Wokingham Integration and Better Care Fund Narrative Plan 2017/19

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1. Introduction

The Wokingham health and social care system is very proud of our success in integrating services. Our approach to integration focuses on:

- supporting Wokingham residents in only telling their story once.
- working on keeping people at their usual place of residence.
- shifting traditional hospital provided care delivery into the community.

Our integration programme is centred around the service users' journey, as illustrated in 'Sam's Story' https://youtu.be/Z3XDy2jzSb4.

We are pleased to present the third Better Care Fund (BCF) plan, following on from the 2014 and 2016 plans. This plan covers two years, from 2017 to 2019. In 2014 Wokingham Clinical Commissioning Group (CCG) and Wokingham Borough Council (WBC) made a commitment to work in partnership towards true integration. Since this time we have seen an improvement in services, the delivery of financial benefits, and most importantly, an improvement in resident's care experience.

We will broadly continue with our original plan, with some moderation to reflect progress made and lessons learnt from challenges and successes from the 2014 and 2016 plans. Given our success so far, we aim to achieve BCF graduation status in 2017/18 in order to build on our integration plans, also incorporating mental health services. Our plan describes how we will continue to meet the national conditions with CCG and WBC contributions above the minimum required pooled funds.

The total pooled fund for Wokingham has increased from £9.54m to £9.87m. The CCG is committed to supporting and maintaining the levels of spends in social care and has increased the minimum contribution by 1.8% for 2017/18 and 1.9% for 2018/19.

The plan was signed off by the Wokingham Health and Wellbeing Board (HWB) Chair, the CCG Accountable officer, the CCG Chair, and the WBC Director of People Services on the 8th September 2017 and will be ratified by the HWB on 12th October 2017 and the Wokingham CCG Council on 19th September 2017.

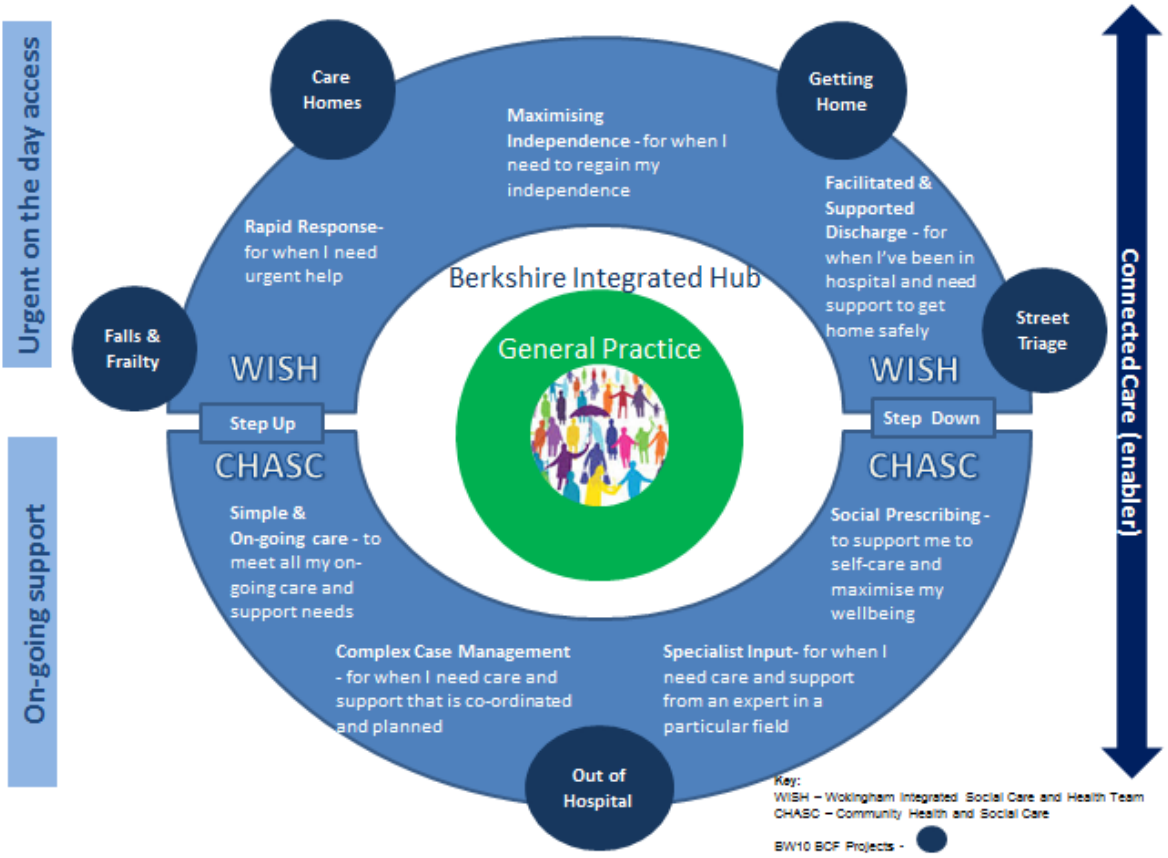
2. What is the local vision and approach for health and social care integration?

Our vision statement: 'Preventing ill health within a growing population and supporting people with more complex needs within the community.'

Our vision for integrated health and social care was developed after Call to Action consultation events and in partnership with all stakeholders in view of the impact of the Care Act 2014, utilising Wokingham's JSNA and Berkshire West CCG's Primary Care Strategy.

Since 2014 we have shaped our vision to reflect stakeholder feedback, developing three core aims: to tell your story once, to remain in your own residence and to shift care to the community. We have translated our vision of Wokingham's integrated services as illustrated below:

Figure 1 Wokingham: User-Focused Health and Social Care System



The new service model focuses on the priorities identified by local people, whilst shifting care out of hospital and delivering effective and efficient services in the community. This aligns completely with the BCF Plan aims of reducing non-elective admissions to hospital, preventing delayed discharges of care, investing in out of hospital services and focusing on preventative services.

We have and plan to continue to deliver on our overall key aims by:

- Providing the right care, by the right people at the right time and in the right place.
- Delivering more easily accessible care seamlessly, across health and social care.
- Supporting people to manage their care and promote health and wellbeing.
- Making the experience of care a more positive one.

Feedback locally and through National Voices has told us that people want the following and we have delivered or plan to deliver this by:

- **People told us they want more care closer to home** – Community Health and Social Care (CHASC) will organise services around GP practices to provide people with access to a wider range of health and care professionals in their local

community. Step-up will enable sub-acute care locally as opposed to attending the acute trust.

- **People told us they want to be seen as people, not conditions** - CHASC and Wokingham's Integrated Health and Social Care team (WISH) will place equal importance on mental and physical health, taking into account people's lives, interests and preferences to provider more holistic and personalised support.
- **People told us that the separation between different services can make it harder to get the right support** – Berkshire Healthcare Foundation Trust (BHFT) has set up the Berkshire Integrated Hub (BIH) so people only need to make one call to access all the services that can help them.
- **People told us they only want to tell their story once** - Connected Care will join up health and social care records so that everyone involved in a person's care has access to the information they need and will help each member of the local health community to look at key items in a person's health and social care record, to improve the integration of services.
- **People told us that waiting for something to go wrong before they get the right support does not make sense** - CHASC supports people to take control of their health and wellbeing to prevent ill health and reduce the amount of time people spend in hospital, through community navigators and MDTs.

By rethinking the way we deliver health and care services across Wokingham Borough, we will transform the system, to secure better outcomes and a more sustainable system for the future. This will include:

- An increased emphasis on prevention, early intervention and empowering individuals to be more independent.
- A further shift of investment from acute and specialist health services to support investment in community-focused provision.
- Exploration by commissioners and providers of new approaches to sharing resources, including knowledge and expertise, where there are demonstrable benefits in doing so.

We are delivering our BCF both locally and through a wider Berkshire West approach. The Wokingham Integrated Strategic Partnership (WISP) comprises of the NHS, social care and voluntary organisations across Wokingham: CCG, WBC, Royal Berkshire Foundation Trust (RBFT), BHFT, Involve (Wokingham voluntary & community sector umbrella organisation), Optalis (social and domiciliary care arms-length provider for WBC) and the Wokingham GP Alliance.

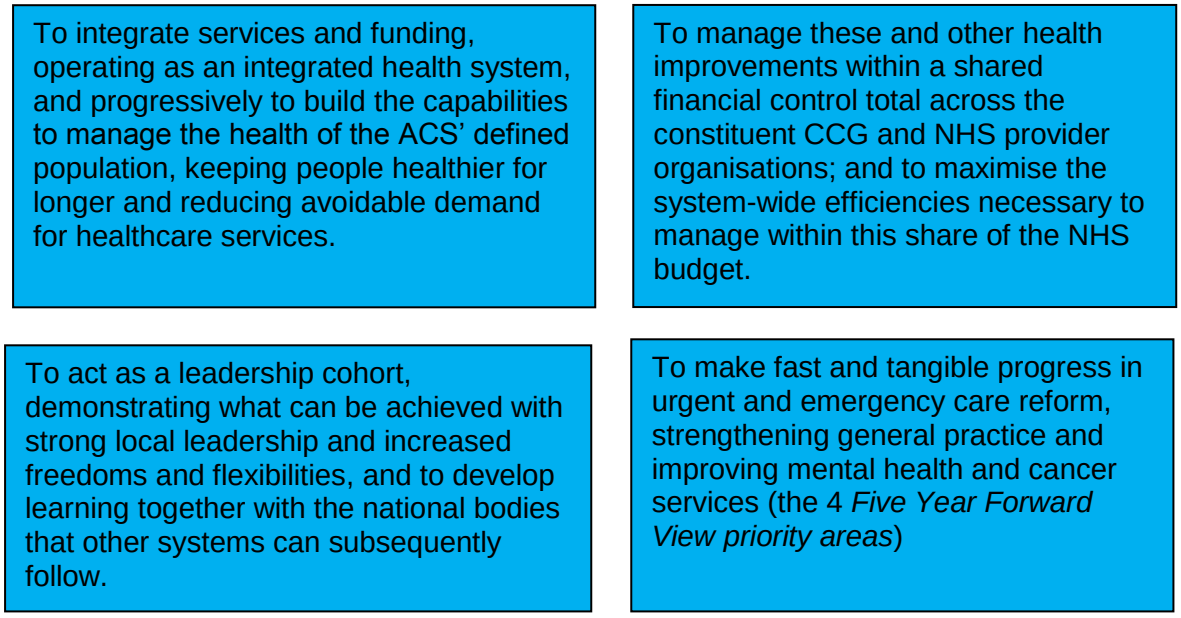
The Berkshire West 10 (BW10) system first came together in 2013, and has continued to progress with the development of a BW10 Integration Programme. The Programme identified three priority areas of work following an initial review of demand and capacity across the health and social care system - Frail Elderly, Children and Young Peoples services and Mental Health. The journey to closer integration is set out our BCF scheme overviews which can be found in Appendices 1, 2 and 3 and the Proposal for Wokingham Adults Integrated Health and Social Care Governance, Appendix 4.

Our partners within the BW10 Programme consist of the four CCGs, the three local authorities, RBFT, BHFT, South Central Ambulance Service (SCAS). Some of our providers - RBFT, BHFT and SCAS provide services across a large footprint,

therefore our Programme feeds into a wider BW10 vision for integration of health and social care.

The Wokingham health and social care system also sits within the Berkshire West Accountable Care System (ACS), which is one of the exemplar sites identified within the Five Year Forward View Next Steps and will support our drive for care integration by 2020. As part of our BCF graduation application we have aligned our programmes of work to fit alongside the Berkshire West ACS. This is in relation to both initiatives and governance.

Figure 2: ACS Key Priorities



Whilst BW10 and ACS are the main drivers for integration across the wider health and social care system, the CCG remains a committed partner to the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability Transformation Plan (STP). The CCG Director of Operations leads on prevention work stream across the BOB footprint.

We are committed to integrating all our adult health and social care services by 2020 and our BCF Programme is the vehicle to deliver this. We have already integrated our short term health and social care teams (BIH) and WISH) and we have robust plans in place to do the same for the long term health and social care teams (CHASC) by the end of 2018/19.

Following a Wokingham workshop in 2016/17 on Integration 2020 with all partners, we are already in development for the following:

- Undertake wider stakeholder consultation – planned for October 2017.
- Implementation Plan rollout - by March 2018.
- More in depth briefings for WISP, HWB and other stakeholders on the rollout – commenced June 2017.
- Undertake wider engagement with town and parish councils – commencing from March 2018.

