other meeting (October; February and June meetings). The Board would receive exceptions from each quarter's Public Health Outcomes Framework at each Board meeting and also the high-level metrics. Board members felt that the metrics needed to be worked up more so that they linked more coherently with the Health and Wellbeing Strategy.
- Actions from the Better Care Fund action plan would be incorporated into the Health and Wellbeing Strategy action plan.
- It was agreed that a glossary of terms would be produced to be included in future Health and Wellbeing Board meeting agendas. This would be useful for non-health Board members in particular.
- Katie Summers suggested that there needed to be greater PR and communication work around the Health and Wellbeing Strategy. Judith Ramsden commented that a resource could be made available to further working with the communities. It was also proposed that Healthwatch Wokingham Borough assist in the promotion of the Health and Wellbeing Strategy.

RESOLVED: That the Board approve this Action Plan to support delivery of the Health and Wellbeing Strategy, and gives full support to all involved in its delivery during the next three years.

9. WEST OF BERKSHIRE SAFEGUARDING ADULTS BOARD ANNUAL REPORT 2015-2016

This item was withdrawn from the agenda.

10. UPDATE ON COMMUNITY NAVIGATORS/ CHASC

The Health and Wellbeing Board received an update on the Community Navigators.

During the discussion of this item, the following points were made:

- The Board noted the aims and purpose of the Community Navigators.
- Katie Summers highlighted the benefits for GPs and patients.
- Navigators were currently based in the following GP practices: Wargrave, Swallowfield, Brookside, Woodley and Wokingham Medical Centre. It was planned to introduce them into other practices including Burma Hills and Woosehill.
- Board members noted the total referrals to community navigators between March 2016-March 2017 and the different referral sources.
- The budget for 2016-17 had been £47,386 and the actual spend £26,907. The underspend in 2016/17 was due to an additional navigator co-ordinator post being budgeted for the last two quarters of 2016/17. Councillor Haitham Taylor commented that only a relatively small number of people had been referred by the Community Navigators and that the cost per referral was still quite high. Katie Summers emphasised that those referred would often be higher users and that it was an invest to save opportunity. She would ask Involve to send the names of those patients who had been referred by the Community Navigators, to the Commissioning Support Unit who would be able to ascertain the number of GP contacts the individual had had over the past 2 years, to better assess the impact of the Community Navigators.
- It had been proposed that a Police Officer would also become a Community Navigator. Judith Ramsden explained that they would receive training so that they would be able to provide people with information if required. Nicola Strudley questioned whether postmen could also be encouraged to be Community Navigators. It was suggested that this be discussed at WISP.
- Katie Summers commented that Involve had found it difficult to find volunteers.
- Beverley Graves suggested that the MICe bus (Mobile Information Centre) and Earley Crescent Resource Centre were possible referral sources.
- Board members requested an update on Community, Health and Social Care at the Board's next meeting.

RESOLVED: That the update on the Community Navigators be noted.

11. HEALTHWATCH WOKINGHAM BOROUGH - EXTRA CARE

Nicola Strudley circulated Healthwatch Wokingham Borough's Annual Report and presented the report produced about Extra Care.

During the discussion of this item, the following points were made:

- The Council's Housing Strategy for Older People had indicated that extra care would be a focus going forwards.
- Two new extra care schemes were due to open in the Borough.
- Healthwatch Wokingham Borough, with the help of volunteer drivers, had undertaken a poll about whether people had given consideration as to where they

would live if they were no longer able to live in their own homes. 95% of those who responded said that they had not.
- Extra care meant different things to different people. Healthwatch had produced a fact sheet to assist people.
- A Healthwatch Wokingham Borough project team had visited the three existing extra care facilities within the Borough and had talked to residents and staff.
- A number of common themes had emerged. Nicola Strudley highlighted specific examples where residents had had issues with building design. One resident had been scared to use their shower because the grab rails had suction cups and they were unconvinced of their safety. Another resident had an issue with bright sunlight streaming into their room during the middle of the day, making it necessary to move rooms.
- Although there were communal areas, they were not necessarily well used and more could be done to encourage this.
- Another theme which had emerged was managing residents' and their families' expectations.
- The report had been sent to the interim commissioner with responsibility for extra care.
- A seminar would be held early in the new year to review progress made against the report.
- Katie Summers commented that the report fitted in with the new work of the Better Care Fund.
- Councillor Haitham Taylor commented that new providers coming into the Borough might have different views on provision. She suggested that Healthwatch Wokingham Borough engage with other providers at an early stage, where possible. It was appreciated that extra care facilities could have several different providers so this could sometimes be complex.
- Judith Ramsden stated that the Council needed to champion what good looked like.
- Beverley Graves asked if support was available for residents who needed help to take medication but could still live at home. It was noted that care calls to help with medication could be arranged and that people could also buy into telephone systems which could act as reminders.

RESOLVED: That the Healthwatch Wokingham Borough's report regarding Extra Care be noted.

12. COMMUNITY SAFETY PARTNERSHIP STRATEGY

This item was deferred to the Board's next meeting in August.

13. INDEPENDENT ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH

The Board received the Independent Annual Report of the Director of Public Health.

During the discussion of this item, the following points were made:

- The Director of Public Health was required to produce an annual report on the health of the local population.
- The report outlined preventable and avoidable deaths in the Wokingham Borough population and the causes of these including smoking; high blood pressure; alcohol; physical inactivity and obesity. It also outlined these issues, the local impact, and evidence based interventions to reduce the harms.
- Darrell Gale explained the difference between preventable and amenable mortality.

- It was noted that across all preventable deaths there was a correlation between the levels of deprivation when the wards were grouped by levels of affluence. In addition, the most deprived groups of people were more likely to engage in multiple risk areas e.g. smoking and drinking alcohol.
- With regards to smoking, the local smoking cessation services targeted those groups with a higher prevalence e.g. routine and manual workers. E-cigarettes were discussed.
- Around 34,200 of the Wokingham CCG population were thought to have high blood pressure and of those only 19,700 were being treated for this. A 20% improvement in blood pressure control could represent a cost saving within 5 years.
- Board members were informed that locally there was a smaller take up of NHS Health Checks than there was nationally.
- The Board discussed the impact of alcohol. In response to a question, Darrell Gale commented that in the Borough, middle aged, middle class working men and women were at risk of alcohol related issues. However, further information would be required to gain a clearer picture of the situation.
- Nicola Strudley asked about support from the business community for those with alcohol issues.
- Katie Summers commented that not all members of the public may be aware of what the safe alcohol limit guidelines were.
- Judith Ramsden proposed that a communication strategy be developed and that the Board agree when during the year particular messages should be amplified.
- Board members were informed that physical inactivity was the cause of 9% of premature mortality.
- Obesity in the Borough, particularly amongst children and young people, was discussed.
- The Health and Wellbeing Strategy would pick up many of the issues identified.

RESOLVED: That the content of the Independent Annual Report of the Director of Public Health be noted.

14. PHARMACEUTICAL NEEDS ASSESSMENT DELIVERY PLAN

The Board noted the Pharmaceutical Needs Assessment Delivery Plan, which outlined the plans being put in place to deliver the new Pharmaceutical Needs Assessment 2018-2021 for the Wokingham Borough.

RESOLVED: That the content of the report be noted and that constituent organisations work with the Public Health Team at Wokingham Borough Council to facilitate the public consultation required to complete the assessment.

15. UPDATES FROM BOARD MEMBERS

The Board noted an update on the work of the Business, Skills and Enterprise Partnership.

RESOLVED: That the update from the Business, Skills and Enterprise Partnership be noted.

16. FORWARD PROGRAMME

The Board discussed the forward programme for the remainder of the municipal year.

During the discussion of the item, the following points were made:

- Board members requested that a glossary of terms be produced to be included in future agendas.
- A further update on Community Health & Social Care (CHASC) be provided at the Board's August meeting.
- It was proposed that Board meetings begin earlier if the agenda was particularly heavy.
- Darrell Gale commented that it was important to get the message out about the danger of children falling out of windows, particularly with a heatwave impending.

RESOLVED: That the forward programme be noted.

17. WOKINGHAM INTEGRATION STRATEGIC PARTNERSHIP TERMS OF REFERENCE

The Board received the Wokingham Integration Strategic Partnership Terms of Reference.

RESOLVED: That the Wokingham Integration Strategic Partnership Terms of Reference be approved.

Wokingham BCF 08 – Community Health and Social Care

July 2017

Community Health & Social Care (CHASC)

Community Health & Social Care Steering Group - a cross agency partnership

NHS Wokingham Clinical Commissioning Group

WOKINGHAM BOROUGH COUNCIL

Berkshire Healthcare NHS Foundation Trust

involve MAKING A DIFFERENCE LOCALLY IN WOKINGHAM BOROUGH

healthwatch Wokingham Borough

optalis choices for living

Wokingham GP Alliance

CHASC Overall Aim

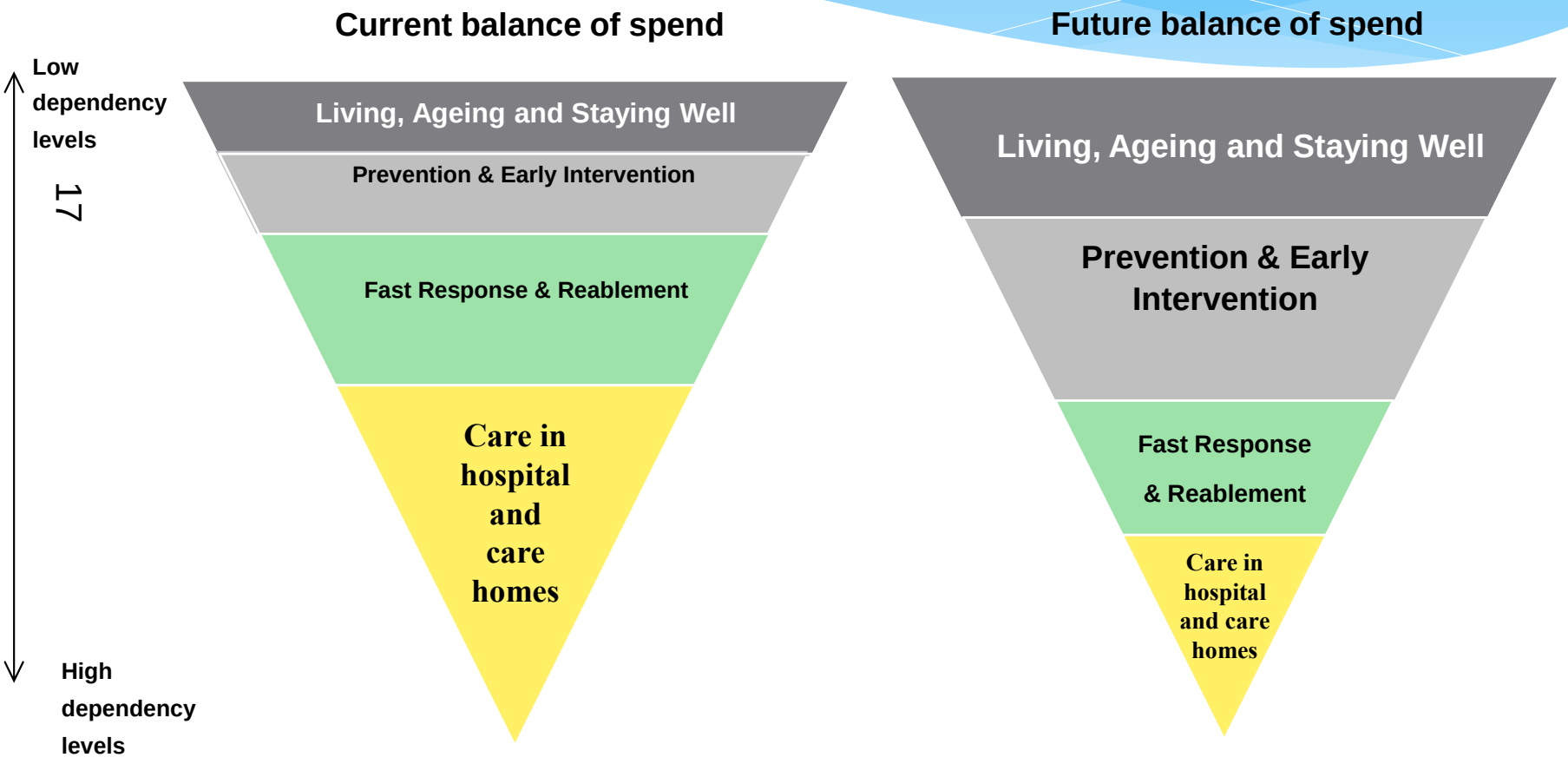
Make the most effective use of all resources in the system

What the project is attempting to address?

* Demands on services
* Financial Pressures
* Pressures in Primary care
* Stretched resources
* Mandatory requirements
* Feedback from service users
* Ageing Population and increase in LTC survival

Our Strategy:
We need to put care in the best place

If we do nothing to meet these challenges, our costs will exceed our funding by about £7m over the next year across the Wokingham health system.



What will CHASC do?

* A single Long-term Health & Social Care Team focused on early interventions and prevention
* Remove organisational boundaries
* Users only tell their story once
* A single key worker
* Development around 3 localities
* Target top 10% of health & social care users
* Work with the 3rd Sector – Community Navigators

Proposed System Model

Objectives/Deliverables

* Unified Point of Access - true single point of access to long-term health and social care
* Case finding/early identification based on risk stratification
* Personalised assessment and care planning – shared paperwork, single assessment and key worker
* Case management and care coordination –simple and complex case management, revised MDT structure and delivery
* Treatment, support and review
* Social Prescribing
* Safeguarding and governance

Financial Benefits

* Reduced NELs
* Reduced A&E attendances
* Reduced/delayed cost of social care packages & placements
* Reduction in use of GP appointments for non-medical problems

People Benefits

* Improved satisfaction of care
* Care and support are centred on the person's needs
* People have a high quality of life, and enjoy their improved health status
* People feel empowered, capable of and engage in self-management
* Care is of high quality and safe
* People experience pro-active, coordinated care and support

Finances

Costs of operation & implementation	16/17	17/18	18/19	19/20	20/21
Localities					
One off costs for implementation	60,803	82,100	0	0	0
On-going costs for running operations	48,896	46,841	150,993	150,993	150,993
Total costs	109,700	128,941	150,993	150,993	150,993

Benefits	16/17	17/18	18/19	19/20	20/21
A&E admissions avoidance	0	-42,415	-84,830	-84,830	-84,830
NEL's avoidance	0	-177,742	-355,484	-355,484	-355,484
Care Home avoidance	0	0	-10,068	-10,068	-10,068
Early intervention opportunities	0	-17,051	-73,637	-73,637	-73,637
Total Benefits	0	-237,208	-524,019	-524,019	-524,019
Net cost / (Benefit)	109,700	-108,267	-373,026	-373,026	-373,026
Cumulative Net Cost / (Benefit)	109,700	1,432	-371,594	-744,620	-1,117,647

Project Plan

Milestone	Milestone Description	Date	Owner/Lead
1	Plan and present Commissioning and Governance process and proposal for Wokingham Integrated Health & Social Care system for commissioning Exec Boards and HWBB approval	June & July 2017	SROs
2	Present final business case to Health and Well-being board for approval	August 2017	SROs and PM
3	Phase 2a Design and Engagement Phase – including the recruitment of the Head of CHASC Phase 2a (i) Delivery around Primary Care (GP alignment in localities and formal agreement on working arrangement – between practices and CHASC)	June 2017 to March 2018	Project Manager/ Providers/ Service Users
4	Phase 2b Implementation of CHASC Phase 2b (i) Testing Phase with a single GP locality Phase 2b (ii) Roll out to the other 2 GP localities	April 2018 to April 2019	Project Manager & Providers
5	Phase 3 Development of future plans with wider partners, to work up as a model in 17/18	September 2018 to March 2019	Project Manager, SRO & GP practices

BW10 INTEGRATION PROGRAMME

Wokingham Community Health & Social Care (CHASC) – (Neighbourhood Clusters, Self-Care and Prevention) BCF Project

Project Initiation Document

DATE & VERSION NO.
26TH JULY 2017 VS. 1.9
BETTER CARE FUND REF:
BCF 08

PROJECT/ SCHEME NAME AND BRIEF DESCRIPTION

This paper sets out the business case for continued Better Care Funding (BCF) funding from 2016/17 to 2020/21for the Community Health and Social care project.

The Community Health and Social Care projects overarching aim is:

'to keep the residents of Wokingham fit, well and living as independently as they can be in their own homes for as long as possible by working as a single health and social care system that supports people, promotes self-care and prevention and ***ultimately makes the most effective use of all resources in the system'***

Community Health and Social Care (CHASC) is about integration. As a person or a clinician, you would not choose to recreate from scratch the historical partitions between primary, community, mental health and social care and acute services. The boundaries make it harder to provide joined-up care that is preventative, high quality and efficient. CHASC aims to dissolve the divides. It involves redesigning care around the health of the population, irrespective of existing institutional arrangements. It is about creating a new system of care delivery that is backed up by a new financial and business model.

CHASC enables alignment of health and social care's objectives for the next 5 years, as seen in the Five Year Forward View, Wokingham Boroughs 21st Century Programme and the CCG Objectives.

1. Health and Social Care Integration – commissioning appropriate health and social care within available resources
2. Smart working - Locality working and dissolving organisational boundaries
3. Assets – making the best use of all public assets
4. Enabling Partnership working

The underlying logic of CHASC is that by focusing on prevention and redesigning care, it is possible to improve health and wellbeing, achieve better quality, reduce avoidable hospital admissions and elective activity, and unlock more efficient ways of delivering care. The model of integrated health and social care will have a much stronger emphasis on empowering clients to take more control over their lives through promoting their independence. The plan is to bring disparate services together and align these services. CHASC will enable the following:

- Pro-active care
- People will only need to tell their story once

- Everyone will have a single care plan
- People will have an accountable key worker
- Reduce duplication of effort by providers

The benefits the project plans to deliver are:

- Reduced Non-Elective (NEL) admissions
- Reduced Accident and Emergency (A&E) attendances
- Reduced/delayed cost of social care packages
- Reduced/delayed care home placements in the long term
- Improved satisfaction of care
- Care and support are centred on the person's needs
- People have a high quality of life, and enjoy their improved health status
- People feel empowered, capable of and engage in self-management
- Care is of high quality and safe
- People experience pro-active, coordinated care and support
- Reduction in use of GP appointments for non-medical problems

Community Health and Social Care system will provide joined up, long-term, health and social care support which will **deliver**:

1. Risk stratification or predictive modelling
2. Care co-ordination
3. Care delivery/Case management
4. Management of ambulatory care-sensitive conditions
5. Primary prevention
6. Self-care

The **impacts** of the project will be:

- Better health for the whole population
- Reduced inequalities in access to health and social care, including improved access to the right service at the right time.
- Reduced variation in outcomes
- Increased quality of care and safety for all residents
- Better value for the taxpayer
- Supporting people to live well in their own homes for as long as they wish and are able to
- Improve residents experience of health and social care
- Contribute to a more sustainable system for the future by reducing demand

The proposal requires gross investment of £691,620 up to 20/21 and will deliver gross savings of £1,809,267 at the end of year 20/21 ROI of 162%. The project is expected to return a net saving in 2018/19 and with savings expected to continue. The funding source is the BCF.

SENIOR RESPONSIBLE PERSON (SRO)	PROJECT / SCHEME MANAGER
Judith Ramsden, Director of People Services Wokingham Borough Council **Katie Summers, Director of Operations, NHS Wokingham CCG**	**Rhian Warner, Project Manager**

Contents

Purpose of Document

The purpose of this document is to define the project, to form the basis for its ongoing management and the assessment of overall success. It also provides a statement of how and when the project's objectives are to be achieved, by showing the major products, activities and resources required on the project.

Specifically the paper aims:

- To explain the rationale behind the Community Health and Social Care Project
- To demonstrate what the programme will deliver in 2016/17 and in the medium term
- To show how the programme might achieve its objectives

Though the PID describes the full breadth of this programme the focus for the rest of 2016/17 will be delivery of the phase 1 objectives.

Recommendations

That Wokingham Integrated Strategic Partnership (WISP) and the Health and Well-being Board agree:

- To proceed with the project as outlined (subject to BCF funding)
- To proceed with BHFT managing the services across the system and the appointment of the Head of Community Health and Social Care as soon as is practicable. BHFT would manage the services on behalf of the partnership, with clear accountability to the local authority for its statutory social care duties.

Section 1 – Project Definition, Description & Purpose

Strategic Case – Project Description and Aims

1.1 Background

This business case builds on the original Neighbourhood Clusters, Self-Care and Prevention business cases which were submitted to WISP in August 2015 and March 2016. The main aim of the Neighbourhood Clusters, Self-Care and Prevention project was:

To strengthen community capacity and improve the health literacy, service quality and outcomes of care for people such that fewer people will require hospital admission and consequently reduce demand on the current health and social care system.

Nationally the NHS England "Five Year Forward View" recognises the financial challenges which face the NHS over the coming years and indicates a drive towards closer integration and joint commissioning between health and social care services, the development of different models of provision including multispecialty community providers, primary and acute care systems and the transformation of primary care. The plan also describes a stronger role for the voluntary sector (which the project will provide core financial support for delivery) with more emphasis on putting patients in control of their own care. It also emphasises the need to exploit the use of technology and the role of public health in achieving better outcomes for communities.

It sets out how organisations might work together to implement new models of care through, for example, "multispecialty community providers (MCPs)", which may include variants aligned to plans for locality development. Establishing an MCP requires local leadership, strong relationships and trust. No system of accountable care will get off the ground and be viable without the inclusion and active support of general practice, working with local partners. As expert generalists, with their registered lists of patients, general practitioners will always be the cornerstone of any system of accountable care provision. The Five Year Forward View also invites organisations to "Get serious about prevention".

The Care Act, 2014 outlines the responsibilities Local Authorities have towards residents as commissioners and their statutory duties to safeguard residents and ensure their wellbeing. The key within this is to emphasise the importance of 'people maintaining their independence as much as possible and for as long as possible'. Over the next few years there will need to be fundamental changes to the way care is delivered and paid for. These changes will mean that users of the service and their carers are in control of their own care and support as part of the Act.

The Adult Social Care Outcomes Framework (ASCOF) is the tool used to measure performance against this ambition and the four domains link into the overall work described in this PID and associated guidance:

- Enhancing quality of life for people with care and support needs
- Delaying and reducing the need for care and support
- Ensuring that people have a positive experience of care and support
- Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm.

The Better Care Fund (BCF) programme has added further momentum to our local integration programme, and offers a vehicle to lever the transformation of health and social care services in the provision of integrated care and support. Integrated commissioning and provision through the use of the BCF also offers an opportunity to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them with 'wraparound' fully integrated health and social care, resulting in an improved experience and better quality of life. The on-going development of these plans will ensure that there is a system-wide shared view of the shape of future integrated services

Wokingham Borough Council has responded effectively to financial austerity and funding reductions since 2010. The point has been reached where a radical, whole-council approach to transformation is required to achieve the efficiencies required over the next three years. A sound, three-year plan has been developed to deliver the necessary savings up to 2019-20. The 21st Century Council programme makes a substantial contribution to that plan. The figure below shows all elements of the programme.

Figure 1 – Wokingham Borough Council, 21st Century Programme

1.1.1 What are the health and social care problems/issues that need to be addressed?

In Wokingham the following have been identified as drivers that need to be urgently addressed:

- The continuing financial pressures, both Health and Social care budgets need to be made financially viable for now and the future, eliminating inefficient duplication of work and hand offs between parties.
- Primary care is under pressure and is at risk of falling over due to workforce issues, the development of Wokingham as an SDL (strategic development location) and single handed practices no longer being viable models of delivery.
- The 2015 Autumn Position Statement and Comprehensive Spending Review mandated Upper Tier Local Authorities and the NHS to deliver health and social care integration plans by April 2017 and full implementation by April 2020. Integration planning is consequently a condition of the 2016/17 Better Care Fund.
- Increasing demands on services - Complex patients in Wokingham Clinical Commissioning Group (CCG) account for 2% of the user population and they form 14.9% of Wokingham CCGs spend on acute hospital care (out-patient appointments, A&E attendances and inpatient admissions), nationally this patient cohort spend is 15%. Whilst this analysis only focuses on secondary care due to availability of data, it is expected that these patients are fairly representative of the type of complex patients that will require the most treatment across the health and social care system.
- In 2013/14[1] (Full data on the population and demographics for Wokingham Borough and Wokingham CCG can be found in **Appendix 1** of this paper):
    - 30 patients had a total of 308 A&E attendances between them
    - 309 patients had a total of 2,649 outpatient appointments in an acute hospital setting
    - Wokingham's average complex patient has 5 inpatient admissions per year across 3 different conditions.
    - Wokingham's CCG spends most on Circulation, Cancer and Musculo-skeletal
    - 60% of these complex patients are aged 65 or over
    - 34% of these complex patients are aged 75 or over
    - 10% of these complex patients are aged 85 or over
- Feedback from service users – they feel that health and social care staff work in silos and that care is not joined up, the voluntary sector will become overwhelmed, services are not always accessible in an easy or timely manner.
- Not intervening early enough in a resident's disease journey, which creates bigger demands and greater need

[1] Commissioning for Value: Where to Look, January 2016, NHS Wokingham CCG, Gateway Ref:04599

- The population is getting older which will lead to greater care demands
- The prevalence of long term conditions is increasing as the population get older
- Traditional care services will not meet the demand for, and expectations of, care across the Borough's population possibly contributing to inequalities of health and wellbeing in Wokingham.

These drivers have led to:

- Variability in health outcomes
- Inequitable resource allocation
- Increasing inequalities
- Increased costs

It is recognised that as a system we need to do things differently in order to manage and reduce the impact of these drivers to deliver the best possible care in the most effective way. As the population ages and long term conditions (LTCs) increase in prevalence, providers and commissioners are being asked to do more with less. In this context, the current approach to care is unsustainable as it is both unaffordable and does not provide people with the person-centred, pro-active, integrated and quality of care they tell us they need.

The current situation is not financially viable and we need to shine an honest light on what we are doing. The BCF, NHS England's Right Care Programme and The Frail Elderly Pathway support the vision set out in the Five Year Forward View with its focus on the transformation of health and social care services to drive improvements in quality and efficiency, to be able to continue to care for our local population in the manner it expects.

1.1.2 Pyramid of Need - The projects target cohort

The target groups that Community Health and Social Care working will focus on, at least initially, are:

- Case Management- Very high intensity services users (and their carers) with complex co-morbidities, the top 2% of users (315 residents). They require multi-disciplinary teams focussing interventions to avoid, anticipate and manage crisis to avoid admission.
- Disease Management – High risk service users often with complex needs, top 3-10% of service users (1261 residents). They require responsive teams focused on managing disease and preventing further ill-health
- Supported Self-Care – Moderate risk service users (70-80% of LTC population). They require supported self-care to maximise independence involving third sector and voluntary organisations
- Prevention & Promotion of Wellbeing – Low risk service users, their carers and the general population. This group need to maintain health and well-being through healthy lifestyles within a cohesive community and might benefit from local information and support to self-care and enhance their health & wellbeing. This group would be predominantly supported by the Public Health services.

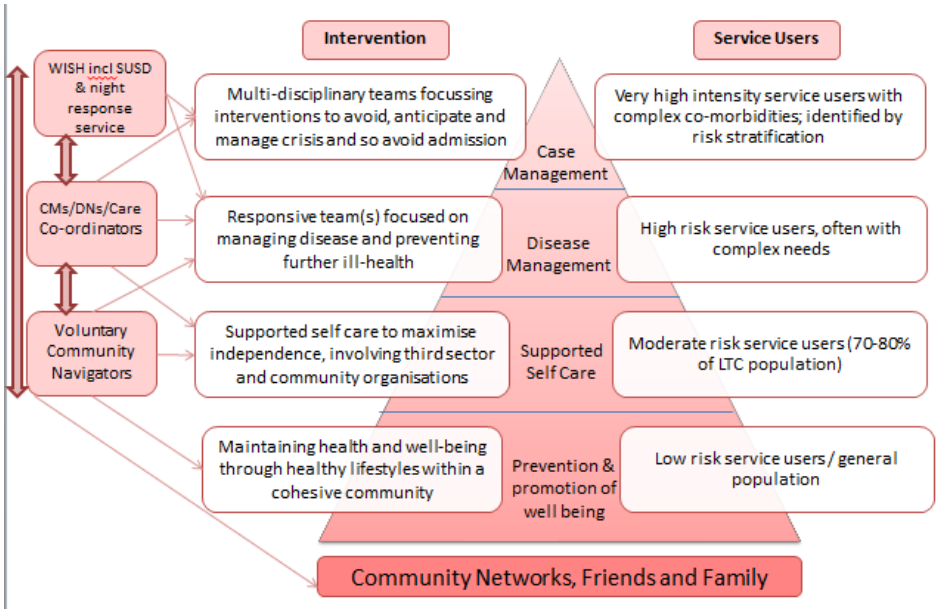


Figure 2 – Pyramid of Need

Clearly, a significant proportion of the care provided will be common to all tiers. However, health and social care needs of the tiers also differ in crucial ways, meaning each tier requires a set of targeted interventions to support people to keep them well. It is important to note that these tiers are fluid. People can and will move between the different levels of care as they experience periods of instability and recover from them. The system response designed will need to be proportionate to the individual's requirements i.e. resources in the right place at the right time and it will not be a one size fits all solution.

1.2 Strategic Fit

This proposal is set in the wider context of increasing health and social care demand, primarily due to demography, and the need for the local authority and Berkshire Healthcare NHS Foundation Trust (BHFT) to achieve challenging savings targets while maintaining/improving the quality/safety of care.

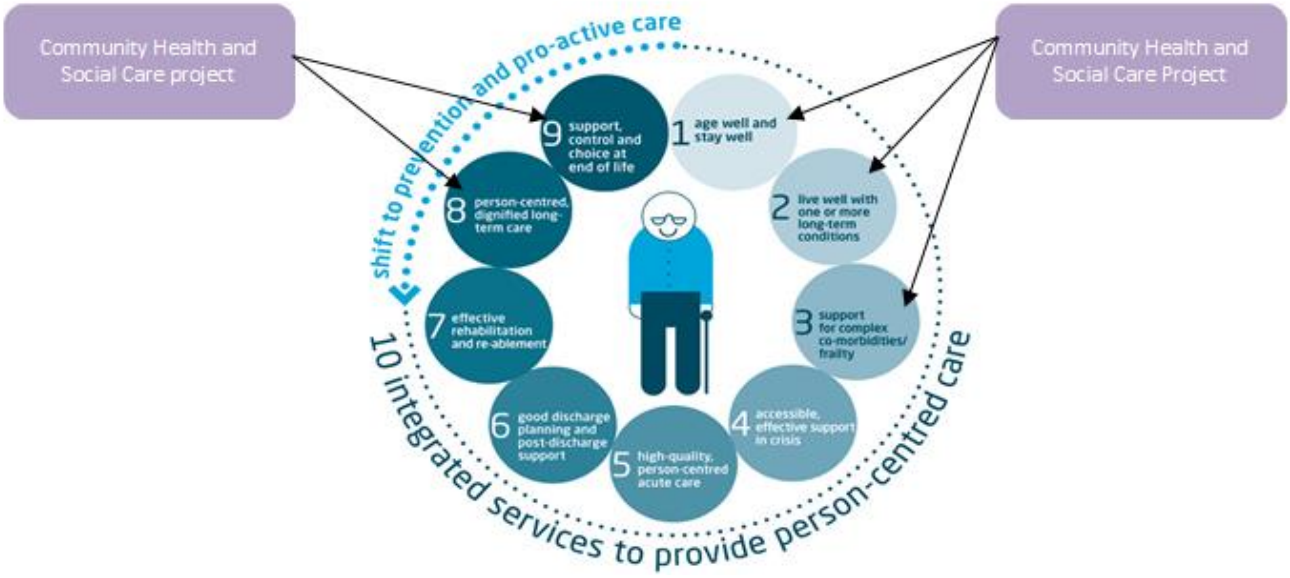


Figure 3 - Sam's Story – BCF 08

The objective of this BCF scheme is to deliver better outcomes for Wokingham clients through an integrated pathway between Health and Social Care. This will support the need to deliver services in a much more cost effective way and deliver savings.

General practice is experiencing unprecedented workload and workforce challenges. When general practice fails, the NHS fails[2]. A big reason to develop CHASC is to provide practical help to sustain general practice right now. CHASC will support practices to work at scale and also to benefit from working with larger community based teams. CHASC opens up new options for partners, clinicians and managers. Over time it should also help with managing demand for general practice, by building community networks, connecting with the voluntary sector, and supporting patient activation and self-care.

This will be achieved through ensuring timely and effective responses to meeting needs of clients based in the community. This scheme sits within the overall BCF programme and will support a renewed focus on decreasing dependency and promoting independence. The need for long term care will be reduced. Doing things once with the right resources identified from the outset, responding quickly and having well trained staff available to meet the needs.

The project is underpinned by health and social care professionals working alongside one another, and with family and carers as expert partners in care, to:

- Provide the right care, by the right people, at the right time and in the right place with more people

[2] The multispecialty community provider (MCP) emerging care model and contract framework, July 2016, Gateway ref: 05637

supported within their community, and the development of 7-day working across Health and Social Care
- Keep the individual at the centre of a co-ordinated health and care system with a single point of contact via a 'hub'
- Develop and earn trust, from patients/service users and across organisational boundaries
- Keep improving health and care systems with the people who use them increasingly involved in the design, delivery and evaluation of services
- Protect community (including family) connections for those with care and support needs, in recognition of the positive impacts these have on emotional and physical wellbeing
- Make the experience of care a more positive one, in which the individual retains as much choice and control as possible.

It provides an opportunity for Health and Social Care, working together to meet the requirements within:
- Care Act, 2014
- The NHS England Five Year Forward View, October 2014.
- The Berkshire West 10 Frail Elderly Programme (FEP) recommendations and implementation plan

Alignment with 16-17 BCF Priorities
- People's experiences of care
- Care outcomes in terms of changes to people's health and wellbeing
- Better use of resources.

Alignment to Wokingham Borough Council Health and Wellbeing Strategy 2014-2017
- Promoting good health throughout life
- Building health and wellbeing into new communities
- Improving life chances
- Older people and those with long term conditions

Alignment to CCG objectives
- To achieve good health outcomes across the patch - benchmarked within the top quartile in UK
- To commission appropriate healthcare within available resources ensuring value for money
- To commission safe, high-quality services which meet the health needs of the Wokingham population through optimum use of the latest technology, with all health and social care professionals working together across the health economy, to ensure that Wokingham residents get the care they need in the most appropriate place
- To optimise patient and public engagement/ involvement to ensure a broad, representative patient/ public voice is heard.

Alignment to Wokingham Borough Councils 21st Century Programme
- Health and Social Care Integration: working with the NHS to deliver better connected care at home, promoting independence and avoiding unnecessary hospital admissions. The Council has to respond to growing demand that is not matched by funding increases
- Smart Working Phase 2: the Council already works smart, and has saved significant sums through reducing its office footprint, including considering the potential future use of Shute End, locality working
- Assets: The Council owns substantial assets in the borough and is working to ensure these are put to best use, and where possible delivering revenue or capital receipts. Linked to this the Council is leading a programme with all public sector partners across Berkshire including police, health and the fire service, to make best possible use of publicly-owned assets and buildings to save public money

Fit with CCG 16-17 Operational Priorities
- Piloting new technology – enabling care
- Innovative approaches to transform clinical pathways building on the Hospital without walls
- Highly responsive urgent and crisis care services outside of hospital
- Successful delivery of QIPP

1.3 Community Health and Social Care Overview

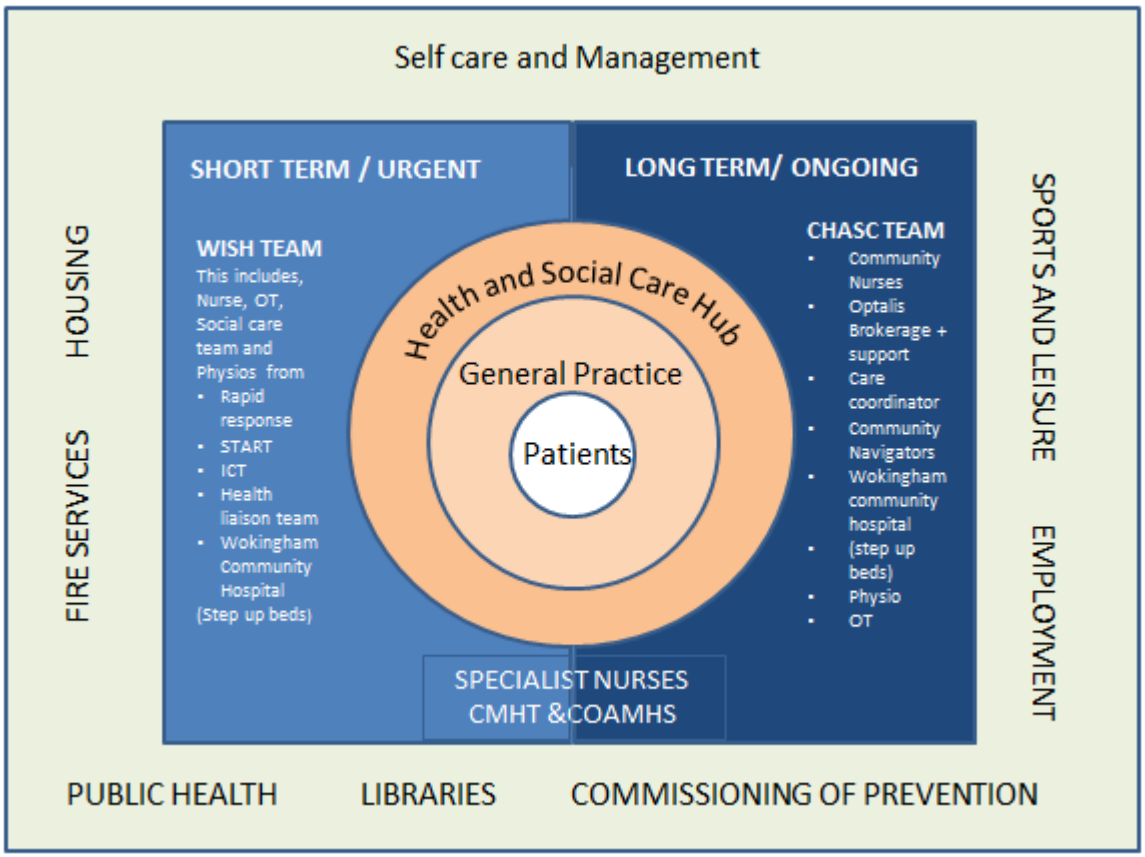
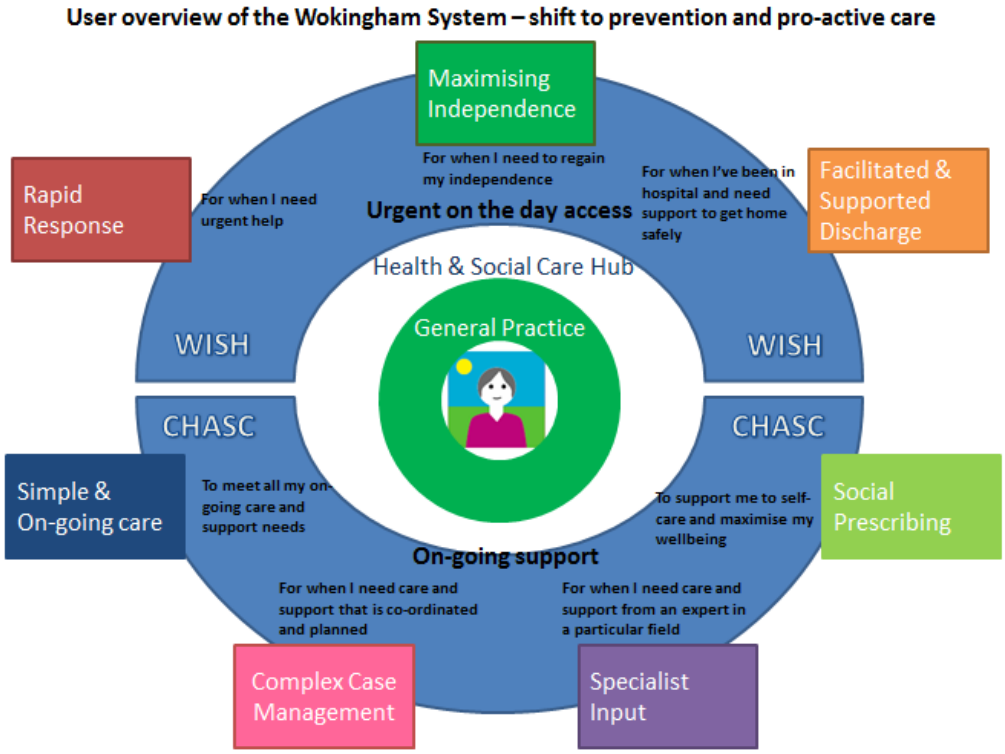


Figure 4 – The proposed system Model

The model shows how the new services created by the BCF programme all fit together and are able to deliver the right care at the right time for all of Wokingham's residents.

For CHASC a simple pattern of services needs to be developed, based around primary care and natural geographies and with a multidisciplinary team. These teams need to work in new ways with specialist services – both community and hospital based, to offer residents a much more complete and less fragmented service.



As the new model is developed there is a need to include both mental health and social care, including the management of the health and social care budget for the care of their service users. Community services also need to reach out into communities more effectively. The opportunity to harness the power of the wider community to support people in their own homes, combat social isolation and improve prevention is not being fully exploited.

We therefore need to design and deliver a service that:

- provides pro-active rather than reactive management, 'doing it better earlier on'
- improves the value and utilisation of resources by streamlining process and procedures and through economies of scale
- reduces/removes barriers by linking services and teams to provide consistency which builds trust
- drives accountability from staff and users
- addresses needs in a timely manner

This case proposes locality-based teams that are grouped around primary care and natural geographies, offering 24/7 services as standard, and complemented by highly flexible and responsive community and social care services[3]. The localities proposed are below.

Figure 5 – Proposed Localities
(Practices and changes in population from now to 2022 – taking into account new housing developments)

The idea of localities has emerged within the context of:

- The MCP vanguard results to date.
    - The building blocks of an MCP are the 'care hubs' of integrated teams. Each typically serves a community of around 30-50,000 people. These hubs are the practical, operational level of any model of accountable care provision. The wider the scope of services included in the MCP, the more hubs you may need to connect together to create sufficient scale.
    - An MCP model is a place-based model of care. It serves the whole population, not just an important subset (such as people over the age of 65).
- Under-developed relationships between health and social care, housing and the voluntary sector, a particular issue given that some people receive care from all or many of these services
- Unwarranted variations in practice

[3] Nigel Edwards, Community Services – How they can transform care. The Kings Fund February 2014

- Local people telling us that they want better access to services and more joined up services
- Financial and demand pressures on the health and social care system, and the need to address these through new ways of working

The Community Health and Social Care project has 2 elements:

1. *Integration of long term health and social care* - Localities are being developed to focus service planning and delivery around local communities with the aim of more effectively coordinating care and support for people with complex needs and emphasising self-care and early, targeted prevention. Within each Locality, Primary Care, Community and Social Care teams will work together to provide integrated out-of-hospital services in the right place at the right time to improve outcomes and will work closely with appropriate local voluntary and community organisations to support people to self-care and prevent further ill health.

The initial phase of this will integrate Wokingham Borough Council's (WBC) long-term social work functions, currently provided by Optalis brokerage and support, with BHFT's community nurse teams. Other organisations' services that may be better delivered on a locality basis may also join the Locality at a later date.

2. *Promoting Self-Care and Prevention* of health and social care issues and conditions, this is being undertaken in partnership with the voluntary sector through Involve who have developed a Volunteer Community Navigator scheme to improve access to local voluntary and community resources by providing targeted, up to date information to service users and their families, and support local people to self-care and maximise their wellbeing.

In February 2015 Jeremy Hunt reported that a fifth of GPs time is spent dealing with patients' social problems, such as debt, isolation, housing, and employment. We do not have data specific for Wokingham and as Wokingham is not described as socio-economically deprived the percentage may be lower. The Low Commission inquiry into social welfare advice provision chaired by Lord Colin Low, reported services located in primary care settings could cut time spent by GPs on benefits issues by 15% and reduce repeat appointments and prescriptions. The report called on NHS commissioners to use welfare advice services to address the social determinants of ill health, improving health outcomes, addressing health inequalities and reducing demand on the NHS.

Social prescribing has been shown to:

- Reduce the use of GP appointments for social problems
- Reduce the level of care required for care packages
- Improve general health
- Improve well-being
- Reduce feelings of isolation
- Help people meet others who have the same diagnosis

These 2 elements form one of the three key parts of Wokingham's Integration plan set out below, which shows how the long-term integrated teams fit with other integrated services such as the Hub and the short-term (WISH) team. This is the final piece of the jigsaw for Wokingham's integrated system.

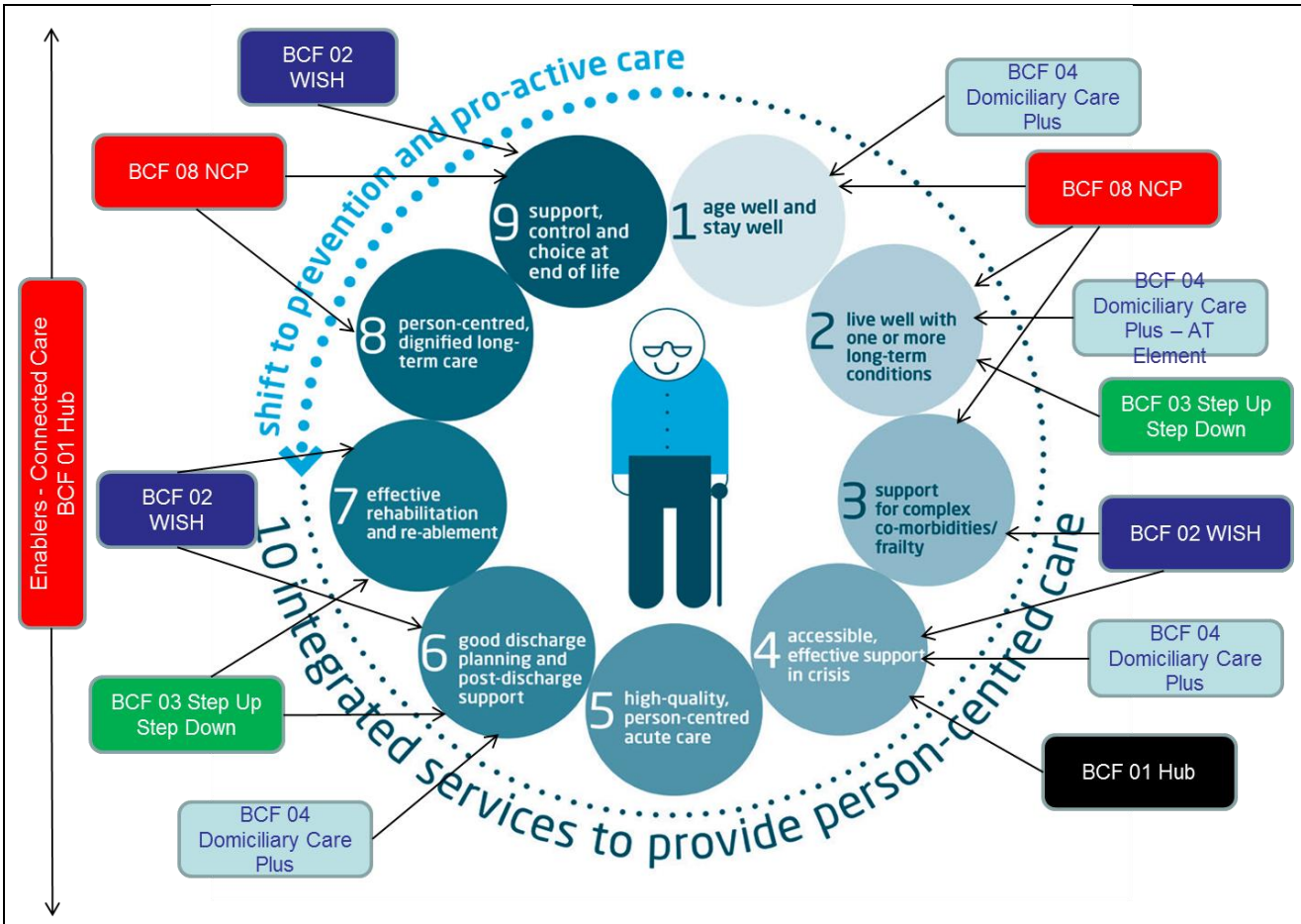


Figure 6 – Sam's story – Wokingham's BCF Programme overview

1.4 CHASC Aims and Impacts

The projects overarching aim is:

'to keep the residents of Wokingham fit, well and living as independently as they can be in their own homes for as long as possible by working as a single health and social care system that supports people, promotes self-care and prevention and **ultimately makes the most effective use of all resources in the system'**

The objectives of the project are:

- Reducing the complexity of services – removing organisational boundaries, single care plan, accountable key workers
- Wrapping services around primary care – delivered with and alongside GPs
- Aligning teams/services and geographical localities to provide most effective coverage that meets the population needs throughout the year
- Building multidisciplinary teams for people with complex needs, including social care, mental health and other services
- Supporting these teams with specialist medical input – particularly for older people and those with long-term conditions
- Building an infrastructure to support the model based on these components including much better ways to measure and pay for services, use of technology, using data to inform care co-ordination and delivery
- Developing the capability to harness the power of the wider community e.g. voluntary sector, fire service
- Ensuring that the response is proportionate to the individuals needs in all aspects of care and safeguarding

Community Health and Social Care system will be responsible for delivering integrated care through smart working, as opposed to isolated care. This will provide person centred care delivered by an appropriate professional from the integrated team. It will be collective, joined up, long-term, health and social care support and will deliver:

- Primary prevention - Reducing the demand for health and care services, by enabling people to enjoy a healthy and active life within their communities, is a key priority for the NHS and social care system. The King's Fund has recently published a resource for local authorities that outline the key priorities for prevention and improving the public's health (Buck and Gregory 2013). The paper highlights partnership working and systematic use of health impact assessments as key and highlights key areas that can improve public health and reduce inequalities.
- Self-care - People with long-term conditions account for 70 per cent of all inpatient bed days (Naylor et al 2013). Self-management programmes, which aim to support patients/service users to manage their own condition, have been shown to reduce unplanned hospital admissions for some conditions such as chronic obstructive pulmonary disease (COPD) and asthma (Purdy 2010).
- Managing ambulatory care-sensitive conditions - Conditions where the need for hospital admissions can be reduced through active management (known as ambulatory care-sensitive (ACS) conditions) accounted for 15.9 per cent of all emergency hospital admissions in England in 2009/10, with an estimated cost of £1.42 billion (Tian et al 2012). The annual Care Quality Commission (CQC) 'state of care' report (2013) found that 'older people are increasingly arriving in A&E with avoidable conditions' such as diabetes or respiratory diseases. The report found that some areas were more able to avoid these admissions and it highlights interaction between primary health care, secondary health care and social care as key (CQC 2013). An emergency admission for an ACSC is often a sign of the poor overall quality of primary and community care. Conditions (such as asthma, diabetes, epilepsy, hypertensive disease, dementia and heart failure) where optimum management can be achieved in the community.
- Risk stratification or predictive modelling - Statistical models can be used to identify or predict individuals who are at high risk of future hospital admissions in order to target care to prevent emergency admissions. In an evaluation of predictive modelling options, Billings et al (2013) suggest:
  - choosing which predictive model should be based on a number of factors, including the intervention design and the data that it will analyse
  - including GP data in predictive modelling is particularly important, and including all patients in an area rather than just those with prior hospital use was found to improve case-finding.

  We will need to consider what data is available to us and it will be a key enabler of the project. One example of a service model that uses risk stratification is 'virtual wards', which provide multidisciplinary case management to people in their own homes identified as high risk, as would be available in a hospital ward, in order to prevent emergency admissions.
- Care co-ordination - Care co-ordination is a person-centred, pro-active approach to bringing health and social care services together around the needs of service users. It involves assessment of an individual's needs, development of a comprehensive care plan and a designated care co-ordinator to manage and monitor services around the individual, recognised in recent changes to the GP contract. Using the GPs anticipatory care plan so that people have one single health and social care plan.
- Care Delivery/ Case management - Co-ordinated and integrated services for people with long-term conditions have potential to deliver better and more cost-effective care if they are well designed, involve professionally trained case managers and care teams, and are embedded in a wider system that supports co-ordinated care (Ross et al 2011). Evidence suggests that a significant proportion of admissions could be avoided if alternative forms of care were available (Health Foundation 2013).

The impacts of the project will be:

- better health for the whole population
- reduced inequalities in access to health and social care, including improved access to the right service at the right time
- reduced variation in outcomes
- increased quality of care and safety for all residents
- better value for the taxpayer
- supporting people to live well in their own homes for as long as they wish and are able to
- improve residents experience of health and social care

- contribute to a more sustainable system for the future by reducing demand

1.5 CHASC - How are we going to do it?

CHASC cannot simply be willed into being through a transactional contracting process. Merely rewiring institutional forms, contracts and financial flows changes nothing. By far the most critical task in developing CHASC is to get going on care redesign, locality by locality. However, to be sustainable and fulfil its potential, CHASC will ultimately need to be commissioned rather than continue to rely on a shared vision and goodwill. In this way money flows and contracts and organisational structures all actively help rather than hinder staff to do the right thing. CHASC may start off as a loose coalition, but sooner or later it has to be established on a sound legal footing under contract.

The proposed changes in service delivery are ambitious and reflect the 5 year vision for health & social care for people in Wokingham. Therefore we need to phase and prioritise the implementation of the model of care, recognising that immediate changes do need to be made. The project will need to be phased into 4 phases to ensure successful delivery.

1. Phase 1 - Volunteer Community Navigators – implementation started March 2016 for completion December 2017
2. Phase 2a – Developing CHASC Model of Care (delivery Q2, Q3 and Q4 17/18) and Phase 2b - Implementing CHASC Model of Care (delivery Q1, Q2, Q3, Q4 18/19)
3. Phase 2a(i) – Delivery around Primary Care (GP alignment in localities and formal agreement on working arrangement – between practices and CHASC – Q2, Q3 and Q4 17/18) and Phase 2b(i) Testing Phase with a single locality (Q1 and Q2 18/19)
4. Phase 3 – Development of future plans with wider partners, to work up as a model in 18/19

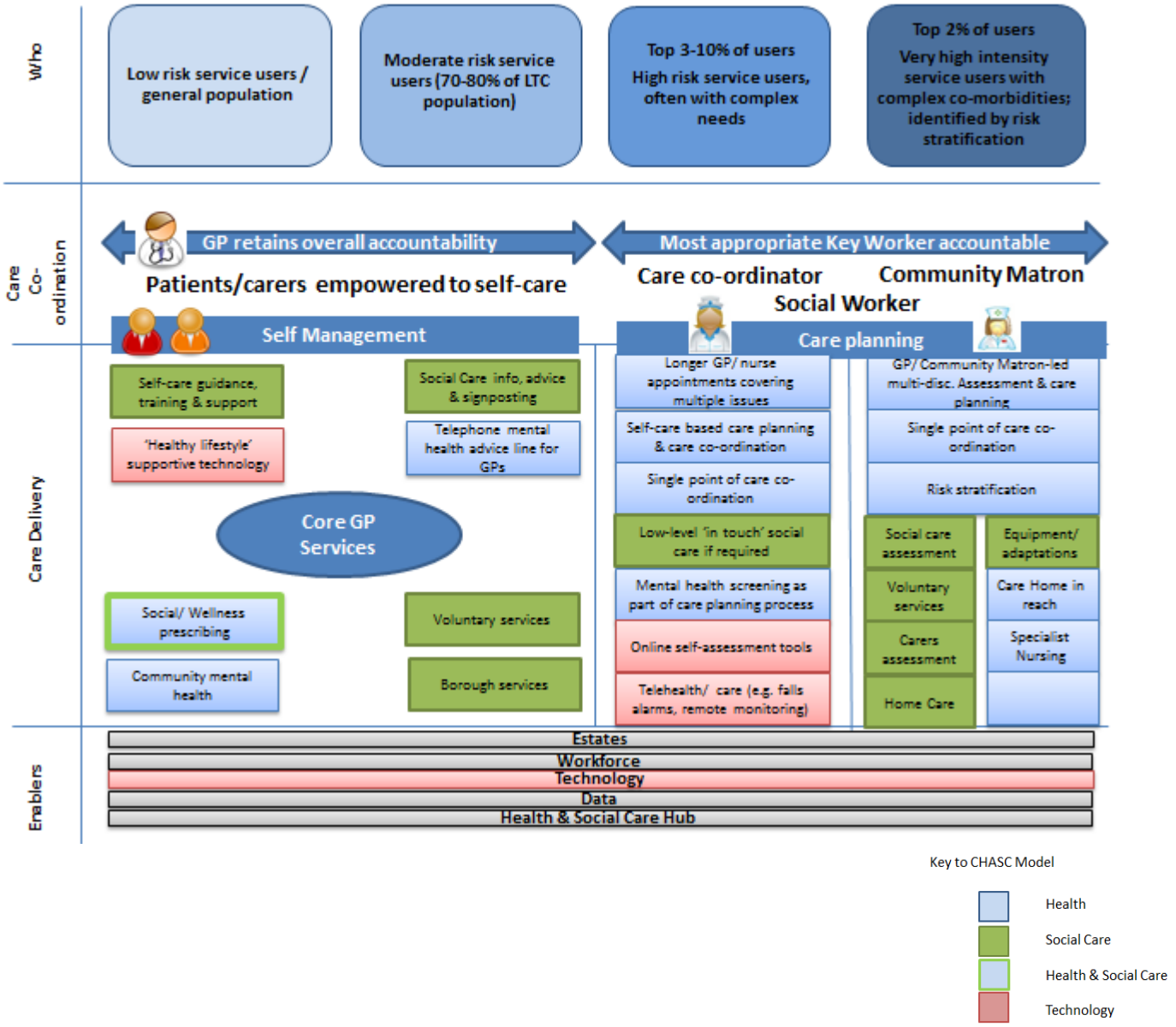
This Business Case lays the foundations for whole systems integration. Achieving the initial savings through the reduction in NELs is critical to enabling further investment in pro-active and preventative services, however through better co-ordination of existing services we can ensure that the benefits can start to be realised.