3. Background and context to the plan

Wokingham borough is a prosperous and a healthy place for most of its residents, but we believe there is much that can be done to make it a better place to live and work. Increasing demand for health and social care services, at a time of downward pressure on NHS and local authority budgets, means that WBC, the CCG and their partners have to consider new ways of working to deliver the outcomes that people need. As a system we have consistently been a top quartile performer whilst being one of the country's lowest funded health and social care systems. Building on successful service transformation, the BCF is providing a platform for developing deeper service integration.

3.1 Key Challenges

In Wokingham, our health and social care system is addressing many challenges:

- Continuing financial pressures, both health and social care budgets need to be made financially viable for now and the future.
- Primary care is under pressure and is at risk due to workforce issues, significant housing growth in the borough and small practices no longer being viable models of delivery.
- Recruitment and retention of adequate numbers of appropriately skilled and experienced staff, that is reflective of pressures being faced across the country,
- The 2015 Autumn Position Statement and Comprehensive Spending Review mandated Upper Tier Local Authorities and the NHS to deliver health and social care integration.
- Increasing demands on services due to an ageing population and increased prevalence of long-term conditions.
- 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 may become overwhelmed, and services are not always accessible in an easy or timely manner.
- Not intervening early enough in a person's disease journey or increasing frailness, which creates bigger demands and greater need.
- The aspirations and needs of the community are changing as people expect more personalised services and more choice and control over how their individual needs are met.

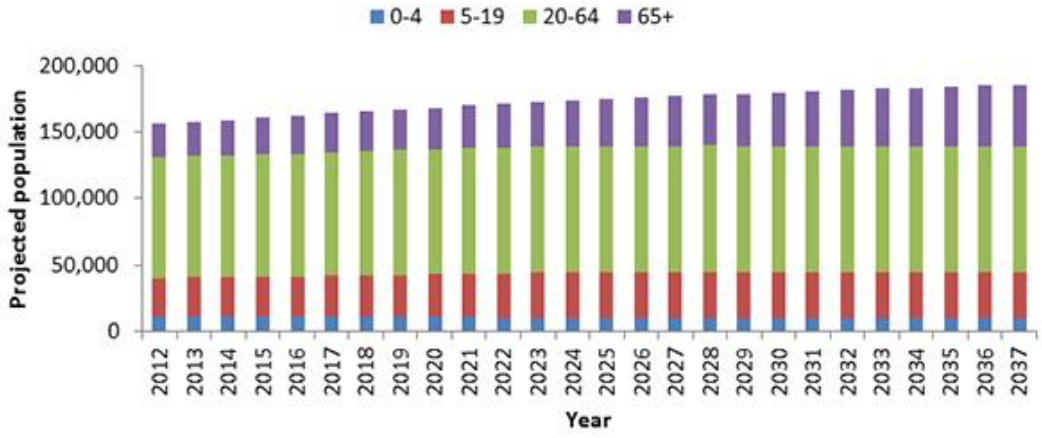
By addressing these challenges we are ensuring that we reduce the variability in health outcomes, inequitable resource allocation, increasing inequalities and increasing costs.

3.2 The needs of our population

The Joint Strategic Needs Assessment (JSNA) identifies three areas of health and wellbeing specific to Wokingham borough to shape our BCF Programme and most recently in the development of CHASC. These areas are "living and working well", "ageing well" and "people and places".

Figure 3 below indicates that there will be an 11.3% rise in the population to 182,256 by 2037 with the number of over 75 year olds set to increase by 83.6%.

Figure 3: Population projection by age groups for Wokingham borough



Source: ONS

Wokingham borough is undergoing a large degree of housing developments, in the form of Strategic Development Locations (SDL). 13,500 new homes are being built between 2016 and 2026; with this influx in housing the population projections produced by the ONS under represent the future populations.

It is important to note that the ethnic mix is becoming more diverse across the Wokingham Borough, with an increase of 1.55% of BME pupils in Wokingham schools in 6months (from July 2016 to January 2017). This is an important trend to monitor as different ethnicities can have differing health needs and co-morbidities.

Figure 4: Wokingham Borough Demographic trends

POPULATION

Additional services for older people, people with long term conditions and carers will be required to meet the needs of the growing population.

- The population of the borough is predicted to increase from 161,400 to 169,000 by 2020
- In addition by 2026 there will be 13,500 new homes in Wokingham Borough
- The number of people living in the borough aged over 75 will increase by 18.5%, from 14,615 in 2015 to 17,320 by 2020

Older People

An increased number of older people will require support, particularly in terms of home care, specialist accommodation and dementia services.

By 2020 it is predicted that:

- The number of people over 65 in the borough living with a long term illness which limits their day to day activity a lot will increase by 19% from 4,442 to 5,290.
- The number of people over 65 living in the borough with dementia will increase by 25%, from 1,873 to 2,340

(source: POPPI)

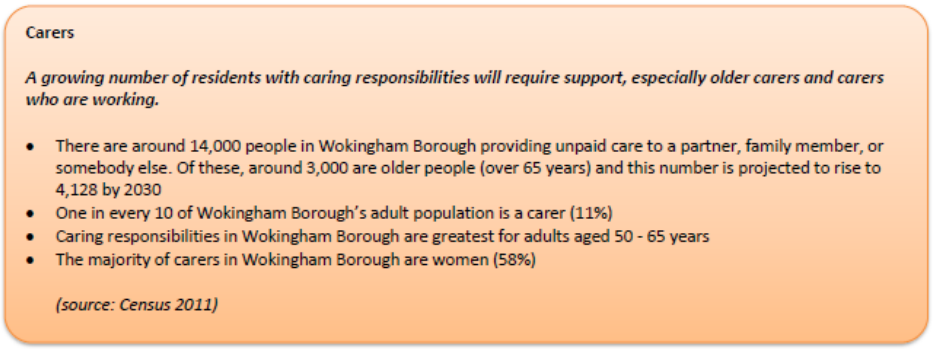
YOUNGER ADULTS

Whilst there is no significant increase in the number of younger adults with social care needs predicted in the near future, more personalised services are needed to better support these residents.

By 2020 it is predicted that:

- The number of people with a moderate to severe learning disability will increase by 2% from 536 to 547
- The number of people aged 55-64 predicted to have a moderate or severe learning disability will increase by 13% from 93 to 107
- The total number of people aged 18-64 with a moderate or serious physical disability living in the borough will increase by 5%, from 10, 093 to 10,570
- The total number of people aged 18-64 with a mental health problem (including personality disorders) living in the borough will increase by 2% from 25,565 to 26,093

(source: PANSI)



Source - Adult Social Care Services - Commissioning Strategy 2016-2021

3.3 Joint Health and Wellbeing Strategy

The Health and Wellbeing Strategy for Wokingham borough has been co-produced with our residents and updated for 2017-2020, with a new action plan to accompany the high-level priorities. This new Health and Wellbeing Strategy sits alongside a number of other plans and strategies that cover either Wokingham borough or a wider footprint.

Rather than looking to cover the whole health and wellbeing agenda, the HWB has agreed four priority areas that it wishes to focus upon:

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

These have been chosen as priority areas because of their importance to improving the health and wellbeing of the people in the borough and they each require a co-ordinated approach from across the health and social care economy. They are closely connected to each other and provide an interlocking set of priorities.

There is also a commitment by the HWB to move beyond the integration of health and social care bringing together a wide range of partners to influence the wider determinants of health including housing, education, regeneration and economic development and, importantly, build on the assets of our people and communities.

3.4 Financial Priorities

A key component of both the CCG and WBC's financial strategy is to maximise the use of resources by ensuring costs incurred are those which deliver the most effective and safe care for people at the best obtainable value.

Both the CCG and WBC have challenging financial targets to meet in 2017/18; the CCG needs to deliver savings of £8m and WBC needs to deliver savings of £6.6m, £1.15m of which is within Adult Social Care (ASC).

Planning ahead to achieve a community delivery system that has a real impact on shifting care out of hospital and delivering quality and efficient services in the community is imperative to ensure we find a way to achieve more and better services with less money. This will result in:

- Better clinical outcomes for people.

- Reducing pressures on acute hospitals.
- Preventing crises in the first place rather than rather than responding to them.

3.5 The Local Care Market

WBC's ASC Market Position Statement 2013-14 and 2016-2021 Commissioning strategy identify key issues (which link to those in **Section 3.1**) within the local social care provider market include:

- Ongoing reduction in the public sector funding.
- High cost of living / shortage of affordable housing in Wokingham Borough
- Impact of a large number of self-funders on local prices.
- Competing for services with other Berkshire Local Authorities.
- Demographic pressures, particularly in terms of meeting the needs of the ageing population, development of services for people with dementia, autism and those with complex needs.
- Transformation of the local market (statutory and non-statutory services) to ensure personalisation and outcomes focused services.

Through BCF monies, the care market is being supported to stabilise and innovate. In particular, BCF funding is being used to develop new models of residential and nursing care; support providers of complex and specialist packages develop services that support residents to manage themselves before reaching a crisis and directing them to services that are run by the third sector e.g. community navigators.

3.5.1 Current Market Position

In advance of publishing a current Market Position Statement (MPS) – the MPS is currently being reviewed by WBC but no timelines for the new document have been set - WBC and the CCG are clear on the type of risks within the market following engagement with providers, particularly in terms of sustainability and priority actions that need to be taken as a result. A summary of these is provided below.

Market Sustainability Risks & Pressures

- Shortfalls in supply in the face of increasing demand and a challenged care home market is resulting in fees levels above the WBC rate agreed.
- Concerns that an unintended consequence of very rigorous and robust safeguarding and regulatory action can contribute to the conditions for provider failure.
- Insufficient diversity of providers in the local market for provision of care for those with complex needs.
- Providers' preference for private clients can reduce availability to take social care referrals.
- Housing stock becoming outdated for modern care service requirements.

In response to these pressures, the following priorities have been identified, some of which are included specifically within the BCF schemes and others are being progressed within WBC and/or CCG.

Market Development priorities

- Specific commissions for Discharge to Assess beds are underway which will support the bed mix available and ensure that more people can make decisions

about their long-term care needs away from a hospital setting.

- Further developing commissioner contingency planning systems and providing training for smaller providers on business continuity.
- Demand management through:
  - Better quality conversations with service users and families on alternative ways of meeting needs that promote independence
  - Clearer expectations from published policy positions on choice of care services, top-ups etc.
  - Better outcomes from providers being appropriately incentivised across preventative partnerships, and signposting to more community options to promote independence, avoid escalation of need and reduce the need for intensive packages of care and care home placements.

3.6 General Practice

Wokingham GP Alliance is now part of the National Association of Primary Care's Primary Care Home - Community of Practice. Primary Care Home is about sharing and using best practice and knowledge across the country. A Wokingham cluster-based model has been in development for three years. In April 2017, all 13 practices in Wokingham came together in an alliance structure, underpinned by a memorandum of understanding and run by an executive board. Several early work streams have been identified including shared clinical pharmacist roles, piloting emergency care practitioner-led home visiting, providing pre-operative assessments in primary care and working with the broader adult community services on redesigning outpatients. The GP Alliance is a key member of both WISP and CHASC.

4. Progress to date

4.1 Self-Assessment

In September 2016 WISP used the BCF self-assessment tool to help reflect and review 2016/17 and plan towards 2017/19. The partnerships considered return on investment in terms of impact on reducing non-elective activity and whether the schemes have delivered the High Impact Changes and meet the strategic vision for integrated care across Wokingham. Through this process we identified:

- Areas of activity that are performing well and how we want to build and develop these.
- Projects that have been slower to get off the ground and what might help in terms of resource and/or linking and scheduling with other planned project activity. Areas which aren't performing so well and taking steps to further review, evaluate or redesign.

The scheme summaries of the self- assessment can be found in **Section 4.4.**

4.2 Efficiency

The review builds on the efficiency programme of WBC's 21st Century Programme, an increased focus around the customer journey rather than traditional service directorates or teams. The programme will ensure customers have access to the right people, with the right knowledge and understanding at the right time. Services

will be significantly faster and more cost effective. This includes a plan to review WISH and pathway processes in2017/18. Together we were able to do some detailed analysis of several of our BCF schemes and projects which tracked specific cohorts of people and their ED attendances, outpatient's appointments and admissions. There was positive impact demonstrated in relation to:

- BI Hub.
- WISH Care Homes – Rapid Response and Treatment Team.
- Connected Care – Information Sharing – Infrastructure team.

4.3 Performance

Wokingham's performance against BCF metrics is on a positive trajectory. Notably our baseline performance in many of the metrics was already in the upper quartile, therefore a stretch in improving an already good performance, but as demonstrated below, truly integrating health and care can lead to cost savings, reduction in activity and overall improved satisfaction and experience for users. Throughout 2016/17, a dashboard of measures was monitored to show performance against the four national metrics and multiple local metrics. The 2016/17 performance dashboard can be found in Appendix 5.

In summary, the full year measures showed:

National Metrics:

- Non-elective admissions – Continued improvement - In 2016/17 NEAs were 12,845, a 1% reduction from 2015/16, 12,940.
- Delayed transfers of care – Continued improvement – In 2016/17 monthly average delayed days were 242 a month, a reduction of 16 %, from 2015/16.
- Permanent admissions to care homes – Sustained – In 2016/17 new admissions were 140, a minimal increase from 138 in 2015/16.
- People remaining at home 91 days after reablement – Underperformed- In 2016/17 metric is 73% of people remained at home, a decrease of 4% from 2015/16 when 77% of people remained at home. N.B. This is largely attributable to the recording of customer information into the care management system and taking the metric from ASCOF, which only captures social care activity.

Further detail on the National Metrics can be found in **Section 10.**

4.4 Progress Review

A yearly BCF review of schemes was carried out in September 2016 by WISP. Schemes were reviewed individually, with opportunity for comment/queries/ suggestions by all stakeholders. Each scheme was subsequently evaluated using the 'Evaluating Performance of BCF Schemes' template (Appendix 6). Key points were:

- **The Berkshire Integrated Hub (BIH)-** *Evaluation Performance Score: 84%*
  - Client experience/feedback to be reviewed in the next phase.
  - Measurability to include number of calls resolved at first contact. No issues reported from general practice or acute hospital although social workers felt more information was needed to allow them to progress the call initially.
  - No other health and social care economy has this integrated process at this point. Slough local authority is interested in learning from us about the BIH.

- Marginal savings compared to having previous separate call centres.

- **WISH -** *Evaluation Performance Score: 86%*
  - DToC performing well, with further positive increase expected.
  - Redesign of reablement with therapy led assessment model being implemented – live date from 1 October 2016.
  - Reablement Support Worker enhanced skills set being implemented – to be completed by end of January 2017.
  - Integrated working has been progressed and this is making a key difference – DToC and permanent placement performance improvements.
  - Reported NEA figures and nursing/ care home avoidance figures encompass all WISH related schemes – project lead working on clarifying WISH impact.
  - Reduction in numbers of permanent care placements – more people are receiving domiciliary care in the home instead.
  - Savings on course for delivery against trajectory.

- **Step Up/Step Down -** *Evaluation Performance Score: 68%*
  - Usage had been predominantly Step Down. Lack of referrals for Step Up.
  - As well as reablement opportunities, the scheme had been extended to include complex discharge packages.
  - Benefit to health in the estimated DToC days saved in acute hospital. Small element of NEA benefit.
  - Home First project may affect demand for Step Down. Consideration to be taken to use the flats for 'discharge to assess' to ensure this resource is used to full effect.
  - Service had been pared down to meet demand – staff night cover reduced, 3 flats in use rather than target 8 flats. This provided some financial savings.

- **Domiciliary Care Plus Night responder –** *Evaluation Performance Score 40%*
  - In the planning stages of this scheme, anecdotal evidence suggested it would be well used. In actuality referrals were minimal, despite extensive promotion.
  - Initially there were some issues around bookings and pathway processes, but these were suitably addressed.
  - Client feedback was very positive.
  - This is a costly service and not offering value for money, however targets were almost achieved and some NEA benefits realised.
  - It was agreed the service isn't sustainable as a stand-alone service, but would work well embedded into another service.
  - 6 month pilot was due to end 24 October 2016 – options for the service were offered.
  - There were mixed feelings for the progress of this scheme however stakeholder recommendation was to continue the pilot for a further 3 months. Project management changed to Intermediate Care service, and staffing reduced to better suit service demand, benefits/targets also reduced to reflect changes.
    N.B Following the extension period, this service ceased 26 January 2017. See Appendix 7: Domiciliary Care Plus Night Responder service end project report

- **Care Homes –** *Evaluation Performance Score: 71%*
  Berkshire West-wide:

- Q1 ED activity had been reviewed – 50% activity outside of hours that Care Homes project responds.
- Not quite meeting target on medication review, but more staff recruitment planned which should improve figures.
- Data review - all but one postcode is unique to care homes in the area, so quality should be considered as 99% accurate.
- Self-reported performance is different to the business case profile. Baseline targets were initially forecast against month 9 of 2015/16. Updated data now available and more realistic targets set.
- Phased roll out complete to all 52 care homes in Berkshire West area.
- Unfilled geriatrician post may have impacted on RRAT success in Q1, although local geriatricians have supported in the interim.
- Review underway of a number of care homes contributing to NEA.

Wokingham Locality relevance:

- Of 176 residents treated by RRAT, 94 were Wokingham residents.
- Wokingham has the greater amount of care homes in Berkshire West (22:55)
- WISH team has seen an improvement in reduction of NEA admissions to Wokingham care homes in Q1.
- Risk share monies for Q1 were discussed – Commissioning Support Unit (CSU) are evaluating Care Homes project across Berkshire West. Q1 calculations received, targets not achieved therefore no risk share monies released. Understaffing of the project has been recognised, with will provide some cost savings – CSU to investigate further.

- **CHASC**

  Primary Prevention and Self Care **-** *Evaluation Performance Score: 74% Evaluation scoring did not include: Plans and outcomes (as yet unidentified) and it was uncertain whether the scheme evidentially supported people at that point.*

  - Project title change from Neighbourhood Clusters to CHASC.
  - Progress had been delayed for a 3 month period whilst a new project manager was appointed (July 2016).
  - PID being reviewed.
  - Scheme reflects a whole system approach with links into secondary services/specialists when needed. May help to reduce referrals.
  - No scheme investment, only project costs (reduction on previous year).
  - Agreed to continue supporting this scheme and invest in the service.

  Community Navigator **-** *Evaluation Performance score (separate to Primary Prevention and Self Care element of CHASC): 76%*

  - Service delivery underway (prior to CHASC service implementation)
  - Communication strategy and implementation underway to drive growth of the service. Referrals mainly received from GPs, need to encourage other services to refer and promote this scheme.
  - Benefits measured by self-reporting using the ‘Ladder of Change’ tool (outcomes based measure).
  - Running costs are minimal; budgets for 2017/18 & 2018/19 include costs for provision of voluntary/charity services.
  - Outcomes need to be reviewed, including NEAs.

4.5 Key initiatives

Key initiatives in our BCF Plan relate to implementing the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care. The High Impact Change Model sets out eight high impact changes that can support local health and care systems reduce delayed transfers of care:

Change 1: Early Discharge Planning.
Change 2: Systems to Monitor Patient Flow.
Change 3: Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector.
Change 4: Home First/Discharge to Assess.
Change 5: Seven-Day Service.
Change 6: Trusted Assessors.
Change 7: Focus on Choice.
Change 8: Enhancing Health in Care Homes.

Getting Home has been identified as a key priority by the Berkshire West A&E Delivery Board and BW10 Delivery Group to support the delivery of 3 of the high impact changes. It aims to promote good practice across the system to reduce both DToCs and NEAs, by improving patient flow. The system will then move towards a position whereby a complete, integrated and trusted assessment is undertaken at the front door of the hospital. Common documentation will be developed to support completion of a clinical and functional assessment which is trusted, shared and not repeated.

The aspiration would be for fully integrated discharge to assess arrangements to be in place for all complex discharges with full assessment of long-term needs being carried out outside of hospital. This will support the majority of patients being able to be discharged from the hospital on their Estimated Date of Discharge with flow maintained 7 days per week.

WISH is our main local scheme which supports the transfers of care with all other schemes acting as enablers. Further information can be seen in **Section 11**.

4.6 Progress of the 2016/17 national conditions

The table below summarises our progress in 2016/17.

Figure 5: National conditions achievements 2016/17

National Conditions 2016/17	Progress achieved in 2016/17
Plans Jointly Agreed	As detailed in our plan BHFT, RBFT, local GPs and ASC all continued to be part of the integration implementation teams. Providers are represented on WISP and are invited to HWB on a regular basis to present information on specific issues. WISP undertook a joint review of schemes for 2016/17.
Maintaining the Provision of Social Care	The core funding for protecting ASC has been maintained year-on-year. Within the total funds available for 2016/17 in the Local Authority hosted Pool, we increased the investment in the Integrated Short Term Health & Social Care teams by £248k compared to 2015/16.
7-Day Services	We have developed a number of 7 day services, including our BI Hub that is available to take referrals and pass onto relevant services seven days of the

	week, facilitating discharge over the weekend. We adopted a whole system whole week approach to ensure that a full range of health and social care services is available 7 days a week. This has been achieved by our integrated short-term team working across a seven day pattern and increasing weekend working by the social work element of this team embedded in the acute trust at weekend, this supports flow of delivery on the weekend and early on a Monday . The delivery of a 7 day rapid response service has been achieved and is ongoing; this has significantly supported the prevention of unnecessary admissions across the 7 day a week. The expansion and refocus on a 7 day rapid response service will significantly support prevention of unnecessary admissions and will be available 7 days a week.
Data Sharing on the NHS Number	We have established a BI Hub call centre at which staff can access both their legacy systems (Rio and Frame Work I) and Connected Care records. All referrals going through the BI Hub can share information with the WISH team, and look up more detailed medical information as appropriate; facilitating the "right service at the right time" aspiration for our local services.
Joint Approach to Assessment	Health and social Care providers evaluated our 2016/17 schemes along with other stakeholders agreed the continuation and varied business cases through our Local integration board. At a more strategic level both main provider trusts have articulated the impact of the BCF in their operating plans. Our BCF projects have been developed and rolled out over a series of WISP meetings involving RBFT, BHFT, WBC, Optalis, Involve and primary care. These meetings have acted as a local catalyst to co-develop new programmes, drawing on provider views about local pressures and opportunities to work differently to achieve better outcomes. Providers are represented on WISP and are invited to HWBB on a regular basis to present information on specific issues. This will all continue in 2017/19.
Agreement on the Consequential Impact of Change	To meet our challenges and overcome the barriers to change in the current system, Berkshire West CCGs along with RBFT and BHFT have established a New Model of Care to operate as an ACS. The ACS is a collective enterprise that will unite its members and bind them to the goals of the health system as a whole. In so doing we will hold ourselves collectively to account for delivering the necessary transformation of services and in getting the most out of each pound spent on the NHS within Berkshire West. Under the new ACS chair, Luke March, a draft strategy has been produced for the NHS in Berkshire West. The ACS is planning to 'see primary care organised into larger "hubs" of practices, around which extended community services can be organised.' This fits with Wokingham's schemes within the BCF, for example - BCF 02 WISH short term team, BCF 03 Step Up /Step Down, BCF 08 CHASC.
Agreement to invest in NHS out of hospital commissioned services	£2,171k of ring fenced funding for out of hospital commissioning and risk share element on NEA reductions was included within the Wokingham plan. The plan included spends totalling £3,644k on out of hospital commissioning and £448k on risk share, exceeding the ring fenced funding by £1,922k. The investment made was predominantly in short term intervention activity, aimed to providing greater support in the home and in care home settings to avoid NEA activity and allow for earlier discharge. In addition, the plan included further investment in Step Up / Step Down beds to provide greater capacity to provide an intermediate care facility with reablement support to avoid admissions and assist with earlier discharge.

We will continue to progress work against the former national conditions 3, 4 and 5 by:

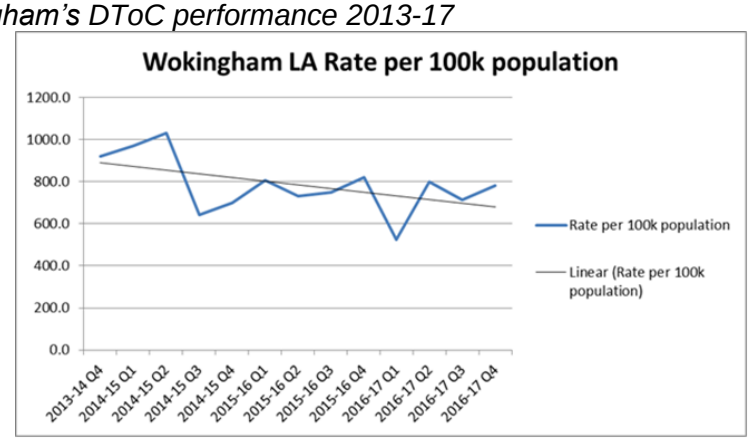
- National condition 3: 7 day services. Continuing to develop 7 day services where they are appropriate and financially viable e.g. Step Up.