Key objective deliverables:

- One service offer across Wokingham Borough to be delivered with and alongside General Practice
- Aligning teams/services and geographical localities to provide most effective coverage that meets the population needs
- Reviewing and agreeing the role and responsibility of all staff groups e.g. community navigators, care coordinators, social workers, GPs and community matrons
- Reviewing and updating all processes to provide efficiency and consistency
- Investigating and implementing technology where needed
- Ensuring mechanisms are in place to use data produced regularly about NELs, A&E admissions, SCAS activity and GP attendances to inform care co-ordination and care delivery is aimed at the right people. The new model is reliant on using high quality business intelligence systems, with data that is as real time as possible. Without these, CHASC is ‘flying blind’. Core aspects of ‘commissioning support’ such as business intelligence will increasingly become ‘population health management support’, and CHASC will need to use these services as a key customer
- Developing partnership working with the 3rd sector
- Delivering services around Primary Care
- Ensuring delivery of statutory local authority duties

1.5.1 Proposed Care Delivery Model – LONG TERM CARE

Figure 7 – Proposed Care Delivery Model



The model may require further refinement during the planning phase. The model builds on the view that at risk people benefit most from high quality, integrated multi-disciplinary care and support which is provided as close to their home environment as possible. To deliver a genuine person-centred approach to care, it is necessary for partners in Wokingham to think across organisational boundaries to create joined-up services operating under a 'one team' ethos. Working with lay partners, clinicians, and health and social care practitioners, the new, long term model of care has been designed based on the pyramid of need defined (Figure 1 page 7).

The transformation of care involves major shifts:

- In the boundary between formal and informal care
- In the use of technology - not only to provide fully interoperable electronic records and real time data, but also to redesign the process of care delivery, for example through phone and Skype consultations, diagnostics, the use of apps and early adoption of innovative drugs and devices.
- In the workforce - it empowers and engages staff to work in different ways by creating new multi-disciplinary teams; by redesigning jobs so that they are more rewarding, sustainable and efficient; and by implementing newer professional roles.

The opportunity for CHASC is across all three. An effective model engages and activates service users, their carers, families and communities in helping to take control of their own care – rather than assuming

that the main source of value is clinicians doing things to people.

The model shows that everyone will receive a level of pro-active care. Care will then 'ramp up' as level of need increases. People will have easy access to health, care, social care, mental health and well-being services. Crucially both physical and mental health needs have equal status and are accounted for under 'health' in the diagram.

- Self-Management - The model focusses on providing high quality through pro-active and preventative action to stop at risk people becoming unwell in the first place.
- General Practice - will remain fundamental to the delivery of care for all tiers, but there will be a greater role for GPs across all settings of care.
- Social Prescribing -It recommends that well-being prescription should be seen as on par with medical prescription. As such, referral to local voluntary and faith organisations that provide well-being activities will be increased.
- Care Co-ordination - The model of care will be underpinned by care co-ordination that will ensure agencies are able to work more effectively together, as opposed to delivering specific elements of care independently.
    - A person's GP will retain overall clinical accountability for that person throughout their care pathway and for those individuals on the community hub caseload, their assigned Locality MDT Co-ordinator will retain overall accountability for the co-ordination of their care throughout their journey including if they require CHASC services. Even though an attitude of co-ordination will be expressed by all professionals, the locality MDT Co-ordinator explicitly functions as the 'glue' between the different services.
    - This will involve ensuring that the persons care plan is up-to-date and acted upon, working with people and other professionals to co-ordinate care more effectively, as opposed to delivering specific elements of care independently and ensuring that everyone involved in the person's care is kept up to date as to where they are on their care journey.
    - The Locality MDT Co-ordinators will organise support to ensure that people receive co-ordinated multi-disciplinary care and will maintain regular contact with people and those providing their care. They will ensure that any change in condition is identified early and escalated to the appropriate professional in a timely manner. The Locality MDT Co-ordinator is the primary point of contact for the person receiving the service.

It will also begin to bring about the whole-system change we know the area needs by:

- Creating a single, integrated, multi-disciplinary team operating under the 'Community Health and Social Care' banner
- Improving the way in which professionals share information within and between organisations, such that a person only needs to tell their story once and has confidence that everyone involved in their care will have access to the medical history
- Placing and increased emphasis on pro-active care and moving as much care as possible out of the hospital and into homes and communities
- Developing step up beds at Wokingham Community Hospital to manage users within their community and prevent acute NEL admissions
- Delivering improvements in access to general practice as described in the General Practice Forward View. E.g. delivering enhanced urgent care services, through clinical hubs with patients immediately accessing GPs, nurse prescribers, pharmacists and dentists through 111 or a single point of access.
- Improve the care co-ordination and delivery of care to not only the top 2% but also the top 10% of users of health and social care

Under the new model of care people will receive:

- Care that is centred around the person's needs, wishes and aspirations e.g. a single point of access to services
- Care that emphasises self-management and the pro-active involvement of individuals in their own care
- Timely health and social care assessments and preventative intervention
- Care planning & co-ordination for integrated health and social care packages
- Access to community assets in parallel with health and social care interventions to improve wellbeing, reduce social isolation and encourage healthier lifestyles

1.5.2 Phase 1 – Volunteer Community Navigator Scheme – delivery 16/17 and 17/18

In order to keep users fit and well early intervention is required as shown in the proposed model. It is aimed at people who might benefit from local information and support to self-care and enhance their health & wellbeing; including low to moderate risk service users, their carers, families and the general public. The overall aim being to promote integrated health and social care, partnered with the voluntary and community sector by improving access to local voluntary and community resources by providing targeted, up to date information to service users and their families.

The scheme provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and well-being. It can also be accessed by all health and social care professionals and well as self-referrals from users. The scheme is currently on a phased roll-out, starting in April 2016 to be able to provide a service to all 13 GP practices in Wokingham by December 2017.

Involve is running the scheme and it requires a part-time employed community navigator coordinator who is responsible for:

- Recruitment of volunteers
- Training of volunteers
- Liaison with GP surgeries for roll-out
- Day to day operational management of the volunteers and the scheme
- Comms and service profile development

Service Description

Referrals can be made on-line, by telephone, by email or on a referral form and mailed to the team.

Once the referral is received the trained volunteer Community Navigators will arrange to meet users at their GP surgery or another community venue to identify their community support needs.

Community Navigators signpost users to appropriate sources of social support and other non-medical services within the community, neighbourhood and beyond.

Community Navigators will assist users by:

- Finding out what they would like to do, their availability, and when.
- Searching for local charities, community groups and organisations that can meet their needs.
- Making the first contact with the organisation on their behalf, if they choose.

Community navigators will follow-up users 4-6 weeks after their appointment to see what services the user took up and what other assistance they may require.

1.5.3 Phase 2a – Developing CHASC Model of Care (delivery Q2, Q3 and Q4 17/18) and Phase 2b - Implementing CHASC Model of Care (delivery Q1, Q2, Q3, Q4 18/19)

Phase 2a - Developing CHASC Model of Care

The proposal requires significant organisational change and coordination across multiple organisations – GPs, BHFT, WBC, Optalis and Involve (voluntary sector). The current services are fragmented with many separate teams. The proposal is to form a single MDT team of social workers, nurses, MDT coordinators and volunteer community navigators to lead on assessment, care planning and coordination to improve the efficiency of the service. Joint commissioning by Wokingham CCG and WBC has been discussed and will be agreed prior to the approval of this business case. A proposal for Wokingham Adults Integrated Health and Social Care Governance will be prepared for agreement by the commissioners and the Health and Wellbeing Board

The services in the system are commissioned currently by WBC and Wokingham CCG and this will continue to be the case. It is proposed in phase 2 that BHFT, WBC and Wokingham GP Alliance will be the organisations that will partner in order to manage and deliver the services provided in the system. In the medium term they will sub-contract services e.g. Optalis and Involve, in order that one board has the management and oversight of the whole system.

It is also proposed that a Head Of Community Health and Social Care is employed, as soon as is

practicable. This would provide the level of oversight required for the planning and development of the model and system. This post will initially require a simple service level agreement (SLA) between WBC and BHFT in the first instance. The SLA will need to include:

- This will be a jointly managed post by WBC and BHFT and the council will empower the manager to direct resource usage and will enable the council to build trust and confidence in the management of the social work function.
- BHFT have agreed that no additional funding is required for this post as it will use existing resources
- There will be matrix accountability to WBC as this post will have equivalent authority of a Head of Adult Social Care and Safeguarding post and will need to comply with WBC's governance and constitution in carrying out the management of social care and the social care function.
- The arrangement can be withdrawn at short notice if there are performance issues in adult social care

During the planning phase we will need to consider/include:

- 'One Team Ethos' - Whilst the Community Nursing and the Brokerage and Support team will be employed by separate partner organisations initially, both services will be providing care for the same cohort of people, but meeting different levels of need, therefore operationally they will need to work together as complementary teams with shared outcomes that have been agreed with the person and their carer. As such all people providing the core services outlined in this Business Case will identify themselves not through their organisational employment but as a member of the 'Community Health and Social Care'. This will be reinforced through visual signs such as uniform and identification lanyards and through shared documentation and processes.
- Different ways of working – what is the purpose of the persons role and how can it be delivered
- The delivery of Wokingham Borough Council statutory duties will require regular reporting to Wokingham's Director of People Services and lead member for Social Care
- A different way of communing, social interaction
- What motivates staff to come to work?
- The move to remote working – need to think differently about how we do it
- Investment in technology to enable such working practices (aligned with the Connected Care project and milestones)
- Voluntary Sector support – provision will need to be made to ensure that the voluntary sector is appropriately supported
- Co-design across the system – commissioners, providers and users will all be involved in the design of the model and the processes required delivering the model
- Review and revision of all SLAs for providers
- Agreement and design of a single care plan

Given the complexity of the project at its dependencies slippage has been built into the implementation plans. At the monthly steering group meeting an update will be given on progress against the plan and any timescale updates that are required. Appendix 2 contains the high level implementation plans

Phase 2b Implementing CHASC Model of Care

Implementation of the model will start in April 2017. Phase 2b implementation will focus on the integration of the BHFT community nursing, Optalis and Community Navigators services.

1.5.4. Phase 2a(i) – Delivery around Primary Care (GP alignment in localities and formal agreement on working arrangement – between practices and CHASC – Q2, Q3 and Q4 17/18) and Phase 2b(i) Testing Phase with a single locality (Q1 and Q2 18/19)

Primary care is now in a position to proceed with an integrated model with community health and social care.

The benefits to primary care will be:

- A reduction in the number of GP appointments for social problems, through the use of Volunteer community navigators and enhanced signposting. West Wakefield Health and Wellbeing Ltd MCP vanguard has increased the number of its patients signposted by care navigators by forty per cent over

three months. A care navigation framework (directory of services) is embedded across practices and receptionists use this to signpost patients to cost effective and appropriate services to meet their needs in a timely manner.

- Provide accessible and responsive urgent and emergency care by delivering enhanced urgent care services, through clinical hubs with patients immediately accessing GPs, nurse prescribers, pharmacists and dentists through 111 or a single point of access. Integrated access means that the CHASC is able to appropriately divert a proportion of potential urgent and emergency care patients away from secondary care but ensure the patient has access to the right point in the system. Better Local Care (Southern Hampshire) MCP vanguard has created a 'same-day access service', which pools together the urgent workload for the participating GP practices into a single service that is operated from a central location and is resourced by the practices. In the six weeks from opening in December 2015, the service handled 5,500 patients - almost two thirds of whom had their needs met over the telephone.

Phase 2a (i)- GP alignment in localities and formal agreement on working arrangement – between practices and CHASC

Considerations for this phase need to include:

- The Wokingham CCG GP practices will need to agree locality alignments and will need some form of alliance federation within the localities
- GPs will want to agree within each locality which will be the host GP site for the locality CHASC team and how the CHASC team will support the sister sites within each locality
- Clarity will be needed around the practice nurse and community nurses roles, this can be addressed in the updated service level agreements with BHFT for Community Nursing
- Exploration around collective GP and CHASC working, including how GPs would support access and deployment of the CHASC services
- Design and agreement of a single, shared care plan for all providers

Phase 2b (ii)– Testing phase with 1 locality

It is proposed that one geographical locality is developed in order to explore and develop the model with the outcomes will helping to shape the other 2 localities. This would include developing a location in Wokingham to provide all the urgent on the day GP appointments, including near patient testing diagnostics. This would enable the GP surgeries to focus and have more time to manage the users with long-term conditions who are high risk or high intensity users.

1.5.5 Phase 3 – Development of future plans with wider partners, to work up as a model in 18/19

There are a wider range of services that could be included in this model. In order to ensure that the new model of care becomes embedded and successful it was decided that in the early phases that these would not be included but would be looked at as a future development for 18/19.

1.6 Outcomes

Avoiding unnecessary emergency hospital admission and / or readmissions is one of the priority outcomes of the programme because of the high and rising unit costs of emergency admission compared with other forms of care. For service users it is crucial to help them to manage the disruption to their lives and to support them to manage their own care in their own homes or care home.

The **outcomes** will be:

- Better health for the whole population – by providing targeted, pro-active care and intervening early in a person's illness pathway. Analysing and using health and social care data collected to target interventions where needed.
- Reduced inequalities in access to health and social care – the system is currently provided by multiple organisations working separately, making navigation of the system difficult for people and users. GPs are the first point of access for many people and they will use the health and social care hub as a single point of access to services.
- Improving access to the right service at the right time – by wrapping services around primary care and developing social prescribing services and use of the voluntary sector.

- Reduced variation in outcomes - by removing the complexity that has resulted from different policy initiatives over the years; ensuring clear lines of accountability and responsibility for staff
- Increased quality of care and safety for all residents – through timely, targeted care co-ordination provided by one responsible organisation
- Better value for the taxpayer – by ensuring the response is proportionate to the person's needs; that resource utilisation is streamlined and economies of scale are utilised; targeting the top 10% of users of services (1,576 people) and not just the top 2% of service users (315 people). Robust mechanisms for the review of long term packages of care.
- Supporting people to live well in their own homes for as long as they wish and are able to
- Improve residents experience of health and social care- by reducing/removing barriers between services and professionals; aligning teams to localities to meet the populations needs
- Contribute to a more sustainable system for the future demand - More efficient working by reducing hand-offs, duplication of effort, organisational boundaries and wasted time and reviewing all processes, allows for more and better quality interventions. Implementing appropriate technology where required. Introduction of enhanced urgent care services to reduce pressure on GPs

1.7 Benefits

The **financial** benefits will be:

- Reduced NELs
- Reduced A&E attendances
- Reduced/delayed cost of social care packages
- Reduced/delayed care home placements in the long term

The **people** benefits will be:

- *People have a higher quality of life, and enjoy their improved health status.* The impact of their conditions on daily life has been lowered considerably. Evidenced by a reduction in NEL & A&E attendance, LOS and readmission within 91 days of those over 65.
- *Improved satisfaction of care.* Care will be better organised and of high quality. The proportion of people satisfied with the care and support services they receive should increase. There should be less fragmentation and duplication.
- *Care and support are centred on the person's needs.* People appreciate that care follows their needs and preferences. Their needs and preferences are incorporated in the care plan.
- *People experience pro-active, co-ordinated care and support.* Care focuses on improving health status and preventing exacerbations. Multi-disciplinary care is co-ordinated by the Care Co-ordinator. People experience a seamless service.
- *Care is of high quality and safe.* Care is provided according to best practice and meets NHS and Care Act standards. Continuous learning framework and monitoring of incidents are in place.
- *People feel empowered, capable of and engage in self-management.* People are actively involved in care planning and have access to support for self-management.

The **Professionals** benefits will be:

- *The person is central to how professionals work together in the multi-disciplinary teams.* The person's needs and preferences shape what care is delivered and how the MDT delivers this.
- *Professionals enjoy their work as together they ensure people get the care they need***.** They provide this care themselves or this is provided by a colleague of the multi-disciplinary team.
- *Professionals will no longer work together across organisations through multi-disciplinary teams.* Instead, organisational barriers removed and there will be investment in integration where needed.
- *Professionals work with clear and well-known paths for referral.* There is a Single Point of Access and the GP and Care Co-ordinator are the key contact points for further information.
- *Increasing mutual respect and trust between different professionals, within and between organisations.*

The **whole system** benefits will be:

- *The system is flexible to meet people's changing needs over time***.** People's needs will vary over time with periods with more or less intensive care. The system supports people through these in a seamless

way.

- *Reduction in use of GP appointments for non-medical problems*
- *On-going co-ordination and integration between health and social care partners.* Establish integrated services that provide co-ordinated and multi-disciplinary care & support with a Single Point of Access.
- *The relations between local providers have strengthened and matured.*
- *Financial pressures on local health and social care providers are reducing and stabilising.* The current resources are able to meet people's need in the community cost effectively.

1.8 Project Outputs

As the services will become integrated there will be a range of new products it will be delivering:

- Shared Paperwork
- Single Assessment
- Integrated Policies and Procedures for the Service
- Shared Risk Stratification tool – to include data sharing from providers to direct care to frequent users of health and/or social care
- Revised MDT structure and delivery
- True single point of access to long-term health and social care
- Review of health and social care pathways and integrate/update as required
- Develop audit tool to measure the quality benefits of the integrated system

The purpose of the following section is to clearly define the benefits to be delivered by the project, how these benefits fit in with local and national strategy to deliver person centred coordinated care, and the metrics to be used to measure progress and asses long term impact. For more information and to assist with completing this section please see the NHS England BCF How to Guide – How to understand and Measure impact https://www.england.nhs.uk/wp-content/uploads/2015/06/bcf-user-guide-04.pdf.pdf

Impacts & Outcomes

	Expected Long Term Impact	Project Benefit/s	Metric / Measure*
Scheme/Project 47	**Improving people's experience of health, care and support**	Improved satisfaction of care.	The proportion of people satisfied with the care and support services they receive should increase. Friends and Family Test or locally devised patient/service user questionnaire
		Care and support are centred on the person's needs.	Audit of patient/service user care plans
	Better Outcomes for patients and service users	People have a higher quality of life, and enjoy their improved health status.	Reduction in NELs, A&E attendances, LOS and readmission rates
		People feel empowered, capable of and engage in self-management	Involve devised outcome measure – Ladder of Change
		Care is of high quality and safe	Reduction in safeguarding reports, complaints, etc.
		People experience pro-active, co-ordinated care and support.	Audit of notes and locally devised patient/service user questionnaire
	Better Use of Resources	Reduction in NEL admissions (BCF metric)	Reduction of 331 NELs for Wokingham 16/17 vs. 15/16 NEL activity for top 10% of population when the system changes have been made will start to deliver in 17/18
		Reduction in A&E attendances	Reduction of 499 A&E attendances for Wokingham 16/17 vs. 15/16 A&E attendances activity for top 10% of population when the system changes have been made will start to deliver in 17/18
		Reduced/delayed cost of social care packages	Social Care packages - Will be monitored in first instance to form a baseline. Will monitor on a monthly basis, total spend of cost of long term care packages, number of social care packages, and average cost of social care packages. Referrals through to the volunteer community navigator scheme and the impact this has on the numbers entering

			long term care. Reduced numbers on waiting lists as redirected to the volunteer scheme.
		Reduced/delayed in permanent care home placements (BCF metric)	Permanent care home placements - Will be monitored in the first instance to form a baseline. Will monitor the number of users of social care packages that become care home admissions each month. Also should monitor local authority monthly care home placements and total spend
		Reduction in use of GP appointments for non-medical problems	At present GP activity is not available so unable to measure this benefit, but will need to explore how this can be measured

Performance Metrics

		Metric	Data Source	Baseline	Target / Impact
Project/Scheme 48	Performance	Social care packages - Will monitor on a monthly basis, total spend on long term care packages, total number of social care packages provided , average cost of social care packages provided	Wokingham Borough Council/Optalis data	This will provide a baseline	No increase/reduction/ delay in total costs of care packages in Wokingham in 16/17
		Permanent care home placements - Will monitor the number of users of social care packages that become permanent care home admissions each month. Also should monitor local authority monthly care home placements and total spend	Wokingham Borough Council/Optalis data	This will provide a baseline	No increase/reduction/ delay in local authority spend on care home placements in 16/17
		Reduction in use of GP appointments for non-medical problems – will work with the GPs/CNS to see if can devise a recording mechanism to be able measure any reductions	GP/CCG data	This will provide a baseline	Increase in GP time to spend with high intensity and high risk users
		Whole Systems Working – Do Multi-Disciplinary Care Meetings take place? Are staff satisfied with whole systems working? Are demand and supply balanced across the system?	BHFT Audit - Review MDT meetings and discuss staff experience At the bi-weekly MDT and reported quarterly at the monthly steering group meeting	No baseline required and will provide a baseline moving forwards	Improved whole system working
		Care Co-ordination - Care and support are centred on the person's needs Has a care plan been established? Is there is an appointed co-ordinator of care (self, carer or professional care co-ordinator)?	BHFT/Optalis Audit - Analyse the care documentation of a random sample of people that has been cared Quarterly - at the monthly steering group meeting	No baseline required and will provide a baseline moving forwards	Improved patient/service user centred care
	a l .	Quality of life and improved health status –	BHFT /Optalis Audit - Analyse the care	No baseline	Increase in quality of life

49		Can the person fulfil their desired activities of daily living (with support)? Is their mental wellbeing is good? Is their physical wellbeing is good? Has there been an admission into acute care?	documentation of a random sample of people that has been cared for and ask feedback from a number of service users. Quarterly - at the monthly steering group meeting	required and will provide a baseline moving forwards	and health status
		People's experience and satisfaction of care – Is care centred on the person? Does the person feel listened to? Does the person understand their care and do they feel involved? Is care consistent and co-ordinated? Is quality of care good? Does the person feel safe?	BHFT/Optalis- Use the outcomes of the Friends and Family test (will need to consider use for social care). In addition get feedback from a number of service users. Quarterly - at the monthly steering group meeting	No baseline required and will provide a baseline moving forwards	Improved patient/service user experience
		Pro-active Care – People experience pro-active, co-ordinated care and support. Have the appropriate assessments been conducted? Has a care plan been established? Is the care plan being implemented?	BHFT/Optalis Audit - Analyse the care documentation of a random sample of people that has been cared Quarterly - at the monthly steering group meeting	No baseline required and will provide a baseline moving forwards	Improved pro-active care
		Quality and Safety – Does care meet NHS and ASC standards? CQC, Monitor and local Wokingham Policy and Procedures Are evaluation processes on-going? Have there been incidents related to whole systems approach?	BHFT/Optalis - Review quality, incidents, safeguarding and evaluation Quarterly - at the monthly steering group meeting	No baseline required and will provide a baseline moving forwards	Improved quality and safety
		Person Centred Care - Care and support are centred on the person's needs Has the person been engaged with? Is shared decision making taking place? Has the person contributed to their care plan? Does the person self-manage? Is the person's carer involved when applicable?	Analyse the care documentation of a random sample of people that has been cared Quarterly - at the monthly steering group meeting	No baseline required and will provide a baseline moving forwards	Improved person centred care
	Financial	Reduction of 331 NELs for Wokingham 16/17 vs. 15/16 NEL activity for top 10% of population	CSU monthly NEL report	15/16 activity	Reduction of 331 NELs
		Reduction of 499 A&E attendances for Wokingham 16/17 vs. 15/16 A&E attendances activity for top 10% of population	CSU monthly NEL report	15/16 activity	Reduction of 499 A&E attendances

Options

Two options were considered:

Option 1: Do nothing – Health and social care services for Wokingham will continue unchanged in from 2016/17 to 2020/21.

This option should be discounted because it does not improve care for people, align with Wokingham's strategic direction nor deliver financial benefits.

Option 2: Integrate the long term health and social care teams to provide people with a single health and social care system

Recommendation

The options have been evaluated against the implications they would have on: the financial resources available in the Wokingham health and care economy, co-location of staff, people's experience of care; realising the Integration strategy, clinical quality and staff satisfaction. (Poor – 1, Satisfactory – 2, Good – 3).

	Financial Affordability	Co-location of staff	People's experience of care	Realisation of integration strategy	Care quality	Staff satisfaction	Total
Option 1	**1**	**1**	**2**	**2**	**2**	**2**	**10**
Option 2	**3**	**3**	**3**	**3**	**3**	**3**	**18**

Option 2 is the preferred option as it balances the need to make rapid progress towards an integrated, multi-disciplinary approach to care, while being able to work within the current financial constraints.

Assumptions and Constraints

Assumptions

- That all Wokingham health and social care organisations will agree to the project and the integration of their services to work in the best possible way for residents. To date there has been no feedback from any of the Wokingham organisations that they are opposed to the project.
- There will be a framework to support, and set expectations for, locality working
- Strong leadership to facilitate the creation of a collaborative culture that emphasises team working and the delivery of highly co-ordinated, consistent and resident-centred care
- Effective IT systems in place to support delivery of care via localities and that appropriate and relevant information is available to the right people in a timely and easily accessible manner
- Suitable accommodation is available within each locality or centrally to provide a team base. This will require review of community asset mapping work previously undertaken, discussion with the Core Strategy group and planners, and approaches to local businesses to enquire about possible assets.
- Residents are open to the concept of "patient activation" (Hibbard, J; Gilburt, H; 2014). This refers to a person's knowledge, skills, ability and willingness to manage their health and care. Staff need the necessary skills and training to support people within a model of self-care, as this goes beyond the provision of information and understanding of their condition(s) to train and empower patients/service users and carers.
- There will need to be discussion and agreement across the Wokingham BCF schemes at WISP to ensure that KPI measurement across all schemes to ensure that there are no benefits overlaps or double counting. The solution may be to have a single target across schemes e.g. combining NEL benefits from WISH and CHASC (circa 370 NELs for WISH and 331 NELs for CHASC would become a

target of 701 NEL reduction)
- BHFT will be the main provider of the Community Health and Social Care Project and will sub-contract the services required to deliver the project. This assumption has been made as for the following reasons:
    - It enables the project to be delivered at speed as it will be the least disruptive
    - Optalis has no experience of managing health services but BHFT have experience of managing social care services
    - As part of the 21st century council plans, WBC plans to be a commissioner and not a provider so this meets the council's strategic needs.

Constraints
- Ensure that in the modelling of the service that local authority statutory duties are able to be carried out according to legislation
- The role out of the Connected Care project as the sharing of patient/service user information is essential for the pathway
- Culture change is a key component in the delivery of new ways of working and may have an impact on the speed of delivery of the programme

Scope and Exclusions

Scope

The following 'core' services are proposed to be included in the first phase of CHASC development:
- Community matrons and District nurses
- Adult long term care - Brokerage & long term support
- CMHT (18-65 yrs.) and COAMHS (65 yrs. +) – in scope but in a longer term approach
- Volunteer Community Navigators
- Commissioning of prevention services and Carer's services that support long-term care
- Primary Care - GP Surgery staff
- Public Health

NOT in scope, as least initially, although the ambition would be to coordinate development of future plans in association with these partners:
- Services where there are a limited number of professional resources (e.g. Specialist nursing teams)
- Community development
- Libraries
- Sport & leisure
- Employment support
- Housing support
- Children's services – transition services
- Acute services

Exclusions

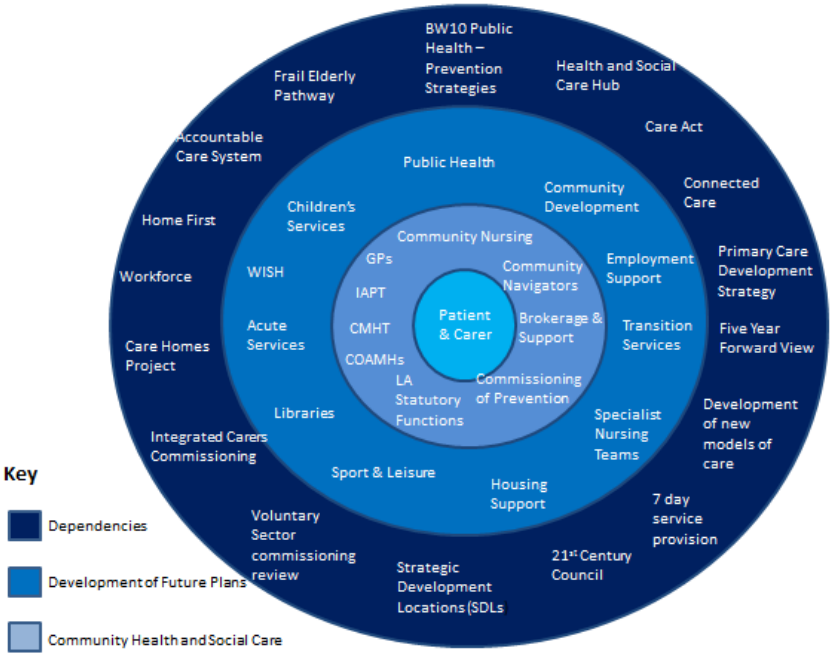
Health and social care services for the following groups will be excluded from the project at this stage but may be considered appropriate at some point in the future:
- Children's services

GPs

Determination of the ownership of GP practices is excluded from the project.