- National condition 4: Data sharing on NHS number. A key enabler to supporting the patient's journey is the sharing of health and social care records. Connected Care is the first programme (Appendix 3) in the country whereby all health and social care records from our partner organisations are shared at this scale and is already showing demonstrable benefits from patient's experience, workforce efficiency and reducing duplication. Across Berkshire there are 17 different organisations that hold data in one or more systems relating to an individual's health, social care and wellbeing. There are different cultures, systems & technology, processes and legislation which drives each of the organisations it is always difficult to get a single view of a person at a point in time, and these are mitigated by strong leadership from the Connected Care project board and strategic planning across health and social care, developing our Local Digital Roadmap. What the Connected Care solution offers is the ability to have a single point of access to a person's health and social care records giving accurate and up to date information at the point in time of accessing the data. This supports the different integrated services in the following ways:
    - No need for multiple laptops to access health and social care data separately
    - Access to real time data reducing the need for phone calls to various organisations to collate pieces of information
    - Reduce the amount of time required to contact the relevant organisations in relation to a person.
    - More accurate data
    - The ability to streamline the integrated services better by creating true single assessments
    - The ability to streamline the transfer of a person from one service to another by developing health and social care pathways
- National condition 5: Joint approach to assessment. A key element of the CHASC service is the development of a joint approach to assessments and care planning ensuring that, where funding is used for integrated packages of care, there will be an accountable professional.

4.7 DToC Review of 2016/17 performance

We have improved our performance on 2015/16 and narrowly missed achieving our targets set for 2016/17, with our overall performance year on year showing a continued downward trajectory, the reverse of the national trend (Figure 6).

Figure 6: Wokingham's DToC performance 2013-17



We set our DToC 2016/17 target of 3516 delayed days in March 2016 and excluded mental health delayed days in this target. Once we started measuring our performance it became clear that BHFT include mental health delayed days in their figures, with a total of 3751 delayed days for 2016/17, 7% above our target. We have adjusted our target for 17/18 to take this into account. If we remove the mental health delayed days we would have over performed against the target by 13% (445 delayed days).

There are a number of factors that drove our DToC performance:

- The WISH team is now co-located for better cooperative working.
- Joint management meetings are held regularly.
- Our Hospital Liaison Team (HLT) is a dedicated hospital discharge team with a clear focus on facilitating timely discharges thus reducing delayed transfers of care. The team work to clear aims and objectives and understand their roles and what is expected of them.
- Information sharing, for example, the weekly circulation of the delays, enabling the team to understand exactly where there are pressures, performance targets are very clear and the team have goals to aim for.
- Analysis of any delay over 5 days is completed weekly, which informs exactly where the delays are situated, within Health, Social Care or self-funding patients. This provides information on the areas where Social Care needs to focus on improvements.
- Compulsory meeting agendas on integration and Nurse Led Rapid Response service commenced in September 2016, with the aim of reducing NEAs.
- The Berkshire West Choice policy has been implemented to address one of the two key areas resulting in delays, that being private funders. This is a work in progress and is monitored for support to the delay avoidance. Continued Health Care (CHC) was the second area of delay, there is now a target set by RBFT that all CHC check lists are to be achieved in 48 hours, feedback is that they are achieving 24 hours.

5. Better Care Fund plan

The table below shows the Wokingham and BW10 BCF Schemes and the associated partnership leaders that are overseeing the schemes and which will be monitored. Some of the year 2 detail will be confirmed during year 1.

Figure 7- 2017-19: Wokingham and BW10 BCF Scheme management

Scheme No	Scheme Name	Health and/or Social care	Scheme Leadership
BCF 01	The Berkshire Integrated Hub. Includes Wokingham Information Network (WIN)	Health and Social care	SRO - David Cahill, Director – Wokingham Locality, BHFT
BCF 02	WISH – Wokingham Integrated Health and Social Care team. Incorporating Step Down project from Jul 2017 (split from BCF 03 SUSD); project renamed Time to Decide.	Health and Social care	PM/SRO -Martin Sloan, Head of WISH Team, BHFT
BCF 03	Step Up (previously Step Up/Step Down, aka SUSD)	Health	SRO - Heidi Ilsley, Head of Adults and Older People's Services, BHFT
BCF 06	Care Homes Berkshire West scheme incorporating Care Homes scheme and reframed Hospital at Home service, and Rapid Response and Treatment (RRAT) for Care Homes	Health	PM - Kam Purewall, Transformation Lead – Care Homes Programme, Wokingham CCG, and Martin Sloan, Head of WISH Team, BHFT SRO – Sam Burrows, Director of Strategy, Berkshire West CCGs
BCF 07	Connected Care	Health and Social care	PM - John Devine, Project Manager - Digital Transformation, NHS South, Central and West CSU. Barbara Sorkin, Project Lead for Wokingham implementation SRO – Katie Summers, Director of Operations - NHS Wokingham CCG
BCF 08	CHASC – Community Health and Social Care (Includes Community Navigator service) Previously titled Neighbourhood Clusters, Primary Prevention and Self-Care	Health and Social care	PM - Michele Hayman-Joyce, Service Transformation Lead, CHASC, WBC SROs – Katie Summers, David Cahill and Judith Ramsden, Director of People Services, WBC
BCF 10	Getting Home	Health	PM - Jenny Reaper, Berkshire West CCGs SRO- Tandra Forster, Head of ASC, West Berkshire Council & Janet Lippett, Care Group Director, RBFT
BCF 11	Out of Hospital	Health	SRO – Eleanor Mitchell, Director of Operations, South Reading CCG
BCF 12	Street Triage – Mental Health	Health	SRO – Bev Searle Director of

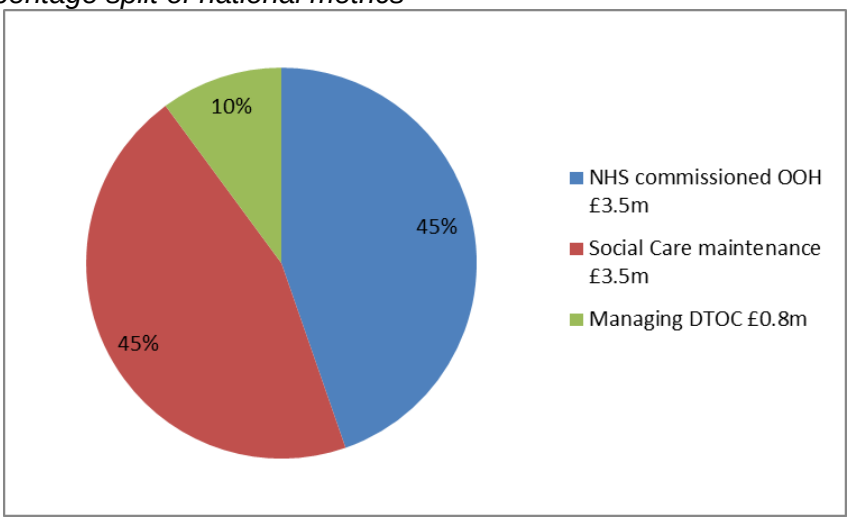
			Corporate Affairs, BHFT
BCF 13	Falls and Frailty - South Central Ambulance Service project	Health	SRO – Carolyn Lawson, Transformation Manager Urgent Care, Berkshire West CCGs

Our programme over the next 2 years (see Wokingham's Summary on a Page – Appendix 8) will continue in the work stream areas outlined in Wokingham's 2016/17 BCF submission. However there have been 3 changes to the Wokingham BCF plan to reflect learning:

- Our BCF programme will move in line with the BW10 ACS. During 2017/18, Wokingham will build on our integration success to bolster governance and partnership working. During Q1, WISP will work towards establishing an enhanced Section 75 agreement. The purpose of this does not seek to replace or in any way override existing service contracts (i.e. contracts between the Commissioner and the Provider for delivery of care). Instead, it will bring organisations together around a common aspiration for joint working across the Wokingham system. It will set out a number of shared objectives and principles, and a set of shared governance arrangements allowing organisations to come together to take decisions.
- As a result of a 'deep dive' review to capture our learnings, BCF 03 Step Up/Step Down has split into 2 separate schemes for 2017/18. A Step Up PID has been approved (BCF 03), providing sub-acute care to reduce ED attendance and NEAs. Step Down has been renamed 'Time to Decide' and governance has been absorbed into the WISH team (BCF 02).
- BCF 04 Domiciliary Care Plus Night Responder Service was underperforming; the service was not accessed as frequently as expected. The service was put under review and a decision was taken to cease the service in January 2017.

For this year's plan, we highlight and focus on a number of existing schemes and also refresh a couple of existing schemes. These are explained below, with scheme plans setting out objectives, milestones, performance indicators and scheme level spending plans which are attached at Appendix 1. Each scheme identifies which national metric it will support and the pie chart below shows the split of the national metrics across these key schemes.

Figure 8: Percentage split of national metrics



As part of our 2 year plan, for 2018/19 we will review progress of our 2017/18 BCF plan, enhancing where necessary. Figure 9 shows a breakdown of our schemes and their funding for 2017/18 and 2018/19.

Figure 9 – Wokingham BCF Schemes and Funding 2017/19

Scheme	Scheme Name	Scheme Type (see table below for descriptions)	Source of Funding	2017/18 Expenditure	2018/19 Expenditure	New/ Existing
1	Health and Social Care Hub	2. Care navigation / coordination	CCG Minimum	£16,038	£16,038	Existing
2	WISH1 Wokingham Integrated Social care Health - LA/LA (fund/provide)	11. Intermediate care services	Local Authority	£842,260	£807,680	Existing
2	WISH2 - LA/BHFT (fund/provide)	11. Intermediate care services	Local Authority	£103,740	£138,320	New
2	WISH3 - CCG/LA (fund/provide)	11. Intermediate care services	CCG Minimum	£292,590	£381,669	Existing
2	WISH4 - CCG/BHFT (fund/provide)	11. Intermediate care services	CCG Minimum	£345,655	£345,655	Existing
2	WISH - Time to Assess (Step Down)	11. Intermediate care services	CCG Minimum	£157,744	£157,744	Existing
3	Step Up	11. Intermediate care services	CCG Minimum	£60,800	£120,000	New
8	CHASC Community Health and Social Care	2. Care navigation / coordination	CCG Minimum	£132,395	£150,993	Existing
6	Care Homes	8. Healthcare services to Care Homes	CCG Minimum	£207,106	£207,106	Existing
11	Speech and Language Therapy	16. Other	CCG Minimum	£54,749	£55,986	Existing
11	Care Home in-reach	8. Healthcare services to Care Homes	CCG Minimum	£165,280	£169,015	Existing
11	Community Geriatrician	12. Personalised healthcare at home	CCG Minimum	£143,587	£146,832	Existing
11	Intermediate Care including integrated discharge, discharge to assess services	11. Intermediate care services	CCG Minimum	£686,945	£702,470	Existing
11	Health Hub	2. Care navigation / coordination	CCG Minimum	£314,032	£321,129	Existing
11	Intemediate Care - night sitting, rapid response, reablement and falls	8. Healthcare services to Care Homes	CCG Minimum	£337,791	£345,425	Existing
7	Connected Care	7. Enablers for integration	CCG Minimum	£300,000	£312,000	Existing
12	Street Triage	11. Intermediate care services	CCG Minimum	£23,000	£40,000	New
13	SCAS Falls & Frailty	11. Intermediate care services	CCG Minimum	£35,000	£70,000	New

5.1 Improved Better Care Fund (iBCF)

We received the following iBCF funding for 2017-19. The Department of Communities and Local Government (DCLG) has allocated the following funding:

2017/18	2018/19
£169,000	£112,780

The iBCF has not affected decisions on our budget. It should be noted the funding received is very minimal compared to other local authorities, this is related to Relative Needs Formula as it affects Wokingham. At this level, we will use the monies to further support existing projects to enable higher success in meeting the national targets and we will continue to do this and report at a national level. We will allocate the iBCF according to where improvements can be made or further sustained. Following Q1 and Q2 2017/18, we will review our existing schemes to identify where the iBCF monies will best support the achievement of the BCF metrics. In the main, this will be with the aim to meet B - Reducing pressures on the NHS (including DToC).

5.2 Support to the Care Homes Market

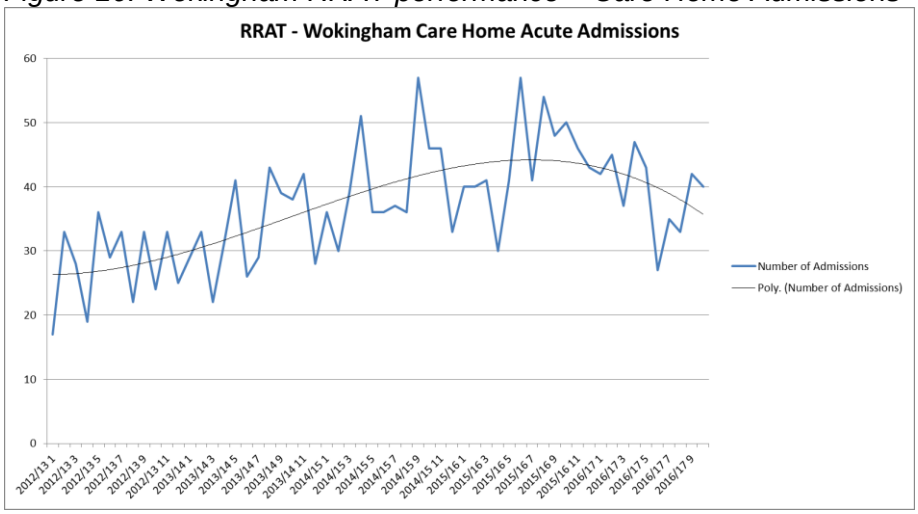
The Care Homes project was established in April 2015 with the aim to provide a consistent approach to improving outcomes for those people living in Nursing and Residential Homes in Berkshire West. The project has the following work streams:

- Rapid Response and Treatment (RRaT) and care home support team - provides 7 days a week, 9am – 7pm treatment via a multidisciplinary team linking in with specialist nurses and therapists and training and education of care home staff.
- Medicines Management - medication reviews of all residents.
- Protocols and Standard.
- Primary Care Provision.
- Quality and Commissioning.

The services offers residents a co-ordinated and joined up health and social care service, reducing unnecessary admissions to hospital, improving the flow of patient from community to acute and back to community and avoiding unnecessary delays in discharges back to the care homes.

The project is showing signs of success; over the last 6 months (M6 to M11) we have demonstrated a 5% reduction in NEAs when compared to M6-M11 15/16 across Berkshire West. Figure 10 below shows our performance locally, with NEAs reducing over time as the service becomes embedded within our borough.

Figure 10: Wokingham RRAT performance – Care Home Admissions



In 2017/18 it will continue to support:

- The Rapid Response team and on-going evaluation of the impact of the service on the delivery of 30% reduction of NEAs.
- A Protocols and Standards process that is supported by all providers focusing on the delivery of quality social and health care and reducing the impact of any necessary interventions outside the care home, in particular length of stay in secondary care.
- A health and social care process for the monitoring of Care Home performance through collaborative working with all providers. Working in partnership to develop a central reporting function that provides comprehensive data on each Care Home, its facilities, specialist competence, staffing skill mix and case reports that share the learning across Berkshire West.

- The Medicines Optimisation Team to ensure medication reviews continue in a timely manner and explore how the team can work more closely/in partnership with the new GP provision to care homes to, increase efficiency.
- The delivery of a new model of GP support to care homes that moves away from the traditional 'reactive' model of care towards a 'proactive 'care model that is centred on the needs of the resident, their families and care home staff.

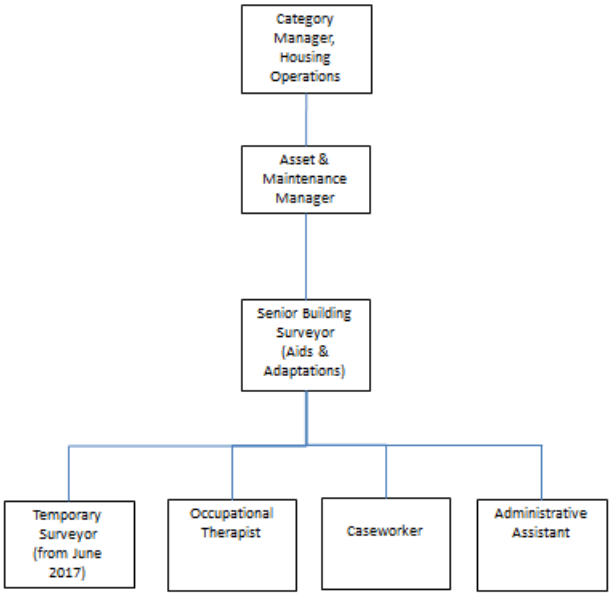
In addition the project will explore the integration of community services and the enhancement of the current provisions to provide clinical support/advice to care homes 24 hours a day, 7 days a week.

5.3 Disabled Facilities Grant

This year's BCF plan aims to see closer working between housing, health and care commissioners and regular liaison meetings and a seat on WISP have been established to evaluate the impact of DFGs and to strengthen the links between DFGs, Community Equipment services and Assistive Technology. This will become a more prominent theme in year 2 of the BCF plan.

WBC's Housing Operations Manager will attend WISP quarterly to present the scheme's use of DFG and pathway for the BCF schemes. The DFG is managed by WBC through the structure shown below:

Figure 11: WBC's DFG Team Hierarchy



In 2016/17:

- A qualified Occupational Therapist now sits alongside the Surveyor within the team to triage requests, prioritising cases which need a quick response, with the best solution.
- A project to refurbish kitchens and bathroom for a sheltered housing scheme has just been completed. Tenants were consulted with directly on how there flat can best meet their needs. This resulted in 12 kitchen and 11 bathroom refurbishments, which will support tenants to stay in their homes and to retain their independence.

In 2017/18:

- We have plans for a 2nd surveyor to minimise waiting time, supporting adaptions required for hospital discharges.
- The team will use learning to for future projects whereby prevention and proactive measures can support people staying in their own homes for longer. There are 2 extra care schemes coming on line later this year.
- The Housing Department have engaged a consultant to review housing needs of the ageing population in Wokingham; this report is due May 2017, the results of which will be used to refresh the Housing Strategy 2015/18.

The CCGs Operating Plan and the Health and Well Being strategy recognise the impact dementia has on health and social care services. A significant proportion of carer's funding is aimed at carer's supporting people with dementia e.g. advice services for YPWD ,Dementia 'Champions' and WBC and the CCG are developing a dementia pathway review from prevention services through to MDT working on those with more advanced dementia.

The DFG is a key opportunity and priority through the coming years to create and enable a strategic approach to use of Assistive Technology as integral to our Adult Social Care health approach and intervention/enabling practice framework.

6. Risk

6.1 A Brief Summary of Risk and Risk Assessment

Our risk register attached in Appendix 9 sets out the key risks affecting BCF plan in 2017/19. WISP has oversight of all scheme risks which are classified by delivery, financial and engagement. They are reviewed in detail on a quarterly basis and if required escalated to other areas charged with governance such as the BW10 Delivery Group dependent on the nature of the risk.

Key risks to both the CCG and WBC will be identified and managed as required under their respective risk management strategies.

6.2 Financial Risk

The existing schemes are investments in long-term services provided in the main by WBC, BHFT and Optalis. Strategic risk of the collapse of one of these providers is therefore assessed as relatively low. Financial risk, therefore, arises primarily from instability within the care home market which may result in increased costs associated with securing care home placements in a "suppliers market" and an associated failure to achieve the required savings targets. These savings targets are challenging and the scale of the challenge when taking into account the state of the care market.

Any further mitigation required if these risks were to crystalize would be agreed in the first instance through WISP, with recommended actions approved through the individual organisation's governance arrangements.

6.3 Risk Share

Our local risk share is based around the approach used in 2016/17 and has been agreed between the CCG and WBC with the risks sat between both parties as commissioners and not with the providers. The risk share is measured on the underlying performance of the individual schemes. Each scheme is reported on a monthly basis including an assessment of risk. This is then consolidated into a single Wokingham Integration Portfolio – Risk Register and reviewed at the monthly WISP meetings by all partners. The key risks are categorised into two sections of high level and low level to provide both strategic level of clarity and completeness.

Locally, financial risk is monitored by WISP and regular meetings with the Senior Responsible Officers. This runs alongside monthly finance meetings of the BW 10 finance sub-group.

Activity performance is monitored for benefits versus spend on a per scheme basis. Where the benefits are forecast to underperform, a financial decision can be taken to mitigate in a timely way. A performance dashboard of Key Performance Indicators is maintained, monitoring the progress against national local metrics of avoidance, saved or reduction. Combined with monthly reporting against budget, with variances flagged for amounts greater than £50k enable the programme to be reviewed.

The baseline NEA in the planning template is a 1.8% reduction on the 2016/17 outturn. Wokingham is fully committed to risk share to incentivise delivery and protect the system. The value of 2017/18 risk share is £477k, a small increase on 2016/17 risk share of £448k. The 2018/19 risk share is £442k. For 2017/18 the NEA will be aggregated and not split per scheme and will be stated in the Section75 agreement.

Figures 12 and 13 show the allocation of risk share across our schemes. The target NEA avoidance activity is mapped to the risk share amount.

Figure 12: Wokingham's allocation of risk share across schemes 2017/18

Scheme	Levels of activity	Average unit rates	NEA Avoidance savings	Weighting	Allocation to Risk Share
WISH - Wokingham Integrated Health & Social Care	184	£1,775	£326,600	11%	£51,391
Step Up	78	£1,775	£137,563	5%	£21,646
CHASC - Community Health and Social Care	166	£1,775	£294,650	10%	£46,364
Care Homes - Rapid Response & Treatment	80	£1,775	£142,000	75%	£357,947
Total	**508**		**£900,813**	**100%**	**£477,347**

Figure 13: Wokingham's allocation of risk share across schemes 2018/19

Scheme	Levels of activity	Average unit rates	NEA Avoidance savings £000's	Weighting	Allocation to Risk Share £000's
WISH - Wokingham Integrated Health and Social Care	184	£1,775	£326,600	5%	£22,122
Step Up	186	£1,775	£330,150	5%	£22,362
CHASC - Community Health and Social Care	332	£1,775	£589,300	8%	£39,916
Care Homes - Rapid Response & Treatment	80	£1,775	£142,000	75%	£357,947
Total	**782**		**£1,388,050**		**£442,347**

6.4 Contingency Funds

We have 2 contingency funds within our plan and are detailed in the table below.

	17/18 £k	2018/19 £k
Wokingham contingency	113	57
CCG contingency	57	47

There is a process through WISP for the allocation of any contingency funds. The WISP partners would review request and through our new Section 75 partnership agreement the funds would be allocated.

7. National Conditions

7.1 National condition 1: jointly agreed plan

This Plan was jointly agreed by WISP on the 6 September 2017. The BCF plan covers the minimum fund specified in the Spending Review and has been through the individual governance structures within commissioning organisations for approval and subsequent approval by the HWB. Health and social care providers evaluated the Wokingham 201616/17 schemes along with other stakeholders agreed the continuation and business cases through WISP. At a more strategic level both main provider trusts have articulated the impact of the BCF in their operating plans.

WISP meetings have acted as a local catalyst to co-develop new programmes, drawing on provider views about local pressures and opportunities to work differently to achieve better outcomes.

Going forward with our BCF plans, we expect that BHFT, RBFT, local GPs, ASC and Involve will all continue to be part of the integration implementation teams. Providers are represented on WISP and are invited to HWB on a regular basis to present information on specific issues.

WBC was awarded £806k of Disabled Facilities Grant (DFG) funding in 2017/18, an increase of £73k (8%) on 2016-17. Within the DFG, an allocation of £82k has been

set aside to support the development and roll out of assistive technology across Wokingham. Appendix 10 - DFG Budget 2017/19 contains further information and detail.

Funding for DFGs is transferred from BCF to WBC Housing where it is managed as capital funding in line with its DFG policy, supporting people to remain independent and living in the community.

7.2 National condition 2: social care maintenance

The 2017/19 BCF plan aims to maintain a consistent level of protection of social care with the BCF funding.

CCG investment of £7.64m in 2016/17 has been increased in line with the NHSE guidance on growth figures of 1.79% to £7.78m in 2017/18, and by a further 1.9% to £7.92m in 2018/19.