Shinfield Medical Practice is included in this model, although it is within South Reading CCG, as a large proportion of the patients registered at this surgery live in Wokingham borough.

Dependencies



As shown above it is clear that CHASC is connected to a whole community strategy. It naturally focusses on health and social care, but both of those things exist within a wider social construct. CHASC is a leading component of sustainable communities that includes public health, housing, leisure, community safety, wider prevention etc. Since January 2017 additional dependencies have been recognised including the Wokingham GP Alliance and the Long Term Conditions Programme Board.

Development of this project will need to align with the following programmes:

- Care Act implementation – especially regarding provision of co-ordinated care and enhancing the provision of comprehensive information and advice about care and support services in the local area;
- Frail Elderly pathway;
- Public Health outcomes framework and development of the Public Health prevention strategy;
- Structures will dovetail with those established for the accountable named GPs and the anticipatory care CES
- The development of new provider models (e.g. ACS)
- Primary Care Development Strategy
- The implementation of the GP DxS (clinical information tool) system.

Specifically within the Better Care Fund Programme:

- Integrated Health & Social Care Hub (BCF 01), in particular avoiding duplication in approach to information provision for self-care and prevention;
- Enhancement of the quality of medical cover for all adult residents of registered Care Homes in Berkshire West (BCF06)
- The implementation of the Berkshire West Connected Care scheme (BCF 07), including the electronic sharing of demographic information using the NHS number as the unique identifier, will significantly enhance the efficiency and effectiveness of the NCTs; and
- WISH (BCF 09), in particular ensuring processes for moving between WISH and CHASC are joined up

Many of these dependencies are programmes and projects being run at a Berkshire West level. For locality working within Wokingham borough to reflect local needs, Berkshire West initiatives will need to allow for a local dimension where appropriate.

Section 2 - Economic and Affordability Case

Budget / Cost Summary

Costs of operation & implementation	16/17	17/18	18/19	19/20	20/21
Localities					
One off costs for implementation	60,803	82,100	0	0	0
On-going costs for running operations	48,896	46,841	150,993	150,993	150,993
Total costs	**109,700**	**128,941**	**150,993**	**150,993**	**150,993**

A breakdown of the cost calculations can be seen in **Appendix 3.**

Source of Funding:

The Community Health and Social Care project is BCF Funded, with additional funding coming from Wokingham's BCF funds. For The Project Manager post is hosted by Wokingham Borough Council and Wokingham CCG.

One-off costs for implementation

At this stage of the project we have identified the following one-off costs:

1. Project Manager Costs

In order to be able to scope, plan and implement the significant change require a project manager is required. Indicative costs of the resourcing are:

- Interim post £450 per day

2. Local programme office support

All BCF projects in Wokingham have access to local programme office support provided by the BCF programme manager, finance manager and support officer. These costs are split between all the Wokingham BCF projects. These costs are pending budget confirmation from 17/18 onwards and are therefore excluded at present (indicative cost circa £20,000).

On-going costs for running operations

At this stage of the project we have identified the following costs. Within this there are also some one off costs:

1. Restructure of the MDT Care coordinators (16/17)

There is funding for 2 WTE MDT administrators, at a higher banding, within BHFT current budgets. The roles were reviewed as part of this project and were down banded and changed to coordinator roles. In order to deliver the locality model an additional MDT co-ordinator is required. The surplus funds generated by the change in banding nearly allows for the additional post. An additional £1,000 is required for BHFT to fund this final post.

2. Voluntary Sector Sustainability (18/19 and 19/20)

A placeholder for charity and voluntary sector sustainability has been added for 18/19 and 19/20 as it is expected that increased numbers of users will be directed towards the voluntary and community sector. The aim of this funding is to be able to provide one-off support to the sector to become more sustainable, e.g. volunteer recruitment, long-term fundraising initiatives. We will carry out a review in 17/18 to assess the impact and whether we would need to provide the additional funding for this sector.

3. Training for new virtual model of delivery (17/18)

The project plans to deliver a new model of working and there may be training needs for the different staff groups and this has been built in to recognise this.

4. IT infrastructure costs(17/18)

BHFT and WBC have differing IT systems, governance of those systems and hardware available to staff. We have already identified that working in a different way may have implications on IT costs e.g. Firewall issues, hardware suitable for remote working.

5. Property costs (17/18)

There may be moving costs and impacts on rents. It is unlikely that additional assets or equipment will be required in year as each team will have those and it should be a case of moving these if required. The project is proposing to co-locate and integrate the services that are involved in long term health and social care, there may be some costs to make existing premises fit for purpose or finding new premises, but as

yet this is an unknown at present. The current rental cost of the space used by the teams is circa £160,000 which is the current market rate for the equivalent space.

The on-going costs that will be incurred year on year are:
1. Volunteer Community Navigator Scheme, including travel and training costs (from 16/17)
The volunteer community navigator scheme will be staffed by volunteers but a part-time service lead is needed to manage, recruit and train the volunteers. This role will also lead the development and implementation of the scheme in practices and across the borough as the service rolls out. Volunteers will require training and there are costs associated with this and volunteers will need to be offered travel expenses incurred whilst performing the role.
2. Investment in MDT (from 18/19)
MDTs will be the central tool for care coordination and ensuring care delivery. We have recognised that there may be additional support requirements for the MDT process to be able to manage the top 10% of users and have built in some investment here for review in 18/19.
3. Marketing and promotion (from 16/17)
The programme will require a robust communications plan and may require some professionally produced information for service users and staff. At this stage of the programme there are no confirmed requirements.

It is not anticipated that there will be any increased costs in staffing in the health and social care teams as there are no new posts required. The current health and social care team staffing cost is circa £3,762,000, this includes on costs but not overheads.

Planned Savings/Efficiencies

Benefits	16/17	17/18	18/19	19/20	20/21
A&E admissions avoidance	0	-42,415	-84,830	-84,830	-84,830
NEL's avoidance	0	-177,742	-355,484	-355,484	-355,484
Care Home avoidance	0	0	-10,068	-10,068	-10,068
Early intervention opportunities	0	-17,051	-73,637	-73,637	-73,637
Total Benefits	**0**	**-237,208**	**-524,019**	**-524,019**	**-524,019**
Net cost / (Benefit)	**109,700**	**-108,267**	**-373,026**	**-373,026**	**-373,026**
Cumulative Net Cost / (Benefit)	**109,700**	**1,432**	**-371,594**	**-744,620**	**-1,117,647**

Net present value **-£951,703**
Payback **18/19**
ROI **162%**
A breakdown of the savings calculations can be seen in Appendix 3
The business case uses SUS data for non-elective admissions (NELs) during 2015/16 within the Wokingham locality as the basis for determining savings to the programme. There are 2 elements of the service that have a direct contribution the overall total savings – Community Navigators and Community Health and Social Care

Efficiency/Savings
An indication from other similar schemes is that there is a potential for savings and these will come predominantly from:
- Reduced NELs
- Reduced A&E attendances

We recognise that this project also has the potential for savings from:
- Reduction in care home placement
- Reduction in care package funding

Assumptions
We have had to build in assumptions for the targets, based on estimates of the impact of an evolving project over its first few years. More ambitious targets will undoubtedly be achieved from year 2 onwards, as locality based working becomes 'business as usual' and as more volunteer Community Navigators are recruited and confidence in their effectiveness increases and as improved provision of targeted information to enable people to self-care and prevent further ill health further delays or prevents people's dependence on health and social care services.

1. Reduced NELs
In order to be able calculate the number of NELs the project can reduce a year the following information was reviewed.
Wokingham 15/16 NEL activity

- 9013 NEL admissions 19+ years and above
- 315 people (19+ years and above) in Wokingham have been identified as the top 2% of health and social care users and accounted for **1567** NELs, an average of 5 NELs, per person
- 473 people (19+ years and above) in Wokingham have been identified as the top 3-5% of health and social care users and accounted for **1286** NELs, an average of 3 NELs per person
- 788 people (19+ years and above) in Wokingham have been identified as the top 5-10% of health and social care users and accounted for **1576** NELs, an average of 2 NELs per person

The activity above demonstrates the use of health by very high intensity service users (top 2%) and the high risk service users (top 3-10%). By changing the model of care it will be possible to better support these users and reduce the NELs activity.

Wokingham's NEL growth was reported as 5% for 15/16 and YTD 16/17 (year to date) NEL growth is 2.99% (N.B. the percentage growth includes the 0 – 19 age group). By integrating services and taking a system approach the project aims to reduce NELs in this group by **7.5%.** This percentage target was agreed as it will not only halt the annual NEL growth seen in 15/16 (5%) that has been experienced year on year, but aims for a small, but realistic downward trajectory (2.5%).

Therefore we propose the following NEL reductions:

- Top 2% - 1567/100 x 7.5 = 117 NEL reduced
- Top 3-5% - 1286/100 x 7.5 = 96 NELs reduced
- Top 5-10% - 1576/100 x 7.5 = 118 NELs reduced

TOTAL NEL reduction – 331 per year.

Assumes relatively low end needs on entry, therefore tariff rates reflected accordingly based on 5 day rate as per SUSD £1,073.97

2. Reduced A&E Attendances
In order to be able calculate the reduction in A&E Attendances the project can reduce a year the following information was reviewed.
Wokingham 15/16 A&E Attendance activity
o 29,649 A&E Attendances in 19+ years and above
o 315 people (19+ years and above) in Wokingham have been identified as the top 2% of health and social care users and accounted for 2315 A&E attendances, an average of 7.3 A&E Attendances, per person
o 473 people (19+ years and above) in Wokingham have been identified as the top 3-5% of health and social care users and accounted for 1981 A&E Attendances, an average of 4.2 A&E Attendances per person
o 788 people (19+ years and above) in Wokingham have been identified as the top 6-10% of health and social care users and accounted for 2383 A&E Attendances, an average of 3 A&E Attendances per person
The activity above demonstrates the use of health by very high intensity service users (top 2%) and the high risk service users (top 3-10%). By changing the model of care it will be possible to better support these users and reduce the A&E Attendance activity.

By integrating services and taking a system approach the project aims to reduce A&E Attendance in this group by 7.5%. This percentage target was agreed as it will not only halt the annual A&E attendance that has been experienced year on year, but aims for a small, but realistic downward trajectory.

Therefore we propose the following NEL reductions:
- Top 2% - 2315/100 x 7.5 = 173 A&E attendances reduced
- Top 3-5% - 1981/100 x 7.5 = 148 A&E attendances reduced
- Top 5-10% - 2383/100 x 7.5 = 178 A&E attendances reduced

TOTAL A&E attendance reduction – 499 per year.

Calculated at £170 per admission

3. Reduction in funding of social care packages

Expectation is the navigator scheme will still achieve reductions in this area as users that may have required packages of care or higher levels of packages of care could be supported by voluntary/charity sector services. We have assumed that 24% of referrals will lead to benefits from reduced social care packages and have calculated a cost benefit of £175 per month (represents 15% reduction on cost of average social care package).

4. Reduction in care home placements

On the basis the above is successful this will naturally lead to reductions in home care placements (suggest this could be year 3 before an effect is seen) This has been calculated based on those for whom the provision of adequate support in the community results in delay in care home admission, assumes delayed entry of 24 months, therefore generates 24 months of cumulative benefit – balanced by the assumption that those kept from care home placements require a home care package, therefore applying same rate as WISH assumptions.

We have assumed that of the 24% of navigator referrals that result in a reduction in funding of social care, 25% of those will benefit from a delay in care home placement which is calculated at differential between £681 per week which is the care home cost versus £267 per week which is the cost of a social care package when the user remains in their own home, which is £414 per week.

Phasing Assumptions

- There will be a slower uptake in year 1 and 2 as the scheme develops and is implemented
- There will be greater impact in year 2 and subsequent years, as more volunteer Community Navigators are recruited and the Community Health and Social care system integrates, there is greater awareness of their presence and increased confidence in their effectiveness
- For community navigators implemented a year 1 & 2 uptake to reduce levels of activity as scheme is embedded into GP's practices (referrals roughly aligned with current activity)
- Benefits realised from home care is 1 year post referral
- The percentage of those benefiting from community care and avoidance of home care will result in a longer term saving to Res care.
- In the longer term, more admissions and more A&E attendances will be prevented through the impact of targeted early self-care / prevention

Impact of Non-Financial Outcomes

An important consideration for investment is the impact on non-financial outcomes:

- The programme will support the Wokingham health and social care economy to achieve its strategic aims.
- The programme is expected to make a significant impact on people's experience of care and their health outcomes.
- The programme supports commissioners and providers to develop a sustainable health and care economy.
    - Reduced cost of social care packages
    - Reduced care home placements
    - Reduced non-medical GP appointments
- In addition, the programme also aims to transform the way organisations work together and as such contribute positively to the work satisfaction of local health and care professionals.

'Dis-benefits'

- There may be a reduction in income for the Royal Berkshire NHS Foundation Trust as project aims to reduce NEL and A&E activity
- BHFT currently rent rooms from GP surgeries at varying costs; this could be a loss of income for the GPs if the community nurses were to vacate.
- Optalis currently rents its office space from WBC for is Brokerage and Support team, this would be a loss of income for WBC, but they may want to re-negotiate with Optalis on the overall contract if this was built into existing contractual arrangements with Optalis.

Payback period

The project is expected to return a net saving in 2018/19.

Section 3 - Project Approach & Governance

Key Project Milestones (to include initial start date, main delivery points and Go Live date)			
Milestone	**Milestone Description**	**Date**	**Owner/Lead**
1	Present draft business case to the Steering Group	13/9/16	Project Manager
2	Present final business case to WISP for approval	14/11/16	Project Manager/WISP
3	Present final business case to relevant CCG, BHFT and WBC boards for approval	October/ November/ December 2016	SROs and DC
4	Plan and present Commissioning and Governance process and proposal for Wokingham Integrated Health & Social Care system for commissioning Exec Boards and HWBB approval	June 2017	SROs
5	Present final business case to Health and Well-being board for approval	August 2017	SROs/ Project Manager/ HWB
6	On-going roll-out of the community navigator service	On-going to December 2017	Involve
7	Prepare detailed project plan	November 2016 & January 2017	Project Manager
8	Phase 2a Design and Engagement Phase – including the recruitment of the Head of CHASC Phase 2a (i) Delivery around Primary Care (GP alignment in localities and formal agreement on working arrangement – between practices and CHASC)	June 2017 to March 2018	Project Manager/ Providers/ Service Users
9	Phase 2b Implementation of CHASC Phase 2b (i) Testing Phase with a single GP locality Phase 2b (ii) Roll out to the other 2 GP localities	April 2018 to April 2019	Project Manager & Providers
10	Phase 3 Development of future plans with wider partners, to work up as a model in 18/19	September 2018 to March 2019	Project Manager & Head of CHASC

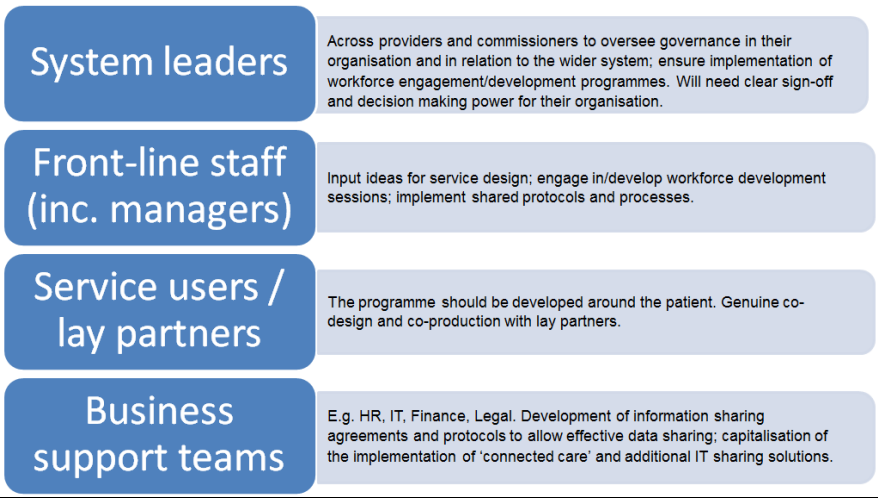
Delivery Chain

The provision of coordinated services though the Community Health and Social Care project is likely to be commissioned by Wokingham CCG in conjunction with Wokingham Borough Council and provided through integrated teams of multi-disciplinary professionals within the Wokingham borough area. Responsibilities and governance will need to be established. Providers of services will include:

- General practice
- Berkshire Healthcare NHS Foundation Trust
- Wokingham Borough Council
- Optalis
- Voluntary sector organisations

The resources for delivery by partners, where applicable, been fully considered. At present only some GPs are engaged in the project as primary care has yet to decide it long term strategy and plans at present. All other partners are fully engaged and part of the project planning.

The roles, responsibilities & accountability of the stakeholders in this programme are summarised below.



Project Organisation, Governance and Controls

Project implementation

Draft refreshed PID to be presented to WISP in September 2016. This will be following consultation through the Steering Group and with key stakeholders.

A project Steering Group is in place to lead on the strategic development and implementation the on-going review and monitoring to ensure success of the project post initial implementation of the Community Health and Social Care Project. A key focus will be ensuring that all enabling work areas critical to the success of the project are engaged and involved in delivery, from development through to implementation and that there is a co-ordinated, coherent set of plans in place to achieve the agreed changes and that these are well communicated across all organisations involved. The Community Health & Social Care steering group membership and meeting frequency has been reviewed and refreshed and is meeting monthly on the 1st Tuesday of the month.

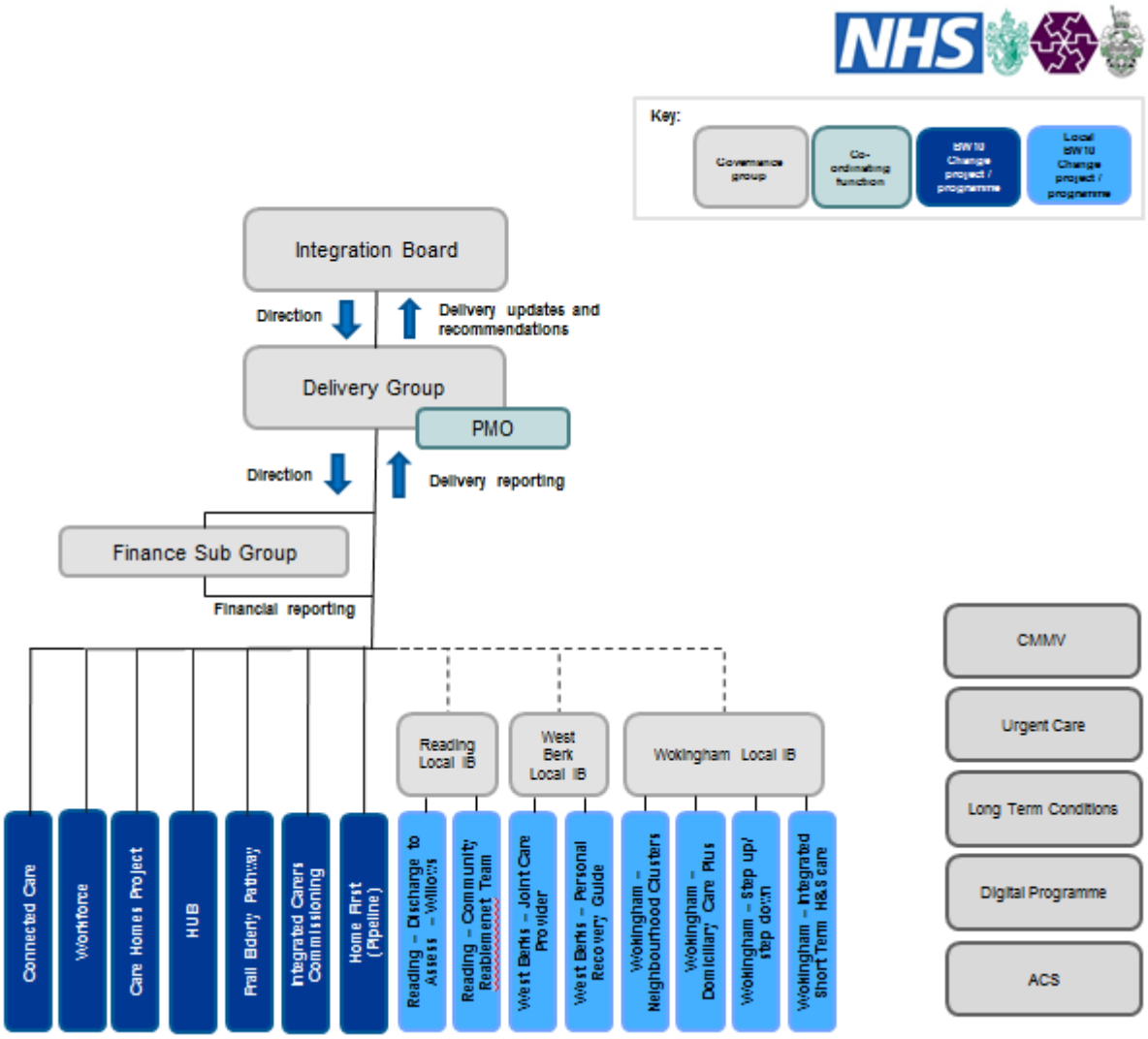
The Steering Group will report into WISP via Highlight reports and where necessary exception report to the SRO outside of these meetings. The steering group will work within the scope of the project as identified within the PID.

At present there is a project manager in post 3 days a week to deliver this project. The project manager will develop a robust implementation plan once the PID is approved to identify what is required to deliver the change. The Project manager will develop appropriate work streams and will develop working groups to deliver the work of the work streams.

Project Structure

Health and Wellbeing Board
↕
WISP
↕
Steering Group ↔ Task and Finish Groups
↕
(may require Locality Working Groups x 3)

Governance Structure



Governance Group and Roles

A dedicated steering group has been established to oversee the development and implementation of the project. The accountability for the delivery of this programme will be to WISP. Local assurance, troubleshooting and escalation will be via the Steering Group.

Steering group reporting bi-monthly to Wokingham Integration Strategic Partnership, and through them, into the Wokingham Borough Health and Wellbeing Board. The Health and Wellbeing Board (HWB) has strategic oversight and governance for related projects within the Better Care Fund.

Monthly written update reports will contain details of progress to date, achievements in the current period and achievements expected in the next period, details of actual or potential problems and suggestions for

their resolution. Exception reports will be produced when any stage of the project plan deviates outside tolerance limits. Exception reports will detail the problem, outline the available options and identify the recommended option;

The steering group will also feed into the Frail Elderly Programme and the Berkshire West 10 Integration Programme.

There are joint SRO arrangements for the programme, having a SRO from both Health and Social care. The project manager will report to joint SROs and day to day operational support is provided by the Wokingham BCF Programme Manager.

Membership

Joint SROs:

- Katie Summers, Director of Operations, Wokingham CCG
- Judith Ramsden, Director of People Services, Wokingham Borough Council

Scheme Project Manager: Rhian Warner

Steering Group Members

Name	Role
Katie Summers	Director of Operations, NHS Wokingham CCG; Joint SRO for this scheme
Judith Ramsden	Director of People Services; Wokingham Borough Council; Joint SRO for this scheme
Philip Sharpe	Interim Assistant Director People Services, WBC
Amit Sharma	GP, Brookside: Wokingham GP Alliance
David Cahill	Director- Wokingham Locality, Berkshire Healthcare Foundation Trust
Rhian Warner	Wokingham BCF Programme Manager
TBC	Optalis
Philip Cook	General Manager; Involve – Wokingham
Darrell Gale	Consultant In Public Health, Wokingham Borough Council
Nicola Strudley/Jim Stockley	Healthwatch Wokingham
Mike Chow	Finance Lead Wokingham BCF, Wokingham Borough Council
Shaun Virtue	Area Commander Bracknell and Wokingham, Thames Valley Police
Heidi Ilsley	Head of CHASC, Berkshire Healthcare NHS Foundation Trust
Michelle Hayman-Joyce	Community Health and Social Care Project Manager

As required additional staff will be invited to the steering group as and when required and may include the following:

- CCG Manager
- WBC representative with strategic/policy/development perspective
- GP from each cluster
- Practice Manager
- Practice Nurse
- MH Lead
- WBC – Community Development Worker link
- Voluntary / community organisation(s)

- Residents/service users (e.g. from PPG Forum; social care user, co-production network),
- Health and Well-being Board member and/or one of the local ward members.

As this programme is proposed as a BW10 Integration project it will develop and maintain the following key control documents for monthly submission to WISP, the Health & Well-being Board and the BW10 Project Management Office (for BWPB / FEP):

- Monthly Highlight/Status report
- Programme Initiation Document and Business Cases
- Delivery Milestone plans
- Risks & Issues and Dependency logs
- Monthly Financial forecast and spend to date statements

The project will have a 6 month post project completion evaluation against the projects objectives and key outputs and include:

- Implementation review
- Finance review
- Activity review
- Benefit realisation
- Risks review
- Lesson learnt

Information Governance

Once operational, the multi-disciplinary teams of staff working within the localities will comply with all requirements regarding data protection and confidentiality.

This project will involve the use of personal data across multiple organisations within the Berkshire West 10 Partnership. In order to ensure the safe governance of information the following will need to be delivered:

- Capitalisation of the implementation of ‘connected care’ and additional IT sharing solutions
- Shared documentation
- Raise awareness of information governance requirements with staff
- Clarity re: information requirements and who needs access to information
- Connected Care BCF project to progress integrated information system

The Adjusted Clinical Groups® (ACG) System is used to help identify health needs and commissioning issues, this data is anonymised.

Risks Management and Contingency Plans

The project has already identified potential risks as well as mitigations to the delivery of the project; these can be seen in the table below with a brief summary of the proposed controls and mitigating actions.

The project is already has a Project Risk log and the project manager is responsible for managing the risk register and escalating risk as required. The Risk Log is attached as an appendix.

The review of the risk log will be a standing item on the Steering Group agenda, to ensure regular, monthly, review of risks and appropriate escalation. Any high risks will be escalated to the Wokingham BCF Programme Risk Register, which is reviewed at the monthly WISP board meeting.

Risk Description	RR	Required controls and actions to reduce/mitigate risk
Stakeholder commitment to the locality model - Risk that not all key stakeholders will be committed to the development and implementation of a locality model (also potential barriers due to conflicting organisational priorities / different internal processes and sign-offs for decision making); also inability to agree what should be included in localities and how they are designed and governed	12	Full involvement, effective engagement and detailed communication at each stage to achieve agreement, support and commitment for the scheme from all key stakeholders, the identification and resolution of any conflicting organisational priorities / different ways of working between the various professionals and any perceptions of professional boundaries that may hinder the project. Will need to consider and develop an appropriate contracting and governance mechanism between all partners. 11/1/17 The CCG is now very much engaged with proposals to take this forward & it was considered that partner organisations also support this. Work is now needed for next steps, engaging with staff and the public to promote the service. To be rolled out once HWBB (Health and Well Being Board) sign off the PID. Healthwatch volunteers/ resources can be utilised if requested – this is a growing base of information and interested participants.
Critical Mass of staff for locality modelling - Some services are currently provided at Berks West level and it may not be easy, nor sensible, to cluster -base. Social Care services also need a critical mass of staff for viability and this needs to be considered	6	Must have a phased approach - identify those services / resources that are 'locality-able' for 1st phase and aspiration list of those services / resources to include later when/if possible. Also need to work closely with all providers to ensure that services are viable
CNS, Patient Information Sharing - Risk of resistance to information sharing across the constituent parts of the local health and social care system that might impinge on the ability of the voluntary Community Navigators to provide accurate and up to date accessible information and signposting	6	to be managed through co-production - full involvement, effective engagement and detailed communication at each stage to achieve agreement, support and commitment for the project from all key stakeholders; to include the identification and resolution of any conflicting priorities within / between relevant professionals and organisations 14/12/16 Currently trying to secure an nhs.net account for Community Navigators to ensure easy information sharing moving forwards
CNS, Insufficient Volunteers - Risk of insufficient volunteers being recruited in each locality to provide the focused support and information required for identified service users	12	To be managed through effective recruitment – i.e. innovative advertising and wide-ranging publicity and the assurance of comprehensive training and support to carry out the role. Also need to ensure retention once recruited. Involve is responsible for ensuring this. 11/1/17 To be discussed at the next meeting – PC to confirm if volunteer numbers are adequate, the status of recruitment and plans to move forward. Community Navigators struggled to get volunteers last year.