Figure 14: 2017-19 Gross Contributions

	2017/18 Gross Contribution	2018/19 Gross Contribution
Total LA contribution exc. iBCF	£1,919,863	£1,973,546
Total iBCF contribution	£169,002	£112,780
Total minimum CCG contribution	£7,777,052	£7,924,816
Total additional CCG contribution	£0	£0
Total BCF pooled budget	**£9,865,918**	**£10,011,142**

The use of this funding covers a range of schemes that will add stability to the local social and health care system, including continued investment into an integrated model of reablement. The existing investment has been reviewed in-year and as part of the two year consultation around jointly commissioned community services.

Wokingham confirms that all partners will continue to meet or exceed contributions agreed via a system-wide approach related to maintaining social care contributions as seen in Figure 15 below. The 2017/19 plan confirms the social care spend from CCG minimum has been uplifted by 1.79%/1.9%, with amounts of £3.66 m/£3.73m for 2017/18 and 2018/19 respectively.

Figure 15: Underlying social care spend schemes

Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	2016/17 Expenditure (£)	2017/18 Expenditure (£)	2018/19 Expenditure (£)	Comments
1	Health and Social Care Hub	2. Care navigation / coordination	2. Single Point of Access		£16,038	£16,038	
2	WISH3- CCG/LA (fund/provide)	11. Intermediate care services	5. Other	£329,000	£292,590	£381,669	HLT, reablement, Rapid, discharge. In 17/18, includes funding Health Liasion Team previously funded by LA. In compliance to NC2.
2	WISH - Time to Assess (Step Down)	11. Intermediate care services	1. Step down	£282,700	£157,744	£157,744	SUSD is split in to Step Down and Step Up
	Domicilliary Plus	Intermediate care services		£76,300			service ceased due to lack of demand
8	CHASC Community Health and Social Care	2. Care navigation / coordination	1. Care coordination		£132,395	£150,993	
21	CCG Carers Fund - LA host	3. Carers services	1. Carer advice and support	£278,000	£195,387	£195,387	Split into two. See below
23	Protection of Adult Social Care	16. Other		£944,000	£960,898	£960,898	
24	Care Act	3. Carers services	2. Implementation of Care Act	£180,639	£183,222	£183,222	
27	Wokingham Contingency - new	16. Other			£68,476	£31,891	
29	IMHA	16. Other			£39,000	£39,000	
30	S256 LA spend	16. Other		£1,506,000	£1,532,957	£1,532,957	
21	Carers Funding - prevention - YPWD+SA	3. Carers services	1. Carer advice and support		£82,613	£82,613	Split away from 11 - CCG Carers Fund
			Total	£3,596,639	£3,661,320	£3,732,413	
					1.80%	*1.94%*	

N.B. Scheme 2 – WISH 3, consists of reablement, rapid response and hospital discharges and Health Liaison Team. WISH 3 has been uplifted the meet National Condition 2 by funding Health Liaison Team £104k which was previously funded by WBC. WBC has agreed to fund an equal amount in BHFT reablement £104k service in WISH2.

The preparation of our BCF plan has been undertaken alongside the planning rounds of both WBC and the CCG and the funding has been aligned to both plans. The approach to planning for the BCF has been consistent with the Department of Health guidance for funding transfers to social care.

Both organisations face increasing cost pressures and savings targets. The schemes within the plan have therefore been identified to specifically address the area of intermediate care services which supports the aim of the plan and will mitigate these key factors.

The protection of social care covers areas of ASC spend which have an indirect impact on prevention such as provision of good quality, fit for purpose, accessible housing, support to the care market, and reablement pathway redesign. Our 2017/19 Plan has built on previous years and continues to invest in schemes which support reablement and step down services. Figure 16 below shows the planned expenditure and percentage of investment by type of scheme.

Figure 16: Social Care spend by type

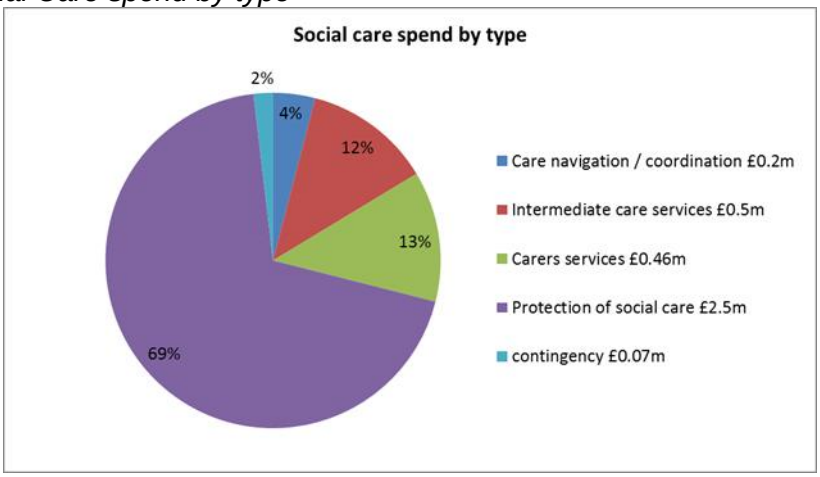


Figure 16 shows that £0.60 m, 25% of the planned social care spends, is from the CCG minimum contribution funds schemes for the integration of health and social care. Funding for Protecting ASC, Care Act duties and S256 has been uplifted by 1.79% in 2017/18. At this time funding for 2018/19 has not been uplifted but will be reviewed during 2017/18 replan with the intention to uplift by at least 1.9%.

7.3 National condition 3: NHS commissioned out-of-hospital services

The CCG minimum allocation for NHS commissioned out-of-hospital services for 2017/18 is £2.21m and for 18/19 is £2.25m, showing that the minimum has been exceeded for both years.

Figure 17 shows how the funding is made up within the plan and the minimum has been exceeded in both years.

Figure 17: Out-of-hospital services scheme funding

Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	2017/18 Expenditure (£)	2018/19 Expenditure (£)
2	WISH4 - Rapid response	11. Intermediate care services	3. Rapid/Crisis Response	£345,655	£345,655
3	Step Up - new scheme	11. Intermediate care services	2. Step up	£60,800	£120,000
40	CCG reablement funds	11. Intermediate care services	4. Reablement/Rehabilitation services	£662,153	£677,118
41	BCF BW10 programme office	7. Enablers for integration	3. Programme management	£110,000	£110,000
42	CCG Contingency	16. Other		£56,853	£47,320
43	Risk Share performance fund	16. Other		£477,347	£442,347
6	Care Homes	8. Healthcare services to Care Homes	2. Other - Physical health/wellbeing	£207,106	£207,106
11	Speech and Language Therapy	16. Other		£54,749	£55,986
11	Care Home in-reach	8. Healthcare services to Care Homes	2. Other - Physical health/wellbeing	£165,280	£169,015
11	Community Geriatrician	12. Personalised healthcare at home	2. Other - Physical health / wellbeing	£143,587	£146,832
11	Intermediate Care including integrated discharge, discharge to assess services	11. Intermediate care services	4. Reablement/Rehabilitation services	£686,945	£702,470
11	Health Hub	2. Care navigation / coordination	2. Single Point of Access	£314,032	£321,129
11	Intemediate Care - night sitting, rapid response, reablement and falls	8. Healthcare services to Care Homes	2. Other - Physical health/wellbeing	£337,791	£345,425
13	SCAS Falls & Frailty	11. Intermediate care services	3. Rapid/Crisis Response	£35,000	£70,000
			Total	£3,657,298	£3,760,404

As outlined in the 2016 BCF submissions for all three local authorities in Berkshire West, we have identified five key NHS commissioned Out of Hospital service investments which sit within the scope of the BCF and it is our intention that these will be carried forward into the 2017/19 plans. These out of hospital services were chosen due to their potential contribution either directly or indirectly to reducing delayed transfers of care, non-elective admissions and supporting effective reablement across the system. For 2017/19 we plan to revise our KPIs where possible for these service lines so as to improve the monitoring against these key performance indicators. We will also continue to review the service lines on a quarterly basis, through the BW10 Delivery Group and to review levels of investment versus impact and make any necessary substitutions or additions with other out of hospital services as part of our integration journey.

The specific services constitute a small proportion of a much wider range of services provided within a block contract held by the Berkshire West CCGs with BHFT, our main community and mental health provider. The specific services are listed in Figure 18 below:

Figure 18: OOH BCF Contribution

OOH Service description	BCF Measure Contribution
Adult Speech & language Therapies	NEAs / Reablement
Care Home In-reach support	NEAs/DToC
Care Of the Elderly (Community Geriatrician Service)	NEAs/DToC/Reablement
'WISH' for Wokingham - Intermediate care (Includes rapid response, night sitting, equipment, integrated discharge team, intermediate care services and reablement	NEAs, DToC
Berkshire Integrated Hub - Single Point of Access	NEAs/DToC/Reablement
DFG	Reablement

During 2016/17 we have reviewed the services above and have identified the importance of each service function in stemming the flow of rising non elective admissions and in particular avoiding care home admissions and ED attendances. Intermediate care, night sitting and reablement have also been significant contributors to help manage delayed transfers of care. The BIH operates as a 24 hour, 7 day a week service.

The key objectives of our services are to:

- Promote independence and improved quality of life for the population of Berkshire West through the delivery of community services to residents in their own homes and in places of residential care.
- Provide support to carers and other health and social care colleagues to facilitate effective care for people with acute and long term health care needs across Berkshire West.
- To contribute to baseline reduction in non-elective admissions, admissions to residential care, DToCs and reablement across Berkshire West.
- Support baseline demand management for urgent care by contributing to the avoidance of ED visits across Berkshire West.

7.4 National Condition 4: Managing Transfers of Care

Our 2017/19 DToC Action Plan, which can be found in **Section10**, sets out our approach to implementing the eight High Impact Changes for Managing Transfers of Care. This plan sets out specific actions which will be collaboratively undertaken by our system partners to deliver each of the eight High Impact Changes, ensuring measured steps are taken to reduce DToC rates within Wokingham. The metrics we submitted to reduce our DToCs are set out at **Section 10**.

The local schemes which support the managing of transfers of care are:

- The Berkshire Integrated Hub.
- WISH – including Step Down.
- Step Up.

In May 2017 the BCF Project leads undertook a self-assessment of the High Impact Change Model, in order to support the development of the DToC action plan, a summary is below:

Figure 19: Wokingham's Self-Assessment against High Impact Model

High Impact Area	Where we are at	Where we are going
Early Discharge Planning	Established	→ Mature
Systems to Monitor Patient Flow	Established	→ Mature
Multi-Disciplinary/Multi Agency Discharge teams	Established	→ Mature
Home first Discharge to Assess	Established	→ Mature
Seven Day Services	Mature	Signs of Exemplary
Trusted Assessors	Plans in Place, working in Partnership	→ Established
Focus on Choice	Established	→ Mature
Enhanced Health in Care Homes	Mature	→ Exemplary

7.4.1 Trusted Assessment

Trusted Assessment is one of the 3 key work streams of the Getting Home project which takes a Berkshire West wide approach. It plans to explore examples of 'Best Practice' used in other areas and then agree a trusted assessment process based on a key worker approach who can undertake health and social care assessments on behalf of multiple teams, using agreed criteria and protocols. The plan is that the inpatient therapists will share their assessments as part of this.

A successful trusted assessor workshop was held in May 2017 with stakeholders across Berkshire West. The focus was to understanding what is meant by a trusted assessor, the operational challenges faced, how to overcome them and what a good trusted assessor approach looks like.

This led to a decision to focus on the reablement pathway. A smaller task and finish group has developed a standard operating procedure, agreed the use of a single referral form and a shared care plan. A scoping exercise is underway and to be completed in September 2017. This will include agreeing a set of targets, who and what is being assessed, agree who can be the trusted assessor, a robust feedback loop and the review mechanism. The group will also explore the option of including the care home element. A pilot will run for 3 months will a provisional start date of October 2017.

In addition to this a small pilot was started in Hurley Ward, RBFT, in June 2017 using the 'discharge to assess' model and the trusted assessor approach. A process was agreed with each locality. The RBFT occupational therapists from Hurley ward being the trusted assessors taking patients home and assessing them in their home with the view to reducing the package of care and freeing up a hospital bed. This pilot will be reviewed at the end of September 2017.

At present within RBFT, an Integrated Discharge Service (IDS) exists to support assessment and discharge. A single IDS referral form has been agreed and signed off, providing a basis for subsequent referrals and assessments reducing duplication.

CHASC plans to link with both Getting Home and Connected Care as it develops a single assessment process across community health, social care and primary care.

8. Overview of funding contributions

Figure 20 sets out the planned contributions for our BCF together with the previous year's figures for comparison. The first four rows are WBC's contribution with the remaining figures being the CCG's investment.