CNS, Low referral numbers - Risk of under-utilisation of the service due to reluctance of professionals and organisations to use social prescribing to refer people to the volunteer Community Navigators / no agreement regarding accountability and liability for 'referred' patients.	12	to be managed through development of the project by co-production so all key stakeholders are engaged; accurate and clear communication about social prescribing, the role of this project and its aims and objectives; volunteer Community navigator induction will include personal meetings with key personnel in the relevant locality; and the volunteer Forum will act as an additional opportunity to engage with relevant professionals and organisations. 14/12/16 Service specification needs to be developed and Involve now have a clear action plan in order to ensure engagement with all relevant referrers
Information governance - Risk of Information governance and sharing issues due to multiple providers delivering the service.	8	Training, support and supervision of volunteers Raise awareness of information governance requirements with staff as rqd. 14/12 /16 Connected Care project will act as an enabler in this area, but the information governance issues will only be resolved when Connected Care becomes available and there may need to be work arounds in the interim period.
CNS, Voluntary sector sustainability - Risk of overwhelming local voluntary and community organisations with referrals from Volunteer Community Navigator scheme	9	Regular contact with VCOs through Involve; and monitoring through CHASC Steering group 14/12/16 In refreshed Business Case (November 2016) have built in financial support for the voluntary sector and in service specification for navigators have added that they will monitor this
Delays around the PID/Business Case - The complexity of the refreshed business case (November 2016) approval process could add delays into the proposed implementation plan for the project	12	Implementation plan is fluid and can be updated to reflect this. Implementation plan needs to be a regular item on the steering Group Agenda. Need to ensure that slippage is built into the implementation plan. 11;/1/17 Looking to progress this item to the implementation delivery plan in the next few months, dependent on approval at January (informal) and February 2017 (formal) HWBB meetings.
Culture change - Culture, physical and structural change within and between organisations is a critical to the success of the CHASC project/service. Culture change is always challenging and can take long periods of time to embed	12	Ensure that there is a robust plan for culture change which must include staff engagement and resident engagement at the earliest stage. Make use of available evidence and methods for achieving culture change.

Section 4 – Co-production, Engagement and Communications

Patient/Service User Engagement and Co-production plan outline

The intention is to fully engage with all key stakeholders during the process of developing the Community Health and Social Care Service, with the scoping, planning and delivery being co-produced through health and social care professionals working closely together to design the most effective model for the service.

Local patients/social care clients, their families/carers, and all relevant support organisations and communities will also be involved and engaged with the design, planning, implementation and delivery of the service, with specific input into the detail around focusing on self-care and primary prevention.

Engagement will be co-designed between the CCG and the unitary authority.

Key stakeholders to be engaged with are:

- Service users (including patients and carers) and / or their representatives, including local voluntary organisations
- Borough and parish councillors
- Service providers: general practice; community nursing teams; local authority teams; mental health

staff, voluntary sector organisations; acute and community trusts
- Public health team regarding prevention and self-care in particular

In order to ensure co-production and engagement of users/patients a plan will be devised which would include:
- A patient/user representative on the steering group - COMPLETED
- Regular workshops/engagement sessions with staff and service users
- Regular feedback to Integration board, Health and Well-being Board and Healthwatch

Equality Impact Assessment

As part of the development of this BC, we have conducted an Equalities Impact Assessment Screening process. This has been informed by the previous cases and the stakeholder engagement activity. We have come to the conclusion that the proposed programme will not negatively impact any of the protected Equality groups. The programme aim is to have a positive impact upon the provision of health and care services on all people over the age of 18 in Wokingham. This will indirectly also benefit their carers and families.

None of the aspects has scored over the threshold of 8 and therefore does not require sign off by the quality team. See **Appendix 4.**

Key Stakeholders/ Clinical Engagement and communications plan outline

Key Stakeholders
- Director of People Services, Wokingham Borough Council
- Director of Operations, Wokingham CCG
- Berkshire Healthcare Foundation Trust (Community Nursing, Adult Mental Health Services and specialist services)
- Optalis
- Involve and volunteer community navigators
- Public Health
- Public/Patient representatives (Service users/lay partners)
- Healthwatch
- Front-line staff (inc. managers)
- Service development staff
- WBC Commissioners
- WISP
- Wokingham Health and Well-being board
- Voluntary sector
- Estates services, WBC and BHFT
- Adult Safeguarding, WBC
- Housing support, WBC
- BW10 Project Management Office
- Community development
- Libraries, WBC
- Sport & leisure, WBC
- Employment support, WBC
- Children's services – transition services

Details of partner engagement already undertaken
Clusters:
- Stakeholder (GP / WBC) workshop (December 2014)

- Stakeholder (GP) workshop (January 2015)
- WISP (January 2015)
- Practice Managers (January 2015)
- Council Executive members (January 2015)
- Have Your Say events (March 15)
- Patient Participation Group Forum (March 2015)
- Health and Wellbeing Board (May 2015)

Overall, these stakeholders indicated their general support for the concept and proposals for neighbour cluster teams. There was a view that, given the complexity of the project, it is important that timescales are realistic. The need for suitable transport and access was an issue that was raised by many stakeholders.

Prevention:

- Patient Participation Group Forum (January 2015)
- Place & Community Partnership / Co-production Network (January 15);
- Survey regarding maximising independence through prevention and self-care (February 15)

Partner Engagement Planned

At present there are no planned partner engagement events until the PID has been agreed. Once the PID has been agreed the project manager will work with WBC Community engagement team to plan what is required.

Clinical Input Requirements

The project require will require clinical input and this will this be sought through the following:

- Engagement sessions with front-line staff
- Programme planning; programme design forums and establishment of programme design teams
- Knowledge sharing and 'up-skilling' of workforce
- Implementing new staffing models based on the new model of care

Communications Plan

A communication plan needs to be developed. Consultation and engagement with professionals and service users will continue throughout the trial period and during the evaluation phase. Recognising the potential challenges involved with meeting the needs of all sectors of the local population, the feasibility of seeking the views of those "seldom heard" within the population will be considered.

Section 5 - Document Information

Document Title	Wokingham Community Health & Social Care (CHASCC) – (Neighbourhood Clusters, Self-Care and Prevention) BCF Project

File path\Filename	Format	Comments
BW10 PID and Business case Wokingham Community Health and Social Care Jul 2017 vs. 1.8	MS Word	Main Document

Supporting Documents	Format	Location/ Comments
1. *Project/Programme Plan*	Excel	Will be submitted as an additional document
2. *Equalities Impact Assessment*	N/A	Appendix 4 in this document
3. *Wokingham Neighbourhood Clusters, Self-Care and Primary Prevention Initiation Document and Business Case (Draft v 8.1) 14th August 2015*	MS Word	Author: Jane Brooks Will be submitted as an additional document
4. *BCF BUSINESS CASE 2016/17 Prepared for WISP Feb 2016; updated 05-5-16 (draft v 8) Neighbourhood Clusters, Self-Care and Prevention*	MS Word	Author: Jane Brooks and James Burgess Will be submitted as an additional document
5. *DISCUSSION PAPER Wokingham Neighbourhood Clusters – structure and organisation Feb 16 (draft v 2.0)*	MS Word	Author: Jane Brooks Will be submitted as an additional document

Responsibilities

Distribution	Project Manager
Ownership	Project Steering Group and WISP
Maintenance	Project Manager

Distribution of Final Version

Copy	Keeper	Area	Purpose	Media
1	Programme Manager	Programme Office	Reference	Paper & Electronic
2	Knowledge Library	Programme Office	Master	Electronic

Version History

Version No./ Status	Issue Date	Author	Quality Review/ Change Date	Reviewed By	Brief Description of Action/Changes
1.1 Draft	August 2016	Rhian Warner	13th September 2016	Steering Group & Rhian Warner	Addition of Financials, proposed model of care and further detail in Background section
1.2 Final	September 2016	Rhian Warner	29th September 2016	Steering Group & Rhian Warner	Removal of structure options and minor amendments in Background section
1.3 Final	October	Rhian Warner	17th October	SROs	Adding in GPs into

	2016		2016		the model, minor changes to steering group board members
1.4 Final	November 2016	Rhian Warner	3rd November	Steering Group	Final review and changes to the order of the narrative in the PID. Update of the project phasing
1.5 Final	November 2016	Rhian Warner	16th November	SROs	Addition of commissioning and improved wording to percentage growth
1.6 Final	January 2017	Rhian Warner	24th January	SROs	Addition of LA information, updated implementation plan, updated financials
1.7 Final	June 2017	Rhian Warner	1st June 2017	SROs	Updated financials to match 17/19 BCF planning and review of project milestones to reflect the pause whilst governance arrangements agreed.
1.8 Final	July 2017	Rhian Warner	11th July	PM Handover	Minor adjustments throughout document following handover review
1.9 Final	July 2017	Rhian Warner	26th July	CHASC Steering Group	Realignment of timelines following discussions re: progression and HWBB sign off in August 2017

Sign Off & Approval (of finances, proposed development)	
Name & Lead function (e.g. Finance, CCG lead, LA Lead):	Authorisation signature:
Wokingham Integrated Strategic Partnership – Stuart Rowbotham/Katie Summers	16/11/16
BHFT David Cahill	1/12/16
Wokingham Borough Council Stuart Rowbotham	19/12/16
Wokingham Clinical Commissioning Group Katie Summers	1/12/16
Wokingham Health and Wellbeing Board	

Appendix 1 – Wokingham CCG and Local Authority Population Demographics

This data has been taken from:

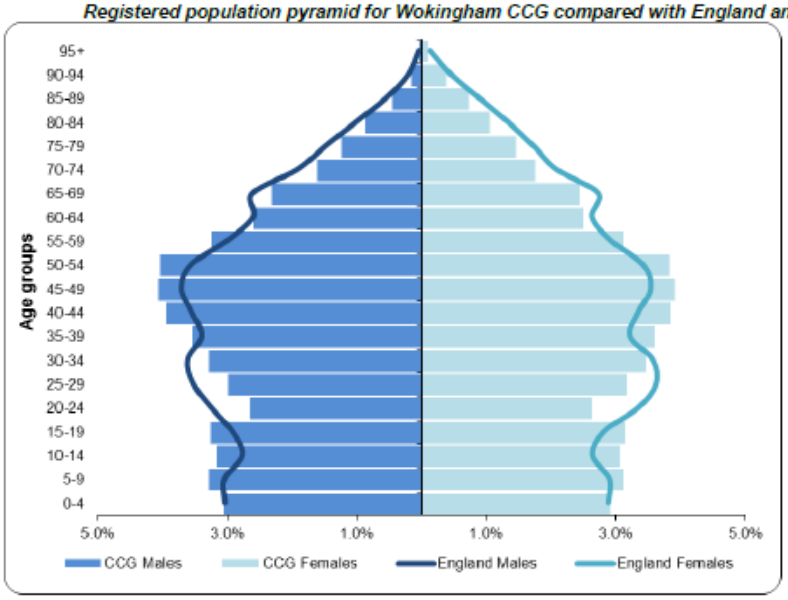
- Wokingham Clinical Commissioning Group: Locality Profile 2015, Public Health Services for Berkshire, November 2015
- Commissioning for Value: Where to Look, January 2016, Right Care Profile, Gateway ref: 04599

Wokingham's population is approximately 159,097 at the 30th June 2015 and with 99.9% registered with one of the 13 GP practices who belong to the Wokingham CCG group

Brookside Group Practice	Burma Hills Surgery	Finchampstead Surgery
Loddon Vale Practice	New Wokingham Road Surgery	Parkside Family Practice
Swallowfield Medical Practice	Twyford Surgery	Wargrave Surgery
Wilderness Road Surgery	Wokingham Medical Centre	Woodley Centre Surgery
Woosehill Surgery		

Population Profile

Registered population pyramid for Wokingham CCG compared with England and Wales at 30-Jun-15

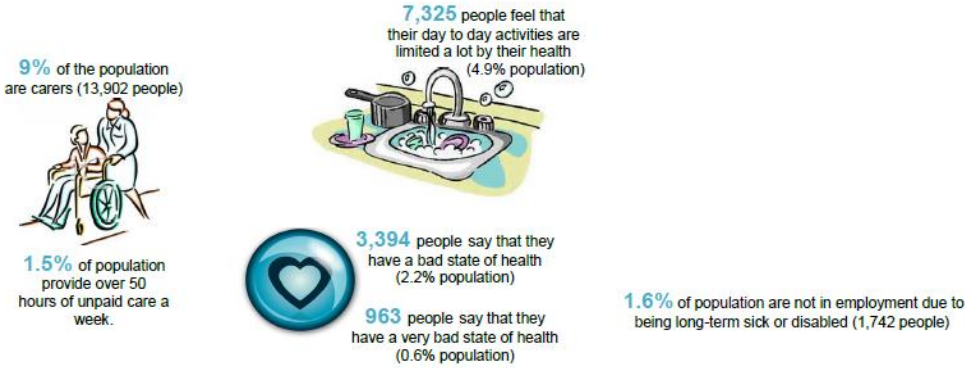


Source: Health and Social Care Information Centre (July 2015)

Age Group	Male	Female	People
0-4	4,885	4,603	9,488
5-9	5,255	4,996	10,251
10-14	5,058	4,663	9,721
15-19	4,593	4,276	8,869
20-24	3,757	3,653	7,410
25-29	4,361	4,369	8,730
30-34	4,596	5,005	9,601
35-39	5,673	5,826	11,499
40-44	6,342	6,181	12,523
45-49	6,466	6,209	12,675
50-54	6,191	6,129	12,320
55-59	5,287	4,925	10,212
60-64	4,183	4,223	8,406
65-69	4,135	4,535	8,670
70-74	3,109	3,370	6,479
75-79	2,382	2,711	5,093
80-84	1,673	2,071	3,744
85-89	836	1,272	2,108
90-94	306	646	952
95+	63	191	254
Total	79,151	79,854	159,005

Demography

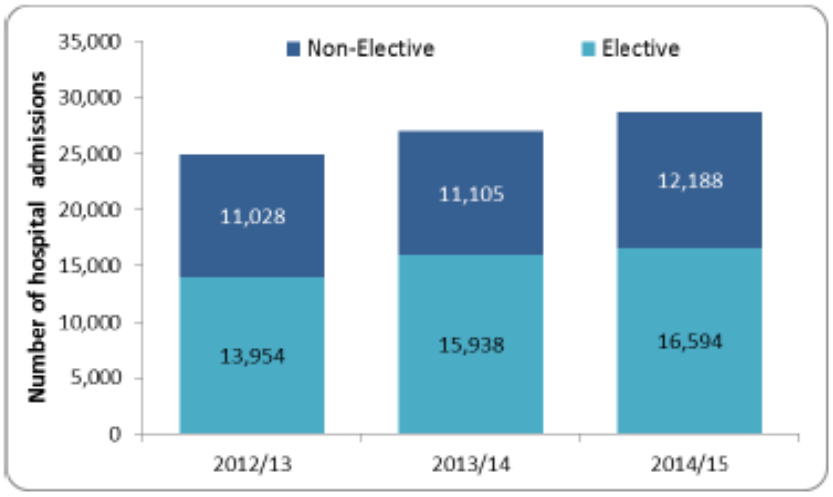
Key demographics from the 2011 census show the following:



Hospital Activity

Wokingham CCG had 80,807 hospital admissions for people aged 18 and over from April 2012 to March 2015. The majority (72%) of these admissions were at Royal Berkshire Foundation Trust.

Wokingham CCG's hospital admissions for people aged 18 and over (2012/13 to 2014/15)



Source: Dr Foster (2015)

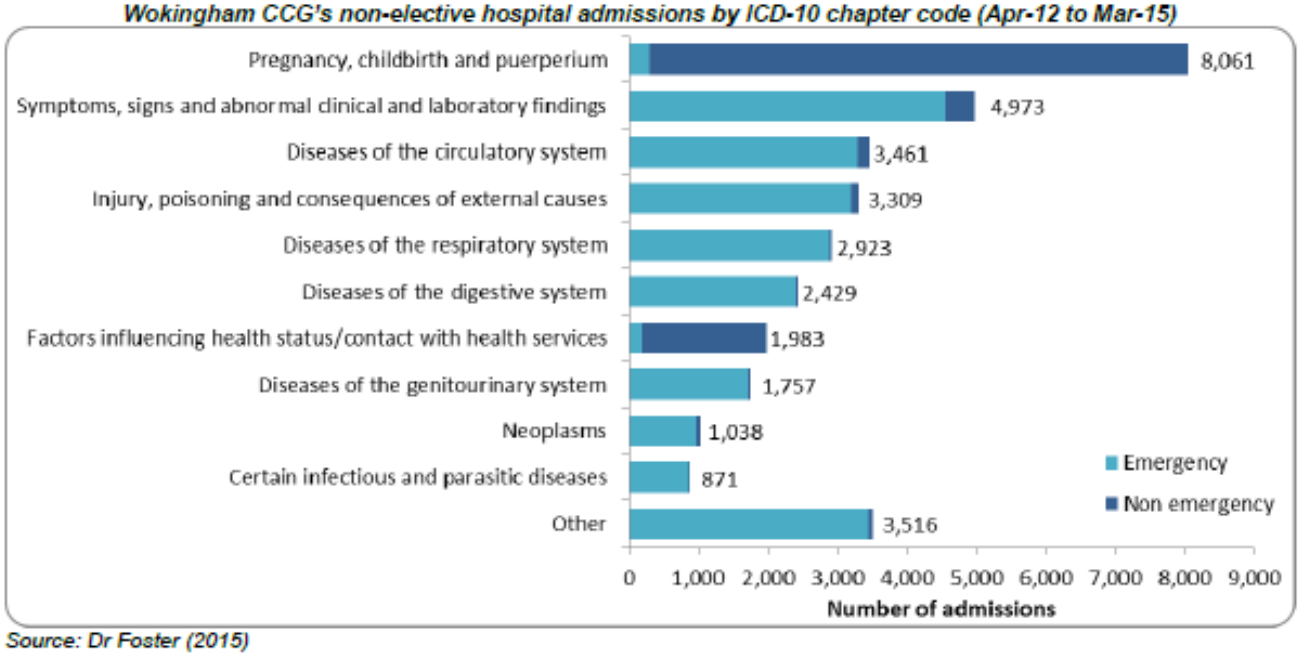
42.5% of hospital admissions for Wokingham CCG residents (aged 18 and over) were non-elective and these made up 82% of bed days from April 2012 to March 2015.

	Elective hospital admissions	Non-elective hospital admissions
Number of admissions:	46,486 elective admissions (57.5% of all admissions)	34,321 admissions (42.5% of all admissions)
Bed days:	39,736 bed days (18.0% of all bed days)	171,788 bed days (82.0% of all bed days)
Average length of stay:	0.9 days	5.0 days

Source: Dr Foster (2015)

The table below summarises Wokingham CCG's non-elective hospital admissions for April 2012 to March 2015 showing the ten most common reasons for admission.

Wokingham CCG's non-elective hospital admissions by ICD-10 chapter code (Apr-12 to Mar-15)



Source: Dr Foster (2015)

Further analysis of the data has shown that there are opportunities to reduce admissions to hospital.

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (ACSCs) include admissions for long-term conditions such as asthma, diabetes, epilepsy, hypertensive disease, dementia and heart failure. These are admissions which could be prevented by effective community care and case-management.

  In 2014/15, Wokingham CCG had 825 unplanned admissions for ACSCs. This is 546 admissions per 100,000 population. The rate of admissions in the CCG continues to be significantly lower than the national rate.
- Emergency admissions for acute conditions that should not usually require hospital admission include disease such as influenza, pneumonia, urinary tract infections and cellulitis. These should be managed without the patient needing to be admitted to hospital.

  In 2014/15, Wokingham CCG had 1,320 emergency admissions for acute conditions that should not require admission. This is 882 admissions per 100,000 population. The rate of admissions in the CCG continues to be significantly lower than the national rate and CCG Comparator group.

Complex Patients

The following data include analysis on inpatient admissions, outpatient and A&E attendances for the 2% of patients that the CCG spends the most on for inpatient admissions (covered by mandatory tariff) in 2013/14. Whilst this analysis only focuses on secondary care due to availability of data, it is expected that these patients are fairly representative of the type of complex patients that will require the most treatment across the health and social care system

2% Most Complex Patients (14.9% of CCG Spend)					
Age	Number of complex patients	Mean Number of Admissions	Mean Number of Different Conditions	Total Spend (£000s)	
0	16	5.4	3.19	£	505
1-4	*	9.0	3.20	£	117
5-9	6	2.8	1.83	£	186
10-14	8	6.0	2.25	£	267
15-19	*	2.4	1.60	£	115
20-24	*	12.7	2.33	£	49
25-29	*	4.0	1.33	£	68
30-34	7	8.9	2.71	£	145
35-39	6	14.5	2.50	£	193
40-44	12	15.2	2.92	£	211
45-49	10	7.4	2.70	£	197
50-54	12	5.3	2.08	£	218
55-59	16	6.9	2.56	£	333
60-64	25	6.5	2.44	£	556
65-69	38	9.6	2.71	£	774
70-74	50	6.4	2.52	£	932
75-79	46	5.7	2.46	£	865
80-84	38	7.4	2.63	£	758
85-89	24	4.1	2.67	£	419
90+	10	3.8	2.60	£	188
TOTAL	345	6.8	2.52	£	7,096

* Represents low number and the total number of complex patients have been adjusted due to suppressed numbers

Public Health England RightCare NHS England

- Your average complex patient has 7 inpatient admissions per year across 3 different conditions(based on programme budgeting categories)
  - Your CCG spends most on Circulation, Cancer and Musculo skeletal
  - 60% of these complex patients are aged 65 or over
  - 34% of these complex patients are aged 75 or over
  - 10% of these complex patients are aged 85 or over
- 91% of the complex patients also had an outpatient attendance during the year
  - 56% of those patients had more than 5 attendances
  - 15% had more than 15 attendances
  - The average patient had 9 attendances a year

- 80% of the complex patients also had an A & E attendance during the year
    - 9% of those patients had more than 5 attendances
    - The average patient had 3 attendances a year

Appendix 2 - Phase 2a and 2b Implementation plans

Phase 2a

Objective	Implementation Milestone	Task Owner		01/04/2017	01/05/2017	01/06/2017	01/07/2017	01/08/2017	01/09/2017	01/10/2017	01/11/2017	01/12/2017	01/01/2018	01/02/2018	01/03/2018	01/04/2018
Phase 2a Localities Development 73	Development of new system/services, including service specification	RW			Draft to CHASC					Slippage						
	Phase 2a (I) Delivery around Primary Care	RW/GP Alliance													Slippage	
	Continued comms and engagement around new locality service	RW													Slippage	
	Governance & Contracting arrangements to be agreed	RW/SROs				Slippage	Slippage	Slippage	Slippage							
	Appointment of Head of CHASC	RW/SROs							Slippage	Slippage	Slippage					
	CHASC Engagement and design sessions with	RW/Staf						Planning	Planning				Slippage			
	CHASC Engagement and design sessions with public/users	RW/Citizens								Planning			Slippage			
	KPIs - ensure all baseline measures and audit tools developed and agreed	RW/Head of CHAS			Final to CHASC					Slippage	Slippage					
	Appoint 3rd Locality MDT coordinator	BHFT Head of Adults				Completed										
	Agree design of system/model of care	Steering Group					Closed as part of service specification development									
	Development of single shared risk stratification tool- Ensuring mechanisms are in place to use data produced regularly about NELs, A&E admissions, SCAS activity and GP attendances to inform care co-ordination and care delivery is aimed at the right people	RW/Head of CHAS												Slippage	Slippage	
	Ensure delivery of statutory duties/responsibilities for social care	RW/SROs							Slippage							
	Revised MDT structure and delivery across localities	RW/Head of CHAS								Slippage						
	Unified/ Single point of access to all services in CHASC	RW/Head of CHAS/Head of Hub													Slippage	
	A locality based locations, virtual alignment and remote working	RW/Estates/Head of													Slippage	
	Alignment of health and social care teams - development of 'one team ethos'	RW/Head of CHAS														
	Development of integrated policies and procedures	RW/Head of CHAS													Slippage	

Phase 2b

Objective	Implementation Milestone	Task Owner	RAG rating	01/04/2018	01/05/2018	01/06/2018	01/07/2018	01/08/2018	01/09/2018	01/10/2018	01/11/2018	01/12/2018	01/01/2019	01/02/2019	01/03/2019	01/04/2019
Phase 2b Localities 74 Implementation	Implementation phase (6 -12 months)	RW/ Operational														
	Phase 2 b (i) Testing Phase with a single GP locality	PM/ GP Alliance														
	Phase 2b (ii) Roll out to the other 2 GP localities	PM/ GP Alliance														
	Continued comms and engagement around new locality service	RW														
	Continued alignment of health and social care teams - development of 'one team ethos'	RW/Head of CHAS														
	Clarification of staff roles and responsibilities	RW/Head of CHAS														
	Review and update all processes to provide efficiency and consistency	RW/Head of CHAS														
	Review of health and social care pathways and integrate/update as required	RW/Head of CHAS														
	Improving the way in which professionals share information within and between organisations	RW/Head of CHAS														
	Continue to develop unified/ single point of access to all services in CHASC	RW/Head of CHAS/Head of Hub														
	Continue embedding locality based locations, virtual alignment and remote working	RW/Estates/Head of														
	Continue development and implementation of shared paperwork	RW/Head of CHAS														
	Development and implementation of single assessment	RW/Head of CHAS														
	Continue implementation of shared risk stratification tool	RW/Head of CHAS														
	Investigate and implement technology where needed	RW														

Appendix 3 – Finance Detail

Cost profiles

Cost base 16/17		Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Total
CHASC and CNS														
Project Management agency consultant	Assumes agency @ 3 days a week at £450 per day	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	**62,100**
Local programme office support		1,742	1,742	1,742	1,742	1,742	1,742	1,742	1,742	1,742	1,742	1,742	1,742	**20,900**
Volunteer navigators	Coordinator 3 days a week @£25k annual equivalent - potential additional staff member from 1 April 2017	1,654	1,654	1,654	1,654	1,654	1,654	1,654	1,654	1,654	1,654	1,654	1,654	**19,848**
Volunteer Training costs	Room hire, refreshments, training materials etc	250			250			250			250			**1,000**
Volunteer Travel costs	Assumes £0.45 per mile x 10 miles x 1 trip a week per referral	92	92	92	92	92	92	114	114	114	137	137	137	**1,304**
CNS Marketing / promotion		200	200	200	200	200	200	200	200	200	200	200	200	**2,400**
Voluntary sector sustainability	Placeholder for charity and voluntary sector sustainability has been added for 18/19 and 19/20	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Investment in MDT coordinators	Additional support requirements for the MDT process to be able to manage the top 10% of users from 18/19													**0**
Restructure of MDT coordinators	Assumes £1k impact per annum as per DC	83	83	83	83	83	83	83	83	83	83	83	83	**1,000**
Training for new virtual model of delivery														**0**
IT infrastructure costs	Firewall issues etc													**0**
Property costs	Moving costs and impacts on rents													**0**
Total Costs		**9,196**	**8,946**	**8,946**	**9,196**	**8,946**	**8,946**	**9,218**	**8,968**	**8,968**	**9,241**	**8,991**	**8,991**	**108,552**

Cost base 17/18		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total
CHASC and CNS														
Project Management agency consultant	Assumes agency @ 3 days a week at £450 per day	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	5,175	**62,100**
Local programme office support														**0**
Volunteer navigators	Coordinator 3 days a week @£25k annual equivalent - potential additional staff member from 1 April 2017	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	**39,696**
Volunteer Training costs	Room hire, refreshments, training materials etc	250			250			250			250			**1,000**
Volunteer Travel costs	Assumes £0.45 per mile x 10 miles x 1 trip a week per referral	229	229	229	229	229	229	229	229	229	229	229	229	**2,748**
CNS Marketing / promotion		200	200	200	200	200	200	200	200	200	200	200	200	**2,400**
Voluntary sector sustainability	Placeholder for charity and voluntary sector sustainability has been added for 18/19 and 19/20	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Investment in MDT coordinators	Additional support requirements for the MDT process to be able to manage the top 10% of users from 18/19	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Restructure of MDT coordinators	Assumes £1k impact per annum as per DC	83	83	83	83	83	83	83	83	83	83	83	83	**1,000**
Training for new virtual model of delivery		5,000												**5,000**
IT infrastructure costs	Firewall issues etc	10,000												**10,000**
Property costs	Moving costs and impacts on rents	5,000												**5,000**
Total Costs		**29,245**	**8,995**	**8,995**	**9,245**	**8,995**	**8,995**	**9,245**	**8,995**	**8,995**	**9,245**	**8,995**	**8,995**	**128,944**

Cost base 18/19		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
CHASC and CNS														
Project Management agency consultant	No requirement from 18/19													**0**
Local programme office support														**0**
Volunteer navigators	Coordinator 3 days a week @£25k annual equivalent - potential additional staff member from 1 April 2017	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	3,308	**39,696**
Volunteer Training costs	Room hire, refreshments, training materials etc	250			250			250			250			**1,000**
Volunteer Travel costs	Assumes £0.45 per mile x 10 miles x 1 trip a week per referral	381	381	381	381	381	381	477	477	477	477	477	477	**5,147**
CNS Marketing / promotion		200	200	200	200	200	200	200	200	200	200	200	200	**2,400**
Voluntary sector sustainability	Placeholder for charity and voluntary sector sustainability has been added for 18/19 and 19/20	4,313	4,313	4,313	4,313	4,313	4,313	4,313	4,313	4,313	4,313	4,313	4,313	**51,750**
Investment in MDT coordinators	Additional support requirements for the MDT process to be able to manage the top 10% of users from 18/19	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	4,167	**50,000**
Restructure of MDT coordinators	Assumes £1k impact per annum as per DC	83	83	83	83	83	83	83	83	83	83	83	83	**1,000**
Training for new virtual model of delivery														**0**
IT infrastructure costs	Firewall issues etc													**0**
Property costs	Moving costs and impacts on rents													**0**
Total Costs		**12,702**	**12,452**	**12,452**	**12,702**	**12,452**	**12,452**	**12,797**	**12,547**	**12,547**	**12,797**	**12,547**	**12,547**	**150,993**

Saving Profiles

Totals	2016/17	2017/18	2018/19	2018/20	2018/21
Levels of activity					
A&E admissions avoidance	0	250	499	499	499
NEL's avoidance	0	166	331	331	331
GP Appointments avoided	19	39	74	99	99
Care Home avoidance	0	0	4	9	16
Early intervention opportunities	16	34	65	86	86

£ benefit realisation from above activity	2016/17	2017/18	2018/19	2018/20	2018/21
A&E admissions avoidance	£ -	£ 42,415	£ 84,830	£ 84,830	£ 84,830
NEL's avoidance	£ -	£177,742	£355,484	£355,484	£355,484
GP Appointments avoided	£ -	£ -	£ -	£ -	£ -
Care Home avoidance	£ -	£ 119	£ 10,068	£ 43,478	£ 94,218
Early intervention opportunities	£ -	£ 20,421	£ 73,637	£159,573	£267,087
Total benefits	**£ -**	**£240,697**	**£524,019**	**£643,365**	**£801,619**

Volunteer Navigators					
Levels of activity	**2016/17**	**2017/18**	**2018/19**	**2018/20**	**2018/21**
A&E admissions avoidance	0	0	0	0	0
NEL's avoidance	0	0	0	0	0
GP Appointments avoided	19	39	74	99	99
Care Home avoidance	0	0	4	9	16
Early intervention opportunities	16	34	65	86	86

£ benefit realisation from above activity	2016/17	2017/18	2018/19	2018/20	2018/21
A&E admissions avoidance	£ -	£ -	£ -	£ -	£ -
GP Appointments avoided	£ -	£ -	£ -	£ -	£ -
Care Home avoidance	£ -	£ 119	£ 10,068	£ 43,478	£ 94,218
Early intervention opportunities	£ -	£ 20,421	£ 73,637	£159,573	£267,087
Total benefits from volunteer Navigators	**£ -**	**£ 20,540**	**£ 83,705**	**£203,051**	**£361,304**

Locality MDT coordinator	2016/17	2017/18	2018/19	2018/20	2018/21
Levels of activity					
A&E admissions avoidance	0	250	499	499	499
NEL's avoidance	0	166	331	331	331

£ benefit realisation from above activity	2016/17	2017/18	2018/19	2018/20	2018/21
A&E admissions avoidance	£ -	£ 42,415	£ 84,830	£ 84,830	£ 84,830
NEL's avoidance	£ -	£177,742	£355,484	£355,484	£355,484
Total benefits from Locality MDT coordinator	**£ -**	**£220,157**	**£440,314**	**£440,314**	**£440,314**

Appendix 4 - Integrated Impact Assessment Tool - Stage 1 Proforma

Area of Quality	Impact Question	Impact	Likeli-hood	Score	Stage 2 req?	Rationale for scoring
Duty of Quality - Could the proposal impact negatively on:	Compliance with the NHS Constitution?	1	1	1	No	This is compliant with the NHS constitution.
	Partnerships?	1	3	3	No	There should be an improvement in partnership working between all partners involved as this project aim is integration. There is a possibility that if there is an adverse event with a service user, partnerships could be affected.
	Safeguarding children or adults?	1	1	1	No	Should improve safeguarding of adults as improving/enhancing quality and safety by removing duplication and provision of services by multiple organisations. N/A for children.
NHS Outcomes Framework – Could the proposal impact negatively on:	Preventing people from dying prematurely?	2	1	2	No	The aim of the project is to reduce the risk of dying prematurely and by bringing services under one organisation and working towards prevention there should be an improvement
	Enhancing quality of life?	1	1	1	No	The project will enhance quality of life as the aim is to provide pro-active, co-ordinated care and support in the most appropriate environment for the service user as opposed to the reducing the risk of admissions to acute care.
	Helping people recover from episodes of ill health or following injury?	1	1	1	No	The project aims to make people feel empowered, capable of and engage in self-management of their health and social care so works to improve recovery
	Ensuring people have a positive experience of care?	1	1	1	No	The project is focussing on delivering care centred on the person, ensuring they feel listened to, understand their care and that they feel involved. The other key delivery of the project is that care is consistent and co-ordinated.
	Treating & caring for people in a safe environment & protecting them from avoidable harm?	5	1	5	No	The project aims to keep people as fit and healthy as they can be in their own homes. There therefore is a small risk that patient safety could be breeched.
Access	Could the proposal impact negatively on patient choice?	2	2	4	No	With one organisation leading the system the offering will be equal across Wokingham. There are service users who wish to be treated in the setting of their choice and they could still choose that option. Service users and or carers could complain if their needs are not met
	Could the proposal impact negatively on access?	1	1	1	No	There is an increase in access as this aims to streamline and join up pathways and organisations.
	Could the proposal impact negatively on integration?	1	3	3	No	The project is based around integration of services and providers so should improve integration. There is a possibility that an adverse event could affect integration.

Duty of Equality **Could the proposal impact negatively on:**	Age?	1	4	4	No	The services are for over 18 year olds, therefore there is no access for service users under the age of 18, but there are already equivalent non-integrated services in place for children.
	Disability?	1	1	1	No	There are no restrictions on disability
	Race?	1	1	1	No	There are no race restrictions
	Religion or belief?	1	1	1	No	There are no religious or belief restrictions
	Sex?	1	1	1	No	There are no restrictions based on a service users sex
	Sexual orientation?	1	1	1	No	There are no restrictions based on a service users sexual orientation
	Gender re-assignment?	1	1	1	No	There are no restrictions based on a service users gender re-assignment
	Pregnancy or maternity?	1	5	5	No	The services do not deliver pregnancy or maternity services as these are provided by other services. Pregnant or new mothers would not be excluded from accessing these services if they required them.
	Marriage & civil partnership?	1	1	1	No	There are no restrictions based on a service user marriage or civil partnership

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Name of person completing assessment: Rhian Warner	Date of assessment: 27th September 2016

High Level Implementation Plan for Wokingham BCF Scheme 8 - Community Health and Social Care (CHASC)

BCF Scheme/ Programme Title	
Project Description	Scheme 8 - Community Health and Social Care
Senior Responsible Officer	Judith Ramsden & Katie Summers
Programme Manager	Julie Stevens
Service Redesign Lead	Rhian Warner
Project Manager	Rhian Warner
Locality/CCG area covered	Wokingham Locality

Community Health and Social care

Overall Project Fit	Objective	Implementation Milestone	Task Owner	RAG rating	01/04/17	01/05/17	01/06/17	01/07/17	01/08/17	01/09/17	01/10/17	01/11/17	01/12/17	01/01/18	01/02/18	01/03/18	01/04/18	Current Status/Additional Comments
	Phase 1 Localities Scoping	Review of Meetings	RW															Completed in 16/17
		Review of 16/17 business case to include: Review and complete locality model options: 3 clusters for long term care self-care and prevention Agree the Localities model	RW															Completed in 16/17
		Update and submit reframed 16/17 business case for approval	RW/WISP				HWBB		HWBB									Final PID prepared for 3rd October Steering Group, required review and final PID ready for 16th Nov 16 and approved at WISP. DC, SR and KS took to WBC, CCG and BHFT Exec boards for approval in Nov 16, Final approval from WBC Exec received 20th Dec 16 with plans to take to Feb 17 HWBB for approval . Delayed from February HWBB whilst agreement of the commissioning and governance process takes place March/April 2017. May 17 Governance proposal to WBC and CCG Exec Boards and to June HWBB. Moved to August HWBB for approval.
		Comms to all stakeholders about agreed model	RW															1/4/17 Comms not yet to all stakeholders as waiting until HWBB approval for governance proposal and CHASC PID. This will be closed and moved to implementation phase. Relationships have been developed in order to roll out comm engagement
		Prepare detailed project plan									Review and update							Completed in 16/17
					01/04/17	01/05/17	01/06/17	01/07/17	01/08/17	01/09/17	01/10/17	01/11/17	01/12/17	01/01/18	01/02/18	01/03/18	01/04/18	
	Self-care/ Prevention	Phase 2a Public Health partnership	RW															
		Implementation of Volunteer Community Navigators (Involve) across Wokingham Borough- Promoting Self-Care and Prevention of health and social care issues and conditions	PC															Roll out to all GP Surgeries by 1/12/17
		Evaluation of CNS Service	PM															To be added into 17/18 plan as will not be ready for review in 16/17
	Objective	**Implementation Milestone**	**Task Owner**		**01/04/17**	**01/05/17**	**01/06/17**	**01/07/17**	**01/08/17**	**01/09/17**	**01/10/17**	**01/11/17**	**01/12/17**	**01/01/18**	**01/02/18**	**01/03/18**	**01/04/18**	
	Phase 2a Localities Development	Development of new system/services, including service specification	RW			Draft to CHASC					Slippage							Draft specification developed with BHFT and Optalis in Feb, March & April 2017. 1st Draft shared for comment at CHASC May 17. At present no sign off or comments until agreement of governance. 1/7/17 Can now progress this work again and will also need a SOPP
		Phase 2a (I) Delivery around Primary Care	RW/GP Alliance													Slippage		Delayed at present due to PID not being signed off.
		Continued comms and engagement around new locality service	RW													Slippage		1/4/17 Paused until HWBB approval. Realigned to Jul 17 start. Remains amber due to realignment
		Governance & Contracting arrangements to be agreed	RW/SROs				Slippage	Slippage	Slippage	Slippage								1/5/17 Proposal paper completed April 17. SROs taking to relevant boards for approval in May17 with plans for Jun 17 HWBB
		Appointment of Head of CHASC	RW/SROs							Slippage	Slippage	Slippage						1/4/17 on hold at present as CHASC PID not approved. Realigned to Jul 17 start. Remains amber due to realignment
		CHASC Engagement and design sessions with staff	RW/Staff						Planning	Planning				Slippage				Planned to start March 17 but on hold until governance and PID approved 1/5/17 Work streams agreed and senior staff allocated. Realigned to start planning from Sept 2017
		CHASC Engagement and design sessions with public/users	RW/Citizens								Planning			Slippage				Planned to start March 17 but on hold until governance and PID approved 1/5/17. Realigned to start October 2017
		KPIs - ensure all baseline measures and audit tools developed and agreed	RW/Head of CHAS			Final to CHASC					Slippage	Slippage						umbrella KPIs and then CHASC KPIs. Meeting booked for 17/5/17. 1/7/17 BCF Programme Manager still working on umbrella KPIs therefore cannot progress. Some of the
		Appoint 3rd Locality MDT coordinator	BHFT Head of Adults				Completed											Appointed and due to start June 17. Started and action now complete
		Agree design of system/model of care	Steering Group					Closed as part of service specification development										Realigned as paused until CHASC PID sign off planned for Jun 17. 1/7/17 Really part of the service specification and can be closed.
		Development of single shared risk stratification tool- Ensuring mechanisms are in place to use data produced regularly about NELs, A&E admissions, SCAS activity and GP attendances to inform care co-ordination and care delivery is aimed at the right people	RW/Head of CHAS												Slippage	Slippage		1/4/17 this should be achieved with the Risk Stratification tool which the CSU are redeveloping for a Sept 17 launch, so timelines realigned. This piece of work will be on-going and for year 1 we will use the list of 650+ patients produced by the CCG for high intensity users as part of the anticipatory care CES.
		Ensure delivery of statutory duties/responsibilities for social care	RW/SROs							Slippage								1/4/17 Made contact with WBC Head of Safeguarding 1/6/17 to be addressed by the governance agreements. 1/7/17 This is really to ensure we don't lose sight of this as part of the development. To be discussed by Head of CHASC , Interim AD of People Services and PM at monthly meetings.
		Revised MDT structure and delivery across localities	RW/Head of CHAS								Slippage							1/7/17 Review of MDTs in progress, have realigned slippage until October due to delayed start of review with services.
		Unified/ Single point of access to all services in CHASC	RW/Head of CHAS/Head of Hub													Slippage		Realigned to Nov 17 start due to governance proposal approval and PID approval
		A locality based locations, virtual alignment and remote working	RW/Estates/Head of CHAS													Slippage		Realigned to Nov 17 start due to governance proposal approval and PID approval
		Alignment of health and social care teams - development of 'one team ethos'	RW/Head of CHAS															Realigned to Nov 17 start due to governance proposal approval and PID approval
		Development of integrated policies and procedures	RW/Head of CHAS													Slippage		Realigned to Nov 17 start due to governance proposal approval and PID approval
	Objective	**Implementation Milestone**	**Task Owner**	**RAG rating**	**01/04/18**	**01/05/18**	**01/06/18**	**01/07/18**	**01/08/18**	**01/09/18**	**01/10/18**	**01/11/18**	**01/12/18**	**01/01/19**	**01/02/19**	**01/03/19**	**01/04/19**	
	Phase 2b Localities Implementation	Implementation phase (6 -12 months)	RW/ Operational Lead															
		Phase 2 b (i) Testing Phase with a single GP locality	PM/ GP Alliance															
		Phase 2b (ii) Roll out to the other 2 GP localities	PM/ GP Alliance															
		Continued comms and engagement around new locality service	RW															
		Continued alignment of health and social care teams - development of 'one team ethos'	RW/Head of CHAS															
		Clarification of staff roles and responsibilities	RW/Head of CHAS															
		Review and update all processes to provide efficiency and consistency	RW/Head of CHAS															
		Review of health and social care pathways and integrate/update as required	RW/Head of CHAS															
		Improving the way in which professionals share information within and between organisations	RW/Head of CHAS															1/4/17 This will have dependencies with the Connected Care Project, therefore rated as Amber at present
		Continue to develop unified/ single point of access to all services in CHASC	RW/Head of CHAS/Head of Hub															
		Continue embedding locality based locations, virtual alignment and remote working	RW/Estates/Head of CHAS															If appropriate, will be agreed during the planning phase
		Continue development and implementation of shared paperwork	RW/Head of CHAS															
		Development and implementation of single assessment	RW/Head of CHAS															
		Continue implementation of shared risk stratification tool	RW/Head of CHAS															
		Investigate and implement technology where needed	RW															

Volunteer Community Navigators Detailed Implementation Plan

Implementation Milestone	Action/Task detail	Task Owner	Group	Month Commencing 01/07/16	01/08/16	01/09/16	01/10/16	01/11/16	01/12/16	01/01/17	01/02/17	01/03/17	01/04/17	01/05/17	01/06/17	01/07/17	01/08/17	01/09/17	01/10/17	01/11/17	01/12/17	Additional Comments
Monthly Meeting	PM to arrange monthly 1:1 meeting with Involve to discuss progression of scheme and any assistance required	PM	Involve			13/09/16	13/10/16	08/11/16	13/12/16	04/01/07												Meeting on the 12/12 with Phil and Marie
Coordinator	Community Navigator Coordinator in post (paid role; 25 hrs. pw;)	PM	N/A					Change in coordinator														Been in post since March 2016
	Recruitment of replacement co-ordinator as current post holder leaving	PC	Involve																			To start 1st week of December
	Modelling of volunteers required in order to understand when further co-ordinator or increase in co-ordinators hours needed.	PC & MJH	Involve																			4/1/16 March June and Sept training days booked for volunteers. Target of 6 volunteers from each of those. That would then give the borough wide cover. Current 5 active and 2 borderline. Would give 25 volunteers, which Phil and Marie would be comfortable with.
Volunteer Recruitment & Training	Volunteer recruitment to continue as an on-going process	Co-ordinator	N/A	6 volunteers			8 volunteers			5 volunteers and 2 office based	6 volunteers and 2 office based.	plan for 6 new volunteers 2 attended first training	4 interviews planned		9 existing CN's and 7 new volunteers in training	10 existing and 6 trained in July, one volunteer stepping down		6 new volunteers				Total cumulative numbers with the aim of having 30 volunteers. This will need to be a continuous process as volunteers will leave. October 2016 - Of those 14, two are now providing admin work behind the scenes, two have resigned from the scheme, one because she moved out of the area and one because he found a job and could no longer commit, one started and is now long term sick (not related to the scheme), one is standing back whilst nursing a sick relative, the other 8 are all active. 4/1/17 2 volunteers unwell, 5 active and 2 office based 4/4/17 7 active volunteers with 2 additional to come on line in April and 4 interviews, 2 leavers in March 6/6/17 9 active volunteers, 8 volunteers being trained by end of June should have 17 volunteers
	Volunteer training programme to run regularly to train new volunteers	Co-ordinator	N/A		03/08/16							1/3 and 8/3			13/6 & 14/6			10/9 & 11/9				Thinking about linking part in with GP receptionists too.
	Regular monthly volunteer emails for engagement and retention	Co-ordinator	Volunteers							18/01/17	15/02/17	15/03/17	19/04/17	17/05/17	21/06/17	19/07/17	16/08/17	20/09/17				To be sent out via email as opposed to paper, ? Team Brief as a header, no more than a page and perhaps use People, Policies, Procedures and Training, Performance and Plans. To start in Jan 17 31/1/17 check with Marie as only seen one. 4/4/17 Monthly email with agenda and minutes Marie to ask Volunteers if this is a sufficient monthly update
	Regular volunteer meetings to be set up for training and development	Co-ordinator	Volunteers				04/10/16	01/11/16	06/12/16	04/01/17	01/02/17	01/03/17	05/04/17	03/05/17	07/06/17	05/07/17	02/08/17	06/09/17				12/16 November meeting cancelled as not enough volunteers could attend.
Paperwork & Pathways	Social prescribing forms and referral pathways developed and then review at 6 months	PC & Co-ordinator	Steering Group						Review	Review and change	Implement											To update the November meeting. RW to meet with Johan Zylstra to discuss. Review of referral form and updated by 31/12/16
	Update of referral form																					4/1/17 sent to DXS co-ordinator to add to the system
	Review of follow-up information requirements									Review and change	Implement											Thinking about carbonated paperwork for helping with this
	Secure Email access to be investigated and implemented	PM & PC	SROs																			Exploring having the form on DXS for GPs. 1/3/17 Involve have been sent information to get NHS.net account. To check on progress in April. 6/6/17 Nearly there now only 1 more form to complete and should be issued.
	Referral pathway development, if needed, to be included in service specification	PM & PC	GPs/Practice mangers																			Meeting GP practice mangers 17th November
	Evaluation tool development	CR	Steering Group																			Evaluation tool being developed in association with Involve; 4 wk. pilot from 10 Dec; anticipate implementation from April 2016
Implementation	Wave 1 Initial Pilot of the service in 3 surgeries: Wargrave Swallowfield Wokingham Medical Centre	PC & Co-ordinator	Involve																			Navigators starting in GP surgeries from March 16 (Wargrave, Wokingham MC & Swallowfield) 12/12/16 Marie to contact WMC, Swallowfield and Brookside to work with receptionists to support training and help look for patients
	Wave 2 - 3 further surgeries (6 in total) Brookside Woodley Centre New Wokingham Road	PC & Co-ordinator	Involve					Brookside Open				Woodley Centre		Now May - New Wokingham Road								Brookside started end of Oct 4/1/17 Nothing has happened to date with Twyford and Parkside. Phil and Marie to email me the new plans by end of this week.
	Wave 3 - 3 further surgeries (9 in total) Wooshill Finchampstead Twyford	PC & Co-ordinator	Involve												Jun/Jul	Wooshill						4/4/17 May possibly be delayed as wave 2 delayed as not recruited volunteers. 4/7/17 volunteers trained and waiting to hear back from Twyford and Finchampstead to get the volunteer in.
	Wave 4 - 4 further surgeries (13 in total) Burma Hills Loddon Vale Wilderness Road Parkside	PC & Co-ordinator	Involve															Sept/Oct				
	Other venues to hold prescribing sessions be explored with WBC, to include community centres and libraries	PC & Co-ordinator & Mark R	Steering Group			27/09/16										SDLs and LSOAs						27/9 initial meeting with PC and Mark Redlearn to discuss opportunities. PC/Involve to follow-up with MR 4/4/17 As yet don't have the critical mass of volunteers to do this piece of work will review again in 3 months 6/6/17 For July meeting will need to discuss LSOAs and SDLs as navigator locations
Data/Report Submission	Monthly data submission to PM and BCF Finance by 2nd working day of the month to include: Navigators Active Surgeries Active Community Venues active Referral Source Number of referrals Reason for referral Ladder of change before Ladder of change after Benefits - reduced GP and A&E attendance, reduced ASC contacts	PC & Co-ordinator	Involve					03/11/16	05/12/16	04/01/17	03/02/17	03/03/17											Involve to agree their internal systems in order to capture the data. Rhian and Marie to look at on the 19th December.
	Present monthly performance updates about CNS to steering group and WISP	PC & Co-ordinator	Steering Group & WISP						No meeting													
	Review of data being submitted as part of service specification development	PM & PC	Steering Group						Review	Review and change	Implement	Completed										RW and Marie meeting 19/12/16
Service Specification	Service Specification for 17/18 to be developed in conjunction with Involve	PM & PC							Draft Written													
	Service specification to be reviewed and agreed by Steering Group	PM	Steering Group							Review	Agree	Agreed										
	Service Specification to go through appropriate boards for approval	PM	Boards										Slippage									Sent to WBC contracting team March 2017. 6/6/17 Still waiting for WBC to send out to Phil has had some verbal communication
80	Robust and continuous comms and marketing required for the service as it is now	PC & PM	Involve																			Regular comms required. 4/7/17 Promotional material to PH and continence service, community geriatrician, RBFT in August 2017
	Meet with Head of Adults BHFT to explore options for increasing use & awareness of CNS	RW &PC	BHFT			27/09/16																At meeting HI suggested we do/contact the following: District Nurse monthly meeting, Community Matrons and MDTs, Inpatient wards, Community Geriatrician, Continence Service, IAPT, MSK Physio @WCH
	Meet with Service Manager, Libraries & Community Development WBC to explore options for increasing use & awareness of CNS	RW &PC	WBC			27/09/16																PC to identify locations required and to let MR know. MR to send PC a list of locations and opening hours. If need further venues MR can link us to parish council venues too.
	Meet with Head of Therapies RBFT to explore options for increasing use & awareness of CNS	RW &PC	RBFT			28/09/16																PC to arrange for co-ordinator to attend Therapies staff meeting and falls or PD clinics. PC to meet with equivalents in West berks and Reading to look at joint approach to shared highlighting social prescribing schemes at RBFT.
	Meet with Health & Social Care Hub to explore options for increasing use and awareness of CNS	RW &PC	BHFT																			To investigate a navigator being based in the Hub and also referrals from the Hub to the service
	Meet with WBC community engagement team to discuss increasing awareness of CNS	PM	WBC				14/10/16	24-Nov														Happy for us to piggy back on their events but they are mostly around planning and development issues, so he wasn't sure how receptive the attendees might be. There is a North Wokingham meeting on the 23rd November where you would be welcome to have a stand. The numbers of local residents are high at this event He also mentioned that they often piggy back on events themselves like, careers fairs, BME Forum (12th November) etc. Not sure how to find out about these but am planning to meet the Communications team from the council now to ask them. The social media stuff is all done by this team and not community engagement, so I am in the process of contacting them too. Dave also mentioned a number of annual Wokingham events that would be good to perhaps try and organise a stand or stall, e.g. May Fair, Wokingham Winter Carnival, Woodley Winter Extravaganza. He did mention that the Sports Development Team would be attending some of these.
	BHFT - Attend DN monthly meeting Meet with Community matrons and investigate VCN attending MDT meetings regularly Meet continence team Meet with IAPT service Meet with MSK Physios Meet with Community Geri Meet with Inpatient team WCH Meet with WISH	PC & Co-ordinator	Involve					CMs 22/11 Cont. 3/11 DNs TBC IAPT 8/11 MSK PT TBC Comm G 15/11 WCH IP 15/11 WISH TBC	CMs 19/12	24/1/17 observe MDT												12/12/16 - Ensure that discuss a rolling plan of comms too. Steve went to meet DNs in November. CMs moved meeting to December due to staff sickness. Not heard anything back from WISH or MSK Physio, so RW will check and let Phil and Marie know what they need to do. 12/16 pm Phil to contact MSK physio to rebook. Rw has made contact again with Martin Sloan today.
	RBFT Attend therapies staff meeting to do a talk Give business cards to therapies team	PC & Co-ordinator	Involve					TBC														12/12/16 - No evidence that this has happened, Phil and Marie will need to arrange to do this in January now. 1/4/17 to arrange the talk once all new promotional material available to hand out after the visit. Likely to be booked in June 2017.
Communications and Marketing	WBC - Faith organisations via Joyce Stoner Contact local events to have a stand at appropriate events Optalis talk and promotional material Link in with Community Development workers via Alison Monroe Meet with SHINE team to link in with their schemes	PC & Co-ordinator	Involve					Optalis 17/10	1/12/16 met with community development workers													11/16 - Joyce stoner has emailed Phil a lot of information that Marie can use. 4/1/17 Phil has sent content to Dave Allen for the Borough Newsletter and Marie getting some GP feedback too.
	GPs Attend GP Council meeting to update GPs Attend Practice Managers monthly meeting Check that all practices have communicated to staff and have promotional material up in waiting areas Regular articles for the GP Newsletter Information for GP Websites	Pm, PC & Co-ordinator	Involve					Council 18/10	Practice Managers Meeting 17/11						20/6 GP Council Meeting							4/1/16 Phil has contacted Sarah Rutland re: Marie attending practice managers meeting. RW has also suggested contacting Andrew Price re: introducing at GP Council meeting too. January practice managers meeting agenda is full so likely to have to wait until Feb meeting. 4/4/17 Keep getting bumped off the Agenda
	Meet with Andrea Jenkins Head of Comms from WBC comms team, to discuss social media awareness raising and general comms thoughts	RW	RW					Emailed 17/10	30-Nov													Meeting her end of November
	Review of promotional material and re-design poster business cards screen savers leaflets carbon prescription pad carbon navigator/patient pad newsletter template navigator recruitment poster	RW	RW, Involve and WBC										Slippage	Completed								11/16 Started the process of review in November
	Delivery of promotional material to GP surgeries, libraries, community centres, parish council spaces,	Marie	Involve												In areas where CNS are	Slippage						6/6 do need 2nd person to support this
	Newsletters - Quarterly Newsletter to all health and social care providers in Wokingham - mailing list to be agreed	Marie	Involve									No template										31/3/17 Delays to newsletter as design not completed or agreed
	Social Media development in conjunction with WBC Comms department	Marie	Involve																			31/3/17To discuss at April meeting to start further work here
Berkshire West Wide thinking and working	Explore the ways of sharing thinking and cooperation between the 3 schemes in each borough *Book an initial meeting with all 3 schemes to discuss	PC	PC, RW and Marie																			31/3/17 Further work required here 4/4/17 All aware of each other now. Would like a joint marketing piece for pan Berks West Services, e.g. Acute etc. CCG (Sarita and Rhiannon) are now thinking about a broader contract for these services, on agenda but not moved.

Phase 1 Localities Scoping - Detailed Implementation Plan

Implementation Milestone	Action/Task detail	Task Owner	Group	Month Commencing									Additional Comments
				01/04/17	01/05/17	01/06/17	01/07/17	01/08/17	01/09/17	01/10/17	01/11/17	01/12/17	
Meetings	Review of the 2 Groups in place for monitoring the project. Steering group and subcommittee at present	**RW**	**Steering Group/ subcommittee**										Completed 16/17
	Review and update the TOR for the steering Group	**RW**	**Steering Group**										Completed 16/17
	Review of the Membership of the groups	**RW**	**Steering Group/ subcommittee**										Completed 16/17
	Agree the TOR	**RW**	**Steering Group**										Completed 16/17
	Agree the groups and membership	**RW**	**Steering Group**										Completed 16/17
Review of 16/17 business case	Review and redevelop the 16/17 business case, focus on: * aims * objectives * benefits * other services that could fit into clusters * Original metrics and KPIs from BCF submission to be revised & agreed	**RW**	**Steering Group**										Completed 16/17
	Engage with all stakeholders as part of the business case review and redevelopment	**RW**	**All stakeholders**										Completed 16/17 - Did not engage with wider public audience as need to get PID agreement to be able to clearly describe plans
	Review and complete costed locality model options: 3 clusters for long term care self-care and prevention	**RW**	**MM**										Completed 16/17
	Agree the name of the Neighbourhood Localities model	**RW**	**Steering Group**										Completed 16/17
	Complete the business case for submission	RW	Steering Group										Completed 16/17
	Business case for review and agreement at Steering Group meeting 13/9/16	RW	Steering Group										Completed 16/17 - Draft PID reviewed 13/9, final PID for reviewed 3/10. At steering group agreed that this was the final PID and the plan was to progress through the approval process.
	Business case for review and agreement at WISP meeting 13/9/17	RW	WISP										Completed in 16/17 - 15/11/16 N.B. Further amendments were made in January 2017 following comment from the LA SLT.