Figure 20: Funding Contributions 2017 - 2019

	2016/17 Gross Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Local Authority Contribution	£1,065,000	£1,070,000	£1,070,000
Carry forward of 16/17 scheme underspend	£101,000	£44,300	£25,000
DFG	£733,000	£805,563	£878,546
Total Local Authority Contribution excl iBCF	£1,899,000	£1,919,863	£1,973,546
iBCF		£169,002	£112,780
Total Minimum CCG Contribution	£7,640,291	£7,777,052	£7,924,816
Total BCF pooled budget	**£9,539,291**	**£9,865,918**	**£10,011,142**

The proposed funding has been included in both the plans and budgets of both WBC and the CCG for the year 2017/19.

The use of the BCF funding is to be agreed by both WBC's Section 151 Officer and the CCG Chief Financial Officer to give transparency on the use of funds for both organisations.

The total funding is shown within the planning template which has been signed off as per the sign off process detailed in **Section 1**.

8.1 Care Act

The BCF will contribute £183k towards WBC's implementation of Care Act. This has been uplifted by 1.79% from 2016/17. At present, 2018/19 has not been uplifted but will be reviewed during the 2017/18 replan with the intention to uplift by at least

1.9%. The funding will contribute towards WBC's costs for implementing Care Act duties.

8.2 Reablement

The existing BHFT contract is uplifted by 3.3% and 2.26%.

Funding for Reablement	16/17	17/18	18/19
- Existing BHFT contract	641	662	677
- Expand BHFT capacity	0	104	138
- Existing START reablement contract	342	347	347
- Expand START capacity		73	146
	983	1186	1308

The WISH team has budgeted an increased spend in reablement in health of £104k/£138k in 2017/18 and 2018/19. This raised an error in the Planning Template of sufficient "Planned Social Care expenditure from the CCG minimum". This could not be funded by the iBCF amounts allocated to Wokingham of £169k/£113k.

To meet the "Planned Social Care expenditure from the CCG minimum", WBC has agreed to fund this from its existing pooled budget. On a bilateral basis, the BCF CCG minimum contribution will fund social care services to the same amount.
The expansion of START capacity is dependent on recruitment. Homecare packages may be substitute to achieve a similar reablement outcome.

8.3 Carer's breaks

The CCG minimum contribution continues to fund £402k into carer support and the voluntary sector. The commissioning arrangements are changed for simplification. Whereas £278k of services were commissioned by WBC, in 2017/18 will be commissioned £195k/£83k by WBC/CCG respectively.

8.4 Social Care

Protection of ASC and S256 spend is increased by 1.79% in 2017/18 and this funding has been confirmed. As per **Section 8.1** 2018/19 funding maintenance will be confirmed during the replan stage.

8.5 iBCF

The iBCF funding has been formally acknowledged and the plan to spend this as outlined in **Section 5.1** has been through formal governance.

8.6 DFG

WBC has agreed with the CCG the use of DFG, which meets the conditions stipulated for its use. It was agreed to spread the funds across a range of schemes for a best outcome:

- Home adaptation £1.3m.
- Assistive technology £83k.
- Joined up approach to improving outcomes across health, social care and housing £35k.

The DFG total consists of £806 new allocation plus £624k carry forward.

	16/17	17/18	18/19
Disabled Facilities Grant	733	806	879
brought forwards	423	624	8
1) home adaptations	497	1304	803
2) use of technologies to support people in their own homes		83	70
3) joined-up approach to improving outcomes across health, social care and housing	35	35	0

9. Programme Governance

9.1 Current Governance

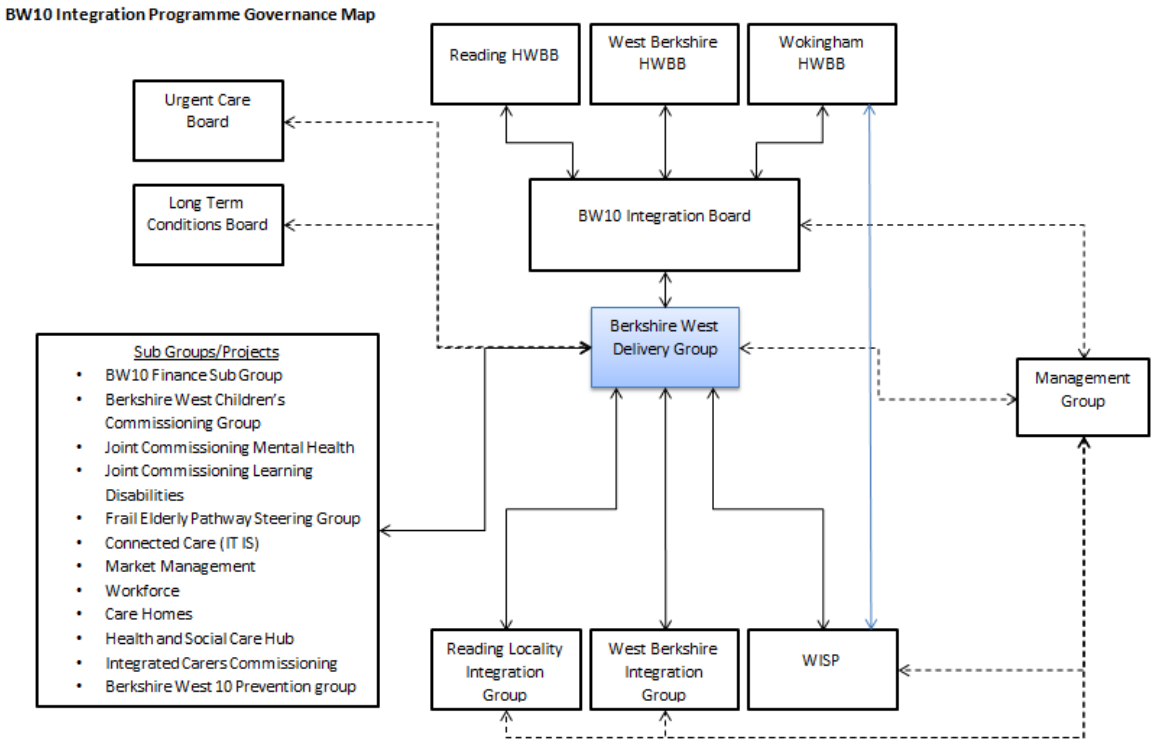
The HWB has a high-level oversight of this BCF plan, governed through WISP and delivered through a local implementation team. WISP specifically looks at bringing together management responsibilities and accountability across health and social care services locally.

The governance and operational structures, which set out the commitment, aims and practical supporting arrangements for joint working, are underpinned by legal agreements as follows:

- S113 agreements allowing managers with joint responsibility employed by either body to perform functions for and be accountable to the other body within an agreed HR framework and within the Schemes of Delegation of each organisation.
- S75 and s10 pooled budget agreements to allow pooling of resources managed by joint commissioners to support integrated commissioning and provision.
- S256 agreements (both nationally required and local) to support expenditure on social care which has a benefit for health services.

Our governance structure and how it is integrated into the wider Berkshire West governance is in Figure 21.

Figure 21: BW10 Governance Structure



Because our local health and social care economy works across unitary authority boundaries, some of our BCF schemes are part of a Berkshire West programme. Therefore governance arrangements are also part of a BW10 Delivery Group and above that the BW10 Integration Board. Both Boards have representatives from each of the partner organisations. The Boards:

- Ensure that the programme delivers its agreed outcomes.
- Route information and decision-making to the appropriate governance structures and HWBs.
- Have oversight of locality integration projects to ensure alignment of Berkshire West-wide projects.
- For these projects, the Board will allocate project resources, receive business cases, receive highlight reports, agree remedial action, and identify and manage risks through a programme risk register.
- Co-produce a system wide organisational development programme in support of the integration programme.
- Balance the demands of this transformation programme alongside the maintenance of ongoing business operations in each organisation.

Senior leaders from the Berkshire West Health and Well-Being boards meet on a monthly basis in the BW10 Integration Board.

9.2 Governance Plans for 2017/19

As we move forward within 2017/18 we plan to our enhance Section 75 agreement to work alongside the Berkshire West ACS with a memorandum of understanding of partnership working between commissioners and providers. The purpose of memorandum aims to strengthen the relationship between commissioners and

providers together around a common aspiration for joint working across the Wokingham system. It will set out a number of shared objectives and principles, and a newly formed governance structure allowing providers to come together to take decisions.

Our proposed enhanced governance seeks to widen the focus of schemes and will draw up our draft expenditure plan for 2017/19 to meet the BCF policy framework March 2017. For example during this year we shall be expanding our plan to incorporate mental health services. All new projects and schemes within BCF go through an Equality Impact Assessment process as part of the development of full business cases. The proposed changes will build on our existing leadership and governance.

More detail can be seen in Appendix 4 - Proposal for Wokingham Adults Integrated Health and Social Care Governance

9. National Metrics

Our BCF schemes support the delivery of the BCF National Metrics. A summary of the impact of the schemes can be seen in Appendix 8 BCF Summary on a Page 2017 -2019.

We also have a wide range of local metrics to ensure balance with the national metrics. Our three key local metrics are:

1. To ensure that we reduce pressure, improve flow in the system and provide better local crisis management we will be monitoring ED attendances for users in Wokingham.
2. To ensure that MDTs are able to support the top 10% of users of services we will be monitoring the number of users reviewed and the impact of the intervention on NEAs, ED attendances and use of out of hours services.
3. To monitor residents ability to manage their own health and well-being we will be monitoring self-reported improvement in their health and wellbeing following contact with Community Navigators.

Our BCF Dashboard in Appendix 5 monitors both the national and local metrics and has been considerably redeveloped in 2016/17.

9.1 Non-elective admissions

We achieved our performance in 2016/17 by integrating health and social care teams (WISH); investing £150k in nurse led rapid response; proactive identification of users with multiple conditions combined with an MDT meeting and highly developed reporting, all of which supported our success. Figures 22 and 23 show our NEA performance.

Figure 22 - 2015/16 vs 2016/17 NEA performance in 75+

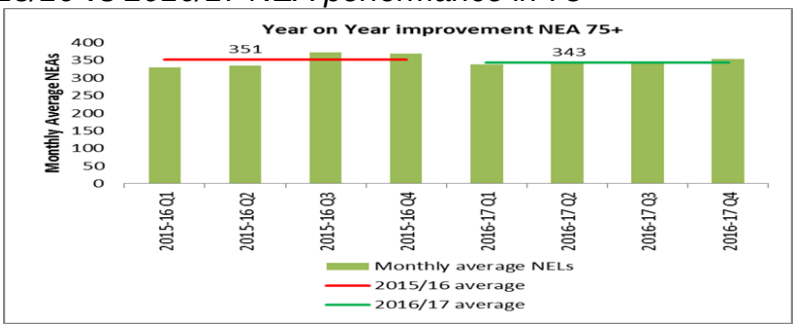
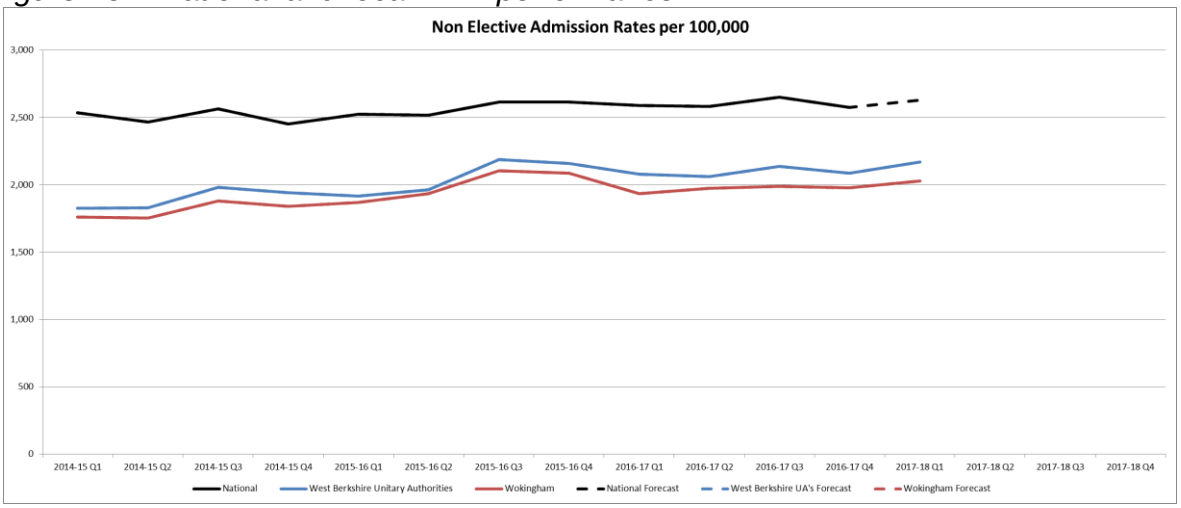


Figure 23 – National and local NEA performance



Our performance over the last 4 years can be seen below and we remain in the upper quartile for NEA performance in England.