Update and submit reframed 16/17 business case for approval	Business case for review and agreement at Wokingham Health and Well-being board	RW	Health and Well being Board			**15/06/17**							Outstanding from 16/17 - BC tabled for presentation and approval on 8/12. As not agreed by WBC was withdrawn from the meeting. Has to be agreed at formal meeting. Change in Exec structure of WBC and new SRO from WBC, who wants to ensure governance, commissioning and accountability is agreed prior to
	Business case for review as a critical friend at BW10 FSG meeting	MC/RW	BW10 FSG										Completed 16/17 - 14th November 2016 - FSG would like regular updates on the project
	Business case for review and agreement at WBC Corporate Leadership Team and BHFT Boards/meetings	SROs	Relevant Organisation Exec Boards										Completed 16/17 - BHFT Agreed October 16, CCG approved November 16 and WBC agreed December 16
Development Phase (6 months)	Once BC has been approved detailed project plan require for development and implementation phase	RW	CHASC Steering Group										Completed in 16/17
Locality MDT Co-ordinators	Role has been approved in principle; role regarded to take account of extended requirements; proceeding to staff consultation (28 days)	PM	N/A										Completed16/17
	Service Specification being developed, with clear pathways identified and development of measurable outcomes	RW	BHFT, CCG										Completed 16/17

Phase 2a Localities Development - Detailed Implementation Plan

Phasing	Implementation Milestone	Action/Task detail	Task Owner	Group	Month Commencing 01/04/17	01/05/17	01/06/17	01/07/17	01/08/17	01/09/17	01/10/17	01/11/17	01/12/17	01/01/18	01/02/18	01/03/18	01/04/18	Additional Comments
Phase 2a	Development of new system/services	Design phase of new model (4 months), including service specification	RW	RW & Head of CHASC								Slippage						1/4/17 Design was due to start in Feb 17 but delays to PID has meant that this has been realigned
	Community Comms and engagement around new locality service	Meet with WBC Community Engagement Lead to discuss Comms and Engagement for the service	RW	WBC	Complete													Initial meeting held 14th October. Completed in 16/17. They are available for working when required
		Engagement with consultative groups e.g. Healthwatch, PPG, Voluntary Sector	RW	Healthwatch, Optalis, BHFT														Met with Healthwatch and PPG 11/16 to discuss CHASC and get feedback on user group development. User group comms have been put on hold until PID and governance approved in June 2017. Met aloes with Public Health and LD Partnership in Feb and March 17.
		Update the Wokingham Scrutiny Committee about model and BC	RW	Overview and Scrutiny Committee	Complete													Completed 8th November 2016
		Agree community engagement plans to include setting up public user group	RW	WBC Community engagement team	Complete, no user group, just information sharing													User engagement has been put on hold until June 2017. Agreed that user engagement will be workshops providing information and asking for feedback and not a user group. 1/7/17 SROs have asked that user engagement is not workshops but just communication of information sessions. To be discussed at August Steering group
		Engagement with public users to include the development of the name of the system/service	RW	Public users							Preparation						Slippage	User engagement has been put on hold until June 2017.
	Interim Contracting and governance arrangements to be agreed	Research contracting and accountability arrangements in place around the UK	RW	RW	Complete													Completed November 2017
		Draft proposal - Agreement from SROs - SROS to take to relevant CCG and LA Exec boards - Fit with the ACS - Final Approval at HWBB	RW	SROs				Slippage	Slippage									Started in December 16. Delays due to exec and SRO changes. Draft proposal agreed by SROs in April 2017 with SROs taking to relevant Execs in May and planned for HWBB June 2017. 1/7/17 Being progressed through Exec teams
	Appointment of Head of CHASC	Write JD, get banded and carry out appropriate consultation with affected staff	RW	SROs/ David Cahill / RW	Complete													Completed in 16/17. JD Drafted in November 2016 shared with SROs and David Cahill and approved. David Cahill job banded post through BHFT in Dec 2016. David Cahill to consult In Jan/Feb 2017
		Advertise post	SROs	David Cahill			Complete											Paused until PID approved in June 2017
		Conduct Interviews	SROs	SROs/ David Cahill			Complete											Paused until PID approved in June 2017
	CHASC Engagement and design sessions with community nursing and social care staff	Initial high level meeting with Community Nursing and Social Care	RW	RW/ HI / MJ	Complete													Set up operational sub-group in Feb 2017, with BHFT and Optalis and started draft of service specification. 1/4/17 Due to governance pause haven't progressed further at present
		Agree plan for staff engagement and design for the model/service spec	RW	RW/ HI / MJ	On hold as no HWBB Approval													1/4/17. Agreed in principal model design, but not staff engagement at present. To discuss at May meeting
		Feedback into monthly steering group meeting	RW	RW														1/4/17 draft specification for CHASC
	Locality MDT coordinators	Agreement from WISP and SROs to proceed with the posts	SROs	WISP	Complete													Completed December 2016
		Consult with existing staff in post	HI	HI and coordinators	Complete													Completed Jan 2017
		Advertise and appoint 3 locality MDT coordinators	HI	HI			Complete											1/4/17 All post appointed to with final MDT co-ordinator starting in June 2017
	Agree design of system/model of care - ensure considering technology	Workshop to agree and confirm system/model of care	RW	Operational Group	Complete													Agreed in 16/17 by operational Group. Taken spec to CHASC SROs want governance agreed before approving model.
		Design and agree locality hub model for alignment of staff, including voluntary sector, health needs and areas of deprivation, GP Alliance and 21st Century Council. N.B. This links into the primary care actions	RW	Operational Group									Slippage					1/4/17 Initial agreement in PID now needs fully scoping. N.B. TVP would be interested in aligning Neighbourhood policing teams if all match.
		Ensure single point of contact (Health and Social Care Hub) in place for all CHASC services	RW	HI & MJ													Slippage	1/4/17 Initial meeting with Berks Int Hub in April to start discussions. Need to discuss with June Ops group
		Develop and agree the fit of the community navigators within the overall CHASC service	RW	HI & PC											Slippage			To discuss at June Ops group
		Development of Care co-ordination, to include - * Accountable key worker * Design and agree single care plan, including information sharing and other shared paperwork * Agreement of the roles and responsibilities of staff groups	RW	Staff user group												Slippage		31/3/17 agreed work streams. 1/4/17 Paused until HWBB PID and governance sign off in May. Realigned for November 2017 start. This action will need to carry into the implementation phase too.
		Revised MDT structure and delivery across localities	RW	Staff user group							Slippage							31/3/17 Not all MDT coordinators in post to start this piece of work and work streams not approved. Delays in April due to Easter leave, but planning work has started. Aiming for task and finish start in June 17.
		Development of Care delivery to include - * Review of all service processes and update where necessary so that they are shared * Review of health and social care pathways * Self management programmes, developing the links with PH and CNS	RW	Staff user group													Slippage	Some of this work will need to continue into 17/18 as it is a large piece of work
		Development of one team ethos - * All staff are members of CHASC - vision and values * Uniforms * ID badges and lanyards, * Shared paperwork * Training * Integrated policies and procedures *Co-location where needed and virtual alignment	RW	HI, MJ & PC													Slippage	1/4/17 Realigned due to delays in PID and governance sign off. This work will need to continue into 17/18 as it is a large piece of work and culture change requires time and leadership.
		Develop of integrated SOPPs where required for the services and an overall CHASC SOPP	RW	HI, MJ & PC														1/4/17 Research what SOPPs the differing services have already, what would we need?
	Making the most of data	Collect and review the Risk stratification / predictive modelling used currently in the system	RW	HI, MJ & JZ														Completed in 16/17
		Agree the risk stratification/predictive modelling to be used for new system	RW	HI, MJ & JZ														Completed 16/17 Will use the new CSU Risk start model
		Ensuring mechanisms are in place to use data produced regularly about NELs, A&E admissions, SCAS activity and GP attendances to inform care co-ordination and care delivery is aimed at the right people	RW	Head of CHASC											Slippage	Slippage		1/4/17 CSU is changing to be the provider of Risk Strat tool and are designing their own for go-live in Sept 2017. Added to work streams as require full work-up and involvement
	KPIs - ensure all baseline measures and audit tools developed and agreed	Review and final agreement of all performance metrics from the PID	RW	RW & Head of CHASC							Slippage							1/4/17 1st Draft to March 17 CHASC SG. 1/5/17 SROs want BCF KPIS and then scheme KPIs, before agreeing scheme KPIs
		Ensure that baseline data is available for all performance measures	RW	RW & Head of CHASC							Slippage							Work started in 16/17, with most measures able to be measured. 1/5/17 Until KPIs are approved this work cant progress any further
		Where no baseline data is available ensure there is a mechanism in place to capture the data to start to provide a baseline	RW	RW & Head of CHASC							Slippage							Work started in 16/17, with most measures able to be measured. 1/5/17 Until KPIs are approved this work cant progress any further
		Develop an Audit tool in order to collect, collate and report the performance data	RW	Staff user group									Slippage					1/5/17 Meeting in April 17 with BHFT Audit team, until KPIs are approved this work cant progress any further.
	Service Specification	Collect and review of all current service specifications that relate to CHASC	RW	HI & MJ														Completed 16/17
		Draft CHASC service specification - to include Primary Care, Community Health, Social Care, CNS and PH	RW	RW	1st Draft				Complete 2nd draft/Final Version	Amend-ments	Approval	Slippage						1/5/17 Realigned as until PID and governance agreed will not be considered or signed off.
		Clarity between practice nurses, district nurse and community matron roles and responsibilities, through service specification	TBC	GP Practices, Head of CHASC								Slippage						
		Share final draft with steering group in August for agreement	RW	CHASC Steering Group						CHASC	CHASC Approval	Slippage						1/5/17 1st draft shared at CHASC SG
		Agreement of service specifications by commissioners and providers	RW	SROs, David Cahill, GP Alliance									Slippage					
	Prevention/Self Care	Community Navigator Service Roll Out	PM	PM & Involve														1/4/17 See Volunteer Navigator Tab for all details
		Meet with Public Health to explore opportunities and synergies to partner with health & social care teams e.g. meetings. The overall aim that PH services become an extension of health and social care services	PM	PM, Head of CHASC & Public Health			Complete											
		Ensure links between all health and social care services and Public Health, carrying out a mapping of PH and H&SC services for links and ensuring that staff have tools to identify services that will benefit users	PH	PM, Head of CHASC & Public Health				Mapped PH Services		Information shared with all services								
		PH staff are invited and involved in all CHASC work streams and task and finish groups during the development phase	PH	PM, Head of CHASC & Public Health														Need to ensure that realtionships are systemised and solidified. Think do we recognise issues and what do we do about it?
		PH training and awareness for all H&SC staff, starting with IST for community health, social care, primary care and Involve	PH	PM, Head of CHASC & Public Health						Design and Develop IST sessions			Deliver IST training			Design and Develop Induction		For primary care will need to explore a session at a TIPs day. Progression of this will be Induction
		Public Health Champions Programme	PH	PM, Head of CHASC & Public Health						Develop PH Champion Role			Recruit and train champions from partners			Roll out champions		Ensure that there is a fit with MECC (Make every contact count)
		Ensure that PH staff become seen as an extension of the H&SC team by including them in MDTs, annual reviews e.g. diabetic, respiratory, LD, social care	PM	PM, Head of CHASC & Public Health				MDT - Task and Finish Group				MDT Pilot and Review					Annual Review Investigation	Will need to liaise with primary care re: many annual reviews and the process.
		Explore opportunities to support residents to access PH services. Financial support for taster sessions	PM/PH	PM, Head of CHASC & Public Health														
Phase 2 a (i)	Delivery around Primary Care	GP practices to agree locality alignment	TBC	GP Alliance			Complete											31/1/17 Initial meeting held at TIPs to open the discussions and GPs now forming an Alliance in Wokingham
		GPs to agree and sign some form of alliance federation within localities	TBC	GP Practices			Complete											
		Agreement of a single GP hub site within each locality for CHASC team to be hosted and how the CHASC team will support the sister practices in the localities	TBC	GP Practices, Head of CHASC														1/5/17 Once GPs have formed Alliance need to discuss this with them.
		Partnership agreement between GPs, BHFT, WBC for CHASC services	TBC	GP Practices, Head of CHASC									Slippage					To be delivered by BCF Programme manager
		Discuss and agree the GP and CHASC working include GP support and deployment of CHASC services	TBC	GP Practices, Head of CHASC				Complete										
Phase 2 b	Implementation plan	Draft implementation plan for CHASC	PM	Head of CHASC														
		Agree implementation plan for CHASC	PM	CHASC Steering Group														

Phase 2b Localities Implementation - Detailed Implementation Plan

Phasing	Implementation Milestone	Action/Task detail	Task Owner	Group	Month Commencing 01/04/18	01/05/18	01/06/18	01/07/18	01/08/18	01/09/18	01/10/18	01/11/18	01/12/18	01/01/19	01/02/19	01/03/19	01/04/19	Additional Comments
Phase 2b	Implementation phase (12 months)		PM/ Operational Lead															
	Continued comms and engagement around new locality service		PM															
	Alignment of health and social care teams - development of 'one team ethos'		PM/Head of CHASC															
	Clarification of staff roles and responsibilities		PM/Head of CHASC															
	Reviewing and updating all processes to provide efficiency and consistency		PM/Head of CHASC															
	Review of health and social care pathways and integrate/update as required	Development of Care delivery to include - * Review of all service processes and update where necessary so that they are shared * Review of health and social care pathways * Management of Ambulatory Care Sensitive Conditions * Self management programmes N.B. Refer to work carried out for WISH	PM	Staff user group														
	Improving the way in which professionals share information within and between organisations		PM/Head of CHASC															
	Single point of access to all services in CHAS		PM/Head of CHASC /Head of BI Hub															
	A single physical location for health and social care teams as well as locality based locations and remote working		PM/ Estates/ Head of CHASC															
	Development and implementation of shared paperwork		PM/Head of CHASC															
	Development and implementation of single assessment		PM/Head of CHASC															
	Development of integrated policies and procedures		PM/Head of CHASC															
	Development of single shared risk stratification tool		PM/Head of CHASC															
	Investigate and implement technology where needed		PM															
Phase 2 b (i)	Testing Phase with a single GP locality																	
Phase 2 b (ii)Phase 2 b (iii)	Roll out to the other 2 GP localities																	

Berkshire West
Accountable Care System

An Update on the Berkshire West Accountable Care System

June 2017

Agenda Item 24.

History of partnership working

- 2013 CCGs and Health and Well Being Boards established – new opportunities and appetite for joint working as a health and social care system
- Health and social care partners apply together to be Integration Pioneers and are in the final 14 nationally
- Undertake a joint development programme – System Vision, Local Leadership
- Establish the BW10 Integration Programme, alongside local integration work with each LA, overseen by 3 HWBs
- Elements of this programme supported by the Better Care Fund

History of partnership working

- LAs identify the opportunity to develop a joint commissioning function
- Health partners identify the opportunity to explore new models of delivery based on a single budget for the whole health system
- Agreement to pursue sector based objectives for one year and start to bring both programmes together in year 2
- Ultimate aim to have a single programme for the whole health and care system delivering new care models and new business models
- BW10 Integration Programme and local integration programmes continue
- Reporting mechanism for the ACS and LA joint commissioning programme to be via the BW10 governance and through to HWBs
- 2016 local NHS partners apply to NHSE for a system control total
- January 2017 CCG present their comprehensive 2 year plan to HWB, including the ACS arrangements and fit with the wider BW10 integration agenda and the STP
- June 2017 BW ACS selected as of only 8 systems nationally to operate as an ACS in shadow form for 2017/18

Why an Accountable Care System?

- A high performing system but increasingly financially challenged. All parts of the system under huge demand pressure
- Different parts of the health system funded differently: PbR, block contract, GMS, PMS and APMS
- Commissioner/provider split creates unhelpful consequences for jointly planning patient care and managing the Berkshire West £
- Primary care under particular pressure: rising demand and expectations, extended access, workforce crisis and lack of financial investment

Berkshire West
Accountable Care System

What is an Accountable Care System?

- A more collaborative approach to the planning and delivery of services with collective responsibility for resources and population health
- Operates on a single budget for the whole health care system
- Funds follow the patient to support pathway and service redesign
- Underpinned by a system financial model – manages risk and aligns incentives
- Organisations working more closely in partnership with system wide governance arrangements – signed a MoU June 2016
- Joined up, better coordinated services with more control and freedom over the total operations of the health and social care system in the area

Berkshire West
Accountable Care System

The development of collaborative commissioning

Strong Commissioner / Provider Split:

- Less opportunity for collaboration
- Organisationally focussed leadership
- Limited integration with local authority services
- Price & volume based payment mechanism

The move to CCGs

- More evidence of collaboration
- Strong clinical leadership
- Joint working with LAs
- Still based on price & volume

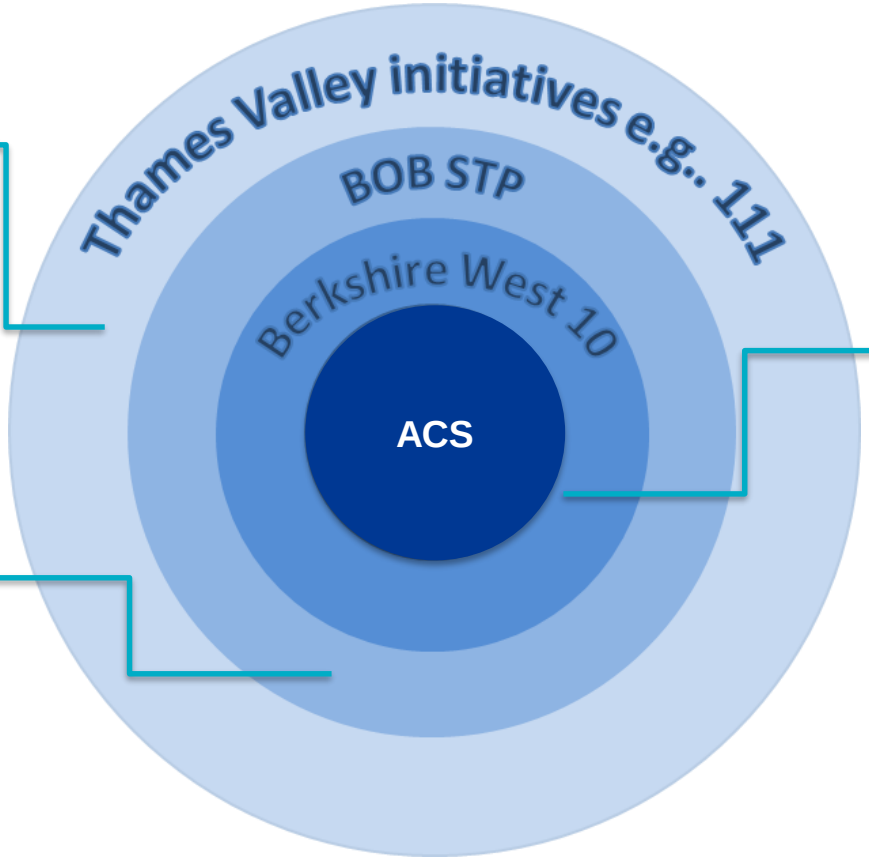
ACS - New Ways of Working

- Shared, non statutory governance
- Joint clinical improvement projects
- System Control Total for Financial Mgt.
- Cost recovery model rather than volume
- Stronger voice for Primary Care
- Enable further social care integration

Berkshire West
Accountable Care System

The ACS programmes fit with other initiatives in our region

We will continue our work with partner organisations to plan for and deliver services effectively at larger scales



The ACS compliments the well established health and social care integration programmes which oversees joint investments and improved system working

Our individual ACS members are an engaged and active part of the Buckinghamshire, Oxfordshire and Berkshire West STP

Berkshire West
Accountable Care System

Progress to date….

- Established new governance arrangements - signed MoU June 2016
- For 17/18 introduced a marginal rate with RBFT to share risk
- Awarded ‘Exemplar’ status June 2017
- Undertook 5YFV stocktake: A&E, MH, Ca, Primary Care
- The work of the ACS overlaps with the joint BW10 programme and the two together form a health and social care transformation continuum
- Commenced the ACS Transformation Programme:
  - New care models: *High intensity users, MSK transformation, Respiratory Care, Outpatients transformation, Meds. management and joint prescribing, bed modelling*
  - New business models: *Back office / support functions, Estates, contractual / financial models*

Berkshire West
Accountable Care System

Next Steps

- Agree a performance contract with NHSE/I – MUST move faster on 5YFV key deliverables – a system benefit
- Get Transformational Funding for the ACS
- Manage to a system £ control total – away from PbR and annual contractual / tactical negotiations
- Collective decisions making and governance
- Work with emerging primary care providers
- In year 2 start to bring BW10 and ACS together – Nick Carter, Chair of BW10 Integration Board will join ACS leadership Group

Berkshire West
Accountable Care System

Implications for the way we work

- Partnerships within the ACS **and** horizontal networks with other health providers
- New approach to independent sector
- Integrated health and local govt. system wide strategy: clinical, digital, estates, workforce
- Combined teams/shared leadership - agnostic about “who” and “where”
- Single system view of performance and quality
- Fundamental change in the commissioner/provider relationship.
- Collective, clinically led decision making on optimal care models/pathways and allocation of the BW £

Berkshire West
Accountable Care System

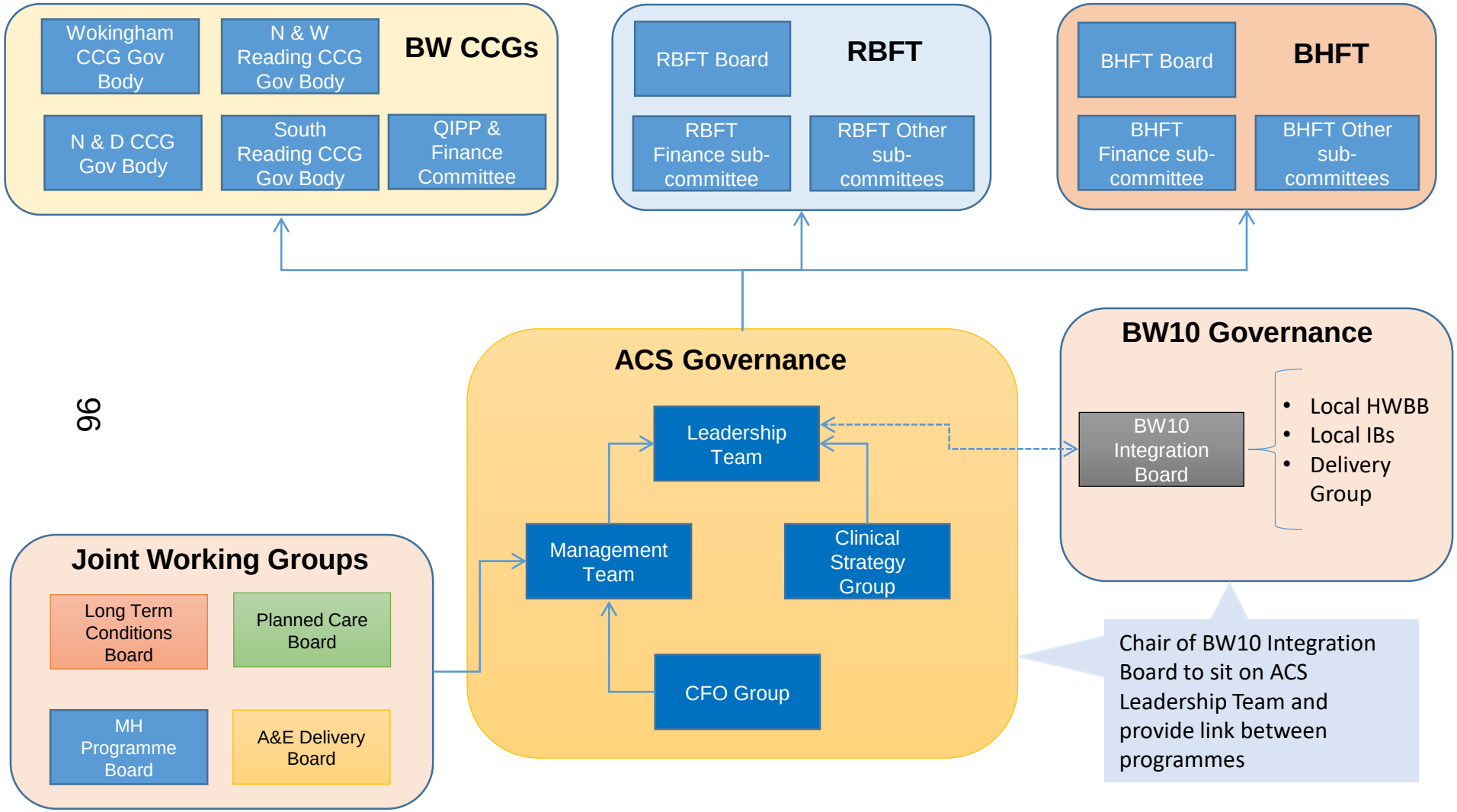
What will be different as a result?

By moving to an ACS Model, we will:

- Work more collaboratively to transform services e.g. Outpatients
- Cover the challenge of lower real-terms allocations
- Ensure each organisation has a stake in the system financial position rather than each constituent standing alone
- Better position the local NHS for wider integration opportunities with local government
- Provide Primary Care a greater platform in the design and evolution of service models
- Flow resource to the parts of the system where it is needed e.g. primary and social care

Berkshire West
Accountable Care System

Berkshire West ACS Governance Framework



TITLE	**Urgent and Emergency Care Delivery Plan: Summary Briefing**
FOR CONSIDERATION BY	Health and Wellbeing Board on 10 August 2017
WARD	None Specific
DIRECTOR/ KEY OFFICER	Katie Summers, Director of Operations, Wokingham CCG

Reason for consideration by Health and Wellbeing Board	To brief the HWBB on plans for a modernised and improved urgent and emergency care service.
Relevant Health and Wellbeing Strategy Priority	Delivering person-centred integrated services.
What (if any) public engagement has been carried out?	Urgent and Emergency Care featured in Berkshire West CCGs' Operating Plan engagement events during Spring 2017.
State the financial implications of the decision	Within commissioner budgets and with national funding streams.

OUTCOME / BENEFITS TO THE COMMUNITY

The Urgent and Emergency Care Delivery Plan seeks to deliver safe, faster and better urgent and emergency care to people of all ages.

RECOMMENDATION

To note this report.

SUMMARY OF REPORT

The purpose of this paper is to brief the HWBB on plans for a modernised and improved urgent and emergency care service as described in the " Urgent and Emergency Care Delivery Plan " which was published by NHS England in April 2017. The paper also confirms the steps that have been taken locally, to date, to support delivery of the plan. The final version of the Berkshire West Delivery Plan will be presented to the October meeting of the Health and Well Being Board.

Background

1. The “Next Steps on the NHS Five Year Forward View (5YFV) “published in March 2017 explains how the four national service improvement priorities for the NHS over the next two years will be delivered. These are urgent and emergency care, primary care, cancer and mental health. The plan clearly sets out the challenge facing the NHS and wider health and care system – to continue to deliver high quality care today, while fundamentally transforming services to deliver the best possible care in the future, all against a background of financial pressures and growing demand. In relation to Urgent and Emergency Care it also restates the requirements in the 2017/18 NHS Mandate – 90 % of emergency patients to be seen within four hours by September 2017, the majority of trusts to meet the 95% standard by March 2018 and a return for the NHS overall to the standard of 95 % during 2018.

2. The “Urgent and Emergency Care Delivery Plan” published in April articulates in more detail the offer, specification, delivery plan, expected costs and benefits of the 7 Urgent and Emergency Care priorities which are expected to deliver the transformation required.

3. The changes come after the NHS coped with its busiest ever winter and which saw a record 23 million people attend A&E in 2016-17, 1.2 million more than 3 years ago. The number of calls to NHS 111 has doubled over the same time frame to 15 million, while ambulances and GPs also saw a record number of patients. With that has been a growing trend for many poeple to turn to A&E or call ambulances when they don’t need such advanced emergency treatment; or going to see their GP when they would be better seeking advice from NHS 111, or remedies from their pharmacist.

“Urgent and Emergency Care Delivery Plan” 7 Priorities

4. The seven key areas of change are listed below together with, where appropriate, a summary of where we are locally in responding to these.

    i. NHS 111 online in 2017: throughout 2017 there will be testing of innovative new models of service that enable patients to enter their symptoms online and receive advice online or a call back.

    ii. NHS 111: Increase the number of 111 calls receiving clinical assessment to a third by March 2018, so that only people who genuinely need to attend A&E, or use the ambulance service, are advised to do this. Locally the CCGs have been leading on the development of a new Integrated NHS111 for Thames Valley – the new ‘front door’ for urgent care, which will go live from 5th September 2017. This service will offer people access to a seamless 24/7 urgent clinical assessment and treatment service – bringing together NHS 111, GP out of hours and other clinical advice, such as dental, medicines and mental health. The new service has been developed around the patient, with a team of clinicians available on the phone when needed, and is linked into a new NHS Clinical Hub, a group of healthcare professionals who can help get the patient the right care at the right time, in the right location. Where social care is accessed via the Berkshire Hub this will also be included. The service will also provide Specialist Palliative Care

advice and support for patients, their families and carers 24/7 365 days a year, the service that was previously provided by Palcall.

iii. Expanding evening and weekend GP appointments to 50 per cent of the public by March 2018, then 100 per cent by March 2019: The ambition is for 100% of practices to be providing extended access by end of 18/19.

iv. Roll out of around 150 standardised 'urgent treatment centres' to offer diagnostic and other services to people who do not need to attend A&E: Will be considered as part of the development of the Berkshire West local plan.

v. Comprehensive front-door clinical screening at every Acute hospital by October 2017: Streaming at the front door will speed up clinical decision making ensuring that people with non-life threatening illness can be immediately directed to a service that better meets their needs. Plans for this are being developed locally and RBH were fortunate to be allocated national capital monies to support the development of their building infrastructure to support the new model of care at the front door of ED. This will be a Primary/Ambulatory Care model encompassing the following:

- Minor injury stream: This will operate 24/7 365 days per annum. It will remain nurse-led as now with low tech diagnostics with no proposed changes to clinical pathways or current governance arrangements.
- Minor illness stream: This will operate 0800 – 2300 365 days per annum. It will be GP and nurse-led with access to low tech diagnostics and prescribing but will not be a GP Practice. This element of the model will be commissioned on a trial basis pending the development of Primary Care Hubs in Reading as it is expected that these hubs will negate the need for the service to be based at the Acute Trust in future.
- Ambulatory Care stream: This will operate 1000 – 2200 365 days per annum. It will be Consultant led with GP input and deliver ambulatory care pathways supported by rapid access diagnostics.
- The Primary Care service being commissioned will deliver the minor illness stream but also perform an important function within the ambulatory care streaming model operating at the front door of RBH. Dr Andy Ciecierski, the CCGs Clinical Lead for Urgent Care is currently working with Dr Will Orr, Clinical Lead for Urgent Care at RBH on a review of ambulatory care pathways.

vi. Hospital to Home: Hospitals, primary care, community care and local authorities working together to address delayed transfers of care. This will include ensuring that a proportion of the £1bn provided for adult social care in the Spring Budget is used to address delayed discharges, freeing up 2,000-3,000 acute hospital beds. The CCGs have been working closely with health and social partners to ensure that patients are sent home as soon as possible and if home is not the most appropriate place for their needs, that they will be promptly transferred to the most appropriate care setting for their needs. We have assessed our current practice against the "8 High Impact Actions For Discharge" and our response to this is contained in the DTOC action plan that will be submitted as part of our Better Care Fund submission.

vii. Ambulances: Implementing the recommendations of the Ambulance Response Programme by October 2017, freeing up capacity for the service to increase their use of Hear & Treat and See & Treat, thereby conveying people to hospital only when this is clinically necessary:

5. For South Central Ambulance the focus will be on:

- Quicker recognition of life threatening conditions(through rollout of the national ambulance response programme)
- Delivery of a more clinically focused response for patients linking into the Integrated Urgent Care service to offer a wider range of alternatives to conveyance to hospital
- Ending long waits for an ambulance and minimising hospital handover delays.

6. This will be delivered by developing the ambulance workforce, increasing their diagnostics and assessment skills, thus enhancing the assessment and treatment provided outside the hospital setting.

Next Steps

7. The Berkshire West A&E Delivery Board which comprises partners from health and social care in Berkshire West is responsible for developing and ensuring implementation of a local action plan in response to the requirements of the Delivery Plan. This is in addition to an STP wide Urgent and Emergency Care Plan currently being developed which deals with those aspects which require a BOB (Berkshire West, Oxfordshire and Bucks) wide response. These are primarily around ambulance services and NHS 111 and are as follows:

- Development of a Service Development plan for NHS 111 Integrated Urgent Care service are across health and social care
- Increased visibility and access to alternative community based services to be directly accessed by the ambulance service
- Enhanced Directory of Services to underpin the response to 111 and 999 calls
- Innovative use of the primary care workforce including their role in Integrated Urgent Care
- Building on existing good practice to develop consistent ambulatory care pathways
- Development of consistent metrics across the acute sector to support analysis of pressure points and heat maps
- Hospitals developing a more consistent interface with Councils for Drug and Alcohol services
- STP workforce plan for community based care
- Co-design of onward care services (including Domiciliary Care) with the Independent sector focused on outcomes

8. Our local A&E Board had a focused workshop on 22th June to develop the local plan and this will be presented to the HWBB in October together with the Thames Valley STP Plan.

Partner Implications

To help manage the increasing demand on urgent and emergency care, local services need to continue to support people in their own homes as far as possible. People attending hospital need to be treated in a timely way and discharged as soon as possible, with appropriate support services in place, such as step-down beds, social care and short-term reablement.

Reasons for considering the report in Part 2
Not applicable

List of Background Papers
None

Contact Katie Summers	**Service** NHS Wokingham CCG
Telephone No 07770 444645	**Email** katie.summers2@nhs.net
Date 01/08/2017	**Version No.** 1

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TITLE	**Wokingham Borough Health and Wellbeing Strategy 2017-2020 - Action Plan Update**
FOR CONSIDERATION BY	Health and Wellbeing Board on 10 August 2017
WARD	None Specific
DIRECTOR/ KEY OFFICER	Judith Ramsden, Director of People Services

Reason for consideration by Health and Wellbeing Board	The new 2017-2020 Health and Wellbeing Strategy and its Action Plan have now both been agreed by the Board. This paper outlines some issues pertinent to finalising a set of metrics which will be used to monitor progress towards the implementation of the strategy, both in terms of outcomes and process.
Relevant Health and Wellbeing Strategy Priority	All.
What (if any) public engagement has been carried out?	The strategy has its roots in responding to the population needs identified in the Joint Strategic Needs Assessment (JSNA) for the Borough and has had the benefit of the input from all Board members who bring their knowledge and expertise of issues from the agencies they represent.
State the financial implications of the decision	There are no financial implications associated with this report.

OUTCOME / BENEFITS TO THE COMMUNITY

The priorities contained within the Health and Wellbeing Strategy and the action plan contain a diverse set of actions which aim to improve the health of people in Wokingham Borough. The Board must have regular assurance from an agreed performance framework that actions taken to meet the strategic aims do indeed lead to improved health and wellbeing in the population as intended.

RECOMMENDATION

That the Board discuss what measures it wishes to monitor in order to assess the implementation of the Strategy Action Plan and what measures it wishes to in order that it may have a clear understanding of the health of the local health and social care system.

SUMMARY OF REPORT

The four priorities of the Health and Wellbeing Strategy are as follows:

- Enabling and empowering resilient communities;
- Promoting and supporting good mental health;
- Reducing health inequalities in our Borough;
- Delivering person-centred integrated services.

The Public Health Outcomes Framework (PHOF) tracks over 60 major public health outcomes, mostly updated annually. The Board are receiving quarterly exceptions

reports on this. This framework is comprehensive; however the priorities and action plan for the strategy were not designed to provide a fit to the framework outcomes, and in order to address performance of the strategy, new process and outcome measures will be required. Work is underway to identify options, and these will be presented to the Board at the August meeting for discussion.

Analysis of Issues

The Board will discuss what it wants in terms of process measures and outcome measures to manage performance of its Strategy Action Plan, and also to get an objective view on the health of the local health and social care economy. These two are not mutually exclusive, but may have some overlap. The discussion will identify responsible parties for supplying and analysing performance data.

Partner Implications
The Joint Health and Wellbeing Strategy includes actions for the Council across a range of services as well as those for partner organisations to create a truly joined-up plan. The performance dashboard for the strategy and for the wider health economy should be seen as a joint endeavour and partners are therefore invited to contribute to a discussion on this.
Reasons for considering the report in Part 2
None.

List of Background Papers
Wokingham Borough Health and Wellbeing Strategy 2017-2020 Wokingham Borough Health and Wellbeing Strategy 2017-2020 Action Plan Wokingham Borough Health and Wellbeing Strategy 2017-2020 Draft Performance Report

Contact: Darrell Gale	**Service:** Public Health
Telephone No: (0118) 908 8293	**Email:** Darrell.gale@wokingham.gov.uk
Date: 31st July 2017	**Version No:** 1

TITLE	**Public Health Outcomes Framework**
FOR CONSIDERATION BY	Health and Wellbeing Board on 10 August 2017
WARD	None Specific
DIRECTOR/ KEY OFFICER	Judith Wright, Interim Strategic Director of Public Health for Berkshire

Reason for consideration by Health and Wellbeing Board	It is agreed, as part of the performance metrics for the Board, to update the Board when the quarterly update to the Public Health Outcomes Framework (PHOF) is received.
Relevant Health and Wellbeing Strategy Priority	All.
What (if any) public engagement has been carried out?	Not Necessary The PHOF is, like all Public Health England (PHE) health profiles, available for full public access.
State the financial implications of the decision	None directly. Investigation and new initiatives to change outcomes with which the Board is concerned may require shifts in resources for partners directly involved.

OUTCOME / BENEFITS TO THE COMMUNITY

Monitoring the PHOF will inform the Board of areas where performance is improving or deteriorating, and thus services and partners can be asked to intervene where necessary.

RECOMMENDATION

That the Health and Wellbeing Board notes the changes in performance outcomes contained in the Public Health Outcomes Framework (PHOF).

SUMMARY OF REPORT

Significant exceptions highlighted by this report are:

- An increase in the emergency hospital admissions for intentional self-harm; and
- Increases across a range of emergency hospital admissions due to falls in people aged 65 and over.

Both areas would warrant investigation in an attempt to reduce these incidents through interventions which prevent further such incidents.

Background

The PHOF profile for Wokingham was last updated on 15 June 2017, and contains a number of indicators where performance had changed since the previous update. Updates are generally all based on annual measures, which are reported at different periods throughout the year, meaning that in each quarterly update there is usually some exception to report upon where performance has changed.

New indicators are sometimes added, or those that have formed part of the PHOF are updated. In the June 2017, two new indicators for BCG vaccination coverage for areas offering universal BCG (3.03ii) and HPV vaccination coverage for two doses (females 13-14 years old) (3.03xvi) were added.

Updates were made to 25 indicators and sub-indicators including 0.2i – Slope index of Inequality in life expectancy at birth, 0.2v – Slope index of Inequality in healthy life expectancy at birth, utilisation of outdoor space for exercise/health reasons (1.16), and cancer diagnosed at early stage (2.19).

Changes to 18 indicators to take account of revisions to the underlying data or changes in methods. This includes a change in the data source for 1.11 – Domestic abuse related incidents and crimes – current method (this data is not comparable with the previous data source, although this is also presented), and a change in calculation method with revised backdated data for 0.2i, 0.2ii, 0.2iii & 0.2vii –slope index of inequality in life expectancy, 0.2v – slope index of inequality in healthy life expectancy, 1.12i - Violent crime (including sexual violence) - hospital admissions for violence and 2.24 - Injuries due to falls in people aged 65 and over.

A population view has now been added to the page tabs for each local area showing a population pyramid based on the latest ONS population estimates.

Analysis of Issues

The indicators which have shown significant changes since they were last reported are:

Indicator	**Period**	**Value**	**Unit**	**Change from** previous	**Recent trend**
2.04 - Under 18 conceptions	2015	8.1	Crude rate per 1,000	↔	↓
2.10ii - Emergency Hospital Admissions for Intentional Self-Harm	2015/16	176.3	DSR* per 100,000	↑	
2.24i - Emergency hospital admissions due to falls in people aged 65 and over (Persons)	2015/16	2237	DSR per 100,000	↑	
2.24i - Emergency hospital admissions due to falls in people aged 65 and over (Male)	2015/16	1853	DSR per 100,000	↑	
2.24i - Emergency hospital admissions due to falls in people aged 65 and over (Female)	2015/16	2536	DSR per 100,000	↑	
2.24ii - Emergency hospital admissions due to falls in people aged 65 and over - aged 65-79 (Persons)	2015/16	1030	DSR per 100,000	↑	
2.24ii - Emergency hospital admissions due to falls in people aged 65 and over - aged 65-79 (Male)	2015/16	760	DSR per 100,000	↔	
2.24ii - Emergency hospital admissions due to falls in people aged 65 and over - aged 65-79 (Female)	2015/16	1273	DSR per 100,000	↔	
2.24iii - Emergency hospital admissions due to falls in people aged 65 and over - aged 80+ (Persons)	2015/16	5738	DSR per 100,000	↑	
2.24iii - Emergency hospital admissions due to falls in people aged 65 and over - aged 80+ (Male)	2015/16	5022	DSR per 100,000	↔	
2.24iii - Emergency hospital admissions due to falls in people aged 65 and over - aged 80+ (Female)	2015/16	6199	DSR per 100,000	↔	

3.08 - Adjusted antibiotic prescribing in primary care by the NHS	2016	1.10	Rate per STAR-PU*	↓	

*DSR or Direct Standardised Rate is the rate of an event compared with a theoretical population of standardised age. This enables populations with different age structures e.g. Wokingham Borough with Reading, to be compared.

*STAR-PU is the Specific Therapeutic group Age-sex Related Prescribing Unit - a value calculated to reflect not only the number of patients in a practice, but also the age and sex mix of that group.

Red arrows indicate that the increase or decrease in a measure show a negative impact on the public health outcome.

Green arrows indicate that the increase or decrease in a measure show a positive impact on the public health outcome.

Teenage conception rates show a downward change since last reported, continuing this positive trend. There is evidence of a slight increase in those conceptions under 16, however this is not seen as statistically significant.

Emergency Hospital Admissions for Intentional Self-Harm have shown an increase from 91.1 to 176.3. This is still below the England value of 196.5, but is concerning and investigating self-harm will form part of the HWB Strategy Action Plan, and Nationally the next guidance on suicide prevention will support us in understanding self-harm.

Emergency hospital admissions due to falls in people aged 65 and over show increases across five of nine indicators. These could warrant an investigation.

Antibiotic prescribing in primary care by the NHS shows a welcome decrease.

Partner Implications
Partners are advised to note changes in the outcomes that affect their objectives and / or populations served.
Reasons for considering the report in Part 2
None.

List of Background Papers
PHOF Wokingham Borough Profile 2017 PHOF Wokingham Borough Profile 2017 PHE PHOF Indicators at a glance (May 2017)

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HEALTH AND WELLBEING BOARD

Forward Programme from June 2017

Please note that the forward programme is a 'live' document and subject to change at short notice.

The order in which items are listed at this stage may not reflect the order they subsequently appear on the agenda.

All Meetings start at 5pm in the Civic Offices, Shute End, Wokingham, unless otherwise stated.

HEALTH AND WELLBEING BOARD FORWARD PROGRAMME 2017/18

DATE OF MEETING	ITEM	PURPOSE OF REPORT	REASON FOR CONSIDERATION	RESPONSIBLE OFFICER / CONTACT OFFICER	CATEGORY
12 October 2017	**Health and Wellbeing dashboard**	To monitor performance	To monitor performance	Health and Wellbeing Board	Performance
	Community Safety Partnership Strategy	To receive the Community Safety Partnership Strategy	To monitor performance	Community Safety Partnership	Performance
	Local Account of Adult Social Care Services 2016-17	To monitor performance	To monitor performance	Judith Ramsden, Director of People Services	Performance
	Public Health Outcomes Framework - exceptions from each quarter	To monitor performance	To monitor performance	Darrell Gale, Consultant in Public Health	Performance
	Health and Wellbeing Strategy Matrix	To monitor performance	To monitor performance	Darrell Gale, Consultant in Public Health	Performance
	Progress report on the Health and Wellbeing Strategy action plan	To monitor performance	To monitor performance	Darrell Gale, Consultant in Public Health	Performance
	Updates from Board members	To receive an update on the work of Board members	To update on the work of Board members	Health and Wellbeing Board	Organisation and governance

	Forward Programme	Standing item.	Consider items for future consideration	Democratic Services	

DATE OF MEETING	ITEM	PURPOSE OF REPORT	REASON FOR CONSIDERATION	RESPONSIBLE OFFICER / CONTACT OFFICER	CATEGORY
14 December 2017	**Health and Wellbeing dashboard**	To monitor performance	To monitor performance	Health and Wellbeing Board	Performance
	Public Health Outcomes Framework - exceptions from each quarter	To monitor performance	To monitor performance	Darrell Gale, Consultant in Public Health	Performance
	Health and Wellbeing Strategy Matrix	To monitor performance	To monitor performance	Darrell Gale, Consultant in Public Health	Performance
	West of Berkshire Adult Safeguarding Report 2016-17	To monitor performance	To monitor performance	Judith Ramsden, Director People Services	Performance
	Updates from Board members	To receive an update on the work of Board members	To update on the work of Board members	Health and Wellbeing Board	Organisation and governance
	Forward Programme	Standing item.	Consider items for future consideration	Democratic Services	

DATE OF MEETING	ITEM	PURPOSE OF REPORT	REASON FOR CONSIDERATION	RESPONSIBLE OFFICER / CONTACT OFFICER	CATEGORY
8 February 2018	**Health and Wellbeing dashboard**	To monitor performance	To monitor performance	Health and Wellbeing Board	Performance
	Public Health Outcomes Framework - exceptions from each quarter	To monitor performance	To monitor performance	Darrell Gale, Consultant in Public Health	Performance
	Health and Wellbeing Strategy Matrix	To monitor performance	To monitor performance	Darrell Gale, Consultant in Public Health	Performance
	Progress report on the Health and Wellbeing Strategy action plan	To monitor performance	To monitor performance	Darrell Gale, Consultant in Public Health	Performance
	Updates from Board members	To receive an update on the work of Board members	To update on the work of Board members	Health and Wellbeing Board	Organisation and governance
	Forward Programme	Standing item.	Consider items for future consideration	Democratic Services	

DATE OF MEETING	ITEM	PURPOSE OF REPORT	REASON FOR CONSIDERATION	RESPONSIBLE OFFICER / CONTACT OFFICER	CATEGORY
5 April 2018	**Health and Wellbeing dashboard**	To monitor performance	To monitor performance	Health and Wellbeing Board	Performance
	Public Health Outcomes Framework - exceptions from each quarter	To monitor performance	To monitor performance	Darrell Gale, Consultant in Public Health	Performance
	Health and Wellbeing Strategy Matrix	To monitor performance	To monitor performance	Darrell Gale, Consultant in Public Health	Performance
	Updates from Board members	To receive an update on the work of Board members	To update on the work of Board members	Health and Wellbeing Board	Organisation and governance
	Forward Programme	Standing item	Consider items for future consideration	Democratic Services	

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Wokingham Borough Health & Wellbeing Board

Glossary of Terms: Updated 1st August 2017

- **ACS** – Accountable Care System: These involve a provider or, more usually, an alliance of providers that collaborate to meet the needs of a defined population. These providers take responsibility for a budget allocated by a commissioner or alliance of commissioners to deliver a range of services to that population, and then work under a contract that specifies the outcomes and other objectives they are required to achieve within the given budget, often extending over a number of years. Variations on these core elements centre on the involvement of general practitioners in the network of providers delivering care and of local authorities as providers and commissioners of services. (Kings Fund, 2017)

- **ARP** – Ambulance Response Programme

- **AUD** – Alcohol Use Disorders

- **BCF** – Better Care Fund: The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible. The BCF has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them integrated health and social care services, resulting in an improved experience and better quality of life.

- **BHFT** – Berkshire Healthcare NHS Foundation Trust: The community and mental health provider Trust for Berkshire.

- **BSEP** – Business, Skills and Enterprise Partnership

- **C&B** – **(Choose and Book):** A national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.

- **CALM** – Campaign Against Living Miserably: A suicide prevention organisation targeting men

- **CAM** - Confusion Assessment Method

- **CAMHS** – Child and Adolescent Mental Health Services

- **CBNRT** - Community Neuro Rehabilitation Team

- **CCG** – Clinical Commissioning Group

- **CDU** – Clinical Decisions Unit

- **CHASC** - Community Health and Social Care

- **CHD** – Coronary heart disease
- **CHIMAT** – Child Health Profiles
- **CNS** – Clinical Nurse Specialist
- **Community Enhanced Service:** A service provided in a community setting which goes above and beyond what is normally commissioned by NHS England, including primary care services that go beyond the scope of the GP contract.
- **Contract Query Notice:**- A specific action taken by the commissioner against the Provider as per the contract. It is a notice served when a contractual target is not being met. As a result of such a notice, an action must be agreed that results in recovery of performance within a set timescale.
- **COF** - Commissioning Outcomes Framework
- **Commissioning**: The process used by health services and local authorities to: identify the need for local services; assess this need against the services and resources available from public, private and voluntary organisations; decide priorities; and set up contracts and service agreements to buy services. As part of the commissioning process, services are regularly evaluated.
- **COPD** – Chronic obstructive pulmonary disease
- **CoSRR** - Continuity of Services risk rating
- **CPA** - **Care Programme Approach:** A system of delivering community mental health services to individuals diagnosed with a mental illness
- **CPN** - Community Psychiatric Nurse
- **CQC** – Care Quality Commission
- **CQUIN** – **Commissioning for Quality and Innovation:** An incentivised financial reward scheme that has been developed to allocate payments to providers if they meet quality outcomes identified to improve local quality issues.
- **CST** - Cognitive Stimulation Therapy
- **CSU** - Commissioning Support Unit
- **DALYs –** Disability Adjusted Life Years: One DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability (WHO).
- **DAAT** – Drugs and Alcohol Team
- **DHR** – Domestic Homicide Reviews

- **DPH** – Director of Public Health
- **DTOC** – Delayed Transfer of Care
- **ECIST** - Emergency Care Intensive Support Team
- **ECO** – Emergency Operations Centre
- **EDT** – Electronic Document Transfer
- **EIP** – Early Intervention Psychosis
- **EOL** – end of life care
- **EPR** – **Electronic Patient Record:** Means of viewing a patient's medical record via a computerised interface.
- **ESD** – Early Supported Discharge service: Pathways of care for people transferred from an inpatient environment to a primary care setting to continue a period of rehabilitation, reablement and recuperation at a similar level of intensity and delivered by staff with the same level of expertise as they would have received in the inpatient setting.
- Frimley
- **FPH** – Frimley Park Hospital
- **GMS** – General Medical Services
- **GRACe** - General Referral Assessment Centre
- **Health inequalities:** The gap in health status and in access to health services between different groups, for example, those with different socioeconomic status or different ethnicity, or populations in different geographical areas.
- **Health-related quality of life:** A combination of a person's physical, mental and social well-being; not merely the absence of disease.
- **HCA –** Health Care Assistants
- **HIPI** – Health Impact of Physical Inactivity
- **HWPFT** - Heatherwood and Wexham Park Hospitals NHS Foundation Trust (Now part of Frimley Health)
- **IAPT** - Improving Access to Psychological Therapies
- **Incidence:** The number of new cases of a disease among a certain group of people during a specific period of time. It is different from prevalence.

- **JSNA** – Joint Strategic Needs Assessment
- **LA** – local authority
- **LAC** – Looked After Children
- **LD** – Learning Difficulties
- **LES** – Local Enhanced Service
- **LOS** - Length of Stay
- **LSCB –** Local Safeguarding Children's Board
- **LSOA** – Lower Layer Super Output Area
- **LTC** – long term conditions
- **MARAC** - Multi Agency Risk Assessment Conference
- **MASH** – Multi Agency Safeguarding Hub
- **MDT** – multi disciplinary team
- **MECC** – Making Every Contact Count:
- **MH** – Mental Health
- **MHFA** – Mental Health First Aid
- **MHP** - mental health practitioner
- **MIU** – Minor Injuries Unit
- **MSLC** - Maternity Services Liaison Committees
- **MVPA** – Moderate to vigorous physical activity
- **Never Events:** Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented
- **NHS Safety Thermometer:** Tool to measure 4 high volume patient safety issues – falls in care; pressure ulcers; urinary infections (in patients with a urinary catheter); and treatment for VTE
- **NICE** – National Institute of Health and Care Excellence
- **NICE advice:** NICE products that update healthcare, public health and social care practitioners on new evidence, or help put NICE guidance into context. They do not contain recommendations. Examples of NICE advice include local government

briefings, evidence summaries - new medicines, and evidence summaries - unlicensed and off-label medicines.

- **NICE guidance:** Evidence-based recommendations produced by NICE. There are 6 types of guidance: guidelines covering clinical topics, medicines practice, public health and social care; diagnostics guidance; highly specialised technology guidance;
  interventional procedures guidance; medical technologies guidance; technology appraisals guidance.

  All guidance is developed by independent committees and is consulted on. NICE may also publish a range of supporting documents for each piece of guidance, including advice on how to put the guidance into practice, and on its costs, and the evidence it is based on.

- **NEET –** Not in Education, Employment, or Training

- **NEA/ NEL** - Non elected admissions

- **OBPs** – Out of Borough Placements

- **ONS** – Office of National Statistics

- **OOH** – Out of Hours

- **OPMHS** – Older Persons Mental Health Services

- **OT** – Occupational Therapy

- **Outlier** - a person or thing situated away or detached from the main body or system.

- **PALS** – Patient Advice and Liaison Service

- **PHE** – Public Health England: An executive agency that delivers services to protect the public's health through a nationwide integrated health protection service, provides information and intelligence to support local public health services, and supports the public in making healthier choices.

- **PHOF** – Public Health Outcomes Framework

- **PMS** – Primary Medical Services/ Psychological Medicine Service

- **Prevalence:** How common a disease or condition is within a population, either at a point in time or over a given period of time (it includes new and existing cases). It is different from incidence.

- **PROMs** - **Patient Reported Outcome measures** are questions asked of patients before and after a specific treatment, to measure improvements to quality of life from the patient’s point of view.

- **QALY - Quality-Adjusted Life Year**: A measure of the state of health of a person or group in which the benefits, in terms of length of life, are adjusted to reflect the quality of life. One QALY is equal to 1 year of life in perfect health. QALYs are calculated by estimating the years of life remaining for a patient following a particular treatment or intervention and weighting each year with a quality-of-life score (on a 0 to 1 scale). It is often measured in terms of the person's ability to carry out the activities of daily life, and freedom from pain and mental disturbance.

- **QIPP** - **Quality, Innovation, Productivity and Prevention.** The purpose of the programme is to support commissioners and providers to develop service improvement and redesign initiatives that improve productivity, eliminate waste and drive up clinical quality.

- **QOF - Quality and Outcomes Framework** : A national incentive scheme for all GP practices in the UK, which rewards them financially for how well they care for patients. Under the scheme, GP practices score points according to their level of achievement against a series of indicators, such as the percentage of patients with a new diagnosis of a disease who are referred for certain tests. NICE makes sure the clinical and health improvement indicators used in the scheme reflect new evidence and rising service standards.

- **RAT** – Rapid Access Treatment

- **RBFT/ RBH:** Royal Berkshire NHS Foundation Trust. Acute hospital trust working from the Royal Berkshire Hospital

- **RCA** – **Root Cause Analysis** - When incidents happen, Roots Cause Analysis Investigation is a means of ensuring that lessons are learned across the NHS to prevent the same incident occurring elsewhere.

- **RCT - Randomised controlled trial:** A study in which a number of similar people are randomly assigned to 2 (or more) groups to test a specific drug, treatment or other intervention. One group (the experimental group) has the intervention being tested, the other (the comparison or control group) has an alternative intervention, a dummy intervention (placebo) or no intervention at all. The groups are followed up to see how effective the experimental intervention was. Outcomes are measured at specific times and any difference in response between the groups is assessed statistically. This method is also used to reduce bias.

- **RGN** - Registered General Nurses

- **RMN** - Registered Mental Health Nurses

- **RTT** - **referral to treatment time: Wa**iting time between being referred and beginning treatment.

- **SCAS** – South Central Ambulance Service

- **SCR** – **Summary Care Record:** Electronic record which contains information about the medicines you take, allergies you suffer from and any bad reactions to medicines you have had in the past.

- **SIRI** – Serious incidents that require investigation
- **SLA** – Service Level Agreement
- **SME** – Small and Medium Enterprises
- **SOBS -** Survivors of Bereavement by Suicide: A national charity providing local support to those bereaved by suicide. There are groups in Wokingham & Newbury
- **SPIN** – Suicide Prevention and Intervention Network
- **SPOC** – Single point of contact
- **SRG** – Systems Resilience Group
- **STAR-PU** - **Specific Therapeutic group Age-sex Related Prescribing Units:** A way of weighting patients to account for differences in demography when distributing resources or comparing prescribing.
- **START** – Short Term Assessment and Reablement Team
- **STP** – Sustainability and Transformation Plan
- **SUSD** – Step Up Step Down
- **Tertiary care**: Care for people needing complex treatments. People may be referred for tertiary care (for example, a specialist stroke unit) from either primary care or secondary care.
- **TVPCA** – Thames Valley Primary Care Agency
- **TVPS** – Thames Valley Positive Support – support to those affected by HIV and HIV testing in Berkshire.
- **UCC** – Urgent Care Centre
- **VTE** - venous thrombosis - blood clot that forms within a vein
- **WBCH** – West Berkshire Community Hospital
- **WIC** – Walk in Centre
- **WISP** – Wokingham Integration Strategic Partnership
- **WTE** - whole-time equivalents (in context of staff)
- **YLL** – years of life lost
- **YPWD** - Younger People with Dementia
- **YTD** – Year to date

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