Year	Total Wokingham NEAs (general & acute), all-ages	Percentage change in NEAs on previous year
2013/14	10,470	N/A
2014/15	11,586	11%
2015/16	12,940	12%
2016/17	12,845	-1%
2017/18	12,612	-1.8%

The CCG operating plan for NEAs was set following the NHS planning rules and includes IHAM (Indicative Hospital Activity Model) growth including demographic growth and a QIPP reduction with a net reduction of 1.8% against 2016/17 out turn. The net reduction target of 1.8% will be a real challenge considering that we are already a high performing system, therefore reductions in NEAs for 2017/18 are challenging.

Based on analysis of year to date performance, and realistic impact of BCF schemes, we have no additional NEA reductions planned for our BCF plan and we are continuing to investigate the inconsistencies, which appear to be a national issue post submission and we expect to revise our submission accordingly.

2017/18 Quarter 1 NEA performance was 5% greater than Q1 2015/16 and 9% greater than the 2017/18 plan. Our plan is currently set as a reduction of 1.8%, which we already believed to be an extremely ambitious target. CHASC and Step Up will be coming on line in Q3 and Q4 which may support us to improve on our current position. We are currently investigating all the reasons for Q1 performance and if we will be able bring performance in line with the plan.

The following BCF 2017/19 schemes will have an impact on NEAs:

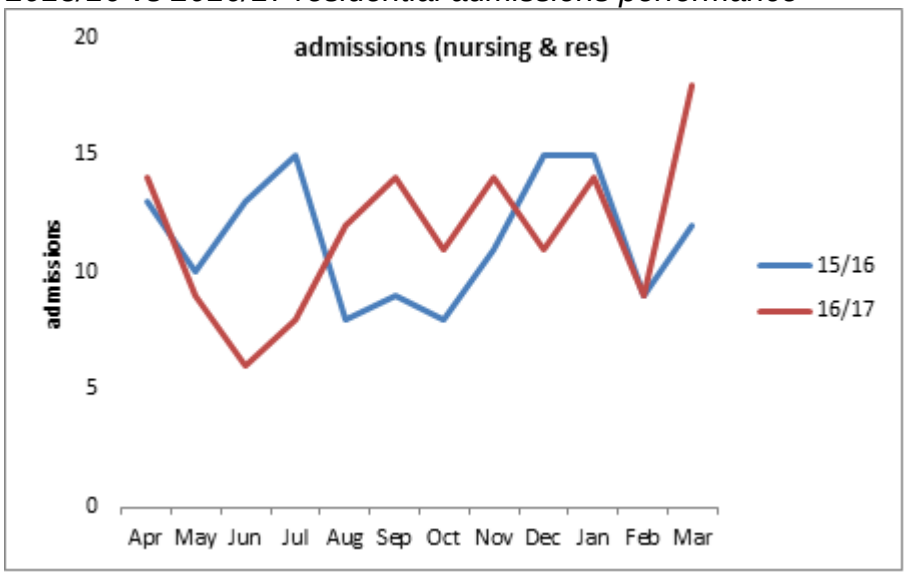
- **WISH** – Rapid response services will have some capacity increases and therefore be more responsive to avoid NEAs.
- **CHASC** – reviewing and scaling our current MDT process to support the top 10% of service users and therefore preventing them from reaching crisis and requiring admission. In 2016/17 we demonstrated a 64% reduction in NEAs for those users who have had an MDT.
- **Step-up** – introducing sub-acute beds in the community setting preventing acute hospital admissions.
- **Falls & Frailty** – This service is both a BCF and QIPP scheme and started as a pilot in October 2015. It involves an advanced paramedic and therapist in a fast response car and has demonstrated excellent outcomes in reducing conveyance rates and thus admission to hospital.
- **Berkshire Integrated Hub –** acts as an enabler reducing NEAs by acting as the single point of access with pathways that ensure that referrals are received in a timely manner and directed to the most appropriate service for need.

The NEA reductions for the above schemes were calculated based on performance in previous years to provide realistic targets for the schemes.

9.2 Admissions to residential care homes

We sustained our performance in 2016/17, with a minimal increase of 2 new admissions than 2015/16. Figure 24 shows our 2016/17 admission trends vs 2015/16, which shows our sustained performance.

Figure 24: 2015/16 vs 2016/17 residential admissions performance



In 2016/17 we have been working hard to keep people in their own homes rather than entering permanent residential placements. Part of this has been through introducing extra care places in the Borough, giving individuals the ability to maintain their independence, through WISH and stay local with support available 24/7 as well as developing Step Down beds.

Our target for 2017/18 is no more than 129 new admissions to residential care homes; this would be 11 less placements than 2016/17. For 2018/19 the target is 131. These targets have been agreed by the operational teams and are based previous year's performance and the plans we have within our schemes for a downward trajectory.

2017/18 first quarter performance is very promising with 26 new to residential and nursing care homes admissions versus a planned target 32. We have to be a little cautious as these numbers do get revised as we get more information from the commissioning teams and care homes.

The following BCF 2017/19 schemes will have an impact on care home admissions:

- **WISH** – Increased capacity with the Reablement service provided by ICT and START enables more people to remain in their own homes for longer, along with the social care team being integrated, providing a more holistic care plan.
- **Step Down** – Delivery as a 'time to decide' model for 2017/18, which has demonstrated in other areas nationally to reduce care home admissions
- **Step Up** – Prevent admissions to the acute hospital with a clear 7 day pathway focussed on reablement.
- **Getting home** - Reduced delays in the wrong setting has a detrimental effect on a person, both physically and mentally, by improving the flow of people through the system, people will be kept in the right place, which maximises independence and reduces the need for long-term care
- **CHASC** - by integrating the long term health and social care teams, social and health care pathways will improve and closer working between them will enable better information for social care assessments therefore brokers can negotiate the most appropriate placements. Earlier intervention in a disease journey will reduce the demand for placements in the longer term.

9.3 Effectiveness of Reablement

There are a number of reasons why we did not improve our performance of the 91 day target in 2016/17:

- Lack of focus on this target.
- Data for this was coming from ASCOF and therefore only the social care reablement data was being captured and not health.
- Ineffective reporting for prior years.

We therefore believe that as we have now resolved the data capture and reporting issues that for 2017/19 we have a target of 74% for 2017/18 and 85% for 2018/19. We have set these targets with the Head of WISH who is certain that once the reporting errors are resolved that the targets are achievable.

2017/18 first quarter performance is not currently available due to some local recording issues that are currently being corrected. We expect to be able to start reporting by October 2017.

The following BCF 2017/19 schemes will have an impact on the effectiveness of reablement:

- **WISH** – Additional funding of £104k for ICT and £73k for START, will make the services more responsive and have increased capacity.
- **Step Down** – The scheme has moved under the management of WISH for 17/18 as part of their suite of reablement services, the right pathways can then be implemented.
- **Step Up** – Focuses on reablement following a sub-acute medical deterioration, and will reduce user's lengths of stay as not in a large acute hospital, which lead to improved reablement outcomes.
- **Getting Home** – Improved flow through the system and avoiding admissions all support the reablement of users in the community.

10. Delayed transfers of care

DToC planning for 2017/18 has been produced in line with the request from NHSE and DOH which requested reduction of delays in terms of average bed days in hospitals.

Figure 25: Wokingham's 2017/18 DToC trajectory

Adult population of **Wokingham**		123,900		
NHS	**Social**	**Both**	**Total/month**	**Total/year**
190	90	40	320	3840
*Using population figure above, 3,840 equates to **8.5** DToC per 100,000*				

Our agreed target for 2017/18 is realistic but ambitious and Figure 26 shows the DToC plan split by organisation.

Figure 26: DToC Trajectory by organisation

Organisation	**Total days delayed (or less) per month**	**Total days delayed (or less) per quarter**
RBFT	173	519
Wokingham Community Hospital	78	234
Mental Health (Prospect Park Hospital)	50	150
FPFT + Other hospitals	19	57
Total	**320**	**960**

The target has been set in this way having given consideration to the delays which WBC is unable to speed up or influence. These continue to account for approximately 70% of our total days delayed, with 38% of this figure being self-funder delays, where the Choice Policy would need to be implemented robustly by the acute and community hospitals to help to reduce this figure. Figures for 2016/17 did not include the mental health delays however these have been included for 2017/18 based on the last year's performance.

In order for RBFT to achieve its target of no more than 3.5% of beds occupied by DToCs, we must have no more than 207 delayed days per month and have set a target of 173 for RBFT, as we believe we can achieve this stretching target with our integrated team.

Our DToC action plan has been developed with all partner agencies across Berkshire West, led by the A&E Delivery Board and is in Figure 27. Governance and oversight of the DToC Action Plan is delivered through a multi-agency WISP which reports back into the A&E Delivery Board, with remedial actions for non-delivery. The DToC metrics agreed have also been shared at the A&E Delivery Board and with each organisation individually.

In Quarter 1 our main aim for DToC's was to sustain our performance. We had a total of 744 delayed days against the plan of 960 and we are delivering against the 3.5% target for the RBFT. We have shared our DToC good practice with the Reading and West Berkshire localities at BW10, to help build a robust approach to DToC across Berkshire West.

We have received minimal iBCF funding which limits further improvement – we can however maximise the current services to manage the DToC delays and ensure that we sustain our current position.

Figure 27 – Wokingham's 2017/18 DToC Action Plan

High Impact Change Area	Action	When
Early discharge planning	• Contract with British Red Cross to support discharge for customers with low level of support network, working jointly with the assessor – **Improve** • Social Worker engagement starts early after admission so that we minimise assessment delays once patient is medically fit - **Sustain**	August 2017
Systems to monitor patient flow	• Having identified customers requiring EMH services where placements can be slow to arrange or become available, by making use of the respite beds for discharge to assess for Social Services funded customers who require EMH residential or return home with high level support - **Improve**	Service level agreement – September 2017
Multi-disciplinary/multi-agency discharge teams (including the voluntary and community sector)	• See Trusted Assessor below - **Sustain** • Project with BHFT – reconciliation of DToC recording, prior to submission to the DoH, have been errors, look to work together to improve accuracy - **Improve**	Review October 2017

Home First/Discharge to Assess	• Work in progress to refine eligibility criteria (in line with the Care Act) and response times with START to achieve 2 hour response to referrals, with service starting promptly to facilitate discharge – **Sustain** • Agreement with extra care schemes to allow tenants to return to their homes following a significant change in need with high level support whilst alternative accommodation is being arranged -**Sustain**	October 2017 June 2017
Seven day services	• Social Worker onsite on Saturday morning - attends the Saturday morning ED meeting for any actions required to prevent an admission. Out of working hours referrals are made directly to Rapid Response to avoid admission – **Sustain**	Review June 2018
Trusted Assessors	• Working with the BW10 Project leads on the Getting Home project to implement Trusted Assessors and MDT working on the acute site	October 2017
Focus on Choice	• An Independent Broker to advise and support self-funding patients. Monitor to ensure sufficient capacity to meet demand – **Sustain** • The Trusts have implemented the Choice Policy - **Sustain** • Work with commissioning and intelligent purchasing to ensure there are sufficient agencies registered with WBC to provide choice - **Sustain**	October 2017 Quarterly capacity review & actioned accordingly
Enhancing health in care homes	• Rapid response and treatment team are working within care homes to support residents to avoid unnecessary admissions into hospital -**Sustain**	April 2017

12. Approval and sign off

The Better Care Fund plan 2017-19 was signed off by the following representatives:

Signed on behalf of Wokingham Clinical Commissioning Group:

Date: 11th September 2017

Dr Cathy Winfield, Chief Operating Officer

Signed on behalf of Wokingham Borough Council:

Date: 11th September 2017

Judith Ramsden, Director of People Services

Signed on behalf of Wokingham Health and Wellbeing Board:

Date: 11th September 2017

Councillor Julian McGhee-Sumner, Chair of Health and Wellbeing Board and Executive Member for Adults' Services

The plan will be ratified by the Wokingham HWB on 12th October 2017 and Wokingham CCG Council on 19th September 2017.

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